Strategic Plan 2012-2017

Michael Fine, MD
Director

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THE GOAL OF PROMOTING AND PROTECTING THE HEALTH OF RHODE ISLANDERS WOULD BE WELL-SERVED BY MAKING OUR STATE THE HEALTHIEST STATE IN THE NATION.
The Rhode Island Department of Health (HEALTH) is shifting its priorities to make Rhode Island the healthiest state in the nation. To achieve such a grand goal, the agency is engaging in initiatives to improve the health delivery system and has taken firm first steps towards a primary care trust that would support a “neighborhood health station” model in each neighborhood of 10,000 or more people. HEALTH is also bringing the idea of “Health in all policies,” and is making great strides to make smoke-free state campuses and grounds, as well as instituting a prescription monitoring program (PMP) that gives providers the ability to check the system before prescribing schedule 2 and 3 medications. HEALTH is also pursuing several avenues to revolutionize its business model, by seeking new ways to fund current programs. In 2013, HEALTH successfully advocated for an increased number of Full Time Equivalent (FTE) positions supported with federal funds. HEALTH has also invested efforts in strengthening its infrastructure, by taking strong steps to become accredited through the Public Health Accreditation Board (PHAB) and is prepared to submit its application in early 2014. Through accreditation efforts, HEALTH has already taken strong steps to bring the Quality Improvement (QI) tools and vocabulary to the staff, and hopes to institute and maintain a culture of QI in the coming years. A statewide health assessment and health improvement plan has also been prepared, and there is a consistent message about performance improvement that is now part of weekly messages at the Executive Committee table. Lastly, HEALTH is approaching the importance of the workforce development in a higher and new way. An annual training plan for staff has been developed and will be renewed each year. The HEALTH Connections newsletter now has eleven editions issued for targeted health professional communities such as physicians, nurses, pharmacists, oral health, emergency medical services, and more.

While it is impossible to fully describe in one document all efforts HEALTH is engaging in to make Rhode Island the healthiest state in the nation, this strategic plan contains key, long-term, overall objectives the Department is pursuing towards its large-scale vision. These objectives, along with all other goals and efforts at the program and micro level, are the foundation that supports the work of the next five years, when we expect to be at a much higher rank from the America’s Health Rankings than we are now (19th in 2013). Please use this strategic plan as a blueprint of the journey HEALTH began in 2011 striving for a destination of an improved delivery system and a stronger infrastructure for much healthier Rhode Islanders by 2017.
IN RHODE ISLAND, ALL PUBLIC HEALTH SERVICES ARE MANAGED BY THE STATE DEPARTMENT OF HEALTH, WITH NO LOCAL PUBLIC HEALTH AGENCIES.
Location and Population Served

HEALTH is located at Three Capitol Hill in the city of Providence, Rhode Island. In Rhode Island, county government was abolished in 1842 and today remains only for the purpose of delineating judicial administrative boundaries.

According to the most recent census data, the current population of Rhode Island is 1,050,292, with 86.3% of white origin. There are no local public health agencies in Rhode Island; all public health services are managed by the State Department of Health.

Mission, Vision, and Values

Mission: To prevent disease and to protect and promote the health and safety of the people of Rhode Island

Vision: Every Rhode Islander should have access to high quality, affordable healthcare, delivered at the most appropriate time and place. All people in Rhode Island will have the opportunity to live a safe and healthy life in a safe and healthy community.

Values: Advocacy, collaboration, integrity

To meet the community’s expectations for high-quality, affordable healthcare, the delivery system must:

- Deliver healthcare according to the latest scientific evidence, using current evidence-based guidelines where available.
- Improve the quality, efficiency, and accessibility of healthcare services.
- Improve affordability by ensuring efficient utilization of healthcare providers and services.
- Partner with the consumer in his/her healthcare.
- Orient the system toward person-centered care, with family involvement as appropriate.
- Respond to the healthcare needs of the community, in terms of access and cultural and linguistic competence.
- Improve the health status of the population.
Governance

The Rhode Island Department of Health is part of the Executive Office of Health and Human Services (EOHHS). EOHHS was created in December 2005 to facilitate cooperation and coordination among the state departments that administer Rhode Island’s health and social services programs.

Agencies under the EOHHS umbrella include: Department of Children, Youth and Families (DCYF), Department of Human Services (DHS), Division of Elderly Affairs (DEA), Division of Veteran Affairs (VA), Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), and the Department of Health (HEALTH). These departments collectively impact the lives of virtually all Rhode Islanders, providing direct services and benefits to more than 300,000 citizens while working to protect the overall health, safety and independence of all Rhode Islanders.

Michael Fine, MD, has served as Director of the Rhode Island Department of Health since July 2011. In this role, Dr. Fine oversees the single state agency, with more than 400 employees and an operating budget of $110 million, and is responsible for coordinating a broad range of public health programs and services.

Organizational Structure

HEALTH is led by the Director, appointed by the state’s Governor. As Rhode Island has no local health departments, the agency coordinates public health activities across the state. All programs and services are coordinated by Divisions and Centers (see Organizational Chart in Appendix 1). Main areas of responsibility include:

1. **Community, Family Health, & Equity**: Works to eliminate disparities in health and access to care, to ensure healthy homes and environments, to prevent and control diseases and disability, to promote health and wellness activities, and to support early childhood development.

2. **Center for Emergency Preparedness & Response**: Protects health during catastrophic events and large-scale disasters and emergencies by coordinating education, assessment, planning, response, and support services with healthcare providers, public safety agencies, and government officials.

3. **Environmental Health Services Regulation**: Licenses and regulates health professionals, facilities, and health plans; monitors the safety of public drinking water and beaches; and assures the safety of the food supply and of radiological equipment.

4. **Center for Health Data & Analysis**: Collects and analyzes health data about Rhode Islanders and uses the data to identify health problems among the state’s population and groups.

5. **Health Information Technology**: Promotes and supports the use of health information technology across the state, including electronic medical records, e-prescribing, and the development of a statewide health information exchange.
6. **Health Laboratories:** Provides analytical surveillance, prevention, and technical laboratory information to support disease surveillance, prevention, and control; environmental health protection; food safety; and emergency response activities.

7. **Infectious Disease & Epidemiology:** Monitors the prevalence of diseases in the community and investigates, controls, and prevents outbreaks.

8. **Management Services:** Manages and delivers efficient personnel, purchasing, finance, and systems support services to the Department in an equitable, effective, efficient, and courteous manner.

9. **Medical Examiners:** Screens deaths for public health significance and determines the cause and manner of deaths.

10. **Center for Public Health Communication:** Provides high-quality, timely, and accurate health information for the public so they can understand health risks and make healthy and safe choices.

11. **Vital Records:** Registers, files, and maintains birth, death, and marriage certificates and publishes related data.
HEALTH DEFINES PERFORMANCE MANAGEMENT AS THE STRATEGIC USE OF PERFORMANCE MEASURES AND STANDARDS TO ESTABLISH PERFORMANCE TARGETS AND GOALS, TO PRIORITIZE AND ALLOCATE RESOURCES, TO INFORM MANAGERS ABOUT NEEDED ADJUSTMENTS OR CHANGES IN POLICY OR PROGRAM DIRECTIONS TO MEET GOALS, TO FRAME REPORTS ON THE SUCCESS IN MEETING PERFORMANCE GOALS, AND TO IMPROVE THE QUALITY OF PUBLIC HEALTH PRACTICE.
Rhode Island uses the Turning Point Performance Management System, which includes four quadrants: Performance Standards, Performance Measurement, Quality Improvement, and Reporting of Progress.

In 2003, the Turning Point tools described performance management as the practice of actively using performance data to improve the public’s health. This practice involves strategic use of performance measures and standards to establish performance targets and goals, to prioritize and allocate resources, to inform managers about needed adjustments or changes in policy or program directions to meet goals, to frame reports on the success in meeting performance goals, and to improve the quality of public health practice.

The four components of performance management are depicted in Figure 1 below.

**Figure 1. Turning Point Framework of Public Health Performance Management System**
The components are described as:

- **Performance Standards** - establishment of organizational or system performance standards, targets, goals, and relevant indicators to improve public health practice
- **Performance Measures** - application and use of performance indicators and measures
- **Reporting of Progress** - documentation and reporting of progress in meeting standards and targets and sharing of such information through feedback
- **Quality Improvement** - establishment of a program or process to manage change and achieve quality improvement in public health policies, programs, or infrastructure based on performance standards, measurements, and reports

HEALTH has adapted the Turning Point framework and designed its own Performance Management System, as shown in Figure 2 below.
Director of Health Michael Fine, MD, is issuing the challenge to make Rhode Island the healthiest state in the nation, defined by the scoring used by America’s Health Rankings® (www.americashealthrankings.org/). As shown in Table 1 below, Rhode Island ranks number 19 in 2013. Note that, Rhode Island ranks first in immunizing adolescents, third in the ratio of primary care physicians, and 10th in public health funding dollars per person.

<table>
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<tr>
<th>Rhodel Island Indicators, according to America’s Health Rankings 2013</th>
<th>2013 VALUE</th>
<th>RANK</th>
<th>NO 1 STATE</th>
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<tr>
<td><strong>BEHAVIORS</strong></td>
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<tr>
<td>Smoking (Percent of adult population)</td>
<td>17.4</td>
<td>14</td>
<td>10.6</td>
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<tr>
<td>Binge Drinking (Percent of adult population)</td>
<td>17.2</td>
<td>30</td>
<td>10.2</td>
</tr>
<tr>
<td>Drug Deaths (Deaths per 100,000 population)</td>
<td>16.0</td>
<td>42</td>
<td>5.0</td>
</tr>
<tr>
<td>Obesity (Percent of adult population)</td>
<td>26.7</td>
<td>13</td>
<td>20.5</td>
</tr>
<tr>
<td>Physical Inactivity (Percent of adult population)</td>
<td>23.4</td>
<td>30</td>
<td>16.2</td>
</tr>
<tr>
<td>High School Graduation Rate (Percent of incoming ninth graders)</td>
<td>76.4</td>
<td>33</td>
<td>91.4</td>
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<tr>
<td><strong>COMMUNITY &amp; ENVIRONMENT</strong></td>
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<tr>
<td>Violent Crime (Offenses per 100,000 population)</td>
<td>252</td>
<td>13</td>
<td>123</td>
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<tr>
<td>Occupational Fatalities (Deaths per 100,000 workers)</td>
<td>3.7</td>
<td>15</td>
<td>1.9</td>
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<tr>
<td>Infectious Diseases (Combined score Chlamydia, Pertussis, Salmonella)</td>
<td>-0.11</td>
<td>27</td>
<td>-0.90</td>
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<tr>
<td>Chlamydia (Cases per 100,000 population)</td>
<td>39.9</td>
<td>23</td>
<td>140.6</td>
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<tr>
<td>Pertussis (Cases per 100,000 population)</td>
<td>5.9</td>
<td>28</td>
<td>0.7</td>
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<tr>
<td>Salmonella (Cases per 100,000 population)</td>
<td>18.4</td>
<td>37</td>
<td>6.6</td>
</tr>
<tr>
<td>Children in Poverty (Percent younger than 18 years)</td>
<td>20.4</td>
<td>28</td>
<td>9.7</td>
</tr>
<tr>
<td>Air Pollution (Micrograms of fine particles per cubic meter)</td>
<td>8.5</td>
<td>16</td>
<td>5.3</td>
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<tr>
<td><strong>POLICY</strong></td>
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<tr>
<td>Lack of Health Insurance (Percent without health insurance)</td>
<td>12.2</td>
<td>14</td>
<td>3.8</td>
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<tr>
<td>Public Health Funding (Dollars per person)</td>
<td>$114</td>
<td>10</td>
<td>$225</td>
</tr>
<tr>
<td>Immunization—Children (Percent aged 19 to 35 months)</td>
<td>72.5</td>
<td>15</td>
<td>80.2</td>
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<tr>
<td>Immunization—Adolescents (Percent aged 13 to 17 years)</td>
<td>82.0</td>
<td>1</td>
<td>82.0</td>
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<td><strong>CLINICAL CARE</strong></td>
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<tr>
<td>Low Birthweight (Percent of live births)</td>
<td>7.4</td>
<td>19</td>
<td>6.0</td>
</tr>
<tr>
<td>Primary Care Physicians (Number per 100,000 population)</td>
<td>173.4</td>
<td>3</td>
<td>196.1</td>
</tr>
<tr>
<td>Dentists (Number per 100,000 population)</td>
<td>59.1</td>
<td>23</td>
<td>85.6</td>
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<tr>
<td>Preventable Hospitalizations (Number per 100,000 Medicare enrollees)</td>
<td>70.3</td>
<td>37</td>
<td>27.4</td>
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<tr>
<td><strong>ALL DETERMINANTS</strong></td>
<td>0.32</td>
<td>13</td>
<td>0.70</td>
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<td><strong>OUTCOMES</strong></td>
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<tr>
<td>Diabetes (Percent of adult population)</td>
<td>9.8</td>
<td>26</td>
<td>7.0</td>
</tr>
<tr>
<td>Poor Mental Health Days (Days in previous 30 days)</td>
<td>4.1</td>
<td>35</td>
<td>2.8</td>
</tr>
<tr>
<td>Poor Physical Health Days (Days in previous 30 days)</td>
<td>4.1</td>
<td>29</td>
<td>2.9</td>
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<tr>
<td>Disparity in Health Status (By educational attainment**)</td>
<td>31.5</td>
<td>36</td>
<td>19.7</td>
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<tr>
<td>Infant Mortality (Deaths per 100,000 live births)</td>
<td>6.6</td>
<td>28</td>
<td>4.4</td>
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<tr>
<td>Cardiovascular Deaths (Deaths per 100,000 population)</td>
<td>238.6</td>
<td>22</td>
<td>186.9</td>
</tr>
<tr>
<td>Cancer Deaths (Deaths per 100,000 population)</td>
<td>193.1</td>
<td>31</td>
<td>141.3</td>
</tr>
<tr>
<td>Premature Death (Years lost per 100,000 population)</td>
<td>6,662</td>
<td>20</td>
<td>5,493</td>
</tr>
<tr>
<td><strong>ALL OUTCOMES</strong></td>
<td>0.00</td>
<td>30</td>
<td>0.33</td>
</tr>
<tr>
<td><strong>OVERALL</strong></td>
<td>0.32</td>
<td>19</td>
<td>0.92</td>
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*Negative score denotes less disease than US average, positive score indicates more than US average

**Difference in high health status between adults aged 25 and older without a high school education and those with at least a high school education

Note that the scores provided for each of the items is the weighted number of standard deviations the state is above or below the national norm. As shown in the table above, for “all determinants”, Rhode Island’s score is 0.32, half the number 1 state (0.70). Likewise, the score for “all outcomes” in our state is 0.32, one third of the number 1 state (0.92).
a. Performance Measurement at HEALTH

Starting in July 2011, HEALTH began an ongoing, organized compilation of program performance measures in one central location and under a uniform format. The resulting document is known by staff as the “Dashboard Report”, and formally titled the “Performance Measures Progress Report.” This report began with just a handful of measures and in less than two years has grown to include performance measures from 36 of the 47 (77%) programs, using the listing that is prepared in the annual State’s Budget.

The Dashboard is an internal management tool that collects performance measures and depicts a quick view of the Department’s activities, and was designed with the following goals in mind:

• To provide a monthly, brief, at-a-glance view of the Department’s activity and overall performance.
• To identify areas of concern that may need attention.
• To inform about at least one meaningful type of measure (activity, quality, outcome) for each program.

Definitions and descriptions of each of the types of measures are included below.

