RI SIM Sustainability Submission
Part 2 - Landscape of Healthcare in Rhode Island & RI SIM Lessons Learned
October 26, 2018

As we reviewed what has changed in Rhode Island's state health landscape since we wrote our original application as a part of our Sustainability Review, we used a number of different source documents. First, the charts below are based on our three main SIM Strategies, as laid out in our Operational Plans. The source documents referenced below are the State Healthcare Innovation Plan (SHIP) which was the SIM Planning Process (2012-13), the Senator Sheldon Whitehouse/RI Foundation Health Compact (2014), Governor Gina Raimondo's Report of the Working Group for Healthcare Innovation (2015), and the SIM Operational Plans (2015–2018). All of our Operational Plans can be found on this page.

Each of the charts lays out our goals from the original documents and where we were when we began the pre-SIM planning process (2012–2013). The second column in each chart gives an overview of where we are now in three areas: SIM-Funded Initiatives, Partner/Other State or National Initiatives, or Community Initiatives that live in our stakeholders' organizations. You can find the most up to date information about the SIM-Funded Initiatives in our AY4 Operational Plan. If you have questions about our Partner or Community Initiatives, please let us know. Stakeholders contributed information throughout this column.

Then, the third column in each chart reflects our Lessons Learned through the SIM grant cycle and activities in each area. We held discussions at our Sustainability Workgroup and Steering Committee meetings, and with our Interagency and Core Staff Team for input into lessons learned. We found that the question "What would we do differently if we could begin SIM again?" was one of the best prompts to get feedback for this column and much of the wording in this section is verbatim from stakeholders.

Linking Payments to Outcomes: Healthcare Spending & Payment Reform

GOALS from source documents:

- Bend the "Cost Curve" of Health Care in Rhode Island (SHIP)
- Transition to Value-Based Care (SHIP)
- A global health spending target (Working Group on Health)

- Reducing waste and overcapacity (Working Group on Health)
- Tying healthcare payments to quality (Working Group on Health)
- Triple Aim (SIM Operational Plans – 2015 through 2018)

Where we started (2012-13)	Where we are now	Lessons Learned
The system of care delivery is fragmented, which can lead to overutilization and higher costs. For example, the 2013 study of the state's hospital capacity suggested that the state may have as many as 200 excess hospital beds. In addition to hospitals, the state may also have excess capacity in nursing homes. The current fee-for-service environment does not support population health, leads to higher unnecessary or inappropriate utilization, and does not promote coordinated care delivery. Improvements in our mental health service delivery system, better coordination of services, and more effective integration of mental health and primary care are vital to high quality patient-centered care—an enormous challenge and opportunity for Rhode Island. There is a lack of consistent transparency among providers and payers that inhibits consumers from selecting care based on value. There is limited knowledge of how the current and future health care workforce is prepared to provide care in a value-based system (both in training and in availability).	SIM-Supported Initiatives: • APM Targets • End of Life Provider Trainings and Patient Engagement • Interprofessional Community Preceptor Institute • Triad Project – Behavioral Health Trainings • PCMH Kids • Measure Alignment • Healthcare Quality Measurement Reporting and Feedback System • HealthFacts RI • Tobacco Cessation Integration and Alignment Project Partner/Other State or National Initiatives: • Medicaid HSTP/Accountable Entities • Primary Care Capitation Pilot, with a push for all-payer participation, including Medicare • OHIC Behavioral Health Parity • Market Stability Workgroup • 6I18 Project at RIDOH • Need to update the 2013 Hospital Study because a hospital has closed	• For all projects, collect data as early as possible and determine what data we need to measure Return on Investment (ROI) from the start • Children's health care (physical and behavioral) has a longer time period to see ROI or other cost benefits. If we invest throughout the life course we may not see immediate returns, but we may save costs later in other systems (education, corrections, etc.) • Providers and healthcare organizations appear to understand the value of publicly accessible healthcare cost and quality information, but there is no existing mechanism to share the information publicly • The quality measures that are easy to calculate are mostly process measures and do not support outcome measurement and the community wants to transition to more outcome measurement. We need technology to make this easier which will help this happen sooner with less provider burden

