Health System Transformation Project Social Determinants of Health Investment Strategy

Introduction

The Rhode Island Executive Office of Health and Human Services (EOHHS) and the Rhode Island Department of Health (RIDOH) are committed to improving health outcomes for all Rhode Islanders and to improving community conditions where Rhode Islanders live, work, and play.

As the State and stakeholders undertake transformational efforts to move the healthcare system to one that is marked by accountability to quality and total cost of care, as well as a focus on population health, EOHHS acknowledges that the successes in terms of both health outcomes and healthcare costs will be drastically limited unless there are actions taken to address the social determinants of health.[1] Our vision for an HSTP social determinants of health investment strategy is to enable stakeholders to address individual health-related social needs and address upstream social determinants of health and racial inequities.

Currently, EOHHS's Accountable Entity (AE) program encourages closer ties among healthcare providers and community-based organizations (CBOs) to help address individual health-related social needs. While partnerships between AEs and CBOs have deployed innovative and thoughtful interventions, yielding substantial benefits for Medicaid members that are attributed to AEs, EOHHS understands that further support and State engagement are needed to ensure that these partnerships reach their full potential, that early successes can be built upon, and that the needs of all parties – and particularly the individuals that both health care providers and CBOs seek to serve – are met. These partnerships have also been very focused on individual health-related social needs, and EOHHS understands that the AE program must engage in efforts to address upstream social determinants of health and inequities as well.

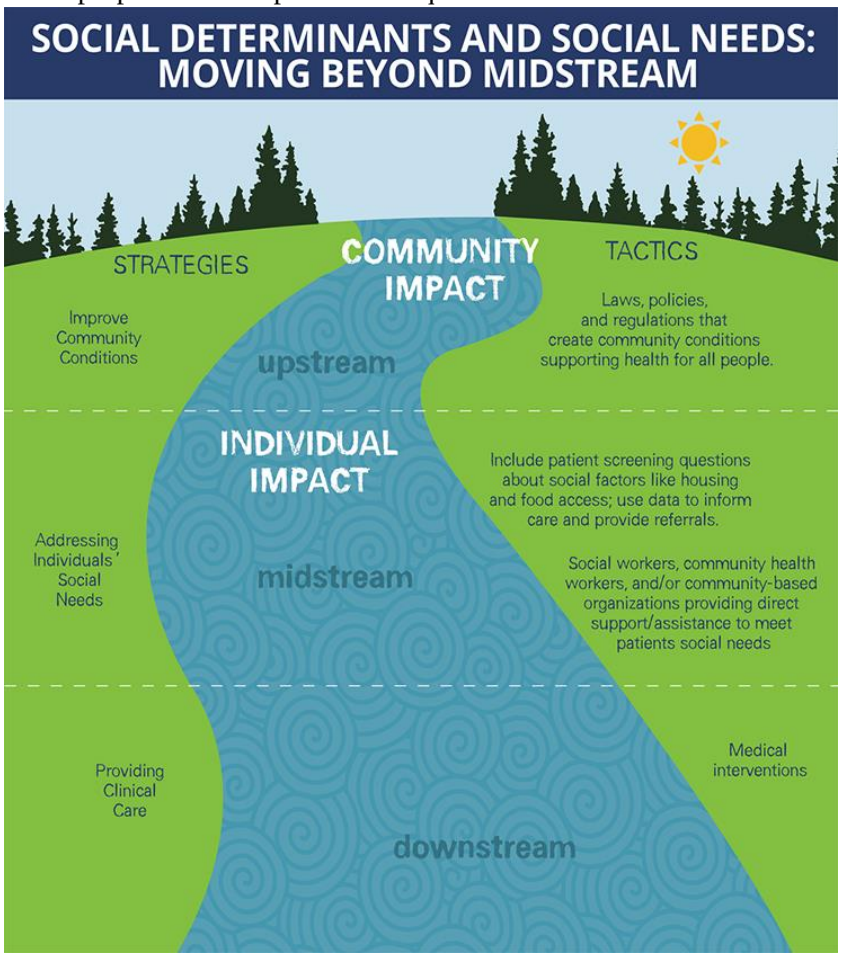
EOHHS intends to deploy Health System Transformation Project (HSTP) resources, approximately $3.5 million, to build CBO and health system capacity to a) address health-related social needs and b) impact community needs through systematic partnerships between AEs, Health Equity Zones, state partners, and other key stakeholders with a goal of improving community conditions. EOHHS and RIDOH recognize that each community is unique and that both community needs and the strategies to achieve systemic changes to meet them will vary. . The purpose of this document is to describe the proposed investments and strategy to reach our vision of reducing racial inequities by addressing the social determinants of health. These strategies were crafted following a literature review, surveys of AEs and CBOs, and stakeholder interviews that were conducted from May through July of 2020.

