Rhode Island
State Innovation Model (SIM)
Test Grant

Better Health, Better Care, and Lower Cost

Final Report

September 27, 2019

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Disclaimer

Acknowledgements:

Summary of Model Test

Overview

Rhode Island is pleased to have received a State Innovation Model Test Grant (SIM) and to provide this Final Report on RI SIM to the Center for Medicare and Medicaid Innovation (CMMI). In these pages, we provide you with an overarching review of our work since February 2015, the final description of our model, lessons learned and most important achievements, and recommendations for the future of state-based health system transformation.
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As we noted when we began RI SIM, Rhode Island has a strong history of health reform. Our Office of the Health Insurance Commissioner (OHIC), created in 2004, provides us with a firm basis of legal and regulatory tools to take advantage of the Affordable Care Act and SIM. Some states used their SIM funds to create Patient Centered Medical Homes (PCMHs), but the fact that OHIC had sponsored the creation of PCMHs in Rhode Island years ago and supported them with their Affordability Standards meant that we could use our RI SIM funds to move transformation along even further.

Our Health Benefits Exchange, HealthSource RI (HSRI), has been a successful state-based exchange since the commencement of the Affordable Care Act (ACA) implementation. HSRI has worked closely with OHIC on rate review and policy initiatives, including reinsurance legislation, to keep insurance costs down.

The Executive Office of Health and Human Services (EOHHS) and Rhode Island Medicaid have worked together throughout the SIM years to use policy and implementation levers to retain safety net coverage for low-income Rhode Islanders and to implement health system transformation innovations with the creation of Accountable Entities (AEs) for Medicaid.

Also, throughout the SIM years we have fostered a Culture of Collaboration within the EOHHS Secretariat – including the Rhode Island Department of Health (RIDOH) and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) – that has been credited for changing how state departments work together. As a continuation of this new Culture of Collaboration, RI SIM participating agencies are now working closely together to support new efforts to promote integrated physical and behavioral health, child well-being, health information technology planning, behavioral health transformation, and more.

Finally, the RI SIM public/private partnership demonstrated by our monthly Steering Committee meetings and ongoing workgroups affirmed that true health system transformation requires participation from both inside and outside of government. The community leadership of our Steering Committee helped ensure that the state staff were serving both public and private needs and requirements.

We will begin our report by reviewing our vision, mission, and principles. When we submitted our initial SIM application in 2014, Rhode Island did not demonstrate as clear a "model test" as other states did. However, over the years of Cooperative Agreement, we developed a strong model and will use that as the outline throughout our report.

Figure 1: Rhode Island's Triple Aim
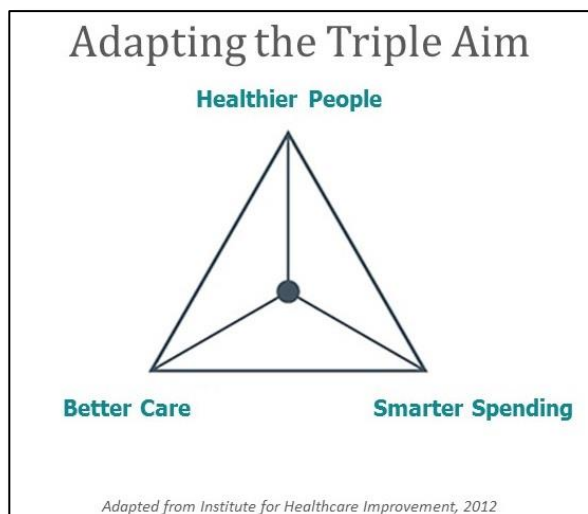
Vision

The vision of the Rhode Island SIM Test Grant represents the desired future state resulting from a transition to value-based care in the state. Our original vision statement, borrowed from the Triple Aim, read:

__Better Care,__ by continuously improving Rhode Islanders' (including quality and satisfaction); __Healthier People__, by enhancing the __physical and behavioral health__ of all Rhode Island's population; and __Smarter Spending__ on healthcare for our residents.

Adapting the Triple Aim

In Part One of our RI SIM Sustainability Plan, we reflected on what we have learned about our vision of the Triple Aim. The following descriptive language reflects the ways that RI SIM now understands and adapts the Triple Aim more completely, and clarifies what it means to us and RI SIM's vision for the future of the state's health system:

Better Health

We look at population health outcomes and disparities across the life course, focusing on equity and the integration of behavioral health (both mental health and substance use) with physical health (including oral health), while also identifying and addressing the social determinants of health (SDOH). Better health includes promoting social cohesion and connectedness to achieve active patient engagement and support recovery from addiction.

Better Healthcare

Better healthcare is achieved with a foundation of longer-term planning for an effective health system that melds payment and delivery reforms with investments in healthcare quality improvement and the health workforce (such as Rhode Island's inter-professional training initiatives), and in building the capacity to identify and address SDOH. Better healthcare includes a focus on provider satisfaction and avoiding burnout.

Smarter Spending

Smarter spending occurs in part through ongoing implementation of OHIC's Affordability Standards, with a continued emphasis on cost management strategies that use practice-based performance improvement strategies. We understand the differences between short-term and long-term cost savings. We also understand that long-term savings require investments (especially in our children) that are often reflected downstream in different areas than the initial expense. For instance, investments in children's behavioral health can reduce costs at the Department of Children, Youth, and Families (DCYF) in the future. Additionally, addressing SDOH will require building a system that supports strategic investments outside of healthcare, including one where financial risk and reward are shared across sectors. For significant long-term savings, we aim to prioritize investments that improve social services and support place-

based community infrastructure to address socio-economic and environmental determinants of health.

Mission

The mission of the Rhode Island SIM Test Grant was to significantly advance progress towards making this vision a reality. To accomplish this, the SIM Steering Committee adopted the following mission statement:

> *Rhode Island SIM is a multi-sectoral collaborative, based on data—with the patient/consumer/family in the center of our work. Rhode Island SIM is committed to an integrated approach to the physical and behavioral health needs of Rhode Islanders, carried out by moving from a fee-for-service healthcare system to one based on value that addresses the social and environmental determinants of health. Our major activities are providing support to the healthcare providers and patients making their way through this new healthcare system. We are building the system upon the philosophy that together—patients, consumers, payers, and policy makers—we are accountable for maintaining and improving the health of all Rhode Islanders.*

This report will illustrate how RI SIM maintained fidelity to its mission throughout the project and how the model we developed reflects the goals described here.

SIM Theory of Change

RI SIM began in 2015, after a planning process out of then Lt. Governor Elizabeth Roberts' office that resulted in the State Healthcare State Innovation Plan. When RI SIM began, Rhode Island's payment system was already changing to focus more on value and less on volume. We had one of the country's most successful Accountable Care Organizations (ACOs) (Coastal Medical), and Rhode Island Medicaid was also starting to build value-based entities (called Accountable Entities (AEs) in Medicaid). Carriers and health systems were already working together, and as noted above, OHIC was using its Affordability Standards to drive reform. Therefore, RI SIM did not need to start from scratch, and our Theory of Change was: *If* Rhode Island SIM makes investments to support providers and empower patients to adapt to these changes, *and* we address the social and environmental determinants of health, *then* we will improve our population health and move toward our vision of the "Triple Aim."

Figure 2: Rhode Island's SIM Theory of Change
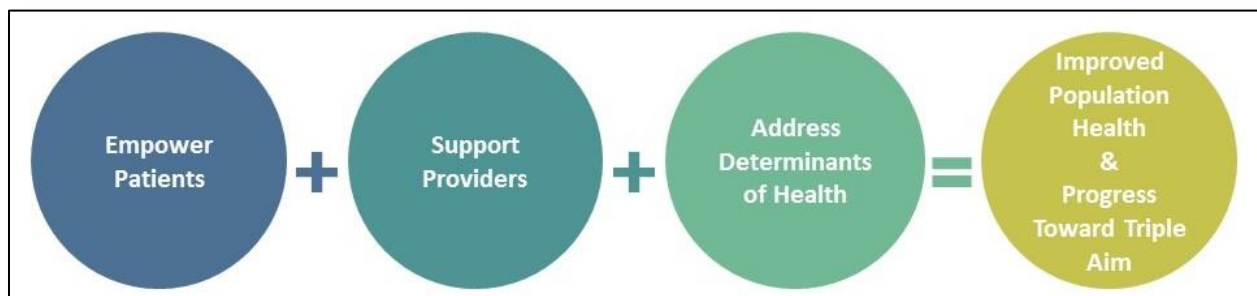
Developing our strategic vision did take some time, however. Our initial SIM request was $60 million, and our final allocation was $20 million. This meant that one of our first strategic tasks was to pare down our initial plan. Without a large model to fund, we had a longer list of

individual projects and it was not immediately clear how the projects could fit together. The state had determined that our public/private Steering Committee would make the final budget decisions (unique among SIM states). Therefore, one of our first key tasks was to finalize our work plan and budget for our [first Operational Plan](#).

When SIM Director Marti Rosenberg joined the project in October 2015, one of her first tasks was to meet with each Steering Committee member individually to get their perspectives and then to lead group Committee discussions. The Transformation Wheel below provided a breakthrough in the deliberations, as it helped clarify how our SIM Test Grant investments fit within a strategic vision for our healthcare system. With patients in the center, and the providers and others who serve patients around the circle, we chose three specific strategies to group our system transformation investments. Once the Steering Committee members saw how the disparate investments came together under these strategies, they unanimously approved the initial funding plan.

Figure 3: Rhode Island SIM Transformation Wheel (updated in 2017)
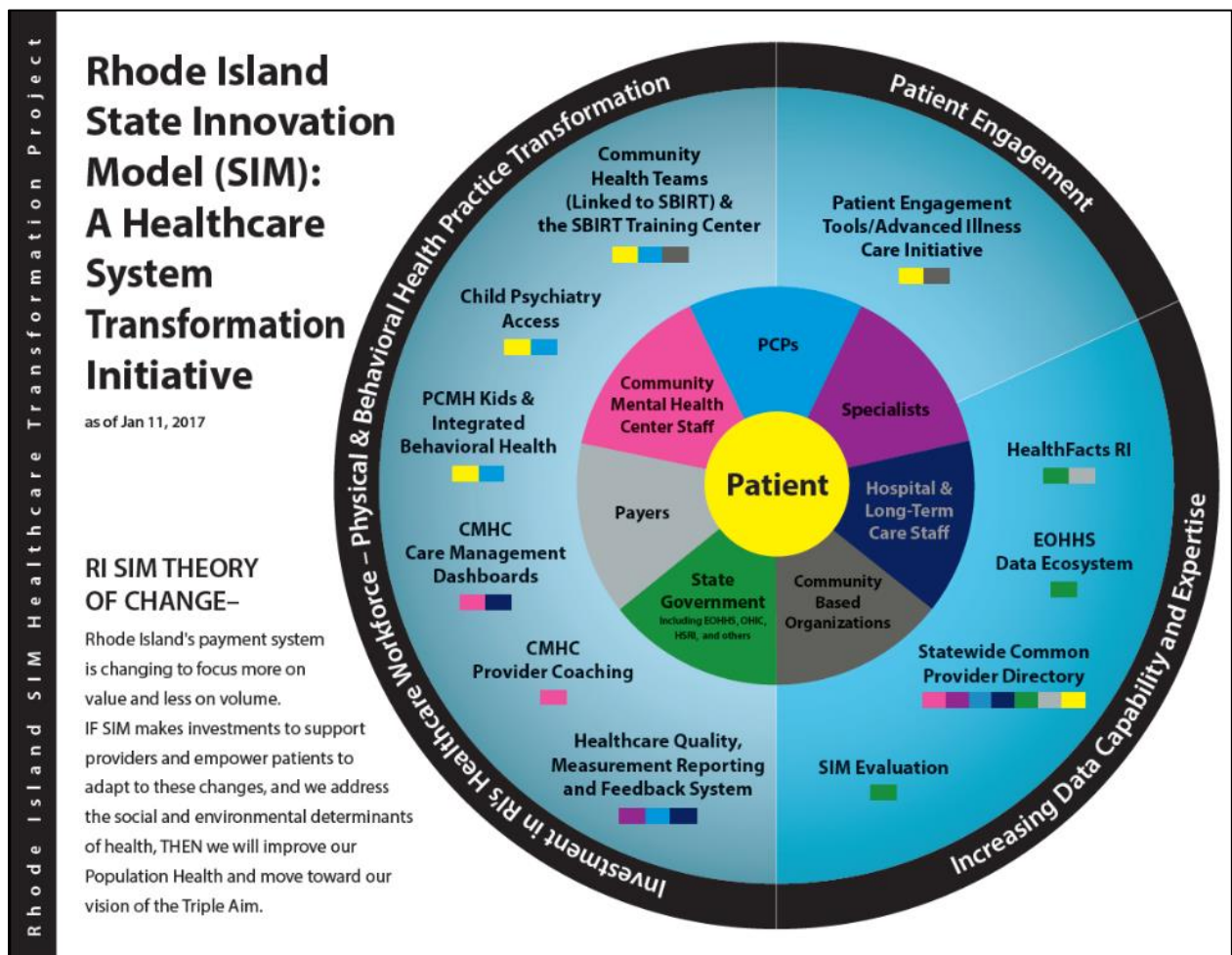
SIM Health Transformation Strategies
SIM's approach to healthcare system transformation combined aspiration and pragmatism, as we worked to align the state's shift from fee-for-service to value-based purchasing with practice

transformation and a focus on integrated population health. Rhode Island's SIM Test Grant was built on the premise that transitioning to healthcare payment models that reward value over volume, and incentivizing providers to work together, is a necessary step toward building a sustainable healthcare delivery system that reaches the following outcomes:

- High quality, patient-centered care that is organized around the needs and goals of each patient;
- The efficient use of resources by providing coordinated and appropriate care in the right setting; and
- The development of a vibrant economy and healthy local communities by addressing the physical and behavioral health needs of residents, including an awareness of SDOH.

Once the Steering Committee had approved the strategic workstreams, we aligned our funding to more specific strategies listed in Figure 4 below. Our practice transformation funding supported efforts to link payment to outcomes. We invested in infrastructure, both through our health information technology projects and our workforce strategic plan. Finally, we committed to improving Rhode Island's population health, especially in eight key focus areas described in depth in our SIM Health Assessment Report. Our SIM budget limitations meant that we were not able to budget as much money to projects that addressed population health as we did in infrastructure projects.

This constraint encouraged us to find more creative ways to carry out these activities, leading to our Integration and Alignment project. By identifying ways that state departments were already undertaking population health improvements, we leveraged other grant funding and staffing. But more importantly, these interagency projects led to the development of the Culture of Collaboration that became SIM's standard operating principle and has continued to inform the way EOHHS agencies, OHIC, and HSRI work together.

Figure 4: SIM Health Transformation Strategies

RI SIM Foundational Principles

The following core elements of Rhode Island's Healthcare Delivery System Transformation Plan provided a roadmap for achieving the strategies listed above.

1. Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing and regulatory levers. Rhode Island adopted the goals of having 50% of commercial, fully-insured and Medicaid payments under an Alternative Payment Model (APM) by 2018, and 80% of respective payments linked to value. As of the end of 2018, 46% of commercial healthcare payments were made under an APM. Furthermore, a significant percentage of commercial population-based contracts have transitioned to downside risk. By 2017, 62% of overall payments were value-based, with approximately 95% of hospital and primary care payments linked to quality.[1] OHIC will continue to focus on areas where the links of payments to quality are low, such as specialty care, in order to increase the overall percentage of value-based payments.

2. Support for multi-payer payment reform and delivery system transformation with investments in workforce and health information technology.
    i. *Investment in practice transformation & development of the healthcare workforce:* These investments in training, coaching, and technology improvements aimed to add to the skills and resources of the providers working within a transforming health system. This was the largest set of RI SIM investments, with a proposed budget of approximately $7.6 million.
    ii. *Patient engagement:* In order to ensure that patients receive the greatest value from payment reform changes, and that they are maximally engaged in positive health behaviors including self-advocacy, RI SIM invested $1.8 million to provide patients access to tools that increase their involvement in their own care.
    iii. *Access to increased data capacity and expertise:* Rhode Island's healthcare community agrees that we are not using data as effectively as we could be – and that we lack both standardized data collection, and training of staff responsible for collecting, inputting, and analyzing the data. RI SIM invested approximately $6.2 million in this data capability pillar to help tie data to quality and outcome improvements.

3. Significant stakeholder engagement in policy development and RI SIM investment decisions through the RI SIM Steering Committee, SIM Workgroups, and agency-specific advisory groups. In Rhode Island, healthcare delivery system transformation is a public-private partnership.

4. Fidelity to our State Health Assessment Report to ensure that transformation is aligned with our vision of improved integrated physical and behavioral health for the state's residents, especially in our eight health focus areas.

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[1] The percentages are weighted by market share of the three largest payers in the RI commercial fully insured lines of business.

5. A Multi-Sector/Multi-Agency Approach. One of SIM's main strategies was to reach a new level of alignment and integration of our existing healthcare innovation initiatives with each other, and with new SIM-funded activities. This allowed us to build on our existing regulatory structure for reform (including OHIC's Affordability Standards and Rate Review capacity, Medicaid's AE and Managed Care Organization (MCO) oversight), expand the reach of these initiatives, avoid duplication of funding, and save money. The SIM Integration and Alignment Initiative sought to maximize impact of public and private investments by starting to build goal-directed, sustainable partnerships that we believe will ultimately cultivate a transformational culture of collaboration in Rhode Island.

The RI SIM Model:

All these foundational components—vision, mission, theory of change, our implementation wheel, and our principles—come together in our RI SIM Model, listed here and described below fully below as we report on our achievements:

1) Strengthening Community/Clinical Linkages
2) Integrating Physical & Behavioral Health
3) Building Workforce Capacity & Infrastructure
4) Integrating Health Information Technology
5) Contributing to a Culture of Collaboration

RI SIM Successes

Throughout our more than four years of work, the state agency, vendor, and private sector members of the RI SIM team focused heavily on the question of whether our activities and investments were working or making a difference. We conducted our own state-based evaluation with the University of Rhode Island (URI), and many of our vendors invested in evaluations of their own. We participated in the national evaluation with RTI and met with them monthly. Our staff team met weekly, planning and debriefing and planning again. We have reams of data to show how we (mostly) met our metrics, and we have one or two particularly notable projects where our test did not work as expected. We spent more than a year with members of our team intensely focused on sustainability, working to ensure that the projects that did work had a path forward either through new funding, agency activities that would continue, or regulations that would maintain the programs.

The outcomes we share throughout this report paint the picture that, yes, RI SIM was a success. But some examples from two particular weeks in August 2019 (6 weeks after RI SIM's formal end) may show more than any evaluation or list of data could.

In these two weeks:

- Two interagency teams, who had not previously written grants together, used the relationships developed by RI SIM to craft a planning grant application to create more family residential substance use disorder (SUD) treatment facilities (stemming from the

landmark Child Maltreatment report from the SIM-funded State Data Ecosystem), and a CMS grant application for improving Medicaid SUD provider capacity, built on what we learned and created through the SIM-funded Triad Behavioral Health Workforce project.

- o As of September 26, 2019, RI EOHHS was awarded the CMS SUPPORT 1003 grant.
- The interagency project focused on sustaining the CHTs met with the RIDOH Family Home Visiting Health Teams twice. They met first in our weekly planning meeting to develop the formal contract for our CHT expansion project for families at risk of SUD, and then as a part of a public/private strategic planning retreat for Substance Exposed Newborns. This alignment was sparked by the CMS release of the Maternal Opioid Misuse NOFO. Rhode Island decided not to apply for the CMS-specific funds, but instead is choosing to carry out a similar project ourselves, with funding from SAMHSA.
  - o At the planning retreat, RIDOH staff made a presentation about MomsPRN, which is a project built on the successes of the SIM-funded PediPRN project for child psychiatric access to primary care. With MomsPRN, Rhode Island's primary birthing hospital will work with obstetricians (OBs) to provide assistance for pregnant women and new mothers at risk for depression and SUDs. The staff doing outreach to the OBs are aligning the MomsPRN program with the CHT/Family Home Visiting outreach, to create one streamlined set of communications to these OB providers.
- Another interagency team is working to implement activities described by Governor Gina Raimondo in her Mental Health Executive Order, aligning four streams of work together that include capacity building for Community Mental Health Centers (CMHCs) (again, those served by the Triad Project) and a Behavioral Health Population Health Plan, served by what we learned during the SIM-funded population health planning work.
- Our Health Information Technology (HIT) team kicked off the formal Strategic Roadmap and Implementation Plan process with a new vendor, Briljent. The list of interviewees for key informant interviews and focus groups is pages long, based on the relationships built during RI SIM and informed by the SIM HIT projects. The HIT team put additional names on the list last week, based on a new energy happening around the eReferral system project that seemed like a distant goal during SIM.

This is just a snapshot of the work that is happening throughout the state – and this list does not include more work happening solely in the private sector. The value of the public/private collaborations that we have strengthened means that there are lines of communication open that will ensure that we bring all of these projects out into the public for shared implementation.

This snapshot does suggest, however, that RI SIM was indeed successful in many ways. We thank CMS and CMMI for your investment and assistance throughout the Cooperative Agreement period and encourage you to review the details of our work in this Final Report.

RI SIM Model:

In the following pages, we describe the RI SIM Model that was the subject of our test, and document outcomes in each of the model components. We also provide much more detailed information about our accomplishments for all of the SIM funded activities in Appendix 1, at the end of this document. Each of the projects is also linked to an associated two-pager on the RI EOHHS website.

Strengthening Community/Clinical Linkages

Community Health Teams (CHTs)

The Rhode Island Health System Integration Project: Coordinating CHTs and Screening, Brief Intervention, and Referral to Treatment (SBIRT) Sites, was aimed at reducing substance, opioid, and alcohol use, and reducing costly healthcare utilization. The Care Transformation Collaborative of Rhode Island (CTC-RI) maintained and supported place-based CHTs in regions of the state and implemented SBIRT to address substance use and behavioral health disorders throughout Rhode Island. Working with primary care providers, CHTs assessed high-risk patient's health needs and coordinated community-based support services.

The project carried out SBIRT screenings throughout the state in over 25 locations including primary care, hospital emergency departments, urgent care centers, and in the Department of Corrections (DOC). CHTs are an integral part of the health transformation plan to improve healthcare and health equity for high-risk, high need patients. CHT staff included medical, behavioral, and community health specialists, that varied across sites. CHT clients were selected to include patients with high medical, social, behavioral, and substance-related needs.

Project Goals included:
- Coordinating SBIRT and CHT activities to foster integrated care
- Implementing SBIRT in 10-12 clinical settings throughout Rhode Island
- Establishing and evaluating CHTs serving Rhode Islanders with greatest unmet clinical needs
- Establishing a consolidated operations model for CHTs and SBIRT to implement integrated health programs in a way that streamline efficiencies

Because the SBIRT project continues through Sept 2021, data collection for this project is ongoing. From our CHT evaluation reports, we know that SBIRT screenings and 10% random six-month re-screenings at CHT sites demonstrated that the SBIRT model works well in CHT settings: people who received brief substance use interventions reduced their past 30-day substance use by 30-40%, a finding that was both statistically significant and clinically meaningful.

Other evaluation highlights include:
- Data from one large site with multiple CHTs demonstrated that in spite of high levels of health and social needs, clients who participated in CHT care met or exceeded most Uniform Data System (UDS) targets for quality medical care.

- CHT clients were seen for an average of 4.7 months (140 days) of CHT care during the evaluation timeframe. Several statistically significant and clinically meaningful changes were demonstrated in many CHT clients who completed follow-up screenings through June 30, 2019.
- CHT clients who completed patient experience surveys were generally in strong agreement with items reflecting excellent levels of patient satisfaction with their CHT care.
- Over 14,000 Rhode Islanders were screened for unhealthy substance use and 20% of those screened received an intervention.

With braided funding from SAMHSA (SBIRT) and CMS (SIM), the integrated approach better supported patients and improved population health by increasing access to community services and resources to address social, behavioral, environmental, and/or complex medical needs. Post-SIM, CTC-RI has secured almost $4M in multi-payer support (Medicaid HSTP, SAMHSA SOR, and CTC multi-payer) to leverage the existing statewide CHT network infrastructure and to serve expanded populations, including but not limited to high risk children and families affected by SUD or opioid use disorder (OUD).

Health Equity Zones

The Health Equity Zones (HEZs), founded and coordinated by RIDOH, are one of the state's premier efforts to address SDOH and link the community to clinical infrastructures. They are becoming more and more effective at improving population health:

- The Pawtucket/Central Falls HEZ achieved a 44% decrease in childhood lead poisoning in Pawtucket by connecting community stakeholders to enforce existing lead remediation policy. In Central Falls, there was a 24% decrease in teen pregnancy. This HEZ was also the first municipality in New England to pass the Green and Complete Streets Ordinance, and their Walking School Bus program decreased absenteeism by nearly 64% and tardiness by over 80% at a local elementary school.
- Coordinated efforts in the Olneyville HEZ led to a 36% increase in access to fresh fruits and vegetables. The Olneyville HEZ also completed construction of 36 affordable rental homes that provided safe, affordable housing and improved neighborhood safety to low-income residents. They also implemented a walking school bus program and improved local parks.
- The West Warwick HEZ helped divert 46 opioid users from the criminal justice system, and they saw a 40% increase in redemption of SNAP farmers' markets benefits. This HEZ also adopted the policy of having Narcan in all police cruisers and implemented Narcan training and distribution and peer recovery services.
- Other HEZs established community gardens and farmers markets, implemented programs to improve maternal and child health, increased community engagement, and engaged over 1000 people in evidence-based chronic disease self-management workshops.

