Rhode to Equity

Building leadership and operational capacity for community-clinical linkages that improve health and social outcomes

Reflection

What does health equity mean to you?

Ways of being and doing

Share your experience

Practice “Yes…and vs. “Yes…but”

Stay curious

Respect Time

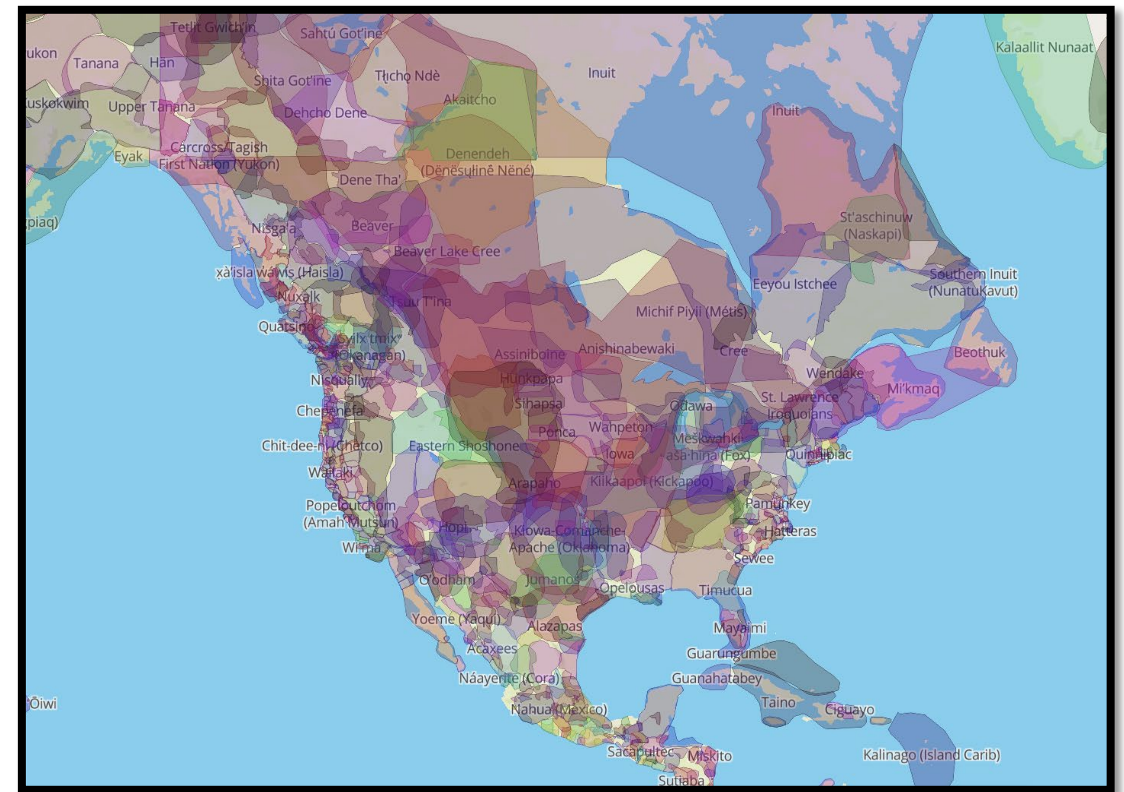
Steal shamelessly (give credit), share generously

Show up, CHOOSE to be present

Land Acknowledgement

Together, we acknowledge indigenous peoples, on whose ancient and sacred land we live, work, and play. As a community, we recognize the ever-present systemic inequities that stem directly from past wrongdoings, and we commit ourselves indefinitely to respecting and reconciling this long history of injustice.

https://native-land.ca/



Agenda

1. Welcome /Reflection
2. Orientation to the Rhode to Equity (R2E)
3. Building your R2E team
4. Break
5. The Double Helix: Changing the World and Ourselves
6. Changing the World: Get Proximate to the Issues
7. Changing Ourselves: Using the Compass assessment to prioritize improvement
8. Next Steps / Evaluation / Closing

Welcome to our Rhode to Equity Teams

Identified HEZ	AE	Local Clinic	CHT	PLE	CBOs
02907 HEZ	Prospect Charter Care & PCHC	St. Joseph Health Center & PCHC	Prospect Health Servic es RI-Medicaid AE & FSRI	Cristy Garcia & Ligna Sanchez	GHHI, UHC, RIDOH, CAPPRI, City of Prov, Housing works
East Providence HEZ	IHP	EBCAP	EBCAP	Jamie Douglas	
Washington County HEZ	Integra & TMIST	South County Medical Group & TMIST	South County Health CHT	TBD	
Central Providence HEZ	PCHC	PCHC	PCHC	TBD	House of Hope, RI Housing, BHDDH
Woonsocket HEZ	Thundermist Health Center	Thundermist Health Center	Thundermist Health Center	TBD	
Pawtucket/CF HEZ	Care New England-Integra	Care New England-Integra	FSRI	Glenit Palacio	Progreso Latino

EOHHS & RIDOH Team

Libby Bunzli
Director of Health System Transformation

Amy Katzen
Senior Policy Analyst

Jen Marsocci
HSTP Project Manager

Allegra Scharff*
Chief of Healthcare Equity

Randi Belhumeur*
Health Systems Transformation Administrator/Policy Liaison

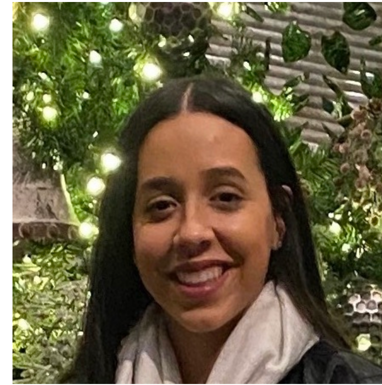
* R2E Coach

Care Transformation Collaborative of RI Team

Debra Hurwitz
Executive Director

Linda Cabral
Program Manager

Susanne Campbell
Senior Project Director



Jazmine Mercado*
Project Coordinator

Sue Dettling*
Practice Facilitator

Suzanne Herzberg*
Practice Facilitator

* R2E Coach

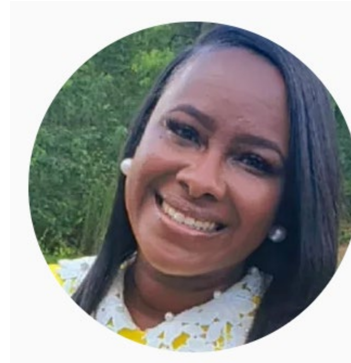
Well-being and Equity (WE) in the World team

