STATE BOARD OF HEALTH

OKLAHOMA STATE DEPARTMENT OF HEALTH

Chickasaw Retreat and Conference Center
Great Room
4205 Goddard Youth Camp Road
Sulphur, OK 73086

August 12-13, 2016

Martha Burger, President of the Oklahoma State Board of Health, called the 411th special meeting of the Oklahoma State Board of Health to order on Friday, August 12, 2016, at 2:14 p.m. The final agenda was posted at 12:00 p.m. on the OSDH website on August 11, 2016; at 12:00 p.m. on the OSDH building entrance on August 11, 2016; and at 12:00 p.m. on the Chickasaw Retreat and Conference Center Development Building entrance on August 11, 2016.

ROLL CALL

Members in Attendance: Martha A. Burger, M.B.A, President; Robert S. Stewart, M.D., Secretary-Treasurer; Ronald Woodson, M.D., Immediate Past President; Jenny Alexopulos, D.O.; Terry R. Gerard, D.O.; Charles W. Grim, D.D.S.; R. Murali Krishna, M.D., Timothy E. Starkey, M.B.A.

Members Absent: Cris Hart-Wolfe, Vice-President

Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Senior Deputy Commissioner; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Tina Johnson, Deputy Commissioner, Community and Family Health Services; Carter Kimble, Office of State and Federal Policy; Don Maisch, Office of General Counsel; Jay Holland, Director, Office of Accountability; VaLauna Grissom, Secretary to the State Board of Health; Commissioner's Office: Diane Hanley.

Visitors in attendance: See list

Call to Order and Opening Remarks

Martha Burger called the meeting to order. She thanked all distinguished guests and staff for their attendance. The Board of Health was honored to have Governor Bill Anoatubby of the Chickasaw Nation in attendance. The Chickasaw Nation is the 12th largest federally recognized tribe in the United States. During Governor Anoatubby's tenure, the Chickasaw Nation has enjoyed improved health care and educational opportunities for youth and unparalleled economic growth. Governor Anoatubby has been an inspiring leader who credits the hard work and dedication of the tribal council, tribal employees and tribal members for their devotion to providing Chickasaw youth a future filled with hope and opportunity.
Ms. Burger invited Governor Anoatubby to say a few words of welcome.

Governor Bill Anoatubby welcomed the Board of Health and guests in attendance.

RETREAT MISSION AND OBJECTIVES

Ms. Burger briefly outlined the retreat mission and objectives:

1. *Strategic changes based on budget/legislation*
2. *Gain a deeper understanding of other influences on population health.*

The Board Planning Committee (Martha, Dr.'s Alexopulos, Grim, Woodson) consulted the 2015 post retreat survey as well as the 2016 Board self-assessment when developing the objectives, agenda & materials.

Ms. Burger will check in with each Board member over the next few months to discuss the results of the Board Assessment.

PANEL DISCUSSION

Ms. Burger introduced Dr. Terry Cline as the panel moderator and explained the panel presentations would be concluded by open discussion among the Board. Dr. Cline kicked off the panel discussion by introducing each presenter and thanking each for attending. Dr. Cline briefly outlined the format for the session as well as the session goals: *inform the Board of Health and guests of health reform efforts, status to date and impacts; highlight coordination of efforts between panelists; and emphasize the impact of these efforts on population health outcomes (primary mission of OSDH).* Julie Cox-Kain, Senior Deputy Commissioner for the Oklahoma State Department of Health presented on the Oklahoma Plan; Nico Gomez, Chief Executive Officer of the Oklahoma Health Care Authority provided background on the Medicaid Rebalancing Act; and Ted Haynes, President of Blue Cross and Blue Shield of Oklahoma on Payment Reform-Value Based followed by open discussion among the Board and guests.
See *Attachment A* for the Oklahoma Plan.

The panel discussion concluded.

PROPOSED EXECUTIVE SESSION

Dr. Alexopulos moved Board approval to move into Executive Session at 4:51 a.m. pursuant to 25 O.S. Section 307(B)(4) for confidential communications to discuss pending department litigation, investigation, claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or employee and pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of information would violate confidentiality requirements of state or federal law.

- OAS 2016-029

Second Dr. Krishna. Motion carried.

AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Woodson
ABSENT: Wolfe

Dr. Grim moved Board approval to come out of Executive Session at 6:23 p.m. and open regular meeting. Second Dr. Stewart. Motion carried.

AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Woodson
ABSENT: Wolfe

No action taken as a result of Executive Session

ADJOURNMENT

Dr. Stewart moved to adjourn. Second Dr. Woodson. Motion carried.

AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Woodson
ABSENT: Wolfe

The meeting adjourned at 6:25 p.m.

Saturday, August 13, 2016

ROLL CALL

Members in Attendance: Martha A. Burger, M.B.A, President; Robert S. Stewart, M.D., Secretary-Treasurer; Ronald Woodson, M.D., Immediate Past President; Jenny Alexopulos, D.O.; Terry R. Gerard, D.O.; Charles W. Grim (arrived approximately 8:45am), D.D.S.; R. Murali Krishna, M.D., Timothy E. Starkey, M.B.A.

Members Absent: Cris Hart-Wolfe, Vice-President

Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Senior Deputy Commissioner; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Tina Johnson, Deputy Commissioner, Community and Family Health Services; Carter Kimble, Office of State and Federal Policy; Don Maisch, Office of General Counsel; VaLauna Grissom, Secretary to the State Board of Health; Commissioner's Office: Diane Hanley, Joy Fugett.

Visitors in attendance: See list

Call to Order and Opening Remarks

Martha Burger, President of the Oklahoma State Board of Health, called the meeting to order at 8:36 a.m. and welcomed this opportunity for good discussion and feedback and encouraged participants to engage in this interactive meeting.

APPROVAL OF JUNE 14, 2016 MEETING MINUTES

Dr. Gerard moved to approve the June 14, 2016 meeting minutes as presented. Second by Dr. Stewart. Motion carried.

AYE: Alexopulos, Gerard, Krishna, Starkey, Stewart, Woodson
ABSTAIN: Burger
ABSENT: Grim, Wolfe

RETREAT OBJECTIVES

VaLauna Grissom, Secretary to the Board of Health, was the facilitator for this meeting and provided an overview of the learning objectives for the day:

- Review how we report progress on the strategic plan.
- Identify top priorities based on budget constraints.
- Discuss budget neutral innovative public practices to achieve priorities.

STATE INNOVATION MODEL PRESENTATION

Julie Cox-Kain, Deputy Secretary of Health and Human Services, provided an update on the Oklahoma State Innovation Model (SIM) design plan, a state plan initiative to improve health outcomes, health system performance, increase quality of care and decrease costs. She discussed the components of the plan which included the plan submission and proposals, the health information technology plan, the current status, general timelines and impacts to the market/health services.
See *Attachment B* for the Oklahoma State Innovation Model presentation.

The presentation concluded.

HIGH LEVEL STRATEGIC PLAN METRICS

The Board was asked to consider the following during the presentation:

- *Are these the right core measures to indicate a population health improvement at the end of our strategic map period?*
- *Do these measures adequately demonstrate functioning of the department?*
- *What does the BOH think about the new outcome visualization? The proxy measures? Is a quarterly dashboard with a final annual scorecard (with national weighted data) the best way to report indicators?*

Julie Cox-Kain provided an overview and history of the Board of Health's desire to be more outcome focused and to see performance measured. As a result, the Department developed dashboards linked to the agency's strategic map in order to illustrate performance across a variety of performance metrics. This included an annual scorecard with red, yellow, and green indicators. However, the feedback received from the Board indicated the annual scorecard data was old and not actionable. Consequently, the Board developed an Ad Hoc Committee to find a mechanism to review more current data through the development of proxy measures. Julie demonstrated the new proxy measures through a new visualization software called Tableau. Tableau will provide board with more current, easily accessible data. The Board agreed that the current core measures and proxy measures presented are the right measures to indicate population health improvement at the end of the strategic map period. The desire is to receive the proxy measures quarterly.

The presentation concluded.

BUDGET CUTS / IMPACT OF BUDGET ON STRATEGIC PLAN BREAKOUT

Deborah Nichols, Chief Operating Officer, provided a brief review of historical reductions to state appropriations since 2009 as well as reductions to state fiscal years 2016 and 2017 and the impact to infrastructure and administration programs over time (28% total reduction in state appropriations since 2009). During the SFY-17 budget process, the Oklahoma State Department of Health (OSDH) was notified through a general appropriation summary document that the SFY-17 appropriation totaled $54,978,498. However it was recently discovered that Senate Bill 1616, the general appropriation bill, reflects a state appropriation to OSDH in the amount of $53,703,390 with the balance, $1,275,108, to be filled using one-time expenditures from OSDH dedicated revolving funds. A legal review has been requested by the OSDH of the Office of Management and Enterprise Services to ensure the general authority given in SB1616 to spend revolving funds supersedes more specific authority for use of those funds. The answer to this question could result in further OSDH budget reductions in SFY '17 totaling 4.7%.

Additionally, the OSDH lost 86 employees in the Voluntary Out Benefit Option (VOBO) in May of 2016. The impact is a loss of institutional knowledge as well as manpower. The result is we have fewer people trying to do more. The Office of Child Abuse Prevention (OCAP) has reduced contracts from 22 in 2009 to 11 due to budget reductions. Regardless of the financial situation, the OSDH will work to be as effective and efficient as possible with the resources we do have.
See *Attachment C* for the Impact of Budget Reductions.

Henry F. Hartsell, Ph.D., Deputy Commissioner of Protective Health Services, briefly discussed the budget impact on mandates and regulatory functions. Due to budget constraints, the frequency of food service inspections has been reduced. The OSDH relies heavily on state appropriations for inspections of facilities with state licenses only, such as assisted living centers, residential care homes, and adult day care centers. The effects of additional reductions could mean a decrease in routine inspections.

Using the current strategic map, participants worked in small groups to identify the percentage of time the OSDH should allocate toward each strategic map priority area. The results were:

- 40% to Improving Targeted Health Outcomes for Oklahomans
- 20% to Expanding and Deepening Partner Engagement
- 20% to Strengthening Oklahoma's Health System Infrastructure
- 20% to Strengthening the Department's Effectiveness and Adaptability

Next, these groups reviewed and identified the top five strategic objectives for the OSDH to focus on in the next strategic plan year. The results were:

- Operationalize OHIP Flagship Priorities
- Focus on Core Public Health Priorities
- Identify and Reduce Health Disparities
- Leverage Technology Solutions
- Engage Communities in Policy and Health Improvement Initiatives

See *Attachment D* for the prioritized strategic map.

The discussion concluded.

WORKING LUNCH

Carter Kimble, Director of the Office of State & Federal Policy, provided a brief overview of the last legislative session and discussed opportunities and challenges for the upcoming session. Fiscal year 2016-2017 appropriations reduction resulted in a revenue failure; however health remained a priority because of the support of many partners. Looking ahead, possible legislative opportunities could include the public health lab, raising fees and passing the cigarette tax. Further discussion on the cigarette tax included the following comments/questions:

- Should we earmark where the money goes or let the legislature decide?
- It was strongly suggested that the money stay within health but have flexibility.
- Could the money be used to get a good return? The largest return would be from Medicaid and the state needs it.
- Some are conflicted about federal matching funds.
- Should be made clear that the health department isn't asking for anything and the tax increase is not for the purpose of generating revenue but rather a public health policy measure with the purpose of reducing the consumption of cigarettes.

The presentation concluded.

INNOVATION BREAKOUT

Tina Johnson, Deputy Commissioner of Community and Family Health Services, shared an example of a successful innovative collaboration between the Choctaw Nation and the OSDH. The Choctaw Nation had 30,000 doses of flu vaccines available but lacked the infrastructure to provide to the community. The OSDH was able to provide the necessary infrastructure, resources and support including public health nurses, staff, computer, filing systems, knowledge, and past experience of conducting mass clinics. Working together this partnership enabled 24,000 flu shot immunizations across 11 counties served by the Choctaw Nation. Additionally, the health department worked alongside with the Chickasaw Nation to provide 10,000 immunizations in their area, as well.

