

**DRAFT 2 FOR REVIEW:  
Rhode Island Health Care System Plan  
April 22, 2025**

*DISCLAIMER: This document was developed over the past year in partnership between the Executive Office of Health and Human Service and our sister state agencies, community partners, and other experts, as part of the Health Care System Planning Executive Order. The document is subject to change based on further review and public comment.*

**Updated document – April 22, 2026**

Draft 2 of the Rhode Island Health Care System Plan incorporates input from Health Care System Planning Cabinet members as well as public comments received during the Cabinet meeting held on Wednesday, April 15, 2026.

This version also reflects additional feedback from State Agency Directors and includes clarifications on a variety of components of the plan (for example, the language in Goal 2 Background Section has been refined to more accurately represent current practices in the state).

This draft is now being shared for further review and feedback from the HCSP Independent Advisory Council, community partners, and other interested parties.

We encourage you to read and react to the document, sharing information either on this [Feedback Form](#), or by email to [ohhs.healthplanning@ohhs.ri.gov](mailto:ohhs.healthplanning@ohhs.ri.gov).

Feedback will be reviewed and integrated to the greatest extent possible before the next Cabinet meeting on May 26, 2026.

## Introduction: Health Care System Planning in Rhode Island

The Office of Health Care System Planning is creating the Rhode Island Health Care System Plan to be a comprehensive roadmap for strengthening and transforming our health system – establishing an operational framework for advancing the goals and recommendations put forth in the 2024 Foundational Report

The Plan is driven by six high-level goals, or vision statements applicable to five system sectors (Primary Care, Behavioral Health, Hospitals, Long-Term Care and Healthy Aging, and Health Related Social Needs).

The Foundational Report identified strategies and activities/tactics for achieving the goals—some activities are already in motion and others are recommendations for action.

### RHODE ISLAND HEALTH CARE SYSTEM PLANNING 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**

The next step is to choose Aims, Measures and Targets for each strategy and then nestle these together within the structure of a measurable, and time-bound long-term plan.

Here in draft for the Cabinet’s and public review is a proposal for a 10-year time frame for the overarching plan, with planned reviews at Year 3 and Year 6 to ensure that the Aims, Strategies and Activities are appropriate given potential changes in the overall federal and state health care and social service ecosystems. Particularly given the upcoming changes to health care and social service access due to the recently Congressionally passed H.R. 1, the State will need to keep a close eye

on the impact of those changes on the components of this Health Care System Plan.

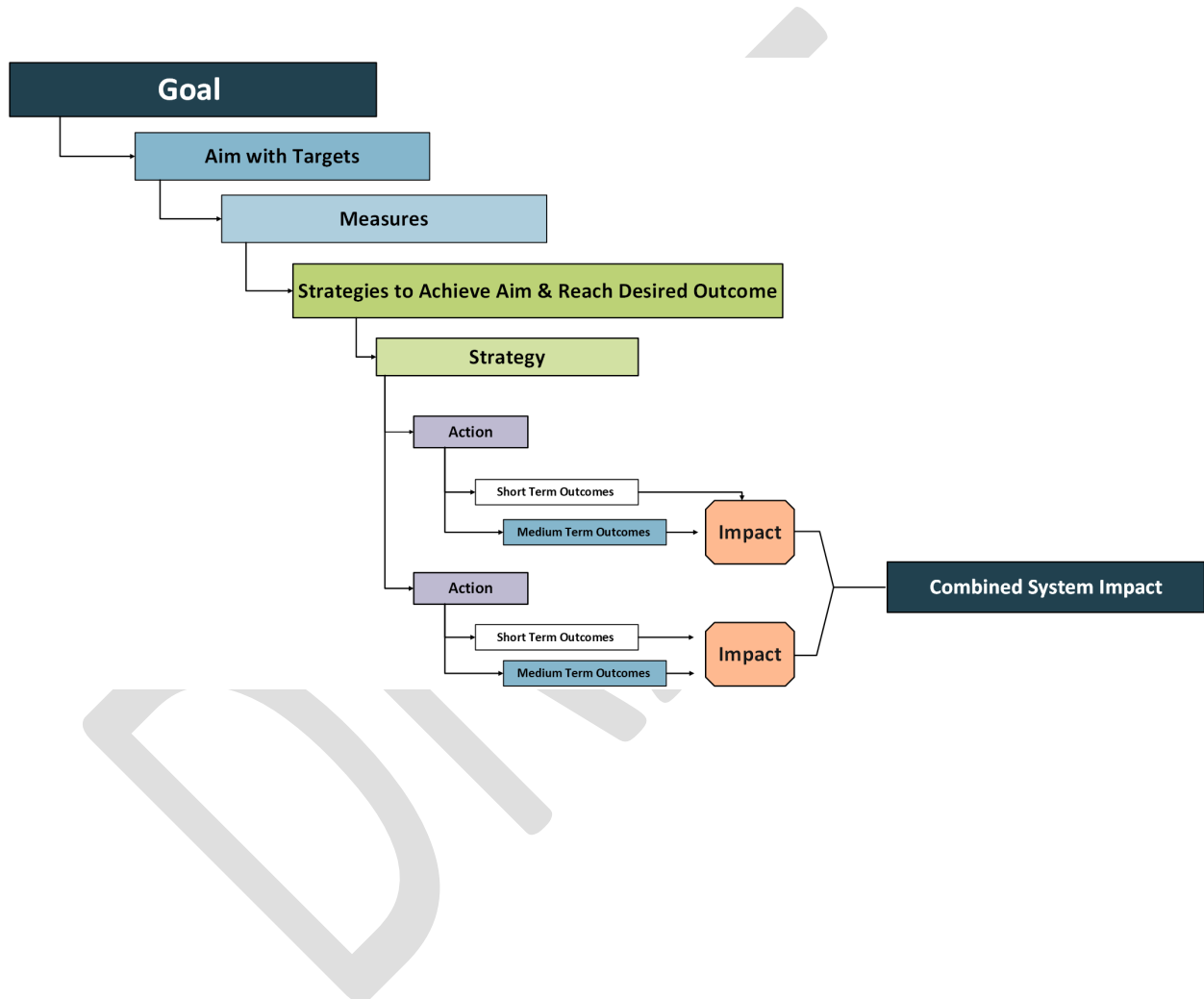
**WORKING DRAFT 2 FOR REVIEW – NOT A FINAL PRODUCT**

