Rhode Island State Profile: Public Health and Primary Care Collaboration

Background

Rhode Island has a centralized public health system in which a single state-level health department oversees public health activities statewide. This structure has worked well for Rhode Island, given the small geographic area of the state, comparatively small population size, and the existing close relationships between state leaders and health practitioners.

In 2010, the Rhode Island Office of the Health Insurance Commissioner implemented the Affordability Standards – new regulations on commercial payers in the state to help support access to health care by addressing some of the systemic drivers of unaffordable health care. One of the major reforms in the Affordability Standards requires commercial health insurance plans in the state to invest in primary care through the advancement of the patient-centered medical home (PCMH) model. The Affordability Standards also require commercial payers in the state to invest a percentage of their revenue into primary care, which has led to the promotion of team-based care (including nurse care managers, care navigators, and integrated behavioral health), the Care Transformation Collaborative (CTC-RI), improved data systems, and other initiatives. Importantly, these commercial payer investments in primary care are not allowed to come from increased premium costs.

In 2015, Rhode Island launched a Health Equity Zones (HEZ) initiative, aimed at centering conversations about health needs, disparities, and goals at the community level. HEZs were designed to serve as backbone organizations, convening community stakeholders to identify the health and social needs and priorities of the community. In addition, HEZs work to enhance community capacity to affect change in ways that reflect community-level priorities. The Rhode Island Department of Health (RIDOH) supports HEZs through "core infrastructure" funding and acts as a liaison, providing support rather than oversight in order to promote social change.

How is collaboration operationalized in Rhode Island?

Affordability Standards and PCMH

In Rhode Island, the patient-centered medical home (PCMH) model gained traction when the Office of the Health Insurance Commissioner implemented the Affordability Standards in 2010. A product of these regulatory changes, CTC-RI was convened by the state Office of the Health Insurance Commissioner to support five pilot primary care practice sites. In 2015, CTC-RI became a distinct nonprofit organization that works to support primary care in the state through stakeholder engagement, evaluation, and scaling best practices. CTC-RI has enhanced data sharing in the state by directing supplemental per member per month payments from health plans to fund improvements in data collection to drive health delivery and health care change at the practice level. Supplemental payments are also available to support other initiatives directed at improving population health. In addition, primary care practices use this funding to apply for National Committee for Quality Assurance (NCQA) PCMH recognition and hire care managers.

"Public Health Out Loud – Grand Rounds"

To foster collaboration and improve communication during the COVID-19 pandemic, the RIDOH held weekly meetings with public health and primary care stakeholders in the state. These meetings were used to share important

information, obtain timely feedback, and identify solutions to pandemic-related challenges. Due to overwhelming support for these weekly public health "grand rounds", RIDOH has continued to host calls. The initiative, now called "Public Health Out Loud - Grand Rounds", focuses on a different public health topic each month (e.g., monkeypox, childhood immunizations, etc.). In addition, the state provides CME for clinicians attending the sessions. These calls provide regular, direct access for primary care physicians to state public health leadership.

Relationships

Rhode Island is a geographically small state with a single, centralized health department. As a result, there is a single chain of decision-making regarding public health decisions for the entire state. This has facilitated relationship building, collaborative action, and well-coordinated funding streams. Many providers and public health leaders have pre-existing relationships. It can be easier to maintain those relationships when you're in a small, closeknit community. "The Governor has my cell phone", is a sentiment expressed by many public health and primary care leaders in the state. Due to the centralized public health system, RIDOH works closely with primary care organizations to promote public health priorities locally.

Impact

Equity

Collective efforts across primary care and public health have resulted in several achievements, including childhood immunization rates that are much higher than the national average. At both the state and provider levels, there is an emphasis on identifying whether disparities exist across patient demographics related to immunizations, making this an easy topic for public health and primary care providers to collaborate on. Rhode Island—in partnership with a diverse group of community stakeholders—has developed a set of Health Equity Measures to guide cross-sector collaboration in addressing barriers and inequities in health.

In Rhode Island, the HEZ model has worked to establish support for public health initiatives at the local level by ensuring community engagement in the process. Health Equity Zones have refocused the conversations about public health at the community-level, ensuring community members and local organizations are active participants in identifying needs and priorities. HEZ priorities focus on upstream determinants that consider the environmental, structural, social and historical context of the community. As a result, HEZs have addressed health care access in creative ways depending on the unique needs of the community served (e.g., mobile health van, public transportation to medical appointments, and assistance with health insurance enrollment).

Trust

Existing close relationships at the onset of COVID-19 allowed for collaborative work during the pandemic. For example, primary care market competitors collaborated with each other to share workflows during the pandemic because they had pre-existing relationships and established trust. Trust built over time with payer organizations in the state allowed for a robust response to changes in care delivery and coverage. Strong/visionary leadership at the state-level has also been important. RIDOH coordinated directly with primary care groups (formally and informally) during the COVID-19 pandemic to learn what resources they needed most. RIDOH is described as nimble—not bureaucratic—and very responsive to immediate community needs.

Learnings and recommendations for other states

- The relatively low pay for the State Public Health Director—in comparison to the State Medical Director—makes it difficult to recruit and retain talent. Similarly, nurses in medical settings are paid much more than public health nurses. Comparable salaries are vital for strong, collaborative leadership and establishing trust.

- When starting work toward collaboration and integration of primary care and public health, level setting and framing to establish shared goals and definitions is key, especially when funding is involved. Ensure that priorities are discussed in a way that makes sense for stakeholders.
- Forming coalitions is vital, and they should be as inclusive as possible. Identify individuals and organizations who can help advocate (e.g., CHWs, schools, religious groups, etc.).
- Create a formal mechanism for regularly connecting health care leaders to public health leaders, like the Public Health Out Loud – Grand Rounds initiative.