Rhode Island Health Care System Planning

2024 Foundational Report

Dear Governor McKee,

Please accept this Foundational Report as the first deliverable of the Health Care System Planning Project identified in your Executive Order 24-04 establishing the State Health Care System Planning (HCSP) Cabinet. The Executive Office of Health and Human Services (EOHHS) and the Health Care System Planning Cabinet are proud to have taken this first step toward meeting the planning process' goal to develop a high-quality, affordable, equitable, accessible, culturally, and linguistically appropriate health care system capable of meeting the varied needs of all Rhode Islanders. This goal is central to EOHHS's mission and guides our work every day – as it guides the work of each of the Cabinet members' state agencies participating in this process.

We are also pleased to have created the EOHHS Independent Advisory Council, to ensure active participation from a vibrant and diverse group of subject matter experts and community partners.

The two most important components of this project are its **collaborative public/private structure** supported by the Advisory Council and its **long-term nature**, as defined in your Executive Order.

You will see throughout the report that we are addressing **five key health care sectors**: Primary Care (including Oral Health), Behavioral Health, Hospitals, Long-Term Care and Healthy Aging, and Health Related Social Needs. For the work in each sector, we engaged community partners from both the Advisory Council and beyond in Workgroups that met publicly for months. Workgroups deliberated on the major challenges and gaps within each sector and have presented sets of recommendations for action for each sector that are all presented in this report.

As the Cabinet and the Workgroups carried out their activities, we all understood that while we are committed to taking whatever immediate action steps we can to address urgent problems within our health care system, the key to this work is its long-term nature. The Cabinet and the state staff supporting it see the tremendous value in long-term planning: setting up formal, ongoing planning structures within state government that can monitor the health of our system in real time, and ensuring new data collection and analysis capacities that will give us the information we need to strengthen our health system.

The long-term structure of the planning also helps us understand that this process will span budget years – continuing in years with budget challenges, such as those we expect this coming year and in years where the state's budgets can be more expansive. In other words, we know that the state is not likely to be able to fund the majority of the recommendations in this report in this coming year. However, in budget years like the one we expect for FY26, we can work together on those activities that do not require new dollars and can look to create structures that can maximize federal dollars or can promote economies of scale.

Throughout our planning, we have been guided by **three additional principles**:

First, **we are not starting this planning process from scratch**. As we carry out this work, we are incorporating recent planning activities that have been done in both the private and public sectors. We are committed to avoiding duplication – and making sure that we are drawing on the good work that already exists throughout the state.

Second, we recognize the importance of the request by the EOHHS Independent Advisory Council to **avoid "analysis paralysis."** We have been aiming to strike a balance between the need for further assessment and

the need for action - to move on ideas that have already been studied in depth and on which there is agreement.

Third, we have embraced the critical task of **breaking down the silos between our health care sectors**. Throughout this report, we identify the interdependencies between the sectors and focus on how we can strengthen the system by ensuring that the people who use it are not stuck between the silos.

We have designed this document to be both a **report of the planning progress so far, and a preliminary documentation of the recommendations for system changes** that the Cabinet has received from the engagement we had with our community partners. The work on each sector is represented in separate chapters, each of which ends with recommendations for action. These include potential legislative proposals, regulatory changes, or program and service expansions – as well as other possible strategic ideas that the state and private sector can incorporate into their planning efforts and operations.

As an example, we know that after the COVID-19 public health emergency, some of our hospitals, nursing homes, and other health care institutions have been experiencing financial challenges. If the State only hears about those challenges when they are dire, then the things we can do to help are limited to crisis management. With regular access to more detailed financial information – and with the staffing allocated by the General Assembly – we will now have a structure and staff who can analyze this information. This means that the State can provide help to our health care institutions more quickly and more effectively. The interventions can be more structural and creative – and can hopefully stave off crises. We are looking to other states with innovative planning structures for ideas and inspiration and determining the short-term structural changes that will have the most impact.

Therefore, we are carrying out this planning effort – and present this initial report to you – as the beginning of a **comprehensive roadmap for strengthening our health system** over the long-term, just as we **also identify the issues in our health care system that need immediate attention**. We are looking to the future even as we prepare to fill pressing gaps in service capacity, address acute challenges, and ensure financial sustainability.

A stronger, more innovative planning structure will allow us to identify those needs, incorporate them into our forecasting, and act on them as quickly as we can.

Governor McKee, thank you once again for support EOHHS and the Health Care System Planning Cabinet in this critical endeavor. We look forward to your thoughts and reactions to this report and to continuing to work with you in support of the health of all Rhode Islanders.

Sincerely,

Richard Charest Secretary	Ana Novais Assistant Secretary

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We appreciate the leadership, vision, and guidance provided by the state agency leadership who comprise the Health Care System Planning Cabinet:

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Matthew Weldon
Director of the Department of Labor and Training

Shannon Gilkey
Postsecondary Education Commissioner

Lindsay Lang
Director of HealthSource RI

We are thankful to the entire EOHHS Independent Advisory Council, comprised of community partners, advocates, and subject matter experts who invested their time participating in this health system redesign initiative. We are especially appreciative of the Community Co-Facilitators who co-led the five sector workgroups:

Behavioral Health Sandra Victorino, Commission for Health Advocacy and Equity - *along with State Co-Facilitators: Director Ashley Deckert and Director Rich Leclerc*

Health Related Social Needs David Cicilline, Rhode Island Foundation - *along with State Co-Facilitators: Director Kimberly Brito and Director Lindsay Lang*

Hospitals John Fernandez, Brown University Health - *along with State Co-Facilitators: Secretary Rick Charest, Assistant Secretary Ana Novais, Commissioner Cory King, and Director Matt Weldon*

Long-Term Care and Healthy Aging Joan Kwiatkowski, PACE Organization of Rhode Island - *along with State Co-Facilitators Director Kristin Sousa, Director Maria Cimini, and Director Kasim Yarn*

Primary Care – Elena Nicolella, Rhode Island Health Center Association - *along with State Co-Facilitators: Director Jerome Larkin & Commissioner Cory King*

Oral Health Sub-Committee of the Primary Health Workgroup Melissa Campbell, Rhode Island Health Center Association & Dr. Samuel Zwetchkenbaum, Rhode Island State Dental Director

EOHHS also expresses gratitude to the several dozen members of the **Health Planning State Interagency Team**, for their hard work and dedication to supporting these and all State efforts to develop a health care system that truly and equitably meets the unique needs of all Rhode Islanders, now and into the future.

Chapter 1: Introduction

Rhode Island Health Care System Planning Foundational Report 2024

In February 2024, Governor Dan McKee signed Executive Order 24-04 establishing the State Health Care System Planning (HCSP) Cabinet, reinforcing his commitment to enhancing the quality, affordability, and accessibility of Rhode Island's health care system and to health equity within the system. This health care planning initiative reflects his deep appreciation of the vital role that a comprehensive health care system plays in ensuring the well-being of all Rhode Islanders and strengthening the state's economy.

There is a great deal of alignment between the goals and action steps laid out in Governor McKee's RI 2030 Plan: Charting a Course for the Future of the Ocean State and the Health Care System Planning (HCSP) Initiative's recommendations, as laid out by the health sector workgroups:

- One of the main focal areas of the Rhode Island 2030 Plan is on strengthening the capacity of State's health care workforce through workforce development and training programs. Similarly, each of the HCSP Initiative's health sector workgroups identified workforce issues as a leading challenge hindering health care system strength.
- The RI 2030 Plan also focuses on building capacity of the behavioral health and long-term care service networks along a full continuum of available services, from more restrictive, including residential services, to least restrictive, in home and community-based settings.
- Finally, the RI 2030 Plan emphasizes strengthening the State's health related social needs service systems to ensure that Rhode Islanders' underlying social needs are met, such as safe, affordable housing, transportation, and access to nutritious food. Similarly, one of the common themes of the HCSP Initiatives recommendations, is the importance of addressing Rhode Islanders' health related social needs.

The connection between quality health outcomes and economic security is also promoted by the World Health Organization (WHO, 2024). The World Health Organization's Department of Health Financing and Economics is dedicated to supporting the development of health systems around the world, largely by promoting health system planning and strategic action (WHO, 2024). The Department has created numerous publications detailing how strong health systems are central to an effective, well-functioning economy, as well as important contributors to better health outcomes and human wellbeing. They are also central to the effective functioning of the economy.

- By improving health, health systems contribute to increasing labor supply and productivity.
- In addition, when viewed as economic sectors, health systems are a major source of employment and produce goods and services that directly contribute to economic growth.
- Well-functioning health systems also have several additional positive externalities, notably on health security and economic security.

Better health outcomes also lead to economic security in these ways:

- Reduced absenteeism from work
- Increased productivity, leading to higher earning potential and job security
- Lower health care costs for companies and individuals

- Reducing financial burdens with protections from medical debt and reductions of out-of-pocket health care costs
- Increased savings for Rhode Island families

And health is connected to education attainment through the following:

- Improved attendance for students and teachers – for more consistent learning
- Improved cognitive functioning, through reliable medical and mental health care helps children with better education achievement
- Fewer health related challenges to learning, including supporting vision care or addressing mental health issues
- Healthier parents can be more involved in their children's education

Health Care System Planning Cabinet Membership and Charge

The HCSP Cabinet is composed of the leadership of the state's key agencies responsible for health and human services and aligned issues, such as workforce and education. Here are the Cabinet's members:

- Richard Charest, Secretary of the Executive Office of Health and Human Services
- Ana Novais, Assistant Secretary of Executive Office of Health and Human Services
- Kristin Sousa, Medicaid Program Director
- Jerome Larkin, MD, Director of the Rhode Island Department of Health
- Kimberly Merolla-Brito, Director of the Department of Human Services
- Richard, Leclerc, Director of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
- Ashley Deckert, Director of the Department of Children, Youth and Families
- Maria Cimini, Director of the Office of Healthy Aging
- Kasim Yarn, Director of the Office of Veterans Services
- Matthew Weldon, Director of the Department of Labor and Training
- Cory King, Health Insurance Commissioner
- Shannon Gilkey, Postsecondary Education Commissioner
- Lindsay Lang, Director of HealthSource RI

The Cabinet members are supported by the staff that work in these agencies who are engaged through a broadly representative Interagency Workgroup.

A fundamental aspect of the Governor's Executive Order was the development of an EOHHS Independent Advisory Council (Advisory Council). The Advisory Council, established at the outset of the initiative, is made up of health care leaders, community agency representatives, and other subject matter experts across the private sector. The Advisory Council met after each of the HCSP Cabinet's meetings to deliberate on the Cabinet's proceedings and provide important input on the planning process. The Advisory Council will continue to play a critical role in ensuring that the state's planning efforts are guided by a diverse range of voices who are actively involved in shaping the health care system. The input from the Advisory Council, along with other critical insights from community residents—especially those directly impacted by gaps in care, disparities in outcomes, and barriers to access—will help ensure that the state's health care planning

efforts are forward thinking and rigorous but also attuned to the realities of the health care and social service landscapes in which they are working. Please see Chapter 13 for additional information about how this process will engage community residents.

The primary charge of the HCSP Cabinet is to evaluate and recommend strategies that prioritize improving quality, affordability, and equity in health care across Rhode Island. Per the Executive Order, the Cabinet's focus is on enhancing the state's oversight, accountability, and planning infrastructure, as well as on developing specific, data-driven recommendations aimed at strengthening the state's health care system, across the care continuum.

The Cabinet's mandate is broad and inclusive and extends to:

- Ensuring timely access to high-quality, linguistically, and culturally responsive care,
- Fostering the integration of services across the continuum,
- Promoting care coordination and seamless care transition,
- Assessing financial and operational stability and effectiveness throughout the health care sectors: hospitals, nursing homes, health centers, and potentially other health and human service providers
- Strengthening education and preventive services activities, and
- Aligning the health care system with current and future needs.

This report is the first deliverable required of the Health Care System Planning Cabinet. It describes the long-term planning process as envisioned in the Executive Order; provides baseline data on the Rhode Island health care system, including a summary of community need and leading population health indicators; lays out initial information on the sectors and cross-cutting issues at the heart of the proposed Health Care System Plan; and provides recommendations created by the vibrant public/private process that EOHHS began in March of 2024.

This report is not a final Health Care System Plan. It is the foundation for the planning process – a roadmap that will support this critical effort to improve Rhode Island's health care system for all the state's residents.

Vision and Structure of the Rhode Island Health Care System Planning Process

Over the last decade, there has been a growing recognition among policymakers, public officials, and health care providers about the importance of creating a comprehensive system-wide plan for the State of Rhode Island that is informed by a statewide landscape analysis and a body of national experience. This Rhode Island Health Care System plan will serve as a roadmap to guide public and private investment and promote collaborative efforts within and across health sectors aimed at enhancing the health care system. As outlined in the Executive Order, for an overarching, unified Rhode Island plan to be effective, it must be:

- **Comprehensive and holistic**, supporting and guiding activities across a broad spectrum of health, social service, and public health providers so as to ensure whole-person care.
- **Data-driven**, using quantitative and qualitative data from primary and secondary sources to assess system strength, monitor and evaluate impact, encourage transparency, and inform decision-making.

- **Collaborative and inclusive**, engaging and empowering a wide array of stakeholders—including policymakers, public agencies, service providers, and the community at large—in a transparent, inclusive, and intentional manner.
- **Action-oriented**, providing measurable and justifiable directions with a clear roadmap for short-term, medium-term, and long-term strategic and tactical actions.
- **Evidence-informed**, adopting strategies and projects that are substantiated by clinical or service provider experience and tailored to meet the specific needs and interests of the target population.

At the outset, the Rhode Island Health Care System Planning effort will provide a framework that clarifies the interdependent components of a comprehensive health care system. **Ultimately, the Health Care System Plan must also provide a vision regarding the broad strategic ideas that will drive health care system transformation, including specific, actionable recommendations that will leverage the State's strengths and existing assets, fill service and workforce related gaps, and address challenges and community needs.**

Critical to the success of this effort is the integration of existing assessments, reports, and other on-going planning efforts. The Executive Order is clear that this effort is not "starting from scratch." Instead, the Cabinet's charge is to build on the extensive public and private sector efforts that are occurring across the system, augment them as appropriate with community input, and serve as the coordinating body of all health care system planning. Information from the existing assessments, reports, and planning efforts have been incorporated into the sector-specific state landscape analyses provided throughout the report and are listed in Appendix C.

Rhode Island Health Care System Planning Structure

The health care system planning structure reflected in this report was developed and agreed upon by the Cabinet and includes two primary features. First, the report identifies five essential **health system sectors** that broadly speaking provide the health related services that are essential to overall health and well-being:

1) Primary care
2) Behavioral health
3) Hospitals
4) Long-term care and healthy aging, and
5) Health related social needs

It is important to note that there are service components within these sectors that overlap (e.g., dental care, medical specialty care, or laboratory and other ancillary services) and that there are interdependencies between the sectors that together create a continuum of care. For this initial report, however, the Cabinet approved the following initial organizational structure for the initial assessment and planning process that is reflected in this report's organization, as well as the document's recommendations and action steps.

Each of the five health system sectors has a Chapter devoted to it in this report, which together provide important information about the national context and the strengths and challenges facing the State's health

system. The health sector chapters also identify the ways that the health sectors intersect. The Chapters end with recommendations and action steps for the sector.

Second, the proposed planning structure identifies a series of **six major cross-cutting structures, systems, or functions** that, as discussed above, support planning, oversight, and accountability and are critical to the performance of the health system. These cross-cutting structures are:

1) Data structures to support transparency and decision-making
2) Workforce transformation
3) Value-based payment models
4) Health information exchange
5) Equity
6) Quality

The first four cross-cutting areas have a Chapter in the report devoted to them, including recommendations and action steps. The cross-cutting area of Equity is woven in throughout the entire document – and the planning process will address quality in subsequent reports.

The Cabinet also recognizes that the health care system must think beyond the provision of treatment and specific services. A strong health care system also includes a breadth of programmatic or service activities aimed and education and awareness, preventive services, chronic disease management and behavior change, and end-of-life care. These concepts will continue to be embedded with the sectors and are equally supported by the cross-cutting structures and systems.

Finally, the Cabinet's health care system planning success is also tied to the application of a set of public health best practices described below: a health-in-all policies approach, addressing health equity, and the importance of community engagement and a public/private partnership.

Sustainability and Institutionalization of Planning: A Marathon, not a Sprint

The Executive Order that created the HCSP Cabinet crafted this endeavor as a robust, long-term effort that will be updated on a regular basis, and guide action over time. A continuous and structured planning process, supported by the HCSP Cabinet and a dedicated office within EOHHS will help to ensure that health care policies remain responsive to current conditions and future uncertainties.

Institutionalizing the health care planning initiative enables the consistent application of data-driven and evidence-based strategies, which are critical for effective implementation and performance improvement. Long-term planning that is deeply embedded in the system helps avoid the piecemeal and reactive approaches that often characterize less structured and more siloed efforts. By making health planning a permanent fixture of the state's strategy, Rhode Island can better align resources with needs, ensuring that investments in health care deliver sustainable improvements. This involves not only the allocation of resources but also the development of structures, data systems, legislative actions, and policies that support the health care workforce, enhance health care facilities, guide payment reform, and leverage technology to improve service delivery and patient outcomes.

Finally, the sustainability of health care planning in Rhode Island is essential for fostering equity and accessibility in health services across the state. A long-term view allows for the implementation of comprehensive strategies that address social determinants of health and reduce disparities in health outcomes, including income, housing, education, etc. Institutional support for continuous improvement and stakeholder engagement ensures that the health system adapts to serve all segments of the population effectively. It also builds public trust and accountability in health services, creating a more inclusive health care environment that supports the well-being of every Rhode Islander. By embedding these processes within the state's governance structures, Rhode Island can ensure that its health care system remains robust, resilient, and reflective of its commitment to the health of all its residents.

Best Practices for Health Care System Strength

The approach and process that was applied to conduct the assessment and planning process reflected in this report is anchored by a series of public health best practices described below that will serve as guideposts for the initiative. Collectively, these best practices ensure a common, consistent approach to the work and help articulate the Cabinet’s vision, goals, and objectives.

1) Health in All Policies

This framework illustrates the importance of addressing living conditions such as housing, education, and employment, which are directly tied to health outcomes. It emphasizes the role of policy in shaping these conditions, showcasing the need for a 'Health in All Policies' approach.

This approach advocates for public health considerations to be integrated into all areas of policymaking, thereby ensuring that improving health outcomes is a central goal in all public initiatives and services. The framework then empowers local communities, municipal and state agencies, health care service providers, and community-based organizations to participate actively in shaping their health outcomes. This engagement is critical for tailoring health initiatives, and the health system itself, to meet local needs effectively and for ensuring that health improvements are community-driven and sustainable.

Figure 1. 1: Health in All Policies

2) Racial and Ethnic Disparities and the Need for Equity in Health and Health Care

The desire to promote health equity and address underlying inequities and health related disparities that impact many segments of the State's population is foundational to this planning process and is found throughout this report.

A landmark report issued by the National Academies of Science, Engineering, and Medicine in 2003 (called *Unequal Treatment*) and updated in 2023 (called *Unequal Treatment Revisited*) examined how racial and ethnic inequities in health and health care impact individual well-being, contribute to millions of premature deaths, and cost the United States hundreds of billions of dollars annually. The 2003 report stated that "Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled. The sources of these disparities are complex, are rooted in in historic and contemporary inequities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, health care professionals, and patients. The report declared that "A comprehensive, multi-level strategy is needed to eliminate these disparities. Broad sectors – including health care providers, their patients, payors, health plan purchases, and society at large – should be made aware of the health care gap between racial and ethnic groups in the United States."

The 2024 update stemmed from a series of public workshops held by a 17-member committee appointed by the National Academies. The updated report reflects on lessons learned over the 20 years between publications, including that it is important "not merely to focus on changing individual behavior but rather to restructure the systems that are producing the inequities in the first place." The workshops led to a set of

recommendations that take in racial and ethnic inequities – as well as others (such as gender, gender identity, sexual orientation, age, disabilities, etc.) that the Cabinet can reflect on, to support Rhode Island's health planning efforts.

3) Community Engagement, Public-Private Partnerships

Finally, to ensure the Health Care System Planning Initiative is as inclusive and informed by those with relevant experience and expertise, the planning process will continue its commitment to ensuring that it collects feedback from a diverse, representative group across the health care continuum, including community residents, organizational representatives, service providers, and advocates – with a focus on those representing community that are often marginalized, underserved, and left out of these planning efforts. These efforts will continue to promote engagement that will ensure that those most directly involved or impacted by the plan have the opportunity to participate in its development.

The Health Care Cabinet and the State Interagency Team are eager to hear feedback from community members on this first Health Care System Planning Report. We encourage you to email us at OHHS.HealthPlanning@ohhs.ri.gov with questions and ideas.

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Chapter 2: Community Need and Health Status Assessment

Introduction

The **Community Health Need and Health Status Assessment** provides foundational insights into the leading health needs and challenges facing Rhode Island communities. As part of the State's broader Health Care System Planning Initiative, this chapter aims to highlight the critical areas the health care system must address to improve health outcomes, reduce disparities, and promote equity. By synthesizing key data and findings, the assessment serves as a critical tool for policymakers, providers, and stakeholders to understand the needs of Rhode Islanders and the health system's role in meeting those needs effectively.

The Assessment is organized into four main sections or domains:

1) Community Characteristics,
2) Health Related Social Needs,
3) Health System and Access Issues, and
4) Population Health Indicators.

Each section is divided into subsections that present key findings, explore associated risks, and discuss the implications for the health system. This structure allows for a clear and comprehensive analysis of the demographic, social, systemic, and health status factors shaping Rhode Island's health care landscape. Together, these sections create a detailed picture of the challenges and opportunities the state must consider as it works to build a resilient, responsive, and equitable health care system.

Domain 1: Community Characteristics

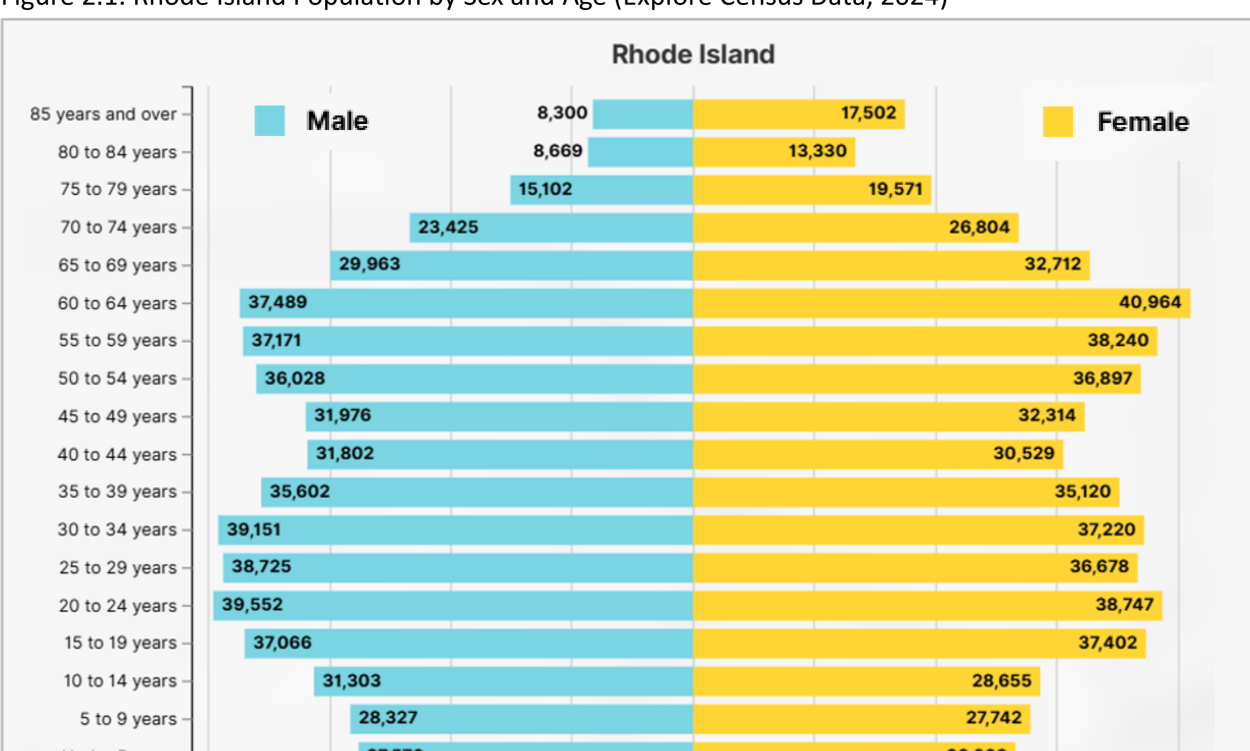
Demographic Overview

Rhode Island, the smallest state in the country, has an estimated population of 1.1 million residents (Explore Census Data, 2024). The state has experienced a modest population growth rate of around 0.2% annually over the past decade, indicating its relatively stable population size.

Rhode Island's population is experiencing demographic shifts, with a significant portion of residents aged 65 and older now comprising 19% of the population, while individuals under 18 account for 20%. The growing aging population of Rhode Island heightens risks associated with increased demand for health care services, housing, and social support systems, while the smaller youth demographic could challenge workforce sustainability and economic growth.

For children aged 0-12, access to early childhood education, childcare, and pediatric healthcare remain critical needs. Addressing these areas is essential to support the growth and well-being of younger populations alongside the 19% of the population who are 65 or older and who require infrastructure and community programs for older adults (Explore Census Data, 2024).

Figure 2.1: Rhode Island Population by Sex and Age (Explore Census Data, 2024)



With respect to race and ethnicity, Rhode Island 's population distribution across the entire state is similar to the nation as a whole. In 2024, 71% of the state's population identified as White, 17% as Hispanic or Latino, 8% as Black or African American, and 4% as Asian. Smaller demographic groups, such as Native American and Pacific Islander communities, made up less than 1% of the total population (Health in Rhode Island, 2024). However, in Providence, the state's population center, the population is much more diverse. In 2024,34% of Providence's population identified as White, Non-Hispanic or Latino, approximately 40% identified as Hispanic/Latino, 13% as Black/African American, and 6% as Asian.

Over the past two decades, Rhode Island has experienced fluctuating growth rates. Between 2000 and 2010, the state's overall population growth was relatively stagnant. However, the Hispanic/Latino population expanded significantly, driven by comparatively higher birth rates and migration relative to other groups. Over the past decade, this group grew by approximately 20%, contributing substantially to statewide population stability and growth. From 2015 to 2024, the state's foreign-born population increased by about 8%, bolstering local workforce needs and enhancing cultural diversity (Explore Census Data, 2024). Migration into Rhode Island included a notable influx of immigrants from Central and South American countries, as well as smaller groups from Southeast Asia and Africa.

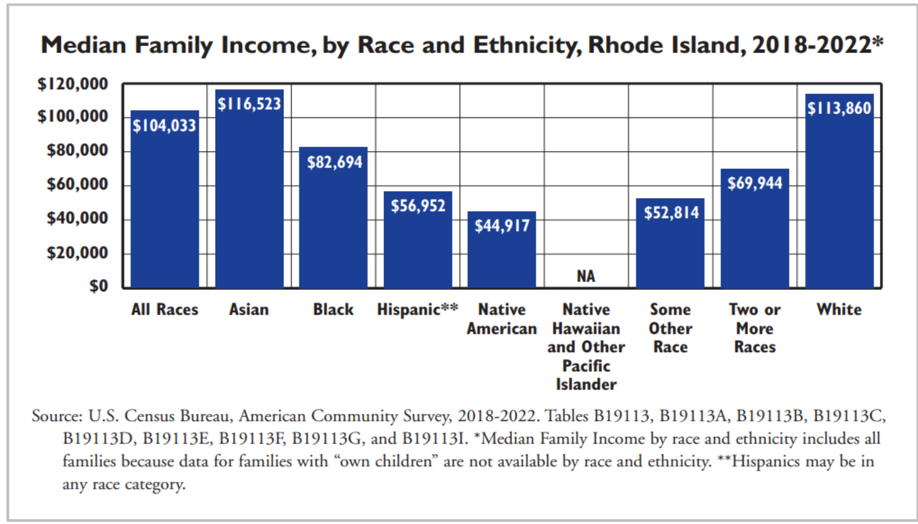
Socioeconomic Status

Rhode Island's labor force remains relatively stable, with approximately 591,300 individuals in the civilian labor force as of mid-2024. The state's unemployment rate stands at 4.6% as of September 2024, reflecting modest fluctuations over recent months (U.S. Bureau of Labor Statistics, 2024). Despite these figures, certain communities—particularly racial minorities and residents in core urban areas—continue to experience higher rates of unemployment and poverty, signaling systemic inequities in economic opportunity. For example, in 2024, while Rhode Island's employment rate overall was 4.6%, the unemployment rate for Blacks/African Americans was 6.2%, 35% higher than the overall rate. For Hispanics/Latinos, the unemployment rate was 5.3%, 15% higher than the state rate (U.S. Bureau of Labor Statistics, 2024). The disparities in unemployment and poverty among marginalized populations contribute to economic instability and exacerbate social inequities. These challenges hinder broader workforce participation and limit access to upward mobility for impacted groups, posing risks to long-term economic growth and social cohesion in Rhode Island.

The per capita income in Rhode Island stands at $46,525, slightly above the national average of $41,261. The median household income is $84,972, reflecting a higher income level than the U.S. median of $77,719. In Providence, the largest city in Rhode Island, income inequality is significant, as reflected by the Gini coefficient of 0.4893. The Gini coefficient is a measure of income distribution on a scale from 0 to 1, where 0 represents perfect equality and 1 represents maximum inequality. In Providence, this value indicates a moderate level of income disparity. For example, the top 20% of households earn an average of $216,907 annually—26 times more than the lowest 20%, who earn just $8,435 (Neilsburg, 2024).

In Rhode Island, income inequality is particularly evident when comparing median family incomes by race. White and Asian families tend to have much higher median incomes, at approximately $104,000 and $116,000, respectively, while Black and Hispanic families earn significantly less, with median incomes of $82,694 and $56,952. The gap between these groups underscores the ongoing economic disparities that affect families of color, compounded by historical and systemic factors such as unequal access to education and employment opportunities (Rhode Island KIDS COUNT Factbook, 2024).

Figure 2.2: Rhode Island Median Family Income, by Race and Ethnicity, 2018-2022 (2024 Rhode Island KIDS COUNT Factbook)



Educational attainment remains a strong predictor of income levels. In Rhode Island, individuals with higher levels of education earn considerably more, with bachelor's degree holders earning almost twice as much as those without a high school diploma. Once again, there is a notable educational attainment gap across racial groups, with Hispanic adults being more likely to not have a high school diploma compared to their white counterparts (Rhode Island KIDS COUNT Factbook, 2024).

Figure 2.3 Rhode Island Educational Attainment by Race (World Population Review, 2024)

Race	Total	High School	Bachelors
White	577,924	535,326	232,022
Hispanic	102,705	75,397	16,486
2+ Races	49,094	40,793	11,721
Other Race	46,064	30,372	6,294
Black	41,986	36,090	10,408
Asian	25,322	22,382	13,777
Native American	2,480	1,807	412
Pacific Islander	503	461	81

The poverty rate in Rhode Island is 10.8%, slightly lower than the national average of 12.5%. Around 114,400 people in the state live below the poverty line (Census Reporter, 2024). However, when considering a broader measure of economic insecurity, approximately 25% of Rhode Island residents live at or below 200% of the federal poverty level (FPL). This includes many working families who struggle to meet basic needs despite earning above the poverty threshold. Additionally, a significant portion of the population, particularly households earning between 200-400% of the FPL, face challenges related to housing affordability, health care costs, and childcare expenses. These groups are often ineligible for public assistance programs but remain economically vulnerable (ObamaCare Facts, 2024).

Geographic Distribution

Rhode Island’s population density is among the highest in the U.S., with significant clustering in urban areas such as Providence, Warwick, and Cranston. The state's population density stands at around 1,066 people per square mile, which is high compared to many other states. This density is concentrated in urban centers like Providence, which has a population density of over 11,000 people per square mile, making it one of the most densely populated cities in New England (Explore Census Data, 2024). Rural regions in Washington County and other parts of the state face more pronounced challenges related to health care access, transportation, and availability of services. The challenges highlighted in rural regions are due to issues like limited health care access, fewer transportation options, and reduced availability of services compared to urban centers like Providence. This disparity stems from the lower population density in rural regions, which makes it less economically viable to establish and maintain extensive health care facilities, public transit systems, and community services.

Income disparities also extend across different regions within Rhode Island. Providence, the state’s capital and largest city with 178,335 residents, exhibits significant income inequality, driven by factors like high housing costs and a concentration of low-wage service jobs. Neighboring cities, including Pawtucket, Central Falls, and Woonsocket, also face pronounced economic challenges. For instance, Pawtucket has a Gini coefficient of 0.4681, indicating moderate income inequality, with the top 20% earning 18 times more than the lowest 20%. Similarly, Woonsocket struggles with income insecurity, as households led by older adults have a median income of $34,996, significantly below the state median of $84,727. Central Falls, with a predominantly working-class population, confronts issues of housing instability and economic marginalization.

In contrast, suburban and rural areas of Rhode Island experience higher incomes and better access to resources, highlighting the stark rural-urban divide in economic opportunities and living conditions.

The state's urban areas, particularly Providence, experience higher income inequality compared to more suburban or rural areas. The income distribution in cities such as Providence is shaped by factors such as higher housing costs and a concentration of low-wage service jobs. Conversely, wealthier suburban regions tend to benefit from higher rates of homeownership, better access to well-paying jobs, and accumulated generational wealth, contributing to the growing rural-urban divide (America’s Health Rankings, 2024).

Cultural Diversity

Rhode Island's cultural diversity is an important aspect of the state's identity, with significant contributions from various immigrant communities and a rich tapestry of languages spoken.

A significant portion of Rhode Island's residents speak languages other than English, with 22.4% of the population reporting non-English languages at home. Spanish is the most common of these, spoken by approximately 12.7% of residents (Explore Census Data, 2024). Other significant languages include Portuguese (spoken by 6.3%) and Italian (4.7%), reflecting the state's strong historical ties to Portuguese-speaking communities and Italian immigrants (Explore Census Data, 2024). Linguistic diversity highlights the need for language access services in education, health care and community outreach programs to ensure social equity for all residents.

Rhode Island is home to a notable immigrant population, with nearly 15% of residents born outside the United States. The immigrant population of Rhode Island is most commonly made up of people from the Dominican Republic, Cape Verde, Brazil, and Guatemala.

The cultural diversity of Rhode Island presents both opportunities and challenges for the health care landscape. The large immigrant population, particularly people from Latin American and Portuguese-speaking countries, require culturally competent care and access to bilingual health care services. The availability of language-concordant care for individuals with limited English proficiency (LEP) is a challenge for Latinx patients in Rhode Island. Existing landscape analyses note that nearly 99% of the state's behavioral health providers primarily spoke English, while only 8% were proficient in Spanish (UnitedHealthcare Community Plan, 2024). When language interpretation is assessed, it is clear that bilingual clinicians or professional, in-person, interpreters are preferred and reduce errors (Escobedo et. al, 2023). As of 2024, Rhode Island has strategically invested in community initiatives to address health challenges faced by the Hispanic population, who encounter obstacles such as limited access to culturally competent care and linguistic barriers. These efforts enhance health literacy, economic stability, and culturally tailored care, fostering better health outcomes for Rhode Island's Hispanic community.

Community Assets and Resources

Rhode Island has a robust network of clinical and non-clinical service providers, including organizations serving children and families, across the full spectrum of Health Related services that are committed to addressing community need and that help to ensure that Rhode Islanders can live healthy, thriving, fulfilling lives. A core element of this Foundational Report is to describe this spectrum of services and identify where there might be gaps in the state's health care system.

Notably, Rhode Island has emerged as a national leader in public health and community-centered initiatives focused "whole-person" care due to its innovative, collaborative, and data-driven approaches. (Robert Wood Johnson Foundation, Systems for Action Research Program, 2024) Programs like Health Equity Zones (HEZ), Prevention Coalitions, and the Governor's Overdose Prevention and Intervention Task Force (Task Force) are significant state assets that address complex public health challenges with targeted strategies. The Health Equity Zones (HEZ) initiative is a place-based approach addressing the unique needs of specific populations by bringing together community leaders, organizations, and residents to create a comprehensive, community-wide strategy for health improvement. By addressing key social determinants of health, such as housing, education, and transportation, HEZs foster long-term health equity and reduces disparities. (National Academy of Medicine, Building Health Equity Zones, 2024) Its measurable success in reducing health inequities has earned national recognition, serving as a model for similar initiatives in other states. The Governor's Overdose Prevention and Intervention Task Force made significant strides in combating the opioid crisis using strategies like naloxone distribution and training, ensuring individuals seeking help can access treatment options without delays, targeted harm reduction strategies in high-risk communities, and others. Please see Chapter 8 for a more detailed review of Rhode Island's innovative approaches to meeting social needs and their consideration in this health care planning process.

Rhode Island's social service infrastructure supports individuals and families by addressing food security, housing stability, and mental health. In 2023, the Department of Human Services reported that nearly

120,000 residents benefitted from SNAP assistance, reflecting the state's commitment to combating food insecurity (Feeding America, 2023). Housing initiatives, such as Rhode Island Housing's "Keep Families Safe" program, secured affordable housing for more than 5,000 families last year (RI Housing, 2023). Social services have extended mental health resources to include crisis hotlines, CCBHCs, and other community-based counseling services, meeting the rising demand spurred by post-pandemic challenges. Partnerships with local nonprofits like Crossroads Rhode Island have been instrumental in supporting unhoused populations and individuals transitioning out of shelters.

Domain 2: Health Related Social Needs

Health related social needs (HRSNs), such as housing instability, food insecurity, challenges accessing transportation, and reduced access to quality education, play a critical role in shaping health outcomes. These factors influence an individual's ability to access care, adhere to treatment plans, and maintain overall wellbeing. Addressing these needs goes beyond clinical care, as data consistently show that unmet social needs lead to poorer health outcomes, higher health care utilization, and increased costs. Understanding and integrating solutions for these challenges into health care systems by reviewing inequities and gaps through data is essential for taking strategic action. The following reviews key indicators of Health Related social needs in Rhode Island.

Housing Stability

Significant research exists on housing, including affordability, quality, safety, and stability, and social determinants of health given the connection between housing and health outcomes and health care costs. (Health Affairs) Research shows that housing costs are a significant driver of insecurity around housing. A cost burden exists when more than 30% of a family's monthly income is spent on housing. In 2022, Rhode Island saw an improvement in those who are housing cost burdened but Rhode Island remains above the national average for this indicator (National Low Income Housing Coalition, 2024) and ranks poorly when compared to other states in the nation, with 32.9% feeling burdened by housing costs (Health in Rhode Island, 2022). National studies indicate that the share of cost-burdened renter households was significantly higher among households of color compared to white households (Joint Center for Housing Studies, 2019). Similar data are needed at the local level to better understand disparities in Rhode Island.

Figure 2.4: Renter Cost Burden

Renter Cost Burden | State of Rhode Island (2023)

Burrillville
North Smithfield
Woonsocket
Cumberland
Lincoln
Glocester
Smithfield
Central Falls
Pawtucket
North Providence
Johnston
Providence
East Providence
Foster
Scituate
Cranston
Barrington
Warren
Warwick
Coventry
West Warwick
Bristol
West Greenwich
East Greenwich
Tiverton
Exeter
North Kingstown
Portsmouth
Jamestown
Middletown
Little Compton
Richmond
Hopkinton
Newport
South Kingstown
Charlestown
Narragansett
Westerly
New Shoreham

11/23/2024, 10:49:07 PM

Renter Cost Burden, Rhode Island | Source: U.S. CENSUS American Community Survey (ACS) 2023

100
0
No Value

1:400,000

0 3.5 7 14mi
0 5 10 20km

University of Rhode Island, Esri, TomTom, Garmin, SafeGraph, FAO, METI/NASA, USGS, EPA, NPS, USFWS

Health Equity Institute | RI Department of Health GIS (Mapping)

In 2023, a worker in Rhode Island needed to earn $40.51 per hour, or $84,270 annually, to afford the average rent without being cost-burdened (KIDS COUNT, 2024). This required hourly wage was more than

three times the state's minimum wage of $13.00 per hour. Rhode Island ranked as the 15th most expensive state in the U.S. for renting a two-bedroom home. For the median renter in Rhode Island, only one city or town—Burrillville—had affordable rental options. Additionally, a household earning the state's median income of $74,489 could not afford to buy a home in any of Rhode Island's cities or towns, according to HousingWorks RI. While federally-funded Section 8 Housing Choice Vouchers can assist, Rhode Island's housing stock faces significant challenges, especially for lower-income residents. Many properties in the state's aging housing inventory require repairs or modernization. Additionally, a shortage of affordable housing has driven up the cost of renting and owning homes, making stable housing increasingly out of reach for low-income families. State law sets a goal for at least 10% of each community's housing stock to qualify as Low- and Moderate-Income Housing (LMIH). However, only five of Rhode Island's 39 cities and towns currently meet this goal. From 2018 to 2022, Rhode Island more than tripled its per capita investment in affordable housing. Despite these efforts, rents in the state increased by 10% from 2019 to 2022, even after adjusting for inflation (KIDS COUNT, 2024). As housing costs continue to rise, many households are spending a disproportionate share of their income on housing, leaving less money available for essentials like food, health care, and transportation.

The lack of affordable housing also contributes to increased rates of homelessness and housing instability, with more people forced to live in overcrowded or substandard conditions. Substantial disparities exist in homelessness. On a single night in 2021, 10 out of 10,000 white individuals (of any ethnicity) were experiencing homelessness, compared to 80 out of 10,000 Black individuals, Native Hawaiian or other Pacific Islander individuals, and 55 American Indian or Alaska Native individuals. Similarly, 11 out of 10,000 non-Hispanic/Latino individuals were experiencing homelessness on the night of the count, compared to 16 out of 10,000 Hispanic or Latino individuals. In addition, 1,461 of the state's 138,566 enrolled students (10.5 per 1,000) were identified as homeless by school personnel during the 2021-2022 school year, with this rate being higher in the four core cities of Central Falls, Pawtucket, Providence, and Woonsocket (16.8 per 1,000). (KIDS COUNT, 2024) (RHODE ISLAND EOHHS, 2024)

For those on fixed incomes or working low-wage jobs, the high cost of housing limits their ability to save or improve their financial situation. Efforts are being made to address this crisis through housing assistance programs, affordable housing initiatives, and state-level policies, but the gap between demand and available affordable units remains a pressing issue impacting many Rhode Islanders.

Food Security

Access to affordable and healthy food is a significant challenge for many lower-income residents in Rhode Island, contributing to food insecurity and poor health outcomes. Food insecure households, 8.6% of Rhode Island households, do not have enough food to meet the needs of all members due to insufficient money or other resources. (USDA, 2020) The state's federally funded food assistance programs, including SNAP (Supplemental Nutrition Assistance Program) and WIC (Women, Infants, and Children) are accessible to those in need with 15% of Rhode Island households receiving food stamps/SNAP. This rate is 29% in Providence and 24% in the Pawtucket region (with other regions equal to or below the statewide rate) (EOHHS, 2024). These programs, however, do not always cover the full cost of nutritious food, leaving many families struggling to afford a healthy diet. Additionally, lower-income communities often face a lack of grocery stores or farmers markets, especially in urban areas, leading to "food deserts" where residents

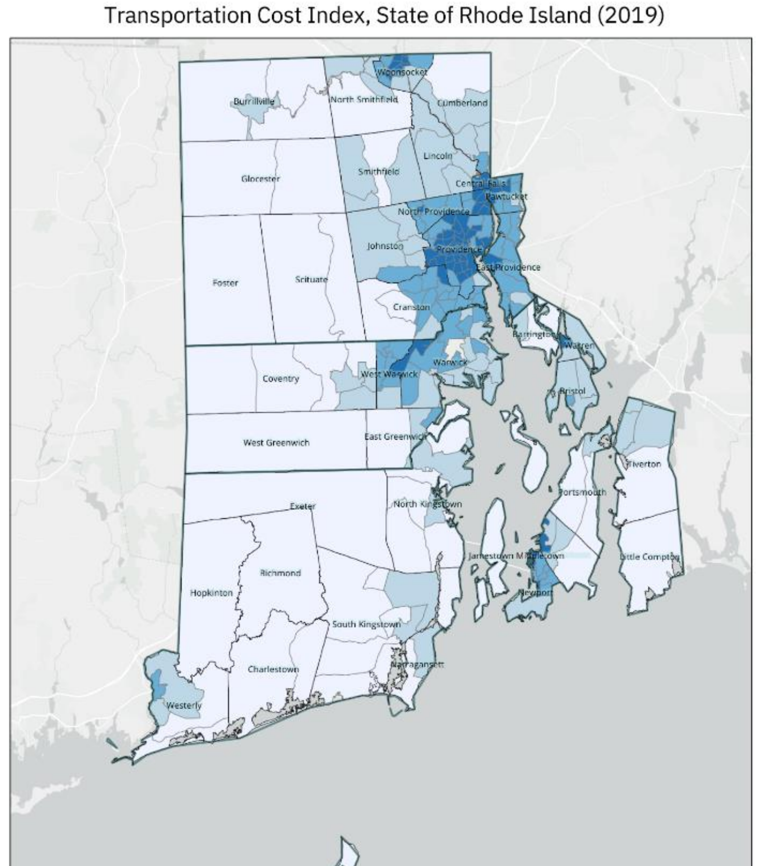
have limited access to fresh fruits, vegetables, and other nutritious foods. Instead, many rely on convenience stores or fast-food options that are less healthy and often more expensive.

From 2016 to 2020, Rhode Island saw a large decrease in food insecurity, but since 2020 a slight increase has occurred (KIDS COUNT, 2024). However, Rhode Island continues to remain well below the national average and is a top performing state for food security. National data reveal that single parent households and Black households are more likely to be food insecure than other groups (USDA, 2023). Similar data are needed at the local level to better understand disparities. The lack of access to affordable, healthy food disproportionately affects low-income households, contributing to higher rates of diet-related health issues like obesity, diabetes, and heart disease. Without affordable options, families may be forced to choose cheaper, less nutritious foods, exacerbating long-term health disparities. Rhode Island has responded with initiatives like food pantries, community gardens, and mobile farmers markets, but the demand for these services often exceeds supply. Addressing food insecurity through improved access to healthy food is critical to enhancing the overall health and well-being of lower-income residents in the state.

Transportation Access

Access to affordable transportation in Rhode Island is a significant challenge for many low-income residents, directly impacting their ability to reach essential services like jobs, health care, and education. While housing costs are the single largest expense for most households, when combined with transportation costs, they account for approximately half of the average U.S. household budget (Bureau of Labor Statistics, 2022). In 2016 Rhode Island was the 11th ranked state for the affordability of transportation, though affordability and access are not synonymous, and more recent data are needed to track progress in this area (Health in RI, 2022). Public transportation in the state, primarily managed by the Rhode Island Public Transit Authority (RIPTA), offers bus services across urban and suburban areas.

Figure 2.5: Transportation Cost Index



For low-income individuals, the cost of transportation can also be a barrier. Owning and maintaining a car is expensive, especially with rising fuel prices, insurance costs, and repair expenses, which are often out of reach for many families. Those relying on public transit may still face challenges due to fares, particularly if they need to travel across multiple zones or frequently use the service. These transportation barriers can limit employment opportunities, as individuals may be unable to access jobs in areas with poor transit coverage or at times when buses are unavailable.

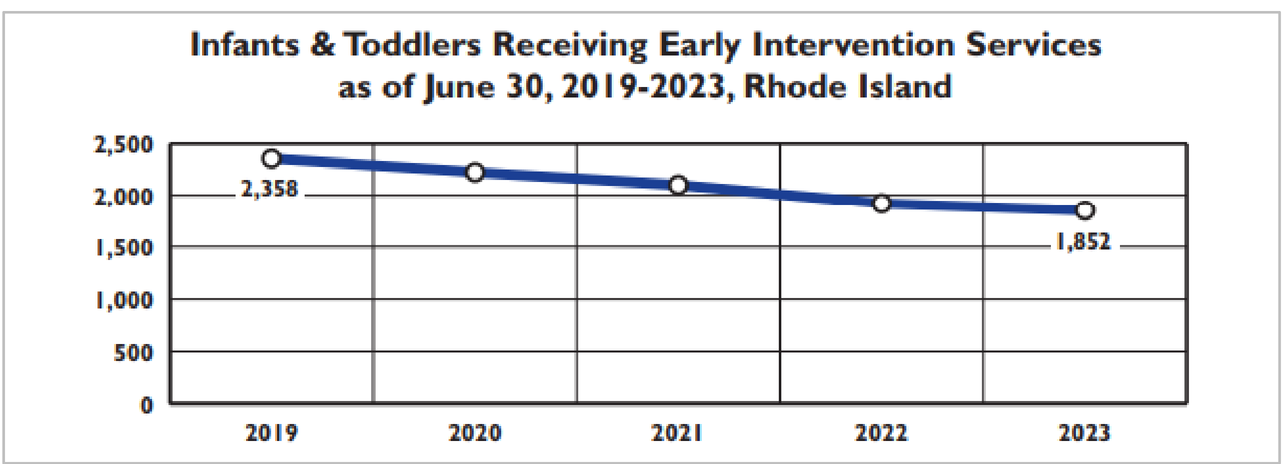
The lack of affordable and reliable transportation affects lower-income residents by restricting their mobility, making it harder to maintain steady employment, attend school, or access health care services. For many, the difficulty in getting to essential services creates a cycle of economic hardship, deepening the disparities they already face.

Education and Literacy

Early Intervention The earliest years are the most critical for brain development. Early Intervention services are available for certain young children with conditions like developmental delays and are crucial for fostering language, social-emotional, and motor skills, with the goal of mitigating intensive supports as they grow older. Access to quality early education is a critical factor in addressing health related social needs, shaping long-term health and developmental outcomes.

In 2023, 6% of Rhode Island's population under age three were enrolled in Early Intervention services. The majority of referrals came from primary health care providers (30%) and parents or guardians (27%). Among those referred, 67% were evaluated and subsequently enrolled in the program. Funding for Early Intervention services was provided through various sources: public insurance, such as RIte Care and Medicaid, covered 59% of enrolled children (1,090 children); private health insurance covered 40% (747 children); and federal IDEA Part C funding supported services for 1% of children who were uninsured (KIDS COUNT, 2024).

Figure 2.6: Infants & Toddlers Receiving Early Intervention Services, 2019-2023
(2024 Rhode Island KIDS COUNT Factbook)



Head Start Early Head Start is an intensive, comprehensive early childhood program serving low-income children birth to age three, pregnant women, and their families. Early Head Start programs serve families with the greatest needs, including families living in or near poverty and families receiving Supplemental Nutrition Assistance Program (SNAP) benefits by providing high-quality early education, nutrition and mental health services, health and developmental screenings and referrals, and fostering the development of healthy family relationships. As of 2023, 520 individuals in Rhode Island, including 505 infants and toddlers and 15 pregnant women, were enrolled in Early Head Start programs. Only an estimated 4% of infants and toddlers in low-income families in the state were enrolled. Staffing shortages posed a significant challenge, with 139 Early Head Start seats—21% of funded capacity—remaining unfilled due to vacancies. Meanwhile, 148 eligible children were on the waiting list for these programs. Early Head Start programs in Rhode Island also prioritized children with high needs, serving 66 infants and toddlers with developmental

delays or disabilities (13% of all enrolled children), 26 children in foster care, and 21 children experiencing homelessness (KIDS COUNT, 2024).

Other Early Learning As of 2024, a significant portion of Rhode Island's early learning programs had achieved high quality ratings, with 83% of licensed childcare centers, 89% of licensed family childcare homes, and 49% of public schools with preschool classrooms participating in the quality rating system. Among these, 26% of early learning centers, 2% of family childcare homes, and 32% of public schools met the benchmarks for a high-quality rating of four or five stars (KIDS COUNT, 2024).

Special Education Early and accurately targeted special education services help students with developmental delays and disabilities improve their academic outcomes and prevent grade retention. As of 2023, 16% of all Rhode Island public school K-12 students were receiving special education services. Students in traditional public school districts within the state's core cities were more likely to receive special education services (19%) compared to their peers in other traditional districts (16%), public charter schools (13%), or state-operated public schools (12%). Racial and ethnic representation included 51% white students, 30% Hispanic students, 10% Black students, and smaller percentages from other groups. A significant portion of these students came from low-income families (58%) or were Multilingual Learners (14%), highlighting the intersection of socioeconomic factors and the need for specialized educational support (KIDS COUNT, 2024).

High School Graduation Rates The Rhode Island four-year graduation rate for the Class of 2023 was 84%, up from 80% for the Class of 2013. The lowest graduation rates were among Multilingual Learners, students receiving special education services, students in foster care, students experiencing homelessness, low-income students, and Hispanic and Native American students (KIDS COUNT, 2024).

Figure 2.7: Rhode Island Four-Year High School Graduation and Dropout Rates by Student Subgroup, Class of 2023 (2024 Rhode Island KIDS COUNT Factbook)

Rhode Island Four-Year High School Graduation and Dropout Rates, by Student Subgroup, Class of 2023

	COHORT SIZE	DROPOUT RATE	% COMPLETED GED	% OF STUDENTS STILL IN SCHOOL	FOUR-YEAR GRADUATION RATE
Female Students	5,407	6%	1%	5%	87%
Male Students	5,642	10%	1%	8%	81%
Multilingual Learners	1,286	18%	<1%	12%	69%
Students Receiving Special Education Services	1,737	11%	2%	21%	66%
Students Not Receiving Special Education Services	9,324	7%	1%	4%	88%
Low-Income Students	5,913	12%	2%	10%	77%
Higher-Income Students	5,148	3%	1%	3%	93%
Students in Foster Care	111	25%	2%	22%	51%
Homeless Students	248	16%	3%	16%	65%
Native American Students	139	18%	1%	6%	74%
Asian Students	291	3%	0%	5%	92%
Black Students	1,007	8%	1%	9%	82%
Hispanic Students	3,172	11%	1%	10%	77%
White Students	6,000	6%	1%	4%	88%
ALL STUDENTS	*11,061*	*8%*	*1%*	*7%*	*84%*

Domain 3: Health Systems & Access

Health Care Infrastructure

The state of Rhode Island boasts a robust health care system, supported by a strong foundation of services across the continuum of care. While the system effectively meets the bulk of the population's needs, gaps exist, access to and engagement in care can be challenging, quality is variable, and, like health systems across the Nation, care can be fragmented and poorly coordinates at times. The Heath Care System Planning Initiative aims to strengthen the state's health care infrastructure by leveraging existing assets, addressing weaknesses, and fostering collaboration among stakeholders to improve accessibility, quality, equity, financial stability, and health outcomes. The following are brief descriptions of the types of health care facilities that provider services across the five health sectors identified through the HCSP process.

Primary Care Services (Including Oral Health) Rhode Island has a diverse mix of providers that provide primary care medical and oral health services, as well as some behavioral health services. Private solo and group primary care practices account for the bulk of the practice settings and remain central to care delivery, often serving as long-standing anchors in their communities. Hospital- and health-system-based practices enhance integration and care coordination, particularly for complex patient populations. Federally Qualified Health Centers (FQHCs) play an essential role in delivering accessible, high-quality care to underserved communities, embodying a commitment to equity.

Behavioral Health Services The State's behavioral health sector includes hundreds of service providers that provide care across a broad continuum of care that face tremendous challenges meeting the growing demand for mental health and substance use care of Rhode Islanders with mild to moderate, emerging needs to those with acute, complex, and persistent issues. Outpatient services, including counseling and medication management, are accessible through private practices, community mental health centers, or tribal programs. Emergency services for those in crisis or on the verge of crisis are provided through a series of crisis and stabilization services, such as Mobile Response and Stabilization Services (MRSS), the States Crisis Intervention Teams, and the State's newly established network of Certified Community Behavioral Health Clinics (CCBHC). Services for those with acute, severe, and persistent behavioral health conditions who need long-term care are provided through a network of outpatient and residential service providers, as well as by psychiatric units within general hospitals or standalone facilities, which provide stabilization for patients in crisis.

Hospital Services Rhode Island's hospital system is comprised of a network of academic medical centers, health systems, and community hospitals, two of which provide comprehensive care and serve as regional hubs for specialized services. The other hospitals offer more localized access to acute care, primarily for those with acute or complex medical conditions but there are a number of facilities that have specialized behavioral health units.

Long-Term Care and Healthy Aging Services At the core of Rhode Island's long-term care sector is a network of nursing homes, skilled nursing facilities, post-acute services organizations, and home health agencies. Nursing homes and other skilled nursing facilities deliver around-the-clock care for patients with significant medical needs. Post-acute rehabilitation centers focus on recovery after hospital stays, helping patients regain functionality and transition back to their homes. Home health agencies extend care into the places where patients live, offering services such as physical therapy, nursing care, and medication management to

promote independence and reduce hospital readmissions. Assisted living facilities cater to those who require help with daily activities but prefer a more independent lifestyle.

The state also has a range of healthy aging services designed to support individuals in home and community-based settings. Programs such as senior centers, adult day health programs, and meal delivery services provide vital resources to older adults and those with developmental, intellectual, or physical disabilities, enabling them to live independently. Additionally, initiatives focused on education, navigation support, and caregiver assistance help individuals and families access the resources they need to maintain independence and quality of life.

Health Related Social Needs Services The State has a network of service organizations and programmatic resources that address residents' Health Related social needs. At the heart of this network are the State's multi-service agencies, such as the State's Community Action Programs, that provide a wide breadth of community-based services and serve as community hubs for services focused on a community's social, environmental, and economic needs, such as food insecurity, housing, employment, and transportation. The State also has a network of food banks, housing development and assistance agencies, jobs and employment training agencies that provide vital supports in more targeted ways. Indian Health Services and other tribal programs provide important health services. Many health care providers have integrated screening for social needs into their practices, fostering partnerships with community-based organizations to provide comprehensive care.

Health Care Provider Workforce Capacity

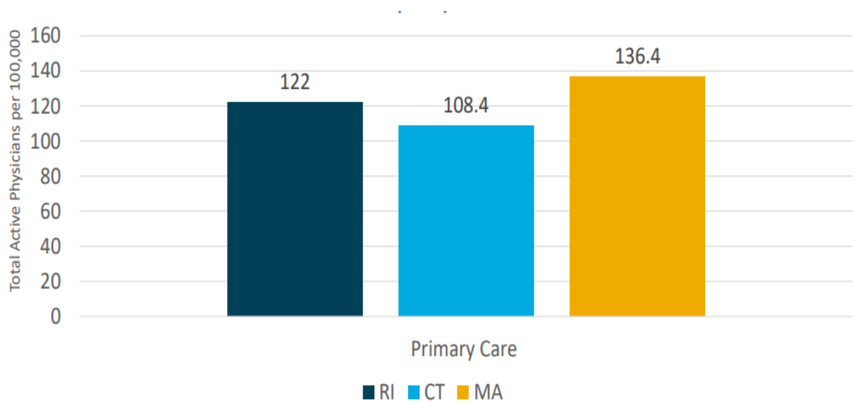
One of the most common and consistent comments gathered through this effort's community engagement activities and the workgroup meetings was the tremendous need for additional data, state data structures and systems to track health care workforce capacity. As one will discover in reading this report, all five of the health sector workgroups that were created as part of the HCSP process identified the need for more data on workforce capacity as one of their core recommendations.

The information provided in the health care sector chapters below include lengthy discussions of the strength and capacity of the State's health system, including its workforce, by sector. This information is critical to the process and will support important action. However, much of the information applied to assess workforce or service-related capacity and the ability of the State's providers to respond to need is imperfect and there is a substantial reliance on qualitative information to assess the existence and magnitude of service gaps or surpluses.

A number of recent studies and analyses have provided estimates of current and future workforce capacity for physicians, nurse practitioners, registered nurses, behavioral health practitioners, and other specific types of providers (OHIC, 2023) (Manatt Health, 2024). The Rhode Island Executive Office of Health and Human Services (EOHHS) dedicates extensive resources to assessing and reporting on workforce capacity through its Workforce Transformation Initiative (EOHHS, 2021), including the development of the Health Workforce Data Dashboard (EOHHS, 2024). Some of these studies, associated analyses, and datasets provide a relatively positive picture of Rhode Island's workforce capacity. Data and associated analyses provided by the Center for Medicare and Medicaid Services (CMS), through the National Plan and Provider Enumeration System, for example show that in 2023 Rhode Island ranked fourth out of all states in the U.S.

in terms of number of active primary care providers, with 301.5 active primary care providers per 100,000 population compared to 232 nationwide (America's Health Rankings, 2023). Similarly, data reported by Health Resource and Services Administration (HRSA} suggests that Rhode Islanders may have more equitable access to primary care than other states. Specifically, HRSA's data shows that as of 2020 there were approximately 138.9 primary care providers per 100,000 people practicing in Rhode Island's medically underserved areas (MUAs), compared to 55.9 nationally, well above the 79.1 primary care physicians per 100,000 in Rhode Island areas that are not MUAs, compared to 79.9 nationally (Milbank Memorial Fund, 2024). A recent study conducted by Manatt Health with funding from the Rhode Island Health Foundation (Manatt Health, 2024) reported that Rhode Island had fewer primary care physicians (PCP) per 100,000 than Massachusetts but more PCPs per population than Connecticut. Specifically, Rhode Island had 122 primary care physicians per 100,000 population, compared to 136 primary care physicians per 100,000 in Massachusetts and 108 primary care physicians per 100,000 in Connecticut.

Figure 2.8: Primary Care Physician Workforce Supply per 100,000 Population (2020)

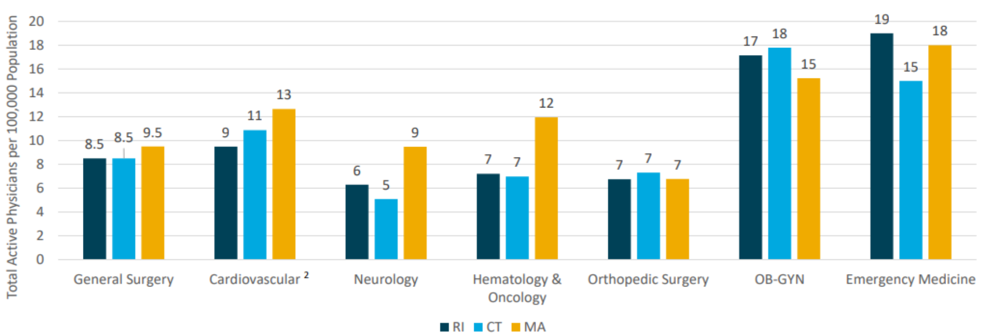


Notes:
[1] Primary care physicians are physicians whose self-designated specialty is one of the following: adolescent medicine (pediatrics), family medicine, general practice, geriatric medicine (family practice), geriatric medicine (internal medicine), internal medicine, internal medicine/ pediatrics, or pediatrics.
[2] Physician workforce is defined as active physicians in the state. Active physicians (both federal and non-federal) are licensed by a state and work at least 20 hours per week. Active physicians also include those working in nonpatient care activities (e.g., medical teaching or research) and include both doctors of medicine (MD) and doctors of osteopathic medicine (DO).

Sources: AAMC, "2021 State Physician Workforce Data Report" (2022); U.S. Census Bureau, "Annual Estimates of the Resident Population by Single Year of Age and Sex" (by State) (2020)

The Manatt Study also reported that Rhode Island's and Connecticut's physician workforce supply are approximately the same per 100,000 across all specialties except emergency medicine. Rhode Island has the most emergency physicians per 100,000 but the lowest number of cardiovascular physicians per 100,000 across Rhode Island, Connecticut, and Massachusetts.

Figure 2.9: Primary Care Physician Workforce by Specialty



Notes:
[1]Physician workforce is defined as active physicians in the state for select specialties. **Active physicians** (both federal and non-federal) are licensed by a state and work at least 20 hours per week. Active physicians also include those working in nonpatient care activities (e.g., medical teaching or research) and include both doctors of medicine (MD) and doctors of osteopathic medicine (DO). Physician workforce supply is not adjusted for non-clinical time per FTE.
[2]Cardiovascular physicians do not include cardiothoracic surgeons. AAMC specialty groupings and corresponding AMA physician professional data specialties included can be accessed here.

Sources: AAMC, "2021 State Physician Workforce Data Report" (2022); U.S. Census Bureau, "Annual Estimates of the Resident Population by Single Year of Age and Sex" (by State) (2020)

While these data are important and will or have already supported some important decision-making, there are concerns regarding the validity, generalizability, and reliability of these data. More robust and continuous monitoring efforts are needed to support the health care system planning process.

Insurance Coverage

According to data from HealthSource RI's 2024 Health Information Survey (Freedman HealthCare, 2024), Rhode Island had one of the lowest uninsured rates in the country, with an uninsurance rate of only 2.2%, compared to 2.9% in 2022. The underinsured rate, defined as those with health insurance who have high out-of-pocket costs, remained relatively stable between 2022 and 2024, growing from 23.7 in 2022 to 28.4% in 2024. Rhode Island's strong health coverage is attributed to effective coordination between HealthSource RI, the state's marketplace, and Medicaid, ensuring continuity even through the reintroduction of Medicaid renewals post-pandemic. The low uninsured rate helps residents access essential preventive care and reduces financial risks from unexpected medical expenses, significantly benefiting public health outcomes. The highest uninsured rates are found among Black/African American Rhode Islanders. In 2024, 4.1% of Black/African Americans in Rhode Island were uninsured, 2.5% of those identifying as Asian, and 1.3% of those identifying as While. Hispanic/Latino residents were more likely to be uninsured than non-Hispanic/Latino residents.

Surprisingly, with respect to household income, of the people in Rhode Island who were uninsured in 2024 , 25.1% of them had incomes over $100,000. The next highest group of uninsured people by income was those with household incomes between $40,000 - $59,999 (23.3%), followed by those with household incomes between $0 - 19,999 (22.1%). The most common reasons reported by these Rhode Island for being uninsured are unaffordable insurance premiums, job loss, and loss of Medicaid coverage. HealthSource RI's summary report can be found on their website (https://healthsourceri.com/survey-rhode-island-sustains-low-uninsured-rate/).

Approximately 27% of Rhode Islanders are covered by Medicaid, with the highest coverage rates found in Providence County, where 33% are enrolled in Medicaid and 4% are uninsured. Newport County follows closely, with 22% covered by Medicaid and 3% uninsured. Newport County also has a notable distinction in its military insurance coverage, where 13% of residents are insured through the military, compared to just 4% statewide. Disparities in health insurance coverage are evident across racial, ethnic, and birthplace lines. Among non-Hispanic White residents, 18% are covered by Medicaid, and 1.6% are uninsured, while among Hispanic or Latino residents, 58% rely on Medicaid, and 8% are uninsured. For non-Hispanic Black residents, 41% are on Medicaid, and 5% are uninsured. These disparities are also seen between U.S.-born and foreign-born residents: 42% of Rhode Islanders born outside the U.S. are covered by Medicaid, with 7% uninsured, compared to 24% and 2%, respectively, for U.S.-born residents (HealthSource RI, 2024).

Figure 2.10: Insurance Status of Rhode Islanders by Selected Demographic Categories (Health in RI, 2024)

	White, non-Hispanic # (%)	Hispanic or Latino # (%)	Black, non-Hispanic # (%)	Asian, non-Hispanic # (%)	Born in US # (%)	Born outside US # (%)
Total Population	736,895	170,739	53,364	36,403	905,217	142,353
Private Insurance	409,697 (55.6)	37,942 (22.2)	21,805 (40.9)	26,977 (74.1)	462,918 (51.1)	47,851 (33.6)
Medicaid	133,171 (18.1)	99,560 (58.3)	21,642 (40.6)	5,032 (13.8)	217,696 (24.0)	59,917 (42.1)
Medicare	152,187 (20.7)	17,638 (10.3)	6,313 (11.8)	2,173 (6.0)	167,915 (18.5)	23,095 (16.2)
Military Insurance	30,394 (4.1)	1,852 (1.1)	— (1.3)	— (1.8)	36,385 (4.0)	— (1.1)
Uninsured	11,445 (1.6)	13,748 (8.1)	2,917 (5.5)	— (4.3)	20,303 (2.2)	9,979 (7.0)

Source: 2022 Health Insurance Survey.[72]

Finally, those who are under- or uninsured are also a consistent category of concern. Rates of concern regarding these groups were highest in the Providence and Pawtucket regions, both of which are in the county with the highest rates of uninsured individuals (3.6%) and individuals covered by Medicaid (33%). Despite being the county with the second-highest rates of uninsurance (3.3%) and Medicaid coverage (22%), Newport had the lowest percentage of respondents selecting this group as among those needing the most help; even so, however, more than one-third of respondents in Newport expressed concern for this population.