Each Cabinet goal aims to improve, re-orient, and ultimately transform Rhode Island's health care system. To achieve these goals, we have been focusing on:

- **Pinpointing the key components** of each goal that will lead to health care system transformation – determining how we move from the goal to implementation steps that will realize significant transformation.
- **Understanding the community's voice** in relation to each goal, including patients & partner and provider organizations. We plan to bring this draft plan to community members before it is finalized, asking questions including whether these components will help meet their needs. How do we make sure the health care system is working for the people who use it?
- **Setting the appropriate targets for our goals** as we look forward 3, 6, and 10 year. What are the specific targets we can reach for each goal, based on our measures, and reviewed against our baselines?
- **Incorporating the 2024 Foundational Plan cross-sector strategies and recommendations** aimed towards reaching our targets and thus achieved the outcomes and impact that we set for ourselves to improve our health care system. After we set state targets, we will be aligning the appropriate recommendations from the 2024 Foundational Plan within a specific implementation plan. The Office of Health Care System Planning continually reviews the Foundation Plan to determine which recommendations are already underway and what new implementation steps are necessary – and how do these steps align within a continuum? We will also be using the recommendations and strategies from other key plans, including but not limited to the Olmstead Plan, the Governor's Overdose Task Force Strategic Plan, Rural Health Transformation Plan, the Children's Behavioral Health System of Care, Workforce Transformation Planning, and the Federal Compliance Advisory Group activities to address H.R.1.
- **Gathering and analyzing the available data** to create baselines as we prepare with the Health Care System Cabinet to set targets and measure progress toward goals. We are preparing to determine how each of our goals should be tracked and measured, how we define our baseline measures, and how do we best set targets that will help achieve transformation.

## Health System Planning Framework Visual

Here is a visual representation of the process described above. For each goal, we propose Aims with Targets, using the Measures provided by state agencies and where available, our community partners. Under each Aim, we will identify the appropriate strategies to achieve that Aim – and then for each strategy, we will identify which of the action steps (i.e., recommendations from the Foundational Plan and other plans described above) are most relevant to implement. Those activities will lead to the outcomes and impact we want to see.



## **Health Care System Planning and House Resolution-1 (HR1)**

Achieving health system transformation requires a plan that connects present day realities with the levers capable of driving change. Rhode Island’s draft Health Care System Plan must consider the current and projected impacts of the recent budget reconciliation bill, H.R.1, which will have far-reaching impacts on our health care system, social service system, and the Cabinet goals for increasing access, affordability and quality.

