September 15, 2020

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RI Executive Office of Health and Human Services
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Dear Amy,

On behalf of the Care Transformation Collaborative of Rhode Island (CTC-RI), I want to congratulate you and your team on the work accomplished to date to develop and share a vision and set of strategies to systemically address the social determinants of health (SDOH). The recently produced document which outlines HSTP's SDOH Investment Strategy now posted for comment is an excellent step toward addressing a set of complex challenges across the system, upstream, midstream and downstream.

CTC-RI respectfully submits the following input on the specific HSTP investments per your request for public comment:

Regarding the introduction and vision, strong and effective coordination between the health care system and community-based organizations is a critical ingredient to the success of the strategy. **Special attention needs to be paid to children and families** since health systems will naturally (and "should") focus efforts on higher cost and rising risk patients. **Leveraging existing assets and natural connections of the two place-based CHTs – Family Services of RI (FSRI) and South County Health (SCH) – both connected to family home visiting services, will facilitate this child/family focus. Engaging schools is also very important in serving high-risk children and families.**

Recognizing the interconnection between Medicaid and commercial coverage for the "working poor", as well as Medicare and dually-eligible members, requires a more comprehensive approach than a simple focus on the Accountable Entity (AE) structure. **A broader multi-payer and multi-sector programmatic and funding strategy will allow for greater long-term equity and sustainability.**

1. Rhode to Equity

CTC-RI strongly supports the expansion and rebranding the Diabetes Health Equity Challenge (HEC) learning collaborative to become the **Rhode to Equity**. Even in just the few months since CTC-RI has worked with RIDOH to launch the HEC, this approach has already proven effective. Here is just one example:

East Bay Community Action Program, Inc. (EBCAP) is one of the HEC teams which includes a representation from: 1) Health Equity Zone (HEZ), 2) community health teams (CHT), 3) clinical practice site (AE), and 4) a person with lived experience. The team completed the Pathway to Population Health

Compass tool and identified 7 people with diabetes to interview about their experiences and needs. Team partners additionally identified assets and needs and developed an AIM statement to provide healthy food to people with diabetes. Resources were identified within the HEZ Community and within the EBCAP social services program. They were able to access gift cards and clinical advice from a dietician. Additionally, they identified people who needed healthy foods by looking at people who were seen at COVID-19 testing sites, clinical sites, community health teams, and behavioral health (BH) sites. The team has started matching the needs with the resources as a first step in building community solutions.

This example illustrates, by focusing on a shared challenge, that clinical and community partners have been able to successfully work together to identify and implement solutions with and for the people living and working in each of the communities in the project.

As part of the HEC, teams were eligible for $20,000 to cover the costs associated with participating in the 5-month learning collaborative (including payment for the person with lived experience). Teams were expected to meet weekly and devote additional time to develop and implement action plans. Team members represented different aspects of the Pathway to Population Health portfolio and each voice was needed to establish stronger clinical and community linkages that improve health and wellbeing of people and places. **The proposed HSTP investment in the Rhode to Equity needs to include funding to support team participation and team coaching support**. It is additionally recommended that the work plan include a focus on obtaining "lessons learned" from the 2 existing teams and identify what is needed to successfully implement action plans during Phase 2 action labs.

Most communities have practices from more than one AE. The Rhode to Equity should recognize this and encourage coordination between the multiple AE practices along with the CHT/HEZ and Managed Care Organizations (MCOs).

For the new Rhode to Equity challenge, **clearer guidance from EOHHS would be helpful to define what constitutes a CHT for this investment opportunity**. For example, will AE-based care management teams qualify as a CHT, or would CHTs need to offer specific services such as community-based behavioral health support? **With funding for the 2 place-based CHTs (SCH and FSRI) secured only until 6/30/21, consideration should be given to the timing of Rhode to Equity challenge and a plan for multi-payer/multi-sector engagement to ensure long-term sustainability.**

From our experience in PCMH transformation, we recommend establishing common standards, goals, metrics across all CHTs; having infrastructure payment and incentive payments for meeting goals, together with a learning community and data management system for reporting metrics. We advocate for a strategy to address a mechanism where by all Medicaid patients have access to CHT and strategy for ensuring that children, families are included in having access to CHT.

We envision the Rhode to Equity as a vehicle to foster meaningful, long-term collaborative relationships between the HEZ, AEs/CHTs and MCOs by providing a model for transformation and cross-sector collaboration.

