



# STRATEGIC PLAN 2012-2017

Michael Fine, MD  
DIRECTOR

FEBRUARY 2014  
[WWW.HEALTH.RI.GOV](http://WWW.HEALTH.RI.GOV)



# TABLE OF CONTENTS

<b>TABLE OF CONTENTS</b>	<b>2</b>
<b>I. EXECUTIVE SUMMARY</b>	<b>3</b>
<b>II. ABOUT THE DEPARTMENT</b>	<b>5</b>
Location and population served	6
Mission, Vision, and Values	6
Governance	7
Organizational structure	7
<b>III. PERFORMANCE MANAGEMENT FRAMEWORK</b>	<b>9</b>
a. Performance Measurement at HEALTH	13
b. Quality Improvement at HEALTH	15
c. Reporting Indicators at HEALTH	16
<b>IV. STRATEGIC PLANNING PROCESS</b>	<b>17</b>
Background	18
Strategic Planning Retreat	18
Strengths and Weaknesses Analysis	18
<b>V. STRATEGIC MAP AND PRIORITIES</b>	<b>21</b>
Rationale for Strategic Focus	24
Strategic foci for the next five years	24
Strategic focus for the next one to three years	24
HEALTH's Policy Opportunities 2012-2013	25
<b>VI. STRATEGIC GOALS AND OBJECTIVES</b>	<b>26</b>
Goal A: Shape the health service delivery system so that Rhode Island achieves the best health outcomes most affordably	27
Goal B: Build population-based primary care and preventive services so that Rhode Island achieves the best health outcomes most affordably	28
Goal C: Promote the value and contributions of public health	29
Goal D: Optimize Department resources in the strategic direction	30
Goal E: Secure and align financial resources with strategic requirements	32
<b>VII. PLAN'S IMPLEMENTATION</b>	<b>33</b>
<b>VIII. APPENDICES</b>	<b>35</b>
<b>LIST OF TABLES AND FIGURES</b>	
Table 1: America's Health Ranking Indicators for Rhode Island, 2013	12
Table 2: List of Healthy People 2020 Indicators	16
Figure 1: Turning Point Framework of Public Health Performance Management System	10
Figure 2: HEALTH's Performance Management System Framework	11
Figure 3: Strategic map prepared at two-day retreat, March 2012	22

THE GOAL OF PROMOTING AND  
PROTECTING THE HEALTH OF  
RHODE ISLANDERS WOULD BE  
WELL-SERVED BY MAKING OUR  
STATE THE HEALTHIEST STATE IN  
THE NATION.



The Rhode Island Department of Health (HEALTH) is shifting its priorities to make Rhode Island the healthiest state in the nation. To achieve such a grand goal, the agency is engaging in initiatives to improve the health delivery system and has taken firm first steps towards a primary care trust that would support a “neighborhood health station” model in each neighborhood of 10,000 or more people. HEALTH is also bringing the idea of “Health in all policies,” and is making great strides to make smoke-free state campuses and grounds, as well as instituting a prescription monitoring program (PMP) that gives providers the ability to check the system before prescribing schedule 2 and 3 medications. HEALTH is also pursuing several avenues to revolutionize its business model, by seeking new ways to fund current programs. In 2013, HEALTH successfully advocated for an increased number of Full Time Equivalent (FTE) positions supported with federal funds. HEALTH has also invested efforts in strengthening its infrastructure, by taking strong steps to become accredited through the Public Health Accreditation Board (PHAB) and is prepared to submit its application in early 2014. Through accreditation efforts, HEALTH has already taken strong steps to bring the Quality Improvement (QI) tools and vocabulary to the staff, and hopes to institute and maintain a culture of QI in the coming years. A statewide health assessment and health improvement plan has also been prepared, and there is a consistent message about performance improvement that is now part of weekly messages at the Executive Committee table. Lastly, HEALTH is approaching the importance of the workforce development in a higher and new way. An annual training plan for staff has been developed and will be renewed each year. The HEALTH Connections newsletter now has eleven editions issued for targeted health professional communities such as physicians, nurses, pharmacists, oral health, emergency medical services, and more.



While it is impossible to fully describe in one document all efforts HEALTH is engaging in to make Rhode Island the healthiest state in the nation, this strategic plan contains key, long-term, overall objectives the Department is pursuing towards its large-scale vision. These objectives, along with all other goals and efforts at the program and micro level, are the foundation that supports the work of the next five years, when we expect to be at a much higher rank from the America’s Health Rankings than we are now (19th in 2013). Please use this strategic plan as a blueprint of the journey HEALTH began in 2011 striving for a destination of an improved delivery system and a stronger infrastructure for much healthier Rhode Islanders by 2017.

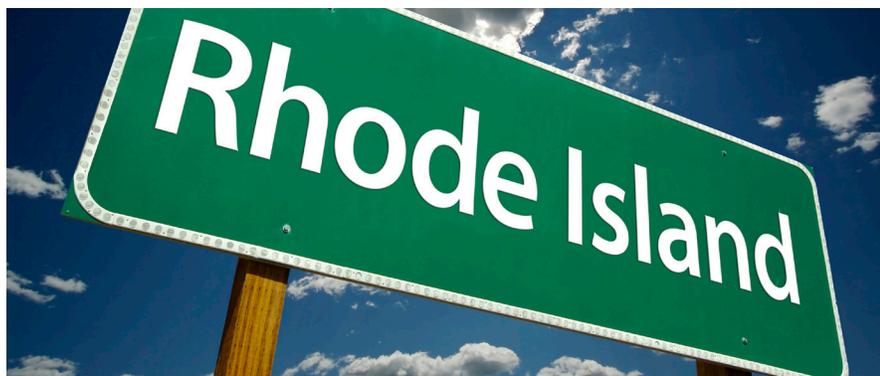


IN RHODE ISLAND, ALL PUBLIC  
HEALTH SERVICES ARE MANAGED  
BY THE STATE DEPARTMENT OF  
HEALTH, WITH NO LOCAL PUBLIC  
HEALTH AGENCIES.

### Location and Population Served

HEALTH is located at Three Capitol Hill in the city of Providence, Rhode Island. In Rhode Island, county government was abolished in 1842 and today remains only for the purpose of delineating judicial administrative boundaries.

According to the most recent census data, the current population of Rhode Island is 1,050,292, with 86.3% of white origin. There are no local public health agencies in Rhode Island; all public health services are managed by the State Department of Health.



### Mission, Vision, and Values

**Mission:** To prevent disease and to protect and promote the health and safety of the people of Rhode Island

**Vision:** Every Rhode Islander should have access to high quality, affordable healthcare, delivered at the most appropriate time and place. All people in Rhode Island will have the opportunity to live a safe and healthy life in a safe and healthy community.

**Values:** Advocacy, collaboration, integrity

To meet the community's expectations for high-quality, affordable healthcare, the delivery system must:

- Deliver healthcare according to the latest scientific evidence, using current evidence-based guidelines where available.
- Improve the quality, efficiency, and accessibility of healthcare services.
- Improve affordability by ensuring efficient utilization of healthcare providers and services.
- Partner with the consumer in his/her healthcare.
- Orient the system toward person-centered care, with family involvement as appropriate.
- Respond to the healthcare needs of the community, in terms of access and cultural and linguistic competence.
- Improve the health status of the population.



## Governance

The Rhode Island Department of Health is part of the Executive Office of Health and Human Services (EOHHS). EOHHS was created in December 2005 to facilitate cooperation and coordination among the state departments that administer Rhode Island's health and social services programs.

Agencies under the EOHHS umbrella include: Department of Children, Youth and Families (DCYF), Department of Human Services (DHS), Division of Elderly Affairs (DEA), Division of Veteran Affairs (VA), Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), and the Department of Health (HEALTH). These departments collectively impact the lives of virtually all Rhode Islanders, providing direct services and benefits to more than 300,000 citizens while working to protect the overall health, safety and independence of all Rhode Islanders.

Michael Fine, MD, has served as Director of the Rhode Island Department of Health since July 2011. In this role, Dr. Fine oversees the single state agency, with more than 400 employees and an operating budget of \$110 million, and is responsible for coordinating a broad range of public health programs and services.

## Organizational Structure

HEALTH is led by the Director, appointed by the state's Governor. As Rhode Island has no local health departments, the agency coordinates public health activities across the state. All programs and services are coordinated by Divisions and Centers (see Organizational Chart in Appendix 1). Main areas of responsibility include:

- 1. Community, Family Health, & Equity:** Works to eliminate disparities in health and access to care, to ensure healthy homes and environments, to prevent and control diseases and disability, to promote health and wellness activities, and to support early childhood development.
- 2. Center for Emergency Preparedness & Response:** Protects health during catastrophic events and large-scale disasters and emergencies by coordinating education, assessment, planning, response, and support services with healthcare providers, public safety agencies, and government officials.
- 3. Environmental Health Services Regulation:** Licenses and regulates health professionals, facilities, and health plans; monitors the safety of public drinking water and beaches; and assures the safety of the food supply and of radiological equipment.
- 4. Center for Health Data & Analysis:** Collects and analyzes health data about Rhode Islanders and uses the data to identify health problems among the state's population and groups.
- 5. Health Information Technology:** Promotes and supports the use of health information technology across the state, including electronic medical records, e-prescribing, and the development of a statewide health information exchange.

**6. Health Laboratories:** Provides analytical surveillance, prevention, and technical laboratory information to support disease surveillance, prevention, and control; environmental health protection; food safety; and emergency response activities.

**7. Infectious Disease & Epidemiology:** Monitors the prevalence of diseases in the community and investigates, controls, and prevents outbreaks.

**8. Management Services:** Manages and delivers efficient personnel, purchasing, finance, and systems support services to the Department in an equitable, effective, efficient, and courteous manner.

**9. Medical Examiners:** Screens deaths for public health significance and determines the cause and manner of deaths.

**10. Center for Public Health Communication:** Provides high-quality, timely, and accurate health information for the public so they can understand health risks and make healthy and safe choices.

**11. Vital Records:** Registers, files, and maintains birth, death, and marriage certificates and publishes related data.



HEALTH DEFINES PERFORMANCE MANAGEMENT AS THE STRATEGIC USE OF PERFORMANCE MEASURES AND STANDARDS TO ESTABLISH PERFORMANCE TARGETS AND GOALS, TO PRIORITIZE AND ALLOCATE RESOURCES, TO INFORM MANAGERS ABOUT NEEDED ADJUSTMENTS OR CHANGES IN POLICY OR PROGRAM DIRECTIONS TO MEET GOALS, TO FRAME REPORTS ON THE SUCCESS IN MEETING PERFORMANCE GOALS, AND TO IMPROVE THE QUALITY OF PUBLIC HEALTH PRACTICE.

Rhode Island uses the Turning Point Performance Management System, which includes four quadrants: Performance Standards, Performance Measurement, Quality Improvement, and Reporting of Progress.

In 2003, the Turning Point tools described performance management as the practice of actively using performance data to improve the public's health. This practice involves strategic use of performance measures and standards to establish performance targets and goals, to prioritize and allocate resources, to inform managers about needed adjustments or changes in policy or program directions to meet goals, to frame reports on the success in meeting performance goals, and to improve the quality of public health practice.

The four components of performance management are depicted in Figure 1 below.

### Public Health Performance Management System



Figure 1. Turning Point Framework of Public Health Performance Management System



The components are described as:

- **Performance Standards** - establishment of organizational or system performance standards, targets, goals, and relevant indicators to improve public health practice
- **Performance Measures** - application and use of performance indicators and measures
- **Reporting of Progress** - documentation and reporting of progress in meeting standards and targets and sharing of such information through feedback
- **Quality Improvement** - establishment of a program or process to manage change and achieve quality improvement in public health policies, programs, or infrastructure based on performance standards, measurements, and reports

HEALTH has adapted the Turning Point framework and designed its own Performance Management System, as shown in Figure 2 below.

### Rhode Island Department of Health's Performance Management System



Figure 2. HEALTH Performance Management System Framework



Director of Health Michael Fine, MD, is issuing the challenge to make Rhode Island the healthiest state in the nation, defined by the scoring used by America's Health Rankings® (www.americashealthrankings.org/). As shown in Table 1 below, Rhode Island ranks number 19 in 2013. Note that, Rhode Island ranks first in immunizing adolescents, third in the ratio of primary care physicians, and 10th in public health funding dollars per person.

**Rhode Island indicators, according to America's Health Rankings 2013**

DETERMINANTS	2013		NO 1
	VALUE	RANK	STATE
<b>BEHAVIORS</b>			
Smoking (Percent of adult population)	17.4	14	10.6
Binge Drinking (Percent of adult population)	17.2	30	10.2
Drug Deaths (Deaths per 100,000 population)	16.0	42	5.0
Obesity (Percent of adult population)	25.7	13	20.5
Physical Inactivity (Percent of adult population)	23.4	30	16.2
High School Graduation Rate (Percent of incoming ninth graders)	76.4	33	91.4
<b>COMMUNITY &amp; ENVIRONMENT</b>			
Violent Crime (Offenses per 100,000 population)	252	13	123
Occupational Fatalities (Deaths per 100,000 workers)	3.7	15	1.9
Infectious Diseases (Combined score Chlamydia, Pertussis, Salmonella*)	-0.11	27	-0.90
Chlamydia (Cases per 100,000 population)	393.9	23	140.6
Pertussis (Cases per 100,000 population)	5.9	28	0.7
Salmonella (Cases per 100,000 population)	18.4	37	6.6
Children in Poverty (Percent younger than 18 years)	20.4	28	9.7
Air Pollution (Micrograms of fine particles per cubic meter)	8.5	16	5.3
<b>POLICY</b>			
Lack of Health Insurance (Percent without health insurance)	12.2	14	3.8
Public Health Funding (Dollars per person)	\$114	10	\$225
Immunization--Children (Percent aged 19 to 35 months)	72.5	15	80.2
Immunization--Adolescents (Percent aged 13 to 17 years)	82.0	1	82.0
<b>CLINICAL CARE</b>			
Low Birthweight (Percent of live births)	7.4	19	6.0
Primary Care Physicians (Number per 100,000 population)	173.4	3	196.1
Dentists (Number per 100,000 population)	59.1	23	85.6
Preventable Hospitalizations (Number per 100,000 Medicare enrollees)	70.3	37	27.4
<b>ALL DETERMINANTS</b>	<b>0.32</b>	<b>13</b>	<b>0.70</b>
<b>OUTCOMES</b>			
Diabetes (Percent of adult population)	9.8	26	7.0
Poor Mental Health Days (Days in previous 30 days)	4.1	35	2.8
Poor Physical Health Days (Days in previous 30 days)	4.1	29	2.9
Disparity in Health Status (By educational attainment**)	31.5	36	19.7
Infant Mortality (Deaths per 100,000 live births)	6.6	28	4.4
Cardiovascular Deaths (Deaths per 100,000 population)	238.6	22	186.9
Cancer Deaths (Deaths per 100,000 population)	193.1	31	141.3
Premature Death (Years lost per 100,000 population)	6,662	20	5,493
<b>ALL OUTCOMES</b>	<b>0.00</b>	<b>30</b>	<b>0.33</b>
<b>OVERALL</b>	<b>0.32</b>	<b>19</b>	<b>0.92</b>

Table 1. America's Health Ranking Indicators for Rhode Island, 2013.

\*Negative score denotes less disease than US average, positive score indicates more than US average

\*\*Difference in high health status between adults aged 25 and older without a high school education and those with at least a high school education

Note that the scores provided for each of the items is the weighted number of standard deviations the state is above or below the national norm. As shown in the table above, for "all determinants", Rhode Island's score is 0.32, half the number 1 state (0.70). Likewise, the score for "all outcomes" in our state is 0.32, one third of the number 1 state (0.92).



**a. Performance Measurement at HEALTH**

Starting in July 2011, HEALTH began an ongoing, organized compilation of program performance measures in one central location and under a uniform format. The resulting document is known by staff as the “Dashboard Report”, and formally titled the “Performance Measures Progress Report.” This report began with just a handful of measures and in less than two years has grown to include performance measures from 36 of the 47 (77%) programs, using the listing that is prepared in the annual State’s Budget.

The Dashboard is an internal management tool that collects performance measures and depicts a quick view of the Department’s activities, and was designed with the following goals in mind:

- To provide a monthly, brief, at-a-glance view of the Department’s activity and overall performance.
- To identify areas of concern that may need attention.
- To inform about at least one meaningful type of measure (activity, quality, outcome) for each program.

Definitions and descriptions of each of the types of measures are included below.

**Activity Measures:**

**Definition:** The volume of the work we do

**Unit of Measure:** In numbers (*i.e., number of calls received, number of licenses renewed*)

**Report Frequency:** Monthly

**Characteristics:** Uses data that are already being collected and tracked and can be easily reported; or uses data that are not currently collected, but are critical for the program to collect and measure

**Quality Measures:**

**Definition:** A measure of the extent to which we accomplish what we are charged to do

**Unit of Measure:** In percentages (*i.e., percentage of tests completed within three days, percentage of cases resolved within 30 days*)

**Report Frequency:** Monthly

**Characteristics:** Must be meaningful

**Outcome Measures:**

**Definition:** A public health measure of the health outcome of the population

**Unit of Measure:** In numbers (i.e., # of HIV deaths), or percentages (prevalence, incidence rates), but always has population as a denominator

**Report Frequency:** Can be reported with data originated by other divisions/units within or outside of the Department

**Characteristics:** Can be reported every 3-6 months or annually

- For purposes of the dashboard, outcomes should be long-term outcomes or program impact/results, and can be measured with data that is collected by another (team, division, database) source
- Value used to compare performance achieved vs. performance expected
- Should be meaningful and understandable
- Should be seen as important and stated in non-technical terms
- Should be valid, reliable, responsive and must have adequate data to support the measure
- Measure what you should, and what you can

**Targets:**

**Definition:** Value used to evaluate performance

**Unit of Measure:** A number or percent

**Report Frequency:** Set usually for one year or more, although it can be revised as a consequence of dramatic changes in program, incidence, funding or another long-lasting event

- Characteristics:**
- Should be set concurrently with consideration of strategic choices and practical performance measures
  - Should be set to trigger a management alert of a performance measure not being achieved, but with enough tolerance so that the alert fires when there is a clear need for intervention
  - If no previous target is available: first measure current performance, then determine a target
  - For measures with long reporting cycles, set some frequent surrogate targets that can be monitored as a proxy
  - To decide on which targets to use, consider the cost (i.e., staff time) of setting data collection and efficiency of target being set

There are 3 types of targets:

- Threshold-based (one side is OK, other side is not)
- Limit-based (0% or 100%) aspirational and inspirational - i.e., getting to 0% may be impractical but is worthy
- Rule-based (need X out of Y to hit a limit or target)

#### **b. Quality Improvement at HEALTH**

HEALTH has been involved in quality improvement (QI) efforts in several parts of the Department for many years in targeted activities, especially in the Chronic Disease and Home Visiting programs. The first agency-wide quality improvement group, however, was convened in late 2011 and received the Train-The-Trainers comprehensive four-day session in July and August 2012. By April 2013, the group completed and exhibited the first set of QI projects, at a first-time QI Fair held during National Public Health Week.

To further strengthen the foundation of QI within HEALTH, the first department-wide Quality Improvement Plan was launched in June 2013 and is designed to advance the following three goals:

1. Develop a strategy to maintain QI capacity
2. Inform and communicate to staff about QI activities
3. Foster and support a culture of QI

Two years after the first QI team was convened, QI is now a sustained effort, with a new group being selected and trained each year, and ongoing QI projects all year long.

