



Rhode Island Health Care System Planning

Goal 4: System Integration and Coordination

December 15th, 2025

RHODE ISLAND

Meeting Agenda



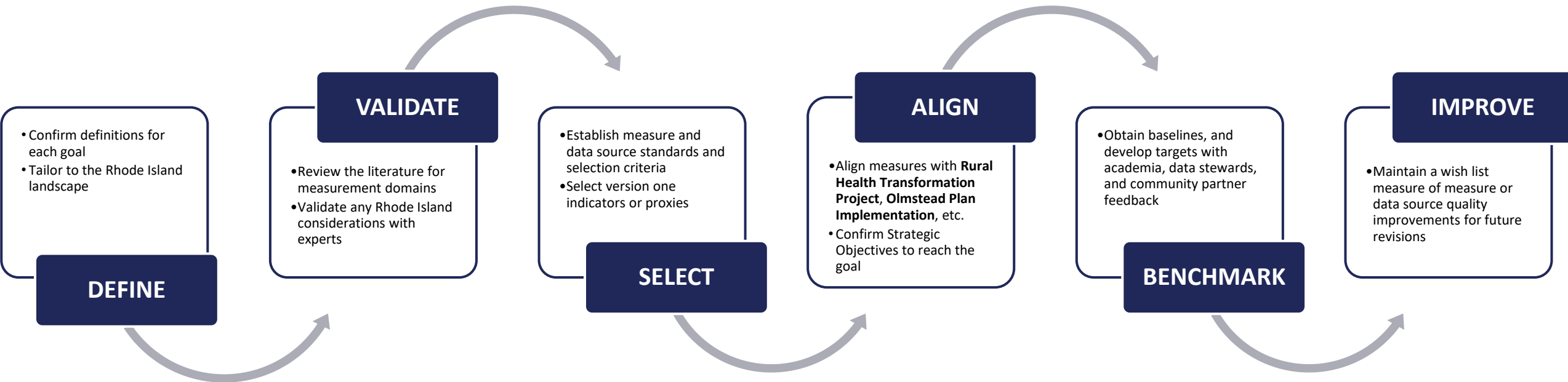
Welcome

- Overview of Planning Process
- Review of prior meeting
 - Review of conversation and feedback
- Goal 4
 - Criteria to guide our conversation
 - Refining the goal
 - Proposed Measure Domains
 - Discussion
 - Next steps
- Public Comment

Review of Approach



Measurement Framework Process



Planned Deliverable: Report to Cabinet



- The deliverable for this part of the planning process is a report to the Health Care System Cabinet that will include:
 - Goals with refined definitions from our discussions in these Advisory Council meetings
 - Proposed measure domains for each goal informed by the Foundational Report and community discussions
 - Initial review and feedback from our Health Care System Planning Data Council on measure domains and proposed methodology for assigning measures to domains

Summary of 12/1/25 Meeting on Goal 1: Access & Affordability



At our last meeting we discussed **Goal 1 – Access and Affordability**. We affirmed definitions of key terms and discussed the perspectives our community partners have about how to operationalize the goal.

Working Definition: Accessible and affordable health care is a person's or a population's ability to identify, reach, and obtain timely and appropriate care without creating undue financial burdens.

Summary of Feedback:

Ensure the access goal encompasses components such as; affordability, sustainability, equity, and lifespan care. Comments included:

1. Address barriers such as transportation, rural access, and geriatric-specific care.
2. Integrate food and behavioral health into access frameworks
3. Strengthen community-based care and consider environmental/economic factors
4. Ensure inclusion of populations such as deaf/deaf-blind/hard of hearing
5. Align with existing cross sector frameworks (CCBHCs, OHIC, etc.)

Summary of 12/1/25 Meeting on Access Goal



Meeting participants also discussed **potential measure domains for Access:**

Affordability	Accessibility	Availability	Accommodation	Acceptability
----------------------	----------------------	---------------------	----------------------	----------------------

Summary of Feedback:

There was general agreement on these measure domains. Additional perspectives included:

1. Develop meaningful metrics: affordability, appropriateness, availability, awareness, autonomy, and patient choice.
2. Include EMS, rural access, regulatory barriers, and insurance as measurable components
3. Ensure accommodations and alignment with Olmstead work
4. Align measurement frameworks with policy, systems, and environmental strategies
5. Affirm cultural and spiritual needs in care provision
6. Consider regulatory barriers to access
7. Embed autonomy and client choice into access

Note: We still need a more in-depth discussion of the affordability component of the goal – and the inclusion of quality.

