



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 structural social determinants of health.¹ Our vision for a Health System Transformation Project (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. This strategy is specific to the HSTP, which is a time-limited program through which federal funds are available to support the establishment of Accountable Entities (AEs). Outside of the HSTP, EOHHS is engaged in a range of other efforts to address social determinants of health, including but not limited to convening an Equity Council that discusses and makes recommendations related to upstream factors in the context of COVID-19 and participation in Governor Raimondo's efforts to invest resources in housing, through a dedicated funding stream, bonds, and revamped governance structures. In the context of HSTP, EOHHS is focused on opportunities to invest in capacity-building so that AEs and other stakeholders will have the tools, skills, and relationships necessary for ongoing engagement in this work. Continued policy work will be necessary to determine how to sustain these investments and incorporate them into the Accountable Entity model.

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

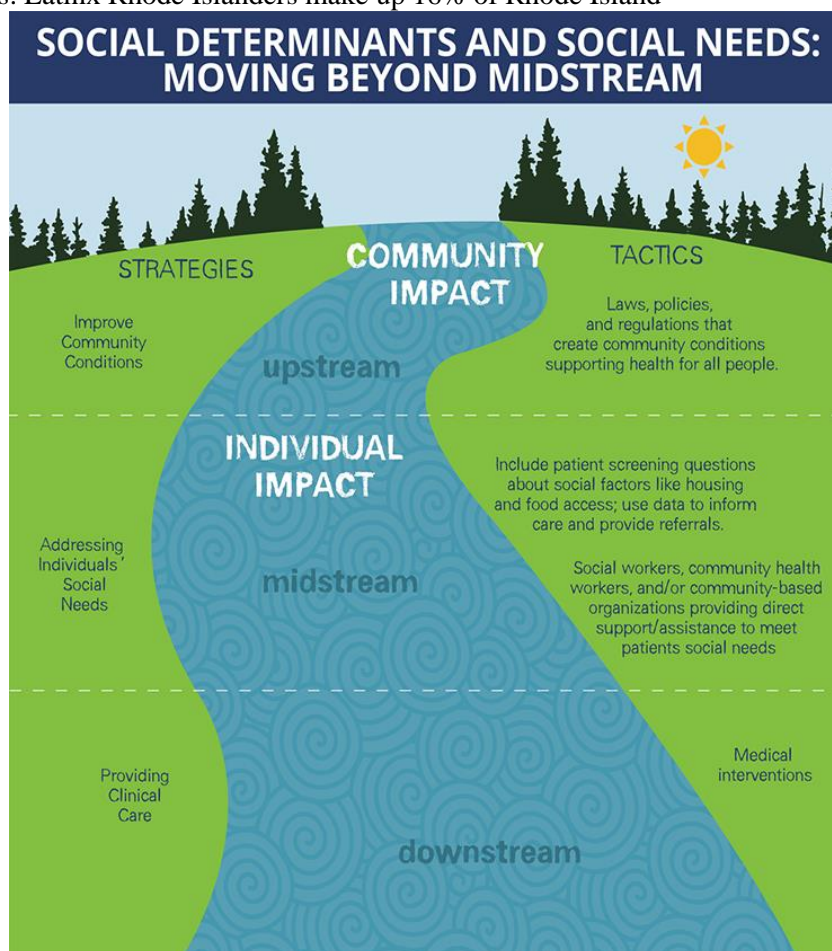
¹ In a recent article, Chris Koller, President of the Milbank Memorial Fund, suggests that now is a unique time for policymakers and purchasers alike to use their leverage to push for changes-to help remake a US healthcare delivery system. Christopher Koller, *Don't Rebuild the Health System, Reorient 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).

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 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



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>.

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 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 envision⁶ that HSTP investments in a social determinants of health strategy will generate:

1. 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
2. Active engagement by health system participants in community-led processes focused on addressing upstream social determinants of health and inequities.

The proposed investments described here are meant to advance this vision and facilitate AEs’ achievement of existing program requirements regarding the social determinants of health. As such,

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/doi/10.1377/hblog20190115.234942/full/>

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-medicare-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.

we are using this document to organize and frame the investments within the two parts of the vision statement.

HSTP Investments

Vision Statement: *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*

Rationale: Since the inception of the program, AEs have been required to develop processes to screen members for individual social needs and employed interventions to address those needs. AEs have forged partnerships with community-based organizations, and 10% of their incentive funds are required to go to organizations outside of the AE to support efforts to address social determinants of health or behavioral health. EOHHS applauds the work to date and aims to invest in infrastructure to support this type of coordination – both in terms of information technology and staffing. EOHHS will procure a Community Resource Platform to enable systematized screening, referral, communication, and data sharing between AEs and community-based organizations. This should support AE workflows as they engage in screening and referral activities regarding social needs and ensure that community-based organizations are not forced to interface with AEs across different platforms.

