Rhode Island

Stakeholder Assessment

Prepared for:
Amy Zimmerman
State HIT Coordinator
Executive Office of Health & Human Services
3 West Road
Cranston, RI 02920

Submitted by:
Sean Carey
Briljent, LLC
7615 W Jefferson Blvd
Fort Wayne, IN 46804
Telephone: 503-522-4820
E-Mail: scarey@briljent.com

February 17, 2020

This page is intentionally left blank.

Table of Contents

Executive Summary ... **1**
Introduction and Methods ... **2**
Overarching Feedback ... **3**
Role of the State ... *3*
Desired Scope of the Roadmap ... *3*
Roadmap Key Principles ... *4*
Governance ... **5**
Technology ... **6**
Statewide Technology Infrastructure ... 6
Health Information Exchange ... 8
Rhode Island Quality Institute ... *9*
CurrentCare ... *9*
Care Management Alerts & Dashboards ... *10*
Other HIE Services ... *10*
Quality Reporting System ... *10*
KIDSNET ... *11*
Other Technical Initiatives ... 12
HealthFacts RI ... *12*
Ecosystem ... *13*
Prescription Drug Monitoring Program ... *13*
Policy/Regulatory ... **15**
APCD and HIE Laws ... 15
Behavioral Health Data Sharing ... 15
Value-Based Care Efforts and the Accountable Entity Program ... 16
State Operations ... **17**
Internal State Stakeholder Feedback ... 17
External Stakeholder Feedback ... 18
Other Feedback ... **18**
Conclusion ... **19**
Appendix 1: List of Stakeholder Interviews ... **20**
Appendix 2: Acronym List ... **1**

List of Tables

Table 1: Overarching Feedback ... 4
Table 2: Governance Feedback ... 6
Table 3: Statewide Technology Infrastructure Feedback ... 8
Table 4: HIE Feedback ... 12
Table 5: Other Technical Initiatives Feedback ... 14
Table 6: Value-Based Care Efforts and AE Program Feedback ... 17

Table 7: Stakeholder List 20
Table 8: Acronym List 1

Executive Summary

The Rhode Island Executive Office of Health and Human Services (EOHHS) is in the process of developing a shared, single, statewide Health Information Technology (HIT) Strategic Roadmap and Implementation Plan to guide HIT activities and investments across the state over the next three years. The statewide HIT Implementation Plan is intended to help prioritize investments and identify opportunities where mutual benefit, interest, and commitment exist for alignment of and potential sharing of HIT systems across governments and the private sector. EOHHS contracted with Briljent, an HIT consulting organization, to conduct this stakeholder assessment and assist in the development of the HIT Strategic Roadmap.

Stakeholder input is a critical component in developing the statewide HIT Strategic Roadmap and Implementation Plan. By understanding stakeholder perspectives regarding HIT needs, challenges, and opportunities, EOHHS, other partner agencies, and community partners will be able to prioritize strategic HIT initiatives and guide future state investments in HIT. For the stakeholder assessment process, Briljent conducted almost 80 interviews with stakeholders and gathered information on current programs, needs, and ideas for the future. This allowed stakeholders to provide input into the development of the HIT Strategic Roadmap and Implementation Plan.

Stakeholders across Rhode Island are excited about the opportunity to develop a statewide HIT Strategic Roadmap and better coordinate on shared investments. Many stakeholders pointed to the long history of collaboration between public and private stakeholders and a shared sense of purpose in improving the quality and value of healthcare services provided. Rhode Island's size was also frequently mentioned as a key enabler, as were the significant HIT investments that have already been made across the state.

There was a strong desire to connect HIT strategy to broader health policy goals, and a sense from many stakeholders that health systems transformation efforts, while prevalent and growing, were not always aligned, especially with regards to HIT capabilities, needs, and investments to date. Almost universally, stakeholders agreed that the State was a key participant in statewide HIT efforts. The need for more coordinated and centralized governance was a key theme, and stakeholders talked about the myriad challenges with the current patchwork of governance structures and processes in place.

CurrentCare is seen by many as a public utility that offers significant potential for advancing health information exchange efforts in the state. The state's current opt-in consent law was seen by most as a significant barrier and led to underutilization of existing investments, confusion across the many services provided by the Rhode Island Quality Foundation (RIQI), and sometimes duplication of efforts to achieve needed exchange goals.

The results of this stakeholder assessment, combined with findings from the Current State HIT Assessment, will guide the development of a gap analysis and provide the framework for the development of the HIT Strategic Roadmap. Rhode Island is well positioned to build upon a strong foundation of HIT efforts and develop a path forward that will support the state's broader health systems transformation goals.

Introduction and Methods

This stakeholder assessment, in conjunction with the Current State HIT Assessment, forms the basis upon which Rhode Island will create a single, statewide HIT Strategic Roadmap and Implementation Plan. The primary purpose of the HIT Strategic Roadmap is to identify HIT priorities to support the State's broader healthcare goals by articulating a shared understanding of guiding principles and roles and developing an actionable plan for governance, technology, and sustainability of HIT initiatives across the state's public and private sectors.

The stakeholder assessment process, carried out by Briljent, collected input from a broad range of key stakeholders across the state. EOHHS identified many individual and organizational stakeholders for Briljent to interview, while others were identified by some of the interviewees. In order to allow interviewees to speak candidly, State staff did not participate in the interviews.

In total, Briljent conducted over 80 interviews with individuals and organizations. These included representatives from the following:

- Public Sector: State Agencies
  - EOHHS and Medicaid
  - Rhode Island Department of Health (RIDOH)
  - Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH)
  - Department of Human Services (DHS)
  - Office of the Health Insurance Commissioner (OHIC)
  - HealthSource RI (HSRI)
  - Division of Information Technology (DoIT)
  - Department of Commerce
- Private Sector: Health Institutions and Community Partners
  - Hospitals and health systems
  - Health plans
  - Physician practices
  - Community health centers
  - Employer representatives
  - Medicaid Accountable Entities (AEs)
  - Behavioral health agencies
  - Long-term care associations
  - Hospital and physician associations
  - Consumer advocacy groups

A full list of interviewees can be found in Appendix 1: List of Stakeholder Interviews.

Although a large number of interviews were conducted, several limitations still exist. Patients and consumers were identified as a key stakeholder segment. However, state leadership and Briljent decided that it would be more effective to begin by interviewing healthcare organizations, so there would be more information available to create a framework for meaningful engagement and feedback from patients and consumers. Second, while a variety of organizations were engaged, it was left up to individual organizations to determine who would participate in interviews. As such, there was variation in the roles represented in the process, and some roles may have more or less representation in the feedback than others. In addition, certain segments, such as independent physician practices, long-term care, and allied health professions, had limited participation in the current assessment phase. Several providers who were contacted for interviews were also too busy with the operational needs of their organization and were not able to participate. Where possible, associations and statewide conveners were engaged and encouraged to pass along information and opportunities to their members.