On July 29, 2025, EOHHS convened the Federal Compliance Advisory Group (FCAG) to review and analyze the potential impacts of H.R.1 on Rhode Island’s Medicaid Programs, SNAP, and HealthSource RI, Rhode Island’s Health Insurance Marketplace. On October 30, 2025, the FCAG produced the Federal Policy Changes Report (FPCR). In the wake of the federal policy changes, the report projects significant costs for the state for each implicated program.

### **Medicaid**

H.R.1 included a total of 22 federal policy changes affecting the Medicaid program in the state. Most of the eligibility changes will impact Medicaid Expansion population (low-income, adults under the age of 65 with no children with incomes up to 138% of Federal Poverty Level). The remaining policy changes group into four main categories (eligibility changes, integrity changes, finance changes and delivery system reform changes) and will lead to potential benefit losses or cuts in services, and new expenses for technology updates.

### **SNAP**

H.R.1 included a total of eight policy changes affecting the Supplemental Nutrition Assistance Program (SNAP). For Rhode Island, only seven of these eight policy changes apply as Section 10104: Internet Expense Restrictions has not been implemented locally. Of the remaining policy changes, they group into three main categories (eligibility changes, finance changes, and benefit changes) and will also lead to losses or cuts in services and new technology updates

### **Health Insurance Marketplace**

H.R.1 included a total of seven policy changes affecting Health Insurance Marketplaces. For Rhode Island, all seven of these policy changes apply locally with six medium or high impact changes and one lower impact change. Additionally, the lack of extension of enhanced Advanced Premium Tax Credits (APTC), and some items from the Marketplace Integrity and Affordability Rule have significant impacts. The federal policy changes that affect Rhode Island can be grouped into four main categories (affordability changes-broad based, enrollment barriers, affordability changes-specific populations, and operational changes) and will lead to Rhode Islanders losing access to insurance either because they will be ineligible or because they will no longer be able to afford coverage.

As the Cabinet completes the Health Care System Plan, it will need to take into account the impacts that H.R.1 will have on the reductions in Plan goals like access, affordability, and quality, even as the Plan may be looking to increase these components.

## Health Care System Cabinet Goals, with Draft Drivers and Aims

### Goal 1: Access & Affordability

*Enabling access to affordable, quality and easy to navigate comprehensive care.*

#### Access Background

Access is the most direct measure of whether the health system is delivering on its fundamental purpose — connecting Rhode Islanders to the care they need, when they need it, in a way they can use and afford. For this plan, accessible and affordable health care is understood as a person’s or a population’s ability to identify, reach, and obtain timely and appropriate care without creating undue financial burdens.

Achieving meaningful access requires addressing five interdependent drivers:

- **Affordability** is a key component of access. If care is unaffordable for an individual or household, it creates a barrier to accessing care. Understanding the interconnected nature of access and affordability, this plan addresses affordability in a dedicated section below.
- **Provider supply** ensures that Rhode Island has sufficient primary care, behavioral health, and oral health providers relative to population needs, supported by strong workforce pipelines and retention strategies.
- **Care Navigation** reflects how well the system helps individuals to move from need to care, including scheduling, language access, wait times, and the availability of alternatives such as telehealth.
- **Systems Integration and Coordination** determines whether structures exist to support continuity across the full continuum of care, including care coordination and referral pathways.
- **Availability of Appropriate Types of Care** ensures that providers have the right training, equipment, and willingness to work with all patients, including, for example, people with disabilities.<sup>1</sup>

Because these drivers span multiple goals, the access component does not operate in isolation.

- **Goal 3** ensures that access improvements are distributed equitably across populations.
- **Goal 4** strengthens the coordination and connectivity needed for seamless care.
- **Goal 6** addresses transportation, housing, food security, and other conditions that determine whether individuals can reach and sustain care.

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<sup>1</sup> Georgia Tech Health Analytics: Five Dimension Framework

Accordingly, this next section focuses on access outcomes and on the levers directly within its scope, i.e., provider supply and care navigation, while relying on other goals to address the enabling conditions that make those outcomes achievable.

## **Aims for Care Navigation**

### ***Aim 1.1: Primary Care and Oral Health Utilization***

- Increase percentage of Rhode Islanders with one primary care and one oral health annual wellness visit (or the appropriate number of pediatric visits) a year from X% to Y% by 2036.

### ***Aim 1.2: Behavioral Health Utilization***

- Increase the percentage of RI residents across the life course with a diagnosed or identified behavioral health need who received treatment in the past year from X% to Y%, by 2036.
- Decrease suicide mortality by 15% by 2030<sup>2</sup>

### ***Aim 1.3: Long-Term Care***

- Increase access to long term care systems (both nursing home beds and supports for those living in the community) for Rhode Islanders with behavioral health issues across the lifespan from X to Y by 2030.

