

Rhode Island State Innovation Model (SIM) Test Grant

Better Health, Better Care, and Lower Cost



Operational Plan Version 1

April 28, 2016

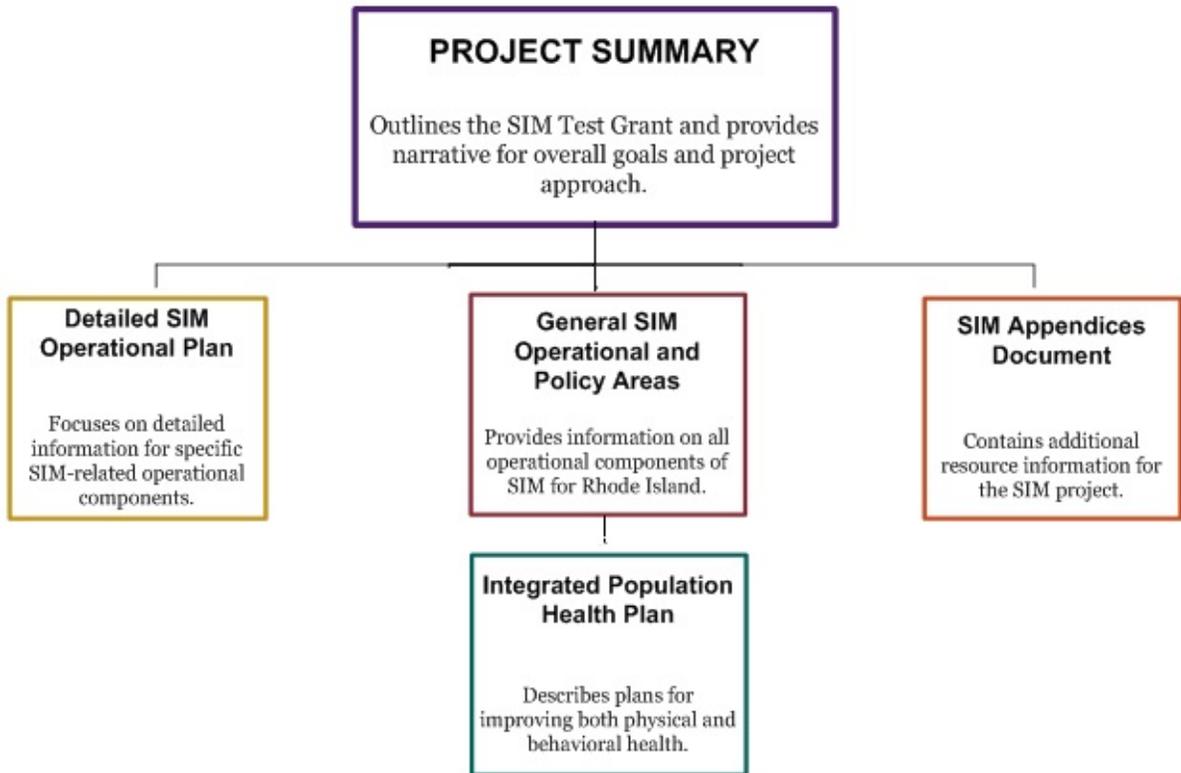
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Visual Organization of the Operational Plan

RHODE ISLAND STATE INNOVATION MODEL (SIM) TEST GRANT Visual Organization of Planning Documents



A. Project Summary

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

Project Narrative

Overview

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

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

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

We are taking an approach that combines aspiration and pragmatism. Our top priority is to improve population health, with an eye on the social and environmental determinants of health, and to align our work on payment reform and delivery system transformation across multiple state agencies and market segments. Our second priority is to identify the ways we can make changes in our small state by leveraging relationships that exist within our communities, and finding new ways to make strategic decisions together. And our third priority is to leverage existing funding while also attracting new funding and reinvesting savings that will allow us to continue to innovate and to sustain the opportunities that SIM dollars are giving us to support higher quality care, for better health, at a lower cost. These priorities are embedded in our Integrated Population Health Plan and Healthcare Delivery System Transformation Plan contained herein.

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

1. Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing and regulatory levers. Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an Alternative Payment Model (APM) by 2018, and 80% of payments linked to value.
2. Support for multi-payer payment reform and delivery system transformation with investments in workforce and health information technology.
3. Significant stakeholder engagement in policy development and SIM investment decisions through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups. In Rhode Island, healthcare delivery system transformation is a public-private partnership.
4. Fidelity to our Integrated Population Health Plan to ensure that transformation is aligned with our vision of improved integrated physical and behavioral health for the state's residents.

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

Rhode Island’s Operational Plan - The Rhode Island State Innovation Model (SIM) Test Grant Operational Plan is a result of continued effort dating back to 2013 when Centers for Medicare and Medicaid Services (CMS) awarded Rhode Island \$1,631,042 to participate in the first round of a multi-year grant. This grant intended to “improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states.” In round one, 25 states were awarded almost \$300 million to develop or test models for health care payment and service delivery reform.

By early 2014, Rhode Island had completed the work of round one through an extensive stakeholder engagement process led by the office of then-Lt. Governor Elizabeth Roberts, with technical assistance from The Advisory Board. The result was the *Rhode Island State Healthcare Innovation Plan: Better Health, Better Care, Lower Cost*. In July 2014, Rhode Island applied for the second round of SIM awards in order to test its model design. As part of round two, 32 awardees received \$660 million. Rhode Island has received a \$20 million award to test its healthcare payment and service delivery reform model using this Operational Plan as the guiding document. The Plan includes an in-depth description of our SIM components fulfilling all of the CMS requirements, and a significant Integrated Population Health Plan that looks equally at physical and behavioral health.

Vision

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

*Continuously improving Rhode Islanders’ **experience of care** (including quality and satisfaction), enhancing the **physical and behavioral health** of all Rhode Island’s population, and **reducing the per capita cost** of healthcare for our residents.*

Mission

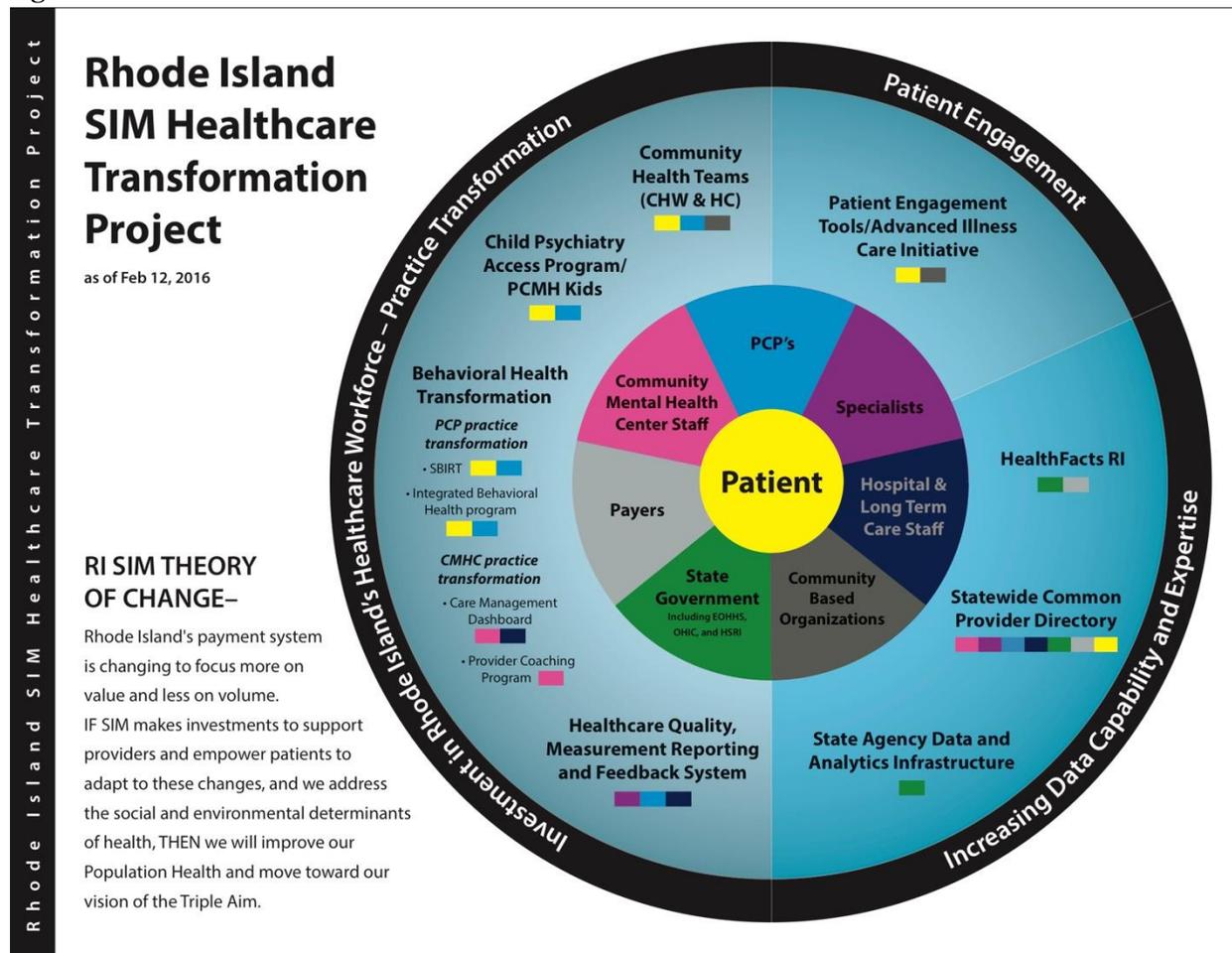
The mission of the Rhode Island SIM Test Grant is to significantly advance progress towards making this vision a reality. To accomplish this, the following mission statement has been established:

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

SIM Theory of Change

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

Figure 1: Rhode Island SIM Transformation Wheel



Core Pillars

All decisions, planned activities, and investments related to the Rhode Island SIM Test Grant represent one or more of the overarching pillars established for this effort. These four core pillars support Rhode Island SIM initiatives and efforts:

- *Investment in practice transformation & development of the healthcare workforce;*
- *Empowerment of patients;*
- *Access to increased data capacity and expertise; and*
- *Shared decision-making authority through a strong public/private partnership.*

Guiding Principles

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

1. *We begin with a commitment to empowering individuals, families, and communities to improve their own health.*

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

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

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

3. *We will improve our ability to collect, share, and use data to drive action.*

Assessment of whole-person health outcomes, risk factors/determinants, interventions, and policy effectiveness requires usable, sustainable, and shared surveillance systems that produce timely measures for action and data. That data is also only truly useful if it is available across institutional or organizational boundaries through accessible and user-friendly health information technology. Our Rhode Island SIM Test Grant Operational Plan and our Integrated Population Health Plan stress the importance of strengthening our data sources and empowering our communities to use those sources effectively to better coordinate care. Rhode Islanders deserve tools to help them make informed decisions about their personal health and the overall health of the state. The Rhode Island SIM Test Grant will use the data we produce and analyze to evaluate our activities on a regular basis and to ensure that we are spending our dollars as effectively as possible.

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

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

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

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

6. *We are committed to recognizing the importance of and addressing the social and environmental determinants of health and health equity.*

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

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

Rhode Island is committed to empowering physical and behavioral healthcare providers to transform their practices “to improve the quality of care, the patient experience of care, the affordability of care, and the health of the populations they serve.” Specifically, providing assistance to grow and strengthen the presence of Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs) and Community

Behavioral Health Centers of Excellence. This empowerment includes support for changes in approach and infrastructure, as well as opportunities to actively participate in the state’s overall efforts to transform our delivery system. Workforce development also plays a role in these efforts, giving providers the skills and additional team members they need to provide comprehensive whole person care.

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

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

Background

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

Historical Context

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

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

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

blocks to improve our population health. However, we also face difficult roadblocks to our population health, such as:

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

Even with our high quality healthcare providers, most would agree that our “healthcare system” lacks coordination among providers, rewards providers with little or no regard to the quality of the care given, and struggles to meet the needs of all patients in terms of access. Now is the time to make the changes we need. Our SHIP plan paved the way with a call for real reforms, noting that “given the current environment of change in healthcare, the window of opportunity to change the healthcare system is open wider than it has been in a generation.” The implementation of federal reforms, changes in the market, aging of the population, and breakdown of the old business model have created an impetus for change. This impetus is further supported by the recent increase in the number of Rhode Islanders covered by health insurance.

Rhode Island is primed for change and innovation, ready to take advantage of the opportunity to shape our healthcare system for the future, focused on lifelong support of physical and behavioral health and wellness, population health, coordinated models of care, and payment transformation. Our leaders came together through the SHIP process and agreed to pursue a sustainable system of supports and services to attain and promote health, as defined above, for all of our residents. In doing so, these leaders recognized that through creative partnerships and hard work, individuals and families can partner with our payers, providers, and health-related community based organizations to attain a new system of care.

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

Driver Diagram

Table 1: Driver Diagram

Vision
<p>IMPROVE THE HEALTH OF RHODE ISLANDERS</p> <p>Create measurable improvements in Rhode Islander's physical and mental health. Targeted measures include, but are not limited to, rates of diabetes, obesity, tobacco use and depression.</p>

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
<p>REDUCE RATE OF INCREASE IN RHODE ISLAND HEALTHCARE SPENDING</p> <p>Move to a “value-based” health care system that pays health care providers for delivering measureable high quality health care, rather than paying providers for the volume of procedures, office visits, and other required services that they deliver.</p>	<p>Change our payment system (all-payer) to 80% value-based by 2018, with 50% of payments in alternative payment methodologies</p> <p>Increase use of data to drive quality and policy</p>	<p>Using plan design, regulatory levers, purchasing/ contracting, and SIM investments, maximize plan choices that support team-based models of care</p> <p>Aligning quality measures for healthcare contracting</p> <p>Enhance and/or create programs to address needs of high utilizers coordinated across payers</p>	<p>(1.1 - 1.2) Continue to implement OHIC's Affordability Standards and Medicaid's Accountable Entities; ensure their alignment and integration with other state and private VBP activities</p> <p>Create an ongoing governance structure to implement the prioritized measure set</p> <p>(1.3 - 1.6) Support integrated Community Health Teams</p>	<p><i>Payer Participation / Health System Landscape Metrics:</i></p> <p>(1.1) Percentage of payments made under an Alternative Payment Model. (1.2) Percentage of payments linked to value.</p> <p><i>Community Health Team Metrics:</i></p> <p>(1.3) Number of active Community Health Teams (CHTs). (1.4) Percent of eligible population served by CHT. (1.5) Percent of referrals served by CHT. (1.6) Percent of Rhode Island residents with access to CHT.</p>	<p>(1.1) 50% by 2018 (1.2) 80% by 2018</p> <p>(1.3 - 1.6) CHT metric targets are in development and will be incorporated into procurement.</p>

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
<p>REDUCE RATE OF INCREASE IN RHODE ISLAND HEALTHCARE SPENDING Move to a “value-based” health care system that pays health care providers for delivering measureable high quality health care, rather than paying providers for the volume of procedures, office visits, and other required services that they deliver.</p>	<p>Change our payment system (all-payer) to 80% value-based by 2018, with 50% of payments in alternative payment methodologies</p> <p>Increase use of data to drive quality and policy</p>	<p>Maximize the use of Rhode Island’s All Payer Claims Database; Complete the Common Provider Directory; Create a Health Care Quality Measurement, Reporting, and Feedback System</p> <p>Enhance state agencies’ data and analytic infrastructure by modernizing the state’s current Human Services Data Warehouse</p>	<p>(1.7) Maximize the use of HealthFacts RI: Support and maintain the claims data collection process; support advanced reports and analytics; and support the coordination of data validation, release, and analysis.</p> <p>(1.8 - 1.9) Complete the Common Provider Directory: Consolidate provider data from multiple sources into a single “source of truth” record; increase the understanding of provider-to-organization relationships; Provide a public portal to search for and locate providers; Provide mastered provider data extracts to integrate into state systems.</p> <p>(1.10) Create a Health Care Quality Measurement, Reporting, and Feedback System that will consolidate quality reporting requirements and facilitation in one place to reduce the reporting burden on providers; Create a provider benchmarking and feedback system to communicate quality back to those who provide care; Provide quality information to the public to support making informed healthcare decisions.</p> <p>Modernize the state’s current Human Services data Warehouse to create an integrated data ecosystem that uses analytic tools, benchmarks, and visualizations; Carry out Qualitative and quantitative evaluation of the effect of alternative payment models in use in Rhode Island and the value of more closely aligning the models across payers</p>	<p>(1.7) Number of publically available reports released from HealthFacts RI.</p> <p>(1.8) Number of state agencies using provider directory.</p> <p>(1.9) Number of private sector health care organizations using provider directory.</p> <p>(1.10) Number of health care organizations/practices sending data to and using data from the Health Care Quality Measurement, Reporting, and Feedback System.</p>	<p>(1.7) X number of reports per quarter.</p> <p>(1.8 - 1.9) Targets are in development.</p> <p>(1.10) By 2018, system is in production and begin piloted with 5-10 practices.</p>

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
<p>SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION Support health care providers in their transition to delivering health care in an environment in which the care is paid for according to a value-based payment arrangement. SIM will invest in work place transformation activities that build upon the professional expertise of x% of Rhode Island's healthcare workforce.</p>	<p>Maximize & support team-based care</p> <p>Better integrate behavioral health into primary care</p> <p>Investments in Rhode Island's Healthcare Workforce</p>	<p>Using plan design, regulatory levers, purchasing/contracting, and SIM investments, maximize plan choices that support team-based models of care</p> <p>Make investments in the following programs for practice transformation: Community Health Teams (CHTs), PCMH Kids, Child Psychiatry Access program, Community Mental Health Center supports, and Health Care Quality Measurement, Reporting, and Feedback System</p>	<p>(2.1 - 2.2) Create 3 new CHTs; Investigate the need for a more formal CHT training and certification program; Provide training to providers (PCPs, CMHCs and hospitals) to better incorporate CHTs into their practices;</p> <p>(2.3) Support the PCMH expansion to 9 pediatrician sites</p> <p>(2.4 - 2.5) Provide child psychiatry consultation services to pediatrician practices; Train PCPs to expand their ability to treat some behavioral health needs in their practices</p> <p>(2.6) Support integration of behavioral health into primary care by providing resources and training for SBIRT in PC practices and evaluation/data collection for 12 Integrated Behavioral Health Model practices.</p> <p>(2.7) Support CMHCs with practice transformation and to receive data about their patients; and</p> <p>Assist providers in aggregating data from their Electronic Health Records, to help make reporting and practice transformation easier; Provide training to providers in how to interpret the data to make positive changes within their practices; Pursue making this quality data available to patients.</p>	<p>(2.1) Number of Community Health Workers certified.</p> <p>(2.2) Number of providers (practices) trained to better incorporate CHTs into their practice.</p> <p>(2.3) Number of clinicians participating in pediatric PCMH program.</p> <p>(2.4) Number of pediatricians who have on-demand access to pediatric behavioral health consultation services.</p> <p>(2.5) Number of pediatricians who have been trained to provide basic psychiatric assessment and treatment services.</p> <p>(2.6) Number of PCPs who have been trained in SBIRT, have access to SBIRT support, and attest to having a reliable location to which patients can be referred for treatment.</p> <p>(2.7) Number of real-time ED and inpatient dashboards in use at CMHCs.</p>	<p>(2.1 - 2.2) Targets in development and will be incorporated into procurement.</p> <p>(2.3) 65 clinicians, including NPs and PAs, by 2016.</p> <p>(2.4 - 2.5) Targets in development and will be incorporated into procurement.</p> <p>(2.6) By 2018, at least [x#] of PCPs and primary care clinicians will have been trained in SBIRT, have on-demand access to SBIRT support, and attest to having a reliable location to which patients can be referred for treatment. By 2018, at least 12 Integrated Behavioral Health Model practices will be in operation and provide ongoing data and analysis to a convening group to support patient outcome measurement and intervention effectiveness.</p> <p>(2.7) By 2018, a real-time ER and Inpatient dashboard will be in production at all CMHCs, who will use the dashboard daily to monitor and improve the care of their patients; By 2018, all CMHCs will have received enhanced training on integrated primary and behavioral healthcare that is appropriate for their populations and techniques for consistent coordination with their patients' primary and secondary care resources (if outside the CMHC).</p>

AIM	PRIMARY DRIVER	SECONDARY DRIVER	INTERVENTIONS	METRIC(S)	TARGET(S)
<p>EMPOWER PATIENTS TO BETTER ADVOCATE FOR THEMSELVES IN A CHANGING HEALTHCARE ENVIRONMENT AND TO IMPROVE THEIR OWN HEALTH</p> <p>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.</p>	<p>Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning</p>	<p>Patient engagement tools or processes</p> <p>End-of-Life/Advanced Illness Care Initiative outreach, and patient and provider education</p>	<p>Create or implement existing processes or tools that allow patients more control of their health and healthcare decision-making; Train providers and patients in how to use these tools to maximize their effectiveness</p> <p>Increase the number of Rhode Islanders with Advance Directives through training of providers and patients; Ensure that Rhode Islanders can upload their Advance Directives to Current Care</p> <p>Use Community Health Teams to help implement Patient Empowerment tools</p>	<p>Metrics in Development</p>	<p>Targets in Development</p>

Core Metrics and Accountability Targets

Core Metric Set

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

Metrics, Baselines, and Accountability Targets

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

Table 2: Metrics, Baselines, and Targets

Milestone/ Objective	Metric	Baseline	Target	Note(s)	Metric Type
Model Performance Metrics are under development.					Model Performance
Move to a value- based health care system that pays healthcare providers for delivering measurable high quality care, rather than paying for volume.	Percentage of payments made under an APM.	2014: 24% Commercial 2014: X% Medicaid	2018: 50%	Commercial refers to commercial fully insured. Medicaid payments reflect those made by Managed Care Organizations. Reporting will be annual or semi- annual.	Payer Participation
Move to a value- based health care system that pays healthcare providers for delivering measurable high quality care, rather than paying for volume.	Percentage of payments linked to value.	2014: X% Commercial 2014: X% Medicaid	2018: 80%	Commercial refers to commercial fully insured. Medicaid payments reflect those made by Managed Care Organizations. Reporting will be annual or semi- annual.	Payer Participation
Support Integrated Community Health Teams	(a) Number of active Community Health Teams. (b) Percent of eligible population served by Community Health Team (c.) Percent of referrals served by CHT. (d) Percent of Rhode Island residents with access to CHT.		Targets under development.		Model Participation

Milestone/ Objective	Metric	Baseline	Target	Note(s)	Metric Type
Investigate the need for a more formal CHW training and certification program; Provide training to providers (PCPs, CMHCs and hospitals) to better incorporate CHTs into their practices;	(a) Number of Community Health Workers certified. (b) Number of providers (practices) trained to better incorporate CHTs into their practice.				Other
Complete the Common Provider Directory: Consolidate provider data from multiple sources into a single “source of truth” record; increase the understanding of provider-to-organization relationships; Provide a public portal to search for and locate providers; Provide mastered provider data extracts to integrate into state systems.	(a) Number of state agencies using provider directory. (b) Number of private sector health care organizations using provider directory.	2016: 0	Targets under development		Other
Create a Health Care Quality Measurement, Reporting, and Feedback System that will consolidate quality reporting requirements and facilitation in one place to reduce the reporting burden on providers; Create a provider benchmarking and feedback system to communicate quality back to those who provide care; Provide quality information to the public to support making informed healthcare decisions.	(a) Number of health care organizations/ practices sending data to and using data from this system.	2016: 0	(a) By 2018, system is in production and being piloted with 5-10 practices		Other

Milestone/ Objective	Metric	Baseline	Target	Note(s)	Metric Type
Provide child psychiatry consultation services to pediatric practices; Train PCPs to expand their ability to treat some behavioral health needs in their practices	(a) Number of pediatricians who have on-demand access to pediatric consultation services. (b) Number of pediatricians who have been trained to provide basic psychiatric assessment and treatment services.	2016: 0	Targets under development		Model Participation
Support integration of behavioral health into primary care by providing resources and training for SBIRT in PC practices and evaluation/data collection for 12 Integrated Behavioral Health Model practices.	(a) Number of PCPs who have been trained in SBIRT by the program, have access to SBIRT support, and attest to having a reliable location to which patients can be referred for treatment.	2016: 0	Targets under development		Other
Support CMHCs with practice transformation and to receive data about their patients;	(a) Number of real-time ER and Inpatient dashboards in use at CHMCs.		Targets under development		Other

Master Timeline

Table 3: Master Timeline

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Planning & Governance															
Overall Program Management and Strategic Planning	Marti Rosenberg														
Lead the SIM core team															Weekly meetings
Oversee vendors															Regular supervision
Lead monthly Steering Committee meetings															Monthly meetings
Creation of the SIM Operational Plan															6/30/2016
Integrated Pop Health Plan (IPH) (Population Health & Behavioral Health)	James Rajotte/ Ann Detrick														
Complete for integration into Operational Plan															6/30/2016
Continued development of IPH															
Ongoing oversight of IPH implementation															
Reporting	Marti Rosenberg														
Quarterly Reports															Quarterly Submissions - Feb, May, Aug, No
Annual Reports															
Investing in Rhode Island's Healthcare Workforce and Practice Transformation															
Practice Transformation Activities															

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Community Health Teams (CHT)	Sarah Nguyen/James Rajotte, with Hannah Hakim														
Participate in Community CHT Workgroup															Monthly meetings
Procurement															
Implementation															
Child Psychiatry Access Program	Ann Detrick														
Procurement															
Implementation															
PCMH Kids	Sarah Nguyen														
Procurement															
Implementation															
Behavioral Health Transformation	Ann Detrick														
<i>Integrated Behavioral Health</i>															
Contracting															
Implementation															
SBIRT															
Procurement															
Implementation															
<i>CMHC Provider Coaching</i>															
Procurement															

SIM Component/Project Area	Component/ Project Lead	Yr	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		1	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	
		4	1	2	3	4	1	2	3	4	1	2	3	4	
Implementation															
<i>Care Management Dashboards</i>															
Contracting															
Implementation															
Healthcare Quality, Measurement Reporting & Feedback System	Melissa Lauer														
Convene meetings of SIM Tech Reporting Workgroup															Monthly meetings
Procurement															
Implementation															
Additional Healthcare Workforce Development															
Convene meetings of a Healthcare Workforce Workgroup to study additional workforce development needs															Consider monthly meeting
Patient Engagement															
Patient Engagement Tools - Details TBD	Ann Detrick/ Melissa Lauer														
Convene meetings of SIM Patient Engagement Workgroup															Monthly meetings
Procurement															
Project Implementation															
End-of-Life/Advanced Illness Care Initiative	Ann Detrick/ Melissa Lauer														

SIM Component/Project Area	Component/ Project Lead	Yr 1	Year 2				Year 3				Year 4				Milestone(s) with Due Dates
		Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Contracting															
Project Implementation															
Increasing Data Capability and Expertise															
Statewide Common Provider Directory	Melissa Lauer														Procured
Project Implementation															
HealthFacts RI (APCD)	Melissa Lauer														Procured
Project Implementation															
State Agency Data and Analytics Infrastructure	Kim Paull														
Procurement															
Implementation															
Using State Regulatory Levers															
Measure Alignment	Cory King														
Implementation of chosen measures															
Ongoing governance of measure alignment through the Measure Alignment Workgroup and Bailit Health Care															Monthly meetings/ Procured
Annual measure review, using the Measure Alignment Workgroup															
Other Regulatory Levers	Cory King/ James Rajotte														

SIM Component/Project Area	Component/ Project Lead	Yr	Year 2				Year 3				Year 4				Milestone(s) with Due Dates	
		1	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q		
		4	1	2	3	4	1	2	3	4	1	2	3	4		
Review of available regulatory levers, using State Interagency Team and other Workgroups																
Addition of new levers, as necessary or appropriate																
Evaluation																
Federal Evaluation	Marti Rosenberg															
Participating in regular communications with national evaluation team																Monthly meetings
Assistance with site visits when needed																
Rhode Island-based evaluation, including Learning Collaborative on Payment Reform Effectiveness	James Rajotte															
Procurement																
Project Implementation																
Internal Tracking of Measures	Cory King, with all SIM Staff															
Procurement																
Project Implementation																

Budget Summary Table

Table 4: Budget Table

SIM Component	Projected Expenditure	Goal/ Primary Driver	Metric
Community Health Teams	\$2,000,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	(a) Number of active Community Health Teams. (b) Percent of eligible population served by Community Health Team (c.) Percent of referrals served by CHT. (d) Percent of Rhode Island residents with access to CHT.
Child Psychiatry Access Program	\$650,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	a) Number of pediatricians who have on-demand access to pediatric consultation services. (b) Number of pediatricians who have been trained to provide basic psychiatric assessment and treatment services.
PCMH Kids	\$500,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Number of clinicians participating in the program.
Behavioral Health Transformation: <i>SBIR</i>	\$480,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	(a) Number of PCPs who have been trained in SBIRT by the program, have access to SBIRT support, and attest to having a reliable location to which patients can be referred for treatment.
Behavioral Health Transformation: <i>Integrated Behavioral Health</i>	\$370,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	Metric(s) in development
Behavioral Health Transformation: <i>Care Management Dashboards</i>	\$150,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	(a) Number of real-time ER and Inpatient dashboards in use at CHMCs.