Julie Cox-Kain shared an example of a Health in All Policies partnership involving the Federal Reserve Bank of Kansas City, Oklahoma City office. Healthy Communities provided the framework for banks to meet the obligations of the Community Reinvestment Act, which required them to invest and fund certain impoverished communities. By way of the Turning Point Coalitions, OSDH has applied to the program and is hoping to be accepted. The OSDH is currently piloting the Reach Out and Read program in five of our county health departments. This program targets impoverished communities who are at a high risk for poor health outcomes. It focuses on the effectiveness of literacy and how early childhood supplemental educational opportunities are not only important to health but to graduation rates, income, and chronic diseases.

Deborah Nichols led a discussion about utilizing innovation as a strategic priority. A team of OSDH employees is working to more precisely identify what needs to be accomplished in order to achieve this strategic priority. Moving forward, the team will use the input from the Board to conduct focus groups throughout the Department. The team has proposed the below definition of innovation:

Definition of Innovation: *Doing new things or doing things in new ways, in a manner that creates value for anyone, anywhere through the application of practical tools and techniques that make changes, large or small, to products, processes, and services that result in added value and contributes to knowledge.*

Participants worked in small groups to consider the following: Group feedback is recorded on each question.

1. What does innovation mean for the OSDH?
    - New partnerships and leveraging those partnerships for different resources including funding but also

being aware of new unusual partnerships we can exploit, targeting new tools and new populations to gain efficiencies, identify new things ad new ways to accomplish the same tasks you are doing now

- Looking at new ways of doing things that capture untouched resources to make positive impact on communities, look at partners that we haven't look at, looking at other ways to do things, doing something in a different way, more efficiently – an example is like looking at our hiring processes, still doing what we are doing but more effectively
- Thinking outside the box, thinking strategically, identifying new partnerships, create a culture where people feel safe to bring forth ideas
- Get out of typical state comfort zone

2. What are the top four characteristics of an innovative culture for the OSDH?
   - Ability to train, feedback for frontline and bottom up, openness to new ideas (good or bad) not accepting the status quo, explicitly dedicate resources and time to image, dedicating resources and time to innovation
   - Open mindedness, supportive, determination, honest, (to be connected, wholesome, complete)
   - Welcomes ideas in a systematic way, a culture where employees felt empowered, good communication and collaboration, show initiative, show imagination
   - Fearless, adaptable, social entrepreneurship, mission oriented, open mindedness, quality improvement, ability to take risks but when take risks you are evaluating

3. Does this definition capture the meaning of innovation? If not, what changes would you recommend to the definition?
   - Clunky word choice, condense, disconnect between definition offered and context mentioned to change thought processes
   - Content was good and focused where it needs to be but needs some wordsmithing
   - Took out the middle part "doing new things or doing things in a new way", replicable, economic
   - Stop after the word "value" - clunky

4. What do you think are the top one and two innovation priorities for OSDH given the current fiscal environment?
   - Dedicating time and resources should be a priority to this activity, empower that culture for frontline staff to be heard and ideas considered
   - Innovation to find efficiencies in the department and identify partnerships that would collaborate to provide public health services and mission
   - New funding partners, creating internal processes for creating innovation and review processes to streamline processes to do things
   - Strategic and innovative partnerships, and leveraging billion dollars in healthcare toward population health

The discussion concluded.

HEALTH IMPACT ASSESSMENTS (HIA) + HEALTH IN ALL POLICIES (HIAP)

Julie Cox-Kain discussed an ongoing Health Impact Assessment (HIA) – Health in All Policies (HiAP) project with the ASPEN Institute and Choctaw Nation that would also tie to the Governor's efforts on education and workforce. This project utilized the Choctaw Nation's model summer school program which focused on children from K-3 grade who were at or below their reading level. Ninety percent of the children who participated in the program improved either in sight words or reading comprehension. The health impact assessment looked at literature around connections between early academic achievement and health risk factors. If a child experiences failure early in life by 3rd grade, he/she is much more likely to engage in high risk behaviors such as substance abuse, teen pregnancy, delinquency, or higher drop-out rates. Evidence indicated that improving early academic achievement has a significant impact on lower income students and

those behind in reading. We recommend investing in early education summer learning programs. Julie mentioned that the Governor is launching a health initiative, Health 360, and has asked Julie to lead it. She briefly reviewed the Health 360 model and goals.
See *Attachment E* for the Health 360 model.

Julie proposed three questions. Further discussion included the following comments/questions:

1. What other things would you like us to take on as a potential health impact assessment?
   - Grocery tax – Is it a tax on Little Debbie's snacks? Don't want to encourage bad choices. No tax or reduce tax on fruits & veggies or produce and fresh meats. Would legislators entertain this idea? Bloomberg idea and New York regulation – it's been shown it's healthier
   - Lower sales tax to no sales tax and compare health benefits (a comparative HIA)
2. What areas of government or organizations should we partner with to jointly implement these kinds of programs? What sort of entities are you thinking about?
   - Local control, implement change at the local level like city councils and County Commissioner's to reach a large number of folks
   - Cities and towns work with local and state health departments
3. What HIA could we do to cause or allow local community leaders to go storm the building to remove all these preemptive clauses?
   - Local control premise is about business
   - Not hard to do a HIA on smoke-free and link to preemption
   - Non-health activities that do have a health impact. What kind of decisions are communities making across the state? Where are they investing their money, roads? Are they making a health benefit? Is there any indirect health benefit in some of their choices and decision?
   - Repository of HIAs, educate local community members, working on this, health benefit
   - One of the important investments a community can make is to educate young minds and brains, have training sessions to hone the skills at an early age and have refresher courses, investment, comprehensive program, within 5-8 years you will see dramatic things happen

The presentation concluded.

SUMMARY, WRAP UP, CLOSING, ADJOURNMENT

The Board concluded the Board Retreat by noting:

- VaLauna will send out an assessment tool for feedback. You will be voting on the retreat location for next year.
- A shortened agenda for this year was welcomed.
- Other than wifi not working properly, the facilities were great.
- Over the next 3 months, Ms. Burger will meet individually with each board member for input and expectations moving forward.

Dr. Krishna moved to adjourn. Second Dr. Gerard. Motion carried.

AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Woodson
ABSENT: Wolfe

The meeting adjourned at 3:01 p.m.
Approved

Martha Burger

Martha Burger, M.B.A.
President, Oklahoma State Board of Health
October 4, 2016

ATTACHMENT A

The Oklahoma Plan

A Health Plan Created by Oklahomans for Oklahoma

Invest in Smart Coverage

- Insure Oklahoma HealthStead Account

- Rebalance Medicaid
- Expand Private Coverage
- Restore Provider Rates
- Promote Personal Responsibility

Pay for Performance

- Pay for Health Outcomes 80% by 2020

- Medicaid & EGID Outcome Based Healthcare
- Measure Outcomes & Pay for Performance
- Invest in Healthcare Transitions

Improve Community Health

- Increase Cigarette Tax

- Prevent 31,800 Kids from Smoking
- Reduce Healthcare Costs
- Save Lives
- Oklahoma Voters Support (62% Favor)

Preserve & Expand Health Workforce

- Support Rural Healthcare Access

- Support Rural Healthcare Access thru Funding Partnerships
- Enable Rural Economic Development
- Improve Quality in Healthcare

Empower Patients & Providers

- Promote Market Driven Data Solutions

- Develop Private/Public Partnerships
- Protect Private Health Information Exchanges
- Promote Data Interoperability
- Empower Patients thru Information

The Oklahoma Plan: High Level Goals

Invest in Smart Coverage

- Improve Access to Efficient Coverage Options
- Provide Coverage that Achieves the Triple Aim
- Address Cost Drivers
- Ensure Robust Access to Behavioral and Mental Health Services
- Promote Patient Responsibility

Pay for Performance

- Move 80% of Payments to Value-Based Purchasing (VBP) by 2020
- Authorize Innovation Waivers (1115 and 1332 Waivers)
- Move All State Purchased to VBP Models
- Invest in HealthCare Transitions

Improve Community Health

- Increase the Price Point of Cigarettes to Improve Health
- Improve Investments in Primary Prevention
- Integrate Community Supports into the Delivery of Care
- Create Regional and Community Accaccountability for Health Outcomes
- Broaden Pay for Performance/Social Impact Bonds

Preserve and Expand Health Workforce

- Create More Funding for Teaching Health Centers
- Expand Access and Utilization of Telemedicine
- Ease Regulatory Barriers to Care
- Support Rural Providers by Paying at the Upper Payment Limit (UPL)

Empower Patients & Providers

- Promote Private and Public Partnerships
- Protect Private Health Information Exchanges
- Promote Data Interoperability
- Empower Patients and Providers through Health Information Exchange
- Increase Transparency of Cost and Quality Data

ATTACHMENT B

Oklahoma State Department of Health

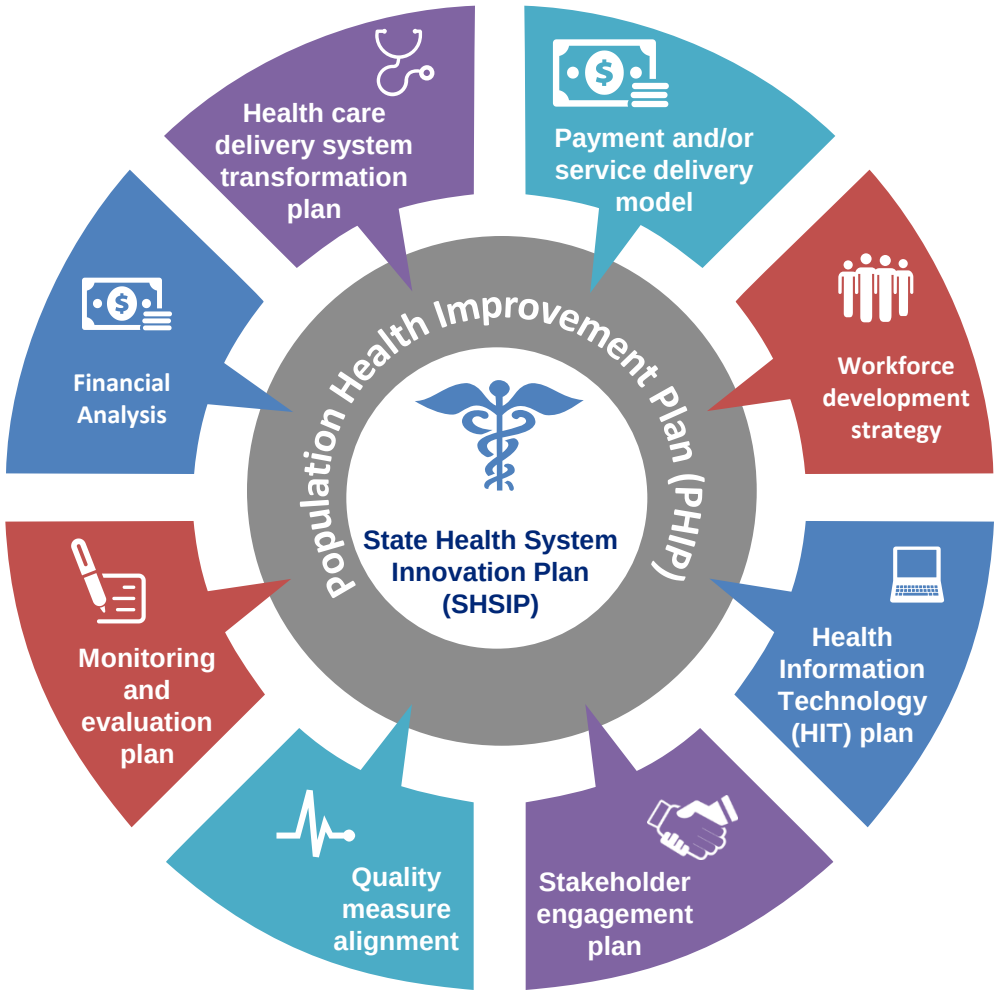
Oklahoma State Innovation Model

Julie Cox-Kain
Deputy Secretary of Health and Human Services
Sr. Deputy Commissioner

Oklahoma State Innovation Model Design Grant - What is it?

