

# Rhode Island State Innovation Model (SIM) Test Grant

*Better Health, Better Care, and Lower Cost*



## Operational Plan

Version 3  
May 9, 2017

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## A. SIM Project Summary

This section updates the outline of Rhode Island’s SIM Test Grant. It provides a narrative for the overall goals and project approach, and contains the following five areas: project narrative, driver diagram, core progress metrics and accountability targets, master timeline, and budget summary table.

### Overview of Changes and Updates

As Version 3 of the Rhode Island SIM Operational Plan, this plan prepares us to move into Award Year 3 and 4 of our SIM Test Grant. This document now includes updates on our progress in Award Year 2 and modifications to our plan for Award Years 3 and 4, given that many of our vendors to do the work outlined in our original Operational Plans have now been procured and their scopes of work clearly defined.

Notable updates from Version 2 to Version 3 of our SIM Operational Plan include:

#### General Themes

- Through our procurements, several of our projects ended up naturally aligned (e.g., Community Health Teams (CHTs) and Screening, Brief Intervention, and Referral to Treatment (SBIRT); Patient-Centered Medical Homes (PCMH)-Kids and Integrated Behavioral Health). We restructured and combined these projects throughout the document.
- Our Integration and Alignment initiative is integrated into our Operational Plan and we describe it throughout the document.
- We have added information on SIM’s focus on outreach, communications, and stakeholder engagement.
- We have excised the Integrated Population Health Plan (IPHP), now referred to as the “State Health Improvement Plan” from this document. Instead, we include a summary of this document and its relationship to SIM, along with a link to our updated Health Assessment Report.
- We replaced the existing Workforce Capacity Monitoring section with an update on our development of a Healthcare Workforce Transformation Plan as part of our Health System Transformation Project (HSTP) in Rhode Island.

#### Project Summary

- Updated the SIM Component Wheel to reflect our current state;
- Changed the Driver Diagram to reflect additional alignment;
- Removed the Metric Table and added the full listing as an Excel Appendix; and
- Updated the Budget Summary Table.

#### Detailed SIM Operational Plan

- Updated the summary of all SIM components, where applicable;
- Updated the overarching SIM Component Summary Table;
- Updated our SIM Sustainability strategies; and
- Revised our Risk Matrix to include changing mitigations and new risks, where applicable.

## **General SIM Operational and Policy Areas**

- Reorganized the SIM Governance and Stakeholder Engagement sections, removing some tables and repurposing as additional Appendices;
- Updated our Healthcare Delivery System and Payment Transformation Plan to reflect accomplishments in Award Year 2 and provide detail on Award Years 3 and 4 plans;
- Provided updates on Leveraging Regulatory Authority, Quality Measure Alignment, and SIM Alignment with State and Federal Initiatives;
- Revised the Health Information Technology Plan, inserting new components, including:
  - Updated Rhode Island Health Data Architecture Diagram;
  - Updated all HIT components with Award Year 2 progress and Award Years 3-4 plan;
  - Detailed some of our sustainability successes for HIT projects which will transition off SIM funding soon;
  - Added a policy levers section;
  - Added a HIT Modular Components section; and
- Described plan to update data collection, sharing, and evaluation section during the first quarter of Award Year 3.

Because we still have several procurements to complete, we still have components of this plan to finish, including some metrics and final budgets for our activities. We intend to finish almost all of the procurements by the summer, and will be working with our Steering Committee to reallocate funds by September.

Therefore, we are looking forward to providing CMMI with a mid-year update of our Operational Plan at the end of the September, when we submit our Annual Report.

# Summary of Model Test

## Overview

Rhode Island’s history of health reform is impressive. We have been innovators, with expansion of Medicaid for children and their parents in the 1990’s; steadfast, in our commitment to build on the market reforms and coverage expansions of the Affordable Care Act; and bold, as we embrace the task of multi-payer delivery system transformation and payment reform as the next crucial step in building a health care system that produces higher quality care, better health, and smarter spending.

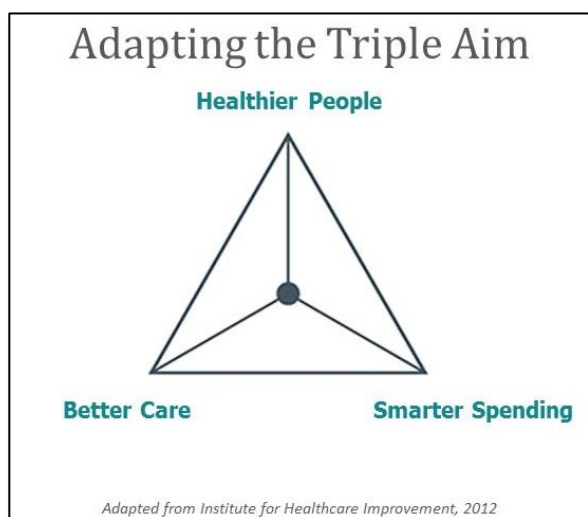
When we received the State Innovation Model Test Grant, we were excited about the opportunity that the dollars and the project structure gives us to take real strides for change while building on our history of reform.

Our challenge was to take this opportunity and use its component parts – the ability to tie our projects to specific metrics for planning and program implementation, the convening function that SIM gives us, and the ability to use our SIM staff and participants to make intentional connections between the related federal and state initiatives aiming at reform – to make more significant change than any of the reform efforts could do alone.

In Award Year 2, we’ve learned that collaboration is key, and that the SIM investments will have the strongest impact if we make sure that they are aligned and integrated with other public and private activities throughout the state. The power of our SIM table is its ability to be the place where conversations and connections happen that might not happen elsewhere.

Our structure is an important part of our success so far. Having SIM staff embedded in five key state agencies, and engaging our diverse Steering Committee, key stakeholders, and the public in a transparent manner have allowed us to make progress in building a culture of collaboration in Rhode Island’s healthcare system. Throughout this updated version of our Operational Plan, we track our first implementation year’s accomplishments and lay out our plans for implementation year two.

**Figure 1: Rhode Island’s Triple Aim**



### Vision

The vision of the Rhode Island SIM Test Grant represents the desired future state resulting from a transition to value-based care in the state. Our vision statement, borrowed from the Triple Aim, reads:

***Better Care***, by continuously improving Rhode Islanders’ (including quality and satisfaction); ***Healthier People***, by enhancing the ***physical and behavioral health*** of all Rhode Island’s population; and ***Smarter Spending*** on healthcare for our residents.

## Mission

The mission of the Rhode Island SIM Test Grant is to significantly advance progress towards making this vision a reality. To accomplish this, the SIM Steering Committee has adopted the following mission statement:

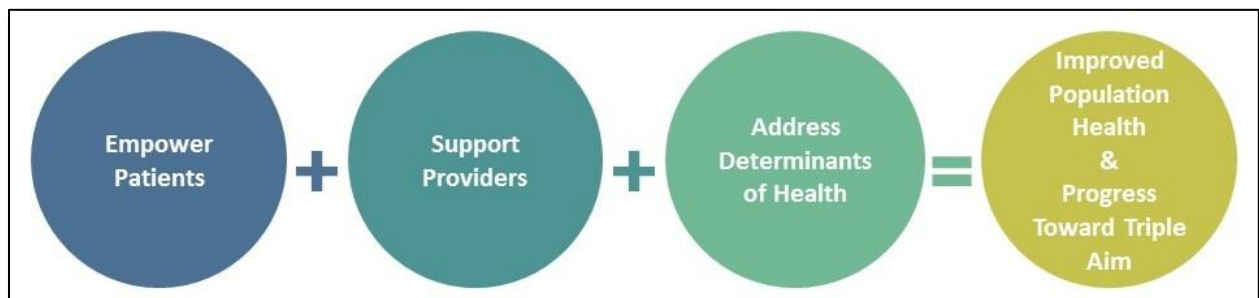
*Rhode Island SIM is a multi-sectoral collaborative, based on data—with the patient/consumer/family in the center of our work. Rhode Island SIM is committed to an integrated approach to the physical and behavioral health needs of Rhode Islanders, carried out by moving from a fee-for-service healthcare system to one based on value that addresses the social and environmental determinants of health. Our major activities are providing support to the healthcare providers and patients making their way through this new healthcare system. We are building the system upon the philosophy that together—patients, consumers, payers, and policy makers—we are accountable for maintaining and improving the health of all Rhode Islanders.*

Rhode Island SIM has maintained fidelity to its mission throughout year one, implementing the projects described below that ultimately aim to shift the healthcare delivery system toward value and high quality care.

## SIM Theory of Change

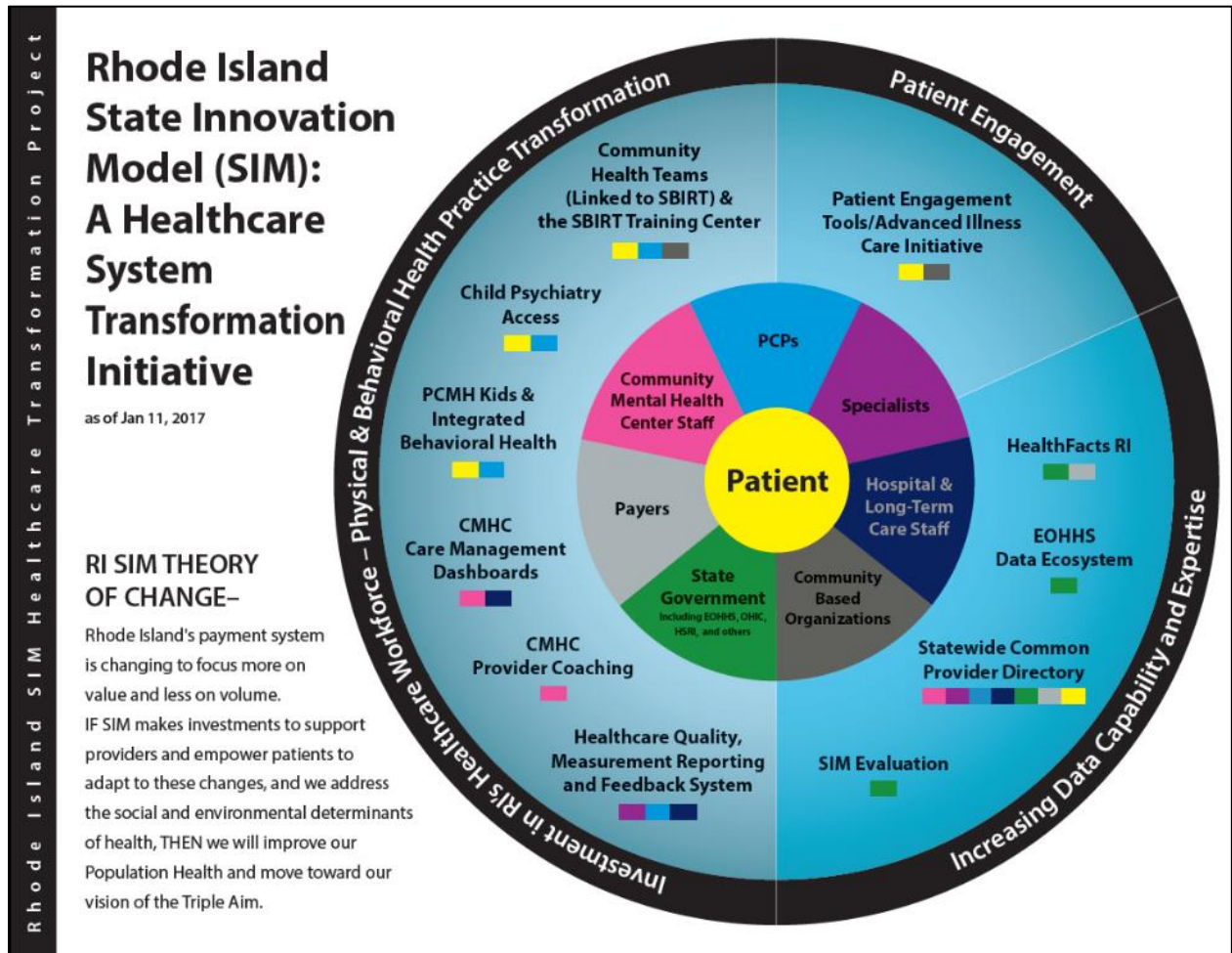
Rhode Island’s payment system is changing to focus more on value and less on volume. IF Rhode Island SIM makes investments to support providers and empower patients to adapt to these changes, and we address the social and environmental determinants of health, THEN we will improve our population health and move toward our vision of the “Triple Aim.”

**Figure 2: Rhode Island’s SIM Theory of Change**



The Transformation Wheel below places our SIM Test Grant investments within our strategic vision for our healthcare system. With patients in the center, and the providers and others who serve patients around the circle, our investments focus on system transformation.

**Figure 3: Rhode Island SIM Transformation Wheel**



### SIM Health Transformation Strategies

SIM's approach to healthcare system transformation combines aspiration and pragmatism, as we align the state's current move away from fee-for-service to value based purchasing with practice transformation and a focus on integrated population health. Rhode Island's SIM Test Grant is built on the premise that transitioning to healthcare payment models that reward value, as opposed to volume, and incentivize providers to work together, is a necessary step toward building a sustainable healthcare delivery system that reaches the following outcomes:

- Promotes high quality, patient-centered care that is organized around the needs and goals of each patient;
- Drives the efficient use of resources by providing coordinated and appropriate care in the right setting; and
- Supports a vibrant economy and healthy local communities by addressing the physical and behavioral health needs of residents, including an awareness of the social determinants of health.

To achieve these outcomes, we have identified three key strategies, listed below. Our practice transformation funding supports efforts to link payment to outcomes. We invest in



infrastructure both through our health information technology projects and our workforce strategic plan. Finally, we are committed to improving Rhode Island’s population health, especially in seven key focus areas described in depth in our [Integrated Population Health Plan](#) (beginning on page 101). Our SIM budget limitations mean that we were not able to budget as much money in projects to address population health as we did in infrastructure projects.

This has encouraged us to find more creative ways to carry out these activities, leading to our Integration and Alignment project. By identifying ways that state departments were already undertaking population health improvements, we have been able to spark collaborations that leverage people and dollars both inside and outside state government. Details of these three strategies are woven throughout the SIM Operational Plan.

**Figure 4: SIM Health Transformation Strategies**



## End State Vision of Transformation

The following core elements of Rhode Island’s Healthcare Delivery System Transformation Plan provide a roadmap for achieving the strategies listed above.

1. Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing and regulatory levers. Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an Alternative Payment Model (APM) by 2018, and 80% of payments linked to value.
2. Support for multi-payer payment reform and delivery system transformation with investments in workforce and health information technology.
  - i. *Investment in practice transformation & development of the healthcare workforce:* These investments in training, coaching, and technology improvements aim to add to the skills and resources of the providers working within a transforming health system. This is the largest set of investments, with a proposed budget of \$7.1 million.
  - ii. *Patient engagement:* In order to ensure that patients receive the greatest value from payment reform changes, and that they are maximally engaged in positive

- health behaviors including self-advocacy, SIM is investing \$2.2 million to provide patients access to tools that increase their involvement in their own care.
- iii. *Access to increased data capacity and expertise:* Rhode Island's healthcare community agrees that we are not using data as effectively as we could be – and that we lack both standardized data collection, and training of staff responsible for collecting, inputting, and analyzing the data. SIM is investing \$5.3 million in this data capability pillar to help tie data to quality and outcome improvements.
  3. Significant stakeholder engagement in policy development and SIM investment decisions through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups. In Rhode Island, healthcare delivery system transformation is a public-private partnership.
  4. Fidelity to our State Health Improvement Plan to ensure that transformation is aligned with our vision of improved integrated physical and behavioral health for the state's residents, especially in our eight health focus areas.
  5. A Multi-Sector/Multi-Agency Approach. One of SIM's main strategies is to reach a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with new SIM-funded activities. This is allowing us to build on current achievements, expand the reach of these initiatives, avoid duplication of funding, and, we expect, save money. The *SIM Integration and Alignment Initiative* aims to maximize impact of public and private investments by building goal directed, sustainable partnerships that we believe will ultimately cultivate a transformational culture of collaboration in Rhode Island.

By the end of the grant period, we aim to produce marked improvements in health care quality, affordability, and population health. Indicators of success will be transformed provider practices poised to succeed under value-based payment arrangements, a capacity to use data more effectively and creatively to make change and monitor system performance, more empowered patients (and families) who act as agents in their care, and a health care system that operates *as a system* and delivers whole person care centered around the goals and needs of each patient.

## Background: SIM Operational Plan

The fundamentals of the Rhode Island SIM Test Grant are based on a vibrant body of healthcare reform work over the past decade that has been described and analyzed by healthcare leaders and stakeholders participating in a variety of initiatives, most notably the [Rhode Island State Healthcare Innovation Plan \(SHIP\)](#) process led by then Lt. Governor Elizabeth Roberts.

The Centers for Medicare and Medicaid Services (CMS) awarded Rhode Island \$1,631,042 to participate in the SHIP process, which was intended to “improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states.”

By early 2014, Rhode Island had completed the work of round one through an extensive stakeholder engagement process led by Lt. Governor Roberts, with technical assistance from The Advisory Board. The result was the *Rhode Island State Healthcare Innovation Plan: Better Health, Better Care, Lower Cost* (SHIP Plan).

The SHIP Plan began with a description of Rhode Island’s current health care system, highlighting the burden of chronic diseases. It identifies heart disease, stroke, diabetes and arthritis as among the most common and costly chronic diseases in the state, tying the presence of these conditions to age adjusted hospitalization and mortality rates. All of these diseases, except for arthritis, are among SIM’s current Health Focus Areas.

The SHIP also identified behavioral health as the “largest single source of burden of disease” in Rhode Island, noting that behavioral health related conditions are among the top three diagnoses for Medicare, Medicaid and commercial health insurance.

In July 2014, Rhode Island applied for the second round of SIM awards in order to test its model design. As part of round two, 32 awardees received \$660 million. Rhode Island has received a \$20 million award to test its healthcare payment and service delivery reform model using this Operational Plan as the guiding document. The Plan includes an in-depth description of our SIM components fulfilling all of the CMS requirements, and a significant Integrated Population Health Plan that looks equally at physical and behavioral health.

### **Historical Context**

Aside from the SHIP, several other bodies of work have contributed to the landscape in which the Rhode Island SIM Test Grant Operational Plan is being built. Initiatives such as the Statewide Healthcare Inventory and the Truven Behavioral Health Report have been instrumental in quantifying the gaps and needs within Rhode Island’s healthcare system. Furthermore, the following examples of initiatives that have preceded SIM or happened alongside SIM have contributed to the sense of urgency for healthcare transformation in Rhode Island:

- The Rhode Island Health Care Planning and Accountability Advisory Council, formed by the Rhode Island General Assembly;
- The Rhode Island Healthcare Reform Commission, created by Governor Lincoln Chafee and chaired by then Lt. Governor Elizabeth Roberts;
- Health Stakeholders Convention led by US Senator Sheldon Whitehouse and Rhode Island Foundation President and Chief Executive Officer Neil Steinberg; and
- Working Group for Healthcare Innovation, convened by Governor Gina Raimondo.

As Rhode Island noted in our SHIP document, the World Health Organization’s definition of health states, “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Rhode Island has the building blocks for a healthy society, including world-class healthcare providers; top medical, nursing, and social work schools; an environment with places to walk and play; a growing community committed to healthy, local food sources; and state leadership that understands how to leverage these building blocks to improve our population health. However, we also face difficult roadblocks to our population health, such as:

- Unacceptable levels of health risks, including lead in our housing stock;
- High opioid addiction rates;
- Rising numbers of children facing behavioral health challenges; and
- Intractable numbers of people with preventable chronic diseases.

Even with our high quality healthcare providers, most would agree that our “healthcare system” lacks coordination among providers, rewards providers with little or no regard to the quality of the care given, and struggles to meet the needs of all patients in terms of access. Now is the time

to make the changes we need. Our SHIP plan paved the way with a call for real reforms, noting that “given the current environment of change in healthcare, the window of opportunity to change the healthcare system is open wider than it has been in a generation.” The implementation of federal reforms, changes in the market, aging of the population, and breakdown of the old business model have created an impetus for change. This impetus is further supported by the recent increase in the number of Rhode Islanders covered by health insurance.

### **Guiding Principles for SIM Implementation**

The Rhode Island SIM Test Grant planning process has been guided by eight principles that together describe the overarching work of our efforts. These principles have been agreed upon by a diverse group of Rhode Island stakeholders from across the state. Our partners draw from state and local government, the private sector, academia, and various community organizations with expertise in both public health and clinical care. These principles guide our population health planning as well as this overall SIM Operational Plan:

**1. *We are committed to empowering individuals, families, and communities to improve their own health.***

Any successful efforts to improve population health must include efforts to activate Rhode Islanders with the skills, knowledge, and motivation they need to live healthy lives. Rhode Islanders deserve access to clear and usable information about how their care is provided, what it costs, and how they are billed. We are also committed to making it easier for local communities to be involved in the development of goals, strategies, and policies that improve conditions impacting their health through effective planning, the use of key regulatory and policy levers, and community engagement. Workforce development is a key tool in these efforts. We aim to empower communities from within by helping residents with existing cultural and linguistic competence receive the training they need to take on new roles such as community health workers, clinicians, and behavioral health specialists.

**2. *We embrace our reliance on multi-sector and multi-agency collaboration.***

Improving population health and decreasing inequalities in health requires a multi-agency, multi-sector, and public/private partnership approach that includes expanding our current understanding of what creates health and focuses on local, geographically based interventions whenever possible. The success of our SIM grant project will rely on significant collaboration among a range of partners, include those in mental health, substance use, primary care, education, public safety, social service, and faith-based communities. Strategic planning must be well coordinated to fully identify the impact of policies not only on overall population health, but also on health disparities. Such coordination will also help to prevent the duplication of efforts, to highlight gaps in service development, and to identify potential useful data linkages. Rhode Island recognizes that policies related to transportation, housing, education, public safety, and environmental protection will affect the health and well-being of residents as much as any policies specifically related to Rhode Island’s public health, medical, and behavioral health system. This requires a “no wrong door” and “health in all policies” approach where the potential health impact is considered.

**3. *We are improving our ability to collect, share, and use data to drive action.***

Assessment of whole-person health outcomes, risk factors/determinants, interventions, and policy effectiveness requires usable, sustainable, and shared surveillance systems that produce timely measures for action and data. That data is also only truly useful if it

is available across institutional or organizational boundaries through accessible and user-friendly health information technology. Our Rhode Island SIM Test Grant Operational Plan and our Integrated Population Health Plan stress the importance of strengthening our data sources and empowering providers, policy makers, and patients to use those sources effectively to better coordinate care. Rhode Islanders deserve tools to help them make informed decisions about their personal health and the overall health of the state. The Rhode Island SIM Test Grant will use the data we produce and analyze to evaluate our activities on a regular basis and to ensure that we are spending our dollars as effectively as possible.

**4. *We are taking an integrated approach to the physical and behavioral needs of Rhode Islanders.***

Rhode Island is committed to developing and implementing an integrated approach to population health that embraces the whole person and considers the physical and behavioral health needs of our residents. By behavioral health, we include mental health and substance abuse. All recommendations and metrics in the Operational Plan and Integrated Population Health Plan reflect this cohesive approach, which we refer to as “whole person care.” For example, although tobacco use, obesity, diabetes, stroke, and heart disease are traditionally considered “physical” diseases, our plans acknowledge and address how these health conditions are intertwined with the behavioral health needs of the state’s population. The plans recognize the significant role primary care practitioners play in addressing the relationship between patients’ physical and behavioral health needs throughout their lifespan, centering the “whole person care” approach as the hallmark of population health improvement efforts in our project.

**5. *We are transforming our healthcare delivery system by moving away from a fee-for-service payment model to a value-based approach.***

Our plan embraces the evolving role of new models of health care delivery such as patient-centered medical homes (PCMHs), accountable care organizations (ACOs), and accountable care communities (ACCs) to improve population health. The plan also recognizes collaborative care approaches that integrate behavioral healthcare into primary care practices. The new system must be multi-payer and collaborative. Included in our approach is a recognition that physical and behavioral health approaches must transform from disease-focused treatment to care that focuses on prevention and early detection. Included in this approach is the integration of evidence-based interventions where appropriate and available. In all these cases, Rhode Island’s healthcare delivery system will accept responsibility for managing care and improving the health of populations through established multi-sector and multi-agency partnerships.

**6. *We recognize the importance of addressing the social and environmental determinants of health and health equity.***

Health is created where we live, learn, work, and play. Therefore, Rhode Island’s SIM Project focuses not only on improving clinical care, but using the levers of public policy and state leadership to influence the various social, economic, and environmental factors that affect all Rhode Islanders’ health outside of the medical and behavioral healthcare delivery systems precisely where they live or work. These considerations include examining strategies that both promote whole community resiliency and recovery, and reduce inequalities in factors that influence health across the diverse populations in our state. Factors promoting and undermining the health of individuals and populations should not be confused with the social processes underlying their unequal distribution in the population. To ensure we capture both processes in Rhode Island, our Integrated

Population Health Plan examines not just statewide estimates for our specific health focus areas, but also disparities in those health outcomes across Rhode Island communities.

**7. *We value consistent and reliable support for providers embarking upon practice transformation.***

Rhode Island is committed to empowering physical and behavioral healthcare providers to transform their practices “to improve the quality of care, the patient experience of care, the affordability of care, and the health of the populations they serve.” Specifically, providing assistance to grow and strengthen the presence of Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs) and Community Behavioral Health Centers of Excellence. This empowerment includes support for changes in approach and infrastructure, as well as opportunities to actively participate in the state’s overall efforts to transform our delivery system. Workforce development also plays a role in these efforts, giving providers the skills and additional team members they need to provide comprehensive whole person care.

**8. *We have a commitment to addressing disparities on many levels.***

We begin with a focus on the individual consumer or patient, their family, and others in their care network—and we end with this focus too. Fundamentally, efforts in population health improvement attempt to bridge what happens in the healthcare delivery setting in the provider’s office, the clinic, or hospital bed to what happens in the places where people live their lives (e.g., home, workplace, school). The activities of our Rhode Island SIM Test Grant and findings within our Integrated Population Health Plan will guide our efforts to improve the health of the entire population of residents, as well as investigate and address why some population groups are healthier than others. This approach requires a focus on the overall distribution of the specific Integrated Population Health Plan priority areas in the state, and the differences between groups to highlight disparities in those health areas.

CMS’ \$20,000,000 investment in Rhode Island’s healthcare system is allowing the SIM Steering Committee and state staff team to bring the SHIP plan to fruition. This Operational Plan describes our system transformation approach, which is made up of several coordinated investments and plans to leverage the state’s regulatory levers to implement reform. The Rhode Island SIM Test Grant is committed to maintaining an energetic level of stakeholder engagement in reform that together, will help build a new, more sustainable healthcare system in the state. This system will be based on value-based payments for care rather than on volume, will prioritize equally physical and behavioral health, and will focus on addressing the social and environmental determinants of health to address our vision of the Triple Aim.

# Updated Driver Diagram

**Table 1: Driver Diagram**

This is our Rhode Island Driver Diagram, laying out our Aims, Primary and Secondary Drivers, Interventions, and associated Metrics.

Vision						
<p><b>IMPROVE THE HEALTH OF RHODE ISLANDERS</b>            Create measurable improvements in Rhode Islander's physical and mental health.            Targeted measures include, but are not limited to, rates of diabetes, obesity, tobacco use and depression.</p>						
AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)	
<p><b>1. REDUCE RATE OF INCREASE IN RHODE ISLAND HEALTHCARE SPENDING</b>            Move to a “value-based” health care system that pays health care providers for delivering measurable high quality health care, rather than paying providers for the volume of procedures, office visits, and other required services that they deliver.</p>	Change our payment system (all-payer) to 80% value-based by 2018, with 50% of payments in alternative payment methodologies	Using regulatory and purchasing/contracting levers at OHIC and Medicaid, implement rules and conditions that expand value-based payment more broadly across the commercial and Medicaid markets	Continue to implement OHIC's Affordability Standards and Medicaid's Accountable Entities; ensure their alignment and integration with other state and private VBP activities	Percentage of payments made under an APM.	50%	
					Percentage of payments linked to value.	80%
		Aligning quality measures for healthcare contracting	Create an ongoing governance structure to implement the aligned measure sets (primary care, ACO, hospital, behavioral health, and maternity) and update metrics as needed	Percentage of insurers/payers adopting the SIM aligned measure sets into their contracts with providers	100%	
		Enhance and/or create programs to address needs of high utilizers coordinated across payers	Support integrated Community Health Teams and Screening, Brief Intervention, and Referral to Treatment (SBIRT) in our unified project	See CHT metrics under aim 2.	See CHT metric targets under aim 2.	
	Provide practices and payers with tools to easily and accurately identify high-risk patients through the Integration and Alignment initiative		TBD – We are in the process of convening stakeholders to identify deliverables that will be of value to the provider community. Once deliverables are identified, we will establish metrics	TBD		
			Maximize the use of HealthFacts RI, Complete the Common Provider	Maximize the use of HealthFacts RI: Support and maintain the claims data collection process; support	# of publicly available reports released from HealthFacts RI per year	6

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
	Increase use of data to drive quality and policy	Directory and Create a Health Care Quality Measurement, Reporting, and Feedback System to create a data infrastructure that can support VBP.	advanced reports and analytics; and support the coordination of data validation, release, and analysis	# of applications/requests for level 2 or level 3 data extracts from HealthFacts RI per year	10
<b>1. REDUCE RATE OF INCREASE IN RHODE ISLAND HEALTHCARE SPENDING,</b> continued	Increase use of data to drive quality and policy continued	Maximize the use of HealthFacts RI, Complete the Common Provider Directory and Create a Health Care Quality Measurement, Reporting, and Feedback System to create a data infrastructure that can support VBP. continued	Complete the Common Provider Directory: Consolidate provider data from multiple sources into a single “source of truth” record; increase the understanding of provider-to-organization relationships; Provide a public portal to search for and locate providers; Provide mastered provider data extracts to integrate into state systems.	CUM # of state agencies using common provider directory	5
				CUM # of private sector health care organizations using common provider directory	15
			Create a Health Care Quality Measurement, Reporting, and Feedback System that will consolidate quality reporting requirements and facilitation in one place to reduce the reporting burden on providers; Create a provider benchmarking and feedback system to communicate quality back to those who provide care; Provide quality information to the public to support making informed healthcare decisions.	CUM # of health care organizations/practices sending data to the Health Care Quality Measurement, Reporting and Feedback system.	10 or more
				CUM # of health care organizations/practices receiving data from the Health Care Quality Measurement, Reporting and Feedback system.	10 or more
		Enhance state agencies' data and analytic infrastructure by modernizing the state's current Human Services Data Warehouse	Modernize the state's current Human Services data Warehouse to create an integrated data ecosystem that uses analytic tools, benchmarks, and visualizations;	N/A	N/A
			Carry out qualitative and quantitative evaluation of the effect of alternative payment models in use in Rhode Island and the value of more closely aligning the models across payers	N/A	N/A
			Work collaboratively with state and community partners to encourage wider clinical data capture (particular focus on BMI) through the Integration and Alignment initiative	TBD	TBD



AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
<b>2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION</b>	Maximize & support team-based care	Using plan design, regulatory and purchasing/contracting levers, and SIM investments, maximize support for integrated team-based models of care	Create up to 3 new CHTs; Investigate the need for a more formal CHT training and certification program, including Screening, Brief Intervention, and Referral to Treatment (SBIRT); Provide training to providers (PCPs, CMHCs and hospitals) to better incorporate CHTs into their practices;	Number of active SIM-funded CHTs	2
				Percent of new, SIM-funded CHTs actively seeing patients	100%
				Number of unique practices utilizing new, SIM-funded CHTs	5-10
<b>2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION</b> Support health care providers in their transition to delivering health care in an environment in which the care is paid for according to a value-based payment arrangement. SIM will invest in work place transformation activities that build upon the professional expertise of x% of Rhode Island's healthcare workforce. continued	Maximize & support team-based care continued	Using plan design, regulatory and purchasing/contracting levers, and SIM investments, maximize support for integrated team-based models of care continued	Create up to 3 new CHTs; Investigate the need for a more formal CHT training and certification program, including Screening, Brief Intervention, and Referral to Treatment (SBIRT); Provide training to providers (PCPs, CMHCs and hospitals) to better incorporate CHTs into their practices; continued	Number of CHTs participating in the statewide CHT consolidated operations model	4
				Percentage of completed data reports submitted by consolidated operations team	100%
				Number of provider trainings delivered about practice transformation and CHT benefits	50
				Percentage of tools and assessments made available to all CHTs in RI that are adopted by intended CHT recipients	TBD
				Percentage of patients referred to applicable CHTs who received services (A: SIM-funded; B: Non-SIM-funded)	100% <i>Note this target is highly aspirational since patients are free to choose whether to receive services or not.</i>
				Percentage of patients referred to and seen by applicable CHTs who then enrolled in CurrentCare	100%
				Percentage of patients referred to and seen by applicable CHTs who received an annual influenza vaccination	100%
				Number of Community Health Workers certified through the Rhode Island Certification Board	65

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
				Percentage of CHTs employing Certified Community Health Workers	100%
				Number of patients in provider panels with referral ties to SIM CHTs	TBD
				Percent of RI residents with access to CHT (SIM funded + Existing)	TBD
<b>2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION</b> continued	Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Make investments in the following programs for practice transformation: Community Health Teams (CHTs), PCMH Kids, Child Psychiatry Access Program, Integrated Behavioral Health & PCMH-Kids, Community Mental Health Center supports, and Health Care Quality Measurement, Reporting, and Feedback System	Support the PCMH expansion to 9 pediatric sites	CUM # of practices participating in the pediatric PCMH program	9
				CUM # of clinicians participating in the pediatric PCMH program	75
				CUM # of patients attributed to practices participating in the pediatric PCMH program	30000
			Provide child psychiatry consultation services to pediatric primary care providers; Train PCPs to expand their ability to treat some behavioral health needs in their practices	CUM # of pediatric primary care practices that have on-demand access to pediatric mental health consultation services	40
				CUM # of pediatric primary care practitioners who have on-demand access to pediatric mental health consultation services	200
				CUM # of pediatric primary care providers who have received consultation to provide basic psychiatric assessment and treatment services	200
				CUM # of patients served under the Child Psychiatry Access Program	7500
			Support integration of behavioral health into primary care by providing resources and training for SBIRT in PC practices and evaluation/data collection for 12 Integrated Behavioral Health Model practices.	CUM # of providers who have been trained in SBIRT	250
				CUM # of practice sites participating in integrated behavioral health initiative	12

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
			Build workforce capacity to maximize the use of existing tobacco cessation resources through the Integration and Alignment initiative	TBD	TBD
			Support CMHCs with practice transformation and to receive data about their patients	CUM # of CMHCs that received provider coaching	8
				CUM # of CMHCs with real-time ED and inpatient dashboards in use	8
				CUM # of providers trained to use dashboards at CMHCs	120
<b>2. SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION,</b> continued	Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Make investments in the following programs for practice transformation: Community Health Teams (CHTs), PCMH Kids, Child Psychiatry Access Program, Community Mental Health Center supports, and Health Care Quality Measurement, Reporting, and Feedback System	Assist providers in aggregating data from their Electronic Health Records, to help make reporting and practice transformation easier; Provide training to providers in how to interpret the data to make positive changes within their practices; Pursue making this quality data available to patients.	Provide learning sessions for providers on interpreting data from the Healthcare Quality Measurement Reporting and Feedback System and how to use it for quality improvement.	At least 2 learning sessions held by 2018, and an additional 4 sessions by 2019.resources (if outside the CMHC).
<b>3. EMPOWER PATIENTS TO BETTER ADVOCATE FOR THEMSELVES IN A CHANGING HEALTHCARE ENVIRONMENT AND TO IMPROVE THEIR OWN HEALTH</b> Engage and educate patients to participate more effectively in their own health care	Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning	Patient engagement tools or processes	Create or implement existing processes or tools that allow patients more control of their health and healthcare decision-making; Train providers and patients in how to use these tools to maximize their effectiveness	Metrics TBD, when procurement is complete (likely 8/1/2017)	Targets TBD within 6 months
			Use Community Health Teams to help implement Patient Empowerment tools	Metrics TBD, when procurement is complete (likely 8/1/2017)	Targets TBD within 6 months

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
<p>in order for them to live healthier lives. Invest in tools (e.g., online applications, patient coaches – appropriate for the patient’s demographic profile) to teach patients how to navigate effectively in an increasingly complicated health care system.</p>		<p>End-of-Life/Advanced Illness Care Initiative outreach, and patient and provider education</p>	<p>Increase the number of Rhode Islanders with Advance Directives through training of providers and patients; Determine whether Rhode Islanders can upload their Advance Directives to Current Care</p>	<p>Metrics TBD, when procurement is complete (likely 8/1/2017)</p>	<p>Targets TBD within 6 months</p>

# Core Metrics and Accountability Targets

## Core Metric Set

For each milestone, or objective, core metrics have been developed to track progress over time and identify implementation barriers related to SIM. The measures are a combination of required items from the Centers for Medicare and Medicaid Services (CMS) and those identified as important by Rhode Island. These measures will be updated quarterly or annually as part of performance monitoring.

Please see our CMS-approved metrics chart that we use for our Quarter Reports [here](#).

### **Metrics, Baselines, and Accountability Targets**

Baseline data for each metric was obtained from a variety of data sources. Below is a table that contains each metric, baseline, and target. Any relevant notes related to the data (e.g., lag times for reporting) are also noted.

Due to uncertainties around project scope until actual procurements take place, some of the metrics and targets that are listed may require revision. We have made our best attempt to specify meaningful metrics and aggressive targets. We will notify CMMI promptly should metrics need revision and seek approval to change them. Any baselines or targets listed as TBD will be populated within 3 - 6 months from the approval date of this operational plan.

Not listed in the linked table are plans to report on a set of clinical quality measures. Once we have built the Quality Measurement, Reporting, and Feedback System we may publicly report aggregate performance on the core quality measures discussed under the quality measure alignment section.

Please note: Some metrics are assessed over populations specific to the SIM programs, and others are assessed over the entire state population.

## Updated Master Timeline

Our SIM Master Timeline is updated for 2017, with significant numbers of intermediate milestones included, as requested in 2016. For ease of review, please find the Master Timeline [here](#).

# Budget Summary Table

**Table 2: Budget Table**

SIM Component	Projected Total Expenditure	Proposed Spending - Award Year 3	Expected Carryover from Award Year 2	Goal/ Primary Driver	Metric
Rhode Island Health System Transformation	In-kind from OHIC and Medicaid	In-kind – Staff	In-kind – Staff	Create measurable improvements in Rhode Islander's physical and mental health.	Percentage of payments made under an APM.
					Percentage of payments linked to value.
Community Health Teams	\$2,000,000 – Training/Capacity Building	\$635,248	\$533,999	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Number of active SIM-funded CHTs
					Percent of new, SIM-funded CHTs actively seeing patients
					Number of unique practices utilizing new, SIM-funded CHTs
					Number of CHTs participating in the statewide CHT consolidated operations model
					Percentage of completed data reports submitted by consolidated operations team
					Number of provider trainings delivered about practice transformation and CHT benefits
					Percentage of tools and assessments made available to all CHTs in RI that are adopted by intended CHT recipients
					Percentage of patients referred to applicable CHTs who received services (A: SIM-funded; B: Non-SIM-funded)
					Percentage of patients referred to and seen by applicable CHTs who then enrolled in CurrentCare

SIM Component	Projected Total Expenditure	Proposed Spending - Award Year 3	Expected Carryover from Award Year 2	Goal/ Primary Driver	Metric
					<p>Percentage of patients referred to and seen by applicable CHTs who then received an annual influenza vaccination</p> <p>Number of Community Health Workers certified through the Rhode Island Certification Board</p> <p>Percentage of CHTs employing Certified Community Health Workers</p> <p>Number of patients in provider panels with referral ties to SIM CHTs</p> <p>Percent of RI residents with access to CHT (SIM funded + Existing)</p>
Child Psychiatry Access Program	\$650,000 - \$216,667/yr for 3 years for psychiatrist phone consultation and face-to-face contact for pediatric practices	\$105,788	\$110,879	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	<p>CUM # of pediatric practices that have on-demand access to pediatric behavioral health consultation services</p> <p>CUM # of pediatric primary care providers who have on-demand access to pediatric mental health consultation services</p> <p>CUM # of pediatric primary care providers who have received consultation to provide basic psychiatric assessment and treatment services</p> <p>CUM # of patients served under the Child Psychiatric Access Program.</p>
PCMH Kids	\$500,000 – over 2 years for Practice Support Specialists, CAHPS pediatric survey, Quality Measurement	\$113,776	\$78,972	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	<p>CUM # of practices participating in the pediatric PCMH program</p> <p>CUM # of clinicians participating in the pediatric PCMH program</p>



<b>SIM Component</b>	<b>Projected Total Expenditure</b>	<b>Proposed Spending - Award Year 3</b>	<b>Expected Carryover from Award Year 2</b>	<b>Goal/ Primary Driver</b>	<b>Metric</b>
	and Reporting, and data analysis				CUM # of patients attributed to practices participating in the pediatric PCMH program
Behavioral Health Transformation: <i>SBIRT</i>	\$480,000 for Training of SBIRT providers	\$153,783	\$8,217	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of providers who have been trained in SBIRT
Behavioral Health Transformation: <i>Integrated Behavioral Health</i>	\$370,000 for a Behavioral Health Practice Facilitator, Data Collection and Analytics, and Training Webinars.	\$103,383	\$83,617	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of practice sites participating in integrated behavioral health initiative
Behavioral Health Transformation: <i>Care Management Dashboards</i>	\$150,000 (15 Dashboards @ \$10,000 each)	\$45,000	\$0	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of CMHCs with real-time ED and inpatient dashboards in use
					CUM # of providers trained to use dashboards at CMHCs
Behavioral Health Transformation: <i>Practice Coaching at Community Mental Health Centers</i>	\$1,200,000 – For practice transformation specialists to work with 8 Community Mental Health Center staff teams	\$300,000	\$400,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of CMHCs that received provider coaching
Healthcare Quality, Reporting, Measurement and Technology	\$1,750,000	\$200,000	\$600,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of health care organizations/practices sending data to the Health Care Quality Measurement, Reporting and Feedback system.

SIM Component	Projected Total Expenditure	Proposed Spending - Award Year 3	Expected Carryover from Award Year 2	Goal/ Primary Driver	Metric
Feedback System					CUM # of health care organizations/practices receiving data from the Health Care Quality Measurement, Reporting and Feedback system.
Patient Engagement & End-of-Life/Advanced Illness Care Initiative	\$2,200,000 for End of Life and Patient Engagement activities	\$400,000	\$645,005	Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning	Metric(s) in development.
HealthFacts RI (Rhode Island's All-Payer Claims Database)	\$2,039,673	\$0	\$9,275	Increase use of data to drive quality and policy	# of publicly available reports released from HealthFacts RI per year
					# of applications/requests for level 2 or level 3 data extracts from HealthFacts RI per year
Statewide Common Provider Directory	\$1,500,000	\$270,000	\$30,000	Increase use of data to drive quality and policy	CUM # of state agencies using common provider directory
					CUM # of private sector health care organizations using common provider directory
Integrated Health and Human Services Data Ecosystem	\$1,800,000 –For staffing (a Database Administrator, Database Architect, and an ETL or Data Modeler) and a vendor to build the Data Ecosystem	\$300,000	\$320,000	Increase use of data to drive quality and policy	N/A
Measure Alignment	Included in the Project Management line item (sub-contractor to Project Management team)	In-kind – Staff	Reflected in staff line below	Create measurable improvements in Rhode Islander's physical and mental health.	N/A

<b>SIM Component</b>	<b>Projected Total Expenditure</b>	<b>Proposed Spending - Award Year 3</b>	<b>Expected Carryover from Award Year 2</b>	<b>Goal/ Primary Driver</b>	<b>Metric</b>
Leveraging Regulatory Authority	In-kind from all SIM participating state agencies	In-kind – Staff	Reflected in staff line below	Create measurable improvements in Rhode Islander's physical and mental health.	N/A
Integration & Alignment Project	In-kind from SIM and agency staff	In-kind -- Staff	Reflected in staff line below	Create measurable improvements in Rhode Islander's physical and mental health.	TBD within 6 months
Workforce Development	In-kind from EOHHS	In-kind – Staff	Reflected in staff line below	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	TBD within 6 months
SIM Project Director and Staffing Across Five Partner Agencies	\$3,000,000 6 staff members, fringe, benefits for 3 years	\$940,000	\$0	Create measurable improvements in Rhode Islander's physical and mental health.	N/A
Project Management	\$1,600,000 for Program Management and subcontractors to write Integrated Population Health Plan and support Measure Alignment	\$0	\$190,000	Create measurable improvements in Rhode Islander's physical and mental health.	N/A
Evaluation	\$700,000 – For a mixed method formative and summative evaluation	\$334,688	\$45,312	Create measurable improvements in Rhode Islander's physical and mental health.	N/A
Other Expenses	\$60,000 – Including travel, audit, and other expenses	\$20,000	\$10,000	N/A	N/A

SIM Component	Projected Total Expenditure	Proposed Spending - Award Year 3	Expected Carryover from Award Year 2	Goal/ Primary Driver	Metric
Other Program Expenses	We will end our UMass Contract on June 30, 2017 and have secured IAPD dollars to fund HealthFacts RI. We will reallocate these dollars by September 30, 2017.	\$0	\$747,054		
Totals		\$3,930,941	\$3,803,056		

## **B. Detailed SIM Operational Plan**

This section provides detailed information on the specific operational components of Rhode Island SIM. The information provided covers the following three areas: Narrative Summary of Components, SIM Component Summary Table, and Risk Assessment and Mitigation Strategy.

# Narrative Summary of SIM Components

## Rhode Island SIM Components

The focus areas of the Rhode Island State Innovation Model (SIM) Test Grant reflected in the SIM Transformation Wheel are the foundational components for this funding investment. Given the overarching aims of SIM, Rhode Island's values, and the current landscape, the Steering Committee has committed to the following components aimed at overall health system change. We describe the components below and summarize them in the SIM Component Summary Table.

### **SIM Governance**

Rhode Island SIM's governance and decision-making authority is shared among a coordinated group of people and agencies, managed by SIM project Director Marti Rosenberg whose office sits at the Office of the Health Insurance Commissioner. Ms. Rosenberg reports to both Commissioner Kathleen C Hittner, and EOHHS Acting Secretary Anya Rader Wallack, and leads a team of individuals hired with SIM dollars and placed at SIM participating agencies. Ms. Rosenberg also leads the SIM Interagency Team that includes representatives from all SIM participating state departments, plus our Steering Committee Chair Andrea Galgay and Vice Chair Larry Warner. This team is responsible for the strategic implementation of the project.

The SIM Steering Committee is the public/private governing body for Rhode Island's SIM project and is comprised of community stakeholders representing health care providers/systems, commercial payers/purchasers, state hospital and medical associations, community-based and long term support providers, and consumer advocacy organizations. The committee has approved four workgroups (Integrated Population Health Plan, Measure Alignment, Patient Engagement, and Technology Reporting) to obtain subject-matter expertise, stakeholder and community input, and implementation recommendations for SIM's transformation efforts. To avoid duplicating community efforts, SIM also obtains valuable input into our work with Community Health Teams and Provider Practice Transformation by participating with two existing community groups.

Ms. Rosenberg has also overseen the work of UMass Medical School (UMASS), the SIM Project Management Vendor. UMASS came on board in January 2016 to manage related project management activities including support for stakeholder management, project meetings, data collection, risk management, communications, sub-contractor management, and work plan management. UMASS has also subcontracted with the Technical Assistance Collaborative (TAC) and the Providence Plan (ProvPlan) to provide expertise in behavioral health and physical health, respectively, and write the Integrated Population Health Plan. In order to reserve dollars for healthcare transformation and program funding, the leadership team has decided to eliminate project management funding as of June 30, 2017. The UMass Contract will end on that date, and as of April 30, 2017, the logistical tasks associated with Program Management have successfully transitioned to SIM staff.

Another key governance tool that we have are our Quarterly Vendor Meetings, so that all of our individual SIM vendors can learn about the larger SIM project as well as each organization's funded activities. This has already begun to facilitate the vendors' abilities to make connections across programs and interventions. Descriptions of key vendors can be found [here](#).

Convening partners in this way enhances SIM's "culture of collaboration" across another group of stakeholders, providing for greater awareness of other teams' initiatives and the breaking down silos that to support greater collaboration, and multi-directional communication. We go beyond hub-and-spoke communication between SIM leadership and vendors, and instead have communication around the circumference of the wheel, generating peer-to-peer conversations and partnering across projects.

## **Health System Transformation Plan**

Rhode Island has been committed to significant system transformation for years. Rhode Island was an early supporter of primary care practice transformation, building a multi-payer patient centered medical home collaborative in 2008, which now comprises 72 practice sites and serves nearly one-third of the state's population. Building on a solid base of transformed primary care, newly forming accountable care organizations, and initial steps toward value-based payment in the commercial market, our primary strategy is to scale value-based payment statewide by setting regulatory targets for insurers to expand value-based payment models in Medicaid and commercial insurance.

Rhode Island is advancing the work of payment reform in a coordinated way. The goal of achieving critical mass for payment reform across Medicare, Medicaid, and commercial insurance is a necessary condition for transforming the healthcare system as a whole.

Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an Alternative Payment Model (APM) by 2018, and 80% of payments linked to value. To achieve our system transformation goal, we are focusing SIM dollars on delivery system transformation with investments in workforce, health information technology, and data capacity, as described below. We also include significant stakeholder engagement in policy development and SIM investment decisions through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups. As we note throughout this document, in Rhode Island, healthcare delivery system transformation is a public-private partnership.

Rhode Island is poised to significantly advance the use of value-based payments and APMs through the implementation period of the SIM grant through regulatory and purchasing activity of both Medicaid and OHIC. As planned, in Award Year 2, Medicaid developed certification standards for Medicaid Alternative Entities (AEs), and our Medicaid Managed Care Organizations (MCOs) are beginning to contract with them on a total cost of care basis for attributed populations, according to specific annual targets specified in the MCO's contract with the state. AEs also focus on the social determinants of health among their attributed populations. The AE contracting mechanisms are one of the primary means for Medicaid to achieve 50% of payments under an APM by 2018. Managed care procurement, contracting, and Accountable Entity accreditation are three crucial purchasing and regulatory levers that are driving achievement of Rhode Island's payment reform targets.

OHIC tracks commercial insurer compliance with their annual APM targets on a semi-annual basis. In addition to semi-annual reporting of APM use, OHIC requires each insurer to develop plans for engagement of specialists in VBP arrangements, including the development of APMs for high volume specialties and specialty care practices. These requirements build on extant rules that obligated insurers to have quality improvement programs with hospitals and tie hospital fee increases to quality performance.

Engagement of payers and providers around payment reform is important for our success.

While we had planned to convene a learning collaborative comprised of providers and payers who are engaged in VBP and APMs, to discuss best practices around VBP contracting methodologies and implementation, to avoid duplicative meetings, we have instead kept these discussions within OHIC's existing committees.

Besides carrying out system transformation activities aimed at improving quality and lowering the cost curve, the state is also helping prepare our provider community for the new Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act (MACRA). To ensure that Rhode Island understands the implications of QPP, Rhode Island has also embedded these discussions in existing stakeholder processes, with training for providers as necessary. The Health Insurance Commissioner put alignment with QPP on the agenda of her Alternative Payment Methodology Advisory Committee in the fall of 2016. **We are leveraging our SIM investments and regulatory and purchasing initiatives to prepare providers in Rhode Island for the QPP.** We are also currently pursuing conversations between Medicaid and the commercial health plans around participation in CPC+, which feeds into CMS's draft QPP rule.

## Investing in Rhode Island's Healthcare Workforce and Practice Transformation

### **Community Health Teams (CHTs) and the SBIRT Training and Resource Center**

During Award Year 2, SIM leadership decided to align our SIM-funded Community Health Team (CHT) and the State's Screening, Brief Intervention, and Referral to Treatment (SBIRT) program, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). This combined project provides a braided funding stream to create a more comprehensive system of care within the community to improve Rhode Islanders' overall health. Entitled *Rhode Island Health System Integration: Coordinating Community Health Teams (CHT) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) Sites*, our project seeks to create more integrated physical and behavioral health services in Rhode Island by increasing the capacity for primary care practices, emergency departments of hospitals, and the Department of Corrections to identify individuals with significant physical and behavioral health needs, coordinate their care effectively, and refer them to programs to assist in addressing additional treatment and/or social service needs.

### **Consolidated Operations Model**

Our project creates a vehicle for the integration and coordination between newly created CHTs and the implementation of new SBIRT capacity throughout Rhode Island under one consolidated operations model. The State's goal is to meld these projects to provide as seamless a set of integrated physical and behavioral services and follow-up as possible for those Rhode Islanders with the greatest unmet clinical or social service needs. The purpose of this combined approach is to establish a sustainable model for consolidated operations of these two community-based health interventions within Rhode Island's health system. This project invests in new SBIRT sites and additional CHTs to meet significant, unmet need. To do this, this health systems integration project will:

- Establish a consolidated operations model for CHTs and SBIRT to ensure the projects are implemented in an integrated fashion, with overlapping goals, staffing approaches, data collection and analysis, information sharing (e.g., using CurrentCare, the statewide health information exchange), and outcomes;



- Implement SBIRT in ten to twelve clinical settings throughout Rhode Island (including primary care sites, hospital emergency departments, and the Department of Corrections);
- Establish at least two additional CHTs serving residents with greatest clinical needs;
- Coordinate SBIRT and CHT activities (especially in engaged clinical settings);
- Provide technical assistance, tools, and training for all CHTs in Rhode Island, with input from CHTs and their staff;
- Provide SBIRT training to all interested providers within the State; and
- Evaluate our model, estimate return-on-investment, and make recommendations for moving forward. Of note, SIM Staff members convened a Joint CHT/SBIRT Evaluation Meeting with the SIM/CHT Evaluator, SBIRT Evaluators, and SBIRT Training and Resource Center to kick-off formal evaluation planning for this joint initiative by providing a venue for introducing staff to one another, sharing scopes of work (as applicable), and developing a schedule for additional coordination needs.

The purpose of our approach is to expand the capacity of CHTs in the state of Rhode Island, normalize the practice of screening and treating patients for substance use disorders, and provide CHT services that address the social/environmental determinants of health to the substance use population through one system of care. The programs are mutually supportive in both design and goals of practice transformation, care integration and coordination, and population health improvements, especially given the co-occurrence of conditions identified within SIM's Health Assessment Report.

Combining CHTs and SBIRT is mutually beneficial. CHTs and SBIRT are intended to serve high-risk, and in many cases, high-cost patients, some of whom are high utilizers of Emergency Departments. By leveraging CHTs alongside SBIRT clinical sites, to screen and identify patients for substance use disorders (which may contribute to frequent ED visits), this project has the ability to prevent and/or decrease ED overutilization. It may also provide necessary supports in the community to an already vulnerable population while simultaneously helping the SBIRT program identify those with the greatest need for treatment.

### **Community Health Team Specifications**

Community health teams have been a critical component of Rhode Island's SIM plan from its inception. CHTs have the potential to facilitate coordinated and integrated care, through the use of dashboards and other tools to attend to the whole person (i.e., both physical and behavioral health needs). CHTs help patients meet unaddressed social, behavioral, and environmental needs that are having an impact on their physical health. Overall, CHTs serve three critical functions:

- Improving population health by addressing social, behavioral, and environmental needs;
- Supporting providers in transitioning to value-based systems of care; and
- Transforming primary care in a way that increases quality of care, improves coordination of care, and reduces/controls related costs and expenditures.

The CHTs our project will provide for will be multi-disciplinary, connected with primary care (meaning an extension of at least one practice into the community setting), and payer agnostic, meaning that any Rhode Islander can receive services from them regardless of who their health insurance carrier is or if they are uninsured. CHTs will focus on primary care practices located in

communities that are not currently served by a CHT in the state and that have large high-risk populations. At least one staff member in each of the CHTs will be trained and dedicated to provide SBIRT screening and resource referrals. The composition of the CHT staff (including those embedded in SBIRT sites) will reflect the needs, language preferences, and diversity of the community being served.

### **SBIRT Site Specifications**

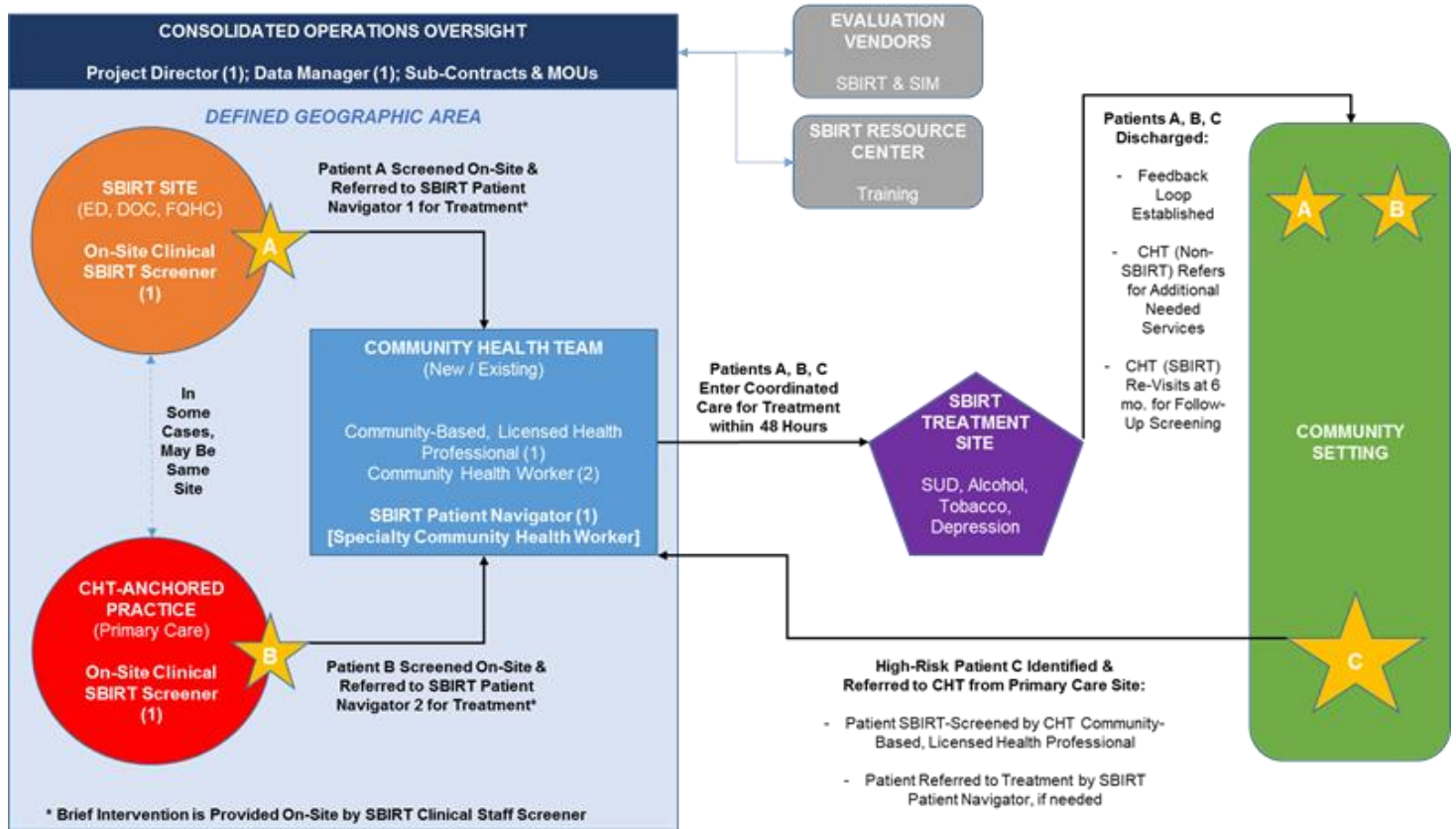
The systemic focus of our RI-SBIRT project is to train and support healthcare workers in the use of SBIRT to promote health and prevent and treat substance use disorders for patients seen in their clinical settings. It will also help integrate medical and behavioral health practices into an efficient, effective system of care that addresses individuals in a holistic manner. SBIRT clinical settings are healthcare settings in Rhode Island serving individuals at higher risk for substance use disorder and unmet treatment needs within communities that have identified substance use treatment as a community need. Primary care practices (including CHTs as extensions of care within the community), Federally Qualified Health Centers, hospital emergency departments, and the Department of Corrections will be included as SBIRT sites. Collectively SBIRT sites will have the capacity to conduct up to an estimated 250,000 SBIRT screenings of Rhode Islanders over a five-year period. SBIRT screening and referral to treatment will also be accessible to all individuals regardless of insurance, SBIRT staff will complete GPRA surveys for all individuals screened. The extent of the GPRA survey is determined by the service received (i.e. individuals who are screened only complete the demographic sections of GPRA where as individuals referred to treatment need a full GPRA).

