RI SIM Sustainability Submission
Part 3 – RI SIM Accomplishments
October 26, 2018

We present our RI SIM accomplishments through the structure of our Driver Diagram. We have broken out each of our Aims and Primary and Secondary Drivers and populated them with the SIM funded projects that fit into each one. (We note that many of these projects have multiple drivers.) We asked each of our vendors to highlight their successes to date, which we listed under each driver below. Then, we added in the state-led projects, including the Culture of Collaboration and Integration and Alignment work that we have accomplished.

AIM 1: REDUCE RATE OF INCREASE IN RHODE ISLAND HEALTHCARE SPENDING: Move to a "value-based" health care system that pays health care providers for delivering measurable high-quality health care, rather than paying providers for the volume of procedures, office visits, and other required services that they deliver.

DRIVER 1

A. Change our payment system (all-payer) to 80% value-based by 2018, with 50% of payments in alternative payment methodologies
    a. Use regulatory and purchasing/contracting levers at OHIC and Medicaid, implement rules and conditions that expand value-based payments (VBPs) more broadly across the commercial and Medicaid markets
    b. Align quality measures for healthcare contracting
    c. Enhance and/or create programs to address needs of high utilizers coordinated across payers

B. Increase use of data to drive quality and policy
    a. Maximize the use of HealthFacts RI, complete the Common Provider Directory, implement Care Management Dashboards, and create a Health Care Quality Measurement, Reporting, and Feedback System to create a data infrastructure that can support VBP
    b. Enhance state agencies' data and analytic infrastructure by modernizing the state's current Human Services Data Warehouse

SIM PROJECTS:

Each of the accomplishments listed below have taken place within the SIM funding period, February 2015 through the present (October 2018). The project names in red were added after the initial SIM time period to meet emerging or new needs, based on a review process with our Steering Committee.

HealthFacts RI (All Payer Claims Database, or APCD)—Freedman Healthcare & Onpoint

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• In the last year, HealthFacts RI has expanded the use of our data to support the RI Medicaid Program's reporting needs. HealthFacts RI has transitioned from a standalone, externally hosted database to a Medicaid module that is state-owned. The database is now accessible to over 50 state analysts through a state-licensed analytics platform. The team has completed training for all analysts and continues to provide support through monthly user groups. • The State has established two successful partnerships with organizations in the community to expand use of the data and support healthcare improvement efforts. HealthFacts RI supports the Care Transformation Collaborative (CTC-RI), Rhode Island's multi-payer patient centered medical home initiative, with performance reporting and contract adjudication for participating practices for utilization, cost, and quality measures. The State has also contracted with Brown University to support their NIH Advance-CTR grant that supports clinical and translational research with partners across the State. This allows researchers to use the data to support applications for additional grant funding for continued healthcare transformation research. Brown and the State will be working together to share methodologies, project findings, and data quality results. • The State has received 18 requests for HealthFacts RI data to date. The RI APCD has established an efficient review process in which applications are typically reviewed and approved in fewer than two months. Over half of the requesters have received the data and are performing analyses.

Care Management Dashboards—Rhode Island Quality Institute (RIQI)

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• RIQI implemented Care Management Dashboards in eight Community Mental Health Organizations (CMHOs), allowing them to access real-time, encrypted notifications to the CMHOs when a patient under their care has an encounter with a hospital emergency department (ED) or becomes an inpatient. Each CMHO now has a Dashboard. • RIQI conducted a return on investment analysis in 2017 which indicated that the dashboard services for all their clients reduced inpatient readmissions by 18.9%; reduced ED visits after inpatient discharges by 18.4%; and reduced ED returns by 16.1%. These improvements in care management helped to avoid approximately 3,244 events with an estimated savings of $7.5 million. • Across the eight implemented organizations, there are approximately 400 clinical record lookups per month.

Healthcare Quality Measurement, Reporting, and Feedback System (eCQM)—IMAT Solutions

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• Rhode Island's eCQM system will allow the collection of data directly from EHRs and other data sources (such as HealthFacts RI), and the implementation of a web-based portal to access measure results. This will improve the quality of care for patients and drive improvement in provider practices by giving feedback to providers, provider organizations, and hospitals about their performance based on quality measures. • Over the past eight months, IMAT has installed and configured the eCQM infrastructure to support test and production environments for onboarding practices and other participants. • The state and IMAT have worked with the Technology Reporting Workgroup to vet eCQM technical requirements. • The state has reached an agreement with an individual practice to connect and collect clinical data for this test.

EOHHS State Data Ecosystem—Freedman Healthcare, URI DataSpark, Onpoint/Abilis

Please provide 2-3 high level bullet points that highlight your accomplishments to date.