## **Provider Supply**

### ***Aim 1.4: Providers Relative to Population***

- Maintain a minimum provider to patient ratio in Rhode Island within primary care, pediatrics, behavioral health, community navigator supports, and oral health per 10,000 population from X to Y, by 2036.

## **Affordability Background**

Affordability is a core component of access. For this plan, health care is considered affordable for an individual or household, if the total cost of care does not prevent them from accessing or delaying necessary health care, does not force trade-offs with basic needs, and does not create undue financial hardship. The total cost of care includes the cost of premiums, deductibles, co-pays, and other out-of-pockets expenses.

Achieving affordability requires strengthening the financial protections available to consumers and moderating the underlying cost of care. Key drivers include:

- **Coverage subsidization:** Coverage is subsidized by employer-sponsored insurance, and public programs such as Medicaid, CHIP, and Marketplace premium tax credits, which help make coverage accessible when underlying costs are high. Subsidization does not reduce the cost of care itself but shifts financial responsibility from individuals to

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<sup>2</sup> [Rhode Island's Suicide Prevention Plan 2023-2030](#) Note: EOHHS will align strategic approaches with RIDOH's Suicide Prevention team to incorporate targets past 2030.

government or employers – and the subsidies can still keep coverage unaffordable for Rhode Islanders<sup>3</sup>.

- **Coverage adequacy:** Insurance coverage alone does not guarantee affordability. High deductibles, copayments, coinsurance, and out-of-pocket maximums can make covered services effectively unaffordable, particularly for individuals with chronic conditions, rare diseases, genetic disorders, and additional debilitating medical conditions. Gaps in dental, vision, behavioral health, and long-term care coverage further expose individuals to direct costs.
- **Public benefit program eligibility requirements:** These include the income thresholds, asset tests, categorical eligibility criteria, and administrative requirements associated with Medicaid, CHIP, and other public programs determine who can access subsidized coverage. Restrictive eligibility criteria, including recent changes to eligibility due to Congressional passage of H.R.1 cuts, leave significant portions of low-income populations without coverage. Enrollment barriers such as complex application processes and frequent redetermination requirements compound the problem.
- **Benefits cliffs:** Benefit cliffs happen when a benefit recipient’s income goes up, exceeding an income eligibility limit. For instance, someone at or below 138% of the Federal Poverty Level – approximately \$22,025 annually for a single person in 2026 – is eligible for Rhode Island Medicaid. Earning a dollar over that limit would make that person not eligible for the program at all. Rhode Islanders at risk for experiencing a benefit cliff are low-income, but not low-income enough – and face an increased financial burden that impacts access to care.<sup>4</sup>
- **Provider accessibility:** For Rhode Islanders who are uninsured or underinsured, federally qualified health centers, rural health clinics, free clinics, and other safety net providers serve as a safety net care option. The geographic distribution, capacity, and financial viability of these providers directly affect whether people without adequate coverage can access affordable care at all.

These drivers span multiple goals, so the affordability section does not operate in isolation.

- **Goal 2** works to achieve and sustain financial stability throughout the system
- **Goal 4** strengthens the coordination and connectivity needed for seamless care.
- **Goal 6** addresses transportation, housing, food security, and other conditions that determine whether individuals can reach and sustain care.

Accordingly, this next section focuses on access outcomes and on the levers directly within its scope; coverage subsidization and adequacy, public benefit program eligibility, and provider accessibility, while relying on other goals to address the enabling conditions that make those outcomes achievable.

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<sup>3</sup> KFF: IRA Health Insurance Subsidies (2024)

<sup>4</sup> National Conference of State Legislatures: Benefits Cliff and Public Assistance Programs, 2024

## **Aims for Moderating Cost of Care**

### **Aim 1.5: Subsidized Coverage**

- Ensure the 2024 Rhode Island Uninsured Rate of 2.2% is preserved by 2036 and decrease the underinsured rate growth trend from 4.7% for years 2022 to 2024 to X% for years 2026 to 2028. *Measured by: HSRI HIS Source for Outcome Measure.*

### **Aim 1.6: Coverage Adequacy**

- Reduce health insurance premium costs as a percentage of median individual or family income for Rhode Islanders from 28% to X% by 2036. *Measured by: RI Business Group on Health source for Outcome Measure.*

### **Aim 1.7: Public Benefit Eligibility**

- Reduce the percentage of RI residents reporting forgone care for them or for family members due to cost from X% to Y%, with measurable reduction in disparities between highest occurrence areas and statewide rates by 2036. *Measured by: BRFSS*

#### **Alternative Option:**

- Reduce the proportion of RI adults, older adults and young people who forgo medical care due to cost from X% to Y% by 2036, while narrowing the gap between communities with the highest rates of forgone care and the statewide average from X to Y.