When braided together, our program will assist in the identification of and continued service delivery to individuals likely to have the greatest unmet needs, including:

- Individuals who have three or more known chronic conditions;
- Individuals who have two or more special healthcare needs (i.e., disabilities);
- Individuals with substance use disorder and at least one other co-morbid physical or behavioral health condition;
- Individuals who are not accessing primary care regularly; and
- Individuals who have had three or more in-patient or emergency department visits within six months.

Together, SBIRT clinical sites and CHTs will be geographic in nature with a strong place-based focus (i.e., providing referral services where people live, work, learn and play). As applicable, CHTs will provide their services to SBIRT clinical sites that do not currently have access to a CHT, in order to address co-morbidities. Sites will maximize utilization of Health Equity Zone resources, existing community assets, and the Community Health Network referral system for chronic disease management to improve the health of patients seen. Sites will support staff obtaining Community Health Worker (CHW) certification for existing and new CHWs. The inclusion of Certified Peer Recovery Specialists and for specialty community-based, licensed health professionals within SBIRT/CHT sites will also be allowed. This may include Certified Tobacco Treatment Specialists, Diabetes Prevention Program Clinical Staff, Chronic Disease Self-Management Educator, or Diabetes Self-Management Educator Staff, and/or Narcan Educators. For more information on the details of this project, please see the Request for Proposal [here](#). We are in the final stages of negotiating our CHT/SBIRT contract and will update CMMI with the details of this project in our September update. (Procurement rules do not allow us to make contract information public until a Purchase Order is issued for the project.)

**Figure 5: Proposed Integration Model for CHTs/SBIRT**



**SBIRT Training and Resource Center**

The SBIRT project will train healthcare workers and community health workers through a partnership with the Rhode Island College (RIC) School of Social Work. As of December 2016, we began funding RIC (\$486,083 over 31 months) to be our SBIRT Training and Resource Center to provide centralized, statewide training and professional development for SBIRT in Rhode Island. RIC has past experience in creating a SBIRT training for professionals and paraprofessionals (of varying backgrounds) in the community. As such, the original RIC curriculum is the foundation of our training program and is being tailored to many audience, including students, social workers, nurses, and/or community health workers. In the context of SIM, RIC will be providing training for all CHT/SBIRT staff, as well as interested providers in the community, and ensuring they are proficient in screening for and identifying substance use disorders, and referring patients for additional services when necessary. Since our funding began, RIC has successfully completed its SIM Vendor Orientation, hired its Project Coordinator, developed population-specific training materials, created clinical case simulations for its training curriculum, developed CEU certificates, completed six SBIRT training sessions, began planning for a simulation lab using medical actors, began to develop ‘train the trainer’ and online SBIRT curricula, started to develop a certification for the training, and identified three languages for training translation moving forward.

**PediPRN – Rhode Island’s Child Psychiatry Access Program**

The SIM-funded pediatric psychiatry referral consultation system has formally established a children’s mental health consultation team to work with primary care providers to meet the

needs of children with mental health care needs. We have contracted with the Emma Pendleton Bradley Hospital with a three year, \$650,000 commitment.

Called [PediPRN](#), the program is based on the model implemented in Massachusetts, which consist of regionally based teams that provide real-time telephone consultation with child psychiatrists, face-to-face appointments for acute evaluations, and assistance with accessing community-based behavioral health services.

Pedi-PRN is designed to assist pediatricians in their efforts to manage children with behavioral and mental health needs in a way that is preventive and responsive to a patients' immediate need. Bradley Hospital is capable of responding to the immediate management needs of children with behavioral health concerns by providing pediatricians with consultation/support and response to emergent situations which will be invaluable for families and children.

We have known about the severe need for psychiatric services for children in Rhode Island for a long time – and there is evidence that this program will work to address the need. One in five (19%) children ages six to 17 has a diagnosable mental health problem, and one in ten has significant functional impairment (Kids Count Factbook, 2017). And a 2014 article in Health Affairs concluded that pediatric primary care providers enrolled in the project reported a dramatic improvement in their ability to meet the psychiatric needs of their patients.

Pediatricians are the front line trusted partner of a parents and children—and the investment of SIM dollars in opportunities for pediatricians to work more directly with families on behavioral health needs is critical to the well-being of Rhode Island children.

Since its December 2016 start date, the Child Psychiatric Access Program has served 79 children and adolescents. The Bradley Hospital team has continued to reach out to pediatric primary care providers and practices to inform them about the new service. In the last month, Bradley staff made three in-person presentations to a large group of pediatric primary care providers in South County and carried out phone outreach to 40 primary care practices statewide. Currently, over 300 pediatric primary care providers (e.g., pediatricians, family practice physicians, Advanced Practice Registered Nurses) in 47 primary care practices have enrolled in the PediPRN program. The PediPRN staff have also reached out to psychiatric providers in Rhode Island to help establish referral sources statewide for children and adolescents who may require follow-up psychiatric and other mental health services after a primary care consultation.

### **Patient-Center Medical Homes for Kids & Integrated Behavioral Health**

SIM has contracted with the Care Transformation Collaboration of Rhode Island (CTC) for both PCMH-Kids and the Integrated Behavioral Health Program, with a three-year, \$870,886 commitment.

#### **PCMH-Kids**

PCMH-Kids builds off CTC's successful adult patient-entered medical home (PCHM) initiative in Rhode Island. PCMH-Kids is extending the transformation of the state's primary care practices to children. PCMH Kids' mission is to engage providers, payers, patients, parents, purchasers, and policy makers to develop high quality family and PCMHs for children and youth that will assure optimal health and development, a commitment to quality measurement, accountability for costs and outcomes, a focus on population health, and dedication to data-driven system improvement. A group of engaged stakeholders and pediatric leaders has been working over the past several years to develop this PCMH-Kids program. A pediatric medical

home initiative is an opportunity to standardize and to improve the patient and family centered care already delivered in pediatric offices around our state. PCMH-Kids is convened by the state's Executive Office of Health and Human Services (EOHHS) and Rhode Island Medicaid program, garnering participation from all four major health plans in Rhode Island.

CTC is working with nine pilot practices, with a target population of 30,000 patients under 18 years of age. The practices have created a common contract with payers. Practices are receiving supplemental payments and on-site, distance, and collaborative learning and coaching to support practice transformation and quality improvement. SIM funding for PCMH-Kids supports the following:

- Practice facilitation and coaching, through a sub-contract;
- Supporting practices with understanding the PCMH-Kids measures and definitions;
- Assisting practices with developing reports to calculate measures in their electronic health record (EHR);
- Assisting practices with developing workflows and processes to regularly produce reports, perform quality assurance and submit data; and
- Assisting practices with analyzing and improving the quality of EHR data.

The PCMH-Kids evaluation includes the use of the Pediatric Consumer Assessment of Healthcare Providers and Services (CAHPS) PCMH Survey, quality measurement and reporting, and utilization measurement, through a sub-contract with the Rhode Island Quality Institute. Included in this evaluation are methods to determine how patients experience care, how to support practice improvements, how to assist practices in measuring their clinical quality measures, and how to best help practices measure their patients' use of high cost services as a proxy for direct cost and effective care coordination data.

Throughout Award Year Two, the PCMH-Kids practices continued to work together on best practices, identifying high-risk patients, and overall improving the health of the youth to invest in the future health of adults. The practices that are participating in the BH learning collaborative focused on ADHD continue to work with the content experts and practice facilitators on deliverables. Two participating Hasbro Pediatric practices that applied to NCQA were notified that they were awarded NCQA level 3 recognition. And, as an example of the SIM culture of collaboration, Bradley Hospital's Dr. Rajvi Broker-Sen presented the Pediatric Psychiatry Resource Network (Pedi PRN) to the practices. They convened on 2/21/17 for the Nurse Care Manager/Care Coordination pediatric focus meeting as a PCMH-Kids contract requirement.

### **Integrated Behavioral Health**

Behavioral health issues are frequently an important area of concern for individuals who visit their primary care practitioners. Behavioral health includes mental health, substance use, and health behaviors. There is ample evidence in medical literature that primary care practices can effectively treat and support many individuals who have mild to moderate behavioral health issues. It is widely acknowledged that, to be successful, the behavioral health focus must be well-integrated into the primary care practice, not simply co-located. SIM's is investing in CTC's behavioral health integration effort along with The Rhode Island Foundation and Tufts Health Plan. SIM is supporting the following activities:

- Depression, anxiety and substance use screening;

- Collaboration of behavioral health specialty staff with nursing/physician personnel;
- Effective use of a behavioral health subject-matter expert(s) to support training and development efforts; and
- Knowledge of appropriate measurement and quality assurance activities.

CTC selected twelve practices for the Integrated Behavioral Health (IBH) Pilot program, with a target population of 58,000 adults 18 and over. Practices were screened on their readiness, with four prerequisites that each practice had to meet:

- Current NCQA Level 2 recognition and continued achievement of CTC program requirements based on stage in developmental contract;
- Team completion and submission of [Maine Health Access Tool](#) with application;
- Electronic health record (EHR) system that can produce registry reports based on PHQ-9, GAD, CAGE-AID screening and re-screening results with sample report or screen shot that demonstrates capacity with application;
- Electronic Health Record (EHR) system that can support a shared behavioral health documentation, care plan and billing; and
- A patient panel of 5,000 patients or an MOU with other practices that articulates how the practices would work together to meet the pilot objectives, share resources and financial support.

Applicants were also rated on other criteria including:

- 1) Electronic Health Record Capacity including ability to bill for behavioral services; registries for depression, anxiety, substance use disorders, high-risk patients; standard plus customized reporting capability; designated electronic health record staff/support; ability to provide quarterly screening reports for depression, anxiety and substance use disorders.
- 2) Behavioral Health Staff including capacity to hire and co-locate or fully integrate behavioral health staff; ability to provide space for behavioral health staff.
- 3) Reporting Capacity including ability to report on number of unique patients with behavioral health encounters; ability to track referrals to specialty behavioral health programs.

For other practices who are still in the process of planning for behavioral health integration, CTC sponsors Learning Sessions and Webinars to facilitate ongoing improvement of primary care medical homes, including incorporating behavioral health care within primary care practices. There is a monthly IBH Workgroup open to all interested primary care practices where information sharing occurs.

There is a phase-in approach for the 12 practices. The first cohort of six practices began in January 2016 and the second cohort of six in November, 2016. Regarding a continuum of BH-PH integration, all of the practices have licensed behavioral health staff co-located or fully integrated on site at the practices. There is a long list of Phase 1 and Phase 2 requirements. Here is a sample:

IBH Start-Up (Award Year 2):

All Phase 1 requirements were implemented within a 6-12 month timeframe.

- Provide baseline report on screening for depression, anxiety, and substance use within one (1) month of award notification;
- Hire behavioral health staff if not already in place with a staffing ratio of 1 FTE for every 5,000 attributed lives with staff ready to see patients within two (2) months of award notification;
- Implement a staffing plan for patients with behavioral health needs to be able to access assessment/treatment with same day to 72 hour access (within one (1) month of start date of IBH clinician or award notification if IBH clinician already hired);
- Establish billing systems that will allow for the billing of behavioral health services and/or establish supervision of behavioral health interns (within three (3) months of start date of IBH clinician or award notification if IBH clinician already hired);
- Produce monthly practice registry reports on screening results (initial and follow-up) within four (4) months of award notification; patients with moderate to high screening scores would be re-screened within six (6) months;
- Produce quarterly reports on screening results within four (4) months of award notification;
- Commit to and host monthly on-site IBH consultation with membership to include practice leadership, physician/clinical champion, nurse care manager, practices (within 30 days of award notification);
- Commit to and participate in quarterly webinar learning events;
- Work to achieve screening targets by twelve (12) months.

#### IBH Performance Year (Award Year 3) requirements:

- Continue to perform start-up components;
- Monitor/improve patients' treatment response through care coordination review of patient registry scores for depression, anxiety and substance use, chronic care quality measures with submission of a PDSA plan to test change for improvement;
- Implement population health review for patients with high ED usage and behavioral health needs and implement IBH strategies including submission of a PDSA to test change for improvement; and
- Achieve screening targets to be eligible for incentive payment.

Since January 2017, the IBH Program has been moving along smoothly and according to plan. CTC is working with the practices on their patient specific data submissions and fine tuning the data elements with Brown University. Dr. Nelly Burdette continues to meet with both cohorts monthly. The initial participating practices have reported increasing screening rates over time for depression, anxiety, and SUD.

#### **Community Mental Health Center Provider Coaching**

A key investment related to our practice transformation focus area will be Provider Coaching within our Community Mental Health Centers. Rhode Island's publicly funded Community Mental Health Centers (CMHCs) are "health homes" for persons with serious mental illnesses. CMHCs are also adapting to new payment methods, moving from fee for service to bundled rates with consumer outcomes as key.

Rhode Island applied for, but did not receive, a CCBHC Program Grant. We had been hoping to use that certification process to improve services – and to augment the changes with SIM

dollars. Now, SIM dollars will stand alone to assist the Centers, although we are always seeking additional funding to maximize improvement.

Through a competitive Request for Proposal (RFP) process, SIM will select expert coaches to **support agency-wide learning among CMHC direct care, supervisory and management staff in Evidence-Based Practices demonstrated in the clinical literature to improve life outcomes for service consumers.** The RFP will focus on a two-year project, with coaching resources provided with greatest intensity in the first year. **As new developments emerge in the behavioral health field** CMHCs need outside coaching and support to build skills in many areas including:

- Service delivery practices such as dual disorders treatment for persons with co-occurring mental health and substance use conditions and enhancement of the integration of behavioral health and primary care.
- Health information technology uses and benefits;
- Collection and measurement of data; and
- Quality improvement practices.

This project is well matched with our Integrated Health Homes initiative at BHDDH, and we will ensure that we work together to align our goals for both.

### **Community Mental Health Center Care Management Dashboards**

An additional priority for the SIM Test Grant is the deployment of advanced technology to build a real-time communication system between Rhode Island hospital providers and CMHCs, which are mutually responsible for the care of approximately 8500 publicly insured individuals with serious mental illness.

SIM has contracted with the Rhode Island Quality Institute (RIQI) for the Care Management Dashboards with a one-year, \$150,000 commitment.

Specifically, SIM funds are being used to develop of an electronic dashboard that delivers real-time, encrypted notifications to the CMHCs when consumers under their care experience a hospital emergency department or inpatient encounter. We are also deploying a Dashboard with our Medicaid fee-for-service Community Health Team, which is called CareLink. These dashboards put critical health information in the hands of the appropriate providers at exactly the right time. This prompt information sharing is expected to facilitate targeted, appropriate clinical interventions, improve care coordination and reduce re-admissions. Ongoing funding for operation of the dashboard will come through a PMPM cost to the CMHCs. In addition to development of the dashboard tool, SIM Test Grant funding covers the cost to train providers in use of this new technology.

So far two of the ten dashboards have been successfully implemented and agreements are being finalized with the remaining implementation partners.



## **Healthcare Quality, Measurement Reporting and Feedback System**

As part of the Rhode Island SIM Test Grant, the state convened a Technology Reporting Workgroup based on directive from the SIM Steering Committee. The workgroup is led by the State Health Information Technology (HIT) Coordinator and the SIM HIT Specialist. This workgroup began meeting in January, 2016 and consists of representatives from state agencies, payers, provider organizations, and quality improvement organizations. The workgroup also conducted a survey of healthcare providers in the state in order to receive additional input on the concept of a centralized quality measurement, reporting, and feedback system. The Technology Reporting Workgroup recommended using SIM funding for the development of a statewide quality reporting system with the goals of:

- Improving the quality of care for patients and driving improvement in provider practices by giving feedback to providers, provider organizations, and hospitals about their performance based on quality measures;
- Producing more valuable and accurate quality measurements based on complete data from the entire care continuum;
- Leveraging centralized analytic expertise to provide valuable and actionable reports for providers and to drive improvements in population health;
- Reducing the duplicate reporting burden upon providers and provider organizations by having a common platform for reporting;
- Publicly reporting quality measurements in order to provide transparency and support patient engagement in making informed healthcare decisions; and
- Using existing databases, resources and/or systems that meet our needs, rather than building from scratch.

The RFP for the Healthcare Quality Measurement Reporting and Feedback System was posted on February 1, 2017, and closed on March 29, 2017. The review committee is currently in the process of reviewing the proposals and selecting a vendor. We expect to complete the procurement process in the summer of 2017.

## **Patient Engagement Tools and End-of-Life/Advanced Illness Care Initiative**

In order to ensure that patients receive the greatest value from payment reform changes, and that they are maximally engaged in positive health behaviors including self-advocacy, SIM is in the process of investing funds to provide patients access to tools that increase their involvement in their own care, including:

- Creating the infrastructure and strategies to allow patients to be more actively involved in their own care across their entire life course. One SIM project in this area is to determine whether we can assist patients to more easily share their advanced care directives and healthcare proxies with their providers;
- Developing patient engagement tools such as health risk assessments; and
- Implementing tools that measure consumer satisfaction as well as behavior change readiness.

In early 2017, RI SIM put out a Request for Proposal focusing on Patient Engagement and End of Life. Guided by the SIM Patient Engagement Workgroup and to maximize the impact of SIM patient engagement funds, all applicants were directed to submit proposals that addressed one or more of the physical or behavioral health focus areas outlined in the SIM Integrated

Population Health Plan. Additionally, all proposals were required to include one or more of the following strategies:

- Maximize relationships and coordination between existing population health efforts within communities
- Focus on the specific points of interaction between targeted populations (e.g., adolescents) and the objective or goal of that interaction (e.g., engaging them in their reproductive health, healthcare, and their privacy rights)
- Address patient ‘disengagement’ or lack of participation in their own healthcare
- Focus on populations with the highest-risk and greatest known disparities
- Focus on prevention, detection and diagnosis, triage and treatment, and/or end-of life
- Improve patients’ health literacy and ability to self-manage their own health and health choices (specifically in the health focus areas listed above)

There were nine responses to the RFP and we are still within the review process. Execution of negotiated contracts is expected to begin August 2017.

Once our procurement process is complete, the Workgroup will continue to meet to monitor the projects, ensure that we are following best practices, and determine other patient engagement activities for SIM.

## Data Capability and Expertise

### HealthFacts RI

The Rhode Island SIM Test Grant is investing funds to support the implementation and maintenance of the All-Payer Claims Database (APCD), named HealthFacts RI. SIM has contracted with the Onpoint and Freedman Healthcare for the HealthFacts RI, with a three-year commitment of approximately \$2.1 million.

The purpose of HealthFacts RI is to ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island’s healthcare delivery system. When it is fully functional, it will provide state agencies and policy makers with the information needed to improve the value of healthcare for Rhode Island residents, illuminating how Rhode Islanders use the healthcare system, the effectiveness of policy interventions, and the health of our communities. HealthFacts RI collects, organizes, and analyzes health care data from nearly all major insurers who cover at least 3,000 individuals in Rhode Island. This information allows users to benchmark and track Rhode Island’s health care system in ways that were previously not possible, such as evaluation hospital readmissions, total cost of care, and utilization of preventive or disease management services.

Through the Rhode Island SIM Test Grant, HealthFacts RI will be used to help the state better understand the healthcare delivery system by:

- Identifying areas for improvement and growth in the healthcare system;
- Understanding and quantifying overall health system use and performance;
- Evaluating the effectiveness of policy interventions; and
- Assessing the health of communities.

Most recently, the data vendor for HealthFacts RI was reprocured and the contract was awarded to Onpoint Health Data. The scope of work for this vendor includes continuing the data aggregation work as well as assisting the state with setting up an analytics platform for HealthFacts RI within the state data center. Additionally, the Data Release Review Board has received several applications for data and has begun to review data requests.

Rhode Island submitted an MMIS IAPD in December 2016 to support the move of HealthFacts RI to the State Data Center and the implementation of analytics tools for Medicaid uses, including to meet the new Access Monitoring Review Plan requirements. We recently received approval for this IAPD plan, and expect to start transitioning HealthFacts RI from its SIM funding and into Medicaid funding in May 2017. For long-term sustainability, HealthFacts RI will change for responses to data requests.

### **Statewide Common Provider Directory**

Payers, providers, and consumers alike need access to accurate provider information. This information ranges from current name, address, and contact information, to specific health plan network information or direct e-mail addresses. In order to maintain accurate provider directories for facilitating payment, care coordination, data analysis (such as with the HealthFacts RI), or health information exchange (HIE), each type of organization expends considerable resources attempting to maintain their own internal provider directories. Additionally, per legislation, Rhode Island's HIE now offers three consent options for providers regarding the visibility of their data: in emergencies only, for all providers, or for only specific providers. Facilitating this last option for only specific providers' visibility on a participants' data requires an accurate provider directory be in place. Finally, there is no central location from which to quantify the number of providers within the state and to which organizations they are affiliated.

Using SIM funds, Rhode Island has contracted with its state designated entity for HIE, Rhode Island Quality Institute to build a Statewide Common Provider Directory, with an overall investment of \$1.5 million. The directory consists of detailed provider demographics as well as detailed organization hierarchy. This organization hierarchy is unique and essential to being able to maintain both provider demographic and contact information, and their relationships to practices, hospitals, ACOs, and health plans. The intent of this project is to:

- Allow for the mastering and maintenance of provider information and organizational relationships to only occur once in the state in a central location;
- Provide a web-based tool that allows a team of staff to maintain the file consumption and data survivorship rules, error check flagged inconsistencies or mapping questions, and manually update provider data or enter new providers;
- Develop and institutionalize the appropriate data mastering and maintenance system to allow for useful data export via a flat file to ensure readiness for a June 2016 launch;
- Provide iterative data exports that allow for hospitals, payers, and state agencies to incorporate the centrally-mastered provider data within their own databases; and
- Increase data availability and transparency with a provider portal and a consumer portal. The design of these portals will take place in 2016, with the anticipated go-live in 2017.

The first phase of the Statewide Common Provider Directory has been built and includes mastering and validation of over 10,000 providers (mostly MD, DO, NP, PA) and 3,500 behavioral health providers. Many additional data sources to supplement the accuracy and completeness of the provider data are in progress. Several Statewide Common Provider Directory extracts have been released to external organizations and state agencies at this time. The work to develop and launch the public web portal has with a soft launch anticipated in mid-2017. A Provider Directory advisory committee consisting of community partners, SIM staff and state agencies has been actively guiding the work of this project, and the SIM Steering Committee has been fully briefed on its progress.

Since SIM Funding for this project ends at the conclusion of the contract in the Summer 2017, the State included additional development and implementation work in the HITECH IAPD-U submitted in December 2016. We have received approval and are currently in the process of setting up this new funding mechanism to allow for a smooth transition.

### **Rhode Island's Integrated Health and Human Services Data Ecosystem**

Rhode Island lacks a modern system for integrating person-level information across our EOHHS agencies (Medicaid, the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), the Department of Children, Youth and Families (DCYF), the Department of Human Services (DHS), and the Department of Health (RIDOH)), and then turning that holistic information into action. These agencies share a mission of providing essential services, safety net support, and public health promotion, while often serving the same people and collecting substantial amounts of data on these beneficiaries. If we are able to combine and better analyze these data, we can obtain critical information about the needs of our population, the effectiveness of our programs, and how to responsibly spend valuable public resources.

With funding from SIM, Rhode Island will take informed, project-based steps that reflect iterative learning and sophistication to build our new data ecosystem, integrating data across our agencies and driving policy with those data. Rhode Island is planning a light, simple and adaptive solution.

Our plan has been to build on a recent assessment of our entire data ecosystem, which includes our current data warehouse and our processes for collecting, managing, and using data, as well as lessons learned from other states.

With the completion of the assessment of the current EOHHS databases complete, state and SIM staff have begun discussing the best approach on how to design an easy to support and sustain EOHHS Data Ecosystem. The plan is to pursue a catered, agile data warehouse approach, which means that the Ecosystem will be developed in short sprints to answer specific policy questions, by bringing in only the specific data elements required to answer the question. The advantages of this approach are that there is less upfront development work, the extensive data quality and cleansing work that would be required will only be performed on data that will be used, and we will be able to adapt and respond to changing needs and experience as we go. Some components of technical infrastructure have been preliminarily designed and will be tested through a prototype to be completed by Fall 2017. The prototype as well as discussions with other state agencies and learning institutions in Rhode Island, will help us design an RFP that will meet our needs as we begin growing the EOHHS Data Ecosystem in the coming year.

## **SIM Evaluation**

There are three parts to our SIM evaluation plan:

- 1) SIM leaders and staff are participating in the Federal evaluation being undertaken by RTI. We have had one site visit in Rhode Island, one round of phone interviews of our key informants with the RTI evaluators, and regular monthly communications (including emails and conference calls) with the RTI Evaluation Team.
- 2) SIM has contracted with the University of Rhode Island (URI) for our State-based evaluation, with a three-year commitment of approximately \$700,000. URI will be focused on studying the effectiveness of our overall program, as well as a select set of interventions (e.g., Pedi-PRN-Child Psychiatry Access Project).
- 3) SIM is also carrying out regular in-house performance monitoring and evaluation of our program, tracking the milestones and metrics we have identified in our planning process.

URI is in the last stages of writing our full Overarching Mixed-Methods Evaluation Plan (both qualitative and quantitative) for our Steering Committee's review and finalization. We aim to ensure that our State-led evaluation efforts are complementary to the Federally-led evaluation, but not duplicative.

We will rely on our in-house evaluation to gather routine information that we must report to CMS and CMMI. Having our professional evaluator allows for a deep dive into those topics where we do not have the expertise or tools to carry out a particular type of in-house evaluation.

Since the inception of this contract in December 2016, URI has:

- Listened in on SIM activities to understand our programs and process.
  - Evaluators join SIM staff on the monthly RTI Evaluation Team calls, attend monthly SIM Steering Committee Meetings, participate in our Quarterly Vendor and Partner Meeting, and are helping us define evaluative roles for SIM Core and vendor staff.
- Finalized a draft of the Overarching Mixed-Methods SIM Evaluation Plan for review with the SIM Interagency Team in April. One specific evaluation activity will be a study on the Return on Investment for SIM-supported CHTs (including the Consolidated Operations Model aligned with SBIRT).
- Implemented a collaborative partnership with Brown University's Research Office for SIM State Evaluation efforts.
- Completed a first draft of the Child Psychiatry Access Project intervention-level evaluation plan.

We also want to note that another set of URI evaluators are carrying out the evaluation of the SBIRT Implementation Project that is formally aligned with SIM's CHT and SBIRT Training and Resource Center procurement. The SBIRT and CHT evaluators work closely together on a routine basis, therefore we are confident that they can collaborate on an effective review of the project. To ensure this collaboration, we have convened both evaluation teams together on several occasions.

Finally, as a part of our evaluation work, we had planned to carry out a Learning Collaborative on Alternative Payment Models in use in the state. However, because of the potential

duplication in meetings and discussions with the work OHIC is carrying out to review APMs, we have replaced this with a process evaluation of SIM organizational dynamics (including our culture of collaboration, which includes our Integration and Alignment work, and our organizing principles, which also includes our unique staffing model).

## Other System Transformation Components

### Measure Alignment

Quality measurement and improvement are integral components of value-based contracting. As value-based payment arrangements become more widely used in Rhode Island, it is important to ensure consistency and coherence in quality measures, to ease administrative burden on providers, and drive clinical focus to key population health priorities. Toward this end, in June 2015, the SIM Steering Committee charged a workgroup comprised of payers, providers, measurement experts, consumer advocates, and other community partners to develop an aligned measure set for use across all payers in the state.

The first product for this committee was a menu totaling 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures). In the fall of 2016, the committee reconvened to create two specialty measure sets: maternity (1 core measure, 9 menu measures) and behavioral health (3 core measures, 18 menu measures). The full list of measures in the [SIM Aligned Measure Sets](#) (including ACO, Primary Care, Hospital, Behavioral Health, and Maternity) are posted online.

Then, between July and October 2016, SIM convened two Specialist Measure Alignment Workgroups to develop recommendations for maternity care and behavioral health measure sets.

Through OHIC's regulatory power, Rhode Island insurers will be required to implement the updated SIM Aligned Measure Sets (above) beginning on or after 7/1/17. So as to align processes between commercial and public payers and reduce administrative burden for providers, Medicaid will also incorporate aligned measures in their performance-based contracts with providers.

### Regulatory Levers

Rhode Island is committed to using multiple regulatory and purchasing levers to advance the policies described in the healthcare delivery system transformation plan above. All the state agencies that are a part of the interagency team are engaged in this work. Starting on Page 150, we have described the key regulatory levers held by our participating state agencies that we will use to help us reach our goals. For example, to facilitate us moving toward our goal of 80% of payments linked to value by 2018, we will use OHIC's Affordability Standards. The standards hold insurance carriers to specific standards to advance value-based purchasing; promote practice transformation and increase financial resources to primary care for population health management; and around hospital contracting.

In another example, Medicaid contracts with Managed Care Organizations (MCOs) and pays them a capitated rate for Medicaid enrollees across different programs. In turn, Medicaid imposes conditions on the MCOs through contracting. The contracting conditions structure how MCOs reimburse providers, measure quality, and support multi-payer programs, such as

the state's multi-payer patient-centered medical home program. As stated in the Rhode Island Healthcare Transformation Plan, Medicaid will use the MCO contracting mechanism to impose specific annual targets for use of APMs by the MCOs, and directives to contract with credential Medicaid Accountable Entities.

Over the first couple of months in 2017, SIM has worked with the Associate Director of the state Office of Regulatory Reform during the statewide effort to review – and if needed, revise or delete – all regulations in the state. This major initiative is providing a new level of access to information about current regulations and the regulation revision process in the state, since agencies are creating a single code of regulations that will be available online. SIM staff is exploring opportunities for work across state agencies in aligning regulations to support SIM aims.

### **Integration & Alignment Project**

Rhode Island's size provides us with a set of opportunities and challenges. The challenges include an economy that must rely on a relatively smaller set of economic drivers than those found in larger states, and a healthcare system that is thus a higher percentage of our economy than in other states. However, our small size provides us with a number of positive opportunities, including the strong relationships that we can build statewide between existing and new interventions.

The number of federal- and state-funded initiatives listed beginning on Page 124 of this plan show that we do have a significant level of reform activities underway. It is often easier for state departments to carry out the grants they have received or the statutory requirements they must fulfill without taking the time to align with other projects. However, the SIM Interagency Team provides us with a forum to share this information and to ensure that state agency activities can be as aligned as possible with each other – to maximize the value of the interventions, serve more people, avoid duplication, and save money.

Therefore, we determined that one of the main articulated strategies of Rhode Island's SIM project will be to pursue a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with new SIM-funded activities. The SIM convened workgroups bring people from multiple agencies and backgrounds into the same room to collaborate and plan together. One major benefit of this collaboration is that needs of all agencies are discussed during the planning phase of our projects, meaning that the result will be more likely to meet each stakeholder's needs.

For example, the Patient Engagement Workgroup has brought together a variety of stakeholders including all our SIM state agencies and has helped us determine a clear set of the highest priorities for patient engagement in the state. This allows all voices and needs to be heard and will result in a very different end result than if only one agencies had determined the type of patient engagement activities to procure. It will also mean that if an agency's priority is not chosen to be developed, representatives from that agency will have a better understanding of why and may agree with the decision.

Several areas for alignment and collaboration come from the Rhode Island Department of Health (RIDOH). RIDOH has a well-established, evidenced-based [Family Visiting program](#) which provides supports and referrals to pregnant women and mothers of children up to age 3. The RIDOH team has offered to share best practices and lessons learned as SIM invests in new

Community Health Teams, which will also work to connect Rhode Islanders with community resources and clinical support as needed.

RIDOH recently completed a [Statewide Health Inventory](#), examining utilization of healthcare services and the capacity of providers to offer needed care. Among the findings was a lack of consistent data about patient demographics – providers rarely collected information about patient race/ethnicity and primary language. RIDOH’s [Commission on Health Advocacy and Equity](#) has reported a similar lack of data on patient demographics. This data gap has made it difficult to paint an accurate picture of existing health disparities. To address this issue, the SIM team plans to develop standard demographic and social determinants of health-related data requirements in all of its procurement contracts. In addition, the Measure Alignment Workgroup will consider adding the same or a subsection of those measures to its core measure set.

RIDOH is also in the process of developing a standard set of metrics to evaluate its Health Equity Zones (described in detail on page 132 of this plan) and its other Community Health Assessment projects. Instead of developing a different set of metrics, RIDOH will use the SIM population health measures and metrics described in the IPH to guide our evaluation work.

Another example that we have described elsewhere in this document is the system transformation goals set by OHIC. When Medicaid began to build its Accountable Entity program, SIM set up a dialogue between the two agencies resulting in Medicaid adopting OHIC’s language on APM implementation.

One last example is our collaboration on the Provider Directory. The Provider Directory will be a very versatile tool that serves a variety of clients, including state agencies, consumers, providers, payers, and numerous organizations. Collaboration and alignment across agencies helps to prioritize certain functionality when many ideas come to mind.

One proposed Provider Directory collaboration has the potential to address the prevalence of obesity in Rhode Island. As the Population Health consultant vendors explored initiatives to reduce obesity in Rhode Island, local experts mentioned that doctors are often reluctant to diagnosis patients, especially children, with obesity. This reluctance comes from a lack of knowledge about how to refer their patients to weight reduction experts. As a result, the SIM team will propose prioritizing nutritionists and dieticians among the specialists to include in its Provider Directory. This addition will give physicians the ability to quickly find licensed experts who can help their patients reach a healthy weight.

In addition, some discussion has begun about adding functions to the Provider Directory that will help with care coordination and tracking at the practice level as well as referral system to help route, track, and close the referral loop. An interagency team will help ensure that these functions meet the needs of EOHHS, BHDDH, OHIC, RIDOH, and our community stakeholders.

In addition to optimizing alignment and collaboration as we implement projects like the Provider Directory, in year 2 we decided to create what we are calling the Integration and Alignment Initiative, which is focused on leveraging SIM’s interagency structure and diverse stakeholder network to have positive impact on population health. This initiative began with the realization that while SIM investments focused more on system change than population health improvements, state agencies and community organizations in Rhode Island are already



carrying out activities that have a positive impact on population health, specifically in our health focus areas. We agreed that SIM was well positioned to act as a convener of these state agencies and community groups. The Integration and Alignment project identified state activities that address population health within the SIM health focus areas, and line them up with each other - and with projects and activities outside of state government as well, to move the needle on population health and maximize the impact of every dollar spent.

Through an iterative process, SIM held discussions with state leaders, agency staff, community stakeholders, and subject matter experts. Between August and December 2016, state staff proposed, researched, refined, and critically assessed several Integration and Alignment Collaborations designed to improve population health within one or more of our health focus areas: obesity, tobacco use, chronic disease, maternal and child health, depression, children with social and emotional disturbance, serious mental illness, and opioid use disorders. Three projects emerged as leading priorities:

- Chronic Disease – Identification of high-risk patients;
- Tobacco Use – Aligning best practices; and
- Obesity – BMI data collection.

In January 2016, we took these project concepts to the SIM Steering Committee and asked for their strategic guidance about which two to pursue. Identification of High-Risk Patients emerged as a clear priority, and the other two projects were tied in importance.

SIM staff appreciated the Steering Committee’s interest in the SIM Integration and Alignment Projects associated with obesity and tobacco and worked with subject-matter experts and state agency colleagues to explore potential strategies for moving these forward. These are discussed in more detail in the SIM Alignment with State and Federal Initiatives section.

This alignment will stem from good, ongoing communication between agencies, facilitated by the SIM process that has been embraced by seven state agencies to this point, and can be joined by other related state departments. For example, as SIM builds up its activities on social and environmental determinants of health, we will be reaching out to the Departments of Environmental Management and Transportation. Both departments already have engaged with RIDOH as members of the RIDOH Commission for Health Advocacy and Equity.

Over the next three years, we have the opportunity to bring their topic areas into the larger SIM portfolio, to lift up the types of conversations that will bring about a “health in all policies” orientation to state government – i.e. the importance of play space for youth to counter obesity and more public transportation to medical practices as a facilitator of health access.

Our high-risk project is moving forward with OHIC as the lead, and a broad range of staff from OHIC, RIDOH, and BHDDH are meeting to plan the tobacco project. We will be developing metrics to evaluate our Integration and Alignment work in Award Year 3.

### **Workforce Development**

In June 2016, EOHHS launched a Healthcare Workforce Transformation (HWT) planning process to assess Rhode Island’s current and projected healthcare workforce needs and educational capacity, and to identify priorities and strategies to align healthcare workforce education and training programs with the objectives of the state’s Health System

Transformation Program (HSTP). We describe the work briefly here and in more detail in the Healthcare Workforce Transformation section below, on page 144.

The HWT process involved the active participation of more than 250 healthcare partners representing providers, educators, policy-makers, payers, community-based organizations, advocates, professional associations and labor organizations to identify the knowledge, skills, training, and experience that will be needed by the current and future healthcare workforce to support health system transformation.

This initial phase of the EOHHS HWT initiative culminated in early May 2017, with the publication of the EOHHS Healthcare Workforce Transformation Report, which includes data (labor market, education, and licensure), best practices (national and local), a compendium of “transformative” occupations, and an inventory of healthcare workforce development resources in RI. Most importantly, the Report identifies three overarching priorities to guide the state’s support for, and development of, the healthcare workforce that Rhode Island will need to achieve its health system transformation goals.

- 1. Healthcare Career Pathways: Skills That Matter for Jobs That Pay**  
Prepare Rhode Islanders from culturally and linguistically diverse backgrounds for existing and emerging good jobs and careers in healthcare through expanded career awareness, job training and education, and advancement opportunities.
- 2. Home and Community-Based Care**  
Increase the capacity of community-based providers to offer culturally-competent care and services in the home and community and reduce unnecessary utilization of high-cost institutional or specialty care.
- 3. Core Concepts of Health System and Practice Transformation**  
Increase the capacity of the current and future workforce to understand and apply core concepts of health system and practice transformation.

In June 2017, EOHHS will convene a HWT Summit which is expected to be attended by over 200 healthcare partners. The Summit will feature presentations and workshops that will focus on transformative healthcare workforce innovations from throughout the U.S. and Rhode Island that are related to the priorities and strategies outlined in the HWT Report. The Summit will also serve to launch the implementation phase of EOHHS’s HWT initiative, in which EOHHS will further engage healthcare educators (especially public institutions of higher education – IHEs – via the DSHP processes) and healthcare providers (especially Accountable Entities-AEs- also via the DSHP process) to address healthcare workforce transformation priorities and health system transformation goals.

# SIM Component Summary Table

**Table 3: Component Summary Table**

This table has been updated with new metrics, and to avoid duplication, with page number references for component descriptions. The Drivers have remained the same.

SIM Component Summary Table					
Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver	Metric
<b>Planning and Governance</b>					
SIM Steering Committee	See Pages 29 & 77	N/A	N/A	Create measurable improvements in Rhode Islander's physical and mental health.	N/A
SIM Project Director and Staffing Across Five Partner Agencies	See Page 73	N/A	\$3,000,000	Create measurable improvements in Rhode Islander's physical and mental health.	N/A
Project Management	See Page 29	University of Massachusetts Medical School	Original amount - \$1,600,000. Updated Amount: \$1,421,329. Cost savings of \$178,671 to be allocated.	Create measurable improvements in Rhode Islander's physical and mental health.	N/A
<b>Rhode Island Health System Transformation</b>					
Transformation through regulatory action and payment reforms	See Page 90	N/A – Carried out by OHIC and Medicaid	In-kind by OHIC and Medicaid	Create measurable improvements in Rhode Islander's physical and mental health.	Percentage of payments made under an APM.
					Percentage of payments linked to value.
<b>Investing in Rhode Island's Healthcare Workforce and Practice Transformation</b>					
Community Health Teams (Linked to SBIRT) & the SBIRT Training Center	See Page 31	To be determined through a competitive RFP process	\$2,000,000 for CHTs; \$480,000 for the SBIRT Training Center	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Number of active SIM-funded CHTs
					Percent of new, SIM-funded CHTs actively seeing patients
					Number of unique practices utilizing new, SIM-funded CHTs
					Number of CHTs participating in the statewide CHT consolidated operations model
					Percentage of completed data reports submitted by consolidated operations team
					Number of provider trainings delivered about practice transformation and CHT benefits
					Percentage of tools and assessments made available to all CHTs in RI that are adopted by intended CHT recipients
					Percentage of patients referred to applicable CHTs who received services (A: SIM-funded; B: Non-SIM-funded)

SIM Component Summary Table					
Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver	Metric
					Percentage of patients referred to and seen by applicable CHTs who then enrolled in CurrentCare
					Percentage of patients referred to and seen by applicable CHTs who then received an annual influenza vaccination
					Number of Community Health Workers certified through the Rhode Island Certification Board
					Percentage of CHTs employing Certified Community Health Workers
					Number of patients in provider panels with referral ties to SIM CHTs
					Percent of RI residents with access to CHT (SIM funded + Existing)
					CUM # of providers who have been trained in SBIRT
Child Psychiatric Access Program	See Page 34	Emma Pendleton Bradley Hospital	\$650,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of pediatric practices that have on-demand access to pediatric behavioral health consultation services
					CUM # of pediatricians who have on-demand access to pediatric behavioral health consultation services
					CUM # of pediatricians who have received consultation to provide basic psychiatric assessment and treatment services
					CUM # of patients served under the Child Psychiatry Access Program.
Practice Transformation - PCMH Kids & Integrated Behavioral Health	See Pages 35 & 36	Care Transformation Collaborative Rhode Island (CTC)	\$870,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of practices participating in the pediatric PCMH program
					CUM # of clinicians participating in the pediatric PCMH program
					CUM # of patients attributed to practices participating in the pediatric PCMH program
					CUM # of practice sites participating in integrated behavioral health initiative
CMHC Provider Coaching	See Page 38	To be determined through a competitive RFP process	\$1,200,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of CMHCs that received provider coaching

<b>SIM Component Summary Table</b>					
<b>Component &amp; Activity/ Budget Item:</b>	<b>Description of activities</b>	<b>Vendor (If known)</b>	<b>Expected Expenditures</b>	<b>Primary Driver</b>	<b>Metric</b>
Care Management Dashboard	See Page 39	Rhode Island Quality Institute	\$150,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of CMHCs with real-time ED and inpatient dashboards in use
					CUM # of providers trained to use dashboards at CMHCs
Integrated Population Health Plan	See Page 83	University of Massachusetts Medicaid School sub-contractors The Providence Plan (ProvPlan) and the Technical Assistance Center (TAC)	Funded within the Program Management vendor line for subcontractor consultants	Create measurable improvements in Rhode Islander's physical and mental health.	N/A
Healthcare Quality, Reporting, Measurement and Technology Feedback	See Page 40	To be determined through a competitive RFP process	\$1,750,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	CUM # of health care organizations/practices sending data to the Health Care Quality Measurement, Reporting and Feedback system.
					CUM # of health care organizations/practices receiving data from the Health Care Quality Measurement, Reporting and Feedback system.
<b>Patient Engagement</b>					
Patient Engagement Tools/ Advanced Illness Care Initiative	See Page 40	To be determined through a competitive RFP process	\$2,200,000	Provide access to patient tools that increase their engagement in their own care. Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning	Metric(s) in development.
					Metric(s) in development.
<b>Increasing Data Capability and Expertise</b>					
HealthFacts RI	See Page 41	Freedman Healthcare, Onpoint,	Original amount: \$2,039,673 Updated amount: \$1,661,296. Cost savings of \$378,383 to be allocated.	Increase use of data to drive quality and policy	# of publicly available reports released from HealthFacts RI per year
					# of applications/requests for level 2 or level 3 data extracts from HealthFacts RI per year
Statewide Common Provider Directory	See Page 42	Rhode Island Quality Institute	\$1,500,000	Increase use of data to drive quality and policy	CUM # of state agencies using common provider directory

<b>SIM Component Summary Table</b>					
<b>Component &amp; Activity/ Budget Item:</b>	<b>Description of activities</b>	<b>Vendor (If known)</b>	<b>Expected Expenditures</b>	<b>Primary Driver</b>	<b>Metric</b>
					CUM # of private sector health care organizations using common provider directory
Integrated Health and Human Services Data Ecosystem	See Page 43	To be determined through a competitive RFP process	\$1,800,000	Increase use of data to drive quality and policy	N/A
<b>Other System Transformation Components</b>					
Measure Alignment	See Page 45	Bailit Health Purchasing	Included in Project Manager Line Item	Increase use of data to drive quality and policy	N/A
Regulatory Levers	See Page 45	Conducted by staff	N/A	Create measurable improvements in Rhode Islander's physical and mental health.	N/A
Integration and Alignment	See Page 46	Conducted by SIM leaders and staff	N/A	Create measurable improvements in Rhode Islander's physical and mental health.	TBD
Workforce Development	See Page 48	Conducted by SIM Staff and the Healthcare Workforce Transformation Committee	N/A	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	TBD
<b>Evaluation</b>					
Evaluation	See Page 44	To be determined through a competitive RFP process	\$700,000	Create measurable improvements in Rhode Islander's physical and mental health.	N/A

## SIM Sustainability Strategies

As the Rhode Island SIM team's efforts have shifted from planning to implementation, we are continuing to design our sustainability model. In addition to addressing the sustainability of each SIM component, we are planning to create an overall sustainability framework for our overarching system changes and population health improvements.

Because we are a model test with significant evaluation built in to our work, we do not yet know what specific initiatives will be the most compelling to sustain, or at this point, what will be the best means for supporting each viable project once the grant period has ended. Therefore, in the coming year we will establish a process for considering sustainability and evaluating potential sustainable program elements based on our experience and other SIM grantees' published work.

In Award Year 3, SIM will plan for overall sustainability by drawing on the following three priorities:

- 1. Establish a SIM Sustainability Planning Workgroup**

The work group shall consist of members of the SIM Core Team, Interagency Team, and Steering Committee. This group will be charged with continuing research on sustainability, reviewing and discussing the project updates and evaluations, conducting an environmental scan of the supports available for sustainability, exploring stakeholder entity readiness and willingness to sustain specific projects, developing the transition plan for projects, and bringing data and recommendations to the Steering Committee around sustainability.

- 2. Leverage the Learnings from SIM Evaluations and Reporting**

SIM will use the results from both the State Evaluator's Assessment as well as the RTI federal evaluation to better understand the effectiveness and impact of each SIM component. The State Evaluator will be conducting a qualitative analysis in addition to a quantitative analysis, so perceptions of key stakeholders on the success or failure of SIM projects will be captured, providing additional insight into the community buy-in and long term viability of these projects. Tracking key metrics outlined in the SIM Metrics Table will also demonstrate whether SIM projects are successful in meeting their intended goals.

- 3. Maintain the Culture of Collaboration**

The SIM grant has been instrumental in cultivating a culture of collaboration in Rhode Island, and the partnerships forged in planning and implementing SIM projects will outlive the SIM grant cycle. We anticipate that by ensuring widespread community buy-in through the Steering Committee's governance structure, the Integration and Alignment Project, and SIM's interagency structure throughout the lifetime of the grant, we will be able to garner support needed to sustain successful projects.

The table below provides assessment criteria, sustainability proposals and measures of success for the major SIM Components:

**Table 4: SIM Sustainability Chart**

SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
<p>Community Health Teams (Linked to SBIRT) &amp; the SBIRT Training Center</p>	<p>Maximize &amp; support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce</p>	<p>Collect data to determine cost effectiveness of consolidated operations and overall ROI. If ROI is significant, would pursue funding from ACOs, infrastructure payments from carriers (through negotiations), or netted out of shared savings.</p> <p>With recent award of a SAMHSA SBIRT grant, the SAMHSA component of the project is secured for just under five years. Through the last two years of SIM and the longer SBIRT project, Rhode Island will explore ROI, create an ongoing train the trainer program to ensure that the program continues, work to build it into provider coaching for the CMHCs and other formal Practice Transformation initiatives, and explore other forms of multi-payer support.</p>	<p>CHTs: Proof that CHTs provide higher quality care and added-value to the practices with which they partner. Proof that CHTs are an essential role for improving care coordination and responding to specialized needs within a less restrictive setting. Elimination of barriers, infrequent care, and lack of access to preventive services by CHTs are keeping individuals out of the ED and/or avoiding readmission.</p> <p>SBIRT: Improvement in behavioral health outcomes of people with substance use disorders. Increased access to screening services for adults within primary care/ health clinic settings, emergency care/health clinic setting, EDs and the Department of Corrections. IT strategies in place so providers can access and score SBIRT questionnaires centrally or through their own Electronic Health Records and share SBIRT results through Current Care for enrolled individuals.</p>
<p>Child Psychiatry Access Program</p>	<p>Maximize &amp; support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce</p>	<p>If the program is found to have an ROI by reducing psychiatric admissions, keeping children out of more restrictive settings, and building the capacity of the primary care provider community, we may be able to explore opportunities to build system capacity to support the program, either on the payer or provider (ACO or MCO) side.</p>	<p>Children with psychiatric needs are cared for in their PCP's offices rather than in EDs or hospitals. PCPs are more confident in their ability to treat children with behavioral health issues. More integration between physical and behavioral health in PCP offices.</p>



SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
<p>PCMH Kids &amp; Integrated Behavioral Health</p>	<p>Maximize &amp; support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce</p>	<p>If the 9 practices successfully transform to meet OHIC's standards, health plans will continue to support their ongoing care management and provide quality incentives. Because health plans are required to have 80% of their contracted practices operating as PCMHs by 2018, they are incentivized to continue their support of PCMH Kids.</p> <p>Evaluation plan to help determine cost savings from reduced ED and inpatient use and how those savings can be deployed to sustain ongoing behavioral health integration in health care settings.</p>	<p>At least 19 practices will come through the initiative and be working on transformation to meet OHIC's standards.</p> <p>Increasing numbers of primary care practices with integrated behavioral health providers on-site.</p> <p>Improvement in rate of screening for anxiety, depression and substance use for persons served by primary care practices that integrate behavioral health care.</p> <p>ED and inpatient savings through reduction in behavioral health symptoms that drive medical/ behavioral health utilization and cost</p>
<p>Care Management Dashboards</p>	<p>Maximize &amp; support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce</p>	<p>One-time payment for dashboard development. CMHCs and Medicaid FFS CHT are expected to pay for maintenance.</p>	<p>CMHCs will have the data they need about patients just admitted for hospital stays or being discharged from the hospital stays. With one in five hospital stays having a behavioral health component, this knowledge will allow CMHC staff or CHTs to communicate with their patients, to help patients follow discharge protocols and avoid additional hospital stays.</p>
<p>CMHC Provider Coaching</p>	<p>Maximize &amp; support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce</p>	<p>The design of this program can ensure that the investment in provider coaching will be built into the infrastructure of the CMHCs for up to 10 years. This includes train the trainer – a ladder of training so that staff turnover will not affect the institutional knowledge. We will develop training manuals that can be consulted by staff, and ongoing refresher courses throughout SIM's 3 years.</p>	<p>CMHC staff learn to incorporate health care coordination into their behavioral health practices, with demonstrated results to include, for example, reduction in rates of smoking, reduction in BMI; increased evidence of healthy eating habits and participation in regular exercise. Overall increase in self-reported quality of life and decrease in expensive inpatient care. (This is a reworking of the primary driver in this case, because instead of integrating behavioral health into primary care, we are integrating primary care into behavioral health.)</p>

SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
<p>Healthcare Quality, Reporting, Measurement and Technology Feedback System</p>	<p>Maximize &amp; support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce</p>	<p>We expect that this feedback system will be of significant use to providers transitioning to QPP – and that they will find it cost-effective to pay for its services after SIM's initial investment to build and refine it.</p>	<p>Providers will have the data in a format that allows them to easily use it for reporting quality measures, quality improvement, learning about best practices among peers, and whole-person care of their patients. Consumers will have access to quality transparency to increase their engagement in healthcare choices.</p>
<p>Patient Engagement/ Advanced Illness Care Initiative</p>	<p>Provide access to patient tools that increase their engagement in their own care.  Assist with advanced illness care planning by promoting end-of-life conversations in the primary care setting.</p>	<p>Patient Engagement – We will create the sustainability models as we continue our planning and RFP creation for patient engagement. We will also ask our vendors to build in sustainability planning into their approach.  End-of-Life Initiative – Just as we plan for the Practice Coaching at CMHCs to create long-term capacity within the agencies, we will build in a significant train the trainer program to maximize the long-term value of the training and group support provided through this program.</p>	<p>Patient Engagement – While the specific goals for patient engagement will be developed as we continue procurement, our overall definition of success will be that patients are more able to take ownership of their care and improve their health.  End-of-Life Initiative – We will see an increase in the number of primary care provider/patient conversations concerning advance care planning, an increase in the documentation of advance care planning, a decrease in unwanted utilization of services among those with advanced illnesses, and improved comfort levels among providers and patients and their families.</p>

SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
HealthFacts RI (Rhode Island's All-Payer Claims Database)	Increase use of data to drive quality and policy	<p>Datasets from HealthFacts RI will be valuable for various research projects, business analytics, and informing healthcare policy. This data is also critical to Medicaid and as such, RI recently received approval of a 5 year IAPD to receive Medicaid enhanced match funding for the continued development and implementation of analytics through a Business Intelligence tool so that state staff can directly access and analyze the data for Medicaid and to continue to maintain and operate the database for Medicaid purposes. Additionally, given the value of the data it will likely be desired by other interested parties. These interested parties will need to pay for the data requested and this supports the Medicaid requirement to cost allocate the use of the system if users beyond Medicaid want to use the data.</p>	<p>Datasets will be used by state staff to meet Medicaid needs. We will also share data with customers through an efficient data release process, expanding the possibilities for learning we can have collectively as a state from the data. Consumers have access to cost data to inform healthcare decisions and increase engagement in their care.</p>
Statewide Common Provider Directory	Increase use of data to drive quality and policy	<p>SIM is funding the initial build and data model design for the provider directory. Given that the provider directory also supports health information exchange needs among and between providers, we have secured 90/10 funding during the next 18 months to complete the development of the system including the provider portal for updating their own information as well as mastering additional types of providers. When fully operational, RIQI will provide extract files for a fee.</p>	<p>Meaningful and accurate provider directory that tracks organizational relationships over time and supports the states' and community's needs. Consumers can search for providers in one place to meet a variety of needs, such as selecting a health plan, finding a physician that can speak their language, etc. Overall it is very important that stakeholders have confidence in the accuracy of the data.</p>

SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
Integrated Health and Human Services Data Ecosystem	Increase use of data to drive quality and policy	The initiative aims to identify program strengths and weaknesses and assure that the State government is using data driven decision making when investing in and supporting programs to meet the needs of the state's population. If ROI is proven and project leadership are confident in the state's ability to maintain the system after the vendor exit, the state will move to incorporate the positions into the general budget and leverage the capital budgeting process to fund future hardware and software needs.	Several critical EOHHS data sets are linked at the person level. Vendor has built a scalable and transferrable master client index. The newly integrated data is being used to enhance the structure and interventions of ACOs and AEs. The integrated data is being used to more holistically measure population health and potential high-risk clients who are unattributed to an ACO or within an ACO and showing excessive use of acute or unnecessary services.
System Transformation	Create measurable improvements in Rhode Islander's physical and mental health.	Rhode Island's system transformation plan exists within the regulatory structure of OHIC and Medicaid. SIM is providing ways to more fully integrate the two sectors, to carry out significant evaluations of the transformations with evaluation dollars, and to lift up the system changes to a wider audience.	A health system where 80% of payments are linked to value and 50% are under an APM.
Workforce Development	Create measurable improvements in Rhode Islander's physical and mental health.	Rhode Island has been working with CMS to secure DSHP funding for workforce development for five years (see page 126). This funding will allow us more time to build in other forms of Medicaid reimbursement and to continue to explore the potential of apprenticeships or similar programs.	A workforce system more prepared to treat patients within the new structures of value-based payments, integrated behavioral health, and transformed primacy care.

SIM Component	Goal/ Primary Driver	Sustainability Proposal	What is Success by SIM's end?
Integration & Alignment	Create measurable improvements in Rhode Islander's physical and mental health.	The structure of our staffing – that we have embedded SIM staff members in each agency rather than having them work out of one SIM office – means that we are purposefully sharing the SIM integration and alignment priorities throughout state government. Our Integration & Alignment project will also allow us to use these additional two years with significant state staff to cultivate relationships among state agencies and between state agencies and private community organizations that can continue beyond the SIM grant period.	SIM activities are carried out effectively and are seamlessly melded into other state agency work. State are aware of the functions and duties of each state agency, and communication flows freely between agencies.
Evaluation		N/A	A deep understanding of our system changes, how APMs will continue to work to drive down costs, and a guide to what SIM activities should be continued with state or other funding, and feedback on the success of our SIM organizational model that will inform decision making about the post-SIM governance structure for projects that that are being sustained.

## Risk and Mitigation Strategy

Rhode Island has been pursuing health transformation for many years, and the SIM Test Grant builds on prior research, policy, law, economics, regulation and clinical innovation in healthcare reform. As a small state, we have the opportunity to work closely with stakeholders statewide, often in face-to-face encounters. As we've noted throughout this document, Rhode Island has a strong tradition of collaboration between federal, state, local, academic, business, and community stakeholders to identify issues and seek collaborative solutions.