- A state plan initiative
- Multi-payer payment and service delivery reform
- Improve health outcomes
- Must improve health system performance, increase quality of care and decrease costs for the following:
  - Medicare
  - Medicaid
  - Children's Health Insurance Program (CHIP) beneficiaries
  - And all residents of participating states

OSIM State Health System Innovation Plan



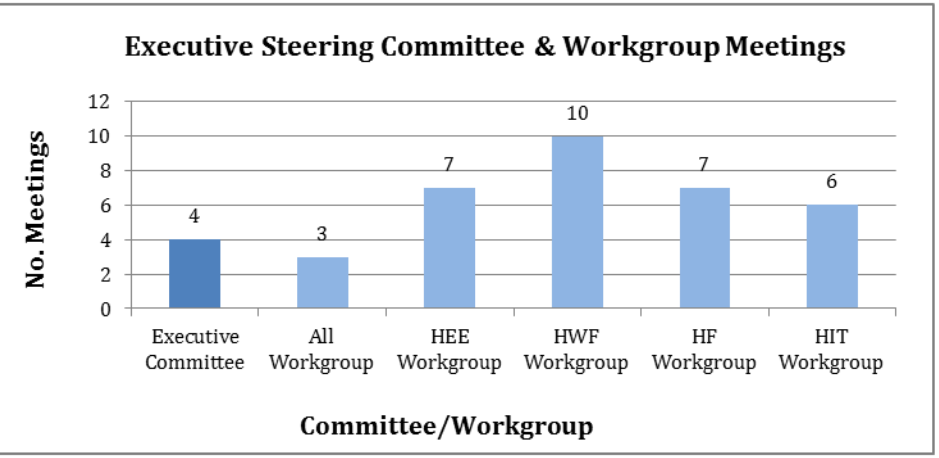
Components of a Successful Model Design Plan

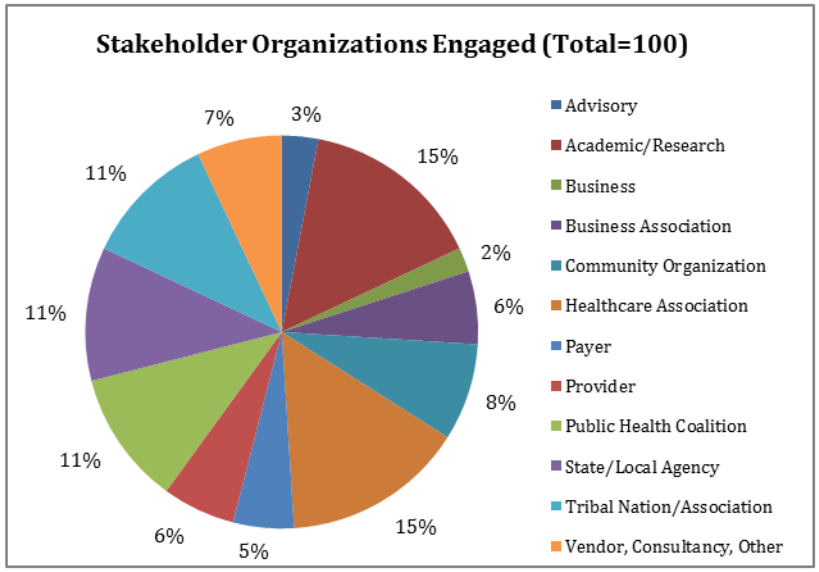
Report on Stakeholder Engagement

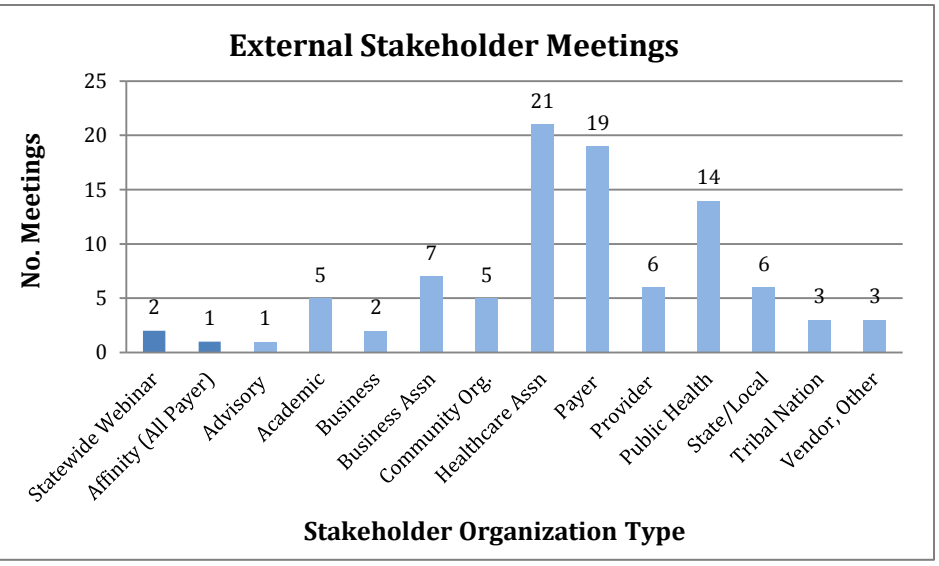
This section details stakeholder engagement activities and analysis and interpretation of key findings on collected data.

Forums and Communication Channels

- Advisory Committees
- Workgroups/Affinity Groups
- Statewide Webinars
- Conference Presentations
- One-on-One Meetings
- Website and Public Comment Box
- Stakeholder Surveys







Goals of OSIM

Create smooth transitions to multi-payer value based payment models and align quality metrics

- Leverage what is already working
- Reduce variation & administrative burden
- Leverage existing technology & systems

Focus on primary cost drivers:

- Tobacco
- Obesity
- Hypertension
- Diabetes
- Behavioral Health

Achieve the Triple Aim

Cost

Quality

Population Health

Improve Population Health by focusing on the total health system and addressing social determinants of health:

- Poverty
- Poor education/literacy
- Poor housing
- Employment/working conditions

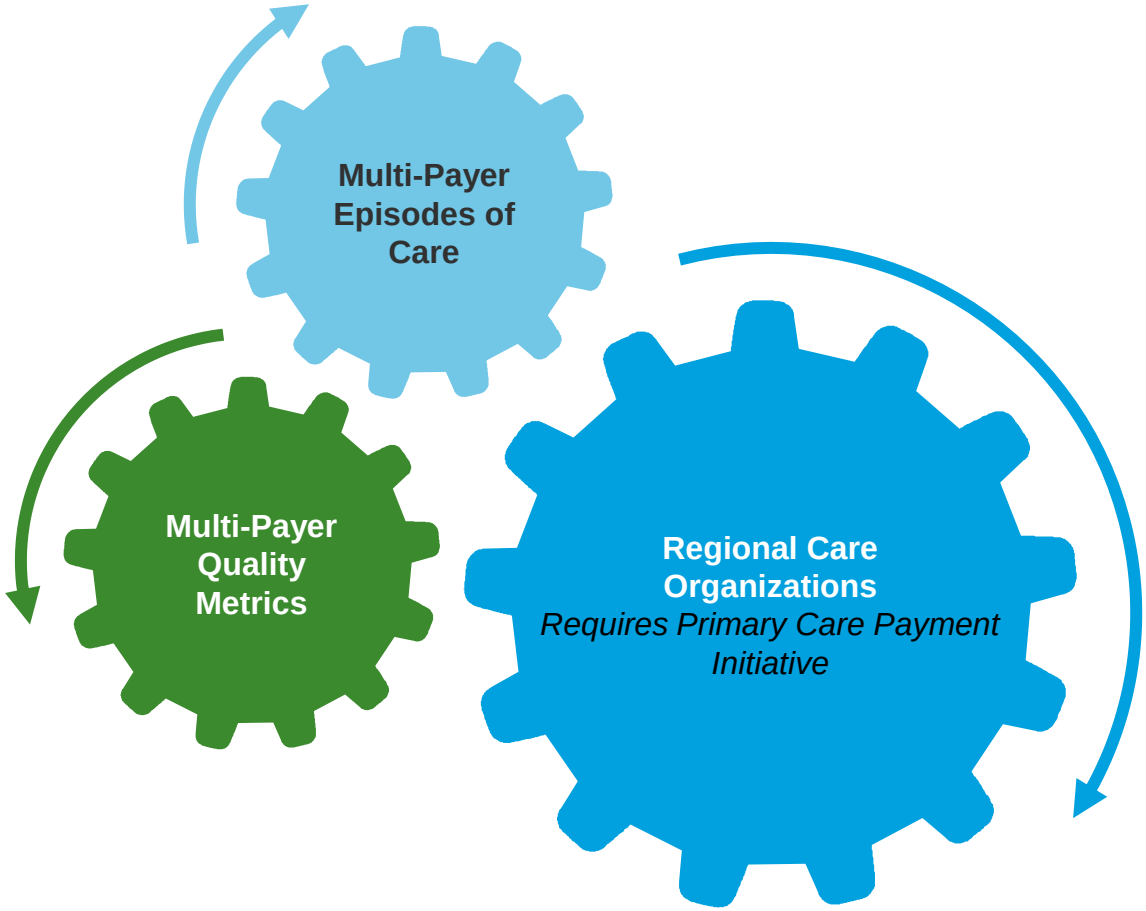
Creating a scalable, flexible model that can be implemented in rural settings.

- Multiple models of care coordination
- Provider directed teams
- Community support structure

SIM Model Proposal

Proposed Model: Three Components

The three components of the proposed model are: Regional Care Organizations (RCOs), Multi-Payer Quality Metrics, and Multi-Payer Episodes of Care.



Quality Metric & Value Based Payment Alignment

Quality Metric Alignment

1. Maximize health impact
2. Attack primary cost drivers & causes of death
3. Reduce burden for providers
4. Add “P”opulation health component

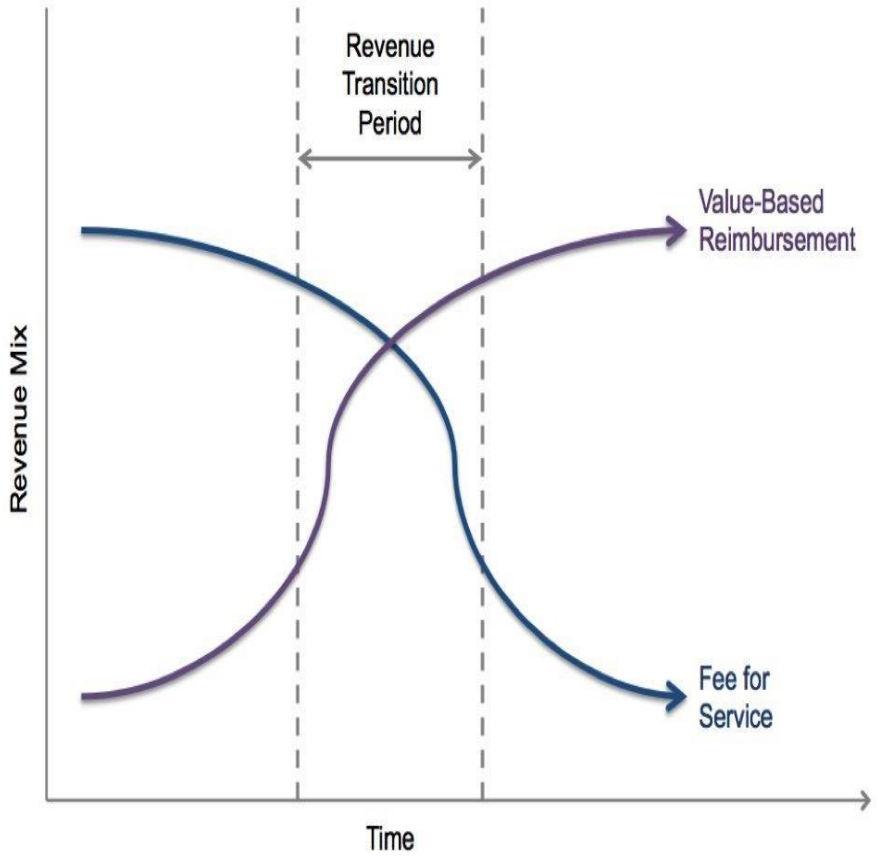
State of Oklahoma High-Cost Condition Relative Cost		
	% Increase	Average Annual Cost
Entire Population	100%	$4,993
Diabetes	349%	$17,426
Obesity	343%	$17,126
Tobacco Usage	345%	$17,226
Behavioral Health	313%	$15,628
Hypertension	283%	$14,130

Quality Metric & Value Based Payment Alignment

80% Value Based by 2020

1. Transition the state insurance programs with other carriers
2. Minimize provider loss through planned transition
3. Invest in provider infrastructure

Minimize Loss During Transition



Quality Measure Alignment

A key finding from the SIM grant was the disjointed, burdensome, or ineffective use and reporting of quality metrics.