**Activity Measures:**

**Definition:** The volume of the work we do

**Unit of Measure:** In numbers (i.e., number of calls received, number of licenses renewed)

**Report Frequency:** Monthly

**Characteristics:** Uses data that are already being collected and tracked and can be easily reported; or uses data that are not currently collected, but are critical for the program to collect and measure

**Quality Measures:**

**Definition:** A measure of the extent to which we accomplish what we are charged to do

**Unit of Measure:** In percentages (i.e., percentage of tests completed within three days, percentage of cases resolved within 30 days)

**Report Frequency:** Monthly

**Characteristics:** Must be meaningful
**Outcome Measures:**

**Definition:** A public health measure of the health outcome of the population

**Unit of Measure:** In numbers (i.e., # of HIV deaths), or percentages (prevalence, incidence rates), but always has population as a denominator

**Report Frequency:** Can be reported with data originated by other divisions/units within or outside of the Department

**Characteristics:** Can be reported every 3-6 months or annually

- For purposes of the dashboard, outcomes should be long-term outcomes or program impact/results, and can be measured with data that is collected by another (team, division, database) source
- Value used to compare performance achieved vs. performance expected
- Should be meaningful and understandable
- Should be seen as important and stated in non-technical terms
- Should be valid, reliable, responsive and must have adequate data to support the measure
- Measure what you should, and what you can

**Targets:**

**Definition:** Value used to evaluate performance

**Unit of Measure:** A number or percent

**Report Frequency:** Set usually for one year or more, although it can be revised as a consequence of dramatic changes in program, incidence, funding or another long-lasting event

**Characteristics:**

- Should be set concurrently with consideration of strategic choices and practical performance measures
- Should be set to trigger a management alert of a performance measure not being achieved, but with enough tolerance so that the alert fires when there is a clear need for intervention
- If no previous target is available: first measure current performance, then determine a target
- For measures with long reporting cycles, set some frequent surrogate targets that can be monitored as a proxy
- To decide on which targets to use, consider the cost (i.e., staff time) of setting data collection and efficiency of target being set
There are 3 types of targets:

- Threshold-based (one side is OK, other side is not)
- Limit-based (0% or 100%) aspirational and inspirational - i.e., getting to 0% may be impractical but is worthy
- Rule-based (need X out of Y to hit a limit or target)

b. Quality Improvement at HEALTH

HEALTH has been involved in quality improvement (QI) efforts in several parts of the Department for many years in targeted activities, especially in the Chronic Disease and Home Visiting programs. The first agency-wide quality improvement group, however, was convened in late 2011 and received the Train-The-Trainers comprehensive four-day session in July and August 2012. By April 2013, the group completed and exhibited the first set of QI projects, at a first-time QI Fair held during National Public Health Week.

To further strengthen the foundation of QI within HEALTH, the first department-wide Quality Improvement Plan was launched in June 2013 and is designed to advance the following three goals:

1. Develop a strategy to maintain QI capacity
2. Inform and communicate to staff about QI activities
3. Foster and support a culture of QI

Two years after the first QI team was convened, QI is now a sustained effort, with a new group being selected and trained each year, and ongoing QI projects all year long.

For questions about the QI Plan from 2013, please contact Magaly.Angeloni@health.ri.gov.
c. Reporting Indicators at HEALTH
All of these indicators are reported in the newly launched software at www.rihealthcarematters.org, and selected measures have been used in the community meetings conducted for purposes of designing the State’s Health Assessment and Health Improvement Plan. In addition to the America’s Health Ranking standards, HEALTH closely monitors the Leading Health Indicators from Healthy People 2020, some of which are also priorities from the National Prevention Strategy (marked with double ** asterisk).

| Access to Health Services | 1. Persons with medical insurance <65 (AHS-1.1)  
2. Persons with a usual primary care provider (AHS-3) [Source of ongoing care] |
|---------------------------|--------------------------------------------------------------------------------------------------|
| Clinical Preventive Services | 3. Adults who receive a colorectal cancer screening based on the most recent guidelines (C-16)  
4. Adults with hypertension whose blood pressure is under control (HDS-12)  
5. Adult diabetic population with an A1c value greater than 9% (D-5.1)  
6. Children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines (IID-8) |
| Environmental Quality | 7. Asthma hospitalizations  
8. Children younger than 6 years of age with a blood lead level of 5 mcg/dL for the first times in their lives (incidence) |
| **Injury and Violence | 9. Fatal injuries (IVP-1.1)  
10. Homicides (IVP-29) |
| Maternal, Infant, and Child Health | 11. Infant deaths (MICH-1.3)  
12. Preterm births (MICH-9.1)  
13. Teen births |
| **Mental Health | 14. Suicides (MHMD-1)  
15. Adolescents who experience major depressive episodes (MDE) (MHMD-4.1) |
| **Nutrition, Physical Activity and Obesity | 16. Adults who are obese (NWS-9)  
17. Children and adolescents who are obese (NWS-10.4) |
| **Reproductive & Sexual Health | 18. Persons living w/HIV and know their serostatus (HIV-13) |
| Social Determinants | 19. Students who graduate with a regular diploma four years after starting 9th grade (AH-5.1) |
| **Substance Abuse | 20. Adolescents using alcohol or any illicit drugs during the past 30 days (SA-13.1) |
| **Tobacco | 21. Adults who are current cigarette smokers (TU-1.1)  
22. Adolescents who smoked cigarettes in the past 30 days (TU-2.2) |

*Table 2. List of Healthy People 2020 Indicators*
Background
In early 2011 the Department of Health welcomed a new agency director, Michael Fine, MD, who previously was medical program director of the state’s Department of Corrections. He is leading the department through a path that made evident the need to update the agency’s Strategic Plan, whose last version had been prepared about 10 years ago. Under his leadership, the strategic planning internal dialogue began during 2011 and was later formalized through a two-day facilitated session with support from a consultant through the Association of State Territorial and Health Officials (ASTHO).

Strategic Planning Retreat
The two-day retreat took place in March 2012 (agenda on appendix # 2) and was conducted at an off-site location with attendance from nearly 40 staff (see appendix 3). Staff invited to the retreat included the top leadership or members of the agency’s Executive Committee, along with the next level of management as well as other key staff. The result was a robust combination of public health experts from each area of the Department and professionals from many disciplines, including attorneys, nurses, managers, financial staff, laboratory specialists, environmentalists, communications staff, and more.

Staff reviewed and discussed a variety of agency-related topics, including the vision and mission of the Department, and agreed that those are still the principles the agency follows, are current and applicable, and therefore no revisions are needed at this point.

Strengths and Weaknesses Analysis
Central to the design of Rhode Island’s strategic dialogue was to complete an inventory of challenges and opportunities the agency should consider for its work in the next few years. With this purpose in mind, and led by the external facilitator, attendees were divided into groups and asked to discuss the most recent internal and external challenges, as well as strengths and opportunities for improvement for the agency. This inventory is shown in the next pages.
<table>
<thead>
<tr>
<th>Strengths</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dedicated staff with knowledge</td>
<td></td>
</tr>
<tr>
<td>• Power and regulatory authority</td>
<td></td>
</tr>
<tr>
<td>• Strong and established infrastructure</td>
<td></td>
</tr>
<tr>
<td>• Competent financial management</td>
<td></td>
</tr>
<tr>
<td>• High ethical standards</td>
<td></td>
</tr>
<tr>
<td>• Successfully compete for federal dollars</td>
<td></td>
</tr>
<tr>
<td>• Recruitment and retention</td>
<td></td>
</tr>
<tr>
<td>• High public trust</td>
<td></td>
</tr>
<tr>
<td>• Scientific knowledge</td>
<td></td>
</tr>
<tr>
<td>• Advocacy</td>
<td></td>
</tr>
<tr>
<td>• Human capital</td>
<td></td>
</tr>
<tr>
<td>• Knowledgeable, respected staff</td>
<td></td>
</tr>
<tr>
<td>• Lead many programs</td>
<td></td>
</tr>
<tr>
<td>• Exceptional partnerships and relationships</td>
<td></td>
</tr>
<tr>
<td>• State</td>
<td></td>
</tr>
<tr>
<td>• Regionally</td>
<td></td>
</tr>
<tr>
<td>• Perceived as a high-functioning, committed Department</td>
<td></td>
</tr>
<tr>
<td>• Good at grants</td>
<td></td>
</tr>
<tr>
<td>• Collect useful data</td>
<td></td>
</tr>
<tr>
<td>• KIDSNET</td>
<td></td>
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<tr>
<td>• Lead</td>
<td></td>
</tr>
<tr>
<td>• Behavioral Risk Factor Survey and Youth Risk Behavior Survey</td>
<td></td>
</tr>
<tr>
<td>• Hospital Discharge Data</td>
<td></td>
</tr>
<tr>
<td>• Partners appreciate and use data</td>
<td></td>
</tr>
<tr>
<td>• Emergency response capabilities</td>
<td></td>
</tr>
<tr>
<td>• The size of the state and its centralization make work more manageable</td>
<td></td>
</tr>
<tr>
<td>• Unbiased advocacy</td>
<td></td>
</tr>
<tr>
<td>• Talented and committed human resources</td>
<td></td>
</tr>
<tr>
<td>• Institutional knowledge</td>
<td></td>
</tr>
<tr>
<td>• Statutory leverage</td>
<td></td>
</tr>
<tr>
<td>• Moral authority</td>
<td></td>
</tr>
<tr>
<td>• Existing community partnerships</td>
<td></td>
</tr>
<tr>
<td>• National reputation</td>
<td></td>
</tr>
<tr>
<td>• Produce measurable results</td>
<td></td>
</tr>
<tr>
<td>• Subject matter expertise</td>
<td></td>
</tr>
<tr>
<td>• Handling emergencies 24/7</td>
<td></td>
</tr>
<tr>
<td>• Communications</td>
<td></td>
</tr>
<tr>
<td>• Legal support is increasing</td>
<td></td>
</tr>
<tr>
<td>• Committed, talented staff</td>
<td></td>
</tr>
<tr>
<td>• Strong leadership</td>
<td></td>
</tr>
<tr>
<td>• Reputation</td>
<td></td>
</tr>
<tr>
<td>• Partnerships</td>
<td></td>
</tr>
<tr>
<td>• Customer service</td>
<td></td>
</tr>
<tr>
<td>• Data and surveillance</td>
<td></td>
</tr>
<tr>
<td>• National recognition</td>
<td></td>
</tr>
<tr>
<td>• Leadership</td>
<td></td>
</tr>
<tr>
<td>• Best practices</td>
<td></td>
</tr>
<tr>
<td>• The size of the state</td>
<td></td>
</tr>
<tr>
<td>• Data-driven policy development and resources allocation are key</td>
<td></td>
</tr>
<tr>
<td>• Skilled, committed staff</td>
<td></td>
</tr>
<tr>
<td>• The Department handles both state and local public health; fewer layers</td>
<td></td>
</tr>
<tr>
<td>• We have the ability to create models of public health because of our scale, etc.</td>
<td></td>
</tr>
<tr>
<td>• Nationally recognized for those models</td>
<td></td>
</tr>
<tr>
<td>• Strong relationships with community partners</td>
<td></td>
</tr>
<tr>
<td>• Can implement plans efficiently</td>
<td></td>
</tr>
<tr>
<td>• Staff</td>
<td></td>
</tr>
<tr>
<td>• Adaptable</td>
<td></td>
</tr>
<tr>
<td>• Flexible</td>
<td></td>
</tr>
<tr>
<td>• Organizational flexibility</td>
<td></td>
</tr>
<tr>
<td>• Strong surveillance data sets</td>
<td></td>
</tr>
<tr>
<td>• Well-established programs</td>
<td></td>
</tr>
<tr>
<td>• Steady</td>
<td></td>
</tr>
<tr>
<td>• Continuous</td>
<td></td>
</tr>
<tr>
<td>• Sustained</td>
<td></td>
</tr>
<tr>
<td>• Strong Incident Command System training</td>
<td></td>
</tr>
<tr>
<td>• Experience/expert staff</td>
<td></td>
</tr>
<tr>
<td>• Low turnover</td>
<td></td>
</tr>
<tr>
<td>• Good at securing federal and private funding</td>
<td></td>
</tr>
</tbody>
</table>
### Weakness/ Areas For Improvement

<table>
<thead>
<tr>
<th>Lack of staff depth</th>
<th>Improve relationships with providers/licensees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operate in crisis mode daily</td>
<td>Need to prioritize functions/ops. programs at health</td>
</tr>
<tr>
<td>Lack of succession planning due to limited staff</td>
<td>What happens to hospitals and what about the delivery system?</td>
</tr>
<tr>
<td>Funding to support core state functions/budget cuts</td>
<td>Staffing</td>
</tr>
<tr>
<td>Physical plant</td>
<td>Training</td>
</tr>
<tr>
<td>Inadequate Human Resources, Information Technology, and Purchasing support</td>
<td>Technology</td>
</tr>
<tr>
<td>External (Office of Health and Human Services, Department of Administration) do not replace staff</td>
<td>Funding</td>
</tr>
<tr>
<td>State compensation system</td>
<td>Crisis mode leads to a lack of strategic focus</td>
</tr>
<tr>
<td>• Inequalities</td>
<td>Reactive vs. proactive</td>
</tr>
<tr>
<td>• Titles/classifications</td>
<td>Reduced morale and efficiency</td>
</tr>
<tr>
<td>• Pay grades</td>
<td>Physical space</td>
</tr>
<tr>
<td>Lack of staff development and training</td>
<td>Layers in government</td>
</tr>
<tr>
<td>Culture rewards silo effect</td>
<td>Inefficiency</td>
</tr>
<tr>
<td>Micromanagement, multiple layers</td>
<td>Need to empower staff more</td>
</tr>
<tr>
<td>Need to optimally use technology</td>
<td>A lack of infrastructure and understanding of the interface between public health and primary care</td>
</tr>
<tr>
<td>Inability to implement succession planning</td>
<td>Communication and coordination with:</td>
</tr>
<tr>
<td>• Personnel policy limits us</td>
<td>• Local governments</td>
</tr>
<tr>
<td>• Impacts workforce competencies</td>
<td>• Diverse populations</td>
</tr>
<tr>
<td>Civil service system</td>
<td>Unfunded mandates</td>
</tr>
<tr>
<td>Limited influence on union contracts</td>
<td>Overextended staff</td>
</tr>
<tr>
<td>Don't communicate/no clarity on our value to the public health/healthcare continuum</td>
<td>Lack of visibility for public health</td>
</tr>
<tr>
<td>High spending on individual health services is contrary to the public health goal of equity; need to invest in community health systems</td>
<td>The public</td>
</tr>
<tr>
<td>Need better coordination and communication across the Department—it's getting worse</td>
<td>Rhode Island General Assembly</td>
</tr>
<tr>
<td>Need to select, articulate and commit to priorities</td>
<td>Need an improved communication strategy</td>
</tr>
<tr>
<td>Need advocacy for Divisions and Centers, not competition for resources</td>
<td>Some areas of low morale and tiredness</td>
</tr>
<tr>
<td>Need a culture of collaboration that values contributions of all staff to the public health mission</td>
<td>Need for coordination within and across Divisions; there is a problem with patchwork funding streams</td>
</tr>
<tr>
<td>Impact of budget cuts on intellectual capital</td>
<td>Personnel system; the movement of Human Resources to Cranston came with issues</td>
</tr>
<tr>
<td>Lack of resources and staff</td>
<td>Purchasing through the Department</td>
</tr>
<tr>
<td>Lack of public recognition of the value of public health</td>
<td>Internal systems are good; outside systems are not</td>
</tr>
<tr>
<td>We do not control the purse</td>
<td>Need a better idea/articulation of how public health intersects with healthcare reform</td>
</tr>
<tr>
<td>Statutory authority and culture need updating</td>
<td>What is the intersect?</td>
</tr>
<tr>
<td>• Coalesce around clear future goals</td>
<td>How do we articulate this?</td>
</tr>
<tr>
<td>• Align statutory authority with goals and objectives/update older statutes</td>
<td>Internally</td>
</tr>
<tr>
<td>• Work together to achieve goals</td>
<td>Externally</td>
</tr>
<tr>
<td>Dependence on:</td>
<td>Would we have resources?</td>
</tr>
<tr>
<td>• General Assembly</td>
<td>Tragedy of the commons; we rely on the same assets until they are exhausted</td>
</tr>
<tr>
<td>• Governor</td>
<td>Do we have a clear identity within OHHS; does this configuration restrict public health advocacy?</td>
</tr>
<tr>
<td>• Office of Health and Human Services</td>
<td>Some areas have high turnover</td>
</tr>
<tr>
<td>• Lack of flexibility of operating within state government</td>
<td>Do we need improved internal communication?</td>
</tr>
<tr>
<td>• Need to dominate communication in healthcare</td>
<td>Inconsistency across organizational units with regard to policies (Human Resources, etc.)</td>
</tr>
<tr>
<td></td>
<td>Need professional grant writers, developers</td>
</tr>
</tbody>
</table>
THE STRATEGIC PRIORITY FOR HEALTH IS TO POSITION THE DEPARTMENT TO LEAD IN IMPROVING HEALTH OUTCOMES WHILE CONTAINING HEALTH COSTS
As a result of the retreat from March 2012, the group’s comments and discussion were summarized into a synthesized, one-page strategic map with a central overall theme and five key strategies, as shown in Figure 3 below.