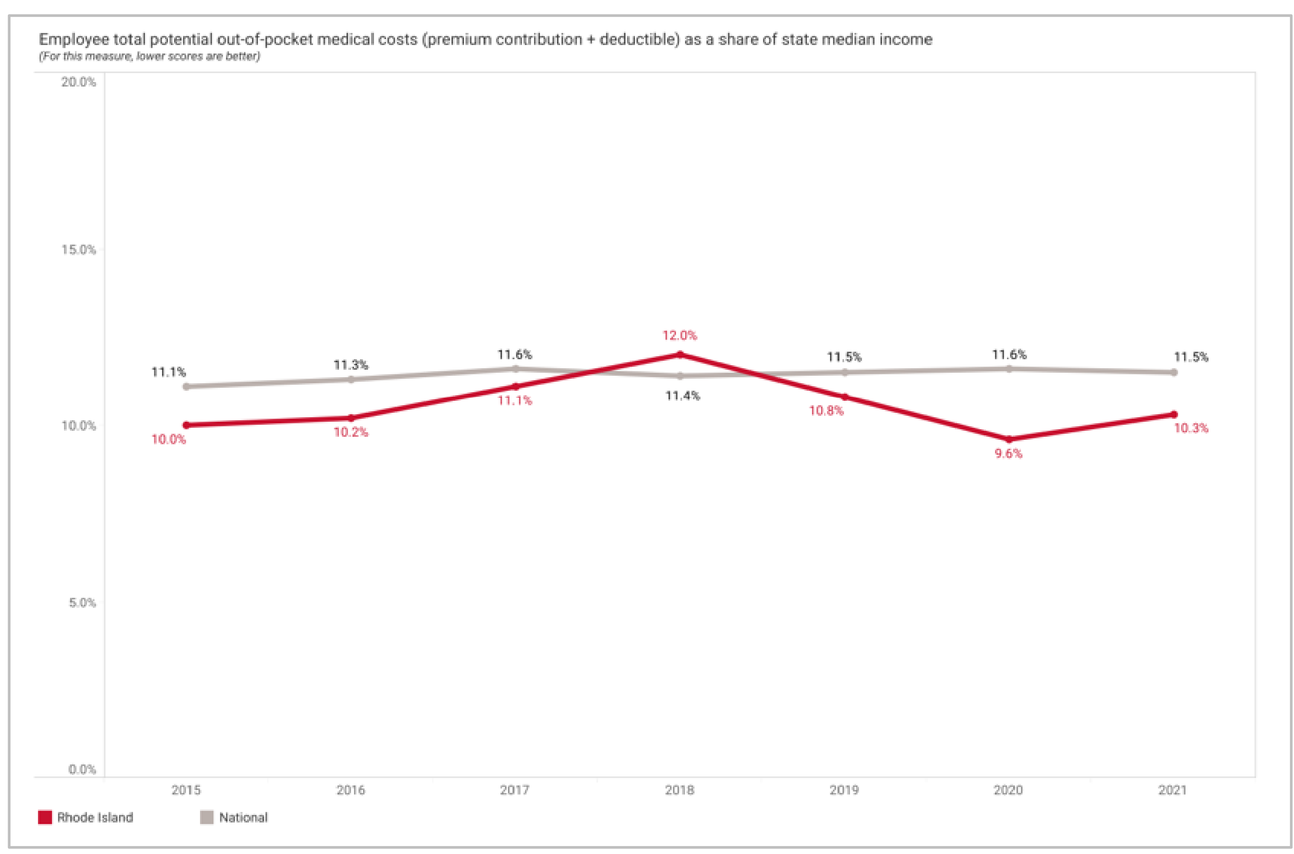
Access Barriers

Financial Barriers Accessing health care in Rhode Island is challenging for many residents, particularly due to financial and social needs barriers and regardless of insurance coverage. For those with low incomes or without health insurance, the cost of health care can be prohibitive. Even with insurance, high deductibles, co-pays, and out-of-pocket expenses make it difficult for many to afford necessary treatments, medications, or specialist care. As a result, people often delay seeking medical help, which can lead to more severe health problems later. In Rhode Island, 7.8% of people reported going without care due to costs, compared to 10.1% nationally (Health in Rhode Island, 2022).

The Affordability Index measures the average cost of an employer-sponsored health insurance policy as a percentage of median household income and serves as a means of understanding impact of total medical health care costs on household budgets. The Affordability Index is often calculated as premium costs equal to or greater than 10%; premium costs equal to or greater than 7% if low income (below 200% FPL);

deductible equal to or greater than 5% of income; out of pocket expenses equal to or greater than 10% of income; or out of pocket expenses equal to or greater than 5% if low income (Commonwealth Fund, 2015). This metric describes the affordability and burden of health care costs to employees (Emanuel, Glickman, and Johnson, 2017). The trend for Rhode Island's Affordability Index is 28.4%, slightly lower than the national average of 29.4% (lower is better). Employees pay a total of 10.3% of income on total out-of-pocket expenses.

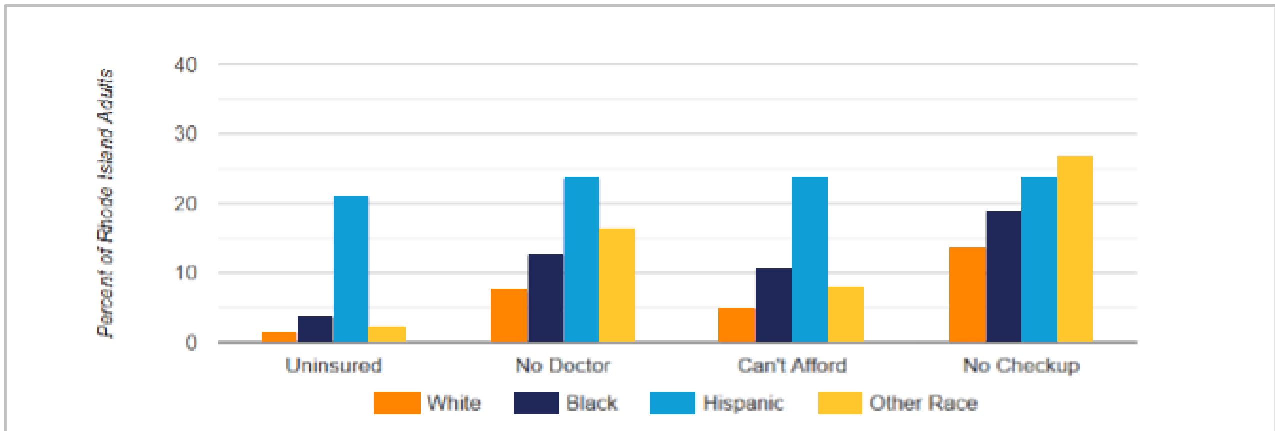
Figure 2.11: Employee total potential out-of-pocket medical costs (premium contribution + deductible) as a share of state median income (Health in RI, 2024)



Having access to medical care helps people live healthy lives and prevents more serious medical conditions from developing. The percentage of Rhode Island adults who did not seek medical care due to cost has decreased since 2017.

Language, Literacy and Cultural Barriers Language barriers, limited health literacy, and cultural differences can prevent individuals from understanding or navigating the health care system effectively. As of recent data, approximately 9.3% of Rhode Island residents reported facing challenges in accessing health care due to language barriers. The prevalence of being uninsured, having no doctor, and experiencing cost barriers to seeing a doctor are highest among Hispanic adults compared with all other racial/ethnic groups (Health in RI, 2022).

Figure 2.12: Rhode Island Adults Medical Coverage by Race (Health in RI, 2024)



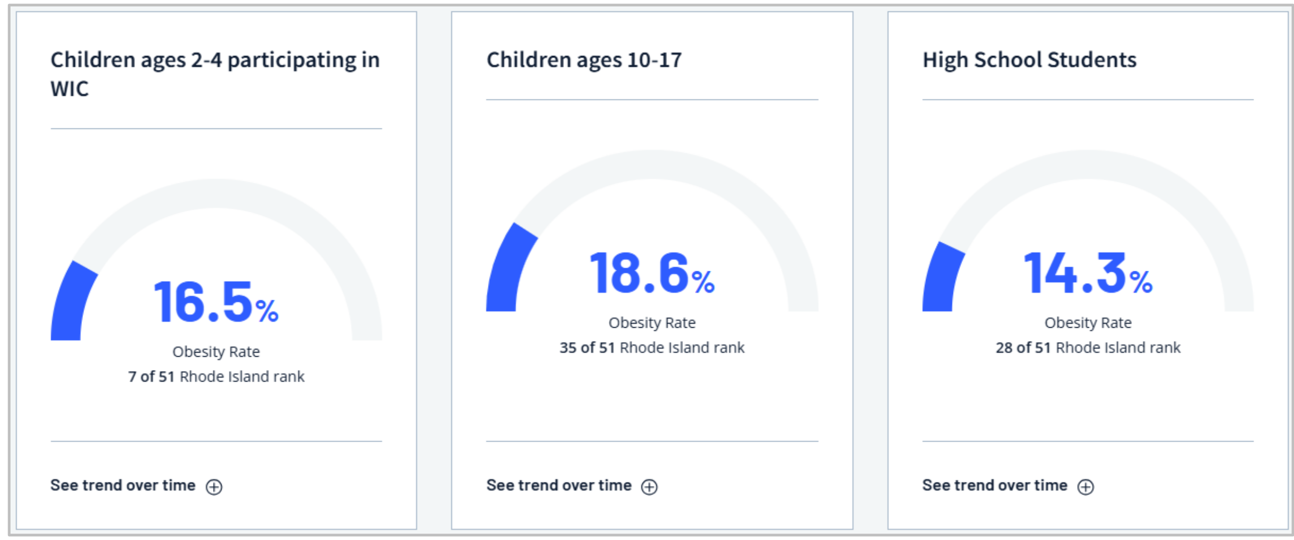
Domain 4: Population Health Indicators/Chronic Disease Prevalence

As of 2023-2024, chronic disease prevalence in Rhode Island reflects trends observed nationally, particularly regarding cardiovascular disease, diabetes, and cancer. The prevalence of diabetes in Rhode Island has slightly increased since 2016. Adults with less than a high school education have consistently had a higher prevalence of diabetes than those with more education, and this disparity has increased since 2017 (Health in RI, 2024). Notably, diabetes management continues to be a priority for state health officials, as it poses significant health risks if left uncontrolled, including complications such as heart disease, etc. Black and Hispanic adults compared to their White and Asian counterparts. Additionally, obesity is more common among residents with lower incomes and educational attainment (Health in RI, 2024).
According to state-level health data, around 30% of adults reported being diagnosed with hypertension, aligning with general U.S. trends for blood pressure concerns. Diabetes affects approximately 10% of Rhode Island's adult population, which mirrors the national prevalence rate for this condition (CDC, 2024). The burden of chronic diseases extends to the management of respiratory and metabolic conditions. Chronic obstructive pulmonary disease (COPD) and asthma remain significant, with asthma affecting nearly 12% of adults in the state.

Obesity

Obesity remains a significant public health challenge in Rhode Island. Recent data indicates that approximately 30.8% of adults in the state have obesity. Rates are higher among individuals aged 45-64. Among children aged 10-17, the obesity rate is 18.6%, ranking Rhode Island 35th nationally. For high school students, the obesity prevalence is 14.3%, reflecting ongoing challenges in addressing healthy behaviors during adolescence (State of Childhood Obesity, 2024). Factors such as food insecurity and limited access to affordable healthy foods and physical activity contribute to these rates. Efforts to combat obesity in Rhode Island include expanding nutrition assistance programs, improving physical activity infrastructure, and supporting community-based health initiatives.

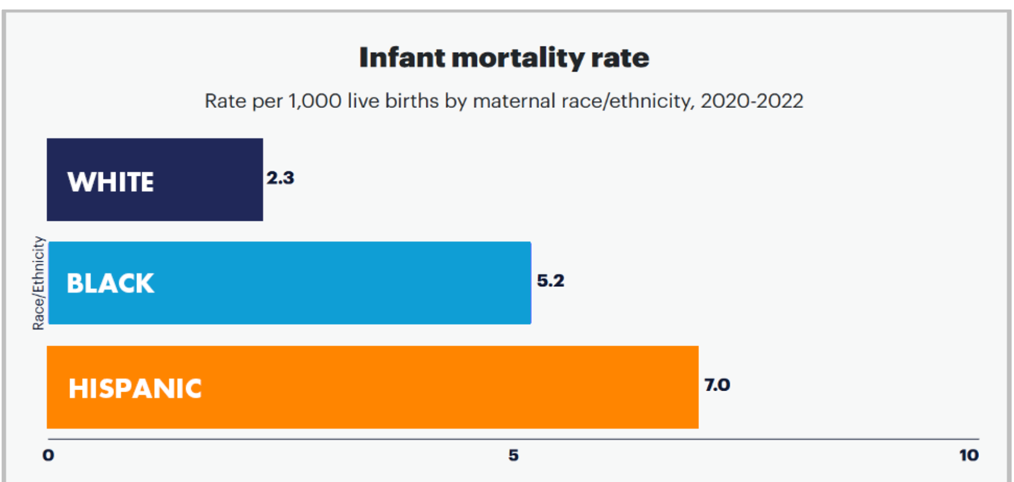
Figure 2.13 Rhode Island Obesity Rates among Children (State of Childhood Obesity, 2024)



Maternal and Child Health

Rhode Island continues to face notable challenges in maternal and child health. The state reported a concerning preterm birth rate of 9.3% in 2022 (March of Dimes, 2024). This rate reflects a disparity in health outcomes, especially among minority racial and ethnic groups. For example, non-Hispanic Black people experience significantly higher rates of preterm births compared to their white counterparts. The preterm birth rate among Black babies is 1.2 times higher than the rate among all other babies. Vulnerable populations, such as low-income families, are also impacted by limited access to early and adequate prenatal care; approximately 15.5% of birthing individuals received inadequate prenatal care in the state. The infant mortality rate among Black babies is 1.8 times the state rate.

Figure 2.14: Rhode Island Infant Mortality Rate by Race (March of Dimes, 2024)

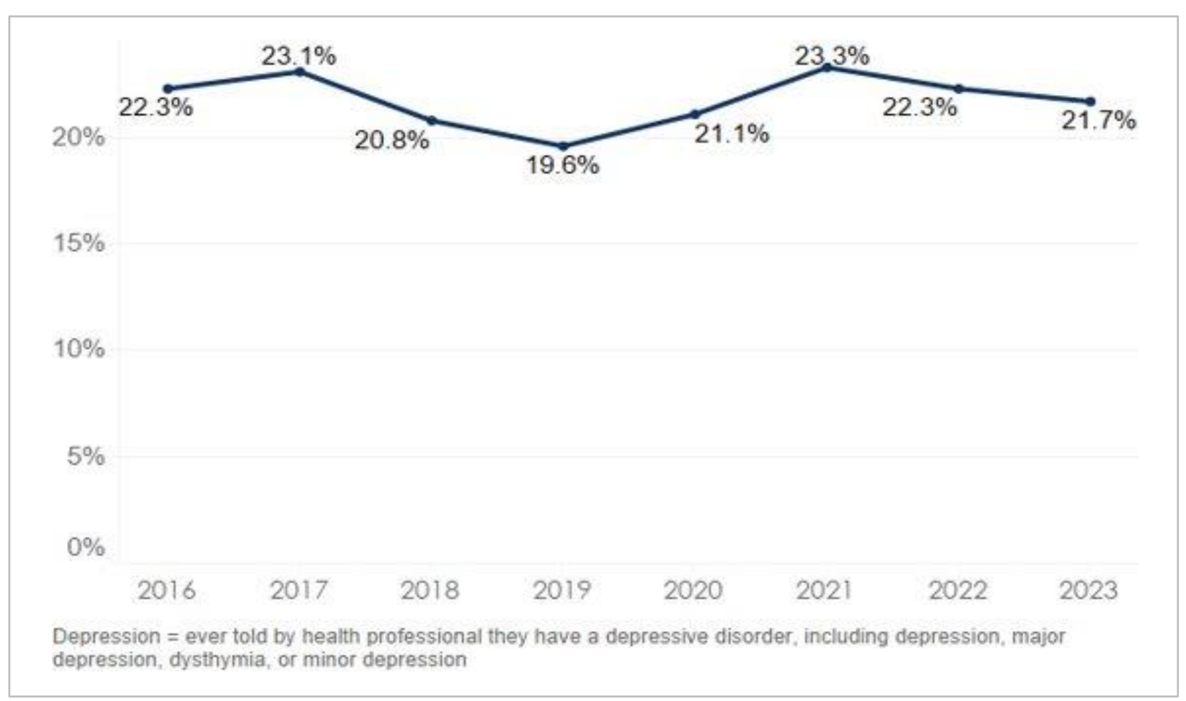


Rhode Island has implemented some proven measures to address these disparities, including Medicaid extensions to one year postpartum and doula care reimbursements to support maternal well-being. These policies aim to improve preventive care and provide additional support during and after pregnancy, particularly for marginalized communities. However, continuous efforts are needed to mitigate persistent health disparities and ensure equitable maternal and child health outcomes for all residents.

Adult Behavioral Health - Mental Health and Substance Use

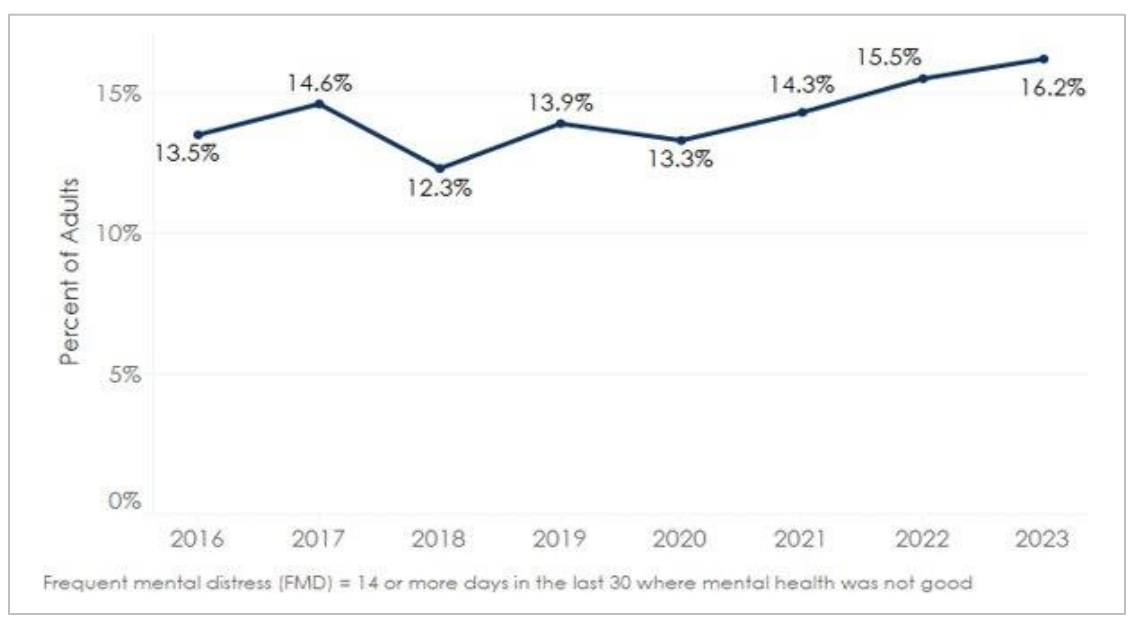
In Rhode Island, according to data from Rhode Island's Behavioral Risk Factor Surveillance System [RI BRFSS] (2023), more than 1 in 5 (21.7%) adults 18 years old or older reported being told by a health professional that they had a depressive disorder and 1 in 6 (16.2%) reported frequent mental distress.[1] In both cases the percentage has increased steadily since 2018, with respect to the percent of adults who reported frequent mental distress the figure grew by 32% between 2018 and 2023.

Figure 2.15: Percent of Adults (18 years old or older) in Rhode Island with Depression, 2023



[1] The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of telephone health surveys that collects information on health risk behaviors, preventive health practices, and healthcare access primarily related to chronic disease and injury. The BRFSS is administered annually to Rhode Island residents ages 18 years and older at random, and the data are weighted so they can be interpreted as representative of the Rhode Island adult population. (https://rhode-island-brfss-rihealth.hub.arcgis.com/)

Figure 2.16: Percent of Adults With Frequent Mental Distress in Last 30 Days



Further analysis shows that the percentages are higher for those who are insured by Medicaid, those who are uninsured, and those in low-income brackets who are disproportionately economically insecure, reinforcing the widely understood connection between mental health and health related social needs, such as insurance status or poverty (RI BRFSS, 2023).

Figure 2.17: Percent of Adults (18 years old or older) in Rhode Island with Frequent Mental Distress by Household Income, 2023

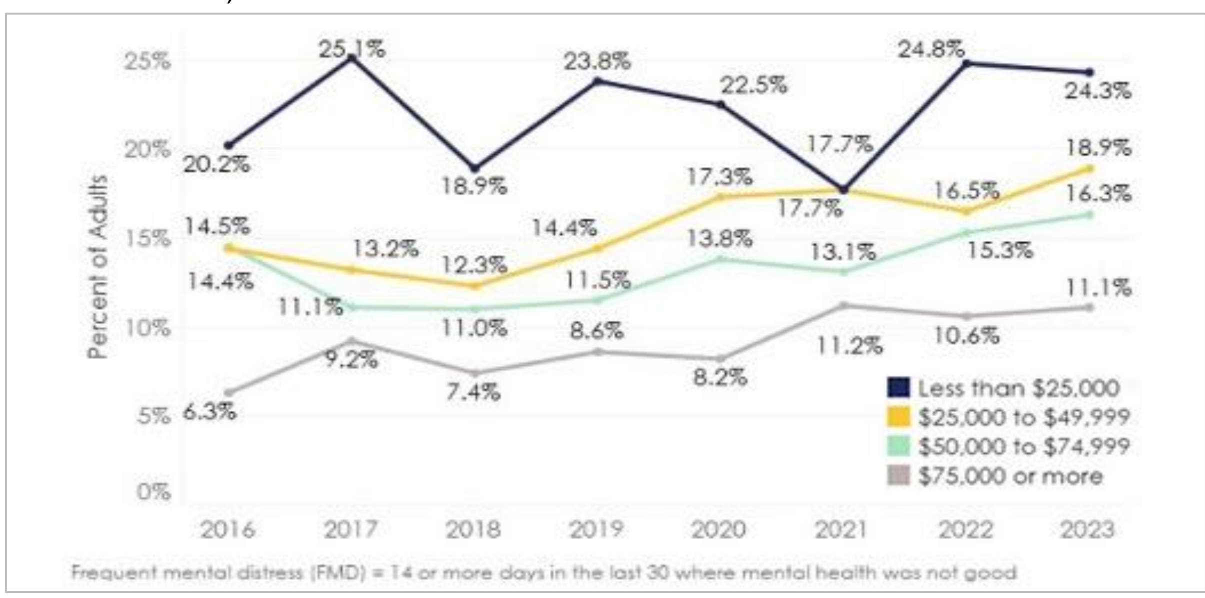
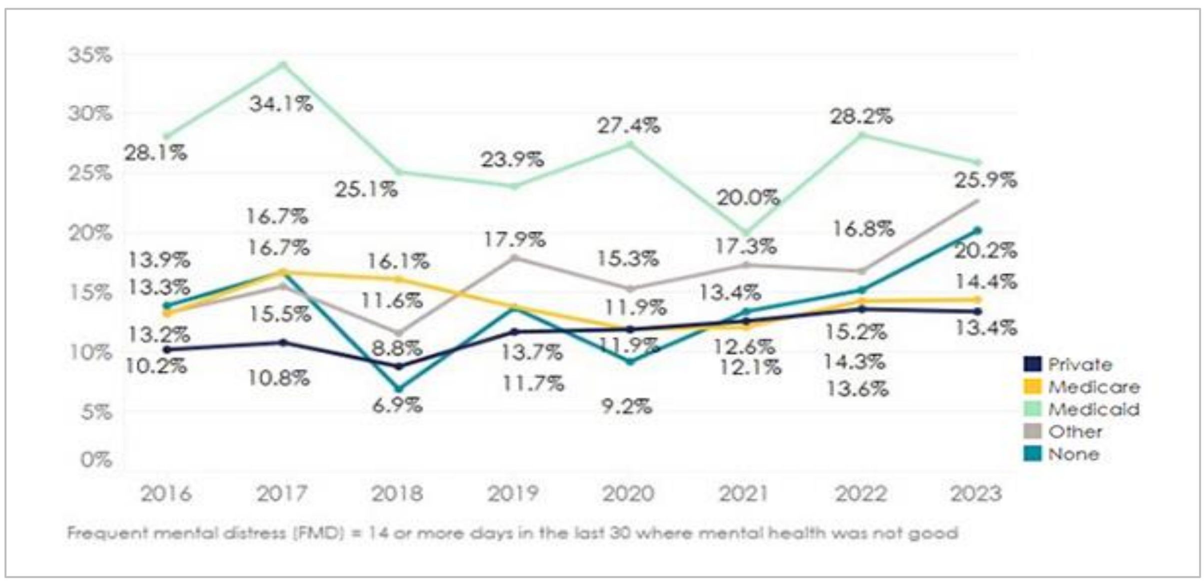
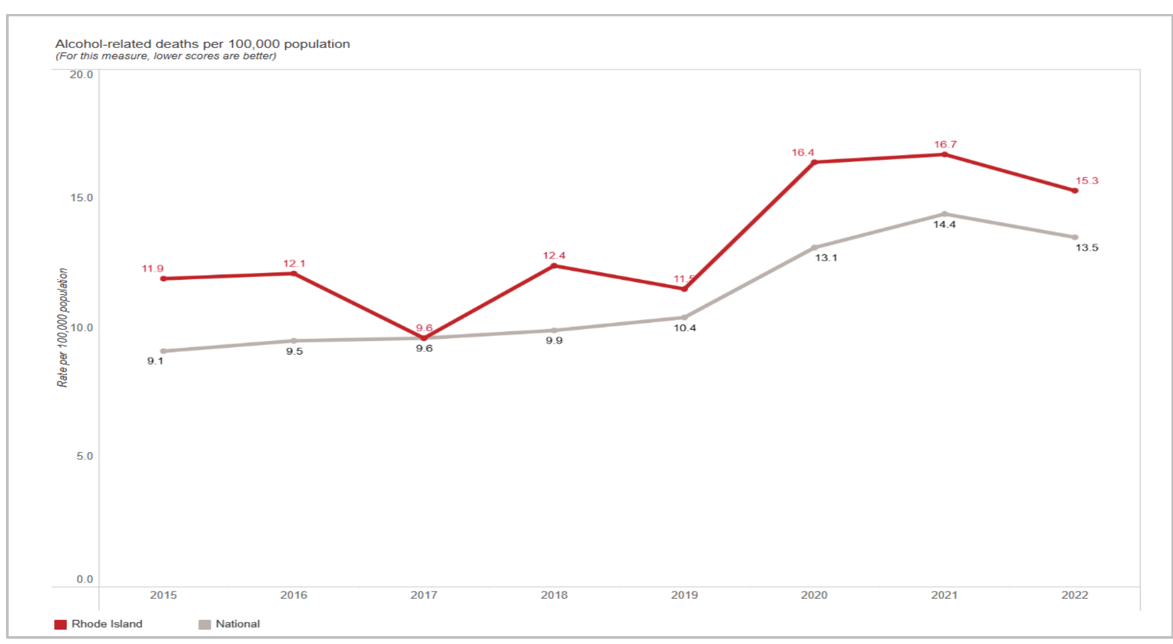


Figure 2.18: Percent of Adults (18 years old or older) in Rhode Island with Frequent Mental Distress by Health Insurance Status, 2023



Substance Use - Alcohol Excessive alcohol use in Rhode Island contributes to both chronic and acute health outcomes. On average, 493 deaths annually in the state are attributable to alcohol consumption, with 87.4% of these involving individuals aged 35 years or older. A majority of these fatalities (59.8%) result from chronic conditions such as Alcohol Use Disorder. Men account for 67.5% of alcohol-related deaths, highlighting gender disparities in the Health Related outcomes of alcohol use (Health in RI, 2024).

Figure 2.19: Rhode Island Alcohol-related deaths per 100,000 population



Efforts to mitigate alcohol-related harm in Rhode Island include public awareness campaigns and community-based interventions focused on reducing binge drinking and improving access to treatment for alcohol use disorders.

The data from the Rhode Island's BRFSS system also highlight the state's substance use challenges. In 2021, 61% of adults reported alcohol use in the past 30 days, which has remained steady since 2016 (RI BRFSS, 2023). Of those, reporting alcohol use approximately 1 in 6 (14%) reported binge drinking.[2] Those identifying as male were more likely to report binge drinking than those identifying as female, with nearly 1 in 5 males reporting binge drinking (18%) and nearly 1 in 10 females (9%). These data have also remained steady since 2016. Alcohol consumption was most common among adults who were white, non-Hispanic and least common among people who were Hispanic. However, the rate of binge drinking was similar by race and ethnicity. Rhode Island adults between the ages of 18-34 were most likely to report alcohol consumption and binge drinking.

Figure 2.20: Percent of Adults (18 years old or older) in Rhode Island Using Alcohol or Binge Drinking by Race / Hispanic or Latino Identity, 2023

	Any alcohol use	Binge drinking
White, Non-Hispanic	60.8%	15.9%
Black, Non-Hispanic	47.6%	16.5%
Hispanic or Latino	43.0%	17.9%
Other race(s), Non-Hispanic	48.7%	16.3%

Any alcohol use = drank any alcohol in the past 30 days

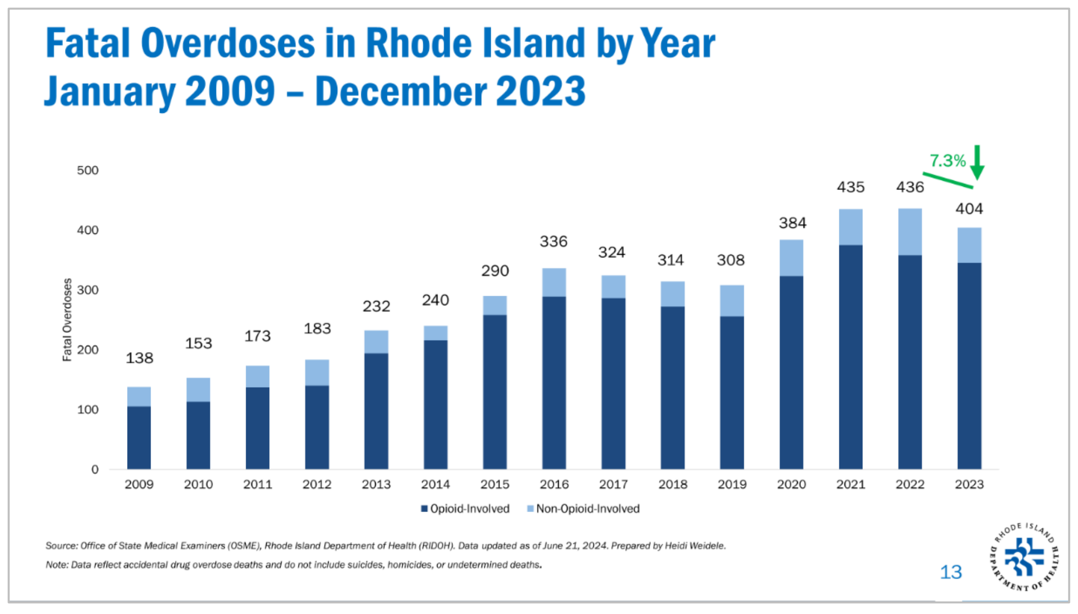
Binge drink = at least 4 alcoholic drinks for females or at least 5 alcoholic drinks for males in one sitting in the past 30 days

Substance Use - Drug Overdoses Rhode Island continues to grapple with significant behavioral health challenges, particularly concerning addiction and overdose outcomes. The state has experienced a persistent rise in fatal overdoses since 2014. Alarmingly, in 2022, approximately 75% of overdose deaths involved fentanyl, a potent synthetic opioid. Overdose incidents span across all age groups, although a disproportionate number are among adult men, who represent about three out of four deaths.

With respect to total drug overdoses (all drugs) in Rhode Island, the figures were relatively stable between 2016 and 2018 (RI BRFSS, 2023). Between 2019 and 2022, Rhode Island experienced a substantial increase in overdoses, but in 2023 saw a considerable decrease in deaths. Specifically, between 2022 and 2023, there was a 7% decline in drug overdose deaths. Opioid overdose comprised the vast majority of these death.

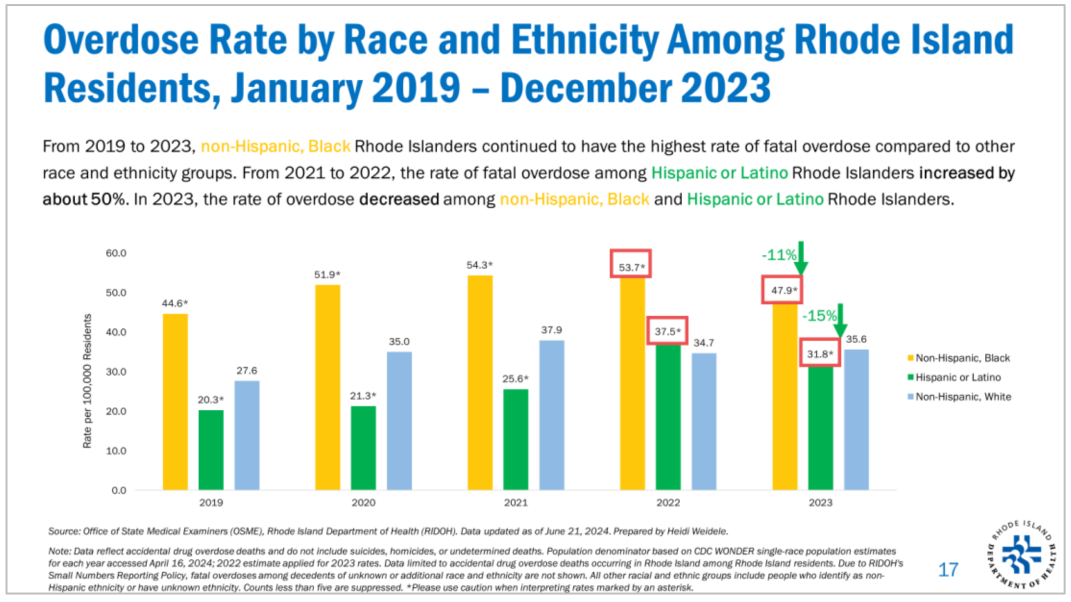
[2] According to the BRFSS, binge drinking is defined as consuming at least four alcoholic drinks for women and five or more for men on a single occasion.

Figure 2.21: Fatal Overdoses in Rhode Island by Year 2009-2023



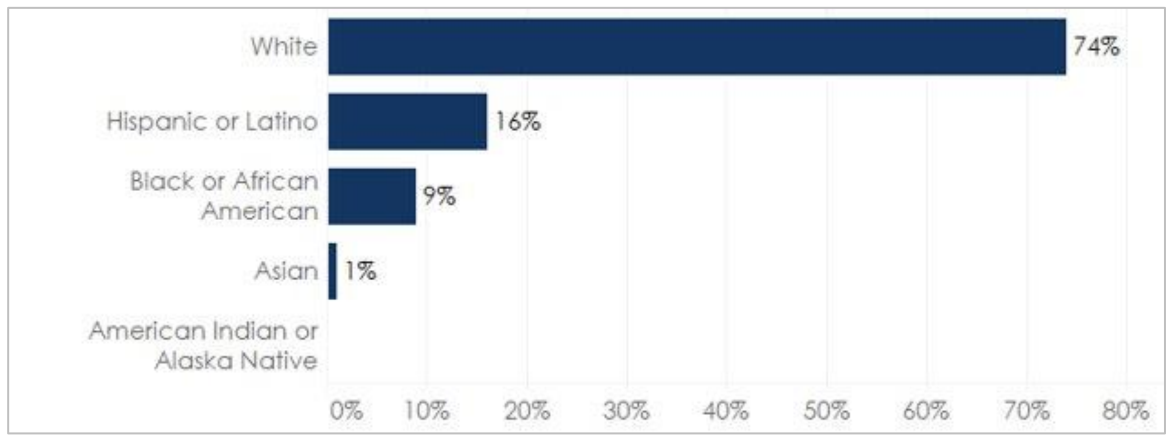
It should be noted that deaths declined by an even larger percent for Black (-11%) and Hispanic/Latino residents (-15%).

Figure 2.22: Overdoes Rate by Race and Ethnicity Among Rhode Island Residents 2019-2023



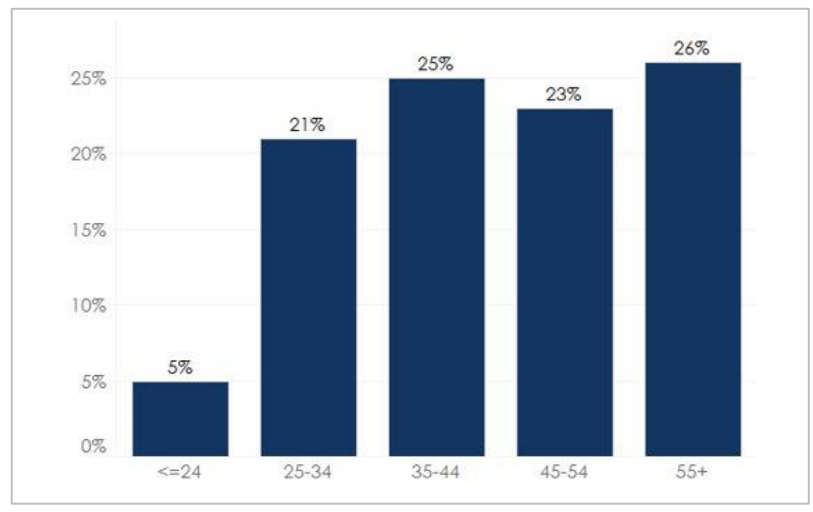
Between 2021 and 2023, those identifying as White comprised the vast majority of deaths at (74%), following by those identifying as Hispanic (16%), and those identifying at Black/African American (9%) (RI BRFSS, 2023).

Figure 2.23: Percent of Drug Overdose Fatalities by Race and Hispanic Identity (2021 Quarter 1 through 2023 Quarter 4)



By age, those who were 24 years old or less comprised the lowest proportion of total deaths (5% or 4 deaths) and the remaining 95% or 77 deaths, were relatively equally distributed across the age spectrum (RI BRFSS, 2023).

Figure 2.24: Percent of Drug Overdose Fatalities by Age Category (2023 Quarter 4)



Children and Youth Mental Health

Mental health problems affect children and youth of all backgrounds. The following subsection draws data from the Rhode Island KIDS COUNT 2024 Factbook (Rhode Island KIDS COUNT), and reflects the challenges that children and families face with respect to the prevalence of mental illness conditions and accessing care for those facing these challenges. In 2022, more than one in four (28.7%) of Rhode Island children ages three to 17 had a mental, emotional, or behavioral health conditions. However, many children and youth have trouble getting mental health treatment. In Rhode Island in 2022, more than half (59%) of children ages three to 17 who needed mental health treatment or counseling had a problem obtaining needed care. Risk factors for childhood mental health disorders include environmental factors like prenatal exposure to toxins (including alcohol), physical or sexual abuse, adverse childhood experiences, toxic stress, a family

history of mental health issues, involvement with the juvenile justice and child welfare systems, living in poverty, and other adverse childhood experiences.

Children living in poverty in Rhode Island are two to three times more likely to develop mental health conditions than their peers (Rhode Island KIDS COUNT, 2024). In 2023, 25% (32,597) of children under age 19 enrolled in Medicaid/RIte Care had a mental health diagnosis. In the same year, 959 Rhode Island children under age 19 enrolled in Medicaid/RIte Care were hospitalized due to a mental health related condition (down from 1,096 in SFY 2021), and 2,598 children had a mental health related emergency department visit (up from 2,246 in 2021).

These challenges are even more extreme for youth identifying as LGBTQ+ (Rhode Island KIDS COUNT, 2024). In 2023, LGBTQ+ Rhode Island high school students reported higher rates of sadness and hopelessness than their peers. LGBTQ+ students, as well as Youth of Color, are more likely to have had their mental health impacted by the COVID-19 pandemic and have additional barriers to accessing and receiving adequate mental health treatment.

Further clarifying the specific challenges that Rhode Island's children, youth, and families face are data from Bradley Hospital and Butler Hospital, the two hospitals in the state that specialize in providing intensive inpatient treatment and psychiatric care to children and youth. In 2023, the most common diagnoses for youth treated at Butler or Bradley Hospitals in the inpatient setting were depressive disorders, anxiety disorders, adjustment disorders, and childhood/adolescent disorders. In 2022, there were 3,265 emergency department visits and 2,271 hospitalizations of Rhode Island children with a primary diagnosis of mental disorder. Of these emergency department visits, 60% were of children enrolled in RIte Care/Medicaid and 36% had commercial insurance.

Unfortunately, these mental health challenges put children and youth with mental health conditions in Rhode Island at increased risk for suicide. In 2023, 36% of Rhode Island high school students reported feeling sad or hopeless for more than two weeks during the past year (Rhode Island KIDS COUNT, 2024). Girls were twice as likely as boys to report these feelings. And in 2023, 9% of Rhode Island high school students reported attempting suicide one or more times during the past year. In Rhode Island between 2018 and 2022, there were 2,448 emergency department visits and 1,349 hospitalizations of youth ages 13 to 19 due to suicide attempts or intentional self-harm. Suicidal or self-injurious behavior accounted for 10% of the reasons for calls to Kids' Link RI in 2023. Between 2018 and 2022, 12 Rhode Island children ages 15 to 19 died due to suicide in Rhode Island.

Health Equity Zones (HEZs)

Overall, preventive health initiatives in Rhode Island focus on addressing social determinants of health and promoting equitable access to resources that enhance long term well-being. A significant initiative is the Health Equity Zones (HEZs), which are community-driven collaboratives established to tackle health disparities as well as health and wellness at the local level. Since 2015, HEZs have been instrumental in engaging residents to develop tailored action plans addressing priorities such as housing, food access, education, and health care connectivity. HEZs have demonstrated a measurable impact on reducing inequities and fostering healthier communities through collective, data-driven approaches.

It is in the state's critical interest to continue prioritizing preventive health initiatives to reduce alarming statistics related to chronic disease, substance use, and health disparities. By expanding the reach of programs like Health Equity Zones and investing in data-driven community health solutions, the state can address root causes of inequities. Strengthening partnerships across sectors and emphasizing preventative care will be critical to reversing upward trends in obesity, alcohol-related mortality, and other public health areas of concern.

For more information about Rhode Island's Health Equity Zones, please reference Chapter 8 of this report, *Health Related Social Needs*.

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Review of Health Sectors

Introduction to the Sector Chapters

The Chapters in this section of the report provide a deep dive into each of the five health sectors identified by HCSP Cabinet that are part of the Rhode Island Health Care System Planning structure, in this order:

- Primary Care
- Behavioral Health
- Hospitals
- Long-Term Care and Healthy Aging
- Health Related Social Needs

Workgroup Contribution to the Sector Chapters

The information in these Sector Chapters of the report – and the efforts of the entire HCSP Initiative – have been fundamentally informed by input and guidance from a series of workgroups that were established for each health sector. At the outset of the initiative, the EOHHS leadership team identified a representative group of subject matter experts, advocates, service providers, and other key stakeholder to effectively inform and guide the planning process. Members of the health sector workgroups were largely drawn from the Independent Advisory Council that was formed as part of the Executive Order. Additional members were added, as appropriate, and the meetings were open to the public. In total, more than 200 people have engaged in this process so far, across all five of the Workgroups and other related activities.

Each Workgroup met at least three times between August and November 2024 to review key deliberate on a series of recommendations that the group collectively believed would strengthen and enhance their particular health sector. A key element to the process, was a Health Care System Planning Retreat, held in November 2024, that allowed the Workgroups to share key findings and their emerging recommendations. This meeting was critical to the process as it allowed for cross-sector discussion and collaboration that was an essential part of the planning process.

State Interagency Planning Team

Another key component of this Health Care System Planning process has been the Health Planning Interagency Team staffed by EOHHS and supported by EOHHS' consultant team from JSI. The Team has been meeting weekly to provide strategic oversight to the process, review progress of the Workgroups, and support the writing of this report.

Content of the Sector Chapters

Each of the Health Sector Chapters begins with a summary of the national trends, driving forces, and innovations that are impacting the particular sector, propelling change or transformation. Then, the chapters review the state landscape analysis that summarizes the issues and themes specific to Rhode Island. These issues and themes were drawn from existing reports and through the community engagement activities of the Workgroups. Each chapter concludes with a listing of the recommendations that arose from the assessment and community engagement efforts.

Following the Health Sector Chapters is a section that addresses the cross-cutting issues that are critical to health system strength and must be addressed and supported, if the system is to effectively integrate and coordinate its efforts across the care continuum:

- Data
- Workforce
- Value-Based Payments
- Health Information Technology

Chapter 3: Primary Care

Definition, Role, and Importance of the Primary Care Sector

Primary care is the foundation of an equitable and high-performing health care system. The National Academies of Science, Engineering, and Medicine (NASEM) defines the nature and impact of high-quality primary care as follows:

> *"Primary care provides comprehensive, person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities. Primary care is unique in health care in that it is designed for everyone to use throughout their lives—from healthy children to older adults with multiple comorbidities and people with disabilities. Absent access to high quality primary care, minor health problems can spiral into chronic disease, care management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and the nation's health care spending soars to unsustainable levels. People in countries and health systems with high-quality primary care enjoy better health outcomes and more health equity." (NASEM, 2021b, p. 3)*

Primary care is critical for initial patient contact, ongoing health maintenance, care coordination, and a healthy population and workforce. It is delivered by a broad team of clinicians, including nurse practitioners (NPs), physician assistants (PAs), internists, pediatricians, and family practitioners, all of whom play vital roles in providing accessible, high-quality care. Primary care clinicians may be supplemented on a team by others, e.g., nutritionists, behavioral health clinicians, community health workers.

A higher per capita supply of primary care physicians is associated with improved mortality outcomes, increased life expectancy, increased receipt of preventive health services, and reduced low birth-weight rates (Basu et al., 2019; Shi, 2012; Starfield et al., 2005; Yanagihara & Hwang, 2022). Important for health equity, access to primary care may have the largest impact on health in areas with the highest levels of income inequality (Shi et al., 2008). Greater primary care availability in a community is also correlated with a decrease in utilization of more expensive types of health services, such as hospitalizations and emergency department visits (Kravet et al., 2008). Primary care clinicians use fewer tests, spend less money, and protect people from overtreatment more than the subspecialists from whom people sometimes seek routine care (Phillips & Bazemore, 2010). Exemplary of primary care's importance, a recent analysis found that addressing basic patient problems in the emergency room costs up to 12 times more than in primary care offices (UnitedHealth Group, 2019). Overall, primary care providers are central to the well-being of Rhode Islanders, the sustainability of the state's health care system, and economic development.

National and Statewide Driving Forces, Trends, and Innovation

Primary care in the U.S. has experienced noteworthy trends in areas such as workforce, access, payment, and practice organization. This section details these changes using the most recent available data and literature. A review of national trends helps contextualize current experience in Rhode Island.

Workforce and Access

The U.S. is facing a nationwide shortage of primary care physicians, which is projected to grow given the large portion of the physician workforce nearing traditional retirement age and accelerated retirement due to physician burnout, exacerbated by COVID-19. As of October 2024, the federal government estimated that an additional 13,297 primary care physicians would have been needed to provide a level of care that would have removed the Health Professional Shortage Area (HPSA) designation for areas with primary care shortages (Health Resources & Services Administration [HRSA], 2024). The Association of American Medical Colleges estimates that by 2034 the U.S. will face a deficit of between 17,800 and 48,000 primary care physicians (IHS Markit, 2021).

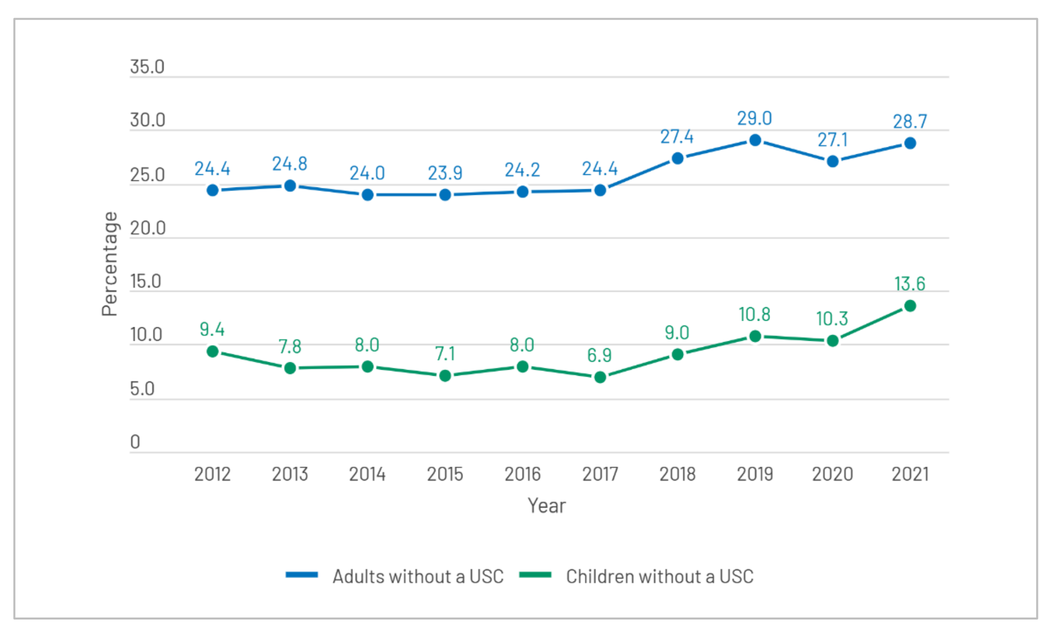
Burnout is a key concern in the primary care workforce driving physicians to reduce or leave clinical practice. Burnout among physicians also negatively affects patient care, including a two-fold increase in odds for unsafe care, unprofessional behaviors, and low patient satisfaction (Panagioti et al., 2018). The Agency for Healthcare Research and Quality (2023) defines burnout as a "workplace-based condition where people experience a long-term stress reaction marked by emotional exhaustion, depersonalization and a lack of sense of personal accomplishment." In 2020, 38% of physicians in the U.S. reported experiencing at least one of the three dimensions of burnout, with primary care physicians reporting higher rates of burnout than most other types of physicians (Shanafelt et al., 2022b). The COVID pandemic accelerated the U.S. physician burnout rate; at the end of 2021, nearly 63% of physicians reported symptoms of burnout (Shanafelt et al., 2022a). Among primary care clinicians, 71% reported that their burnout or mental exhaustion had reached an all-time high during the pandemic, and one in four primary care clinicians reported they intended to leave practice over the next several years (Horstman & Lewis, 2022).

There are not enough new physicians entering the primary care workforce to make up for the increases in physicians retiring. Since 2011, the percentage of U.S. trained M.D. physicians who have matched into primary care positions has been on the decline (Knight, 2019). A study of career plans of internal medicine residents from 2019 to 2021 found that fewer than 9% of third-year internal medicine residents were interested in primary care (Paralkar et al., 2023). From 2012 to 2020, only about 20% of all physicians completing their residency were practicing primary care two years later (Milbank Memorial Fund, 2023). In 2020, rates of physicians entering primary care differed substantially across states, with higher percentages of new primary care physicians in western and rural states (e.g., Alaska and Maine) (Milbank Memorial Fund, 2023).

Amid the physician shortage, nurse practitioner (NP) and physician assistant/associate (PA) roles are growing, helping fill gaps in the primary care physician workforce. A 2021 report from the National Academies of Sciences, Engineering and Medicine estimated that between 24% and 39% of NPs practiced ambulatory primary care and the Bureau of Labor Statistics reports that NPs are the fastest growing profession in the U.S. (NASEM, 2021a; U.S. Bureau of Labor Statistics, 2022). The American Association of Physician Associates estimates that 20% of practicing PAs are working in primary care (American Academy of PAs, 2023).

Workforce shortages have impacted access to primary care. Primary care access in the U.S. is lagging, especially in underserved communities. Many Americans do not have an ongoing primary care relationship. From 2012-2021, the percent of adults without a usual source of care rose from 24.4% to 28.7% and the percentage of children without a usual source of care increased from 9.4% to 13.6% (Milbank Memorial Fund, 2024).

Figure 3.1: Percentage of the US Population Without a Usual Source of Care (2012-2021)



Data Source: Milbank Memorial Fund analyses of Medical Expenditure Panel Survey data, 2012-2021.[3]

About 76 million Americans live in Health Resources and Services Administration-designated primary workforce shortage areas (HRSA, 2024). Another way of measuring equitable primary care access is measuring the number of primary care physicians per 100,000 population in medically underserved areas (MUAs). An MUA is an area designated by HRSA as having too few primary care providers, high infant mortality, high poverty levels, or a large elderly population. As of 2020, there were approximately 55.8 primary care providers per 100,000 people in MUAs, well below the rate of 79.7 primary care physicians per 100,000 in areas that are not MUAs (Milbank Memorial Fund, and the Physicians Foundation, 2023).

[3] **Notes:** Usual source of care (USC) ascertained whether that is a particular doctor's office, clinic, health center, or other place where the individual usually goes when sick or in need of health advice. No usual source of care includes those who reported no usual source of care and those who indicated the emergency department as their usual source of care.

Primary care spending and payment models

Nationwide spending on primary care represents a small percentage of total health care expenditures and has been trending downward. A Milbank Memorial Fund analysis of health care spending from 2012 to 2021 found that primary care's portion of total health care expenditures decreased from 5.4% to 4.7% (Milbank Memorial Fund, 2024). At the payer level, the percentage of total health care expenditures dedicated to primary care by commercial payers and Medicaid decreased over this time period, while Medicare's investment in primary care as a percentage of total health care expenditures was stagnant. This pattern reflects both changes in levels of primary care investment as well as the rapid rate of growth in non-primary care spending.

Figure 3.2: Primary Care as a Percentage of Total Health Care Expenditures (2012-2021)

Data Source: Milbank Memorial Fund Analyses of Medical Expenditure Panel Survey data, 2012-2021[4]

Primary care nationwide has also been slow to adopt value-based payment (VBP), despite evidence that practices receiving VBP are more likely to engage in efforts to improve care. Although VBP models have become more common across the U.S. health care system (increasing from 30% to 40% of payments between 2016 and 2021), research suggests that primary care providers continue to be paid largely through fee-for-service (FFS) models (Health Care Payment Learning and Action Network, 2022; Horstman & Lewis, 2023). The Commonwealth Fund's 2022 survey of 1,000 U.S. primary care physicians found that 71% of respondents reported receiving any FFS payments, while only 46% reported receiving revenue from shared savings (with upside or downside risk), capitation, or population-based payment models (Horstman & Lewis, 2023). Larger practices, those part of integrated health systems and those in suburban or urban areas were more likely to report receiving revenue from these VBP models (Horstman & Lewis, 2023).

[4] **Notes:** The definition of primary care is restricted to care delivered by primary care physicians in the following specialties: family medicine, general practices, internal medicine, geriatrics, pediatrics, and osteopathy.

Physician reimbursement and salaries

Primary care physicians receive lower reimbursement rates than specialists. This has been facilitated by the way the reimbursement system is structured, which contributes to undervaluation of services. Physician reimbursement is based on relative value units (RVUs) that are applied to each service delivered. Primary care physicians typically focus on delivering cognitive services, which typically involve evaluating, diagnosing, and managing a patient's condition through history-taking, physical examinations, decision-making, and care coordination. The RVU system tends to assign higher values to procedural services (e.g., surgery, injections, biopsies) which are more often performed by specialists. However, the Centers for Medicare & Medicaid Services (CMS) has taken two recent actions to address this under-reimbursement for primary care:

- CMS recently finalized increases to the RVUs used to reimburse Medicare cognitive work in ambulatory care. Beginning in 2024, providers can now bill for the G2211 add-on code, which is designed to capture the complexity and cognitive intensity of office and outpatient evaluation and management services (CMS, 2023b). This add-on code was originally scheduled for implementation in 2021 but was delayed by Congress. From 2024 onwards, providers can bill for G2211 separately when they are the focal point for all of a patient's health care needs, which is expected to better recognize the value of longitudinal care, especially in primary care settings. This adjustment addresses concerns that cognitive work had been undercompensated compared to procedural services.
- CMS' proposed Medicare Fee Schedule for 2025 introduces "Advanced Primary Care Management" (APCM) codes, aimed at strengthening primary care (CMS, 2024c). These codes bundle services such as 24/7 access, care management, care coordination, and ongoing communication, which previously had to be billed separately. Providers can bill for these services based on the number of chronic conditions a patient has, with monthly reimbursement ranging from $10 to $110. This approach attempts to address long-standing issues in the fee-for-service model, which has under-reimbursed primary care, especially for work done outside of traditional office visits.

In terms of starting salary, primary care physicians often earn lower incomes than specialists. Average salary offers for primary care including internists, family medicine physicians, and pediatricians rank at the bottom of medical specialties (see Figure 3.3). For context, it is important to note that the average medical school debt is $202,453, excluding premedical undergraduate and other educational debt (Hanson, 2023).

Figure 3.3 Starting Salary Offers by Medical Specialty (2020-2021 and 2021-2022)

Medical Specialty	2020/2021 Average Salary Offer	2021/2022 Average Salary Offer	Year over Year Change
1. Orthopedic Surgeon	$546,000	$565,000	3%
2. Cardiologist (Interventional)	$611,000	$527,000	-16%
3. Urologist	$497,000	$510,000	3%
4. Gastroenterologist	$453,000 **	$486,000	7%
Cardiologist (Non-invasive); counted with #2 above	$446,000	$484,000	8%
5. Radiologist	$401,000	$455,000	12%
6. Pulmonologist/Critical Care	$385,000	$412,000	6%
7. Hematologist/Oncologist	$385,000	$404,000	5%
8. Anesthesiologist	$367,000	$400,000	8%
9. Dermatologist	$378,000	$368,000	-3%
10. Oral Maxillofacial Surgeon	NA*	$368,000	NA*
11. Neurologist	$332,000	$356,000	7%
12. Obstetrician-Gynecologist	$291,000	$332,000	14%
13. Psychiatrist	$279,000	$299,000	7%
14. Hospitalist	NA*	$284,000	NA*
15. Rheumatologist	NA*	$258,000	NA*
16. Internal Medicine (Internist)	$244,000	$255,000	5%
17. Family Medicine Physician	$243,000	$251,000	3%
18. Pediatrician	$236,000	$232,000	-2%
19. Certified Registered Nurse Anesthetist	$222,000	$211,000	-5%
20. Nurse Practitioner	$140,000	$138,000	-1%

*NA – This specialty was not among the top 20 in demand for the assessed year; average salary offers are not available.

Practice Organization

Nationally, physician practice arrangements have shifted away from private practice and towards larger, employed practices. Between 2012 and 2022, the American Medical Association (AMA) reported that the share of physicians who work in practices wholly owned by physicians (i.e., private practices) dropped by 13 percentage points from 60.1% to 46.7% (Kane, 2023). The AMA reported that practice size has also changed, with a continued redistribution of physicians from small to large practices. The percentage of physicians in practices with 10 or fewer physicians fell from 61.4% in 2012 to 51.8% in 2022 (Kane, 2023). In comparison, the percentage of physicians in practices with 50 or more physicians grew from 12.2% to 18.3% (Kane, 2023). There have also been changes in practice type. Forty-two percent of physicians worked in single specialty practices and 26.7% in multi-specialty practices in 2022, reflecting a shift of about four percentage

points since 2012 from the former practice type to the latter (Kane, 2023). While this data encompasses physicians across all specialties, it highlights trends that also impact primary care.

Patient Centered Medical Home (PCMH) adoption

Starting in 2007, primary care began receiving heightened national health policy attention, driven in large part by the emergence of the PCMH model. Rhode Island was at the forefront of this movement, with the state actively promoting and implementing the PCMH model as a way to promote team-based, coordinated care with a focus on quality and cost containment. The PCMH model quickly gained national recognition, leading to broader adoption (The National Committee for Quality Assurance [NCQA] (2024) reports that 25 public sector medical home initiatives across 22 states require or incentivize NCQA's PCMH Recognition). However, in the years that followed, attention began to shift towards other models, most notably Accountable Care Organizations (ACOs) and total cost of care (TCOC) models. This shift reflects the evolving understanding that while primary care is essential, a comprehensive approach that considers the entire health care system is necessary to improve quality and control costs.

Centers for Medicare & Medicaid Services (CMS) Initiatives

The federal government has led multiple efforts to support value-based primary care payment models and enhanced care delivery.

- CMS' Comprehensive Primary Care (CPC) Model and the subsequent Comprehensive Primary Care Plus (CPC+) Model included prospective care management fees and the opportunity to earn shared savings or payments for performance in addition to usual payment. Thirty-five Rhode Island practices participated in CPC+, which ran from 2017 through 2021 (CMS, 2023a).
- CMS' Primary Care First (PCF) model includes two cohorts of participating practices (Cohort 1 began in 2021 and Cohort 2 began in 2022) each with a five-year performance period. Under PCF, practices must meet quality standards in order to be eligible for a performance-based adjustment to their primary care model payments. Thirty-five Rhode Island practices are participating in PCF (CMS, 2024a).
- CMS announced a new voluntary primary care model in June 2023 – the Making Care Primary (MCP) model – that builds upon the CPC, CPC+, and PCF models (CMS, 2024d). The MCP model is a 10.5-year multi-payer model that aims to help primary care physicians gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration and drive equitable access to care (CMS, 2024d). CMS selected eight states to participate in the MCP model (Rhode Island is not one of these states).[5]
- CMS announced a new 10-year, voluntary, state TCOC model in September 2023 – the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model – which includes a primary care component. Primary Care AHEAD will align with ongoing Medicaid transformation efforts within each participating state and primary care practices participating in the model will

[5] The eight states are Colorado, North Carolina, New Jersey, New Mexico, New York, Minnesota, Massachusetts, and Washington.

receive a Medicare care management fee to meet transformation requirements for person-centered care (CMS, 2024b). Rhode Island was selected to be a participant in the third cohort AHEAD model, starting on January 1, 2027.

Statewide Landscape

Structure and Distribution of Services

The majority of Rhode Island primary care practices are affiliated with an ACO or Accountable Entity (AE). Of the 182 practices that the Office of the Health Insurance Commissioner (OHIC) assessed for PCMH recognition in 2022, 32% were affiliated with Integra Community Care Network, 19% were affiliated with Prospect CharterCARE, and 18% were affiliated with Brown University Health (known as Lifespan at the time). The remaining 24% of ACO/AE-affiliated practices were associated with Brown Health Medical Group Primary Care, Integrated Healthcare Partners, Providence Community Health Centers, or Thundermist Health Center. Only 8% of submitting practices were not affiliated with an ACO or AE. Of note, Coastal Medical (previously Rhode Island's largest independent primary care group) was acquired by Lifespan) in 2021.

OHIC's PCMH data also suggest that the majority of Rhode Island primary care practices are small (five or fewer clinicians), and the majority of Rhode Island clinicians work in small or mid-sized practices. OHIC collects practices' Physician National Provider Identifier (NPI) numbers (reflecting MDs, DOs, PAs, and NPs) as a part of its PCMH recognition assessment. In 2022, 75% of practices that OHIC assessed for PCMH recognition had five or fewer clinicians, 19% had between six and ten clinicians, and only 6% of practices had more than 10 clinicians (see Figure 3.4). Forty-two percent of clinicians worked in practices with five or fewer other clinicians, 33% of clinicians worked in practices with between six and 10 other clinicians and 26% of clinicians worked in practices with more than 10 other clinicians (see Figure 3.4). OHIC analysis in prior years indicated that those Rhode Island practices that do not seek PCMH recognition are all small, indicating that the percentage of practices that are small and the percentage of clinicians that work in small practices are even higher than 75% and 42%, respectively.

Figure 3.4. Estimated Rhode Island Practices and Clinicians by Practice Size

Practice Size	Estimated Percentage of Practices by Size	Estimated Percentage of Clinicians by Practice Size
Small Practice (1-5 PCPs)	75 percent	42 percent
Mid-Sized Practice (6-10 PCPs)	19 percent	33 percent
Large Practice (>10 PCPs)	6 percent	26 percent

Data Source: OHIC analysis of 2021-2022 PCMH practice data.

Discussion of Capacity, Unmet Need, and Workforce Shortages

Provider counts suggest that Rhode Island may be doing better than the rest of the country in terms of its primary care workforce. According to CMS' National Plan and Provider Enumeration System, as of October 2024 Rhode Island ranked fourth out of all states in the U.S. in terms of number of active primary care providers, with 301.5 active primary care providers per 100,000 population (defined broadly to include licensed general practice, family practice, obstetrics and gynecology, pediatrics, geriatrics, internal medicine, physician assistants and nurse practitioners) per 100,000 population, compared to 232 nationwide (America's Health Rankings, 2023). A Milbank Memorial Fund analysis found that, in 2021, Rhode Island had 134 primary care clinicians per 100,000 population (restricted to clinicians practicing family medicine, general practices, internal medicine, geriatrics, pediatrics, and osteopathy and including estimates of nurse practitioners and physician assistants working in primary care), compared to 106 nationwide (Milbank Memorial Fund, 2024).

However, these provider counts possess one notable limitation – one provider may not represent one full time equivalent, as some providers practice part-time. A recent Brown University analysis of 2022-2023 data from Rhode Island's All-Payer Claims Database (APCD) found that when counting full time equivalents (FTE) primary care providers, the actual number of full-time primary care physicians in Rhode Island was cut in half. The same trend held true for NPs and PAs practicing primary care in Rhode Island. This finding suggests that published provider counts dramatically overestimate primary care capacity in Rhode Island, because many primary care providers are not working full-time and are not serving full patient panels.

Furthermore, data published in the past decade offer further insights into Rhode Island's primary care workforce shortages. In 2019 alone, Rhode Island experienced a net loss of 14 primary care physicians per 100,000 population, or 4% of its primary care physician population (Primary Care Collaborative, 2023). Rhode Island is expected to have a deficit of almost 100 primary care providers by 2030 (Care Transformation Collaborative of Rhode Island [CTC-RI], 2023). As of 2018, about 44% of Rhode Island family physicians were over the age of 55 and nearing retirement age (Petterson et al., 2018). Rhode Island is also losing the new physicians it trains to other states. There are two family medicine residency training programs in Rhode Island. Between 2011 and 2017, Rhode Island produced a total of 87 family physicians from its two, family medicine residency training programs; of these, 38 (44%) stayed in-state (Petterson et al., 2018). During this time period, the loss of state-trained family physicians was partially offset by the in-migration of 26 family physicians trained in other states (Petterson et al., 2018). Finally, statements from primary care providers in the press and in stakeholder interviews (summarized later in this chapter) paint a picture of a primary care workforce that is stretched thin and is unable to provide care to all the patients who need it, particularly new patients (Russo, 2023).

Notwithstanding the aforementioned Brown University analysis of the APCD data, we note that there is no consistent and comprehensive data source on the Rhode Island primary care workforce, making it difficult to assess the current state of primary care workforce shortages. Such a resource would promote better understanding and would allow for tracking the impact of strategies to strengthen the workforce.

In terms of access, Rhode Islanders may have more equitable access to primary care than other states. A Milbank Memorial Fund analysis found that in 2021, Rhode Island had 155 providers per 100,000 people in areas with high Social Deprivation Index (SDI) areas, which is above the nationwide figure of 112 providers per 100,000 people in areas with high SDI (Milbank Memorial Fund, 2024). Rhode Island had lower rates of adults without a usual source of care than the U.S. In 2022, 11% of Rhode Island adults reported not having a personal health care provider, compared to 16% of adults nationally (https://healthinri.com/data/adults-without-a-usual-source-of-care). However, disparities exist among Rhode Island adults by race, ethnicity, education, and socioeconomic status. For example, in 2022, 24% of Hispanic adults, 13% of Black adults, 19% of adults in the lowest income bracket, and 21% of adults without a high school degree reported not having a usual source of care (compared to 8% among White adults, 6% among adults in the highest income bracket and 9% among adults with some post-high school education) (https://healthinri.com/data/adults-without-a-usual-source-of-care). This suggests that Rhode Island still has an opportunity to address inequities in primary care access.

Other Key Themes from Services Providers, Community Members, and Other Stakeholders

The HCSP Cabinet considered stakeholder input and perspectives on the state of primary care in Rhode Island. In 2023, OHIC conducted a series of semi-structured interviews with providers, payers, and patient advocates about Rhode Island's primary care system. The HCSP Primary Care Workgroup offered additional input on the main challenges and opportunities facing primary care in Rhode Island during the workgroup process. The themes that emerged from these conversations are summarized below, organized by stakeholder group.

Provider Perspective

Workforce Workforce challenges were the chief concern described by primary care practices. Physicians were concerned about the lack of urgency or even dialogue about the primary care physician shortage. Interviewees cited examples of at-risk patients who were unable to access primary care, and the health consequences to them of not doing so. Others described an "existential threat" to primary care and predicted a full crisis within five years without significant action. Specific workforce challenges cited were:

- More primary care physicians are retiring than are being replaced.
- Workforce shortages create burnout, which then leads to further shortages.
- Pay for primary care is non-competitive, both compared to other medical specialties and to primary care pay in other states.
- Workforce shortages are not only a problem for physicians, but for advanced practitioners and medical assistants too.
- Rhode Island is not retaining the physicians who train in the state.
- Workforce shortages are a barrier to delivery of team-based care.

