

Rhode Island State Innovation Model (RI SIM)



SIM Sustainability Plan: Part I

Version 2 — December 3, 2018

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Disclaimer

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- **SIM Sustainability Workgroup**, made up of stakeholders from a variety of organizations representing the health system, all of which are committed to improving health in Rhode Island;
- **SIM Core Staff and SIM Interagency Teams**, including both SIM-funded and non-SIM-funded staff from the Executive Office of Health and Human Services (EOHHS) and member Departments, as well as the Office of the Health Insurance Commissioner; and
- **SIM Steering Committee and Interested Parties**, who are the community and state decision-makers who guide and advise SIM’s work.

Lastly, please note that the project described was supported by Grant Number 1G1CMS331405 from the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The research presented here was conducted by the awardee. Findings might or might not be consistent with or confirmed by the findings of the independent evaluation contractor.

System Transformation End State Vision

RI SIM began our project with the Triple Aim as our vision and through all we have learned over the last three years of the SIM process, the central tenets of our vision based on the Triple Aim of healthcare remain intact.

Adapting the Triple Aim

The following descriptive language reflects the ways that RI SIM now understands and adapts the Triple Aim more completely, and clarifies what it means to us and RI SIM's vision for the future of the State's health system:

Better Health

We look at population health outcomes and disparities across the life course, focusing on equity and the integration of behavioral health (including mental health and substance use) with physical health (including oral health), while also identifying and addressing the social determinants of health. Better health includes promoting social cohesion and connectedness to achieve active patient engagement and support recovery from addiction.

Better Healthcare

This includes a foundation of longer-term planning for an effective health system that melds payment and delivery reforms with investments in healthcare quality improvement and the health workforce (such as Rhode Island's inter-professional training initiatives), and in building the capacity to identify and address social determinants of health. Better healthcare includes a focus on provider satisfaction and avoiding burnout.

Smarter Spending

This includes ongoing implementation of OHIC's Affordability Standards with a continued emphasis on cost management strategies that use practice-based performance improvement strategies. We understand the differences between short-term and long-term cost savings. We also understand that long-term savings require investments (especially in our children) that are often reflected in different areas than the initial expense. For instance, investments in children's behavioral health in one year can reduce costs in DCYF in future years. Additionally, addressing social determinants of health will require building a system that supports strategic investments outside of healthcare including one where financial risk and reward are shared across sectors. For significant long-term savings, we aim to retain investments that improve social services and support place-based community infrastructure to address socio-economic and environmental determinants of health.

RI SIM Payment and Delivery Reform Goals

When RI SIM began our project, we made it clear that in Rhode Island, the state and private entities were already moving from volume to value. The Office of the Health Insurance Commissioner (OHIC) and Medicaid were taking the lead on the state side to increase their pursuit of value-based strategies through OHIC's [Affordability Standards](#) (Section 10, Page 16) and other regulatory actions. Medicaid was creating Accountable Entities through their relationships with Managed Care Organizations. Private organizations such as Blue Cross & Blue Shield of Rhode Island, Coastal Medical, and the Integra ACO were providing more and more care through value-based arrangements.

Rhode Island's Approach

Our theory of change stated that since Rhode Island was already pursuing this course of action, our top priority was to support the people and institutions that were making these changes. Thus, our funding focused on practice and workforce transformation, patient engagement, and improving our state infrastructure, with a focus on Health Information Technology (HIT) improvements. Rhode Island's unique regulatory advantage, then, is that our goals for payment and delivery reform are built into our existing structure. OHIC's ongoing activities to support their Affordability Standards are the way that Rhode Island is sustaining our payment and delivery reforms, setting annual targets, and evaluating how we are doing in meeting those goals. The process is entirely transparent, with significant stakeholder participation.

In fact, the annual process has just begun this October 2018. OHIC's two primary stakeholder committees—the Alternative Payment Model Workgroup and the Care Transformation Workgroup—have just started to meet to carry out their regulatorily-required activities. These documents lay out all the goals and activities still to be undertaken by the state—and this process continues seamlessly through our regulatory structure. The other annual process carried out by OHIC is the Measure Alignment review. The State's Measure Alignment work started within SIM, creating an aligned set of measures and a menu set. We have added on to that measure work, and OHIC has inserted the requirements to use the measure sets into its state regulations as well. See page 20 of the linked OHIC regulations noted above.

OHIC and Medicaid work together as much as possible, to align their regulatory actions. Medicaid's Accountable Entity program uses the same measures and aligns their system transformation efforts wherever possible. The best way to see Rhode Island's ongoing payment and delivery system reform is to explore these documents. We are happy to share the results of this year's work when the conclusory documents are finalized with the Commissioner's signature this winter. We have also included the Final Alternative Payment Model Report from winter 2018, to demonstrate how the committee work turns into annual state policy.

Figure 1: Additional OHIC Documentation



Alternative Payment Model Targets

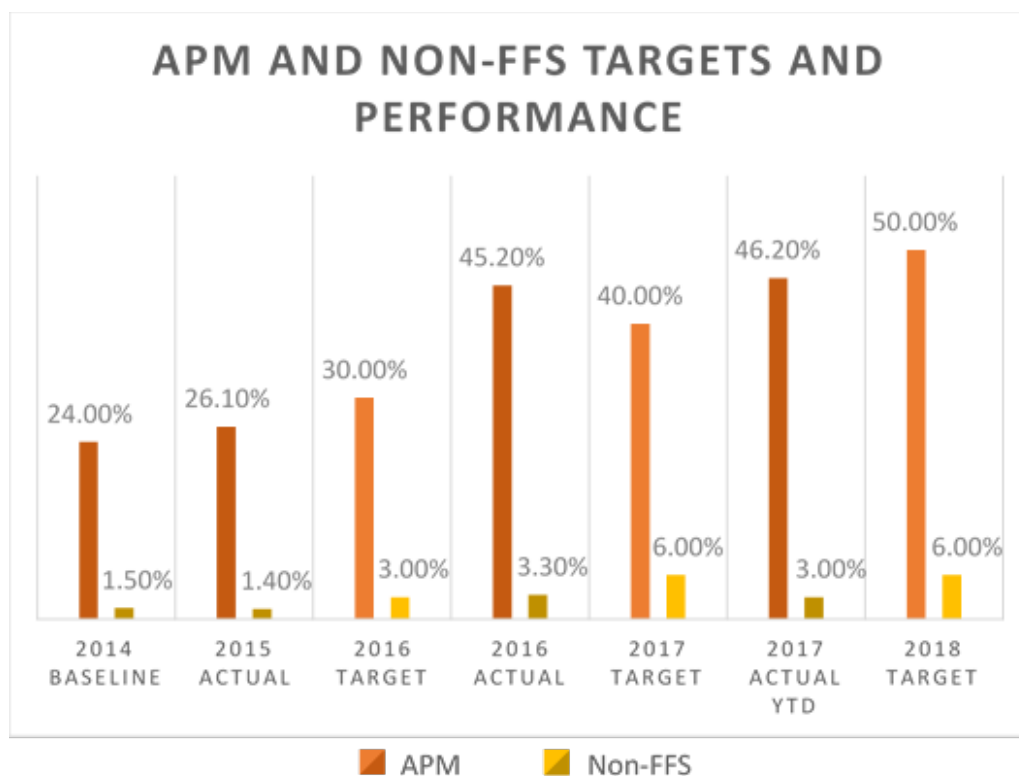
Finally, OHIC has been overseeing the drive to our APM targets. We have excerpted the following from our AY4 Operational Plan (taken from between Pages 98 and 108 and updated in October 2018):

Award Years 3-4 (Implementation)

The following information pertains to Year 3 implementation:

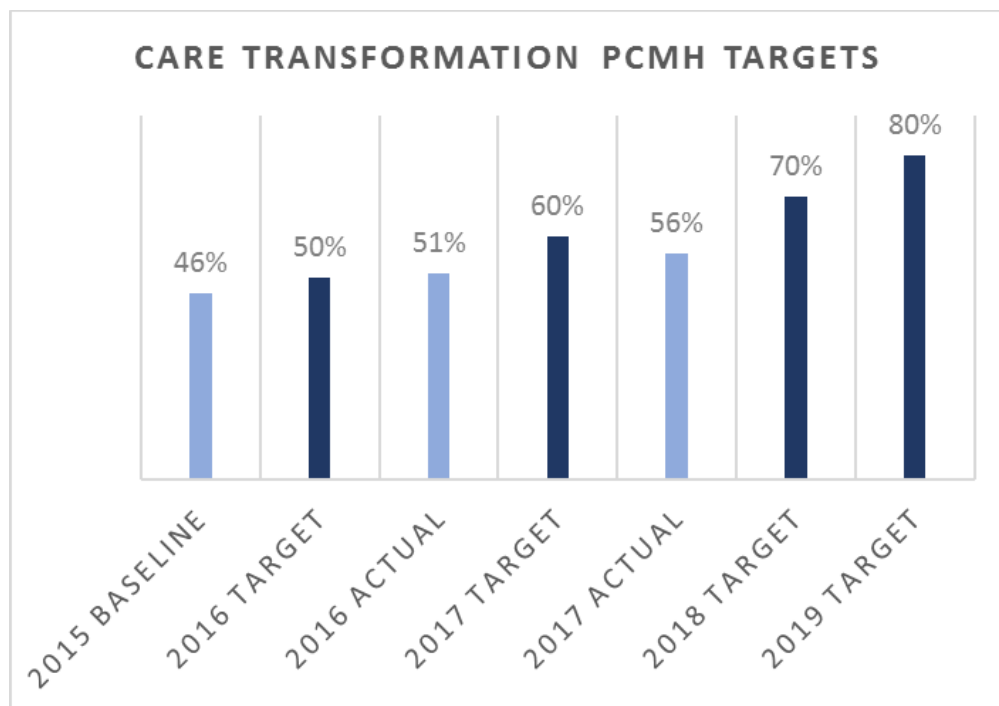
- In the early months of 2018, OHIC evaluated commercial insurer performance relative to the 2017 APM and Care Transformation targets. When payments under APMs relative to total medical spend was aggregated across insurers, OHIC found that insurers surpassed the 2017 target, achieving 46.20% of payments in an APM, as shown in Figure 12 below. No insurer met the Non-Fee-For-Service target, however. OHIC has found that there is a lack of payment arrangements in the Rhode Island market that could be classified as stage 4 APMs according to the LAN Framework, such as capitation or bundled payments. To support insurers and providers in moving toward these types of arrangements, OHIC has taken a number of actions, including the development of a primary care capitation model by a work group in 2017, the planned implementation of said capitation model in a small cohort of practices in a multi-payer fashion and the analysis of commonly defined episodes of care that will inform the development of bundled payment arrangements that can be adopted in a multi-payer manner. These activities are further articulated in the [2018 APM Plan](#), which was signed into effect by Commissioner Marie Ganim on January 24th, 2018.
- In addition to these activities, OHIC will also be leading a work group to explore pediatric APMs, to promote continued engagement of our pediatric provider community in healthcare reform and to ensure that pediatrics is not neglected as an unintended consequence of pursuing savings through common means such as chronic care management. OHIC will also be exploring regulatory authority and potential methodology for assessing provider financial capacity for risk bearing.

Figure 2: Rhode Island Commercial Payment Reform Performance and Targets, 2018



- The State’s 2017 care transformation target was to achieve 60% of primary care providers operating within a PCMH (insurers had unique targets based on baseline performance). While insurers missed this target by about 4%, as shown in Figure 139 below, upon review of practice performance relative to OHIC’s three-part PCMH definition, 39 practices submitted data to OHIC and failed to achieve PCMH status. OHIC has noted that a significant number of clinicians are affiliated with a Federally Qualified Health Center that either failed to meet the Cost Management Strategies, or did not report to OHIC at all, despite participating in a transformation initiative or achieving PCMH status last year. OHIC has been coordinating with the insurers and CTC-RI to encourage these practices through practice facilitation and contracting mechanisms to achieve all OHIC PCMH requirements in 2018.
- Recognizing the growing presence of ACOs in Rhode Island’s care delivery landscape, OHIC is directing insurers to focus on practices that have not yet achieved PCMH status but are affiliated with an ACO or system of care. OHIC is also recognizing the ACO role in transformation and has developed a set of criteria against which to evaluate the supports and programming offered by ACOs to gear their practices up to be operating as a PCMH (as defined by OHIC). This will enable an ACO’s practices that are participating in their transformation program to be entitled to infrastructure payments from insurers.
- As articulated in the [2018 Care Transformation Plan](#), signed into effect by Commissioner Marie Ganim on January 24th, 2018, OHIC will support continued transformation of primary care by revising the cost management requirements of OHIC’s PCMH definition, investigating and addressing administrative challenges associated with behavioral health integration, and working with other state agencies to improve data sharing and communication between providers when patients cross organizational lines or clinical settings.

