CHILDREN'S HealthWatch

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September 21, 2021

Congressional Social Determinants of Health Caucus

Re: Request for Information

Chairwoman Bustos, Chairman Cole, Chairman Butterfield, Chairman Mullin, and distinguished members of the Congressional SDOH Caucus:

Thank you for the opportunity to inform the work of the Congressional SDOH Caucus. Please accept these comments on behalf of Children's HealthWatch, a nonpartisan network of pediatricians, public health researchers, and children's health and policy experts committed to improving children's health in America.

Section 1 – Experience with SDOH Challenges

What specific SDOH challenges have you seen to have the most impact on health? What areas have changed most during the COVID-19 pandemic?

Although hardships experienced across the SDOH jeopardizes the health of people of all ages, the impact is particularly concerning for young children. Early childhood is a critical window of growth and cognitive development for children; during this period, the architecture of a child's brain is formed and even brief periods of deprivation have long-term impact on health and educational outcomes.[1] Investments in child well-being and that of their families in this sensitive period is critical, and has clear positive effects into adulthood.

Children's HealthWatch seeks to improve the health and development of young children and their families by informing equitable policies that address and alleviate economic hardships and dismantling systems of institutionalized discrimination and inequity at the root of these hardships. Our work begins with research interviewing caregivers of young children on the frontlines of pediatric care, in urban emergency departments and primary care clinics in five cities: Boston, Minneapolis, Little Rock, Baltimore, and Philadelphia. Since 1998, we have interviewed over 75,000 caregivers of children under four years of age and analyzed those interviews to determine the impact of unmet social needs and public policies on the health and development of young children.

Based on our extensive research, we understand the harmful health consequences of financial instability, as well as the critical role of federal government, programs, and policies in stabilizing young families, improving health, and promoting racial health equity. Specifically, our research focuses on the following social determinants of health (SDOH): nutrition, housing, health care, child care, utilities income and wealth, employment, adverse childhood experiences and experiences of discrimination. Our research – in addition to that of others – shows that lack of access to these basic needs is associated

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with poor child health and development, poor parental physical and mental health, child hospitalization rates, and learning and behavioral/emotional impairments.[2,3,4] The health impact of these hardships is often compounded, as they are frequently experienced simultaneously, often as a result of limited income and resources.[5]

Research from Children's HealthWatch and others show that public assistance programs across SDOH mitigate or alleviate these health impacts. However, several interrelated burdens and barriers exist within the structure and implementation of public benefit programs that limit their ability to engage all those eligible to participate and, as a result, may limit their effectiveness in addressing SDOH. These include language (written and verbal, and inadequate translation or multi-lingual services) and technology inaccessibility, numerous barriers to application and recertification requirements (e.g. in-person visits and limited location/hours, long wait times on helplines, frequent recertification periods, repetitive applications across benefit programs), and complicated program eligibility and requirements.

Income is strongly associated with positive health outcomes, but several interrelated challenges may prevent families from steadily increasing income and improving health. Families who earn low wages often have incomes that fluctuate based on seasonal earnings and irregular hours.[6] Fluctuations in income not only make it difficult to plan a family budget but can also make it challenging for families to stay connected to programs because the family may appear to be over income one month and yet qualify the next. Unpredictable income can also result in reduced or lost benefits when families must report temporary earnings. These burdens and barriers result from inefficient and inequitable program design. In addition to those embedded in the design of programs, several barriers exist that deter participation in critical benefit programs. For example, experiencing discrimination while trying to access a program. These barriers prevent continuous access to evidence-based support, particularly for Black, Indigenous, people of color (BIPOC) and immigrants; for many programs – including entitlement programs, such as the Supplemental Nutrition and Assistance Program (SNAP) – only a fraction of those eligible participate.

Inadequate funding of and restricted eligibility for assistance programs leave out millions of families in need. For example, three out of four eligible, low-income at-risk renters do not receive federal assistance due to funding limitations.[7] This has led to extensive waitlists – which families can report being on for over ten years – and housing authorities closing waitlists in response to high demand and limited supply. Similarly, the availability of child care subsidies – another basic need for working families with children that consistently takes up an outsized portion of a families' budget – do not meet the current need. While public investment in these critical programs creates opportunities for families across the country, current levels of funding are inadequate to meet the needs of all families, particularly those with low incomes.

