Diversified Reporting Services, Inc.

RPTS EUELLJ

HIF175140

EMPOWERED BY DATA:

LEGISLATION TO ADVANCE EQUITY AND PUBLIC HEALTH

THURSDAY, JUNE 24, 2021

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m. via Webex, Hon. Anna Eshoo [chairwoman of the subcommittee], presiding.

Present: Representatives Eshoo, Matsui, Castor, Sarbanes, Welch, Schrader, Cardenas, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Craig, Schrier, Trahan, Fletcher, Pallone (ex officio); Guthrie, Upton, Burgess, Griffith, Bilirakis, Long, Bucshon, Mullin, Hudson, Carter, Dunn, Curtis, Crenshaw, Joyce, and Rodgers (ex officio).

Staff Present: Shana Beavin, Professional Staff Member; Jeff Carroll, Staff Director; Waverly Gordon, General

Counsel; Tiffany Guarascio, Deputy Staff Director; Perry Hamilton, Clerk; Zach Kahan, Deputy Director Outreach and Member Service; Una Lee, Chief Health Counsel; Meghan Mullon, Policy Analyst; Joe Orlando, Policy Analyst; Michael Ovlin, Health Fellow; Tim Robinson, Chief Counsel; Chloe Rodriguez, Clerk; Kylea Rogers, Staff Assistant; Andrew Souvall, Director of Communications, Outreach, and Member Services; Kimberlee Trzeciak, Chief Health Advisor; Alec Aramanda, Minority Professional Staff Member, Health; Sarah Burke, Minority Deputy Staff Director; Theresa Gambo, Minority Financial and Office Administrator; Seth Gold, Minority Professional Staff Member, Health; Grace Graham, Minority Chief Counsel, Health; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Bijan Koohmaraie, Minority Chief Counsel, O&I Chief Counsel; Clare Paoletta, Minority Policy Analyst, Health; Kristin Seum, Minority Counsel, Health; Kristen Shatynski, Minority Professional Staff Member, Health; and Olivia Shields, Minority Communications Director; Michael Taggart, Minority Policy Director; and Everett Winnick, Minority Director of Information Technology.

*Ms. Eshoo. The Subcommittee on Health will now come to order. And due to COVID-19, today's hearing is being held both remotely and in person.

For members and witnesses taking part remotely, microphones will be set on mute to eliminate background noise. Members and witnesses, you will need to unmute your microphone when you wish to speak.

Since members are participating from different locations at today's hearing, recognition of members for questions will be in the order of subcommittee seniority. So keep that in mind.

The documents for the record should be sent to Meghan Mullon at the email address that has been provided to your staff. All documents will be entered into the record at the conclusion of the hearing.

The chair now recognizes herself for five minutes for an opening statement.

Underfunded and under threat. That was the Associated Press and Kaiser Health News indictment of the U.S. public health system, based on their award-winning investigation last year. The investigation found that, since 2010, spending for state public health departments dropped by 16 percent per capita, and spending for local health departments fell by 18 percent. At least 38,000 state and local public health jobs have disappeared since the 2008 recession.

Our hollowed-out public health system explains why we have seen COVID-19 cases tracked using fax machines and COVID-19 vaccines recorded on little, white, paper cards. These antiquated methods are embarrassing for our country that once held a -- had a globally-respected public health system. And our disarrayed data collection has brought our -- consequences for so many Americans. It has allowed racial health disparities to flourish without intervention. And as the common maxim goes, "You can't manage what you can't measure.''

The 13 bills our subcommittee is considering today begin to rebuild our public health systems beyond pen-and-paper data collection and inconsistent definitions. Several of the bills use data to help our health systems improve the overall health and wellness of local populations, rather than treat individual sickness.

I am proud to co-lead, with Representative Peters, the Health Statistics Act, which directs the CDC to develop uniform, public health data standards for state and local health departments.

Put simply, public health data is a mess. A striking example is the incomplete and inconsistent COVID-19 case counts and death tallies, which is addressed by bills authored by Representatives Castor, Speier, and Bera.

Beyond COVID-19, inconsistent public health data have

been raised repeatedly as an issue before this subcommittee in hearings. An example of this is that there is not a single standard for how to define a gun death or maternal death. My legislation with Representative Peters carries out several recommendations from the GAO and the National Academies of Science to make vital health statistics electronically available and comparable.

Robust and accessible public health data is a critical tool for state and local officials in their efforts to address the social determinants of health that perpetuate the inequities in our communities. Representative Barragan's Improving Social Determinants of Health Act builds and complements the Health Statistics Act by authorizing a new CDC program that would use the improved and available health data to address structural challenges, such as unsafe housing, poor transportation, or food deserts.

The remaining bills work together to use public health data to address health disparities starting at conception through childhood, and into adulthood. I am proud that our subcommittee is once again leading the charge in a bipartisan way to promote health equity through evidence-based, data-driven policy.

Taken together, these 13 bills will make real and lasting change to rebuild our public health system so we can address both new health emergencies, like COVID-19, as well

as the systemic issues of poverty and inequality.

[The prepared statement of Ms. Eshoo follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. The chair now is pleased to recognize our ranking member of the subcommittee, Mr. Guthrie, for five minutes --

*Mr. Burgess. Madam Chair? Madam Chair? This is Burgess. I wonder if I could just ask for a point of personal privilege before Mr. Guthrie is recognized.

*Ms. Eshoo. Certainly.

*Mr. Burgess. Several people on this subcommittee are old enough to remember when we had a different subcommittee chair. And it was at that time that I was assisted so ably by my young staff.

Elizabeth Allen is going to be leaving my office now. She has accepted a position at Boston College to get an MBA, and it is quite a step -- needless to say, quite a step up for her.

We have all benefitted from her experience and her knowledge over the time that she has been associated with the Health Subcommittee's work. So I thought, if I could, I would just like to acknowledge the service of Elizabeth Allen, and perhaps we could give her a brief round of applause.

*Ms. Eshoo. Absolutely, thank you.

[Applause.]

*Ms. Eshoo. And we thank her for her wonderful service, and wish her well.

The chair now recognizes the wonderful ranking member of our subcommittee, Mr. Guthrie.

*Mr. Guthrie. Thank you. Thank you, Chair Eshoo, and thanks to Elizabeth. And I always enjoyed working with her, as well.

So thank you for your hard work, and good luck at Boston College.

And thanks for holding this important hearing today.

Before us today we have several bills pertaining to social determinants of health, as well as collecting health data. I look forward to hearing from the witnesses regarding these bills.

As currently defined by the CDC, social determinants of health are conditions and places where people live, learn, work, and play that affect a wide range of quality-of-health and quality-of-life risks and outcomes. I have seen and heard, firsthand, the benefits that Medicare Advantage can do to help address social determinants of health for senior.

For example, a recent study showed that Medicare Advantage plans continue to offer benefits that help Americans with their social determinants of health. Specifically, the study found 27 percent of Medicare Advantage plans offered in-home services; 57 percent offered meal delivery; 57 percent offered transportation services; and 11 percent offered home modification. Additionally, they

found that 94 percent of plans now offer telehealth as a base benefit. These benefits can continue without policy changes or site-of-service restrictions, post-pandemic.

Since 2015 I have led the bipartisan member letter in support of Medicare Advantage. In 2020 we had over 300 Members sign the annual letter to HHS in support of the program. It has been a bipartisan effort, and I want to take this opportunity to thank Representatives Cardenas, Blumenauer, and Kelly for all of their hard work on this letter.

Medicare Advantage has demonstrated how successful private insurance plans can be, if given the proper flexibilities. That is, if my colleagues do not force Medicare for All on all Americans, and take away this choice for nearly 29 million beneficiaries. Nearly half of the eligible Medicare population that is -- is estimated to choose MA for 2022. Medicare for All would prevent Americans from choosing this option that provides quality health care, and supplemental services, and helps address social determinants of health.

Medicare for All will lead to worst-case scenario for seniors, longer wait times, and diminished patient control over their own health care.

Today we are considering several health bills -- health data bills. Useful health data is important, but some of the

bills before us today are too narrow in scope, and are duplicative of current efforts. In addition, it does not seem there is a consensus on what -- who needs to collect what data, how it will be used, and who will have access to it, and how to do that in a way that doesn't add more administrative expense.

COVID-19 shed light on the need for more public health data infrastructure, and we must use lessons learned to prepare for future pandemics, rather than continuing to focus on COVID-19's specific authorities and programs.

For example, H.R. 778 would establish new CDC grants to states that choose to develop and use digital contact tracing technology for COVID-19, which seems duplicative of programs that have already been funded in response to the pandemic. CDC has already received funds to do just that, and we should first evaluate how those funds are being spent.

Additionally, H.R. 791, the Tracking COVID-19 Variants Act, includes provisions that will require the CDC to issue guidance regarding collaborations in data sharing for COVID-19 sequencing, while further enacting a pilot program by expanding existing data linkages. Data sequencing is already being done on variants today.

Further, H.R. 976, the ETHIC Act, would retroactively require states to report specific COVID-19 data to the CDC, as a condition on receiving certain COVID-19 funding.

Currently, states are already required to report some of this data.

I am looking forward to examining and building on ideas like Mr. Curtis's bipartisan legislation, H.R. 3969, which would allow spending on social determinants of health to be included in health insurance plans' medical loss ratio calculation, so to encourage Medicare Advantage and Medicare managed care organizations to take further action to support social determinants of health.

I support Dr. Burgess's bill, the Social Determinants of Health Data Analysis Act, which would require GAO to report on the actions taken by the Secretary of HHS to address social determinants of health.

In closing, I hope we can work in a bipartisan way to improve America's public health infrastructure, so we are better prepared and ready to address the next pandemic. As we continue working, we need to ensure Americans' hard-earned taxpayer dollars are being used efficiently and not on duplicate efforts. I look forward to having a productive discussion today on how to have better healthcare data and address social determinants of health.

[The prepared statement of Mr. Guthrie follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. And I yield back my time.

*Ms. Eshoo. The gentleman yields back. The chair now is pleased to recognize the chairman of the full committee, Mr. Pallone, for his five minutes for an opening statement.

*The Chairman. Thank you, Chairwoman Eshoo.

Throughout the COVID-19 pandemic, Federal, state, and local public health leaders have faced barriers to collecting and discussing the data needed to fully respond to a public health crisis. It is this vital data that provides government officials and health leaders the critical insight needed to develop the best guidance in response to public health crisis. And as a result of these barriers, public health departments at all levels of government have, at times, lacked the information they needed to better understand the significant impacts of the pandemic on our most vulnerable communities.

Unfortunately, the U.S. public health surveillance infrastructure was fragmented and inconsistent long before this COVID pandemic. Insufficient funding, limited resources, inadequate training, combined with differing state and county laws, and non-existent data standardization procedures are several of the many factors that limit public health data.

The slate of bills we are considering today will make targeted improvements across three key areas. First, we will

discuss establishing a uniform Federal strategic action plan, as well as data standards and a data sharing policy. Second, several of the bills we are considering will improve the collection of public health data that reveals the drivers of health inequities. And third, we will discuss proposals to assist states in the creation of a public health data infrastructure necessary to appropriately deploy resources and essential interventions.

I want to commend the chair and the sponsors of these bills for their leadership in advancing policy solutions for some of our country's most pressing health policy concerns.

Public health data is essential to the health of our country. It may not seem very interesting, but it is very important. This data allows us to understand which communities need resources, how many, and when. It allows us to better target health inequities and address them, accordingly. Public health data also gives government and local leaders the ability to make up-stream policy changes, and implement prevention work.

Now, many of the bills we will discuss today also address the importance of better understanding and researching social determinants of health to improve the overall health status of the United States. These bills take steps to eliminate the lingering health inequities that exist and burden some of our most vulnerable communities.

Uniform data collection is imperative to better understanding the inequities in our healthcare system, and to guide real change. To effectively adapt interventions designed to advance health equity, we have to be able to standardize and collect data related to key social conditions. We will hear from the witnesses today about legislation that will help give states the tools they need to design effective interventions to address certain social determinants of health. These interventions will also improve the health and well-being of some of our most vulnerable populations, including by expanding access to evidence-based tobacco cessation treatment through the Medicaid program.

In finding comprehensive solutions to our fragmented public health data is of the utmost importance. With resources that Congress has provided through the COVID-19 relief packages, including the CARES Act and the American Rescue Plan, we know that data modernization is underway, and we must now continue that work to ensure that research labs, providers, and public health departments are working with real-time current data, and have a better understanding of social determinants of health.

So I look forward to hearing from our witnesses and working together with our colleagues on these legislative proposals today.

[The prepared statement of The Chairman follows:]

**********COMMITTEE INSERT**********

*The Chairman. Chairwoman Eshoo, I just want to say to you and the ranking member, you know, we are now -- you know, the pandemic, hopefully, is winding down. But the pandemic showed us that, whether it was the public health infrastructure or the data collection -- you know, I am talking about state labs, the supply chain, so many things that really showed that -- need a lot of work, and didn't work well during the pandemic.

And so I think that -- I just want everyone to know that myself and the members of this committee -- and I know you, in particular, Ms. Eshoo -- we want to get to the bottom of this, and make sure that we are better prepared in the future, for future pandemics. And that is going to mean a lot in terms of, you know, things that maybe don't sound very interesting, but are important, like data collection, like infrastructure for public health, like the state labs, like the supply chain. It is only if we can improve those things that we can be better prepared for future pandemics, and I just want to stress that today.

I don't know how much the media cares about this, but it is very important, it really is, and that is what I wanted to stress.

So thank you, I yield back.

*Ms. Eshoo. -- chairman, and it is exactly why we are bringing these 13 bills forward, and have the outstanding

witnesses that are with us today to give us their opinion, given their background and experience.

The chair now is pleased to recognize the ranking member of the full committee, Congresswoman Cathy McMorris Rodgers, for her five minutes for an opening statement.

*Mrs. Rodgers. Thank you, Madam Chair.

Social and economic conditions have a powerful influence on our health and well-being. Dependable transportation, job security, and access to healthy foods are all factors that make a difference in the prevention and management of many conditions like diabetes, heart disease, and obesity.

Today 9.3 million Americans are currently on the sidelines and out of work. Unemployed individuals are more likely to suffer from illnesses such as high blood pressure, stroke, heart attack, and arthritis. Unemployment leads to worse health outcomes, on average, for all workers, regardless of their baseline measure of health. It is a cycle of despair that must be broken to promote healthier families.

We need to get Americans back to work. People need hope and a purpose. It means more than a job. It is about dignity and the opportunity for a better life. And we are only at the beginning of understanding the impact of the pandemic lockdowns on mental health. This is a crisis. One hospital I talked to said social isolation is the biggest

concern for seniors, not to mention the rise in mental health emergencies that we have seen for our children.

For hope and real results, we should be looking to how the private sector and communities are leading the way for healthier futures. In my district, to help people without transportation, Washington State University partnered with Range Health to purchase a mobile health unit to provide primary care, non-invasive procedures, and preventative screenings for underserved, rural communities. Some ride share apps are also allowing eligible patients to order rides to and from doctors' appointments, often paid for by health insurance companies. Meal delivery service are also helping seniors access nutritional food. And Medicare Advantage offers coverage options for these services.

According to a recent CMS report, 60 percent of Medicare Advantage beneficiaries are enrolled in a plan that offers food assistance. The number of seniors that choose Medicare Advantage plans offering these supplemental benefits like food assistance, housing, pest control tripled between 2020 and 2021. I look forward to listening to and learning more from our witnesses today on how Medicare Advantage flexibilities are helping address social determinants of health in our seniors, and what more that we can do to incentivize the private sector.

In 2021 Medicare Advantage plans covered 26 million

people, which is a little over 40 percent of the entire Medicare population. Seniors from all walks of life are choosing these private-run plans over government-run fee-for-service plans. They are spending less and getting better preventative care because of it.

I am extremely concerned by proposals from my Democrat colleagues that would ban Medicare Advantage plans, and move everyone to a one-size-fits-all, government-run plan. The Federal Government should provide incentives, and enable the private sector to tackle these social determinants in a way that empowers local communities. However, as we look at data policies, we need to be very clear with the American people about who is collecting what data, and how it will be used.

Some of the bills today authorize enormous sums of money before we even have a clear understanding of what the private sector, state, local, and Federal Government is already doing, and what is working. That approach may work in scoring some political points, but it doesn't drive results.

I also have concerns continuing short-sighted, COVID-19-specific legislation. I recently spoke with former CDC director, Dr. Redfield. He said that the big pandemic is yet to come. We don't know that it will be coronavirus, pandemic flu, or something entirely new. We need to be working on preparing data systems and public health for all threats, not just COVID, and take into account where these systems are

after the large investment and lessons learned from COVID-19.

We should be empowering innovative methods that are backed by trust, trusted data, to address social determinants of health. Doctors, hospital, state and local governments, communities groups, and health insurers are leading the way, tackling social determinants of health. We need to enable their continued leadership and success, and remove any arbitrary roadblocks.

[The prepared statement of Mrs. Rodgers follows:]

**********COMMITTEE INSERT**********

*Mrs. Rodgers. I am looking forward to today's discussion, and I yield back.

*Ms. Eshoo. The gentlewoman yields back. I thought I knew just about everything in terms of benefits in Medicare Advantage; I didn't know that pest control was one of them.

The chair would like to remind members that, pursuant to committee rules, all members' written opening statements will be made part of the record.

I now would like to introduce our witnesses.

Dr. Karen DeSalvo is the chief health officer for Google Health. She previously served as the acting assistant secretary for health, and the national coordinator for health information technology at HHS.

Welcome, Dr. DeSalvo, we are thrilled to have you with us.

Dr. Romilla Batra is the chief medical officer for the SCAN Health Plan, which is one of our nation's largest not-for-profit Medicare Advantage plans.

Welcome to you.

Ms. Beth Blauer is the assistant vice provost for public sector innovation, and the data lead for the Johns Hopkins University's Coronavirus Resource Center.

Welcome to you, we look forward to your testimony.

Dr. Faisel Syed is the national director of primary care for ChenMed, which is a fully capitated primary care practice

for seniors. He is also testifying on behalf of the America's Physician Groups.

Welcome to you, and we all look forward to your testimony.

And Dr. Kara Odom Walker, who is the executive vice president and the chief population health officer for the Nemours Children's Health System.

So welcome to each one of you. The entire subcommittee is very grateful that you have agreed to testify.

And Dr. DeSalvo, you have -- you are recognized for five minutes for your testimony, and please unmute.

STATEMENT OF KAREN DESALVO, M.D., M.P.H., M.SC, CHIEF HEALTH OFFICER, GOOGLE HEALTH; ROMILLA BATRA, M.D., M.B.A., CHIEF MEDICAL OFFICER, SCAN HEALTH PLAN; BETH BLAUER, EXECUTIVE DIRECTOR, JOHNS HOPKINS UNIVERSITY CENTERS FOR CIVIC IMPACT; FAISEL SYED, M.D., NATIONAL DIRECTOR OF PRIMARY CARE, CHENMED; AND KARA ODOM WALKER, EXECUTIVE VICE PRESIDENT AND CHIEF POPULATION HEALTH OFFICER, NEMOURS CHILDREN'S HEALTH SYSTEM

STATEMENT OF KAREN DESALVO

*Dr. DeSalvo. Thank you, Chairwoman Eshoo, Ranking Member Guthrie, and distinguished members of the committee. I appreciate the opportunity to appear today. My name is Dr. Karen DeSalvo, and I am a physician and former local and national public health official who has spent my career working at the intersection of clinical care, public health, and digital innovation to improve the conditions in America's most vulnerable communities.

Currently I serve as the chief health officer at Google, and remain engaged in efforts to address the public's health collaboratively, including through my role as co-convener of the National Alliance to Impact the Social Determinants of Health with former HHS Secretary, Michael Leavitt; and as a member of the Robert Wood Johnson Foundation National

Commission to Transform Public Health Data Systems.

Today's hearing takes place at an historic moment, as we chart the road to recovery from the greatest public health emergency in over a century. I applaud the subcommittee for their leadership during the pandemic, and for advancing a bold vision for public health transformation that intersects with data modernization and health equity. The vision recognizes how COVID-19 pulled back the curtain on the structural failings that contribute to inequities in our current public health system: chronic underfunding, obsolete digital infrastructure, and longstanding capacity gaps.

I have seen these shortcomings firsthand. That is why I believe building resilient and equitable public health systems begins with crosscutting solutions, a theory of change that is captured in the Public Health 3.0 framework. I am excited that many of the proposed bills in today's hearing share this ethos, and offer the following recommendations to inform the subcommittee's vital work.