Figure 3: Rhode Island Commercial PCMH Performance and Targets, 2018



The following information pertains to Year 4 implementation:

- Moving forward, Rhode Island is poised to continue to significantly advance the use of multi-payer VBP and APMs through the implementation period of the SIM grant and beyond. OHIC will continue to track commercial insurer compliance with their annual APM targets on a semi-annual basis.
- In September of each year, OHIC will administer a survey to primary care practices to assess achievement of the PCMH cost containment strategies. OHIC will also collect data on clinical quality performance measures. These elements will be combined to produce a list of practices sites and associated clinician rosters who have met the OHIC definition of PCMH.
- OHIC will assess compliance with commercial insurer payment reform targets, care transformation requirements, and hospital contracting requirements in the context of the annual rate review process in 2018 and 2019. The Commissioner may consider each insurer's efforts to meet the delivery system and payment reform targets as a factor in her decision to approve, modify, or reject any regulatory filing. OHIC will publish public reports on insurer compliance with the annual APM and PCMH targets.

Continued Engagement of Payers and Providers

Rhode Island is advancing the work of payment reform in a coordinated way. The goal of achieving critical mass for payment reform across Medicare, Medicaid, and commercial insurance is a necessary condition for transforming the healthcare system as a whole. As noted above, Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an APM by 2018, and 80% of payments linked to value. While we had planned to carry out a Learning Collaborative on VBP implementation, we determined that it would be duplicative of the significant stakeholder engagement that OHIC organizes throughout its workgroup processes. SIM is available to help OHIC with its stakeholder work, and OHIC reports that many SIM participants have begun to attend OHIC meetings.

Additionally, the Rhode Island State Employees Health Plan, which covers about 44,000 members, is an important lever toward our APM goals. The state health plan is currently administered by UnitedHealthcare and it participates in UnitedHealthcare's ACO shared savings program. To the extent a state employee is cared for by a practice in one of our three ACOs (Coastal Medicine, Lifespan, or the Rhode Island Primary Care Physicians Corporation), they are considered to be participating in the corresponding ACO program. As of March 31, 2016, 76% of State of Rhode Island members are attributed to an ACO or another population-based program (such as the PCMHs through CTC). As Rhode Island prepares to re-procure the State Employee Health Plan, OHIC has engaged with the Department of Administration to encourage the state to include requirements to align with SIM initiatives. Proposed contractual requirements included the adoption of the SIM Aligned Measures, the continued submission of claims data to the APCD, and the support of PCMH transformation. It is not yet clear whether the state will agree to include these requirements.

RI SIM Healthcare Spending or Savings Goal

Over the years, various Rhode Island government and healthcare leaders have discussed setting healthcare spending goals. Through the advocacy of the Raimondo administration and a \$550,000 grant from the Peterson Center on Healthcare, the SIM Steering Committee and other stakeholders have begun to lay the groundwork for a formal and serious look at developing a state cost growth target for healthcare, through the RI Healthcare Cost Trends Collaborative Project.

This project is guided by a Steering Committee comprised of government, business and community leaders, and will leverage the state's existing APCD to identify cost drivers, develop an annual health care cost growth target, and inform system performance improvements. The Steering Committee was convened in August 2018 by EOHHS and OHIC, in partnership with Brown University and the Peterson Center on Healthcare. Rhode Island joins only a handful of U.S. states to launch a comprehensive effort to measure health care expenditures, examine how dollars are spent, and set a spending target. The group will also draw upon work done by the Massachusetts' Health Policy Commission, which has set annual health care cost growth targets since 2013.

RI Healthcare Cost Trends Collaborative Aims

At the first meeting, the Committee reviewed their charge. The Steering Committee will specifically advise the State on:

1. The methodology to measure and report on the total cost of health care in Rhode Island;
2. The methodology to establish an annual health care cost growth target to first employ in 2019;
3. How to analyze and report publicly on state, insurer, and provider performance relative to the target;
4. A data analysis plan designed to measure health system cost performance on a pilot basis during 2018-2019; and
5. A data analysis and use plan to guide future, ongoing analysis of cost growth drivers and sources of cost growth variation.

The group has discussed the analytic methodology for the study population, patient attribution, data sources, and outcome definitions. The initial phase of work will analyze claims data to identify cost trends and drivers of cost in the state. The specific short-term aims of this work are threefold: (1) to assess cost trends in Rhode Island, (2) to assess select cost drivers in the state, and (3) to deconstruct total medical expenditures by volume and price.

Rhode Island Population Health Goals

From our AY4 Operational Plan (Page 88), here are Rhode Island’s Population Health Goals, informed and adopted by RI SIM:

Figure 4: Rhode Island Population Health Goals



Population Health Targets

Also from our AY4 Operational Plan (Page 91), here are population health targets from the Rhode Island Department of Health (RIDOH):

Figure 5: Original RIDOH Key Metrics by Health Focus Area

Health Focus Area	Integrated Population Health Goal	Original Key Metrics (Revisions Underway)
Obesity	Reduce obesity in children, adolescents, and adults	Decrease the proportion of Rhode Island adults who are obese from 27% to 24% by 2020.
		Decrease the proportion of Rhode Island high school students who are obese from 12% to 10.8% by 2020.
		Increase the proportion of Rhode Island adults participating in physical activities during the past month from 77.5% to 86.5% by 2020.
Chronic Disease	Reduce chronic illnesses, such as diabetes, heart disease, asthma, and cancer	Increase the proportion of the diabetic population with an A1c value less than 8% from 68.2% to 73.8% by 2020.
		Increase the average percentage of weight-loss among participants who complete the diabetes prevention program from 5.7% to 7% by 2020.
	Improve emergency response and prevention in communities	Decrease stroke deaths from 33.4/100,000 to 38/100,000 by 2020.
		Increase the proportion of adults aged 20 years and older who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911 or other emergency number from 37% to 40.9% by 2020.
Maternal and Child Health	Promote the health of mothers and their children	Decrease the proportion of children ages 3-5 with dental caries experience in their primary teeth from 29.4% to 26.5% by 2020.
		Maintain the proportion of screen-positive children who receive follow up testing with in the recommended time period at 100% through 2020.
		Increase the proportion of children in participating primary care practices who receive regular standardized developmental screening to from 54% to 75% by 2020.
		Increase the proportion of children aged 6 to 9 years with dental sealants from 11 % to 20 % by 2020.
		Increase the number of women with Medicaid insurance who visit the dentist during pregnancy from 28% to 32 % by 2020.
		Increase the percentage of adolescents (ages 12-17) with a preventive medical visit in the past year 68.3% to 74.5% by 2020.
	Reduce environmental toxic substances, such as tobacco and lead	Decrease the statewide incidence rate of Rhode Island children aged 1-5 years with blood lead levels ≥ 5 ug/dL from 4.1% to less than 2% by 2020.

	Improve access to care include physical health, oral health, and behavioral health systems	Increase the proportion of children, adolescents and adults who used the oral health care system in the past year from 42.1 % to 40 % by 2020.
		Increase the number of RI children with special needs (birth to 18) who participate in enhanced medical home practices to double the number 1495 Number to 2990 Number by 2020.
	Improve emergency response and prevention in communities	Increase RI's Hospital Pediatric Emergency Readiness score from 61.2 to above national median (69.1) by 2020.
	Ensure that quality public health data are collected consistently using current technology	Increase the number of immunization data submitters who submit data at least once annually, using HL7 standards from 122 to 200 by 2020. Increase the number of annual hits on KIDSNET by all healthcare providers from 1,124,177 to 1,600,000 by 2020.
Tobacco Use	Reduce environmental toxic substances, such as tobacco and lead	Decrease cigarette smoking by Rhode Island adults from 16.3% to 12 % by 2020.
		Decrease the proportion of Rhode Island adults exposed to secondhand smoke in the home 7.8% to 4.8% by 2020.
Depression		Decrease the RI suicide rate from 12.6/100,000 to 10.2/100,000 by 2020.
Children with Social and Emotional Disturbance	Improve access to care include physical health, oral health, and behavioral health systems	Increase annually the number of Rhode Islanders who have access to primary care (medical, behavioral, and oral) services through implementation of primary care workforce programs from 85,500 to 90,000 by 2020.
Serious Mental Illness		
Opioid Use Disorder	Reduce substance use disorders	Decrease the proportion of adults reporting use of any illicit drug during the past 30 days from 14.75% to 7.1% by 2020.
		Decrease the proportion of high school students reporting use of marijuana during the past 30 days to from 23.6% to 21.2% by 2020.
		Decrease the proportion of high school students who report they ever used prescription drugs (e.g., OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription from 11.6% to 9 % by 2020.
	Decrease the number of overdose drug deaths annually from 257 to 160 by 2020.	
	Analyze public health data to monitor trends, identify emerging problems, and determine populations at risk	Increase the monthly average of unique providers checking Prescription Drug Monitoring Program (PDMP) each month from 1,062 to 2,500 by 2020.

Conclusion

RI SIM understands that knowing where we are headed is the only way that we will know when we have achieved our goals. We have kept this End State Vision in mind as we have carried out our project—and we will keep it front and center in this final year. When we think about sustaining SIM, we are focused on much more than simply sustaining our funded projects. We aim to sustain the drive toward health system transformation and improvements in population health; the awareness and prioritization of addressing the social and environmental determinants of health; and ensuring the continuance and deepening of our Culture of Collaboration that has allowed to achieve as many of our stated goals as we have.

The next section contains information pertaining to the Landscape of Healthcare in Rhode Island, in accordance with our Sustainability submission.

Healthcare Landscape

Overview

As we reviewed what has changed in Rhode Island's state health landscape since we wrote our original application as a part of our Sustainability Review, we used a number of different source documents. First, the charts below are based on our three main SIM Strategies, as laid out in our Operational Plans. The source documents referenced below are the [State Healthcare Innovation Plan](#) (SHIP) which was the SIM Planning Process (2012-13), the [Senator Sheldon Whitehouse/RI Foundation Health Compact](#) (2014), Governor Gina Raimondo's [Report of the Working Group for Healthcare Innovation](#) (2015), and the SIM Operational Plans (2015–2018). All of our Operational Plans can be found on [this page](#).

Landscape Matrices

Each of the charts lays out our goals from the original documents and where we were when we began the pre-SIM planning process (2012–2013). The second column in each chart gives an overview of where we are now in three areas: SIM-Funded Initiatives, Partner/Other State or National Initiatives, or Community Initiatives that live in our stakeholders' organizations. You can find the most up to date information about the SIM-Funded Initiatives in our [AY4 Operational Plan](#). If you have questions about our Partner or Community Initiatives, please let us know. Stakeholders contributed information throughout this column.

SIM Lessons Learned

Then, the third column in each chart reflects our Lessons Learned through the SIM grant cycle and activities in each area. We held discussions at our Sustainability Workgroup and Steering Committee meetings, and with our SIM Interagency and Core Staff Teams for input into lessons learned. We found that the question “What would we do differently if we could begin SIM again?” was one of the best prompts to get feedback for this column and much of the wording in this section is verbatim from stakeholders.

Please see the full matrices located on the next ten pages.

Figure 6: Landscape Matrix for Linking Payment to Outcomes

Linking Payments to Outcomes: Healthcare Spending & Payment Reform		
<p>Goals from source documents:</p> <ul style="list-style-type: none"> • Bend the “Cost Curve” of Health Care in Rhode Island (SHIP) • Transition to Value-Based Care (SHIP) • A global health spending target (Working Group on Health) • Reducing waste and overcapacity (Working Group on Health) • Tying healthcare payments to quality (Working Group on Health) • Triple Aim (SIM Operational Plans – 2015 through 2018) 		
Where we started (2012-13)	Where we are now	Lessons learned
<p>The system of care delivery is fragmented, which can lead to overutilization and higher costs. For example, the 2013 study of the state’s hospital capacity suggested that the state may have as many as 200 excess hospital beds. In addition to hospitals, the state may also have excess capacity in nursing homes.</p> <p>The current fee-for-service environment does not support population health, leads to higher unnecessary or inappropriate utilization, and does not promote coordinated care delivery.</p> <p>Improvements in our mental health service delivery system, better coordination of services, and more effective integration of mental health and primary care are vital to high quality patient-centered care—an enormous challenge and opportunity for Rhode Island.</p>	<p>SIM-Supported Initiatives:</p> <ul style="list-style-type: none"> • APM Targets • End of Life Provider Trainings and Patient Engagement • Interprofessional Community Preceptor Institute • Triad Project – Behavioral Health Trainings • PCMH Kids • Measure Alignment • Healthcare Quality Measurement Reporting and Feedback System • HealthFacts RI • Tobacco Cessation Integration and Alignment Project 	<ul style="list-style-type: none"> • For all projects, collect data as early as possible and determine what data we need to measure Return on Investment (ROI) from the start • Children’s health care (physical and behavioral) has a longer time period to see ROI or other cost benefits. If we invest throughout the life course we may not see immediate returns, but we may save costs later in other systems (education, corrections, etc.) • Providers and healthcare organizations appear to understand the value of publicly accessible healthcare cost and quality information, but there is no existing mechanism to share the information publicly • The quality measures that are easy to calculate are mostly process measures and do not support outcome measurement and the community wants to transition to more