Accordingly, we have been aware of risks and issues that might have affected the success of the SIM Test Grant project in the state, and have worked actively in the past year to mitigate those risks.

As a result, few of the risks have materialized as issues, and as the program has moved into implementation, a number of the risks have been downgraded as the program has matured. The single class of risk that has materialized across multiple instances—as we forecast and reported over the past year—has been delays in procurement. We were able to mitigate that to some degree by conducting frequent work sessions and engaging in close communication with the other state entities responsible for various approval processes. With experience, we have managed to minimize delays within the team, and the last two quarters have seen a significant number of the SIM procurements begin implementation.

Implementation-dependent risks have not had a chance to materialize, since many of the projects have just entered implementation. They include “Challenges to achieving expected program outcomes” and “Project implementation does not work as planned.” Those risks are being actively monitored by SIM staff across the projects.

### Approach

The Rhode Island SIM team has created a risk and mitigation matrix based on standard project management practice, where each risk is assessed based on likelihood of occurrence, impact of occurrence, and assigned a 1-5 (low-high) scale value. The likelihood and impact are multiplied to produce a risk score. These scores have no intrinsic meaning, other than to allow relative comparisons of risks.

### Risk Mitigation Principles

The following are the general principles that Rhode Island SIM proposed last year and that we are continuing to use to address project risks:

- **Involvement of a diverse group of stakeholders, with significant communication.**

By engaging stakeholders across the spectrum of our work, we increase our ability to call on subject matter experts for assistance in our projects – and decrease the chances that we will encounter problems that we cannot solve. All SIM activities follow Rhode Island's Open Meetings laws, ensuring public notice of all meetings and transparency of meeting proceedings. This year, community participation has been heavy, and most stakeholders attend regularly. We have not experienced any issues resulting from lack of involvement or input.

- **Robust and active project management.**  
Project management was at the top of Rhode Island’s priorities when engaging consultants to assist with the SIM Model Test Grant, and the teams are following project management best practices in developing, managing, and tracking activities. Moreover, we have implemented an oversight structure for the SIM investment projects that will ensure that the SIM staff managing the vendors can provide active monitoring and controlling of risks during the project lifecycle.
- **Following evidence-based practices.**  
We have engaged experts in population health planning and behavioral health planning, as well as measure development and other technical specialties for SIM. Their expertise is being heavily leveraged in researching policies and best practices that can be applied to Rhode Island from within and outside of the state.

Identifying and mitigating risks is an ongoing process. Periodic reassessment is the best means for addressing currently unidentified risks. Success at early and active mitigation may prevent later risks from developing. And while SIM leadership has been satisfied with our current risk mitigation strategy, we remain alert to potential new risks during implementation. If we need to define additional risk mitigation strategies, we will work through our Interagency Team.

Rhode Island has a unique advantage for a project of this size. A large proportion of the stakeholders already know each other and have worked together previously on our long history of healthcare transformation. This has made early SIM work well-informed, collaborative and efficient. Points of view on issues – even if people are not always in agreement – are usually understood. Methods for problem-solving have been tested, and are effective.

Finally, one of the most significant mitigating factors is that the political leadership in the state is well aligned around the issues and needs for Rhode Island, and they are prepared to work together to meet those needs. As such, they have been strong supporters of the SIM Test Grant, and we expect that support to extend throughout the life of the project.

## Risk Register

The Rhode Island SIM team identified nineteen key risks and the mitigation strategies to address them. They are ordered within Risk Category, then by highest Risk Score in the following table.

**Table 5: Risk Register**

		<i>Likelihood it will occur</i>	<i>Impact if it occurs</i>	<i>Risk Score</i>	
	<b>Risk Category/ Risk</b>	(1-5)	(1-5)	(=Likelihood X Impact)	<b>Mitigation Plan</b>
<b>Procurement</b>					
1	<p>Deadlines for procurements are missed</p> <p>Purchasing process is lengthy; funds cannot be disbursed and applied to the objectives sufficiently rapidly, making it more difficult to achieve our goals.</p>	5	4	20	<p>Prioritize procurement in our work plan above other projects. The SIM team will work collaboratively and efficiently to minimize delivery time to Purchasing. To that end, the SIM team:</p> <ul style="list-style-type: none"> <li>• Created a small procurement staff team dedicated to expediting the process end-to-end.</li> <li>• Conducted initial exploration with all approving entities to ensure we understand their rules and process</li> <li>• Met with Department of Administration leadership to engage them in grant goals and get their commitment to timely purchasing and contract administration</li> </ul> <p>Current contractors will be enlisted for support in any processes where there is not a conflict of interest.</p> <p><b>Update: These mitigations were consistently applied, and while there were delays, many procurements have closed in the last two quarters. We also received permission to handle some procurements at the Executive Office level, rather than at State Purchasing, which has provided some additional flexibility.</b></p>



		<i>Likelihood it will occur</i>	<i>Impact if it occurs</i>	<i>Risk Score</i>	
	<b>Risk Category/ Risk</b>	(1-5)	(1-5)	(=Likelihood X Impact)	<b>Mitigation Plan</b>
2	Protracted contract negotiations once a vendor is selected	4	4	16	Send out state contract template/terms and conditions with RFP and request that vendors identify what issues they have with the state contract and alternative language when they submit their proposal so the state can be prepared ahead of time for contract negotiations with the vendor. <b>Update: We have had delays with contract negotiations. Some were due to complicated contracts, and others were due to timing issues with attorneys. Applying lessons learned and advance preparation for contract reviewers in advance has somewhat mitigated the risk going forward, but the issues remain.</b>
3	Inadequate bids on Specific RFPs	2	2	4	Provide thorough bid guidance in RFP. Conduct robust RFP distribution efforts through current stakeholders and the wider state healthcare network <b>Update: Solicitations have been widely publicized, and this has not been an issue to date.</b>
<b>Metrics and Measures</b>					
4	Project implementation does not work as planned	4	4	16	Hold regular internal evaluations to assess implementation and find problems quickly. Work with stakeholders to find solutions to the problems without delay. <b>Update: This has not been an issue to date, but a number of projects are just beginning implementation. We have established a robust project reporting, tracking, and management system for our investments (#12, below), and all vendors receive training to ensure a consistent approach across the portfolio.</b>
5	Lack of Data Availability to Meet Need	2	2	4	Aggressively pursue data availability early, to establish parameters of what is possible. Work within the state's current data teams and offer to add SIM staffing resources if necessary. Prioritize other data for acquisition at a later time. If there is a lack of data about "net new" or unstudied program activities to identify benchmarks or targets, set targets and reassess at mid-year to determine their reliability and validity. Work with stakeholders to assure access to data at the provider and payer level. <b>Update: This has not been an issue to date, and we foresee no risk at present.</b>
<b>Technology &amp; Data</b>					
6	IT development lifecycle takes longer than expected.	4	3	12	Set realistic goals during the planning phase, prioritizing activities that must be done by deadlines versus those that can wait. Use iterative IT development life cycle process and implement incrementally so as to accomplish most critical functionality first.

		<i>Likelihood</i> if it will occur	<i>Impact</i> if it occurs	<i>Risk Score</i>	
	<b>Risk Category/ Risk</b>	(1-5)	(1-5)	(=Likelihood X Impact)	<b>Mitigation Plan</b>
					<b>Update: Some delays have occurred on all of our successfully procured HIT components due to IT development lifecycles, (including HealthFacts RI, Provider Directory, and Care Management Dashboards). In each instance, we have successfully worked with our vendors to manage the risks and ensure that delays do not pose a risk to accomplishing our goals by extending contracts and incorporating service level credits in new HIT contracts to discourage future delays.</b>
7	Technology does not exist to support needs	2	2	4	Conduct thorough assessment of business requirements; make technical selection based on priorities and cost benefit of build vs. buy. Implement infrastructure that is extensible and scalable and can easily be modified to meet users changing needs <b>Update: The assessments of business requirements as well as the use of ONC TA through SIM has allowed us to accurately judge the industry and issue RFPs for which technology already exists or can be developed. Throughout all of our RFPs, we have encouraged the use of existing technology which has allowed vendors to be creative and resourceful.</b>
8	Technology or Data is Not in Compliance with Standards	1	4	4	Identify standards before conducting technical assessment <b>Update: This has not been an issue to date, and we do not anticipate it becoming one.</b>
9	Privacy concerns disrupt project plans or timelines	2	2	4	Involve the community of stakeholders in any decisions that may have privacy implications and discuss the potential for duplication of data systems and interfaces as a result of limiting data sharing. Seek to identify how widespread the privacy concerns are to gauge the implications for moving ahead or not and/or identifying alternate options for achieving the same goal. <b>Update: Privacy concerns have slowed some of the plans for our projects, such as HealthFacts RI and Provider Directory, however they have not affected the overall success of the technology implementation.</b>
10	Internal staffing lacks skills to achieve goals	2	2	4	Assess current staff skill levels related to data analytics as well as IT development, incorporate training opportunities for existing workforce, and in any new hiring, choose new staff with needed skillsets to fill in gaps. Leverage staff experience within stakeholder organizations. <b>Update: This has not been an issue to date.</b>
<b>Program Implementation</b>					

		<i>Likelihood it will occur</i>	<i>Impact if it occurs</i>	<i>Risk Score</i>	
	<b>Risk Category/ Risk</b>	(1-5)	(1-5)	(=Likelihood X Impact)	<b>Mitigation Plan</b>
11	Challenges obtaining a no-cost extension	3	5	15	<p>We recognize that there are no guarantees for No Cost Extensions, but our procurement delays (see Risk 18, below) make obtaining a no-cost extension an important consideration so that we may get the full benefit of our investment activities that we have approved with our vendors.</p> <p>Projects falling at the end of the procurement cycle tend to be some of the most complex and correspondingly have a significant likelihood of making significant and durable contributions to Rhode Island's healthcare transformation. We will work closely with CMS to determine the best ways to allow these projects to reach their full potential.</p>
12	Challenges achieving our expected program outcomes	4	3	12	<p>Base solutions on evidence. Set clear, concrete goals for initiatives, with achievable objectives and work with our subject matter experts and other stakeholders to address challenges. Provide sufficient funding to achieve success. Ensure robust quality assurance, measures, and metrics capture mechanisms. Carry out regular monitoring of progress, tied to data on quality.</p> <p><b>Update: This has not been an issue to date, but a number of projects are just beginning implementation, and we will be alert for project delays or issues with deliverables. Longer-term, we will be looking closely at program outcomes, since evidence of success will be vital for sustainability.</b></p>

		<i>Likelihood it will occur</i>	<i>Impact if it occurs</i>	<i>Risk Score</i>	
	<b>Risk Category/ Risk</b>	(1-5)	(1-5)	(=Likelihood X Impact)	<b>Mitigation Plan</b>
13	Vendors for SIM funded projects do not perform as planned, e.g. timeline, deliverables, quality, or budget	3	3	9	<p>Each SIM vendor received Orientation and Training to give them a consistent overview of SIM, and an overview of program management roles and process, supported by a set of project management templates. This set included templates for monthly reporting (monthly progress, next steps, and key strategic decisions made, Gantt chart, milestone update, and key risks/issues for escalation), as well as an Excel-based timeline. We have also provided Training in Vendor Management 101 to all our Agency Project leads. This focused on managing the key project variables of time, cost, and quality. Our process for managing vendor progress includes:</p> <ol style="list-style-type: none"> <li>1. Monthly calls with the vendors and Agency Leads 3-5 days after receipt of the Monthly Report. An agenda typically covers these topics: <ol style="list-style-type: none"> <li>a. Progress made since the last call.</li> <li>b. Receipt of deliverables as required and of required quality.</li> <li>c. Actions planned for the next 30-60-90 days (or other relevant time period). Challenges anticipated in that time period and associated recovery plans.</li> <li>d. Actions the vendor, agency lead, or others can take to remove roadblocks.</li> <li>e. Effects of the above on overall project timeline.</li> <li>f. Billing or other financial issues</li> </ol> </li> <li>2. SIM Staff provide updates at the first Staff meeting post their call with the vendor. This short verbal update covers: <ol style="list-style-type: none"> <li>a. All on track except (scope, schedule and deliverables, budget, or resources)</li> <li>b. Brief summary of what is not working and recovery plan</li> <li>c. What help is needed and from whom</li> </ol> </li> </ol>

		<i>Likelihood it will occur</i>	<i>Impact if it occurs</i>	<i>Risk Score</i>	
	<b>Risk Category/ Risk</b>	(1-5)	(1-5)	(=Likelihood X Impact)	<b>Mitigation Plan</b>
14	Lack of alignment between federally funded projects and difficulty aligning existing state projects	1	2	2	<ul style="list-style-type: none"> <li>Continue outreach to state agencies and community agencies with federal funds, maintaining close contact with stakeholders</li> <li>Increase sense of ownership by involving stakeholders in incremental policy development process.</li> <li>If funding is pursued through other sources, maintain contact with those stakeholders.</li> <li>Active, consistent engagement of executive leadership across the Executive Office of Health and Human Services, OHIC, HealthSource RI, and the Governor's Office</li> </ul> <p><b>Update: This has not been an issue to date.</b></p>
15	Participation in SIM activities by providers or patients does not meet expectations, reducing the chance of achieving expected outcomes	1	2	2	<p>Make and set realistic goals for participation based on historical experience; incorporate stakeholder outreach plans into vendor contracts; increase outreach efforts if participation falls short of expectations.</p> <p><b>Update: This has not been an issue to date, and we don't anticipate it becoming one. Participation has been strong by community stakeholders, including community advocates and providers.</b></p>
16	Timeline or Timeframe Interruption (e.g., staff illness, other issue)	1	2	2	<p>Prioritize scope elements. Cross-train staff in each other's initiatives. Be prepared to de-scope lower priority elements if needed.</p> <p><b>Update: This has not been an issue to date.</b></p>
<b>Staffing</b>					
17	Non-SIM Agency Infrastructure Staff	3	4	12	<p>Agency staff from organizations that are not aligned with SIM priorities may not be able to expedite processes, or seek accelerated decisions in order to minimize SIM activities, including procurements and related financial and contractual activities.</p>
18	Staff departures – Project Director	1	3	3	<p>Our Project Director has made a commitment to the state to the end of the grant period. While she is playing a significant role in engaging stakeholders and facilitating the work of the SIM Steering Committee, the structure of the project means that she has back-up from other SIM-specific staff and colleagues throughout SIM participating agencies. We are also cross-training staff in the Director's initiatives.</p> <p><b>Update: This has not been an issue to date.</b></p>

		<i>Likelihood</i> of it will occur	<i>Impact</i> if it occurs	Risk Score	
	Risk Category/ Risk	(1-5)	(1-5)	(=Likelihood X Impact)	Mitigation Plan
19	Staff departures – Other Staff	2	2	4	<p>As noted above, we are confident that our broad staffing structure and culture of sharing information would make a staff departure manageable from a risk perspective. Additionally, within our team (and noted in our timeline), staff have been paired up for many of the SIM-related activities to ensure coverage in the event a staff member departs the team and/or has a personal emergency and may not be available during critical implementation times.</p> <p><b>Update: This has not been an issue to date. The SIM team experienced one staff departure last year for a position which was filled quickly. Other staff in the host agency were able to take over the work during the vacancy.</b></p>

## **C. General SIM Operational and Policy Areas**

This section of the SIM Operational Plan document describes core operational components of the SIM Test Grant and discusses their alignment with the Integrated Population Health Plan. Discussion items include but not limited to governance, stakeholder engagement, healthcare transformation, payment delivery models, and regulatory authorities. Also included are cross-cutting topics such as measure alignment, workforce development, health information technology, and evaluation.

# SIM Governance

## Governance and Management Structure

### SIM Project Leadership

Rhode Island SIM is at heart a public/private partnership, as well as an interagency collaboration. Therefore, its governance structure and decision-making authority is shared among a coordinated group of people and agencies, managed by SIM Project Director Marti Rosenberg. Hired in October 2015, Ms. Rosenberg's office sits at the Office of the Health Insurance Commissioner, and she reports to both Commissioner Kathleen C Hittner, and the acting EOHHS Secretary Anya Rader Wallack.

Ms. Rosenberg leads a staff team made up of individuals hired with SIM dollars and placed within other State agencies. These staff members officially report to staff at each agency, but come together in a team that meets weekly and works together on all SIM projects. In addition to regular staff meetings, the team holds regular meetings specific to: communications, outreach, and engagement; SIM workgroups; procurement; and vendor contract management. The attached SIM Organizational Chart depicts the SIM staffing structure, including SIM designated and other state staff who support SIM efforts and the UMass Medical School project management team.

The next level of SIM activity takes place within our SIM's Interagency Planning Team, facilitated by Ms. Rosenberg. The Interagency team includes staff at various levels from all SIM participating state departments, plus our Steering Committee Chair, Andrea Galgay. The SIM Interagency Planning Team is responsible for the strategic implementation of the project: financial and planning oversight, organizing SIM goals and deliverables, overseeing stakeholder engagement, and tracking metrics.

While regulatory promulgation and procurement issues will continue to be carried out by state government, the SIM Steering Committee is the public/private governing body for Rhode Island's SIM project. The committee's primary function is to set strategic direction, create policy goals, approve the funding plan, and provide oversight over SIM implementation. The committee meets monthly and is comprised of community stakeholders who represent health care providers and health systems, commercial payers, state hospital and medical associations, community-based and long term support providers, and advocacy organizations. We understand that resting SIM decision-making in this public/private Steering Committee is unique in the country.

Another way that we benefit from the public/private partnership nature of SIM is through our Workgroups. The workgroups allow us to garner subject-matter expertise, receive stakeholder and community input, and secure implementation recommendations for SIM's transformation efforts. The Steering Committee has approved four specific SIM workgroups around our key test components to date and may request additional workgroups as necessary. Current workgroups include Integrated Population Health Plan, Measure Alignment, Patient Engagement, and Technology Reporting. The scope and nature of these groups will be further discussed in the next section on Stakeholder Engagement.



## **Governor's Office Engagement in SIM**

In February 2013 Rhode Island was awarded a CMMI State Innovation Model Design Grant to develop a State Health Care Innovation Plan (SHIP). The then Lt. Governor Elizabeth H. Roberts led the project known as Healthy Rhode Island, engaging multiple stakeholders to review current state payment and delivery system reform initiatives; identify data sources and baseline data for outcomes measures and financial analysis; and identify available and needed policy lever changes. The resulting SHIP document defined the strategy and mechanisms for moving Rhode Island's health care delivery system to a value-driven, community-based, and patient centered system.

With a change in administration in January, 2015, Rhode Island's new Governor Gina M. Raimondo appointed Ms. Roberts as Secretary of the Executive Office of Health and Human Services (EOHHS) where she continued to champion the SIM effort in Rhode Island until she left the position in February 2017. Now, Acting Secretary Anya Rader Wallack is helping provide support for SIM.

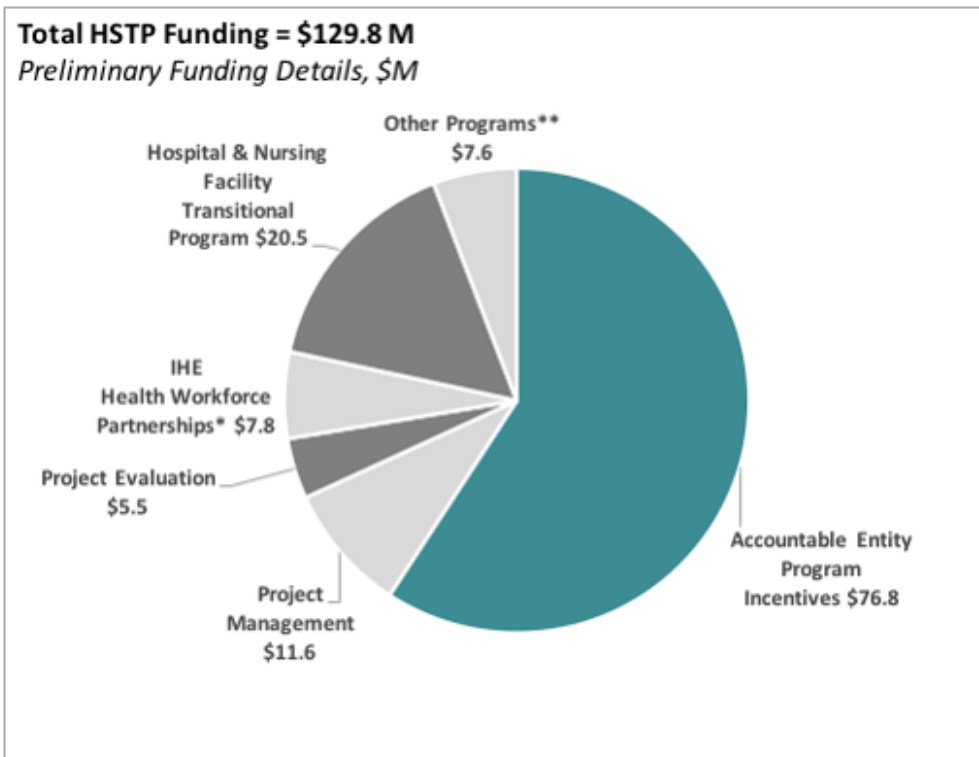
Governor Raimondo's office retains a strong connection to the project with representation on the SIM Interagency Team, the SIM Steering Committee, and the ability to attend SIM workgroups. The SIM Project Director engages in bi-weekly updates with Governor's Office staff to keep the administration aware of SIM activities and ensure coordination of efforts across all state healthcare innovation efforts.

## **Health System Transformation Project**

On February 26, 2015, Governor Gina Raimondo issued Executive Order 15-08, establishing the Working Group to Reinvent Medicaid. In July 2015, the Working Group delivered a multi-year plan for the transformation of the Rhode Island (RI) Medicaid program. In May of 2016, Rhode Island submitted an 1115 Waiver request to CMS to implement the Rhode Island Health System Transformation Project (HSTP) to support and sustain this transformation. CMS subsequently approved this request in October of 2016, with up to \$129.8 million available for Rhode Island's use. The HSTP proposes to foster and encourage this critical transformation of Rhode Island's system of care by supporting an incentive program for hospitals and nursing homes, a health workforce development program, and Accountable Entities.

To be more effective, health care must transform at the level of the patient and provider. The health care delivery system at this level of care cannot transform without a significant infusion of new health professionals as well as retraining of the current workforce. In partnership with the Rhode Island's State Innovation Model (SIM) project, EOHHS is providing statewide leadership to develop plans, policies, programs, and resources that align Rhode Island's healthcare workforce education and training programs with Rhode Island's health system transformation and population health goals.

**Figure 6: Total Health System Transformation Project Funding**



\*Health Workforce Partnerships includes \$5.4 M for Workforce Development and \$2.4 M for Program Operations.

\*\*Other Programs includes: Consumer Assistance, Wavemaker Fellowship, TB Clinic, RI Child Audiology Center, and Ctr for Acute Infectious Disease Epidemiology. Includes some unavailable funding.

### Regulatory Authority

Our SIM leaders understand that one of the key tools that we have to implement our transformation agenda are the regulatory levers that each participating state agency holds. Examples of these levers are OHIC’s rate review responsibilities, and their Affordability Standards regulations. The Department of Health is responsible for licensing hospitals and healthcare providers, and issuing Certificates of Need. Our specific plan for using regulatory levers to meet our transformation goals is included in the Leveraging Regulatory Authority section of this plan. Additionally, all of Rhode Island’s state agencies are in process of reviewing and updating current policies and regulations through the Office of Regulatory Reform (ORR). SIM is engaging these State agencies in conversations around regulations that impact health system transformation and population health within Rhode Island.

### Staffing Roles and Responsibilities

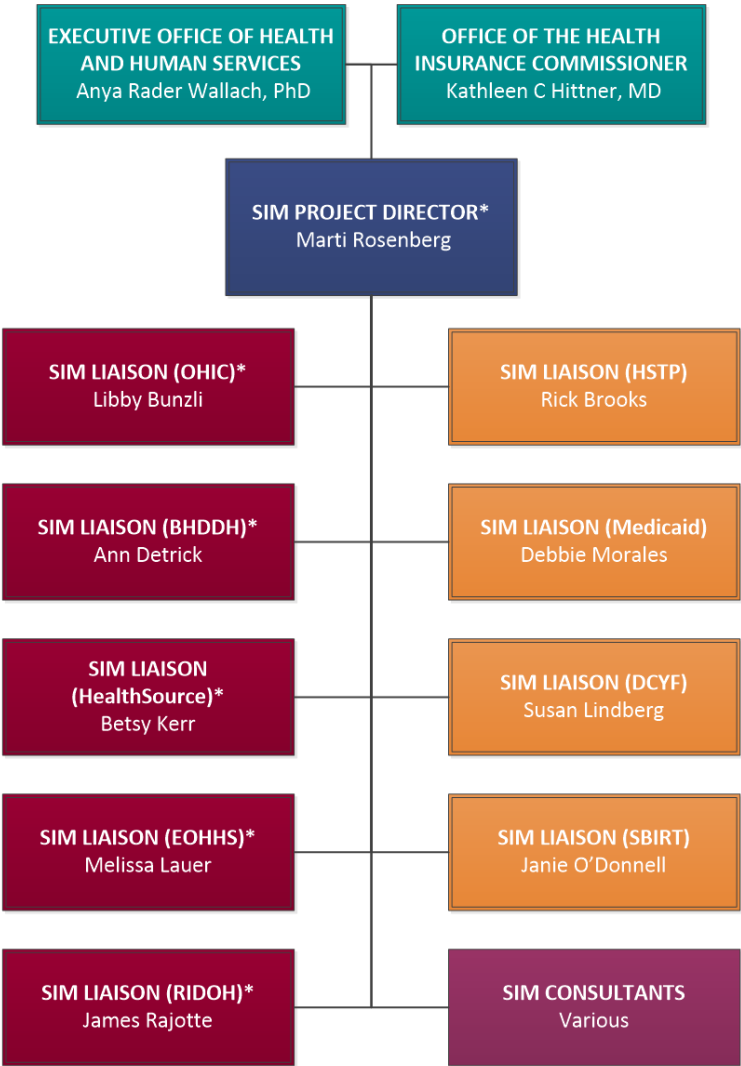
Our SIM teams work together efficiently, with clearly defined responsibilities, managed by Project Director Marti Rosenberg. Each of our SIM-funded staff people were hired with specific job descriptions laying out the work that they would do in their individual departments and thus, the expertise and relationships they bring to the staff and interagency teams. The following chart details how our staff roles and responsibilities are generally divided:

**Table 6: Staffing Roles and Responsibilities**

Agency	Staff Title	Roles and Responsibilities
SIM	SIM Project Director	Oversee the implementation of the SIM grant, managing the staff and interagency teams, and staffing the Steering Committee. Oversee the procurement of the SIM transformation agenda, as well as the vendors hired to carry out the funded activities. Serve as the SIM liaison to the Governor’s office, agency directors, and other state health leaders, and SIM’s federal program officers and technical assistance providers. In this leadership role, guide the Multi-Sector/Multi-Agency alignment approach.
Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH)	SIM Project Manager	Represent BHDDH on Interagency Team. Link behavioral health to physical health change components and serve as BHDDH lead on Integrated Population Health plan. Oversee behavioral health transformation elements, including managing procurement and implementation of projects such as Community Mental Health Center Provider Coaching, Child Psychiatry Access Project, and SBIRT. Carry out tasks as team member on BHDDH’s CCBHC effort which aligns with state’s value-based purchasing goals.
Executive Office of Health and Human Services	HIT Specialist	Represent the HIT division of EOHHS on the Interagency Team. Provide oversight to the implementation of the technology components of our transformation agenda, ensure that technology information and data are available to SIM workgroups to weave in our HIT activities throughout all transformation work. Assist with sustainability strategies to ensure the continuance of HIT investments beyond SIM funding.
Rhode Island Department of Health	Chief Health Program Evaluator	Represents RIDOH at, and assists SIM in leading the SIM Interagency Team. Oversees the creation and implementation of the State Health Improvement Plan, ensuring alignment with the physical and behavioral health components of our transformation agenda. Participates in the management and implementation of our Community Health Team, State Evaluation, SBIRT Training and Resource Center procurements. Provides oversight of strategic partnerships, grant writing, assists with overall SIM project management, and is a backup for the SIM Project Director, as applicable. This position also provides coordination and alignment with over an estimated 20 programs internally at RIDOH.
HealthSource RI	Value-Based Purchasing Analyst	Represent HealthSource RI on the Interagency Team. Work with commercial carriers, Medicaid, and others to help guide the design of insurance plans, both QHP and Medicaid Managed Care, in support of value-based care and our transformation agenda. Also, lead HealthSource RI in reviewing and analyzing plan filings, and support the exchanges implementation of approved plans. Advise EOHHS efforts to develop models for value based purchasing in Medicaid.

Agency	Staff Title	Roles and Responsibilities
Office of the Health Insurance Commissioner	Principal Policy Associate	Represent OHIC on the Interagency Team. Provide subject matter expertise and technical assistance to the SIM team on value-based purchasing, alternative payments models, and the regulatory activity needed to achieve our transformation goals. Provide technical expertise on practice transformation for health system reforms, including how our funded activities and uses of regulatory levers will help us reach our overall system change goals.

**Figure 6.1: SIM Staffing Chart**



*\*Asterisk denotes SIM-Funded Staff*

# Stakeholder Engagement

## Rhode Island's Approach

Rhode Island has always valued the inclusion of public and private stakeholders in efforts to transform our health care system. Our SIM Test Grant proposal was built on the intensive stakeholder engagement that was a hallmark of the State Health Innovation Plan creation that led to the SIM Model Design process. Expanding on the Healthy Rhode Island Stakeholder Work Group of 150 participants, SIM has extended its reach to over 300 stakeholders representing state government, payers, hospitals, physicians, long-term-care and behavioral health providers, community organizations, employers, and patient advocates.

The goals and objectives of the SIM effort can only be attained through continuing a robust and inclusive process that engages our stakeholders. Rhode Island is relying on its experience in facilitating meaningful stakeholder engagement and the participation of an expansive and representative group of participants to meet the challenges of health system transformation. Under the Rhode Island SIM Test Grant, Rhode Island is continuing in that tradition and implementing this grant in an open and transparent manner. Rhode Island is pursuing the implementation with active collaboration within state government and in explicit partnership with external public and private sector entities.

The success of Rhode Island's SIM Test Grant rests on our ability to implement three foundational changes in state government: improved internal alignment, explicit external partnerships, and effective use of information technology. To achieve these changes and meet the objectives of the grant, Rhode Island must have engaged key stakeholders representing state government, community organizations, payers, and providers.

## Description of Stakeholders

SIM identifies our stakeholders in three working groups:

- SIM Core Staff Team;
- SIM Interagency Team; and
- SIM Steering Committee.

### **SIM Core Staff Team**

The Core Staff Team meets weekly and is comprised of staff from the Executive Office of Health and Human Services, the Department of Health, HealthSource RI, the Department of Behavioral Health, Developmental Disabilities, and Hospitals, Medicaid, and the Office of the Health Insurance Commissioner. SIM project director Marti Rosenberg is responsible for communicating with the Center for Medicare and Medicaid Innovation (CMMI) and organizing the goals and deliverables of the SIM State Interagency Team, including development of project materials.

### **SIM State Working Group & SIM Interagency Team**

At the beginning of the SIM grant, Rhode Island had a multi-agency team identified as the SIM State Working Group that met on a weekly basis, comprised of staff from EOHHS and OHIC. The team was responsible for the implementation of the SIM Grant with the original charge to:

- Pursue the goals related to improved coordination of regulatory, fiscal, and policy levers;
- Work with other entities to ensure state efforts on data collection, reporting, and analyses are integrated and not duplicative; and
- Lead the transformation of state health and human services agencies, operating in a well-coordinated, cost-effective, transparent environment that is focused on the people of Rhode Island and the improvement of the state’s health care system.

In May 2015, the Working Group expanded to include core staff members and additional agency leads to create the SIM Interagency Team. The Team continues to evolve and expand, including additional staff member participation from the following state departments: Behavioral Health, Developmental Disabilities, and Hospitals, Children Youth, and Families; Executive Office of Health and Human Services; Health; HealthSource RI, Medicaid, Department of Corrections, and the Office of the Health Insurance Commissioner. Meeting weekly, the team is responsible for the strategic implementation of the project, including organizing SIM goals and deliverables, and tracking metrics. It is led by Marti Rosenberg.

### **SIM Steering Committee**

The SIM Steering Committee is the public/private governing body for Rhode Island’s SIM project. Members fall into five categories: medical providers and systems, commercial payers and purchasers, professional associations, consumer advocacy organizations, and state government leaders.

The Steering Committee is charged with setting the strategic direction and policy goals. While regulatory promulgation and procurement issues will continue to rest with the state government, the Steering Committee exercises leadership discretion over the implementation of the SIM grant. The current Steering Committee is comprised of several members of the original Healthy Rhode Island Steering Committee (convened during the SIM Model Design process) who were actively engaged in the development of the SIM Grant.

The official members of the Steering Committee are the organizations, and each organization has identified an individual to provide guidance and subject matter expertise to the committee. This person is expected to participate for the full four-year grant period – and if he or she is unavailable for a meeting, is expected to ensure that an organizational representative attends in their absence. Each stakeholder may also be asked to participate in a workgroup to be established as required by the Steering Committee (See Table [G2](#)). Each stakeholder organization is also expected to facilitate the transformation of the health care system and the work of the Steering Committee as it relates to their organizations and the community at large. They are also expected to assure coordination between their organization and the Steering Committee.

The Steering Committee meets monthly (excluding a summer hiatus). All meetings are subject to the state’s statutory open meeting requirements, through the Secretary of State’s website. Steering Committee agendas, minutes, and supporting documents are also posted on the EOHHS Rhode Island website. Members of the public are welcome and are given the opportunity to provide comment at every meeting.

[Table G3](#) provides a full list of Steering Committee member organizations, their representatives on the Committee, their workgroup participation, and rationale for being involved.

### **Steering Committee Leadership Transition**

SIM Steering Committee experienced a change in leadership in the summer of 2016, with Committee Chair Lou Giancola stepping down from his position after years with the project. This transition provided an opportunity to bring in new leadership and vision to the Committee with the appointment of Andrea Galgay as Chair and Larry Warner as Vice Chair of the SIM Steering Committee.

Chair Andrea Galgay is Director of ACO Development for Rhode Island Primary Care Physicians Corporation, a 350-member, statewide multi-specialty physicians Independent Practice Association. Vice Chair Larry Warner is the Healthy Lives Strategic Initiative Officer at the Rhode Island Foundation—one of the nation's oldest and largest community foundations, and the largest funder of Rhode Island's nonprofit sector.

### **Steering Committee Expansion**

The transition in leadership provided an opportunity for the SIM Project director to reach out individually to Steering Committee member organizations to assess their interest and desire to continue to participate. This also provided an opportunity to evaluate any gaps in representation at the table. As a result, all but one member recommitted, three organizations replaced existing members with someone new, and seven new members accepted our invitation to join the Steering Committee.

New Steering Committee member organizations included additional community clinicians, consumer advocates, higher education, and housing:

- Brenda Clement - HousingWorks RI;
- Mary Dwyer, RN – Rhode Island State Nurses Association;
- Dean Gary Liguori - University of Rhode Island College of Health Sciences;
- James McNulty - Mental Health Consumer Advocates of Rhode Island;
- Kathy Sullivan – Rhode Island Student Assistance Services;
- Tara Townsend - Rhode Island Parent Information Network; and
- Caroline Troise, MD.

There Steering Committee Members replaced their organizational representatives:

- Katherine Dallow, Blue Cross & Blue Shield of Rhode Island;
- Julie Lange – Rhode Island Health Center Association;
- Kim O'Connell - South County Health; and
- Tilak Verma, MD – Tufts Health Plan.

Most Steering Committee member representatives participated in a formal orientation that provided an in depth overview the project.

## SIM Outreach and Engagement

### Outreach and Engagement Strategic Plan

One of SIM's top priorities is to engage current stakeholders and potential partners in our work, paying close attention to how we communicate with each of these entities. The SIM outreach, engagement and communications strategic plan has two main components: Healthcare Reform Messaging and Coordination, and Priority Stakeholder Engagement and Outreach.

Given the ever-changing political climate, SIM recognized the need to have a consistent message regarding healthcare reform, and for that message to be aligned with other health-focused state agencies. Engaging communication directors at the Executive Office of Health and Human Services (EOHHS), SIM began this alignment work through sharing existing SIM initiatives and learning more about how health system transformation is being described and talked about across state agencies. Furthering the spirit of collaboration, SIM staff members have begun to participate in the monthly Health Communications meetings with communication directors from each EOHHS agency and is spearheading an initiative to further engage the Governor's office and other non-health state agencies in message alignment.

To maximize SIM's relationships and reach within the state it was essential to develop a strategy for identifying potential stakeholders, determining the rationale for engaging them, how and when to engage them, and how to ensure that we are maintaining and strengthening existing relationships. SIM staff identified three priorities for stakeholder engagement and outreach:

- Strengthening and maximizing engagement with agencies with whom SIM is already working with;
- Focus on spreading the word throughout the state about SIM investments, including but not limited to the Provider Directory, Community Health Teams, Child Psychiatry Access Project, and end of life planning; and
- Foster new relationships that are not health specific but influence health system transformation such as Rhode Island Department of Education, Rhode Island Department of Transportation Authority, Department of Labor and Training, and the Children's Cabinet.

### SIM Slide Deck

A significant amount of SIM's outreach involves presenting to and engaging community groups. The SIM team developed a comprehensive presentation that condenses the Operational Plan, Integrated Population Health Plan, and the achievements of SIM to date into a twenty to thirty-minute presentation that can be presented by any member of the core staff team. The slide deck highlights the history of SIM in Rhode Island; the inter-agency, inter-disciplinary, and public-private make up Rhode Island SIM stakeholders; how SIM defines health; SIM's strategy for achieving health system transformation; where SIM is investment in system change or population health improvements; and how to become involved in SIM work. The slide deck has been used for community presentations, and shared with Steering Committee members who were encouraged to distribute and use it within their own organizations.

Increasing community and strategic partner awareness of SIM is a key part of our Operational Plan goals. Since the development of the SIM slide deck, SIM staff members have given over 32 presentations between September 2016 and April 2017. The deck is available [here](#) and a full list of presentations can be found [here](#). We have also turned the deck into a Fact Sheet, found [here](#). Outreach has included presentations about SIM to other



groups as well as including community stakeholders to share their work and engage in concrete discussions on where our work interests and action steps.

### **Workgroups**

The Steering Committee has commissioned four of our own Workgroups to provide subject-matter expertise, community input, and recommendations for action. The Steering Committee may request the establishment of more workgroups as necessary. As described throughout this plan, current workgroups include:

- **Integrated Population Health** – providing subject-matter expertise and strategic oversight of the creation of Rhode Island’s Integrated Population Health Plan and alignment of measures across the physical, behavioral, and overall health care continuum.
- **Measure Alignment** – providing subject matter expertise for the creation of Rhode Island’s aligned measure set and governance for the measure set, responsible for an annual review and updates to the set.
- **Patient Engagement** – assisting with an inventory of current patient engagement activities taking place in Rhode Island and providing recommendations for filling patient engagement gaps.
- **Technology Reporting** – providing subject matter expertise on the creation and implementation of Rhode Island’s Healthcare Feedback System and potentially other IT-related SIM projects.

### **Strategic Partnerships**

SIM has been aligning the strong momentum that is building around system transformation in Rhode Island. Through our strategic partnerships, we completed the following activities between September 2016 and April 2017:

- Provided a health systems innovation and action planning session at the Rhode Island Health Equity Summit
- Testified at the Rhode Island Senate’s Commission on Health Literacy to provide SIM’s perspective on the topic and how it aligns to health system transformation
- Met with the Governor’s Food Insecurity Coordinator to ensure our work is complementary and that related health issues are well-represented in our state’s first ever Food Strategy Plan to be released in May 2017.
- Participated in the rollout of the “Rhode Island Sexual Health Profile,” a collaboration between the Rhode Island Department of Health and the Rhode Island Department of Education on a publication that describes the current landscape of sexual health among adolescents in Rhode Island. It also provides recommendations for future public health policymaking.
- Assisted in convening six small Workforce Development work sessions and two larger Workgroup meetings in concert with the state’s Health System Transformation Project; and
- Diversified the SIM Steering Committee (noted above).

### **Agency and Partner Communications**

A significant part of the SIM Outreach and Engagement Strategy is to strengthen lines of communication and proactively share SIM work with community and state partners. To achieve this, SIM has engaged communications leadership at the EOHHS and participates in EOHHS’s

monthly meeting with communication leads from each of the State's health agencies. Additionally, SIM has highlighted a different activity or initiative each month in RIDOH's monthly Health Connections newsletter which is distributed to all healthcare providers in the state. To ensure that all SIM partners have access to the most recent information available, a significant amount of time and effort has been put into building and maintaining the SIM website and associated materials. The website serves as a landing page for partners to find meeting announcements and minutes, the Operational and Integrated Population Health Plans, procurement updates, and other relevant information. Strong and consistent communication is key to keeping our stakeholders engaged and successfully implementing healthcare system change in Rhode Island.

### **Community Group Engagement**

To strengthen our stakeholder engagement and prevent duplication of efforts, SIM participates with the Community Health Teams group organized by the Care Transformation Collaborative Rhode Island. CYC has generously invited SIM to be a regular part of their agendas and allow us to consult with the experts sitting around their tables. Additionally, SIM has been invited to participate in the Commission for Health Advocacy and Equity, a group of policy-makers from various state entities. This group may be an extension for overarching alignment, vetting of new regulatory lever ideas, and integration activities.

### **Strategies for Maintaining Stakeholder Commitment**

The Rhode Island SIM Test Grant is committed to the public/private partnership that is the hallmark of our structure and process. While it may be possible for state government to work alone to transform our health care system by amending statutes and imposing new regulations on payers and providers, the participation of stakeholders is fundamental to achieving a coordinated transformation, ensuring community consensus and achieving our goals of supporting better patient care, improving population health, and reducing the cost of health care. Community organizations bring a clear understanding of the risks and benefits, barriers and drivers, and overall impact of a transformed health care system on their constituents. Payers bring a wealth of information about the implications of a transformed payment system on the insurance market and the health care system. The participation of providers, both hospitals and physician groups, is needed to share an assessment of the work they have already begun in developing alternative payment models, and the impact of these changes on Rhode Island's healthcare workforce.

What makes the Rhode Island SIM Test Grant unique among SIM-recipient states is the extent to which our public/private partnership has decision-making authority over the entire grant spending priorities. Though EOHHS is responsible for coordinating the organization, finance, and delivery of services and supports provided through state agencies, the steering committee is the driving force behind Rhode Island SIM Test Grant activities including defining stakeholder outputs and deliverables. This level of engagement from the private sector in implementing a federal grant is new and notable. These private sector organizations are in true partnership with the state, determining how Rhode Island SIM Test Grant funds will have an impact on the overall health system of Rhode Island—not just helping in an advisory capacity. The Steering Committee assisted in the hiring of our SIM Project Director and, as the law allows, helped with the strategic thinking behind the procurement of our transformation activities.

The dual role of the Steering Committee chair is an integral component of our method for stakeholder engagement. The Chairperson is also an active participant of the SIM Interagency

Planning team, attending weekly meetings and monthly planning sessions with the EOHHS Secretary and the Health Insurance Commissioner. This dual role provides a direct communication link between the two groups and ensures stakeholder input into all SIM Test Grant activities. Andrea Galgay, Director of ACO Development at Rhode Island Primary Care Physicians Corporation, has served as Steering Committee Chair since August 2017. Her energy and input has been integral to ensuring open communication between the two groups and helping to develop the state's system transformation implementation. And before Ms. Galgay, Lou Giancola began the SIM project with the same energetic leadership.

SIM Project Director Marti Rosenberg works with partner agencies to lead and coordinate the accomplishment of grant deliverables. Key functions of this position related to stakeholder engagement include:

- Supporting and facilitating Steering Committee operations;
- Coordinating the development and preparation of all materials to support the deliberations of the Steering Committee;
- Presentation of subject matter information and data to Steering Committee;
- Convening and coordinating the work of the SIM Interagency Planning Team; and
- Establishing and maintaining relationships within partner state agencies, with community stakeholders, and workgroups to successfully accomplish project objectives.

Besides the organizations officially on the Steering Committee, SIM works with several critical partners that have been engaged in transformative work for many years. These include the Rhode Island Quality Institute (the state's Regional Health Information Organization), Healthcentric Advisors (the state's quality improvement organization), and the Care Transformation Collaborative of Rhode Island (a patient-centered medical home initiative), as well as other organizations. Due to their clear commitment and their past, present, and future efforts to transform health care, they are actively engaged in SIM implementation as members of Workgroups, but because it was recognized early on that they were likely to be contractors at some point in the process, they were not officially appointed to the Steering Committee.

Similarly, SIM engages with other stakeholders who are not official Steering Committee members, such as leaders of community action agencies, advocacy groups, and other interested parties. Much of the outreach at this level is conducted through Steering Committee workgroups as identified in Table [G2](#) and by the presentations in the community that we have described above.

Rhode Island has a strong history of community-based engagement in our healthcare system. SIM's structure, process, goals, and planned strategies all flow from that history and commitment to the idea that it will take all of us working together to create the healthcare system that will improve population health, improve healthcare, and hold down costs.

# Rhode Island SIM Health Assessment Report

## Overview

The SIM Test Grant from the Centers for Medicare and Medicaid Services is unique, focusing equally on system transformation—moving state healthcare systems from volume to value-based—and population health improvement. We know that the cost of healthcare, including behavioral healthcare, is growing at an unsustainable rate in Rhode Island and across the United States. While the United States spends a higher amount on healthcare when compared to other developed countries, we have lower life expectancy than others. For every dollar the United States spends on healthcare, we spend approximately 55 cents on the social services within our health system. This is approximately a quarter of what other developed countries spend on social services, many of which have better overall life expectancy. Smarter spending and improved health are a focus of our health system transformation efforts such as SIM in Rhode Island. To this end, SIM and our partners are working to institutionalize a population health improvement model within the Rhode Island’s healthcare delivery system. Rhode Island’s health leaders are taking advantage of SIM’s dual emphasis to maximize changes in our health system and improvements in our residents’ health in eight specific health focus areas.

**Figure 7: SIM Health Focus Areas**



The first part of our work on population health assessed and documented the needs in Rhode Island and our priorities for change related to the eight health focus areas. Originally called the “Integrated Population Health Plan” and developed as part of our first version of the SIM Operational Plan, the document was an exploration of our health focus areas, leveraging background research, and an initial draft work plan for improvement activities. Our original [document](#) (which starts on page 101) has since been extracted and updated from the SIM Operational Plan, becoming a stand-alone, living document that will be updated to reflect new information that becomes available as the additional parts of our plan are developed and capture the evolving health needs of Rhode Islanders. This stand-alone document is a comprehensive [Health Assessment Report](#) of our eight health focus areas. This link is to the latest draft of the document, which is still in production. We will update you with the final version when it is complete, close to June 30, 2016.

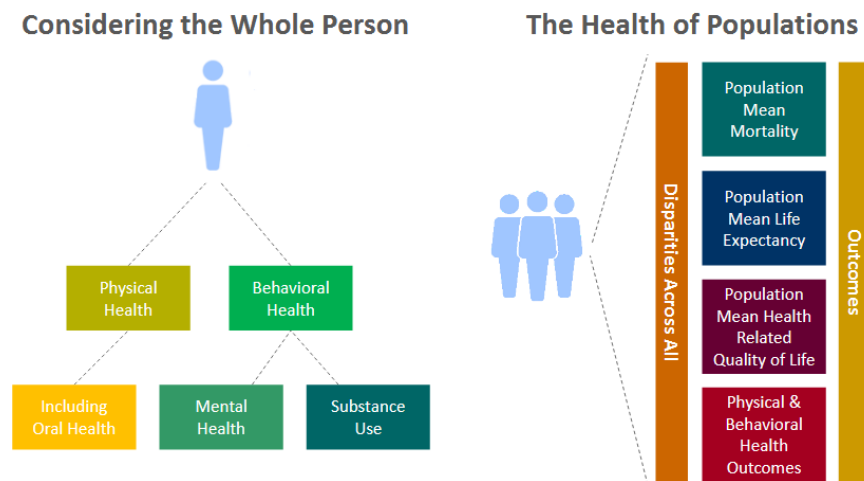
### State Health Improvement Plan

Moving forward, as we continue to develop other parts of our population health plan, it will be published separately and referred to as the “Rhode Island State Health Improvement Plan,” serving as a centralized source document for statewide population health planning. This approach to our plan in Rhode Island is ideal because the plan can be updated in one central

location and then be referenced, as needed, for multiple needs across State and local agencies. Establishing this process for population health planning further strengthens Rhode Island’s culture of collaboration and enhances the State’s ability to have cross-sector impacts on population health. Additionally, this plan will satisfy the Community Health Assessment and Health Improvement Plan requirements established by the Public Health Accreditation Board and as components of Rhode Island’s legislatively mandated State Health Plan.

As we have created the State Health Improvement Plan, we have affirmed our definition of population health. The Plan views health from the perspective of the “whole-person,” including a focus on both the mind and the body. In Rhode Island, the term “population health” includes both physical and behavioral health; the term “physical health” includes oral health, and the term “behavioral health” includes both mental health and substance use. Health is considered a resource for everyday life and is created where we live, learn, work, and play. Many factors impede an individual’s ability to achieve optimal health, including inadequate access to quality healthcare. In our population health planning efforts, we feel it is imperative to consider all the determinants of health affecting Rhode Islanders.

**Figure 8: Rhode Island Definition of Population Health**



### Achieving the Triple Aim

In order for Rhode Island to achieve our Triple Aim goals, our healthcare, public health, behavioral health, social service, academic, and community development sectors must work together and collaborate. Only with this collaboration will we be able to ensure that all Rhode Islanders can reach their highest health potential, regardless of who they are or where they live. To remove the systemic and structural barriers within the healthcare delivery system that can inhibit population health improvement, the State decided that a multi-sector and multi-agency approach is needed to help Rhode Island transition from an uncoordinated, provider- and payer-centric care environment into a well-coordinated, integrated, equitable, and patient-centered health system.

In this new framework, our vision is that our public health, behavioral health, social service, and healthcare delivery systems are not only efficiently coordinating integrated care, these systems are also continuously improving the quality of our services, reducing the cost of our care, and focusing on improving our population health outcomes for everyone.

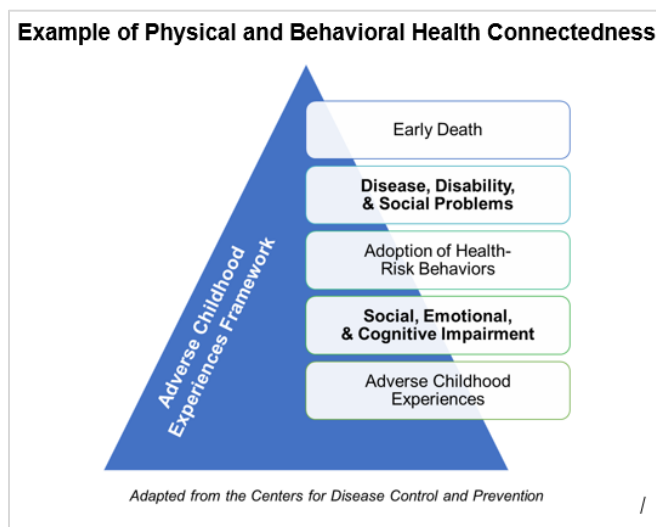
When we first developed the SIM Operational Plan, in April 2016, and reviewed sources for the creation of what was our Integrated Population Health Plan and is now the first iteration of our State Health Improvement Plan, we aligned our eight health focus areas across sectors, geographies, programs, and assessments. We used this work to inform SIM’s population health and system transformation activities. Our Health Assessment Report—the first part of our State Health Improvement Plan—includes a deep dive into each of the eight areas. This will help to inform our population health improvement activities areas by providing data that are reflective of historic trends, existing disparities, co-occurrences and co-morbidities between physical and behavioral health conditions, life course considerations, and, where applicable, attributed costs.

What is most important about our health focus areas is the awareness that the boxes for each focus area are permeable, rather than isolated. Each focus area has an impact on the others, as they co-occur and affect the lives of our Rhode Island families. An integrated healthcare system will recognize these connections and help patients find, access, and maintain the care— physical, behavioral, and oral—that they need. Within the profiles of our eight health focus areas and their co-morbidities in our Health Assessment Report section of our State Health Improvement Plan, we indicate baselines wherever applicable. These baselines may be used within the SIM Test Grant, which is important because we cannot measure change unless we know where we begin.

### **Establishing a Continuum of Integrated, Quality Care**

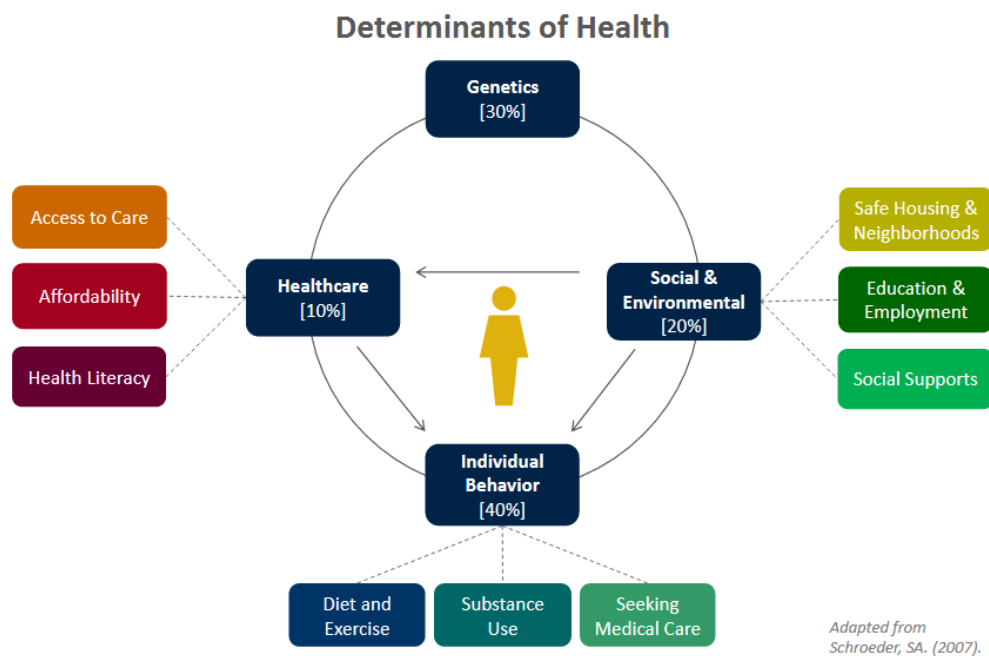
Throughout the development of our State Health Improvement Plan, we have paid special attention to addressing population health across the continuum of care—from prevention through end-of-life care. We aim to reduce disparities while improving outcomes, maximizing early intervention at the earliest stages of life and rehabilitation in the later. An example of the need for this continuum of care and its integration is a framework focused on Adverse Childhood Experiences. Figure 9 shows the significant impact of physical and behavioral health integration, especially when a young person experiences repeated adverse childhood incidences—from social, emotional, or cognitive impairment, to demonstrating health-risk behaviors, to demonstrating health-risk behaviors, and the likely possibility of disease, disability, or early death. This is why we have included Maternal and Child Health as one of our health focus areas.

**Figure 9: Adverse Childhood Experiences**



Our SIM Operational Plan includes the strategies and activities we intend to help change our healthcare delivery system and yield improvements in population health. Too often, however, Rhode Island’s healthcare interventions focus solely on the healthcare delivery system, from which only about 10% of health issues stem. While 30% of health outcomes that stem from genetics, that leaves 60% of our health that is created by the social and environmental determinants of health, such as housing and neighborhood quality, educational opportunities, and social supports, as well as individual health behaviors greatly influenced by these determinants (for example, diet and exercise, healthcare utilization, and substance use). Therefore, SIM is going beyond the health system transformation conversations to link these reform efforts to how we think about the world around us and Rhode Island’s commitment health equity by addressing and investing in the social and environmental determinants.

**Figure 10: Determinants of Health**



## An Emphasis on Collective Impact

SIM has invested time and resources in the State Health Improvement Plan because of our overall approach to improving population health. Our Theory of Change states that population health improvements will only happen when we share responsibility for and collectively engage in:

- Reforming the healthcare delivery system;
- Addressing the social and environmental determinants of health; and
- Creating change within a culture of collaboration and integration.

For this reason, our State Health Improvement Plan began as a requirement of our SIM Operational Plan and has since become a living document. In the context of improving population health, we, both SIM and other stakeholders, are actively knitting together:

- Healthcare reforms that move us from a volume- to value-based system of quality care;
- A focus on health equity, addressing the social and environmental determinants of health; and
- A culture of collaboration, alignment, and integration, serving as a common framework for collective action that is creating strong new bonds between State departments, among the State, and with our community partners.

### **Driving Forces**

We know we face crucial healthcare challenges in Rhode Island. The opioid epidemic and fentanyl-laced street drugs are creating an overdose crisis that is killing Rhode Islanders and straining the resources of our behavioral health system, frontline healthcare facilities, and first responders. Our fragmented children’s behavioral health system is not able to adequately cope with the rise in toxic stress and adverse childhood experiences that Rhode Island’s children are facing. And the benefits that Rhode Island has experienced from the Affordable Care Act—leading to a historic low in our rate of people without access to insurance—is at risk from changes to the law in Washington, D.C.

Because the problems we face are so complex, we have designed SIM to be multi-layered in its approach to creating a health system and as a catalyst for establishing a coordinated population health planning process in Rhode Island. Because health happens in the community more than just in the doctor’s office, our SIM Steering Committee is a broad, diverse group of stakeholders with decision-making power over SIM investments. Improving population health demands a connection between the clinical and community settings, therefore SIM is focusing on investments such as Community Health Teams, Screening, Brief Intervention, and Referral to Treatment services, the PediPRN Child Psychiatry Access Project, and initiatives such as our Integration and Alignment Projects as key activities for creating improvements. And because health challenges affect people differently, with more pronounced negative outcomes depending on race, ethnicity, income, and zip code, we will ensure that our State Health Improvement Plan and our SIM projects work to reduce disparities and propose policies that specifically take the need for reduction into account.

### **A Common Framework for Health Improvement**

Rhode Island SIM’s State Health Improvement Plan is a step toward the development of our Statewide Integrated Population Health Framework. The framework started with RIDOH’s efforts to improve population health, but through SIM is expanding to and representing more of state government. RIDOH began by setting three leading priorities to improve population health:

- I. Address the social and environmental determinants of health in Rhode Island;
- II. Eliminate disparities of health in Rhode Island and promote health equity; and
- III. Ensure access to quality health services for Rhode Islanders, including our vulnerable populations.



