

Public Comment on EOHHS SDOH Investment Strategy

Integra appreciates the opportunity to provide comment on EOHHS's HSTP Social Determinants of Health (SDOH) Investment Strategy. We commend EOHHS for its timely and creative proposals to address critical issues that affect the health and well-being of Rhode Islanders, and the success of the Accountable Entities (AE) program. We agree that our ability to achieve improvements in health outcomes and reductions in health care costs will be "drastically limited unless there are actions taken to address the social determinants of health."

One of the fundamental questions that EOHHS must grapple with is where responsibility for addressing these social determinants should reside. Certainly, as an Accountable Entity and a health system, we have an obligation to invest resources and effort into eliminating racial bias, reducing disparities in outcomes, and addressing social needs that directly affect the health of the population for which we are accountable. At the same time, we encourage EOHHS to challenge the assumption that health systems and Accountable Entities should hold primary responsibility for addressing "upstream" social determinants of health and racial inequities. We cannot do it alone, and all parties would benefit from clarity on our mutual roles and responsibilities in a collective impact approach.

In the end, the activities and priorities that we gloss under the umbrella of "addressing social determinants of health" boil down to programs to mitigate the negative effects of poverty and systemic racism. Of course it is absolutely critical for health systems and community organizations to work together with the state to identify and address barriers to health and improve equity of outcomes for our populations. As a health system of care, though, our focus is necessarily both narrow and fragmented, focusing only on our patients and the specific communities where they live—and we don't have exclusive responsibility, because other organizations are facing the same challenges, in the same communities, for the same residents. The structure of the AE program and of the health care system in general means that an AE like Integra can never be as effective or efficient at addressing SDOH as a state agency could be.

For that reason, in addition to the specific comments below, we strongly urge EOHHS to focus their strategy around large-scale, statewide, coordinated investments, and to try to avoid the temptation to simply delegate these investments to private entities (whether they are health systems or community organizations). Only EOHHS has the reach, funding, and mandate to make changes far enough "upstream" to have a transformative impact on SDOH.

We also strongly recommend that EOHHS work with other players in the health care system, including managed care organizations and the Office of the Health Insurance Commissioner, to ensure that statewide investment in addressing SDOH is not limited to Medicaid. Only a truly comprehensive approach, that allows systems of care to think about how to address SDOH across payers, will be able to be successful.

That said, while we believe that the strategy needs to "think big," we also recommend EOHHS not overlook the value of "starting small." Our early pilot efforts to coordinate with community organizations, through our Integra Social Partnerships Innovation Initiative (I-SPII), have already begun to have an impact and to suggest promising approaches for future collaboration. We would be happy to share some of those initial findings and successes with EOHHS, and look forward to an opportunity to meet one-on-one this fall.

Comments related to Rhode to Equity and AE engagement with HEZs (Strategy 1 and 4)

Rhode Island is becoming a national leader in implementing strategies to break down siloes and address the social determinants of health. EOHHS presents two strategies in this HSTP investment strategy in which Health Equity Zones and Accountable Entities—each its own multi-stakeholder initiative—collaborate around health equity and SDOH. Integra is highly supportive of this approach, and has been an active participant in the Health Equity Challenge, and has partnerships with the both the Central Providence and Pawtucket/Central Falls HEZ. We offer several supportive comments and questions to consider:

GEOGRAPHIC OVERLAP: What happens in the Rhode to Equity model (Strategy 1) and AE engagement with HEZs (Strategy 4) when more than one AE has a substantial population in a given geography? Is the vision that multiple AEs partner with a given HEZ and CHT under the auspices of a single, focused convening—or would there need to be a different grouping for each AE? We caution that managing relationships with multiple AEs would put an undue burden on HEZs in high need communities. How would concerns about competition among AEs (for resources and covered lives) be managed?

LACK OF GEOGRAPHIC COVERAGE: Conversely, what happens in the Rhode to Equity model when no single AE has a substantial population in a given geography—for example in rural areas, higher-income areas with pockets of poverty, or geographies with high proportions of uninsured residents? There a risk of exacerbating inequities in this case, and we encourage EOHHS to step in with strategies to mitigate this risk.

REACHING THE MOST MARGINALIZED: It is our understanding that HEZs have done excellent work in convening and uplifting community voices. But a pitfall in community engagement is that those who have the ability to attend meetings, and formulate their perspectives in ways that are legible to existing systems, can predominate over those with barriers to attending and being heard. HEZs are at different levels of maturity and activity in different parts of the state. Service providers have established a strong presence in the HEZs— is there evidence that those most directly impacted by adverse SDOH have attained a similar voice? We urge EOHHS to consider how AE-HEZ collaborations (Strategies 1 & 4) can ensure that community engagements continually center the perspectives of people impacted by the social, economic and environmental roots of ill health. How will the participatory budgeting process (Strategy 5) ensure this approach as well?

SOLUTIONS BEYOND ZIP CODE: Many adverse social determinants of health are concentrated geographically—but the solutions to unequally distributed conditions may be more effectively addressed in ways that are not hyper-local. For example, people experiencing homelessness may congregate or reside in specific locations as a downstream consequence of policy and economic conditions—but sustainable solutions require (at least) statewide engagement to address those conditions at their roots in budgets, employment policy, behavioral healthcare access, service coordination, etc. Integra suggests allowing for the possibility of one or more “Rhode to Health” convenings that are defined by subject matter as opposed to geography. To extend the example, a working group on housing and homelessness could follow a similar, focused format, and allow for HEZ(s) to participate, without restricting the scope to a given ZIP code.

