OHIP/OSIM
Health Workforce Workgroup
Meeting Minutes

	Health Workforce Workgroup Meeting
DATE	February 29, 2016
TIME	1:30 pm – 3:30 pm
LOCATION	Oklahoma State Department of Health
FACILITATORS	Alex Miley, MPH, OSIM Project Director Jana Castleberry, Project Manager, OHIP Workforce Workgroup
MEMBER ATTENDEES	Andy Fosmire, Vice President for Rural Health, Oklahoma Hospital Association Buffy Heater, Director, Planning and Performance, Oklahoma Health Care Authority (OHCA) Cassidy Heit, Public Policy & Communications Associate, Oklahoma Primary Care Association Chad Landgraf, GIS Analyst, OSU Center for Rural Health Cynthia Scheideman-Miller, Director, Telehealth Alliance of Oklahoma Debbie Blanke, Assistance Vice Chancellor, Oklahoma Department of Regents Jackye Ward, Deputy Director, Oklahoma Board of Nursing James Jane Nelson, Executive Director, Oklahoma Nurses Association Janie Thompson, Physician Program Manager, Physician Manpower Training Commission Joyce Lopez, Program Manager, Chronic Disease, OSDH Kim Chuculate, CEO, Northeastern Tribal Health System Kyle Foster, OK State Regents for Higher Education Lara Skaggs, Program Manager, Health Careers Education, Oklahoma Department of Career Tech Education Lisa Wynn, COO, Oklahoma Foundation for Medical Quality Mark Rogers, Executive Director, Little Axe Health Center, Absentee-Shawnee Tribe Mary Holter, Clinical Assistant Professor, Health Sciences Center, OU College of Nursing Melissa Johnson, OK State Medical Association Pete Aran, M.D., Medical Director of Population Health, Blue Cross and Blue Shield Randy Curry, D.Ph., Rural Health Coordinator, College of Pharmacy Todd Hallmark, Executive Director of Health, Choctaw Nation of Oklahoma Tracy Patten, Pharm.D., Captain, U.S. Public Health Service Tina Johnson, Director of Nursing Services, OSDH William Pettit, D.O., Associate Dean, Oklahoma State University Health Sciences Center
GUESTS	Spencer Kusi, Isaac Lutz, Joe Fairbanks, Jane Garner, Keianna Dixon, Jim Jones
HANDOUTS	OSIM Health Workforce Workgroup Meeting Agenda, PowerPoint Presentation, OSIM Comment Rubric for Health Workforce Workgroup

KEY OUTCOMES

- Stakeholders recommended outreach to state/public employees (ideally from each of the state agencies) to ensure their perspectives are incorporated into this proposed new model
- Stakeholders requested talking points on the model's use of capitated payments to use when communicating the model goals to their organization
- Stakeholders requested talking points on how rural, independent providers could form an RCO
- Stakeholders representing tribal nations expressed concern that the proposed new model would negatively impact their health care systems by taking away members and consequently reducing the federal payments that they receive for their subsidized health care systems.
- Stakeholders suggested additions to the State Governing Body: adding a legislative representative, (based on stakeholder feedback) possibly including 2 voting members from providers on the board (Suggestion was to ensure representation from nursing profession)

ACTION ITEMS

- Update Section C: Stakeholder Engagement Plan, of the State Health System Innovation Plan (SHSIP), with an appendix item with the full list of stakeholder organizations engaged
- Update Section D: Health System Design and Performance Objectives, of the SHSIP, to include a focus on childhood obesity under the obesity goal
- Ensure that all references to "physicians" are changed to "providers" in the model/SHSIP
- Collect stakeholder comment rubrics and incorporate feedback in the model design
- Create talking points on how a group of rural providers can form an RCO
- Incorporate more robust provider support into model

AGENDA & DISCUSSION NOTES

1. Welcome / Introductions

Welcome from Jana Castleberry, HW Workgroup Project Manager. The Health Workforce Workgroup will appoint a new chair to replace Deidre Meyers who has moved to a different position. The goal is to have a new workgroup chair by the next meeting in March.