For questions about the QI Plan from 2013, please contact [Magaly.Angeloni@health.ri.gov](mailto:Magaly.Angeloni@health.ri.gov).

**c. Reporting Indicators at HEALTH**

All of these indicators are reported in the newly launched software at [www.rihealthcarematters.org](http://www.rihealthcarematters.org), and selected measures have been used in the community meetings conducted for purposes of designing the State’s Health Assessment and Health Improvement Plan. In addition to the America’s Health Ranking standards, HEALTH closely monitors the Leading Health Indicators from Healthy People 2020, some of which are also priorities from the National Prevention Strategy (marked with double \*\* asterisk).

<b>Access to Health Services</b>	1. Persons with medical insurance <65 (AHS-1.1) 2. Persons with a usual primary care provider (AHS-3) [Source of ongoing care]
<b>Clinical Preventive Services</b>	3. Adults who receive a colorectal cancer screening based on the most recent guidelines (C-16) 4. Adults with hypertension whose blood pressure is under control (HDS-12) 5. Adult diabetic population with an A1c value greater than 9% (D-5.1)
	6. Children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines (IID-8)
<b>Environmental Quality</b>	7. Asthma hospitalizations 8. Children younger than 6 years of age with a blood lead level of 5 mcg/dL for the first times in their lives (incidence)
<b>**Injury and Violence</b>	9. Fatal injuries (IVP-1.1) 10. Homicides (IVP-29)
<b>Maternal, Infant, and Child Health</b>	11. Infant deaths (MICH-1.3) 12. Preterm births (MICH-9.1) 13. Teen births
<b>**Mental Health</b>	14. Suicides (MHMD-1) 15. Adolescents who experience major depressive episodes (MDE) (MHMD-4.1)
<b>** Nutrition, Physical Activity and Obesity</b>	16. Adults who are obese (NWS-9) 17. Children and adolescents who are obese (NWS-10.4)
<b>**Reproductive &amp; Sexual Health</b>	18. Persons living w/HIV and know their serostatus (HIV-13)
<b>Social Determinants</b>	19. Students who graduate with a regular diploma four years after starting 9th grade (AH-5.1)
<b>**Substance Abuse</b>	20. Adolescents using alcohol or any illicit drugs during the past 30 days (SA-13.1)
<b>**Tobacco</b>	21. Adults who are current cigarette smokers (TU-1.1) 22. Adolescents who smoked cigarettes in the past 30 days (TU-2.2)

*Table 2. List of Healthy People 2020 Indicators*



DURING THE STRATEGIC PLANNING RETREAT IN MARCH 2012, LEADERSHIP AND KEY MANAGEMENT STAFF REVIEWED THE VISION AND MISSION OF THE DEPARTMENT AND DISCUSSED THE CHALLENGES AND OPPORTUNITIES THE AGENCY SHOULD CONSIDER FOR ITS WORK IN THE COMING YEARS.

## Background

In early 2011 the Department of Health welcomed a new agency director, Michael Fine, MD, who previously was medical program director of the state's Department of Corrections. He is leading the department through a path that made evident the need to update the agency's Strategic Plan, whose last version had been prepared about 10 years ago. Under his leadership, the strategic planning internal dialogue began during 2011 and was later formalized through a two-day facilitated session with support from a consultant through the Association of State Territorial and Health Officials (ASTHO).

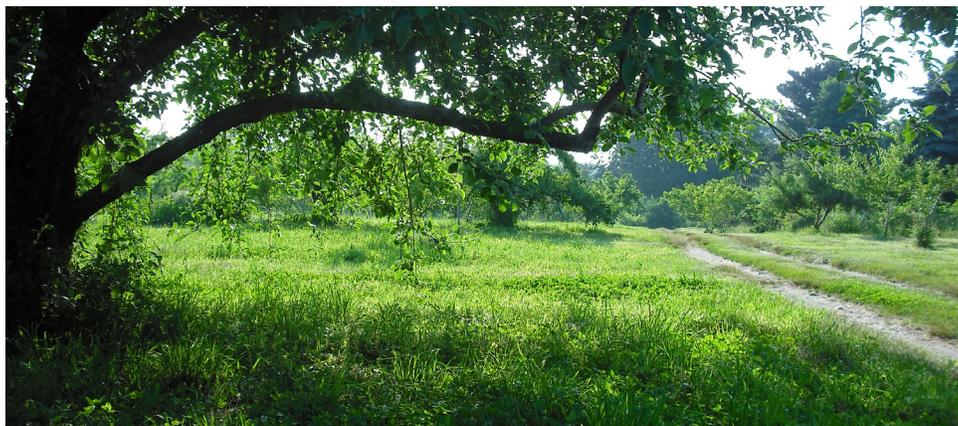
## Strategic Planning Retreat

The two-day retreat took place in March 2012 (agenda on appendix # 2) and was conducted at an off-site location with attendance from nearly 40 staff (see appendix 3). Staff invited to the retreat included the top leadership or members of the agency's Executive Committee, along with the next level of management as well as other key staff. The result was a robust combination of public health experts from each area of the Department and professionals from many disciplines, including attorneys, nurses, managers, financial staff, laboratory specialists, environmentalists, communications staff, and more.

Staff reviewed and discussed a variety of agency-related topics, including the vision and mission of the Department, and agreed that those are still the principles the agency follows, are current and applicable, and therefore no revisions are needed at this point.

## Strengths and Weaknesses Analysis

Central to the design of Rhode Island's strategic dialogue was to complete an inventory of challenges and opportunities the agency should consider for its work in the next few years. With this purpose in mind, and led by the external facilitator, attendees were divided into groups and asked to discuss the most recent internal and external challenges, as well as strengths and opportunities for improvement for the agency. This inventory is shown in the next pages.



<b>Strengths</b>	
<ul style="list-style-type: none"> <li>• Dedicated staff with knowledge</li> <li>• Power and regulatory authority</li> <li>• Strong and established infrastructure</li> <li>• Competent financial management</li> <li>• High ethical standards</li> <li>• Successfully compete for federal dollars</li> <li>• Recruitment and retention</li> <li>• High public trust</li> <li>• Scientific knowledge</li> <li>• Advocacy</li> <li>• Human capital               <ul style="list-style-type: none"> <li>• Knowledgeable, respected staff</li> <li>• Lead many programs</li> </ul> </li> <li>• Exceptional partnerships and relationships               <ul style="list-style-type: none"> <li>• State</li> <li>• Regionally</li> </ul> </li> <li>• Perceived as a high-functioning, committed Department</li> <li>• Good at grants</li> <li>• Collect useful data               <ul style="list-style-type: none"> <li>• KIDSNET</li> <li>• Lead</li> <li>• Behavioral Risk Factor Survey and Youth Risk Behavior Survey</li> <li>• Hospital Discharge Data</li> <li>• Partners appreciate and use data</li> </ul> </li> <li>• Emergency response capabilities</li> <li>• The size of the state and its centralization make work more manageable</li> <li>• Unbiased advocacy</li> <li>• Talented and committed human resources</li> <li>• Institutional knowledge</li> <li>• Statutory leverage</li> <li>• Moral authority</li> <li>• Existing community partnerships</li> <li>• National reputation</li> <li>• Produce measurable results</li> <li>• Subject matter expertise</li> </ul>	<ul style="list-style-type: none"> <li>• Handling emergencies 24/7</li> <li>• Communications</li> <li>• Legal support is increasing</li> <li>• Committed, talented staff</li> <li>• Strong leadership</li> <li>• Reputation</li> <li>• Partnerships</li> <li>• Customer service</li> <li>• Data and surveillance</li> <li>• National recognition               <ul style="list-style-type: none"> <li>• Leadership</li> <li>• Best practices</li> </ul> </li> <li>• The size of the state</li> <li>• Data-driven policy development and resources allocation are key</li> <li>• Skilled, committed staff</li> <li>• The Department handles both state and local public health; fewer layers</li> <li>• We have the ability to create models of public health because of our scale, etc.</li> <li>• Nationally recognized for those models</li> <li>• Strong relationships with community partners</li> <li>• Can implement plans efficiently</li> <li>• Staff               <ul style="list-style-type: none"> <li>• Adaptable</li> <li>• Flexible</li> <li>• Organizational flexibility</li> </ul> </li> <li>• Strong surveillance data sets</li> <li>• Well-established programs               <ul style="list-style-type: none"> <li>• Steady</li> <li>• Continuous</li> <li>• Sustained</li> </ul> </li> <li>• Strong Incident Command System training</li> <li>• Experience/expert staff</li> <li>• Low turnover</li> <li>• Good at securing federal and private funding</li> </ul>



**Weakness/ Areas For Improvement**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Lack of staff depth</li> <li>• Operate in crisis mode daily</li> <li>• Lack of succession planning due to limited staff</li> <li>• Funding to support core state functions/budget cuts</li> <li>• Physical plant</li> <li>• Inadequate Human Resources, Information Technology, and Purchasing support</li> <li>• External (Office of Health and Human Services, Department of Administration) do not replace staff</li> <li>• State compensation system             <ul style="list-style-type: none"> <li>• Inequalities</li> <li>• Titles/classifications</li> <li>• Pay grades</li> </ul> </li> <li>• Lack of staff development and training</li> <li>• Culture rewards silo effect</li> <li>• Micromanagement, multiple layers</li> <li>• Need to optimally use technology</li> <li>• Inability to implement succession planning             <ul style="list-style-type: none"> <li>• Personnel policy limits us</li> <li>• Impacts workforce competencies</li> </ul> </li> <li>• Civil service system</li> <li>• Limited influence on union contracts</li> <li>• Don't communicate/no clarity on our value to the public health/healthcare continuum</li> <li>• High spending on individual health services is contrary to the public health goal of equity; need to invest in community health systems</li> <li>• Need better coordination and communication across the Department—it's getting worse</li> <li>• Need to select, articulate and commit to priorities</li> <li>• Need advocacy for Divisions and Centers, not competition for resources</li> <li>• Need a culture of collaboration that values contributions of all staff to the public health mission</li> <li>• Impact of budget cuts on intellectual capital</li> <li>• Lack of resources and staff</li> <li>• Lack of public recognition of the value of public health</li> <li>• We do not control the purse</li> <li>• Statutory authority and culture need updating             <ul style="list-style-type: none"> <li>• Coalesce around clear future goals</li> <li>• Align statutory authority with goals and objectives/update older statutes</li> <li>• Work together to achieve goals</li> </ul> </li> <li>• Dependence on:             <ul style="list-style-type: none"> <li>• General Assembly</li> <li>• Governor</li> <li>• Office of Health and Human Services</li> </ul> </li> <li>• Lack of flexibility of operating within state government</li> <li>• Need to dominate communication in healthcare</li> </ul> | <ul style="list-style-type: none"> <li>• Improve relationships with providers/licenses</li> <li>• Need to prioritize functions/ops. programs at health</li> <li>• What happens to hospitals and what about the delivery system?</li> <li>• Staffing</li> <li>• Training</li> <li>• Technology</li> <li>• Funding</li> <li>• Crisis mode leads to a lack of strategic focus</li> <li>• Reactive vs. proactive</li> <li>• Reduced morale and efficiency</li> <li>• Physical space</li> <li>• Layers in government</li> <li>• Inefficiency</li> <li>• Need to empower staff more</li> <li>• A lack of infrastructure and understanding of the interface between public health and primary care</li> <li>• Communication and coordination with:             <ul style="list-style-type: none"> <li>• Local governments</li> <li>• Diverse populations</li> </ul> </li> <li>• Unfunded mandates</li> <li>• Overextended staff</li> <li>• Lack of visibility for public health</li> <li>• The public</li> <li>• Rhode Island General Assembly</li> <li>• Need an improved communication strategy</li> <li>• Some areas of low morale and tiredness</li> <li>• Need for coordination within and across Divisions; there is a problem with patchwork funding streams</li> <li>• Personnel system; the movement of Human Resources to Cranston came with issues</li> <li>• Purchasing through the Department</li> <li>• Internal systems are good; outside systems are not</li> <li>• Need a better idea/articulation of how public health intersects with healthcare reform</li> <li>• What is the intersect?</li> <li>• How do we articulate this?</li> <li>• Internally</li> <li>• Externally</li> <li>• Would we have resources?</li> <li>• Tragedy of the commons; we rely on the same assets until they are exhausted</li> <li>• Do we have a clear identity within OHHS; does this configuration restrict public health advocacy?</li> <li>• Some areas have high turnover</li> <li>• Do we need improved internal communication?</li> <li>• Inconsistency across organizational units with regard to policies (Human Resources, etc.)</li> <li>• Need professional grant writers, developers</li> </ul> |
|--|--|



THE STRATEGIC PRIORITY FOR  
HEALTH IS TO POSITION THE  
DEPARTMENT TO LEAD IN  
IMPROVING HEALTH OUTCOMES  
WHILE CONTAINING HEALTH COSTS



As a result of the retreat from March 2012, the group's comments and discussion were summarized into a synthesized, one-page strategic map with a central overall theme and five key strategies, as shown in Figure 3 below.

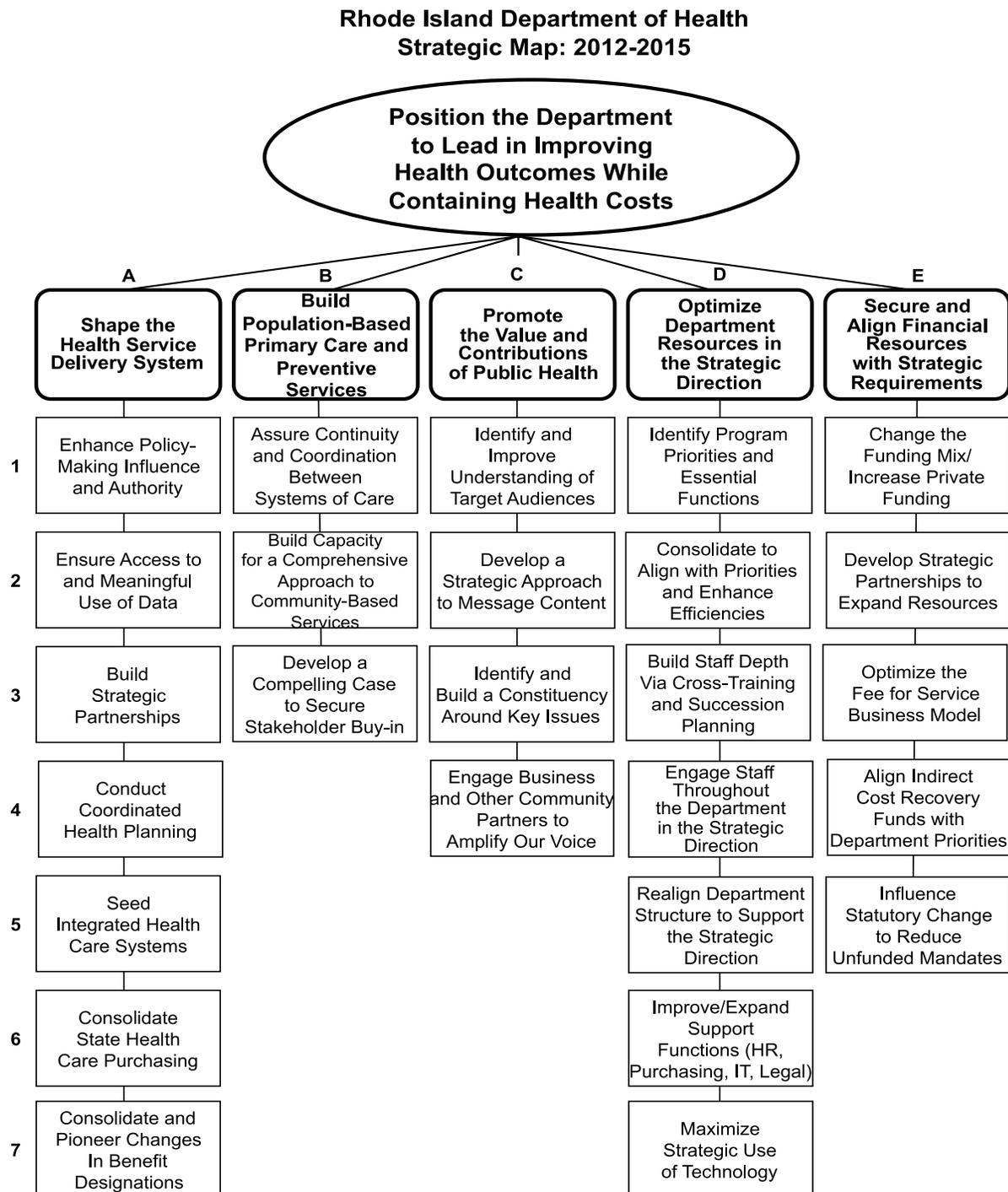


Figure 3. Strategic Map prepared at two-day retreat in March 2012



The strategic priorities for HEALTH are to:

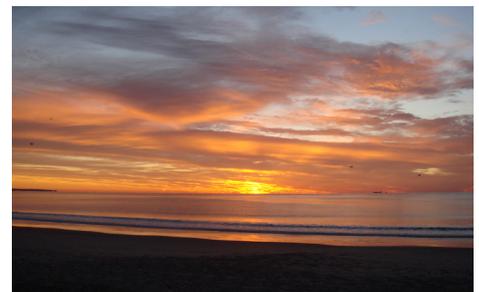
- Redirect the Rhode Island healthcare delivery system so that it focuses on improving the measured health of all Rhode Islanders while containing health costs.
- Redirect the Rhode Island Department of Health so that we focus on improving the measured health of all Rhode Islanders while containing health costs.

And will be measured by:

- Reduction in years of potential life lost and days of lost work, school, and leisure in Rhode Island
- Improvement of social capital in Rhode Island
- Reduced opioid overdose deaths

As a result of the retreat, the TSI Consulting Partners facilitator prepared a 31-page complete report (see appendix 4) that was shared with leadership and management.

During the weeks after the retreat and using the strategic map, a document outlining the short term and longer term strategic focus and priorities was also prepared, and is entirely reproduced on the next two pages.



## RATIONALE FOR STRATEGIC FOCUS

By Dr. Michael Fine

Social factors are the dominant predictor of the health of Rhode Islanders. Evidence shows that the more we invest in education, housing, the environment and public safety, the healthier Rhode Islanders will become. But spending on medical services consumes the bulk of public spending – consuming fully one third of all state revenue dollars – and private spending on health services eclipses all Rhode Island, and is likely one and a half times the entire state budget. HEALTH is well positioned to build collaborations of all health care providers, following the instructions of the Governor and General Assembly, to help remodel the delivery system while practicing the best public health, so that system is focused on improving public health outcomes and lowering cost, so that the health of Rhode Islanders improves, our health care costs become affordable, and the economy of Rhode Island improves, and thus position the state to invest in education and housing and public safety, and thereby improve our health and well-being further.

HEALTH can also lead by improving the consumer experience in interactions with the Department. A reorganization of departmental resources and space can and will improve the business model of the Department while allowing us to focus on our core mission.

### Strategic foci for the next five years

Focus on improving the measured health of all Rhode Islanders while containing health costs

- Reduce years of potential life lost and days of lost work, school, and leisure in RI
- Improvement of social capital in Rhode Island
- Improvement of economic status and resiliency in Rhode Island
- Assure equality and the ability to function at work, home, and school, and participate in the civic life of Rhode Island

### Priorities:

- Redirect the Rhode Island healthcare delivery system so that it focuses on improving the measured health of all Rhode Islanders while containing health cost.
- Redirect HEALTH to focus on improving the measured health of all Rhode Islanders while containing health cost.

