Introduction

Rhode Island's SIM Model Test Proposal positively responds to the premise on which the SIM effort is based, "that state innovation with broad stakeholder input and engagement, including multi-payer models, will accelerate delivery system transformation to provide better care at lower costs.[1]" This project narrative reflects how Rhode Island state government will fulfill our potential to be a critical and effective partner to the federal government and other health care payers to improve population health, to transform the health care delivery system; and to decrease per capita health care.

Rhode Island's state health and human service agencies have actively pursued efforts to enhance and accelerate the development of an innovative health care system. Rhode Island has a tradition of expanding affordable insurance coverage, most recently reflected in the decisions to expand Medicaid and to establish a state-based marketplace. Explicit efforts to transform the way health care is delivered and reimbursed are evident in the Office of Health Insurance Commissioner's (OHIC) Affordability Standards[2], the Department of Behavioral Healthcare, Developmental Disabilities and Hospital's (BHDDH) development of health home models, and the Department of Health's community assessments. Various state agencies have collaborated on jointly governed health information technology projects including *currentcare*, the statewide health information exchange, and the All-Payer Claims Database. Many of these efforts have been very successful. They have not, however, always been aligned. At times, this lack of coordination can result in a more confusing system for the people we serve and we suspect makes us collectively less effective. This proposal builds on previous efforts but reflects an understanding of how state government might be a stronger agent for healthcare transformation.

[1] State Innovation Models: Round Two of Funding for Design and Test Assistance Cooperative Agreement Initial Announcement Funding Opportunity Number: CMS-1G1-14-001 page 2
[2] http://www.ohic.ri.gov/Committees_HealthInsuranceAdvisoryCouncil_Affordability%20Report.php

We believe our ability to impact the system requires that we, the state agencies, work together better, that state government work more closely with the private sector, and that the work we do is based on evidence. These three tools will enable us to develop and sustain a coordinated, strategic, deliberate, and long-term approach to the transformation of our health care delivery system.

In order to be more effective, state government needs to be better coordinated and aligned. The SIM Grant provides entities across state government an initial focus and forum for that collaboration. In support of the SIM effort, state agencies will be meeting regularly to understand how our specific regulations and proposed legislation might impact the goals of the SIM Project. Through this communication and analysis, our regulatory initiatives can be better aligned and program funding and implementation can be understood from a broader perspective. As we develop processes to communicate and better align efforts over the four-year grant period, we will internalize that coordination so that it is sustained once the grant period has ended.

We do recognize that the goals of the SIM Grant go well beyond publicly-funded services and that success in achieving improvements in population health requires not only internal alignment but explicit partnership with the community, including payers, providers, community-based agencies, and consumers. We propose to implement the SIM Grant through a partnership between state agencies and private entities. This partnership, the Healthy Rhode Island Steering Committee, will govern the implementation of this grant. Decisions on the direction of the grant and how funds are allocated will be made by members of this Committee. The partnership will reflect true shared governance across government and the private sector. More information, including the members of the Healthy Rhode Island Steering Committee, is provided in ***Section 6 Stakeholder Engagement***.

Today, state government does not consistently understand the impact of our health and human services policy decisions on the people we serve. We can usually describe the number of people impacted and sometimes the cost of an initiative, but we are generally unable to analyze whether a program actually met the goals we established. We have data but are often unable to use it effectively. We are proposing to use SIM Grant funds to improve state government's capacity to collect, store, and use data. This proposal seeks $3,000,000 to modernize state data management, analytics, and information technology. With those funds, we will develop and implement an enterprise wide technical architecture that leverages, aligns, and integrates existing systems such as the Executive Office of Health and Human Services' (EOHHS) Data Warehouse and Medicaid Management Information System, the State's new eligibility and enrollment system, the All Payer Claims Database, and public health data sets. Multiple state agencies, including the EOHHS, the Departments of Health; Human Services; BHDDH; Children, Youth, and Families; Corrections; Labor and Training; OHIC; and the Department of Administration, including HealthSource RI will be engaged in this effort. We have already developed an inventory of existing State data systems. With technical assistance from a consultant, we will understand how to use the various data systems to tell us how we are progressing on our SIM grant goals. This integrated approach to data will be the basis of our SIM Grant evaluation effort and will enable us to understand the impacts of our efforts at the person level. This initiative will begin to develop a data-driven culture within state government.

With these three foundational changes in state government: better internal alignment; effective external partnerships, and improved data analytics capacity, we will implement the the required elements of the SIM Model Test.

Section 1: Plan for Improving Population Health

We will use the first 12 months of the grant to fully develop our Population Health Plan. This effort will be directed by a Senior Public Health Epidemiologist from the Department of Health (DOH) and a Chief of Transformation from BHDDH. They will oversee the work of two vendors we will hire to develop the Population Health Plan. The first is a vendor responsible for the overall development of the plan, working with the Healthy Rhode Island Steering Committee to assess the overall health of the state and identify measurable goals, objectives and interventions. This vendor will also be tasked with monitoring and evaluating our progress in meeting those goals. We have allocated $750,000 for this work. Based on the FOA directions and our efforts on the State Health Innovation Plan, we aspire to focus population health in the following areas:

(1) Obesity, diabetes, heart disease and stroke;

(2) Smoking prevalence;

(3) Cancer morbidity and mortality;

(4) Preventable emergency department visits, hospitalizations, and readmissions;

(5) Behavioral health morbidity and mortality;

(6) Prevention of infectious disease;

(7) Child health: immunizations, developmental screening and referral, and asthma control;

(8) Infant mortality (Cesarean section rate and premature delivery); and

(9) End of life care and palliative care.