<p>There is a lack of consistent transparency among providers and payers that inhibits consumers from selecting care based on value.</p> <p>There is limited knowledge of how the current and future health care workforce is prepared to provide care in a value-based system (both in training and in availability).</p> <p>There are uneven expectations and knowledge around value-based care practices and a lack of provider education.</p> <p>There are significant outpatient behavioral health needs.</p>	<p>Partner/Other State or National Initiatives:</p> <ul style="list-style-type: none"> • Medicaid HSTP/Accountable Entities • Primary Care Capitation Pilot, with a push for all-payer participation, including Medicare • OHIC Behavioral Health Parity • Market Stability Workgroup • 6I18 Project at RIDOH • Need to update the 2013 Hospital Study because a hospital has closed <p>Community Initiatives:</p> <ul style="list-style-type: none"> • CPC+ Participation • Care Transformation Collaborative's PCMH adult practice transformation • Proposed hospital mergers • Accountable Health Communities • Hospital strikes have impacts on other facilities because of diversion needs 	<p>outcome measurement. We need technology to make this easier which will help this happen sooner with less provider burden</p> <ul style="list-style-type: none"> • We can use existing regulatory levers and requirements to ensure outcome-based expenditures (e.g. hospital community benefits) • Provider engagement in alternative payment methodologies (APMs) is still limited but is improving. While providers are aware of APMS they are not necessarily actively engaged or always willing to participate. We should still acknowledge that these APMs are still based on an underlying fee-for-service structure. • Rhode Islanders continue to have a need to better understand the healthcare pressure points and have a willingness to directly address where spending is highest. • Collecting data is not enough, we need to act on the information we receive about costs and cost containment • Measure alignment has been one of Rhode Island's largest successes in the state's efforts to reduce administrative burden for both providers and payers. • Many APMs have not been being implemented long enough to fully understand ROI or benefit.
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Figure 7: Landscape Matrix for Planning and Aligning for a Healthy Population

Planning & Aligning for a Healthy Population: Access to & Quality of Healthcare in Rhode Island

Goals from source documents:

- Improve the Quality of Health Care in Rhode Island (SHIP)
- Ensuring all Rhode Islanders have access to care (Working Group on Health)
- Improve the health of Rhode Islanders (Working Group on Health & SHIP)
- Triple Aim – SIM Operational Plans

Where we started (2012-13)	Where we are now	Lessons learned
<p>The current practice of care transitions increases the vulnerability of readmissions/reduced adherence to evidence-based procedures and poorer health outcomes.</p> <p>The highest risk (top 5%) population is costly due to multiple co-morbidities and requiring a high intensity of services.</p> <p>Many Rhode Islanders in the population referred to as the “Rising Risk” population (those with one or two chronic conditions) receive uncoordinated and disparate preventive care that leaves them vulnerable to higher costs and in danger of rising to the high-risk category.</p> <p>There is a high prevalence of mental illness and substance abuse, as well as the high cost of treating these conditions.</p>	<p>SIM-Supported Initiatives</p> <ul style="list-style-type: none"> • PCMH Kids • Integrated Behavioral Health (IBH) Project, as a model • Community Health Teams/SBIRT – including pharmacy and nutrition services* (See note about the (*) items under Lessons Learned). • Integration & Alignment work (multiple agencies working together) as a model • Unified Social Service Database for referrals • Behavioral Health Integration as a strategy to address behavioral health issues • Conscious Discipline • Behavioral Health Billing & Coding • Consumer Engagement Platform • State Data Ecosystem • HealthFacts RI • Care Management Dashboards* • Pedi-PRN (Child Psychiatry Access)* 	<ul style="list-style-type: none"> • The initiatives with the asterisks (*) to the left are noted as good models to emulate or learn from for the future. • Must be specific about integration of behavioral health by calling it out—and do the same with oral health. • As above, investments in population health for children are crucial. • Investments in care for seniors must also be looked as a continuum along the life course. • From our High-Risk Integration & Alignment Project: Screening for social determinants of health is key, but there is not only one way to do it—what questions are asked will depend on who is conducting the screening • As we continued to gain insights into the grant deliverables—and the differences between where we started and where we needed to end up—we

<p>Community-based organizations are unevenly equipped to participate in health care and are poorly coordinated with the areas of greatest need.</p> <p>The current health care system allocates few resources to incorporating social determinants of health into the care delivery and payment system.</p> <p>Community Health Workers are under-recognized.</p> <p>Populations with complex or specialized health care needs face ad hoc, non-standard, or marginal care structures.</p> <p>There are public health requirements for population health improvement plans and hospital requirements for community health needs assessments.</p>	<ul style="list-style-type: none"> • Triad Training Project for Behavioral Health • Interprofessional Community Preceptor Institute • End of Life Projects* • Health Assessment Report • HEZ investments • Measure Alignment • STR Grant • eCQM project • Tobacco and BMI Integration & Alignment Projects • EOHHS Workforce Summit and the Rhode Island Healthcare Workforce Transformation Report • Public SIM Workgroup meetings • Development of a standard framework for system reform and population health stakeholder engagement through outreach presentations <p>Partner/Other State or National Initiatives</p> <ul style="list-style-type: none"> • Medicaid HSTP/Accountable Entities • Patient Centered Pharmacy Program • Close partnership with CurrentCare/Health Information Exchange • Major changes in behavioral health (BH) co-payments and utilization review (Example: BCBSRI lowered BH co-pays from a specialist copay to a primary care copay, and no longer requires prior approval) 	<p>would have been more strategic about aligning population health and system reform investments.</p> <ul style="list-style-type: none"> • We learned about the limitations of our ability to show a ROI and gained a much better understanding of the interplay between the social determinants of health, the value of e-Referrals, and “closing the loop technology” to help us meet our goals. • Technologies to support new population health activities are key because this work is not well supported in electronic health records (EHRs), but adoption and uptake is difficult without the potential users seeing it work first. • Technology should not be an afterthought. There should be more upfront attention given to technology needs/workflow with EHRs, etc. as projects are developed (Example: SBIRT with GPRA/SPARS). Also, we need upfront discussions of who will own and maintain data once the system is developed. • We need more resources to develop a true ongoing State-level Health Improvement Plan, and to further define the metrics for the state associated with our population health goals.
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	<p>for in-network mental health or substance use disorder services).</p> <ul style="list-style-type: none"> • 23 Integrated Population Health Goals, which started at RIDOH • LTSS Workforce Think Tank • Health Literacy – HSRI • SBIRT spin-offs in pediatrics and with school counselors • Institutes for higher education and unique partnerships with RIDOH Academic Center and HSTP higher education partners, following the Workforce Strategic Plan • Ryan White Funding • Medicaid ISAs, within the HSTP Workforce Transformation program with our Institutes of Higher Education • RIDOH Academic Center and MOUs with state high education institutions • Governor’s Opioid Overdose Taskforce and Data Council • EOHHS Ecosystem Governing Board • Children’s Cabinet • RI College HRSA grant for SBIRT training • EOHHS participation in the RI Public Transit Authority Transportation Taskforce Workgroup <p>Community Initiatives</p> <ul style="list-style-type: none"> • Additional CHTs 	<ul style="list-style-type: none"> • We need to better understand the process of braiding funding and the benefits (and challenges) of doing that. • We did not do as much direct patient engagement as we had hoped. • We want to develop stronger ties to schools and the educational community, including school wellness committees, the Health Schools Coalition, and school nurses (which could happen through PediPRN).
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	<ul style="list-style-type: none"> • Trainings by the Substance Use and Mental Health Leadership Council • Accountable Health Communities • Quality Tracking, such as: HEDIS measures for insurers; national hospital quality rating system measures; NCQA accreditation of PCMHs; FQHC quality measure reporting; indicators in national surveys like BRFSS PRAMS; and others, which include questions about the context or quality of services 	
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Figure 8: Landscape Matrix for Developing Infrastructure for Quality Care

Developing Infrastructure for Quality Care: Health Information Technology & Data

Goals from source documents:

- Expanding and improving health IT & Utilization of Data (Working Group on Health)
- SIM HIT Goals – Operational Plans

Where we started (2012-13)	Where we are now	Lessons learned
<p>Data show that there are disparities between groups, e.g., Medicaid and commercially insured populations.</p> <p>The current practice of care transitions increases vulnerability to readmissions and/or reduced adherence to evidence-based procedures, leading to poorer health outcomes.</p> <p>There are unrealized opportunities for the health care system to incent higher levels of patient engagement.</p> <p>Data lives in silos across the state: state databases, provider systems, and payer systems, making it difficult to leverage for value-based care and population health.</p>	<p>SIM-Supported Initiatives</p> <ul style="list-style-type: none"> • State Data Ecosystem • Healthcare Quality Measurement Reporting and Feedback System • Provider Directory • Care Management Dashboards • Consumer Engagement Platform • USS Database • SBIRT • HealthFacts RI • BMI Integration & Alignment Project <p>Partner/Other State or National Initiatives</p> <ul style="list-style-type: none"> • Medicaid technology under MMIS, E&E and HITECH I-APDs • CurrentCare/Health Information Exchange • DataSpark, University of Rhode Island • UHIP/RI Bridges challenges have an impact on rest of HIT work 	<ul style="list-style-type: none"> • Define use cases more specifically to better support linking value to sustainability • Focus early on sustainability, with more community engagement along the development cycle with potential customers • Using IT to track social determinants of health care led to new data on risks and gaps • Demos of IT systems during procurement are extraordinarily helpful in selecting the right vendor • The demand from providers is quickly advancing to focus on value being linked to full EHR integration • It would be beneficial to have one EHR for schools across the state • Great to build new systems but sustainability costs money

<p>There had been privacy concerns around HIT initiatives, and there wasn't effective legislation around telemedicine.</p>	<ul style="list-style-type: none"> • Blackstone Valley Community Health Center Health Record • RIQI Dashboards (besides the Care Management Dashboards) • Work with the Hassenfeld Institute, Brown University • RIDOH Health Inventory and HIT Survey • Kidsnet and other RIDOH systems • Shared Plans of Care with RIDOH and CEDAR programs • Community Health Network at RIDOH • HIT Advisory Committee • There are still multiple trains running to address some SIM Health Focus Areas (e.g. SIM Steering vs. Children's Cabinet vs other state agency committees), but now the trains are communicating back and forth more than they were. <p>Community Initiatives</p> <ul style="list-style-type: none"> • Other Current Care Initiatives at RIQI • SNAP Pilot project with 4 sites 	<ul style="list-style-type: none"> • Costs dollars and time to collect and send data—we need to remember this when we ask for data collection • There are continual barriers to improving care coordination for patients with substance use disorder diagnoses due to 42 CFR Part 2 • Looking back, we might wish that the community were all on one system. Looking forward, we should try to align on one system for new initiatives rather than going our separate ways • It is important to get firm commitments from partners, especially where sustainability is concerned • It is helpful to understand exactly where there are opportunities for demonstrable ROI when it comes to sustaining investments • It is especially difficult to measure outcomes, such as with behavioral health data, because the data is not always in the system. We need a single source of truth for data integration • We should have initially included Delta Dental in HealthFacts RI • We should engage the State of Rhode Island's health data and employee benefits staff more
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Figure 9: Landscape Matrix for Building a Culture of Collaboration

Building a Culture of Collaboration

Goals from source documents:

- SHIP planning
- Office of Health Policy & Planning (from the Whitehouse/ Rhode Island Foundation Compact)

Where we started (2012-13)	Where we are now	Lessons learned
<p>SHIP public/private planning process</p> <p>During the process, community members said that in order to be involved, they needed to have decision-making power</p>	<p>SIM-supported Initiatives</p> <ul style="list-style-type: none"> • SIM Steering Committee, with decision-making power. • Public SIM Steering Committee and Workgroup meetings, designed to maximize stakeholder input in planning and learning • SIM Interagency Team • SIM embedded staffing model • Integration & Alignment projects – High Risk Assessment, Tobacco Cessation, and BMI • Unified Social Service Directory, to maximize the ways that the state uses and pays for data 	<ul style="list-style-type: none"> • Importance of interagency communication for collaboration and a broad group of stakeholders • The embedded staff model provided many benefits to collaboration • The value of increased communication between state agencies on aligning activities • How to improve purchasing processes for other state agencies seeking large multi-agency grants • Difficulty of too many projects, with procurements (RFP complexity and time), budgeting, and the need for financial staff • Question branding the project as SIM versus a broader “Health Reform” name • Difficulty in engaging actual patients and consumers • There was a long ramp up process – taking what seemed like too long to decide on leadership and specific plans. However, because the right “mindset” was needed to ensure trust of one another, the protracted start-up, while painful,

	<ul style="list-style-type: none"> • Quarterly SIM Vendor Meetings, and resulting vendor-to-vendor partnerships • State level SIM/Health Equity Zones (HEZ) collaboration • SIM Culture of Collaboration Evaluation • SBIRT/CHT Braided Funding <p>Partner/State Initiatives</p> <ul style="list-style-type: none"> • Other state interagency teams have begun since SIM: Ecosystem Board, EOHHS Public Affairs Team, Opioid Task Force and Data Team • Project Advisory Group for Ecosystem • Children’s Cabinet • Internal RIDOH SIM Partner Workgroup • Internal RIDOH/BHDDH Cross-agency meetings • EOHHS Directors’ Meeting • EOHHS Active Contract Management Workgroup • Governor’s Hunger Elimination Task Force <p>Community Initiatives</p> <ul style="list-style-type: none"> • Health Equity Zones 	<p>may have helped with collaboration. We needed a common language and means of communicating</p> <ul style="list-style-type: none"> • It has been more fun over the past 1.5 years, since the project has really taken off • With behavioral health work, in particular, there are many organizational cultures, so opportunities for points of connection still can be hard to figure out • However, primary care has many successes with a focus on team-based care and outreach to community providers • The relationship between BHDDH and RIDOH has improved. Going forward, we need to determine how the particular goals and day to day operations of each state agency assure productive working relationships among themselves • We also need to look beyond just state agencies for collaboration, for example, with the Children’s Cabinet, they are looking beyond to the community • Data sharing has great promise for assuring connections across various entities in the state, such as that shown by the Data Ecosystem and BMI data coming from the health plans. For example, with BMI, we now have a baseline, so let’s not scrap this, but build on it annually: What are our goals? Are we meeting the goals? Do we have new goals? • As the grant period draws to an end, there should be a formal hand off of the Steering Committee to another entity. • Finally, as we look to sustaining the SIM project, it is not only about (or even primarily about) the sustainability of our funded projects. As we noted in our End State Vision document, when we think about sustaining SIM, we are focused on sustaining the drive toward health system transformation and improvements in population health; the
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	<ul style="list-style-type: none"> • Accountable Health Communities • Pharmacy Transformation Workgroup 	<p>awareness and prioritization of addressing the social and environmental determinants of health; and ensuring the continuance and deepening of this Culture of Collaboration that has allowed to achieve as many of our stated goals as we have.</p>
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CMS-RI SIM Question and Answer on State Landscape

The following questions were posed to RI SIM from CMS. The subsequent answers provided by the State detail additional context associated with Rhode Island's health systems transformation landscape:

Political Transitions, Market Changes, and Population Health Characteristics

Have any political transitions, market changes, or changes in population characteristics occurred that have impacted or have the potential to impact the awardee's SIM work? How might those changes pose opportunities or challenges to the awardee's work?

