Rhode to Equity Request for Applications

A. The Opportunity

The Rhode to Equity is an innovative funding opportunity made available through the RI Executive Office of Health and Human Services (RI-EOHHS) Health Systems Transformation Project (HSTP). The intent of this twelve-month learning and action collaborative is to provide up to 6 cross-sector teams with the opportunity to test and evaluate strategies that will build leadership and operational capacity for clinical-community linkages, resulting in place-based communities that improve both health and social outcomes.

B. Background and Context

1. Diabetes Health Equity Challenge

This work builds on the foundational work that was led by Rhode Island Department of Health's (RIDOH) *Diabetes Health Equity Challenge* where content experts from Wellbeing and Equity (WE) in the World provided technical assistance to two place-based teams that supported residents living with diabetes in the context of COVID-19. With project management and facilitative support from the Care Transformation Collaborative of RI, teams applied the tools developed through 100 Million Healthier Lives and the Pathways to Population Health (P2PH) framework to advance population health equity. Most importantly, teams built relationships between place-based community and clinical assets in Rhode Island including Accountable Entities (AEs), Health Equity Zones (HEZ) and Community Health Teams (CHTs). More information on HSTP strategies, the P2PH Model, and CTC-RI can be found in Attachment A.

2. Key Population Health Foundational Concepts

Rhode to Equity will be aligned with Pathways to Population Health foundational concepts.

Figure 1: Foundational Concepts

C. Rhode to Equity

1. About Rhode to Equity

In Rhode to Equity, teams will apply these guiding principles and the Pathways to Population Health framework to advance health equity in Rhode Island through clinical-community partnerships. To do this, teams will:

a) Learn from the person and plan for the population.

b) Focus on improving health and well-being for those at highest risk of health inequities. This will include an analysis of how underlying social determinants (availability of food, housing, digital access, etc.) and groundwater issues (racism, income inequality, residential segregation, etc.) drive health and life inequities.

c) Improve the health and well-being of people affected by inequities with active participation of persons with lived experience of inequities (equity in process and in outcomes).

d) Improve the health and well-being of geographic communities through an understanding of the community's specific needs and assets.

e) The teams—comprised of the AE/local clinical team(s), the Health Equity Zone, the Community Health Team (CHT) and other community-based organizations, and people with lived experience of inequities—will actively collaborate to achieve the goals of this initiative.

f) Improve population health equity outcomes through the strategic design and implementation of a balanced portfolio of interventions across the community and clinic to address upstream, midstream, downstream, and groundwater issues, using the Pathways to Population Health approach.

2. Benefits of Participation

Selected teams will:

a) Receive funding that assists with covering the costs of team participation;

b) Obtain customized technical assistance from national health equity content experts;

c) Be supported in applying well designed, evidence-based population health tools;

d) Engage with peers through learning sessions to explore "cross pollination" of ideas and understanding;

e) Be positioned to scale the team's work to further advance community and clinical solutions and policy.

3. Rhode to Equity Aim and Team Objectives

This project seeks to cultivate robust relationships among RI-EOHHS' Accountable Entities (AEs), community-based organizations, Health Equity Zones (HEZs), and Community Health Teams through the establishment of *place-based teams* that undertake collaborative *action* to improve clinical outcomes and social, environmental and economic drivers of health - the social determinants of health (SDoH) - that impact up to 80% of individuals' health.

a) Build a place-based community collaboration to improve population health outcomes with an equity lens:

- Engage a multi-sector team, including community residents, community-based organizations engaged with Health Equity Zones, community health teams, and primary care clinics who are all working to improve health equity within a specific geography.
- Connect with local partners motivated to take action to address health, well-being and equity together;
- Partner with people/patients with lived experience to inform the team on community needs and community solutions.
- All members of the team actively engage in activities of the learning collaborative.

b) Conduct innovative and strategic activities to improve population health equity:

- In order to understand which people are not thriving within both the AE's attributed population and the population residing in the HEZ catchment area, stratify these populations based on medical, place-based, and equity risks. Stratification will identify individuals at high and medium/rising risk based on physical health, mental health, social well-being, place, and equity factors (race/ethnicity, immigration, education level, etc.) Teams will have access to appropriate stratification tools for attributed AE members and HEZ community members;