RIDOH leads a strong ongoing evaluation effort, with regular meetings including HEZ leadership from throughout the state. They shared the following lessons learned, which could help maximize population health improvements:

Funding: Improving population health through true community engagement needs a consistent and reliable funding base. When braided funding comes with different funding periods, timelines, and requirements from external funders, it creates administrative burdens that make planning and implementation difficult.

Measuring Progress: Over the past year, RIDOH implemented Statewide Health Equity Indicators, which offer a framework to identify and address disparities in SDOH throughout the state. This framework can be utilized to begin engaging multiple stakeholders and agencies to align their efforts to address these barriers to health among Rhode Islanders, through HEZs and other health equity initiatives. The HEZ model has demonstrated successes in coordinating existing community-based interventions and bringing together community stakeholders and residents to work toward common community-identified and community-prioritized goals.

Formal Evaluation Insights: The evaluation director from the Brown University Division of Biology and Medicine conducted a review of year-end reports submitted by each HEZ community to examine the structures, process, and outputs of each HEZ, and to identify common themes related to five evaluation questions developed by RIDOH in the second year of the HEZ initiative. Some key findings from this report were that there was an increase in collaboration and trust between HEZ participants over time, but there is a need for more evaluation to characterize those partnerships and the level and quality of engagement from HEZ participants and community residents. Additionally, several HEZs worked to enact policy changes at multiple levels, but those efforts may have been underreported and it is unclear how involved community residents were in policy-related efforts. Through this evaluation, HEZ communities also cited challenges such as staff turnover, inconsistent or limited funding, and difficulty sustaining community engagement.

The SIM Steering Committee doubled its contribution to the HEZs in Award Year 4, from $250,000 to $500,000, because despite all of the noted challenges, the HEZs continue to engage more community partners and increase their effectiveness over time.

Integrating Physical & Behavioral Health

Child Psychiatry Access Project

The Child Psychiatry Access Project (PediPRN) sought to increase the knowledge, skill, and confidence of pediatric primary care providers (PPCPs) in screening and managing children with mild to moderate behavioral health needs within their appropriate scope of practice in primary care. PediPRN is housed at Bradley Hospital, Rhode Island's sole pediatric psychiatry hospital, and provides same-day case consultations to PPCPs by Bradley staff psychiatrists in diagnosis and medication management. They also assist with care coordination by a licensed social worker, and provide referrals to indicated local behavioral health services as needed. Reducing the number of referrals to specialty psychiatry and keeping mild to moderate behavioral health needs within the primary care environment promotes the rational use of scarce specialty resources for more complex and higher-acuity children.

Throughout SIM, PediPRN provided consultation to 175 providers and served 693 unique children, exceeding enrollment targets for providers and reporting high provider satisfaction

with their services. PediPRN coordinated with another SIM-funded initiative, PCMH-Kids, to ensure all PCMH-Kids practitioners have access to PediPRN consultations. In response to requests from enrolled PPCPs, PediPRN developed and successfully launched the PediPRN Intensive Program, a CME-accredited course that provides advanced training in child psychiatry to PPCPs. A critical lesson learned was to start face-to-face outreach efforts to providers early and continue them frequently throughout the course of the project. In-person visits to PPCP's offices to support understanding and utilization of the available PediPRN services had a significant impact.

In addition, there is no up-to-date curated list of pediatricians practicing within Rhode Island, and PediPRN staff spend significant time developing and maintaining an internal list. Given that many child psychiatrists do not offer outpatient services and/or are not available for new patients, statistics on the availability of child psychiatrists often do not reflect the true need. In addition, identifying PPCPs within locales that have a shortage of available psychiatric services remains a challenge.

PediPRN's internal evaluation showed accomplishments in critical outcomes, including the following impact on utilization: The High utilizers (defined as more than 5 contacts with the program) showed higher increase in mental health claims managed by other providers than the Low utilizers (defined as 5 or fewer contacts) after participating in PediPRN. There were only minimal differences between the two groups in terms of change in other practice patterns. Higher utilizers showed higher proportions of claims handled by PCPs, as well as lower number of claims and higher cost for non-mental health claims. Notably, they also showed lower number of ER visits, and lower number of hospitalizations. Given the marked differences between these groups of providers in terms of patient populations, these results should be interpreted with caution.

PediPRN is fully sustained through combined funds from a Health Resources and Services Administration (HRSA) grant awarded to RIDOH, Blue Cross Blue Shield of RI (BCBSRI), and the van Beuren Charitable Foundation. Rhode Island Medicaid is currently pursuing CMS approval of a waiver to reimburse for telephonic psychiatric consultations for children and adults.

PCMH-Kids

PCMH-Kids is a multi-payer initiative that extends the transformation of primary care in Rhode Island to children and works towards achieving the triple aim of improving patient/family satisfaction, spending healthcare dollars more wisely, and improving population health. SIM funding, together with funding from the health plans, enabled an initial nine primary care practices to develop high quality, family and patient-centered medical homes for children and youth. Practices 1) received on-site and distance collaborative learning and coaching to support practice transformation, quality improvement, and improve patient and family centered care processes; 2) employed staff to provide care coordination and build team-based care; 3) achieved NCQA PCMH recognition; 4) increased access by offering care beyond Monday-Friday business hours; and 5) used Electronic Health Records (EHRs) to identify high-risk, high-need children and families and monitor population health, especially for developmental screening and body mass index (BMI). Through a Learning Collaborative effort, many of the practices have

integrated behavioral health into primary care by screening children for ADHD/ADD, new mothers for postpartum depression, and adolescents for SUDs.

Based on the outcomes of the PCMH-Kids pilot, Neighborhood Health Plan of Rhode Island (NHPRI) and UnitedHealthcare (UHP) supported a PCMH-Kids expansion in July 2017, that added ten additional practices, bringing the total numbers to approximately 66,000 covered lives and 120 providers participating in pediatric PCMH practices. Based on continued success, the health plans have additionally approved a third PCMH-Kids expansion that expanded the program to 17 additional practice sites in July 2019, with early onboarding that began in April 2019. With this expansion, PCMH-Kids will now represent more than 50% of the children in Rhode Island and nearly all of the state's pediatric Medicaid population.

PCMH-Kids and the Integrated Behavioral Health (IBH) initiative have also received national recognition. CTC and IBH primary care practice Associates in Primary Care presented at the PCMH Congress national conference in September 2018, and PCMH-Kids Co-Chairs (Drs. Patricia Flanagan and Elizabeth Lange) were honored with an AAP national award—the Calvin C.J. Sia Community Pediatrics Medical Home Leadership award—at the November 2018 annual meeting.

Some of the key metrics achieved by PCMH-Kids include: improved BMI and developmental screening and counseling; improved customer experience; improved postpartum depression screening; improved SBIRT for adolescents; and reduced ED visits (Year 2). PCMH-Kids will be sustained through multi-payer support and funding, with the potential for additional multi-sector funding.

Integrated Behavioral Health (IBH) Pilot
CTC-RI led an adult IBH PCMH project with ten adult primary care practices through joint funding from the Rhode Island Foundation, Tufts Health Plan, and SIM to:
- Conduct universal screening for depression, anxiety, and SUD;
- Improve access to brief behavioral health intervention for patients with moderate depression, anxiety, SUD, and co-occurring chronic conditions;
- Employ a behavioral health staff person (e.g., MSW) to lead interdisciplinary care coordination for patients with mental health and/or SUD conditions; and,
- Test a proposed financial model for long term sustainability with particular attention to ED and inpatient use/total cost of care.

A fundamental component of this project is the provision of training and consultation services by a subject matter expert in the integration of behavioral and physical healthcare. The subject matter expert is engaging and coaching all the practices, including physician leaders.

- 10 primary care practices, representing 42,000 adults, integrated behavioral health into primary care; patients are now systematically screened for depression, anxiety, and SUDs, which is now considered the standard of care.
- Universally, primary care practices communicated the positive impact IBH has had for providers and patients.

- CTC was able to demonstrate that IBH in primary care positively impacts [screening rates](#), [total cost of care](#), [ED visits](#) and [Inpatient visits](#).
- A more robust matched comparison quantitative research project with Brown University is underway with completion date scheduled for late 2019.

Based on the positive results from the IBH pilot program:

- CTC was able to secure funding from UHP and recently launched another IBH pilot program for adults representing nine primary care practices. These practices are in the process of implementing universal screening for depression, anxiety, SUDs, and health-related SDOH. During this expansion, CTC will reference the findings of SIM's billing and coding research completed by Bailit Health to inform their plans for the future.
- Medicaid's AEs have included requirements for implementing strategies to address behavioral needs within primary care; Integra (one of the AEs) is contracting with CTC to assist them with supporting practices with implementing behavioral health within primary care. Rhode Island Foundation and Tufts are providing funding to test the IBH model in pediatric practices; CTC will be selecting eight practices, representing 30,000 patient lives, to participate in a pediatric IBH learning collaborative opportunity.
- RIDOH obtained HRSA funding to implement universal screening (depression, anxiety, and SUDs) within OB/GYN practices and will be contracting with CTC to provide selected practices with practice facilitation support.

Billing and Coding

In May and June of 2018, the Bailit Health consulting firm interviewed individuals from six organizations to gain greater insight into several administrative barriers that were identified during the Care Transformation Collaborative of Rhode Island's (CTC-RI) evaluation of its IBH Pilot program. As a result of these interviews, and a review of CTC-RI's evaluation of its IBH Pilot program, Bailit Health identified the following administrative barriers to behavioral health integration in primary care:

- Patients are required to pay two co-payments on the same day for behavioral health services delivered in an integrated primary care setting;
- There is variation in billing and coding policies for integrated services, causing confusion among practices and inconsistencies in what services are reimbursable; and
- There is variation in payer credentialing of provider practices in an integrated environment.

In its 2019 Care Transformation Plan, OHIC established the IBH Work Group (Work Group) to identify potential solutions to the aforementioned barriers. The Work Group met four times between February and June 2019. Each meeting was well attended by between 40 and 50 people. Among the people attending were representatives of integrated and non-integrated primary care practices, behavioral health providers practicing in integrated and non-integrated settings, hospital-based systems, community health centers, health insurers, and consumer organizations. In between meetings, OHIC and Bailit Health interviewed three primary care practices and requested information from insurers. OHIC and Bailit sought data from the primary care practices and insurers to help quantify the administrative barriers being discussed, and to identify payer policies and practices related to the issues of focus. Findings from these

information gathering efforts were used to support Work Group discussions. In August of 2019 the Work Group completed a report of recommendations for the Health Insurance Commissioner's consideration. Below is a summary of the Work Group's recommendations:

1. Payers should eliminate copayments for patients who have a behavioral health visit with a qualified in-network behavioral health provider on the same day and in the same location as a primary care visit at a qualifying primary care practice. The Commissioner will determine which practices are qualifying practices based on responses to questions added to the existing PCMH survey for health plan administration beginning January 1, 2021. Payers will also need to develop a code modifier or another process that when implemented by practices is as consistent as possible across payers and approved by OHIC.

2. Payers should adopt policies for Health and Behavior Assessment/Intervention (HABI) codes that are no more restrictive than current CMS' Coding Guidelines for HABI codes.

3. Payers should remove limits on coverage and eliminate out-of-pocket costs to patients for the most common preventive behavioral health screenings for the most common behavioral health conditions in primary care, so long as the behavioral health screen is clinically appropriate and administered by an individual under their scope of practice and who is eligible to bill payers for their services.

These regulatory changes should make a meaningful difference for patients seeking integrated behavioral health care and for providers striving to provide this important care.

Behavioral Health Rate Modeling

In order to continue RI SIM's work toward behavioral health parity, an interagency group contracted with the Milliman consultant firm to have them complete a review of the rates for the following services in order to support Rhode Island's behavioral health safety net providers:

- Integrated Health Homes (IHH)
- Assertive Community Treatment (ACT)
- Mental Health Psychiatric Rehabilitative Residences (MHPRR)
- Residential Programs for Substance Use Disorders (SUDs)
- Partial Hospitalization
- Intensive Outpatient Services and Programs
- Psychiatry/Prescriber
- Registered Nursing
- Principal Counselor/Counselor

The firm carried out a complete rate modeling exercise for these services, which entailed developing a framework of an "Independent Model" which works to estimate the costs of services built from the "ground up." Milliman achieved this by estimating the labor costs associated with providing each service, and utilizing publicly available data, such as from the Bureau of Labor Statistics, coupled with information gathered from in-person interviews with

behavioral health providers. Milliman also communicated their progress with a state team to ensure proper input from key personnel.

Milliman completed in-depth interviews, engaging our provider community to ensure collaboration and complete understanding of the services being offered in Rhode Island. By the end of the SIM grant period, the consultants began the process of completing a final report. The rate review was jointly funded by SIM and with additional funds from BHDDH. These BHDDH funds continued the work beyond the end of the SIM grant. Ensuring the financial stability of safety net providers will help strengthen the overall service system—and integrating and destigmatizing behavioral health through this work directly relates to and enhances other RI SIM initiatives, such as IBH.

Building Workforce Capacity & Infrastructure

In this section of the report, we provide details on three specific RI SIM-funded projects, and then discuss our more overarching Workforce Transformation more fully below.

Behavioral Health Workforce Development Project

The Behavioral Health Workforce Development Project, henceforth referred to as the Triad Project, set out with the explicit goals of: improving outcomes for consumers with behavioral health (BH) conditions; increasing the skills and effectiveness of providers in evidence-based practices in line with BHDDH's core competencies; improving provider capacity to address leadership development, recruitment and onboarding of new staff; empowering and supporting existing staff along a career lattice; and creating a sustainable approach to organizational and staff development. Led by JSI Research and Training Institute, Inc. (JSI) with Rhode Island College (RIC) and the Substance Use and Mental Health Leadership Council (SUMHLC) as subcontractors, the Triad engaged 273 staff across 17 organizations in direct trainings; 128 providers in collaborative statewide meetings; and worked with 21 organizations on infrastructure development through multiple avenues, ultimately impacting 711 additional staff due to professional development and infrastructure changes. Participating providers overwhelmingly (>80%) rated offered trainings as 'excellent' in knowledge level of trainer, preparation of trainer, responsiveness to their needs, and in communication style.

The Triad Project supported the creation of partnerships for pipeline development of a more diverse behavioral health workforce. Partners included behavioral health organizations, universities, and community-based economic development organizations. New internships were developed in collaboration between Dorcas House International (a refugee and immigrant services nonprofit), Community Care Alliance (a CMHC in a critically underserved area), and Parent Support Network with eight students being placed in internships. More supportive internships were developed between CCA and RIC. Ten students were placed in this enhanced internship model which included an integrated curriculum supporting students interning as they were exposed to a variety of behavioral health roles within CCA.

A major accomplishment of the project was the creation of a set of competency manuals for specific roles validated broadly among the Rhode Island BH provider community, which BHDDH's Division of Quality Management have taken up as standards of quality care to be used for technical assistance in the continuous quality improvement process with BHDDH-licensed providers. These manuals cover SUD counselors, case managers, milieu counselors, medical

assistants in behavioral health agencies, and nurses employed in a residential treatment setting. Another critical success was the education of leaders and clinical supervisors at behavioral health agencies to improve the retention of employees by promoting empowerment and teamwork within their organizations. A better trained and supported workforce will manifest enhanced competency and job satisfaction, ultimately improving retention.

JSI cited the following key lessons learned in their internally developed evaluation report:

1) Onsite training broadens access across staff of an organization and ensures that many people can apply learning together. This helps the organization shift its approach and implement new concepts, as it is difficult for one team member to "take a new concept home," such as onboarding, and then be successful in the change management process without support and engagement across multiple levels of an organization.
   a) This model was implemented with the Yale Leadership training and with on-site technical assistance offered via individual subcontracts and after the Clinical Supervisor Coaching Academy, all of which demonstrated the success of this principle of generating multi-level organizational buy-in.
2) There are constraints in developing career ladders. Rhode Island's BH agencies understand the benefits of providing a career lattice for their staff and that it is a key component of an overall strategy to improve staff recruitment and retention. However, agencies identified the insufficiency of current reimbursement rates as a primary barrier to developing upward and lateral mobility options for employees. Agencies are unable to offer financial rewards to staff who develop new skills and acquire new responsibilities.
3) Leadership turnover is a driver in low workforce retention. Investment in leadership development that can stabilize leadership supports staff retention across the organization.

JSI's formal evaluation report additionally outlined these primary future-looking takeaways:

1) It is important to pilot trainings and get feedback from target agencies before scaling distribution.
2) Development of standard competencies provides a common framework for future training aligned with what provider organizations have identified as key skills and knowledge needed for their staff.
3) The relationship between BHDDH and its licensed agencies around training benefits from the culture and message of BHDDH supporting organizations as a technical assistance provider.
4) The Triad model created a bridge between providers and academic institutions that supported investments in curricula development and revision from the academic perspective, and training opportunities from the provider perspective. Further benefit was found in supporting linkages that can work collaboratively on workforce development.
5) Quality measures for BH service are linked to designing workforce development plans and identifying the skills and trainings of most value for the improvement of service quality. Continuing investment in and thinking on health outcome measurement science in behavioral health will support and guide the future of workforce development.

Interprofessional Community Preceptor Institute (ICPI)

The ICPI is an ambitious undertaking that brings Medicaid's IHE partners (in addition to the Alpert Medical School at Brown University) together with SIM's public health and population health partners to expand community-based, interprofessional education, and practice. The

ICPI is responsive to several workforce transformation priorities identified in the Report, including:

- Expanding Community-Based Health Professional Education;
- Preparing the Current and Future Health Professionals to Practice Integrated, Team-Based Care; and
- Teaching Health System Transformation Core Concepts, including SDOH, health equity, and population health.

Historically, health professional education and practice have been conducted in silos that limit opportunities for collaborative, team-based learning and caregiving—often to the detriment of health professionals and their patients/clients. Furthermore, clinical experiences for health professional students are frequently limited to acute care institutions, even as care and services increasingly move to outpatient settings. To offset these trends, the ICPI set out to:

a) expand opportunities for interprofessional teams of students to learn with, from, and about one another in community settings;
b) Increase student understandings of population health and SDOH;
c) Train and support staff from community-based healthcare and social service providers to serve as preceptors for interprofessional teams of students;
d) Strengthen interprofessional practice in community settings; and
e) Develop pathways to employment from IHEs to community-based providers.

In less than 18 months, the ICPI conducted extensive outreach and recruitment, developed curricula for community-based preceptors and students, provided training and support for two separate cohorts, conducted an in-depth program evaluation, produced a video about ICPI, and established lasting partnerships among educators and provider organizations. In total, ICPI trained 29 staff from 15 healthcare and social service agencies who served as preceptors for 111 health professional students.

As a result of ICPI, the three public IHEs have increased their investments in, and commitment to, interprofessional, community-based learning. This includes long-term system changes at the IHEs, such as institutional support for interdepartmental and interscholastic coordination of clinical placements, faculty development, grant development, committees, research, and publications. In addition, as a result of a strategic planning process conducted in the last two months of the project, the IHEs (and the Brown medical school) reached consensus on a set of recommendations to:

a) Formalize and expand existing interprofessional education activities and partnerships under the auspices of the RI Collaborative for Interprofessional Education and Practice (RICIEP), and
b) Incorporate future ICPI efforts within the RICIEP.

Rhode Island Medicaid and its IHE partners are committed to sustaining the ICPI with HSTP funds and IHE resources.

HopeHealth Complex Care Conversations Training

HopeHealth (previously Hope Hospice and Palliative Care) conducted 31 eight-hour workshops that equipped participating clinicians with the knowledge and tools needed for effective prognostication, goals of care discussions, and advance care planning conversations with their seriously-ill patients. The program used experiential learning and role plays to educate

clinicians on how to effectively engage with their patients around end-of-life decision-making. Most clinicians never receive this type of training and as such, the Complex Care Conversations Training had a significant impact on the attendees who completed our three-month follow-up evaluation, all of whom are members of the healthcare workforce.

As a result of the training, the majority of respondents now focus on building trust, being respectful and seeking permission from patients before beginning a goals of care conversation and ensure that they understand their patient's goals at the end of the conversation. Most felt that the training improved their patient communication abilities overall and almost 90% felt that they are better able to respond to patient and family emotions. More than 90% felt the training improved their ability to identify the patients who could benefit from a goals of care conversation.

Through the use of learned tools and strategies for having complex care conversations, we hoped to reduce burnout and improve satisfaction among clinicians who care for seriously ill patients. In addition, a healthcare workforce that is more communicative and understanding enhances the patients' ability to be engaged in their healthcare decisions. Clinicians who participated in the Complex Care Conversations training reported on a number of changes to their practice patterns as a result of the training and demonstrated a positive impact on both patient and clinician experiences.

In addition, HopeHealth has received a commitment from the two internal medicine residency directors at Brown to send all of their second-year residents to the training, as well as their general internal medicine faculty members. True clinician transformation will occur when teaching clinicians how to effectively talk with and engage their patients becomes as much a part of medical education training programs as understanding anatomy and disease processes. While HopeHealth did achieve targets for number of clinicians trained, only 30% of the 508 attendees were physicians or other ordering clinicians. One of the most frequently heard objections to the training from physicians was "*I've been having these conversations with my patients for xx years, I know how to do this already*". Ordering clinicians reported high confidence in their own abilities prior to receiving the training. Those that completed the training were asked to reflect on their skills beforehand compared to after; overwhelmingly, they agreed that their preexisting confidence overinflated their actual skill. This distinction proved a significant barrier to engaging ordering clinicians even for free CME-accredited training.

HopeHealth anticipates that an external pressure such as the State of Rhode Island mandating Complex Care Conversations Training to be part of continued medical licensure will be necessary in order to engage the clinicians that can make the most impact on systems change. Another explicit area for improvement is targeted outreach to engender higher participation from specialists who would greatly benefit from the training. The majority of physicians trained under SIM were internal medicine practitioners, while specialties that would highly benefit were not well-represented (such as oncologists, cardiologists, and nephrologists).

Additional End of Life Projects: [Advance Care Planning](#) & the [Consumer Engagement Platform](#)

RI SIM also supported two additional end of life projects: Advance Care Planning (ACP) and Community Campaign through Healthcentric Advisors (HCA), and development of the

Consumer Engagement Platform (CEP) through Rhode Island Quality Institute (RIQI). Both investments demonstrated improvements to optimize workforce capacity and infrastructure. Through the Advance Care Planning (ACP) and Community Campaign, HCA accomplished the following:

- The ACP project created a Train-the-Trainer curriculum for physician's offices, nursing homes, assisted living facilities, and nursing education programs, and created a network of ACP educators throughout this work.
- The effort reached over 597,000 consumers through communications campaigns, with most reached through social media. For those who attended in-person community events, 95% reported that they understood the importance of ACP and 85% indicated a desire to complete an advance care plan.
- There was a 127% relative improvement rate in participating providers' use of ACP billing codes.

This project was a one-time investment that has resulted in concrete collateral that can continue to be used to reach and educate Rhode Islanders on advance care planning and end of life decisions.

Please see the description of the CEP below, in the Health Information Technology section of this report.

SBIRT Training and Resource Center

The SBIRT Training and Resource Center provided training and support to healthcare workforce across all levels of healthcare spectrum to improve their abilities to motivate and educate patients with risky or unhealthy substance use. The Center was one of RI SIM's first procurements and was able to easily surpass its goal of training 250 providers throughout Rhode Island, with a total of 1555 providers trained.

Beyond the numbers, however, the Center carried out a project that RI SIM sees as critical to addressing Rhode Island's opioid crisis and our significant behavioral health needs: addressing the stigma. We know that research carried out by RIDOH's Substance Exposed Newborns Taskforce showed that stigma is still one of the top issues facing patients as they determine whether and how to seek treatment for addition. With SIM funding, the Center directly addressed stigma with its public awareness campaign: "We Ask Everyone." They distributed 1,255 "We Ask Everyone" pins and 487 "We Ask Everyone" posters to underline that screening for substance use was universal in providers' offices. And in the final SIM year, they worked with providers to expand the "We Ask Everyone" campaign to include questions about gender, sexual identity, and end of life issues.

The Autism Project - Conscious Discipline®

Through our Health System Transformation work, Rhode Island SIM funded a pilot project to address children's social and emotional needs through the Autism Project of Rhode Island. Conscious Discipline® (CD) is an evidence-based, classroom program with pilot teacher training sites in elementary schools in Providence, East Providence, and Burrillville.