The state political transitions that have occurred during our SIM award years have not been significant enough to have an impact on our work. SIM was planned during the previous administration, out of then Lt. Governor Elizabeth Roberts' office. When Governor Gina Raimondo was elected, Lt. Governor Roberts became Secretary of EOHHS and Health Insurance Commissioner Kathleen Hittner (who had also helped write the grant) remained in her position. When both leaders left their positions, the new leaders (Eric Beane, EOHHS Secretary and Marie Ganim, OHIC Commissioner) were very strongly supportive of SIM and our work. The transitions were seamless.

In terms of our insurance market, as we have noted throughout these documents, Rhode Island was moving from volume to value before the SIM grant was awarded. We are able to track carrier and provider points of view on a regular and in-depth basis because of the strong relationships between OHIC and the commercial carriers and providers; Medicaid and their MCOs; and HealthSource RI (HSRI) and all of the carriers with which they work. The state's significant stakeholder engagement also ensures that we are aware of insurance market changes. The most significant state-based changes have been:

- *More movement to value-based care, as documented in our Operational Plan and metrics;*
- *Movement of the Medicaid Accountable Entities (AEs) from their pilot project to six certified AEs;*
- *Increased patient-centered medical home (PCMH) penetration, and questions about whether we are close to reaching the limit of new PCMH practices because small practices are less likely to participate; and*
- *Exploration of a primary care capitation model.*

State leadership has been consistently concerned about potential changes to the Affordable Care Act (ACA) on the Federal level. When the Administration changed the rules for Cost Sharing Reductions, OHIC, and HSRI were able to respond immediately to help Rhode Island consumers. In response to other Federal changes, the two agencies worked together to convene a Market Stability Workgroup in April 2018, with three guiding principles: sustain a balanced risk pool; maintain a market attractive to carriers, consumers, and providers; and protect coverage gains achieved through the ACA. Open to the public and comprised of diverse stakeholders representing health insurers, employers, healthcare providers and consumers, the Workgroup held eight weekly meetings and released a final report in June 2018. The Workgroup recommended that the legislature pass enabling legislation to pursue a 1332 waiver request as provided for under the ACA to implement a reinsurance program. The Workgroup recognized that 1332 waiver applications require a stakeholder review process. The state reinsurance program would be designed to mitigate premium increases in the year 2020 and beyond. In addition to leveraging federal pass-through savings, we would identify matching funding from other sources and proposed separately through future legislation. The enabling

legislation passed in June 2018, allowing the state to apply for the waiver. The Workgroup is reconvening in the fall of 2018 to continue their work ensuring a stable health insurance market in Rhode Island.

Finally, regarding our overall healthcare landscape, we are confident that between OHIC, Medicaid, and HSRI, the state is in the position to monitor any of the potential changes and ensure that our push toward health system transformation remains on track.

Model Participation and Value-Based Payment Transitions

What proportion of payers and providers are participating in the awardee's model during the final award year compared with the pre-implementation period?

First, with respect to the commercial market, each payer was making strides toward value-based care during the pre-implementation period. However, OHIC's Affordability Standards set a time table for the transition to value-based payments, which means that all payers are now involved. Medicaid's creation of their creation of Accountable Entities (AE) structure happened during the SIM time period – but to be clear, this was not a SIM initiative. All three of the Medicaid Managed Care Organizations (MCOs) are participating in the AE program. Medicaid's contracts with Medicaid MCOs have requirements for APM targets that align with OHIC's APM Plan. Please see [Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners](#) for more information.

Alternative Payment Model and Quality Measure Alignment

To what extent are payers aligned on key model features like payment methodology and quality measures? How has providers' participation in Alternative Payment Models more broadly (SIM models or otherwise) grown or changed over the course of SIM?

Providers in Rhode Island are significantly aligned on these key APM model features. The dual push toward APMs within the commercial market, combined with Medicaid's AE accomplishments, has ensured that overall, more providers than ever are participating with programs or are part of organizations that are aimed at moving toward value and taking on risk. According to the most recent available OHIC data, 49.1% of PCPs in Rhode Island's commercial market are associated with ACOs. Medicaid data shows that approximately 52.4% of PCPs in Rhode Island were associated with AEs during the same time period. We anticipate that we will have updated data available by the end of AY4 Q2. As noted through these sustainability documents, RI SIM's Measure Alignment process was an early win that set us up to focus more intently on quality through our eCQM health information technology (HIT) project. We have regular access to provider groups through our SIM Steering Committee, through OHIC's strong stakeholder processes with their APM and Care Transformation Committees, and through RIDOH's provider committees. We also connect with RIDOH through their regular newsletters that go to the entire provider network in the state.

Implementation Experience, Unintended Consequences, and Lessons Learned

Consider the awardee's implementation experience and any unintended consequences. How did the awardee expect to operationalize its SIM work, and how did this work plan unfold? What infrastructure (HIE, staff capacity, etc.) did the awardee intend to develop, and was that infrastructure implemented? What model(s) has the awardee implemented in comparison to what the awardee originally planned to

implement? If the awardee changed its approach in model(s) implemented, what prompted the change in approach?

As CMS and the Rhode Island SIM team have always understood, Rhode Island's SIM grant was different from other states because of the pre-SIM existence of OHIC. OHIC's regulatory structure had allowed Rhode Island to develop some of the institutional components that other states were using their SIM funds to create: PCMHs, support for ACOs, etc. We have already noted throughout this Sustainability Submission that Rhode Island's theory of change stated that since Rhode Island was already moving from volume to value, SIM's niche would be to support the individuals and institutions that were making those changes.

Therefore, our model test was different than the tests of other states. We tested support for practice transformation, investments in workforce transformation (including a wide variety of training opportunities for providers at all levels), a discrete set of patient engagement initiatives, and the value of HIT as critical tools toward transformation. We did not change that model throughout our Award Years. However, there were two critical parts of our model that emerged as we implemented the grant: the integration of physical and behavioral health and our Culture of Collaboration. We did not realize how important they would become when we began, but they transformed our model.

1. Integration of Physical and Behavioral Health

RI SIM's initial Operational Plan defined health in general and then specifically population health. In collaboration with stakeholders, we defined health as follows: "When we talk about health, we mean physical health and behavioral health. When we talk about behavioral health, we mean mental health and substance use." Later, we added: "When we talk about physical health, we include oral health." Another part of our initial grant application was a proposal to write a Behavioral Health Plan as well as the required Population Health Plan. The next important decision we made about that writing was to say that because we believed that behavioral health must be understood to be at parity with physical health, that we would write one plan that would integrate what we knew and what we wanted to achieve about both components of health. Then, when our staff came on board, they started visiting with community stakeholders throughout our early outreach efforts and held the Integrated Population Health Workgroup. During those visits, the more we talked about the importance of intertwining physical and behavioral health, the more central it became to our vision of our model test. It Here are some of our activities within SIM toward that end:

- Focusing specifically on the integration of behavioral and physical health, the Steering Committee supported and approved funding for the IBH project at the Care Transformation Collaborative (CTC-RI). This project is just one of several SIM-funded ventures focused on behavioral health, along with our Child Psych Access Project (Pedi-PRN), the Behavioral Health Workforce Transformation (Triad) training project, and the State Data Ecosystem, whose first project focused significantly on behavioral health needs.*
- We were successful in expanding the reach of our original SBIRT project by working with BHDDH to apply for a significant SBIRT grant from SAMHSA. This led to the opportunity to braid SIM funding for our Community Health Teams (CHTs) (which we had always planned would include a behavioral health team member) and the SAMHSA funding for SBIRT. Our CHTs are now intentionally integrating physical and behavioral health throughout the state, carrying out SBIRT screenings and referring for physical, behavioral, and social determinants of health needs. As of 10/22/2018, a total of 8,345 SBIRT screenings have been completed throughout Rhode Island.*

- We created our Integration & Alignment project on high risk assessments, that included components on the social determinants of health and the cross section with behavioral health. This project has transitioned into our work on the Unified Social Service Directory.
- The state as a whole is also focusing on improving behavioral health services, following Governor Gina Raimondo's [Executive Order on Behavioral Health](#), signed May 4, 2018, to reaffirm and expand the state's commitment to those with mental illness and substance abuse disorders. This fall, led by the EOHHS, key state agency leadership have been traveling through the state holding a series of public conversations, mental health, addiction, and available treatment.
- BHDDH is focused heavily on addressing the opioid crisis. They are implementing a State Opioid Response grant from SAMHSA, with the ability to fund a number of initiatives that should improve services for Rhode Islanders. One of these is BH Link, which is a comprehensive program intended to serve those individuals who are experience behavioral health crises by establishing a community-based, 24/7 hotline and triage center. The hotline is a one-stop, statewide 24/7 call-in center and the triage center is a 23/7 community-based walk-in or drop-off facility, where clinicians will connect people to immediate, stabilizing emergency care and refer to long-term care and recovery supports.
- OHIC has begun to focus heavily on implementing the state's parity law, with both consumer protection activities (including a Market Conduct Examination of Rhode Island's four major health insurers) and regulatory changes that ensure that people who need behavioral health services are treated the same as those who need physical health services. This has led them to create a Behavioral Health Fund, administered by the Rhode Island Foundation, that will make grant distributions to support strategies and service models that enhance primary and secondary prevention and access to high quality, affordable behavioral healthcare services. The fund is supported by an initial contribution of \$1 million a year for five years from Blue Cross & Blue Shield of Rhode Island (BCBSRI) and may also be supported by others in the future.

When we finish evaluating SIM, the integration of physical and behavioral health will be a key focus—and we know that RTI has noted this in their discussions of our work.

2. RI SIM's Culture of Collaboration

RI SIM has proceeded generally within the structure envisioned by our grant-writers: a strong public/private partnership with decision-making that includes community members and not just state employees; an interagency team of staff members embedded in five health-focused state agencies; and an interagency team that meets regularly and includes agency staff beyond the specific SIM staff to provide strategic advice and logistical support. However, this structure has contributed more to our outcomes and impact than the SIM planners likely ever imagined. This structure had some strategic components, but other logistical ones as well:

Steering Committee as Transformational Policy Leaders

When state leadership first wrote the SIM grant, they approached community partners to ask them to serve on an advisory committee. The CEO of BCBSRI at the time reportedly replied that community members were always being asked to serve on these advisory committees, but they did not have a stake in the decision-making. The state's response was to offer that the SIM Steering Committee would be the major decision-making body for the project. The state would bring funding and major program decisions before the body, as if it was the organization's Board of Directors – and would run by modified consensus. The staff has held to this promise and

has run all overall budget decisions and major programmatic direction by this group. (Following state law, the procurement processes and detailed implementation decisions for vendor contracting must remain the purview of state employees.)

Interagency Team as the Weekly Strategic Working Group

It took time to get the SIM program off the ground, due to challenges with hiring and procurement. Until there were SIM staff, the key health-related state agencies devoted their staff members to handle all initial activities: directing the hiring process, starting the first procurements of the project management staff, communicating with CMS, etc. This Interagency Team grew into a critical part of our entire project. Once we hired staff, some of these Interagency Team members reduced the time they spent on the project, but others remained. The ongoing members who are not SIM staff include the Health Insurance Commissioner (first Dr. Kathleen Hittner and then Dr. Marie Ganim), one of the RIDOH Medical Directors (Dr. Ailis Clyne), the state’s HIT Coordinator (Amy Zimmerman), and the EOHHS Workforce Strategies Lead (Rick Brooks). We met almost weekly for about two years, and in the last year have met an average of bi-weekly. We have also recruited new people to join the Interagency Team, including the Director of the Health System Transformation Project (Lauretta Converse) and members of the EOHHS Policy and Communications staff (Tarah Provencal, Ashley O’Shea). Our work includes SIM strategic planning, including managing the Steering Committee agenda and reviews of many SIM vendor projects, as well as larger interagency events and opportunities. These can include strategizing new grant opportunities, presentations from key state partners, and determining responses on legislative issues.

