Strategic Planning Conference 2015

Wednesday, August 12, 2015
Embassy Suites, Oklahoma City, OK

Oklahoma HealthCare Authority

WEDNESDAY: SESSION I

Welcome / Opening Remarks

- Ed McFall, OHCA Board Chairman
- Nico Gomez, CEO, OHCA

WEDNESDAY: SESSION 2

OHCA Overarching Goals & Agenda Highlights

Moderator

- Buffy Heater, Chief Strategy Officer, OHCA

WEDNESDAY: SESSION 3

Panel Discussion

Rural Health

WEDNESDAY SESSION 3

Panel Discussion on Rural Health

Moderator:

- Carrie Evans, Chief Financial Officer, OHCA

WEDNESDAY SESSION 3

Panel Discussion on Rural Health

Panelists:

- Michael Woods, Program Director, Rural Medicine, OU School of Community Medicine
- William J. Pettit, Associate Dean of Rural Health, OSU College of Medicine
- Doug Cox, Oklahoma State Representative
- Rob Standridge, Oklahoma State Senator
- Andy Fosmire, Vice-President of Rural Health, Oklahoma Hospital Association
- Lyle Roggow, President, Duncan Area Economic Development Foundation

RURAL HEALTH

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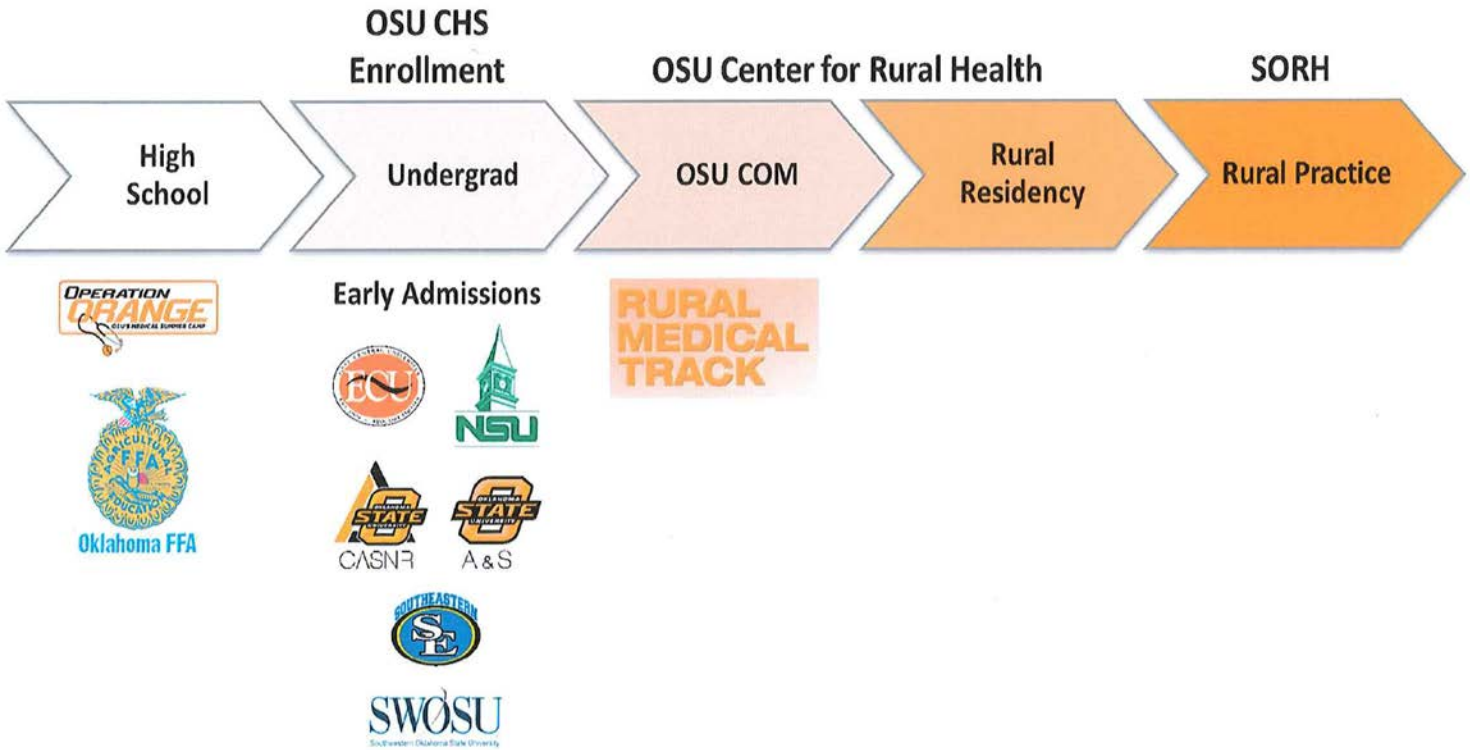
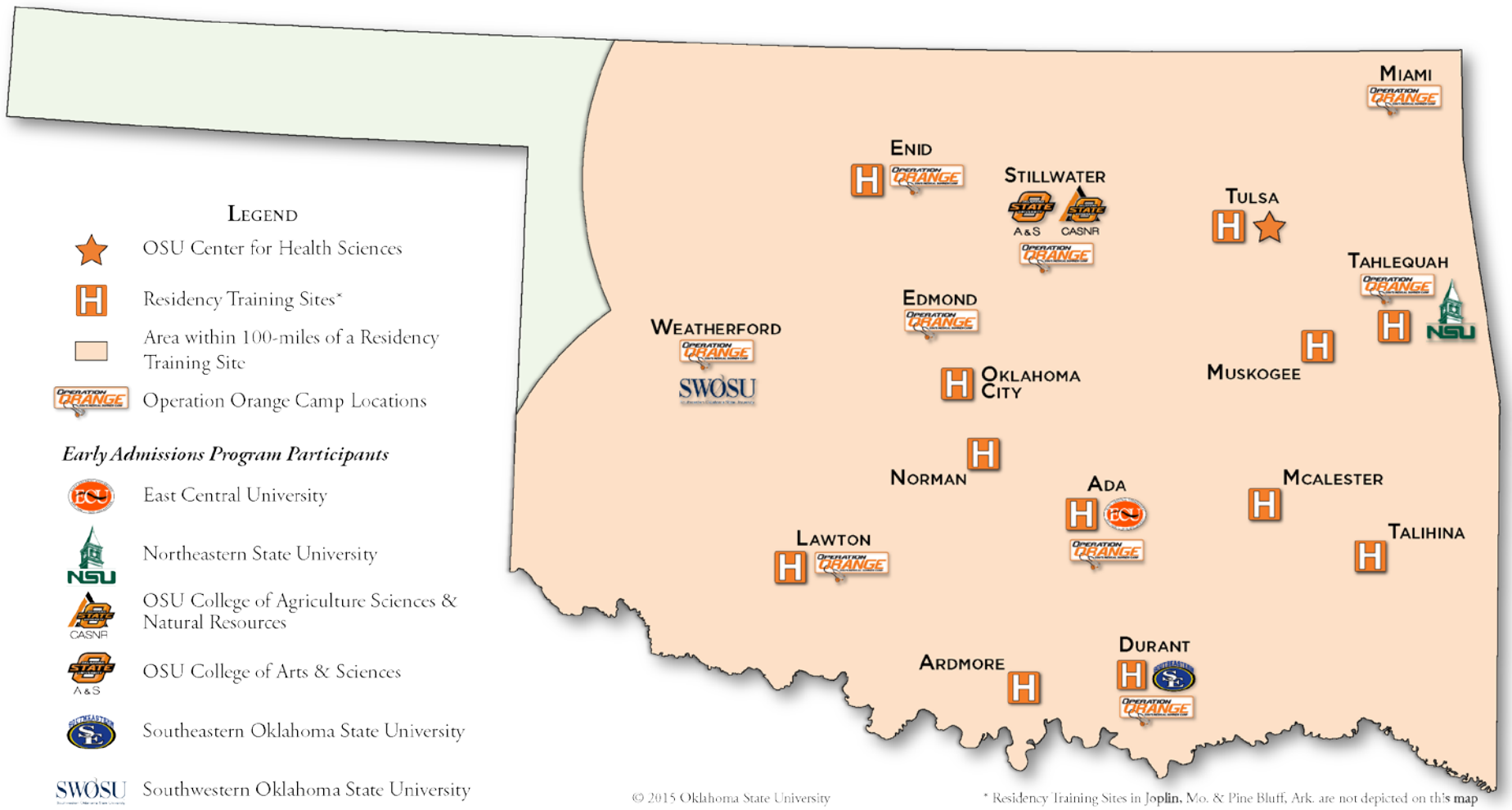
Nature & Nurture