### Strategic focus for the next one to three years

- Position the Department to lead in improving health outcomes while containing health costs

### Priorities:

- Shape the health service delivery system so that Rhode Island achieves the best health outcomes most affordably

- Build population-based primary care and preventive services so that Rhode Island achieves the best health outcomes most affordably
- Promote the value and contributions of public health
- Optimize Department resources in the strategic direction
- Secure and align financial resources with strategic requirements

### HEALTH's Policy Opportunities 2012-2013

- Primary Care Trust
- Smoking on state campuses and grounds
- Opioid overdose deaths
  - Prescription Monitoring Program (PMP) Legislation
  - Non-Pharmacologic Multidisciplinary Chronic Pain Center
- Hospital insolvency act
- Certificates of Need (CON) and Health Care Act (HCA) Reform
- Quality Assurance and Improvement for Public Health Indicators in primary care practices
  - Designation and registration of primary care practices
  - Licensure of medical assistants and care managers
  - Purchasing mechanism to pay practices for QA/QI
  - HEALTH practice performance data bank
  - Medicaid participation in service-line programs
  - Programs to include:
    - Opt-out testing for HIV and Hepatitis C
    - Teenage pregnancy and premature death reduction
    - Obesity prevention
    - Immunization rates
  - Public Health Grand Rounds
    - License fee reduction for participants
- Public Rhode Island Primary Care Medical Program/School
- HIV and Hepatitis C testing at Department of Corrections
- Obesity Prevention
  - SNAP waiver to restrict food purchases
  - Sugar-sweetened Beverage Tax
  - Calorie labeling

In the months after the retreat, key members of the Department's leadership developed specific goals and objectives for each of the key priorities from the strategic map. The details of those goals are included in the next section.

GOAL A: SHAPE THE HEALTH SERVICE DELIVERY SYSTEM SO THAT RHODE ISLAND ACHIEVES THE BEST HEALTH OUTCOMES MOST AFFORDABLY

GOAL B: BUILD POPULATION-BASED PRIMARY CARE AND PREVENTIVE SERVICES SO THAT RHODE ISLAND ACHIEVES THE BEST HEALTH OUTCOMES MOST AFFORDABLY

GOAL C: PROMOTE THE VALUE AND CONTRIBUTIONS OF PUBLIC HEALTH

GOAL D: OPTIMIZE DEPARTMENT RESOURCES IN THE STRATEGIC DIRECTION

GOAL E: SECURE AND ALIGN FINANCIAL RESOURCES WITH STRATEGIC REQUIREMENTS

# STRATEGIC GOALS AND OBJECTIVES

## Goal A: Shape the health service delivery system so that Rhode Island achieves the best health outcomes most affordably

Objective	Activity	Current Status	Measure	Target	Contact
1. Enhance policy-making influence and authority	Develop regulations revisiting public hearing before hospital relicensing	Regulation being drafted	Regulation adopted	June 2014	Leonard Green
	Fund HEALTH Connections for all licensed professionals	Complete	Monthly dissemination	March 2014	James Palmer
	Be present at all policy tables critical to delivery system development	Assessment ongoing	Assessment done, priorities established	June 2016	David Heckman
2. Ensure access to and meaningful use of data	Change HIE process from Opt-in to Opt-out	Needs support from Governor's Office	Legislation passed	November 2013	David Heckman
	Convene a workgroup to define workforce needs and gap	Discussing license sustainability	Workgroup meetings	Feb 2015	James McDonald, MD
	Explore funding to reinstate funds for hospital financial data	Not active	Legislation adopted, funds budgeted	July 2014	David Heckman Mira DeBarros Leonard Green
3. Build strategic partnerships	Conduct a Community Health Assessment	In process	Finalized goals and objectives for the healthcare system	December 2015	Magaly Angeloni
4. Conduct coordinated health planning	Quarterly and Annual reports to the legislature	The Healthcare Planning and Accountability Advisory Council will meet in early 2014 to identify a work plan for the rest of this year	Complete a July 31 report to the legislature	July 31, 2014	Michael Dexter
5. Seed integrated healthcare systems	Collaborate with the Office of the Health Insurance Commission (OHIC) to draft Accountable Care Organizations (ACO) regulations	Being explored by OHIC and Office of Lt. Governor	Regulations adopted	Drafted June 2014; Adopted December 2014	David Heckman Leonard Green
	Collaborate with OHIC for statute changes of the ACO	Not active, awaiting OHIC	Statute drafted, introduced, and passed	Draft December 2014; Introduced February 2014; Passed July 2014	David Heckman
	Redraft network adequacy regulations	Discussions started	Regulations promulgated	December 2014	Valentina Adamova
6. Consolidate state healthcare purchasing	Partner with the Department of Administration (DOA) to advocate with policy partners to align with HIX	No action	Have all state employees buy through HIX	December 2016	Michael Fine, MD
			Have all municipal employees buy through HIX	December 2017	Michael Fine, MD
7. Consolidate and pioneer changes in benefit designations	Not in our current jurisdiction, but discussions with the Department of Administration are ongoing	Ongoing discussions	Change in wellness incentives	December 2014	Sarah Harrigan



## STRATEGIC GOALS AND OBJECTIVES

### Goal B: Build population-based primary care and preventive services so that Rhode Island achieves the best health outcomes most affordably

Objective	Activity	Current Status	Measure	Target Date	Contact
1. Assure continuity and coordination between systems of care	Develop Regulations Committee	Not yet formed	Regulations drafted and promulgated	June 2014	Michael Fine, MD
	Interface with America's Health Rankings	America's Health Rankings and Program staff currently meeting	10% reduction in Ambulatory Sensitive Conditions (ASC) of Emergency Department (ED) utilization	June 2016	Edward D'Arezzo
	Expand Emergency Medical Services (EMS) innovations state-wide	Currently, we are exploring proposed amendments to the Rules and Regulations Relating to EMS to benefit the concept of mobile integrated health / community paramedicine.	10% reduction in "frequent flyer" ED presentation	June 2017	Jason Rhodes
2. Build capacity for a comprehensive approach to community-based services	Identify targets of opportunity for medical care system impact on behaviors, social determinants, and built environment	Implementation of Quality Improvement activities for key public health indicators such as immunization rates have already started and are ongoing	Priority criteria determined; List prioritized	December 2014	Ana Novais
	Develop neighborhood health station "build out" pilots with patient-centered medical home practices	Grant application submitted	Buy-in secured; Practice plans developed	June 2016	Michael Fine, MD
	Operational neighborhood health stations	To initiate when funding is identified	50% of priority criteria implemented in one or more practices	December 2017	Ana Novais
3. Develop a compelling case to secure stakeholder buy-in	Create a list of stakeholders and conduct initial outreach	"Grass Tops" list in development; facilitator funding secured	70 stakeholders contacted	June 2014	Michael Fine, MD
	Research/prepare presentation materials	Introductory materials developed	20 meetings	June 2015	Ana Novais
	Conduct surrogate training and a peer-to-peer outreach campaign	Materials in development	Tertiary organizing achieved	June 2016	David Heckman

# STRATEGIC GOALS AND OBJECTIVES

## Goal C: Promote the value and contributions of public health

Objective	Activity	Current Status	Measure	Target Date	Contact
1. Identify and improve understanding of target audiences	Increase partnerships with key stakeholders to conduct the state's health assessment	Workgroup meeting regularly	Number of new external partners participating in community health assessment efforts	Obtain five new external partners per year	Magaly Angeloni
	Achieve wider utilization of community input gathered throughout the Department into tangible priorities included in the Community Health Improvement Plan	Workgroup meeting regularly	Annual update of Community Health Improvement Plan	Produce a yearly updated report	Magaly Angeloni
2. Develop a strategic approach to message content	Develop standard messaging around the Director's key priorities	In progress: have developed State of the State's Health, talking points on substance abuse, flu vaccinations	Annual update of key messages and opportunities for dissemination	Produce yearly updated messaging	Center for Public Health Communications, Michael Fine, MD
	Increase number of campaigns and materials using local, target audience research to inform messaging	In progress	Number of programs allocating budgets for target audience research in message development and/or testing	20% of projects coming through CPHC will involve some level of local audience research	Center for Public Health Communications
	Increase the number of professional groups receiving HEALTH Connections on a routine basis	In progress: seven versions of HEALTH Connections already established, four more slated to begin in 2014	Need Measure for HEALTH connections	Need target date for HC	Center for Public Health Communications
3. Identify and build a constituency around key issues	Maintain agency's capacity in the use of Quality Improvement methods	Staff to be part of the Quality Improvement team is identified and trained each year	Number of staff trained in QI and who complete QI projects on an ongoing basis	- Train 20% of staff in QI tools - Complete 20 QI projects each year	Magaly Angeloni
	Promote the goals of public health among staff	Implementation of the Workforce Development Plan began in early 2014	Number of staff who complete public health-related courses in TRAIN each year	Number of training in public health topics taken by staff; Offer PH101 once a year	Magaly Angeloni
4. Engage business and other community partners to amplify our voice	Develop annual State of the State's Health presentation to be presented at various venues	In progress: presented at State House, Feb 2014	Number of community/business partners receiving presentation	Give the presentation at least five times per year to key partners	Center for Public Health Communications
	Work more closely with community partners and business community in developing targeted messages	In progress: tracking information through Materials Development and Production Forms	Number of programs engaging business or community partners in message development and/or testing	90% of projects coming through CPHC will involve community/business partners in their development	Center for Public Health Communications



# STRATEGIC GOALS AND OBJECTIVES

## Goal D: Optimize Department resources in the strategic direction

Objective	Activity	Current Status	Measure	Target Date	Contact
1. Identify program priorities and essential functions	Engage the Operations Group and Executive Committee in discussions to ensure understanding of priorities and essential functions	Ongoing	Discussions with the Executive Committee	June 2014	Michael Fine, MD
	Utilize essential functions as a springboard to develop HEALTH's Continuity of Operations Plan (COOP)	On hold	Reconvening of COOP Managers Work Group	September 2014	Alysia Mihalakos
	Coordinate with the Community Health Assessment activities to ensure an informed and coordinated approach to priorities	Ongoing activity	Incorporation of the Community Health Assessment findings into priority identification	December 2014	Magaly Angeloni
	Coordinate with the America's Health Ranking Team to ensure consistency of efforts	America's Health Ranking team meets regularly	Incorporation of America's Health Ranking priorities into efforts of the Department	December 2014, Annual progress report	Michael Fine, MD
2. Consolidate to align with priorities and enhance efficiencies	Assess and, if necessary, realign the organizational structure of the Department to align with Departmental priorities	Scheduled to start in early 2014	Realignment, creation, or elimination of Departmental activities	October 2014	Sarah Harrigan
	With realignment planning complete, develop, vet, and exercise the Department's COOP Plan	On hold	Vetted and signed plan; completed tabletop exercise	Plan: Dec. 2015; Exercise: June 2016	Alysia Mihalakos
	Determine the effectiveness and viability of the existing "center" concept	Met with CHDA and CPHC leads and they presented a position paper to Director	Meeting with Center Leads	Dec. 2014	Leonard Green
3. Build staff depth via cross-training and succession planning	Recruit for a Department-wide training position	Position not funded	Recruitment of an individual with organizational training and workforce development expertise	January 2014	Leonard Green
4. Engage staff throughout the Department in the strategic direction	Ensure that the members of the Operations Group and Executive Committee utilize their internal Division and Center modes of communication to inform their respective staff of the strategic direction of the Department	In progress	Discussions in all the organizational structures of HEALTH	June 2014	Executive Committee
	Utilize the intranet to post information that is relevant to the strategic direction of the Department	In process: have posted information about accreditation and a draft of the Health Assessment	Posting of information regarding strategic direction on the Intranet	Ongoing	Center for Public Health Communications
	Hold All-Employee Meetings to inform the Department staff of Department strategic direction	Quarterly or as needed	Meetings where strategic direction is discussed	Ongoing	Michael Fine, MD



## STRATEGIC GOALS AND OBJECTIVES

Objective	Activity	Current Status	Measure	Target Date	Contact
5. Realign Department structure to support the strategic direction	Assess funding streams (grants, contracts, general fund appropriation) for consistency with strategic direction of the Department	Hiring for CFO is in process	The extent to which the current funding (general funds and federal funds) are supportive of, and consistent with, the strategic direction	June 2014	CFO
	Assess the indirect fund account to determine if it is utilized most effectively to accomplish the strategic direction	Ongoing activity. First major assessment was completed. Review and adjustments are ongoing.	Assessment done and appropriate adjustments made	June 2014	CFO
6. Improve/expand support functions (HR, Purchasing, IT, Legal)	Continue meetings with the Director of Health, Deputy Director of Health, Director of Administration and Executive Director of Administration to ensure the Department receives the necessary level of support in these support functions	Ongoing activity	Monitor the responsiveness of the functions that reside in other Departments	Ongoing	Michael Fine, MD
	Assess the structure within our Division of Management Services and other divisions to determine the most efficient method to accomplish purchasing functions	In progress	Incorporation of these topics as agenda items on the monthly meeting; Resolution of specific issues	Feb. 2015	Sarah Harrigan
	Continue to work closely with Human Resources, Legal, and Information Technology groups to improve needed services	Ongoing meetings as needed	Meetings are held and resolution to various issues is achieved	Ongoing	Sarah Harrigan
7. Maximize strategic use of technology	Continue the Informatics Work Group to maximize, when possible, the interoperability of technology and to maximize the efficiency and strategic use of existing technology (e.g., licensing, Kidsnet, VR 2000)	Meetings are held biweekly and submissions for review are received and dispositioned	Number of issues reviewed quarterly	Ongoing	Leonard Green
	Recruit for an Informatician	Completed: Position filled	Hiring completed	Feb. 2014	Samara Viner-Brown



# STRATEGIC GOALS AND OBJECTIVES

## Goal E: Secure and align financial resources with strategic requirements

Objective	Activity	Current Status	Measure	Target Date	Contact
1. Change the funding mix/increase private funding	Hire a Funds Development Coordinator/ Grant Writer as a dedicated resource to identify new funds	Position has been posted and resumes received	Recruitment of a qualified individual for this position	April 2014	Michael Fine, MD, Leonard Green, CFO
	Reinvigorate our relationship with the Rhode Island Public Health Institute (RIPHI) as a non-profit private partner to administer grants	Collaborating with new Director of RIPHI on new grant funding	Number of new activities conducted in partnership with RIPHI since 2014	December 2014 and yearly thereafter	Leonard Green
	Develop strategies to increase the number of restricted-receipt accounts for HEALTH	Work in progress	Establishment of at least one new restricted receipt account	June 2015	David Heckman, Michael Fine, MD
2. Develop strategic partnerships to expand resources	Increase/cultivate partnerships with community agencies, foundations, and other organizations	To begin after the Development Coordinator is hired	Number of applications submitted to new funding partners, foundations, etc.	June of every year	Funds Development Coordinator, CFO
	Build upon current activities with board members of hospitals to jointly design and implement activities to expand resources	Ongoing	Joint development of new activities	June of every year	Leonard Green
	Leverage current partnerships with key stakeholders (e.g., Leadership Rhode Island, Medicaid)	Ongoing	Development of new activities with key partners	December of every year	Leonard Green or designee
3. Optimize the fee-for-service business model	Conduct an environmental scan of neighboring states to compare charges for similar services in a geographically-appropriate fashion	To begin after the Development Coordinator is hired	Completion of the environmental scan	June 2014	Funds Development Coordinator, CFO
	Review the statute and regulatory language that governs what HEALTH can charge for preparation of data or reports	Delayed due to change in Chief Legal Counsel	Report of the analysis	June 2014	David Heckman, Chief Legal Counsel, CFO
	Review current fees and assess other services for which no charge is currently assessed	Same as above	Report of recommendations	June 2014	Chief Legal Counsel, CFO
4. Align indirect cost recovery funds with Department priorities	Ensure the indirect cost fund is consistent with HEALTH's strategic priorities	Ongoing review	Report on the indirect cost fund	June 2014	CFO or designee
	Inventory current applicability and use of the indirect cost fund and recommend adjustments/revisions accordingly	Ongoing review	Report on the indirect cost fund	June 2014	CFO or designee
5. Influence statutory change to reduce unfunded mandates	Prepare and present documentation of HEALTH's serious lack of resources that prevents us from conducting regular program work	Scheduled to start in April 2014	Completion of an initial report and preparation of an annual report thereafter	Reports prepared in June 2014, 2015, and 2016	Leonard Green or designee
	Itemize unfunded mandates and analyze them to ensure they are aligned with HEALTH's strategic goals and priorities. If not, decide if they should be transferred, modified, or halted permanently, etc.	Work begun in 2012-2013 has not continued and will recommence in 2014	Completion of an inventory and preparation of recommendations	First inventory conducted in February 2012; Recommendations December 2014; Progress report December each year starting 2015	David Heckman, Leonard Green

ALTHOUGH SIGNIFICANT EFFORTS HAVE BEEN DEVOTED TO A NUMBER OF PROGRAMMATIC EFFORTS IN THE MONTHS SINCE THE RETREAT, THERE ARE TWO THAT ARE NOT ONLY RELEVANT BUT ALSO OF HIGH SIGNIFICANCE TO THE DEPARTMENT'S FUTURE. THESE EFFORTS ARE THE STRATEGIES TO MAKE RHODE ISLAND THE HEALTHIEST STATE IN THE COUNTRY AND THE PRIMARY CARE TRUST.

In July 2012, four months after the Strategic Plan Retreat, the group was invited again by the Director to review the overarching five-year goals and discuss next steps (see appendix # 5).

During the summer of 2012 the Director held conversations with the Executive Office of Health and Human Services (EOHHS), the Governor's Office, and key members of the state's Legislature regarding the overall strategic priorities for the Department and gained their full support. Counting on the state's leadership support, the Department began full implementation of the strategic priorities stated in this document.

Although significant efforts have been devoted to a number of programmatic efforts in the months since the retreat, there are two that are not only relevant but also of high significance to the Department's future. These efforts are the strategies to make Rhode Island the healthiest state in the country, and the Primary Care Trust.

With regard to making Rhode Island the healthiest state in the country, the Director formed and is leading the America's Health Rankings group, charged to develop a long-term effort to bring Rhode Island to a higher ranking. This group, AHR, was convened in early 2013, and has been meeting biweekly and is composed of about half of the Executive Committee members (see list of AHR members on appendix 6). Part of these conversations resulted in the one-page strategic priorities summary, included in appendix 7.