SIM Public Workgroups

Throughout the course of the grant period, SIM convened publicly-noticed Workgroups to further engage stakeholders and collect focused input on key components of the grant. As with our Steering Committee, bringing diverse stakeholders to talk together has been the cornerstone of this effort and the results are two-fold: 1) In the short term, SIM gains thoughtful input on the topic hand; and 2) State agency staff and community partners have yet another opportunity to learn and work together in the same room on shared challenges. The chart below shows the trajectory of our Workgroup activity over the grant period.

Figure 10: Active SIM-Convened Public Workgroups by Award Year

AY1 + AY2	AY3	AY4
Integrated Population Health	Sustainability	Sustainability
Technology Reporting	Technology Reporting	Healthcare Technology
Patient Engagement	Patient Engagement	
Measure Alignment	Measure Alignment	

Embedded Staff as Strategic Collaboration Agents

The concept of embedding staff in state agencies stemmed first from a logistics issue. The state wanted multiple departments to participate and knew that it was likely that they did not have adequate staff to do so. Also, it might have been difficult to secure the FTE capacity in any one agency. Putting SIM staff in the agencies, therefore, made sense. When the staff were hired, and began to work together, the agencies realized that the strength that they were creating in this even more aligned interagency team was very important. The staff

members all carry out specific agency functions related to health transformation and population health improvements and then come together to run SIM as a team.

The most important thing about all these structural components is that they turned into a key part of our Rhode Island model—to lift up and value the development of a Culture of Collaboration. We pursued these collaborative activities because they made sense to us as a way to work—agencies working together and finding new ways to collaborate would streamline our state system and potentially save money when we reduced duplication of effort. Having providers work together on our Measure Alignment project made sense as a way to reduce their reporting burden—so of course, OHIC and Medicaid should both require the same measures for each of their reporting requirements. RIDOH had been creating a list of Population Health goals for years—but all state agencies carried out activities that can improve Rhode Island’s population health—so RIDOH opened up the goals list for each of the other agencies to add their priorities. Similarly, the three SIM Integration and Alignment initiatives launched in AY3 grew out of our emphasis on working collectively to maximize resources—human, financial and information—across agencies and silos.

We have many other examples of how the agencies are working together in these ways—and what is exciting is that our community partners are noticing. At our Steering Committee meetings and in our other workgroups, they are commenting that they see a new alignment between the agencies and that it helps them in their work. In addition, the administration as a whole is mirroring the SIM structure and has created multiple other interagency teams—for instance on communications and policy and on active contract management. Because of the importance of this emerging part of our model, we have included it in our state evaluation, and we will know more about the outcomes of the structure at the end of AY4.

Conclusion

Our SIM stakeholders—both community and state, staff, and supporters—have valued the conversations that have contributed to this review of our state landscape and lessons learned. The process has been useful as we continue to determine how to sustain the health system transformation and population health improvements that are at the heart of SIM—as we also hope to sustain the most successful of the SIM project. Next, please see our Accomplishments section, which finishes this *Sustainability Plan—Part I* submission.

SIM Accomplishments

We present our RI SIM accomplishments through the structure of our Driver Diagram. We have broken out each of our Aims and Primary and Secondary Drivers and populated them with the SIM funded projects that fit into each one. (We note that many of these projects have multiple drivers.) We asked each of our vendors to highlight their successes to date, which we listed under each driver below. Then, we added in the state-led projects, including the Culture of Collaboration and Integration and Alignment work that we have accomplished.

Reduce Rate of Increase in Rhode Island Healthcare Spending (Aim 1)

Move to a “value-based” healthcare system that pays health care providers for delivering measurable high-quality health care, rather than paying providers for the volume of procedures, office visits, and other required services that they deliver.

Primary and Secondary Drivers for Aim 1

Change our payment system (all-payer) to 80% value-based by 2018, with 50% of payments in alternative payment methodologies (Primary Driver). Secondary drivers include:

- A. Use regulatory and purchasing/contracting levers at OHIC and Medicaid, implement rules and conditions that expand value-based payments (VBPs) more broadly across the commercial and Medicaid markets
- B. Align quality measures for healthcare contracting
- C. Enhance and/or create programs to address needs of high utilizers coordinated across payers

Increase use of data to drive quality and policy (Primary Driver). Secondary drivers include:

- A. Maximize the use of HealthFacts RI, complete the Common Provider Directory, implement Care Management Dashboards, and create a Health Care Quality Measurement, Reporting, and Feedback System to create a data infrastructure that can support VBP
- B. Enhance state agencies' data and analytic infrastructure by modernizing the state’s current Human Services Data Warehouse

SIM Projects Addressing Driver Diagram—Aim 1

Each of the accomplishments listed below have taken place within the SIM funding period, February 2015 through the present (October 2018). The project names and/or vendor names with two asterisks (***) indicated were added after the initial SIM time-period to meet emerging or new needs, based on a review process with our Steering Committee.

Figure II: Accomplishments Summary for SIM Driver Diagram—Aim 1

HealthFacts RI (All-Payer Claims Database, or APCD) <i>Vendor: Freedman Healthcare & Onpoint</i>
<ul style="list-style-type: none">• In the last year, HealthFacts RI has expanded the use of our data to support the RI Medicaid Program’s reporting needs. HealthFacts RI has transitioned from a standalone, externally hosted database to a Medicaid module that is state-owned. The database is now accessible to over 50 state

analysts through a state-licensed analytics platform. The team has completed training for all analysts and continues to provide support through monthly user groups.

- The State has established two successful partnerships with organizations in the community to expand use of the data and support healthcare improvement efforts. HealthFacts RI supports the Care Transformation Collaborative (CTC-RI), Rhode Island's multi-payer patient centered medical home initiative, with performance reporting and contract adjudication for participating practices for utilization, cost, and quality measures. The State has also contracted with Brown University to support their NIH Advance-CTR grant that supports clinical and translational research with partners across the State. This allows researchers to use the data to support applications for additional grant funding for continued healthcare transformation research. Brown and the State will be working together to share methodologies, project findings, and data quality results.
- The State has received 18 requests for HealthFacts RI data to date. The RI APCD has established an efficient review process in which applications are typically reviewed and approved in fewer than two months. Over half of the requesters have received the data and are performing analyses.

Care Management Dashboards

Vendor: Rhode Island Quality Institute (RIQI)

- RIQI implemented Care Management Dashboards in eight Community Mental Health Organizations (CMHOs), allowing them to access real-time, encrypted notifications to the CMHOs when a patient under their care has an encounter with a hospital emergency department (ED) or becomes an inpatient. Each CMHO now has a Dashboard.
- RIQI conducted a return on investment analysis in 2017 which indicated that the dashboard services for all their clients reduced inpatient readmissions by 18.9%; reduced ED visits after inpatient discharges by 18.4%; and reduced ED returns by 16.1%. These improvements in care management helped to avoid approximately 3,244 events with an estimated savings of \$7.5 million.
- Across the eight implemented organizations, there are approximately 400 clinical record lookups per month.

Healthcare Quality Measurement, Reporting, and Feedback System (eCQM)

Vendor: IMAT Solutions

- Rhode Island's eCQM system will allow the collection of data directly from EHRs and other data sources (such as HealthFacts RI), and the implementation of a web-based portal to access measure results. This will improve the quality of care for patients and drive improvement in provider practices by giving feedback to providers, provider organizations, and hospitals about their performance based on quality measures.
- Over the past eight months, IMAT has installed and configured the eCQM infrastructure to support test and production environments for onboarding practices and other participants.
- The state and IMAT have worked with the Technology Reporting Workgroup to vet eCQM technical requirements.
- The state has reached an agreement with an individual practice to connect and collect clinical data for this test.

EOHHS State Integrated Data Ecosystem

Vendor: Freedman Healthcare, URI DataSpark, Onpoint/Abilis

- Onpoint and the State developed the technical architecture to fully operationalize the EOHHS State Data Ecosystem and support analyses and focused data projects. The Ecosystem model now includes 21 data sets from five key agencies, including DCYF, DHS, Medicaid, RIDOH, BHDDH, and DLT.

- Through our developed prioritization process, the state-initiated three analytic projects using the Ecosystem’s data. The focus areas for these projects include deep-dive analyses on the following subject areas:
 - *Child Maltreatment Prevention Project*
A cross-agency project focused on assessing the risk factors and opportunities for potential points of prevention for child abuse and neglect through state-administered services.
 - *SIM Population Health Project*
Guided by the SIM Project team, the Ecosystem project team is developing a report on the costs of co-occurrences, co-morbidities, and poly-morbidities of the eight SIM health focus measures. Phase II of this project will be to conduct a deeper dive on costs and utilization patterns of the RI population with diabetes and depression.
 - *RIDOH Pre-Term Birth Project*
Using Vital Records and Medicaid claims, the Ecosystem team is working with RIDOH to understand the proportion of pregnant women eligible for 17 hydroxyprogesterone (17-P) who receive it during pregnancy. This medication can be given to pregnant women with a past singleton preterm birth to reduce the risk of recurrent preterm birth. Anecdotally, there is suspicion nationwide that many pregnant women eligible for this treatment are not receiving it.

Unified Social Services Directory **

Vendor: United Way

- The Unified Social Service Directory is allowing RI SIM to explore the opportunity to develop an integrated, coordinated, statewide infrastructure for addressing the Social Determinants of Health (SDOH).
- It is our intent that this common infrastructure could begin with the development and maintenance of a single statewide database of community-based organizations, services, and public benefits.
- RI SIM has leveraged additional dollars from RIDOH to invest jointly in improving and validating data in the core database from which we are building the SDOH resource, United Way’s 2-1-1. United Way is validating the data.
- United Way and RIDOH have begun a pilot project, building the connection to transfer data from 2-1-1 (based on Mediware software) to a RIDOH eReferral system (based on Salesforce software).
- Once this transfer takes place successfully, United Way will work with Lifespan and Care New England to transfer data to their Salesforce-based software.
- We are also now planning how to move the project out into the wider community.

State-Based SIM Evaluation

Vendor: University of Rhode Island

- Moved from planning to implementation across several project specific evaluations.
- Provided intensive, collaborative efforts related to Community Health Team (CHT) evaluation, which has helped us firm up the evaluation plan and ensure shared metrics across teams.
- Supported SIM evaluation by bringing on additional consulting support for project management and the culture of collaboration evaluation through this contract (Glickman Consulting).

Integrated Behavioral Health Billing and Coding Research Project**

Vendor: Bailit

- To assess issues around coding, reimbursement for certain services, patient financial burden due to copays, and provider credentialing, Michael Bailit interviewed six integrated primary care/behavioral health care practices whose staff who are knowledgeable about administrative barriers to integrated behavioral health.

- OHIC brought these findings to the Care Transformation Advisory Committee and will examine how to give these topics a more detailed focus and assess how to move forward to reduce barriers to integrating physical and behavioral health in day to day practice workflows.

Support Provider Practice Transformation and Improve Healthcare Provider Satisfaction (Aim 2)

Support health care providers in their transition to delivering health care in an environment in which the care is paid for according to a VBP arrangement. SIM will invest in work place transformation activities that build upon the professional expertise of Rhode Island's healthcare workforce.

Primary and Secondary Drivers for Aim 2

Maximize and support team-based care (Primary Driver). Secondary drivers include:

- A. Using plan design, regulatory and purchasing/contracting levers, and SIM investments, maximize support for integrated team-based models of care

Better integrate behavioral health into primary care investments in Rhode Island's healthcare workforce (Primary Driver). Secondary drivers include:

- A. Make investments in the following programs for practice transformation: CHTs, Child Psychiatry Access Program, IBH & PCMH-Kids, CMHC supports, and Health Care Quality Measurement, Reporting, and Feedback System

SIM Projects Addressing Driver Diagram—Aim 2

Each of the accomplishments listed below have taken place within the SIM funding period, February 2015 through the present (October 2018). The project names and/or vendor names with two asterisks (***) indicated were added after the initial SIM time-period to meet emerging or new needs, based on a review process with our Steering Committee.

Figure 12: Accomplishments Summary for SIM Driver Diagram—Aim 2

<p>Community Health Teams & Screening, Brief Intervention, and Referral to Treatment (SBIRT) <i>Vendor: CTC-RI (with Diabetes Education Partners** and URI)</i></p>
<ul style="list-style-type: none"> • Under a centralized operations model, expanded Community Health Teams (CHTs) from two sites to six geographic locations serving over 400 high-risk patients. • In collaboration with the Diabetes Education Partners, CHTs now have access to nutrition and pharmacy consultation services through CHT/SBIRT site workflows. • Policies and procedures have been developed to provide pharmacist and nutrition resources to assist CHTs and SBIRT staff, including Home safety protocol and the referral process through the Community Health Network (CHN) at RIDOH and submitted to DEP for action. • Through a braided SAMHSA funding arrangement, established over 20 sites where SBIRT screening are taking place, with 8,345 screenings completed throughout Rhode Island as of 10/22/2018. • In collaboration with URI, worked with CHT partners to establish key performance measures that will be reported for program monitoring and evaluation purposes.