We recognize that this is an ambitious and broad group. In the first months of the grant, the Healthy Rhode Island Steering Committee will determine the prioritization of these areas to use in the development of our Population Health Plan.

We will hire a second vendor who will be responsible for ensuring our Population Health Plan explicitly recognizes the behavioral health needs of our residents. This vendor will also assist in the implementation of the transformation of our behavioral health system, in concert with our overall healthcare delivery transformation. Rhode Island's vision is to ensure that all Rhode Islanders have the opportunity to achieve the best possible mental health and well-being within healthy local communities that promote empowerment, inclusion, and shared responsibility. To meet this goal, Rhode Island envisions a population health model that:

- Is based on the need and demand for behavioral health services across the continuum of age groups from infancy through older adults
- Embraces decision-making based on evidence based practices for each age cohort to create effective prevention and treatment delivery, and
- Ensures effective action through the collaborations with state agencies, private partners and community participants.

The lifespan approach acknowledges the evidentiary links of mental and substance use disorders across an individual's life, beginning in infancy and childhood, having the greatest impact among young adults, and continuing through to late adulthood for many individuals. Age appropriate interventions and treatment can help to curb the impact of behavioral health disorders, providing that the best treatment practices are available within local communities. We have allocated $750,000 for this work.

The development of the Population Health Plan will be supported by several existing initiatives. Among these is a study on the demand, supply and cost of behavioral health treatment that will be completed within the pre-implementation period as well as existing and continuing community health assessments and already available data.

Section 2 Health Care Delivery Transformation Plan

The goals, objectives, and interventions of Rhode Island's Population Health Plan will directly address changes needed in the health care delivery system. Rhode Island's Population Health Plan and Healthcare Delivery System Plan will be consonant. They will both focus on transforming the health care delivery system to the Value-Based Care Paradigm described in the State Health Innovation Plan. Rhode Island envisions a new system of care that supports lifelong health for the state's populations. There are six fundamental characteristics to our vision of value-based care.

The first two characteristics are **an orientation to outcomes** and **population health management**. In addition to a focus on clinical quality measures, a supported model of care in the Value-based Care Paradigm will be aligned and committed to population health goals and objectives that match the aspirations, needs, and objectives of the community.

The third involves **effective provider relationships**. In a value-based system, multi-disciplinary teams are key components in linking health care practice to population health management. They build connections between the practice of health care and the community (primary care practice and community-based organizations) as well as between different health care providers (primary care, hospital, and specialty care).

The fourth characteristic is the **person seeking care is active and engaged**. Individuals have important roles to play in maintaining and improving their own health. The new model of

care is based on people working with their providers to select appropriate treatments—shared decision making. People are also expected to provide feedback on health care processes and outcomes as part of the practice's quality improvement efforts.

The fifth characteristic involves **alternatives to fee-for-service payment models**. Payment models such as pay-for-performance and shared savings have been developed to replace traditional fee-for-service in a way that supports providers working with patients to attain and maintain health, while preserving the system of care to treat illness and injury. Through this proposal, we expect that at the end of the grant period, 80% of payments to providers from all payers are in fee-for-service alternatives that link payment to value.

The sixth characteristic is the **effective use of health information technology**. Rhode Island's Value-Based Care Paradigm relies on health information technology as a necessary element supporting transformation.

Our Health Care Transformation Plan will be driven by the Population Health Plan. The specific initiatives included in the Transformation Health Plan will be determined by the Healthy Rhode Island Steering Committee. This grant proposal seeks funding in two areas to support the transformation of our health care delivery system. The first is through explicit funding for new models of care or enhancements to existing models that are already alternatives to a volume-based delivery of care. We have allocated $4.6 million towards this effort and provide additional information on the use of those funds in ***Section 3 Payment and Service Delivery Model***. The second area is in Health Information Technology. We believe investments in facilitating the use and exchange of data can have far reaching impacts in the way health care is delivered. We are proposing to use $6.8 million to support our Health Information Infrastructure. Additional information is provided in ***Section 5 Health Information Technology.***

Section 3 Payment and Service Delivery Model

With the characteristics of the Value-Based Care Paradigm as our guideposts, we will use this grant to impact payment and service delivery models by expanding existing models and supporting provider organizations to meet the Value-based Care Paradigm. Existing and new models will need to highlight how they will respond to a person's behavioral health needs. While the Value-Based Care Paradigm does not prescribe a specific model, we recognize that the Patient Centered Medical Home (PCMH) and Health Homes models hold promise to achieve our vision. These models are already well-developed in Rhode Island.