Figure 3. Strategic Map prepared at two-day retreat in March 2012
The strategic priorities for HEALTH are to:

- Redirect the Rhode Island healthcare delivery system so that it focuses on improving the measured health of all Rhode Islanders while containing health costs.
- Redirect the Rhode Island Department of Health so that we focus on improving the measured health of all Rhode Islanders while containing health costs.

And will be measured by:

- Reduction in years of potential life lost and days of lost work, school, and leisure in Rhode Island
- Improvement of social capital in Rhode Island
- Reduced opioid overdose deaths

As a result of the retreat, the TSI Consulting Partners facilitator prepared a 31-page complete report (see appendix 4) that was shared with leadership and management.

During the weeks after the retreat and using the strategic map, a document outlining the short term and longer term strategic focus and priorities was also prepared, and is entirely reproduced on the next two pages.
RATIONAL FOR STRATEGIC FOCUS
By Dr. Michael Fine

Social factors are the dominant predictor of the health of Rhode Islanders. Evidence shows that the more we invest in education, housing, the environment and public safety, the healthier Rhode Islanders will become. But spending on medical services consumes the bulk of public spending – consuming fully one third of all state revenue dollars – and private spending on health services eclipses all Rhode Island, and is likely one and a half times the entire state budget. HEALTH is well positioned to build collaborations of all health care providers, following the instructions of the Governor and General Assembly, to help remodel the delivery system while practicing the best public health, so that system is focused on improving public health outcomes and lowering cost, so that the health of Rhode Islanders improves, our health care costs become affordable, and the economy of Rhode Island improves, and thus position the state to invest in education and housing and public safety, and thereby improve our health and well-being further.

HEALTH can also lead by improving the consumer experience in interactions with the Department. A reorganization of departmental resources and space can and will improve the business model of the Department while allowing us to focus on our core mission.

Strategic foci for the next five years
Focus on improving the measured health of all Rhode Islanders while containing health costs
- Reduce years of potential life lost and days of lost work, school, and leisure in RI
- Improvement of social capital in Rhode Island
- Improvement of economic status and resiliency in Rhode Island
- Assure equality and the ability to function at work, home, and school, and participate in the civic life of Rhode Island

Priorities:
- Redirect the Rhode Island healthcare delivery system so that it focuses on improving the measured health of all Rhode Islanders while containing health cost.
- Redirect HEALTH to focus on improving the measured health of all Rhode Islanders while containing health cost.

Strategic focus for the next one to three years
- Position the Department to lead in improving health outcomes while containing health costs

Priorities:
- Shape the health service delivery system so that Rhode Island achieves the best health outcomes most affordably
In the months after the retreat, key members of the Department’s leadership developed specific goals and objectives for each of the key priorities from the strategic map. The details of those goals are included in the next section.

- Build population-based primary care and preventive services so that Rhode Island achieves the best health outcomes most affordably
- Promote the value and contributions of public health
- Optimize Department resources in the strategic direction
- Secure and align financial resources with strategic requirements

HEALTH’s Policy Opportunities 2012-2013

- Primary Care Trust
- Smoking on state campuses and grounds
- Opioid overdose deaths
  - Prescription Monitoring Program (PMP) Legislation
  - Non-Pharmacologic Multidisciplinary Chronic Pain Center
- Hospital insolvency act
- Certificates of Need (CON) and Health Care Act (HCA) Reform
- Quality Assurance and Improvement for Public Health Indicators in primary care practices
  - Designation and registration of primary care practices
  - Licensure of medical assistants and care managers
  - Purchasing mechanism to pay practices for QA/QI
  - HEALTH practice performance data bank
  - Medicaid participation in service-line programs
  - Programs to include:
    - Opt-out testing for HIV and Hepatitis C
    - Teenage pregnancy and premature death reduction
    - Obesity prevention
    - Immunization rates
  - Public Health Grand Rounds
    - License fee reduction for participants
- Public Rhode Island Primary Care Medical Program/School
- HIV and Hepatitis C testing at Department of Corrections
- Obesity Prevention
  - SNAP waiver to restrict food purchases
  - Sugar-sweetened Beverage Tax
  - Calorie labeling
GOAL A: SHAPE THE HEALTH SERVICE DELIVERY SYSTEM SO THAT RHODE ISLAND ACHIEVES THE BEST HEALTH OUTCOMES MOST AFFORDABLY

GOAL B: BUILD POPULATION-BASED PRIMARY CARE AND PREVENTIVE SERVICES SO THAT RHODE ISLAND ACHIEVES THE BEST HEALTH OUTCOMES MOST AFFORDABLY

GOAL C: PROMOTE THE VALUE AND CONTRIBUTIONS OF PUBLIC HEALTH

GOAL D: OPTIMIZE DEPARTMENT RESOURCES IN THE STRATEGIC DIRECTION

GOAL E: SECURE AND ALIGN FINANCIAL RESOURCES WITH STRATEGIC REQUIREMENTS
<table>
<thead>
<tr>
<th>Objective</th>
<th>Activity</th>
<th>Current Status</th>
<th>Measure</th>
<th>Target</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Enhance policy-making influence and authority</td>
<td>Develop regulations revisiting public hearing before hospital relicensing</td>
<td>Regulation being drafted</td>
<td>Regulation adopted</td>
<td>June 2014</td>
<td>Leonard Green</td>
</tr>
<tr>
<td></td>
<td>Fund HEALTH Connections for all licensed professionals</td>
<td>Complete</td>
<td>Monthly dissemination</td>
<td>March 2014</td>
<td>James Palmer</td>
</tr>
<tr>
<td></td>
<td>Be present at all policy tables critical to delivery system development</td>
<td>Assessment ongoing</td>
<td>Assessment done, priorities established</td>
<td>June 2016</td>
<td>David Heckman</td>
</tr>
<tr>
<td>2. Ensure access to and meaningful use of data</td>
<td>Change HIE process from Opt-in to Opt-out</td>
<td>Needs support from Governor's Office</td>
<td>Legislation passed</td>
<td>November 2013</td>
<td>David Heckman</td>
</tr>
<tr>
<td></td>
<td>Convene a workgroup to define workforce needs and gap</td>
<td>Discussing license sustainability</td>
<td>Workgroup meetings</td>
<td>Feb 2015</td>
<td>James McDonald, MD</td>
</tr>
<tr>
<td></td>
<td>Explore funding to reinstate funds for hospital financial data</td>
<td>Not active</td>
<td>Legislation adopted, funds budgeted</td>
<td>July 2014</td>
<td>David Heckman, Mira DeBarros, Leonard Green</td>
</tr>
<tr>
<td>3. Build strategic partnerships</td>
<td>Conduct a Community Health Assessment</td>
<td>In process</td>
<td>Finalized goals and objectives for the healthcare system</td>
<td>December 2015</td>
<td>Magaly Angeloni</td>
</tr>
<tr>
<td>4. Conduct coordinated health planning</td>
<td>Quarterly and Annual reports to the legislature</td>
<td>The Healthcare Planning and Accountability Advisory Council will meet in early 2014 to identify a work plan for the rest of this year</td>
<td>Complete a July 31 report to the legislature</td>
<td>July 31, 2014</td>
<td>Michael Dexter</td>
</tr>
<tr>
<td>5. Seed integrated healthcare systems</td>
<td>Collaborate with the Office of the Health Insurance Commission (OHIC) to draft Accountable Care Organizations (ACO) regulations</td>
<td>Being explored by OHIC and Office of Lt. Governor</td>
<td>Regulations adopted</td>
<td>Drafted June 2014; Adopted December 2014</td>
<td>David Heckman, Leonard Green</td>
</tr>
<tr>
<td></td>
<td>Collaborate with OHIC for statute changes of the ACO</td>
<td>Not active, awaiting OHIC</td>
<td>Statute drafted, introduced, and passed</td>
<td>Draft December 2014; Introduced February 2014; Passed July 2014</td>
<td>David Heckman</td>
</tr>
<tr>
<td></td>
<td>Redraft network adequacy regulations</td>
<td>Discussions started</td>
<td>Regulations promulgated</td>
<td>December 2014</td>
<td>Valentina Adamova</td>
</tr>
<tr>
<td>6. Consolidate state healthcare purchasing</td>
<td>Partner with the Department of Administration (DOA) to advocate with policy partners to align with HIX</td>
<td>No action</td>
<td>Have all state employees buy through HIX</td>
<td>December 2016</td>
<td>Michael Fine, MD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Have all municipal employees buy through HIX</td>
<td>December 2017</td>
<td>Michael Fine, MD</td>
</tr>
<tr>
<td>7. Consolidate and pioneer changes in benefit designations</td>
<td>Not in our current jurisdiction, but discussions with the Department of Administration are ongoing</td>
<td>Ongoing discussions</td>
<td>Change in wellness incentives</td>
<td>December 2014</td>
<td>Sarah Harrigan</td>
</tr>
</tbody>
</table>
Goal B: Build population-based primary care and preventive services so that Rhode Island achieves the best health outcomes most affordably

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activity</th>
<th>Current Status</th>
<th>Measure</th>
<th>Target Date</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assure continuity and coordination between systems of care</td>
<td>Develop Regulations Committee</td>
<td>Not yet formed</td>
<td>Regulations drafted and promulgated</td>
<td>June 2014</td>
<td>Michael Fine, MD</td>
</tr>
<tr>
<td></td>
<td>Interface with America’s Health Rankings and Program staff currently meeting</td>
<td>America’s Health Rankings and Program staff currently meeting</td>
<td>10% reduction in Ambulatory Sensitive Conditions (ASC) of Emergency Department (ED) utilization</td>
<td>June 2016</td>
<td>Edward D’Arezzo</td>
</tr>
<tr>
<td></td>
<td>Expand Emergency Medical Services (EMS) innovations state-wide</td>
<td>Currently, we are exploring proposed amendments to the Rules and Regulations Relating to EMS to benefit the concept of mobile integrated health / community paramedicine.</td>
<td>10% reduction in “frequent flyer” ED presentation</td>
<td>June 2017</td>
<td>Jason Rhodes</td>
</tr>
<tr>
<td>2. Build capacity for a comprehensive approach to community-based services</td>
<td>Identify targets of opportunity for medical care system impact on behaviors, social determinants, and built environment</td>
<td>Implementation of Quality Improvement activities for key public health indicators such as immunization rates have already started and are ongoing</td>
<td>Priority criteria determined; List prioritized</td>
<td>December 2014</td>
<td>Ana Novais</td>
</tr>
<tr>
<td></td>
<td>Develop neighborhood health station “build out” pilots with patient-centered medical home practices</td>
<td>Grant application submitted</td>
<td>Buy-in secured; Practice plans developed</td>
<td>June 2016</td>
<td>Michael Fine, MD</td>
</tr>
<tr>
<td></td>
<td>Operational neighborhood health stations</td>
<td>To initiate when funding is identified</td>
<td>50% of priority criteria implemented in one or more practices</td>
<td>December 2017</td>
<td>Ana Novais</td>
</tr>
<tr>
<td>3. Develop a compelling case to secure stakeholder buy-in</td>
<td>Create a list of stakeholders and conduct initial outreach</td>
<td>“Grass Tops” list in development; facilitator funding secured</td>
<td>70 stakeholders contacted</td>
<td>June 2014</td>
<td>Michael Fine, MD</td>
</tr>
<tr>
<td></td>
<td>Research/prepare presentation materials</td>
<td>Introductory materials developed</td>
<td>20 meetings</td>
<td>June 2015</td>
<td>Ana Novais</td>
</tr>
<tr>
<td></td>
<td>Conduct surrogate training and a peer-to-peer outreach campaign</td>
<td>Materials in development</td>
<td>Tertiary organizing achieved</td>
<td>June 2016</td>
<td>David Heckman</td>
</tr>
</tbody>
</table>
## Goal C: Promote the value and contributions of public health

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activity</th>
<th>Current Status</th>
<th>Measure</th>
<th>Target Date</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify and improve understanding of target audiences</td>
<td>Increase partnerships with key stakeholders to conduct the state’s health assessment</td>
<td>Workgroup meeting regularly</td>
<td>Number of new external partners participating in community health assessment efforts</td>
<td>Obtain five new external partners per year</td>
<td>Magaly Angeloni</td>
</tr>
<tr>
<td></td>
<td>Achieve wider utilization of community input gathered throughout the Department into tangible priorities included in the Community Health Improvement Plan</td>
<td>Workgroup meeting regularly</td>
<td>Annual update of Community Health Improvement Plan</td>
<td>Produce a yearly updated report</td>
<td>Magaly Angeloni</td>
</tr>
<tr>
<td>2. Develop a strategic approach to message content</td>
<td>Develop standard messaging around the Director’s key priorities</td>
<td>In progress: have developed State of the State’s Health, talking points on substance abuse, flu vaccinations</td>
<td>Annual update of key messages and opportunities for dissemination</td>
<td>Produce yearly updated messaging</td>
<td>Center for Public Health Communications, Michael Fine, MD</td>
</tr>
<tr>
<td></td>
<td>Increase number of campaigns and materials using local, target audience research to inform messaging</td>
<td>In progress</td>
<td>Number of programs allocating budgets for target audience research in message development and/or testing</td>
<td>20% of projects coming through CPHC will involve some level of local audience research</td>
<td>Center for Public Health Communications</td>
</tr>
<tr>
<td></td>
<td>Increase the number of professional groups receiving HEALTH Connections on a routine basis</td>
<td>In progress: seven versions of HEALTH Connections already established, four more slated to begin in 2014</td>
<td>Need Measure for HEALTH connections</td>
<td>Need target date for HC</td>
<td>Center for Public Health Communications</td>
</tr>
<tr>
<td>3. Identify and build a constituency around key issues</td>
<td>Maintain agency’s capacity in the use of Quality Improvement methods</td>
<td>Staff to be part of the Quality Improvement team is identified and trained each year</td>
<td>Number of staff trained in QI and who complete QI projects on an ongoing basis</td>
<td>- Train 20% of staff in QI tools - Complete 20 QI projects each year</td>
<td>Magaly Angeloni</td>
</tr>
<tr>
<td></td>
<td>Promote the goals of public health among staff</td>
<td>Implementation of the Workforce Development Plan began in early 2014</td>
<td>Number of staff who complete public health-related courses in TRAIN each year</td>
<td>Number of training in public health topics taken by staff; Offer PH101 once a year</td>
<td>Magaly Angeloni</td>
</tr>
<tr>
<td>4. Engage business and other community partners to amplify our voice</td>
<td>Develop annual State of the State’s Health presentation to be presented at various venues</td>
<td>In progress: presented at State House, Feb 2014</td>
<td>Number of community/business partners receiving presentation</td>
<td>Give the presentation at least five times per year to key partners</td>
<td>Center for Public Health Communications</td>
</tr>
<tr>
<td></td>
<td>Work more closely with community partners and business community in developing targeted messages</td>
<td>In progress: tracking information through Materials Development and Production Forms</td>
<td>Number of programs engaging business or community partners in message development and/or testing</td>
<td>90% of projects coming through CPHC will involve community/business partners in their development</td>
<td>Center for Public Health Communications</td>
</tr>
</tbody>
</table>
## Goal D: Optimize Department resources in the strategic direction