There are uneven expectations and knowledge around value-based care practices and a lack of provider education. There are significant outpatient behavioral health needs.	Community Initiatives: • CPC+ Participation • Care Transformation Collaborative's PCMH adult practice transformation • Proposed hospital mergers • Accountable Health Communities • Hospital strikes have impacts on other facilities because of diversion needs	• We can use existing regulatory levers and requirements to ensure outcome-based expenditures (e.g. hospital community benefits) • Provider engagement in alternative payment methodologies (APMs) is still limited but is improving. While providers are aware of APMS they are not necessarily actively engaged or always willing to participate. We should still acknowledge that these APMs are still based on an underlying fee-for-service structure. • Rhode Islanders continue to have a need to better understand the healthcare pressure points and have a willingness to directly address where spending is highest. • Collecting data is not enough, we need to act on the information we receive about costs and cost containment • Measure alignment has been one of Rhode Island's largest successes in the state's efforts to reduce administrative burden for both providers and payers. • Many APMs have not been being implemented long enough to fully understand ROI or benefit.

Planning & Aligning for a Healthy Population: Access to & Quality of Healthcare in Rhode Island		
GOALS from source documents:		
• Improve the Quality of Health Care in Rhode Island (SHIP) • Ensuring all Rhode Islanders have access to care (Working Group on Health)		• Improve the health of Rhode Islanders (Working Group on Health & SHIP) • Triple Aim – SIM Operational Plans
Where we started (2012-13)	**Where we are now**	**Lessons Learned**
The current practice of care transitions increases the vulnerability of readmissions/reduced adherence to evidence-based procedures and poorer health outcomes. The highest risk (top 5%) population is costly due to multiple co-morbidities and requiring a high intensity of services. Many Rhode Islanders in the population referred to as the "Rising Risk" population (those with one or two chronic conditions) receive uncoordinated and disparate preventive care that leaves them vulnerable to higher costs and in danger of rising to the high-risk category. There is a high prevalence of mental illness and substance abuse, as well as the high cost of treating these conditions. Community-based organizations are unevenly equipped to participate in health care and are poorly coordinated with the areas of greatest need. The current health care system allocates few resources to incorporating social determinants of health into the care delivery and payment system. Community Health Workers are under-recognized.	SIM-Supported Initiatives • PCMH Kids • Integrated Behavioral Health (IBH) Project, as a model • Community Health Teams/SBIRT – including pharmacy and nutrition services* (See note about the (*) items under Lessons Learned). • Integration & Alignment work (multiple agencies working together) as a model • Unified Social Service Database for referrals • Behavioral Health Integration as a strategy to address behavioral health issues • Conscious Discipline • Behavioral Health Billing & Coding • Consumer Engagement Platform • State Data Ecosystem • HealthFacts RI • Care Management Dashboards* • Pedi-PRN (Child Psychiatry Access)* • Triad Training Project for Behavioral Health • Interprofessional Community Preceptor Institute • End of Life Projects* • Health Assessment Report • HEZ investments • Measure Alignment	• The initiatives with the asterisks (*) to the left are noted as good models to emulate or learn from for the future. • Must be specific about integration of behavioral health by calling it out—and do the same with oral health. • As above, investments in population health for children are crucial. • Investments in care for seniors must also be looked as a continuum along the life course. • From our High-Risk Integration & Alignment Project: Screening for social determinants of health is key, but there is not only one way to do it—what questions are asked will depend on who is conducting the screening • As we continued to gain insights into the grant deliverables—and the differences between where we started and where we needed to end up—we would have been more strategic about aligning population health and system reform investments. • We learned about the limitations of our ability to show a ROI and gained a much better understanding of the interplay between the social