- Conducted analyses to determine the extent to which RI-SBIRT has been able to reach low-income and minority populations throughout the State—these results were accepted for presentation at the Rhode Island Health Equity Summit and will help inform strategies to address health disparities.

RI SBIRT Training and Resource Center

Vendor: Rhode Island College

- Over two years, we have trained 794 healthcare workers in SBIRT, and we are currently on pace to eclipse over 1,000 healthcare professionals by the end of SIM funding;
- Trained three unique agencies in Year One and, to date, 19 unique agencies in Year Two for a total of 22 unique agencies.
- Trained over 60 dentists, dental assistants, and dental hygienists as part of a dental mini-residency, allowing for the expansion of SBIRT practice into the dental arena to help close the gap in separation between oral, physical, and behavioral health;
- Trained one certified SBIRT trainer in Year One and, to date, three certified trainers in Year Two for a total of four certified trainers.
- Launched the *We Ask Everyone* Campaign to normalize conversations about substance use in practices and the community, including the use of billboards/bus stops for raising awareness; and
- Obtained anecdotal data which support that patients and providers are becoming more comfortable having conversations about substance use in healthcare settings and education and identification of unhealthy substance use.

PCMH—Kids / Integrated Behavioral Health (IBH) Pilot

Vendor: CTC-RI

- Integrated Behavioral Health (IBH)
 - CTC is pleased that an IBH qualitative evaluation and utilization results studied through the APCD are demonstrating the impact of the program. CTC-RI completed the qualitative evaluation study working with Roberta Goldman, PhD and Mardi Coleman, MSc.
 - Universally, primary care practices communicated the positive impact IBH has had for providers and patients.
 - The evaluation study offered recommendations on how to strengthen the implementation framework for further spread. APCD data indicates a directional improvement in risk-adjusted total cost of care, emergency department, inpatient visits, and costs for IBH Cohorts 1 and 2 when compared to the non-IBH comparison group and non-CTC comparison group.
 - A more robust matched comparison quantitative research project with Brown University underway with completion date scheduled for 2019.
- PCMH-Kids
 - Based on the outcomes of the PCMH-Kids pilot, the health plans supported a PCMH-Kids expansion in July 2017, adding ten additional practices bringing the total number of covered lives to ~66,000 with ~120 providers participating in pediatric PCMH practices.
 - Based on continued success, the health plans have additionally approved a third PCMH-Kids expansion, beginning 1/1/2019.
 - PCMH-Kids and IBH initiatives have received national recognition: a) CTC and IBH primary care practice Associates in Primary Care presented at PCMH Congress national conference in September 2018; b) PCMH-Kids Co-Chairs (Dr. Flanagan and Dr. Lange) are being honored with an AAP national award—the Calvin C.J. Sia Community Pediatrics Medical Home Leadership award—at the November 2018 annual meeting.

Child Psychiatry Access Program / Suicide Prevention Initiative** / Mental Health First Aid**

Vendor: Emma Pendleton Bradley Hospital

- **Pedi-PRN**
 - As of June 30, 2018, Pedi-PRN has served 403 children, with 342 providers are enrolled from 57 practices throughout the state. Bradley has completed 526 encounters or telephonic consultations.
 - As part of its ongoing outreach, Pedi-PRN contacted 25 enrolled practices and visited 19. The face-to-face visits provided direct feedback by providers and changes are in the planning phases to improve the educational/training services.
 - Bradley Hospital/Pedi-PRN submitted a HRSA grant in partnership with RIDOH. BCBSRI also partnered to support Pedi-PRN.
 - The Pedi-PRN Intensive Program (PIP) was developed to meet a need identified by the enrolled pediatric PCPs to provide an in-depth training in child mental health topics. The model is based on the Child and Adolescent Psychiatry for Primary Care (CAP-PC) program in New York. PIP will enroll up to 16 providers from 16 unique practices for the 10-session certificate program.
- **Suicide Prevention Initiative**
 - Bradley held specialized trainings regarding suicide screening and the Suicide Prevention Initiative (SPI) protocol within several schools in the Providence district. They introduced the SPI protocol and facilitation of service coordination with the pediatrician in charge of a health clinic embedded in Central Falls Schools.
 - The Kids'Link crisis phone triage services were enhanced by adding staffing coverage during high volume call times.
 - Bradley was able to increase awareness of the Kids'Link service through the increased availability of marketing materials in English and Spanish.
 - To increase safety for children after a crisis evaluation, Bradley has ordered medication lock bags. They are working to determine the most appropriate manner to distribute the bags to families after crisis evaluation.
- **Mental Health First Aid**
 - Bradley Hospital held two Youth Mental Health First Aid classes which certified a total of 38 new Youth Mental Health First Aiders.
 - Based on high demand, Bradley is planning to increase the number of trainings—holding 20 trainings before the end of the SIM grant period. Each session will train and certify up to 20 individuals per session with a total of between 360 and 400 people trained in these critical skills.

Interprofessional Community Preceptor Institute**

Vendor: Rhode Island College

- Training our community-based workforce is an essential part of rebalancing our healthcare system. The preceptor project ensures that undergraduate and graduate students enrolled in Rhode Island higher education institutions are trained in the community rather than at large in-patient facilities.
- A core group of faculty members from nursing (CCRI, RIC, URI), social work (RIC), pharmacy (URI), physical therapy (URI and CCRI), geriatric education center (URI), dental (CCRI) and medicine (AMS at Brown University) developed a training curriculum for community preceptors, who will supervise these students on an ongoing basis. It is a 30-hour training that involves online work, face to face meetings, and a site-based project.
- RIC serves as the fiscal home for the preceptor project coalition. The group identified and recruited the pilot cohort of 13 community preceptors from eight community-based agencies and 5 different health professions.
- Each agency will also bring its healthcare students together for inter-professional learning. The project will recruit and train a second cohort of community preceptors to precept interprofessional teams of students between December 2018 and May 2019.
- RIC has identified an outside evaluator to assess process outcomes.

Health Equity Zones**

Vendor: Rhode Island Department of Health

- SIM and HEZ staff have teamed up to increase awareness of healthcare transformation and community/clinical linkages. The SIM team has presented at 2 HEZ Learning Community events to increase understanding of healthcare transformation within community partnerships and organized a well-attended joint workshop on community clinical linkages at the RI Health Equity Summit in September 2018.
- To maximize collaboration between HEZ, SIM, and the rest of our interagency partners:
 - RIDOH HEZ team participated on the Accountable Entity (AE) Review Committee with SIM team to advocate for greater community clinical linkages.
 - RIDOH and SIM leadership have partnered on three community site visits to help state agency directors better understand how agency programing can be leveraged to improve the community/clinical linkages necessary to realize healthcare transformation goals.
 - HEZ and SIM staff participated jointly in an off-site retreat to debrief on the current successes and challenges of the HEZ implementation.
 - HEZ and SIM staff collaborated on the development of RI Health Equity Indicators to develop a baseline for measuring the social, economic, and environmental determinants of health through the Community Health Assessment Group in alignment with the 23 population health goals.
- RIDOH's Director was recently elected as President of the Association of State and Territorial Health Officials and is using HEZ as a platform for her presidential challenge.
- The Rhode Island Foundation recently awarded \$3.6 million to six programs through their Fund for a Health RI, including five HEZ sites, to support projects that will integrate community and clinical provision of care. These projects build on SIM/HEZ culture of alignment and collaboration and are intended to create more effective community/clinical linkages.

Provider Coaching

Vendor: John Snow Institute (JSI)

- JSI has completed a comprehensive needs assessment. They identified key informants who completed structured interviews and held formal and informal conversations with community stakeholders. They assessed and ranked results to set priorities. Along with this preparatory work, JSI established a Strategic Evaluation Planning Team to lead the evaluation throughout the project.
- JSI convened two learning collaborative cohorts—one with case managers and the other with substance use treatment providers—who identified core competencies needed for successful delivery of evidence-based behavioral healthcare. They have developed training tools in these competencies for both case managers and substance use treatment providers.
- JSI has drafted a survey tool to assess the behavioral health market atmosphere, and results will direct the ongoing work and inform future pathways for development.

Empower Patients to Better Advocate for Themselves in a Changing Healthcare Environment and to Improve Their Own Health (Aim 3)

Engage and educate patients to participate more effectively in their own health care in order for them to live healthier lives. Invest in tools (e.g., online applications, patient coaches appropriate for the patient’s demographic profile) to teach patients how to navigate effectively in an increasingly complicated health care system.

Primary and Secondary Drivers for Aim 3

Provide access to patient tools that increase their engagement in their own care and assist with advanced illness care planning (Primary Driver). Secondary drivers include:

- A. Patient engagement tools or processes
- B. End-of-life/advanced illness care initiative outreach, as well as patient and provider education

SIM Projects Addressing Driver Diagram—Aim 3

Each of the accomplishments listed below have taken place within the SIM funding period, February 2015 through the present (October 2018). The project names and/or vendor names with two asterisks (**) indicated were added after the initial SIM time-period to meet emerging or new needs, based on a review process with our Steering Committee.

Figure 13: Accomplishments Summary for SIM Driver Diagram—Aim 3

Advance Care Planning (ACP) and Community Campaign <i>Vendor: Healthcentric Advisors (HCA)</i>
<ul style="list-style-type: none">• ACP is a discussion that most people prefer to avoid. Through the SIM grant, HCA began to reverse taboos associated with ACP through a social media campaign, community education events and targeted presentations.• The use of thought-provoking stories and providing opportunities for candid discussions with smaller groups has proven to be very effective. This has been especially helpful getting past the initial hesitancy to discuss ACP and has led to meaningful conversations. Our multifaceted outreach has reached over 200,000 people.• We have established a strong connection to the Spanish speaking community through our partnership with Progreso Latino. They have utilized their extensive networking system and provided translation for all project materials in their outreach efforts.• By working side by side with them during events and educational opportunities, we can reach both the Spanish and English-speaking segments of the community.• We have created a website for ACP, which is available in both English and Spanish. Through the MyCCV.org website, community members and providers can access educational information, ACP forms, and materials for providers to incorporate ACP into their daily workflows. The website is broken down into three distinct sections:<ul style="list-style-type: none">○ Information for Everyone page which includes patients, veterans, families, caregivers, and the faith community○ Spanish page (Mi Cuidado, Mi Eleccion, Mi Voz)○ Healthcare provider page
Complex Care Conversations <i>Vendor: Hope Hospice and Palliative Care of Rhode Island</i>

- Hope Hospice conducted 16 eight-hour *Complex Care Conversations* training sessions conducted in Year One with a total of 278 providers trained. This exceeded our Year One goal to train 192 providers by 44%.
- The training demonstrated a significant positive impact on attendee’s knowledge, attitudes, and behavior. Hope Hospice uses a Pre/Post Training Assessment to determine the participant’s ability/comfort level with 11 aspects of complex care conversations.
- Forty-seven percent of respondents reported that they were somewhat or very skilled in these 11 aspects before the training while after the training the result was 91%. In a follow-up assessment three months after the training, 95% of respondents reported that they were better able to identify patients who would benefit from a goals of care conversation; 91% felt more comfortable communicating serious news; 95% were better able to respond to patient/family emotions; and 91% had increased the number of goals of care/advance care planning conversations they were having with patients.
- In addition, 88% stated that they had found greater personal and professional satisfaction in caring for patients with serious advanced illness.
- Hope Hospice is conducting a Provider Impact analysis on a quarterly basis to determine the impact of the training on the participant’s practice patterns.
- The organization is tracking the use of Advance Care Planning (ACP) codes submitted by providers to insurance carriers, which means that the providers have had these conversations with their patients.
- To date, we have seen a steady increase in the use of ACP codes among trained providers as well as an increase in the length of stay for their patients who were referred to Hospice.

Consumer Engagement Platform

Vendor: RIQI

- Development of the platform side of the Consumer Engagement Platform (CEP) has been mostly completed, with a few additional pieces of functionality left to be finalized.
- Platform integration with CurrentCare for advance directive documents is under development. This will allow advance directives uploaded through the platform to be shared as part of the patient’s longitudinal record in CurrentCare.
- We have determined three major barriers to the SDOH screening implementation that limit the ability for anyone in the community to use the CEP at this time: various EHR providers are adding SDOH assessment functionality to their products; participants in the Accountable Health Communities grant have little flexibility in the systems they can use for screening; and that screening is still not happening in many provider offices.
 - Therefore, we are pulling back on the creation of those modules so that we are not creating a product that providers are not likely to use.
 - This will allow us to use the CEP for other provider needs not currently met by their EHRs—in the future (post-SIM) we can revisit whether there are use cases attached to SDOH screening.

Conscious Discipline

Vendor: The Autism Project

- The Autism Project has brought the Conscious Discipline (CD) evidence-based practice to elementary schools in three pilot sites—Providence, Burrillville, and East Providence— serving over 300 students.
- Fourteen teachers and administrators have attended multi-day trainings in CD.
- These teachers and administrators then provided training to an additional 1300+ teachers, family members and community members.

- Children in the demonstration classrooms were given pre- and post-Devereux Students Strengths Assessments (DESSA). The DESSA is a standardized, strength-based measure of the social and emotional competencies of children in kindergarten through 12th grade.
- The difference in the pre- and post-assessments in each of the classrooms shows statistically significant improvement with T Score changes between 9 – 17 points, or a 5% –9% change.
- This means that the adults are able to control their emotions in a much more effective way, allowing the children to navigate their way through their days at school and their evenings at home more calmly and able to learn.