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activity</th>
<th>Current Status</th>
<th>Measure</th>
<th>Target Date</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify program priorities and essential functions</td>
<td>Engage the Operations Group and Executive Committee in discussions to ensure understanding of priorities and essential functions</td>
<td>Ongoing</td>
<td>Discussions with the Executive Committee</td>
<td>June 2014</td>
<td>Michael Fine, MD</td>
</tr>
<tr>
<td></td>
<td>Utilize essential functions as a springboard to develop HEALTH's Continuity of Operations Plan (COOP)</td>
<td>On hold</td>
<td>Reconvening of COOP Managers Work Group</td>
<td>September 2014</td>
<td>Alysia Mihalakos</td>
</tr>
<tr>
<td></td>
<td>Coordinate with the Community Health Assessment activities to ensure an informed and coordinated approach to priorities</td>
<td>Ongoing activity</td>
<td>Incorporation of the Community Health Assessment findings into priority identification</td>
<td>December 2014</td>
<td>Magaly Angeloni</td>
</tr>
<tr>
<td></td>
<td>Coordinate with the America's Health Ranking Team to ensure consistency of efforts</td>
<td>America's Health Ranking team meets regularly</td>
<td>Incorporation of America’s Health Ranking priorities into efforts of the Department</td>
<td>December 2014, Annual progress report</td>
<td>Michael Fine, MD</td>
</tr>
<tr>
<td>2. Consolidate to align with priorities and enhance efficiencies</td>
<td>Assess and, if necessary, realign the organizational structure of the Department to align with Departmental priorities</td>
<td>Scheduled to start in early 2014</td>
<td>Realignment, creation, or elimination of Departmental activities</td>
<td>October 2014</td>
<td>Sarah Harrigan</td>
</tr>
<tr>
<td></td>
<td>With realignment planning complete, develop, vet, and exercise the Department’s COOP Plan</td>
<td>On hold</td>
<td>Vetted and signed plan; completed tabletop exercise</td>
<td>Plan: Dec. 2015; Exercise: June 2016</td>
<td>Alysia Mihalakos</td>
</tr>
<tr>
<td></td>
<td>Determine the effectiveness and viability of the existing “center” concept</td>
<td>Met with CHDA and CPHC leads and they presented a position paper to Director</td>
<td>Meeting with Center Leads</td>
<td>Dec. 2014</td>
<td>Leonard Green</td>
</tr>
<tr>
<td>3. Build staff depth via cross-training and succession planning</td>
<td>Recruit for a Department-wide training position</td>
<td>Position not funded</td>
<td>Recruitment of an individual with organizational training and workforce development expertise</td>
<td>January 2014</td>
<td>Leonard Green</td>
</tr>
<tr>
<td>4. Engage staff throughout the Department in the strategic direction</td>
<td>Ensure that the members of the Operations Group and Executive Committee utilize their internal Division and Center modes of communication to inform their respective staff of the strategic direction of the Department</td>
<td>In progress</td>
<td>Discussions in all the organizational structures of HEALTH</td>
<td>June 2014</td>
<td>Executive Committee</td>
</tr>
<tr>
<td></td>
<td>Utilize the intranet to post information that is relevant to the strategic direction of the Department</td>
<td>In process: have posted information about accreditation and a draft of the Health Assessment</td>
<td>Posting of information regarding strategic direction on the Intranet</td>
<td>Ongoing</td>
<td>Center for Public Health Communications</td>
</tr>
<tr>
<td></td>
<td>Hold All-Employee Meetings to inform the Department staff of Department strategic direction</td>
<td>Quarterly or as needed</td>
<td>Meetings where strategic direction is discussed</td>
<td>Ongoing</td>
<td>Michael Fine, MD</td>
</tr>
<tr>
<td>Objective</td>
<td>Activity</td>
<td>Current Status</td>
<td>Measure</td>
<td>Target Date</td>
<td>Contact</td>
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<tr>
<td>5. Realign Department structure to support the strategic direction</td>
<td>Assess funding streams (grants, contracts, general fund appropriation) for consistency with strategic direction of the Department</td>
<td>Hiring for CFO is in process</td>
<td>The extent to which the current funding (general funds and federal funds) are supportive of, and consistent with, the strategic direction</td>
<td>June 2014</td>
<td>CFO</td>
</tr>
<tr>
<td></td>
<td>Assess the indirect fund account to determine if it is utilized most effectively to accomplish the strategic direction</td>
<td>Ongoing activity. First major assessment was completed. Review and adjustments are ongoing.</td>
<td>Assessment done and appropriate adjustments made</td>
<td>June 2014</td>
<td>CFO</td>
</tr>
<tr>
<td>6. Improve/expand support functions (HR, Purchasing, IT, Legal)</td>
<td>Continue meetings with the Director of Health, Deputy Director of Health, Director of Administration and Executive Director of Administration to ensure the Department receives the necessary level of support in these support functions</td>
<td>Ongoing activity</td>
<td>Monitor the responsiveness of the functions that reside in other Departments</td>
<td>Ongoing</td>
<td>Michael Fine, MD</td>
</tr>
<tr>
<td></td>
<td>Assess the structure within our Division of Management Services and other divisions to determine the most efficient method to accomplish purchasing functions</td>
<td>In progress</td>
<td>Incorporation of these topics as agenda items on the monthly meeting; Resolution of specific issues</td>
<td>Feb. 2015</td>
<td>Sarah Harrigan</td>
</tr>
<tr>
<td></td>
<td>Continue to work closely with Human Resources, Legal, and Information Technology groups to improve needed services</td>
<td>Ongoing meetings as needed</td>
<td>Meetings are held and resolution to various issues is achieved</td>
<td>Ongoing</td>
<td>Sarah Harrigan</td>
</tr>
<tr>
<td>7. Maximize strategic use of technology</td>
<td>Continue the Informatics Work Group to maximize, when possible, the interoperability of technology and to maximize the efficiency and strategic use of existing technology (e.g., licensing, Kidsnet, VR 2000)</td>
<td>Meetings are held biweekly and submissions for review are received and dispositioned</td>
<td>Number of issues reviewed quarterly</td>
<td>Ongoing</td>
<td>Leonard Green</td>
</tr>
<tr>
<td></td>
<td>Recruit for an Informatician</td>
<td>Completed: Position filled</td>
<td>Hiring completed</td>
<td>Feb. 2014</td>
<td>Samara Viner-Brown</td>
</tr>
</tbody>
</table>
## STRATEGIC GOALS AND OBJECTIVES

### Goal E: Secure and align financial resources with strategic requirements

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activity</th>
<th>Current Status</th>
<th>Measure</th>
<th>Target Date</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Change the funding mix/increase private funding</td>
<td>Hire a Funds Development Coordinator/Grant Writer as a dedicated resource to identify new funds</td>
<td>Position has been posted and resumes received</td>
<td>Recruitment of a qualified individual for this position</td>
<td>April 2014</td>
<td>Michael Fine, MD, Leonard Green, CFO</td>
</tr>
<tr>
<td></td>
<td>Reinvigorate our relationship with the Rhode Island Public Health Institute (RIPHI) as a non-profit private partner to administer grants</td>
<td>Collaborating with new Director of RIPHI on new grant funding</td>
<td>Number of new activities conducted in partnership with RIPHI since 2014</td>
<td>December 2014 and yearly thereafter</td>
<td>Leonard Green</td>
</tr>
<tr>
<td></td>
<td>Develop strategies to increase the number of restricted-receipt accounts for HEALTH</td>
<td>Work in progress</td>
<td>Establishment of at least one new restricted receipt account</td>
<td>June 2015</td>
<td>David Heckman, Michael Fine, MD</td>
</tr>
<tr>
<td>2. Develop strategic partnerships to expand resources</td>
<td>Increase/cultivate partnerships with community agencies, foundations, and other organizations</td>
<td>To begin after the Development Coordinator is hired</td>
<td>Number of applications submitted to new funding partners, foundations, etc.</td>
<td>June of every year</td>
<td>Funds Development Coordinator, CFO</td>
</tr>
<tr>
<td></td>
<td>Build upon current activities with board members of hospitals to jointly design and implement activities to expand resources</td>
<td>Ongoing</td>
<td>Joint development of new activities</td>
<td>June of every year</td>
<td>Leonard Green</td>
</tr>
<tr>
<td></td>
<td>Leverage current partnerships with key stakeholders (e.g., Leadership Rhode Island, Medicaid)</td>
<td>Ongoing</td>
<td>Development of new activities with key partners</td>
<td>December of every year</td>
<td>Leonard Green or designee</td>
</tr>
<tr>
<td>3. Optimize the fee-for-service business model</td>
<td>Conduct an environmental scan of neighboring states to compare charges for similar services in a geographically-appropriate fashion</td>
<td>To begin after the Development Coordinator is hired</td>
<td>Completion of the environmental scan</td>
<td>June 2014</td>
<td>Funds Development Coordinator, CFO</td>
</tr>
<tr>
<td></td>
<td>Review the statute and regulatory language that governs what HEALTH can charge for preparation of data or reports</td>
<td>Delayed due to change in Chief Legal Counsel</td>
<td>Report of the analysis</td>
<td>June 2014</td>
<td>David Heckman, Chief Legal Counsel, CFO</td>
</tr>
<tr>
<td></td>
<td>Review current fees and assess other services for which no charge is currently assessed</td>
<td>Same as above</td>
<td>Report of recommendations</td>
<td>June 2014</td>
<td>Chief Legal Counsel, CFO</td>
</tr>
<tr>
<td>4. Align indirect cost recovery funds with Department priorities</td>
<td>Ensure the indirect cost fund is consistent with HEALTH’s strategic priorities</td>
<td>Ongoing review</td>
<td>Report on the indirect cost fund</td>
<td>June 2014</td>
<td>CFO or designee</td>
</tr>
<tr>
<td></td>
<td>Inventory current applicability and use of the indirect cost fund and recommend adjustments/revisions accordingly</td>
<td>Ongoing review</td>
<td>Report on the indirect cost fund</td>
<td>June 2014</td>
<td>CFO or designee</td>
</tr>
<tr>
<td>5. Influence statutory change to reduce unfunded mandates</td>
<td>Prepare and present documentation of HEALTH’s serious lack of resources that prevents us from conducting regular program work</td>
<td>Scheduled to start in April 2014</td>
<td>Completion of an initial report and preparation of an annual report thereafter</td>
<td>Reports prepared in June 2014, 2015, and 2016</td>
<td>Leonard Green or designee</td>
</tr>
<tr>
<td></td>
<td>Itemize unfunded mandates and analyze them to ensure they are aligned with HEALTH’s strategic goals and priorities. If not, decide if they should be transferred, modified, or halted permanently, etc.</td>
<td>Work begun in 2012-2013 has not continued and will recommence in 2014</td>
<td>Completion of an inventory and preparation of recommendations</td>
<td>First inventory conducted in February 2012; Recommendations December 2014; Progress report December each year starting 2015</td>
<td>David Heckman, Leonard Green</td>
</tr>
</tbody>
</table>
ALTHOUGH SIGNIFICANT EFFORTS HAVE BEEN DEVOTED TO A NUMBER OF PROGRAMMATIC EFFORTS IN THE MONTHS SINCE THE RETREAT, THERE ARE TWO THAT ARE NOT ONLY RELEVANT BUT ALSO OF HIGH SIGNIFICANCE TO THE DEPARTMENT’S FUTURE. THESE EFFORTS ARE THE STRATEGIES TO MAKE RHODE ISLAND THE HEALTHIEST STATE IN THE COUNTRY AND THE PRIMARY CARE TRUST.
In July 2012, four months after the Strategic Plan Retreat, the group was invited again by the Director to review the overarching five-year goals and discuss next steps (see appendix # 5).

During the summer of 2012 the Director held conversations with the Executive Office of Health and Human Services (EOHHS), the Governor’s Office, and key members of the state’s Legislature regarding the overall strategic priorities for the Department and gained their full support. Counting on the state’s leadership support, the Department began full implementation of the strategic priorities stated in this document.

Although significant efforts have been devoted to a number of programmatic efforts in the months since the retreat, there are two that are not only relevant but also of high significance to the Department’s future. These efforts are the strategies to make Rhode Island the healthiest state in the country, and the Primary Care Trust.

With regard to making Rhode Island the healthiest state in the country, the Director formed and is leading the America’s Health Rankings group, charged to develop a long-term effort to bring Rhode Island to a higher ranking. This group, AHR, was convened in early 2013, and has been meeting biweekly and is composed of about half of the Executive Committee members (see list of AHR members on appendix 6). Part of these conversations resulted in the one-page strategic priorities summary, included in appendix 7.

Finally, and perhaps the effort that has taken the priority among the initiatives from this strategic plan, is the Primary Care Trust (PCT). The PCT group was convened by the Director in late 2012 and has been meeting weekly as well as monthly. (See list of individuals involved in the PCT group on appendix 8). By the end of 2012, the PCT group developed a presentation with the goals and vision to reformulate the healthcare in the state, documenting the high financial and social costs of healthcare, and introducing a new way of healthcare: with a single payer for primary care that preserves the patients’ choice and uses all other healthcare market components intact (see appendix 9).

As other components of the strategic plan develop, the Director leads and is closely involved in the activities described as part of the five strategic goals of this plan, in section VI. Beginning in early 2015, and annually thereafter, the Department will prepare an annual report on progress made by the agency in the work to position the Department to lead in improving health outcomes while containing health costs. These updates will be posted on the intranet for access by all staff.
Appendix # 1: Current Rhode Island Department of Health’s Organizational Chart

Appendix # 2: Agenda, Strategic Meeting
March 20-21, 2012

Appendix # 3: Attendees to Strategic Planning Retreat, March 2012

Appendix # 4: Meeting Summary, March 20-21, 2012

Appendix # 5: Strategic Planning Session: Overarching 5-year goals, July 12, 2012

Appendix # 6: HEALTH’s America’s Health Ranking (AHR) Workgroup Members

Appendix # 7: Strategic Priorities: Making Rhode Island the Healthiest State in the Nation

Appendix # 8: HEALTH’s Primary Care Trust (PCT) Workgroup Members

Appendix # 9: “How the Healthcare Market is at War with Health” Presentation from Dr. Michael Fine
Appendix #1: Current RI Department of Health's Organizational Chart
Appendix # 2: Agenda Strategic Meeting March 20-21, 2012

Rhode Island Department of Health
Strategic Planning Meeting
Agenda: March 20-21, 2012

Tuesday, March 20, 2012

8:00am  Welcome and opening remarks

8:15  Overview of Strategic Effectiveness—Laurie Schulte

8:30  Assessment of the Department of Health’s current situation
• Critical issues facing the Rhode Island healthcare delivery system—next three to five years, including how medical costs and healthcare reform will impact public health and public health funding
• Strengths of the Department
• Weaknesses/areas of needed improvement

10:00  Break

10:15  Assessment of the Department’s current situation (continued)

12:00pm  Lunch

1:00  Future direction of the Department
• Mission
• Central challenge
• Strategic priorities

3:30  Break

3:45  Strategic Mapping—setting objectives for each strategic priority

5:00  Adjourn

Wednesday, March 21, 2012

8:00am  Finalizing the Strategic Map

10:00  Break

10:15  Establishing priorities for the next 12 months

11:00  Implementation planning
• Identifying tracks of work for the next 12 months
• Beginning to organize for implementation

12:00pm  Lunch

1:00  Implementation planning (continued)

2:30  Break

2:45  Next steps and wrap up
• Communicating with key stakeholders
• Moving to implementation
• Establishing a timetable for reviewing progress and making needed adjustments

3:30  Adjourn
### Appendix # 3: Attendees to Strategic Planning Retreat on March 2012

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
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<th>Name</th>
<th></th>
<th>Name</th>
<th></th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alysia Mihalakos</td>
<td>13</td>
<td>Donna Costantino</td>
<td>25</td>
<td>June Swallow</td>
<td></td>
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<tr>
<td>2</td>
<td>Ana Novais</td>
<td>14</td>
<td>Douglas Axelsen</td>
<td>26</td>
<td>Leonard Green</td>
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<td>3</td>
<td>Andrea Bagnall-Degos</td>
<td>15</td>
<td>Edward D’Arezzo</td>
<td>27</td>
<td>Magaly Angeloni</td>
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<td>4</td>
<td>Bruce McIntyre</td>
<td>16</td>
<td>Emily Lefebvre</td>
<td>28</td>
<td>Michael Dexter</td>
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<tr>
<td>5</td>
<td>Carol Hall-Walker</td>
<td>17</td>
<td>Ernest Julian</td>
<td>29</td>
<td>Michael Fine</td>
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<tr>
<td>6</td>
<td>Carrie Bridges</td>
<td>18</td>
<td>Ewa King</td>
<td>30</td>
<td>Nicole Alexander</td>
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<tr>
<td>7</td>
<td>Christina Stanley</td>
<td>19</td>
<td>Jacqueline Kelley</td>
<td>31</td>
<td>Patricia Raymond</td>
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<td>8</td>
<td>Christine Goulette</td>
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<td>James McDonald</td>
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<td>Peter Simon</td>
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<td>9</td>
<td>Colleen Fontana</td>
<td>21</td>
<td>Jan Shedd</td>
<td>33</td>
<td>Raymond Rusin</td>
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<td>10</td>
<td>Dara Chadwick</td>
<td>22</td>
<td>Jason Rhodes</td>
<td>34</td>
<td>Robert Vanderslice</td>
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<tr>
<td>11</td>
<td>David Heckman</td>
<td>23</td>
<td>Jay Garrett</td>
<td>35</td>
<td>Samara Viner-Brown</td>
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<td></td>
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<tr>
<td>12</td>
<td>Dona Goldman</td>
<td>24</td>
<td>John Fulton</td>
<td>36</td>
<td>Utpala Bandy</td>
<td></td>
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</tr>
</tbody>
</table>
Appendix # 4: Meeting Summary, March 20-21, 2012

Rhode Island Department of Health
Strategic Planning Retreat
Meeting Summary: March 20-21, 2012

INTRODUCTION
Laurie Schulte, Vice President of TSI Consulting Partners, welcomed participants to the strategic planning session and thanked them for their participation.

