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Purpose of this Document

This document is intended to support the **Rhode Island Health Care System Planning (HCSP) Initiative and specifically the Hospital Sector Working Group Discussion for Meeting #2, on October 17th**.

- Please reference the Meeting #2 PowerPoint for an executive summary of problem statements and solutions.
- This document provides supporting details on both the problem areas and solutions as discussed in one on ones with working group members.
- These materials should be considered preliminary working documents, in support of Meeting #2. Problem statements and solutions identified here have not yet been confirmed by the working group as a whole.

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Additional Details: Problems & Strategies

Problems to Consider

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Priority Level A

#1: Lack of Statewide Health System Oversight, Data Infrastructure, and Long-Term Planning

a) Need for an established, resourced, ongoing process and structure to monitor and maintain community needs, system capacity, rate adequacy and hospital fiscal stability
   - Crisis has not been adequately identified - Unlike Massachusetts, RI hasn't had spectacular failures leading to immediate action.
   - Lack of data collection, appropriate data governance, oversight, and long-term vision to inform this process - re: community needs (considering outmigration of services), system capacity, rate adequacy, hospital fiscal stability
   - Certificate of Need (CON) process isn't working
     - Most proposals are approved, causing unnecessary duplication of services which is diluting hospital volume and increasing operating costs.
     - CON process itself is outdated (e.g. length of time for proposal review, $ thresholds, etc.)
     - Conditions on approvals lack substance and enforcement (e.g., remaining nonprofit, locally owned)
   - Historically RI hospitals have built specialized capacity for new services without sufficient demand to deliver them efficiently detracting from core services and populations, causing financial distress
     - Need to identify services/specialties needed in-state vs those that can be provided by bordering states

b) Lack of transparency of hospital and health system fiscal performance, underlying costs, and payment rates
   - Specific concern regarding lack of transparency and oversight over hospital operating cost and health system expenditures
   - Little insight/acknowledgement of the impact of integrated physician practices on hospital financial performance and operational challenges

c) Some existing regulatory structures to leverage (identified in Legal and Regulatory Framework, February 21, 2023 | Manatt, Phelps & Phillips, LLP)– but insufficiently resourced, lacking "teeth" and not aligned.

d) Lack integrated multi-payor regulatory/oversight processes between EOHHS, OHIC, RIDOH, and OAG.
   - Current regulatory authority structure for health system planning is too dispersed to be effective

e) Strong private equity guardrails in the hospital sector, but limitations in other sectors (e.g., physician practices, urgent care centers, nursing homes, etc.)

f) Limited focus on statewide health equity

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- Impact of hospital financial instability on communities with high Medicaid reliance and reliance on EDs
- Concern regarding hospital compliance with and investment through the Community Benefit requirements – lack of state enforcement mechanisms
- Lack of transparency into disparities in health outcomes by race, ethnicity by hospital
- Lack of coordination across the continuum of care, including with community organizations, social service providers, and others that can ensure people are accessing preventative care

g) Hospital concerns with increasing prior authorizations and denials, most notably in the Medicare Advantage space. Some cited lack of reg pathways that incorporate Medicare Advantage oversight, payers noted that these policies are needed given increasing hospital revenue cycle management and upcoding strategies. Many states are passing legislation to fix prior authorization issues.

h) Hospital system silos – limited collaboration to identify and disseminate best practices that address system-wide challenges

#2: Reimbursement Not Keeping Pace with Rising Costs

a) Wages and benefits
- Lack of sufficient wages and benefits to encourage retention – specifically a concern when competing with bordering states
- High physician pay subsidies
- Lack of affordable accommodation for residents and the healthcare workforce more broadly
- Cost of medical training is too high

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b) Key drivers of rising operating costs
- Payor behaviors – Increasing claims denials and prior authorizations with ongoing arbitrary changes, resulting in high legal fees and operating losses, especially in Medicare Advantage (MA) - MA programs have been a net negative for physicians, compared to traditional Medicare
- Scale – "small/medium" hospitals and health systems by national standards limits efficiency in large part due to high administrative infrastructure costs
- Excessive documentation requirements – EMR systems designed for billing improvements, but reducing staff efficiency
- Increasing cost of medical supplies and drugs
- Overhead (e.g., payment of physician subsidies, legal fees, etc.)
- System costs - purchasing of physician practices by large health systems.