Research shows that health outcomes are determined by several factors. Genes and biology and clinical care each account for 10% of the variation in health outcomes across people. The physical environment, healthy behaviors, and social and economic factors account for 10%, 30%, and 40%, respectively. This

[1] In a recent article, Chris Koller, President of the Milbank Memorial Fund, suggests that now is a unique time for policymakers and purchasers alike to use their leverage to push for changes-to help remake a US healthcare delivery system. Christopher Koller, *Don't Rebuild the Health System, Reorient It*, MILBANK MEMORIAL FUND (2020) *available at* https://www.milbank.org/2020/05/dont-rebuild-the-health-system-reorient-it/ (last visited Aug. 7, 2020).

means that community conditions affecting the physical environment, behaviors, and social and economic factors together account for 80% of the difference in health outcomes across people.[2]

Communities of color in what is now the United States have been systematically subjected to racism and poverty since long before the nation's founding. As a result, there are significant racial and ethnic disparities in health outcomes and healthcare access, which, as supported by the previously mentioned research, is largely influenced by community conditions. A recent illustration of the impact of this painful dynamic is the COVID-19 pandemic, in which Rhode Islanders of color have experienced disproportionate case rates and outcomes. Latinx Rhode Islanders make up 16% of Rhode Island residents, but represent 44% of COVID-19 cases and over one third of hospitalizations. African Americans, who comprise 6% of the population, comprise 13% of COVID-19 cases and 14% of COVID-19 hospitalizations. There are also stark disparities by geography. For example, the rate of COVID-19 cases in the 02863-zip code in Central Falls is almost 30 times the rate of cases than in the 02874-zip code in Washington County. The drivers of these disproportionate impacts are inequities in social determinants of health such as health care access and utilization, types of employment, income, and access to housing.[3]



The "Social Determinants and Social Needs: Moving Beyond Midstream" graphic provides a framework for social determinants of health interventions that EOHHS and RIDOH are using to guide HSTP investments. It illustrates the concept of upstream, midstream, and downstream actions to improve health.[4] Upstream actions have a community impact and include "laws, policies, and regulations that create community conditions supporting health for all people." Midstream and downstream actions have an impact on individuals. Midstream actions address "individuals' social needs," while downstream actions include clinical care and medical interventions.

Because Medicaid eligibility is largely determined by an individual's income

[2] Determinants of Health Model based on frameworks developed by: Tarlov AR. *Ann N Y Acad Sci* 1999; 896: 281-93; and Kindig D, Asada Y, Booske B. *JAMA* 2008; 299(17): 2081-2083.

[3] Centers for Disease Control & Prevention, *COVID-19: Health Equity Considerations and Racial and Ethnic Minority Groups* (July 24, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.

[4] Brian Castrucci & John Auerbach, *Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health*, HEALTH AFFAIRS (Jan. 16, 2019), *available at* https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/

level, members experience higher rates of health-related social needs, including homelessness/unstable housing, food insecurity, lack of reliable transportation, limited access to child care, interpersonal violence, impacts of incarceration, and increasing social isolation, now being exacerbated by COVID-19. For purposes of both primary prevention and optimal management of existing health problems, it is vital to address these social needs as they affect individuals. It is also vital to address the underlying root causes of racial injustice and socio-economic disparities at the community level.

EOHHS and RIDOH intend to pursue a dual, mid- and up-stream approach, recognizing that by treating individual needs alone (mid and downstream) without addressing systemic factors like an acute shortage of affordable housing or the presence of food deserts in communities of color (upstream), it becomes likely that patients will be referred to service providers who cannot meet their needs.[5] Furthermore, without addressing the systemic drivers of inequity, the healthcare system will be perpetually paying on the back-end for poor health outcomes, while investments in treating individual health-related social needs become another cost within the healthcare system.

Vision

EOHHS and RIDOH envision[6] that HSTP investments in a social determinants of health strategy will generate:

- Robust coordination between healthcare providers and community-based organizations so that both parties are well-equipped to collaboratively address individual health-related social needs; and
- Active engagement by health system participants in community-led processes focused on addressing upstream social determinants of health and inequities.