First, while data analytics and IT infrastructure are important, it is imperative that legislation and policymaking focus on the systems that collect, exchange, and act on data, rather than the data itself. Recently-proposed legislation for the Public Health Infrastructure Fund highlights the stable foundation of resources that health departments will need, from infrastructure upgrades to workforce investments

and operational design.

Second, public-private partnerships can maximize the value of data for governmental public health. There are numerous examples of such partnerships during COVID-19. To optimize these beyond the pandemic, we need to develop data infrastructure within public health focused on racial and rural disparities like the ones proposed in the bills today.

Third, achieving equity requires expanding our understanding of what data can be useful. Projects like our Google COVID-19 Search Symptoms Trends show how public health can leverage novel data signals in a privacy-preserving manner to inform research and public health decision-making, such as where to dedicate more resources. In addition, data systems aimed at addressing inequities should integrate sources from the social and human services sectors.

Fourth, data systems need to be built to describe and address inequities, not only at the individual level, but at the system level, too. For example, knowing that kids in a certain neighborhood are unhealthy is just one step. But understanding where kids might not have access to sidewalks and playgrounds could help communities take action.

Fifth and finally, the CDC's data modernization initiative would benefit from incorporating the lessons learned from high tech: the opportunities to do more than rewire the current 20th century public health systems, but to

reimagine it. 21st Century Cures articulated such a vision by advocating the use of open -- standards and FHIR-based application programming interfaces, or APIs, for the health care system. The same can be used for public health.

We should also ensure that states and localities are not rushed in spending the funds, and that they have an appropriately resourced workforce to maximize impact.

In closing, I want to reiterate my thanks for the opportunity to testify and emphasize the critical importance of the topics covered in today's hearing. I look forward to working with the subcommittee on opportunities to strengthen our nation's public health infrastructure to achieve health for all equitably. I look forward to your questions.

[The prepared statement of Dr. DeSalvo follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Thank you very much, Dr. DeSalvo.

Next, Dr. Romilla Batra, you are recognized for your five minutes of testimony.

STATEMENT OF ROMILLA BATRA

*Dr. Batra. Thank you so much. Good morning, Chairwoman Eshoo, Ranking Member Guthrie, and distinguished members of the Health Subcommittee. My name is Romilla Batra. I am a primary care physician and chief medical officer of SCAN Health Plan. Thank you for giving me the opportunity to address how SCAN addresses social determinants of health, what supplemental benefits we provide, and our recommendations. My remarks will briefly cover who we are, how do we serve our members and our communities, and our focus on the older adult population at large.

SCAN stands for Senior Care Action Network. We were founded in 1977, and we are a not-for-profit MA plan. We are mission-based organization, and our mission is keeping seniors healthy and independent. And the true story is it was started by 12 angry seniors who truly believed there was more to health than doctors and medications and nursing homes. They wanted to age in place, and live in their communities. They were the true pioneers who knew why social determinants of health are so important to be fulfilled.

And since then we have taken care of that population. We have provided a special needs plan, and we are the only plan in California to offer a fully integrated, dual eligible special needs plan. We serve about 220,000 beneficiaries in

California, and we have been consistently CMS-ranked a 4.5-star plan, so we are really proud of the quality of care that we provide.

Addressing social determinants of health is really important to improve health outcomes, as these factors represent 70 percent of the drivers affecting a person's overall health status. We see that in studies. We see that also in our data. So our approach to addressing social determinants of health is identifying what the social risks are, stratifying the population so we can match them with programs and benefits, serving our members and clients, measuring the impact, scaling the programs, and, as a not-for-profit organization, running our own community-based organization in the community that serves older adults and their caregivers.

In terms of identification, we have consistently done health risk assessment to gather not only health data, but also social needs data, as well as demographic data. That is race and language, including newly-started sexual orientation and gender identification data. We have data on 90 percent of our population on their race and language, which really helps us serving them better.

In terms of stratifying and serving them, we offer different programs. I would like to quickly highlight one of them. It is a member-to-member program, where we take our

own members, who then are our employees, train them in motivational interviewing. They then engage with our members, help them around social isolation, addressing their social needs, mental health. Last year we were able to reach out to about 10,000 of our members through this program. We had a very high adoption rate of 50 percent, and saw a statistically significant improvement in things like incontinence, falls, physical activity, and social isolation.

On the other extreme, we also have programs like connecting provider to home, where we have a social worker and a community health worker from a community that addresses the needs of the top one percent of our population who have high social burden and high medical burden. A great story of Mr. M, who lived in a mobile home, had a history of falling, did not have access to food, did not have access to resources to pay for his utility bills. A community health worker was going -- was able to stop in, helped with filling out forms for application for Medicare, get assistance from community around utility payments, able to connect them with benefits around food, as well as able to go over the doctor's appointment to help with the DME. Those are the kind of things that make a difference in terms of their health outcomes.

We continue following our data to find where there are unmet needs, and addressing supplemental benefits to address

them. In terms of our supplemental benefits, we are very grateful for the Congress for helping us do the flexibility. Because of the flexibility, we are able to offer multiple benefits. I will highlight one of them. It is called the Return to Home Benefit, which addresses the needs of older adults getting discharged to their home. We provide in-home caregiving, meals, homemaking services, care coordination to pick up that medication, as well as caregiving support.

Finally, my recommendation would be that, as a not-for-profit MA plan with a long history of serving older adults, these are very important needs. We ask that Congress include SDOH such as food insecurity to the criteria for supplemental benefits more broadly than only specific chronic conditions.

Finally, we recommend you consider supporting H.R. 2166, Ensuring Parity in MA and PACE for Audio-Only Telehealth bill. Wi-Fi access became a huge social determinant of health need during the pandemic, and digital divides were huge, so we truly believe this can make a difference.

There is also a Senate companion bill, Ensuring Parity in MA Audio -- for Audio-Only that we would love -- like to recommend.

On behalf of SCAN, thank you for your ongoing commitment to improving the care for older adults. We welcome the opportunity to be a resource to members of this committee, if you can be of service. Thank you again for the honor to

speak before this distinguished committee. Thanks.

[The prepared statement of Dr. Batra follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Thank you. Thank you, Dr. Batra.

I think that it would be really helpful if the witnesses -- because this is a legislative hearing -- and with the extraordinary experience and background that you all have, if you could weave into your comments if you think we are hitting the mark with any one of these bills, any suggestions, critiques, comments about them, I think, would be most helpful to the members of the subcommittee.

Next, Ms. Blauer, it is a pleasure to welcome you again. Thank you. And you are recognized for your five minutes of testimony.

STATEMENT OF BETH BLAUER

*Ms. Blauer. Thank you very much, Chairman Eshoo, Ranking Member Guthrie, and members of the subcommittee. Thank you for inviting me to participate in today's hearing, and for dedicating your time to an examination of the role of data and health outcomes.

My first job in the public sector was nearly two decades ago, when I worked as a juvenile probation officer for the State of Maryland. I left the state after leading an ambitious, cross-government data initiative that was credited with significant outcomes for residents, ranging from market reductions in infant mortality, nation-leading school performance, and record low crime rates. Since 2015 I have led a center at Johns Hopkins University focused on building the capacity of local leaders to use data to improve outcomes. And for the last 17 months I have been the data lead for the Johns Hopkins University Coronavirus Resource Center. I have seen the very best and the very worst of data use.

The bills that are the subject of today's hearings go a long way to realign Federal resources with interventions that are proven, measurable, and focused on ending multi-generational health and well-being disparities.

In the last 18 months, governments at all levels did

something incredibly remarkable. They built data collection efforts, shared data, and made real-time decisions based on near-time data. Never before has the nation endeavored to realize a coordinated effort around data sharing, data-informed decision-making, and collective outcome measurement at such scale. Local and state governments used every possible lever to stall the spread of this disease, including the very difficult decisions of closing businesses and schools.

What has this last year taught us about using data to collectively solve problems? At the Johns Hopkins Coronavirus Resource Center, we became a trusted resource for millions of viewers, worldwide. Over the course of weeks, JHU developed a methodology for scraping public data, and encouraged state and local governments to share their data in standardized ways. JHU data scientists set up an internal governance, and articulated standard collection methods under the guidance of public health and medical experts. We openly shared the entire process with the public.

By January 2021 we had accrued more than a billion views. Our audience included news outlets, local governments, and everyday people that were making deeply personal decisions about how they would navigate their public lives. The backdrop to our entire pandemic experience was and continues to be a hunger for sound, publicly-available

data.

This Congress has an opportunity to capitalize on the public demand for data, the financial investments we have already made in data infrastructure, and the newly-minted analytic skill that has emerged across government during COVID-19, and improve upon the systems to provide accountability, accessibility, consistency, equity, and sustainability. But there are some lessons that I can offer that have been helpful over the course of my public-sector career.

First, we need data standards. The first instinct when you consider strengthening a data practice is to think about IT modernization or tools. But the truth is, one of the most important elements of a strong data practice is actually in the governance and the alignment of creating a common language, and rules around how and why data is collected and applied to problem solving. This will not be solved by one agency. This is an interagency dilemma that requires a centralized administrative focus.

Second, we must invest in better demographic data collection. State and Federal demographic data does not align. Inconsistencies and categorization between states, and even within states, make data incomparable, and can obfuscate the disproportionate effects that the pandemic -- and, in reality, all programs -- targeted, entrenched social

determinants of health have had on people of color. Without standards there is no way to analyze available data to locate vulnerable populations, and appropriately intervene.

Finally, whenever possible, we must make data public. While I applaud that many of these bills require data collection in a manner that is anonymized, disaggregated, and stratified, they do not at all provide a plan for public dissemination. These data will be high quality, high resolution, and in high demand.

Government will not be able to turn the tide on social determinants of health alone. It will require deep coordination and public engagement in the most intimate of ways. Our centers at JHU continue to work to build the capacity of local leaders to use more data as they examine their practice, and architect on-the-ground strategies to deliver better outcomes for people. But they need the support of our partners within the Federal Government to have the greatest impact.

I am so thankful to be included in the hearing today, and I look forward to fielding any questions. Thank you.

[The prepared statement of Ms. Blauer follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Well, we are very thankful to you. Your testimony was highly instructive.

Next it is a pleasure to once again welcome and thank Dr. Faisel Syed for -- and you are now recognized for your five minutes of testimony.

STATEMENT OF FAISEL SYED

*Dr. Syed. Thank you, Chairwoman Eshoo, Ranking Member Guthrie, and members of the subcommittee. I am Dr. Faisel Syed, and I am honored to testify on behalf of America's Physician Groups.

APG is a national professional organization that represents over 300 physician groups and 195,000 physicians who provide care to nearly 45 million patients. APG member organizations share a vision to transition from a fee-for-service system to a value-based system, where physician groups are accountable for the cost and quality of care.

I always wanted to be a doctor. I was appalled that people died because they had no access to medical care. I joined one of the largest FQHCs in the country because they treated everyone the same, regardless of their ability to pay. Today I am the national director of primary care for ChenMed. We are a fully capitated primary care practice for senior citizens. But I am also a son. And today's hearing is about my dad.

Dad was an inventor, but then he got sick: heart disease, diabetes, chronic low back pain, and memory loss. Dad saw five specialists, but not a PCP. None of them spoke with each other. Dad was taking pills for side effects from other pills. I convinced him to sign up for a Medicare

Advantage plan, where a PCP would coordinate his care. Today Dad's heart function is normal. His diabetes is under control. His back pain and memory loss are gone, and he is on very few meds. So when we talk about Medicare Advantage, I think about Dad and people in this country like him, who are older and medically complex.

My patients are over 70 years old, suffer from 5 or more chronic medical conditions, and live on fixed incomes. These people fought in wars, and marched for civil rights. Today they are some of the most underserved in America.

We claim to have the world's best health care system, and if you have money, the care you get is remarkable. But the color of your skin, the balance in your bank account, and the diploma hanging on your wall have more to do with staying healthy than pathophysiology. We cannot improve health care for everyone if the access to health care or healthy lifestyles are beyond someone's means. Low-income and minority populations in the United States don't live as long as more affluent Americans. There are zip codes in New Orleans where life expectancy is only 54 years old. In more affluent zip codes a few miles away, life expectancy is close to 80.

Medicare Advantage is the great equalizer, and plays an instrumental role in the transformation of our nation's health care system. It rewards physicians who participate in

high-risk contracts for the value of their services. The Medicare Advantage value-based payment arrangement creates three distinct advantages: a team-based primary care delivery system; incentives for delivering primary care in the right setting; and a holistic approach that addresses the patient's mental health, behavioral health, and home environment needs. Medicare Advantage acknowledges that 70 percent of medical outcomes are based on patient lifestyle.

I can offer tailored solutions to people with food and housing insecurities, health literacy, and transportation issues. Because we are fully capitated, I can focus on prevention and early intervention. I invest the time it takes to build trust and influence patient behavior. Thanks to Medicare Advantage, I can offer exercise classes to patients who are afraid to take a walk through their neighborhoods, on-site medication pick-up to patients who have no way to get to a pharmacy, social services to help patients eat healthier. And I can see patients as often as needed to prevent little problems from becoming big ones.

I had a patient once who was an uncontrolled diabetic. He refused to take insulin. Medicare Advantage gave me the time to get to know him. He told me about living on a fixed income, and not having enough money to buy groceries. I earned his trust. He drank six to nine sodas every day. I made a deal with him. I wouldn't bug him about the insulin

if he cut back on the soda. I suggested he drink seltzer with artificial sweetener. It turns out he liked the fizz more than the soda. Within a few months we got his blood sugar under control without a single shot of insulin. That is the beauty of Medicare Advantage.

At ChenMed we practice a high-touch preventative model. Our patients have 35 percent fewer emergency room visits and 51 percent fewer hospitalizations than the average Medicare beneficiary. We did a survey, and 94 percent of our patients said they were highly satisfied with the care they received. Our model fulfills the promise of Medicare Advantage, and restores the sacred doctor-patient relationship. Let's prioritize what is working, and make it better. Thank you.

[The prepared statement of Dr. Syed follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Thank you, Doctor. Maybe it will come up during the questions from members, but I want to remind the witnesses that this hearing is about public health agencies in the country. It is wonderful to hear about how wonderful Medicare Advantage is, but we have 13 bills that we are examining in this legislative hearing today, so I hope that those that are not speaking to those, that your experience will be probed by members as to what is before us, and that is the 13 bills that we are examining today, to see if we are on the mark or off the mark, and if we can do better, and what is missing, and all of that.

So it is a pleasure to recognize Dr. Kara Odom Walker, and you are recognized for your five minutes of testimony. And thank you again for being willing to be a witness.

STATEMENT OF KARA ODOM WALKER

*Dr. Walker. Thank you so much. Good morning, everyone, and Chairwoman Eshoo, Chairman Pallone, Ranking Members McMorris Rodgers and Guthrie, and distinguished members of the committee. My name is Dr. Kara Odom Walker, and I am executive vice president and chief population health officer at Nemours Children's Health, and I am honored to testify to get -- today, and hope to speak to some of those questions.

Nemours is one of the nation's largest and -- pediatric health systems, including two freestanding children's hospitals and a network of nearly 80 primary and specialty care practices across 5 states. We seek to transform the health of children by adopting a holistic health model that utilizes innovative, safe, and high-quality care, while also caring for the health of the whole child beyond medicine.

Decades of research demonstrate that substantially reducing disparities require a multi-generational approach, starting in the early years of a child's life, and with the help of the mother. We know that children who live in the most economically disadvantaged counties in America die at rates up to five times those of their peers in the -- and are three times more likely to lack regular access to healthy food -- times more likely to drop out of high school.

If effectively implemented, and designed in consultation with those they intend to serve, numerous policy approaches can substantially reduce disparities and improve health. Nemours is appreciative that the subcommittee is considering legislation to advance these aims.

Nemours supports the Caring for Social Determinants of Health Act, and commends Congresswoman Lisa Blunt Rochester and Congressman Gus Bilirakis for introducing this bill. It would require the Secretary of Health and Human Services to update guidance to state health officials regarding strategies to address social determinants of health in Medicaid and CHIP. This bill would ensure that, as new bright spots and approaches emerge, they are disseminated to states to spread what works.

Nemours also appreciates the subcommittee's consideration of the Quit Because of COVID-19 Act introduced by Congresswoman Lisa Blunt Rochester and Congressman Brian Fitzpatrick. This bill would expand coverage of comprehensive tobacco cessation services for individuals -- Medicaid and CHIP. One of the many benefits of increased access to cessation services and decreased tobacco use is the potential for reduced secondhand smoke exposure in infants and children. This would also help address disparities. Despite similar or lower smoking rates compared to other racial and ethnic groups, African Americans have the highest

rates of tobacco-related cancer, and are more likely to die from the disease. As a family physician, I am strongly supportive of H.R. 2125.

Nemours also supports the Improving Social Determinants of Health Act and the Social Determinants Accelerator Act, which would invest in Federal, state, local, and organizational capacity to address the social determinants of health. One social factor of particular importance to the health of children is the health of their mother, which is why Nemours supports the Data to Save Moms Act and the Social Determinants for Moms Act. We believe these bills are a very important step in addressing maternal health outcomes.

Another important opportunity relates to data sharing across sectors. In my prior role as the secretary of health and social services in Delaware, I saw firsthand that, with the right data and technology systems, it was possible to better identify high-risk populations, reveal where disparities exist, and implement targeted interventions at the individual and population level.

We are seeing pockets of innovation across the country, and making exciting progress in Delaware -- the Delaware integrated data system in order to integrate data across multiple agencies that provide services to families. We in Delaware are launching a screening tool to help identify special needs, partnering with Delaware 211, and creating a

central resource.

To catalyze and spread this needed innovation, Nemours supports the LINC to Address Social Needs Act, which would also support public-private partnerships to develop or enhance integrated, cross-sector solutions. We believe that -- for delivery and payment models, and you have heard a bit about how that can happen. So pairing with work to advance and incentivize valuable payment and delivery models can incentivize health.

The COVID-19 pandemic laid bare the inequities that exist across so many domains. Out of this historic challenge is an opportunity to rethink the way we deliver health care, starting with pediatrics. We encourage the subcommittee to build on this tremendous legislative work stemming from today's hearing to facilitate and incentivize -- and family health models -- the data. We look forward to continuing to work with you to advance equity, and help create the healthiest generations of children.

[The prepared statement of Dr. Walker follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Thank you very much for your testimony, Dr. Walker.

We will now move to member questions, and the chair recognizes herself for five minutes.

To Dr. DeSalvo, you were the health commissioner of the City of New Orleans. Describe for us, please, the public health data that was available to you in that position. How old was it? How was it collected? Was there the ability to share with other community-based organizations?

And also, describe the ideal for public health data for local health officers. Would it be real-time? Would it be accessible? Would it be shareable?

And any comments, recommendations, critiques you have of the bills that are being considered today?

*Dr. DeSalvo. Thank you, Congresswoman. Yes, I had the great honor of serving the people of New Orleans. It was at a time when data systems were even more nascent than they are now. And we had to do a lot of work to just understand what was on the minds of the people in our community, through coffees in community centers or in church halls. And it was an inefficient and incomplete way to really understand the health of our community.

I had to do that kind of work, in addition to the quantitative data I had, because, to your question, a lot of the data and information local health officers even have now

is stale, old, a couple of years, often. So I am -- I was looking in the rearview mirror, and didn't have a good sense of what was happening in the now for my community, much less how to forecast what might be happening in the future.

There were -- when you are a local health officer, you also have this sense, Congresswoman, that you are swimming in data all around you, but you don't have access, because it is in silos, whether that is in electronic health records or in -- even public health data systems. And it isn't designed or built to be interoperable and give you the answers that you need about inequities, for example.

So the ideal systems are really ones that are, by design, thinking about data harmonization, and the committee is looking at some bills like H.R. 2503 that talk about the important need to, by design, build open standards that are interoperable so all these systems talk to each other.

We have good standards that we can draw from that we began to build for the health care system. So a different use, it is in public health, but basically it is a way to measure things like blood pressure consistently, and record that.

The same thing for an important public health challenge like maternal mortality, which you mentioned.

So we have to be able to have a standard way that communities can collect and then act on the data.

I would say the other important component of the data systems is to feel more comfortable using novel signals. This is the imperative in the 21st century. And there is work that, for example, using information on public sentiment or, in our case, we have made available a search symptoms trends data that can give information about what is on the community's minds. And the way I used to go into the church hall and talk to folks, it is another way to get more quantitative information that is anonymized and private to augment other data systems. And it is more timely, actionable, granular than the kind of data that most public health has right now.