- Understand the lived experience, needs, and assets of those at highest and medium/rising risk;
- Identify at least one underlying contributor to health inequity in which the team wishes to make measurable progress that requires clinical and community collaboration. Teams may address a wide range of social and health needs (e.g., inequities in behavioral health in the context of homelessness; inequitable outcomes for a chronic condition in the context of food insecurity; or disparities in COVID vaccination due to lack of community trust from systemic racism). It is expected that efforts to improve social and health needs will yield benefits for AE quality performance as well, particularly as teams work to address social barriers to care;
- Identify existing stakeholders, actors, initiatives, and assets that can support work to address the specific area of population health and equity;
- Identify the systems that are perpetuating inequity in physical and behavioral health outcomes and in social determinant outcomes (e.g., root causes such as racism, immigration status; in other words, policies and structures that lead to inequity).
- Build strategic partnerships to advance equity with appropriate stakeholders and actors identified above;
- Develop a balanced portfolio of strategies to a) understand the community conditions and root causes underlying a population's failure to thrive and b) meet the needs of the population that isn't thriving;
- Learn from other localities from across the country who have addressed the specific area of inequity to see if their successes might be adaptable to the local context;
- Develop and implement a way to measure inequities in health and well-being and to address social determinants, leveraging the tools available through Well Being In the Nation (WIN) and also leveraging local measurement systems;
- Identify and implement strategies to track any healthcare cost savings generated by these activities, so as to build the case for ongoing investment.
- Share data and lessons learned during implementation in a transparent way and contribute to the evaluation process.

c) Develop a pathway for sustainable systems change within team member organizations and in the community:

- Using the Pathways to Population Health (P2PH) Compass Assessment tool, set goals, create action plans, and measure/monitor progress in changing organizations' systems. As part of these action plans, team members will:
    - Identify effective policies and other levers to create systemic change;
    - Identify leaders who are willing and able to support the development of this work in the long term;
    - Apply a "strategic systems change" approach to addressing the targeted area of inequity to advance communities of solutions; and

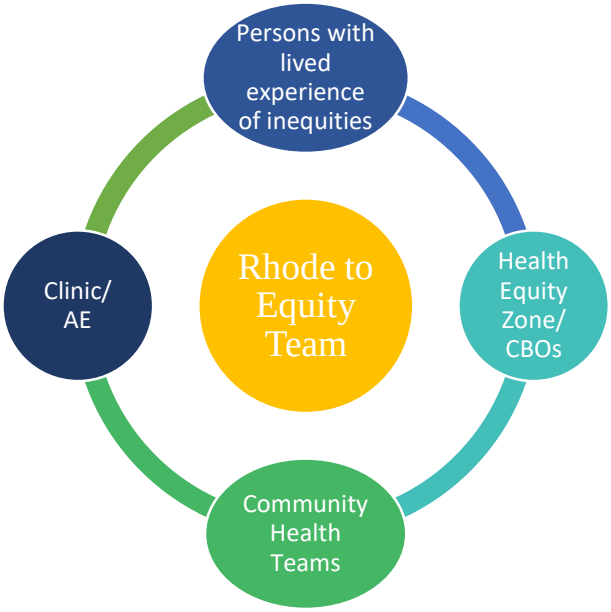
- Partner with MCOs to use claims data to better understand individual patients' risk over time.

D. Team Composition, Roles and Responsibilities

1. Team Composition

Rhode to Equity will bring together teams consisting of 1) AEs (at both the leadership and clinic level), 2) Health Equity Zones (backbone agencies, CBO partners), 3) Community Health Teams and 4) persons with lived experience of inequity (PLE) (see Figure 2). Team participants will commit to a common aim, a place-based population of focus, a set of measures and collaborative actions to improve downstream, midstream, and upstream care and conditions. Managed care organizations will be resources for teams, especially at the stage of population risk stratification.

Figure 2: Rhode to Equity Team Composition



Because multiple AEs may serve many members in the geographic area served by a HEZ, teams may include more than one AE. Each AE must be represented by a local clinic/practice in addition to staff from the AE itself. In all cases, we encourage teams to build on and strengthen existing networks, assets, data, and efforts. Subject to these team composition requirements, teams are expected to choose their own members. As described below, support will be available to potential team members through the process of team formation.