Overarching Feedback

Stakeholders across Rhode Island are excited about the opportunity to develop a statewide HIT Strategic Roadmap and better coordinate on shared investments. Many stakeholders pointed to the long history of collaboration between public and private stakeholders and a shared sense of purpose in improving the quality and value of healthcare services provided. Rhode Island's size was also frequently mentioned as a key enabler, as were the significant HIT investments that have already been made across the state.

Many stakeholders spoke to the positive experience of Rhode Island's State Innovation Model (SIM) grant program, especially as a model for coordination and convening, shared decision-making, and transparency of efforts. There was a strong desire to build upon that work, though also caution that SIM was successful, in part, because of the shared purpose and access to resources, and that it would be important to ensure both of those enablers were in place to support the statewide HIT Strategic Roadmap.

> ***"SIM worked because everyone was at the table."***
>
> **– State Employee**
>
> ***"The leadership of SIM was crucial to its success. We need visionary leadership to move [the HIT Roadmap] forward."***

Stakeholders also spoke to the need to have a clear understanding and shared agreement about the state's healthcare goals. When asked about what HIT infrastructure was needed, many stakeholders commented that infrastructure should be linked to overarching priorities to ensure it would meet the actual business and use cases needed.

Broadly speaking, there was also alignment in stakeholder feedback on the barriers facing HIT initiatives across the state. Stakeholders spoke frequently of resource limitations, both in terms of money and people, competition and market dynamics, and changes around effective coordination across a myriad of state agencies and programs engaged in health and human services work.

Role of the State

Almost universally, stakeholders agreed that the State was a key participant in statewide HIT efforts, though there were differing views on the role the State should play. Several stakeholders saw the state as best suited to function as the central convener, while others believed that the State should participate in efforts as a payer alongside other health plans. Whatever the role for the State, there was also interest from stakeholders in having it clearly defined and articulated, as it was noted that the State sometimes played a regulatory role, sometimes acted as a funder of efforts, and sometimes acted as a centralized coordinator and convener. Many stakeholders agreed that the State, working closely and collaboratively with community stakeholders, was best suited to lead the development of a cohesive approach to health policy including a statewide vision for health care that could act as a guiding framework for HIT investments.

Desired Scope of the Roadmap

Stakeholders shared mixed views on how ambitious the scope and scale of the HIT Strategic Roadmap should be. Many stakeholders believed, given Rhode Island's size, previous investments, and history of strong public-private collaboration, there was tremendous opportunity for a bold vision of HIT services that would support broader healthcare needs. Some believed the State should propose an ambitious plan and tackle large, high-value opportunities with significant impact. Others believed the State should select smaller, more manageable initiatives and build incrementally over time. Stakeholders with the latter view

tended to also have concerns about the State's past performance with IT initiatives, which may be a driver. Given these divergent views on scope and content, additional stakeholder input may be needed to determine consensus on a path forward. Alternatively, it may be advisable to build incrementally while developing deeper stakeholder trust and confidence in the ability to execute. The strong stakeholder support for increased, transparent community governance may provide an ideal venue for this development process.

Some of the diverging views were connected with stakeholder perceptions about the State's ability to successfully implement large-scale information technology (IT) initiatives. Many stakeholders referenced the State's eligibility and enrollment project, the Unified Health Infrastructure Project (UHIP), as an example of a problematic IT project, and shared examples of continued data quality problems with information received out of the system.

Roadmap Key Principles

In terms of roadmap principles and guiding values, many stakeholders shared that patients are core to the work of their organizations and agencies and should be kept at the center of thinking. Several stakeholders also wanted to ensure patients were included in the development of the roadmap process itself, though some shared concerns about making sure the engagement was meaningful and respectful of patients' time and understanding of HIT. There was also some concern shared about patient involvement in the identification and prioritization of specific HIT initiatives. For example, a few stakeholders commented that patients should provide input on the needs or outcomes required rather than on the specific technologies or approaches.

Stakeholders also shared that provider burden should be a top concern of the HIT Strategic Roadmap. Many stakeholders agreed that HIT has contributed to provider burden and burnout, though some indicated that HIT-related burden was perhaps a consequence of other demands, requirements, and administrative complexity rather than the technology itself. There was strong interest across both state agencies and private stakeholders to reduce provider burden, ease access to information and better incorporate it into clinician workflows, and simplify information sharing and reporting where possible. Considering the role of HIT in administrative simplification was also identified as an opportunity.

Table 1 provides overarching stakeholder feedback. (Note: **Bold** text indicates strongest agreement among stakeholders on feedback.)

Table 1: Overarching Feedback

Strengths	Needs
• **Excitement for a statewide HIT Strategic Roadmap to coordinate shared investments** • **History of collaboration among public & private stakeholders** • Positive experience with SIM coordination, convening, shared decision-making, & transparency	• **Clear understanding/shared agreement about the State's healthcare goals** • **Link HIT infrastructure to overarching priorities** • Better communication about initiatives & progress • Defining the role of the State, vision, & goals with community collaboration • Articulating approach to execute health priorities & HIT strategies • Engaging consumers/patients

Opportunities	Barriers
• **Alignment among state agencies & private stakeholders to reduce provider burden by improving access to information, integrating solutions in clinical workflows, & simplifying information sharing & reporting** • Leveraging existing consumer engagement activities across advisory councils, health equity zones, or other conveners • Desire for a shared, bold vision	• **Limited resources (money and people)** • Effective coordination across state agencies & programs engaged in health/human services work • Increasing provider burden with inefficient HIT solutions & infrastructure

Governance

Rhode Island has a long history of collaboration and shared decision-making across HIT investments. Within state government, a number of HIT initiatives cross agencies and programs. Public and private stakeholders have developed and maintained a robust statewide health information exchange (HIE), and SIM launched a number of initiatives involving both state government and community partners. Rhode Island also has a number of existing governance structures in place, some created by state statute and others created to oversee specific projects.

Stakeholders overwhelmingly agreed that coordinated, centralized HIT governance would be beneficial. Many existing committees and workgroups are comprised of the same stakeholder representatives, and yet significant gaps in awareness of and information about related initiatives exist. Several stakeholders shared they had been part of workgroup committees and yet did not know the status of those initiatives. Other stakeholders were unaware of initiatives or governance entities, even though representatives from their organizations were participating or involved.