Populations with complex or specialized health care needs face ad hoc, non-standard, or marginal care structures. There are public health requirements for population health improvement plans and hospital requirements for community health needs assessments.	• STR Grant • eCQM project • Tobacco and BMI Integration & Alignment Projects • EOHHS Workforce Summit and the Rhode Island Healthcare Workforce Transformation Report • Public SIM Workgroup meetings • Development of a standard framework for system reform and population health stakeholder engagement through outreach presentations Partner/Other State or National Initiatives • Medicaid HSTP/Accountable Entities • Patient Centered Pharmacy Program • Close partnership with CurrentCare/Health Information Exchange • Major changes in behavioral health (BH) co-payments and utilization review (Example: BCBSRI lowered BH co-pays from a specialist copay to a primary care copay, and no longer requires prior approval for in-network mental health or substance use disorder services). • 23 Integrated Population Health Goals, which started at RIDOH • LTSS Workforce Think Tank • Health Literacy – HSRI • SBIRT spin-offs in pediatrics and with school counselors • Institutes for higher education and unique partnerships with RIDOH Academic Center and HSTP higher	determinants of health, the value of eReferrals, and "closing the loop technology" to help us meet our goals. • Technologies to support new population health activities are key because this work is not well supported in electronic health records (EHRs), but adoption and uptake is difficult without the potential users seeing it work first. • Technology should not be an afterthought. There should be more upfront attention given to technology needs/workflow with EHRs, etc. as projects are developed (Example: SBIRT with GPRA/SPARS). Also, we need upfront discussions of who will own and maintain data once the system is developed. • We need more resources to develop a true ongoing State-level Health Improvement Plan, and to further define the metrics for the state associated with our population health goals. • We need to better understand the process of braiding funding and the benefits (and challenges) of doing that. • We did not do as much direct patient engagement as we had hoped. • We want to develop stronger ties to schools and the educational community, including school wellness committees, the Health Schools

	education partners, following the Workforce Strategic Plan • Ryan White Funding • Medicaid ISAs, within the HSTP Workforce Transformation program with our Institutes of Higher Education • RIDOH Academic Center and MOUs with state high education institutions • Governor's Opioid Overdose Taskforce and Data Council • EOHHS Ecosystem Governing Board • Children's Cabinet • RI College HRSA grant for SBIRT training • EOHHS participation in the RI Public Transit Authority Transportation Taskforce Workgroup Community Initiatives • Additional CHTs • Trainings by the Substance Use and Mental Health Leadership Council • Accountable Health Communities • Quality Tracking, such as: HEDIS measures for insurers; national hospital quality rating system measures; NCQA accreditation of PCMHs; FQHC quality measure reporting; indicators in national surveys like BRFSS PRAMS; and others, which include questions about the context or quality of services	Coalition, and school nurses (which could happen through PediPRN).

Developing Infrastructure for Quality Care: Health Information Technology & Data		
GOALS from source documents: • Expanding and improving health IT & Utilization of Data (Working Group on Health)	• SIM HIT Goals – Operational Plans	
Where we started (2012-13)	**Where we are now**	**Lessons Learned**
Data show that there are disparities between groups, e.g., Medicaid and commercially insured populations. The current practice of care transitions increases vulnerability to readmissions and/or reduced adherence to evidence-based procedures, leading to poorer health outcomes. There are unrealized opportunities for the health care system to incent higher levels of patient engagement. Data lives in silos across the state: state databases, provider systems, and payer systems, making it difficult to leverage for value-based care and population health. There had been privacy concerns around HIT initiatives, and there wasn't effective legislation around telemedicine.	SIM-Supported Initiatives • State Data Ecosystem • Healthcare Quality Measurement Reporting and Feedback System • Provider Directory • Care Management Dashboards • Consumer Engagement Platform • USS Database • SBIRT • HealthFacts RI • BMI Integration & Alignment Project Partner/Other State or National Initiatives • Medicaid technology under MMIS, E&E and HITECH I-APDs • CurrentCare/Health Information Exchange • DataSpark, University of Rhode Island • UHIP/RI Bridges challenges have an impact on rest of HIT work • Blackstone Valley Community Health Center Health Record • RIQI Dashboards (besides the Care Management Dashboards) • Work with the Hassenfeld Institute, Brown University • RIDOH Health Inventory and HIT Survey • Kidsnet and other RIDOH systems • Shared Plans of Care with RIDOH and CEDAR programs • Community Health Network at RIDOH	• Define use cases more specifically to better support linking value to sustainability • Focus early on sustainability, with more community engagement along the development cycle with potential customers • Using IT to track social determinants of health care led to new data on risks and gaps • Demos of IT systems during procurement are extraordinarily helpful in selecting the right vendor • The demand from providers is quickly advancing to focus on value being linked to full EHR integration • It would be beneficial to have one EHR for schools across the state • Great to build new systems but sustainability costs money • Costs dollars and time to collect and send data—we need to remember this when we ask for data collection • There are continual barriers to improving care coordination for patients with substance use disorder diagnoses due to 42 CFR Part 2 • Looking back, we might wish that the community were all on one