• Onpoint and the State developed the technical architecture to fully operationalize the EOHHS State Data Ecosystem and support analyses and focused data projects. The Ecosystem model now includes 21 data sets from five key agencies, including DCYF, DHS, Medicaid, RIDOH, BHDDH, and DLT.
• Through our developed prioritization process, the state-initiated three analytic projects using the Ecosystem's data. The focus areas for these projects include deep-dive analyses on the following subject areas:
  ○ **Child Maltreatment Prevention Project:** A cross-agency project focused on assessing the risk factors and opportunities for potential points of prevention for child abuse and neglect through state-administered services.
  ○ **SIM Population Health Project:** Guided by the SIM Project team, the Ecosystem project team is developing a report on the costs of co-occurrences, co-morbidities, and poly-morbidities of the eight SIM health focus measures. Phase II of this project will be to conduct a deeper dive on costs and utilization patterns of the RI population with diabetes and depression.
  ○ **RIDOH Pre-Term Birth Project:** Using Vital Records and Medicaid claims, the Ecosystem team is working with RIDOH to understand the proportion of pregnant women eligible for 17 hydroxyprogesterone (17-P) who receive it during pregnancy. This medication can be given to pregnant women with a past singleton preterm birth to reduce the risk of recurrent preterm birth. Anecdotally, there is suspicion nationwide that many pregnant women eligible for this treatment are not receiving it.

Unified Social Services Directory—United Way

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
The Unified Social Service Directory is allowing RI SIM to explore the opportunity to develop an integrated, coordinated, statewide infrastructure for addressing the Social Determinants of Health (SDOH). It is our intent that this common infrastructure could begin with the development and maintenance of a single statewide database of community-based organizations, services, and public benefits. • RI SIM has leveraged additional dollars from RIDOH to invest jointly in improving and validating data in the core database from which we are building the SDOH resource, United Way's 2-1-1. United Way is validating the data. • United Way and RIDOH have begun a pilot project, building the connection to transfer data from 2-1-1 (based on Mediware software) to a RIDOH eReferral system (based on Salesforce software). • Once this transfer takes place successfully, United Way will work with Lifespan and Care New England to transfer data to their Salesforce-based software. • We are also now planning how to move the project out into the wider community.

SIM State-Based Evaluation—University of Rhode Island

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• Moved from planning to implementation across several project specific evaluations • Provided intensive, collaborative efforts related to Community Health Team (CHT) evaluation, which has helped us firm up the evaluation plan and ensure shared metrics across teams • Supported SIM evaluation by bringing on additional consulting support for project management and the culture of collaboration evaluation through this contract (Glickman Consulting)

Behavioral Health Billing and Coding Research Project—Bailit

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• To assess issues around coding, reimbursement for certain services, patient financial burden due to copays, and provider credentialing, Michael Bailit interviewed six integrated primary care/behavioral health care practices whose staff who are knowledgeable about administrative barriers to IBH • OHIC brought these findings to the Care Transformation Advisory Committee and will examine how to give these topics a more detailed focus and assess how to move forward to reduce barriers to integrating physical and behavioral health in day to day practice workflows.

AIM 2: SUPPORT PROVIDER PRACTICE TRANSFORMATION AND IMPROVE HEALTH CARE PROVIDER SATISFACTION: Support health care providers in their transition to delivering health care in an environment in which the care is paid for according to a VBP arrangement. SIM will invest in work place transformation activities that build upon the professional expertise of Rhode Island's healthcare workforce.

DRIVER 2

A. Maximize & support team-based care
    a) Using plan design, regulatory and purchasing/contracting levers, and SIM investments, maximize support for integrated team-based models of care
B. Better integrate behavioral health into primary care investments in Rhode Island's Healthcare Workforce
    a) Make investments in the following programs for practice transformation: CHTs, Child Psychiatry Access Program, IBH & PCMH-Kids, CMHC supports, and Health Care Quality Measurement, Reporting, and Feedback System

SIM PROJECTS:

Community Health Teams & Screening, Brief Intervention, and Referral to Treatment (SBIRT) —CTC-RI (with Diabetes Education Partners and URI)

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• Under a centralized operations model, expanded CHTs from two sites to six geographic locations serving over 400 high-risk patients; • In collaboration with the Diabetes Education Partners, CHTs now have access to nutrition and pharmacy consultation services through CHT/SBIRT site workflows; • Policies and procedures have been developed to provide pharmacist and nutrition resources to assist CHTs and SBIRT staff, including Home safety protocol and the referral process through the Community Health Network (CHN) at RIDOH and submitted to DEP for action; • Through a braided SAMHSA funding arrangement, established over 20 sites where SBIRT screening are taking place, with 8,345 screenings completed throughout Rhode Island as of 10/22/2018; • In collaboration with URI, worked with CHT partners to establish key performance measures that will be reported for program monitoring and evaluation purposes; and • Conducted analyses to determine the extent to which RI-SBIRT has been able to reach low-income and minority populations throughout the State—these results were accepted for presentation at the Rhode Island Health Equity Summit and will help inform strategies to address health disparities.