There was also strong agreement that HIT governance should be connected to, and driven by, broader health policy initiatives and goals. HIT was broadly seen as an enabler for health systems transformation efforts. In addition, many stakeholders shared that HIT initiatives were long-term investments, and there was a strong desire for better coordination and centralized overarching health planning where there were opportunities for shared infrastructure or reuse.

> ***"The opportunity is good because people are at the table—but not boldly yet: there's only a million people in Rhode Island; we should be able to do this."***
>
> **– Community Stakeholder**

Stakeholders shared mixed, and sometimes contradictory, views on the ideal venue for coordination, with some seeing it as primarily a role for the State to convene, and others believing that the coordination should occur in the private space with the State participating in its role as a payer of Medicaid services. Some stakeholders viewed the Rhode Island Quality Institute (RIQI) board as a potential convening group, while others mentioned the Rhode Island Foundation. While not all stakeholders shared their reasoning behind suggesting certain venues for coordination, those that did, shared anecdotes of positive and negative experiences with certain conveners, though there was little common alignment.

There was strong interest in better alignment between existing governance structures and workgroups, perhaps by creating a cascading approach or better linking groups focused on governance and strategy with groups focused on implementation of specific initiatives. Within initiatives, some stakeholders also

shared that there may be value in breaking apart certain workstreams and creating focused subcommittees that could tackle more technical needs with the stakeholder representatives best suited for specific work and needs. There was also support for ensuring that governance and workgroups included not only a variety of stakeholder/provider types, but also a variety of roles and perspectives, including physician/clinical, executive leaders, and initiative users.

Many stakeholders shared that one of the first goals of a governance group should be to develop rules of the road for the sharing of information and mechanisms for incentivizing participation or holding organizations accountable for following those rules. In many cases, challenges with information sharing were attributed to organizational, political, or regulatory barriers as opposed to technical ones. Stakeholders shared that a central governance group might be able to provide a venue to address those barriers and support efforts to share information more effectively.

Because of the multiple governance groups, some stakeholders also recommended that roles and scope be clarified. One suggestion was to have a clear responsibility accountability matrix (or Responsible, Accountable, Consulted, and Informed [RACI] chart) to help communicate those roles and cross-linkages.

Table 2 provides stakeholder feedback regarding governance. (Note: **Bold** text indicates strongest agreement among stakeholders.)

Table 2: Governance Feedback

Strengths	Needs
• **Strong interest in defining cascading governance models coordinating & defining focused workgroups** • Lots of overlapping participation in groups • Long history of collaboration & shared decision-making	• **Centralized coordination, convening, & clarity/assignment of roles** • Continuous communication on status, progress, & organization involvement • Identifying opportunity for shared infrastructure/reuse • Defining convener & venue for coordination
Opportunities	**Barriers**
• **Connect HIT governance to boarder health policy initiatives & transformation goals** • Leverage existing committees & workgroups with broad stakeholder representations • Alignment with existing governance structures & workgroups • Link workgroups across strategic initiatives and identify subgroups with specific focus areas to address technical or policy needs	• **Numerous governance structures created to oversee specific projects, but lack of coordination/communication across structures** • **Unclear "rules of the road" for information sharing & program participation** • **Desire for clarity around roles/responsibilities across participants** • Indistinct methods for sharing information, incentivizing participation, accountability, & decision-making

Technology

Statewide Technology Infrastructure

Many stakeholders identified the need for a centralized, statewide infrastructure to facilitate HIE. Core identity services, such as a statewide master patient index, provider directory, and patient-provider attribution services, were frequently mentioned. Stakeholders also identified needs such as a direct

address directory, centralized care plan registry for individuals with complex care needs, and statewide communication tools.

Several stakeholders were part of the effort to build a statewide provider directory, though many were unaware that the project had been indefinitely paused. Some stakeholders identified challenges with the provider directory development process that included having an unclear business or use case for initial development, an uncertain financial sustainability plan, and a lack of communication regarding project status and issues. Stakeholders shared that sometimes discussions regarding the provider directory did not include all of the appropriate roles from organizations. They highlighted the need to involve people from many different levels and job types when planning core infrastructure such as the provider directory. They noted that different phases of an initiative may also impact the people who need to participate, with decisions about strategy and financing needing to involve one set of stakeholders, and detailed or technical work possibly needing different people involved.

> ***"Little gets done because regulatory levers aren't often aligned. It's frustrating because we have examples of how it's worked well in the past."***
>
> **– Healthcare Organization**

Some stakeholders shared that core infrastructure should be linked to regulatory or policy levers when possible. Requiring participation in certain centralized efforts was seen as a key component of success, and several stakeholders referenced the SIM Aligned Measure Set work as an example of how this worked well in the past. Some stakeholders shared anecdotes about cases where regulatory or policy levers weren't linked and how this caused the initiatives to falter or struggle. Examples included the provider directory's struggle to build out viable business cases and the Quality Reporting System's initial lack of committed Medicaid MCOs.

All stakeholders spoke to the scarcity of available resources to support initiatives. Many were supportive of a public utility approach to funding shared infrastructure; but there was also strong agreement that the value of tangible benefits needed to exceed the costs involved. Improved efficiency, lower direct costs, better clinical outcomes, and higher reimbursement were all mentioned as potential benefits that would be of value.

Several stakeholders brought up challenges with statewide investments related to market dynamics and competition. In some cases, stakeholders shared that their own investments in internal HIT capacity, such as building interfaces with key trading partners or investing in shared population health platforms, were a competitive advantage, and duplicating those investments at a statewide level would not provide a significant benefit to them. In instances, such as investing in a shared platform for specialty referrals, a few stakeholders commented that recent trends in practice consolidation might make obtaining stakeholder agreement on implementation difficult.

Table 3 provides stakeholder feedback regarding statewide technology infrastructure. (Note: **Bold** text indicates strongest stakeholder alignment on feedback.)

