Transcript of the Socially Determined Podcast

"Braiding Funding to Promote Health Equity in Rhode Island"
with Ana Novais, Executive Director at the Rhode Island Department of Health
2019

ANNOUNCER:
Welcome to Socially Determined, a podcast about the social determinants of health. This podcast is hosted by Dr. Gabriel Kaplan, Board President of the National Association of Chronic Disease Directors. Dr. Kaplan speaks with Ana Novais, Executive Director, Rhode Island Department of Health, about how Rhode Island has graded funding to address health equity. Thank you for joining us. Enjoy the program.

DR. GABRIEL KAPLAN:
Hello, Ana, and welcome to the podcast. Thank you for joining us.

ANA NOVAIS:
You're welcome. I'm glad to be able to join you.

DR. GABRIEL KAPLAN:
Can you set the stage for us in terms of the chronic disease burden in Rhode Island? What are some of the more common concerns and how is the state doing in addressing them?

ANA NOVAIS:
I think we have kind of basically the same general concerns as everybody else and the same burden of chronic disease as everybody else. So Rhode Island, 56% of all adults have at least one chronic disease and one in four people have multiple chronic conditions. That is slightly higher than the national average of 45%. From a diabetes perspective, we have 9.4% of the state's adult population know that they have diabetes and from a programs perspective, we've been trying to address it from the traditional community education campaigns. We've had the diabetes prevention work, and so we've been rethinking about how we change our language in terms of our campaigns. We're not calling it a diabetes campaign because when someone has diabetes, it's already too late, so we're trying to see how we can get people to pay attention early.

Cancer continues to be an issue in Rhode Island. While we've had very strong results with screening and we have an enormous number of women being screened—in fact, we used to even claim that we had eliminated our racial disparities in terms of screening because we have more black women being screened—but we still have disparities because of the mortality and the burden of disease itself in the black women. And asthma, it's another area from a chronic disease perspective that we pay attention, with an estimate of 11% of Rhode Island adults that currently have asthma, which is also higher than what you have for the adult US population at 8.3%. So that's some of the data, and we approach it from the traditional way, so with education, with engagement clinical community connections, but that's where we also start

thinking about the impact that the social determinants had and we start our approach, start changing the way we responded to it.

DR. GABRIEL KAPLAN:
Rhode Island established an innovative approach to population health. It's garnering national attention. You developed health equity zones to impact health issues in their own unique microcosms and locations. Tell us a bit about why and how those were established.

ANA NOVAIS:
So for some of the reasons that I talked about before, the fact that even when we made good improvements in our population health outcomes, when you start diving deep in the data and you start looking at how well is the overall population doing, we realized that we still had enormous disparities by race and ethnicity, by geographic location, by gender, by education, and most important for us was the fact that the next generations, as I like to say, my children generation, and if you have children, your children generation had a lower life expectancy than we did. So where did we got things wrong? And how could we change the way we did public health so we could truly improve population health outcomes? That's where our health equity zones came from because if we truly believe that the things that impact our health, things such as education, as housing, as employment, your level of how much money you make, having insurance, not having insurance. Those things that impact one's life; the social and environmental determinants—the only way for us to address them was through a place-based approach.

And the belief that if you address those you're going to be able to impact all of the other chronic diseases that I've talked about—diabetes, cancer, asthma—because those are the same determinants. So we've created these place-based initiatives that is truly a community led initiative where communities are coming together defining their geographic location or area, the zone. They are either creating new collaborative or maintaining expanding existing collaborative, doing an assessment not only of gaps that exist within the community and need, but also of the assets that exist within the community. The level of community readiness to take ownership of their issues and change them. So they do their needs assessment, they do their assets assessment, they identify their priorities, they then use evidence-based interventions, a menu of interventions that we provided them, and select how they're going to respond to the priorities that they identify, and then they implement that plan of action that is a community-driven plan of action developed and implemented by the collaborative that has what we call meaningful representation of residents, not just the usual suspects, but also an expectation for engagement to lead a variety of cross-sector of public and private stakeholders including residents.

DR. GABRIEL KAPLAN:
And then these health equity zones deploy the strategies that you offer. Do they have to deploy strategies from a number of different areas or can they really customize the local effort?

