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Pawtucket/Central Falls

Health through Healthy Eating and Active Living

2022-2027 SDOH Accelerator Plan

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Introduction

In February 2022, the Rhode Island Department of Health (RIDOH) partnered with Local Initiatives Support Corporation (LISC) Rhode Island to develop a five-year SDOH Accelerator Plan to advance health equity, reduce disparities, and improve health outcomes in Pawtucket and Central Falls, Rhode Island. LISC is the backbone agency of the Pawtucket Central Falls Health Equity Zone (HEZ). The strategic planning process included participation from a variety of cross-sector collaborators with a vested interest in the health of the Pawtucket and Central Falls communities.

The catchment area of the Pawtucket and Central Falls HEZ and the three Social Determinants of Health (SDOH) focus areas were chosen based on demographic characteristics including health status, community profile, chronic disease burden, and available healthcare systems as well as a high prevalence of behavioral-related factors such as tobacco use, physical inactivity, and access to healthy foods. The SDOH focus areas include Public Spaces, Food and Nutrition, and Community-Clinical Linkages.

Background

Community Background

The SDOH Accelerator Plan will focus on the communities of Pawtucket and Central Falls, Rhode Island, and the plan builds upon the foundations set by the Pawtucket Central Falls HEZ. The catchment area is inclusive of the cities of Pawtucket and Central Falls, which are two adjacent urban municipalities with a combined population of over 90,000 residents, representing about 9% of Rhode Island's total population. As compared to Rhode Island as a whole, both cities are more densely populated. As indicated in Table 1, residents of both cities are relatively younger as compared to the State, and both Central Falls and Pawtucket are more racially diverse compared to Rhode Island.

Table 1. Demographic Information, Rhode Island and by City, 2015-2019

	Rhode Island	Pawtucket	Central Falls
Population			
Total Population	1,057,231	71,844	19,429
Population Per Square Mile	870.9	8,194.9	16,173.6
Median Age	40	38	30
Race			
White	80.5%	61.6%	48.5%
Black/African American	6.8%	17.6%	12.7%
Ethnicity			
Hispanic (of any race)	15.4%	25.3%	66.4%
Language Spoken at Home			
Only English	77.6%	58.0%	32.6%
Spanish	12.3%	20.5%	56.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019

In addition, 32.8% of residents in Central Falls and 18.6% in Pawtucket live below the federal poverty level (FPL). In Pawtucket, 30.0% of youth live in poverty. This increases to 44.9% in Central Falls. Providence County, in which the catchment area is located, has the highest rate of food insecurity (12.6%) compared to other counties. Food insecurity skyrocketed during the COVID-19 pandemic. In 2019, Progreso Latino's Central Falls Food Pantry served 1,124 households. In 2020, the pantry transitioned into a massive anti-hunger operation that served over 15,000 households. More than 50% of residents in both cities are either insured by Medicaid or Medicare or are uninsured. Environmentally, Interstate 95 runs through several Pawtucket neighborhoods, and canopy cover within Pawtucket and Central Falls is ranked among the lowest in the state.

Due to limitations on data, Rhode Island Behavioral Risk Factor Surveillance System (BRFSS) data at the state level was used as a predictor at the local level. The 2019-2020 Rhode Island BRFSS was analyzed to determine differences in chronic diseases and risk factors among Rhode Island adults older than 18. **Risk factors by race/ethnicity.** Obesity was higher among non-Hispanic Blacks (35.0%; CI=28.9%-41.2%) and significantly higher among Hispanics (36.7%; CI=32.4%-41.0%) compared to non-Hispanic whites (29.4%; CI=27.9%-30.9%). Non-Hispanic Blacks (29.3%; CI=23.3%-35.3%) and Hispanics (42.4%; CI=38.2%-46.7%) were significantly more likely to report not participating in any physical activity in the last month compared to non-Hispanic whites (21.2%; CI=19.9%-22.5%). Non-Hispanic whites (13.0%; CI=11.9%-14.1%) were more likely to report being a current smoker compared to Hispanics (10.0%; CI=7.4%-12.6%) and significantly more likely compared to non-Hispanic Blacks (7.8%; CI=5.0%-10.5%). **Risk factors by household income.** Obesity was higher within households with annual incomes under $25,000 (36.1%; CI=30.9%-41.3%) and between $25,000-$50,000 (36.8%; CI=30.8%-42.9%) compared to incomes above $50,000 (31.5%; CI=27.9%-35.1%). Respondents with annual incomes under $25,000 (41.0%; CI=35.8%-46.2%) and between $25,000-$50,000 (40.2%; CI=34.0%-46.3%) were more likely to report physical inactivity compared to incomes above $50,000 (36.8%; CI=32.9%-40.6%). Current smoking was higher within households of annual incomes under $25,000 (24.9%; CI=20.2%-29.7%) and between $25,000-$50,000 (24.2%; CI=19.0%-29.3%), compared to those above $50,000 (17.7%; CI=14.7%-20.7%). The differences noted for obesity, physical inactivity, and smoking were not statistically significant by household income.

Chronic disease by race/ethnicity. The percentage of non-Hispanic whites (29.2%; CI=27.9%-30.4%) who have ever been told they have arthritis was significantly higher than for non-Hispanic Blacks (17.0%; CI=13.1%-20.9%) and Hispanics (12.6%; CI=9.9%-15.3%). The percentage of non-Hispanic whites (4.4%; CI=3.9%-4.9%) who have ever been told they have coronary heart disease (CHD) was significantly higher than for non-Hispanic Blacks (2.1%; CI=0.8%-3.4%) and Hispanics (2.1%; CI=1.0%-3.2%). There were no significant differences for diabetes by race/ethnicity; non-Hispanic whites (10.0%; CI=9.2%-10.8%) compared to non-Hispanic Blacks (11.9%; CI=8.6%-15.2%) and Hispanics (11.3%; CI=8.9%-13.7%). **Chronic disease by household income.** Respondents with annual household incomes under $25,000 were significantly more likely than those from income households above $50,000 to report ever being told by a provider that they had diabetes. There were no significant differences among respondents with annual household incomes under $25,000, between $25,000-$50,000, and above $50,000 who report ever being told by a provider that they have heart disease or arthritis (Table 2).

Cancer incidence (2011-2018) among Rhode Island adults ages older than 40 within Pawtucket and Central Falls was close to the state average (96%). Lung/bronchus (SRI: 113%) and colon/rectum (SRI: 107%) cancer rates are higher in the Pawtucket and Central Falls catchment area than state

average. This may be reflective of factors such as smoking, second-hand smoke, radon, and occupational exposures for lung/bronchus cancer, and may be associated with lower screening and overweight, smoking, alcohol consumption, diet, and smoking as it pertains to colon/rectum cancer.

Table 2. Percent of Rhode Island adults who report ever being told by a physician that they have diabetes, arthritis, coronary heart disease, by household income

Income	Variable	Label	% "Yes"	95% CI
<$25,000	**Diabetes**	**Ever told diabetes**	**19.3%**	**15.5-23.0**
	Arthritis	Ever told have arthritis	34.0%	29.3-38.6
	CHD	Ever told CHD	5.4%	3.5-7.2
$25,000-$50,000	Diabetes	Ever told diabetes	16.3%	12.3-20.4
	Arthritis	Ever told have arthritis	32.1%	26.9-37.3
	CHD	Ever told CHD	4.2%	2.4-6.0
≥$50,000	Diabetes	Ever told diabetes	12.4%	10.4-14.4
	Arthritis	Ever told have arthritis	30.1%	27.0-33.3
	CHD	Ever told CHD	5.7%	4.3-7.1

Bold indicates significantly higher prevalence compared to household income ≥$50,000
*Ever told diabetes excludes gestational diabetes
SOURCE: Rhode Island Behavioral Risk Factor Surveillance System, 2019-2020

Community Health Issues

Community health issues were identified through a variety of data collection methods. In 2022, data gathering efforts for this plan included a document review, secondary data analysis, and primary data collection including a stakeholder survey, four focus groups, and six key informant interviews. Questions in the survey, focus groups, and interviews focused on existing strengths, barriers/challenges, suggestions for improvement, most impacted populations, potential partners, and visions for the future in the three identified priority areas of Public Spaces, Food and Nutrition, and Community-Clinical Linkages. Three of the four focus groups were conducted in-person, while the fourth was conducted with an existing group that regularly meets virtually. Three of the four focus groups were conducted in both English and Spanish with the assistance of live translation. Over 100 individuals provided their feedback and experiences by participating in these data gathering activities. Secondary data sources included the *U.S. Census Bureau's American Community Survey, 2021 Status Report on Hunger in Rhode Island,* and the *2021 Rhode Island SNAP Report*.

The key themes and recommendations from these efforts were synthesized and compiled, and key findings informed the goals, objectives, and strategies within the SDOH Accelerator Plan. Identified primary health issues regarding Pawtucket and Central Falls' public spaces include accessibility, safety, cleanliness, and maintenance. Respondents elevated issues of food affordability, lack of garden space, the existence of food deserts, and a lack of regular and reliable transportation to get food. Concerning community-clinical linkages, respondents mentioned language barriers, stigma of accessing services, lack of awareness of existing programs, lack of workforce capacity to staff services, difficulties connecting to mental health providers, and transportation issues accessing care.

Selected Populations

Based on the data provided above, the SDOH Accelerator Plan will focus on all people living in Pawtucket and Central Falls, Rhode Island, with a focus on identified populations most impacted by health inequities as defined by community members, other stakeholders, and health disparities data. These populations include BIPOC (Black, Indigenous, and People of Color), children, families who do not drive, families without insurance, immigrants and refugees, people with lower incomes, non-English speakers, older adults, people experiencing homelessness, and people with disabilities.

Partnerships

Leadership Team and Multisectoral Partners

The Pawtucket Central Falls Health Equity Zone with Local Initiative Support Corporation as the backbone agency (PCF HEZ/LISC) and RIDOH convened a diverse Leadership Team of local public health officials and representation from multiple sectors to develop a plan to address SDOH. The Leadership Team includes a wide range of collaborators from sectors including government, education, non-profit organizations, coalitions, healthcare, and public health. A list of Leadership Team members can be found in Appendix A. The Leadership Team played an integral part in developing and reviewing the SDOH Accelerator Plan. Their role included providing guidance on data collection sources to inform the plan; developing a vision and mission for the plan; brainstorming, developing, and refining goals, objectives, success measures, and strategies for each of the three identified SDOH priority areas; prioritizing strategies to implement in the plan's first year; and developing action steps, person(s) responsible, timeline, monitoring and evaluation approaches, and resources required for the first year of implementation.

The Leadership Team was engaged in a series of eight virtual and in-person meetings from March to July 2022. Between meetings, Leadership Team members provided their feedback on iterative plan components. The PCF HEZ/LISC and RIDOH worked together to identify potential Leadership Team members and participants in the process. To ensure strong resident voice in the plan, three residents were engaged at multiple stages in the Leadership Team and in-person sessions. The focus groups consisted of all residents and their feedback was incorporated into the planning process. Throughout the planning process, all partners had multiple opportunities to review all elements of the SDOH Accelerator Plan and its Year One Implementation Plan. Planning participants were also key in identifying ongoing efforts to minimize and avoid the duplication of services.

Shared Vision, Mission, and Goal Statements

A shared vision and mission are critical for the success of any plan. After being presented with key findings from data collection efforts, the Leadership Team brainstormed key concepts for the vision and mission of the SDOH Accelerator Plan. From these key concepts, Health Resources in Action (HRiA), who was contracted to facilitate the planning process and draft the SDOH Accelerator Plan, prepared multiple vision and mission statements for the Leadership Team to choose from. Below are the shared vision and mission statements for the SDOH Accelerator Plan adopted by the Leadership Team.

Vision: *Pawtucket and Central Falls are healthy, inclusive, and equitable communities where residents are safe, secure, and empowered to live to their highest potential*.

Mission: *Through comprehensive and culturally appropriate efforts, we empower community voice and improve systems to ensure healthier and more equitable communities in Pawtucket and Central Falls*.