RI SBIRT Training and Resource Center—Rhode Island College (RIC)

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• Over two years, we have trained 794 healthcare workers in SBIRT, and we are currently on pace to eclipse over 1,000 healthcare professionals by the end of SIM funding; • Trained three unique agencies in Year One and, to date, 19 unique agencies in Year Two for a total of 22 unique agencies. • Trained over 60 dentists, dental assistants, and dental hygienists as part of a dental mini-residency, allowing for the expansion of SBIRT practice into the dental arena to help close the gap in separation between oral, physical, and behavioral health; • Trained one certified SBIRT trainer in Year One and, to date, three certified trainers in Year Two for a total of four certified trainers. • Launched the We Ask Everyone Campaign to normalize conversations about substance use in practices and the community, including the use of billboards and bus stops for raising awareness; and • Obtained anecdotal data which support that patients and providers are becoming more comfortable having conversations about substance use in healthcare settings and education and identification of unhealthy substance use.

PCMH-Kids / Integrated Behavioral Health (IBH)—Care Transformation Collaborative Rhode Island (CTC-RI)

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
Integrated Behavioral Health (IBH) • CTC is pleased that an IBH qualitative evaluation and utilization results studied through the APCD are demonstrating the impact of the program. CTC-RI completed the qualitative evaluation study working with Roberta Goldman, PhD and Mardi Coleman, MSc. Universally, primary care practices communicated the positive impact IBH has had for providers and patients. The evaluation study offered recommendations on how to strengthen the implementation framework for further spread. APCD data indicates a directional improvement in risk-adjusted total cost of care, emergency department, inpatient visits, and costs for IBH Cohorts 1 and 2 when compared to the non-IBH comparison group and non-CTC comparison group. A more robust matched comparison quantitative research project with Brown University underway with completion date scheduled for 2019. **PCMH-Kids** • Based on the outcomes of the PCMH-Kids pilot, the health plans supported a PCMH-Kids expansion in July 2017, adding ten additional practices bringing the total number of covered lives to ~66,000 with ~120 providers participating in pediatric PCMH practices. Based on continued success, the health plans have additionally approved a third PCMH-Kids expansion, beginning 1/1/2019. • PCMH-Kids and IBH initiatives have received national recognition: a) CTC and IBH primary care practice Associates in Primary Care presented at PCMH Congress national conference in September 2018; b) PCMH-Kids Co-Chairs (Dr. Flanagan and Dr. Lange) are being honored with an AAP national award—the Calvin C.J. Sia Community Pediatrics Medical Home Leadership award—at the November 2018 annual meeting.

Child Psychiatry Access Program, Suicide Prevention Initiative, and Mental Health First Aid – Emma Pendleton Bradley Hospital

Please provide 2-3 high level bullet points that highlight your accomplishments to date.

Pedi-PRN:

- As of June 30, 2018, Pedi-PRN has served 403 children, with 342 providers are enrolled from 57 practices throughout the state. Bradley has completed 526 encounters or telephonic consultations.
- As part of its ongoing outreach, Pedi-PRN contacted 25 enrolled practices and visited 19. The face-to-face visits provided direct feedback by providers and changes are in the planning phases to improve the educational/training services.
- Bradley Hospital/Pedi-PRN submitted a HRSA grant in partnership with RIDOH. BCBSRI also partnered to support Pedi-PRN.
- The Pedi-PRN Intensive Program (PIP) was developed to meet a need identified by the enrolled pediatric PCPs to provide an in-depth training in child mental health topics. The model is based on the Child and Adolescent Psychiatry for Primary Care (CAP-PC) program in New York. PIP will enroll up to 16 providers from 16 unique practices for the 10-session certificate program.

Suicide Prevention Initiative:

- Bradley held specialized trainings regarding suicide screening and the Suicide Prevention Initiative (SPI) protocol within several schools in the Providence district. They introduced the SPI protocol and facilitation of service coordination with the pediatrician in charge of a health clinic embedded in Central Falls Schools.
- The Kids'Link crisis phone triage services were enhanced by adding staffing coverage during high volume call times.
- Bradley was able to increase awareness of the Kids'Link service through the increased availability of marketing materials in English and Spanish. To increase safety for children after a crisis evaluation, Bradley has ordered medication lock bags. They are working to determine the most appropriate manner to distribute the bags to families after crisis evaluation.