SIM Component	Projected Expenditure	Goal/ Primary Driver	Metric
Behavioral Health Transformation: <i>Practice Coaching at Community Mental Health Centers</i>	\$1,200,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	(a) Number of CMHCs served by the program.
Healthcare Quality, Reporting, Measurement and Technology Feedback System	\$1,750,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce	(a) Number of health care organizations/ practices sending data to and using data from this system.
Patient Engagement & End-of-Life/Advanced Illness Care Initiative	\$2,200,000	Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning	Metric(s) in development.
HealthFacts RI (Rhode Island's All-Payer Claims Database)	\$2,039,673	Increase use of data to drive quality and policy	N/A
Statewide Common Provider Directory	\$1,500,000	Increase use of data to drive quality and policy	a) Number of state agencies using provider directory. (b) Number of private sector health care organizations using provider directory.
Integrated Health and Human Services Data Ecosystem	\$1,800,000	Increase use of data to drive quality and policy	N/A
SIM Project Director and Staffing Across Five Partner Agencies	\$3,000,000	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
Project Management Vendor	\$1,600,000	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
Evaluation	\$700,000	Create measureable improvements in Rhode Islander's physical and mental health.	N/A
Other Expenses	\$60,000	N/A	N/A
Total	\$19,999,673		

B. Detailed SIM Operational Plan

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

Narrative Summary of SIM Components

Rhode Island SIM Components

The focus areas of the Rhode Island State Innovation Model (SIM) Test Grant reflected in the SIM Transformation Wheel are the foundational components for this funding investment. Given the overarching aims of SIM, Rhode Island's values, and the current landscape, the Steering Committee has committed to the following components aimed at overall health system change. The components described below and summarized in the SIM Component Summary Table on Page 37 are as follows:

- Planning and Governance;
- Investments in Rhode Island's Healthcare Workforce and Practice Transformation;
- Patient Engagement;
- Data Capability;
- Regulatory Levers; and
- Evaluation.

Planning and Governance

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

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

Ms. Rosenberg also oversees the work of UMass Medical School (UMASS), the SIM Project Management Vendor. UMASS came on board in January 2016 to manage related project management activities including support for stakeholder management, project meetings, data collection, risk management, communications, sub-contractor management, and work plan management. UMASS has also subcontracted with the Technical Assistance Collaborative (TAC) and the Providence Plan (Prov Plan) to provide expertise in behavioral health and physical health, respectively, and write the Integrated Population Health Plan.

Investing in Rhode Island's Healthcare Workforce and Practice Transformation

Community Health Teams (CHTs):

Community health teams are a critical component of Rhode Island's SIM plan. CHTs currently serve as extensions of primary care, helping patients meet unaddressed social, behavioral, and environmental needs that are having an impact on their physical health. Overall, CHTs serve three critical functions:

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

All CHTs employ community health workers who are non-licensed generalists serving as peer navigators, care coordinators, or resource specialists. Many teams also include a licensed behavioral health provider and nurse care manager who are considered health coaches. Some CHTs also have other health coaches, such as licensed professionals in pharmacy or nutrition, as well as healthcare professionals serving as clinical educators. CHTs also serve as an educator and resource to healthcare professionals by teaching healthcare workers about the benefits of: CHTS in general, patient-centered care, simultaneous treatment of behavioral and physical health needs, and on how addressing patients' social needs will aid in improving health. CHTs are also specifically focused on the following objectives:

- Through active identification and outreach, assisting individuals and/or families to develop ongoing and consistent relationships with primary care providers and obtain primary care services based on their need;
- Helping staff extend their reach and actively engage patients or families who are at high risk in primary care, home based and community settings;
- Enhancing continuity of care for patients by sharing information through electronic or other means (consistent with the language and literacy needs of the patient or their family);
- Increasing the ability of patients and families to access appropriate community services and resources to address identified social, behavioral, environmental and complex medical needs that have an impact on health

In order to maximize improvements in Rhode Island's population health, address and improve our social and environmental determinants of health, and make progress in eliminating health disparities within our state, CHTs services should be available to all Rhode Islanders who need that level of multi-disciplinary, community-based services to address the factors that impact our health. We have adopted the following criteria to identify individuals considered at "highest risk" and who are eligible for CHT services:

- Individuals who have three or more known chronic conditions;
- Individuals who have two or more special healthcare needs (i.e., disabilities);
- Individuals who are not accessing primary care regularly;
- Individuals who are unable to access healthcare due to cost; and
- Individuals who have three or more in-patient or emergency department visits within six months.

Given the current estimated need for those at “highest-risk” and the even larger need for full community access, it is clear that SIM funding is limited in what it can address adequately. The ability of CHTs to adequately serve clients to address social and environmental determinants of health also depends on the existence of adequate social services and supports in the larger community. And thus, the Steering Committee has decided to prioritize a segment of Rhode Island for services. SIM will invest the money allocated for CHTs to meet significant, unmet need as determined by our Integrated Population Health Plan (IPHP) and data from relevant state agencies. SIM’s investment will also include data collection from the CHTs we fund, to explore sustainability options and opportunities for expansion over time.

At this time, SIM funded teams will be required to participate in a coordinated statewide approach to operation, management, and oversight of CHTs. This approach to a centralized yet collaborative provision of overarching infrastructure aims to maximize alignment with state policy and health reform goals, as well as reduce duplication of effort and operational costs. Within this framework, clinical oversight would appropriately remain at the community-level.

The SIM Steering Committee approved the following plan, which reflects conversations that have happened in workgroups or other forums:

1. SIM will invest in enhancements for the current Community Health Teams with the following:

- Centralized, statewide training and professional development—including promotion of community health worker (CHW) certification;
- Platforms for information sharing (e.g., care management dashboards and shared plans of care);
- Development, collection, and sharing of screening/other clinical tools for inter-team implementation; and
- Development and evaluation of a financial model for long-term sustainability.

2. SIM will invest in up to two new teams:

SIM is committed to funding one or two new CHTs to bring this model’s benefits to more people, particularly those located in underserved areas or areas currently not served in the state. Additional emphasis may be placed on geographic locations where there is evidence that there is an increased need for these types of patient-centered services. Minimum requirements for a CHT to receive funding include the following:

- A new CHT should be multi-disciplinary, payer agnostic, connected with primary care, and consist of both community health workers and health coaches;
- CHWs are non-licensed generalists with a CHW certification (in the absence of certification, those currently acting as peer navigators/care coordinators/resource specialists are considered CHWs).
- Health coaches are licensed healthcare professionals with community health focus and/or specialization who provide clinical education and input into clinical decisions related to care.
- The composition of the CHT and the disciplines participating in the teams should reflect the needs and diversity of the community being served;
- The CHT should be accessible to all individuals regardless of insurance (i.e., the CHT funded by SIM should not exclude anyone because of the insurance that they have or because they are uninsured); and

- The CHT should work directly in the home or the community to address factors that impact people’s health, including social, behavioral, and environmental determinants of health.
- SIM is also prepared to fund the oversight, data collection, and financial support for all existing multi-payer Community Health Teams, to align the teams’ day-to-day work, streamline administrative operations, and save money.

Child Psychiatry Access Program and Patient-Center Medical Homes for Kids:

The pediatric psychiatry referral consultation system will establish a children’s mental health consultation team to work with primary care providers to meet the needs of children with mental health care needs. The program is based on the model implemented in Massachusetts, which consist of regionally based teams that provide real-time telephone consultation with child psychiatrists, face-to-face appointments for acute evaluations, and assistance with accessing community-based behavioral health services.

The Access Program is designed to assist pediatricians in their efforts to manage children with behavioral and mental health needs in a way that is preventive and responsive to a patients’ immediate need. The funding will create an entity capable of responding to the immediate management needs of children with behavioral health concerns by providing pediatricians with consultation/support and response to emergent situations which will be invaluable for families and children.

We have known about the severe need for psychiatric services for children in Rhode Island for a long time – and there is evidence that this program will work to address the need. One in five (19%) children ages six to 17 has a diagnosable mental health problem, and one in ten has significant functional impairment (Kids Count Factbook, 2015). And a 2014 article in Health Affairs concluded that pediatric primary care providers enrolled in the project reported a dramatic improvement in their ability to meet the psychiatric needs of their patients.

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

PCMH-Kids builds off of the successes of Care Transformation Collaborative in Rhode Island (CTC-RI), the adult patient-entered medical home (PCHM) initiative in Rhode Island. PCMH-Kids is extending the transformation of primary care practices in Rhode Island to children. PCMH Kids’ mission is to engage providers, payers, patients, parents, purchasers, and policy makers to develop high quality family and PCMHs for children and youth that will assure optimal health and development, a commitment to quality measurement, accountability for costs and outcomes, a focus on population health, and dedication to data-driven system improvement. A group of engaged stakeholders and pediatric leaders has been working over the past several years to develop this PCMH-Kids program. A pediatric medical home initiative is an opportunity to standardize and to improve the patient and family centered care already delivered in pediatric offices around our state. PCMH-Kids is convened by the state’s Executive Office of Health and Human Services (EOHHS) and Rhode Island Medicaid program, garnering participation from all four major health plans in Rhode Island. The nine selected pilot practices have created a common contract with payers. Practices are receiving supplemental payments and on-site, distance, and collaborative learning and coaching to support practice transformation and quality improvement. SIM funding for PCMH-Kids will include support for the following:

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

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

Behavioral Health Transformation:

Integrated Behavioral Health Behavioral health issues are frequently an important area of concern for individuals who visit their primary care practitioners. Behavioral health includes mental health, substance use, and health behaviors. There is ample evidence in medical literature that primary care practices can effectively treat and support many individuals who have mild to moderate behavioral health issues. It is widely acknowledged that, to be successful, the behavioral health focus must be well-integrated into the primary care practice, not simply co-located. The Rhode Island SIM Test Grant will invest in a qualified provider with experience and skill in establishing an integrated behavioral health program in Rhode Island, preferably with multi-payer sources. This overarching behavioral health integration effort will be the foundation for this component of our investment in this focus area, including the following activities:

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

SBIRT Training Another priority for behavioral health transformation in Rhode Island is to decrease the use, and impact, of tobacco, alcohol and other drugs. As an example of the need, when compared to national prevalence data, Rhode Island has a higher proportion of adults diagnosed with alcohol abuse or dependence and adults who could benefit from, but are not receiving needed treatment. The toll of tobacco in Rhode Island is high: 1800 adults die each year from cigarette smoking and 500 young people under 18 become new daily smokers each year. Four adult priority populations report higher than average cigarette smoking: adults of low socioeconomic status, African Americans, adults with physical and/or mental disabilities and adults with chronic disease.

In response to this need, the Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) has applied for a Collaborative Agreement for Screening, Brief Intervention and Referral to Treatment (SBIRT) grant from the Substance Abuse and Mental Health Service Administration (SAMHSA). If funded, this grant will offer, over a five

year period, alcohol, drug and tobacco screening to 250,000 Rhode Island adults. Based on the outcome of these screenings, individuals will be referred for brief interventions or treatment, as appropriate. Priority populations for this grant are patients of Federally Qualified Health Centers (FQHCs) in six Rhode Island Health Equity Zone (HEZ) communities with the highest need as well as persons who are being discharged from State Department of Corrections facilities. If this grant is funded, a cadre of 12 Health Educators and 12 Health Navigators will work in the designated sites, and SIM Test Grant funds will be used to provide ongoing training to this workforce. If the grant is not funded, SIM dollars will support training programs for existing SBIRT providers throughout the state.

Provider Coaching at Community Mental Health Centers A second investment related to this focus area will be provider coaching. Rhode Island’s publicly funded Community Mental Health Centers (CMHCs) are “health homes” for persons with serious mental illnesses. These CMHCs are also involved in a Federal Planning Grant designed to change their status to Certified Community Behavioral Health Clinics (CCBHCs). This status could bring new Medicaid funds to the CCBHCs by early 2017 if our state is successful in bidding for a two-year Federal pilot project. CCBHC status will increase the CMHCs’ capacity to serve individuals of all ages with mental health and substance use disorders. As CCBHCs, they will increase the integration of behavioral health and physical health care and boost their use of evidence-based practices. CMHCs are also adapting to new payment methods, moving from fee for service to bundled rates with consumer outcomes as key. Through a competitive Request for Proposal (RFP) process, expert coaches will be selected to help the CMHCs navigate change. The RFP will focus on a three year project, with coaching resources provided with greater intensity in the first year and phasing out over the second and third years. With rapid changes, CMHCs need outside coaching and support to build skills in many areas including:

- Clinical practices, such as connecting more effectively with primary care providers;
- Health information technology uses and benefits;
- Collection and measurement of data; and
- Quality improvement practices.

Care Management Dashboards An additional priority for the SIM Test Grant will be deployment of advanced technology to build a real-time communication system between Rhode Island hospital providers and CMHCs, mutually responsible for the care of approximately 8500 publicly insured individuals with serious mental illness. Specifically, SIM funds will be used for the development of an electronic dashboard that delivers real-time, encrypted notifications to the CMHCs when consumers under their care experience a hospital emergency department or inpatient encounter. The goal is to put critical health information in the hands of the appropriate providers at exactly the right time. This prompt information sharing is expected to facilitate targeted, appropriate clinical interventions, improve care coordination and reduce re-admissions. Ongoing funding for operation of the dashboard will come through a PMPM cost to the CMHCs. In addition to development of the dashboard tool, SIM Test Grant funding will cover the cost to train providers in use of this new technology.

Additional Healthcare Workforce Development As we move forward in our work with Practice Transformation activities - CHT’s, SBIRT, Integrated Behavioral Health Program, Care Management Dashboard, Provider Coaching Program, and healthcare Quality, Measurement Reporting and Feedback System – we will clarify existing workforce development needs and identify additional areas needing support.

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

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

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

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

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

SIM convened a Workgroup of community members and experts to help us determine our desired parameters and scope for our investments. Members discussed the criteria by which we would select engagement tools, approaches and services, as well as the metrics to be used to assess the degree of engagement with individuals and with the population as a whole. The group has agreed to continue to assist SIM in preparing for a procurement process through which we can identify the patient engagement projects reflecting creativity and best practices

Data Capability

HealthFacts RI The Rhode Island SIM Test Grant will invest funds to support the implementation and maintenance of the All-Payer Claims Database (APCD), named HealthFacts

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

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

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

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

Using SIM funds, Rhode Island has contracted with its state designated entity for HIE to build a Statewide Common Provider Directory. This directory will consist of detailed provider demographics as well as detailed organization hierarchy. This organization hierarchy is unique and essential to being able to maintain not only provider demographic and contact information, but their relationships to practices, hospitals, ACOs, and health plans. The intent of this project is to:

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

- Increase data availability and transparency with a provider portal and a consumer portal. The design of these portals will take place in 2016, with the anticipated go-live in early 2017.

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

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

Our approach will build on an ongoing assessment of our entire data ecosystem, which includes our current data warehouse and our processes for collecting, managing, and using data, as well as lessons learned from other states. Funding from SIM will support a transitional vendor to guide our development of an in-state, hosted solution. We will also work with the vendor to develop a complete modernization staffing and structure plan to guide the state during the transition to full ownership of the solution.

Regulatory Levers

Rhode Island is committed to using multiple regulatory and purchasing levers to advance the policies described in the healthcare delivery system transformation plan above. All of the state agencies that comprise the interagency team are engaged in this work. Starting on Page 81, we have described the key regulatory levers held by our participating state agencies that we will use to help us reach our goals. For example, to facilitate us moving toward our goal of 80% of payments linked to value by 2018, we will use OHIC's Affordability Standards. The standards hold insurance carriers to specific standards to advance value-based purchasing; promote practice transformation and increase financial resources to primary care for population health management; and around hospital contracting.

In another example, Medicaid contracts with Managed Care Organizations (MCOs) and pays them a capitated rate for Medicaid enrollees across different programs. In turn, Medicaid imposes conditions on the MCOs through contracting. The contracting conditions structure how MCOs reimburse providers, measure quality, and support multi-payer programs, such as the state's multi-payer patient-centered medical home program. As stated in the Rhode Island Healthcare Transformation Plan, Medicaid will use the MCO contracting mechanism to impose specific annual targets for use of APMs by the MCOs, and directives to contract with credential Medicaid Accountable Entities.

Evaluation

There are three parts to our SIM evaluation plan:

- 1) SIM leaders and staff will participate in the federal evaluation being undertaken by RTI. We expect three site visits, and regular monthly communications with the evaluation team.
- 2) SIM will retain professional outside evaluators to carry out a focused evaluation on the effectiveness of our project. We are in the process of preparing our procurement process for this vendor. They will be chosen through a competitive Request for Proposals (RFP). One particular part of this evaluation process is a project recently approved by our Steering Committee to document and compare the effects of Alternative Payment Models in use in the state. The purpose would be to learn how the models work, what related activities most support their success, and whether alignment of models across payers and providers would yield a greater impact on desired outcomes.
- 3) SIM will carry out regular in-house monitoring and evaluation of our program, tracking the milestones and metrics we have identified in our planning process.

As we procure and begin to work with our professional evaluator, we will determine the scopes of each of these efforts, to ensure that they are complementary but not duplicative. We know that we have information that we must report to CMS and CMMI, and our in-house evaluation work will be in service to those requirements. Our learning collaborative work can be more long-term and aspirational. And our professional evaluation can cover those topics where we do not have the expertise or tools to carry out a particular type of in-house evaluation.

SIM Component Summary Table

Table 5: Component Summary Table

SIM Component Summary Table				
Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver
Planning and Governance				
SIM Steering Committee	The SIM Steering Committee is the public/private governing body for Rhode Island’s SIM project. The committee’s primary function is to set strategic direction, create policy goals, approve the funding plan, and provide oversight over the implementation of the SIM grant. The committee meets monthly and is comprised of community stakeholders who represent health care providers/systems, commercial payers/purchasers, state hospital and medical associations, community-based and long term support providers, and consumer advocacy organizations.		N/A	Create measurable improvements in Rhode Islander's physical and mental health.
SIM Project Director and Staffing Across Five Partner Agencies	Staff at each participating state agency will carry out day to day functions of the SIM project and work together on the SIM Interagency Team. Participating state agencies are: Executive Office of Health and Human Services (EOHHS), Office of the Health Insurance Commissioner (OHIC), Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH), Department of Health (RIDOH), and HealthSource RI. We also work closely with the Department of Children, Youth, and Families, but they do not have a dedicated SIM staff person.		\$3,000,000	Create measurable improvements in Rhode Islander's physical and mental health.
Project Management Vendor	The Project Management Vendor (UMASS) manages SIM related project management activities including support for stakeholder management, project meetings, data collection, risk management, communications, sub-contractor management, and work plan management.	University of Massachusetts Medical School	\$1,600,000	Create measurable improvements in Rhode Islander's physical and mental health.

SIM Component Summary Table

Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver
Investing in Rhode Island's Healthcare Workforce and Practice Transformation				
Community Health Teams	Community health teams (CHTs) currently serve as extensions of primary care, helping patients meet unaddressed social, behavioral, and environmental needs that are having an impact on their physical health. Overall, CHTs improve population health by addressing social, behavioral, and environmental needs. Our SIM-funded teams will also support providers in transitioning to value-based systems of care; and help transform primary care in a way that increases quality of care, improves coordination of care, and reduces/controls related costs and expenditures. In order to maximize improvements in Rhode Island's population health, address and improve our social and environmental determinants of health, and make progress in eliminating health disparities within our state, CHTs services should be available to all Rhode Islanders who need that level of multi-disciplinary, community-based services to address the factors that impact our health. In particular, SIM will fund two areas of work for CHTs in Rhode Island: Building the capacity of current teams to serve their patients more effectively, and supporting up to two new CHTs. The new CHTs will be multi-disciplinary (including behavioral health providers and community health workers); connected to a provider within a certain geography; accessible to all regardless of insurance; and reflective of the diversity of the communities they serve.	To be determined through a competitive RFP process	\$2,000,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce
Child Psychiatry Access Program	The Pediatric Psychiatry Referral Consultation project will establish a children's mental health consultation team to support pediatricians and other primary care doctors serving children and adolescents with mental health conditions. The Access Program is designed to assist the pediatricians and other physicians to treat children with behavioral and mental health needs in a way that is preventive and responsive to a patient's immediate circumstances. This consultation, support and response to emergent situations will be invaluable for families. This project will also provide ongoing physician training to ensure that the delivery of care for children and adolescents can be in the least restrictive setting possible.	Pursuing single source procurement	\$650,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce

SIM Component Summary Table

Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver
PCMH Kids	PCMH-Kids builds off of the successes of Care Transformation Collaborative in Rhode Island (CTC-RI), the adult patient-entered medical home (PCHM) initiative in Rhode Island. PCMH-Kids is extending the transformation of primary care practices in Rhode Island to children by engaging providers, payers, patients, parents, purchasers, and policy makers to develop high quality family/youth/children-focused PCMHs that will assure optimal health and development. PCMH-Kids is convened by the state's Executive Office of Health and Human Services (EOHHS) and Medicaid program, with participation from all four major health plans. Nine pilot practices have created a common contract with payers and are receiving supplemental payments and on-site, distance, and collaborative learning and coaching to support practice transformation and quality improvement. SIM funding for PCMH-Kids will include support for practice facilitation and coaching, practice assistance with reporting and analyzing data, and overall program evaluation.	Pursuing single source procurement	\$500,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce
Behavioral Health Transformation: <i>Integrated Behavioral Health</i>	The Rhode Island SIM Test Grant will fund a qualified provider with experience and skill in helping primary care practices, representing multiple payers, to integrate behavioral health care into their clinical work. The qualified provider will have expertise facilitating within primary care practices: 1) depression, anxiety and substance use screening; 2) collaboration of behavioral health specialty staff with nursing/physician personnel; 3) use of behavioral health subject-matter expert(s) to support training and development efforts; and 4) development of knowledge about appropriate measurement and quality assurance activities.	Pursuing single source procurement	\$370,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce
Behavioral Health Transformation: <i>SBIRT</i>	Rhode Island seeks to decrease the use of tobacco, alcohol and other drugs. The Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) has applied for a Collaborative Agreement for Screening, Brief Intervention and Referral to Treatment (SBIRT) grant from the Substance Abuse and Mental Health Service Administration (SAMHSA). If funded, this grant will offer, over a five years, alcohol, drug and tobacco screening to 250,000 adults. As needed, referrals will be made to brief interventions or treatment. Priority populations are individuals living in designated high need areas and persons leaving Department of Corrections' facilities. If the grant is funded, SIM Test Grant funds will support ongoing training to a 24 person workforce of Health Educators and Navigators. If the grant is not funded, SIM will still fund training programs for existing SBIRT providers throughout the state.	To be determined, once we learn the outcome of the SAMHSA grant	\$480,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce

SIM Component Summary Table

Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver
Behavioral Health Transformation: <i>Provider Coaching</i>	Another behavioral health investment will be provider coaching. Rhode Island’s publicly funded Community Mental Health Centers (CMHCs) are “health homes” for persons with serious mental illnesses. SIM Test Grant funds will be used to support an expert coaching program to help CMHCs improve their effectiveness in addressing consumers’ health care needs. Expert coaches will help CMHC staff: 1) improve clinical practices, such as connecting more effectively with primary care providers; 2) learn health information technology uses and benefits; 3) collect and measure data; and 4) strengthen quality improvement practices.	To be determined through a competitive RFP process	\$1,200,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island’s Healthcare Workforce
Behavioral Health Transformation: <i>Care Management Dashboard</i>	The SIM Test Grant will fund a real-time communication system between Rhode Island hospital providers and CMHCs, mutually responsible for the care of approximately 8500 publicly insured individuals with serious mental illness. An electronic dashboard will deliver real-time information to the CMHCs when their consumers have a hospital emergency department or inpatient encounter. This effort will support targeted, clinical interventions, improve care coordination and reduce re-admissions. Ongoing funding for operation of the dashboard will come through a PMPM cost to the CMHCs. In addition to development of the dashboard, SIM Test Grant funds will cover training to providers in use of this new technology.	Pursuing single source procurement	\$150,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island’s Healthcare Workforce

SIM Component Summary Table

Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver
<p>Integrated Population Health Plan</p>	<p>Rhode Island aims to achieve measurable improvement in the health and productivity of all Rhode Islanders. To achieve this aim, the healthcare delivery, public health, community development, and social service sectors as well as the many academic, public, and private institutions in our state will work together to ensure that all Rhode Islanders are able to achieve their highest health potential, without system/structural barriers. This population health improvement effort requires multi-sector/multi-agency collaborations to help us transition from an uncoordinated, healthcare provider and payer-centric care focused health services environment to an environment where public health, social service, and healthcare delivery systems are well-integrated as well as outcomes-oriented and person-centric.</p> <p>Although the Integrated Population Health Plan focuses on specific physical and behavioral health conditions or diseases, our aim is to create an approach that centers on wellness, not disease. As the plan evolves, our strategies will move towards methods that help Rhode Islanders live long, productive and healthy lives, addressing them not as patients but as people.</p> <p>Our approach to population health improvement focuses on health across the life course (from birth to death) from the perspective of the "whole-person" and includes behavioral health, where behavioral health includes mental health and substance use disorders. It is a population health vision, with the goals of improving the health and wellbeing of all Rhode Islanders; to promote "any door as the right door" to identifying mental illness and substance use disorders early and providing the supports and interventions to enable people to recover rapidly; to create healthy, resilient inclusive communities throughout Rhode Island, and to ensure that persons with physical or behavioral health conditions, including severe and persistent mental illness and/or addictive disease, have access to evidence-based services that support recovery and full inclusion in their communities in the least restrictive setting possible.</p>	<p>University of Massachusetts Medicaid School sub-contractors The Providence Plan (ProvPlan) and the Technical Assistance Center (TAC)</p>		<p>Create measurable improvements in Rhode Islander's physical and mental health.</p>

SIM Component Summary Table

Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver
Healthcare Quality, Reporting, Measurement and Technology Feedback	Based on significant stakeholder input, SIM will fund the development of a statewide quality reporting system to help providers "enter data once and analyze many time." Our goals for the reporting system are to improve the quality of care for patients and driving improvement in provider practices by giving feedback to providers, provider organizations, and hospitals about their performance based on quality measures; produce more valuable and accurate quality measurements based on complete data from the entire care continuum; leverage centralized analytic expertise to provide valuable and actionable reports for providers and to drive improvements in population health; reduce the duplicate reporting burden upon providers and provider organizations by having a common platform for reporting; publically report quality measurements in order to provide transparency and support patient engagement in making informed healthcare decisions; and use existing databases, resources and/or systems that meet our needs, rather than building from scratch.	To be determined through a competitive RFP process	\$1,750,000	Maximize & support team-based care Better integrate behavioral health into primary care Investments in Rhode Island's Healthcare Workforce
Patient Engagement				
Patient Engagement	In order to ensure that patients receive the greatest value from payment reform changes, and that they are maximally engaged in positive health behaviors including self-advocacy, SIM will invest funds to provide patients access to tools that increase their involvement in their own care, including creating the infrastructure to allow patients to more easily share their advanced care directives and healthcare proxies with their providers; developing patient engagement tools such as health risk assessments; and implementing tools that measure consumer satisfaction as well as behavior change readiness.	To be determined through a competitive RFP process	\$1,700,000	Provide access to patient tools that increase their engagement in their own care.
End-of-Life/ Advanced Illness Care Initiative	We know that patients and providers both avoid discussions about end-of-life planning, leading to unwanted medical care and family distress. SIM will fund Advance Care Planning Discussion trainings, to support providers in carrying out patient engagement activities in the event of advanced illness. The program will promote effective collaboration between patients, families, and providers in making healthcare decisions; improve health literacy among patients and their families; and provide opportunities for participants to complete advance directives.	Pursuing single source procurement	\$500,000	Provide access to patient tools that increase their engagement in their own care. Assist with advanced illness care planning