c) Reimbursement limitations, especially Medicaid
- Commercial appears comparable to bordering states (as reported by Manatt Health RI Hospital and Health System Study, March 2024)
- Medicaid rate adequacy (data not available) but substantive concerns noted
- Suppressed reimbursements create high risk of hospital closures

d) Medicaid reimbursement structure
    - Not predicable - Highly dependent on supplemental payment components outside of rates (e.g., UPL, DSH, SDPs, GME)
    - Not sufficiently leveraging federal match – MCO tax, provider tax opportunity, perception that Rhode Island is leaving federal dollars on the table

e) Negotiated fees
    - Rates and fees are negotiated (for commercial, MA, Medicaid managed care), not set, and can vary substantially based on market power – leaving smaller providers disadvantaged
    - Limited political will to hold commercial carriers accountable for having a sufficient network. Note, the AG's office planning to release a report in a few weeks demonstrating this issue.

f) Hospital accountability & payment reform
    - Need for hospital accountability for rising operating costs –state fiscal monitoring tied to penalties/incentives, or global budget
    - Global budgeting & AHEAD as potential pathway to accountability
        - Some noted challenges/limitations of value based payments (VBP) and/or global budgets as a solution, such as limited financial support and state capacity for effective planning, adding to existing payer and payment complexity, need for multi-payer participation, concerns regarding risk transfer to financially fragile provider organizations and losses on VBC contracts eliminating operating margins.

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#3: Limitations in Investment and Technology

a) Low margins limiting ongoing investments in facilities, fixed assets, IT infrastructure and cybersecurity
    - Hospital facilities in the state are largely out of date and need capital for significant investments to overhaul and remodel

b) Small/Medium scale, financial instability limits access to capital/bond markets

c) Challenges of working with small independent insurers who are required to have their own infrastructure, impacting costs and operations, which limits their ability to invest in systems that help hospitals from a data perspective.

d) Regulatory environment
    - Limitations on partnerships across state lines
    - Hospital Conversion Act is arduous and costly, limiting mergers that could bring needed investments

e) Technology gaps
    - Lack of EMR alignment across hospitals and providers
    - Poor communication across providers even using the same EMR system
    - Lack of needed EMR functionality, fair contracting terms
    - EMRs lack clinical-centered design, causing inefficiencies, steep learning curves, etc.

f) Cybersecurity risks causing business continuity risks

- Reliance on tech means if systems go down, hospitalists can't write orders – all operations stop
- Lack of thought leaders in cybersecurity – both in state positions and in the hospital systems
- Asymmetric cybersecurity regulatory environment (hospitals have very clear penalties, whereas vendors do not have that same level of regulatory oversight)

Priority Level B

#4: Workforce Challenges

a) Lack of access to physicians/specialists – patients are waiting several months to get an appointment
b) Nursing & Tech shortages
   - In the past, nurses generally had a dedicated CNA, now there is one CNA split between 2 or 3 nurses.
   - RN and ancillary staff supply shortages - decreasing percentage of licensed RNs interested in pursuing careers in the industry (50% in 2018 down to 38% in 2023 (RI EOHHS, Health Workforce Data Dashboard))
   - Lack of clear and robust career ladder from CNA to LPN or RN – among those with a valid license record with RI, only 8% have gone on to become an RN since 2010 (RI EOHHS, Health Workforce Data Dashboard)
   - Lack of experiential training and apprenticeship programs leaving entry level nursing staff not prepared to work independently, leading to faster burnout and high turnover
   - Limited surgical and diagnostic imaging Technologists and Technicians – only one surgical tech associates programs in the state

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c) Lack of hospital wide strategic workforce planning, career path development and implementation – insufficient managerial resources and capacity within hospitals to take advantage of existing state workforce programs and partner with Department of Labor on addressing emerging workforce needs
d) Lack of engagement and partnership between hospital leadership and physicians/specialists

#5: ED Utilization, Primary Care Capacity and Prevention

a) Inappropriate ED utilization for services that could be better handled in the community (e.g., dental, BH, sore throats, sinus infections)
   - Lack of sufficient access to primary care in the community
   - Access is limited by language barriers, lack of after-hours capacity, primary dental capacity, and BH capacity in the community
   - Little visibility into where bed/ED capacity bottlenecks are, making it challenging to fix access issues.
b) Primary care and alternatives (Checking for data/evidence)
   - Lack of access to primary care physicians, causing increased ED utilization, impacting RI's most vulnerable populations the hardest – need for targeted investment in primary care capacity