With help from SIM, several additional State agencies contributed to the formalization of a total of five strategies, with 23 integrated population health goals. While all agencies do not have explicit roles within each goal, the entire array of goals, represents the breadth of interagency efforts across entities to improve health. Our five strategies for improving population health are:

1. Promote health living for everyone through all stages of life;
2. Ensure access to safe food, water, and healthy environments in all communities;
3. Promote a comprehensive health system that a person can navigate, access, and afford;
4. Prevent, investigate, control, and eliminate health hazards and emergent threats; and
5. Analyze and communicate data to improve the public's health.

Within each of these five strategies, we have established integrated population health goals. The goals most related to the efforts of our SIM Test Grant are noted below. Click [here](#) for a full list of the State's integrated population health goals.

- Reduce obesity in children, teens, and adults;
- Reduce chronic illnesses, such as diabetes, heart disease, asthma, and cancer;
- Promote the health of mothers and their children;
- Promote behavioral health and wellness among all Rhode Islanders;
- Reduce the incidence of substance use disorders;
- Support Rhode Islanders in ongoing recovery and rehabilitation for all aspects of health;
- Reduce environmental toxic substances, such as tobacco and lead;
- Improve access to care including physical health, oral health, and behavioral health systems;
- Expand models of care delivery and healthcare payment focused on improved outcomes\*
- Build a well-trained, culturally-competent, and diverse health system workforce to meet Rhode Island's needs;
- Increase patients' and caregivers' engagement within care systems;
- Reduce substance use disorders;
- Minimize exposure to traumatic experiences, such as bullying, violence, and neglect;
- Encourage Health Information Technology adoption among RI healthcare providers as a means for data collection and quality improvement;
- Enhance and develop public health data systems to support public health surveillance and action;
- Develop and implement standards for data collection to improve data reliability and usability; and
- Improve health literacy among Rhode Island residents.

We will further develop key metrics to measure the State's progress towards achieving these goals as a part of our SIM efforts. Since our SIM Operational Plan has assembled key metrics as part of our Driver Diagram to track our progress towards within SIM, many of these may be aligned as key metrics within the State's integrated population health framework. Our SIM Interagency Team and SIM Steering Committee use these metrics to monitor the SIM investments to ensure that we are on track. It is important to recognize that these statewide integrated population health goals do not supersede any State agency-specific strategic plans or activities, but simply provide a broader umbrella under which activities representative of Rhode

Island's commitment to collaboration on improving population health can be brought together. For example, some of SIM's activities, such as healthcare workforce transformation, health information technology development, and our Integration and Alignment Projects are examples of efforts within this umbrella that will help us continue to knit our work together.

## Future Directions

Rhode Island's SIM Test Grant has given us critical resources to begin this work, but they are limited and ultimately, they will end. Through our sustainability efforts, we expect this to be the beginning of a long-term commitment by the State's leadership to continue this connection between research, planning, and action for improving population health. Given this approach, we plan to:

- Continue to **explore the data** about our population health and over time, add health focus areas will inform us about the challenges ahead.
- Delve more deeply into **population health questions** for better planning: From a life-course perspective (how do health challenges change from birth to death), from an intervention lens (how best can we intervene along the continuum of care to create change), and from a co-occurrence and co-morbidity approach (how often do health challenges appear with each other and how are they affected by each other).
- Design our value-based purchasing and other healthcare reforms to have a **positive impact on Rhode Island's population health**.
- Develop and monitor a comprehensive set of **health improvement activities** that are implemented to reach our integrated population health goals.

Throughout this process, we look forward to maximizing our collaboration with the broadest group of Rhode Islanders, getting feedback, challenges, and assistance. We welcome everyone to join and participate in our Integrated Population Health Workgroup. We are excited about this opportunity to formalize a process for integrated and coordinated population health planning and look forward to sharing more information as it becomes available.

# Healthcare Delivery System and Payment Transformation Plan with Detailed SIM Work Plans

Traditional state functions for advancing policy consist of the state as convener, purchaser, regulator, infrastructure funder, and evaluator.<sup>1</sup> Rhode Island's State Innovation Model (SIM) Test Grant is structured such that its footprint marks each of these domains of state action and, at a high level, SIM acts as a collaborative space, or hub, for interagency policy alignment and coordination as well as a public/private partnership with its Steering Committee and other stakeholders. Rhode Island is committed to transform the local healthcare system through the coordinated use of regulatory and purchasing levers, direct investment in workforce and health information technology infrastructure, and public-private collaboration.

## Baseline and Vision

Rhode Island's current healthcare system is not built to achieve the socially desirable results of improved physical and behavioral health for the state's residents, nor is the system financially sustainable. Rhode Island's current healthcare system relies on fee-for-service reimbursement, which rewards volume generation and promotes fragmentation of care, resulting in duplication of lab and imaging services, unnecessary hospitalizations and emergency department visits, and unmet patient needs. There remain important gaps in health information technology, data infrastructure, and support for Rhode Island's healthcare workforce as well.

Through the assistance of a State Innovation Model Design grant in 2013, and the development of the Rhode Island SIM Test Grant proposal in 2014, Rhode Island's healthcare stakeholders, public and private, have asked what resources, policy initiatives, and market rules are necessary to transform the local healthcare system to meet the goals of the Triple Aim.

As noted above, Rhode Island's SIM Test Grant is built on the premise that transitioning to healthcare payment models that reward value, as opposed to volume, and incentivize providers to work together, is a necessary step toward building a sustainable healthcare delivery system that:

1. Promotes high quality, patient-centered care that is organized around the needs and goals of each patient;
2. Drives the efficient use of resources by providing coordinated and appropriate care in the right setting; and
3. Supports a vibrant economy and healthy local communities by addressing the physical and behavioral health needs of residents, including an awareness of the social determinants of health.

Changing financial incentives is necessary, but not sufficient, for building a healthcare system that meets our vision. Rhode Island's SIM Test Grant coordinates state agency purchasing and regulatory initiatives along with private sector efforts to promote value-based payment and integrated delivery system structures, such as accountable care organizations (ACOs), which support population health management. At the same time, the Rhode Island's SIM deploys

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<sup>1</sup> Recommendations Regarding State Action to Promote and Regulate Accountable Care Organizations (ACOs). A Legislative Report Required by Section 6(n) of the Rhode Island Health Care Reform Act of 2013 RIGL 42-14.5-3.

direct investments in system transformation, encompassing support for Rhode Island’s healthcare workforce and health information technology infrastructure.

Rhode Island views payment reform as a necessary ingredient toward building integrated delivery models, such as accountable care organizations (ACOs), which can manage population health, provide high quality services, and reduce cost. We envision ACOs as relying on a foundation of patient-centered medical homes (PCMHs) which have links to the community through community health teams (CHTs). In order for providers to form partnerships and work in an integrated way, the prevailing payment models which incent and reward integration must achieve critical mass across all payers. While payment reform is already underway in Rhode Island, below we articulate an innovative regulatory approach that will spur greater uptake of value-based payment in Rhode Island, ultimately shaping the pace and content of system transformation. Our hypothesis is that payment reform will drive the continuing development of existing ACOs, incent continuing practice transformation in primary care, and change the economic dynamics of our healthcare system. To facilitate this transformation, we will use SIM dollars to make investments in infrastructure and untested, but promising, models of care delivery.

Robust primary care infrastructure represents necessary groundwork for system transformation and successful implementation of payment models that reorient provider financial incentives toward value. At the outset of the SIM project, Rhode Island had a strong base of transformed primary care practices to build on. In 2015 about 55 percent of primary care network clinicians (including Nurse Practitioners and Physician Assistants) were based in practices that had achieved NCQA Level 3 accreditation or were on the path toward achieving NCQA Level 3 accreditation. Two long-standing initiatives have prepared this groundwork for system transformation and payment reform. The first is Rhode Island’s multi-payer patient-centered medical home (PCMH) initiative, Care Transformation Collaborative of Rhode Island (CTC), which includes 72 practice sites. The second was a concurrent PMCH initiative through Blue Cross Blue Shield of Rhode Island. Additional opportunities are also emerging to support practices through transformation, including CPC+, the Transforming Clinical Practices Initiative (TCPI), and ACO sponsored activities.

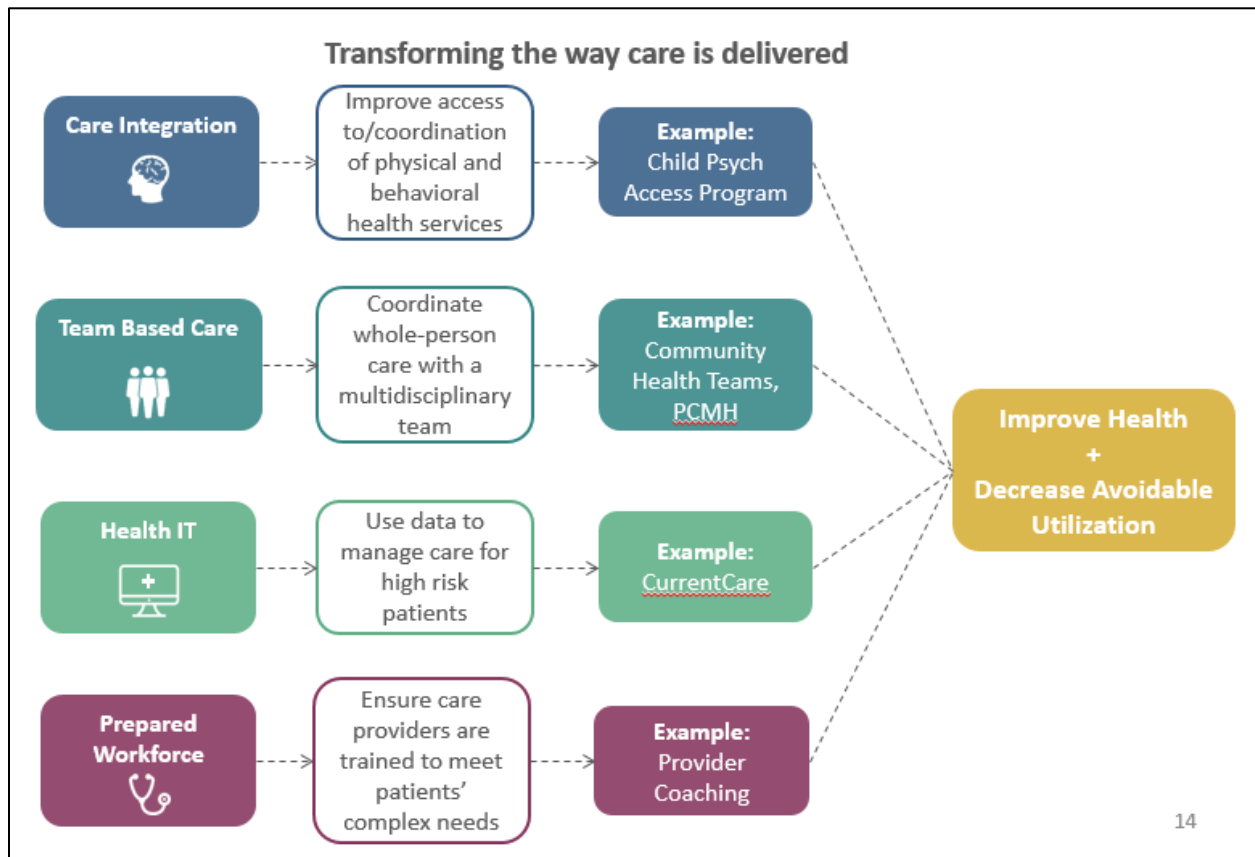
## The Rhode Island Approach to Transformation

The Rhode Island approach to healthcare system transformation is statewide, and SIM sees itself as one part of a larger whole that is composed of existing policy and infrastructure. Conceptually, Rhode Island approaches payment reform and care transformation as two sides of the same coin, where alternative payment models will not be successful unless providers have established clinical processes to maximize access, data tools to monitor performance, and the appropriate team composition to coordinate care. Conversely, providers will not have the capacity to optimize the efficiency and quality of their care if they are bound to fee-for-service payment structures.

Rhode Island is unique in that it is the only state to have a designated *health* insurance regulator, the Office of the Health Insurance Commissioner (OHIC), which has the ability to establish contingencies for commercial payers to abide by as a condition of rate approval. Further, OHIC is statutorily obligated to “view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public

through overall efficiency, improved health care quality, and appropriate access.”<sup>2</sup> To this end, OHIC has promulgated regulations, most notably the Affordability Standards (described more on page 118), intended to encourage wider adoption of alternative payment methodologies, or those that reward value over volume, and to increase investments in high quality, transformed primary care. Additionally, the state Medicaid program is making investments in VBP through its Accountable Entity initiative, where contracts are being made on a total cost of care basis, and providers are held to standards for care delivery.

**Figure 11: Transforming the Way Care Is Delivered in Rhode Island**



SIM is building on this existing theoretical and policy framework to approach healthcare transformation in a way that is additive and not duplicative, and comprises the following elements:

1. Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing and regulatory levers. Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an Alternative Payment Model (APM) by 2018, and 80% of payments linked to value<sup>3</sup> with a regulatory strategy to achieve these goals.

<sup>2</sup> R.I. Gen. Laws § 42-14.5-2 (emphasis added).

<sup>3</sup> Rhode Island will track payments linked to value by crediting the total dollar value of provider contracts with performance-based incentives (such as P4P) toward the numerator of the ratio.

2. Support for multi-payer payment reform and delivery system transformation with investments in workforce and health information technology.
3. Significant stakeholder engagement in policy development and SIM investment decisions through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups. In Rhode Island, healthcare delivery system transformation is a public-private partnership.
4. Fidelity to our State Health Improvement Plan to ensure that transformation is aligned with our vision of improved physical and behavioral health for the state's residents.
5. A Multi-Sector/Multi-Agency Approach. One of the main strategies of Rhode Island's SIM project is to pursue a new level of integration and alignment of our existing healthcare innovation initiatives with each other, and with new SIM-funded activities. This will allow us to build on current achievements, expand the reach of these initiatives, avoid duplication of funding, and, we expect, save money.

The transformation activities executed and planned within each of these four elements are discussed below.

### **1: Value-Based Payment Using Purchasing and Regulation**

Coordinated and aligned approaches to expanding multi-payer value-based payment models (Medicaid and commercial insurance) through state purchasing and regulatory levers.

Current initiatives through the Centers for Medicare and Medicaid Services (CMS) and the Health Care Payment Learning and Action Network (LAN) emphasize the importance of reaching a “**critical mass**” of payers engaged in payment reform to ensure that the attendant financial incentives of value-based payments are strong enough to support system transformation.<sup>4</sup> Rhode Island has derived great benefit from the Alternative Payment Model Framework developed by the LAN and published in January 2016. In what follows, the terms *value-based payment* (VBP) and *alternative payment models* (APM) are consistent with APM Framework categories 2 – 4 (VBP broadly) and 3 – 4 (APM), respectively.

At the outset of the SIM project, uptake of VBP and APMs was uneven across the local Rhode Island healthcare market. Commercial insurers and their provider networks had the longest experience contracting under VBP and APMs. In 2014, 24% of commercial insured medical payments were made under an APM, largely comprised of fee for service payments made under population-based APMs with shared savings. These contracts were generally no more than two years old. Moreover, all commercial insurers with a minimum of 10,000 covered lives were required by the Office of the Health Insurance Commissioner to have quality improvement programs with hospitals, and to tie at least 50% of annual hospital price increases to quality, which are subject to an overall inflation cap. Commercial insurers also had pay for performance contracts in place with most of their primary care networks.

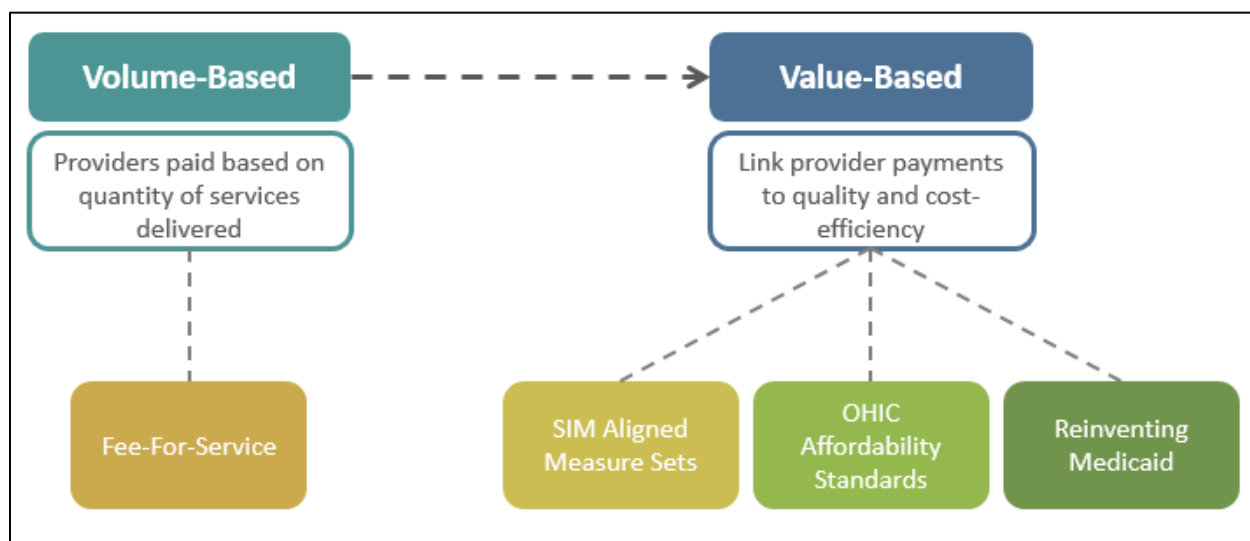
By July 15, 2016, Rhode Island provided updated data on the penetration of APMs in the commercial market and baseline data on uptake of VPB models, the latter of which was projected to touch 50% of medical spending. VBP models and APMs were in an early stage of development in the Medicaid market and baseline data became available in the summer of 2016, as shown below. Quality measures used for value-based contracting were not aligned across major payers, thus creating demands among provider organizations to align quality measures as

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<sup>4</sup> Rajkumar R, Conway P, Tavenner M. CMS – Engaging Multiple Payers in Payment Reform. JAMA. 2014; 311(19): 1967-1968.

a means to facilitate implementation of innovative payment models and ease administrative burden.

**Figure 12: SIM’s Volume to Value-Based Healthcare Strategy**



### **Award Year 1 (Pre-Implementation)**

To accelerate payment reform, and coordinate action across all payers, the Office of the Health Insurance Commissioner (OHIC) and Medicaid stewarded two closely aligned processes to advance VBP and APMs in their respective market jurisdictions. OHIC and Medicaid have explicitly aligned payment reform targets with those announced in January 2015 by then Secretary of Health and Human Services Sylvia Mathews Burwell,<sup>5</sup> later adopted by the LAN, and those articulated in the SIM Round Two Test Grant Funding Opportunity Announcement. As a core component of its model test, Rhode Island intends is driving achievement of the CMS/LAN goals at the state level using significant regulatory levers at Medicaid and OHIC.

In Award Year 1 the SIM Project Director coordinated meetings between OHIC and Medicaid to ensure alignment of these initiatives. The SIM project has initiated an unprecedented level of interagency coordination and alignment in Rhode Island. The use of state regulatory and purchasing levers to achieve the state’s payment reform targets are discussed in turn.

### **Commercial Insurance Regulation**

#### Payment Reform

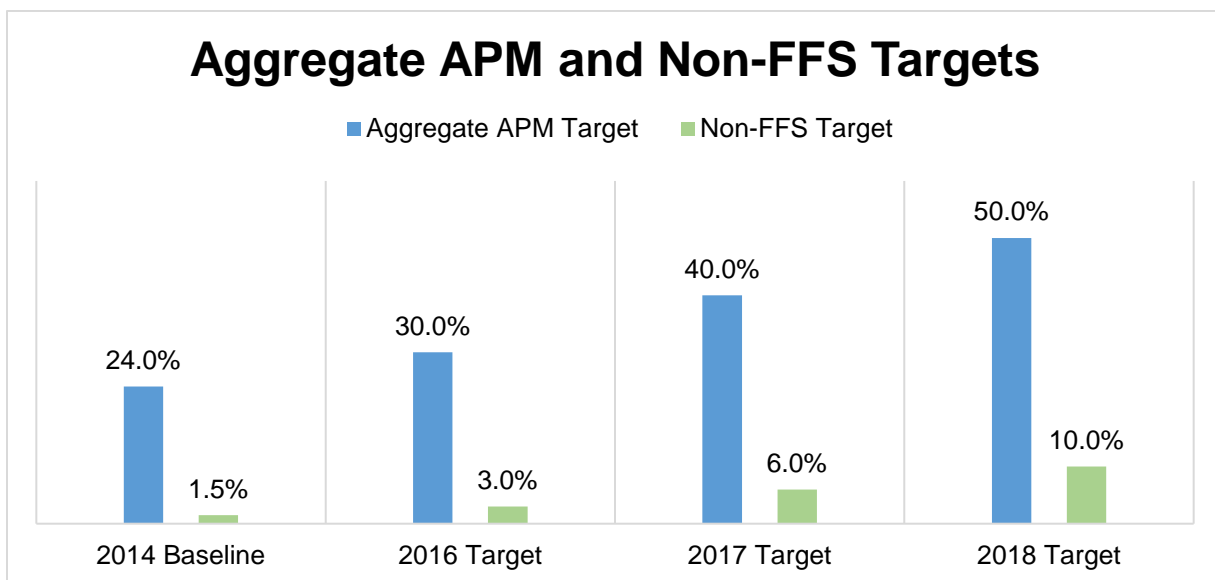
In February 2015, the beginning of the Rhode Island grant period, OHIC promulgated regulations that required commercial insurers to “significantly reduce the use of fee-for-service payment as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-

<sup>5</sup> U.S. Department of Health and Human Services. (2015). *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value* [Press Release]. Retrieved from <http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>

service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.”<sup>6</sup> To carry out this provision OHIC convened an Alternative Payment Methodology Advisory Committee, which held two rounds of meetings, in the spring and fall. The key objectives of the meetings were to define APMs, collect data from health plans to measure the baseline rate of APM uptake, and to develop **binding annual regulatory targets** for commercial insurer use of APMs through 2018. The outcome of the OHIC process was the promulgation of regulatory targets for commercial insurers based on percent of insured medical spending that is made under an APM according to the following schedule:

	2014 Baseline	2016 Target	2017 Target	2018 Target
APM Target	24.0%	30.0%	40.0%	50.0%
Non-FFS Target	1.5%	3.0%	6.0%	10.0%

**Figure 13: Rhode Island Commercial Payment Reform Targets**



In consultation with stakeholders, OHIC developed the following specific definition of APMs:

*“Alternative Payment Methodology means a payment methodology structured such that provider economic incentives, rather than focus on volume of services provided, focus upon:*

- *Improving quality of care;*
- *Improving population health;*
- *Reducing cost of care growth;*
- *Improving patient experience and engagement, and*
- *Improving access to care.*

*To qualify as an APM, the payment methodologies must define and evaluate cost performance relative to a “budget” that may be prospectively paid or retrospectively reconciled. Providers*

<sup>6</sup> OHIC Regulation 2 Section 10(d)(2)



are rewarded for managing costs below the budget (should quality performance be acceptable), by retaining some or all of the savings. Providers may also be responsible for some or all of the costs that exceed the budget.

While generally not employing the aforementioned budget methodology, pay-for-performance payments and supplemental payments for patient-centered medical home functions paid to PCPs or to ACOs will be included in the calculation of an insurer's APM target for calendar years 2016 and 2017.

Health plans shall also receive credit for pay-for-performance payments and supplemental payments to specialists intended to provide incentives to improve communications and coordination among PCPs and specialists.

Approved Alternative Payment Methodologies include:

- Total cost of care budget models;
- Limited scope of service budget models;
- Episode-based (bundled) payments;
- Infrastructure payments and pay-for-performance payments for 2016-2017, and
- Other non-fee-for-service payments that meet the definition above as approved by OHIC.”

The targets promulgated by OHIC, and presented in Figure 13 above, are defined as follows:

- (1) “Alternative Payment Methodology Target” means the aggregate use of APMs as a percentage of an insurer’s annual commercial insured medical spend. The APM Target shall include:
  - All fee-for-service payments under a population-based total cost of care contract with shared savings or shared risk;
  - Episode-based (bundled) payments; primary care, specialty care or other limited scope-of-service capitation payments, and global capitation payments;
  - Supplemental payments for infrastructure development and/or Care Manager services to patient-centered medical homes, specialist practices, and accountable care organizations, and all pay-for-performance payments for 2017, and
  - Shared savings distributions.
- (2) “Non-Fee-for-Service (FFS) Target” means the use of strictly non-fee-for-service alternative payment methodology payments as a percentage of an insurer’s annual commercial insured medical spend. The Non-FFS target defined in this subsection (2) is a subset of the APM Target defined in subsection (1), above. The Non-FFS Target shall include:
  - Episode-based (bundled) payments, either prospectively paid or retrospectively reconciled, with a risk component;
  - Limited scope-of-service capitation payments and global capitation payments;
  - Quality payments that are associated with a non-fee-for-service payment (e.g., a quality payment on top of a bundled payment or PCP capitation);
  - Shared savings distributions, and

- *All supplemental payments for infrastructure development and/ or Care Manager services to patient-centered medical homes, specialist practices, and accountable care organizations, for 2017.*

We know that it is important to determine the impact of APMs on the entire market, including the self-insured market. While OHIC's jurisdiction spans fully insured plans only, and regulatory targets for use of APMs are established on the basis of fully insured medical spend, it is reasonable to expect that the use of APMs measured on the basis of self-insured medical spend will track closely with fully insured due to insurers' use of single contracts with providers that do not differentiate members by funding status. Baseline data on APM use in the commercial market in 2014 found that the percentage of medical payments made under an APM was roughly the same when evaluated over self-insured spend and fully insured spend. Therefore, we expect the effects of commercial insurance regulation with respect to health care payment models to have a spill-over effect on self-insured medical spend.

### Care Transformation

As noted earlier, robust primary care infrastructure represents necessary groundwork for system transformation and successful implementation of payment models that reorient provider financial incentives toward value. Thus, care transformation is also a crucial piece driving the healthcare system toward a critical mass of value-based payment. Commercial insurers are required by OHIC to expand the percentage of their primary care networks that are functioning as patient-centered medical homes. OHIC aims to have 80% of insurer network primary care clinicians practicing in a PCMH by 2019. Working with its Care Transformation Advisory Committee, OHIC has adopted a more rigorous definition of PCMH and a payment model geared toward sustaining transformed practices.

Beginning in 2017, commercial insurers will have to meet targets for percentage of primary care clinicians practicing in a PCMH based on the following definition of PCMH:

- *Practice is participating in or has completed a formal transformation initiative (e.g., CTC-RI, PCMH-Kids, RIQI'S TCPI, or a payer- or ACO-sponsored program) or practice has obtained NCQA Level 3 recognition. Practice meeting this requirement through achievement of NCQA Level 3 recognition may do so independent of participating in a formal transformation initiative.*
- *Practice has implemented the following specific cost-management strategies:*
  - *Develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future;*
  - *Practice uses data to implement care management, focusing on high-risk patients and interventions that will impact ED and inpatient utilization;*
  - *Implements strategies to improve access to and coordination with behavioral health services;*
  - *Expands access to services both during and after office hours;*
  - *Develops service referral protocols informed by cost and quality data provided by payers; and*
  - *Develops/maintains and avoidable ED use reduction strategy.*
- *Practice has demonstrated meaningful performance improvement on a set of clinical quality measures that are derived from the SIM aligned measure set. The measures for PCMHs are given as follows:*

- The measures for internal medicine and family practices are:
  - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (<8.0%);
  - Controlling High Blood Pressure;
  - Tobacco Use: Screening and Cessation Intervention;
  - Adult Body Mass Index Assessment;
  - Screening for Clinical Depression and Follow-Up Plan.
  
- The measures for pediatric practices are:
  - Body Mass Index Assessment for Children/Adolescents;
  - Counseling for Nutrition and Physical Activity for Children/Adolescents;
  - Counseling for Physical Activity for Children/Adolescents;
  - Developmental Screening.

Performance improvement requirements on the PCMH measures vary by year, and are given as follows:

- a. For 2017 recognition:
  - i. Internal medicine and family practices: Improve by 3 percentage points on 2 of 3 of the following measures: diabetes HbA1c control, blood pressure control and tobacco use assessment and counseling measures relative to performance one *or* two years prior or achieve the national 66<sup>th</sup> percentile benchmark (or a RI benchmark if a national benchmark is not available).
  - ii. Pediatric practices: Improve by 3 percentage points on 2 of the 4 measures relative to performance one *or* two years prior or achieve the national 66<sup>th</sup> percentile benchmark (or a RI benchmark if a national benchmark is not available).
  
- b. For 2018 recognition:
  - i. Internal medicine and family practices: Improve by 3 percentage points on 3 of the 5 HbA1c, blood pressure control and tobacco use assessment and counseling measures relative to performance one *or* two years prior or achieve the national 66<sup>th</sup> percentile benchmark (or a RI benchmark if a national benchmark is not available).

#### *Pediatric Practices*

Improve by 3 percentage points on 2 of the 4 measures relative to performance one *or* two years prior or achieve the national 66<sup>th</sup> percentile benchmark (or a RI benchmark if a national benchmark is not available).

In 2017, practices that meet the three components of the OHIC PCMH definition will be counted toward achievement of the insurers' PCMH targets. We intend, with CMMI approval, to report data on five clinical quality measures currently being reported by PCMHs in the state. While this approach does not provide a statewide number, it does represent clinical quality performance for patients who receive their care in PCMHs, which are an important component of Rhode Island's delivery system transformation strategy.

Once a practice has completed a formal transformation initiative and achieved NCQA Level 3 accreditation, and demonstrates annual implementation of cost containment strategies and

performance improvement, the practice will be entitled to an ongoing care management payment and an opportunity to earn a performance bonus. The levels of payment will be negotiated between the practice and the health plans, but the Commissioner has articulated to the health plans that the payment must be meaningful.

As noted above, the Care Transformation Collaborative of Rhode Island, launched in 2008 and jointly overseen by OHIC and EOHHS, brings together key health care stakeholders to promote care for patients with chronic illnesses through the patient-centered medical home (PCMH) model. CTC began with five pilot sites in 2008 and has grown to 550 providers in 81 practice sites, with pediatric sites added in 2016 (72 original sites plus 9 pediatric sites). CTC is expanding in the summer of 2017 and is currently conducting outreach to encourage adult and pediatric practices to apply. Currently, over 330,000 Rhode Islanders receive their care from practices participating in PCMH system reforms. The PCMH program is sustained through a multi-payer effort in the form of a per member per month contribution from the carriers based on attributed membership.

Rhode Island has also been selected as one of 14 geographic areas throughout the U.S. that will be participating in CPC+, as three out of four commercial payers and Medicaid fee-for-service applied. Currently, 31 Rhode Island practices are participating in the advanced payment model. Payers and stakeholders are making diligent efforts to align with SIM and with existing initiatives such as CTC and TCPI.

Because of the strength of our current practice transformation work, our SIM project decided to fund the smaller CTC-led Integrated Behavioral Health (IBH) program referenced above, with 58,000 participants. The SIM funds being used to pilot this IBH program will help us identify if there is a return on investment. If a ROI is realized, CTC, along with interested state agencies and the SIM team will work with the insurers to invest some of the savings into expanding the program to additional sites. OHIC and EOHHS will continue to identify potential regulatory levers to incent such an expansion.

### Enforcement

To implement and enforce the commercial payment reform targets, OHIC leverages its statutory authority and prior approval rate review process. Two of OHIC's statutory purposes grant the Office a clear directive to improve the healthcare system as a whole:

- Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
- View the health care system as a comprehensive entity and encourage and direct health insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access. (R.I.G.L 42-14.5-2).

Furthermore, the Health Insurance Commissioner possesses authority to consider whether an insurer has implemented effective delivery system and payment reform strategies in the context of the annual rate approval process. Operationally, OHIC's regulatory levers facilitate collective action across commercial payers to invest in delivery system transformation and implement payment reform to improve the system as a whole and to make health insurance more affordable.

### State Medicaid Reforms

Rhode Island's Medicaid program contracts with two Managed Care Organizations (MCOs) for most beneficiaries and services. In 2015, Medicaid, as regulator and purchaser, embarked on a lengthy public process to transform the state's Medicaid program and drive transformation of the healthcare system as a whole. This process resulted in several key reforms, including a Medicaid Accountable Entities (AE) Coordinated Care Pilot Program. Under the Coordinated Care Pilot Program, pilot AEs enter into contractual arrangements with Medicaid MCOs to manage a population of Medicaid members under a risk adjusted total cost of care arrangement. The Coordinated Care Pilot offered two tracks:

- **Type 1 Coordinated Care Pilot: Total Population, All Services:** This track offered an opportunity to contract for all Medicaid attributed populations, for all Medicaid services.
- **Type 2 Coordinated Care Pilot: All Services to Populations of Persons with Severe and Persistent Mental Illness (SPMI)/Severe Mental Illness (SMI):** This track offered an opportunity to contract for a specialized Medicaid population, for all Medicaid services. Type 2 pilots were only established for persons with SPMI or SMI.

AEs are expected to develop and prove competency in two priority areas: 1. Integration and coordination of long-term services and supports; 2. Physical and behavioral health integration. Experience from the Coordinated Care Pilot Program will inform certification standards for Medicaid AEs. AE certification is discussed under Years 2-4: Implementation, below.

Medicaid also developed incentive payment programs for hospitals and nursing homes under the Rhode Island Health Transformation Program (RIHTP).

Medicaid has adopted language developed by OHIC which defines APMs and specifies the types of payment models which shall be credited toward each insurer's APM targets. They have developed certification standards for Medicaid AEs. Medicaid MCOs are expected to contract with AEs on a total cost of care basis for attributed populations, according to specific annual targets specified in the MCO's contract with the state.

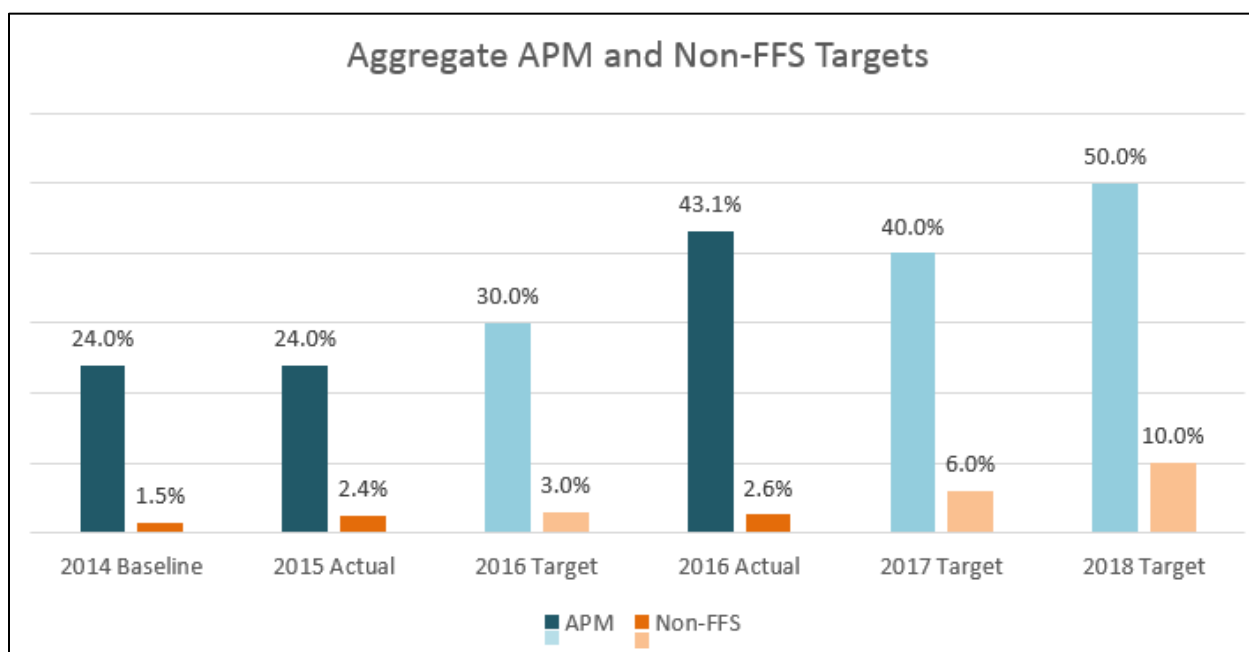
Rhode Island does not prioritize one APM over another. However, given the focus of using healthcare payment to improve overall efficiency, clinical quality, and support whole person care, and to meet an ultimate target of 50% of medical payments by 2018, total cost of care budget models will invariably play a crucial role.

### **Award Year 2**

#### APM Implementation

In January of 2017, OHIC reviewed insurer data submissions detailing the distribution of medical dollars under existing payment models relative to the total medical spend. Payment percentages made under APM and non-fee-for-service arrangements are aggregated across payers, as shown in Figure 14, to show 2016 performance relative to its target; payers exceeded the APM target by a collective 13.1%, while falling behind the non-fee-for-service target by 0.4%.

**Figure 14: Rhode Island Commercial Payment Reform Performance and Targets**



In the second quarter of 2016, OHIC implemented the provisions of the 2016-17 Care Transformation and Alternative Payment Methodology (APM) Plans. In the implementation work, OHIC reviewed insurer primary care network files to assess the penetration of PCMH and ACO delivery models, and operationalized OHIC's three-part definition of PCMH by rolling out self-attestation surveys for primary care practices to report to OHIC on implementation of cost management strategies and clinical quality performance data.

In October 2016, OHIC compiled numerators and denominators for these metrics from existing PCMHs to establish baseline performance data, with the intention to track the data annually and compare practices to their baselines. Performance on quality measures varied widely by the number of years the practice had participated in transformation. As more practices begin to transform, the coverage of these metrics will expand.

In the fall of 2016, OHIC convened the Care Transformation and APM Advisory Committees to develop 2017-18 Care Transformation and APM Plans, which contain key definitions and annual targets that set payers up for achieving the long term APM and PCMH targets set forth in the Affordability Standards. Both plans were approved by Health Insurance Commissioner Kathleen C Hittner on January 27<sup>th</sup>, 2017.

The 2017-18 Care Transformation Plan includes OHIC's 3-part definition of PCMH, which establishes cost management and performance improvement requirements in addition to NCQA recognition. The Plan also establishes three work groups that have been meeting since January of 2017. The Small Practice Engagement Work Group is tasked with creating an outreach strategy to engage small practices in transformation, and using collective knowledge and experiences to create a prioritized list of practices that are likely to participate in transformation. The High-Risk Patient Identification Work Group is researching best practices and evidence based approaches to practice based assessment of risk, with attention on how to incorporate social determinants of health. Lastly, a Primary Care APM Work Group will be exploring clinical

processes that are possible under a non-fee-for-service driven model. This work will begin once the group has finished designing a primary care APM.

The 2017-18 APM Plan introduces a downside risk requirement with unique targets for physician-based versus hospital-based ACOs, in addition to APM and non-fee-for-service targets. Additionally, the Plan establishes two work streams that will support the plans in attaining their targets. The APM Advisory Committee has been meeting since February of 2017 to explore various mechanisms for implementing bundled payments for commonly defined episodes within total cost of care contracts, particularly to facilitate achievement of the non-fee-for-service target. Once this policy conversation is finished, work groups will be established to define up to three episodes and parameters for bundled payments. The Primary Care APM Work Group has been convening since January of 2017 to design a primary care APM and parameters for adoption in that can be used in payer-provider contracts.

OHIC will continue to implement the 2017-18 Care Transformation and APM Plans, and will analyze financial data and primary care network files submitted by each commercial payer in July to assess achievement of the targets.

### **Links to APM Documents**

The following are links to additional resources pertaining to APMs:

- [2016-2017 OHIC APM Plan](#);
- [Background of APM Planning](#), with additional information;
- [2016-2017 Care Transformation Plan](#) and;
- [Background of Care Transformation Planning](#), with additional information.

### **Award Years 3-4 (Implementation)**

Rhode Island is poised to significantly advance the use of multi-payer VBP and APMs through the implementation period of the SIM grant. AEs must demonstrate the capacity to integrate and manage the full continuum of physical and behavioral healthcare, from preventive services to hospital based and long-term services and supports. AEs must also focus on the social determinants of health among their attributed populations. The AE contracting mechanism will be one of the primary means for Medicaid to achieve 50% of payments under an APM by 2018. Managed care procurement, contracting, and Accountable Entity accreditation are three crucial purchasing and regulatory levers that will drive achievement of Rhode Island's payment reform targets.

OHIC will track commercial insurer compliance with their annual APM targets on a semi-annual basis. In addition to semi-annual reporting of APM use, OHIC will require each insurer to develop plans for engagement of specialists in VBP arrangements, including the development of APMs for high volume specialties and specialty care practices. These requirements build on extant rules that obligated insurers to have quality improvement programs with hospitals and tie hospital fee increases to quality performance.

In September of each year, OHIC will administer a survey to primary care practices to assess achievement of the PCMH cost containment strategies. OHIC will also collect data on clinical quality performance measures. These elements will be combined to produce a list of practices sites and associated clinician rosters who have met the OHIC definition of PCMH.

OHIC will assess compliance with commercial insurer payment reform targets, care transformation requirements, and hospital contracting requirements in the context of the annual rate review process in 2017, 2018, and 2019. The Commissioner may consider each insurer's efforts to meet the delivery system and payment reform targets as a factor in her decision to approve, modify, or reject any regulatory filing. OHIC will publish public reports on insurer compliance with the annual APM and PCMH targets.

### **Continued Engagement of Payers and Providers**

Rhode Island is advancing the work of payment reform in a coordinated way. The goal of achieving critical mass for payment reform across Medicare, Medicaid, and commercial insurance is a necessary condition for transforming the healthcare system as a whole. As noted above, Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an APM by 2018, and 80% of payments linked to value.

While we had planned to carry out a Learning Collaborative on VBP implementation, we determined that it would be duplicative of the significant stakeholder engagement that OHIC organizes throughout its workgroup processes. SIM is available to help OHIC with its stakeholder work, and OHIC reports that many SIM participants have begun to attend OHIC meetings, especially around the High-Risk planning.

Additionally, the Rhode Island State Employees Health Plan, which covers about 44,000 members, is an important lever toward our APM goals. The state health plan is currently administered by UnitedHealthcare and it participates in UnitedHealthcare's ACO shared savings program. To the extent a state employee is cared for by a practice in one of our three ACOs (Coastal Medicine, Lifespan, or the Rhode Island Primary Care Physicians Corporation), they are considered to be participating in the corresponding ACO program. As of March 31, 2016, 76% of State of Rhode Island members are attributed to an ACO or another population based program (such as the PCMHs through CTC).

### **Exploring Alignment with Medicare's Quality Payment Program**

On April 27<sup>th</sup>, CMS released proposed rules implementing the Quality Payment Program (QPP). The QPP implements key provisions of the Medicare Access and CHIP Reauthorization Act (MACRA). To ensure that Rhode Island understands the implications of QPP and to explore the alignment of existing SIM initiatives with QPP, Rhode Island is also embedding these discussions in existing stakeholder processes like the Alternative Payment Methodology Advisory Committee, and ensuring that our care transformation initiatives are preparing practices for meeting QPP delivery and reporting requirements. **We aim to leverage our SIM investments and regulatory and purchasing initiatives to prepare providers in Rhode Island for the QPP.** We will collaborate with Healthcentric Advisors, which received an award from CMS to be the New England QPP Support Center.

### **Tracking System Transformation**

In order to track the progress of system transformation, Rhode Island has committed to tracking and publishing information on the use of APMs and VBPs across payers and provider participation in PCMHs and ACOs. The following table shows the key metrics for tracking the progress of system transformation.



**Table 7: Key Metrics for Tracking Progress of System Transformation**

Metric Title	Data Source	Reporting Frequency	Definition
Payments made under alternative payment models (Commercial Insurers) - APM Categories 3 + 4	OHIC	Annual	Percentage of fully insured commercial medical payments made under an alternative payment model (APM)
Members attributed to total cost of care alternative payment models (Commercial Insurers) - APM Categories 3 + 4	OHIC	Annual	Percent of plan members attributed to a population-based contract with total cost of care accountability.
Payments made under Value-based payment models (Commercial Insurers) - APM Categories 2 +3 + 4	OHIC	Annual	Percentage of fully insured medical payments tied to value
Payments made under alternative payment models (Medicaid MCOs) - APM Categories 3 + 4	EOHHS	Annual	Percentage of Medicaid MCO medical payments made under and APM
Members attributed to total cost of care alternative payment models (Medicaid MCOs) - APM Categories 3 + 4	EOHHS	Annual	Percent of plan members attributed to a population-based contract with total cost of care accountability.
Use of Value-based payment models (Medicaid MCOs) - APM Categories 2 +3 + 4	EOHHS	Annual	Percentage of Medicaid MCO medical payments tied to value
PCPs participating in ACOs	OHIC	Annual	% of network PCPs participating in ACOs and who are attributed patients for whom they are assuming clinical and financial accountability
PCPs practicing in PCMHs	OHIC	Annual	% of network PCPs practicing in PCMHs
Commercial members attributed to PCMHs	OHIC	Annual	% of commercial insured members attributed to a PCMH
Medicaid members attributed to PCMHs	EOHHS	Annual	% of Medicaid MCO members attributed to a PCMH

**2: Multi-Payer Reform Using Workforce Development and HIT**

SIM is supporting multi-payer payment reform and delivery system transformation with investments health information technology and significant workforce planning.

Despite significant investments in healthcare system transformation from payers, providers, community non-profits, and the state, as well as preliminary steps to transition toward value-based payment models that support that transformation, there are still meaningful gaps in health information technology, data analytics, and workforce supports to achieve the Rhode Island vision outlined above.

**Award Year 1 - Pre-Implementation**

During year one of the grant, the SIM Project Director met with each member of the SIM Steering Committee, to ascertain where the greatest needs in our healthcare system were, and

how SIM investments could best address those needs. The question of how Rhode Island was to allocate SIM funds presented a choice between going “narrow and deep” or “wide and thin.” Through a lengthy and iterative process of consensus building, the SIM Steering Committee endorsed three interconnected buckets of SIM program investment:

- Investment in Rhode Island’s Healthcare Workforce – Practice Transformation;
- Investment in Patient Engagement; and
- Investment in Increasing Data Capability and Expertise.

The investments within each of these buckets address a critical need, which will facilitate payment reform and delivery system transformation.

Supporting healthcare providers at all levels with practice transformation activities is critical to building a sustainable healthcare system that meets patient needs and pursues improved population health as its outcome. Rhode Island has a mature multi-payer patient-centered medical home (PCMH) program and a strong commitment to support primary care. Given that primary care providers have assumed greater accountability for improving system performance and population health, the investments in the practice transformation bucket are intended to provide support for drawing linkages between patient care and community resources (Community Health Teams (Linked to SBIRT) & the SBIRT Training Center), access to expertise outside of the primary care office (through the Child Psychiatry Access Program), PCMH Kids and Integrated Behavioral Health, Care Management Dashboards for Community Mental Health Centers (CMHCs), provider coaching for CMHCs, and a technology platform for collecting clinical data and reporting measures to payers. All of these activities are meant to ensure that providers can work to the top of their licenses and experience more job satisfaction. SIM has convened several workgroups in this area in order to further define these areas of practice transformation and to ensure that SIM-funded resources are coordinated and not duplicative of private sector resources.

There was broad agreement among the SIM Steering Committee that patient behavior was a critical piece of the overall project. In discussions about our Driver Diagram, certain assumptions about patient behavior undergirded the causal pathways from interventions and drivers to program aims. Patients must become active agents in their health and healthcare. To support patient agency, the SIM Patient Engagement Workgroup began holding meetings in year one to determine the tools and information necessary to meet this goal.

Data analytic capacity and expertise is critical to improving and evaluating healthcare system performance. The SIM Steering Committee authorized investments in HealthFacts RI (Rhode Island’s all payer claims database), a statewide Common Provider Directory, the development of an EOHHS Data Ecosystem (agile data warehouse), and our SIM Evaluation.

Pre-implementation activities for the above areas of practice transformation, patient engagement, and data analytic capacity and expertise include convening workgroups and stakeholder meetings to ensure proper allocation of resources and community buy-in, working through the state procurement system to buy services as appropriate, and developing metrics to measure success for each of these investments. The procurement of funds for HealthFacts RI and the Common Provider Directory has happened, and the funds began flowing to these projects in year one.

## **Award Year 2**

In year two, Rhode Island worked diligently to scope and procure the services and structures necessary to carry out the activities enumerated in the Wheel (See our [Master Timeline](#)).

### Practice Transformation

In Award Year 2, Rhode Island procured the following practice transformation efforts which are currently in the implementation phase:

- Child Psychiatry Access Program;
- PCMH Kids & Integrated Behavioral Health; and
- CMHC Care Management Dashboards.

Efforts to procure are still ongoing with the remaining three projects. Community Health Team/SBIRT procurement will be complete by June 2017, and the other two are expected to be complete by the end of 2017:

- Community Health Teams and the SBIRT Training and Resource Center;
- CMHC Provider Coaching; and
- Healthcare Quality Measurement Reporting and Feedback System.

**Child Psychiatry Access Program**, operated by the Emma Pendleton Bradley Hospital, began start-up activities in September 2016, and went “live” in mid-December 2016, providing mental health consultation services to pediatric primary care providers.

**PCMH Kids & Integrated Behavioral Health** were awarded to the Care Transformation Collaborative of RI (CTC-RI) through a Single Source procurement process that began in July, 2016. The contract for both programs was effective January 1, 2017.

The **CMHC Care Management Dashboards** have been implemented at two CMHCs and the Medicaid Community Health Team so far, and we have already seen great success that has led to meaningful interventions by Nurse Care Managers. The remaining CMHCs are in the process of entering agreements and supplying patient panel files to RIQI to implement their dashboards. EOHHS has begun convening a set of interested parties at EOHHS and its agencies to design the state-focused dashboard, and will finalize the design in Award Year 3.

### Data Analytic Capacity and Expertise

During Award Year 2, SIM made considerable progress on the data analytic capacity and expertise components of our plan. Rhode Island successfully procured a SIM Evaluator, and also successfully completed the re-procurement of the HealthFacts RI data vendor.

Medicaid received approval for an Implementation Advanced Planning Document (IAPD) from CMS to support the migration and implementation of HealthFacts RI in the State Data Center and the implementation of analytics tools in order to support new Medicaid program needs to evaluate both access to care and the Health System Transformation Project. We have recently received approval for both of these proposals. This IAPD will also support ongoing maintenance and operations of HealthFacts RI when the migration is complete, and ensures continued sustainability. It is important to note that while HealthFacts RI is considered to be a modular component of the Medicaid system in that it is helping to meet specific Medicaid business process and data needs, a data release process exists whereby other state agencies and external

interested parties can request data for a fee. These funds will also continue to support the data system and allows costs to be allocated to those using the system beyond Medicaid.

An internal State Data Ecosystem team has been meeting regularly to work on the design and implementation plan of the State Data Ecosystem based on the assessment of state health and human services data assets and capabilities completed to help support the initial planning. The team has prioritized ensuring that the design for the system leverages existing assets, is MITA compliant, uses agile development methods, and brings in outside expertise as needed. We are in the midst of a deploying a prototype to test some of the software selected to support the project and garner a better understanding of where a vendor may be required to move the project forward. A vendor was also recently contracted to perform an analysis of another data warehouse that exists at the University of Rhode Island, to help the planning team determine what pieces of this warehouse can be leveraged to support the Ecosystem. After this new assessment and prototype are complete this summer, the team will evaluate the results and determine the next steps to achieve the ecosystem goal. The team is planning to submit an IAPD to ensure continued funding and sustainability beyond the SIM support.

The SIM funded work to implement the Provider Directory is coming to an end, with a plan to utilize HITECH IAPD approval to continue to expand functionality and implement the Provider Directory while it transitions to be self-sustaining through use of data extracts.

**Years 3-4 - Implementation**

In years 3-4, Rhode Island plans to apply the following principles to the implementation of these activities:

- Ongoing evaluation, including mid-course adjustments as necessary;
- Flexibility in the design and implementation of these activities to account for potential changes to the health care environment; and
- Continued stakeholder engagement among governmental agencies and private sector participants, including providers, payers, and community organizations.

The charts below provide detailed work plan information about the interventions described in this chapter, as requested.

**Table 8: Practice Transformation Work Plan (Team-Based Care)**

Primary Driver: Maximize & support team-based care					
Milestone/ Measure of Success	Budget Activity	Action Step	Timeline	Cost	Vendor /Lead
Intervention: Create at least two new CHTs; Investigate the need for more formal CHT training and certification program. Provide training to providers (PCPs, CMHCs, and hospitals) to better incorporate CHTs into their practices.					
Procure vendor for the implementation of Community Health Teams (Including SBIRT)	N/A	Contract signed with selected vendor.	Completed by June 31, 2017	\$0	SIM Staff

<b>Primary Driver:</b> Maximize & support team-based care					
<b>Milestone/ Measure of Success</b>	<b>Budget Activity</b>	<b>Action Step</b>	<b>Timeline</b>	<b>Cost</b>	<b>Vendor /Lead</b>
Completion of work to design, develop, and implement the shared CHT/SBIRT project.	Budget activities TBD	Action steps TBD	TBD	\$2,000,000	TBD
Completion of work to design and implement the SBIRT Training Center.	N/A	Contract signed	December, 2016	\$480,000	Rhode Island College School of Social Work

**Table 9: Practice Transformation Work Plan (Behavioral Health Integration)**

<b>Primary Driver:</b> Better integrate behavioral health into primary care investments in Rhode Island's healthcare workforce					
<b>Milestone/ Measure of Success</b>	<b>Budget Activity</b>	<b>Action Step</b>	<b>Timeline</b>	<b>Cost</b>	<b>Vendor</b>
<b>Intervention: Support PCMH expansion to 9 pediatrician sites</b>					
Provide Project Management for the PCMH-Kids program	Staff salaries for project manager and project coordinator	Manage the PCMH-Kids Program	January 1, 2017 to April 30, 2019	\$249,180	CTC-RI
Practice Support Specialists assist PCMH-Kids practices with practice transformation	Staff salaries for practice support specialists	Provide practice support to PCMH-Kids practices	January 1, 2017 to April 30, 2019	\$163,626	CTC-RI
CAHPS pediatric PCMH survey conducted at each practice	CAHPS survey fees	Support CAHPS Administration at PCMH-Kids practices	January 1, 2017 to April 30, 2019	\$68,580	CTC-RI
Evaluate the PCMH-Kids program	Evaluation expenses	Conduct evaluation of PCMH-Kids program	January 1, 2017 to April 30, 2019	\$19,500	CTC-RI
<b>Intervention: Provide child psychiatry consultation services to pediatrician practices. Train PCPs to expand their ability to treat some behavioral health needs in their practices.</b>					
Increase the availability of mental health care for children and adolescents by introducing psychiatric consultation	Recruitment of Bradley Staff positions	Recruited: 1.0 FTE Board Certified Child Psychiatrist .5 FTE LICSW/LMHC .5 FTE Care Coordinator	Dec. 1, 2016 to Jan. 15, 2017	\$650,000 over 3 years	Emma Pendleton Bradley Hospital

<b>Primary Driver:</b> Better integrate behavioral health into primary care investments in Rhode Island's healthcare workforce					
<b>Milestone/ Measure of Success</b>	<b>Budget Activity</b>	<b>Action Step</b>	<b>Timeline</b>	<b>Cost</b>	<b>Vendor</b>
services into the scope of primary care practices					
	Enrollment of Pediatric Primary Care Practitioners/Practices	Recruited: 310 Pediatric Primary Care Providers Recruit 47 Pediatric Primary Care Practices	Dec. 1, 2016 to May 1, 2017  Recruitment process is ongoing.		Emma Pendleton Bradley Hospital
Create a strong primary care/specialist mentoring relationship between pediatric primary care practitioners and child psychiatrists.	Training and Mentoring of Pediatric Primary Care Practitioners/Practices	Training Needs of Primary Care Providers identified.  Mentoring plan created and implemented.  Training opportunities presented.	Nov. 15, 2016 and ongoing  Mar. 1, 2017 to Sept 1, 2017		Emma Pendleton Bradley Hospital
Collect data to track key indicators	Design and implement data reporting process	Process implemented	Mar. 1, 2017 to May 15, 2017		Emma Pendleton Bradley Hospital
<b>Intervention:</b> Support integration of behavioral health into primary care by providing resources and training for SBIRT in PC practices and evaluation/data collection for 12 Integrated Behavioral Health Model practices.					
Pilot primary care practices received practice transformation facilitation to integrate behavioral health	Subject matter expert salaries to support practice transformation facilitation	Provide practice transformation facilitation support to practices to integrate behavioral health	January 1, 2017 to December 31, 2018	\$166,000	CTC
Data at pilot sites is collected.	Data collection activities	Collect data at pilot sites.	January 1, 2017 to December 31, 2018	\$60,000	CTC
Data analyzed for outcomes	Data analysis fees	Conduct analysis of data collected from pilot sites	January 1, 2017 to December 31, 2018	\$144,000	CTC
<b>Intervention:</b> Support CMHCs with practice transformation and to receive data about their patients					
Implementation of Care Management Dashboards at 8 RI CMHCs	Implement a Care Management Dashboard at a CMHC	Execute maintenance contract, import test patient panel file, test patient panel file, provision users, train	Completed by August 31, 2017	\$120,000	RIQI

<b>Primary Driver:</b> Better integrate behavioral health into primary care investments in Rhode Island's healthcare workforce					
<b>Milestone/ Measure of Success</b>	<b>Budget Activity</b>	<b>Action Step</b>	<b>Timeline</b>	<b>Cost</b>	<b>Vendor</b>
		users, import production-ready panel file, go-live.			
Implementation of a Care Management Dashboard at the Medicaid CHT	Implement a Care Management Dashboard at the Medicaid CHT	Execute maintenance contract, import test patient panel file, test patient panel file, provision users, train users, import production-ready panel file, go-live.	Completed on March 22, 2017	\$15,000	RIQI
Implementation of a Care Management Dashboard within Medicaid and/or BHDDH	Implement a Care Management Dashboard at Medicaid and/or BHDDH	Execute maintenance contract, import test patient panel file, test patient panel file, provision users, train users, import production-ready panel file, go-live.	Completed by August 31, 2017	\$15,000	RIQI
Intervention: Assist providers in aggregating data from their Electronic Health Records, to help make reporting and practice transformation easier; provide training to providers in how to interpret the data to make positive changes within their practices; Pursue making this quality data available to patients.					
Procure vendor for the Healthcare Quality Measurement Reporting and Feedback System	N/A	Contract signed with selected vendor.	Completed by August 31, 2017	\$0	SIM Staff
Completion of work to design, develop, and implement the Feedback System	Budget activities TBD	Action steps TBD	TBD	\$1,750,000	TBD

### Patient Engagement

To fully transform our healthcare system, we must engage patients and consumers to be involved in their own care, enabling them to take control of their health. This means they will be active members of their health care team, will actively participate in the creation and implementation of their care plans, and will actively self-manage their chronic conditions and health behaviors. We have identified that one critical gap in patient engagement activities in the state involves patients, families, and caregivers dealing with advanced illness and/or end-of-life care and will devote a portion of our patient engagement activities to supporting those individuals, as described on Page 40 above.