CONSULTING RESOURCES FOR RHODE TO EQUITY: We recommend that EOHHS defer specifying that Wellbeing and Equity in the World will act as the consultant and facilitator for all initiatives under the Rhode to Equity strategy. Integra suggests that an open procurement process could result in a broader set of options to facilitate focused health equity engagements under this strategy. Potentially EOHHS could pre-approve multiple vendors and allow groups to choose consulting services that are best suited to their needs and scope.

Comments related to sustaining CHTs and CHWs (Strategy 2)

SUSTAINING CHTs Integra believes that all Rhode Islanders should be able to access high quality, coordinated services provided by interdisciplinary teams including community health workers. Our AE program has built a robust team providing such services to our Medicaid members experiencing medical and social complexity. The CTC-RI Community Health Teams (CHTs) have built similarly robust geographically-defined teams providing such services in a payer-agnostic way. MCOs also provide care management services utilizing team-based CHWs. AE, CTC-RI and MCO teams therefore have overlapping populations, catchment areas and accountabilities—and poor visibility into each other’s programming and clientele. EOHHS “recognizes that [...] it is important to address the duplication and fragmentation that can happen when multiple organizations seek to serve the same population with similar services.”

However, the suggestion that individual AEs’ HSTP projects or Rhode to Equity engagements develop strategies for eliminating overlap is likely insufficient to address these systemic challenges comprehensively. Integra suggests that EOHHS and OHIC allocate funds for a system-wide study of coordination and sustainability problems and solutions, and identify a funding source for any needed infrastructure to facilitate coordination. Broadly, we believe a model in which AEs and ACOs lead CHT services for populations for which they are accountable, and independent CHTs lead services for other payers and the uninsured—and in which there is an efficient and clear mechanism for assigning the appropriate team—would help ensure equity and coordination.

SUSTAINING CHWs: Integra is supportive of steps to promote the long-term sustainability of community health workers, a critical workforce for achieving health equity. While we support the option for fee-for-service reimbursement under Medicaid (whether through existing or new mechanisms), we believe that effective CHW-client engagements are built on trust, and trust takes time. Creating sustainability mechanisms that depend on or incentivize volume could have unintended consequences, including over-medicalization and prioritization of clients who require less time. Such effects could exacerbate, rather than improve health equity gaps. The state should incorporate voices from the field, and lessons from other states, in designing a sustainability strategy that incorporates multiple options and remains true to the spirit of the CHW field built on trust, time, and accompaniment.

Comments related to the Community Information and Referral Platform (Strategy 3)

There are large differentials of power and resources between healthcare organizations and providers of social services. And among CBOs themselves, there are differentials among large, established nonprofits, and small, grassroots community organizations. In the context of such differentials, the culture of the organizations with the resources tends to predominate—meaning that the priorities, language, information systems, and values of the well-resourced organizations prevail. Partnerships between CBOs and healthcare organizations can therefore reproduce broader inequities, including systemic racism, in ways that may not be easily visible to those with power.

Integra believes that all five strategies EOHHS is proposing should integrate mechanisms to evaluate and attend to such dynamics in process, outcomes and relationship. In particular, we suggest that Strategy 3, the Community Information and Referral Platform (CIRP), has the potential to reproduce inequities in unanticipated ways. We suggest that there are a number of complex considerations in evaluating a potential platform, which include:

- What is the opportunity cost of adopting a platform? Are referrals and linkages the most urgent investment need, as opposed to investments in capacity to provide social services?
- Has a large range of CBOs provided input into the structure and function of such a platform? Will such a platform drive resources towards organizations that are already well-resourced, and away from those with less—further replicating disparities among communities and the organizations serving them?
- What does the platform’s structure imply about what information is valuable?
- What working relationships among organizations does a platform prefigure—for example, what is the nature of a “referral,” and what relations does that imply and promote? Do resources follow referrals?

- Are healthcare organizations able to engage in multiple ways to reflect different relationships with community partners, or is there a single mode of engagement?
- Does the platform provide added value to trusting relationships between professionals and clients, or attempt to automate process best performed by people?
- Does a platform displace or disrupt existing informational systems in the place, and is this a net good?

We suggest that the best fit for a platform may be one that preserves a lighter touch, and maximum flexibility. Good intentions around implementing a coordinated information system may accidentally worsen health inequities by being overly prescriptive, or failing to incorporate flexibility, community voice, and a robust analysis of organizational issues at play.

Comments related to Participatory Budgeting (Strategy 5)

We applaud EOHHS's foray into participatory budgeting, and caution that meaningfully engaging people without a technical background in budgeting processes, and centering the voice of those directly impacted by systemic racism, poverty, stigma and systems failure is very difficult. We encourage EOHHS to provide for facilitators with credibility and a proven track record among communities of color, and provide sufficient time and financial support to allow for a deep, authentic engagement—including funds to compensate participants for time engaged in this process.