*Ms. Eshoo. That is fascinating. Let me ask Ms. Blauer and Dr. DeSalvo. In both of your written testimonies you say that hospital data is some of the most reliable data.

And Dr. DeSalvo, I was especially struck by your point that hospital records are what enabled health officials to sound the alarm about the Flint water crisis. So my question is why is hospital data so reliable, and how can we make this data more widely available to local health departments?

I am assuming that there isn't interoperability between the public agency and the hospitals.

*Dr. DeSalvo. Congresswoman, in the HITECH Act we invested resources to digitize health care. So now we have relatively reliable data in the health care systems that we

have already shown can be used for public health crises like identifying Flint. There is a system in New York City that can identify chronic disease. And in Massachusetts there are also systems that can look for communicable disease outbreaks.

So -- but there are some examples where we know that that data is helpful in identifying public health challenges. The reality is, also, that in HITECH public health wasn't resourced to be able to receive that data and anonymize it and make use of it in the way that Dr. Blauer has, for example, in some of the work that she has done to create dashboards that really -- they can be useful to the community and to the country. So it is an untapped resource that -- but there are some great examples.

I might even call out Oklahoma, another state that has been using EHR data to look for public health challenges. But it needs to be scaled. We need to do more to make sure that those systems are interoperable. And this is an historic opportunity in the bills that you have before you to begin to move in that direction, to really think about designing with a standardized approach, and being able to make that information useful, not just for individuals, but also for the public's health.

*Ms. Eshoo. Yes, most helpful, most helpful. Thank you.

The chair now recognizes our wonderful ranking member, Mr. Guthrie, for your five minutes to question.

*Mr. Guthrie. Thank you, Madam Chair. I appreciate that. I appreciate the recognition.

Actually, if you look at Mr. Curtis's bill, he is looking at changing the medical loss ratio to incentivize spending on social determinants of health, such as Medicare Advantage plans do, and I think Medicaid managed care does, as well. And Dr. Burgess's bill looks at collecting data on social determinants of health so that we can use this information.

I think what Medicare Advantage does is important in order to lay out what private health insurance plans, if they had the flexibility, would do. And I have a couple of questions.

One, Dr. Batra and Dr. Syed, if you could address this -- you know, and I know the reality of it, but one of the criticisms, which I think is inaccurate, is that, if you have Medicare Advantage plans, they cherry-pick -- you cherry-pick who is in your plan. And therefore, obviously, if you are a health insurance company, you would, if you could cherry-pick, pick healthy and not people with other conditions. But it is quite the opposite, with the flexibility incentives that Medicare Advantage has, and I think, Dr. Syed, you talked about that in your testimony, and Dr. Batra.

So you talk about -- just kind of re-emphasize, given the flexibility you have in Medicare Advantage plans to spend money on social determinants of health, one, that you are bringing in people that are -- that have chronic conditions, that are sick. And not only are you bringing them into your program, but you are giving them far better services than they get in the Medicare fee-for-service plans. Could you address that, one, that the criticism of cherry-picking, if you do, which I don't think that you do, and the other one is how your plans are structured that are so much better for people with chronic conditions, like Mr. Curtis's bill is trying to allow health insurance companies to do with their medical loss ratio flexibility.

So, Dr. Batra, if you would, go first.

*Dr. Batra. Sure. So we serve about 15,000 duals, you know, so that tells you, out of a 220,000 population, 15,000 are on a fully-integrated dual eligible special needs plan.

We also serve folks who are low-income subsidy folks. We serve folks who are in social vulnerability index four and five. So we serve all throughout the population.

If you look at the social HRA that I spoke about, about 10 to 15 percent of our people have indicated, when we do their initial HRAs, that they have food insecure (sic). We have two or three percent of people who say they are housing insecure, many people who say -- who are transportation

insecure. So they are people from all backgrounds.

In terms of how we address their needs, it is through our supplemental benefits. We offer in-home benefits that include meals. We have a third of our population that complains of living alone and falling. We have benefits, where we send up occupational therapists in their homes, so they can help with safety, and be able to mobilize better within their own home setting.

So those are two very high-level examples. Transportation is a big issue if you are an older adult, especially during the pandemic, when you wanted to get vaccinated, you wanted to have access to that ride that would take you to where you needed to get the vaccine. That is the other benefit that we bring across.

Ninety percent of our membership, more or less, use medication, and 90 percent of that membership takes a zero dollar medication. So that is what we also bring, is that affordability to them, so they can really -- you know, and those are the people who can use that benefit. So we do serve people from all walks of life.

*Mr. Guthrie. Thank you.

And Dr. Syed?

[Pause.]

*Dr. Syed. Thank you.

*Mr. Guthrie. If you would like to address it -- okay,

thanks.

*Dr. Syed. Yes. ChenMed goes where the need is. And my biggest challenge, ever since I completed residency training, has always been access. And I have learned with Medicare Advantage that Medicare Advantage opens the door. I mean, I am able to give my patients and their families my cell phone number. They call me if they are feeling, like my wife likes to say -- a little icky. And if I need help getting a patient to stick to a treatment plan, I am able to call the kids and grandkids for backup.

My team texts my patients daily about health, simple messages like reminding them to get a flu shot, or staying hydrated on a hot summer day. We even call our patients weekly. We call them love calls. Even if our patients feel good, they make them feel better, just by saying hello. And I am able to see my patients at least on a monthly basis. This is how we are able to prevent little problems from becoming big ones.

I -- food -- when I think about the social determinants, I think about food insecurity and --

*Mr. Guthrie. Unfortunately, I only have about 18 seconds left.

*Dr. Syed. Oh, sure, sorry.

*Mr. Guthrie. So I apologize.

*Dr. Syed. Sure, sorry.

*Mr. Guthrie. I just wanted to kind of summarize and tie this to the legislative hearing that -- H.R. 976, giving private insurance plans flexibility within their medical loss ratio, will allow other plans like Medicare Advantage to social determinants of health spending that are important to the health care, even though it may not be directly to -- through their healthcare spending, but the things that matter on people being healthy. And that is why I think this is an important discussion.

So thank you very much. And I appreciate it, and I yield back my time.

*Ms. Eshoo. The gentleman yields back. The chair now recognizes the chairman of the full committee, Mr. Pallone, for your five minutes of questions.

*The Chairman. Thank you, Chairman Eshoo, and thanks to the witnesses for being with us.

As we know, robust public health data plays a critical role in improving public health. And I wanted to start with Dr. DeSalvo.

You have worked firsthand both in the Federal Government and in industry on improving the collection and sharing of health data, and know well how these investments can help improve health outcomes. For example, you played a leading role in implementation of the HITECH Act. In your testimony you noted that CDC's data modernization initiative would

benefit from the lessons of HITECH. So let me ask you, can you discuss, Doctor, further what lessons learned from HITECH should be incorporated into the policies that we are considering to improve public health data collection, if you will?

*Dr. DeSalvo. Thank you, Congressman. It is an important opportunity for the country to, of course, recognize that we have created a digital infrastructure for health care. On the other hand, we now are about to embark on something like that for the public health infrastructure. And I do very much appreciate your comments that this could be boring for some people, but it is vitally important to the health of our communities.

The specific areas where I think the country learned some lessons from the implementation of HITECH include, first, around data and standards. That means, as we design the system going forward, what we should reflect on is that, rather than allowing each information technology system to develop its own proprietary standards, its own special way of doing things, we should create an open opportunity where there is shared standards. There is already -- we don't have to invent many of those. There is organizations called standards bodies that are already working with the CDC and public health officials around the country to identify and clarify which standards we can use as the foundation, so the

building blocks all talk to each other, and we start with interoperability as the base case.

The second is to make certain that we are thinking about the uses. What is the end that we have in mind? And, as the committee is articulating in a number of the bills, equity has to be a part of how we design this system. Yes, we need the system to be able to identify infectious diseases, and track on communicable disease for communities, but we also need to do that in a way that allows us to know where the resources need to be applied most. So building into that design, understanding of what are data systems that have to tell the story around equity, or around important public health challenges like maternal mortality.

The last thing I would say is timing. We pushed out the funding for HITECH, and the system stood up. There was some training for workforce, but it delayed a little bit behind when the systems were actually up and running. And I think what we all know is that it takes humans, it takes people to not only work those systems, but to interpret the data and the public health -- for the public's health, and work with community organizations to put it to good use to make change on the ground.

So we have to make certain that our workforce efforts are not only focused on COVID, but thinking more broadly about the infrastructure of public health, and how to make

that a durable, longstanding opportunity to make good use of the data to improve health and equity in communities.

*The Chairman. Let me ask about resources, because, you know, Congress has provided funding for public health data and modernization in the CARES Act and Rescue Plan appropriations. But these were one-time investments. And you said that health departments need stable resources.

So the LIFT America Act, which was introduced by Energy and Commerce Democrats, has this core public health infrastructure program to help fund public health needs such as facilities or equipment upgrades, workforce capacity, health info systems. Can you just comment on this program?

In your view, what further steps should the Federal Government be taking to help improve public health data collection?

*Dr. DeSalvo. Well, I -- Congressman, I first want to just say thank you to Congress for recognizing how important the issue is. The public health community, of which I am a member, really is appreciative of the opportunity to meet the needs of the public.

However, I think you are raising the important point, that it -- data doesn't happen in isolation, it requires a system, which means we not only need to have strong data systems upgrades initially, but they have to be durable and sustainable, so that the health departments can refresh the

computers they have, or the -- refresh the IT security systems that they have over time. So it is an ongoing commitment that they would need to make, to make sure they can meet the population's needs.

They also need workforce, they need partnerships, they need basic infrastructure to keep the lights on every day. I mean, it is really -- would be hard to explain for many people in America how under-resourced and challenged many health departments in America are. I used to say, when I was health commissioner, we do our work with two nickels and some friends, and we are really thankful for a lot of our friends.

This is an opportunity in this pandemic, a learning moment, that we have a critical infrastructure that has been struggling to meet the needs of the population's health, is ready to do more. And I think, through partnership, we certainly can think about investing in the whole system, not just the data systems. But I think we are on a good path, as a country.

*The Chairman. All right. Thank you so much.

Thank you, Madam Chair.

*Ms. Eshoo. The gentleman yields back. The chair is now pleased to recognize the ranking member of the full committee, Mrs. McMorris Rodgers.

You have five minutes for your questions.

*Mrs. Rodgers. Thank you, Madam Chair.

Dr. Syed, we are talking a lot about the need for more data. I wanted to ask, based upon your experience working at a FQHC, and at ChenMed, can you just further elaborate on the role of the doctor-patient relationship in addressing social determinants of health?

*Dr. Syed. Thank you. It is so important for doctors to know about every emergency room visit. I was shocked when -- during my time at the FQHC, that half of all medical care in the City of Tampa was delivered in the emergency room setting, and then even further shocked, when I joined ChenMed, that in the United States, at least pre-COVID, half of all medical care was delivered in the emergency room setting. So doctors must know about every emergency room visit. They must know about things like when a patient doesn't fill their prescription refill. They must know about every referral when the patients are being referred to specialists.

It is so important for doctors to also understand the costs of health care. You know, doctors should be more concerned about the medical complexity of their patient, rather than the medical complexity of the charting, which, unfortunately, is what we see in the fee-for-service healthcare system.

*Mrs. Rodgers. Thank you.

Dr. Batra, on Capitol Hill right now there is a number

of Members, Democrats, that have been promoting the Medicare for All proposal. And the effect of Medicare for All would be to ban private health insurance plans, including Medicare Advantage plans.

When you look at who is leading the way right now in addressing social determinants of health, it is really private -- it is the private sector -- by the work that SCAN is doing. I wanted to ask, are there specific programs that you would like to highlight, as far as the success that could be implemented by employer or individual health insurance plans?

*Dr. Batra. Absolutely. Thank you for giving me the opportunity. I think one of the programs that I highlighted, I -- we call it the peer-to-peer program, and I think that has played a key role for us.

I absolutely agree with Dr. Syed, physicians are busy, physicians really want to build that trust, but we also know that trust can be built with peers. So we have been utilizing our own members to engage with members in a way they can relate to in the way they can empathize, in the way that they can understand around barriers that are big for this older adult population: social isolation, 30 percent of our members tell us they feel lonely all the times or more than half the time.

Similarly, around incontinence and falls, so our peer-

to-peer program, which extends the reach of the physician team, has been able to do that. So I think that is a very key program.

The other program I would quickly like to highlight is our community health worker program. If we truly want to address health outcomes in an equitable manner, we need to recruit people from the community that have the trust of the community, that can build on the trust of the community, that can not only help them navigate this very complex healthcare system for our members, but also be able to connect them to community-based resources if they are not available, let's say, with an MA plan, in terms of benefits and programs.

We have a very successful program we just published in a very well-reputed Journal of Geriatric Society. And that is exactly what that program does, is it takes the physician's care plan, and makes the care plan really happen where the patient wants it, in their home setting, in the community setting, versus in the ER, in the hospital.

*Mrs. Rodgers. Thank you. Thank you.

Dr. DeSalvo, the CDC has received over $1 billion from COVID relief packages to update, modernize public health infrastructure at the state, local, and Federal level. I wanted to ask, what are the metrics that you would recommend that we use to determine whether or not those dollars are being spent wisely and driving results?

*Dr. DeSalvo. Congresswoman, thank you for the question. And I think we can learn a lot from what has already worked on the ground. I will begin there.

In states like Washington State, particularly a community like Spokane, that has a lot of historic work that it has done in partnership with community to address the public's health -- it was one of our Public Health 3.0 communities that I visited when I was in the administration, and learned from -- and what you learn from that is begin with the end in mind.

And as a country, if we want to address inequities in top public health issues, there are bills before us today, for example, about maternal mortality and the disparities in it for Black women, in particular. We could begin with what -- we call that -- and then work backwards, and say -- then we need data that is going to inform actions at the community level to drive change.

I will particularly call out, though, I think the importance of what was asked for in the data modernization initiative by Congress, and that was for CDC to develop a strategic plan, and because that will be essential to have clarity about what needs to happen by when, and by whom. Those are the use cases. And then, rather than just collecting data for data's sake, it must be done with the intention of improving the public's health, going forward.

So a strategic plan, led by CDC, which is called for.

And I think, in addition, I would just call out Congressman Burgess's bill to think about what is already happening at HHS, and this opportunity to do an assessment inside of the government of what are the levers that could be used. Once we understand from the data the challenges that need to be solved, how can we act on that to improve health equitably and address social determinants, because there are many -- probably already underway, and it would be good to not be duplicative, but to make sure that we are being as efficient as possible, because the public is counting on it.

*Ms. Eshoo. The gentlewoman's time --

*Mrs. Rodgers. Thank you all.

I yield back.

*Ms. Eshoo. -- has expired. It is a pleasure to recognize the gentlewoman from California, Ms. Matsui, for your five minutes of questions.

*Ms. Matsui. Thank you very much, Madam Chair, and I -- this is a terribly important hearing we have today with much legislation.

You know, last week we examined the importance of increasing vaccinations to improve public health. And I would ask the witnessed how we can help providers and public health systems modernize Immunization Information Systems to help support this goal.

And may I say this? Public health is so important. Public health involves the whole community. It involves people who don't have access easily to health systems. And I really feel -- I have got a huge health system in my district, four major hospital systems. I really -- I also have a great string of community health centers, too. And I really have a wonderful public health center, too. But I must say this, that we have not funded public health in the way we should be. And I think every time we get some sort of pandemic, or some sort of crisis, we go back again and say, well, this is what we should have been doing. We can't do that any longer.

So I really feel hearings like this are so important because, you know, we look at the social determinants data, and that exacerbates health disparities. And the bills today we are examining can provide a range of solutions to capture these central data that is important to ensure that people don't fall through the cracks as they did this time, as we promote health and mitigate disparities beyond health care, including access to healthy food, education, housing, and transportation.

So I am really interested in exploring how we can strengthen public health reporting by leveraging both clinical and public health data. And a lot of this data is not just in the health arena, either; it is in schools and

education systems. It is in -- just as somebody said before, just listening to people, encouraging conversation. Those kinds of data is really important to actually understand fully what is happening.

Ms. Blauer, you highlighted the need for robust data collection, and reporting systems at the local and state levels. And this on-the-ground expertise is really important. So as we build out our health data utility infrastructure, how can we coordinate more on the state-level health information exchanges and other clinical data sources?

I know there is a lot of conversation that goes on with our community health centers and the public health area, but how can we facilitate this even more, so that it goes up -- so that we can actually capture the data, understand what is happening throughout, not only the state itself, but throughout the regions?

Ms. Blauer?

*Ms. Blauer. Thank you, Congresswoman, for the question.

There are -- one of the things I have learned in my experience in the public service is that there are some of the most important thinkers and subject matter experts across the board in government. We have some of the smartest thinkers, but we need to invest in the skills of subject matter experts to actually use data to solve hard problems.

So there is one part where -- we need to start investing in the capacity of people who are actually charged with leading programs on how they can use data.

The health information exchanges are also incredibly rich resources that exist that have great data and great data skills, but there is a disconnect between the exchanges and those people on the ground who are responsible for delivering programs. And so we need to start thinking about how can we build the capacity so that we are scoping our problems, that we are thinking about our problems in a way that elicit the right kinds of data responses, and that we have the skills to actually take that data and apply it to solutioning.

*Ms. Matsui. Okay, well, thank you.

Dr. DeSalvo, we are talking about structural racism here. It is a public health crisis. And I thank you for drawing attention to this in your testimony. This was a huge issue after Hurricane Katrina. And 15 years later, what has the COVID pandemic revealed about the structural racism in the digital infrastructure?

*Dr. DeSalvo. Thank you for raising the issue. It has been such an important conversation in the pandemic. But as you say, it is not a new conversation in many circles. We saw it very clearly after Hurricane Katrina. I saw it, personally, as I was on the streets delivering care to people, that where you live matters so much.

It was described by another witness, a 25-year gap in life expectancy in New Orleans, a whole generation, based upon where people live. And where people live is not just about a choice, it is also about structural systems that cause redlining and other factors that make a difference in the access you have to food, and education, and economic opportunity.

It has really motivated many of us in public health to focus on this as a public health issue. In fact, in a recent National Academy of Medicine report I had the chance to co-author with Bob Hughes from Missouri, we talked specifically about how, coming out of the pandemic, equity and racism will have to be priorities for public health, and that the data systems that are built will have to be capable of providing information not only about individuals and how their health is different, predicated on things like the color of their skin, or race and ethnicity, but also, what are the structural systems supporting them? What are the school food programs? What is the access to sidewalks, so kids can walk to school?

So it is a double-layer system, not just -- that looks at people, but also at the context in which they live.

*Ms. Matsui. So thank you very much. I have gone way over my time. And thank you very much for your testimony.

And thank you, Madam Chair, and I yield back.

*Ms. Eshoo. he gentlewoman yields back. It is a pleasure to recognize the gentleman from Michigan, Mr. Upton, for your five minutes of questions.

*Mr. Upton. Well, thank you, Madam Chair. Thanks for this hearing today.

The ability to access and use information is certainly critical to many aspects of health care and health system operations. And the further embrace of real-world data and evidence, including SDOH data, can all help improve the facets on health care.

The 21st Century Cures Act included provisions to improve data sharing through reforms to the statute created by the HITECH Act that established the Office of the National Coordinator, ONC. However, as we know, this issue is bigger than ONC. How we use the data today is negatively impacted by a number of things, including how we regulate data use, or how capable the agencies of HHS are using the data well.

Representative DeGette and I released a discussion draft earlier this week that we are calling Cures 2.0 to help solve some of the issues that we are discussing. I would like to focus on two of those provisions.

Ms. Blauer, section 304 of Cures 2.0, entitled "Increasing Use of RWE'' builds on FDA's efforts by requiring HHS to outline approaches to maximize and expand the use of RWE, and establish a task force to develop recommendations on

ways to encourage patients to engage in RW (sic) data generation. So as we consider ways to improve data access and use -- in use for many in health, how important is the patient participation in data access for the FDA or other healthcare operations?

*Ms. Blauer. Thank you, sir, for your question.

So I want to start by saying that I think a lot about resident engagement and patient engagement in data across the board. I think we need to be incredibly comprehensive as we think about how we reflect the realities of life in a way that we collect data, and patient information is at the center of that consideration.