Payment Models Practices cited two discrete difficulties relating to insurer payment models. A subset of interviewees felt that lack of adoption of primary care capitation was problematic because capitation provides practices with financial flexibility to reconfigure their practice teams, support team-based care and to increase primary care physician compensation. Practices identified one commercial payer (Blue Cross &

Blue Shield of Rhode Island) and Medicare as the only payers presently offering primary care capitation in Rhode Island. Other interviewees stated that the delayed distribution of ACO shared savings payments was problematic because payments were made up to a year after the performance period ended, and the amounts were unpredictable. One practice explained that the latter impeded its practice from making investments in innovative processes to improve care delivery. More recent conversations with practice organizations in late 2024 emphasized the problem of unpredictable shared savings payments, as many ACOs failed to achieve 2023 shared savings in commercial and Medicare Advantage contracts, leaving the ACOs without funds to support their care management infrastructure and to fund primary care clinician bonus payments.

Prior Authorization Insurer prior authorization was described as “an annoyance” by one physician, and more harshly by other interviewees. Practices reported that the burden, while not new, has worsened over time and, in some instances, is a barrier to delivering efficient and effective patient care. Multiple practices were grateful for OHIC’s recent work on prior authorization through its Administrative Simplification Task Force but at least one practice did not think OHIC’s current work went far enough to address the issue.

Electronic Health Record Documentation Demands Physicians expressed a common concern that Electronic Health Records (EHRs) have led to a shift in their roles, with one physician characterizing primary care providers as "clerks/typists" due to the extensive data entry and navigation requirements. Furthermore, providers were notably bothered by the substantial uncompensated time needed to respond to patient portal messages within the EHR, which can increase workload and stress. While acknowledging the necessity of digitized health records, providers emphasized the ongoing need to optimize these systems to better align with their workflow and patient-care responsibilities.

Lack of Specialist Engagement Several interviewees expressed concerns regarding the role of specialists, particularly in the context of health care spending growth and the success of the ACO model. They pointed out that specialist services often come at a higher cost, and the extensive use of specialized procedures and treatments can significantly contribute to the overall increase in health care expenditures. Providers also noted that many specialists appeared to lack a genuine interest or financial incentive to collaborate and coordinate effectively with primary care practices on patient care or cost reduction.

Payer Perspective

Workforce Challenges The insurers recognized the workforce shortage in primary care. The insurers emphasized what they saw as the pivotal role that VBP models and team-based care can play in addressing these workforce shortages. Moreover, the insurers highlighted the need to incentivize providers to adopt VBP models by linking them to infrastructure improvements, technology integration, and competitive compensation, especially for recruiting new physicians. One insurer shared how it monitors stinting measures to ensure that patient panels are not being expanded at the expense of patient care. Overall, the insurers expressed a commitment to working collaboratively with primary care practices to help them navigate the evolving health care landscape and ensure that workforce challenges are effectively addressed to provide quality care to patients.

Payment Models Insurers shared that primary care capitation, which providers used to regard with reluctance, has gained support from providers, particularly large practice groups. One insurer shared that it has made progress on primary care capitation in the commercial market, however, less so than in the Medicare Advantage market. An insurer suggested bringing transparency to shared savings payments to ensure primary care providers are seeing the rewards of their performance, ideally through salary support to assist with the current workforce challenges.

Prior Authorization Insurers either did not raise prior authorization as a challenge facing primary care providers or expressed a more positive perspective of prior authorization processes than the primary care physician interviewees. One insurer described its proactive approach to addressing prior authorization challenges, monitoring denials, and providing targeted outreach to resolve issues when specific offices face high denial rates. The insurers viewed OHIC and CTC-RI's prior authorization initiatives favorably. Since the time of these interviews, one insurer reported removing prior authorizations requirements for primary care practices.

Technology Challenges The insurer interviewees recognized the substantial technology challenges that many primary care providers are facing. The insurers acknowledged that not all providers are equally equipped or comfortable with capturing and transmitting data electronically, especially small independent providers, which is a burden that needs to be overcome if these providers are to participate in VBP. The insurers emphasized the need for continued support and resources to help practices overcome these technology-related obstacles and ensure they can adapt to the evolving health care landscape.

Consumer Advocate Perspective

OHIC interviewed two representatives from a consumer advocacy organization that serves a broad range of Rhode Islanders, who highlighted several challenges and opportunities for primary care in Rhode Island:

- Timely access to primary care is increasingly difficult for consumers, especially for consumers on Medicaid and patients who are non-English speaking.
- Fragmented care is a concern, especially for children with special needs receiving care across state borders and patients seeking behavioral health care.
- If finalized, CMS' proposed rule to allow providers to bill Medicare for community health integration services conducted by community health workers may have a positive impact on Rhode Island Medicaid and commercial primary care payment in the future.
- Rhode Island would benefit from an additional medical school to produce primary care physicians.

The HCSP process intends to include additional health care public engagement, which will provide additional consumer input and perspectives about primary care access and disparities in case.

Alignment of Cross-Cutting Issues Across the Health Care Sectors

Each HCSP workgroup has identified how the cross-cutting issues described in the introduction of this report have arisen as priorities to address in the Workgroup's recommendations. We have addressed the issues in the primary care sector description above. In this section of the Primary Care chapter, we recap the most important connections between the cross-cutting issues and the primary care sector – and how the ongoing planning process should continue to explore these connections.

Workforce

While all sector chapters addressed workforce challenges, the provider stakeholder community declared workforce issues to be a critical top priority. Their perspective was that for the HCSP planning process to be successful, the state must urgently address the needs in this area.

Data Monitoring, Oversight, and On-going Assessment and Surveillance Structures/Systems

Creating an aligned data hub is an overarching recommendation of this report. Most critically for the primary care sector is the fact that, as noted above, there is no consistent and comprehensive data source on the Rhode Island primary care workforce, making it difficult to assess and target primary care workforce shortages, and to evaluate the effectiveness of interventions to solve them. To be successful, the proposed data hub must address these specific needs.

Value-based Payment (VBP) Models

In Rhode Island, the transition toward VBP models has been slow, with some efforts to move away from FFS payment. However, primary care practices have more experience with VBP than some other sectors reflected in this report. For instance, some practices are adopting primary care capitation in commercial contracts with at least one commercial insurer, which provides a more predictable revenue stream and supports team-based care. Rhode Island primary care practices have also participated in CMS' primary care VBP demonstrations for Medicare (e.g., Primary Care First). However, despite these developments, FFS payment methods still dominate, and not all practices are fully integrated into value-based care arrangements.

It will be important for the HCSP process to help determine the extent to which Rhode Island wants to continue moving toward more significant adoption of VBC. As an example, the state is gradually working toward increased use of alternative payment models (APMs) in primary care. Of note, for its most recent Medicaid managed care procurement, the state updated its model contract to explicitly require MCOs to collaborate with the state and its contractors to design and implement a primary care capitation APM. EOHHS further reserved the right to implement primary care capitation during the term of the Model Contract, requiring MCOs to agree to implementation timeframes established by EOHHS. The implementation of these new requirements has been delayed, however, by a challenge to the procurement outcome.

Health Information Technology and Exchange

Health Information Technology (HIT) plays a critical role in Rhode Island's primary care infrastructure, though there are varying levels of adoption across practices. Larger systems and hospital-affiliated practices tend to have more advanced EHR systems and better access to data exchange platforms, while smaller, independent practices may face challenges with full integration. HIT is essential for enabling coordinated care and participating in value-based care models, yet the resources required for full adoption can be a barrier, particularly for smaller providers. And there are challenges for primary care practices to communicate with other entities, including social service providers, for coordination of care.

Rhode Island has invested in several initiatives to support the adoption and use of HIT across primary care practices. One key resource is CurrentCare, Rhode Island's statewide health information exchange (HIE). Managed by the Rhode Island Quality Institute (RIQI), CurrentCare enables providers to securely share patient health information across systems, improving care coordination and reducing duplication of services. Primary care providers connected to CurrentCare can access critical patient data, such as lab results, medication history, and hospital discharge summaries, enabling them to deliver more informed and efficient care.

CTC-RI also provides technical assistance and resources to help primary care practices, particularly smaller and independent practices, adopt HIT and implement quality improvement strategies. Through CTC-RI, practices receive support for integrating EHR systems, enhancing data analytics capabilities, and improving care coordination through better use of HIT.

Despite these resources, disparities in technology adoption persist, particularly among smaller practices that may lack the financial and technical capacity to fully integrate EHR systems or participate in statewide health information exchanges. To be successful, the HCSP process should continue to explore what changes in HIT adoption are necessary to help the primary care sector accomplish the goals that are set out in the Workgroup recommendations.

Health Equity

As mentioned above, disparities in access to primary care exist among Rhode Island adults by race, ethnicity, education, and socioeconomic status. In 2022, 24% of Hispanic adults, 19% of adults in the lowest income bracket, and 21% of adults without a high school degree reported not having a usual source of care. These figures compare to eight percent among White adults, 6% among adults in the highest income bracket, and 9% among adults with some post-high school education) (Rhode Island Foundation, n.d.). This suggests that Rhode Island still has an opportunity to address inequities in primary care access.

Rhode Island's primary care workforce does not reflect the racial and ethnic diversity of its population. Having providers of the same race and ethnicity as patients is vital for fostering trust, improving communication, and delivering culturally competent care. Studies consistently demonstrate that racial and ethnic concordance between patients and providers enhances patient satisfaction, increases the likelihood of shared decision-making, and improves adherence to treatment plans (Alsan et al., 2019; Ojikutu et al., 2020). While comprehensive data on the racial and ethnic composition of Rhode Island's primary care providers are lacking, a recent report to the state legislature found notable disparities (Rhode Island Primary Care Physicians Advisory Committee, 2024). Only 12% of licensed family practice physicians in Rhode Island

are Black or Hispanic, compared to 31% of the state's population. Similarly, just 10% of licensed internal medicine physicians and pediatricians are Black or Hispanic. Among primary care providers, the most diverse group is licensed family and individual across the lifespan APRNs/nurse practitioners, of whom 15% identify as Black or Hispanic, still far below the state's population proportion. Addressing these gaps is critical to ensuring equitable access to culturally responsive care.

Disparities exist in Rhode Island's primary care quality measures across different racial and ethnic groups. In 2022, breast cancer screening rates in Rhode Island showed that 84% of White women received mammograms, compared to 80% of Black women and 77% of Hispanic women (America's Health Rankings, 2022a). For colorectal cancer screening, 68% of White populations were screened, 74% of Black populations, and only 57% of Hispanic populations, highlighting a substantial gap for Hispanic individuals (America's Health Rankings, 2022b). Additionally, cervical cancer screening rates in 2022 were 60% for White women but significantly lower at 34% for Hispanic women (America's Health Rankings, 2020). These disparities emphasize the importance of culturally competent care and the implementation of strategies to enhance access to quality health care services for all racial and ethnic groups in Rhode Island.

These disparities in primary care access, provider demographics, and quality measure performance underscore the need for targeted intervention to improve access to primary care for all Rhode Islanders, increase representation of minorities in primary care provider roles, and reduce disparities in quality of care in primary care settings.

Primary Care Core Recommendations and Action Steps

The Health Care System Planning Cabinet recommends the following medium and long-term actions to strengthen Rhode Island's vulnerable primary care infrastructure.

Payment and Investment

1. Ensure primary care practices provide and are appropriately paid for coordinated, comprehensive team-based primary care. Action steps include:
    a. Ensure the Medicaid primary care Alternative Payment Model required under the AHEAD Model is adequately funded.
    b. Increase aligned multi-payer primary care capitation opportunities that support team-based care and simplify administrative burden. Payers should provide practices with technical support to facilitate the transition to capitation.
    c. Conduct an analysis of the costs of effective team-based primary care.

Primary Care Practice Support and Workforce Retention

2. Reduce administrative burdens on primary care providers. Action steps include:

   a. Require health plans to reduce prior authorization volume through OHIC regulation and other means.

   b. Simplify and automate EHR documentation requirements whenever possible.

   c. Increase investments in health information technology to facilitate the provision of high-quality primary care, through engagement with, but not limited to, the EOHHS HIT Steering Committee.

3. Reduce the health education debt of primary care providers, including nurse practitioner and physician assistant students. Action steps include:

   a. Offer free tuition or scholarships to students who commit to 6-8 years of primary care practice in the state of Rhode Island.

   b. Invest state funds in the Rhode Island Health Professional Loan Repayment Program.

   c. Clarify and better coordinate provision of information about applying for state and federal scholarships, loan forgiveness, and loan repayment programs.

Workforce Recruitment

4. Establish a “Work in Rhode Island” program that gathers insights on current barriers and facilitators to practicing primary care in Rhode Island and designs support and marketing initiatives. Action steps include:

   a. Conduct surveys of current primary care providers, with a focus on people of color, to better understand their experience and what would increase the likelihood they will stay in Rhode Island. Identify actions that could be taken to address survey findings, if not already being addressed.

   b. Emphasize recruitment of people who reflect the communities served. This includes people from the underrepresented in medicine group, including but not limited to multilingual providers, people with lived experience, and people who identify as LGBTQ.

   c. Establish a “Work in Rhode Island” marketing campaign focused on graduating primary care NPs, PAs, and medical residents.

   d. Work with high schools and CTE programs to increase interest in and preparedness to work in primary care.

5. Increase the number of individuals who train in primary care in Rhode Island and then continue to work in primary care in Rhode Island. Action steps include:

   a. Identify how Graduate Medical Education can better target primary care.

   b. Work with training institutions to establish primary care tracks, enhance existing primary care programs, and foster commitments to workforce training and development.

   c. Identify and increase the number of primary care practices serving as training sites for medical students and residents, nurse practitioners and physician assistants.

   d. Train residents in clinic settings that utilize advanced primary care constructs, such as care coordination and population health management.

e. Convene leadership and program directors for primary care training programs to collaborate on primary care workforce development and enhancement of the student experience.

Integration

6. Invest in the advancement and implementation of primary care that is coordinated across providers (specialists, hospitals, long-term care) and is closely integrated with, but not limited to, behavioral health, oral health, health related social needs, and public health. Action steps include:

a. Incentivize the implementation activities that increase the integration of oral health and primary care. Examples of activities could include:

i. Increase oral health screening and fluoride varnish application in primary care practices

ii. Facilitate interoperability between primary care and oral health through CurrentCare or Electronic Health Record (EHR) integration

iii. Use emerging technologies, such as telehealth and teledentistry, to coordinate care, manage complex patients, and close referral loops.

iv. Support co-location of care (i.e., payment of public health dental hygienist (PHDH) services in medical and community-based settings.)

v. Engage primary care practices to integrate oral health competencies and capabilities as well as promote improving communication between dental and primary care teams

b. Support PCMH practices to achieve NCQA Distinction in Behavioral Health Integration.

c. Incentivize primary care practices to assess and incorporate health related social needs into patient care plans and refer to social services resources, when available.

Monitoring and Accountability

7. Collect, analyze, monitor, and report on data points describing the state of Rhode Island's primary care system and evaluate the impact and effectiveness of current and future programs and initiatives. Any additional activity the State takes on this recommendation should not increase administrative burdens on primary care clinicians in any way. Action steps include:

a. Establish and publicize a Primary Care Dashboard that tracks:

i. Current workforce (e.g., number of current primary care providers, level of clinical activity/FTEs, size of patient panels), with benchmarks from other states whenever possible

ii. Future workforce (e.g., number of trainees graduating from a Rhode Island institution of higher education)

iii. Patient experience accessing primary care (e.g., percent of adults reporting a usual source of care)

iv. Primary care quality of care metrics

Short-Term Recommendations Focused on Current Funding Crisis

In late 2024, Rhode Island primary care organizations are struggling financially, including but not limited to poor ACO financial performance in 2023 and lack of public and private payer funding directed towards care

management infrastructure. The following short-term recommendations are focused on the current funding crisis facing some primary care organizations.

1. Oversight/Organization

- Convene stakeholders (OHIC, Medicaid, payers, health systems, primary care providers, and the Rhode Island Foundation) to address financial threats and explore support mechanisms like loans, pre-payments, grants, and services provision.
- Meet with legislative leaders to propose a Primary Care Stabilization package addressing urgent needs.

2. Financial Stabilization

- Provide prepayments based on past revenue and guaranteed infrastructure payments for primary care providers, including Medicaid-supported joint funding with health plans.
- Educate practices on new Medicare codes (effective January 2025) offering higher payments for chronic care management.
- Ensure Medicare and Primary Care First practices leverage available codes for financial relief and encourage commercial payers to adopt similar approaches.

3. Teaching Health Center Graduate Medical Education (THC GME)

- Protect accredited THC residency programs, leveraging HRSA funding and additional short-term financial support.

4. Burden Relief

- Convene stakeholders to implement efficient pharmaceutical therapeutic substitutions and streamline approval processes.

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Chapter 4: Oral Health

Definition, Role, and Importance of the Oral Health Sector

The dental and oral health care sectors play critical roles in supporting oral health, with oral health playing a critical role in overall health and quality of life, as noted by the World Health Organization (2022):

> *Oral health is the state of the mouth, teeth, and orofacial structures that enables individuals to perform essential functions, such as eating, breathing, and speaking, and encompasses psychosocial dimensions, such as self-confidence, well-being, and the ability to socialize and work without pain, discomfort, and embarrassment. Oral health varies over the life course from early life to old age, is integral to general health and supports individuals in participating in society and achieving their potential.*

Dental services are those provided in a dental office or clinic, which may be located in a community private practice, a hospital, health center, or other location, with trained dental professionals. Oral health services take a broader approach, addressing prevention, education, and the connection between oral and overall health, often provided in primary care and public health settings. Dental services are thus a subset of oral health services, with the latter encompassing both individual care and community health strategies. A great deal of oral health services provided in the primary care settings and there is an increasing appreciation for the importance of integrating oral health into primary care as a way of promoting greater efficiency and a more holistic approach to care. The oral health services provided in the primary care setting range from preventive services for young children, such as oral health education and fluoride varnish, to oral health screenings and assessments for adults, to oral comfort services by nurses for those in palliative care.

Having a robust and functional dental care system for restoring, replacing, moving, and removing teeth or for oral health procedures, such and addressing periodontal conditions, will always be critical. These clinical activities require clinicians with a special set of skills, equipment, and settings to assure care is safe and of high quality. Certainly, dental care professionals are central to this work, and to Rhode Islanders' ability to work, learn, and thrive. Nonetheless, there is broad agreement for the important role that primary care practices can play to expand access to oral health services more broadly.

The 2021 report *Oral Health in America: Advances and Challenges* from the National Institutes of Health identified critical challenges when there is lack of access to regular dental care (National Institute of Dental and Craniofacial Research, 2021).

- Lack of access to regular dental care can result in ineffective and expensive overuse of hospital emergency departments (EDs)—which can have a negative impact on the economy.
- The largest burden of disease occurs among marginalized groups, including those living in poverty, racial and ethnic minorities, frail elderly, immigrant populations, those with special health care needs, and others. All of these groups suffer higher burdens of oral disease and may face numerous barriers to accessing routine preventive and other dental services.

National and Statewide Driving Forces, Trends, and Innovations

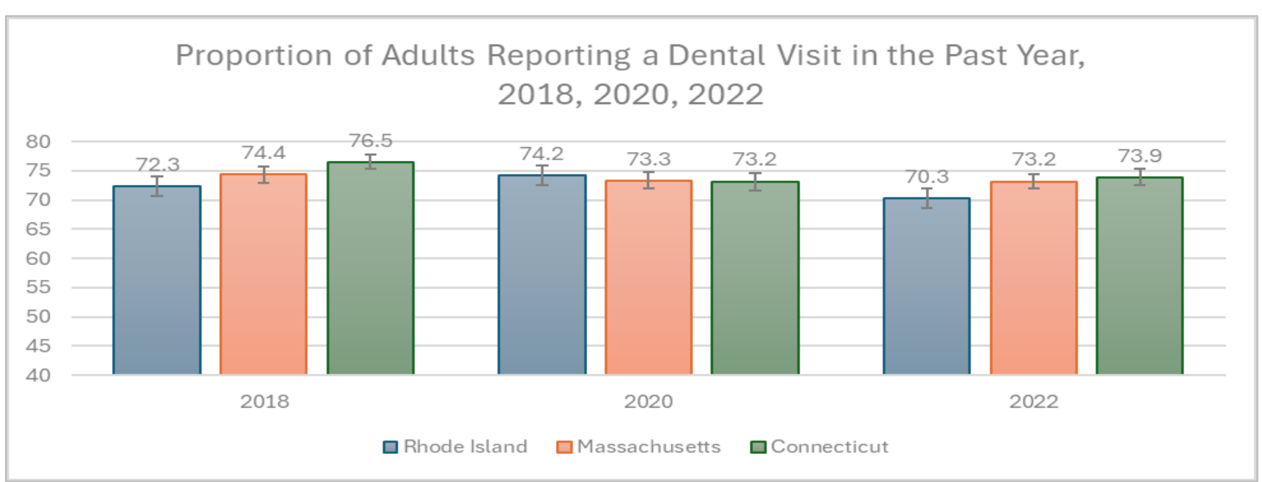
Dental care in the U.S. has experienced noteworthy trends in areas such as workforce, access, payment, and practice organization. This Chapter details these changes using the most recent available data and literature. A review of national trends helps contextualize current experience in Rhode Island.

Access to care – Adults

With improvement in dental coverage for children in Medicaid through the Affordable Care Act, the proportion of children with a dental visit has increased and the disparities by race and ethnicity have decreased. While some improvement is seen for seniors, adults nationally have lower use of services with greater disparities (Health Policy Institute & American Dental Association).

In Rhode Island, data are available for adults from the Behavioral Risk Factor Surveillance Survey (BRFSS) on use of dental services. While numbers tend to be higher as they are self-reported, they do allow comparisons across states and by key factors.

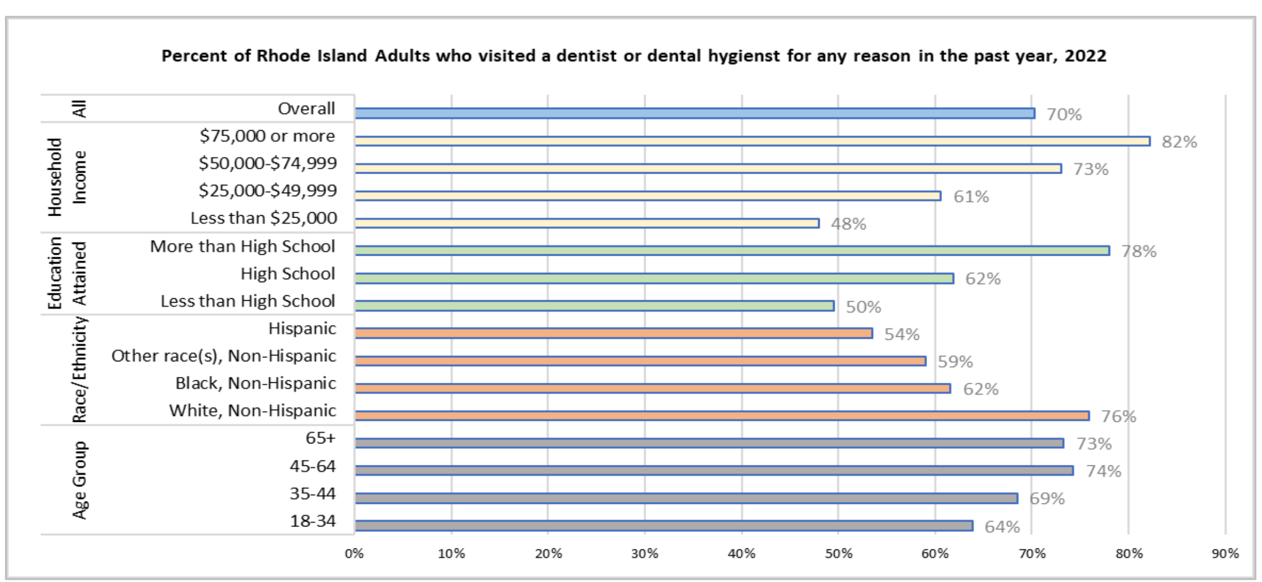
Figure 4.1: Rhode Island compared to neighboring state in use of dental services. Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data.



Rhode Island reported lower rates of adults with dental care than neighboring states in 2018 and 2022. Over 3% more adults in Massachusetts and Connecticut had dental visits compared to Rhode Island (Centers for Disease Control and Prevention).

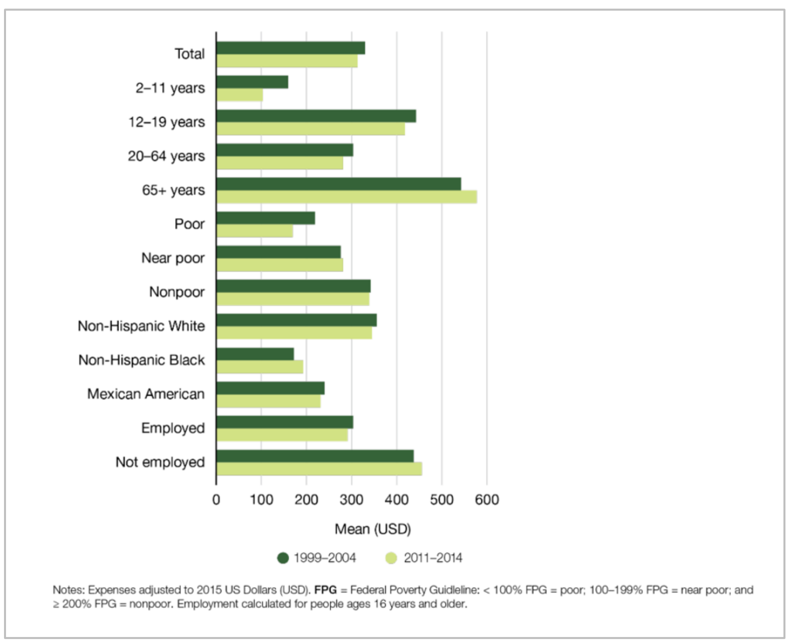
The disparities in Rhode Island adult dental visits are noted in the chart below by household income, education, and race/ethnicity (Centers for Disease Control and Prevention).

Figure *4.2: Disparities in use of dental services, 2022. Rhode Island Behavioral Risk Factor Surveillance Survey*



Nationally, in 2022, out of pocket dental expenses per person were estimated at over $300, according to the Agency for Healthcare Research and Quality (Agency for Healthcare Research and Quality). This amount has decreased for many groups, except those over 65 and those not employed where it has increased.

Figure 4.3: Mean out-of-pocket dental expenditures per person in dollars (adjusted). United States, Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey (MEPS), public use data, 1999-2004 and 2011-2014.



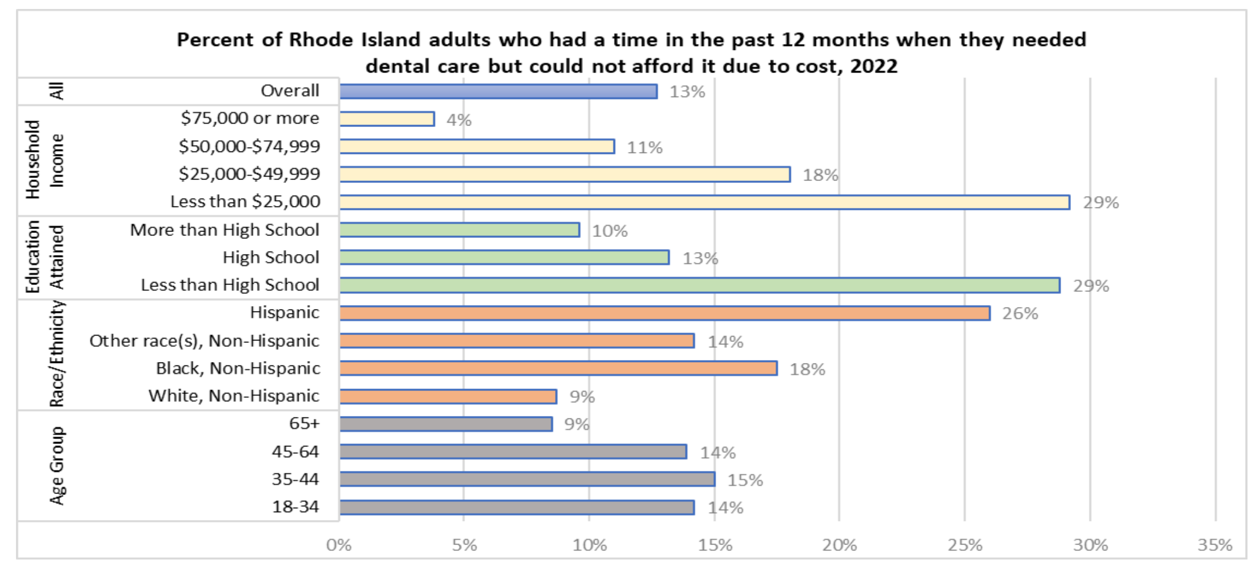
Nationally, dental care is the health care service most likely to be avoided due to cost. Almost 13% of Americans avoided dental care, compared to less than *half for medical, prescriptions, and mental health services (Health Policy Institute & American Dental Association, 2023).*

Figure 4.4: Percentage of people who did not obtain needed health care services due to cost, 2023.

12.7% DENTAL
5.2% MEDICAL
4.8% PRESCRIPTIONS
4.6% MENTAL HEALTH

In Rhode Island, while overall 13% of adults reported there was a time they did not obtain dental care due to cost, that proportion is double for those with lower incomes and less education, and those who are of Hispanic ethnicity.

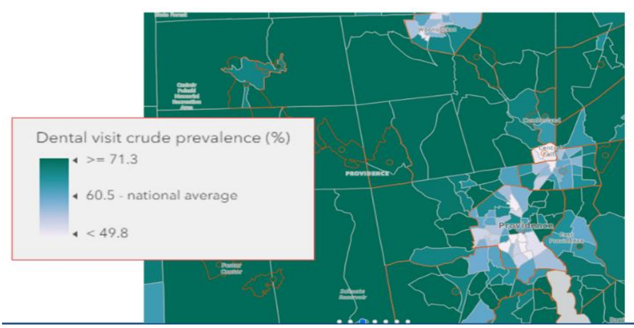
Figure 4.5: Percent of adults who had a time in the past 12 months when they needed dental care but could not afford it due to cost, 2022, Behavioral Risk Factor Surveillance Survey.



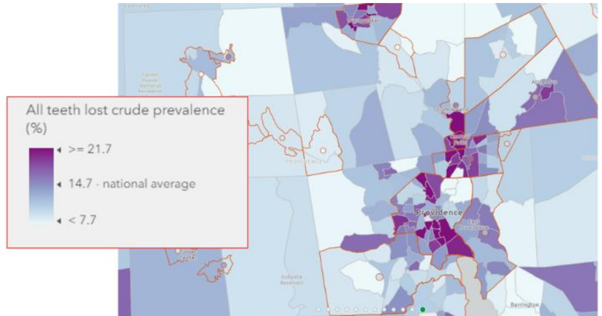
Rhode Island also has significant difference in oral health access and outcomes based on zip code, with adults in Central Falls, Pawtucket, Providence (except 02906), and Woonsocket having lower rates of dental

visits and higher rates of missing teeth compared to those in other zip codes (Centers for Disease Control and Prevention, 2022).

Figure 4.6: Prevalence of Dental Visits for Rhode Island Adults and Prevalence of Complete Tooth Loss for Older Adults, 2022



Dental visit prevalence, Rhode Island adults, 2022, by location. For dark green areas, over 70% of adults had a dental visit, compared to less than 50% in light areas.



Prevalence of complete tooth loss, adults over age 65, Rhode Island 2022. For dark purple areas, over 1 in 5 seniors are missing all teeth, compared to less than 1 in 10 in light areas.

Access to Care - Children

Routine dental care for children is critical to prevent disease leading to pain and infection, but also to set up good habits for life. Rhode Island children are fortunate to have high rates of dental coverage, largely attributed to the State's strong Medicaid program and the Affordable Care Act. Providing preventive care is cost effective, because the alternatives, which include both use of dental care under general anesthesia and use of emergency rooms, can be very costly. Irrespective of insurance, as shown in Figure 4.7, Rhode Island children and youth had lower rates of dental visits at 81.6% compared with children and youth in Massachusetts (85.7%) and Connecticut (86.2%) (Maternal and Child Heald Bureau). Rates of preventive dental visits among children with Medicaid are lower than all New England states with the exception of Maine (Medicaid.gov). Figure 4.8 then shows that while significant improvement in rates were noted from 2006-2019, largely attributed to the RIte Smiles managed care program, the COVID-19 pandemic reduced rates of use.

Figure 4.7: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year, 2016-2020, National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau

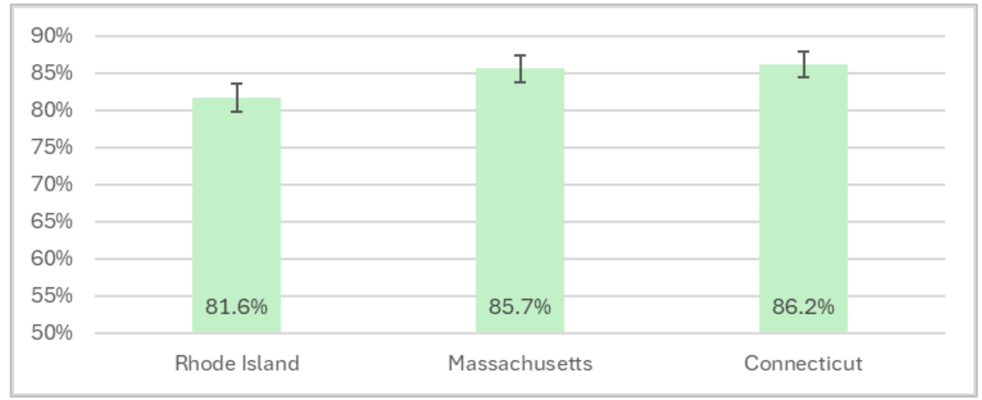
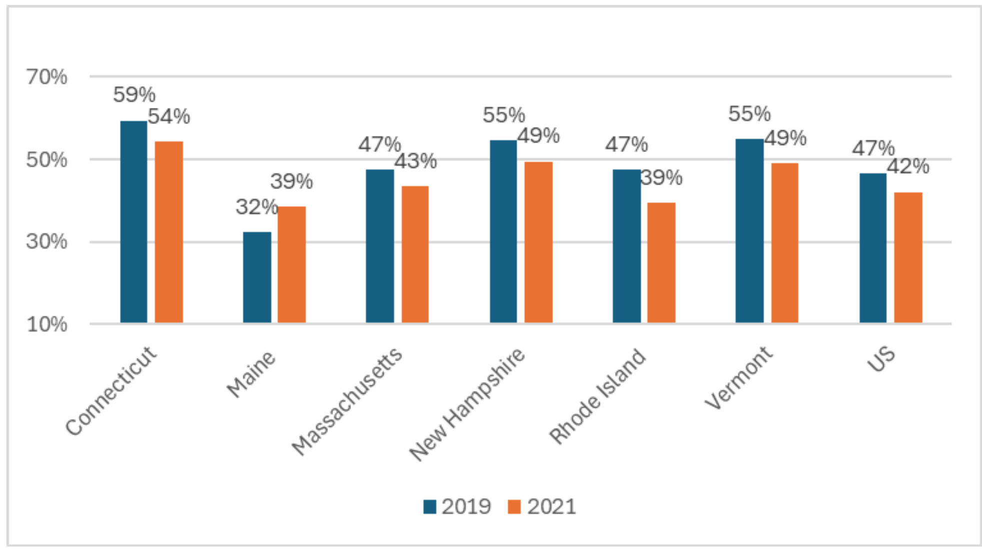


Figure 4.8: Preventive Dental Visit, 2019, 2021 Children Aged 0-20 with Medicaid. CMS-416 Data



Dentist Participation in Medicaid

Nationally and in Rhode Island, access to dental care is challenging for those without insurance and those with low incomes. A significant factor in the rates of dental visits among children, youth, and adults with Medicaid is the ability to find dental practices that participate in Medicaid. In Rhode Island, dental safety-net providers, including Federally Qualified Health Centers (FQHCs), have experienced a rise in demand for care leading to longer wait times. It is not uncommon for people wait overnight to participate in the two-day, RI Mission of Mercy event to obtain care, a volunteer-based program available once a year. While helpful, this program is not designed to address the full breadth of unmet need and certainly does not take the place of a dental home.

Low dentist participation in Medicaid impacts access both because the FQHCs do not have capacity to take on all patients with Medicaid, and there are many parts of the state without a health center. For example,

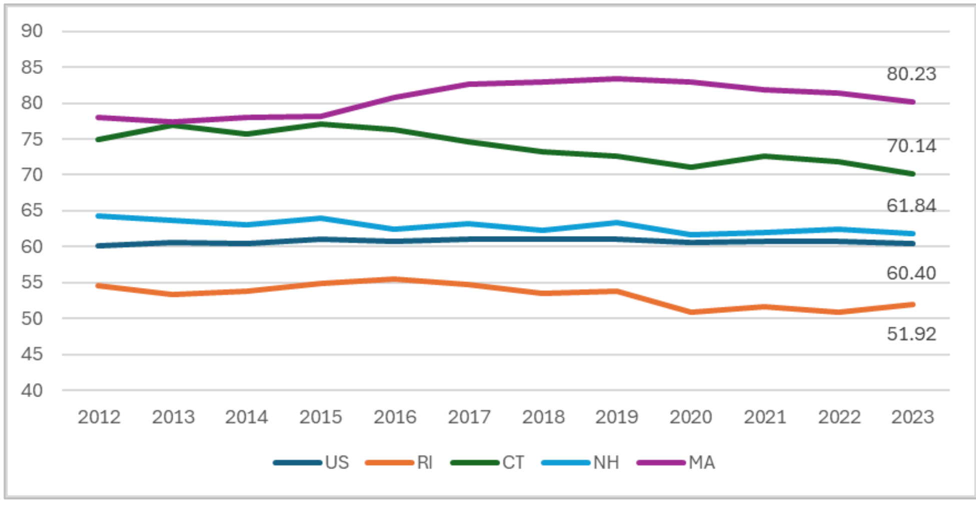
East Providence does not have a health center with a dental clinic or a dentist who participates in the adult dental program, impacting access for residents of the city.

Reasons often cited for low dentist participation in Medicaid include low reimbursement rates, broken appointments and patient non-compliance, and burdensome paperwork (Mofidi et al., 2002). While Rhode Island did have a Medicaid dental rate increase in 2022, the impact was minimal in increasing provider participation. Dentists share anecdotally that they are very busy due to the state's low dentist to provider ratio, and should they wish to take on more patients and more work, they would prefer it be for higher remunerative activity. They also report that if commercial reimbursement rates were higher, it might make it easier to cross-subsidize Medicaid rates.

Dentist Workforce

As noted in Figure 4.9 below, Rhode Island's dentist-to-population ratio is 51.9 per 100,000 people, lower than the national average of 60.4 and neighboring states Massachusetts (80.2) and Connecticut (70.1) (Health Policy Institute & American Dental Association). Rhode Island's sole dental education program accredited by the Commission on Dental Accreditation (CODA), is the Community College of Rhode Island (CCRI), which provides training for dental assisting and dental hygiene, but not dentistry.

Figure 4.9: Dentists per 100,000 People, New England States, 2012-23. American Dental Association, Health Policy Institute

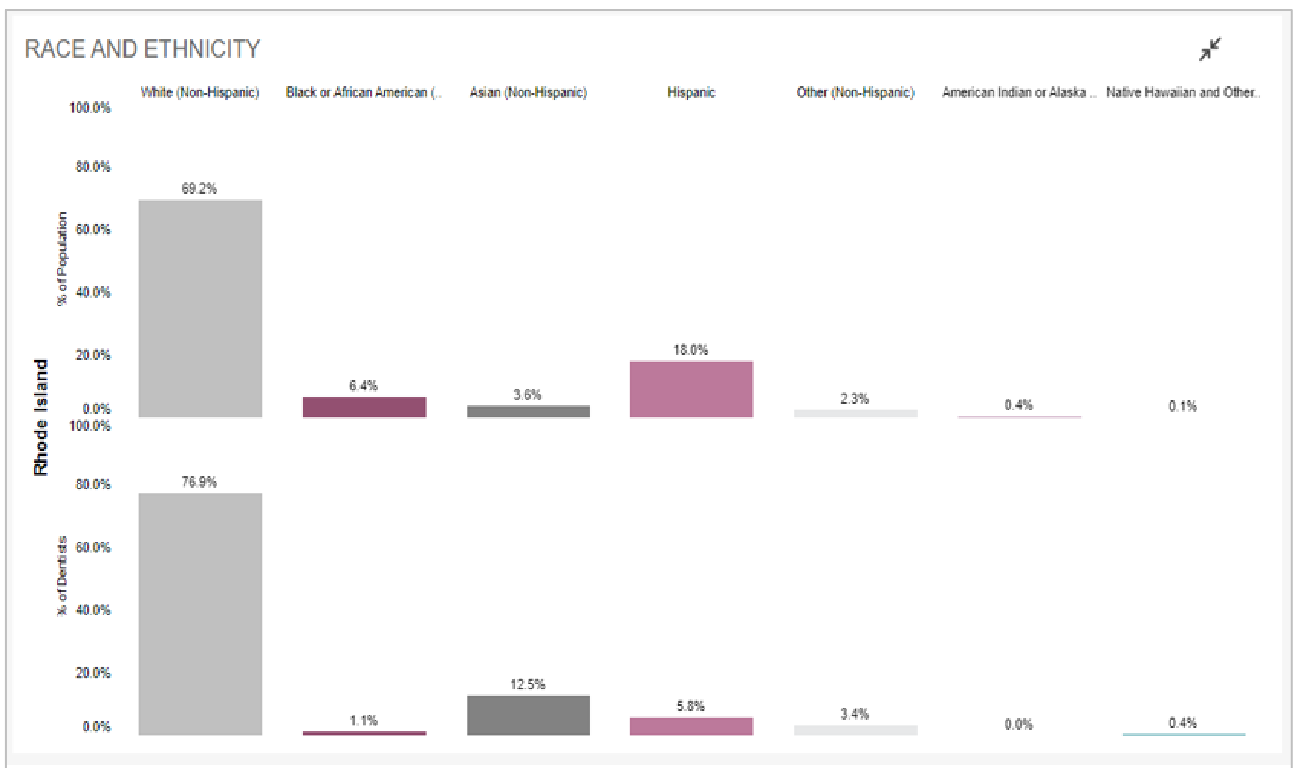


There are currently 70 dental schools in the United States, including three in Boston, MA, one in Hartford, CT, and one in Portland, ME. The number of students in first year classes each year who report their state of residence as Rhode Island is typically low, an average of 8 per year across the 70 dental schools. Even when viewed by proportion based on state overall population, Rhode Island is lowest of all the New England states. This likely reflects a low exposure to dental careers during education and can have impact on the number that will return to the state upon graduation.

Diversity of Dentists

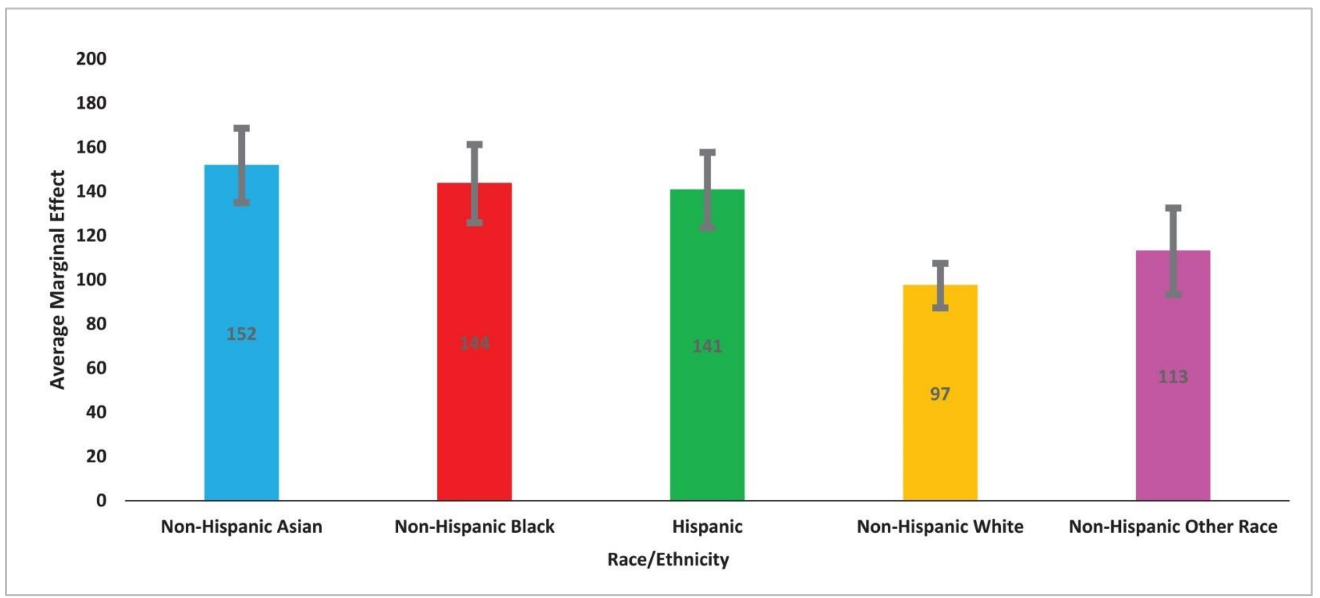
While there is increasing gender diversity among dentists in Rhode Island with over one-third of dentists now women, racial and ethnic diversity is lacking. This reduces the ability of patients to find providers with similar lived experience and shared language. While 6.4% of Rhode Islanders are Black or African American, only 1.1% of dentists are, and while 18% of the state is Hispanic, only 5.8% of dentists are (American Dental Association).

Figure 4.10: Rhode Island Population and Dentist Proportion by Race/Ethnicity, 2023. American Dental Association, Health Policy Institute.



Additionally, research from the American Dental Association Health Policy Institute found that at a national level, a dentist's race or ethnicity can be an important predictor in participating in Medicaid programs. They found that non-Hispanic white dentists practicing in majority non-White zip codes had fewer patients with Medicaid than non-White dentists practicing in majority non-White zip codes (Nasseh et al., 2022).

Figure 4.11: Average Marginal Effect (Difference in Expected Number of Medicaid Patients) of Dentist Locating in a Majority Non-White Zip Code by Race/Ethnicity. From Nasseh, Fosse, Vujicic. Authors analysis based on 2017 T-MSIS Medicaid dental claims data.



Dental Workforce Members

Dental offices cannot function with dentists alone. Auxiliary staff, including dental hygienists, dental assistants, and front desk staff are critical for safe and efficient functioning. New members of the dental workforce are used effectively in other states, including community dental health coordinators and dental therapists.

Dental Hygienists The Oral Health Subgroup recognizes the role of prevention to reduce the need for cost- and time-intense treatment and how a robust dental hygienist and public health dental hygienist (PHDH) workforce is critical for this prevention work. PHDHs can serve in a number of types of care sites to improve access, including home and community-based settings, long-term care sites, schools, and more. While current laws do allow billing of services to Medicaid, older adults may have other coverage and benefit from care at home. For example, dual eligibles, those with both Medicare and Medicaid, may have a Medicare Advantage plan with a dental component. However, current statute prohibits coverage of services of a PHDH through these plans.

Dental Assistants High quality infection control falls on the shoulders of dental assistants, and at no time was this more apparent than during the COVID-19 pandemic where dental offices had a high record of safe practice. As work became increasingly demanding, Rhode Island dentists noticed greater difficulty achieving proper staffing, often attributable to higher wages across state lines. Except for dental assistants involved with anesthesia during surgery, there is no licensure of assistants in Rhode Island. Assistants have shared that licensure could increase the prestige of the profession and may also improve information sharing.

Community Dental Health Coordinators The American Dental Association has developed this position to serve offices which recognize the role of social determinants of health in oral health, and the challenges

patients may have with appointment compliance, oral health literacy, and behavior change. These are dental assistants or hygienists who receive additional training in areas such as cultural competence and more. In Rhode Island, community health workers may receive oral health training to improve their ability to help patients be successful in achieving optimum oral health.

Dental Therapists/ Advanced Dental Hygiene Practitioners These are newer members of the dental workforce found in other states. They expand access by performing additional dental services such as minimally invasive fillings and other therapeutics. Similar to a nurse practitioner or physician assistant on the medical side, these professionals' free dentists up to work to the maximum of their license.

Oral Health Integration

The concept of integrating oral health into the primary care setting arose from the fact that historically, across the nation, a very low percentage of young children see a dentist for preventive services, which is the time that children are most susceptible to early childhood caries. Oral health education, preventive services (such as fluoride varnish), oral health screening, and risk assessment can be done effectively during a pediatric well-child visit, thereby expanding access to care. These preventive oral health services can also be done effectively in other settings too, such as in prenatal care, oncology, and behavioral health settings.

Dentist Reimbursement

Providing dental services is costly, and includes components such staff salaries, equipment, supplies, insurance, and technological advancements. Anecdotally, dentists have reported substantial increases in costs after the pandemic, especially with respect to staff salaries. The increased costs are greatly impacted by the need for Rhode Island's dental practices to compete with Massachusetts and Connecticut with respect to salaries and pay. Both these boarding states pay higher salaries for dental hygienists and dental assistants, which further drives up costs. Dentist education has also become more costly, resulting in increased long-term debt for dentists, often over a half million dollars.

The Oral Health Subgroup reviewed dentist reimbursement using data from FAIR Health, an independent, national nonprofit organization, that compiles and analyzes state health care claim records. These data include both out-of-network price (the charge dentists give to those without insurance), and in-network price, (the amount a health plan will pay to those in their network). Both out-of-network and in-network prices were significantly lower in Rhode Island than in neighboring states, even when comparing cities with equivalent costs of living. The Subgroup also noted that the proportion that the in-network price made up of the out-of-network price was smaller. If the out-of-network price is based on the cost of providing services, this means dental practices will find insurance reimbursement less likely to meet expenses. Dentists report needing to see more patients to meet their expenses, resulting in fatigue and burnout.

Figure 4.12: Comparison of costs/price by region using FAIRHealth Consumer

Zip Code	D0150 comprehensive dental exam, new patient		D0210 X-rays full mouth series		D1110 Prophylaxis (simple cleaning) adult		D2392 2-Surface Composite posterior restoration (filling)		D7140 Simple Extraction	
	Out-of-Network Price	In-Network Price	Out-of-Network Price	In-Network Price	Out-of-Network Price	In-Network Price	Out-of-Network Price	In-Network Price	Out-of-Network Price	In-Network Price
02908 Providence	$109	$48	$175	$83	$130	$83	$290	$145	$300	$120
02888 Warwick	$115	$49	$182	$83	$126	$81	$291	$154	$270	$118
06101 Hartford	$146	$87	$208	$128	$135	$87	$340	$206	$208	$128
01608 Worcester	$165	$96	$212	$131	$153	$99	$344	$208	$212	$131
02134 Boston	$164	$99	$233	$144	$170	$110	$366	$222	$325	$186
05401 Burlington	$144	$86	$222	$138	$157	$102	$353	$214	$303	$174
04106 Portland	$160	$96	$203	$125	$138	$89	$355	$215	$250	$143
03101 Concord/Manchester	$160	$96	$209	$129	$142	$92	$359	$217	$306	$175

The overarching challenge that Rhode Island's health system faces is the difficult interplay between insurance reimbursement and the ability to provide adequate services. Insurance reimbursement rates are tied closely to premiums, which are tied closely to salaries. Because reimbursement rates are lower, Rhode Island salaries may be lower than their equivalent jobs in these neighboring communities. Fewer dentists equal less access for Rhode Islanders.

However, keeping premiums affordable is critical for access – because patients need to be able to afford the services. And dental insurance benefits can differ significantly across plans both between and within insurers. The lower the premium, the less likely costly services will be covered including services such as root canals and tooth replacement. Consumers make treatment decisions based on cost which may have long-term impact – and when consumers delay root canals, they can face even more difficult and expensive services in emergency rooms. When they delay tooth replacement, they could see an impact on their employment, self-esteem, and ability to integrate in society.

The Oral Health Subgroup will continue to address these challenging dichotomies throughout the long-term health care system planning process, working with the Primary Care Workgroup.

Additional themes from Dental Professions and Other Stakeholders.

In 2023, the Oral Health Program (OHP) at the Rhode Island Department of Health (RIDOH) began a process to develop a dental workforce strategic plan with support from a grant from the Health Resources and Services Administration (HRSA) (Rhode Island Department of Health, 2024). RIDOH OHP contracted with Health Resources in Action (HRiA) to facilitate the process. HRiA both surveyed the dental workforce and conducted key informant interviews. As part of that process, they presented the following data:

Question	Most common responses
Strengths of the workforce	Supportive colleagues/team members
Challenges faced by the workforce	Low reimbursement rates Insufficient staffing/hiring issues Job-related stress/burnout/physical demands Lack of specialists
Potential reasons to leave the Rhode Island workforce	Low reimbursement rates Insufficient staffing/hiring issues Staff turnover/retention issues

Data

As part of this Oral Health Subgroup process, along with the Dental Workforce Strategic Plan work, it has become apparent that data for oral health measures are not consistent and often lacking. This may be attributed to multiple sources of data, lack of diagnosis codes, lack of uniform health information technology in the dental field, and inconsistent oversight of dental processes. Incomplete or non-ideal data makes quality improvement difficult.

Oral Health Core Recommendations and Action Steps

Dental Workforce Retention

1. Reduce administrative burdens on dental care providers. Action steps include:
    a. Align administrative credentialing and other administrative agency forms and processes with those of the American Dental Association to reduce administrative burden,
    b. Address current barriers to public health dental hygienists credentialing.
    c. Streamline pre-authorization system for procedures.
    d. Survey dental professionals to analyze the time it takes to complete current administrative measures to set a baseline.
    e. Analyze the efficacy and efficiencies of existing processes and protocols, such as reviewing current administrative measures for consolidation or removal.
2. Reduce the health education debt of dental professionals. Action steps include:
    a. Invest state funds in the Rhode Island Health Professional Loan Repayment Program.
    b. Increase investment in scholarships for dental and public health dental hygienists and low-cost training programs for dental professionals including community based CCRI dental assistant training, dental front desk staff, and community dental health coordinator training.

Dental Payment and Investment

3. Align payments for dental care to be more closely competitive with neighboring states while ensuring plans are affordable for employers, employees, or those purchasing in the market. Action steps include:
    a. Review reimbursement rates using FAIR Health.
    b. Review dental insurance premiums.
    c. Review costs of providing dental care.
    d. Establish payment options that are a hybrid or fee-for-service and prospective capitation.
    e. Increase uptake of diagnostic codes to promote evidenced-based dentistry.
4. Assure robust participation in Medicaid dental programs by practices across the state in both private practices and health centers. Action steps include:
    a. Review payment structure to ensure it covers costs of care.
    b. Develop policies that remove barriers and increase access.
    c. Maintain and increase the coverage of dental services by Medicaid.
    d. Provide training to increase awareness of populations seeking care and decrease stigma.

Integration Payment and Investment

5. Invest in oral health integration in primary and behavioral health care settings. Action steps include:
    a. Advance medical dental integration value-based care and medical integration models to align health care systems, patients, and providers, including:
        i. Provision of minimally invasive care, especially in alternate settings including primary care, behavioral health, that can be performed by alternate dental providers working collaboratively with a dentist.
        ii. Invest in and promote health information technology (i.e., electronic health records) that is inclusive of dental to advance integration and interoperability (i.e. CurrentCare).
        iii. Use emerging technologies, such as telehealth and teledentistry, to coordinate care, manage complex patients, and close referral loops.
        iv. Support co-location of care (i.e., payment of PHDH in medical and community-based settings).
        v. Engage primary care practices to integrate oral health competencies and capabilities as well as promoting dental and primary care teams work together to establish open lines of communication.
        vi. Support the inclusion of oral health screening and fluoride varnish application as quality measures in managed care contracts.
        vii. Promoting use of portable or mobile services to reach vulnerable populations in other health and community-based settings.

Dental Workforce Recruitment

6. Develop a statewide Dental Recruitment and Retention Program that coordinates the identification, recruitment, training, and support of individuals committed to dental careers in Rhode Island. Action steps include:
   a. Identify opportunities and barriers to advance dental health care professional education, licensing pathways, and practice, such as limited licenses for foreign-trained dentists, advancing utilization of public health dental hygienists, and other advanced practice professionals.
   b. Establish a "Work in Rhode Island" marketing campaign focused on graduating dental students, dental hygiene students, and residents.
   c. Promote high school programs that introduce dental careers.
   d. Expand partnerships with pre-dental programs at local colleges.
   e. Promote dental staff, including public health dental hygienists in interprofessional settings.
   f. Emphasize recruitment of people from underrepresented populations.
7. Increase the capacity and quality of dental care training sites and promote practicing in Rhode Island upon completion. Action steps include:
   a. Identify and increase the number of practices serving as training sites for dental health professional students, residents, and non-clinical support staff.
   b. Consider additional dental residencies in hospitals and health centers associated with medical training programs, to support interprofessional education and practice.
   c. Leverage any development of a medical school at URI to consider the inclusion of a dental school or annex program.
   d. Establish initiatives during and after residencies to support trained residents to continue to practice in state.

Overall Monitoring and Accountability

8. Collect, analyze, monitor, and report on data points describing the state of Rhode Island's dental/oral health care system and evaluate the impact and effectiveness of current and future programs and initiatives. Action steps include:
   a. Ensure resources for the collection and analysis of oral health data through the State Data Ecosystem.
   b. Use Dental Quality Alliance performance-based quality metrics across all payors.
   c. Collaborate with state-based coalitions to support data collection and distribution and for initiatives related to advancing quality improvement.

d. Establish and publicize a Dental Health Care System Dashboard that tracks current workforce (e.g., number of current dental providers, level of clinical activity, size of patient panels), future workforce, and patient experience (e.g., adults with access to usual source of care).

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Chapter 5: Behavioral Health

Definition, Role, and Importance of the Behavioral Health Sector

Behavioral health refers to the promotion of mental well-being and the prevention, treatment, and recovery from mental health conditions and substance use disorders. Behavioral health encompasses a broad spectrum of conditions that affect emotional, psychological, and social functioning. These include mental illnesses such as depression, anxiety, schizophrenia, and post-traumatic stress disorder (PTSD), as well as substance use disorders involving alcohol, opioids, and other drugs. The concept of behavioral health recognizes the interconnectedness of mental health and substance use with overall physical health and well-being, making it a critical component of any comprehensive health care system.

> According to the Substance Abuse and Mental Health Services Administration [SAMHSA] (2023a), mental health includes a person's emotional, psychological, and social well-being. It affects how a person thinks, feels, and acts, and helps determine how a person handles stress, relates to others, and makes choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.
>
> Substance use disorder (SUD) is a treatable mental health disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Symptoms can be moderate to severe, with addiction being the most severe form of SUD. People with SUD may also have other mental health disorders, and people with mental health disorders may also struggle with substance use (National Institute of Mental Health, 2024).

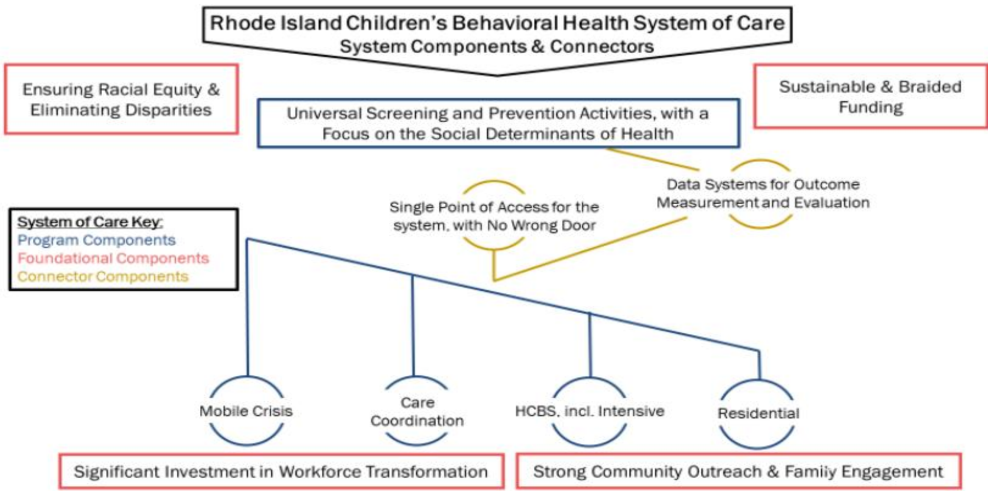
The behavioral health system in the United States and Rhode Island is made up of a comprehensive continuum of services designed to address the behavioral health needs of children and adults across all stages of wellness and recovery. This continuum helps to ensure that individuals, families, and caregivers have access to a wide range of services, from prevention and early connections to care to intensive treatment and long-term recovery support. It also includes services that support healthy child development and wellbeing within a family system, such as parenting support, family counseling, and programs that promote safe and nurturing environments. These services aim to help children develop a sense of wellbeing and the skills to thrive in school and in their communities, fostering resilience, social-emotional learning, and academic success. The continuum also includes services that address the Health Related social needs that can be at the root of behavioral health challenges, that address barriers to access, and that help promote engagement in care. These services are crucial for those with acute and chronic behavioral health conditions, helping to support people on their path to recovery, live more safely, or sustain their recovery.

This multifaceted continuum of services is essential to creating a responsive and equitable behavioral health system that meets individuals and families where they are, addressing both immediate needs and underlying factors that influence well-being. By integrating services across health care, community resources, and social support systems, the continuum promotes seamless transitions between levels of care, ensuring that individuals and families receive the appropriate level of support at the right time. The comprehensive nature of the continuum fosters a holistic approach, meant to address the diverse needs of children and adults, ensuring individuals receive appropriate care at every stage of their mental health and substance use journey. The continuum must also empower families/caregivers to support their

children/youth. Finally, the service system needs to focus not only on clinical treatment but also on addressing social determinants of health and empowering individuals and families to live healthy, thriving, and fulfilling lives.

In 2020, EOHHS created and tasked an interagency team with the creation of the Rhode Island Behavioral Health System of Care for Children and Youth Strategic Plan. At the heart of this Plan was the development and adoption of the Rhode Island Children's Behavioral Health System of Care Framework (EOHHS, 2022).

Figure 5.1: Rhode Island Children's Behavioral Health System of Care



This framework embodies many of the principles discussed above but is focused on the unique needs of children, youth, and their families or caregivers. The framework draws heavily on the academic literature and body of best practice and is being used to guide the state's efforts. Specifically, the framework helps to ensure that services for children and youth and their families or caregivers are guided by family and youth voices, accessible, high-quality, family-focused, culturally-competent, and that they incorporate elements of a population-based, holistic, public health framework.

For the purposes of this chapter of the report, we are representing the behavioral health service continuum with a more simplified structure that includes four interconnected components. This structure was applied by the Behavioral Health Workgroup to organize its discussions and explore the strengths, weaknesses, and strategic opportunities for improvement across the behavioral health service continuum in the context of both children and adults – and ensure that children, youth, and adults receive appropriate care at every stage of their mental health and substance use journey. The four components are:

- Health Related Social Needs
- Prevention and Early Connection to Care
- Crisis Assessment, Initial Treatment/Intervention, and Linkages to Comprehensive Care
- Comprehensive Care, Treatment, Ongoing Support, and Recovery

Note: In the 2024 General Assembly Session, the State Senate passed a Resolution respectfully requesting EOHHS to initiate the planning process to establish a "unified system of care for publicly funded behavioral and mental health care and substance use treatment by no later than July 1, 2026." The Resolution requests that the EOHHS plan address the location in state government of the children's behavioral health **authority** and whether it should move from DCYF to another agency. EOHHS is to carry out this planning with an initial report due to the Senate by April 1, 2025. The Senate acknowledged this Health Care System Planning process in their request – and Secretary Charest has directed the work to be carried out by the Behavioral Health Workgroup as part of the Health Care System Planning Initiative. EOHHS has begun this planning but is not including information about it in this Foundational Report.

National and Statewide Driving Forces, Trends, and Opportunities

This section examines the national and statewide driving trends, forces, innovations, and opportunities that are shaping the behavioral health system, specifically with respect to increased demand, workforce shortages, financial sustainability, and the emphasis of health related social needs. A clear grasp of these broader trends provides a strong foundation for the recommendations that have been put forth in this section, enabling the HCSP initiative to develop strategies that are informed by and aligned with the national experience.

Increased demand for behavioral health services

The prevalence of mental health conditions and substance use disorders has risen significantly, particularly since the COVID-19 pandemic, straining resources, workforce, and infrastructure. This surge highlights the need for expanded services, additional training, and innovative delivery models. Service gaps are especially acute in intensive, long-term care such as hospital-based services, partial hospitalization, residential services, and intensive outpatient programs. These shortages disproportionately affect those who are non-English speakers, from diverse cultures, justice involved, insured by Medicaid, or are impacted by social factors, such as poverty, racism, or other forms of discrimination (Lopes, 2022) (Bethune, 2022).

Shortages of intensive, long-term behavioral health services—such as hospital-based care, partial hospitalization, residential services, and intensive outpatient programs—create significant challenges for the health care system and limit access to appropriate care. Individuals needing high-intensity services often face long wait times, delayed transitions, or diversion to under-resourced settings. This leads to overburdened hospital inpatient and emergency departments, resulting in overcrowding, longer stays, and prolonged wait times, while placing additional stress on providers who may lack specialized behavioral health training (American Hospital Association, 2021) (CMS, 2023).

The lack of adequate intensive and long-term care options, particularly for adults, often results in patients being transitioned to inappropriate settings. When higher or lower levels of behavioral health care are inaccessible, patients may remain in overly restrictive or insufficiently supportive environments, leading to poor outcomes. For example, patients may stay in acute hospital settings longer than needed, be discharged prematurely to ill-equipped home or outpatient settings, or even to the street if they are unstably housed. This misalignment strains community resources like emergency departments, inpatient settings, and outpatient clinics, which are left managing high-risk cases without adequate support. The absence of a full

continuum of care also hampers effective recovery pathways, making it difficult for patients to transition from intensive services back to community-based care (Lutterman, 2022) (Janke, 2022).

Workforce shortages and burnout

The behavioral health sector is experiencing critical workforce shortages, which are compounded by increasing demand for mental health and substance use services across the United States. Shortages span across all types of providers—psychiatrists, psychologists, licensed social workers, counselors, behavioral health specialists, and essential support staff. Among these, psychiatrists are in particularly high demand as they provide critical diagnostic and medication management services, but the number of psychiatrists entering the workforce does not match the growing need. Many regions, especially rural and underserved areas, struggle to recruit and retain mental health professionals, creating “behavioral health deserts” where individuals face long waits or travel distances for treatment. Social workers and counselors, who form the backbone of community mental health services, are similarly affected, as increased caseloads and limited resources often prevent them from providing the consistent, individualized support that many clients require (Counts, 2023).

These shortages are further exacerbated by high levels of burnout among behavioral health professionals. The field is demanding both emotionally and administratively, with high caseloads, intensive documentation requirements, and limited resources. These factors put a major strain on the workforce and reduce job satisfaction. Many providers face secondary trauma as they work with clients dealing with severe issues, including addiction, trauma, and crisis interventions. As a result, behavioral health professionals are often compelled to reduce their hours or leave the field altogether, worsening the shortage and limiting access for those seeking care. Burnout and workforce scarcity contribute to a feedback loop where fewer professionals are available, resulting in increased strain on those who remain, ultimately impacting patient outcomes and service quality (SAMHSA, 2022).

Financial sustainability issues

Financial sustainability is a significant challenge for behavioral health service providers, driven by payment structures, workforce shortages, and rising costs. Payment models that cover preventive and supportive services that help to address behavioral health conditions early and before the onset of more serious conditions are vital. It is also important to develop payment models that address challenges with prior authorization requirements or that focus more on medical services than on other important social, familial, emotional, and behavioral factors.

Medicaid’s generally lower reimbursement rates strain providers serving Medicaid patients, limiting their ability to sustain or expand services – although the new Certified Community Behavioral Health Clinics (CCBHCs) may address some of these traditional Medicaid rate challenges. The lack of parity in reimbursement between physical and behavioral health care further disadvantages behavioral health providers. These financial pressures hinder innovation, service expansion, and investment in care models needed to meet growing demands and improve outcomes (Pollack, 2024) (American Hospital Association, 2024).

Workforce challenges also threaten the sustainability and quality of behavioral health services as high turnover drives up recruitment and retention costs. Clinics face pressure to offer competitive salaries, benefits, and training while managing limited revenue and rising expenses in technology, facilities, and regulatory compliance. Financial instability restricts providers' ability to attract clinicians, worsening shortages. These challenges, coupled with discrepancies in reimbursement rates between commercial insurance and Medicaid, compromise access, quality, and continuity of care, particularly for those disproportionately impacted by HRSNs. Providers struggle to deliver comprehensive, timely services and adapt to evolving community needs (American Hospital Association, 2023).

Need for behavioral health parity

Behavioral health parity ensures equal treatment and coverage for physical and behavioral health within health insurance policies and care standards. It addresses historical disparities in how health plans have covered behavioral health services compared to physical health. The national Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 mandates that mental health and substance use disorder benefits cannot be more restrictive than physical health benefits in terms of treatment limitations, cost-sharing, and access to care (Mark, 2024) (CMS, 2023). Parity is crucial for reducing stigma and systemic barriers that prevent individuals with mental health or substance use disorders from accessing care. Standardizing coverage lowers out-of-pocket costs and promotes timely access to services (NAMI, 2024).