ANA NOVAIS:

So it's totally customized by their own prioritization process that is as I said community led. The way we designed the program is that the community identifies their priorities and they develop a plan of action. We provide them with the menu of interventions and that is given to us by the different program streams that we have within the health department. But one community may decide to focus on obesity, for example, and another community may decide to focus on maternal and child health. Another one may decide to focus on drug overdose. So they all change their focus, and as long as they use evidence-based interventions we are able to fund those interventions with funding from the different funding streams. We also stress to them that they needed to do not just—this was not a service driven response, it needed to be policy level change interventions that were truly improving the social and environmental conditions enriching.

DR. GABRIEL KAPLAN:
We all knew these kinds of programs have to have some funding source. Rhode Island braided funding from multiple sources to conduct and sustain this work. Can you tell us how this was implemented in more practical terms? How did you identify which funding sources you could use? And then what were some of the lessons learned and challenges you found in braiding from different funding source?

ANA NOVAIS:
Well, that was not easy. Let me start by saying that [laughter] because we know that braiding funding is not the most evident thing to do, but that was the only way we foresee that it was possible for us to have this comprehensive place based local approach to the community needs. And so what we did, we pulled together. We braided funding from Hudson, CDC, CMS, with state innovation model, state funding, block grant funding. We used the CDC, the integrated, famously integrated but not integrated chronic disease 14-22 and 13-05 funding. So we pulled all of those fundings together. And then based on the work plans that the organizations developed as they develop a plan of action, we asked them to truly identify the specific activity as it's connected with the different funding streams that we have.

So we basically have a second process in the developing of a work plan and then of a work budget that captures at the activity level the different funding streams. So for example, let's suppose initially we identify for ourselves as a state all of the different fundings that are available. So we had chronic disease funding, mental health funding, diabetes, tobacco, obesity, whatever funding we had at the finance part of the braid. And then as we know exactly how much funding we have from each categorical funding we ask the—how deputy zones as part of the constructing their budget. They start by identifying all of the different strategies at the line budget, at the line item in the budget. So they would have obesity strategies, diabetes strategies, and so forth.

And we then create what we're calling a distributed budget which means that we pool from the identified funding streams, the allocations-based made based on the total funding that we have available and based on their work plan. This allows us to keep the integrity of each funding stream because we're pooling the funding stream that is needed for that specific activity. So for the agency itself, they don't see all of these maps that we're doing in the background. But we created the complicated spreadsheets, and I'm more than happy to share those with you at a later date. We created the spreadsheet that allows us to connect to first identify all of the

funding, available funding, then a work plan that has specific activities that then translate into a line budget, a budget that has line items. And we pool the funding to support those line items.

DR. GABRIEL KAPLAN:
Yeah, so particular funds support particular kinds of activities that are in their work plan?

ANA NOVAIS:
Yes. And because they are all connected we are able to not only get the report in terms of the outcomes of that activity, report it to us and we can then report back to the federal government keeping the integrity and the deliverables of the federal grant intact while allowing us for this creativity in how we braid the funding that goes to each agency. And so each agency would have a different braid on a sense based on their work plan on their identified priorities and on the available—availability of funding that we have at the state level.

DR. GABRIEL KAPLAN:
Were the interests of the community such that you were able to sort of draw from the different funding sources in proportion to the amount that they were contributing or did you find that communities were gravitating towards particular strategies and to, therefore, particular kinds of funding?

MS. ANA NOVAIS:
Yes. So for example, when we were relying a lot on 14—I think it was 1422 that had a lot of diabetes funding. Not all of the communities wanted to do diabetes work and do— implement the BDP and so forth interventions. And so we had more funding for diabetes, that interest in the community level. And we needed to work with our communities to see if they wanted to have—if we could spark the interest from the community for them to do that work. And when they didn't—because the other thing that to find what are the partners in the collaborative would be interested in doing the work. We use the collective impact framework, so we have a backbone organization that is who gets the funding initially directly and then disperses the funding to the other members of the collaborative as appropriately.