The strengths-based program helps teachers, students, and parents respond to everyday events, including conflicts, as learning opportunities. Both adults and children learn constructive approaches to regulating their emotions and using better decision-making strategies, laying a positive foundation for children's futures. Over the course of the SIM grant, the Autism Project and Conscious Discipline (CD) has served over 300 students, with fourteen teachers and administrators who attended multi-day CD trainings. 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 ranging from 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.

Integrating Data and Heath Information Technology

Health Information Technology (HIT) was a key component of the RI SIM project from the very beginning. Indeed, one of the most important lessons learned from our overall SIM project was that HIT needs to be at the center from the kick-off of any project, because if we do not know what data we need to collect and how we are going to store and analyze it, we cannot be effective.

RI SIM funded five external facing HIT systems and one state-focused project: the State Data Ecosystem. The Ecosystem is an integrated data environment that provides operational analytic solutions to state agencies and self-service analytics for staff across the state. We have integrated, at the person level, ten data sources across EOHHS and a few other agencies; developed a robust person matching process; and delivered several major and dozens of smaller data-driven projects that have, in some cases, directly led to state policy changes.

The project Goals and Objectives were to:

- Create a mechanism to access integrated data for each person, tied to operational purpose, in a user-friendly way that enables self-service analytics for operations and increases performance management.
- Develop programs that respond to lived experience, help Rhode Islanders fulfill their potential, and responsibly steward state resources using the integrated data made available to State agencies.
- Respond nimbly to changing policy and operational needs while controlling total costs through the State's ownership, operationalization, and optimization of the data ecosystem.

As we developed the Ecosystem, we identified nine principles that provided the foundation for the work.

- Curated: Environment is agile and includes only relevant data elements

- Secure: Adheres to best practices and industry standards through regular, independent security audits, regular testing, and role-based permissions
- Builds on existing environment
- High quality: Data is standardized, verified, and cleaned
- Drives agency performance: Provides specific, critical data to drive agency operations
- Collaborative, data-driven culture: Cross-agency governance structures built with agency input, program-led product design
- Interactive: Intuitive tools plus a simplified model encourages use by all authorized users
- Integrated: Data for each person is connected across state agencies

After the initial creation, the Ecosystem team carried out the following:

- Three major board-approved projects completed—including the Child Maltreatment Report that has become the foundation of multiple post-SIM implementation projects
- 12+ smaller projects completed
- Established and fully operationalized the Ecosystem Data Integration Board and conducted quarterly meetings
    - The Board provides strategic oversight on new data integration and data product selection and ensures that the work aligns with Medicaid priorities. The Board includes SIM leadership
- Established and fully operationalized the Data Stewards Group and conducted monthly meetings
    - The Data Stewards Group supports the functional implementation of new data sources and data product development and implementation
- Integrated ten data sets at the person level within the ecosystem environment
- Licensed, onboarded, and provided training to 100 PowerBI Users to increase data access and self-service

And therefore, the Ecosystem team achieved the following accomplishments:

- All EOHHS agencies executed an Executive Data-Sharing Agreement that specifies the overarching use cases for which data can be shared among EOHHS agencies.
- Ten data sources have been integrated—linked at the person and family level—including Medicaid claims, vital statistics, behavioral and mental health, early intervention, immunization, lead, the Rhode Island Department of Labor and Training (DLT) wage, and Supplemental Nutrition Assistance Program (SNAP) Temporary Assistance for Needy Families (TANF), and Childcare enrollment data.
- As a result, the Ecosystem has developed and deployed many previously unavailable reporting dashboards to support key EOHHS business priorities.

One of the most important components of work to create the Ecosystem—and one of our most important insights out of the project—was that the same Culture of Collaboration, described elsewhere in this report, was the key to its success. Sharing data takes trust, and trust takes careful development. Throughout this project, the Ecosystem team created data sharing standards and followed them conscientiously. The team created a model built on self-service, which is why they invested the time and energy in training their state colleagues on how to use the system and carry out their own analyses.

The state has sustained the Ecosystem for FY 20 and looks forward to continuing to benefit from its creation and development.

We describe the rest of our five HIT activities and the lessons learned from them in the Health Information Technology section below.

Sustaining SIM - Contributing to a Culture of Collaboration

As we have shared previously, RI SIM was an interagency project from the beginning, with participation from EOHHS, BHDDH, RIDOH, OHIC, and HSRI. RI SIM also worked with DCYF, the Department of Education, and the Department of Human Services at times during the cooperative agreement process.

One of the most important strategies RI SIM used to institutionalize this interagency partnership with embedded staff members, with our staff members at EOHHS, RIDOH, BHDDH, OHIC, and HSRI. The value of these embedded staff became clear throughout the project, as they ensured that the partnerships and the awareness of the effectiveness of true interagency collaboration were institutionalized. RI SIM funded a formal evaluation of what we eventually named the "Culture of Collaboration." In two surveys, a strong majority of the state agency staff and private sector members of the RI SIM Steering Committee affirmed that Rhode Island's interagency approach did create a collaborative culture:

Figure 5: Culture of Collaboration Evaluation Results - Overall

Overall Impression

The SIM initiative **cultivates a culture of collaboration** in Rhode Island's healthcare delivery system (n = 148; additional 9 abstained)

Rated 4 or 5

State Agency Employee: 81%

Non State Agency Employee: 85%

$\chi 2$ P-value = 0.96

83%   2018: 70%
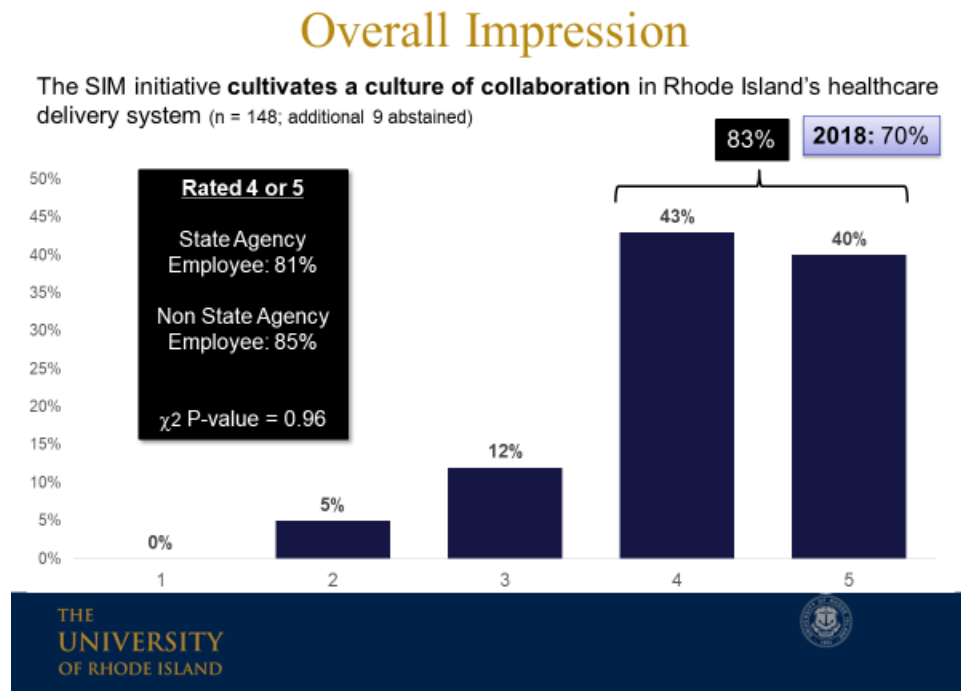
In addition, 78% of respondents agreed that the culture change was an effective approach to prioritize health system and workforce transformation and engage in strategic planning:

Figure 6: Culture of Collaboration Evaluation Results - Structure

SIM Structures Fit Engagement Needs

The SIM **governance model and steering committee structure** reflects the need to engage both public and private partners in healthcare transformation (n = 127; additional 28 abstained)

"I love how anyone can speak at these meetings…not just the committee members around the table…

…audience participation is encouraged, in real time—that makes this whole process and work stronger."

87% 2018: 75%

Rating	Percentage
1	2%
2	6%
3	6%
4	37%
5	50%
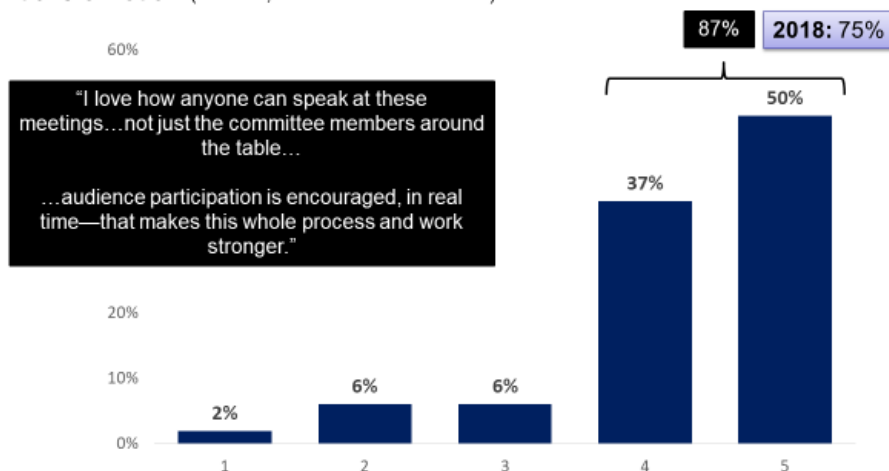
As Rhode Island looks to continue health system transformation post-SIM, we will continue to use this public/private model to maximize the value of our work. The most important structure for our public/private model was the RI SIM Steering Committee. The evaluation survey shows that participants felt that it was an effective table for decision-making and prioritization.

Figure 7: Culture of Collaboration Evaluation Results - Governance

Governance: Several Positive Attributes

General agreement that Steering Committee…	2018	2019
Has been effective for decision making and allocation of funding	62%	70% ⬆
Represents key stakeholders	72%	87% ⬆
Has been an effective approach to prioritize health system transformation needs and engage in strategic planning	71%	78% ⬆

Note: % indicates total who rated this statement as a 4 or 5 out of 5. Green arrows are of interest only – do not indicate statistical significance.

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Another key structure that SIM created was our quarterly vendor meetings, where we brought together all of the organizations that were doing the transformation work on the ground with the state agency representatives. During these meetings, we encouraged the vendors to work together on their own, not relying on the SIM staff to facilitate collaboration. This led to projects such as social work interns participating in the integrated physical and behavioral health practices and the three End of Life agencies meeting together to collaborate without SIM staff present.

Figure 8: Culture of Collaboration Evaluation Results – Public-Private Structure

Public-Private Structures Are Valued

Qualitative Themes: SIM Model

- Increased communication
- Increased understanding of roles
- Increased collaborations

Among and between state agencies and organizations

"At vendor meetings, I learn about what other folks are doing and **as a result, have created some partnering opportunities that I would not have known about** otherwise…

…by attending SIM Steering Committee meetings [I] had **opportunities to talk with other people that I would not have done otherwise**..."

"The **SIM table** has been an important place to bring State agencies, health plans and providers and other service providers into the **planning, development and implementation of key strategic initiatives** geared to improve population health."

As one of the focus group participants noted in the RI SIM evaluation of our Culture of Collaboration: "Because the [culture of collaboration] is now part of our culture, we're going to sustain it because now it's how we're used to behaving… it is the way we do business now."

The Culture of Collaboration has been one of the most important parts of our SIM sustainability plan. As you can see from our Final Sustainability Update, almost each of our 20+ projects have a sustainability path of some sort. For some of the biggest projects, the projects have additional grant funding or Medicaid dollars to continue the work (CHTs/SBIRT, PCMH Kids, IBH, State Data Ecosystem, eCQM, and Pedi-PRN). For others, we have leveraged other staff or regulatory opportunities (Measure Alignment, Child-Wellbeing (off of the State Data Ecosystem Child Maltreatment study), End of Life project, or the Behavioral Health Workforce training project). See the Measure Alignment Case Study below.

But the fact that our Culture of Collaboration has taken root in Rhode Island has led to some of the most important sustainability components of the SIM project. We have a growing number of interagency teams implementing activities stemming from SIM. We are coming together to seek new funding (currently, the pursuit of an ACF grant on Child Well-Being and a CMS grant on

provider capacity building); implementing new work (continuing and expanding CHTs); and carrying out strategic planning (HIT Strategic Roadmap and Behavioral Health Population Health Planning).

Indeed, throughout our sustainability planning for CMS (See [Sustainability Plan 1](#) and [Sustainability Plan 2](#)), we have determined that the definition of sustainability goes beyond just additional funding. Rather, it includes a range of organizational and regulatory activities that allow the activities to continue on through state government and in the private sector.

Sustainability Case Study: Measure Alignment

One strong example of RI SIM's sustainability planning and implementation is our long-term Measure Alignment project. We provide a case study of that effort here.

The Measure Alignment project began in 2015, just as SIM was getting underway. The Chair of our Steering Committee at the time, South County Health CEO Lou Giancola, wanted to address the number of metrics that individual providers and hospitals were mandated to report to carriers and quality organizations. The Committee wanted to ensure consistency and coherence in quality measures, to ease administrative burden on providers, and drive clinical focus to key population health priorities. The SIM team chartered a work group comprised of payers, providers, measurement experts, consumer advocates, and other community partners to develop an aligned measure set for use across all payers in the state.

Quality Measure Alignment Process

Because of former Chairman Lou Giancola's support for this process, he worked with the Hospital Association of Rhode Island, BCBSRI, UHP, and NHPRI to raise the funding to hire Michael Bailit and his team at Bailit Health to consult on this process. The Bailit team provided technical and facilitative support to the Work Group.

Award Year 1 - Pre-Implementation
The Measure Alignment Work Group held 12 meetings between July 2015 and March 2016. The goal that the Work Group set for itself was to develop a menu of measures from which payers could pick, and specific core sets of measures to be included in all contracts. At the outset, the Work Group adopted 11 criteria for measure selection:

1. Evidence-based and scientifically acceptable;
2. Has a relevant benchmark (use regional/community benchmark, as appropriate);
3. Not greatly influenced by patient case mix;
4. Consistent with the goals of the program;
5. Useable and relevant;
6. Feasible to collect;
7. Aligned with other measure sets;
8. Promotes increased value;
9. Presents an opportunity for quality improvement;
10. Transformative potential; and

11. Sufficient denominator size.

The Work Group used the measure selection criteria to assess the relative merits of including measures in the menu and core sets. Measure selection criteria were also used to score designated measures for a second round of review.

The Work Group reviewed existing measures used in value-based contracts between payers and providers in Rhode Island. These measures were cross-walked to the CMS Medicare Shared Savings Program and 5-Star measure sets to assess alignment using the Buying Value Tool. The measures were also cross-walked to SIM population health priorities, including diabetes, obesity, tobacco use, and hypertension. Measures were grouped by domain, including preventive care, chronic illness care, institutional care, behavioral health, overuse, consumer experience, utilization, and care coordination. The measures represented a mix of claims-based measures, and measures based on clinical data, or a combination of claims and clinical data. Work Group members were also asked to submit measures for consideration by the Work Group that were not currently used in contracting.

The final product 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. The Measure Alignment Work Group was silent on whether measures shall be used for payment only, versus payment and/or reporting. Specific targets and incentives associated with the measures will be left up to negotiation between the health plans and providers.

Award Year 2
The Measure Alignment Work Group convened in November of 2016 to conduct its annual review of the three measure sets that were endorsed by the SIM Steering Committee in March 2016. Under the facilitation of Bailit Health, the Work Group reviewed measures with a change in NQF or NCQA status, new HEDIS measures, and measures recommended by the specialist Work Groups. The Workgroup decided to remove two measures from the SIM Aligned Measure Sets because NQF removed its endorsement of those measures and recommended removing one additional measure pending Medicaid's input. The Work Group also added ten measures to the SIM Aligned Measure Sets, which included new HEDIS measures and recommended measures from the specialist Work Groups—described below.

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 2017 rates to be approved. The updated SIM Aligned Measure Sets will be effective for insurer contracts with hospitals, ACOs, and primary care practices beginning on or after January 1, 2017. Additionally, in January 2017 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 also be issuing an interpretive guidance document to payers for using the measure sets in contractual payment arrangements.

In an effort to align processes between commercial and public payers and 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 AE program anticipates alignment of the SIM quality measures as part of the program's APM or total cost of care guidance. The APM guidance is in the process of being developed.

In Award Year 2, SIM also convened two Specialist Measure Alignment Work Groups between July and October 2016 to develop recommendations for additional measure sets for specialty care, particularly for maternity care and behavioral health. Both Work Groups were composed of payers, provider groups, professional associations, state agency/public payer representatives, and advocates, and adopted the same selection criteria used by the original SIM Measure Alignment Work Group. The Work Groups reviewed specialist measures that are already included in the three measure sets, measures currently in use in provider contracts in Rhode Island, and measures recommended by Work Group members. Each Work Group developed a measure set with a "core set" and "menu set", consistent with the existing three measure sets. Additionally, the Behavioral Health Measure Set includes an additional set of "BHDDH Measures" that Medicaid Integrated Health Homes are required to submit to BHDDH.

Years 3-4 - Implementation
In 2017, Measure Alignment was successfully transitioned to OHIC after their regulations were updated to require commercial insurers to use the SIM Aligned Measure Sets in any contract with a financial incentive tied to quality[2]. The Measure Alignment regulation also states that OHIC will convene a Quality Measure Alignment Review Committee each year that will review all 5 measure sets and revise, remove, or add new measures as needed due to changes in clinical standards or statewide population health priorities. This Review Committee met and fulfilled its regulatory duties under the leadership of OHIC for the first time in the fall of 2017.

In anticipation of the 2018 annual review, OHIC convened a subgroup of the Work Group in June to discuss statewide strategic health priorities on which to focus during the 2018 Annual Review. The subgroup members expressed the most interest in the following priority areas: SDOH, behavioral health, access, and clinician burnout. The 2018 Annual Review consisted of four meetings between July 17, 2018 and August 27, 2018. The Work Group reviewed each of the five measure sets, considering: follow-up items from the 2017 annual review, measures with modest room for improvement, use of measures in contracts, measures Work Group participants proposed changing, changes to HEDIS measures, and potential measures to add addressing the four strategic health priorities. Following the 2018 Annual Review process, the proposed composition of the five measure sets as follows:

- ACO Measure Set: 63 measures (10 core, 47 menu, 6 developmental)
- Primary Care Measure Set: 35 measures (7 core, 22 menu, 6 developmental)

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[2] See OHIC Regulation 2, section 10(d)(3)

- Hospital Measure Set: 22 measures (8 core, 13 menu, 1 developmental)
- Maternity Care Measure Set: 10 measures (1 core, 8 menu, 1 developmental)
- Behavioral Health Measure Set:
  - Mental Health: 15 measures (0 core, 11 menu, 4 developmental)
  - Substance Use Treatment: 4 measures (1 core, 2 menu, 1 developmental)

The full list of measures in the SIM Aligned Measure Sets (including ACO, Primary Care, Hospital, Behavioral Health, and Maternity), guidance documentation, and measure specifications are posted online.

Using Health Information Technology to Support Aligned Measures

While the Aligned Measure Set Work Group was carrying out its initial review of the measures, the Health Information Technology (HIT) SIM team began to convene a Technology Reporting Work Group based on a directive from the SIM Steering Committee. The Work Group was led by the State Health Information Technology (HIT) Coordinator and the SIM HIT Specialist and included representatives from state agencies, payers, provider organizations, and quality improvement organizations. The Work Group conducted a survey of healthcare providers in the state in order to receive additional input on the concept of a centralized quality measurement, reporting, and feedback system—knowing that the Measure Alignment Work Group was carrying out its work. The Technology Reporting Work Group recommended using SIM funding for the development of a statewide quality reporting system with the following goals:

- Improving the quality of care for patients and driving improvement in provider practices by giving feedback to providers, provider organizations, and hospitals about their performance based on quality measures;
- Producing more valuable and accurate quality measurements based on complete data from the entire care continuum;
- Leveraging centralized analytic expertise to provide valuable and actionable reports for providers and to drive improvements in population health;
- Reducing the duplicate reporting burden upon providers and provider organizations by having a common platform for reporting;
- Publicly reporting quality measurements in order to provide transparency and support patient engagement in making informed healthcare decisions; and
- Using existing databases, resources and/or systems that meet our needs, rather than building from scratch.

The SIM Steering Committee approved this plan and the staff team carried out a formal Request for Proposals process starting February 2017. We finalized a contract with IMAT Solutions, Inc. in January 2018.

Throughout the development of this system, now officially named the Rhode Island Quality Reporting System (QRS), stakeholders were engaged through the Technology Reporting Work Group to guide and build trust in the development of the measures and data sharing policy. The initial implementation went live on July 8, 2019 and includes 53 measures, which were selected

based upon their inclusion in the Aligned Measure Set, Medicaid Meaningful Use reporting, or state reporting programs; their use of only clinical data; and their active use in contracts or programs. For example, a measure may have been in the Aligned Measure Set and required only clinical data, but did not appear to be used in any contracts, so it would not be included in the initial scope.

During RI SIM, eight total healthcare organizations began onboarding to the system. The July 8, 2019 launch marked one community health center entering production. Six of the remaining eight organizations had live data feeds into the test environment and were working on data validation, and the last organization was not able to initiate data feed efforts until post-SIM because of lack of attention from their EHR vendor.

Overall there is considerable engagement and interest from all major health insurers in Rhode Island and many healthcare organizations continuing to explore engagement. Further, the Technology Reporting Work Group is a demonstration of how competitors in the health insurance and healthcare marketplace can come together to support detailed review and input on the development of a statewide IT system and leverage the particularized expertise of various participants to create a better product.

Quality Reporting System Lessons Learned:

The original focus was on providers, but shortly after initiating work with the selected vendor it was discovered that payers also had significant in meeting emerging HEDIS requirements for clinical data exchange.

While originally the plan was to only receive data via a C-CDA feed, we quickly learned from practice experts that it was necessary to be flexible with how data was sent to the system, because some EHRs could not generate a well-formed C-CDA.

The original plan was to connect the HIE operated by RIQI to the new IMAT Solutions system to eliminate the needs for already-connected practices to purchase a new C-CDA interface. It took many months to determine that this was a complex effort due to legal and technical considerations that could not be accomplished successfully to ensure launch of the system during SIM. We made the formal strategic switch to connect practices directly in the fall of 2019. In the future it is recommended to parallel track the ideal (connectivity through the HIE) and the immediately possible (new feeds from EHRs) to support a pilot project.

IMAT would have been able to complete connection with practices very quickly (with an estimate of one to three months per EHR vendor). However, for the EHR vendors, this type of voluntary data sharing was a low priority and they were very focused on completing mandatory efforts for their clients. This led to unforeseen delays in connectivity of six to nine months, and we are now estimating future timelines factoring in this new information.

Based on the experience during our SIM effort, we have identified several key things that will be helpful post-SIM:
- Participation from more healthcare organization as data sources

- Continuing and new engagement from entities that ask providers to report to them
- Successfully implementing a connection with RIQI

Aligned Measures as an Example of Long-Term Sustainability

The alignment of these projects throughout the SIM process was notable. Prior to SIM, the HIT team and OHIC had not worked together in any meaningful way—and certainly would not have considered that the regulatory power of OHIC to require carriers to request data would have been implemented through a software project out of EOHHS. And because the Aligned Measure Sets are now officially part of the OHIC process, they will continue on, as a lasting legacy of the SIM project.

Now that we know the power of aligning these different approaches, we are taking steps to replicate them. For example, thanks to conversations held throughout the SIM project, we are convening a broad interagency team to determine whether and how to create an eReferral system with close the loop technology. EOHHS has written this into our IAPD plan for 90/10 funding; Medicaid is discussing this with their AEs; OHIC is interested in exploring this with its regulated carriers; and RIDOH, DCYF, the Office of Healthy Aging, and the Office of Veterans Affairs are all interested in how this will allow their stakeholders to address SDOH.

This case study is just one example of the ways that Rhode Island has used our SIM funding, SIM staffing, and interagency and public/private team-building to maximize our ability to transform both the efficiency of state government and our healthcare system as a whole.

Other Major RI SIM Strategies & Projects

The following are reports on our other major RI SIM projects: Alternative Payment Models (APMs), Population Health Improvements, Healthcare Workforce Transformation, and Health Information Technology.

Alternative Payment Models (APMs)

Payment Reform

The SIM grant tasked states with leveraging their regulatory authority to drive transformation of the healthcare system. The SIM Operational Plan identified OHIC and the Medicaid program as the principal state agencies for advancing payment reform in the state. The transition from fee-for-service to APMs was a core focus of the SIM grant. OHIC convened stakeholders to discuss various payment reforms over the life of the grant and developed the parameters of primary care APMs and other value-based payment models. OHIC sets payment reform standards for insurers, including annual targets for use of APMs, data reporting requirements, and quality program development and measurement requirements. OHIC's Affordability Standards established annual APM targets for commercial insurers to meet, and the Office monitors the use of APMs in the commercial market on a semi-annual basis.