The Leadership Team developed one goal statement for each of the three identified SDOH priority areas. More information about these goal statements can be found in the following Approach section.

Programs and Resources for SDOH

Existing Resources and Programs

In addition to the foundation and infrastructure built by the Pawtucket and Central Falls Health Equity Zone, the data gathering efforts in March 2022 illuminated a wide range of resources and programs for each of the three SDOH priority areas (Table ***1***3).

Table 1. Existing Resources and Programs

Public Spaces	Food and Nutrition	Community-Clinical Linkages
• Existence of green spaces, parks, and multiple community gardens enjoyed by residents • Central Falls Complete Streets ordinance passed in 2018 • City of Pawtucket's utilization of Complete Street approach	• Culturally diverse and culturally specific food outlets • Local food pantries and soup kitchens • Supplemental Nutrition Assistance Program (SNAP)/Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) accepted at Farmer's market • Recent state legislation (e.g., increasing minimum wage, doubled annual funding for Rhode Island Community Food Bank) • Community-based organizations dedicated to improving food accessible • Limited delivery options • Limited mobile food resource - discounted purchase	• Rhode Island Diabetes Health Equity Challenge – utilized Pathways to Population Health model • Chronic disease prevention and management programs • Access to local community health centers • Range of specialties available • Expansion of community health workers (CHWs) in the area

Approach

SDOH Priority Areas

As defined by the [US Centers for Disease Control and Prevention](), *the social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes*. These conditions greatly impact health outcomes and can be attributed to a wide range of health disparities and inequities.

Before engaging the Leadership Team, RIDOH and PCF HEZ/LISC determined the SDOH Accelerator Plan would focus on three SDOH priority areas: Built Environment, Food and Nutrition Security, and Community-Clinical Linkages. When engaging with community, RIDOH and PCF HEZ/LISC opted to use more accessible language and substituted "Public Spaces" for the term "Built Environment." The PCF HEZ's *Needs Assessment and Updated Action Plan, 2019-2020* and chronic disease data were critical in the decision-making process as priority focus areas were chosen. Table 4 provides a summary of the relationship between each Priority Area, its potential impact, and associated Healthy People 2030 SDOH Objectives.

Table 4. SDOH Priority Areas, Impacts, and Key Healthy People 2030 SDOH Objectives

SDOH Priority Area	Impact*	Key Healthy People 2030 – SDOH Objective
Public Spaces	*A healthy built environment facilitates access to transportation and physical resources that enhance quality of life, minimizes exposures to environmental contaminants, and supports physical activity, safe and accessible recreation, and other protective factor that improve chronic disease outcomes.*	*Increase the proportion of adults who walk or bike to get places — PA-10* *Increase the proportion of adolescents who walk or bike to get places — PA-11* *Reduce the number of days people are exposed to unhealthy air — EH-01* *Increase the proportion of adults who do enough aerobic physical activity for extensive health benefits — PA-03* *Increase the proportion of adolescents who do enough aerobic physical activity — PA-06* *Increase the proportion of older adults with physical or cognitive health problems who get physical activity — OA-01*

SDOH Priority Area	Impact*	Key Healthy People 2030 – SDOH Objective
Food and Nutrition Security	*Enhancing durable access to and routine consumption of adequate, nutritious food supports overall health, reduces morbidity and mortality associated with chronic disease, and decreases healthcare utilization.*	*Reduce household food insecurity and hunger — NWS-01* *Eliminate very low food security in children — NWS-02* *Increase fruit consumption by people aged 2 years and over — NWS-06* *Increase vegetable consumption by people aged 2 years and older — NWS-07*
Community-Clinical Linkages	*Effective community-clinical linkages improve chronic disease outcomes by increasing access to and utilization of preventive services in local communities.*	*Increase the number of community organizations that provide prevention services — ECBP-D07* *Increase the proportion of adults who get recommended evidence-based preventive health care — AHS-08* *Increase the proportion of health care visits by adults with obesity that include counseling on weight loss, nutrition, or physical activity — NWS-05*

*Source: *US Centers for Disease Control & Prevention, 2022*

Development of Plan Components

PCF HEZ/LISC and RIDOH leadership extended the invitation to Leadership Team members and other stakeholders to join as participants in the planning sessions. Planning participants took part in a virtual pre-planning session conducted by HRiA to ensure planning participants were well prepared for the planning sessions, understood the evolution and context for the SDOH Accelerator Plan, and were clear about expectations for engagement.

Following the pre-planning session, two half-day in-person planning sessions were held in May 2022 in Pawtucket, Rhode Island. The sessions were structured in both small- and large-group formats to develop plan components (e.g., goals, objectives, potential success measures, strategies, and potential partners). Sessions were facilitated by consultants from HRiA. Sessions included opportunities for cross-priority feedback and refinement of each of the core elements of

the strategic plan. Over 30 people participated across the pre-planning and planning sessions. See Appendix B for a list of planning participants.

Based on the output from the strategic planning sessions, HRiA developed a draft strategic plan. The draft plan was then circulated to participants for electronic feedback. HRiA compiled the feedback, revised the plan for overall consistency, and discussed recommendations for final revisions with RIDOH and PCF HEZ/LISC. RIDOH and PCF HEZ/LISC completed a final review of the draft before approving the plan outlined in this document.

Outcome Objectives and Activities

The anticipated reach of activities is all people living in Pawtucket and Central Falls, Rhode Island. Some activities or strategies will impact those outside of the cities of Pawtucket and Central Falls who travel to the area to enjoy its public spaces, participate in the food economy, and receive clinical services. The SDOH Accelerator Plan has the potential to impact all Rhode Island residents through statewide advocacy efforts in the three priority areas.

As outlined in Table 5, the SDOH Accelerator Plan will lead to several anticipated policy, systems, environmental, programmatic, and infrastructure outcomes.

Table 5. Anticipated SDOH Accelerator Plan Outcomes

	Public Spaces	Food and Nutrition	Community/ Clinical Linkages
Policy Outcomes	• Complete Streets ordinances established and implemented in all areas of Pawtucket and Central Falls	• Food policy gaps across the lifespan are identified and addressed	• Increased number of providers who accept all forms of insurance
Systems Outcomes	• A public space community needs assessment is implemented • Needs are prioritized in collaboration with collaborators and community members	• Asset map of food resources, programs, and partnerships is created	• Increased number of clinical providers utilizing a universal referral platform
Environmental Outcomes	• Increased number of accessible public spaces (e.g., more bike lanes, sidewalks adapted for walking, older adult fitness loops) • Increased amount of green space	• Spaces for people to prepare and enjoy culturally appropriate food together are established	• Increased number of transportation services to access healthcare
Programmatic Outcomes	• Opportunities for youth involvement in improving public spaces are expanded and supported • An anti-pollution campaign is established	• Expanded awareness of food and nutrition assistance programs and policies	• Increased number of providers trained in racial equity • Increased number of evidence-based community-based prevention initiatives
Infrastructure Outcomes	• Neighborhood watch groups and/or community groups are engaged to improve cleanliness and safety	• Increased number of food-based partnerships • Referral system for emergency food sustained • Paid food ambassador initiative established and sustained • Year-round food markets expanded	• CHW demographics are reflective of Pawtucket and Central Falls demographics • More mobile integrated health services are established

The following pages outline the goals, objectives, success measures, strategies, and potential partners for the three priority areas of the SDOH Accelerator Plan. See Appendix C for definitions of these planning terms. See Appendix D for a list of Acronyms used in the SDOH Accelerator Plan.

Vision	Pawtucket and Central Falls are healthy, inclusive, and equitable communities where residents are safe, secure, and empowered to live to their highest potential.
Mission	Through comprehensive and culturally appropriate efforts, we empower community voice and improve systems to ensure healthier and more equitable communities in Pawtucket and Central Falls.

Priorities	Goals	Objectives
Priority Area 1: Public Spaces	Goal 1: All people have welcoming, safe, clean, accessible, and inclusive public spaces.	1.1: Increase the accessibility of public spaces by 2027. (Developmental)
		1.2: Identify public space needs in each district by 2027.
		1.3: Develop two new green spaces in areas of need as prioritized by the community by 2027.
		1.4: Increase the number of public spaces that are enhanced/improved in Pawtucket and Central Falls to address cleanliness and safety by 2027. (Developmental)
		1.5: Establish and implement Complete Streets ordinances in Pawtucket and Central Falls by 2027.
Priority Area 2: Food and Nutrition	Goal 2: All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.	2.1: Increase consumption of fruits and vegetables by 2027. (Developmental)
		2.2: Increase the number of access points in Central Falls and Pawtucket to improve access to fresh produce by 2027. (Developmental)
		2.3: Decrease the percentage of Pawtucket and Central Falls residents that are experiencing food insecurity by 2027. (Developmental)
		2.4: Increase the number of food-based and other social service partnerships by 2027. (Developmental)
Priority Area 3: Community-Clinical Linkages	Goal 3: All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.	3.1: Increase access to transportation services to healthcare by 2027. (Developmental)
		3.2: All people will be served within one month of seeking routine care by 2027.
		3.3: Increase the number of clinical providers who utilize a universal referral platform to address SDOHs with patients who are medically underserved by 2027. (Developmental)
		3.4: Increase the number of providers trained in racial equity and results-based accountability to improve cultural sensitivity by 20% by 2027.
		3.5: Increase the number of certified CHWs who are from, reflective of, and serving the Pawtucket and Central Falls communities by 2027. (Developmental)
		3.6: Increase the number of people participating in evidence-based, community-based prevention initiatives by 2027. (Developmental)

Priority Area 1: Public Spaces

Goal 1: All people have welcoming, safe, clean, accessible, and inclusive public spaces.

Objective 1.1: Increase the accessibility of public spaces by 2027. (Developmental)

Success Measures

- Number of public spaces that are accessible to people of all abilities is increased
- Number of public spaces where accessibility is increased

Strategies

1.1.1 Create a map and multilingual signage of accessible recreational sites, structures, and walking paths.
1.1.2 Implement community events that promote activity (e.g., Cyclovia).
1.1.3 Implement more bike lanes and adapt sidewalks for walking.
1.1.4 Create an Americans with Disabilities Act (ADA)-compliant older adult fitness loop.
1.1.5 Include accessibility in improvement and development projects.

Potential Partners

- Accessibility & Inclusion Consulting LLC, Annette Bourbonniere
- Blackstone Valley Community Action Program - Woodlawn Community Center
- Cities of Pawtucket and Central Falls Departments of Public Works
- Cities of Pawtucket and Central Falls Planning Departments
- Cities of Pawtucket and Central Falls Parks and Recreation Departments
- GrowSmartRI
- Local fitness centers
- School officials and partners
- School districts

Objective 1.2: Identify public space needs in each district by 2027. (Developmental)

Success Measures

- Number of public space needs identified
- Number of conversations with district representatives

Strategies

1.2.1 Implement public space community needs assessment.
1.2.2 Contact district representative to discuss public space need.
1.2.3 Prioritize needs in collaboration with primary collaborators.

Potential Partners

- Community leaders
- Council members
- Groundwork Rhode Island
- RIDOH Climate Change and Health Program
- Roots to Empower
- Southside Community Land Trust (SCLT)
- Youth sports organizations
- Cities of Pawtucket and Central Falls Departments of Public Works
- Cities of Pawtucket and Central Falls Planning Departments
- Cities of Pawtucket and Central Falls Parks and Recreation Departments

Objective 1.3: Develop two new green spaces in areas of need as prioritized by the community by 2027.

Success Measures

- Number of new or updated green spaces
- Number of green space acreage

Strategies

1.3.1 Establish baselines for green space acreage and number of green spaces.
1.3.2 Use assessment to identify green space opportunities.
1.3.3 Engage community in selection process to identify areas of need.
1.3.4 Collaborate with Groundwork Rhode Island to promote tree program.
1.3.5 Collaborate with Cities of Pawtucket and Central Falls Departments of Public Works to implement green spaces.
1.3.6 Leverage funding for additional community gardens and maintain existing community gardens.

