



# Rhode Island Health Care System Planning

**Goal 1: Affordability**

**Goal 6: Health Related Social Needs**

**January 9, 2026**

**RHODE ISLAND**

# Meeting Agenda



- Welcome
- Planning Process Updates:
- Discussion: Reviewing Affordability (Goal 1) and Health Related Social Needs (Goal 6)
- Public Comment

# Dec. 15, 2025 Meeting Overview: System Integration (Goal 4)



At the December 15<sup>th</sup> Long-Term Planning Meeting discussing System Integration, participants made the following points:

- **Metrics & Accountability:** Strong push to define SMART objectives, assign metrics, and set 5–10-year targets.
- **Integration Challenges:** Need to bridge gaps between primary care, behavioral health, and specialized care (e.g., TBI).
- **Measurement & Outcomes:** Calls for clear, practical metrics to define success.
- **Real-World Application:** Emphasis on grounding discussions in day-to-day examples.
- **Workforce & Caregivers:** Workforce stability and caregiver engagement are essential to integration.
- **Value-Based Care:** Must be tied into integration discussions.
- **Alignment:** Integration efforts should connect with existing OHIC/EOHS work to avoid redundancy.
- **Long-Term Planning:** Transformation requires proactive, strategic planning, not crisis-driven responses.

# Takeaways from Goal 4 Discussion



Here are specific takeaways that participants put forward for both the content and the process of the State's long-term health care system planning:

## Content

- Ensure workforce stability and caregiver engagement are part of integration planning.
- Explicitly link integration goals to access, affordability, and value-based care.
- Maintain focus on transformational change, not just monitoring

## Process

- Request to circulate materials *before* meetings whenever possible, to help streamline the public input process.
- Develop measurable outcomes and long-term targets for integration domains.
- Consider breakout groups for deeper exploration (e.g., HRSN integration).
- Gather and share real-world examples to ground discussions.

# Data Council Convened



We have engaged data stewards and subject-matter experts to ensure that rigorous, validated methods guide the identification and assignment of measures to each domain. This approach is designed to support the development of measurable, effective, and truly transformational strategic objectives as we continue in our planning process.

## Current Data Council participants:

EOHHS Office of Data, Analytics, and Evaluation  
BHDDH, RIDOH, DCYF Data Stewards  
Rhode Island Longitudinal Data System  
University of Rhode Island, Rhode Island College, Brown University  
Freedman Healthcare

# Discussion: Affordability (Goal 1, part 2)


## Goal 1: Access and Affordability

- Ensure access to affordable, quality and easy to navigate comprehensive care

## 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.

Measure Domains for Access				
<b>Accessibility</b> <ul style="list-style-type: none"><li>• "Location of supply that aligns with location of clients or demand"</li></ul>	<b>Affordability</b> <ul style="list-style-type: none"><li>• "Prices of services meet client's income and ability to pay"</li></ul>	<b>Availability</b> <ul style="list-style-type: none"><li>• "Size or volume of supply meets client's needs"</li></ul>	<b>Accommodation</b> <ul style="list-style-type: none"><li>• "Delivery of healthcare accommodates client's needs"</li></ul>	<b>Acceptability</b> <ul style="list-style-type: none"><li>• "Healthcare providers accept all clients regardless of their characteristics"</li></ul>



## Measure Domains for Affordability

### Individual/Household

- Health care is affordable for an individual or household when the total cost of care does not prevent them from accessing and/or delaying necessary health care, does not force trade-offs with basic needs, and does not create undue financial hardship.

### Employers

- Health care is affordable for an employer when the cost of providing health benefits for employees is sustainable relative to the organization's revenue and workforce needs.

### Whole Health System

- Health care is affordable at the state or system level when total health spending grows at a rate aligned with the state's economic growth, while ensuring equitable access, high-quality outcomes, and efficient use of resources across the population.

# Proposed Affordability Measure Domains



Measure Domains	Domain Descriptions	Measure Examples
<b>Individuals &amp; Families</b>	Health care is affordable for an individual or household when the total cost of care does not prevent them from accessing and/or delaying necessary health care, does not force trade-offs with basic needs, and does not create undue financial hardship.	<ul style="list-style-type: none"> <li>Percentage of people who skipped or delayed care for cost reasons</li> </ul>
<b>Employers</b>	Health care is affordable for an employer when the cost of providing health benefits for employees is sustainable relative to the business's/organization's revenue and workforce needs.	<ul style="list-style-type: none"> <li>Cost of health benefits for employer (affordability standards, from the IRS)</li> <li>Business/Organization revenue</li> </ul>
<b>Whole Health System</b>	Health care is affordable at the state or system level when total health spending grows at a rate aligned with the state's economic growth, while ensuring equitable access, high-quality outcomes, and efficient use of resources across the population.	<ul style="list-style-type: none"> <li>Consumer price index</li> <li>Gross State Product</li> <li>Personal or Household income</li> </ul>

# Discussion



1. Do these domains capture your thoughts on measuring affordability?
2. Is there anything missing that you'd want to add?

