



Rhode Island Health Care System Planning

Long-Term Planning – Goals 5 and 3

January 15th, 2025

RHODE ISLAND

Meeting Agenda



- Welcome
- Planning Process Updates
 - Overview of previous meeting:
 - Goal 1 (part 2): Affordability
 - Goal 6: Health Related Social Needs
- Discussion:
 - Goal 5
 - Goal 3
- Next steps and upcoming meetings
- Public Comment

Proposed Measure Domains for Affordability



Overview of last meeting's discussion and feedback

Measure Domains for Affordability

Individual/Household	Employers	Whole Health System
<ul style="list-style-type: none">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">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.	<ul style="list-style-type: none">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.

Main points of feedback from community partners:

1. Emphasis that affordability cannot be pursued in isolation from system sustainability
2. Affirmation that data council work will be shared and reviewed with advisory council
3. Ensuring specific language for patient populations – i.e., moving away from "client" terminology

Aligning the HRSN and Health Care Systems

Impact of HRSNs on the System

- Alignment processes in use by health care organizations to connect the two systems.

Degree of Alignment

- HRSNs, like malnutrition, that lead to disparate population health outcomes, like chronic disease.

Financial Investment

- Investments (or lack of investments) in addressing upstream social determinants and supporting the HRSN system and providers.

1. Recommendation to de-medicalize interventions that address health related social needs and move those costs out of the health system. Stated desire from some community partners to ensure the medical system does not lead the charge in address root causes.
2. Participants discussed approaches to measuring the work of existing programs and alignment between systems.
3. Community partners discussed the difficulties in measuring the impact of work in preventing negative health outcomes – it is difficult to evaluate the scope of the problems we avoid with good prevention work.

Goal 5: Strengthening Services and Appropriate Utilization



Goal 5: Strengthen preventive, primary physical, behavioral, and oral health care services to maintain **appropriate utilization** and promote efficiencies

Goal 5 Working definitions: The effective management of healthcare resources to provide the right care at that right place and the right time – the National Academy of Medicine’s definition of quality care. In this Goal, the Cabinet identified strengthening primary care and promoting efficiencies as a part of pursuing quality care with appropriate utilization.

Discussion:

1. What would you add to this? What would you change?

- **Primary Care:** Promote preventative health and wellness programs.
- **Oral Health:** Focus on preventive measures and education about good oral hygiene practices.
- **Hospitals:** Increase preventive care funding, including mobile clinics, free screening events, and vaccine drives.
- **Behavioral Health:** Focus on "prevention and early intervention strategies that can help identify and address mental health concerns before they escalate."
- **Optimize ER Use:** Implement systems to redirect non-emergency cases to PCPs or urgent care to alleviate ER overcrowding.

Foundational Report Recommendations



- **Behavioral Health:** 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, and support the development and implementation of comprehensive prevention, education, and outreach campaigns.
- **Primary Care:** 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
- **Cross-Cutting (Workforce):** Continue to expand data collection, integrate data, and build Rhode Island's analytic capacity, 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

Right Care, Right Place, Right Time

Effectiveness of Care

- Evaluates how well health systems deliver necessary medical treatments and interventions. Metrics may include:
 - Percentage of patients receiving required vaccinations and screenings
 - Management of chronic diseases like diabetes/hypertension.

Quality

- Patient Safety
- Effectiveness
- Patient Centeredness
- Timeliness
- Efficiency
- Equity

Experience of Care

- Centers on patient satisfaction and overall experience within the healthcare system.
 - Communication between healthcare providers and patients
 - Responsiveness of staff
 - Satisfaction with received care

Utilization and Risk Adjusted Utilization

- Evaluates how health care resources are used within a system.
 - Hospital readmissions
 - Emergency Department usage
 - Frequency of certain healthcare services