Furthermore, some assistance programs, particularly housing and child care, may not meet the needs or preferences of eligible families, which may have ripple effects on other SDOH for families. For example, even when a family is able to access rental subsidies, they are often limited in choice of neighborhood

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due to well-documented racial discrimination and source of income discrimination in housing as well as inadequate supply of affordable housing. This has severe implications for families' social and emotional health, as well as their employment. In these circumstances, a family may be forced to move away from or may be unable to move to their desired community, where they have fostered deep social and community connections, in order to access available affordable housing. Geographic displacement to obtain housing may also create difficulties maintaining or gaining employment, as the available housing may not be in proximity to the workplace and have limited transportation available. This interlocking nature of discrimination and affordability limits neighborhood choice and drives inequities in health and opportunity for families. Additionally, for many families, the interrelated barriers of cost, location, hours, quality, cultural appropriateness, and availability of child care may restrict parents' ability to pursue work, training, and/or education.[8]

Since the start of the pandemic, prevalence of hardships has increased for families with children, particularly for families of color. Millions of families have struggled to maintain housing, put food on the table, and access child care. In response to the increase in hardship and new and exacerbated access challenges, Congress and Federal agencies authorized new policies and assistance programs (e.g. Emergency Rental Assistance, eviction moratorium, Economic Impact Payments, Pandemic-EBT) and transformed existing programs to better address challenges and meet need (e.g. increased SNAP benefit levels, increased and expanded tax credits, flexibilities within benefit programs). These changes decreased barriers to participation and have been critical to addressing SDOH during the pandemic, and research has already demonstrated their rapid stabilizing effects. For example, the first monthly disbursements of the expanded Child Tax Credit coincided with reduced reported food insufficiency and trouble paying household expenses among families with children.[9] Recent data has also shown that the supplemental poverty level decreased and then remained stable during the pandemic, likely due to significant federal investment.[10]

What types of gaps in care, programs, and services serve as a main barrier in addressing SDOH in the communities you serve?

The barriers listed previously (e.g. language and technology inaccessibility, barriers to application and recertification requirements, complicated and inconsistent program eligibility and requirements, program churn, and inadequate funding) are major gaps that need to be addressed to enable families with low incomes to access programs that support financial stability and promote health. An additional barrier to addressing SDOH is that government programs and policies are often not developed, implemented, or evaluated using a racial equity lens, and as a result may exacerbate racial and health inequities. These programs are often not informed by the people and communities that they serve, and as a result do not appropriately respond to differences in access, trust, and program impact among various populations. As acknowledged, these programs are also often developed, implemented, and evaluated in siloes, minimizing the ability to holistically address SDOH. The Congressional SDOH Caucus

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should urge agencies to provide, analyze, and share disaggregated data on program barriers' and impact, as well include and center throughout the process people with lived experience, BIPOC, and immigrant families. To address program access barriers and better meet the needs of families, the Caucus should advocate with members of Congress to:

- Improve and adequately fund public assistance programs:
    - Increase sustained investment in critical federal assistance programs to adequately meet need.
    - Expand eligibility limits and remove asset limits for federal assistance programs.
    - Account for income fluctuations by calculating income over a longer period of time for federal nutrition, housing, energy, cash, and child care assistance programs.
    - Create a more gradual decline in benefits across assistance programs that avoid an abrupt reduction or loss of benefits ("the cliff effect") and provide a smooth off-ramp for families joining or advancing in the workforce.
    - Expand eligibility for SNAP, Temporary Assistance for Needy Families (TANF), Medicaid, Supplemental Security Income (SSI) and other means-tested federal programs for all immigrants and eliminate the five-year waiting period for eligible immigrants in programs.
- Increase access to public assistance programs:
    - Improve outreach and awareness to ensure that all families receive the benefits for which they are eligible.
    - Increase federal funding and technical assistance for efforts to create a common application portal to allow families to apply for numerous benefits for which they are eligible at the same time. This would help to stabilize families across needs simultaneously.
    - Accommodate the needs of working parents by extending agency/program office hours and allowing online certifications and trainings.
    - Track peak times of in-person, online or telephonic contact and adjust staffing accordingly to decrease wait times for assistance.
    - Implement longer recertification periods to reduce paperwork and help families to bolster and stabilize their income as they make progress towards earning enough to make progress towards earning enough to consistently meet basic expenses.
- Promote economic mobility:
    - Transform economic policies so families have the tools to achieve financial security necessary to support educational and career advancement.
    - Increase equitable access to high-quality child care, Kindergarten, elementary, and secondary education.
    - Remove systemic barriers to educational and occupational opportunities and wealth accumulation.