Potential Partners

- Cities of Pawtucket and Central Falls Planning Departments
- RIDOH Climate Change and Health Program
- Rhode Island Executive Climate Change Coordinating Council (EC4)
- Cities of Pawtucket and Central Falls Departments of Public Works
- GrowSmartRI
- PCF Development

Objective 1.4: Increase the number of public spaces that are enhanced/improved in Pawtucket and Central Falls to address cleanliness and safety by 2027. (Developmental)

Success Measures

- Number of public spaces enhanced
- Number of complaints received by Parks and Recreation Department

Strategies

1.4.1 Engage community collaborators to develop and implement a coordinated plan for improved cleaning, maintenance, and safety.
1.4.2 Engage and create neighborhood watch groups and/or community groups for cleanliness and safety.
1.4.3 Expand and support opportunities for youth involvement.
1.4.4 Implement an anti-pollution campaign.

Potential Partners

- Local Boys & Girls Clubs
- Center for Health and Justice Transformation
- Cities of Pawtucket and Central Falls Departments of Public Works
- Cities of Pawtucket and Central Falls Parks and Recreation Departments
- Law enforcement
- The Pawtucket Foundation
- PCF Development
- YMCA of Pawtucket

Objective 1.5: Establish and implement Complete Street ordinances in Pawtucket and Central Falls by 2027.

Success Measures

- Number of Complete Streets ordinances established
  - Central Falls *Green & Complete Streets Ordinance* established in 2018
- Number of Complete Streets ordinances implemented

Strategies

1.5.1 Promote the 50/50 sidewalk program (Complete Streets).
1.5.2 Establish a Pawtucket Complete Streets ordinance with community input.
1.5.3 Implement the Central Falls and Pawtucket Complete Streets ordinance with community input.
1.5.4 Advocate for more 50/50 sidewalk program funding.

Potential Partners

- Business associations
- Cities of Pawtucket and Central Falls Planning Departments
- Cities of Pawtucket and Central Falls Parks and Recreation Departments
- School officials and partners
- School districts
- Senior centers
- SCLT

Priority Area 2: Food and Nutrition

Goal 2: All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.

Objective 2.1: Increase consumption of fruits and vegetables by 2027. (Developmental)

Success Measures

- Percentage of residents who report consuming daily recommended amounts of fruits and vegetables

Strategies

2.1.1 Establish and/or extend a paid food ambassador initiative to promote the consumption of fruits and vegetables.
2.1.2 Create environments and spaces for people to prepare and enjoy culturally appropriate food together.
2.1.3 Identify gaps from infancy through older adulthood in food policy and nutrition education.
2.1.4 Explore ways to address gaps in food policy and education across the lifespan.

Potential Partners

- AmeriCorps Seniors RSVP
- Blackstone Valley Community Action Program, Woodlawn Community Center
- Blackstone Valley Emergency Food Center
- RIDOH Center for Food Protection
- School officials and partners
- School districts
- Rhode Island Public Health Institute (RIPHI), Food on the Move
- FoodCorps
- Pawtucket Soup Kitchen
- Rhode Island Food Council
- University of Rhode Island (URI) Cooperative Extension
- URI SNAP-Ed Nutrition Education program
- URI Master Gardener program
- Family Service of Rhode Island (FSRI)
- Progreso Latino
- SCLT

Objective 2.2: Increase the number of access points in Central Falls and Pawtucket to improve access to fresh produce by 2027. (Developmental)

Success Measures

- Number of access points to fresh produce

Strategies

2.2.1 Expand or increase the number of mobile food/produce markets that are year-round.
2.2.2 Expand or increase the number of stationary food/produce markets that are year-round.
2.2.3 Create more year-round garden spaces (indoor and outdoor) and paid job opportunities.
2.2.4 Explore other funding sources and structures to include undocumented Rhode Islanders in SNAP benefits.
2.2.5: Provide resources and technical assistance to safely grow food at home and schools.

Potential Partners

- Blackstone Health, Inc.
- The Elisha Project
- Farm Fresh Rhode Island's Market Mobile
- Harvest Kitchen
- Nourish RI
- RIPHI, Food on the Move and retail SNAP incentive legislation
- RI Farm to School Network
- Rhode Island Rhode Island Food Policy Council
- RIDOH Center for Food Protection
- URI SNAP-Ed Nutrition Education program
- SCLT
- URI Master Gardener program

Objective 2.3: Decrease the percentage of Pawtucket and Central Falls residents that are experiencing food insecurity by 2027. (Developmental)

Success Measures

- Percentage of residents experiencing food insecurity (available at county-level)
- Number of SNAP-eligible individuals who are enrolled in SNAP
- Number of WIC-eligible individuals who are enrolled in WIC
  - 2022: Pawtucket – 1,935 individuals enrolled; Central Falls – 1,077 individuals enrolled
- Percentage of WIC-eligible individuals unserved (not enrolled in WIC)
  - 2022: Pawtucket – 56.02%; Central Falls - 46.18%
  - 2022: Rhode Island – 55.62%
- Number of free or reduced lunch eligible students enrolled in free or reduced lunch and breakfast programs
- Number of households served at Progreso Latino Food Pantry
  - 2019: 1,124 households
  - 2020: > 15,000 households

Strategies

2.3.1 Identify a baseline and trend of Pawtucket and Central Falls residents who are food insecure.
2.3.2 Expand awareness of food and nutrition assistance programs and policies.
2.3.3 Expand eligibility of food and nutrition assistance programs and policies, advocate for state funding increase for SNAP incentives such as Food on the Move and Bonus Bucks.
2.3.4 Advocate for broader and culturally relevant WIC options.
2.3.5 Advocate for the sustainability of state legislation that provides SNAP Incentive at all retail settings.
2.3.6 Advocate for legislation that could assist undocumented Rhode Islanders through a program like SNAP.
2.3.7 Expand or increase the number of emergency food resources.
2.3.8 Ensure a strong referral system for emergency food and market available resources.

Potential Partners

- Nourish RI
- Public housing authorities and public senior housing
- Rhode Island Community Food Bank

- Rhode Island Department of Human Services (DHS), SNAP outreach vendors
- RIDOH WIC program
- Rhode Island Rhode Island Food Policy Council
- United Way of Rhode Island
- URI SNAP-Ed Nutrition Education program

Objective 2.4: Increase the number of food-based and other social service partnerships by 2027. (Developmental)

Success Measures

- Number of food-based partnerships
- Number of social service partnerships

Strategies

2.4.1 Create shared definition of partnership and establish baselines.
2.4.2 Create an asset map of resources, programs, and partnerships.
2.4.3 Explore digital and non-digital communication platforms to share information on resources, programs, and partnerships.
2.4.4 Expand partnerships to explore upstream (e.g., poverty reduction) policy changes.
2.4.5 Work with local business owners to offer more culturally appropriate and healthy food options.

Potential Partners

- Central Falls School District Wellness Committee
- School districts
- Rhode Island Commerce Corporation (Commerce)
- Farm Fresh Rhode Island
- Rhode Island Community Food Bank
- Rhode Island Rhode Island Food Policy Council
- Unite Rhode Island
- United Way of Rhode Island
- Progreso Latino
- The Elisha Project
- FSRI

Priority Area 3: Community-Clinical Linkages

Goal 3: All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.

Objective 3.1: Increase access to transportation services to health care by 2027. (Developmental)

Success Measures

- Number of transportation services to access healthcare
- Number of transportation programs available to access healthcare
- Number of patients who report transportation as a barrier to healthcare access (Source: SDOH screening data collected by providers)

Strategies

3.1.1 Identify a baseline (including what services are already available).
3.1.2 Educate people on the existing options, including transportation to appointments.
3.1.3 Advocate for continuation of reliable, low-cost or free transportation options (e.g., including continuing Uber and Lyft programs that started during the COVID-19 pandemic).
3.1.4 Explore what other similar communities are doing that could be implemented in Pawtucket and Central Falls.
3.1.5 Work with partners to create more low-cost or free transportation options (e.g., community/clinic van services).
3.1.6 Advocate for more mobile integrated health services.
3.1.7 Explore non-traditional partnerships (e.g., bring specialists to Pawtucket and Central Falls).
3.1.8 Advocate for increased reimbursement rates for mobile services (e.g., supplies, mileage, etc.) and for ongoing telehealth and telehealth reimbursement.
3.1.9 Establish agreements, or support the State in establishing agreements, with insurance companies to facilitate transportation with their participants for appointments.

Potential Partners

- Caregiver advocacy groups (e.g., disabled, seniors, children with special needs)
- Community clinics
- Community organizations that refer or advocate for services
- Front office staff at clinics to ask about potential barriers
- Insurance companies
- Rhode Island Public Transit Authority (RIPTA)
- Uber/Lyft/other ride sharing options
- Accountable Entities (AEs)
- Community Health Network (CHN)
- Rhode Island Parent Information Network (RIPIN)

Objective 3.2: All people will be served within one month of seeking routine care by 2027.

Success Measures

- Number of people served within one month of referral by their primary care provider who are seeking routine behavioral health and oral healthcare

Sources

- Provider quality metrics
- Electronic Medical Records (EMRs)
- Patient satisfaction survey results

Strategies

3.2.1 Collaborate with behavioral health and oral health providers to expand hours of services and explore other reasons for waitlists.

3.2.2 Support advocacy at the state level for increased reimbursement rates to draw more providers to the area.

3.2.3 Support advocacy at the state level for increasing the number of providers, especially dental and behavioral health, who accept all forms of insurance.

3.2.4 Partner with practices (AEs) that are transitioning to value-based care versus fee-for-service.

3.2.5 Advocate for incentives to draw providers to the area and keep local trainees in the area after graduation.

3.2.6 Educate Pawtucket and Central Falls students on career pathways in local healthcare professions and work with the programs to have a warm handoff to local students. (See also 3.5.1)

3.2.7 Advocate for funding to expand free clinic hours and pay/compensate care team members.

3.2.8 As part of advocacy efforts, partner with people with lived experience of lack of access to care to share their stories with the Rhode Island Executive Office of Health and Human Services (EOHHS), the Governor, etc.

Potential Partners

- The American Association of Retired Persons (AARP) Rhode Island
- AEs
- Advocacy groups (student; seniors; veterans; people in recovery, with mental illness, with chronic health conditions; etc.)
- Apprenticeship Rhode Island
- The Warren Alpert Medical School of Brown University
- Community Health Worker Association of Rhode Island (CHWARI)
- Clinical professional associations (visiting nurses, CHWARI, American Academy of Pediatrics, therapists, etc.)
- Office of the Lieutenant Governor Long Term Care Coordinating Council (LTCCC)
- Office of the Health Insurance Commissioner (OHIC)
- Rhode Island EOHHS
- Rhode Island Medicaid program
- School districts; local universities, colleges, and technical schools
- School-based clinics and school-based educators

Objective 3.3: Increase the number of clinical providers who utilize a universal referral platform to address SDOHs with patients who are medically underserved by 2027. (Developmental)

Success Measures

- Number of clinical providers utilizing a universal referral platform (e.g., Unite Us) Source: Unite Us data and data from other platforms
- Number of referrals to mental health, behavioral health, oral health, social services, preventative screenings, etc.
- Number of community-based organization (CBO) and social service agencies in the Pawtucket and Central Falls catchment area enrolled with Unite Us

Strategies

3.3.1 Promote awareness of Unite Us with providers and CBOs.

3.3.2 Improve the referral system by conducting an assessment to determine what systems/platforms providers are using, identify current gaps in the e-referral platform, and identify barriers to implementing Unite Us (e.g., training, time, money, trust).

3.3.3 Advocate for providers and Pawtucket and Central Falls CBOs to enroll in Unite Us, including potential incentives for provider and CBO participation, so that there are more local resources within Unite Us.

3.3.4 Promote the training of universal referral platform users.

3.3.5 Create or utilize existing communication mechanisms to share success stories and best practices.

Potential Partners

- CHWs
- Family Care Community Partnership (FCCP)
- Schools
- Senior centers

Objective 3.4: Increase the number of providers trained in racial equity and results-based accountability to improve cultural sensitivity by 20% by 2027.