The Patient Engagement Workgroup has convened to define patient/consumer/family engagement, identify the current state and gaps of Rhode Island's engagement activities, and recommend areas for investments to the SIM Steering Committee. This committee work was

carried out during the beginning of Award Year 2, with implementation of accepted recommendations to occur in Award Years 3-4.

**Table 10: Patient Engagement Work Plan**

<b>Primary Driver:</b> Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning.					
<b>Milestone/ Measure of Success</b>	<b>Budget Activity</b>	<b>Action Step</b>	<b>Timeline</b>	<b>Cost</b>	<b>Vendor/ Lead</b>
Intervention: SIM is in the process of procuring Patient Engagement projects. We will provide an update on this procurement with our Annual Report, by September 30, 2017.					
Procure vendor(s) for patient engagement activities	N/A	Contract signed with selected vendor(s).	Aimed to be complete by August 31, 2017	\$0	SIM Staff
Completion of patient engagement activities	Budget activities TBD	Action steps TBD	TBD	\$2,200,000	TBD

Data Analytic Capacity and Expertise

In years 3-4, SIM state staff will continue to implement the four SIM components that are contributing to the increase in data analytic capacity and expertise required to measure and inform our transformation efforts. Two of our activities have expended all allocated SIM funds, but are continuing with alternate funding sources and will continue to be a focus of SIM efforts. These projects are: maintaining and issuing reports and data from HealthFacts RI (the all payer claims database) and completing the build of the provider directory and making its data available to state agencies, healthcare organizations, providers, and consumers in the form of aggregate files and a user-friendly website

The remaining two projects, integrating data across EOHHS agencies in an agile state data ecosystem and driving policy with those data and our SIM Evaluation are continuing along with SIM funding exclusively.

**Table 11: Data Analytic Capacity and Expertise Work Plan**

<b>Primary Driver:</b> Increase use of data to drive quality and policy					
<b>Milestone/ Measure of Success</b>	<b>Budget Activity</b>	<b>Action Step</b>	<b>Timeline</b>	<b>Cost</b>	<b>Vendor/ Lead</b>
Intervention: Maximize the use of HealthFacts RI: Support and maintain the claims data collection process; support advanced reports and analytics; and support the coordination of data validation, release and analysis.					
Transition from SIM funding to approved IAPD funding	N/A	Transition from SIM funding to approved IAPD funding	Beginning May 1, 2017	No cost to SIM	EOHHS



<b>Primary Driver:</b> Increase use of data to drive quality and policy					
<b>Milestone/ Measure of Success</b>	<b>Budget Activity</b>	<b>Action Step</b>	<b>Timeline</b>	<b>Cost</b>	<b>Vendor/ Lead</b>
Provision of Project Management for APCD Implementation	Staffing Support	Facilitate weekly ISW meetings; Act as liaison for data submitters and other state initiatives; strategic planning	Until September 2017 (1-year contract extension expected)	No cost to SIM	Freedman Healthcare
Effective management and support of the Data Release Review Board (DRRB)	Staffing support	Facilitate DRRB per Open Meetings Law; prepare materials and applications for review; train board members	Until September 2017 (1-year contract extension expected)	No cost to SIM	Freedman Healthcare
Data released to applicants	Staffing support	Support production, transmittal, and payment of data release files; Develop strategic marketing plan; tracking of data release requests	Until September 2017 (1-year contract extension expected)	No cost to SIM	Freedman Healthcare
Ability to use data for internal and external data reports	Staffing support	Development and refinement of reporting specifications and measures	Until September 2017 (1-year contract extension expected)	No cost to SIM	Freedman Healthcare
Lockbox including the opt-out portal are operational	Staffing support and service licensing and support	Operate Opt-out portal; Operate MPI process on quarterly data submissions	Ongoing	No cost to SIM	Onpoint Health Data
Data collection and aggregation are operational	Staffing support and service licensing and support	Operate data collection and aggregation process on quarterly data submissions	Ongoing	No cost to SIM	Onpoint Health Data
Value-added analytics components applied	Staffing support	Apply value-added analytics components to aggregated data	Ongoing	No cost to SIM	Onpoint Health Data
Annual Level 3 Data Sets available for release	Staffing support and service licensing and support	Creation of Level 3 Data Sets annuals	Ongoing	No cost to SIM	Onpoint Health Data
Incorporation of Statewide Common Provider Directory Files	Staffing support	Import Common Provider Directory Files	Ongoing	No cost to SIM	Onpoint Health Data
Analytic reports created	Staffing support and service licensing and support	Ad-hoc, planned data analyses completed	Ongoing	No cost to SIM	Onpoint Health Data
Visioning and Design of BI Tool completed	Staffing support and service licensing and support	Work with state staff to vision and design BI tool implementation	TBD	No cost to SIM	Onpoint Health Data

<b>Primary Driver:</b> Increase use of data to drive quality and policy					
<b>Milestone/ Measure of Success</b>	<b>Budget Activity</b>	<b>Action Step</b>	<b>Timeline</b>	<b>Cost</b>	<b>Vendor/ Lead</b>
Data Model developed	Staffing support and service licensing and support	Work with state staff to develop a data model	TBD	No cost to SIM	Onpoint Health Data
BI Tool Mapped	Staffing support and service licensing and support	Work with state staff to map data to the BI tool	TBD	No cost to SIM	Onpoint Health Data
Quality assurance and maintenance completed	Staffing support and service licensing and support	Work with state to perform QA support and maintenance	TBD	No cost to SIM	Onpoint Health Data
Staff trained to use BI tool and provided support as needed	Staffing support and service licensing and support	Work with state staff to train state users and provide support as needed	TBD	No cost to SIM	Onpoint Health Data
<b>Intervention: Complete the Common Provider Directory: Consolidate provider data from multiple sources into a single “source of truth” record; increase the understanding of provider-to-organization relationships; Provide a public portal to search for and locate providers; Provide mastered provider data extract to integrate into state systems.</b>					
Ability to import and export files into and out of the provider directory	Import, test, transform and load provider information into a common provider directory	Import 14 data files into provider directory	Jan. 16, 2016 to July 31, 2017	\$720,000	RIQI
	Develop output files for state agency use	Export 8 data files from provider directory	June 30, 2016 to July 31, 2017		
Support, maintain, and operate provider directory infrastructure	Monthly maintenance cost	Contribute to fixed costs to support, maintain, and operate provider directory software, external database licensing, hardware and software maintenance and upgrades, website user provisioning and support	Jan. 16, 2016 to July 31, 2017	\$220,000	RIQI
Maintain a project plan and establish collaborative state-wide provider directory data management policies	Documented Project Plan	Deliver Project Plan	Completed July 2016	\$15,000	RIQI
	Documented Data Dictionary	Deliver Data Dictionary	Completed July 2016		
	Documented Data Mastering and Survivorship Rules	Deliver Data Mastering and Survivorship Rules	July 2017		

<b>Primary Driver:</b> Increase use of data to drive quality and policy					
<b>Milestone/ Measure of Success</b>	<b>Budget Activity</b>	<b>Action Step</b>	<b>Timeline</b>	<b>Cost</b>	<b>Vendor/ Lead</b>
Develop public facing website with provider lookup functionality	Provider directory website specifications document	Deliver provider directory website specifications document	Completed March 2017	\$135,000	RIQI
	Provider directory website development project plan	Deliver provider directory website development project plan	April 2017		
	Provider directory website prototype	Deliver provider directory website prototype	By December 31, 2016		
	Live, secure, updated provider directory website	Go-Live on provider directory website	By July 31, 2017		
Master Provider Records	Master medical providers	Master 8500 medical providers (MD, DO, PA, NP)	By July 31, 2017	\$409,250	RIQI
	Master behavioral health providers	Master 3600 behavioral health providers	By July 31, 2017		
Continue Provider Directory Development beyond SIM funding	No longer SIM funded	Continue to collaborate with SIM on provider directory development	August 1, 2017 and ongoing.	No SIM cost	RIQI
<b>Intervention:</b> Maximize the state's current Human Services Warehouse to create an integrated data ecosystem that uses analytic tools, benchmarks, and visualizations					
Develop a prototype of tabular data model and user interface using 3 different data sets to assess performance, robustness and scalability of the selected tools	Purchase of equipment and software	Prototype tested	Completed by September 30, 2017	\$125,000	EOHHS
Complete assessment of state analytic environment including current state data systems	N/A (funded outside of SIM)	Assessment complete	Completed by November 30, 2017	N/A	Freedman Healthcare
Develop RFP for vendor to support technical and/or staffing needs	N/A	RFP posted	Completed by February 2018	N/A	EOHHS
Procure Ecosystem vendor	N/A	Contract signed with selected vendor.	Completed by June 30, 2018	N/A	EOHHS
Completion of work to design, develop, and implement the EOHHS Data Ecosystem	Budget activities TBD	Action steps TBD	TBD	\$1,675,000	TBD

## Leveraging Regulatory Authority

Rhode Island is committed to using multiple regulatory and purchasing levers to advance the policies described in the healthcare delivery system transformation plan above. All of the state agencies that comprise the interagency team are engaged in this work. The following provides an overview of the key state regulatory levers that are currently being used, or plan to be used, to drive system transformation. As the SIM project progresses, the state interagency team will work with additional agencies (e.g. Department of Children, Youth, and Families, Rhode Island Department of Education, and Rhode Island Department of Transportation) to determine the appropriate usage of their regulatory levers. The structure of the SIM staff team, where staff are embedded in their respective agencies, allows the SIM project to effectively use the state's regulatory levers to advance the SIM goals.

### Executive Office of Health and Human Services

The Executive Office of Health and Human Services (EOHHS) is the home of the SIM grant. EOHHS comprises the state Medicaid agency, the Department of Human Services, the Department of Health, the Department of Behavioral Health, Developmental Disabilities and Hospitals, and the Department of Children, Youth and Families.

#### Medicaid

The Medicaid program possesses regulatory and purchasing levers that are critical to the success of Rhode Island's Healthcare Transformation Plan. The ability of Medicaid to contract directly with providers or with health plans to assume risk for the Medicaid population grants the program significant leverage to shape the healthcare delivery system.

Currently, Medicaid contracts with Managed Care Organizations (MCOs) and pays them a capitated rate for Medicaid enrollees across different programs. In turn, Medicaid imposes conditions on the MCOs through contracting. The contracting conditions structure how MCOs reimburse providers, measure quality, and support multi-payer programs, such as the state's multi-payer patient-centered medical home program. As stated in the Rhode Island Healthcare Transformation Plan, Medicaid will use the MCO purchasing and contracting mechanism to require specific annual targets for use of APMs by the MCOs, and directives to contract with credentialed Medicaid Accountable Entities. Medicaid also controls provider reimbursement rates for its population and is designing incentive payment programs for hospitals and nursing homes.

As discussed further in the Healthcare Delivery System and Payment Transformation Plan, Medicaid is leading an [Accountable Entities \(AE\) Coordinated Care Pilot Program](#) which will allow credentialed AEs to enter into arrangements with MCOs that manage a specific population of Medicaid members under a risk-adjusted total cost of care contract. This regulatory lever will be used to meet the following high-level set of metrics, which are aligned with the SIM payment reform goals:

- By 2018, 90 percent of Medicaid payments to providers will have some aspect that is tied to quality or value;
- By 2018, 50 percent of Medicaid payments will be made through an "alternative payment model," including payments to Accountable Care Organizations, bundled payments, or others; and

- By 2018, 25 percent of Medicaid members will be enrolled in an accountable integrated provider network.

These Medicaid payment reform goals, combined with the statement that AEs should be PCMH-based (at least 50% of the AE's attributed members must be enrolled in a qualified PCMH as defined by the Office of the Health Insurance Commissioner) are actively moving Rhode Island's healthcare system towards value-based purchasing and towards achieving the Triple Aim.

### **Medicaid Health System Transformation Project**

A key piece of our Delivery System Transformation work is our partnership with Medicaid and their Designated State Health Program (DSHP) Healthcare Transformation project. The project has received a waiver from CMS that will help Accountable Entities achieve Rhode Island's "Reinventing Medicaid" and Triple Aim objectives. As we have noted before, the waiver change seeks federal authority to claim federal matching funds for a variety of services, including state university and college programs training the health workforce. We have successfully partnered with the Executive Office of Health and Human Services and Medicaid to support Workforce Transformation activities.

### **Rhode Island Department of Health**

The Rhode Island Department of Health (RIDOH) maintains primary responsibility for the interests of life and health among the peoples of the state. RIDOH is the lead agency for investigations into the causes of human disease, the prevalence of epidemics and endemics among the people, the sources of mortality, the effect of localities, employments and all other conditions and circumstances on the public's health. RIDOH is charged with ascertaining the causes and the best means for the prevention and control of diseases or conditions detrimental to the public health. RIDOH is responsible for the adoption of proper and expedient measures to prevent and control diseases and conditions detrimental to the public health in the state.

RIDOH publishes and circulates, from time to time, information that the Director may deem to be important and useful for dissemination among the people of the state. With no local health departments within the state, RIDOH provides advice in relation to those subjects relating to public health that may be referred to it by the general assembly or by the governor when the general assembly is not in session, or when requested by any city or town. RIDOH adopts and promulgates rules and regulations that it deems necessary to carry out the responsibility invested in the agency. The overall scope of RIDOH's roles and responsibilities includes, but is not limited to: health planning, vital records, immunization, facilities regulation, healthcare professional licensing, vital records, disease outbreak response, food and water safety, laboratory testing, and other aspects of health promotion. Most notably, RIDOH maintains the decision-making authority, as well as the ability to include conditions of approval, for healthcare consolidations and mergers through the [Hospital Conversion Act](#) and [Certificate of Need](#) programs. This regulatory authority has been leveraged to assist SIM in pursuing health system transformation (see an example of related conditions of approval [here](#) and [Guiding Principles Letter](#) for the Certificate of Need process from RIDOH Director Nicole Alexander-Scott, MD.

RIDOH also regulates the Health Information Exchange and HealthFacts RI (our All-Payer Claims Database) as described in more detail in the Health Information Technology Plan. RIDOH has statutory authority to require public reporting by any of its licensed professionals and facilities. Leveraging the public reporting authority beyond current programs will require regulatory changes. We will consider and discuss with stakeholders any regulatory changes that will help further our SIM goals.

Furthermore, RIDOH maintains responsibility for the establishment of a recurring Statewide Health Inventory and State Health Plan. This responsibility was set forth within the [Rhode Island Access to Medical Technology Innovation Act \(RIGL 23-93-5\)](#). SIM will continue to use the findings of the Statewide Health Inventory as we transform our healthcare delivery system. SIM will also continue to support, as applicable, the development of the State Health Improvement Plan as a part of RIDOH's mandate to create a State Health Plan. SIM sees the value in working with RIDOH to ensure population health improvements are a cross-sector collaboration.

As the SIM project progresses and if appropriate, RIDOH may choose to use its regulatory levers around community benefit requirements, licensing, boards, and scope of practice, complaints investigation health planning (e.g., managed care, certificate of need, healthcare utilization review), emergency medical services, and facilities regulation to coordinate efforts to streamline Rhode Island's healthcare delivery system. For example, licensing requirements for some programs within healthcare academic institution (i.e., hours needed for completion) can be set by RIDOH. In some cases, with nursing and nursing assistant programs, the professional boards set some, if not all, of the curriculum through the Center for Professional Boards and Commissions. Other administrative authority may include changes to e-licensing or auto-enrolling in e-prescribing systems, licensing-fee incentives, and continuing education leers for specialized topics.

### **Department of Behavioral Health, Developmental Disabilities and Hospitals**

Under Rhode Island General Laws, the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) is responsible for providing services to persons with mental illness and substance abuse, developmental disabilities and chronic, long-term medical and psychiatric conditions. The Department serves more than 50,000 persons per year through State personnel as well as community providers. BHDDH holds oversight, quality assurance and patient protection responsibilities for providers under state licensing regulations.

Medicaid reforms have been changing both mental health and substance use service delivery in the state. Health Homes serve: 1) persons with opioid use disorders and 2) individuals with severe and persistent mental illness (SPMI) and severe mental illness (SMI).

In a recent contractual change, two MCOs now oversee payments to Community Mental Health Organizations (CMHOs) who serve as Health Homes for persons with SPMI or SMI conditions. Bundled Medicaid rates have been established for levels of care based on acuity with a focus on consumer outcomes.

A planning grant initiative has begun to credential the CMHOs as Certified Community Behavioral Health Clinics (CCBHCs) and to develop a Prospective Payment System, per the Federal Protecting Access to Medicare Act, 2014. Rhode Island will submit an application in October 2016 requesting funding for the two-year Federal pilot program that will bring to awardee states a 90%/10% matching rate and enable qualified providers to offer more comprehensive, robust mental health and substance use services.

BHDDH's programs and regulatory levers support the core elements of Rhode Island's Healthcare Delivery System Transformation Plan. Through its contracting authority, BHDDH is promoting the use of value-based payment models for the SPMI/SMI population. The programs and levers also address key component health areas of our State Health Improvement Plan, including serious mental illness and opioid use disorder.

BHDDH's programs and regulatory levers support the core elements of Rhode Island's Healthcare Delivery System Transformation Plan. Through its contracting and credentialing authority, BHDDH is the use of value-based payment models (e.g. bundled payments) for the SPMI/SMI population and developing credentialing standards for CMHOs that will further the goals listed in Rhode Island's SIM project. Additionally, the focus of Health Homes on the SPMI/SMI population specifically addresses one of the health focus areas outlined in the State Health Improvement Plan and will serve as a way to promote more coordinated, efficient care which will advance Rhode Island's delivery system transformation efforts.

## Office of the Health Insurance Commissioner

Pursuant to RIGL §42-14.5-2 (4)-(5), the Office of the Health Insurance Commissioner (OHIC) has a statutory mandate to direct health insurers toward policies and practices that improve the health care system as a whole. It has a number of regulatory levers that it has been using for years to help push changes in our healthcare system toward value rather than volume. Now, working with Medicaid, the two agencies together are able to use their authority to significantly advance the SIM Test Grant's work.

OHIC exercises prior approval Form and Rate Review authority for the individual, small group, and large group markets. As of April 2015, 232,297 people obtained insurance coverage through these markets. The annual review of health insurance forms and rates places critical scrutiny on the factors underlying medical trend, insurer administrative costs, and insurer financial strength.

OHIC also leverages its rate review authority and statutory mandate around system transformation to impose a set of initiatives to improve the healthcare system and support more affordable health insurance. These standards, known as the Affordability Standards, comprise three major elements:

- Standards to advance value-based purchasing;
- Standards to promote practice transformation and increase financial resources to primary care for population health management; and
- Standards around hospital contracting.

OHIC uses its rate review authority and statutory mandates to work with stakeholders (payers, providers, businesses, and consumers) to develop [annual plans](#) that increase the adoption of value-based purchasing models and patient-centered medical homes. OHIC's regulatory levers as related to SIM are discussed in further detail in the Healthcare Delivery System Transformation Plan and SIM Alignment with Federal and State Initiatives sections.

In January, OHIC's 2017-2018 Care Transformation and Alternative Payment Methodology (APM) Plans were finalized and approved by Commissioner Hittner. These Plans outline goals and targets that are designed to facilitate achievement of the Affordability Standards' regulatory requirements with regard to payment reform and care transformation. The Plans are the product of a rigorous and collaborative stakeholder engagement process that occurred between October and December of 2016, and included representatives of health plans, providers, ACOs, consumer advocates, and state agencies.

## HealthSource RI

HealthSource RI (HSRI) is Rhode Island's health insurance exchange, providing insurance to 35,000 Rhode Islanders. The regulatory levers they command in order to help institute payment reforms throughout Rhode Island's healthcare system include the following:

- HSRI Qualified Health Plan certification for individual and small group products—By coordinating with OHIC, EOHHS, and carriers, HSRI can actively solicit plans that advance payment reforms, such as plan designs that promote the use of patient-centered medical homes or plan designs that advance value-based payment models through provider contracting.
- HSRI consumer education efforts—Empowering consumers to make better healthcare choices, both in choosing plans and when using services. HSRI's experience with consumer education is pivotal to SIM's patient engagement initiative and to improving patients' overall experience of care.
- HSRI is currently exploring and analyzing the feasibility of providing coordination of state employee health plans in an effort to achieve alignment of benefits and incentives for delivery system reform across another population within Rhode Island.

## Aligning Regulatory Levers to Counter Fragmentation

As noted elsewhere in this plan, SIM has facilitated the alignment of OHIC and Medicaid around regulations that move our health system from volume to value. Medicaid's regulations for its Accountable Entities match those of OHIC's for the commercial market, which is important because the same carriers provide coverage in both markets.

Through our Integration & Alignment Project, we are expanding these types of collaborations to strengthen the ability of the state to achieve our goals, and to make it easier for those entities regulated by the state to follow an aligned set of rules.

SIM is also working with other state partnerships to maximize alignment and counter fragmentation. For example, the Rhode Island Children's Cabinet plays an important role in ensuring positive health and safety outcomes for children and youth in Rhode Island. Committed to strengthening the collective impact of state agencies serving children, youth and families, Governor Raimondo and the state agency directors who sit on the Cabinet have recently convened a cross agency work group to map children's behavioral health services, funding streams and regulatory/governance structures. Keenly aware of the operational demands of the SIM population health plan, the Cabinet prioritized assessing these items now so that the policy and implementation recommendations yielded by the SIM team can be adequately and appropriately supported by a governance structure and service continuum that is accessible and responsive to Rhode Island's children, youth and families.

Regulatory review in Rhode Island has presented SIM with an opportunity to support regulatory alignment in service of SIM aims across the broader state system of executive departments, boards and commissions. As noted elsewhere in this document, Governor Raimondo signed an Executive Order in 2015 mandating that all rules and regulations be reviewed and where needed, clarified and brought up-to-date; or if obsolete, be removed. In addition, these newly-reviewed regulations also are being brought into a single statewide regulatory code repository to ensure access and to facilitate public participation in the regulation development and review process. This has provided SIM-aligned agencies with the opportunity to identify and track these



rules, regardless of which state agency promulgates them. We have created a simple regulation tracking and notification system using outputs from state databases and publicly available tools. Once captured, relevant SIM Core Team members will review these regulations. The team will decide whether there is an opportunity to advance SIM aims, and if so, which SIM-supporting agency should follow up with the responsible (non-SIM) agency. This will give us the opportunity to meet with representatives from the responsible agencies to understand their rulemaking process, to explain the SIM project, and to explore ways in which we can work together on rules reform on behalf of population health or health reform.

## Quality Measure Alignment

Quality measurement and improvement are integral components of value-based contracting. As we pursue our target of having 80% of payment linked to value and value-based payment arrangements become more widely used in Rhode Island, it is important to ensure consistency and coherence in quality measures, to ease administrative burden on providers, and drive clinical focus to key population health priorities. Toward this end, in June 2015, the SIM Steering Committee charged a workgroup comprised of payers, providers, measurement experts, consumer advocates, and other community partners to develop an aligned measure set for use across all payers in the state.

### Quality Measure Alignment Process

Because of former SIM Steering Committee Chairman Lou Giancola's support for this process, he worked with the Hospital Association of Rhode Island, Blue Cross Blue Shield of Rhode Island, UnitedHealthcare of New England, and Neighborhood Health Plan of Rhode Island to raise the funding to hire Michael Bailit and his team at Bailit Health Purchasing to consult on this process. The Bailit team provided technical and facilitative support to the workgroup.

Michael Bailit has supported multiple state efforts related to measure alignment in addition to his current work in Rhode Island with the SIM Measure Alignment Work Group. Past projects with multi-payer measure alignment include completed projects for the states of Maine, Oregon, Pennsylvania, Vermont, and Washington. Bailit has also assisted with measure set development for the states of California, Colorado, Massachusetts, and Missouri. For some of these projects, he has supported state work by using the Measure Selection Tool that it developed with Robert Wood Johnson Foundation funding for the Buying Value project.

### Award Year 1 - Pre-Implementation

The Measure Alignment Workgroup held 12 meetings between July 2015 and March 2016. The goal that the workgroup set for itself was to develop a menu of measures from which payers could pick, and specific core sets of measures to be included in all contracts. At the outset, the workgroup adopted 11 criteria for measure selection:

1. Evidence-based and scientifically acceptable;
2. Has a relevant benchmark (use regional/community benchmark, as appropriate);
3. Not greatly influenced by patient case mix;
4. Consistent with the goals of the program;
5. Useable and relevant;
6. Feasible to collect;
7. Aligned with other measure sets;
8. Promotes increased value;
9. Presents an opportunity for quality improvement;
10. Transformative potential; and
11. Sufficient denominator size.

The workgroup used the measure selection criteria to assess the relative merits of including measures in the menu and core sets. Measure selection criteria were also used to score designated measures for a second round of review.

The workgroup reviewed existing measures used in value-based contracts between payers and providers in Rhode Island. These measures were cross-walked to the CMS Medicare Shared Savings Program and 5-Star measure sets to assess alignment using the Buying Value Tool. The measures were also cross-walked to SIM population health priorities, including diabetes, obesity, tobacco use, and hypertension. Measures were grouped by domain, including preventive care, chronic illness care, institutional care, behavioral health, overuse, consumer experience, utilization, and care coordination. The measures represented a mix of claims-based measures, and measures based on clinical data, or a combination of claims and clinical data. The measure review process took several months to complete, as each measure was given individual consideration. Workgroup members were also asked to submit measures for consideration by the workgroup that were not currently used in contracting.

The final product was a menu totaling 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures). Core measures are required to be in all performance-based contracts of the relevant type: primary care, hospital, ACO. Beyond the core measures, health plans and providers may select measures from the menu for inclusion in contracts. The Measure Alignment Workgroup was silent on whether measures shall be used for payment only, vs. payment and/or reporting. Specific targets and incentives associated with the measures will be left up to negotiation between the health plans and providers.

## **Award Year 2**

The Measure Alignment Workgroup convened in November of 2016 to conduct its annual review of the three measure sets that were endorsed by the SIM Steering Committee in March 2016. Under the facilitation of Bailit Health Purchasing, the Workgroup reviewed measures with a change in NQF or NCQA status, new HEDIS measures, and measures recommended by the specialist workgroups. The work group decided to remove two measures from the SIM Aligned Measure Sets because NQF removed its endorsement of those measures, and recommended removing one additional measure pending Medicaid's input. The Workgroup also added ten measures to the SIM Aligned Measure Sets, which included new HEDIS measures and recommended measures from the specialist workgroups – described below.

All commercial insurers signed OHIC's 2017 Rate Approval Conditions, which included a requirement to adopt the SIM Aligned Measure Sets in any contract with a performance component as a condition for their 2017 rates to be approved. The updated SIM Aligned Measure Sets will be effective for insurer contracts with hospitals, ACOs, and primary care practices beginning on or after January 1, 2017. Additionally, in January 2017 OHIC amended State Regulation 2, which delineates the powers and duties of its office, to include implementation of the SIM Aligned Measure Sets in any contract with primary care providers, specialists, hospitals, and ACOs that incorporate quality measures into the payment terms. OHIC will also be issuing an interpretive guidance document to payers for using the measure sets in contractual payment arrangements.

In an effort to align processes between commercial and public payers and reduce administrative burden for providers, Medicaid has incorporated the SIM Aligned Measure Sets into the Medicaid Performance Goal Program (PGP). The Medicaid Performance Goal Program aligns with the SIM quality measure set as well as additional measures that assess health plan performance against EOHHS goals and/or align with the CMS child and adult core measures that EOHHS reports to CMS. The PGP is used to incent the health plans to improve across various domains, which in turn influences provider performance based contracts. In addition,

the Medicaid Accountable Entity program anticipates alignment of the SIM quality measures as part of the program's Alternative Payment Methodology (APM) or total cost of care guidance. The APM guidance is in the process of being developed.

In Award Year 2, SIM also convened two Specialist Measure Alignment Workgroups between July and October 2016 to develop recommendations for additional measure sets for specialty care, particularly for maternity care and behavioral health. Both workgroups were composed of payers, provider groups, professional associations, state agency/public payer representatives, and advocates, and adopted the same selection criteria used by the original SIM Measure Alignment Workgroup. The workgroups reviewed specialist measures that are already included in the three measure sets, measures currently in use in provider contracts in Rhode Island, and measures recommended by workgroup members. Each workgroup developed a measure set with a "core set" and "menu set", consistent with the existing three measure sets. Additionally, the Behavioral Health Measure Set includes an additional set of "BHDDH Measures" that Medicaid Integrated Health Homes are required to submit to BHDDH.

### **Years 3-4 - Implementation**

Due to changes in clinical standards, retirement of existing measures and introduction of new ones, and changing public health priorities, the measure review group will continue to refine the measure set, and explore the utility of creating additional specialty measure sets.

Once the Health Care Quality Measurement, Reporting and Feedback System is built, Rhode Island may scale the system to facilitate public reporting on the core measures. Please see Page 164 for a more detailed description of the Reporting and Feedback System, and how we envision it collecting data from a variety of sources, ideally leveraging existing infrastructure, collecting and mastering the data within a data intermediary, and analyzing and viewing those data through an analytics engine with external public and provider facing website.

### **Aligned Measure Sets**

The full list of measures in the [SIM Aligned Measure Sets](#) (including ACO, Primary Care, Hospital, Behavioral Health, and Maternity) are posted online.

# SIM Alignment with State and Federal Initiatives

Below is an updated list of the key projects with which SIM expects to collaborate in year 3 of the project.

## Current CMMI Projects and Awards

### CPC+

Rhode Island is one of 14 regions across the country participating in CPC+ a partnership between payers from the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, commercial health plans, and primary care providers. The CPC+ Initiative is an advanced primary care medical home model that offers an innovative payment structure to support delivery of comprehensive primary care.

The Rhode Island region has 31 primary care practices; 10 practices in Track 1 and 21 practices in Track 2. Starting in CPC+ Year 1, practices in both tracks are expected to make changes in the way they deliver care, focusing five Comprehensive Primary Care Functions:

1. Access and Continuity;
2. Care Management;
3. Comprehensiveness and Coordination;
4. Patient and Caregiver Engagement; and
5. Planned Care and Population Health.

CPC+ uses quality performance measures to assess improvements in the quality of care over time in CPC+ practices. Quality measures include the patient experience of care survey, claims-based utilization measures, and eQMs.

The initial steps for SIM and CPC+ collaboration have begun. Our close partner CTC is serving as a multi-payer convener for CPC+, as well as providing technical assistance to the Track 1 practices. Healthcentric Advisors is serving as the regional technical assistance representative for the Track 2 practices. There is recognition that some of the Health IT requirements under CPC+ align closely with SIM funded initiatives as well as those described in the State Medicaid Health IT Plan and in the most recent HITECH IAPD update, and SIM will serve as a convener to ensure that alignment across all these initiatives continues. One of the challenges that SIM will address is the misalignment between the CPC + measure set and the SIM Aligned Measure Set, which has already become a difficulty for providers.

### Transforming Clinical Practice Initiative (TCPI)

The Transforming Clinical Practice Initiative is designed to help clinicians achieve large-scale practice transformation. The initiative is designed to support more than 140,000 clinician practices nationally over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies. The initiative is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more wisely. TCPI's goals are to:

- Promote broad payment and practice reform in primary care and specialty care;
- Promote care coordination between providers of services and suppliers;
- Establish community-based health teams to support chronic care management; and

- Promote improved quality and reduced cost by developing a collaborative of institutions that support practice transformation.

In Rhode Island, the TCPI project is being carried out by the Rhode Island Quality Institute (RIQI). As a Practice Transformation Network, RIQI is in the process of recruiting 1,500 clinicians to expand their quality improvement capacity, learn from one another, and achieve common goals of improved care, better health, and reduced cost. The network is providing practice transformation assistance, care coordination tools and services, performance measurement, and reporting and evaluation to help participating clinicians meet the initiative's phases of transformation and associated milestones, clinical and operational results.

In their TCPI planning, RIQI aligned their measures to match SIM's (with CMS' approval), and we are in regular contact with RIQI staff to ensure that we are working together as closely as possible to coordinate practice transformation efforts. We will also discuss the low EHR adoption rate with the TCPI leadership. We may find a way to address this by thinking about it together.

As we have noted elsewhere in the Operational Plan, SIM is working with RIQI, CTC, and Healthcentric Advisors to coordinate the physician practice assistance work being carried out by the four projects. The TCPI project lead recently presented an updated to our state interagency team. And together, we will be using the Statewide Common Provider Directory to track which practices are receiving assistance, and where there are gaps. This joint practice assistance review is an overall part of our integration and alignment work.

### **Accountable Health Communities**

Rhode Island Medicaid, RIDOH, and SIM worked together to assist two private sector health organizations apply for funding within the current Accountable Health Communities (AHC) cooperative agreement application. We are pleased that Care New England/Integra ACO was chosen to receive the five-year cooperative agreement and we look forward to working with them closely to ensure that their work is successful, and that it aligns with SIM.

The Integra AHC Partnership will:

1. Systematically screen Rhode Island Medicare and Medicaid beneficiaries to identify those with unmet health-related social needs in the core areas of housing, food insecurity, utility needs, interpersonal violence, and transportation, and the supplemental areas of substance use/addiction and independent living/caregiver support;
2. Increase Rhode Island Medicare and Medicaid beneficiaries' awareness of community resources available to address unmet health-related social needs;
3. Provide navigation services to high-risk Rhode Island beneficiaries to increase the connection with effective community resources to address their needs; and
4. Optimize Rhode Island's capacity to address health-related social needs through quality improvement, data collection, and alignment of community-based resources.

Their overarching goal is to achieve, by Year 5, a two percent decrease in the average total cost of care for participants relative to the 5-year trend at initiation of the grant.

The project will focus in three distinct geographic regions in Rhode Island which include our core cities with the most economic need and several rural communities that are challenged by

lack of transportation and health access. At some of Rhode Island's busiest hospitals and behavioral health sites, patients will be screened for health-related social needs. Those determined to be at highest risk will receive navigation assistance, to be conducted by specially trained navigators. Where these sites overlap with our SBIRT and community health team sites, we will specifically align the work to maximize resources for patients.

## **EOHHS Programs, with Federal and State Funding**

### **Integrated Care Initiative**

A recent focus of the State's Medicaid program has been on EOHHS' Integrated Care Initiative (ICI), which is designed to better align the care and financing of Medicare and Medicaid, promote home and community based care, and provide cost-effective care for adults with disabilities and the elderly. During Phase I of the ICI, EOHHS established a capitated Medicaid managed care plan for adults with full Medicare (Parts A, B, and D) and full Medicaid coverage, as well as Medicaid-only adults who receive long-term services and supports (LTSS). There currently are about 16,500 people enrolled in the Medicaid managed care plan established during Phase I.

Under Phase II, Rhode Island established a fully integrated capitated Medicare-Medicaid plan for adults with full Medicare (Parts A, B, and D) and full Medicaid coverage. Federal authority for Phase II is through the Center for Medicare and Medicaid Services (CMS) Financial Alignment Demonstration (FAD) is a federal demonstration to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health, and LTSS for Medicare-Medicaid enrollees. Approximately 13,000 people have enrolled in the Medicare-Medicaid plan since inception in July 2016.

### **Medicaid 1115 Waiver**

Rhode Island submitted an extension request to its current 1115 Waiver in 2013. The 1115 Waiver was approved in January 2014. The original waiver allowed Rhode Island to operate the entire Medicaid program under a single 1115 demonstration. The Rhode Island Medicaid Reform Act of 2008 directed the State to apply for a "global" demonstration under the authority of Section 1115(a) of Title XIX of the Social Security Act. The Rhode Island Global Consumer Choice Compact 1115 Waiver Demonstration (1115 Waiver) established a new Federal-State agreement that provides the State with substantially greater flexibility than is available under existing program guidelines. The State has used the additional flexibility afforded by the 1115 Waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure beneficiaries receive the appropriate services in the least restrictive and most appropriate setting.

The 1115 Waiver has three major program goals: to re-balance the publicly funded long term care system, to ensure all Medicaid beneficiaries have access to a medical home and to implement payment and purchasing strategies that ensure a sustainable, cost-effective program.

On October 20, 2016, CMS approved an amendment that provides for federal funding of designated state health programs (DSHPs) that promote healthcare workforce development to ensure access to trained healthcare professionals for eligible individuals. This DSHP funding will be phased down over the period of the demonstration, as the State develops alternative funding sources for these programs. We submitted an amendment on May 17, 2016 that requested federal funding of DSHPs to ensure the continuation of workforce training and other

vital health care programs. The State will devote increased state resources during the period of this demonstration to a “Health System Transformation Project” that will have a positive impact on the Medicaid program. DSHP funding will be limited to the additional state funding attributable to the establishment of Accountable Care Entities through Medicaid managed care contracts, net of savings attributable to the operation of those entities and the costs associated with the Hospital and Nursing Home Incentive program. The Accountable Entities (AEs) will be responsible for improving the quality of care, and there will be Alternative Payment models established, between MCO health plans and AEs through the development of value-based contracts. The amount of DSHP funding will be phased down over the period of the demonstration as the implementation costs associated with AEs diminish and savings resulting from their operations reduce funding needs.

### **Medicaid Accountable Entities**

Through its contracted Medicaid Managed Care Organizations (MMCOs), EOHHS is supporting the development of an Accountable Entities Coordinated Care pilot program. This is part of a broader initiative by EOHHS to promote and support the development of integrated multi-disciplinary Accountable Entities (AEs) capable of providing superior health outcomes for Medicaid populations within value based payment arrangements. The pilot program began in 2016, and will provide a fast-track path for interested organizations to partner with EOHHS and its contracted MMCOs in transforming the structure of the health care delivery system to reward value instead of volume. AE rules are being developed in consultation with the value-based changes undertaken by OHIC so that the two agencies are working together and aligned.

EOHHS intends that certified AEs will provide the central platform for transforming the structure of the delivery system as envisioned in the Final Report of Rhode Island’s Reinventing Medicaid Working Group that was convened by Governor Raimondo in March of 2015.

The core objectives of the AE program include:

- Substantially transitioning away from fee-for-service models.
- Defining Medicaid-wide population health targets, and, where possible, tie them to payments.
- Using the aligned measures set created by the SIM stakeholder team.
- Maintaining and expanding on our record of excellence in delivering high quality care.
- Delivering coordinated, accountable care for high-cost/high-need populations.
- Ensuring access to high-quality primary care.
- Shifting Medicaid expenditures from high-cost institutional settings to community-based settings.

The State’s Medicaid Program has made considerable progress on its [Accountable Entities \(AE\) initiatives](#). Rhode Island launched its first pilot AE in the 2016. As an integral component of the Health System Transformation Program (HSTP), \$76.8 million dollars of HSTP dollars will be allocated to support the Rhode Island Medicaid Accountable Entity program. This performance based infrastructure funding will be distributed via our managed care contracts and will provide Medicaid AEs with the support needed to build infrastructure, capacity, and tools for system transformation, innovation and clinical transformation and integration. Here is an update of our AE activities:



- Medicaid submitted its *Claiming Protocol* to CMS in early 2017. The Claiming Protocol describes the claiming methodology for the source of funds. This document was subsequently approved in April 2017.
- The [AE Roadmap](#) describes the conceptual framework and design of the Medicaid AE program. CMS approval of the AE roadmap is necessary for the use of funds. To obtain stakeholder feedback on the design of the program, Medicaid shared a draft of the AE roadmap with stakeholders in December 2016. EOHHS received comments and feedback from 24 stakeholders representing an array of advocacy, community, provider organizations, and managed care organizations.
- Stakeholder engagement is ongoing on both the comprehensive AEs and Specialized AEs for Long-Term Services and Supports. EOHHS held at least three stakeholder sessions as well as one on one meetings with each Medicaid AE as well as with the MCOs to obtain additional input on AE design and development. This feedback was used to inform the final draft of the AE roadmap.
- EOHHS will continue to engage stakeholders in the Specialty AE design and development. We want to pilot an interim model, with the goal of alignment with the Comprehensive AEs in the future.
- EOHHS has also engaged in one on one meetings and presentation with various stakeholders, community and provider group to provide more information on the program development and next steps. EOHHS has made 13 presentations to date to various community and providers groups.
- The final version of the AE roadmap was submitted to CMS on April 14, 2017.

Our next phase key deliverables include the certification standards, total cost of care (including quality), attribution methodology, and incentive funding guidance.

### **Rhode Island EHR Incentive Program**

The Rhode Island EHR Incentive program submitted both the IAPD-U and the updated SMHP in December 2016. The SMHP integrated the full HIT vision for Rhode Island and included the SIM-funded HIT components.

SMD 16-003 expanded the opportunities for 90/10 funding to encompass all Medicaid providers, in an effort to recognize the need for information sharing among all of a patient's treating providers. In response, Rhode Island's EHR Incentive Program sought approval on additional projects beyond the funding received previously through the per member per month model. The IAPD-U was approved by CMS, and Rhode Island is working on implementing the projects, which are:

- Connecting the EMS system at DOH to the HIE bi-directionally, and creating alerts to providers;
- Connecting the Medicaid Community Health Team (CareLink) to the HIE;
- Connecting the Prescription Drug Monitoring Program (PDMP) to the HIE;
- Advanced ED Alerts – This will put important, high value alerts in the ED workflow in their EHR (ED Tracking Board), including information about ED utilization, PDMP flags, etc.;
- Connect Kidsnet to the HIE;
- Expand Kidsnet to be an Adult Immunization Registry;
- Continued Provider Directory Implementation; and
- Planning for an eReferral feature in Provider Directory; and

- Creating an HIE Registry/Form Module – to support the development of shared care plans, SBIRT screening, and eMOLST in the HIE.

### **Medicaid EHR Incentive Program**

EOHHS administers the Medicaid EHR incentive program and, as part of that program, has successfully been receiving 90/10 funding since 2012 to help support the continued development and implementation of CurrentCare, Rhode Island's statewide Health Information Exchange (HIE). The Rhode Island Quality Institute (RIQI), which serves as the state's regional health information organization and was designated as the state's HIE, implemented a voluntary funding model in 2012 whereby all of the major commercial insurers, a number of self-funded employers including state employees, and Medicaid started contributing \$1.00 per member per month based on the number of lives. This funding model has supported the activities such as onboarding of providers, onboarding additional data submitting partners (including practices sending CCDs) enrollment of individuals into CurrentCare, and some of the very early provider directory design work.

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- Continued Provider Directory Implementation;
- Planning for an eReferral feature in Provider Directory; and
- Creating an HIE Registry/Form Module – to support the development of shared care plans, SBIRT screening, and eMOLST in the HIE.

### **Home Stabilization Services**

This EOHHS program focuses on the social and environmental determinants of health. Home Stabilization is designed to provide supports to Medicaid beneficiaries so that they can continue to live in their home. The specific goals of the program include:

1. Promoting living in the community successfully and reducing unnecessary institutionalization;
2. Addressing social determinants of health; and
3. Promoting a person-centered, holistic approach to care.

The State will certify qualified *Home Stabilization* providers who offer a range of time-limited, flexible services to coach individuals in maintaining successful tenancy. The core areas include:

1. Early identification and intervention of behaviors that may jeopardize housing;
2. Education and training on the roles, rights, and responsibilities of landlords and tenants;
3. Coaching on developing and maintaining relationships with landlords or property managers;
4. Advocacy and linkage with community resources to prevent eviction when housing may be jeopardized;
5. Assistance with the housing recertification process; and
6. Coordinating with tenants to review, update, and modify housing support plans.

The next steps for the Home Stabilization program is to complete and implement the Home Find component of the program which will allow agencies to assist and guide individuals through the process of locating and applying for housing.

### **Money Follows the Person**

Rhode Island was awarded a Money Follows the Person (MFP) Demonstration Grant in April 2011. The goal of the demonstration is to assist the state in rebalancing the long-term services and supports system by increasing use of community based care and decreasing use of institutional care. Through the program, participants transition from nursing facilities to the community with enhanced home and community based services. MFP support strengthens the state's ability to provide home and community based services and promotes choice of long-term care settings. MFP transitions will continue through December 2018, and the grant will end on September 30, 2020. Rhode Island has facilitated 285 transitions from program inception through March 31, 2017.

### **Adult Medicaid Quality Grant**

CMS awarded EOHHS an Adult Medicaid Quality Grant (AMQ) in December 2012 to: 1) develop State capacity in the measurement, analysis, and reporting of health care quality; 2) establish a core set of regularly reported Adult Quality Measures across Medicaid populations and enhance the communication of these measures within and among state agencies and stakeholders; and 3) improve the quality of care delivered to Medicaid members. The grant came to a close December 20, 2016. Accomplishments include:

- Established the Analytic & Evaluation Unit to inform program evaluation efforts across EOHHS: increased the capacity to calculate AMQ measures across Medicaid, assessed current data infrastructure and capabilities; and currently working to standardize recipient categories and develop file structures that can link claims from all data sets into more manageable analytical files.
- Completion of a Transitions of Care Quality Improvement Program (QIP) that brought together hospitals and community providers to measure and improve information transfer upon patient discharge.
- Completion of an Antidepressant Medication Management QIP that analyzed strategies to improve the rate of adherence for newly prescribed antidepressant medication. EOHHS and the University of Rhode Island are continuing this partnership post grant period.

- Completion of an Electronic Health Record Project that analyzed the feasibility and validity of collecting diabetes screening measures directly from EHRs versus through claims data.

## RIDOH Programs

Within the context of SIM, it is critical to align programs that are complimentary and supportive to each other, particularly when addressing any determinant of health (i.e., healthcare). While SIM provides a tremendous amount of resources to build community extensions (e.g., CHTs) from the healthcare setting into the community setting to improve healthcare, it also is a vehicle through which addressing the social and environmental determinants of health can be catalyzed within the healthcare sector. Conversely, the following programs at RIDOH highlight just some of the aligned work that is focused on starting within the community setting to address the social and environmental determinants of health, as well as those also now extending into the healthcare setting or facilitating health system change. By complementing SIM in this way, community-clinical linkages are strengthened from both sides of the equation and population health improvement becomes more readily achieved.

### Center for Health Data, Analysis, and Public Health Informatics

There are numerous surveillance systems, databases, and measurement sources that serve as primary information sources and collection methods at RIDOH. RIDOH collects information and analyzes it on a program-specific level, and at times, within the [Center for Health Data and Analysis](#) (CHDA), which produces data briefs and a variety of other dissemination documents. Sharing of data is initiated by data requests, media inquiries, and publication needs. Shared data abides by the Department's policy for dissemination of data. Typical modes of distribution include infographics and posters for stakeholder meetings and conferences, publications, on websites, and in the form of data briefs/books. File sharing can be requested between agencies and requires a Memorandum of Agreement. One example that is critical to the State Health Improvement Plan's Health Assessment report is the [Behavioral Risk Factor Surveillance System](#) (BRFSS), which is a primary collection method for population health. The RI BRFSS is a multi-modal landline and cell-phone survey that represents a sample of Rhode Island residents. The survey is conducted in monthly replicates, for which information covering health-related behaviors, chronic conditions and preventive health practices is collected from respondents ages 18 and older. Rhode Island has participated in the BRFSS since 1984, with financial and technical support provided through a cooperative agreement with the CDC and from additional funding received from various RIDOH sources. Prior surveys have been a key source of data for supporting public health programs and health-related legislation within Rhode Island. In addition, RI BRFSS data has been used for assessing Rhode Island's improvement in key health risk behaviors.

### Certification of Community Health Workers (CHWs)

Certification of Community Health Workers (CHWs) has been identified as a priority for RIDOH and the development of a [certification process](#) has been established through the Rhode Island Certification Board to strengthen and grow this important workforce. Community Health Teams (CHTs) are a central SIM priority, and so this work is critical to SIM's success. In addition to certification, there are several CHW infrastructure building projects in the planning stages that involves a partnership with Rhode Island College These include offering the CHW core competency training, supporting CHW employers, and providing additional opportunities for specialization in focus areas such as behavioral health. (We will include conversations with Medicaid and carriers around credentialing and reimbursement options.) CHWs are frontline public health workers who serve as a liaison between health/social services and the community

to facilitate access to services and improve the quality and cultural responsiveness of service delivery. Typically, CHWs are non-licensed, gain expertise from life experience and some community/health education. This lack of health professional licensing makes it difficult for CHWs to receive reimbursement for the valuable role they play in improving the health of their community and working with a CHT. See this recent [Rhode Island Medical Society publication](#) for more information on CHTs.

### **Community Health Network**

In their work to connect Rhode Islanders with appropriate clinical and community resources, Community Health Teams have the potential to move the needle on a number of our health focus areas, including tobacco use, obesity, heart disease and stroke. A potential partner in these efforts is the [RIDOH Community Health Network](#). The Community Health Network consists of a coordinated system to provide evidence based and best practice education to activate patients and improve patient skills necessary to self-manage their chronic condition(s). The Community Health Network is a partnership between multiple evidence-based programs based at RIDOH and within community organizations that work on chronic disease management. The Community Health Network is building a skilled workforce of expertly trained staff both professional and community health workers who provide disease/self-management programs, chronic disease management programs, and patient navigation. Components of the system include a centralized referral system with secure fax and email to RIDOH; follow up with the patient to assist with access to the CHN resources, and communication back to the practice concerning the patient experience.

### **Comprehensive Cancer Control Program**

This [Comprehensive Cancer Prevention and Control Program](#) for Rhode Island offers an opportunity to work together by increasing our efforts to prevent and control cancer as well as to improve the quality of life for cancer survivors. It serves as a blueprint for statewide coordination of ongoing and necessary public and private cancer control efforts. This program addresses several key cross-cutting issues: primary prevention of cancer; coordinated early detection and treatment; cancer survivorship needs; policy, systems and environmental change; and health disparities and equity, which are all critically important to improving the lives of Rhode Islanders. The community Partnership to Reduce Cancer worked closely with RIDOH staff to develop new priority goals, objectives, and strategies. RIDOH envisions collaborating with many stakeholders, including government, business, healthcare, research, and non-profit organizations to achieve common goal of reducing the burden of cancer in Rhode Island. Recently, palliative care and end-of-life care have become a particular focus for this program and its stakeholders.

### **Health Equity Zones**

Health Equity Zones (HEZ) are contiguous geographic areas that have measurable and documented health disparities, poor health outcomes, and identifiable social and environmental conditions to be improved. HEZ Collaboratives are designed to achieve health equity by eliminating health disparities using place-based strategies to promote healthy communities. The [10 HEZ Collaboratives](#) are funded with State and Federal dollars in partnership with RIDOH. The HEZs support innovative approaches to prevent chronic diseases, improve birth outcomes, and improve the social and environmental conditions of neighborhoods across five counties statewide, all of which are core focus areas for the Accountable Health Communities grant initiative described above. Drawing on our guiding principles, the HEZ Collaborative is built on meaningful and true engagement of multi-sector key stakeholders working together, and include municipal leaders, residents, businesses, transportation entities, faith leaders, community

planners and partners, law enforcement, education systems and health systems, among others. For more background, review this [Rhode Island Medical Society publication](#) to learn about RIDOH's approach to using HEZ as a place-based intervention.

### **HIV/AIDS Program—90 | 90 | 90 Initiative**

At the Rhode Island World AIDS Day event in December 2015, the Rhode Island Department of Health announced its commitment to reaching the 90 | 90 | 90 targets set by the UNAIDS, an international health organization that has as its goal to end the AIDS epidemic through ambitious testing and treatment activities. Rhode Island has developed the following 2020 targets:

- 90% of Rhode Islanders who are living with HIV will know their status;
- 90% of Rhode Islanders who are living with HIV will be engaged in care; and
- 90% of Rhode Islanders who are living with HIV will have an undetectable viral load.

In order to achieve these targets the RIDOH has created a 90 90 90 Steering Committee composed of representatives from AIDS Service Organizations, city governments, community-based organizations, and hospitals. The Steering Committee meets regularly to review progress towards the [90 | 90 | 90 Program](#) and targets, as well as to explore ways to increase engagement in medical care and address social determinants of health related to housing, social support and mental health services, and case management for people living with HIV in Rhode Island. RIDOH is also developing an Adolescent Sexual Health Profile, for which SIM was a participating stakeholder.

### **Maternal and Child Health (Title V) Program**

The Maternal and Child Health (Title V) Program is based upon a four-pillar approach to public health that has guided the development of [Rhode Island's Title V Program](#) and includes the social and environmental determinants of health, life course approach, and integration of programs. RIDOH used the information gathered from the community meetings, the analysis of the data from the various sources available to the department and its experience in the implementation of its maternal and child care services from prior years to select its program priorities for the next five years. There is a consensus evolving from the data, the community meetings, as well as input from various partnerships, that an important program priority is Access to Care through the medical home. The components of the medical home emphasize primary care with a strong focus on care coordination, preventive care, and an emphasis on healthy lifestyles.

### **Mobile Integrated Health and Community Paramedicine Program**

The Rhode Island Mobile Integrated Health and Community Paramedicine (MIH/CP) Program allocates and provides the resources for planning and implementing this effort to use the skills and resources of Emergency Medical Services (EMS) practitioners (Emergency Medical Technicians and Paramedics) to serve in an expanded healthcare role within the community. The potential for EMS to provide expanded services has created considerable attention and discussion about their potential to increase patient access to primary and preventative care, provide wellness interventions, decrease emergency department utilization, save healthcare dollars, and improve patient outcomes. There is a broad consensus within EMS that MIH/CP programs are not one-size-fits-all, but should be developed to meet community needs. It is also widely accepted that MIH/CP programs should not duplicate or compete with already existing services, but should fill gaps in those services. The MIH-CP planning process will help

determine those gaps through a community needs assessment, with final goal of integrating the systems of care to promote health and wellness for all within the respective communities.

### **Office of Primary Care and Rural Health**

The [Office of Primary Care and Rural Health](#) addresses health disparities created by lack of access to high-quality health care due to financial, cultural and geographic barriers. The office recruits a diverse primary care workforce of medical, dental and mental health care providers through operation of the Health Professionals Loan Repayment Program, the physician waiver program for holders of J-1 Visas and coordination of National Health Service Corps programs. In addition, it annually assesses the existing workforce's capacity to meet the medical, dental and mental health services needs of Rhode Islanders; collaborates with organizations and facilities to apply for Health Professional Shortage Area (HPSA) designation and funding where need exists to improve access to healthcare; assists those working to increase access to primary care services for all; and reduces disparities seen in our rural populations.

### **Oral Health Program**

The [Oral Health Program](#) works to achieve optimal oral health for all by eliminating oral health disparities in Rhode Island while integrating oral health with overall health. This program has a focus on prevention of oral disease through assurance of state-level oral health and public health leadership and enhancement of community efforts to prevent, control, and reduce of oral diseases. In addition, the oral health program works with health professionals, partners, and the Rhode Island Oral Health Commission to build and sustain community capacity for high-quality, culturally-sensitive oral health services. This includes the expansion of services for underserved adults through the creation of an Advanced Education in General Dentistry Residency Program, provision of mobile dental programs serving Medicaid elders in nursing homes, and training of primary care providers about oral disease risk assessment/disease management.

### **Prescription Drug Overdose Prevention Program**

In addition to participating in and co-leading the Overdose Prevention and Intervention Task Force with BHDDH, RIDOH maintains the [Prescription Drug Overdose Prevention Program](#) to decrease nonfatal and fatal drug overdoses and to educate prescribers about responsible prescribing practices. (Please see Page 137 for a description of the Task Force.)

### **RIDOH 6|18 Initiative**

Rhode Island is partnering with [CDC's 6|18 Initiative](#), alongside healthcare purchasers, payers, and providers, to improve health and control health care costs. This initiative provides these partners with rigorous evidence about high-burden health conditions and associated interventions to inform their decisions to have the greatest health and cost impact. This initiative offers proven interventions that prevent chronic and infectious diseases by increasing their coverage, access, utilization and quality. Additionally, it aligns evidence-based preventive practices with emerging value-based payment and delivery models. National this initiative addresses six common and costly health conditions (of which Rhode Island is currently addressing two: tobacco use and asthma) using 18 proven specific interventions.

### **RIDOH Academic Center**

RIDOH's Academic Center is a new initiative that aims to achieve excellence in public health practice while producing the next generation of multidisciplinary public health practitioners. This area of focus at RIDOH aligns with the workforce capacity and monitoring component of the SIM initiative. The [RIDOH Academic Center](#) focuses on building a competent public health

workforce with subject-matter expertise, researching for new insights and innovative solutions to health problems, and evaluating effectiveness and quality of public health services, all of which advance progress towards improved public health functioning (assessment, policy development and assurance), enhanced public health outcomes, and health equity. Rhode Island's SIM Project and RIDOH's Academic Center can align through strengthening the integration of scholarly activities with public health practice by instilling a culture of learning and innovative implementation along with continuous quality improvement in the areas of practice transformation and population health needs.

### **Rhode Island Chronic Care Collaborative**

In 2003 the Diabetes Prevention and Control Program and Quality Partners of Rhode Island (now Healthcentric Advisors) received a grant from the Robert Wood Johnson Foundation's Improving Chronic Illness Care program to train physician practice teams based on the Bureau's Collaborative model from 1999. The [Rhode Island Chronic Care Collaborative](#) has continued to use the Learning Model from the Institute for Healthcare Improvement to train participating teams in the implementation of the Chronic Care and Improvement Models. Included in this work are both the Care, Community, and Equity programs and the Diabetes Prevention in Rhode Island Action Plan to Scale and Sustain the National Diabetes Prevention Program, with which SIM collaborates.

### **Wisewoman Program**

Established by the CDC, the [Wisewoman Program](#) helps low income women aged 30 to 64 with limited or no health insurance live longer and feel better by improving their heart health. In Rhode Island, this program ensures services for women who participate in the Women's Cancer Screening Program; provides free screening for heart disease, lab work and test results for cholesterol, blood pressure, and blood sugar; offers free health coaching in nutrition, physical activity, and quitting smoking, plus free fitness and weight loss programs; and provides free glucose strips for women with diabetes. This program aligns well with SIM's health focus area of Chronic Disease.

## **BHDDH - Federal SAMHSA Grants**

### **Mental Health and Substance Use Block Grants**

Mental Health and Substance Use Block Grants available for all 50 states are non-competitive grants awarded annually to states that provide funding for mental health and substance abuse services. Priorities for BHDDH's Block Grant funds in FY2016-2017 include: 1) adults with serious mental illness, with a focus on reducing unnecessary Emergency Department use, hospital admissions, readmissions and inappropriate lengths of stay; 2) older adults with serious emotional disturbance with a focus on developing a needs assessment and joint action plan with partnership agencies in Rhode Island, including the Division of Elderly Affairs (DEA), Executive Office of Health and Human Services (EOHHS), Community Mental Health Organizations, and the Rhode Island Elder Mental Health Advisory Council; 3) persons with serious mental illness who are homeless and need affordable housing with supportive services that focus on housing retention. Additional focus is directed to helping these individuals gain access to resources to which they are entitled, including Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP). Social Security; 4) persons who have or are at risk of having Substance Use Disorders and/or Serious Mental Illness/Serious Emotional Disturbance; 5) persons who are at risk for tuberculosis; 6) pregnant and parenting women with



substance use disorders and their children; and 7) transition age youth/young adults with severe mental illness and co-occurring disorders.