Marta Kuperwasser
Director of Operations

Fany Flores-Maldonado
Project Coordinator

Seth Fritsch
Project Manager and Coach

Somava Saha
Founder and Executive Lead



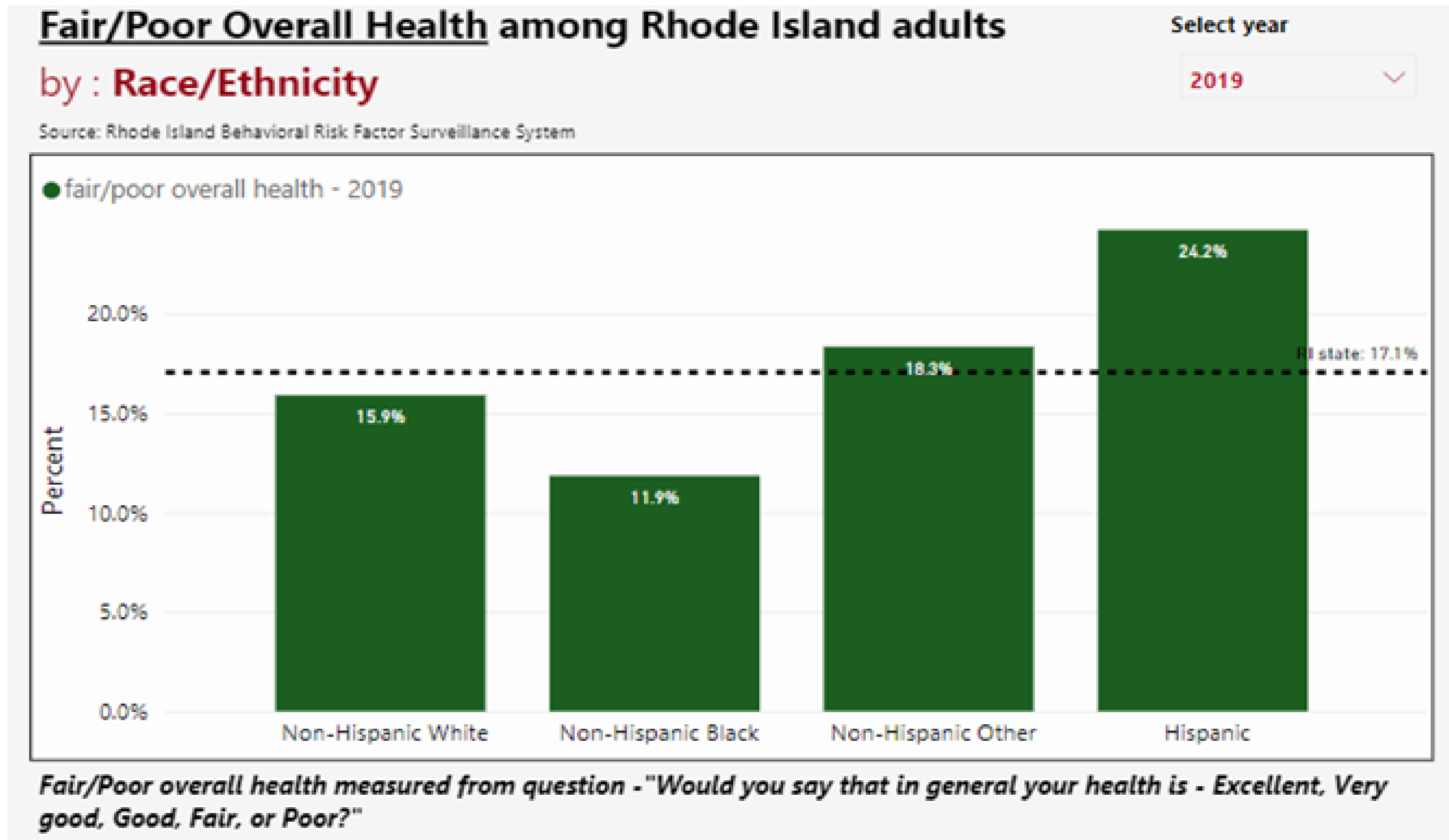
Yolanda Roary
Coach

Kirsten Meisinger
Coach

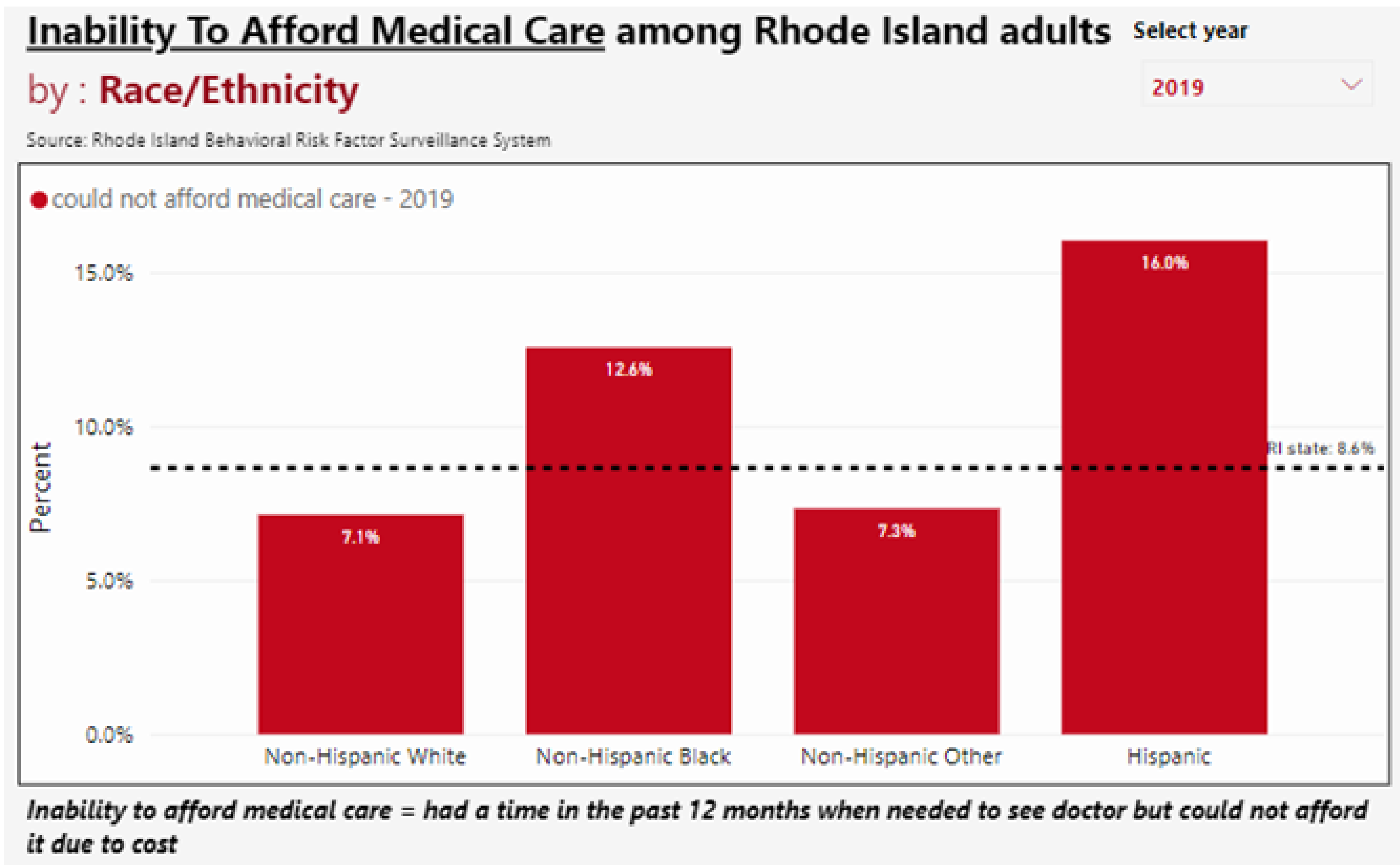
WELL BEING
IN THE NATION
NETWORK

100 Million
Healthier Lives

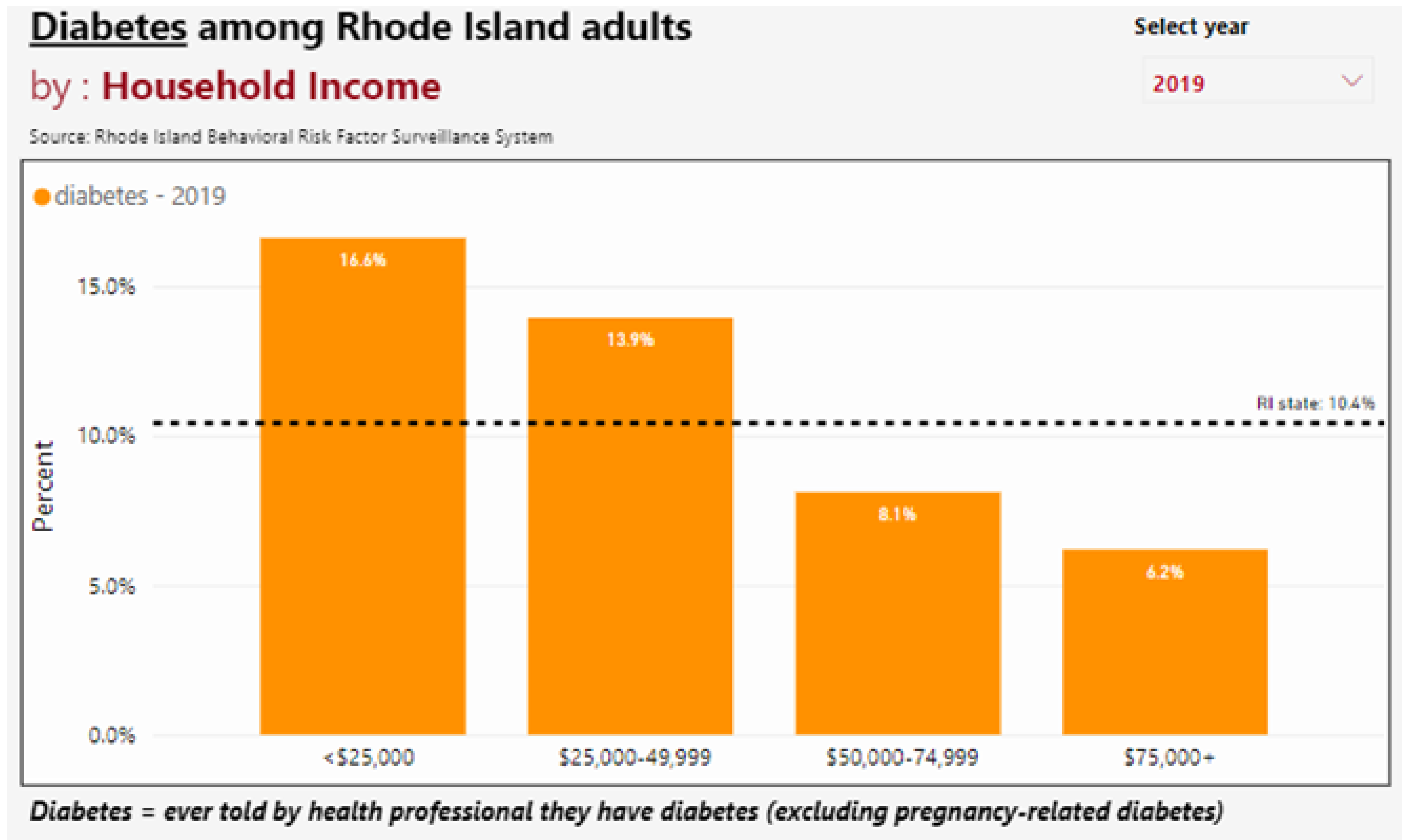
A disproportionate burden of poor health on racial and ethnic groups in Rhode Island



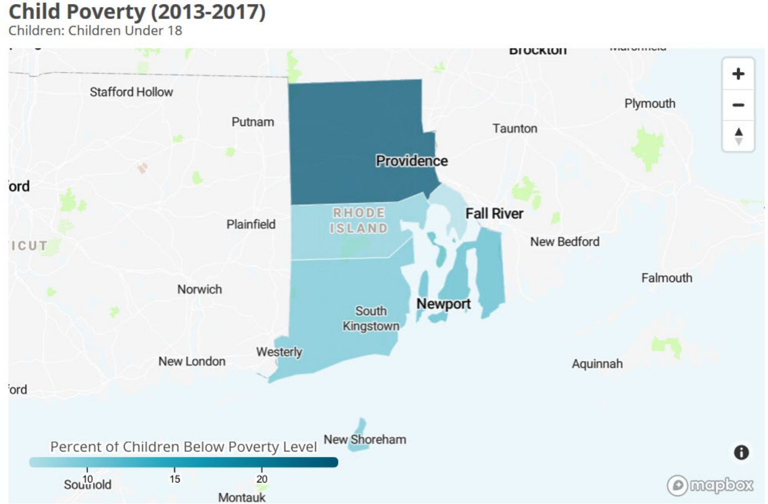
A disproportionate burden of poor health on racial and ethnic groups in Rhode Island