Success Measures

- Number of providers trained
- Percentage of acceptable training evaluation scores

Strategies

3.4.1 Identify the number of providers who serve Pawtucket and Central Falls, and what percentage of them are already trained in racial equity and results-based accountability.

3.4.2 Educate providers about available continuing medical education (CME) / continuing education unit (CEU) credits relevant to racial equity and results-based accountability to improve cultural sensitivity, including culturally and linguistically appropriate services (CLAS) standards.

3.4.3 Partner with organizations that provide annual trainings to better understand the population of patients for whom the primary care team is responsible.

3.4.4 Advocate for patient satisfaction survey questions on racial equity and cultural sensitivity.

3.4.5 Explore possibility of partnering with providers to implement patient satisfaction survey regarding cultural sensitivity.

Potential Partners

- Care Transformation Collaborative of Rhode Island (CTC-RI)
- Federally Qualified Health Centers (FQHC) / AEs (Blackstone Valley Community Health Center [BVCHC], Integra Community Care Network)
- HEZ resident leaders (including youth)
- Medicaid/Managed Care Organizations (MCOs)
- RIDOH
- Higher education clinical schools
- School nurses
- United Way of Rhode Island

Objective 3.5: Increase the number of certified CHWs who are from, reflective of, and serving the Pawtucket and Central Falls community by 2027. (Developmental)

Success Measures

- Percentage of CHWs that serve the Pawtucket and Central Falls community with demographics that are reflective of Pawtucket and Central Falls demographics
- Number of CHWs who are from and serving the Pawtucket and Central Falls community

Strategies

3.5.1 Educate Pawtucket and Central Falls students on career pathways in local healthcare professions. (See also 3.2.8).
3.5.2 Advocate for funding to hire and retain CHWs (e.g., free education).
3.5.3 Advocate for reimbursement for services provided by CHWs and support state advocacy efforts for increasing pay.
3.5.4 Advocate to current and potential CHW employers for incentives for CHW training (e.g., childcare, time off).
3.5.5 Advocate to current and potential CHW employers for incentives to draw CHWs to the area and recruit CHWs who are reflective of the Pawtucket and Central Falls community.
3.5.6 Identify a central coordinator/convener for CHWs (e.g., to share best practices, advocate for CHWs, connect to other CHW networks).
3.5.7 Support local grassroots CHW networking efforts.

Potential Partners

- CHWARI
- Community colleges
- RI EOHHS
- Pawtucket and Central Falls youth
- Pawtucket and Central Falls Rhode to Equity team
- Rhode Island Department of Labor and Training (DLT)
- RIDOH CHW Program
- School districts
- Technical schools
- FSRI

Objective 3.6: Increase the number of people participating in evidence-based, community-based prevention initiatives by 2027. (Developmental)

Success Measures

- Number of programs
  - 2022: 7 Community Health Network (CHN) programs
- Number of CBOs that offer programs
  - 2022: 5 CBO
- Number of participants, including demographic information
  - CHN referrals
    - 2019: 86 CHN referrals
    - 2022: 59 CHN referrals (Jan – Aug)
  - CHN participant language spoken of referrals
    - 2019: English: 59; Spanish: 24; Portuguese: 2; Unknown: 1
    - 2022: English: 16; Spanish: 40; Portuguese: 1; Unknown: 8

Strategies

3.6.1 Create an asset map of what initiatives currently exist to identify where initiatives are needed.
3.6.2 Explore ways to share information about available community resources with CHWs.
3.6.3 Advocate for training for CHWs to facilitate community health programs.
3.6.4 Advocate for CBOs to be compensated/have funding invested/allocated from the healthcare sector (MCOs, etc.).
3.6.5 Work with partners to offer incentives for community members to participate in community-based preventative initiatives.
3.6.6 Expand the CHN to include other organizations.
3.6.7 Advocate for community-based prevention initiatives to be more inclusive of all community members (e.g., culture, ability, documentation status, housing status) and to be held at locations convenient and accessible to all community members.

Potential Partners

- Churches
- Community service providers
- Cultural centers
- Housing and recovery programs
- RIDOH
- RIPIN
- Schools
- Senior centers
- URI SNAP-Ed Nutrition Education program
- CHN
- FSRI

Evaluation Plan and Data Integration

The goal of the Evaluation Plan is to monitor and guide the implementation of the SDOH Accelerator Plan. Measures have been established with each objective that address policy, systems, and environmental changes to support physical activity, healthy diet, and enhance access to effective medical care and community resources to improve health status and eliminate health inequities in chronic disease and chronic disease outcomes among residents of Pawtucket and Central Falls.

The **purposes** of evaluating the SDOH Accelerator Plan are to benchmark successes, be responsive to community need, work towards each priority area's **goals**, and inform and strengthen the efforts of RIDOH, PCF HEZ/LISC, and community partners in implementing the SDOH Accelerator Plan. There are three priorities in the SDOH Accelerator Plan: *Public Spaces*, *Food and Nutrition*, and *Community-Clinical Linkages*. Each priority is supported by four to six SMART (Specific, Measurable, Achievable, Relevant, Time-phased) or developmental objectives. The Leadership Team developed at least one success measure to track the objective and additional measures to evaluate progress for each of the SDOH Accelerator Plan's 15 objectives (see Appendix E – Objectives and Success Measures for more information). The SDOH Accelerator Plan will be monitored with support from RIDOH, PCF HEZ/LISC, and the Leadership Team. Evaluation findings will help RIDOH and PCF HEZ/LISC determine which strategies to continue, to adapt, to replicate, and/or to deprioritize.

The first step in determining how strategies and outcomes (or success measures) will be measured was prioritizing 20 strategies (of the Plan's total 85 strategies) to implement in the Plan's first year. The Leadership Team developed action steps, determined responsible parties, and brainstormed monitoring and evaluation approaches for these 20 strategies (see Appendix F – Implementation Plan for more information). Data sources include the Pawtucket Central Falls HEZ; RIDOH; Rhode Island Rhode Island Food Policy Council; Cities of Pawtucket and Central Falls Parks and Recreation, Planning, Public Works, and School Departments; US Census Bureau's American Community Survey; AEs; and Unite Us. The Leadership Team will convene the Health Equity Zone collaborative in the Fall 2022 to further engage the planning team and community members to establish leadership in each priority area, including the evaluation components of the plan. Please see Table 6 for Evaluation Questions; Indicators; and Data Sources, Collection Methods, Timing, and Analysis.

Table 6. Evaluation Plan

Evaluation Questions	Indicator(s)	Data Source	Data Collection Method	Data Collection Timing	Data Analysis	Person(s) Responsible
Approach Was funding secured to support implementation of plan? To what extent were partners and stakeholders involved in the implementation of strategies?	Amount of funding secured Number of priority areas supported with funding Number of Public Spaces working Group, Food and Nutrition task force; and Community-Clinical Linkages working group members Number of working group and task force meetings Number of HEZ monthly agendas with policy items from working groups and task force	Working groups and task force Meeting agendas and attendance records Monthly meeting agendas	Collect meeting minutes and attendance records Collect meeting agendas	Quarterly	Count number of members Count number of unique sessions, attendees Count number of plan activities included on agendas	RIDOH and PCF HEZ/LISC

Evaluation Questions	Indicator(s)	Data Source	Data Collection Method	Data Collection Timing	Data Analysis	Person(s) Responsible
Efficiency What were the challenges to accomplishing strategies?	Number and type of facilitators and barriers to completing priority area strategies	Working groups and task force interviews PCF HEZ/LISC staff interviews	Conduct interviews annually	Annually in September/October	Identify and summarize common actions or resources that did and did not help in the implementation of strategies Identify and summarize changes	RIDOH and PCF HEZ/LISC
Effectiveness Did actions impact measures?	Number of actions implemented Number of measures evaluated	PCF HEZ/LISC; RIDOH; Rhode Island Rhode Island Food Policy Council; Cities of Pawtucket and Central Falls' Parks and Recreation, Planning, Public Works, and School Departments; US Census Bureau's American Community Survey; AEs; and Unite Rhode Island	Request data quarterly from data sources and working groups and task force	Quarterly	Identify and summarize success and challenges in action implementation Identify and summarize measure outcomes	RIDOH, PCF HEZ/LISC, Leadership Team, working groups, task force

Evaluation Questions	Indicator(s)	Data Source	Data Collection Method	Data Collection Timing	Data Analysis	Person(s) Responsible
Sustainability What processes or systems have been established to sustain the working groups and task force?	Description of systems in place to sustain active working groups and task force Number and type of facilitators and barriers to ongoing working groups and task force	Document analysis of strategy records, meeting agendas, and member interviews	Document analysis of project records Conduct interviews annually	Annually in September/October	Identify process Identify and summarize changes	RIDOH, PCF HEZ/LISC, Leadership Team, working groups, task force
Impact Were objectives achieved?	Number of measures with improvements	PCF HEZ/LISC; RIDOH; Rhode Island Rhode Island Food Policy Council; Cities of Pawtucket and Central Falls' Parks and Recreation, Planning, Public Works, and School Departments; US Census Bureau's; American Community Survey; AEs; and Unite Rhode Island	Request data quarterly from data sources and working groups and task force	Annually	Identify and summarize measure outcomes	RIDOH, PCF HEZ/LISC, Leadership Team, working groups, task force

Sustainability

Health Equity Zones utilize a braided funding model and PCF HEZ/LISC is executing a number of projects that will support items identified for implementation in the first year. PCF HEZ/LISC will convene the Pawtucket Central Falls HEZ Collaborative in the Fall 2022 to review the SDOH Accelerator Plan and establish leadership in the three priority areas and continue the ongoing goal of securing funding to support its implementation through 2027. The Pawtucket Central Falls HEZ looks for ways to continue the comprehensive approach to health regularly, and they anticipate a grant that will incorporate increased food access into opioid recovery efforts, as well as being able to make a few small grants in the new year to green spaces.

Examples of year one implementation strategies that currently have financial support for implementation include:

1. PCF HEZ/LISC is supporting multiple organizations in the current year at over $190,000 to deploy CHWs in Pawtucket and Central Falls, as well as to convene CHWs in the two communities. The CHWs are directly supporting individuals in identifying food and nutrition resources, providing nutrition education, and screening for SDOH needs. These CHWs are supporting both increased community-clinical linkages and increasing food and nutrition access and education. In convening additional CHWs, the impact is expanded systemically in Pawtucket and Central Falls as resources and access to CHW services is shared across the network. *The source of this funding is from RIDOH's CHW Program funded by the CDC.*
2. Through the Rhode Island Medicaid *Rhode to Equity* initiative, $77,900 is granted to PCF HEZ/LISC, a person with lived experience, and a community partner. PCF HEZ/LISC will continue to convene the Rhode to Equity team focused on improving community-clinical linkages with PCF HEZ/LISC, an AE (Integra Community Care Network/Care New England Medical Group [CNEMG] primary care practice that serves Pawtucket and Central Falls), and the Community Health Team (FSRI). The focus of the team is to improve access of healthy food to improve health outcomes for patients with chronic diseases and the community at large. As a result of this plan PCF HEZ/LISC will re-establish the Food and Nutrition task force to carry out the food and nutrition portion of this plan. *The source of this funding is from Rhode Island Medicaid funded by the US Centers for Medicare and Medicaid Services.*

In addition to the outlined ideas to sustain each of the year one strategies, there are several approaches to expand, diversify, and sustain implementation efforts of the SDOH Accelerator Plan as a whole:

- The existing **Pawtucket Central Falls HEZ** is an integral community asset that can assist with sustaining implementation efforts. The Pawtucket Central Falls HEZ regularly convenes and mobilizes a wide range of multi-sector partners. They convene the full HEZ collaborative monthly. Additionally, the Pawtucket Central Falls HEZ convenes four task forces (Substance Use and Mental Health, Policy, Youth Engagement, and Resident Engagement).
- The SDOH Accelerator Plan was built from primary input of **Pawtucket and Central Falls community members**, who are empowered to bring new ideas to the table to expand and diversify the implementation efforts. The plan was written to be adapted over time with input from community members.