Two key things came from this finding:

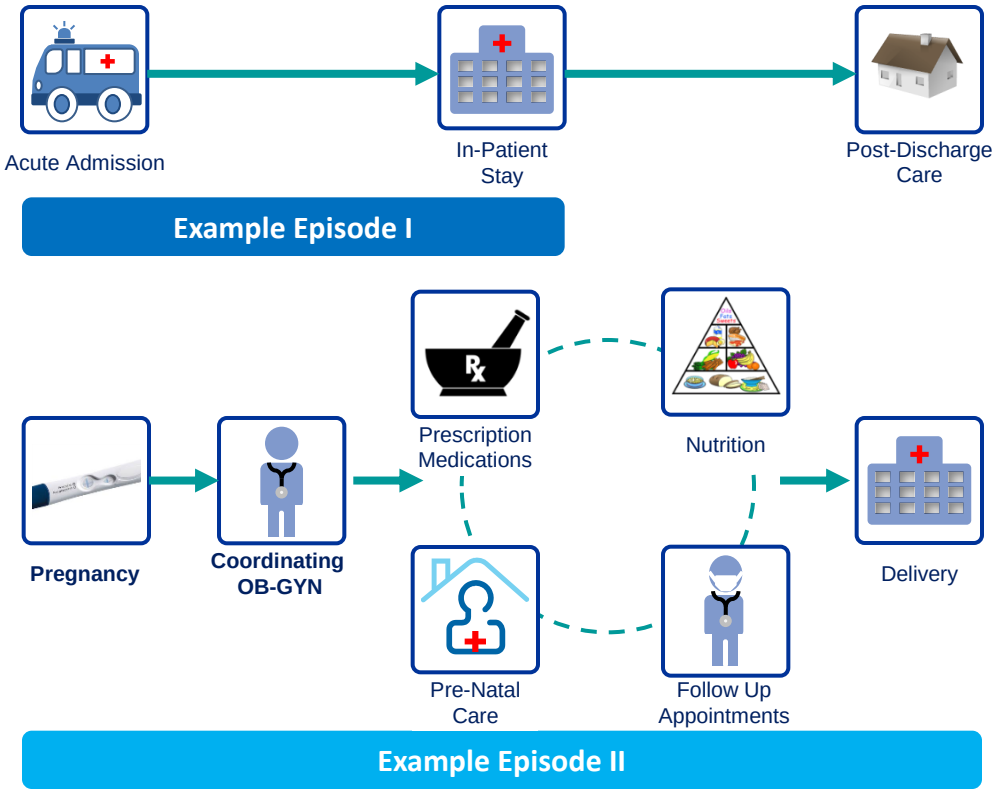
1. Recommendations to establish a Quality Metrics Committee to compile a list of recommended measures for state purchased healthcare and private payers

2. Take a deeper dive into what quality metrics would be most effective to use based on our population health priorities (obesity, tobacco use, hypertension, diabetes, behavioral health)

SIM also proposed a list of quality metrics to align payers and hold the RCO model accountable that can be found in the SHSIP. The 11 multi-payer measures are below:

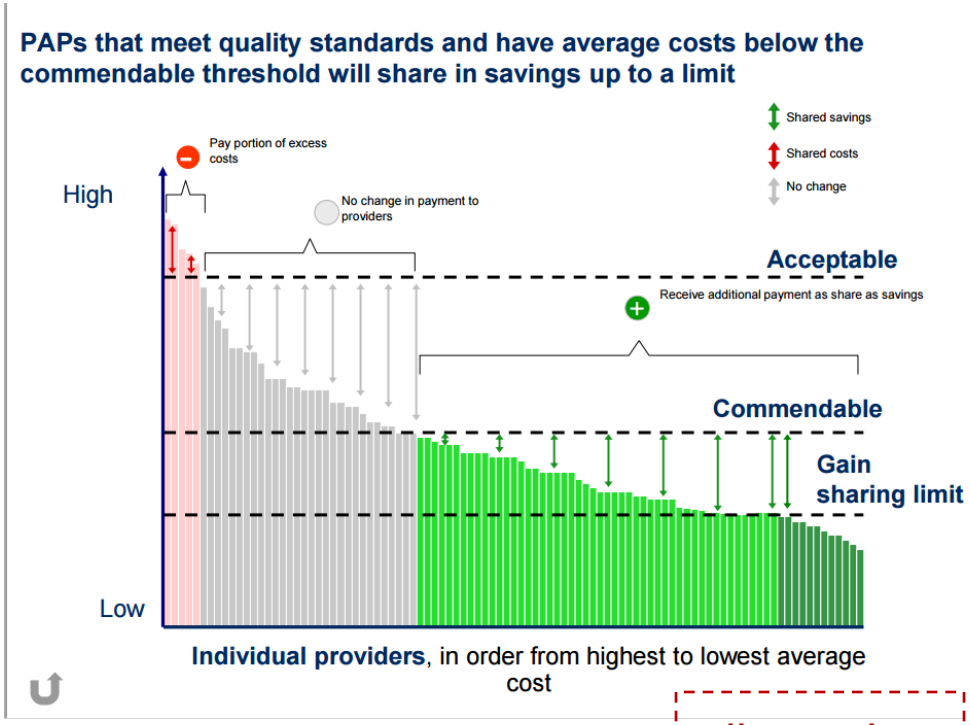
NQF 0028: Tobacco Screening	**NQF 0059: Diabetes management poor control**	**NQF 1932: Diabetes screening of schizophrenia or bipolar**
USPTF: Blood Glucose screening for overweight or obese 40-70 yrs	**NQF 0018: Controlling high blood pressure**	**NQF 0421: BMI screening and follow up**
NQF 0024: Weight assessment for children/adolescents	**NQF 0105: Anti-depressant medication management**	**NQF 048: Depression Screening**
NQF 004: Initiation and engagement of alcohol and other drug dependence treatment	**NQF 0576: Follow up after hospitalization (within 30 day) (BH primary diagnosis)**	

Episodes of Care – Payment Model Design



- Episodes begin with a triggering event
  - E.g. Acute admission to a hospital
  - E.g. Confirmation of pregnancy
- Episode lasts until a pre-determined duration elapses
  - E.g. 60-day postpartum upon completion or termination of pregnancy
- Episodes define which related services and patients will be considered within the episode's performance year
  - E.g. Certain patients with complex conditions may be excluded and non-related services would also be excluded for episode
- PAPs are initially paid on a fee for service basis and then retroactively evaluated against a set benchmark for the average cost of the care delivered per episode

Episodes of Care – Payment Model Design (continued)



Source: http://www.paymentinitiative.org/

Illustrative

- Each episode for a particular condition has an overall performance year in which all patient episodes for that condition are aggregated and evaluated against benchmarks for cost and/or quality of care
- PAPs that come in under the cost benchmarks receive a percentage of the savings as a bonus, provided they also meet quality benchmarks
- PAPs that exceed the acceptable level of costs may have to pay a portion of the overrun as a penalty
  - Penalties are capped to ensure provider viability

Regional Care Organizations: Overview

What are Regional Care Organizations?

RCOs are local, risk-bearing care delivery entities that are accountable for the total cost of care for patients within a particular region of the state

Governed by a partnership of health care providers, community members, and other stakeholders in the health systems to create shared responsibility for health

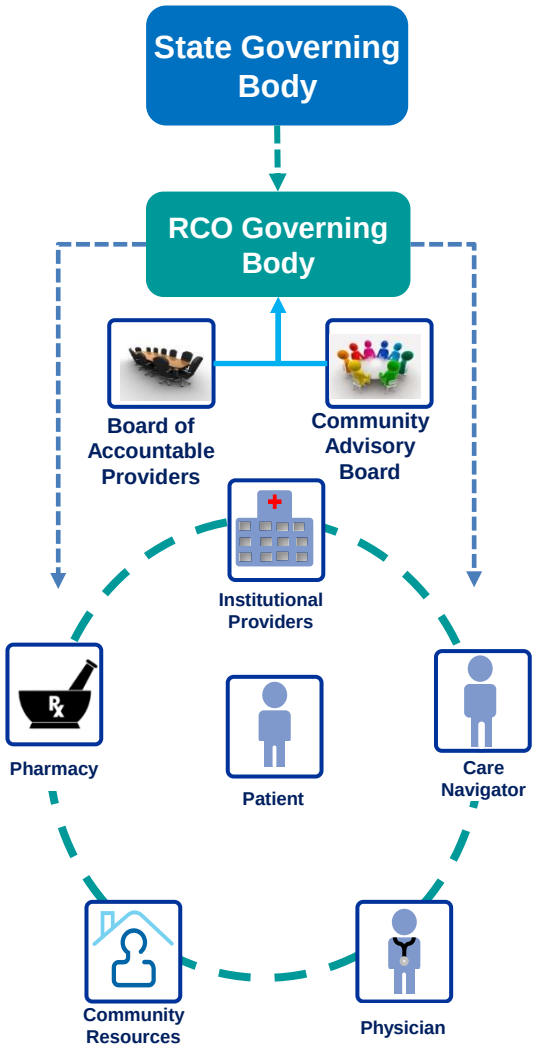
RCOs will meet a high bar of patient centered care through a focus on primary care and prevention strategies, using care coordination and the integration of social services and community resources into care delivery

Utilize global, capitated payments with strict quality measure accountability to ensure cost and quality targets are being met statewide

Will create local delivery strategies that best utilize current healthcare resources and non-traditional health care workers and services, such as community health workers, local community partners, housing, et al