Mental Health First Aid:

- Bradley Hospital held two Youth Mental Health First Aid classes which certified a total of 38 new Youth Mental Health First Aiders. Based on high demand, Bradley is planning to increase the number of trainings—holding 20 trainings before the end of the SIM grant period. Each session will train and certify up to 20 individuals per session with a total of between 360 and 400 people trained in these critical skills.

Interprofessional Community Preceptor Institute – Rhode Island College

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• Training our community-based workforce is an essential part of rebalancing our healthcare system. The preceptor project ensures that undergraduate and graduate students enrolled in Rhode Island higher education institutions are trained in the community rather than primarily at large in-patient facilities. A core group of faculty from nursing (CCRI, RIC, URI), social work (RIC), pharmacy (URI), physical therapy (URI and CCRI), geriatric education center (URI), dental (CCRI) and medicine (AMS at Brown University) developed a training curriculum for community preceptors, who will supervise these students on an ongoing basis. It is a 30-hour training that involves online work, face to face meetings, and a site-based project. • RIC serves as the fiscal home for the preceptor project coalition. The group identified and recruited the pilot cohort of 13 community preceptors from eight community-based agencies and 5 different health professions. Each agency will also bring its healthcare students together for inter-professional learning. The project will recruit and train a second cohort of community preceptors to precept interprofessional teams of students between December 2018 and May 2019. • RIC has identified an outside evaluator to assess process outcomes.

Health Equity Zones—Rhode Island Department of Health (RIDOH)

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• SIM and HEZ staff have teamed up to increase awareness of healthcare transformation and community/clinical linkages. The SIM team has presented at 2 HEZ Learning Community events to increase understanding of healthcare transformation within community partnerships and organized a well-attended joint workshop on community clinical linkages at the RI Health Equity Summit in September 2018. • To maximize collaboration between HEZ, SIM, and the rest of our interagency partners: 1) RIDOH HEZ team participated on the Accountable Entity (AE) Review Committee with SIM team to advocate for greater community clinical linkages. 2) RIDOH and SIM leadership have partnered on three community site visits to help state agency directors better understand how agency programing can be leveraged to improve the community/clinical linkages necessary to realize healthcare transformation goals. 3) HEZ and SIM staff participated jointly in an off-site retreat to debrief on the current successes and challenges of the HEZ implementation. 4) SIM and HEZ collaborated on the development of RI Health Equity Indicators to develop a baseline for measuring the social, economic, and environmental determinants of health through the Community Health Assessment Group in alignment with the 23 population health goals. • RIDOH's Director was recently elected as President of the Association of State and Territorial Health Officials and is using HEZ as a platform for her presidential challenge. • The Rhode Island Foundation recently awarded $3.6 million to six programs through their Fund for a Health RI, including five HEZ sites, to support projects that will integrate community and clinical provision of care. These projects build on SIM/HEZ culture of alignment and collaboration and are intended to create more effective community/clinical linkages.

Provider Coaching—John Snow Institute

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• JSI has completed a comprehensive needs assessment. They identified key informants who completed structured interviews and held formal and informal conversations with community stakeholders. They assessed and ranked results to set priorities. Along with this preparatory work, JSI established a Strategic Evaluation Planning Team to lead the evaluation throughout the project. • JSI convened two learning collaborative cohorts—one with case managers and the other with substance use treatment providers—who identified core competencies needed for successful delivery of evidence-based behavioral healthcare. They have developed training tools in these competencies for both case managers and substance use treatment providers. • JSI has drafted a survey tool to assess the behavioral health market atmosphere, and results will direct the ongoing work and inform future pathways for development.

AIM 3: EMPOWER PATIENTS TO BETTER ADVOCATE FOR THEMSELVES IN A CHANGING HEALTHCARE ENVIRONMENT AND TO IMPROVE THEIR OWN HEALTH: Engage and educate patients to participate more effectively in their own health care in order for them to live healthier lives. Invest in tools (e.g., online applications, patient coaches appropriate for the patient's demographic profile) to teach patients how to navigate effectively in an increasingly complicated health care system.

DRIVER 3

A. Provide access to patient tools that increase their engagement in their own care and assist with advanced illness care planning
    a. Patient engagement tools or processes
    b. End-of-Life/Advanced Illness Care Initiative outreach, and patient and provider education

SIM PROJECTS:

Advance Care Planning (ACP) and Community Campaign—Healthcentric Advisors (HCA)

Please provide 2-3 high level bullet points that highlight your accomplishments to date.