Addressing health related social needs (HRSN)

Addressing HRSNs through partnerships and targeted interventions has become a national priority, aiming to reduce disparities and improve behavioral health outcomes. The focus on HRSNs in behavioral health reflects a growing understanding that mental health and substance use outcomes are deeply influenced by factors beyond traditional medical care. HRSNs such as housing stability, income and food security, education (primary, secondary, post-secondary, vocational, etc.), job training opportunities, employment, and access to social supports play a critical role in shaping individuals' mental health and their risk of substance use disorders. Those with unmet social needs are less likely to move to or sustain their recovery and less likely to engage in care. For many these issues are also at the heart of their mental health or substance use issues, as individuals experiencing poverty or housing insecurity are at a higher risk for both mental health challenges and substance use issues. Similarly, limited access to quality education and employment can lead to economic instability, creating barriers to accessing mental health services and reducing resilience against mental health stressors. Addressing these HSRNs has therefore become a national priority in behavioral health, with an emphasis on building partnerships across health care, social services, housing, education, and community organizations to create comprehensive and coordinated interventions (MHANational, 2016) (SBM, 2022).

Emphasis on prevention, education, individual/family support, and early connections to care.

There is a clear national shift emphasizing the need for the behavioral health system to prioritize prevention, early intervention, and supportive services through a system of care framework as the foundation of care – a public health approach - rather than acute care and treatment services. Historically, resources have been disproportionately spent on acute care, which, while essential, reflects a more reactive response that waits until individuals are in crisis before intervening. By prioritizing prevention, education,

stigma reduction, and crisis assessment/stabilization as well as building natural supports, peer supports, and incorporating family/youth voices, behavioral health systems can more effectively allocate resources toward proactive strategies that prevent behavioral health challenges or at least address them early before they progress and become acute and more costly. This restructured approach allows for more sustained, long-term impact on public health (MHANational, 2015) (Buka, 2022).

For children, early access to care requires children's systems that "screen in" patients to recognize early signs of distress, as opposed to the adult system's focus on severe symptom thresholds. Early recognition allows for interventions that can prevent long-term behavioral health challenges. Also, families are central to identifying challenges, providing continuity of care, and supporting trauma recovery. Family engagement in care improves outcomes by fostering holistic, wraparound approaches that address the needs of both the child and their caregivers.

Services for children, youth, and families both in school and in community-based settings

There is an increasing appreciation for the need to expand and build the capacity of resources in both school settings for those children and youth attending school and in community-based settings for those youth no longer attending school and because of limited hours in school (daily and because of vacation times), to enhance identification, facilitate early connections to care, and provide sustained support to children or adolescents and their families or caregivers needing care. Building system and provider capacity in both school- and community-based settings is essential to addressing the growing mental health needs of children and youth in Rhode Island and nationwide. Rising levels of anxiety, depression, and behavioral health concerns, along with the impacts of toxic stress, adverse childhood experiences (ACEs), and family trauma, significantly heighten the risk of future behavioral health issues and involvement with the justice system or the child protection system. Expanding resources in schools and communities is critical for early identification, timely connections to care, and sustained support for affected children, adolescents, and their families (SAMHSA, 2024) (US Dept of Education, 2024).

Fewer administrative, regulatory, and licensure requirements

Nationally, regulatory and licensure requirements are seen as limiting growth, challenging recruitment and retention, and imposing significant costs. Extensive documentation, compliance with diverse regulations, and multiple reporting standards consume time and resources, diverting attention from patient care and reducing providers' capacity to serve more patients. These administrative burdens strain the behavioral health workforce, drive up operational costs, and threaten financial sustainability (American Association of Community Psychiatrists, 2018) (Zhu, 2024) (Colorado Behavioral Healthcare Council, 2020). Obtaining and maintaining licensure involves lengthy, complex processes, including paperwork, background checks, and continuing education mandates, which can be particularly challenging for smaller providers and those operating in multiple states. These barriers deter new providers and inhibit expansion. Streamlining administrative processes (e.g., documentation, billing requirements) harmonizing standards (e.g., quality standards, contracting and reporting requirements), and simplifying licensure/credentialing requirements are often critical to fostering growth, financial sustainability, and addressing workforce shortages in behavioral health.

Behavioral health navigation and care coordination

Behavioral health navigation services are increasingly recognized nationwide as essential for addressing the complexities of the care system. Navigators help individuals understand their treatment options, connect with appropriate providers, and coordinate care, addressing barriers such as transportation, insurance challenges, and language access. These services are especially crucial for vulnerable populations, including those with co-occurring disorders, older adults, immigrants, and low-income individuals. Nationally, there is a growing emphasis on effective navigation services to reduce stigma, improve access to timely care, and foster resilience and self-sufficiency among individuals seeking behavioral health support. Similarly, care coordination, including wraparound facilitation modeled on evidence-based programs like Wraparound Milwaukee (Milwaukee County, 2024) and New Jersey 's Children System of Care Programing (NJ DCF, 2024) are emerging as a critical strategy to ensure continuity and quality of care. These wraparound programs emphasize comprehensive, family-centered approaches, providing intensive care coordination and skill-building support for children and families. By integrating care across systems, such as education, health care, and social services, they help families navigate complex systems, address their unique needs, and create sustainable plans for success. Behavioral health navigators trained in mental health and substance use issues play a vital role in these efforts, helping individuals, families, and caregivers identify services, share information among providers, and monitor patient progress (Agency for Healthcare Research and Quality, 2015).

Statewide Landscape

Structure and Distribution of Services

During the assessment portion of this planning work, an extensive amount of data was gathered from the Department of Children, Youth, and Families (DCYF) and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) to better understand the structure and distribution of services across Rhode Island's behavioral health system. Understanding this structure and the distribution of these services is critical to assessing service gaps, strengths, and limitations.

However, as will be discussed at length in this section below and throughout this report, there is extremely limited actionable data available to state agency staff, service providers, or other key stakeholders to evaluate the extent of the existing service gaps or shortages, where the gaps are across the continuum, why those gaps exist (e.g., issues of reimbursement, workforce shortages, high costs, care transitions/care coordination), and how best to address them. This lack of actionable data underscores the need for improved data systems capable of tracking service availability and the nature of existing service gaps by type of service, geography, linguistic/cultural responsiveness, and other competencies that ensure that those in need are getting the appropriate person-/family-centered care they need to address their issues and thrive.

Despite the need for more data, it is important to note that the current network of service organizations that is providing services across the State is considerable. As part the HCSP assessment, DCYF and BHDDH provided data on the number of licensed provider organizations with whom they contract. These data show that combined, BHDDH and DCYF contract with nearly 100 service provider organizations that provide a broad continuum of services to adults, youth, and children across the age spectrum, including to families

and caregivers. These organizations provide services in home- and school-based settings as well as at more than 300 community-based service site locations across the State.

Together, these organizations provide more than 20 different categories of service, including intensive hospital-based services for those with acute needs; stabilization services for those in crisis; intensive services in residential, outpatient, home, and school-based settings; services provided in comprehensive behavioral health service centers (e.g., CCBHCs) that provide assessment, treatment, referral, and other supportive services; and small and large service organizations that provide general outpatient services for those with mild, moderate, or emerging needs. As discussed above, the current network is extensive, but more data is needed to determine exactly how well these programs are able to meet community need and the demand for service.

What is also clear from the community input in this planning process is that these services are not as integrated and coordinated as they need to be so as to create a unified, streamlined behavioral health system capable of meeting the needs of individuals and families in Rhode Island. Some of the core recommendations included below for the ongoing planning process include the need to address these data and evaluation needs and to use this new understanding to improve care for all Rhode Islanders.

The next section provides qualitative information, drawn primarily from existing reports, stakeholder interviews, Behavioral Health Workgroup discussions, and input from other community engagement initiatives that examines the system's capacity to meet current and future needs and demand for services.

Discussion of Capacity, Unmet Need, and Workforce shortages

These qualitative findings, focus on identifying and clarifying existing service gaps, workforce shortages, and unmet needs, as well as on other related issues that directly impact providers' ability to operate and community residents' ability to access and engage in the services they need. This context is essential for understanding and supporting the recommendations outlined below and to facilitating the immediate action that is required to strengthen the system, while more precise data tools are being developed.

Addressing behavioral health service gaps Workgroup members emphasized the need to expand capacity for intensive services in home as well as community programs for children, youth, adults, and older adults, each of whom face different challenges and need age-appropriate competent care. Workgroup participants often addressed the need for child-specific competencies in Rhode Island's behavioral health workforce, agreeing that "children are not miniature adults." Children's developmental stages, family dynamics, and social environments significantly shape their behavioral health.

While recognizing the need for long-term data to guide these efforts, members agreed that immediate action is essential to address gaps, particularly in some hospital-based and other intensive services, including inpatient care, partial hospitalization, and intensive residential, outpatient, and home-based programs, including transitional/respite housing. Participants also expressed hope that CCBHCs will address gaps in outpatient services as well.

The emphasis on the need for additional residential and facility-based care was largely expressed by those advocating for adults, while those advocating for enhanced services for children and youth emphasized the

need for greater capacity in home-based or intensive outpatient programs. Many of the children and youth service advocates also reflected on the recent increase in capacity with respect to long-term services across the continuum, including hospital-based services for those with acute needs and more family-based services in home/community settings, with peer supports. As discussed above, numerous interviewees and workgroup participants alluded to challenges with respect to transitioning children/youth and adults from the hospital-setting to safe, appropriate settings in the community, which often lead to longer than necessary hospital stays.

Child/youth advocates discussed the need for additional evidence-based supports and programming in home/community settings, including peer supports. Adult advocates discussed the need for a broader range of long-term, intensive service capacity across the continuum in hospital, residential, and outpatient settings. More data collection and analysis are needed, but at least for children/youth, hospital stakeholders have reported fewer children or youth boarding in children's hospitals throughout 2024 – and this Health Care System Planning data process improvements can assist with this need, as noted below.

Workgroup members expressed that the gaps disproportionately affect those who are non-English speakers, from diverse cultures, justice involved, insured by Medicaid, or are impacted by social factors, such as poverty, racism, or other forms of discrimination. These segments are more likely to face long wait-times or barriers to transitioning to appropriate programs. Those engaged in interview and workgroup deliberations, particularly reflected on the challenges of non-English speakers and individuals from diverse cultural backgrounds who often struggle to access culturally and linguistically responsive care. Capacity issues are especially acute for specific populations, such as pregnant and parenting women, individuals with I/DD, and justice or child protection system-involved individuals.

Expanding residential, group home, and intensive outpatient facilities – especially for adults – was a common recommendation to improve care transitions and ensure individuals receive care in the least restrictive, most appropriate settings. Older adults also need appropriate services if they live in congregate care settings, like assisted living or nursing homes. With respect to children and youth, participants on the workgroup felt strongly that the emphasis needed to be on ensuring that they were in the least restrictive settings possible and on continuing to develop home-based programs. Participants noted that this meant prioritizing community-based, home-and school-centered services that allow children to grow, learn, and develop in familiar, supportive environments, rather than in restrictive or institutional care settings. Transitional housing and family housing programs were also highlighted as critical for supporting long-term health, well-being and recovery as well as providing stability for those awaiting appropriate placements or transitioning to independent living.

Sustainability Issues and Workforce Shortages Consistent with national trends, Workgroup participants and interviewees highlighted payment and cost challenges that limit providers' ability to expand capacity, meet community needs, and sustain operations. Inadequate reimbursement rates, high workforce recruitment and retention costs, and increased expenses for technology and overhead often leave providers operating on minimal margins. These financial constraints disproportionately impact organizations serving Medicaid-insured and uninsured residents due to lower payment rates compared to commercial insurers or Medicare. Some providers reported prioritizing commercially insured patients to sustain operations, further limiting access for underserved populations.

Many of those engaged through this work reflected on the recent rate increases for behavioral health providers across the board and the cost-based reimbursement policies that are part of the new CCBHC program. These increases and policies were welcomed and appreciated and there was agreement that these changes will certainly have a positive impact, but those engaged were concerned that that the increases would not be enough to address the financing challenges impacting the system.

Workforce shortages exacerbate these financial pressures, with too few trained professionals, such as psychiatrists, social workers, and counselors, to meet demand. Low reimbursement rates and high education costs deter individuals from entering the field, while those who do often face burnout and high turnover due to overwhelming caseloads. These issues reduce access and quality of care, as patients experience longer wait-times, and less personalized treatment.

Combined financial and workforce challenges, particularly in recruiting and retaining staff, restrict access, limit service offerings, and stifle innovation. Providers struggle to meet demand, adopt new practices, or improve care quality. Addressing these issues is essential to ensure the sustainability, effectiveness, and equity of the behavioral health sector, particularly for underserved populations.

Same-day behavioral health care, including mobile treatment Workgroup participants, interviewees and existing reports emphasized the need to strengthen behavioral health urgent care services, addressing a critical gap in the care continuum. Many individuals in mental health crises face barriers to timely, appropriate care, often defaulting to emergency departments ill-equipped to handle behavioral health needs, leading to long waits, inadequate treatment, and reliance on law enforcement, which can worsen outcomes.

The rollout of the state's CCBHC program was seen as a positive step, though concerns remain about integration and implementation. Participants stressed the importance of monitoring and refining the program as needed. Additionally, expanding crisis response and stabilization services was a priority, with the child/youth group emphasizing the need to ensure that Mobile Response and Stabilization Services (MRSS) continue to be provided to fidelity.

Preventing justice and child protection involvement There is a substantial need to expand and enhance programs that prevent initial justice involvement of adults and youth – and help transition people out of the justice system or the child protection system. Significant progress has been made by the State, mostly recently with the implementation of new home-based services provided through DCYF. This has helped to reduce the number of children or youth in DCYF out-of-home care from 2182 on June 30, 2018, to 1298 on January 1, 2025 - a 40% reduction. Action steps should include expanding specialized behavioral health triage staff capacity, supporting training, and enhancing triage protocols in hospital emergency departments, community health centers, and other community agencies with a special emphasis on pre-arrest diversion.

Workgroup participants and interviews with community members highlighted the need to reduce justice and child protection involvement in behavioral health crises, particularly among vulnerable populations. Participants emphasized the lack of accessible crisis response options, leading to emergency room visits, arrests, or child protection referrals. Many shared concerns about how individuals in crisis, especially youth and those with mental health or substance use challenges, face criminalization or family separation due to

inadequate supports. The feedback underscored the need for proactive interventions that focus on stabilization and de-escalation rather than punitive responses.

Recommendations include expanding behavioral health programs to reduce reliance on the justice system and child protection services through improved triage protocols, training, and enhanced capacity in emergency departments, community health centers, and other agencies. Pre-arrest diversion programs and a centrally located diversion center for justice-involved individuals were widely supported. By equipping providers with tools for assessment, stabilization, and referral, the system can address crises more effectively, fostering a compassionate, community-centered approach that prioritizes health and safety.

Care transitions There is a need to promote timely, seamless transitions from hospital and other community settings for those with acute or complex behavioral health issues so as to reduce lengthy hospital stays, prevent “observation” stays, and otherwise prevent hospital patients from experiencing extensive delays awaiting care transitions to ensure that patients are receiving appropriate, quality, person-centered care in a timely manner.

Workgroup discussions and state reports highlighted the urgent need for improved discharge processes and expanded capacity for intensive behavioral health services. Patients often remain in temporary, inadequate settings due to a lack of housing – or of detox/stabilization, residential, or group home beds. These shortages stem from limited bed availability or insufficient staffing and program capacity to accommodate individuals with severe behavioral health conditions. As a result, patients are sometimes placed in settings that are safe but not fully suited to their needs.

This issue imposes significant financial and operational strains on hospitals, which must provide costly care for patients who no longer require emergency or inpatient services. Prolonged inpatient or observation stays increase hospital costs and reduce bed availability, further limiting access for other patients in need (Lutterman, 2022).

The Workgroup reflected that a critical first step might be to conduct a targeted assessment that supported a better understanding of the extent of the issue and the causal or associated factors that either support or hinder improvement.

Other key themes from services providers, community members, and other stakeholders

The findings below in this section relate specifically to service issues outside of service capacity, workforce shortages, and unmet needs. As with the themes above, these issues were identified through existing reports, interviews, or workgroup discussions. This information is important to understand as it provides the supporting information or context for the recommendations identified below:

Fragmentation of Services There is a substantial need to address the fragmentation of services and the silos that exist between state agencies, local schools, and service providers. Many Workgroup participants and interviewees described the behavioral health system as fragmented, “siloed,” and often poorly coordinated, leading to duplicated services, burdens on patients and families, and delayed, restrictive, or non-person-centered care. One key factor noted was the lack of coordination among state and local agencies, including DCYF, BHDDH, RIDE, RIDOH, Medicaid, and school departments. These silos can limit access, hinder appropriate engagement in care, and reduce the quality and effectiveness of services.

Transition Between Systems Transitions from pediatric to adult care and from adult to older adult services are critical for individuals with behavioral health challenges. These shifts often expose gaps, such as the lack of age-appropriate services or abrupt discontinuation of supports, leading to instability and worsening outcomes. Ensuring early, person-centered care during these transitions is vital to fostering stability and long-term recovery.

Participants in the Behavioral Health Workgroup emphasized the need for coordinated, tailored transitions to reduce care gaps and enhance continuity. Expanding efforts in clinical and non-clinical settings to support person-centered transitions and care plans can prevent lapses in treatment, improve outcomes, and reduce the societal burden of untreated behavioral health conditions.

Participants also noted the need to involve families in the provision of children's behavioral health care. Families provide the context for early identification of issues, continuity of care, and long-term support – making them critical components of transitions between systems. In addition, children aging out of the child-serving system often experience an abrupt reduction in services, leaving them vulnerable to significant challenges. These include gaps in behavioral health services, a lack of affordable housing, and difficulties accessing higher education or workforce training. Without safeguards and targeted support, these youth are at increased risk of homelessness, unemployment, and untreated mental health conditions. Addressing these vulnerabilities requires a coordinated approach that ensures continuity of care, affordable housing options, and accessible pathways to education and employment.

Promote person- and family-centered care and harm-reduction efforts Harm-reduction interventions prioritize safety and well-being while helping individuals manage their conditions to reduce risks and improve quality of life. Workgroup participants emphasized the importance of adopting a person- or family-centered approach, focusing on individuals' unique needs, addressing intergenerational trauma and a mistrust of institutions and government programs, and fostering collaborative, tailored care plans. This approach was seen as essential to strengthening the behavioral health system and improving outcomes.

Gaps in Behavioral Health Services for Privately Insured Families - Families with private insurance often face significant barriers to accessing intensive behavioral health services due to limited coverage by commercial carriers. As a result, these families frequently rely on state-funded programs to fill the gap, which strains public resources and leaves the needs of privately insured children underserved. Participants discussed the need to align private and public systems to improve service delivery and ensure parity.

Address the burden of administrative, regulatory, and licensure requirements To address the administrative, regulatory, and licensure burdens noted above, participants suggested streamlining administrative processes and simplifying licensure and credentialing to reduce barriers and ease operational burdens. These changes would allow providers to focus on patient care and innovation while improving Rhode Island's competitiveness in recruiting and retaining the behavioral health workforce.

Alignment of Cross-Cutting Issues

Across the Health Care Sectors – Each HCSP workgroup has identified how the cross-cutting issues described in the introduction of this report have arisen as priorities to address in the workgroup's recommendations. We have addressed the issues specific to the behavioral health sector above. In this section of the Behavioral Health Chapter, we clarify the most important cross-cutting connections between the behavioral health sector and other sectors across the health system.

Workforce

Workforce issues were discussed throughout the Workgroup's deliberations and was identified as a priority. Recommendations focused on expanding and building the capacity of the existing behavioral health workforce, as well as diversifying the workforce with responsive linguistic and cultural responsiveness. The Behavioral Health Workgroup also emphasized the importance of continued efforts to assist the peer-support worker segment of the workforce as well as on facilitating implicit bias training, and anti-stigma campaigns for health sector staff **who serve those with behavioral health issues.**

Data Monitoring, Oversight, and On-going Assessment and Surveillance Structures/Systems

There was a clear consensus regarding the need for an aligned data hub and additional data structures/systems to support oversight, monitoring, and planning. Most critically for the behavioral health sector is the need for systems to assess capacity and identify service gaps or workforce shortages that hinder access, engagement, and care transitions. These systems must have the ability to track the capacity of the system to meet community need and the demand for services as well as track how effectively and seamlessly individuals transition from one level of treatment to another. The workgroup also discussed the need for systems to track workforce development efforts and the quality and impact of the service system, particularly with respect to assessing equity and disparities.

Value-based Payment Models

Discussions with service providers and subject matter experts highlighted the need for more effective, more nimble payment models that helped to promote growth, financial sustainability, and the adoption of innovative service programs, including ones that focus on prevention. Participants also emphasized the need for value-based payment models that provide robust support for providers, and include a commitment to equity and family-centered care – as well as those that incent growth and drive innovation in ways that facilitate the implementation of best practice and improve both the impact and quality of care.

Health Information Technology and Exchange

Health Information Technology (HIT) plays a critical role in Rhode Island's primary care infrastructure, though there are varying levels of adoption across practices. Larger systems and hospital-affiliated practices tend to have more advanced EHR systems and better access to data exchange platforms, while smaller, independent practices may face challenges with full integration. HIT is essential for enabling coordinated care and participating in value-based care models, yet the resources required for full adoption can be a barrier, particularly for smaller providers. The behavioral health sector has relatively limited experience with health information exchange and adoption has been slow. Greater emphasis needs to be made to promote the adoption and use of use of the state's health information exchange, CurrentCare. Efforts also need to be made to develop tools tailored to the behavioral health sector that support information sharing and the integration of behavioral health utilization data and other relevant information to support care management of behavioral health patients.

State Structure and Data Systems Necessary to Promote Strength and Impact

Need for a dedicated structure to oversee implementation.

A dedicated structure, such as an office within the Executive Office of Health and Human Services (EOHHS), is essential for the effective implementation, integration, and monitoring of health care system planning initiatives. Such an office would centralize oversight responsibilities, ensuring that diverse components of the health care system—such as behavioral health, primary care, health related social needs services, and public health—are aligned and working toward cohesive goals. By focusing on integration, this office can streamline efforts across multiple agencies, prevent duplication, and promote a coordinated approach that maximizes resources. Additionally, an office focused on monitoring impact would be able to track the results of initiatives over time, using data to evaluate outcomes, inform adjustments, and guide future planning. This accountability structure would help maintain alignment with the overarching vision of the EOHHS and ensure that health system improvements are sustained, equitable, and responsive to the evolving needs of the population.

Need for data structures and systems to support monitoring, evaluation, and decision-making

Data systems are critical for effective health care planning, monitoring, and decision-making. They provide reliable, centralized information that helps health leaders assess service performance, address population needs and adapt strategies proactively. Robust data infrastructure fosters transparency, supports accountability, and enables systems to identify emerging issues and opportunities for improvement before they affect care or resources.

Workgroup participants emphasized data as a critical gap in planning, highlighting the need to assess service capacity, identify gaps, and plan growth. Tools like RI's BH Link (www.riopenbeds.org) streamline referrals and should be enhanced to assess gaps and guide strategy. EOHHS and RIDOH should expand data dashboards to track health equity, care quality, and system transitions. Additionally, data systems should analyze financial sustainability, ensuring transparency in costs and payments so providers receive fair compensation and can sustain programs for all Rhode Islanders.

Behavioral Health Core Recommendations and Action Steps

Health Related Social Needs

- Expand housing options and programs that ensure access to safe, stable, and affordable housing for all, including low-barrier supportive, transitional, and respite housing options for those with severe and persistent mental illness (SPMI), ensuring that Rhode Islanders do not need to become unhoused to be eligible for participation.
- Expand and enhance initiatives that promote comprehensive screening, assessment, and referrals to address health related social needs of individuals across the age spectrum, including families/caregivers.
- Introduce and promote policies that reduce children's exposure to toxic stress and enhance interventions that strengthen resources.
- To prevent or help transition people out of the justice system or the child protection system involvement, continue to develop or enhance programs in both clinical and non-clinical settings that provide enabling and supportive services, including care navigation, to address health related social needs for vulnerable Rhode Islanders across the age spectrum and their families/caregivers.
- Expand and enhance employment, job training, and workforce initiatives aimed at promoting employment or meaningful engagement in the community for adults and transition age youth, with a focus on individuals in different stages of behavioral health treatment and recovery.

Prevention, Family Supports, and Early Connections to Care

1. As prevention is the fundamental building block of a Behavioral Health System of Care, expand and enhance prevention programming tailored appropriately to individuals across the age spectrum and their families/caregivers, to prevent the progression of serious mental illness and substance use disorders, particularly with respect to suicide or overdose prevention – and support the development and implementation of comprehensive prevention, education, and outreach campaigns to raise awareness, reduce stigma, and encourage early connections to care.

2. Scale up investments in social emotional learning, peer support, and therapeutic groups for students experiencing trauma and acute depression/anxiety, including mental health first aid resources, within all school districts in Rhode Island.

3. Continue to promote and support universal behavioral health screenings in both clinical and non-clinical settings for individuals across the age spectrum, including families/caregivers, creating actionable steps to ensure that these efforts include resources for referral pathways and the availability of supports for those identified as needing services.

Crisis Assessment, Initial Treatment, and Linkages to Care

1. Follow SAMHSA's vision for crisis services: "Someone to talk to. Someone to respond. A safe place for help" by supporting and maintaining the State's 988 crisis phone line, in-person crisis services, and BH Link.

2. Support, track, and evaluate the implementation of Rhode Island's Certified Community Behavioral

Health Clinics (CCBHCs) to ensure that all individuals in need have access in particular to 24/7 crisis support, including mobile crisis teams, screening and assessment, care planning and coordination, peer supports, and comprehensive behavioral health treatment services, with connections to social services, regardless of their ability to pay.

3. Ensure the continuation of Mobile Response and Stabilization Services (MRSS) for children/youth to fidelity through MRSS implementation, with a focus on ensuring provision of the model's stabilization services. The MRSS program is being carried out through CCBHCs in State Fiscal Year 2025. Several Workgroup members have proposed that it be implemented separately from CCBHCs in future years.

Comprehensive Treatment, Care, Support, and Recovery

1. Ensure that Medicaid behavioral health reimbursement rates and funding levels allow service providers to implement and sustain quality, person- and family-centered services, recruit necessary workforce members, address wage increases, and foster innovation.
2. Implement initiatives to increase behavioral health workforce capacity to support the provision of services across the age spectrum and settings, with an emphasis on increasing the number of psychiatrists, psych-nurse practitioners, therapists, peer-support staff, and other behavioral health specialists.
3. Children/Youth Focused: Support and expand strong treatment and programmatic family-centered, trauma-informed, age-/developmentally-/culturally appropriate services that are aligned with the educational system and available both in schools for children or youth in school, and in the community for youth not attending school. Use the System of Care Framework, which includes a strong focus on prevention, access to crisis services, care coordination through wrap-around services, a range of treatment options from community-based to residential, and support for recovery.
4. Close gaps in behavioral health services in long-term and intensive care settings across the age spectrum - including for those with severe and persistent mental illness and those with I/DD and brain injuries - to ensure that care is person-centered and that care transitions to home or community settings are timely, in-state, and appropriate. Use data to confirm the size of the gaps, in order to determine the scale of the need – and ensure care across the age spectrum, including for older Rhode Islanders in long-term care services.
5. Support safe, appropriate, and timely hospital discharges for those in need of intensive behavioral health services across the age spectrum, in order to reduce unnecessary hospital inpatient and emergency department stays or long delays with respect to care transitions and ensure that those in need are transitioned to the most appropriate, person-centered, and developmentally appropriate setting.
6. Expand and enhance initiatives that integrate behavioral health into adult and pediatric primary care, as well as other clinical settings for adults, children, and youth so as to strengthen the system of care, expand access and improve engagement in care.

Workforce

1. Expand and enhance workforce development and training initiatives to increase the number of bilingual and multilingual providers, ensuring access to linguistically and culturally responsive behavioral health care for all Rhode Islanders, across the age spectrum, including their families and caregivers.
2. Expand and enhance training and technical assistance programs that educate or reinforce principles of equity rooted in anti-racism to clinical and non-clinical service providers across the care continuum, including those that provide behavioral health services and those that provide other enabling and supportive services, across all settings.
3. Strengthen family-friendly workplace policies such as paid family medical leave and economic support for families and increasing access to high-quality early care and learning.

Data structures and systems

1. Consistently apply a data-driven system for monitoring, evaluating, and improving programs and service delivery to promote quality, effectiveness, and greater impact with respect to system transformation and performance improvement efforts. Action steps include:
   a. The State should develop robust data dashboards and other structures that support quality and performance improvement, capacity assessment, and broader planning efforts so as to support system transformation and strengthening efforts. As a part of this development, map out existing data sources, gaps, and processes for overlaying data.
   b. The EOHHS data analytics team should collect and analyze feedback from Rhode Islanders across the age spectrum on an ongoing basis, including families/stakeholders, with the aim of better understanding issues of access and engagement in care.

Community engagement

1. Explore and enhance the policies and structures that ensure that the community, including community residents, individuals with lived experience, service providers, and other key stakeholders, are engaged in both advisory and decision-making roles, prioritizing the inclusion of diverse community partners, including youth/family, caregivers, and advocates. Action steps include:
   a. Increase access to non-clinical supports and peer accompaniment for families, as they provide education, knowledge about, and connection to needed supports and serve to bridge communication between behavioral health and pediatric providers and youth/families in crisis.
   b. Engage families – and especially youth – in planning, education, and communications activities through student associations and parent groups, especially including youth alumna of behavioral health programs and services.

Health equity

1. Main strategy: EOHHS is committed to ensuring that the State's behavioral health system provides equitable services and supports that are accessible and responsive to individuals across the age spectrum, including their families/caregivers, irrespective of race, religion, national origin, gender, gender identity and expression, sexual orientation, physical disability, socioeconomic status, geography,

language, immigration status, or other characteristics. Action steps include:

a. Engage diverse communities in behavioral health and system of care planning conversations, prioritizing those with lived experience.
b. Increase the diversity of the overall health care workforce (clinical and non-clinical).
c. Reduce inappropriate criminalization of behaviors and social groups by ensuring that providers understand and are self-aware of racial, ethnic, sex/gender, religious and other biases.

As a reminder, this Health System Planning Process will take up the 2024 State Senate's Resolution respectfully requesting EOHHS to initiate the planning process to establish a "unified system of care for publicly funded behavioral and mental health care and substance use treatment by no later than July 1, 2026." EOHHS and its partners will carry out this planning process within the Health Care System Planning initiative. There are no proposals or recommendations on this topic ready for publishing for this Foundational Report.

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Chapter 6: Hospitals

Definition, Role, and Importance of the Hospital Sector

Hospitals, as defined by the American Hospital Association (AHA), are licensed institutions with a minimum of six beds, primarily offering diagnostic and therapeutic patient services for various medical conditions. These facilities are characterized by organized physician staff and continuous nursing services under registered nurse supervision. The World Health Organization (WHO) similarly defines hospitals as establishments that provide active medical and nursing care, offer inpatient accommodation, and are permanently staffed by at least one physician. Hospitals vary by type of service, ownership, size, and length of stay (CDC, 2024).

In the continuum of care, hospitals occupy a critical role by providing specialized and intensive care that is not typically available in outpatient settings. As of 2022, hospitals accounted for 30.4% of total U.S. health expenditures, reflecting the sector's significant role in national health care spending (Cox et al., 2024). Locally, in Rhode Island, hospitals made up 36.4% of total health expenditures in 2020, the latest year of health expenditure data by state as reported by CMS (CMS Office of the Actuary, 2022).

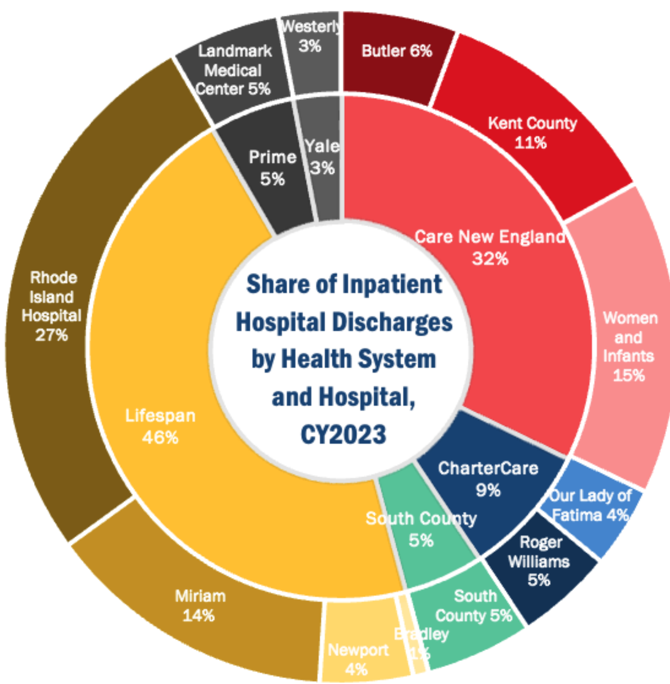
National and Statewide Driving Forces, Trends, and Innovation

The U.S. hospital sector is a diverse and complex system that plays a central role in the nation’s health care delivery. As of 2024, the American Hospital Association (AHA) reported 6,120 hospitals in the United States. This sector includes a mix of non-profit facilities (58%), for-profit entities (24%), and government-owned hospitals (18%) (AHA Data Hub, 2022). These hospitals span general acute care, specialty hospitals, and long-term care facilities, highlighting the sector’s role in both immediate and chronic care settings.

Rhode Island’s hospital landscape includes sixteen hospitals across seven hospital systems[6], comprising 10 acute care hospitals, three psychiatric hospitals, two rehabilitation hospitals, and one long-term acute care hospital, as shown in Figure 6.2 below. Inpatient discharges for all short-term acute care hospitals and privately owned psychiatric hospitals are represented in Figure 6.1. In 2023, the largest share of inpatient hospital discharges in Rhode Island was handled by Brown University Health (46%), formerly known as Lifespan, followed by Care New England (32%), both of which are nonprofit health systems (*Hospitalization Discharge Data: Department of Health*, 2024). CharterCARE is the only for-profit health system in Rhode Island.

[6] Includes Encompass Health, owner of Rehabilitation Hospital of Johnston in addition to the six health systems represented in the RIDOH hospital discharge data and included in the graphic above.

Figure 6.1: Share of Rhode Island Inpatient Hospital Discharges by Health System and Hospital, CY 2023



Note. RI State-run facilities and the rehabilitation hospitals do not report to the RIDOH hospital discharge data set and therefore are not represented. Source: RIDOH, Hospital Discharge Data, CY2023

Financial Outlook

Figure 6.2: Rhode Island Hospital Sector

Rhode Island Hospitals

Short term acute care hospitals

1. Kent Hospital	6. Newport Hospital
2. Woman & Infants	7. The Miriam
3. Our Lady of Fatima	8. Rhode Island Hospital
4. Roger Williams	9. Landmark Medical
5. South County Hospital	10. Westerly Hospital

Psychiatric hospitals

11. Bradley Hospital
12. Butler Hospital
13. Rhode Island State Psychiatric Hospital

Long term acute care hospitals

14. Eleanor Slater Hospital

Rehabilitation hospitals

15. Rehabilitation Hospital of Johnston
16. Rehabilitation Hospital of Rhode Island

The financial performance of hospitals has been significantly affected by the COVID-19 pandemic. Between 2021 and 2022, hospitals generally experienced large declines in operating margins, driven by increased costs and decreased revenues. 2022 was the worst financial year for hospitals and health systems since the start of the COVID-19 Pandemic, with approximately 50% of US hospitals closing the year with negative operating margins as growth in expenses outpaced revenue increases (Swanson, 2023). Rhode Island hospitals were similarly impacted, with the state's acute care hospitals seeing a drop in operating margins from 1.07% in FY2018 to 0.17% in FY2022 (Manatt Health, 2024).

Figure 6.3: Rhode Island Health System Performance

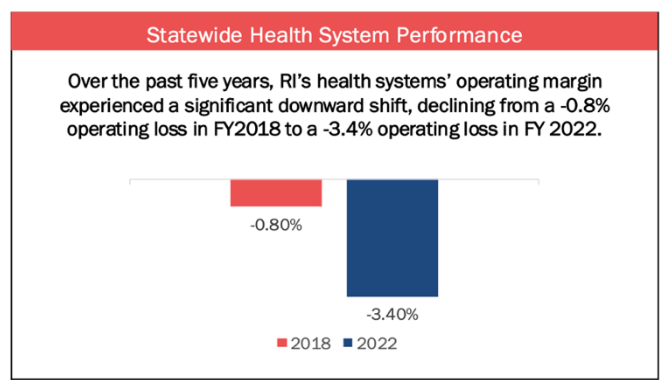
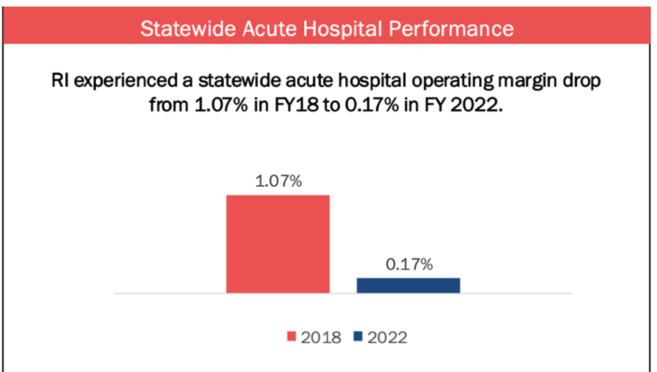


Figure 6.4: Rhode Island Acute Hospital Performance



Note. Source: Manatt Health. (2024). (rep.). *Examining the Financial Structure and Performance of Rhode Island's Acute Hospitals and Health Systems.*

Some recovery has been observed nationally, with U.S. hospital operating margins improving by 4.9% year-to-date as of August 2024 (Strata, 2024). Locally, most Rhode Island hospital systems have also seen advancements. Despite this improvement, margins remain below pre-pandemic levels, with the industry still facing financial uncertainty. Hospitals generally require operating margins of 3% to cover expenses (Southwick, 2024), while 4% is the level needed for investment in capital projects and growth (Kaufman Hall, 2024). Both nationally and in Rhode Island, hospitals are struggling to reach this threshold.

Scale matters, and as such, smaller hospitals are more likely to face financial struggles - particularly those with annual revenues under $500M. As a small state, many Rhode Island hospitals fall into this category, as shown below.

Figure 6.4: Rhode Island Health System and Hospital Performance, FY22

Note. Health system data sourced from Manatt Health. (2024). Examining the Financial Structure and Performance of Rhode Island's Acute Hospitals and Health Systems.; hospital data sourced from NASHP Hospital Cost Tool, Hospital Level Data Set, July 2, 2024. https://tool.nashp.org/. Analysis does not include Prime Healthcare Services

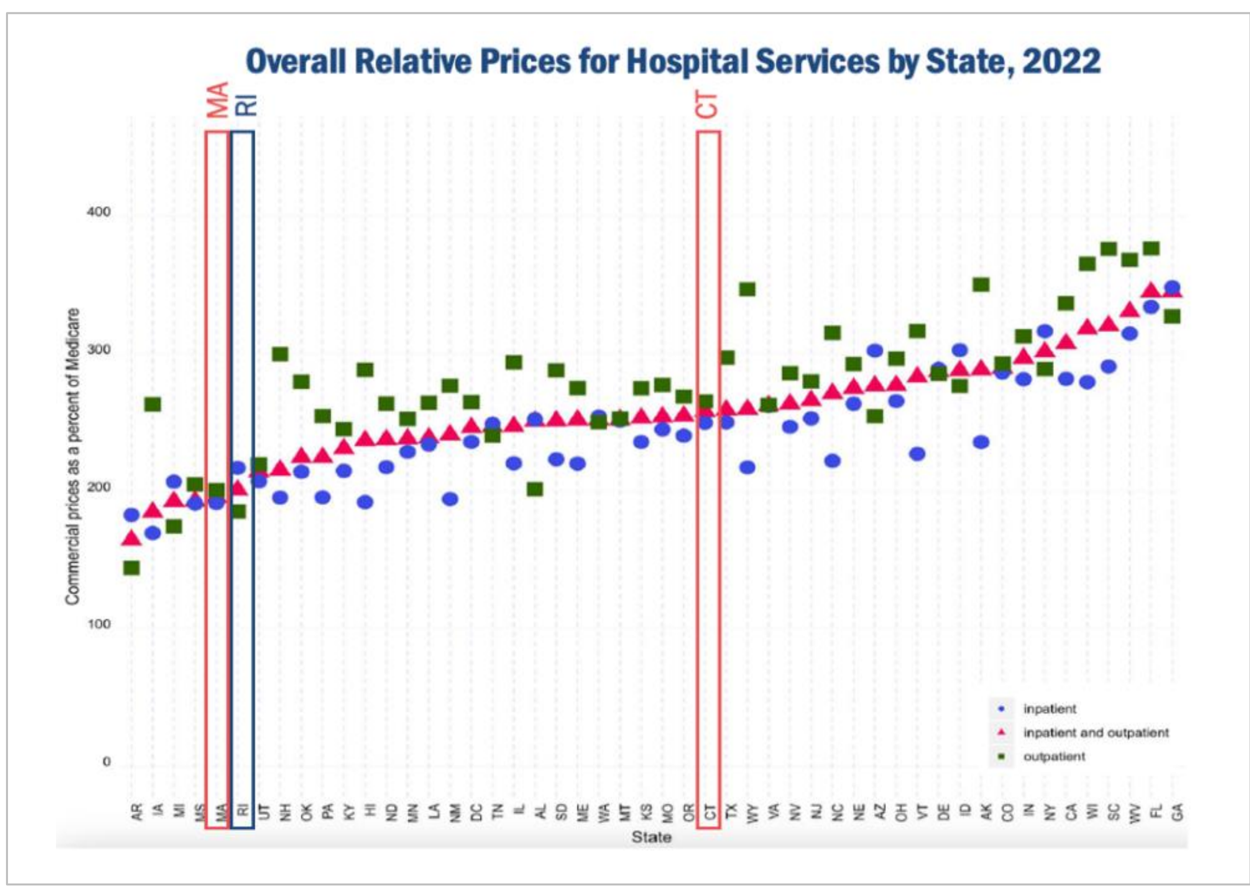
Health system	Health System Operating Revenue ($ Millions)	Health System Operating Margin	Hospital	Hospital Net Patient Revenue[7] ($ Millions)	Hospital Operating Margin
Brown University Health (formerly Lifespan)	$2,828	-2.0%	Rhode Island Hospital	$1,365	10.0%
			Newport Hospital	$121	1.7%
			The Miriam Hospital	$473	3.2%
Care New England (CNE) Health System	$1,230	-4.8%	Kent County Memorial	$345	-7.9%
			Women & Infants Hospital	$435	10.3%
Prospect CharterCARE LLC	$350	-7.8%	Roger Williams Medical Center	$168	-6.6%
			Our Lady of Fatima Hospital	$136	-5.5%
South County Health	$223	-2.9%	South County Hospital	$213	17.8%
Yale New Haven (Westerly Only)	$114	-11.9%	The Westerly Hospital	$113	1.5%
Prime	Not available		Landmark Medical Center	$136	11.7%

[7] Net patient revenue is used as a proxy for operating revenue, absent all payor operating revenue in NASHP cost tool data.

financial information. The Rhode Island statewide operating margin analysis includes Yale New Haven Health operating revenue and expense financials ONLY for The Westerly Hospital. The CNE Health System operating loss of $58 M is partly comprised of a $24 M goodwill impairment associated with Southeastern Healthcare System, Inc., and Affiliates for Memorial Hospital closure. Financials were not able to be confirmed and updated for FY 2023 in the given timeframe, but audited financials for RI Health Systems are largely publicly available.

Commercial Prices Relative to Medicare[8]

Figure 6.5: Overall Relative Prices for Hospital Services by State, 2022



Payment rates are a key factor impacting hospital financial performance. The RAND 5.0 hospital price transparency study found a wide variation in relative prices across states in 2022, as depicted in Figure 6.5 (Whaley et al., 2024).[9]

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[8] The "Commercial Prices Relative to Medicare" section updates findings reported in the Manatt Health Study (March 2024), using the latest 2022 data from RAND 5.0 and includes overall relative price, in addition to Inpatient and Outpatient Facility relative prices.

[9] RAND defines Relative Price as the ratio of the actual private/commercial allowed amount divided by the Medicare allowed amount for the same services provided by the same hospital

In 2022, average overall relative price for hospital services nationwide was 254% of Medicare, including inpatient and outpatient facilities, plus associated professional fees, across all data contributors. Rhode Island employer-sponsored health plans paid an average of 201% of Medicare allowed costs for hospital services. Comparatively, Connecticut's average relative price was 22% higher, just above the nationwide average and Massachusetts average relative price was 3% lower than Rhode Island (Whaley et al., 2024). Relative prices for inpatient and outpatient facility services specifically, can be found below.

Figure 6.6: Average Relative Price Comparison, Overall Hospital Services and Percentage Difference Compared to Rhode Island, 2022

Average Relative Price Comparison, 2022		
	Overall Hospital Services	% Difference Compared to RI
CT	258%	+22%
RI	201%	-
MA	195%	-3%

Figure 6.7: Average Relative Price Comparison, Inpatient and Outpatient Facilities, 2022

Average Relative Price Comparison, 2022		
	Inpatient Facility	Outpatient Facility
CT	256%	286%
RI	227%	189%
MA	194%	205%

Medicaid Hospital Expenditure

In addition to base payments for hospital services, Rhode Island uses a combination of supplemental payment types**,** including Disproportionate Share Hospital (DSH) payments, Upper Payment Limit (UPL) payments, Graduate Medical Education (GME) payments for teaching hospitals, and as of 2024, State Directed Payments (SDP). Historically, DSH payments constituted the majority of supplemental funding, accounting for 96% in SFY 2020. However, by 2024, SDPs largely replaced DSH, reducing its share to 5% of total supplemental payments.

Supplemental payments in Rhode Island have more than doubled over the past five years and make up a growing share of total Medicaid payments to hospitals, increasing from 20% to 29% from state fiscal year (SFY) 2020 to SFY 2024.

Figure 6.8: Rhode Island Medicaid Hospital Expenditures SFY 2020-2024

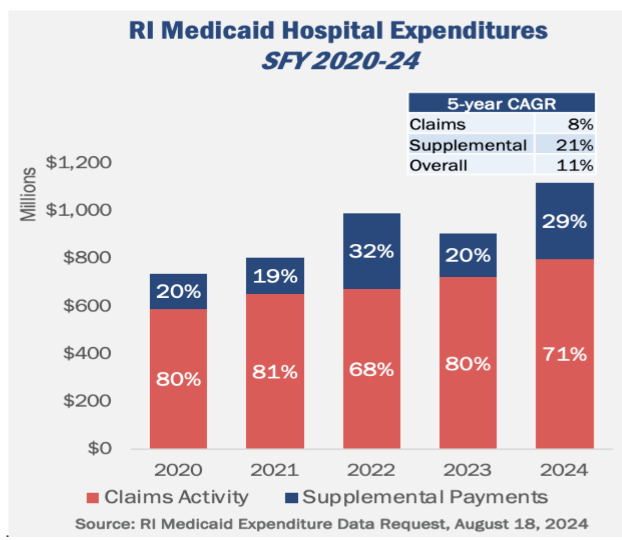
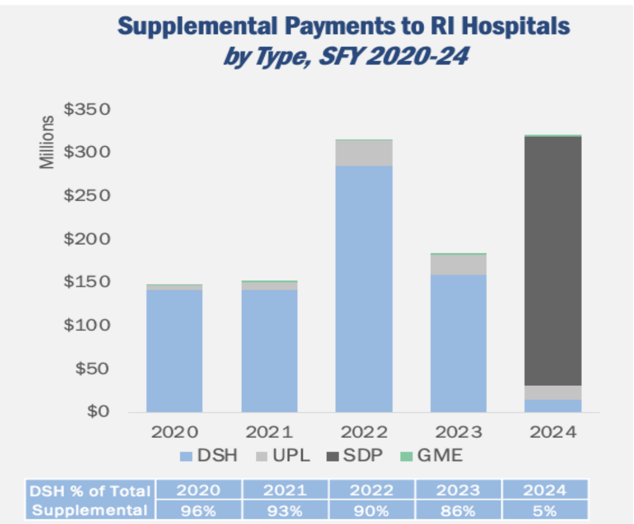


Figure 6.9: Supplemental Payments to Rhode Island Hospitals by Type, SFY 2020-2024



Note. Source: RI Medicaid Expenditure Data Request, August 18, 2024. RI Medicaid hospital expenditures reported here exclude payments made to Eleanor Slater and out-of-state hospitals. Additionally, claims activity for SFY 2024 includes projected expenditures for Q3 and Q4. Claims activity growth rate includes growth in rates and utilization.

Key Trends and Challenges

Seven primary national trends are shaping the future of the hospital sector.

Trend #1: Consolidation and Financialization

One prominent trend is the consolidation and financialization of hospitals. Increasingly, hospitals are merging with larger health systems to gain economies of scale, and nonprofit hospitals are transitioning to for-profit structures. This trend reflects a broader movement within the health care industry toward financial models that emphasize investor-owned entities (KFF, 2024).

Figure 6.10: Evidence of Consolidation, Trends of Hospitals in Health Systems vs. Hospitals Not in Health Systems

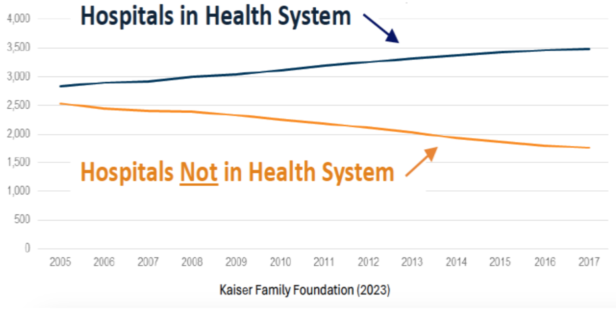


Figure 6.11: Evidence of Financialization, Private Equity Hospitals, 2024

Note. Source: Excerpt from "Consolidation and Financialization in Health Care" presentation by Zirui Song, MD, PhD, Harvard Medical School, Massachusetts General Hospital at NASHP on September 9, 2024

Trend #2: Shifting Payor Mix

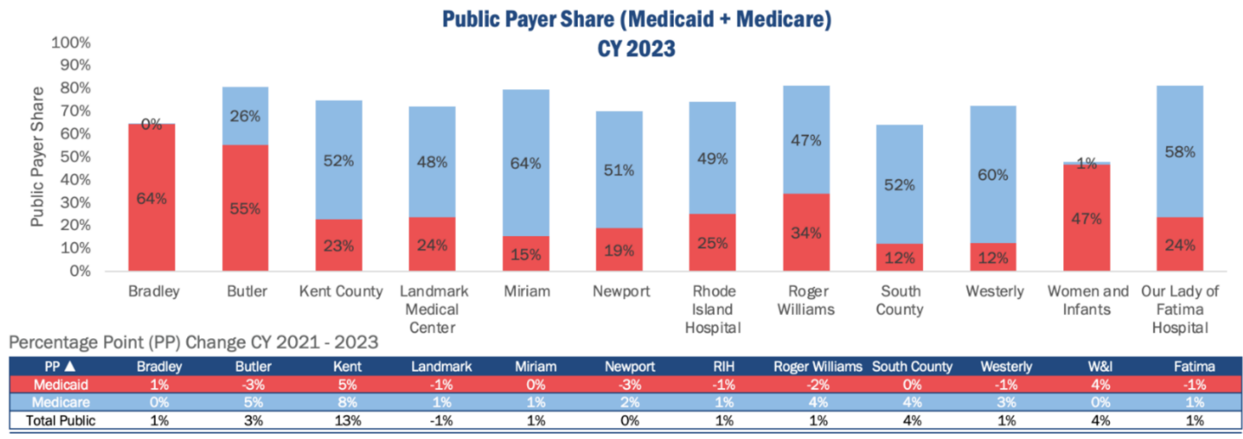
Another significant national trend is the shifting payer mix toward public payors, which offer lower reimbursement rates compared to commercial insurance. The U.S. health care system is seeing more patients moving from commercial insurance into Medicare, a trend considered to have the greatest long-term impact on hospital revenues (Javanmardian, 2024). This shift is also present in Rhode Island, where the public payer share of inpatient hospital discharges continues to rise, with Medicare serving as a primary driver of this shift (*Hospitalization Discharge Data: Department of Health*, 2024).

Figure 6.12: Percentage Growth of Public Payers in Rhode Island, CY 2021-2023

Statewide	2021	2023	PP ▲
Medicare	41%	43%	2%
Medicaid	27%	28%	1%
Public Payer Total	**68%**	**71%**	**3%**
Commercial	26%	25%	-1%
Self-Pay	4%	2%	-2%
Other	3%	3%	0%

Note. *Source: RIDOH, Hospital Discharge Data, CY 2023. Public payer share based on share of inpatient discharges.*

Figure 6.13: Public Payer Share by Rhode Island Hospital, CY 2023



Percentage Point (PP) Change CY 2021 - 2023

PP ▲	Bradley	Butler	Kent	Landmark	Miriam	Newport	RIH	Roger Williams	South County	Westerly	W&I	Fatima
Medicaid	1%	-3%	5%	-1%	0%	-3%	-1%	-2%	0%	-1%	4%	-1%
Medicare	0%	5%	8%	1%	1%	2%	1%	4%	4%	3%	0%	1%
Total Public	1%	3%	13%	-1%	1%	0%	1%	1%	4%	1%	4%	1%

Note. Source: RIDOH, Hospital Discharge Data, CY 2023. Public payer share based on share of inpatient discharges.

Small shifts in payor mix can have substantive impact on hospital margins, as evidenced by the variance in margins by payor shown below:

Figure 6.14: 2022 Operating Margin by Payor

Health System	Hospital	Commercial	Medicaid	Medicare	Medicare Advantage
Care New England	Kent Hospital	-17%	-1%	-2%	2%
	Woman & Infants	22%	4%	-31%	-26%
CharterCare	Roger Williams	-182%	5%	18%	21%
	Our Lady of Fatima	-19%	8%	-7%	-3%
Lifespan	Newport Hospital	22%	-16%	-9%	-5%
	Rhode Island	18%	-12%	15%	19%
	The Miriam	8%	-48%	13%	16%
Prime Healthcare	Landmark	2%	6%	25%	28%
South County Health	South County	45%	-53%	-12%	-8%
Yale New Haven	Westerly	31%	-60%	-10%	-6%

Note. Source: NASHP Hospital Cost Tool, Hospital Level Data Set, July 2, 2024. https://tool.nashp.org/.

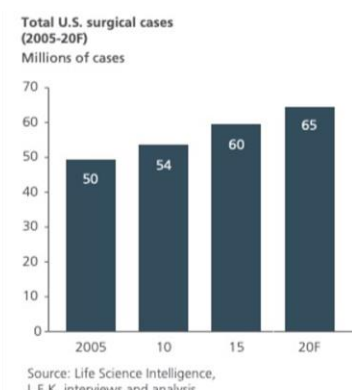
Trend #3: Reduced Safety Valve

The financial outlook for hospitals is further complicated by the end of stimulus funds and public health emergency-related reimbursement enhancements, which once provided critical support to hospitals.

Trend #4: Shift from Inpatient to Outpatient Settings

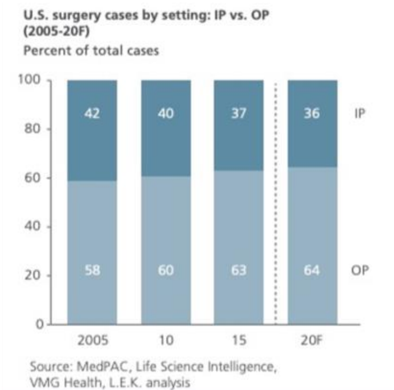
Hospitals are also shifting more care to outpatient settings, nationally and locally. Nationally, these shifts, along with changes to Medicare payment rules, have left hospitals treating more complex, higher-cost patients in inpatient settings, where reimbursement rates often fail to cover the costs of care (AHA, 2024).

Figure 6.15: Total US Surgical Cases, 2005-2020



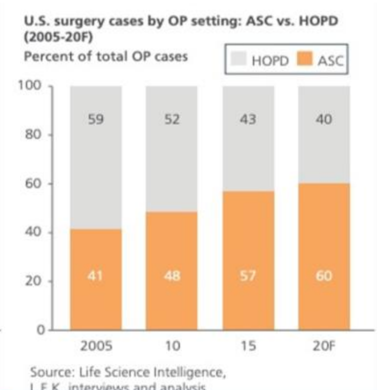
Total US surgical cases are projected to grow nationally at 1.8% per year from 2005 to 2020, or 1.6% per year from 2015-2020

Figure 6.17: US Surgery Cases by Setting, IP vs. OP, 2005-2020



- Outpatient cases are a growing share of surgical cases, increasing to 64% in 2020
- Implied projected outpatient growth rate: 2.4% from 2005-2020, or 1.9% from 2015-2020

Figure 6.18: US Surgery Cases by OP Setting: ASC vs. HOPD, 2005-2020



- ASCs account for a growing share of OP, increasing to 60% in 2020
- Implied projected ASC case growth rate: 5.1% from 2005-2020, or 3.0% from 2015-2020

Note. Source: Excerpt from "Care New England Ambulatory Surgery Center Certificate of Need" report by Faulkner Consulting Group, May 2021

Trend #5: Technology Investments in EMR and Cyber-security

Technology investments, such as those in electronic medical records (EMRs) and telemedicine services, continue to reshape hospital operations. Rhode Island hospitals utilize widely adopted systems like Epic, Cerner, and Meditech, which, while improving patient care, have also contributed to provider burnout due to their time-intensive nature. See Figure 6.19 for 2024 distribution of EMRs in Rhode Island hospitals.

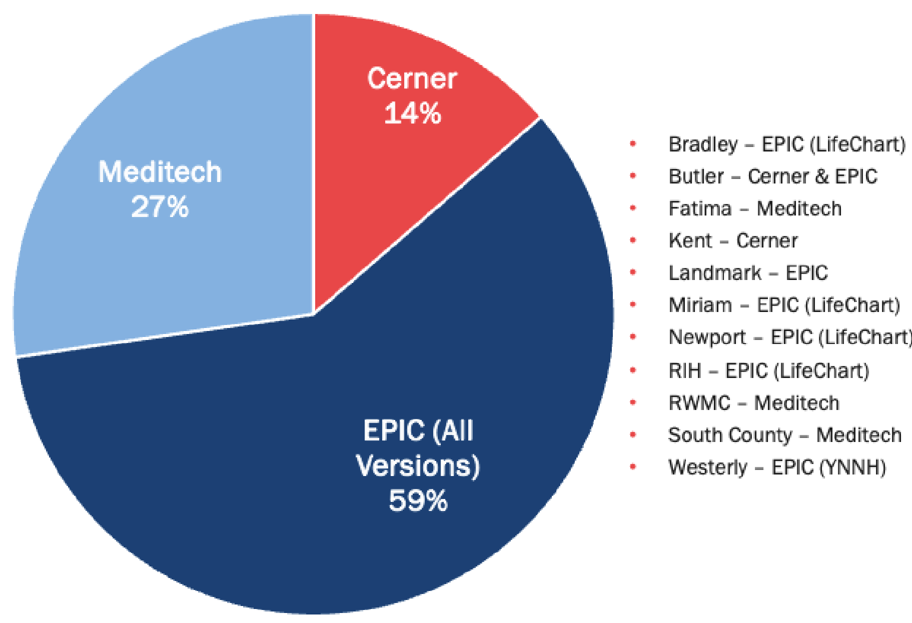
EMR Systems have been seen to both improve patient care and increase operational efficiency (Zhang & Zhang, 2016)**:**

- EMR systems enhance accuracy and accessibility of patient information and support clinical decision-making and continuity of care.
- EMR systems generate meaningful statistics used in health care service planning and management.

However, EMR systems can often be time consuming and burdensome to doctors, nurses, and other providers (National Academies of Sciences, Engineering, and Medicine, 2019):

- Nurses and doctors on average spend 50% of their workday with EMRs instead of with patients and some emergency department physicians cited spending most of their time using EMRs.
- Health care providers often associate burnout with EMR use.

Figure 6.19: Distribution of EMR Systems Adopted in Rhode Island Hospitals



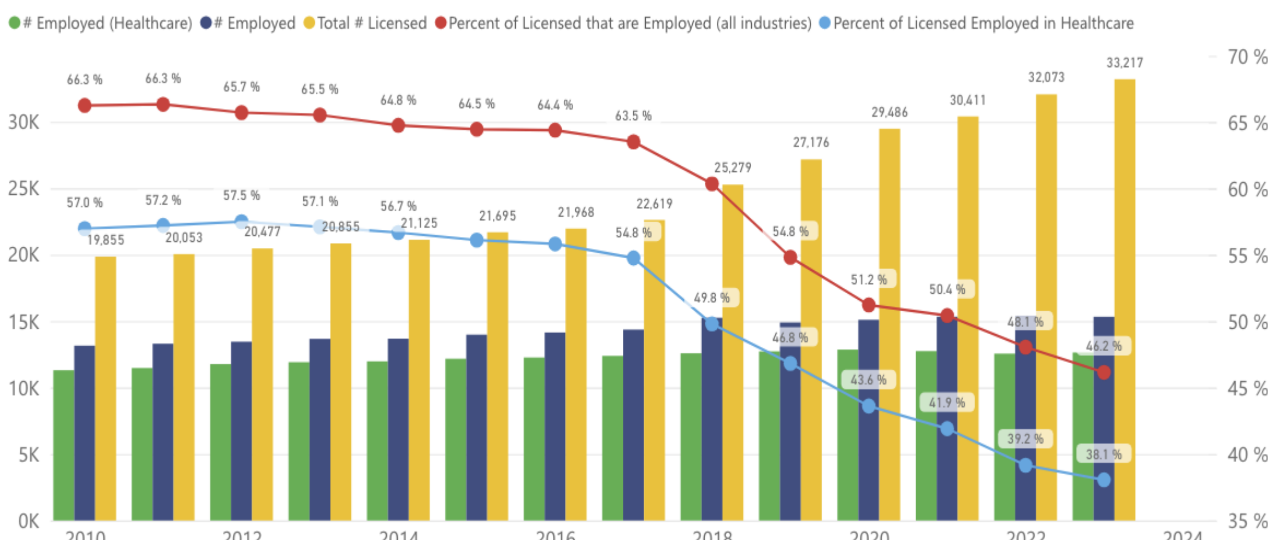
Note. EMR systems for rehabilitation hospitals were unable to be confirmed for inclusion, and state-owned hospitals are not currently utilizing EMR systems but are in the procurement process.

Trend #6: Staffing Shortages

Staffing shortages remain a significant challenge both nationally and in Rhode Island, where providers face persistent shortages of registered nurses (RNs) and other essential staff, further straining hospital resources (*Costs of Caring | AHA*, 2024).

While the total number of licensed RNs in Rhode Island has been steadily increasing over the last eight or more years, the percentage of licensed RNs who are employed in the health care industry has dropped from 56% to 38% over the same period, as shown below (Ganguly et al., 2024).

Figure 6.20: Registered Nurses in Rhode Island, 2010-2023



Note. Partial data for CY2024 is not reported but is available on the RI EOHHS Health Workforce Data Dashboard through July 15, 2024, https://eohhs.ri.gov/health-workforce-dashboard. Beginning in CY2024, we should expect to see significantly fewer total licensed RNs, and a more accurate reflection of the true nursing workforce in RI due to the Nurse Licensure Compact (effective 1/1/24).

Trend #7: Demographic Shift

Finally, an aging population and the increasing prevalence of chronic conditions are placing additional pressure on hospital resources across the U.S. This demographic shift is leading to more resource-intensive care needs, exacerbating existing operational challenges.

Statewide Landscape

Structure and Distribution of Services

The structure and distribution of hospital services in Rhode Island is composed of a mix of acute care, psychiatric, rehabilitation, and long-term acute care facilities. As previously mentioned, Rhode Island has 16 hospitals distributed across seven hospital systems. Of these, 10 are acute care hospitals, three are psychiatric hospitals, two are rehabilitation hospitals, and one is a long-term acute care hospital (LTACH). The two dominant health systems—Brown University Health (formerly Lifespan) and Care New England—

account for the majority of inpatient discharges, with Brown University Health handling 46% and Care New England 32% as of 2023 (*Hospitalization Discharge Data: Department of Health*, 2024). Smaller hospitals and specialized facilities, including rehabilitation and psychiatric hospitals, complement the broader acute care services provided by these major systems.

Brown University Health and Care New England serve the bulk of the population, offering a wide range of services, including high-complexity inpatient care and a full spectrum of diagnostic and therapeutic services. In addition, the Rhode Island State-operated Eleanor Slater Hospital is in the process of transitioning into a true LTACH, designed to provide specialized care for medically complex patients.

Discussion of Problem Areas in Rhode Island's Hospital Sector

Using one on one interviews with hospital workgroup participants and existing local data, six problem areas were identified as high priority for Rhode Island's hospital sector. Problem areas address capacity concerns, unmet patient needs, and workforce shortages among many other challenges. Problem areas are categorized into Priority A and Priority B, with Priority A representing those more narrowly focused on the hospital sector and affiliated health systems, and Priority B highlighting crosscutting issues. As such, Priority B areas require supporting action and cross-sector collaboration to be effectively addressed.

The following section presents detailed problem statements, categorized by problem area. These statements are based on comprehensive feedback gathered from all stakeholders involved in the interview and workgroup process. In some instances, additional study is required to verify the accuracy of the identified issues; as such, recommendations include some areas for further study.

Priority A Problem Areas Include:

- Problem #1: Lack of Statewide Health System Oversight, Data Infrastructure, and Long-Term Planning
- Problem #2: Reimbursement Not Keeping Pace with Rising Costs
- Problem #3: Limitations in Investment and Technology

Problem Areas: Priority Level A

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

Rhode Island's hospital sector lacks a centralized, well-resourced oversight mechanism. Without robust long-term planning and data governance, critical gaps exist in monitoring community needs, hospital capacity, and fiscal stability. Detailed problem statements are below.

a) Rhode Island needs 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, Rhode Island 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, especially regarding community needs (considering outmigration of services), system capacity, rate adequacy, and hospital fiscal stability.

- Certificate of Need (CON) process isn't working.
  - Most proposals are approved, leading to unnecessary duplication of services which can then dilute hospital volume and increase operating costs.
  - CON process itself is outdated (e.g., length of time for proposal review, dollar thresholds for review).
  - Conditions on approvals lack substance and enforcement. Conditions may include remaining nonprofit and locally owned, but these conditions are not being monitored or enforced.
- Historically, Rhode Island hospitals have built specialized capacity for new services without sufficient demand to deliver them efficiently, thus detracting from core services and populations, causing financial distress.
  - Need to identify services or specialties needed in-state versus 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 concerns regarding lack of transparency and oversight over hospital operating cost and health system expenditures.
- Little insight into, nor acknowledgement of, the impact of integrated physician practices on hospital financial performance and operational challenges.

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

d) Rhode Island lacks integrated multi-payor regulatory and oversight processes between EOHHS, OHIC, RIDOH, and the Office of the Attorney General.

- Current regulatory authority structure for health system planning is too dispersed to be effective.

e) There are strong private equity guardrails in the hospital sector, but fewer protections in other sectors (e.g., physician practices, urgent care centers, nursing homes, etc.)

f) There is a limited focus on statewide health equity within the hospital sector.

- Rhode Island needs more information about the impact of hospital financial instability on communities with high Medicaid reliance and outsized dependance on Emergency Departments for non-emergent situations.
- Concerns regarding hospital compliance with and investment through the Community Benefit requirements, and a lack of state enforcement mechanisms.

- There is a lack of transparency into disparities in health outcomes by race and 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 preventive care.

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

h) Hospital systems are operating in silos, with limited collaboration to identify and disseminate best practices that address system-wide challenges.