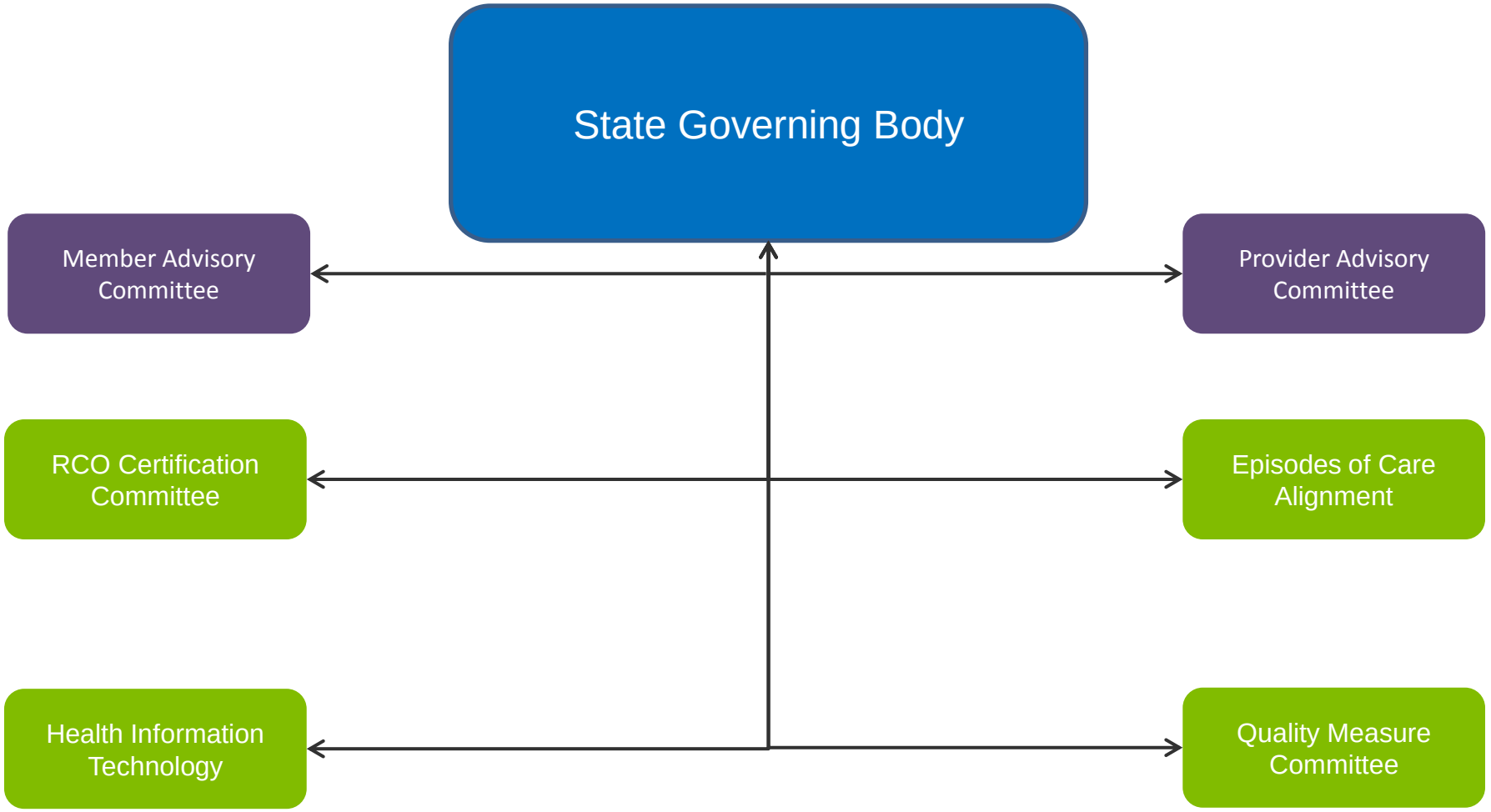
Initially, this model is proposed for all state purchased health care, which comprises a quarter of the state's population

Regional Care Organization



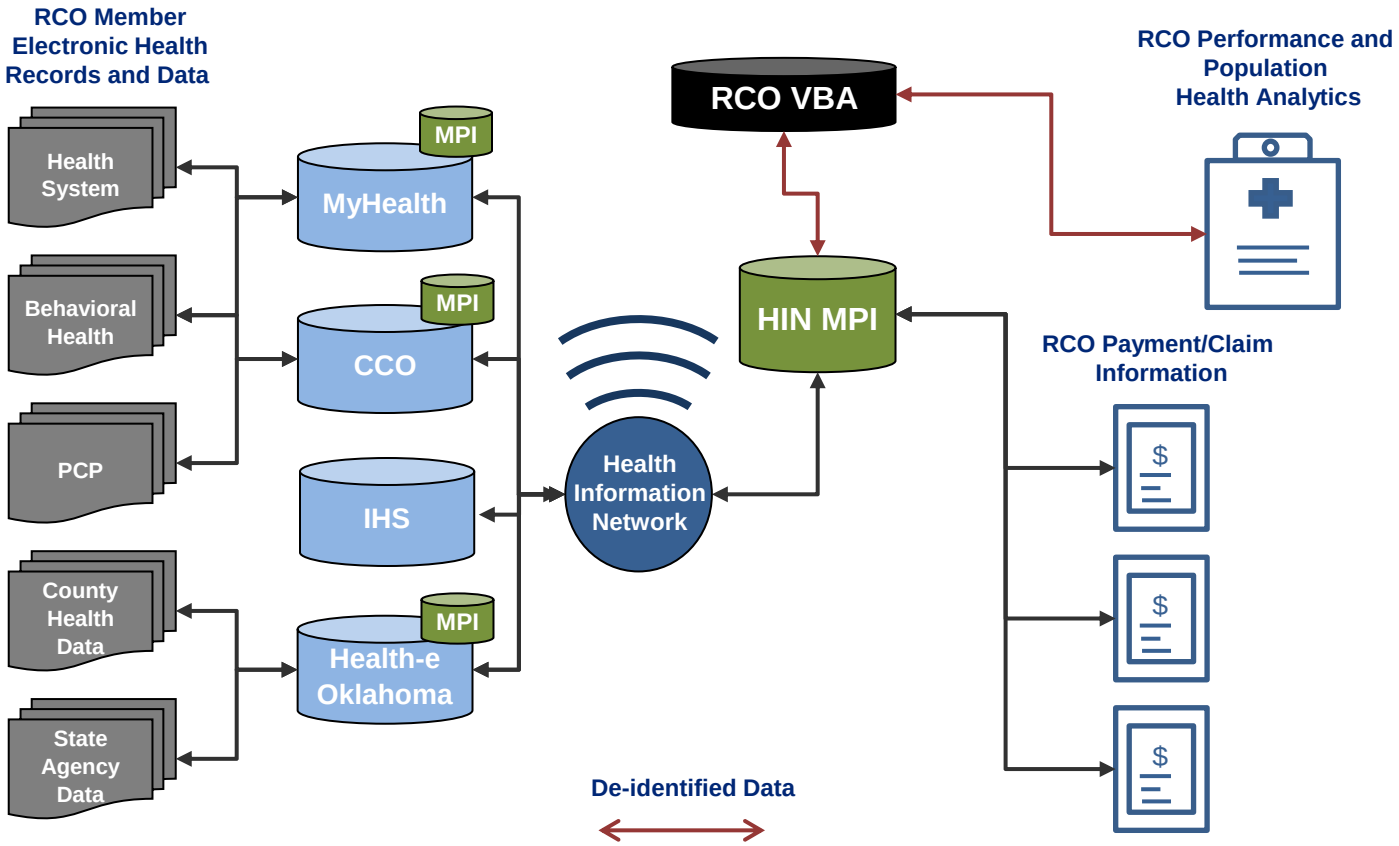
- Risk adjusted PMPM, globally capitated rate to RCO
- 80% of payments made by RCO to providers will be in a selected APA by 2020
- Community Quality Incentive Pool pays for meeting quality benchmarks set by SGB
- Integrate the social determinants of health through CAB, flexible spending, human needs survey, quality measures, and resource guide
- RCO will articulate best delivery system for region to meet a high bar of quality care based on standards set by SGB
- RCOs will organize a governance structure that incorporates the providers and community they serve
- RCOs will connect to an interoperable HIE to ensure the data to best manage patient care and analyze performance is available to all participating