Review of Health System Goals



1. Ensure **access** to affordable, quality and easy to navigate comprehensive care
2. Ensure **solvency** of the health care system
3. Ensure health **equity** and reduce disparities in access and outcomes
4. Foster an **integrated delivery system** that coordinates care across full spectrum of health services focused on population health, seamless transitions, system-preparedness, and patient-centered care
5. Strengthen **preventative, primary physical, oral health & behavioral health care services** to maintain appropriate utilization & promote efficiencies
6. Invest in efforts to address the **social factors that impact health**

Moving Forward: From Access to System Integration



- Interdependencies for access are reflected in each of our other goals (system solvency, health equity, appropriate utilization, and health related social needs) and cross-sector strategic approaches (HIT, Workforce, Data, etc.)
- Thus, our planning cycle does not need to move through the goals in strict order, but rather, we can explore how they are connected and reinforce one another.
- Today, we are considering System Integration throughout the health system, which builds on the foundation of access.

Goal 4: System Integration and Coordination



Goal 4: Health System Integration and Coordination



Goal 4: Foster an **integrated delivery system** that coordinates care across the **full spectrum of health services** focused on *population health, seamless transitions, system preparedness and patient-centered care*.

Working Definition of Goal Components, synthesized from the literature:

Health system integration and coordination is *the process* of aligning services, organizations, and/or functions to deliver effective, unified care.

What's missing? What would you add or change?

Example Descriptions from the Literature of an Integrated Health System



The literature notes that System Integration is more of a process to achieve outcomes than an end goal in and of itself. Here is a sample of System Integration descriptions that we have found in our research.

- Evidence-informed
- Led by whole-system thinking
- Equitable
- Governed through shared accountability
- Centered around patient needs
- Co-located services

What's missing? What would you add or change?

Planning Approach



Step 2: Assess Cross-Sector Community Feedback



- Foster an **integrated and person-centered system** that addresses the root causes of social needs, increasing funding for evidence-based programs and improving coordination among organizations.
- **Community-Provider Collaboration:** Encourage better collaboration between healthcare providers and community organizations to address social needs comprehensively.
- Implement **more comprehensive care teams** and increase support for nurse practitioners and physician assistants to share the workload.
- **Community Integration:** Integrate the public in shaping research and data collection efforts, allowing them to "have a say in what's happening in their community."

Step 2: Assess Cross-Sector Community Feedback



- **Lack of Centralized Data Systems:** The current system lacks a "centralized portal," with hospitals and specialists often having "different electronic systems" that are not coordinated. This makes it difficult to track a patient's full history.
 - **Relevant Metrics:** There's interest in data on specific community health topics such as "diabetes, percentages of childhood diabetes," "cancer rates" (especially linked to environmental factors), "asthma," and "immunization rates and disease surveillance."
 - **Highlight specific community health topics on dashboards,** such as food access, housing stability, chronic disease rates, mental health, substance abuse, environmental health, immunization rates, and community safety.

Approach



Strategic Integration

- Analyze transitions-of-care system-wide to **identify bottlenecks** in patient flow between settings of care (Cross-Cutting Data, 210).
- Continuing work to improve **information sharing during transitions of care**, such as between hospitals, primary care practices, and skilled nursing facilities (Cross-Cutting HIE, 264).
- Promote 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 (Community Recommendations, 271).

Practice Integration

- 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*** (Primary Care, 70).
- Invest in ***oral health integration in primary and behavioral health*** care settings (Oral Health, 90).
- 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 (HRSN, 198).