2. Expectations of the Team as a Whole

In order to achieve the objectives described above, teams will:

a) Focus on the geographic area jointly served by the HEZ and other team members.

b) Commit to learning about needs and solutions from people with lived experience of inequity.

   i. Teams will engage with persons with lived experience of inequity as a full partner in the "regular" work of the team (see "partner" defined in Attachment B). This includes participation in all/most meetings, including in smaller meetings related to advancing equity in programs, processes, and strategy.

   ii. People with lived experience should be engaged on the clinical and community side to better understand and contribute to meeting the needs of the community. For example, clinic team members can integrate interviews with persons with lived experience of inequity into regular clinical encounters and HEZ staff can speak with community members about community needs in the course of the HEZ's regular interactions with community members.

c) Select at least one population at high or medium/rising risk for health inequities, informed by the input of community residents and risk stratification. There is a great deal of flexibility with respect to selecting a target population. For example, this could be adults experiencing homelessness and mental health issues; immigrant children who are having difficulty accessing disability services due to immigration policy; older adults from a racial and ethnic minority group who are experiencing premature diabetes and cardiovascular disease, etc.

d) Use the key population health foundational concepts, guiding principles, and P2PH framework to plan, implement, and evaluate a strategic and balanced portfolio of interventions to advance health equity through clinical-community linkages.

e) Expand strategic multi-sector geographic partnerships to achieve the plan and meet the needs of the target population (e.g., partnerships to support older adults with devices and/or broadband for digital inclusion; partnership with senior centers/schools).

f) Participate in virtual learning sessions, coaching calls every two weeks, and weekly team meetings to develop and implement and evaluate strategic action plans.

g) Participate in Rhode to Equity strategy meetings, as requested.

h) As applicable, leverage the Community Resource Platform to support communication, referral tracking, and information sharing between team participants.

i) **All Team Members: Anticipated Time Commitment for Meetings:**

   i. Launch session (estimated at 8 hours, and may be offered as 2 4-hour sessions)

   ii. Weekly 1-hour coaching sessions

   iii. Team meetings: 1 hour every two weeks to conduct action plan work (coaches will not be present at these meetings)

   iv. Quarterly momentum sessions to learn from cohort teams and to touch base with other cohort teams (2 hours per quarter); WE Team may engage national experts/other states or localities who have advanced population health and equity

   v. Report out sessions

3. Roles and Responsibilities of Individual Team Members

a) Roles and Responsibilities of the HEZ/community partners

HEZ, acting as lead for the Community Partners, will be responsible for developing a balanced set of policies and programs to create community conditions that sustainably meet the needs of those affected by health inequities.

Deliverables/Expectations:

i. Partner with the AE/clinic, Community Health Team, and managed care organizations to receive and utilize place-based data on the health and social needs of the AE's attributed Medicaid members residing in the HEZ region;

ii. Engage with multiple stakeholders, potentially including community residents, AEs/clinics, CBOs/other agencies, and/or CHTs that operate within the HEZ but are not on the team, in order to obtain additional input/data to fully understand community needs.

iii. Stratify the places (neighborhoods) that have the poorest health and well-being outcomes (COVID-19, social determinants, and root causes of intergenerational poverty, e.g., structural racism).

iv. Develop/advance a multisector strategic implementation plan that includes input from the clinic and community health team and person with lived experience to address underlying determinants of health, including those revealed by COVID-19;

v. Lead the implementation of programs, policies, and investments to address identified inequities;

vi. Provide input about these needs to the greater team as part of broader community/clinical plan;

vii. Evaluate whether initiatives have led to improvement together with community residents experiencing these inequities.

b) Roles and Responsibilities of the AE/clinic team

The AE/clinic team is responsible for programmatic approaches to meet the needs of the clinical population of patients it directly serves. This team will work to stratify which patients living in the geographic area serviced by the HEZ are most affected by inequities, understand their assets and gaps/needs, and develop and implement strategies to address these needs.

Deliverables/Expectations:

i. Stratify risk of the population based on chronic physical or behavioral health condition, COVID-19, social risk, and equity risk (race, gender, place, education, income, etc.) with identification of people in the highest risk, medium/rising risk, and lowest risk categories;

ii. Build partnerships, processes and agreements between the AE/local clinic, Community Health Team, and MCOs to receive population management data and strategize about meeting the needs of highest and rising risk patients;

iii. Engage clinic patients in conversations around community conditions and potential solutions within their neighborhood;

iv. Refer the highest risk and/or medium/rising risk patients to the Community Health Team and/or other care management resources;

v. Develop a strategic plan to address identified needs through a combination of clinical-community linkages and a balanced portfolio of upstream, midstream, and downstream strategies;

vi. Create a storyboard detailing the data and outcomes; and

vii. Provide input about the identified needs to the greater team as part of broader community plan.

c) Roles and Responsibilities of the Community Health Team (CHT)

The CHT will work to meet the needs of people most affected by inequities (those at highest and/or medium/rising risk) who have a chronic physical or behavioral health condition and social needs who are residing in the community. They will also provide input into the development of community policies. The CHTs are mobile teams connected to a specific geographic area that can be composed of a community health worker, behavioral health clinician, peer recovery specialist, and/or other clinical or community supports. For the purpose of this project, a CHT may be a CTC-participating CHT, an AE-based or community-based CHT, an Assertive Community Treatment CHT, or other comparable team.