Accomplishments within Overarching SIM Activities

In addition to each of the accomplishments of the SIM funded projects linked to specific Driver Diagram Aims, we have also made significant strides across state agencies and community partners regarding the Culture of Collaboration and Integration and Alignment. We have added several other new SIM activities or have deepened cross-cutting activities that we had originally conceived of as part of our model test.

Culture of Collaboration and Integration and Alignment

As we have discussed throughout this writing on SIM sustainability, a primary strategy of Rhode Island's SIM project has been to pursue a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with SIM-funded activities. SIM has regularly convened working groups which bring people from multiple agencies and backgrounds into the same room to collaborate and plan together. This practice works on both strategic and tactical levels. When we bring people together to plan, they are more likely to experience a stake in the outcome, which tends to keep them at the table. And tactically, if they are part of the planning, the resulting initiatives may be more likely to meet their needs.

For example, the Patient Engagement Workgroup brought together a variety of stakeholders, including all our SIM state agencies, and helped us determine a clear set of the highest priorities for patient engagement in the state. Through this process, the voices of the state agencies and community members were heard, resulting in a procurement that was reflective of not only the state perceived needs but also our community members. Specifically, the process resulted in a procurement that narrowed the parameters to SIM's eight health focus areas, required a clear demonstration of need for the target audience, and provided the opportunity for vendor proposals to be creative.

RI SIM has also implemented our Integration and Alignment Initiative, which is focused on leveraging SIM's interagency structure and diverse stakeholder network to have positive impact on population health. This initiative began with the realization that while SIM investments focused more on system change than population health improvements, state agencies and community organizations in Rhode Island are already carrying out activities that have a positive impact on population health, specifically in our health focus areas. We agreed that SIM was well positioned to act as a convener of these state agencies and community groups. The Integration and Alignment project identified state activities that address population health within the SIM health focus areas and aligned them with each other—and with projects and activities outside of state government as well. This will help to move the needle on population health and maximize the impact of every dollar spent.

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

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

This alignment stems from positive, ongoing communication between agencies, facilitated by the SIM process that has been embraced by seven state agencies to this point, and can be joined by other related state departments. For example, as SIM builds up its activities on social and environmental determinants of health, we have reached out to the Divisions of Elderly Affairs and Veterans Affairs. Both departments are talking with us about their resource directories for their respective populations, focused on the SDOH. Each project has brought a diverse array of in-state and community experts to the table to identify areas of common priority and opportunities to maximize impact by working collaboratively.

Tobacco Cessation Project

Key accomplishments from the integration and alignment project facilitated by RI SIM include:

- Development of Cessation Benefits Matrices for providers;
- Movement toward embedding Quitworks in HIT platforms;
- Inclusion of tobacco cessation in SBIRT Training and Provider Coaching RFP;
- Partnership with CDC funded 6|18 initiative at RIDOH;
- Interagency learning, including the integration of oral health;
- Using claims to answer questions about utilization and reimbursement;
- Reviewing the regulatory framework for Certified Tobacco Treatment Specialists (CTTS) workforce;
- Support the streamlining of CTTS and other professional training programs;
- Continued promotion of Quitworks and the Quitline; and
- Strategic alignment across state agencies.

High-Risk Patient Identification/SDOH Screening Project

Key accomplishments from the integration and alignment project facilitated by RI SIM include:

- Collaborative learning processes to understand and share best practices in high-risk patient identification;
- Consensus on importance of unified strategy on defining and measuring SDOH;
- Planned implementation of a pilot for screening and referral;
- Align CEP pilot with the development of Unified Social Service Directory; and
- Partner with CHTs and other providers to work toward standardized data collection using Z-codes.

BMI Data Collection for Children and Adolescents Project

Key accomplishments from the integration and alignment project facilitated by RI KIDSCOUNT with assistance from RI SIM and other partners include:

- Launched a “proof of concept” to determine if BMI data on children and adolescents in Rhode Island could be collected that is representative of the state;
- De-identified data collected from managed care organizations (MCOs) and CurrentCare and merged with KIDSCOUNT data, including demographic information. The data fields collected included: Height and weight; BMI; ICD9, ICD10 or HCPCS (billing) codes related to BMI; included codes for both children and adults because sometimes adult codes are used for teens;
- Worked with the Hassenfeld Institute to compare the data sample to census data and determined that the sample was representative of Rhode Island’s four core cities: Providence, Central Falls, Woonsocket, and Pawtucket;
- Data was further analyzed, categorizing it BMI by age group, race/ethnicity, towns, and cities; and
- Compared to national clinical rates of BMI, the Rhode Island data was similar to the NHANES (National Health and Nutrition Examination Survey), the National Survey of Children’s Health, and with self-reported information from the Rhode Island Youth Risk Behavioral Surveillance System (YRBSS).

New Rhode Island SIM-Related Initiatives

Our SIM process—focused on collaboration, with plenty of opportunity for review and refinement of our models—led us organically to spark new ideas and create new activities. Some of these activities were focused on by SIM, but others were led by other agencies and partnered on by SIM. We have listed new SIM-led activities above in our vendor descriptions and include additional SIM or state-wide new activities below:

Deepening SIM’s Measure Alignment Work

We have described our Measure Alignment project often, as a way to help providers by honing the number of measures on which they are required to report to state regulators. The final product of our initial Measure Alignment activity was a menu totaling 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures). Core measures are required to be in all performance-based contracts of the relevant type: primary care, hospital, ACO. Beyond the core measures, health plans and providers may select measures from the menu for inclusion in contracts.

In many states, state government can be a part of creating aligned measures, but state officials do not have the authority to implement them; in Rhode Island, OHIC has that authority. In 2017, all commercial insurers signed OHIC’s 2017 Rate Approval Conditions, which included a requirement to adopt the SIM Aligned Measure Sets in any contract with a performance component as a condition for their rates to be approved. The updated SIM Aligned Measure Sets became effective for insurer contracts with hospitals, ACOs, and primary care practices beginning on or after January 1, 2017. Additionally, OHIC amended State Regulation 2, which delineates the powers and duties of its office, to include implementation of the SIM Aligned Measure Sets in any contract with primary care providers, specialists, hospitals, and ACOs that incorporate quality measures into the payment terms. OHIC will be issuing an interpretive guidance document to payers for using the measure sets in contractual payment arrangements. OHIC conducts an annual review of the five SIM Aligned Measure Sets (Primary Care, Hospital, Accountable Care Organizations (ACOs), Behavioral Health, and Maternity). SIM’s Measure Alignment Work Group reviews measures that are in

existing contracts with plans and providers, and updates the measure sets to account for measures that had a change in NQF or NCQA status, new HEDIS measures, and measures recommended by work group participants.

To assist in aligning processes between commercial and public payers and to reduce administrative burden for providers, Medicaid has incorporated the SIM Aligned Measure Sets into the Medicaid Performance Goal Program (PGP). The Medicaid PGP aligns with the SIM quality measure set as well as additional measures that assess health plan performance against EOHHS goals and/or align with the CMS child and adult core measures that EOHHS reports to CMS. The PGP is used to incent the health plans to improve across various domains, which in turn influences provider performance-based contracts. In addition, the Medicaid Accountable Entity (AE) program anticipates alignment of the SIM quality measures as part of the program's Alternative Payment Methodology (APM) or total cost of care guidance. The APM guidance is in the process of being developed.

Furthering SIM's Integration of Physical and Behavioral Health

SIM's efforts in this area are described in greater detail in the Landscape section. Below are highlights of SIM's work surrounding IBH:

- The state as a whole is also focusing on improving behavioral health services, following Governor Gina Raimondo's [Executive Order on Behavioral Health](#), signed May 4, 2018 to reaffirm and expand the state's commitment to those with mental illness and substance abuse disorders. This fall, led by the Executive Office of Health and Human Services, key state agency leadership have been traveling through the state holding a series of public conversations, mental health, addiction, and available treatment.
- Focusing specifically on the integration of behavioral and physical health, the Steering Committee supported the IBH project at CTC-RI.
- We were able to successfully expand the reach of our original SBIRT project by working with BHDDH to apply for a significant SBIRT grant from SAMHSA.
- We created our Integration & Alignment project on high risk assessments, which included components on the SDOH and the cross-section with behavioral health.
- BHDDH is strongly focused on addressing the opioid crisis. They are implementing a State Opioid Response grant from SAMHSA, with the ability to fund a number of initiatives that should improve services for Rhode Islanders.
- OHIC is actively implementing the state's parity law, with both consumer protection activities (including a Market Conduct Examination of Rhode Island's four major health insurers) and regulatory changes that ensure that people who need behavioral health services are treated the same as those who need physical health services.
- OHIC's focus on behavioral health has led them to create a Behavioral Health Fund, administered by the Rhode Island Foundation. The Fund will make grant distributions to support strategies and service models that enhance primary and secondary prevention and ensure access to high-quality, affordable behavioral healthcare services.
- When we finish evaluating SIM, the integration of physical and behavioral health will be a key focus—and we know that RTI has noted this in their discussions of our work.

Facilitating Health System Planning

During SIM's sustainability planning process, we asked our Steering Committee, Interested Parties, and Sustainability Workgroup questions about the direction the state should go post-SIM. Stakeholders frequently mentioned that we should move forward with some sort of larger, overall plan for Rhode Island's system transformation and population health. SIM's Operational Plan has been a positive step in many people's eyes, laying out definitions and shorter-term goals surrounding the SIM grant. The next steps envisioned by many in our community is a longer-term, more expansive plan that could provide a roadmap for what the state wants to achieve as a whole. It could guide investments by private entities and help set bounds for decisions by everyone in the health system. The Rhode Island Foundation has publicly expressed interest in helping to facilitate such a plan, and they are currently looking at next steps in this process. This planning process is envisioned as a public/private partnership, and the SIM team has offered to help in any way it can.

Next Priorities in Health System Transformation

The following projects, policies, and pilots represent health system transformation priorities identified to continue within the immediate horizon in Rhode Island:

Rhode Island Healthcare Cost Trends Collaborative Project

This project is guided by a Steering Committee comprised of government, business, and community leaders and will leverage the state's existing APCD to identify cost drivers, develop an annual health care cost growth target, and inform system performance improvements. The Steering Committee was convened in August 2018 by EOHHS and OHIC, in partnership with Brown University and the Peterson Center on Healthcare. Rhode Island joins only a handful of U.S. states to launch a comprehensive effort to measure health care claims, examine how dollars are spent, and set a spending target. The group will also draw upon work done by the Massachusetts' Health Policy Commission, which has set annual health care cost growth targets since 2013. The project is funded by a \$550,000 grant from the Peterson Center on Healthcare.

Primary Care Capitation

To support the adoption of non-fee-for-service payments in Rhode Island, OHIC facilitated a work group process to plan the implementation of primary care capitation across a common group of practices and payers. This work built upon a capitation model that was designed by the same work group in 2017. OHIC also convened a separate work group to adapt the capitation model for pediatric practices. Throughout 2018, the work group has refined aspects of the APM, evaluated readiness of each insurer, and worked with ACO leadership to identify interested practices. OHIC will continue to move this work forward in the next year with active implementation likely to begin in 2020.

Health System Transformation Project and Accountable Entities

The Rhode Island Medicaid Health System Transformation Project (HSTP) has supported the establishment of Accountable Entities (AE) to work in partnership with MCOs to achieve the core principles of "Reinventing Medicaid", including:

- Paying for value, not for volume;
- Coordinating physical, behavioral, and long-term healthcare;
- Rebalancing the delivery system away from high-cost settings; and
- Promoting efficiency, transparency, and flexibility.

SIM projects align closely with the objectives of HSTP and AEs, and many have partnered directly with AEs and affiliated provider organizations. As such, AEs represent an important potential sustainability strategy for many SIM projects.

Rhode Island's Affordability Standards

OHIC is continuing the Care Transformation Advisory Committee and Alternative Payment Methodology (APM) Advisory Committee to further value-based system transformation in Rhode Island. More specifically:

- *Care Transformation Advisory Committee*

OHIC's Care Transformation Plan became effective in early 2018. The plan describes OHIC's three-part definition of PCMHs, annual targets for the insurers to transform primary care practices, and activities that OHIC and stakeholders will undertake throughout the year to support PCMH adoption and implementation.

- The 2018 target for commercial insurers is to transform 50% of those practices that are affiliated with ACOs but have not yet achieved NCQA PCMH recognition; for 2019, the target is 90%.
- OHIC will reconvene the Advisory Committee for a series of three meetings in the fall of 2018 to review and discuss the operational definition of a PCMH, practice reporting requirements, transformation targets, and cost strategies.
- The group will also review the results of CTC-RIs IBH Pilot, with the goal of improving processes and removing barriers for behavioral health and physical health integration.

- *APM Advisory Committee*

OHIC continues its work on developing a multi-payer APM. The 2018 plan includes insurer targets for APMs and non-Fee for Service (FFS) payments, as well as a minimum downside risk requirement for Total Cost of Care contracts.