Health System Information Structures

- Structural aspects of health systems.
 - Technology
 - Staffing levels

Measure Domains: Right Care, Right Time, Right Place

<p>Effectiveness of Care</p> <ul style="list-style-type: none"> • Evaluates how well health systems deliver necessary medical treatments and interventions. 	<p>Quality</p> <ul style="list-style-type: none"> • Patient Safety • Effectiveness • Patient Centeredness • Timeliness • Efficiency • Equity 	<p>Experience of Care</p> <ul style="list-style-type: none"> • Centers on patient satisfaction and overall experience within the healthcare system. 	<p>Utilization and Risk Adjusted Utilization</p> <ul style="list-style-type: none"> • Evaluates how health care resources are used within a system. 	<p>Health System Information Structures</p> <ul style="list-style-type: none"> • Structural aspects of health systems.
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Goal 5: Strengthen preventive, primary physical, behavioral, and oral health care services to maintain **appropriate utilization & promote efficiencies**

Discussion:

1. Do these domains adequately capture the focus on quality – Right Care, Right Time, Right Place – within the definition of Appropriate Utilization?
2. How best can we consider the promotion of efficiencies at the patient, provider and health system levels?
3. Will these domains adequately support the strengthening of preventive, primary physical, behavioral, and oral health care services?

Goal 3: Health Equity



Goal 3: Ensure health equity and reduce disparities in access and outcomes

Working Definition: Fair access to resources to address variations in health outcomes and the root causes of disease.

Discussion:

1. Anything to add to this definition?

Community Feedback



- **Respect for Essential Services:** A participant specifically emphasized the need to **respect health centers, food pantries, and supermarkets**, asserting that everyone has a right to health and essential resources
- **Prioritize person-centered care:** ensuring that families are actively involved in decision-making and care planning.
- **Financial Accessibility:** Recommendations included making healthcare **affordable and accessible for all**, reducing costs, and simplifying insurance processes. Reducing eligibility requirements for social service programs was also suggested to serve a wider population.
- **Building Trust and Transparency:** Improvements in communication between patients and doctors, continuity of care providers, and greater transparency regarding healthcare costs were seen as vital for building trust within the community.

Example Foundational Report Recommendations



- **Behavioral Health:** 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.
- **Hospitals:** Provide an evidence base to inform future health system investments. Specifically considering Rhode Island specific hospital capacity versus regional hospital capacity, hospital versus alternative structures, health equity, and geographic differences.
- **Health Related Social Needs:** Expand structures or systems ... that work to raise awareness, share information, and promote collaboration across state and private agencies/coalitions.

Rhode Island's Health Equity Measures

Integrated Healthcare	Community Resiliency	Physical Environment	Socioeconomics	Community Trauma
<ul style="list-style-type: none">• Healthcare Access• Social Services• Behavioral Health	<ul style="list-style-type: none">• Civic engagement• Social Vulnerability• Equity in Policy	<ul style="list-style-type: none">• Natural Environment• Transportation• Environmental Hazards	<ul style="list-style-type: none">• Housing Cost Burden• Food Insecurity• Education	<ul style="list-style-type: none">• Discrimination• Criminal Justice• Public Safety

The Rhode Island Health Equity Measures were created with an inclusive public process in 2016. These domains and measures consider many broad factors beyond the health care system.

Structuring Fair Access throughout the Plan



Measuring the Structures that Support Fair Access Throughout the Plan

Accurate and Timely Data on Inequities	Effective and Sustainable Interventions	Policy and Governance	Outcomes
<ul style="list-style-type: none">• Collection, Reporting, and Analysis of Standardized Data to understand foundational variations in health outcomes	<ul style="list-style-type: none">• Organizational engagement strategies that support fair access to health services	<ul style="list-style-type: none">• Understanding broad participation practices and the consideration of a variety of perspectives in policy creation	<ul style="list-style-type: none">• Assessing variations in health outcomes and the external factors that influence them

Adapting work from the National Academy of Medicine, the four measure domains proposed above are aimed at creating a structured approach to assessing the processes that influence the health care system's ability to ensure fair access to resources, address variations in health outcomes, and understand the root causes of disease.