Payment reform in Rhode Island has progressed significantly under the SIM grant. In last iteration of the Affordability Standards in 2015, OHIC established payment reform targets for 2016 through 2018. Working with its APM Advisory Committee, OHIC dove into discrete areas of payment reform, such as risk-based contracting, primary care APMs, and episode-based payments. In 2017, OHIC sought to deepen its focus on payment reform by developing a capitation model for primary care. In August 2017, the Primary Care APM work group completed its work and OHIC issues its final recommendations.

As of the end of 2018, 46% of commercial healthcare payments were made under an APM. Furthermore, a significant percentage of commercial population-based contracts have transitioned to downside risk. By 2017, 62% of overall payments were value-based, with approximately 95% of hospital and primary care payments linked to quality.[3] OHIC will continue to focus on areas where the links of payments to quality are low, such as specialty care, in order to increase the overall percentage of value-based payments.

There is evidence in Rhode Island and nationally that APMs have led to healthcare cost savings through the more efficient delivery of healthcare and more active management of patients' healthcare needs. OHIC views payment reform and delivery system transformation as mutually necessary activities to create a healthcare environment that supports affordable health insurance, access to care, and population health. OHIC is presently revising the Affordability Standards to extend payment reform as an imperative of public policy beyond the end of the SIM grant.

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[3] The percentages are weighted by market share of the three largest payers in the RI commercial fully insured lines of business.

Figure 9: Dollars Paid Under APMs and APM Dollars as Percent of Total Medical Spending 2014 - 2017
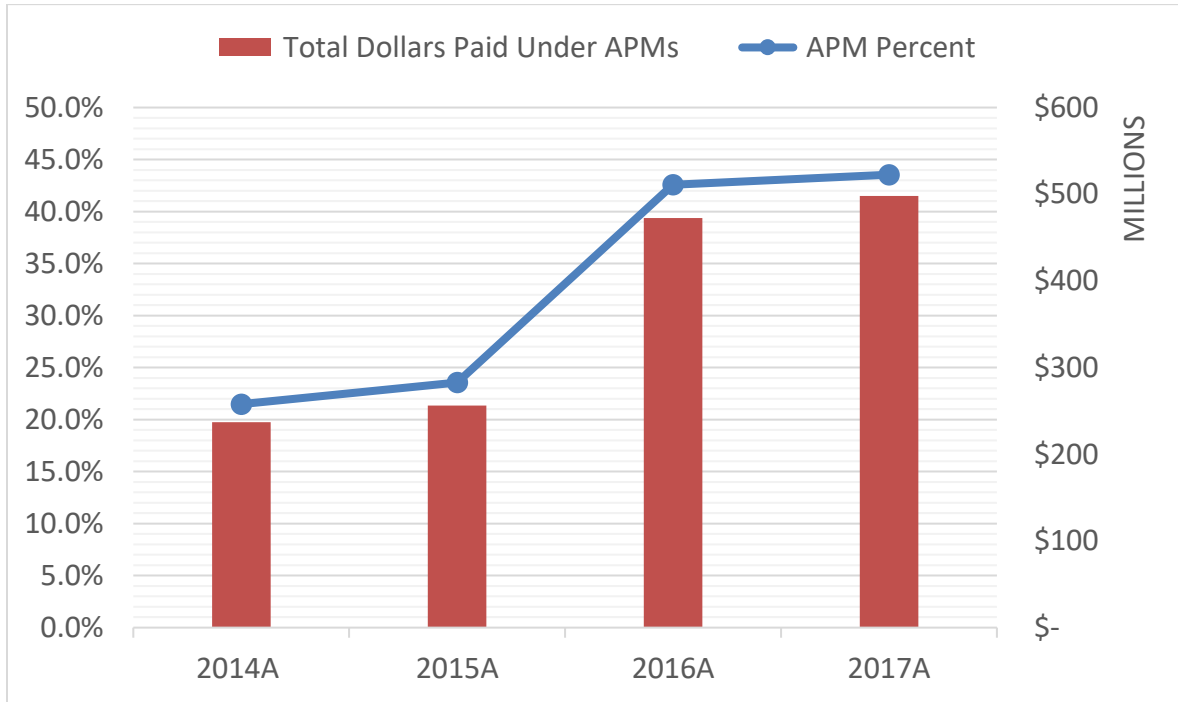

Figure 10: Dollars Paid Under Population-based Contracts | Total & Percent of Total APM Payments 2014 - 2017
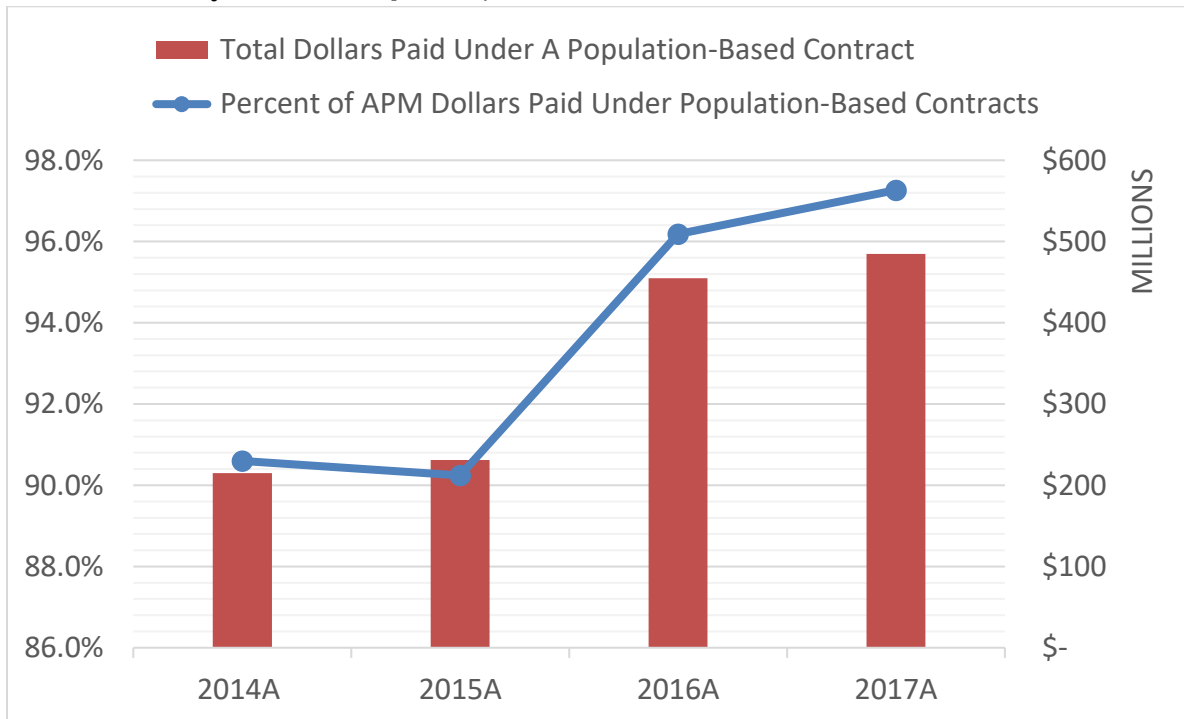
Figure 11: Distribution of Population-based Contract Claims Payments in Upside-only vs. Downside Risk Models
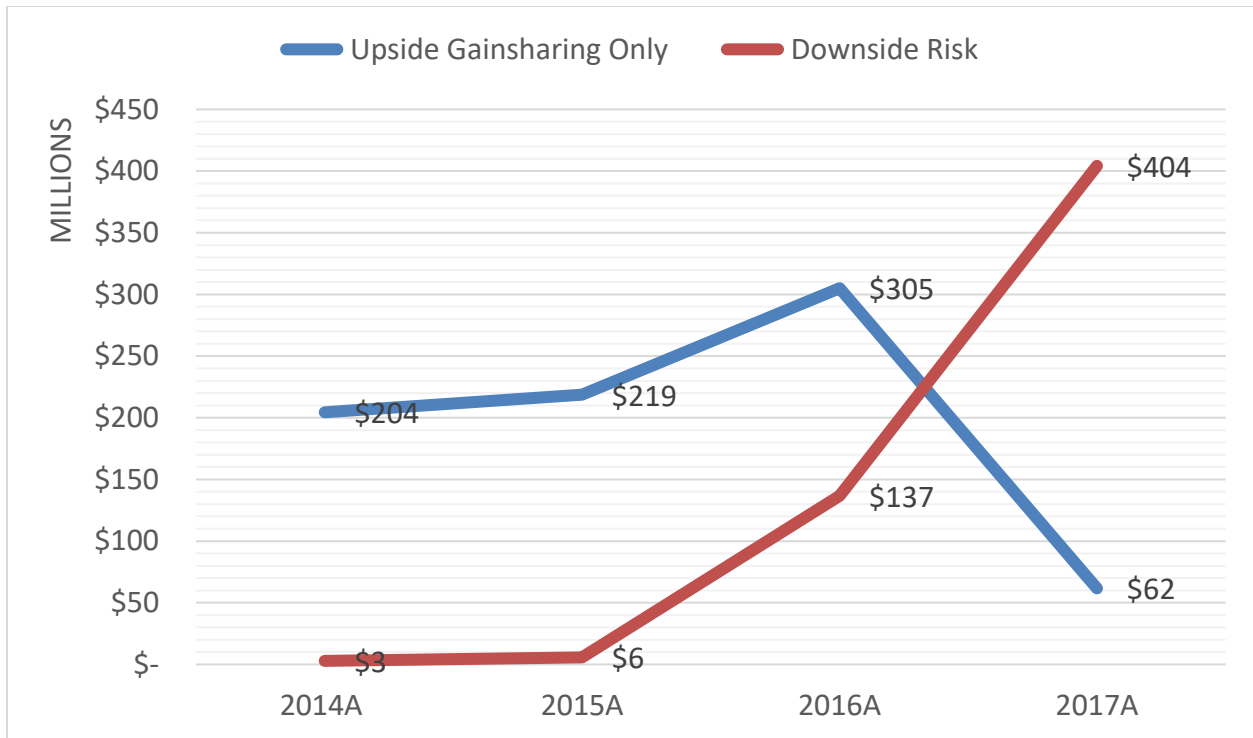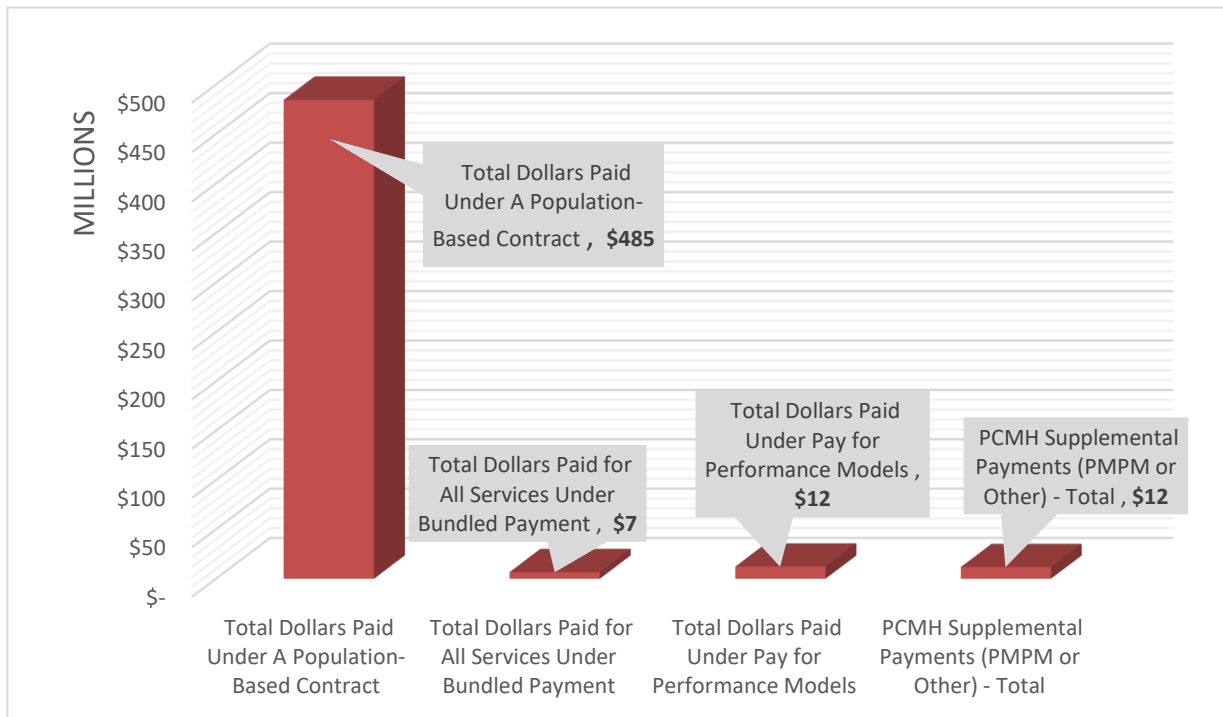

Figure 12: Distribution of Dollars by Type of APM & Non-FFS Sources in 2017

Population Health Improvements

In Award Year 2 (our first implementation year), RI SIM's Integrated Population Health Work Group met four times between February and May 2016 and their valuable input culminated in the completion of Rhode Island's Health Assessment Report that was previewed at the SIM Steering Committee's June 2017 meeting. In all our communications about the Rhode Island SIM project, we emphasize a lifespan approach to population health, spanning birth to death. We also emphasize a "whole person" approach that focuses on both mind and body. When we say "population health" we mean physical and behavioral health, with physical health including oral health, and behavioral health including both mental health and substance use. Rhode Island's SIM population health planning originally focused on seven key areas where we anticipated opportunities for improvements: obesity; tobacco; chronic disease (including diabetes, heart disease, and stroke); depression; children with social and emotional disturbances; serious mental illness; and OUD. During the summer of 2016, we decided to add Maternal and Child Health as our eighth SIM health focus area. Additionally, we began to discuss Oral Health in our population health work.

By the end of this period, SIM finalized the Health Assessment Report. Originally part of our Operational Plan, the writing of the Health Assessment Report emphasized the document as a free-standing, living resource that will serve as the state's central population health planning document in the future.

During the second implementation year, the Integrated Population Health Work Group process identified ways to integrate and align efforts of state and community agencies around our SIM population health focus areas. In addition, during the summer of 2016, our SIM team worked with SIM participating agency leaders to plan a facilitated brainstorm for SIM-aligned initiatives that would benefit from multi-agency participation and SIM support. After that work session, our SIM team carried out additional research and discussions to further flesh out the ideas.

After presenting the projects to the SIM Steering Committee for strategic guidance, three emerged as leading priorities: Chronic Disease—Identification of high-risk patients/SDOH; Tobacco Use – Aligning best practices; and Obesity—BMI data collection. This alignment stems from good, 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. Key accomplishments included:

1.   Chronic Disease; Project: High Risk Patient Identification and SDOH
Major accomplishments to date include:
   - Collaborative learning process to understand and share best practices in high risk patient identification
   - Consensus on importance of unified strategy on defining and measuring SDOH
   - Leverage the CEP project to build a HIT platform for SDOH assessment and standardized data collection

- Planned implementation of a pilot for screening and referral processes
- Partner with CHTs and other providers to work toward standardized data collection using Z-codes

2. Tobacco Use; Project: Aligning Best Practices in Tobacco Assessment, Referral, and Treatment.

 Major accomplishments to date include:
- 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, apparently one of the only states doing this
- Using claims to answer questions about utilization and reimbursement
- Reviewing regulatory framework for CTTS workforce
- Support streamlining of CTTS and other professional training programs
- Continued promotion of Quitworks and the Quitline
- Strategic alignment across state agencies

3. Obesity; Project: Leveraging Infrastructure for Statewide BMI Data Collection
 Major accomplishments to date include:
- Data project led by RI KidsCount, RIDOH, BCBSRI, and Brown University
- Aggregated clinical and claims BMI data for children in RI
    o Leveraged existing data sources
    o Analyzed representativeness of sample to draw localized conclusions around obesity
- Supported submission of claims data by major health plans to be included in data project
- Facilitated discussion at SIM Steering Committee to present data findings and consider further data collection or application of findings

In Award Year 3, RIDOH submitted work that resulted from the Tobacco Cessation Integration and Alignment Project to the Centers for Disease Control and Prevention (CDC) as the Tobacco Control Program's (TCP's) grant-required Year 5 Success Story. The work was entitled, "Integration of Cessation Services into Behavioral Health Programming to Impact Priority Populations in Rhode Island."

From 2016-2019, the TCP awarded CODAC Behavioral Healthcare a contract to deliver tobacco treatment services at designated health centers and to provide evidence-based treatment training to health and behavioral healthcare providers. CODAC, a non-profit organization based in Rhode Island, has provided treatment, recovery, and prevention services to individuals, families, and communities for more than 40 years. With locations across the state, CODAC is uniquely positioned to provide a wide range of outpatient and off-site services to those struggling with the challenges of substance use and other behavioral healthcare issues. During the contract period, CODAC created the Tobacco Cessation Services of RI (TCSRI) to focus on tobacco use and dependence with this population and to enhance and expand evidence-based cessation services for current tobacco users across the state by increasing treatment capacity

through a multi-faceted, reinforcing approach, and generate sustainability of tobacco treatment services. Ultimately, this initiative aimed to embed tobacco cessation services in the clinical settings as well as promoting use of Quitline services by this population.

In addition, as part of SIM final reporting, all vendors were asked to identify outcomes related to integrated population health that can be reviewed in latter sections of this report. Examples include: CHTs/SBIRT, IBH, PediPRN, Quality Measures Alignment, and OHIC Work Groups, among others.

In the last version of our SIM Operational Plan, our Population Health Plan was updated to include the following:

- Through partnership with RIDOH, SIM revised and transformed RIDOH's previous Community Health Assessment (CHA) into a living document called the Health Assessment Report (HAR). The HAR is the first component of the State Health Improvement Plan (SHIP). The SHIP was designed to meet SIM's requirements from the Centers for Medicare and Medicaid Services (CMS), RIDOH's requirements for a State Health Plan, and PHAB's requirements for a Community Health Assessment, and Health Improvement Plan.

- The **Health Assessment Report (Component A)** answers the question: *What Are Some of Our Health Problems?* The HAR provides an initial profile of eight aligned health focus areas across the State's and community partners' assessments. Profiles include historic trends, existing disparities, co-occurrences, and co-morbidities between physical and behavioral health conditions, considerations across the life span, and, where applicable, attributed costs. These profiles inform Rhode Island's population health planning efforts.

- Rhode Island's **Population Health Strategy (Component B—Page 84)** answers the question: *What Are Our Goals and How Are We Organizing?* The initial draft of this component encompasses the State's leading priorities, core strategies, and integrated population health goals (inclusive of key metrics) for improving population health. Specifically, this component will be further developed to articulate the commitment to developing the culture of collaboration across agencies and ensuring the collective impact required to improve population health outcomes for Rhode Islanders. Emphasizing the current and future states of Rhode Island's approach to improving population health, this component will delineate the roles that health system transformation, social and environmental determinants of health, and integrated physical and behavioral health have in improving health and addressing disparities. Post-SIM, we are carrying out a Behavioral Health Population Health Planning Process that is building on this Health Assessment Report.

- The **Health Improvement Plan (Component C--Example)** answers the question: *What Are We Doing to Achieve Our Goals?* This component currently provides specific details on activities being implemented to advance the State's integrated population health goals, organizing and delineating agency-specific key investments, activities that are essential to making health improvements a reality in Rhode Island. At this time,

RIDOH-specific activities have been delineated and a robust set of intermediate measures used to set targets for and assess progress toward implementation of key investments have been established. This component will ultimately be expanded to represent a multi-agency, cross-sector action plan for population health.

- Lastly, **Performance Monitoring Updates (Component D)** answers the question: *How Will We Know and Demonstrate How We Are Doing?* This component is, at this point, comprised of RIDOH's annual progress updates and reports reflecting the performance of key investments toward reaching the State's population health goals. Using the key metrics, intermediate measures, and other quantitative/qualitative reports, this evaluation of Rhode Island's approach toward improving population health will provide a continual opportunity for quality improvement. Other project updates are also being aligned and included, such as for the Opioid Overdose Task Force and the Community Health Assessment Group.

Healthcare Workforce Transformation

In the summer of 2016, SIM and EOHHS jointly initiated a Healthcare Workforce Transformation planning process to assess healthcare workforce development needs and capacity and to recommend priorities and strategies to prepare the current and future healthcare workforce with the knowledge and skills needed to help Rhode Island achieve its system transformation and population health goals. This planning process culminated with the issuance of a Healthcare Workforce Transformation Report, which identified the following three key priorities and accompanying strategies.

Healthcare Career Pathways: Skills That Matter for Jobs That Pay
Prepare Rhode Islanders from culturally and linguistically diverse backgrounds for existing and emerging good jobs and careers in healthcare through expanded career awareness, job training and education, and advancement opportunities.

Strategies
- Support the Entry-Level Workforce: Improve recruitment, retention, and career advancement
- Increase Diversity and Cultural Competence: Increase the cultural, ethnic, and linguistic diversity of licensed health professionals
- Develop Youth Initiatives to Expand the Talent Pipeline: Increase healthcare career awareness, experiential learning opportunities, and readiness for health professional education
- Address Provider Shortages: Remediate shortages among certain health professions

Home and Community-Based Care
Increase the capacity of community-based providers to offer culturally-competent care and services in the home and community and reduce unnecessary utilization of high-cost institutional or specialty care.

Strategies

- Expand Community-based Health Professional Education: Educate and train health professional students to work in home and community-based settings
- Prepare Healthcare Support Occupations for New and Emerging Roles: Prepare healthcare support occupations to work in home and community-based settings

Core Concepts of Health System and Practice Transformation

Increase the capacity of the current and future workforce to understand and apply core concepts of health system and practice transformation.

Strategies

- Prepare current and Future Health Professionals to Practice Integrated, Team-Based Care: Increase the capacity of health professionals to integrate physical, behavioral, oral health, and long-term care
- Teach Health System Transformation Core Concepts: Educate the healthcare workforce about the significance of value-based payments, care management, SDOH, health equity, population health, and data analytics.

Since its publication in May 2017, the Healthcare Workforce Transformation Report has served as a guide for workforce investments by the Rhode Island Medicaid Health System Transformation Project (HSTP). Through a partnership with Rhode Island's public institutions of higher education (IHE), Medicaid has invested HSTP funds in the development of career pathways, diversity initiatives, IBH, interprofessional education, experiential learning, research, and continuing education that are aligned with health system transformation goals.

SIM workforce investments have similarly been informed by the Healthcare Workforce Transformation Report and have leveraged the work of the Medicaid-IHE partnerships. Of particular note are the SIM-funded *Interprofessional Community Preceptor Institute (ICPI)* and the *Behavioral Health Workforce Development/Provider Coaching Project (Triad),* both of which are described above.

Workforce Transformation: Lessons Learned

As SIM has undertaken various transformative initiatives, it has become increasingly clear that it is not possible to transform the health system without also transforming the workforce. To do so, healthcare workforce transformation must focus on both the future workforce and the current workforce. It also must focus on the school as well as the student, the supervisor as well as the worker, and the sector as well as the employer. And it must consider the regulatory, statutory, and financial environment of the healthcare industry and the state.

ICPI and the Triad Project both highlighted the need for curriculum changes to better prepare future health professionals for our rapidly evolving health system; and, in response, the IHEs are developing or implementing new curricula, academic programs, and degree requirements.

ICPI and the Triad Project also highlighted the need for and the challenge of providing continuing education and professional development for the current workforce. While there is little disagreement about the importance of continuing education, both projects encountered significant barriers, including:

- Conducting training on-the-clock (often at the cost of lost revenue to the employer),
- Motivating employees to pursue training on their own time
- Rewarding employees who successfully complete training

ICPI and the Triad Project also reinforced the need for numerous strategies to improve workforce recruitment and retention, including:

- Career awareness initiatives;
- Outreach to underrepresented populations;
- Academic and career advising;
- Employer/education partnerships;
- School-to-employment pipelines;
- Experiential learning opportunities;
- Career ladders;
- Supervisor training;
- Employee engagement and satisfaction;
- Online and blended learning models;
- Licensure and other credentials that increase quality of care and jobs; and
- Provider reimbursement models that address workforce needs.

It is worth noting that many of the above strategies are equally relevant to other areas of critical workforce needs and shortages, most notably long-term care. It is also noteworthy that EOHHS has partnered with DLT to increase the awareness of the public workforce system about the needs and opportunities that exist in healthcare and social services and the importance of developing a comprehensive approach to healthcare workforce development such as is described above.

EOHHS remains committed to providing leadership that will continue to build upon the work of SIM, including the need for workforce transformation initiatives that support the state's vision for health system transformation.