# Discussion: Goal 6

**Goal 6:** Invest in efforts to address the **social factors that impact health**

**Goal 6 Working definition:** Understanding the interplay between the health-related social needs system and the health system – and the allocation of resources towards initiatives that improve the social conditions influencing people's health within both systems.



# Discussion: Goal 6

Considering the "what" for goal 6: The **social factors that impact health**

## **Social determinants of health (SDOH)**

The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH refers to **community-level factors**. They are sometimes called “social determinants of health.”

[\(Adapted from CDC Healthy People 2030\)](#)

## **Health-related social needs (HRSN)**

Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use. **HRSN refers to individual-level factors** such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation. [\(Adapted from HHS\)](#)

# Goal 6 Cross-Sector Community Feedback



- Address the **widespread difficulty in accessing fundamental programs** and services for basic life necessities like **housing, food security, and transportation**.
- Improve public awareness of available resources and navigation of complex systems, which are currently perceived as piecemeal and hard to find.
- **Increase accessibility and eligibility** for social services programs (e.g., SNAP, WIC).
- Reduce eligibility requirements for social needs programs to fit a wider variety of people.
- 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.

# Goal 6 Foundational Report Recommendations



## **Advancing Strategies to Improve Structural Drivers of HRSNs**

- 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.
- Strengthen comprehensive understanding of the downstream impacts of addressing SDOH on HRSNs and Healthcare demand to inform value-based payments, cost savings, and HRSN reinvestment recommendations by conducting data analysis, research, and literature reviews

## **Integrating and Coordinating Interagency HRSN Services**

- 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.

## **Building Capacity and Coordinating HRSN Care**

- 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.

# SDOH-HRSN-Healthcare Continuum



**Social,  
Environmental,  
Economic  
Conditions**

- Food Insecurity
- Housing Insecurity/Unsafe Housing



**Community  
Based HRSN  
Supports**



- Food Pantries
- Affordable Housing Vouchers or Permanent Supportive Housing Programs



**Healthcare**



- Ensuring more appropriate utilization of health care services for food or housing, rather than emergency use for food or shelter

**Foundations: Structures, Policy, Data, Resources, Service Delivery, and Workforce**

# Discussion: Measuring the Investment of Health-Related Social Needs



For Rhode Island’s health planning purposes, we want to focus on the **alignment** of the health care system and the health-related social needs organizations/system – and the **collaboration** and **engagement** of the entities with each other.

## To achieve this, we must:

1. Understand the impact of HRSNs and SDOHs on the Health System
2. Understand the ways that the organizations/systems work together and the gaps between them – the best ways to ensure the appropriate utilization as in the example on the last slide
3. Consider more strategic approaches to addressing HRSNs and SDOHs throughout the health system
4. What else?

Thus, we are looking to determine the best approaches to enable us to measure the efforts to create alignment and collaboration between the HRSN and Health Systems and to understand how the investments in each of them should better work together.

# Measuring the Alignment of the Health Care and Social Needs Systems



**Discussion:** Here are some draft Measure Domains to consider. What works, and what would you add/edit?

## Draft Measure Domains for Aligning the Health Care and HRSN Systems

Degree of Alignment	Impact of HRSNs on the System	Financial Investment
Alignment processes in use by health care organizations or HRSN organizations to connect the two systems.	HRSNs, like malnutrition, that lead to disparate population health outcomes, like chronic disease.	Investments (or lack of investments) in addressing upstream social determinants and supporting the HRSN system and providers.
We have discussed the difficulty of measuring these processes. What else would you suggest here?	In other words, how do we measure the strain placed on the health system of a unmet health related social need that then turns into a health need?	How do we measure the impact of different levels of investment in these systems?

# Next Steps and Updated Meeting Schedule



## **Thursday, January 15th from 3-4:15pm (virtual)**

- Goal 3: Health Equity
- Goal 4: Appropriate Utilization

## **Friday, January 23rd from 9:30-10:45am (virtual)**

- Goal 2: System Solvency
- Any additional Topics or Follow Up

## **Tuesday, January 27th from 1-2:45pm (in-person)**

- Health Care System Planning *Cabinet meeting*

# Public Comment