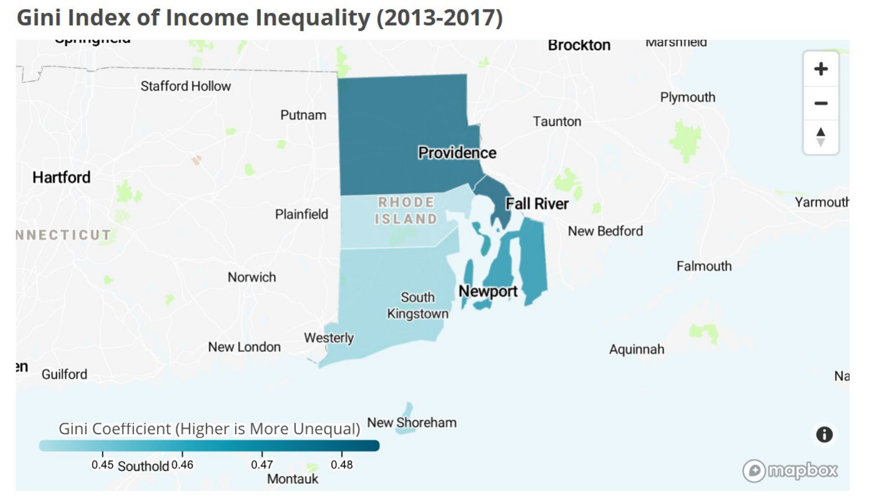


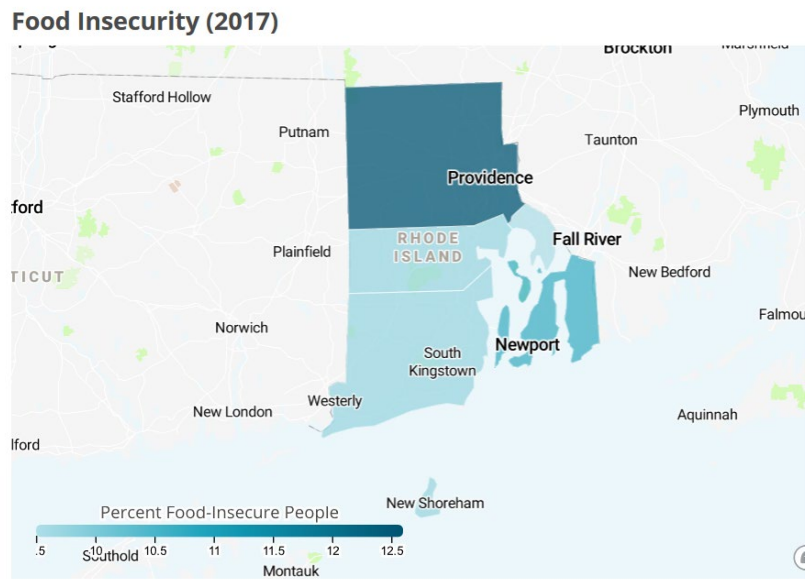
People with diabetes in Rhode Island who are economically insecure