State Governing Body – Example Advisory Boards and Committees



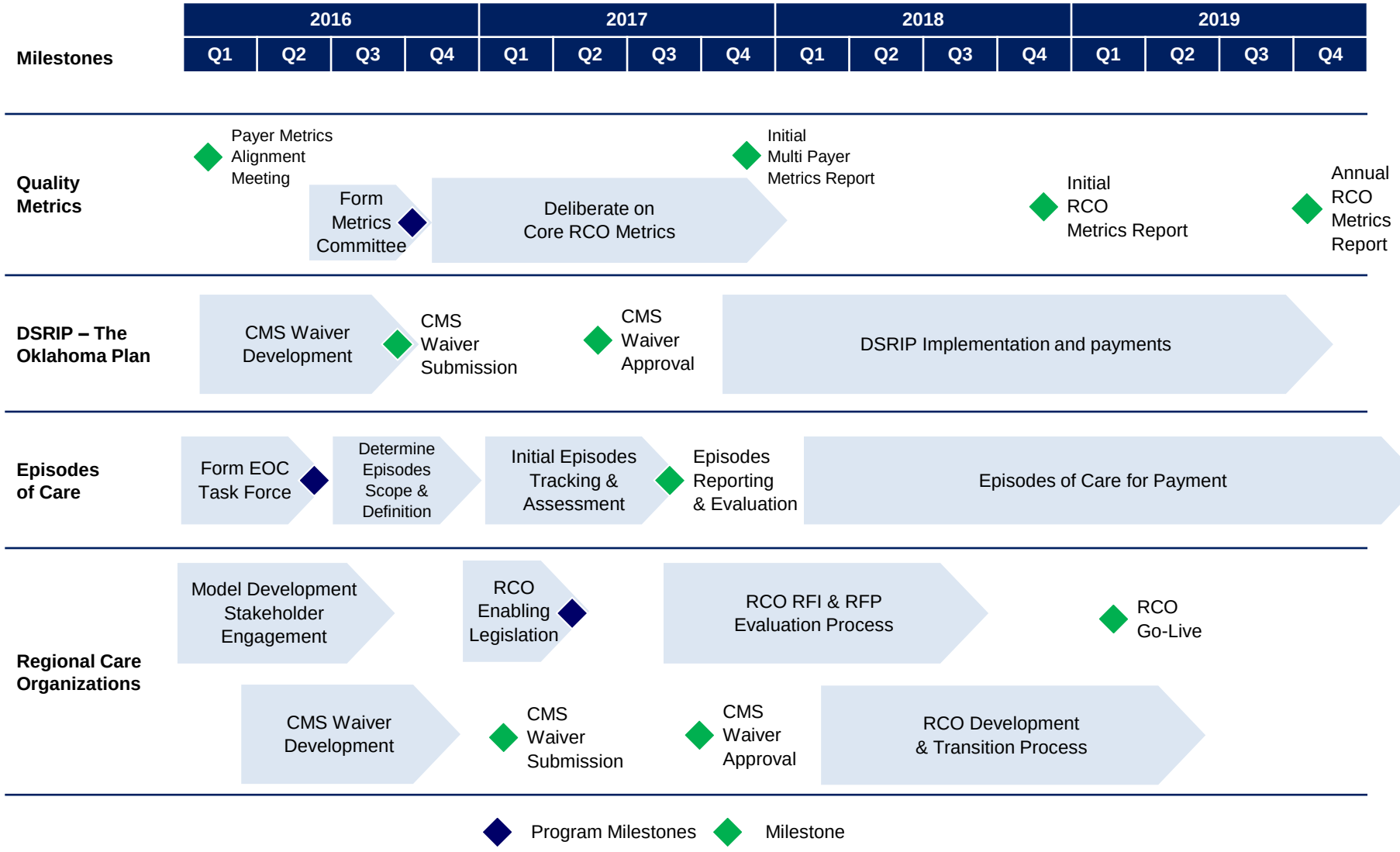
OSIM Health Information Technology Plan

RCO Technology Supports: VBA / HIN Conceptual Design



Next Steps & Timeline

OSIM Operational Roadmap: Healthcare System Initiatives



Impacts to Market/Health Services

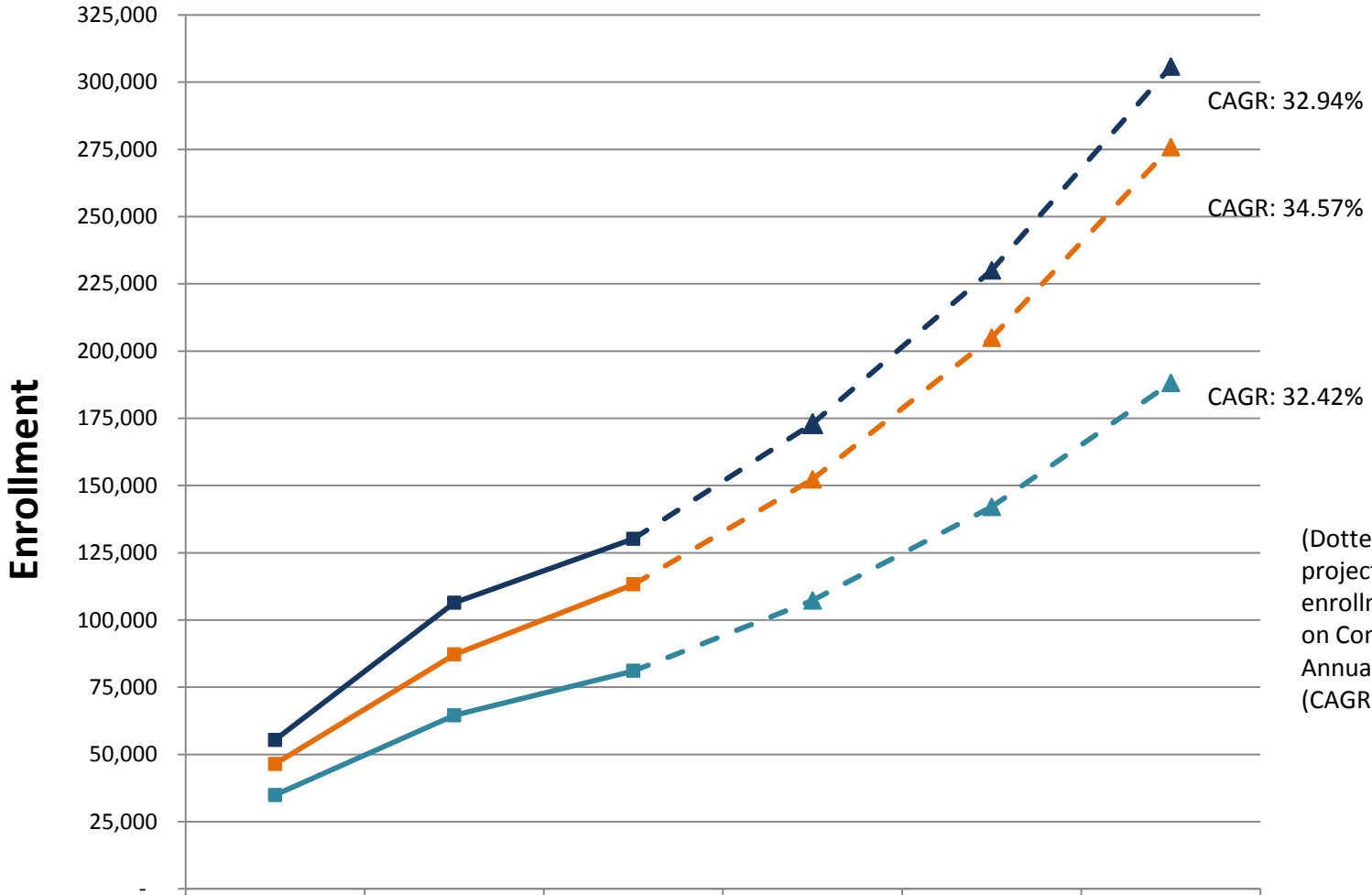
Federally Facilitated Marketplace (FFM) Enrollment: Year over Year Enrollment

	2014		2015		2016		Compound Annual Growth Rate (Effectuated)
	Pre-effectuated	Effectuated	Pre-effectuated	Effectuated	Pre-effectuated	Effectuated	(Effectuated Only)
Enrollment	69,221	55,407	126,115	106,392	145,329	130,178	32.94%
APTC Enrollment	46,460		87,136		113,209		34.57%
CSR Enrollment	34,906		64,543		81,053		32.42%

FFM Average Advanced Premium Tax Credits (APTC) and Premium Cost

	2014	2015	2016	Compound Annual Growth Rate (Effectuated)
Enrollment	55,407	106,392	130,178	32.94%
Average Monthly Premium (Total)	$277	$295	$376	10.72%
Average Monthly APTC	$212	$206	$298	12.02%
Average Monthly Premium After APTC	$65	$89	$80	7.17%
Estimated Annual Total of APTC	$140,955,408	$263,001,024	$465,516,528	48.92%
Estimated Annual Amount Spent on Premium	$184,172,868	$376,627,680	$590,487,408	47.46%

Federally Facilitated Marketplace (FFM) Enrollment: Projected Enrollment

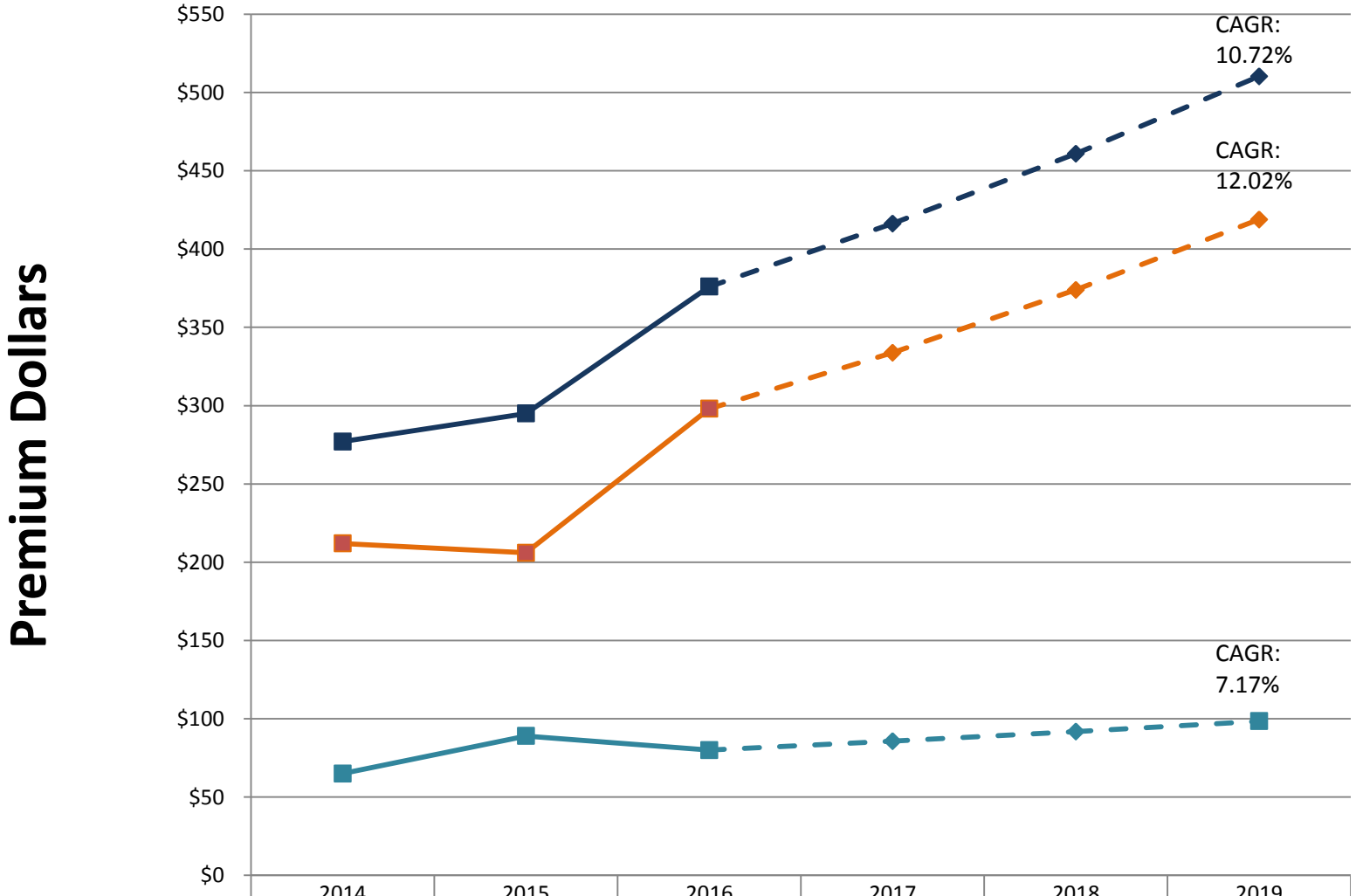


	2014	2015	2016	2017	2018	2019
Enrollment	55,407	106,392	130,178	173,059	230,064	305,847
APTC Enrollment	46,460	87,136	113,209	152,345	205,011	275,883
CSR Enrollment	34,906	64,543	81,053	107,330	142,127	188,204

(Dotted lines are projected enrollment based on Compound Annual Growth Rate (CAGR))

FFM: Projected Annual Premium and APTC

(Dotted lines are projected enrollment based on Compound Annual Growth Rate (CAGR))



	2014	2015	2016	2017	2018	2019
Average Monthly Premium	$277	$295	$376	$416	$461	$510
Average Monthly APTC	$212	$206	$298	$334	$374	$419
Average Monthly Premium after APTC	$65	$89	$80	$85.74	$91.88	$98.47

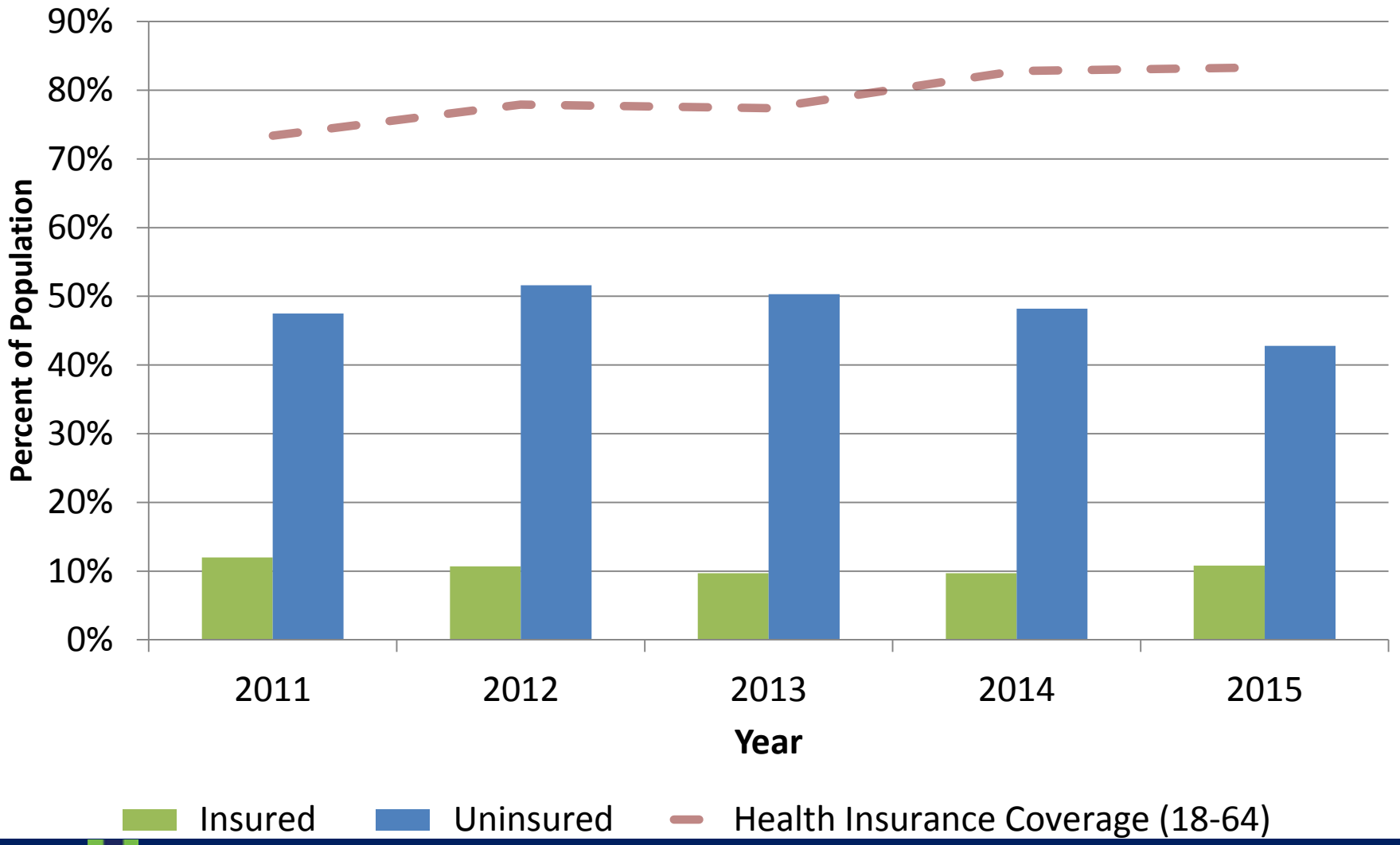
2016 FFM Enrollment by FPL

Total Number of Individuals Who Selected a Plan (not effectuated)	Number of Plans with FPL Status	<100% of FPL	≥100% - ≤150% of FPL	>150% - ≤200% of FPL	>200% - ≤250% of FPL	>250% - ≤300% of FPL	>300%- ≤400% of FPL	>400% of FPL
145,329	134,266	4%	38%	23%	16%	9%	8%	2%