	• HIT Advisory Committee • There are still multiple trains running to address some SIM Health Focus Areas (e.g. SIM Steering vs. Children's Cabinet vs other state agency committees), but now the trains are communicating back and forth more than they were. Community Initiatives • Other CurrentCare Initiatives at RIQI • SNAP Pilot project with 4 sites	system. Looking forward, we should try to align on one system for new initiatives rather than all going our separate ways • It is important to get firm commitments from partners, especially where sustainability is concerned • It is helpful to understand exactly where there are opportunities for demonstrable ROI when it comes to sustaining investments • It is especially difficult to measure outcomes, such as with behavioral health data, because the data is not always in the system. We need a single source of truth for data integration • We should have included Delta Dental in HealthFacts RI from the start • We should engage the State of Rhode Island's health data and employee benefits staff more

Culture of Collaboration		
GOALS from source documents:		
• SHIP planning • Office of Health Policy & Planning (from the Whitehouse/ Rhode Island Foundation Compact)		
Where we started (2012-13)	**Where we are now**	**Lessons Learned**
SHIP public/private planning process During the process, community members said that in order to be involved, they needed to have decision-making power	SIM-supported Initiatives • SIM Steering Committee, with decision-making power. • Public SIM Steering Committee and Workgroup meetings, designed to maximize stakeholder input in planning and learning • SIM Interagency Team • SIM embedded staffing model • Integration & Alignment projects – High Risk Assessment, Tobacco Cessation, and BMI • Unified Social Service Directory, to maximize the ways that the state uses and pays for data • Quarterly SIM Vendor Meetings, and resulting vendor-to-vendor partnerships • State level SIM/Health Equity Zones (HEZ) collaboration • SIM Culture of Collaboration Evaluation • SBIRT/CHT Braided Funding Partner/State Initiatives • Other state interagency teams have begun since SIM: Ecosystem Board, EOHHS Public Affairs Team, Opioid Task Force and Data Team • Project Advisory Group for Ecosystem • Children's Cabinet	• Importance of interagency communication for collaboration and a broad group of stakeholders • The embedded staff model provided many benefits to collaboration • The value of increased communication between state agencies on aligning activities • How to improve purchasing processes for other state agencies seeking large multi-agency grants • Difficulty of too many projects, with procurements (RFP complexity and time), budgeting, and the need for financial staff • Question branding the project as SIM versus a broader "Health Reform" name • Difficulty in engaging actual patients and consumers • There was a long ramp up process – taking what seemed like too long to decide on leadership and specific plans. However, because the right "mindset" was needed to ensure trust of one another, the protracted start-up, while painful, may have helped with