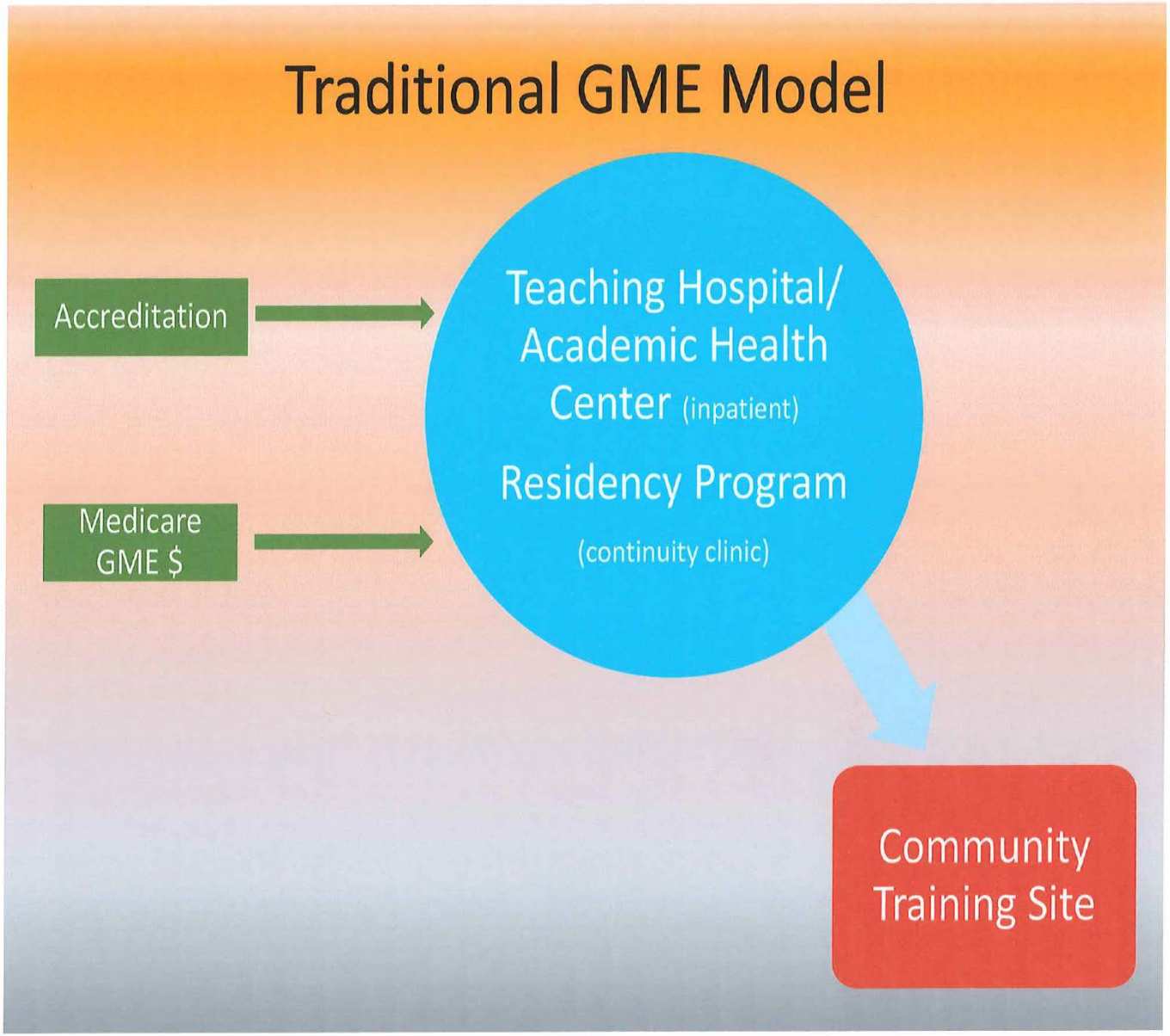
See: Ballance, D., Kornegay, D. and Evans, P. (2009), Factors That Influence Physicians to Practice in Rural Locations: A Review and Commentary. The Journal of Rural Health, 25: 276–281. doi: 10.1111/j.1748-0361.2009.00230.x

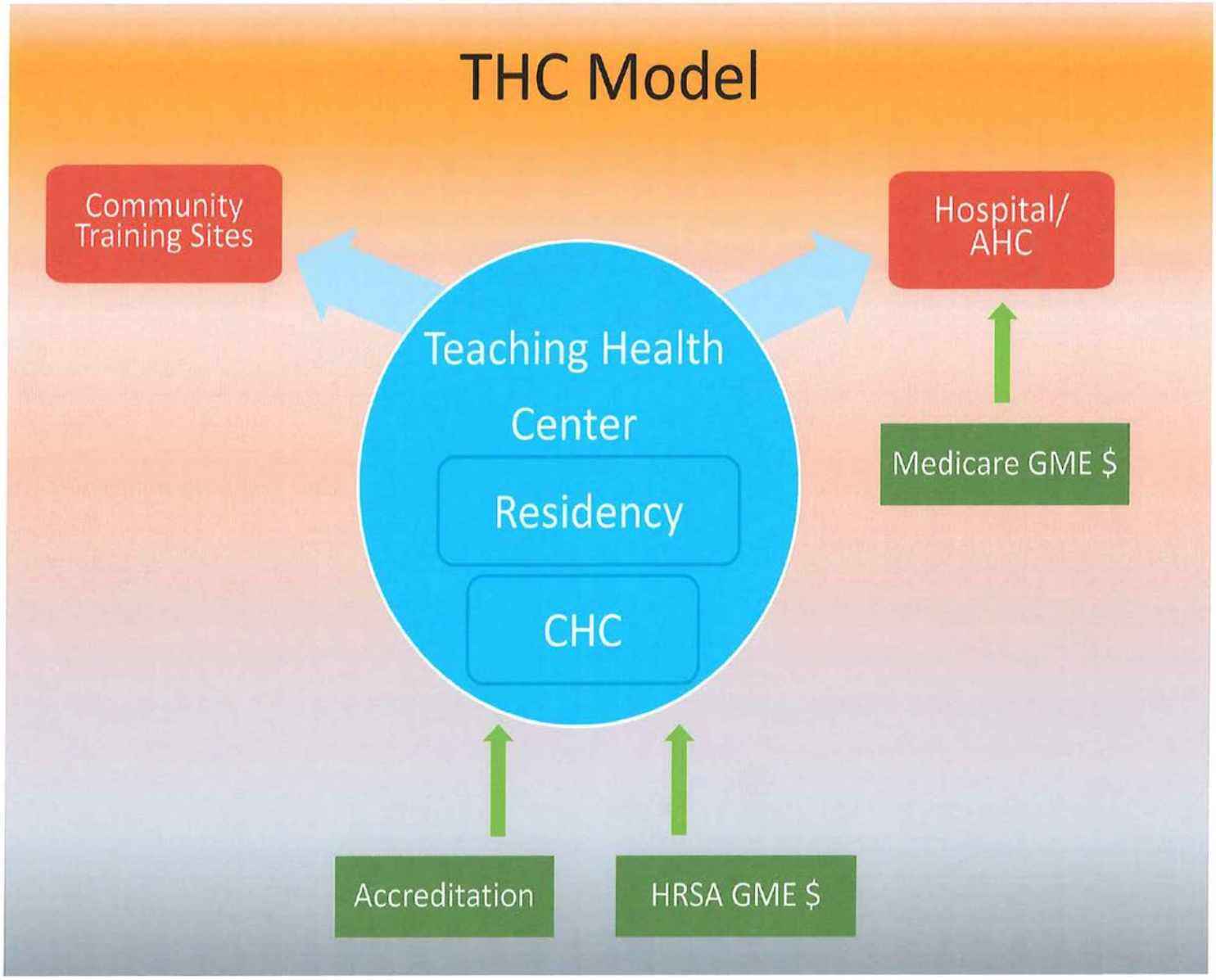
Osteopathic Medicine

OSU Center for Health Sciences
Rural Health Care Training Footprint



* Residency Training Sites in Joplin, Mo. & Pine Bluff, Ark. are not depicted on this map


Traditional GME Model
Accreditation
Medicare GME $
Teaching Hospital/ Academic Health Center (inpatient)
Residency Program
(continuity clinic)
Community Training Site


THC Model
Community Training Sites
Hospital/ AHC
Teaching Health Center
Residency
CHC
Medicare GME $
Accreditation
HRSA GME $

WEDNESDAY: SESSION 4

Interactive Planning Session

Insure Oklahoma

WEDNESDAY: SESSION 4

Insure Oklahoma

Facilitator:

- Becky Pasternik-Ikard, Deputy State Medicaid Director, OHCA

Subject Matter Experts:

- Melissa Pratt, Insure Oklahoma Administrator, OHCA
- Tywanda Cox, Chief of Federal and State Policy, OHCA
- Julie Cox-Kain, Oklahoma Deputy Secretary of Health and Human Services, Senior Deputy Commissioner, OSDH
- Melanie Fourkiller, Policy Analyst, Choctaw Nation of Oklahoma

INSURE OKLAHOMA

Helping Oklahomans Stay Strong

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HELPING OKLAHOMANS STAY STRONG

https://www.youtube.com/watch?v=5nxqi-mw7oc

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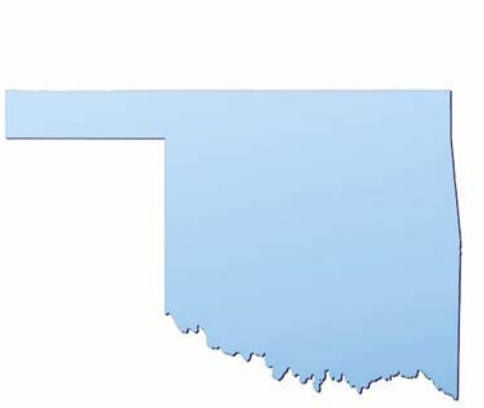
ABOUT INSURE OKLAHOMA

Created in 2005, Insure Oklahoma bridges the health coverage gap for low-income, working Oklahomans.

WHAT IS INSURE OKLAHOMA?



State health coverage program for lower-income Oklahomans

Open to qualified, working adults ages 19-64

Monthly subsidy or premiums based on income, household size

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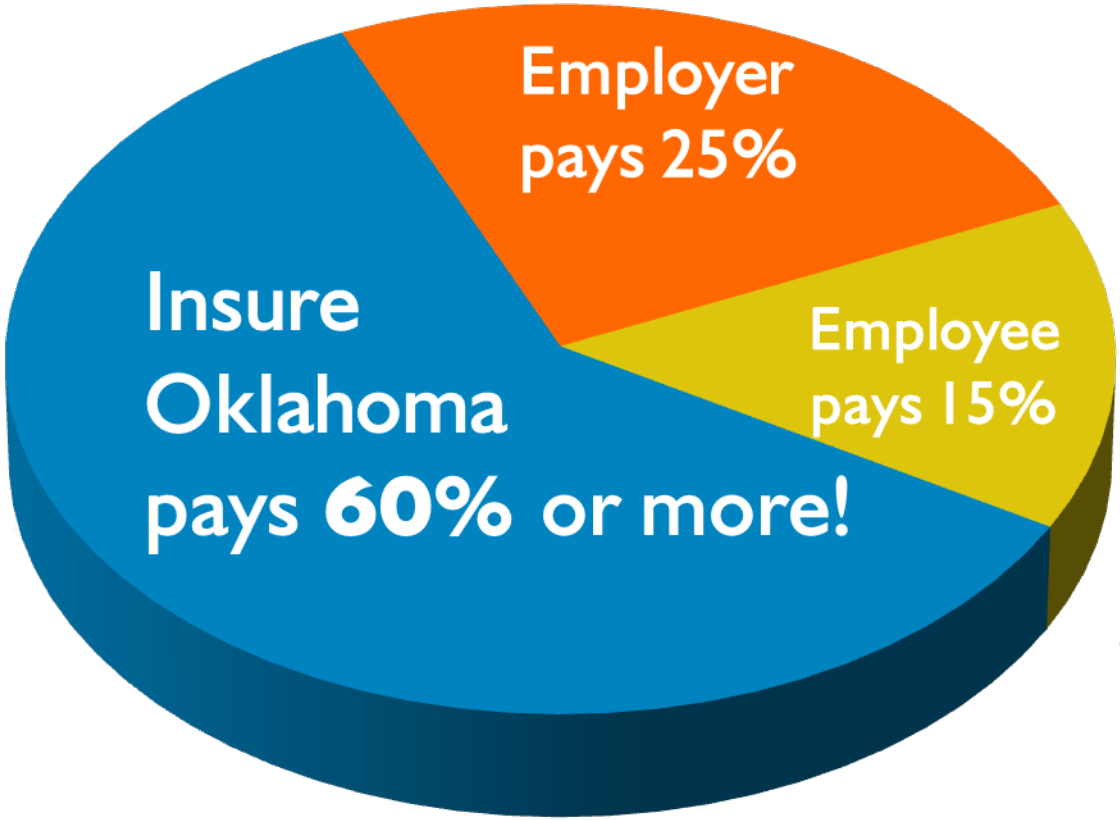
EMPLOYER SPONSORED INSURANCE

Insure Oklahoma ESI provides premium assistance subsidies to businesses that offer a qualified health plan, reducing the cost burden for both the business and enrolled employee.