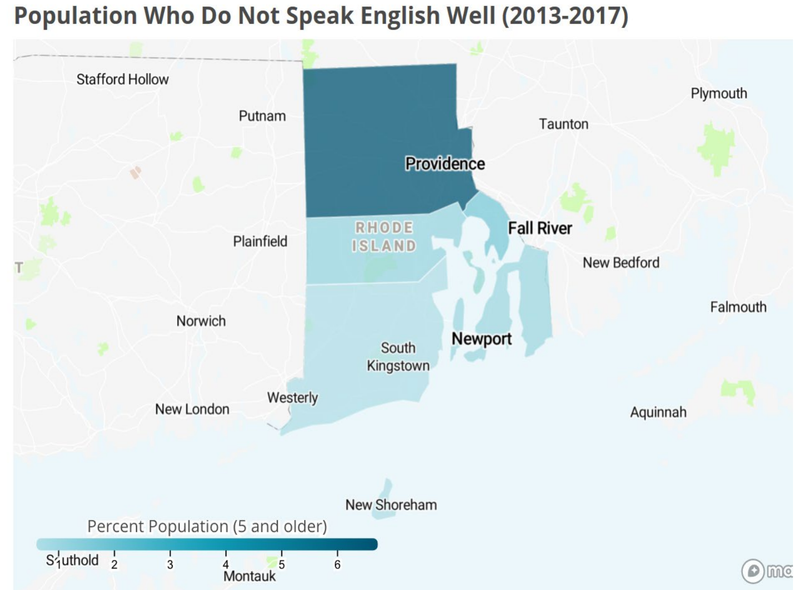


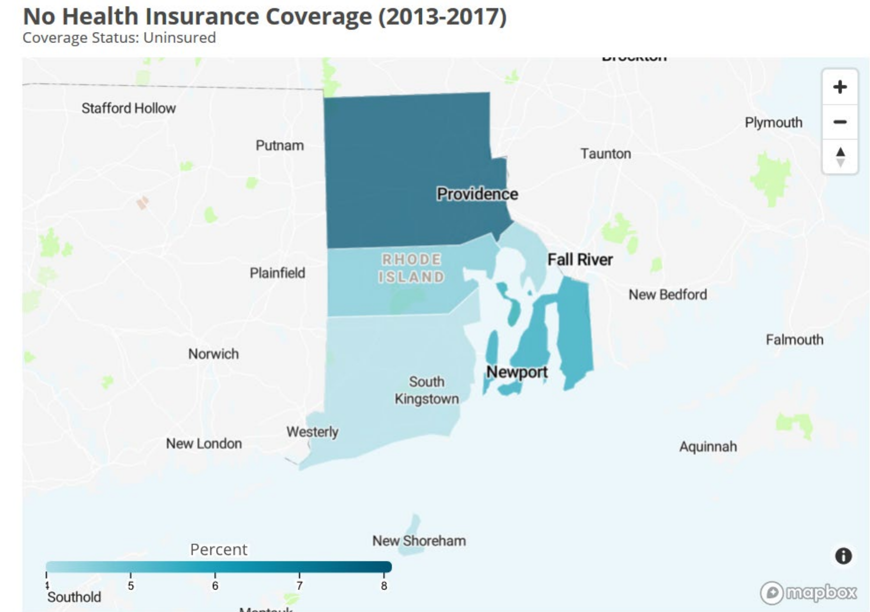
Patterns by place in Rhode island



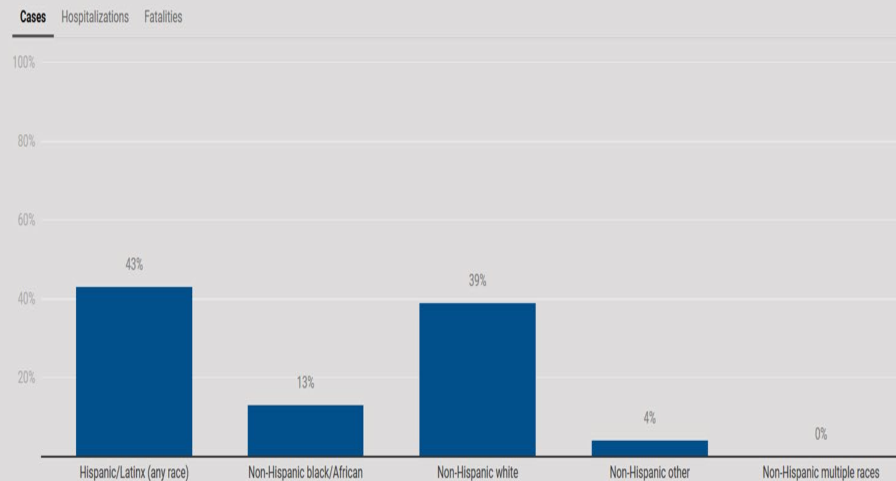


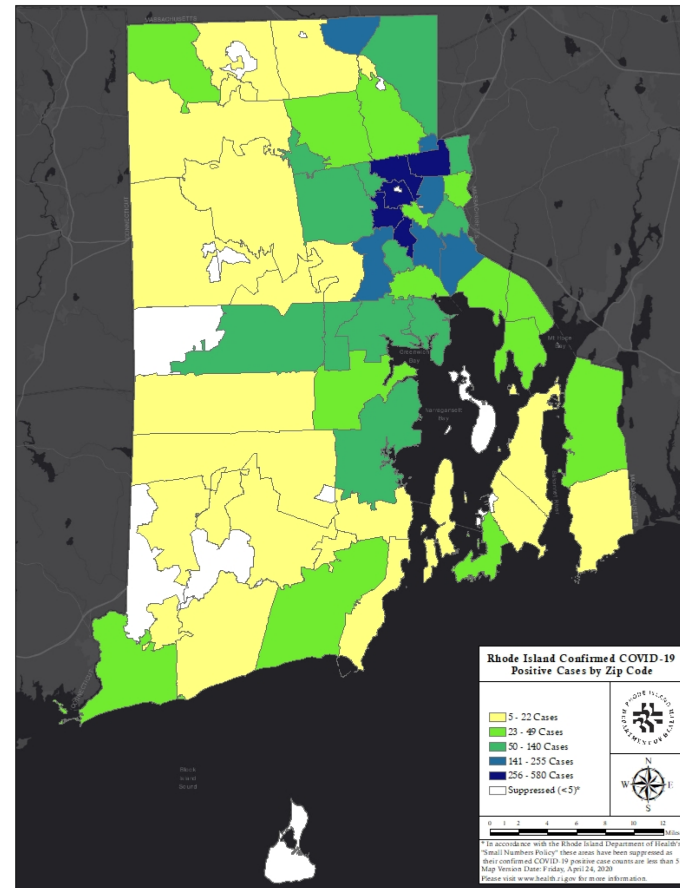


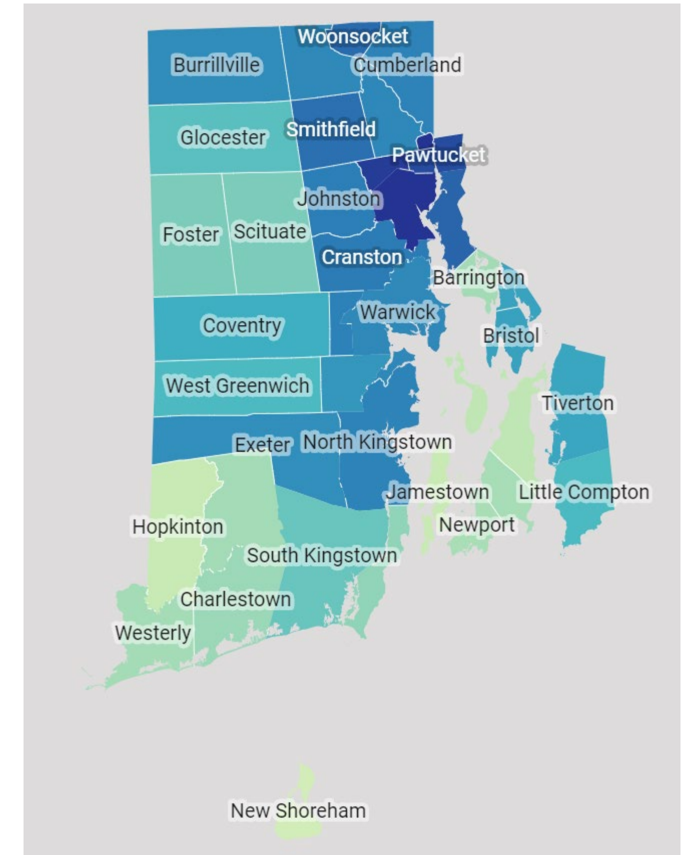




Race, Place, and Health in the Context of COVID-19







https://ri-department-of-health-covid-19-data-rihealth.hub.arcgis.com/

What is the Rhode to Equity?

Funded by RI Executive Office of Health and Human Services (Health Systems Transformation Project (HSTP) and RI Department of Health to:

1. Enhance place-based teams with local partners and community residents funded to improve population health with an equity lens

2. Apply evidence-based Pathways to Population Health tools to more effectively build responsive community-clinical linkages that improve health (physical and behavioral) and social outcomes

3. Use clinical and community data to identify population health needs, test strategic actions, and build sustainable community solutions

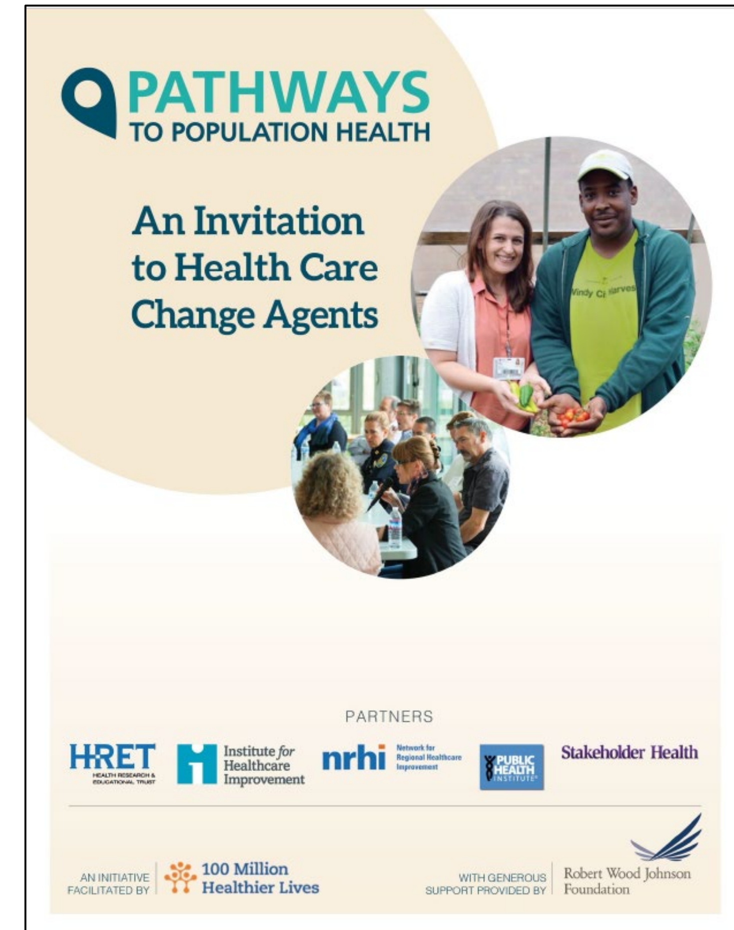
What is the Rhode to Equity?

PATHWAYS
TO POPULATION HEALTH

Pathways to Population Health

Tools developed by 100+ health care and public health organizations and adopted by 250+

Useful in aligning assets to advance population and community health with an equity lens



Six Foundational Concepts of Population Health Improvement

1. Health and well-being develop over a lifetime.
2. Social determinants drive health and well-being outcomes throughout the life course.
3. Place is a determinant of health, well-being, and equity.
4. The health system needs to address the key demographic shifts of our time.
5. The health system can embrace innovative financial models and deploy existing assets for greater value.
6. Health creation requires partnership because health care only holds a part of the puzzle.

What creates health? ⟷ How can health care engage?

How can we improve population health with an equity lens?

1. Understand the population through data, story and partnership
2. Stratify the population – who is at highest risk of not thriving?
   - People
   - Places
   - Systems driving inequities
3. Make it easy to care for the whole person
4. Work to address the underlying conditions in the community that would solve the problem for everyone
5. Apply a current day and historic equity lens

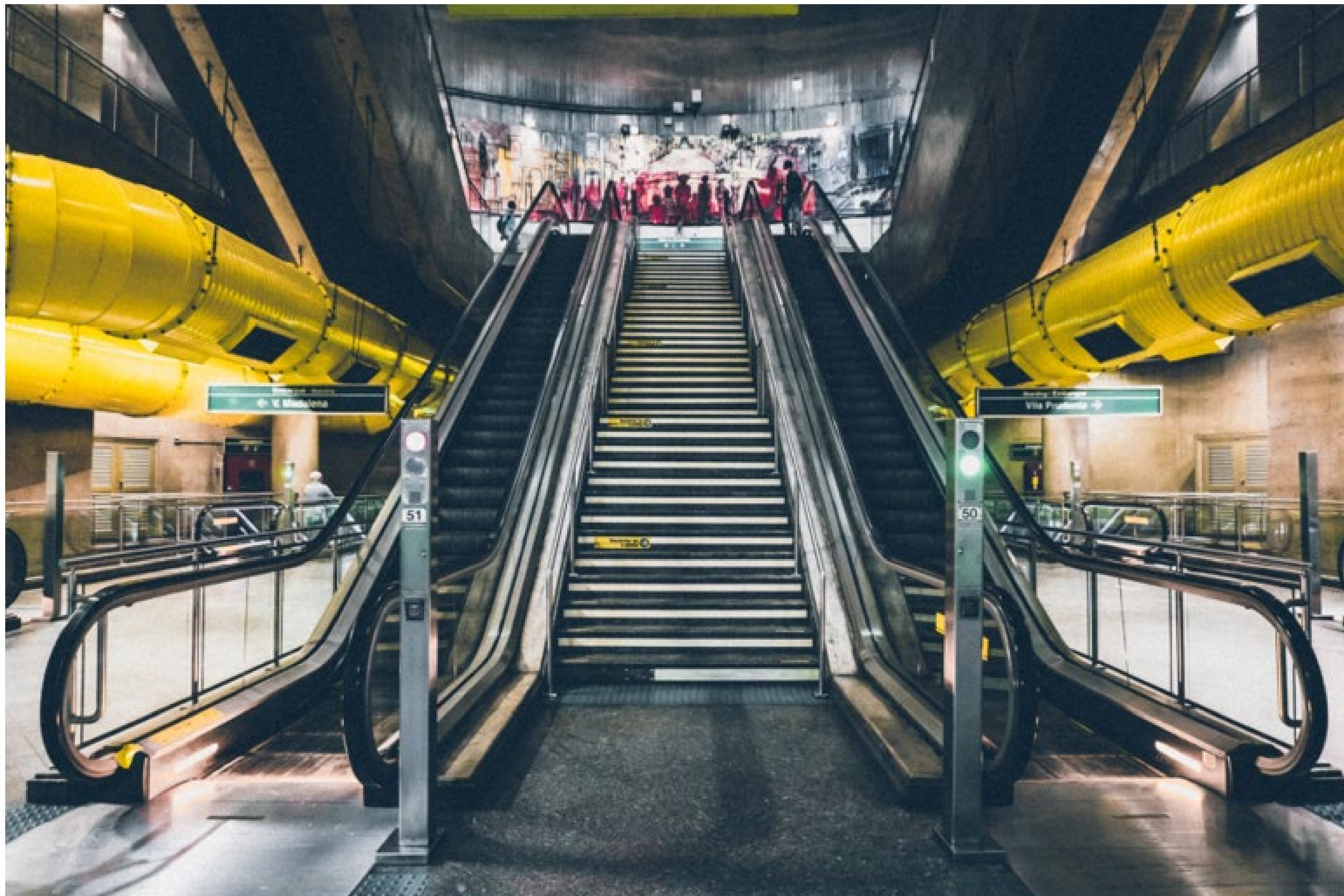


Photo courtesy of Kaique Rocha. Metaphor courtesy of Camara Jones and Natalie Burke.

