

Public Listening Session  
Working Group for Healthcare Innovation  
Tuesday October 13, 2015  
6:00pm – 7:30pm

## Meeting Minutes

### I. **Welcome**

Secretary Roberts welcomed the crowd to Juanita Sanchez for an important discussion. She thanked Mayor Elorza and the Providence Public Schools for hosting us this evening, and advised there are interpreter services available tonight for Spanish language speaker. Tonight a brief presentation will be given to discuss what is happening with the Working Group for Healthcare Innovation, and then hear from Director of Health Dr. Nicole Alexander Scott on some public health conversations with the state. Following that, the goal is to hear from the public gathered here this evening.

*Slides available online and upon request via email at [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov)*

### II. **Director of Health Nicole Alexander Scott, MD, MPH**

*Slides available online and upon request via email at [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov)*

### III. **Public Comment** – Participants were asked to identify themselves if they wish to have their comments attributed to themselves. Those who wished to remain anonymous could do so.

The main questions that were presented to the group for reflection and brainstorming were:

Secretary Roberts: I think that we need to make recreational athletic activities less expensive for families, particularly in our cities. Use it as a means of increasing physical activity and help to build communities and social skills. Physical education programs in schools are no longer as intensive or lengthy as they used to be, so we need to focus on those.

Tina Spears: Finding community based placements, community based supports for those with chronic illness. HBTS, PASS and respite care. A [chronically ill] child often has the need for therapy and treatment, those programs are available to individuals but it is challenging to keep continuity of care of them, as the provider network in the community isn't there. While we want to build community programming for seniors and children with disabilities, right now we see a big gap for families. I think in keeping our thoughts on making a child healthier, that is all children, and thus these are big issues.

Anonymous Commenter: Community Support for psychological services as well. Many will use the dieticians at Miriam [Hospital] for psychological support, as that is what they have access to for eating disorders or behavioral health issues, thus we are filling a void.

Anonymous Commenter: I believe there is a growing gap between keeping our seniors living independently, and the number of seniors that need those services. There is a huge gap in the middle of those that don't get what they need. I have seen a woman in her apartment, slightly disabled, who cannot get out of her home, no family to rely on for support, and she cannot access transportation services, or helpers in the community to help someone like that. Not enough money to pay for the services she needs but also has a bit too much to qualify for Medicaid.

Anonymous Commenter: I am also a dietician, with the URI Community Nutrition Information Program, and SNAP, and the EFNED through URI Providence. We do community education and nutrition in the communities, not one on one with dieticians, and we specifically teaches families with children in the home. As you say diabetes, and many chronic illnesses are nutrition based. When we talk about health disparities, nutrition disparities more often negatively impact low income families. We are doing good work in communities, but we are finding resistance in the health centers. If there is a way to link the SNAP benefits to nutrition education on the health care model I would advocate for that. In particular we struggle as they request detailed evidence based research – we do have it, but it seemingly is not getting high enough up for anything to happen. Other health centers we have just entered partnerships, and we see opportunities there, like Thundermist.

Anonymous Commenter: A few years ago each city and town supposedly had a wellness committee, and it has gone a bit by the wayside. It was dieticians, physical education teachers, and others and I think that is a good thing to revive.

Secretary Roberts: I am interested in that as I was a part of the legislature that passed that law and to my knowledge it has not been repealed. Within the school districts there were to be wellness committees.

Anonymous Commenter: In looking at these, I say yes and... When there is stress, and other factors involved in your life often there are things that prevent people from becoming healthy. We say social determinants of health, and we look to health solutions in metrics only. All of this is important, but there are also cultural differences and other issues – we

need to take it to the next level and see all the barriers come together.

Director Alexander Scott: I didn't share the metrics that we have, as [we felt] that might be too much data tonight, but we do have one metric where we look to see if a child has an individual caring for her/him who has full time employment. There are a percentage of programs across the state that use social determinants for policy and decision making. It is a key point, part of the push, and why we included some of those. As we talk about redefining healthcare delivery we need to think about how we choose metrics that are outside the typical healthcare model. We have to find the happy medium where, 1. We look at what is happening in the community, the stressors, the violence, safety, etc. and then 2. We ask are there metrics over time that we can use to reflect that in keeping with some healthcare metrics that at the moment we use predominantly. But definitely an appreciated push.

Anonymous Commenter: I also hear a lot about access to social services. I don't think we value the fields enough, or have enough funding for these positions, thus not attracting people, not expanding in a field that could be helpful. How do we change that for a public health perspective?

Director Alexander Scott: We have a slide in our decks back at the office that shows that the United States pays the most for healthcare, but we do not have the highest return on investment compared with other countries around the world. I share that with a slide which shows some who may pay the total amount with better outcomes but with a ratio of higher input to social services and lesser input to healthcare. We need to pay for health care, but we need to be thoughtful and strategic about how we pay for social services as those clearly impact life expectancy and health outcomes.