PREMIUM COST-SHARING



"This program is a perfect opportunity for small business owners to offer their employees insurance."

– Oklahoma Small Business Owner, 2012

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INDIVIDUAL PLAN

Insure Oklahoma IP provides a limited health coverage option for qualified Oklahomans and is administered through the OHCA.

COVERAGE HIGHLIGHTS

Preventive Care

Prescriptions

ER Visits & Hospital Stays

Specialists

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HOW MUCH DOES IP COST?

Average Premium cost is $36.80 per month

- **OV– $4**
- **Hospital IP – $50 / OP– $4**
- **ER– $30 (waived if admitted)**
- **RX – $4 Generic / $8 Brand**

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MOVING FORWARD

- Employer Portal
- Online Enrollment
- HomeView

CONTACT

Visit www.insureoklahoma.org

for more information

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Insure Oklahoma Authority & Processes

Tywanda Cox
Chief of Federal & State Policy

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OPERATIONAL AUTHORITY

Waiver Authority

- Section 1115a SSA

Waiver Period

- Initial 5 year award; thereafter 3 year renewal periods

Budget Neutrality

TRANSPARENCY REQUIREMENTS

- Public Input (CFR §431.400)
  - Public Notices
    - Two Forms of Public Hearing
    - 30 Day Comment Period
      - OHCA/CMS

TRIBAL CONSULTATION

Federal Requirements

- 28 CFR Part 35(Sec. 5006(e) ARRA)

State Plan Requirements

OHCA Tribal Priority

- Annual Consultation
- Bi-Monthly Consultation
- Setting National Standards

2014 OHCA & TRIBAL PLANNING MEETING

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2015 OHCA & TRIBAL PLANNING MEETING

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Contact

Tywanda.cox@okhca.org

405-522-7153

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Oklahoma HealthCare Authority

Oklahoma State Department of Health

Working Toward Payment and Delivery Systems That Support High-Value Health Care

Oklahoma SIM (“OSIM”) Project Overview

The “Triple Aim” for Health Care

The Centers for Medicare and Medicaid Services’ (CMS) adopted the Triple Aim: improving care and population health while decreasing costs.

Improve Health Outcomes

Improve the health of populations, through attacking the upstream causes of ill health such poor nutrition, physical inactivity, and substance abuse

Improve Quality of Care

Improve care for individuals, aligned to the six dimensions of health care performance listed in the Institute of Medicine’s 2001 report “Crossing the Quality Chasm”: safety, effectiveness, patient-centeredness, timeliness, efficiency, equity

Reduce Heath Care Expenditures

Reduce per-capita costs of health care by eliminating waste and inefficiencies in the health care system

Overview of the State Innovation Model Project

The mission of the State Innovation Model (SIM) project aligns to the Triple Aim Strategy to improve care, population health, and costs.

Current System	Future System
• Fee-for-service/encounter based • Poor coordination and management for chronic diseases • Lack of focus on the overall health of the population • Unsustainable costs • Fragmented delivery system with variable quality	• Patient-centered (mental, emotional, and physical well-being) • Focused on care management and chronic disease prevention • New focus on population-based quality and cost performance • Reduces costs by eliminating unnecessary or duplicative services • Incentivizes quality performance on defined measures

Source: CMS SIM Round Two Funding Opportunity Announcement Webinar

Oklahoma's Population Health Target Issues

The OSIM project focuses on 5 population health target issues, including the top focus areas discussed in the State's "Healthy Oklahoma 2020" Plan (OHIP 2020).

Heart Disease

- Heart disease is the leading cause of death in Oklahoma.
- In 2010, Oklahoma had the 3rd highest death rate for heart
- disease in the nation.
- In 2012, heart disease accounted for 1 in 4 Oklahoma deaths.

Tobacco Use

- Smoking is Oklahoma's leading cause of preventable death.
- Smoking kills more Oklahomans than alcohol, auto accidents, AIDS, suicides, murders and illegal drugs combined.
- In 2012, approximately 1 in 4 Oklahoma adults smoked, compared to 1 in 5 nationally.

Obesity

- Oklahoma is the 6th most obese state in the nation.
- Excess weight increases the risk of developing chronic disease, such as heart disease, stroke, and diabetes.
- In 2013, 12% of youth were obese and 15% were overweight.

Diabetes

- In 2010, Oklahoma has the 4th highest rate of death due to diabetes in the nation.
- Type 2 diabetes accounts for the vast majority of all diabetes cases (90-95%) and can be prevented through healthy food choices, physical activity, and weight loss.

Behavioral Health

- Oklahoma consistently ranks among the highest in the nation for rates of mental illness and addiction, as well as prescription drug abuse, underage drinking, and suicide.
- In 2014, 21.9% of adult Oklahomans reported having a mental health issue and 12% experienced a substance abuse issue.

Three-Phased Vision for Health Care Improvement

The OSIM project is divided into three phases of work that will ultimately lead to improved population health outcomes and greater cost savings

Phase 1

Achieve Consensus on Population and Clinical Level Measures

Achieve consensus among stakeholders on the alignment of a socio-ecological model that includes clinical and population-based health measures for selected health topics:

Health Topics:

- Obesity
- Diabetes
- Hypertension
- Tobacco

Phase 2

Select Care Delivery and New Payment Models

Assess and determine what multi-payer, value-based purchasing model will achieve common priorities and goals.

Models:

- Patient-Centered Medical Home
- Health Homes
- Health Access Networks
- Comprehensive Primary Care

Phase 3

Develop Value-Based Analytics Tool (VBA)

Identify strategies to increase adoption of Electronic Health Records (EHR) and attainment of Meaningful Use (MU) among providers. Initiate planning to develop a VBA tool.

Data Types:

- Clinical
- Claims
- Workforce
- Eligibility

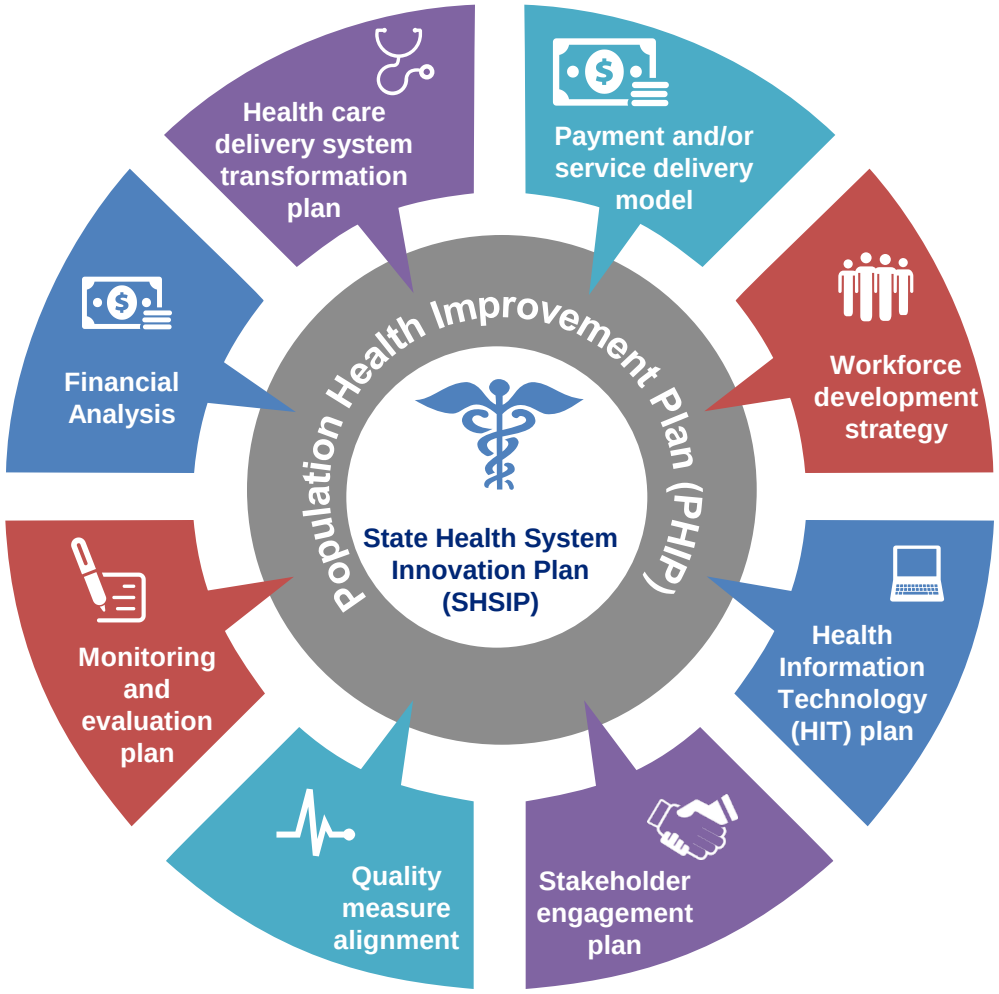
OSIM Goals

Finalize planning to:

- Coordinate public health and health care services and goals
- Improve population health outcomes
- Achieve health equity (rural, behavioral health, socioeconomic, race/ethnicity)
- Align clinical population health outcomes
- Achieve savings from multi-payer value-based purchasing

OSIM State Health System Innovation Plan

Oklahoma will develop a State Health System Innovation Plan – or "Model Design Plan" – as the final deliverable for the OSIM project.