Discussion: Structures that Support Fair Access



Measuring the Structures that Support Fair Access Throughout the Plan

Accurate and Timely Data	Effective and Sustainable Interventions	Policy and Governance	Outcomes
<ul style="list-style-type: none">• Collection, Reporting, and Analysis of Standardized Data to understand foundational variations in health outcomes	<ul style="list-style-type: none">• Organizational engagement strategies that support fair access to health services	<ul style="list-style-type: none">• Understanding broad participation practices and the consideration of a variety of perspectives in policy creation	<ul style="list-style-type: none">• Assessing variations in health outcomes and the external factors that influence them

1. What are additional opportunities for integrating a structured and/or sustainable approach to supporting fair access to health care?

Next Steps and Updated Meeting Schedule



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 (hybrid)

RI Department of Administration/Teams

- Health Care System Planning Cabinet meeting

Public Comment



Additional Slides/ To Be Deleted



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?

Supplemental Measures of Health-Related Social Needs



Health Related Social Needs (Supplemental Domains (CMS))				
Financial Strain	Employment	Disabilities	Education	Physical Activity
- Ability to pay for basic needs	- Ability to obtain and maintain employment	- Physical, mental or emotional conditions	- Patient access or history with schooling/training	- Weekly exercise
Substance Use	Mental Health			
- Alcohol, tobacco, and/or drug use	- Mental health challenges			

Example Descriptions from the Literature of an Integrated Health System

System Integration is more of a process than an end goal. The literature notes several may not be viewed as an end goal, but rather a process to achieve outcomes. Here is a sample of descriptions:

- Evidence-informed
- Led by whole-system thinking
- Governed through shared accountability
- Equitable
- Collaborative
- 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).

Measure Domains for Appropriate Utilization

Effectiveness of Care	Access/Availability of Care	Experience of Care	Utilization and Risk Adjusted Utilization	Health System Information Structures
<ul style="list-style-type: none">• Evaluates how well health systems deliver necessary medical treatments and interventions. Metrics may include:<ul style="list-style-type: none">• Percentage of patients receiving required vaccinations and screenings• Management of chronic diseases like diabetes/hypertenion.	<ul style="list-style-type: none">• Considering our previous measures from Access and Affordability Goal	<ul style="list-style-type: none">• Centers on patient satisfaction and overall experience within the healthcare system.<ul style="list-style-type: none">• Communication between healthcare providers and patients• Responsiveness of staff• Satisfaction with received care	<ul style="list-style-type: none">• Evaluates how health care resources are used within a system.<ul style="list-style-type: none">• Hospital readmissions• Emergency Department usage• Frequency of certain healthcare services	<ul style="list-style-type: none">• Structural aspects of health systems.<ul style="list-style-type: none">• Technology• Staffing levels

Considering Affordability at Multiple Levels



Measure Domains	Domain Descriptions
Individuals & Families	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.

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).