So we have to, obviously, make sure that we include all of the protections and the privacy and advocacy that is required to keep people's personal information safe, and make sure that they are informed significantly in order for the safe collection of that qualitative contribution to data collection, but also to really understand why it is important to have individual information as part of a consideration for data collection.

*Mr. Upton. Thank you.

Dr. Walker and DeSalvo, my staff over the years has communicated with CMS and other agencies about the current capabilities of their computer systems. Generally speaking, the feedback has not been terrific.

One provision of Cures 2.0 would begin the process of Congress working with HHS to update CMS and other computer systems with the goal of helping these agencies use the data better. So as we consider the bills before us today, I am curious to your thoughts on whether improving CMS data capabilities through modern computing approaches can help support our goals.

[Pause.]

*Dr. Walker. Thank you. I will go first, and I really appreciate the opportunity.

From a state perspective, we certainly would appreciate having additional support for CMS to update systems, to allow for us to work together as states try to engage and leverage data that is available. I think, as we learn more about the impacts of social determinants of health, there are models that can test how we support payment strategies and delivery system innovation.

For example, the CMMI's Integrated Care for Kids model and the maternal opioid use model, as well as other programs like Medicaid waivers, really allow you to look at how you are investing in the earliest years of life. But the challenge is understanding what is working, and you need data to do that programmatic evaluation and assessment.

We know, at Nemours, as we try to deploy value-based services and new types of care delivery, we absolutely need

opportunities to work with CMS to develop demonstration models to invest in the data and really figure out how to implement value-based care.

*Dr. DeSalvo. I will just maybe add a related issue, if I could, Congressman, which is to -- first of all, I am not an expert in the CMS data systems, though my appreciation is that they are in need of some upgrade. And I think, as Dr. Odom Walker is describing, that opportunity there has to do with making sure that we can meet the needs of the population's health, using data that can support value-based care models, or global health models.

But I particularly wanted to call out that in Cures 1 there was a push towards open APIs, FHIR-based systems, which I know you and your team are familiar with, those same models can be applied to public health. And as we think about modernizing the public health data infrastructure, and because of 21st Century Cures, there has been a movement in the field with public health and the digital world to create that kind of an interoperable system, so we don't repeat any of the mistakes the country made with HITECH. So thank you for that direction envisioning.

*Ms. Eshoo. The gentleman's time has expired, and I thank him.

It is a pleasure to recognize the gentlewoman from Florida, Ms. Castor, for your five minutes.

And I want to remind members that questions are being -- those that are -- I am sorry. We are calling on members in the order of subcommittee seniority, okay? Just as a reminder.

Ms. Castor, you are on.

*Ms. Castor. Right. Thank you very much, Madam Chair. Thank you for calling this very important hearing, and thank you for including my bill with Congresswoman Underwood, the Ensuring Transparent, Honest Information on COVID Act, the ETHIC Act.

Colleagues, this committee, Democrats and Republicans, have really shined the light on the lack of transparency and the consistency around COVID-19 data during the pandemic. And I think there are three main issues: one, many local communities and states did not have the modern data reporting systems in place; two, there was a troubling pattern in a number of places of withholding COVID-19 data, censoring of data, whether it is nursing home infections and deaths, or overall mortality rates, or testing, very serious issues there; and then three, of course, we don't have the Democrat -- demographic data we need on health disparities, and we are -- we have to do better on that.

Communities, businesses, public health experts need this consistent and transparent health information to help keep families safe, and to implement effective measures, and do it

efficiently.

So through the bipartisan -- as Chairman Pallone said, through the bipartisan emergency relief packages, this committee really helped direct huge new investments in -- to update data reporting at the CDC. But we are going to need to provide additional direction. And in addition to the bills that get to it through standards, which is very important, the ETHIC Act also will do this through transparency and data reporting.

One, it will require states, local communities, tribal and territorial governments to report COVID-19 data, including demographic information to the CDC; and two, make sure that it is all reported up to the public.

And then, two, we are going to -- we need to tap the expertise of the National Academy of Sciences Engineering and Medicine to review the current system, and provide us with additional recommendations on public health data, infrastructure, and reporting.

So for Ms. Blauer, thank you so much for your long time and very important work to improve health outcomes using data, but especially for your work and that of Johns Hopkins, the Coronavirus Resource Center, over the last year. In your testimony you say that consistency across states is going to be vitally important. You highlight the ETHIC Act -- thank you very much -- but can you also talk about how -- what do

you see that we need to do to ensure dependable, transparent data for the public, for communities, for businesses going forward?

What else do we need to be doing?

*Ms. Blauer. Thank you, Congressman, for the question. I can say with great authority that there is a hunger at the state and local levels for standards, for this common language that actually can help guide the way that we collect and think about data across our states and our cities.

We had, over the course of our managing the Coronavirus Resource Center, daily calls with mayors, with governors, with people from local communities, from health departments that were seeking advice on how they should collect this data, how they should express this data to the public, how they should be thinking about letting this data support their decision-making, and they were searching for support and validation of their approaches.

So, again, while the systems that collected this data were often shoestring operations in some cases, started with manual collections that did mature over time, I think the reality is that these organizations across the board in state and local communities were really seeking that kind of high-level validation that what they were collecting and how they were using this data was the right path forward.

And they also wanted to be able to look at their

neighbors and say, "I see that you are having better experience in managing this part of the pandemic. I want to learn from you.'' And with -- in the absence of those standards and that common language, it became very difficult to do apples-to-apples comparison across the geographies.

And so the role of Federal Government here could really be let's create that common language, let's provide those standards, and then let's provide the support for the state and local communities who are going to be navigating these health challenges in a way that they can learn from each other, they can learn from their wins, they can learn from their failures, but then they can also think really critically about how they are applying that data to the policy levers that have been so critical to the way we have navigated the pandemic. Thank you again.

*Ms. Castor. Thank you very much.

And I yield back.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Virginia, Mr. Griffith.

*Mr. Griffith. Thank you very much, Madam Chair. I am very happy to follow Congresswoman Castor talking about ensuring transparent, honest information on COVID-19.

Ms. DeSalvo, it is being reported that there are financial ties between Google and EcoHealth Alliance, a

company that was collaborating with the Wuhan Institute of Virology to conduct bat coronavirus and other virus research. As donors to EcoHealth Alliance, do you support its lack of cooperation with my request and the requests of other members of this committee, as we seek information about the origins of COVID-19?

*Dr. DeSalvo. I appreciate the question, Congressman. I don't have all the details of that report, but I believe the reporting has been inaccurate. The one-off grants that were received by that researcher were years ago, and pre-date the pandemic. So my appreciation is they are not related.

*Mr. Griffith. Well, and they certainly pre-date the pandemic, as far as the base research. But the data indicates that there was a 2010 study on that bat flaviviruses that was listed as being supported by Google. There is also a 2014 study on -- if I am pronouncing it correct -- henipavirus, which infects fruit bats and micro bats. And that was in -- on the spillover. And then a 2018 EcoHealth Alliance paper entitled, "Serologic and Behavioral Risk Survey of Workers with Wildlife Contact in China.'' That was made possible with the contributions of Google.

So it is -- it clearly pre-dates the coronavirus outbreak, but this research has been going on for over a decade. And the real question is, does Google support or condemn EcoHealth Alliance that they donate to?

Do they support or condemn the stonewalling of Members of Congress who are trying to get information about what happened with COVID-19, and what the origins really are, whether it was a wet market situation, or was it a lab leak?

*Dr. DeSalvo. With respect to the -- to this particular investigator, or set of investigators, as I said, I haven't seen the reports, and I am not intimately familiar with the work.

What I can submit to you is that we will work with you and your office, and come back with answers that you may have, and see that we have the right people who have more intimate knowledge of the situation.

*Mr. Griffith. And I appreciate that. I would also appreciate any conversations, emails, et cetera, that Google may have had from EcoHealth Alliance that may have indicated to them information about COVID-19, since you all were involved in earlier studies related to bat viruses that Mr. Daszak of EcoHealth Alliance was one of the authors of saying that this was clearly coming from wet markets and from bats, and you all were involved in that. Any conversations you all might have had in 2019, 2020, or 2021 regarding that, if you could get me that information, that would be greatly appreciated. And can you commit to working with us to get that information?

*Dr. DeSalvo. I certainly commit to working with you

all, and I will have the right people follow up with your office.

*Mr. Griffith. I appreciate that greatly. You know, it is important that, as we talk about having an honest and transparent discussion about these items, that we move forward working together. And is Google prepared -- because it has been criticized in the past for failing to demonstrate a commitment to fostering open debate on scientific issues such as this -- is Google prepared to commit to such an open debate?

*Dr. DeSalvo. I tell you, Congressman, I very much appreciate you asking that, because, as a physician, the debate about the medical treatments, and origins, and even the diagnosis of COVID has been a rich and complex environment for the past year-and-a-half, and not only for the medical community and the public health community, but the community at large has been involved in trying to understand, as we learn on the journey, what works, what doesn't work, how should we be protecting people in communities, how should we treat our patients in the hospital or at home.

So as that information has evolved, we have relied on trusted authorities like the CDC or the World Health Organization outside of the U.S. to provide authoritative content, so we can lean on the group of scientists that build

consensus statements from those authoritative groups. And then we use that to inform policies that we apply to information, not only to raise up important quality information that we want people to have, people -- to protect themselves and their families, but also --

*Mr. Griffith. Yes, ma'am.

*Dr. DeSalvo. -- harmful misinformation.

*Mr. Griffith. And I appreciate that. And I think we should go forward working together. And I hope that Google will have an open policy on scientific discussion, because the EcoHealth president has recently been taken off of or left the WHO study, and it is now becoming clear that they are somehow involved. We don't know exactly how, because they are stonewalling us. And all we want here are answers to the American people.

I yield back.

*Ms. Eshoo. The gentleman yields back. It is a pleasure to recognize the gentleman from Vermont, Mr. Welch, for his five minutes of questions.

*Mr. Welch. Thank you very much. I want to thank all the witnesses for being here. And I want to bring up Congresswoman Bustos's Social Determinants Accelerator Act, and I am a cosponsor, and it is really important in Vermont.

In -- the Vermont housing needs assessment in 2020 showed that more than 19,000 Vermont households face housing

quality issues. It includes homes with coal or limited heating sources, 40-year-old mobile homes, incomplete plumbing, and so on. And unfortunately, too many Vermonters do live in these conditions.

Dr. Walker, you mentioned the Social Determinants Accelerator Act in your testimony. And the bill, as you know, would create a program at CMS to provide grants to state and local governments to develop plans to combat social determinants of health that are resulting in negative health outcomes. The -- are you aware of any cities or states who have developed a strong model to improve housing and health outcomes at the same time?

*Dr. Walker. Thank you, Congressman. I think there are a variety of examples that are critically important, not only around housing, but also around non-medical transportation, home-delivered meals, and educational services. And some states have incorporated waivers into their Medicaid program. I think a few examples exist, including North Carolina, where they are incorporating this into their value-based payment. Maryland is certainly implementing a program to support individuals with developmental disabilities. And there are others -- Minnesota's waiver that looks at the provision of housing stabilization for individuals who are at risk for homelessness.

I think using these examples and innovations are

helpful. They also allow us to invest in families with long-term impacts on the health and wellness and mental health and well-being of children and adolescents. And so having these examples is helpful, but encouraging it across our nation could be a tremendous health impact.

*Mr. Welch. Thank you, Dr. Walker.

And Dr. DeSalvo, you also discussed the need to address social determinants of health, housing being one of them. How can investment in updated health data systems, including the use of qualitative data, which you mentioned, help improve public health, and build up our communities suffering from systemic health inequalities?

*Dr. DeSalvo. Thank you, Congressman, for the question, and I will answer it. I do want to first give a shout-out to Vermont, who has done some great work, particularly for populations with substance use disorder, in understanding how to blend and grade resources to address social determinants of health, including housing -- housing being, for people, probably the most important social determinant of health. We saw that firsthand after Katrina, and we see that every day in communities. So I also appreciate you raising a really important foundational structure for individuals.

Two particular points. One is that data is -- has to be timely, actionable, and granular. It has to be not only quantitative, because you need anonymous population-level

information that you can map to direct intervention, but you also need the voice of community. Some of the bills today include that concept, that there have to be community advisory voices, particularly those bills -- the bill about maternal child health.

But that is true in every context. And that can be done manually, if you will, human to human, and that is important. It can be augmented by additional data sources. I mentioned information that Google has made available to public health on the open repository, including search symptoms trends. Again, this is anonymized data that is at the population level that could be useful to augment that important data that public health needs to take action.

Final point, these bills, many of them speak to this idea of community collaboration and partnership. I think you will find threads throughout many of the successful projects in communities that it is really about everyone coming together to create the conditions for health, not any one sector alone. So public health with business, faith-based and others.

I will just -- for your information, and for your staff, particularly, the NASDOH, the National Alliance for the Social Determinants of Health, has a report on their website that talks about some great examples across the country, and a playbook for how communities can do this, including what

the data needs might be.

*Mr. Welch. Thank you very much.

Madam Chair, I yield back.

*Ms. Eshoo. The gentleman yields back. The chair is now pleased to recognize Dr. Bucshon from Indiana for your five minutes of questions.

*Mr. Bucshon. Thank you, Madam Chairwoman, and thank you for having this hearing. This is really important.

Social determinants of health are critical in today's health care system to improving health outcomes, and better understanding why social situations that people in our society are in actually have a substantial effect on their ability to lead healthy lives and to get good outcomes.

But it is a very complicated subject. I have worked on -- a lot on maternal mortality and maternal health. And, you know, we have had testimony from physicians from Parkland Hospital in Dallas, for example, which -- that is a public hospital for the underserved, and many of their patients are on Medicaid, and their health outcomes were outstanding as it relates to maternal health. And then we heard testimony from other areas of the country that also service underprivileged and primarily Medicaid patients, where their data wasn't quite as good.

So we really need to know why this is, and why that -- and I think part of that is because Parkland Hospital has

data-driven protocols to how they take care of patients, at least in the maternal health. But this is also across our health care system.

It is all about innovation, I think, in health care. Innovation and better-collected data help promote a more value-based system that, in my view, helps lead to better outcomes, because we are able to determine why the outcomes are poor in one area that serves a similar population, but outstanding in another area of our society.

One area I want to focus on was the provider's role in gathering and collecting of data. As we know, doctor burnout is at an all-time high. Most of the time, the main reason, in my view, for this is due to the burdensome paperwork and duplicative administrative tasks that a lot of physicians don't feel they signed up for. They want to take care of people. All of this has doctors spending more time doing paperwork and less time with their patients. While I think data is important and should be incentivized, I am cautious not to put more of a burden on doctors and other providers who already need more time with their patients.

In that vein, Dr. Syed, it is my understanding that there are existing ICD-10 codes for social determinants of health that most doctors aren't collecting at the moment. In order to properly advance social determinants of health policies, someone will have to be responsible for reporting

the data collected. In your experience, who is responsible for collecting the data needed for better social determinants of health?

And whose responsibility would it be if some of these bills considered today would become law?

*Dr. Syed. Thank you. In my past life at the -- in the FQHC world, it was in the fee-for-service system. It wasn't in a value-based system like I am currently in with Medicare Advantage. So I was forced to focus on sick care. I have always felt like I was two steps behind. I remember I was always reacting to problems that were already out of control. See, in the Medicare Advantage environment, practicing preventive medicine keeps all of us -- not only the doctors, the nurses, all of our care team members -- many steps ahead. And that is when you are able to notice the small changes before they really become the big ones.

So it should be the primary care doctor being at the center of the care delivery system.

*Mr. Bucshon. Yes, well, I appreciate that, and I think, you know, that does add some administrative burden. But I do agree that there has to be someone -- the primary care doctor, you know, is kind of the captain of the ship. And so I just want to make sure whatever we do doesn't unnecessarily burden providers.

And so I want to talk a little bit more about your

experience with -- in Medicare Advantage. Why do you think it is more of the -- that more of the Federal Government and state governments are so hesitant to embrace the existing approach that gives plans and providers a risk-adjusted amount of money that lets them decide which social determinate interventions need to take place without adding more burden-inducing reporting and box checking?

Because what you just described sounds better to me than maybe the system that you had experience with before.

*Dr. Syed. Well, sure. I mean, all of us got into medicine to help people. None of us thought that we would be getting into health care and spend hours every day focused about the documentation required for reimbursement.

So what I would like to see is, really, more education about Medicare Advantage, because our current system is based on sick care, rather than primary care. You see, with the Medicare Advantage model, it puts the primary care doctors at the very center of the entire care delivery system. You see, then the doctor has the time to look into the causes of the causes, and then you get to know the patients better than any other random doctor.

I think what you mentioned about the choice, patients should be able to go to any doctor they want whenever they want. And it sounds great in theory, but when your health is on the line, you really want a referral from the doctor who

knows you the best, the one that you trust the most. And with the Medicare Advantage world, yes, I just want to say that that it gives me the time to establish the trust with my patients, and make the same referrals I would for my mom or my dad.

*Ms. Eshoo. I hate to interrupt --

*Mr. Bucshon. Thank you for that information, and I yield back.

*Ms. Eshoo. Thank you. Thank you very much, Doctor. It is a pleasure to recognize the gentleman from Oregon, Mr. Schrader, for your five minutes of questions.

*Mr. Schrader. Thank you very much, Madam Chair, I appreciate it.

I, too, am a supporter and cosponsor of Ms. Bustos's bill on the Social Determinants Accelerator Act, and I think it is very important to have that coordination. We have heard here today from our witnesses and others that, without that coordination, it is very difficult to get things done.

And in my home state of Oregon, one of the big projects that has worked extremely well is our coordinated care organizations to deliver Medicaid or Oregon Health Plan benefits for a lot of folks. And they are grown up from the ground up. It is not something that is put top-down from Washington, D.C. And it actually has those social determinants worked on by the community organizations that

know that community best, and I think that is what Dr. Bucshon was alluding to, and I would agree with him.

We shouldn't be managing counting different things that should be about providing quality health care. Doctor Syed, I think, hit the nail on the head in his comments and responses there. I think it is just so important to coordinate this sort of thing.

Dr. Blauer, with the interagency council suggested in the Bustos bill, how do you see that getting out best practices like we have in Oregon to folks around the country?

*Ms. Blauer. Thank you, Congressman, for the question. I think the most important thing is that, often times, particularly when we talk about data or IT infrastructure, our gut is to put data and IT folks on these interagency committees. And what we need are subject matter experts who are knowledgeable about the impacts of program decision-making and the realities of program delivery on the ground.

So I think, first and foremost, you need to make sure that they are staffed with people who have deep, programmatic expertise, and who understand what the objectives of the work are, and understand how they can leverage tools and technology to actually do the delivery of the services and to support the work of the committee. So subject matter expertise, absolutely.

And then prioritization. We need leadership that

actually can lead with prioritization. We will end up in a boil-the-ocean moment if we don't have clear goals that are articulated and measurable, and that we can focus our work collectively on. There is a lot of work to be done, and without that kind of direction that will allow for us to have those sort of clear priorities outlined, we are going to be in a situation where we are going to get overwhelmed very quickly. And governance allows you to create prioritization with the inputs of that subject matter expertise. Thank you.

*Mr. Schrader. Very good. Thank you. Thank you.

Dr. Syed, you talked about being fully capitated. Fully -- that that makes a difference. What is your definition of fully capitated to make the Medicare Advantage system work, in your eyes?

*Dr. Syed. It is a model of -- especially with primary care, where the doctors are not concerned about generating revenue by billing. Being fully capitated, we take on the full responsibility of the total health of the patient. And so it gives us the flexibility to treat seniors with multiple chronic medical issues according to their actual individual situations.

*Mr. Schrader. I agree with that, and I think that is -- points to Dr. Bucshon's concern about it shouldn't be the M.D. that has to worry about counting all the widgets, and worrying about reimbursement. If you have a coordinated care

group like we have in Oregon, that organization deals with that and decides, along with the physicians, with the hospitals, with the mental health providers, with the pharmacies about who is getting what amount of money based on those local needs.

I don't see why we don't even just transition to that. Fee-for-service is so outmoded. I have remote parts of my district, very rural parts, that are part of coordinated care districts that provide much better health service tailored to those individuals.

Dr. Walker, I appreciate you mentioning the value-based payments, you know, as we just discussed here. Were -- what policy should we be pursuing to foster growth in that arena?

We are actually trying to do that -- Mr. Guthrie, Mr. Mullin, and I -- with regard to pharmaceuticals. But I think it, obviously, applies here, in terms of just care delivery. What should we be doing to foster growth in that area?