Laurie provided an overview of strategic effectiveness — an organization's ability to set the right goals and consistently achieve them.

Organizations with high strategic effectiveness:
- Quickly formulate a “good enough” strategic plan.
- Move immediately to implementation—letting implementation teach them the ways that the strategy is on target and ways it needs to be improved.
- Review progress on implementation regularly with honesty and candor.
- Make needed adjustments based on what is working, what isn’t, and how the world has changed.
- Focus on results, not activities.

Laurie also outlined the agenda for the strategic planning session:
- Assess the current situation of the Rhode Island Department of Health.
- Set the future direction of the Department.
- Create a strategic map that depicts how to move from “current” to “future.”
ASSESSING THE CURRENT SITUATION

Assessing the current situation of the Department of Health is a first step in setting its future direction. Participants met in small groups to assess the current situation of the Department. The groups addressed three core questions:

- Critical issues facing the Department over the next three to five years, including how medical costs and health care reform will impact public health and public health funding
- Strengths of the Department
- Weaknesses/areas of needed improvement

A summary of the small group reports follows.

Critical Issues Facing the Department over the Next Three to Five Years, Including Consideration of How Medical Costs and Health Care Reform Will Impact Public Health and Public Health Funding

GROUP 1: CAROL HALL WALKER, BOB VANDERSLICE, DOUG AXELSON, ED D’AREZZO, EMILY LEFEVBRE, EWA KING

Critical Issues the Department Will Face over the Next Three to Five Years

- Financial failure of hospitals
- Increased cost of the health care delivery system
- Lack of money for prevention; medical and health care disconnect
- Reduction in funding; need to increase or keep steady
- Workforce development to meet needs
- Lack of a team approach to connect patients to county supports for improved self-management
- Training
  - Time
  - Money
  - Depth of staff leaves gaps.
- Fragmented health care
  - Redundancies/test
  - Lack of coordination/communication
  - Lack of understanding of the system
- Health care reform implementation
  - Cost
  - “How to”
- Lack of political will to change
  - Proactive
  - Prevention
  - Pendulum swings
- Primary care shortages
Consideration of How Medical Costs and Health Care Reform Will Impact Public Health and Public Health Funding

- Payor system
  - Change the way existing health care is financed.
  - Explore new ways to reallocate money.
  - Reorganize services to make them more effective.
- Vertical integration/continuum
- Integration of medical into community
  - County Health Workers
  - Volunteerism
  - Patient navigators
- Pay now and/or pay later.
- Improve medical/social services received by vulnerable populations.
  - Support of housing
  - Coordinated support direct services
- Long-term care
  - Costly
  - Better integrate the delivery of medical care and long-term care.
- There is an opportunity for public/private partnerships.
  - Home health care
  - Adult day care
  - Assisted living
- Reduce disparities: social determinants of health

GROUP 2: DARA CHADWICK, MAGALY ANGELONI, PETER SIMON, CARRIE BRIDGES, PATRICIA RAYMOND, LENNY GREEN

- Identity
  - Helping others understand public health and the value of public health to them
  - Understanding the role and value of public health along the public health-health care continuum
- Managing expectations, redefining “health”
- Training and growing the public health workforce to respond to current and future needs
  - Inadequate workforce competency
  - Inadequate workforce flexibility
- Need clarity on public health priorities
- Preparing our systems for technological advancements
- Hospital solvency
  - How many are needed
  - Where
  - The will to change
- Applying public health expertise to the health care delivery system
  - To improve quality and reduce expenditures
  - To increase efficiency
GROUP 3: MICHAEL FINE, MIKE DEXTER, DAVID ______, JAY GARRETT, BRUCE McINTYRE, JAMES MCDONALD

- Community hospitals losing money
- Cost of health reform
- Health care is bankrupting the economy.
- Poor outcomes
- Behavioral lifestyles equal poor health.
- Money to specialists rather than to primary care physicians
- The impact on communities of corporate health and wellness “sales”
- The notion of “health” has been hijacked.
- Deconstruction of communities
- Defunding public health
- A need to focus on public health rather than on medical services
  - (Q)(T)/M
  - Move money from sub-specialties to primary care.
- Push to profit undermines the patient experience.

GROUP 4: CHRIS GOULETTE, ANDREA BAGNALL-DEGOS, UTPALA BANDY, JASON RHODES, COLLEEN FONTANA, ERNIE JULIAN

- Legislation and technology
  - Politics
  - Elections
- E-medicine/health gap
- Quality improvement in all sectors of medicine and the health gap
- Reducing budgets are impacting staffing competencies.
  - Retirements
  - Institutional knowledge
- Hospital system changes and delivery system impact a backslide in public health outcomes.
- Increasing demand for communication and information
- Rising health care costs and the reasons why
- Meeting the needs of a diverse population
- Having a clear understanding of health’s role
  - Public health emergencies
  - The public’s perception of the health and value of public health services
  - This leads to funding.
- Address the gap in care.
  - Primary care
  - Health care’s changing role
- Market prevention as a way of reducing health care costs and incentivize this for providers.
- Improve public health’s understanding of health care reform.
- Unfunded mandates

GROUP 5: ANA NOVAIS, JUNE SWALLOW, DONNA COSTANTINO, SAM VINER-BROWN, JOHN FULTON, CHRISTINA STANLEY, DONA GOLDMAN

- As federal and state funding is cut, more services are placed on primary care providers, community health centers, etc.
- Electronic Health Records
  - The ability to provide reports
  - Building to a more population-based delivery
- Need to build community clinical linkages to address the challenges of health care delivery
- Paying attention to the redesign of the clinical system; where is public health in health care reform?
- Workforce needs
  - In and out of the Department
  - Standards/skills
  - Standardization needed, e.g. clinical assistance
- Primary care numbers are dropping.
  - Dentists
  - Physicians
  - Not enough replacements
- The health of the hospital system
  - Can community hospitals survive?
  - Need to push for more community-based services
  - Do we have capacity?
- Will people “fall through the cracks” with health care reform?
- Is it the job of public health to meet these needs?
- What are the incentives to go into:
  - Public health
  - Primary care medicine
- Need a better model for integration of primary and secondary medical care
- Need to develop the activated patient
- We have focused efforts on a subset of large primary care practices.
  - How do we expand to smaller practices?
  - How do we increase the focus on primary care and the public health delivery system?
    - There is too much attention focused on health care delivery—not enough on these other things.
- A good indicator: keeping patients out of emergency departments
- How do we build in preventive services across the health care system?
  - Standards for preventive services?
  - Reimbursement?
  - Built into Medicaid and other third party packages?
Federal cutbacks are on the way; we are too dependent on federal funding.

**Strengths of the Department of Health**

**GROUP 1**
- Dedicated staff with knowledge
- Power and regulatory authority
- Strong and established infrastructure
- Competent financial management
- High ethical standards
- Successfully compete for federal dollars
- Recruitment and retention
- High public trust
- Scientific knowledge
- Advocacy

**GROUP 2**
- Human capital
  - Knowledgeable, respected staff
  - Lead many programs
- Financially well-managed
- Exceptional partnerships and relationships
  - State
  - Regionally
- Perceived as a high-functioning, committed Department
- Good at grants
- Collect useful data
  - KIDSNET
  - Lead
  - BRFSS and YRBS
  - HDD
  - Partners appreciate and use data.
- Emergency response capabilities
- The size of the state and its centralization make work more manageable.

**GROUP 3**
- Unbiased advocacy
- Talented and committed human resources
- Institutional knowledge
- Statutory leverage
- Moral authority
- Existing community partnerships
- National reputation
- Produce measurable results
GROUP 4
- Subject matter expertise
- Handling emergencies 24/7
- Communications
- Legal support is increasing.
- Committed, talented staff
- Strong leadership
- Reputation
- Partnerships
- Customer service
- Data and surveillance
- National recognition
  - Leadership
  - Best practices
- The size of the state

GROUP 5
- Data-driven policy development and resources allocation are key.
- Skilled, committed staff
- The Department handles both state and local public health; fewer layers.
- We have the ability to create models of public health because of our scale, etc.
- Nationally recognized for those models
- Strong relationships with community partners
- Can implement plans efficiently
- Staff
  - Adaptable
  - Flexible
  - Organizational flexibility
- Strong surveillance data sets
- Well established programs
  - Steady
  - Continuous
  - Sustained
- Strong I.C.S. system/training
- Experience/expert staff
- Low turnover
- Good at securing federal and private funding

Weaknesses/Areas of Improvement of the Department of Health

GROUP 1
- Lack of staff depth
- Operate in crisis mode daily.
- Lack of succession planning due to limited staff
- Funding to support core state functions/budget cuts
- Physical plant
- Inadequate HR/IT support
• External (OHHS, DOA) do not replace staff.
• State compensation system
  o Inequalities
  o Titles/classifications
  o Pay grades
• Lack of staff development and training
• Culture rewards silo effect.
• Micromanagement, multiple layers

GROUP 2
• Need to optimally use technology
• Inability to implement succession planning
  o Personnel policy limits us.
  o Impacts workforce competencies
• Civil service system
• Limited influence on union contracts
• Don’t communicate/no clarity on our value to the public health/health care continuum
• Increased spending on individual health services is contrary to the public health goal of equity; need to invest in community health systems.
• Need better coordination and communication across the Department—it’s getting worse.
• Need to select, articulate and commit to priorities
• Need advocacy for Divisions and Centers, not competition for resources
• Need a culture of collaboration that values contributions of all staff to the public health mission

GROUP 3
• Impact of budget cuts on intellectual capital
• Lack of resources and staff
• Lack of public recognition of the value of public health
• We do not control the purse.
• Statutory authority and culture need updating.
  o Coalesce around clear future goals.
  o Align statutory authority with goals and objectives/update older statues.
  o Work together to achieve goals.
• Dependence on:
  o General Assembly
  o Governor
  o OHHS
• Succession planning
• Lack of flexibility of operating within state government
• Need to dominate communication in health care
• Improve relationships with providers/licensees.
• Need to prioritize functions/ops. programs at health
• What happens to hospitals and what about the delivery system?
GROUP 4
- Staffing
- Training
- Technology
- Funding
- Support structures
  - HR
  - IT
  - Purchasing
- Crisis mode leads to a lack of strategic focus.
  - Reactive vs. proactive
  - Reduced morale and efficiency
- Physical space
- Layers in government
  - Inefficiency
  - Need to empower staff more
- A lack of infrastructure and understanding of the interface between public health and primary care
- Communication and coordination with:
  - Local governments
  - Diverse populations

GROUP 5
- Unfunded mandates
- Overextended staff
- Lack of visibility for public health
  - The public
  - Rhode Island General Assembly
  - Need an improved communication strategy
- Some areas of low morale and tiredness
- Need for coordination within and across Divisions; there is a problem with patchwork funding streams.
- Personnel system; the movement of HR to Cranston came with issues.
- Purchasing through the Department
- Need more IT
- Internal systems are good; outside systems are not.
- Need a better idea/articulation of how public health intersects with health care reform
  - What is the intersect?
  - How do we articulate this?
    - Internally
    - Externally
  - Would we have resources?
- Tragedy of the commons; we rely on the same assets until they are exhausted.
Do we have a clear identity within OHHS; does this configuration restrict public health advocacy?
Lack of succession planning
Some areas have high turnover.
Do we need improved internal communication?
Inconsistency across organizational units with regard to policies (HR, etc.)
We need professional grant writers, developers, etc.

Discussion of the assessment of the current situation included the following points.

- Trusting public health is different than valuing public health.
  - The public trusts the Department.
  - It is known and respected.
  - Some of its activities, e.g. prevention, are not visible to the public.
  - There is room to build the public’s understanding and value of public health.
- The Department can strengthen its relationships with key communities.
  - It can activate local communities to address health issues.
  - This is part of the Department’s state and local role.
- Many of the issues facing the Department are grounded in a lack of focus.
  - There are many “programs.”
  - Limited staff is spread thin, with few on any one project.
  - This explains why staff is tired.
  - The Department has the capability to scale up in response to environmental requirements, e.g. H1N1.
  - This is a context in which to think about the future role of the Department.
- In addition to increasing staffing, the Department can also:
  - Increase learning.
  - Emphasize strategic thinking vs. managing.
- Many of the Department’s priorities are mandated.
  - This presents management challenges.
  - Funding streams are dedicated.
  - It’s a complicated situation.
  - The situation is not sustainable.
  - The Department must prioritize over time to move in a positive direction.
- The Department doesn’t discontinue anything.
  - It must identify its core business.
  - It needs to overcome resistance to prioritization.
  - There are different definitions of what is core; the Department must:
    - Establish high-end goals
    - Get people on board—which can be difficult.
  - We can “gracefully exit” programs/initiatives.
- Other ways to prioritize include:
  - Doing things differently
  - Outsourcing projects
  - Etc.
  - If the Department doesn’t articulate its priorities, there is no way to influence them.
There is a difference between advocating for one's individual program and doing what’s best for the people of Rhode Island.
- Priorities must be transparent.
- Politics impact this context.

- There is an opportunity to increase interactions with the business community.
  - There is opportunity for expanded partnerships.
  - A communications strategy will be required.

- Overall, there was a high level of agreement across participants on the current situation facing the Department.
  - We must focus on what we can do.
  - There is good news.
  - All are committed.
  - We can build on that.

**SETTING FUTURE DIRECTION**
Laurie Schulte provided a brief overview of the key elements of an organization's future direction.

- An organization’s mission states why it exists, its reason for being, its fundamental purpose. It’s an enduring statement that usually remains the same for many years, providing long-term continuity and direction for the organization.
- Vision articulates the long-term outcome or end-state that the organization will make a definitive contribution to creating.
- Strategy outlines what the organization needs to do at this point in its history. It is more focused and time bound than mission and vision—often looking to the next three to five years.
- An organization’s core values and/or guiding principles outline its unique approach, its norms for “how we do things” in the organization.
- An organization’s tactics outline “how to” implement its strategy.
Mission and Vision
As context for setting future direction for the Department of Health, participants reviewed the mission and vision of the Department.

MISSION OF THE RHODE ISLAND DEPARTMENT OF HEALTH
Protect and promote the health of all Rhode Islanders.

VISION FOR THE RHODE ISLAND DEPARTMENT OF HEALTH
All people in Rhode Island will have the opportunity to live a safe and healthy life in a safe and healthy community.

The group considered the appropriateness of the mission and vision to the future direction of the Department. Discussion included the following points.
- Even if the group agrees to add an impact on health system changes to its strategy, the fundamental purpose of the Department is the same.
- The breadth of the mission and vision as currently stated is advantageous in that it doesn’t restrict the Department.
- A disadvantage is that the Department can be expected to do anything and everything.
- The group discussed whether “health” is jargon.
  - There are many definitions of health.
  - Its meaning has been co-opted in some circles.
  - Does health mean health equity?
  - The group considered and rejected a revision to “optimal health,” as health is not measurable and this distinction also has multiple definitions.
- The group discussed whether the notion of “well-being” should be included in the mission; this would include the social determinants of health, such as education, income, geography, etc.
- After formulating the strategic map for the Department, the group revisited mission and vision and agreed that:
  - Both continue to provide sufficient long-term direction and continuity for the Department.
  - The new strategy is aligned with them.