Components of a Successful Model Design Plan

OHIP/OSIM Stakeholder Workgroup Deliverables

The four workgroups will help facilitate, monitor, and evaluate the various components of the Model Design Plan to ensure a state-based solution for transforming Oklahoma's health care system.

Health Efficiency and Effectiveness

- Population Health Needs Assessment
- Value-Based Delivery and Payment Methodology Transformation Plan
- In-State Evaluation Plan with Quality Metrics Draft

Health Workforce

- Health Workforce Data Catalog
- Health Workforce Assessment:
  - Provider Landscape, Provider Organization Landscape, Gap Analysis, Environmental Scan, Emerging Trend, Policy Prospectus

OHIP/OSIM Workgroups

Health Finance

- Market Effects on Health Care Transformation
- Care Delivery Model Assessment
- High-Cost Delivery Services
- Financial Forecast of New Payment Delivery Models

Health Information Technology

- Electronic Health Records Survey
- Electronic Health Records Adoption Analysis
- Health Information Exchange Environmental Scan
- Value Based Assessment Roadmap
- Health Information Technology Plan

1332 State Innovation Waivers

Overview of Section 1332 Waivers

States may request waivers from HHS and the Treasury Department of certain requirements of the Affordable Care Act (ACA)

- State innovation waivers are the progeny of bipartisan pre-ACA proposals to give states flexibility to be laboratories of health policy.
- Waiver proponents across ideological spectrum view section 1332 as vehicle for diverse system-wide changes.
- While broad reforms are possible, section 1332 can also be used to smooth jagged edges of ACA through narrowly targeted waivers.
- Use of section 1332 will vary, reflecting differing state needs and goals.
- Waivers must preserve coverage and fiscal parameters of ACA.

Timing and Effective Date

1332 waivers cannot take effect before January 1, 2017, but states will need to engage if to implement in 2017.

Federal Funding

States are entitled to the subsidies their residents would have received if state proposes to waive subsidies and use funds for other purposes.

Source: Robert Wood Johnson Foundation, State Health Reform Assistance Network, Charting the Road to Coverage, 2014

Four Areas of Innovation

States may propose innovations and alternatives to four pillars of the ACA

1 ***Individual Mandate***

States can modify or eliminate the tax penalties that the ACA imposes on individuals who fail to maintain health coverage.

2 ***Employer Mandate***

States can modify or eliminate the penalties that the ACA imposes on large employers who fail to offer affordable coverage to their full-time employees.

3 ***Benefits and Subsidies***

States can modify the rules governing what benefits and subsidies must be provided within the constraints of section 1332's coverage requirements.

4 ***Exchanges and QHPs***

States can modify or eliminate QHP certification and the Exchanges as the vehicle for determining eligibility for subsidies and enrolling consumers in coverage.

Source: Robert Wood Johnson Foundation, State Health Reform Assistance Network, Charting the Road to Coverage, 2014

Four Guardrails for Waiver Approval

A state waiver application must satisfy four criteria to be granted

1 ***Scope of Coverage***

The waiver must provide coverage to at least as many people as the ACA would provide without the waiver.

2 ***Comprehensive Coverage***

The waiver must provide coverage that is at least as "comprehensive" as coverage offered through the Exchange. Whether coverage is as comprehensive as Exchange coverage must be certified by the CMS chief actuary based on data from the state and comparable states.

3 ***Affordability***

The waiver must provide "coverage and cost sharing protections against excessive out-of-pocket" spending that is at least as "affordable" as Exchange coverage.

4 ***Federal Deficit***

The waiver must not increase the federal deficit.

Source: Robert Wood Johnson Foundation, State Health Reform Assistance Network, Charting the Road to Coverage, 2014

Coordination with Other Waivers

Section 1332 waivers can be coordinated with Medicaid and Medicare waivers, which may create opportunities for states to address differences among these federal programs that may impede efforts to pursue multi-payer delivery system reform.

1332 Waiver

ACA requires that HHS and Treasury coordinate their review of section 1332 waivers with existing waiver authority under federal law.

1115 Waiver - Medicaid

HHS may waive Medicaid requirements if doing so is "likely to assist in promoting the objectives" of the Medicaid statute.

Medicare waivers

HHS is permitted to modify Medicare payment to test methods to improve efficiency of the Medicare program.

Key Points

Section 1332 does not expand waiver authority for Medicaid or Medicare.

- State Exchanges can diverge from the federal model even without a waiver.
- Many innovations can be implemented without a waiver!
- Reforms that do not require a waiver:
  - Tie QHP certification to quality targets or payment reform
  - Eliminate bronze or platinum plans
  - Add state subsidies
  - Merge markets (individual, small group, large group)
  - Modify essential health benefits benchmark

Source: Robert Wood Johnson Foundation, State Health Reform Assistance Network, Charting the Road to Coverage, 2014

Questions

WEDNESDAY: SESSION 5

Interactive Planning Sessions Recap

Moderator

- Buffy Heater, Chief Strategy Officer, OHCA

RECESS

Reconvene Strategic Planning Conference

8:30AM THURSDAY, AUGUST 13, 2015

Registration Open 8:00am

Strategic Planning Conference 2015

Thursday, August 13, 2015
Embassy Suites, Oklahoma City, OK

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THURSDAY: SESSION 6

Welcome / Opening Remarks

- Ed McFall, OHCA Board Chairman
- Nico Gomez, CEO, OHCA

THURSDAY: SESSION 7

Panel Discussion

OHCA Goal #7 - Collaboration

THURSDAY: SESSION 7

Panel Discussion: Goal # 7 Collaboration

Panelists:

- Nico Gomez, CEO, OHCA
- Terry Cline, Oklahoma Secretary of Health and Human Services, Commissioner, OSDH
- Steven Buck, Deputy Commissioner, Communications and Prevention Services, ODMHSAS
- Deidre Myers, Deputy Secretary of Workforce Development, Oklahoma Office of Workforce Development, OSU-OKC

THURSDAY: SESSION 7

Panel Discussion: Goal # 7 Collaboration

Panelists (cont.):

- AJ Griffin, Oklahoma State Senator
- Jack Sommers, Chief Medical Officer, Community Care of Oklahoma
- Frank Lawler, Medical Director, Oklahoma Employee Group Insurance Division
- Teresa Huggins, CEO, Stigler Health & Wellness Center, Inc., Secretary, Oklahoma Primary Care Association

THURSDAY: SESSION 8

Presentation Session

Alternative Delivery Systems: Patient Centered Medical Home (PCMH) from the Member's Perspective

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THURSDAY: SESSION 8

Alternative Delivery Systems: Patient Centered Medical Home (PCMH) from the Member's Perspective

Presenters:

- Garth Splinter, State Medicaid Director, OHCA
- Becky Pasternik-Ikard, Deputy State Medicaid Director, OHCA

THURSDAY: SESSION 8

Panelists:

- Aramis Singleton, SoonerCare Medical Home Member
- Shannon George, SoonerCare Member
- Michael Tillman, SoonerCare Member

PHPG

SOONERCARE CHOICE PROGRAM
INDEPENDENT EVALUATION
STATE FISCAL YEAR 2014

PREPARED FOR: *STATE OF OKLAHOMA, OHCA*

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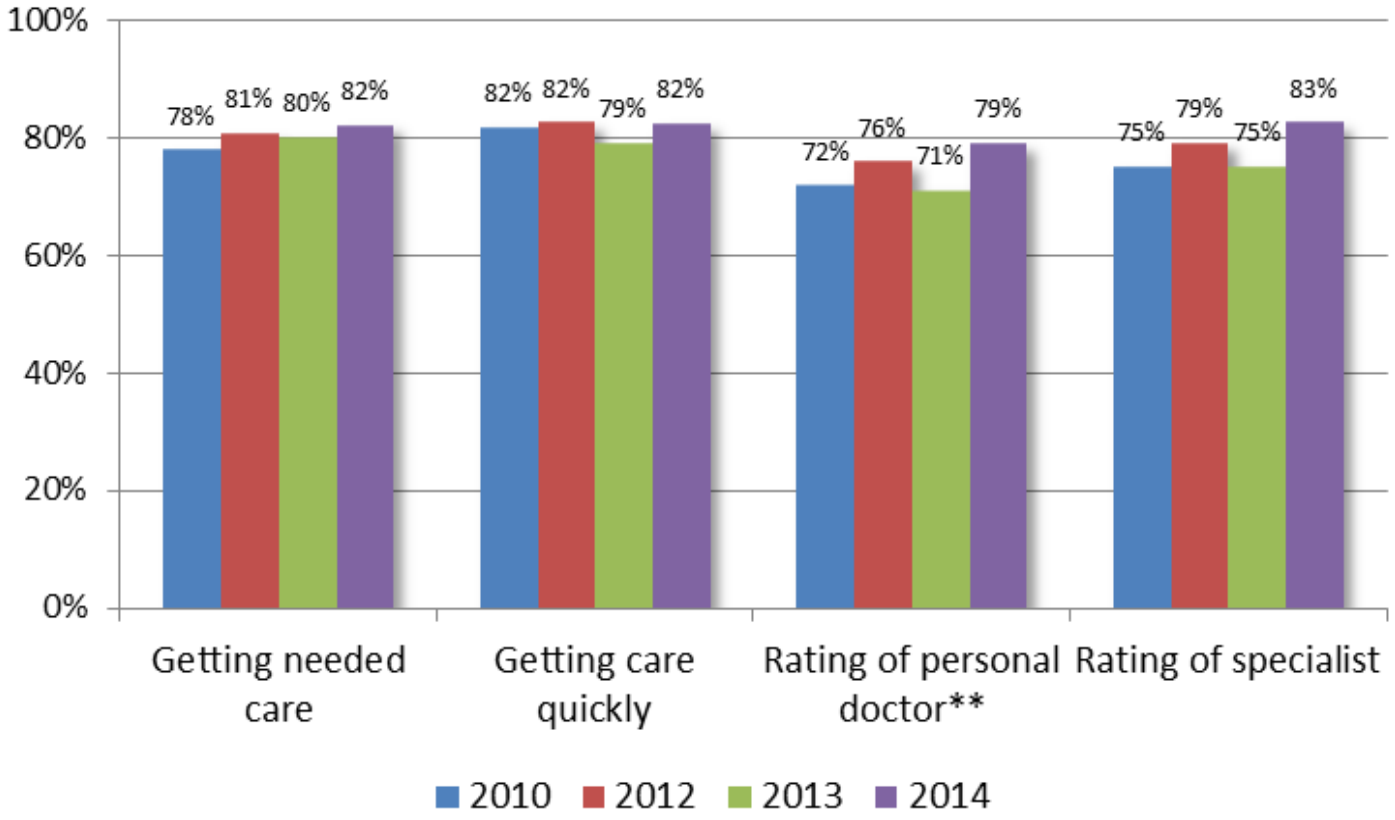
ACCESS TO CARE