2. State Health System Innovation Plan (SHSIP) Overview

Alex Miley, OSIM Project Director

- Review of the status of eleven sections of SHSIP model proposal that have been completed:
  - Description of State Healthcare Environment
  - Stakeholder Engagement Report
  - Value System Design and Performance Objectives
  - Value-Based Payment and/or Service Delivery Model
  - Plan for Healthcare Delivery System Transformation

    - Plan for Improving Population Health
    - Health Information Technology Plan
    - Workforce Development Strategy
        - Jana Castleberry has condensed work of workgroup and analysis/evaluation to develop this section
- The next version of the draft of the SHSIP will be available in approximately two weeks. Stakeholder review period will continue throughout most of March. "Completed" in the slide presentation should reflect that the section is "Out for Review".
- The proposed model name has been changed from Communities of Care Organizations (CCOs), to Regional Care Organizations (RCOs) to resolve any confusion with other CCOs.
- The description of the state healthcare environment is the longest section and provides a good foundation for the plan in the following four sections: Population Health Outcomes, Health System Performance, Environmental Context, and Health Initiatives.
- Stakeholder Engagement guided the model design. More details regarding stakeholder engagement will be provided.
- The Health System Design and Performance Objectives section provides details about the population health flagship issues and healthcare value-based payment and delivery strategies for SIM. Goals for health expenditures and quality of care were included, as well as the population health goals of tobacco, behavioral health, diabetes, obesity, and hypertension.
- The Value-Based Payment and Service Delivery Model section details the proposed Oklahoma model: Regional Care Organizations (RCOs), multi-payer quality measures, and multi-payer episodes of care. Included are model tenets, RCO Governance, quality metrics, and episodes of care.
- The Healthcare Delivery System Transformation Plan outlines the phased implementation process for stakeholder adoption of: Phase 1, establishing the foundation for value-based care; Phase 2, enhancing the delivery system, and Phase 3, implementing the RCOs. Phase 2 includes the episodes of care (asthma, perinatal, total joint replacement, chronic obstructive pulmonary disease, and congestive heart failure) and a risk-based system for providers.
- The plan for improving population health describes current initiatives and the proposed model that will improve overall population health in Oklahoma. Drivers include federal, state, and local initiatives; SIM strategies and activities; and a roadmap to health improvement.
- The Health Information Technology (HIT) objectives and strategies to achieve HIT interoperability in Oklahoma and move toward value-based purchasing were outlined. These objectives and strategies represent how other SIM states leveraged and supported the establishment of a statewide Health Information Network (HIN).
- The workforce development strategy includes data collection and analysis; statewide coordination of efforts; workforce redesign; and pipeline, recruitment, and retention. The strategy is based upon the work of the OHIP health workforce workgroup.

SHSIP Discussion

- ◊ **Any initial thoughts and feedback on the SHSIP draft?**
- ◊ **Any question of how to access the document or find a section?**

https://www.ok.gov/health/Organization/Center_for_Health_Innovation_and_Effectiveness/Oklahoma_State_Innovation_Model_(OSIM)/

Stakeholder Feedback/Comments

- Additional outreach to more stakeholders is needed, including state employees at different agencies. (OSDH will look into this. Turning Point Coalitions and community advocacy

organizations provided feedback. A complete list of stakeholder organizations will be provided.)

- Consumers should be represented as well. (Response: the Medicaid Member Advisory Panel meets regularly and provides member feedback to OHCA.)
- Childhood nutrition in not mentioned in the SHSIP obesity goal. (OSDH mentioned current initiatives around childhood nutrition in Section B, and plans to incorporate these initiatives into the new model in Sections B and G would be tied back to the obesity goal in Section D.)

3. Review of Model Goals and Discussion

- A review of model goals and discussion was conducted.
- Goals of OSIM:

  To achieve a multi-payer state plan to move current healthcare payment methodologies from a volume-driven, fee-for-service to a system where payments to providers are based on methodologies that reward value and address persistent issues with cost, quality, and population health.
- Reviewed additional goals:
  - Achieve Triple Aim
  - Creative opportunities for multi-payer initiatives that pay for outcome improvement across the primary drivers of poor health and healthcare costs increases
  - Integrate health care and population/community health
  - Create a scalable model that can be implemented in rural Oklahoma settings
  - Address social determinants that prevent individuals from achieving optimal health
  - Focus on total health system
- Reviewed conceptual design tenets of the proposed model:
  - Incorporate drivers of health outcomes
  - Integrate delivery of care
  - Drive alignment to reduce provider burden
  - Move toward value-based payment with realistic goals
- Stated that stakeholder feedback has pointed to the need for foundational elements added to the health system in order to support this transformation

Model Goals Discussion (Model Design)

- ◊ **Do these goals and tenets reflect the conversation of stakeholders to date?**
- ◊ **Any changes, deletions, or additions?**
- ◊ **Do you believe there is multi-payer alignment of purpose around these goals and tenets?**
- ◊ **Is there multi-stakeholder agreement around these goals and tenets?**
- ◊ **Barriers to achieving these in Oklahoma?**