### **Aim 1.8: Sustaining Financially Viable Practices**

- Increase the number of primary care and pediatric practices and providers participating in value-based care arrangements from X% to Y% by 2036
- Maintain annual CCBHC funding at or above X amount through 2036.
- Maintain annual FQHC funding at or above X amount through 2036.
- Is there an oral health target here as well?

## Goal 2: System Solvency

*Ensure solvency of the health care system.*

### System Solvency Background

This plan defines system solvency as the health care system's capacity to achieve and sustain financial stability through adequate total reimbursement relative to expenses and efficient management aimed at maintaining continuous, high-quality care and access for all populations.

Achieving system solvency flows from a range of drivers:

- **Adequate public payer reimbursement relative to reasonable cost:** Medicare and Medicaid rates that fall persistently below the cost of providing services create structural losses that providers must absorb or offset elsewhere<sup>5,6</sup>. This is most acute for nursing facilities and primary care practices, behavioral healthcare providers and certain hospitals in Rhode Island where public payers dominate the revenue mix and commercial volume is insufficient to compensate<sup>7</sup>.
- **Moderating commercial reimbursement where cost-shifting has produced excess margins:** In markets where provider consolidation has generated significant negotiating leverage, commercial reimbursement has in many instances more than offset public payer shortfalls<sup>8</sup>. State policy has a role in moderating commercial rate growth to ensure that aggregate reimbursement reflects efficient cost rather than market power, consistent with affordability goals<sup>9</sup>. In Rhode Island's the Affordability Standards<sup>10</sup> established by Office of the Health Insurance Commissioner have been in place since 2011 and include a cap on hospital costs that does moderate cost growth.
- **Labor costs and workforce shortages,** particularly in primary care, behavioral health, and direct care, drive reliance on contract and temporary staffing at significant cost premiums, compressing margins and creating structural financial fragility that cannot be resolved through reimbursement adjustments alone.
- **The challenge of the tension between entities balancing volume and occupancy relative to fixed costs:** Most provider costs are fixed or semi-fixed (although some providers can implement variable staffing models). When patient volume falls below the threshold required to cover overhead, whether from competition, demographic shifts, or migration of services to alternative settings, per-unit costs rise and margins deteriorate rapidly regardless of reimbursement levels. However, this conflicts with Rhode Island's stated desire to prioritize prevention and to serve people in the least restrictive settings possible.

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<sup>5</sup> American Hospital Association, Fact Sheet Medicare and Medicaid Constitute Majority of Hospital Payments, 2026

<sup>6</sup> Association of Commercial-to-Medicare Relative Prices with Health System Financial Performance (Blavin, et. al, 2023)

<sup>7</sup> Medicaid and CHIP Payment and Access Commission (MACPAC)

<sup>8</sup> [GAO: Health Care Consolidation](#)

<sup>9</sup> Center on Health Insurance Reforms

<sup>10</sup> [Rhode Island Office of the Health Insurance Commissioner: Affordability Standards](#)

- **Managing debt load and capital structure:** Providers carrying excessive long-term debt relative to their equity base have limited financial flexibility when margins compress. Debt service obligations that cannot be covered by operating income are a proximate cause of insolvency, particularly for smaller and independent providers that lack the balance sheet strength of large health systems. We must also consider the need to fund depreciation.
- **Operational efficiency** where cost per unit of service, administrative overhead, and revenue cycle performance determine how much margin remains after covering direct care costs. Providers with inefficient operations face solvency risk even where reimbursement is adequate.
- **Appropriate use of resources, e.g., chronic care vs. acute care hospitals** – Additional text to be added

These drivers span multiple goals, so aims for achieving system solvency do not operate in isolation.

- **Goal 1** works to ensure that patients in the system can access and afford the care they need and seeks to maintain a system that has sufficient providers
- **Goal 4** strengthens the coordination and connectivity needed for seamless care.
- **Goal 6** addresses transportation, housing, food security, and other conditions that determine whether individuals can reach and sustain care.

Accordingly, this next section focuses on system solvency outcomes and on the levers directly within its scope; adequate reimbursement and efficient management, while relying on other goals to address the enabling conditions that make those outcomes achievable.