PCMH: CSI-RI currently includes 48 practice sites; with over 300 primary care providers serving 220,000 Rhode Islanders (approximately 20% of the state's population.) CSI-RI recently announced its fifth expansion and plans to add 20 new practices serving an additional 100,000 Rhode Islanders. With the expansion, approximately 30% of the state's population (and approximately 40% of the adult population) will have access to high performing patient centered medical homes through CSI-RI. CSI-RI is a multi-payer initiative including Medicaid and Medicare through a Multi-Payer Advanced Primary Care Practice Grant.

Health Homes: In order to better serve Rhode Island's Medicaid beneficiaries with multiple chronic conditions, BHDDH and EOHHS have initiated three health home models. These health home initiatives focus on children with special healthcare needs, adults with serious and persistent mental illness, and opiate dependent individuals. The Health Home models have expanded access to more integrated care and measurable improvements in appropriate use of health care services.

ACO: Coastal Medical Practice is an ACO comprised entirely of physicians and supporting staff. The organization began as a primary care practice but has expanded to include some specialties

such as cardiology, pulmonary, pediatrics, and infectious diseases. Coastal Medical has a patient panel of approximately 105,000. Currently Coastal Medical participates in the Medicare Shared Savings Program. There are other existing models of ACOs in Rhode Island, but the model is not widespread. We will establish a sub-committee of the Healthy Rhode Island Steering Committee to explore the ACO model and how it might be best applied to Rhode Island. We will use resources of vendor contracts to support this effort, including the Project Management Office and the Population Health Plan vendor.

Our proposal seeks funding for the following projects we believe will directly impact our progress in healthcare transformation:

Practice Assistance *Funding Request: $650,000*

Value-based care practice coaching, training and technical assistance will be made available to providers across the state. Taking the form of the provision of Quality Assessment and Quality Improvement in the value-based care paradigm, the Transformation Network will provide services directly to practices to develop care coordination processes, leverage in-practice EMRs to derive population health management capabilities and quality measurement training. The work in practices begins in year 2 of the Model Test. Strategies will be conducted in such a way as to spread the resources through train-the-trainer and peer practice support models. Other grant opportunities such as the Transforming Clinical Practices Initiative will be pursued to supplement these efforts.

Community Health Teams *Funding Request: $1,000,000*

The state will foster the creation of Community Health Teams and develop tools and resources to ensure a strong connection between the clinical and community setting. Additional sources of funding through grants will be explored to supplement these efforts.

Patient Centered Medical Home Expansion *Funding Request: $500,000*

This effort expands the PCMH program to pediatrics.

Child Psychiatry Access Program *Funding Request: $750,000*

These funds will be used to implement a pilot initiative for a children's mental health consultation team designed to help targeted primary care providers meet the needs of children with psychiatric problems. We will explore other funding through other sources such as the Department of Education or the Administration on Children and Families.

Advanced Illness Care Initiative *Funding Request $420,000*

In an effort to maintain patient and family-centered care throughout the lifespan, the Transformation Network will scale successful pilots in palliative and end of life care statewide.

Behavioral Health Transformation *Funding Request: $1,250,000*

The Transformation Network will be responsible for the implementation of transformation efforts in the behavioral health system. This initiative would support the statewide implementation of SBIRT as a way to integrate substance abuse prevention and early treatment across the system. Additional activities will be identified in the planning process.

We will leverage the SIM grant funds available for the transformation of the delivery of health care services by ensuring the Healthy Rhode Island Steering Committee implements the initiatives in an explicitly coordinated manner. For example, the efforts to transform the system for the delivery of behavioral health services will be reflected in and supported by our Community Health Team initiative.

Section 4 Leveraging Regulatory Authority

This grant proposal recognizes the power of state government's regulatory authority to significantly change the health care delivery and payment landscape. The SIM Grant provides

the state entities directly engaged in the health and human services field to coordinate and collaborate efforts to support our Population Health Plan goals. The state members of the Healthy Rhode Island Steering Committee will also look to other departments to explore additional levers and opportunities for collaboration; these include the Departments of Education, Labor and Training, and Business Regulation. Through the development of the State Health Innovation Plan and the development of this grant proposal, the state entities with the regulatory, policy, and financial tools to impact the health care delivery system and the health of our communities have already begun this process of communication and collaboration. Those entities and the levers they bring to this effort are listed below:

Executive Office of Health and Human Services: EOHHS is responsible for coordinating the organization, finance, and delivery of services and supports provided through the Departments of Children, Youth and Families; Health; Human Services; and Behavioral Healthcare, Developmental Disabilities and Hospitals. It is also the single state Medicaid agency. There are currently 260,000 Rhode Island residents receiving some form of Medicaid or CHIP-funded benefit. The majority of Medicaid/CHIP eligible individuals are enrolled in a managed care delivery system, with 77% participating in a risk-based managed care organization model. At this time, EOHHS is pursuing a Financial Alignment Demonstration with CMS for the dually-eligible population. Through this grant, EOHHS seeks to align its managed care organization and primary care case management contractual provisions to support the Value-Based Care Paradigm, in concert with other public and commercial purchasers of health care. Additionally, EOHHS will assess its policies across the EOHHS Departments to determine any opportunities to better align publicly financed health care and human services to the goals of this grant.