Table 3: Statewide Technology Infrastructure Feedback

Strengths	Needs

• **Some investments (e.g., CurrentCare) are broadly supported & seen as a public utility**
• **Investments with clear business/use cases identified (e.g., Care Management Alerts & Dashboards [CMAD]) are widely seen as successful**
	• Centralized statewide (reusable) infrastructure of the following to support electronic HIE:
	  • Statewide master patient index
	  • Provider directory
	  • Patient-provider attribution services
	  • Direct address directory
	  • Centralized care plan registry for individuals with complex care needs
	  • Single e-referral platform for Social Determinants of Health (SDOH) needs
	• Inclusion of correct roles/representatives within organizations from different levels during various project phases
	• Identifying roles and expectations of data users, senders, & intermediaries

Opportunities	**Barriers**
• Link to regulatory/policy levers where possible • Looking for centralized efforts where there is strong interest in participation • Learn from successful coordinated, centralized efforts (e.g., SIM Aligned Measure Set)	• Unclear business case or use case for developing large investments • Undefined financial sustainability plans and lack of communication on status/progress for HIT projects

Health Information Exchange

The need for robust, comprehensive health information across the state and beyond was identified by most stakeholders as a core foundation to their business and operational objectives. Stakeholders shared differing levels of sophistication with existing tools and efforts, with hospitals and health systems more likely to be using a variety of technologies and initiatives to facilitate exchange, and smaller providers, specialists, and long-term care providers using more limited methods of exchange.

> ***"There is a phenomenal opportunity [for HIT] if there can be one place for clinical data."***
>
> **– Physician Group Practice**
>
> ***"Interoperability is the biggest challenge to be addressed."***
>
> **– Primary Care Clinic**

Virtually all stakeholders were aware of CurrentCare and/or HIE services provided by RIQI, though there was also widespread confusion and misunderstanding of distinctions. Many stakeholders could not distinguish between CurrentCare services and RIQI services, and several did not understand how services were funded. Some, for instance, believed that all services, including CurrentCare and Care Management Alerts and Dashboards (CMAD), should be covered by the contributions of the State and health plans through the per-member, per-month joint funding plan.

Rhode Island Quality Institute

As the state-designated entity for HIE in Rhode Island, RIQI plays a unique role in the community. Many stakeholders had extensive experience working with RIQI on initiatives, including several individuals who had been involved in the early planning and development of the CurrentCare infrastructure.

In April 2019, RIQI experienced a significant transition in its executive leadership and, during the course of stakeholder interviews, was led by an interim Chief Executive Officer (CEO). Many stakeholders commented on this change, with some sharing that it was a time of uncertainty for the organization, and others feeling hopeful that the change in leadership would be good for the organization and its efforts. Several stakeholders shared concerns about business and operational decisions that RIQI had made in the past, commenting that there had been "mission creep" and a seeming lack of focus on developing and improving core HIE infrastructure and exchange. A few stakeholders from both healthcare organizations and state agencies shared mixed feedback on project delivery experience, saying that some projects went well while others seemed to run into problems. This mixed experience led those stakeholders to be more cautious in their recommendations about the role that RIQI should play in statewide efforts.

Stakeholders were also concerned about resource availability at RIQI, both in terms of access to financial resources and stable funding, as well as having sufficient staff with the right technical and business skills to accomplish the work. There was widespread support for locating core statewide services at RIQI and leveraging the interfaces and technical connections already in place for additional needs, but also hesitation about whether the organization had the ability to deliver.

Due to the substantial investments already in place, many stakeholders commented that RIQI was a natural statewide hub for information sharing and suggested better leveraging it as a conduit for other needs. Some examples included connecting to national initiatives such as eHealth Exchange, CommonWell Health Alliance, and Carequality, as well as vendor-specific efforts like Epic's Care Everywhere. Building on this central hub model, stakeholders believed it would be efficient to invest in data normalization and terminology services that would facilitate better consolidation of data and ease the exchange between different electronic health records (EHRs) and data systems.

CurrentCare

Most stakeholders were aware that CurrentCare was the statewide HIE. Stakeholders shared mixed views on the completeness, usability, and effectiveness of the service. Some identified themselves as heavy users of CurrentCare, incorporating information into their EHRs, automating queries within workflows, and building processes around checking the CurrentCare portal for necessary information. For these stakeholders, they found CurrentCare invaluable and were generally pleased with the support they received from RIQI.

> ***"It needs to be easier to find information. It can't be like searching for the needle in the haystack every time."***
>
> **– Medical Practice Chief Information Officer (CIO)**
>
> ***"CurrentCare is a fantastic resource."***
>
> **– Community Health Center**

A couple of stakeholders stated that bi-directional interfaces with CurrentCare were not available and accessing information through the portal was not an effective way for clinicians to gather information. Other stakeholders shared that the portal interface was clunky and difficult to use. Many stakeholders commented on the limited volume of patients in CurrentCare due to Rhode Island's HIE consent law, and

virtually all stakeholders thought a change in the consent law was necessary for the HIE to be able to maximize its value to the community. In many cases, stakeholders desired single sign-on access and better integration of information into existing clinical systems and workflows.

Care Management Alerts & Dashboards

CMAD was viewed by many stakeholders as a significant accomplishment of statewide HIE services. Stakeholders who used CMAD almost universally saw it as critical for their day-to-day operations. Several stakeholders commented on the cost of CMAD, stating that it was too high to enroll their entire patient panel. Others were happy that Medicaid would soon be supporting access to the dashboards for patient enrolled in AEs, but they questioned why other patients were not included.

> ***"We live and die by the Care Management [Alerts &] Dashboards."***
>
> **– Community Health Center**
>
> ***"[Care Management Alerts & Dashboards] have been a game-changer for care coordination efforts."***
>
> **– Medicaid Policy Staff**

Some stakeholders asked about alerts being expanded to include other encounter events and transitions of care. Suggestions included skilled nursing admissions and discharges, as well as adding additional information to the alert such as the primary care coordinator or a way to indicate to a broader care team who was following up on the event.

Other HIE Services

Several health plans indicated they were in discussions or had begun implementing additional services from RIQI to support Healthcare Effectiveness Data and Information Set (HEDIS) reporting needs. Two stakeholders shared they were in the process of implementing emergency department (ED) Scalable Medical Alert Response Technology (SMART) notifications to bring additional information to ED users. While they were hopeful that the service would be valuable, they indicated it was too early to tell whether it would meet their business needs. There was some concern about the development of tools, such as the ED SMART notifications, as certain stakeholders thought there were already better tools available in the market that could be adopted without building something unique for Rhode Island.

The cost for HIE services was frequently raised as a concern, and stakeholders reported adopting partial solutions (e.g., by not including their entire patient panel in the CMAD service), delaying implementation of desired services, or forgoing them altogether. Some stakeholders with out-of-state operations shared that the cost for RIQI's services was significantly more than their costs to connect with other regional HIEs.