SIM Component Summary Table

Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver
Increasing Data Capability and Expertise				
HealthFacts RI	The Rhode Island SIM Test Grant is investing funds to support the implementation and maintenance of the All-Payer Claims Database (APCD), named "HealthFacts RI." HealthFacts RI collects, organizes, and analyzes health care data from nearly all major insurers who cover at least 3,000 individuals in Rhode Island. This information allows users to benchmark and track Rhode Island's health care system in ways that were previously not possible. When fully implemented, HealthFacts RI will ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island's healthcare delivery system. It will also provide state agencies and policy makers with the information needed to improve the value of healthcare for Rhode Island residents and will illuminate how Rhode Islanders use the healthcare system, the effectiveness of policy interventions, and the health of our communities.	Freedman Healthcare, OnPoint, and 3M	\$2,039,673	Increase use of data to drive quality and policy
Statewide Common Provider Directory	Payers, providers, and consumers all need access to accurate provider information. Using SIM funds, Rhode Island has contracted with its state designated entity for HIE to build a Statewide Common Provider Directory. The provider directory is a database with a web-based tool that allows a staff team to maintain the file consumption and data survivorship rules, error check flagged inconsistencies or mapping questions, and manually update provider data or enter new providers. It will consist of detailed provider demographics as well as detailed organization hierarchy. This organization hierarchy is unique and essential to being able to maintain not only provider demographic and contact information, but their relationships to practices, hospitals, ACOs, and health plans.	Rhode Island Quality Institute	\$1,500,000	Increase use of data to drive quality and policy

SIM Component Summary Table

Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver
Integrated Health and Human Services Data Ecosystem	<p>Rhode Island lacks a modern system for integrating person-level information across our agencies and then turning that holistic information into action. While EOHHS has built a data warehouse that stores many different sources of data – in addition to separate data sets that live within each agency – there is limited capacity to first connect and then share those linked data, either at the person level or in the aggregate. If we are able to combine and better analyze these data, we can obtain critical information about the needs of our population, the effectiveness of our programs, and how to responsibly spend valuable public resources.</p> <p>With funding from SIM, Rhode Island will take informed, project-based steps that reflect iterative learning and sophistication to build our new data ecosystem, integrating data across our agencies and driving policy with those data. This approach differs from a traditional, expensive and “all at once” Data Warehouse project that is common to many data integration initiatives. Rather than seek to purchase or build a large system that will attempt to integrate all data and develop user interfaces that satisfy many user needs – a process that could take years, come with high upfront costs, and that would rely on our existing knowledge to guide design and decision making – Rhode Island is planning a lighter, simpler and more adaptive solution.</p>	To be determined through a competitive RFP process	\$1,800,000	Increase use of data to drive quality and policy
Regulatory Levers				
Measure Alignment	<p>Quality measurement and improvement are integral components of value-based contracting. As value-based payment arrangements become more widely used in Rhode Island, it is important to ensure consistency and coherence in quality measures, to ease administrative burden on providers, and drive clinical focus to key population health priorities. Toward this end, between June 2015 and March 2016, the Measure Alignment Workgroup created by the SIM Steering Committee created an aligned measure set with 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures). See appendices for additional information and measure specifics. The workgroup was made up of payers, providers, measurement experts, consumer advocates, and other community partners. The next step is for OHIC to create the implementation process for the measures and for the workgroup to create a governance process for annual review and updating of the set.</p>	Bailit Health Purchasing	Included in Project Manager Line Item	Increase use of data to drive quality and policy

SIM Component Summary Table

Component & Activity/ Budget Item:	Description of activities	Vendor (If known)	Expected Expenditures	Primary Driver
Other Regulatory Levers	Rhode Island is committed to using our multiple regulatory and purchasing levers to advance the policies described in the healthcare delivery system transformation plan above. All of the state agencies that comprise the interagency team are engaged in this work, identifying the regulatory abilities they have now to move the payment system, support providers and patients, and thus improve population health and address costs. For example, OHIC's Affordability Standards described within the Operational Plan on Page 82 hold insurance carriers to specific standards to advance value-based purchasing; promote practice transformation and increase financial resources to primary care for population health management; and around hospital contracting;	Conducted by staff	N/A	Create measurable improvements in Rhode Islander's physical and mental health.
Evaluation				
Evaluation	SIM will retain professional outside evaluators to carry out part of our evaluation process, but we will be monitoring and evaluating the milestones and metrics we identify in-house as well. The Steering Committee has also approved a learning collaborative process to study the efficacy of value-based payments to increase quality, improve population health, and lower costs. Our learning collaborative work can be more long-term and aspirational. And our professional evaluation can cover those topics where we do not have the expertise or tools to carry out a particular type of evaluation well.	To be determined through a competitive RFP process	\$700,000	Create measurable improvements in Rhode Islander's physical and mental health.

Risk and Mitigation Strategy

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

Accordingly, we are aware of risks and issues that may affect the success of the SIM Test Grant project in the state, and are working actively to mitigate those risks.

Approach

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

Risk Mitigation Principles

The following are the general principles that SIM is using to address the risks that we face:

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

By engaging stakeholders across the spectrum of our work, we increase our ability to call on subject matter experts for assistance in our projects – and decrease the chances that we will encounter problems that we cannot solve. All SIM activities follow Rhode Island's Open Meetings laws, ensuring public notice of all meetings and transparency of meeting proceedings.

Robust and active project management.

Project management was at the top of Rhode Island's priorities when engaging consultants to assist with the SIM Model Test Grant, and the teams are following project management best practices in developing, managing, and tracking activities.

Following evidence-based practices.

We have engaged experts in population health planning and behavioral health planning, as well as measure development and other technical specialties for SIM. Their expertise is being heavily leveraged in researching policies and best practices that can be applied to Rhode Island from within and outside of the state.

Identifying and mitigating risks is an ongoing process. Periodic reassessment is the best means for addressing currently unidentified risks. Success at early and active mitigation may prevent later risks from developing.

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

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

Risk Register

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

Table 6: Risk Register

		<i>Likelihood it will occur</i>	<i>Impact if it occurs</i>	<i>Risk Score</i>	
	Risk Category/ Risk	(1-5)	(1-5)	(=Likelihood X Impact)	Mitigation Plan
Procurement					
1	Deadlines for procurements are missed Purchasing process is lengthy; funds cannot be disbursed and applied to the objectives sufficiently rapidly, making it more difficult to achieve our goals.	5	4	20	Prioritize procurement in our workplan above other projects. The SIM team will work collaboratively and efficiently to minimize delivery time to Purchasing. To that end, SIM team will: <ul style="list-style-type: none"> • Create a small procurement staff team dedicated to expediting the process end-to-end. • Conduct initial exploration with all approving entities to ensure we understand their rules and process Current contractors will be enlisted for support in any processes where there is not a conflict of interest.
2	Inadequate bids on Specific RFPs	3	4	12	Provide thorough bid guidance in RFP. Conduct robust RFP distribution effort.
3	Inability to Disburse Funds in Allotted Time	3	3	9	Front-load the procurement/award process so that funds are disbursed as early as possible.
Metrics and Measures					
4	Lack of Data Availability to Meet Need	5	4	20	Aggressively pursue data availability early, to establish parameters of what is possible. Prioritize other data for acquisition at a later time. If there is a lack of data about “net new” or unstudied program activities to identify benchmarks or targets, set targets and reassess at mid-year to determine their reliability and validity.
5	Project implementation does not work as planned	5	4	20	Hold regular internal evaluations to assess implementation and find problems quickly. Work with stakeholders to find solutions to the problems without delay.

		<i>Likelihood</i> it will occur	<i>Impact</i> if it occurs	Risk Score	
	Risk Category/ Risk	(1-5)	(1-5)	(=Likelihood X Impact)	Mitigation Plan
Technology & Data					
6	Technology Does Not Exist to Support Needs	4	3	12	Conduct thorough assessment of business requirements; make technical selection based on priorities and cost benefit of build vs. buy.
7	Technology or Data is Not in Compliance with Standards	3	4	12	Identify standards before conducting technical assessment.
Program Implementation					
8	Challenges achieving our expected program outcomes	3	3	9	Base solutions on evidence. Set clear, concrete goals for initiatives, with achievable objectives and work with our subject matter experts to address challenges. Provide sufficient funding to achieve success. Ensure robust quality assurance, measures, and metrics capture mechanisms.
9	Lack of alignment between federally funded projects	2	4	8	<ul style="list-style-type: none"> • Continue outreach to state agencies and community agencies with federal funds, maintaining close contact with stakeholders • Increase sense of ownership by involving stakeholders in incremental policy development process. • If funding is pursued through other sources, maintain contact with those stakeholders. • Active, consistent engagement of executive leadership across the Executive Office of Health and Human Services, OHIC, HealthSource RI, and the Governor's Office
10	Timeline or Timeframe Interruption (e.g., staff illness, other issue)	1	3	3	Prioritize scope elements. Cross-train staff in each other's initiatives. Be prepared to de-scope lower priority elements if needed.

C. General SIM Operational and Policy Areas

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

The Integrated Population Health Plan, required as Section 3, is placed in Appendix A because it will be a living document, planned to be regularly updated and expanded in scope. It will be aligned with the RIDOH Strategic Priorities and the legislative requirement for a State Health Plan.

SIM Governance

Governance and Management Structure

SIM Project Leadership

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

Ms. Rosenberg leads a staff team made up of individuals hired with SIM dollars and placed at our member agencies. These staff members officially report to other staff members at the agencies, but they come together in a team that meets weekly and works together on all SIM projects. The attached SIM Organizational Chart depicts the SIM staffing structure including SIM designated and other state staff who support SIM efforts and the UMass Medical School project management team.

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

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

Another way that we benefit from the public/private partnership nature of SIM is through our Workgroups. The workgroups allow us to garner subject-matter expertise, receive stakeholder and community input, and secure implementation recommendations for SIM's transformation efforts. The Steering Committee has approved four specific SIM workgroups around our key test components to date and may request additional workgroups as necessary. Current workgroups include the following:

- **Integrated Population Health Plan, Measure Alignment** – providing subject matter expertise and strategic oversight of the creation of Rhode Island's Integrated Population Health Plan
- **Measure Alignment** – providing subject matter expertise for the creation of Rhode Island's aligned measure set. Eventually this will transform into the governance committee for the measure set, responsible for an annual review and updates to the set.

- **Patient Engagement** – assisting with an inventory of current patient engagement activities taking place in Rhode Island and providing recommendations for filling patient engagement gaps.
- **Technology Reporting** – providing subject matter expertise on the creation and implementation of Rhode Island’s Healthcare Feedback System and potentially other IT-related SIM projects.

To guard against duplicative meetings and extra work for the SIM staff, SIM is participating with two existing community groups to further our work with Community Health Teams and Provider Practice Transformation. These community workgroups have generously invited SIM to be a regular part of their agendas and allow us to consult with the experts sitting around their tables.

Governor’s Office Engagement in SIM

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

With a change in administration in January, 2015, Rhode Island’s new Governor Gina M. Raimondo appointed Ms. Roberts as Secretary of the Executive Office of Health and Human Services (EOHHS) where she continues to champion the SIM effort in Rhode Island.

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

Coordination of Private and Public Efforts

The administration has launched additional initiatives that align with SIM efforts. In February 2015 Governor Raimondo signed an executive order creating the Working Group to Reinvent Medicaid which subsequently developed a plan both to improve the quality of care and to reduce costs for Rhode Island taxpayers. Then, building on the successful and ongoing efforts to make positive changes in the Medicaid program, the Governor assembled a group of 41 stakeholders – providers, insurers, advocates, businesspeople, and legislators – called the Workgroup Group for Healthcare Innovation. Governor Raimondo wrote an executive order charging the workgroup to propose solutions to spark innovation across healthcare and achieve healthcare’s “Triple Aim” of improved health, enhanced patient experience, and reduced per-capita costs. In December 2015 the group unveiled a plan for a global health spending target, value-based payment reform, access to care, health information technology, population health goals, and opportunities to reduce waste and overcapacity. The Governor’s office is continuing to determine how to implement this plan, and is communicating with SIM staff to promote alignment.

Regulatory Authority

Our SIM leaders understand that one of the key tools that we have to implement our transformation agenda are the regulatory levers that each participating state agency holds. Examples of these levers are OHIC’s rate review responsibilities, and their Affordability Standards regulations. The Department of Health is responsible for licensing hospitals and healthcare providers, and issuing Certificates of Need. Our specific plan for using regulatory levers to meet our transformation goals is included in the Leveraging Regulatory Authority section of this plan.

Staffing Roles and Responsibilities

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

The following chart details how our staff roles and responsibilities are generally divided:

Table 7: Staffing Roles and Responsibilities

Agency	Staff Title	Roles and Responsibilities
SIM	SIM Project Director	Oversee the implementation of the SIM grant, managing the staff and interagency teams, and staffing the Steering Committee. Oversee the procurement of the SIM transformation agenda, as well as the vendors hired to carry out the funded activities. Serve as the SIM liaison to the Governor’s office, agency directors, and other state health leaders, and SIM’s federal program officers and technical assistance providers.
Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH)	SIM Project Manager	Represent BHDDH on Interagency Team. Link behavioral health to physical health change components and serve as BHDDH lead on Integrated Population Health plan. Oversee behavioral health transformation elements, including managing procurement and implementation of projects such as Community Mental Health Center Provider Coaching, Child Psychiatry Access Project, and SBIRT. Carry out tasks as team member on BHDDH’s CCBHC effort which aligns with state’s value-based purchasing goals.
Executive Office of Health and Human Services	HIT Specialist	Represent the HIT division of EOHHS on the Interagency Team. Provide oversight to the implementation of the technology components of our transformation agenda, Ensure that technology information and data are available to SIM workgroups, to weave in our HIT activities throughout all transformation work.
Health	Chief Health Program Evaluator	Represent RIDOH on the Interagency Team. Oversee the creation and implementation of the Integrated Population Health plan, ensuring alignment with the behavioral health components of our transformation agenda. Participate in the

		implementation of our Community Health Team project. Assist with evaluation activities.
HealthSource RI	Value-Based Purchasing Analyst	Represent HealthSource RI on the Interagency Team. Work with commercial carriers, Medicaid, and others to help guide the design of insurance plans, both QHP and Medicaid Managed Care, in support of value-based care and our transformation agenda. Also, lead HealthSource RI in reviewing and analyzing plan filings, and support the exchanges implementation of approved plans. Advise EOHHS efforts to develop models for value based purchasing in Medicaid.
Office of the Health Insurance Commissioner	Principal Policy Associate	Represent OHIC on the Interagency Team. Provide subject matter expertise and technical assistance to the SIM team on value-based purchasing, alternative payments models, and the regulatory activity needed to achieve our transformation goals. Provide technical expertise on practice transformation for health system reforms, including how our funded activities and uses of regulatory levers will help us reach our overall system change goals.

Figure 2 shows a detailed organizational chart of SIM project staff and is followed by a detailed table describing the roles of each individual.

Similarly, all Requests for Proposals (RFPs) include detailed Scopes of Work which make clear the roles and responsibilities expected of vendors. The chart below describes the major responsibilities of our current SIM vendors:

Table 8: Vendor Roles and Responsibilities

Vendor	Roles and Responsibilities
University of Massachusetts Medical School	Provide project management and oversight to sub-contractors who are carrying out the writing and research of the Integrated Population Health Plan and the facilitation of the Measure Alignment process
Freedman Healthcare, OnPoint Health Data, and 3M Healthcare	This team of vendors has managed the creation and programming of HealthFacts RI, our all payer claims database. Freedman provides project management, OnPoint is our data aggregator, and 3M is our data analyst.
Rhode Island Quality Institute	This nonprofit organization is Rhode Island's designated health information exchange. They have created and managed our Statewide Common Provider Directory.

Figure 2: SIM Project Staffing Organizational Chart

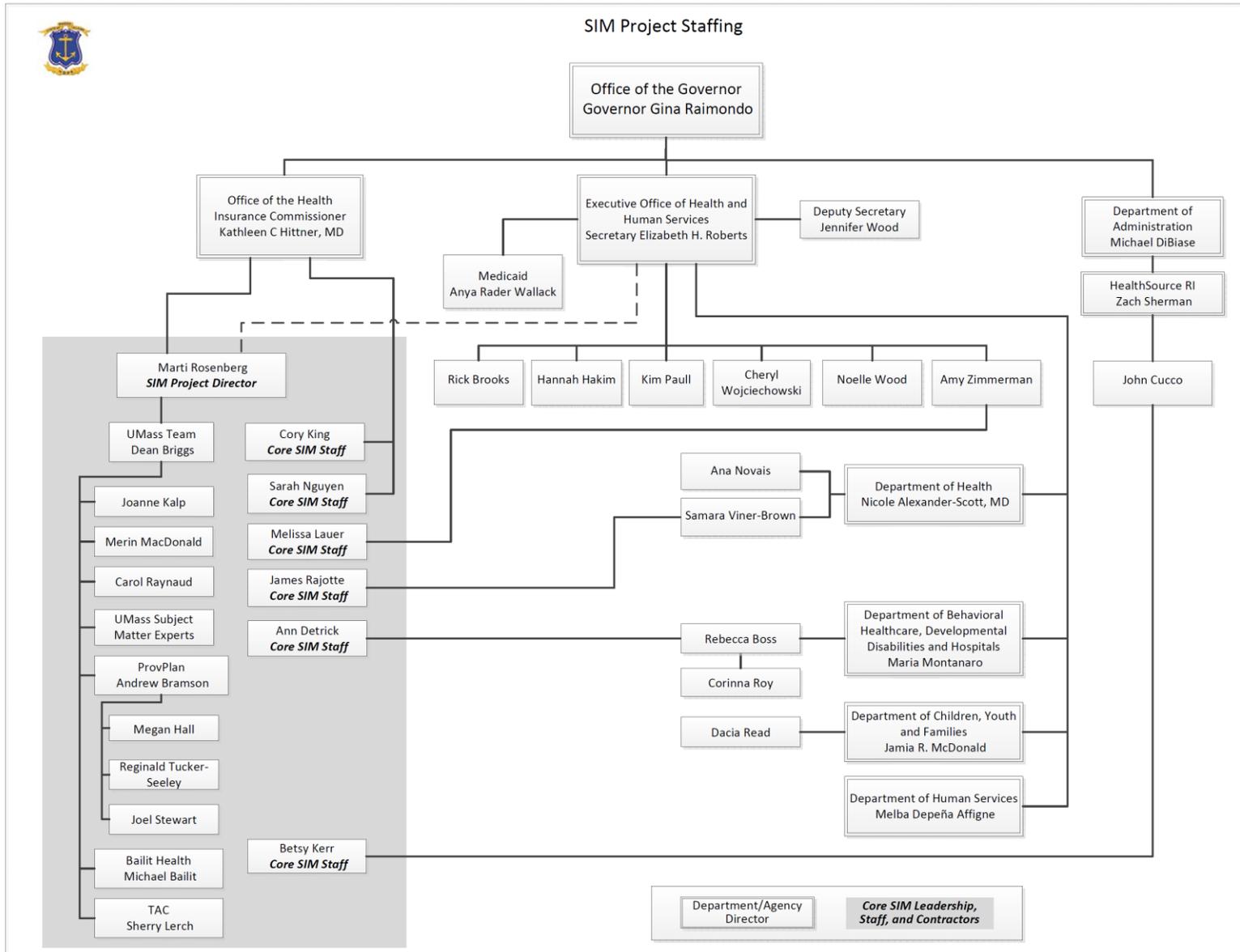


Table 9: SIM Project Staffing

SIM Component/Project Area Key Staff Directory				
SIM Component/ Project Area	Component/Project Lead		Contact Information	
	Position/Title	Name	Phone Number	Email Address
SIM Dedicated Staff				
SIM Director	SIM Project Director	Marti Rosenberg	401-462-9659	Marti.Rosenberg@ohic.ri.gov
Department of Behavioral Healthcare Developmental Disabilities and Hospitals	Chief of Transformation	Ann Detrick	401-462-3542	Ann.Detrick@bhddh.ri.gov
Department of Health	Chief Health Program Evaluator	James Rajotte	401-222-5142	James.Rajotte@health.ri.gov
Executive Office of Health and Human Services	HIT Specialist	Melissa Lauer	401-462-6485	Melissa.Lauer@health.ri.gov
HealthSource RI	Value-Based Purchasing Analyst	Betsy Kerr	401-462-3598	Betsy.Kerr@exchange.ri.gov
Office of the Health Insurance Commissioner	Principal Policy Associate	Cory King	401-462-9658	Cory.King@ohic.ri.gov
Office of the Health Insurance Commissioner	Principal Policy Associate	Sarah Nguyen	401-462-9643	Sarah.Nguyen@ohic.ri.gov
SIM Workgroups				
Integrated Population Health Workgroup	Lead staff	Ann Detrick James Rajotte	401-462-3542 401-222-5142	Ann.Detrick@bhddh.ri.gov James.Rajotte@health.ri.gov
Measure Alignment Workgroup	Lead staff	Cory King	401-462-9658	Cory.King@ohic.ri.gov
Patient Engagement Workgroup	Chair	Jim Berson		JBerson@gpymca.org
Technology Workgroup	Lead Staff	Melissa Lauer Amy Zimmerman	401-462-6485 401-462-1730	Melissa.Lauer@health.ri.gov Amy.Zimmerman@ohhs.ri.gov
SIM Steering Committee Members				

SIM Component/Project Area Key Staff Directory				
SIM Component/ Project Area	Component/Project Lead		Contact Information	
	Position/Title	Name	Phone Number	Email Address
SIM Steering Committee	Committee Chair, representing South County Health	Lou Giancola	401-788-1602	LGiancola@schospital.com
SIM Steering Committee	Member, representing Lifespan	Mark Adelman		MAdelman@lifespan.org
SIM Steering Committee	Member, Director RI Department of Health	Nicole Alexander-Scott, MD	401-222-2232	Nicole.AlexanderScott@health.ri.gov
SIM Steering Committee	Member, Deputy Chief of Staff Office of the Governor	Eric Beane	401-222-8147	Eric.Beane@governor.ri.gov
SIM Steering Committee	Member, representing Greater Providence YMCA	Jim Berson		JBerson@gpymca.org
SIM Steering Committee	Member, representing Tufts Health Plan	David Brumley		David_Brumley@tufts-health.com
SIM Steering Committee	Member, representing RI Kids Count	Elizabeth Burke Bryant		Ebb@rikidscount.org ;
SIM Steering Committee	Member, representing Rhode Island Business Group on Health	Al Charbonneau		AlCharbonneau@verizon.net
SIM Steering Committee	Member, Director RI Department of Human Service	Melba Depena	401-462-0632	Melba.Depena@dhs.ri.gov
SIM Steering Committee	Member, representing Prospect Medical Holdings	Christopher Dooley		Christopher.Dooley@chartercare.org
SIM Steering Committee	Member, representing RI Primary Care Physicians Corp	Andrea Galgay		AGalgay@ripccp.com

SIM Component/Project Area Key Staff Directory				
SIM Component/ Project Area	Component/Project Lead		Contact Information	
	Position/Title	Name	Phone Number	Email Address
SIM Steering Committee	Member, representing UnitedHealthcare of New England	Neil Galinko		NGalinko@uhc.com
SIM Steering Committee	Member, representing RI Health Care Association	Jane Hayward		JHayward@RIHCA.org ;
SIM Steering Committee	Member, RI Health Insurance Commissioner	Kathleen Hittner, MD	401-462-9638	Kathleen.Hittner@ohic.ri.gov
SIM Steering Committee	Member, representing RI Medical Society	Peter Hollmann, MD		PHollmann@lifespan.org
SIM Steering Committee	Member, representing Care New England	Dennis Keefe		DKeefe@CareNE.org
SIM Steering Committee	Member, representing Coastal Medical	Alan Kurose, MD		GAKurose@coastalmedical.com
SIM Steering Committee	Member, representing CareLink	Joan Kwiatkowski		JKwiatkowski@carelink-ri.com
SIM Steering Committee	Member, representing Gateway Health Care	Richard Leclerc		RLeclerc@lifespan.org
SIM Steering Committee	Member, representing Blue Cross Blue Shield of RI	Gus Manocchia, MD		augustine.manocchia@bcbstri.org
SIM Steering Committee	Member, representing Neighborhood Health Plan of RI	Peter Marino		PMarino@nhpri.org
SIM Steering Committee	Member, Office of the Governor Policy Staff	Sam Marullo	401-222-2080	Sam.S.Marullo@governor.ri.gov

SIM Component/Project Area Key Staff Directory				
SIM Component/ Project Area	Component/Project Lead		Contact Information	
	Position/Title	Name	Phone Number	Email Address
SIM Steering Committee	Member, Chief Strategy Officer RI Department of Children Youth & Families	Jamia McDonald	401-528-3540	Jamia.McDonald@ohhs.ri.gov
SIM Steering Committee	Member, Director RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals	Maria Montanaro	401-462-2339	Maria.Montanaro@bhddh.ri.gov
SIM Steering Committee	Member, Secretary Executive Office of Health and Human Services	Elizabeth H. Roberts	401-462-5274	Elizabeth.Roberts@ohhs.ri.gov
SIM Steering Committee	Member, representing Charter CARE	Lester Schindel		Lester.Schindel@chartercare.org
SIM Steering Committee	Member, Director of HealthSource RI	Zachary Sherman	401-462-3592	Zachary.Sherman@exchange.ri.gov
SIM Steering Committee	Member, representing The Rhode Island Foundation	Neil Steinberg	401-274-4564	NSteinberg@rifoundation.org
SIM Steering Committee	Member, representing The Substance Use and Mental Health Leadership Council of RI	Susan Storti		SStorti@sumhlc.org
SIM Steering Committee	Member, Medicaid Director	Anya Rader Wallack	401-462-2488	Anya.Wallack@ohhs.ri.gov

Vendor Procurement

SIM has completed the hiring of all of our state staff members, following Rhode Island's strict hiring processes. This included posting the job announcements on the state procurement website, recruiting a hiring team, and completing one or more face-to-face interviews. We sought the assistance of SIM Steering Committee members and other community stakeholders to disseminate job postings throughout their professional networks, and the hiring committee for the Project Director included a number of community participants. Should we need to hire additional staff members throughout the project, we would continue to follow these rules.

Additional vendors will be engaged to fully implement Rhode Island's SIM Transformation activities, using the rigorous process required by the state purchasing office. All vendor procurement is managed by state staff (rather than vendors) and meetings are underway to develop Requests for Proposals according to state procurement procedures to solicit the remaining vendors.

Staff Training

As noted above, each designated SIM staff person was hired as a subject-matter expert and works within one of the SIM partner agencies. Each agency has provided orientation materials as appropriate for that agency and each staff member is supervised by appropriate agency staff. SIM staff participate in webinars such as SIM Learning Events and are encouraged to attend state and national conferences as appropriate to their area of expertise.

Evaluation and Continuous Quality Improvement

SIM has planned an overall project evaluation process with both internal and professional activities that is described in the Program Monitoring and Reporting section of this plan. However, the staff and interagency teams are committed to the concept of continuous quality improvement and thus carry out routine evaluations and debriefs on a regular basis to ensure that the project is on track. For example, following every Steering Committee meeting, the staff and interagency teams carry out a debrief conversation to evaluate how the meeting went and what follow-up is needed. Immediately following every public workgroup meeting on our Integrated Population Health Plan, we hold a meeting with all of the participating vendors to determine next steps.

Stakeholder Engagement

Rhode Island's Approach to Stakeholder Engagement

Rhode Island has traditionally valued the inclusion of the public and private stakeholders in efforts to transform our health care system. The Rhode Island State Innovation Model (SIM) Test Grant proposal is built on the intensive stakeholder engagement that was a hallmark of the State Health Innovation Plan creation that led to the SIM Model Design process. The Healthy Rhode Island Stakeholder Work Group consisted of nearly 150 stakeholders representing state government, payers, hospitals, physicians, long-term-care and behavioral health providers, community organizations, employers, the Narragansett Indian Tribe, and patient advocates.

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

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

Description of Stakeholders

Stakeholders were originally organized into three working groups:

- Core State Team;
- SIM State Working Group; and
- SIM Steering Committee.