Department of Health: DOH's regulatory philosophy is to align rules and regulations across the department to drive policy. This regulatory authority includes 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 there are numerous opportunities to promulgate regulations in support of the Value-Based Care Paradigm. Examples include utilizing the licensing authority to incentivize the Value-Based Care Paradigm, such as, offering discounts on fees to health professionals who certify as a care team; developing a regulatory "tunnel" to allow ACOs to apply for a single facility license rather than a separate license for each building and practice as current regulation requires; updating Emergency Medical Services (EMS) regulations to support use of EMS for both prevention and coordination of primary care; coordinating professional practice regulations to define team-based practices and develop professional alignment to improve public health outcomes. In addition to regulatory authority, DOH also leverages existing policies and practices to drive healthcare facilities and professionals towards a Value-Based Care Paradigm. An example is adding conditions to the licenses of health care facilities to improve public health outcomes. This authority has most recently been used in the Certificate of Need process with several hospital acquisitions and the introduction of Minute Clinics. Conditions include setting clear expectations for the community assessment plans that IRS requires from non-profit hospitals through their 990H and conducting a joint public hearing process for health facilities. This is currently underway for hospitals.

Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals: BHDDH administers a comprehensive system of care for people with varying disabilities, including individuals with mental illness, physical illness, developmental disabilities, and substance use

disorders. BHDDH also organizes 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, and an administrator of funding, serving approximately 46,500 individuals through its Behavioral Healthcare system. Through its regulatory authorities, BHDDH has been actively working to create solutions that would support the Value-Based Care Paradigm and improve not only behavioral health, but the overall health and quality of life for all Rhode Islanders. BHDDH's approach extends beyond traditional treatment arenas to include prevention and integration efforts. Within state law, the Director of BHDDH is given 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. While BHDDH maintains responsibility for insuring adequate funding of services, it also demands that these funds support programs that are founded in evidence-based practices and support positive outcomes. Examples of these efforts include support of peer specialists on Community Mental Health Organization Health Home teams, creation of Health Homes in Opioid Treatment Programs, use of recovery coaches to respond to overdose survivors in the Emergency Departments, and focus on employment and housing first initiatives. In collaboration with stakeholders, BHDDH proposes a Behavioral Healthcare System Transformation that supports incorporation of evidence-based practices as well as increased efficiencies in the service delivery system. Through this grant, BHDDH will assess and align its current policies as they relate to establishing integrated primary care and behavioral healthcare in the community within a population health approach. BHDDH is committed to use this grant to explore alternative policy tools that better align the current system in terms of practices; delivery platform, benefit design/management and purchasing/financing to

better meet the health service needs of persons with complex mental health and substance use problems (i.e. persons who are often high utilizers of acute, emergency and psychiatric inpatient services and for whom access to primary care through traditional models is limited), while addressing rising costs of care.

Office of the Health Insurance Commissioner: OHIC exercises prior approval rate and form review authority for individual, small group, and large group insurance markets. As of December 2013, these markets comprised 245,000 members (204,000 of whom were RI residents). OHIC developed the Affordability Standards in 2009 to establish measurable standards for insurers to promote system-wide affordability of coverage and strategic investment in primary care infrastructure. These standards can be used to help further the principles of the Value-Based Care Paradigm. OHIC can continue to require insurers to meet targets for primary care spending. OHIC can require insurers to place increased emphasis on non-fee-for-service investment and expand the set of allowable non-FFS investments to include support for Community Health Teams or other interventions that strengthen the state's primary care practices. OHIC can also help align reporting requirements in PCMH models including outcome and quality measures, across payers and can incentivize insurers to move toward population-based contracting, including both upside and downside risk. Additionally, OHIC has required insurers to file plans that have innovative network designs that take advantage of different care delivery models. OHIC could also build insurer-specific price transparency tools that allow both providers and consumers to better understand the cost and price variation of health care services by disclosing price information that allows for cost-effective clinical referrals and engagement in care coordination activities.

Department of Administration: DOA administers the State Employee Health Plan, covering over 50,000 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. As of July 12, 2013, approximately 26,000 individuals were enrolled in a Qualified Health Plan through the Individual Market and 1,693 through the SHOP Market. HealthSource RI 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. By encouraging outcome measures to be a key focus of new, innovative plans, HealthSource RI is a catalyst for delivery system change. HealthSource RI takes a unique approach of negotiating with carriers as a partner, rather than a regulator, to achieve these goals. Additionally, HealthSource RI uses its direct interactions with consumers as an opportunity to educate about health coverage decisions. Through a combination of customer support, marketing, and outreach, HealthSource RI informs consumers about what health plan options are right for them. This includes making sure customers understand new and innovative plans that use integrated networks to drive better care delivery, as well as understanding how their plan works and how to use it to access appropriate care. HealthSource RI is also in position to convey additional information to consumers such as enhanced quality and outcome metrics as they are developed. More educated consumers will be able to make better decisions and become more active in selecting and accessing care.

Section 5 Health Information Technology

Data and the use of data to drive health care transformation is a cornerstone of Rhode Island's SIM Model Test Proposal. New payment and delivery models will not be successful without a significant investment in our health information technology (HIT) infrastructure. *Governance:* In order to assure strong communication between the overall SIM governance structure, the governance of the HIT plan, and the various other HIT related boards and committees, the current State HIT Coordinator and a HIT specialist funded with this grant, will assure communication, coordination, and alignment across the various governing bodies. The State HIT Coordinator and HIT specialist will convene quarterly meetings with the Healthy Rhode Island Steering Committee to assure: the state HIT plan is being implemented; there is consistency and alignment across the state and its stakeholders in implementing an interoperable HIT plan that supports the model test activities; and proper governance for shared services is developed.