• ACP is a discussion that most people prefer to avoid. Through the SIM grant, HCA began to reverse taboos associated with ACP through a social media campaign, community education events and targeted presentations. The use of thought-provoking stories and providing opportunities for candid discussions with smaller groups has proven to be very effective. This has been especially helpful getting past the initial hesitancy to discuss ACP and has led to meaningful conversations. Our multifaceted outreach has reached over 200,000 people.
• We have established a strong connection to the Spanish speaking community through our partnership with Progreso Latino. They have utilized their extensive networking system and provided translation for all project materials in their outreach efforts. By working side by side with them during events and educational opportunities, we can reach both the Spanish and English-speaking segments of the community.
• We have created a website for ACP, which is available in both English and Spanish. Through the MyCCV.org website, community members and providers can access educational information, ACP forms, and materials for providers to incorporate ACP into their daily workflows. The website is broken down into three distinct sections:
  • *Information for Everyone* page which includes patients, veterans, families, caregivers, and the faith community
  • *Spanish page (Mi Cuidado, Mi Eleccion, Mi Voz)*
  • *Healthcare provider page*

Complex Care Conversations—Hope Hospice and Palliative Care of Rhode Island

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• Hope Hospice conducted 16 eight-hour ***Complex Care Conversations*** training sessions conducted in Year One with a total of 278 providers trained. This exceeded our Year One goal to train 192 providers by 44%. • The training demonstrated a significant positive impact on attendee's knowledge, attitudes, and behavior. Hope Hospice uses a ***Pre/Post Training Assessment*** to determine the participant's ability/comfort level with 11 aspects of complex care conversations. Forty-seven% of respondents reported that they were somewhat or very skilled in these 11 aspects before the training while after the training the result was 91%. In a follow -up assessment three months after the training, 95% of respondents reported that they were better able to identify patients who would benefit from a goals of care conversation; 91% felt more comfortable communicating serious news; 95% were better able to respond to patient/family emotions; and 91% had increased the number of goals of care/advance care planning conversations they were having with patients. In addition, 88% stated that they had found greater personal and professional satisfaction in caring for patients with serious advanced illness. • Hope Hospice is conducting a ***Provider Impact*** analysis on a quarterly basis to determine the impact of the training on the participant's practice patterns. The organization is tracking the use of Advance Care Planning (APC) codes submitted by providers to insurance carriers, which means that the providers have had these conversations with their patients. To date, we have seen a steady increase in the use of ACP codes among trained providers as well as an increase in the length of stay for their patients who were referred to Hospice.

Consumer Engagement Platform— Rhode Island Quality Institute (RIQI)

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• Development of the platform side of the Consumer Engagement Platform (CEP) has been mostly completed, with a few additional pieces of functionality left to be finalized. • Platform integration with CurrentCare for advance directive documents is under development. This will allow advance directives uploaded through the platform to be shared as part of the patient's longitudinal record in CurrentCare. • We have determined three major barriers to the SDOH screening implementation that limit the ability for anyone in the community to use the CEP at this time: various EHR providers are adding SDOH assessment functionality to their products; participants in the Accountable Health Communities grant have little flexibility in the systems they can use for screening; and that screening is still not happening in many provider offices. Therefore, we are pulling back on the creation of those modules so that we are not creating a product that providers are not likely to use. This will allow us to use the CEP for other provider needs not currently met by their EHRs—in the future (post-SIM) we can revisit whether there are use cases attached to SDOH screening.

Conscious Discipline—The Autism Project

Please provide 2-3 high level bullet points that highlight your accomplishments to date.
• The Autism Project has brought the Conscious Discipline (CD) evidence-based practice to elementary schools in three pilot sites—Providence, Burrillville, and East Providence— serving over 300 students. • Fourteen teachers and administrators have attended multi-day trainings in CD. These teachers and administrators then provided training to an additional 1300+ teachers, family members and community members. • Children in the demonstration classrooms were given pre- and post-Devereux Students Strengths Assessments (DESSA). The DESSA is a standardized, strength-based measure of the social and emotional competencies of children in kindergarten through 12th grade. The difference in the pre- and post-assessments in each of the classrooms shows statistically significant improvement with T Score changes between 9 – 17 points, or a 5% –9% change. This means that the adults are able to control their emotions in a much more effective way, allowing the children to navigate their way through their days at school and their evenings at home more calmly and able to learn.

Accomplishments within Other SIM Activities

In addition to each of the accomplishments of the SIM funded projects, we have also made significant strides across state agencies and community partners regarding the Culture of Collaboration and Integration and Alignment. We have also added several other new SIM activities or have deepened activities that we had originally conceived of as part of our model test.