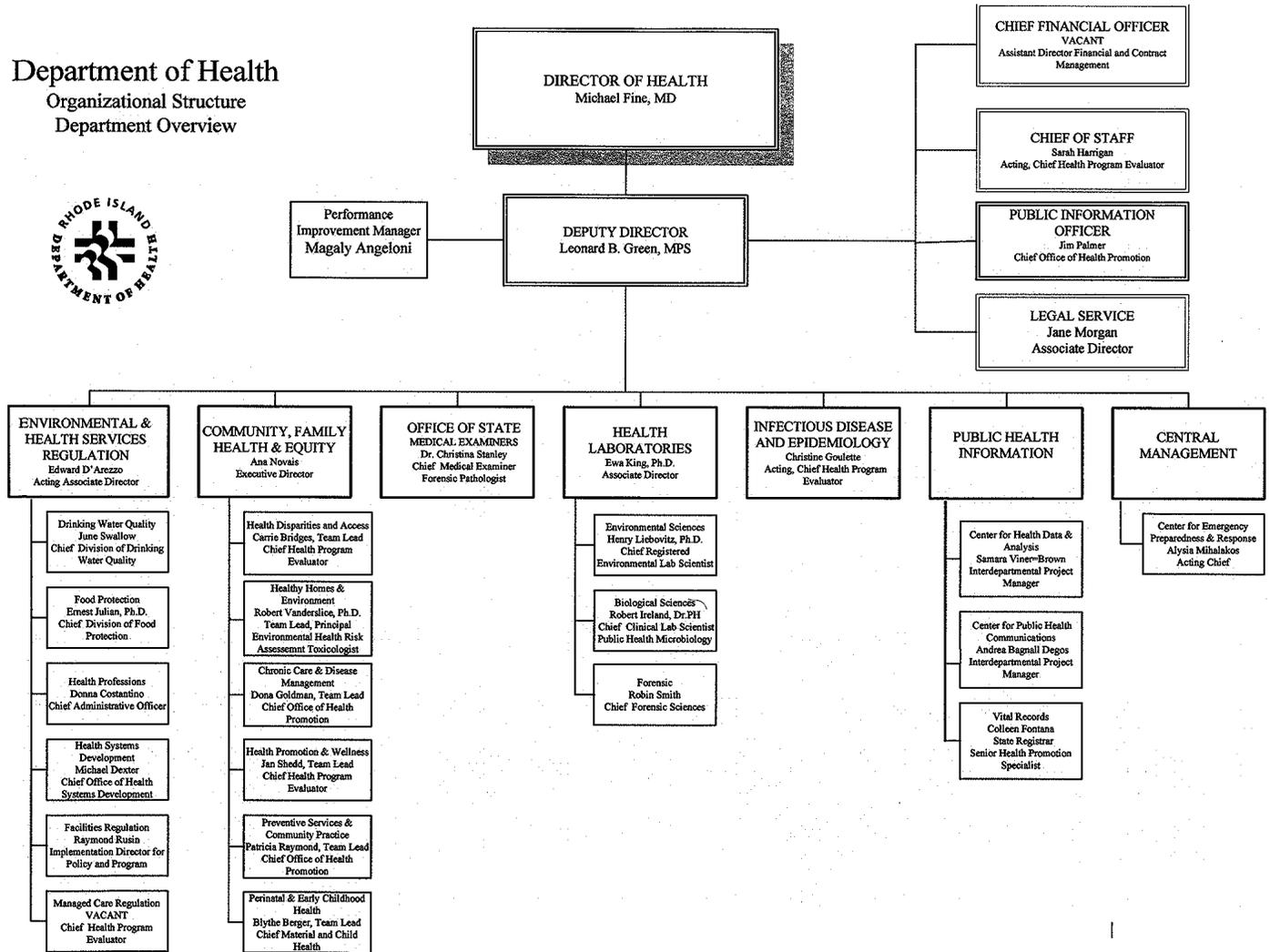
Finally, and perhaps the effort that has taken the priority among the initiatives from this strategic plan, is the Primary Care Trust (PCT). The PCT group was convened by the Director in late 2012 and has been meeting weekly as well as monthly. (See list of individuals involved in the PCT group on appendix 8). By the end of 2012, the PCT group developed a presentation with the goals and vision to reformulate the healthcare in the state, documenting the high financial and social costs of healthcare, and introducing a new way of healthcare: with a single payer for primary care that preserves the patients' choice and uses all other healthcare market components intact (see appendix 9).

As other components of the strategic plan develop, the Director leads and is closely involved in the activities described as part of the five strategic goals of this plan, in section VI. Beginning in early 2015, and annually thereafter, the Department will prepare an annual report on progress made by the agency in the work to position the Department to lead in improving health outcomes while containing health costs. These updates will be posted on the intranet for access by all staff.

- Appendix # 1: Current Rhode Island Department of Health's Organizational Chart
- Appendix # 2: Agenda, Strategic Meeting  
March 20-21, 2012
- Appendix # 3: Attendees to Strategic Planning  
Retreat, March 2012
- Appendix # 4: Meeting Summary, March 20-21, 2012
- Appendix # 5: Strategic Planning Session: Overarching  
5-year goals, July 12, 2012
- Appendix # 6: HEALTH's America's Health Ranking (AHR)  
Workgroup Members
- Appendix # 7: Strategic Priorities: Making Rhode Island  
the Healthiest State in the Nation
- Appendix # 8: HEALTH's Primary Care Trust (PCT)  
Workgroup Members
- Appendix # 9: "How the Healthcare Market is at War  
with Health" Presentation from  
Dr. Michael Fine

Appendix # 1: Current RI Department of Health's Organizational Chart

Department of Health  
Organizational Structure  
Department Overview



## Appendix # 2: Agenda Strategic Meeting March 20-21, 2012

**Rhode Island Department of Health  
Strategic Planning Meeting  
Agenda: March 20-21, 2012****Tuesday, March 20, 2012**

- 8:00am** Welcome and opening remarks
- 8:15** Overview of Strategic Effectiveness—Laurie Schulte
- 8:30** Assessment of the Department of Health's current situation
- Critical issues facing the Rhode Island healthcare delivery system—next three to five years, including how medical costs and healthcare reform will impact public health and public health funding
  - Strengths of the Department
  - Weaknesses/areas of needed improvement
- 10:00** Break
- 10:15** Assessment of the Department's current situation (continued)
- 12:00pm** Lunch
- 1:00** Future direction of the Department
- Mission
  - Central challenge
  - Strategic priorities
- 3:30** Break
- 3:45** Strategic Mapping—setting objectives for each strategic priority
- 5:00** Adjourn

**Wednesday, March 21, 2012**

- 8:00am** Finalizing the Strategic Map
- 10:00** Break
- 10:15** Establishing priorities for the next 12 months
- 11:00** Implementation planning
- Identifying tracks of work for the next 12 months
  - Beginning to organize for implementation
- 12:00pm** Lunch
- 1:00** Implementation planning (continued)
- 2:30** Break
- 2:45** Next steps and wrap up
- Communicating with key stakeholders
  - Moving to implementation
  - Establishing a timetable for reviewing progress and making needed adjustments
- 3:30** Adjourn



## Appendix # 3: Attendees to Strategic Planning Retreat on March 2012

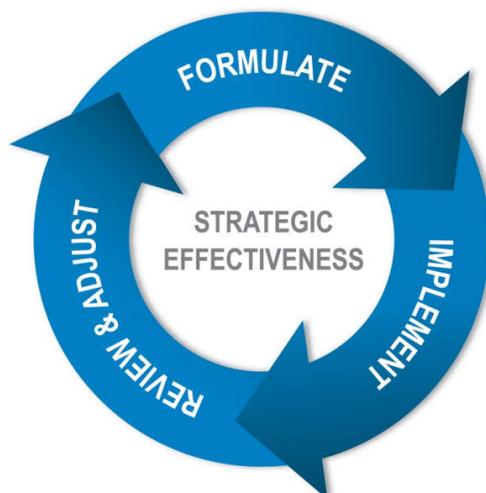
1. Alysia Mihalakos
2. Ana Novais
3. Andrea Bagnall-Degos
4. Bruce McIntyre
5. Carol Hall-Walker
6. Carrie Bridges
7. Christina Stanley
8. Christine Goulette
9. Colleen Fontana
10. Dara Chadwick
11. David Heckman
12. Dona Goldman
13. Donna Costantino
14. Douglas Axelsen
15. Edward D'Arezzo
16. Emily Lefebvre
17. Ernest Julian
18. Ewa King
19. Jacqueline Kelley
20. James McDonald
21. Jan Shedd
22. Jason Rhodes
23. Jay Garrett
24. John Fulton
25. June Swallow
26. Leonard Green
27. Magaly Angeloni
28. Michael Dexter
29. Michael Fine
30. Nicole Alexander
31. Patricia Raymond
32. Peter Simon
33. Raymond Rusin
34. Robert Vanderslice
35. Samara Viner-Brown
36. Utpala Bandy

## Rhode Island Department of Health Strategic Planning Retreat Meeting Summary: March 20-21, 2012

### INTRODUCTION

Laurie Schulte, Vice President of TSI Consulting Partners, welcomed participants to the strategic planning session and thanked them for their participation.

Laurie provided an overview of strategic effectiveness – an organization's ability to set the right goals and consistently achieve them.



Organizations with high strategic effectiveness:

- Quickly formulate a “good enough” strategic plan.
- Move immediately to implementation—letting implementation teach them the ways that the strategy is on target and ways it needs to be improved.
- Review progress on implementation regularly with honesty and candor.
- Make needed adjustments based on what is working, what isn’t, and how the world has changed.
- Focus on results, not activities.

Laurie also outlined the agenda for the strategic planning session:

- Assess the current situation of the Rhode Island Department of Health.
- Set the future direction of the Department.
- Create a strategic map that depicts how to move from “current” to “future.”



## ASSESSING THE CURRENT SITUATION

Assessing the current situation of the Department of Health is a first step in setting its future direction. Participants met in small groups to assess the current situation of the Department. The groups addressed three core questions:

- Critical issues facing the Department over the next three to five years, including how medical costs and health care reform will impact public health and public health funding
- Strengths of the Department
- Weaknesses/areas of needed improvement

A summary of the small group reports follows.

### **Critical Issues Facing the Department over the Next Three to Five Years, Including Consideration of How Medical Costs and Health Care Reform Will Impact Public Health and Public Health Funding**

GROUP 1: CAROL HALL WALKER, BOB VANDERSLICE, DOUG AXELSON, ED D'AREZZO, EMILY LEFEBVRE, EWA KING

#### *Critical Issues the Department Will Face over the Next Three to Five Years*

- Financial failure of hospitals
- Increased cost of the health care delivery system
- Lack of money for prevention; medical and health care disconnect
- Reduction in funding; need to increase or keep steady
- Workforce development to meet needs
- Lack of a team approach to connect patients to county supports for improved self-management
- Training
  - Time
  - Money
  - Depth of staff leaves gaps.
- Fragmented health care
  - Redundancies/test
  - Lack of coordination/communication
  - Lack of understanding of the system
- Health care reform implementation
  - Cost
  - "How to"
- Lack of political will to change
  - Proactive
  - Prevention
  - Pendulum swings
- Primary care shortages



*Consideration of How Medical Costs and Health Care Reform Will Impact Public Health and Public Health Funding*

- Payor system
  - Change the way existing health care is financed.
  - Explore new ways to reallocate money.
  - Reorganize services to make them more effective.
- Vertical integration/continuum
- Integration of medical into community
  - County Health Workers
  - Volunteerism
  - Patient navigators
- Pay now and/or pay later.
- Improve medical/social services received by vulnerable populations.
  - Support of housing
  - Coordinated support direct services
- Long-term care
  - Costly
  - Better integrate the delivery of medical care and long-term care.
- There is an opportunity for public/private partnerships.
  - Home health care
  - Adult day care
  - Assisted living
- Reduce disparities: social determinants of health

GROUP 2: DARA CHADWICK, MAGALY ANGELONI, PETER SIMON, CARRIE BRIDGES, PATRICIA RAYMOND, LENNY GREEN

- Identity
  - Helping others understand public health and the value of public health to them
  - Understanding the role and value of public health along the public health-health care continuum
- Managing expectations, redefining “health”
- Training and growing the public health workforce to respond to current and future needs
  - Inadequate workforce competency
  - Inadequate workforce flexibility
- Need clarity on public health priorities
- Preparing our systems for technological advancements
- Hospital solvency
  - How many are needed
  - Where
  - The will to change
- Applying public health expertise to the health care delivery system
  - To improve quality and reduce expenditures
  - To increase efficiency



- Requires leadership and will
- Do we drive change or adapt to change?
- Tension between funding sources
  - Federally funded
  - Report to the governor/General Assembly

GROUP 3: MICHAEL FINE, MIKE DEXTER, DAVID \_\_\_\_\_, JAY GARRETT, BRUCE MCINTYRE, JAMES McDONALD

- Community hospitals losing money
- Cost of health reform
- Health care is bankrupting the economy.
- Poor outcomes
- Behavioral lifestyles equal poor health.
- Money to specialists rather than to primary care physicians
- The impact on communities of corporate health and wellness “sales”
- The notion of “health” has been hijacked.
- Deconstruction of communities
- Defunding public health
- A need to focus on public health rather than on medical services
  - (Q)(T)/M
  - Move money from sub-specialties to primary care.
- Push to profit undermines the patient experience.

GROUP 4: CHRIS GOULETTE, ANDREA BAGNALL-DEGOS, UTPALA BANDY, JASON RHODES, COLLEEN FONTANA, ERNIE JULIAN

- Legislation and technology
  - Politics
  - Elections
- E-medicine/health gap
- Quality improvement in all sectors of medicine and the health gap
- Reducing budgets are impacting staffing competencies.
  - Retirements
  - Institutional knowledge
- Hospital system changes and delivery system impact a backslide in public health outcomes.
- Increasing demand for communication and information
- Rising health care costs and the reasons why
- Meeting the needs of a diverse population
- Having a clear understanding of health’s role
  - Public health emergencies
  - The public’s perception of the health and value of public health services
  - This leads to funding.
- Address the gap in care.
  - Primary care
  - Health care’s changing role



- Market prevention as a way of reducing health care costs and incentivize this for providers.
- Improve public health's understanding of health care reform.
- Unfunded mandates

GROUP 5: ANA NOVAIS, JUNE SWALLOW, DONNA COSTANTINO, SAM VINER-BROWN, JOHN FULTON, CHRISTINA STANLEY, DONA GOLDMAN

- As federal and state funding is cut, more services are placed on primary care providers, community health centers, etc.
- Electronic Health Records
  - The ability to provide reports
  - Building to a more population-based delivery
- Need to build community clinical linkages to address the challenges of health care delivery
- Paying attention to the redesign of the clinical system; where is public health in health care reform?
- Workforce needs
  - In and out of the Department
  - Standards/skills
  - Standardization needed, e.g. clinical assistance
- Primary care numbers are dropping.
  - Dentists
  - Physicians
  - Not enough replacements
- The health of the hospital system
  - Can community hospitals survive?
  - Need to push for more community-based services
  - Do we have capacity?
- Will people “fall through the cracks” with health care reform?
- Is it the job of public health to meet these needs?
- What are the incentives to go into:
  - Public health
  - Primary care medicine
- Need a better model for integration of primary and secondary medical care
- Need to develop the activated patient
- We have focused efforts on a subset of large primary care practices.
  - How do we expand to smaller practices?
  - How do we increase the focus on primary care and the public health delivery system?
  - There is too much attention focused on health care delivery—not enough on these other things.
- A good indicator: keeping patients out of emergency departments
- How do we build in preventive services across the health care system?
  - Standards for preventive services?
  - Reimbursement?
  - Built into Medicaid and other third party packages?



- Federal cutbacks are on the way; we are too dependent on federal funding.

### **Strengths of the Department of Health**

#### GROUP 1

- Dedicated staff with knowledge
- Power and regulatory authority
- Strong and established infrastructure
- Competent financial management
- High ethical standards
- Successfully compete for federal dollars
- Recruitment and retention
- High public trust
- Scientific knowledge
- Advocacy

#### GROUP 2

- Human capital
  - Knowledgeable, respected staff
  - Lead many programs
- Financially well-managed
- Exceptional partnerships and relationships
  - State
  - Regionally
- Perceived as a high-functioning, committed Department
- Good at grants
- Collect useful data
  - KIDSNET
  - Lead
  - BRFSS and YRBS
  - HDD
  - Partners appreciate and use data.
- Emergency response capabilities
- The size of the state and its centralization make work more manageable.

#### GROUP 3

- Unbiased advocacy
- Talented and committed human resources
- Institutional knowledge
- Statutory leverage
- Moral authority
- Existing community partnerships
- National reputation
- Produce measurable results



## GROUP 4

- Subject matter expertise
- Handling emergencies 24/7
- Communications
- Legal support is increasing.
- Committed, talented staff
- Strong leadership
- Reputation
- Partnerships
- Customer service
- Data and surveillance
- National recognition
  - Leadership
  - Best practices
- The size of the state

## GROUP 5

- Data-driven policy development and resources allocation are key.
- Skilled, committed staff
- The Department handles both state and local public health; fewer layers.
- We have the ability to create models of public health because of our scale, etc.
- Nationally recognized for those models
- Strong relationships with community partners
- Can implement plans efficiently
- Staff
  - Adaptable
  - Flexible
  - Organizational flexibility
- Strong surveillance data sets
- Well established programs
  - Steady
  - Continuous
  - Sustained
- Strong I.C.S. system/training
- Experience/expert staff
- Low turnover
- Good at securing federal and private funding

**Weaknesses/Areas of Improvement of the Department of Health**

## GROUP 1

- Lack of staff depth
- Operate in crisis mode daily.
- Lack of succession planning due to limited staff
- Funding to support core state functions/budget cuts
- Physical plant
- Inadequate HR/IT support



- External (OHHS, DOA) do not replace staff.
- State compensation system
  - Inequalities
  - Titles/classifications
  - Pay grades
- Lack of staff development and training
- Culture rewards silo effect.
- Micromanagement, multiple layers

## GROUP 2

- Need to optimally use technology
- Inability to implement succession planning
  - Personnel policy limits us.
  - Impacts workforce competencies
- Civil service system
- Limited influence on union contracts
- Don't communicate/no clarity on our value to the public health/health care continuum
- Increased spending on individual health services is contrary to the public health goal of equity; need to invest in community health systems.
- Need better coordination and communication across the Department—it's getting worse
- Need to select, articulate and commit to priorities
- Need advocacy for Divisions and Centers, not competition for resources
- Need a culture of collaboration that values contributions of all staff to the public health mission

## GROUP 3

- Impact of budget cuts on intellectual capital
- Lack of resources and staff
- Lack of public recognition of the value of public health
- We do not control the purse.
- Statutory authority and culture need updating.
  - Coalesce around clear future goals.
  - Align statutory authority with goals and objectives/update older statutes.
  - Work together to achieve goals.
- Dependence on:
  - General Assembly
  - Governor
  - OHHS
- Succession planning
- Lack of flexibility of operating within state government
- Need to dominate communication in health care
- Improve relationships with providers/licensees.
- Need to prioritize functions/ops. programs at health
- What happens to hospitals and what about the delivery system?



## GROUP 4

- Staffing
- Training
- Technology
- Funding
- Support structures
  - HR
  - IT
  - Purchasing
- Crisis mode leads to a lack of strategic focus.
  - Reactive vs. proactive
  - Reduced morale and efficiency
- Physical space
- Layers in government
  - Inefficiency
  - Need to empower staff more
- A lack of infrastructure and understanding of the interface between public health and primary care
- Communication and coordination with:
  - Local governments
  - Diverse populations

## GROUP 5

- Unfunded mandates
- Overextended staff
- Lack of visibility for public health
  - The public
  - Rhode Island General Assembly
  - Need an improved communication strategy
- Some areas of low morale and tiredness
- Need for coordination within and across Divisions; there is a problem with patchwork funding streams.
- Personnel system; the movement of HR to Cranston came with issues.
- Purchasing through the Department
- Need more IT
- Internal systems are good; outside systems are not.
- Need a better idea/articulation of how public health intersects with health care reform
  - What is the intersect?
  - How do we articulate this?
    - Internally
    - Externally
  - Would we have resources?
- Tragedy of the commons; we rely on the same assets until they are exhausted.



- Do we have a clear identity within OHHS; does this configuration restrict public health advocacy?
- Lack of succession planning
- Some areas have high turnover.
- Do we need improved internal communication?
- Inconsistency across organizational units with regard to policies (HR, etc.)
- We need professional grant writers, developers, etc.