*Dr. Walker. Thank you, Congressman, for the question. I think it is essential, as some of the bills indicate, that we need to incorporate incentives, expertise, and make sure that states have the bandwidth to move forward with value-based payment. That often can start with Medicaid, but go beyond, once you learn the lessons. Medicare Advantage is fully taking on this value-based payment role.

But it does take a bit of guidance. And, you know, the

Caring for Social Determinants Act does include a recommendation to include the updated guidance to allow for innovations like the CCOs to flourish in other places. But it does take leadership, it takes alignment, and it takes the right expertise. That is where, you know, having data to look at the alignment of incentives can be incredibly helpful, too.

*Mr. Schrader. Very good, thank you. Thank you all for your work.

And I yield back, Madam Chair.

*Ms. Eshoo. The gentleman yields back. It is a pleasure for the chair to recognize the gentleman from Oklahoma, Mr. Mullin, for your five minutes of questions.

*Mr. Mullin. Madam Chair, thank you so much. Thank you for putting this hearing together.

Doctor DeSalvo -- I hope I am saying that right. If I am not, please correct me. I -- based on your experience in public as a public official, can you kind of speak to the importance of aligning Federal programs to address the social determinants of health?

*Dr. DeSalvo. Thank you, Congressman. On behalf of my husband's family, I will say it is DeSalvo.

*Mr. Mullin. Oh, thank you.

*Dr. DeSalvo. You know, Congressman, in Oklahoma you have an incredible example of how a group of primary care

clinicians came together to create an information exchange -- this is My Healthy Data -- and built a global population health model like we were just describing, to really allow the docs to care about the patients, and then the data gets collected around them, and the patients -- that data now tells the story of a community's health, as well.

So it is informing public health action. It is a wonderful example of how Federal action to spur the innovation and models of primary care, of health information exchange can then also not only improve the care of patients, but begin to tell a story and -- or improve the care of populations that -- that group, for example, has done incredible work in COVID, creating dashboards that can help the community understand -- I believe you had the opportunity to see some of those. So --

*Mr. Mullin. I have.

*Dr. DeSalvo. You know, I think it is a wonderful, also, example of how the foundation of electronic health record information that -- primarily for the use of individuals, when anonymized, can be useful to help understand the health of a whole community. And it is the kind of innovation that we could spur or scale across the country, and shorten the timeline to being able to do good work.

What is great about that particular effort, by the way,

is that it is transparent. The docs have a lot of say in the data, and how it is used, but also it helps to build a virtuous cycle of improving the quality of care and, as I said, improving the health of the population.

*Mr. Mullin. Are there any examples, like, in your experience that you can use to kind of highlight on how this has been working?

*Dr. DeSalvo. Definitely. I think, in addition to the example in My Healthy Data, there is a couple of states that have been leaders in this area of using existing data that was built on a foundation, often from a Federal program, and then gets expanded.

I will call out another primary care example, one called Macroscope, which was built in New York City by the public health department using data from their primary care clinics, a similar idea. We already have data. Let's not repeat the collection. Let's be efficient. Let's anonymize it, and use it as a way to understand what are the rates of diabetes and high blood pressure in our community. And it is a pretty timely, actionable, granular set of data that public health now can use to target interventions, to address inequities, to address the social determinants of health.

I could go on a long list, Congressman, but I think what I would love for the committee and for others to know is innovation in -- between public-private partnerships,

community led, on the ground is happening all over America. I visited so many in the course of my career. We have written about them in Public Health 3.0, and the National Academy of Medicine report I referred to earlier that we just recently put out on public health. So we have a sense of what works, and we have a sense also of what works from the data.

Now what we need to do is make sure that we have got strategy, and prioritization, and direction, but also fill gaps in the data layers, and make sure that that data layer is interoperable, and can help us address inequities.

*Mr. Mullin. Well, that actually leads me right into my next question, which was going to be what can Congress do to kind of help -- easier for private sector and nonprofits to work together on various funding streams to coordinate in this way?

*Dr. DeSalvo. This is an interesting and complex area. One of the calls that comes from community often is, when they create collaborations, they want to not only share governance and data, but they want to be able to pool or share resources. And there are actually -- there is more latitude, probably, than many communities realize. Communities like Oregon, or Rhode Island, Vermont have found ways to blend and braid funding to support particularly low-income populations and address social determinants.

But I will tell you what, I have done that on the other end, when I was health commissioner addressing needs of youth and violence. It is very hard to blend and braid funds sometimes. So I think some of the considerations in the bills -- for example, these interagency councils -- could be to catalog or understand what are the flexibilities that communities could use to, not only blend and braid the public-sector dollars, but how can the private sector contribute in a way that is again, transparent, shared governance, and shared accountability for the outcomes.

*Mr. Mullin. Doctor, thank you so much.

And Madam Chair, I will yield back the remainder of my time. I want to thank you again for putting this together, though. This is vitally important to a lot of our communities, especially the rural parts of the country.

*Ms. Eshoo. It is, and you asked wonderful questions. Thank you.

The gentleman yields back. The chair now has the pleasure of recognizing Mr. Cardenas from California for your five minutes of questions.

*Mr. Cardenas. Thank you, Madam Chairwoman, and also thank you, Ranking Member Guthrie, for having this very, very important hearing. And I always appreciate all of our experts coming to educate us policymakers so that we make sure that we can do the best job we can to serve our country.

And we are up here on a 30,000-foot level, and you are there, on the ground, so thank you so much for all of your expertise and your wonderful insight.

Also, Chair and Ranking Member, thank you so much for putting H.R. 3969 on the agenda today, as well. I am chairing that bill with Representative Curtis, and I appreciate it being in the hearing today. This bill would include spending on activities related to social determinants of health, and the calculation of private health insurance plans and medical loss ratio.

In introducing this legislation, we recognize that social determinants of health like reliable transportation, availability of nutritious food, safe housing are all primary drivers of health outcomes. And to achieve health justice and equality for all, we must be more intentional about how we address their impact in all parts of our health care ecosystem.

Dr. Batra, in your testimony you discussed the Senior Care Action Network, SCAN, the approach to addressing social determinants of health. Could you please talk about the impact of this approach on members in your network?

*Dr. Batra. Absolutely. I think we started off by making sure we collect data the way the members want the total data to be reported, how they identify. So for us, having the data around race and language was very important.

Similarly, we have collected years' worth of data on our members around their social needs, their transportation, food insecurity, loneliness, in-home caregiving and support, hearing dysfunction. And we have really used that data to help identify members, and even connect them to the right benefits and the right programs.

So, for example, 70 percent of our population suffers from hearing dysfunction, which, as you know, can interfere with so many different things, lead to isolation, lead to loneliness, also lead to poor health outcomes. We have hearing aids as one of our supplemental benefits. So we try and engage with members and connect them to that.

Similarly, a good example during the pandemic was around transportation. People wanted to get the vaccine, did not have caregivers around them, had a son or daughter-in-law living in a different state. We were able to arrange those rides for them.

The other unique thing that we did during the pandemic and vaccination was, as people were getting vaccinated in doctors' offices and convention centers and pharmacies, we had folks who were homebound and could not leave their homes. We were able to get the vaccine to their home, not only for the members, but also the caregivers, because they were the ones taking care of their loved one, who happened to be with us.

So those are some of the high-level benefits that we have used. We have done studies that show that, if you have transportation insecurity or food insecurity, you are going to have a worse outcome on your diabetes. And so we are consistently looking at ways and engaging our population with -- whether it be a program or a benefit, and ensuring them they have it, so as to fulfill their needs.

*Mr. Cardenas. Yes, thank you. And can you give us at least one example about what we can do, going forward, as Congress?

What kind of effort can Congress afford you out there in the community?

*Dr. Batra. Absolutely. So as we -- you know, first and foremost, I want to really thank the Congress for providing us the flexible -- benefit flexibility. We were able to design all these newer benefits to meet the social needs of the population that started in 2019. So the benefits that I alluded to: in-home caregiving, meals after discharge, care coordination, support, and occupational therapist. However, these are based on medical needs, so you have to have a qualifying diagnosis, like you have diabetes, or you have heart disease, or end stage renal disease.

If you truly believe there should be equality for all, if you truly believe that social needs are the first and foremost drivers of health, then perhaps we should be allowed

to kind of design some of the benefits based on the social needs of the population. So that is one area that comes to my mind.

And the second area is, during the pandemic, as we were scrambling, we did about 100,000 social outreach calls to -- checking on members. We actually have a benefit that helps people sign up so they can -- somebody can be their help, so they can have the telehealth visit to their doctors. We notice there are zip codes with a high social vulnerability index, where people did not have access to Wi-Fi and iPads and technology. And for those, the telephonic assistance was really, really important in order to extend the reach of the primary care physician. That is the other area we really want Congress's help, in keeping telephone as one of the ways of engaging with the member, engaging with the patients, and helping them.

*Mr. Cardenas. Thank you, Dr. Batra. And it is very rare for us Members of Congress to get a thank you. So thank you for slipping that thank you in there.

And I just wanted to say how focused many of us are on making sure that we modernize our public health data, infrastructure, and outreach, because those are some of the major lessons that we learned during this pandemic.

My time has expired, Madam Chair, thank you so much for having this hearing. I yield back.

*Ms. Eshoo. You are most welcome. It is a pleasure to recognize one of the doctors on our subcommittee. And we have, I think, five. I think five doctors.

Dr. Dunn from Florida, you are recognized for your five minutes of questions.

*Mr. Dunn. Thank you very much, Madam Chair, and also thank you, Ranking Member Guthrie, for hosting this hearing today to examine the ways that data can affect public health.

You know, over the course of the COVID-19 pandemic, Congress spent hundreds of millions of dollars to support data collection and data infrastructure modernization. And whether those dollars were used for a centralized CDC data assimilation, or grants to states and local governments for data collection, the money is already out the door. And we need to evaluate how these funds are being used, I think, before we consider another slate of new bills to advance more data collection as it relates to improving the care of the health of the American people.

High-quality health care starts with the doctor-patient relationship. Dr. Syed said that in his testimony. And then it should consider the individual needs of patients. You can't just crunch data and pigeonhole people without taking a holistic approach to the patient.

We also can't rely on bureaucrats in Washington to make decisions about health care for our individual patients.

People simply cannot be reduced to a set of data points, no matter how voluminous they are.

I also want to associate myself with the remarks of my colleague, Dr. Burgess, when thinking about requiring more and more data collection. The potential that that information will be shared across other entities requires that we have reliably strong safeguards in place to ensure patient data remains private, and that HIPAA protections are, in fact, upheld. And with that I would like to ask Dr. Syed a question.

I appreciated reading your testimony, hearing your views on creating more value in the healthcare system. You touched on coordination of care, and a strong doctor-patient relationship, and matching the resources to the patient's needs in order to drive improved outcomes. It seems to be you are an advocate for the flexibilities that the Medicare Advantage system allows, in terms of value. And you cited many examples in your testimony, and let me say I share those views with you.

From your perspective, is increased data collection in the primary care setting the sine qua non to improved health outcomes?

And so a lot of these proposals are talking about involving significant additional reporting requirements, and gathering a great deal of data. And I know personally that

doctors are already suffering from a fair amount of burnout and stress over administrative burdens. Dr. Bucshon made allusion to that in his questions. What is your perspective on that question, sir?

*Dr. Syed. Thank you very much. I -- with regards to data, and collecting more data to improve patient health, there is some things that I feel, as a doctor, I could speak to.

When we are talking about improving health, I am thinking about, if we know medications are critical to improving health, we should not let patients walk out the door without their medications. Like, if we know that heart disease is the number-one killer in the country, then we should have cardiologists working hand in hand with the primary care doctors. And if we know that a major part of improving health is overcoming the barriers to the care, then we should have social workers integrated into the care teams.

I think, rather than collecting more data, we should kind of relook at how care delivery is happening right now in the country. And to what someone else said earlier today, you know, if we know that doctors are getting burnt out from doing all the non-doctor work, we should have the care teams take over all the administrative duties, and just let the doctors be doctors.

*Mr. Dunn. So I -- and let me say I like that answer

very much. It certainly would have made my life a little easier the last 10 or 15 years.

You shared a story about uncontrolled diabetes, I believe, in your father.

*Dr. Syed. Sure.

*Mr. Dunn. And I think that you would agree that data helps with that. But also, it is that personal time you spend with them, saying, "Let's work with each other, and let's do the right things.'' In other words, it is really a relation step with the doctor-patient relationship. Would you agree with that?

*Dr. Syed. Absolutely. I think about -- yes, absolutely. I think about a patient I had with morbid obesity. And because of the flexibility with the Medicare Advantage program, I was able to see him as often as I needed to see. And I was more of a health coach than I was a doctor for him. And I was able to -- in six months I was able to see him seven times, and get his weight down from 250 to 220 pounds. In my previous job, I couldn't even see him more than twice a year. So that is just the difference. It is a different, completely different, approach towards delivering on the care.

*Mr. Dunn. Certainly -- our time is about over here -- I was saying I certainly appreciate that. I agree with you.

In Florida we experimented with sort of a hybrid

Medicare Advantage/Medicare fee-for-schedule, so -- the specialists and the primary care, working together.

But I thank you for your comments, I thank the witnesses, and I thank our chair and ranking member, and I yield back.

*Ms. Eshoo. The gentleman yields back, It is a pleasure to recognize the gentleman from Maryland, Mr. Sarbanes.

You have five minutes to question. Great to see you.

*Mr. Sarbanes. Yes. Thank you, Madam Chair. I want to thank the witnesses for being here for this important hearing.

I deeply share the concerns of my constituents and those at our hearing today about the impacts that the coronavirus has had on communities of color. I believe Congress should use every available tool -- and equitable recovery, as well as address the root causes that have created health disparities for years.

For too long, the Federal Government has failed to adequately recognize and address structural racism as the public health crisis that it is. Black and Brown communities have been denied access to quality, affordable health care, have faced barriers to securing safe, quality, affordable housing, and have suffered the consequences of environmental racism for generations.

The COVID-19 pandemic, as we know, unveiled and exacerbated longstanding racial disparities in health outcomes. It is time we recognize and treat structural racism and police brutality through a public health lens when we can.

Under the Biden Administration, the CDC has begun this work by declaring racism a public health threat, and committing to addressing racism in the context of health equity. I commend the CDC for this step, and we in Congress are committed to assisting in the effort. One way to do that is by passing the bills we are discussing today, including the Anti-Racism and Public Health Act and the Social Determinants Accelerator Act.

The Anti-Racism and Public Health Act is a critical bill introduced by my colleagues, Representatives Ayanna Pressley and Barbara Lee. This bill would expand Federal research and investment into the public health impacts of structural racism, require the Federal Government to proactively develop anti-racist health policy, and take a public health approach to combating police violence. Among other things, it would create a national center for anti-racism at the CDC, which would award grants to study the health impacts of structural racism.

Dr. Walker, I wanted to turn to you to elaborate on this a little bit. What is the significance of the CDC

recognizing racism as a public health issue?

*Dr. Walker. There is clear evidence that racism creates a public health threat, and it creates not only immediate stressors, but also long-term health effects that we need to combat.

But many of those factors are ones that we have talked about, the social indications around housing, around transportation, around can you just get access to the care that you need?

We know, for children and adolescents, some of those factors are around mental health access and needs, and resources in schools. And so having the ability to really provide Federal resources to make sure that states and local communities can invest in these factors, and increase the ability to address it at a community need base, on those priorities and those areas of local context are important for us to be able to incentivize health and well-being at the most local level.

*Mr. Sarbanes. Thank you very much. And I am sure you would agree that gathering up research and data in this space, and having that inform this perspective on the health impacts of structural racism, is also a key undertaking.

What significance would it have to establish a national center for anti-racism to serve as a resource hub to share information at the Federal, state, and local levels, in your

view?

*Dr. Walker. I think that the benefit is that we could make sure that there is some data standardization, but also expertise that often is not accessible in state agencies. So having a national center can lend technical support, can lend some data standardization, but also can support -- and collaboration with academic partners in state and local data. And I think having those resources come together in a national center can be very beneficial, and can't necessarily be done 50 times over in other areas. And I think that is a -- national center, we have worked with them in the past, and I think can be a great resource.

*Mr. Sarbanes. Thank you.

Ms. Blauer, at Johns Hopkins -- and let me just say how proud I am, being from Baltimore, about the great work that Johns Hopkins has done, particularly gathering critical data during the pandemic, and the university's Coronavirus Resource Center, as we all know, was a trusted source of information for so many people over the past year.

Could you expand on the role data played in responding to the pandemic, and what additional data and resources might have been helpful, particularly to respond better to the challenges faced by communities of color during the pandemic?

*Ms. Blauer. Yes, thank you, Congressman. I can say that it wasn't until several months into the pandemic

response in our work that states even started to release COVID data, demographic data that was rich enough for us to even validate, the kind of frontline anecdotal information we were getting about the disproportionality that that virus was having on residents.

And it has taken us a long time to even get any kind of guidance around demographic sharing of data. We are still only at the CDC reporting around 60 percent of demographic data for the cases and the deaths of people that have been impacted disproportionately by the virus. We are still operating, certainly, in an environment of confusion when it comes to the disproportionality and the effects. And so having some guidance and some standardization around demographic data is so vital as we continue this last mile of work around COVID, but certainly as we think about how we look at the social determinants of health, and the role that data plays in deepening disparities and exacerbating bad outcomes for people. Thank you.

*Mr. Sarbanes. Thank you, I yield back.

*Ms. Eshoo. The gentleman's time has expired. The gentleman from Georgia, Mr. Carter, you are recognized for your five minutes of questions.

Where are you?

*Mr. Carter. Thank you very much, Madam Chair, and thank --

*Ms. Eshoo. Are you in the car?

*Mr. Carter. -- the witnesses --

*Ms. Eshoo. Are you in the car? Where are you?

*Mr. Carter. No.

[Laughter.]

*Mr. Carter. I am in the hearing room.

*Ms. Eshoo. Oh, good, okay. I am glad you got out of your car.

*Mr. Carter. I am, too. Thank you, Madam Chair, and thank the witnesses for being here. Very important subject matter.

Dr. Batra -- I apologize -- and Dr. Syed, Medicare Advantage plans have more than doubled enrollment over the past decade, and these plans clearly offer beneficiaries greater benefits and care versus traditional fee-for-service plans. And this is good. This is a good product that, obviously, is being utilized, and I am glad to hear that.

My question, Dr. Batra, is this. How would beneficiaries benefit by Medicare Advantage plans offering new and existing breakthrough technologies and devices that are FDA-approved, but do not fit into an existing benefit category for certain targeted populations, like those with chronic conditions?

*Dr. Batra. Yes, we -- I think what we have done consistently is look at, as these new things become

available, what has shown proven evidence, what has shown to prove -- help with the needs of the membership that we serve. Wherever we have, you know, guidance from Medicare, either through their NCDs or LCDs, we follow those guidances. Where we don't have guidance available right away, we look at other data sources, other peer-reviewed studies, other evidence-based sources, and see if we can fit the need of the population, and go from there on.

The other thing that we have done and encouraged in our members is, as things become available, some of them are in the experimental trial phases, which is available through them -- to them through Medicare trials.

*Mr. Carter. I don't mean to interrupt you, but I indicated if they were FDA-approved.

*Dr. Batra. Oh, they are FDA-approved, and we do have the flexibility in evaluating what is available, in terms of evidence, and then considering them for the right populations.

*Mr. Carter. Okay, and you have a review process for that, whereas you review it among your yourselves --

*Dr. Batra. Yes.

*Mr. Carter. -- and decide whether it is going to be covered or not?

*Dr. Batra. Yes, we do have medical policy departments that work together alongside our provider partners, working

very closely with our provider partners, alongside experts -- some of them are academic experts -- to review them on a case-by-case basis, to look at the needs in a population, to look at what else is available, to look at the comparative effectiveness. So multiple factors play a role in that.

*Mr. Carter. Okay. Dr. Syed, what about you? What about your company?

*Dr. Syed. Our -- we understand that more than 70 percent of modifiable health outcomes are actually based on a preventive lifestyle, lifestyle interventions. So when you have a system that is focused on prevention, and the doctors are allowed to focus on prevention, then the patients are more safe at home, rather than going to the hospitals. It eliminates all the medical costs, actually, before they even occur. You know, we focus on improving health and reducing suffering through preventive and early interventive measures.

If there is an FDA-approved treatment, or a product that can help benefit the patients, then, as long as it is FDA-approved, then we would evaluate that on a case-by-case basis.

*Mr. Carter. Do the individual patients have some type of appeal process, some kind of prior approval process, or anything through your company?