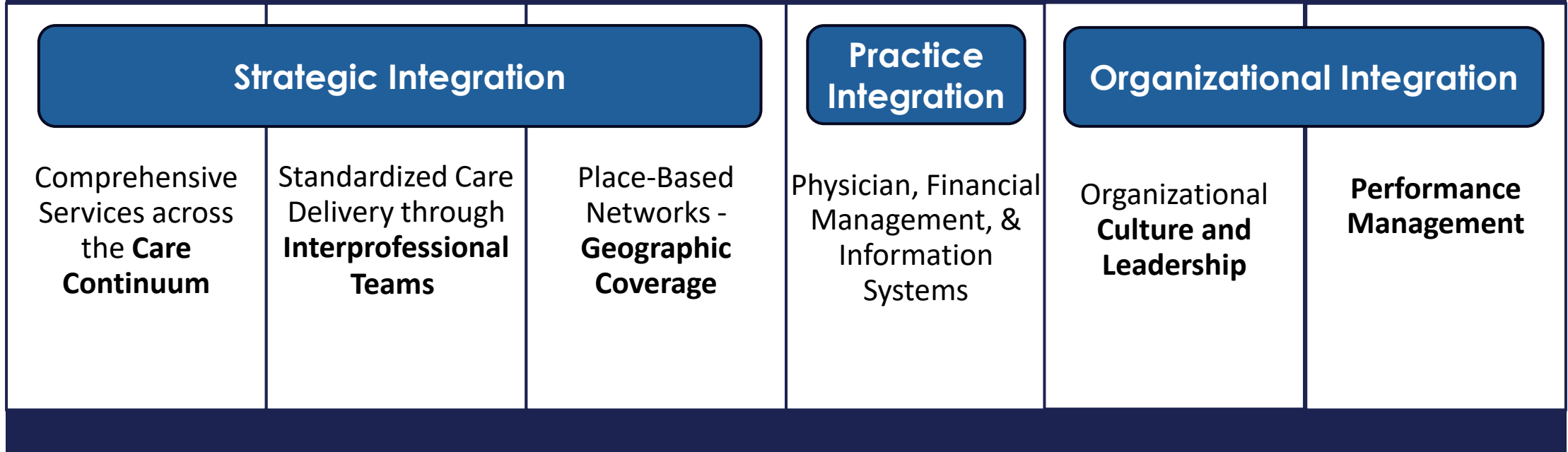
Organizational Integration

- 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

Physician, Financial Management & Information Systems

Organizational Culture and Leadership

Performance Management

Example Measures:

- Coordinated transitions in care across services
- Shared programs across sectors/services
- Wait time for referral to treatment by provider type

Example Measures:

- Using a shared clinical pathway across care sectors (e.g., diabetes care, asthma care).
- Provider developed, evidence-based care guidelines and protocols to enforce one standard of care, regardless of where patients are treated

Example measure:

- Maximize patient accessibility and minimize duplication of services
- Primary care network structures in place

Example measures:

- Physician integration within care teams and across sectors
- Practitioner payment models that support integration Aligning service funding to ensure equitable funding distribution for different services or levels of services
- Shared patient electronic charts across continuum of care accessible to patients

Example Measures:

- Extent to which organizational goals and objectives are aligned across care sectors
- Leaders with vision who are able to instill a strong cohesive culture

Example Measures:

- Outcomes are being measured (clinical, quality, population health, etc.)
- 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	Physician, 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



Appendix Slides



Affordability vs. Solvency



Affordability is the ability to pay for goods or services within a budget, typically understood by income relative to expenses.

Affordability assesses short-term financial management and sustainability.

In the case of the health care system, when we talk about affordability, we propose considering affordability for individuals, employers, and the system as a whole.

Solvency is the ability of institutions within the health system to meet long-term financial obligations and ensure that liabilities do not exceed assets.

Solvency assesses long-term financial health.

As we consider our health care system, when we talk about solvency, we would consider solvency of individual institutions and the system as a whole.

System Integration and Coordination

Comprehensive Services across the Care Continuum	Geographic Coverage and Rostering	Information Systems	Physical Integration	Financial Management
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Standard Measures of Health-Related Social Needs



Here are a number of accepted measure domains for HRSNs:

Health Related Social Needs (CMS)

Living Situation	Food	Transportation	Utilities	Safety
Housing stability Housing quality	Food purchasing	Access to reliable transportation	Ability to pay utility bills	Violence and/or elder or child abuse

Supplemental Measures of Health-Related Social Needs (CMS)

Financial Strain	Employment	Disabilities	Education	Physical Activity
Mental Health	Substance Use			

Appropriate Utilization and Service Delivery

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Considering Affordability at Multiple Levels

Level	Working Definition	Example Measures
Individuals & Families	Health care is affordable for an individual or household when the total cost of care does not prevent them from accessing necessary health care, does not force trade-offs with basic needs, and does not create undue financial hardship.	- Measure domains
Employers	Health care is affordable for an employer when the cost of providing health benefits is sustainable relative to the organization's revenue and workforce needs.	- Measure domains
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	- Measure domains

Health Related Social Needs

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Definitions

Goals: are the high-level aims, or vision statements for what the State will achieve over the period of the plan and across interrelated system sectors.