Health Information Technology

Statewide Common Provider Directory

Using RI SIM funds, Rhode Island contracted with its state-designated entity for HIE, Rhode Island Quality Institute to build a Statewide Common Provider Directory, with an overall investment of $1.64 million. The directory was to consist of detailed provider demographics as well as detailed organization hierarchy. This organization hierarchy is unique and essential to being able to maintain both provider demographic and contact information, and their relationships to practices, hospitals, ACOs, and health plans. The intent of this project was to:

- Allow for the mastering and maintenance of provider information and organizational relationships to only occur once in the state in a central location;
- Provide a web-based tool that allows a team of staff to maintain the file consumption and data survivorship rules, error check flagged inconsistencies or mapping questions, and manually update provider data or enter new providers;
- Develop and institutionalize the appropriate data mastering and maintenance system to allow for useful data export via a flat file to ensure readiness for a June 2016 launch;
- Provide iterative data exports that allow for hospitals, payers, and state agencies to incorporate the centrally-mastered provider data within their own databases; and
- Increase data availability and transparency with a provider portal and a consumer portal.

RI SIM funding supported a variety of activities, including the intake and aggregation of 14+ data sources, the mastering over 11,000 providers (MD, DO, NP, PA) and 3,500 behavioral health providers, the initial development of a website for access by consumers and providers, and the export of some data files for use by state agencies.

The software did work, but the data needed ongoing cleaning and verification. The sustainability model for the project called on customers to pay for the provider directory service, which would have supported the ongoing mastering—but after the software was built, we determined that customers were not ready to accept this data and pay for it.

Therefore, in December, RIQI requested and after consultation with CMS, the state agreed that it would be appropriate to pause the project and undertake a reassessment, with a focus on the business case and how best to work with potential customers to get to our end goal of a successful Provider Directory. CMS also made available technical assistance (TA) from ONC. With ONC's guidance, RIQI met with providers and carriers in the community to reconfirm the sustainable business case and market interest. The State interviewed state agency colleagues who would potentially use the Directory. Once this assessment was completed it was clear that there were three major use cases of interest to stakeholders. Stakeholders were brought together to a meeting facilitated by ONC TAs to validate this information and rank the use cases (1. credentialing, 2. referrals, and 3. analytics).

Unfortunately, the Provider Directory in its current state could not serve these use cases and would need additional development to become a marketable product. Without additional

funding to take a clear next step, the State decided to end the project and document the lessons learned.

In Spring 2019 RIQI decided to launch the Provider Directory public-facing website to allow users to search the provider information aggregated and mastered in late 2018. The portal can be accessed at https://pd.riqi.org.

Lessons learned:
Overall this project was a great learning experience, and both the State and RIQI have since changed our approaches to vetting projects and ensuring there are meaningful use cases for the anticipated users. Other learnings from RIQI include:

- Data validation is a very manual, intensive, and thus costly process;
- It was difficult for customers to quantify the value of data files;
- Technology advancements during development changed the demand to real-time data;
- Many stakeholders are dedicating in-house resources and have committed internal funding toward achieving specific organizational objectives, such as credentialing;
- Organizations needed to have time to review the data themselves;
- Users needed lead time and development to be ready to change internal systems/ workflows to utilize the product;
- The project needed both effective internal and community data governance processes to be successful;
- Multiple use cases were identified as valuable and "critical" to payers and providers;
- Use cases were not well vetted—a system with specific use cases allows for a more compelling case for sustainability;
- Provider directory objectives were too broad and intended to do everything for everyone;
- Provider data processes and needs are complex;
- Organizations have varying levels of maturity with provider data processes; and
- Integrated, shared provider data requires business process and workflow redesign.

Many of these lessons can be applied to other HIT investments and concepts, and the State has already successfully integrated the learnings into existing and future technical efforts.

Care Management Dashboards

An additional priority for RI SIM has been the deployment of advanced technology to build a real-time communication system between Rhode Island hospital providers and CMHCs, which are mutually responsible for the care of approximately 8,500 publicly-insured individuals with serious mental illness.

SIM entered into a $150,000 contract with the Rhode Island Quality Institute (RIQI) to implement Care Management Dashboards in all CMHCs and the Medicaid CHT. In addition to implementations of the dashboard tool, RI SIM covered the cost to train providers in use of this new technology. Specifically, SIM funds were used to implement electronic dashboards that deliver real-time, encrypted notifications to the CMHCs when consumers under their care

experience a hospital emergency department or inpatient encounter. All of the dashboards are now live in the CMHCs. We also deployed a Dashboard with our Medicaid fee-for-service CHT, which was called CareLink, however, this dashboard was shut down when the Medicaid CHT closed in November 2017.

The dashboards put critical health information in the hands of the appropriate providers at exactly the right time. This prompt information sharing is beginning to facilitate targeted, appropriate clinical interventions, improve care coordination, and reduce re-admissions. RIQI conducted a return on investment analysis in 2017 that indicated that the dashboards 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%. Together, this helped to avoid approximately 3,244 events with an estimated savings of $7.5 million. Ongoing funding for operation of the dashboard comes through a PMPM cost to the CMHCs. Across the eight implemented sites, RIQI continues to see approximately 400 clinical record lookups per month.

Lessons Learned:
Based on feedback received from users, learnings through the facilitated workflow integration design, and the State evaluation effort, RIQI has shared several lessons learned. To further improve the CMDs, it will be important to explore approaches to expanding the available data sources to include Rhode Island's adult psychiatric hospital (Butler Hospital) and/or other regional hospitals outside of Rhode Island. Many users suggested that RIQI work to improve the interface and interoperability with the Statewide HIE—CurrentCare, such as making it possible to open the patient's CurrentCare record directly from the CMD product. Others requested that RIQI make the dashboards more functional to specific practice needs and use cases where possible and work to reduce the overwhelming amount of information for users. Lastly, RIQI would like to increase the analytic capabilities of the Dashboards.

When examining the project overall, it would appear to be highly successful. The CMHCs are using the dashboards to change their practice to help facilitate care coordination as designed, and the insights from the formal evaluation (linked to below) were very positive.

Consumer Engagement Platform (CEP)
Under the Patient Engagement and End-of-Life/Advanced Illness Care Initiative, RI SIM awarded Rhode Island Quality Institute $650,000 to implement a CEP attached to the Health Information Exchange. This CEP had two major purposes through this grant funding: 1) provide the ability for consumers or their providers to upload advance directives for sharing among other providers; 2) create an electronic platform to allow for screening and assessment tools to be developed. The platform has a consumer-facing and provider-facing view.

The platform was successfully launched at the end of 2018 and was piloted with nine practices that work with CTC-RI, including CHTs. Each participating practice developed AIMS specific to their organization's needs based upon their workflow and capabilities as part of the pilot. Patients now have the ability to upload and share their advance care plans, specifically advance directives and Medical Orders for Life Sustaining Treatment (MOLST), and have those documents shared through CurrentCare. In the spirit of integration and alignment, the requirements gathering for this component including our other end-of-life vendors (HopeHealth and Healthcentric Advisors) and the roll-out of this tool was promoted among these two vendors

as well. Additionally, the same platform is being leveraged using HITECH IAPD and Rhode Island Foundation funding to support SBIRT screenings for use as part of the CHT/SBIRT project. This component is expected to go live later in 2019.

The ability for individuals to upload advance directives is a pilot project to support construction of an advance directive registry in the future. This system was officially branded as "Know My Health [KMH]."

This RI SIM effort successfully implemented a web-enabled patient information collection tool that stores and shares that information with the Rhode Island provider community and with CurrentCare. The ability to share this information (specifically Advance Directives and Medical Orders for Life Sustaining Treatment) is a significant milestone for CurrentCare. Additionally, the HIE now has the capability to collect health information via form and document upload tools. Assessments, surveys, reports can now be readily created to meet the needs of the Rhode Island provider community, such as SBIRT assessments, SDOH assessments, GPRA forms, Medical History forms, etc.

Lessons Learned
There were several RIQI leaders on the project at different times in the two years this project was active, including four Project Managers and three Business Owners. This caused some gaps each time the project was handed off, delayed the project and disrupted continuity.

Originally, we had planned to pilot a SDOH screening tool to demonstrate the assessment tool capabilities within KMH. However, building off of lessons learned within the Provider Directory project and further feedback from the community, we determined that a significant number of SDOH assessment tools were already in place or in planning with existing EHR's of healthcare organizations, and thus there was not enough demand for the SDOH screening tool. As partners, RIQI and the State were able to listen to this feedback and change course due to significant barriers; however, this could have been recognized and accomplished earlier in the project.

Additionally, RIQI's initial proposed timeline was too aggressive and not feasible. They needed to allow more time for requirements gathering and solutions design. With more time up-front a more thorough assessment of RIQI's own internal capabilities, specifically the around the CurrentCare patient portal software, could have been completed and would have benefited RIQI.

For launch, it would have been helpful to address workflow integration considerations early in the planning process and to properly identify the MOLST data as protected health information prior to implementation, which would have mitigated contractual delays.

All-Payer Claims Database
Under SIM, Rhode Island established an All-Payer Claims Database (APCD) called HealthFacts RI, administered by EOHHS through a selected vendor. As a deidentified database of all claims submitted in Rhode Island—including all Medicaid, Medicare, and commercial plans (excepting some of the self-insured)—the APCD established an avenue for State employees and researchers to assess the full landscape of healthcare spending and utilization across Rhode Island. Since the database is deidentified, it is able to be used by external researchers, subject to project-by-

project approval by the public/private APCD governance committee. To date, HealthFacts has generated 14 publicly available data reports and received 31 requests for data extracts.

Rhode Island's APCD was additionally used as a data source for multiple SIM vendor-led evaluations to assess program outcomes. For example, end-of-life projects by Healthcentric Advisors, HopeHealth, and the RIQI explicitly promoted and provided training to providers in completing advance care planning (ACP) documentation and resulting reimbursement options for those conversations with patients, which would result in an expected increase in utilization of ACP conversation billing codes. The APCD allowed those vendors and the State evaluator, URI, to assess billing codes submitted to commercial plans and Medicare, a pivotal portion of the target population. As explained in the corresponding Evaluation Report (Appendix X), APCD claims showed an increase in use of ACP-related billing codes across all payers after providers received training in ACP conversations and billing.

United Way: Unified Social Service Directory (USSD)

The Unified Social Service Directory (USSD) is allowing RI SIM to explore the opportunity to develop an integrated, coordinated, statewide infrastructure for addressing SDOH. The goal is that this common infrastructure could begin with the development and maintenance of a single statewide database of community-based organizations, services, and public benefits. United Way and RIDOH began a pilot project, building the connection to transfer data from 2-1-1 (based on Mediware software) to a RIDOH electronic referral management system (based on Salesforce software). The SIM grant allowed 2-1-1 to hire a team of validators to examine and update close to 100% of the 2-1-1 database by 6/30/2019. Efforts to select an IT platform, establish protocols for data standardization and maintenance, and develop a plan for building connections with existing HIT platforms are ongoing.

State-Led Program Evaluation and Reporting Overview

For the SIM Test Grant program, we were guided in our evaluation and monitoring by the *CDC Framework for Program Evaluation in Public Health*. The Rhode Island SIM Core Staff Team acknowledged that the ability to conduct this type of program evaluation would be based partly on the ability to obtain vendor-driven data and access to individuals engaged in the SIM program(s). Because of this, extra emphasis was placed on the engagement of stakeholders throughout SIM's performance monitoring and program evaluation processes.

Evaluation activities are intended to assess planning efforts and collaboration, identify root causes of success and challenges, detail efficiencies created, document the importance of infrastructure, and examine data to inform SIM's current implementation, future sustainability, and translation to other projects within Rhode Island.

Evaluation Process

Six steps, embedded in a continuous process of improvement through program evaluation, were the fundamental elements of the State-Based SIM Evaluation project. For more detail on each of these steps with respect to the SIM State-Based Evaluation, please see the Overarching

[Mixed-Methods SIM Evaluation Plan.](#) The figure below summarizes the steps used within the evaluation approach:

Figure 13: SIM State-Based Evaluation Process
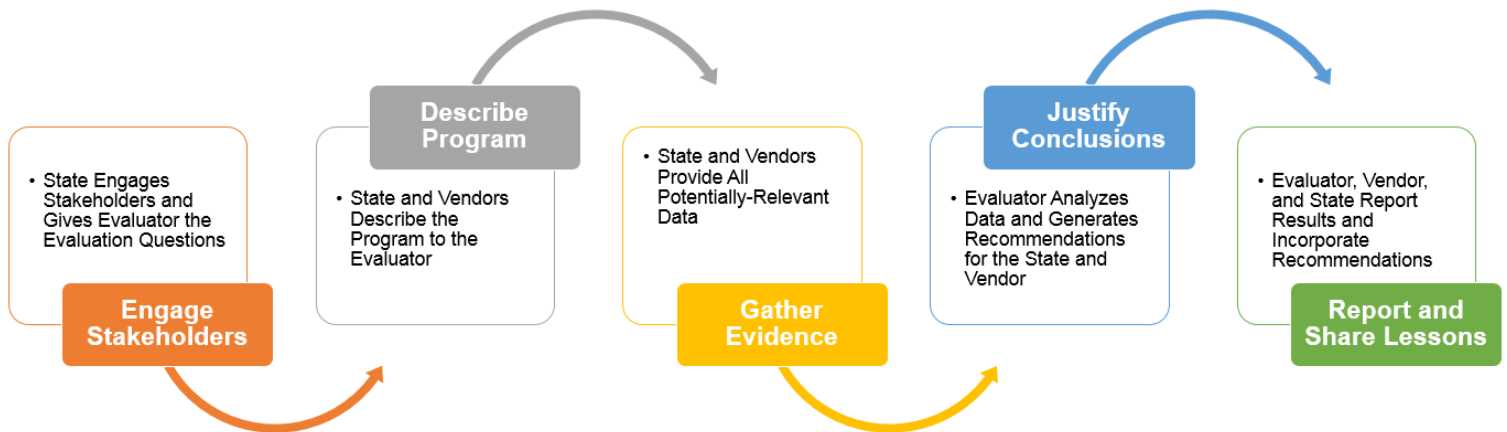
1. **Engage stakeholders.**
   Engaging stakeholders through various SIM Work Groups and participating in the SIM Steering, Interagency, other Work Group, and Core Staff meetings (as deemed appropriate). This included participation in debrief conversations to evaluate how each meeting went and what follow-up is needed.

2. **Describe the program.**
   Describing the program as depicted by the Rhode Island SIM Operational Plan and additional procurement documents with SIM vendors.

3. **Focus the evaluation design to set goals for what we are studying.**
   Focusing the evaluation design to align with available SIM-outlined goals (including data and metrics), Steering Committee areas of interest, and return on investment (ROI) study needs—including looking at where value is added even if true ROI cannot be calculated.

4. **Gather credible evidence.**
   Gathering credible evidence using existing a mixed-method approach, defined measures, available or improved data collection, and methods to address identified gaps or needs.

5. **Justify conclusions.**
   Justifying conclusions on an annual basis using findings from mixed-methods evaluation, qualitative and quantitative analysis, anecdotal evidence, and stakeholder feedback.

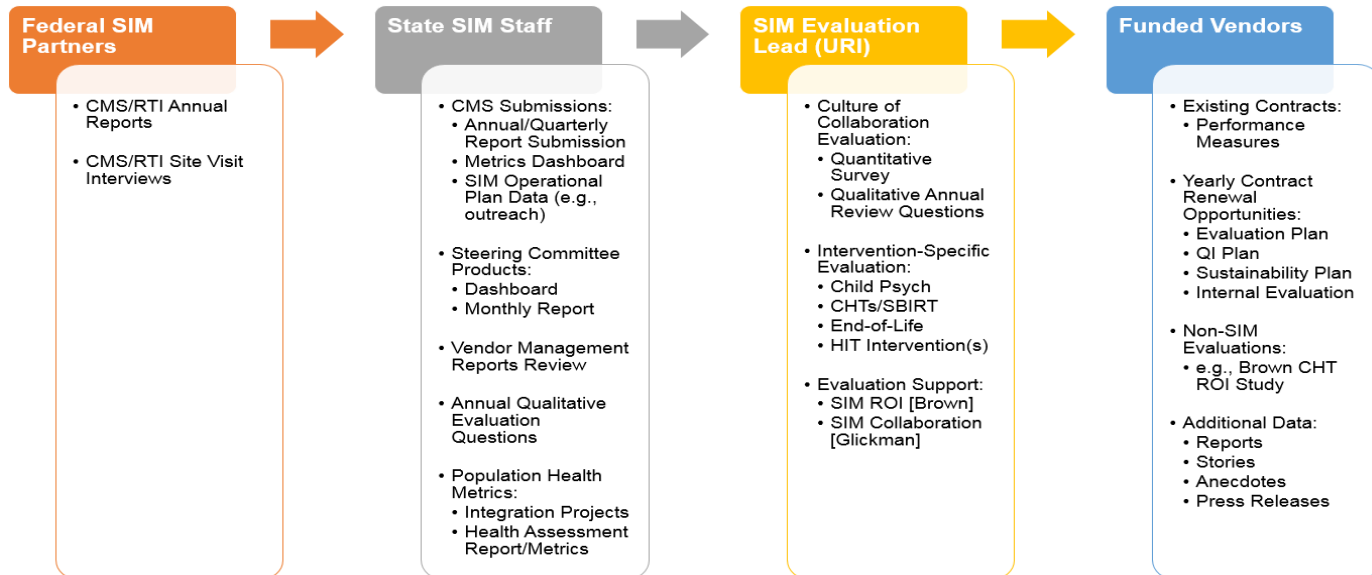6. **Ensure use and sharing lessons learned.**
   Ensuring usefulness of findings and sharing lessons learned with internal and external partners, as well as incorporate recommendations for moving forward.

Final State-Led Evaluation Efforts Summary

Through a Memorandum of Understanding (MOU) with URI's Institute for Integrated Health and Innovation, RI SIM formalized the state-based evaluation in 2016. During AY2, SIM staff held an initial planning meeting with the evaluation team to outline broad parameters and discuss the development of the overarching evaluation plan for SIM. Key evaluators (and sub-vendors) were onboarded to the SIM project, attended SIM Steering Committee meetings, participated in national evaluation calls, and met with key SIM vendors/partners. As noted previously, URI drafted and finalized the Overarching Mixed-Method SIM Evaluation Plan based on SIM leadership and SIM stakeholder feedback.

In accordance to the Overarching Mixed-Method SIM Evaluation Plan, the SIM State-Based Evaluation was informed by work being carried out by four distinct stakeholder groups: Federal SIM evaluators, Rhode Island SIM staff, Rhode Island's SIM State-Based Evaluation Lead (URI), and SIM's funded vendors. Each of these stakeholders had access to or provided specific information that was leveraged to inform SIM's State-Based Evaluation. In addition, the evaluation team coordinated with other SIM-related evaluations led by other vendors, Federal partners, or handled within the SIM Core Staff Team via contract management and metrics review. The figure below depicts the four stakeholder groups and summarizes inputs available for evaluation:

Figure 14: Evaluation Roles and Available Inputs

Federal SIM Partners
- CMS/RTI Annual Reports
- CMS/RTI Site Visit Interviews

State SIM Staff
- CMS Submissions:
  - Annual/Quarterly Report Submission
  - Metrics Dashboard
  - SIM Operational Plan Data (e.g., outreach)
- Steering Committee Products:
  - Dashboard
  - Monthly Report
- Vendor Management Reports Review
- Annual Qualitative Evaluation Questions
- Population Health Metrics:
  - Integration Projects
  - Health Assessment Report/Metrics

SIM Evaluation Lead (URI)
- Culture of Collaboration Evaluation:
  - Quantitative Survey
  - Qualitative Annual Review Questions
- Intervention-Specific Evaluation:
  - Child Psych
  - CHTs/SBIRT
  - End-of-Life
  - HIT Intervention(s)
- Evaluation Support:
  - SIM ROI [Brown]
  - SIM Collaboration [Glickman]

Funded Vendors
- Existing Contracts:
  - Performance Measures
- Yearly Contract Renewal Opportunities:
  - Evaluation Plan
  - QI Plan
  - Sustainability Plan
  - Internal Evaluation
- Non-SIM Evaluations:
  - e.g., Brown CHT ROI Study
- Additional Data:
  - Reports
  - Stories
  - Anecdotes
  - Press Releases

Federal SIM Partners and Coordination of Efforts

The SIM Core Staff Team, in partnership with the SIM State-Based Evaluation Team, continues to ensure that State-led evaluation efforts are complementary to the federally-led evaluation by RTI, but not duplicative in nature. SIM Core Staff Team members continue to participate in federal evaluation team calls, supporting RTI evaluators with additional information, as needed.

During evaluation calls with RTI this year, SIM Core Staff Team members addressed behavioral health integration plans, patient engagement, population health, and OHIC's Affordability Standards. Additionally, SIM clarified questions regarding the Operational and Integrated Population Health Plans, updated evaluators on the HealthFacts RI governance council, discussed the integration and alignment of SIM with the CPC+ initiative, and updated the federal team on the procurement status of the services for the SIM State-Based Evaluation.

RTI also conducted interviews either via in-person site visits and/or phone calls with many different stakeholders associated with the RI SIM interventions, including Steering Committee members and State staff. Thus far, interviews have included project directors, participating providers, and other staff/consumers who could offer an informed perspective on SIM's work to date.

RI SIM Core Staff Team members helped to facilitate RTI phone calls with State leaders as part of this effort. Lastly, SIM Core Staff Team members continued to assist RTI in reviewing the yearly federal evaluation documents assembled as part of CMMI's evaluation of SIM. The SIM State-Based Evaluation utilized these annual federal reports as one source of data for Rhode Island's evaluation of SIM.

State SIM Staff and Overall Project Reporting

State SIM staff (most oftentimes the SIM Core Staff Team) maintained primary responsibility for overall project reporting to a variety of audiences. Internally, state SIM staff conducted in-house reviews, when necessary, as a part of the evaluation strategy. SIM Core Staff Team members (including the Culture of Collaboration Consultant) assisted SIM with gathering routine information and metrics that were reported to CMS on a quarterly and annual basis, and to the SIM Steering Committee and Interested Parties on a monthly basis. The metrics associated with the Driver Diagram and Quarterly Metrics submission were used in all evaluation activities. When necessary, monthly reports for SIM Steering Committee were provided in addition to regular Metrics Dashboards provided at each meeting. Information compiled for CMS and/or SIM Steering Committee Reporting were generated from the regular review of vendor management reports, work group meeting summaries, and other source documents for information. SIM staff carried out process evaluation and held strategic planning retreats to enable identification of promising practices and lessons learned.

Here in an example of the metrics dashboards prepared for the RI SIM Steering Committee. This was presented at the July 2019 Steering Committee meeting, with final numbers on a set of SIM-funded projects:

Figure 15: Final SIM Performance Metrics, Part 1

Total SIM Performance Metrics Through June 30, 2019

Metric	Unit Measure	Cumulative Performance Value	Goal Value	% Goal Met Performance/Goal
Conscious Discipline in-school consultations	# hours	881	881	100%
Patients attributed to practices participating in PCMH-Kids	# patients	82,672	30,000	276%
Commercial members attributed to all PCMHs	% of commercial insured members	72%	60%	120%
Advance Directives uploaded and available in the HIE (CurrentCare)	# advance directives	402	50	804%
Patient/family member participation in ACP group visit pilot	% of patients identified by practitioners in their panels	235/500 (47%)	30%	157%
Providers trained in Complex Care Conversations	# providers	511	480	107%
Behavioral health workforce training and development participation	# providers trained and impacted	1,112	500	222%

Figure 16: Final SIM Performance Metrics, Part 2

Total SIM Performance Metrics Through June 30, 2019

Metric	Unit Measure	Cumulative Performance Value	Goal Value	% Goal Met Performance/Goal
Patients served under child psychiatry access program (PediPRN)	# children	693	600	116%
Providers trained in SBIRT by Training & Resource Center	# providers	783	240	326%
Patients served by SIM-funded Community Health Teams	# patients	1,828	1,000	183%
Face-to-face patient encounters with SIM-funded Community Health Team	# encounters	9,122	5,000	182%

As part of SIM Staff engagement within Rhode Island's evaluation, SIM Core Staff Team members worked in partnership with URI to design and disseminate a series of five qualitative questions that were tailored for the following audiences: Internal Agency Partners (e.g., collaborating RIDOH programs); SIM Interagency Team Partners (e.g., EOHHS, OHIC); and SIM Vendors (e.g., Bradley Hospital). SIM staff provided the answers to these questions to URI for analysis. These questions, or variations of them, were repeated at various intervals across modalities and partner groupings during the SIM project timeframe. While the specific questions tailored for each audience varied slightly, a variety of the following questions were used:

- How has engagement in SIM positively influenced your program, your partnerships, and a general culture of collaboration?
- What resources, if any, has your program obtained and/or leveraged since engaging with the SIM Test Grant?
- How has your engagement with SIM and SIM-funded project allowed your organization to advance health system policy and align with other efforts in Rhode Island?
- What major barriers arose and/or still exist that inhibit integration of SIM with your program?
- What programmatic evidence exists to demonstrate that SIM has influenced the provision of better-quality care, improved population health, and/or smarter health system spending?
- Lastly, summarize the impact of time on your program in one to three sentences. Please also include one example of something that was happening before SIM that has changed for the better after SIM engagement.