*Dr. Syed. I -- that I am not -- in the full risk model, I am not aware of having to go through that type of

process.

*Mr. Carter. Okay, all right, let me move on.

Dr. Batra, again, I serve a very rural community, and many of my constituents have trouble getting to physicians for care. Even during the past six months, many of these same constituents could not access vaccines for extended periods of time. It appears that SCAN Health plans have been recognized as a leader in getting COVID vaccines to homebound and rural patients. Can you share with us what you all are doing to -- that maybe other plans could duplicate to improve access to care for beneficiaries in rural communities?

*Dr. Batra. Absolutely. We absolutely follow the principle of leave no older adult behind. So, right from the very beginning, as the vaccine was being developed, we put all hands on deck on figuring out how do we get the right people to the right places. Those who could drive, how do we get them there, give them information, and those who could not get there, how do we get them rides to get there?

But we also serve a large swath of people who are homebound members, who have caregivers taking care of them. So we worked very closely with an organization that then deploys paramedics in people's homes that could carry the vaccine in a safe way, had oversight provided by nurses and physicians. We were able to schedule those visits for them. And within the comfort of their own home, under watch of a

paramedic, as well as the oversight of a nurse, we were able to deliver those vaccines in people's arms. To date we have done several hundred of those, and we will continue doing that with the goal of leaving no older adults behind.

*Mr. Carter. Well, I just want to compliment you and thank you, for your service to the rural communities, in particular, is extremely important. So thank you.

And I will yield back.

*Ms. Eshoo. The gentleman yields back, and now another one of the doctors on our subcommittee, Dr. Ruiz from California.

You are recognized for your five minutes of questions.

*Mr. Ruiz. Thank you, Chair. This is so important. Finally, it is a pre-med dream come true. You see, back in the 1990s, when I was pre-med and in medical school, those of us who understood social determinants of health would shout it out in lectures. We would talk about it in the halls of the different academic hospitals. And everybody was so singularly focused on the specifics of medicine, that they didn't really understand.

And now we are actually having a hearing on how to improve data collection for social determinants of health and our public health system. This is groundbreaking. This is incredible. This is the spear of much more to come, the tip of an iceberg.

And I am so proud of Congressional Hispanic Caucus member Nanette Barragan, and all the other members of our committee who have pushed forward great legislation to finally get our social determinants of health in the limelight, so that we can really take a comprehensive look at health.

It is not just the absence of disease. It is the ability to enjoy one's life, and have wellness and fulfill our human potential in our communities. And from breathing in the toxic air around the Salton Sea in my district, to working in the fields, the grape fields, the bell pepper fields under the blazing sun, to food insecurity, I have seen firsthand in my district how social determinants negatively affect my constituents and my patients -- I am an emergency physician, by the way -- my patients' health.

So many of my constituents do not have access to healthy foods, whether that is because they live in a food desert or because healthy food is more expensive. Ironically, the same farm workers who pick the healthy foods can't afford those healthy foods at this -- sometimes, or they do not have adequate health insurance.

So no matter what the reason is, all these factors contribute to higher rates of underlying chronic diseases like obesity. In fact, nearly half of Black and Hispanic Americans are living with obesity, and this puts them at

greater risk of 200 serious diseases, including serious conditions like diabetes, and heart disease, and serious complications of COVID-19.

This is why I joined several of my colleagues in introducing H.R. 1577, the Treat and Reduce Obesity Act, which would increase access to effective treatments for obesity. Bills like the Treat and Reduce Obesity Act, as well as several that are under consideration today, will help us address some of these social determinants of health, straight on.

And while it is critical to address the social determinants of health in order to improve the health of all Americans, we cannot do that without really understanding the problem. And to really understand the problem, we need adequate, accurate, and timely data that describes the social factors that impact health outcomes like economic status, access to transportation, access to healthy foods, educational attainment, housing, and environmental influences on health.

This data has been challenging to procure in public health, in part due to a number of barriers that range from inadequate design of systems like electronic health records to the use of phone survey systems, and a lack of trust for those being asked about their social risk factors.

Dr. DeSalvo, can you speak more on the importance of

collecting health quality data on the social determinants of health, and then how to translate that into actual policy and public health programs?

*Dr. DeSalvo. Congressman, let me just first say I woke up with that same enthusiastic pep in my step today. This is, like, 20 or 30 years of work, and all the data, equity, and public health together, and the social determinants are just the things that I care so passionately about. So I appreciate your enthusiasm, and really look forward to working with you and others as we bring this to fruition.

Maybe I will just hearken back to my experiences in New Orleans, since you mentioned obesity, and say that when I was the health commissioner, one of the first -- when I went two blocks down the street from my medical school, where I was faculty, and took the helm of the health department, I had in my head all the information from the quantitative survey data I had seen saying that cardiovascular disease and cancer were killing the people in my community. And I needed to focus on that.

Within the first five minutes of the first coffee I had in a church hall, they said, "Our priorities are violence, mental health, and economic opportunity.'' And it was a real mind shift for me, of really respecting and appreciating that the data I might see that is quantitative and collected in some ways doesn't always reflect the now, and what is on the

mind of my community.

And so mixing qualitative and quantitative is important. We can scale that by leveraging novel data sources. I mentioned earlier search symptoms trends that public health could use. It is anonymous, and can give them a snapshot of their community.

But I took those lessons from them, and I looked at a through line, and realized that fitness, obesity, lack of nutritional fitness were contributing to cancer and cardiovascular disease. And as I talked to them more, I realized they needed sidewalks, playgrounds, access to healthy foods. We had to work with our economic department to get grocery stores to go in communities. We had to work on school lunches. Kids designed it, told us they wanted -- you know, how they wanted the salad, what would drive them to go away from French fries and pizza, and have some other healthy food. We did it with kids, not for them.

So I think what -- once you have the data in front of you, quantitative and qualitative, local leaders can bring people together, and that community can make decisions about how to make interventions and measure success, so we can know what works and continue on that generational trajectory of improving health.

*Mr. Ruiz. I love it. Thank you all for the work you do.

*Ms. Eshoo. The gentleman's time has expired. The gentleman from Florida, Mr. Bilirakis.

*Mr. Bilirakis. Thank you, Madam Chair.

*Ms. Eshoo. You have 10 minutes for your questions.

*Mr. Bilirakis. I appreciate it. Thank you. Thanks for holding this very important hearing. Madam Chair, data drives decision-making, as you know. And the integrity of these decisions lies in the integrity of the data.

As you know, I am from the great state of Florida, and Florida's COVID-19 story is one of success driven by reliable data and following the science. I have included a press release exposing myth versus fact regarding Florida's COVID-19 data. And I ask unanimous consent that this be entered into the record, Madam Chair.

[Pause.]

*Mr. Bilirakis. Madam Chair?

*Ms. Eshoo. Did you hear? So ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Bilirakis. Yes, I -- okay, thank you. Yes, I didn't hear that. Thank you.

Dr. Walker, Representative Blunt Rochester and I introduced the bipartisan Collecting and Analyzing Resources Integral Necessary for Guidance for Social Determinants Act (sic), and it is H.R. 3891 -- excuse me, 3894. And what it does is it provides regularly-updated guidance to states to address social determinants of health under Medicaid and CHIP, building upon the success that some state Medicaid programs have already had since testing innovative delivery and payment models.

Additionally, several members of this committee are championing the Social Determinants Accelerator Act, which is H.R. 2503, which would help states and communities devise strategy to better leverage existing programs and authorities to improve the health and well-being of those participating in Medicaid.

So my question is a couple of questions. How might HHS do more to coordinate social determinant efforts, even without additional congressional authority?

And then also, could you explain how HHS could use its leadership in Medicaid to more broadly catalyze efforts to better coordinate and measure the impact of resources and initiatives that address social determinants of health?

And this is for Dr. Walker.

*Dr. Walker. Thanks, Congressman, for the opportunity to address this question.

It is absolutely critical to think about how to refine ongoing guidance to states around how to address social determinants of health. We know these impacts continue to evolve, and so, even when I was state secretary of health and social services, it was extremely helpful to have this updated guidance provided. It informs waivers, it informs how you can think about state plan amendments. And as you mentioned, it doesn't require, necessarily, additional authority, but gives clarity around where existing resources can be deployed and used most efficiently.

And there are several models out there. So another strategy could be that models like that at the state level are incentivized through CMMI or other waiver authority like North Carolina's.

I expect we will continue to learn from these models, so having evaluations and the data available can be incredibly useful, but also providing resources for technical assistance, updated guidance, and examples are tremendously beneficial. Thank you.

*Mr. Bilirakis. Thank you. And the next question is for Dr. Batra.

Recently I introduced H.R. 4074, the Addressing Social Determinants in Medicare Advantage Act, which increases

flexibility for Medicare Advantage to offer supplemental benefits that would help address social determinants of health. Can you discuss how supplemental benefits have improved the lives of your members, and how adding benefits that address social determinants of health in Medicare Advantage, and broadening beyond just those with specific chronic conditions would mitigate social inequities, and allow plans to assist even more members in need?

*Dr. Batra. Absolutely. I have shared with the committee before we really appreciated getting that flexibility. Post that flexibility, we have designed multiple, newer benefits. I mentioned our benefit called Return to Home around medications, care coordination, and in-home caregiving. We also introduced benefits like respite care for our populations who have caregivers who could use that kind of help, so we use benefits for that.

Beyond that, we extended our meal benefits to provide meals for our folks suffering from chronic conditions, who perhaps need that meal for their diabetes, or need a meal for their end stage renal disease that is appropriate for the condition, so they can have a better food lifestyle in order to improve on the chronic conditions.

So those are a few high-level benefits that we introduced. We have seen, based on our -- either both the utilization adoption data, as well as our outcomes data when

we look at our utilization from ER visits, or admissions, or improvement in diabetes control and improvement because of those kind of benefits.

We continue looking at more benefits. And as I had shared with the committee, I would love to have benefits based on your social needs or just based on your medical conditions. Right now we do have the flexibility, but they are still tied to chronic conditions like diabetes, or heart disease, or cardiovascular disease, or chronic kidney disease. But we know, as I shared, we have about 20 percent of our membership that has, at one time or the other, shared with us they have food insecurity. We would be able to do more, if we were able to address the needs of a larger population, not limiting ourselves just to chronic conditions. Thank you.

*Mr. Bilirakis. Thank you.

And I just want -- Madam Chair, this particular bill, H.R. 4074, I filed it, due to timing, alone. But I welcome bipartisan support, both in this committee, Ways and Means, and any members that want to -- I think this is a very important issue for the constituents.

Thank you, and I yield back. Thank you for the extra time, Madam Chair.

*Ms. Eshoo. Yes. The gentleman yields back. It is a pleasure to recognize the gentlewoman from Michigan, Mrs.

Dingell, for five minutes of questions.

*Mrs. Dingell. Thank you --

*Ms. Eshoo. Right there from the very beginning, and taking everything in. And I think we hear more bounce in your voice, so you are feeling better.

*Mrs. Dingell. We are getting there, slow but sure.

*Ms. Eshoo. Good, good.

*Mrs. Dingell. Thank you Madam Chair -- wonderful -- and Ranking Member Guthrie for convening this hearing to discuss legislation to address deficiencies in public health data and technologies, which I really care about.

As our witnesses have mentioned, the HITECH Act and funding have led to improvement in data collection that have helped drive better outcomes for patients in the clinical settings. However, while we have seen additional resources directed at gathering and disseminating actionable public health data during the COVID-19 pandemic, longer-term reforms are needed to address these gaps in our public health data infrastructure.

Additionally, doing so will allow us to better direct health care resources towards areas of greatest need to better address deep-seated inequities in disadvantaged communities or populations. And I love seeing Dr. Ruiz excited, so I want to get him the data he needs to be able to do that.

But my questions are for you, Dr. Batra, because it was good to see you highlight the Independence at Home program in your testimony. IAH ensures Medicare patients can maintain their independence, while meeting their unique medical needs and lowering costs. And I was glad to part with my colleagues on this committee as part of a bipartisan effort to successfully reauthorize and expand the IAH program at the end of last year.

Dr. Batra, you also mentioned that voluntary health risk assessments used to identify members' health needs have a 35 percent response rate -- not very good -- with a completion rate of 80 percent for special need plan members. What barriers do you see in raising response rates for these assessments?

*Dr. Batra. Absolutely. Right now, the way we do these assessments are either over the phone or through mailing. But you are absolutely correct. We could do more.

We have a significant membership that is aging in and joining MA plans, including ours. For them we have to be ready to provide an online assessment, if that is the way they want to engage with care. So that is one area that we are exploring.

The other area that we are also exploring is for folks who perhaps are homebound, have caregivers who are really busy doing other things, and not have the time to fill out

the assessments, or they are not available themselves -- of assessments. So could we go into their homes, and help do those kind of assessments to get a better idea on them? That is a second way of doing it.

The other things that we are also exploring is building out these assessments in different languages. We are based out of California. We serve a diverse population that speaks many different languages. We right now have assessments that are available in three to four languages. We need to address the needs of our population. We really have to expand those languages, as well, so we can really get feedback from all of our members, not just a some -- of our members.

So those are a few areas that we are thinking about.

And then finally, you know, our providers also do a lot of assessments, and we are looking at interoperability to say, hey, where we do not have those assessments, perhaps our providers have it. How do we get that data, and build it in our system, so that we have a more holistic understanding of our population?

*Mrs. Dingell. So let me follow up on that -- and I am going to run out of time, so I am not going to be able to ask all my questions -- but how do non-responses and other gaps in data affect your organization's ability to provide targeted intervention to seniors, based on social determinants of health?

*Dr. Batra. It does make a big difference because we -- generally, when we get this data, that is where we act on. We have an algorithm to say who is going to reach out, who should be offered certain programs, who should be enrolled in certain services. So we are always looking, how can we make our data more comprehensive and robust?

And our approach has been to work with our providers to see how we can further make that data more comprehensive.

Our approach also has been how do we engage with caregivers? Perhaps they are also the people who can help us in getting those assessments completed.

How do you work with community-based organizations? Looks like Meals on Wheels that perhaps are going in people's homes, and get data from that perspective.

So we are trying to look from everybody who is available at the community level, at the individual level, at the provider level, at the delivery system level to make that data complete.

*Mrs. Dingell. Okay, so I am going to rush a question. So missing, incomplete, or non-standard public health data is more common than anybody would like, particularly when it comes to long-term services and supports, as well as other services utilized by our nation's seniors, which I care deeply about. And I was a caregiver. Yes, I could have filled it out better than anybody.

But how would uniform public health standards, like those in the Health Statistics Act before us today, as well as improved quality measures for LTSS improve your organization's ability to meet the need of older adults your organization serves?

And you have one second.

*Dr. Batra. Absolutely. We do have a fully integrated dual eligible specialties plan, so we do offer those long-term services and supports. We absolutely believe in the importance of it. And so we are working with in-home community partners, caregivers, formal and informal, in completing the data.

*Mrs. Dingell. Okay, thank you.

I yield back, Madam Chair.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Utah, Mr. Curtis, for your five minutes of questions.

*Mr. Curtis. Thank you, Madam Chair. I am pleased to be here today.

Dr. Batra, my bipartisan legislation co-led by my friend Mr. Cardenas that we are discussing today aims to give private individual market health insurance plans more flexibility and incentive to spend money focused on improving patient outcomes. It does this, specifically, allowing plans to count social determinants of health expenditures toward

the Affordable Care Act's medical loss ratio requirement. Services could include partnering with ride sharing companies to help beneficiaries to get to and from appointments, or even paying for groceries.

While SCAN is a Medicare Advantage plan not in the individual market, could you explain how insurance plans are engaged in providing social determinants of health services to beneficiaries?

*Dr. Batra. For us, as a MA plan, we design our benefits based on the supplemental benefits that are made available. One more time, they are made available based on the chronic conditions that they have. If you look at our ongoing data, and look at opportunities to close gaps in care, whether they be social gaps in care or, in some context, it may be even medical gaps in care, like affordable medications or access to telehealth vendors, so our approach of planning and designing benefits is based on that approach, and also offered through the Congress giving us the flexibility to design these kind of benefits with social needs as one of the drivers.

*Mr. Curtis. So that plays right into my next question, which is what can Congress be doing to help offer incentives to help you do your job better?

*Dr. Batra. In my mind, offering these benefits in a more holistic manner will really help us a lot.

So right now, the benefit, one more time, are based on your medical condition, which we know is the driver for 10 or 15 percent of your overall outcome. If we were able to design those benefits based on your social conditions -- perhaps you are housing insecure, and do not have other chronic conditions that may have qualified you for a benefit, that would be one idea for us to do it.

And also thinking of populations that perhaps are not completely fitting into the MA mold, so people experiencing homelessness. Could we offer them some differentiated benefits, based on their social needs versus just their medical needs, is another one that comes to my mind.

*Mr. Curtis. That is good. Thank you. Could you comment on this -- along those same lines, would it be helpful to remove some of the barriers such as reforming Stark Law, and could that enhance care coordination between providers, increasing savings for the patients?

*Dr. Batra. It is always great, and being a primary care physician, the more we can collaborate and coordinate with the primary care physician -- not only just the primary care physician, but their teams, and their extensions of their teams, whether it be in the hospital setting, or be it in the ER setting, we are always looking at opportunities to do more of it, whether it be through the data exchange, or it be through our teams, or working closely together.

*Mr. Curtis. Thank you.

Dr. DeSalvo, could you talk for a minute about how Google is partnering with health care systems or insurance plans to gain a stronger understanding for health care trends in certain communities, or within patient populations?

*Dr. DeSalvo. Thank you for the question, Congressman. I think one of the opportunities that we all have has come up in the hearing, and that is how can the data that is already available be more intuitive, more accessible, easier for the doc or nurse to find right at the bedside or in the clinic.

Also, for the patient, how do we minimize or reduce the need for them to repeat over and over again what their medical conditions are, or, in the case of social determinants, to have to prove they are hungry or unhoused over and over again. What are the ways that we can be more efficient and effective with the data that we are already collecting?

And so, in that context, Ascencion Health System asked if Google could be helpful to apply that notion of making the electronic health record data easier to find, and make it more intuitive for doctors when we are trying to make sure we can not only get through the day with our patients, but be able to spend time looking them in the eye, and not looking at the computer.

*Mr. Curtis. Yes.

*Dr. DeSalvo. So that is an example --

*Mr. Curtis. If --

*Dr. DeSalvo. -- of how we are working on data.

*Mr. Curtis. I am going to jump in on you, simply because we are --

*Dr. DeSalvo. Okay.

*Mr. Curtis. -- so short on time. Talk to me for just a little bit about privacy of this data, and how do we put patients totally in charge of their own data, and still reach our interoperability goals?

Is block chain technology -- what technology is out there that we can be thinking about to give patients total control over their data?

*Dr. DeSalvo. Oh, thank you. Thank you for raising that, because, first and foremost, people do need to understand how their data is being used. That is the transparency piece. They need to have choice about who is going to get it, and then control across the journey, something that I spent a lot of my career working on.

And in fact, as we have talked about earlier today, 21st Century Cures pushed this idea of APIs, doorways to the data that consumers control. So it is a great example of how consumers have the control of saying, "I want this data, and I want to share it in -- with these trusted health care partners,'' for example. All of that would fall under HIPAA,

and with consent, so that the notions are already there, and the systems are building.

And the last administration, in the interoperability rule, further pushed this idea, technologically, raising an important additional concept, which is are there ways that data isn't all stored in one place, and that it can be visited or borrowed in the moment, when the person is either critically ill, having a heart attack, or when you need to use it for more long-term diabetes care?

For pretty early in the journey of knowing how tools like block chain will work, though, there are many in the health care system, in the health care environment, in the technology environment trying to understand it.

I just want to emphasize the point again that consumers do --

*Ms. Eshoo. The gentleman's time is --

*Mr. Curtis. Yes, I am so sorry.

*Ms. Eshoo. It has expired, I am sorry.

*Mr. Curtis. Yes, Madam Chair, I yield my time. Thank you.

*Ms. Eshoo. Okay, thank you.

*Mr. Curtis. And I hope we can explore that in more detail later.

*Dr. DeSalvo. I would be delighted to.

*Ms. Eshoo. Good. It is a pleasure to recognize the

gentlewoman from New Hampshire, Ms. Kuster.

*Ms. Kuster. Thank you very much, Madam Chair, and thank you for bringing us together today to discuss the opportunities and legislation to bolster equity within public health. Today's hearing is timely, as we continue to safely reopen our economy from the grips of the COVID-19 pandemic, and examine many of the underlying health inequities that existed before COVID.