To achieve robust coordination between healthcare providers and community-based organizations, EOHHS seeks to invest in:

- Enabling infrastructure and establishing a set of guidelines to facilitate member-centered coordination by supporting communication and navigation. This will support consistency across system actors within the healthcare and community systems to achieve administrative efficiencies and analytic capabilities to better serve Medicaid members' whole person needs. Such infrastructure will also help our members navigate the complex network of health care providers and community services that have developed over time. (See investments 2 and 3 below)

[5] See Elizabeth Tobin-Tyler & Benjamin Ahmad, *Marrying Value-Based Payment and the Social Determinants of Health through Medicaid ACOs: Implications for Policy and Practice*, MILBANK MEMORIAL FUND (2020), (discussing this dynamic as the problem of "building bridges to nowhere"), *available at* https://www.milbank.org/publications/marrying-value-based-payment-and-the-social-determinants-of-health-through-medicaid-acos-implications-for-policy-and-practice/

[6] This vision is consistent with and supports the long-term vision outlined in the "Health in Rhode Island: A Long Term Vision" plan which was unveiled in January 2020. That vision, "Rhode Island is the healthiest state in the nation," articulates three tenants, that Rhode Islanders: have the opportunity to be in optimal health; live, work, learn and play in healthy communities; and have access to high-quality and affordable healthcare.

- A learning collaborative model that will support healthcare and community-based providers in using these tools and translating standards into practice workflows, as well as building partnerships that can enable a dialogue and problem solving around both mid- and up-stream barriers to health. Only with consistent partnership between the healthcare system and community organizations, a partnership that must be facilitated and supported, can such barriers be addressed.(See investments 1, 4, and 5 below)

To achieve active engagement by the health system participants in community-led processes focused on upstream social determinants, EOHHS intends to build upon the robust, community-based collaborative infrastructure established by RIDOH's Health Equity Zone (HEZ) initiative. The HEZ provide a governance structure that puts decision-making in the hands of the community. The HEZ also provide a process for understanding communities' specific needs and assets, an essential component for achieving health equity. EOHHS seeks to implement a strategy to connect AEs and other health system actors to the HEZ infrastructure as partners in addressing upstream determinants of health. This partnership model recognizes that while it would not be reasonable to expect the health system to resolve these issues on its own, the health system, like other community actors, does have a role to play. EOHHS will also allocate funds to communities directly through a participatory budgeting process, which will give communities the power to decide how to direct those resources.

Proposed HSTP Investments

1. **Rhode to Equity**

RIDOH is currently supporting a project called the "Diabetes Health Equity Challenge: Supporting the community during the COVID-19 pandemic." The project is a short-term (five month) learning collaborative to build clinical-community linkages to support people living with diabetes who might be especially vulnerable to equity gaps in the context of COVID-19. Under the program, geographically-based teams applied to collaboratively work to improve outcomes for people with diabetes who are at risk of poor outcomes in the context of the pandemic. Teams consist of an AE, a Health Equity Zone; a Community Health Team; and community member with lived experience. There are currently two teams participating in the Challenge. Teams receive coaching in applying Pathways to Population Health[7] tools from national experts through a Learning Collaborative, as well as technical assistance in implementing local practice/organization changes and working towards upstream solutions to solve systemic health inequities.

EOHHS and RIDOH will collaborate to expand the Health Equity Challenge, renaming it "Rhode to Equity," so that all six (6) AEs can participate. Teams will receive facilitation and coaching through Well-Being and Equity in the World via a Learning Collaborative structure. Limited financial support will be available to support organizations and individuals in spending time engaging in the Learning Collaborative. Teams will identify health outcomes on which to focus (e.g., diabetes in the current model), as well as the social needs/ risk factors that they will address in order to improve the focal health outcome and the communities where individuals live, work, and play. These areas of focus can be the

[7] See *Population Health: Resources*, INSTITUTE FOR HEALTHCARE IMPROVEMENT, http://www.ihi.org/Topics/Population-Health/Pages/Resources.aspx (last visited Aug. 7, 2020); Somava Saha Stout et al., *Pathways to Population Health: An Invitation for Health Care Change Agents*, *available at* https://52617c5c-94de-4151-8b87-7265db51f116.filesusr.com/ugd/d072cc_8742cb3e9c5e410ba57ef587603f5983.pdf (last visited Aug. 7, 2020).

same areas currently being addressed by AEs, but areas for which integration with a HEZ and other CBOs will be beneficial in fully meeting patient need. It is intended that through this collaborative the team members will develop the skills and processes needed to better coordinate the healthcare services and social services to improve health outcomes for Medicaid members. Although managed care organizations (MCOs) are not a required team member, they are encouraged to participate. EOHHS anticipates MCOs will offer these teams the resources they have already built that will be helpful to the success of these collaboratives, such as, but not limited to, claims data analysis.