Policy: Policy and regulatory levers to accelerate standards based HIT adoption are described in ***Section 4 Leveraging Regulatory Authority.***

Infrastructure: Efforts to improve the state's ability to use data are described in the introduction of the Project Narrative and in the explicit funding requests listed below.

Technical Assistance: Several resources exist to provide technical assistance for providers related to the implementation of the state HIT plan. The regional extension center will continue to provide technical assistance to providers around adoption of electronic health records, direct messaging, and currentcare. The practice transformation funds as well as specific HIT initiatives listed below will also support technical assistance to providers.

Our proposal seeks to invest $6.8 million in this infrastructure. While Rhode Island has been committed to building both statewide and targeted HIT infrastructure, we need to ensure the different projects are not built and implemented in isolation of each other. Through this SIM opportunity, our approach will be to develop HIT initiatives that are synergistic with each other and with what is already in existence. Viewed in totality, these initiatives, coupled with what is in place will provide coherent, streamlined, less duplicative, more cost effective infrastructure for the collection, sharing, and analysis of both clinical and claims health care information at the individual, provider, and population level. We have selected five HIT initiatives that we believe are required investments in order for us to advance our transformation goals.

1. Health Care Quality Measurement, Reporting and Feedback System: $2,216,903

This statewide system is focused on collecting providers' clinical data at the individual or aggregate level (ideally electronically from an EHR), calculating a harmonized set of clinical quality measures, benchmarking the measures, and providing feedback to providers for quality improvement purposes. The focus of this effort would be to reduce the reporting burden on providers by having them submit their data to one system and then allow this system to send the standardized quality measure data securely to all to required state and federal entities as well as other stakeholders such as payers.

2. Statewide Common Provider Directory: $1,500,000

RIQI, as the state designated entity for health information exchange, has been building a provider directory. This proposal seeks to supplement the existing effort to allow the tool to serve as the state's Single Common Provider Directory Database (CPDB). Not only will this leverage the federal investment made to date, but creating this shared service will significantly reduce the individual provider data management needs of numerous state initiatives and allow bi-directional

interfaces to occur in near-real-time. By developing this shared service, information about relationships between individual providers and provider organizations will be available and consistent across various programs. This will be critical when calculating quality, utilization and cost measures upon which provider and provider organizations will be paid.

3. Patient engagement tools: $1,000,000

Funding is being requested in year one to expand the services of currentcare, the statewide health information exchange, to support patient engagement by developing a set of consumer facing tools. These tools will allow an individual to view, download or transmit their own longitudinal record from currentcare, and self-report, store and upload their own demographic data, past medical, past family history, and important documents such as power of attorney, advance directives, MOLST, self-monitoring/biometric data into currentcare. This self-generated data could then be shared with providers through currentcare. This would significantly reduce the number of forms individuals have to fill out when seeing a new provider.

4. All Payer Claims database (APCD)- $2,039,673

The state is currently developing an APCD. Funding that has been obtained to date includes funding to operate the database, support the implementation of a business intelligence tool for analysis and work with a data and analytics vendor to produce the initial series of reports. Additional funding is needed to continued operations and additional report generation in order to assure sufficient data collection and analysis related to value based purchasing such that revenue generation mechanisms can be implemented to sustain the APCD over time.

Together, we believe these investments in HIT, coupled with our efforts to improve the state's data and analytics capacity and specific transformational activities, will enable Rhode

Island to make significant progress in achieving a value-based, person and community-centered health care system.

Section 6 Stakeholder Engagement

The scope and scale of the transformation that Rhode Island intends through its SIM Model Test proposal demands an intensive, committed and well-managed process to engage the entire community. Specifically, the rate of transformative change asked of payers, providers and community-based organizations that impact the health of the community requires collaborative efforts to ensure attainment of goals. Fortunately, Rhode Island has a demonstrated history of stakeholder engagement in health matters that has led to consensus on policy goals and implementation success. Healthy Rhode Island will continue this tradition of engagement as both a demonstration of the state's commitment to the goals of the project and as a critical success factor to meeting the goals set out by the State Healthcare Innovation Plan.

The first and most direct level of stakeholder engagement is the ***Healthy Rhode Island Steering Committee***, the governing body for the grant effort. Recognizing that the Healthy Rhode Island effort is a partnership of state officials and policymakers and the private health care system, the steering committee includes state officials, insurers, hospitals, a primary care-based ACO, the largest primary care independent physicians association, the state medical society. The steering committee membership is detailed in Figure 1. This committee is charged with setting the strategic direction and policy goals of the grant effort. While regulatory promulgation and procurement issues will rest with the state government, the steering committee will exercise leadership discretion over the implementation of Healthy Rhode Island. Each private organization listed in Figure 1 has confirmed their willingness to participate through a letter found in the Letters of Support section.