### **Collaborative Agreement to Benefit Homeless Individuals**

Rhode Island Collaborative Agreement to Benefit Homeless Individuals (CABHI) is a three-year grant serving 300 persons. The grant supports veterans and individuals experiencing chronic homelessness who have substance use disorders, serious mental illness, or co-occurring mental health and substance use disorders by enhancing the state's infrastructure through ensuring these high-risk individuals have access to treatment, permanent supportive housing, peer and recovery supports, and mainstream services. Through this grant, BHDDH and its partners in the community are: 1) improving statewide strategies to address planning, coordination, and integration of behavioral health and primary care services, and permanent housing to reduce homelessness; 2) increasing the number of individuals, residing in permanent housing, who receive behavioral health treatment and recovery support services; and 3) increasing the number of individuals placed in permanent housing and enrolled in Medicaid and other mainstream benefits (e.g., SSI/SSDI, TANF, and SNAP).

### **Project for Assistance in Transition from Homelessness Program**

Project for Assistance in Transition from Homelessness Program (PATH) assists homeless men and women with mental illnesses and co-occurring substance abuse disorders in getting treatment and transition to permanent housing. The program provides community-based outreach, mental health, and substance abuse treatment and other support services throughout the state.

### **Healthy Transitions**

Healthy Transitions is five-year grant, serving 2500 youth and young adults ages 16-25. It focuses on helping persons who are at risk for developing, or who have already developed a serious mental health condition. The implementation communities for this grant are Warwick and Woonsocket. Serving the communities at large in these locales, the grant activities will focus on public awareness of the early warning signs of mental illness in young people and how to take action; active outreach, engagement and referral; access to effective clinical and supportive interventions; and sustainable infrastructure changes to improve cross system coordination, training, service capacity and expertise. The grant is supported by a Project Director at BHDDH and Youth Coordinator at Department of Children, Youth and Families. This initiative is helping to forward the work of Rhode Island's Children's Cabinet.

### **Strategic Prevention Framework Partnerships for Success**

The Rhode Island Strategic Prevention Framework Partnerships for Success (SPF-PFS) project enhances efforts to stop underage drinking with youth ages 12-17. Additional priorities are reducing marijuana use among youth 12-17 and assessing prescription drug use and misuse among youth and young adults ages 12-25 and the resultant burden of this drug use. There is emphasis on funding sub-recipients in twelve Rhode Island communities of high need, who comprise a sizable percentage of the state's population.

### **SBIRT**

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a five year BHDDH initiative funded by SAMHSA on behalf of the entire population of Rhode Island. Through the SBIRT grant, a total of up to 250,000 screenings will be carried out over the next five years, covering tobacco, alcohol, marijuana, other substances and depression. The SBIRT initiative will be tied into the Governor's Overdose Prevention and Intervention Task Force. Screenings will be

delivered to individuals in primary care and health centers, emergency departments and the Department of Corrections.

Because SBIRT and Community Health Teams will both be engaging with primary care practices and we did not want to create unnecessary overlap, SIM and BHDDH worked closely with each other to braid the funding and tie the programs together in one RFP. SBIRT screeners will work closely with SIM-funded Community Health Teams which provide services to individuals with complex health issues. Among those prioritized for substance use screenings will be persons living in DOH-designated [Health Equity Zones](#).

### **Opioid Initiatives**

The [Opiate Overdose Prevention and Intervention Task Force](#) was convened by Governor Raimondo in 2015 in response to an epidemic of deaths in the state from opioid overdoses in the previous 18 months. Co-chaired by the Director of BHDDH and RIDOH, additional partners in the Governor's initiative include the Brown University School of Public Health, legislators, physician and nursing organizations, institutes of higher education, insurers and business leaders. In May 2016, the Task Force issued a Strategic Action Plan outlining multiple steps to be taken throughout the state to reduce the opioid overdose death rate. Efforts are underway in the areas of: 1) prevention to help doctors protect their patients through safe prescribing practices; 2) rescue to increase access to naloxone; 3) treatment to expand availability of Medication Assisted Treatment (MAT), like methadone and buprenorphine and 4) recovery through an increase in peer recovery services and treatment.

Through grant funding from the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC), BHDDH is expanding MAT Prescription Drug and Opioid Addiction services in response to the overdose crisis in the state. Services to 2,300 persons will be provided by six Centers of Excellence (COE) over a 3-year period. Currently a COE has been established at Eleanor Slater Hospital. A Request for Proposals (RFP) has been issued to create another hospital-based COE in the Greater Providence Area. Four additional COEs will be developed in subsequent years. Related to this effort, BHDDH has completed certification standards for COEs.

### **OHIC**

Rhode Island's Office of the Health Insurance Commissioner (OHIC) has led a variety of initiatives to reform the health care delivery and payment system as part of its mission to improve the affordability of health insurance for consumers and employers. OHIC first implemented its Affordability Standards in 2010, focusing on increasing primary care spend, accelerating patient-centered medical home efforts, and reducing the rate of hospital cost increases. In February 2015, after an intensive stakeholder process to solicit recommendations and comments, OHIC updated its Affordability Standards to recognize current developments in the health care sector. The revised Affordability Standards focus on practice transformation (including Patient-Centered Medical Home adoption) and driving health care payment practices toward value-based models. OHIC continues to work with its stakeholders and other health care reform efforts in the state. Through these collaborations, which include the SIM project and Reinventing Medicaid, OHIC aims to drive the system toward value, composed of efficiency and quality, inclusive of clinical-best practices, safety, and patient satisfaction.

To assist in this work, OHIC has convened two committees: Care Transformation Advisory Committee and the Alternative Payment Methodology Advisory Committee, described more fully on page 97 of this plan.

As noted above, the 2017-18 Care Transformation Plan establishes three work groups that have been meeting since January of 2017. The Small Practice Engagement Work Group is tasked with creating an outreach strategy to engage small practices in transformation, and using collective knowledge and experiences to create a prioritized list of practices that are likely to participate in transformation. The High-Risk Patient Identification Work Group is researching best practices and evidence based approaches to practice based assessment of risk, with particular attention on how to incorporate social determinants of health. Lastly, a Primary Care APM Work Group will be exploring clinical processes that are possible under a non-fee-for-service driven model. This work will begin once the group has finished designing a primary care APM.

All of these OHIC Committees significantly contribute to the stakeholder engagement that supports the SIM project. OHIC will continue to work with other state agencies as part of the SIM effort to align delivery and payment system reform efforts.

## **Governor's Office Initiatives**

### **Reinventing Medicaid**

In February 2015, Governor Raimondo established the [Working Group for Reinventing Medicaid](#) with the duty to review the current Medicaid program and recommend specific quality improvement and cost containment measures for redesigning Medicaid<sup>11</sup>. The group identified many shortcomings of the current program, including misaligned incentives across the delivery system, fragmented and non-coordinated service delivery, and an inability to address social determinants of health, that ultimately result in high costs and less than favorable outcomes. The Working Group's final report includes ten goals based on four principles: 1) Pay for value, not for volume; 2) Coordinate physical, behavioral, and long-term healthcare; 3) Rebalance the delivery system away from high-cost settings; and 4) Promote efficiency, transparency, and flexibility. The report suggests leveraging the role of SIM to define desired population health outcomes as well as a set of aligned measures that can be drawn upon to evaluate the success of the Reinventing Medicaid interventions. In order to achieve the goals set out in the report, the Working Group recommends robust stakeholder engagement and coordination between public and private healthcare reform efforts.

### **Governor's Working Group for Healthcare Innovation**

Building on the successes of Reinventing Medicaid, the Governor's [Working Group for Healthcare Innovation](#) was established in July 2015 and charged with making recommendations to establish a global healthcare spending cap, tie payments to quality, create a statewide performance management framework for achieving population health goals, and develop a coordinated health information technology system<sup>12</sup>. With the Triple Aim as the ultimate goal in mind, the Working Group articulated four major recommendations: 1) Create an Office of Health Policy to set statewide health policy goals and oversee effective implementation; 2) Hold the system accountable for cost and quality, and increase transparency through a spending target; 3) Expand the state's healthcare analytic capabilities to drive improved quality at sustainable costs; 4) Align policies around alternative payment models, population health, health information technology, and other priorities. Under the first recommendation, the Working Group calls for the creation of a comprehensive state population health plan, which would be best served by ongoing SIM processes that should combine existing state health

planning documents and include details on quality metrics, capacity and needs planning, workforce development, and performance management.

### **Children’s Cabinet**

SIM continues to work with other state partnerships to maximize alignment and counter fragmentation. For example, SIM has served as an ongoing resource and partner to the Rhode Island Children's Cabinet, re-convened by Governor Raimondo in 2015 to strengthen the collective impact of state agencies serving children, youth and families. In 2016, the Cabinet launched a cross agency work group to map children's behavioral health services, funding streams and regulatory/governance structures. Starting in 2017, the Children’s Cabinet has also committed to working on the Governor’s Third Grade Reading Action Plan to double the number of third graders reading at grade level by 2025. The Action Plan recognizes the array of supports required to reach this ambition goals and includes health indicators that impact school readiness, safety net services and community engagement along with education-related goals and metrics. SIM’s partnership with the Cabinet on these two initiatives will be especially salient in 2017 and directly inform SIM’s State Health Improvement Plan, including the development of a set of shared statewide goals. More information on the Cabinet and The Third-Grade Reading Action Plan are available on the [Children’s Cabinet webpage](#).

### **Food Strategy**

SIM’s work with Rhode Island’s new Director for Food Strategy is an excellent example of how SIM seeks to align with initiatives across diverse sectors that have an impact on population health outcomes. By working together, SIM has been able to provide coordinated, system-level input to the Food Strategy Director during the state’s Food Strategy planning process. At the same time, by seeking out and supporting this partnership, SIM has had the opportunity to include its “health in all policies” perspective in the planning process including: direct input on the impact of lack of food access on a range of health outcomes; participation in community-based meetings to engage stakeholders; and representation on a Hunger Task Force to be convened later this year. Additional plans for SIM and the Food Strategy office include adding health data to a newly released GIS-mapping tool and partnering to jointly engage state transportation agencies to improve access to food and health services. More information is available on the [Rhode Island Food Strategy webpage](#).

### **Other State Departments for SIM Alignment**

SIM’s multi-sector/multi-agency approach applies equally to our system changes and our and population health improvement programs. Throughout this plan, we have described the process of establishing meaningful connections with entities within our healthcare system – and we are also committed to building connections outside of the traditional public health and healthcare delivery systems. Especially as we wrote our State Health Improvement Plan, we assessed the strategic goals and current initiatives of state departments to identify areas of common focus and opportunities for linkage with population health planning.

As we noted in the Population Health section of the plan, building a community health business model in Rhode Island will require the commitment and cohesive policy making of a wide range of state government actors. Below, we flag some of the key state agencies that we will prioritize with this part of the Integration & Alignment Project.

### **Rhode Island Department of Corrections (DOC)**

The Department of Corrections is a part of our SBIRT/Community Health Team project. We were required to choose a special population for the SAMHSA SBIRT grant, and we chose people connected to the corrections department. We have been including DOC staff on our interagency team and SBIRT planning team, and will soon be meeting with the Chair of the Parole Board.

In addition, the Governor's Working Group for Justice Reinvestment, established in July 2015, is tasked with improving the treatment of mental illness and substance abuse, among other directives. While a formal plan for achieving this task is not yet available, working group materials recommend requiring a behavioral health screening pre-arraignment to identify risks and needs, and to increase access to timely behavioral health services among probationers. This presents a clear opportunity for alignment with SIM's integrated population health, as access to quality behavioral health care is one of the plan's top priorities.

### **Rhode Island Department of Education (RIDE)**

Rhode Island's Strategic Plan for Education 2015-2020 includes a goal of increasing early childhood developmental screening rates for children aged 3-5 by 15%. This will be achieved in part through promotion of the use of high-quality health and educational screening of young children and the distribution of family-friendly information about early childhood development. There is a clear opportunity for partnership between the healthcare delivery system and department of education; healthcare providers and schools can collaborate to establish protocols for ensuring that all students have access to well child visits and early childhood screening, and that the importance of education to child wellbeing is communicated to parents. The Strategic Plan for Education also calls for collaborations with public and private behavioral health providers to expand the quality and quantity of in-school behavioral health services. Again, there is an opportunity to develop and leverage mutually beneficial partnerships between schools, state agencies, and healthcare providers to maximize access to behavioral health services in the school setting.

SIM has also connected with RIDE around our SBIRT project and they have expressed interested in helping to explore how we can bring services to schools.

### **Rhode Island Department of Children, Youth, and Families (DCYF)**

In the Rhode Island Title IV-B Child and Family Service Plan, DCYF identifies the priority to reduce reliance on congregate care and increase community-based service supports for children and families through investments in effective wraparound care coordination. This priority aligns with SIM's emphasis on care integration, and offers a dynamic opportunity for partnership between DCYF, healthcare providers, and social service providers to implement a "no wrong door" approach and ensure coordinated access to medical, behavioral health, and social services, particularly among some of our most vulnerable residents.

DCYF has just begun with a new Director, Trista Piccola. We have briefed her on the SIM project, and together, we are thinking through ways that we can more closely collaborate.

### **Division of Planning – Economic Development**

Rhode Island Rising, the state's Economic Development Plan released in 2014, identifies an overarching goal of coordinating economic, housing, and transportation investments to yield economic gain, create resilient communities, and improve quality of life. A particular focus is on incorporating pedestrian and bicycle amenities into redevelopment opportunities and promoting alternative transportation to connect people to housing, jobs, and services. Aligning

the population health plan with these goals presents a unique opportunity to address environmental and social determinants of health through the development of healthy communities.

The logical next step to building a community health business model would be to reach out to these state departments to establish a common vision, identify interventions, and explore available resources that can be leveraged.

## Key Planning Documents for Reforming Healthcare in Rhode Island

Besides the initiatives listed above, the state has commissioned several investigations into the current health of populations in Rhode Island, the performance of health reform efforts, and the remaining challenges. While these analyses and reports focus on various aspects of the healthcare delivery system, a recurring theme in the recommendations is the need for coordination and alignment between stakeholders, initiatives, and segments of the delivery system. We have provided a summary of these reports and their respective recommendations to add to the picture of our health reform landscape.

### Healthcare Utilization and Capacity Study

In late 2015 RIDOH, in consultation with the Health Care Planning and Accountability Advisory Council (HCPAAC), conducted a [statewide healthcare utilization and capacity study](#) as required by the Rhode Island Access to Medical Technology Innovation Act of 2014 (RI Gen. Laws § 23-93-5(b))<sup>13</sup>. The study collected data on the location, distribution, and nature of healthcare resources in healthcare settings across the state. Detailed surveys were completed by providers in primary care settings, outpatient specialty practices, behavioral health settings, hospitals, nursing facilities, assisted living residences, adult day care programs, home health settings, MRI imaging centers, ambulatory surgery centers, and dialysis centers.

A patient and community survey was also administered. A study of this magnitude had not been completed in Rhode Island since the 1980's. Results indicated an overall shortage of primary care providers, limited data on patient race, ethnicity, and primary language and lack of interpreter services, limited availability of assisted living residences for Medicaid patients, and persisting financial barriers to care. RIDOH recommends exploring strategies for recruitment and retention of primary care providers, implementing uniform data collection of demographic information and identification of cost barriers, and improving access to community-based care. Data collection and analysis will be repeated annually, and the data collected will be used to establish and maintain a statewide health plan; like the Governor's working groups, the report suggests drawing on the work of SIM in the creation of a population health plan.

### Truven Report

Around the same time, Truven Health Analytics was contracted by EOHHS, BHDDH, RIDOH and OHIC to conduct detailed analyses and develop a report evaluating current statewide demand, spending, and supply for the full continuum of behavioral health services in Rhode Island<sup>14</sup>. [The analysis](#), published in September 2015, applied a population health approach by organizing population groups and evaluating need, prevention, and treatment services by lifespan stage. Key findings indicated that children in Rhode Island face higher risks for developing mental health and substance use disorders compared to other New England states, Rhode Island spends more on behavioral health than other states, and reporting and service delivery systems are fragmented. The report articulates three recommendations: 1) place greater investment in efficacious preventive services for children and families, 2) shift financing from

high-cost, intensive, and reactive services to evidence based services that promote patient-centered, outcome focused, coordinated care, 3) enhance infrastructure to promote population health based approach to behavioral healthcare.

### **Health Disparities Report**

The Rhode Island Commission for Health Advocacy and Equity, a group established by statute in 2011 (RI Gen. Laws §23-64.1) and supported by RIDOH, [submitted a report to the General Assembly](#) in January 2015, detailing a study of health disparities in six key health areas: maternal and child health, asthma, obesity, diabetes, heart disease, and oral health<sup>15</sup>. The report focused heavily on the social determinants of health and disparities between groups of Rhode Islanders regarding educational attainment, disability status, race and ethnicity, and income. In addition to specific health topic area recommendations, the report gives global recommendations for improving health equity. These include: adopting a health in all policies approach, improving systems for collecting health disparities data, strengthening Rhode Island's capacity to address health inequities, expanding partnerships, and coordinating efforts for action.

### **Rhode Island's Strategic Plan for Addiction and Overdose**

The opiate epidemic, and increase in related deaths due to overdose, in Rhode Island spurred Governor Raimondo to issue Executive Order 15-14. The Order established creation of a broadly representative Task Force charged with developing a strategic plan for impacting opiate use disorders in Rhode Island. Co-chaired by the Directors of the BHDDH and RIDOH, the Task Force sought expert advisors who reviewed the existing literature on addiction and overdose; conducted over 50 interviews with local, national, and international stakeholders and experts; collected input from the Rhode Island community; and hosted two public forums with expert and community panels. These efforts culminated in ["Rhode Island's Strategic Plan for Addiction and Overdose,"](#) which established the long-term goal of reducing overdose related deaths by one-third within the next three years. The Task Force issued a report of recommendations intended to move Rhode Island forward in meeting this goal, including: a "no-wrong door approach to accessing medication assisted treatment; increasing access to evidence-based treatment and recovery supports for opiate abuse/dependence; requiring training for physicians and law enforcement personnel; reducing administrative barriers that limit access to opioid use disorder treatment; and requiring data collection and reporting on measure that will assess the impact of the proposed interventions.<sup>7</sup>

### **Housing Reports**

In 2012 the Rhode Island Division of Planning, Housing Resources Commission collaborated with Rhode Island Housing and the United Way to develop a strategic plan for ending homelessness, entitled Opening Doors Rhode Island. One of the key goals of this plan is to improve health and housing stability through strengthening access to behavioral healthcare services among vulnerable populations, expanding access to primary care, and leveraging Medicaid funding to finance services in supportive housing. Access to both primary and behavioral health care aligns with the mission of the population health plan, and since permanent supportive housing interventions have been shown to demonstrate significant reductions in overutilization of medical resources, opportunities for collaboration should be of mutual interest to housing advocates and health reformers.

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<sup>7</sup> Rhode Island's Strategic Plan on Addiction and Overdose, 2015

In addition, data-focused community organization HousingWorks RI recently published a report entitled [An Exploratory Study of the Affordable Care Act and Housing in Rhode Island](#). We have also just brought HousingWorks RI's director, Brenda Clement, on to our Steering Committee, and have asked her to present on the report at our May meeting.

### **Additional Community Research**

In addition to the reports mentioned above, there are a number of community nonprofits or research entities that create health-related reports that are very helpful to the SIM project. These organizations include Kids Count (whose Executive Director is on the SIM Steering Committee), the Economic Progress Institute; the Rhode Island Public Expenditure Council (RIPEC), Rhode Island Medical Society (whose Director of Government and Public Affairs is a member of the Integrated Population Health Workgroup), and the Rhode Island Business Group on Health (whose Executive Director is also on the SIM Steering Committee).



# Healthcare Workforce Transformation

In the summer of 2016, SIM and EOHHS jointly initiated a Healthcare Workforce Transformation planning process to assess healthcare workforce development needs and capacity and recommend priorities and strategies to prepare the current and future healthcare workforce with the knowledge and skills needed to help Rhode Island achieve its system transformation and population health goals. This planning process, which was conducted with support from Jobs for the Future (JFF), culminated with the issuance of a [Healthcare Workforce Transformation Report](#). The Executive Summary and Strategy Grid below summarize the process, findings, and recommendations.

## Healthcare Workforce Transformation Report

Rhode Island is changing the way it delivers and pays for healthcare—care that doesn't stop at the doctor's office or the hospital bed. It extends to where people live, work, play, and learn. It rewards quality outcomes rather than quantity of patient visits. It is a “team sport,” rather than a solo endeavor, bridging physical and behavioral health, and clinical and non-clinical providers, such as social workers and community health workers. This approach to care is data-driven and evidence-based—tracking patient populations to identify risks and measure results. Its point of departure is not limited to the episode of care for an individual; rather, it manages care for populations and seeks out “upstream” causes of health problems, such as housing, income, access to healthy food, and transportation.

Rhode Island's overarching goals for transforming the health system mirror the “triple aim” of the Affordable Care Act: better care, smarter spending, and healthier people. “Better care” is patient-centered, accessible, culturally competent care, delivered by practitioners working at the top of their license or job description, and focused on keeping people well. “Smarter spending” is more efficient use of health resources to lower the per capita cost of care—through paying for value rather than volume of services; encouraging prevention; and rebalancing care from costly hospital or nursing home stays to home and community-based care. “Healthier people” means enhancing the overall health of the population—including physical, oral, and behavioral health, while coordinating the care for specific populations, with chronic disease or multiple conditions, and addressing social determinants of health. To achieve the triple aim goals, Rhode Island has mounted a number of initiatives to change healthcare payment policies and service delivery—working through both the state Medicaid program and commercial insurers.

None of these changes in healthcare are possible without a transformed workforce—with the right workers, with the right skills and tools, in the right place at the right time. To determine what this workforce looks like and how to prepare for it, the Rhode Island Executive Office of Health and Human Services (EOHHS), in partnership with the State Innovation Model Test Grant (SIM), convened a cross-section of stakeholders from the state's healthcare providers, education and training organizations, and policymakers in health and workforce. This group, the RI Healthcare Workforce Transformation Committee, gathered to establish workforce priorities and weigh potential strategies, assembling as a full group in October 2016, and then breaking into eight topical subcommittees for more intensive discussion in November. Topics analyzed included primary care, behavioral health practice and integration, social determinants of health, health information technology, oral health, chronic disease, and home and community-based care. In December 2016, the full group reconvened to consider cross-cutting strategies and their feasibility, and in February 2017, the group discussed the prioritization of these strategies.

This report, prepared by Jobs for the Future (JFF), provides background research to support Rhode Island’s development of a healthcare workforce transformation strategy. It analyzes workforce and educational needs required to achieve the triple aim of better care, smarter spending, and healthier people. To determine workforce needs in a changing healthcare environment, this study asks not just how many new workers are needed in particular occupations, but how to renew the skills of the existing workforce to assume new and evolving healthcare roles in new settings.

To define these needs and how to address them, JFF interviewed a cross-section of the state’s healthcare employers, educators, and policymakers about changes in health care payment and delivery and their impact on the workforce; the adoption of new roles and occupations critical to delivering better care; changes in skill and performance requirements; and the capacity of the state’s education and training entities to meet new health workforce needs. Data from Healthcare Workforce Transformation Committee meetings, interviews, and literature on health workforce transformation helped build a portrait of Rhode Island’s current health workforce situation and potential strategies for the state to consider in achieving transformation goals.

This analysis was complemented by analysis of labor market information on present and projected employment trends in key healthcare professional and support occupations, as well as vacancies and skills sought by employers. The analysis focuses in depth on occupations considered strategic to transforming Rhode Island’s health system, such as nurses, community health workers, and behavioral health professionals. The report also provides data on the number of graduates from the state’s higher education health professional programs, and the employment of these graduates in the state and in the health care industry.

Based on our analysis and on the discussions of the Healthcare Workforce Transformation Committee, we have identified three key priorities and accompanying strategies, and then a more complete chart of our potential tactics.

We will be presenting the report at a Workforce Summit in June, co-sponsored by the National Governor’s Association, EOHHS, and SIM – and will begin the task of prioritizing the goals, strategic, and tactics for next steps.

### **Healthcare Career Pathways: Skills That Matter for Jobs That Pay**

Prepare Rhode Islanders from culturally and linguistically diverse backgrounds for existing and emerging good jobs and careers in healthcare through expanded career awareness, job training and education, and advancement opportunities.

#### **Strategies**

- Support the Entry-Level Workforce: Improve recruitment, retention, and career advancement
- Increase Diversity and Cultural Competence: Increase the cultural, ethnic, and linguistic diversity of licensed health professionals
- Develop Youth Initiatives to Expand the Talent Pipeline: Increase healthcare career awareness, experiential learning opportunities, and readiness for health professional education
- Address Provider Shortages: Remediate shortages among certain health professions

## **Home and Community-Based Care**

Increase the capacity of community-based providers to offer culturally-competent care and services in the home and community and reduce unnecessary utilization of high-cost institutional or specialty care.

### **Strategies**

- Expand Community-based Health Professional Education: Educate and train health professional students to work in home and community-based settings
- Prepare Healthcare Support Occupations for New and Emerging Roles: Prepare healthcare support occupations to work in home and community-based settings

## **Core Concepts of Health System and Practice Transformation**

Increase the capacity of the current and future workforce to understand and apply core concepts of health system and practice transformation.

### **Strategies**

- Prepare current and Future Health Professionals to Practice Integrated, Team-Based Care: Increase the capacity of health professionals to integrate physical, behavioral, oral health, and long-term care
- Teach Health System Transformation Core Concepts: Educate the healthcare workforce about the significance of value-based payments, care management, social determinants of health, health equity, population health, and data analytics.

Finally, in November, Governor Raimondo announced that Rhode Island has partnered with the federal Centers for Medicare and Medicaid Services (CMS) to leverage nearly \$130 million in federal funds over the next five years to further transform our healthcare system to support better care and healthier Rhode Islanders. The Designated State Health Program (DSHP) funds will be used to support Alternative Entities. Medicaid will also be able to help strengthen the state's healthcare workforce pipeline through investments in our state intuitions of higher education.

## EOHHS/SIM Healthcare Workforce Transformation Priorities and Strategies to Support Health System Transformation Goals

<b>PRIORITY: Build Healthcare Career Pathways to Develop Skills that Matter for Jobs that Pay</b>
<b>Prepare Rhode Islanders from culturally and linguistically diverse backgrounds for good jobs and careers in healthcare through expanded career awareness, job training and education, and advancement opportunities</b>
<b>SUPPORTING THE ENTRY-LEVEL WORKFORCE: Improve recruitment, retention, and career advancement of entry-level workers</b>
Address issues of compensation, work load, and/or job satisfaction to improve recruitment and retention of entry-level workers
Establish core competencies for all unlicensed, entry-level occupations
Develop advanced certifications in specialties such as behavioral health, gerontology, and chronic diseases to increase the knowledge, skills, compensation, and career advancement opportunities of entry-level occupations
Reduce financial and logistical barriers associated with pre-employment requirements, e.g., criminal background checks, physical exams, and vaccinations
Revise Certified Nursing Assistant regulations to update scope of practice, training, and testing requirements to reflect varied and emerging roles
Consider licensure or certification for unlicensed occupations such as Community Health Workers, Medical Assistants, Case Managers, Peer Recovery Specialists, and Dental Assistants
Align publicly-funded job training programs with health system transformation priorities
<b>DIVERSITY AND CULTURAL COMPETENCE: Increase the cultural, ethnic, and linguistic diversity of licensed health professionals</b>
Create more diverse talent pipelines by providing healthcare career awareness, academic advising, mentoring, financial assistance, and supportive services for youth and adults in targeted populations
Build career ladders for individuals now working in entry-level health support occupations, such as nursing assistants or medical assistants
Develop pre-apprenticeships to address gaps in foundational and employability skills to diversify the ranks of apprentices, increasing access for racial, ethnic, and linguistic minorities
Offer training and testing for CNAs and other entry-level occupations in languages other than English
Utilize the RI Department of Health licensure process to analyze the ethnic and linguistic diversity of health professionals
<b>YOUTH INITIATIVES: Increase healthcare career awareness, experiential learning opportunities, and readiness for health professional education</b>
Build broader, more diverse talent pipelines by developing healthcare career awareness programs and training in middle- and high-schools
Identify resources and healthcare employer partners to increase paid internships and work experiences for youth
Develop Career & Technical Education programs that prepare students for emerging, in-demand healthcare jobs and careers
<b>PROVIDER SHORTAGES: Remediate shortages among certain health professions</b>

Determine the nature of shortages (e.g., statewide, regional, by payer) and causes of shortages (e.g., compensation, workload, job satisfaction)
Enhance loan forgiveness, tax credits, and/or other financial incentives to improve recruitment and retention of providers
Maximize federal assistance for federally-designated provider shortage and/or underserved areas
Expand appropriate use of telemedicine (e.g., monitoring, diagnosis, treatment, consults, and referrals)
Cross-train clinical psychologists as psychiatric advanced practice RNs to increase patient access to prescribers
Consider establishing a licensure category, educational program, and payment structure for Advanced Dental Hygienist Practitioners to augment the dentist workforce and expand access to underserved Rhode Islanders
Utilize the licensure process to collect the Nursing Workforce Minimum Data Set needed to more accurately assess the supply of RNs

**PRIORITY: Expand Home and Community-based Care**

**Increase the capacity of community-based providers to offer culturally-competent care and services in the home and community and reduce unnecessary utilization of high-cost institutional or specialty care**

**HEALTH PROFESSIONAL EDUCATION: Educate and train health professional students to work in home and community-based settings**

Expand partnerships between health professional education programs and community-based healthcare and service providers, such as primary care providers, behavioral health providers, community health teams, and Health Equity Zones, to increase clinical placement opportunities for students
Expand inter-professional classroom instruction to increase student understandings of home and community-based approaches to improve population health
Expand home and community-based residency programs to enable newly-licensed graduates to obtain specialized training

**EMERGING ROLES AND OCCUPATIONS: Prepare healthcare support occupations to work in home and community-based settings**

Strengthen the ability of home health aides and personal care assistants to work in home settings by providing training keyed to special needs of the home environment and preparation to respond to behavioral health needs
Retrain or upskill current occupations such as medical assistants, patient access representatives, home-based workers, and mental health caseworkers in core CHW skills: patient engagement and navigation of community supports
Research the potential business case for financing and sustaining CHWs through evaluation of patient impacts and development of an evidence base.
Explore emerging home and community-based workforce options (e.g., EMTs, LPNs, Peer Recovery Specialists, Medication Aides, Navigators, telemedicine)
Support the emerging role of public health dental hygienists by finalizing licensure regulations, developing training capacity, and determining deployment and funding plans

**PRIORITY: Teach Core Concepts of Health System & Practice Transformation**

**Increase the capacity of the current and future healthcare workforce to understand and apply core concepts of health system and practice transformation**

**INTEGRATED TEAM-BASED CARE: Increase the capacity of current and future health professionals to integrate physical, behavioral, oral health, and long-term care through interdisciplinary, team-based practice.**

Incorporate understandings of integrated physical, behavioral, and oral health into all health professional education programs

Expand inter-professional health education activities among higher education programs (e.g., nursing, social work, pharmacy, medicine, etc.)

Expand continuing education, supervisor training, and leadership development to support integrated, team-based care

Provide continuing education to behavioral health professionals on assessment, diagnosis, treatment, and/or referral of physical and oral healthcare issues

Provide continuing education to primary care providers on assessment, diagnosis, treatment, and/or referral of behavioral and oral health issues

**HEALTH SYSTEM TRANSFORMATION CONCEPTS: Educate the current and future health care workforce about the importance of value-based payment, care management, social determinants of health, health equity, population health, and data analytics.**

Engage and support higher education partners and others to develop a “clearinghouse” of content-specific training modules (for-credit, not-for-credit, or continuing education) that can be delivered in the classroom, workplace, and/or on-line.

# Health Information Technology Plan

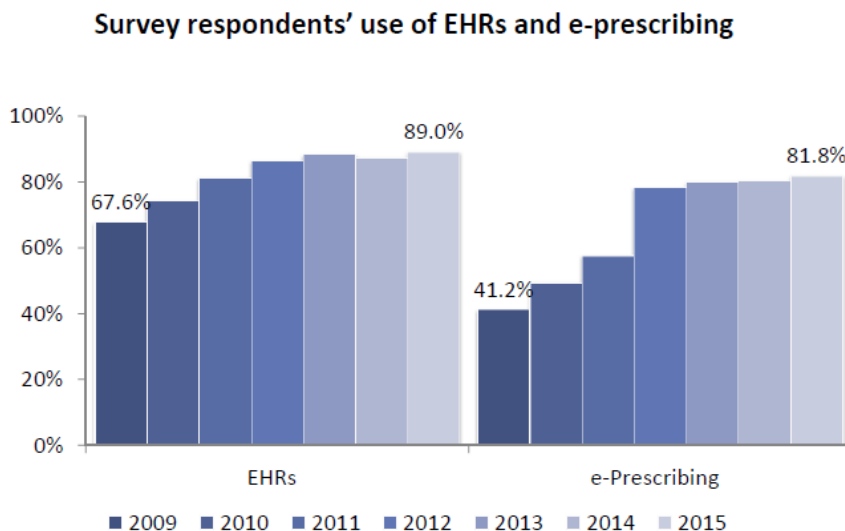
Health Information Technology (HIT) projects are foundational elements in our plan for Rhode Island’s health system transformation. Rhode Island has been and continues to be a leader in statewide HIT investments. Starting in 1997, the Rhode Island Department of Health (RIDOH) implemented KIDSNET, an integrated child health information system, which has served as a pediatric health information exchange for public health programs and pediatric providers. In 2004 Rhode Island initiated efforts to build a statewide health information exchange (HIE). In 2009, the state began to monitor Electronic Health Records (EHRs) and e-prescribing adoption rates, and in 2011 efforts to design and build an all payer claims database (APCD) were underway. Rhode Island has also been developing a single platform (the Unified Health Infrastructure Project, or UHIP) which integrates and tracks eligibility determination for HealthSource RI, Medicaid and other human services programs. As evidenced by the above, Rhode Island considers HIT a cornerstone of our strategy to increase Rhode Island’s healthcare quality – and to implement our strategic Integration & Alignment Project. We can build on the strong relationships that exist between programs and use technology to make these links actionable.

## HIT Adoption and Use

Over the past few years, Rhode Island healthcare providers have made great strides in HIT adoption and use. RIDOH had been conducting an annual HIT Survey since 2009, and switched to a biannual HIT survey in 2015. RIDOH also completed its first statewide healthcare inventory in 2015. The HIT survey measures adoption by physicians, while the inventory measures adoption by facility and location. The 2017 HIT survey is being developed and will be administered in Spring 2017. When results become available, they will be analyzed and reviewed to help inform ongoing HIT strategies for adoption and use.

The 2015 HIT Survey had a 66% response rate and found that of responding physicians, 89.0% had an EHR and 81.8% were e-prescribing. Figure 15 shows the EHR and e-prescribing rates as reported in the HIT Survey for Rhode Island physicians from 2009-2015.

**Figure 15: HIT Survey Results, Use of EHRs and E-Prescribing, 2009-2015**



In addition to the physician HIT survey, and as a roadmap for how Rhode Island can improve HIT adoption rates, it is also useful to look at EHR adoption rates by practice type or location. Rhode Island’s EHR adoption across hospitals is 92.3%, across outpatient specialty locations is 72.7%, and across primary care locations is 82.6%. It is clear that while Rhode Island’s average EHR adoption rate across all locations is 77.2%, which is close to the national average of 78%, efforts to increase EHR adoption need to be focused on specialists and behavioral health facilities or providers. Table 12 shows EHR adoption rates by location type, illustrating the gaps in EHR adoption rates.

**Table 12: EHR Adoption Rates, Statewide Healthcare Inventory, 2015**

Survey	Total Locations	Response Rate	EHR Adoption Rate
Hospital	13	100%	92.3%
Nursing Facility	89	100%	80.9%
Outpatient Specialty	418	60%	72.7%
Primary Care	311	94.5%	82.6%
Behavioral Health	48	79.2%	39.6%
Psychologists	108	88.9%	33.3%
Psychiatrists	49	100%	24.5%

*Notes: Not all respondents answered the EHR adoption questions; there is possible overlap between the outpatient specialty and psychologists survey results; and some outpatient specialty practices are co-located with hospitals.*

Rhode Island community organizations have leveraged numerous federal funding opportunities to help increase HIT adoption. In 2010, the Rhode Island Quality Institute (RIQI) received Office of the National Coordinator for Health Information Technology (ONC) funding to serve as a regional extension center, was designated by the state to serve as the state’s designated HIE entity to continue to build out CurrentCare (the state’s HIE), and was awarded a Beacon grant to focus on how HIT adoption could drive improvements in health care. While all of these grants have ended, RIQI continues to build out and operate CurrentCare and has also recently received additional ONC HIE grants focusing on long term care and behavioral health connectivity to CurrentCare. Additionally, RIQI received a Transforming Clinical Practice Initiative grant (TCPI) to assist providers (primarily specialists) with practice transformation (including EHR and HIE adoption) in preparation for value based purchasing models. SIM works closely with RIQI in all aspects of HIT, and is specifically coordinating work with their TCPI project.

EOHHS administers the Medicaid EHR Incentive program. As part of this program, EOHHS funds RIQI to provide additional technical assistance to Medicaid providers who are struggling to meet Meaningful Use. This contract ended May 31, 2017, and was considered a great success.

Lastly, Healthcentric Advisors, a Rhode Island-based nonprofit serves as the as the regional Quality Improvement Organization (QIO), supporting practice transformation and HIT adoption. They also contract with RIDOH to conduct the annual HIT Physician Survey as part of a larger health care public reporting program primarily focused on Long-Term and Post-Acute Care facilities (LTPAC) and hospitals.



## State HIT Governance

Rhode Island has a history of HIT governance that relies on working collaboratively across both state agencies as well as with external partners. Given the success of this approach and the notion that many of the HIT initiatives provide the tools and infrastructure upon which various departments rely, no single state agency has the responsibility for overseeing all of the HIT initiatives within state government. Rather the state has adopted an interagency team approach to managing a number of specific HIT initiatives such as the APCD, the Statewide Provider Directory, and UHIP (Rhode Island's integrated Health and Human Services eligibility and insurance exchange platform).

The EOHHS and affiliated state agency principals (Cabinet Directors) work together along with staff from the Governor's office to provide strategic direction on HIT initiatives. Principals meetings are held periodically – and their staff members who populate the various interagency teams keep the principals well informed on the current status, discuss any existing barriers and challenges, problem solve as needed, and continue to strategically align across HIT initiatives as appropriate.

Rhode Island is currently coordinating governance for HIT development statewide through collaboration of State Agency Principals at RIDOH, EOHHS, and OHIC. Rhode Island incorporates the community in the governance for the statewide HIT effort through both the SIM Steering Committee and RIQI Board meetings. Both entities include healthcare leaders and State Principals.

While much of the work is accomplished in interagency teams, there are also designated agency staff responsible for managing the various HIT initiatives. The EOHHS Director of Analytics provides critical leadership and support to a number of HIT initiatives internal to EOHHS and its agencies such as the project, the UHIP Medicaid Management Information Systems, and the current EOHHS data warehouse. The Director of Analytics also serves on the APCD interagency team and importantly, will oversee the SIM state data ecosystem effort.

The State HIT Coordinator is also located within EOHHS and is responsible for managing the state's oversight of Rhode Island's state designated entity for HIE, assuring that our statewide HIE meets the state's needs, serving as a liaison and helping to align statewide HIT efforts across and within Rhode Island, and overseeing the state's Medicaid EHR Incentive Program and its program manager. She also oversees the state's SIM HIT work plan, and serves on additional community-facing HIT projects, such as the APCD interagency team and the provider directory oversight group.

Additionally the SIM staff person at EOHHS is an HIT Specialist who reports to the State HIT Coordinator to specifically drive the development and implementation of the SIM HIT plan.

Finally, there is a Health Informatics Coordinator position located at RIDOH. This staff person is responsible for coordinating the work among the public health HIT systems (such as the PDMP, KIDSNET, syndromic surveillance, medical licensure and the statewide HIE), serving as the public health meaningful use coordinator, and serving on the APCD and provider directory interagency teams.

It is also important to note that the state has a centralized Department of IT located within the Department of Administration which handles all technical facilitation centrally for the state. Any

IT staff located within an agency are typically part of this centralized IT department but physically located at the agency for which they perform their duties. The State CIO/Chief Digital Excellence Officer and his staff work closely with each agency within state government as well as with the state interagency teams on HIT projects that are housed within state government. They also consult on all HIT related procurements to assure state IT standards are adhered to.

As stated above, SIM places great value and emphasis on engaging the community and working collaboratively with external partners in developing overall HIT strategy for the state. This partnership and the requisite community input is provided through different mechanisms. Governance of the statewide HIE is primarily through the state designated entity: the Rhode Island Quality Institute's (RIQI) Board of Directors as well as their community based committees. The state is well-aligned with RIQI, as the Health Insurance Commissioner and Secretary of EOHHS serve as ex-officio, non-voting members on the RIQI board and the State HIT Coordinator serves on all of RIQI's community based committees. These committees provide valuable input to RIQI as we move together in a direction of development activities that support both service delivery reform (technology to assist care coordination, transitions of care, and care management) and value-based payment reform (technology to assist with over-utilization, such as alerts and Care Management Dashboards).

There is also a statutory HIE Advisory Commission that is responsible for advising the Director of Health on the uses of HIE data as well as a statutory APCD Data Release Review Board that provides similar advice to the Director of Health for the APCD. While the HIE Advisory Commission's primary role is in advising regarding privacy and security of the information within the HIE, often the Director asks them to advise around new concepts RIQI may be developing. The APCD Data Release Review Board's primary objective is to review data requests applications, however they have also been helpful in gauging community reaction to the types of data products that will be offered and identifying some gaps in data products that would leave some potential customers wanting. In addition, through RIQI, the Provider Directory Advisory Committee which was originally convened only with representatives of state agencies and RIQI is now expanding to include providers, payers and consumers to help ensure that the development of the provider directory aligns with reform efforts in the states, and that RIQI does not work in an information silo. Lastly, the Healthcare Quality Measurement Reporting and Feedback System being developed through SIM is being governed by a workgroup of the SIM Steering Committee. This committee was essential to SIM for our understanding of the community needs around quality measurement and in our development of the RFP for the system to meet those needs.

The biggest risk around these multi-stakeholder structures that help support the state's reform efforts is that the stakeholder groups may recommend or request features that are currently not allowed by state law, may require additional stakeholders to accomplish, could take a longer time to complete than possible, or may be too technologically difficult to accomplish without additional funds. For example:

- Including all payers' provider network data in the Provider Directory – This is a common request at every meeting, but requires that the payers be willing to provide this data. They have some reasonable concerns about doing so, and thus negotiating data sharing agreements has been very difficult or in some cases, not possible.
- Combining claims and clinical data – Right now HealthFacts RI is a mandate, but by law must be de-identified. A combination of claims and clinical data can only be accomplished if the payers volunteer to include claims data in the HIE for enrolled patients.

- Single statewide patient portal – This is a common request, but the technological barriers to accomplishing this are high, and there are also concerns about a unified patient portal making it more difficult for providers to get patients to use their portals so that providers can obtain credit for meaningful use.

It can sometimes be difficult to find stakeholders who have the interest, time, and commitment to serve on our stakeholder groups, so there is always a risk that inability or slowness to act on recommendations may disenfranchise stakeholders over time. The state makes an effort to be open about potential barriers and the slowness of some processes such as legislative or regulatory change to support any changes to alleviate some of this risk.

There is also occasionally some risk posed by multi-stakeholder governance groups being overly cautious with privacy and security concerns even beyond the requirements of state and federal law and regulations, and thus inadvertently making recommendations that are overly protective and contrary to standard practice.

While there is no central single state agency responsible for all components of the state’s HIT efforts, there is unprecedented collaboration occurring across state government and with the community to strategically align, leverage, and coordinate HIT activities across the state in support of our Triple Aim goals in Rhode Island.

## HIT Policy Levers

### Enacted Policy Levers

Rhode Island has enacted a variety of HIT policy levers to support SIM, the transition to value-based payment, quality improvement and interoperability. Table 13 describes those policy levers related to SIM and the HIE.

**Table 13: Health IT Policy Levers That Support SIM**

Policy Lever	Topic Focus	Mechanism	Target	Status
<b>Accountable Care Arrangements</b>	Payments	<p><b>Payer Contracts:</b> HIT requirements are being incorporated into Accountable Entity (AE) Certification requirements, pending final approval:</p> <ul style="list-style-type: none"> <li>• Use of CEHRT</li> <li>• Bi-directional integration with HIE</li> <li>• Enroll patients in CurrentCare</li> <li>• Use of Patient Portals</li> <li>• Use of Care Management Dashboards and/or Care Management Alerts</li> <li>• Contribute provider files to Statewide Common Provider Directory</li> </ul>	MCOs/ Providers	Planned
<b>Advanced Primary Care Arrangements</b>	Payments	<p><b>Statutory/Regulatory Authority:</b> OHIC allows practices to apply for OHIC-PCMH status, which can be</p>	Commercial Health Plans/ Providers	Effective July 11, 2016.

Policy Lever	Topic Focus	Mechanism	Target	Status
		met in a couple of different ways including by proving NCQA-3 Recognition. Commercial health plans are obligated to pay OHIC-PCMH practice Support Payments if they are included in the plan's OHIC PCMH target count.		
<b>APCD Policies</b>	Governance	<b>Statutory/Regulatory Authority:</b> RIDOH requires payers with greater than 3,000 members to submit claims data to the APCD.	Payers	Effective July 2013
<b>Certificate of Need (CON) Regulations</b>	Governance	<b>Statutory/Regulatory Authority:</b> For each new CON request, RIDOH incorporates conditions into the approval. These conditions include: <ul style="list-style-type: none"> <li>• Incorporating SIM recommendations into the implementation plan</li> <li>• Participation in CurrentCare, including enrollment of patients and bi-directional exchange</li> </ul>	Facilities	Rolling decision dates
<b>E-Prescribing Mandate or Encouragement</b>	Governance	<b>Other:</b> RIDOH has authorized the prescribing of controlled substances electronically, and strongly encourages e-prescribing as a safe opioid prescribing practice; <b>Pending Statutory Authority:</b> A bill was submitted in the 2017 legislative session to mandate e-prescribing.	Providers	Effective 2014
<b>HIE Advisory Commission</b>	Governance	<b>Statutory Authority:</b> RIDOH operates an HIE Advisory Commission comprised of members of the community which serves an advisory role to the Director of Health regarding the privacy and security of protected health information in the state designated HIE.	HIE	Effective 2013
<b>Prescription Drug Monitoring Programs (PDMP)</b>	Governance	<b>Statutory/Regulatory Authority:</b> The RIDOH requires that pharmacies report dispensing data within 24 hours, and that prescribers check the PDMP before prescribing an opioid for the first time or every 6 months.	Pharmacies/ Prescribers	Reporting Effective 1997; Prescriber requirements effective 2016.
<b>State Appropriated Funds</b>	Funding	<b>Other:</b> The state appropriates Medicaid's 10% share of the per member per month allocation that all major payers pay to support the operations of the HIE.	HIE	Effective 2012
<b>State Purchasing/</b>	Governance	<b>Payer Contracts:</b> Medicaid incorporated clauses in the MCO	MCOs	Effective 2017

Policy Lever	Topic Focus	Mechanism	Target	Status
<b>Contracting of Health Care Services</b>		contracts to encourage participation in SIM activities, including the provider directory.		
<b>State-level Legal Protections</b>	Governance	<b>Statutory/Regulatory Authority:</b> The HIE statute and regulations provide immunity for providers from criminal or civil liability arising from any good faith reliance on information provided through the HIE.	Providers	Effective 2008
<b>Telemedicine</b>	Governance	<b>Statutory/Regulatory Authority:</b> Rhode Island law (§27-81-4) requires that insurers provide coverage for the use of telemedicine services.	Payers	Effective January 1, 2018

### Privacy Protection Policies

A variety of state policies limit Rhode Island’s ability to leverage our HIT infrastructure as some other states are able to do. Notably, we cannot combine the claims data in HealthFacts RI with the clinical data in our HIE.

Rhode Island has distinct laws and statutory requirements governing the development, use and release of data from HealthFacts RI and the statewide HIE. However, Rhode Island laws make linking the two databases challenging and require each system to have its own community based commission. Both commissions are required to advise the Director of Health, which does allow the Director to create a coordinated strategy out of what would otherwise appear to be separate silos. While the specific focus and tasks for each committee differ, Rhode Island’s strategy and criteria for data use (as permitted by law) are similar. The State’s aligned data strategies help coordinate the HIT governance across these and other efforts. Moreover, the same state staff are responsible for both HealthFacts RI and the HIE, giving staff a broader understanding of the current HIT effort, and leveraging the synergistic potential of the two programs.

The State recognizes the benefits of directly linking HealthFacts RI data with the HIE data. Currently, HealthFacts RI has only de-identified data, which can only be released as such. The HIE data is identifiable but only includes a portion of Rhode Islanders and can only be shared to support treatment and coordination of care or for public health purposes. These constraints inhibit SIM’s ability to link these two specific databases.

Despite the challenges, state and RIQI staff have begun to identify potential ways to address this need. Rhode Island continues to explore implementing options such as:

1. Adding an extract of CurrentCare data to HealthFacts RI by sending it through the lockbox vendor, de-identifying it, and adding it to HealthFacts RI’s analytics tool and extracts.
2. Amending state laws to reflect the needs and requests of providers throughout the state to deliver thoughtful value-based care in APMs.
3. With the agreement of the payers and providers, building a separate system that shares data between payers and providers under HIPAA compliant business associate agreements.

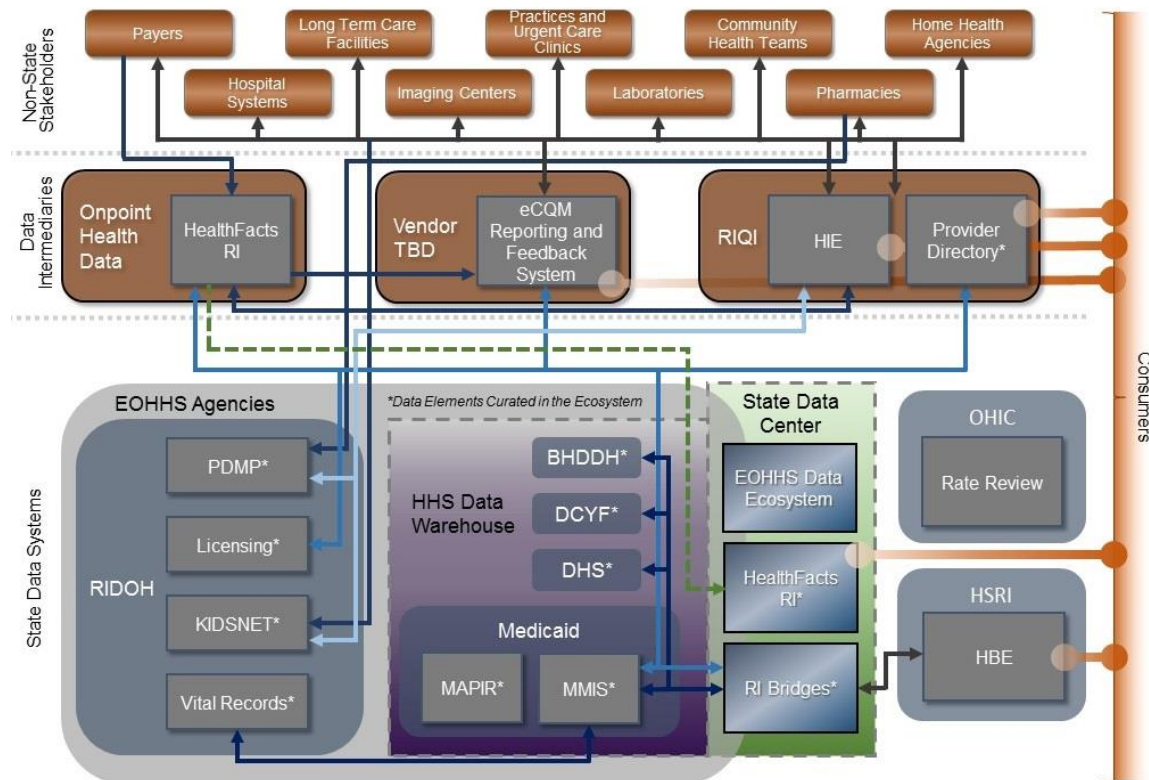
Over the past year several meetings have been held with state leadership and legal counsel to discuss the intricacies of the policy around these two data sets. To move ahead and make these critical decisions, we will depend on our stakeholders for input and advice. The most effective way to seek this advice will be for us to hold two or more educational forums to which we can invite members of the CurrentCare and HealthFacts RI oversight boards, and SIM’s Technology workgroup. We will use these forums to have the experts in attendance review the options and make recommendations to the appropriate bodies – the HIE and HealthFacts RI Advisory Commissions, the SIM Steering Committee, or state leaders.

Rhode Island is committed to improving the value of our statewide HIT infrastructure while serving the privacy of our residents.

## Existing State HIT Systems

Rhode Island's investments in HIT include a diverse group of systems that help reduce administrative waste, increase EHR adoption, support interoperability, and improve care coordination. This updated Data Architecture Diagram describes the relationships between these systems and they are described in further detail below.

**Figure 16: Rhode Island Health Data Architecture Diagram**



## UHIP

The Unified Health Infrastructure Project (UHIP) is designed to be a single technical platform that supports Medicaid and other state human service eligibility, collecting consumer information in a centralized resource. UHIP is an interagency initiative between HealthSource

RI, the Executive Office of Health and Human Services (EOHHS), and the Office of the Health Insurance Commissioner (OHIC). While UHIP has experienced serious challenges in its roll-out, Governor Raimondo has assigned new leadership to a turn-around team which is having some success in fixing the problems. The state is fully committed to ensuring that all Rhode Islanders can efficiently get the benefits to which they are entitled.

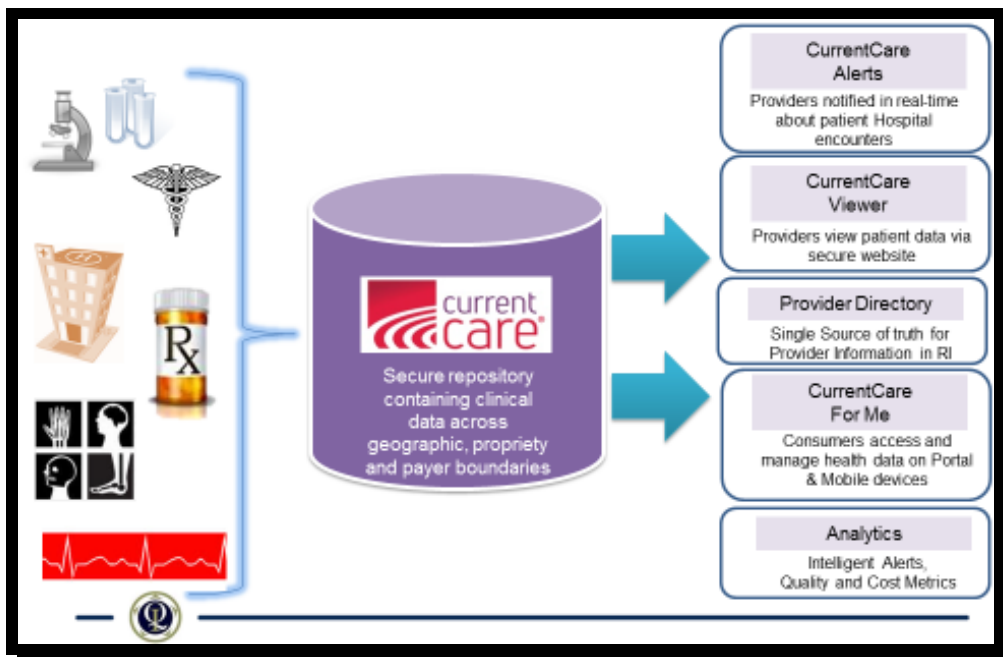
### KIDSNET

KIDSNET, administered by RIDOH, is the state’s confidential, computerized child health information system serving families, pediatric providers, and public health programs. It helps ensure that all children in Rhode Island are as healthy as possible by tracking health screenings and connecting children to important early intervention programs. Operational since January 1, 1997, KIDSNET captures information on all children born in the state, as well as from children born out of state who see a Rhode Island participating provider or receive services from a program participating in KIDSNET.

### CurrentCare

CurrentCare is the statewide Health Information Exchange (HIE), operated by RIQI, the state’s designated regional health information exchange organization (RHIO) entity. Rhode Island’s HIE is a secure electronic system that allows doctors and other caregivers immediate access to an enrolled patient’s up-to-date health information in order to provide the best possible and most comprehensive care. CurrentCare went live in 2010 and is governed by the HIE Act of 2008, which requires individuals to voluntarily participate in the program. Participants agree to have their data be stored and shared through CurrentCare with provider users they authorize. CurrentCare also provides Hospital Alerts to subscribed providers to inform them of emergency department (ED) or hospital admission, discharge, or transfer of their patients. A CurrentCare Patient Portal is under development and will be tested by a pilot group in the spring of 2016. As of March 2016, there are 435,000 actively enrolled participants, which represents about 43 % of Rhode Island’s population.

**Figure 17: CurrentCare Data Exchange Diagram**



## Prescription Drug Monitoring Program

The RIDOH maintains a Prescription Drug Monitoring Program (PDMPo) which collects dispensing data for Schedule II, III, and IV prescriptions from all pharmacies in the state. Prescribers and pharmacists can log in to the PDMP portal to look up dispensing information on patients they are serving, improving the ability of providers to make informed prescribing decisions.

## HealthFacts RI

HealthFacts RI is Rhode Island's all payer claims database (APCD). It consolidates an individual's de-identified claims from all payers longitudinally in a central database, preparing the data to be used for analysis to ensure transparency about health care costs, utilization, and quality in the state. The Rhode Island General Court enacted [Chapter 23-17.17-9, Health Care Quality and Value Database](#) in 2008, which directed RIDOH to establish and maintain the Rhode Island All-Payer Claims Database and gave the state the authority to require insurance companies to provide de-identified healthcare claims data for services paid on behalf of enrollees. Planning for the development of HealthFacts RI began in 2012 when funding became available, and RIDOH promulgated [regulations](#) in 2013. While other funds were used to build the initial HealthFacts RI database with historical data, funding for the ongoing ability to fully implement, maintain, and analyze the data is part of our SIM HIT plan and will be discussed in more detail below.

## SIM Test Grant HIT Components

While HIT adoption is continuing to become more prevalent among the larger practices in Rhode Island, many providers, practices, healthcare organizations, and the state itself are struggling to find the resources and means to fully and effectively use EHRs and claims data to drive improvements in health care quality and reduce the cost of care. Given that data continues to aggregate in individual EHRs, in ACOs and health plans, and within projects such as CurrentCare, HealthFacts RI, and RI Bridges, Rhode Island needs an effective, thoughtful, and integrated analytic strategy to support the state's SIM goals and drive health care transformation efforts.