- The SDOH Accelerator Plan was created in conjunction with and is supported by the **Rhode Island Department of Health**. RIDOH has strong connections to other state agencies and regions in other areas of Rhode Island and can serve as a conduit to other possible funding opportunities and strategies.

Through the iterative and collaborative process of developing the SDOH Accelerator Plan, RIDOH and PCF HEZ/LISC are confident that the plan will be sustained over time, with support from vested community members, partners, and other collaborators.

Implementation Plan

The components included in this report represent the strategic framework for a data-informed, strategic plan. Given the unpredictable nature of changing resources, priorities, and events, the Leadership Team examined the 85 strategies and prioritized a subset of 20 strategies to start implementing in the first year of the SDOH Accelerator Plan. When thinking about which strategies to prioritize for the first year of implementation, the Leadership Team considered:

1. Is the strategy foundational? Does it need to happen first, before other strategies?
2. Is there already momentum for the strategy?
3. Is it feasible to start the strategy in the coming year?

Individual responses were tallied, and 20 strategies were prioritized to initiate in the first year of the SDOH Accelerator Plan. RIDOH, PCF HEZ/LISC, and Leadership Team members developed a Year 1 Implementation Plan that includes: prioritized strategies and specific one-year action steps with timelines, identified lead responsible parties and resources for each prioritized strategy. The implementation plan includes monitoring and evaluation processes and procedures to ensure that successes and challenges are captured on an annual basis. Working groups for each priority area, comprised of partners, collaborators, and community participants, are responsible for this annual process for implementing and updating the plan.

See Appendix F for the Year 1 Implementation Plan which includes detailed information about implementing proposed strategies and activities, a description of partner participation, monitoring and evaluation approaches, and required resources for sustainability.

Appendices

Appendix A: Leadership Team Members

Appendix B: Planning Session Participants

Appendix C: Strategic Planning Definitions

Appendix D: Acronyms Used in the SDOH Accelerator Plan

Appendix E: SDOH Accelerator Plan SMART Objectives and Success Measures

Appendix F: Year One Implementation Plan

Appendix A: Leadership Team Members

Scott Hewitt	BVCHC
Allison Tovar	Brown University
Patricia Martinez	Central Falls School District
Elizabeth Moreira	City of Pawtucket
Jenna Nelson	FSRI
Thomas Kinzel	FSRI
Arleen Hernandez	Groundwork Rhode Island
Brady Dunklee	Integra Community Care Network
Sara Castaneda	Progreso Latino
Carlene Fonseca	Resident
Erika Vallejo	Resident, Central Falls School District
Caitlin Mandel	Rhode Island Rhode Island Food Policy Council
Lauren Conkey	RIDOH Center for Health Promotion
Allegra Scharff	RIDOH Health Equity Institute
Nancy Sutton	RIDOH Center for Chronic Care & Disease Management
Rebecca Marcus	Rhode Island LISC
James Logan	Rhode Island LISC
Robyn Hall	Rhode Island LISC
Nati Taveras	Rhode Island LISC
Jennifer Costanza	Pawtucket Central Falls HEZ evaluator
Matt Helm	RIPHI/Food on the Move
Tarshire Battle	SCLT
Heidi Hetzler	URI SNAP-Ed Nutrition Education program
Maria Marin	Pawtucket Family YMCA

Appendix B: Planning Session Participants

RIDOH and PCF HEZ/LISC would like to thank all the planning session participants (listed below) for their attention and involvement during the planning sessions and their ongoing commitment to health equity in Pawtucket and Central Falls.

- Alison Tovar – Brown University
- Allegra Scharff – RIDOH
- Arleen Hernandez – Groundwork Rhode Island
- Rebecca Marcus – Rhode Island LISC
- Brady Dunklee – Integra Community Care Network
- Breanne DeWolf – RIDOH
- Carlene Fonseca – Resident
- Caitlin Mandel – Rhode Island Rhode Island Food Policy Council
- Cara Mitchell – Farm Fresh Rhode Island
- Danai Boone – RIDOH
- Edward G. Soares – City of Pawtucket
- Elizabeth Moreira – City of Pawtucket
- Elisabeth Adler – Integra Community Care Network
- Emily Miller – City of Central Falls
- Erika Vallejo – Resident
- Geraldine McPhee – RIPIN
- Heidi Hetzler – URI SNAP-Ed Nutrition Education program
- James Logan – Rhode Island LISC
- Jane Garvey – Integra Community Care Network
- Jenna Nelson – FSRI
- Jennifer Costanza – Pawtucket Central Falls HEZ Evaluator
- Joseph Diaz – CNEMG
- Lauren Conkey – RIDOH
- Maria Marin – Pawtucket Family YMCA
- Mary Lou Moran – Leon Mathieu Senior Center
- Matilda Xavier – BVCHC
- Matt Helm – RIPHI/Food on the Move
- Matthew Harvey – Integra Community Care Network
- Melissa Flaherty – Pawtucket Homeless Working Group
- Nancy Sutton – RIDOH
- Nati Taveras – RI LISC
- Olivia Gaudineer – RIDOH
- Pamela Marroquin – Children's Friend
- Patricia Martinez – Central Falls School District
- Robert Runge – CIty of Pawtucket
- Robyn Hall –Rhode Island LISC
- Samba Ndoye – Resident
- Sara Castaneda – Progreso Latino
- Scott Hewitt – BVCHS
- Steve Sypek – Help the Homeless RI
- Tara Cooper – RIDOH
- Tarshire Battle – Roots to Empower/SCLT
- Thomas Kinzel – FSRI
- Victoria Parker –RIDOH
- Wanda Casiano –City of Central Falls
- Yuselly Mendoza – RIDOH

Appendix C: Strategic Planning Definitions

Term	Definition/Description
Priority	Key issues identified from an assessment that provide a focus for planning.
Goal	A goal is a broadly stated, non-measurable change in the priority area. It describes in broad terms a desired outcome of the planning initiative.
Objective	Objectives articulate goal-related outcomes in specific and measurable terms. Objectives state how much of what you hope to accomplish and by when. Objectives are SMART (Specific, Measurable, Achievable, Relevant, Time-phased).
Success Measures	Measure(s) of progress or completion of a goal or objective. These measures demonstrate if the goal or objective was successful in impacting the priority.
Strategies	A strategy is a statement of how an objective will be achieved. It is less specific than action steps but tries broadly to answer the question, "How can we get from where we are now to where we want to be?"
Monitoring/Evaluation Approaches	The approaches used to track and monitor progress on strategies and activities (e.g., quarterly reports, participant evaluations from training)
Action Steps	The activities outlining the steps taken to achieve each strategy, arranged chronologically by start dates.
Implementers	The key person(s) or organization(s) that will be: • R=Responsible party - Who is responsible for ensuring this action is completed? • C=Consultants - Who should be consulted to help complete this action? • A=Approvers - Who needs to approve this action before it can be marked complete?
Resources Needed	All resources needed for this strategy. (Examples: funding, staff time, space needs, supplies, technology, and equipment)

Appendix D: Acronyms Used in the Accelerator Plan

ADA	Americans with Disabilities Act
BIPOC	Black, Indigenous, and People of Color
CBO	Community-Based Organization
CEU	Continuing Education Unit
CHW	Community Health Worker
CHWARI	Community Health Worker Association of Rhode Island
CME	Continuing Medical Education
CNEMG	Care New England Medical Group
DPW	Department of Public Works
HEZ	Health Equity Zone
HRiA	Health Resources in Action
LISC	Local Initiatives Support Corporation
OHA	Rhode Island Office of Healthy Aging
PCF	Pawtucket and Central Falls
RIDE	Rhode Island Department of Education
RIDOH	Rhode Island Department of Health
SCLT	Southside Community Land Trust
SDOH	Social Determinants of Health
SNAP	Supplemental Nutrition Assistance Program
WIC	Women, Infants, and Children

Appendix E: SDOH Accelerator Plan SMART Objectives and Success Measures

	Objectives	Success Measures
1.1	Increase the accessibility of public spaces by 2027.	• Number of public spaces that are accessible to people of all abilities is increased • Number of public spaces where accessibility is increased
1.2	Identify public space needs in each district by 2027.	• Number of public space needs identified • Number of conversations with district representatives
1.3	Develop two new green spaces in areas of need as prioritized by the community by 2027.	• Number of new or updated green spaces • Number of green space acreage
1.4	Increase the number of public spaces that are enhanced/improved in Pawtucket and Central Falls to address cleanliness and safety by 2027.	• Number of public spaces enhanced • Number of complaints received by Parks and Recreation Department
1.5	Establish and implement Complete Street ordinances in Pawtucket and Central Falls by 2027.	• Number of Complete Streets ordinances established • Number of Complete Streets ordinances implemented
2.1	Increase consumption of fruits and vegetables by 2027.	• Percentage of residents who report consuming daily recommended amounts of fruits and vegetables
2.2	Increase the number of access points in Central Falls and Pawtucket to improve access to fresh produce by 2027.	• Number of access points to fresh produce
2.3	Decrease the percentage of Pawtucket and Central Falls residents that are experiencing food insecurity by 2027.	• Percentage of residents experiencing food insecurity (available at county-level) • Number of SNAP-eligible individuals who are enrolled in SNAP • Number of WIC-eligible individuals who are enrolled in WIC • Percentage of WIC-eligible individuals unserved (not enrolled in WIC) • Number of free or reduced lunch eligible students enrolled in free or reduced lunch and breakfast programs • Number of households served at Progreso Latino Food Pantry
2.4	Increase the number of food-based and other social service partnerships by 2027.	• Number of food-based partnerships • Number of social service partnerships
3.1	Increase access to transportation services to health care by 2027.	• Number of transportation services to access healthcare • Number of transportation programs available to access healthcare • Number of patients who report transportation as a barrier to healthcare access
3.2	All people will be served within one month of seeking routine care by 2027.	• Number of people served within one month of referral by their primary care provider who are seeking routine behavioral health and oral healthcare
3.3	Increase the number of clinical providers who utilize a universal referral platform to address SDOHs with patients who are medically underserved by 2027.	• Number of clinical providers utilizing a universal referral platform (e.g., Unite Us) Source: Unite Us data and data from other platforms • Number of referrals to mental health, behavioral health, oral health, social services, preventative screenings, etc. • Number of community-based organization (CBO) and social service agencies in the Pawtucket and Central Falls catchment area enrolled with Unite Us

3.4	Increase the number of providers trained in racial equity and results-based accountability to improve cultural sensitivity by 20% by 2027.	• Number of providers trained • Percentage of acceptable training evaluation scores
3.5	Increase the number of certified CHWs who are from, reflective of, and serving the Pawtucket and Central Falls community by 2027.	• Percentage of CHWs that serve the Pawtucket and Central Falls community with demographics that are reflective of Pawtucket and Central Falls demographics • Number of CHWs who are from and serving the Pawtucket and Central Falls community
3.6	Increase the number of people participating in evidence-based, community-based prevention initiatives by 2027.	• Number of programs • Number of CBOs that offer programs • Number of participants, including demographic information

Appendix F: Year One Implementation Plan

Priority 1:	**Public Spaces**
Goal 1:	**All people have welcoming, safe, clean, accessible, and inclusive public spaces.**
Objective 1.1:	**Increase the accessibility of public spaces by 2027. (Developmental)**

Success Measures

- Number of public spaces that are accessible to people of all abilities is increased
- Number of public spaces where accessibility is increased