Central Challenge and Strategic Priorities
Participants were asked to identify—in a word or phrase—the central challenge that the Department of Health faces over the next three years. A summary of responses follows:
- Funding for the core State work that we’re required to do
- Setting meaningful and financially achievable goals
- Communicating what health is and where it comes from
- Maintaining a competent and skilled workforce
- Obtaining the ability to prioritize our work
- Prioritizing what really counts
- Getting the public to understand what we do
- Achieving health equity for all Rhode Islanders
- Increasing resources in a changing political environment
• Messaging
• Containing medical costs so that public health and social programs can be funded
• Having people change their behaviors to be more healthy
• Unfunded mandates
• Having people listen to us when we make our points
• Making our internal processes more efficient and effective to overcome our limitations
• Appropriate allocation of resources based on defined priorities of the DOH; “fish or cut bait”
• Clarifying and providing leadership for core functions/goals that we are uniquely positioned to fulfill
• Creating efficiencies and eliminating redundancies
• Resources
• Finding a way for our public health systems to meet the demands of technology
• Prioritizing goals and resourcing achievement
• Moving towards a more proactive vs. reactive strategy in our day-to-day business
• Resources, visibility, priorities, morale
• Developing a clear and transparent system within the DOH
• Leadership during treacherous times
• Addressing social determinants of health
• Public perception: engine vs. caboose
• The ability to concentrate resources to respond to emerging health threats

Using a one-page graphic representation of a strategic map, Laurie Schulte explained the concepts of central challenge and strategic priorities.

• The oval at the top of the strategic map is the central challenge.
  o It is the focal point for strategy.
  o It focuses on what the organization needs to do in the next three years to support its mission.
• The central challenge is supported by some number of strategic priorities.
  o Strategic priorities are the few critical things we must do in order to meet our central challenge.
  o The number of strategic priorities can vary, but is never fewer than three or more than six.
• There are two tests of a strategic priority:
  o Is each priority necessary to meet the central challenge?
  o Are the strategic priorities taken together sufficient to meet the challenge?
• For improved clarity and understanding by those external to the planning group, the group agreed to call the central challenge the “strategic focus.”

Based on participant input on the strategic focus, Laurie then presented a “first draft” of a possible strategic focus and strategic priorities for the Department of Health for the next three years. After discussion and revision, the group agreed to the following version as “good enough” to begin work to develop strategic objectives for the map.
Discussion of the strategic focus and strategic priorities included the following points.

- In discussing the strategic focus, “Position the Department to lead in improving health outcomes while containing health costs,” the following points were made.
  - The strategic focus is not equivalent to the Department’s mission; however, it must fit within the umbrella of the mission.
  - The strategic focus is about bringing a public health focus to the health care delivery system.
  - To avoid reinforcing fragmentation, the strategic focus is purposely not inclusive of all the Department’s programs.
  - The biggest opportunity to move health forward rests with social and environmental root causes—including protection.
  - This is broader than the health care delivery system.
  - Over the next three years, the biggest public health threat is the explosion of health care costs; the Department must act to address this.
  - Given the need to continue to maintain programs and the time that it will take to do this work, the group supports the notion of “positioning” the Department to lead in this area; the work must be staged appropriately, yet with urgency.
  - It’s important for planning participants to wear their departmental hats, not their individual program-based hats, as they formulate strategy for the Department.
- The group discussed the difference between authority and influence; the Department’s power rests in both areas.
  - The Department has some indirect and some direct ability to lead in containing health care costs.
  - There are many mission-based ways to do this, including:
    - Population-based primary care
Chronic disease and prevention outside of emergency rooms
- Food and water
  - The Department may not have led in this way to the extent that it could have in the past.
  - Costs are much broader than the health care delivery system costs.
- Part of the reason why health care and medical costs have increased so substantially is because public health hasn’t been at the table.
  - The Department must not shy away from the health care/medical piece of exploding costs.
  - The Department’s position in the State allows it to step up to this challenge.
- In Strategic Priority D, “Secure and focus resources”:
  - The resources to be secured are to be redirected toward this new strategic work.
  - Focusing the resources will help the Department move away from current silos.
- The Department was able to prioritize and rally around the H1N1 issue.
  - Despite limited staff, this was a big part of why those efforts were successful.
  - It was not a formal prioritization process although it was still a priority.
  - Importantly, while it was successful, this work was still a significant burden on staff.
- Strategic Priority E, “Align Department operations with strategic requirements,” includes reinforcing a shared commitment throughout the Department to the strategic focus.
- The group developed Cross-cutting Strategic Priority F, “Engage the Department in the strategic focus.” In strategic map logic, a cross-cutting strategic priority:
  - Is placed at the bottom of the strategic map to show that it is foundational to the strategy
  - Spans the map from left to right to demonstrate that efforts to achieve the cross-cutting priority will be embedded in the efforts to implement all the other strategic priorities on the map.
  - No plan to implement the other strategic priorities will be considered complete unless it includes emphasis on the cross-cutting priority.

**Strategic Mapping**

In order to develop a strategic map for the Department of Health, participants worked in small groups to identify objectives that support each strategic priority. A summary of the small group reports follows:

**Strategic Priority A: Optimize the Program Portfolio (Doug Axel, Bruce Mcintyre, Ewa King, June Swallow, Colleen Fontana, Michael Fine)**
- Reduce demand on indirect cost recovery funds by identifying funded programs that are less of a priority to public health direction.
- Develop a process to change statutes which are requiring DOH to maintain programs.
- Identify underfunded programs and determine health priority and impact.
- Develop a business evaluation model process which would identify the cost of a program and the required fee to be charged to cover the program.
• Review the organizational structure to identify consistency and effectiveness by:
  o Benchmarking to national standards
  o Span of control
  o Product and function
  o Comparison to other states
  o Historical comparisons
  o Resource adequacy

Strategic Priority B: Promote the Value and Contributions of Public Health
(Andrea Bagnall-Degos, David _____. Carol Hall Walker, Dara Chadwick, Bob Vanderslice, Lenny Green)

• Strategic plan for all messages/content
  o Research audiences.
  o Develop targeted messages.
  o Health in all policies
    ■ Life
    ■ Neighborhood
  o Identify “what’s in it for me.”
  o Who delivers the message?
  o Include a call to action as part of the content.
    ■ Audience size
    ■ Audience motivation

• Identify and build constituencies.
  o Select key issues.
  o Prioritize.
  o Segment audiences.
  o Achieve some things collectively.

• Engage business and other community partners.
  o ROI/win-win/save money.
  o Reframe how we convey data to make it relevant to a broader audience.
  o Grass roots/creative approaches
  o List serves/narrow casts/social media
  o Be clear on “what’s in it for them” vis-à-vis the benefits of public health.
  o Amplify our voice.

• Engage the Department in the strategic focus.
  o Internal communication
    ■ Internet
    ■ What’s on the plate?
    ■ All employees e-mail/meeting
    ■ Governor’s report
    ■ A big investment
  o What’s in it for me?
    ■ Job
    ■ Improve ways of doing business.
STRATEGIC PRIORITY C: BUILD STRATEGIC PARTNERSHIPS TO SHAPE THE HEALTH SERVICE DELIVERY SYSTEM (ANA NOVAIS, CHRISTINA STANLEY, DONA GOLDMAN, UTPALA BANDY, SAM VINER-BROWN, PATRICIA RAYMOND)

- Create a policy environment that allows the Department to shape rather than influence service.
  - Legislators
  - Local community advocates
  - Payers/purchasers of health care
  - Providers in the health care system
  - Health planning
  - Primary care investments
  - Primary care standards of quality
  - Have a percent investment by health plan for public health.

- Move HIE to gain a better repository of data to:
  - Drive policy agenda.
  - Monitor health care outcomes.
  - Ensure access and meaningful use.

- Change the environment where services are delivered.
  - Build population-based primary care.
  - Assure continuity and coordination of care between systems of care.
  - Regional approaches

- Partner with the community and existing services to build and expand capacity for a comprehensive approach to community-based services.

STRATEGIC PRIORITY D: SECURE AND FOCUS RESOURCES (ERNIE JULIAN, JAMES McDONALD, JOHN FULTON, CARRIE BRIDGES, CHRIS GOULETTE)

Financial Resources

- Change the funding mix/increase private funding.
- Develop strategic partnerships with Medicaid and other third party payers.
- Fee for service business model

People

- Amend FTE cap.
- Maximize interns, etc.
- Public Health Institute
- Infrastructure improvement
  - HR
  - Purchasing
  - IT
  - Legal
- Strategic HR management
  - Who gets the FTE?
  - New competencies
STRATEGIC PRIORITY E: ALIGN DEPARTMENT OPERATIONS WITH STRATEGIC REQUIREMENTS
(ED D’AREZZO, JASON RHODES, DONNA COSTANTINO, JAY GARRETT, EMILY LEBEVRE,
MAGALY ANGELONI)

- Identify priorities and essential functions.
- Identify areas of potential consolidation to enhance efficiencies.
- Realign Department structure (reorganization).
- Build depth in priority areas through cross-training staff and conduct succession planning.

Based on the above input and the discussion that followed, the group developed the strategic map on the following page to guide the Department of Health during the next three years.
# Appendix A: Strategic Map

## Rhode Island Department of Health Strategic Map: 2012-2015

### Position the Department to Lead in Improving Health Outcomes While Containing Health Costs

<table>
<thead>
<tr>
<th>A</th>
<th>Shape the Health Service Delivery System</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enhance Policy-Making Influence and Authority</td>
</tr>
<tr>
<td>2</td>
<td>Ensure Access to and Meaningful Use of Data</td>
</tr>
<tr>
<td>3</td>
<td>Build Strategic Partnerships</td>
</tr>
<tr>
<td>4</td>
<td>Conduct Coordinated Health Planning</td>
</tr>
<tr>
<td>5</td>
<td>Seed Integrated Health Care Systems</td>
</tr>
<tr>
<td>6</td>
<td>Consolidate State Health Care Purchasing</td>
</tr>
<tr>
<td>7</td>
<td>Consolidate and Pioneer Changes in Benefit Designations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>Build Population-Based Primary Care and Preventive Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assure Continuity and Coordination Between Systems of Care</td>
</tr>
<tr>
<td>2</td>
<td>Build Capacity for a Comprehensive Approach to Community-Based Services</td>
</tr>
<tr>
<td>3</td>
<td>Develop a Compelling Case to Secure Stakeholder Buy-in</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>Promote the Value and Contributions of Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify and Improve Understanding of Target Audiences</td>
</tr>
<tr>
<td>2</td>
<td>Develop a Strategic Approach to Message Content</td>
</tr>
<tr>
<td>3</td>
<td>Identify and Build a Constituency Around Key Issues</td>
</tr>
<tr>
<td>4</td>
<td>Engage Business and Other Community Partners to Amplify Our Voice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D</th>
<th>Optimize Department Resources in the Strategic Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify Program Priorities and Essential Functions</td>
</tr>
<tr>
<td>2</td>
<td>Consolidate to Align with Priorities and Enhance Efficiencies</td>
</tr>
<tr>
<td>3</td>
<td>Build Staff Depth Via Cross-Training and Succession Planning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>Secure and Align Financial Resources with Strategic Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Change the Funding Mix/Increase Private Funding</td>
</tr>
<tr>
<td>2</td>
<td>Develop Strategic Partnerships to Expand Resources</td>
</tr>
<tr>
<td>3</td>
<td>Optimize the Fee for Service Business Model</td>
</tr>
<tr>
<td>4</td>
<td>Align Indirect Cost Recovery Funds with Department Priorities</td>
</tr>
<tr>
<td>5</td>
<td>Realign Department Structure to Support the Strategic Direction</td>
</tr>
<tr>
<td>6</td>
<td>Improve/Expand Support Functions (HR, Purchasing, IT, Legal)</td>
</tr>
<tr>
<td>7</td>
<td>Maximize Strategic Use of Technology</td>
</tr>
</tbody>
</table>

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Draft 03/21/12
Discussion of the strategic map included the following points.

- The challenges facing the Department can be summed up as follows:
  - Funding cuts
  - The opportunity provided by hospital insolvencies
  - The negative impact of health care costs on the economy
  - While the group agreed to greater specificity in the strategy to help prevent loss of focus, these high-level, encompassing issues must remain top of mind.

- Because health care is such a significant piece of the State’s economy, leveraging the Department’s expertise in support of the strategic focus should result in:
  - A positive environment for businesses in Rhode Island
  - Economic opportunity
  - Addressing the social determinants of health
  - Improved health outcomes

- Subsequent to the strategic mapping exercise, the group reworked the strategic priorities and objectives.
  - The former Strategic Priority C, “Build strategic partnerships to shape the health service delivery system,” was expanded to A, “Shape the health service delivery system,” and B, “Build population-based primary care and preventive services.”
  - Both columns were moved to the left to emphasize their significance.
  - While partnerships remain critical, they are a subset of column A and are now reflected as Objective A-3, “Build strategic partnerships.”
  - Other columns were realigned and consolidated, resulting in the map on the prior page.

- In discussing Objective A-1, “Enhance policy-making influence and authority,” the following points were made:
  - There is a balance/mix of influence and authority.
  - Health can’t be legislated.
  - Partnerships/relationships make it happen.
    - Getting the right legislation requires contributions beyond the Department of Health.
    - Multiple stakeholders must influence the legislature.

- Payment reform is outside of the Department’s statutory scope of work and is thus not reflected in the strategy; the Department can be an influencer in this area.

- Objective A-5, “Seed integrated health care systems,” means moving toward an integrated system that focuses on all of the elements of the system to improve health outcomes.

- Objective A-6, “Consolidate State health care purchasing,” means increasing State control of health insurance for those who get their insurance through the State.
  - 30%-40% of the population does so, making the State the single largest purchaser.
  - There is as-yet unrealized benefit from this position.

- In Strategic Priority B:
  - “Primary care” is not intended to be defined traditionally.
  - Clinical prevention can’t succeed if services/resources are not available in the community due to:
- Access
- Culture
- Etc.

- One way to address staffing issues included in Strategic Priority D, “Optimize Department resources in the strategic direction,” is by maximizing the potential of a Public Health Institute. This would include moving projects/initiatives from the Department to the Institute.

- Objectives D-1, “Identify program priorities and essential functions,” and D-2, “Consolidate to align with priorities and enhance efficiencies,” will result in the redirection of freed-up funds to priorities and underfunded programs.

- Objective D-1 includes determining the impact and priority of underfunded programs.

- In discussing Objective D-5, “Realign Department structure to support the strategic direction,” the following points were made:
  - In high-performing organizations, strategy drives organizational structure: the Department’s strategic focus is the umbrella under which structure must be considered.
  - The strategic direction and the substance of column D may require a revision to the organizational chart.
  - The Executive Committee and Chiefs/team leads will play a primary, active role in designing/carrying out the new structure.
  - Operationalizing the new structure will be tied to implementation of the strategy.

- Objective D-6, “Improve/expand support functions,” recognizes that:
  - Some staff are spending time doing administrative work outside their scope of responsibility.
  - Solid HR, Purchasing, IT and Legal will make time for staff to focus on strategic work.

- Objective D-7, “Maximize strategic use of technology,” recognizes that:
  - The Department does a good job with what it has.
  - However, its technology resources are lagging.
  - Maximized technology improves effectiveness/efficiency and reduces duplication.
  - This is a resources issue.
    - What can the Department stop doing to free up resources to maximize the use of technology?
    - This requires discipline.

- Objective E-2, “Develop strategic partnerships to expand resources,” includes partnerships with third party payers/Medicaid with the goal of:
  - Saving them money
  - Having them redirect some of those savings to the Department to be used for prevention

- The prior cross-cutting strategic priority, “Engage the Department in the strategic focus,” was revised to Objective D-4, “Engage staff throughout the Department in the strategic direction.”
• As the Department evolves to support the new strategy, the types of core values and guiding principles that are appropriate throughout the Department will become clearer.
• The group is aware that its core public health functions are not reflected on the strategic map.
  o The strategic focus assures that the core public health functions will continue with precision and excellence as important work of the Department.
  o These functions should now be seen through the lens of the strategic focus.