Rhode Island's SIM Health Information Technology Plan has two major strategies:

1. Improve our collective analytic capacity for the data we already have; and
2. Implement technology and tools that support our transformation activities.

There are five major projects in Rhode Island's Health Information Technology Plan:

- HealthFacts RI;
- Statewide Common Provider Directory;
- Integrated Health and Human Services Data Ecosystem;
- Healthcare Quality Measurement, Reporting, and Feedback System; and
- CMHC Care Management Dashboards.

Rhode Island has developed these projects so that they are all interconnected and interdependent. To sufficiently and adequately understand and increase the value of the healthcare being provided in Rhode Island, we are pursuing a value-added central collection of



provider data, claims data, and clinical data that goes beyond the siloed data housed at each individual healthcare organization and state agency. The proposed implementation timeline for these activities is incorporated in the Master Timeline, and we have included detailed work plans in the SIM components section. The contributing entities include payers, providers, and state agencies. When the projects are fully implemented, each system will feed off the knowledge and value-added features located in the others.

## **HealthFacts RI**

SIM Test Grant funds are supporting the implementation and maintenance HealthFacts RI. Its purpose is to ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island's healthcare delivery system. When fully implemented, it will also provide state agencies and policy makers with the information they need to improve the value of healthcare for our residents. It has begun to illuminate how Rhode Islanders use the healthcare system, the effectiveness of policy interventions, and the health of our communities. HealthFacts RI began collecting data in 2015 and includes historical data from 2011-2014.

## **Use of HealthFacts RI**

With the passage of the Affordable Care Act, 95% of Rhode Islanders are now covered by insurance<sup>8</sup>. Most of their encounters with the healthcare delivery system will result in the payment of a claim processed by one of the insurers in the state, including Medicaid. A claim contains a wealth of health and cost information such as the diagnosis, basic demographic information, provider information, cost information (including total cost and out-of-pocket cost), and type of treatment provided.

Rhode Island has taken extensive precautions to protect patient privacy in the database, while ensuring that the data is still longitudinal and useful to agencies, legislators, and researchers. HealthFacts RI does not collect any direct patient identifiers and is fully de-identified. A unique member ID allows for longitudinal analysis across payers and time. The APCD legislation also allows individuals to opt-out of having their data collected.

HealthFacts RI collects, organizes, and analyzes health care data from nearly all major insurers. This information allows users to benchmark and track Rhode Island's health care system in ways that were previously not possible. We can now consider questions such as:

1. How do patients of commercial insurers fare on preventable hospital readmissions compared to those in Medicare or Medicaid?
2. How much are we spending on healthcare in Rhode Island and what drives that spending?
3. What do we know about the types of patients who miss critical preventive or disease management services?

As the data collected by HealthFacts RI grows, we will better understand the healthcare delivery system by identifying areas for improvement, growth, or contraction; we will be able to better quantify overall health system use and performance; we can more effectively evaluate the effectiveness of policy interventions, and assess the population's health.

One of the great benefits of creating a database like this is that individuals can be tracked over time, even if they change insurers. With HealthFacts RI, analysis of the lifespan will be possible

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<sup>8</sup> <http://healthsourceri.com/press-releases/healthsource-ri-reports-uninsured-rate-drops-to-5/>

to help understand, for example, the scope of an entire health episode (i.e. an entire knee replacement and recovery, severity of illness, or potentially preventable events).

Table 14 describes potential state agency uses of HealthFacts RI, and Table 15 describes potential non-state user uses of HealthFacts RI. These analyses will support a host of new activities under value-based payment. Policy makers and researchers will use this knowledge to inform the way care is delivered and paid for, in order to move the system toward a higher-quality, greater-value paradigm.

**Table 14: Potential Use of HealthFacts RI by State Agencies**

Audience	Potential HealthFacts RI Uses
Medicaid	<ul style="list-style-type: none"> <li>• Conduct analyses to meet federal reporting requirements for Medicaid, such as the Access Monitoring Review Plan requirement.</li> <li>• Evaluation of the Long-Term Care Rebalancing and Accountable Entities programs.</li> <li>• Monitor, both all-cause and preventable hospital readmissions by provider, demographic, year, geography, admitting diagnosis, or post-discharge services. Compare to other payer types.</li> <li>• Analyze the use of appropriate care settings: trends in ED, clinics, or office visits</li> <li>• Understand the effect on patient health care of interventions, such as long term care rebalancing and the transition to Accountable Entities</li> <li>• Monitor the types of outpatient services used after a hospital discharge for those who are and who are not readmitted</li> </ul>
Department of Children, Youth and Families	<ul style="list-style-type: none"> <li>• Spot trends in groups of children with lead poisoning and help identify safer environments for children to live and play</li> <li>• Identify patterns of access to care for children with behavioral health conditions or diagnoses</li> <li>• Explore patterns of children who visit the ER frequently for non-emergent conditions</li> </ul>
Department of Health	<ul style="list-style-type: none"> <li>• Monitor trends in disease prevalence, co-morbidities, and emerging infectious diseases</li> <li>• Design and evaluate interventions to address trends in opioid and prescription drug abuse</li> <li>• Monitor prescription refill patterns as a proxy for medication adherence monitoring</li> <li>• Understand patterns in care migration and service use outside of Rhode Island to support the Certificate of Need process</li> <li>• Monitor and use data to promote screening and prevention services</li> </ul>
Department. of Human Services	<ul style="list-style-type: none"> <li>• Better understand the medical experience of demographic groups that receive DHS benefits, such as WIC and SNAP</li> <li>• To better tailor benefit and service experiences, monitor trends in patient health, spending, and use by zip code to find similar demographic groups</li> </ul>
Division of Elderly Affairs	<ul style="list-style-type: none"> <li>• Test, evaluate and monitor the effect of different long term care arrangements on patient health and spending</li> <li>• Compare duration, intensity, and types of service use for elders who continue to live in the community versus those who enter nursing home care</li> <li>• Create profiles to help predict elders at risk of missing needed care</li> </ul>

Audience	Potential HealthFacts RI Uses
Healthsource RI	<ul style="list-style-type: none"> <li>• Develop portraits of those enrolled in plans sold through HealthSource RI compared to rest of state</li> <li>• Understand how people use health care when they have diverse types of insurance coverage</li> <li>• Better understand patterns of coverage churn</li> <li>• Monitor patient out-of-pocket comparisons by plan type/metal value</li> </ul>
Office of the Health Insurance Commissioner	<ul style="list-style-type: none"> <li>• Provide information about costs of services to consumers</li> <li>• Review cost trend drivers to support rate review</li> <li>• Compare increases in actual medical spending versus premium payments</li> <li>• Monitor out-of-pocket spending and total cost of care</li> <li>• Project effects of hospital system consolidation on price</li> </ul>
State Innovation Model (SIM)	<ul style="list-style-type: none"> <li>• Support modeling and evaluation of new payment designs</li> <li>• Establish baseline and quantify total spending for patient cohorts attributed to particular practices</li> </ul>

**Table 15: Potential Use of HealthFacts RI by Non-State Users**

Audience	Potential HealthFacts RI Uses
Consumers	<ul style="list-style-type: none"> <li>• Quality and cost information for different products, carriers, and provider groups or health systems</li> </ul>
Payers	<ul style="list-style-type: none"> <li>• Risk-adjusted payment comparisons</li> <li>• Program evaluation</li> <li>• Health reform initiatives</li> <li>• Provider-specific measures (utilization and quality)</li> <li>• Methodologies for attribution, risk-adjustment, and predictive modeling</li> <li>• Information on behavioral health</li> <li>• Market analysis</li> </ul>
Providers	<ul style="list-style-type: none"> <li>• Risk-adjusted peer comparisons for practice improvement and transformation</li> <li>• Referral costs</li> <li>• Patterns of care (flow of patients to other specialists, etc.)</li> <li>• Episode groupers</li> <li>• Market analysis</li> </ul>
Researchers	<ul style="list-style-type: none"> <li>• Wide range of research projects to be approved by Data Release Board, such as: <ul style="list-style-type: none"> <li>○ Epidemiology</li> <li>○ Evaluation of program effectiveness</li> <li>○ Comparative effectiveness</li> </ul> </li> </ul>
Other Commercial Users	<ul style="list-style-type: none"> <li>• Pharmaceutical, medical device trials and research to be approved by Data Release Board</li> <li>• Market analysis</li> </ul>

Additionally, HealthFacts RI data will be available by request to any number of stakeholders, including nonprofits, other state governments, and researchers. While some aggregated data sets are posted on the RIDOH website, detailed line level data sets can be released after review of an application. These line level data sets do not contain any identifying information; however, there are scenarios where there may be enough information that when combined with another

dataset an individual could be identified. To help reduce the chance of privacy violations, the RIDOH Director convenes the All Payer Claims Database Data Release Review Board, an eleven-member advisory board, to review applications for data. The purpose of the board is to ensure that data requestors will maintain patient privacy. Any data release which has a potential to identify any individual will only be released with an appropriate Data Use Agreement (DUA) between RIDOH and the recipient. Additionally, the Data Release Review Board will take into consideration the recipient’s ability to secure and protect the data when making a recommendation about data release.

Value-based healthcare requires transparency.<sup>9</sup> Meaningful cost and quality information is key to building a healthcare system that pays for quality and outcomes instead of more services that may or may not improve patient health. However, despite years of measurement efforts, patients, employers, public purchasers, health plans, and even providers, have almost no reliable information about the relative cost and quality of healthcare services. Payment reform and delivery system redesign are front and center as national priorities – and to make them work, we need transparent performance information to know that we are paying for the right care at the right cost.

**Status of HealthFacts RI**

HealthFacts RI includes claims data for any commercial, self-insured, Medicare, and Medicaid entities which covers over 3,000 lives. The database includes membership, paid medical claims, paid pharmacy claims, and provider data from 2011 to present. Data collection began in 2014, and currently comes from seven commercial and two public payers. In 2016, we completed the on-boarding of CVS and began the on-boarding of Blue Cross Blue Shield of Massachusetts.

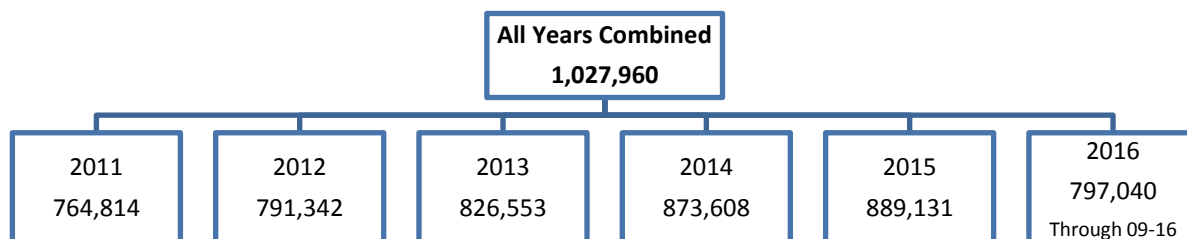
The contract for our previous APCD data aggregator had ended in 2016, necessitating re-procurement and we released the RFP for a Data Vendor in October of 2016. The APCD team restructured the vendor model based upon the experiences over the last few years and consolidated the aggregation and analytic functions under a single vendor, increasing efficiency and accountability. The state selected Onpoint Health Data as the vendor as of March 2017.

**Table 16: Payers submitting data to HealthFacts RI**

Commercial Payers	Public Payers
Blue Cross & Blue Shield of Rhode Island	Medicaid
United Healthcare	Medicare (Parts A, B, D)
Neighborhood Health Plan of Rhode Island	
Tufts Health Plan	
Harvard Pilgrim	
Aetna	
Cigna	
CVS	
In-process: Blue Cross Blue Shield of Massachusetts	

<sup>9</sup> <http://www.nrhi.org/work/multi-region-innovation-pilots/center-healthcare-transparency/>

**Figure 18: Unique Covered Lives in HealthFacts RI Database**



### **Governance of HealthFacts RI**

HealthFacts RI is managed by an Interagency Staff Workgroup (ISW) made up of representatives from four state agencies: EOHHS, HealthSource RI, RIDOH, and OHIC. This workgroup meets weekly to monitor the progress of the vendors' work and to plan next steps. The agency principals are kept up to date on the status and asked to weigh in on major decisions through regular meetings. (Please note: as described above, because of state privacy laws, there cannot be coordination between CurrentCare and the APCD governance.)

As mentioned above and as required by statute, there is an APCD Data Release Review Board whose purpose is to ensure that data requestors such as researchers, program evaluators, payers etc., will maintain patient privacy. HealthFacts RI will be ready to start releasing data files to requestors in the middle of 2017. In response to the recent U.S. Supreme Court ruling in *Gobeille v. Liberty Mutual*, Rhode Island issued a memo to data submitters informing them that the decision does not apply to HealthFacts RI because the statute enacting the APCD is very different from the Vermont statute reviewed by the Supreme Court. Rhode Island imposes reporting requirements on insurers – not ERISA governed self-insureds. There is no personally identifiable information in the database, and individuals are given the opportunity to opt out of the database.

### **SIM Funding of HealthFacts RI**

The HealthFacts RI SIM project has been supported by the work of several contracted vendors for project management, data aggregation, and analytics.

Freedman Healthcare provides project management and subject matter expertise for HealthFacts RI. The project management team organizes meetings, manages communications, coordinates with the vendors, and manages the data release process.

Our data aggregation vendor, Onpoint, subcontracts with Arcadia Healthcare to facilitate the data de-identification process, which allows for people to be matched longitudinally across payers while keeping individual identities masked. Payers submit their member eligibility files on a quarterly basis and receive a Unique Member ID (UMID) back to incorporate into their systems. Arcadia also maintains an [opt-out website](#) and the Rhode Island Health Insurance Consumer Support Line allows individuals to opt-out over the phone.

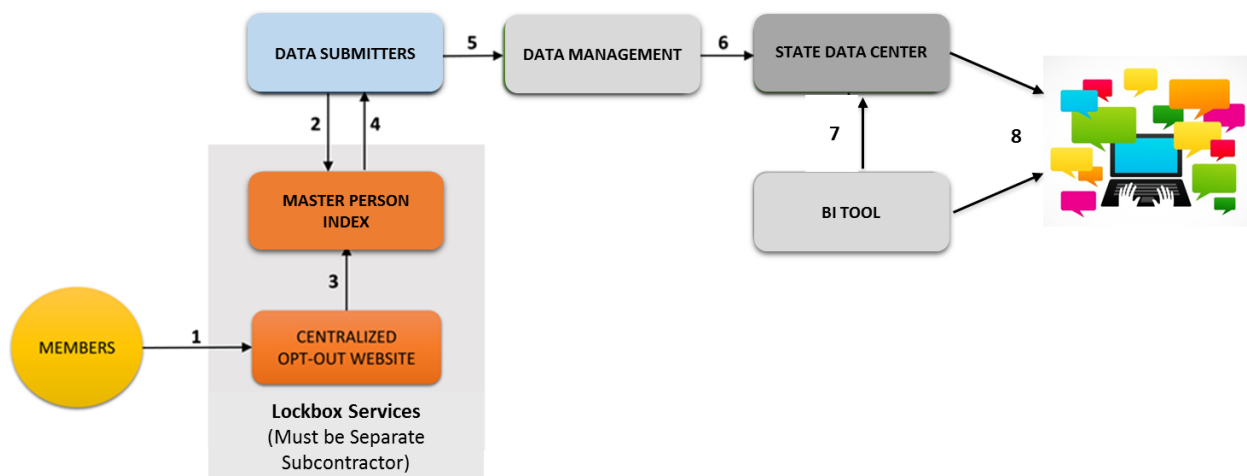
Next, the payers submit fully de-identified member eligibility, provider, medical claims, and pharmacy claims files to the data aggregator (Onpoint) including the UMID assigned by Arcadia in place of names and other sensitive identifiers. The data aggregator applies data processing rules to combine files together to construct the database.

Until mid-2016, the underlying data was then sent to our analytics vendor, 3M HealthCare, which provided additional analytic data processes and applied a variety of analytic value-adds to the data. The analytics vendor hosted a web-based analytics tool that provided some state agency employees the ability to analyze the data in a visual way.

Because of implementation challenges and increasing Medicaid needs for the data, the ISW realized that this analytics model was not ideal for accomplishing all of the HealthFacts RI goals. The group carefully considered several options for restructuring data access, and determined that the best option would be to transition the analytics component in-house, to be hosted at the Rhode Island State Data Center. Within the State Data Center, state agency staff are provided VPN access to the data to be able to run direct SQL queries and to access the data through different business intelligence tools. However, in order to support this change, we recognized that additional training would be needed for our HealthFacts RI staff to be able to support several Medicaid analytics needs.

This redesign came at a convenient time for us, because Onpoint’s contract was coming to an end and the state was due to issue another RFP. The design of this RFP included a short-term training component to have the vendor bring in expertise to train state staff in Export Transform and Load process, SQL server setup, database modeling, and incorporation into BI tools. In March 2017, the state awarded the contract to Onpoint, which retained their existing lockbox subcontractor, Arcadia, and is bringing on a new partner, Abilis, to train state staff for the analytics component. The work to transition the database to the state data center and complete the training is expected to be finalized by the end of 2017. This new model will more closely integrate HealthFacts RI into the Medicaid/EOHHS Data Ecosystem as described below.

**Figure 19: HealthFacts RI Infrastructure Diagram**



### Statewide Common Provider Directory

There are three important reasons that SIM prioritized funding the creation of a Statewide Common Provider Directory:

1. Payers, providers, and consumers alike need access to accurate provider information, including current provider name, address, and contact information, and practice affiliations, specific health plan network information, and direct e-mail addresses. In order to maintain accurate provider directories for facilitating payment, care

- coordination, or data analysis (such as with HealthFacts RI), each type of organization expends considerable resources attempting to maintain their directories. One statewide directory provides economies of scale for both dollars and time.
2. Per legislation, CurrentCare offers three consent options for providers to view data: in emergencies only, to only specific providers, or to all providers. Facilitating the option that only specific providers can view a participant's HIE data requires an accurate provider directory.
  3. Finally, there is no central location from which to identify the total number of providers (including primary care providers) practicing within Rhode Island or to identify how providers are affiliated. It is difficult to determine, for example, who belongs to what "practice," with which hospital a provider is affiliated, or how many physician practices exist in the state, etc. In 2015, RIDOH conducted a Statewide Healthcare Inventory of all services and providers in the state. A team of eight interns worked through the physician licensing database and determined whether each physician was actively practicing, practicing primary care, and the location of their practice(s). Thus, collecting this data required a considerable amount of manual work and phone calls – and we will need updated data in 2017 when the survey is conducted again. The Common Provider Directory will cut down on this type of duplicative activity going forward.

Using SIM funds, Rhode Island contracted with RIQI to build our Statewide Common Provider Directory, which includes detailed provider demographics and detailed organizational hierarchies. This organizational hierarchy capability is unique and essential to being able to maintain provider demographic and contact information, with a special focus on provider relationships to practices, hospitals, ACOs, and health plans. The Directory means that the mastering and maintenance of provider information and organizational relationships needs to take place only once, in a central location.

The provider directory is a database with a web-based tool that allows a team of RIQI staff to maintain the file consumption and data survivorship rules, error check flagged inconsistencies or mapping questions, manually update provider data, or enter new providers. The process of taking in data from external sources and reviewing inconsistencies is termed "mastering." RIQI has mastered 10,000 MD, DO, PA, and NPRN records as well as 3500 behavioral health provider records. With the appropriate data mastering and maintenance system in place, RIQI successfully launched the ability to have a useful data export via a flat file ready with a go-live in August 2016. These data exports will allow hospitals, payers, and state agencies to incorporate the centrally mastered provider data within their own databases.

The provider directory has a provider portal that when fully functional will allow providers to look up information on other providers that may not be public such as "direct" email addresses and to update their own data as needed. It is also in the final stages of completing a consumer portal which will allow individuals to access information on providers and provider organizations. The design of these portals took place in 2016 and early 2017, with the anticipated go-live in Summer 2017.

### **Project Management**

RIQI manages this project in partnership with a Provider Directory Advisory Committee (PDAC). The PDAC consists of RIQI leadership and provider directory staff, representatives from the major stakeholder state agencies (RIDOH, EOHHS, HealthSource RI and OHIC), the HealthFacts RI project management vendor, and most recently payers and providers. The group

has been convening at least monthly, with additional meetings as needed. The PDAC has overseen the creation of data stewardship and survivorship rules, and acts as an advisory body over the design and implementation of the provider directory. RIQI has recently decided to formalize the committee even more and is planning to add other community members in order to obtain broader input and advice regarding rules and assumptions about provider data. For example, when the PDAC began designing a sample extract, it invited providers into the discussion to inform RIQI about which extract elements are important to share publicly and which data elements are considered too sensitive to share, such as birth date and/or DEA number for writing prescriptions.

**Directory Data Sources**

The Statewide Common Provider Directory is being developed by RIQI with their HIE vendor, Intersystems. It was decided early on that the Healthcare Provider Directory (HPD) standard would not meet the business case needs, and so an independent data model has been constructed with a goal to make it extensible and flexible to fit future unforeseen needs.

The Provider Directory can receive multiple data feeds and matches those feeds based upon NPI (national provider identifier), provider name, etc. The initial data sources include the NPPES national database of providers, a purchased dataset from HealthMarket Science, RIQI’s internal database maintained from its role as the state’s Regional Extension Center, and a file from one of the major hospital systems in the state. Future data sources include the payers, the Department of Health’s licensing database, Medicaid provider database, APCD provider files, and data from additional providers or provider networks. Not all prospective organizations perceived as data sources have agreed to supply their own provider files, especially due to concerns about sharing of private or proprietary information. In order to reduce this risk, Data Use Agreements can incorporate special sharing rules, and the submitting organizations are encouraged to participate in the PDAC which will also make data sharing governance rules. The PDAC is also working on an effort to reduce the burden on payers to submit provider files to both the Provider Directory and HealthFacts RI.

**Looking Forward**

RIQI made a presentation to the SIM Steering Committee in March 2017, on the details and upcoming roll-out of the Provider Directory. Upon the formal launch of the provider and consumer directory portals, we will provide be training and assistance around how to use the website, how to create a user account for providers to update their own data as well as how to update their own data. We will also provide consumer announcements and support for using the website, including mechanisms to report errors and other instructions.

There are numerous ways that the Provider Directory can be used to support a variety of stakeholders. We foresee the directory as being of great value to the community, and RIQI plans to provide directory extracts at a subscription style fee in order to help sustain the directory and the necessary staff in the future. Table 17 describes the various interested stakeholders and potential uses of a Provider Directory.

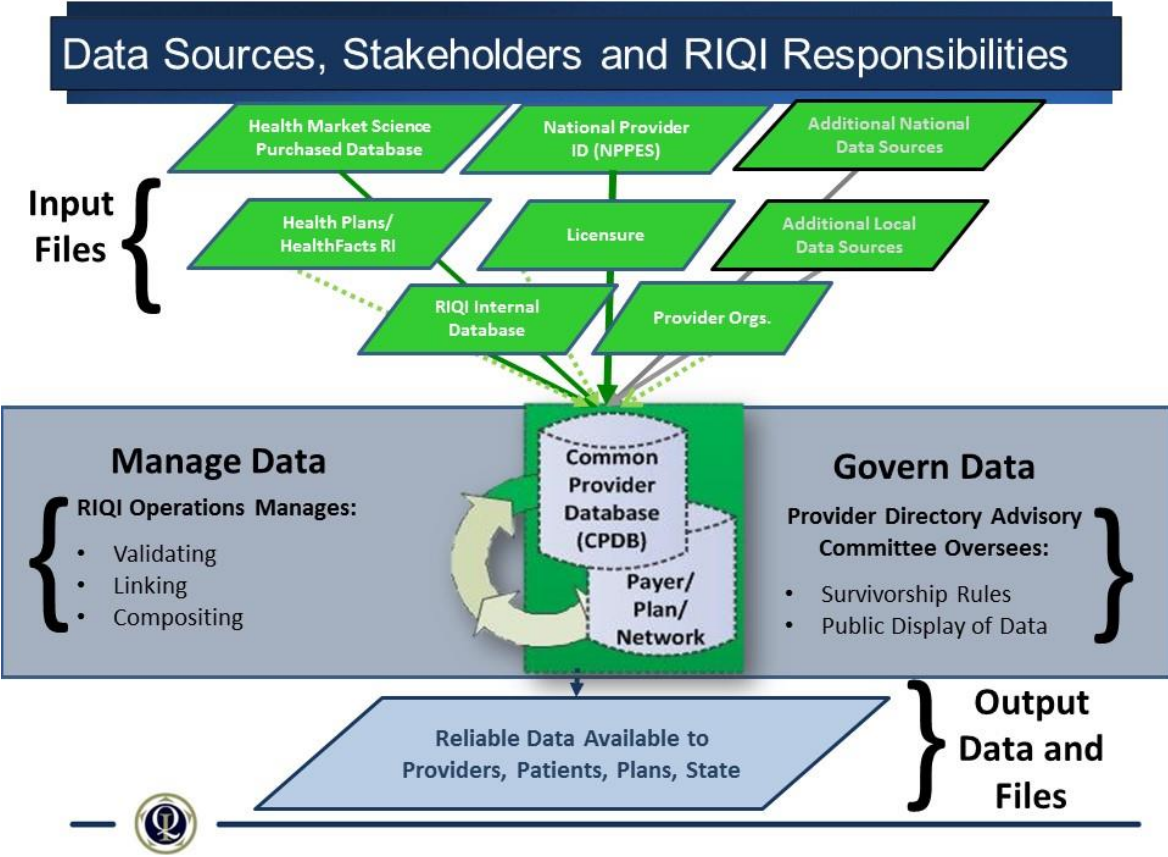
**Table 17: Potential Use of Provider Directory**

Audience	Potential Provider Directory Uses
State Agencies	<ul style="list-style-type: none"> <li>• Reduce resource needs to maintain internal provider directories</li> <li>• Support analytic needs, such as with HealthFacts RI analyses</li> </ul>



Audience	Potential Provider Directory Uses
Consumers	<ul style="list-style-type: none"> <li>Find a provider that fits the consumer's preferences</li> </ul>
Payers	<ul style="list-style-type: none"> <li>Support Qualified Health Plans and Medicare Advantage Plans in meeting regulatory requirements from CMS</li> <li>Understand the scope and location of providers for network design</li> <li>Support a more accurate internal provider directory</li> </ul>
Providers	<ul style="list-style-type: none"> <li>Find providers for referrals</li> <li>Support a more accurate internal provider directory</li> <li>Communicate to consumers more details about offered services</li> </ul>
Researchers	<ul style="list-style-type: none"> <li>Comprehensive understanding of the RI Healthcare system</li> <li>Evaluation of intervention impacts on access to healthcare services</li> </ul>
Other Commercial Users	<ul style="list-style-type: none"> <li>Support a more accurate internal provider directory</li> <li>Contact information for a variety of commercial purposes</li> </ul>

**Figure 20: Provider Directory Conceptual Diagram**



## **EOHHS Data Ecosystem**

SIM is helping transition the state's health care system to one dominated by value-based care, to lower costs and improve population health. The data ecosystem, a project-based network of linked person-level data and the technological systems that support its use, undergirds these goals by supporting data-driven and surgical approaches to improving and monitoring population health and holistic evaluations of our transition to Value Based Care.

Value based care and population health rely on understanding the whole person and the complete characteristics of a target population in order to tailor interventions to their needs – to meet people where they are. We also know that social determinants of health – measures that go beyond what can be captured on a claim, or even in a medical record – are stronger levers on healthcare spending and population health than purely medical factors.

The Rhode Island Executive Office of Health and Human Services holds rich sets of data for each of the programs and agencies it administers, many of which reflect social determinants of health, income supports and medical interventions. Our agencies often provide services to the same people. However, they remain unlinked, supporting only the program or agency from which they originate. Tying this information together with analyses at the person level will allow not just state government, but the state generally, to run smarter, more complete value based care arrangements that target specific populations and their unique needs. Data can then be used at both the individual level to provide better services and reduce gaps in care and services, and in the aggregate to drive overall policy decisions. The ability to share health and human services data across the EOHHS agencies is clearly permissible by state statute and will allow for a more complete evaluation of both the overall trajectory of care transformation and the relative success of different kinds of, and providers of, value-based care. Additionally, we will identify what policies, procedures, authorizations and data use agreements will be needed prior to engaging in data sharing initiatives with non EOHHS state agencies,

For instance, by linking KIDSNET data – vital information on children in Rhode Island hosted by RIDOH – with Medicaid and eventually commercial enrollment data, child welfare information, and income support services for the child's family, we can begin to answer question such as:

- Which high utilizers or particularly high-risk families and individuals are not enrolled in an Accountable Entity or Accountable Care Organization? Which have not seen a primary care clinician for either well or sick visits and are showing signs of social and income deterioration that may not have yet impacted claims costs? Can we get in front of a potential medical catastrophe by proactively linking these patients to focused care management and wrap around services?
- How do we best alert ACOs that some of their attributed children have had a positive screen for Early Intervention services, for lead levels, or for nurse home visiting and support them in providing need enhanced social worker, nurse care manager, or other medical and social support?
- What services, education, or other resources (based on known medical conditions from Medicaid and BHDDH claims) can the ACO bundle into a state-provided nurse home visit to maximize family engagement with preventive and behavioral health care?
- For families of children who screen positive for birth defects, high lead levels, or other points of stress in critical developmental years, what can an ACO do to ensure families remain enrolled in income supports and the other critical social services that they are receiving?

- Which Medicaid high utilizers, when combined with social support, economic, demographic, and other social determinants of health information, are most likely to benefit from case management interventions? Who are most likely to be homeless and benefit from home stabilization services, thus lowering costs?
- If one person in a family is a high utilizer, how can an ACO help the whole family maintain stability and thus lower medical costs and avoid high acuity settings?
- If the family received WIC, SNAP, or TANF, could an ACO build into the family’s care plan reminders for renewals and support for interacting with DHS if benefits are interrupted? Can care plans emphasize self-care for known chronic diseases that will flare without attention (theoretically exacerbated by stress, focusing on the care of others). Can care managers inform families of low-acuity alternatives for emergency rooms, ambulance transport and urgent care centers? For high-risk cases, can care managers train families on how to manage, identify signs of true emergency at home?

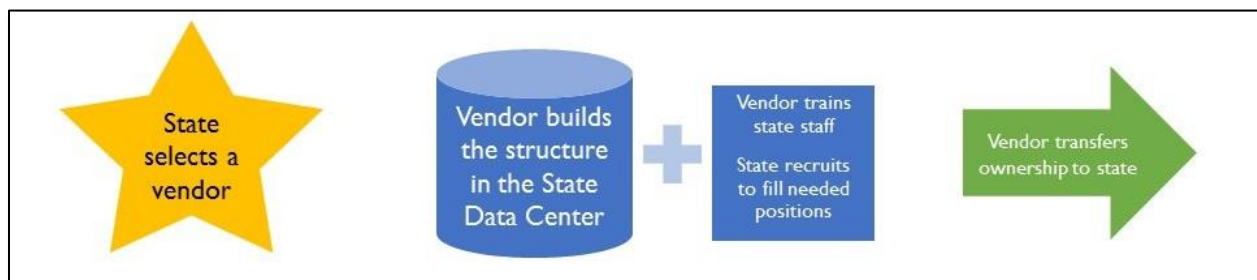
Through the use of the data ecosystem, we will aim to:

- Help Rhode Islanders fulfill their potential;
- Dignify individual circumstances; and
- Responsibly steward state resources.

EOHHS needs to be able to understand the people we serve as whole human beings, rather than recipients of individual programs. This means we need data that connects each person. We need this data quickly in a user-friendly environment for it to be useful. To respond nimbly to the changing policy and operational needs while controlling total costs, the state needs to own, operate, and optimize this data ecosystem. The Data Ecosystem will help all EOHHS agencies meet our missions, support state health reform such as SIM and HSTOP, and meet Medicaid’s federal standards under MITA.

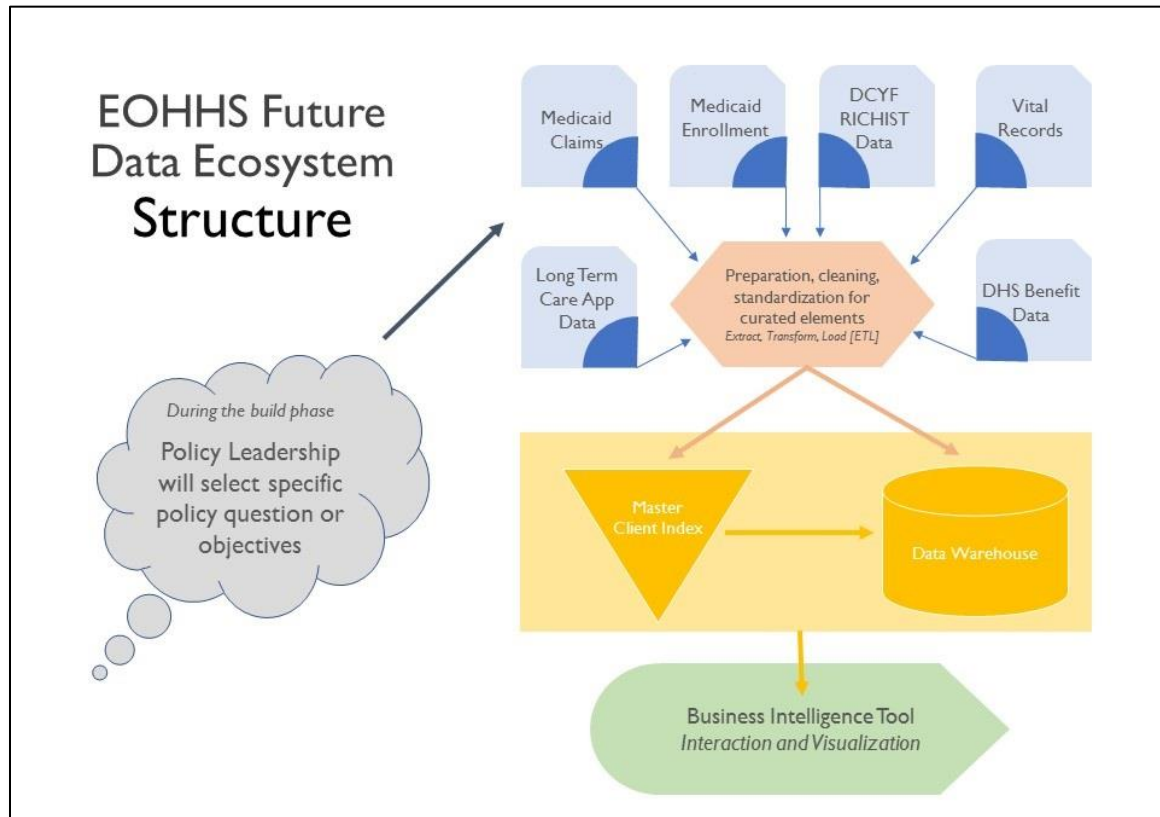
We will build the ecosystem through an agile development framework supported by an expert vendor to get us up and running. The vendor will build the structure in the state data system and train state staff. We will recruit new staff to fill needed positions to support the system once the vendor transfers ownership to the state (Figure 21).

**Figure 21: EOHHS Data Ecosystem Vendor Model**



Within the agile development framework the Data Ecosystem will operate on short work cycles that produce a working product at the end. Each of these cycles will answer a specific policy question or objective (Figure 22). Through the results-oriented activity, each cycle will add more features, data fields, and functions to the previous version (Figure 23).

**Figure 22: EOHHS Future Data Ecosystem Structure**

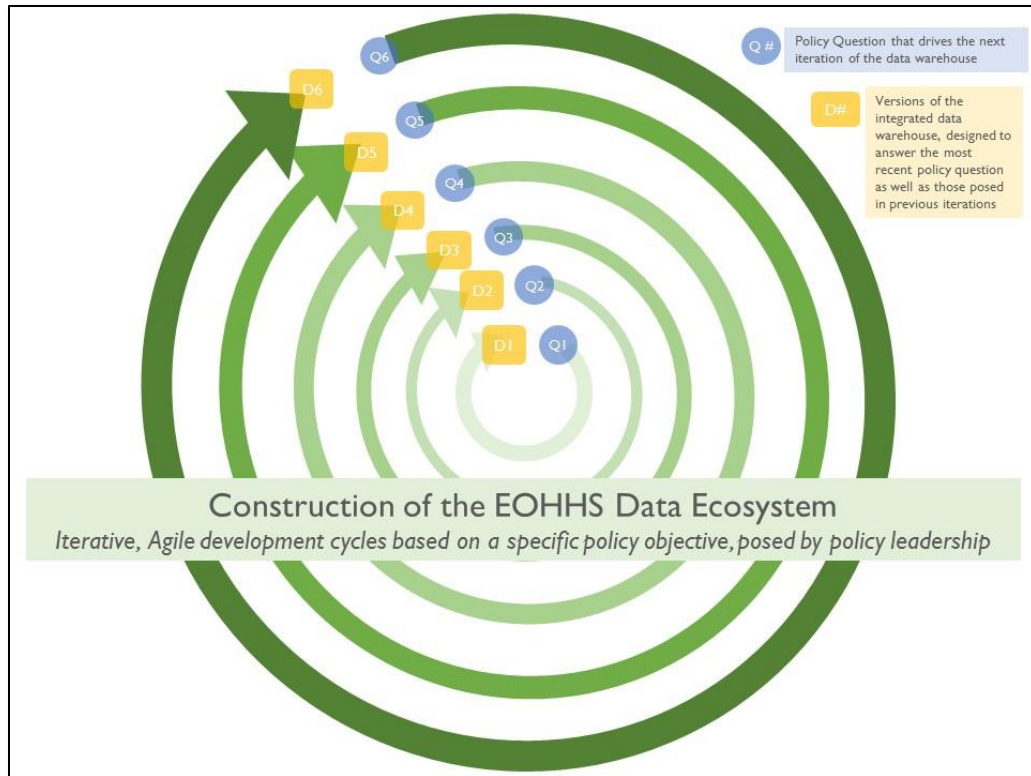


To implement the EOHHS Data Ecosystem, we have established two teams: a staff working team and a leadership team.

The staff working team meets on a weekly basis to manage each component of the work. The team is taking the lead on developing any applicable IAPD and the RFP, and will review proposals and select a vendor. They will then work with the selected vendor to implement the project and ensure that along the way the EOHHS Data Ecosystem continues to meet the needs and specifications of state leadership. This team includes staff from EOHHS and its agencies, the Department of Information Technology, and SIM core staff.

The leadership team meets monthly and guides the project. This group will select the objectives for each next version once the agile process begins. The leadership group consists of leaders from EOHHS, the Department of Information Technology, additional SIM core staff and the SIM Director, and the legislature.

**Figure 23: EOHHS Data Ecosystem Agile Construction**



During the implementation, we are committed to eight core principles. These principles were developed by the staff working team and leadership team using the results of the assessment, our past experiences with data projects, and the vision for what the EOHHS Data Ecosystem will be. They are:

1. **Integrated:** Data for each person is connected across agencies
2. **Policy and Program Driven:** Designed to answer specific, critical questions posed by leadership and informed by programmatic needs.
3. **Curated:** Includes the most relevant data elements
4. **High quality:** All data is standardized, verified, and cleaned before entering the ecosystem
5. **Interactive:** Intuitive tools plus a simplified data model encourages use by all users
6. **Designed for analysis:** The data model is built to quickly answer both operational and creative queries
7. **State owned & directed:** Lives at the State Data Center and is run by state employees rather than an outside company
8. **“Agile” construction:** Following best practices in warehouse design, we will build a full working version of the system every 1-4 months, adding features and adjusting as we go

This scalable and sustainable model will be developed in a manner that complies with all state and federal privacy statutes and will enhance our ability to measure holistic outcomes of our residents as we transition to value-based care.

Though the initial emphasis, as envisioned and funded by SIM, will be on those who interact with EOHHS programs, we will be able to learn things about a significant number of Rhode Islanders, including those served by Medicaid, DHS, DCYF, and BHDDH. The benefit to this design is that we will know more about our most vulnerable population group, those who most benefit from holistic interventions in social determinants of health.

## **Phases and Milestones**

Initial Phase: July 2016 through July 2018:

- **Award Year 2:** July 1, 2016 -June 30, 2017
  - Completed the data warehouse and analytic environment assessment (funded through other sources)
  - Began to use the findings of the assessment to determine how we will prioritize 1-3 research questions that rely on linked data, execute data linking pilots and test existing capacity. What skills, tools, and knowledge does the state have already and what does it lack? Which are most critical to supplement? What is the best way to supplement – through training, through software-as-service, through licensing and hosting services, through hands-on teaching and training of ETL (Extract, Transform, and Load) and data modeling, through contractual arrangements with staffing vendors?
  - Based on results of assessment and pilot, began to develop the RFP for project-based ecosystem launch services. Began to assess state and federal statutes for sharing data with non-EOHHS state and other agencies and gain an understanding of what is needed to enable data sharing Staff are using SIM Technical Assistance resources to help discover information about the work other states have done in this area.
- **Award Year 3:** July 1, 2017 – June 30, 2018
  - Complete the procurement for the Ecosystem vendor by June 2018. Within the agile data warehouse design framework, the vendor integrates EOHHS data sets on a project specific basis using either the servers and capacity at state data center or the existing HHS warehouse
  - Vendor builds a master client index generator for extensive future use
  - ETL scripts and data models are built with the expectation of handoff to state; extensive state partnership and documentation are required
  - Vendor builds a user interface on top of data model to facilitate widespread use of the integrated database among agencies
  - A key component of the training is how to strategically integrate a new dataset at the person level, which the state staff will be expected to do with non-EOHHS datasets

Phase II:

- **Award Year 4:** July 1, 2018-June 30, 2019
  - Over the course of the year, vendor transitions ecosystem to state and/or contractual staff

- Permanent staff gain experience in model maintenance, trouble shooting, and enhancements to the architecture, interface and value-added components based on customer need
- Begin to incorporate data from outside EOHHS
- **Beyond:** July 1, 2-19-June 30, 2020 – Non-SIM Funded
  - Transition to state staff complete
  - Critical datasets, both within and outside of EOHHS, are incorporated into ecosystem
  - Implement policies, procedures, authorizations, and data use agreements to enable data sharing outside of EOHHS.

## **Healthcare Quality Measurement Reporting and Feedback System**

During year one, stakeholders helped SIM study community needs, and determined that to help meet our goal of moving our healthcare system from volume to value, SIM should prioritize funding for a Healthcare Quality, Measurement, Reporting and Feedback System (Feedback System).

Having reliable and consistent clinical quality data is an absolute requirement for measuring quality within a value-based payment system. While some clinical quality measures can be calculated from claims data only, there are many that must be calculated from clinical data recorded in patient medical records at the points of care.

There are several initiatives within Rhode Island that require providers to submit clinical quality measure data. These include:

- The Care Transformation Collaborative’s multi-payer primary care and patient centered medical home transformation initiative (CTC);
- Payers’ contractual requirements;
- The RIDOH Chronic Care Collaborative (RICCC); and
- A myriad of national level quality initiatives such as the EHR Incentive Program, ACO program, Physician Quality Reporting System (PQRS), and National Committee for Quality Assurance (NCQA) certification programs.

The CTC and RICCC processes to collect quality measures involve manual report calculation at many of the participating practices using National Quality Forum (NQF)-based home-grown measures, and there is no guaranteed consistency in the measure calculation across all participants.

Emerging standards and the 2014 Certified EHR Technology (CEHRT) standards support more consistent quality measure reporting across different EHR vendors as compared to a manual reporting pull. Furthermore, there is a considerable burden upon payers to have quality reporting systems in place to receive their certification through NCQA. The data received by payers in claims alone is not sufficient nor accurate enough to forgo the manual audit of patient records at the point of care or the acceptance of a certain level of unreliability in the quality metric.

Three 2015 studies shed light on Rhode Island’s data needs. The studies indicate that there is a lower-than-desired capacity to perform data analytics in the state, but that providers and others do have the intention to spend great sums of money to support analytic needs. RIQI conducted an analytics inventory at the request of their Board of Directors. This inventory was conducted through a survey of state agencies, and a range of provider organizations (large, small,

independent, hospital affiliated, federally qualified health centers, community mental health centers, etc.), as well as payers, educational institutions, and community partners in the state. The study found that respondents had a need to calculate numerous high priority measures (including ambulatory quality measures, identification and management of high-risk patients, and analysis of utilization/cost of care indicators). However, these entities did not all have the systems in place to measure the information they needed. Only 76% of providers could collect ambulatory quality measures. Only 68% of providers could identify and manage high-risk patients, and 56% could measure utilization/cost of care indicators. Furthermore, the level of satisfaction with those analytic systems was extremely low. Half of respondents planned new systems for identification and management of high-risk patients, and around 20% planned new systems for ambulatory quality measures and utilization/cost of care analysis.<sup>10</sup>

We also find important data about EHR adoption rates in RIDOH’s Statewide Healthcare Inventory, conducted in 2015. The survey found that there was wide disparity in practices’ ability to analyze data. While 85% of hospitals had reporting software to help analyze data only 52% of nursing facilities, 26% of primary care practices, 23% of behavioral health clinics, and 17% of outpatient specialty practices had this software, as shown in Table 18.

**Table 18: EHR Adoption Rates Compared to Availability of Reporting Software, by Location Type, RIDOH Statewide Healthcare Inventory, 2015**

Survey	EHR Adoption Rate	Reporting Software
Primary Care	82.6%	26%
Outpatient Specialty	72.7%	17%
Behavioral Health Clinics	39.6%	23%
Nursing Facilities	80.9%	52%
Hospitals	92.3%	85%

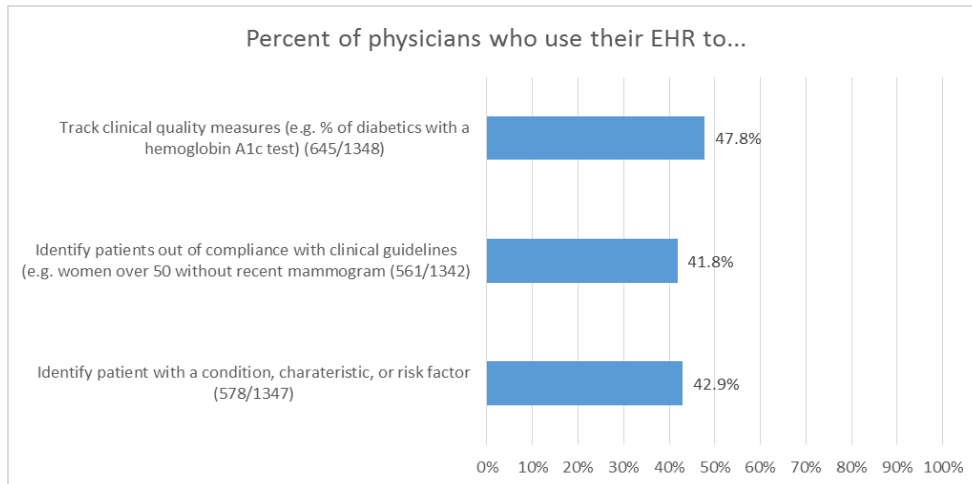
Providers were also surveyed about their use of EHR Technology from a population health perspective. Out of the 1,350 respondents, only 34.2% reported that they are using their EHR for population health management, 31.1% were not, and 24.7% did not know. However, compared to 2014, the number of respondents using their EHR for population management increased 7.8% and those who did not know decreased by 7.1%. This indicates that there is a shift to population health and to reducing the cost of healthcare with EHR technology.

One of the goals of the physician survey was to identify the provider’s use of their EHR to track quality measures and population health. Almost 50% of our providers are using their EHR for clinical quality measure monitoring and for patient reminder messaging.

<sup>10</sup> Rhode Island Quality Institute Analytics Inventory, 2015.

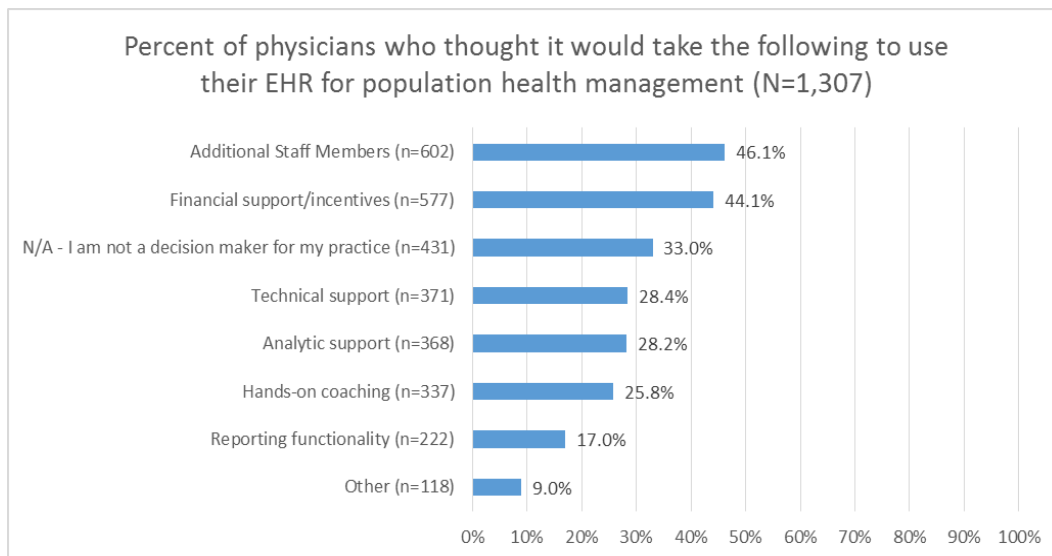


**Figure 24: HIT Survey, Physician Use of EHR, 2015**



The HIT survey also measured the barriers preventing providers from using their EHR for population health. As noted in the Figure 24, the primary reason that providers did not use the EHR for population health was the lack of adequate staff or financial support.

**Figure 25: 2015 HIT Survey, EHR Use for Population Health Management, 2015**



These data indicate that providers in the state are not prepared to measure and understand their own quality of care, much less proactively address gaps in care that lead to low quality measure performance.

**Feedback system Award Year 1 (Planning)**

A number of stakeholders considering these challenges have been participating in the SIM Technology Reporting Workgroup at the behest of the Steering Committee. The workgroup is led by the State HIT Coordinator and the SIM HIT staff person at EOHHS. It began meeting in January 2016, and consists of representatives from state agencies, payers, provider organizations, and quality improvement organizations. The workgroup also conducted a survey

of healthcare providers in the state to receive additional input on the concepts we were considering for the Feedback System. The Workgroup and the Steering Committee endorsed the development of a central quality measurement, reporting and feedback system to address this lack of readiness. However, we learned through stakeholder feedback that to pay for quality, there must be:

- Confidence that each participant is being measured consistently. This cannot be dependent upon the EHR vendor used at the participant’s service location;
- Cost alignment – i.e. the cost of measuring the practice should not exceed the benefits of high value cost arrangements;
- Confidence in the accuracy of the measurement;
- Arrangements that risk adjust, even if the data itself cannot be risk adjusted – i.e. leniency for specific practices that are known to have more complex populations; and
- Confidence in the attribution of a patient population to a specific practice.

The benefits of calculating measures centrally include:

- Consistent attribution methodology;
- Consistent measure methodology;
- Potential for lower costs to practice for measurement; potential for lower costs to payers for measurement; and
- Potential for risk adjustment that could be consistent.

The Workgroup proposed a set of goals and features for this system and the SIM Steering Committee approved the following proposal at the February 11, 2016, Steering Committee Meeting:

**Figure 26: Technology Reporting Workgroup Recommendation to SIM Steering Committee**

Providers, ACOs and facilities in Rhode Island have a variety of reporting requirements which will only increase under a value-based payment system. Numerous sources support the assumption that analytic resources and capabilities are insufficient in the state to empower providers and organizations to most effectively use their ever-growing and extremely valuable data. Furthermore, numerous organizations in the state are working toward creating their own quality measurement systems that will meet their needs, including payers, practices, and practice transformation organizations. With this understanding of our current environment, the Technology Reporting Workgroup recommends funding the development of a statewide quality reporting system with the goals of:

- Improving the quality of care for patients and driving improvement in provider practices by giving feedback to providers, provider organizations and hospitals about their performance based on quality measures
- Producing more valuable and accurate quality measurements based on complete data from the entire care continuum
- Leveraging centralized analytic expertise to provide valuable and actionable reports for providers and to drive improvements in population health
- Reducing the duplicate reporting burden upon providers and provider organizations by having a common platform for reporting
- Publicly reporting quality measurements in order to provide transparency and support patient engagement in making informed healthcare decisions

- Using existing databases, resources and/or systems that meet our needs, rather than building from scratch

The Workgroup has determined that to achieve these goals, the system would need serve as a common platform for quality measurement, quality improvement, and reporting. It would need to be able to accomplish the following, at a minimum:

- Easily capture data in a standard and consistent manner (no extra work for providers)
- Calculate measures from our SIM harmonized measure set and relevant national measure sets
- Become a Qualified Clinical Data Registry (QCDR) to allow the reporting of results directly to CMS, NCQA, and the payers, and fulfill additional reporting obligations on behalf of providers
- Benchmark providers at the provider level and the provider organization level
- Consist of detailed, individual level data from multiple sources matched to a single person, and make that data available to providers to improve individualized care while appropriately protecting confidentiality
- Share analyses and results back to providers, provider organizations, payers, state government, and, eventually, the public

This project should begin with a focus on collecting data from practices with Electronic Health Records (EHRs). In addition, the state must set up a governance structure with adequate community and provider engagement to determine what data is shared to whom and how it is shared.

There are multiple levels of governance necessary for the statewide Healthcare Quality Measurement, Reporting, and Feedback System. We used the output of the Technology Reporting Workgroup as we wrote and issued a request for proposals. The state procurement team has considered the Workgroup's feedback throughout the procurement process.

In Award Year 2, we designed the infrastructure of this system and the competitive bidding process to procure a vendor began in January 2017. We can envision this system collecting data from a variety of sources, ideally leveraging existing infrastructure; collecting and mastering the data within a data intermediary, and analyzing and viewing those data through an analytics engine with external public and provider facing website. See Figure 27 below.

Several SIM staff participated in the SIM electronic CQM technical assistance meeting convened in Washington, DC in early September, and requested several subject matter expert reviews on the final draft of the Feedback System RFP. The feedback was extraordinarily helpful, and we refined the RFP language based on it.

The RFP was posted in January 2017, and proposals were submitted on March 29. We aim to complete the process of selected the vendor by the summer of 2017.

### **Award Years 3-4 - Implementation**

Once the vendor(s) has been procured, the SIM HIT Specialist at EOHHS will oversee the vendor contract(s) and begin the process of establishing this system. This work will take place over a series of phases. Some details of the timeline will be determined based upon vendor proposals.

Initial Phase: July 2017 through 2018

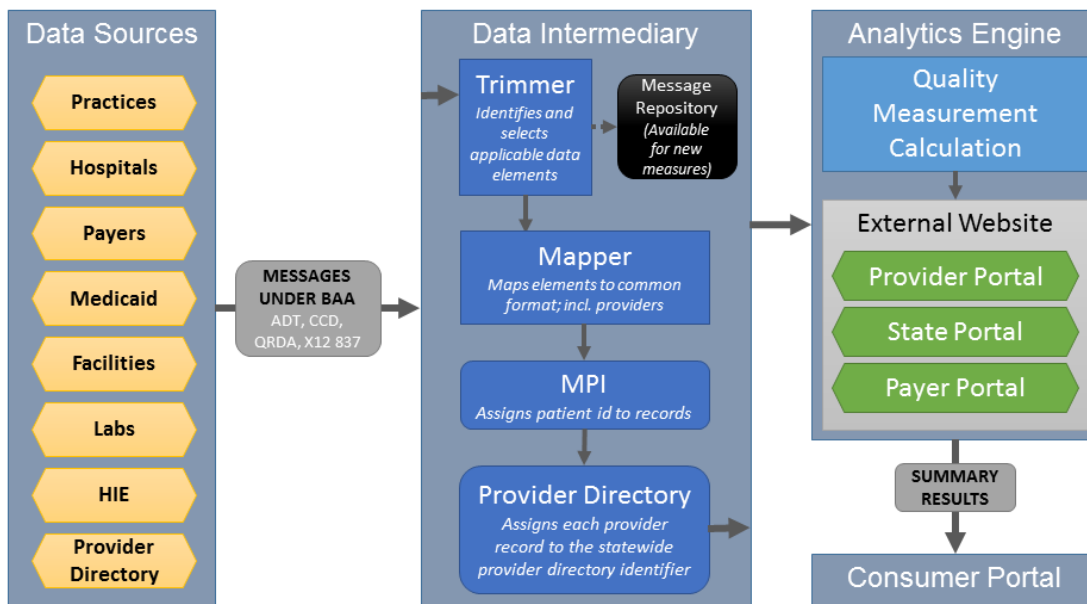
- **Award Year 3:** July 1, 2017 – June 30, 2018
  - Initial setup and deployment of technology

- Link with existing data sources, such as the HIE, Provider Directory, HealthFacts RI (as allowed by applicable laws)
- Provider Portal Launch
- Pilot group onboarding, training, and testing with initial measure set
- Data quality improvement with EHR vendors
- Technology Reporting Workgroup meets to establish governance rules
- Qualified Clinical Data Registry (QCDR) certification
- Payer Portal Launch; State Portal Launch

Phase II: Operationalization

- **Year 4: July 1, 2018-June 30, 2019**
  - Second pilot group onboarding, training and testing
  - Add expanded measure set
  - Consumer Portal Launch
  - Technology Reporting Workgroup meets to maintain governance rules
  - Continuing onboarding of providers
  - Additional measures added

**Figure 27: Conceptual Diagram, Clinical Quality Measurement, Reporting, and Feedback System**



This system will require fully engaging a variety of providers and their staff. We will provide training on the provider website itself and practice coaching for how to utilize the provider portal within the clinical and care management workflows. We will ensure that our practice transformation partners, including CTC, Healthcentric Advisors and the TCPI project at RIQI all have enough training to assist the providers with whom they work.

Once the system is procured, we will convene a new governance group with the appropriate stakeholders to inform the state on the level of data sharing and benchmarking that should occur between providers and the state, between the state and providers, and with consumers.

This was a strong recommendation of the Technology Reporting Workgroup and also arose as a priority in the provider survey.

There are numerous policy and regulatory levers that various state agencies could use to promote the use of this system. For example, OHIC could include its use as part of the SIM aligned measurement initiative. Levers would only be applicable once the system were fully implemented, tested and operating smoothly

### **Care Management Dashboards**

As described above, SIM is supporting the implementation cost of Care Management Dashboards for Community Mental Health Centers, the Medicaid community health team (Carelink), and for one state agency dashboard. These dashboards display real-time and historical information on hospital and ED utilization by their entire patient populations. Powered by the HIE infrastructure, these dashboards can show the exact location and status of patients being seen in all acute care hospitals in the state, as well as trending information about the subscriber's patient panel. This enables immediate intervention by the patients' care team. Additionally, the Dashboards retain information on patients for six months to provide additional trending information to users. This project has already been approved by the SIM Steering Committee and will be completed by the end of 2017.