Strategies	**Actions**	**Implementers** R: Responsible Party C: Consultant	**Y1 Timeline**				
			2022	**2023**			
			Q4 **Oct-Dec**	**Q1** **Jan-Mar**	**Q2** **Apr-Jun**	**Q3** **Jul-Sep**	**Q4** **Oct-Dec**
1.1.1 Create a map and multilingual signage of accessible recreational sites, structures, and walking paths.	a. Define what the map is going to feature and create shared language for terms like accessible (without losing sight of ADA and safety), recreational site based on defined values.	R: Public Spaces (PS) working group C: PCF HEZ/LISC C: Accessibility & Inclusion Consulting LLC Annette Bourbonniere	X				
	b. Engage collaborators for input including community members and city and town officials (including establishing spaces owned by the city and how frequently they are used).	R: PS working group C: PCF HEZ/LISC C: DPW (responsible for signage)	X				
	c. Secure the resources needed (funding, people) and create a workplan in partnership with collaborators.	R: PS working group C: Sign company		X	X		
	d. Implement workplan.	R: PS working group C: PCF HEZ/LISC				X	X
1.1.2 Implement community events that promote activity (e.g., Cyclovia).	a. Conduct an environmental scan of community events that support physical activity that are open to the public.	R: PS working group C: Local fitness centers and studios C: City Parks and Recreation Departments C: School officials and partners	X	X	X	X	

Priority 1:	**Public Spaces**						
Goal 1:	**All people have welcoming, safe, clean, accessible, and inclusive public spaces.**						
Objective 1.1:	**Increase the accessibility of public spaces by 2027. (Developmental)**						
	b. Reach out to local fitness centers and studios to explore offering free fitness classes in public spaces, a trade show/fair, and partnering to offer reduced/free rates.	R: PS working group C: Local fitness centers and studios C: City Parks and Recreation Departments C: School officials and partners C: Health insurance companies and other potential sponsors	X	X	X	X	
	c. Explore the feasibility of creating new/additional self-led walking tours of Pawtucket and Central Falls sharing history of City and residents (e.g., history of Cape Verdean and Colombian communities, industrial history). (Coordinate with Strategy 1.1.1)	R: PS working group C: Already established tours C: Blackstone Valley Tourism Council C: Historians C: Brown University Center for the Study of Slavery & Justice C: Colombian Cultural Society C: Cape Verdean Heritage Committee C: Other cultural groups (Syrian, Polish)		X	X	X	
	d. Create and offer sports leagues in spaces that are low-investment and that adults and children can play together (e.g., pickleball).	R: PS working group C: YMCA (already offering pickleball) C: City Planning Departments C: City Parks and Recreation Departments		X	X	X	X
	e. Explore an indoor space for younger children (10 and younger) to be physically active (children and adults together).	R: PS working group C: Kidz Wurld C: City officials C: Local businesses C: Carlene Fonseca	X	X	X	X	

Priority 1: Public Spaces

Goal 1: All people have welcoming, safe, clean, accessible, and inclusive public spaces.

Objective 1.1: Increase the accessibility of public spaces by 2027. (Developmental)

	f. Partner with local businesses and organizations to build incentives for families into all programming.	R: PS working group C: Local businesses and other potential sponsors C: Schools, Rhode Island Department of Education (RIDE)	X	X	X	X	X
1.1.4 Create an ADA-compliant older adult fitness loop.	a. Research examples and reach out to cities and towns who have done something similar.	R: City Planning Departments R: PS working group C: AARP Livable Communities	X				
	b. Assess placement of fitness loop (with the guidance of Pawtucket/Central Falls residents with disabilities and their families) and find appropriate location.	R: PS working group R: City Planning Departments C: Local senior centers C: Rhode Island Office of Healthy Aging (OHA)		X			
	c. Pitch project to mayor's office and Planning Department directors.	R: PS working group R: City Planning Departments					
	d. Secure funding.	R: City Planning Departments				X	
	e. Go through design process with a design company and create a request for proposal to build.	R: City Planning Departments				X	X
	f. Implement the building process. Provide information to the community about this process.	R: Company that won the bid A: City Planning Departments					X

Resources Required (human, partnerships, financial, infrastructure, or other)

- Accessibility & Inclusion Consulting LLC Annette Bourbonniere
- City of Pawtucket Department of Public Works
- City of Pawtucket Planning Department for Grants
- City Parks and Recreation Departments
- Funding to create the map, signage
- GrowSmartRI
- Local fitness centers
- School officials and partners

Priority 1:	**Public Spaces**
Goal 1:	**All people have welcoming, safe, clean, accessible, and inclusive public spaces.**
Objective 1.2:	**Identify public space needs in each district by 2027.**

Success Measures

- Number of public space needs identified
- Number of conversations with district representatives

Strategies	Actions	Implementers R: Responsible Party C: Consultant A: Approvers	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
1.2.1 Implement public space community needs assessment.	a. Explore existing data and community needs assessments. Compile what already exists and identify gaps for further assessment (looking broadly at spaces, programming).	R: PS working group R: City Planning Departments C: Family Self-Sufficiency Program C: PCF HEZ C: School districts C: PCF Prevention Coalitions C: Comprehensive Plan	X				
	b. Launch a multilingual, multi-mode (e.g., online, paper) community survey (adults and youth) based on identified gaps (use visuals/mapping, not just text). Ask about improvements to parks/spaces that already exist, demographic/ disability status data to understand how differences may impact access/use of these spaces.	R: PS working group C: Progreso Latino Food Bank C: PCF HEZ C: Schools (back to school events)	X	X			
	c. Compile all data and review. Look at results and compare with the plan. Look at where public spaces are needed and would be convenient/accessible.	R: PS working group C: City Planning Departments		X	X		

Priority 1: Public Spaces

Goal 1: All people have welcoming, safe, clean, accessible, and inclusive public spaces.

Objective 1.2: Identify public space needs in each district by 2027.

	d. Create a community needs assessment report and create a slide deck with summary findings.	R: PS working group C: City Planning Departments				X	X
	e. Get community input (potentially from a public meeting).	R: PS working group				X	X
1.2.2 Contact district representative to discuss public space need.	a. Identify district representatives.	R: PS working group				X	
	b. Reach out to schedule meetings/conversations with district representatives.	R: PS working group				X	
	c. Share compiled information from community needs assessments and outline needs for funding.	R: PS working group					X
	d. Reach out to mayor's office and city department heads to keep them engaged in the process and request funding.	R: PS working group C: Mayor's Offices and City department heads					X

Resources Required (human, partnerships, financial, infrastructure, or other)

- RIDOH Climate Change and Health Program
- Community leaders
- City Council members
- Youth sports organizations

Priority 1:	Public Spaces
Goal 1:	**All people have welcoming, safe, clean, accessible, and inclusive public spaces.**
Objective 1.3:	**Develop two new green spaces in areas of need as prioritized by the community by 2027.**

Success Measures

- Number of new or updated green spaces
- Number of green space acreage

Strategies	Actions	Implementers R: Responsible Party C: Consultant	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
1.3.1 Establish baselines for green space acreage and number of green spaces.	a. Compile a list of the existing green spaces and ongoing development (e.g., Sacred Heart tennis courts, Tidewater Landing project, etc.)	R: PS working group R: City Planning Departments	X				
	b. Identify city-owned vacant lots that could potentially be green spaces.	R: PS working group C: City officials (e.g., City Planning Departments, Mayor's Offices, redevelopment agency, etc.)		X			
	c. Based on identified lots, explore funding required based on similar vacant lot greening projects in other communities, and potential funding sources.	R: PS working group			X	X	
	d. Present proposals to the respective cities.	R: PS working group					X

Resources Required (human, partnerships, financial, infrastructure, or other)

- City of Pawtucket Planning Department for Grants
- City Planning Departments
- RIDOH Climate Change and Health Program
- Departments of Public Works
- Funding: work with business owners and other outside investors to see if they would support creation of green spaces
- GrowSmartRI
- Pawtucket Central Falls Community Development Corporation

Priority 1:	Public Spaces
Goal 1:	All people have welcoming, safe, clean, accessible, and inclusive public spaces.
Objective 1.4:	Increase the number of public spaces that are enhanced/improved in Pawtucket and Central Falls to address cleanliness and safety by 2027. (Developmental)

Success Measures

- Number of public spaces enhanced
- Number of complaints received by Parks and Recreation Department

Strategies	Actions	Implementers R: Responsible Party C: Consultant	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
1.4.1 Engage community collaborators to develop and implement a coordinated plan for improved cleaning, maintenance, and safety.	a. Engage Parks and Recreation Departments to get this work on their radar and continue to build partnership.	R: PS working group C: Parks and Recreation Departments	X	X	X	X	
	b. Engage Public Works Department and other stakeholders like Groundwork Rhode Island to get input and build partnership for cleaning and maintenance.	R: PS working group C/R: DPW C: Groundwork Rhode Island/other relevant organizations that employ youth C: Pawtucket Youth Commission C: City Planning Departments - looking at zoning and development					X
	c. Draft the plan with next steps based on conversations with community stakeholders.	R: PS working group					X

Priority 1:	Public Spaces
Goal 1:	All people have welcoming, safe, clean, accessible, and inclusive public spaces.
Objective 1.4:	Increase the number of public spaces that are enhanced/improved in Pawtucket and Central Falls to address cleanliness and safety by 2027. (Developmental)

Resources Required (human, partnerships, financial, infrastructure, or other)

- Local Boys & Girls Clubs
- Center for Health and Justice Transformation
- DPW
- Law enforcement
- Pawtucket Foundation
- Pawtucket Central Falls Community Development Corporation YMCA

Priority 2:	**Food and Nutrition**
Goal 2:	**All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.**
Objective 2.1:	**Increase consumption of fruits and vegetables by 2027.**

Success Measures

- Percentage of residents who report consuming daily recommended amounts of fruits and vegetables

Strategies	Actions	Implementers R: Responsible Party C: Consultant A: Approvers	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
2.1.1 Establish and/or extend a paid food ambassador initiative to promote the consumption of fruits and vegetables.	e. Identify existing food ambassadors and document how they work, what organization they work for, and who they work with.	C: Progreso Latino C: Hunger Elimination Task Force C: Rhode Island Community Food Bank C: URI SNAP-Ed Nutrition Education program C: Academic partners C: PCF HEZ Food and Nutrition task force	X				
	f. Identify and explore other food ambassador models to take advantage of learnings.	R: PCF HEZ Food and Nutrition task force C: Hunger Elimination Task Force C: Roots 2Empower and SCLT	X				
	g. Define role of food ambassador and what they'll be doing in the community, particularly in relation to CHW role.	R: Organizations employing ambassadors C: Roots 2Empower C: URI SNAP-Ed Nutrition Education program C: Integra Community Care Network C: CNEMG C: Unite Rhode Island	X				

Priority 2:	Food and Nutrition						
Goal 2:	All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.						
Objective 2.1:	Increase consumption of fruits and vegetables by 2027.						
	h. Find resources to fund, sustain, and evaluate (e.g., insurance companies, United States Department of Agriculture (USDA) grants, Papitto Foundation, etc.) food ambassador initiative.	C: Progreso Latino R: Academic partners C: Integra Community Care Network A: Roots 2Empower and SCLT	X				
	i. Define and launch infrastructure for initiative – (e.g., which organization may be employing ambassadors).	C: RIPHI/Food on the Move C: Nourish Rhode Island C: Integra Community Care Network C: URI SNAP-Ed Nutrition Education program C: PCF HEZ Food and Nutrition task force	X				
	j. Identify existing community partnerships and understand how different organizations are working together on issues food and nutrition security.	R: PCF HEZ Food and Nutrition task force C: RIPHI/Food on the Move C: Nourish Rhode Island	X				
	k. Identify food ambassadors (e.g., hold community meetings or focus groups).	C: Progreso Latino C: FSRI		X	X		
	l. Establish strategies for how individuals can access food ambassadors (and learn more about them).	R: Organizations employing ambassadors C: Food ambassadors C: Progreso Latino C: RIPHI/Food on the Move C: Nourish Rhode Island A: Roots 2Empower and SCLT A: URI SNAP-Ed Nutrition Education program		X	X		
	m. Establish operational plans and seek existing infrastructure or continued funding to sustain the program.	R: Organizations employing ambassadors C: RIPHI/Food on the Move C: PCF HEZ Food and Nutrition task force		X	X		