Sector-Specific and Cross-Sector Outcomes : How the goal statements will translate to outcomes within each sector, with an awareness of our cross-sector strategies.

Strategic Objectives: are the action steps to achieve the goals. Some strategies are already in motion; others will be recommended for action. All strategies need to be specific, measurable, actionable, relevant, and timebound (SMART), with clear **targets** toward our goals.

Performance Measures: the way to assess progress on the targets that contribute to achieving the strategic objectives. Performance measures inform progress on overall plan implementation.

Standard Measures of Social Drivers of Health

And here are a number of accepted measure domains for social drivers of health

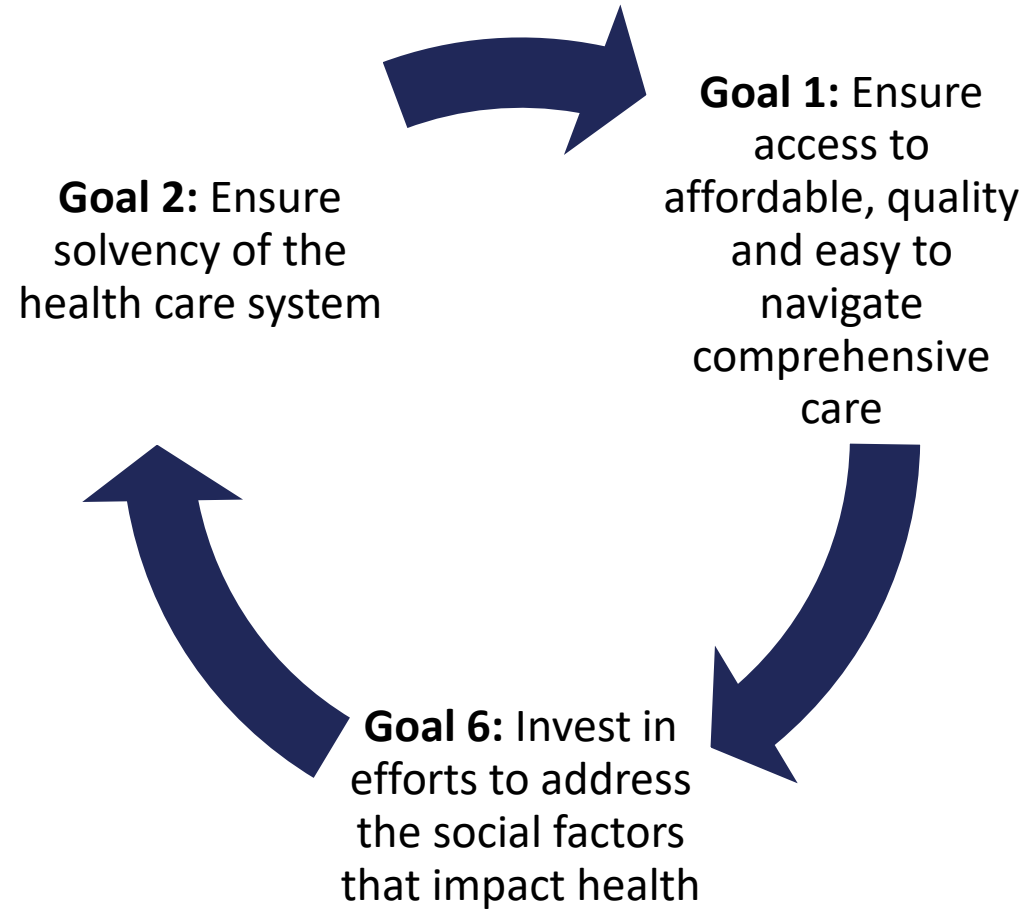
Social Drivers of Health (Healthy People 2030)				
Economic Stability	Education Access and Quality	Health Care Access and Quality	Neighborhood and Built Environment	Social and Community Context
<ul style="list-style-type: none">• Employment• Income• Expenses• Financial Support	<ul style="list-style-type: none">• Level of education• Graduation rates	<ul style="list-style-type: none">• Availability of healthcare services• Insurance coverage• Quality of care	<ul style="list-style-type: none">• Housing quality• Transportation options• Access to healthy foods	<ul style="list-style-type: none">• Family support• Community engagement• Experiences of discrimination