So, for example, for diabetes, we end up having that conversation with the backbone organization to say how can they either expand, change, or for them to acknowledge that we were going to need to probably engage in direct contracting outside of the collaborative and outside of the backbone organization to be able to spend that money. On other areas, it's the opposite. So we had an overwhelming response for drug overdose prevention. Every single one of our health equity zones had identified opioid as an issue and a priority. We did not have enough funding at the beginning to do and respond, but we were able to use the fact that they had built that infrastructure and that we had supported the build-out of infrastructure to reach out to the behavioral health agency at the state level, and say to them, "How can you support this work? Here is the assessment that was done. Here are the evidence-based programs that they are using. Can we use some of your funding to put in these contracts so this community can respond?" So it varies.

DR. GABRIEL KAPLAN:
You were also able to leverage the Rhode Island Foundation to enhance your grantmaking abilities. What was that proposal like to the foundation? And how has the partnership been working to improve local communities?

ANA NOVAIS:
So it was a lot of education with our stakeholder partners at the state level. Kind of doing the same work at the state level as we are asking our communities to do to collaborate, to align resources, to agree on a shared vision, and then move forward. And while we do that easily with our partners, it doesn't mean that we do it as easily at the state level. And so it was a long engagement with the Rhode Island Foundation, talking over and over with them about the importance of shifting how they're doing investments at the local level to make sure that they were supporting the same kind of investment that we were making and as we were doing at the same kind of approach. And once they agree on the approach, because it's still their own competitive process. It was us working with the health equity zones to make sure that they were aware of that, that they were applying for the funding, and that they were doing so in a way that was not necessarily aligned with the work that was already in place. And so that it was complimentary of the work that we had put forward. And so we were successful in a sense that they have six grantees, five of them were current health equity zones, and the sixth one was, in fact, a partner. A member of one health equity zone collaborative. It was not the backbone, but it was one of the member agencies.

DR. GABRIEL KAPLAN:
So this program's been going on for a few years now, what are some of the successes of this work? What challenges do you see in the future?

ANA NOVAIS:
So I think some of the challenges, for me, is how do you support the—an important component is the infrastructure of the backbone agency. And we didn't necessarily pay that much attention to the infrastructure of the backbone organization. And I think it's extremely important to be able to do that. How much do we work with the backbone organization, so they are able to be that glue—it's an important component. And so having funding that is not categorical funding for the activities and implementation itself, but to support that infrastructure is a challenge. In terms of outcomes, I can tell you that four years into implementation, here are some of the results that we have, and some of them are by statewide. For example, we've had an increase of 163% in community engagement. Just that, for itself, for me, it's amazing. We've had impact where we have folks that now sitting that were residents that were disengaged, were receiving services for WIC, for SNAPs. We have some of them now sitting as City Council at the city where the health equity zone was. And those at times are difficult to present as successful outcomes and measures to our funders because they want to know, "What's the decrease in childhood lead poisoning prevention? What's the decrease in diabetes?"

But we also have some of those at the local level. So, in one city, for example, in Pawtucket, we had a decrease in childhood lead poisoning of 44%. Central Falls, another health equity zone, we had a decrease in teen pregnancy of 24%. In two other health equity zones that focus on feelings of loneliness in the senior population, they had a decrease of 13%. In our diabetes prevention program, statewide, for 21% of the participants, we saw a decrease in body weight of 5 to 7 percent. We saw an increase of 40% in redemption of SNAPs farmer's market incentives. We saw an increase of 36% in access to fruits and vegetables. We saw more than 1,000 graduates from evidence-based chronic disease self-management workshops, statewide. More than 1,000 graduates. We saw 46 opioid users being diverted from the criminal justice system in one small West Warwick city in Rhode Island. So that's the kind of outcome that we are seeing

along with this amazing community engagement and empowerment and ownership. Taking their own health in their own hands and being a voice and speaking out loud where before they did not. The amount of energy that you see across these health equity zones is for me, outside of those specific, very measurable individual outcomes, what I see statewide.

DR. GABRIEL KAPLAN:
That's very inspiring. Thank you. I know Dr. Anthony Iton, who is a leader in this field, talks about the importance of community engagement and community participation as really key goals in this work. And the fact that this is a major outcome of your initiative really underscores that A, it matters and B, you can really affect it by providing resources and the opportunity for communities to shape this. What opportunities are you working on now that are really exciting to you, in terms of building health equity and reducing chronic disease partly through this approach?