Quality Reporting System

Many stakeholders were aware of the State's investment in a Quality Reporting System (QRS) (formerly called the Healthcare Quality Measurement Reporting and Feedback System) and agreed that a centralized reporting solution for quality measures would be beneficial. Beyond that, stakeholders had mixed views on the purpose, role, and sustainability plan for the QRS. Stakeholders who were involved in early implementation efforts described the benefits of the proposed solution but questioned whether it would be adopted by the Medicaid managed care organizations (MCOs) and other health plans necessary for full impact. Other stakeholders questioned whether the QRS had a clearly defined business case and sustainable funding identified. In general, stakeholders disagreed on who should pay to sustain the system, with many provider stakeholders believing that health plans should pay for the system and health plans generally favoring a user fee or shared funding approach. There was also confusion about

how the QRS initiative interacted with RIQI and CurrentCare. A few stakeholders asked whether the systems were duplicative, and at least one suggested that QRS could possibly replace CurrentCare at some point. Some stakeholders commented that the State should require participation in the QRS by key Medicaid providers and MCOs in order to reduce administrative burden, similar to how OHIC developed the Aligned Measure Set and then required commercial and Medicaid health plans to adopt them.

Patient identity and attribution were identified as concerns by most stakeholders in some form or another. Some stakeholders were concerned about the effectiveness of patient matching given challenges with the quality of other state data systems, such as eligibility and enrollment data. Others saw the lack of a statewide universal unique identifier as a barrier to reuse of the data. There was also a concern about how data would be collected for patients attributed to practices through various programs (such as AEs) but never seen by the practice. Some stakeholders were concerned about data quality and completeness and, in particular, about using Continuity of Care Documents (CCDs) to extract quality measures given challenges with CCD data quality and standardization.

Stakeholders commented on the need to build on investments being made in the QRS, including the exploration of combining clinical and claims data for improvement purposes and allowing application programming interface (API) access to specific data elements. Stakeholders were interested in the ability to receive practice- and provider-level feedback from the system. In addition, several stakeholders requested clearer communication about the proposed and allowed uses of the data within the system, more detail about specific program limitations and gaps, and a clear picture of the implementation timeline.

KIDSNET

A few stakeholders commented on the value of KIDSNET, the state's childhood information system. The longitudinal nature of data, relative completeness, and ability to run actionable reports were highlighted as benefits of the system. These stakeholders also questioned whether KIDSNET could be linked to CurrentCare to improve access and integration of the data.

> ***"KIDSNET is great—it's such a relief when you have the information you need."***
>
> **– Chief Medical Officer, Practicing Physician**

Table 4 provides stakeholder feedback regarding HIE. (Note: **Bold** text indicates strongest agreement among stakeholders.)

Table 4: HIE Feedback

Strengths	Needs
• **HIE data is a core foundation to stakeholders' business and operational objectives** • **Awareness of CurrentCare & other HIE services** • Unique role of State Designated Entity (SDE) for HIE, RIQI, & in community • Integrated information in EHRs & automated queries in clinical workflows by establishing processes to check CurrentCare • CMAD critical to day-to-day operations	• **Comprehensive health information across state for all stakeholders** • **Clarity on HIE services, funding, leadership, & overall efforts** • Core, reusable HIE infrastructure/exchange • **Understanding of CurrentCare's completeness & usability** • Bi-directional interfaces/ease of portal use • Communication of value proposition & evaluation of business case for new HIE tools • Addressing data quality/completeness for all HIE services • Integration of KIDSNET & other public health programs with CurrentCare
Opportunities	**Barriers**
• Building on core statewide services at RIQI, leveraging established interfaces & technical connections to meet additional needs • Medicaid support for AE patient dashboards • Expanding alerts with other encounter events, (e.g., skilled nursing admissions & discharges) • Addition of useful information on care coordinator & team	• Differing technical maturity levels with technology tools/efforts across hospitals & small providers • Confusion/misunderstanding about different HIE services • Resource availability at RIQI & confidence on successful project delivery • Limited patient data volume due to HIE consent law • Usability of CurrentCare Viewer • Cost of CMAD & other HIE services • Delayed or discontinued implementations resulting in diverted stakeholder investments

Other Technical Initiatives

HealthFacts RI

Stakeholders generally felt like HealthFacts RI, the state's all-payer claims database (APCD), was beginning to show value for state policymakers and other state program needs. Work was underway to expand the collection of non-claims-based payment information common to Alternative Payment Models (APMs), including dental claims, and work with self-insured employers to improve reporting of claims that were exempted by Gobeille v. Liberty Mutual Insurance Company.

For external users, cost was frequently cited as a limiting factor for the usability of HealthFacts RI data, with many stakeholders sharing that the cost was prohibitive for their use in practice improvement efforts, especially related to total cost of care initiatives. Many stakeholders shared that access to claims data in a standardized format would be hugely beneficial, especially if the data could be linked with clinical data and used to drive practice and system-level improvement. A few stakeholders shared that the

de-identification requirements of HealthFacts RI data were problematic for patient linking and practice improvement needs and that a legislative change might be required to maximize the value of the HealthFacts RI investments.

Most provider stakeholders were receiving some claims-based data from their contracted health plans, especially when in accountable care relationships such as the AE Program. However, many shared that information they received from plans varied in content, completeness, and format, making it difficult to use the data effectively. One organization shared that due to the non-standard nature of the data, and the associated resources required to make the data useable, they have decided to contract with only one MCO for the AE Program.

All health plan stakeholders commented on the multiple needs for claims information. They shared that data submissions to multiple government agencies and provider organizations were resource-intensive and inefficient and expressed a desire for a single reporting mechanism where information could then be routed as needed.

Ecosystem

Knowledge of the EOHHS Data Ecosystem was widespread, both within state government as well as with external stakeholders. Stakeholders were generally excited about the opportunities to better leverage state data to improve program operations, develop policy proposals, and support research efforts.

Internal state stakeholders shared that part of the success of the data ecosystem was that it was built using the following process:

1. Defining operating principles
2. Developing technology and data sources iteratively
3. Delivering early and quick value by answering pertinent research and policy questions

This approach stands in contrast to the typical implementation of enterprise data warehouses where planning and implementation can take years, and there is an emphasis on adding as many data sources as possible. Stakeholders generally had favorable views of the data ecosystem's future, especially as more self-service options became available.

External stakeholders were also interested in ways that the ecosystem could be leveraged for external research applications and to support public-private efforts in the public and population health sectors.

Prescription Drug Monitoring Program

Stakeholders were generally satisfied with their access to the Prescription Drug Monitoring Program (PDMP) and were excited about opportunities for better workflow integration, including embedded access and tailored alerts in the ED. Some stakeholders commented that the PDMP could be expanded to include additional medications (e.g., Methadone, which was mentioned several times) or even all prescribed and dispensed medications, which would aid in medication reconciliation and complex care management functions.