Core State Team

The Core State Team met weekly February through April 2015 and was comprised of heads of staff from the Executive Office of Health and Human Services (EOHHS) and the Office of the Health Insurance Commissioner (OHIC). This team, headed by the acting SIM project director, was responsible for interfacing with the Center for Medicare and Medicaid Innovation (CMMI) and organizing the goals and deliverables of the SIM State Working Group, including development of project materials.

SIM State Working Group

The SIM State Working Group also met on a weekly basis during this time period and was comprised of additional EOHHS and OHIC staff. This team was responsible for the implementation of the SIM Grant. The team's original charge was to:

- Pursue the goals related to improved coordination of regulatory, fiscal, and policy levers;
- Work with other entities to ensure state efforts on data collection, reporting, and analyses are integrated and not duplicative; and

- Lead the transformation of state health and human services agencies, operating in a well-coordinated, cost-effective, transparent environment that is focused on the people of Rhode Island and the improvement of the state’s health care system.

SIM Steering Committee

The SIM Steering Committee held its first meeting on March 10, 2015 and has met monthly ever since (excluding a summer hiatus). This committee is the public/private governing body for the grant effort. It is charged with setting the strategic direction and policy goals. While regulatory promulgation and procurement issues will continue to rest with the state government, the Steering Committee exercises leadership discretion over the implementation of the SIM grant. The current Steering Committee is comprised of several members of the original Healthy Rhode Island Steering Committee (convened during the SIM Model Design process) who were actively engaged in the development of the SIM Grant and participated in the face-to-face interview for the SIM Test Grant proposal, and other community stakeholders.

Current Organization of Stakeholders

It became clear by May, 2015 that this structure needed to evolve to maximize our team’s efficiency in implementing SIM grant deliverables. In May, 2015 the Core State Team and the SIM State Working Group were combined into the SIM Interagency Planning Team and has met weekly since then. This team is now led by Marti Rosenberg who was hired as SIM Project Director in October, 2015. More recently, we have established several SIM Steering Committee workgroups to operationalize the Rhode Island SIM Test Grant.

SIM Interagency Team

Weekly SIM Interagency Planning Team meetings are attended by department heads, SIM dedicated staff and other staff members from the following state departments: Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH); Children Youth, and Families (DCYF); Executive Office of Health and Human Services (EOHHS); Health; HealthSource RI, Human Services, (DHS), and the Office of the Health Insurance Commissioner (OHIC). This new team is responsible for the strategic implementation of the project: organizing SIM goals and deliverables, and tracking metrics.

Additional Workgroups

The SIM Steering Committee continues to meet monthly. This public/private group remains the governing body of group and is charged with setting the strategic direction and policy goals of the grant effort. The Steering Committee has commissioned four of our own Workgroups to provide subject-matter expertise, community input, and recommendations for action. The Steering Committee may request the establishment of more workgroups as necessary. Current workgroups include:

- Integrated Population Health Plan;
- Measure Alignment;
- Patient Empowerment; and
- Technology Reporting.

Community Group Engagement

As noted above, to avoid duplicative meetings and extra work for the SIM staff, SIM is participating with two existing community groups to further our work with Community Health

Teams and Provider Practice Transformation. SIM is a regular part of their agendas so that we may consult with the experts sitting around their tables.

Entities Represented as Stakeholders

Tables 10 and 11 illustrate that Rhode Island has established meaningful relationships with a significant number of key stakeholders who are representative of their populations. Representatives from healthcare providers and systems, commercial payers and purchasers, state hospital and medical associations, community-based and long term support providers, and consumer advocacy organizations are engaged and actively committed to the implementation of the Rhode Island SIM Test Grant.

Stakeholders by Group

Table 10 lists stakeholder entities grouped into categories for each stakeholder group.

Stakeholders on Steering Committee

Table 11 lists each SIM Steering Committee stakeholder categories and their members, as well as the rationale for their engagement.

Table 10: Stakeholders by Group

		Medical Providers & Systems	Commercial Payers & Purchasers	State Hospital & Medical Associations	Community -based & Long Term Support Providers	Consumer Advocacy Organizations & Other Community Entities	State Government, Councils, Commissions, etc.
Interagency Planning Workgroup		Lou Giancola, CEO South County Health					EOHHS BHDDH DCYF DHS HEALTH HealthSource RI OHIC
SIM Steering Committee		Care New England Charter CARE Coastal Medical Lifespan RI Primary Care Physicians Corporation South County Health	Blue Cross Blue Shield of RI Neighborhood Health Plan of RI Tufts Health Plan UnitedHealthcare of New England	RI Business Group on Health RI Council of Community Mental Health Organizations RI Health Center Association RI Medical Society	CareLink YMCA of Greater Providence	RI Kids Count RI Foundation	EOHHS BHDDH DCYF DHS HEALTH HealthSource RI OHIC Office of the Governor
SIM Steering Committee Workgroups	Patient Engagement	Lifespan Care New England South County Health RI Primary Care Physicians Corporation The Providence Center UMass--CTC	Blue Cross Blue Shield of RI Neighborhood Health Plan of RI Tufts Health Plan UnitedHealthcare of New England	RI Medical Society RI Health Center Association RI Business Group on Health	CareLink YMCA of Greater Providence	RI Kids Count RI Foundation RI Parent Information Network Right Question Institute National Academy for State Health Policy Healthcentric Advisors RI Quality institute RTI International	EOHHS BHDDH DCYF DHS HEALTH HealthSource RI OHIC Office of the Governor Dept Labor & Training State Council on the Arts Commission on the Deaf & Hard of Hearing

		Medical Providers & Systems	Commercial Payers & Purchasers	State Hospital & Medical Associations	Community -based & Long Term Support Providers	Consumer Advocacy Organizations & Other Community Entities	State Government, Councils, Commissions, etc.
Technology Reporting		University Medicine Prospect Medical Holdings UMass—CTC East Bay Community Action Program Comprehensive Community Action Program	Blue Cross Blue Shield of RI Neighborhood Health Plan of RI UnitedHealthcare of New England	Hospital Association of RI		Healthcentric Advisors RI Kids Count RI Quality institute	EOHHS BHDDH
	Measure Alignment	Lifespan Care New England Women & Infants Hospital University Medicine	Blue Cross Blue Shield of RI Neighborhood Health Plan of RI UnitedHealthcare of New England Tufts	Hospital Association of RI RI Health Center Association RI Medical Society American Academy of Pediatrics RI	Brown University	RI Quality institute RI Parent Information Network	EOHHS BHDDH DCYF DHS HEALTH
		Integrated Population Health Plan	Gateway Health Horizon Healthcare Partners Integra Community Care Network PCMH-K Hasbro Children's Center Prospect Charter Care The Providence Center	Blue Cross Blue Shield of RI Neighborhood Health Plan of RI	RI Academy of Pediatrics RI Business Group on Health RI Health Center Association RI Medical Society		RI Parent Information Network RI Quality institute

Table 11: Stakeholders on Steering Committee

Stakeholder Information	Background and Rationale for Engagement
<p>Payers: Blue Cross Blue Shield RI Neighborhood Health Plan Tufts Health Plan UnitedHealthcare of NE</p>	<p>All of Rhode Island’s major commercial and Medicaid managed care payers are involved in SIM. The perspective of leaders from the payer community ensures that we have a clear understanding of the implications of a transformed payment system for insurers and for their members. Our goal is to move forward in a consistent, coordinated fashion on projects such as implementing an aligned measure set, creating a shared technology and reporting feedback system, and addressing the social and environmental determinant of health through Community Health Teams as the state and the payers make changes toward a value-based healthcare system.</p>
<p>Providers (Hospitals): Care new England Charter CARE Lifespan South County Hospital</p>	<p>Hospital stakeholders bring valuable experience and lessons-learned to the table. The three Rhode Island hospital systems and the one independent hospital listed are all currently engaged some level of payment reform, forming partnerships and aligning with payers to design new payment reform models.</p>
<p>Providers (Physician Practices): Coastal Medical RI Primary Care Physicians Corporation (RIPCPC)</p>	<p>Coastal Medical is Rhode Island’s largest, Private Group Practice, a Medicare Shared Savings Program Accountable Care Organization (ACO), and a Patient Centered Medical Home. Coastal physicians care for over 105,000 patients across Rhode Island and Massachusetts. RIPCPC is an independent practice association (IPA) that was formed to provide a venue for smaller independent practices to work together with the ultimate goal of improving quality of care for their patients. RIPCPC’s PCPs care for over 340,000 patients throughout the state. Both groups bring experience with working with hospitals on new payment models.</p>
<p>Providers (other): CareLink</p>	<p>CareLink is a nonprofit management service organization that provides key strategic business activities to its members who serve older adults and adults with disabilities, and consultation services to other health care providers. CareLink brings their experience with long-term care service models.</p>
<p>Community Entities: RI Business Group on Health Rhode Island Foundation Rhode Island Health Center Association RI Kids Count Rhode Island Medical Society Substance Use and Mental Health Leadership Council YMCA of Greater Providence</p>	<p>Each community entity represents their members on the Steering Committee, bringing to the body information about the impact of a transformed health care system on their membership, how the changes will improve population health and patient care for their membership, and thinking together about how the changes could reduce the cost of health care. We are asking members to assist with evaluating the risks and benefits of change and the identification of barriers, drivers, and priorities to consider in developing the Integrated Population Health Plan with a focus on behavioral health transformation.</p>
<p>EOHHS – Executive Office of Health & Human Services</p>	<p>EOHHS is responsible for coordinating the organization, finance, and delivery of services and supports provided through BHDDH, DCYF, DHS, and HEALTH. It is administering the SIM grant for the state and it is also the single state Medicaid agency. EOHHS has the legal authority to amend Medicaid related statutes/regulations related to payment reform and service delivery.</p>

Stakeholder Information	Background and Rationale for Engagement
RIDOH – Department of Health	RIDOH is the state agency specifically responsible for preventing disease and protecting and promoting the health and safety of the people of Rhode Island. RIDOH’s regulatory authority includes the ability to collect and track data for population health purposes, along with setting minimum standards of operations for 26 types of health care facilities, setting minimum qualifications and standards of care for 35 health-related professions, setting licensing fees for health professionals, and influencing prescribing behavior. Within this broad-based authority, RIDOH has numerous opportunities to develop and implement a population health plan as well as promulgate regulations in support of the Value-Based Care Paradigm.
BHDDH – Department of Behavioral Health, Developmental Disabilities, and Hospitals	BHDDH administers a comprehensive system of care for people with mental illness, physical illness, developmental disabilities, and substance use disorders, and administers a coordinated system of mental health promotion and substance abuse prevention. BHDDH is the State Mental Health Authority, the State Substance Abuse Authority, the licensing body of Behavioral Healthcare Organizations, an administrator of funding, and has the authority to propose, review, and/or approve proposals, policies or plans involving insurance and managed care systems for mental health and substance abuse services. BHDDH is a critical partner within SIM in carrying out a Behavioral Health Transformation plan as part of the Integrated Population Health Plan.
DCYF – Department of Children, Youth, and Families	DCYF was not part of the original list of state government stakeholders but has been added since the implementation of the grant in recognition of the role the agency plays in the health and well-being of children and specifically in its role as the children’s behavioral health authority. DCYF works closely with other state agencies including BHDDH and HEALTH to focus on improvements in child behavioral health, ensuring strong coordination of care for children in foster care. DCYF works with Medicaid in particular around children’s health care needs as they transition out of state care. DCYF’s work with SIM will inform the identification of barriers, drivers, and priorities to consider for children’s behavioral health as we develop and implement the Integrated Population Health Plan with a focus on behavioral health transformation.
DHS – Department of Human Services	DHS was not part of the original list of State government stakeholders but has been added since the implementation of the grant in recognition of the role the agency plays in the provision of services that are integral to health and well-being, including access to food, child care, and income assistance. DHS services benefit families, adults, children, elders, individuals with disabilities and veterans. DHS’s role is to assist with evaluating the risks and benefits of change and the identification of barriers, drivers, and priorities to consider in developing the Integrated Population Health Plan with a focus on behavioral health transformation.
OHIC –Office of the Health Insurance Commissioner	Rhode Island is the only state in the country with a health insurance commissioner. OHIC exercises prior approval rate and form review authority for individual, small group, and large group insurance markets. As of April 2014, these markets comprised 234,000 members (206,000 of whom are RI residents). OHIC revised its Affordability Standards in February 2015 to establish measurable standards for insurers to promote system-wide affordability of coverage and strategic investment in primary care infrastructure. SIM is using these standards to help further the principles of the Value-Based Care Paradigm.

Stakeholder Information	Background and Rationale for Engagement
<p>DOA – Department of Administration</p> <ul style="list-style-type: none"> a. HealthSource RI b. State Employee Health Care 	<p>DOA administers the State Employee Health Plan, covering over 35,000 Rhode Islanders between employees, dependents and retirees. DOA is currently exploring the development of an alternative health plan offering that includes a focus on health improvement through the use of value based networks and plan design. DOA also houses HealthSource RI, the state-based insurance market place that supports the Value-based Care Paradigm by working with health insurers to develop and promote health insurance plans focused on providing better care. Specifically, HealthSource RI has worked with health insurers on new plans with limited, integrated networks that incorporate an emphasis on patient-centered care and alternatives to traditional fee-for-service reimbursements.</p>

Strategy for Maintaining Stakeholder Commitment

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

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

Each organization on the SIM Steering Committee has identified an individual to provide guidance and subject matter expertise to the committee. This person is expected to participate for the full four-year grant period – and if he or she is unavailable for a meeting, is expected to ensure that an organizational representative attends in their absence. Each stakeholder may also be asked to participate in a workgroup to be established as required by the Steering Committee (See Table 1). Each stakeholder organization is also expected to facilitate the transformation of the health care system and the work of the Steering Committee as it relates to their organizations and the community at large. They are also expected to assure coordination between their organization and the Steering Committee.

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

The dual role of the Steering Committee chair is an integral component of our method for stakeholder engagement. The Chairperson is also an active participant of the SIM Interagency Planning team, attending weekly meetings and monthly planning sessions with the EOHHS Secretary and the Health Insurance Commissioner. This dual role provides a direct communication link between the two groups and ensures stakeholder input into all SIM Test Grant activities. Louis Giancola, CEO of South County Health, has served as Steering Committee Chair since in the inception of the committee. His energy and input has been integral to

ensuring open communication between the two groups and helping to develop the state's system transformation implementation.

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

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

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

Similarly, SIM engages with other stakeholders who are not official Steering Committee members, such as leaders of community action agencies, advocacy groups, and other interested parties. Much of the outreach at this level is conducted through Steering Committee workgroups as identified in Table 10. We are also planning public forums throughout the state, where members of the public can contribute and react to our Integrated Population Health Plan.

Under the direction of Governor Raimondo, there are two other large public health reform efforts that have been taking place over the past year which coordinate with SIM. First, the state began a re-design of the Medicaid Program¹ in 2015. The Governor appointed a diverse group of health care professionals, patient advocates, businesspeople and other policy leaders to address the structural challenges facing Rhode Island's Medicaid system. The effort is now being implemented, and informs Rhode Island's SIM activities.

Second, the Governor created the Working Group for Healthcare Innovation to provide recommendations regarding a global health spending cap for Rhode Island, to support the SIM goals of tying 80% of healthcare payments to quality by 2018, developing a next-generation health information technology system for all payers, and establishing performance management frameworks to achieve population health and wellness goals. The Workgroup has issued its first report, and SIM is prepared to continue working with the group as it moves forward.

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

¹ <http://reinventingmedicaid.ri.gov/>

Integrated Population Health Plan

See Appendix 1.

Healthcare Delivery System and Payment Transformation Plan

Traditional state functions for advancing policy consist of the state as convener, purchaser, regulator, infrastructure funder, and evaluator.² Rhode Island's State Innovation Model (SIM) Test Grant is structured such that its footprint marks each of these domains of state action and, at a high level, SIM acts as a collaborative space, or hub, for interagency policy alignment and coordination as well as a public/private partnership with its Steering Committee and other stakeholders. Rhode Island is committed to transform the local healthcare system through the coordinated use of regulatory and purchasing levers, direct investment in workforce and health information technology infrastructure, and public-private collaboration.

Baseline and Vision

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

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

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

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

Changing financial incentives is necessary, but not sufficient, for building a healthcare system that meets our vision. Rhode Island's SIM Test Grant coordinates state agency purchasing and regulatory initiatives along with private sector efforts to promote value-based payment and delivery system structures that support population health management, and are enabled by value-based payment. At the same time, the Rhode Island SIM Test Grant deploys direct investments in system transformation, encompassing support for Rhode Island's healthcare workforce and health information technology infrastructure.

² Recommendations Regarding State Action to Promote and Regulate Accountable Care Organizations (ACOs). A Legislative Report Required by Section 6(n) of the Rhode Island Health Care Reform Act of 2013 RIGL 42-14.5-3.

The Rhode Island Approach to Transformation

The Rhode Island approach to healthcare system transformation is statewide and comprises the following elements:

1. Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing and regulatory levers. Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an Alternative Payment Model (APM) by 2018, and 80% of payments linked to value.
2. Support for multi-payer payment reform and delivery system transformation with investments in workforce and health information technology.
3. Significant stakeholder engagement in policy development and SIM investment decisions through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups. In Rhode Island, healthcare delivery system transformation is a public-private partnership.
4. Fidelity to our Integrated Population Health Plan to ensure that transformation is aligned with our vision of improved physical and behavioral health for the state's residents.

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

1: Value-Based Payment Using Purchasing and Regulation

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

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

At the outset of the SIM project, uptake of VBP and APMs was uneven across the local healthcare market. Commercial insurers and their provider networks had the longest experience contracting under VBP and APMs. In 2014, 24% of commercial insured medical payments were made under an APM, largely comprised of fee for service payments made under population-based APMs with shared savings. These contracts were generally no more than two years old. Moreover, all commercial insurers with a minimum of 10,000 covered lives were required to have quality improvement programs with hospitals, and to tie at least 50% of annual hospital price increases to quality, which are subject to an overall inflation cap. Commercial insurers also had pay for performance contracts in place with most of their primary care network. VBP models and APMs were in an early stage of development in the Medicaid market. Quality measures used for value-based contracting were not aligned major payers.

³ Rajkumar R, Conway P, Tavenner M. CMS – Engaging Multiple Payers in Payment Reform. JAMA. 2014; 311(19): 1967-1968.

Year 1 (Pre-Implementation)

To accelerate payment reform, and coordinate action across all payers, the Office of the Health Insurance Commissioner (OHIC) and Medicaid stewarded two closely aligned processes to advance VBP and APMs in their respective market jurisdictions. OHIC and Medicaid have explicitly aligned payment reform targets with those announced in January 2015 by Secretary of Health and Human Services Sylvia Mathews Burwell⁴ and those articulated in the SIM Round Two Test Grant Funding Opportunity Announcement.

The SIM Project Director coordinated meetings between OHIC and Medicaid to ensure alignment of these initiatives. The SIM project has initiated an unprecedented level of interagency coordination and alignment in Rhode Island.

In February 2015, the beginning of the Rhode Island grant period, OHIC promulgated regulations that required commercial insurers to “significantly reduce the use of fee-for-service payment as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.”⁵ To carry out this provision OHIC convened an Alternative Payment Methodology Advisory Committee, which held two rounds of meetings, in the spring and fall. The key objectives of the meetings were to define APMs, collect data from health plans to measure the baseline rate of APM uptake, and to develop binding annual regulatory targets for commercial insurer use of APMs through 2018. The outcome of the OHIC process was the promulgation of regulatory targets for commercial insurers based on percent of insured medical spending that is made under an APM according to the following schedule:

Table 12: Rhode Island Commercial Payment Reform Targets

Year	Target
2016	30%
2017	40%
2018	50%

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

- **Type 1 Coordinated Care Pilot: Total Population, All Services:** This track offered an opportunity to contract for all Medicaid attributed populations, for all Medicaid services.

⁴ U.S. Department of Health and Human Services. (2015). *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value* [Press Release]. Retrieved from <http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>

⁵ OHIC Regulation 2 Section 10(d)(2)

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

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

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

Years 2-4 (Implementation)

Rhode Island is poised to significantly advance the use of VBP and APMs through the implementation period of the SIM grant. In year two, Medicaid will develop certification standards for Medicaid AEs. Medicaid MCOs will be expected to contract with AEs on a total cost of care basis for attributed populations, according to specific annual targets specified in the MCO's contract with the state. AEs must demonstrate the capacity to integrate and manage the full continuum of physical and behavioral healthcare, from preventive services to hospital based and long-term services and supports. AEs must also focus on the social determinants of health among their attributed populations. The AE contracting mechanism will be one of the primary means for Medicaid to achieve 50% of payments under an APM by 2018.

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

During year two of the grant, the SIM team will convene a learning collaborative comprised of providers and payers who are engaged in VBP and APMs, to discuss best practices around VBP contracting methodologies and implementation. With an eye toward process and program evaluation, the learning collaborative will shed light on what works, and discuss potential alignment of VBP contracting strategies. The collaborative will provide a valuable forum for providers and payers to learn from one another, to ensure that we maximize the potential of payment reform to support delivery system transformation and meet our cost, quality, and population health goals.

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.

2: Multi-Payer Reform Using Workforce Development and HIT

Support for multi-payer payment reform and delivery system transformation with investments in workforce development and health information technology.

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

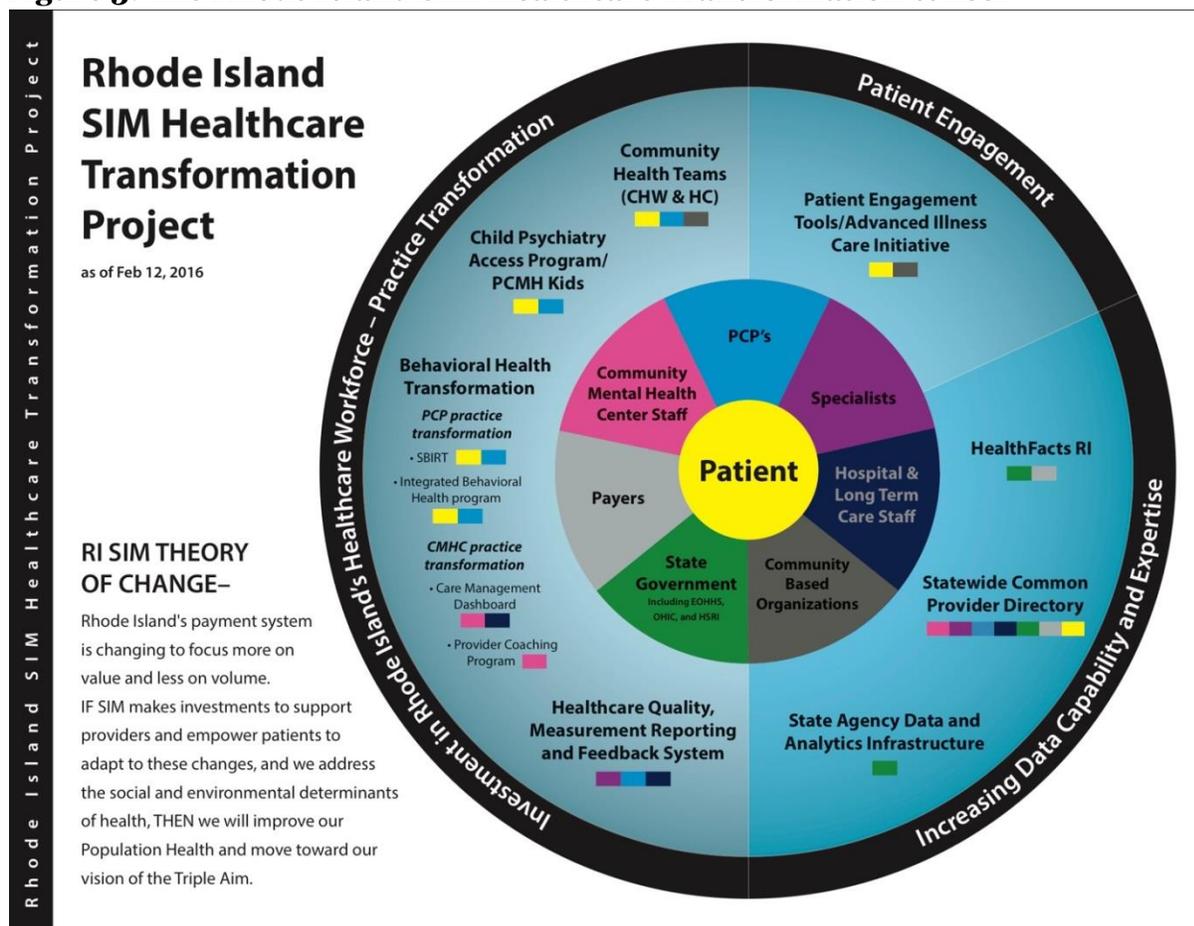
Year 1 - Pre-Implementation

During year one of the grant, the SIM Project Director met with each member of the SIM Steering Committee. The purpose of these meetings was to ascertain where the greatest needs are, and how SIM investments could best address those needs. The question of how Rhode Island should allocate SIM funds presented a choice between going “narrow and deep” or “wide and thin.” Through a lengthy and iterative process of consensus building, the SIM Steering Committee endorsed three interconnected buckets of SIM program investment:

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

The investments within each of these buckets address a critical need, which will facilitate payment reform and delivery system transformation. Figure 3, known among SIM stakeholders as “The Transformation Wheel” illustrates the portfolio of SIM investments authorized by the SIM Steering Committee.

Figure 3: The Rhode Island SIM Healthcare Transformation Wheel



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

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

Data analytic capacity and expertise is absolutely critical to improving and evaluating healthcare system performance. The SIM Steering Committee authorized investments in HealthFacts RI (Rhode Island's all payer claims database), a statewide Common Provider Directory, and infrastructure enhancements to Rhode Island's Data Warehouse.

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

Years 2-4 - Implementation

In year two, Rhode Island will procure the services and structures necessary to carry out the remaining activities enumerated in the Wheel. Rhode Island plans to apply the following principles to the implementation of these activities:

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

Practice Transformation

During Years 2-4, Rhode Island will continue to strengthen its health care workforce and the connection of that workforce to the community through the practice transformation initiatives outlined in the Wheel. The workgroups mentioned in the Year 1 Pre-Implementation phase will continue and be used for community feedback.

- Community Health Teams;
- Child Psychiatry Access Program;
- Behavioral Health Transformation; and
- Health Care Quality, Measurement Reporting and Feedback System.

Patient Engagement

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

The Patient Engagement Workgroup has convened and agreed to define patient/consumer/family engagement, identify the current state and gaps of RI's engagement activities, and recommend areas for investments to the SIM Steering Committee. This work will be carried out during the beginning of Year 2, with implementation of accepted recommendations to occur in Years 2-4.

Data Analytic Capacity and Expertise

We know that analytic capacity and expertise is absolutely critical to improving and evaluating healthcare system performance. In years 2-4, SIM state staff will continue to implement the four SIM components that will provide the data analytic capacity and expertise required to measure and inform our transformation efforts. These include maintaining and issuing reports and data from HealthFacts RI (the all payer claims database); completing the build of the provider directory and making its data available to state agencies, healthcare organizations, providers, and consumers in the form of aggregate files and a user-friendly website; and integrating data across EOHHS agencies in a state data ecosystem and driving policy with those data.

3: System Transformation Using Stakeholder Engagement

In Rhode Island, healthcare delivery system transformation is a public-private partnership. There is significant stakeholder engagement in policy development and SIM investments through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups.

Rhode Island has a long tradition of stakeholder engagement in policy development. The state's small size enables key stakeholders to physically convene on a regular basis and with relatively little cost. Healthcare reform in Rhode Island has benefitted greatly from this tradition. Under the leadership of then-Lieutenant Governor Elizabeth Roberts (who now serves as Secretary of the Executive Office of Health and Human Services) the Rhode Island Healthcare Reform Commission stewarded a process of lengthy public engagement around Affordable Care Act implementation. The Healthcare Reform Commission infrastructure was leveraged during Rhode Island's State Innovation Model Design phase, and supplemented by topic-specific workgroups, developed the State Health Innovation Plan (SHIP) which served as the basis of Rhode Island's State Innovation Model Test Proposal.