**Implementation Planning**

**Setting Implementation Priorities**
The group prioritized the efforts to implement the strategic map during the next 12 months using two different approaches. First, it surveyed each person’s thinking on the allocation of the organization’s time and energy that should be devoted to each column of the map during the next 12 months. (100 points represents all the resources that will be spent on implementation.) A summary of each person’s input follows.

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Next, the group surveyed perceptions of which objectives on the map are the most important to emphasize during the next 12 months. Each person was given five votes, and a summary of the “straw vote” is depicted in the table below.

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<tr>
<td>705</td>
<td>525</td>
<td>495</td>
<td>915</td>
<td>560</td>
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</tbody>
</table>

These “straw polls” will provide guidance on the most important things for the Department of Health to focus on as it proceeds with implementation planning.
Identifying Tracks of Work

Laurie Schulte introduced the group to the concept of a “track of work.”

- A track of work is a single map objective or a group of related objectives that use the same resources.
- Tracks of work are a means of getting organized for implementation.
- Organizations generally focus on no more than three to five tracks in a 12-month implementation period.

Participants agreed that the following tracks of work should receive primary emphasis during the next 12 months.

PROGRAM/FUNCTION PRIORITIES

- Objective D-1: Identify program priorities and essential functions.
- Objective D-2: Consolidate to align with priorities and enhance efficiencies.
- Objective D-4: Engage staff throughout the Department in the strategic direction.
- Objective D-5: Realign Department structure to support the strategic direction.

LEGISLATIVE CHANGE

- Objective E-5: Influence statutory change to reduce unfunded mandates.
- Objective A-1: Enhance policy-making influence and authority.

PARTNERSHIPS

- Objective A-3: Build strategic partnerships.
- Objective C-3: Identify and build a constituency around key issues.
- Objective E-2: Develop strategic partnerships to expand resources.
- Objective A-1: Enhance policy-making influence and authority.

POPULATION-BASED PRIMARY CARE

- Objective B-2: Build capacity for a comprehensive approach to community-based services.
- Objective A-4: Conduct coordinated health planning.

Discussion of the tracks of work included the following points.

- Implementation of the tracks of work incorporates three issues:
  - Priority
  - Interdependence
  - Sequence
- The Partnerships track of work, specifically Objective C-3:
  - Includes key content and messaging to build a constituency around key issues
  - Will require input from the Communications group/Dara Chadwick
- In discussing the Population-based Primary Care track of work, the following points were made:
  - What resources required prior to being able to undertake the work in Objective B-2?
  - How do we develop a QA process for primary care practice around public health outcomes?
  - We must engage primary care practices in the public health purposes of primary care.
This will require:

- Bringing resources to them
- Thinking about their practice as a population

- Dr. Fine explained the concept of a Primary Care Trust as:
  - A model from England not yet in the United States
  - A quasi-public health entity that becomes the fund holder for all primary care services; insurance companies are not involved.
  - Providing incentives based on financial savings
  - Allowing for the building of a primary care infrastructure where it doesn’t exist

- The entire effort behind the Primary Care track of work applies a broad approach to primary care, not a narrow one.

- The Legislative Change track of work includes the Department’s policy-making authority reflected in Objective A-1; the Department’s influence on policy making in Objective A-1 is reflected in the Partnerships track of work.

Developing Preliminary Implementation Plans

Participants met in small groups to begin developing implementation plans for each track of work. A summary of the small group reports follows.

**Program/Function Priorities: Donna Costantino, Doug Axelsson, June Swallow, Ed D’Arezzo, Jay Garrett, Ana Novais, Emily Lefebvre, Ernie Julian**

<table>
<thead>
<tr>
<th>Result</th>
<th>Deadline</th>
<th>Accountability</th>
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<tbody>
<tr>
<td>Establish clear criteria for prioritization.</td>
<td>First quarter of the implementation period</td>
<td>Executive Committee and Office Chiefs</td>
</tr>
<tr>
<td>Recommendations for a list of core essential public health programs/functions</td>
<td>First quarter of the implementation period</td>
<td>Executive Committee and Office Chiefs</td>
</tr>
<tr>
<td>Develop a plan to engage and involve staff.</td>
<td>First 3-6 months of the implementation period</td>
<td>Communications</td>
</tr>
<tr>
<td>Recommendation for organizational change and strategic disinvestment to target resources to higher priorities</td>
<td>First 9-12 months of the implementation period</td>
<td>Executive Committee and Office Chiefs</td>
</tr>
<tr>
<td>Standardization of processes across Divisions/Centers, including clear written administrative and operational policies and procedures</td>
<td>12 months into the implementation period with annual review</td>
<td>Key administrators</td>
</tr>
</tbody>
</table>


### Legislative Change

**JAMES MCDONALD, UTPALA BANDY, MIKE DEXTER, DAVID ____,** 
**CHRIS GOULETTE, MAGALY ANGELONI**

<table>
<thead>
<tr>
<th>Result</th>
<th>Deadline</th>
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<tr>
<td>Assess OM’s.</td>
<td>June 2012</td>
<td>David ____</td>
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<tr>
<td>• Keep/funding/staff</td>
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<td>• Eliminate</td>
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<td>• Current status</td>
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<td>Identify and prioritize the health system changes.</td>
<td>June 2012</td>
<td>Multidisciplinary work group</td>
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<tr>
<td>• Assess our sphere of influence/authority to identify gaps.</td>
<td>October 2012</td>
<td>Multidisciplinary work group</td>
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<td>• Design strategy to get to desired position.</td>
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### Partnerships

**CAROL HALL WALKER, CHRISTINA STANLEY, ANDREA BAGNALL-DEGOS,**
**BRUCE MCINTYRE, EWA KING, SAM VINER-BROWN, COLLEEN FONTANA, LENNY GREEN,**
**PATRICIA RAYMOND, DARA CHADWICK**

<table>
<thead>
<tr>
<th>Result</th>
<th>Deadline</th>
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<tr>
<td>An active network of diverse advocacy partners for public health</td>
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<td>Form a Department-wide internal work group using existing efforts and engaged staff and resources</td>
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<tr>
<td>• E.g. business community, legislative, public</td>
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<tr>
<td>• Gap analysis fuels strategic approach.</td>
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<td>Public/private partnerships to expand the Department’s resources/capacity for public health</td>
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<td>• MOU</td>
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<td>• Partners provide additional human/data sharing resources</td>
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<td>Establish communications delivery system with potential partners.</td>
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<tr>
<td>• Target audience research</td>
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<td>• Communications plan/engagement</td>
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<td>Result</td>
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| Inventory of primary care assets including:  
  - Supplies  
  - Architecture  
  - Utilization  
  - Quality assurance measures | May 2012 | Thomas, Mike Dexter, and a Primary Care Officer |
| Gaps analysis based on model, inventory | May 2012 | Thomas, Mike Dexter, and a Primary Care Officer |
| Model  
  - “Artist’s conception” of population-based primary care delivery system  
  - Robust primary care  
  - Comprehensive community-based services | October 2012 | Primary care study group |
| QA/QI strategic plan for optimal QA/QI processes in primary care practices | January 2013 | Dona Goldman, Andrea Bagnall-Degos, Dara Chadwick |
| Primary care trust feasibility study | April 2013 | Michael Fine |
| Three EMS pilot programs: community-based EMS/treatment in the field | January 2013 | Jason Rhodes |

**Evaluation Indicators**
- Inventory/gaps analysis (one product): completed report
- Model: white paper
- QA/QI strategic plan: strategic plan
- Primary care trust feasibility study: feasibility study
- EMS pilot programs: operational pilots in three communities

Discussion of the preliminary implementation plans included the following points.
- The most important key to effective implementation is effective leadership in three critical roles:
  - The executive leader or sponsoring leader is the person or group that makes the “go/no go” decision on implementation and allocates human and financial resources necessary to support effective implementation.
  - The front line leader is the person or group that has designated responsibility to implement a specific implementation priority or initiative.
o The consultative or supportive leader is the person or group with the responsibility of providing critical support (expertise, coaching, resources, etc.) to the front line leaders. In addition, the supportive leader may have the responsibility for the coordination of all implementation efforts. These leaders often come from key support functions such as human resources, performance management, organizational development or information technology.

- The first two results in the Program/Function Priorities implementation plan will happen in parallel; establishing clear criteria for prioritization has to be completed prior to finalizing a recommendation on a list of core essential public health programs and functions.
- There should be a transparent process for vetting of the prioritization criteria that engages relevant staff across the Department.
- The timing of implementation for Legislative Change will need to be aligned with legislative session timing.
- The Partnerships track of work may include work beyond public health and into the delivery system.
  o This is to be determined, but the Department wants to take a broader approach.
  o This has not traditionally been done.
  o The gap analysis will shed light on this issue.
- The ability of the Department to enhance its policy making influence and authority is dependent on which pieces of system change it wants to tackle first.

Next Steps
At the conclusion of the meeting, the group identified the following next steps.

TSI Next Steps
TSI will provide the following documents to Lenny Green by April 6 for distribution to session participants:
- A final version of the strategic map
- A “presentation version” of the strategic map
- A protocol for the communications session outlined below
- A comprehensive written summary of the strategic planning session

Communicating the Strategic Plan
A key aspect of the strategic planning process is communicating the draft strategic plan to key constituents and securing their feedback on it. The group identified the following stakeholders with whom the plan will be communicated.

INTERNAL STAKEHOLDERS
- Department staff
  o The Director will hold an all employees meeting to be scheduled as soon as possible.
  o Communications will issue an internal press release with similar messaging.
  o The group should consider a formal, strategic communications strategy that continues consistently throughout the implementation process.
- Ideally, the communications session will include:
A presentation of the draft strategic plan by members of the planning group—including the process, mission, vision and new strategic map; 12-month implementation priorities still need to be finalized and so will not be included in communications as yet.

- Time for clarifying questions to ensure understanding
- A structured opportunity to secure feedback from participants, based on questions similar to the following:
  - What are the strengths of the strategic plan?
  - What issues/concerns do you have?
  - What suggestions do you have to ensure successful implementation of the strategy?
- If there is insufficient time at the all employees to secure feedback, alternate mechanisms will be developed.
- Laurie Schulte is available by phone to provide additional guidance to the process.

- Leadership will revise the strategic map as appropriate based on the feedback received.

**EXTERNAL STAKEHOLDERS**

- Communications with external stakeholders will be conducted after internal communications. Potential external stakeholders include:
  - Various advisory bodies/individuals; communications to be put on their meeting agendas
  - Sister State agencies; the strategy would be shared as an example mechanism
  - HHS, when the strategy and approach to implementation are finalized
  - Communications to external stakeholders should focus on what the Department is doing differently.

**Implementation Planning**

- A second round of implementation planning will be undertaken by those who participated in the planning session; formal ongoing implementation leads and teams will be identified subsequent to the second round of implementation planning.
- An immediate next step is for planning group participants to review the meeting summary to confirm or revise the first-year implementation priorities.
  - The second round of implementation planning may be required to make this decision about priorities.
  - Further reflection and digestion of the planning session is required prior to a short-term conversation about next steps.
- Those involved in implementation planning should be thoughtful about preparing the groundwork for the third through fifth years.
- Round 2 implementation will include:
  - Completion of the preliminary implementation plans for each assigned track of work, using today’s draft plans as input
  - Ensuring the preliminary implementation plans are completed and submitted for review by a specified deadline, tbd
- Leadership should consider holding a coordination meeting to:
Compare work across the tracks in order to identify resource requirements and what’s realistic to accomplish in 12 months.

- Identify those leads and teams who will do the work of implementation.
- Resource implementation (time, money, personnel, systems resources).

- Once assigned, implementation teams will continue to improve the implementation plans as necessary/appropriate as they carry out the work.
- The goal is for implementation to begin in April of 2012.
- Importantly, the Department must identify those things that it will stop doing in order to operationalize implementation. The new strategic work will not succeed if it is simply an “add on” to already overburdened staff.
- It will be important for the Department to ensure “quarterly pacing” to:
  - Set itself up for early wins.
  - Ensure momentum behind implementation continues and success spreads.
- Happily, the Department has several positives in regard to strategic planning, including:
  - Articulated goals
  - Buy-in at the top
  - Action that is happening
  - Hopefully resources will follow this momentum.
  - The work needs to get done.

**“Review and Adjust” Process**

Laurie Schulte outlined the following as possible elements of a review and adjust process for the Department.

- Using regular leadership meetings for:
  - Implementation updates
  - Resolution of implementation issues/problems

- Periodic review and adjust sessions
  - Two to three times per year
  - More detailed review of progress with implementation of each track of work, including:
    - Accomplishments
    - Issues/problems/gaps
    - Lessons learned
    - Next steps
  - Review and adjust the strategic map and implementation plans as needed.
  - Per Dr. Fine’s request, goals for years three to five will be staged as part of the review and adjust process.
    - The group should plan a two to three hour exercise in a month or two to take a year three to five view of its strategy.
    - The goal is to ensure the Department stays ahead of planning for these out years.
  - It’s critical that those involved with strategy formulation and implementation ensure regular, consistent and frequent communication throughout the Department.
In the past, strategy implementation has stalled—we don’t want that to happen this time.
This is particularly important in a stressful environment.

- Staff must be reassured that the core functions for the Department will continue.
  - The attempt of the strategy is not to eliminate any program that is underfunded.
  - Many of these are still important and will continue.
  - The strategic map is a reshaping and realignment of the Department’s strategic focus.
  - All programs and functions should use the strategy as a lens for how they undertake their work.
  - Both realigning the Department as well as continuing core public health functions are a part of the Department’s work.
    - The strategic focus is a trigger.
    - The work of the Department can and needs to be broader than this.

- Annual strategy update
  - Typically a one-day retreat
  - Review progress on implementation (one of the periodic review and adjust sessions).
    - Identify accomplishments.
    - Resolve any implementation issues.
  - Update the strategic map based on:
    - What was learned from implementation
    - What’s working and what isn’t
    - How the environment has changed
  - Set implementation priorities for the next 12 months.
  - Align budget and human resources.