Table 5 provides stakeholder feedback regarding other technical initiatives. (Note: **Bold** text indicates strongest agreement among stakeholders. Because many of these technical initiatives have targeted audiences, only some stakeholders provided feedback. This made it hard to assess how broad stakeholder agreement is regarding these initiatives)

Table 5: Other Technical Initiatives Feedback

Strengths	Needs
HealthFacts RI • HealthFacts RI beginning to show value for policy & program needs • HealthFacts RI planned expansion to support APMs & additional claims data sources *Other systems* • EOHHS Data Ecosystem enables state data, improving program operations, policy proposals, & research efforts • Access to PDMP data & improving workflow integration into EHR & ED alerts	*HealthFacts RI* • Standard format of claims-based data extracts from MCOs & improvement of completeness for usability *Other systems* • More clarity to external stakeholders about the Data Ecosystem (value, data sources, data access) for research & public-private efforts • Alignment of technical initiatives with existing & planned HIT infrastructure
Opportunities	**Barriers**
HealthFacts RI • Access to standardized claims data in common format would be very beneficial • Plan for linking clinical & claims data to drive practice & system-level improvements • Defining roles of HealthFacts RI & QRS for practice-level improvement activities and identifying potential integration points *Other systems* • Expanding PDMP to include additional medications &/or all dispensed medications for medication reconciliations & care management	*HealthFacts RI* • HealthFacts RI data use cost is prohibitive for practice improvement efforts • Deidentification requirements of APCD data are challenging for patient linking & practice improvement needs • Lack of access to standardized content, format, & completeness of claims data reduces usability & increases resources needed

Policy/Regulatory

APCD and HIE Laws

Virtually all stakeholders interviewed described the opt-in consent requirement of CurrentCare as a significant barrier to the system realizing its full value as a statewide HIE. Numerous stakeholders described the extensive investments that had been made in enrolling both patients and providers in CurrentCare, but shared that despite those investments, barely half of Rhode Islanders were enrolled in the service. In addition, because of the current consent law, even when a patient is enrolled in CurrentCare, there is currently no way to add historical medical records. Instead, information in CurrentCare only begins accruing after the enrollment is processed. Stakeholders working in the behavioral health space shared that CurrentCare offered potential value to support care coordination and complex care management, but that clearly communicating the information-sharing process was crucial to building and maintaining trust with many patients.

Some stakeholders shared concerns that RIQI was involved in both CurrentCare and other HIE services like CMAD. The distinction between CurrentCare, which has consent limitations due to the HIE Act, and other HIE services, which are governed under business associate agreements allowed by the Health Insurance Portability and Accountability Act (HIPAA), was not always clearly understood.

Also, as previously noted, some stakeholders described the restriction on combining APCD data with identified clinical data to be a barrier for its effective use as a tool for practice improvement and total cost of care management efforts.

Behavioral Health Data Sharing

Many stakeholders commented on the need for more effective information sharing between physical health and behavioral health providers. A large portion of stakeholders shared concerns about differing interpretations of federal law, especially around 42 Code of Federal Regulations (CFR) Part II regulations governing substance use treatment programs. Rhode Island also has a Mental Health Law that includes some privacy protections, and stakeholders sometimes conflate state and federal laws when communicating barriers to information sharing. There was a strong desire for the State to take some action, either by convening providers and developing a shared agreement, or by issuing statewide policy guidance on the State's interpretation of "allowable sharing." Stakeholders also shared concerns about the technological capabilities to properly segment specially protected information and provide an accounting of disclosures as required by law.

Several stakeholders brought up the lack of Admit, Discharge, Transfer (ADT) alerts from Butler Hospital, a psychiatric hospital, in CMAD. These patients were more likely to be involved in some sort of complex care management program, and providers stated that it was difficult to effectively manage the care of those patients without access to real-time hospitalization data. Two stakeholders mentioned that information sharing from their organization was limited due to their interpretation of the state's mental health law.

Virtually all healthcare organizations involved in the state's AE Program shared frustration with getting access to the data needed to effectively manage performance on a seven-day follow-up after hospitalization for mental illness. Stakeholders shared that not having access to the necessary information made it seem like a "black box" metric and that performance on it was left entirely up to chance.

Value-Based Care Efforts and the Accountable Entity Program

There was wide variation in the readiness and interest in investing in HIT to support value-based care efforts, including the Medicaid AE Program. Some healthcare organizations reported significant investments in infrastructure and capabilities to support value-based care, while others reported few to none. Other stakeholders shared mixed views on how quickly the state was moving towards value-based care payment models, with several sharing that the state payment landscape was still very firmly entrenched in a fee-for-service (FFS) world. One payer expressed significant concern about provider readiness for value-based care and felt trapped between consumer demand for broad networks and strong policy pressure to control or reduce spending.

Participants in the AE Program expressed many concerns about the consistency of program requirements, transparency about State efforts to support those requirements, and variation in implementation between the Medicaid MCOs. Many stakeholders also shared frustrations about the amount and quality of data received from the State, including enrollment data, AE attribution, and performance on quality measures. Stakeholders broadly agreed that the development of program requirements, such as quality measure reporting or SDOH screening and referrals, seemed to occur without discussion about the technology or infrastructure necessary to support those requirements. This led to confusion about the role of statewide technology initiatives like QRS, as well as concern that stakeholders would begin investing in individual technologies to meet program needs where it may have been more efficient to invest in a centralized system or service instead. All AE Program stakeholders expressed a desire for the State to better integrate technology discussions into the AE Program requirement development.

> ***"Given what is expected of [the AEs], it is in everyone's interest to invest in a single, statewide e-referral platform."***
>
> **– AE Stakeholder**

Many stakeholders shared that a statewide coordinated approach for a system to support e-referrals for identified SDOH needs was a high priority to reduce the risk of multiple, unaligned investments in separate systems. There was strong support to build upon investments already made in the community, such as the resource directory built by United Way/211. There was also some interest in a system that could support referrals between medical providers, with a few stakeholders believing it would be the most important centralized investment the State could make. A few shared that the market dynamics and individual clinician requirements would make a centralized medical referral platform extremely risky to undertake collectively.

Many stakeholders spoke to the need for better care coordination, especially among the many entities serving people with complex care needs. However, they shared that there were significant gaps in the ability to identify those patients and the care team members, as well as effectively communicate within the team. One group suggested a need for better coordination of care team members working with high-risk populations, perhaps through the development of a shared care plan accessible across provider organizations. Another stakeholder saw the primary care-led care coordination model as challenging for certain populations who may be better served by a care manager, social worker, or behavioral health home as the lead coordinator. In such approaches, a more flexible approach to statewide health information exchange may be needed.