- Inadequate leveraging of FQHC system to reduce avoidable ED use - payment model should be an opportunity
- Most Rhode Islanders cite lack of open alternatives as reasons for using ER for 'non-emergency' care. *(checking for data)*
- Seriously ill patients are overwhelming EDs and being treated, admitted rather than having the appropriate palliative care consults
- The purchasing of physician practices by large health systems is hindering practice innovation and health systems are losing money on them.

c) Behavioral Health & HRSNs
- Lack of HRSN navigators/centralized resources to appropriately support patients frequenting the ED
- Early and pending investments in mobile crisis CCBHC, and community BH alternatives making a difference, must grow/maintain
- Challenges with ED triage, specifically for patients with behavioral health needs

#6: Length of Stay and Care Transitions

a) Patient Complexity - Higher acuity patients are staying in hospitals longer

b) Community Alternatives
- Underprepared for rapidly aging population – lack of focused investment in community-based social and medical services for elders to avoid admissions both to hospitals and to SNFs.
- Care transitions to post-acute care, LTC, BH care and social services are a challenge
- Financial stability of alternative community settings is at risk in part due to workforce
- BH inpatient stays are significantly longer than necessary due to lack of step-down options

c) Long lengths of stay due to lack of nursing home beds and cuts to homecare agencies largely due to reimbursement issues.

d) Lack of sufficient physician training in palliative care extending lengths of stay when individuals should be moved earlier into hospice settings

e) Lack of standardized approach to managing care transitions

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Strategies to Consider

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Policy and Regulation	Funding and Infrastructure	Payment
Quick Hits		
1. Perform initial analysis & build state infrastructure/capacity for ongoing **Hospital Fiscal Transparency & Performance Monitoring (with equity lens)** ○ **Authority** - Leverage existing EOHHS and RIDOH authority - Ensure mechanism is in place to enable full access to both for-profit and nonprofit hospital finances/data. Build in authority to hire independent auditors at the expense of the hospitals to support comprehensive assessment of private equity and other investor-based organizations with complex/opaque financial structures. ○ **Components** - Create baseline analysis/initial dashboard of a) hospital and health system fiscal stability b) operational/efficiency metrics and c) system and population characteristics including disparities in health outcomes by geography, race/ethnicity, gender; hospital bed capacity and ED boarding. ○ **Process & Structure** - Implement data governance for hospital and health system financials that incorporates hospital input on measures, data presentation, and interpretation of hospital/health system data. Establish processes to support public access and use of data by providers, partners, researchers and to incorporate patient-centered perspective of patients and community members. ○ **Compliance** - Incorporate meaningful financial transparency compliance rules (quarterly reporting of health system/parent company financials), with stringent consequences for non-compliance (i.e., Medicaid funding cuts). ○ **Use** - Treat fiscal oversight like a bond holder, with defined triggers for intervention (Establish audit requirements based on days of cash on hand (e.g., 50 days, 30 days). ▪ Consider employing risk-based classification of health systems (red/yellow/green) that can be tied to tiered merger/acquisition oversight requirements (e.g., increased oversight for at-risk entities, reduced/minimal oversight for financially sound entities) ○ **Scope** - Consider broader application of financial transparency and monitoring requirements beyond hospitals to include physician practices, FQHCs, and nursing homes.	5. **Tackle hospital operating costs/ efficiency -** Establish pathway & funding for **hospital learning collaborative** on best practices in hospital operations to identify pathways to reduce administrative costs (e.g., billing codes, leveraging the health information exchange, EMRs, centralized back-office infrastructure etc.) ○ Document and share relevant learnings with community partners (e.g., assistance with Medicaid billing) 6. **Seek 1115 Waiver authority and funding** to support findings from hospital fiscal monitoring ○ **Authority:** Seek DSHP/CNOM authority to authorize federal match for current state university health workforce expenditures ○ **Use**: Potential Uses of funds: ▪ 1) Pay for performance on key measures of hospital operational efficiency/financial improvement ▪ 2) Added support for financially unstable hospitals (NY-like model) – focusing investment on hospitals in at risk communities ▪ 3) infrastructure funds for hospitals participating in global budgeting, plus ongoing funds tied to quality outcomes for participating hospitals	**8. Medicaid Payment – Step 1** ○ **Study**: Conduct a comprehensive hospital, primary care, and targeted physician/specialist Medicaid rate study across all DRGs to inform Medicaid rate decision. Begin with hospital DRGs, then assess physician/specialist rates based on priority physician practice areas identified by hospitals. ○ **Protect:** Maintain state directed payment one-time payment mechanisms to protect hospitals while studies are completed ○ **Funding:** Leverage hospital tax – Increase hospital tax in line with CMS rules for existing redistributions of provider taxes to fold back into provider system. Consider pursuing statutory authority to protect funds, however this approach could risk CMS review. Monitor/follow new federal guidance and restrictions. Potentially leverage alternate or supplemental sources of funds (e.g., savings from state health plan (reference #27 below)) 9. **Consider aligning cadence of Medicaid state directed payments** with hospital fiscal year – admin fix

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- Funding - Leverage portion of hospital tax to fund ongoing state infrastructure.