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Again, Children's HealthWatch adamantly recommends that in the process of identifying such barriers and solutions include the perspectives of those with lived expertise and BIPOC and immigrant communities that have been historically and systemically shut out of policy debates. To improve program implementation and coordination, it is essential that people with low incomes that have experience accessing (or attempting to access) assistance programs are placed at the center of these discussions. This will achieve stronger services and better outcomes for all people and is critical for enacting policies and procedures that respond to the realities of families with low incomes.

Is there a unique role technology can play to alleviate specific challenges (e.g. referrals to community resources, telehealth consultations with community resource partners, etc.)? What are the barriers to using technology in this way?

Barriers to participating in public programs are compounded when families are required to complete multiple, repetitive applications and processes across benefit programs. The development of more universal and widespread tools for coordination, such as the creation of a common application portal for safety-net programs, is critical to support this effort. Research from Children's HealthWatch found that families who received housing subsidies, SNAP, and WIC were 72 percent more likely to be housing secure than those who received a housing subsidy alone.[11] Receiving support for two essential expenses – housing and food – likely allowed families to dedicate what they would have spent on those bills to other basic needs, like utilities, health care or child care. These findings in addition to others support the need for and impact of co-enrollment of families in government assistance programs as a mechanism to help families access the most comprehensive coverage and benefits for which they are eligible.[12] Such integrated eligibility would also decrease cost and administrative burden. Furthermore, leveraging Medicaid expansion infrastructure to enroll patients in multiple programs based on eligibility would improve health and economic security without overburdening the clinical delivery systems.[13]

Congress and implementing agencies should use technology to streamline access and decrease barriers to program participation, including to:

- Make COVID-19 waivers permanent to allow online and phone certifications, trainings, education and other remote processes.
- Track peak times of in-person, online or telephonic contact and adjust staffing accordingly to decrease wait times for assistance.
- Improve outreach and awareness to ensure that all families receive the benefits for which they are eligible.
- Coordinate and link data across government agencies (e.g. through the creation of a Common Application).

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Once implemented, agencies should also engage in a large, multilingual and culturally appropriate outreach and awareness campaign, in coordination with each other and on-the-ground organizations, to raise awareness of these options. For additional strategies and case studies, we recommend the report *Technology, Data, and Design-Enabled Approaches for a More Responsive, Effective Social Safety Net*.[14]

While utilizing technology will allow for better engagement and decreased barriers among many families, Congress must be aware that those with limited access to technology will continue to face difficulties. As such, these options should always be in addition to other mechanisms for program access and delivery. However, one opportunity to address this gap is to make families aware of other assistance programs that provide free or low-cost access to technology. For example, USDA could inform participants of the AT&T access program, which provides discounted Internet service to households that participate in SNAP.[15,16]

Section 2 – Improving Alignment

How could federal programs such as Medicaid, CHIP, SNAP, WIC, etc. better align to effectively address SDOH in a holistic way? Are there particular programmatic changes you recommend?

Often driven by a lack of financial resources, SDOH are interrelated and unmet social needs are often experienced simultaneously, compounding the health risk posed to children and their families. However, programs that address SDOH are often developed and implemented without coordination with one another. As mentioned previously, a common application portal and other integrated eligibility systems and processes would allow families to apply for numerous benefits for which they are eligible at the same time. This would help to simultaneously stabilize families across needs by maximizing enrollment in all programs for which a family is eligible. In addition, when families earn more income – for example through additional or fluctuating hours or an increase in wages – they are often abruptly cut off from assistance programs. This phenomenon, known as the "cliff effect", prevents families from becoming financially stable and mobile. To address this, programs should account for income fluctuations by calculating income over a longer period of time for federal nutrition, housing, energy, cash, and child care assistance programs. These programs should also be revised to include a more gradual decline in benefits across assistance programs that avoid an abrupt reduction or loss of benefits and provide a smooth off-ramp for families in the workforce.