While CurrentCare only includes data on patients that have enrolled, the contract for our Care Management Dashboards gives Community Mental Health Centers (CMHCs) and others the ability to include data on all patients. RIQI has negotiated with all acute care hospitals to have a real-time view of their patients' hospital and Emergency Department utilization, allowing an earlier start for care coordination. RIQI has served as a data intermediary in a HIPAA compliant fashion and has already begun to work on establishing Business Associate Agreements and maintenance contracts with each recipient. Technical work has begun with each hospital. In these agreements, the hospital allows for broad sharing of the clinical data shared through ADT and other feeds. For the time being, RIQI is only using these agreements with the data in ADT feeds.

To ensure compliance with HIPAA, the client organization that enters into a service agreement with RIQI (for example, a CMHC) must provide a list of patients in their patient panel, with whom the client has a treating relationship. These panels are updated in the RIQI system monthly. To facilitate this data sharing, RIQI must take the following major steps for each implementation:

1. Execute a HIPAA compliant Care Management Services Contract with the client;
2. Receive and import a test panel file into the RIQI secure FTP and create; maintenance contracts with each recipient dashboard system;
3. Test the patient panel file;
4. User training; and
5. Import of a production ready file and go-live.

Provisioning and technical work began in November 2016. In March 2017, two additional dashboards went live at East Bay Community Action Program and Carelink (the Medicaid CHT). The remaining 6 CMHO dashboards are expected to go live in Summer 2017, and the last dashboard for a state agency is in the design phase. This dashboard will likely be different than the others, to serve a larger population.

## Technical Assistance

### Technical Assistance for Providers

Making sure that the technology tools we are developed are adopted and used regularly is a critical part of achieving our overall SIM goals. While the SIM HIT plan focuses on the adoption of the tools such as the APCD, Common Provider Directory and the Feedback System, the SIM team recognizes the need to provide technical assistance (TA) to providers and other users of the system in advance of their deployment so that providers can take full advantage of the new capacity.

Given the numerous practice transformation activities that are under way in Rhode Island, we plan to leverage the Practice Transformation workgroup to ensure that the TA we provide is effective and not duplicative. We will work with the vendors of the HIT systems to develop tools around the identified needs such as standardizing data collection in the EHR, use cases to demonstrate how data can best be analyzed, and training module for the systems. By working with the Practice Transformation Workgroup, we will be collaborating with CTC and TCPI to align training – and to determine if those entities can carry out the training alongside the work they are doing with practices. The HIT infrastructure development we are investing in will assist in the missions of the organizations that participate in the Practice Transformation Workgroup, and we envision synergies in working together to incorporate use of SIM invested infrastructure to meet others' programmatic goals beyond SIM. In this way, providers will be able to see how SIM's HIT Tools can address their data and care management needs in support of delivering high quality care under VBP systems. Finally, SIM will work with all of the state's HIT governance entities including the Reporting and Quality Measurement Feedback Workgroup, the Provider Directory Advisory Committee, the APCD Data Review Board, the HIT Advisory Commission, and the SIM Steering Committee to help identify TA needs and whether they are being met through existing programs.

### Technical Assistance through ONC

We have leveraged the opportunity to seek technical assistance through SIM from subject matter experts at ONC. In 2016-2017, these activities included:

- Participating in state listening sessions at HIMSS 2016 and HIMSS 2017;
- Participating in an electronic clinical quality measurement in-person TA Convening in September 2016;
- Participating in the *Executing on Multi-Payer Health IT Alignment* in-person TA convening in Portland, OR in May 2017; and
- Numerous TA requests with specific questions about activities in other states to assist with the research for planning, design, and development of our HIT RFPs.

## SIM HIT Modular Functions

We have described in detail the specifics around the operations of each of our SIM components independently throughout this Operational Plan. The following section provides further detail about our Health IT planning and framework in each Health IT Modular Function; however, in the interest of brevity and lack of repetition, the information is summary in nature across multiple SIM components.

## **Foundational Components for Governing Health IT**

### **Accountable Oversight and Rules of Engagement**

As described earlier, Rhode Island has taken a serious, multi-stakeholder approach to the accountable oversight and rules of engagement of all SIM Health IT components. This includes community-based advisory committees/boards for HealthFacts RI, Provider Directory, the Feedback System, as well as the HIE and Interagency workgroups, and the SIM Steering committee to encourage statewide collaboration and support for all components.

Many of these stakeholder groups are required through legislative and regulatory authority, which helps ensure the oversight will continue over time. These groups are essential to the creation of data use rules, and the projects' continued adaptability over time as needs and culture change.

### **Policy/Legal**

Founding legislation enables the collection of sensitive data in the HIE and HealthFacts RI, with a clear goal to protect individual privacy and ensure appropriate data stewardship. While at times this can create barriers in Rhode Island that are not seen in other states, the overall motivation is prudent. We carefully consider the concerns of residents and stakeholders to work toward meaningful data that can be leveraged for current and future needs without posing excessive risk to anyone. Given changes in how health care is delivered and paid for, the state, our community partners and stakeholders will continue to reevaluate if statutory or regulatory changes are needed to support health care transformation efforts. For example, the HIE Act of 2008 was amended in 2016 to allow payers to access their insured populations' clinical data for care coordination and quality assurance purposes. Additionally, the state is beginning to engage in stakeholder dialogue related to the current consent model and whether changes are needed to support changing health care delivery and payment models.

Additional regulatory levers are used to encourage the participation in the HIE and SIM initiatives, including CON conditions, MCO contract provisions, and Accountable Entities requirements.

Rhode Island encourages voluntary participation in HIT initiatives, such as the HIE. However, there are circumstances where the need is so great it warrants mandating participation, for example with data submission to HealthFacts RI (a partial data set is not valuable), and with the Prescription Drug Monitoring Program (pharmacies must report and providers must use it). Rhode Island continues to review over time whether the evidence-base or demand leans toward a recommendation to further mandate additional participation.

### **Financing**

Rhode Island has been successful in funding large portions of the HIT infrastructure costs through various financing models, grants and cooperative agreements, such as the SIM Test Grant. The table below shows funding mechanisms used to support each of the SIM-related HIT components.

**Table 19: Financing by SIM-Related HIT Component**

System	Historical Funding Mechanisms	Current Funding Mechanisms	Other Future Funding Ideas
<b>HealthFacts RI</b>	<ul style="list-style-type: none"> <li>• HSRI grants</li> <li>• OHIC Rate Review Grants</li> <li>• SIM</li> <li>• Ryan White HIV/AIDS Program Rebate funds</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid MMIS IAPD</li> <li>• Data release revenues (Cost allocation)</li> <li>• SIM (non-eligible expenses)</li> </ul>	
<b>HIE</b>	<ul style="list-style-type: none"> <li>• Various HIE/RHIO grants</li> <li>• Voluntary PMPM by payers</li> <li>• Medicaid 90/10 IAPD</li> </ul>	<ul style="list-style-type: none"> <li>• Voluntary PMPM by payers</li> <li>• HITECH-IAPD</li> <li>• Client fees for some services</li> </ul>	<ul style="list-style-type: none"> <li>• In the future, we can seek grants or other donations of funding in support of the HIE.</li> </ul>
<b>Provider Directory</b>	<ul style="list-style-type: none"> <li>• SIM</li> </ul>	<ul style="list-style-type: none"> <li>• HITECH-IAPD</li> <li>• SIM</li> </ul>	<ul style="list-style-type: none"> <li>• Data Extract Fees</li> </ul>
<b>Feedback System</b>	N/A	<ul style="list-style-type: none"> <li>• SIM</li> <li>• HITECH-IAPD</li> </ul>	<ul style="list-style-type: none"> <li>• Client Fees</li> </ul>
<b>EOHHS Data Ecosystem</b>	N/A	<ul style="list-style-type: none"> <li>• SIM</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid MMIS IAPD</li> </ul>
<b>Care Management Dashboards</b>	N/A	<ul style="list-style-type: none"> <li>• Implementation: SIM</li> <li>• Ongoing maintenance PMPM fee from practices/ACOs/payers, etc.</li> </ul>	

Rhode Island often depends upon grant and Medicaid IAPD funding to support its key HIT infrastructure. Rhode Island has a unique advantage, because since 1993 MCO contracts have included a mainstreaming policy, which required that providers participating in any of the MCO’s commercial plans must also accept that payer’s Medicaid plan. This has resulted in virtually 100% of RI providers qualifying as Medicaid providers. This has made it so that little or no cost allocation is required to support HIE infrastructure in the state.

**Business Operations**

Operations of statewide HIT infrastructure depend upon statutory and regulatory authority, privacy protection needs, etc. Table 20 describes the business operations model for each system.

Much of Rhode Island’s HIT infrastructure is operated by public-private partnerships with our vendors and stakeholders in the community to help guide the policy and procedures of each component. This helps engender trust about the use of sensitive data throughout the community.



**Table 20: Business Operations by SIM-Related HIT Component**

System	Responsible Organization			Contracts/ Agreements
	Data Steward	Operations	Data Management Practices & Procedures	
<b>HealthFacts RI</b>	EOHHS/ RIDOH	ISW	<ul style="list-style-type: none"> <li>• ISW</li> <li>• Data Release Review Board (advisory to Director of Health)</li> </ul>	<ul style="list-style-type: none"> <li>• Vendor contracts to facilitate work</li> <li>• Data use agreements with data users</li> </ul>
<b>HIE</b>	RIQI	RIQI	<ul style="list-style-type: none"> <li>• RIQI</li> <li>• HIE Advisory Commission (advisory to Director of Health)</li> </ul>	<ul style="list-style-type: none"> <li>• Contract with EOHHS to serve as State Designated Entity</li> <li>• Contract with EOHHS for special projects</li> <li>• BAA's with data submitters</li> <li>• Data use agreement with users</li> </ul>
<b>Provider Directory</b>	RIQI	RIQI	<ul style="list-style-type: none"> <li>• RIQI</li> <li>• Provider Directory Advisory Committee</li> </ul>	<ul style="list-style-type: none"> <li>• Contract with EOHHS for development and implementation and data extracts for state agency use</li> <li>• Data use agreements with data submitters</li> <li>• Data use agreements with data users</li> </ul>
<b>Feedback System</b>	Vendor TBD	Vendor TBD with SIM Project Manager	<ul style="list-style-type: none"> <li>• Vendor TBD</li> <li>• SIM Technology Reporting Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>• Contract with EOHHS for development and implementation</li> <li>• BAAs with data submitters</li> <li>• Data use agreements with users</li> </ul>
<b>EOHHS Data Ecosystem</b>	EOHHS	EOHHS	EOHHS	Agreements with data stewards for data included from non-EOHHS agencies
<b>Care Management Dashboards</b>	RIQI	RIQI	RIQI	Contract with EOHHS only for implementation of 10 dashboards

**Core Infrastructure**

**Security Mechanisms**

All systems and vendors are required to operate in ways that secure protected health information in compliance with HIPAA and state privacy laws. Stringent extra privacy protections are included for the HIE and for HealthFacts RI in both statute and regulations.

This means data is encrypted in motion and at rest, appropriate business associate agreements and data use agreements are in place with all applicable parties, and privacy and security

policies and practices are employed by all organizations that have access to protected health information. We speak regularly with state legal counsel to confirm that appropriate policies and protections are in place.

Community advisory committees such as the HIE Advisory Commission and the APCD Data Release Review Board provide additional external oversight by reviewing applications for data use and the policies and practices we have in place, as well as any proposed changes. They make recommendations to the Director of Health.

We also work closely with our state Division of IT when developing new systems especially if the systems are managed in house (such as the EOHHS data eco system). When we procure outside services through an RFP process, we often seek to have an DOIT staff person as part of the review committee.

### Consent Management

The method of managing consent can vary by SIM-related HIT component, based upon regulatory requirements and restrictions or potential data uses. Table 21 describes the consent management methods for each component and how we carefully oversee each one to ensure that appropriate consent and privacy protections are in place. The state has invested considerable funds in developing specialized systems to manage consent.

**Table 21: Consent Management by SIM-Related HIT Component**

System	Consent Policies and Procedures
<b>HealthFacts RI</b>	While all APCD data is de-identified, individuals are still allowed to opt-out of the APCD. In order to ensure that data from multiple payers can be linked together at the person level but remain de-identified, the data aggregation vendor subcontracts with a lockbox vendor to serve as the master patient index and the opt-out portal. Individuals who wish to opt-out can do so through the web portal or by phone. Individuals who opt-out never have sensitive claims data sent to the aggregation vendor, as payers are responsible for leaving their data out of the data submissions.
<b>HIE</b>	Individuals must opt-in to having their data be sent to the HIE and they can decide who can access their data with in the HIE. Individuals may opt-in via a physical paper form at medical offices which confirms the participants' identity, or via an enrollment website which uses identity confirmation software similar to that used in the financial industry. A secondary consent is required on an annual basis at each facility covered under 42 CFR Part 2 to allow for data from that facility to be shared via the HIE.
<b>Provider Directory</b>	The Provider Directory Advisory Committee serves to recommend which data elements may be shared with the public versus other types of data users, to ensure that sensitive numbers or contact methods can only be shared with those who are authorized to see them.
<b>Feedback System</b>	Providers will have to prove that they have a treating relationship with patients in order to see detailed patient information in the system without requiring additional patient consent. Additionally, role-based permissions will ensure that each user may only see the granularity of data they are entitled to see. The Technology Reporting Workgroup will assist in creating rules for access.
<b>EOHHS Data Ecosystem</b>	While the data sets which will make up the Ecosystem may have sensitive data in them, the Ecosystem will only include data elements for which there are data use agreements in place and a specific reason to use that data element. Data will only be accessible to authorized state users.

<b>Care Management Dashboards</b>	Data is shared according to HIPAA covered entities, which must send monthly patient panel reports to RIQI thereby attesting to having a treating relationship with that patient. No additional patient consent is required, and only patients on these lists are included in the practice's dashboard view.
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### **Identity Management**

*For Systems users:* Each system includes a set of policies and procedures around confirming the identity of any users with access to protected health information. Users are provisioned in a hands-on method where the lists of users are provided to the data steward to set up accounts, rather than having self-registration. The HIE relies on organizations which manage their own users to keep up to date lists of staff and the level of access allowed.

*For patients:* Given the various HIT systems that are in place, and based on their statutory and regulatory requirements and when and how they were developed, there are several different MPIs being used to manage patient identities. The HIE's MPI employs the Quadramed MPI tool and an operations team to work through ambiguous matches. HealthFacts RI utilized a lockbox vendor to match individuals separate from the claims data to allow for matching while still ensuring the database is truly de-identified.

The MPIs for the EOHHS Data Ecosystem and the Feedback System are still being determined, although we are hoping to leverage an existing MPI at either HealthFacts RI, the HIE, or others that may exist with the state system. We are in discussion with the state Division of IT to determine and identify interest in and feasibility of developing a master data management approach with a Master MPI to link the various system specific MPIs.

### **Provider Directories**

Prior to the creation of the Statewide Common Provider Directory, each data set and data system had to maintain its own provider directory. Each one would have certain most accurate data elements and data elements that were likely to be incorrect or outdated. With the Statewide Common Provider Directory, we are working to replace the provider directories in our existing systems such as the HIE and HealthFacts RI with the mastered provider directory, and we are looking to ensure that the Statewide Common Provider Directory is leveraged as the provider directory for any new systems such as the Feedback System.

### **Extract Transform Load (ETL) Functions**

#### **Data Quality & Provenance**

The major components where Data Quality and Provenance are key are HealthFacts RI, the HIE, and the Feedback System. Contracts with our vendors and state designated entity require careful data quality processes to ensure that the data sent in was created at the source, was unaltered during the ETL process, and any mappings are traceable. The vendors work with the data submitters to ensure data submitted meets the minimum requirements. The data quality process for the EOHHS Data Ecosystem is still being designed, but the agile framework for this system will facilitate careful integration work with a focus on data quality.

#### **Data Extraction**

Our vendors are asked to use national standards for data exchange and extraction wherever it is possible. This helps to reduce the development work necessary for data exchange and ensure the security of the data in transit.

## Data Transformation

Our vendors perform data transformation activities upon data whenever data from multiple sources is aggregated. Often the codes or descriptions of items from the host data system (such as an EHR) are localized, and mapping may be required to compare apples to apples in the aggregated data set. Documentation of any data transformation ensures that any changes can be traced back to the original value and corrected should errors be discovered or policies change.

## Data Aggregation

In Rhode Island data aggregation occurs primarily in two locations: the HIE for clinical data and HealthFacts RI for claims data. These two systems are kept separated for now due to differences in privacy laws, however SIM is developing strategies to include de-identified clinical data elements in HealthFacts RI.

The model of the EOHHS Data Ecosystem relies on master person indexing across different data sets to link data rather than aggregation. This model will either consist of a centralized table that maps a single person ID to the person IDs in each individual dataset, or the inclusion of the Ecosystem person ID in each individual data set. The former is likely to be the chosen model, and we are considering the pros and cons of both methods to help make the final decision.

## Health IT Technical Functions

### Reporting Services

The translation of raw data to meaningful reports is in its infancy in our SIM model. The major plans for reporting services are:

- Care Management Dashboards to report out ADT data collected in the HIE through a web portal.
- HealthFacts RI public reports to highlight high importance data as reviewed by state analyst posted on the RIDOH website.
- The Feedback System, which will empower providers, payers, and policy makers with more accurate quality measurement reports available through a web portal to lead to improved outcomes.

### Analytics Services

Table 22 describes analytics services performed within each data system. There is a general trend to begin to focus more on analytics and parsing large sets of aggregated data for important data points.

**Table 22: Analytics Services by SIM-Related HIT Component**

System	Consent Policies and Procedures
HealthFacts RI	Analytics services can be performed on HealthFacts RI data through three primary mechanisms: <ol style="list-style-type: none"><li>1. Ad-hoc analysis performed by the aggregation vendor</li><li>2. Analysis performed by state staff through the state data center tools, such as SQL and the BI tool</li><li>3. Analysis by external stakeholders who have applied for and received data from HealthFacts RI.</li></ol>
HIE	RIQI has a growing analytics team to help develop new ways to understand the data in the clinical data repository at the HIE. This staff is working on reports to

	demonstrate ROI and new mechanisms to provide data back to providers to improve patient outcomes, such as the Care Management Dashboards.
<b>Feedback System</b>	The vendor (TBD) will be required to analyze the clinical data in the Feedback System for results on the SIM Aligned Measure Set and other clinical quality measures. These results can be reported back to providers and to reporting entities such as payers.
<b>EOHHS Data Ecosystem</b>	State staff will be provided training and access to the data sets incorporated in the Ecosystem to allow state agencies to answer specific question to drive policy.

### **Notification Services**

The HIE provides notification for ADTs in two major ways:

- CurrentCare Alerts – These alerts send a direct secure message to providers associated with a CurrentCare-enrolled patient when they are admitted, discharged, or transferred from any of the state’s acute care hospitals. This can also include notifications sent to patient-designated proxies.
- Care Management Alerts – These alerts send a direct secure message to providers associated with a patient through a provider-submitted panel which demonstrates a treating relationship with the patient when the patient is admitted, discharged, or transferred from any of the state’s acute care hospitals.

Some new notification services are under development including the overdose alerts to be sent through both CurrentCare Alerts and Care Management Alerts if a patient experiences an overdose of any kind. We acknowledge that there is a delicate balance between providing important notifications to providers and sending too many messages that can cause notification fatigue and remove the benefits of the alert. Because of this concern, we are rolling out additional notification services with caution and only on high-importance issues.

### **Exchange Services**

The primary method of exchange services in Rhode Island is through the HIE. The HIE typically collects data in the repository that has been “pushed” from the source EHR. There are some exceptions to this that require a “pull” query based on the agreement with the data source.

The Feedback System will depend heavily on exchange services as well, but the model is yet to be determined as we procure this vendor.

### **Consumer Tools**

The statewide HIE now has a consumer portal called CurrentCare For Me which is available to anyone so that they may log in and view their own personal health record. In the future, patients can set up proxies with access to the records and alerts for ADTs.

Through SIM we will launch consumer-focused tools that focus on transparency, such as public-facing reports from HealthFacts RI with a focus on price transparency with a specific focus on Medicaid, a public Provider Directory portal, and potentially, depending upon the selected vendor, a quality measurement public portal as a component of the Feedback System.

### **Provider Tools**

With additional new technology builds, we are adding additional provider tools to the mix. Providers have had access to the HIE’s provider portal, CurrentCare Viewer, for many years, but through SIM we are adding a provider portal for the Statewide Common Provider Directory which will allow them to see sensitive contact information unavailable to the public. We are also adding a quality measurement portal as a component of the Feedback System. Lastly, the Care

Management Dashboards (which were developed before SIM, but for which implementation costs are being supported) also provide a separate provider dashboard.

With these additional provider portals, we are pursuing options to allow for single sign on solutions. The first integrations will be a solution that connects the Provider Directory portal, the Care Management Dashboards, and the CurrentCare Viewer to ensure that providers only need log in to one of those systems in order to use both interchangeably. As additional infrastructure is deployed, we will consider to be mindful of provider portal fatigue and strategize ways to leverage existing provider portals to share the data providers need.

### **Patient Attribution**

There are two main purposes of patient attribution methodologies in Rhode Island: for data sharing standards and for quality measurement.

RIQI uses a patient attribution methodology to allow for data sharing on patients within a provider's specific panel in the Care Management Dashboards/Alerts products. To facilitate this patient attribution, the provider self-attests to a set of patients through a patient panel file. This file is loaded into the RIQI system.

Other patient attribution for quality measurement is not done in any standard way for the state systems under SIM. Each payer has its own patient attribution methodology, including Medicaid and the MCOs. The goal is to choose a specific patient attribution methodology to use between HealthFacts RI and the Feedback System in the last two years of SIM. We will seek stakeholder consensus to help make this decision. However, because it is possible that we will not find a singular patient attribution methodology that will meet all needs, we will remain open to many potential applications.

## D. Program Evaluation, Monitoring, and Reporting

Program evaluation is fundamental to assessing whether or not designed activities achieve the desired results once implementation begins. When conducting program evaluation, it is important to follow established methodologies, where applicable. For the Rhode Island State Innovation Model (SIM) Test Grant, the adapted framework within which program monitoring and reporting will occur is guided by the *Centers for Disease Control and Prevention (CDC) Framework for Program Evaluation in Public Health*. The six evaluation steps outlined by the CDC framework (noted below in Figure 28) include:

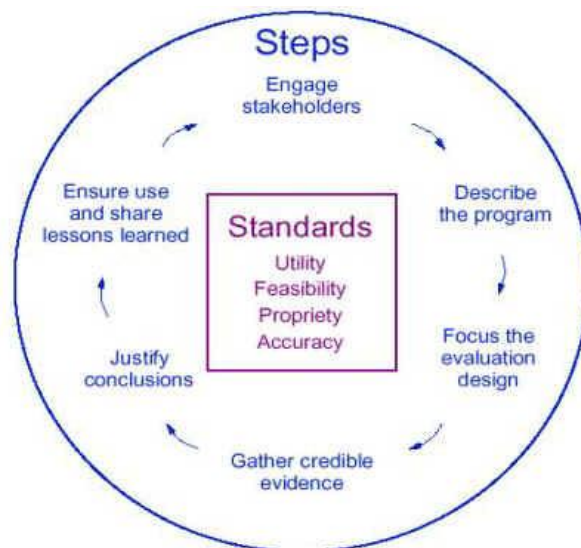
1. Engaging stakeholders;
2. Describing the program;
3. Focusing the evaluation design to set goals for what we are studying;
4. Gathering credible evidence;
5. Justifying conclusions; and
6. Ensuring use and sharing lessons learned.

These six steps are embedded in a continuous process of improvement through program evaluation. These steps, while modified, are anchored as the fundamental components for Rhode Island SIM evaluation.

In accordance with our SIM State Evaluation Plan:

- SIM's evaluation vendor has been procured and a Memorandum of Understanding has been established. SIM's vendor is the University of Rhode Island's (URI) Institute for Integrated Health and Innovation. We have begun vendor orientation, including training on required state and federal reporting.
- SIM leaders and staff are participating in the Federal evaluation being undertaken by RTI. We have had one site visit in Rhode Island, one round of phone interviews of our key informants with the RTI evaluators, and regular monthly communications (including emails and conference calls) with the RTI Evaluation Team.
- SIM has contracted with the University of Rhode Island (URI) for our State-based evaluation, with a three-year commitment of approximately \$700,000. URI will be focused on studying the effectiveness of our overall program, as well as a select set of interventions (e.g.,PediPRN Child Psychiatry Access Project).
- SIM is also carrying out regular in-house performance monitoring and evaluation of our program, tracking the milestones and metrics we have identified in our planning process.
- URI is in the last stages of writing our full Overarching Mixed-Methods Evaluation Plan (both qualitative and quantitative) for our Steering Committee's review and finalization. We aim to ensure that our State-led evaluation efforts are complementary to the Federally-led evaluation, but not duplicative.
- We will rely on our in-house evaluation to gather routine information that we must report to CMS and CMMI. Having our professional evaluator allows for a deep dive

**Figure 28: Program Evaluation Steps**



into those topics where we do not have the expertise or tools to carry out a particular type of in-house evaluation.

Furthermore, since the inception of this contract in December 2016, URI has:

- Listened in on SIM activities, to understand our programs and process.
- Evaluators join SIM staff on the monthly Federal RTI Evaluation Team calls, attend monthly SIM Steering Committee Meetings, participate in our Quarterly Vendor and Partner Meeting, and are helping us define evaluative roles for SIM Core and vendor staff.
- Finalized a draft of the [Overarching Mixed-Methods SIM Evaluation Plan](#) for review with the SIM Interagency Team in April. One specific evaluation activity will be a study on the Return on Investment for SIM-supported CHTs and (including the Consolidated Operations Model aligned with SBIRT).
- Implemented a collaborative partnership with Brown University's Research Office for SIM State Evaluation efforts.
- Started a draft of the [Child Psychiatry Access Project intervention-level evaluation plan](#).
- Given that the evaluation of the SBIRT Implementation Project that is formally aligned with SIM's CHT and SBIRT Training and Resource Center procurements, the SBIRT and CHT evaluators work closely together on a routine basis, therefore, and we are confident that they can collaborate on an effective review of the project. To ensure this collaboration, we have convened both evaluation teams together on several occasions.

In addition, as a part of our evaluation work, we had planned to carry out a Learning Collaborative on Alternative Payment Models in use in the state. However, because of the potential duplication in meetings and discussions with the work OHIC is carrying out to review APMs, we have replaced this with a process evaluation of SIM organizational dynamics (including our Integration and Alignment work within our culture of collaboration, which includes our Integration and Alignment work, and our organizing principles, which also includes our unique staffing model).

As part of performance management, SIM has standardized and institutionalized a Vendor Orientation and Training. The SIM team has completed orientation and training for the SIM's implementation vendors, as they come on line. To date, we have delivered orientation and training to Bradley Hospital, the University of Rhode Island, Rhode Island College, and the Care Transformation Collaborative Rhode Island. These sessions are intended to engage vendors with the larger community of SIM; to help them understand our goals and objectives, and to make them a contributing part of the overall integration and alignment effort. In addition, vendors are required to meet contractually-stipulated reporting requirements that devolve from state and federal government requirements. We want vendors across the project portfolio to perform these tasks in a consistent and efficient way, in order to minimize costs and facilitate quality delivery.

We have also created a vendor management guidance document, to encourage and support consistency of management of our SIM vendors in the delivery of their interventions. The guidance document reviews the process for regular project oversight, using the monthly report required from SIM vendors. The process includes a monthly staff call with the vendor to review the report, followed by a brief update at SIM staff meetings about the progress of the vendor project. The document also addresses management of project scope, costs, quality, and time.



Lastly, SIM has ensured all vendors participate in a Quarterly SIM Vendor and Partner Meeting. We held our initial, quarterly multi-project vendor/partner group meeting in March. The goals of the meeting were to enable SIM vendors to learn more about the larger SIM project as well as each organization's funded activities and enable them to make connections across programs and interventions, enhancing SIM's "culture of collaboration." The meeting was very successful, providing a forum for people to meet potential partners in Rhode Island's healthcare reform efforts, many for the first time and identifying potential collaborations to be addressed at future meetings. These quarterly meetings will support the integration and alignment goals as they apply to vendors.

## Evaluation Strategy and Plan

### Step 1: Engage Stakeholders

Stakeholder engagement is the first step in the cyclical evaluation process. The persons who will be implementing or affected by the strategies defined are the stakeholders. Obtaining input from stakeholders in the development of this evaluation plan remains critical. Stakeholders also help to ensure that we are asking the right questions, collecting the right data, and using our evaluation results effectively.

Internal and external partners attend regularly scheduled workgroup and team meetings. Many partners are also involved in various academic and professional organizations. A smaller subgroup has been and will likely continue to be convened to vet measures selected as part of the Driver Diagram. An additional group will likely be formed as part of ongoing measurement needs for the State Health Improvement Plan. These groups will continue to collaborate, prioritize, and/or develop evaluation questions and associated measurements. These groups will work together to determine feasible data sources, data collection methods, and indicators for our in-house tracking process. Over the course of the grant period, stakeholder engagement will be instrumental in redefining and focusing the scope of the evaluation, particularly as it relates to the resources available for ongoing evaluation and sustainment efforts.

In addition, we will be able to share these data sources and metrics with our professional evaluators and provide them with subject-matter experts for consultation.

### Step 2: Describe the Program

SIM will be able to use the writing throughout this Operational Plan to describe our program to our evaluators and to stakeholders assisting with our monitoring.

### Step 3: Focus the Evaluation Design

Designing an evaluation process that allows for making interim adjustments to programmatic direction, improving the way interventions are implemented, and providing iterative evidence to stakeholders on program success is critical. According to the Centers for Medicare and Medicaid Services (CMS), program evaluation for SIM must include regular, quantifiable measurement of model impact. Included in this in-house evaluation process are measures of effectiveness for policy change, regulatory lever use, and intervention implementation.

We will also work with our professional evaluators to help them plan the evaluation design.

### A Defined Purpose

In an effort to focus efforts, we have the following primary purposes for our in-house evaluation:

- Assess planning efforts and collaboration among our strategic partners;
- Identify root causes for intervention successes and challenges related to both practice transformation, patient empowerment, and population health improvements;
- Detail efficiencies created by policy and regulatory changes; and
- Document the importance of increasing the capacity for supporting infrastructure such as workforce development and data availability; and
- Provide data-driven recommendations for sustainability beyond SIM.

### Evaluation Questions

At least four overarching evaluation questions guide the evaluation of the SIM effort:

- To what extent has the Rhode Island SIM Test Grant strengthened population health?
- To what extent has the Rhode Island SIM Test Grant transformed the healthcare delivery system?
- To what extent has the Rhode Island SIM Test Grant decreased per capita healthcare spending?
- To what extent did the Rhode Island SIM Test Grant foster collaboration, align efforts across sectors and between partners, and increase data-driven decision-making?
- To what extent has SIM developed a culture of collaboration and developed best practices associated with its organizing principles and staffing model?

### Quality Improvement and Procurement Reporting

While the data pertaining to the Driver Diagram and State Health Improvement Plan will provide the basis for process, outcome, and balancing measures for which analysis will help in justifying SIM investments, we can gather additional evaluation data through the SIM procurement process and negotiated scopes of work with sub-recipients. Where applicable, collecting information and then reporting aggregate data using the CDC’s framework for “Mapping to a Series of Outcomes,” will help Rhode Island quantify the success of interventions and identify potential root causes if sub-optimal results are achieved. To help assure all purposes of the evaluation are met, we will consider the following types of outcomes during reporting:

**Table 23: Mapping to a Series of Outcomes**

Outcome Type	Description
Participation	Measure of the number of people reached/engaging
Reactions	Measure of the degree of interest and passion for work
Learning	Measure of increased knowledge, skills, and understanding
Actions	Measure of behavioral patterns of change in a target group
System and Environment	Measure of changing social, economic, or environmental conditions
Health	Measure of contributions to health indicators

### Step 4: Gather Credible Evidence

To support ongoing process and outcome evaluation, we are specifying metrics based on drivers and interventions presented within the Driver Diagram. CMMI requires states specify metrics in three areas:

- Model Participation;
- Payer Participation; and
- Model Performance.

To date, we have specified a suite of metrics for tracking implementation of SIM programs, such as Community Health Teams, SBIRT training, and clinical quality reporting and feedback, which align with CMMI's request for model participation metrics. We have also specified system transformation metrics that measure outcomes of the use of our regulatory levers, such as percent of medical service payments made under an alternative payment model, which align with CMMI's Payer Participating metrics. Rhode Island is committed to sharing all data relating with implementation of value-based payments in terms of dollars, covered lives, and provider participation, which we collect through existing regulatory initiatives.

We continue to engage stakeholders to specify model performance metrics, which seek to measure the outcome of our SIM project across domains of cost, quality, utilization, and population health. In the coming weeks SIM staff will be working with stakeholders through the Measure Alignment Work Group to develop model performance metrics, baselines and targets on measures such as hospital readmission rates, emergency department visits, diabetes care, behavioral health, and total cost of care. A full matrix describing all metrics is in development and will be updated along with the Driver Diagram prior to June 30, 2016.

### **Data Collection**

We will be using several data collection methods, including both qualitative and quantitative methods, for our SIM evaluation. Using multiple procedures for gathering, analyzing, and interpreting data, the evaluation will gain greater credibility and provide a clearer picture of the program. We will make modifications as needed to account for the evolving nature of the program. Additional detail on data collection can be found in the Data Collection, Sharing, and Evaluation section of this document. All quality and cost measures will use the entire Rhode Island population as the denominator. Where applicable, we will also collect and analyze demographics and disparity data—and we will share our data with our professional evaluator.

### **Step 5: Justify Conclusions**

Evaluation will be a critical component of all of our efforts—both in-house and professionally. To incorporate evaluation across SIM investments and activities, we will maximize the following to provide additional data upon which conclusions can be drawn:

- All procurement via Request for Proposals or Single Source Procurements will include requirements for developing activity objectives, logic models, and evaluation plans;
- All procurement via Request for Proposals or Single Source Procurements will include requirements to report performance data relative to activity objectives regularly and alongside annual reports;
- Vendors will submit regular progress reports to Project Management and Project Officer staff;
- Cross-cutting interventions, such as those being implemented for workforce development and health information technology, will include requirements for evaluation information in a variety of ways, including case studies, lessons learned, and metrics.
- We will bring together the vendors for shared learning opportunities, to collaborate across separate transformation activities.

- We will ensure that our professional evaluators have access to all of this information to inform their work.

### **Step 6: Ensure Use and Share Lessons Learned**

SIM leaders and staff are committed to using the evaluation information described throughout this document to measure our successes, identify and address our challenges, and chart new paths for changing our healthcare system. The public nature of SIM ensures that we will share evaluation information with our agency partners, our Steering Committee stakeholders, and the general public at our regular meetings and at other special opportunities. We will create a specific communications plan for sharing this information.

## Data Collection and Sharing

Rhode Island will require regular data about cost, quality, and utilization to fully understand the impact of the SIM Test Grant initiatives. Some existing data sources for this information are available. Since Rhode Island's SIM Test Grant is a statewide initiative, we will measure outcomes across the state as a whole, and compare the majority of outcomes against those of other (non-SIM) states. There are five major datasets where health indicators data are or will be collected for sharing and evaluation in Rhode Island and will be leveraged for our SIM project:

- HealthFacts RI;
- Medicaid;
- RIDOH Center for Health Data and Analysis (CHDA) Data Sources;
- HealthSource RI Qualified Health Plan Enrollee Survey;
- Electronic Clinical Quality Measurement, Reporting, and Feedback System; and
- State Data Ecosystem and EOHHS Data Warehouse.

Recently, the University of Rhode Island (URI) acquired DataSpark (a data hub containing various linked Rhode Island data sets) and will leverage this acquisition for the benefit of SIM data collection and evaluation. As such, continued discussions between URI and EOHHS on the State Data Ecosystem continue as planning is well underway. This ecosystem will be leveraged as an analytical tool for evaluation (if available), as will HealthFacts RI.

It is important to note that the SIM Evaluator Vendor (URI) is finalizing the Overarching Mixed-Methods Evaluation Plan. Until this is finalized, along with intervention-specific evaluation plans, it would be premature of us to have identified each and every data source to be used for these purposes. We intend to provide a more concrete list in September 2017.

However, SIM Core Staff have already created numerous additional sources of data aside from those discussed below. OHIC is already capturing metrics as part of the SIM Operation Plan and we have written in metrics into every contract as part of our procurement process. SIM Core Staff have also created source data repositories on our SIM Shared Drive for the following information:

- Staff calendar tracking for important events and updates;
- Outreach and engagement, as well as attendance, tracking;
- Data use agreements and MOUs; and
- Standardized contract language, working with our evaluator as an advisor.

Furthermore, EOHHS is one unified legal entity, meaning that no data sharing agreements are required between different Departments that make up the office (including Medicaid, RIDOH, and DCYF). Data use involving protected health information would be limited to appropriate uses under HIPAA and state privacy laws.

For data sharing with agencies outside of EOHHS, we can work with those agencies to put the necessary data sharing agreements in place that will support us achieving our SIM Goals. We will be determining which external data sources will be needed and creating a plan to gain access to that data in Award Year 2. Also we acknowledge that one part of meeting our SIM goals, especially within our Integration & Alignment Project, may be our need to share data more broadly with outside agencies, and will include this concept in our strategies for data sharing and collection.

## **HealthFacts RI**

Claims data from payers with at least 3,000 enrolled members is submitted quarterly to HealthFacts RI, the SIM Test Grant-funded all payer claims database. This include CMS provided Medicare Part A, B, and D claims data, private insurance (including Medicare Advantage plans), and Medicaid data. Claims data will be used to understand the cost of care provided in value-based payment arrangements, as well as some key indicators of utilization and quality that are available in claims data.

Although de-identified, patient data in HealthFacts RI does carry a unique patient identifier which will allow for an identifier to be assigned when patients are covered by the SIM program activities for tracking and evaluation purposes. The metrics which will be measured using HealthFacts RI are indicated in the metrics section of this document.

We prioritize HealthFacts RI's careful privacy protections and procedures. Although de-identified, there is still enough information in HealthFacts RI to potentially identify a participant. Therefore HealthFacts RI data releases are governed by the Data Release Review Board (DRRB) – an 11-member advisory board to the Director of Health. Some data can be released in aggregate form without review by the DRRB, but anything which is claim line level or does not conform to pre-approved files may require a data release application. Rhode Island staff will assist CMS and/or its contractors in navigating the state legislated data release process, should it be necessary, and waive any standard fees for data. The HealthFacts RI analytics vendor is responsible for providing data extracts for partners, including file specifications.

## **Medicaid**

Our Medicaid agency is also supplying detailed Medicaid member information by request to CMS and federal evaluators as needed for surveys, focus groups, and/or key informant interviews. Medicaid is dedicated to measuring and understanding the impact of the state's initiatives to improve care, and will facilitate all appropriate data sharing in compliance with state and federal laws.

We have already shared the data required by our RTI evaluators for their recent site visit to Rhode Island (May 23-25, 2016), including Medicaid members and behavioral health providers. We now have the process set up to continue to share data with RTI as necessary, including access to the appropriate, secure data-sharing technology.

## **Center for Health Data and Analysis (CHDA) Data Sources**

There are numerous surveillance systems, databases, and measurement sources that serve as primary information sources and collection methods at RIDOH. Information once collected, is analyzed on a program-specific level, and at times, by the Center for Health Data and Analysis (CHDA) for the production of data briefs and a variety of other dissemination documents. Sharing of data is initiated by data requests, media inquiries, and publication needs. Shared data abides by the Department's policy for dissemination of data. Typical modes of distribution include infographics and posters, stakeholder meetings and conferences, publications, on websites, and in the form of data briefs/books. File sharing can be requested between agencies and requires a Memorandum of Agreement.

**Table 24: Summary Table of CHDA Data Sources**

Data Set Name	Data Set Description	Collection Period and Methods	Data Availability
Hospital Discharge Data (HDD)	When a patient is discharged from an Inpatient stay in a Rhode Island hospital, the hospital is mandated to report the patient's information to the Center for Health Data & Analysis at the Department of Health.	Quarterly. Most recent - October 1, 2013 to December 31, 2013. Data are extracted from hospital billing systems, non-billing items are added, and the data are submitted to the Center for Health Data and Analysis, either directly or through a contracted data processor.	Available on request. Data available approximately 6 months after the end of each calendar quarter.
Emergency Department Data	When a patient is discharged from an Emergency Department visit at the ER in a Rhode Island hospital, the hospital is mandated to report the patient's information to the Center for Health Data & Analysis at the Department of Health. Patients whose visit resulted in an Admission are not included in this data set but are included in the Hospital Inpatient data set.	Quarterly. Most recent - October 1, 2013 to December 31, 2013. Data are extracted from hospital billing systems, non-billing items are added, and the data are submitted to the Center for Health Data and Analysis, either directly or through a contracted data processor.	Available on request. Approximately 6 months after the end of each calendar quarter.
Behavioral Risk Factor Surveillance System (BRFSS)	The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based computer-assisted telephone interview survey. The collection process uses uniform guidelines and a standard questionnaire. In collaboration with other state health departments, the Centers for Disease Control and Prevention, and other department programs, a survey instrument is developed. The survey is administered as a random-digit dial telephone survey of non-institutionalized people age 18 or older. Information on health status, health risk behaviors, preventive practices, healthcare access, and prevalence of chronic conditions is collected and analyzed.	Collected since 1984. Most recent data available 2012. Collected on an ongoing basis by telephone interviews (random digit dial landline and cell phones) conducted by a contractor selected by competitive bid.	Available on request. Data are available in June for the prior year's data collection.

Pregnancy Risk Assessment Monitoring System (PRAMS)	Pregnancy Risk Assessment Monitoring System (PRAMS) was initiated in 1987 as part of the Centers for Disease Control and Prevention (CDC) initiative to reduce infant mortality and low birthweight. In recent years, the program has been expanded in support of CDC's Safe Motherhood Initiative to promote healthy pregnancies and the delivery of healthy infants. PRAMS is an ongoing, population-based surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy and during the child's early infancy among a stratified sample of women delivering a live birth.	Monthly. Last completed year of data collection is 2012. Last completed weighted data set available is 2011.	Available on request.
Violent Death Reporting System	Violent death surveillance with data collected from multiple sources. Uses data from medical examiner files, law enforcement reports, vital records, and others on deaths due to homicide, suicide, deaths of undetermined manner, and unintentional firearms deaths. Funding is from CDC.	Ongoing data collection	Partial and aggregate data available on request. Also available on CDC WISQARS <a href="http://www.cdc.gov/injury/wisqars/index.html">http://www.cdc.gov/injury/wisqars/index.html</a>
Youth Risk Behavior Survey (YRBS)	To assess health-risk behaviors in public school students grades 6 through 12 that contribute to the major causes of death, disease, injury, and social problems.	Biennially (odd years). Data is available about 4-5 months after data collection is completed.	Available on request.
KIDSNET	KIDSNET is a population based integrated child health information system that facilitates the collection and appropriate sharing of preventive health services data for the provision of timely and appropriate follow-up. KIDSNET serves as Rhode Island's childhood immunization registry for children up to age 19 and links data from ten different public health programs (newborn bloodspot, hearing and developmental screening, vital records, home visiting, immunization, lead screening, WIC, Early Intervention and Asthma) as well as having indirect connections with birth defects and foster care data.	Ongoing. Data collection begins at birth with the electronic birth certificate and a chart review for developmental risk factors. Program data is submitted electronically from 8 participating childhood public health programs as infants and children receive these services. Home visiting and some immunization data are entered manually.	Aggregate data available.



Maternal and Child Health Data	To determine maternal and child health needs of Rhode Islanders and assess health status and well-being of children and families.	Dependent on availability of vital statistics data. As each new year of vital records data become available, they are added to the database.	Available on request.
3RNET	Tracks the name and specialties of doctors who want to obtain employment in the state of RI	Bi-monthly. Most recent data available - February - March, 2014.	Raw data available on request
Birth Records	RIGL 23-3-10 requires registration of all birth records, from which data are derived. The data set covers all child born in the state of Rhode Island or a child born out-of-state to a Rhode Island resident.	Ongoing. Data collected since 1982. Most recent -March 2014. Data are collected from the seven RI birthing hospitals, office of vital records for home births and any of the 57 reporting jurisdictions within the USA where a RI resident had a birth.	De-identified, partial dataset available on request. Preliminary data on births occurring in Rhode Island are available within one year after the end of the calendar year, including out-of-state births to RI residents. Final data are available no sooner than 2 years after the end of the calendar year.
Fetal Death Records	RIGL 23-3-10 requires registration of spontaneous fetal death records and reports of induced fetal deaths. Data are derived from these records and reports. Data set covers all fetal deaths (spontaneous or induced), which occurs in the State of Rhode Island.	Ongoing. Data collected since 1985. Most recent -December 2013. Data are provided by Institutions and Funeral Directors.	De-identified, partial dataset available on request. Preliminary data on fetal deaths occurring in Rhode Island are available within one year after the end of the calendar year. Final data are available no sooner than 2 years after the end of the calendar year

### HealthSource RI Qualified Health Plan Enrollee Survey

In order to holistically evaluate the effectiveness our work, it is essential to collect and evaluate not only outcomes data but also information on customer perception and experience. As the health insurance exchange for the state, HealthSource RI (HSRI) has worked with carriers participating in the Marketplace to evaluate consumer experience with enrollment and insurance plan utilization. Developed by CMS and administered via an approved survey vendor, the Qualified Health Plan (QHP) Enrollee Survey was Beta tested in the first half of 2015 and will be fully implemented nationwide in 2016. The QHP Enrollee Survey will evaluate nine areas of plan enrollment and use including: access to care, access to information, care coordination, cultural competence, plan administration, rating of health care, rating of health plan, rating of personal doctor, and rating of specialist. The survey results will be made publicly available in fall 2016 to consumers, carriers, and state exchange's in an effort to drive evidence-based decision making in plan development and to provide additional information to consumers to aid in plan selection. Information gathered from the QHP Enrollee Survey, as well as enrollment and claims data will enhance HSRI's effort to address the health insurance needs of Rhode Island consumers. This information will also be used to assist in the development of innovative plans offered through the exchange.

### Healthcare Quality Measurement, Reporting, and Feedback System

This SIM Test Grant funds an electronic clinical measurement reporting and feedback system which will begin to collect more detailed clinical data across a broader population of consumers in Rhode Island. It is unlikely that this system will be adequate to measure outcomes across the state by the end of project period or confidently provide a historical understanding of clinical quality. We recognize that clinical quality data on our population is relatively sparse and

inconsistent, a weakness which will be strengthened for future evaluation activities with this new data system.

### **Social and Environmental Determinants of Health Measurement**

RIDOH has convened an internal and external Community Health Assessment Group (CHAG) to development measures of health equity for Rhode Island, using local data systems. In addition, the CHAG, as a group of evaluation experts, is working to determine a common evaluation and health equity indicators for specifically for the HEZ and other healthy equity work being done by RIDOH. The Rhode Island SIM Chief Health Program Evaluator has been invited to be a participant on both the internal and external groups to ensure integration with SIM and maximize incorporation of new measures through this bi-directional alignment approach. This group will build on the progress being made on the national level through recent reports from the Institute of Medicine.

### **Additional Evaluation Data**

We are committed to supporting any evaluation efforts taking place within our SIM Test Grant. This spans from the federal evaluation team contracted by CMS to individual evaluation teams within our SIM Components. To date we have supplied data to the evaluators whenever requested and will continue to do so throughout the duration of our SIM Test Grant, including any file specifications or other support materials.

Additionally, OHIC will continue to leverage regulations in place that allow it to request data from payers specifically to support the SIM Test Grant, to ensure the data used in the evaluation efforts is comprehensive and will accurately describe the impact of our activities in Rhode Island.

# Fraud and Abuse Prevention, Detection, and Correction

The State Office of Program Integrity (OPI) ensures compliance, efficiency, and accountability within the health and human services programs administered by the Executive Office of Health and Human Services (EOHHS) by detecting and preventing fraud, waste, and program abuse and ensuring that state and federal dollars are spent appropriately, responsibly, and in accordance with applicable laws.

The OPI has developed protocols and procedures to detect and deter fraud, waste and abuse. The OPI is focusing on all publicly funded health and human services programs, not just Supplemental Nutrition Assistance Program (SNAP) and Medicaid, using sophisticated data mining and modeling techniques to identify unusual patterns of purchasing and billing by third parties.

The guiding principles of the OPI are that it:

1. Strives to achieve the most cost efficient health care system possible while further enhancing the quality and appropriateness of services delivered.
2. Requires and supports efforts that enable health care providers to identify and resolve issues themselves.
3. Holds provider agencies accountable for building and maintaining systems to prevent improper billing.
4. Increases the usage of the administrative tools such as payment suspension, prepayment review, audit, sanction, and individual and entity exclusion when improper payments are discovered.
5. Develops and communicates consistent measures of the effectiveness of program integrity that capture cost reduction and avoidance, as well as recoveries, and minimize costs imposed by reviews and investigation.
6. Recognizes areas of vulnerabilities that adversely affect program integrity.

The Office of Program Integrity is committed to identifying fraud, waste and abuse in Medicaid and in all health and human service programs. The OPI utilizes advanced analytics software that assigns scores to claims for potential healthcare fraud. This scoring looks for duplicate claims, individuals with multiple member ids, suspicious provider network activity, peer comparison for both providers and members, and predictive analytics that identify scenarios where activities should have happened that did not. The resulting scoring is displayed in an advanced visual interface to allow investigators to review and assess the results of the analysis.

The OPI actively pursues any leads indicating fraudulent practices and uses them as a source to begin investigations. To increase our effectiveness, the OPI is partnering with Medicare and Medicaid insurance companies to share information about fraudulent activity and to conduct joint investigations.

The OPI also receives complaints from patients, their families, other providers, former employees of a provider, and through federal and state referrals. Office staff triage and investigate every valid complaint.

Decisions rendered by the review process can result in refunds to the program for inappropriate payments, training on how to correct or improve billing practices, referral to licensing boards,

and/or referral to the RI EOHHS Office of Program Integrity and the RI Office of the Attorney General for suspected fraudulent practices.

The Office of the Attorney General's Medicaid Fraud and Patient Abuse Unit enforces the laws pertaining to fraud in the state Medicaid program and prosecutes cases of abuse, neglect, or mistreatment of patients in all state healthcare facilities. The Unit prosecutes criminal activity, pursues civil remedies where appropriate and participates with federal and state authorities in a variety of inter-agency investigations and administrative proceedings. Unit prosecutors, auditors, investigators and health care professionals employ a multi-disciplinary approach to combat health care fraud and patient abuse.

## Conclusion

As a Test Grant, Rhode Island's SIM project is committed to evaluation – always asking what are we doing that is effective? How could we be more effective? How can we work together more closely with state agencies in government and our partners in the community?

From the start, this Operational Plan has given us a tremendous opportunity to sit back, ask these questions, and use the answers to better focus our work.

We are pleased to share this third iteration of the Plan with you and look forward to your comments and questions.

## Acronym and Abbreviation List

The following is a list of acronyms and abbreviations used in the Project Summary for the Operational Plan.

Acronym	Meaning
ACA	Affordable Care Act
ACC	Accountable Care Community
ACO	Accountable Care Organization
ACS-CDC	American College of Surgeons – Centers for Disease Control and Prevention
ADHD	Attention Deficit Hyperactivity Disorder
AE	Accountable Entities
AHC	Accountable Healthcare Communities
AMQ	Adult Medicaid Quality Grant
APCD	All Payer Claims Database (HealthFacts RI)
APM	Alternative Payment Model
BCBSRI	Blue Cross & Blue Shield of Rhode Island
BH	Behavioral health
BHDDH	Department of Behavioral Health, Developmental Disabilities, and Hospitals
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CABHI	Collaborative Agreement to Benefit Homeless Individuals
CAHPS	Consumer Assessment of Hospital and Provider Services
CAPTA	Child Abuse and Prevention Treatment Act
CAUTI	Catheter Associated Urinary Tract Infection
CCBHC	Certified Community Behavioral Health Clinic
CCD	Continuity of Care Documents
CDC	Centers for Disease Control and Prevention
CDOE	Certified Diabetes Outpatient Educators
CEDARR	Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation
CEHRT	Certified Electronic Health Record Technology
CEU	Continuing Education Unit
CHAG	Community Health Assessment Group
CHH	CEDARR Health Home
CHIP	Children’s Health Insurance Program
CHDA	Center for Health Data and Analysis
CHN	Community Health Network
CHNA	Community Health Needs Assessment
CHT	Community Health Team
CHW	Community Health Worker
CLABSI	Central Line Associated Blood Stream Infection
CMHC	Community Mental Health Center

<b>Acronym</b>	<b>Meaning</b>
CMHO	Community Mental Health Organization
CMMI	Centers for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
COD	Co-Occurring Disorder
COE	Centers of Excellence
CON	Certificate of Need
COPD	Chronic Obstructive Pulmonary Disease
CPC+	Comprehensive Primary Care Plus
CS4RI	Computer Science for Rhode Island
CSC	Coordinated Special Care
CTC	Care Transformation Collaborative
CTTS	Certified Tobacco Treatment Specialist
CVDOE	Cardiovascular Disease Outpatient Educator
DCYF	Department of Children, Youth and Families
DEA	Division of Elderly Affairs
DEA Number	Drug Enforcement Administration Number
DEI	Disability Employment Initiative
DHS	Department of Human Services
DLT	Department of Labor and Training
DOA	Department of Administration
DOC	Department of Corrections
DOE	Department of Education
DRRB	Data Release Review Board
DSHP	Designated State Health Program
DUA	Data Use Agreement
EBP	Evidence Based Practice
eCQM	Electronic Clinical Quality Measures
ED	Emergency Department
EHR	Electronic Health Record
EOHHS	Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ERISA	Employee Retirement Income Security Act
ETL	Extract, Transform, Load
FAD	Financial Alignment Demonstration
FFS	Fee For Service
FTE	Full Time Equivalency
FQHC	Federally Qualified Health Center
GDP	Gross Domestic Product
GPRA	Government Performance and Results Act
HARI	Hospital Association of Rhode Island
HARP	Home Asthma Response Program
HbA1c	Hemoglobin A1c

<b>Acronym</b>	<b>Meaning</b>
HCPAAC	Health Care Planning and Accountability Advisory Council
HEDIS	Healthcare Effectiveness Data and Information Set
HEZ	Health Equity Zone
HH	Health Home
HIE	Health Information Exchange
HIT	Health Information Technology
HOPWA	Housing Opportunities for Persons with AIDS Program
HPD	Healthcare Provider Directory
HPSA	Health Professional Shortage Area
HPV	Human Papillomavirus
HRiA	Health Resources in Action
HSRI	HealthSource RI
HSTP	Health System Transformation Program
HUD	U.S. Department of Housing and Urban Development
HWT	Healthcare Workforce Transformation
IAPD	Implementation Advanced Planning Document
IBH	Integrated Behavioral Health
ICI	Integrated Care Initiative
IDD	Intellectual and Developmental Disabilities
IHD	Ischemic Heart Disease
IHH	Integrated Health Home
IP	Inpatient
IPHP	Integrated Population Health Plan
IPS	Individual Placement and Support
ISW	Interagency Staff Workgroup
JFF	Jobs for the Future
LAN	Learning and Action Network
LE	Life Expectancy
LMI	Labor Market Information
LTPAC	Long-Term and Post-Acute Care
LTSS	Long-Term Services and Supports
MACRA	Medicare Access and CHIP Reauthorization Act
MAPCP	Multi-Payer Advanced Primary Care Practice
MAT	Medication Assisted Treatment
MITA	Medical Information Technology Architecture
MCO	Managed Care Organizations
MFP	Money Follows the Person
MHPSA	Mental Health Professional Shortage Area
MMCO	Medicaid Managed Care Organization
MOLST	Medical Orders for Life Sustaining Treatment
MOU	Memorandum of Understanding
MMIS	Medicaid Management Information Systems



<b>Acronym</b>	<b>Meaning</b>
MRSA	Methicillin-Resistant Staphylococcus Aureus
NCQA	National Committee for Quality Assurance
NEAIC	New England Asthma Innovation Collaborative
NHPRI	Neighborhood Health Plan Rhode Island
NHSC	National Health Service Corp
NICU	Neonatal Intensive Care Unit
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NQF	National Quality Forum
OHIC	Office of the Health Insurance Commissioner
ONC	Office of the National Coordinator
OPI	Office of Program Integrity
ORR	Office of Regulatory Reform
PATH	Project Assistance in Transition from Homelessness
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PDAC	Provider Directory Advisory Committee
PDMP	Prescription Drug Monitoring Program
PDSA	Plan Do Study Act
PMPM	Per Member Per Month
PQRS	Physician Quality Reporting System
ProvPlan	Providence Plan
PSH	Permanent Supportive Housing
PY	Program Year
QHP	Qualified Health Plan
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QPP	Quality Payment Program
RFP	Request for Proposal
RHIO	Regional Health Information Exchange Organization
RIC	Rhode Island College
RICCC	Rhode Island Chronic Care Collaborative
RIDE	Rhode Island Department of Education
RIDOH	Rhode Island Department of Health
RIHTP	Rhode Island Health Transformation Program
RIMS	Rhode Island Medical Society
RIPCPC	Rhode Island Primary Care Physicians Corporation
RIQI	Rhode Island Quality Institute
ROI	Return on Investment
RTI	Response to Intervention
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment

<b>Acronym</b>	<b>Meaning</b>
SDOH	Social Determinants of Health
SE	Supported Employment
SED	Serious Emotional Disturbance
SHIP	State Health Innovation Plan
SIM	State Innovation Model Test Grant
SMHP	State Medicaid Health IT Plan
SMI	Severely Mentally Ill
SNAP	Supplemental Nutrition Assistance Program
SNF	Skilled Nursing Facility
SNFRM	Skilled Nursing Facility Readmission
SPA	State Plan Amendment
SPF-PFS	Strategic Prevention Framework – Partnership for Success
SPMI	Severely and Persistently Mentally Ill or Serious and Persistent Mental Illness
SSI	Surgical Site Infection or Supplemental Security Income
SSI/SDI	Supplemental Security Income/ Supplemental Disability Income
SUD	Substance Use Disorder
TA	Technical Assistance
TAC	Technical Assistance Collaborative
TANF	Temporary Assistance for Needy Families
TCPI	Transforming Clinical Practice Initiative
UHIP	Unified Health Infrastructure Project
UMASS	University of Massachusetts Medical School
UMID	Unified Multi-Purpose ID
UNAIDS	United Nations Program on HIV/AIDS
URI	University of Rhode Island
VBP	Value-Based Payment or Value-Based Purchasing
WIA	Workforce Investment Act
WIC	Women Infants Children
YRBSS	Youth Risk Behavior Surveillance System

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