Discussion of the assessment of the current situation included the following points.

- Trusting public health is different than valuing public health.
  - The public trusts the Department.
  - It is known and respected.
  - Some of its activities, e.g. prevention, are not visible to the public.
  - There is room to build the public's understanding and value of public health.
- The Department can strengthen its relationships with key communities.
  - It can activate local communities to address health issues.
  - This is part of the Department's state and local role.
- Many of the issues facing the Department are grounded in a lack of focus.
  - There are many "programs."
  - Limited staff is spread thin, with few on any one project.
  - This explains why staff is tired.
  - The Department has the capability to scale up in response to environmental requirements, e.g. H1N1.
  - This is a context in which to think about the future role of the Department.
- In addition to increasing staffing, the Department can also:
  - Increase learning.
  - Emphasize strategic thinking vs. managing.
- Many of the Department's priorities are mandated.
  - This presents management challenges.
  - Funding streams are dedicated.
  - It's a complicated situation.
  - The situation is not sustainable.
  - The Department must prioritize over time to move in a positive direction.
- The Department doesn't discontinue anything.
  - It must identify its core business.
  - It needs to overcome resistance to prioritization.
  - There are different definitions of what is core; the Department must:
    - Establish high-end goals
    - Get people on board—which can be difficult.
  - We can "gracefully exit" programs/initiatives.
- Other ways to prioritize include:
  - Doing things differently
  - Outsourcing projects
  - Etc.
  - If the Department doesn't articulate its priorities, there is no way to influence them.



- There is a difference between advocating for one's individual program and doing what's best for the people of Rhode Island.
  - Priorities must be transparent.
  - Politics impact this context.
- There is an opportunity to increase interactions with the business community.
  - There is opportunity for expanded partnerships.
  - A communications strategy will be required.
- Overall, there was a high level of agreement across participants on the current situation facing the Department.
  - We must focus on what we can do.
  - There is good news.
  - All are committed.
  - We can build on that.

## SETTING FUTURE DIRECTION

Laurie Schulte provided a brief overview of the key elements of an organization's future direction.



- An organization's mission states why it exists, its reason for being, its fundamental purpose. It's an enduring statement that usually remains the same for many years, providing long-term continuity and direction for the organization.
- Vision articulates the long-term outcome or end-state that the organization will make a definitive contribution to creating.
- Strategy outlines what the organization needs to do at this point in its history. It is more focused and time bound than mission and vision—often looking to the next three to five years.
- An organization's core values and/or guiding principles outline its unique approach, its norms for "how we do things" in the organization.
- An organization's tactics outline "how to" implement its strategy.

## Mission and Vision

As context for setting future direction for the Department of Health, participants reviewed the mission and vision of the Department.

### MISSION OF THE RHODE ISLAND DEPARTMENT OF HEALTH

Protect and promote the health of all Rhode Islanders.

### VISION FOR THE RHODE ISLAND DEPARTMENT OF HEALTH

All people in Rhode Island will have the opportunity to live a safe and healthy life in a safe and healthy community.

The group considered the appropriateness of the mission and vision to the future direction of the Department. Discussion included the following points.

- Even if the group agrees to add an impact on health system changes to its strategy, the fundamental purpose of the Department is the same.
- The breadth of the mission and vision as currently stated is advantageous in that it doesn't restrict the Department.
- A disadvantage is that the Department can be expected to do anything and everything.
- The group discussed whether "health" is jargon.
  - There are many definitions of health.
  - Its meaning has been co-opted in some circles.
  - Does health mean health equity?
  - The group considered and rejected a revision to "optimal health," as health is not measurable and this distinction also has multiple definitions.
- The group discussed whether the notion of "well-being" should be included in the mission; this would include the social determinants of health, such as education, income, geography, etc.
- After formulating the strategic map for the Department, the group revisited mission and vision and agreed that:
  - Both continue to provide sufficient long-term direction and continuity for the Department.
  - The new strategy is aligned with them.

## Central Challenge and Strategic Priorities

Participants were asked to identify—in a word or phrase—the central challenge that the Department of Health faces over the next three years. A summary of responses follows:

- Funding for the core State work that we're required to do
- Setting meaningful and financially achievable goals
- Communicating what health is and where it comes from
- Maintaining a competent and skilled workforce
- Obtaining the ability to prioritize our work
- Prioritizing what really counts
- Getting the public to understand what we do
- Achieving health equity for all Rhode Islanders
- Increasing resources in a changing political environment



- Messaging
- Containing medical costs so that public health and social programs can be funded
- Having people change their behaviors to be more healthy
- Unfunded mandates
- Having people listen to us when we make our points
- Making our internal processes more efficient and effective to overcome our limitations
- Appropriate allocation of resources based on defined priorities of the DOH; “fish or cut bait”
- Clarifying and providing leadership for core functions/goals that we are uniquely positioned to fulfill
- Creating efficiencies and eliminating redundancies
- Resources
- Finding a way for our public health systems to meet the demands of technology
- Prioritizing goals and resourcing achievement
- Moving towards a more proactive vs. reactive strategy in our day-to-day business
- Resources, visibility, priorities, morale
- Developing a clear and transparent system within the DOH
- Leadership during treacherous times
- Addressing social determinants of health
- Public perception: engine vs. caboose
- The ability to concentrate resources to respond to emerging health threats

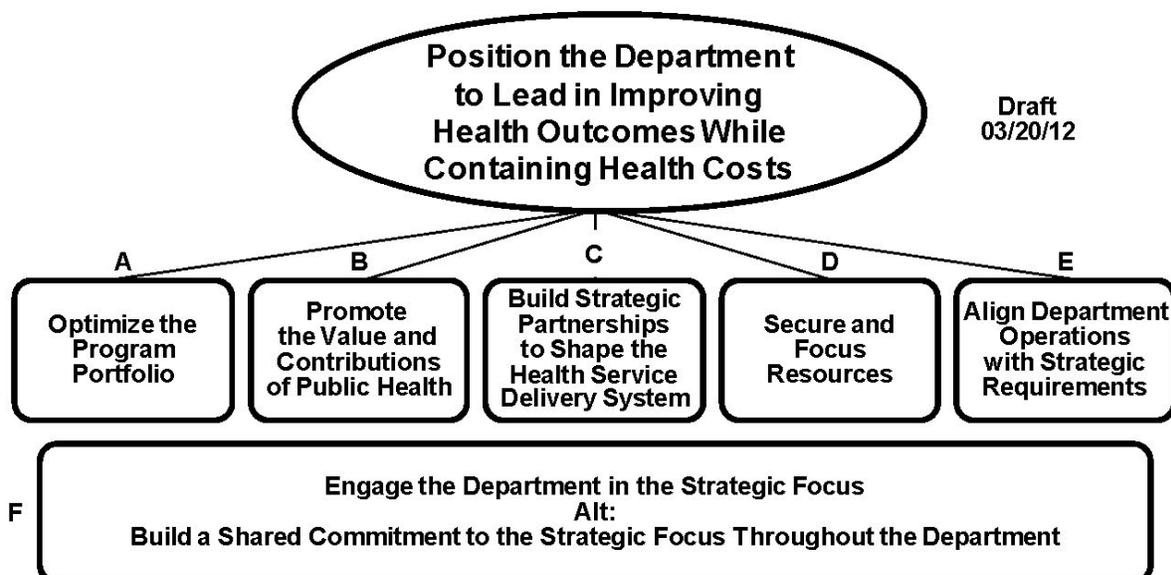
Using a one-page graphic representation of a strategic map, Laurie Schulte explained the concepts of central challenge and strategic priorities.

- The oval at the top of the strategic map is the central challenge.
  - It is the focal point for strategy.
  - It focuses on what the organization needs to do in the next three years to support its mission.
- The central challenge is supported by some number of strategic priorities.
  - Strategic priorities are the few critical things we must do in order to meet our central challenge.
  - The number of strategic priorities can vary, but is never fewer than three or more than six.
- There are two tests of a strategic priority:
  - Is each priority *necessary* to meet the central challenge?
  - Are the strategic priorities taken together *sufficient* to meet the challenge?
- For improved clarity and understanding by those external to the planning group, the group agreed to call the central challenge the “strategic focus.”

Based on participant input on the strategic focus, Laurie then presented a “first draft” of a possible strategic focus and strategic priorities for the Department of Health for the next three years. After discussion and revision, the group agreed to the following version as “good enough” to begin work to develop strategic objectives for the map.



**Rhode Island Department of Health  
Strategic Map: 2012-2015**



Discussion of the strategic focus and strategic priorities included the following points.

- In discussing the strategic focus, “Position the Department to lead in improving health outcomes while containing health costs,” the following points were made.
  - The strategic focus is not equivalent to the Department’s mission; however, it must fit within the umbrella of the mission.
  - The strategic focus is about bringing a public health focus to the health care delivery system.
  - To avoid reinforcing fragmentation, the strategic focus is purposely not inclusive of all the Department’s programs.
  - The biggest opportunity to move health forward rests with social and environmental root causes—including protection.
  - This is broader than the health care delivery system.
  - Over the next three years, the biggest public health threat is the explosion of health care costs; the Department must act to address this.
  - Given the need to continue to maintain programs and the time that it will take to do this work, the group supports the notion of “positioning” the Department to lead in this area; the work must be staged appropriately, yet with urgency.
  - It’s important for planning participants to wear their departmental hats, not their individual program-based hats, as they formulate strategy for the Department.
- The group discussed the difference between authority and influence; the Department’s power rests in both areas.
  - The Department has some indirect and some direct ability to lead in containing health care costs.
  - There are many mission-based ways to do this, including:
    - Population-based primary care

- Chronic disease and prevention outside of emergency rooms
    - Food and water
  - The Department may not have led in this way to the extent that it could have in the past.
  - Costs are much broader than the health care delivery system costs.
- Part of the reason why health care and medical costs have increased so substantially is because public health hasn't been at the table.
  - The Department must not shy away from the health care/medical piece of exploding costs.
  - The Department's position in the State allows it to step up to this challenge.
- In Strategic Priority D, "Secure and focus resources":
  - The resources to be secured are to be redirected toward this new strategic work.
  - Focusing the resources will help the Department move away from current silos.
- The Department was able to prioritize and rally around the H1N1 issue.
  - Despite limited staff, this was a big part of why those efforts were successful.
  - It was not a formal prioritization process although it was still a priority.
  - Importantly, while it was successful, this work was still a significant burden on staff.
- Strategic Priority E, "Align Department operations with strategic requirements," includes reinforcing a shared commitment throughout the Department to the strategic focus.
- The group developed Cross-cutting Strategic Priority F, "Engage the Department in the strategic focus." In strategic map logic, a cross-cutting strategic priority:
  - Is placed at the bottom of the strategic map to show that it is foundational to the strategy
  - Spans the map from left to right to demonstrate that efforts to achieve the cross-cutting priority will be embedded in the efforts to implement all the other strategic priorities on the map.
  - No plan to implement the other strategic priorities will be considered complete unless it includes emphasis on the cross-cutting priority.

### Strategic Mapping

In order to develop a strategic map for the Department of Health, participants worked in small groups to identify objectives that support each strategic priority. A summary of the small group reports follows:

STRATEGIC PRIORITY A: OPTIMIZE THE PROGRAM PORTFOLIO (DOUG AXELSON, BRUCE MCINTYRE, EWA KING, JUNE SWALLOW, COLLEEN FONTANA, MICHAEL FINE)

- Reduce demand on indirect cost recovery funds by identifying funded programs that are less of a priority to public health direction.
- Develop a process to change statutes which are requiring DOH to maintain programs.
- Identify underfunded programs and determine health priority and impact.
- Develop a business evaluation model process which would identify the cost of a program and the required fee to be charged to cover the program.



- Review the organizational structure to identify consistency and effectiveness by:
  - Benchmarking to national standards
  - Span of control
  - Product and function
  - Comparison to other states
  - Historical comparisons
  - Resource adequacy

STRATEGIC PRIORITY B: PROMOTE THE VALUE AND CONTRIBUTIONS OF PUBLIC HEALTH  
(ANDREA BAGNALL-DEGOS, DAVID \_\_\_\_\_, CAROL HALL WALKER, DARA CHADWICK, BOB VANDERSLICE, LENNY GREEN)

- Strategic plan for all messages/content
  - Research audiences.
  - Develop targeted messages.
  - Health in all policies
    - Life
    - Neighborhood
  - Identify “what’s in it for me.”
  - Who delivers the message?
  - Include a call to action as part of the content.
    - Audience size
    - Audience motivation
- Identify and build constituencies.
  - Select key issues.
  - Prioritize.
  - Segment audiences.
  - Achieve some things collectively.
- Engage business and other community partners.
  - ROI/win-win/save money.
  - Reframe how we convey data to make it relevant to a broader audience.
  - Grass roots/creative approaches
  - List serves/narrow casts/social media
  - Be clear on “what’s in it for them” vis-à-vis the benefits of public health.
  - Amplify our voice.
- Engage the Department in the strategic focus.
  - Internal communication
    - Internet
    - What’s on the plate?
    - All employees e-mail/meeting
    - Governor’s report
    - A big investment
  - What’s in it for me?
    - Job
    - Improve ways of doing business.



**STRATEGIC PRIORITY C: BUILD STRATEGIC PARTNERSHIPS TO SHAPE THE HEALTH SERVICE DELIVERY SYSTEM (ANA NOVAIS, CHRISTINA STANLEY, DONA GOLDMAN, UTPALA BANDY, SAM VINER-BROWN, PATRICIA RAYMOND)**

- Create a policy environment that allows the Department to shape rather than influence service.
  - Legislators
  - Local community advocates
  - Payers/purchasers of health care
  - Providers in the health care system
  - Health planning
  - Primary care investments
  - Primary care standards of quality
  - Have a percent investment by health plan for public health.
- Move HIE to gain a better repository of data to:
  - Drive policy agenda.
  - Monitor health care outcomes.
  - Ensure access and meaningful use.
- Change the environment where services are delivered.
  - Build population-based primary care.
  - Assure continuity and coordination of care between systems of care.
  - Regional approaches
- Partner with the community and existing services to build and expand capacity for a comprehensive approach to community-based services.

**STRATEGIC PRIORITY D: SECURE AND FOCUS RESOURCES (ERNIE JULIAN, JAMES McDONALD, JOHN FULTON, CARRIE BRIDGES, CHRIS GOULETTE)**

*Financial Resources*

- Change the funding mix/increase private funding.
- Develop strategic partnerships with Medicaid and other third party payers.
- Fee for service business model

*People*

- Amend FTE cap.
- Maximize interns, etc.
- Public Health Institute
- Infrastructure improvement
  - HR
  - Purchasing
  - IT
  - Legal
- Strategic HR management
  - Who gets the FTE?
  - New competencies



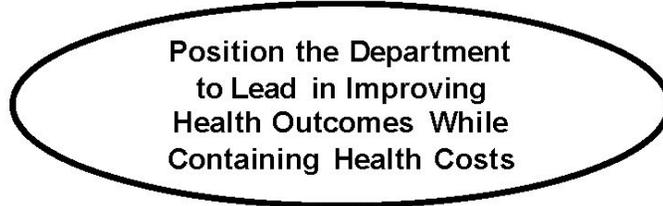
STRATEGIC PRIORITY E: ALIGN DEPARTMENT OPERATIONS WITH STRATEGIC REQUIREMENTS  
(ED D'AREZZO, JASON RHODES, DONNA COSTANTINO, JAY GARRETT, EMILY LEFEBVRE,  
MAGALY ANGELONI)

- Identify priorities and essential functions.
- Identify areas of potential consolidation to enhance efficiencies.
- Realign Department structure (reorganization).
- Build depth in priority areas through cross-training staff and conduct succession planning.

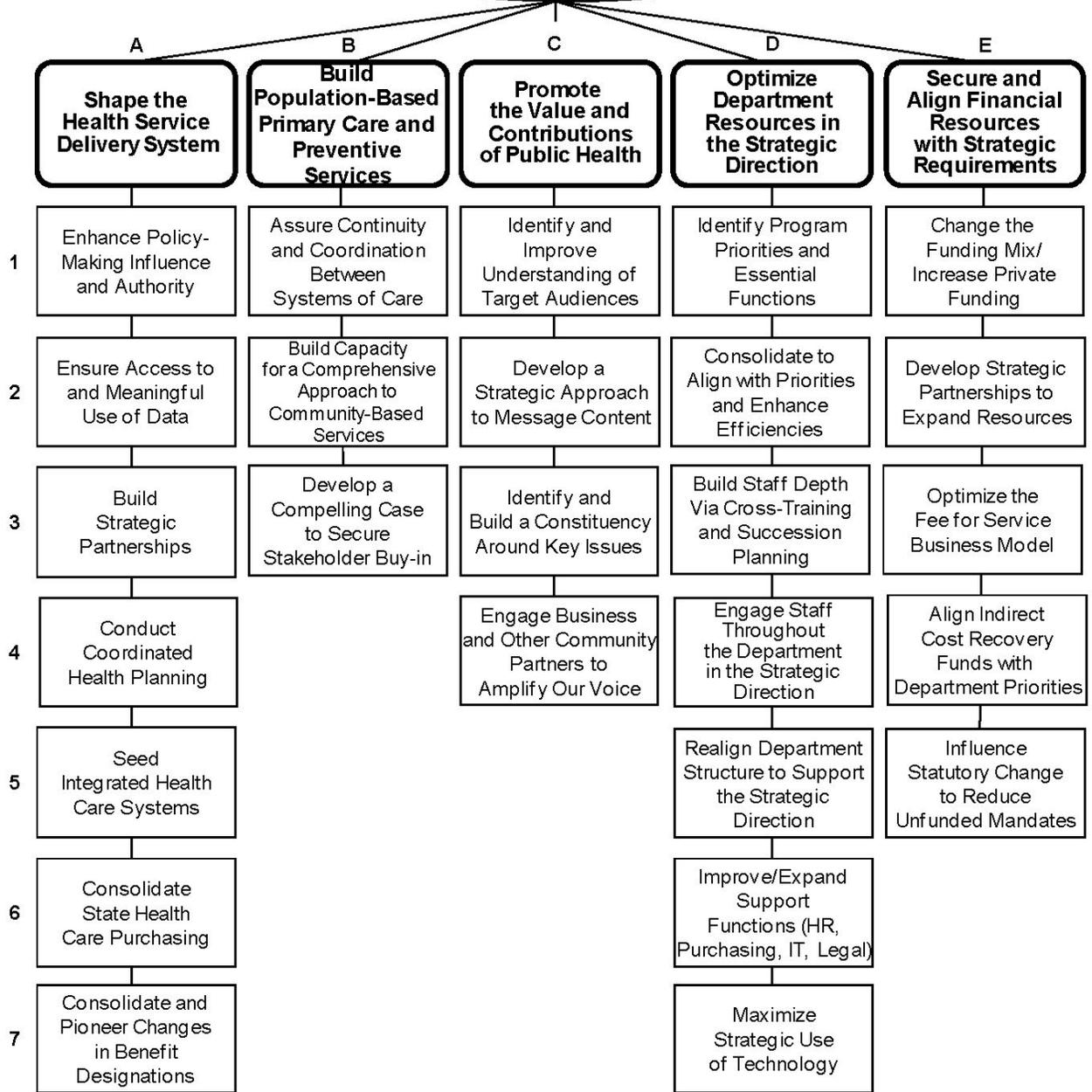
Based on the above input and the discussion that followed, the group developed the strategic map on the following page to guide the Department of Health during the next three years.