Stakeholder Feedback/Comments

- Consideration of Tribal impact? Tribal entities want to ensure that they do not inadvertently lose Medicaid members to the RCO, which amounts to losing a member of their subsidized health system. Tribal entities are concerned about losing revenue that allows them to provide care to all Tribal members. Different solutions will be needed for different sizes and organization of others. (OSDH Staff are looking into that issue. There will be a discussion with tribal entities to ensure to have tribal feedback. Jana will share meeting information.)
- Does this model include all payers (Private, public, and self-funded)? (OSDH responded that it could but that the initial plan is aimed at public employees and Medicaid. The goal is that all payers would eventually operate under this model.)
- Feedback includes concerns that the plan presented looks like a giant step toward moving to

capitated payments. Providers are concerned about capitated payments such as in the 1980s that providers worked to overturn. In past experience, capitated payments in Oklahoma led to negative outcomes, such as the closing of psychiatric/inpatient behavioral health beds across the state. (OSDH clarified that the model has major differences from the HMO programs of the 1980s and 1990s. The capitated payments will be given to the RCOs, not providers, and the model governance and decision-making integrates providers and consumers in a community-led effort.)

- Recommendations from Workforce workgroup point towards incorporating provider supports into model.
- A suggestion was made to create talking points for providers who have those concerns to explain how this plan is different and how it would look different for the providers. (For example, the RCO will have capitated payments for quality and episodes of care.)
- Behavioral Health Needs were discussed. Consider ensuring patient access to high quality care; perhaps include that as an objective.
- Will Insure Oklahoma be a part of this model? (OSDH: Yes, there are ongoing discussions on how that might take place as they are addressing program changes in programs such as the Aged, Blind, and Disabled (ABD) population and Insure Oklahoma.)
- The Board of Accountable Providers was discussed. Stakeholders suggested having providers at the table during discussions about how to improve outcomes. Providers having a voice in quality measures, protocols, and benchmarks will encourage adoption.
- Incorporating provider support into the planning and redesign will help reduce burdens and support providers through the transition.
- How will rural areas that want to increase access to care make sure they do not crowd out individual providers that provide access but may not fit into or be a part of the RCO? (OSDH has heard concerns about rural individual providers being unable to participate. More discussion on this issue is needed.)
- Most providers will fit within the proposed structure. It will be important to include them in committee structures, make sure there is a safety net in place in case changes indirectly and unintentionally affect access to care. (OSDH has considered this and will expect the RCO to work with the unique structures of their community.)

4. Regional Care Organization (RCO) Model Design

Alex Miley, OSIM Project Director

- An overview of RCOs was provided. The RCOs are accountable for total cost of care within their regions. They will be local and risk-bearing. Tenets of shared responsibility for health include governance structure, focus on patient-centered care, primary care and prevention, and care coordination to integrate social services into care delivery.
- A structural model of the RCO governance was presented. Comment from workgroup: References to primary care “physician” in the model should be replaced with “primary care provider”.
- The risk bearing RCO under the current proposal would accept actuarial risk and performance risk for the population and region they serve. The draft model requires RCOs to be licensed to sell insurance in Oklahoma.

RCO Model Topic Discussion

- ◊ **How likely is this as a multi-payer model?**
- ◊ **Is the model and payment mechanism feasible in Oklahoma?**
- ◊ **Should the RCO be accountable for both actuarial and performance outcomes for the**

population they are delivering services to?

- ◊ **What are challenges or barriers to implementing the RCO model in Oklahoma?**
- ◊ **What foundational elements must be in place to successfully achieve the RCO model?**
- ◊ **How should Oklahoma transition to RCOs?**

Stakeholder Feedback/Comments

- If the system will be multi-payer from day one, how will buy-in be fostered with no incentive? Suggest putting more strength in requirement to participate. (OSDH responded that quality metrics will be utilized and aligning metrics with private payers will support.)
- Discussion started around bringing more payers under the umbrella to further reduce provider burden. Including the self-insured is an important segment of the market. These inclusions make the model more feasible.
- Addressing the insurance requirement can be done in different ways. One organization may be able to provide expertise for geographic areas with fewer resources.
- What kind of administrative costs are required to run the RCO? Will money for patient care be diverted from patient care to build administrative structures? (OSDH responded that in other RCO models, the patient-centered medical home integrates quality measures. It can be difficult in states without state-based exchanges to provide a mechanism to leverage.)
- Comments included that, if primary prevention were reimbursed, you could see a return on investment. When community resources are not available to address problems, those areas are not supporting the providers. For example, health coaches struggle when diabetes prevention classes are not offered. Community resources must be offered for providers. Suggestion is to work toward fostering a multi-payer system moving from chronic care to prevention and to provide an arsenal of resources for those providers. (OSDH responded that community assessments will initially help to determine how to best support providers.)
- Medicaid members are required to have choice. If there is only one RCO in an area, how will that be addressed? Oklahoma population is 33% rural. (OSDH responded that in areas that are not a metropolitan statistical area, states can require that members enroll in the one plan providing care. Discussion about those mechanisms will continue.)
- Clarification of who would sell insurance was discussed. Physicians would sell insurance or partner with someone who could, and questions about how a group of rural physicians would start an RCO arose. Talking points to address this would be helpful. (In Oregon, a group of FQHCs partnered with plans to provide services. OSDH staff will put together information to answer the question, clarify details, and provide feedback.)
- What happens to OHCA under this plan? (OSDH responded that many funding streams will be maintained, but the agency will look different. Quality, compliance, and protecting providers and members are tasks maintained. Analysis will be needed to see what statutory changes would be needed as move forward.)
- Questions were raised of how administrative costs can be used to support RCO-related activities. (OSDH responded that continued discussion and more information will be provided.)