2. Develop a **Statewide Acute Care Plan based on a deep dive analysis of capacity and needs**. (to be reevaluated every 5+ years)
   - **Authority -** Leverage existing Office of Health System Development, RIDOH authority. Consider consolidating responsibilities that are currently spread across state agencies to drive strategic healthcare planning.
   - **Components -** Plan must: (1) Identify where/what acute care services are needed, including bed capacity, RI specific vs regional capacity, (2) Prioritize service capacity for vulnerable communities, considering health equity and geographic differences, (3) Specify hospital vs. alternative community capacity options for specific geographies (ref examples from #20 below), and (4) Identify where/when to transition to centralized technology.
   - **Starting Point -** Ensure hospital community health needs assessments are leveraged. Potentially leverage/build on Statewide Health Inventory study – currently an unfunded legislative mandate.
   - **Community Engagement** - Process and structure to incorporate patient-centered perspective of patients and community members.
   - **Use -** Plan to provide a roadmap to inform infrastructure investment decisions, CON process reforms.
   - **Funding -** Leverage portion of hospital tax to fund this analysis on an ongoing basis as needed (every 5+ years)

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3. **Consider options to reduce the administrative and fiscal burden of prior authorizations and denials**, most notably in Medicare Advantage
   - State oversight and monitoring of prior authorization processing to ensure health plan denials are within the bounds of reasonable benchmarks (e.g. auditing of denial outliers). Consider national best practices and pathways to have these rules apply to Medicare Advantage (e.g., implement participation conditions on Medicaid, DSNP, delegated authority).
   - Consider limiting prior authorization – e.g., no prior authorization for providers who implement certain tools/processes or have proven track record; or no prior authorization for specified services *(pending initiative)*
   - Consider eliminating prior authorization requirements and perform an annual audit for monitoring purposes

4. Implement policies to **increase RiteShare take-up as a mechanism to maximize employee enrollment in employer sponsored commercial coverage** and lower unnecessary reliance on Medicaid. *(pending initiative)*

- 4) Added workforce investments

7. **Build state expertise in cyber security**, identify funding opportunities

for MCOs, OMB, others?

10. **Consider changing Medicaid payment policy to pay on discharge DRG** to align with other payors

Short Term

Policy and Regulation

11. **Enhance monitoring and enforcement of community benefit compliance** - review community benefit investments by hospitals in other states to assess impact on community health, unnecessary use of ER, and other measures related to building community-based, preventive care network.
    - Including oversight and enforcement of hospital PILOT agreement community contribution commitments

12. **Require hospitals acquire NCQA health equity accreditation** to be provide structure to better institutionalize associated initiatives and investments

13. **Restructure Oversight of Mergers and Hospital Conversion –**
    - **Expand Scope**: Consider expanding Hospital Conversion Act beyond hospitals to leverage these guardrails on private equity investments in other sectors (physician practices, urgent care) that focus on preventing harms and negative outcomes, so that “returns on investment” don’t detract from patient care[1]
    - **Limit Application:** Reduce regulatory barriers to non-profit mergers and out of state alignments for entities with strong fiscal stability – as they limit critical operational and fiscal improvements
    - **Reduce administrative burden** of hospital conversion review process.

14. **Reform CON Process**
    - **Transform/**enhance CON process to be based on long-term health system plan and needs assessment, relying more heavily on data with input from expert state staff (i.e., only allow applications for services/infrastructure needed as outlined in needs assessment)
    - **Increase $ threshold**, thereby decreasing purchases needing approval as we increase financial monitoring as an alternative.
    - Implement, monitor, and enforce **conditions on approval** to ensure intended outcomes are attained. Fund state resources to monitor these conditions.