Problem #2: Reimbursement Not Keeping Pace with Rising Costs

Hospitals in Rhode Island are experiencing significant financial strain demonstrated by persistent negative operating margins due to rising operating costs. Aside from the rising cost of medical supplies, prescription drugs, wages and benefits, and information technology, Rhode Island hospitals have been experiencing high rates of claims denials and prior authorizations resulting in high overhead costs attributable to legal fees and administrative burden. While there has not been a recent comprehensive and comparative study of Medicaid reimbursement rates, the consensus among workgroup participants is that Medicaid rates are likely inadequate and are contributing to inequities in access for individuals using Medicaid. Additionally, supplemental payments which are perceived to be a less reliable and therefore less predictable source of income, have more than doubled over the past five years and make up a growing share of total Medicaid payments to hospitals, increasing from 20% in SFY 2020 to 29% in SFY 2024 (RI Medicaid Expenditure Data Request, August 18, 2024). Many participants also called for hospital accountability over rising operating costs and operational efficiency. Detailed problem statements are below.

a) Wages and benefits

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

a) Key drivers of rising operating costs

- Payor behaviors, where hospitals identified 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, with "small/medium" hospitals and health systems by national standards limits efficiency in large part due to high administrative infrastructure costs.
- Excessive documentation requirements, where EMR systems are designed for billing improvements, but are reducing staff efficiency.
- Increasing cost of medical supplies and prescription drugs.
- Overhead, including payment of physician subsidies, legal fees, etc.
- System costs, including purchasing of physician practices by large health systems.

b) Reimbursement limitations, especially Medicaid

- Commercial reimbursements appear comparable to bordering states (as reported by Manatt Health RI Hospital and Health System Study, March 2024).
- Substantial concerns noted about Medicaid rate adequacy, although supporting data are not available here.
- Suppressed reimbursements create high risk of hospital closures.

c) Medicaid reimbursement structure

- Structure is not predictable and is highly dependent on supplemental payment components outside of rates (e.g., UPL, DSH, SDPs, GME).
- There is a perception that Rhode Island is not sufficiently leveraging federal match, including potential MCO tax and provider tax opportunities.

d) Negotiated fees

- Rates and fees are negotiated (not set) for commercial insurance, (MA, and Medicaid managed care), and can vary substantially based on entities' market power. This leaves smaller providers disadvantaged.
- There is limited political will to hold commercial carriers accountable for having a sufficient network.

e) Hospital accountability & payment reform

- There is a need for hospital accountability for rising operating costs, with state fiscal monitoring potentially tied to penalties/incentives, or accountability through hospital global budgets.
- Global budgeting and the recently awarded AHEAD Cooperative agreement can be a potential pathway to accountability.
- Some noted challenges or limitations of value-based payments (VBP) and/or global budgets as a solution. Identified challenges include limited financial support and state capacity for effective planning adding to existing payer and payment complexity, the need for multi-payer participation, the transfer of risk to financially fragile provider organizations, and losses on VBC contracts eliminating operating margins.

Problem #3: Limitations in Investment and Technology

Rhode Island hospitals face significant barriers to capital investment in infrastructure, technology, and cybersecurity due to financial instability. Outdated facilities and insufficient electronic medical records (EMR) interoperability reduce operational efficiency, while limited access to funding hampers the modernization of essential services. Detailed problem statements are below.

a) Low margins are 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 hospitals and health systems paired with financial instability limits access to bond markets and other sources of capital.

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

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

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

f) Cybersecurity risks are causing business continuity risks
   - Reliance on technology means that if systems go down, hospitalists can’t write orders, and all operations stop.
   - There is a lack of thought leaders in cybersecurity, both in state positions and in the hospital systems
     - The cybersecurity regulatory environment is asymmetric (e.g., hospitals have clear penalties for non-compliance, whereas vendors do not have that same level of regulatory oversight)

Priority Level B Problem Areas Include:

- Problem #4: Workforce Challenges

- Problem #5: ED Utilization, Primary Care Capacity and Prevention
- Problem #6: Length of Stay and Care Transitions

Priority Level B

Problem #4: Workforce Challenges

Hospitals in Rhode Island face severe workforce shortages, as is true nationally across many health care sectors. Workgroup participants emphasized the Rhode Island hospital sector as being particularly impacted by shortages of nurses, physicians, surgical technologists, and diagnostic imaging staff across all modalities. A lack of strategic workforce planning, including collaboration across hospitals and with local universities, as well as clear career pathways has led to high turnover, while inadequate wages and benefits further exacerbate recruitment challenges. The shortage of technical apprenticeship programs has also impacted the readiness of health care workers, leading to faster burnout. Detailed problem statements are below.

a) Lack of access to physicians and specialists, with patients waiting several months to get an appointment.

b) Nursing & Technologist shortages

  - In the past, nurses generally had a dedicated Certified Nursing Assistant (CNA), now there is one CNA split between two (2) or three (3) nurses.
  - Registered Nurse (RN) and ancillary staff supply shortages. The Rhode Island EOHHS, Health Workforce Data Dashboard shows a decreasing percentage of licensed RNs interested in pursuing careers in the industry (50% in 2018 down to 38% in 2023).
  - Lack of clear and robust career ladder from CNA to Licensed Practical Nurse (LPN) or RN – among those with a valid license record with Rhode Island, only 8% have gone on to become an RN since 2010 (Rhode Island EOHHS, Health Workforce Data Dashboard).
  - Insufficient experiential training and apprenticeship programs, that are leaving entry level nursing staff not prepared to work independently and leading to faster burnout and high turnover.
  - Limited surgical and diagnostic imaging Technologists and Technicians. There is only one surgical technologist degree program in the state.

c) Lack of hospital wide strategic workforce planning, career path program development and implementation due in part to insufficient managerial resources and capacity within hospitals to take advantage of existing state workforce programs and to partner with the Department of Labor on addressing emerging workforce needs.

d) Lack of engagement and partnership between hospital leadership, physicians, and specialists.

Problem #5: ED Utilization, Primary Care Capacity and Prevention

Rhode Island's emergency departments (ED) are frequently used for non-emergency care due to inadequate community access to primary care and preventive services. Issues such as limited after-hours care and behavioral health (BH) services contribute to inappropriate ED utilization, disproportionately affecting vulnerable populations. Detailed problem statements are below.

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 ED capacity constraint details (e.g., when, where, wait times), making it challenging to develop focused strategies to improve community alternatives.

a) Primary care and alternatives

- There is a lack of access to primary care physicians, causing increased ED utilization which is impacting Rhode Island's most vulnerable populations the hardest. Rhode Island needs targeted investment in primary care capacity.
- Inadequate leveraging of Federally Qualified Health Center (FQHC) system to reduce avoidable ED use. Alternative payment models may provide an opportunity for targeted solutions.
- Most Rhode Islanders cite lack of open alternatives as reasons for using the ED for 'non-emergency' care.
- Seriously ill patients are overwhelming EDs and being treated and 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.

b) Behavioral Health & Health Related Social Needs (HRSNs)

- Lack of HRSN navigators and centralized resources to appropriately support patients frequenting the ED.
- Early and pending investments in mobile crisis CCBHC, and community BH alternatives are making a difference, and therefore must continue to grow and be maintained.
- Hospitals are experiencing challenges with ED triage, specifically for patients with behavioral health needs.

Problem #6: Length of Stay and Care Transitions

Hospitals in Rhode Island face challenges with extended patient lengths of stay due to increased patient complexity, a lack of adequate community-based care alternatives, and inefficiencies in transitioning patients to post-acute care settings. Delays in discharge are exacerbated by a shortage of nursing home beds and step-down care facilities, as well as burdensome prior authorization requirements, putting additional strain on hospital resources. Detailed problem statements are below.

a) Increased patient complexity means higher acuity patients are staying in hospitals longer

b) Community alternatives
  - Rhode Island is underprepared for its rapidly aging population and has lacked focused investment in community-based social and medical services for elders to avoid admissions both to hospitals and to Skilled Nursing Facilities (SNFs).
  - Care transitions from hospitals to post-acute care, long term care, behavioral health care, and social services are a challenge.
  - Financial stability of alternative community settings is at risk in part due to workforce.
  - Inpatient behavioral health stays are significantly longer than necessary due to a lack of step-down options.

c) Lack of available nursing home beds and cuts to homecare agencies, largely due to reimbursement issues, are contributing to long lengths of stay.

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

e) Each hospital has developed its own approach to managing care transitions, without any statewide alignment or consistency.

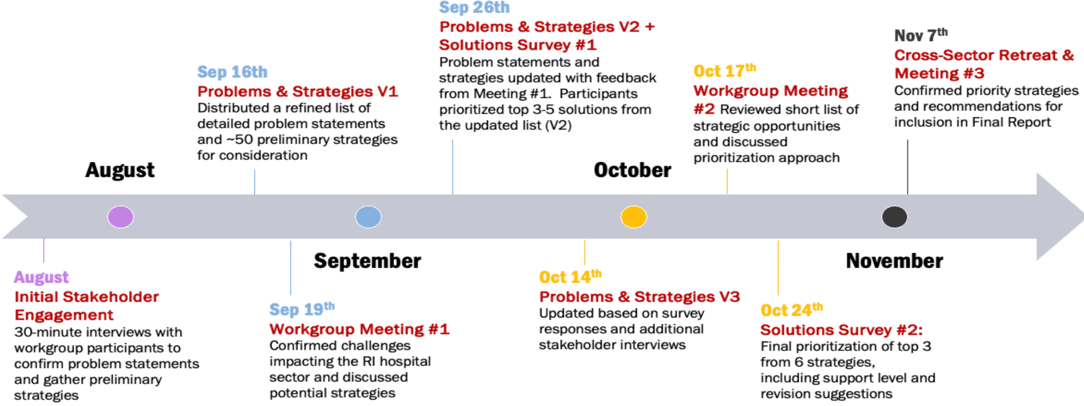
Hospital Core Recommendations and Action Steps

The workgroup was composed of more than 25 non-state participants including several local hospital CEOs and other leaders, physicians, insurers, business representatives, community-based advocates, and other subject matter experts. In August, FCG began the workgroup's engagement, with one-on-one interviews of nearly all participants. Interviews added color and detail to existing problem statements released by the HCSP Cabinet in May 2024 and generated an initial list of preliminary strategies and opportunities to address hospital sector challenges. Figure 6.21 outlines the workgroup process and timeline, going from initial interviews to agreement on final recommendations.

Figure 6.21: Hospital Sector Workgroup Process and Timeline, 2024

The following principles were designed with input from hospital workgroup participants to guide the process and products of the workgroup and to ensure the overarching goals set by the Rhode Island HCSP Initiative were achieved.

Hospital Workgroup Principles



1. **Ensure equitable, affordable access to health care for all**, while ensuring adequate provider capacity & high-quality patient experience
2. **Focus on solutions and root causes** – avoid too much study, identify actions
    - **Prioritize** – identify and focus on the highest priority items
    - **Address underlying issues** to avoid replicating challenges
    - **Don't recreate the wheel** – build on existing capacity, learnings, expertise, wherever possible
3. **Data informed** decisions – some may need to be "longer term" to enable access to better data
    - Propose some **quick fixes** to ensure things don't "break" while longer cycle, data driven decisions are underway
    - Ensure quick fixes consider root causes and don't perpetuate existing inequities
4. **Stay in the hospital sector "lane"** – but identify cross-cutting and/or overlapping priorities that need to be tackled in other workgroups.
    - Maintain a **system & statewide lens for solutions** – focus on what the state and system as a whole should do, not individual hospitals
5. **Maximize federal participation** – leverage match, enhanced match, whenever possible.
    - Where additional federal funding is identified, ensure it doesn't displace existing State funding
    - Collectively aim to **keep health care revenues in the broader health care sector**
6. **Strive to support the creation of high-quality, well-paid positions** with comprehensive benefits

Recommendations and Action Steps

Workgroup participants began with a list of more than 50 strategies to consider, and together they refined considerably to reach agreement on a handful of priority recommendations. Several original strategies were bundled into each of the resulting priority recommendations while others remain ideas for future consideration. Below is a high-level summary of the three final prioritized hospital sector recommendations, in order of priority as ranked by the workgroup. Please see the full Foundational Report for a more detailed review of all of the Hospital Workgroup's Recommendations, including detailed action plans.

Medicaid Payment

Priority Recommendation #1. Take action to address the financial strain on Rhode Island's hospitals due in part to high public payor mix and workgroup noted inadequacies in public payor rates contributing to inequities in access for individuals using Medicaid. Action steps include:

a. Pursue pathways to maximize federal contributions to make interim adjustments to rates and/or state directed payments while performing a comprehensive rate study to include hospitals, primary care, and physicians/specialists;

b. Based on study, adjust Medicaid rates using federal contributions and alternative sources of funds, as needed;

c. Consider statewide, coordinated rate reform to improve inequities in access for Medicaid patients

Fiscal Transparency & Performance Monitoring

Priority Recommendation #2. Establish Hospital/Health System Fiscal Transparency, Solvency & Performance Monitoring (with equity lens), informing and quantifying the workgroup identified crisis in hospital fiscal stability and requiring active provider engagement in long-term sustainability efforts. See a draft of the fiscal transparency and performance monitoring framework below in Figure 6.22. Action steps include:

a. Establish infrastructure/capacity for ongoing fiscal transparency, solvency and performance monitoring and perform initial analysis;

b. Seek Medicaid 1115 Waiver authority and funding to support findings from hospital fiscal monitoring;

c. Tackle hospital operating costs/efficiency through statewide learning collaborative

Figure 6.22: Draft Framework for Fiscal Transparency and Monitoring Dashboard

RI EOHHS: *Draft* Health Care Provider Financial Health and Efficiency Dashboard

Domain	Purpose	Rationale	Sample Metrics
1. Financial and Licensure Status	Assess provider financial and licensure status to identify potential short- and longer-term risks.	• Identify risks for abrupt facility closure. • Inform health system planning and policy relative to cost containment, access to care, health outcomes and equity, and community benefit.	• Standardized financial information, at the parent and entity levels, for comparison between peers and over time. • Facility licensure in-good-standing per State Survey Agency.
2. Characteristics	Explore the characteristics that contribute to financial status and efficiency.	• External and internal factors impact providers' financial position and relative efficiency.	• Market share • Bed occupancy • Services provided • Payer mix • Price
3. Expense Decisions	Explore the prioritization and allocation of expenses.	• Expenses and expense allocation impact financial status, relative efficiency, affordability, health outcomes and equity.	• Operating costs by expense category • Net revenue compared to costs • Cost-to-charge ratio
Phase II Domains			
4. Utilization, Outcomes, and Health Equity	Assess utilization patterns and trends relative to cost, quality, equity.	• Utilization impacts revenue and financial status. • Trends can signal quality of care, equity of access and outcomes, and show migration between settings and providers.	• Case mix-adjusted discharges • ED visits by level of intensity • Readmission rates • Inpatient stays and outpatient visits (by age, gender, race, geography)
5. Community Benefit	Assess health care charitable organization community benefit.	• All health care charitable organizations are required to develop annual community benefits plans to ensure the unique health care needs of a community are met.	• Reported community benefit funds from the Form 990 Schedule H • Community Health Needs Assessment and implementation plan

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Acute Care Plan

Priority Recommendation #3. Develop a Statewide Acute Care Plan, informed by a deep dive analysis of statewide capacity and needs to provide an evidence base for future health system investments. Action steps include:

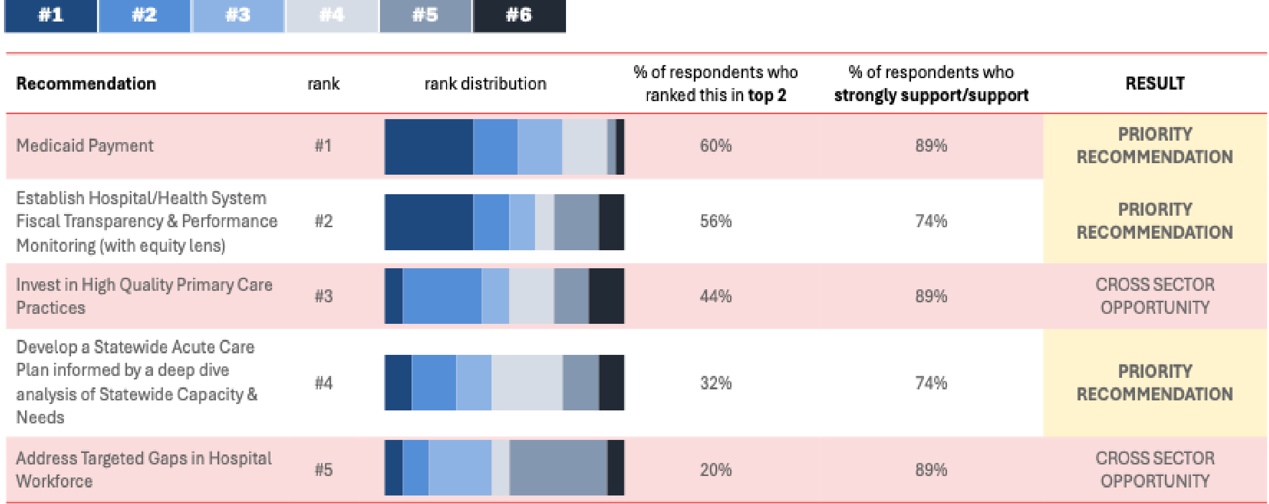
a. Consider Rhode Island specific versus regional capacity, hospital versus alternative structures, health equity, and geographic differences. Use Certificate of Need (CON) as an implementation tool for the Acute Care Plan, where appropriate.

These final recommendations were based on survey results shown below, which were used to rank the top five (5) recommendations discussed at the final workgroup meeting. Of the top five recommendations, all are supported or strongly supported by 74% - 89% of workgroup participants,[10] and more than 50% of the workgroup ranked Medicaid Payment (#1) and Fiscal Transparency & Performance Monitoring (#2) as one of their top two priorities.

[10] Responses to Survey #2 were received from 27 out of 34 workgroup participants.

Figure 6.23: Rank Distribution of Hospital Workgroup Priorities

Rank Distribution Color Key:



Recommendation	rank	rank distribution	% of respondents who ranked this in **top 2**	% of respondents who **strongly support/support**	RESULT
Medicaid Payment	#1		60%	89%	PRIORITY RECOMMENDATION
Establish Hospital/Health System Fiscal Transparency & Performance Monitoring (with equity lens)	#2		56%	74%	PRIORITY RECOMMENDATION
Invest in High Quality Primary Care Practices	#3		44%	89%	CROSS SECTOR OPPORTUNITY
Develop a Statewide Acute Care Plan informed by a deep dive analysis of Statewide Capacity & Needs	#4		32%	74%	PRIORITY RECOMMENDATION
Address Targeted Gaps in Hospital Workforce	#5		20%	89%	CROSS SECTOR OPPORTUNITY

The Hospital Workgroup ultimately chose to prioritize three recommendations with the understanding that primary care investment and hospital workforce considerations are being more comprehensively addressed by experts in other HCSP workgroups. Medicaid Payment (#1), Fiscal Transparency & Performance Monitoring (#2), and Acute Care Plan (#4) will be further elaborated on in Appendix D.2.

Cross-sector opportunities for collaboration and to breakdown silos

The hospital workgroup was composed of experts from all backgrounds including primary care, behavioral health, health related social needs, long term care, and workforce. This representation of experts allowed the workgroup to consider several opportunities involving cross-sector collaboration that would ultimately support challenges in the hospital sector.

Two cross-sector opportunities that rose to the top involved investment in high quality primary care (recommendation #3) and addressing targeted gaps in hospital workforce (recommendation #5). These recommendations are broadly supported by the hospital workgroup; however, the group noted that additional input is needed from the relevant HCSP workgroups to better define appropriate action steps needed for them to be successfully implemented. Cross-sector recommendations from the hospital workgroup are described in further detail below. Additional comments provided by workgroup participants are included below each recommendation for consideration. Please also see the section on interdependencies between all health care sectors in this report on page 203.

Invest in High Quality Primary Care Practices (Ranked #3)

- Purpose: State could play a role in ensuring primary care practices are paid sufficiently, irrespective of whether they are independent or part of a health system.
- Assess Gaps: Consider including primary care practices and FQHCs in the financial transparency and monitoring initiative (#2) to assess targeted gaps in financial performance and operational efficiency and identify high performing, high quality practices.

- Develop Interventions - Payment: Ensure appropriate incentives are in place to reward efficiency and drive quality outcomes (e.g., Alternative Payment Models to support physician productivity). Payment models should support team-based care.

These comments, gathered in writing through a workgroup survey, provide additional insights that, while not part of the Workgroup's full consensus, offer valuable alternative perspectives.

Primary Care Investment: Additional comments for consideration
To remain competitive with neighboring states, recruitment and retention needs to be addressed across the full spectrum of medical specialties.

Address Targeted Gaps in Hospital Workforce (Ranked # 5)

- Assess Gaps. Develop data-driven identification of priority workforce gaps based on the EOHHS Health Workforce Data Dashboard and statewide Department of Labor and Training workforce data. Collect feedback on identified gaps from hospital sector to refine priorities based on hospital/geography specific experience.
- Develop Interventions. Based on priority workforce gaps identified, develop a recommended set of targeted statewide interventions to address these gaps using structures that encourage a diverse workforce, representative of Rhode Island's population. Leverage 1115 Waiver as a source of funds.
    - Possible interventions could include the following, some of which have been developed or explored by the EOHHS Workforce Planning Team:
        - Creating programs to mitigate nursing shortages and support CNA to LPN or RN career ladders.
        - Implementing scholarship or incentive-based programs to encourage students and young professionals to pursue specific fields in the health care industry (e.g., diagnostic imaging or medical lab technologists).
        - Establishing additional Surgical Technologist degree programs in the area, as there is currently only one such program in Rhode Island at New England Institute of Technology.
        - Developing partnerships across hospitals and with community-based workforce development providers (e.g., Genesis Center) to address these gaps and connect them to untapped community capacity.
    - Any package of interventions must include wraparound supports and case management that can eliminate barriers to training and employment.

As noted above, the comments below lacked a consensus discussion but have been included to ensure comprehensive consideration of all expert input.

Hospital Workforce: Additional comments for consideration

- Specific strategies are needed to improve health care worker wages, including instituting state policies to make it easier for workers to choose union representation.
- Urgent attention is needed to address workforce outmigration—without comprehensive rate reforms, inadequate health care delivery system funding will continue to result in locally trained professionals leaving the state.
- Hospitals with residency programs should be required to develop strategies that prioritize retaining local talent, including creating preferential pathways for residents interested in working in Rhode Island (e.g., Butler Psych Fellowship) and expanding primary care training opportunities.
- The Governor's Workforce Board should prioritize hospital workforce development as a critical short-term strategic initiative.

Please see **Appendix D.2** for the following additional details:

- Top three Hospital Recommendations, with significant detail on implementation steps.
- Additional cross sector ideas generated by workgroup participants but not prioritized by the workgroup.
- Additional hospital sector specific ideas for consideration that were not incorporated into priority recommendations. Note that this is a comprehensive list of ideas heard that have not been fully vetted by the workgroup.

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Chapter 7: Long-Term Care & Healthy Aging

Definition, Role, and Importance of the Long-term Care and Healthy Aging Sector

Long-term Services and Supports (LTSS) are services designed for individuals with intellectual and developmental disabilities (I/DD) and older adults to support functional, physical, and psychological well-being. Healthy Aging is a process of developing and maintaining functional ability across the lifespan that enables wellbeing in old age.

The Kaiser Family Foundation's definition of long-term services and supports (LTSS) closely mirrors the Centers for Medicare and Medicaid Services' (CMS) and the Rhode Island Office of Healthy Aging's (OHA) definition of LTSS and highlights the breadth of services necessary to support those at any age with disabilities to live full lives (Chidambaram & Burns, 2024).

> *"Long-term services and supports (LTSS) encompasses the broad range of paid and unpaid medical and personal care services that assist with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping).*
>
> *They are provided to people who need such services because of aging, chronic illness, or disability and include services such as nursing facility care, adult daycare programs, home health aide services, personal care services, transportation, and supported employment. These services may be provided over a period of several weeks, months, or years, depending on an individual's health care coverage and level of need."*

The goal of long-term care is to enhance quality of life and promote independence, dignity, and choice. These services are provided by a network of long-term care and home and community-based service providers. Rhode Islanders who meet the state Medicaid financial and level of care requirements are eligible for Home and Community-Based Services (HCBS) and facility-based care (e.g., nursing home care), depending on their level of need. Those who do not financially qualify may be eligible for services offered by The Office of Healthy Aging.

EOHHS oversees Home and Community-Based Services to support individual's health and personal care needs to live as independently as possible. Services covered include:

- Homemaker CNA services
- Special medical equipment
- Meals on Wheels
- Personal emergency response systems
- Case management
- Minor assistive devices
- Senior companion
- Assisted living
- Personal care services
- Self-directed care
- Respite

Multiple Rhode Island government offices coordinate, oversee, and regulate LTSS, many under the auspices of EOHHS. Working collaboratively on behalf of Rhode Islanders with disabilities are OHA, RI Medicaid, DHS,

OVS, BHDDH, RIDOH, the Office of Rehabilitation Services and the Department of Housing. These agencies work closely with a broad range of community partners.

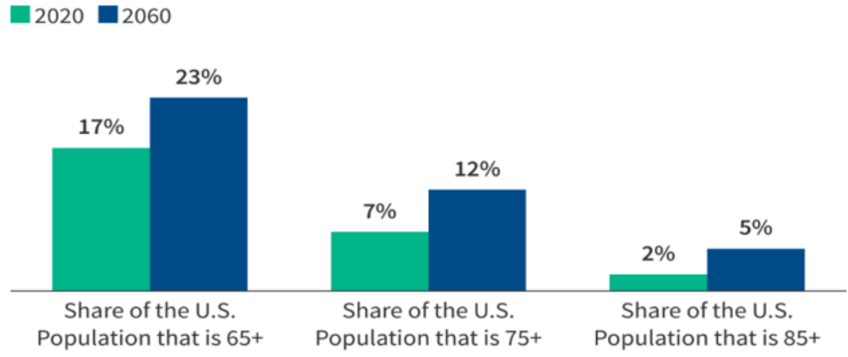
In addition to formal caregivers, Rhode Islanders with disabilities also significantly benefit from care provided by families, friends, and informal caregivers. Providing support for informal caregivers to alleviate the physical, emotional, and financial burdens associated with caregiving is of paramount importance. Supportive services enable family members to balance their caregiving responsibilities with other aspects of their lives. Caregiver support is crucial for maintaining the overall well-being of both caregivers and care recipients, ensuring that individuals can age with dignity and independence.

Importance of the Long-Term Care and Healthy Aging Services

Nationally our country is aging, and with increased longevity comes an increased rate of chronic disease and functional disability, which in turn results in increased health care demands and even greater need for thoughtful and innovative approaches to care needs for the aging population. The growth of the older adult population and the population of individuals with I/DD highlights the need for Rhode Island to leverage existing structures to support individuals and their caregivers over an expanding lifespan. Based on 2021 calculations, the average 65-year-old male in the U.S. born today should expect to live another 17 years, and the average woman should expect to live an additional 20 years than older adults today (Social Security Administration; Tibco Statistica, 2023). Earlier deaths are driven by a number of health and social factors, including individual and community-level poverty, income inequality, racial segregation, and social isolation (Office of Disease Prevention and Health Promotion).

While the share of the population over 65 is increasing, most notably the share of older adults in their 80s, 90s, and above is growing at an even faster rate. An increasing number of older adults are living alone without natural supports of family and friends. As this population ages, many will turn to public programs for assistance in accessing health care and fulfilling the activities of daily living. Supporting care and services for the older population is critical for ensuring that what matters most to each individual can be honored, and for ensuring that the cost of care can be managed across the continuum of acute, post-acute, and community-based settings.

Figure 7.1: US Aging Population by Age group, 2020 and Projected 2060



More than half of all people aged 65 and over (56%) are estimated to need paid LTSS at some point. More than one third of people aged 65 and older (37%) will receive nursing home care, with a small fraction (9%) requiring nursing home level of care for two or more years (Johnson & Favreault, 2021). Studies of the impact of economic hardship highlight that, "overall, 69 percent of US older adults experience [economic] hardship for at least one year after age 65, and 53 percent experience hardship for at least three years" (Johnson & Favreault, 2021). Rhode Islanders who are members of racial or ethnic minorities are more likely than white non-Hispanic populations to experience economic hardship as they age, and those experiencing economic hardship are more likely to rely on community resources. Looking toward the future, a higher share of people under age 65 live in poverty and will enter their older years with greater reliance on public systems (Cubanski et al., 2016).

Changing demographics and the need for supportive services

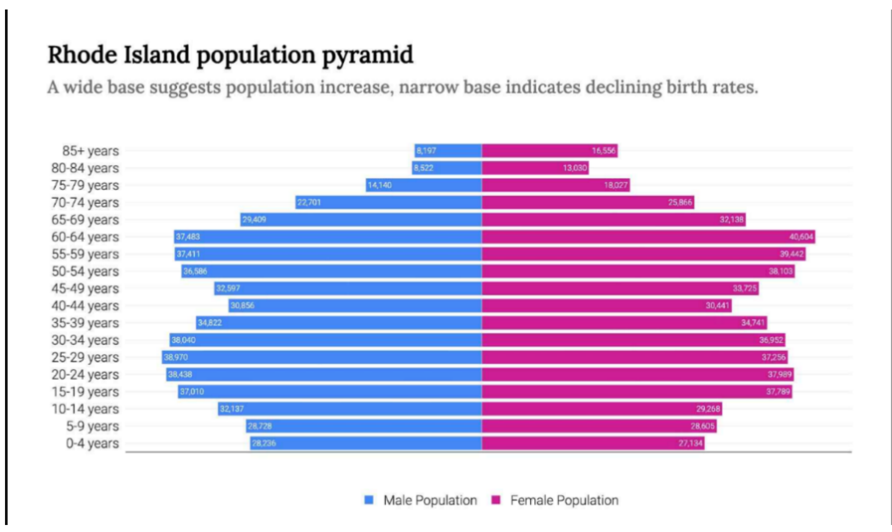
In 2023, 19.4% of Rhode Island's population was age 65 or older, higher than the national average of 17.7%, and this segment of the state's population has increased from 17.8% in 2018 (KFF, 2022). The young Baby Boomers and older Generation X members (ages 55-64) represent another 14.5% of the Rhode Island population. Taken together, these age groups represent over a third (34.1%) of the state's population and signal a pressing need to consider emerging needs and redesign existing systems to address the needs of a growing population of older adults.

One of the fastest-growing population segments in Rhode Island is individuals aged 85 and older. In 2023, this group included 25,000 people, accounting for 2.1% of the state's population. Over the next 20 years, the number of centenarians—those aged 100 and older—is expected to quadruple. These significant demographic shifts will increase pressure on an already strained health care system which is experiencing workforce shortages, and it will intensify demands on social support services such as transportation,

personal care, and nutrition programs—resources that are especially vital for individuals in their 10th and 11th decades of life (Schaeffer, 2024).

Conversely, the state's population age 18 and younger is declining and is outnumbered by those age 65+, creating a demographic inversion that will limit the pool of workers across all industries and strain the future formal and informal caregiving workforce (United States Census Bureau, 2020). Also faced nationally, this population inversion demands attention and challenges states to think differently about how to align the needs of the population and allocate state resources. The population by age and gender is represented below.

Figure 7.2: Rhode Island Population by gender and age, 2021 US Census Bureau, American Community Survey



Additionally**,** a growing proportion of the state's population lives with a physical, intellectual, or cognitive disability of some kind. In 2024, EOHHS estimates that 24.1% of Rhode Island's current population lives with some sort of a disability, and among those younger than age 65, 9.7% of the state's population were individuals living with a disability (Official State of Rhode Island, 2024). With a growing proportion of Rhode Islanders living with a disability, the risk for social isolation and its poor health consequences increases. Those who experience physical, cognitive, and intellectual disabilities face tremendous challenges in social interaction and engagement. America's Health Rankings reports that Rhode Islanders aged 65 and older are at an increased risk of social isolation compared to other states. Social isolation is exacerbated for those living in poverty (11.8%), living alone, being divorced, separated or widowed, having never married, or having a disability or difficulty living independently (United Health Foundation).

With greater longevity and an increasing number of people of all ages living with a disability, a growing volume of Rhode Islanders will require the assistance of medical care and social supports to continue to function effectively (United States Census Bureau). In addressing state health policy challenges, Sarah Booth, Director of the Center on Aging at Tufts University in Massachusetts, recently shared, "The challenge is that more and more people are living disabled for longer periods of time before life ends, which has huge

consequences for society in terms of health care, culture, and ethics… leading to research addressing *how can we live longer and live better*?" (Booth, 2024).

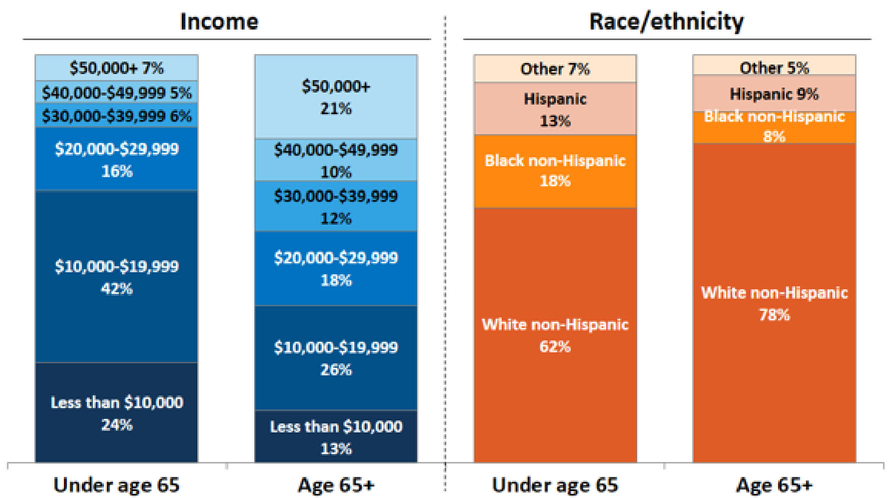
Lower socio-economic status equates with poorer health status, and disproportionately affects those of racial and ethnic minorities, people living with disabilities, and those with limited English proficiency. The percentage of Rhode Island adults aged 65+ with income below the poverty level increased from 9.5% in 2020 to 2022 to 12.3% in 2023 and is now higher than the national older adult poverty rate of 10.3% (United Health Foundation, 2024). National poverty rates have been on the rise for the older population since 2016 when adults with income below the poverty level sat at 8.6% (Healthy Aging Data Reports). These issues create health inequities that translate into poorer outcomes and greater dependence on community supports.

Rhode Island has an opportunity to identify approaches to aging and disability care that focus on preventive care, wellness, and home and community-based services to preserve functional capacity and delay the emergence and extension of disability. Purposeful living is a goal of all people, regardless of age. A strong plan for those with disabilities must address the health and social supports needed by all people across the age span with functional and cognitive limitations.

Preparing for the needs of a large segment of aging Rhode Island adults and people living with disabilities requires a thoughtful approach to integration of health care and social support offered in the least restrictive setting. Expanding health span, the number of years when the population is healthy, rather than focusing on lifespan, is a key goal for a high-performing health care system in Rhode Island.

Equity has emerged as a critical factor affecting the risk and duration of the need for financial assistance in accessing care, with those at the lowest income levels representing the highest risk for needing care and for the longest duration of time. Research reported by the U.S. Department of Health and Human Services reported in 2021 that a much higher share (65%) of those in the lowest quintile of earnings will need LTSS, versus about half of those in the middle and highest quintiles of lifetime earnings (Johnson & Favreault, 2021). Those interviewed as key informants noted the need for future financial support to pay for LTSS for those whose incomes modestly exceed Medicaid thresholds, given that service needs over a longer lifespan will drain their financial ability to pay for needed care. The graph below represents the income and race/ethnicity distributions of Medicare beneficiaries under age 65 (due to disability) and those over age 65.

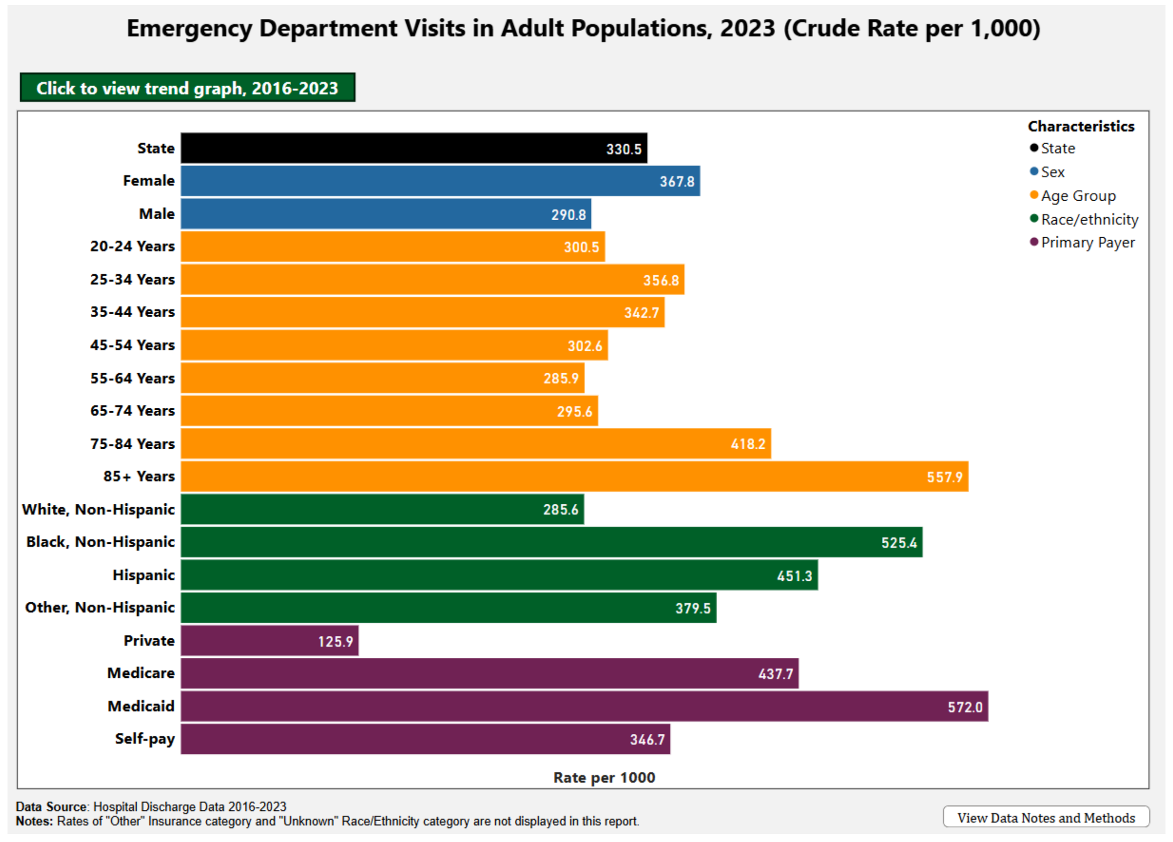
Figure 7.3 Income Characteristics of Medicare Beneficiaries by Age and Race



Access to reliable and effective long-term care services and supports also relies heavily on an adequate workforce. Critical workforce shortages and cost and occupancy pressures in hospitals, nursing homes, and assisted living facilities, necessitate investments in community-based programs that can avert the need for facility-based care. For example, interviews with Rhode Island health care leaders underscored the importance of leveraging existing evidence-based programs such as Meals-on Wheels, utilizing the capacity of community-based programs such as Adult Day and PACE programs, and leveraging local senior centers as important community hubs for dissemination of information and volunteer networks. Rhode Island health care leaders emphasized the need to expand the numbers of people served in community settings and to extend the geographic reach of existing programs that have demonstrated a positive return on investment such as the Village Commons of RI model and caregiver support services. These services help to support people in community settings and delay or eliminate the need for facility-based services.

Emphasis on preventive care directed toward older adults, such as fall risk reduction, will be critical to avoid worsening disability and increased costs. In Rhode Island, in 2023, older adult visits to the emergency department exceeded visits by other age groups, and the number one reason for older adults' emergency room visits were falls. Furthermore, for Rhode Islanders aged 55 and above, falls and hip fractures were the top two nonfatal injuries leading to hospitalizations, with the highest proportion for those aged 85 and above (Power BI). Addressing safety at home and supporting informal caregivers can help to prevent the frequency of falls. The graph below illustrates the rate of emergency department visits by sex at birth, age group, race, and insurance status for Rhode Island's adult populations for the year 2023 and is drawn from the All-Payer Claims Database (APCD).

Figure 7.4: Adult Emergency Department Visit Rate, Rhode Island, 2023



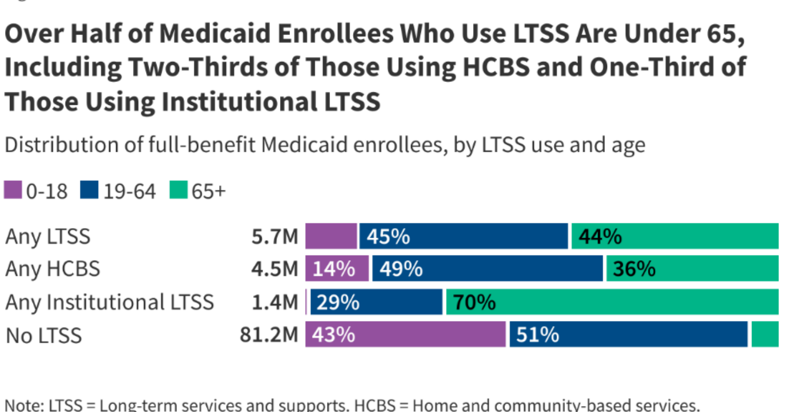
Additionally, a recurring theme emerging from the workgroup discussions and the key informant interviews was the need to communicate the range of available resources provided by OHA, BHDDH, and the RI Office of Veterans Services (OVS), and other agencies, as well as the need for navigation support to facilitate transitions of care.

Leading Trends Impacting the Long-Term Care and Healthy Aging Sector

Medicaid is the primary payor of LTSS

The cost of LTSS is typically not covered by Medicare or private insurance. Nationally, Medicaid covers more than half of LTSS, and over half of Medicaid enrollees who use LTSS are under age 65, with one-third using institutional care, and two-thirds using home and community-based services (Chidambaram, 2022). Even for those who qualify, key informants in Rhode Island expressed concern that many beneficiaries were unable to access all the services and hours for which they qualified due to workforce shortages. The following graph illustrates the national distribution of Medicaid enrollees by age and LTSS use.

Figure 7.5: Distribution of Medicaid LTSS 65+ and Younger



Those in the middle class are squeezed

Those who fall below the poverty level are able to qualify for Medicaid-funded assistance in accessing community and facility services, but those in the middle class do not have such access. Increasingly, older adults who do not qualify for Medicaid cover the cost of supports and services out of pocket or go without. Many are financially squeezed, often forgoing health care due to rising housing costs, and this is exacerbated by inflation that has outstripped wage gains (United Health Foundation, 2024). Given these economic realities, the ability of middle-class Rhode Islanders to afford the need for services as they age is increasingly beyond reach.

Veterans range across the age spectrum with varied needs

Rhode Island is home to nearly 64,000 Veterans (4.5% of the population, compared to 6.1% in the US) (US Census Data, 2024). Approximately 48% of Rhode Island veterans are aged 65 and above. Key informant interviews highlighted that the OVS enjoys a positive state-wide presence, providing rapid response to Veterans who call the state's Veterans customer service line, and supporting an active community-based partnership system with referrals of Veterans to over 100 nonprofit organizations throughout the state.

There are several health care settings and eligibility pathways for services specifically designed for Veterans, with the Providence VA Medical Center the primary source of health care for Veterans. The Rhode Island Veterans Home, located in Bristol, was rebuilt in 2017 with a 208-bed capacity, including 192 nursing home level beds, and 16 independent living units. The site in Bristol, in use since the Civil War, offers a lovely and historic setting. However, its setting in a region with high-housing costs makes recruiting frontline staff especially challenging. The Veterans Home nursing facility occupancy is currently approximately 75%. The Home maintains a waitlist of approximately 200 Veterans, and residents range in age from 75 to over 100. All but four are male.

The Veterans Home's new design of 10-12 bed pods provides an updated care delivery setting but makes staff deployment less efficient. Bristol's housing prices are out of reach of the direct care provider workforce with average wages for a certified nursing assistants (CNA) reported to be $40,000.

National and Statewide Driving Forces, Trends, and Opportunities

This section examines the national and statewide driving trends, forces, innovations, and opportunities that are shaping the long-term care and health aging sector nationally. A clear grasp of the national trends provides an important foundation for the recommendations that have been put forth in this report, enabling the Rhode Island Health Care System Planning initiative to develop strategies that are informed by and aligned with the national experience and responsive to the State's unique landscape.

Workforce Shortages

Health care workforce shortages severely limit capacity across the continuum of care, creating critical bottlenecks that prevent individuals from transitioning to less restrictive care environments. These challenges, particularly in long-term care and healthy aging services, undermine the quality of care for older adults and those with disabilities, affecting essential dimensions such as person-centered care and equity. A shortage of skilled caregivers, coupled with high turnover rates, disrupts the delivery of consistent, individualized care. Residents in care facilities often experience reduced continuity and familiarity with staff, which is vital to maintaining dignity and quality of life. Overburdened staff face burnout, further diminishing service quality. These issues ripple across care settings, from nursing homes to community-based services, exacerbating disparities in access and reinforcing systemic inequities in health outcomes.

The workforce crisis is particularly acute in low-income and underserved areas, where shortages hinder equitable access to care. One major consequence is extended hospital stays for older adults and individuals with disabilities, classified as "observation" or "boarding" cases. These delays often result from a lack of facilities or community services equipped to manage patients with complex needs, or insufficient staff to provide necessary care. This not only prevents patients from receiving care in the least restrictive environment but also reduces hospital bed availability for acute-care patients, driving up overall health care costs.

Interviews with providers also highlight geographic disparities in recruitment and retention, with challenges most pronounced in remote areas, including island communities. These regions face heightened difficulty in attracting certified nursing assistants and clinical staff, further straining the local health care system. Addressing these workforce gaps is essential to improving care transitions, ensuring equitable access, and meeting patient needs across the continuum of care.

Financial stability of community and facility-based providers at risk

The long-term care sector in Rhode Island faces significant financial challenges, driven by workforce shortages and rising operational costs, particularly in settings reliant on public funding. Recruitment and retention issues increase expenses for training, onboarding, and overtime, often forcing providers to cut back on quality improvement or service expansion efforts. Limited funding further hinders the development of services for older adults and individuals with disabilities, especially those requiring behavioral health support. Financial pressures, including rising costs for supplies, transportation, and unreimbursed facility investments, exacerbate these challenges, impacting nursing homes, assisted living facilities, PACE centers, adult day centers, and community health centers.

A recent Faulkner Consulting Group (FCG) study highlighted these risks, focusing on Medicaid-dependent facilities. Of the 72 facilities that were part of the analysis, nine of the facilities were deemed to be both highly critical to Medicaid and have concerning financial profiles. These nine facilities represent 18% of total beds and 17% of Medicaid-provided bed-days. The report also reported that the state experienced a 10% reduction in the number of nursing homes and a 5% reduction in the number of nursing home beds since 2018. The FCG report provided a wide breadth of other important information, but the totality of their report underscores the financial challenges that many facilities face and the associated risks to the state. The chart below, taken from the Faulkner report illustrates the reduction in capacity.

Figure 7.6: Reduction in Rhode Island Nursing Home Capacity 2018-2023

Capacity Reductions 2018/2023

Since 2018, the number of Nursing Facilities has declined by 10% while the number of beds has declined 5%, from 8,658 to 8,199 due to 8 facility closures.

Nursing Facility Beds
8,658
8,199
Beds
2018 2023

Nursing Facilities
82
74
Facilities
2018 2023

Facilities Closed/Converted Since 2018 (8)
Ballou*
Charlesgate*
Elderwood Riverside*
Hallworth
Park View
Watch Hill
Woodpecker*
North Bay/Brookdale (converted to only AL)

*identified as high risk in either 2020 or 2021 risk analysis

Source: EOHHS BM-64 reports by facility 2018-2023 | 6 | RHODE ISLAND

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It should be noted that many of those engaged in the planning process reflected on the recent Medicaid reimbursement increases and said that the increases provided relief for some providers but not all, and most of those engaged were concerned that these increases were not adequate to address the sustainability issues that long-term care providers are currently facing (OHIC, 2023).

Federal and state regulatory measures

Federal and state regulatory measures are not consistently serving as effective indicators of quality, and in some cases, they may hinder the ability to expand desired care models. Rhode Island health care leaders have identified significant challenges in monitoring quality across the continuum of care. For example, while nursing homes are regulated by the Rhode Island Department of Health in alignment with the Centers for Medicare and Medicaid Services (CMS), other community-based services do not provide quality ratings.

For nursing homes, quality data is published quarterly on the Department of Health's website, including overall star ratings and specific metrics such as staffing, health inspections, and quality measures. Additional data includes resident care ratings, family care ratings, and the percentage of health care workers who received follow-up vaccines. Although this information provides valuable insights, concerns persist about the effectiveness of follow-up measures for poorly rated nursing homes as the number of citations for Immediate Jeopardy citations more than doubled from 15 in 2022 to 35 as of mid-December of 2024. One issue is the potential for oversight demands to inadvertently allow staff flagged for concerns, including abuse allegations, to move between facilities without adequate resolution. Addressing these gaps will require stronger enforcement mechanisms, better tracking of workforce issues, and a more comprehensive approach to evaluating and reporting quality across all care settings. Many thought that the state needed to improve its enforcement of existing statutes related to quality of care and workforce standards in health care, including the long-term care sector. Many of the relevant statutes have been unenforced for years, which has hindered progress in improving conditions for workers and care outcomes for patients and residents.

Access to community-based services

The ability of Rhode Islanders to access essential community-based services is significantly hindered by several interconnected barriers, including affordability, Medicaid eligibility requirements, and delays in Medicaid enrollment processes. For many individuals, particularly those with low incomes or high levels of need, the cost of services outside of Medicaid coverage is prohibitive, leaving them without access to critical supports. Compounding this issue for some, Medicaid's eligibility criteria can be complex and challenging to navigate, often excluding individuals who fall into gaps between qualifying thresholds or who experience fluctuations in income. Even for those who meet eligibility requirements, delays in processing Medicaid applications and enrollments can create further obstacles, leaving some individuals without timely access to services they urgently need. These systemic challenges place vulnerable populations at greater risk of unmet needs and increase reliance on emergency care and institutional settings, which are more costly and less preferred by many. Addressing these barriers requires streamlining Medicaid processes, revisiting eligibility thresholds to ensure inclusivity, and expanding funding and policy initiatives aimed at reducing the cost burden of community-based services for those who fall outside Medicaid's reach.

Inadequate supports and services for informal caregivers

Caring for older adults and people with disabilities often falls to informal caregivers, including family members and friends, who provide essential, unpaid support. These caregivers play a vital role in enabling individuals to remain in their homes and communities, preserving their quality of life while reducing the need for costly institutional care. However, informal caregiving comes with substantial personal and financial burdens, including emotional stress, physical strain, and lost income due to reduced workforce participation. As the population ages and demand for caregiving rises, the lack of robust supports for informal caregivers threatens the sustainability of this critical component of the health care system, highlighting an urgent need for systemic interventions.

In Rhode Island, an estimated 121,000 informal caregivers provide 113 million hours of care annually to older adults and individuals with disabilities, contributing an economic value of more than $2 million

statewide. Approximately 60% of these caregivers work full- or part-time, adding stress to family dynamics and imposing financial burdens. Informal caregivers, who provide an average of 18 hours of care per week, are a critical resource for individuals experiencing physical and cognitive decline. However, the demands of caregiving often result in significant personal sacrifices, including impacts on caregivers' mental health and reduced capacity to participate in the paid workforce.

The Rhode Island Office of Healthy Aging oversees programs that offer respite care and financial support for informal caregivers, but these programs often have income eligibility requirements that leave many caregivers without assistance. Those who do not qualify face heightened strain, reducing their ability to sustain caregiving responsibilities over the long term. Expanding support services, such as training, respite, and financial compensation for a broader group of informal caregivers, is essential to strengthening the caregiving system. By alleviating caregiver burdens, these efforts can improve the sustainability of home-based care, delay long-term care placements, and ease the cost and pressure on publicly funded systems, particularly as workforce shortages intensify in the coming decade.

Affordable and accessible housing is inadequate for the need

The lack of affordable and accessible housing is a critical issue nationwide, particularly for older adults and individuals with disabilities. These populations often face additional barriers, including fixed incomes, mobility challenges, and the need for housing that accommodates their specific health and support needs. The high cost of housing and limited availability of accessible units frequently force these individuals into settings that are either unsustainable or overly restrictive. The housing crisis also undermines the ability of people with disabilities and older adults to live independently and fully participate in their communities, making it a pressing concern for policymakers and service providers alike.

The federal Olmstead Act requires the state to provide the least restrictive environment to live, work, and receive services for people with disabilities. However, The RI Life Index survey (RI Life Index, 2023) and the Housing Fact Book provide by HousingWorks RI shows that those with median income across the entire state struggle to buy homes. Consequently, a private home setting may not be affordable to many of those living with a disability. Accessory dwelling units (ADUs) provide an opportunity to fulfill the intention of the Olmstead Act. In 2022, Rhode Island amended the 2017 law that had previously made it easier for adults over 62 to live in an ADUs. The 2022 law (RI General Assembly, 2022) increased flexibility and removed the age restriction (HousingWorks RI, 2022).

Information about services and how to access them is unclear

Rhode Island is home to a range of robust programs designed to support disabled and aging populations, providing essential services such as in-home care, transportation assistance, meal delivery, and social engagement opportunities. These programs, operated by state agencies, nonprofit organizations, and community groups, often serve as vital lifelines for individuals seeking to maintain their independence and quality of life. However, a significant barrier for many Rhode Islanders is the lack of clear and centralized information about available services and how to access them.

Many individuals and families struggle to navigate fragmented systems, with information dispersed across multiple websites, agencies, and organizations. As a result, despite the strength of these programs, their

impact is limited when potential beneficiaries are unaware of their existence or uncertain about eligibility and application processes. Improving access to information through streamlined communication and user-friendly platforms is critical to ensuring these populations can fully utilize the resources available to them.

Rhode Island has established a centralized information and referral system called The Point to serve as a hub for disseminating critical information about long-term services and supports (LTSS) to individuals in need. This system aims to simplify access to resources and guide residents through the often-complex processes of identifying and securing support for aging and disability-related needs. However, many stakeholders involved in this work have highlighted the need for the Office of Health and Human Services (OHS) to enhance its marketing efforts to raise awareness of The Point and foster broader community engagement with this resource. OHS has initiated these efforts and is working proactively to increase visibility and conduct targeted outreach to help ensure that more Rhode Islanders, particularly those in underserved or hard-to-reach populations, are aware of and can fully benefit from this centralized system.

More people are aging alone which increases social isolation and decline in overall health.

An increasing number of people are aging alone, leading to greater social isolation and a decline in overall health. As society changes, more individuals are entering older adulthood without a spouse or close family—a trend known as "solo aging." This shift is significant because older adults will increasingly rely on friends and non-family caregivers for necessary assistance. The rise in solo aging results from changes in marriage rates, lifelong partnerships, and birthrates. Across the United States, approximately 28% of adults over age 65 live alone, totaling about 22 million people according to the 2020 census. The rate of childlessness, whether by choice or circumstance, has almost doubled with the boomers (U.S. Census, 2021) and remains high in subsequent generations.

Living alone without regular social interaction leads to social isolation. A recent report by the U.S. Surgeon General titled The United States Surgeon General Advisory on the Epidemic of Loneliness and Isolation (US Surgeon General, 2023) documents the detrimental health impacts of poor or insufficient social connections, including increased risks of heart disease, stroke, dementia, and premature death. The report highlights that social isolation and loneliness have far-reaching implications for health and well-being, with half of older adults reporting feelings of loneliness before the COVID-19 pandemic. Rhode Island ranks 41st out of 50 states (with 1 being best) in risk of social isolation (United Health Foundation, 2022).

Implementing thoughtful approaches to support older adults living alone—such as expanding Age-Friendly Community efforts to provide intergenerational support and broadening the reach of the Village model—can help alleviate the demands on the formal care sector. Elder abuse, financial fraud, and exploitation are serious risks for older adults, particularly those who are socially isolated or in poor physical or mental health. The Rhode Island Attorney General's Office reports that one out of ten people over age 60 who live at home experience physical, financial, or emotional abuse (RI Attorney General, 2022).

Alzheimer's disease and related disorders

Alzheimer's disease and related disorders significantly affect older adults and their families, with the risk increasing with age. According to the Alzheimer's Association, 1 in 20 people at age 65 and 1 in 3 at age 85 are affected. Older Black Americans are about twice as likely, and older Hispanics 1.5 times more likely, to have Alzheimer's or dementia compared to older Whites. Many individuals with Alzheimer's also experience other health issues, such as like heart disease and diabetes, compounding their care needs.

As cognitive function declines, individuals face challenges with daily tasks, are at higher risk of injury, and require increasing levels of care. This rising prevalence of cognitive decline puts significant strain on both formal and informal caregiving systems. In Rhode Island, the long-term care system may not be fully prepared to meet the growing demand for suitable care settings and supports for individuals with Alzheimer's and related disorders. Addressing these challenges offers an opportunity to develop comprehensive solutions that support individuals and their caregivers while strengthening care systems.

Health care disparities

Health care disparities and barriers to access disproportionately affect minorities and individuals with lower socio-economic status, underscoring the need for greater health equity in aging and disability services. These disparities, rooted in racism, discrimination, agism and other systemic inequities, create significant challenges for vulnerable populations, limiting their ability to access timely, affordable, and culturally competent care. For aging individuals and those with disabilities, these inequities exacerbate existing vulnerabilities, impeding their ability to live independently and maintain their health and well-being.

Nationally, health care disparities are stark, particularly for people of color. While Rhode Island boasts a higher rate of overall insurance coverage compared to the national average, gaps remain for Black and Hispanic/Latino residents. In 2024, 4.1% of Black residents and 7.1% of Hispanic/Latino residents in Rhode Island are uninsured, compared to lower rates among other groups. Of those uninsured, approximately one-third may qualify for subsidized coverage through the health insurance exchange, and 28% may be eligible for Medicaid. This indicates a significant opportunity to close coverage gaps through targeted outreach, enrollment assistance, and policy changes that simplify access to these programs.

Encouragingly, adults aged 65 and older have the lowest rate of uninsurance across all races and ethnicities, at just 0.3% (HealthSource RI), largely due to Medicare coverage. However, this statistic masks deeper issues related to the quality and accessibility of care for older adults of color. For example, racial and ethnic minorities often experience disparities in the diagnosis and management of chronic conditions, access to long-term services and supports, and availability of culturally competent providers. These disparities can result in poorer health outcomes, reduced quality of life, and increased reliance on emergency and institutional care.

Addressing these challenges requires a multi-faceted approach, including expanded outreach to enroll eligible individuals in coverage, investment in community-based care models, and the development of culturally responsive services. By prioritizing health equity, Rhode Island can ensure that aging and disability services better meet the needs of all residents, regardless of race, ethnicity, or income, and promote more equitable health outcomes statewide (HealthSource RI).

Fragmentation and lack of state coordination

Multiple Rhode Island agencies oversee services for older adults and people with disabilities, including the Office of Health and Human Services, the State Medicaid Program, the Department of Health, the Office of Healthy Aging, the Office of Rehabilitation Services, the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals, the Office of Veterans Services, and the Department of Housing. This broad oversight structure often results in fragmented management, as noted by members of the Long-Term Care and Healthy Aging Workgroup. Providers report delays in adapting services to meet demand due to overlapping agency responsibilities and oversight.

Beyond state agencies, there are over 40 task forces, workgroups, and committees providing guidance on aging and disability programs, along with more than a dozen professional associations representing health and community-based services. This complex landscape can dilute efforts and hinder effective coordination. Key informants recommend that Rhode Island assess and streamline organizational structures to better align the work of agencies, associations, and committees, improving coordination and creating more effective input into state policy and service delivery.

Other issues affecting LTSS and Aging

Several additional factors impact the ability of disabled and aging populations to remain in community settings.

Adequate nutrition is critical for older adults and individuals with disabilities, as it directly affects their strength, function, and overall health. Programs like Meals on Wheels and Senior Meals not only provide essential nutrition but also reduce social isolation by fostering social engagement.

Advancements in assistive technology offer significant potential to enhance safety, independence, and quality of life. The Rhode Island Department of Rehabilitation, through its Assistive Technology Access Partnership and the RI Council on Assistive Technology, provides tools and services such as voice-activated devices, adapted computers, and home automation systems to support daily activities. Nationwide, private companies are also investing in innovative solutions, including remote patient monitoring and telehealth, which can improve care access for those managing chronic conditions and disabilities.

Ageism, or prejudice based on age, is another concern that impacts health and well-being. It is prevalent in the U.S. and often manifests implicitly or explicitly in health and social service systems. Research by Yale University Professor Becca Levy shows that ageism contributes to poorer health outcomes, while positive attitudes toward aging can increase lifespan by an average of 7.5 years. Addressing ageism is essential to improving health equity and outcomes for older populations.

Statewide Landscape

Structure and Distribution of Services

Children and adults with disabilities often require assistance with self-care and daily living activities. While caregiving is frequently provided by family and friends, many individuals rely on public services to meet these needs. These long-term care services may be delivered in home settings, community-based programs like Adult Day, PACE, or Assisted Living, or facility-based care such as nursing homes. Access to these services can be through private pay or government assistance, with systems that often operate independently from one another.

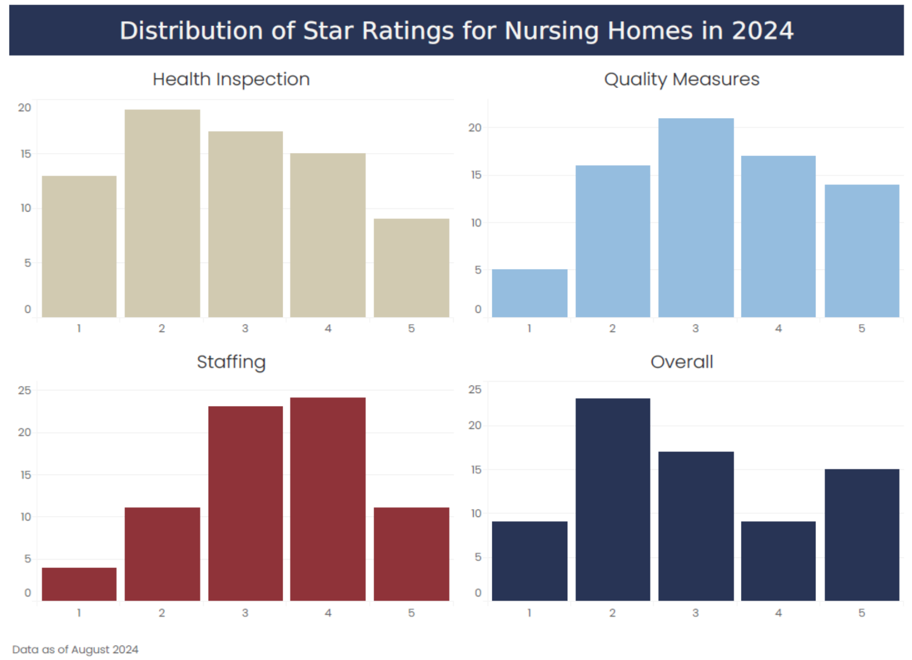
The financial landscape of long-term care in Rhode Island reflects shifting trends. In 2023, nursing home care costs totaled $220 million, nearly 20% lower than in 2019, while spending on home and community-based services rose to $116 million, a 54% increase over the same period (RI LTSS Annual Performance Report: SFY 2019-SFY 2023). Notably, nearly 40% of Rhode Islanders using home and community-based services are aged 18–64, with higher per-person spending compared to those aged 65 and older.

The following is a discussion of how the service system for long-term care and aging services are structured in Rhode Island.

Nursing Homes, Certified Nursing Facilities Rhode Island currently operates nursing facilities serving Medicaid following significant upheaval in the last decade. Between 2018 and 2023, 10 Nursing Facilities have either closed or converted ownership or converted beds. An assessment of nursing facility risk by The Faulkner Group highlighted that 13% (9) facilities representing 17% of state Medicaid days were designated as having significant financial risk. The average number of beds available per facility is approximately 112, similar to national averages (Faulkner, 2024). Importantly, in the past decade, Rhode Island has seen a dramatic shift from non-profit nursing homes to for profit nursing homes such that for-profit ownership dominates the statewide nursing home landscape. Key informants expressed concern about the impact on quality and accessibility of for-profit nursing home beds, especially for patients covered by Medicaid.

RIDOH's Health's Office of Facilities Regulations inspects nursing homes on behalf of the Centers for Medicaid and Medicare Services as "deemed oversight." Their review includes health and facility inspections and assessment of quality measures. In 2024, the Office of Facilities Regulation reported 32 Rhode Island nursing facilities with a 4- or 5-star rating (ranking range of 1-5 where 5 is the highest rating), while 20 nursing facilities were rated only 1 or 2 stars on several measures (RIDOH, 2024). The graph below represents the distribution of nursing homes by star ratings on three measures and overall, during 2024.

Figure 7.7: Distribution of Star Ratings for Nursing Homes in 2024



Nursing facilities served 5,806 patients in 2023 in long-term custodial care, primarily serving those over age 65. Just under 18% of Medicaid nursing home patients were ages 18-64, nearly a 20% decrease since 2019. Likewise, Medicaid-eligible aged + in nursing home custodial care (4,875 in 2023) dropped 18.5% from 2019 as capacity decreased due to nursing home closures and inadequate workforce (Rhode Island EOHHS, 2022). The average occupancy in nursing facilities in Rhode Island is approximately 82%.

Workforce shortages continue to challenge nursing homes in meeting state minimum staffing mandates. The average number of nursing hours (all types – CNA, LPN, RN) per resident per day is 3.61. This compares favorably to new CMS requirements to provide each resident with a minimum of 3.48 hours of nursing care per day. Rhode Island regulations require nursing facilities to provide 3.81 hours of direct nursing care per day by January 2023 (Combined RN and CNA). However, this Rhode Island minimum staffing requirement remains unenforced by the RIDOH due to workforce shortages.

Assisted Living Facilities (ALF) Rhode Island has 65 assisted living facilities serving approximately 5000 residents. (Rhode Island EOHHS, 2024). Approximately 19% of all assisted living units in Rhode Island are licensed Medicaid units with just over 700 units occupied by Medicaid eligible individuals ages 65 and above, and just over 200 units occupied by Medicaid eligible adults ages 18 to 64. There are three licensed memory care facilities, with key informant interviews pointing to the inadequacy of these specialized memory care facilities to serve aging Rhode Islanders.

With national trends and the state's commitment to serve Rhode Islanders in the least restrictive environment, assisted living facilities are an important option. With Rhode Island nursing home closures and the number of older adults requiring assistance that does not meet nursing home acuity levels (especially

the cohort over age 85), investing in adequate assisted living capacity is increasingly important. (Source: CLA: Top 5 Trends Shaping the Senior Living and Care Industry in 2024).

Program for All-inclusive Care for the Elderly The Program for All-inclusive Care for the Elderly (PACE) provides a community-based alternative to nursing home care. Nearly all participants are dually eligible for Medicare and Medicaid and live in their own homes. PACE provides services in the home, adult day center, and health care clinics. As the insurer, provider, and coordinator of care, PACE emphasizes overall wellbeing with health and wellness care, socialization, and programming for participants, and support of caregivers.

PACE Rhode Island provides four sites in East Providence, Westerly, Woonsocket, and Newport serving a total of 644 participants with capacity to serve a greater number of eligible older adults.

Home Care Rhode Island has three not-for-profit and 50 for-profit home care agencies, but comprehensive data on the number of individuals served and hours of care provided is unavailable. However, programs overseen by the Office of Healthy Aging provided home care to approximately 4,500 adults aged 65 and older and 1,500 adults with disabilities aged 18–64 in 2023.

Home care services for people with disabilities and older adults primarily include Medicare-certified skilled care and non-skilled personal care:

- Skilled care is a Medicare-covered benefit for individuals with clinical needs requiring specialized services. It includes nursing care, physical therapy, occupational therapy, speech therapy, and other specialized clinical services. Certified Nursing Assistant (CNA) services may be included if the patient qualifies for skilled care and services are part of a physician-approved care plan.
- Non-skilled care is provided by licensed or unlicensed personal care providers who assist with activities of daily living (e.g., eating, bathing, dressing, mobility, and toileting) and functional activities such as medication adherence. Non-skilled care is typically not covered by Medicare but may be covered by Medicaid or other specialized programs.

Veterans Home The Rhode Island Veterans Home, operated by the Rhode Island Department of Veterans Affairs, is a 208-bed facility located in Bristol, designed to provide comprehensive care and support for veterans. The home includes 192 long-term care beds, focusing on skilled nursing care, rehabilitative services, and support for daily living activities for veterans who require ongoing assistance. The remaining 16 beds are reserved for independent veterans, offering a more residential setting for those who can maintain a higher degree of autonomy. This combination of services reflects a commitment to addressing the diverse needs of veterans, from those requiring intensive care to those who value independence within a supportive community.

Currently operating at approximately 75% capacity, the Veterans Home faces challenges largely due to workforce shortages, which mirror trends seen in other long-term care facilities nationwide. The home provides not only medical and rehabilitative care but also a range of social, recreational, and therapeutic programs aimed at enhancing veterans' quality of life. Its location on a sprawling campus overlooking Mount Hope Bay offers a tranquil environment for residents, fostering a sense of community and connection among those who have served.

The Village Commons of RI The Village Commons of RI model is a volunteer-driven, community-based program designed to support older adults in maintaining independence and aging in place. Based on a "neighbors helping neighbors" concept, it currently operates in Aquidneck Island, Barrington, Burrillville, Edgewood, Glocester, Providence, and Westerly. As of December 31, 2023, the Village Commons of RI includes 274 volunteers serving 450 members, reaching approximately 1,300 residents. Membership is income-based, with a recommended dues structure, ensuring accessibility for a range of participants.

This member-driven model addresses the growing demand for aging support as formal caregiving becomes increasingly costly and limited. Nationally, Village models emphasize community volunteerism, providing services such as transportation, light household assistance, and social engagement opportunities. While primarily a private pay model, the Village Commons presents an opportunity for private and public payers to subsidize memberships, making this resource available to more individuals.