Member Satisfaction

- Consumer Assessment of Healthcare Providers and Systems survey (CAHPS) is used to measure member satisfaction
- Satisfaction with adult services has increased since 2010, with all measures rising from 2013 to 2014
- Satisfaction with services for children has shown an almost uninterrupted rise since 2011 across all measures

PHPG - SoonerCare Choice Evaluation

Satisfaction with Care for Adults*

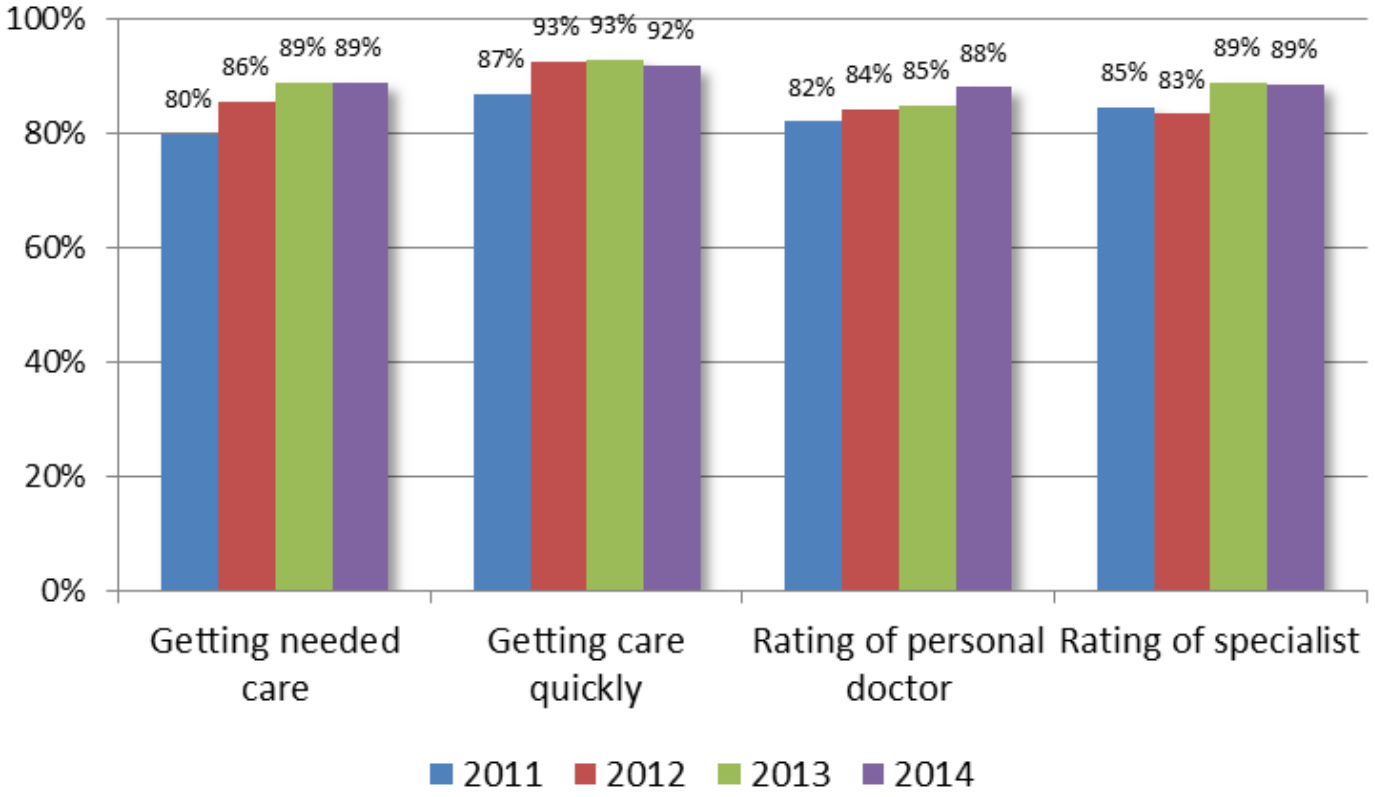


*Note: Percent rating 8, 9 or 10 on a 10-point satisfaction scale; "Getting care quickly" is a composite measure based on questions regarding satisfaction with obtaining needed care, both urgent and non-urgent

**Increase in Rating of Personal Doctor from 2013 to 2014 was statistically significant

Sources: CAHPS Health Plan Survey Adult Version – Telligen through 2012; Morpace for 2013 - 2014 (surveys are conducted from July to December of year preceding reporting year)

Satisfaction with Care for Children*



*Note: Percent rating 8, 9 or 10 on a 10-point satisfaction scale

Sources: CAHPS Health Plan Survey Child Version – Telligen through 2012; Morpace for 2013 - 2014 (surveys are conducted from July to December of year preceding reporting year)

THURSDAY: SESSION 9

Interactive Planning Session

Impacts of Care Coordination on Health Outcomes

THURSDAY: SESSION 9

Impacts of Care Coordination on Health Outcomes

Facilitator:

- Marlene Asmussen, Director, Population Care Management, OHCA

THURSDAY: SESSION 9

Subject Matter Experts:

- Carolyn Reconnu-Schoffner, Assistant Director of Population Care Management, OHCA
- Della Gregg, Health Management Program Supervisor, OHCA
- Andy Cohen, President, Pacific Health Policy Group
- Tony Russell, Behavioral Health Specialist, OHCA

SOONERCARE PCM-HMP-CCU INDEPENDENT EVALUATION

THE PACIFIC HEALTH POLICY GROUP
AUGUST 2015

PCM OB/PEDIATRICS EVALUATION

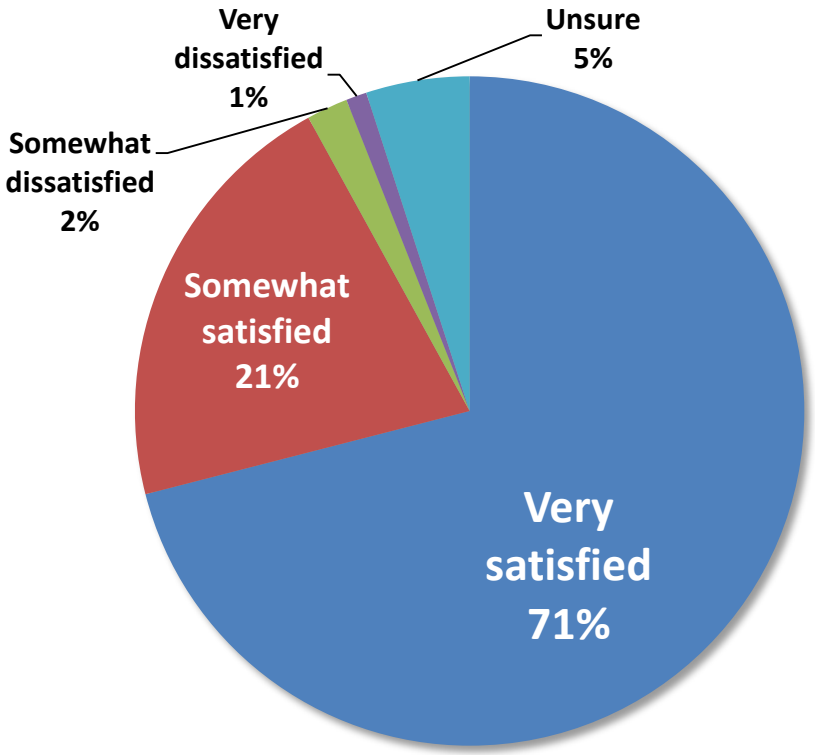
- Programs Evaluated
  - OB Outreach / At-Risk OB Program
  - High risk OB Program
  - Fetal Infant Mortality Reduction (FIMR) Mom Program
  - At-Risk Newborn Program
  - Private Duty Nursing
  - Inter-conception Care (ICC) Program
  - Pre-natal and Post-partum Depression Screening & Referral
  - Synagis Case Management

PCM OB/PEDIATRICS EVALUATION

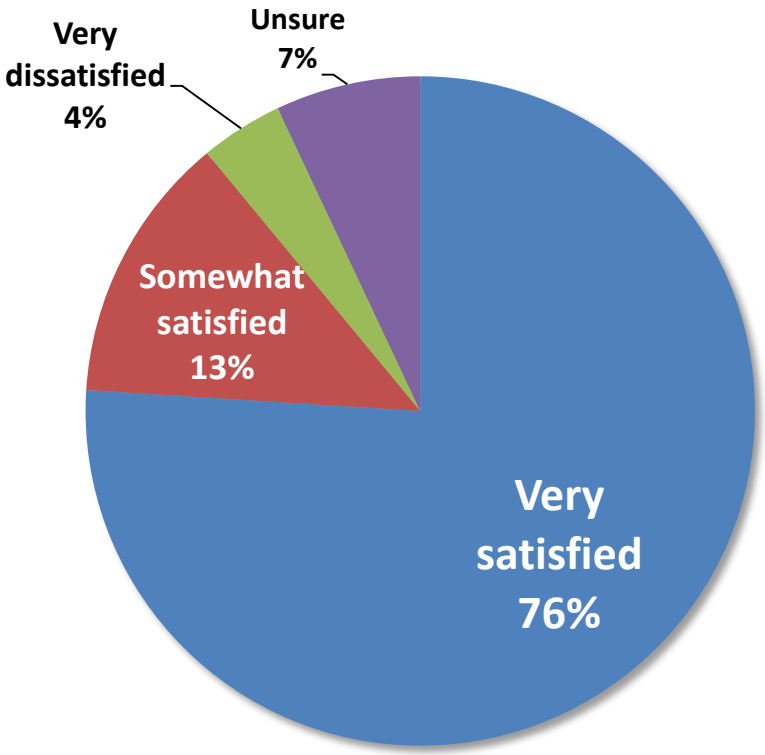
- Evaluation Components
  - PCM process, including:
    - Members enrolled in active case management
    - Outreach/contacts
  - Member Satisfaction
  - Program Outcomes, including:
    - Early gestation/low birthweight rates
    - Hospital readmission and ER visit rates
    - Per member cost trends