## **Aims for Adequate Reimbursement**

### **Aim 2.1: Payer Mix**

- Increase the share of hospitals meeting minimum thresholds for both operating margin and days cash on hand, which capture complementary aspects of financial performance,<sup>11</sup> from X% to Y%, by 2036.

### **Aim 2.2: Cost Growth Relative to Rates**

- Reduce the share of nursing homes at risk of closure as defined by operating margin, days cash on hand, occupancy rate, and Medicaid census thresholds from X% to Y%, by 2036.

### **Aim 2.3: Administrative Burden**

- Reduce Prior Authorizations by X% by 2036.

## **Aims for Efficient Management**

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<sup>11</sup> Association of Commercial-to-Medicare Relative Prices with Health System Financial Performance (Blavin, et. al, 2023)

**Aim 2.4: Workforce Stability**

- Reduce contract and temporary staffing as a percentage of total labor across hospitals, nursing facilities, and primary care practices from X% to Y%, by 2036.

**Aim 2.5: Operational Efficiency**

- By 2036, increase the share of financially viable primary care and pediatric practices as defined by operating margins sufficient to sustain care management functions and participation in value-based care arrangements from X% to Y%.

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## **Goal 3: Health Equity**

*Ensure health equity and reduce disparities in access and outcomes.*

### **Health Equity Background**

Health equity requires that every Rhode Islander has a fair and just opportunity to achieve their highest level of health. This plan aims to address variations in health outcomes and root causes of disease as they are distributed across the state.

Achieving health equity depends on addressing three interrelated drivers that influence access, service utilization, and health outcomes:

- **Location** determines the availability and accessibility of health services, including where primary care, behavioral health, oral health, and long-term services and supports exist relative to their patients, and what the transportation options are to help people reach them. Variations in provider distribution, infrastructure, and service capacity across rural, suburban, and urban areas influence whether individuals can obtain timely and appropriate care.
- **Population level characteristics** consider disability status, income level, age, insurance coverage, race, sex, and other characteristics that impact an individual's ability to sustain engagement with the health system. These factors shape exposure to health risks, service need, and the level of support required to achieve comparable outcomes across populations.
- **Environmental factors** such as housing stability, food availability, transportation access, social supports impact health status and an individual's ability to maintain continuity of care.<sup>12</sup> Environmental factors are a key component to addressing health equity.

These drivers span multiple goals, so aims for achieving health equity do not operate in isolation.

- **Goal 1** works to ensure that patients in the system can access and afford the care they need and seeks to maintain a system that has sufficient providers
- **Goal 4** strengthens the coordination and connectivity needed for seamless care.
- **Goal 5** strengthens quality outcomes across population level characteristics
- **Goal 6** addresses transportation, housing, food security, and other conditions that determine whether individuals can reach and sustain care.

Accordingly, this next section focuses on equitable health outcomes and on the levers directly within the health equity scope; geographic location and population level characteristics, while relying on other goals to address the enabling conditions that make those outcomes achievable.

The following aims build on ongoing statewide efforts to narrow differences in health outcomes across Rhode Island's communities. Initiatives such as the Rural Health Transformation Project, which is designed to reduce imbalances between rural and urban populations, the Overdose Taskforce, which supports individuals at risk of overdose, and the Olmstead Planning efforts,

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<sup>12</sup> [Rhode Island Health Care System Planning Foundational Report, Ch. 8, 2024](#)

which strengthen services for residents with disabilities demonstrate the state’s commitment to reducing variations in health outcomes for its residents. Beyond these initiatives, the state remains dedicated to ensuring that every community can achieve its highest level of health.

## **Aims for Geographic Location**

### ***Aim 3.1: Rural Health Transformation***

- Increase the number of Rhode Islanders living in rural areas accessing primary care, behavioral health, oral health, long-term care, and specialty services, by 2036.

### ***Aim 3.2: Overdose Deaths***

- Decrease the number of overdose deaths annually in the state from 436 in 2022 (the highest number of deaths recorded) to 305 by 2030. (Note: We will work with the Governor’s Overdose Task Force to update the targets for 2036.)

### ***Aim 3.3: Service Coordination for Rhode Islanders with Disabilities***

- Increase stability of community placements, discharges and transitions, and home-based nursing care, by 2036.
- (LTSS) Increase the number of Rhode Islander adults, older adults, and youth served in community settings by XX and extend the geographic reach of quality, evidence-based community programs to XX number of additional locations by 2036.