Year 1 -Pre-Implementation

Rhode Island's SIM project relies on significant stakeholder engagement to achieve consensus on where our healthcare system's needs are, and how we can best address those needs. During year one of the grant, the SIM Steering Committee met seven times and reached consensus on a portfolio of SIM funded investments for the life of the grant. The Steering Committee also

endorsed several workgroups to advise or develop specific products within the grant. These workgroups include:

- Integrated Population Health Plan
- Measure Alignment
- Technology Reporting
- Patient Engagement

In addition, SIM is working with two community groups that have brought stakeholders together to focus on Community Health Teams and Provider Practice Transformation. Rather than form our own competing workgroups that would bring people to duplicative meetings, we have asked these community organizations to allow Healthy Rhode Island to put topics on these workgroups' agendas and have them serve as our touchpoints on these issues. Workgroups have been an effective mechanism for processing the needs and goals of the larger community and achieving buy-in for specific investments and initiatives.

Years 2-4 -Implementation

All of these workgroups will continue through year two of the grant. The Integrated Population Health Workgroup will continue to meet on a quarterly basis, to check in on the progress toward population health improvement goals. The Technology Reporting Workgroup will continue to refine the scope of the Quality Measurement, Reporting and Feedback System for procurement by the state. The Patient Engagement Workgroup will continue to meet to assess the tools necessary to equip consumers with information to become effective consumers of health care. The Measure Alignment Work Group is discussed at length in that specific section. We may create additional workgroups in year two, including a group on Workforce Development.

4: Transformation Using Population Health Planning

Fidelity to our Integrated Population Health Plan to ensure that transformation is aligned with our vision of improved physical and behavioral health.

Rhode Island has committed to improving the physical and behavioral health of its residents. The Integrated Population Health Plan provides a philosophy and a set of recommendations for stakeholders, including state agencies, to ensure that policymaking and delivery system transformation are in agreement with our vision for improved population health. Rhode Island understands that much of what determines health is contingent on factors outside of medical care delivery. However, as payment models change to enable and incent system transformation, stakeholders should assess whether these models and structures are supporting improvements in the health of the population and communities served by the system. In the long-term evaluation of dental and vision with respect to population health may be required.

Year 1 -Pre-Implementation

In year one Rhode Island developed the Integrated Population Health Plan, included as a separate document to this Operational Plan. The Integrated Population Health Plan was completed with considerable guidance from the Rhode Island Department of Health and the Department of Behavioral Health, Developmental Disabilities and Hospitals.

RIDOH, which oversees the state's certificate of need (CON) program, has explicitly incorporated the following agency priorities into its guiding principles to review CON applications:

- Address social and environmental determinants of health;
- Eliminate disparities of health and promote health equity;

- Ensure access to quality health services for all Rhode Islanders, including vulnerable populations.

Years 2-4 - Implementation

SIM will continue to work with its partner agencies to expand on the Integrated Population Health Plan. We see it as a living document that will grow and adapt to modifications in policies or regulatory levers, changes in our overall population health, or to accomplishments of our SIM projects.

The SIM structure – with both interagency and public/private participation and our evaluation plan – will give us the platform and the flexibility to return to the Integrated Population Health Plan on a regular basis for review. We will measure the accomplishments of our work against its baseline and use its information to guide SIM decision-making.

Leveraging Regulatory Authority

Rhode Island is committed to using multiple regulatory and purchasing levers to advance the policies described in the healthcare delivery system transformation plan above. All of the state agencies that comprise the interagency team are engaged in this work. The following provides an overview of the key state regulatory levers that are currently being used, or plan to be used, to drive system transformation.

Executive Office of Health and Human Services

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

Medicaid

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

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

Department of Health

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

RIDOH publishes and circulates, from time to time, information that the Director may deem to be important and useful for dissemination among the people of the state. With no local health departments within the state, RIDOH provides advice in relation to those subjects relating to public health that may be referred to it by the general assembly or by the governor when the general assembly is not in session, or when requested by any city or town. RIDOH adopts and promulgates rules and regulations that it deems necessary to carry out the responsibility invested in the agency. The overall scope of RIDOH's roles and responsibilities includes, but is not limited to: health planning, vital records, immunization, facilities regulation, healthcare

professional licensing, vital records, disease outbreak response, food and water safety, laboratory testing, and other aspects of health promotion.

Department of Behavioral Health, Developmental Disabilities and Hospitals

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

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

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

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

Office of the Health Insurance Commissioner

Pursuant to RIGL §42-14.5-2 (4)-(5), the Office of the Health Insurance Commissioner has a statutory mandate to direct health insurers toward policies and practices that improve the health care system as a whole. OHIC exercises prior approval form and rate review authority for the individual, small group, and large group markets. As of April 2015, 232,297 people obtained insurance coverage through these markets. The annual review of health insurance forms and rates places critical scrutiny on the factors underlying medical trend, insurer administrative costs, and insurer financial strength. OHIC leverages its rate review authority and statutory mandate around system transformation to impose a set of initiatives to improve the healthcare system and support more affordable health insurance. These standards, known as the Affordability Standards, comprise three major elements:

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

HealthSource RI

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

- HSRI Qualified Health Plan certification—By coordinating with OHIC, EOHHS, and carriers, HSRI can actively solicit plans that advance payment reforms
- HSRI consumer education efforts—Empowering consumers to made better health choices, both in choosing plans and when using services
- Possible coordination of state employee plan with HSRI, for combined purchasing power
- HSRI's SHOP (Small Business Health Options Program) is providing services and insurance products to small employers

Quality Measure Alignment

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

Quality Measure Alignment Process

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

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

Year 1 - Pre-Implementation

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

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

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

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

The final product was a menu totaling 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures). See appendices for additional information and measure specifics.

Years 2-4 - Implementation

Two concurrent processes will occur during the implementation period. First, during year two, OHIC and EOHHS will develop a regulatory framework to mandate use of the core measure sets and adherence to the measure menu by regulated insurers. OHIC will issue regulations covering commercial insurers and EOHHS will incorporate the measure sets into its MCO contracts. The state will also develop a formal group to refine the menu and core sets over time. Due to changes in clinical standards, retirement of existing measures and introduction of new ones, and changing public health priorities, the measure review group will meet annually to refine the measure set.

In year two, the SIM team will also initiate a series of specialized work groups to align measures for specialty providers. The tentative schedule is to review measures for behavioral health providers, maternity care, cardiology, and orthopedics. For the latter two specialties, Rhode Island is awaiting further articulation by CMS of how the recently developed CMS Core Measure Set will be used.

Aligned Measure Sets

SIM Aligned Hospital Measure Set

Total Measures: 20

Core Measures by Domain (6)

Behavioral Health (1)

- Follow-Up After Hospitalization for Mental Illness (7-day)

Consumer Experience (1)

- HCAHPS - *questions not specified*

Institutional Care (4)

- Follow-Up After Discharge from ED for Mental Health or Substance Abuse
- HAI-2: CAUTI: Catheter-Associated Urinary Tract Infection
- HAI-6: Clostridium Difficile (C.diff.) Infections
- READM-30-HOSP-WIDE: Hospital-wide Readmission

Menu Measures by Domain (14)

Behavioral Health (1)

- 30-day Psychiatric Inpatient Readmission

Care Coordination (1)

- Care Transition Record Transmitted to Health Care Professional

Institutional Care (12)

- American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure
 - HAI-3: SSI: Colon - Surgical Site Infection for Colon Surgery
 - HAI-4: SSI: Hysterectomy - Surgical Site Infection for Abdominal Hysterectomy
- Cesarean Rate for Nulliparous Singleton Vertex (PC-02)
- Elective Delivery Prior to 39 Completed Weeks Gestation (PC-01)
- HAI-1: CLABSI: Central Line-Associated Blood Stream Infection
- HAI-5: Methicillin-resistant Staphylococcus Aureus (or MRSA) Blood Infections
- PC-05: Exclusive Breast Milk Feeding
- READM-30-AMI: Heart Attack Readmission
- READM-30-HF: Heart Failure Readmission
- READM-30-PN: Pneumonia Readmission
- STK-4: Thrombolytic Therapy
- SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge
- Transition Record with Specified Elements Received by Discharged Patients

SIM Aligned ACO Measure Set

Total Measures: 59

Core Measures by Domain (11)

Behavioral Health (2)

- Follow-Up after Hospitalization for Mental Illness (7-day)
- Screening for Clinical Depression and Follow-Up Plan

Chronic Illness (2)

- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
- Controlling High Blood Pressure

Consumer Experience (1)

- PCMH CAHPS (for primary care) - *questions not specified*

Preventive Care (6)

- Breast Cancer Screening
- Colorectal Cancer Screening
- Tobacco Use: Screening and Cessation Intervention
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Developmental Screening In the First Three Years of Life
- Adult BMI Assessment

Menu Measures by Domain (48)

Behavioral Health (5)

- 30-day Psychiatric Inpatient Readmission
- Anti-Depressant Medication Management
- Follow-Up Care for Children Prescribed Attention – Deficit/Hyperactivity Disorder
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia – *Medicaid only*

Care Coordination (1)

- Care Transition Record Transmitted to Health Care Professional

Chronic Illness (5)

- Medication Management for People with Asthma
- Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mmHg)
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

Consumer Experience (3)

- ACO CAHPS - Access to Specialist
- PCMH CAHPS (for primary care) - *questions not specified*
- HCAHPS - *questions not specified*

Institutional Care (16)

- American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure
 - HAI-3: SSI: Colon - Surgical Site Infection for Colon Surgery
 - HAI-4: SSI: Hysterectomy - Surgical Site Infection for Abdominal Hysterectomy
- Cesarean Rate for Nulliparous Singleton Vertex (PC-02)
- Elective Delivery Prior to 39 Completed Weeks Gestation (PC-01)
- HAI-1: CLABSI: Central Line-Associated Blood Stream Infection
- HAI-2: CAUTI: Catheter-Associated Urinary Tract Infection
- HAI-5: Methicillin-resistant Staphylococcus Aureus (or MRSA) Blood Infections
- HAI-6: Clostridium Difficile (C.diff.) Infections
- PC-05: Exclusive Breast Milk Feeding
- READM-30-AMI: Heart Attack Readmission
- READM-30-HF: Heart Failure Readmission
- READM-30-HOSP-WIDE: Hospital-wide Readmission
- READM-30-PN: Pneumonia Readmission
- STK-4: Thrombolytic Therapy
- SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge
- Follow-Up After Discharge from ED for Mental Health or Substance Abuse
- Transition Record with Specified Elements Received by Discharged Patients

Overuse (5)

- Appropriate Testing for Children with Pharyngitis
- Use of Imaging Studies for Low Back Pain
- Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
- PointRight Pro 3.0 30-Day All-Cause SNF Rehospitalization
- Plan (ACO) All-Cause Readmission

Preventive Care (10)

- Cervical Cancer Screening
- Chlamydia Screening
- Adolescent Well Care Visits
- Human Papillomavirus (HPV) Vaccine for Female Adolescents
- Childhood Immunization Status
- Immunization Status for Adolescents

- Lead Screening for Children
- Annual Dental Visits – *Medicaid only*
- Frequency of Ongoing Prenatal Care – *Medicaid only*
- Prenatal and Postpartum Care: Postpartum Care Only

Utilization (3)

- Percentage of Prescriptions that are Generic Scripts
- Inpatient Visits/1000 (Inpatient Utilization - General Hospital/Acute Care)
- ED visits per 1000

SIM Aligned Primary Care Measure Set as of March 10, 2016

Primary Care-Influenced Measures: 34

Core Measures by Domain (7)

Behavioral Health (1)

- Screening for Clinical Depression and Follow-Up Plan

Chronic Illness (2)

- Controlling High Blood Pressure*
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)*

Preventive Care (4)

- Adult BMI Assessment*
- Tobacco Use: Screening and Cessation Intervention*
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**
- Developmental Screening In the First Three Years of Life**

Menu Measures by Domain (27)

Behavioral Health (5)

- Follow-Up after Hospitalization for Mental Illness (7-day)
- 30-day Psychiatric Inpatient Readmission
- Anti-Depressant Medication Management
- Follow-Up Care for Children Prescribed Attention – Deficit/Hyperactivity Disorder
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Chronic Illness (5)

- Medication Management for People with Asthma
- Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mmHg)*
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

Consumer Experience (1)

- PCMH CAHPS (for primary care) - *questions not specified*

Overuse (3)

- Plan (ACO) All-Cause Readmission
- Appropriate Testing for Children with Pharyngitis
- Use of Imaging Studies for Low Back Pain

Preventive Care (10)

- Breast Cancer Screening
- Colorectal Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening

- Adolescent Well Care Visits
- Human Papillomavirus (HPV) Vaccine for Female Adolescents
- Childhood Immunization Status
- Immunization Status for Adolescents
- Lead Screening for Children
- Annual Dental Visits – *Medicaid only*

Utilization (3)

- Percentage of Prescriptions that are Generic Scripts
- Inpatient Visits/1000 (Inpatient Utilization - General Hospital/Acute Care)
- ED visits per 1000

* CTC-RI measure

** PCMH-Kids measure

SIM Alignment with State and Federal Initiatives

One of the goals of Rhode Island's State Interagency Team and our significant stakeholder process is to make ourselves aware of the existing healthcare innovation initiatives occurring within the state so that we can build on their achievements and avoid duplication of funding. The list below lays out the initiatives currently underway in Rhode Island that we are aware of, and how our SIM project relates to, aligns with, or augments these efforts.

Current CMMI Projects and Awards

Health Care Innovation Awards

The Health Care Innovation Awards are three-year grants that are provided to organizations to implement new ideas in order to deliver better care to Medicare, Medicaid and the Children's Health Insurance Program CHIP recipients. The Rhode Island recipients are presently: Health Resources in Action, Women and Infants Hospital, and the University of Rhode Island. According to the CMMI website,

The Health Care Innovation Awards are funding up to \$1 billion in awards to organizations that are implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs.

The Health Resources in Action "New England Asthma Innovation Collaborative" (NEAIC) is a multi-state, multi-sector partnership convened by the Asthma Regional Council of New England (ARC). They have created an innovative Asthma Marketplace in New England to increase the supply and demand for high-quality, cost-effective health care services delivered to Medicaid children with severe asthma.

RI SIM can learn about NEAIC's workforce development activities that are training community health workers focused on asthma treatment and prevention. We have met HRiA staff and will continue to connect with them to explore whether our community health teams can work together and learn from each other, rather than duplicating efforts.

We can also connect with the Partnering with Parents program at Women and Infants Hospital, which is improving services for approximately 2400 families in Rhode Island who have pre-term or high-risk full term babies with a Neonatal Intensive Care Unit (NICU) admission of 5 or more days. The program has hired, trained and deployed Early-Moderate Preterm, Late Preterm, and high-risk Full Term family care teams to offer education and support to parents during the transition from the NICU to home, and monitor infants' growth and development. RI SIM can also learn from these community health workers and work to align our teams with theirs.

Bundled Payments

Kent Hospital, Newport Hospital, Rhode Island Hospital, The Miriam Hospital and multiple home health agencies are operating with Bundled Payment Models Two and Three, in which payments are structured around an episode of care (Two: Acute and Post-Acute, Three: Post-Acute Episode Only.) While bundled payments are not an explicit part of our SIM Model Test today, we will follow this program to monitor its outcomes.

Multi-Payer Advanced Primary Care Practice (MAPCP)

Under this demonstration, fee-for-service Medicare joined the state-based Chronic Care Sustainability Initiative (now called the Care Transformation Collaborative or CTC) multi-payer medical home demonstration. Rhode Island is one of eight states chosen to participate in this unique state-federal partnership, where CMS agreed to join multi-payer demonstrations based on state-designed payment and delivery system reforms. CTC is a close SIM partner, and we are working together to request ongoing Medicare participation in the state's multi-payer medical home collaborative.

Transforming Clinical Practice Initiative (TCPI)

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

- Promote broad payment and practice reform in primary care and specialty care,
- Promote care coordination between providers of services and suppliers,
- Establish community-based health teams to support chronic care management, and
- Promote improved quality and reduced cost by developing a collaborative of institutions that support practice transformation.

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

In their TCPI planning, RIQI aligned their measures to match SIM's (with CMS' approval), and we are in regular contact with RIQI staff to ensure that we are working together as closely as possible to coordinate practice transformation efforts

Accountable Health Communities

Rhode Island Medicaid, RIDOH, and SIM have been working together to assist several private sector health organizations apply for funding within the current Accountable Health Communities (AHC) grant application. We expect at least two bridge organizations to submit applications by the May 18th CMS deadline – and we hope that at least one of those organizations is chosen. We believe that the aim of the grant – to systematically identify the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries, (including those who are dually eligible), and address their identified needs – will be an important addition to the SIM impact on Rhode Island's Population Health.

EOHHS Programs, with Federal and State Funding

Integrated Care Initiative

A recent focus of the State's Medicaid program has been on EOHHS' Integrated Care Initiative (ICI), which is designed to better align the care and financing of Medicare and Medicaid, promote home and community based care, and provide cost-effective care for adults with disabilities and the elderly. During Phase I of the ICI, EOHHS established a capitated Medicaid managed care plan for adults with full Medicare (Parts A, B, and D) and full Medicaid coverage, as well as Medicaid-only adults who receive long-term services and supports (LTSS). There currently are about 21,000 people enrolled in the Medicaid managed care plan established during Phase I.

Under Phase II, Rhode Island will establish a fully integrated capitated Medicare-Medicaid plan for adults with full Medicare (Parts A, B, and D) and full Medicaid coverage. Federal authority for Phase II is through the Center for Medicare and Medicaid Services (CMS) Financial Alignment Demonstration (FAD), a federal demonstration to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health, and LTSS for Medicare-Medicaid enrollees. About 10,000-14,000 people are expected to enroll in the Medicare-Medicaid plan.

Medicaid 1115 Waiver

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

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

The 1115 Waiver savings fell short of promised levels, in part because the State realized that many of the elderly Medicaid recipients who could have been eligible to be transferred out of long term care facilities did not have safe, community-based housing to which they could return. The State recently submitted an extension request with a specific focus on enabling funds to be used to support housing.

Medicaid Health Homes

Although CMS financial support recently ended, Rhode Island continues to support three of these Medicaid innovative complex care delivery models; one is for the pediatric population and builds upon a pre-existing program called Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation (CEDARR). The other two are adult-focused programs. The Integrated Health Home is for the serious and persistent mentally ill population and is operated by the eight Community Mental Health Organizations licensed by BHDDH. The other adult

health home is for persons who are receiving Opioid Treatment, such as Methadone Maintenance and who have or who are at risk of other chronic conditions. This program is operated by the BHDDDH-certified Opioid Treatment Programs. According to CMS, health homes are designed to serve Medicaid enrollees who meet one of the following criteria (Centers for Medicare and Medicaid Services, 2010):

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Early data suggests that families using the CEDARR program have an improved quality of life – and SIM can learn from this data when evaluating our Community Health Teams.

Medicaid Accountable Entities

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

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

The core objectives of the AE program include:

- Substantially transition away from fee-for-service models.
- Define Medicaid-wide population health targets, and, where possible, tie them to payments.
- Use the aligned measures set created by the SIM stakeholder team.
- Maintain and expand on our record of excellence in delivering high quality care.
- Deliver coordinated, accountable care for high-cost/high-need populations.
- Ensure access to high-quality primary care.
- Shift Medicaid expenditures from high-cost institutional settings to community-based settings.

Home Stabilization Services

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

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

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

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

Money Follows the Person

In April 2011, a Money Follows the Person (MFP) demonstration grant was awarded to Rhode Island. This \$27 million grant provides Rhode Island with support to achieve its goal of rebalancing the long term care systems. The goals are to support the transition of individuals out of long term care facilities and back into their home through the use of improved home and community-based services as well as to eliminate the barriers and mechanisms in state laws, state Medicaid plans or state budgets that prevent or restrict the flexible use of Medicaid funds. The grant was extended so that the last year of transition will take place in 2018, with the grant officially ending by September 30, 2020.

Adult Medicaid Quality Grant

CMS awarded EOHHS an Adult Medicaid Quality Grant (AMQ) in December 2012 to: 1) develop State capacity in the measurement, analysis, and reporting of health care quality; 2) establish a core set of regularly reported Adult Quality Measures across Medicaid populations and enhance the communication of these measures within and among state agencies and stakeholders; and 3) improve the quality of care delivered to Medicaid members. CMS recently approved a second No-Cost Extension of the grant extending the end date to December 20, 2016.

Accomplishments to date include:

- Established the Analytic & Evaluation Unit to inform program evaluation efforts across EOHHS: increased the capacity to calculate AMQ measures across Medicaid, assessed current data infrastructure and capabilities; and currently working to standardize recipient categories and develop file structures that can link claims from all data sets into more manageable analytical files.
- Completion of a Transitions of Care Quality Improvement Program (QIP) that brought together hospitals and community providers to measure and improve information transfer upon patient discharge.
- Entering final phase of an Antidepressant Medication Management QIP to improve rate of adherence for newly prescribed antidepressant medication.
- Awaiting final report on an Electronic Health Record Project to analyze the feasibility and validity of collecting diabetes screening measures directly from EHRs versus through claims data.

RIDOH Programs

Health Equity Zones

Health Equity Zones are contiguous geographic areas that have measurable and documented health disparities, poor health outcomes, and identifiable social and environmental conditions to be improved. Health Equity Zones (HEZs) are designed to achieve health equity by eliminating health disparities using place-based strategies to promote healthy communities. The 11 HEZ Collaboratives are funded with State and Federal dollars in partnership with the Rhode Island Department of Health (RIDOH). The HEZs support innovative approaches to prevent chronic diseases, improve birth outcomes, and improve the social and environmental conditions of neighborhoods across five counties statewide, all of which are core focus areas for the Accountable Health Communities grant initiative described above. Drawing on our guiding principles, the HEZ Collaborative is built on meaningful and true engagement of multi-sector key stakeholders working together, and include municipal leaders, residents, businesses, transportation entities, faith leaders, community planners and partners, law enforcement, education systems and health systems, among others.

Certification of Community Health Workers (CHWs)

Certification of Community Health Workers (CHWs) has been identified as a priority for RIDOH and the development of a certification process is well-underway to strengthen and grow this important workforce. Community Health Teams are a central SIM priority, and so this work is critical to SIM's success. In addition to certification, there are several CHW infrastructure building projects in the planning stage that involves a partnership with Rhode Island College to offer the CHW core competency training, support CHW employers, and provide additional opportunities for specialization in focus areas such as behavioral health. CHWs are frontline public health workers who serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural responsiveness of service delivery. Typically, CHWs are non-licensed, gain expertise from life experience and some community/health education. This lack of health professional licensing makes it difficult for CHWs to receive reimbursement for the valuable role they play in improving the health of their community and working with a community health team.

Academic Center

RIDOH's Academic Center is a new initiative that aims to achieve excellence in public health practice while producing the next generation of multidisciplinary public health practitioners. This area of focus at RIDOH aligns with the workforce capacity and monitoring component of the SIM initiative. The Academic Center focuses on building a competent public health workforce with subject-matter expertise, researching for new insights and innovative solutions to health problems, and evaluating effectiveness and quality of public health services, all of which advance progress towards improved public health functioning (assessment, policy development and assurance), enhanced public health outcomes, and health equity. Rhode Island's SIM Project and RIDOH's Academic Center can align through strengthening the integration of scholarly activities with public health practice by instilling a culture of learning and innovative implementation along with continuous quality improvement in the areas of practice transformation and population health needs.

BHDDH - Federal SAMHSA Grants

Mental Health and Substance Use Block Grants

Mental Health and Substance Use Block Grants available for all 50 states, are non-competitive grants awarded annually to states that provide funding for mental health and substance abuse services. Priorities for BHDDH's Block Grant funds in FY2016-2017 include: 1) adults with serious mental illness, with a focus on reducing unnecessary Emergency Department use, hospital admissions, readmissions and inappropriate lengths of stay; 2) older adults with serious emotional disturbance with a focus on developing a needs assessment and joint action plan with partnership agencies in Rhode Island, including the Division of Elderly Affairs (DEA), Executive Office of Health and Human Services (EOHHS), Community Mental Health Organizations, and the Rhode Island Elder Mental Health Advisory Council; 3) persons with serious mental illness who are homeless and need affordable housing with supportive services that focus on housing retention. Additional focus is directed to helping these individuals gain access to resources to which they are entitled, including Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP). Social Security; 4) persons who have or are at risk of having Substance Use Disorders and/or Serious Mental Illness/Serious Emotional Disturbance; 5) persons who are at risk for tuberculosis; 6) pregnant and parenting women with substance use disorders and their children; and 7) transition age youth/young adults with severe mental illness and co-occurring disorders.

Collaborative Agreement to Benefit Homeless Individuals

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

Project for Assistance in Transition from Homelessness Program

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

Healthy Transitions

Healthy Transitions is five-year grant, serving 2500 youth and young adults ages 16-25. It focuses on helping persons who are at risk for developing, or who have already developed a serious mental health condition. The implementation communities for this grant are Warwick and Woonsocket. Serving the communities at large in these locales, the grant activities will focus on public awareness of the early warning signs of mental illness in young people and how to take action; active outreach, engagement and referral; access to effective clinical and supportive

interventions; and sustainable infrastructure changes to improve cross system coordination, training, service capacity and expertise. The grant is supported by a Project Director at BHDDH and Youth Coordinator at Department of Children, Youth and Families. This initiative is helping to forward the work of Rhode Island's Children's Cabinet.

Strategic Prevention Framework Partnerships for Success

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

OHIC

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

To assist in this work, OHIC has convened two committees: Care Transformation Advisory Committee and the Alternative Payment Methodology Advisory Committee.

Care Transformation Advisory Committee

This Committee is charged with developing an annual care transformation plan designed to achieve the new Affordability Standards requirement: 80% of the primary care practices contracting with the Health Insurer are to be functioning as Patient-Centered Medical Homes (PCMHs), no later than December 31, 2019. The Care Transformation Committee advises OHIC on the challenges faced by provider, insurer and consumer stakeholders and devises possible responses to these issues. The plan, which includes yearly targets for PCMH adoption and activities to support care transformation, is submitted for the Health Insurance Commissioner's approval each year.

Alternative Payment Methodology Committee

This Committee is charged with developing an annual Alternative Payment Methodology (APM) plan for increasing the use of alternative payment methodologies aimed at driving payment toward value-based models that reward improved quality, efficiency and patient-centric care delivery. The plan, which includes types of payments that qualify as APM payments, annual targets, target dates, and steps payers will take to achieve these targets, is also submitted for the Health Insurance Commissioner's approval annually.

These two Committees significantly contribute to the stakeholder engagement that supports the SIM project. They have been convened twice, once in spring 2015 to develop the 2016 Care Transformation and APM Plans and once in fall 2015 to develop the 2017 plans. In February 2016, the Commissioner approved the 2017 plans. OHIC anticipates working with committee members to implement the plans throughout 2016 and will reconvene the two Committees in the fall to discuss activities and targets for 2018. OHIC will continue to work with other state agencies as part of the SIM effort to align delivery and payment system reform efforts.

Governor's Office Initiatives

Finally, Governor Gina Raimondo created the Working Group for Healthcare Innovation in 2015, to build on the foundation of our Working Group to Reinvent Medicaid and to improve patient care and health outcomes, and lower costs for all Rhode Islanders. Chaired by Health and Human Services Secretary Elizabeth Roberts, the group developed recommendations to improve the state's healthcare system, support better health outcomes, lower costs and provide businesses with more predictability, including the creation of an Office of Health Policy within EOHHS to better coordinate health policy decisions that affect all Rhode Islanders, and the consideration of a global healthcare spending target. The administration is in the process of determining how to implement the recommendations.

Workforce Capacity Monitoring

Stakeholder Engagement

Fundamental to restructuring the healthcare delivery system and achieving the triple aim is the development and support of a workforce that has the training, knowledge, and experience necessary to deliver healthcare and wellness services in new and innovative ways. This is likely to entail new job titles, new duties, new work settings, and new skill sets for healthcare employees. This “workforce transformation” cannot and will not be achieved by a single healthcare provider, educational institution, or payer. Rather, it will take an unprecedented collaborative and visionary approach by all stakeholders to identify and implement new workforce development strategies that will successfully address the current and projected workforce needs of healthcare providers and the community at-large.