PCM OB/PEDIATRICS EVALUATION RESULTS

Member Satisfaction with OB Programs



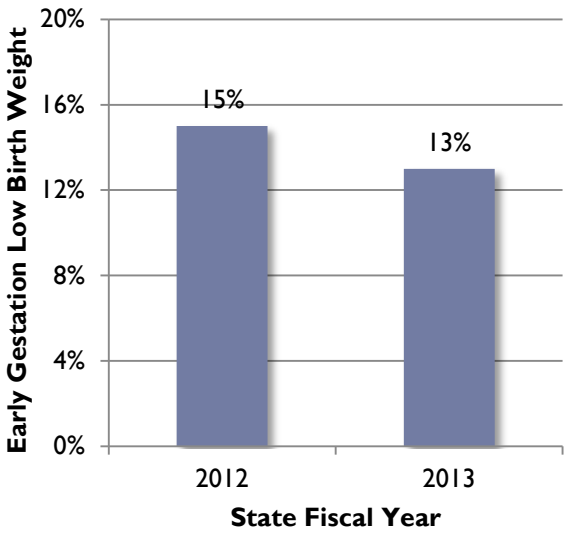
Member Satisfaction with Pediatric Programs



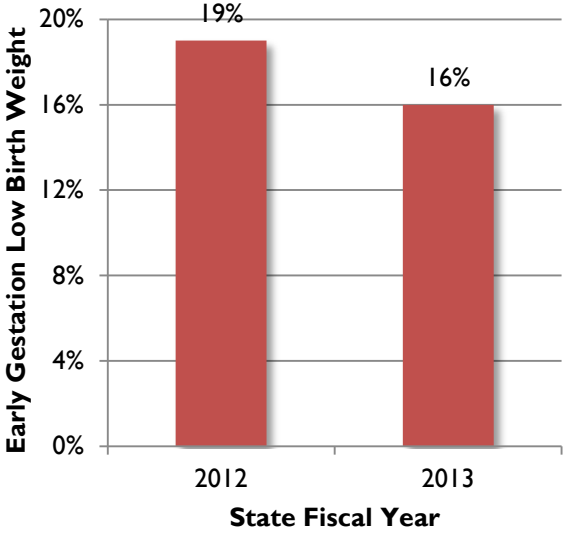
PCM OB/PEDIATRICS EVALUATION RESULTS

*At Risk & High Risk OB Programs – Early Gestation/Low Birth Weight Rates**

At Risk



High Risk

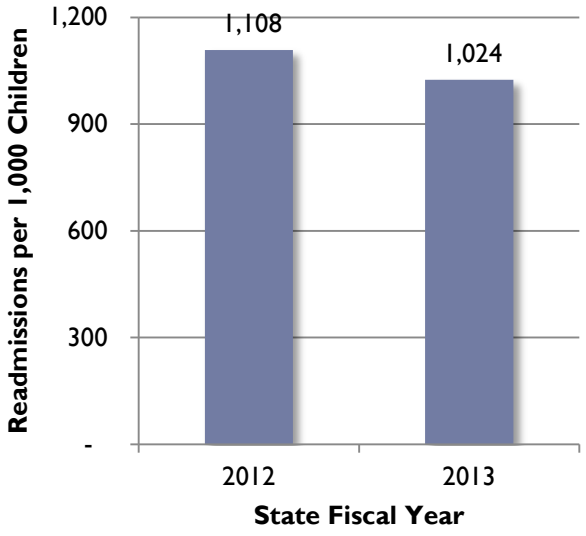


* 2012 – 2013 rates are for SoonerCare members who were enrolled in the At Risk and High Risk OB Programs. AROB LBW rate fell by 13.3 percent; HROB LBW rate fell by 15.8 percent.

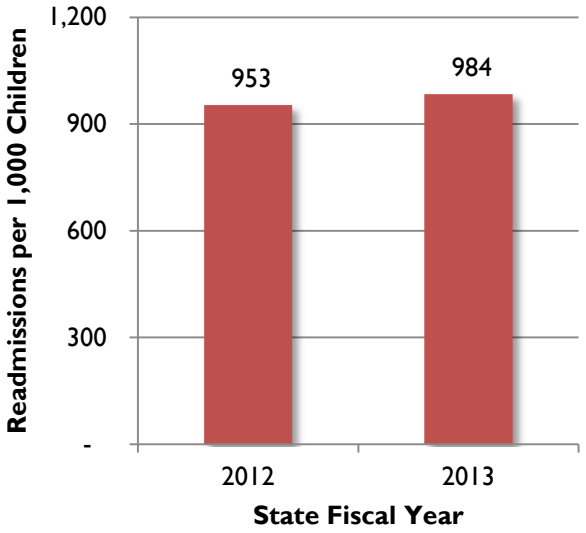
PCM OB/PEDIATRICS EVALUATION RESULTS

*At Risk & High Risk OB Programs – Newborn Readmission Rates**

At Risk



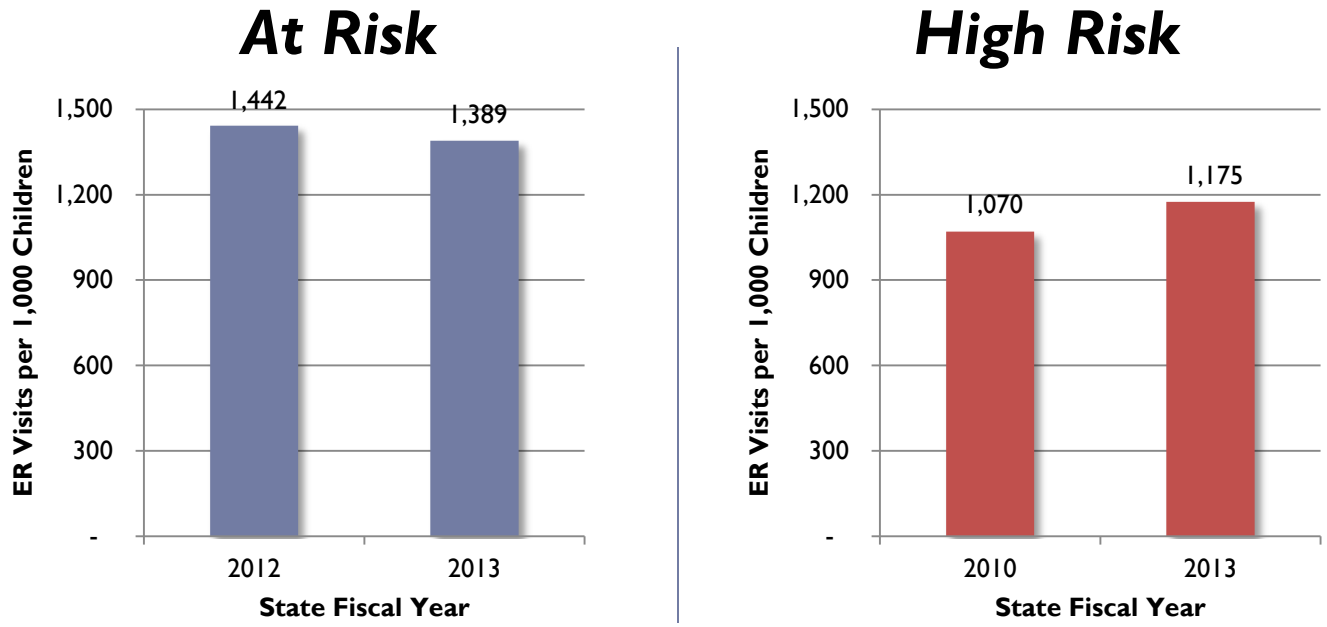
High Risk



* 2012 – 2013 rates are for SoonerCare members who were enrolled in the At Risk and High Risk OB Programs. AROB readmission rate fell by 7.6 percent; HROB readmission rate increased by 3.3 percent.

PCM OB/PEDIATRICS EVALUATION RESULTS

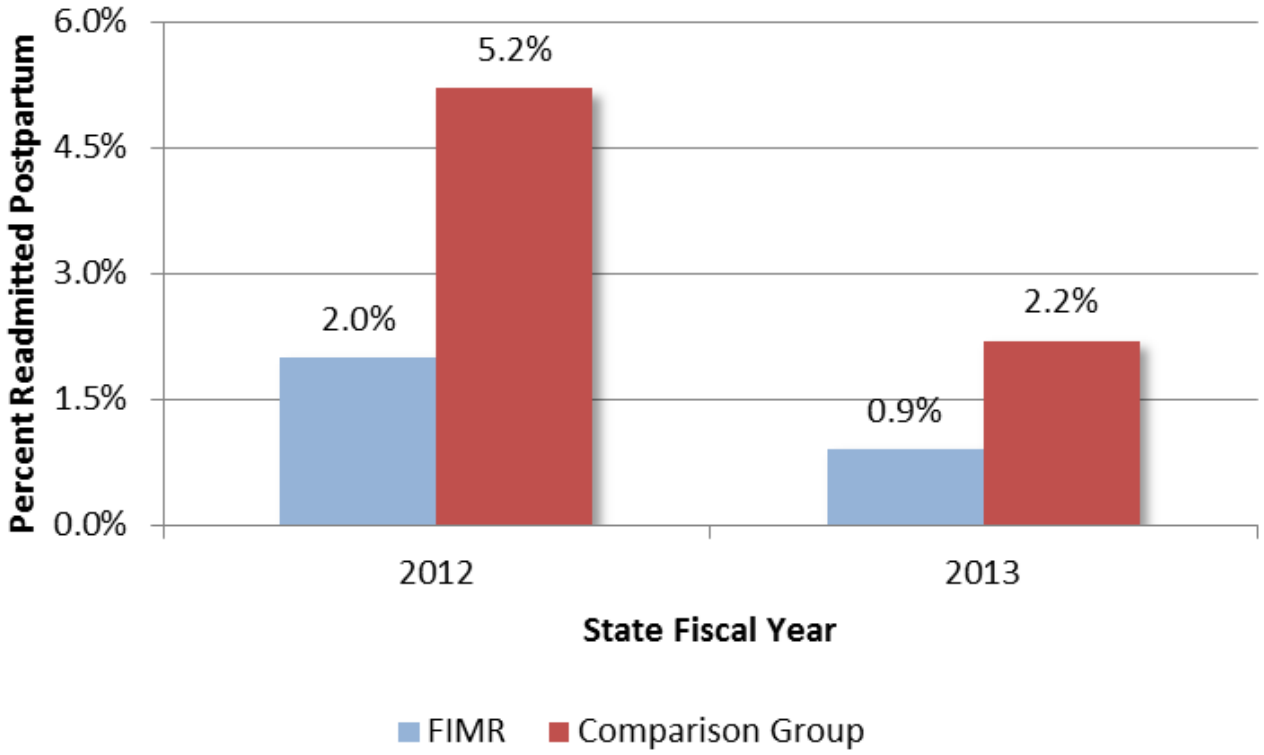
*At Risk and High Risk OB Programs – ER Visit Rates**



* 2012 – 2013 rates are for SoonerCare members who were enrolled in the At Risk and High Risk OB Programs. AROB ER visit rate fell by 3.7 percent; HROB ER visit rate increased by 9.8 percent.