## **Aims for Population Level Characteristics**

### ***Aim 3.4: Maternal Morbidity and Mortality***

- Increase positive Maternal Health outcomes, understood by (but not limited to) decreased maternal mortality and morbidity rates from X% to Y% by 2036.

### ***Aim 3.5: Preventive Pediatric Care***

- This aim is under development, additional language will be added

### ***Aim 3.6: Healthy Aging***

- Decrease isolation, depression and substance use among low-income older adults from X to Y by 2036.

### ***Alternative Option:***

- Increase social connectedness, well-being and coping skills among low-income older adults from X to Y by 2036.

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## Goal 4: System Integration and Coordination

*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.*

### System Integration and Coordination Background

An integrated and coordinated health system is one in which care is connected across settings, providers, and sectors so that Rhode Islanders — particularly those with complex needs — experience seamless transitions, avoid preventable gaps in care, and receive the right care at the right time in the right place. Integration requires three conditions, or drivers, to be in place simultaneously:

- **Connectivity** - the physical and digital infrastructure to connect providers and systems
- **Continuity** - the people and processes to actively manage care across transitions and settings
- **Governance and Accountability** - structures that ensure the system performs as a whole rather than as a collection of parts.

Underpinning all three is **sufficient capacity** across the full continuum of care — without it, coordination has nowhere to send people.

Goal 4 is both a prerequisite for and a product of progress across all the other goals.

- **Goal 1** depends on integration to ensure that provider supply and navigability translate into connected, continuous care rather than isolated encounters — a system can have sufficient providers and still fail patients at the transitions between them.
- **Goal 2** is strengthened by integration because coordinated care reduces avoidable utilization, preventable hospitalizations, and the costly downstream consequences of fragmented care.
- **Goal 3** requires that integration efforts explicitly reach populations who face the greatest structural barriers to connected care — without this approach, integration improvements can widen rather than narrow disparities.
- **Goal 5** depends on the data infrastructure and care coordination capacity built under this goal — quality cannot be measured or improved consistently across a fragmented system.
- **Goal 6** requires the cross-sector connectivity and closed-loop referral infrastructure that integration makes possible. Clinical care and social services cannot work together without the systems and relationships to connect them.

Accordingly, this next section focuses on the outcomes and the levers directly within the system integration and coordination scope; continuity and connectivity, while relying on other goals to address the enabling conditions that make those outcomes achievable.

### Aims for Connectivity

**Aim 4.1: Care Transitions**

- By 2036, improve care transition outcomes for Rhode Island residents discharged from inpatient care. Here are potential metrics by which we can measure this for setting targets.
  - (1) increase the percentage of RI residents discharged from a behavioral health inpatient stay who receive a follow-up visit within 7 days from X% to Y%, and
  - (2) reduce the 30-day readmission rate after medical inpatient discharge from X% to Y%.

**Aim 4.2: Behavioral Health and Primary Care Integration**

- Increase the percentage of Rhode Island adults, older adults, and youth with a behavioral health need who have an established connection to primary care from X% to Y%, by 2036.

**Aim 4.3: Health Information Technology**

- Increase the percentage of RI primary care, pediatric, behavioral health, and oral health practices with updated Electronic Health Records (EHRs) from X% to Y%, by 2036.  
*Measured by: RIDOH HIT Survey.*

**Aims for Continuity**

**Aim 4.4: Continuum Capacity**

- By 2036, achieve and maintain appropriate licensed capacity per 10,000 population across the full continuum of physical health, behavioral health, and long-term care settings, as defined by benchmarks established in the first planning cycle, with occupancy rates indicating neither critical shortage nor significant underutilization.  
*Measured by: TBD*

**Aim 4.5: Workforce**

- This aim is being developed in partnership with the EOHHS Workforce Transformation Team

## Goal 5: Strengthening Services

*Strengthen preventive, primary physical and behavioral health care services to maintain appropriate utilization and promote efficiencies.*

### Strengthening Services Background

Strengthening preventive, primary physical and behavioral health care services is essential to ensure that Rhode Islanders receive high-quality care delivered at the right place and at the right time.<sup>13</sup> For this plan, strengthening services has been defined as the effective management of health care resources to improve quality, enhance patient experience, and ensure that care is delivered efficiently and appropriately across settings. A high performing system consistently delivers evidence-based care, minimizes avoidable utilization, and achieves strong population level quality outcomes.

Strengthening the quality of services requires addressing three interdependent drivers – and these quality drivers have a particularly high number of linked aims.