The Rhode Island Executive Office of Health & Human Services has recently demonstrated its commitment to aligning healthcare workforce development and delivery system transformation by creating the position of Director of Healthcare Workforce Transformation, which will be responsible for developing and overseeing the implementation of a healthcare workforce transformation plan for the state. This workforce planning process will engage a multi-stakeholder Healthcare Workforce Transformation Committee comprised of key stakeholders representing healthcare providers, educators (K-12 and post-secondary), professional associations, labor organizations, managed care organizations, and appropriate state agencies. The Workforce Transformation Committee will advise the workforce planning process and develop strategies that support the SIM project, as well as Rhode Island’s Medicaid-led Health System Transformation Program. Specifically, the Healthcare Workforce Transformation Committee will:

- Develop a profile of the current healthcare workforce in Rhode Island, including job titles, duties, employment levels, education requirements, skill requirements, licensure requirements, etc.
- Determine the type of continuing education and training needed by the current workforce, consistent with anticipated healthcare delivery system restructuring
- Develop a profile of the future healthcare workforce in Rhode Island, consistent with anticipated healthcare delivery system restructuring
- Determine the type of training and education needed to prepare the future workforce, consistent with anticipated healthcare delivery system restructuring
- Determine the capacity of healthcare providers and education and training institutions to meet the education and training needs of the current and future workforce
- Identify barriers to achieving workforce transformation, and strategies to overcome such barriers, including: labor market competition among healthcare providers; divergent patient care models and skill mixes among healthcare providers; lack of coordination and/or consensus among education and training providers; resistance from employees, professional association, and unions; workforce skills gaps; limited training and education capacity; prohibitive training costs, etc.
- Develop workforce transformation metrics

Research and Studies

A number of on-going and ad hoc efforts have been undertaken in Rhode Island to document current healthcare workforce supply and demand, as well as current and projected employment levels, by occupation and sectors of the healthcare industry.

Department of Labor & Training Labor Market Information

The Labor Market Information (LMI) division of the Rhode Island Department of Labor & Training collects and reports a wealth of labor market data on a regular or as-needed basis. This data – which is derived from census data, wage records, and employer surveys -- is often further analyzed, customized, and cited by educators, healthcare providers, policy-makers, and others to assist in planning efforts. Some examples of useful LMI data include:

For every healthcare occupation

- Total employed
- Projected employment over 10 years
- Projected growth rate over 10 years
- Projected vacancy rate (growth plus attrition)
- Age of workforce
- Wage rates (average minimum, mean, maximum)
- Unemployment rates and numbers
- Current job postings
- Educational requirements
- Comparisons with same occupations in other states

For all healthcare employers

- Number of employers by sector (eg, hospital, long-term care, ambulatory)
- Total employment by sector
- Age of workforce by sector
- Wage rates by sector

According to the most recent LMI data, Rhode Island's Healthcare and Social Assistance sector employed 81,413 people in the third quarter of 2015, representing nearly 20% of the state's entire private sector workforce. Of these, 18,414 were employed in nursing and residential care facilities, 23,675 in hospitals, 26,544 in ambulatory healthcare services, and 12,780 in social assistance. Furthermore, the Healthcare and Social Assistance sector is comprised of 3,332 distinct employers. 85% of these entities employ fewer than 20 workers; while 25% of the healthcare and social assistance workforce is employed by just 53 employers.

Table 13: Rhode Island’s Healthcare and Social Assistance Sector Workforce

Healthcare & Social Assistance	Total	0-19	20-49	50-99	100-249	250-999	1000+
Ambulatory Healthcare Services							
# of Firms	1,830	1,608	123	48	32	19	-
# of Employees	26,544	7,765	3,693	3,389	4,487	7,210	-
Hospitals							
# of Firms	21	•	•	•	•	6	8
# of Employees	23,675	•	•	•	•	4,762	18,657
Nursing and Residential Care Facilities							
# of Firms	175	90	29	40	64	12	-
# of Employees	18,414	160	930	2,836	9,601	4,887	-
Social Assistance							
# of Firms	1,306	1,194	65	28	11	8	-
# of Employees	12,780	3,655	1,981	1,919	1,713	3,512	-
Total							
Total # of Firms	3,332						
Total # of Employees	81,413						
<i>Note: Some Hospital data has been omitted in order to preserve the confidentiality of individual entities.</i>							
<i>Source: RI DLT, September 2015 QCEW</i>							

Workforce Intermediaries

For the past ten years, the Governor’s Workforce Board of Rhode Island has supported “Industry Partnerships” to raise awareness of the workforce needs of employers in vital sectors of the Rhode Island economy. In the past year, these Industry Partnerships have been designated as “Real Jobs Rhode Island Partnerships” under a new program run by the Department of Labor & Training. Real Jobs partnerships will continue to serve as workforce intermediaries by providing essential information about the workforce needs, challenges, and opportunities in their industry, so that providers of workforce education, training, and other pre-employment services are well-positioned to respond to employer demand.

In 2014, Rhode Island’s healthcare industry partners published a skills gap study entitled, [*Rhode Island’s Healthcare Workforce: Assessing the skills gap and providing recommendations to meet the industry needs*](#). The study provides a detailed profile of our current and projected healthcare workforce supply and demand, identifies workforce skills gaps and other workforce challenges, and offers recommendations to address the education and training needs of healthcare employers and workers.

Among the key recommendations in the report were to:

- Develop and expand experiential learning opportunities (i.e., internships, clinical placements, residency programs, etc.)
- Develop career pathways that provide coaching, support, continuing education, and career advancement at all steps on the career ladder
- Incorporate “soft skills” training (i.e., communication, problem-solving, teamwork, cultural competency, etc.) in all workforce training
- Formalize and strengthen partnerships between healthcare providers and educators

Department of Health

In 2015, the Rhode Island Department of Health (RIDOH) published its first biennial Statewide Health Inventory of “all healthcare facilities, health services, and institutional health services”, with data on the location, distribution, and nature of the state’s healthcare resources, in

accordance with Rhode Island law. The law also requires RIDOH to conduct a statewide healthcare utilization and capacity study, and to create a statewide health plan that incorporates the data and analysis of the Statewide Health Inventory to develop the state's Integrated Population Health Plan. While the Statewide Health Inventory does not evaluate the current capacity or need for specific healthcare occupations, it does provide a highly detailed assessment of the range of healthcare services and resources in Rhode Island, and offers several key findings that have implications for workforce development, including:

- The number of full-time equivalents of primary care physicians is up to 40% lower than previous estimates and is about 10% less than national standards for adequate access to care.
- Substantially limited data exists across practices and facilities regarding the race, ethnicity and primary languages of patients, and there is a lack of appropriate interpreter services at many healthcare facilities and practices.
- As the Reinventing Medicaid initiative seeks to expand access to community-based settings for long-term care, 51% of assisted living residences reported they are not accepting new Medicaid patients.
- The survey of patients and communities in Rhode Island suggests that financial barriers, such as high co-pays and deductibles, may be preventing Rhode Island residents from receiving the care they need when they get sick.

In the coming year, RIDOH intends to expand upon the Statewide Health Inventory by conducting surveys of Rhode Island's licensed healthcare professionals to assess their education, years of service demographics, employment status, and other characteristics that determine the capacity of our healthcare workforce.

Private studies

In addition to the public reports and analyses that will guide SIM workforce strategies, workforce studies and plans are periodically conducted by health systems, colleges and universities, trade associations, professional associations, and public agencies. These reports will also help to inform the work of the SIM project. In addition, SIM may elect to conduct additional labor market research, as warranted, in order to fully assess the workforce needs of our healthcare providers and communities.

Specific SIM-Related Workforce Issues

The SIM project has identified several priorities for healthcare workforce and practice transformation. The following provides a brief overview of the challenges and opportunities for each.

Behavioral Health/Substance Abuse

As noted elsewhere, Rhode Island faces substantial healthcare, workforce, and cost-related challenges in responding to the substantial behavioral health needs in Rhode Island, including substance abuse, trauma, Alzheimer's and dementia, and developmental disabilities. The increasing demand for services, an aging workforce, and high employee turnover rates have all contributed to a growing behavioral health labor shortage. Solutions to this shortage will require an increased focus on developing behavioral healthcare career pathways, as well as on new care delivery models, both of which will require innovative approaches to preparing the behavioral healthcare workforce.

Community Health Workers

Like many states, Rhode Island is actively exploring the use and potential of Community Health Workers in supporting patients and caregivers as integral members of Community Health

Teams. The Rhode Island College Community Health and Wellness Program has partnered with healthcare providers and policy-makers to identify the need and opportunities for training, and perhaps certifying, Community Health Workers. Currently, there is little consensus regarding the scope of practice, training and education, certification, or compensation of Community Health Workers in Rhode Island. The SIM project recognizes the importance of clarifying these issues pertaining to Community Health Workers, as well as for other poorly-defined occupations such as Patient Navigators, Care Coordinators, Medical Assistants, etc.

Information Technology

Under the leadership of Governor Gina M. Raimondo, Rhode Island has launched several new initiatives to increase the information technology skills of the state's workforce. Among these new initiatives are P-Tech (a dual enrollment program that enables high school students to access college-level courses and internships in IT occupations); TechHire (a competency-based IT training program for unemployed and underemployed Rhode Islanders); and CS4RI (a high school-based computer science initiative). In addition, YearUp-Providence, a one-year, intensive training program for low-income young adults, has launched a partnership with Lifespan, Rhode Island's largest hospital system, to provide hands-on skill development, college credits, and corporate internships in healthcare information technology. These IT programs can and will be leveraged by SIM to increase the health IT capacity of the healthcare workforce.

Health Professional Education

Integral to the SIM Workforce and Practice Transformation model will be the need to prepare Registered Nurses and other health professionals for working in interdisciplinary teams and in specialties such as home care, behavioral health, chronic care management, community health, health informatics, and other areas of focus in the SIM project. To accomplish this specialized training, it will be essential for healthcare providers and educators to join forces to provide expanded and focused clinical and didactic training both pre- and post-licensure. The SIM project will convene and support providers and educators to develop innovative approaches to health professional education.

Legislative, Regulatory or Executive Actions

Licensure and Scope of Practice issues

As the SIM project embarks on workforce and practice transformation, it is likely that consideration and development of new or expanded healthcare worker roles will raise challenging issues regarding scope of practice and licensure. SIM can provide a table at which such issues can be thoughtfully addressed, in collaboration with educators, providers, professional associations, labor organizations, and policy-makers, in order to develop a consensus around the definitions, certification, and/or licensure requirements necessary to achieve an efficient and effective healthcare workforce.

Budgetary issues

The SIM recognizes that workforce and practice transformation inevitably raises questions and challenges related to employee compensation, working conditions, and retention. This is particularly true of entry-level workers such as home health aides, peer recovery specialists, direct support workers for individuals with developmental disabilities, community health workers, and Certified Nurses' Aides. While such issues cannot be addressed by funding alone, the desire to create a stable and skilled workforce may have budgetary implications.

Tuition and/or loan forgiveness for health professional graduates who remain in Rhode Island and practice in priority settings is another potential workforce strategy that might require legislative and/or executive branch action.

Provider incentives to support workforce development

As Rhode Island further develops provider incentives to transform the healthcare delivery system, opportunities may also exist to enlist and align providers in achieving healthcare workforce development objectives. For example, community-based healthcare providers might be offered incentive payments for providing internship opportunities, clinical placements, and/or employment opportunities to students and/or recent graduates. Such incentives would likely require regulatory action.

Health Workforce Capacity Programs

Healthcare education and training capacity

Much like Rhode Island's healthcare delivery system, Rhode Island's healthcare education and training providers are numerous, varied, and, in some cases, siloed and/or duplicative. At Rhode Island's three public institutions of higher education alone, there are more than 100 distinct healthcare education degree and certificate programs. In addition, four private colleges and universities in the state offer more than 20 other healthcare degree programs. Rhode Island also has one medical school, the Albert Medical School at Brown University, which has seven affiliated teaching hospitals and awards approximately 100 MD degrees each year.

Scores of non-credit healthcare workforce training programs are also offered by colleges, high schools, community-based organizations, and proprietary training providers in Rhode Island. These programs often serve low-income, unemployed, and underemployed adults, and are typically supported by public workforce development funds.

The extent to which the "output" of these many degree-granting and not-for-credit programs meets or exceeds current and projected labor market demand in Rhode Island's healthcare sector has yet to be assessed, and will be a major focus of SIM research.

Workforce planning by healthcare educators and providers

In 2015, Rhode Island's healthcare Industry Partnership, in collaboration with the Governor's Workforce Board and the Office of the Post-Secondary Commissioner, convened a half-day meeting of more than 50 healthcare employers and college-level educators to review Rhode Island labor market and college graduation data in order to determine 1) whether the DLT's 10-year labor market projections were corroborated by the providers and educators; 2) whether the healthcare education programs have the capacity to meet the current and projected labor market demand for college-prepared health professionals; and 3) if not, what could be done to adapt or expand current capacity to meet future demand.

Among the key takeaways from the meeting were 1) the need for new strategies to prepare newly graduated RNs to work in specialty areas; 2) the growing need for behavioral health occupations such as Licensed Chemical Dependency Specialist; and 3) and the importance of cultural competence and soft skills (e.g., communication, teamwork, problem-solving).

Rhode Island's Commissioner of Post-Secondary Education remains engaged and committed to increasing the alignment and capacity of the state's higher education institutions with the in-demand occupations in Rhode Island's healthcare industry. Similarly, the Rhode Island Department of Labor & Training is committed to supporting workforce development initiatives

that respond to employer demand in the healthcare sector, and the Rhode Island Department of Education is committed to developing career pathways for high school students, as well as adult learners, that align with the workforce needs and opportunities in Rhode Island's key industry sectors, such as healthcare.

There is a broad cross section of workforce development partners in Rhode Island that stand ready to respond to the workforce needs of Rhode Island's evolving healthcare delivery system. The SIM project will convene these agencies as new partners in our work so that together with healthcare industry representatives, we can help build the healthcare workforce of the future.

Health Information Technology

Health Information Technology (HIT) projects are foundational elements in our plan for Rhode Island’s health system transformation. Rhode Island has been and continues to be a leader in statewide HIT investments. Starting in 1997, the Rhode Island Department of Health (RIDOH) implemented KIDSNET, an integrated child health information system, which has served as a pediatric health information exchange for public health programs and pediatric providers. In 2004 Rhode Island initiated efforts to build a statewide health information exchange (HIE). In 2009, the state began to monitor Electronic Health Records (EHRs) and e-prescribing adoption rates, and in 2011 efforts to design and build an all payer claims database (APCD) were underway. Rhode Island has also been developing a single platform (RI Bridges, formerly known as UHIP) which integrates and tracks eligibility determination for HealthSource RI, Medicaid and other human services programs. As evidenced by the above, Rhode Island considers HIT a cornerstone of our strategy to increase Rhode Island’s healthcare quality.

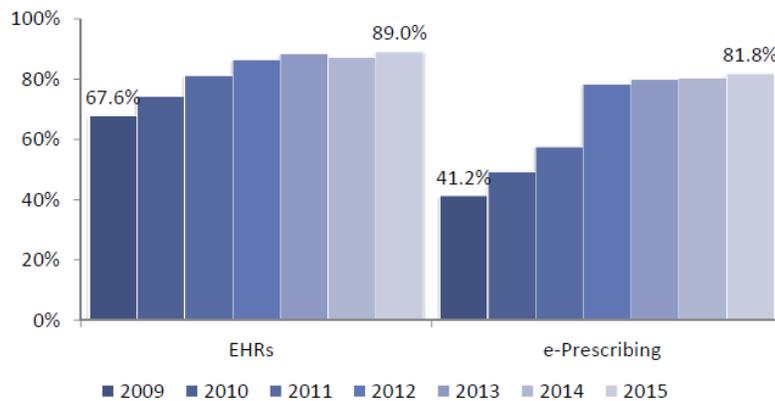
HIT Adoption and Use

Over the past few years, Rhode Island healthcare providers have made great strides in HIT adoption and use. RIDOH has conducted an annual HIT Survey since 2009, and completed its first statewide healthcare inventory in 2015. The HIT survey measures adoption by physicians, while the inventory measures adoption by facility and location.

The 2015 HIT Survey had a 66% response rate and found that of responding physicians, 89.0% had an EHR and 81.8% were e-prescribing. Figure 4 shows the EHR and e-prescribing rates as reported in the HIT Survey for Rhode Island physicians from 2009-2015.

Figure 4: HIT Survey Results, Use of EHRs and E-Prescribing, 2009-2015

Survey respondents’ use of EHRs and e-prescribing



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

facilities or providers. Table 14 shows EHR adoption rates by location type, illustrating the gaps in EHR adoption rates.

Table 14: EHR Adoption Rates, Statewide Healthcare Inventory, 2015

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

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

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

EOHHS administers the Medicaid EHR Incentive program. As part of this program, EOHHS funds RIQI to provide additional technical assistance to Medicaid providers who are struggling to meet Meaningful Use. Lastly, Healthcentric Advisors, a Rhode Island-based nonprofit serves as the as the regional Quality Improvement Organization (QIO), supporting practice transformation and HIT adoption. They also contract with RIDOH to conduct the annual HIT Physician Survey as part of a larger health care public reporting program primarily focused on Long-Term and Post-Acute Care facilities (LTPAC) and hospitals.

Existing State HIT Systems

Rhode Island's investments in HIT include a diverse group of systems that help reduce administrative waste, increase EHR adoption, support interoperability, and improve care coordination. The most relevant of those systems include:

RI Bridges

RI Bridges (formerly known as Unified Health Infrastructure Project, UHIP) is designed to be a single technical platform that supports Medicaid and other state human service eligibility, collecting consumer information in a centralized resource. RI Bridges is an interagency initiative between HealthSource RI, the Executive Office of Health and Human Services (EOHHS), and the Office of the Health Insurance Commissioner (OHIC).

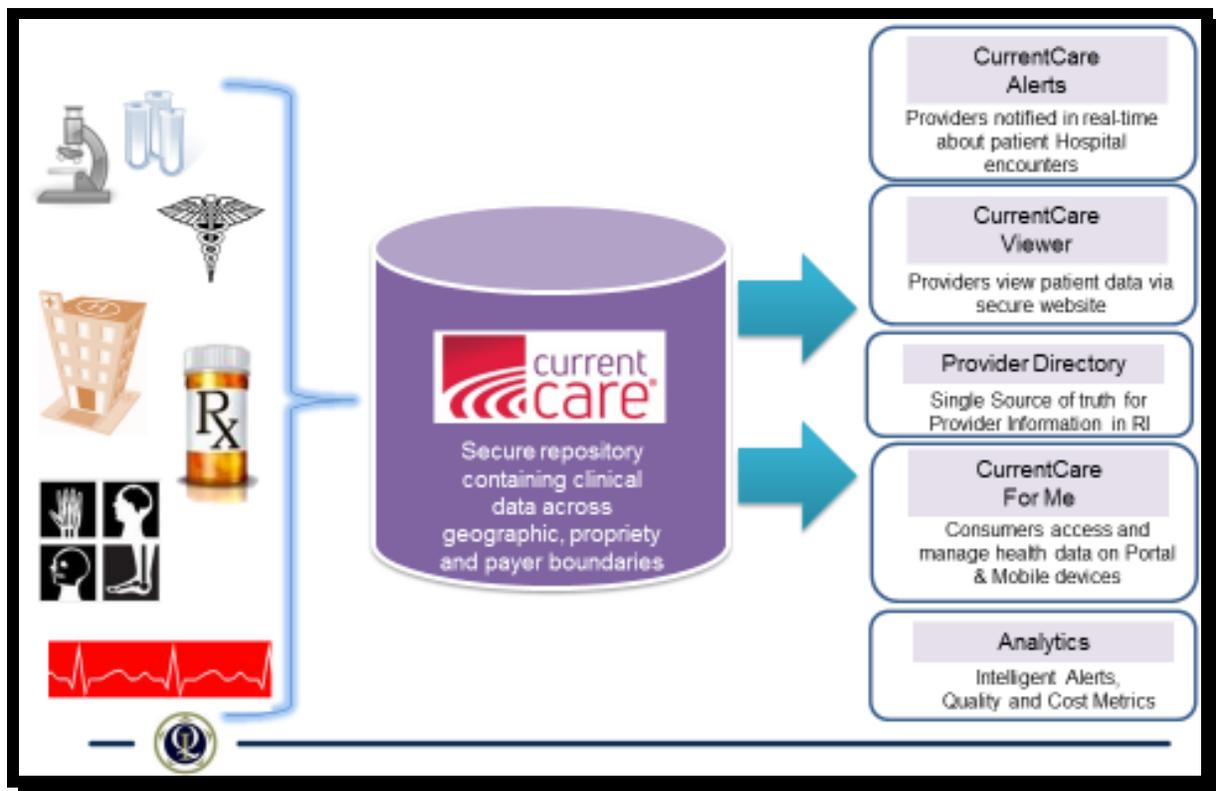
KIDSNET

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

CurrentCare

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

Figure 5: CurrentCare Data Exchange Diagram



Prescription Drug Monitoring Program

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

HealthFacts RI

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

SIM Test Grant HIT Components

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

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

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

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

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

Rhode Island has developed these projects so that they are all interconnected and interdependent. To sufficiently and adequately understand and increase the value of the healthcare being provided in Rhode Island, we are pursuing a value-added central collection of provider data, claims data, and clinical data that goes beyond the siloed data housed at each individual healthcare organization and state agency. Contributing entities will include payers, providers, and state agencies. When the projects are fully implemented, each system will feed off the knowledge and value-added features located in the others.

HealthFacts RI

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

Use of HealthFacts RI

With the passage of the Affordable Care Act, 95% of Rhode Islanders are now covered by insurance⁶. Most of their encounters with the healthcare delivery system will result in the payment of a claim processed by one of the insurers in the state, including Medicaid. A claim contains a wealth of health and cost information such as the diagnosis, basic demographic information, provider information, cost information (including total cost and out-of-pocket cost), and type of treatment provided.

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

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

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

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

One of the great benefits of creating a database like this is that individuals can be tracked over time, even if they change insurers. With HealthFacts RI, analysis of the lifespan will be possible to help understand, for example, the scope of an entire health episode (i.e. an entire knee replacement and recovery, severity of illness, or potentially preventable events).

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

⁶ <http://healthsourceri.com/press-releases/healthsource-ri-reports-uninsured-rate-drops-to-5/>

Table 15: Potential Use of HealthFacts RI by State Agencies

Audience	Potential HealthFacts RI Uses
Department of Children, Youth and Families	<ul style="list-style-type: none"> • Spot trends in groups of children with lead poisoning and help identify safer environments for children to live and play • Identify patterns of access to care for children with behavioral health conditions or diagnoses • Explore patterns of children who visit the ER frequently for non-emergent conditions
Department of Health	<ul style="list-style-type: none"> • Monitor trends in disease prevalence, co-morbidities, and emerging infectious diseases • Design and evaluate interventions to address trends in opioid and prescription drug abuse • Monitor prescription refill patterns as a proxy for medication adherence monitoring • Understand patterns in care migration and service use outside of Rhode Island to support the Certificate of Need process • Monitor and use data to promote screening and prevention services
Department. of Human Services	<ul style="list-style-type: none"> • Better understand the medical experience of demographic groups that receive DHS benefits, such as WIC and SNAP • In order to better tailor benefit and service experiences, monitor trends in patient health, spending, and use by zip code to find similar demographic groups
Division of Elderly Affairs	<ul style="list-style-type: none"> • Test, evaluate and monitor the effect of different long term care arrangements on patient health and spending • Compare duration, intensity, and types of service use for elders who continue to live in the community versus those who enter nursing home care • Create profiles to help predict elders at risk of missing needed care
Healthsource RI	<ul style="list-style-type: none"> • Develop portraits of those enrolled in plans sold through HealthSource RI compared to rest of state • Understand how people use health care when they have different types of insurance coverage • Better understand patterns of coverage churn • Monitor patient out-of-pocket comparisons by plan type/metal value
Medicaid	<ul style="list-style-type: none"> • Monitor, both all-cause and preventable hospital readmissions by provider, demographic, year, geography, admitting diagnosis, or post-discharge services. Compare to other payer types. • Analyze the use of appropriate care settings: trends in ED, clinics, or office visits • Understand the effect on patient health care of interventions, such as long term care rebalancing and the transition to Accountable Entities • Monitor the types of outpatient services used after a hospital discharge for those who are and who are not readmitted
Office of the Health Insurance Commissioner	<ul style="list-style-type: none"> • Provide information about costs of services to consumers • Review cost trend drivers to support rate review • Compare increases in actual medical spending versus premium payments • Monitor out-of-pocket spending and total cost of care • Project effects of hospital system consolidation on price
State Innovation Model (SIM)	<ul style="list-style-type: none"> • Support modeling and evaluation of new payment designs • Establish baseline and quantify total spending for patient cohorts attributed to particular practices

Additionally, HealthFacts RI data will be available by request to any number of stakeholders, include nonprofits, other state governments, and researchers. While some aggregated data sets are posted on the RIDOH website, detailed line level data sets can be released after review of an application. The RIDOH Director convenes the All Payer Claims Database Data Release Review Board, an eleven-member advisory board, to review applications for data. The purpose of the board is to ensure that data requestors will maintain patient privacy. We will begin releasing data through this process in the second half of 2016.

Value-based healthcare requires transparency.⁷ Meaningful cost and quality information is key to building a healthcare system that pays for quality and outcomes instead of more services that may or may not improve patient health. However, despite years of measurement efforts, patients, employers, public purchasers, health plans, and even providers, have almost no reliable information about the relative cost and quality of healthcare services. Payment reform and delivery system redesign are front and center as national priorities – and to make them work, we need transparent performance information to know that we are paying for the right care at the right cost.

Status of HealthFacts RI

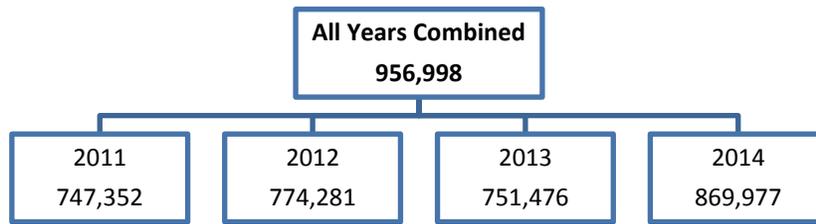
HealthFacts RI includes claims data for any commercial, self-insured, Medicare, and Medicaid entities which covers over 3,000 lives. The database includes membership, paid medical claims, paid pharmacy claims, and provider data from 2011 to present. Data collection began in 2014, and currently comes from seven commercial and two public payers. In 2016, we will on-board two additional commercial payers, CVS and BCBS of MA. State users have access to data as soon as six months after the service happened.

Table 16: Payers submitting data to HealthFacts RI

Commercial Payers	Public Payers
Blue Cross & Blue Shield of Rhode Island	Medicaid
United Healthcare	Medicare (Parts A, B, D)
Neighborhood Health Plan of Rhode Island	
Tufts Health Plan	
Harvard Pilgrim	
Aetna	
Cigna	
In-process: CVS and Blue Cross Blue Shield of Massachusetts	

⁷ <http://www.nrhi.org/work/multi-region-innovation-pilots/center-healthcare-transparency/>

Figure 6: Unique Covered Lives in HealthFacts RI Database



Governance of HealthFacts RI

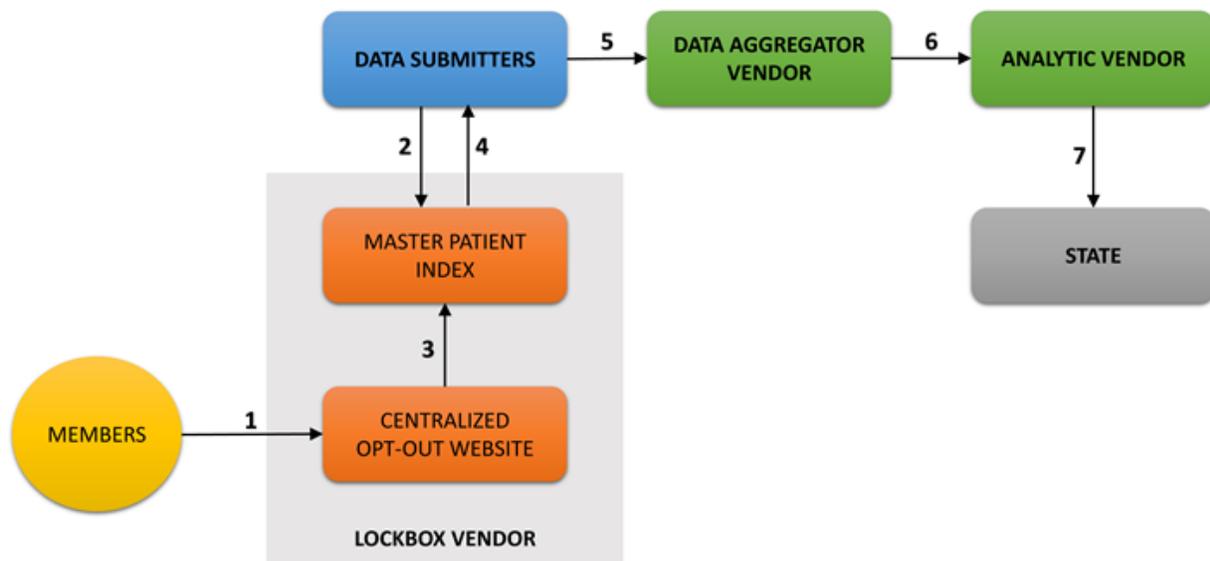
HealthFacts RI is managed by an Interagency Staff Workgroup made up of representatives from four state agencies: EOHHS, HealthSource RI, RIDOH, and OHIC. This workgroup meets weekly to monitor the progress of the vendors’s work and to plan next steps. The agency principals are kept up to date on the status and asked to weigh in on major decisions through regular meetings.