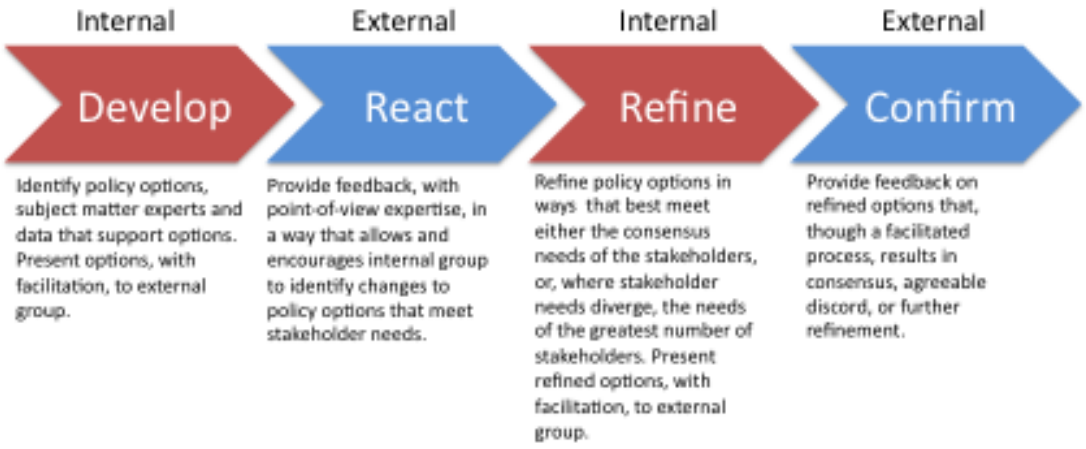
Figure 1: HEALTHY RHODE ISLAND STEERING COMMITTEE

State: Office of Governor Office of Lt. Governor Executive Office of Health and Human Services Department of Health Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals Office of Health Insurance Commissioner Department of Administration – HealthSource RI and State Employee Health Plan **Payer Organizations:** Blue Cross Blue Shield of RI Neighborhood Health Plan Tufts Health Plan United Healthcare of New England **Hospitals:** Lifespan Care New England South County Hospital Charter CARE	**Physicians and Practice:** Coastal Medical Rhode Island Primary Care Physicians Corporation RI Health Center Association Rhode Island Medical Society **Behavioral Health:** RI Council of Community Mental Health Organizations Drug and Alcohol Treatment Association of Rhode Island **Children and Youth:** RI Kids Count **Long-term Care** Carelink **Community** YMCA of Greater Providence Rhode Island Foundation

In addition to the steering committee, this grant proposal will build on the intensive stakeholder engagement that was a hallmark of the SIM Model Design process. The Healthy Rhode Island Stakeholder Work Group consists 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. This work group, will review policy proposals, respond to questions of strategy and direction and provide advice and feedback to the steering committee.

Rhode Island intends to use its common stakeholder engagement method to develop its plan for improving population heath as well as ongoing project engagement. An iterative policy development blueprint used in the process to develop HealthSource RI and to create the State

Healthcare Innovation Plan will be employed. The four-step flow for policy development relies on heavy interaction between state staff and stakeholders in which staff, working with technical assistance and under the guidance of state leadership, develop specific policy recommendations. Stakeholders are invited and encouraged to react to the recommendation. Staff takes those reactions and refines the policy. Finally, the refined policy recommendation is brought back to stakeholders to confirm that the stakeholders affirm the recommendation, or, if stakeholders disagree with the recommendation, allows for the opportunity to advocate for changes. This process is represented in Figure 2.



Rhode Island's commitment to stakeholder engagement was a key ingredient to the development of the State Health Innovation Plan. The goals and objectives of the Healthy Rhode Island effort will only be attained through a similarly robust, inclusive process. Rhode Island will rely on its experience in facilitating meaningful stakeholder engagement and an expansive and representative group of participants to meet the challenge of health system transformation.

Section 7 Quality Measure Alignment

The alignment of quality measures across all payers in Rhode Island is a core requirement of the state's effort to build an HIT-enabled measurement infrastructure to evaluate and ensure progress on our Population Health Plan. Features of this infrastructure include expanded adoption and meaningful use of electronic health records, a streamlined data collection and management system, and timely and comprehensive measurement feedback and reporting. This section describes how we will leverage past and current efforts to facilitate development of a standardized set of metrics. We are fortunate to have a strong foundation for this work, as evidenced by the following.

The Rhode Island Quality Institute's (RIQI) Beacon Community Program[3] fostered a successful collaboration among participating practices, including CSI-RI practices, to establish a set of standardized process and outcome measures for diabetes, depression screening, and tobacco cessation intervention. The 10-month long effort included physicians, nurses, QI and practice transformation professionals, and data analysts, resulting in a common set of agreed upon quality measures for the programs and a process for maintaining efforts.

To ensure continued harmonization of measures of health and care quality, the long-standing CSI-RI embedded a similar process in both its Data and Evaluation Committee and its Practice Reporting Workgroup. The resultant measure set reflects population health promotion, is used to monitor and reward primary care practice performance to this day, and includes: Tobacco screening and cessation counseling; body mass index (BMI) and weight management counseling; and measures related to diabetes management (e.g. HbA1c; blood pressure; LDL). The CSI-RI practices also regularly report on depression screening and hypertension.