5. **State Innovation Model Governance to SIM Implementation Governance**
   - The State Governing Body and examples types of advisory boards and committees which might be formed was presented. Suggestions included establishing Member Advisory and Provider Advisory committees, and RCO Certification, Quality Measures, Health Information Technology and Episodes of Care Alignment committees.
   - The structure and function of the state governing body (SGB) was presented. The SGB provides oversight to the RCOs, and its composition may evolve to be multi-payer.
   - Members will include the Oklahoma Health Care Authority, the Employee Group Insurance

Division, the OSDH, the Department of Mental Health and Substance Abuse Services, the Insurance Department, representatives from both Member and Provider Advisory Committees, and Tribal Representation. Both Commercial Payer and Self-Insured Representation have been suggested to include.

Comments, Questions, and Discussion on Governance

- ◊ **Suggestions from stakeholders suggest that the governance body should be comprised of people who pay for care, people who provide care, and people who receive care. Does the governance model represent the groups necessary to ensure proper governance of the model?**
- ◊ **Are representatives present in numbers to appropriately reflect the stakeholders they represent?**
- ◊ **As a multi-payer initiative, how should state RCO governance evolve to ensure proper representation of other payers? Should there be a timeline for this?**
- ◊ **What are challenges or barriers that must be overcome to ensure proper governance?**

Stakeholder Feedback/Comments

- If commercial payers and self-insurers are not included at the beginning, it might not happen.
- A nurse should be included in governance. Nurses have been identified as instrumental in transformation of health care in the U.S.
- To support integration of mental health, the largest group of behavioral health providers, licensed professional counselors (LPCs) should be included. Mental health should be well-represented at this level. Discussion about different provider types followed.
- Term limits, a rotation of members, and ability to meet quorum and work efficiently were suggested. Teleconferencing utilization would be helpful.
- A target size of the governance committee was determined to be best at 9-12 members.
- Including a policy-maker was suggested. A member of the legislature was suggested, then recognized two would be needed for the House and Senate, and challenges of knowledge and scheduling were presented. Legislative liaisons for agencies may be a more efficient resource with a broad range of knowledge of all legislative activities and members.
- Increasing the number of provider members was suggested. Other considerations of subcategories such as big health systems, academic physicians, rural individual doctors, pharmacies, care managers, and several lay people also were suggested as possibilities. Some members will fit in multiple areas, such as physicians who work with Blue Cross and Blue Shield and academic physicians.
- A suggestion of creating a larger board that meets less often coupled with a smaller executive committee was suggested.
- Suggestions for involving payers as soon as possible were made. Consider leaving seats open to fill with what the group sees as the best fit at a later date.

6. Other Business (Waiver Legislation)

- Current legislation addressing an innovation waiver is being considered to allow the state to begin exploring waivers. Possible waivers include the Delivery System Reform Incentive Payment (DSRIP), 1332 and 1115 waivers.
- OSDH requested the bill in order to assure appropriate authority to proceed with waiver development.
- There is no plan to reduce state Medicaid Graduate Medical Education payments to universities, hospitals, or physicians. In fact, the goal is to ensure preservation of all current state-level GME funding streams.

Next Steps

- Please submit the OSIM comment rubric or more feedback and comments in any form. A new version of SHSIP plan will be available in approximately two weeks with feedback incorporated and the timeline adjusted.
- The next Health Workforce Workgroup meeting is March 30 from 1:30-3:30 at OSDH.
- More information is available at https://www.ok.gov/health/Organization/Center_for_Health_Innovation_and_Effectiveness/Oklahoma_State_Innovation_Model_(OSIM)/