2016 FFM Enrollment by

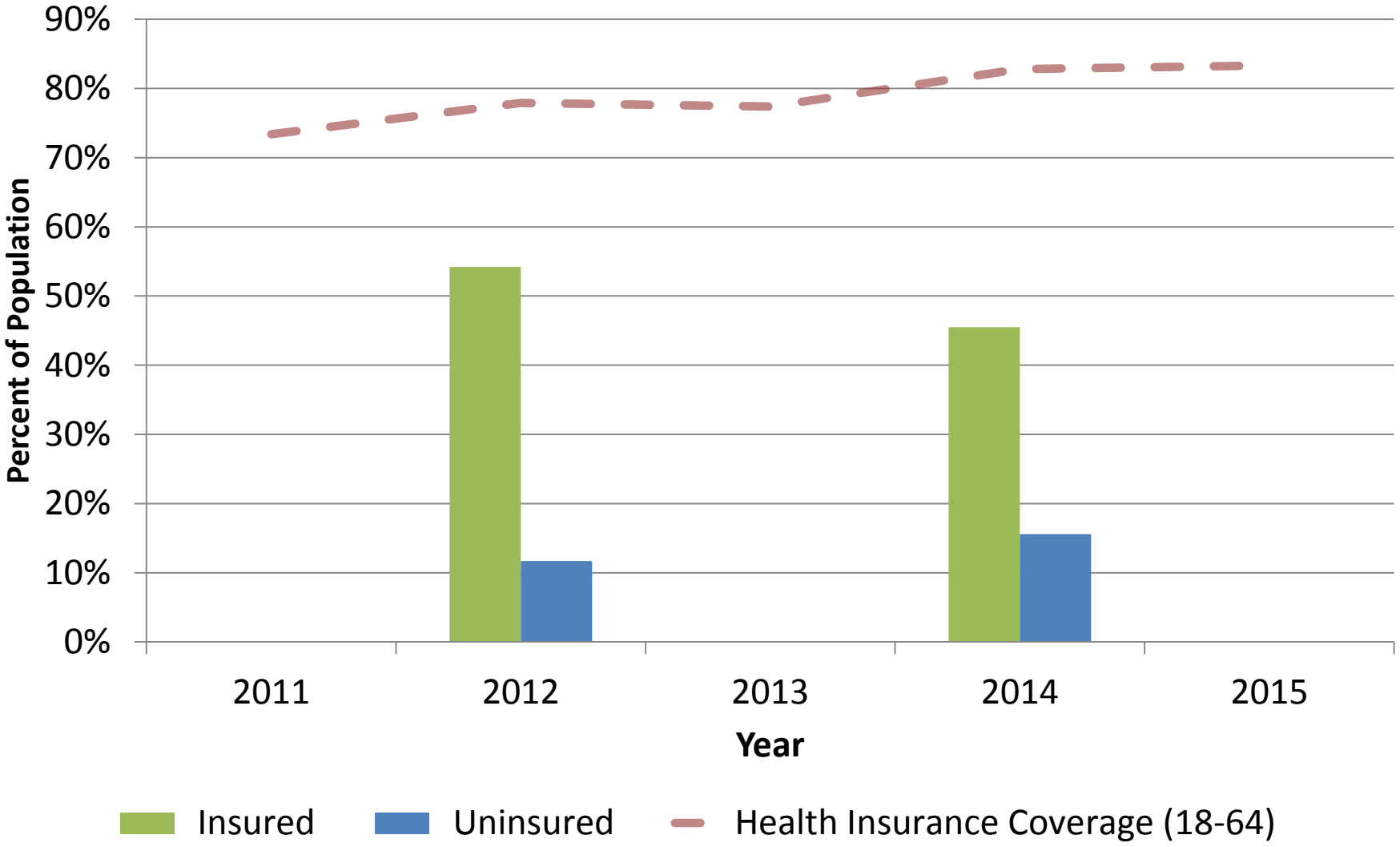
Total Number of Individuals Who Selected a Plan (not effectuated)	Number of Plans with Rural Status	In Zip Codes Designated as Rural	In Zip Codes Designated as Urban
145,329	145,329	37%	63%

Needed a doctor last year but cost was too high



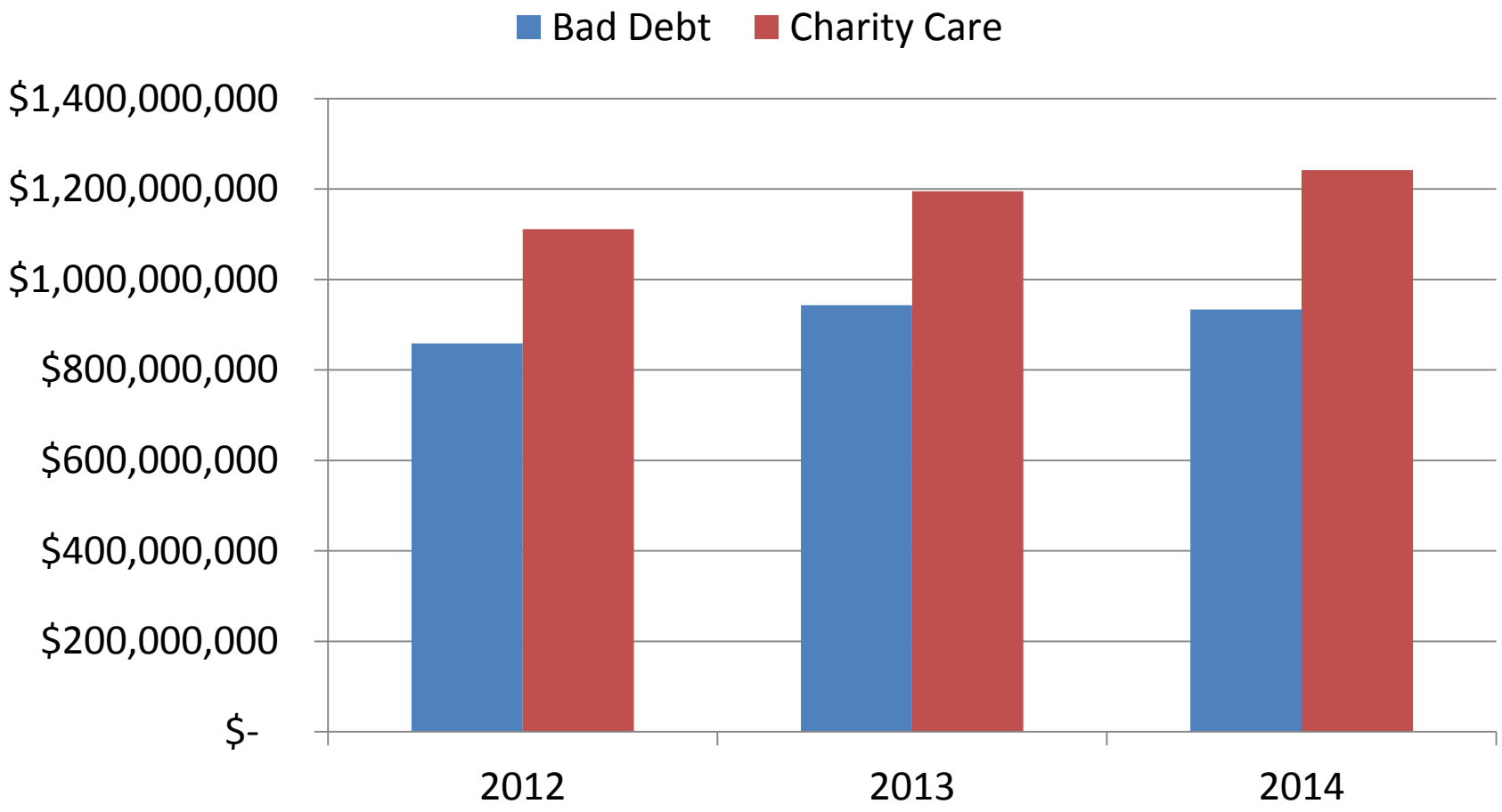
Oklahoma State Department of Health, Health Care Information, BRFSS 2011-2015

PSA test in past 2 years (men age 40+)



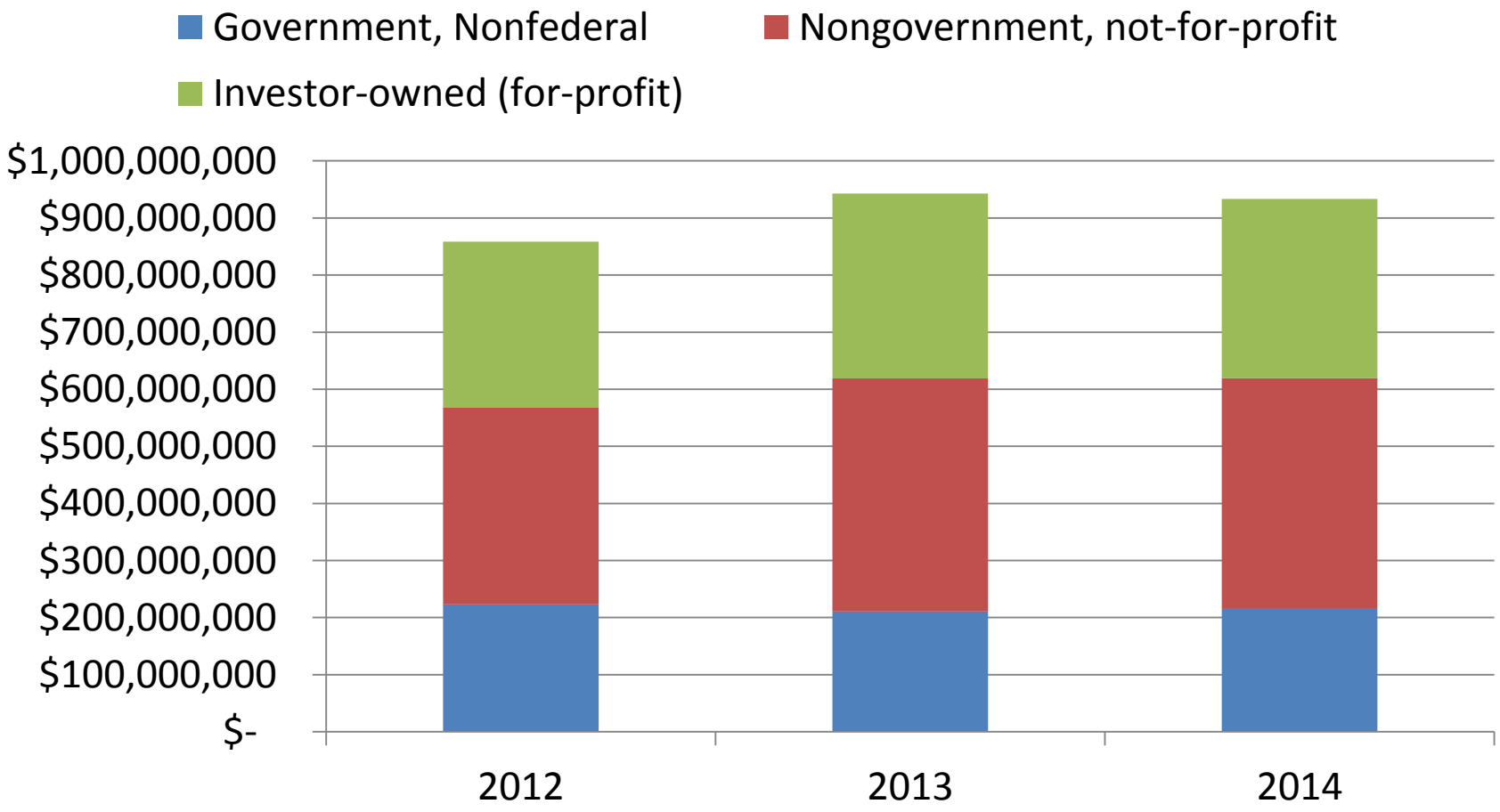
Oklahoma State Department of Health, Health Care Information, BRFSS 2011-2015