Culture of Collaboration & Integration and Alignment

As we have discussed throughout this writing on SIM sustainability, a primary strategy of Rhode Island's SIM project has been to pursue a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with SIM-funded activities. SIM has regularly convened working groups which bring people from multiple agencies and backgrounds into the same room to collaborate and plan together. This practice works on both strategic and tactical levels. When we bring people together to plan, they are more likely to experience a stake in the outcome, which tends to keep them at the table. And tactically, if they are part of the planning, the resulting initiatives may be more likely to meet their needs.

For example, the Patient Engagement Workgroup brought together a variety of stakeholders, including all our SIM state agencies, and helped us determine a clear set of the highest

priorities for patient engagement in the state. Through this process, the voices of the state agencies and community members were heard, resulting in a procurement that was reflective of not only the state perceived needs but also our community members. Specifically, the process resulted in a procurement that narrowed the parameters to SIM's eight health focus areas, required a clear demonstration of need for the target audience, and provided the opportunity for vendor proposals to be creative.

RI SIM has also implemented our Integration and Alignment Initiative, which is focused on leveraging SIM's interagency structure and diverse stakeholder network to have positive impact on population health. This initiative began with the realization that while SIM investments focused more on system change than population health improvements, state agencies and community organizations in Rhode Island are already carrying out activities that have a positive impact on population health, specifically in our health focus areas. We agreed that SIM was well positioned to act as a convener of these state agencies and community groups. The Integration and Alignment project identified state activities that address population health within the SIM health focus areas, and aligned them with each other—and with projects and activities outside of state government as well. This will help to move the needle on population health and maximize the impact of every dollar spent.

Through an iterative process, SIM held discussions with state leaders, agency staff, community stakeholders, and subject matter experts. Between August and December 2016, state staff proposed, researched, refined, and critically assessed several Integration and Alignment Collaborations designed to improve population health within one or more of our health focus areas: obesity, tobacco use, chronic disease, maternal and child health, depression, children with social and emotional disturbance, serious mental illness, and opioid use disorders. After presenting the projects to the SIM Steering Committee for strategic guidance, three emerged as leading priorities:

- Chronic Disease – Identification of high-risk patients/Social determinants of health;
- Tobacco Use – Aligning best practices; and
- Obesity – BMI data collection.

This alignment stems from positive, ongoing communication between agencies, facilitated by the SIM process that has been embraced by seven state agencies to this point, and can be joined by other related state departments. For example, as SIM builds up its activities on social and environmental determinants of health, we have reached out to the Divisions of Elderly Affairs and Veterans Affairs. Both departments are talking with us about their resource directories for their respective populations, focused on the SDOH.

Each project has brought a diverse array of in-state and community experts to the table to identify areas of common priority and opportunities to maximize impact by working collaboratively. Key accomplishments include:

Tobacco:

- Development of Cessation Benefits Matrices for providers
- Movement toward embedding Quitworks in HIT platforms
- Inclusion of tobacco cessation in SBIRT Training and Provider Coaching RFP
- Partnership with CDC funded 6|18 initiative at RIDOH
- Interagency learning, including the integration of oral health
- Using claims to answer questions about utilization and reimbursement
- Reviewing the regulatory framework for CTTS workforce
- Support the streamlining of CTTS and other professional training programs
- Continued promotion of Quitworks and the Quitline
- Strategic alignment across state agencies

High Risk Patient Identification/SDOH:

- Collaborative learning processes to understand and share best practices in high-risk patient identification
- Consensus on importance of unified strategy on defining and measuring SDOH
- Planned implementation of a pilot for screening and referral
- Align CEP pilot with the development of Unified Social Service Directory
- Partner with CHTs and other providers to work toward standardized data collection using Z-codes

BMI Data Collection for Children and Adolescents

- Launched a "proof of concept" to determine if BMI data on children and adolescents in Rhode Island could be collected that is representative of the state
- De-identified data collected from managed care organizations (MCOs) and CurrentCare and merged with KIDSCount data, including demographic information. The data fields collected included
    - Height and weight
    - BMI
    - ICD9, ICD10 or HCPCS (billing) codes related to BMI
        - Included codes for both children and adults because sometimes adult codes are used for teens
- Worked with the Hassenfeld Institute to compare the data sample to census data and determined that the sample was representative of Rhode Island's four core cities: Providence, Central Falls, Woonsocket, and Pawtucket.
- Data was further analyzed, categorizing it BMI by age group, race/ethnicity, towns, and cities
- Compared to national clinical rates of BMI, the Rhode Island data was similar to the NHANES (National Health and Nutrition Examination Survey), the National Survey of Children's Health, and with self-reported information from the Rhode Island Youth Risk Behavioral Surveillance System (YRBSS).