As mentioned above and as required by statute, there is APCD Data Release Review Board whose purpose is to ensure that data requestors such as researchers, program evaluators, payers etc., will maintain patient privacy. HealthFacts RI will be ready to start releasing data files to requestors in the second half of 2016. In response to the recent U.S. Supreme Court ruling in *Gobeille v. Liberty Mutual*, Rhode Island issued a memo to data submitters informing them that the decision does not apply to HealthFacts RI because the statute enacting the APCD is very different from the Vermont statute reviewed by the Supreme Court. Rhode Island imposes reporting requirements on insurers – not ERISA governed self-insureds. There is no personally identifiable information in the database, and individuals are given the opportunity to opt out of the database.

SIM Funding of HealthFacts RI

The HealthFacts RI SIM project consists of three vendor contracts – project management, data aggregation, and analytics vendors.

Figure 7: HealthFacts RI Infrastructure Diagram



Freedman Healthcare provides project management and subject matter expertise for HealthFacts RI. The project management team organizes meetings, manages communications, coordinates with the vendors, and manages the data release process.

Our data aggregation vendor, Onpoint, subcontracts with Arcadia Healthcare to facilitate the data de-identification process, which allows for people to be matched longitudinally across payers while keeping individual identities masked. Payers submit their member eligibility files on a quarterly basis and receive a Unique Member ID (UMID) back to incorporate into their systems. Arcadia also maintains an [opt-out website](#) and the Rhode Island Health Insurance Consumer Support Line allows individuals to opt-out over the phone.

Next, the payers submit fully de-identified member eligibility, provider, medical claims, and pharmacy claims files to the data aggregator (Onpoint) including the UMID assigned by Arcadia in place of names and other sensitive identifiers. The data aggregator applies data processing rules to combine files together to construct the database.

The underlying data is then sent to our analytics vendor, 3M HealthCare, which provides additional analytic data processes and applies a variety of analytic value-adds to the data. The analytics vendor hosts a web-based analytics tool that provides state agency employees the ability to analyze the data in a visual way.

Statewide Common Provider Directory

There are three important reasons that SIM prioritized funding the creation of a Statewide Common Provider Directory:

- 1) Payers, providers, and consumers alike need access to accurate provider information, including current provider name, address, and contact information, and practice affiliations, specific health plan network information, and direct e-mail addresses. In order to maintain accurate provider directories for facilitating payment, care coordination, or data analysis (such as with HealthFacts RI), each type of organization expends considerable resources attempting to maintain their directories. One statewide directory provides economies of scale for both dollars and time.
- 2) Per legislation, CurrentCare offers three consent options for providers to view data: in emergencies only, to only specific providers, or to all providers. Facilitating the option that only specific providers can view a participant's HIE data requires an accurate provider directory.
- 3) Finally, there is no central location from which to identify the total number of providers (including primary care providers) practicing within Rhode Island or to identify how providers are affiliated. It is difficult to determine, for example who belongs to what "practice," with which hospital a provider is affiliated, or how many physician practices exist in the state, etc. In 2015, RIDOH conducted a Statewide Healthcare Inventory of all services and providers in the state. A team of eight interns worked through the physician licensing database and determined whether each physician was actively practicing, practicing primary care, and the location of their practice(s). Thus, collecting this data required a considerable amount of manual work and phone calls – and we will need updated data in 2017 when the survey is conducted again. The Common Provider Directory will cut down on this type of duplicative activity going forward.

Using SIM funds, Rhode Island has contracted with RIQI to build our Statewide Common Provider Directory, which will include detailed provider demographics and detailed organizational hierarchies. This organizational hierarchy capability is unique and essential to

being able to maintain provider demographic and contact information, with a special focus on provider relationships to practices, hospitals, ACOs, and health plans. The Directory will mean that the mastering and maintenance of provider information and organizational relationships will take place only once, in a central location.

The provider directory is a database with a web-based tool that allows a team of RIQI staff to maintain the file consumption and data survivorship rules, error check flagged inconsistencies or mapping questions, manually update provider data, or enter new providers. With the appropriate data mastering and maintenance system in place, RIQI expects to have a useful data export via a flat file ready with a go-live in June 2016. These data exports will allow hospitals, payers, and state agencies to incorporate the centrally mastered provider data within their own databases.

The provider directory will have a provider portal which will allow providers to look up information on other providers that may not be public such as “direct” email addresses and to update their own data as needed. It will also have a consumer portal which will allow individuals to access information on providers and provider organizations. The design of these portals will take place in 2016, with the anticipated go-live in early 2017.

Project Management

RIQI manages this project in partnership with a Provider Directory Advisory Committee (PDAC). The PDAC consists of RIQI leadership and provider directory staff, representatives from the major stakeholder state agencies (RIDOH, EOHHS, HealthSource RI and OHIC), the HealthFacts RI project management vendor, and most recently payers and providers. The group has been convening at least monthly, with additional meetings as needed. The PDAC has overseen the creation of data stewardship and survivorship rules, and acts as an advisory body over the design and implementation of the provider directory. RIQI has recently decided to formalize the committee even more and is planning to add other community members in order to obtain broader input and advice regarding rules and assumptions about provider data. For example, when the PDAC began designing a sample extract, it invited providers into the discussion to inform RIQI about which extract elements are important to share publically and which data elements are considered too sensitive to share, such as birth date and/or DEA number for writing prescriptions.

Directory Data Sources

The Statewide Common Provider Directory is being developed by RIQI with their HIE vendor, Intersystems. It was decided early on that the Healthcare Provider Directory (HPD) standard would not meet the business case needs, and so an independent data model has been constructed with a goal to make it extensible and flexible to fit future unforeseen needs.

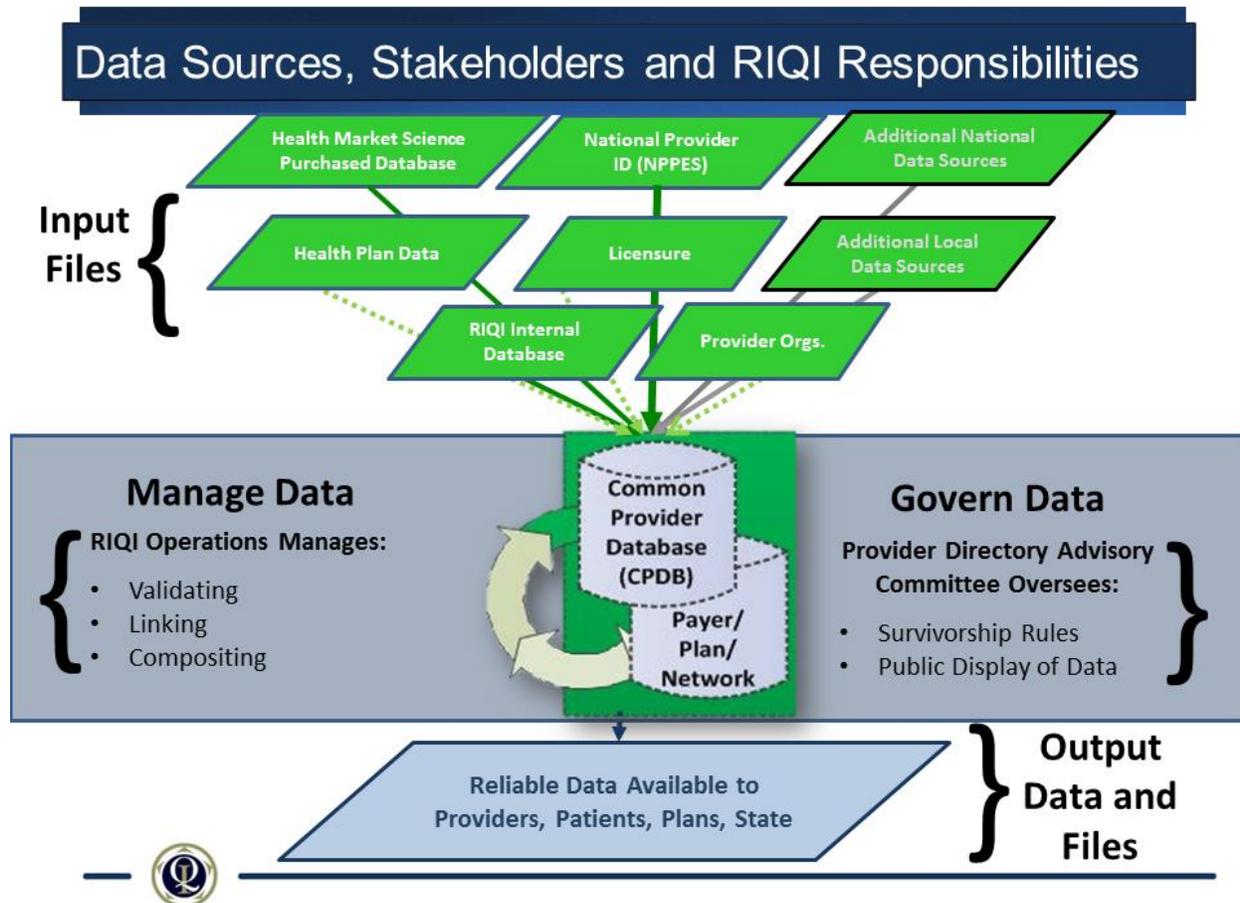
The Provider Directory can receive multiple data feeds and matches those feeds based upon NPI (national provider identifier), provider name, etc. The initial data sources include the NPPES national database of providers, a purchased dataset from HealthMarket Science, RIQI’s internal database maintained from its role as the state’s Regional Extension Center, and a file from one of the major hospital systems in the state. Future data sources include the payers, the Department of Health’s licensing database, Medicaid provider database, APCD provider files, and data from additional providers or provider networks.

Looking Forward

Upon the launch of the provider and consumer directory portals, we will provide training and assistance around how to use the website, how to create a user account for providers to update

their own data as well as how to update their own data. We will also provide consumer announcements and support for using the website, including mechanisms to report errors and other instructions.

Figure 8: Provider Directory Conceptual Diagram



Integrated Health and Human Services Data Ecosystem

The Rhode Island Executive Office of Health and Human Services (EOHHS) exists to maximize the collective impact of its component programs and agencies – Medicaid, the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), the Department of Children, Youth and Families (DCYF), the Department of Human Services (DHS), and the Department of Health (RIDOH). These agencies share a mission of providing essential services, safety net support, and public health promotion, while often serving the same people and collecting large amounts of data on these beneficiaries.

Unfortunately, Rhode Island lacks a modern system for integrating person-level information across our agencies and then turning that holistic information into action. While EOHHS has built a data warehouse that stores many different sources of data – in addition to separate data sets that live within each agency – there is limited capacity to first connect and then share those linked data, either at the person level or in the aggregate. If we are able to combine and better analyze these data, we can obtain critical information about the needs of our population, the effectiveness of our programs, and how to responsibly spend valuable public resources.

With funding from SIM, Rhode Island will take informed, project-based steps that reflect iterative learning and sophistication to build our new data ecosystem, integrating data across our agencies and driving policy with those data. This approach differs from a traditional, expensive and “all at once” Data Warehouse project that is common to many data integration initiatives. Rather than seek to purchase or build a large system that will attempt to integrate all data and develop user interfaces that satisfy many user needs – a process that could take years, come with high upfront costs, and that would rely on our existing knowledge to guide design and decision making – Rhode Island is planning a lighter, simpler and more adaptive solution.

Our approach will build on an ongoing assessment of our entire data ecosystem, which includes our current data warehouse and our processes for collecting, managing, and using data. Lessons from that assessment will help us identify the most productive project-based steps to begin to better integrate agency data. Funding from SIM will support a transitional vendor to guide our development of an in-state, hosted solution. We will direct this vendor to use best practices in Agile data warehouse development to build linked environments that meet our specific initial business needs and let us plan for the future when we can add further data sources, environments, and interfaces as our capacity develops. We will also work with the vendor to develop a complete modernization staffing and structure plan to guide the state during the transition to full ownership of the solution.

We are following a model developed by Washington State and New York City, which both successfully built integrated data systems with this iterative, project-based approach. In this context, “project-based” means defining an existing and pressing business need that relies on linked data, developing a forward-thinking solution to link the data and developing a functional, light interface to allow users to interact with and learn from the linked data. Though there are drawbacks to this kind of small scale, iterative development, including piecemeal success and solutions that are designed first to fit project needs and only second to meet potential future uses, the advantages for entities, such as state agencies, that lack large pools of resources, including money, technical expertise, and time to deliver early successes, are clear.

Our vision is that each of our projects will teach our data users and modelers how to approach these kinds of projects in the future. We will learn more from each step of this process about more responsibly and efficiently deploying our technical resources. Rather than building a single, large system or data model that attempts to be all things for a variety of users and agencies, we will create products that are real, functional, and meet clearly-defined business requirements.

Healthcare Quality Measurement Reporting and Feedback System

Rhode Island’s SIM project is focused on the transformation of our health system from one based on volume to a system based on value. During the past year, stakeholders helped SIM study community needs, and determined that SIM should prioritize funding for a Healthcare Quality, Measurement, Reporting and Feedback System (Feedback System).

Having reliable and consistent clinical quality data is an absolute requirement for measuring quality within a value-based payment system. While some clinical quality measures can be calculated from claims data only, there are many that must be calculated from clinical data recorded in patient medical records at the points of care.

There are several initiatives within Rhode Island that require providers to submit clinical quality measure data. These include:

- The Care Transformation Collaborative’s multi-payer primary care and patient centered medical home transformation initiative (CTC),
- Payers’ contractual requirements,
- The RIDOH Chronic Care Collaborative (RICCC), and
- A myriad of national level quality initiatives such as the EHR Incentive Program, ACO program, Physician Quality Reporting System (PQRS), and National Committee for Quality Assurance (NCQA) certification programs.

The CTC and RICCC processes to collect quality measures involve manual report calculation at many of the participating practices using National Quality Forum (NQF)-based home-grown measures, and there is no guaranteed consistency in the measure calculation across all participants.

Emerging standards and the 2014 Certified EHR Technology (CEHRT) standards support more consistent quality measure reporting across different EHR vendors as compared to a manual reporting pull. Furthermore, there is a considerable burden upon payers to have quality reporting systems in place in order to receive their certification through NCQA. The data received by payers in claims alone is not sufficient nor accurate enough to forgo the manual audit of patient records at the point of care or the acceptance of a certain level of unreliability in the quality metric.

Three 2015 studies shed light on Rhode Island’s data needs. The studies indicate that there is a lower-than-desired capacity to perform data analytics in the state, but that providers and others do have the intention to spend great sums of money to support analytic needs. RIQI conducted an analytics inventory at the request of their Board of Directors. This inventory was conducted through a survey of state agencies, and a range of provider organizations (large, small, independent, hospital affiliated, federally qualified health centers, community mental health centers, etc.), as well as payers, educational institutions, and community partners in the state. The study found that respondents had a need to calculate numerous high priority measures (including ambulatory quality measures, identification and management of high-risk patients, and analysis of utilization/cost of care indicators). However, these entities did not all have the systems in place to measure the information they needed. Only 76% of providers could collect ambulatory quality measures. Only 68% of providers could identify and manage high risk patients, and 56% could measure utilization/cost of care indicators. Furthermore, the level of satisfaction with those analytic systems was extremely low. Half of respondents planned new systems for identification and management of high risk patients, and around 20% planned new systems for ambulatory quality measures and utilization/cost of care analysis.⁸

We also find important data about EHR adoption rates in RIDOH’s Statewide Healthcare Inventory. The survey found that there was wide disparity practices’ ability to analyze data. While 85% of hospitals had reporting software to help analyze data only 52% of nursing facilities, 26% of primary care practices, 23% of behavioral health clinics, and 17% of outpatient specialty practices had this software, as shown in Table 17.

⁸ Rhode Island Quality Institute Analytics Inventory, 2015.

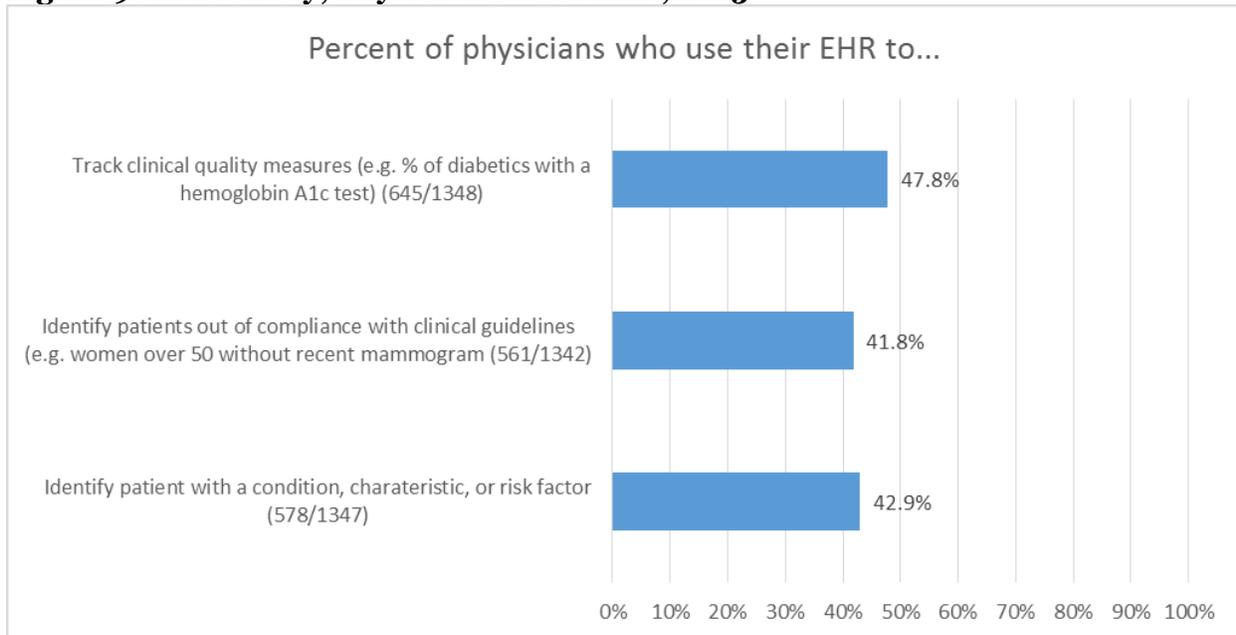
Table 17: EHR Adoption Rates Compared to Availability of Reporting Software, by Location Type, RIDOH Statewide Healthcare Inventory, 2015

Survey	EHR Adoption Rate	Reporting Software
Primary Care	82.6%	26%
Outpatient Specialty	72.7%	17%
Behavioral Health Clinics	39.6%	23%
Nursing Facilities	80.9%	52%
Hospitals	92.3%	85%

Providers were also surveyed about their use of EHR Technology from a population health perspective. Out of the 1,350 respondents, only 34.2% reported that they are using their EHR for population health management, 31.1% were not, and 24.7% did not know. However, compared to 2014, the number of respondents using their EHR for population management increased 7.8% and those who did not know decreased by 7.1%. This indicates that there is a shift to population health and to reducing the cost of healthcare with EHR technology.

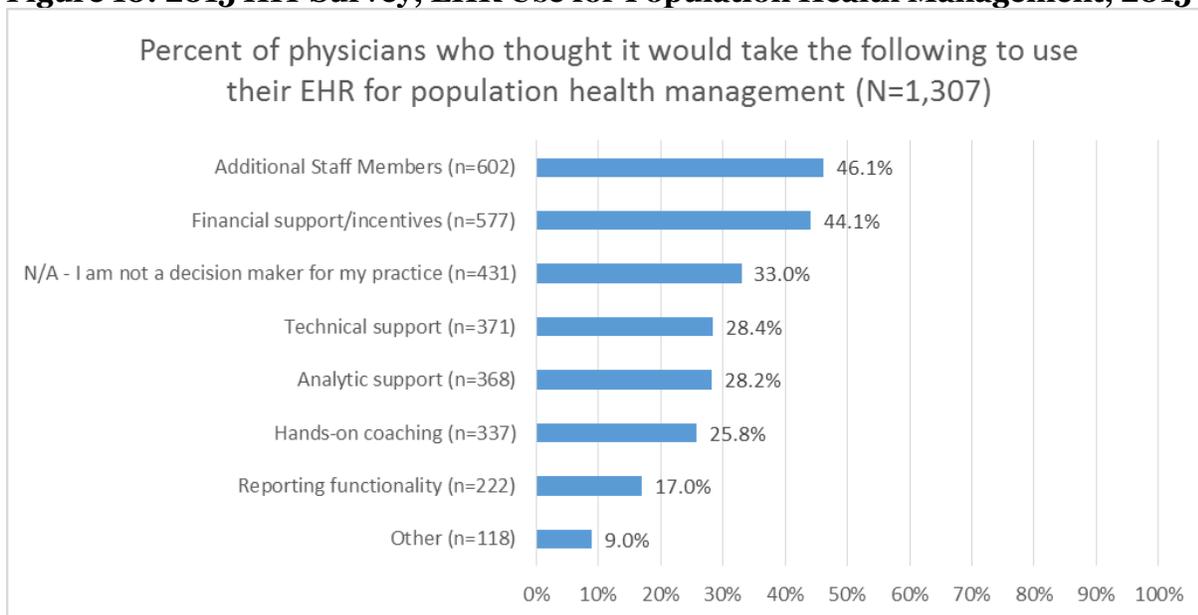
One of the goals of the physician survey was to identify the provider’s use of their EHR to track quality measures and population health. Almost 50% of our providers are using their EHR for clinical quality measure monitoring and for patient reminder messaging.

Figure 9: HIT Survey, Physician Use of EHR, 2015



The HIT survey also measured the barriers preventing providers from using their EHR for population health. As noted in the Figure 10, the primary reason that providers did not use the EHR for population health was the lack of adequate staff or financial support.

Figure 10: 2015 HIT Survey, EHR Use for Population Health Management, 2015



These data indicate that providers in the state are not prepared to measure and understand their own quality of care, much less proactively address gaps in care that lead to low quality measure performance.

Feedback system Year 1 (Planning)

A number of stakeholders considering these challenges have been participating in the SIM Technology Reporting Workgroup at the behest of the Steering Committee. The workgroup is led by the State HIT Coordinator and the HIT Specialist hired specifically for SIM. It began meeting in January, 2016, and consists of representatives from state agencies, payers, provider organizations, and quality improvement organizations. The workgroup also conducted a survey of healthcare providers in the state in order to receive additional input on the concepts we were considering for the Feedback System. The Workgroup and the Steering Committee endorsed the development of a central quality measurement, reporting and feedback system to address this lack of readiness. However, we have learned through stakeholder feedback that in order to pay for quality, there must be:

- Confidence that each participant is being measured consistently. This cannot be dependent upon the EHR vendor used at the participant's service location.
- Cost alignment – i.e. the cost of measuring the practice should not exceed the benefits of high value cost arrangements
- Confidence in the accuracy of the measurement
- Arrangements that risk adjust, even if the data itself cannot be risk adjusted – i.e. leniency for specific practices that are known to have more complex populations.
- Confidence in the attribution of a patient population to a specific practice.

The benefits of calculating measures centrally include:

- Consistent attribution methodology
- Consistent measure methodology
- Potential for lower costs to practice for measurement; potential for lower costs to payers for measurement
- Potential for risk adjustment that could be consistent

The Workgroup proposed a set of goals and features for this system and the SIM Steering Committee approved the following proposal at the February 11, 2016, Steering Committee Meeting:

Figure 11: Technology Reporting Workgroup Recommendation to SIM Steering Committee

Providers, ACOs and facilities in Rhode Island have a variety of reporting requirements which will only increase under a value-based payment system. Numerous sources support the assumption that analytic resources and capabilities are insufficient in the state to empower providers and organizations to most effectively use their ever-growing and extremely valuable data. Furthermore, numerous organizations in the state are working toward creating their own quality measurement systems that will meet their needs, including payers, practices, and practice transformation organizations.

With this understanding of our current environment, the Technology Reporting Workgroup recommends funding the development of a statewide quality reporting system with the goals of:

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

The Workgroup has determined that in order to achieve these goals, the system would need serve as a common platform for quality measurement, quality improvement, and reporting. It would need to be able to accomplish the following, at a minimum:

- Easily capture data in a standard and consistent manner (no extra work for providers)
- Calculate measures from our SIM harmonized measure set and relevant national measure sets
- Become a Qualified Clinical Data Registry (QCDR) to allow the reporting of results directly to CMS, NCQA, and the payers, and fulfill additional reporting obligations on behalf of providers
- Benchmark providers at the provider level and the provider organization level
- Consist of detailed, individual level data from multiple sources matched to a single person, and make that data available to providers to improve individualized care while appropriately protecting confidentiality
- Share analyses and results back to providers, provider organizations, payers, state government, and, eventually, the public

This project should begin with a focus on collecting data from practices with Electronic Health Records (EHRs). In addition, the state must set up a governance structure with adequate community and provider engagement to determine what data is shared to whom and how it is shared.

There are multiple levels of governance necessary for the statewide Healthcare Quality Measurement, Reporting, and Feedback System, and for now, the Technology Reporting Workgroup will continue to advise state staff on the fundamental goals and features of the system that would best support the collective needs of the community. State staff will use the output of the Technology Reporting Workgroup as they write and issue a request for proposals.

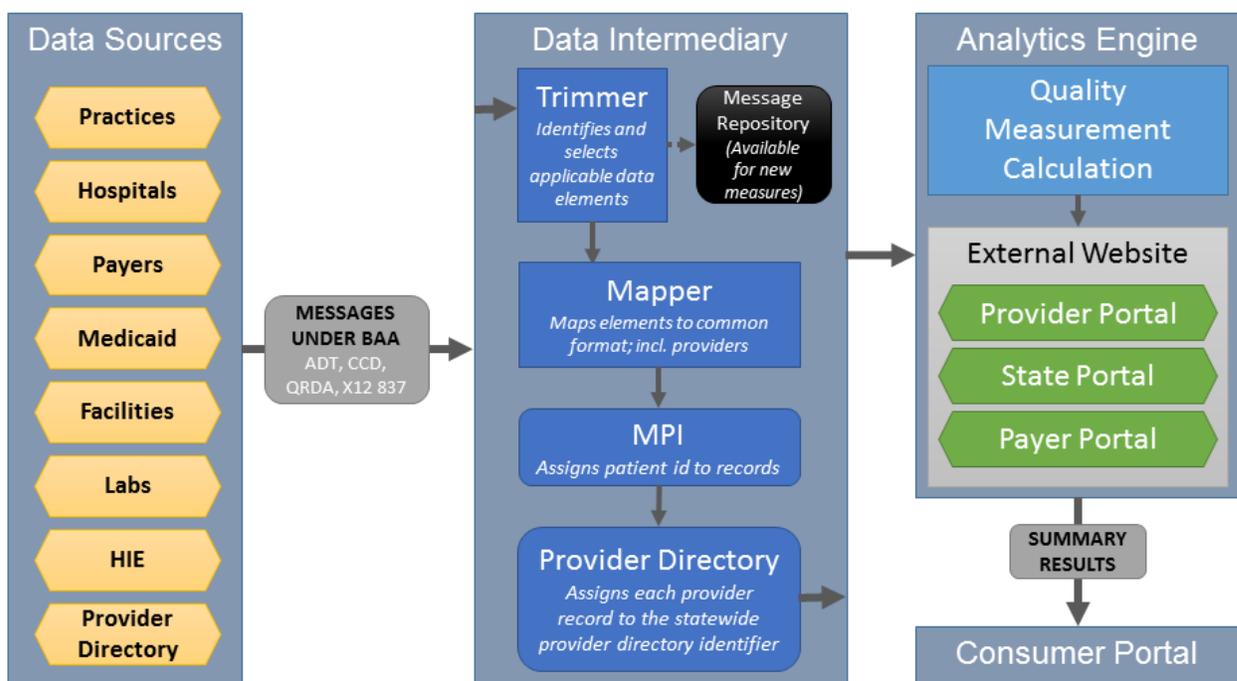
The state procurement team will consider the Workgroup’s feedback throughout the procurement process.