[3] The Beacon Community Program was created as part of the American Recovery and Reinvestment Act and provides communities with funding to build and strengthen their health information technology (HIT) infrastructure.

In 2010-2011, the RI Department of Health expanded measure harmonization by convening state agencies (DOH, EOHHS, OHIC) and community organizations (RIQI, RI Quality Partners, Brown University) to reach consensus on three additional measures: Hospital readmissions, Ambulatory care sensitive (ACS) admissions, and Preventable ED visits. The standardized measures, based on national recommendations, allowed for comparison across populations and payers, and were used in the Beacon and CSI-RI projects as well as others. The group's work resulted in a recommendation to DOH to implement an All Payer Claims Database that would provide these and other measures by provider group and across payers on a risk-adjusted basis. The APCD is now almost complete, with data available by the end of 2014. The system will be critical to meeting of the goals of this grant.

On another front, Healthcentric Advisors, the Medicare Quality Improvement Organization in RI, used a multi-stage consensus process, as part of their Safe Transitions Project, to develop specific standards and consistent, statewide expectations for addressing gaps in patient activation and communication during cross-setting care transitions.[4] Their process involved: reviewing the medical literature and standards; ascertaining community preferences; drafting measures; soliciting input around content and feasibility; and obtaining endorsement from the targeted community provider group, EDs and hospitals, and other stakeholders (e.g., state agencies, payers). This process is ongoing and allows for periodic measure updates.

The need to harmonize measurement was discussed during State Health Innovation Plan development by the HIT and Measurement workgroup. Two primary barriers were identified: the lack of a statewide governance structure for improving and publishing harmonized measures, and the lack of a single entity to aggregate, analyze, and report measures. We will address these

[4] http://www.healthcentricadvisors.org/safe-transitions-cp/bps.html

barriers through work of the Healthy Rhode Island Steering Committee and the proposed Rhode Island Health Care Quality Measurement, Reporting and Feedback System.

The selection of appropriate measures is a core activity of the first year of the grant. Efforts will be informed by the aforementioned initiatives, as well as work at the Federal level. The Department of Health and Human Services' Measurement Policy Council, the unified set of electronic clinical quality measures, and electronic health record requirements all will inform measure selection. In 2012 EOHHS was awarded a CMS Adult Medicaid Quality, which is supporting RI to develop staff and system capacity to collect and analyze the CMS' Adult Core Quality Measure set across Medicaid. During the selection process, we will take care to select measures aligned with ongoing state and federal initiatives so that the results are useful for comparisons among providers, programs, and payers, within Rhode Island and beyond.

The Healthy Rhode Island Steering Committee will accelerate these efforts by leveraging the experience of CSI-RI, RIQI, and Healthcentric Advisors to implement the stakeholder consensus process. Given the number of focus areas we have chosen to address through the grant, and the intensive process it takes to build trust and agreement around measurement, we recognize the need to be judicious in choosing measures to reflect our Population Health goals.

The second way in which we will address barriers to harmonized measurement is through our Health Care Quality Measurement, Reporting and Feedback System**.** This system would support statewide capacity to obtain, analyze, benchmark, and feedback healthcare data from providers and their practice settings. A centralized system also could streamline redundant reporting processes for providers and payers. This would result in a more efficient use of the limited resources available for informing quality monitoring and improvement, health care purchasing, and consumer choice.

Section 8 Monitoring and Evaluation Plan

The Executive Office of Health and Human Services (EOHHS), as the grant manager, will be responsible for monitoring and evaluating the grant at the State level. EOHHS will enter into an agreement with an internal evaluation contractor to assist in this effort. A subcommittee of the Healthy Rhode Island Steering Committee will be formed to advise and inform monitoring and evaluation efforts. The Monitoring and Evaluation Plan will be finalized in the first year of the grant. The Healthy Rhode Island Model Test Proposal includes six broad components.

Test Component 1: Increasing the capacity of the State to accelerate healthcare transformation: This component posits that health care system transformation would be accelerated if the skills and orientation of the State entities engaged in healthcare, the current State use of regulatory and other powers, and the current State ability to use data effectively, were enhanced and better coordinated.

Test Component 2: Implementing a shared public/private governance model: This component seeks to test if healthcare transformation is facilitated by a shared public/private partnership. The "problem" or gap that this component addresses is the lack of a single entity to guide and monitor the transformation of our health care system.

Test Component 3: Plan to Improve Population Health: Our monitoring and evaluation efforts for this component will seek to understand the impact that the development and implementation of the Plan have on our ability to meet the aim of improving population health. Were we improving population health before the introduction of the Plan? If yes, are we improving at a faster rate? We also want to understand the effectiveness of the Plan itself – did we choose the right focus areas, measures and interventions?

Test Component 4: Transforming the Behavioral Health System: The inclusion of this component in our grant proposal addresses the need to improve access to comprehensive and coordinated behavioral healthcare.

Test Component 5: Implementing a Transformation Network: The initiatives under the Transformation Network are intended to advance existing models that meet the Value-based Care Paradigm and to develop new ones.

Test Component 6: Using Health Information Technology to Enable Transformation Efforts: This proposal seeks to use health information technology in two ways: to improve the State's ability to collect, analyze, and report data and to impact care delivery at the provider level.