I have often said that this pandemic pulled back the curtain on so many health inequities and injustices, and it is critical for this committee to identify and advance legislation that will support the health care delivery and public health approaches for these impacted communities.

One of my main focuses in Congress has been addressing health access issues in rural communities, which are often times underserved and under-resourced, to address their unique health challenges. We need to take a comprehensive approach to tackling this problem, which includes everything from expanding primary care options to increasing access to fresh foods and produce.

The existence of food deserts represents a real challenge for our rural communities that is directly linked to worst health outcomes for rural Americans. Without access to fresh food, Granite Staters who live in food deserts may be at higher risk of diet-related health conditions such as

diabetes, cardiovascular disease, and obesity.

So that is why I am so pleased that today's hearing includes legislation sponsored by my colleague and good friend, Congresswoman Cheri Bustos, the Social Determinants Accelerator Act, which I am also proud to support. Economic and social conditions such as stable housing, access to transportation, and healthy food have a significant impact on public health and wellness, and this legislation will help states and localities devise strategies to leverage existing programs and boost health outcomes.

So my question is for Ms. Odom Walker.

Ms. Walker, your testimony touches on this bipartisan legislation, and the positive impact it will have on health infrastructure investments. Can you expand on this, and discuss how this legislation will help rural communities address health disparities and negative social determinants of health?

*Dr. Walker. Thank you, Congresswoman, for the commitment and need to elevate issues around inequities. And there is an interconnection between how we look at health and all of the social factors that influence our health outcomes.

Being able to accelerate what works and do more of it, along the lines of creating partnerships between Federal, state, and local agencies is important. And we know that, in the light of the pandemic, that those interconnections were

even more important. The inequities were highlighted.

And so having the ability to provide technical assistance and resources to make sure that we are doing more of what works, and focusing on the communities of greatest need, it is critically important. We know that those technical resources aren't always available, and having the data, having the know-how to really move beyond what is kind of being done would promote health more broadly. Thank you.

*Ms. Kuster. Great. Well, thank you. Now, your expertise is children's health. And I appreciated you highlighting the intersectionality of children and maternal health. Can you discuss some of the specific challenges that parenting women face in rural communities?

And how can this committee advance meaningful legislation to tackle the underlying negative social determinants for new mothers and their children?

*Dr. Walker. Absolutely. I think, again, it shows in the midst of the lifelong journey of health that health starts pre-conception. It starts during a healthy pregnancy. And the health of mothers is linked to the health of their children. And rural communities often don't have those same wraparound services, but could be supplemented by home visiting programs and other factors, other supports.

We know that factors like trauma and stress of the mother, even before conception, can impact the life course of

the child, well into adulthood. We need to make sure that there are resources for addressing maternal depression, and some of that could be supported through telehealth supports, even if local resources are not available.

But I think some of these other factors around nutrition, and how we really think about creating that support impact both cognitive well-being and others. So trying to figure out how to deploy some of it through telehealth resources, as well as local community resources can be a benefit, particularly in rural communities.

*Ms. Kuster. Well, and thank you for your reference to telehealth, because often transportation is a real barrier to access to health care.

And with that, on the stroke of zero, I will yield back to the chair. And thank you so much.

*Ms. Eshoo. Excellent, thank you.

It is a pleasure to recognize the gentleman from Texas, Mr. Crenshaw, for your five minutes of questions.

*Mr. Crenshaw. Thank you, Chairwoman. Thank you for holding this hearing today. It is an important one. And I want to talk about the variable that we are trying to understand, the social determinants of health. It goes -- and going all the way upstream to understand what might be impeding access to care, what is preventing people from living a healthy lifestyle.

So I am glad to hear that our private plans are working on this already. And as I know, many of them are solving problems of nutrition, which is a really critical piece of preventing health issues through food -- you know, and one example is through food subscriptions, like Hello Fresh. Many offer rides through Uber or Lyft, so they can get access to their doctor.

So first, I think we have to make sure that the government isn't putting barriers in place that would impede private plans from addressing social determinants. And I am glad that my colleagues, Mr. Curtis and Mr. Cardenas, have a bill to do just that.

Second, as we think through how to properly integrate these social determinants into our public health plans, I want to make sure we are thinking through social determinants as a piece of the puzzle, and not the sole solution to healthcare problems.

Finally, it is important to acknowledge, as we use social determinants to improve health outcomes, some of our most fundamental healthcare programs are still in desperate need of real programmatic updates. And simply integrating social determinants won't get at some of the most critical issues with Medicaid and Medicare, which is the fee-for-service system. So even the most straightforward solutions are really complicated by rules regarding payments, and what

regulations on what services to cover.

Dr. Batra, my first question is for you. What lessons can the Federal Government take from the private plans on how to properly balance social determinants, as they are integrated into our more complicated public healthcare system?

*Dr. Batra. I think the few things to learn from MA plans -- and I can speak for my plan -- is having a very person-centered view, and starting from what matters to the patient. And what matters to the member or patient or beneficiary is access, affordability, experience, and living the life to the fullest. So you have to balance all of them out.

Medications is a big deal for them, so having affordable medications available to them. Access is huge, and access getting to the doctor, so that is where social benefits become important to it.

But also, when you cannot get to the doctor, how do you get to access, whether it be through telehealth, or it be in-home health, if required, is another piece of it.

*Mr. Crenshaw. But can we get to that point without actually innovating the process of what we choose to cover?

I mean, you know, without reforming the fee-for-service system?

You know, will traditional Medicare have to create and

approved new benefit categories for, you know, those Ubers, or that nutritional support? Is that really the most effective way?

*Dr. Batra. That is true, you will have to overhaul it. Like hearing aids, for example, is not a Medicare-covered benefit. So being a primary care physician, dental is so integral to your medical health, as well as your overall health -- is not currently covered by Medicare. There are other areas. Like, vision is not currently covered by Medicare.

So there have to be certain areas of priority. And given today, where we are -- technology can play a lot of role in some of these areas. As we think about rural area, for example, telehealth access could be one of them. Similarly, addressing social needs could be another one of them. And yes, you know, we can deliver food much better now, perhaps, than we could have done a few years back. So those all become core to it.

And you are right, there has to be a balance between social and medical on both sides, I would say. Not only social and medical --

*Mr. Crenshaw. Yes.

*Dr. Batra. -- but functional and behavioral, as well.

*Mr. Crenshaw. Thank you. My next question is for Dr. Syed.

You know, based on your primary care experience, the practice you represent is dedicated to improving primary care for seniors. And I would like to know, would integrating a program modeled on direct primary care, which currently does not exist within our Federal payers like Medicare and Medicaid, but would allow for beneficiaries a personal primary care coordinator, would you find that beneficial to improving health outcomes?

*Dr. Syed. You know, I find full risk, full capitated doctors and direct primary care doctors having much in common. I often times compare our -- both styles of practicing medicine. We are both two arrows that have been shot out of the same fee-for-service bow.

Definitely, there is a population of patients that benefit -- that would benefit from direct primary care. I believe now there are over 20,000 direct primary care doctors out of 200,000 primary care doctors in the country. So for a set population, I see there being benefit there. But in the world where I live in, my patients are struggling with the basics. We have centers, for example, in St. Louis, where more than 90 percent of the patients rely on us to provide them transportation services.

*Mr. Crenshaw. In my remaining time, could you also comment on the question I asked about moving from a fee-for-service to a value-based system, and how that is necessary to

really innovate, and to be able to cover these social determinants?

*Dr. Syed. Absolutely. I would like for you all to think about value-based care, or especially the fully capitated value-based care model, as full responsibility, where the doctors, the primary care doctors and the primary care delivery team, assume all the responsibility. If the quality of the care is expensive, it is on the doctor. If --

*Ms. Eshoo. Yes, the gentleman's time has expired.

*Dr. Syed. Oh --

*Ms. Eshoo. I am sorry to interrupt.

*Dr. Syed. Sure.

*Ms. Eshoo. Okay?

*Mr. Crenshaw. Okay.

*Ms. Eshoo. Thank you.

*Mr. Crenshaw. I yield back my negative time.

*Ms. Eshoo. Thank --

*Mr. Crenshaw. Thank you, Chairwoman.

*Ms. Eshoo. I now would like to recognize the gentlewoman from Illinois, Ms. Kelly.

And for those that are with us today as witnesses, she really is the mother of the issue of maternal health on our subcommittee.

So, Congresswoman Kelly, take it away.

[Pause.]

*Ms. Eshoo. Are you there?

*Voice. It seems like she is having technical --

*Ms. Eshoo. She may be having technical difficulties. Then let's give her a few minutes.

Are you there, Robin?

[Audio malfunction.]

*Ms. Eshoo. No, I think there is something wrong with your audio. Maybe they can get it straightened out, and we will come back to you.

I will recognize the gentlewoman from California, Ms. Barragan, for five minutes of questions.

*Ms. Barragan. Thank you, Chair Eshoo, for holding this important hearing on advancing equity in public health, and for including my bill, the Improving Social Determinants of Health, as part of the conversation.

I also want to thank my committee colleagues who have cosponsored --

*Ms. Kelly. Can you hear me?

*Ms. Barragan. Maybe we can ask her to mute.

*Ms. Kelly. Can you hear me?

*Ms. Eshoo. If Robin is on -- and I don't see you -- please mute, and we are going to circle back with you. But there is some background noise, so make sure you are muted, and we will be back to you in a few minutes for your five minutes of questions.

You could proceed.

*Ms. Barragan. Thank you, Chair Eshoo.

I also want to thank my committee colleagues --

*Ms. Kelly. I don't know what is going on.

*Ms. Barragan. I want to thank my committee colleagues, Representatives Butterfield, Cardenas, Clarke --

*Ms. Kelly. Can you hear me?

*Ms. Eshoo. -- recognizing you now, because we had some audio problems, but -- so please mute, so that we don't have your background noise. Congresswoman Barragan is -- has her five minutes now, and we will circle back to you. Okay?

*Mr. Ruiz. I will text --

*Ms. Eshoo. I hope you can hear me.

*Mr. Ruiz. I will text Representative Kelly, and if our -- if committee staff can text her and her staff, as well, I think that --

*Ms. Eshoo. Well, my staffer is contacting her staffer. It is like, you know, my office calls yours, but it is -- so far, it is not working. So I am trying to intervene by just -- by saying so.

Okay. Ms. Barragan, you can --

*Mr. Ruiz. Can we give Representative Barragan a full five minutes, due to those --

*Ms. Eshoo. I am not taking time out of her time for the interruption.

You can proceed.

*Ms. Barragan. Okay, thank you, Chair Eshoo.

I also want to take a moment to thank committee colleagues, Representatives Butterfield, Cardenas, Clarke, Blunt Rochester, Rush, Kelly, Welch, and Castor for cosponsoring this critical legislation.

The COVID-19 pandemic has had a devastating impact on communities of color. My district is nearly 90 percent African American and Latino, and I have seen what the crisis has done to low-income and underserved communities that don't have access to the services they need. Lack of access to transportation, unsafe or unstable housing, and food insecurity put individuals at a higher risk for worse health outcomes. Addressing these social determinants of health is crucial to reducing health disparities, not only during the current crisis, but as we work to strengthen our public health infrastructure into the future.

That is why I introduced the Improving Social Determinants of Health Act, which would provide funds to the CDC to establish a program focused specifically on social determinants. It would also establish a grant program for local public health departments to tackle these underlying issues that contribute to inequity.

Dr. Walker, how have social determinants of health contributed to minority health disparities, including

worsening health outcomes for those in underserved communities?

And why have these factors made it harder to care for communities of color during the recent pandemic?

*Dr. Walker. I think one of the first things that I recognized when the pandemic arrived in Delaware was that the communities of color would be most dramatically impacted, because they were unable to follow my basic advice of stay home and stay safe. They had to go to work. They had to put food on the table, and they were worried about their livelihood, and staying housed. And I think those are the challenges that we are trying to navigate as you think about social factors: How do we bring them together when issues around poverty and food insecurity all coalesce?

So having resources, technical assistance, data to inform better and more efficient program delivery, or community health worker support, or linkages would be a tremendous asset, not only to emerge from the COVID pandemic, but also to promote better health at local communities to really address the inequities that we have long known existed, so we could start to think about structural racism and the multi-level interventions that need to be developed and addressed.

And we will have to do it collaboratively, with community voices, with stakeholders engaged from the start.

Thank you for that question.

*Ms. Barragan. Thank you.

Ms. Blauer, data from the CDC found that African Americans and Latinos were nearly three times more likely than White Americans to be hospitalized with COVID-19, and twice as likely to die from the virus. Factors such as a lack of insurance, limited access to health care services, working in occupations in which telework is not an option, and being more likely to face eviction and homelessness in times of economic instability are only some of the reasons these disparities exist.

Unfortunately, there is a lack of complete, accurate, and standardized race and ethnicity data to help paint the full picture. The question is what existing state and Federal data infrastructure should be used to ensure clinicians and health systems and health plans that are implementing programs to address social determinants of health have accurate and comprehensive data on patient populations who would most benefit from these programs?

And where does the Federal Government need to make additional investments?

*Ms. Blauer. Thank you, Congresswoman. It is a very good question, and it is one that I have been thinking a lot about over the course of the last 17 months.

We still are completely in the dark in really

understanding, fundamentally, where populations had major obstructions to even accessing the very basic tools that they needed to navigate this pandemic, like testing and vaccine access. And that is because of the limitations on demographic data that has been paired with the release of COVID-19 information.

So first and foremost, there must be standardization and requirements on how data is collected, and how data is shared from local authorities, health departments, state health departments to the Federal Government, and there needs to be an optimization of not only how that data is collected, but how that data is broadly shared, so that local policymaking can align to where those needs are, so we can deploy the resources, so that people that are living in communities, particularly those that are disproportionately affected by health disparities, have equal access to the very tools that they are going to need to navigate not only this pandemic, but the very real health challenges that are associated with navigating all of the social determinants of health that you have remarked on in your comments today. So thank you for the question.

*Ms. Barragan. Thank you so much.

And thank you, Madam Chairwoman, for your patience, given the interruption. With that, I yield back.

*Ms. Eshoo. You are most welcome. Now, let's see if

our friend, Ms. Kelly, is -- I see her room on the screen, but I don't see her.

*Ms. Blunt Rochester. Madam Chairwoman, Ms. Kelly is in a dual committee, and so asked if I would --

*Ms. Eshoo. Okay, all right. Then the chair will go to recognizing the gentlewoman from Delaware, Ms. Blunt Rochester, for your five minutes of questions.

*Ms. Blunt Rochester. Thank you so much, Madam Chairwoman, for the recognition. And thank you to all the witnesses for being here today to discuss the important slate of bills at the intersection of data, health equity, public health infrastructure, and healthy outcomes.

I also want to give a special thank you and recognition to Dr. Kara Odom Walker from Delaware, a phenomenal job, and thank you for being here today.

I am also pleased to see two bills from the Black Maternal Health Momnibus Act being discussed today, and I look forward to having my colleagues support our bill, my bill. It is a bipartisan bill, the Moms Matter Act, H.R. 909, which is part of the Momnibus. The Moms Matter Act would make community investments to support moms struggling with maternal mental health and substance use conditions, and also grow the health care workforce in those sectors.

We know that maternal mental health is deeply tied to and predicted by the social determinants of health. Given

that next month is Black Maternal Mental Health Awareness Month, I hope that the committee will consider this bill and the entire Momnibus.

And Dr. Walker, could you share how -- how would improving maternal mental health and the health of mothers impact the lifelong health trajectory of their children?

*Dr. Walker. Thank you, Congresswoman, and thank you for your leadership to our great state.

I have to say that investing in maternal health, particularly around mental health, does have long-term impacts. We know that they are linked. We know that factors that happen early in pre-conception around trauma and stress during pregnancy and early post-natal care that -- risk their own lives, but also that of their child. And it is a huge factor in how children develop.

So maternal depression is linked to so many other outcomes for children: their economic success, long term; their ability to succeed in school; the likelihood that they will access child care and early education. And I think what we know is that even things around preconception diet all have longlasting impacts.

So if we can really think about the cognitive and behavioral development and the support of moms, making sure that we are looking at maternal depression, can ultimately impact a generation, ultimately impact the well-being of the

child. And I think what we have seen in COVID is that this issue is more important now, more than ever.

*Ms. Blunt Rochester. Yes. Well, shifting gears, Americans with lower incomes are frequent targets of tobacco industry marketing, and often face financial and other stressors that can lead to continued tobacco use.

As we know, tobacco use is a key driver of poor health outcomes, and a major health equity concern. Medicaid enrollees use tobacco at more than twice the rate of those with private health insurance. Yet Medicaid tobacco cessation treatment is often less comprehensive than what private health insurance plans are required to provide.

In addition, there are barriers such as co-pays and sometimes prior authorization or step therapy that can also impact the insurance types.

Tobacco use also negatively impacts our nation's children. More than half of all children with asthma get their coverage through Medicaid and CHIP, and exposure to secondhand smoke can cause asthma attacks. That is why I was proud to introduce the Quit Because of COVID-19 Act, H.R. 2125, which would expand comprehensive tobacco cessation coverage to all Medicaid and CHIP enrollees. Fundamentally, this bill is really about equity, giving Medicaid enrollees equal access to effective tobacco cessation treatment so that they can live healthy lives.

And as we talk about recognizing and addressing social needs and improving health data systems, I can't help but think of Delaware's leadership as the first state to launch a statewide health information exchange back in 2007, the Delaware Health Information Network, otherwise known as the DHIN.

And so, Dr. Kara Odom Walker, if you could, just speak a little bit about the opportunities to leverage clinical health information networks like the DHIN to strengthen our public health data and public health response to both pandemics and the social determinants of health.

*Dr. Walker. Thank you, Congresswoman. We know that health information exchanges make it easier to exchange clinical information for treatment, care coordination. All of the witnesses have talked about that interconnection. And we are very fortunate to have a statewide health information exchange. This would allow us to really think about an opportunity to expand HIEs' ability and strength to not just look at clinical data, but also how we leverage social determinants of health data, because they are interconnected, and they are causal, and they really do indicate the need.

We really do need, as physicians, to think about the wraparound indicators around health, not just what is happening in that one-on-one patient encounter, but what happens when they are home, when they are at church, when

they are in their communities. And I must say that the pandemic has shown us that even more data integration across state lines is challenging. And so having the ability to share information in that way could be incredibly helpful for COVID. We needed that. We needed --

*Ms. Blunt Rochester. Thank you --

*Dr. Walker. -- to create a response across the board.

*Ms. Eshoo. The gentlewoman's time --

*Ms. Blunt Rochester. Thank you, Dr. Walker.

*Ms. Eshoo. -- has expired.

*Ms. Blunt Rochester. Thank you, Dr. Walker.

And I yield back, Madam Chairwoman.

*Ms. Eshoo. Okay, let's see. We need a band to welcome her back.

Are you there, Robin? There you are.

*Ms. Kelly. I am here. Can you hear me?

*Ms. Eshoo. Wonderful, all right.

*Ms. Kelly. Okay.

*Ms. Eshoo. We are thrilled to recognize you for your five minutes of questions.

*Ms. Kelly. Thank you --

*Ms. Eshoo. And all the --

*Ms. Kelly. Thank you, Chairman Eshoo and Ranking Member Guthrie for holding this hearing to discuss how we can improve our public health data infrastructure to advance

equity and address social determinants of health.

The COVID-19 pandemic has highlighted the gaps in our public health data infrastructure, but also provides an opportunity to better integrate and standardize data collection. Unfortunately, data on race and ethnicity continue to be incomplete across the public health system. This data -- these data are critical to identifying and addressing disparities in disease, prevalent health care access, and health outcomes. Addressing the social determinants of health is an important way to tackle health disparities.

I applaud Congresswoman Bustos's work on the Social Determinants Accelerator Act, and Representative Pressley's Anti-Racism in Public Health Act. Too often, social determinants of health is used as a stand-in for addressing issues of interpersonal and systemic racism. So it is important to continue addressing racism in public health.

Dr. Walker, how does racism and other structural inequities drive social determinants of health?

And specifically in your experience, how does it affect the health of pregnant individuals and their infants?

*Dr. Walker. Thank you, Congresswoman. We know that social determinants of health matter. And in fact, you know, what we do in a medical setting is -- about 10 percent of long-term life expectancy. And for that reason, many have

written about it -- the National Academy of Medicine.