Year 2-4 - Implementation

Once the vendor(s) has been procured, the SIM HIT Specialist will oversee the vendor contract(s) and begin the process of establishing this system.

We are currently designing the infrastructure of this system and will begin the competitive bidding process to procure a vendor in June 2016. We can envision this system collecting data from a variety of sources, ideally leveraging existing infrastructure; collecting and mastering the data within a data intermediary, and analyzing and viewing those data through an analytics engine with external public and provider facing website. A conceptual diagram is below:

Figure 12: Conceptual Diagram, Clinical Quality Measurement, Reporting, and Feedback System



This system will require fully engaging a variety of providers and their staff. We will provide training on the provider website itself and practice coaching for how to utilize the provider portal within the clinical and care management workflows.

Once the system is procured, we will convene a new governance group with the appropriate stakeholders to inform the state on the level of data sharing and benchmarking that should occur between providers and the state, between the state and providers, and with consumers. This was a strong recommendation of the Technology Reporting Workgroup and also arose as a priority in the provider survey.

There are numerous policy and regulatory levers that various state agencies could use to promote the use of this system. For example, OHIC could include its use as part of the SIM aligned measurement initiative. Levers would only be applicable once the system were fully implemented, tested and operating smoothly

Additional HIT Activities

Besides the four major projects described above, SIM is also planning to fund at least three additional projects that include HIT components as tools to support transformation activities. We describe them briefly here and in more detail on Pages 28-36.

- **Care Management Dashboards:** SIM will provide Community Mental Health Centers (and will likely provide Community Health Teams) with dashboards that display real-time and historical information on hospital and ED utilization by their entire patient populations. Powered by the HIE infrastructure, these dashboards can show the exact location and status of patients being seen in all of the acute care hospitals in the state, as well as trending information about the subscriber's patient panel. This enables immediate intervention by the patients' care team.
- **Advanced Directives Registry:** SIM will help implement a centralized registry for advanced directives and other end-of-life documents, such as the Medical Order for Life Sustaining Treatment (MOLST). We are currently exploring whether and how we can implement this as a feature of the CurrentCare consumer portal.
- **Shared Care Plan:** SIM is exploring the implementation of a central shared care plan system to help coordinate care plans for patients who frequent multiple care settings, and whether and how we can institute this as a feature of the CurrentCare consumer portal.
- **Patient Engagement Tools:** The patient engagement workgroup is working on identifying patient engagement strategies and tools to support our SIM goals. While we do not yet know what tools will be selected, it is likely that HIT that supports patient engagement will become part of our HIT Plan.

Program Monitoring and Reporting

Program evaluation is fundamental to assess whether or not designed activities achieve the desired results once implementation begins. When conducting program evaluation, it is important to follow established methodologies, where applicable. For the Rhode Island State Innovation Model (SIM) Test Grant, the adapted framework within which program monitoring and reporting will occur is guided by the *Centers for Disease Control and Prevention (CDC) Framework for Program Evaluation in Public Health*. The six evaluation steps outlined by the CDC framework (noted below in Figure 13) include:

1. Engaging stakeholders;
2. Describing the program;
3. Focusing the evaluation design to set goals for what we are studying;
4. Gathering credible evidence;
5. Justifying conclusions; and
6. Ensuring use and sharing lessons learned.

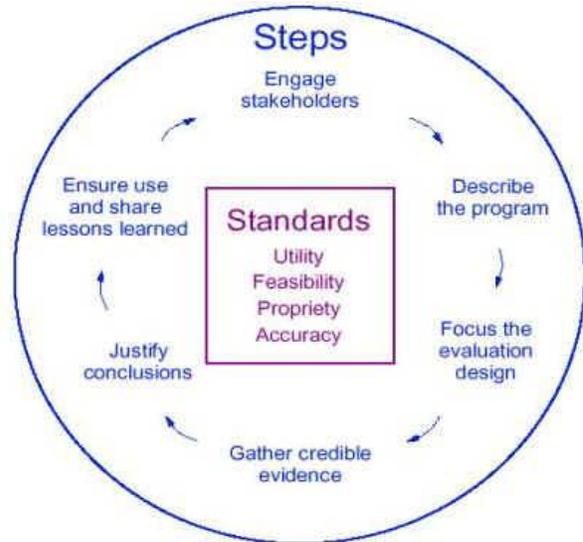
These six steps are embedded in a continuous process of improvement through program evaluation. These steps, while modified, are anchored as the fundamental components for Rhode Island SIM evaluation.

There are three parts to our SIM evaluation plan:

- 1) SIM leaders and staff will participate in the federal evaluation being undertaken by RTI. We expect three site visits, and regular monthly communications with the evaluation team.
- 2) SIM will retain professional outside evaluators to carry out a focused evaluation on the effectiveness of our project. We are in the process of preparing our procurement process for this vendor. They will be chosen through a competitive Request for Proposals (RFP). One particular part of this evaluation process is a project recently approved by our Steering Committee to document and compare the effects of Alternative Payment Models in use in the state. The purpose would be to learn how the models work, what related activities most support their success, and whether alignment of models across payers and providers would yield a greater impact on desired outcomes.
- 3) SIM will carry out regular in-house monitoring and evaluation of our program, tracking the milestones and metrics we have identified in our planning process.

As we procure and begin to work with our professional evaluator, we will determine the scopes of each of these efforts, to ensure that they are complementary but not duplicative. We know that we have information that we must report to CMS and CMMI, and our in-house evaluation work will be in service to those requirements. Our learning collaborative work can be more long-term and aspirational. And our professional evaluation can cover those topics where we do not have the expertise or tools to carry out a particular type of in-house evaluation.

Figure 13: Program Evaluation Steps



Evaluation Strategy and Plan

Step 1: Engage Stakeholders

Stakeholder engagement is the first step in the cyclical evaluation process. The persons who will be implementing or affected by the strategies defined are the stakeholders. Obtaining input from stakeholders in the development of this evaluation plan remains critical. Stakeholders also help to ensure that we are asking the right questions, collecting the right data, and using our evaluation results effectively.

Internal and external partners attend regularly scheduled workgroup and team meetings. Many partners are also involved in various academic and professional organizations. A smaller subgroup has been and will likely continue to be convened to vet measures selected as part of the Driver Diagram. An additional group will likely be formed as part of ongoing measurement needs for the Integrated Population Health Plan. These groups will continue to collaborate, prioritize, and/or develop evaluation questions and associated measurements. These groups will work together to determine feasible data sources, data collection methods, and indicators for our in-house tracking process. Over the course of the grant period, stakeholder engagement will be instrumental in redefining and focusing the scope of the evaluation, particularly as it relates to the resources available for ongoing evaluation and sustainment efforts.

In addition, we will be able to share these data sources and metrics with our professional evaluators and provide them with subject-matter experts for consultation.

Step 2: Describe the Program

SIM will be able to use the writing throughout this Operational Plan to describe our program to our evaluators and to stakeholders assisting with our monitoring.

Step 3: Focus the Evaluation Design

Designing an evaluation process that allows for making interim adjustments to programmatic direction, improving the way interventions are implemented, and providing iterative evidence to stakeholders on program success is critical. According to the Centers for Medicare and Medicaid Services (CMS), program evaluation for SIM must include regular, quantifiable measurement of model impact. Included in this in-house evaluation process are measures of effectiveness for policy change, regulatory lever use, and intervention implementation.

We will also work with our professional evaluators to help them plan the evaluation design.

A Defined Purpose

In an effort to focus efforts, we have the following primary purposes for our in-house evaluation:

- Assess planning efforts and collaboration among our strategic partners;
- Identify root causes for intervention successes and challenges related to both practice transformation, patient empowerment, and population health improvements;
- Detail efficiencies created by policy and regulatory changes; and
- Document the importance of increasing the capacity for supporting infrastructure such as workforce development and data availability; and
- Provide data-driven recommendations for sustainability beyond SIM.

Evaluation Questions

At least four overarching evaluation questions guide the evaluation of the SIM effort:

- To what extent has the Rhode Island SIM Test Grant strengthened population health?
- To what extent has the Rhode Island SIM Test Grant transformed the healthcare delivery system?
- To what extent has the Rhode Island SIM Test Grant decreased per capita healthcare spending?
- To what extent did the Rhode Island SIM Test Grant foster collaboration, align efforts across sectors and between partners, and increase data-driven decision-making?

As noted above, our Steering Committee is particularly interested in the question of best practices in the creation of value-based payment systems and alternative payment models. During year two of the grant, the SIM team will convene a learning collaborative comprised of providers and payers who are engaged in VBP and APMs, to discuss best practices around VBP contracting methodologies and implementation, to participate in a mixed qualitative and quantitative research project. As a part of our process and program evaluation, the learning collaborative will shed light on what works, and discuss potential alignment of VBP contracting strategies. The collaborative will provide a valuable forum for providers and payers to learn from one another, to ensure that we maximize the potential of payment reform to support delivery system transformation and meet our cost, quality, and population health goals.

Proposed Learning Collaborative Participants:

- All payers (Medicaid, BCBSRI, UnitedHealthcare, NHPRI, Tufts Health Plan, Medicare)
- All provider participants in alternative payment models, including:
 - Medicare Accountable Care Organizations (ACOs)
 - Medicaid Accountable Entities (AEs)
 - Medicare bundled payment demos
 - Commercial payers' APMs

Proposed Research questions (to be asked at baseline and annually for three years):

- What alternative payment models (APMs) are in use?
- What population health management initiatives (practice changes/clinical management changes) have been prompted by, coupled with or supported by the APMs?
- What has been the effect of the payment models and related interventions on cost and quality?
- Is there value in more closely aligning or more broadly diffusing models across payers?
- If so, how could closer alignment and broader diffusion be achieved?

Step 4: Gather Credible Evidence

To support ongoing process and outcome evaluation, we are specifying metrics based on drivers and interventions presented within the Driver Diagram. CMMI requires states specify metrics in three areas:

- Model Participation
- Payer Participation
- Model Performance

To date, we have specified a suite of metrics for tracking implementation of SIM programs, such as Community Health Teams, SBIRT training, and clinical quality reporting and feedback, which align with CMMI's request for model participation metrics. We have also specified system transformation metrics that measure outcomes of the use of our regulatory levers, such as percent of medical service payments made under an alternative payment model, which align with CMMI's Payer Participating metrics. Rhode Island is committed to sharing all data relating with implementation of value-based payments in terms of dollars, covered lives, and provider participation, which we collect through existing regulatory initiatives.

We continue to engage stakeholders to specify model performance metrics, which seek to measure the outcome of our SIM project across domains of cost, quality, utilization, and population health. In the coming weeks SIM staff will be working with stakeholders through the Measure Alignment Work Group to develop model performance metrics, baselines and targets on measures such as hospital readmission rates, emergency department visits, diabetes care, behavioral health, and total cost of care. A full matrix describing all metrics is in development and will be updated along with the Driver Diagram prior to June 30, 2016.

Data Collection

We will be using several data collection methods, including both qualitative and quantitative methods, for our SIM evaluation. Using multiple procedures for gathering, analyzing, and interpreting data, the evaluation will gain greater credibility and provide a clearer picture of the program. We will make modifications as needed to account for the evolving nature of the program. Additional detail on data collection can be found in the Data Collection, Sharing, and Evaluation section of this document. All quality and cost measures will use the entire Rhode Island population as the denominator. Where applicable, we will also collect and analyze demographics and disparity data—and we will share our data with our professional evaluator.

Step 5: Justify Conclusions

Evaluation will be a critical component of all of our efforts—both in-house and professionally. To incorporate evaluation across SIM investments and activities, we will maximize the following to provide additional data upon which conclusions can be drawn:

- All procurement via Request for Proposals or Single Source Procurements will include requirements for developing activity objectives, logic models, and evaluation plans;
- All procurement via Request for Proposals or Single Source Procurements will include requirements to report performance data relative to activity objectives regularly and alongside annual reports;
- Vendors will submit regular progress reports to Project Management and Project Officer staff;
- Cross-cutting interventions, such as those being implemented for workforce development and health information technology, will include requirements for evaluation information in a variety of ways, including case studies, lessons learned, and metrics.
- We will bring together the vendors for shared learning opportunities, to collaborate across separate transformation activities.
- We will ensure that our professional evaluators have access to all of this information to inform their work.

Step 6: Ensure Use and Share Lessons Learned

SIM leaders and staff are committed to using the evaluation information described throughout this document to measure our successes, identify and address our challenges, and chart new paths for changing our healthcare system. The public nature of SIM ensures that we will share evaluation information with our agency partners, our Steering Committee stakeholders, and the general public at our regular meetings and at other special opportunities. We will create a specific communications plan for sharing this information.

Data Collection, Sharing, and Evaluation

Rhode Island will require regular data about cost, quality, and utilization to fully understand the impact of the SIM Test Grant initiatives. Some existing data sources for these information are available. Since Rhode Island's SIM Test Grant is a statewide initiative, we will measure outcomes across the state as a whole, and compare the majority of outcomes against those of other (non-SIM) states. There are five major datasets where health indicators data are or will be collected for sharing and evaluation in Rhode Island and will be leveraged for our SIM project:

- HealthFacts RI
- Medicaid
- Behavioral Risk Factor Surveillance System (BRFSS)
- HealthSource RI Qualified Health Plan Enrollee Survey
- Electronic Clinical Quality Measurement, Reporting, and Feedback System

HealthFacts RI

Claims data from payers with at least 3,000 enrolled members is submitted quarterly to HealthFacts RI, the SIM Test Grant-funded all payer claims database. This include CMS provided Medicare Part A, B, and D claims data, private insurance (including Medicare Advantage plans), and Medicaid data. Claims data will be used to understand the cost of care provided in value-based payment arrangements, as well as some key indicators of utilization and quality that are available in claims data.

Although de-identified, patient data in HealthFacts RI does carry a unique patient identifier which will allow for an identifier to be assigned when patients are covered by the SIM program activities for tracking and evaluation purposes. The metrics which will be measured using HealthFacts RI are indicated in the metrics section of this document.

We prioritize HealthFacts RI's careful privacy protections and procedures. Although de-identified, there is still enough information in HealthFacts RI to potentially identify a participant. Therefore HealthFacts RI data releases are governed by the Data Release Review Board (DRRB) – an 11-member advisory board to the Director of Health. Some data can be released in aggregate form without review by the DRRB, but anything which is claim line level or does not conform to pre-approved files may require a data release application. Rhode Island staff will assist CMS and/or its contractors in navigating the state legislated data release process, should it be necessary, and waive any standard fees for data. The HealthFacts RI analytics vendor is responsible for providing data extracts for partners, including file specifications.

Medicaid

Our Medicaid agency is also supplying detailed Medicaid member information by request to CMS and federal evaluators as needed for surveys, focus groups, and/or key informant interviews. Medicaid is dedicated to measuring and understanding the impact of the state's initiatives to improve care, and will facilitate all appropriate data sharing in compliance with state and federal laws.

Behavioral Risk Factor Surveillance System (BRFSS)

The Rhode Island Department of Health (RIDOH) collects data for a variety of surveillance systems, databases, and measurement sources. For population health, the Behavioral Risk Factor Surveillance System (RI BRFSS) is a primary collection method. The RI BRFSS is a multi-modal landline and cell-phone survey that represents a sample of Rhode Island residents. The survey is conducted in monthly replicates, for which information covering health-related

behaviors, chronic conditions and preventive health practices is collected from respondents ages 18 and older. Rhode Island has participated in the BRFSS since 1984, with financial and technical support provided through a cooperative agreement with the CDC and from additional funding received from various RIDOH sources.

The RI BRFSS is performed to specifications provided by CDC to the 50 states and seven territories that participate in the surveillance system. Prior surveys have been a key source of data for supporting public health programs and health-related legislation within Rhode Island. In addition, RI BRFSS data has been used for assessing Rhode Island's improvement in key health risk behaviors. The RI BRFSS is also one of the sources for key indicator data used in Healthy Rhode Islanders 2020 and by numerous RIDOH programs. Information provided by the RI BRFSS is not available from other sources within the State and as part of a nationwide surveillance system, the BRFSS provides comparisons with other states and the nation.

There are also numerous other surveillance systems, databases, and measurement sources that serve as primary information sources and collection methods at RIDOH. Information once collected, is analyzed on a program-specific level, and at times, by the Center for Health Data and Analysis for the production of data briefs and a variety of other dissemination documents. Sharing of data is initiated by data requests, media inquiries, and publication needs. Shared data abides by the Department's policy for dissemination of data. Typical modes of distribution include infographics and posters, stakeholder meetings and conferences, publications, on websites, and in the form of data briefs/books. File sharing can be requested between agencies and requires a Memorandum of Agreement.

HealthSource RI Qualified Health Plan Enrollee Survey

In order to holistically evaluate the effectiveness our work, it is essential to collect and evaluate not only outcomes data but also information on customer perception and experience. As the health insurance exchange for the state, HealthSource RI (HSRI) has worked with carriers participating in the Marketplace to evaluate consumer experience with enrollment and insurance plan utilization. Developed by CMS and administered via an approved survey vendor, the Qualified Health Plan (QHP) Enrollee Survey was Beta tested in the first half of 2015 and will be fully implemented nationwide in 2016. The QHP Enrollee Survey will evaluate nine areas of plan enrollment and use including: access to care, access to information, care coordination, cultural competence, plan administration, rating of health care, rating of health plan, rating of personal doctor, and rating of specialist. The survey results will be made publicly available in fall 2016 to consumers, carriers, and state exchange's in an effort to drive evidence-based decision making in plan development and to provide additional information to consumers to aid in plan selection. Information gathered from the QHP Enrollee Survey, as well as enrollment and claims data will enhance HSRI's effort to address the health insurance needs of Rhode Island consumers. This information will also be used to assist in the development of innovative plans offered through the exchange.

Healthcare Quality Measurement, Reporting, and Feedback System

This SIM Test Grant funds an electronic clinical measurement reporting and feedback system which will begin to collect more detailed clinical data across a broader population of consumers in Rhode Island. It is unlikely that this system will be adequate to measure outcomes across the state by the end of project period or confidently provide a historical understanding of clinical quality. We recognize that clinical quality data on our population is relatively sparse and inconsistent, a weakness which will be strengthened for future evaluation activities with this new data system.

Fraud and Abuse Prevention, Detection, and Correction

The State Office of Program Integrity (OPI) ensures compliance, efficiency, and accountability within the health and human services programs administered by the Executive Office of Health and Human Services (EOHHS) by detecting and preventing fraud, waste, and program abuse and ensuring that state and federal dollars are spent appropriately, responsibly, and in accordance with applicable laws.

The OPI has developed protocols and procedures to detect and deter fraud, waste and abuse. The OPI is focusing on all publically funded health and human services programs, not just Supplemental Nutrition Assistance Program (SNAP) and Medicaid, using sophisticated data mining and modeling techniques to identify unusual patterns of purchasing and billing by third parties.

The guiding principles of the OPI are that it:

1. Strives to achieve the most cost efficient health care system possible while further enhancing the quality and appropriateness of services delivered.
2. Requires and supports efforts that enable health care providers to identify and resolve issues themselves.
3. Holds provider agencies accountable for building and maintaining systems to prevent improper billing.
4. Increases the usage of the administrative tools such as payment suspension, prepayment review, audit, sanction, and individual and entity exclusion when improper payments are discovered.
5. Develops and communicates consistent measures of the effectiveness of program integrity that capture cost reduction and avoidance, as well as recoveries, and minimize costs imposed by reviews and investigation.
6. Recognizes areas of vulnerabilities that adversely affect program integrity.

The Office of Program Integrity is committed to identifying fraud, waste and abuse in Medicaid and in all health and human service programs. The OPI utilizes advanced analytics software that assigns scores to claims for potential healthcare fraud. This scoring looks for duplicate claims, individuals with multiple member ids, suspicious provider network activity, peer comparison for both providers and members, and predictive analytics that identify scenarios where activities should have happened that did not. The resulting scoring is displayed in an advanced visual interface to allow investigators to review and assess the results of the analysis.

The OPI actively pursues any leads indicating fraudulent practices and uses them as a source to begin investigations. To increase our effectiveness, the OPI is partnering with Medicare and Medicaid insurance companies to share information about fraudulent activity and to conduct joint investigations.

The OPI also receives complaints from patients, their families, other providers, former employees of a provider, and through federal and state referrals. Office staff triage and investigate every valid complaint.

Decisions rendered by the review process can result in refunds to the program for inappropriate payments, training on how to correct or improve billing practices, referral to licensing boards,

and/or referral to the RI EOHHS Office of Program Integrity and the RI Office of the Attorney General for suspected fraudulent practices.

The Office of the Attorney General's Medicaid Fraud and Patient Abuse Unit enforces the laws pertaining to fraud in the state Medicaid program and prosecutes cases of abuse, neglect, or mistreatment of patients in all state healthcare facilities. The Unit prosecutes criminal activity, pursues civil remedies where appropriate and participates with federal and state authorities in a variety of inter-agency investigations and administrative proceedings. Unit prosecutors, auditors, investigators and health care professionals employ a multi-disciplinary approach to combat health care fraud and patient abuse.

Acronym and Abbreviation List

The following is a list of acronyms and abbreviations used in the Project Summary for the Operational Plan. For definitions of terms, see the Glossary of Terms section of the Appendices document.

Acronym	Meaning
ACA	Affordable Care Act
ACC	Accountable Care Community
ACE	Adverse Childhood Event
ACO	Accountable Care Organization
ACS-CDC	American College of Surgeons – Centers for Disease Control and Prevention
AE	Accountable Entities
AE-C	Certified Asthma Educator
AHC	Accountable Healthcare Communities
AMQ	Adult Medicaid Quality Grant
APCD	All Payer Claims Database (HealthFacts RI)
APM	Alternative Payment Model
ARC	Asthma Regional Council
BCBSRI	Blue Cross & Blue Shield of Rhode Island
BH	Behavioral health
BHDDH	Department of Behavioral Health, Developmental Disabilities, and Hospitals
BHOLD	Behavioral Health On-Line Data
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CABHI	Collaborative Agreement to Benefit Homeless Individuals
CAHPS	Consumer Assessment of Hospital and Provider Services
CAPTA	Child Abuse and Prevention Treatment Act
CAUTI	Catheter Associated Urinary Tract Infection
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control and Prevention
CDOE	Certified Diabetes Outpatient Educators
CEDARR	Comprehensive Evaluation, Diagnosis, Assessment, Referral and Reevaluation
CEHRT	Certified Electronic Health Record Technology
CHH	CEDARR Health Home
CHIP	Children’s Health Insurance Program
CHN	Community Health Network
CHNA	Community Health Needs Assessment
CHT	Community Health Team
CHW	Community Health Worker
CLABSI	Central Line Associated Blood Stream Infection

Acronym	Meaning
CMHC	Community Mental Health Center
CMHO	Community Mental Health Organization
CMMI	Centers for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
COD	Co-Occurring Disorder
CON	Certificate of Need
COPD	Chronic Obstructive Pulmonary Disease
CS4RI	Computer Science for Rhode Island
CSC	Coordinated Special Care
CTC	Care Transformation Collaborative
CTTS	Certified Tobacco Treatment Specialist
CVDOE	Cardiovascular Disease Outpatient Educator
DCYF	Department of Children, Youth and Families
DEA	Division of Elderly Affairs
DEA Number	Drug Enforcement Administration Number
DEI	Disability Employment Initiative
DHS	Department of Human Services
DLT	Department of Labor and Training
DOA	Department of Administration
DOC	Department of Corrections
DOE	Department of Education
DRRB	Data Release Review Board
EBP	Evidence Based Practice
ED	Emergency Department
EHR	Electronic Health Record
EOHHS	Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ERISA	Employee Retirement Income Security Act
FAD	Financial Alignment Demonstration
FQHC	Federally Qualified Health Center
GDP	Gross Domestic Product
HARI	Hospital Association of Rhode Island
HARP	Home Asthma Response Program
HbA1c	Hemoglobin A1c
HCPAAC	Health Care Planning and Accountability Advisory Council
HEZ	Health Equity Zone
HH	Health Home
HIE	Health Information Exchange
HIT	Health Information Technology
HOPWA	Housing Opportunities for Persons with AIDS Program
HPD	Healthcare Provider Directory
HPSA	Health Professional Shortage Area

Acronym	Meaning
HPV	Human Papillomavirus
HRiA	Health Resources in Action
HSRI	HealthSource RI
HUD	U.S. Department of Housing and Urban Development
IBH	Integrated Behavioral Health
ICI	Integrated Care Initiative
IDD	Intellectual and Developmental Disabilities
IHD	Ischemic Heart Disease
IHH	Integrated Health Home
IP	Inpatient
IPHP	Integrated Population Health Plan
IPS	Individual Placement and Support
LAN	Learning and Action Network
LE	Life Expectancy
LMI	Labor Market Information
LTPAC	Long Term and Post Acute Care
LTSS	Long-Term Services and Supports
MAPCP	Multi-Payer Advanced Primary Care Practice
MCO	Managed Care Organizations
MFP	Money Follows the Person
MHPSA	Mental Health Professional Shortage Area
MMCO	Medicaid Managed Care Organization
MOLST	Medical Orders for Life Sustaining Treatment
MRSA	Methicillin-Resistant Staphylococcus Aureus
NCQA	National Committee for Quality Assurance
NEAIC	New England Asthma Innovation Collaborative
NHPRI	Neighborhood Health Plan Rhode Island
NHSC	National Health Service Corp
NICU	Neonatal Intensive Care Unit
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NQF	National Quality Forum
OHIC	Office of the Health Insurance Commissioner
ONC	Office of the National Coordinator
OPI	Office of Program Integrity
PATH	Project Assistance in Transition from Homelessness
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PDAC	Provider Directory Advisory Committee
PDMP	Prescription Drug Monitoring Program
PMPM	Per Member Per Month
PQRS	Physician Quality Reporting System

Acronym	Meaning
PRAMS	Pregnancy Risk Assessment Monitoring System
ProvPlan	Providence Plan
PSH	Permanent Supportive Housing
PY	Program Year
QCDR	Qualified Clinical Data Registry
QHP	Qualified Health Plan
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
RFP	Request for Proposal
RHIO	Regional Health Information Exchange Organization
RICCC	Rhode Island Chronic Care Collaborative
RIDE	Rhode Island Department of Education
RIDOH	Rhode Island Department of Health
RIHTP	Rhode Island Health Transformation Program
RIMS	Rhode Island Medical Society
RIPCPC	Rhode Island Primary Care Physicians Corporation
RIQI	Rhode Island Quality Institute
RTI	Response to Intervention
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDOH	Social Determinants of Health
SE	Supported Employment
SED	Serious Emotional Disturbance
SHIP	State Health Innovation Plan
SIM	State Innovation Model Test Grant
SMI	Severely Mentally Ill
SNAP	Supplemental Nutrition Assistance Program
SNF	Skilled Nursing Facility
SNFRM	Skilled Nursing Facility Readmission
SPA	State Plan Amendment
SPF-PFS	Strategic Prevention Framework – Partnership for Success
SPMI	Severely and Persistently Mentally Ill or Serious and Persistent Mental Illness
SSI	Surgical Site Infection or Supplemental Security Income
SSI/SDI	Supplemental Security Income/ Supplemental Disability Income
STARS	Standardized Tobacco Assessment for Retail Settings
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
TAC	Technical Assistance Collaborative
TANF	Temporary Assistance for Needy Families
TCPI	Transforming Clinical Practice Initiative
UHIP	Unified Health Infrastructure Project

Acronym	Meaning
UMASS	University of Massachusetts Medical School
UMID	Unified Multi-Purpose ID
VBP	Value-Based Payment or Value-Based Purchasing
WIA	Workforce Investment Act
WIC	Women Infants Children
W-P	Wagner-Peyser Act
YRBSS	Youth Risk Behavior Surveillance System

Appendices

A: Integrated Population Health Plan

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