PCM OB/PEDIATRICS EVALUATION RESULTS

*FIMR Mom Program – 30-Day Readmission Rate versus Comparison Group**



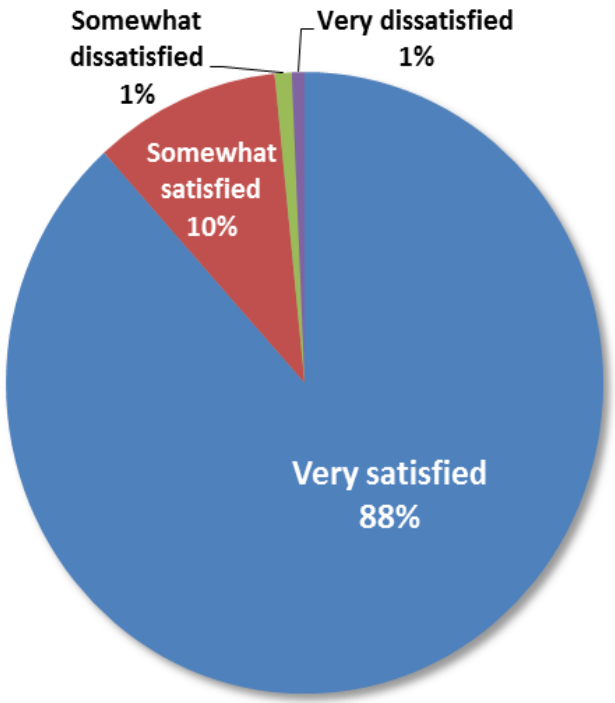
* 2012 – 2013 FIMR rates are for SoonerCare members who were enrolled in the FIMR Mom Program. Comparison group data taken from 10 non-FIMR counties with similar infant mortality rates to the FIMR counties.

HMP-CCU EVALUATION

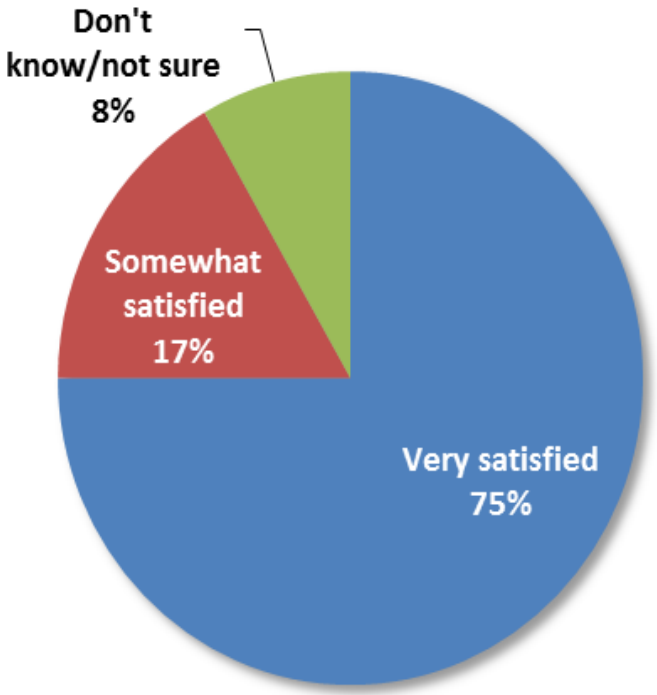
- Programs Evaluated
  - SoonerCare HMP (second generation)
  - SoonerCare CCU
- Evaluation Components
  - Participant satisfaction and self-reported health status
  - Quality of care
  - Utilization impact (inpatient and ER)
  - Cost effectiveness

HMP-CCU EVALUATION RESULTS

HMP/CCU Member Satisfaction

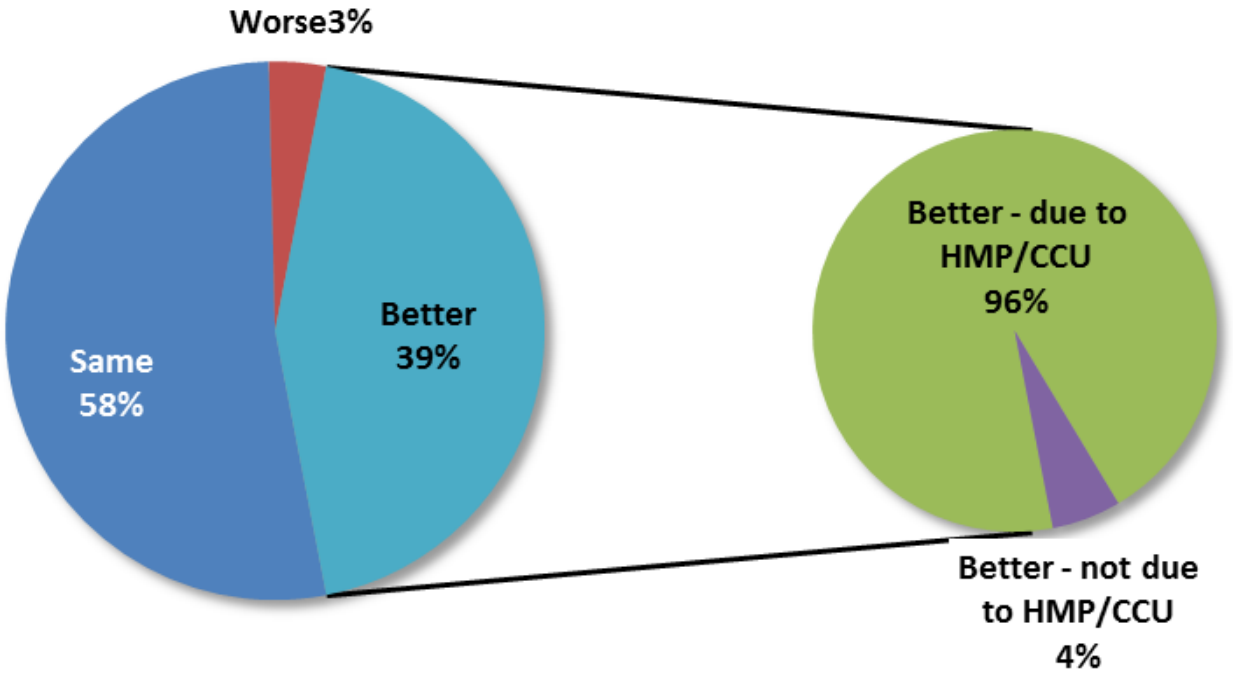


HMP Provider Satisfaction



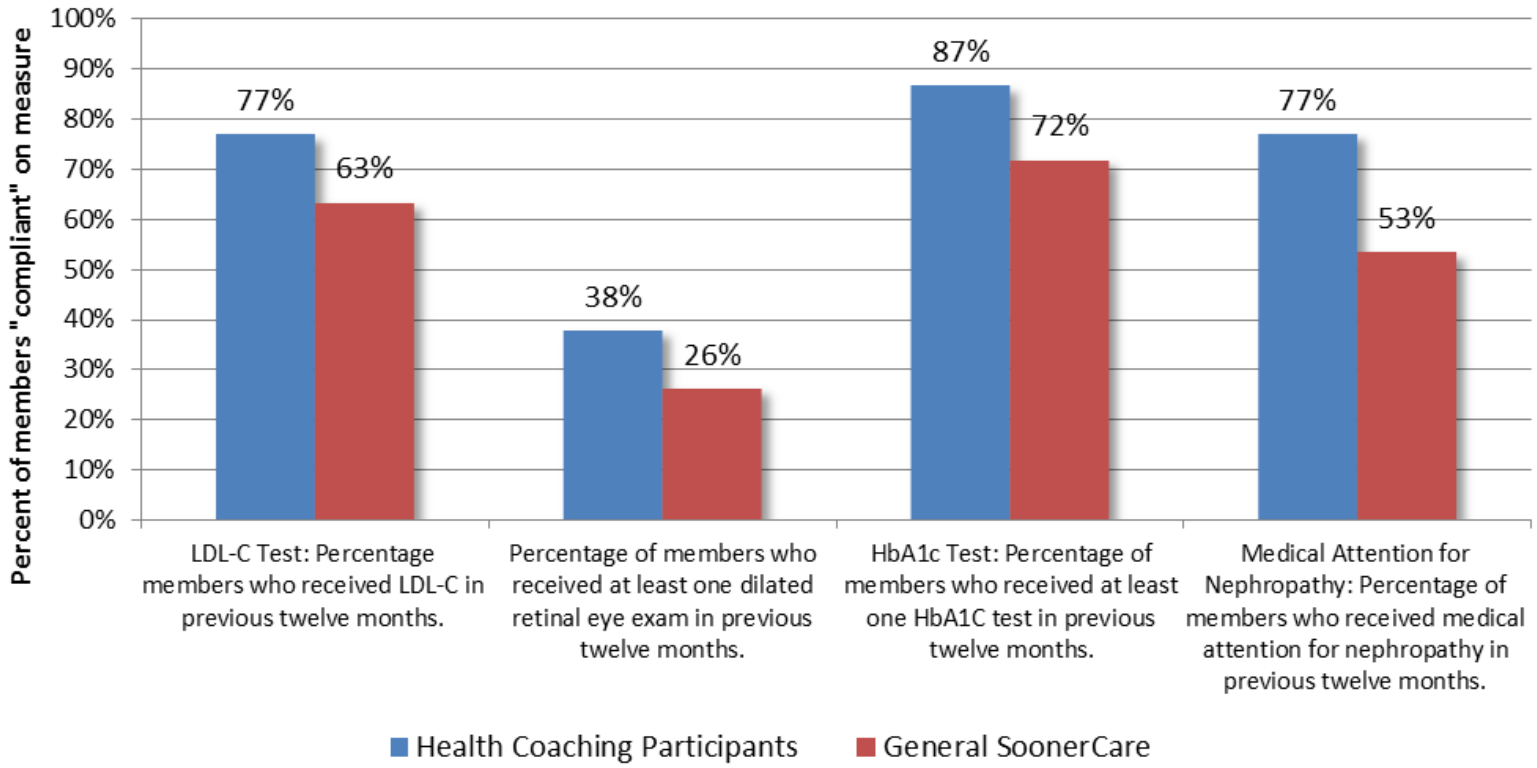
HMP-CCU EVALUATION RESULTS

Health Status since Enrollment (Self-Reported)