15. **Implement** authority and governance model based on best practices to support state oversight and monitoring of **prior authorizations and denials, incorporating Medicare Advantage if possible.**

Funding and Infrastructure

16. **Explore resources through Office of National Coordinator (ONC) for Health Information Technology** for cyber security and/or new technology infrastructure – should be available with enhanced match

17. **Enhance Hospital EMR functionality & streamline communications within and across EMR systems**
    - **Leverage CMS Information Blocking and Interoperability & Patient Access Rule** – conditions of participation in Medicaid, Medicare – to require EMR vendors to provide needed/federally required functionality to streamline communications.
    - **Find a funding pathway to** clinically centered EMR investment (rather than billing centered)
        - **Potential sources of funds**: State bond issuance, braided federal grant funds, EPIC, Brown University, other?
        - **Tie funding** to multi-year participation in AHEAD global budget.

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Payment

18. **Medicaid Payment – Step 2**
    - **Rates:** Adjust Medicaid payment rates based on results of comprehensive rate study, comparative to Medicare, other states. Transition state directed payment, other one-time hospital payment mechanisms into rate adjustments – predictable source of funds
    - **Funding:** Leverage increases to hospital tax - represents Medicaid share of increase, without any added state budget (if allowable).
    - **Application:** Consider tiered/differential payments tied to participation in AHEAD or other pay for performance goals (fiscal monitoring/quality measures). Incorporate additional infrastructure supports for hospitals to support this model (see funding and infrastructure solutions).

19. **AHEAD model/Global Budgeting Supports** - incorporate additional infrastructure supports for hospitals to support this model (see funding and infrastructure solutions). **Hold solvency funds aside** for participating hospitals in case of financial issues *(pending initiative)*

[1] Note, what defines private equity continues to evolve – need flexibility to ensure that any statutory or regulatory reform can be adequately leveraged to address new and changing actors.

Policy and Regulation	Funding and Infrastructure	Payment
Longer Term		
20. Based on outcomes of statewide capacity/needs assessment (and fiscal status of hospitals), **consider alternative community capacity options** for specific geographies. E.g., ○ **Consider repurposing facilities and staffing at risk hospitals to provide care to local communities through different models,** like the CMS rural health model ○ Consider **Free Standing EDs (FSEDs)** –partnered with nearby hospitals and supported with seamless transport/transitions for high acuity patients. Explore regulatory framework – conflicting views on this approach ○ Consider **specialty Congestive Heart Failure (CHF) chronic care centers** in vulnerable communities and resource with teams of providers (NPs, dieticians, PAs etc.) inclusive of remote monitoring, team home visits and treatment centers for patients with a variety of chronic diseases – keeping them out of the hospital. 21. State strategy to **address drug costs and access issues -** Implement new oversight authorities over Pharmacy Benefit Managers (PBMs) (e.g., new licensure process that prohibits certain policies and practices that harm consumers/raise costs, financial review process). Several states are taking action to better regulate PBMs[2].	**22.** Could **consider a single statewide EMR**– pros and cons noted. 23. **Consider State bond issuance** to provide infrastructure support for deferred maintenance, facilities, and IT tied to financial reporting and efficiency metrics to ensure return on investment.	**24. Medicaid Payment - Step 3** Consider state-wide, coordinated rate reform and alignment. For example: ○ Consider **an all-payor standardized rate** for hospital services, based on the Maryland model. ○ Consider **increasing Medicaid hospital and physician rates to be one to one with Medicare** to improve inequities in access for Medicaid patients. 25. Consider **single statewide health system** solution. 26. **Consider a two-system solution** - one community-based system focused on chronic condition care with superior primary care, and one focused on acute care needs. Each hospital system has a niche in the market minimizing unnecessary overlap of service delivery between hospitals. 27. Negotiate **lower commercial rates/hospital payments for state employee health plan, use state savings to increase Medicaid rates** which are matchable – resulting in a net win for hospitals. Need to explore financial details.

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[2] United States Government Accountability Office. Prescription Drugs – Select States' Regulation of Pharmacy Benefit Managers. https://www.gao.gov/assets/d24106898.pdf.