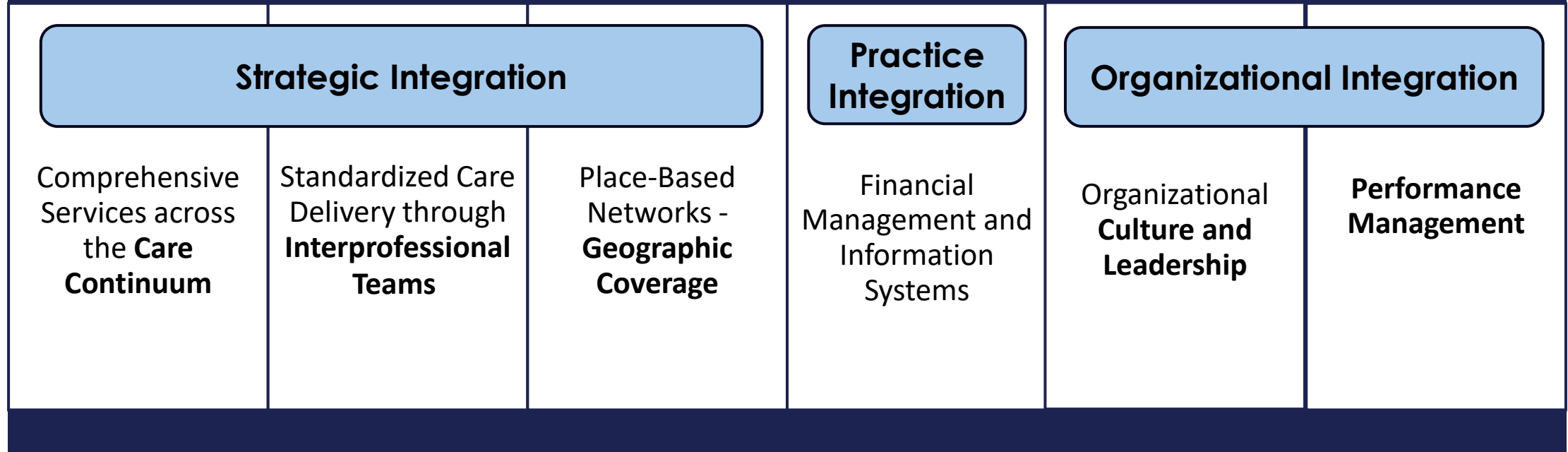
Organizational Integration

- Scale and ***align existing state initiatives*** that work to address the social, environmental, and economic factors that impact health and wellbeing, across all agencies (HRSN, 196).
- Create investment opportunities to ***promote meaningful integration*** of behavioral and physical health care services for beneficiaries (Cross-Cutting HIE, 264).
- ***A dedicated structure***, is essential for the effective ***implementation, integration, and monitoring of health care system*** planning initiatives (Behavioral Health, 108).

Approach



System Integration and Coordination



System Integration Potential Measure Domains

Coordinated transitions across the continuum of care

Standardized Care Delivery through Interprofessional Teams

Place-Based Networks and Geographic Coverage

Financial Management & Information Systems

Organizational Culture and Leadership

Performance Management

- Cooperation between health and social care organizations
- Access to care continuum with multiple points of access
- Emphasis on wellness and health promotion

- Provider-developed, evidence-based guidelines and protocols to enforce a unified standard of care, regardless of where the patient is treated
- Interprofessional teams across the continuum of care

- Maximize patient accessibility and minimize duplication of services

- Sufficient funding to ensure adequate resources for sustainable change
- Efficient information systems that enhance communication and information flow across the continuum of care

- Organizational support with demonstration of commitment
- Extent to which organizational goals and objectives are aligned across care sectors

- Stated commitment to quality of services, evaluation, and continuous care
- Performance measurement indicators and tools are in place and being used regularly

Goal: Foster an integrated delivery system that coordinates care across the full spectrum of health services focused on population health, seamless transitions, system preparedness and patient-centered care.

Strategic Integration			Practice Integration	Organizational Integration	
Comprehensive Services Across the Care Continuum	Standardized Care Delivery through Interprofessional Teams	Place-Based Networks – Geographic Coverage	Financial Management and Information Systems	Organizational Culture and Leadership	Performance Management

Discussion Questions

1. Do these measure domains capture what we are aiming to achieve with this goal?
2. What's most important?
3. What's missing?
4. What should be revised?

■ Convening our Data Council

- We have begun the process of convening a Data Council of academic and data experts from across the state
- This council will review the measure domains, assess current measures from across the state, and propose the best methodology for assigning specific measures to domains that fit the Rhode Island landscape.
- We will bring community perspectives gathered from these Advisory Council meetings to the Data Council – and then questions from the Data Council back here to the Advisory Council.

Our next Advisory Council meeting is TBD (likely week of January 5) - plus we have a meeting already set for January 15th at 3pm, where we'll do a deep dive into the next goal.

Public Comment