Why a balanced portfolio?

Effectiveness: Because over 10 years on the Triple Aim journey, we learned that health systems and communities that didn't have a balanced portfolio could not move population level outcomes.

Efficiency and abundance: Because when a balanced portfolio is aligned, it creates new synergies and efficiencies that make the work easier (and less costly) by leveraging assets across clinical and community areas.

Equity: Because it offers us strategies to address the root causes of inequities

Four Portfolios of Population Health Action

Improving the health and wellbeing of **people**

P1: Physical and/or Mental Health

Population Management

P2: Social and/or Spiritual Well-being

Equity

P3: Community Health and Well-being

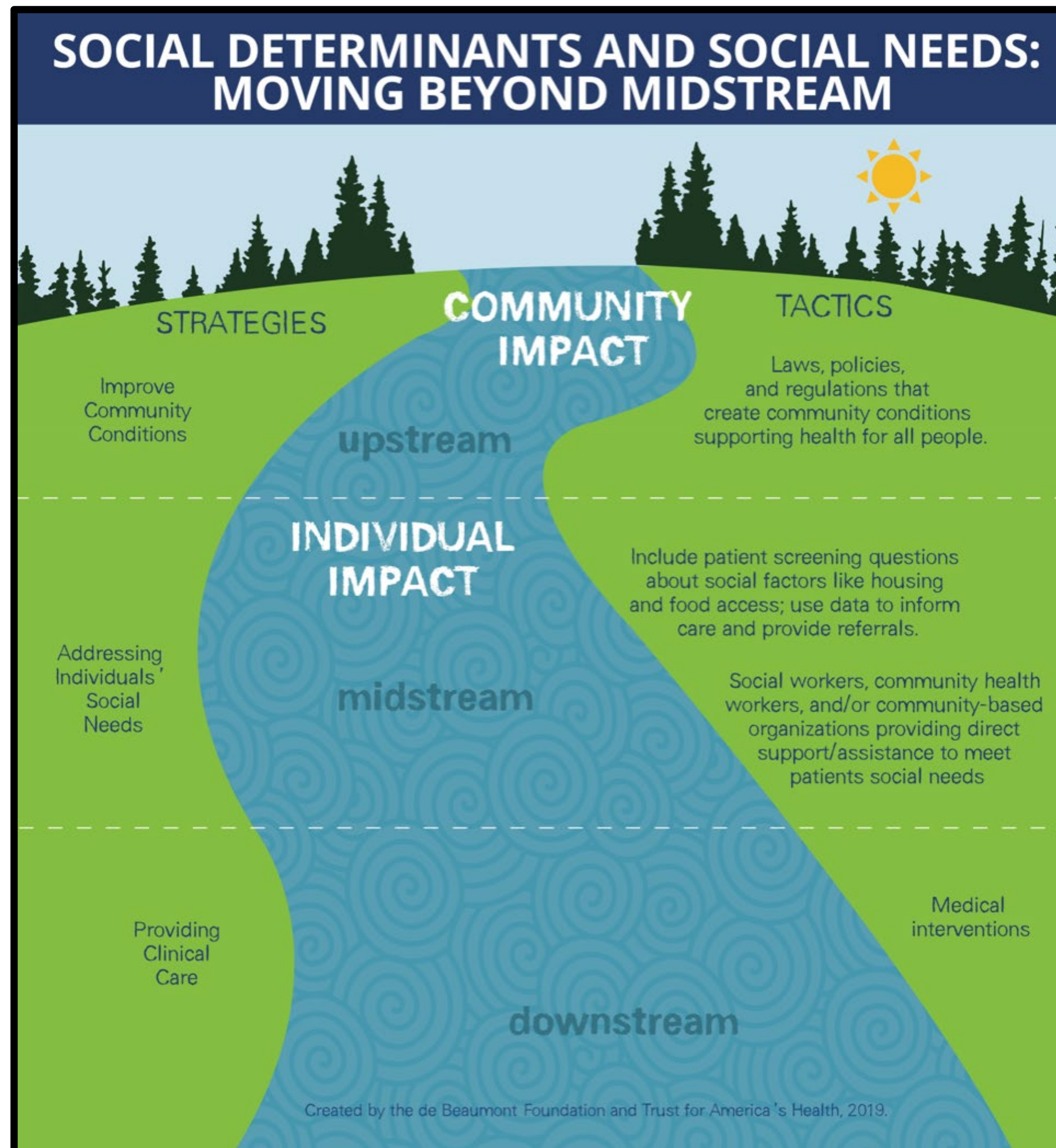
Community Well-being Creation

P4: Communities of Solutions

Improving the health and wellbeing of **places**

Improving the systems that drive (in)equity

Core Concept:
Upstream,
Midstream,
Downstream,
Groundwater



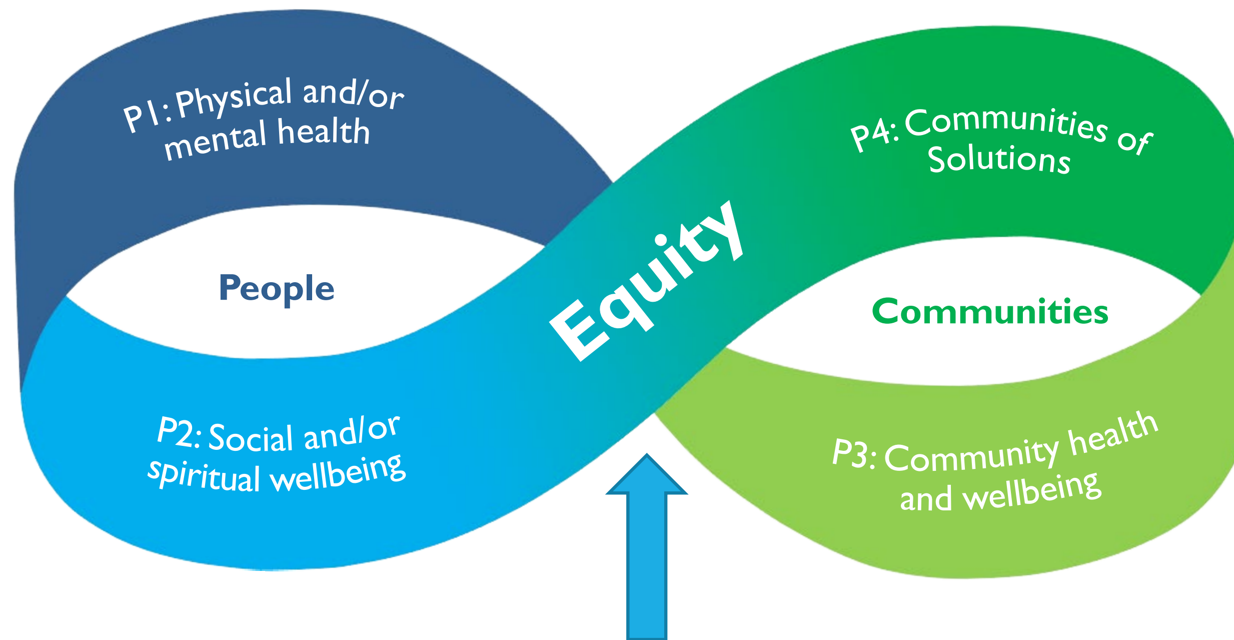
Trust for America's Health

de Beaumont
BOLD SOLUTIONS FOR HEALTHIER COMMUNITIES™

From Charity to Equity to Liberation: Pathways to Health Equity

Downstream (medical needs for people we reach)

Midstream (social needs for people we reach)