Policy and Regulation	Funding and Infrastructure / Payment
Cross Sector Opportunities: Workforce	
28. **Tie free health professional education** (CCRI & other) **to in state needs** – require those receiving in state education to work in RI for X yrs. **29.** Create pathways (regulatory, payment) for **virtual nursing** **30. Consider requiring entities to enter Labor Peace Agreements to receive Medicaid funding** – allowing unions to fight together/on behalf of hospitals for higher wages.	31. Develop **paid nursing apprenticeships** on night shifts for senior nursing students – may need to address credit requirement challenges with accreditors. 32. Summer earn while you learn: **Utilize CCRI nursing faculty to provide on-site hospital training for new nursing hires/recent grads** for hospitals with shortages/without capacity to provide appropriate oversight/training needed in the first 3 months of a nursing career. **33. Support targeted gaps in hospital workforce** ○ Implement programs (scholarship/incentive-based?) to **encourage more diagnostic imaging and medical lab technologists** ○ **Establish additional Surgical Technologist Associate Programs** in the area – currently only one program at NEIT ○ **Partner hospitals with community-based workforce development providers** (e.g., Genesis Center, RI Nurses Institute Middle College (local HS)) to address these gaps and connect them to untapped community capacity.

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<table>
<tr><th>Policy and Regulation</th><th>Funding and Infrastructure</th><th>Payment</th></tr>
<tr><td colspan="3">Other Sector Opportunities</td></tr>
<tr><td colspan="3">Primary Care</td></tr>
<tr><td>34. Rebuild primary care capacity, infrastructure and incentives to create urgent care within practices.

35. Loan forgiveness for primary care physicians to address shortage

36. Evaluate the role of community health centers (for example, FQHCs)
○ Assess ability for these providers to address access from a health equity perspective effectively given their locations and the patients they serve.</td><td>37. Implement <u>AI Scribes to reduce documentation burden</u> for PCPs</td><td>38. Invest in high quality primary care practices
○ <u>Purpose</u> - State could play a role in taking the burden off hospitals to support primary care and ensure the money stays within primary care. Hospitals control the majority of primary care, but don't have the margins to support.
○ <u>Assessment</u> - Consider including primary care practices and FQHCs in financial transparency and monitoring initiative (#1 above) to assess targeted gaps in financial performance and operational efficiency and identify high performing, high quality practices.
○ <u>Payment</u> - Ensure appropriate incentives are in place to reward efficiency and drive quality outcomes (e.g., APM to support physician productivity).

39. Move primary care payment to capitation model to allow stable funding to support base operations coupled with incentives to reduce utilization that they can control, like ED utilization.

40. Consider Statewide Medicaid ACO, with one central contract under OHIC.</td></tr>
<tr><td colspan="3">Behavioral Health</td></tr>
<tr><td>41. Consider additional intermediate care facilities, specifically ICF/IDs to bridge the transition from inpatient to community settings.

42. Open a small stabilization/community discharge unit in Butler – can be interim or partial solution to the lack of step-down options but ultimately need additional ICF capacity.</td><td></td><td>44. Maintain/add funding for mobile crises and community based intensive care program and CCBHCs – these are making an impact.
○ Leverage OHIC authority to ensure these services are covered and funded across payers (not just for Medicaid)
○ Consider reinvesting 911 tax into crisis system

45. Expand community based long term care models to support SPMI population and prevent "deep end churn"</td></tr>
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Policy and Regulation	Funding and Infrastructure	Payment
43. Expansion of BH disciplines with evidence-based practices – seek federal match to invest in innovative BH workforce solutions.		46. Create financial incentives for **additional BH support/community providers**– especially in MH Professional Shortage Areas (MHPSAs), as noted in Northern RI. ○ Build on CCBHC requirements specifically monitoring and targeting these gaps. ○ Leverage Mental Health parity law to establish and monitor BH Network Adequacy **47. Add another BH-link** in the southern part of state
Health Related Social Needs (HRSN)		
48. Central patient navigator for HRSN providers to refer patients with SDOH needs who are returning to hospitals daily – deepen hospital-HEZ relationships, identifying common goals and utilize/build on HEZ health referral pathway project. ○ Identify pathways for investing in and compensating these networks of community providers for referrals and provision of supportive services – hospital investment? Other?		
Long Term Services and Supports (LTSS)		
49. Develop/invest in/ensure regulatory pathways for **innovative alternative post-acute care models**[3] ○ Create **standardized model for care transitions management**	**50. Retooling of Eleanor Slater Hospital** to a true long term acute care hospital (LTACH) with a modernized facility to treat medically complex patients *(pending initiative)*	

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[3] Reference innovations at Kent Hospital - Units that specialize in care of the elderly (ACE@Kent) have demonstrated shorter length of stays, fewer transfers to post-acute units (SNF), and lower re-admission rates; hospitalization at home (Kent@Home) has demonstrated similar impact on healthcare utilization when compared to a traditional hospital setting.