Additional opportunities to better align programs to effectively address SDOH include:

- Continuing and expanding automatic eligibility across programs to reduce administrative burdens on families and administering agencies.
- Co-locate services and program enrollment specialist to support families access multiple resources at once (e.g. partner with assistance offices in hospitals, neighborhood health centers, housing, and early childhood settings – such as Head Start – that primarily serve families with low incomes to support access to a range of resources at once).

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What are the key challenges related to the exchange of SDOH data between health care and public health organizations and social service organizations? How do these challenges vary across social needs (i.e., housing, food, etc.)? What tools, resources, or policies might assist in addressing such challenges?

Agencies at the federal, state, and local level often collect and analyze data – including disaggregated data – on program participation and outcomes, but these efforts are often focused only on a narrow set of variables within the domain of the agency itself. This siloed process limits the ability to understand how these programs operate together to support children and families and how outcomes are improved across sectors. In doing so, agencies miss opportunities to understand the landscape of programs and interventions that serve the needs of families, and coordinate strategies that target or improve interventions across SDOH.

To address this and improve our ability to respond to the complex realities of child and family life, government can utilize modern data science to link data across systems and sectors. An opportunity to do so is applying similar methodology as the Massachusetts Public Health Data Warehouse[17] – a successful cross-sector database to explore the causes and consequences of opioid use disorder – to SDOH. This would demonstrate how government-funded child and family programs interact to affect multiple outcomes across the lifespan. This methodology exists in Massachusetts, and has been useful in planning successful public health interventions. Through better coordination and deeper understanding of access to services, health care utilization, school readiness and achievement, or employment and earnings, states and municipalities would be able to implement better policies and programs to address the needs of children and families – informed by data**.** Furthermore, creating opportunities to distinguish the effects of programs and policies by race, ethnicity, gender, region, and income through an annual report is a critical step toward examining the racial equity implications of policies and seeking opportunities to advance equity.

Another barrier to data sharing between health care, public health, and social service organizations is inconsistent data platforms. Standardizing tools and platforms across organizations and sectors may enable institutions to more easily share and analyze data.

In data sharing concerns exist around confidentiality and surveillance. Maintaining HIPAA compliance is critical for partnership to succeed, however the legal tools available for partnership can be burdensome. Guidance from the federal government on how health care, public health, and social service organizations can establish data sharing partnerships in compliance with privacy laws across sectors would be helpful.

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Section 3 – Best Practices and Opportunities

What are some programs/emergency flexibilities your organization leveraged to better address SDOH during the pandemic (i.e., emergency funding, emergency waivers, etc.)? Of the changes made, which would you like to see continued post-COVID?

Programs and emergency flexibilities authorized by Congress and agencies during the pandemic were critical to support families and protect their health and well-being. The following programs have provided evidence of effectives in reducing food insecurity and other hardships. These flexibilities should be made permanent:

- Expansions made to the CTC and EITC
    - Increase of CTC to $3,000 for children ages 6 to 18, and $3,600 for children under age 6.
    - Fully refundable CTC
    - Availability of advance monthly CTC payments.
    - Increase of EITC for individuals without qualifying children.
    - In addition, eligibility for CTC should be restored to immigrant children with ITINs.
- Direct, recurring cash payments to families.
- Emergency Rental Assistance Program.
- Investments in housing vouchers with services.
- Waivers granted by USDA to provide flexibilities in administering SNAP, WIC, and other child nutrition programs.
- Boost to SNAP benefit levels.
- Summer EBT.
- Expanded access to affordable ACA marketplace plans and Medicaid.
- Extended sick leave and medical leave.
- Additional funding for LIHEAP to meet need.