ANA NOVAIS:
So one of the things that we're doing—Dr. Alexander-Scott, as you know, is ASTHO's president. And so one of the ways that we are putting this work forward also at the national level—she's using these as the foundation of the ASTHO President's Challenge, and ASTHO made the commitment for the next two years to stay with this challenge and not just change. ASTHO just released a request for states to apply for a learning collaborative, in terms of, "How do we do this work at the local level?" We also received an award from Robert Wood Johnson Foundation to be able to develop a tool kit on how to do this work, both at the state level for other guidance for at the state departments but also at the local level, guidance for local for how to do this because, as you know, Rhode Island is unique in the sense that we don't have local health departments. The other thing that we're doing to assure the sustainability of the initiative. It's also working with our legislators to build health equity zones champions at the legislature. So we can see, have our own allocation for funding that allows us to better support the build-out of the infrastructure, and continue to expand the program. We now have 10 health equity zones.

We are finishing up the first cohort. We brought three new health equity zones to start the new cohort. The second cohort in July, starting July 1st. We are working with working though this challenge from the Federal Reserve bank, and we want it to create the same kind of the alignment that we had with the Rhode Island Foundation. And so we saw that two of the cities that came were working cities challenge funded by the Federal Reserve banks. So we're aligning again and complementing the work being done at the local level. Being mindful of that. And we've been doing what we call legislative day held at the hill. And where we take our health equity zones to our state house, and we bring all of the legislatures, and they engage and they learn. And so for the first time, this year, at the end of every budget hearing that we had, I had at least one or two persons from the legislatures coming and saying, "I'm a big health fan and champion, and I'm going to work to put some funding together." The other thing that we're doing is having statewide conversations around equity.

So we have for the last three years have an annual health equity summit where we bring folks together at the state level, and we're starting to bring outside of the state to have this conversation. How are we successful in moving forward with the health equity agenda? And then internally, we've made health equity a very clear priority. It's a stated leading priority for our department. And we have the stated expectation and the engagement with every single program within the department. About what does health equity mean to your program? How

does using these lenses of equity change to where you do your business? And to where you do public health. It's bringing the laboratory, the nursing homes, because they all have a change to be made by using this lens into the way they do public health. And that's the next step that we're doing now.

DR. GABRIEL KAPLAN:
Well, it sounds like you really had some many successes. You've brought in additional resources because of enthusiasm for this model. You've increased community levels of engagement. And you've produced some really meaningful health outcomes and now, you've begun to win legislative champions for this effort to perhaps even broaden that and really move into a national perspective to do technical assistance to other states that want to follow your lead. So I congratulate you for the outstanding success and thank you very much for the outstanding model and leadership you all have shown us. Thank you.

ANA NOVAIS:
Oh, you're welcome. It's been a great challenge but we have a great team here in Rhode Island. With Carol and everybody else in the team that has challenged and have been challenged by it, but pushing forward and staying true to the model. It's been an honor. So thank you for asking us to share too. We appreciate and we look forward to other ways and times to collaborate with the National Association of Chronic Disease Directors.

DR. GABRIEL KAPLAN:
Is there a place that people who are listening to this podcast can go on your website to learn more about the braiding of funding and the health equity zones in Rhode Island?

ANA NOVAIS:
Absolutely. If they go to www.health.ri.gov/hez, they will find all of this information.

DR. GABRIEL KAPLAN:
So for the audience that URL is health.ri.gov/hez. Hez, standing for health equity zones. So please, go there for more information and we'll have links to those web resources available to you from the website leading to this podcast. Thank you.

ANA NOVAIS:
Folks need to understand that while it's not easy to do the braided funding, it's challenging, it's cumbersome, but it's possible. And that's what I think at the end of the day matters. We sometimes shy away from doing this kind of comprehensive work because we don't have funding. But every single funding stream that we get from the feds, let's say to address the social determinants, let's say to address to achieve equity. So if we truly challenge ourselves, I think sometimes the values are more perceived than real and we can find ways to work around them.

DR. GABRIEL KAPLAN:
Ana, thank you so much for your time today. This is a great story for our listeners. We really appreciate you sharing it with us.

ANA NOVAIS:
Thank you so much for inviting us to share.

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