The Village Commons of RI plays an important role in the State's continuum of long-term care and healthy aging services by bridging the gap between complete independence and formal care. It allows older adults to remain in their homes longer, reducing reliance on costly institutional care while fostering community connections and enhancing quality of life. This model complements other care options by offering a sustainable, community-focused solution that supports aging with dignity and autonomy.

Federally Qualified Health Centers and Care Provided to Dually-Eligible Residents Federally Qualified Health Centers (FQHCs) are playing an increasing role as part of the long-term care and healthy aging service continuum, particularly for older adults and individuals with disabilities who face economic insecurity and who are disproportionately impacted by social factors, including racism and discrimination. Originally designed to serve children and families, FQHCs are adapting to the growing needs of an aging population, with older adults representing an increasingly significant portion of their patient base. These centers provide comprehensive, community-based primary care services, including preventive care, chronic disease management, and behavioral health support, often serving as a critical safety net for those who might otherwise lack access to health care.

FQHCs are uniquely positioned to address the social determinants of health that disproportionately affect economically insecure populations, including limited access to transportation, nutritious food, and safe housing. They often deliver care in underserved areas where older adults and individuals with disabilities face significant barriers to accessing traditional health care services. By offering sliding-scale fees, language services, and culturally competent care, FQHCs ensure that vulnerable populations receive equitable and personalized health care.

As part of the long-term care and healthy aging continuum, FQHCs play a vital role in early intervention and ongoing management of health conditions, reducing the need for more intensive and costly services. They serve as a bridge between community-based support systems and more formal long-term care settings, helping older adults and individuals with disabilities maintain independence and improve quality of life. By integrating medical, behavioral, and social care, FQHCs are well-suited to meet the complex needs of aging populations while advancing health equity and addressing disparities.

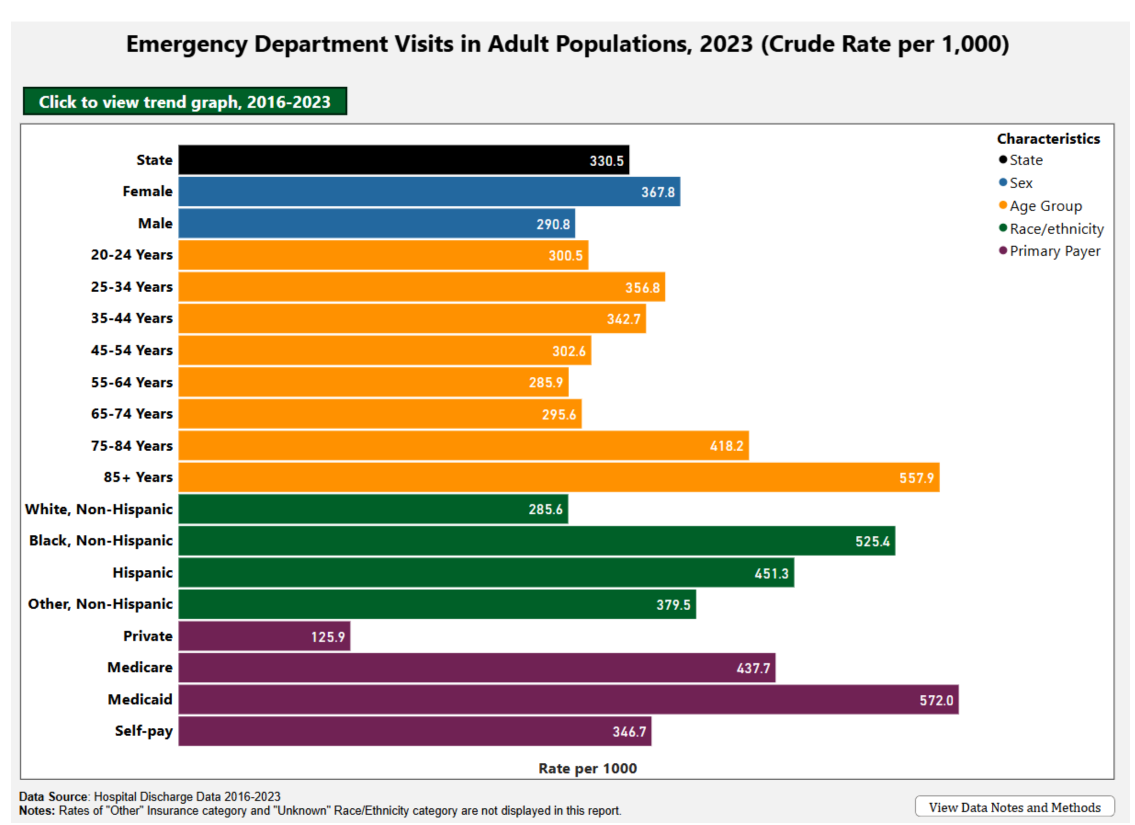
Hospitals and Emergency Rooms Hospitals, including their emergency departments (EDs), play a crucial role in Rhode Island's long-term care and healthy aging service system, serving as both a point of entry and a

safety net for older adults and individuals with disabilities. Rhode Island's 14 nonprofit hospitals, with 2,124 beds, provide critical acute care and specialized services, addressing the complex medical needs of aging populations. However, the high utilization of emergency departments by older adults highlights gaps in the continuum of care, as well as the need for more integrated and preventive health systems.

Emergency departments often act as a primary health care access point for older adults, particularly those managing chronic conditions or facing barriers to accessing routine care. In 2024, 26% of Rhode Islanders aged 65 and older sought care in an ED, with a significant portion (16.3%) visiting three to five times within the year. This high reliance on EDs underscores systemic issues such as insufficient access to primary care, limited availability of home- and community-based services, and challenges in managing transitions between care settings. For many older adults, ED visits serve as a stopgap in the absence of adequate support to address medical, social, or functional needs in less intensive settings.

Hospitals are also key players in care transitions, often discharging older adults to rehabilitation centers, skilled nursing facilities, or home-based care programs. When supported by effective care coordination, hospitals can reduce readmissions and improve patient outcomes. Initiatives such as hospital-based care management programs and geriatric EDs are emerging strategies to provide tailored care for aging populations, emphasizing preventive approaches and linkage to community resources. Strengthening these roles within the health care system can help reduce reliance on emergency services and foster better integration of hospitals within the long-term care and healthy aging continuum.

Figure 7.8: Emergency Department Visits in Adult Populations, 2023



Adult Day Health Rhode Island has 31 licensed Adult Day facilities which provided services to 195 adults aged 18-64 and 737 people age 65 and older in 2023. While the 2023 figures represented a decline of approximately 5% for those aged 18-65since the pre-COVID year 2019, they were similar to pre-COVID levels of attendance for those 65 and older.

Discussion of Capacity, Unmet Need, and Workforce Shortages

Information gathered from key informant interviews, review of Rhode Island data, literature reviews, existing state reports, and Workgroup meetings highlighted a range of findings in six core areas of importance for Long Term Services and Supports and Healthy Aging. The following is a bulleted summary of the findings drawn from these sources, which provide additional important context for the recommendations provided below.

Financial stability, quality, accountability, and regulatory frameworks

Insights from interviews, workgroup discussions, and recent reports corroborate the national trends and highlight the substantial challenges to the financial stability, quality, and accountability of Rhode Island's long-term care and healthy aging sector. There are clear concerns that the reimbursement rates for facility- and community-based care have not kept pace with rising costs, even with adjustments implemented in October 2024. Many believe that this funding gap places pressure on providers, limiting their ability to maintain services and hire staff, which in turn affects the quality and availability of care for older adults and individuals with disabilities.

Behavioral health needs remain a critical area of concern, with many facilities and community-based providers unable to meet the specialized requirements of this population. Additionally, the demand for dementia-related care continues to outstrip supply, creating challenges for families seeking cost-effective options. These gaps underscore the need for a stronger, more coordinated approach to address the specific needs of Rhode Island's aging population.

The financial instability of the long-term care sector is further evident in the rising number of nursing home closures, the transition of many facilities to for-profit models, and a reduction in available beds due to workforce shortages. Interviewees and workgroup participants noted that these trends have reduced overall capacity and exacerbated access challenges. Furthermore, the predominance of private pay models in assisted living facilities leaves Medicaid beneficiaries with few viable options for supportive residential care. To address these systemic issues, stakeholders emphasized the importance of aligning reimbursement rates with actual costs, investing in workforce development, and strengthening regulatory frameworks to balance accountability with flexibility and innovation.

Workforce Challenges

Again, corroborating national trends, the workforce challenges are a pressing issue across Rhode Island's health care sector, with shortages affecting nearly every level of service and every geographic region. Insights from interviews, workgroup discussions, and recent reports reveal that the problem is particularly acute in long-term services and supports (LTSS), where vacancies for certified nursing assistants (CNAs) and registered nurses (RNs) are among the most severe. However, the impact extends beyond providers that

directly provide long-term care and other supports. These shortages impact those who are aging, older adults, and those who are disabled in other settings too, including primary care, medical specialty care, behavioral health, personal care, and other essential clinical and non-clinical, social services geared to these populations, creating widespread gaps in the long-term care and healthy aging care continuum.

High turnover rates and persistent vacancies diminish the quality of care across all settings, increasing costs for health care employers and the broader system. Employers bear the financial burden of recruitment, training, and temporary staffing while struggling to maintain consistent and high-quality care for patients. These challenges ripple across the health care system, leading to delays in service, burnout among remaining staff, and reduced outcomes for patients and families relying on these critical services.

Rhode Island's providers also face intense competition for a limited skilled workforce, both within the state and with neighboring Massachusetts and Connecticut. This regional competition exacerbates recruitment and retention difficulties, particularly for roles requiring specialized training. Addressing these challenges requires targeted strategies such as enhancing workforce development programs, increasing wages and benefits, and creating career pathways for those who desire them that attract, retain, and build the capacity of health care workers. Stakeholders emphasized that these efforts are vital to ensuring the sustainability of Rhode Island's health care system and meeting the growing needs of its aging and disabled populations.

Community-based Options

Community-based LTSS options are critical for supporting older adults and individuals with disabilities, enabling them to live independently and age in place. However, interviews, workgroup discussions, and recent reports highlight significant gaps and challenges across the continuum of community-based options that impact access and the ability of residents to access the person-/family centered care they need and desire. One major issue is the lack of subsidized care for those who do not meet Medicaid eligibility requirements, leaving many individuals unable to afford the services they need. For some programs, such as PACE and Adult Day Health, unfilled capacity coexists with waitlists elsewhere, suggesting inefficiencies in matching services to those in need.

Existing programs like Meals on Wheels, the Village Commons of RI, and Age-Friendly Communities provide cost-effective models for supporting older adults living in the community. These programs promote independence, social connection, and well-being, but they are largely reliant on private funding, membership dues, or public support that is not always sufficient. Taking steps to strengthen, promote greater stability, and financial sustainability of these programs could enhance their reach and allow them to better serve a broader segment of Rhode Island's aging and disabled populations, including those who cannot afford private pay options.

Local senior centers also play a vital role, acting as a backbone of information, resources, and support for older adults, their families, and caregivers. They offer a range of services, from social engagement to health and wellness programs, often filling critical gaps in the care continuum. Despite their importance, many senior centers operate on limited budgets and face challenges in meeting the growing demand for their services.

Informal caregivers, primarily family members and friends, provide the majority of unpaid care for older adults and individuals with disabilities, including through programs such as Personal Care Attendant and Shared Living. However, there are few organized supports for these caregivers, leaving many to shoulder financial, emotional, and physical burdens alone. Compounding these challenges is the shortage of affordable, accessible housing for the aging and disabled populations, which limits options for safe and sustainable community living. Addressing these interconnected issues requires enhanced coordination, expanded funding, and a strategic focus on scaling up effective community-based solutions to meet the growing needs of Rhode Island's population.

Healthy Living

Healthy living is a cornerstone of aging well and maintaining independence, yet many older adults and individuals with disabilities face significant barriers that compromise their well-being. Insights from interviews, workgroup discussions, and recent reports highlight the pervasive issues of loneliness and social isolation, which are linked to poor health outcomes, including increased risks of heart disease, depression, and dementia. Disabilities involving vision, hearing, mobility, and cognition exacerbate these challenges, further isolating individuals and accelerating cognitive decline. Addressing these issues requires deliberate efforts to foster social connections and provide accessible supports for those living with disabilities.

Intergenerational programs and opportunities for socialization play a vital role in improving health and wellness across all age groups. By creating spaces for meaningful interactions between generations, these programs foster a sense of purpose, belonging, and community while reducing the stigma often associated with aging and disability. Social engagement also mitigates the effects of ageism, a prevalent form of discrimination in U.S. culture that contributes to declining health and early mortality. Combating both societal and internalized ageism can improve mental and physical health outcomes, empowering older adults to maintain an active and fulfilling lifestyle.

Low-cost, holistic approaches to healthy living—such as encouraging movement, healthy diets, nurturing relationships, and fostering a sense of belonging and purpose—are especially effective for older adults and those with disabilities. Programs that promote these elements can enhance quality of life while reducing health care costs by preventing or delaying the onset of chronic conditions. Integrating these strategies into community-based services, senior centers, and health care systems can help Rhode Islanders live longer, healthier lives while addressing the systemic challenges of aging and disability.

Innovation

Innovation plays a critical role in addressing the challenges and opportunities within Rhode Island's long-term services and supports (LTSS) system. For example, insights gathered from interviews, workgroup discussions, and state reports highlight the potential of graduates from Rhode Island's colleges, universities, and technical schools as a valuable workforce resource to support the state's aging and disabled populations. By continuing to foster partnerships with higher education institutions, the state can expand workforce development programs, offer intergenerational initiatives, and create opportunities for students to gain practical experience while serving the community. Additionally, many institutions nationally and across the State have leveraged their land and facilities to develop innovative housing and service models,

such as age-friendly communities, Village Commons of RI, and accessible living spaces, benefiting both older adults, students, families/caregivers, and other segments of the community.

The modernization of health care provider licensing systems emerged as a key priority in feedback from stakeholders. According to the Rhode Island Department of Health, outdated licensing processes create administrative burdens and delays, hindering workforce growth and the implementation of innovative care solutions. Streamlining licensure systems can remove barriers to workforce entry and enable providers to adopt efficient, new models of care. Addressing these challenges will enhance the capacity and responsiveness of Rhode Island's LTSS system and better position the state to meet evolving care needs.

Stakeholders also emphasized the importance of exploring national best practices and innovative approaches to community-based care. These strategies include integrating technology, remote monitoring, and other tools to support care, and purpose-driven living environments that allow older adults and individuals with disabilities to remain in their communities longer. Such efforts improve quality of life, reduce reliance on institutional care, and create a more cost-effective, sustainable system. By integrating these insights, Rhode Island can harness innovation to strengthen its LTSS framework and advance healthy aging solutions.

Coordination of the work of state agencies and supporting organizations

Insights from interviews, workgroup discussions, and recent reports reveal a pressing need to improve the coordination of state agencies and organizations serving older adults and people with disabilities. Currently, multiple state offices, including the Office of Healthy Aging, The State's Medicaid Program, the Office of Veterans Services, and Department of Health, oversee different aspects of long-term services and supports (LTSS). However, these agencies often operate independently, with directives that do not always align, creating inefficiencies and gaps in service delivery.

In addition to state agencies, dozens of committees, organizations, and workgroups work independently to improve LTSS, further complicating coordination efforts. While these groups bring valuable expertise and community perspectives, their lack of alignment can dilute their impact. Encouragingly, the Rhode Island State Legislature, including a committee led by Representative Carson, is actively working to develop a Multi-Sector Master Plan on Aging. This initiative, in close concert with this planning effort, represents an opportunity to unify the efforts of state agencies, legislative bodies, and supporting organizations under a cohesive framework. By fostering collaboration and streamlining directives, Rhode Island can create a more effective and integrated system to address the needs of its aging and disabled populations.

Additional Data and Needs Assessment

A substantial amount of Rhode Island-specific data on population characteristics, workforce supply, and health care and social service capacity has provided valuable insights for this report. However, there is a significant need for more data to enhance health and social service planning and monitoring, particularly for state agency oversight, policymakers, and service providers to better understand the capacity, financial sustainability, quality, and accessibility of this segment of the health system. Below is a list of the identified data and assessment needs, which highlight areas where the Workgroup found data to be limited or unavailable. The Workgroup emphasized the importance of creating a comprehensive system of resources

and dashboards to facilitate ongoing assessment, planning, and implementation in the Long-Term Care and Healthy Aging Sector. The additional data and assessment needs include:

- Expanded **data resources to assess and monitor the capacity of the full range of Home and Community-Based and facility-based services**: This includes assessment and public reporting of capacity of both community-based (HCBC), homecare, adult day, Assisted Living, and facility-based care settings.
- Regular and updated information to capture the volume of people who **are boarding in hospitals** and other sites to better quantify the need for community-and facility-based services.
- Survey data on older adults and people with disabilities to capture **individual and caregiver needs**.
- More detailed data on the **current licensed health care and the social support workforce** across the care continuum. These data might include sites of work, (in-state/ out of state), FTEs, etc.
- Updated Data from **higher educational settings** reporting the deployment of new health care graduates by institution.
- Data on **housing capacity** adapted to meet the needs of older adults and people living with disabilities at all levels of income.
- **Quality metrics** for levels of care funded by Medicaid for services available to older adults and people living with disabilities; post on publicly accessible site.

The available service analysis also demonstrates a need to expand the number of providers and services to serve the growing needs of the disabled and older adult population.

Discussion of Specific Cross-Cutting Issues

The following is a discussion of the series of cross-cutting issues that have been identified as part of this planning initiative and that are seen as critical to the strength of the state's health care system, including the behavioral health system. These issues must be considered when developing plans or taking actions to strengthen the system of care. The reflections below provide insights in to how these cross-cutting issues manifest with respect to the behavioral health system.

Workforce

As noted earlier, workforce shortages in community-based and facility-based care have enormous impact on older people and those with disabilities. Inadequate workforce in community-based settings may mean that people are held in acute care settings long after they are considered medically eligible for discharge or are shunted to a more restrictive care setting. In the community, it may also result in people receiving fewer services than they are qualified to receive or are placed on a waiting list and decline in health and function while awaiting service. Many Rhode Island LTSS services are unable at present to recruit and retain a skilled workforce, and this reduces the overall availability of services to a growing population of people in need. It also places informal caregivers at risk for decline in health as many are physically and mentally burdened by serving as the sole providers of care.

Data Capture, Analysis, Oversight, and On-going Monitoring

The development of expanded data systems on workforce, quality of care in community and facility settings, and of the unmet needs of the population will inform planning and create capacity to measure improvement over time.

Revision of Payment Models and Value-based Payment Methods

Current payment structures are not able to keep up with the demands of quality care and the workforce recruitment and retention, and they do not necessarily incentivize high quality service.

Health Information Technology (HIT) and Exchange

Improvement in HIT exchange would serve to facilitate a smoother transition of care and service. In an era of increased technology, seamless health information exchange would serve both patients and the systems that serve them by reducing redundancy and creating more efficient and well-informed care.

Central Coordination of the Various State Entities Serving Populations in Need

While there are many Rhode Island entities organized and dedicated to serving older adults and people with disabilities, the lack of a coordinating entity risks inefficiency and duplication of efforts. The size of the state lends itself to improved coordination efforts.

Enhanced Behavioral Health System and Services

Older adults and those living with disabilities experience behavioral health needs just as other segments of the population, and those with pre-existing behavioral health needs age into older adulthood. Older populations and those who are disabled have increased challenges in mobility, hearing, vison, and cognition that may make accessing behavioral health services especially challenging. Further, the pool of workers with interest or expertise in working with these populations is limited. To meet these increasing needs, attention should be given to expanding this area of interest to serve older people and the disabled.

Long-Term Care & Healthy Aging Core Recommendations and Action Steps

Financial Stability, Quality, Accountability, and Regulatory Frameworks

1. Assess gaps in the supply of services across socioeconomic levels and geographic regions to meet the needs of older adults and those with disabilities to determine current and future needs.
2. Address gaps in behavioral health services for older adults and I/DD populations in LTC settings.
3. Address Medicaid payment methodologies to ensure adequacy and accountability and align payment with performance metrics to incentivize quality care.
4. Establish staff training programs for nursing homes and ALF on issues of aging and disability care.
5. Consider establishing a process to apply to all LTSS provider types to assure that services respond to the needs of the state and the communities they serve.
6. Review, assess, and remove barriers to enrollment, transitions of care, and regulatory requirements that impede innovation in care delivery and workforce development.

7. Explore and create a flexible licensure category and/or flexible licenses to enable a qualified workforce to move among different levels of care, people to remain in community settings.

Workforce Recruitment, Retention, and Development

1. Work with state and community partners and existing initiatives to support and provide strategies and solutions to build and sustain a strong multidisciplinary workforce prepared to address the health related and social service needs of an aging population and individuals with intellectual and developmental disabilities (I/DD).
2. Work with providers to develop short and mid-term affordable housing pilot programs to attract new employees.
3. Annually review provider reimbursement and align payment increases with performance metrics to enable providers to provide quality care and attract and retain qualified staff.
4. Create employee education and training standards across the service continuum of LTSS and provide employee training tailored to meet the specialized needs of an aging population and individuals with intellectual and developmental disabilities (I/DD). Embed education and training requirements in licensure and funding requirements.
5. Address workforce safety in both community and facility-based settings to assure a healthy workforce that is prepared to meet the needs of both patients and providers.

Develop & Expand Community-Based Options

1. Create a pool of funding to subsidize care for older adults and individuals I/DD who are low income but do not qualify for Medicaid, emphasizing community-based services.
2. Work with community partners to create, fund, and promote accessible educational and supportive services to meet the needs of informal caregivers & natural supports.
3. Develop, market, and promote OHA's full range of services, including THE POINT as a primary source of information and referral for older adult & disability services and *MyOptionsRI* to assist in understanding options available.
4. Develop approaches to promote collaboration across associations, task forces, and workgroups for the benefit of older adults and people living with disabilities.
5. Work to develop flexible solutions to allow the deployment of resources to remote sections of the state that may address reimbursement, incentives, or regulatory barriers.
6. Explore, develop, and expand innovative community-based service solutions including, but not limited to, Meals on Wheels, Village Commons of RI, SASH (supports and services at home), CAPABLE (community aging in place, better living for elders), and Home Cost Share to reach more older adults and people with disabilities in the least restrictive environment.
7. Assess the adequacy of providers in emerging Medicare Advantage programs.

Healthy Living

1. Explore emerging evidence-based programs that improve the health of older adults, including building on Age-Friendly and Village model programs and expanding evidence-based programs such as Meals on Wheels.
2. Create an "Innovation Fund" that encourages the design and testing of new concepts or systems of care in the least restrictive environment for older adults and those living with disabilities.
3. Seek state, health plan, and foundation funding to support social impact work and to pilot evidence-based programs to improve quality and health outcomes and reduce social isolation, especially for communities facing the greatest health disparities.
4. Consider developing programs to address the functional needs of special populations who have difficulty engaging in broad programs. This may include persons with I/DD, home bound older adults, persons with behavioral health needs, and formerly incarcerated individuals who have not had the opportunity to engage in social supports or programs.

Coordinate the Work of State Offices involved in LTSS Regulation and Service Provision

1. Undertake a comprehensive evaluation of the needs of the aging and I/DD communities in order to assess needs, align goals, inform future planning, and oversee the effectiveness of existing services.
2. Identify an umbrella organization to review and prioritize data needs and continuum of care challenges and recommend solutions.
3. Promote collaboration across state and community councils, workgroups, and taskforces to ensure that resources are deployed efficiently and effectively.
4. Evaluate supportive funding to programs and services that have demonstrated the capacity to support older people and those living with disabilities in community settings in Rhode Island, including The Village Common of RI, Age-Friendly Rhode Island, Housing Works RI, and more.
5. Explore best practices in housing development for employees adjacent to/ on health and senior care campuses.
6. Work collectively to study and enact regulations that enable a supportive housing license.

Innovation

1. Explore ways to adapt new and emerging technologies that improve home and community-based care, such as remote patient monitoring tools, technologies to facilitate home-based access to care, and caregiver supports.
2. Create an "Innovation Fund" that encourages the design and testing of new concepts or systems of care that meet the needs of individuals with I/DD and older adults.
3. Explore best practices for housing for employees adjacent to and affiliated with health and senior care campuses.
4. Survey licensed providers at least annually to assess capacity, quality, and gaps in beds/services/ and

staff and reasons for gaps. The survey would inform and help prioritize which pilot programs would best address gaps in meeting service needs.

5. Engage and fund social service agencies with regular contact with older adults, such as the Community Action Programs, to formally do home checks and to report on findings to the central hub (which could be the local senior center or OHA).

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Chapter 8: Health Related Social Needs

Definition, Role, and Importance of the Health Related Social Needs (HRSN) Sector

Social determinants of health (SDOH) are the underlying conditions that shape health and behavioral health outcomes.

Social determinants are the broad, systemic factors and conditions in which people are born, grow, live, work, and age. Examples include economic security, education, housing, neighborhood safety, and access to health care. These upstream factors are often the root causes that shape overall physical and emotional health outcomes for populations. (CDC, 2024)

HRSNs are the tangible effects of adverse social determinants of health.

Health Related Social Needs (HRSNs) are the tangible, immediate needs individuals experience as a result of adverse social determinants of health. For instance, a lack of affordable housing (SDOH) can result in an individual's need for emergency housing support (HRSN). (US Dept HHS, 2023)

Figure 8.1: Social Determinants of Health

Social Determinants of Health, CDC.Gov

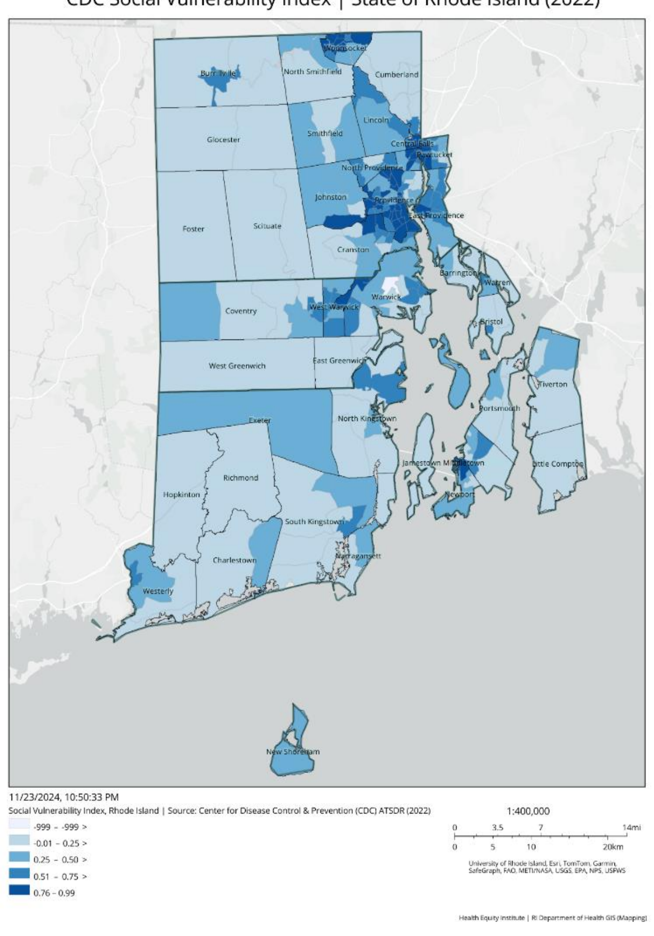
Figure 8.2: Social Determinants of Health and Associated Health Related Social Needs

SOCIAL DETERMINANTS OF HEALTH	HEALTH RELATED SOCIAL NEEDS
Physical environment: natural environment, transportation, environmental hazards	• Lack of access to appropriate transportation • Lack of accessibility for people with disabilities • Lack of access to greenspace, sidewalks, and parks • Exposure to environmental hazards
Socioeconomics: housing cost burden, food security, education	• Access to appropriate and affordable housing • Lack of access to healthy food • Barriers to quality education

Community trauma: discrimination, criminal justice, public safety	• Impacted by systemic racism • Inequitable treatment by the criminal justice system • Affected by public safety concerns such as violence or criminal activity
Accessible health care: health care access, social services, behavioral health	• Issues like homelessness or lack of social support make preventive or primary care difficult to access • Impacted by community trauma requiring mental health counseling to address stress, anxiety, depression, or PTSD
Community resiliency: civic engagement, social vulnerability, equity in pay	• Communities with active civic engagement often implement programs or policies that address social vulnerability

Up to 80% of an individual's health is influenced by social determinants, underscoring their critical role in shaping health and well-being (Braveman, 2014). SDOH and HRSNs do not impact all individuals and populations equally. Structural inequities and systemic disparities result in inequitable distribution of adverse outcomes, with certain communities bearing a disproportionate burden of poor health, economic instability, and limited access to resources. Health equity strategies, like addressing HRSNs, seek to eliminate these disparities. Addressing SDOH and HRSNs is fundamental to improving overall well-being, as these factors significantly influence an individual's ability to maintain good health. HRSNs such as housing stability, access to nutritious food, and transportation directly impact a person's capacity to follow medical treatments, engage in preventive care, and manage chronic conditions effectively. Social determinants like education, economic stability, and safe neighborhoods play a broader role in shaping health outcomes across populations. By addressing these needs, health care systems can shift from a reactive approach to a proactive model; fostering a healthier, more resilient population, reducing disparities that disproportionately affect vulnerable groups, while also meeting the quadruple aim of health care: improving population health, enhancing the patient experience, reducing costs, and improving provider well-being improving population health, enhancing the patient experience, reducing costs, and improving provider well-being (JHMHP, 2021).

Figure 8.3: Rhode Island Rates of Social Vulnerability



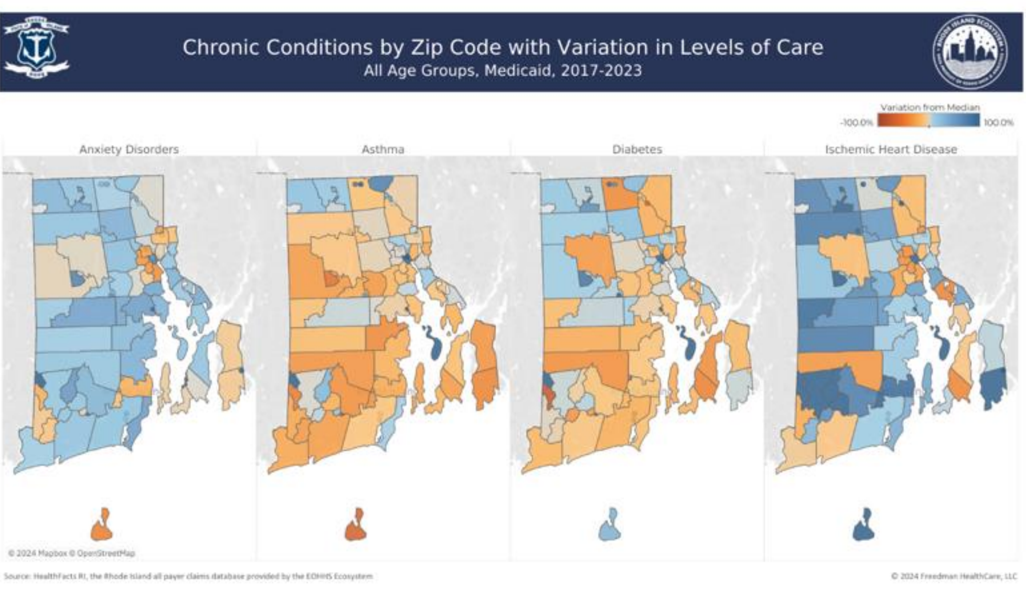
The financial implications of addressing HRSNs and SDOH are profound, as unmet social needs often lead to preventable health care costs. Individuals without access to stable housing or transportation may miss follow-up appointments, delay care, or rely on costly emergency services for non-urgent needs. By investing in programs that address these upstream factors, avoidable health care utilization across the entire health care system can be significantly reduced. One illustration of this impact is providing appropriate and stable housing for individuals with chronic illnesses, which has been shown to significantly decrease health care costs while improving patient outcomes. For instance, 21% of childhood asthma cases are due to exposure to indoor moisture and mold in homes, and children of households with low incomes suffer from asthma at twice the rate of households with high incomes. Removing these triggers result in $3,800 reductions in three-year medical costs for children. Among households with low incomes, moving into more affordable (and stable) housing was associated with 18% fewer emergency department visits and 20% more primary care visits, which combined equate to a 12% ($580) decrease in Medicaid health care expenditures from the previous year (Habitat for Humanity, 2021). Among women who moved from high- to low-poverty neighborhoods using HUD's Moving to Opportunity vouchers, the prevalence rate of extreme obesity reduced by 19% and that of diabetes dropped by 22% after 10 to 16 years of moving, compared with women who did not have access to the vouchers (NEMJ, 2011). These savings and health improvements not

only benefit health care providers and payers but also create a more financially sustainable system where saved resources can be reinvested into other priority areas.

Preventing individuals from needing high-acuity care improves the financial and operational stability of the health care system. Addressing HRSNs reduces services like avoidable emergencies, helping health care organizations better predict service demands and plan necessary budgets and staffing more effectively. With fewer high-acuity cases, resources such as emergency rooms, ICUs, long term care beds, high acuity behavioral health services, emergency response, and hospital beds can be redirected to handle more predictable and manageable care needs. This improves efficiency within the entire health system, easing pressure on critical infrastructure and helping to address staffing challenges.

The maps below utilize the CMS Chronic Conditions Warehouse (CCW) categories to group chronic conditions and highlight that there is variation in the level of care that persons with a diagnosed condition receive. The darker shades of orange indicate less care is delivered than the median. The darker shades of blue indicate a higher-than-median level of care. The maps do not capture access to care for chronic conditions for persons who do not have a diagnosis or who have a diagnosis and have not accessed care that can be measured through an insurance claim. These maps demonstrate how health care utilization and access can be evaluated relative to geography. Similarly, Health Related Social Needs can be evaluated by geography and there are significant opportunities to explore these data in tandem to better identify where health related social needs may impact health care utilization and health outcomes.

Figure 8.4: Rhode Island Prevalence of Chronic Conditions by Zip Code



Reducing the strain on the health care workforce is another key benefit of addressing HRSNs and SDOH. When patients' social needs are met, the demand for high-acuity, resource-intensive care decreases, alleviating the burden on emergency and critical care teams. Providers can focus more on preventive and routine care, which is less stressful and time-intensive compared to managing frequent crises or preventable complications. Furthermore, aligning social care with health care delivery supports a more collaborative approach among care teams, including community health workers and social service providers,

reducing the workload on clinical staff. This holistic model fosters a healthier work environment, reduces burnout, and enhances provider satisfaction.

Ultimately, prioritizing HRSNs and SDOH supports a transformative shift in health care delivery by improving overall well-being, reducing preventable costs, and easing the pressures on the health care workforce. Addressing these factors helps create a system that is more sustainable, equitable, efficient, and patient-centered. It empowers individuals and communities to achieve better health while ensuring that the health care system is resilient and capable of meeting the diverse needs of the population. This approach is not just a matter of improving individual lives; it is a strategic investment in the sustainability and effectiveness of the entire health care ecosystem. The following examples illustrate how HRSNs can profoundly impact the health system and individual outcomes:

- **A Person Lacking Access to Adequate Nutrition** An older adult capable of living independently but lacking consistent access to adequate nutrition is hospitalized repeatedly for malnourishment and is subsequently referred to a long-term care facility. Solving this individual's health related social needs by connecting them to an adequately resourced community-based organization that can provide meals as needed has been shown to help prevent further hospitalization, avoid escalation to long-term care, improve the patient experience, and significantly reduce the cost of care associated with meeting this individual's needs. (National Association of Area Agencies on Aging, 2021)
- **An Individual with a Serious and Persistent Mental Illness is Housing Insecure** An individual with a serious and persistent mental health condition experiences housing insecurity as they transition from one unstable, temporary setting to another, such as a family member's house, doubling up with friends, or a behavioral health residential care setting. Their mental health behaviors strain their relationships with family and friends, leading to escalating behaviors and, ultimately, chronic homelessness. Without resolving their housing instability, the individual experiences an acute mental health crisis that results in inpatient hospitalization. During their hospital stay, they lose their current housing situation and cannot be discharged due to a lack of safe, appropriate housing options, leading to a prolonged and costly inpatient stay. Coordinated HRSNs services and outpatient behavioral health care could have addressed their needs early, preventing escalation, reducing costs, and alleviating pressure on the hospital system.
- **A New Mother is Economically Insecure and Has Challenges Engaging in Postpartum Care** A new parent in a shift-based job without adequate sick time benefits can't attend postpartum visits due to a lack of transportation and financial resources. She also struggles to secure basic newborn necessities like diapers and formula. As her postpartum recovery does not progress as expected, she develops a preventable, serious septic infection, requiring a two-week hospital stay. This could have been avoided with simple transportation assistance to her primary care visits and the ability to take time off work without risking her job, allowing for early detection and treatment with antibiotics.

The Importance of Developing a Robust HRSN System of Care

Addressing both SDOH and HRSNs requires coordinated efforts across sectors, involving health care systems, government, private sector partners, philanthropy, and most importantly community organizations.

As described above, developing a robust HRSNs system of care that operates separately, but aligned and integrated with the existing health care and behavioral health care system is essential for addressing the root causes of poor health and creating a more effective and equitable health care system in Rhode Island. A robust, independent HRSNs system allows for specialized focus on social factors such as housing, food security, transportation, and employment without being constrained by the clinical priorities of traditional health care settings. However, close alignment and integration with the health system ensures that these services complement medical care, creating seamless pathways for individuals to access both health and social supports. This structure allows the HRSNs system to function as a critical partner, helping to reduce the burden on health care providers by addressing the non-clinical factors that drive demand for high-acuity, and other preventable, medical services and highlighting the continuum of care between health care, behavioral health, and health related social needs.

The impact of such a system is transformative, as it enables the health care system to focus on delivering medical care while ensuring that individuals' social needs are met through a dedicated network of HRSNs providers. By creating strong referral pathways, shared data systems, and collaborative protocols, the two systems can work in tandem to improve health outcomes, reduce disparities, and lower health care costs. For example, a hospital discharge team can refer a patient with housing insecurity to an HRSNs provider, ensuring they receive stable housing support while continuing their medical treatment. This coordinated approach not only prevents worsening health conditions but also improves patient satisfaction, reduces readmissions, and promotes long-term well-being. Aligning a distinct yet integrated HRSNs system through investment in existing community based HRSNs providers is a strategic way to build a holistic model of care that enhances population health and strengthens the overall health care ecosystem.

Evidence strongly indicates that meeting these social needs reduces the prevalence of chronic disease complications (Am J Prev Med, 2017), shortens hospital stays (Commonwealth Fund, 2022), and decreases the likelihood of readmissions. (J Gen Intern Med, 2021). Additionally, this proactive approach enhances preventive care by enabling individuals to attend regular medical appointments and adhere to treatment plans without the barriers posed by unmet social needs. The resulting cost savings can be reinvested into both health care and social service systems, creating a sustainable model that benefits individuals, providers, and payers alike. By improving well-being and addressing root causes, a robust HRSNs system of care not only enhances individual lives but also strengthens the entire health system's ability to sustainably deliver efficient, effective, and equitable care.

Some examples of these savings and benefits include:

- Referring housing support to homeless patients with chronic conditions reduces health care costs by more than 12% over a year due to fewer emergency room visits and hospitalizations (Centers for Outcomes Research and Education, 2024).
- Medicare Advantage Programs offering food, transportation and home modification services realized a return on investment of 3:1 (Commonwealth Fund, 2024) by reducing hospital admissions and improving health outcomes.
- Targeting food insecurity has been found to reduce health care costs up to $2,400 per patient annually and access to medically tailored meals was associated with a 16% net reduction in overall health care costs,

49% fewer inpatient hospital admissions, and 72% fewer admissions into skilled nursing facilities compared with the control group (BMJ, 2020).

- High-needs patients–defined as those who represent a small percentage of the population but a high portion of health care spending–have been shown to often face unmet social needs. Addressing these needs reduce overall health care spending by as much as 10-15%, saving thousands of dollars per patient per year (Commonwealth Fund, 2021).

Social factors play a significant role in shaping health outcomes and the overall functioning of the health care system. When these factors are addressed through comprehensive HRSNs interventions, the system becomes more efficient, costs are reduced, and individuals experience better health and well-being. Conversely, when social determinants like housing, nutrition, and transportation are ignored, they often lead to preventable health crises, unnecessary hospitalizations, and long-term care needs, placing significant strain on health care resources.

At the outset of the Rhode Island Health Care System Planning (HCSP) Initiative, the HCSP Cabinet expressed their commitment to recognizing that the services aimed at addressing people's health related social needs are part of the state's health system and must be included in the planning process, if the State is to develop a strong health system.

Rationale for a Health Related Social Needs System of Care

Addressing SDOH and HRSNs requires a coordinated, cross-sector effort that brings together clinical and non-clinical service providers, public agencies, and community-based organizations.

Participants in the Health Related Social Needs Workgroup strongly agreed on the urgency of developing a comprehensive, coordinated, and integrated HRSNs system of care to address these challenges. Such a system must strategically align resources across the health system, leadership, and stakeholders to address SDOH at a systemic level. A robust HRSNs system of care should convene service providers, community leaders, and organizations to coordinate services within communities, reducing service gaps and avoiding duplication. By fostering collaboration and sharing best practices, this system ensures that resources are used effectively. A key component is the establishment of a seamless screening and referral process that connects health care providers to a centralized community resource hub, enabling patients to transition smoothly from clinical care to community-based support, and when needed from community-based support to clinical care. This alignment enhances patient well-being while building a more resilient and responsive health care infrastructure.

System-wide coordination is essential to breaking down silos that often exist across sectors. For example, state agencies may allocate resources and set priorities independently, leading to inefficiencies. Similarly, private sector organizations often work within the constraints of limited funding to address the needs of their specific populations, which can result in overlapping services and missed opportunities for collaboration. Meanwhile, health care systems frequently treat patients whose needs extend far beyond the scope of traditional medical care. An integrated HRSNs system bridges these divides, ensuring that resources are aligned, priorities are shared, and services are coordinated to maximize impact. By fostering collaboration across public and private sectors, the health care system, and community organizations, this

system of care addresses HRSNs holistically, ultimately improving outcomes for individuals and families while strengthening the overall care ecosystem.

Framework: Domains of Impact

The HRSNs Workgroup and other stakeholders provided significant input through the recent process that led to the development of a framework to describe the proposed HRSNs system of care. The workgroup's deliberations provided a strong foundation for identifying these areas of focus and underscored the importance of aligning efforts across sectors and systems to address HRSNs effectively.

This framework includes three domains of impact, with six corresponding foundations, needed to drive action towards a coordinated and comprehensive HRSNs system. Although these Domains exist across a continuum, separating by domain provides structure to allow strategic alignment of activities.

Figure 8.5: Health Related Social Needs Framework: Domains of Impact

HRSN Framework: Domains of Impact

Advancing Strategies to Improve the Structural Drivers of HRSN	Integrating and Coordinating Interagency HRSN Services	Building Capacity & Coordinating HRSN Care
Develop and refine the conditions and systems that create the need for HRSN services and supports that if left untreated become healthcare services	Continue to Integrate efforts across agencies, organization, and structures (e.g. HEZs) to support the delivery of HRSN services across the state.	Continue to build capacity and enhance how HRSN services are delivered and coordinated at the community or service provider-level to meet community need

Foundations: Structures, Policy, Data, Resources, Service Delivery, and Workforce

The Domains of Impact: Key Drivers for Effectively Addressing Health Related Social Needs

The **Domains of Impact** represent three critical drivers for meeting HRSNs:

1. **Advancing upstream strategies** to address the structural drivers (SDOH) that create HRSNs and the need for health care services and treatments.
2. **Integrating and coordinating interagency HRSN services** to support the effective delivery of these services.

3. **Building capacity and coordinating HRSNs care** to meet community needs and ensure individuals have access to coordinated, comprehensive support.

Advancing Strategies to Address the Structural Drivers of HSRNs

The first domain focuses on addressing the root causes of HRSNs by improving the SDOH that generate the need for these services. When left untreated, these social needs escalate into more significant health care demands. Numerous states have developed statewide programs and leadership structures to address underlying social determinants through deliberate and coordinated action, thus driving upstream change. These efforts include reallocating resources to areas of greatest need, enhancing data systems to identify and track opportunities for improvement, and prioritizing initiatives that promote economic security, affordable housing, food access, services, and accessibility for people with disabilities, quality education, and other convergent policy efforts. Rhode Island is seen as a national leader in the development and implementation of transformational efforts to improve the upstream SDOH through the ongoing efforts of the **Health Equity Zones Initiative** and is well positioned to expand on the success of that initiative to further improve the upstream factors that drive HRSNs.

Integrating and Coordinating Interagency HRSN Services

The second domain emphasizes the importance of aligning government systems and structures statewide to integrate HRSNs services effectively. This work involves creating an **Interagency Leadership Team** tasked with developing and implementing a framework for collaboration across departments and agencies. Importantly, this effort builds on existing strengths—Rhode Island already has numerous initiatives and programs addressing various aspects of HRSNs. Examples include the **Health Equity Zones Initiative**, food security programs, affordable housing projects, temporary income support, workforce and employment resources, and behavioral health collaborations, which collectively provide a strong foundation upon which to build a more integrated system.

Building Capacity and Coordinating HRSNs Care

The third domain focuses on ensuring that all Rhode Islanders in need of HRSNs services can easily access the support they require. Efforts in this domain would expand existing strengths while addressing opportunities to enhance coordination and capacity statewide. The workgroup highlighted the importance of supporting health care providers and community-based organizations in their ability to meet individual needs and establishing streamlined referral mechanisms to connect patients with services efficiently. Delivering care within individuals' communities, where HRSNs interventions are often most cost-effective and impactful, was identified a central priority.

National and Statewide Driving Forces, Trends, and Opportunities

Efforts to address the health related social needs in the U.S. have received substantial support from federal agencies such as the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS). Numerous states have also developed and implemented initiatives aimed at the creation of oversight structures and initiatives that guide, integrate, and coordinate statewide efforts,

support screening, assessment, and referral processes for HRSNs, enhance reimbursement or provide funding, and build workforce capacity. This section details these trends, forces and opportunities drawing from information gathered from the literature, interviews, and discussions with the Workgroup.

Federal Support and Policy Guidance

The White House and Federal Agencies Recommend Specific Action on SDOH The White House released a report entitled, **The U.S. Playbook to Address Social Determinants of Health** in 2023. The report includes three high level recommendations to support the effort. These three recommendations are: expand **data gathering and sharing**, support **flexible funding** to address SDOH, and support **backbone organizations**. The report specifically calls out Rhode Island Health Equity Zones as a best practice. (White House, 2023)

HHS Call to Action The U.S. Department of Health and Human Services (HHS) issued a report, *Call to Action: Addressing Health Related Social Needs in Communities Across the Nation* (HHS, 2024), which envisions a system where health and social care systems are aligned to ensure equitable, person-centered outcomes for all individuals, regardless of their circumstances. This initiative emphasizes fostering cross-sector partnerships—including health care, social services, public health, and health information technology—to address HRSNs and improve community health. ***Community based backbone organizations*** are highlighted for their role in managing community-based partnerships and building infrastructure to integrate health care and social care. ***Community Care Hubs*** are also recommended as central entities to streamline care coordination between health care providers and community-based organizations, leveraging networks to enhance service delivery and outcomes. Additionally, the report underscores the importance of ***standardized data systems and health IT tools*** to monitor social determinants of health (SDOH), improve cross-sector referrals, and ensure accountability in addressing unmet HRSNs, with hospitals and other providers expected to contribute to data collection and quality reporting.

Centers for Medicare & Medicaid Services Demonstration Waivers and Other Tools The Centers for Medicare & Medicaid Services (CMS) provides states with tools to address HRSNs through various Medicaid authorities, including Section 1115 demonstrations, managed care in lieu of services (ILOSs), state plan authorities, and Section 1915 waivers. In December 2022, CMS introduced a framework allowing states to offer time-limited nutrition and housing services, along with the necessary infrastructure to support these programs. This initiative expands Medicaid's role in addressing social determinants of health, enhancing care delivery and outcomes for beneficiaries. Starting January 1, 2024, Medicare will further support these efforts by separately reimbursing providers for Social Determinants of Health (SDOH) risk assessments under the Physician Fee Schedule final rule, enabling the identification of unmet social needs that may influence medical care. These developments reflect a growing acknowledgment of the importance of integrating social care into health care systems to improve health equity and outcomes. (Medicaid, 2023) (CBPP, 2024)

State Strategies to Improve Structural Drivers of Health Related Social Needs

Across the nation, states are developing proactive and intentional plans to address HRSNs by establishing structures and initiatives that integrate social care with health care systems. These efforts are driven by a recognition of the profound impact that social determinants have on health outcomes, system efficiency,

and equity. By addressing upstream factors like housing stability, food security, and transportation access, states are improving health and well-being, streamlining operations, reducing workforce challenges, and promoting equity **while addressing health disparities. These programs showcase diverse strategies, from aligning cross-sector partnerships to leveraging technology and community-driven models, aimed at creating sustainable, person-centered systems of care that benefit both individuals and health care providers.**

States' Structures

Following Rhode Island's leadership, eight states have established **Health Equity Zones** (HEZ) including California, Georgia, Illinois, Indiana, Ohio, Oklahoma, Texas, and Washington. HEZ are specific areas where collaboratives of community stakeholders, organizations, and residents, convened by a backbone organization, work together to develop sustainable, tailored interventions targeting the root causes of health inequities. Nineteen other states are interested in implementing the model and have received technical assistance from Rhode Island on HEZ implementation.

Massachusetts is implementing strategies to address social determinants of health through initiatives like the **Health Equity Compact (HEC)** (https://healthequitycompact.org/) and **Advancing Health Equity Massachusetts (AHEM) (https://www.mass.gov/advancing-health-equity-in-ma)**, the latter modeled after Rhode Island's Health Equity Zones. The Compact unites more than 80 leaders from various sectors to dismantle systemic barriers and promote equitable practices, with a focus on governance, measurement, and social determinants. Key aspects of HEC include promoting collaboration across diverse stakeholders—such as health care providers, community organizations, and state agencies—to coordinate funding and ensure HRSNs initiatives are sustainable. AHEM, on the other hand, targets maternal health disparities and broader social inequities, piloting innovative strategies in regions with significant health disparities to create actionable change.

New York created the **Bureau of Social Determinants of Health (BSDH)** to lead a comprehensive approach to addressing HRSNs. The bureau focuses on integrating health and human services, prioritizing vulnerable populations to improve health outcomes. Initiatives like North Carolina's **Healthy Opportunities Program** complement New York's efforts by addressing specific needs such as housing and food security for Medicaid beneficiaries, demonstrating the value of targeted interventions in improving population health.

State Efforts to Integrate and Coordinate HRSN Services

The Massachusetts Health Equity Compact offers a framework for leveraging existing regulatory authority to fund efforts addressing HRSNs. Through its **"Act to Advance Health Equity,"** the Compact outlines strategies to integrate health equity priorities into state policies and resource allocation. It encourages investments in community-based infrastructure and partnerships to align health care with social care systems, focusing on addressing the structural inequities that contribute to disparities in health outcomes. The Compact also emphasizes the importance of data-driven decision-making to standardize health equity metrics and track progress, using tools like data-sharing frameworks and interoperability standards.

In New York, the **Bureau of Social Care and Community Supports** works to integrate health and human services, working closely with community-based organizations to improve health outcomes. This integration

includes initiatives such as medically tailored meals and street medicine services for underserved populations.

State Efforts to Support Screening, Assessment and Referral for *HRSNs*

Massachusetts' initiatives, including the **MassHealth Equity Incentive Program**, encourage health care providers to **integrate assessments of social needs** into their practice. This program incentivizes providers to adopt culturally responsive practices and address health disparities directly. New York's expansion of community health worker services also reflects this integration, allowing **providers to screen for unmet social needs and connect patients** to necessary resources.

Minnesota's **"Co-Creating a Shared Approach to Social Needs Resource Referrals"** initiative focuses on improving collaboration and technology use to streamline access to essential social services. By creating a comprehensive resource directory, the program simplifies assessments and referrals, making it easier for individuals to navigate social support systems. This approach enhances coordination among health care providers and community organizations, fostering collaboration to address social needs more effectively.

North Carolina's Office of Health Equity works to coordinate services through the **Healthy Opportunities Program**, which creates a network for connecting Medicaid enrollees with community resources by **electronically linking** individuals to social services and allowing for continuous feedback on their needs. The **standardized screening questions** further enhance this integration, ensuring that health care providers can identify and address the social determinants affecting their patients' health.

State Medicaid *Incentives Initiatives*

New York's Medicaid system is innovative in its approach to reimbursement for social care interventions. The state requires that all new Value Based Payment (VBP) arrangements include at least one social care intervention, aligning financial incentives with the goal of addressing social determinants. Similarly, North Carolina's Healthy Opportunities Program tests Medicaid-funded interventions that target housing, food, and transportation needs, showcasing how Medicaid can support broader social health initiatives. Massachusetts also emphasizes reimbursement reforms through the MassHealth Equity Incentive Program, which rewards providers for practices that reduce health disparities, highlighting the potential of Medicaid funding to drive systemic change.

Workforce Development *Initiatives*

Workforce development is a critical component of health equity efforts in Massachusetts. The Health Equity Compact promotes programs focused on recruiting and training talent from communities of color, ensuring that the workforce reflects the diversity of the populations served. Similarly, New York's initiatives to expand community health worker services underscore the importance of building a workforce capable of addressing health related social needs.

North Carolina is working to build a Community Health Worker Initiative as part of its broader strategy to address social determinants of health. This initiative aims to enhance the workforce's capacity to connect individuals with necessary resources, illustrating the essential role of trained professionals in promoting

health equity. In Minnesota, efforts to establish standards and tools for resource referrals also involve training for providers, ensuring they are equipped to navigate and address the complex social needs of their clients.

Rhode Island Health Related Social Needs Services Landscape

Rhode Island has a comprehensive network of high-quality health and social services providers actively working to meet the diverse needs of its residents. Community-based coordinating agencies and referral systems play a pivotal role in connecting individuals to essential resources, including health care, housing support, and social care.

Rhode Island has earned a reputation for creating services and care delivery models, including Health Equity Zones and community health workers, that have become national best practices. This infrastructure not only improves outcomes for residents but also demonstrates how coordinated efforts can transform community health. Here is a review of these Rhode Island Resources.

Structure and Distribution of Services

Rhode Island's Health Equity Zones (HEZs) represent an innovative, community-focused approach to improving social determinants of health. Rhode Island's HEZ initiative currently encompasses 14 regions where public and private sectors collaborate to improve social, economic, and environmental conditions of a respective community. With more than 1,800 leaders and 300 organizations involved, HEZs have reduced social vulnerability, increased access to health care, and lowered health care costs for residents (NAM, 2023). These zones foster locally tailored solutions to health disparities, enhancing both care coordination and overall community health. A recent evaluation tracked SDOH over four years in HEZ and non-HEZ communities. From 2018 to 2022, SDOH scores in HEZ communities improved by 21%, while non-HEZ communities saw only a 0.4% improvement. These results support the HEZ initiative's powerful impact (RIDOH, 2024).

The state also benefits from Community Action Agencies (CAAs), which provide diverse services including emergency housing, food assistance, education programs, and financial counseling. Certified Community Behavioral Health Clinics (CCBHCs) expand behavioral health services for individuals with serious mental illnesses and substance use disorders. Rhode Island's Home and Community-Based Services (HCBS) and Long-Term Services and Supports (LTSS) further cater to individuals with chronic needs, offering flexible care options from home-based services to institutional care.

Resource referral systems like United Way's 211 and Unite Us Rhode Island streamline access to essential services. The 211 helpline connects residents to housing, childcare, and more, while Unite Us uses software to facilitate coordinated care referrals from providers, ensuring timely support for HRSNs. These systems emphasize efficiency, accessibility, and equity in addressing the complex needs of the state's residents.

Community health workers are pivotal in bridging gaps in care, especially in underserved areas. Supported by the Community Health Worker Association of Rhode Island (CHWARI), these professionals address social determinants of health through education, care coordination, and public health initiatives. CHWARI's training programs and certification standards have strengthened the workforce, ensuring high-quality care delivery and contributing to better health outcomes across Rhode Island.

Key themes in Workgroup Discussions and Key Informant Interviews: Gaps and Needs

Over the course of the Rhode Island Health System Planning initiative, key stakeholders participated in the HRSNs Workgroup and in interviews to provide vital feedback from the field. These participants highlighted key strengths and areas of improvement, brought forward specific recommendations, and created goals for improving the HRSNs system.

Lack of Aligned State Structures to Support Health Related Social Needs System

Workgroup discussions and key informant interviews highlighted significant challenges in Rhode Island due to the lack of aligned state structures for overseeing and coordinating health care and social service systems. Participants emphasized the need for robust organizational and leadership frameworks to drive strategic action, advanced data systems to support decision-making and evaluation such as demand and capacity of HRSN services and public/private resource adequacy to meet needs, and policies that foster community engagement and cross-sector partnerships. While addressing HRSNs can help reduce demand for high-acuity care, participants noted it cannot independently resolve every issue affecting health care and behavioral health service demands, or their associated costs.

There was unanimous agreement from stakeholders that leaders from government agencies should collaborate to strategically align interdepartmental investments with community-identified needs to address persistent inequities that contribute to poor outcomes. By building and enhancing partnerships with sister agencies, non-health resources can be directed toward these priorities, with an initial focus on food and housing. HRSNs Workgroup members proposed that this could be achieved if the State established an interdepartmental HRSNs leadership council to meet regularly to align priorities.

Sustainable progress requires intentional efforts to achieve systemic changes to the social, environmental, and economic conditions affecting Rhode Island communities. Economic insecurity remains a primary barrier to health and well-being, contributing to unsafe housing, food insecurity, limited health care access, and transportation challenges. These challenges disproportionately impact individuals based on location, economic status, race, ethnicity, and age, exacerbating disparities. Comprehensive reforms addressing these root causes are essential for reducing the overall demand for HRSNs services and improving outcomes.

Need for Enhanced Coordination of HRSNs Services

Workgroup members and others provided feedback highlighting the need for improved coordination in delivering HRSNs services. Strategic planning is hampered by limited understanding of the full capacity of Rhode Island's HRSNs service system. Effective communication, coordination, and alignment of resources between clinical and community providers are essential to avoid duplication of services, which often creates confusion in access and referral pathways. Stakeholders emphasized the importance of delivering social supports within community settings to ensure proximity, cultural appropriateness, and integration with local resources. However, communities in Rhode Island lack sufficient capacity and infrastructure to support the delivery of social services, coordinate care, and address the SDOH that drive health outcomes. Health Equity Zones were identified as a scalable model to enhance community-based services, facilitate clinical-community coordination, and improve conditions that reduce reliance on health and behavioral health

services.

While the state is rich in these high-quality efforts, fragmented social services and complex eligibility requirements remain barriers to effective delivery and access. The ability to most effectively address HRSNs is hindered by a fragmented approach to financing and service delivery. The lack of centralized alignment and coordination at the state level creates gaps in service integration. Without clear policies and structured coordination, these programs often function in silos, limiting their effectiveness in addressing the complex needs of consumers. Streamlining policies and aligning services across state agencies is critical to ensuring that HRSNs interventions are both comprehensive and responsive to community needs.

Navigating the HRSNs Service System is Challenging

Workgroup members and others identified significant challenges in navigating HRSNs services, citing inconsistencies in assessment, referrals, and access to outcomes across providers and health care systems. Providers often lack clarity on where and how to refer patients for community-based HRSNs services. Participants emphasized the need for comprehensive training in HRSNs service delivery, including the development of core competencies that are culturally and linguistically appropriate. Integrating HRSNs care delivery and coordination into ongoing health care planning was seen as essential for Rhode Island's health care system. However, requiring clinical providers to address SDOH directly has contributed to burnout, driven by vertical integration models that lack the horizontal community support needed for effective service delivery and coordination. Community health workers, trained as system navigators, were highlighted as vital to easing these challenges and achieving HRSNs system integration.

Additional Data and Assessment Needs

Data Needs

The workgroup emphasized the critical need for robust data collection and reporting to better define and understand the Health Related Social Needs (HRSN) sector. Currently, there is limited data available on the scope of services, utilization patterns, and connections between HRSN interventions, health care costs associated with treating unmet HRSNs across the health care system, and health indicators, such as long-term health and behavioral health outcomes. This data gap hampers efforts to demonstrate the value of addressing HRSNs across priority areas of the health care system. Collecting such data is essential for identifying strategies and interventions that improve both HRSNs outcomes and broader SDOH.

However, existing data systems fall short of capturing the demand for and delivery of HRSNs services within the health care system. Electronic Health Records (EHRs) often lack dedicated fields for documenting patient HRSNs, and most insurers do not have mechanisms for reimbursing HRSNs-related services. Furthermore, community-based HRSNs providers are typically disconnected from centralized health care data systems, limiting the ability to integrate and analyze data effectively. To overcome these challenges, the workgroup advocates for adopting standardized tools, such as Z codes from the ICD-10 system. These codes can document non-medical factors influencing health, including homelessness and extreme poverty, facilitating research, policy development, and coordinated care. Expanding awareness, payer support, and integration of Z codes into EHRs could significantly improve care coordination, reduce health disparities, and optimize outcomes.

Data System Needs

Beyond data gaps, the workgroup highlighted the absence of a comprehensive statewide system to track HRSNs service delivery and associated financial resources. This lack of centralized inventory impedes coordinated efforts and effective resource allocation. A standardized model for assessing and monitoring HRSNs services is critical for measuring their impact on health outcomes and health care costs.

Although the state does have multiple community health needs assessments that include analysis of SDOH and HRSNs that are conducted at on a regular, semi-regular, and ad-hoc basis, these assessments currently are not leveraged to establish a comprehensive understanding of the current burden of SDOH and HRSNs on the health care system.

The limited use of Z codes further exacerbates these challenges. Many providers are either unaware of their importance or unable to utilize them effectively due to inconsistent integration into EHRs. The workgroup stressed the need for quantifiable data on the financial benefits of HRSNs interventions to demonstrate their cost-effectiveness and guide resource investment. Developing a centralized data system and improving the adoption of tools like Z codes will be pivotal in advancing health equity through evidence-based, data-driven interventions and fostering a more coordinated HRSNs system of care.

Lastly, Rhode Island is lacking a centralized community health needs assessment (CHNA) repository and standardized data collection. This limits the current capacity to correlate HRSN data with APCD and z-code reporting. In turn, there is severely limited ability to formulate insights into supply and demand of HRSN, SDOH burden, and their longitudinal impacts.

Health Related Social Needs - Core Recommendations and Action Steps

Currently, Rhode Island has a broad array of high quality HRSNs services but lacks the supporting infrastructure needed to fully recognize their impact on improving both patient wellbeing and efficient distribution of limited health care resources. The strategies outlined below were developed and endorsed by the HSRNs Workgroup. They aim to improve SDOH and establish a high functioning, effective, and efficient HRSNs system of care for Rhode Island. Each strategy is focused on one or more of the Three Domains of HRSNs Impact as described above: *Advancing Strategies to Improve Structural Drivers of HRSNs, Integrating and Coordinating Interagency HRSNs Services, and Building Capacity and Coordinating HRSNs Care.*

The HCSP Cabinet makes the following recommendations to create the structures necessary to coordinate HRSNs services.

Advancing Strategies to Improve Structural Drivers of HRSNs

1. Develop refine, and align state structures to oversee, coordinate, assess, promote, and implement strategic actions that will improve SDOH, with a specific focus on communities with a high prevalence of HRSNs. Action steps include:
    a. Establish an interagency leadership team to strategically align interdepartmental investments with community identified needs to drive equitable, structural changes to SDOH.
    b. Build and enhance partnerships with sister agencies to support aligned investment of non-health resources into community needs and priorities.

   c. Support sustainability of aligned investment through evaluation of the impact on health and wellbeing.

2. Refine and apply existing data systems to monitor, inform, and guide decision making aimed at identifying areas where investment in improvements of SDOH can have the greatest impact on the demand for HRSNs. Action steps include:
   a. Integrate MyNeighborhood SDOH and Ecosystem databases to align health care utilization data with SDOH prevalence and burden data.
   b. Establish Z Code or commensurate coding system within health care to establish data needed inform HRSNs resource alignment within the State Data Ecosystem.
   c. Create centralized CHNA repository and standardized data practices.

3. Strengthen comprehensive understanding of the downstream impacts of addressing SDOH on HRSNs and Health care demand to inform value-based payments, cost savings, and HRSN reinvestment recommendations by conducting data analysis, research, and literature reviews. Action steps include:
   a. Conduct and report ROI analyses across HRSNs public investments.
   b. Conduct and report ROI analyses across HRSNs private investments.
   c. Recommend hospitals engage in ROI of addressing HRSN within their systems to understand utilization and cross-reference by cost.

4. Scale and align existing state initiatives that work to address the social, environmental, and economic factors that impact health and wellbeing, across all agencies. Action steps include:
   a. Establish state community investments team tasked with aligning existing state investments to improve community conditions impacting SDOH.
   b. Identify existing and emergent opportunities to leverage federal, philanthropic, and state resources to improve SDOH and scale HRSNs service delivery capacity.

Integrating and Coordinating Interagency HRSN Services

5. Inventory the specific programs and services being conducted across public state agencies and private organizations/coalitions that screen, assess, link, and provide HRSNs services. Action steps include:
   a. Develop framework, strategy, and priorities to capture HRSNs resources across the state.
   b. Inventory all public/private HRSN resources currently provided across the State, starting with HHS agencies.

6. Expand structures or systems (e.g., Health Equity Zones, Community Health Workers, Certified Community Behavioral Health Clinics, Regional Prevention Coalitions) that work to raise awareness, share information, and promote collaboration across state and private agencies/ coalitions to promote and provide HRSNs services. Action steps include:
   a. Develop framework for multi-sector collaborative leadership team including representation from existing HEZs, government, philanthropy, community organizations, and others as appropriate to scale and align HRSN and other services addressing health equity across the state.

7. Develop and implement a strategic framework for aligning state resources that promotes collective action, leverages resources across all sources, and streamlines service delivery models, to meet community needs. Action steps include:
    a. Create a process that a multi-sector collaborative leadership team can use to scan and assess services across the state identifying gaps, duplication, and best practices.
    b. Implement universal community health needs assessment to establish collection standards, repository for data collected, and longitudinal data to support the alignment of state, private, and philanthropic efforts to improve SDOH and meet HRSNs service delivery needs.

Building Capacity and Coordinating HRSN Care

8. Scale the adoption of service delivery models, standardized tools, and workflows in clinical and non-clinical settings for screening, assessment, and referrals between HRSNs services and the rest of the health care system. Action steps include:
    a. Explore assessment and referral protocols that integrate into EHRs and are the least administratively burdensome to providers.
    b. Research and share models for HRSNs referral platforms that are utilized in other states successfully.
    c. Work with health care and HRSNs providers to understand and eliminate barriers to referral platform utilization.
    d. Develop plan to pilot HRSN referral platform in communities with highest level of SDOH burden and greatest HRSNs care demands.

9. Identify and adopt a clinical community care coordination model (e.g., a Community Care Hub) that links service providers with the community-based organizations that address HRSNs to enhance the referral processes between service providers across the continuum. Action steps include:
    a. Engage states actively leveraging a CCH model to explore how to right size that model for Rhode Island.
    b. Identify target communities based on prior involvement in community care model efforts, such as Community Health Teams and AEs.
    c. Pilot CCH model in target communities, tracking efficacy and ROI.

11. Continue to explore and pilot, targeted payment models that facilitate the adoption of a coordinated community clinical HRSNs care model. Action steps include:
    a. Research and report how TPMs and other incentives can support activities such as screening for heath related social needs, referring patients to community-based resources, and achieving improved health outcomes tied to addressing social needs.
    b. Identify options for leveraging variable payment models to support population-based payments to HRSNs providers to ensure adequate capacity to meet demand for services.
    c. Pilot population-based payments withing target communities with high HRSN demand, with a specific focus on establishing right pocket cost savings ROI to drive sustainable investment.

12. Expand and enhance HRSNs provider capacity to ensure all a robust, high quality HRSNs system of care. Action steps include:
    a. Conduct assessment of the current HRSNs provider landscape to determine areas of improvement.
    b. Leverage findings from HRSNs sector assessment to inform recommendations for improving the capacity, sustainability, and integration of the HRSNs system into Rhode Island's health care system.
13. Bolster the capacity and integration of CHWs, peer-support staff, social workers, and other frontline HRSNs service providers as part of the HRSNs system of care. Action steps include:
    a. Inventory existing HRSNs community care providers to establish baseline data on the raw count of workers, roles, location, certification, and other relevant criteria.
    b. Identify service gap areas.
    c. Assess current levels and models for compensating frontline HRSNs service providers.
    d. Establish recommendations to sustainably fund frontline HRSNs workers based on relative demand and impact.

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Cross-Cutting Issues and Interdependent Strategies Between Sectors

Interdependencies and Cross-Cutting Issues

As noted throughout this report, Rhode Island's Health Care System Planning (HCSP) process focuses on five major system components–Primary Care, Behavioral Health, Hospitals, Long-Term Care, and Health Related Social Needs–and then a set of cross-cutting strategies: Data, Equity, Health Information Technology (HIT), Quality, Value-Based Payment, and other Payment Models (VBP), and Workforce.