Example Access Definitions and Measure Domains



Authors	Definition	Measure Domains
Dutton 1986	Utilization viewed as the product of patient's characteristics plus provider and system attributes	Financial Time Organizational Factors
Haddad & Mohindra 2002	The opportunity to consume health goods and services	Availability Affordability Acceptability Adequacy
Peters et al. 2008	Access viewed as including actual use of services. A clear emphasis is given to consider both users and services characteristics in evaluation of access. The notion of fit between users and services is identified.	Quality Geographic Accessibility Availability Financial Accessibility
Levesque et al. 2013	Conceptual framework of Access: the opportunity to identify, seek, reach, obtain, or use healthcare and to ensure the fulfillment of the needs for these services.	Approachability Availability Accommodation Affordability Appropriateness

Cross-Goal Considerations



Rhode Island's Working Definition of Access



Goal 1: Ensuring 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.

Examples of Interdependences that will Inform our Access Planning

- System Interoperability
- Quality Care Delivery
- Healthcare Integration
- System Solvency
- Care Continuums
- Workforce Transformation

Planning Approach



Considering Affordability at Multiple Levels

Level	Working Definition	Example Measures
Individuals & Families	<p>Health care is affordable for an individual or household when the total cost of care does not prevent them from accessing necessary health care, does not force trade-offs with basic needs, and does not create undue financial hardship.</p>	<ul style="list-style-type: none"> - Ability to pay (premiums, out-of-pocket costs) - Delaying or forgoing medical, dental, or mental health care due to cost
Employer	<p>Health care is affordable for an employer when the cost of providing health benefits is sustainable relative to the organization's revenue and workforce needs.</p>	<ul style="list-style-type: none"> - Sustainable cost growth - Competitive benefit offerings - Balanced cost-sharing - Predictable year-over-year spending
Whole Health System	<p>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</p>	<ul style="list-style-type: none"> - Health spending does not outpace GDP or state revenue - Efficient delivery - Equitable access - Sustainable public budgets - Population health improvement

Step 2: Assess Cross-Sector Community Feedback

Access

Community Recommendations and Feedback

- Make healthcare more **accessible and affordable for everyone**, regardless of economic situation or insurance type.
- The system for obtaining health insurance is "designed to be complex," and for many, health itself feels "out of reach" or a "nightmare" due to "deductibles and high costs."

Olmstead Plan Healthcare Access Community Feedback

- The community said that many healthcare providers lack training in disability care, home care aides need better training and oversight, Medicaid reimbursement rates, and fifteen-minute appointments make it harder for providers to serve patients with disabilities, and the shortage of sign language interpreters limits access to care (*Olmstead Plan, 37*).
- When someone has a major mental illness and you send them out with a paper, it is not enough. It sets them up to fail, which is demoralizing." - *Olmstead Community Listening Session Participant*

Plan Integration to other State Efforts (Short, Mid, and Long-Term Planning Considerations)



Access

Rural Health Transformation Program Initiatives

- **Anticipated Initiatives to Support Access:**

- 2: Rural Community-Integrated and Mobile Health Services
- 3: Expand Access to Rural Community Resources
- 4: Rural EMS Health Access and Integration
- 5: Rural Hospital-at-Home Program
- 6: Expand BH Services to Rural Regions
- 7: Strengthen Rural Oral Health Delivery

Federal Compliance Advisory Group

- Anticipated challenges for access – SNAP, Medicaid, Health Insurance Marketplace

Approach



Long-Term Care

- Explore ways to adapt new and emerging technologies that improve home and community-based care to facilitate home-based access to care, and caregiver supports.
- Promote collaboration across state and community councils, workgroups, and taskforces to ensure that resources are deployed efficiently and effectively.