Other new Rhode Island Initiatives

Our SIM process—focused on collaboration, with plenty of opportunity for review and refinement of our models—led us organically to spark new ideas and create new activities. Some of these activities were focused on by SIM, but others were led by other agencies and partnered on by SIM. We have listed new SIM-led activities above in our vendor descriptions and include additional SIM or state-wide new activities below:

1) *Deepening of our Measure Alignment Work*

   We have described our Measure Alignment project often, as a way to help providers by honing the number of measures on which they are required to report to state regulators. The final product of our initial Measure Alignment activity was a menu totaling 59 measures. Included within the menu were core measure sets for ACOs (11 measures), primary care providers (7 measures), and hospitals (6 measures). Core measures are required to be in all performance-based contracts of the relevant type: primary care, hospital, ACO. Beyond the core measures, health plans and providers may select measures from the menu for inclusion in contracts.

   In many states, state government can be a part of creating aligned measures, but state officials do not have the authority to implement them; in Rhode Island, OHIC has that authority. In 2017, all commercial insurers signed OHIC's 2017 Rate Approval Conditions, which included a requirement to adopt the SIM Aligned Measure Sets in any contract with a performance component as a condition for their rates to be approved. The updated SIM Aligned Measure Sets became effective for insurer contracts with hospitals, ACOs, and primary care practices beginning on or after January 1, 2017. Additionally, OHIC amended State Regulation 2, which delineates the powers and duties of its office, to include implementation of the SIM Aligned Measure Sets in any contract with primary care providers, specialists, hospitals, and ACOs that incorporate quality measures into the payment terms. OHIC will be issuing an interpretive guidance document to payers for using the measure sets in contractual payment arrangements.

   To assist in aligning processes between commercial and public payers and to reduce administrative burden for providers, Medicaid has incorporated the SIM Aligned Measure Sets into the Medicaid Performance Goal Program (PGP). The Medicaid PGP aligns with the SIM quality measure set as well as additional measures that assess health plan performance against EOHHS goals and/or align with the CMS child and adult core measures that EOHHS reports to CMS. The PGP is used to incent the health plans to improve across various domains, which in turn influences provider performance-based contracts. In addition, the Medicaid Accountable Entity (AE) program anticipates alignment of the SIM quality measures as part of the program's Alternative Payment Methodology (APM) or total cost of care guidance. The APM guidance is in the process of being developed.

OHIC conducts an annual review of the five SIM Aligned Measure Sets (Primary Care, Hospital, Accountable Care Organizations (ACOs), Behavioral Health, and Maternity). SIM's Measure Alignment Work Group reviews measures that are in existing contracts with plans and providers, and updates the measure sets to account for measures that had a change in NQF or NCQA status, new HEDIS measures, and measures recommended by work group participants.

2) *Integration of Physical and Behavioral Health*

Below are highlights of SIM's work surrounding IBH. SIM's efforts in this area are described in greater detail in the Landscape document.

- The state as a whole is also focusing on improving behavioral health services, following Governor Gina Raimondo's Executive Order on Behavioral Health, signed May 4, 2018 to reaffirm and expand the state's commitment to those with mental illness and substance abuse disorders. This fall, led by the Executive Office of Health and Human Services, key state agency leadership have been traveling through the state holding a series of public conversations, mental health, addiction, and available treatment.
- Focusing specifically on the integration of behavioral and physical health, the Steering Committee supported the IBH project at the CTC.
- We were able to successfully expand the reach of our original SBIRT project by working with BHDDH to apply for a significant SBIRT grant from SAMHSA.
- We created our Integration & Alignment project on high risk assessments, which included components on the SDOH and the cross-section with behavioral health.
- BHDDH is strongly focused on addressing the opioid crisis. They are implementing a State Opioid Response grant from SAMHSA, with the ability to fund a number of initiatives that should improve services for Rhode Islanders.
- OHIC is actively implementing the state's parity law, with both consumer protection activities (including a Market Conduct Examination of Rhode Island's four major health insurers) and regulatory changes that ensure that people who need behavioral health services are treated the same as those who need physical health services.
- OHIC's focus on behavioral health has led them to create a Behavioral Health Fund, administered by the Rhode Island Foundation. The Fund will make grant distributions to support strategies and service models that enhance primary and secondary prevention and ensure access to high-quality, affordable behavioral healthcare services.

When we finish evaluating SIM, the integration of physical and behavioral health will be a key focus—and we know that RTI has noted this in their discussions of our work.

3) Health Planning:

During SIM's sustainability planning process, we asked our Steering Committee, Interested Parties, and Sustainability Workgroup questions about the direction the state should go post-SIM. Stakeholders frequently mentioned that we should move forward with some sort of larger, overall plan for Rhode Island's system transformation and population health.