Rhode Island Department of Health  
Strategic Map: 2012-2015



Draft  
03/21/12



Discussion of the strategic map included the following points.

- The challenges facing the Department can be summed up as follows:
  - Funding cuts
  - The opportunity provided by hospital insolvencies
  - The negative impact of health care costs on the economy
  - While the group agreed to greater specificity in the strategy to help prevent loss of focus, these high-level, encompassing issues must remain top of mind.
- Because health care is such a significant piece of the State's economy, leveraging the Department's expertise in support of the strategic focus should result in:
  - A positive environment for businesses in Rhode Island
  - Economic opportunity
  - Addressing the social determinants of health
  - Improved health outcomes
- Subsequent to the strategic mapping exercise, the group reworked the strategic priorities and objectives.
  - The former Strategic Priority C, "Build strategic partnerships to shape the health service delivery system," was expanded to A, "Shape the health service delivery system," and B, "Build population-based primary care and preventive services."
  - Both columns were moved to the left to emphasize their significance.
  - While partnerships remain critical, they are a subset of column A and are now reflected as Objective A-3, "Build strategic partnerships."
  - Other columns were realigned and consolidated, resulting in the map on the prior page.
- In discussing Objective A-1, "Enhance policy-making influence and authority," the following points were made:
  - There is a balance/mix of influence and authority.
  - Health can't be legislated.
  - Partnerships/relationships make it happen.
    - Getting the right legislation requires contributions beyond the Department of Health.
    - Multiple stakeholders must influence the legislature.
- Payment reform is outside of the Department's statutory scope of work and is thus not reflected in the strategy; the Department can be an influencer in this area.
- Objective A-5, "Seed integrated health care systems," means moving toward an integrated system that focuses on all of the elements of the system to improve health outcomes.
- Objective A-6, "Consolidate State health care purchasing," means increasing State control of health insurance for those who get their insurance through the State.
  - 30%-40% of the population does so, making the State the single largest purchaser.
  - There is as-yet unrealized benefit from this position.
- In Strategic Priority B:
  - "Primary care" is not intended to be defined traditionally.
  - Clinical prevention can't succeed if services/resources are not available in the community due to:



- Access
  - Culture
  - Etc.
- One way to address staffing issues included in Strategic Priority D, “Optimize Department resources in the strategic direction,” is by maximizing the potential of a Public Health Institute. This would include moving projects/initiatives from the Department to the Institute.
- Objectives D-1, “Identify program priorities and essential functions,” and D-2, “Consolidate to align with priorities and enhance efficiencies,” will result in the redirection of freed-up funds to priorities and underfunded programs/functions.
- Objective D-1 includes determining the impact and priority of underfunded programs.
- In discussing Objective D-5, “Realign Department structure to support the strategic direction,” the following points were made:
  - In high-performing organizations, strategy drives organizational structure; the Department’s strategic focus is the umbrella under which structure must be considered.
  - The strategic direction and the substance of column D may require a revision to the organizational chart.
  - The Executive Committee and Chiefs/team leads will play a primary, active role in designing/carrying out the new structure.
  - Operationalizing the new structure will be tied to implementation of the strategy.
- Objective D-6, “Improve/expand support functions,” recognizes that:
  - Some staff are spending time doing administrative work outside their scope of responsibility.
  - Solid HR, Purchasing, IT and Legal will make time for staff to focus on strategic work.
- Objective D-7, “Maximize strategic use of technology,” recognizes that:
  - The Department does a good job with what it has.
  - However, its technology resources are lagging.
  - Maximized technology improves effectiveness/efficiency and reduces duplication.
  - This is a resources issue.
    - What can the Department stop doing to free up resources to maximize the use of technology?
    - This requires discipline.
- Objective E-2, “Develop strategic partnerships to expand resources,” includes partnerships with third party payers/Medicaid with the goal of:
  - Saving them money
  - Having them redirect some of those savings to the Department to be used for prevention
- The prior cross-cutting strategic priority, “Engage the Department in the strategic focus,” was revised to Objective D-4, “Engage staff throughout the Department in the strategic direction.”



- As the Department evolves to support the new strategy, the types of core values and guiding principles that are appropriate throughout the Department will become clearer.
- The group is aware that its core public health functions are not reflected on the strategic map.
  - The strategic focus assures that the core public health functions will continue with precision and excellence as important work of the Department.
  - These functions should now be seen through the lens of the strategic focus.

## IMPLEMENTATION PLANNING

### Setting Implementation Priorities

The group prioritized the efforts to implement the strategic map during the next 12 months using two different approaches. First, it surveyed each person's thinking on the allocation of the organization's time and energy that should be devoted to each column of the map during the next 12 months. (100 points represents all the resources that will be spent on implementation.) A summary of each person's input follows.

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>
0	0	25	50	25
30	10	20	30	10
25	10	30	25	10
40	20	10	20	10
50	20	10	10	10
15	60	5	10	10
20	20	10	40	10
30	15	10	15	30
40	30	0	30	0
10	20	20	20	30
30	10	10	30	20
10	15	20	30	25
30	20	20	20	10
5	5	40	40	10
20	15	15	30	20
20	10	10	40	20
20	10	10	40	20
20	20	10	30	20



<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>
15	20	15	40	10
25	20	5	25	25
40	20	20	10	10
15	15	20	25	25
30	10	20	30	10
10	10	15	35	30
25	10	20	25	20
10	10	10	40	30
10	10	10	50	20
10	10	10	50	20
30	20	15	25	10
30	20	30	10	10
10	10	10	30	40
30	30	20	10	10
<b>705</b>	<b>525</b>	<b>495</b>	<b>915</b>	<b>560</b>

Next, the group surveyed perceptions of which objectives on the map are the most important to emphasize during the next 12 months. Each person was given five votes, and a summary of the “straw vote” is depicted in the table below.

	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>
<b>1</b>	11	2	1	24	4
<b>2</b>	1	12	5	9	13
<b>3</b>	11	5	12	4	1
<b>4</b>	5	X	2	9	0
<b>5</b>	2	X	X	8	14
<b>6</b>	2	X	X	0	X
<b>7</b>	0	X	X	1	X

These “straw polls” will provide guidance on the most important things for the Department of Health to focus on as it proceeds with implementation planning.



## Identifying Tracks of Work

Laurie Schulte introduced the group to the concept of a “track of work.”

- A track of work is a single map objective or a group of related objectives that use the same resources.
- Tracks of work are a means of getting organized for implementation.
- Organizations generally focus on no more than three to five tracks in a 12-month implementation period.

Participants agreed that the following tracks of work should receive primary emphasis during the next 12 months.

### PROGRAM/FUNCTION PRIORITIES

- Objective D-1: Identify program priorities and essential functions.
- Objective D-2: Consolidate to align with priorities and enhance efficiencies.
- Objective D-4: Engage staff throughout the Department in the strategic direction.
- Objective D-5: Realign Department structure to support the strategic direction.

### LEGISLATIVE CHANGE

- Objective E-5: Influence statutory change to reduce unfunded mandates.
- Objective A-1: Enhance policy-making influence and authority.

### PARTNERSHIPS

- Objective A-3: Build strategic partnerships.
- Objective C-3: Identify and build a constituency around key issues.
- Objective E-2: Develop strategic partnerships to expand resources.
- Objective A-1: Enhance policy-making influence and authority.

### POPULATION-BASED PRIMARY CARE

- Objective B-2: Build capacity for a comprehensive approach to community-based services.
- Objective A-4: Conduct coordinated health planning.

Discussion of the tracks of work included the following points.

- Implementation of the tracks of work incorporates three issues:
  - Priority
  - Interdependence
  - Sequence
- The Partnerships track of work, specifically Objective C-3:
  - Includes key content and messaging to build a constituency around key issues
  - Will require input from the Communications group/Dara Chadwick
- In discussing the Population-based Primary Care track of work, the following points were made.
  - What resources required prior to being able to undertake the work in Objective B-2?
  - How do we develop a QA process for primary care practice around public health outcomes?
  - We must engage primary care practices in the public health purposes of primary care.



- This will require:
  - Bringing resources to them
  - Thinking about their practice as a population
- Dr. Fine explained the concept of a Primary Care Trust as:
  - A model from England not yet in the United States
  - A quasi-public health entity that becomes the fund holder for all primary care services; insurance companies are not involved.
  - Providing incentives based on financial savings
  - Allowing for the building of a primary care infrastructure where it doesn't exist
- The entire effort behind the Primary Care track of work applies a broad approach to primary care, not a narrow one.
- The Legislative Change track of work includes the Department's policy-making *authority* reflected in Objective A-1; the Department's *influence* on policy making in Objective A-1 is reflected in the Partnerships track of work.

**Developing Preliminary Implementation Plans**

Participants met in small groups to begin developing implementation plans for each track of work. A summary of the small group reports follows.

PROGRAM/FUNCTION PRIORITIES: DONNA COSTANTINO, DOUG AXELSON, JUNE SWALLOW, ED D'AREZZO, JAY GARRETT, ANA NOVAIS, EMILY LEFEBVRE, ERNIE JULIAN

<b>Result</b>	<b>Deadline</b>	<b>Accountability</b>
Establish clear criteria for prioritization.	First quarter of the implementation period	Executive Committee and Office Chiefs
Recommendations for a list of core essential public health programs/functions	First quarter of the implementation period	Executive Committee and Office Chiefs
Develop a plan to engage and involve staff.	First 3-6 months of the implementation period	Communications
Recommendation for organizational change and strategic disinvestment to target resources to higher priorities	First 9-12 months of the implementation period	Executive Committee and Office Chiefs
Standardization of processes across Divisions/Centers, including clear written administrative and operational policies and procedures	12 months into the implementation period with annual review	Key administrators



LEGISLATIVE CHANGE: JAMES McDONALD, UTPALA BANDY, MIKE DEXTER, DAVID \_\_\_\_\_,  
CHRIS GOULETTE, MAGALY ANGELONI

<b>Result</b>	<b>Deadline</b>	<b>Accountability</b>
Assess OM's. <ul style="list-style-type: none"> <li>• Keep/funding/staff</li> <li>• Eliminate</li> <li>• Current status</li> </ul>	June 2012	David _____
Identify and prioritize the health system changes. <ul style="list-style-type: none"> <li>• Assess our sphere of influence/authority to identify gaps.</li> <li>• Design strategy to get to desired position.</li> </ul>	June 2012  October 2012	Multidisciplinary work group  Multidisciplinary work group

PARTNERSHIPS: CAROL HALL WALKER, CHRISTINA STANLEY, ANDREA BAGNALL-DEGOS,  
BRUCE MCINTYRE, EWA KING, SAM VINER-BROWN, COLLEEN FONTANA, LENNY GREEN,  
PATRICIA RAYMOND, DARA CHADWICK

<b>Result</b>	<b>Deadline</b>	<b>Accountability</b>
An active network of diverse advocacy partners for public health <ul style="list-style-type: none"> <li>• E.g. business community, legislative, public</li> <li>• Gap analysis fuels strategic approach.</li> </ul>		Form a Department-wide internal work group using existing efforts and engaged staff and resources
Public/private partnerships to expand the Department's resources/capacity for public health <ul style="list-style-type: none"> <li>• MOU</li> <li>• Partners provide additional human/data sharing resources</li> </ul>		
Establish communications delivery system with potential partners. <ul style="list-style-type: none"> <li>• Target audience research</li> <li>• Communications plan/engagement</li> </ul>		

POPULATION-BASED PRIMARY CARE: PETER SIMON, DONA GOLDMAN, JASON RHODES,  
MICHAEL FINE, JOHN FULTON, CARRIE BRIDGES

<b>Result</b>	<b>Deadline</b>	<b>Accountability</b>
Inventory of primary care assets including: <ul style="list-style-type: none"> <li>• Supplies</li> <li>• Architecture</li> <li>• Utilization</li> <li>• Quality assurance measures</li> </ul>	May 2012	_____ Thomas, Mike Dexter, and a Primary Care Officer
Gaps analysis based on model, inventory	May 2012	_____ Thomas, Mike Dexter, and a Primary Care Officer
Model <ul style="list-style-type: none"> <li>• “Artist’s conception” of population-based primary care delivery system</li> <li>• Robust primary care</li> <li>• Comprehensive community-based services</li> </ul>	October 2012	Primary care study group
QA/QI strategic plan for optimal QA/QI processes in primary care practices	January 2013	Dona Goldman, Andrea Bagnall-Degos, Dara Chadwick
Primary care trust feasibility study	April 2013	Michael Fine
Three EMS pilot programs: community-based EMS/treatment in the field	January 2013	Jason Rhodes

#### *Evaluation Indicators*

- Inventory/gaps analysis (one product): completed report
- Model: white paper
- QA/QI strategic plan: strategic plan
- Primary care trust feasibility study: feasibility study
- EMS pilot programs: operational pilots in three communities

Discussion of the preliminary implementation plans included the following points.

- The most important key to effective implementation is effective leadership in three critical roles:
  - The executive leader or sponsoring leader is the person or group that makes the “go/no go” decision on implementation and allocates human and financial resources necessary to support effective implementation.
  - The front line leader is the person or group that has designated responsibility to implement a specific implementation priority or initiative.



- The consultative or supportive leader is the person or group with the responsibility of providing critical support (expertise, coaching, resources, etc.) to the front line leaders. In addition, the supportive leader may have the responsibility for the coordination of all implementation efforts. These leaders often come from key support functions such as human resources, performance management, organizational development or information technology.
- The first two results in the Program/Function Priorities implementation plan will happen in parallel; establishing clear criteria for prioritization has to be completed prior to finalizing a recommendation on a list of core essential public health programs and functions.
- There should be a transparent process for vetting of the prioritization criteria that engages relevant staff across the Department.
- The timing of implementation for Legislative Change will need to be aligned with legislative session timing.
- The Partnerships track of work may include work beyond public health and into the delivery system.
  - This is to be determined, but the Department wants to take a broader approach.
  - This has not traditionally been done.
  - The gap analysis will shed light on this issue.
- The ability of the Department to enhance its policy making influence and authority is dependent on which pieces of system change it wants to tackle first.

## NEXT STEPS

At the conclusion of the meeting, the group identified the following next steps.

### TSI Next Steps

TSI will provide the following documents to Lenny Green by April 6 for distribution to session participants:

- A final version of the strategic map
- A “presentation version” of the strategic map
- A protocol for the communications session outlined below
- A comprehensive written summary of the strategic planning session

### Communicating the Strategic Plan

A key aspect of the strategic planning process is communicating the draft strategic plan to key constituents and securing their feedback on it. The group identified the following stakeholders with whom the plan will be communicated.

#### INTERNAL STAKEHOLDERS

- Department staff
  - The Director will hold an all employees meeting to be scheduled as soon as possible.
  - Communications will issue an internal press release with similar messaging.
  - The group should consider a formal, strategic communications strategy that continues consistently throughout the implementation process.
- Ideally, the communications session will include:



- A presentation of the draft strategic plan by members of the planning group—including the process, mission, vision and new strategic map; 12-month implementation priorities still need to be finalized and so will not be included in communications as yet.
- Time for clarifying questions to ensure understanding
- A structured opportunity to secure feedback from participants, based on questions similar to the following:
  - What are the strengths of the strategic plan?
  - What issues/concerns do you have?
  - What suggestions do you have to ensure successful implementation of the strategy?
- If there is insufficient time at the all employees to secure feedback, alternate mechanisms will be developed.
- Laurie Schulte is available by phone to provide additional guidance to the process.
- Leadership will revise the strategic map as appropriate based on the feedback received.

#### EXTERNAL STAKEHOLDERS

- Communications with external stakeholders will be conducted after internal communications. Potential external stakeholders include:
  - Various advisory bodies/individuals; communications to be put on their meeting agendas
  - Sister State agencies; the strategy would be shared as an example mechanism
  - HHS, when the strategy and approach to implementation are finalized
  - Communications to external stakeholders should focus on what the Department is doing differently.

#### Implementation Planning

- A second round of implementation planning will be undertaken by those who participated in the planning session; formal ongoing implementation leads and teams will be identified subsequent to the second round of implementation planning.
- An immediate next step is for planning group participants to review the meeting summary to confirm or revise the first-year implementation priorities.
  - The second round of implementation planning may be required to make this decision about priorities.
  - Further reflection and digestion of the planning session is required prior to a short-term conversation about next steps.
- Those involved in implementation planning should be thoughtful about preparing the groundwork for the third through fifth years.
- Round 2 implementation will include:
  - Completion of the preliminary implementation plans for each assigned track of work, using today's draft plans as input
  - Ensuring the preliminary implementation plans are completed and submitted for review by a specified deadline, tbd
- Leadership should consider holding a coordination meeting to:



- Compare work across the tracks in order to identify resource requirements and what's realistic to accomplish in 12 months.
- Identify those leads and teams who will do the work of implementation.
- Resource implementation (time, money, personnel, systems resources).
- Once assigned, implementation teams will continue to improve the implementation plans as necessary/appropriate as they carry out the work.
- The goal is for implementation to begin in April of 2012.
- Importantly, the Department must identify those things that it will stop doing in order to operationalize implementation. The new strategic work will not succeed if it is simply an “add on” to already overburdened staff.
- It will be important for the Department to ensure “quarterly pacing” to:
  - Set itself up for early wins.
  - Ensure momentum behind implementation continues and success spreads.
- Happily, the Department has several positives in regard to strategic planning, including:
  - Articulated goals
  - Buy-in at the top
  - Action that is happening
  - Hopefully resources will follow this momentum.
  - The work needs to get done.

### **“Review and Adjust” Process**

Laurie Schulte outlined the following as possible elements of a review and adjust process for the Department.

- Using regular leadership meetings for:
  - Implementation updates
  - Resolution of implementation issues/problems
- Periodic review and adjust sessions
  - Two to three times per year
  - More detailed review of progress with implementation of each track of work, including:
    - Accomplishments
    - Issues/problems/gaps
    - Lessons learned
    - Next steps
  - Review and adjust the strategic map and implementation plans as needed.
  - Per Dr. Fine’s request, goals for years three to five will be staged as part of the review and adjust process.
    - The group should plan a two to three hour exercise in a month or two to take a year three to five view of its strategy.
    - The goal is to ensure the Department stays ahead of planning for these out years.
  - It’s critical that those involved with strategy formulation and implementation ensure regular, consistent and frequent communication throughout the Department.



- In the past, strategy implementation has stalled—we don't want that to happen this time.
  - This is particularly important in a stressful environment.
- Staff must be reassured that the core functions for the Department will continue.
  - The attempt of the strategy is not to eliminate any program that is underfunded.
  - Many of these are still important and will continue.
  - The strategic map is a reshaping and realignment of the Department's strategic focus.
  - All programs and functions should use the strategy as a lens for how they undertake their work.
  - Both realigning the Department as well as continuing core public health functions are a part of the Department's work.
    - The strategic focus is a trigger.
    - The work of the Department can and needs to be broader than this.
- Annual strategy update
  - Typically a one-day retreat
  - Review progress on implementation (one of the periodic review and adjust sessions).
    - Identify accomplishments.
    - Resolve any implementation issues.
  - Update the strategic map based on:
    - What was learned from implementation
    - What's working and what isn't
    - How the environment has changed
  - Set implementation priorities for the next 12 months.
  - Align budget and human resources.



## Appendix # 5

## 7/12/12 Strategic Planning Session: Overarching 5-year goals

**Overarching 5-year goals: Food for thought****Where do we need to be?**

- Shaping the healthcare delivery system
- Reducing years of potential life lost

**What do we need to accomplish?**

- Lowest cost healthcare in the U.S.
- Best measured social capital in the U.S.