We will monitor implementation of these components and evaluate their impact through process and outcome measures, with a focus on three key outcomes (1) strengthening population health; (2) transforming the health care delivery system; and (3) decreasing per capita health care spending.

Process Measures The process measures for all test components will align with the activities and milestones listed in the Operational Plan and further developed in Year 1 of the grant. For example, in the first year, did the State enter into a contract for advanced epidemiological support? To the extent specific initiatives require discreet process measures, they will be included. For example, in the development of the Child Psychiatry Access Project, we will include specific process measures related to the design of the effort. A potential process measure is variation in how primary care physicians use the service.

Outcome Measures

Strengthening Population Health:

Test Component (TC) 1, 2: We do not believe these components will have any direct quantifiable impact on population health

TC 3: As we implement the Population Health Plan, specific health focus areas, such as smoking and obesity prevalence, and diabetes treated to goal will be measured and tracked. Referencing the nine clusters of outcomes described in the Population Health Plan section, we will choose and prioritize additional outcome measures to help us understand how the work products of this effort positively impacted improvements in the health of Rhode Islanders. These measures will be examined iteratively, so that we can adjust interventions and target risk factors as necessary. In other words, would population health have improved at this rate without a concerted effort by the state and its partners to develop this Plan?

TC 4: We will measure the transformation of the Behavioral Health system with several outcome measures. We will use the measures included in the report, *Substance Use and Mental Health in Rhode Island; A State Epidemiological Profile,*[5] as the basis.

TC 5: Several of the initiatives included under the Transformation Network will have explicit measures related to population health and will be reflected in the Population Health Plan. Any that are not will be included in the overall grant evaluation effort.

TC 6: The HIT Plan is based on the concept that health IT can have a direct impact on people's health. For example, one measure is the number of individuals accessing preventive care as a result of identification through an EHR.

Transforming the Health Care Delivery System:

TC 1: Outcome measures associated with this component address the effectiveness of regulatory or policy changes. In order to understand if regulatory changes actually make a difference in the problem we were seeking to address, we will need to develop reliable indicators and appropriate

[5] http://www.bhddh.ri.gov/MH/pdf/RI_EPI_PROFILE_2010.pdf

research designs. One of the activities we will pursue in the first year of the grant is a full assessment of the regulatory tools available to the State entities on the Steering Committee. New opportunities to use those regulatory powers in support of this effort will include a plan for evaluation.

TC 2: While we believe the shared governance model will be an effective tool in the transformation of the health care delivery system, it is not clear how its direct impact on the system itself might be measured. We will seek technical assistance to develop these measures.

TC 3, 4: We will include measures of Population Health Plan and Behavioral Health Transformation interventions that will impact the health care payment and delivery system. These include Avoidable ED visits; 30 day all cause hospital readmissions; and Readmissions under the Medicare Payment Reduction Program for specific diagnoses.

TC 5: Several of the initiatives included under the Transformation Network will have explicit measures related to changes in the payment and delivery of health services and will be included in our Measurement and Evaluation efforts.

TC 6: The HIT Plan is intended to significantly impact the health care system.

Decreasing Per Capita Health Care Spending: We will measure the impact of the Test on per capita health care spending and trend by following the approach outlined in Financial Analysis Model. We will also look at total adjusted cost of care in Medicaid as well as through the data in the All Payer Claims Database.

Our ability to collect, analyze, and report integrated data will be enhanced through the roll-out of our All Payer Claims Database. As the statewide quality reporting measurement and feedback system is procured and implemented, we will use existing processes and develop interim methods to monitor and evaluate the grant as well as report our progress.

Section 9 Alignment with State and Federal Innovation

Rhode Island has been very active in delivery system transformation efforts and the Healthy Rhode Island Project seeks to build on the work already underway.

The most notable effort in Rhode Island is the statewide, all-payer Patient Centered Medical Home project, known as CSI-RI. CSI is a collaborative, all-payer PCMH effort of over 45 practices and 14 Community Health Centers that provides care to 250,000 Rhode Islanders. Payment rates are tied to achievement of clinical quality, utilization and process improvement targets. CSI is one of the 8 Medicare Advanced Primary Care Practice demonstration sites and was the nation's only statewide Beacon Community.

Rhode Island also has participation in the Medicare Shared Savings Program. Coastal Medical, a physician based ACO that provides care to over 10% of Rhode Islanders, is the state's current MSSP participant. Care New England, a major health system, has announced a partnership with the Rhode Island Primary Care Physicians Corporation to enter into the MSSP by January, 2015.

Four Rhode Island hospitals also participate in the Innovation Center's Bundled Payment Model 2 program and twenty-four providers (representing more than 25% of the state's long-term care facilities) participate in the Bundled Payment Model 3 program. Rhode Island providers also participate in three Health Care Innovation Awards focusing on at-risk newborns, childhood asthma and integrating care for persons with developmental disabilities.

These specific programs, coupled with the ongoing innovation in the state's health care market, represent the basis for growth of the value-based care paradigm. These early innovators will be the leaders of transformation of the system as a whole and will help to set the strategic direction and specific objectives of Healthy RI in the pre-implementation year.