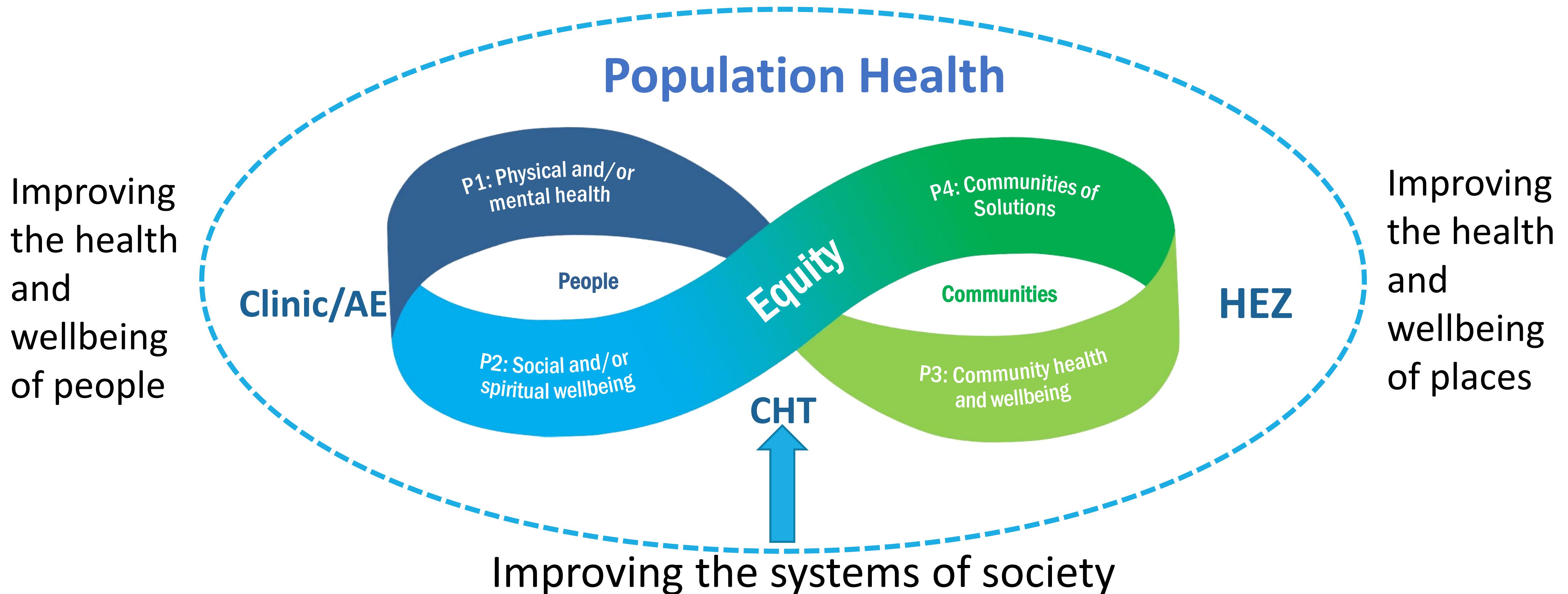


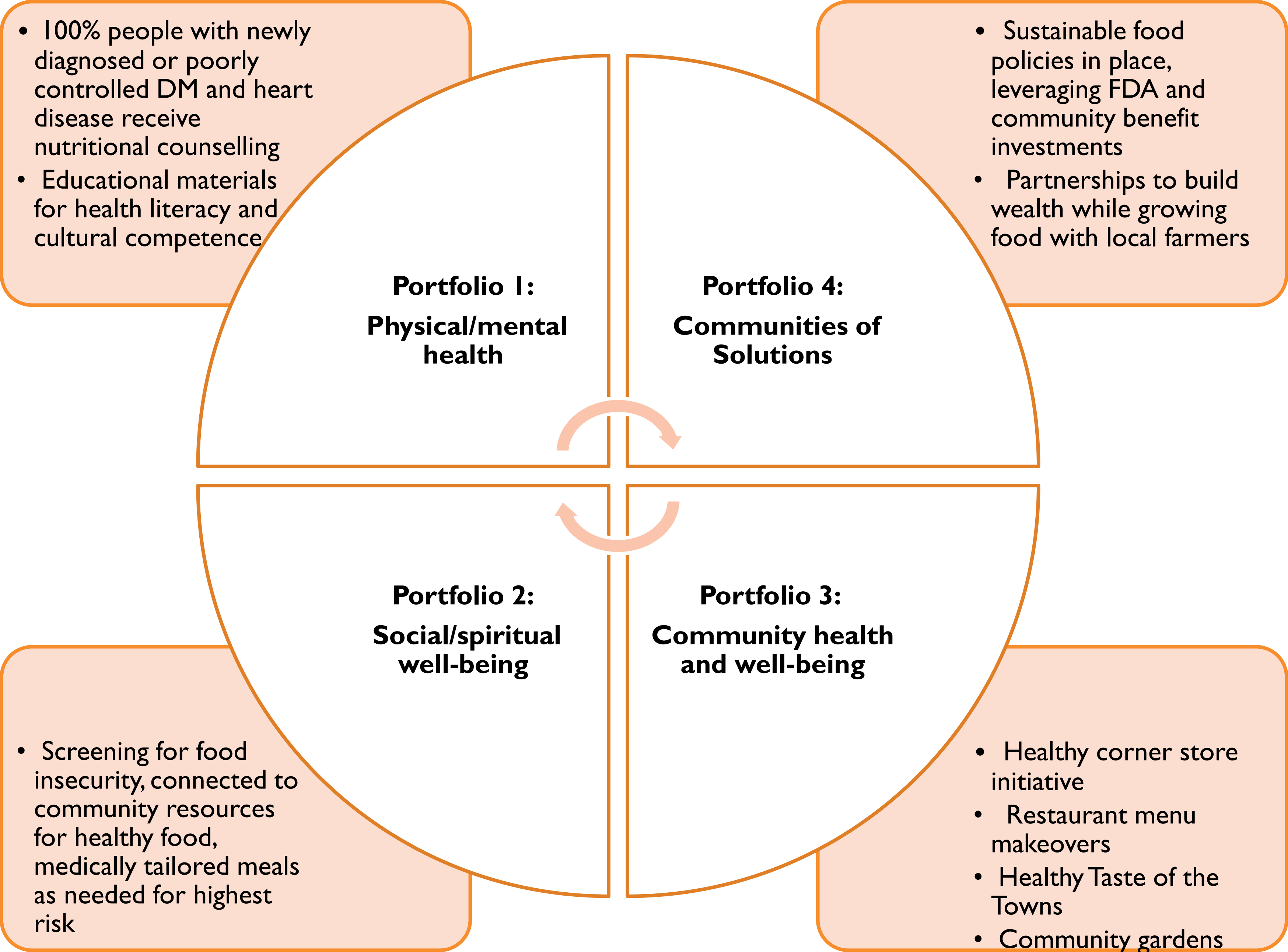
Groundwater – address root causes and legacies

Upstream- change underlying community conditions for SDOH

Improving the systems of society to "reverse the down escalator"

Pathways to Population Health: 4 Interconnected Portfolios of Work



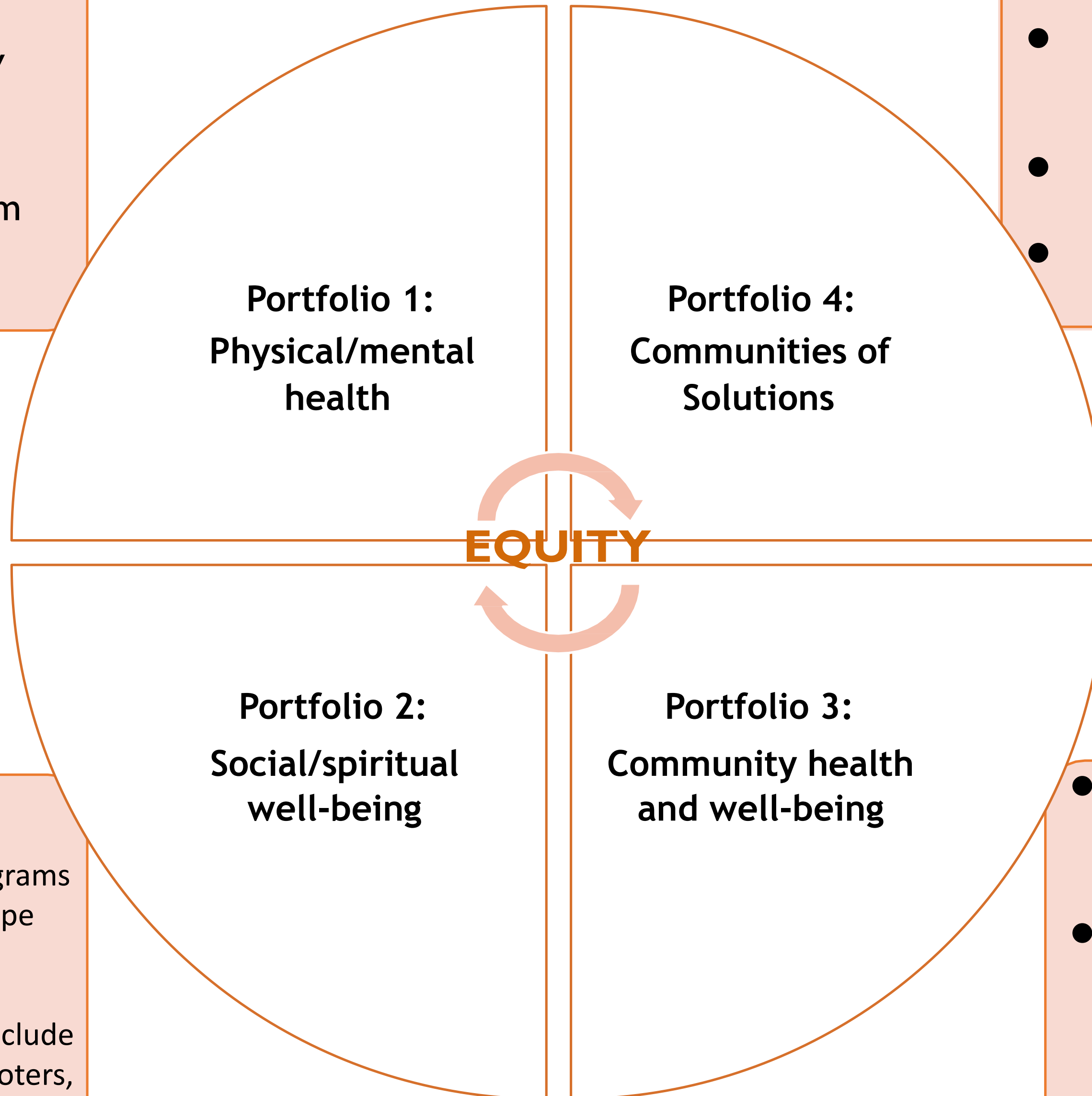

BALANCED PORTFOLIO
• 100% people with newly diagnosed or poorly controlled DM and heart disease receive nutritional counselling
• Educational materials for health literacy and cultural competence
• Sustainable food policies in place, leveraging FDA and community benefit investments
• Partnerships to build wealth while growing food with local farmers
Portfolio 1:
Physical/mental health
Portfolio 4:
Communities of Solutions
Portfolio 2:
Social/spiritual well-being
Portfolio 3:
Community health and well-being
• Screening for food insecurity, connected to community resources for healthy food, medically tailored meals as needed for highest risk
• Healthy corner store initiative
• Restaurant menu makeovers
• Healthy Taste of the Towns
• Community gardens