We were also pleased that URI could add an additional evaluation component at the end of the project: a qualitative evaluation focused on the Quadruple Aim. Some healthcare entities add the fourth aim of improving clinician experience or having more satisfied providers to IHI's Triple Aim. While RI SIM has been focused on the triple aim in developing and implementing initiatives, this evaluation conducted interviews to identify if and how the SIM-funded initiatives may have influenced the fourth aim. To do this, URI examined providers' perceptions of how the SIM-funded initiative contributed to their feelings toward provider burnout and satisfaction. URI also examined provider perceptions of the value-add of the SIM-funded initiatives to their practices with the following overarching questions:

- How have the SIM-funded initiatives contributed to 1) provider satisfaction and 2) avoiding provider burnout?
- How do providers who participated in the SIM-funded initiatives describe the value-add of the SIM initiative to their practices?

SIM Evaluation Lead (URI) and Intervention-Specific Evaluations

By having funded the SIM State-Based Evaluation (led by URI) as part of the SIM Health System Transformation Wheel, the State had the bandwidth to take a deeper dive into specific aspects of or interventions essential to the SIM health system transformation process. More specifically, URI engaged in those topics where the State SIM Staff did not have the expertise or

tools to carry out an in-house, independent evaluation. It is important to note that to avoid duplication, the state-based evaluation did not include evaluation of interventions for which RTI is evaluating via consumer interviews (e.g., PCMH-related work). The state-based evaluation was also not focused on evaluation for those SIM-funded projects for which there is already an independent evaluation being performed as part of the project's scope of work (e.g., IBH pilot). To this end, there were six intervention-specific evaluation efforts related to SIM for which an evaluation plan was established, data collection was completed, and recommendations were issued as SIM ends:

1. **Child Psychiatry Access Program (PediPRN)**

2. **Community Health Teams (Including SBIRT Braiding)**

3. **End of Life Advanced Directive Projects**

4. **Care Management Dashboards**

5. **Culture of Collaboration**

6. **Qualitative Provider Interviews**

Significant findings from the above reports have been highlighted throughout this document. In addition, several SIM vendors conducted internal evaluation efforts and submitted final reports at the close of the grant period. Here is an example of one of those internal evaluation efforts:

7. **Behavioral Health Workforce Development (Triad Project)**

Conclusion

In our very first RI SIM Operational Plan, we wrote:

By the end of the grant period, we aim to produce marked improvements in healthcare quality, affordability, and population health. Indicators of success will be transformed provider practices poised to succeed under value-based payment arrangements, a capacity to use data more effectively and creatively to make change and monitor system performance, more empowered patients (and families) who act as agents in their care, and a healthcare system that operates more *as a system* and delivers whole person care centered around the goals and needs of each patient.

As this report demonstrates, we have made significant strides toward most of these goals. We are excited by two recent articles demonstrating progress, knowing that RI SIM's contribution was a part of these achievements:

Rhode Island: A Most-Improved State in Health Performance, by Michelle Alletto and Health Insurance Commissioner Marie Ganim, from the Commonwealth Fund website

And from Health IT Analytics, this article on our [State Data Ecosystem: Data Integration, Analytics Support Public Health in Rhode Island](#)

As we move on from RI SIM, we know that we still have work to do to get us to the desired end state outlined above. These priorities include:

- Continue exploration of multi-payer APMs, such that public and private payers align in their payment methodologies to streamline administrative processes and clinical priorities for providers and to achieve a critical mass of payments falling under the model to improve the likelihood of meaningful provider behavior change. A key focus of this exploration is on the feasibility of implementing a primary care APM in a common set of practices contracting on a capitated basis with public and private payers.
- Continue to move away from fee-for-service as a payment methodology. The predominant APM in Rhode Island is total cost of care (TCOC), and we recognize that when payments that fall under the TCOC arrangements continue to be paid on a fee-for-service basis, incentives across providers and payers will continue to have a degree of misalignment.
- Increase the adoption of downside risk arrangements with a sufficient amount of risk to encourage improvements in efficiency and quality and reduce unnecessary utilization.
- Further integration of behavioral health and SDOH in primary care. We are seeing that progress made in these areas is occurring in pockets throughout the state, and there is room for expanding models (including SIM-funded initiatives) that are shown to be effective.
- More focus on reducing disparities in population healthcare, especially racial and ethnic disparities.
- Meaningfully addressing provider administrative burden without diminishing progress made to transform primary care practices throughout the state.

Rhode Island is very grateful to have been awarded a State Innovation Model Test Grant and thanks CMS and CMMI for your support and partnership over the past four and a half years.

Appendix 1: Accomplishments Summary for SIM Activities, Organized by Driver Diagram Aims

The following charts lay out accomplishments for our SIM-funded projects in the areas laid out in our Driver Diagram:

Aim 1 - Reduce Rate of Increase in Rhode Island Healthcare Spending Move to a "value-based" healthcare system that pays healthcare providers for delivering measurable high-quality healthcare, rather than paying providers for the volume of procedures, office visits, and other required services that they deliver.

EOHHS Integrated Data Ecosystem *Vendor: Freedman Healthcare, URI DataSpark, OnPoint/Alibis*

Past Accomplishments:
- *Onpoint and state agencies 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 large and numerous smaller analytic projects using the Ecosystem's data. The focus areas for these larger projects included 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.*

Final Accomplishments:
The last Ecosystem Project through the end of SIM was a set of data tools and training to help EOHHS agencies better carry out Active Contract Management (ACM). We created:
- *ACM Dashboard for Medicaid MCOs and AEs shared with plans on ongoing basis. Metrics in the Dashboard include prioritized process, outcome and measures on high-risk populations*

Investment Status:
- *The state received IAPD approval for the Ecosystem and has secured the state 10% match necessary through SFY 2020. We continue to investigate potential partnerships and grant-funded opportunities in addition to Federal support.*

Legislation, Regulatory, or Waiver Change Needed:
- *Not Applicable*

Expected Changes:
- *The structure and process for the Ecosystem will remain the same – but the Ecosystem Board will choose new projects over time.*

Scaling Opportunities:
- *We will be able to scale the Ecosystem based on funding.*

Stakeholder Engagement:
- *The Ecosystem will continue to engage stakeholders throughout state government, through the established Data Stewards Group and Project Advisory Group structure. The Data Stewards Group supports data governance and the use case and project prioritization. Project Advisory Groups help guide projects once established. In order for an agency to secure Ecosystem resources, they must provide staffing to help define the question, guide the research, and inform the analyses. We also continue to focus on training as many state agency staff as possible to use the Ecosystem tools and data, which increases its sustainability.*

Sustainability Challenges:
- *The Ecosystem's value for the state is immense. We are pleased with the support that it is currently receiving from the state administration. We will continue to find funding to sustain its use–and to keep the data in the system fresh. Its value is based on continually updated data.*

HealthFacts RI (All-Payer Claims Database, or APCD)
Vendor: Freedman Healthcare & OnPoint

Past Accomplishments:
- *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 PCMH 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.*

Mid-Project Updates to Accomplishments:
- *Multiple SIM vendors have been working with HealthFacts RI to get data to evaluate their projects, including CTC-RI for the CHTs and IBH, Bradley Hospital for Pedi-PRN, and Healthcentric Advisors for their End of Life Project.*

Final Accomplishments
- *21 data requests filled:*
  - *13 standard data extract delivered to 9 organizations*
  - *4 custom RI state agency data requests fulfilled*
  - *4 data requests fulfilled for SIM projects to support their SIM evaluation efforts*
  - *15 interactive public facing reports developed*
- *Monthly data collection from eight commercial data submitters, Medicaid (including MCOs) and Medicare (including Medicare Advantage plans)*
- *Enrollment and claims data available for more than 1.8 million unique individuals between January 2011 and December 2018.*

Investment Status:
- *The state has received IAPD approval for the APCD and state match is provided through revenue from external data requests.*

Legislation, Regulatory, or Waiver Change Needed:
- *None*

Expected Changes:
- *None*

Scaling Opportunities:
- *Aiming to sustain at the current scale.*

Stakeholder Engagement:
- *Continuing current stakeholder engagement work, as laid out in our AY4 Operational Plan with a goal to increase use of the APCD statewide.*

Sustainability Challenges:
- *HealthFacts RI is currently sustained through IAPD funding.*

Care Management Dashboards
Vendor: Rhode Island Quality Institute (RIQI)

Past Accomplishments:
- *RIQI implemented Care Management Dashboards in eight Community Mental Health Organizations (CMHOs), allowing them to access real-time, encrypted notifications 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 (ROI) 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.*

Mid-Project Accomplishments:
- *URI is working on an evaluation of the Care Management Dashboards, and RIQI has been able to assist through outreach to the CMHOs and providing data about usage.*

Final Accomplishments

- *URI completed the Dashboard evaluation which indicated:*
    - *Examining the effect pre- and post-implementation for ED visits resulted in a significant decrease ($p < 0.05$) in the number of visits per 1000 member months of nearly 40 visits*
    - *There were approximately six fewer inpatient stays per 1000 member months post-CMD implementation*
    - *Similar findings were found when examining psychiatric stays, with significant reductions post-implementation ($p < .05$) of approximately four stays per 1000 member months*
    - *There was quantitative and qualitative support for the increased efficiency of using the CMDs to help identify and manage high-risk panel members*
    - *The CMDs facilitated the creation of new, successful interventions and protocols to provide greater care coordination, discharge management and transitions of care, and medication tracking*
    - *60% of users surveyed report that they are using the CMD many times per day*

- o *Over half of the care managers reported spending 11 or more hours on high-risk patient identification in 2016 and all reported spending at least 6–10 hours per week on the task. In 2018, half of those surveyed were spending five hours of less on the task, indicative of much greater efficiency in the process of identifying high risk patients*
  - o *Not only has the program resulted in improved efficiency in identifying high-risk clients, it has also led to greater levels of perceived success at identifying appropriate candidates for care management, supported throughout the qualitative interview results*
  - o *The quantitative survey data indicated that the sites were consistently using the CMD to assist in discharge planning, scheduling appropriate follow-ups, and for trends and other analytic functions*
  - o *The use of the CMDs and enhanced awareness of the program goals has led the majority of sites (71.43%) to develop a variety of practice level interventions to help reduce ED visits and inpatient admissions*
- *When examining the project overall, it would appear to be highly successful. The CMHCs are using the Dashboards to change their practices to help facilitate care coordination as designed.*

Investment Status:
- *The Dashboards are sustained through maintenance payments that the CMHOs provide. The state has received approval for funding through the HITECH IAPD and is looking to expand the Dashboards to all of the Medicaid AEs using this approval. Many of the CMHOS fall under the umbrella of a Medicaid AE.*

Legislation, Regulatory, or Waiver Change Needed:
- *Not Applicable*

Expected Changes:
- *With a transition to Medicaid AEs, CMHOs will be able to track more of their patients. There will be no additional changes under our SIM initiative.*

Scaling Opportunities:
- *We are aiming to scale this to all Medicaid patients that are in a Medicaid AE using the HITECH funding.*

Stakeholder Engagement:
- *Continuing current stakeholder engagement work, as laid out in our AY4 Operational Plan*

Sustainability Challenges:
- *The biggest identified sustainability challenge for the Dashboards is that the cost to maintain them is significant for organizations such as CMHOs. Unfortunately, under current payment models, the savings achieved through reductions in hospital and ED admissions is not passed on to those organizations that are paying to maintain the*

> *Dashboards. We anticipate that these savings will be transferred to the CMHOs over the course of the Medicaid AE program, which provides incentives to providers through the MCOs.*

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

Past Accomplishments:
- *Rhode Island's eCQM system allows for 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 Work Group to vet eCQM technical requirements.*
- *The state has reached an agreement with an individual practice to connect and collect clinical data for this test.*

Mid-Project Accomplishments:
- *There are now six practices onboarding to the eCQM system. It is anticipated to go live in AY4 Q2.*
- *The bulk of the initial work of the Technology Reporting Work Group has been completed, and the Work Group has transitioned to maintenance mode, which means that it will primarily work on final governance policies and procedures, updates to existing measures, and adding new measures.*

Final Accomplishments
- *Infrastructure: Completed the procurement and setup of all required hardware comprising four separate environments (Test/Training, Development, Production, Disaster Recovery)*
- *Reporting Setup*
  - *SIM Technology Reporting Work Group has met regularly since June 2018*
  - *50/53 measures have completed the development cycle*
- *Data sourcing*
  - *First participating practice data feed into Production*
  - *Additional seven practice/organizations are in the process of onboarding*
    - *Four practices/organizations are in the test cycle with training and data validation underway*
- *EOHHS has engaged with all major health insurers to discuss how best to leverage this system to meet their reporting needs.*

Investment Status:
- *In Discussion—This is sustained for FY2020: CMS approved 90/10 funding through the HITECH IAPD and the legislature approved the match in the state FY20 budget.*

Legislation, Regulatory, or Waiver Change Needed:
- *Not Applicable*

Expected Changes:
- *None*

Scaling Opportunities:
- *This project is strengthened through scaling, because increased data improves the accuracy of the measures. The state will continue to scale and bring on more users.*

Stakeholder Engagement:
- *Continuing current stakeholder engagement work and review in our HIT Strategic Roadmap and Implementation Plan*

Sustainability Challenges:

- *Funding sustainability*

  o *While we anticipate that we can fund this through the Medicaid HITECH IAPD, and have confirmed state match, this approval will end in 2021. We will need to determine how to sustain through MMIS IAPDs and continue to identify state match.*

- *Participatory sustainability*
  o *This system is dependent upon having viable use cases. While there is considerable interest and support in the community, we must have a governance process in place that maintains trust and also deliver on the promises to reduce provider reporting burden. The Technology Reporting Work Group and EOHHS/Medicaid are working to develop that community governance process which will need to adapt to changing needs in order to be successful.*

*Unified Social Service Directory (USSD)***
Vendor: United Way

Past Accomplishments:
- *The USSD allowed RI SIM to explore the opportunity to develop an integrated, coordinated, statewide infrastructure for addressing 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 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 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).*
- *Care New England's determined that its IT platform was not be compatible with 2-1-1's Mediware software. United Way then began working with Coastal Medical Group to assess their readiness and capabilities to act as a test site for the project.*
- *We are also now planning how to move the project out into the wider community.*

Final Accomplishments:
- *The SIM grant allowed 2-1-1 to hire a team of validators to examine and update close to 100% of the 2-1-1 database by 6/30/2019. All agencies and services are now coded with AIRS Taxonomy, an international standard for Information and Referral organizations.*
- *United Way and RIDOH completed the work for the RIDOH pilot project.*
- *Post-SIM, United Way continues to meet with community stakeholders to assess their resource needs and to summarize technological requirements for the development of the USSD and connection with existing HIT Platforms.*
- *Efforts to select an IT platform, establish protocols for data standardization and maintenance, and develop a plan for building connections with existing HIT platforms are ongoing.*

Investment Status:
- *In discussion*

Legislation, Regulatory, or Waiver Change Needed:
- *In discussion*

Expected Changes:
-

Scaling Opportunities:
- *United Way continues to collect information from stakeholders, staff, subcontractors, and other community partners who have implemented similar projects in their efforts to scale up the project once the initial data feeds are complete.*

Stakeholder Engagement:
- *Continuing current stakeholder engagement work, as laid out in our AY4 Operational Plan, with both community and state agency stakeholders*

Sustainability Challenges:
- *Long-term funding remains in question—we are reviewing the potential to partner with state agencies and community stakeholders to optimize funding streams and reduce duplication of resources. The alignment of community and state dollars will be instrumental to the sustainability of the USSD post-SIM.*

SIM State-Based Evaluation
Vendor: University of Rhode Island (URI)

Past Accomplishments:
- *Finalized AY4 Evaluation Plans for all five SIM evaluation components, conducted a set of key informant interviews for the Culture of Collaboration evaluation, and submitted the initial report on Bradley Hospital's Child Psychiatric Access Project (Pedi-PRN).*
- *Developed an effective data collection process that will work across diverse CHT settings, with the first two sets of pre/post outcome data produced and sent to the evaluation team from CHT partners. Additional RTT (Referral Triage Tool) data received and analyzed from a subset of CHT partners to supplement existing evaluation efforts and guide sustainability planning.*
- *Reviewed all project data collection efforts with SIM Core Staff to fine-tune the process and facilitate continuous program improvement for the duration of SIM.*
- *Completed key informant interviews, began conducting focus groups, drafted quantitative re-survey, and analyzed qualitative AY2/AY3 partner feedback to inform the Culture of Collaboration sustainability efforts.*
- *Assisted relevant SIM Core Team staff and/or vendor staff to assist with the provision of URI-obtained/analyzed data for AY4 Steering Committee project reviews focused on sharing lessons learned and looking ahead to sustaining positive change and practices.*
- *Moved from planning to implementation across several project specific evaluations.*
- *Provided intensive, collaborative efforts related to 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).*

Final Accomplishments:
1. *Impacts on Physical and Behavioral Health Integration:*
   - *PediPRN program evaluation documented success at engaging PPCPs using services to help manage behavioral health issues*
2. *Impacts on Healthcare Workforce Transformation:*
   - *Qualitative research support for positive impact of SIM on provider satisfaction and burnout across 14 SIM-funded projects*
3. *Impacts on Patient Engagement:*
   - *End of Life projects documented high outreach with patients and families around end of life discussions and advance directives*
4. *Impacts on Data Capability and Expertise:*
   - *Care management Dashboards provided enhanced data support at the CMHCs to aide in care coordination and analytics efforts to help identify high-risk patients*
5. *Impacts on Population Health:*
   - *CHTs provided care for high needs patients and documented initial improvements in health outcomes at discharge*
   - *Use of CMDs at CMHCs was linked with reduced ED and inpatient stays*

Investment Status:
- *On hold—**pending additional funding based on analysis of ongoing needs.***

Legislation, Regulatory, or Waiver Change Needed:
- *No—existing purchasing levers allow for development of MOUs with state universities for research/evaluation/training.*

Learnings:
- *Lessons Learned:*
  - *Engage with the vendors as soon as possible to develop evaluation plans, data collection processes, and feedback systems.*
  - *Plan immediately for post-award evaluation based on vendor procurement delays and outcome data availability.*
- *Promising Practices:*
  - *Working with vendors and SIM leadership was essential to collecting relevant, high-quality data for evaluative purposes*
  - *Engaging in data presentations and discussions*
- *Formal Evaluation Insights:*
  - *Not applicable, not formally evaluated*

Scaling Opportunities:
- *Contingent upon sustainability of projects being evaluated and for evaluation post-SIM award*
- *Additional evaluations could be considered for projects currently within scope and/or other SIM projects being sustained that are not currently within the evaluation scope.*

Stakeholder Engagement:
- *Continuing culture of collaboration with SIM partners and relationships built, as applicable.*

Sustainability Challenges:
- *Currently working to sustain the evaluation efforts related to CHT implementation efforts*
- *Working individually with sustained SIM projects to ensure they have access to evaluation reports to aide in planning for evaluation efforts moving forward*

Integrated Behavioral Health (IBH) Billing and Coding Research Project**
Vendor: Bailit Health

Past Accomplishments:
- *Bailit Health interviewed six integrated primary care/behavioral healthcare practices whose staff are knowledgeable about administrative barriers to IBH t**o assess issues***

around coding, reimbursement for certain services, patient financial burden due to copayments, and provider credentialing.

- *OHIC brought these findings to the Care Transformation Advisory Committee and examined how to give these topics a more detailed focus and assessed how to move forward to reduce barriers to integrating physical and behavioral health in day-to-day practice workflows.*

Final Accomplishments:
- *OHIC convened a Work Group in February 2019 to discuss the administrative barriers identified in the CTC-IBH pilot and during the practice interviews described above. The Work Group discussed how to work toward payer alignment and streamlining of billing and coding processes to address these barriers and made recommendations to the Health Insurance Commissioner in August 2019 for potential action.*
- *Bailit also performed a data evaluation of CHTs at Thundermist Health Center and included a set of recommendations for future CHT data collection and evaluation strategies. OHIC continues to work with other agencies (Medicaid/AEs, BHDDH, and others) post-SIM to maximize the ability of providers to integrate physical and behavioral health.*

Investment Status:
- *One-Time Investment*

Legislation, Regulatory, or Waiver Change Needed:
- *Not Applicable*

Expected Changes:
- *Not Applicable*

Scaling Opportunities:
- *Not Applicable*

Stakeholder Engagement:
- *Continuing current stakeholder engagement work, as laid out in our AY4 Operational Plan.*

Sustainability Challenges:
- *Not Applicable*

Rhode Island Statewide Health Inventory&&
Vendor: RIDOH/JSI

Past Accomplishments:
- *The SIM Steering Committee voted in November 2018 to contribute to RIDOH's legislatively-mandated Statewide Health Inventory, building upon the first iteration issued in 2015.*
- *See http://www.health.ri.gov/publications/reports/2015HealthInventory.pdf for more information on the 2015 results.*
- *This project's scope of work has been finalized to evaluate the access and barriers to medical services in the state through surveys tailored to specific provider groups or consumers.*
- *SIM provided funding to support the scope of work associated with the 2018/2019 Statewide Health Inventory, including support for project management, survey design, stakeholder engagement, and data cleaning/analytics.*
- *RIDOH and EOHHS signed an MOU to begin this work and RIDOH is drafting plans to analyze recent specialty surveys conducted (e.g., EMS, Behavioral Health) to generate reports for inclusion within the Inventory.*
- *RIDOH reviewed the information collected, analyzed, and reported in the 2015 Provider Inventory, to determine what updated data should be included in the 2018/2019 Inventory that may inform statewide health planning efforts.*

Final Accomplishments:
1. ***Overall:***
   - *Partnership with RIDOH Pharmacy Work Group that created new Pharmacy Survey*
   - *74% survey response rate for Oral Health survey*
   - *100% survey response rate for Dialysis Survey*
2. ***Impacts on Physical and Behavioral Health Integration:***
   - *The primary care survey reports on physical and behavioral health integration and future iterations may include data supportive of SIM's approach to integrated care delivery.*
3. ***Impacts on Healthcare Workforce Transformation:***
   - *Each of the Inventory surveys aims to capture information on staffing per service category and providers and their full-time equivalents. Several surveys also include questions on the ideal number of FTEs in order to treat patients. Survey results will allow RIDOH to assess where there are workforce shortages and where more resources could be devoted.*
4. ***Impacts on Patient Engagement:***
   - *The Patient and Community Survey has been posted to the RIDOH website in English and Spanish (Portuguese will also be available soon). This survey will allow RIDOH to better understand the community's experience with healthcare in Rhode Island and access to care from the perspective of community members.*
5. ***Impacts on Data Capability and Expertise:***
   - *SIM grant has allowed our team to purchase Qualtrics Survey Software. All surveys were built through Qualtrics and unique links were coded to each survey participant. This allows for participants to close and reopen the survey,*

with their data being saved each time they move to the next page of the survey. Survey participants can also forward their unique link to others to collaborate on completing the survey, and previously entered data would populate for each through using the same coded links. Qualtrics also allows reminder emails to go out on a regular basis to any survey participants who have not yet completed the survey. This feature has been key in increasing the survey response rate.

   o *JSI will be working with the RIDOH team to conduct the data analysis. This was made possible through the SIM grant.*

6. ***Impacts on Population Health:***
   o *This study, once complete, is intended to inform the development of an evidence-based population health plan for the state.*

Investment Status:
- *In Discussion*

Legislation, Regulatory, or Waiver Change Needed:
- *No—Legislation (but not a funding source) already exists (See 2014 Rhode Island General Assembly passed the Rhode Island Access to Medical Technology Innovation Act [RIGL Chapter 23-93]).*

Learnings:
- ***Lessons Learned:***
   o *Contact information our team uses is from RIDOH's licensure database. We have found that the information providers include in their licensure application is not always accurate*
   o *Continue to reach out to relevant work groups or relevant interest groups prior to distributing specific surveys*
   o *Analysis of health inventory data with a particular focus on behavioral health and the opioid crisis*
   o *Use of inventory data for additional healthcare planning*

Scaling Opportunities:
- *Contingent upon health planning discussions within Rhode Island as a part of SIM sustainability, the Statewide Health Inventory could be expanded to address additional healthcare landscape questions, if desired.*

Stakeholder Engagement:
- *Continuing culture of collaboration with SIM partners and relationships built, as applicable.*

Sustainability Challenges:
- *Some funding received through SOR Opioid Grant for Survey Data Analysis*

- *Findings from JSI's analysis will be used to create recommendations to address barriers to access*
- *Working relationship with healthcare partners and stakeholder to review surveys before distribution*
- *2021 Statewide Health Inventory (and future iterations) will be used to assess changes in access to care*

AIM 2 - Support Provider Practice Transformation and Improve Healthcare Provider Satisfaction Support healthcare providers in their transition to delivering healthcare in an environment in which the care is paid for according to a value-based payment arrangement. SIM will invest in work place transformation activities that build upon the professional expertise of Rhode Islanders.