Deliverables/Expectations:

i. Receive referrals and conduct outreach to the highest and/or medium/rising risk people (identified by the clinic team), on an as-needed basis. Some people might be referred directly to the clinic's case management team;

ii. Determine assets and needs of highest and/or medium/rising risk groups and collect baseline data;

iii. Develop individualized plans to meet the needs of each referred person;

iv. Have a system in place to communicate back to the clinic the status and/or outcome of each referred person (close the loop), including regular working huddles; and

v. Provide input about these needs to the greater team as part of broader community plan.

E. Funding:

Based on the different roles and amount of time expected for each team member, the following funding will be available for each team member:

1. Health Equity Zone:

The HEZ will receive up to $77,900 (inclusive of payment to person (s) with lived experience and potential payment to community partners)

This funding assumes that one staff person will attend all meetings and perform approximately 20 hours per week of work outside of meetings. This funding includes the provision of a living wage hourly rate for at least one person (s) with lived experience of inequity to attend all meetings. If applicable, it would also include:

- Resources to support additional community-based organizations to participate on the team; and
- Resources to pay for an interpreter for the person(s) with lived experience at all meetings, if appropriate for that person.

2. Accountable Entity and Local Clinic/Practice:

The AE and local clinic/practice will receive $23,300

This funding assumes that one staff person will attend all meetings and perform approximately 6 hours per week of work outside of meetings.

3. Community Health Team:

The CHT will receive $14,000

Funding for participating Community Health Teams will be provided to cover the time spent in team meetings and performing work directly tied to the Rhode to Equity project.

F. Rhode to Equity Phase 1 Application Timeline and Planning Process

Rhode to Equity Phase 1 will support motivated teams to engage in a planning process to coordinate and accelerate their journey to achieving improved population health with an equity lens – the opportunity for all people to reach their full potential and contribute to the wellbeing of their community.

CTC recognizes that forming a team to apply to participate in Rhode to Equity may be a significant task, and CTC and WE in the World will offer support for team formation as described in the application timeline below.

Application Timeline:

Activity	Time
Post Request for Applications	February 5, 2021
Stakeholders submit questions and CTC posts written answers	Rolling basis Submit to: deliverables@ctc-ri.org
Webinars **Zoom Information:** https://ctc-ri.zoom.us/j/4665707463?pwd=V2huN0VDSmtrTUY4TTNQZi9iRHZ2dz09 Meeting ID: 466 570 7463 Passcode: 646876	• March 26, 2021 (2:00-3:30pm) • April 13, 2020 (11:30-1:00pm)
Office Hour application consulting available from WE Team **Zoom information:** https://weintheworld-org.zoom.us/j/92177879408 Meeting ID: 921 7787 9408	• April 1, 2021 (10:00-11:00am) • April 22, 2021 (10:00-11:00am) • May 13, 2021 (10:00-11:00am)
Application due:	May 21, 2021 **Submit to:** deliverables@ctc-ri.org **Contact person:** Jazmine Mercado, Program Coordinator Cell: 401-323-1414 Email: Jmercado@ctc-ri.org
Review and Selection process	May 21, 2021-June 4, 2021
Teams notified of selection with each team member sent Participative Agreement (Adobe-sign) and Compass Assessment	June 4, 2021
Participative Agreements due back from each team member (Adobe-sign) and W-9 as applicable	**Due:** June 18, 2021
Accepted teams complete Compass Assessment	**Due:** June 18, 2021
Team participation in "Kick off "session **Zoom information to follow**	• July 14, 2021 (1:00-5:00 pm)

G. Evaluation Criteria

The criteria that will be used to evaluate applications will be posted on the CTC-RI website by March 1, 2021.

Rhode to Equity APPLICATION

Application due May 21, 2021. For narrative responses, please write no more than 300 words for each response.