The role of the community health worker has become a prominent feature of interventions to address individual level social needs, which we have seen take form in Rhode Island and nationally. The state and others have invested significantly in developing the community health worker workforce and deploying community health interventions, most notably through Community Health Teams funded by the State Innovation Model test grant and subsequently HSTP. It is EOHHS' intention to sustain the infrastructure that has been developed to date, and to allow AEs the flexibility to reconfigure the role of community health workers within broader care teams. To this end, EOHHS will continue to invest in community health teams, while taking steps to transfer the administration and operations of those teams to the AEs. EOHHS also intends to pursue coverage of community health worker services as a covered benefit, to ensure this critical function can be sustained beyond the lifetime of HSTP.

EOHHS has chosen not to dictate payment arrangements between AEs and community-based organizations but will continue to require that AEs invest 10% of incentive funds in the community. Furthermore, EOHHS believes that a centralized platform to support referrals and data collection as well as a sustainable funding stream for community health workers will makes it easier for AEs and community-based organizations to determine collaboratively how services in the community are rendered, navigated, and financed.

Investment #1: : Community Resource Platform (CRP)

When healthcare organizations screen and 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.

With a patient's consent, the CRP 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 (see investment #3 below), as well as AE-CBO partnerships in general. The CRP 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). In particular, EOHHS expects that data related to gaps in resource availability can help illustrate racial inequities. This will facilitate advocacy by healthcare organizations and CBOs to increase resources for CBOs and the communities in which their patients live, with a strong emphasis on ensuring adequacy of resources for communities of color.

EOHHS recognizes that some AEs have already purchased technology platforms designed to achieve these CRP goals and does not intend to require that AEs use the platform procured by EOHHS. However, we have heard from both AEs and CBOs that a single platform that can be used across the state will be highly valuable. A single platform will allow CBOs to invest their staff time and effort to maximize understanding and use of the platform, rather than needing to divide attention and effort across multiple platforms. Use of a single system will reduce the administrative burden of daily use and increase the degree to which CBOs integrate the platform into their daily workflow. AEs that adopt the CRP will benefit from state-supported training and ongoing engagement with the vendor. Additionally, a single, centralized platform can enable the state to observe the collective needs of our population and resource gaps to inform program and policy decisions.

Investment #2: Community Health Teams

The Community Health Teams (CHT), which are funded in part through HSTP, consist of community health workers (CHW), 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). One critical aspect of CHT work is to make the healthcare system more accessible for patients and to bridge the historical and current gap that can be present between local communities and healthcare providers, especially for patients who may be subject to racism in different

areas of their lives – including in health care. CHTs are a critical element building trust and engagement between communities and the healthcare system.

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. EOHHS notes that the current CTC-led CHT program receives funding from several sources in order to implement the CHTs for patients with different insurance. HSTP funds are used to pay for services delivered to Medicaid members.

Recognizing that HSTP funds are finite, EOHHS will pursue long-term sustainability for CHTs. First, EOHHS has submitted for consideration through the Governor’s budget process for state fiscal year 2022 a proposed initiative that includes the coverage of community health worker services. The passage of such an initiative would enable EOHHS to pursue CMS authority to include CHW services within the Medicaid benefit package, and sustainably finance these services. States such as Minnesota and Oregon have already received CMS authority for such reimbursement. In addition, EOHHS will work with CHTs, MCOs/payers 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. EOHHS understands that for CHW services and certain other elements of CHT work, fee-for-service billing may not be efficient and may also incentivize “volume over value.” EOHHS expects to explore alternative payment methodologies, including but not limited to primary care capitation and care coordination capitation. 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 community health work, 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.

Vision Statement: *Generate active engagement by health system participants in community-led processes focused on addressing upstream social determinants of health and inequities*

Rationale: EOHHS recognizes that addressing upstream social determinants of health is a paradigm shift and that AEs are not expected to singlehandedly solve systemic social problems. However, as stated above, without consideration of the structural factors that disadvantage certain populations that manifest in poorer health and higher costs, our collective ability to impact social determinants of health will be limited.

Strategically, EOHHS intends to foster this engagement primarily by building upon the robust, community-based collaborative infrastructure established by RIDOH’s Health Equity Zone (HEZ) initiative. 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 HEZs. The Rhode to Equity described above is the primary path through which EOHHS and RIDOH will support development of these connections. The HEZs provide a governance structure that puts decision-making in the hands of the community. The HEZs 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.