Triad Project—Behavioral Health Workforce Project (formally Provider Coaching)
Vendor: JSI Research and Training Institute, Inc. (JSI)

Past Accomplishments:

- *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 project evaluation.*
- *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.*

Mid-Project Updates to Accomplishments:
- *JSI developed its evaluation methodology and created a system for measuring reach and impact of each aspect of the project. At this time, JSI evaluation staff is concerned that it will not have enough data to carry out the full evaluation by the June 30 SIM end date.*
- *Extensive technical assistance (TA) was provided to three subcontract-awarded provider organizations. All three received their first round of funding to enable fundamental workflow and administrative changes in response to the provided TA, and subsequent evaluation of those changes within the provider organizations.*
- *RIC, under subcontract with JSI, finalized the curriculum for an "Introduction to Behavioral Health" course and submitted it for review and approval to the College's curriculum committee. A previously approved course developed through this project, "Managing Behavioral Health Organizations," is being offered in the Spring 2019*

semester. RIC's counseling program faculty is continuing to develop two new graduate courses with emphasis on practice in the community public mental health system.

- *In collaboration with Yale's Department of Psychiatry, RIC recruited 4-6 behavioral health agency partners for engagement and partnership meetings in mid-January.*
- *Multi-level workforce training will be launched shortly, with independently developed and customized courses for high-level leadership (RIC/Yale collaboration), middle management (JSI), and clinical supervisors (Substance Use and Mental Health Leadership Council) expected to begin in January. RIC has also begun the paraprofessional training course, which meets weekly.*
- *A health equity training course has finished development and is slated for implementation.*

Final Status:

- *JSI and its subcontractors originally targeted 25 organizations, 150 training/activity sessions, and 500 persons participating in all activities. At the end of the award period, they achieved 39 participating organizations in 148 sessions, and 1,112 staff members participated in training and technical assistance activities. An additional 711 staff were impacted by professional development and infrastructure changes that resulted from technical assistance subcontracts directly to BH agencies. Finally, 128 individuals from the provider community participated in collaborative statewide meetings, a true achievement in extensive stakeholder engagement.*
- *From the beginning, sustainability for this project focused on the longevity of information and materials developed, all of which are now owned by the State and can be disseminated to all Rhode Island providers for free use. These products include an onboarding process-building toolkit, an e-Learning course for new hires about the Rhode Island BH system, and targeted materials for building competency in evidence-based practices as requested by BH agencies.*
- *SIM also funded the creation of new undergraduate and graduate courses in behavioral health offered at RIC, and integration of BH simulations in the RIC nursing program.*
- *Perhaps most importantly, JSI and its subcontractors developed sets of competency manuals for case managers, SUD counselors, milieu counselors, medical assistants employed in BH settings, and nurses employed in residential SUD treatment facilities.*

Investment Status:

- *A limited number of additional technical assistance subcontracts will be made available through SOR grant funding to BHDDH. The State will remain with JSI as the contracted vendor to ensure continuity of services.*
- *BHDDH's Division of Quality Management intends to use the developed training products and particularly the competency manuals as resources for continuous quality improvement with licensed SUD and mental health providers. As standardized manuals vetted through considerable engagement with the BH provider community that provide development resources for each domain, they are invaluable for standardizing high-quality delivery of care throughout Rhode Island. In the future, given available funding, more roles will be considered for development of matching competency manuals.*

Legislation, Regulatory, or Waiver Change Needed:
- *Training remains fiscally unsupported by current reimbursement rates.*

Expected Changes:
- *In February 2019, we noted that we were working closely with JSI to monitor spend-down as we approach June 30 and anticipate offering additional subcontracts to CMHOs and opioid treatment providers. A second session of the clinical supervisors coaching academy may be run by SUMHLC due to high demand. RIC will be seeking to establish an ongoing forum for RIC and potentially URI faculty to convene with agency organization executives regarding their workforce needs and potential internship placement opportunities.*
- ***Final update:*** *We are pleased to report that the above expected changes were carried out with high responsiveness to needed course-correction, and JSI and its subcontractors were able to complete the full scope of intended activities, except for internal evaluation efforts, which were limited due to time constraints.*

Scaling Opportunities:
- *BHDDH's ongoing Training and Technical Assistance contract makes use of products created under the Triad Project and has as of 2019 revised its approach to be informed by findings from the Triad Project. It now emphasizes individualized technical assistance and agency-tailored delivery of trainings rather than broad statewide training opportunities. However, the funds available for Training and Technical Assistance are limited compared to the scale of SIM funds, and were additional resources made available, many SIM-initiated activities could resume at a statewide level.*

Stakeholder Engagement:
- *In the final report from JSI's internal evaluation, early and ongoing stakeholder engagement directly from behavioral health providers was cited as critical to the success of the project. Stakeholders were engaged in the development of all training materials and delivery methods, and trainings were pilot-tested in smaller groups before launching to a broader audience, allowing continuous and direct stakeholder feedback and input.*

Sustainability Challenges:
- *As it stands, training is not well supported through rates for the behavioral health workforce, which experiences significant staff turnover on a continual basis and has identified greater competency needs for incoming staff.*
- *Training is additionally challenging to support in the behavioral health workforce due to staff shortages. Staff may be unable to attend even free trainings due to lack of available coverage for their duties.*
- *The existing system relies strongly on BHDDH-funded training contracts. JSI's work will provide a platform for BHDDH to pursue continued development and coaching, along with an ongoing critical examination of reimbursement rates in behavioral health in the state.*

Child Psychiatry Access Program (PediPRN) / Suicide Prevention Initiative** / Mental Health First Aid**
Vendor: Emma Pendleton Bradley Hospital

Past Accomplishments:

- **Pedi-PRN**
  - As of June 30, 2018, Pedi-PRN has served 403 children, with 342 providers 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 (SPI)**
  - 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.
  - Adding staffing coverage during high volume call times enhanced the Kids'Link crisis phone triage services.
  - Bradley increased awareness of the Kids'Link service through the increased availability of marketing materials in English and Spanish.
  - To increase children's after a crisis evaluation, Bradley has ordered medication lock bags. They are determining the most appropriate way to distribute the bags to families after crisis evaluation.

- **Mental Health First Aid (MHFA)**
  - 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 360-400 people trained in these critical skills.

Mid-Project Updates to Accomplishments:
- As of December 31, 2018, Pedi-PRN has served 554 children, with 360 providers enrolled from 61 practices throughout the state.

Final Accomplishments:
- *PediPRN served 693 unique children, median age 13 years. 51% of children served had multiple psychiatric diagnoses, 20% had multiple psychiatric medications, and 12% had a history of suicidal intent or self-harm. 930 encounters were completed throughout the course of the award, with 73% regarding medication, 23% seeking referrals to local resources, and 17% requesting consultation on diagnosis. (Consultations can cover multiple topics.)*
- *To increase use of services, PediPRN staff made on-site physical outreach to 57 enrolled practices and collected stakeholder input regarding ways to improve the service.*
- *In collaboration with the Mental Health First Aid project, they offered Youth Mental Health First Aid to 19 PPCPs.*
- *The numbers are echoed by qualitative feedback from providers: "PediPRN has been a tremendous resource for the pediatric community in RI."*

Investment Status:
- *Sustained at RIDOH via 5-year HRSA grant (through 2023) and through partnership with BCBSRI and the van Bueren Charitable Foundation.*

Legislation, Regulatory, or Waiver Change Needed:
- *Medicaid, working with CMS, is considering a waiver amendment allowing for billing of telephonic psychiatric consultations. At this time, it appears that CMS may require a pilot period under the proposed billing scheme.*

Expected Changes:
- *Bradley expects to ramp up evaluation efforts in the ending months of SIM. As part of this aim, they will get data from the All-Payer Claims Database to develop a landscape analysis of child psychiatry access in Rhode Island.*
- ***Final update:** Bradley was able to obtain an identified cohort of data for their patients served from the All-Payer Claims Database and continues ongoing evaluation of their services.*

Scaling Opportunities:
- *The PediPRN program scaled consistently throughout SIM and raised goals for practices, providers, and patients reached. Scaling continued throughout the end of SIM and into the HRSA grant period. The SPI program will continue at a reduced scale post-SIM, and the MHFA program used SIM funding to offer an increased number of free-to-participants training opportunities.*

Stakeholder Engagement:
- *PediPRN will work in collaboration with MomsPRN, a new matching service targeting pregnant and parenting women with psychiatric needs being piloted through RIDOH, to ensure providers are aware of all available psychiatric consultative resources.*

- *Feedback from participating providers led to the successful creation and launch of the PediPRN Intensive Program, which provides CME-accredited advanced training in child psychiatry to PPCPs.*

Sustainability Challenges:
- *Long-term viability of the PediPRN model is dependent on securing sustainable billing practices for telephonic psychiatric consultation services. Until this is secured, services are reliant on grant funding, which will allow for efficacy evaluation to inform legislative changes in telehealth billing.*
- *The SPI program will need to seek funding sources to sustain the extra phone coverage hours of the Kids'Link network that were provided by SIM. Options continue to be in discussion.*
- *MHFA anticipates relying on primary care practices and school districts opting to fund the training sessions directly in the absence of secured grant funding.*

Interprofessional Community Preceptor Institute**
Vendor: Rhode Island College (RIC)

Past Accomplishments:
- *Training our future healthcare workforce to work in interprofessional teams and in community settings is an essential part of transforming our health system. The community preceptor project expands opportunities for undergraduate and graduate students enrolled in Rhode Island institutions of higher education to learn about population health, SDOH, care management, and other core aspects of community-based health and social services.*
- *A core group of faculty members 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 preceptor training curriculum for staff from community-based agencies, who will supervise and support students who are placed with their agencies. 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 consortium.*
- *The group identified and recruited the pilot cohort of 13 community preceptors from eight community-based agencies and 5 different health professions in 2018. A second cohort of 16 preceptors from 8 community-based healthcare and social service agencies began training in December 2018 and will develop and support interprofessional student projects at their agencies through May 2019*
- *RIC has identified an outside evaluator to assess process outcomes.*

Mid-Project Updates to Accomplishments:
- *The Community Preceptor project has enlisted the services of a videographer to document and promote its efforts. The full-day training for preceptors was recorded, and follow-up site visits and interviews with preceptors and possibly students, will document preceptor and student learning experiences. The video will serve as a tool for prospective preceptors and faculty to further develop community-based interprofessional learning opportunities for healthcare students.*

Final Status
- *The total number of agencies involved in both cohorts was 15, with 29 preceptors.*
- *Relationship-building between participating community agencies and the Institutes of Higher Education (IHEs – including CCRI, RIC, URI, and AMS) was cited as a key outcome. The relationships were engendered through IHE faculty offering training components to preceptors. Those trainings listed as most valuable by preceptors were: Four Competencies of Interprofessional Collaborative Practice; Debrief on Integrating Student Learning Needs and Course Objectives; and ICPI Project Development and Design.*
- *SIM funded strategic planning for ongoing inter-professional education activities, and developed a plan for a more formal organization, with shared goal-setting and funding. EOHHS will continue to support the development of this organization post-SIM.*

Investment Status:
- *ICPI partners submitted a proposal to the Health System Transformation Project awarded to Rhode Island for funding to fully sustain the project and is awaiting approval.*

Legislation, Regulatory, or Waiver Change Needed:
- *Not Applicable*

Expected Changes:
- *The Community Preceptor leadership team has recognized the logistical challenges for students, faculty, and community partners to schedule interprofessional learning opportunities. As such, the leadership team has begun to explore the possibility of developing an online clinical placement registry to facilitate student placements. The leadership team has also begun to explore ways to further educate, engage, and support faculty around the importance of interprofessional, community-based learning opportunities for students.*

Scaling Opportunities:
- *Increase capacity of current and new community-based agencies to provide placement opportunities for students.*
- *Invite additional higher education institutions to participate.*
- *Expand and strengthen collaborations between schools and community-based agencies.*
- *Develop online clinical placement tool (as noted above).*
- *Conduct faculty workshops on interprofessional education.*
- *Continue to develop the more formal interprofessional education organization to carry out the activities listed above.*

Stakeholder Engagement:
- *Stakeholder engagement remains a core tenant of this project post-SIM.*

- *Participating agencies' preceptors remain highly engaged, with many offering involvement in a prospective Cohort III under future funding in order to better support newly participating agencies. Some have offered to sit on an ICPI Advisory Board.*

Sustainability Challenges:
- *Leverage Medicaid HSTP funding to sustain and scale community preceptor project.*
- *Secure commitment of academic partners to sustain and scale community preceptor project. (Note: Expanded community-based learning opportunities for students are a priority for our higher education partners.)*
- *Explore potential of integrating community preceptor project with RI Interprofessional Education Collaborative with philanthropic and/or HSTP support.*

Health Equity Zones**
Vendor: Rhode Island Department of Health (RIDOH)

Past Accomplishments:
- *SIM and HEZ staffs 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 SIM's Interagency partners:*

  o *RIDOH HEZ team participated on the AE Review Committee with SIM team to advocate for greater community clinical linkages.*
  o *RIDOH and SIM leadership have partnered on three community site visits to help state agency directors better understand how agency programming can be leveraged to improve the community/clinical linkages necessary to realize healthcare transformation goals.*
  o *HEZ and SIM staff participated jointly in an off-site retreat to debrief on the current successes and challenges of the HEZ implementation.*
  o *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.*
- *During the CMS RI site visit in November, RIDOH and SIM highlighted HEZ by visiting the Olneyville HEZ.*
- *HEZ presented at the January 2019 Steering Committee meeting to provide an update on progress and sustainability.*
- *HEZ and SIM staff collaborated through the Community Health Assessment Group on the development of Rhode Island Health Equity Indicators to develop a baseline for measuring the social, economic, and environmental determinants of health, aligned with the 23 population health goals.*
- *The Rhode Island Foundation recently awarded $3.6 million to six programs through their Fund for a Healthy RI, including five HEZ sites, to support projects that will*

integrate community and clinical provision of care, building on SIM/HEZ culture of alignment and collaboration to create more effective community/clinical linkages.

- *Evaluation of HEZ has found that outcomes include:*

  o *44% ↓ in childhood lead poisoning (Pawtucket)*
  o *24% ↓ in teen pregnancy (Central Falls)*
  o *13% ↓ in feelings of loneliness (West End, Elmwood, & Southside Providence)*
  o *5-7% ↓ in body weight for 20% of Diabetes Prevention Program participants (Statewide)*
  o *40% ↑ in redemption of SNAP farmers' market incentives (West Warwick)*
  o *36% ↑ in access to fruits and vegetables (Olneyville)*
  o *250% ↑ in community engagement (Statewide)*
  o *46 opioid users diverted from the criminal justice system (West Warwick)*
  o *>1000 graduates of evidence-based chronic disease self-management workshops (Statewide)*

Final Accomplishments:
Impacts on Physical and Behavioral Health Integration:
- *HEZ alignment with SBIRT/CHTs.*

Impacts on Healthcare Workforce Transformation:

- *The SIM and HEZ teams conducted presentations to increase awareness of healthcare transformation and community-clinical linkage, including presentations at two HEZ Learning Community Events, to discuss healthcare transformation within community partnerships, and a panel at the RI Health Equity Summit about community-clinical linkages. In addition to promoting healthcare transformation, the Health Equity Zones have also worked with CHTs and have helped train and engage Community Health Workers.*

Impacts on Patient Engagement:

- *Leadership from SIM and RIDOH partnered on 3 community site visits to help state agency directors better understand how state agency programming can be leveraged to improve community-clinical linkages that are necessary to realize healthcare transformation goals.*

Impacts on Data Capability and Expertise:

- *The SIM team collaborated with RIDOH to develop and implement a set of Statewide Health Equity Indicators to improve surveillance of socioeconomic and environmental factors that drive health inequities in Rhode Island. The Statewide Health Equity Indicators will help to identify barriers to health for Rhode Islanders, such as access to healthcare, transportation, housing, food insecurity, and education, and track progress toward addressing them. These indicators will also be used to help assess the impact of health equity initiatives, including the Health Equity Zones.*

Impacts on Population Health:

- *The Pawtucket Central Falls HEZ achieved a 44% decrease in childhood lead poisoning in Pawtucket by connecting community stakeholders to enforce and existing lead*

remediation policy. In Central Falls, there was a 24% decrease in teen pregnancy. The PCF HEZ was also the first municipality in New England to pass the Green and Complete Streets Ordinance, and their Walking School Bus program decreased absenteeism by nearly 64% and tardiness by over 80% at a local elementary school. Coordinated efforts in the Olneyville HEZ led to a 36% increase in access to fresh fruits and vegetables. The Olneyville HEZ also completed construction of 36 affordable rental homes that provided safe, affordable housing to low-income residents and improved neighborhood safety. They also implemented a walking school bus program and improved local parks. The West Warwick HEZ helped divert 46 opioid users from the criminal justice system, and they saw a 40% increase in redemption of SNAP farmers' markets benefits. The WW HEZ also adopted the policy of having Narcan in all police cruisers and implemented Narcan training and distribution and peer recovery services. Other HEZs established community gardens and farmers markets, implemented programs to improve maternal and child health, increased community engagement, and engaged over 1000 people in evidence-based chronic disease self-management workshops.

Investment Status:
- *In Discussion—requires additional partnerships, continued multi-level evaluations, and innovative funding models*

Legislation, Regulatory, or Waiver Change Needed:
- *None*

Learnings:
- *Lessons Learned:*
- *Leadership from the HEZ communities reported that consistency and reliability of funding continues to be a challenge, especially because of different funding periods, timelines, and requirements from external funders. There is an administrative burden to maintaining multiple grants that reportedly makes planning and implementation difficult. External funding was also often linked to specific programmatic goals or outcomes, but there was limited funding to the HEZ infrastructure. HEZ communities need funding that is not tied to programmatic to ensure that the model is successfully implemented. Changes in federal funding have also driven some staffing and infrastructure changes.*

- *Promising Practices:*
- *Implementation of the Statewide Health Equity Indicators offers a framework to identify and address disparities in SDOH throughout the state. This framework can be utilized to begin engaging multiple stakeholders and agencies to align their efforts to address these barriers to health among Rhode Islanders, through HEZ and other health equity initiatives. The HEZ model has demonstrated successes in coordinating existing community-based interventions and bringing together community stakeholders and residents to work toward common community-identified and community-prioritized goals.*

- *Formal Evaluation Insights:*
The evaluation director from the Brown University Division of Biology and Medicine conducted a review of year-end reports submitted by each HEZ community to examine

the structures, process, and outputs of each HEZ, and to identify common themes related to five evaluation questions developed by RIDOH in the second year of the HEZ initiative. Some key findings from this report were that, over time there was an increase in collaboration and trust between HEZ participants, but there is a need for more evaluation to characterize those partnerships and the level and quality of engagement from HEZ participants and community residents. Additionally, several HEZs worked to enact policy changes at multiple levels, but those efforts may have been underreported and it is unclear how involved community residents were in policy-related efforts. Through this evaluation, HEZ communities also sited challenges such as staff turnover, inconsistent or limited funding, and difficulty sustaining community engagement. However, despite challenges, HEZ programs expanded, more community partners were engaged, and there was a reported increase in community awareness of the HEZ initiative. The results of this evaluation report will inform future evaluation and sustainability efforts for the Health Equity Zones initiative.

Scaling Opportunities:

- *Letters of intent are due in early February for qualified municipalities and nonprofit community-based organizations that would like to become new members of the Health Equity Zone initiative by applying for a portion of the $1.4 million allocated by RIDOH.*
- *New HEZ applicants chosen by RIDOH on March 15, 2019 (per Updated Accomplishments) will result in an initial contract period, beginning in approximately July 2019 and continuing for one year, with the option to renew for up to four additional 12-month periods.*
- *Opportunities also may exist for the leveraging of existing and/or scaling to new HEZs within geographic areas covered by AEs in Rhode Island.*

Stakeholder Engagement:

- *Continuing culture of collaboration with SIM partners and relationships built, as applicable.*

Sustainability Challenges:

The Health Equity Zones Initiative is RIDOH's primary approach for developing community-led infrastructure that is needed to move upstream and address the social, environmental, and economic determinants of health, while strengthening the voice of residents and partners at the local level. Sustainable funding for this model is essential to its long-term impact. To continue to support the development of resources needed to implement the HEZ initiative, RIDOH is continuing to pursue and secure state and federal funds to braid together to support the needs identified by the HEZ. Additionally, RIDOH is engaging local, State, and national philanthropic organizations, government agencies, and partners to identify opportunities for coordinated investments at the community level. For example, the Rhode Island Foundation (RIF), a local philanthropic funder, recently established the Fund for a Healthy RI to support projects that build on the SIM/HEZ culture of collaboration and is intended to create more effective community-clinical linkages. RIF funded six collaborations; all six were connected to Health Equity Zones. Other sustainability strategies include requiring healthcare systems to invest in their surrounding community through HEZ via current policy and regulatory levers, aligning

community evaluations, assessments, and investment strategies with the HEZ using collective impact methodology, and actively engaging with funded partners to identify opportunities for collaboration.

PCMH-Kids Pilot
Vendor: CTC-RI

Past Accomplishments:
- *Based on the outcomes of the PCMH-Kids pilot, NHPRI, and UHP supported a PCMH-Kids expansion in July 2017, adding ten additional practices, thereby 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) were honored with an AAP national award—the Calvin C.J. Sia Community Pediatrics Medical Home Leadership award—at the November 2018 annual meeting.*

Final Accomplishments:
- *CTC began Cohort 3, which expanded the program to 17 additional practice sites in July 2019, with early onboarding that began in April 2019.*
- *CTC and PCMH-Kids leadership worked with EOHHS and Managed Medicaid plans to provide one-time bridge funding for Cohort 1, for the timeframe 1/1/19 to 6/30/19.*
  - *PCMH Kids successfully extended the transformation of the state's primary care practices to children with all practices achieving and maintaining NCQA recognition;*
  - *Integrated employees with new skills who provided care coordination services for "at risk" children*
  - *Developed a commitment to shared learning and data-driven system improvement by participating in annual learning collaboratives based on a selected behavioral health topic*
- *Key Metrics: Improved BMI and Developmental screening and counseling; improved Customer experience: access, communication, office staff; improved Postpartum Depression Screening; improved Screening, Brief Intervention and Referral to Treatment: Adolescents; and reduced ED visits (Year 2)*

Investment Status:
- *In Discussion*

Legislation, Regulatory, or Waiver Change Needed:
- *Yes, for PCMH-Kids. Medicaid has included funding for PCMH-Kids in SFY 2020 MCO rates, which was approved by the legislature.*

Expected Changes:
- *In Discussion*

Scaling Opportunities:
- *CTC expanded the program to 17 additional practice sites in July 2019, with early onboarding beginning in April 2019.*

Stakeholder Engagement:
- *Continuing current stakeholder engagement work, as laid out in our AY4 Operational Plan.*

Sustainability Challenges:
- *PCMH Kids Cohort 1 multi-payer contract ended 12/31/18. OHIC has successfully worked with the commercial payers to provide PCMH Kids practices with sustainability payments effective 1/1/19 and EOHHS has incorporated sustainability rate changes into the 2020 fiscal budget;*
- *PCMH Kids has partnered with American Academy of Pediatrics, Children's Cabinet, Medicaid AEs, and RIDOH.*
- *Applied to Rhode Island Foundation to fund Pediatric IBH initiative and jointly applied with RI DOH for HRSA "Healthy Tomorrow" funds.*

Integrated Behavioral Health (IBH) Pilot
Vendor: CTC-RI

Past Accomplishments:
- *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 dissemination. APCD data indicate 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 is underway with completion date scheduled for late 2019.*

Final Accomplishments:
- *10 primary care practices, representing 42,000 adults, integrating behavioral health into primary care. Patients are now systematically screened for depression, anxiety, and SUDs, which is now considered the standard of care.*

- *Several barriers that were identified during the pilot and subsequent action led to the following significant changes in policy. RI OHIC worked with health plans and legislators to pass bills to reduce co-pay amounts charged to patients when they receive behavioral health services in primary care practices and require that health plans process behavioral health credentialing applications within 45 days. OHIC is leading further efforts to address remaining barriers.*
- *CTC has been able to demonstrate that IBH in primary care impacts total cost of care, ED visits and Inpatient visits.*

Investment Status:
- *CTC has sustained parts of the project and is expanding to new populations. However, the project still needs an ongoing sustainability model. See Scaling Opportunities below.*