The Rhode to Equity creates a process for healthcare providers and community partners to come together and workshop an issue collaboratively. Through this approach, and with the help of a facilitator, the stakeholders are able to translate each other's respective languages and create working relationships that recognize the value that each group brings with the common goal of improving the health and wellbeing of the people that they mutually serve and support. We envision the Rhode to Equity as a vehicle to foster meaningful, long term collaborative relationships between the HEZ, AEs/CHTs and MCOs by providing a starting point for that collaboration.

The current Health Equity Challenge is slated to run through September 2020. Beginning in October, RIDOH plans to engage in a process with current participants and consultants to identify lessons learned to help improve the program design before expansion.

2. Sustain Community Health Teams

The Community Health Teams (CHT), that are funded in part through HSTP, consist of community health workers, a behavioral health provider, a peer recovery specialist, a "Screening, Brief Intervention, and Referral to Treatment" screener, and access to specialty consultants and referrals to non-medical services based on social determinants of health screening. The network of Rhode Island CHTs is an extension of primary care, working to facilitate access to community-based services to address complex environmental, medical, and behavioral health needs. CHTs are supported by the Care Transformation Collaborative (CTC).

EOHHS will continue to sustain the existing network of CHTs with HSTP funds and make administrative changes to promote closer alignment with AE operations. Existing contracts between EOHHS and CTC to support CHTs will be extended through June 30, 2021. Beginning in July 2021, EOHHS plans to integrate CHTs into the AE program, continuing to sustain CHTs with HSTP funds for the remainder of the HSTP program.

Recognizing that HSTP funds are finite, EOHHS will pursue long-term sustainability for CHTs. First, EOHHS will research waivers approved in other states, identify options that could permit reimbursement for community health worker services, and consider whether any of these options should be proposed as additional investments in our state budget. In addition, EOHHS will work with CHTs, MCOs/payors and AEs to ensure that providers are able to bill for all services that are already covered by Medicaid. This may include identifying and addressing any barriers to billing as well as ensuring comprehensive understanding of what is covered. Finally, EOHHS will work with AEs, OHIC, payers, and others to develop a sustainable payment model under which all entities whose patients/clients already benefit from CHTs or could benefit from CHTs, contribute to sustaining CHTs.

EOHHS recognizes that in addition to sustaining CHTs, it is important to address the duplication and fragmentation that can happen when multiple organizations seek to serve the same population with similar services. EOHHS encourages MCOs, AEs and CBOs to identify duplication in their model as part of this comprehensive sustainability strategy and would be interested in HSTP projects that look to eliminate

overlap in community health work that may arise from participation in Rhode to Equity, or in other areas of collaboration. EOHHS looks forward to working with stakeholders to identify solutions to duplication of CHW and CHT services and expects that addressing this problem will also enhance sustainability.

3. **Invest in IT Systems to Support Coordination: Community Information and Referral Platform (CIRP)**

When healthcare organizations refer patients to CBOs to address health-related social needs, there is generally no feedback mechanism for the healthcare organization to know the outcome of the referral, precluding effective follow-up and outcome measurement. CBOs receiving referrals from healthcare providers generally have no access to the health care provider's information about the patient, which may limit the CBO's ability to provide holistic care and require an individual to share the same information repeatedly with different service providers, which can be a daunting process for the individual. In addition, there is also no effective way to document system-level data about CBOs' capacity to deliver services to address health-related social needs, besides anecdotal information. This lack of data makes it difficult to show how an inability to address social needs impacts healthcare provision, the cost of that care, and the potential return on investment on spending on broader social needs.

It is intended that with a patient's consent, the CIRP would allow a healthcare provider to send an electronic communication with relevant information about the client to the CBO, before the client arrives, allowing the CBO to spot issues that impact service delivery. If the client arrives and receives a service, the CBO can report back to the healthcare provider, closing the loop. If the CBO does not feel they can assist the patient, they can communicate this back to the provider or send the referral to another CBO. This may help reduce patients' experience of being shuffled across many different organizations that are not able to assist them. If the patient does not seek out the service, or if the CBO cannot immediately meet the patient's needs (for example if the patient is placed on a housing waiting list) the healthcare provider will also receive that information and know that the patient's problem could still exist.

We see this platform as centralized infrastructure that can help sustain implementation of CHTs and community clinical linkages achieved through the Rhode to Equity. The CIRP can support health care organizations and CBOs to work as a team on issues that arise. If a client has multiple needs and has received multiple referrals, the CBOs and any CHT involved in the care would be able to communicate with each other and the healthcare provider as needed. Additionally, the platform would allow collection of data about the types of services that CBOs are not able to provide, whether due to limited staff capacity at the local CBOs or limited community resources (e.g., inadequate supply of affordable housing). This will facilitate advocacy by healthcare organizations and CBOs to increase resources for CBOs and the communities in which their patients live.