Which innovative state, local, and/or private sector programs or practices addressing SDOH should Congress look into further that could potentially be leveraged more widely across other settings? Are there particular models or pilots that seek to address SDOH that could be successful in other areas, particularly rural, tribal or underserved communities?

The most simple and effective approach to address SDOH and fight economic inequality and financial instability is to put more money back into the pockets of the people who need it most. In order to alleviate economic hardship and promote the health and well-being of every child and family living in the US, we must actively dismantle systems of institutionalized discrimination and inequity at the root of

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these hardships, and target the inequitable distribution of wealth and income, particularly across racial lines. An approach to boost income also gives families freedom and dignity by enabling them to prioritize their own basic need and to make choices that are best for their family. Further, when families have money to spend, they do so in the communities in which they live, thus stimulating local economies.

Several municipalities across the US have launched innovative Guaranteed Income pilot programs. Often targeted to families with low incomes and communities of color, these pilot programs examine the relationship between direct cash – without restrictions – and health and financial outcomes. The Stockton Economic Empowerment Demonstration (SEED) – the first mayor-led guaranteed income demonstration in the country – launched in 2019 and provided 125 randomly selected residents who met income eligibility (median income at or below $46,033) with $500 per month for 24 months. Notably, the cash was unconditional – meaning there were no strings attached or work requirements for recipients. Evaluation of the first year of this pilot found that a guaranteed income reduced income volatility, enabled residents to find full-time employment, alleviated financial scarcity, and was associated with better health outcomes including enhanced well-being and lower depression and anxiety.[18] The Magnolia Mother's Trust, which provided $1,000 per month for 12 months to Black mothers living in federally subsidized housing in Jackson, MS, is another example of the success of guaranteed income. The pilot's 2020 evaluation report found that mothers who received the monthly payments were better able to pay all of their bills on time, were able to save for emergencies, and had enough money for food, transportation, and health insurance.[19] These results are reinforced by findings around the success of EIPs to alleviate financial strife during the pandemic. Given these findings demonstrating the ability of direct payments to promote health and simultaneously address multiple SDOH, a guaranteed income model should be scaled and implemented across the country. In particular, guaranteed income should be prioritized for those in underserved communities that have faced historic and perpetual inequities in income, wealth, and health.

Given the evidence base about the importance of the early years in influencing lifelong health trajectories, what are the most promising opportunities for addressing SDOH and promoting equity for children and families? What could Congress do to accelerate progress in addressing SDOH for the pediatric population?

As a network of pediatricians and child health researchers, we know that in order to thrive children need consistent access to safe and high-quality housing, nutrition, health care, early learning, utilities, and all other basic needs. To ensure that this is possible, large investments must be made in public assistance and the social safety net as described previously to meet the needs of all families. In addition, Congress must ensure that all working families are able to earn a living wage. Multi-sector and structural changes to address the underlying causes driving economic instability, in addition to improving and restructuring existing assistance programs, are critical to address SDOH and promote equity for children and families.

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This includes prioritizing efforts to raise income and wealth, with a focus on policies to close income and wealth gaps. In order to effectively promote long term financial stability and economic mobility, Congress should focus on policies and programs that are rooted in advancing racial equity, help families of color and families with low incomes build assets and wealth, and center on the voices of people with lived experience.

Quantitative and qualitative reports show that BIPOC and immigrants disproportionately experience barriers in accessing and participating in public programs. Specifically, BIPOC and immigrant families, as well as families with low incomes experiencing hardship, experience discrimination across programs and public settings. An analysis of Children's HealthWatch data found that half of caregivers with low incomes experienced discrimination in their lifetime; among those that reported household food insecurity, over 21 percent experienced discrimination when applying for public assistance.[20] Discrimination, as well as stigmatization, against BIPOC and immigrant families attempting to engage with public benefit programs creates a major barrier to participation. Programs and policies intended to improve financial stability and health are only partially effective without simultaneously addressing racism and discrimination. While policy design is important, it is equally important to evaluate that the targeted support is provided in a thoughtful, racially equitable way and that programs include a robust implementation and monitoring plan. Furthermore, agencies should ensure that staff on the ground interacting with participants and implementing the programs are doing so in an equitable and professional manner. One opportunity to promote this is train staff (e.g. caseworkers and case managers) on trauma-informed approaches and implicit bias. Policies to racial inequities should directly address and respond to the disparate impacts and be deeply rooted in the specific community's history of discrimination rather than a broad-based approach to engaging and responding to community needs.