**Comments:**

- Define how we want to shape the healthcare delivery system- better health outcomes and increase economic productivity for the state
- Look at reducing days of lost work due to illness/injury vs. years of potential life lost?
- Increases in physical and social function
  - Days of work lost
  - Days of school missed
  - Days of leisure lost
- Improving health outcomes- We treat symptoms not root cause. We need to switch that strategy.
- Move from treatment incentives to wellness incentives
- Keep focus on public health interventions
- There is a missing link between population health and exam room
- Influencing vs. shaping the healthcare delivery system. We need to define healthcare delivery system.
- Two types of population-based primary care
  - Physicians looking at quality of care within their treatment population
  - Look at entire population within a geographic region to explore how the population is serviced by the healthcare system
- Need our data to inform policy in a more visible way
- Health service vs. healthcare delivery system?
- Key questions:
  - Where are we going?
    - Reduce years of potential life lost and days of lost work and school in RI
    - Improve social capital in RI
    - Improve economic status and resiliency in RI
    - Assure equality and the ability to participate in the democratic process in RI
  - How will we get there?
    - Redirected RI healthcare delivery system such that it focuses on where we are going
    - Redirected RI Dept. of Health such that it focuses on where we are going
- Assessment, policy, assurance: need to keep these core public health functions in mind

- We are not going outside our core functions, it is doing our core functions differently
- Traditionally two worlds: public health and healthcare delivery system. We must bridge the gap to accomplish the 5-year goals together
- Need to prioritize our work to accomplish goals. Can't keep adding on to current load and not removing items.
- Where does EOHHS, the Governor, and Legislature see HEALTH in the next 5 years?
- Need to look at strategies for achieving these goals.

## Appendix # 6: HEALTH's America's Health Ranking (AHR) Workgroup Members

Michael Fine, MD, Chair

Ed D'Arezzo

Christine Goulette

Lenny Green

Sarah Harrigan

David Heckman

James McDonald, MD

Jane Morgan

Ana Novais

Jim Palmer

Samara Viner-Brown



## Appendix # 7 : Strategic Priorities : Making Rhode Island the Healthiest State in the Nation



## Making Rhode Island the Healthiest State in the Nation

### Strategic Priorities 2013-2014

#### 1 Improved Delivery System

- ▶ **Primary Care Trust / Neighborhood Health Stations**
- ▶ **Strengthened CurrentCare**
- ▶ **Hospital Consolidation**
  - Hospital Insolvency Act
  - Hospital closure: authority and process

#### 2

#### Health In All Policies



- ▶ **Tobacco**
  - Smoke-free state campuses and grounds
  - Point-of-sale parity & controls
- ▶ **Obesity Prevention**
  - SNAP waiver to restrict food purchases
  - Sugar-sweetened beverage tax
  - Fat and calorie labeling
- ▶ **Prescription Drug Overdose Deaths**
  - Prescription Monitoring Program
  - Multi-disciplinary Chronic Pain Center
- ▶ **Guns: Register, Insure**
- ▶ **Annual Address: "The State of Rhode Island's Health"**

#### 3

#### Revolutionize HEALTH's Business Model



- I. **Multi-payer Innovations Trust: Private Payer Supported / Not General Revenue**
  - ▶ Opt-out testing for HIV and Hepatitis C
  - ▶ Teenage pregnancy and premature birth reduction
  - ▶ Obesity prevention
  - ▶ Multi-disciplinary chronic pain treatment center
  - ▶ Lead poisoning prevention
  - ▶ HIV and Hepatitis C testing in Corrections
- II. **Restricted Receipt Accounts**
  - ▶ FTE Cap
  - ▶ Food inspection
  - ▶ Board of Health Professionals Licensure & Discipline
  - ▶ CON and HCA applications/fees and restricted accounts
  - ▶ Medical marijuana
  - ▶ Prescription monitoring program

#### 4

#### Build a Sustainable Workforce / Health Professionals and Others



- ▶ Public Rhode Island Primary Care Medical School
- ▶ Licensure of Medical Assistants, Care Managers, Navigators and Health Coaches

## Appendix # 8: HEALTH's Primary Care Trust (PCT) Workgroup Members

Michael Fine, MD, Chair

Lenny Green

David Heckman

James McDonald, MD

Jane Morgan

Ana Novais

Amy Nunn (Rhode Island Public Health Institute)

Sophie O'Connell

Jim Palmer

Roy Smoot



Appendix # 9: "How the Healthcare Market is at War with Health" Presentation from Dr. Fine



Boiling Frogs, The Three Pipers, The Primrose Path, The Drinking Gourd, Magellan's Ships, and The Yellow Brick Road

## How The Healthcare Market Is at War with Health

How Rhode Island Can Protect Truth, Justice and The American Way; Improve Health; Reduce Cost; Restore our Economy

*And How We Can Do It First -- without packing a lunch!*

Rhode Island Department of Health  
Michael Fine, MD, Director



### Who helped me put this talk together

- Roy Smoot
- David Heckman
- Dara Chadwick
- John Fulton
- Anne Berg
- Steven Petterson PhD
- Robert Phillips MD
- Andrew Bazemore MD
- Shannon Brownlee

• And many other friends and teachers

(responsibility for the accuracy of the information is mine alone)

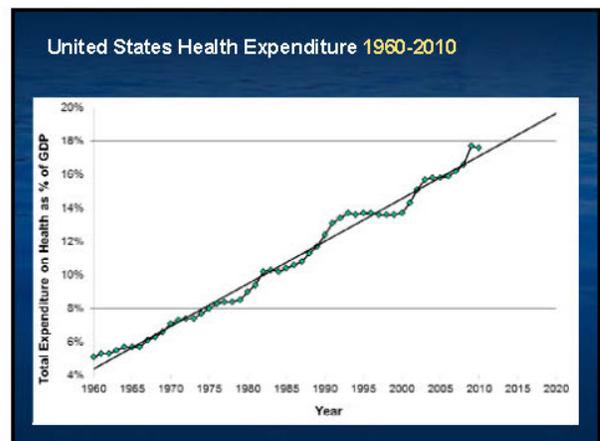


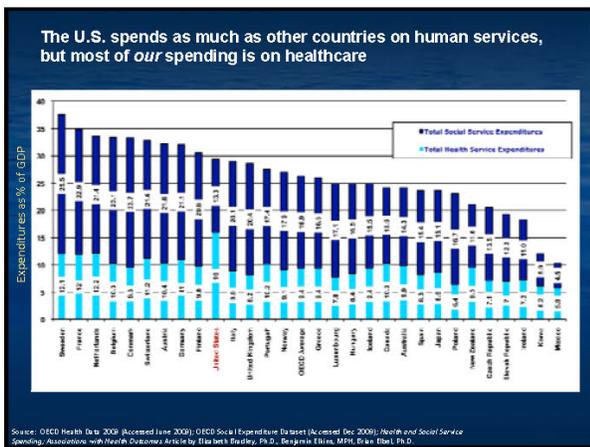
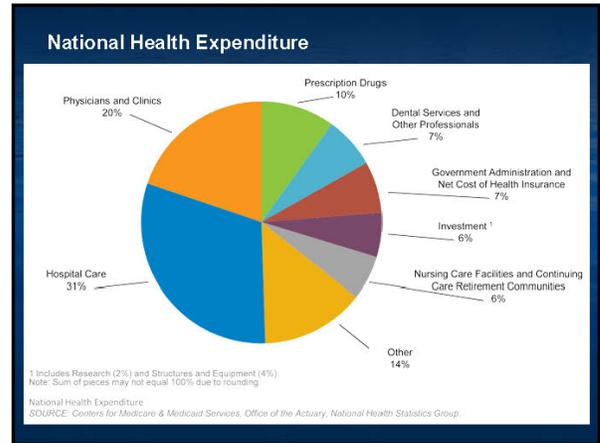
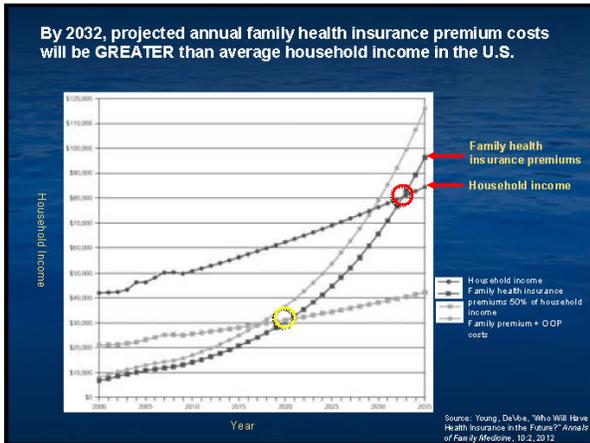
### What I'll Be Talking About

- Healthcare is crippling the nation's economy
- Medical care doesn't matter much for health – but human services spending does
  - So medical care is making health unachievable
- Primary Care can reduce healthcare costs
  - (and leave us money to spend on education, housing, public safety and the environment)
- Primary care is the only medical service that significantly impacts population health
- A Primary Care Trust can bring primary care to all Rhode Islanders



## The Boiling Frog



**We spend too much on healthcare**

**We spend more per person on healthcare than Japan and the United Kingdom combined.**

**Healthcare Costs Contribute To GM'S Bankruptcy**

Healthcare costs add **\$1,525** to the price of every General Motors vehicle. The company spent **\$4.6 billion** on healthcare in 2007, more than the cost of steel.

As a result of these crushing healthcare costs, American businesses are losing their ability to compete in the global marketplace. Healthcare at General Motors puts the company at a \$5 billion disadvantage against Toyota, which spends \$1,400 less on healthcare per vehicle.

Source: <http://www.healthreform.gov/ports/in-action/>

**Healthcare Cost Is Crippling The U.S. Economy**

*"Rising health-care costs are at the core of the United States' long-term fiscal imbalance... It is no exaggeration to say that the United States' standing in the world depends on its success in constraining this health-care cost explosion; unless it does, the country will eventually face a severe fiscal crisis or a crippling inability to invest in other areas."*

-Peter Orszag, "Foreign Affairs" July/August 2011

Impact of Healthcare Spending



Situation of the U.S. Healthcare Market

- Overpriced by a factor of 2
  - We waste \$600-850 billion every year (about 1/3 of total healthcare expenditure)<sup>2</sup>
- Underperforming
  - Health system world ranking: 37<sup>2</sup>
  - Leaves out 48.6 million people<sup>3</sup>
  - Kills 100,000 people a year by accident<sup>4</sup>
- Bankrupting the nation
  - Cannibalizing the rest of our social services, making health impossible
  - Doesn't even provide universal access to primary care, the only medical service associated with improved population health
- No clear mission, other than profit for investors

Sources: 1. Kelley, Robert, "Where Can \$100 Billion in Waste Be Cut Annually From the U.S. Healthcare System?" The Atlantic, Analysis, white paper, <http://www.theatlantic.com/health/policy/healthcare/waste/gel/14192/>; 2. World Health Report 2002, <http://www.who.int/whr/2002/en/index.html>; 3. US Census Bureau, "Income, Poverty, and Health Insurance Coverage in the US, 2011," <http://www.census.gov/hhes/health/2011/>; 4. Squelcher, David, "The Institute of Medicine, 'Closing the Quality Chasm: A New Health System for the 21st Century,' 2001."

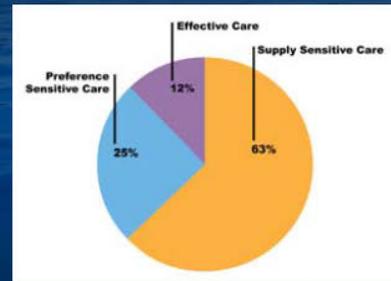


Healthcare Waste By Category



Source: Kelley, Robert, "Where Can \$100 Billion in Waste Be Cut Annually From the US Health Care System?" Med Econ Analytics, white paper, <http://www.medeconanalytics.com/healthcare/waste/gel/14192/>

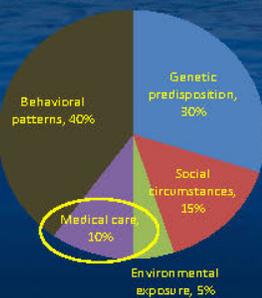
Proportion of Medicare Spending Attributed to Each Category of Care



Source: John, Elvénberg, and Continous, 2016

Only 10% of population health outcomes are due to medical care

Proportional Contribution to Premature Death



Source: Schrader, Steve A., MD, "We Can Do Better—Improving the Health of the American People," *N Engl J Med* 2007; 357: 1221-1228



The major determinants of population health are social measures

- Smoking and Environmental Exposures
- Income Inequality
- Race
  - As a marker for the impacts of racism on the measured health outcomes of individuals
- Primary Care Supply

*So all this spending doesn't buy us anything we can use.*



### Healthcare has FAILED to deliver health!

- **86% or more** of our healthcare spending is on medical services <sup>1</sup>
  - Most experts estimate about 1/3 of what we spend on medical services is unnecessary, harmful, or fraudulent<sup>2</sup>
- And medical services contribute only about **10%** to population health outcomes<sup>3</sup>
- **90%** of population health outcomes are produced by:
  - Education
  - Environment
  - Housing
  - Behavior
  - Genetics
  - **Social organization**

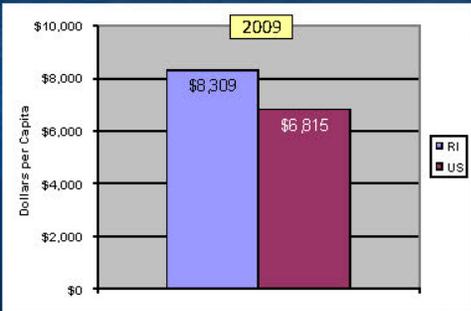
Source: 1) OIG, Office of the Inspector General, National Health Statistics Group, "Holley, Robert, 'Where Can \$700 Billion in Waste Be Cut Away?' from 'The US Health Care System: Health Care Expenditures While Living', Schmandt, Steve, A. M.D., Yale Center for Health Equity, Improving the Health of the American People, 2) H. Engl. J. Med. 2007; 357: 1221-1226.



### Rhode Island itself spends too much on healthcare




### Rhode Island Healthcare Costs: 22% Higher Than The National Average



Year	RI (Dollars per Capita)	US (Dollars per Capita)
2009	\$8,309	\$6,815

Source: Kaiser Family Foundation, State Health Facts

### Rhode Island spends too much on healthcare

In 2011, the cost of a family health insurance plan through an employer was **\$15,273.**

In 2011, the average annual wage for an employee of a private company in Rhode Island was **\$43,526.**



### Rhode Island spends too much on healthcare

If Rhode Island had simply kept Medicaid spending from increasing from 2010 to 2011, the projected savings for the state would have been more than **\$26 million.**



That's equivalent to the salaries of about **686 new teachers.**

Source: OIG 2011 Health Expenditures by State of Rhode Island, Kaiser Family Foundation State Health Facts, and NERA Teacher Salary Report



### Rhode Island spends too much on healthcare

In FY2010, the state of Rhode Island spent **\$709 million** on Medicaid.

In FY2012, the Total Spend for Rhode Island Medicaid recipients was **\$1.9 billion.**

The state spent **\$250 million** on health insurance for state employees. **\$168 million** for municipal employees (FY2010)

Grand total spend: about **\$2.5 billion**, of which about \$1.3 billion is state tax dollars, and \$1.2-1.6 billion is Federal tax dollars

Source: Kaiser Family Foundation, State Health Facts



### Rhode Island spends too much on healthcare

- Total healthcare expenditures in Rhode Island in 2009: **\$8.8 billion** (a little larger than the entire state budget for all state services)
- Average annual percent growth in healthcare expenditures in Rhode Island, 1991-2009: **6.3%**
- We estimate healthcare **costs rose by \$553.5 million** from 2009-2010
- At the 08-09 teacher salary rate, this \$553 million is equivalent to the salaries of **14,477 new teachers** in Rhode Island
- **If we waste 30%, then we are wasting about \$2.5 billion a year**
  - Which could fund a considerable tax reduction, many more teachers, lots of new housing – and get the roads fixed!



Source: Kaiser Family Foundation, State Health Profiles, NBER, Teacher Salaries report

And we die sooner.

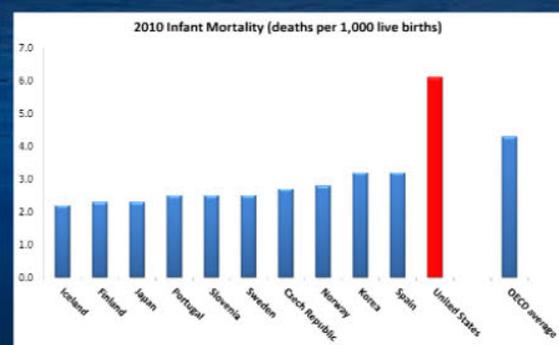


### We spend TWICE what other industrialized countries spend, and we have a shorter life expectancy



Source: OECD Health Data 2012, all data from 2010 or more recent year

### Our infant mortality rate is more than twice the rate of countries that spend far less



Source: OECD Health Data 2012

### Healthcare in Rhode Island, despite some successes, is an economic drain

- **Best immunization rates in the U.S.**
- Tight control of infectious diseases
- Smoking rates reduced
- Issues: substance abuse, obesity, cancer, heart disease

#### BUT

- Healthcare consumes almost **\$2.5 billion** of public spending by Rhode Island
  - Almost 1/3 of which (**more than \$800 million**) is wasted



Source: RI HHS, CMS, RLE Care /Sharon Browne, quoted in "RI Record", Vol. 101, No. 8, 4/17/2009

### The healthcare market has also failed Rhode Island

- 1,200 unnecessary deaths a year from heart disease and stroke
  - 80,500 Rhode Islanders have untreated high blood pressure
  - 64,000 Rhode Islanders have inadequately treated high blood pressure
  - 32,000 Rhode Islanders with undiagnosed and untreated diabetes
    - 15,000 Rhode Islanders with inadequately treated diabetes
  - 63% of Rhode Islanders overweight or obese
  - 163,000 Rhode Islanders still smoking
- 200 unnecessary deaths a year from colon cancer
- Almost 200 drug-related deaths a year (2/3 involved a prescription opioid).
- 100-200 unnecessary deaths and 300-400 unnecessary hospitalizations a year from
  - 80,000 Rhode Islanders not vaccinated against influenza
- 100 unnecessary new cases of HIV/AIDS per year



Source: CDC National HIV Behavioral System raw data, AHRFES raw data © DC, National Immunization Survey

## THE THREE PIPERS

A.K.A., The Three Horsemen of the Apocalypse



### Marketing

- Pharmaceutical Marketing<sup>1</sup> (2004) **\$57.5 Billion**
- Tobacco Industry<sup>2</sup> (2006) **\$12.4 Billion**
- Food Industry<sup>3</sup> **\$10 Billion**
  - To kids **\$1.6 Billion**
- Pornography (1998) **\$1 to 14 Billion**
- Hospital Marketing (2012) **\$1.5 Billion**
- Total 2012 Budget, Centers for Disease Control and Prevention **\$11.2 Billion**

<sup>1</sup>Caplan AA, Leifer J. "The Cost of Pushing Pills: A New Estimate of Pharmaceutical Promotion Expenditures in the United States." *PLoS Medicine*. January 5, 2004.  
<sup>2</sup>United States Commission on Tobacco Report to Congress (<http://www.usctc.gov/20060909/20060909report.pdf>), Washington, Federal Trade Commission, 2006.  
<sup>3</sup>Consumer Union, California Public Health Network. "Out of Balance: Marketing of 'Soft', Candy, Snack and Fast Foods to Children." *Health Affairs*. <http://www.healthaffairs.org/pubs/060909/060909ca.htm>, September 2005.