Secretary Roberts: I think often we think that we need money so we solve the problem. We have a lack of capacity in our services, but sometimes we also have licensure issues that can be prohibitive. If you need \$3,000 to pay for your license when you have graduated, you are limited – as you need to practice before you can make money and you cannot make practice without a license. One thing I would like to do is take a holistic look at the process and what are the barriers to improved health, access to service, and something as simple as sidewalks in the neighborhood that could be the driver. Not always the complex issues, sometimes the simple things make a positive change.

Anonymous Commenter: The mindset of a lot of the public is to put a band aid on it... later. Its not always about 'let's take care of ourselves now.' It changes a bit, but slowly, and I think that can make this process take a long time.

Secretary Roberts: True but I will challenge some assumptions - we do not give people the options to change their behaviors – McDonald’s is cheaper than fruits and vegetables. Violent neighborhoods prohibit kids from going out of doors – we can not only blame people, we need to look at ourselves.

AJ: My name is AJ and I am a transgender male. I have concerns about parity, and I want to bring these issues to the attention of Rhode Island. I want to call on our officials to effect a policy on this. It is a tough and sensitive topic, and it is also the right thing to do. RI was one of the first states to pass a gender nondiscrimination policy, but I feel that the community does not have access to the necessary care to really assist where we need it. Many states have taken the lead on this, five states have changed their Medicaid policies to include changes on this. I want the state to hear about this, and would love to work together on this. I appreciate the opportunity to speak.

Director Alexander Scott: You shared a few changes that the states made, but can you be more specific?

AJ: Removed exclusions in Medicaid policies - diagnosis of gender disorder.

Secretary Roberts: As the person who is responsible for the Medicaid program, we are far along in the process about changing the policy on that and are also working with our commercial insurers on that. The ACA does require a conversation on parity. I am hopeful that we will have some concrete news quite soon, and I am very aware of the barriers. Health equity, population that is at a significant disadvantage to the population and to the providers who can provide care. For those interested there is a group building a network of providers in the state, there is an organization, AHAB, through Brown.

AJ: I also want to thank the Providence mayor for removing exclusions from the gender disparity law in Providence cities.

Senator Pichardo: I just came from another meeting from the area around Amos House, near Central High School, Classical High School and the issues around mental health. I think about it in a sense that, for us, we have a component with youth and improving the health status of RI it is important as they are growing up. I have a child who is 14, and I know they aren’t participating as much. We want to listen to what they have to say, and think about how to engage. There are emotional issues,

homelessness around the schools, and we need to think about how we get the youth to impact that. I worked at RI Hospital for 17 years before being elected. The Emergency Room was the primary care provider for so many Rhode Islanders. In the last report we saw that we are trying to reduce some of that through the use of health centers. And I see adult day care centers, which keep older people more active. That is great that is what we need, and need to think about ways to engage various demographics at different stages. Finally, regarding the minority community, we should give thought to having more departments accountable to the goals of closing the minority health disparity gap. How do we put more teeth into those issues so that we can respond more effectively? How do we change it, how do we work on better outcomes. Let's look at each of those questions.

Director Alexander Scott: To your last point, are you referencing the Commission for Health Advocacy & Equity and wanting to see their action and presence more?

Senator Pichardo: Yes, and they have been, so we need more engagement with them from the side of the health systems.

Director Alexander Scott: Yes, I have worked closely with the Commission and they have been responsive to the push to generate more discussion to fulfill what the legislation really set out, which was tremendous, beyond responsive, putting together reports, strategic plans, definitions on health equity. The goal from all of our standpoints is to promote at the state level and give our partners and agencies this good work and items to latch on to.

Tina Spears: As a middle aged white female I have no troubles with the system. I have coverage, I get what I need, and I can navigate the system. I have a primary care provider – I am all set. My son with disabilities was a different story – this system was not easy to navigate, and I ended up giving up my full time job to handle his care. I had the fortune of being able to do that, and so many cannot. Thinking more out of the box for how to support those who have children with disabilities, and then also supporting their adult parents who are aging and require more assistance. Think about children with special health care needs – what could have been provided as a part of an extended school day, think about things that are community. The second portion of that was that my son had very complicated chronic illness that led to his death – and the palliative care and end of life care isn't really there for the families and care givers. We need to think about that for families, we should be more holistic. Finally I'll offer another personal experience – my stepfather with serious alcohol and drug addiction issues had diabetes which went uncared for. He ended up getting gangrene and became a high utilizer, six months of hospitals

and nursing homes before he died. We need to think about mitigating issues when they begin – not just preventative, but also handling treatment well at the start.

Director Alexander Scott: What additions to the system, with those very helpful and touching examples, would have helped that with your son and your stepfather? I have ideas in mind, like another worker in the community to help?

Tina Spears: Yes, I think about my stepdad – there was no way he would have gone to see a doctor. But if there was someone there who could identify that he could not manage his disease, or have been with a nurse caring in the home once a week, that may have helped to regulate a treatment plan. And to the other point, we have institutional palliative care, but not palliative care out in the community level. Home and Hospice does not do palliative care to the extent you would think for pediatrics. They do try, but I don't think it is as advanced as it is in other states.

- IV. Adjourn – Secretary Roberts and Director Alexander Scot thanked everyone from coming out this evening, for sharing their personal experiences, which are pivotal to informing the work that that the state will do on this Working Group, and in efforts moving forward.