2. <u>Sustain Community Health Teams (CHTs)</u>

We are gratified to see the value and importance placed on community health workers (CHWs) and CHTs included as one of the 5 key investments. Under CTC-RI's multi-payer CHT pilot, over $5M has been invested over 5 years in the development and evaluation of the CHTs. CTC-RI's CHT model utilizes

CHWs and BH Clinicians as a critical extension of primary care, especially for individuals and families who have a high level of chronic care, behavioral health and/or social needs. Outside evaluation findings as well as our own internal data collection demonstrated the value of this intervention. A Brown University study shows reduction in total cost of care for CHT members when compared to a matched comparison group (over $6,000 less annually with an estimated annual return on investment of $2.85 for every $1 invested). Additionally, the University of RI has reported improvements in clinical scores and improvements in social needs for CHT members served after only 5 months.

As referenced above, CTC-RI has invested in formalizing partnerships between RIDOH family home visiting programs and CHTs. The result has increased cross-agency, multi-disciplinary, team-based approaches to serving families with complex needs. This is particularly true for our 2 CHT teams (FSRI and SCH). We see value in expanding this approach to serve more families with continued CHT support.

We want to recognize the 2 CHT models that CTC-RI supports and the value for continued support for both models. The teams that are based in a Federally Qualified Health Center (FQHC) are clearly part of their AE's care management functions and have enough volume to be internally focused. **The place-based teams have found success in serving multiple AEs and providers with a multi-payer approach.** It is evident that CTC-RI's CHTs provide more intensive community-based and BH supports to the clients they serve and can serve as an adjunct to existing care management services.

We also want to strongly emphasize the comments in the Strategy document regarding the need for sustainable funding for the teams (see page 5, HSTP Strategy document). To fully achieve their potential, these CHTs, and the organizations that employ them, need a sustainable, multi-year stream of funding aligned closely with the AEs, HEZ and other efforts to address SDOH and provide care coordination for families with complex, high levels of need. Without a reliable, multi-year funding stream, it will continue to be challenging to make the longer-term investments needed for this program to reach its full potential. Here are some of the benefits that we believe will be realized once a sustainable funding source is in place:

- Ability to invest in more robust data collection, including using the state's QRS system to measure quality and to tailor agencies' EHRs to expand patient data capture.
- Ability to set performance standards and identify metrics that can be measured over a time frame longer than 12 months. Ability to expand more multi-disciplinary teams to serve high-risk families. Increased coordination with RIPIN can also strengthen a coordinated approach for children and families.

- Ongoing collaboration with Medical-Legal Partnership Boston (MLPB).
- A multi-sector funding/investment approach including hospitals can help provide significant resources to the community-based teams for relatively small investments from the different sectors.

Further, our experience on the ground confirms that the development of a sustainable funding stream will be most impactful if it is firmly placed within a service delivery framework that is multi-payer and multi-sector. This will ensure that we support full access for all individuals and families in need of services with no financial, insurance or geographic barriers to service.

3. <u>Invest in IT Systems to Support Coordination: Community Information and Referral Platform (CIRP)</u>
CTC-RI has been an active participant in discussions regarding the need for state adoption of an e-referral system. Based on our experience working with clinical providers / systems of care to facilitate

practice transformation as well with initiatives with strong community ties such as the CHTs and HEC, we submit the following suggestions to further improve the outcome of the effort to standup an e-referral system:

- Maximize connectivity with other systems to the extent possible, including to the HIE.
- Promote the use of one e-referral platform statewide, to the extent possible. With multiple platforms currently being promoted, we recommend EOHHS take leadership on the use of a **single statewide system** to ensure widespread use. Our concern is that with multiple e-referral systems in use in RI, providers will not use them.
- Ensure that the e-referral system is also available to health plans. This is an important way to improve coordination and reduce duplication of services.
- Address concerns around patient consent, stigma and privacy while maximizing care coordination and avoiding duplication of services.
- This system needs to be able to easily and effectively identify a “primary care manager/ quarterback”.
- This is a complex undertaking; recommend including strategy of using a peer learning community approach that includes goals, deliverables, infrastructure and incentive payment, and peer learning community approach.

4. AE Engagement with HEZ

While we agree with AE engagement with HEZ, we also think that the CHTs are an important midstream delivery system that should also engage with HEZ. We see the clinical – community linkages being strengthened through collaborative models like the Pathways to Population Health.

5. Participatory Budgeting

We applaud EOHHS for taking this bold and inclusive step to engage communities in a participatory budgeting process. This demonstrates the commitment to equity and inclusion. This process will likely facilitate the identification of people with the lived experience, so important to this overall proposal. This may be a good forum to share community health needs assessments that hospitals are required to conduct.

Sincerely,

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