In addition to discrimination and stigmatization, immigrants experience significant de jure barriers to engaging in public benefit programs. Eligibility for federal nutrition, housing, and health insurance programs are complex and vary widely for immigrants across immigration statuses. These barriers to programs are rooted in systemic racism and xenophobia and impact the health of children in immigrant families. Removing barriers, including the 5-year bar on legal immigrants, to assistance programs and increasing access to health insurance are critical for promoting health equity among children and families.

In addition, agencies must coordinate with each other, the Administration, and local/state groups to cease hateful rhetoric, discriminatory policy-making (such as the 2019 changes to the public charge rule), and capricious immigration enforcement measures over the past few years increased fear among immigrant communities and has prevented engagement in critical benefit programs. Research has shown decreases in participation across multiple public assistance programs among families with immigrant members, for which they are eligible, concurrent with harsh rhetoric and publicized immigration enforcement policies – known as the chilling effect.[21,22,23] Our research at Children's HealthWatch demonstrated from 2017 to 2018 a significant reduction in eligible immigrant families

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participating in the Supplemental Nutrition Assistance Program (SNAP) and an increase in child food insecurity.[24] In order to respond to this harm, we strongly encourage all agencies to engage in a proactive outreach and public education campaign that is linguistically and cultural appropriate through deep engagement with trusted, community-based leaders. Such a campaign would send a strong signal to immigrants and their families that they can apply for immigration status changes and benefits even if a family member needs to rely on health care, nutrition, housing, or other public assistance. This is critical to reduce the chilling effect that has been documented over the past few years, and to ensure that families and children are willing to access critical supports for their health and development. Public messaging and education, backed up by policy change, will address persistent inequities among immigrant communities that deepened over the past few years, and will advance equity within programs. In addition, each agency and their supporting local/state offices must ensure that information on programs and policies are available and promoted in many languages. Immigrants experience further hurdles in program access due to inequitable availability of materials that respond to language needs.

People with disabilities, particularly those who are BIPOC or immigrants, often experience multi-marginalization and cumulative barriers to accessing benefit programs. These include specific in-person requirements and processes, and limited resources to respond to the needs of those with disabilities. Families of children with special health care needs are often not granted access to disability benefits, and experience great difficulty in accessing programs.[25] A lack of accessible, affordable, integrated housing at large and within public housing options may be single largest obstacle to community integration for people with disabilities.[26] Accessible housing must be integrated into communities and housing assistance, and be inclusive of all family members and children; buildings and complexes which are entirely occupied by people with disabilities are segregated housing options.

It is important to note that people are often a part of multiple historically oppressed groups and therefore experience multi-marginalization and compounded barriers and discrimination. While Congress and implementing agencies must consider outcomes of policies and programs for each group individually in order to understand disparate affects and inform changes, they should also understand that many individuals and families are at the intersection of these identities.

Section 4 – Transformative Actions

Alternative payment models help to measure health care based on its outcomes, rather than its services. What opportunities exist to expand SDOH interventions in outcome-based alternative payment models and bundled payment models?

Movement towards value-based payment models, in response to the influence of SDOH, has motivated providers and payers to invest in screening for and addressing unmet social needs among patients across a spectrum of SDOH. This often includes screening for unmet needs across food, housing, transportation, utilities, health care, and employment, among others. This approach has