	• Internal RIDOH SIM Partner Workgroup • Internal RIDOH/BHDDH Cross-agency meetings • EOHHS Directors' Meeting • EOHHS Active Contract Management Workgroup • Governor's Hunger Elimination Task Force Community Initiatives • Health Equity Zones • Accountable Health Communities • Pharmacy Transformation Workgroup	collaboration. We needed a common language and means of communicating • It has been more fun over the past 1.5 years, since the project has really taken off • With behavioral health work in particular there are many organizational cultures, so opportunities for points of connection still can be hard to figure out • However, primary care has many successes with a focus on team-based care and outreach to community providers • The relationship between BHDDH and RIDOH has improved. Going forward, we need to determine how the particular goals and day to day operations of each state agency assure productive working relationships among themselves • We also need to look beyond just state agencies for collaboration, for example, with the Children's Cabinet, they are looking beyond to the community • Data sharing has great promise for assuring connections across various entities in the state, such as that shown by the Data Ecosystem and BMI data coming from the health plans. For example, with BMI, we now have a baseline, so let's not scrap this, but build on it annually:

		What are our goals? Are we meeting the goals? Do we have new goals? • As the grant period draws to an end, there should be a formal hand off of the Steering Committee to another entity. • Finally, as we look to sustaining the SIM project, it is not only about (or even primarily about) the sustainability of our funded projects. As we noted in our End State Vision document, when we think about sustaining SIM, we are focused on sustaining the drive toward health system transformation and improvements in population health; the awareness and prioritization of addressing the social and environmental determinants of health; and ensuring the continuance and deepening of this Culture of Collaboration that has allowed to achieve as many of our stated goals as we have.

- Have any political transitions, market changes, or changes in population characteristics occurred that have impacted or have the potential to impact the awardee's SIM work? How might those changes pose opportunities or challenges to the awardee's work?

  The state political transitions that have occurred during our SIM award years have not been significant enough to have an impact on our work. SIM was planned during the previous administration, out of then Lt. Governor Elizabeth Roberts' office. When Governor Gina Raimondo was elected, Lt. Governor Roberts became Secretary of EOHHS and Health Insurance Commissioner Kathleen Hittner (who had also helped write the grant) remained in her position. When both leaders left their positions, the new leaders (Eric Beane, Secretary of EOHHS and Marie Ganim, Health Insurance Commissioner) were very strongly supportive of SIM and our work. The transitions were seamless.

  In terms of our insurance market, as we have noted throughout these documents, Rhode Island was moving from volume to value before the SIM grant was awarded. We are able to track carrier and provider points of view on a regular and in-depth basis because of the strong relationships between OHIC and the commercial carriers and providers; Medicaid and their MCOs; and HealthSource RI (HSRI) and all of the carriers with which they work. The state's significant stakeholder engagement also ensures that we are aware of insurance market changes. The most significant state-based changes have been:

  - More movement to value-based care, as documented in our Operational Plan and metrics
  - Movement of the Medicaid Accountable Entities (AEs) from their pilot project to 6 certified AEs
  - Increased patient-centered medical home (PCMH) penetration, and questions about whether we are close to reaching the limit of new PCMH practices because small practices are less likely to want to participate
  - Exploration of a primary care capitation model

  State leadership has been consistently concerned about potential changes to the Affordable Care Act (ACA) on the federal level. When the Administration changed the rules for Cost Sharing Reductions, OHIC and HSRI were able to respond immediately to help Rhode Island consumers.

  In response to other federal changes, the two agencies worked together to convene a Market Stability Workgroup in April 2018, with three guiding principles: sustain a balanced risk pool; maintain a market attractive to carriers, consumers, and providers; and protect coverage gains achieved through the ACA. Open to the public and comprised of diverse stakeholders representing health insurers, employers, healthcare providers and consumers, the Workgroup held eight weekly meetings and released a final report in June 2018. The Workgroup recommended that the legislature pass enabling legislation to pursue a 1332 waiver request as

provided for under the ACA to implement a reinsurance program. The Workgroup recognized that 1332 waiver applications require a stakeholder review process. The state reinsurance program would be designed to mitigate premium increases in the year 2020 and beyond. In addition to leveraging federal pass-through savings, we would identify matching funding from other sources and proposed separately through future legislation. The enabling legislation passed in June 2018, allowing the state to apply for the waiver. The Workgroup is reconvening in the fall of 2018 to continue their work ensuring a stable health insurance market in Rhode Island.