Even at Nemours we were trying to figure out how to launch a social determinants of health screener to better understand all of the needs of the child. And we do that in pediatrics from day one of life, beyond. But what we know is that some of those predictors actually happen during the maternal period, during pre-conception, during the pregnancy. And so, if we can incorporate those same principles and strategies earlier on, we will have a chance to promote better health, long term.

*Ms. Kelly. Thank you. I would like to submit to the record "Addressing Racism and Socioeconomic Influencers,'' co-authored by the National Partnership for Women and Families and the National Birth Equity Collaborative, as part of their Saving the Lives of Moms and Babies series.

Also, Dr. --

*Ms. Eshoo. So ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Kelly. What are the current gaps in maternal health data collection?

*Dr. Walker. We know that we have data gaps, and some of those data challenges are around just having accurate, reliable, standardized race/ethnicity data incorporated and geocoded at the local level. So having data dashboards is critically important. We are, at Nemours, trying to geocode information that we have. But we see differences by race, ethnicity in who reports their own information. And I think that is an opportunity to provide guidance, to provide technical assistance, and really think about data standards to make it more informative and more useful, to allow the collaborations between public health agencies and health systems to better represent what is going on, and address those inequities in case.

*Ms. Kelly. Is it currently being collected by community organizations or the private sector that will be helpful to integrate with the clinical data, to better understand maternal health risk factors?

*Dr. Walker. Yes, it is being collected, but I think the challenge is that there often are gaps in what we have. For example, we have some information in our health record that isn't necessarily the same as what is in our health information exchange. And so there just is a process of making sure we are using the best data available, that we are

using self-reported race/ethnicity, and that we are sharing that same information at the highest quality available with others who are trying to collaborate, and really address inequities.

But it does take everyone. Otherwise, we are without that data and high-quality data. We are -- our challenge in trying to overcome the barriers and leaving people out, particularly in communities of color.

*Ms. Kelly. Thank you, and I yield back.

*Ms. Eshoo. The gentlewoman yields back. I am glad it all got straightened out, and thank you, Robin, you are wonderful.

The chair is pleased to recognize the gentlewoman from Minnesota, Ms. Craig, for your five minutes. Thanks for your patience. We are thrilled you are on the committee.

*Ms. Craig. Well, thank you so much, Chairwoman Eshoo, and especially for holding this incredibly important hearing today. And thank you to all of our witnesses for being so patient with us and our very many questions, as well.

I appreciate, especially, the focus on the drivers of health disparities: race, ethnicity, sexual orientation, gender identity, and social determinants of health like access to transportation and housing.

I represent a district that is equal parts urban, suburban, and rural. And many folks living outside of the

major cities don't have reliable access to in-person appointments with medical professionals. I was recently appointed to serve on the Select Committee on Economic Disparity and Fairness and Growth, where I will have an opportunity to address the economic inequalities faced by rural communities, disparities that have a direct impact on health care access and outcomes.

I am also a proud cosponsor of many of the bills up for discussion today, including H.R. 2503, the Social Determinants Accelerator Act. Introduced by Congresswoman Bustos, this bill would create a program at CMS to provide grants to state and local governments to develop plans to combat social determinants of health that are negatively impacting health outcomes.

With that, my first question is to Dr. Odom Walker.

Rural residents in my district face long drive times to the doctor, and lack of high-speed Internet. For instance, rural Minnesotans seeking inpatient mental health and chemical dependency treatment must travel three times longer than urban patients, on average. And many in my district have limited to no broadband access, making it very difficult to reach them via virtual health care. This lack of access, undoubtably, leads to worse health outcomes, and it is not an uncommon story in my part of Minnesota.

How could the Social Determinants Accelerator Act, Dr.

Walker, which invests in state and local capacity, help rural communities fight these factors that are leading to negative health outcomes?

*Dr. Walker. Thank you for the question, Congresswoman. I think it is unique, and one of the opportunities with the Accelerator Act is that -- you invest at the local level to hear from stakeholders, hear from communities about their particular situation and needs.

For example, maybe a strategy that could be invested is a telehealth kiosk that is at a local entity, a community center, something that is, you know, commonly available, to provide that telehealth and broadband access in a stable way. These are the kind of ideas that some have deployed, but it needs scale. It needs, you know, to do more of it where it works, because just putting telehealth into place doesn't necessarily overcome those challenges. And if you have to drive three hours to the doctor, that also is not necessarily addressing the challenges of rural communities.

So really trying to figure out how to make it unique for the community that we are talking about, and making sure that we are looking at the right lens, the right problem, and with the right data is really important in this bill.

*Ms. Craig. Thank you so much, Dr. Walker. My next question is for Dr. DeSalvo.

I am a proud original cosponsor of the Black Maternal

Health Momnibus Act, which includes H.R. 925, the Data to Save Moms Act. One provision of the Data to Save Moms Act would provide funding to promote representative community engagement within maternal mortality review committees, which are multi-disciplinary committees in states and cities that perform comprehensive reviews of deaths during or up to one year after pregnancy.

Dr. DeSalvo, why is it important to gather a diverse range of perspectives in maternal health data collection and reporting processes, including to the elevation of voices and experiences of people from communities most severely impacted by our nation's maternal mortality crisis, particularly communities of color?

*Dr. DeSalvo. Thank you for the question, Congresswoman.

We have an expression in public health that the work needs to be done with community, not to community. And that particular part of the Momnibus package describes that so well, that it is not just about experts looking at the data, people in medicine, or even public health professionals. It has to be done with community to understand what is being seen, and how to identify appropriate interventions that are culturally appropriate, linguistically appropriate, and are going to meet the needs of the community.

So that kind of engagement is essential, really, when we

are tackling major public health challenges like maternal mortality, which is higher than any other high-income country and rising in the U.S., and particularly acute for communities of color.

So the suite of bills not -- really helps us understand. It is quantitative. It is the voice of community. And, as you have raised in the prior question, it is a multi-pronged approach. It is not just about great medical care. We have to make sure people have access to the social needs being addressed, as well.

*Ms. Craig. Thank you so much, Dr. DeSalvo.

And with my time expired, Madam Chairwoman, I will yield back.

*Ms. Eshoo. The gentlewoman yields back. It is now a pleasure to recognize another one of the new members to our subcommittee in this Congress, one of the five women on the Democratic side of the aisle, the woman from Texas, Mrs. Fletcher.

You have five minutes for your questions. Thanks for your patience.

*Mrs. Fletcher. Well, thank you so much, Chairwoman Eshoo, for holding this hearing. And thank you to all of our witnesses for sharing your testimony with us today. It is really thoughtful, really insightful.

Social determinants of health has been an issue that

people in my district in Houston have been concerned about, researching, talking about in ways that are constructive and useful. In fact, we had a town hall on this topic shortly before the pandemic, and several roundtable discussions. And so I just really appreciate the perspective that you brought today, because, of course, we have seen during the COVID-19 pandemic that these issues affected outcomes across the country, as many of my colleagues have already discussed today.

So I think what has been really useful today is making clear to all of us on the committee the need for data to address the deficiencies in our public health care system. We have a great slate of bills to really get at that. And I think it is, you know, not just data itself, but more inclusive data that takes into account the social determinants of health, as we move forward.

And so, Dr. DeSalvo, I was really interested in your comments on creating a system with the community to collect data and address social determinants of health. And as we have seen from the COVID-19 vaccine rollout, for example, you know, as of earlier this month, I think June 7th, less than a quarter of Black Americans had received their first shot. And there is a considerable amount of mistrust in the health care system among minority populations. And this can be a huge barrier for people getting the care that they need.

So from your experience, how can we collect health data in a way that engages impacted communities to better address their needs?

*Dr. DeSalvo. Thank you for the question, Congresswoman, and just to acknowledge Houston as a place that has done some great work in multi-sectoral collaboration. And so you all do know how to address social determinants in a public-private-sector fashion.

With respect to seeing the data and being able to act on it, I will give you some examples that relate to public-private sector coordination and ways, certainly, that we at Google have been thinking about partnering, particularly with academics.

Early in the pandemic it was clear that there needed to be more understanding of how COVID-19 was disproportionately impacting communities of color. We worked with Morehouse, with the David Satcher Institute, to develop a COVID equity tracker that will also be able to now report out on other inequities or disparities in related diseases, like diabetes. So it is an opportunity for us to not only help them with data, but to help build technical capacity that can support public health decision-making.

Another more recent example, since you raised vaccines, is work that we have done with the Harvard Medical School and Ariadne Labs, again, to not only provide data insights, but

provide technical assistance and partner with them so public health departments, health care systems can see where there are vaccine deserts. Who needs extra help getting to a vaccine? Should we put up a pop up clinic on this corner to reach more people? Those are ways where everybody together can really begin to meet people where they are to get them the services that they need.

*Mrs. Fletcher. Terrific. Well, thank you for that, and I want to move on with the time I have to talk about another issue, which is that many public and nonprofit safety net hospitals serve large populations of low-income and diverse patients, and they are challenged by numerous social risk factors. And some have come together to share and innovate on best practices. And, you know, I have seen that in Houston, especially -- you know, we have a really good collaboration, and I think that is a part of how we do things in Houston. But they often lack data platforms that track both medical and social conditions, and facilitate access to services that respond to those needs.

So, Dr. Walker, in the time I have left I want to talk about your testimony. You talked about the fact that public and community-based organizations haven't been given the same level of investment as other healthcare organizations. Would you agree that investments for data platforms and safety net providers who often struggle under difficult financial

circumstances could drive progress in addressing health inequity?

*Dr. Walker. Absolutely. I think data informs strategy. And without that data, we are often leaving people out, leaving individuals and populations out, and have an incomplete picture of where we need to deploy public health resources, or make policy decisions, which, underlyingly, has been the challenge with exacerbating disparities.

I think that there is another benefit -- in the seconds I have -- just to have data available as a common good, instead of having disparate organizations, health systems and others, trying to piece it together.

*Mrs. Fletcher. Wonderful. Well, thank you so much.

And I am almost out of time, so I want to thank you again, Chairwoman Eshoo, for holding this hearing. I am so supportive of the legislation that we have covered today, and I am grateful for the chance to learn more from this wonderful panel of witnesses. Thank you so much, and I yield back.

*Ms. Eshoo. Thank you. Now I -- let's see. Oh, another one of our wonderful doctors, the gentlewoman from Washington State, Dr. Schrier.

You have five minutes for your questions.

*Ms. Schrier. Well, thank you, Madam Chair, and thank you to all the witnesses who spoke today.

Dr. Walker, I am so intrigued by the endless possibilities that data sharing and interoperability offer to improve childhood outcomes. So, from the perspective of a pediatrician, I think, wow, it would be really helpful to know which of my patients qualify for free and reduced lunch at school, because that could help guide me in conversations about nutrition and financial stressors, housing, whether the parents have the bandwidth or the resources to help their kids in school. It would even help me focus on community resources like story time at the library.

It would also be really helpful to know which of my patients rely on WIC and SNAP, since poor nutrition is associated with adverse behavioral and academic outcomes, but also with tooth decay. And so I could use that knowledge in the clinic to, say, apply fluoride to all my patients' teeth, as opposed to just hoping that they will follow through and see a dentist.

I would imagine that this kind of information would be really helpful for teachers, as well, to know which of their students are homeless or relying on social services.

So my question for you, Dr. Walker, is how do parents feel about data sharing between public health, social services, schools, and doctors?

*Dr. Walker. Thank you so much for that question, and I often think of the context of families, and how, as

physicians, we are often limited by not having the entire picture. And if I knew that a student wasn't doing well in school, in that clinical interaction I could ask whether they have been tested or need to be retested for vision screening, or have a hearing test, and whether that is a promoter.

But I do think that the issue of trust in data sharing is a real one, and one that we are always careful in navigating. But with the right support, the right technical assistance, we could make sure that we have the right data analytics in a protected environment, and allow us to think about how to do this in the right way, learn from those early adopter states that have already figured some of this out, like Oregon and some that we have mentioned earlier, North Carolina --

*Ms. Schrier. Right.

*Dr. Walker. And then some of --

*Ms. Schrier. And I think that brings me --

*Dr. Walker. -- that innovation.

*Ms. Schrier. Thank you. I think that brings me to my next question for Dr. DeSalvo.

First, I just want to thank you for your work on the app that we use in Washington State that was developed by Google, in combination or in partnership with our department of public health, so that, if you have got your phone with you, and you are near somebody with a positive COVID test, it

notifies you.

And so, given that experience with public-private partnerships and with privacy, I was just wondering, when we talk about kind of a relationship between schools and social services and public health and doctors' offices, how do you address privacy issues related to that kind of data sharing that would help patients and would -- yes, how would you address the privacy issues?

*Dr. DeSalvo. Yes, Congresswoman, thank you so much for raising the question. And I will echo what Dr. Walker shared, which is -- I am an internist. And always, we want to know more about the home context, or the social context to understand if that is what is, you know, driving some of the -- uncontrolled diabetes, as an example.

I think what I have learned from not only patients, but what people tell you in focus groups and surveys, and you being -- when the National Partnership for Women and Families does surveys, or the -- or when we did the -- met the office of national coordinator -- is people want to know that they can have some sense of knowledge about who has access to their data. That is the transparency part. And they very often -- people they trust. They just need to know that they have some control over how that happens.

And the -- in this space that you are describing, which -- I mean, technically, some of those entities fall outside

of HIPAA -- there has been a lot of work in thinking about how, as we are going to -- as a healthcare system, and a public health system, be more inclusive of data, give consumers that choice and control --

*Ms. Schrier. That makes sense.

*Dr. DeSalvo. -- sharing.

I will just call out the particular place that provides the -- that has been doing the thinking on it. It is a group called the CARIN Alliance, not as in my Karen, but C-A-R-I-N, working with consumers and others to understand content.

*Ms. Schrier. Thank you. One more question for you. There is a lot of what-ifs about COVID, and how we handled it, what could have gone better. And I think about whether, you know, if we had a really modernized, interoperable digital, wonderful health infrastructure, if we could have used, say, wastewater testing for COVID in order to really direct our public health response, and now we are talking about tracking COVID-19 variants in a -- in one of the bills being discussed today. How could an optimally-situated public health department use data about new variants to curb spread of disease?

*Dr. DeSalvo. In a few seconds, just to say what was desperately missing for public health was not only the now, casting the data that Dr. Blauer was able to provide the country, but the opportunity to forecast and be able to

predict what -- where the virus was going to spread, and where variants would spread into the future.

We have partnered to create a system called Global.Health with Global Public Health to begin to advance that work in forecasting. But the bills that you have before you, the kind of work that Congress is doing, is thinking about not just the data, but the infrastructure and the people who work on that data around it. So it has got to be a system in order to prevent the kind of outcomes that we had in this last pandemic.

*Ms. Schrier. Thank you very much.

I yield back.

*Ms. Eshoo. The gentlewoman yields back. I am getting a kick out of myself saying "yields back,'' because I have let so many members to go way over. So they really don't have any time to yield back, but we have accommodated everyone. I hate to cut people off, because everything, every question and answer, is just so important to us.

And now, last, but certainly not least, a real value-added new member to the committee, the gentlewoman from Massachusetts, Congresswoman Trahan.

You have five minutes for your questions.

*Mrs. Trahan. Well, thank you --

*Ms. Eshoo. How about five and a half?

*Mrs. Trahan. The joys of going last, I get a little

extra time. No, thank you, Chairwoman Eshoo. And thank you to all the witnesses here today. It has been so informative.

There is no question public health data is multi-faceted, and it resides in different agencies and institutions that span across, you know, social services, education, behavioral science, and so much more. And improving data collection and closing those gaps is critical to our -- not only addressing the ongoing COVID-19 pandemic, but all of our other public health challenges.

You know, in 2015 my home state of Massachusetts recognized the value that data innovation has in inadequately -- excuse me, in adequately addressing public health crises, and passed Chapter 55, a law which authorized the Massachusetts department of health to link multiple, traditionally-siloed data sets with insight into the opioid crisis, an approach that had never been before sort of cross-studied. And the reports and underlying analysis drew insight from a database that linked mental health data, jail and prison data, vital records, you know, substance addiction treatment data, ambulance and counter information, the states' all-payer claims database, and others. And based on all those insights from Chapter 55, the reporting and the data visualizations, measures like limiting first-time opioid prescription to 7 days, a first in the nation measure, was signed into law.

So in 2017, when opioid-related overdose deaths fell for the state population as a whole, data showed it rose by 44 percent for Black males. And this data led the health department to develop a community-based public awareness campaign to focus on and reach Black men.

So you know, Dr. DeSalvo, I will start with you. Can you just speak once again to how cross-departmental sharing of information can be used to drive policy to combat public health crises in the country, such as the opioid epidemic?

*Dr. DeSalvo. Yes. Thank you so much, Congresswoman, for reminding all of us that bubbling under the surface is another epidemic that was here prior to the pandemic, and is beginning to re-emerge. So we have to, when we are thinking about building public health data systems, we have to remember they need to be useful, not only for communicable disease, but for other conditions that affect communities, opioids being a great example in Massachusetts, in this case, as in others.

It has been smart about leveraging multiple data sources that tell the story of a person's health or a community's health beyond just the health care episode. You are describing data sources that describe there are social and human services interactions, as well as their healthcare needs. And all of that will be necessary, if you are going to take a multi-pronged approach to developing community

interventions to drive equity and address social determinants, as well as medical needs, and then measure the outcomes, as you describe.

So a takeaway for me from that lesson you all have been teaching the country is multiple sources of data needed to tell the story of somebody's health or needs, and take action in a multi-pronged way at the community level, and know if we are making a difference in outcome. And we need to build those systems to be agile, so they can address the multitude of community needs that are there on the front lines.

*Mrs. Trahan. Thank you. You know, one other thing that was made clear to me is that, in order to collect robust data to tackle these public health crises, we must heavily invest in both public health infrastructure and workforce in the field of data and informatics.

And over the years, researchers have discovered a large variety of human biases that shows the things that people understand or believe do not always reflect what is actually happening in the real world.

And so question for you, Dr. Walker, could you just speak to how investing in a diverse pipeline of individuals and health data analytics can work to mitigate, you know, unconscious bias in the analysis of data that drives our policies?

*Dr. Walker. Thank you for that question. I think

having a diverse workforce is -- allows you to interpret the data in the right way. But I would also say it is not just about the professional workforce. It is also trying to figure out how to have community and stakeholders involved in that data interpretation stage.

So thinking about piecing together information, whether it is for the opioid pandemic or other inequities, we know that bringing them together is critically important, and requires an investment of expertise, but also of what you do with it, and how you put it out to the world, whether it is a data dashboard that we found incredibly valuable in the past year-and-a-half, or whether it is putting it in the hands of local community advisory boards who can say whether, for their community, it is more important to have broadband investments or to think about transportation.

So I think it is essential, and we just have to figure out where to --

*Mrs. Trahan. Yes. Well, thank you. And making that data consumable is job number one, so we know how to act on it.

So I am out of time, even though the chairwoman was gracious enough to give me a little bit more. So thank you so much for all of your input today. It is very helpful in our policymaking.

I yield back.

*Ms. Eshoo. The gentlewoman yields back.

Well, we have come to a conclusion of all of this time with members asking their questions. I want to thank each one of the witnesses.

You have been with us for a long time today, almost 4 hours, 20 minutes shy of 4 hours. So I hope you had breakfast, because you certainly have missed lunch.

Dr. DeSalvo, Dr. Batra, Ms. Blauer, Dr. Syed, and Dr. Walker, you have all been terrific.

Now, members have 10 business days to submit additional questions for the record. So witnesses, we are asking you to please respond as promptly as possible to the written questions that are going to be submitted to you.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. And now I want to go to my friend, the ranking member of the subcommittee, Mr. Guthrie, because we have 23 documents to be submitted into the record, and I would like to request unanimous consent, but I need your consent.

Is Mr. Guthrie with us?

*Mr. Guthrie. Our side consents.

*Ms. Eshoo. There you are. Thank you very much.

All right. So there is unanimous consent to enter the these documents into the record, and I think that is it.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. So thank you, everyone. Bravo to each one of the witnesses. It was a terrific hearing.

And we are going to move these bills. We have 13 today, in this legislative hearing. I think six -- I think there are six or seven that are bipartisan. So we are always pleased and proud about that.

But all of them are a reflection of the very important work of many Members of Congress in writing the legislation, and having our subcommittee have the honor of having a legislative hearing.

So God bless all of you. God bless our country. Thank you for being witnesses.

And the Subcommittee on Health will now adjourn.

[Whereupon, at 2:12 p.m., the subcommittee was adjourned.]