The Health Care System Cabinet and the EOHHS Independent Advisory Council provided guidance to the planning staff team and the Health Sector Workgroups about the importance of identifying and discussing the interdependencies that exist across the health system. They also asked the workgroups to recommend action, as appropriate, with respect to the collaborative activities that need to take place to promote the partnerships, care coordination, service integration, and care navigation that is necessary to address community needs or strengthen the health system. These efforts are critical to breaking down the silos that can often be barriers to addressing existing challenges and promoting, quality, accessibility, sustainability, and equity.

As these interdependencies continue to be identified, the Sectors can add the necessary action steps so that the cross-cutting issues can be addressed.

In order to fully acknowledge the Cabinet's directive, this section includes a review of some of the most compelling interdependencies between and among the sectors that each Workgroup identified, and a summary of some of the key cross-cutting analyses from each sector. Then, in the next four chapters, the report presents deeper examinations of four cross-cutting strategies: Data, Workforce, HIT, and VBP.

As the Cabinet, the Advisory Council and the state interagency planning team moves forward toward implementing Report recommendations, it will be critical for them to return regularly to this set of interdependencies, to ensure that they continue to prioritize the collaborative activities necessary to facilitate action and to address the challenges identified.

Selected Examples of Key Sector Interdependencies

Example 1: Primary Care and Behavioral Health

The percentage of primary care visits that address mental health concerns was growing nationally prior to the pandemic, rising to 16% between 2016 and 2018 (Rotenstein, 2023). That was before the large increase in mental health needs and utilization that was triggered by the pandemic (Cantor, 2023). For these reasons, multiple interdependencies exist between the primary care and behavioral health sectors. First, for Rhode Island primary care practices adopting an integrated behavioral health model, there is a workforce need for qualified behavioral health clinicians. Second, for non-integrated practices and for patients whose needs require specialties and support that an integrated practice cannot provide, an adequate behavioral health workforce is needed for referral services. Finally, the integration of primary care and behavioral health often assumes that primary care practices must include behavioral health providers. The HCSP process can also explore how primary care providers and principles can be integrated into behavioral health practices.

Example 2: Primary Care and Hospitals

In 2016 the percentage of primary care physicians employed by a hospital or community health center was 47% (Cantor, 2023). That percentage has likely increased in more recent years, as suggested by hospital acquisitions of primary care practices such as Brown Health's (formerly Lifespan) acquisition of Coastal Medical in 2021. The implication of this trend is that any effort to support and sustain Rhode Island primary care must involve hospitals – and the exploration of this situation should be an ongoing component of the HCSP process. Two examples shed light on this interdependency: 1) increased investments in primary care must flow down to primary care clinicians and their team members, and 2) efforts to provide true team-based care will require hospitals to hire the necessary team members.

Change to patient perspective and the impacts on patients when things are well integrated and coordinated.

Example 3: Behavioral Health and Hospitals

There are substantial challenges transitioning patients from hospital inpatient and emergency department settings to appropriate behavioral health settings. Clear triage protocols are essential to identify needs promptly, reducing unnecessary hospital stays and boarding times. Strong discharge planning with follow-up protocols and structured referrals helps patients transition efficiently to community-based settings, easing capacity strains and freeing hospital resources for acute medical needs.

Building behavioral health capacity is critical to sustaining these improvements. Intensive case management teams can support transitions by addressing logistical barriers and guiding patients to appropriate outpatient or community services. Expanding pre- and post-hospital resources like crisis stabilization units, residential treatment, and intensive outpatient programs ensures timely follow-up, reduces relapse risks, and improves care quality. Strengthened protocols and expanded resources streamline patient flow, reduce hospital stays, and provide continuous, tailored care.

Example 4: Primary Care and Long-Term Care and Healthy Aging Services

The interdependencies between the primary care sector and the long-term care and healthy aging sector are meaningful during a period when the population of Rhode Island, like the nation, is aging. The interdependencies include the need for growing numbers of geriatricians, as well as NPs and PAs trained in geriatric care, and adequate community-based services to help older patients age in place and receive supports when discharged from an acute or post-acute care setting. The HCSP process must ensure inclusion of data reflecting long-term care for both older Rhode Islanders and those with long-term disabilities, so that these interdependencies can be more effectively defined.

Example 5: Behavioral Health and Long-Term Care and Healthy Aging

More effective collaborative models between long-term care facilities and behavioral health providers must be developed to address the needs of residents in long-term care facilities with acute or chronic behavioral health challenges. Many residents enter with pre-existing conditions or develop issues like depression or substance use due to isolation, cognitive decline, or chronic illness. Long-term care facilities often lack the expertise to manage these needs, leading to unmet care and poorer outcomes. Partnerships with behavioral health providers can ensure residents receive comprehensive care addressing both physical and behavioral health. Such collaborations should include formal agreements defining roles, on-site

consultations, staff training, and seamless referral pathways for intensive care. Such partnerships allow long-term care staff to focus on core responsibilities while leveraging behavioral health expertise to improve resident well-being. A statewide strategy can help scale these efforts and ensure equitable access.

Example 6: Primary Care and Health Related Social Needs Services

Primary care is at the front line of confronting the health related social needs of their patients. These needs often create a barrier to timely receipt of preventive care and to management of chronic conditions. With health related social needs screening an increasingly common protocol for primary care practices, care teams need community resources to which to refer their patients. Yet, these resources are not always present, which creates a discomfort and frustration for primary care teams. Primary care practices and their patients need access to adequate social services to address patient health related social needs. The HCSP process should continue to explore these critical connections and what data and action steps are necessary to ensure adequate alignment.

Sustainable reimbursement structures are critical, incentivizing facilities to integrate behavioral health services through staffing or external partnerships. Payment models must account for the resources needed to care for residents with behavioral health needs, enabling facilities to accept referrals and provide high-quality, person-centered care. Aligning incentives supports better outcomes for residents and strengthens the health care system.

Example 7: Behavioral Health and Health Related Social Needs

The Behavioral Health Workgroup discussions reflected a commitment to developing more effective and efficient systems to ensure that those with emerging, acute, or chronic behavioral health conditions were screened for, assessed, and linked to health related social needs services. This will require the behavioral health and health related social needs sector to work collectively to align efforts, as neither can fully address these needs in isolation. A statewide approach is essential to ensure individuals identified with HRSNs in clinical or non-clinical settings are seamlessly connected to necessary services.

Similar to primary care integration, an effective HRSNs system requires shared infrastructure, referral pathways, and data-sharing between sectors. Embedding Community Health Workers or navigators in behavioral health clinics can strengthen links to housing, food assistance, and employment programs. A unified statewide plan ensures resources are used effectively and models are scaled equitably, bridging care gaps, and addressing root causes to support early intervention and prevent crises.

Example 8: Health Related Social Needs and Medical Services in General

As noted throughout the report, the connection between social determinants and health outcomes is undeniable. Addressing HRSNs is no longer optional; it is essential for improving patient wellbeing, reducing provider burnout, and ensuring financial sustainability. Health care organizations should proactively address HRSNs to better positioned to meet value-based care goals, enhance patient satisfaction, and deliver a compelling return on investment (ROI). The HRSNs Workgroup understands the complex challenges facing the health care system from hospital infrastructure needs, provider reimbursement, shortages and burnout, among others. Workgroup members see the goals of meeting HRSNs as congruent with meeting these other goals.

In particular, the Workgroup supports a recommendation for hospitals to conduct HRSNs return on investment studies to quantify the impact HRSNs assessment and referral could have on their bottom lines, and to meet the quadruple aim.

The HRSNs Workgroup also views assessment and referral for HRSNs into health care protocols and EHRs as a critical step to understand and meet HRSN. To do so, partnership with health care systems and providers is required. Starting with willing provider groups and systems, the workgroup recommends building on the learnings from the creation of the Unite Us technology platform and recommends exploring the development of community-owned and sustainable community care hub as well as piloting formal protocol for assessment and referral systems in the clinical setting.

These examples of interdependencies underline the importance for the planning process of breaking down the silos between the sectors. The Cabinet and the Advisory Council will ensure that the Workgroups and staff team continue to identify additional opportunities for alignment through the plan design and the implementation.

Cross-Cutting Issues

The following report sections provide a deep exploration of four of the key cross-cutting issues: Data, Workforce, Value-Based Payments, and Health Information Technology.

Chapter 9: Data

Recommendations for Strengthening Data to Support Health Care System Planning in Rhode Island

Background

Rhode Island Executive Order 24-04 (McKee, 2024) stipulates that the Cabinet focus on "integrating oversight and accountability of the health care system using quality data and make recommendations for establishing a framework for regulating and overseeing the entire System of Care." As such, this chapter offers recommendations to improve the quality and availability of data for health care system planning, monitoring and oversight, and evaluation.

The Health Care System Planning initiative draws on existing data to inform the assessments and recommendations offered throughout this report. Each of the contributing workgroups generated analytical questions to inform their understanding of the challenges and opportunities within and across Rhode Island's health care system.

EOHHS contracted with Freedman Health Care (FHC) to serve as the data analytic team for the report. FHC is a consulting firm that partners with state health agencies to analyze and improve health data for understanding state-specific health care needs and driving policy decisions. FHC contributes solutions to states' unique needs while aligning and advancing national trends in health data analytics. FHC also serves as the project management and technical support vendor for the Rhode Island EOHHS Medicaid IT Enterprise environment. This work includes providing project management, subject matter expertise, database architecture, and analytics in support of the Rhode Island Data Ecosystem, the State's All-Payer Claims Database (known as HealthFacts RI), and the Office of the Health Insurance Commissioner's Cost Trends Data Hub and reports.

FHC assisted the workgroups by sorting their questions into near-term and longer-term analytic projects. Near-term requests were answered by gathering and analyzing data and generating numerous data visualizations and analyses to inform and describe the findings and recommendations surfaced in this phase of the Health Care System Planning initiative. These visualizations and data are being prepared for posting on the Rhode Island Health Care System Planning website, where visitors can explore and interact with the information. Some examples of the data that will be available include:

- An interactive dashboard to display health care workers that are entering and leaving the workforce, by license type, from 2011through 2024. This analysis was completed to support better understanding of the current workforce supply and workforce trends.
- Interactive maps that display variation in the level of care that persons with a diagnosed condition receive. The Health Related Social Needs Workgroup was interested in understanding how care received for chronic conditions varies across regions.
- An interactive dashboard for exploring the top ten diagnoses for Rhode Islanders for each year from 2016 to 2023, by age band. The dashboard was developed for the Long-term Care and Healthy Aging Workgroup, and shows how different age cohorts vary in diagnoses, how and where care was provided, and how diagnoses changes over time.

- Additional dashboards and static visualizations developed for the sectors will be included on the website, aligning with the questions each sector aimed to explore. This website will continue to be populated as the Rhode Island Health Care Planning System team moves into the Implementation phase, including visualizations yet to be developed described in the recommendations section below.

The broader recommendations encompassed in this chapter enable the longer-term workgroup-specific data recommendations collected by FHC and presented throughout the report, as well as in the data recommendations compendium below.

This data analytic process underscored for the Cabinet and the State staff the importance of an increasingly formalized data infrastructure for the Health Care Planning structure. This understanding led to the set of recommendations offered here on how data can be more easily and quickly brought to bear to inform planning, monitoring, and oversight, and to evaluate the system reforms set in motion by this work overall.

Key Themes from Work-to-Date

This phase of system assessment and recommendations development surfaced several key themes about how data can best support Health Care System Planning:

1. Health Care System Planning relies on available data but also requires new data types to be collected.
    a. Existing and new data types can be used together to accomplish fiscal transparency and performance monitoring for health care entities such as hospitals, behavioral health providers, skilled nursing facilities, and federally qualified health centers.
2. When data are combined, they provide clearer insights into the health system's interdependencies.
    a. Health Related Social Needs (HRSNs) information, such as spatial distribution of socioeconomic characteristics, environmental impacts and assets, transportation access and safety can be combined with other data to better understand health outcomes.
3. Regular system monitoring through established and accessible modalities (i.e. performance monitoring dashboards) streamlines information to more rapidly inform and improve decision-making.
    a. Data from the Healthcare Workforce Data Hub are readily available to support workforce recommendations and these data can be enhanced by gathering additional information about the workforce through licensure.
    b. Fiscal transparency and performance monitoring of health care providers can be similarly accessible through regularly updated dashboards.
4. Standard units of analysis will help planning participants understand and address health equity. Wherever possible, analyses should array information by race, gender, sexual orientation and gender identity, disability status, age, socio-economic status, primary language spoken, and geography. Note: Best practices for the collection and reporting of sexual orientation and gender identity (SOGI) information are evolving and yet-to-be standardized. New information and analyses produced from these data should be for the purpose of advancing equity and health for LGBTQ+

individuals and populations. A risk assessment specific to the LGBTQI+ population should be considered when reporting this information.

a. Data products designed to isolate and sort the variables that impact health will improve health outcomes. The variables identified through health planning can be isolated with a consistent methodology across analyses (such as standard geographic regions).

Recommendations for Ongoing Data System Improvements

Summary of Recommendations

With consideration for the themes above, as well as the overarching goal of supporting a high-quality, affordable, equitable, accessible, culturally, and linguistically appropriate health care system, here are a set of high-level recommendations to address data gaps and limitations identified by the health care system planning initiative:

1. Centralize more health care data in the Rhode Island EOHHS Data Ecosystem; use the Ecosystem as the health data hub for health care system capacity planning, oversight and monitoring, and evaluation.
2. Develop fiscal transparency and performance-monitoring dashboards utilizing Rhode Island EOHHS Data Ecosystem infrastructure.
3. Analyze transitions-of-care system-wide to identify bottlenecks in patient flow between settings of care.

The Rhode Island EOHHS Data Ecosystem is central to the recommendations above. Rhode Island has been at the forefront of integrated health data systems and continues to invest in and improve this work. The Ecosystem was established in 2017 and is an exemplar across the country in data governance, safety, and system integrity. Through carefully governed, permissioned access to de-identified data, the Ecosystem is used by both state and non-state partners to conduct research to better understand the state health and human services system and its impact on individuals, cohorts, and populations. The Ecosystem integrates data from many different sources to provide a more complete, interconnected picture of the well-being of individuals, families, and communities in Rhode Island. Some key partners contributing data to the Ecosystem include Medicaid, DCYF, DHS, DLT, RIDOH’s Center for Health Data and Analytics, and the Rhode Island Coalition to End Homelessness. Since being established, the Ecosystem has continued to grow and develop its capabilities as a health data source for Rhode Island. The following recommendations, described below in more detail, align with the Ecosystem’s planned upgrades and capacity expansion already underway.

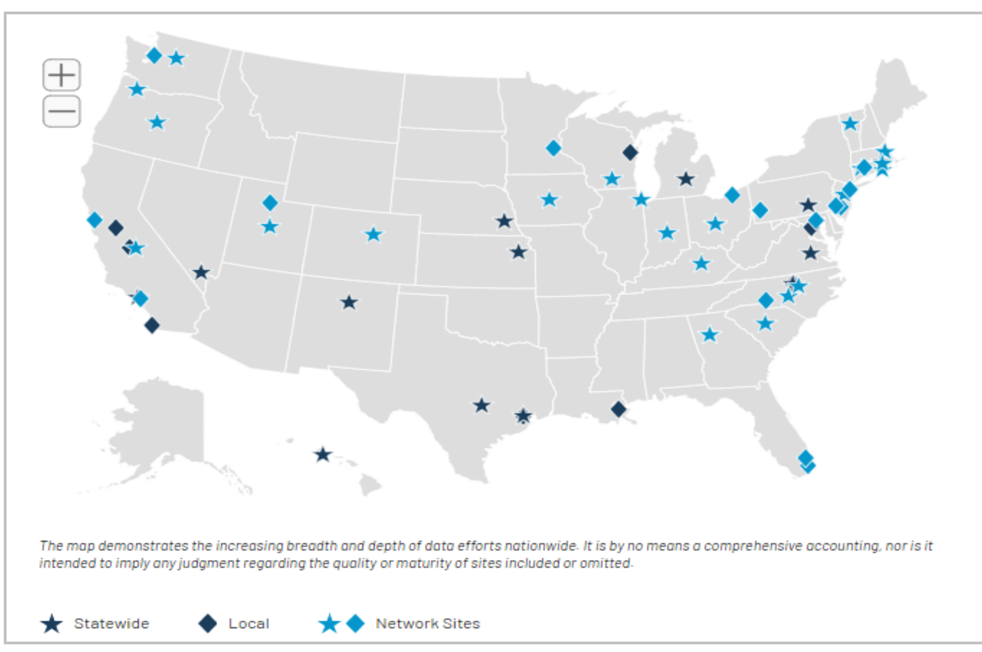
1. Centralize more health data in the Rhode Island EOHHS Data Ecosystem; use the Ecosystem as the health data hub for health care system capacity planning, oversight and monitoring, and evaluation

Health and human services data in the United States are often as fragmented as the systems they describe, scattered across silos with limited coordination or integration. Recognizing this challenge, states are

increasingly centralizing and coordinating health data to gain a more comprehensive understanding of health outcomes, disparities, access, and costs. Centralized data systems enhance insights for policymaking and regulation by consolidating diverse data sources, streamlining analyses, and enabling the creation of unified, actionable narratives.

Unified health data systems are known in numerous ways: data hubs, ecosystems, data collaboratives, data intermediaries, and state health data organizations (McAvey, 2024). Many of these efforts share the goal of centralizing data and combining information across various sources to provide a unified, more complete understanding of individuals and populations experiencing the multiple dimensions of the health and human services system. Dimensions often include health care coverage types, services, programs, and information about environmental factors that influence health. Figure 1 below maps the health data integration efforts currently underway in the United States (Actionable Intelligence for Social Policy, 2024)

Figure 9.1: Integrated Data Systems



As a trusted convener and data steward, the Rhode Island EOHHS Data Ecosystem is positioned to serve as the central hub for health care data in Rhode Island, supporting comprehensive health care system planning. With established structures already in place including statutory authority, governance, data stewardship, funding sources, and an existing bank of data, the Ecosystem can serve as the comprehensive health care data hub and analytical resource for health care system planning.

Action Steps

Figure 9.2

Key Short-Term Action Steps	Rationale
1. Designate the Rhode Island EOHHS Data Ecosystem as Health Data Hub.	A clear designation of the Ecosystem as a health data hub provides support for incorporating new data to meet health planning data needs while allowing for stream-lined decision-making.
2. Prioritize and stage identified data types for Ecosystem integration. Example of potential first phase priorities may include the following types of anonymized, secure data: • Hospital Discharge Data • Health Related Social Needs Data • Longitudinal Data System (LDS) and educational outcomes data	Centralizing more health data in the Ecosystem will improve access to comprehensive information and reduce effort and costs associated with gathering data from multiple sources to support holistic health system planning, monitoring, and evaluation. Adhering to the Ecosystem's nationally recognized data governance model ensures safety, security, and de-identification of data.
3. Complete data inventory to inform prioritization of additional health data to be housed within the Ecosystem.	Conduct inventory to include review of existing data and new data collection priorities and identify key partnerships for identifying priority data for integration.
4. Establish process and criteria for proposing additional existing data types to be included in the Ecosystem.	Criteria should reflect the potential health system impact of integrating new data types within the Ecosystem.
5. Prioritize and stage new data types for Ecosystem integration, in alignment with dashboard Recommendation 2: • Hospital financial data • Skilled nursing facility financial data • Federally qualified health center data • Behavioral health facility financial data • Health related social needs data (i.e. closed loop referrals)	Collection and use of new data types can happen simultaneously with integration of existing data types.

2. Publish fiscal transparency and performance-monitoring dashboards using the Rhode Island EOHHS Data Ecosystem infrastructure to incorporate additional and new data types

Fiscal Transparency Dashboards Consistent with national trends, there is growing concern and interest in health care provider entity fiscal transparency, solvency, and performance. Across workgroups involved in this phase of the health care system planning initiative, there was strong support for utilizing existing data as well as collecting new data to populate performance-monitoring dashboards for a variety of health and human services system provider types. An example framework for a hospital fiscal transparency and monitoring dashboard is featured in the hospital-focused chapter of this report (see Figure 6.22). While certain metrics are specific to the hospital industry, many sample metrics in the framework are applicable across care settings and facilities within the health care system and contribute to a starting template for additional dashboards.

A suite of dashboards focused on fiscal transparency, solvency, and performance will not only provide critical information relative to a specific provider type, but this information can also help to explain and address the pressures created by system interdependencies. For example, understanding skilled nursing facility (SNF) bed availability can help to streamline patient care transitions as they move from the hospital to the SNF setting, which will have a direct impact on hospitals' patient census and bed availability. Similarly, if Rhode Islanders are unable to access appropriate primary care services, such as in a federally qualified health center, they may seek costly, non-emergent care in a hospital emergency department setting or suffer a health emergency because of a lack of preventive and more comprehensive primary care services.

Performance-monitoring dashboards can leverage existing information from Rhode Island's health data assets, such as utilization data from the All-Payer Claims Database (APCD). The APCD, known has HealthFacts RI, is a large-scale database that systematically collects health care claims data from a variety of payer sources, including Medicare, Medicaid, and Rhode Island's largest commercial payers. The information is anonymous and cannot be linked to particular people. The APCD provides information about the quality, cost, and efficiency of Rhode Island's health care delivery system. The system includes information about eligibility, medical claims, dental claims, pharmacy claims, provider details, and alternative payment models (APMs). The APCD offers important insights about health care provider entities with respect to spending and utilization, access, and quality but new data types are also required for fiscal transparency and solvency monitoring, in particular. The workgroups support the creation of the following dashboards for the short-term, to facilitate fiscal transparency, solvency, and performance monitoring:

- Hospital fiscal transparency and performance monitoring (see exhibit below for example, or we could reference page number with example from other section of report)
- Skilled nursing facility financial transparency and performance monitoring
- Primary care beginning with Federally Qualified Health Center financial transparency and performance monitoring
- Behavioral health facility financial transparency and performance

Workforce Dashboards Alongside interest in dashboards for tracking fiscal transparency and facility solvency, workgroups also focused on dashboards and data hubs particularly relevant to the health care workforce. The following recommendations speak to the need for more refinement in understanding the

capacity of the primary care and behavioral health care workforce. Recommendations for improving understanding of the health care workforce at large are included in the health care workforce section.

- Develop and publish primary care and behavioral health provider dashboards focused on:
  - Current workforce (e.g., number of current primary care providers, level of clinical activity/FTE, size of patient panels mapped by geography)
  - Future workforce (e.g., number of trainees graduating from Rhode Island institution of higher education, number of trainees remaining in practice in Rhode Island)
  - Patient experience (e.g., adults with access to usual source of care)

Action Steps

Figure 9.3

Key Short-Term Action Steps	Rationale
1. Develop project plan for implementing dashboards.	Identifying new data types, authorities to collect the data, and stakeholders across different provider entities requires a detailed project plan to organize and implement the effort. Dashboards from existing data also require project planning.
2. Determine prioritization of dashboard development or simultaneous development across provider types.	A more focused or step-wise approach may deliver a final product faster than a simultaneous development approach and the trade-offs should be weighed.
3. Ensure specific data structure and monitoring and evaluation efforts are developed and applied to inform the State's efforts to promote health equity and address disparities.	Applying standard units of analysis will help understand and address health equity.
4. Create "mock" dashboards modeled from Draft Health Care Provider Financial Health and Efficiency Dashboard featured in report.	Mock dashboards provide a test case for the measures and metrics that stakeholders have identified for inclusion in the dashboard.
5. Incorporate feedback to create Phase I Dashboard for publication.	Dashboards for ongoing fiscal transparency and solvency monitoring should reflect input from the entities supplying the data.

3. Analyze transitions-of-care system-wide to identify bottlenecks in patient flow between settings of care – and based on analysis, consider real-time bed availability tools

The health care system planning initiative prioritizes better understanding and monitoring of health care system capacity. In so doing, the workgroups recommend near-term analysis of patient transitions between settings of care. Such an analysis will provide additional insight into the factors that may be inhibiting or complicating transitions and impacting system or provider-specific capacity. The analysis is a first phase of

ongoing work to allow the state and its provider network to simultaneously monitor the demand for a certain service and the capacity of the service provider network to meet the demand. Longer-term, developing and applying tools, such as real-time bed availability tracking, including associated analytics that systematically monitor the data gathered by the tracking tool, could greatly support health system planning.

Action Steps

Figure 9.4

Key Short-Term Action Step	Rationale
1. Develop analytical plan for a system-wide assessment of transitions of care and identification of bottlenecks and contributing factors.	Understanding where and why there are barriers to care in the most appropriate, least-cost setting is critical for optimizing health system capacity, access to care, and health outcomes.

Conclusion

Governor McKee's Executive Order creates a framework for health care system planning in Rhode Island and anchors this work with an integrated, system-wide approach that is grounded in data. Reflecting this approach, the recommendations in this chapter emphasize continued data integration by centralizing more health and human services data within the Rhode Island EOHHS Data Ecosystem and data-driven fiscal transparency and performance monitoring dashboards and analyses. Taken together, these recommendations promise to continue the optimization of existing data assets and to provide appropriately governed information for ongoing health care system planning, performance monitoring, and evaluation, with the goals of improving health outcomes, access, and the quality, affordability, and equity of care for Rhode Islanders.

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Chapter 10: Workforce

Introduction

In early 2022, EOHHS, in partnership with the Rhode Island Department of Labor and Training (DLT) and the Rhode Island Office of the Postsecondary Commissioner (OPC), launched a statewide Health & Human Services Workforce Planning and Implementation Initiative (HWPI) in response to widespread concerns from providers, patients, and advocates about the adverse impact that workforce challenges were having on the ability of health and human services agencies to provide timely access to quality care and services.

In April 2022, EOHHS convened an HWPI Summit to further define the nature and extent of workforce challenges and to begin to develop and implement immediate and longer-term solutions. Since that time, more than 600 public and private sector partners from more than 200 organizations have participated in committees, workgroups, stakeholder update meetings, private sector advocacy efforts, training and education programs, data webinars, and two additional Summits to improve Rhode Island's ability to attract, train, retain, and sustain a diverse, talented, and dedicated health care workforce.

The findings and recommendations included in this section are informed by, and responsive to, the workforce challenges that have been identified by the HCSP sector workgroups. Every sector workgroup discussed the difficulties associated with recruiting and retaining a workforce that has the knowledge, skills, and diversity needed to serve their patients and clients. Every sector identified the importance of developing pipelines for their future workforce, career advancement opportunities for their current workforce, and sustainable wages and working conditions for all employees. Further, sector workgroups consistently emphasized the importance of systemwide workforce planning, workforce development partnerships, robust workforce data analytics – and funding and policy to facilitate these priorities.

It should be noted that the recommendations contained in this section are intended to be cross-cutting and, as such, do not explicitly address unique, sector specific issues. Such issues, if any, have been left to the sector workgroups to highlight.

Overview of the Current Health and Human Service Professional Workforce

Rhode Island's health and human services workforce consists of licensed occupations as well as non-licensed roles - which, along with administrative and operational personnel, provide critical workforce capacity necessary to provide patients with sufficient, culturally and linguistically appropriate, responsive care across the health and human services continuum.

Each state's approach to licensing and credentialing health and human services occupations differs, and many occupations are regulated by national or regional certification bodies as well as licensing bodies. Some professions require both certification and licensing to enable the health professional to practice in the field. An example of this in Rhode Island would be the Licensed Chemical Dependency Professional License, which has a prerequisite of attainment of an Alcohol and Drug Counselor certification, via the Rhode Island Certification Board (RICB).

Licensed Health & Human Services Occupations

Rhode Island licenses a wide array of health and allied health professional occupations, all of which are defined by specific State statutes and regulations. Licensed occupations are also regulated by respective Licensing Boards through the RI Department of Health.

There are dozens of licensed health occupations, and each discipline, regardless of its size or representation, plays a vital and unique role within the complex, interdependent health care delivery ecosystem. Each profession contributes specialized skills, knowledge, and expertise that address specific patient needs and ensure the overall functionality and resilience of the health care system.

There are several occupations which, combined, make up a statistical majority of the total licensed health workforce. These include but are not limited to: Registered Nurse (33,235 total licensees in 2023), Nursing Assistant (17,890 in 2023), Licensed Clinical & Independent Clinical Social Worker (combined total of 4,276 in 2023), Licensed Practical Nurse (3,244 in 2023), and Advanced Practice Nurse (3,229 in 2023). In addition, there are currently 7,135 Allopathic Physicians (MDs) and 683 Osteopathic Physicians (DOs) licensed in Rhode Island.

Refer to Appendix E.2 for a full list of health licensees and brief occupational definitions.

Non-Licensed Health and Human Services Occupations Providing Critical Workforce Capacity

The Rhode Island Certification Board credentials select occupations in the field of addiction treatment, prevention, and recovery support, as well as community health. Those certified (but not licensed) occupations include Certified Peer Recovery Specialist (CPRS); Provisional Alcohol and Drug Counselor (PADC); Certified Alcohol and Drug Counselor (CADC); Certified Advanced Alcohol and Drug Counselor (CAADC); Certified Clinical Supervisor (CCS); Certified Prevention Specialist (CPS); Certified Community Health Worker (CCHW); and Certified Perinatal Doula (CPD).

Peer-support staff, such as individuals with lived experience, recovery coaches, and community health workers, play a critical role in the health care delivery system by fostering trust, reducing stigma, bridging gaps in care, and ultimately enhancing patient outcomes.

In addition to those occupations certified by the RICB, there are many other vital **non-licensed,** *and not necessarily certified*, health and human service occupations in Rhode Island which include, but are not limited to, the following:

- Behavioral Health Case Manager
- Dental Assistant
- Direct Support Professional
- Medical Assistant
- Personal Care Aide
- Surgical Technologist

It is also notable that there is a lack of consistency in job titles, training requirements, and scope of work for many unlicensed occupations in health and human services, particularly in the human services/social assistance sector. For example, a lack of clarity in the role and requirements of Behavioral Health Case

Manager contributes to a lack of reliable occupational data, unclear career paths, and unclear or inconsistent job expectations between employers and employees.

For more detailed profiles of prevalent professional licensed occupations, see Appendix E.2.

The Health Care Workforce Shortage Crisis

Data show that Rhode Island is experiencing severe workforce shortages across the health and human services sector, the State's single largest employment sector. The DLT has projected 75,596 open positions in this field between 2022 and 2032, including 25,554 openings for health care practitioners and technical occupations, 41,128 for health care support roles, and 9,914 for community and social assistance positions. Approximately 76% of these openings are considered high growth and/or high demand.

Health and human service provider partners participating in the HWPI and the Health Care System Planning processes have voiced serious concerns about significant workforce shortages that continue to grow while the supply of workers is shrinking. This mirrors a national trend of growing deficits across many health and human service occupations and is backed up by recent DLT employment data and projections showing significant projected employment openings in the health and human service workforce in Rhode Island (see table below). For more information on DLT/BLS industry and occupational data, visit DLT Labor Market Information division's website, found at this link: RI Department of Labor and Training - Data Center.

Figure 10.1: Top 20 Highest Openings - Health and Human Service Occupations (2022 - 2032), Rhode Island Department of Labor and Training 2022 – 2032 Industry & Occupational Projections

SOC Title	2022 Employment	2032 Employment	Change	Total Transfers	Total Exits	Total Openings	Education Code
Home Health and Personal Care Aides	8,065	9,998	1,933	6,025	7,225	15,183	High school diploma or equivalent
Nursing Assistants	9,064	10,008	944	7,465	6,035	14,444	Postsecondary nondegree award
Registered Nurses	11,924	12,703	779	2,533	4,088	7,400	Bachelor's degree
Medical Assistants	3,227	3,599	372	2,742	1,601	4,715	Postsecondary nondegree award
Social and Human Service Assistants	2,765	3,155	390	1,690	1,305	3,385	High school diploma or equivalent
Social Workers, ALL	3,010	3,287	277	1,339	1,076	2,692	Master's degree
Physical and Occupational Therapists, ALL	3,604	4,043	439	866	1,067	2,372	Master's degree
Technologists and Technicians, ALL	2,870	3,014	144	797	973	1,914	Associate/Bachelor's degree
Pharmacy Technicians	1,648	1,876	228	887	689	1,804	High school diploma or equivalent
Medical and Health Services Managers	1,669	2,118	449	783	527	1,759	Bachelor's degree
Counselors, ALL	1,491	1,737	246	739	570	1,555	Master's degree
Licensed Practical and Licensed Vocational Nurses	1,660	1,806	146	609	702	1,457	Postsecondary nondegree award
Nurse Practitioners	1,441	2,087	646	391	390	1,427	Master's degree

SOC Title	2022 Employment	2032 Employment	Change	Total Transfers	Total Exits	Total Openings	Education Code
Dental Assistants	815	844	29	675	461	1,165	Postsecondary nondegree award
Psychologists, ALL	1,664	1,804	140	557	439	1,136	Doctoral or professional degree
Physicians, ALL	3,194	3,250	56	193	657	906	Doctoral or professional degree
Phlebotomists	669	701	32	534	336	902	Postsecondary nondegree award
Social and Community Service Managers	924	1,035	111	438	316	865	Bachelor's degree
Dental Hygienists	891	923	32	199	389	620	Associate's degree
Pharmacists	1,316	1,428	112	190	317	619	Doctoral or professional degree

Between 2022-2032, there will be substantial demand for workers across numerous occupations, including but not limited to: registered nurses, social workers, counselors, physicians, nurse practitioners, social and human service assistants, medical assistants, nursing assistants, personal care aides, and physical and occupational therapists. Most of the job openings (88%) will be due to turnover and exits from the labor force. Innovative strategies to train new workers and retain the current workforce are needed to avoid worsening shortages.

Rhode Island DLT's 2022-2032 occupational projection data can also be looked at from a sector perspective. The following charts feature the top 10 job openings in Rhode Island from 2022-2032 for these sectors: Hospitals; Ambulatory Health Care Services; Nursing & Residential Care Facilities; and Social Assistance. Note: the DLT/Bureau of Labor Statistics (BLS) sector/industry categories do not perfectly align with the five sectors identified by the HCSP. Further, there is no comparable BLS category for behavioral health. As such, the Behavioral Health chart below shows the top 11 Behavioral Health occupations by total openings in any setting or sector.

Figure 10.2: Hospital Sector - Top 10 Total Job Openings (2022 – 2032), Rhode Island Department of Labor and Training 2022 – 2032 Industry & Occupational Projections

SOC Title	2022 Employment	2032 Employment	Change	Total Transfers	Total Exits	Total Openings	Education
Registered Nurses	6,792	7,119	327	1,431	2,309	4,067	Bachelor's degree
Nursing Assistants	1,606	1,685	79	1,288	1,041	2,408	Postsecondary nondegree award
Medical Assistants	827	947	120	713	416	1,249	Postsecondary nondegree award
Medical Secretaries and Administrative Assistants	770	808	38	400	418	856	High school diploma or equivalent
Phlebotomists	570	596	26	454	286	766	Postsecondary nondegree award

Medical and Health Services Managers	560	704	144	261	176	581	Bachelor's degree
Psychiatric Technicians	618	660	42	271	248	561	Postsecondary nondegree award
Psychiatric Aides	325	340	15	294	194	503	High school diploma or equivalent
Clinical Laboratory Technologists and Technicians	637	666	29	193	221	443	Bachelor's degree
Physicians	1,046	1,085	39	63	218	320	Doctorate

Figure 10.3: Rhode Island Department of Labor and Training 2022 – 2032 Industry & Occupational Projections - Ambulatory Health Care Services Sector - Top 10 Total Job Openings

SOC Title	2022 Employment	2032 Employment	Change	Total Transfers	Total Exits	Total Openings	Education
Medical Assistants	2,263	2,502	239	1,914	1,118	3,271	Postsecondary nondegree award
Nursing Assistants	1,759	1,989			1,186	2,883	Postsecondary nondegree award
Home Health and Personal Care Aides	1,318	1,525		1,467	1,137	2,292	High school diploma or equivalent
Registered Nurses	2,124	2,315	230	457	737	1,385	Bachelor's degree
Nurse Practitioners	1,045	1,570	207	290	289	1,104	Master's degree
Dental Assistants	774	800	26	640	437	1,103	Postsecondary nondegree award
Medical Secretaries and Administrative Assistants	983	1,020	37	507	531	1,075	High school diploma or equivalent
Social and Human Service Assistants	526	600	74	322	248	644	High school diploma or equivalent
Dental Hygienists	865	896	31	193	378	602	Associate's degree
Medical Assistants	2,263	2,502	160	1,914	1,118	3,271	Postsecondary nondegree award

Figure 10.4: Nursing & Residential Care Sector - Top 10 Total Job Openings (2022 – 2032), Rhode Island Department of Labor and Training 2022 – 2032 Industry & Occupational Projections

SOC Title	2022 Employment	2032 Employment	Change	Total Transfers	Total Exits	Total Openings	Education
Nursing Assistants	3,654	4,072	418	3,024	2,445	5,887	Postsecondary nondegree award
Home Health and Personal Care Aides	2,750	3,371	621	2,042	2,448	5,111	High school diploma or equivalent
Registered Nurses	1,306	1,457	151	284	459	894	Bachelor's degree
Residential Advisors	347	404	57	438	210	705	High school diploma or equivalent
Social and Human Service Assistants	478	561	83	297	229	609	High school diploma or equivalent
Licensed Practical and Licensed Vocational Nurses	614	682	68	228	263	559	Postsecondary nondegree award
Amusement and Recreation Attendants	55	64	9	100	67	176	No formal educational credential
Social and Community Service Managers	172	201	29	83	60	172	Bachelor's degree
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	147	176	29	75	58	162	Bachelor's degree
Occupational Therapy Assistants	86	103	17	83	47	147	Associate's degree

Figure 10.5: Social Assistance Sector - Top 10 Total Job Openings (2022 – 2032), Rhode Island Department of Labor and Training 2022 – 2032 Industry & Occupational Projections

SOC Title	2022 Employment	2032 Employmen t	Change	Total Transfers	Total Exits	Total Opening s	Education
Home Health and Personal Care Aides	3,201	4,216	1,015	2,474	2,967	6,456	High school diploma or equivalent
Social and Human Service Assistants	1,139	1,310	171	699	540	1,410	High school diploma or equivalent
Nursing Assistants	474	626	152	431	348	931	Postsecondary nondegree award
Child, Family, and School Social Workers	530	601	71	245	183	499	Bachelor's degree
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	274	364	90	147	115	352	Bachelor's degree
Social and Community Service Managers	314	361	47	151	109	307	Bachelor's degree
Residential Advisors	94	105	11	116	56	183	High school diploma or equivalent
Registered Nurses	166	208	42	38	62	142	Bachelor's degree
Rehabilitation Counselors	166	171	5	74	55	134	Master's degree
Therapists, All Other	136	159	23	39	48	110	Bachelor's degree

Figure 10.6: Behavioral Health Occupations - Top 11 Total Job Openings (2022 – 2032), Rhode Island Department of Labor and Training 2022 – 2032 Industry & Occupational Projections

SOC Title	2022 Employment	2032 Employment	Change	Total Transfers	Total Exits	Total Openings	Education
Social Workers2 (21-1029, 21-1021, 21-1022, 21-1023)	3,010	3,287	277	1,339	1,076	2,692	Bachelor's degree
Social and Human Service Assistants	2,765	3,155	390	1,690	1,305	3,385	High school diploma or equivalent
Psychologists2 (19-3039, 19-3033, 19-3034)	1,664	1,804	140	557	439	1,136	Doctoral or professional degree
Counselors2 (21-1019, 21-1018)	1,148	1,376	228	584	456	1,268	Master's degree
Therapists, All Other	1,099	1,205	106	305	374	785	Bachelor's degree
Social and Community Service Managers	924	1,035	111	438	316	865	Bachelor's degree
Psychiatric Technicians	627	670	43	275	252	570	Postsecondary nondegree award
Psychiatric Aides	325	340	15	294	194	503	High school diploma or equivalent
Community Health Workers	128	146	18	80	55	153	High school diploma or equivalent
Community and Social Service Specialists, All Other	137	146	9	82	57	148	Bachelor's degree
Psychiatrists	325	346	21	20	69	110	Doctoral or professional degree

1 Totals for Social Workers, Psychologists, and Counselors include combined data from the Standard Occupational Codes shown above.

Licensees Not Employed in Health Care in Rhode Island

Compounding the challenge of filling projected job openings is that there are thousands of licensed health care professionals in Rhode Island who are not employed in health care settings in the state. Some are employed in other industries or other states. Others work for temp agencies or are in private practice. And some are not in the workforce. The percent of licensed professionals employed in health care in Rhode Island has been steadily declining since 2010. The table below shows the decline in the percentage of licensed professionals employed in health care, and those employed in Rhode Island in any setting, between 2015 and 2023.

Figure 10.7: Total Licensed and Employed (2015-2023), Rhode Island EOHHS Health Workforce Dashboard

Year	Total Licensed	# Employed in Health Care	% Employed in Health Care	# Employed in Rhode Island	% Employed in Rhode Island
2015	47,512	29,636	62.4%	34,319	72.2%
2016	47,944	29,858	62.3%	34,599	72.2%
2017	48,364	29,955	61.9%	34,678	72.7%
2018	51,181	30,080	58.8%	35,653	69.7%
2019	53,965	30,616	56.7%	35,867	66.5%
2020	57,496	30,681	53.4%	36,101	62.8%
2021	58,825	30,340	51.6%	36,245	61.6%
2022	61,136	30,342	49.6%	36,832	60.2%
2023	63,396	31,460	49.6%	37,555	59.2%

Registered nurses, social workers, and licensed mental health counselors are significant drivers of this trend. There are thousands of licensed RNs who are not working in Rhode Island. This reflects a significant increase in out-of-state LPN and RN licensees when Rhode Island left the interstate nursing compact in 2017.

The interstate nursing compact is an agreement among participating states to recognize the license of specified categories of health professionals who live in another state - and to permit those health professionals to practice in another state – if that other state is a party to the compact.

We expect that the total RN and LPN licensees will drop significantly because Rhode Island rejoined the compact in 2024. Similarly, the number of LICSW, LMHC, and LMFT has increased significantly in recent years, but only 42.5% to 57.5% are employed in Rhode Island and only 31% to 38.6% are employed in health care settings. This is likely due to licensees working in a) private practice and b) telemedicine – neither of which is counted as employment in the DLT's wage records.

Figure 10.8: Total Employed Versus Licensed by Occupation, 2015 Compared to 2023, Rhode Island EOHHS Health Workforce Dashboard

	2015			2023		
Occupation	Total Licensed	Employed in Health Care (Rhode Island)	Employed in Rhode Island (any setting)	Total Licensed	Employed in Health Care (Rhode Island)	Employed in Rhode Island (any setting)
Licensed Practical Nurse	2,236	1,379 (61.7%	1,518 (67.9%)	3,109	1,581 (50.9%)	1,780 (57.3%)
Registered Nurse	21,703	12,176 (56.1%)	13,988 (64.5%	31,219	12,005 (38.5%)	14,316 (45.9%)
Advanced Practice RN	817	518 (63.4%)	594 (72.7%)	3,334	1,388 (41.6%)	1,589 (47.7%)
LCSW	765	421 (55.0%)	578 (75.6%)	1,670	645 (38.6%)	960 (57.5%)
LICSW	1,897	709 (37.4%)	1,057 (55.7%)	2,798	782 (27.9%)	1,214 (43.4%)
LMHC	652	267 (41.0%)	359 (55.1%)	1,488	461 (31.0%)	633 (42.5%)

Nursing professions are in BLUE
Behavioral professions are in YELLOW

Impact of Workforce Shortages on Quality of Patient Care and Economic Growth

Health care workforce shortages have significant consequences for Rhode Islanders. Staffing shortages lead to poor patient outcomes, including higher risk of missed diagnoses or incomplete treatment plans, decreased time for patient interactions and screening, longer patient wait times for appointments and treatments, and increased errors, patient falls, hospital-acquired infections, and mortality rates (He, Staggs, Bergquist-Beringer, & Dunton, 2016). They also limit access to care, with many patients unable to receive the community-based services they need and often turning to emergency rooms or costly hospital stays.

Beyond the direct impact on health care, these workforce challenges also have broader economic implications. A healthy population is crucial for economic growth and development. Poor health leads to higher rates of unemployment, lower productivity, substantial economic costs associated with presenteeism and lost workdays, and impacts overall quality of life. Addressing the health care workforce crisis is therefore essential for Rhode Island's economic well-being and prosperity.

Drivers of Workforce Shortages

These workforce shortages are driven by a confluence of factors that are also reflected in the Sector Chapters above:

High Levels of Stress and Burnout Health care workers, especially those in direct patient care roles, often face long shifts, emotional strain, risk of illness, injury, and violence, and high-stakes responsibilities that lead to significant stress and burnout. The COVID-19 pandemic further exacerbated these pressures.

Low Reimbursement Rates and Wages Reimbursement rates for health care services play a critical role in shaping workforce shortages, particularly in primary care, in behavioral health, or in rural or underserved areas. Low reimbursement rates, especially from Medicaid and Medicare, often fail to cover operational costs, discouraging providers from practicing in these fields or regions. Providers in underserved areas face additional challenges, as a higher proportion of patients rely on government-funded insurance, exacerbating financial strain. The earnings gap between high-reimbursement specialties and lower-paying fields like primary care also steers professionals away from these essential roles. Furthermore, low rates can force providers to see more patients or work longer hours to maintain financial stability, leading to burnout and higher attrition rates. These challenges are compounded by the career decisions of students and residents, who often avoid lower-paying fields due to concerns about repaying educational debt.

In addition, low reimbursement rates often translate into low wages for health care staff who do not bill directly for their services. This is particularly true for direct care and unlicensed workers and those who work in lower paid settings. For example, PHI (n.d.), a national direct care workforce research and advocacy organization, reports that 39% of all direct care workers in Rhode Island (Nursing Assistants and Personal Care Aides) receive some form of public assistance (29% are on Medicaid), while 46% of direct care workers employed in home care receive public assistance.

Disparities in Compensation Across Settings and Other States or Industries Challenges to recruitment and retention of the health and human services workforce are also due to pronounced compensation disparities across different sectors, settings, and geographic regions. Wage differences are creating significant challenges for workforce retention and recruitment. These wage differences include substantial disparities

between health care settings, such as hospitals, nursing homes, and ambulatory services; gaps compared to other states; and competition from industries offering more lucrative compensation packages.

Disparities in Compensation Between Settings For example, certain sectors of the health and human services industry struggle to compete for workers because of the significant variances in compensation between sectors. For example, hospitals tend to have the highest median annual wages among health care settings for most, but not all occupations.

Figure 10.9: 2023 Annualized Median Earnings by Occupation and Setting, Rhode Island EOHHS Health Workforce Dashboard

Occupation	Hospitals	Nursing & Residential	Ambulatory	Social Assistance	Govt.
CNA	$40,876	**$37,410**	$28,042	$21,956	$48,076
LPN	$51,072	**$66,676**	$47,816	$47,380	$70,222
RN	**$77,956**	$74,656	$75,540	$46,400	$89,028
APRN	$109,210	$76,572	**$107,658**	$119,860	$68,034
Dental Hygienist	$65,092	- - -	**$60,322**	$73,808	$51,032
LCSW	$56,472	$61,970	**$59,690**	$58,152	$68,220
LCDP	$67,600	$56,324	**$60,154**	$58,140	$65,904
LMHC	$70,196	$64,924	**$58,936**	$59,628	$70,820
LICSW	$69,154	$65,408	**$59,982**	$63,208	$70,012

BLUE indicates the health care setting with the highest median annual earnings per occupation.
GREEN indicates those occupations for which the highest median annual earnings is in government.
BOLD indicates the setting with the largest number of licensees.

There is also significant competition from the employment services sector (a proxy for temporary workers). This is particularly pronounced in nursing occupations. While the number of RNs and APRNs employed in health care settings has either remained relatively stable or slightly increased, the employment of LPNs, RNs and APRNs has significantly increased in the Employment Services sector - which offers higher wages and more choice in schedules and volume of hours. This explains one of the reasons that licensees in nursing occupations do not appear to be working in health and human services - temp agencies are not health and human service employers). It also explains why health care employers have difficulty hiring.

Figure 10.10: Employment Growth - Health Care Settings Compared to Employment Services (2019 and 2023), Rhode Island EOHHS Health Workforce Dashboard

	Health care Settings			Employment Services		
Occupation	Total Employed - 2019	Total Employed - 2023	% Growth	Total Employed - 2019	Total Employed - 2023	% Growth
NA	13,108	13,288	1.4%	1,952	2,633	34.9%
LPN	1,506	1,706	13.1%	238	475	99.6%
RN	12,739	12,600	-1.1%	810	1,334	64.6%
APRN	1,153	1,457	26.4%	17	35	106.0%

It is also important to note that per diem employees are often directly employed by health care employers (i.e., not 'temp agencies') and further add to the challenges of staffing with a "contingent workforce."

Disparities in Compensation for Similar Positions Between States and Other Industries In addition, the salaries for health and human services in Rhode Island are much lower compared to similar positions in other states, making it harder to attract and retain people in Rhode Island.

Figure 10.11: Bureau of Labor Statistics -May 2023 Median Hourly Wage Regional Comparison - Select Occupations

Occupation	Rhode Island	Massachusetts	Connecticut
RN	$45.60	$47.95	**$48.37**
Nursing Assistant	$20.00	**$21.25**	$19.66
Nurse Practitioner	$61.89	**$66.62**	$65.09
Dental Hygienist	$40.36	**$48.44**	$45.43
Surgical Technician	$30.19	$32.62	**$38.55**
Medical Assistant	$21.15	$22.97	**$22.01**
SU/BH, Mental Health Counselor	$22.13	$26.40	**$28.23**

Note. Data retrieved from U.S. Bureau of Labor Statistics. (2024, April). May 2023 occupational employment and wage statistics (OEWS) tables. *U.S. Department of Labor.* Retrieved November 2024, from https://www.bls.gov/oes/tables.htm.

Specific note. The *highest wage for each occupation is indicated in **BOLD.***

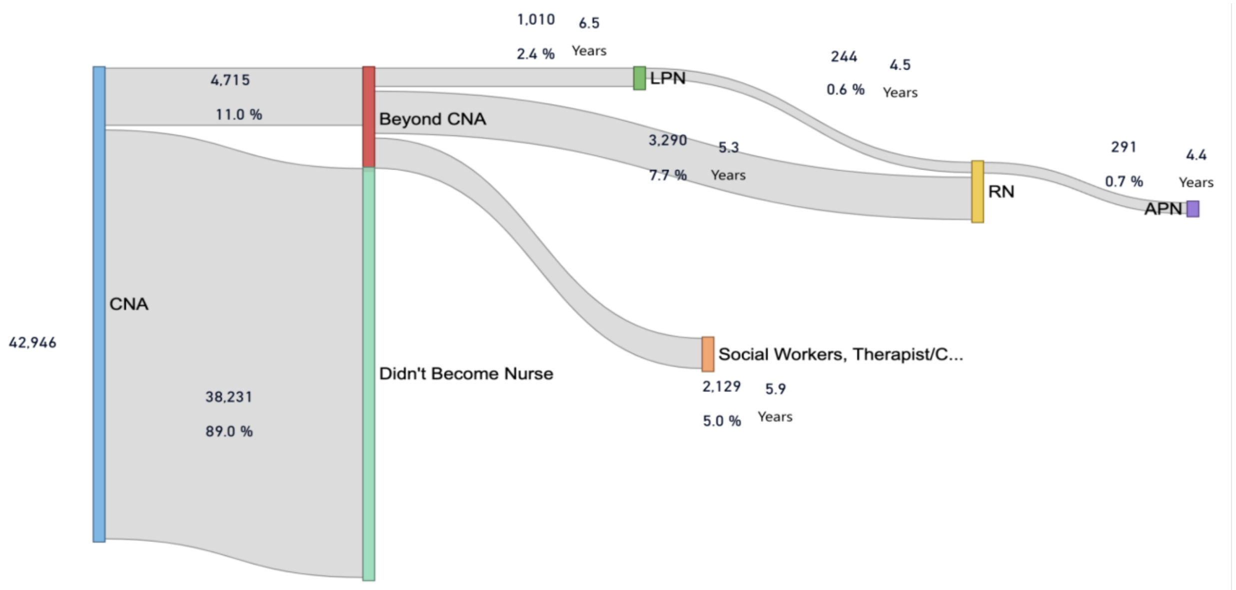
Finally, when compared to other fields that may require similar or even fewer qualifications but offer better pay, benefits, or schedules, some health care careers can seem less attractive. For example, while LPN and IT support specialists have similar earnings potential, LPNs tend to have less predictable schedules, more physically and emotionally demanding work environments, more formal training and licensure requirements, and fewer opportunities for career advancement.

Limited Opportunities for Career Growth One often-cited cause of high turnover in the health care workforce is the lack of career advancement opportunities, particularly for those in the lowest wage occupations. Without robust pathways to higher-level positions, employees, particularly working adults, may find it hard to progress. In addition, many licensed positions in health and human services require advanced degrees, certifications, or significant experience.

In addition, the cost of education and training for these programs can be substantial. Many students and working adults who are considering continuing their education are wary of accumulating significant student debt, especially when wages in some of these professions do not align with the investment required for training. For example, roles such as social workers, and mental health counselors often do not offer salaries that are commensurate with high tuition costs, making alternative career paths more appealing. In addition, not all professionals have the means or time to pursue these additional credentials, especially when balancing demanding work schedules and personal responsibilities. This can result in fewer individuals meeting the qualifications for higher-level roles.

For example, as the chart below shows, of the nearly 43,000 individuals who have been licensed as a CNA since 2010, only 7.7% have gone on to become a Registered Nurse.

Figure 10.12: Career Progression Among CNA License Holders (2010-2024, All Races/Ethnicities), Rhode Island EOHHS Health Workforce Dashboard



Alternative Career Options As health care roles become increasingly stressful and demanding, professionals are considering alternative careers that provide better work-life balance, flexibility, and satisfaction. The rise of remote work and opportunities in sectors like technology, consulting, and education has given health care workers more appealing alternatives that may offer competitive pay, less stress, and more advancement options. In addition, the expansion of telehealth has become attractive to many health and human services workers because it offers work-life balance by providing greater scheduling flexibility, reduced physical strain, and the ability to work from more comfortable environments. Similarly, many mental health professionals are increasingly choosing private practice due to financial benefits, including higher earning potential and greater control over billing.

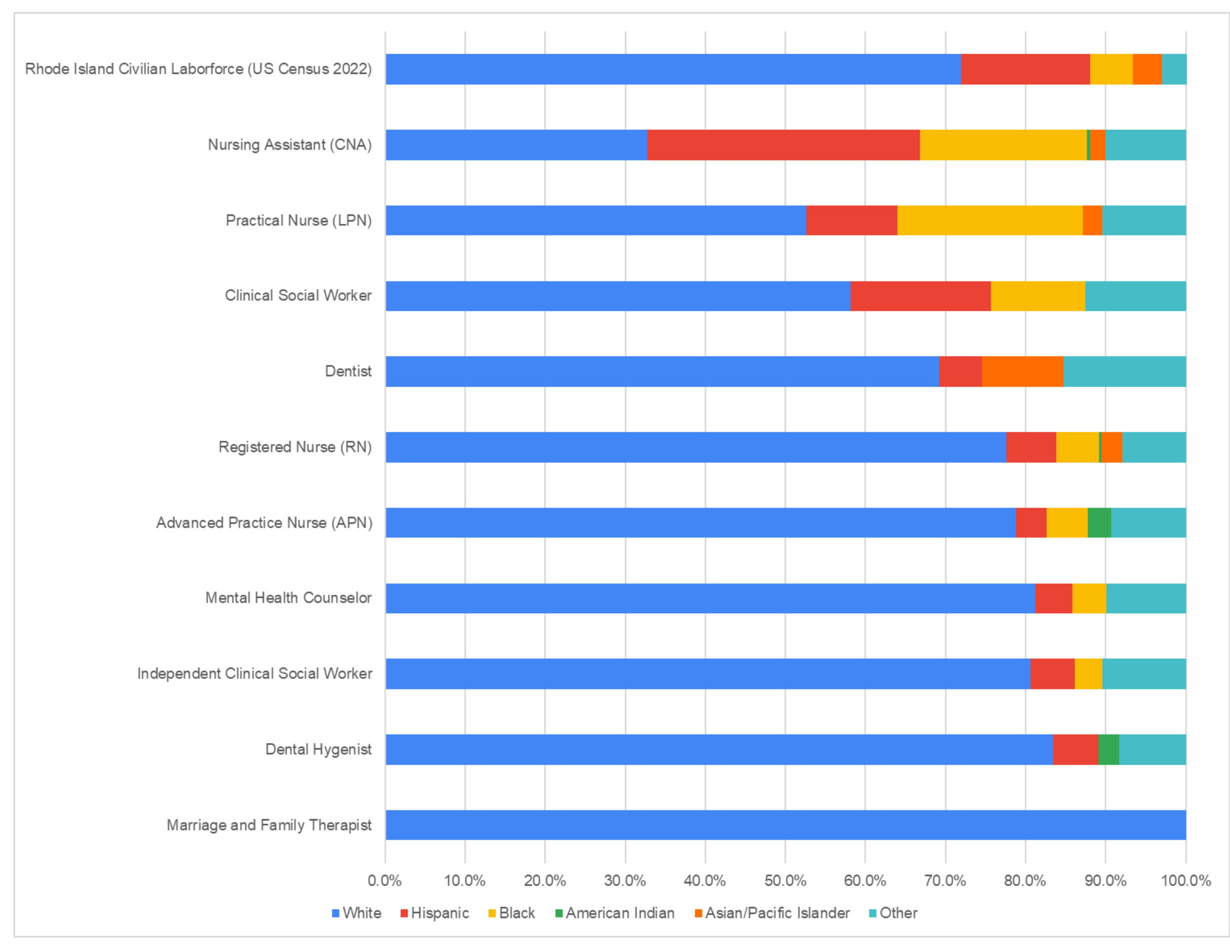
Housing and Childcare Barriers Housing and childcare challenges are major contributors to workforce shortages in health and human services, as the high cost and limited availability of these essentials make it difficult for employees to sustain their roles. Health care and human service workers, many of whom earn modest wages, often struggle to afford housing near their workplaces, forcing them into longer commutes that add stress and reduce time for personal or family responsibilities. Simultaneously, the rising cost of childcare can consume a significant portion of their income, creating financial strain that may push them to leave the field for jobs with better pay, remote work options, or more family-friendly schedules. These barriers disproportionately affect women, who make up a significant share of the health and human services workforce, exacerbating gender inequities and further shrinking the talent pool.

Administrative Burdens The increased focus on documentation, compliance, and insurance requirements adds to the administrative load for providers, detracting from patient care and contributing to frustration.

Racial and Ethnic Disparities Among Health and Human Service Professional Licensees

In addition to the overall workforce shortages, data shows that the health and human service professional workforce does not reflect the racial, ethnic, linguistic, and cultural diversity of the population it serves. This is particularly true for roles such as registered nurses, nurse practitioners, mental health counselors, and dental hygienists.

Figure 10.13: Race and Ethnicity by Occupation Compared to the Rhode Island Population, 2023



(Rhode Island EOHHS Health Workforce Dashboard, n.d.)

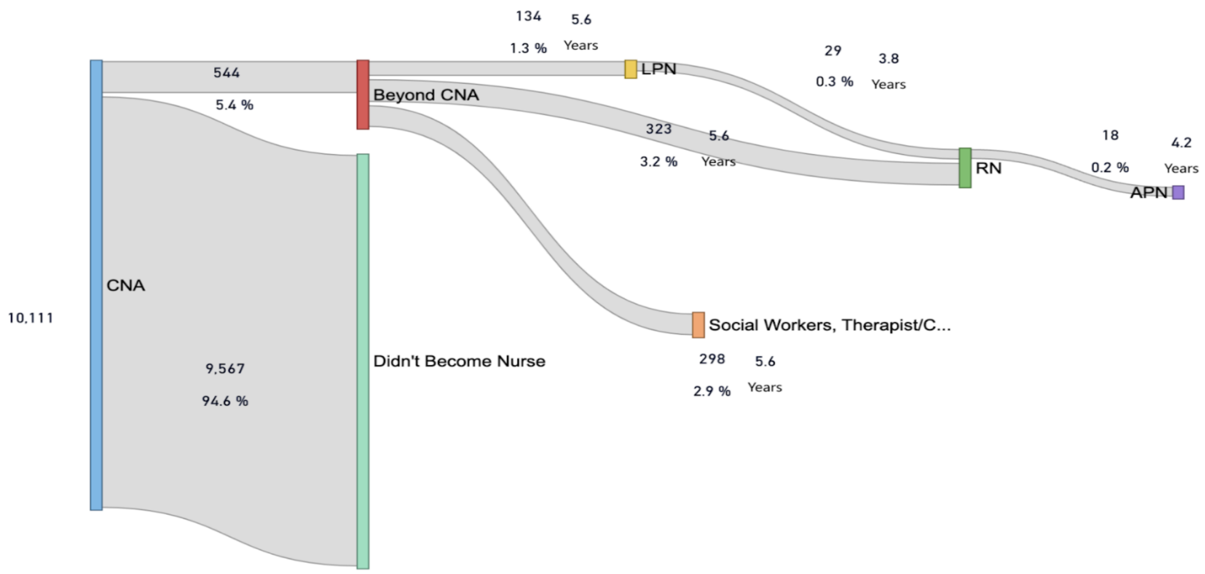
Racial and ethnic disparities among health and human service professional licensees represent a significant challenge that impacts workers, families, communities, and the patients or clients they serve. Specifically:

- **Adverse Impacts on Workers, Families, and Communities** The presence of racial and ethnic disparities in the licensed health and human service workforce adversely affects the workers themselves but also the families and communities that depend on their services. Workers of color face structural racism - and they and other workers (e.g., women, members of the LGBTQ community, those with disabilities) face discrimination in the workplace. In addition, they often face a lack of representation and support within their professions, contributing to lower job satisfaction

and higher rates of burnout. These challenges can ripple through families and communities, leading to fewer culturally competent health care providers and exacerbating inequities in health outcomes. Patients and clients benefit from a workforce that reflects their own backgrounds, as it fosters trust, improves communication, and enhances the quality of care.

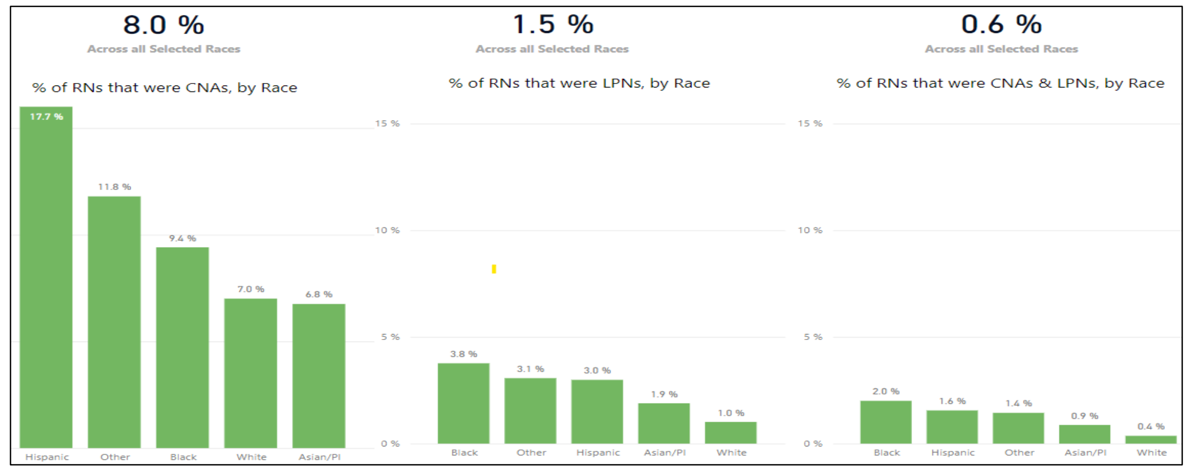
- **Implicit Bias and Its Consequences** Implicit bias within health and human services impacts job satisfaction, employee engagement, and career advancement, further contributing to recruitment and retention challenges. When biases influence hiring, promotions, or everyday workplace interactions, they can create environments where professionals of color feel undervalued or overlooked. This contributes to feelings of disengagement and can dissuade talented individuals from continuing in their roles or aspiring to leadership positions. Such dynamics perpetuate a cycle of under-representation and limit opportunities for diverse professionals to contribute meaningfully to their organizations.
- **Recruitment and Development of Underrepresented Populations** The failure to adequately recruit and develop talent from historically under-represented populations in health and human services perpetuates disparities within the workforce. Effective recruitment strategies must go beyond surface-level diversity initiatives to create pathways for training, mentorship, and professional development that support long-term career growth. Without targeted efforts to bring in and nurture diverse talent, the workforce remains homogeneous, limiting the potential for varied perspectives that improve problem-solving and enhance patient care. For example, while 7.7% of all CNAs licensed in Rhode Island since 2010 have advanced along the career pathway to Registered Nurse, only 3.2% of CNAs in Rhode Island who identify as Hispanic and 3.9% of CNAs who identify as Black have advanced to RN (Rhode Island EOHHS, n.d.).

Figure 10.14: Career Progression Among Hispanic CNA License Holders (2010-2024), Rhode Island EOHHS Health Workforce Dashboard



While career advancement from CNA to RN is infrequent, and even less common for CNAs of color, it is noteworthy that RNs (and LPNs) of color are much more likely to have started out as CNAs. For example, as the graph below shows, nearly 18% of Hispanic RNs were previously CNAs, while only 7% of White RNs started as CNAs. This clearly indicates that the CNA role has been an important starting point on career pathways for licensed nurses of color.

Figure 10.15: % of RNs who were previously CNAs or LPNs by Race and Ethnicity (2010-2024), Rhode Island EOHHS Health Workforce Dashboard



Disparities in Occupations and Earnings

Available data demonstrate disparities in occupational representation, earnings, and work settings of licensed health and human service professionals. For instance, professionals of color are frequently under-represented in higher-paying occupations within the health and human services sector. These roles often require advanced education, credentials, or access to professional networks that may be less accessible to under-represented groups due to historical and ongoing inequities. Conversely, people of color are overrepresented in lower-paying, frontline roles that, while essential, do not offer the same level of financial stability or career advancement opportunities. For example, as compared to other nursing occupations, CNAs have minimal entry requirements. As such, CNA is a more accessible occupation for individuals who face barriers to higher education, including those from underrepresented minority groups. This imbalance underscores the importance of addressing barriers to education, and professional development that can pave the way for equitable representation in higher-paying positions.

And, as mentioned earlier, median annual earnings are typically highest in hospital settings, where the licensed workforce tends to be disproportionately white. In contrast, community-based health settings, which often serve low-income and racially diverse communities, employ a larger proportion of professionals of color and offer significantly lower median earnings. This economic disparity reinforces systemic inequities. In addition, occupations with the lowest median earnings in their sector typically have the highest percentage of Hispanic and Black individuals, and vice versa.

Figure 10.16: 2023 Median Earnings and Race and Ethnicity by Selected Occupation

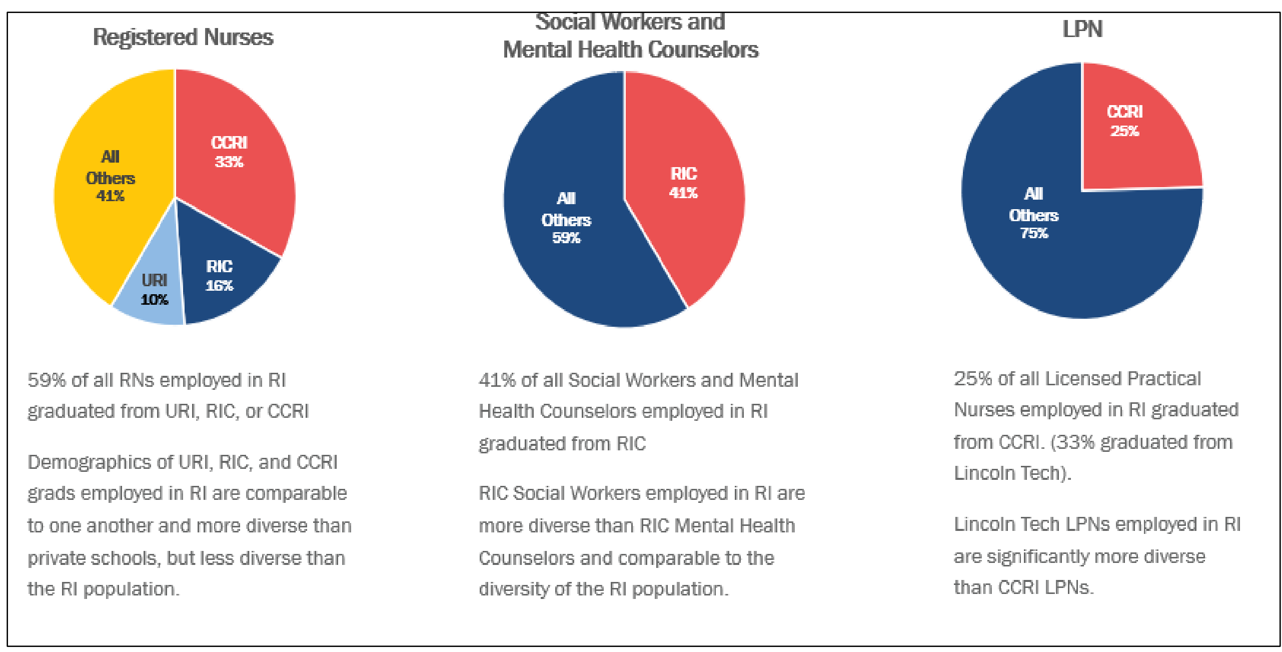
Occupation	White	Hispanic	Black	Median Earnings (all health care)
CNA	32%	35%	21%	$33,924
LPN	49%	12%	27%	$58,252
RN	76%	8%	7%	$76,320
APRN	77%	5%	7%	$108,076
DH	81%	8%	- - -	$60,636
LCSW	58%	20%	12%	$58,844
LCDP	78%	9%	9%	$59,454
LMHC	86%	5%	5%	$61,348
LICSW	83%	8%	5%	$63,236
ABA	100%	- - -	- - -	$71,248
Rhode Island Working Age Population*	**71.9%**	**16.2%**	**5.3%**	

**Note.* Data for Rhode Island Working Age Population retrieved from U.S. Census Bureau. (n.d.). *American Community Survey (ACS): Data.* U.S. Census Bureau. Retrieved October 2024, from https://www.census.gov/programs-surveys/acs/data.html. Data for selected Rhode Island Health Professional Licensees retrieved from Rhode Island EOHHS. (n.d.). Health workforce dashboard*. Rhode Island EOHHS*. Retrieved November 2024, from https://eohhs.ri.gov/health-workforce-dashboard.