Priority 2:	**Food and Nutrition**						
Goal 2:	**All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.**						
Objective 2.1:	**Increase consumption of fruits and vegetables by 2027.**						
	n. Establish data collection tools for evaluation of program to show success of program and how it leads to increased consumption of fruits and vegetables.	R: Organizations employing ambassadors C: Brown University, Alison Tovar C: RIPHI/Food on the Move C: PCF HEZ Food and Nutrition task force		X	X		
2.1.3 Identify gaps from infancy through older adulthood in food policy and education.	a. Establish infrastructure of who's involved in food policy and education work; and convene group (Food and Nutrition Task Force).	R: PCF HEZ Food and Nutrition task force C: Rhode Island Food Policy Council C: Director of Food Strategy for the Commerce	X				
	b. Create a map of existing stakeholders in PCF that are involved in food policy or nutrition education	R: PCF HEZ Food and Nutrition task force C: Rhode 2 Equity C: OHA C: Meals on Wheels		X			
	c. Define areas within food policy and nutrition education to focus on and their geographic scope.	R: PCF HEZ Food and Nutrition task force C: Progreso Latino C: Nourish Rhode Island C: Rhode 2 Equity A: URI SNAP-Ed		X			
	d. Engage residents (e.g., focus groups) and/or convene a civic engagement group to identify gaps in food policy & nutrition education, and get more specific on scope of gap assessment.	R: Progreso Latino C: Rhode 2 Equity		X			

Priority 2:	**Food and Nutrition**						
Goal 2:	**All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.**						
Objective 2.1:	**Increase consumption of fruits and vegetables by 2027.**						
2.1.4 Explore ways to address gaps in food policy and nutrition education across the lifespan.	g. Engage residents in policy advocacy efforts (e.g., convene civic engagement group).	R: Food and Nutrition Task Force C: Nourish Rhode Island		X	X	X	X
	h. Determine what data and root cause analysis might be needed to address gaps.	R: Food and Nutrition Task Force C: URI SNAP Ed C: RIDOH		X			
	i. Identify existing data, compile and/or collect data (e.g., to help establish baseline of consumption of fruits and vegetables, with a focus on most impacted populations).	R: Food and Nutrition Task Force (R - possibly) C: Food on the Move C: URI SNAP Ed C: Academic partners		X	X		
	j. Create a new or support an existing ambassador/consultant/lobbyist to state legislature.	R: PCF HEZ Food and Nutrition task force C: Nourish Rhode Island C: Rhode Island Food Policy Council C: Rhode Island Community Food Bank		X			
	k. Share updates from Nourish Rhode Island to Food and Nutrition Task Force.	R: Nourish Rhode Island R: Food and Nutrition Task Force	X	X	X	X	X
	l. Connect with other HEZs to collaborate on other statewide food policy and education issues	R: PCF HEZ C: Other HEZs C: RIDOH	X	X	X	X	X

Priority 2:	Food and Nutrition
Goal 2:	All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.
Objective 2.1:	Increase consumption of fruits and vegetables by 2027.

Resources Required (human, partnerships, financial, infrastructure or other)

- Academic partners
- AmeriCorps Seniors RSVP
- Age Friendly Rhode Island Food and Nutrition workgroup
- Blackstone Valley Community Action Program's Woodlawn Community Center
- Blackstone Valley Emergency Food Center 75 Benefit St. Pawtucket
- CNEMG (Denisse Abreu)
- DOH Food Inspection/Licensing Department
- Family Services of RI
- Food on the Move at Rhode Island Public Health Institute
- FoodCorps
- Hunger Elimination Task Force
- Incentives for programs/organizations for data sharing
- Integra Community Care Network
- Local Schools
- Meals on Wheels
- Nourish Rhode Island
- Office of Healthy Aging
- Pawtucket Soup Kitchen
- Progreso Latino
- Resources required to establish and maintain Food and Nutrition Task Force
- Rhode2Equity
- Rhode Island Food Bank
- Rhode Island Food Policy Council
- SNAP-Ed
- Tashire Battle, Roots 2Empower and SCLT
- URI Cooperative Extension, SCLT
- URI Master Gardener Program
- URI SNAP-Ed Program
- Unite Rhode Island

Priority 2:	Food and Nutrition							
Goal 2:	All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.							
Objective 2.2:	Increase the number of access points in Central Falls and Pawtucket to improve access to fresh produce by 2027. (Developmental)							

Success Measures

- Number of access points to fresh produce

Strategies	Actions	Implementers R: Responsible C: Consultants	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
2.2.1 Expand or increase the number of mobile food/produce markets that are year-round.	a. Establish baseline or map to see what mobile food/produce markets are currently available.	R: Food and Nutrition Task Force C: RIPHI C: Farm Fresh Rhode Island C: Rhode 2 Equity	X	X			
	b. Identify which PCF populations currently have access to mobile food/produce markets and prioritize gaps.	R: Food and Nutrition Task Force C: RIPHI C: Farm Fresh Rhode Island C: Rhode 2 Equity	X	X			
	c. Identify barriers to operating year-round.	R: Food and Nutrition Task Force C: Mobile food/produce markets C: Rhode 2 Equity		X	X	X	X
	d. Identify funding needed to accomplish strategy.	R: Food and Nutrition Task Force C: Mobile food/produce markets C: Rhode 2 Equity		X	X	X	X
	e. Consult with year-round markets to identify best practices.	R: Food and Nutrition Task Force C: Mobile food/produce markets C: Rhode 2 Equity		X	X	X	X

Priority 2:	Food and Nutrition						
Goal 2:	**All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.**						
Objective 2.2:	**Increase the number of access points in Central Falls and Pawtucket to improve access to fresh produce by 2027. (Developmental)**						
	f. Identify partnerships to enable/support year-round markets.	R: Food and Nutrition Task Force C: Rhode Island Community Food Bank		X	X	X	X

Resources Required (human, partnerships, financial, infrastructure or other)

- Blackstone Health Inc.
- Elijah Project
- Farm Fresh Market Mobile
- Food on the Move at Rhode Island Public Health Institute
- Harvest Kitchen
- Host locations to set up mobile food markets
- Marketing resources
- Master Gardeners
- Nourish Rhode Island
- Partners to get the word out on mobile food markets
- Rhode2Equity
- RI Community Food Bank
- RI Farm to School Network
- RIDOH Food Protection/Licensing
- SNAP Ed
- SCLT
- Tourtellot – food produce vendor
- URI Master Gardener Program

Priority 2:	**Food and Nutrition**
Goal 2:	**All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.**
Objective 2.3:	**Decrease the percentage of Pawtucket and Central Falls residents that are experiencing food insecurity by 2027. (Developmental)**

Success Measures

- Percent of residents experiencing food insecurity (available at county-level)
- Percent of SNAP- eligible individuals who are enrolled in SNAP

Strategies	Actions	Implementers R: Responsible Party C: Consultant	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
2.3.2 Expand eligibility of food and nutrition assistance programs and policies, advocate for state funding increase for SNAP (Supplemental Nutrition Assistance Program) incentives such as Food on the Move and Bonus Bucks	a. See Action Steps highlighted in Strategy 2.1.4.						
	b. Assess recent Medicaid expansion's effect on food access (See 2.1.4b).	C: Rhode Island DHS					
2.3.5 Identify a baseline and trend of PCF residents who are food insecure.	a. Identify a point-person or organization to explore potential data sources.	R: Food and Nutrition Task Force	X				
	b. Engage with partners to share SDOH screening data and whether incentives are required.	R: Integra Community Care Network C: Blackstone Valley CHC		X			
	c. Explore statewide data and the possibility to obtain municipal-level data on food insecurity for all of Rhode Island.	R: RIDOH (Quarantine and Isolation unit potentially?) C: Rhode Island Community Food Bank		X			
	d. Explore county-level data.	C: Food Table		X			

Priority 2:	Food and Nutrition
Goal 2:	All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.
Objective 2.3:	Decrease the percentage of Pawtucket and Central Falls residents that are experiencing food insecurity by 2027. (Developmental)

Resources Required (human, partnerships, financial, infrastructure or other)

- Age Friendly Rhode Island Food and Nutrition workgroup
- Blackstone Valley CHC
- Rhode Island Food Policy Council
- Incentives for organizations to share their data
- Nourish Rhode Island (SNAP Incentive legislation)
- Office of Healthy Aging – might have data for older adults
- Public Housing and Public Senior Housing
- RI Community Foodbank
- RI Data Ecosystem
- RI Department of Education
- RI DHS SNAP Outreach vendors
- RI DOH WIC Program
- SNAP Ed
- United Way/ 211
- University of Rhode Island SNAP-ED

Priority 2:	Food and Nutrition
Goal 2:	All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.
Objective 2.4:	Increase the number of food-based and other social service partnerships by 2027. (Developmental)

Success Measures

- Number of food-based partnerships
- Number of social-service partnerships

Strategies	Actions	Implementers R: Responsible Party C: Consultant	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
2.4.2 Create an asset map of resources, programs, and partnerships. (See 2.1.3.b and 2.2.1.a)	a. Identify who is most important to have at the table.	R: Food and Nutrition Task Force C: Progreso Latino C: RIPHI	X				
	b. Identify available user-friendly mapping tools that meet the needs of Food and Nutrition Task Force (e.g., easily updated, able to be shared). Look into Brown Univ map for Health & Nutrition Resources in RI: https://s4.ad.brown.edu/hassenfeld/en/nutrition/	R: Food and Nutrition Task Force C: Brown University		X	X		
	c. Look to other websites, reports, asset maps to see what already exists.	R: Food and Nutrition Task Force		X	X		
	d. Identify what types of resources (e.g., infrastructure assets, etc.), programs (e.g., state agencies, CBOs, etc.), and partnerships to include in the asset map.	R: Food and Nutrition Task Force C: Progreso Latino C: RIPHI		X	X		
	e. Present draft of asset map and provide opportunities for input and refinement.	R: PCF HEZ				X	

Priority 2:	**Food and Nutrition**						
Goal 2:	**All people can participate in a thriving food system that has culturally appropriate, affordable, healthy, and enjoyable food year-round.**						
Objective 2.4:	**Increase the number of food-based and other social service partnerships by 2027. (Developmental)**						
	f. Incorporate feedback to final Year 1 asset map.	R: PCF HEZ				X	
	g. Update asset map annually.	R: PCF HEZ C: Food and Nutrition Task Force					

Resources Required (human, partnerships, financial, infrastructure or other)

- Age Friendly Rhode Island Food and Nutrition workgroup
- Brown University
- Central Falls Schools wellness committee
- Commerce
- Farm Fresh RI
- Food and Nutrition Task Force
- Food on the Move
- Integra Community Care Network's Existing Food Resource List
- Nourish Rhode Island
- Progreso Latino
- RI Dept. of Education
- RI Rhode Island Food Policy Council
- RI Public Health Institute
- Unite Rhode Island
- United Way / 211
- URI SNAP Ed

Monitoring/Evaluation Approaches

- Gauge usage of asset map
- Collect number of residents impacted by increased partnerships

Priority 3:	**Community-Clinical Linkages**
Goal 3:	**All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.**
Objective 3.1:	**Increase access to transportation services to health care by 2027. (Developmental)**

Success Measures

- Number of transportation services to access health care
- Number of transportation programs available to access health care
- SDOH screening data collected by providers

Strategies	Actions	Implementers R: Responsible Party C: Consultant	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
3.1.1 Identify a baseline (including what services are already available).	a. Establish a list of partners (e.g., insurance providers, PCPs, RIPTA) and conduct outreach to inquire about what they are doing to support people with transportation insecurities (coverage/funding and services provided). • https://healthyagingdatareports.org/rhode-island-healthy-aging-data-report/	R: CCL Working Group R: Maria Isabel Marin outreach to Oak Street R: Matt Harvey outreach to Integra Community Care Network/CNEMG R: Kinzel Thomas outreach to Coastal Medical & Hillside Family Medicine R: Maria Isabel Marin outreach to Neighborhood Health RI, Tufts, BCBS R: Allegra Scharff outreach to United, Medicaid, Lifespan R: Scott Hewitt outreach to Medicare (Medicare Advantage Plans), Blackstone Valley Health Care, Jenks Pediatrics C: RIPTA Human Services Coordinating Council C: EOHHS C: Community Liaisons for insurance providers C: PCP Case Managers C: CBOs	X				