### The Medical Industrial Complex

- U.S. Specialty/Primary Care Ratio is about 70/30
- Academic Medical Centers treat just 1% of the U.S. population
- Treatment recommendations come from academic medicine, research, pharma, medical device manufacturers and their revolving doors



### Health Insurance

- Used as a means to promote access to health services in a nation without a healthcare system
- Unintended side effect:
  - Removes "skin in the game" as a check on cost
  - Doesn't discriminate well between needed and unnecessary services



### Our products and our marketing cause our illness

- Cigarettes
- Cars
  - Reduced exercise
  - Environmental impacts
- Corn
  - Diabetes
  - Obesity
  - High blood pressure
  - Heart disease
- Labor-Saving Devices
- Hospitals and Pharmaceuticals
  - 100,000 deaths from errors<sup>1</sup>
  - Many more from known side effects and adverse reactions
- Popular culture
  - Depression and anxiety
  - Sexually transmitted disease
  - Adolescent pregnancy
- Suburban sprawl
  - Isolation and depression

**"we have met the enemy and he is us."**

-POGO

Source: Institute of Medicine. "Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century." 2001.



### Healthcare reform will fix this, right?







### The Primrose Path



### Healthcare Reform 2014: What We'll Get

- Healthcare market reforms
  - Guarantee issue so more people have health *insurance*
- A weak **insurance** mandate
- More people in, still 20 million left out in 2014, and 23 million left out by 2019<sup>1,2,3</sup>
  - Medicaid (**insurance**) expansion/subsidies for lower income Americans
- **No public plan**
- **Insurance** purchasing exchanges
- **\$11 Billion to CHCs**<sup>4</sup>
- Lower Medicare cost growth<sup>5</sup>

Source: 1) Urban Institute, Health Policy Center, "Where's Myrtle? Healthcare for All Leaves 23 Million Uninsured," MPR News 3/24/2014; 2) Burke, Patrick, "100,000 Americans Will Leave 20 Million Uninsured," CNBC.com 3/25/2014; 3) Lee, Emily Oshiro, "Two Years after the Health Reform, More than 20 Million Still Lack Health Insurance," Center for American Progress 3/20/14; 4) IHS, "ACA Savings Report 2012"; 5) Urban Institute, Health Policy Center, "Where's Myrtle? Healthcare for All Leaves 23 Million Uninsured," MPR News 3/24/2014.



### Healthcare 2014: What We'll Get

- Continued cost growth anyway
  - 5-10% a year OR MORE<sup>1</sup>
  - **25% of GDP by 2025**<sup>2</sup>
- Few likely or predictable improvements in population health
  - We are *not* talking about the elimination of:
    - HIV/AIDS
    - Prescription opioid overdose deaths
    - Colon cancer deaths
    - Obesity, heart disease, diabetes, and stroke
    - Adolescent pregnancy
    - Smoking
- **NO** likely improvements in social determinants
  - No change or worsening income inequality
  - No change in health disparities
  - No change in reading level at 4<sup>th</sup> grade
  - Uncertain impact on social cohesion and civic trust
- **A healthcare *insurance* and medical services market that is still for profit**

Source: 1) Katherine et al, "National Health Expenditure Projections: Model Annual Growth Until Coverage Expands and Economic Growth Accelerates," Health Affairs, 30(12):2611-2620(2011) The American Enterprise Institute for Public Policy Research



### Major Omissions

- **No direct infrastructure building**
- **Healthcare remains a for-profit business**
- **No controls on industries' ability to impact the legislative process in their own interest**
- **(We fed the fox, and left the fox in control of the henhouse)**



### Healthcare Reform 2014: What We'll Get

- Substantial improvements to access and the function of the insurance market
- But this is **INSURANCE MARKET REFORM**—it will provide more Americans access to health insurance
  - **HOWEVER**, it will benefit *insurance companies*, pharma, device manufacturers, specialists, and hospitals most
  - **And it will COST more money than any of us can count**
- (When was the last time an insurance company did your pap smear, called you back at 3 in the morning when your kid was sick, bugged you to quit smoking, or gave you a flu shot?)



### The Drinking Gourd

The Arc of History is long, but tends toward justice.

– Martin Luther King, Jr.

You Americans usually get the right answer—after you've tried all the other ones.

– Winston Churchill



### Primary Care is associated with lower health costs and better health outcomes

**Primary Care Professionals**

- Family physicians
- Primary care pediatricians
- Primary care internists
- Obstetricians/gynecologists
- Nurse practitioners
- Pharmacists
- Nurse and lay midwives
- Home health nurses and aides
- Physician assistants
- Psychologists and social workers
- Nutritionists
- Physical therapists
- EMTs and paramedics
- Dentists
- Community health workers



### Primary Care is associated with lower health costs and better health outcomes

- **Primary Care Practices**
  - Onesies and twosies
  - Larger multi-professional primary care groups
    - Bristol County Medical Center
    - Coastal
    - Anchor
    - Hillside Avenue Family and Community Medicine
    - Atlantic Medical Group
    - Remember RIGHA?
- **Patient Centered Medical Homes**
  - Recent NCOA (read, business) sponsored process to standardize and improve primary care
  - Electronic medical records
  - Quality assurance programs with reporting of quality indicators
  - Focused on the patient experience
- **Community Health Centers**
  - Best measured primary care outcomes in the US
  - Usually multi-professional
  - First primary care practices to integrate mental health



### Primary Care is associated with lower health costs and better health outcomes

**Primary Care Variables/Measures**

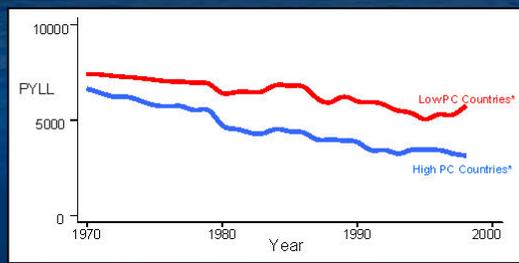
- Primary Care Supply
- Primary Care Architecture
- Primary Care Utilization

**Primary Care Cost**

- Per-person, per-year cost of health insurance **\$8,000**
- Per-person, per-year cost of health insurance administrative overhead **\$800-\$1,600**
  - 10-20 % of premium
  - Doesn't include 10% inefficiency built into medical cost, from billing
- Per-person, per-year cost of primary care **\$300-\$400**



### Primary Care Strength and Premature Mortality in 18 OECD Countries



**Starfield 1004 04-247**

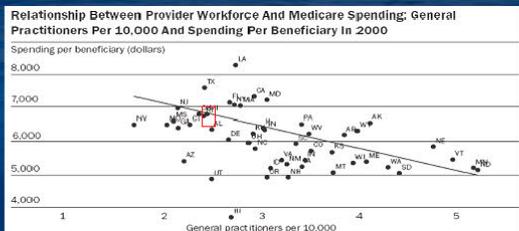
\*Predicted PYLL (both genders) estimated by fixed effects, using pooled cross-sectional time series design. Analysis controlled for GDP, percent elderly, doctors/capita, average income (ppp), alcohol and tobacco use. R<sup>2</sup>(within)=0.77.

Source: Morlock et al, Health Care Fin Rev 2002; 38:531-66.



### Primary Care Supply and Healthcare Cost

**Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000**



**SOURCES:** Medicare claims data; and Area Resource File, 2003.

**NOTE:** Total physicians held constant.



### Primary Care Supply and Quality

**Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000**



**SOURCES:** Medicare claims data; and Area Resource File, 2003.

**NOTES:** For quality ranking, smaller values equal higher quality. Total physicians held constant.



Some of the evidence

- Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005; 83(3):457-502.
- Green LA, Fryer GE, Jr., Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. *N Engl J Med* 2001; 344(26):2021-2025.
- Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Aff* 2004.
- Shi L, Starfield B, Kennedy B, Kawachi I. Income inequality, primary care, and health indicators. *J Fam Pract* 1999; 48(4):275-284.
- Robert Graham Center, National Association of Community Health Centers, Capital Link. Access granted: The primary care payoff. 2007. Washington DC.
- Phillips RL, Dodo MS, Green LA, Fryer GE, Bazemore AV, McCoy KI et al. Usual source of care: an important source of variation in healthcare spending. *Health Aff (Millwood)* 2009; 28(2):567-577.
- DeVoe JE, Fryer GE, Phillips R, Green L. Receipt of preventive care among adults: Insurance status and usual source of care. *Am J Public Health* 2003; 93: 786-91.
- Franks P, Fiscella K. Primary care physicians and specialists as personal physicians — healthcare expenditures and portality experience. *J Fam Pract*. 1998 Aug;47(2):105-9.



Some of the evidence

- Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics* 2004;113:1493-98, 99.
- Ullie-Blanton M, Hoffman C. The role of health insurance coverage in reducing racial/ethnic disparities in healthcare. *Health Aff* 2005;24:398-408.
- DeVoe JE, Tillotson C, Wallace LS. A usual source of care as a health insurance substitute for diabetes? *Diabetes Care* 2009 [Epub 27 February 2009].
- Starfield B. Access, primary care, and the medical home: rights of passage. *Med Care* 2008;46:1015-16.
- Weiner J, Gillam S, Lewis R. Organization and financing of British primary care groups and trusts: observations through the prism of US managed care. *Journal of Health Services and Research Policy* 2002;7:43-60.
- Carlisle R, Avery A, Marsh P. Primary care teams work harder in deprived areas. *Journal of Public Health Medicine* 2002;24:43-8.
- Horrocks S, Anderson E, Salisbury C. Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal* 2002; 324:819-23. [3].
- Campbell SM, Hann M, Hacker J, Burns C, Oliver D, Thapar A, et al. Identifying predictors of high quality care in English general practice: observational study. *British Medical Journal* 2001;323:784-7.



Some of the evidence

- Starfield B and Shi L. "Policy Revisited: Determinants of Health: An International Perspective." 2002 *Health Policy* 60:297-56.
- Starfield B. "The Primary Care Effect: Part 1." 1994 *Lancet* 344(6:800):1124-30.
- Starfield B. "Primary Care and Health: A Cross-National Comparison." 1991 *JAMA* 266(4):2245-71, 70.
- Shi L, et al. "Primary Care, Heart Mortality, and Low Birth Weight in the States of the USA." May 2001. *Journal of Epidemiology Community Health* 55(6):374-80.
- Green LA, et al. "The Physician Workforce of the United States: A Family Medicine Perspective." The Robert Graham Center, 2004.
- Campbell RL, et al. "Geographical Variation and the Supply of Primary Care Physicians in Florida." January 2003. *Fam Med* 35(1):10-4.
- Roetzheim RG, et al. "Primary Care Physician Supply and Colorectal Cancer." December 2001. *Journal of Family Practice* 50(6):2127-31.
- Shi L and Starfield B. "Primary Care, Income Inequality, and Self-Reported Health in the United States: A Mixed-Level Analysis." 2000 *In vivo* (Geneva). *Journal of Health Services* 30(5):547-55.
- Ferraro JM, et al. "Effects of Physician Supply on Early Detection of Breast Cancer." November-December 2000. *J Am Board Fam Pract* 13(6):405-14.
- Shi L, et al. "Income Inequality, Primary Care, and Health Disparities." April 1999. *Journal of Family Practice* 48(4):274-84, 83.
- Shi L and Starfield B. "The Ability and Unmet Health Care Needs: The Influence of Multiple Risk Factors." February 2005. *Journal of General Internal Medicine* 20(2):340-54.
- Shi L, Green LA, and Hays RD. "Primary Care, Ethnicity and Racial Disparities in Self-Reported Health Status." November-December 2001. *J Am Board Fam Pract* 14(6):445-52.
- Shi L, et al. "Primary Care, Social Inequality, and All-Cause, Heart Disease, and Cancer Mortality in U.S. Counties, 1980." April 2005. *American Journal of Public Health* 95(4):674-80. April 2005. Institute of Medicine. *United States: Closing Racial and Ethnic Disparities in Health Care*. National Academy Press, Washington, DC, 2003.



Projected Heart Disease Mortality in the U.S. with Improved Primary Care Supply

- Heart disease mortality reduced by **16%**
- **102,000** deaths per year averted

Source: HRSA Area Resource File raw data, <http://artf.hrsa.gov>



Projected Infant Mortality in the U.S. with Improved Primary Care Supply

- Infant mortality reduced by **13%**
- **37,245** deaths per year averted

Source: HRSA Area Resource File raw data, <http://artf.hrsa.gov>



Projected Stroke Mortality in the U.S. with Improved Primary Care Supply

- Stroke mortality reduced by **5%**
- **6,600** deaths per year averted

Source: HRSA Area Resource File raw data, <http://artf.hrsa.gov>



### Projected Diabetes Mortality in the U.S. with Improved Primary Care Supply

- Diabetes mortality reduced by **4%**
- **2,700** deaths per year averted

Source: HRSA Area Resource File raw data, http://arhhsa.gov



### Projected Cancer Mortality in the U.S. with Improved Primary Care Supply

- Cancer mortality reduced by **1%**
- **6,000** deaths per year averted
- That's about **twice** the yearly improvement we now experience with all other interventions combined

Source: HRSA Area Resource File raw data, http://arhhsa.gov



### Projected Life Expectancy in the U.S. with Improved Primary Care Supply

- Improves by **1 full year**
- *A greater improvement than during the period 2000-2006, despite investing more than **\$2 trillion** a year in health services during that time*

Source: HRSA Area Resource File raw data, http://arhhsa.gov



### Projected Total Yearly Deaths Averted in the U.S. with Improved Primary Care Supply

**154,545**  
Lives. People. Neighbors. Friends. Family.

**513 Rhode Islanders**  
Lives. People. Neighbors. Friends. Family. Quahoggers.

Source: HRSA Area Resource File raw data, http://arhhsa.gov



### Cost projections: what would healthcare in the U.S. cost after healthcare reform if primary care supply was the same as the 5 best states?

Everyone in, no change in primary care supply	\$125-250 Billion new Cost
Everyone in, improved supply, system as it is	\$45 Billion SAVINGS
Every in using CHCs	\$253 billion SAVINGS
No one else in, improved supply	\$211 billion SAVINGS

Source: HRSA Area Resource File raw data, http://arhhsa.gov

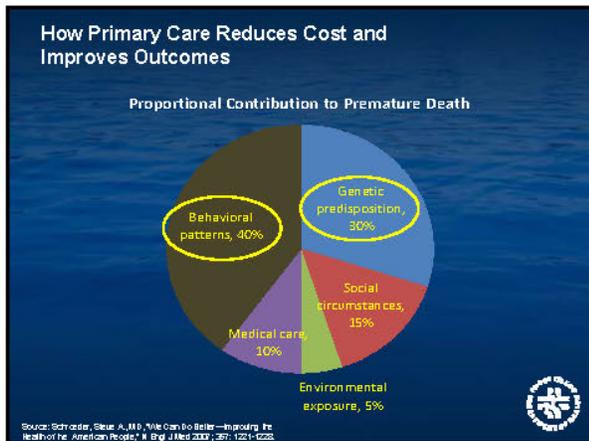


### And That's Just By Pushing on Primary Care Supply

- **What happens when we add:**
  - Multidisciplinary teams
  - Open access
  - Extended hours
  - Neighborhood outreach
  - Home Health
  - Mental and Behavioral Health
  - Substance Abuse Prevention
  - Integrated EMR with built in registry and advanced reporting?

Source: HRSA Area Resource File raw data, http://arhhsa.gov



- ### How Primary Care Reduces Cost and Improves Outcomes
- Counseling changes behaviors (40%)
    - (How do you spell *Prochaska*, anyway?)
  - Prevention mitigates the impact of genetics (30%)
  - (And that's before we put all that saved money to use, improving education, housing public safety and the environment)

- ### Why Primary Care Is the Leverage We Need
- Reduces cost by expanding access to:
    - right time
    - right place
    - right size services
  - Expanded primary care supply and Patient Centered Medical Home is associated with reduction in emergency department use by **50% or more**
    - And reduction in hospital utilization by **25% or more**

- ### Why Primary Care Is the Leverage We Need
- Spreads the value of prevention to more, or maybe to all.
  - When everyone has primary care...
    - everyone with diabetes and high blood pressure is identified and their complications can be controlled
    - Almost everyone who might get colon cancer has it prevented by colonoscopy
    - Almost everyone who might get cervical cancer has it prevented by pap smears
    - Many more people who might get breast cancer have it prevented by mammography
    - Everyone with HIV is tested, identified, and treated – and can't transmit HIV
    - Everyone gets a flu shot

## Magellan's Ships

### Magellan's Ships

**A Healthcare System:**  
 An *organized architectonic of medical and health services*, designed to care for all Americans—preventing disease, treating illness and injury, and creating equal life chances, so all Americans (or, at least, all Rhode Islanders) have **equal life chances**—have an equal ability to **function in their communities** and an equal ability to **participate in the democratic process**.



### Magellan's Ships

**IMAGINE A HEALTH CARE SYSTEM**

One Primary Care Center for every community of 10,000 people that...

- Is a mile or two from home
- Has many different kinds of health professionals
  - Doctors, nurse practitioners, nurses, pharmacists, physical therapists, psychologists, social workers, substance abuse counselors, nutritionists, nurse and lay midwives, community health workers, home health aides, EMTs, paramedics: you name em. We got em.
- Is open 8am - 8pm and weekends
- Provides 90% of the health services the community needs, and does it so that 90% of the people in each community want to use their health center.



### The Yellow Brick Road



**The Primary Care Trust is a financing mechanism that will allow us to build a primary healthcare system for Rhode Island.**



### A Primary Care Trust

- **A single-payer system**, but just for primary care, leaving the rest of the healthcare market—specialists, hospitals, and the health insurance system—intact.
- **Organizes and simplifies primary care payment**, so that primary care practices are paid to deliver healthcare to communities, in addition to delivering sick care to individuals.
- **Builds primary care practices in every Rhode Island community**
  - Building on our existing practices and community health centers
  - Practices run by private enterprise, not government
  - But a not-for-profit healthcare system at the end of the day
- **Preserves patient choice**
  - (Guaranteed, no death panels)



### A Primary Care Trust

- Improved health outcomes
- Reduced cost: **30-50%!!!** (if we can get rid of unnecessary care and put prevention to work)
- Builds local economies and communities
- Provides most medical services people need
- Accessible and affordable
- Promotes relationships, which is what most people mean by health.
- A public health care system, once everyone is in.



### Summary and Conclusions

- Healthcare is crippling the nation's economy
- Medical care doesn't matter much for health – but human services spending does
  - So medical care is making health unachievable
- Primary Care can reduce health care costs
  - (and leave us money to spend on education, housing, public safety and the environment)
- Primary care is the only medical service that significantly impacts population health
- A Primary Care Trust can bring primary care to all Rhode Islanders



### Is Primary Care for all Rhode Islanders possible?

**If you can see the invisible, you can do the impossible.**

-Bernard Lown, M.D.

1985 winner of the Nobel Peace Prize for his work with *International Physicians For the Prevention of Nuclear War*






**Summary and Conclusions**

- Healthcare is crippling the nation's economy
- Medical care doesn't matter much for health – but human services spending does
  - So medical care is making health unachievable
- Primary Care can reduce health care costs
  - (and leave us money to spend on education, housing, public safety and the environment)
- Primary care is the only medical service that significantly impacts population health
- A Primary Care Trust can bring primary care to all Rhode Islanders