ALIGNED PORTFOLIO - MENTAL HEALTH AND TRAUMA INFORMED COMMUNITY

- Integrate BH into primary care continuum
- Expand access to specialty psychiatric care through telehealth
- Support respite/short term crisis intervention tactics

PEOPLE

- Adopt a Mental Health Ministry framework
- Faith-based first responder programs such as Hope coaches, Fresh Hope Support groups, MHFA training, Pastoral education
- Expand wellness ministries to include MH: Weslyn nurse/health promoters, education, meditation, yoga,



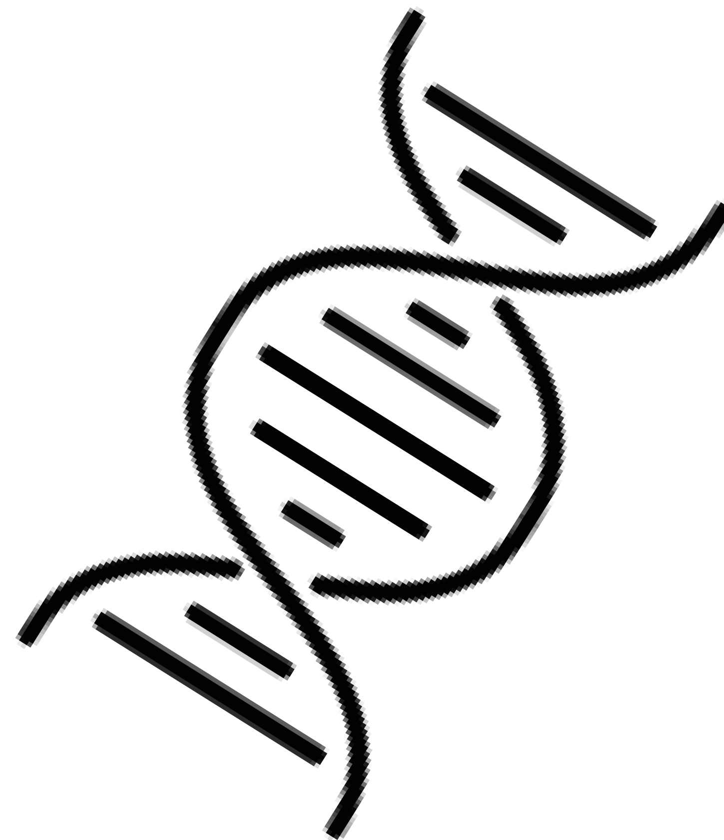
- Support strategies to prevent trauma in the community
- Plan and implement a strategy for a Trauma Informed and Resilient community (multisector)
- Access to meaningful employment and volunteering opportunities
- Interrupt school to prison pipelines

PLACES

- Access to healthy activities and supports (social emotional, physical)
- Equitable access to basic needs.

DOUBLE HELIX APPROACH

- **Change the world** (Population health equity)
  Improving the health and well-being of people and places that aren't thriving
- **Change ourselves** (Long-term system change)
  inside your policies, relationships and processes and those in the community



A SPIRAL OF TRANSFORMATION

- Continually moving to greater depth and scale

PHOTO BY JULIANA MALTA ON UNSPLASH

LET'S START BY UNDERSTANDING THE POPULATION! CASE STUDY INSTRUCTIONS (ABOUT 30 MIN)

- Read your assigned case study carefully
- Facilitators will lead a group discussion about questions 1 & 2
- Individually choose one question (3-7) and type in your answer below
- Facilitators will lead a group discussion about the responses

Who is Involved?

Components of the 6 Place-Based Teams:

1. Health Equity Zone public health & community leaders
2. Community resident(s) with lived experience of inequities
3. Accountable Entity primary care practice leaders
4. Community Health Team (could include ACT team/Family Home Visiting program)

Team Support:

Health Equity Content Experts:

WE in the World who helped develop the Pathways to Population Health tools in the context of 100 Million Healthier Lives

Rhode to Equity Facilitators:

- Care Transformation Collaborative of Rhode Island
- Rhode Island Department of Health
- Coaches for People with Lived Experience

Stakeholder Engagement

- Where are they?
- What are their interests?
- What assets do they control?
- Who they reach / have trust with?

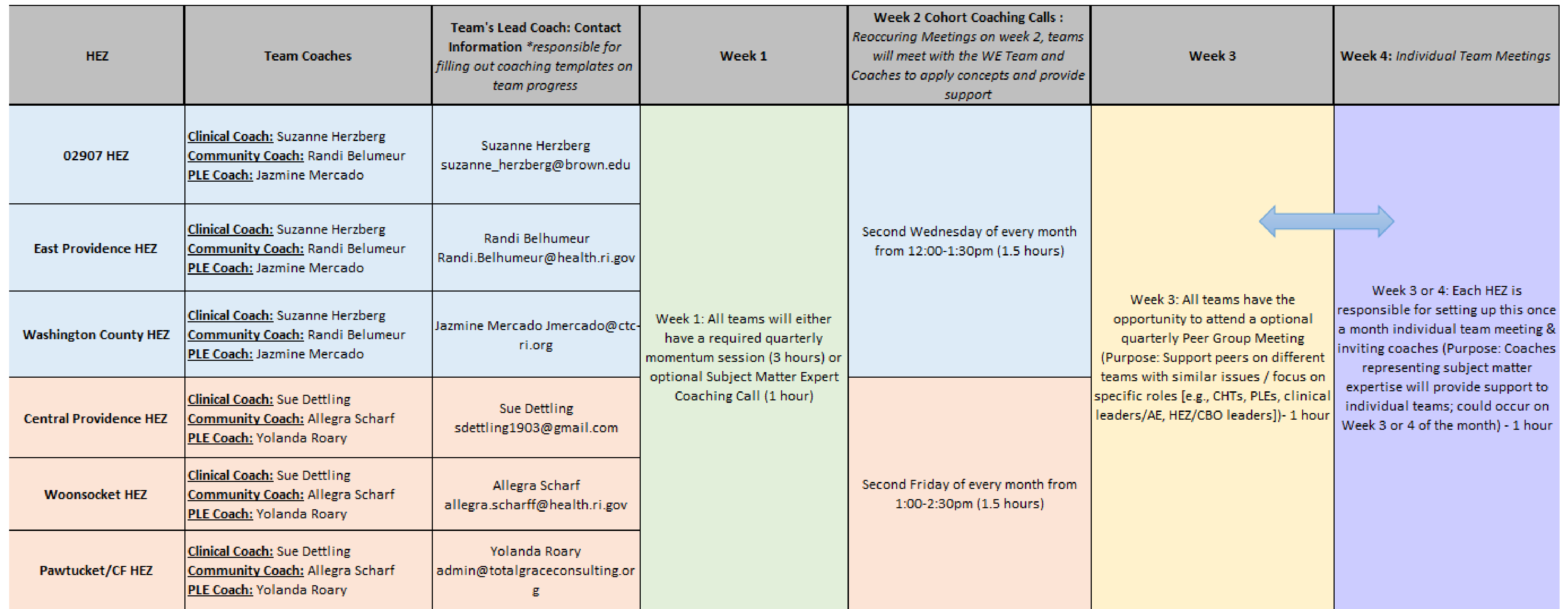
Lived Experience

A person with lived experience is someone who has lived (or is currently living) with the issues the community is focusing on and who have insight to offer about the system as it is experienced by someone engaged in it (e.g., a person who was formerly or is currently experiencing homelessness and can offer insight into that experience). The insight that may be offered is valuable data resource.

Engaging People with Lived Experience

- Approach with respect, as a valuable resource and contributor of their community
- Assess the challenges and barriers people with lived experience may have as leaders
- Collaborate as a partner, not as a provider
- Be intentional of how community residents can be meaningful contributors
- Create a safe and brave space where community members feel comfortable sharing their concerns
- Provide financial compensation and development opportunities

Team Engagement during R2E



HEZ	Team Coaches	Team's Lead Coach: Contact Information *responsible for filling out coaching templates on team progress*	Week 1	Week 2 Cohort Coaching Calls : *Reoccuring Meetings on week 2, teams will meet with the WE Team and Coaches to apply concepts and provide support*	Week 3	**Week 4:** *Individual Team Meetings*
02907 HEZ	**Clinical Coach:** Suzanne Herzberg **Community Coach:** Randi Belumeur **PLE Coach:** Jazmine Mercado	Suzanne Herzberg suzanne_herzberg@brown.edu	Week 1: All teams will either have a required quarterly momentum session (3 hours) or optional Subject Matter Expert Coaching Call (1 hour)	Second Wednesday of every month from 12:00-1:30pm (1.5 hours)	Week 3: All teams have the opportunity to attend a optional quarterly Peer Group Meeting (Purpose: Support peers on different teams with similar issues / focus on specific roles [e.g., CHTs, PLEs, clinical leaders/AE, HEZ/CBO leaders])- 1 hour	Week 3 or 4: Each HEZ is responsible for setting up this once a month individual team meeting & inviting coaches (Purpose: Coaches representing subject matter expertise will provide support to individual teams; could occur on Week 3 or 4 of the month) - 1 hour
East Providence HEZ	**Clinical Coach:** Suzanne Herzberg **Community Coach:** Randi Belumeur **PLE Coach:** Jazmine Mercado	Randi Belhumeur Randi.Belhumeur@health.ri.gov				
Washington County HEZ	**Clinical Coach:** Suzanne Herzberg **Community Coach:** Randi Belumeur **PLE Coach:** Jazmine Mercado	Jazmine Mercado Jmercado@ctc-ri.org				
Central Providence HEZ	**Clinical Coach:** Sue Dettling **Community Coach:** Allegra Scharf **PLE Coach:** Yolanda Roary	Sue Dettling sdettling1903@gmail.com		Second Friday of every month from 1:00-2:30pm (1.5 hours)		
Woonsocket HEZ	**Clinical Coach:** Sue Dettling **Community Coach:** Allegra Scharf **PLE Coach:** Yolanda Roary	Allegra Scharf allegra.scharff@health.ri.gov				
Pawtucket/CF HEZ	**Clinical Coach:** Sue Dettling **Community Coach:** Allegra Scharf **PLE Coach:** Yolanda Roary	Yolanda Roary admin@totalgraceconsulting.org				

Let’s take a break!