EOHHS recognizes that some AEs have already purchased technology platforms designed to achieve these CIRP goals and does not intend to require that AEs use the platform procured by EOHHS.

4. **AE engagement with HEZ**

EOHHS recognizes the value of the Health Equity Zone (HEZ) infrastructure. The HEZ is an innovative, place-based approach that brings people together to build healthy, resilient communities across our state. The HEZ model encourages and equips the whole community to collaborate to create healthy places for people to live, learn, work, shop, socialize and play. With 80% of health outcomes being determined in the communities where members live, it is essential to create meaningful connections between the AEs, MCOs and the HEZ. The Rhode to Equity described above is the primary path through which EOHHS and RIDOH will support development of these connections.

In addition to Rhode to Equity, and building from the relationships developed through that work, EOHHS envisions that AEs will be active participants within the HEZ but not be held "responsible" for fixing everything. AE participation within the HEZ will take place with the mutual understanding that all participants are unique and bring assets/value to the table and that the HEZ is designed to lift up the equity framework. AEs will engage with an appreciation that the community understands their unique needs and is able to prioritize those needs.

EOHHS and RIDOH will utilize the Rhode to Equity to facilitate initial engagement and continuously evaluate opportunities to support AE-HEZ partnerships. One important step towards identifying these additional opportunities is to conduct data collection and analysis of the geographic overlap between HEZ regions and where AE attributed patients live. Where a HEZ and an AE are serving the same population, there is an opportunity for collaboration to serve this population. Where there are AE patients in an area not served by a HEZ, EOHHS will work with RIDOH to determine how best to establish a HEZ as needed.

To support meaningful AE participation in the HEZ, EOHHS and RIDOH will work with AEs and HEZ to explore areas for engagement. Initial engagement will be facilitated through the Rhode to Equity by having HEZ and AEs jointly identify strategies to address one or more social determinant of health and its relationship to a specific health outcome within the AE/MCO cost model. This approach will provide valuable learning opportunities for both the AE and HEZ that can be expanded on as these partnerships expand and findings from the geographic analysis are refined. Additional opportunities could include:

- MCOs and AEs can collaborate with HEZ by contributing data analytics to complement HEZ information-gathering, action planning, and impact evaluation/performance management.

- MCOs and AEs can help connect community needs identified through the HEZ to clinical outcomes to identify areas of mutual interest/impact.

- Using lessons learned through the Rhode to Equity, the AEs and HEZs can establish long term joint plans of action to improve upstream barriers to health that are specific to the community and inclusive of the priorities and voice of the people who will be impacted within the community.

- AEs can engage as a member of the HEZ collaborative.

5. Participatory Budgeting

Participatory Budgeting is a democratic process in which a government agency funds a facilitator who assists members of the community to decide how to spend part of a public budget. Participatory budgeting provides community members with true decision-making power over real money. It gives voice to the community and those with lived experience of systemic racism, of what it means to navigate the health system as a BIPOC, and as a Medicaid beneficiary. It brings those we serve "into the room" in a meaningful way.

Participatory budgeting funds from HSTP will be focused on addressing upstream social determinants of health, while remaining consistent with the obligation to use HSTP funds towards "the establishment of AEs." EOHHS and RIDOH recognize that although the healthcare providers and social service providers play a very large role, there also need to be investments in the communities in which Medicaid members

live, pray, and play in order to ensure the success of the AE program and the improvement of Medicaid members' health outcomes.

Funds made available for participatory budgeting would be in addition to the $3.5 million committed to the other strategies identified above. EOHHS and RIDOH expect to announce more information, including the timeline for the project and the level of funding, this fall.

Conclusion

EOHHS and RIDOH will work with stakeholders to pursue five (5) closely related investment strategies that, together, will enhance Rhode Islanders' health and wellbeing by addressing both individual health-related social needs (midstream interventions) and community health and wellbeing (upstream interventions). These strategies are:

1. Rhode to Equity – Midstream and Upstream
2. Sustain Community Health Teams – Midstream
3. Invest in IT Systems to Support Coordination: Community Information and Referral Platform (CIRP) – Midstream
4. Accountable Entity Engagement with Health Equity Zones – Upstream
5. Participatory Budgeting – Upstream

EOHHS and RIDOH recognize that substantial work lies ahead to design each investment to maximize their impact, and look forward to collaborating closely with stakeholders, including AEs, CBOs, HEZ, MCOs, and individuals with lived experience in this effort. EOHHS and RIDOH also recognize that there is tremendous overlap amongst the five strategies and will work to ensure that there is coordination between the above investments.