EOHHS recognizes the challenges in connecting AEs, many of which serve patients across wide geographies, with a system of HEZs, which are place-based in nature. Further, there is no pre-existing, evidence-based model for systems-level community-clinical alignment. Therefore, it is the intention of EOHHS to approach this kind of engagement thoughtfully and with humility, and these investments represent a first step intended to forge a path for AEs, HEZs, and the state to enhance our collective ability to improve socio-economic conditions that impact health. As such, EOHHS is investing in a technical assistance program through which AEs, HEZs, CHTs, and other community members will engage in structured collaboration around a common, measurable goal. With the assistance of the tools and coaching described below, AEs, HEZs, and others will develop the shared understanding, relationships, skills, and capacity to work together effectively. These strong relationships, skills, and organizational capacities will be the foundation of the long-term community-clinical alignment that EOHHS seeks to foster. EOHHS expects that doing this work through the lens of a specific project will allow participants to form these connections more effectively than would be possible through more abstract discussions. The projects themselves are not expected to fully resolve local SDOH problems but will make positive impacts on the communities served while building AEs' organizational expertise in implementing place-based initiatives.

A second strategy to build community-clinical engagement is through participatory budgeting, through which AEs will collaborate with local communities to allocate HSTP funds to directly address communities' needs and give communities the power to decide how to direct those resources.

Investment #3: 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 Health⁷ tools

⁷ See *Population Health: Resources*, INSTITUTE FOR HEALTHCARE IMPROVEMENT, <http://www.ihc.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->

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.

The Pathways to Population Health framework encourages organizations to increase their capacity in four domains:

- Supporting physical and mental health – e.g., team-based care, behavioral health integration, care management
- Supporting social and/or spiritual well-being – e.g., social determinant screening and referrals to resources
- Supporting community health and well-being – e.g., community partnerships
- Supporting communities of solutions – e.g., policy work

The two existing Health Equity Challenge teams completed the Pathways to Population Health Compass assessment tool to identify the state of each participant’s activities to advance these domains, as well as components of stewardship, equity, payment, and partnerships with people with lived experience. The purpose of the assessment is to identify areas where team members will need to direct more improvement efforts and to then identify areas where team members did improve at the end of the project.

The assessment consists of a series of statements that represent the current state of an organization’s work, each of which is associated with a numerical score. For example, under Stewardship, an organization might choose “Our board and senior leadership do not consider addressing the health of the population, at large, to be our organization’s responsibility,” which is a score of 0, or “Our organization is part of a multi-stakeholder coalition working to improve health, well-being, and equity in our communities, with shared governance and dedicated resources to advance the work across stakeholders,” which is a score of 4. Through the work of the Health Equity Challenge, the two teams made changes in their organizational practices that led to meaningful improvements in participants’ Compass assessment scores.

EOHHS and RIDOH will collaborate to expand the Health Equity Challenge, renaming it “Rhode to Equity,” so that all six (6) AEs have the opportunity to participate. EOHHS and RIDOH understand that several AEs serve patients across several Rhode Island regions and that in several communities several AEs may serve patients in the same geography. For this reason, EOHHS and RIDOH plan to permit flexibility on team composition, allowing AEs to participate in up to two teams and also allowing more than one AE to participate on a single Rhode to Equity team. 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.

The core work of Rhode to Equity teams will be to jointly 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. Through Rhode to Equity, participating AEs, HEZs, and other CBOs will develop a joint plan to tackle a health outcome of their choosing that is targeted to address the needs of AEs’ patients and their communities. These areas of focus can be the 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. EOHHS

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and RIDOH recognize that it may be important for teams to invite one or more other CBO partners to the table to bring specific expertise related to the social need/risk factor the team chooses to work to address. This would potentially include organizations that provide or do work related to social services, legal services, behavioral health services, and/or services for people with intellectual/developmental disabilities. 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. One benefit of this is that the team members are expected to develop the skills and processes needed to better coordinate the healthcare services and social services to improve health outcomes for Medicaid members. In addition, the collaborative is expected to support participants in joint work to address upstream social determinants of health, including through engagement in advocating for positive policy change.

EOHHS and RIDOH expect that these changes in organizational processes and practices will be reflected in improved Compass assessment scores, which will demonstrate how participants have enhanced their midstream and upstream work as well as their internal processes and practices to improve equity and eliminate racism within their organizations. EOHHS expects that Compass assessment improvements will be even greater than those seen in the Health Equity Challenge, because teams will have a full year for the work. It is EOHHS' hypothesis that the organizational changes reflected in improved Compass assessment scores will enable AEs to better manage population health, which should ultimately be reflected in TCOC.

This investment in team members' organizational capacity (including skills, processes, collaborative relationships, and focus on midstream and upstream work) will ensure that teams can continue their Rhode to Equity projects, engage in additional projects, and continue their joint work to improve health and wellbeing long after this specific program comes to an end.

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.

Investment #4: 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. EOHHS expects that AEs will be engaged in the participatory budgeting process as a way to further community-clinical engagement.

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 in late 2021.

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. Community Resource Platform (CRP) – Midstream
2. Community Health Teams – Midstream
3. Rhode to Equity – Midstream and Upstream
4. 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, HEZs, 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.