Table 6 provides stakeholder feedback regarding value-based care efforts and the AE Program. (Note: **Bold** text indicates strongest agreement among stakeholders.)

Table 6: Value-Based Care Efforts and AE Program Feedback

Strengths	Needs
• **Readiness & interest in investing in HIT to support value-based care** • Strong interest in centralized reporting solution if it will reduce burden, improve access to clinical data, & drive system improvement	• **Statewide coordinated approach for SDOH referral platform & implementation** • Alignment of program requirements with technical capabilities & infrastructure needs to support these requirements • Better care coordination across entities for people with complex needs & addressing challenges for identifying patient care team members • Communication of business case & developing financial sustainability plan for QRS • Articulation of QRS & RIQI interaction to reduce perception of duplicate efforts
Opportunities	**Barriers**
• Identifying ways to improve state data for AE Program operational needs • Developing SDOH e-referral approach by convening interested stakeholders, developing requirements, & implementing • Requiring participation in QRS by key Medicaid providers & MCOs • Integrate clinical and claims data for practice level and system level improvement purposes	• Program requirements consistency, amount, and quality of data received from state (i.e., enrollment data, AE attribution, and quality measurement performance) • Difficult to identify complex needs patients, care team members, and communication with team • APCD privacy law limits linking claims/ clinical data

State Operations

Stakeholders, both within state government and from community partners, shared feedback about state operations and the State's role in HIT efforts.

Internal State Stakeholder Feedback

Most state employee stakeholders shared positive experiences with the State's role in HIT initiatives and expressed hope about future opportunities. Several stakeholders commented on the value of SIM, especially in how it provided resources and support for convening and cross-agency collaboration. There was a strong desire to build upon investments already in place, but also caution about adding additional internal governance or coordination without specific purpose. For new investments, stakeholders cautioned about investing too sparsely and not having sufficient resources to complete work or have an impact. There was a sense that there was no shortage of ideas in state agencies, but that the process for determining what ideas should be funded should be clear, transparent, and aligned with agency objectives.

Stakeholders communicated a need to balance information access and sharing with the burden of additional meetings. They suggested a tiered approach of meetings, pushed information sharing (e.g., e-mails or newsletters), and known places to pull information as needed (Web sites or committee notes).

Many stakeholders shared concerns about having adequate resources to complete necessary work and maximize the value of current investments and data resources. IT resources were frequently described as scarce, and state policy restrictions sometimes prevented agency staff from contracting with outside resources even if money was available through federal grants or other funding sources. Many stakeholders commented on the state's full-time equivalent (FTE) cap that limited staff positions, even if financial resources were available. This scarcity sometimes caused conflicts as programs competed for access to those limited resources.

The need to coordinate HIT initiatives and work within and between agencies was highlighted by many stakeholders. At RIDOH, where the public health informatics coordinator position was vacant at the time of the interviews, many stakeholders commented on the value of the position and shared that it was difficult to stay coordinated without that resource in place. In particular, the public health informatics coordinator was seen as the crucial link across programs, between agencies, and with the centralized DoIT, who has oversight over large IT initiatives and resources. Several stakeholders indicated they would not have been aware of HIT opportunities without that position in place.

In addition to needing sufficient staff, state stakeholders commented that having staff with the right skills and training was essential. Skills such as data science, SAS, and informatics training were all highlighted.

Several stakeholders shared there were insufficient IT resources available, as well as uncertainty about the role of DoIT in project oversight. Stakeholders stated that the State project review process, which DoIT had recently implemented, felt like a "black box" process and that they had little information about what to expect with the process or the status of projects currently under review. Program staff relied on the individual agency's assigned IT manager, but there were differing views on whether the process was effective in supporting agency IT needs.

External Stakeholder Feedback

Stakeholders from community partners expressed concern about the State's ability to execute large-scale IT projects. Some of these concerns stemmed from experience with UHIP, and others were rooted in a perception that the State lacked sufficient resources to manage and implement technology initiatives. In order for projects to be successful, stakeholders commented that adequate and capable project resources and oversight were needed.

Some stakeholders also expressed concern about frequent leadership changes at the State and the impact this had on the State's long-term health policy goals, as well as the associated commitment to HIT initiatives that were designed to support those policy goals. Stakeholders also shared that it was difficult for their own organizations to commit to large-scale investments in the HIT needed to support those policy goals without some level of certainty that the goals would remain consistent in the future.

Other Feedback

Many stakeholders shared ideas and feedback on a variety of topics not covered elsewhere in this report. Some of these ideas included the following:

- Coordinating with border states and leveraging learnings from across the country
- Common credentialing
- Creating access to medication fill data to support care coordination and promote patient safety

-
- Creating a venue to share security and privacy best-practices and collaborate on shared areas of concern

Conclusion

This stakeholder assessment, combined with the Current State HIT Assessment, provides a strong foundation for building a single, statewide HIT Strategic Roadmap. Stakeholders are excited about the possibility for aligning public and private interests, coordinating on shared investments, and developing a sustainable approach to collaboration on HIT efforts. Building on a significant foundation of HIT investments and strong history of community collaboration, Rhode Island is well positioned to develop a path forward that will support the state's broader health system transformation goals.

Broadly speaking, stakeholders want more formal, coordinated centralized planning and governance, a focus on core health information exchange capabilities that builds on previous investments in CurrentCare and related services, and greater alignment between health policy efforts and HIT initiatives. Stakeholders also desire a focus on regulatory and policy alignment, including coordination and clarity around behavioral health information sharing and a change to Rhode Island's HIE consent policy.

Based on the HIT Current State Assessment and the Stakeholder Assessment, Briljent has also identified a number of opportunities for further exploration to inform the development of the HIT Strategic Roadmap. This work will include significant input from state agencies and community partners to help ensure the HIT Strategic Roadmap represents the needs and priorities of the broader Rhode Island community.

Appendix 1: List of Stakeholder Interviews

Table 7 provides a list of Departmental Leadership Interviews by stakeholder.