Legislation, Regulatory, or Waiver Change Needed:
- *None*

Expected Changes:
- *In Discussion*

Scaling Opportunities:
- *Based on results from the IBH pilot program, CTC was able to secure funding from UHP and recently launched another IBH pilot program for adults representing 9 primary care practices. These practices are in the process of implementing universal screening for depression, anxiety, SUDs and health related SDOH. During this expansion, CTC will reference the findings of SIM's billing and coding research completed by Bailit Health to inform their plans for the future.*
- *Medicaid AEs have included requirements for implementing strategies to address behavioral needs within primary care; Integra (one of the AE's) is contracting with CTC to assist them with supporting practices with implementing behavioral health within primary care*
- *Rhode Island Foundation and Tufts are providing funding to test the IBH model in pediatric practices; CTC will be selecting 8 practices, representing 30,000 patient lives, to participate in a pediatric IBH learning collaborative opportunity*
- *RIDOH has obtained HRSA funding to implement universal screening (depression, anxiety, and SUDs) within OB/GYN practices and will be contracting with CTC to provide selected practices with practice facilitation support.*

Stakeholder Engagement:
- *Continuing current stakeholder engagement work, as laid out in our AY4 Operational Plan.*

Sustainability Challenges:
- *CTC continues its efforts to secure sustainability funding.*

- *The work is partially sustained: CTC recommends more action is needed to develop an Alternative Payment Model in Primary care. In the interim period, action has been taken to reduce co-pay burden for patients and OHIC has created a task force to identify and make recommendations for further action. Medicaid's AEs are being asked to identify and implement behavioral health strategies for primary care practices. CTC is continuing its efforts to provide practices with concrete tools they can use for calculating ROI and monitoring financial performance.*

Community Health Teams (CHTs) & Screening, Brief Intervention, and Referral to Treatment (SBIRT) Sites
Vendor: CTC-RI (with Diabetes Education Partners via RIDOH**)

Accomplishments:
- *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 is 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.*
- *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.*
- *The CHT/SBIRT and Evaluation teams developed an effective data collection process and distributed data collection guidance that will work across diverse CHT settings, with the first two sets of pre/post outcome data produced and sent to the evaluation team.*
- *Full data collection began in October and by January 9, 151 patients have completed intake evaluation tools (pre-intervention), 202 have completed screenings collected, and discharge evaluations are now also being completed (post-intervention).*
- *An evaluation of a small sample of Referral Triage Tool (RTT) data from a subset of CHT partners has noted that CHTs reduce RTT scores from intake to discharge by an average of 7.1 points (p<.0001) with no difference by gender or age.*
- *CTC-RI formed a new partnership with the Medical-Legal Partnership Boston (MLPB) to provide technical assistance to the CHTs seeing patients with legal and/or human rights needs as well as Diabetes Education Partners to provide community-based pharmacy and nutrition consults to CHT patients with demonstrated need.*

Final Accomplishments:
- *Under a centralized operations model, eight CHTs served over almost 3,000 high-risk patients.*

- *Through SAMHSA funding, SBIRT services are delivered at 25 sites with 14,534 screenings completed throughout Rhode Island as of 6/30/2019. 2,845 SBIRT screenings were conducted by CHTs over 21 months.*
- *A standard set of metrics were collected for CHT program evaluation and monitoring purposes. While burdensome, the ability to collect and report these data allowed us to validate the impact that we all believed CHTs are having on the patients being served.*
- *One CHT created a social support group of participants facing similar hardships which increased patient engagement and helped individuals feel more control of their own health and care plan; a core tenet of CHTs.*
- *CHT clients who completed patient experience surveys were generally in strong agreement with items reflecting excellent levels of patient satisfaction with their CHT care.*
- *Follow-up screenings at CHT sites demonstrated that the SBIRT model works well in CHT settings and that people who received brief substance use interventions reduced their past 30-day substance use by 30-40%, a finding that was both statistically significant and clinically meaningful.*
- *Among CHT clients, there was 30-40% statistically significant reductions in health risk over time; statistically significant reductions in SDOH over time; 30-35% reductions in levels of depression and anxiety over time; reductions in levels of substance use over time; statistically significant improvements in support, health knowledge and understanding, and numbers of days where the client could not function properly due to mental health problems or due to either physical or mental health*
- *CTC-RI will be continuing their relationship with the Medical-Legal Partnership Boston (MLPB) to provide technical assistance to the CHTs seeing patients with legal and/or human rights needs. MLPB engagement may expand their reach to the home visiting programs under RIDOH.*
- *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.*

Investment Status:

- *Over $3M in multi-payer support to leverage the existing statewide CHT network infrastructure and to serve expanded populations, including but not limited to: high risk children and families affected by OUD/SUD.*

Legislation, Regulatory, or Waiver Change Needed:

- *Yes—continued investigation of SBIRT reimbursement codes in partnership with Medicaid/OHIC; exploration of reimbursement for certified community health workers through waivers; and investigation of integrated billing and coding with OHIC.*

Expected Changes:
- *Without new funds replacing the SIM CHT funding, the CHT/SBIRT Consolidated Operations structure is likely to change given that the SAMHSA SBIRT funding braided for this project will continue beyond SIM for at least two years.*
- *Contingent upon the results of the SIM-funded, non-GPRA SBIRT pilot in OB-GYNs, future SBIRT implementation sites may change to include additional OBGYN settings beyond SIM.*
- *Unfortunately, sustainability of non-GPRA SBIRT beyond SIM is unlikely to be retained, decreasing the State's ability to maximize substance use screening as part of practice transformation outside of SIM's IBH project that is likely to continue.*

Scaling Opportunities:
- *SAMHSA continues to fund SBIRT through September 2021*
- *Multi-payer investment of over $3M to serve expanded populations including, but not limited to: high risk children and families affected by OUD/SUD.*
- *CTC-RI worked with Day Health Strategies to complete a sustainability study which involved an environmental scan and key informant interviews.*

Stakeholder Engagement:
- *Multi-State Agency and statewide provider support to leverage the existing statewide CHT network infrastructure with expansion*
- *Provider engagement for sustainability efforts after SAMHSA's SBIRT funding concludes in 2021*

Sustainability Challenges:
- *Due to procurement delays with this project and the need to develop a comprehensive set of evaluation measures across diverse stakeholders, the evaluation team has mostly received intake data to date and runs the risk of not enough comparative data for sustainability planning purposes.*
- *An equal number of matching patients with post-intervention discharge evaluations is critical, and a significant outreach effort is underway to adjust for this need.*
- *Because the average stay in a CHT is 215 days, the sample size needed may only be reached by August-October 2019 (beyond SIM) assuming all 151 patients are discharged in 7 months.*
- *A significant outreach effort is underway, but more data and analytics will likely be needed beyond the end of SIM.*

SBIRT Training and Resource Center
Vendor: Rhode Island College (RIC)

Past Accomplishments:
- *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/bus stops for raising awareness*
- *Obtained anecdotal data that 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.*
- *The SBIRT Training and Resource Center presented their results and sustainability plans to the SIM Steering Committee in November 2018, where the Directors of Medicaid and BHDDH engaged in a dialogue around scope and scaling opportunities.*
- *To date, the SBIRT Training and Resource Center has provided RI-SBIRT training directly to all Lifespan hospitals and Women & Infants Hospital.*
- *Since the inception of SIM, existing agency staff have been trained in and, in some cases, new staff hired/trained in SBIRT have been embedded at: CHTs (i.e., Blackstone Valley Community Health Center, East Bay Community Action Plan, Family Services of Rhode Island, South County Hospital, and Thundermist Health Center); The Providence Center (who are embedded in Kent and Butler hospitals); Other CHT/SBIRT partners (such as Comprehensive Community Action Program, Rhode Island Parent Information Network, and South County Health).*
- *Evaluation has revealed significant changes in trained providers' attitudes, knowledge, and confidence, including: stronger agreement that involvement with a patient can make a difference in his/her substance use; stronger disagreement that patients would be angry if asked questions about their substance use; and for both general SBIRT knowledge (e.g., risky drinking levels) and motivational interviewing skills.*

Final Accomplishments:
- *Impacts on Physical and Behavioral Health Integration:*
  - *Improved care delivery by enhancing informed practice by promoting healthcare providers to ask key questions regarding substance use in various healthcare settings.*
  - *Provided coaching in primary and integrated healthcare sites (13 adult/ 11 pediatric) on better integration of SBIRT in their workflow to maximize and support team-based care.*
  - *Example: On March 9th the SBIRT training and resource center was invited to conduct an SBIRT training for over 60 Dentists, Dental Assistants, and Dental Hygienists as part of a Dental Mini-Residency funded by DOH. This was an opportunity to expand the SBIRT practice into a new realm, oral-health, and close the gap in the separation between oral, physical, and behavioral health.*

- *Impacts on Healthcare Workforce Transformation:*
  - *Provided training and support to 1555 healthcare workforce (beyond our initial target of 250) across all levels of healthcare spectrum to improve their abilities to motivate and educate patients with risky or unhealthy substance use.*
  - *Example: Based on available data from November 2017 through March 2019, the SBIRT Training & Resource Center at RIC effectively trained over 700 providers.*

The Core SBIRT Training was evaluated with a pre-test measure prior to Module 1 and a post-test measure after Module 2 (or Module 1 for some non-vendors). As compared to non-vendor trainees, vendor trainees found the Core SBIRT Training more satisfying and saw fewer barriers to implementing SBIRT. From pre- to post training, both vendor and non-vendor trainees generally improved in confidence and knowledge; however, non-vendor trainees also perceived more value on SBIRT following training.

- *Impacts on Patient Engagement:*
  - *Directly addressed stigma associated with substance use and provided direct path to health-related referrals.*
  - *Example: During a follow up site visit to a hospital emergency department one Social Worker reported that the "WE Ask Everyone" poster and pins given to him at the SBIRT Module 1 training had resulted in increased referrals to treatment from emergency department.*

- *Impacts on Data Capability and Expertise:*
  - *N/A*

- *Impacts on Population Health:*
  - *Directly addressed stigma associated with being asked questions related substance use in medical provider offices by launching a public awareness campaign "WE ASK EVERYONE."*
  - *Expanded the "WE ASK EVERYONE" campaign message beyond substance use to gender and sexual identity and end of life issues.*
  - *Additional Key Metrics: "WE ASK EVERYONE" pins distributed: 1255*
  - *Additional Key Metrics: "WE ASK EVERYONE" posters distributed: 487*

Investment Status:
- *In Discussion – we are awaiting decisions from potential funding sources. We are also working with additional partners to increase funding opportunities to provide support beyond SIM funding, including CVS, RI AAP, SUMHLC, United Way, and the Governor's Office.*

Legislation, Regulatory, or Waiver Change Needed:
- *Yes—investigation of SBIRT reimbursement codes; investigation of CE requirements.*

Learnings:
- *Lessons Learned:*
  - *Referral resources for SUDs in Rhode Island are still not adequate to meet needs.*
  - *Systems for treatment are disconnected and difficult to navigate.*
  - *Normalizing questions remains challenging.*
  - *Improve notification processes for sites/partners who need new hires trained in order to adequately prepare training calendar.*
  - *Be more proactive with CHT and SBIRT Site training protocol as a subset of the Training Plan.*
  - *Expand training to other behavioral health integration topics, especially related to SUD.*
  - *Build relationships with SUD treatment providers.*

- o *Study changes in patient/provider comfort with SUD-related questions.*

- *Promising Practices:*
  - o *SBIRT has implications for the workplace. Collaborating on the Governor's Recovery Friendly Workplace Initiative to ensure key messages and resources from the SBIRT Training and Resource Center are included.*
  - o *Expansion into Prenatal/OB care- Collaboration with pilot program with Tri-County OBGYN for prenatal health program.*
  - o *Expansion to Pediatrics—Partnered with RI AAP/CTC for the Adolescent SBIRT Learning Collaborative and RIC secured/incorporated online simulations through Kognito for adolescent SBIRT as well as offering onsite practice coaching for identified practices (11 sites).*
  - o *Expansion to Student Assistant Services SBIRT Training & Resource Center conducted training for all RI Student Assistance Services counselors in middle and high school in Rhode Island and incorporated online simulations through Kognito for adolescent to enhance practice skills.*
  - o *Expansion to School Nurses—SBIRT Training & Resource Center conducted training for all public-school nurses in middle and high school in Rhode Island and incorporated online simulations through Kognito for adolescents to enhance practice skills.*
  - o *Expansion to Dentists and Dental Hygienists—SBIRT Training & Resource Center conducted training for Dental Mini-Residency hosted by RIDOH.*
  - o *Expansion to Firefighters—The City of Providence has launched "Safe Stations" for people seeking help for substance use, and the RI Training & Resource Center has been working to be able to offer training to firefighters in the future.*
  - o *Interprofessional Events—RIC has had ongoing partnerships with RIC Social Work and Nursing; URI Nursing and Physical Therapy; and Warren Alpert Medical School at Brown University to conduct interprofessional trainings for students with SBIRT as an ongoing theme and intervention utilized in the live case simulations.*
  - o *Development of Videos for Enhanced Learning—Utilized funds from SIM to create videos to support providers and employers on "How To" conversations with live SBIRT simulations. (videos are in final edit stages and will be uploaded to RISBIR.org website under the "Resource" tab by July 31, 2019.)*

- *Formal Evaluation Insights:*
  - o *Significant changes in attitude—Stronger agreement that involvement with a patient can make a difference in their substance use. Stronger disagreement that patients would be angry if asked questions about their substance use*
  - o *Significant increase in knowledge—For both general SBIRT knowledge (e.g., standard drink size, risky drinking levels) and motivational interviewing skills.*
  - o *Positive training experiences with SBIRT—Training participants reported positive training experiences in SBIRT trainings.*
- *Training provided across community provider profession and degree status*

Scaling Opportunities:
- *Exploring continued utilization of online SBIRT modules with other potential funders to ensure SBIRT training availability opportunities to meet substance use and/or opioid-related continuing education credits and provide additional targeted training, such as stigma-reduction training and medication-assisted treatment training.*
- *Continuing to increase outreach and implementation by developing a long-term collaborative relationship with RI American Academy of Pediatrics and CTC-RI to*

expand the learning collaborative for Pediatric SBIRT beyond 11 pediatric practices across RI remains a possibility.

Stakeholder Engagement:
- *Continuing culture of collaboration with SIM partners and relationships built, as applicable.*

Sustainability Challenges:
- *Sustainability Status: 1) Partially sustained- continued funding through State Opioid Response (SOR) grant at reduced capacity. The SOR funding will continue to support SBIRT training of healthcare professionals in the State. 2) Additional funds obtained from Rhode Island Foundation by RIC SSW to provide preventative screenings in two communities—Woonsocket (with the highest opioid overdose death rate in the State) and South Providence (overdose death rate higher than the national average)*
- *Scale: Level Effort—Continue to provide training to healthcare professionals and support existing SBIRT integrated practices and to provide the training of trainers curriculum to build capacity in agencies*

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 healthcare in order for them to live healthier lives. Invest in tools (e.g., online applications, patient coaches who are appropriate for the patient's demographic profile) to teach patients how to navigate effectively in an increasingly complicated healthcare system.

Complex Care Conversations
Vendor: HopeHealth (formerly Hope Hospice and Palliative Care of RI)

Past Accomplishments:
- *HopeHealth 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 attendees' knowledge, attitudes, and behavior. HopeHealth uses a Pre/Post Training Assessment to determine the participant's ability/comfort level with 11 aspects of complex care conversations.*
- *Forty-seven percent 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 (ACP) 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 illnesses.*
- *HopeHealth 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 ACP 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.*

Mid-Project Updates to Accomplishments:
- *HopeHealth completed initial rounds of the Patient/Family Satisfaction Survey, distributed in a limited fashion (due to privacy and sensitivity concerns) to patients of the HopeHealth-associated Coastal Medical practice.*
- *The initial round reached 29 out of 89 patients/families called (response rate of 33%). Eighty-three percent of respondents found the complex care conversation helpful and 79% felt the provider elicited their priorities. Participants were asked to recommend palliative care on a scale of 1 to 10; the average response was 7.9.*

Final Status:
- *In total, HopeHealth conducted 31 training sessions with 511 clinicians. Within a cohort of clinicians at HopeHealth, ACP documentation increased by 80% and within Coastal Medical clinicians, documentation increased by 124%.*
- *Overall, trained clinicians who responded to a follow-up survey reported: increased satisfaction in caring for seriously ill patients (84% of respondents); increasing numbers of goals of care conversations with seriously ill patients and their families (73%); better able to identify patients who could benefit from a goals of care conversation (>90%); more effective in responding to patient and family emotions (>90%). Overall, trained clinicians reported greater personal and professional satisfaction in caring for seriously ill patients because they were better able to focus on the process rather than the outcome by accepting outcomes other than what they deemed as 'successful'.*

Investment Status:
- *Sustained through RIDOH's Comprehensive Cancer Control Program, and in collaboration with BCBSRI.*
- *Long-term, HopeHealth is pursuing the inclusion of Complex Care Conversations Training in the curricula of medical and nursing programs.*

Legislation, Regulatory, or Waiver Change Needed:
- *None—investigation of healthcare curriculum changes may be helpful.*

Expected Changes:
- *Due to the nature of the funding secured through RIDOH, HopeHealth anticipates a greater focus on training providers and staff treating cancer patients.*

- *They also expect to focus on offering fewer training opportunities with larger numbers of participants per session, in response to feedback received from CME accreditation staff regarding cost effectiveness.*
- ***Final update:*** *The expected redirection was successful in allowing HopeHealth to meet their target number of clinicians trained.*

Scaling Opportunities:
- *HopeHealth is pursuing expansion into pre-workforce student programs, initially at Brown Medical School and possibly at several nursing schools.*

Stakeholder Engagement:
- *Facilitated stakeholder engagement work as laid out in our AY4 Operational Plan.*
- *Engaging nursing associations and schools for expansion opportunities.*

Sustainability Challenges:
- *Long-term viability without grant funding is contingent on charging for participation. Concerns have been raised about the level of participation if there is a cost.*
- *A potential solution is to pursue integration into continuing education requirements. HopeHealth is in discussions about this possibility.*

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

Past Accomplishments:
- *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:*

- o *Information for Everyone page which includes patients, veterans, families, caregivers, and the faith community*
- o *Spanish page (Mi Cuidado, Mi Eleccion, Mi Voz)*
- o *Healthcare provider page*

Mid-Project Updates to Accomplishments:
- *Healthcentric Advisors recorded and edited a simulation training video and completed an accompanying educational guide for use with medical residents. These will ensure that Rhode Islanders can use the training materials post-SIM.*
- *Five pilot presentations and a strategy session were completed at provider practices. Outreach is ongoing to physician practices to participate in the pilot group medical visit.*

Final Update:
- *Healthcentric developed a Train-the-Trainer curriculum for physician's offices, nursing homes, assisted living facilities, and nursing education programs. A network of ACP educators was created throughout this work.*
- *Over 597,000 consumers were reached through communications campaigns, with most reached through social media. For those who attended in-person community events, 95% reported that they understood the importance of ACP and 85% indicated a desire to complete an ACP.*
- *There was a 127% relative improvement rate in participating providers' use of ACP billing codes.*

Investment Status:
- *This was a One-Time Investment*
- *Materials remain available on MyCCV.org in both English and Spanish*

Legislation, Regulatory, or Waiver Change Needed:
- *OHIC promoting inclusion of an ACP quality measure such as Medicare measure #47 in the Aligned Measure Set would assist in engaging providers and payers.*

Expected Changes:
- *Healthcentric reports ongoing challenges connecting with patients to commit to attending pilot group medical visits (although the patient meetings at community events were quite positive). Individuals still prefer to avoid topics surrounding end of life care and ACP. Given this challenge, they are brainstorming innovative ways to improve engagement and may shift goals for the pilot group, with a focus instead on evaluation of barriers to success and potential strategies for overcoming them.*
- ***Final update:*** *Despite successes in overall consumer engagement, the pilot group visit at physicians' offices did not reach target participation. Barriers identified included too many other competing time demands on providers, and the persistent taboos around discussions of end-of-life. Success for group visits requires that the visits by actively promoted by providers at those practices.*

Scaling Opportunities:
- *Aiming to integrate 1:1 ACP conversations into primary care practices via an aligned quality measure, facilitated by OHIC's regulatory authority.*

Stakeholder Engagement:
- *This project centered around stakeholder engagement and successfully met outreach targets.*
- *Healthcentric reached out to RIC and URI nursing schools to incorporate ACP into nursing education.*

Sustainability Challenges:
- *A Train-the-Trainer program was developed to expand the number of people and agencies trained in ACP, and the MyCCV.org website will continue be maintained by Healthcentric Advisors with all tools and resources.*
- *However, the sustainability of this work is in question unless a way can be found to fully integrate ACP into provider workflows.*

Consumer Engagement Platform (CEP)
Vendor: Rhode Island Quality Institute (RIQI)

Accomplishments:
- *Development of the platform side of the Consumer Engagement Platform (CEP) has been mostly completed, with a few additional pieces of functionality left to finalize.*
- *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 unlikely 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.*

Updates to Accomplishments:
- *The CEP went live in late December 2018. There are 10 pilot practices in the process of getting credentialed and trained to use the system.*
- *Under HITECH IAPD funding with match from the RI Foundation, RIQI is currently adding SBIRT screening and reporting to the CEP. We are evaluating additional use cases for this system.*

Final Accomplishments:
- *Patients now have the ability to upload and share their ACPs, specifically advance directives and Medical Orders for Life Sustaining Treatment (MOLST), with not only their primary care providers but also with the Rhode Island healthcare community that accesses CurrentCare.*
- *402 patients have had their ACP Documents uploaded into the Know My Health platform via 9 practice sites participating in the pilot program.*
- *Each participating practice developed AIMS specific to their organization's needs based upon their workflow and capabilities as part of the learning collaborative, see summary of AIM statements here....*
- *Successfully implemented a web-enabled patient information collection tool that stores and shares that information with the Rhode Island provider community through a statewide database called Know My Health and with CurrentCare. The ability to share this information (specifically Advance Directives and Medical Orders for Life Sustaining Treatment) is a significant milestone for CurrentCare.*
- *Now have the capability to collect health information via form and document upload tools; assessments, surveys, reports can now be readily created to meet the needs of the Rhode Island provider community, such as SBIRT assessments, SDOH assessments, GPRA forms, Medical History forms, etc.*

Investment Status:
- *This system has been leveraged to help meet BHDDH's SAMHSA SBIRT grant reporting requirements, and thus will be sustained through SBIRT grant funding for the next couple of years. Providers will still be able to also use it for advance directives. Additional concepts are being considered.*

Legislation, Regulatory, or Waiver Change Needed:
- *Not Applicable*

Expected Changes:
- *Not Applicable*

Scaling Opportunities:
- *We are working on adding additional use cases to this system and leveraging it to address provider burden, which we believe will make it more valuable to the community.*

Stakeholder Engagement:
- *We are increasingly discussing other opportunities to leverage the platform with other state agencies.*

Sustainability Challenges:
- *Sustaining the CEP is dependent upon it possessing valuable uses. We have committed to maintain it in the short term (over the next couple of years) through SBIRT funding.*

Conscious Discipline©
Vendor: The Autism Project

Accomplishments:
- 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.
- 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.
- Rhode Island, with leadership from TAP, is hosting the 2020 National Conference on Conscious Discipline.
- The CD program was recently featured in a local television news program's "Health Check" report. The story featured Patty Carosotto's Pre-K classroom and included comments from TAP Director, and Acting Secretary of the Rhode Island Executive Office of Health and Human Services. The segment aired on January 24, 2019.

Final Accomplishments:
- Over the course of the SIM grant, the Autism Project and Conscious Discipline (CD) has served over 300 students, with 14 teachers and administrators who 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.

Investment Status:
- In Discussion—There is at least one new opportunity through another grant received by the state that may provide continued support for this project. This project also has limited financial support for CD from other sources.

Legislation, Regulatory, or Waiver Change Needed:
- Not Applicable

Expected Changes:
- If funding is limited post-SIM, we expect that TAP will rely more on their Train-the-Trainer model, strengthened by the SIM investment, to continue expansion.

Scaling Opportunities:
- *RI will be hosting the 2020 Conscious Discipline national conference. The Director sees this as an excellent opportunity to expand awareness and provide training to more teachers, parents, and potential future trainers.*

Stakeholder Engagement:
- *TAP Director is in ongoing discussions with existing and new stakeholders, including the Policy Director of the Governor's Children's Cabinet. TAP Director also joined the Early Intervention Interagency Coordinating Council (ICC) Work Group aiming to improve the quality of early education programs, including Social Emotional Learning (SEL). The Work Group also includes key health and education state agencies, Bradley Hospital, community partners, and early childhood center leaders. The ICC is the governing oversight board for all Early Education in Rhode Island.*

Sustainability Challenges:
- *TAP is taking a number of steps to raise additional funds and work toward sustainability, including:*

  o *Exploring other sources of funding (local districts and state agencies)*
  o *Working closely with early childhood agencies and programs*
  o *Engaging higher education in discussions to embed the curriculum in early childhood education programs*
  o *Support expanded use of DESSA (standardized, strength-based observation tool)*
  o *Share district and classroom level data and results more widely*
  o *Emphasize the Train-the-Trainer and parent-education components of the CD model*
  o *Raise visibility and educate schools and policymakers about the CD model*

- *Key challenges to date include:*
  o *Competing needs for limited funds to support school-based interventions*
  o *Competing SEL models and programs*