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been critical to connecting families to emergency and long-term assistance and other interventions that address individual need and mitigate or prevent their health consequences. Challenges exist, however, including limited provider time to screen and intervene, lack of a quick multi-domain screening tool, and ability of institutions to suitably identify needs and provide targeted resources. The CMS Innovation Center and its 5-year Accountable Health Communities Model, while still under way, is an encouraging approach that demonstrates the need and political will to address this critical gap. Beyond expansion of this model, the *Improving Social Determinants of Health Act of 2021* is a promising legislative opportunity to address limited health care resources and challenges to implementation of effective value-based care. Supported by hundreds of professional health organizations and networks, health insurers, and community-based organizations, the *Improving SDOH Act* would enable health providers and systems to better coordinate, support, and align SDOH best practices and capacity building activities. In coordination with the Centers for Disease Control and Prevention, federal agencies such as CMS, and local public health departments, the Act would support these activities by ensuring that there are resources and policies in place to intervene effectively. Specifically, through increased funding opportunities, technical training, and evaluation assistance, scaled data collection and analysis, and identification and coordination of best practices, this act would increase the public health sector's capacity to engage with the health care sector and fully address SDOH priorities beyond temporary referrals and interventions.[27] Efforts like these are important to ensure that health systems are not only supporting their patients in achieving holistic health, but that providers also have the systems and resources to do so in ways that are sustainable, evidence-based, and avoid harms to patients.

A critical element of transformation, particularly for new models of care, is measurement and evaluation. With SDOH in mind, which are the most critical elements to measure in a model, and what differences should be considered when measuring SDOH outcomes for adults vs children?

Drawing from the lessons of Wilson and Jungner's principles of screening, models of care that incorporate SDOH screening and interventions should first and foremost achieve clarity of purpose – by identifying the particular social determinants of concern to patient health, health care providers' ability to suitably identify those needs, and what targeted actions will be taken – to best inform screening tool selection, social interventions, and subsequent outcomes measurement and evaluation approaches.[28] It is important that this process involve members of the community as co-equal partners in identifying the SDOH elements and outcomes of importance.

Any model of care that seeks to measure SDOH outcomes should focus measurement and evaluation on the providers' and institutions' ability to effectively 1) measure and 2) address health related social risks or concern (e.g., food insecurity, housing instability, transportation). A recent report from the National Committee for Quality Assurance (NCQA) describe health care organizations' use of both process (i.e., the number of patients screened or referred) and outcome (i.e., improvement from a

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baseline, meeting quality targets, impact on health care utilization) measures to evaluate the impact of their overall SDOH strategy and specific interventions.[29] This report also made note that the field currently focuses more on process measures for specific social needs rather than health outcomes and health care utilization outcomes.[30] Medicaid policy at the federal and state level should work to build the capacity of health care institutions to engage in meaningful process and outcomes measurement, while also strengthening the social safety net by reimbursing SDOH interventions, reinvesting savings to expand social services, and engaging cross-sector collaborations.[31]

How can Congress best address the factors related to SDOH that influence overall health outcomes in rural, tribal and/or underserved areas to improve health outcomes in these communities?

While many policies strongly recommended in this RFI response seek to strengthen assistance programs across SDOH and needs, we must acknowledge that access to financial resources is it at the core of these recommendations. Wealth and income inequality are growing and continue to disproportionately harm the youngest children from families of color with low incomes. Implementing and expanding programs and policies that serve young children and their families is an investment in the success and future health of our nation. Furthermore, acknowledging that systemic racism has contributed to disproportionate rates of poverty and health disparities among people of color – and prioritizing policies that respond to and rectify this – is critical to effectively promote economic mobility. Congress should enact long-term policies that respond to the current health and economic crises and provide the foundation for family health and ability to thrive. These include policies related to income, housing, nutrition, energy, health care, and early education and child care. Specifically, Congress should focus on cross-agency coordination and sustained program implementation that will increase the ability of all people to afford basic needs – most notably those disproportionately impacted by financial hardship, including families with young children, families of color, and immigrant families. Families with low incomes often experience co-existing material hardships; thus multi-sector and structural changes to address the underlying causes driving economic instability, in addition to improving existing assistance programs, are critical to reduce poverty and address SDOH. This includes prioritizing efforts to raise income and wealth, with a focus on policies to close income and wealth gaps. In order to effectively promote long term financial stability and economic mobility, Congress should focus on policies and programs that are rooted in advancing equity, help currently deprived families build assets and wealth, and center on the voices of diverse people with lived experience.

Sincerely,

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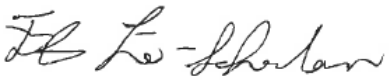

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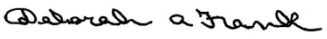

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