- For 2018, insurers should take actions such that 50% of insured medical payments are made through an APM and 6% are made through non-FFS models.
- To support this, OHIC is working with payers and providers to implement a pilot of the primary care capitation model that was developed by a working group in 2017.
- OHIC will reconvene the APM Advisory Committee for a series of three meetings in the fall of 2018 to discuss the possibility of modifying the above targets for 2019 and the implementation of a multi-payer APM pilot to launch in early 2019.

Conclusion

Rhode Island's healthcare leadership is proud to be a SIM grant participant. We are pleased with what we have accomplished since receiving the grant, and we are even more excited about our future plans that have been made possible by the grant process. As we noted in our End State Vision section, our understanding of all of the ways that we can implement the Triple Aim has deepened, giving us an excellent platform from which to achieve much more post-SIM. We are taking advantage of all of the time we have left with our SIM funding, focusing on sustainability throughout this final Award Year. We have also greatly appreciated working with your CMS team, and learning from them throughout this process. We are looking forward to your thoughts and insights about these sustainability documents and will be happy to answer any questions you have or provide additional information. Thank you.

Appendix 1: Sustainability Strategies and Workplan

Excerpted and adapted from the Award Year 4 RI SIM Operational Plan

Overview

In AY3, we noted that as the RI SIM team's efforts were shifting from planning to implementation, we were continuing to design our sustainability model. Throughout AY3, we have begun our sustainability plan in earnest, creating an overall sustainability framework for our overarching system changes and population health improvements. In Award Year 3, SIM planned for overall sustainability by carrying out the following:

Establishing a SIM Sustainability Planning Workgroup

The Workgroup consists of members of the SIM Staff and Interagency Teams, as well as members of the Steering Committee and our Interested Parties – and is chaired by SIM Steering Committee Vice-Chair Larry Warner. This group is charged with continuing research on sustainability, reviewing and discussing the initiative updates and evaluations, conducting an environmental review of the supports available for sustainability, exploring stakeholder entity readiness and willingness to sustain specific projects, developing the transition plan for projects, and bringing data and recommendations to the Steering Committee around sustainability. We launched the workgroup in December 2017 and have carried out two additional meetings since then. We also began our research and learning process including participating in CMS sustainability webinars, attending the ONC in person meeting in February 2018, and additional conversations with healthcare entities in other states.

Leveraging the Learnings from SIM Evaluations and Reporting

SIM will use the results from both the State Evaluator's Assessment as well as the RTI federal evaluation to better understand the effectiveness and impact of each SIM component. The State Evaluator will be conducting a qualitative analysis in addition to a quantitative analysis of four specific SIM projects and our overall Culture of Collaboration (see Page 199 on our evaluation plan). We are looking to capture perceptions of key stakeholders on the success or failure of SIM projects, which will provide additional insight into the community buy-in and long-term viability of these projects. We are collecting and tracking data and metrics to better understand our progress and potential impact across the initiative. This effort will be more robust in AY4 now that almost all of our procurement is complete.

Maintain the Culture of Collaboration

The SIM grant has been instrumental in cultivating a culture of collaboration in Rhode Island, and we continue to rely on the culture of collaboration built through SIM to achieve our objectives and maintain high engagement. We expect that the partnerships forged in planning and implementing SIM initiative will outlive the SIM grant cycle. By ensuring widespread community buy-in through the Steering Committee's governance structure, the Integration and Alignment Project, and SIM's interagency structure throughout the lifetime of the grant, we will be able to determine the best ways to sustain our health system transformation and population health improvements, as well as garnering the support needed to sustain successful funded projects.

Sustainability Planning Process and Products for Award Year 4

What follows is an outline of our sustainability planning process now underway and continuing into Award Year 4. It includes:

- Planning Goal and Definitions
- Sustainability Planning Framework and Workplan
- Key Stakeholders and Roles
- Expected Final Sustainability Products

Our Sustainability Planning Goal and Working Definition

By June 2019, we will have successfully implemented a set of strategies that will ensure the future sustainability of the health system reforms and population health improvements that have been supported by the overall SIM initiative once the grant period ends in June 2019.

Working Definition for Sustainability

The ability to maintain or support an activity or process over the long term – or the endurance of systems or processes. We are keeping in mind the following:

- Some elements of the initiative may be sustainable but others not
- Some particular SIM investments may be “one-time” only, requiring few resources to maintain
- Other elements may not have worked as intended so may be ended, modified, or combined with other models or programs*

**Definition Adapted From: Slide Presentation on “Sustaining SIM Programs: Lessons Learned from Multi-Stakeholder Initiatives” led by Dr. Kelly Devers, NORC, University of Chicago, October 2017*

Our Sustainability Planning Framework and Workplan

The primary aim of our sustainability planning process is to focus on what steps we must take to ensure that RI stays firmly on the path toward health system transformation and population health improvements. In order to achieve this goal, we are using four key SIM components as a framework for our sustainability planning. Key components of our Sustainability Planning Framework include:

1. Rhode Island’s interagency model and promotion of a “Culture of Collaboration” – By looking at the value of this internal state collaboration, what can we learn about what structures will allow us to maximize health system transformation and improvements in population health?
2. SIM’s public/private collaboration, including our SIM Steering Committee and individual workgroups – Similarly, what is the right, ongoing structure for the collaboration between community partners and the state in achieving health system transformation?
3. Individual SIM-funded projects – As noted above, which of our funded projects can be sustained and how?
4. Shared knowledge and learning from the overall SIM initiative – What else should we take from the initiative, to ensure that we maximize learning from the entire enterprise?

Draft Sustainability Planning Workplan (As of April 25, 2018)

The following information represents RI SIM’s workplan for sustainability planning:

1. *Open the Conversation*

The first two meetings of the Sustainability Workgroup, plus a conversation at the SIM Steering Committee, were intended to surface ideas, concerns, questions, and external considerations from stakeholders to inform our process, within the four key SIM components noted above. The staff team is reviewing the information gleaned from these conversations and will ensure that the stakeholder input is included in the process moving forward. Most of the feedback is centered in the following categories:

- System transformation & payment reforms;
- Population health improvement;
- Collaborative, system-wide, state level health planning;
- Understanding and sustaining successful infrastructure supported by SIM, especially public/private partnership, and the culture of collaboration;
- Financial considerations and funding strategies;
- Key environmental considerations, both internal and external;
- Evaluation and measuring value, impact and return on investment; and
- Strategies for shared knowledge and learning.

2. *Specific Sustainability Planning Activities*

Using the following key considerations as the starting point for our investigation, the staff and Interagency Team are taking the lead in reviewing our overall transformation efforts. The Sustainability Workgroup will provide feedback and guidance at critical junctures. Key considerations:

- Impact/Reach—What do we know now? What else do we need to know in the future? Are we collecting the metrics needed to answer future questions?
- Environmental Review—What questions do we need answered?
- Key Stakeholders/Partners Review—needs to be involved in determining future of this project/aspect of SIM? What level of support – and from whom – currently exists?
- Additional Brainstorming—Are there Other Considerations for Sustainability (i.e. external/internal forces, cost, infrastructure, other dependencies, policy direction, etc.)?
- Cost Framing—What Will Sustainability Cost? This can include necessary financial investments and HR/staff time.

As part of these activities, we will consider the following types of data and information as inputs to inform this assessment:

- Metrics collected from SIM-funded projects;
- State population health goals & other priorities of the state administration;
- Data and evaluation results from SIM-funded projects and other SIM activities;
- Environmental scan and other research;
- Research from other initiatives outside of Rhode Island; and
- Use of national technical assistance resources through CMMI.

We will also be meeting and working with the CMS All Payer Team, to discuss the possibility of creating an all-payer model for Rhode Island with Medicare, as a part of our work to sustain our health system transformation model.

3. *Recommendations to the Steering Committee*

The outcome of the work noted above will be a set of recommendations to the SIM Steering Committee, at its June or July meeting. The staff and interagency teams will carry out the analysis of the inputs referenced above, and craft an initial draft of recommendations to the Steering Committee. We will vet these with key leadership and stakeholders before presenting the recommendations to the Steering Committee. The recommendations will include action steps and strategic priorities for AY4 to ensure the future sustainability of the health system reforms and population health improvements that have been supported by the overall SIM initiative once the grant period ends in June 2019. Our goal is to bring this work to the Steering Committee, presenting a draft for initial feedback in June and completing the approval process at the July Steering Committee meeting. The recommendations will include:

- Strategic priorities that reflect the SIM Steering Committee’s commitment to achieving Rhode Island’s End State Vision, to be submitted to CMS in Quarter 1 of AY4.
- Actions to be taken in AY4 to clarify health system sustainability planning, population health improvements, and specific sustainability activities reflecting the Sustainability Planning Framework’s Four Key Components. Specific actions are included throughout our AY4 Workplan.

4. *Implementation of Recommendations*

A major thrust of our AY4 activities will be to implement the action steps referenced above, as we continue the oversight of our SIM-funded projects and other activities, such as Integration and Alignment. Our staffing resources will be split between this ongoing oversight and sustainability activities (and thus our staffing budget will be split in this way as well). Our Interagency Team will split its work between ongoing project oversight and sustainability planning and implementation as well. The Sustainability Workgroup will continue to provide insights and support as we look forward. We will communicate with CMS on the progress and outcomes of this work in the following ways:

- Biweekly calls with our Program Officer Gigi Kuberski;
- Regular materials sent to Ms. Kuberski and our technical assistance team;
- Quarterly reports;
- Operational Plan–Sustainability Sections Parts I and II;
- Part I—End State Vision, State Accomplishments, and Changes in Environment submission by September 30, 2018. It will include:
 - Rhode Island’s detailed end state vision—We will document our targets and our desire to continue the payment and delivery system reforms that we have been undertaking within OHIC and Medicaid.
 - Our state accomplishments to date, with a focus on our SIM work, and the work throughout our state agencies that has been SIM’s foundation.
 - A review of any expected changes in state leadership.
 - Our lessons learned thus far through SIM
- Part II—Roadmap for Sustaining SIM Investments submission by December 31, 2018 (later amended to January 30, 2019). It will include:
 - A detailed plan for sustainability our major SIM investments to achieve our End State Vision.
 - We have included sustainability planning throughout our project workplans in this document.

- We acknowledge that some investments may continue by transitioning to other state agencies and/or funders, some may evolve, and some may end.
- We will include an analysis of the work to that point, focusing on the implementation and effectiveness of our model and individual funded activities.
- We will discuss the scaling and other activities that it will take to sustain our initiatives.
- We look forward to requesting additional TA for our sustainability work if necessary.

Stakeholders and Roles

With an effort this large, we plan to use our human resources effectively. Here are the roles that our stakeholders are playing:

Sustainability Workgroup

The SIM Sustainability Workgroup, chaired by SIM Steering Committee Vice Chair Larry Warner, includes SIM Steering Committee members, SIM Interested Parties from throughout the Rhode Island healthcare and social service community, SIM vendors, state agency leadership and staff, and SIM core staff members. As noted above, the Workgroup's main objective is to help guide the development of a set of Sustainability Recommendations for consideration by the full Steering Committee in Spring 2018 and then to continue to inform and guide the implementation activities. As noted above, the adoption and implementation of the final recommendations to ensure future sustainability will direct SIM's work in the fourth year of the federal grant (July 2018 – June 2019). All Sustainability Workgroup sessions are open, public meetings and SIM encourages diverse and full participation. Meeting materials are posted on the RI Secretary of State website as well as on the SIM Meetings and Agendas webpage.

SIM Staff and Interagency Teams

As described above, members of the SIM Staff and Interagency Teams are charged with preparing the recommendations to be presented to the Steering Committee after vetting by state leadership and Sustainability Workgroup members – and then with carrying out the approved activities. State staff will consult subject matter experts from inside and outside state government, including our SIM vendors.

SIM Steering Committee and State Government Leadership

As the SIM decision-making body, the SIM Steering Committee will approve a final Sustainability Plan and oversee its implementation by state agency leadership, the state Interagency Team, and SIM Staff. Throughout this process, EOHHS, OHIC, and HSRI leadership play a key role in guiding and vetting ideas to be put forward to the Steering Committee.

Healthcare and Social Service Sector Leadership

Our stakeholders include key healthcare leaders (including those from the areas of primary care, behavioral health, oral health, hospital, and carrier communities) plus those leaders focused on the social and environmental determinants of health with diverse perspectives to share in this process. SIM will be sure to gather their opinions through the Steering Committee, Sustainability Workgroup, and through other discussions throughout the spring.

Final Products

By December 2018, we will have a multi-part Sustainability Roadmap that will include:

- A documented sustainability planning process;
- The set of recommendations voted on by our Steering Committee to move our work in AY4 toward continuing our health system transformation and population health improvement work; and
- Rhode Island's End State Vision Document and Roadmap for Sustaining SIM Investments (described above).

Together, the work products will reflect:

- Buy-in from key state leaders to ensure that our end state vision is aligned with the state's health planning priorities;
- Integration of CMS Sustainability Planning Deliverables and deadlines;
- Alignment with other SIM streams of work that will have an impact on and inform the planning effort including:
 - Communication and Outreach—SIM, vendors/partners, and agencies highlighting SIM;
 - SIM-led Evaluation—both efforts commissioned by SIM and led by individual vendors;
 - Vendor management—to ensure that all metrics needed are collected and timely; and
 - National Evaluation—including any information gleaned from RTI reports.

Contact Information

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