Rhode Island Public Higher Education Pipelines into Health Care

Rhode Island's institutions of higher education (IHE) make a major contribution to Rhode Island's licensed health professional workforce. Fifty-nine percent of all RNs working in Rhode Island graduated from the University of Rhode Island (URI), Rhode Island College (RIC), or the Community College of Rhode Island (CCRI); 41% of all SW and MHC working in Rhode Island graduated from RIC; and 25% of all LPNs working in Rhode Island graduated from RIC. It is also noteworthy that 33% of LPNs working in Rhode Island graduated from Lincoln Technical Institute (Lincoln Tech), a private, for-profit, non-credit bearing career training school.

Figure 10.17: % Employed Select Health and Human Service Occupations in Rhode Island by Public IHE, 2023



Note. Data retrieved from Rhode Island EOHHS (n.d.). Health workforce dashboard. *Rhode Island EOHHS*. Retrieved May 2024, from https://eohhs.ri.gov/health-workforce-dashboard.

While demographics are NOT shown in the above graphic, data from the EOHHS Health Workforce Dashboard shows that the race and ethnicity of graduates from nursing programs at URI, RIC, and CCRI who are working in Rhode Island are similar to one another, more diverse than grads from private IHEs, but less diverse than Rhode Island's working age population. Among social workers and mental health counselors, we know that social workers who graduate from Rhode Island College and are employed in Rhode Island are more diverse than mental health counselors who graduated from Rhode Island College and are comparable to the diversity of the Rhode Island population. Among working LPNs, Lincoln Tech grads are significantly more diverse than CCRI grads, with 69% of CCRI identifying as White, but just 40% of Lincoln Tech grads identifying as white.

Insufficient workforce data collection and analytics capacity

Robust and responsive data systems are needed for state leaders to answer their most pressing questions about health and human services workforce needs and how to address them. Such data systems provide critical infrastructure for understanding dynamic workforce trends, identifying emerging gaps, and strategically allocating resources to meet workforce needs. Without real-time data analytics, policymakers are essentially operating in the dark, making decisions based on outdated information or anecdotal evidence that may not reflect current realities in health care and human services sectors. The most effective data systems can illuminate critical patterns such as impending retirement waves, emerging shortages, and demographic shifts in professional populations. By integrating data from multiple sources—including wage records, educational institutions, professional licensing boards, and certification boards—state leaders can develop nuanced, proactive strategies that address specific workforce challenges. While significant progress

has been made to integrate data from wage records and licensure boards—and make the data publicly available through the EOHHS Health Workforce Dashboard—the data sets do not currently include individual-level data on:

- Hourly wages or part-time/full-time status
- Job title or role
- Languages spoken other than English
- Anticipated retirement dates

In addition, Rhode Island (and all states) have limited ability to quantify current health care job vacancies or forecast long-term labor market demand by occupation or setting; nor does Rhode Island have a way to quantify the number of health care licensees employed outside of Rhode Island or who are self-employed. As noted in the Cross-Cutting Chapter on Data, continued investment to expand data integration and build Rhode Island data analytics infrastructure are needed.

Progress and Recommendations

Guided by extensive stakeholder input, as well as data, research, and best practices, the HWPI has pursued a variety of short-term and longer-term strategies to address Rhode Island's persistent health care workforce challenges. These strategies have been focused on **pipelines** to recruit and train a skilled and diverse health care workforce, **career pathways** to support the career advancement of health care workers, **rates and wages** to adequately compensate health care workers, and **data** analytics to measure progress in each of these areas. Below is a description of the progress that HWPI has made since its inception in 2022, followed by recommendations to sustain and scale up the advances made within each of these initiatives.

Pipelines

To encourage students, recent immigrants, unemployed workers, career changers, and current health care workers to consider a career in health care it is important to:

- Increase awareness among students, families, and educators of the breadth of health care opportunities and targeting potential candidates who may not have considered the field.
- Build a pipeline of future health care professionals by preparing students with skills and credentials before they enter the workforce.
- Address skill gaps among unemployed and underemployed adults, especially those from underrepresented groups.
- Support hands-on training.
- Address regulatory barriers to reduce delays and improve accessibility for diverse populations.
- Address credentialing and licensure gaps for foreign trained professionals.

Pipelines - Progress to Date

Recent efforts to develop and strengthen health care workforce pipelines include the following:

Health care career awareness In 2023, EOHHS launched the "Caring Careers" campaign to raise awareness of the many job and career opportunities in health care. This initiative has centered around the development and promotion of CaringCareers.RI.gov – the only resource of its kind in Rhode Island, providing information about health care employment, training, and continuing education opportunities – through online marketing, social media, and grassroots outreach. To date, the Caring Careers campaign has reached tens of thousands of Rhode Islanders and has helped to promote and fill health care job vacancies.

Career & Technical Education Many of Rhode Island's future health care job openings will be filled by individuals who are not yet in the workforce. This includes high school students who are in the process of considering and refining their academic and career interests. To ensure that our high schools are preparing students for jobs and careers in health care, HWPI is supporting the expansion of health care related CTE programs in communities throughout Rhode Island. EOHHS has worked closely with Rhode Island Department of Education, the Governor's Workforce Board, local school districts, and health care employers to facilitate partnerships and increase awareness among educators, students, and industry about health care education, employment, and career opportunities.

Pre-employment job training Our public-private partnership has long recognized the importance of providing pre-employment training for unemployed and under-employed adults, particularly from untapped or underrepresented communities, to obtain the skills and credentials needed to fill much-needed roles in health care settings. Specifically, the DLT's Real Jobs RI program, RIDE-funded community-based adult education providers, institutions of higher education, and proprietary training providers have all provided skills-based training – with funding from state and federal government, private sector partners, and individuals – to prepare thousands of Rhode Islanders for jobs in health care. Regrettably, federal and state job training funds are diminishing, even as demand for health care workers continues to exceed supply in many occupations.

Clinical placements for health professional students More than half of Rhode Island's currently licensed health professionals received their professional education in Rhode Island. An essential component of this education is supervised clinical training which enables students to develop hands-on clinical skills, and which frequently leads to future employment opportunities in the state. However, health professional higher education programs and students are struggling to find sufficient numbers of quality clinical placements, as health care providers are increasingly unable or unwilling to assume the staffing and financial burdens associated with providing clinical placements.

In 2024, the RI General Assembly enacted and funded the Primary Care Training Program to support expanded clinical training opportunities for primary care practitioners (physicians, advanced practice nurses, and physician assistants) in community settings. However, no such resources exist for any other health professions, such as Registered Nurses, Social Workers, Mental Health Counselors, Oral Health professionals, Pharmacists, Physical Therapists, etc.

Foreign-trained health professionals Rhode Island is home to many hundreds of foreign-trained health professionals who are unable to practice their licensed profession in the state due to the lack of reciprocity

between Rhode Island and their native country. RIDOH and DLT have supported the efforts of the Welcome Back Center to review and re-credential these professionals by providing English language training, transcript review, and/or required coursework to enable these individuals to become re-credentialled and employed in Rhode Island.

Similarly, OPC has enlisted the support of the National Association of Higher Education Systems (NASH) to convene Rhode Island stakeholders and develop recommendations to reeducate, re-credential, and re-employ refugees and asylees – including health professionals – living in Rhode Island.

Pipelines - Recommendations

To build on the work to date and respond to the numerous workforce issues that were raised by the Sector Workgroups, the Health Workforce Planning Initiative recommends the following:

1. **Caring Careers:** ARPA funding for Caring Careers will end as of March 31, 2025. Identifying new sources of funds for Caring Careers will ensure the continuation of this valuable and unique resource for workers, employers, and all Rhode Islanders.

2. **Career & Technical Education:** To help ensure a diverse, adequately prepared, and multi-generational pipeline of health and human service workers in Rhode Island, the State should work to continue expanding the capacity of successful health care CTE programs, as well as expand CTE health careers pathways to incorporate additional health care on-ramps, such as one focused explicitly on behavioral health. These opportunities should also be extended to students in middle school or younger, as early exposure to the field is critical to generating interest. In tandem with expanding CTE programming, the State should expand CTE partnerships and alignment with higher education, including articulation agreements, additional offerings around dual & concurrent enrollment, advanced standing, and AP courses. Finally, the state should support increased coordination, infrastructure, and opportunities around school and employer partnerships, work-based experiential learning, mentorship, guest speakers, and worksite tours.

3. **Pre-Employment Training** Labor market data indicate that there will continue to be significant demand for direct care workers (e.g., Nursing Assistant, Personal Care Aide, Medical Assistant, Dental Assistant, Behavioral Health Case Manager). Employers, educators, and training providers will continue to look to the public workforce system for funds to provide pre-employment training for these roles. To this end, public workforce funds (e.g., RI Job Development Fund (JDF), Adult Education, Workforce Innovation and Opportunity Act (WIOA)] should be earmarked for health care workforce development in order to meet employer demand, provide good jobs and careers, and ensure access to health care services for all Rhode Islanders.

4. **Clinical Placement Sites** To ensure the adequacy of clinical placement sites, resources are needed to support and compensate sites for increased costs and/or lost revenue resulting from providing clinical supervision (i.e., precepting) to students. In addition, the state should identify resources and capacity to house a clinical placement registry that would enable schools, students, and health care providers to efficiently arrange clinical placements that meet their collective needs.

5. **Welcome Back Center** The efforts of the Welcome Back Center are enabling foreign-trained health professionals to return to the health care workplace in Rhode Island. These multi-year efforts are in their

early stages and must be sustained in order to fully achieve their potential. NASH's recommendations, which are expected to call for expedited licensure pathways for foreign-trained health professionals, should be fully supported by the State.

Career Pathways

To retain talent in the workforce, increase worker satisfaction, diversify the workforce, and improve patient care outcomes, it is important to:

- Provide structured and supported opportunities through training, education, tuition supports, and credentials, for those who aspire to obtain a higher-paid occupation as well as for those who wish to remain and grow within their current occupation.
- Ensure that educational opportunities are affordable, convenient, and relevant with portable, industry-recognized credentials.
- Provide critical "wraparound" supports to help working adults overcome the significant financial, academic, and logistical challenges to pursuing continuing education and training while also balancing work and family responsibilities.

Career Pathways - Progress to Date

There have been several promising health care career ladder innovations in Rhode Island in recent years – particularly for lower-wage direct care workers who are more likely to be immigrants and people of color. These range from trainings that increase knowledge, skills, credentials, and, in some cases, wages in one's current occupation, as well as higher education that leads to a health professional degree and licensure. Recent efforts to build supported career pathways in Rhode Island, include:

Non-Credit Training for Incumbent Workers Various training programs have been developed and provided to health care workers with a focus on expanding knowledge and skills within their current occupation. In some cases, these trainings lead to certifications and higher rungs on a pay scale (e.g., Behavioral Health certification for home care agencies and workers, and Medication Aide training for Nursing Assistants). In other cases, training has been embedded into apprenticeships and other career ladder programs for occupations such as Case Managers. In addition, continuing education programs in topics such as trauma-informed care, Alzheimer's and dementia, and social determinants of health have been offered as professional development opportunities and/or for continuing education units.

Wrap-around supports In 2020, the state established the Office of the Post Secondary Commissioner established the Rhode Island Reconnect Program, funded by a $500,000 grant from the Lumina Foundation. Then, in the Fiscal Year 2023 budget, Governor McKee allocated additional funding to support the program's expansion. The Reconnect program aims to assist adult learners in completing degrees, credentials, or job training by providing personalized assistance through educational navigators who help identify goals, create actionable plans, and connect individuals to necessary resources. Additionally, the program addresses non-tuition financial barriers, offering support for expenses like childcare, transportation, and technology needs.

Health Professional Equity Initiative and Ladders to Licensure Career ladder initiatives that focus on supporting paraprofessional health care workers to obtain a health professional degree and license include

the Health Professional Equity Initiative (HPEI) and its successor, Ladders to Licensure. HPEI is an ARPA-funded partnership between EOHHS and the RI Reconnect program of OPC that has provided tuition assistance and comprehensive wraparound support to paraprofessionals employed in Home and Community-Based Services (HCBS) settings. More than 100 direct care workers have been supported in their higher education journey and most will have completed their studies and obtained a professional license in nursing or behavioral health care within the next six months.

Ladders to Licensure was enacted into law and funded by the Rhode Island General Assembly in 2024 to support partnerships between higher education and a minimum of three employers to develop formal and lasting career pathways that support paraprofessional health care workers to advance in their careers and obtain a health professional license. Three partnerships have been approved for funding, which will start on January 1 and run through June 30, 2025.

Higher Education Affordability Programs Most higher-paid health professions require a higher education credential. Depending on the profession, this can range from a diploma or Associate's degree to a Bachelor's degree, Master's degree, or PhD. For many Rhode Islanders, the higher education costs associated with these degrees is often intimidating or prohibitive. Fortunately, the State has a variety of programs designed to offset the cost of higher education for eligible individuals. These programs utilize a variety of strategies, ranging from scholarships to loan repayment to tax credits. In addition, most of these programs have limited funding and/or limiting eligibility requirements. Examples of such programs include:

- *Health Professional Loan Repayment Program (HPLRP)*, which repays a portion of higher education debt, subject to occupation, place of employment, duration of employment of the health professional, and available funding.
- *Wavemaker Fellowship*, which provides a tax credit based on years of credited service, subject to occupation, place of employment, duration of employment, higher education debt, and available funding.
- *Promise Scholarship (CCRI)*, which provides up to two years of full, last-dollar scholarships, subject to age, graduation date from high school, full-time status, and other factors.
- *Hope Scholarship (RIC)*, which provides up to two years of full, last-dollar scholarships, subject to completion of two prior years at RIC, full-time status, and other factors.
- *Fresh Start Scholarship (CCRI)*, offers Rhode Island residents who have previously attended CCRI but have not earned a degree, the opportunity to return and complete their education tuition-free for up to two semesters

It is important to note that HPLRP and Wavemaker require individuals to front the cost of their education, which may be a deterrent for low-wage workers. The Promise and Hope Scholarships do not require such upfront tuition payments; however, the age and/or full-time enrollment requirements make these programs unavailable to most full-time workers.

Recommendations

To build on the work to date and respond to the numerous workforce issues that were raised by the Sector Workgroups, the Health Workforce Planning Initiative recommends the following:

1. **Ladders to Licensure** To be successful, Ladders to Licensure will require multi-year funding. It is critically important that the State maintain its investment in Ladders to Licensure to increase the supply and diversity of licensed health professionals in Rhode Island.

2. **Health Professional Loan Repayment Program** HPLRP has proven to be an effective recruitment and retention tool in eligible primary care settings and occupations. HPLRP recipients provide primary care services to medically underserved populations in Health Professional Shortage Areas. Since 2013, 91% of HPLRP loan recipients have continued to practice in Rhode Island after completing their service obligations. In addition, HPLRP loan recipients are disproportionately from underrepresented populations among clinicians. In 2007, the State discontinued its contribution to HPLRP, and all State funds (which are required to obtain federal matching funds) are now provided by private sector organizations. Renewed State funding would increase the number of primary care clinicians who could be supported to practice in Rhode Island's Health Professional Shortage Areas

3. **RI Promise and Hope Scholarships** The State should revise eligibility requirements for Rhode Island Promise and Hope Scholarships to include part-time students (including working adults), certificate programs, and Master's-level programs. If need be, the State should phase-in this expansion of the Promise and Hope Scholarships by prioritizing health care-related programs.

Rates and Wages

To stabilize the workforce and improve recruitment and retention, it is important to use the OHIC rate review process to review and adjust provider rates as needed to ensure parity across payors, sectors, and states, and to further ensure that such rate increases translate into corresponding wage increases.

Rates and Wages - Progress to Date

Recent efforts to increase wages of health care providers, include:

One-time adjustments and reimbursement rate increases To help address the workforce challenges that had been exacerbated by the pandemic, the State allocated CARES Act and ARPA funds to health care providers to help improve recruitment and retention through hiring bonuses, retention incentives, temporary pay increases, and training and education stipends for direct care workers. These investments were made with one-time funds that helped to temporarily stabilize the workforce, but that did not address chronic workforce shortages.

Medicaid rate increases To keep pace with other states, industries, and payers, avoid the funding cliff associated with one-time payments, and increase the capacity of health care organizations to recruit and retain staff, the State has reviewed and adjusted certain provider rates, including hospitals, nursing homes, and pediatric practices. In addition, OHIC conducted a rate review in 2023 that resulted in significant adjustments to social and human service program reimbursement rates, particularly in the areas of behavioral health, children's services, and HCBS.

Rates and Wages - Recommendations

To build on the work to date and respond to the numerous workforce issues that were raised by the Sector Workgroups, the Health Workforce Planning Initiative recommends the following:

1. **Link wage increases to rate increases** As the State continues to respond to concerns from health care providers that inadequate reimbursement rates are hampering their ability to attract and retain health care workers, it must ensure that rate increases directly translate into wage increases. This should include requirements that specify a percentage of the reimbursement rate increase that must be passed through to employees in the form of increased compensation. This must also include transparency, reporting, and enforcement provisions to assure the public that rate increases are being utilized as intended to improve workforce recruitment and retention.

2. **Monitor adequacy and parity of recent rate increases** In order to maintain and expand adequacy and parity of provider rates, the State must continue to analyze the impact of recent rate increases, and through OHIC's process, implement further rate adjustments as needed, to ensure that rates are sufficient to sustain a diverse, well-trained, stable workforce and to provide timely access to quality care and services for all Rhode Islanders.

Health Care Workforce Data

To improve Rhode Island's ability to analyze and project workforce supply and demand, diversity, educational attainment, career pathways, employment status, earnings, turnover, and disparities, it is important to continue to expand data collection, integrate data, and build Rhode Island's analytic capacity.

Workforce Data - Progress to Date

Recent efforts to improve data collection, integration, and analysis include:

Health Care Workforce Dashboard The newly created EOHHS Healthcare Workforce Dashboard is an interactive tool that enables health care providers, educators, policymakers, and other stakeholders to better understand the characteristics and trends in Rhode Island's licensed health professional workforce, including the number licensed and employed, race and ethnicity, age, gender, annual earnings, and nursing career progression by occupation, school, and health care setting.

Expanded data collection New statutory language has clarified and expanded the authority of RIDOH licensure boards to collect additional data elements from health professional licensees – such as languages spoken, place of employment, and retirement plans – which would further enhance Rhode Island's health care labor market intelligence.

Workforce Data - Recommendations

To build on the work to date and respond to the numerous workforce issues that were raised by the Sector Workgroups, the Healthcare Workforce Planning Initiative recommends the following:

1. **Health Professional Licensure data-sharing** Continue to grow the capacity of the Healthcare Workforce Data Dashboard by transmitting all licensed health professional data into the Dashboard, including, as soon as possible, physician specialty data which will improve the ability of the State to quantify the current and

projected supply of physicians by specialty.

2. **Expand Health Professional Licensure data collection** Utilize RIDOH's enhanced statutory authority to collect important and necessary additional data elements from licensed health professionals.

3. **Data analytics capacity** Support a dedicated health workforce data analyst to enhance the utility of the Health Workforce Data Dashboard.

4. **Longitudinal Data System** Integrate education and training data from the RIOPC Longitudinal Data System into the EOHHS Data Ecosystem to improve the capacity of the Health Workforce Data Dashboard to analyze the effectiveness of health care workforce training, education, and career pathways programs.

5. **Wage record data** Expand the DLT's wage record data collection to include hourly wages and/or hours worked and job titles for all Rhode Island-based employees.

6. **Certified and unlicensed workers** Develop strategies to collect and analyze data for unlicensed health care workers, including workforce data reporting requirements for State-funded health care providers, and data-sharing by the Rhode Island Certification Board.

7. **Predictive Workforce Modeling** Enlist national labor market expertise to forecast health care workforce supply and demand based on demographic trends, disease patterns, payment models, technology, and other predictive variables.

8. **Health care workforce data integration** Integrate all health care workforce data within EOHHS, including licensure data, Health Professional Shortage Areas, loan repayment, Health Inventory, and the Data Ecosystem.

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Chapter 11: Value-Based Payment

Definition, Role, and Importance of Adopting Value-Based Payment Approaches in Health Care

Experts have long recognized the fee-for-service (FFS) approach to health care payments as problematic; it encourages overutilization and care fragmentation, leading to higher overall spending without necessarily improving health care quality and outcomes. Value-based payment (VBP), on the other hand, aligns financial incentives with patient needs; it rewards quality and outcomes, encouraging providers to focus on cost-effective care that enhances patient health and satisfaction.

VBP is implemented through alternative payment models (APMs). APMs encompass a diverse array of payment structures, including pay-for-performance incentives, bundled payments, capitation, shared savings/risk arrangements and global budgets, each varying in their focus and degree of provider risk assumption. The Healthcare Payment Learning and Action Network (HCP-LAN) has categorized different types of APMs based on the extent to which they move away from the FFS structure as outlined in Figure 11.1 (The Mitre Framework, 2017).

The evidence on VBPs' impact on cost, quality, equity, and patient outcomes is limited and mixed. Most of the existing research evaluates the impact of pay-for-performance programs as they have been the most common and established APMs (Damberg, 2014). The number of implemented programs and the availability of studies to evaluate VBP effectiveness decreases as one moves to more advanced APMs. Some studies have shown successes with models that shift greater accountability onto providers, which supports the overall movement to advanced APMs (Crooke, 2021). It remains to be seen, however, whether these outcomes can be sustained.

Despite mixed evidence on the impact of APMs on outcomes, it is clear is that FFS payments contribute to increased spending (Li, 2022) (Wagenschieber, 2024) (Mafi, 2021). There is general consensus that as health care costs continue to rise, moving away from FFS towards APM approaches will be critical to meaningfully change health care delivery and create a more affordable and sustainable system.

Figure 11.1: HCP-LAN Alternative Payment Model Framework

CATEGORY 1 FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION – BASED PAYMENT
	A **Foundational Payments for Infrastructure & Operations** (e.g., care coordination fees and payments for HIT investments)	**A** **APMs with Shared Savings** (e.g., shared savings with upside risk only)	**A** **Condition-Specific Population-Based Payment** (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B **Pay for Reporting** (e.g., bonuses for reporting data or penalties for not reporting data)	**B** **APMs with Shared Savings and Downside Risk** (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	**B** **Comprehensive Population-Based Payment** (e.g., global budgets or full/percent of premium payments)
	C **Pay-for-Performance** (e.g., bonuses for quality performance)		**C** **Integrated Finance & Delivery System** (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	**4N** Capitated Payments NOT Linked to Quality

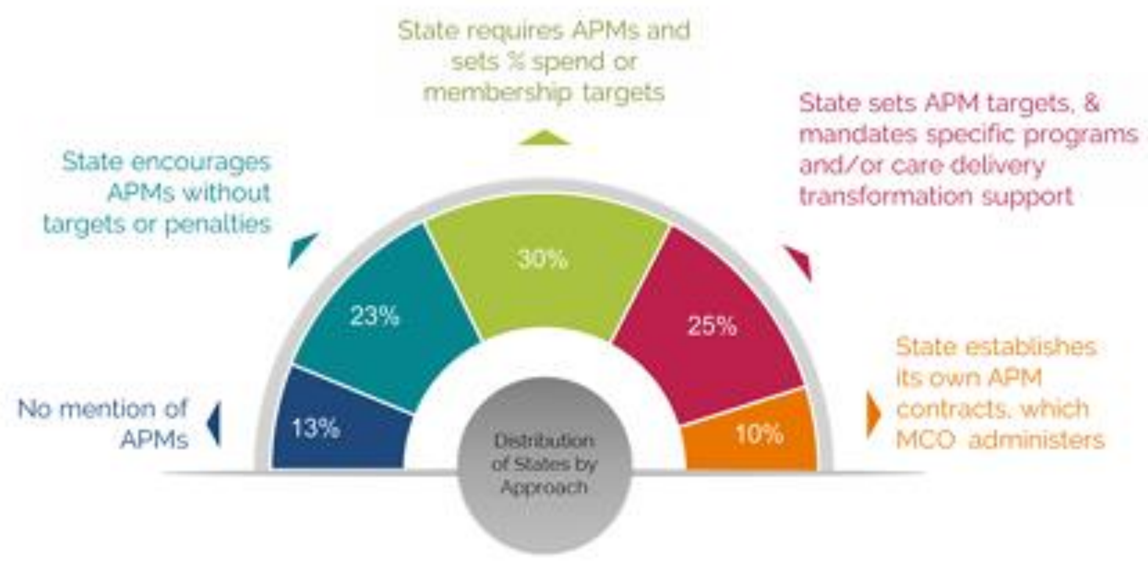
SOURCE: Health Care Payment Learning & Action Network, “Alternative Payment Model Framework,” 2017.

National Trends in APM Adoption

While the concept of “paying for value and not volume” has existed for a while, the last two decades have seen a significant increase in APM implementation. In the early 2000s, the Centers for Medicare and Medicaid Services (CMS) began initial discussions and implemented pilot programs to explore alternatives to the traditional FFS payment models (CMS 2012). The Patient Protection and Affordable Care Act (PPACA) further solidified the federal government’s commitment to VBP, with the establishment of initiatives such as hospital VBP programs, various episode-based payments, and the Medicare Shared Savings Program (MSSP) which was meant to encourage the formation of Accountable Care Organizations (ACOs). The MSSP has grown significantly since it was established in 2012 and CMS data show that as of January 2024, there are 480 Shared Savings Program ACOs providing care to an estimated 10.8 million Medicare beneficiaries. APM adoption also expanded across payer types and various care settings, with state Medicaid programs and commercial insurers implementing similar models to those of CMS. At the state level, many state

Medicaid programs also began requiring managed care organizations (MCOs) to increase their use of APMs. In a review of 40 Medicaid MCO contracts, the Catalyst for Payment Reform found that states took varied approaches, some taking more flexible approaches while others being more prescriptive as illustrated in Figure 11.2 (Catalyst for Payment Reform, 2019).

Figure 11.2: The Spectrum of Approaches to Payment Reform in MCO Contracting

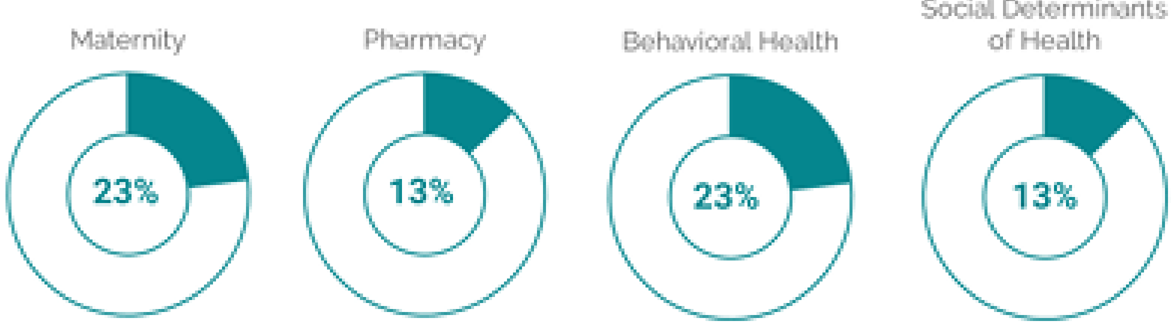


The Catalyst for Payment Reform, "Medicaid Managed Care Contracts as Instruments of Payment Reform: A Compendium of Contracting Strategies," December 2019.

Consistent with the needs, the Medicaid population's health needs, the largest focus for payment reforms was in the following areas (see Figure 11.3):

- **Maternity**, such as payment models to improve birth outcomes, reduce C-sections, and discourage early elective delivery.
- **Pharmacy**, including payment models that mandate transparency and rebate pass throughs, and prohibit price spreading.
- **Behavioral health**, including incentives to support integration of behavioral and physical health, ensure early care utilization for prevention, increase access to medication assisted therapy, and achieve quality goals.
- **Social determinants of health**, for example, incorporating social determinants into the MCO's broader APM strategy, and offering performance bonuses to community health workers (Catalyst for Payment Reform, 2019).

Figure 11.3: Percentage of States Whose Model Contracts Mandate Value-Based Payment in Specific Areas



SOURCE: Adapted from The Catalyst for Payment Reform, "Medicaid Managed Care Contracts as Instruments of Payment Reform: A Compendium of Contracting Strategies," December 2019.

In the commercial market, one of the nation's largest commercial VBP programs is the California Value Based Pay-for-Performance (VBP4P) program, which was launched by the Integrated Health Care Association (IHA) in 2001 in collaboration with major health plans in California. Under the VBP4P, provider organizations earn shared savings based on quality, total cost of care and resource utilization.

In 2009, Blue Cross Blue Shield Massachusetts (BCBSMA) implemented the first of its kind commercial global budget payment model called the Alternative Quality Contract (AQC). The AQC combines a fixed per-patient payment with substantial performance incentive payments tied to quality measures. During the first eight years after its introduction, the AQC was associated with slower growth in medical spending on claims, resulting in savings that over time began to exceed incentive payments. Unadjusted measures of quality under this model were higher than or similar to average regional and national quality measures.

Some states have also begun measuring and reporting on APM adoption in the commercial market. Oregon collects data and reports on APM adoption by market and by HCP-LAN category, including for the commercial market. Notably, Oregon, similar to Rhode Island (as discussed below), has a voluntary compact with more than 40 health care organizations committed to "participate in and spread" value-based payment with a goal of having 70% of payments be value-based by 2024 (Oregon Sustainable Health Care Cost Growth Target Implementation Committee, 2020). In addition, the Connecticut Office of Health Strategy (OHS) is statutorily required to monitor statewide APM adoption. OHS recently began collecting APM payment and covered lives data for the commercial and Medicare Advantage markets and reported on APM adoption for the first time in late 2024 (Gifford, 2022).

Despite efforts among Medicare, Medicaid, and commercial payers to adopt VBP, FFS remains the dominant form of payment. In 2022, only 41.3% of U.S. health care payments were tied to some form of alternative payment model. Payments through models that were population-based and involved some shared risk were even less prevalent, representing only 24.5 % of health care payments. The highest adoption of APMs was seen in Medicare Advantage, where 57.2% of payments were tied to Category 3 or 4 APMs, with 38.9% of payments in two-sided risk APMs (Categories 3B and 4). Traditional Medicare had 41.4% of health care dollars in Categories 3 and 4, and 30.2% were in two-sided risk APMs. For Medicaid, 40.3% of payments in

Categories 3 and 4 and 18.7% were in two-sided risk APMs, while the commercial market had 34.6% of payments in Categories 3 and 4 and 16.5% in two-sided risk APMs (HCPlan, 2023).

Landscape of VBP Activities in Rhode Island

VBP Implementation

There is strong commitment among health care stakeholders in Rhode Island to adopt VBP. Rhode Island has prioritized ACO adoption for its Medicaid program. As part of its Health System Transformation Program (HSTP), the state launched the Accountable Entities (AE) program in 2018–the state's version of ACOs that is run through managed care–after a two-year pilot. Now in the seventh year, the program includes seven EOHHS-certified AEs, six of which have taken on downside risk.
EOHHS also requires its contracted MCOs to significantly reduce the use of FFS payments and replace them with qualified APMs that incentivize better quality and more efficient delivery of health care services, including progressive movement toward Health Care Payment Learning & Action Network (LAN) Category 4 population-based payment APMs. MCOs must have at least 60% of the medical portion of their capitation flow through TCOC based contracts with EOHHS-certified AEs. EOHHS also set non-AE APM targets, designed to increase over time as outlined in Table 11.1:

Figure 11.4. Rhode Island Medicaid Contract Requirements for APM Adoption

HCP-LAN Category	Contract Period			
	2024-2025	2025-2026	2026-2027	2027-2028
2B-C: FFS payment linked to quality and value	12%	17%	22%	25%
3: APMs built on FFS architecture	7%	10%	13%	15%
4: Population-based payment	2%	3%	4%	5%

SOURCE: Rhode Island Medicaid Managed Care Model Contract

For its most recent Medicaid managed care procurement, the EOHHS updated its model contract to explicitly require MCOs to collaborate with the State to design and implement a primary care capitation APM. EOHHS further reserved the right to implement primary care capitation during the term of the Model Contract, requiring MCOs to agree to implementation timeframes established by EOHHS. However, implementation of these contract requirements has been delayed pending the outcome of a challenge to the procurement process and outcome.

In the commercial market, the Rhode Island Office of the Health Insurance Commissioner has advanced payment and delivery system reforms through "Affordability Standards" – a set of requirements that commercial health insurers must meet to demonstrate the affordability of their products. In 2015, OHIC published the Alternative Payment Methodology Plan which required commercial health insurers to direct 30% of medical payments through an APM by 2016. The target has been set at 50% since 2018, which has been met by plans statewide (see Figure 11.4). Overall, health care dollars in an APM totaled approximately $504 million in the commercial market in 2023. A significant portion of these payments (97%) have been through population-based ACO contracts (see Table 11.2). Three of the commercial ACOs also participate in the Medicare Shared Savings Program and the Medicaid AE program.

Figure 11.5: Rhode Island Commercial APM Target Performance (2016-2023)

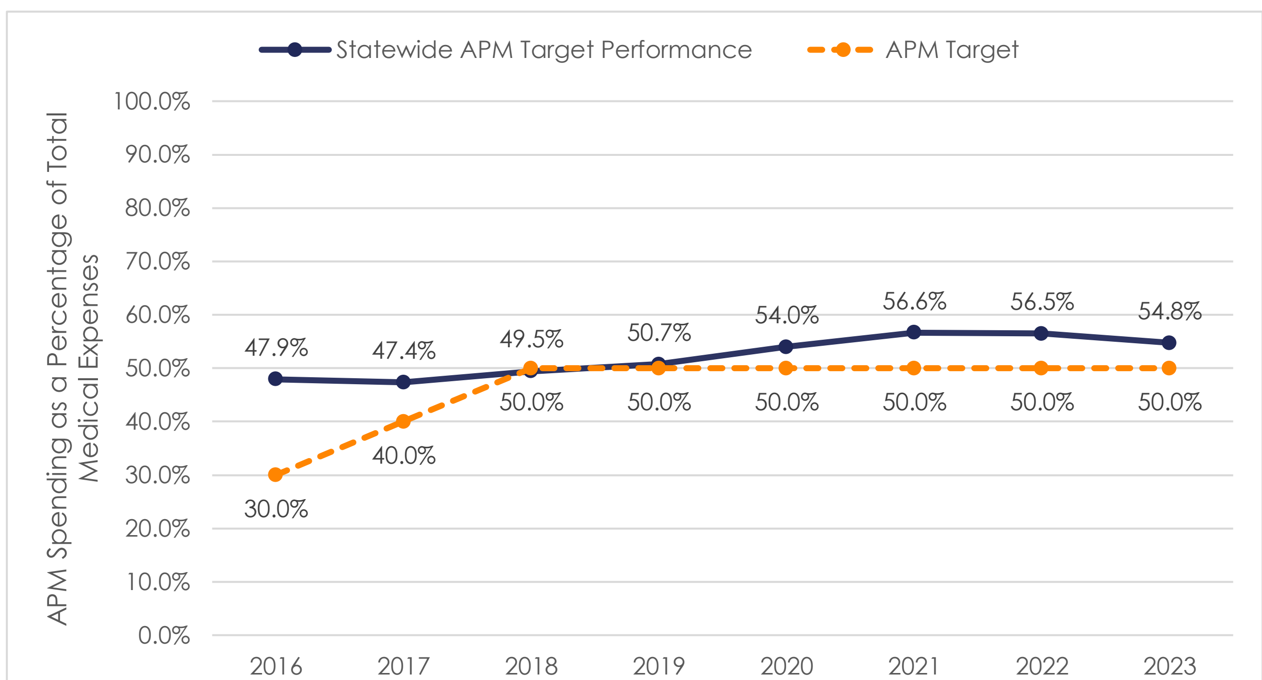


Table 11.2: 2023 Rhode Island Commercial Spending by APM Category

APM Category	2023 Spending	% of Total APM Spending
Capitation/Full Risk Model	$737,801	0%
PCMH Supplemental Payments	$451,288	0%
Settlement Payments under Bundled Payments	$0	0%
Total Dollars Allowed for All Services Under Bundled Payment	$363,123	0%
Total Dollars Paid Under a Population-Based Contract	$489,451,470	97%
Total Dollars Paid Under Pay-for-Performance Models	$12,795,147	3%
Other*	$673,613	0%
Total APM Spending	$504,472,443	100%

* Other Alternative Payments are payments that reward quality and efficiency, other than limited capitation, bundled payment and Pay-for-Performance models.

SOURCE: OHIC analysis of APM data submitted by commercial insurers.

OHIC has also long supported VBP approaches for primary care. In 2017, OHIC convened a workgroup to develop recommendations on a multi-payer primary care APM. This workgroup recommended adopting a complete capitated payment for specified primary care services while maintaining pre-existing member

cost-sharing agreements. In 2020, OHIC updated the Affordability Standards to require insurers to develop and implement a prospectively paid APM for primary care, but in doing so did not specify that the APM must be the capitated model that was recommended by the OHIC workgroup. Instead, the Affordability Standards highly encouraged alignment. The updated Standards also required that insurers have at least 20% of insured Rhode Island resident covered lives be attributed to a primary care APM by the end of 2024, with the percentage increasing to 60% by the end of 2025. The requirements around the types of primary care APMs that could be counted to meet these thresholds were broad, however. Consequently, while insurers have met the requirement to have a certain portion of covered lives to a primary care APM, uptake of OHIC workgroup's consensus model has been slow, with only one commercial payer (Blue Cross Blue Shield of Rhode Island BCBSRI) and Medicare offering primary care capitation to Rhode Island practices at present.

Viewing VBP as a key health care affordability strategy, in 2022, leaders of 21 organizations in the state signed a compact to accelerate advanced VBP model adoption. As part of the compact, stakeholders committed to exploring ways to introduce and/or expand upon three types of advanced VBP modes: (1) hospital global budgets; (2) prospective payment for specialty care; and (3) prospective payment for primary care.

In keeping with this commitment, OHIC convened a workgroup that developed parameters of a hospital global budget payment model that could be successfully implemented in the state (OHIC, 2023). EOHHS subsequently applied for CMS' the All-Payer Health Equity Approaches and Development (AHEAD) model initiative, key components of which involve the implementation of an all-payer hospital global budget, as well as primary care capitation. In October 2024, Rhode Island was chosen as one of the states to participate in CMS' AHEAD Model.

VBP Impacts

As noted earlier, the adoption of primary care capitation in Rhode Island has been slow. Nevertheless, it remains a key area of focus for BCBSRI. BCBSRI has reported that the flexibility it offers has allowed practices to build care teams that can manage patients efficiently, and further open up access. BCBSRI has also seen an increase in practices expressing interest in the model and intends to continue promoting its adoption.

On the ACO/AE side, stakeholders have recently shared mixed perspectives about their success and future. Commercial and Medicare ACOs accrued shared savings for many years, but in 2023 some experienced significant shared losses that they expect to continue in 2024. In Medicaid, the latest publicly available data show that all AEs earned shared savings during PY 4 (July 1, 2021 – June 30, 2022). Actual medical spending for AEs' attributed members ranged from 9.6% to 14.5% lower than TCOC targets (Presentation to the EOHHS Accountable Entity Advisory Committee, 2024). More recent internal data from insurers, however, show losses.

In addition, EOHHS' evaluation of the AE program found mixed results on its effectiveness. Members attributed to AEs had better outcomes than non-AE members attributed on some measures, but poorer outcomes on others. Moreover, the AE program did not have a significant impact on total Medicaid spending (Ewald, 2023).

Insurers interviewed noted that while the additional care management has resulted in better performance on some quality measures, it has not been enough to truly change the trajectory of utilization. Some insurers also indicated that a significant portion of the savings achieved in the early years by ACOs/AEs involved shifting sites of care from more expensive to less expensive facilities, rather than by reducing avoidable or inappropriate care.

Value-Based Care - Core Recommendations and Action Steps

The following text describes recommendations to facilitate successful adoption of advanced APMs in the state. While there was not a HCSP VBP Workgroup that mirrored the Workgroups for each of the Health Sectors, these recommendations have been informed by multiple discussions at public meetings led by OHIC and others; by a review of the national literature by Bailit Health; through interviews that Bailit Health conducted with Rhode Island health plan representatives and Accountable Care Organizations, and by a review of the recommendations from other Sector Workgroups, to ensure alignment.

Leverage Rhode Island's Participation in the CMS AHEAD Model to Advance Multi-payer Alignment *Discussed by the Cost Trends Steering Committee and by a 2022-2023 OHIC-convened Hospital Global Budget Working Group.*

Multi-payer alignment in VBP requirements can help streamline care delivery and improve provider take- up of VBP models. Having the same metrics, financial incentives, and care transformation requirements–within and across payer types–creates stronger incentives among providers to participate and prioritize APM adoption. They give providers the efficiencies of scale that would make VBP participation and the associated infrastructure investments worthwhile.

Rhode Island should leverage its recent acceptance into CMS' AHEAD Model to facilitate multi-payer APM alignment. As noted, the AHEAD model requires implementation of a multi-payer hospital global budget model, as well as a primary care APM. This provides the first real opportunity for the state to move hospital payment away from FFS and to a more sustainable model for hospitals, payers, and patients, with Medicare as an aligned partner. It also offers the potential to pick up the pace of transition to primary care prospective payment and increased multi-payer primary care investment.

Related Action Steps:

- In developing the hospital global budget model and primary care APM for AHEAD, the state should prioritize alignment in key payment model parameters, performance measures used, and data and reporting requirements.
- Rhode Island should leverage the financial and technical support available through CMS, and the state's AHEAD model governing body to develop model specifications that encourage broad participation among providers and insurers.

Ensure Adequacy and Stability of Payments under VBP and Facilitate Adoption of Primary Care Capitation

Discussed at two meetings of OHIC's Payment and Care Delivery Advisory Group, at the Cost Trends Steering Committee, its prior VBP Workgroup, and OHIC's former APM Committee, and its Primary Care APM Work Group.

The care delivery transformation that is needed for VBP to be successful places additional demands on providers, and they need additional support to be able to effectively carry them out. Providers note that payments under VBP need to be stable and adequate to support and sustain this. For example, an evaluation of CMS' Primary Care First (PCF) VBP model found that although PCF model payments were more generous on average than FFS payments, most practices felt they were inadequate to implement their planned care delivery changes. As a result, practices reported having to reduce their care management staffing because of the perceived funding shortfall.

In Rhode Island, stakeholders indicate that ACO/AEs have historically used shared savings and incentive dollars to build the care management infrastructure and hire more care managers. However, with ACOs/AEs currently facing losses in shared-risk contracts and Medicaid HSTP incentive dollars eliminated for AEs, multiple ACOs and AE report being seriously challenged to maintain their care management infrastructure. Without the certainty of payments, practices will be reluctant to engage in downside risk APMs and make the necessary infrastructure investments they require.

Related Action Steps:

- The State and insurers should consider incorporating funding for care management and care coordination into ACO/AE contracts, and not making those payments subject to shared savings performance risk to sustain the infrastructure investments that ACOs/AEs have made.
- Medicaid should consider requiring its contracted MCOs to implement primary care capitation.

Address Gaps in Primary Care Recruitment and Retention and Optimize the Existing Workforce

Discussed at the Health Care System Planning Primary Care Workgroup.

Primary care providers are critical to achieving the goals of VBP to manage care for complex patients with multiple chronic conditions and reduce complications and the need for expensive procedures further down the road. Like the rest of the nation, however, Rhode Island has a primary care workforce shortage that has left many PCPs overwhelmed, and care coordination and documentation requirements under VBP only compound this. The underlying causes of PCP workforce shortages and burnout need to be addressed in order to increase PCP participation in VBP.

Related Action Steps:

- Implement initiatives that enhance primary care workforce recruitment and retention and provides primary care practice supports, as detailed further in the Primary Care Sector Chapter of this report.
- Encourage payment models that promote team-based care, with health care providers operating within the full scope of their profession. Link financial and other incentives in these payment models to productivity.

Address Specialty Care as Part of the Continuum of Covered Services in VBP Models. *Discussed at OHIC's Cost Trends Steering Committee, at OHIC's prior VBP Work Group, OHIC's Payment and Care Delivery Advisory Group, and OHIC's former APM Committee.*

For a long time, many stakeholders have expressed concerns about the lack of engagement and accountability among specialists in value-based care and payment. When interviewed, insurers noted that they have some pay-for-performance programs involving specialty providers but have not been able to make headway with payment models that move away from FFS as the base payment model. They indicated that many specialists do not have interest or financial incentive to collaborate on patient care and cost reduction, which is a major gap in ACO/AE efforts to address spending growth and total cost of care.

Related Action Steps:

- The state should explore how to bring payment incentive structures into alignment across different provider types, including payments that encourage care coordination between PCPs and specialty physicians, e-consults and e-referral systems, and virtual co-management of certain conditions.
- ACO/AEs should consider including specialist physicians in shared savings.

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Chapter 12: Health Information Exchange

Definition, Role, and Importance of Health Information Exchanges

Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers, and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety, and cost of patient care.

Appropriate, timely sharing of vital patient information can better inform decision making at the point of care and allow providers to

- Avoid readmissions
- Avoid medication errors
- Improve diagnoses
- Decrease duplicate testing

Rhode Island's HIE provides a publicly funded and regulated avenue for streamlined and centralized statewide electronic records exchange, utilizing a multi-payer shared services model in voluntary alignment and collaboration with all of Rhode Island's major health plans and health systems. This statewide shared infrastructure model allows for considerable cost efficiencies and economies of scale, with the potential to replace or reduce many other software and operational costs for health plans and health systems while respecting patient choice.

The RI HIE Act of 2008 (R.I. Gen. Laws § 5-37.7-1) defines the roles of the Regional Health Information Organization (RHIO) and the statewide Health Information Exchange (HIE) and establishes important patient privacy and security protections to ensure patient health information is secure and shared appropriately. The RHIO serves as the State Designated Entity (SDE) for health information exchange in Rhode Island and operates the HIE under state authority.

Health Information Exchange (HIE)

The software system that mobilizes health care information electronically across organizations within a region or community. Also referred to as the "HIE System." The HIE System refers primarily to the information technology required to exchange health information electronically, including:

- HIE applications, software, and tools, such as patient and provider portals
- Data processing environments, including standardization and normalization
- Implementation and integration services with Data Sharing Partners
- Identity management (Master Patient Index)
- Consent management and compliance, including for sensitive record-sharing
- Technical and end-user documentation
- Privacy and security of PHI/PII
- Testing and quality assurance of all features
- Event notification services (hospital discharges)

Regional Health Information Organization (RHIO)

This is the organization that provides administrative and financial services, as well as operational support, to the HIE.

- *Administrative services to the HIE:* These services may include support for a governance/decision-making structure of the HIE; communications; policy development and promulgation; and others. The RHIO's administrative services to the HIE, including its policies and governance, are subject to state oversight under the contract between the state and the designated RHIO.
- *Financial services to the HIE:* These services may include developing of business plan to sustain the HIE; securing appropriate funds to capitalize and operate the HIE System; paying subcontractors; or maintaining appropriate accounting systems.
- *Operational support to the HIE:* As part of its operational support to the HIE, the RHIO must translate policy decisions into direction for the design and development of the HIE System. This frequently includes extensive user training and outreach, as well as technical assistance to providers.

Current Structures in Rhode Island (State Law and Regulation)

The Rhode Island Quality Institute (RIQI) has served as the State's RHIO since the inception of the statewide HIE in Rhode Island. In this capacity RIQI operates the current statewide HIE, named CurrentCare. Development of CurrentCare began in 2004 through the support of an Agency for Healthcare Research and Quality grant that was awarded by RIDOH to a separate HIE vendor for initial development. In 2008, RIDOH selected RIQI to be the RHIO and transferred ownership of the HIE contract with InterSystems to RIQI. Over time, management of the RHIO contract moved from RIDOH to EOHHS.

The law initially required consumers to opt in to the HIE in order for the HIE to collect health care information. On June 30, 2021, the RI General Assembly passed a modification to the HIE Act to change this requirement to an opt-out model for data disclosure, rather than an opt-in model for data collection. (R.I. Gen. Laws § 5-37.7-7) Legislation to revise the 2008 HIE Act to move from an "opt-in to collect" to an "opt-out to disclose" consent model passed the Rhode Island state legislature in June 2021 and was signed by Governor McKee in July 2021. In converting to an opt-out consent model, the health data from data-sharing partners (DSPs) will flow into CurrentCare for all patients who receive care at participating DSPs; patients will then have the option to opt out of disclosing those data to other health care providers, but it will be retained for HIPAA-compliant public health and regulatory purposes.

RIDOH promulgated related regulations in November 2022. Then, EOHHS and RIDOH jointed issued a Request for Information in December 2022 and recently completed the competitive Request for Proposals for designation of the RHIO and HIE that was launched in October 2023. The newly awarded contracts started July 2024. The Rhode Island Quality Institute (RIQI) will remain as the State's RHIO, and CRISP Shared Services (CSS) will provide the core HIE technology infrastructure.

With the implementation of the opt-out to disclose consent model, the State anticipates that the data volume and demand for uses of data will at least double. Historically, approximately 45-50% of Rhode Islanders have enrolled in CurrentCare under the opt-in to collect process, and based on market research of comparable state implementations, EOHHS expects a <5% opt-out rate. The new system will incorporate

event notification services, particularly discharge notifications, and 42 CFR Part 2 compliant behavioral health record-sharing as a part of core services.

In addition, EOHHS worked with the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) to revise the 50-year-old state mental health law (R.I. Gen. Laws § 40.1-5-26). The revised law makes explicit that mental health treatment records can be included in the HIE and exchanged for care coordination without specific written patient consent. This aligns closely with recent changes made on the federal level to 42 CFR Part 2 by SAMHSA for Part 2 covered substance use treatment providers, ensuring simplicity and reduced administrative burden for sharing behavioral health records.

National Trends, Driving Forces, and Innovation in HIE

Understanding the national landscape of HIEs is critical as a backdrop for the state's health system planning efforts. National trends, driving forces, and innovations in HIEs provide a framework that can guide the state in creating a robust and interconnected health care infrastructure. These advancements emphasize the importance of seamless data exchange, improved care coordination, and patient-centered approaches, all of which are vital to addressing the challenges and opportunities within the state's health care system. By aligning state-level planning with these national developments, the state can build on proven strategies, leverage cutting-edge technologies, and position its health system to meet the needs of all residents effectively. Below, the leading trends and innovations shaping the HIE landscape at the national level highlight key areas for consideration in the state's planning process.

Advancement of Interoperability Standards

National efforts to adopt frameworks such as Fast HealthCare Interoperability Resources (FHIR) and the United States Core Data for Interoperability (USCDI) are setting the stage for states to implement more cohesive data-sharing systems. For the state, leveraging these standards can ensure that providers, payers, and public health entities can communicate effectively, improving care coordination and supporting real-time decision-making. This interoperability is particularly vital for integrating diverse systems in a way that aligns with the state's broader goals for a unified health system.

Implementation of the 2024–2030 Federal Health IT Strategic Plan

This national roadmap emphasizes improved data access and exchange to enhance care delivery and public health outcomes. States can align their plans with this strategy to secure federal support, ensure compliance with evolving regulations, and position their systems to benefit from nationwide health IT advancements. Embedding these priorities into the state's health care plan can help build a system that is both forward-looking and resilient.

Digital Quality for Value-Based Payment

A core principle of value-based payment is measuring and assessing the value provided. Traditionally, this has been accomplished at the health plan level through data available in the claims payment process, or accomplished at the provider level out of their Electronic Health Records. As the national landscape moves to a deeper focus on measuring value, there is an increasing need for digital quality measurement, an approach that leverages all available sources of data for an operationally optimal measurement of

performance. CMS issued a Digital Quality Measurement Strategic Roadmap in March 2022, and the National Committee for Quality Assurance has announced its intention to transition nearly all HEDIS measure specifications to a digital quality format over the next five years. This has significant downstream implications for health plans and providers.

Trusted Exchange Framework and Common Agreement

The Trusted Exchange Framework and Common Agreement™, known as TEFCA™, operates in the United States as a nationwide framework for health information sharing as required in the 21st Century Cures Act. TEFCA was created by the U.S. Department of Health & Human Services Assistant Secretary for Technology Policy (ASTP) to remove barriers for sharing health records electronically among health care providers, patients, public health agencies, and payers. TEFCA is a legal and technical framework that supports regional HIEs in data exchange across the country with other regional HIEs. It is in early stages of adoption and recently became operational in December 2023. Rhode Island plans to participate as opportunity arises.

Technology Advancement for Community Care Coordination

Increasingly, HIEs and other HIT vendors are developing web-based tools that facilitate medical providers collaborating with behavioral health and community-based services under a team-based care model. These tools include obtaining electronic informed consent to share behavioral health data with medical providers, benefits applications, and screening processes, and “close-loop” referrals between different service providers, including to non-clinical social service organizations to address health related social needs.

Current State Landscape

EHR Adoption

EHR adoption in Rhode Island has been extremely successful. As of the EHR Incentive Program sunsetting on December 31, 2021, EOHHS had paid 1,294 applications for a total of $35M distributed payments to Rhode Island Medicaid eligible providers and hospitals over ten years, since 2011.

EHR adoption among physicians increased from 68% in 2009 to 95% in 2023, with uptake leveling off in recent years. While prevalence of e-prescribing has largely remained steady since 2013, it increased from 84% to 94% between 2019 and 2023, likely due to new state regulations in 2020 that mandated e-prescribing for controlled substances.

In 2021, the most frequently utilized EHR for Rhode Island physicians was Epic Systems for both hospital-based and office-based physicians (55% and 28%, respectively). The next most common EHRs for hospital-based physicians were Cerner (16%) and Meditech (9%). Among office-based physicians, the next most common EHRs were eClinicalWorks (20%) and Athena Health (11%). Other EHR vendors with relatively small market share in Rhode Island included Greenway, Modernizing Medicine, Ingenix/Caretracker, NextGen, gGastro, Amazing Charts, and Practice Fusion.

It should be noted that despite a small overall market share, most of Rhode Island’s Federally Qualified Health Centers (FQHCs) operate on NextGen. Additionally, around 3% of hospital-based respondents utilized the VA Hospital’s EHR, VistA.

Figure 12.1 Rhode Island Physicians Using EHRs and Other Electronic Supports

			Office-based specialty	
Measure from 2023 Health IT Survey	Hospital (N=441)	Office (N=1,161)	PCP (N=447)	Non-PCP (N=704)
Physicians with EHRs, %	98%	93%	96%	92%
Physicians who e-prescribe, %	87%	96%	99%	94%
Physicians who use telemedicine, %	42%	80%	92%	73%

CurrentCare

The existing statewide HIE, CurrentCare, contains records on more than 540,000 unique individuals under the opt-in consent model. There are more than 2,000,000 unique individuals captured over all time. There are 51 active data-sharing partner organizations over 40 inbound interfaces and 20 outbound interfaces, covering the following file types:

- Continuity of Care Documents (CCDs) for clinical encounters
- Discharge Continuity of Care (CoCs) documents for hospital and ED visits
- Admission, Discharge, and Transfer Notifications
- Encounter Data (Medications, Conditions, Allergies, Vital Signs)
- Test Results (Labs, Medical Imaging Reports, EKG Reports)
- EMS Encounter Run Reports

The current list of data-sharing partners is available at: https://riqi.org/dataguide

Strategic Roadmap – HIE Recommendations

Rhode Island EOHHS recently engaged in a multi-year HIT planning effort with contracted consultants and released the Rhode Island HIT Strategic Roadmap in July 2020. The full documents are available here: https://eohhs.ri.gov/initiatives/health-information-technology

Here are the consensus issues that were flagged, and the State's current status in addressing each:

Issue	Description	Current Activities
Governance	Stakeholders identified a need for coordinated statewide alignment on key HIT topics.	The State established the Rhode Island HIT Steering Committee in December 2020, a public/private partnership aimed at improving knowledge-sharing, alignment, and shared decision-making, which typically meets monthly.

Health information exchange	There was widespread overall community support for the transition to the opt-out consent model for the HIE. The Rhode Island state assembly revised the RI HIE Act of 2008, and the governor signed the revision into law in July 2021.	Implementation is actively underway. All provider organizations are strongly encouraged to work with RIQI to establish new data feeds as data-sharing partners and new user account access. Go-live for the new system is expected April 2025.
Demographic data	Accurate, reliable, and complete demographic data is needed as a foundational requirement to detect and address health inequities. Multiple data standards and privacy and sensitivity requirements make this a difficult task.	OHIC recently convened a demographic data standards workgroup to create recommendations for statewide standards in race, ethnicity, language, disability, sexual orientation, and gender identity. RIDOH worked with EOHHS and the Care Transformation Collaborative (CTC) to leverage a CDC grant to assist primary care practices in improving their demographic data collection. This work was extremely valuable and has been continued to be funded by United Healthcare as a quality improvement initiative.
Behavioral health	A key priority for Rhode Island is to create investment opportunities to support behavioral health providers in modernizing their technological infrastructure. This is a critical investment to promote shifting to value-based payment in behavioral health, and to meaningfully integrate behavioral and physical health care services for beneficiaries.	EOHHS and BHDDH incorporated technology infrastructure requirements into Rhode Island's Certified Community Behavioral Health Center (CCBHC) state-specific model, with costs included in rate setting. The new HIE includes extensive support for behavioral health record-sharing and EOHHS is actively seeking to encourage participation from behavioral health providers.
Electronic clinical quality measurement	Rhode Island is a national leader in transformation of Medicaid quality outcomes reporting and is frequently looked to by other states as an example in innovative and efficient centralization of electronic clinical quality measurement (ECQM). This is part of the overall shift to value-based contracts incorporating upside and downside risk, which is strongly encouraged by CMS, and the foundational quality reporting for the Medicaid core measure set is a federal requirement.	EOHHS successfully connected over 40 Medicaid primary care providers' EHRs to the Quality Reporting System in September 2021 and achieved Data Aggregator Validation certification from NCQA in February 2022 for the majority of data submitters. We have maintained these feeds and certification since. With the shift to the opt-out HIE, we are assessing opportunities to create efficiencies by leveraging the HIE as a data source for quality reporting, and intend to issue a competitive procurement for the new approach in 2025.

Transitions of care	Continuing work to improve information sharing during transitions of care, such as between hospitals, primary care practices, and skilled nursing facilities (SNFs).	Work on this has continued between EOHHS, RIDOH, CurrentCare, and community stakeholders; however, the COVID-19 pandemic significantly delayed progress. Currently Rhode Island is developing a strategic approach to promote SNF participation in the HIE to allow for electronic notification of admission and discharge to the patient's care team.
Core identity services	Core identity services, such as provider directory, statewide master patient index, single sign-on capabilities, and patient-provider attribution.	Previous efforts in Rhode Island in this area encountered significant challenges and the State is cautiously assessing potential future work. The new HIE will incorporate elements of a provider directory by associating (attributing) patients with their care team members. Single sign-on capabilities are pursued in all projects.
Federal policy alignment	Federal policy alignment, including opportunities related to the ONC and CMS Interoperability Rules around info blocking, hospital alerts and notifications, and patient access to data.	We have already seen improvements in hospital discharge notifications due to these rules, and are actively pursuing providing additional technical assistance to providers and health plans.
Public health data modernization	The Data Modernization Initiative (DMI) aims to transform public health data systems by focusing on workforce development, governance, and technology modernization. This collaborative, jurisdiction-specific approach ensures adaptable solutions to advance public health informatics and digital transformation.	Through systematic assessments of infrastructure and processes, DMI identifies gaps and crafts strategic, actionable roadmaps tailored to organizational needs. Work is currently underway to complete a Health Systems Inventory Assessment (HSIA) and an overall RIDOH data strategy plan and roadmap.

Chapter 13: Consumer Engagement

Role and Importance of Consumer Engagement in Health Care System Planning

Consumer input is a critically important and valued component of the HCSP Cabinet's health care systems planning process. Executive Oder 24-04, which established the Health Care System Planning Cabinet (HCSP Cabinet), states that the HCSP Cabinet shall engage and solicit broad input from an array of stakeholders, including, but not limited to, EOHHS' Independent Advisory Council under R.I. Gen. Laws § 42-7.2-7, and other stakeholders who have an expertise in various areas.

The following represents a summary of the work that the Health Care System Planning Interagency Team has undertaken to obtain consumer input to date and its plan to continue to solicit such input during 2025. An important part of this process will include focused efforts to obtain input from a broad range of health care consumers throughout the state while also ensuring representation from the following especially vulnerable populations:

- People residing in high-density communities
- Black, Indigenous, and People of Color (BIPOC) community members
- Lesbian, gay, bisexual, transgender, queer and/or questioning, intersex, asexual plus (LGBTQIA+) persons
- Refugees
- Pregnant individuals, mothers, and children
- Young people who have experienced foster care
- Survivors of family violence
- Older Rhode Islanders
- Individuals with disabilities
- Individuals with behavioral health conditions, including substance use disorder
- Recently released incarcerated persons
- Unsheltered and homeless people

Receiving consumer input from Rhode Islanders with a variety of experiences within the state's health care system will help shape implementation plans and action steps for the recommendations and action steps proposed in this report.

Key 2024 Consumer Engagement Activities

In 2024, the HCSP Interagency Team:

- Developed key informant consumer interview questions (in English and Spanish) and a facilitator's guide for use with consumers as a part of the HCSP Cabinet's work. The team recognized the need to offer different surveys and interview questions to best meet the needs of each consumer population approached.

- Conducted a focus group in August of 2024 with parents and caregivers on the Parent/Caregiver Advisory Council facilitated by RIDOH's Family Home Visiting Program. The interview questions were translated into Spanish and a Spanish-speaking interpreter was present during the focus group. (Please see below for a summary of key input).
- Conducted community listening sessions and disseminated consumer surveys as part of Rhode Island's efforts to develop and implement the community integration standards set forth in the Olmstead decision and the mandates of Title II of the federal Americans with Disabilities Act (ADA). Olmstead community engagement and implementation efforts will continue through at least March 31, 2025.
- Launched a process to obtain health care consumer input via Rhode Island's Health Equity Zones (HEZs), connecting health care consumers via the existing community network across the 14 HEZs. Consumer surveys and an interview questions/facilitators guide are in the process of being finalized and HEZs will take the lead organizing efforts to engage consumers and obtain input.
- Is finalizing a plan intended to coordinate culturally appropriate, equitable, mutually reinforcing, and non-duplicative consumer outreach and engagement to inform the HCSP Cabinet's long-term health care systems planning work. The plan's strategic goals focus on 1) increasing opportunity for diverse people with lived experiences to voice recommendations for health care systems improvements, 2) including all Rhode Island populations, with a particular focus on the populations listed above, as a part of the health care systems planning process, and 3) establishing continuous consumer input and engagement opportunities as part of the HCSP Cabinet's long-term health care systems planning work.
- The Interagency Team will obtain additional consumer input from the entities mentioned above, as well as from related social service organizations, state government agencies, behavioral health agencies and those that serve people with substance use conditions, and other participating organizations in the Health Care System Planning process. In November of 2024, HCSP Cabinet staff began reaching out to these organizations and agencies to seek any available consumer information they feel comfortable sharing in the aggregate and/or to find opportunities to solicit input from a diverse group of consumers in 2025.
- The Interagency Team also plans to post a consumer input survey in English and Spanish on the Health Care Cabinet member agencies' websites in 2025.

Preliminary Findings of 2024 Consumer Engagement Activities

- EOHHS identified the following key findings from our community engagement process to date. Some consumers identified positive experiences in health care including easy access to primary care and specialists through insurance networks, satisfaction with telehealth for convenience, and timely emergency care at places like Hasbro. However, some consumers also expressed challenges including difficulty finding providers accepting state insurance, long wait times in emergency rooms, poor communication and follow-up, and transportation issues, particularly with state medical transportation. Suggested improvements included focus on better follow-up communication,

increasing provider availability, expanding telehealth, improving insurance coverage, and addressing health care discrimination through sensitivity training.

Positive Consumer Feedback	
Access to Care	▪ Many people were able to find a Primary Care Physician (PCP) or specialists with the **help of their insurance companies or provider networks**, ensuring timely care. ▪ Some patients appreciated **direct access to specialists** through their PCPs ▪ **Telehealth** was highly praised for convenience, saving time, and avoiding the need to travel. It worked especially well for counseling or brief consultations.
Emergency Care	▪ Participants shared **positive experiences with emergency departments** (ED). For instance, quick attention, child-friendly environments, and clear communication during emergencies at an ED helped ease anxiety.
Appointments and Follow-ups	▪ Several patients expressed satisfaction with **same-day appointments** or flexible scheduling, particularly for pediatric care. ▪ **Good communication and follow-up** were highlighted by some respondents, including doctors using portals to track and respond to patient inquiries quickly.
Transportation	▪ Some individuals did not face transportation issues, as they had reliable personal transportation or were able to access convenient locations.

	Challenges and Issues
Finding Providers	▪ **Difficulty finding doctors** accepting state insurance or other specific types of insurance was a recurring theme. Several people mentioned long waitlists, especially for adult PCPs or pediatricians. ▪ Some individuals had negative experiences with **overburdened providers**, like rushed appointments or providers with too many patients to give quality care. The lack of nearby pediatricians in rural areas also posed a challenge.
Emergency Department Experiences	▪ Several participants experienced **long wait times in the ED**, leading to frustration, with one person noting that they left after hours of waiting.
Appointment Access and Delays	▪ **Accessing appointments** was a common concern, particularly with non-urgent care. Delays in getting callbacks from doctors or messages sent via portals caused frustration, and there were complaints about **appointments being difficult to schedule quickly**. ▪ **Specialists** were particularly hard to access, with waiting times of several months.
Telehealth	▪ While many praised telehealth for convenience, some noted **limitations** in not receiving thorough exams and missing out on physical assessments.
Follow-up and Communication	▪ **Poor follow-up** was a significant issue. Some reported that their providers failed to follow through on referrals or test results, leading to delays and additional work for patients to track down needed information. ▪ Several participants voiced frustration with **miscommunication and delayed responses** to messages from providers.
Transportation Issues	▪ For those relying on **state medical transportation**, participants reported that it was often unreliable, leading to late arrivals for appointments or cancellations. A lack of coordination between appointment scheduling and transportation availability was mentioned as a problem.
Racism and Discrimination	▪ Some patients reported experiences of **racial discrimination** in health care settings, such as being treated dismissively or accused of drug-seeking behavior due to their ethnicity.

	▪ Issues like **lack of sensitivity training** and **provider bias** were highlighted as contributing to negative health care experiences for certain populations.
Insurance and Cost	▪ **High costs** and **insurance coverage issues** were recurring concerns. Participants reported frustration with **expensive insurance premiums**, **high out-of-pocket costs**, and challenges in finding doctors that accept their insurance. ▪ **Prescription coverage** was another issue, with some individuals unable to afford necessary medications due to insurance refusals or high out-of-pocket expenses.

Suggested Improvements by Participants:

1. **Improved Follow-Through:**
   - Greater accountability for **communication and follow-up** by health care providers. This includes ensuring referrals, test results, and messages are tracked and responded to promptly.
2. **Increased Availability of Providers:**
   - More **PCPs** accepting state insurance, better geographical access to health care providers, and incentives for doctors to take on new patients, especially in rural areas.
3. **Transportation Solutions:**
   - Introduce **ride-share options** (like Uber or Lyft) for medical appointments, possibly subsidized, and work with local municipalities to provide more accessible transportation.
4. **Telehealth Expansion:**
   - Increase **telehealth availability** for more types of appointments, particularly for routine consultations and follow-ups, to save time and improve accessibility.
5. **Insurance Reforms:**
   - Efforts to make **insurance more affordable** and improve coverage for all patients, with particular attention to prescription drug costs and the network of doctors accepting insurance.
6. **Addressing Discrimination:**
   - Provide **sensitivity training** for providers to ensure equitable treatment of all patients, irrespective of background or insurance type. Address discrimination, especially against marginalized groups, and ensure that **patient concerns** are taken seriously.