REVIEW YOUR COMMUNITY DATA

Data sources

- Community Assessment data results
- Patient data
- Stories from people living with inequities

Questions to consider

- What equity issues exist?
- Who is experiencing inequity?
- What systemic issues create this inequity?

UNDERSTANDING YOUR POPULATION

- As a team, identify at least 7 people with lived experience of the issue and equity challenges
- Meet with them to ask them open ended questions about how this pandemic is affecting them and how they are managing . Listen for through it. Listen to their stories.
- Ask them what their greatest needs are and what would help them to thrive
- Ask them about potential solutions they think would really help them
- This is a quality improvement project, not a research project. You do not need to get IRB approval.

USE AN UNDERSTANDING OF YOUR POPULATION TO:

Use these conversations to:

- **Identify themes** that emerge in terms of needs and opportunities
- Place these in the **assets and needs worksheet** and work with your team to identify how you might meet the priority needs
- Identify **potential solutions** and **partnerships**
- Identify **additional stakeholders** to engage who might have some of the pieces of the puzzle needed to advance solutions
- Identify **people with lived experience** who could become a member of your team (thoughtful, collaborative, able to both bring their lived experience and think more broadly about the problem, people who can easily reach others to gather their input)

7 STORIES WORKSHEET

	Story element/theme	**Story element/theme**	**Story element/theme**	**Story element/theme**
System factor				
Barrier				
Asset				
Opportunities for change				
Bright spots				

UNDERSTANDING YOUR POPULATION

- Where are people with lived experience in your community?
- Who is connected to them?
- How can you arrange to meet with 7 people?

Note: These are informal and important conversations in which your team can gain insight into the experience of your community and system. You should listen carefully with the humble intent of understanding (and maybe even finding people who will join your efforts).

P2PH COMPASS

THE PURPOSE

The purpose of the Compass is to:

1. Assess where your team is currently
2. Spark meaningful conversations
3. Improve how you work together to address equity

ADAPTED P2PH COMPASS

- Community Collaborations
- Stewardship
- Equity
- Partnerships with People with Lived Experience

- Portfolio 1: Physical and/or Mental Health (Data, Team-Based Care, Behavioral Health Integration, Care Management)
- Portfolio 2: Social and/or Spiritual Well-Being (Data, Social Determinant Screening/Referrals)
- Portfolio 3: Community Health and Well-Being (Data, Community Partnerships, Community Benefit)
- Portfolio 4: Communities of Solutions (Data, Leveraging Nontraditional Roles, Policy)

Core Transformation Skills

COMMUNITY COLLABORATION

		Not yet started	Starting – "We're in the early stages and are still figuring things out"			Gaining skill - "We're getting the hang of this!"			Sustaining - "This is who we are and how we do our work"		
1. We partner across sectors (public health, health care, social service, business, etc.) to improve health and wellbeing in our communities.	**Not sure or NA**	We usually work alone.	We have formed partnerships, largely within one sector.			About half of the relevant sectors are engaged to address the priorities at hand.			Most (>75%) relevant sectors are working together to create systems and policies to support lasting change.		
Our organization	**Not sure or NA**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Our community collaboration	**Not sure or NA**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Core Transformation Skills

COMMUNITY COLLABORATION

		Not yet started	Starting – "We're in the early stages and are still figuring things out"			Gaining skill - "We're getting the hang of this!"			Sustaining - "This is who we are and how we do our work"			Where are you currently?
2. We form partnerships strategically to achieve our goals.	Not sure or NA	We form partnerships largely to meet funding requirements.	Our partnerships are mostly based on existing relationships. These aren't always the right partnerships to effectively address the problem we're trying to solve.			We have begun to strategically map our partnerships to align to what we are trying to accomplish. We have expanded partnerships to include organizations who can address this.			We routinely assess our partnerships to see whether they support what we are trying to accomplish. We expand and shrink partnerships to achieve our community's goals.			
Our organization	Not sure or NA	1	2	3	4	5	6	7	8	9	10	
Our community collaboration	Not sure or NA	1	2	3	4	5	6	7	8	9	10	

Core Transformation Skills

EQUITY: Consider how your organization and/or community collaboration works toward health equity. Select the description that best represents their attitudes, behaviors, or actions.

		Not yet started	**Starting – "We're in the early stages and are still figuring things out"**			**Gaining skill - "We're getting the hang of this!"**			**Sustaining - "This is who we are and how we do our work"**			**Where are you currently?**
6. There is a shared commitment to health equity across our community.	**Not sure or NA**	People don't yet have a shared sense of commitment to health equity in our community.	A few people (<10%) have begun to develop a shared commitment to health equity.			A significant number of people (11-30%) have a shared commitment to health equity. They are only in 1-2 sectors.			A significant number of people (>40%) across 3 or more sectors have begun to develop a shared commitment to health, equity.			
Our community collaboration	**Not sure or NA**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Core Transformation Skills

PARTNERSHIPS WITH PEOPLE WITH LIVED EXPERIENCE: Consider how your organization partners with people with lived experience of inequity in the process of creating change. Select the description that best represents their attitudes, behaviors, or action.

		Not yet started	**Starting – "We're in the early stages and are still figuring things out"**			**Gaining skill - "We're getting the hang of this!"**			**Strengthening - "This is who we are and how we do our work"**			**Where are you currently?**
8. We partner with people with lived experience of inequity to create change.	**Not sure or NA**	We do not have formal mechanisms to engage the people we aim to serve in co-designing the services delivered or changes created by our organization.	We have established advisory groups (like a patient and family advisory council (PFAC) or resident advisory council (RAC)) but do not yet partner with them in a meaningful way.			We routinely engage our people with lived experience of inequity (or whatever we are trying to improve) to help identify how to improve our services			All improvement projects are co-designed with people with lived experience, who remain active members of the improvement teams in developing the solutions. People with lived experience are active leaders of change initiatives in our organization and/or community.			
Our organization	**Not sure or NA**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

COHORT ASSIGNMENTS

Identified HEZ	AE	Local Clinic	CHT	PLE	CBOs	Team Coaches	Team's Lead Coach: Contact Information *responsible for filling out coaching templates on team progress*
West Elmwood HEZ	Prospect Charter Care & PCHC	St. Joseph Health Center & PCHC	Prospect Health Services RI-Medicaid AE & FSRI	Cristy Garcia & Ligna Sanchez	GHHI, UHC, RIDOH, CAPPRI, City of Prov, Housing works	**Clinical Coach:** Suzanne Herzberg **Community Coach:** Randi Belhumeur **PLE Coach:** Jazmine Mercado	Suzanne Herzberg suzanne_herzberg@brown.edu
EBCAP HEZ	IHP	EBCAP	EBCAP	Jamie Douglas		**Clinical Coach:** Suzanne Herzberg **Community Coach:** Randi Belhumeur **PLE Coach:** Jazmine Mercado	Randi Belhumeur Randi.Belhumeur@health.ri.gov
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Central Providence HEZ (ONENB)	PCHC	PCHC	PCHC	TBD	House of Hope, RI Housing, BHDDH	**Clinical Coach:** Sue Dettling **Community Coach:** Allegra Scharf **PLE Coach:** Yolanda Roary	Sue Dettling sdettling1903@gmail.com
Woonsocket HEZ	Thundermist Health Center	Thundermist Health Center	Thundermist Health Center	TBD		**Clinical Coach:** Sue Dettling **Community Coach:** Allegra Scharf **PLE Coach:** Yolanda Roary	Allegra Scharf allegra.scharff@health.ri.gov
Pawtucket/CF HEZ (LISC)	Care New England-Integra	Care New England-Integra	FSRI	Glenit Palacio	Progreso Latino	**Clinical Coach:** Sue Dettling **Community Coach:** Allegra Scharf **PLE Coach:** Yolanda Roary	Yolanda Roary admin@totalgraceconsulting.org

CHANGE PACKAGE AND DELIVERABLES TRACKING SHEET

- All documents, tools, templates and resources will be able to be accessed via our Rhode to Equity Google Docs Folder. More details to follow at the next coaching call.

REPORTING

- On the 30th of each month, the team is responsible for answering 4 questions on a shared document.
  - 1. Describe how you achieved your milestone
  - 2. What is a take-away from your progress this month?
  - 3. What support do you need to succeed?
  - 4. What planning needs to happen for next month?

NEXT STEPS

To do:

- Create your team's storyboard
- Teams must identify PLE and CBOs
- Choose up to 3 Compass improvement areas
- Identify and listen to (at least) 7 community members, note themes during this quarter

Coming up:

- Next session is July 29, 12-4p
- Cohort coaching Aug 11 or 13
- Monthly Team meetings (HEZ leads will schedule meeting series beginning in **August**)

ANNOUNCEMENTS

- HEZ July 2021 Learning Community – July 20-22
  - HEZ Core Elements, Governance, Evaluation, etc.

    Register: https://tinyurl.com/5ammwv3v

- Translation/Interpretation needs for full participation in meetings – let us know!

TELL US ABOUT YOUR EXPERIENCE TODAY…

THANK YOU!

RHODE TO EQUITY