Appendix # 5

7/12/12 Strategic Planning Session: Overarching 5-year goals

**Overarching 5-year goals: Food for thought**

**Where do we need to be?**
- Shaping the healthcare delivery system
- Reducing years of potential life lost

**What do we need to accomplish?**
- Lowest cost healthcare in the U.S.
- Best measured social capital in the U.S.

**Comments:**

- Define how we want to shape the healthcare delivery system- better health outcomes and increase economic productivity for the state
- Look at reducing days of lost work due to illness/injury vs. years of potential life lost?
- Increases in physical and social function
  - Days of work lost
  - Days of school missed
  - Days of leisure lost
- Improving health outcomes- We treat symptoms not root cause. We need to switch that strategy.
- Move from treatment incentives to wellness incentives
- Keep focus on public health interventions
- There is a missing link between population health and exam room
- Influencing vs. shaping the healthcare delivery system. We need to define healthcare delivery system.
- Two types of population-based primary care
  - Physicians looking at quality of care within their treatment population
  - Look at entire population within a geographic region to explore how the population is serviced by the healthcare system
- Need our data to inform policy in a more visible way
- Health service vs. healthcare delivery system?
- Key questions:
  - Where are we going?
    - Reduce years of potential life lost and days of lost work and school in RI
    - Improve social capital in RI
    - Improve economic status and resiliency in RI
    - Assure equality and the ability to participate in the democratic process in RI
  - How will we get there?
    - Redirected RI healthcare delivery system such that it focuses on where we are going
    - Redirected RI Dept. of Health such that it focuses on where we are going
- Assessment, policy, assurance: need to keep these core public health functions in mind
• We are not going outside our core functions, it is doing our core functions differently.
• Traditionally two worlds: public health and healthcare delivery system. We must bridge the gap to accomplish the 5-year goals together.
• Need to prioritize our work to accomplish goals. Can’t keep adding on to current load and not removing items.
• Where does EOHHS, the Governor, and Legislature see HEALTH in the next 5 years?
• Need to look at strategies for achieving these goals.
Appendix # 6: HEALTH’s America’s Health Ranking (AHR) Workgroup Members

Michael Fine, MD, Chair
Ed D’Arezzo
Christine Goulette
Lenny Green
Sarah Harrigan
David Heckman
James McDonald, MD
Jane Morgan
Ana Novais
Jim Palmer
Samara Viner-Brown
Appendix #7: Strategic Priorities: Making Rhode Island the Healthiest State in the Nation

Making Rhode Island the Healthiest State in the Nation
Strategic Priorities 2013-2014

1. Improved Delivery System
   - Primary Care Trust / Neighborhood Health Stations
   - Strengthened CurrentCare
   - Hospital Consolidation
     - Hospital Insolvency Act
     - Hospital closure: authority and process

2. Health In All Policies
   - Tobacco
     - Smoke-free state campuses and grounds
     - Point-of-sale parity & controls
   - Obesity Prevention
     - SNAP waiver to restrict food purchases
     - Sugar-sweetened beverage tax
     - Fat and calorie labeling
   - Prescription Drug Overdose Deaths
     - Prescription Monitoring Program
     - Multi-disciplinary Chronic Pain Center
   - Guns: Register, Inspect, Insure
   - Annual Address: “The State of Rhode Island’s Health”

3. Revolutionize HEALTH’s Business Model
   I. Multi-payer Innovations Trust: Private Payer Supported / Not General Revenue
      - Opt-out testing for HIV and Hepatitis C
      - Teenage pregnancy and premature birth reduction
      - Obesity prevention
      - Multi-disciplinary chronic pain treatment center
      - Lead poisoning prevention
      - HIV and Hepatitis C testing in Corrections
   II. Restricted Receipt Accounts
      - FTE Cap
      - Food inspection
      - Board of Health Professionals Licensure & Discipline
      - CON and HCA applications/fees and restricted accounts
      - Medical marijuana
      - Prescription monitoring program

4. Build a Sustainable Workforce / Health Professionals and Others
   - Public Rhode Island Primary Care Medical School
   - Licensure of Medical Assistants, Care Managers, Navigators and Health Coaches
Appendix # 8: HEALTH’s Primary Care Trust (PCT) Workgroup Members

Michael Fine, MD, Chair
Lenny Green
David Heckman
James McDonald, MD
Jane Morgan
Ana Novais
Amy Nunn (Rhode Island Public Health Institute)
Sophie O’Connell
Jim Palmer
Roy Smoot
Appendix # 9: “How the Healthcare Market is at War with Health” Presentation from Dr. Fine

Who helped me put this talk together

• Roy Smoot
• David Heckman
• Dara Eshchriek
• John Fulton
• Anne Berg

• Steven Petterson PhD
• Robert Phillips MD
• Andrew Becton MD
• Shannon Brownlee

• And many other friends and teachers

(responsibility for the accuracy of the information is mine alone)

What I’ll Be Talking About

• Healthcare is crippling the nation’s economy
• Medical care doesn’t matter much for health — but human services’ spending does
  — Some medical care is making health unachievable
• Primary Care can reduce healthcare costs
  — (and leave us money to spend on education, housing, public safety and the environment)
• Primary care is the only medical service that significantly impacts population health
• A Primary Care Trust can bring primary care to all Rhode Islanders

United States Health Expenditure 1980-2010

The Boiling Frog
By 2023, projected annual family health insurance premium costs will be GREATER than average household income in the U.S.

The U.S. spends as much as other countries on human services, but most of our spending is on healthcare.

We spend too much on healthcare

Healthcare Costs Contribute To GM’s Bankruptcy

Healthcare costs add $1,525 to the price of every General Motors vehicle. The company spent $4.6 billion on healthcare in 2007, more than the cost of steel.

As a result of these crushing healthcare costs, American businesses are losing their ability to compete in the global marketplace. Healthcare at General Motors puts the company at a $5 billion disadvantage against Toyota, which spends $1,400 less on healthcare per vehicle.

Healthcare Cost Is Crippling The U.S. Economy

"Rising health-care costs are at the core of the United States’ long-term fiscal imbalance... it is no exaggeration to say that the United States standing in the world depends on its success in constraining this health-care cost explosion; unless it does, the country will eventually face a severe fiscal crisis or a crippling inability to invest in other areas."

-Peter Orszag, "Foreign Affairs" July-August 2011
**Situation of the U.S. Healthcare Market**

- Overpriced by a factor of 2
  - We waste $300-500 billion every year (about 1/3 of total healthcare expenditures)
- Underperforming
  - Health system world ranking: 37th
  - Lower 10% in most studies
  - This 300,000 people yearly estimated
- Disrupting the nation
  - Contributing to the rise of our social services, making health impossible
- Doesn’t even provide the basic care to primary care; it is only medical service associated with improved population health
- No clear mission, other than profit for investors

**Healthcare Waste By Category**

- Preventable Conditions & Avoidable Care
- Lack of Care Coordination
- Provider Deficiency & Errors
- Administrative System Deficient
- Fraud & Abuse
- Unmeasured Use

**Proportion of Medicare Spending Attributed to Each Category of Care**

- Effective Care 25%
- Supply Sensitive Care 35%
- Preference Sensitive Care 15%
- Mixed Sensitive Care 33%

**Only 10% of population health outcomes are due to medical care**

**The major determinants of population health are social measures**

- Smoking and Environmental Exposures
- Income Inequality
- Race
  - As a marker for the impacts of racism on the measured health outcomes of individuals
- Primary Care Supply

So all this spending doesn’t buy us anything we can use.
Healthcare has FAILED to deliver health!

- 80% or more of our healthcare spending is on medical services.
  - Most experts estimate about 1/3 of what we spend on medical services is unnecessary, harmful, or fraudulent.
- And medical services contribute only about 10% to population health outcomes.
- 90% of population health outcomes are produced by:
  - Education
  - Environment
  - Housing
  - Behavior
  - Genetics
  - Social organization

Rhode Island itself spends too much on healthcare

Rhode Island Healthcare Costs: 22% Higher Than The National Average

<table>
<thead>
<tr>
<th>Year</th>
<th>Out-of-Pocket Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$5,325</td>
</tr>
<tr>
<td>2011</td>
<td>$5,475</td>
</tr>
</tbody>
</table>

Rhode Island spends too much on healthcare

In 2011, the cost of a family health insurance plan through an employer was $15,273.

In 2011, the average annual wage for an employee of a private company in Rhode Island was $43,526.

Rhode Island spends too much on healthcare

If Rhode Island had simply kept Medicaid spending from increasing from 2010 to 2011, the projected savings for the state would have been more than $26 million.

That's equivalent to the salaries of about 686 new teachers.

Rhode Island spends too much on healthcare

In FY2010, the state of Rhode Island spent $709 million on Medicaid.

In FY2012, the total Medicaid recipients was $1.3 billion.

The state spent $230 million on health insurance for state employees.
- $159 million for municipal employees (FY2012)
- Gross total spent about $2.5 billion, of which about $1.3 billion is state tax dollars, and $1.2-1.6 billion is federal tax dollars.
Rhode Island spends too much on healthcare

- Total healthcare expenditures in Rhode Island in 2009: $8.8 billion (a little larger than the entire state budget for all state services)
- Average annual percent growth in healthcare expenditures in Rhode Island: 1991-2009: 6.3%
- We estimate healthcare costs were $551.5 million from 2009-2010
- At the $39,000 teacher salary rate, this $553 million is equivalent to the salaries of 14,177 new teachers in Rhode Island
- If we waste 30%, then we are wasting about $2.5 billion a year
  - Which could fund a considerable tax reduction, many more teachers, more police, more housing, and get the roads fixed!

Source: U.S. Census Bureau 2010 Census and Rhode Island Office of Health Planning and Policy Development.

And we die sooner.

We spend TWICE what other industrialized countries spend, and we have a shorter life expectancy

![Graph showing life expectancy and healthcare spending comparison between countries.](chart)

Source: E.J. Woolcock, 2006

Our infant mortality rate is more than twice the rate of countries that spend far less

![Graph showing infant mortality rates across different countries.](chart)

Source: E.J. Woolcock, 2006

Healthcare in Rhode Island, despite some successes, is an economic drain

- Best immunization rates in the U.S.
- Tight control of infectious diseases
- Smoking rates reduced
- Issues: substance abuse, obesity, cancer, heart disease

**BUT**
- Healthcare consumes almost $2.6 billion of public spending by Rhode Island
  - Almost 1/3 of which (more than $800 million) is wasted

Source: Barnes, T. 2013. What can we do to help? Rhode Island Center for Policy Studies for Children. All rights reserved.

The healthcare market has also failed Rhode Island

- 1,200 unnecessary deaths a year from heart disease and stroke
  - 60% of Rhode Islanders have untreated high blood pressure
  - 54,000 Rhode Islanders have diabetes with untreated high blood pressure
  - 23,000 Rhode Islanders with untreated and uncontrolled diabetes
  - 18,000 Rhode Islanders with high blood pressure and untreated diabetes
  - 62% of Rhode Islanders were overweight or obese
  - 40% of Rhode Islanders did not receive screening or care
  - 45,000 Rhode Islanders lacked dental care
  - 200 unnecessary deaths a year from colon cancer
  - Almost 200 drug-related deaths a year (200 involved a prescription opioid)
  - 100-200 unnecessary deaths and 300-400 unnecessary hospitalizations a year from
  - 90,000 Rhode Islanders not vaccinated against influenza
  - 100 unnecessary new cases of HIV/AIDS per year
THE THREE PIPERS
A.K.A., The Three Horsemen of the Apocalypse

The Medical Industrial Complex
- U.S. Specialty/Primary Care Ratio is about 70:30
- Academic Medical Centers treat just 1% of the U.S. population
- Treatment recommendations come from academic medicine, research, pharma, medical device manufacturers and their revolving doors

Health insurance
- Used as a means to promote access to health services in a nation without a healthcare system
- Unintended side effect
  - Removes "skin in the game" as a check on cost
  - Doesn't discriminate well between needed and unnecessary services

Healthcare reform will fix this, right?

Marketing
- Pharmaceutical Marketing (2004) $57.5 Billion
- Tobacco Industry (2008) $12.4 Billion
- Food Industry
  - To kids $10 Billion
  - Pornography (1999) $1.6 Billion
- Hospital Marketing (2012) $1 to 14 Billion
- Total 2012 Budget, Centers for Disease Control and Prevention $11.2 Billion

Our products and our marketing cause our illness
- Cigarettes
- Cars
- Financial services
  - Environmental impacts
- C.F.D.
- Glucotics
- Cholesterol
- High blood pressure
- Heart disease
- Labor Saving Devices
- Hospitals and Pharmaceuticals
- 100,000 deaths from "errors"
- Many more from known side effects and adverse reactions
- Popular culture
  - Drug use and mortality
  - Smoking and heart disease
  - Adverse interactions
- Subliminal appeal
  - Insanity and depression

“we have met the enemy and he is us.”
- JFK
The Primrose Path

Healthcare Reform 2014: What We'll Get

- Affordable coverage for all
- No more 12-month coverage gap
- No more pre-existing condition denials
- No more annual dollar limits
- No more lifetime dollar limits
- No more rescission of policies

Appendices

Healthcare 2014: What We'll Get

- Continued cost growth: 
  - $500 billion by 2018
  - 30% of GDP by 2030
- Few likely or probable improvements in population health: 
  - No more talking about the preventive
  - Smoking
  - Prescription opioid epidemic
  - Cervical screening
  - Obesity, tobacco, diabetes, and stroke
  - Alzheimer’s
  - Suicide
- No likely improvements in social determinants: 
  - No change in economic inequality
  - No change in racial disparities
  - No change in housing tenure
  - No change in access to care
  - No change in education and training
- A healthcare insurance and medical services market that is
  still not secure

Major Omissions

- No direct infrastructure building
- Healthcare remains a for-profit business
- No controls on industries’ ability to impact the legislative process in their own interest

We fed the fox, and left the fox in control of the henhouse

Healthcare Reform 2014: What We’ll Get

- Substantial improvements to access and the function of the insurance market

But this is INSURANCE MARKET REFORM—it will provide more Americans access to health insurance

- HOWEVER, it will benefit insurance companies, pharma, device manufacturers, specialists, and hospitals most

And it will COST more money than any of us can count

- When was the last time an insurance company did your payday cash, called your back at 3 in the morning when your kid was sick, begged you to quit smoking, or gave you a life lesson

The Drinking Gourd

The Arc of History is long, but tends toward justice.

— Martin Luther King, Jr.

You Americans usually get the right answer—after you've tried all the other ones.

— Winston Churchill
Projected Diabetes Mortality in the U.S. with Improved Primary Care Supply

- Diabetes mortality reduced by 4%
- 2,700 deaths per year averted

Projected Cancer Mortality in the U.S. with Improved Primary Care Supply

- Cancer mortality reduced by 1%
- 6,000 deaths per year averted
- That’s about twice the yearly improvement we now experience with all other interventions combined

Projected Life Expectancy in the U.S. with Improved Primary Care Supply

- Improves by 1 full year
- A greater improvement than during the period 2000-2006, despite investing more than $2 trillion a year in health services during that time

Projected Total Yearly Deaths Averted in the U.S. with Improved Primary Care Supply


Cost projections: what would healthcare in the U.S. cost after healthcare reform if primary care supply was the same as the 5 best states?

| Everyone in, no change in primary care supply | $125-250 Billion new Cost |
| Everyone in, improved supply, system as it is | $45 Billion SAVINGS |
| Everyone in using CINs | $293 billion SAVINGS |
| No one else in, improved supply | $211 billion SAVINGS |

And That’s Just By Pushing on Primary Care Supply

- What happens when we add:
  - Multidisciplinary teams
  - Open access
  - Expanded hours
  - Neighborhood outreach
  - Home Health
  - Mental and Behavioral Health
  - Substance Abuse Prevention
  - Integrated EMR with built-in registry and advanced reporting
How Primary Care Reduces Cost and Improves Outcomes

- Counseling changes behaviors (40%)
  - (How do you spell Providence, anyway?)
- Prevention mitigates the impact of genetics (30%)
  - (And that's before we put all that saved money to use, improving education, housing public safety and the environment)

Why Primary Care Is the Leverage We Need

- Reduces cost by expanding access to:
  - right time
  - right place
  - right size services
- Expanded primary care supply and Patient Centered Medical Home is associated with reduction in emergency department use by 50% or more
  - And reduction in hospital utilization by 25% or more

Magellan's Ships

A Healthcare System:

An organized architectonic of medical and health services, designed to care for all Americans—preventing disease, treating illness and injury, and creating equal life chances. So all Americans (or, at least, all Rhode Islanders) have equal life chances—have an equal ability to function in their communities and an equal ability to participate in the democratic process.
**Strategic Map and Priorities**

**PLAN’S IMPLEMENTATION**

**Appendices**

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**Magellan’s Ships**

**IMAGINE A HEALTH CARE SYSTEM**

One Primary Care Center for every community of 10,000 people that:

- is a mile or two from home
- sees many different kinds of health professionals
- has many different kinds of health professionals
- Deters, nurse practitioners, nurses, pharmacists, physical therapists, psychologists, social workers, substance abuse counselors, nutritionists, nurses and lay advocates, community health workers, home health aides, EMTs, paramedics
- doesn’t get bored
- Preserves $90% of the health services the community needs, and does all so that 90% of the people in each community want to use their health center.

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**A Primary Care Trust**

- A single payer system, but just for primary care, leaving the rest of the health care financing system intact.
- Organizes and simplifies primary care payment, so that primary care practices are paid to deliver health care to communities.
- In addition to delivering health care to individuals.
- Builds primary care practices in every Rhode Island community.
- Practices vary in size and the size of the community.
- Practices vary by private enterprise, not government.
- But a non-profit health care system at the end of the day.
- Preserves patient choice.
  - Guaranteed, no death panels.

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**Summary and Conclusions**

- Healthcare is crippling the nation’s economy.
- Medical care doesn’t matter much for health — but human services spending does.
- So medical care is making health unachievable.
- Primary Care can reduce healthcare costs.
- (And leave us money to spend on education, housing, public safety, and the environment.)
- Primary care is the only medical service that significantly impacts population health.
- A Primary Care Trust can bring primary care to all Rhode Islanders.

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**Is Primary Care for all Rhode Islanders possible?**

If you can see the invisible, you can do the impossible.

-Bernard Lown, M.D.

1985 winner of the Nobel Peace Prize for his work with Physicians for the Prevention of Nuclear War.
Summary and Conclusions

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