Finally, regarding our overall healthcare landscape, we are confident that between OHIC, Medicaid, and HSRI, the state is in the position to monitor any of the potential changes and ensure that our push toward health system transformation remains on track.

- **CMS Question:** What proportion of payers and providers are participating in the awardee's model during the final award year compared with the pre-implementation period?

> First, with respect to the commercial market, each payer was making strides toward value-based care during the pre-implementation period. However, OHIC's Affordability **CMS Question:** Standards set a time table for the transition to value-based payments, which means that all payers are now involved.

> Medicaid's creation of their creation of Accountable Entities (AE) structure happened during the SIM time period – but to be clear, this was not a SIM initiative. All three of the Medicaid Managed Care Organizations (MCOs) are participating in the AE program. Medicaid's contracts with Medicaid MCOs have requirements for APM targets that align with OHIC's APM Plan. Please see Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Partners for more information.

- **CMS Question:** To what extent are payers aligned on key model features like payment methodology and quality measures? How has providers' participation in Alternative Payment Models more broadly (SIM models or otherwise) grown or changed over the course of SIM?

> Providers in Rhode Island are significantly aligned on these key APM model features. The dual push toward APMs within the commercial market, combined with Medicaid's AE accomplishments, has ensured that overall, more providers than ever are participating with programs or are part of organizations that are aimed at moving toward value and taking on risk. According to the most recent available OHIC data, 49.1% of PCPs in Rhode Island's commercial market are associated with ACOs. Medicaid data shows that approximately 52.4% of PCPs in Rhode Island were associated with AEs during the same time period. We anticipate that we will have updated data available by the end of AY4 Q2.

As noted through these sustainability documents, RI SIM's Measure Alignment process was an early win that set us up to focus more intently on quality through our eCQM health information technology (HIT) project.

We have regular access to provider groups through our SIM Steering Committee, through OHIC's strong stakeholder processes with their APM and Care Transformation Committees, and through RIDOH's provider committees. We also connect with RIDOH through their regular newsletters that go to the entire provider network in the state.

CMS Questions on Lessons Learned: Consider the awardee's implementation experience and any unintended consequences. How did the awardee expect to operationalize its SIM work, and how did this work plan unfold? What infrastructure (HIE, staff capacity, etc.) did the awardee intend to develop, and was that infrastructure implemented? What model(s) has the awardee implemented in comparison to what the awardee originally planned to implement? If the awardee changed its approach in model(s) implemented, what prompted the change in approach?

RI SIM Response:

As CMS and the Rhode Island SIM team have always understood, Rhode Island's SIM grant was different from other states because of the pre-SIM existence of OHIC. OHIC's regulatory structure had allowed Rhode Island to develop some of the institutional components that other states were using their SIM funds to create: PCMHs, support for ACOs, etc. We have already noted throughout this Sustainability Submission that Rhode Island's theory of change stated that since Rhode Island was already moving from volume to value, SIM's niche would be to support the individuals and institutions that were making those changes.

Therefore, our model test was different than the tests of other states. We tested support for practice transformation, investments in workforce transformation (including a wide variety of training opportunities for providers at all levels), a discrete set of patient engagement initiatives, and the value of HIT as critical tools toward transformation. We did not change that model throughout our Award Years. However, there were two critical parts of our model that emerged as we implemented the grant: the integration of physical and behavioral health and our Culture of Collaboration. We did not realize how important they would become when we began, but they transformed our model.

1) **Integration of Physical and Behavioral Health**—SIM's initial Operational Plan defined health in general and then specifically population health. In collaboration with stakeholders, we defined health as follows: "When we talk about health, we mean physical health and behavioral health. When we talk about behavioral health, we mean mental health and substance use." Later, we added: "When we talk about physical health, we include oral health."

    Another part of our initial grant application was a proposal to write a Behavioral Health Plan as well as the required Population Health Plan. The next important decision we made about that writing was to say that because we believed that behavioral health must be understood to be at parity with physical

health, that we would write one plan that would integrate what we knew and what we wanted to achieve about both components of health.