Priority 3:	Community-Clinical Linkages						
Goal 3:	**All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.**						
Objective 3.1:	**Increase access to transportation services to health care by 2027. (Developmental)**						
	b. Identify utilization of eligible Medicaid patients using covered transportation options	R: Community-Clinical Linkages (CLL) Working Group C: Long Term Coordinating Care Group	X				
	c. Explore methods for assessing utilization and who may already be gathering that information, to identify needs gap.	R: CCL Working Group		X			
3.1.3 Advocate for continuation of reliable, low-cost or free transportation options (e.g., including continuing Uber and Lyft programs that started during the pandemic).	a. Utilize information gathered/learnings under 3.1.1 to identify pros and cons to inform and identify options for advocacy efforts.	R: CCL Working Group	X				
	b. Identify and determine how to engage existing and new partners to expand advocacy efforts and/or share costs.	R: CCL Working Group	X				
	c. Based on options selected, determine where advocacy efforts will be directed.	R: CCL Working Group	x	x			

Priority 3:	Community-Clinical Linkages
Goal 3:	All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.
Objective 3.1:	Increase access to transportation services to health care by 2027. (Developmental)

Resources Required (human, partnerships, financial, infrastructure or other)

- Age Friendly Rhode Island transportation work group
- Blackstone Valley Health Care
- Caregiver advocacy groups (disabled, seniors, children w/ special needs)
- Coastal Medical & Hillside Family Medicine
- Community clinics
- Community Organizations that refer or advocate for services
- EOHHS
- Financial resources/funding for continuation/establishment/expansion of transportation options
- Front office staff at clinics to ask about potential barriers
- Insurance companies (Tufts, BCBS)
- Integra Community Care Network/CNEMG
- Jenks Pediatrics
- Lifespan
- Long Term Coordinating Care Group
- Mental Health Association of Rhode Island has access to services (Melissa Flaherty is on their mailing list)
- Neighborhood Health RI
- Oak Street
- Point of contact for implementation efforts (Priority leads, Strategic Plan leader for implementation)
- RIPTA (provides bus passes for individuals with documented disabilities)
- RIPTA Human Services Coordinating Council
- Uber/Lyft/other ride sharing orgs

Priority 3:	Community-Clinical Linkages
Goal 3:	All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.
Objective 3.2:	All people will be served within one month of seeking routine care by 2027.

Success Measures

- Number of people served within one month of referral by their primary care provider who are seeking routine behavioral health and oral health care.

Strategies	Actions	Implementers R: Responsible Party C: Consultant	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
3.2.1 Collaborate with behavioral health and oral health providers to expand hours of services and explore other reasons for waitlists.	a. Work with BVCHC, Integra Community Care Network, Coastal, Jenks, and CNEMG to identify where they do and do not refer for behavioral health and dental care and why.	R: CCL Working Group C: Providers C: Insurance companies		X	X		
	b. Work with partners to establish a list of the pool of providers and outreach to them to understand their waitlists (length of wait list and reasons), starting within PCF, then looking at surrounding areas.	R: CCL Working Group C: Providers C: Insurance companies C: Workforce Work Group led by Rhode Island EOHHS					
	c. Compile a table of what other areas/states have done in terms of efforts to expand hours of service for providers.	R: CCL Working Group		X	X		
	d. Identify ways to incentivize providers to address the various wait list issues, including hours of services.	R: CCL Working Group		X	X		

Priority 3:	Community-Clinical Linkages
Goal 3:	All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.
Objective 3.2:	All people will be served within one month of seeking routine care by 2027.

Resources Required (human, partnerships, financial, infrastructure or other)

- AARP Rhode Island Chapter
- Accountable Entities (BVCHC, Integra Community Care Network)
- Administrators of Local Health Care Organizations (who could be offering extended hours)
- Advocacy groups (students, seniors, veterans, people in recovery, living w/ mental illness, chronic health conditions, etc.)
- Apprenticeship RI
- Brown University, School of Medicine
- CHWARI
- Cities and local Councils
- Clinical Professional Associations (Visiting Nurses, CHWs, AAP, Therapists, etc.)
- Dental and BH professional associations not already listed?
- FQHCs
- Insurance companies
- Lt. Governor's Long Term Care Coordinating Council
- Office of the Healthy Insurance Commissioner (OHIC)
- Providers
- RI EOHHS - Medicaid
- RI Medicaid, EOHHS
- School Districts, Local universities, colleges, technical schools
- School-based clinics/educators
- Workforce Work Group

Priority 3:	Community-Clinical Linkages
Goal 3:	**All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.**
Objective 3.5:	**Increase the number of certified CHWs who are from, reflective of, and serving the Pawtucket and Central Falls community by 2027. (Developmental)**

Success Measures

- CHW demographics are reflective of PCF demographics
- CHWs are from and serving the PCF Community

Strategies	Actions	Implementers R: Responsible Party C: Consultant	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
3.5.5 Advocate for incentives to draw CHWs to the area and recruit CHWs who are reflective of the Pawtucket and Central Falls community.	a. Determine baseline Number of CHWs that service the community and the gap in need versus capacity	R: CCL Working Group C: CHWARI – Sarah Lawrence – for list of CHWs C: Social Service agencies in the area C: Agencies who provide other wrap around supports for people in the community		X			
	b. Outreach to organizations who already employ CHWs to gather information on their success with CHWs, incentives offered, demographics, and quality metrics tracked.	R: CCL Working Group C: CHWARI – Sarah Lawrence – for list of CHWs C: Social Service agencies in the area C: Agencies who provide other wrap around supports for people in the community C: Elected officials		X			

Priority 3:	**Community-Clinical Linkages**
Goal 3:	**All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.**
Objective 3.5:	**Increase the number of certified CHWs who are from, reflective of, and serving the Pawtucket and Central Falls community by 2027. (Developmental)**

	c. Develop and/or adapt existing promotional materials to share with PCF organizations who might hire, or who already employ CHWs, on the role of CHW's and the importance of recruiting CHWs who are reflective of the PCF community. https://nachw.org/chw-document-resource-center/	R: CCL Working Group C: Blackstone Valley Community Health C: Progreso Latino C: YMCA C: Neighborhood Health RI C: FSRI C: Integra Community Care Network			X		
	d. Identify which CHW incentives we would want to advocate for (e.g., more pay, benefits, reward & recognition for CHWs)	R: CCL Working Group C: PCF CHW Network C: Medicaid (reimbursement program) C: Integra Community Care Network C: CHWARI C: CHWs C: Office of Healthy Aging - grant for ARPA funding to encourage groups to develop CHW programs (outreach to PCF awardees)			X	X	
	e. Identify and determine how to engage existing and new partners to expand advocacy efforts and/or share costs.	R: CCL Working Group			X	X	
	f. Based on advocacy options selected, determine where advocacy efforts will be directed.	R: CCL Working Group			X	X	

Priority 3:	**Community-Clinical Linkages**						
Goal 3:	**All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.**						
Objective 3.5:	**Increase the number of certified CHWs who are from, reflective of, and serving the Pawtucket and Central Falls community by 2027. (Developmental)**						
3.5.6 Identify a central coordinator/convener for CHWs (e.g., to share best practices, advocate for CHWs, connect to other CHW networks).	a. Define the role & responsibilities of the central coordinator/convener.	R: CCL Working Group C: CHWARI C: PCF HEZ/LISC C: FSRI (funded by LISC) C: R2E (Rhode to Equity) C: Certified CHWs	X				
	b. Identify resources needed to support this role (e.g., backbone organization to provide financial support, city budget support for this position)	R: CCL Working Group C: CHWARI C: PCF HEZ/LISC C: Certified CHWs C: Elected officials C: RIDOH (grant funding)	X	X			
	c. Partner with PCF HEZ/LISC and CHWARI to identify individuals who might be interested in this role. • Important that this person be someone *from* the community who understands the community and who has lived experience.	R: CCL Working Group C: CHWARI C: PCF HEZ/LISC C: Certified CHWs		X	X		
	d. Establish process for selecting a person to fill this role.	R: CCL Working Group C: PCF HEZ/LISC C: Certified CHWs			X		

Priority 3:	Community-Clinical Linkages
Goal 3:	All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.
Objective 3.5:	Increase the number of certified CHWs who are from, reflective of, and serving the Pawtucket and Central Falls community by 2027. (Developmental)

Resources Required (human, partnerships, financial, infrastructure or other)

- Blackstone Valley Community Health
- Certified CHWs
- CHWARI
- EOHHS
- Rhode Island Department of Workforce and Training
- FSRI
- Integra Community Care Network
- Neighborhood Health RI
- Office of Healthy Aging
- PCF CHW Network
- PCF HEZ
- PCF Youth
- Progreso Latino
- R2E (Rhode to Equity)
- Rhode to Equity
- RI DOH CHW Program
- School District, Technical Schools, Community Colleges
- Social Service Agencies
- YMCA

Priority 3:	**Community-Clinical Linkages**
Goal 3:	**All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.**
Objective 3.6:	**Increase the number of people participating in evidence-based, community-based prevention initiatives by 2027. (Developmental)**

Success Measures

- Number of programs
- Number of CBOs that offer programs
- Number of participants, including demographic information

Strategies	Actions	Implementers R: Responsible Party C: Consultant	Y1 Timeline				
			2022	2023			
			Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
3.6.1 Create an asset map of what initiatives currently exist to identify where initiatives are needed.	a. Reach out to organizations that serve PCF to identify what information they have on initiatives that already exist.	R: CCL Working Group C: RIDOH/EOHHS C: PCF HEZ/LISC C: Senior Centers C: CODAC mobile van C: CHN -Community Health Network C: Brown University C: Lifespan C: Integra Community Care Network/CNEMG C: Project Weber Renew (PWR)			X		

Priority 3:	**Community-Clinical Linkages**
Goal 3:	**All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.**
Objective 3.6:	**Increase the number of people participating in evidence-based, community-based prevention initiatives by 2027. (Developmental)**

	b. Create a survey to gather information on prevention initiatives and information for future 3.6 strategies. • What initiatives the organization provides in these areas. Are they evidence-based? Are they community based? • How is the community engaged? • Is community feedback collected? • Utilization data - attendance • Evaluate effectiveness • Timeframe of initiatives • Eligibility/who can use or access • Barriers to access • How are initiatives funded? • Capacity to accept additional participants • Etc.	R: CCL Working Group R: HEZ Collaborative (ask) R: Student C: HEZ Collaborative Meeting C: Gateway (the community mental health center for PCF) C: Butler Hospital				X	
	c. Analyze data collected and identify gaps in prevention initiatives.	R: CCL Working Group R: Student				X	X
	d. Determine how to share the data collected and who to share it with. Consider options at the time of survey design, and revisit/refine after data is synthesized.	R: CCL Working Group				X	X

Priority 3:	Community-Clinical Linkages
Goal 3:	**All people have timely access to coordinated, affordable, and appropriate resources and support systems to improve overall health outcomes.**
Objective 3.6:	**Increase the number of people participating in evidence-based, community-based prevention initiatives by 2027. (Developmental)**

Resources Required (human, partnerships, financial, infrastructure or other)

- Lifespan
- Brown University
- Butler Hospital
- CNEMG
- Central Falls City Administration
- Charter Care
- Churches
- CODAC
- Community Health Network (CHN)
- Community service providers
- Cultural centers
- EOHHS
- Funding (staffing, incentives, communications, etc.)
- Gateway
- Housing
- Infrastructure for coordinating efforts – being the central convener
- Integra Community Care Network/CNEMG
- Pawtucket City Administration
- Project Weber Renew (PWR)
- Recovery programs
- RIDOH
- RIPIN
- Schools
- Senior Centers
- URI SNAP-Ed – could hold culturally relevant classes on healthy eating/cooking at clinical settings and/or train CHWs etc. on best practices related to nutrition education