- **Patient experience** reflects how individuals perceive their care. Positive patient experience supports engagement, adherence to treatment, and continuity of care, all of which contribute to improving outcomes and reducing avoidable utilization.
- **Appropriate Utilization** ensures that services are used when clinically indicated and are delivered in the most suitable setting.
- **Quality Outcomes** indicate the performance of the health system on standard indicators such as chronic disease management, follow-up after hospitalization, preventive screenings, and improved behavioral health outcomes. These measures provide objective indicators of system performance and highlight areas where targeted improvement can enhance efficiency and population health.

These drivers are a product and indicator for multiple goals, so aims for strengthening services and attaining quality outcomes do not operate in isolation.

- **Goal 1** directly informs patient experience and ability to utilize services, directly impacting outcomes.
- **Goal 3** seeks to understand quality improvements and their distribution across populations.
- **Goal 4** strengthens the coordination and connectivity needed for seamless care
- **Goal 5** strengthens quality outcomes across population level characteristics
- **Goal 6** addresses transportation, housing, food security, and other conditions that determine whether individuals can reach and sustain care.

Accordingly, this next section focuses on quality outcomes and the levers directly within the scope of strengthening services; patient experience, appropriate utilization, and quality outcomes, while relying on other goals to address the enabling conditions that make those outcomes achievable.

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<sup>13</sup> National Academy of Medicine: Quality of Care Definition

## **Aims for Patient Experience**

### ***Aim 5.1: Survey Data***

- Increase patient experience scores (HCAHPS Patient Survey) in hospitals across the state from X to Y as measured by hospital satisfaction scores or community needs assessments by 2036.

### ***Aim 5.2: Appropriate Utilization***

- Decrease avoidable emergency department visits and avoidable hospitalizations from X to Y by 2036.

### ***Aim 5.3: Quality Measure Outcomes***

- By 2036, improve outcomes for the three lowest performing quality measures experiencing either stagnation or downward trends in performance quality scores from the OHIC quality measure set.
  - Current (2026) stagnated or quality measures experiencing downward trends in the OHIC Quality Measure Set:
    - HaA1c, Controlling High Blood Pressure, and Follow Up after Hospitalization for Mental Illness (7-day)

## **Goal 6: Health Related Social Needs**

*Invest in the social factors that impact health.*

### **Health Related Social Needs Background**

Health related social needs (HRSNs) play a significant role in shaping health outcomes and an individual's ability to engage with the health system. The ability to address HRSNs consistently and effectively is shaped by three core drivers:

- **Identification of social and environmental factors** enables providers and community partners to understand the non-clinical factors affecting the health of Rhode Islanders. Reliable identification supports timely referrals, targeted interventions, and improved coordinated across service systems.
- **Access to community-based resources** including housing support, food assistance, transportation, and social support networks determine whether identified needs can be addressed. Adequate capacity, geographic reach, and coordination among community organizations are essential to ensuring individuals receive appropriate and timely care.
- **Cross-sector coordination and referral pathways** ensure that individuals can move seamlessly between clinical and non-clinical services. This includes closed referral loops through system coordination, shared information systems, and value-based payment models that support integrated approaches to addressing health-related social needs.

These drivers are a product and indicator for multiple goals and do not operate in isolation.

- **Goal 1** directly informs patient experience and ability to utilize services, directly impacting outcomes.
- **Goal 2** is strengthened by addressing the social factors that impact health because it reduces avoidable utilization, preventable hospitalizations, and the costly downstream consequences of fragmented care.
- **Goal 3** seeks to understand quality improvements and their distribution across populations.
- **Goal 4** strengthens the coordination and connectivity needed for seamless care
- **Goal 5** strengthens quality outcomes across population level characteristics

Accordingly, this next section focuses on quality outcomes and the levers directly within the scope of strengthening services; patient experience, appropriate utilization, and quality outcomes, while relying on other goals to address the enabling conditions that make those outcomes achievable.

One of the most important considerations when looking at health related social needs is how to ensure that Rhode Islanders' needs are addressed by the appropriate care system at the right time. How can the healthcare system address what rightly belongs within it – while coordinating and communicating with the social services system? And how can the systems determine the most efficient and effective place to put the costs of these needs?

## **Aims for Non-Clinical Factors Impacting Health**

### ***Aim 6.1: Value Based Payment***

- By 2036, Rhode Island will establish a state specific value-based payment model for social services entities to provide health-related social needs care.

## **Glossary of Terms and Acronyms**

At the end of the document, we will include a Glossary of Terms and a definition of acronyms. These are in process.