Then, when our staff came on board, they started visiting with community stakeholders throughout our early outreach efforts and held the Integrated Population Health Workgroup. During those visits, the more we talked about the importance of intertwining physical and behavioral health, the more central it became to our vision of our model test. It Here are some of our activities within SIM toward that end:

- Focusing specifically on the integration of behavioral and physical health, the Steering Committee supported and approved funding for the IBH project at the Care Transformation Collaborative (CTC-RI). This project is just one of several SIM-funded ventures focused on behavioral health, along with our Child Psych Access Project (Pedi-PRN), the Behavioral Health Workforce Transformation (Triad) training project, and the State Data Ecosystem, whose first project focused significantly on behavioral health needs.
- We were successful in expanding the reach of our original SBIRT project by working with BHDDH to apply for a significant SBIRT grant from SAMHSA. This led to the opportunity to braid SIM funding for our Community Health Teams (CHTs) (which we had always planned would include a behavioral health team member) and the SAMHSA funding for SBIRT. Our CHTs are now intentionally integrating physical and behavioral health throughout the state, carrying out SBIRT screenings and referring for physical, behavioral, and social determinants of health needs. As of 10/22/2018, a total of 8,345 SBIRT screenings have been completed throughout Rhode Island.
- We created our Integration & Alignment project on high risk assessments, that included components on the social determinants of health and the cross section with behavioral health. This project has transitioned into our work on the Unified Social Service Directory.
- 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 EOHHS, key state agency leadership have been traveling through the state holding a series of public conversations, mental health, addiction, and available treatment.
- BHDDH is focused heavily 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. One of these is BH Link, which is a comprehensive program intended to serve those individuals who are experience behavioral health crises by establishing a community-based, 24/7 hotline and triage center. The hotline is a one-stop, statewide 24/7 call-in center and the triage center is a 23/7 community-based walk-in or drop-off facility, where clinicians will connect people to immediate, stabilizing emergency care and refer to long-term care and recovery supports.
- OHIC has begun to focus heavily on 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. This has led them to create a Behavioral Health Fund, administered by the Rhode Island Foundation, that will make grant distributions to support strategies and service models that enhance primary and secondary prevention and access to high quality, affordable behavioral healthcare services. The fund is supported by an initial contribution of $1 million a

year for five years from Blue Cross & Blue Shield of Rhode Island (BCBSRI) and may also be supported by others in the future.

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.

2) **RI SIM Culture of Collaboration**—RI SIM has proceeded generally within the structure envisioned by our grant-writers: a strong public/private partnership with decision-making that includes community members and not just state employees; an interagency team of staff members embedded in five health-focused state agencies; and an interagency team that meets regularly and includes agency staff beyond the specific SIM staff to provide strategic advice and logistical support. However, this structure has contributed more to our outcomes and impact than the SIM planners likely ever imagined.

This structure had some strategic components, but other logistical ones as well:

- **Steering Committee as Transformational Policy Leaders**—When state leadership first wrote the SIM grant, they approached community partners to ask them to serve on an advisory committee. The CEO of BCBSRI at the time reportedly replied that community members were always being asked to serve on these advisory committees, but they did not have a stake in the decision-making. The state's response was to offer that the SIM Steering Committee would be the major decision-making body for the project. The state would bring funding and major program decisions before the body, as if it was the organization's Board of Directors – and would run by modified consensus. The staff has held to this promise, and has run all overall budget decisions and major programmatic direction by this group. (Following state law, the procurement processes and detailed implementation decisions for vendor contracting must remain the purview of state employees.)