1. **Team member identification. Add additional rows as needed.**

	Primary contact person	Email address	Phone
Health Equity Zone			
Accountable Entity			
Local clinic/practice			
Community Health Team			
Person(s) with lived experience (Resource Faculty)			
Other (e.g., other community-based organization)			

2. **Describe the geographic region that the team will serve. This should align with the region served by the participating HEZ.**

3. **Describe any experience team members have of working together to address health equity. If you have engaged in a specific collaboration before, describe what you did, how that affected your collaboration, and what outcomes came from that collaboration.**

4. **Describe what a diverse team to address health equity means to you. Why are you interested in building such a team?**

5. **Describe any experience members of your team have in collaborating with people with lived experience of inequities.**

6. **Describe what each organization hopes to learn and achieve by participating in the Rhode to Equity during this 12-month learning collaborative.**

7. **Describe at least one goal you have for the collaboration you are building and, what would motivate you to sustain this team after Rhode to Equity? (please answer both parts of this question)**

8. **Describe the data and data systems you expect to use to understand the population of focus (on both the clinical and community side) and the inequities that the team decides to address in this project.**

9. **HEZ: Please include a budget for the inclusion of person(s) with lived experience.**

Compass Assessment

Each team member on each team selected to participate in Rhode to Equity must complete the Compass Assessment. Completing the Assessment will prepare team members to begin Rhode to Equity work with an understanding of their own current state (baseline measure). The Assessment is expected to take less than one hour for an individual to complete.

The Compass Assessment will be sent to selected teams together with the participative agreement and posted on the CTC-RI website by June 4, 2021.

Attachment A

Background information on HSTP:

The Rhode to Equity is outlined in the HSTP Social Determinants of Health Investment Strategy released in November 2020 (HSTP Social Determinants of Health Investment Strategy_Final.pdf (ri.gov).

Background on Well-being and Equity in the World (WE in the World and Pathways to Population Health (P2PH):

WE in the World was initially convened ty the Institute for Healthcare Improvement (IHI) to advance multi-sector improvement in population and community health. WE in the World focuses on adapting and scaling frameworks and tools that change mindsets and behaviors to improve health, well-being and create a culture of health.

The P2PH model has been developed, tested and scaled in the field, with significant improvements in building readiness and capacity in health care organizations and communities to work together to advance equitably advance population health. The P2PH four portfolios offer a simple way for health care organizations to organize their work in service of ultimately achieving a balance over time for greatest impact. Two portfolios relate to improving the health and well-being of the people health care is directly accountable for, and two relate to improving the health and well-being of the places a health care organization might be working (the places).

The Well-being and Equity in the World (WE in the World), together with EOHHS, RI DOH and CTC-RI, will design, support and/or facilitate design sessions for the Rhode to Equity to engage communities in a learning collaborative. The WE team will additionally support the development of a measurement and evaluation approach using an adapted Pathway to Population Health Compass Assessment tool. The WE team will host virtual sessions to support clinical-community partners who want to apply for the Rhode to Equity with the intent of supporting teams as they define roles and responsibilities, engage people with lived experience in meaningful ways and engage appropriate stakeholders to support system change.

Background on the Care Transformation Collaborative of Rhode Island (CTC-RI) and Wellbeing and Equity in the World (WE in the World):

CTC-RI was convened in 2008 by the Office of the Health Insurance Commissioner (OHIC) and RI-EOHHS to lead primary care transformation in Rhode Island in the context of an integrated health system. CTC-RI has years of experience in leading and collaborating on successful learning collaboratives, such as the *Diabetes Health Equity Challenge.*

CTC-RI's role in the Rhode to Equity roll out is to support the day-to-day project and event management and to provide thought leadership as an active contributor to this model, community facilitation and evaluation. CTC-RI Practice Facilitators will also be trained as coaches to be able to serve in this role alongside WE in the World.

Role of EOHHS and Rhode Island Department of Health:

The Rhode Island Department of Health has been on a journey to improve population health outcomes with an equity lens through its nationally renowned HEZ and successful primary care transformation efforts. The Medicaid Accountable Entities are now in their third year of implementation, working to screen for social needs and connect people with community health teams to meet the needs of people at high risk. Although the "legs of the stool" exist (AE, HEZ and CHT), these efforts can now coalesce into a comprehensive community-clinical linkage strategy that is funded through HSTP support along with EOHHS and RI DOH leadership.

Attachment B

Levels of Potential Engagement of Community Residents in Health Improvement Work with Expectation of Resource Faculty Engagement at the Partnership Level

	Consultation	Involvement	Partnership
Direct service provision	Ask what a client would want/need in terms of a service	Motivational interviewing integrated; health literacy; shared decision-making	Peer to peer (CHW, Housing Advocate), collaborative planning around individual health goals
Community or system design and governance	Journey-mapping, surveys (before, during, after), focus groups	Advisory Board, community members on task force, work groups	Community champions as part of leadership team or leading initiatives
Policymaking	Community needs assessment, virtual town hall meeting	Community recommendations integrated into improvement plan	Equal representation in decision-making over resources