Table 7: Stakeholder List

Organization/Program	Stakeholder
Departmental Leadership Interviews	
Office of the Health Insurance Commissioner (OHIC)	Commissioner Marie Ganim Cory King Marea Tumber
Rhode Island Department of Health (RIDOH)	Sandra Powell
Medicaid	Debbie Morales Melody Lawrence Kristin Sousa Libby Bunzli
HealthSource RI	Former Director Zach Shermann Betsy Tavares Director Lindsay Lang
Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH)	Corinna Roy
Department of Human Service (DHS)	Yvette Mendez Caitlin Molina
Department of Information Technology (DoIT)	Chirag Patel
Agency-Level Program and Technical Staff	
BHDDH Systems	Brendan Mahoney Jamieson Goulet Olivia King Diane Cavanaugh
eReferral System	Marti Rosenberg
Department of Corrections (DOC)	Jennifer Clarke, MD Pauline Marcussen
Executive Office of Health and Human Service (EOHHS) All Payer Claims Database (HealthFacts RI)	Tanya Bernstein Brian Boates
EOHHS State Data Ecosystem	Kim Paull Jessie Hole Alyssa Ribeiro
EOHHS Long-Term Services and Supports (LTSS)	Brian Gosselin
EOHHS Medicaid Analytics	Bill McQuade
EOHHS Medicaid Systems	Hector Rivera Nicole Nelson Rob Tingle Stan Prokop
EOHHS Promoting Interoperability Program	Stan Prokop Robin Smith

Organization/Program	Stakeholder
RIDOH Cancer Registry	Eric Lamy Junhie Oh
RIDOH Diabetes, Heart Disease and Stroke	Megan Fallon Adrian Bishop Randi Belhumeur Carol Votta Meaghan Joyce
RIDOH Chronic Disease Program	Nancy Sutton
RIDOH Agency IT Manager	Bob Childs
RIDOH eReferral System	Blythe Berger Kristin Lehoullier (consultant)
RIDOH Center for Vital Records	Roseann Giorgianni
RIDOH Pediatric Medical Director	Ailis Clyne, MD
RIDOH Center for Health Promotion	James Rajotte
RIDOH Center for Health Data Analysis	Samara Viner-Brown Leanne Lasher
RIDOH Infectious Disease	Bridget Teevan
RIDOH KIDSNET	Ellen Amore Kim Salisbury-Keith Tricia Washburn
RIDOH PDMP	James McDonald, MD Peter Ragosta Victoria Ayers Meghan McCormick
EOHHS Ryan White Program	Paul Loberti Andre Parker Nestor Dellagiovanna
RIDOH HIV, Hepatitis, Sexually Transmitted Diseases (STDs) & Tuberculosis	Thomas Bertrand Teddy Marak
RIDOH Oral Health	Samuel Zwetchkenbaum, DDS, MPH Sadie DeCourcy
RIDOH Health Equity	Chris Ausura
Office of Healthy Aging	Mackenzie Thiessen
Community Partners	
Rhode Island Quality Institute (RIQI)	Neil Sarkar Scott Young Michael Dwyer
HopeHealth	Diana Franchitto
Healthcentric Advisors	John Keimig Lauren Capizzo Rebekah Gardner, MD Blake Morphis Kathy Calandra Bryan Los

Organization/Program	Stakeholder
Care Transformation Collaborative RI	Debra Hurwitz Pano Yeracaris, MD Susanne Campbell Candice Brown
Care New England	James Fanale, MD Phil Kahn
Neighborhood Health Plan of Rhode Island	Beth Marootian Greg Velander
Blue Cross & Blue Shield of Rhode Island	Matt Collins, MD Gus Manocchia, MD Amar Gurivireddygari
UnitedHealthcare Community Plan	Patrice Cooper Marty Haglund Mike Baillie
Tufts Health Plan	Domenic Delmonico Joseph Imbimbo Juan Lopera
Rhode Island Primary Care Physicians Corporation	Al Puerini, MD Andrea Galgay
United Way of RI	Angela Bannerman Ankoma Cristina Amedeo
Blackstone Valley Community HealthCare	Ray Lavoie Jonathan Mudge Sandy Pardus
Brown Medicine	David Hemendinger
Coastal Medical	Al Kurose, MD Ed McGookin, MD Mice Chen
Integrated Healthcare Partners	Michael Lichtenstein Diane Evans Kimber Barton
Integra Community Care Network	Matt Harvey Melanie Brites
Thundermist Health Center	David Bourassa Cynthia Skevington Matt Roman Gloria Rose Chris Corin Elizabeth Lynch
Providence Community Health Centers	Jonathan Gates, MD Andrew Saal, MD Raymond Parris
Prospect Health Services Rhode Island	Amanda Cox Garry Bliss Rebecca Broccoli
Yale New Haven	Lisa Edwards
South County Health	Gary Croteau

Organization/Program	Stakeholder
Lifespan	Cedric J. Priebe III, MD
Brown University School of Medicine	Jack Elias, MD
Hospital Association of Rhode Island	Gina Rocha Lisa Tomasso
Rhode Island Medical Society	Peter Hollmann, MD
LeadingAge RI	Jim Nyberg
Emergency Medicine	Megan Ranney, MD
Delta Dental	Tom Chase
RI Parent Information Network (RIPIN)	Sam Salganik
The Substance Use and Mental Health Leadership Council of RI	Susan Storti
Center for Treatment and Recovery	Wendy Looker
RI Free Clinic	Marie Ghazal
Business Group on Health	Al Charbonneau
Rhode Island Commerce Corporation (RICC)	Melissa Simon

Appendix 2: Acronym List

Table 8 provides a list of acronyms used in this document.

Table 8: Acronym List

Acronym	Definition
ADT	Admit, Discharge, Transfer
AE	Accountable Entity
APCD	All-Payer Claims Database
API	application programming interface
APM	Alternative Payment Model
BHDDH	Behavioral Healthcare, Development Disabilities, and Hospitals
CCD	Continuity of Care Document
CEO	Chief Executive Officer
CFR	Code of Federal Regulations
CIO	Chief Information Officer
CMAD	Care Management Alerts & Dashboards
DHS	Department of Human Services
DoIT	Division of Information Technology
ED	emergency department
EHR	electronic health record
EOHHS	Executive Office of Health and Human Services
FFS	fee-for-service
FTE	full-time equivalent
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	health information exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	health information technology
IT	information technology
LTSS	Long-Term Services and Supports
MCO	managed care organizations
OHIC	Office of the Health Insurance Commissioner
PDMP	Prescription Drug Monitoring Program

Acronym	Definition
QRS	Quality Reporting System
RACI	Responsible, Accountable, Consulted, and Informed
RICC	Rhode Island Commerce Corporation
RIDOH	Rhode Island Department of Health
RIPIN	Rhode Island Parent Information Network
RIQI	Rhode Island Quality Institute
SDE	State Designated Entity
SDOH	Social Determinants of Health
SIM	State Innovation Model
SMART	Scalable Medical Alert Response Technology
STD	sexually transmitted disease
UHIP	Unified Health Infrastructure Project