Behavioral Health

- Expand and enhance initiatives that integrate behavioral health into adult and pediatric primary care to strengthen the system of care and expand access
- 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

Health-Related Social Needs

- 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 process between service providers across the continuum

Approach



Discussion on Metrics Framework

Access

Accessibility

- "Location of supply that aligns with location of clients or demand"

Affordability

- "Prices of services meet client's income and ability to pay"

Availability

- "Size or volume of supply meets client's needs"

Accommodation

- "Delivery of healthcare accommodates client's needs"

Acceptability

- "Healthcare providers accept all clients regardless of their characteristics"

Thinking about the sectors we've been focused on (Primary Care, Behavioral Health, Hospitals, Long-Term Care, and HRSNs) ...

- Do these Measure Domains work in all the sectors?
- If not, is there another suggestion for the sector in which you work?
- Is there anything specific to rural health that you would suggest as a Measure Domain?

Discussion: Metrics Framework



Thinking specifically about the sector in which you work:

- Are there specific measures or measure domains that your sector uses for Access or Affordability that we should consider?
- How far into the future is your sector considering access or affordability?
- Tell us about any other cross-sector work or efforts that are occurring to **measure, improve, or understand** Access/Affordability

Cabinet 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 & behavioral health care services** to maintain appropriate utilization & promote efficiencies
6. Invest in efforts to address the **social factors that impact health**

As we review our goals, is there anything missing that you would like to suggest to the Health Care System Planning Cabinet?

Next Steps

- With help from our data consultants and subject matter experts, EOHHS will take the next steps with this feedback and create proposals for ongoing consideration.
- We will continue the discussion of Access and Affordability – and address these interdependences that we shared earlier.
- If you have ongoing ideas for metric frameworks and measures, please be in touch: marti.Rosenberg@ohhs.ri.gov.

Thank you!

System Integration and Coordination

Comprehensive Services across the Care Continuum

- Coordinated transitions across the continuum of care
- Client care is coordinated between sectors and providers within health system and with supporting services such as education and social services

Geographic Coverage and Rostering

- Primary care network structures in place

Standardized Delivery through Interprofessional Teams

- Team effectiveness
- Use of Shared clinical pathways across the continuum of health care and geography
- Individualization of care pathways for patients with co-morbidities

System integration and Coordination

Performance Measurement	Information Systems	Organizational Development	Physician Integration	Financial Management
<ul style="list-style-type: none">• Performance measurement indicators and tools in place• Clinical outcomes being measured• Data tracked and shared with stakeholders	<ul style="list-style-type: none">• Shared information systems across sectors• Shared patient electronic charts across continuum of care accessible to patients• Data collected is used for service planning	<ul style="list-style-type: none">• Policies and procedures• Culture and leadership• Goals and objectives aligned across sectors• Cultural Competency• Patient engagement	<ul style="list-style-type: none">• Physician integration within care teams and across sectors	<ul style="list-style-type: none">• Attainment of goals and objectives are supported by funding and human resource allocation

Public Comment



Measuring the Alignment of the Health Care and Social Needs Systems



Alignment of the Health Care and Social Needs Systems

Investment in addressing upstream social determinants and supporting the HRSN system and providers.

Financial Measures:

Rates of Investment/ Spending in improving the Social Determinants versus Health Care costs that stem from a lack of a HRSN (i.e., ED visits for unhoused people)

Process Measures:

Alignment processes in use by health care system or HRSN organizations to connect the two systems, etc.

Outcome Measures:

Understanding HRSNs that create disparate population health outcomes

Discussion: we want to consider the mechanisms of the system that impact each of these health-related social need measures and how we can work to transform the system...

- Do these measure domains capture this?
- What is missing?