SIM's Operational Plan has been a positive step in many people's eyes, laying out definitions and shorter-term goals surrounding the SIM grant. The next steps envisioned by many in our community is a longer-term, more expansive plan that could provide a roadmap for what the state wants to achieve as a whole. It could guide investments by private entities and help set bounds for decisions by everyone in the health system.

The Rhode Island Foundation has publicly expressed interest in helping to facilitate such a plan, and they are currently looking at next steps in this process. This planning process is envisioned as a public/private partnership, and the SIM team has offered to help in any way it can.

Next Priorities in Healthcare Transformation:

1) *Rhode Island Healthcare Cost Trends Collaborative Project:*

   This project is guided by a Steering Committee comprised of government, business, and community leaders and will leverage the state's existing APCD to identify cost drivers, develop an annual health care cost growth target, and inform system performance improvements. The Steering Committee was convened in August 2018 by EOHHS and OHIC, in partnership with Brown University and the Peterson Center on Healthcare. Rhode Island joins only a handful of U.S. states to launch a comprehensive effort to measure health care claims, examine how dollars are spent, and set a spending target. The group will also draw upon work done by the Massachusetts' Health Policy Commission, which has set annual health care cost growth targets since 2013. The project is funded by a $550,000 grant from the Peterson Center on Healthcare.

2) *Primary Care Capitation*

   To support the adoption of non-fee-for-service payments in Rhode Island, OHIC facilitated a work group process to plan the implementation of primary care capitation across a common group of practices and payers. This work built upon a capitation model that was designed by the same work group in 2017. OHIC also convened a separate work group to adapt the capitation model for pediatric practices. Throughout 2018, the work group has refined aspects of the APM, evaluated readiness of each insurer, and worked with ACO leadership to identify interested practices. OHIC will continue to move this work forward in the next year with active implementation likely to begin in 2020.

3) The Rhode Island Medicaid Health System Transformation Project (HSTP) has supported the establishment of Accountable Entities (AE) to work in partnership with MCOs to achieve the core principles of "Reinventing Medicaid", including:

    - Paying for value, not for volume
    - Coordinating physical, behavioral, and long-term health care
    - Rebalancing the delivery system away from high-cost settings
    - Promoting efficiency, transparency, and flexibility

    SIM projects align closely with the objectives of HSTP and AEs, and many have partnered directly with AEs and affiliated provider organizations. As such, AEs represent an important potential sustainability strategy for many SIM projects.

4) Affordability Standards

- Care Transformation Advisory Committee
    - OHIC's Care Transformation Plan became effective in early 2018. The plan describes OHIC's three-part definition of PCMHs, annual targets for the insurers to transform primary care practices, and activities that OHIC and stakeholders will undertake throughout the year to support PCMH adoption and implementation. The 2018 target for commercial insurers is to transform 50% of those practices that are affiliated with ACOs but have not yet achieved NCQA PCMH recognition; for 2019, the target is 90%. OHIC will reconvene the Advisory Committee for a series of three meetings in the fall of 2018 to review and discuss the operational definition of a PCMH, practice reporting requirements, transformation targets, and cost strategies. The group will also review the results of CTC-RIs IBH Pilot, with the goal of improving processes and removing barriers for behavioral health and physical health integration.

- Alternative Payment Methodology (APM)
    - OHIC continues its work on developing a multi-payer APM. The 2018 plan includes insurer targets for APMs and non-Fee for Service (FFS) payments, as well as a minimum downside risk requirement for Total Cost of Care contracts. For 2018, insurers should take actions such that 50% of insured medical payments are made through an APM and 6% are made through non-FFS models. To support this, OHIC is working with payers and providers to implement a pilot of the primary care capitation model that was developed by a working group in 2017. OHIC will reconvene the APM Advisory Committee for a series of three meetings in the fall of 2018 to discuss the possibility of modifying the above targets for 2019 and the implementation of a multi-payer APM pilot to launch in early 2019.

Conclusion

Rhode Island's healthcare leadership is proud to be a SIM grant participant. We are pleased with what we have accomplished since receiving the grant, and we are even more excited about our future plans that have been made possible by the grant process.

As we noted in our End State Vision document, our understanding of all of the ways that we can implement the Triple Aim has deepened, giving us an excellent platform from which to achieve much more post-SIM.

We are taking advantage of all of the time we have left with our SIM funding, focusing on sustainability throughout this final Award Year. We have also greatly appreciated working with your CMS team, and learning from them throughout this process.

We are looking forward to your thoughts and insights about these sustainability documents and will be happy to answer any questions you have or provide additional information. Thank you.