Oklahoma Hospitals, Total Bad Debt / Charity Care



Source: American Hospital Association (AHA) Annual Survey

Oklahoma Hospitals, Total Bad Debt by Type



Source: American Hospital Association (AHA) Annual Survey

Questions

Oklahoma State Department of Health

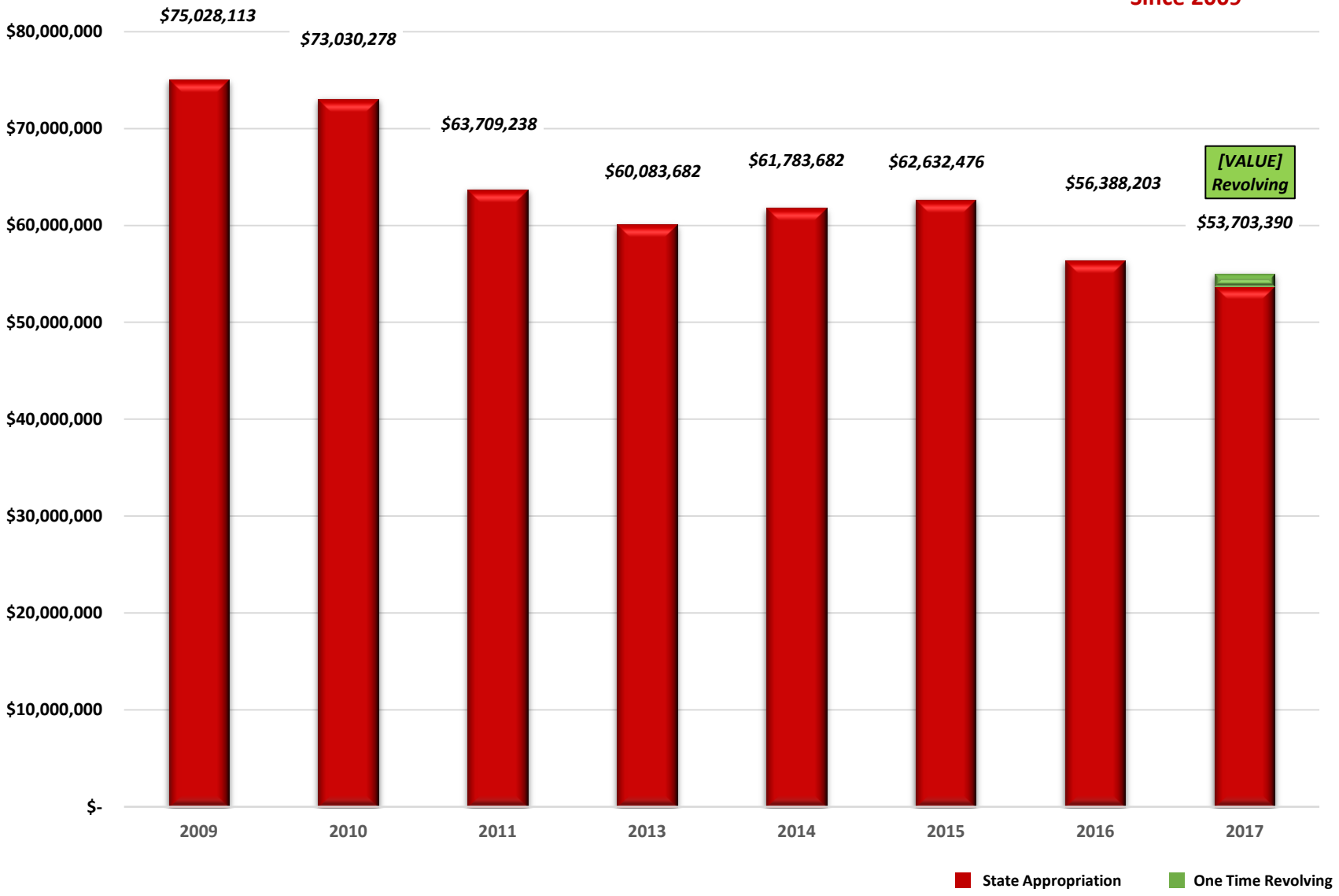
State Appropriation Reductions

SFY- 16 & SFY - 17

August 2016

OSDH Appropriations History
SFY 2009 - SFY 2017

28.42% Reduction in State Appropriation Since 2009



SFY 16 & SFY 17 State Appropriation Reductions

SFY-16 Revenue Failure - 7%		
OSDH Infrastructure	$	1,242,691
Federally Qualified Health Centers (FQHC) Start Up Funding	$	319,531
Federally Qualified Health Centers (FQHC) Uncompensated Care	$	741,051
Cord Blood Bank	$	500,000
Strategic Planning (STEP-UP) Software Purchase	$	220,000
Dental Health Education Services	$	220,000
Colorectal Cancer Screening	$	200,000
Ryan White Part B Program	$	786,000
Oklahoma Athletic Commission	$	14,000
Total	**$**	**4,243,273**

SFY-17 Revenue Failure 4.76% in General Revenue		
OSDH Infrastructure (VOBO State Savings)	$	914,566
Federally Qualified Health Centers (FQHC) Uncompensated Care	$	237,891
Oklahoma Child Abuse Prevention Services	$	252,933
County Health Department Closures ($360,000 Local Millage)	$	-
HIS – Reduction to Health Improvement Services due to unintended reduction to state appropriation in SB 1616.	$	1,275,108
Oklahoma Athletic Commission	$	4,315
Total	***$***	***2,684,813***

SB 1616 General Appropriations Bill

OSDH received a one time appropriation in revolving funds to be used for public health activates as outlined in SB 1616 in the amount of $1,275,108.

The following Services were <u>not</u> restored for SFY-17:

- OSDH Infrastructure budgeted at SFY-16 ending balance
- Cord Blood
- Colorectal Cancer Screening (Restored $50,000)
- FQHC Start Up Funding
- Dental Health Education Services
- Ryan White – Utilizing Drug Rebate Funds

SFY – 17 Impact OSDH Due to State Appropriation Reductions

- ***Federally Qualified Health Centers (FQHC) Uncompensated Care - $237,891 Reduction***

  OSDH restored funding to Federally Qualified Health Centers in the amount of $2,314,586 and is anticipated to support approximately 12,352 encounters. The SFY-17 funding amount represents an overall decrease of 9.32% from beginning SFY-16.

- ***OCAP – $252,933 Reduction***

  OCAP would be impacted in all three scenarios through the elimination of contractors performing family services using the Healthy Family America (HFA) program. OCAP currently has 11 Start Right contracts to provide home visitation services statewide, reduced from 22 contracts in SFY09.

- ***OSDH VOBO (State Savings) - $914,556***

  86 Positions were vacated in SFY-16

  69 of the 86 will not be filled for the next two years

- ***Health Improvement Services (HIS) - $1,275,108***

  Reduction to Heath Improvement Services due to reduction to state appropriation per SB 1616. Office of Management and Enterprise Services issues a one time appropriation of revolving funds.

- ***Performance Related Impacts:***
  - Loss of institutional knowledge (VOBO)
  - County Health Department Closures (Estimated Savings $360,000)
  - Suspension of all state funded positions in various years to meet the reduction.
  - Financial Management Services has had a significant impact:
    - 12% reduction in staff in FY2016 (8 positions)
    - 29% vacancy rate for two consecutive years
    - Accounting system from 1974 – need to modernize
    - Billing system needs modernization in order to bill insurers and bring in revenue
    - Impacts the ability to complete administrative requirement timely such as federal and state reporting payment of invoices.
    - Multiple systems that are unable to speak to each other
    - Paper driven
    - Customer service suffers
    - Slow down in completing contracts and purchases

ATTACHMENT D

Oklahoma State Department of Health
Strategic Map: 2016-2020

Top 5
Supplemental

Achieve Demonstrated Improvements in Population Health

	A = 45% Range 25-60	B = 20% Range 10-30	C = 15% Range 10-35	D = 20% Range 5-30
	Improve Targeted Health Outcomes for Oklahomans	**Expand and Deepen Partner Engagement**	**Strengthen Oklahoma's Health System Infrastructure**	**Strengthen the Department's Effectiveness and Adaptability**
1	Operationalize OHIP Flagship Priorities 3	Identify and Develop Public Health Champions	Reduce Barriers to Accessible Care	Cultivate a Competent, Adaptive, Customer-Oriented OSDH Workforce
2	Focus on Core Public Health Priorities 2	Develop Strategic Partnerships to Achieve Prioritized Health Outcomes	Champion Health Workforce Transformation	Foster Excellence Through Continuous Quality Improvement and Accreditation
3	Identify and Reduce Health Disparities 3	Engage Communities in Policy and Health Improvement Initiatives 2	Align Health System Goals and Incentives Across the Spectrum	Evaluate and Improve Agency Processes and Communication
4	Use a Life Course Approach to Health and Wellness	Leverage Shared Resources to Achieve Population Health Improvements	Achieve Compatible HIE Across Public and Private Sectors	Leverage Technology Solutions 3
5		Promote Health in All Policies (HiAP) Across Sectors	Evaluate and Reduce Regulatory Barriers to Health Outcome Improvement	Encourage a Culture of Innovation
6				Optimize Resources by Targeting High-Value Outcomes
F	**Address the Social Determinants of Health and Improve Health Equity**			
G	**Promote Health Improvement Through Policy, Education and Healthy Behavior**			
H	**Foster Data-Driven Decision Making and Evidence-Based Practices**			

ATTACHMENT E

Oklahoma Health 360

Healthy Citizens and Strong Families
Julie Cox-Kain Deputy Secretary of Health and Human Services

Life expectancy ⟷ **Healthy Life Expectancy** ⟷ **Years of Potential Life Loss**

Process for Evaluation of Health Priority Areas

HEALTH PRIORITY AREA(S) TBD

Access
1) MEASURE: Burden, Investment, Performance
2) SYNTHESIZE: Evidence-based Practice
3) ASSESS: Inventory State Assets
4) ANALYZE: Review Program Fidelity

Wellness
1) MEASURE: Burden, Investment, Performance
2) SYNTHESIZE: Evidence-based Practice
3) ASSESS: Inventory State Assets
4) ANALYZE: Review Program Fidelity

Prevention
1) MEASURE: Burden, Investment, Performance
2) SYNTHESIZE: Evidence-based Practice
3) ASSESS: Inventory State Assets
4) ANALYZE: Review Program Fidelity

Social Stability
1) MEASURE: Burden, Investment, Performance
2) SYNTHESIZE: Evidence-based Practice
3) ASSESS: Inventory State Assets
4) ANALYZE: Review Program Fidelity

Recommendations

What is the best investment to improve health?

- Refer to Health In All Policies/ HIA Team:
  - HHS Team
  - Education
  - Correction
  - Transportation
  - Public Safety
  - OMES
  - Workforce
- Refer to OHIP and/or Other Workgroup
- Refer to Quality Improvement
- TBD or New Action