- **Interagency Team as the Weekly Strategic Working Group**—It took time to get the SIM program off the ground, due to challenges with hiring and procurement. Until there were SIM staff, the key health-related state agencies devoted their staff members to handle all initial activities: directing the hiring process, starting the first procurements of the project management staff, communicating with CMS, etc. This Interagency Team grew into a critical part of our entire project. Once we hired staff, some of these Interagency Team members reduced the time they spent on the project, but others remained. The ongoing members who are not SIM staff include the Health Insurance Commissioner (first Dr. Kathleen Hittner and then Dr. Marie Ganim), one of the RIDOH Medical Directors (Dr. Ailis Clyne), the state's HIT Coordinator (Amy Zimmerman), and the EOHHS Workforce Strategies Lead (Rick Brooks). We met almost weekly for about two years, and in the last year have met an average of bi-weekly. We have also recruited new people to join the Interagency Team, including the Director of the Health System Transformation Project (Lauretta Converse) and members of the EOHHS Policy and Communications staff (Tarah Provencal, Ashley O'Shea). Our work includes SIM strategic planning, including managing the Steering Committee agenda and reviews of many SIM vendor projects, as well as larger interagency events and opportunities. These can include strategizing new grant opportunities, presentations from key state partners, and determining responses on legislative issues.

- **SIM Public Workgroups**—Throughout the course of the grant period, SIM convened publicly-noticed Workgroups to further engage stakeholders and collect focused input on key components of the grant. As with our Steering Committee, bringing diverse stakeholders to talk together has been the cornerstone of this effort and the results are two-fold: 1) In the short term, SIM gains thoughtful input on the topic hand; and 2) State agency staff and community partners have yet another opportunity to learn and work together in the same room on shared challenges. The chart below shows the trajectory of our Workgroup activity over the grant period.

Active SIM-Convened Public Workgroups by Award Year

AY1 & AY2	AY3	AY4
Integrated Population Health	Sustainability	Sustainability
Technology Reporting	Technology Reporting	Healthcare Technology
Patient Engagement	Patient Engagement	
Measure Alignment	Measure Alignment	

- **Embedded Staff as Strategic Collaboration Agents**—The concept of embedding staff in state agencies stemmed first from a logistics issue. The state wanted multiple departments to participate and knew that it was likely that they did not have adequate staff to do so. Also, it might have been difficult to secure the FTE capacity in any one agency. Putting SIM staff in the agencies, therefore, made sense. When the staff were hired, and began to work together, the agencies realized that the strength that they we were creating in this even more aligned interagency team was very important. The staff members all carry out specific agency functions related to health transformation and population health improvements and then come together to run SIM as a team.

The most important thing about all these structural components is that they turned into a key part of our Rhode Island model—to lift up and value the development of a Culture of Collaboration. We pursued these collaborative activities because they made sense to us as a way to work—agencies working together and finding new ways to collaborate would streamline our state system and potentially save money when we reduced duplication of effort. Having providers work together on our Measure Alignment project made sense as a way to reduce their reporting burden—so of course, OHIC and Medicaid should both require the same measures for each of their reporting requirements. RIDOH had been creating a list of Population Health goals for years—but all state agencies carried out activities that can improve Rhode Island's population health—so RIDOH opened up the goals list for each of the other agencies to add their priorities. Similarly, the three SIM Integration and Alignment initiatives launched in AY3 grew out of our emphasis on working collectively to maximize resources—human, financial and information—across agencies and silos.

We have many other examples of how the agencies are working together in these ways—and what is exciting is that our community partners are noticing. At our Steering Committee meetings and in our other workgroups, they are commenting that they see a new alignment between the agencies and that it helps them in their work. In addition, the administration as a whole is mirroring the SIM structure and

has created multiple other interagency teams—for instance on communications and policy and on active contract management.

Because of the importance of this emerging part of our model, we have included it in our state evaluation, and we will know more about the outcomes of the structure at the end of AY4.

Conclusion:

Our SIM stakeholders—both community and state, staff, and supporters—have valued the conversations that have contributed to this review of our state landscape and lessons learned. The process has been useful as we continue to determine how to sustain the health system transformation and population health improvements that are at the heart of SIM—as we also hope to sustain the most successful of the SIM project.

Next, please see the Accomplishments document, which finishes this Sustainability submission.