HMP-CCU EVALUATION RESULTS

*Quality of Diabetes Care – HMP**

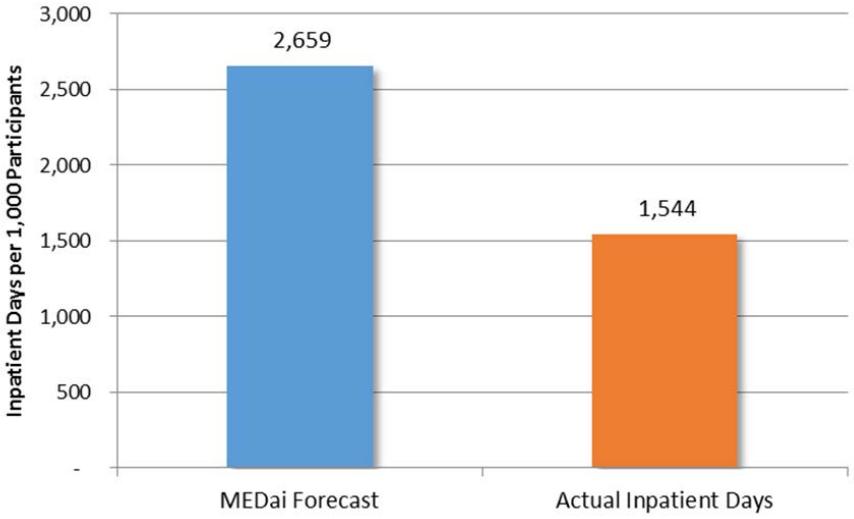


* The difference between SoonerCare HMP Health Coaching participants and general SoonerCare population was statistically significant for all four measures (at 95% confidence level). CCU results were similar to HMP but due to smaller sample size only Nephropathy measure was statistically significant.

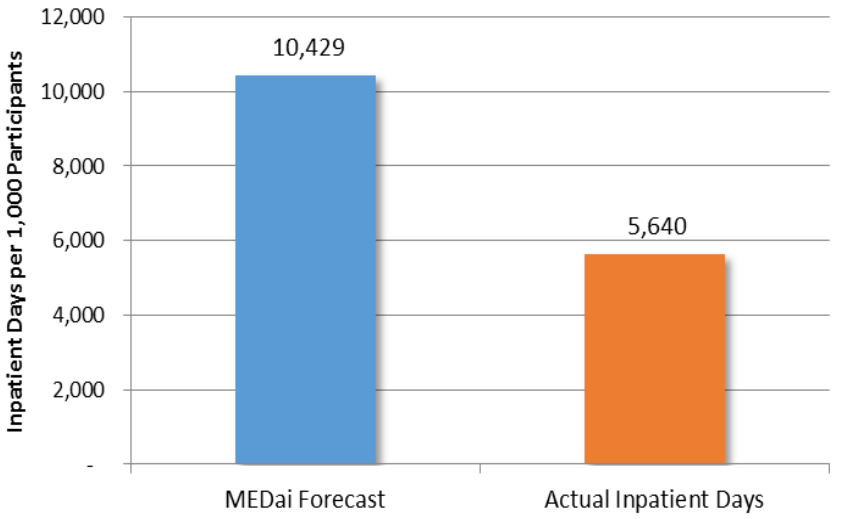
HMP-CCU EVALUATION RESULTS

*Inpatient Days – All Participants**

HMP – Health Coaching



CCU

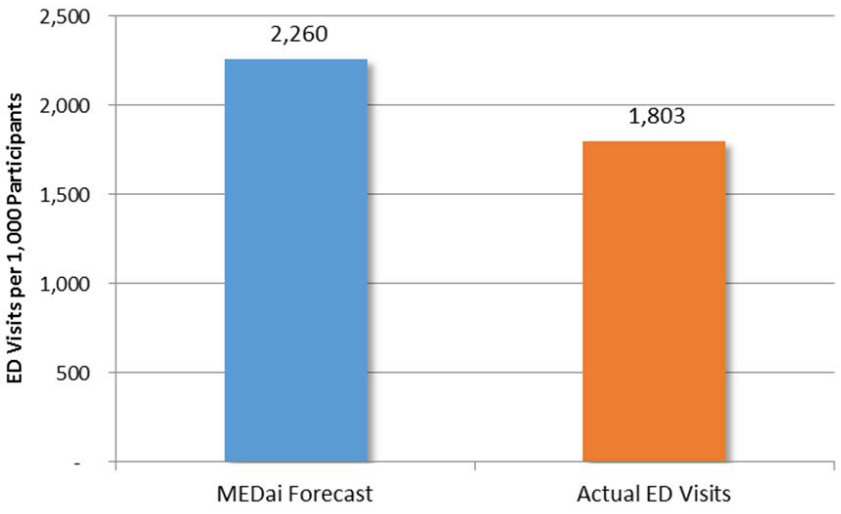


*MEDai 12-month forecast versus actual, per 1,000 participants (rate for all Oklahomans is 577 per 1,000).

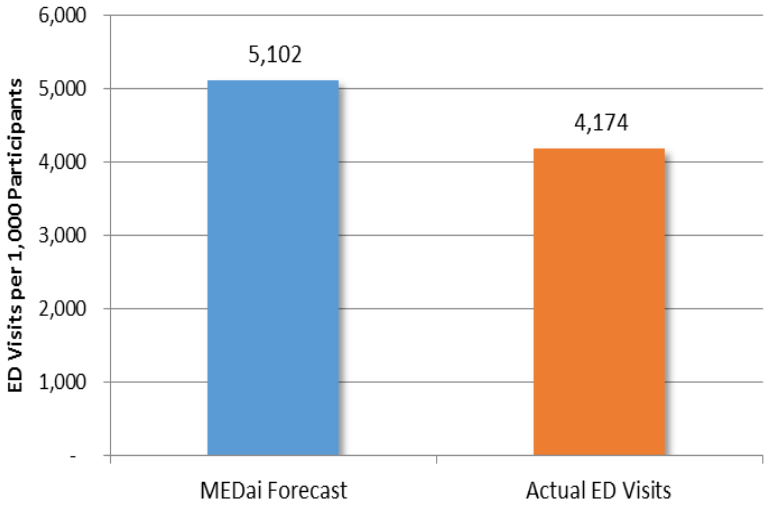
HMP-CCU EVALUATION RESULTS

*ER Visits – All Participants**

HMP – Health Coaching



CCU

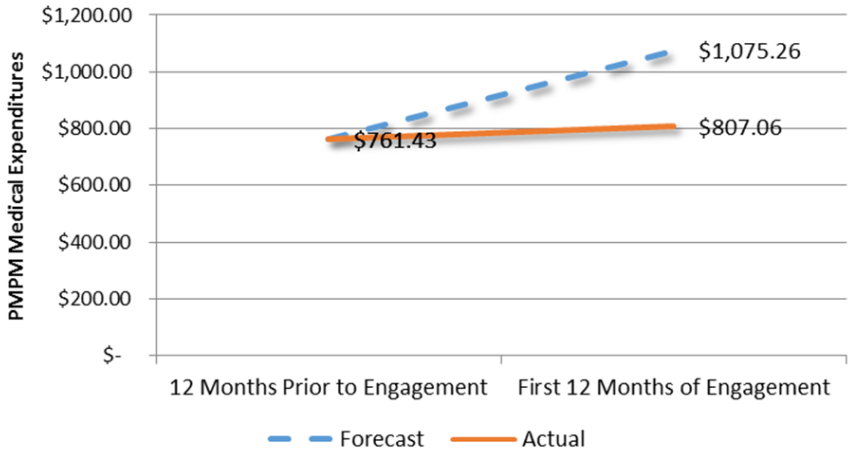


*MEDai 12-month forecast versus actual, per 1,000 participants (rate for all Oklahomans is 486 per 1,000).

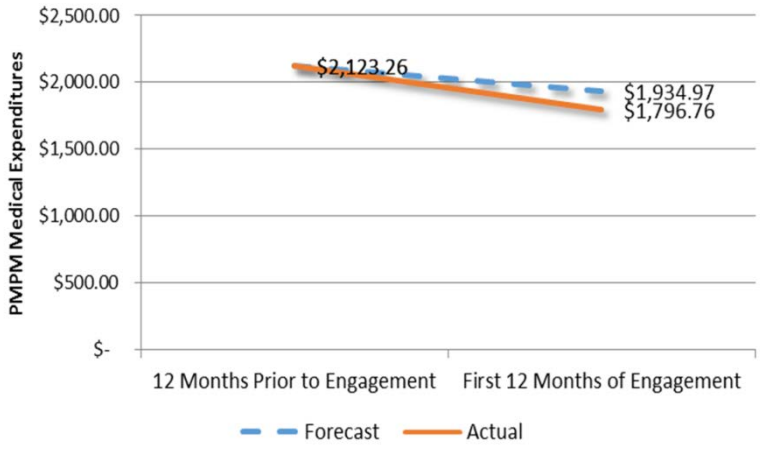
HMP-CCU EVALUATION RESULTS

Per Member Per Month Cost – All Participants

HMP – Health Coaching



CCU



HMP-CCU EVALUATION RESULTS

HMP-CCU Net SFY 2014 Savings

Program	Medical Savings	Administrative Costs	Net Results	Return-on-Investment
HMP*	$23,690,330	($7,741,729)	$15,948,601	206.0%
CCU**	$409,654	($747,373)	($337,718)	(45.2%)
TOTAL	**$24,099,984**	**($8,489,102)**	**$15,610,883**	**183.9%**

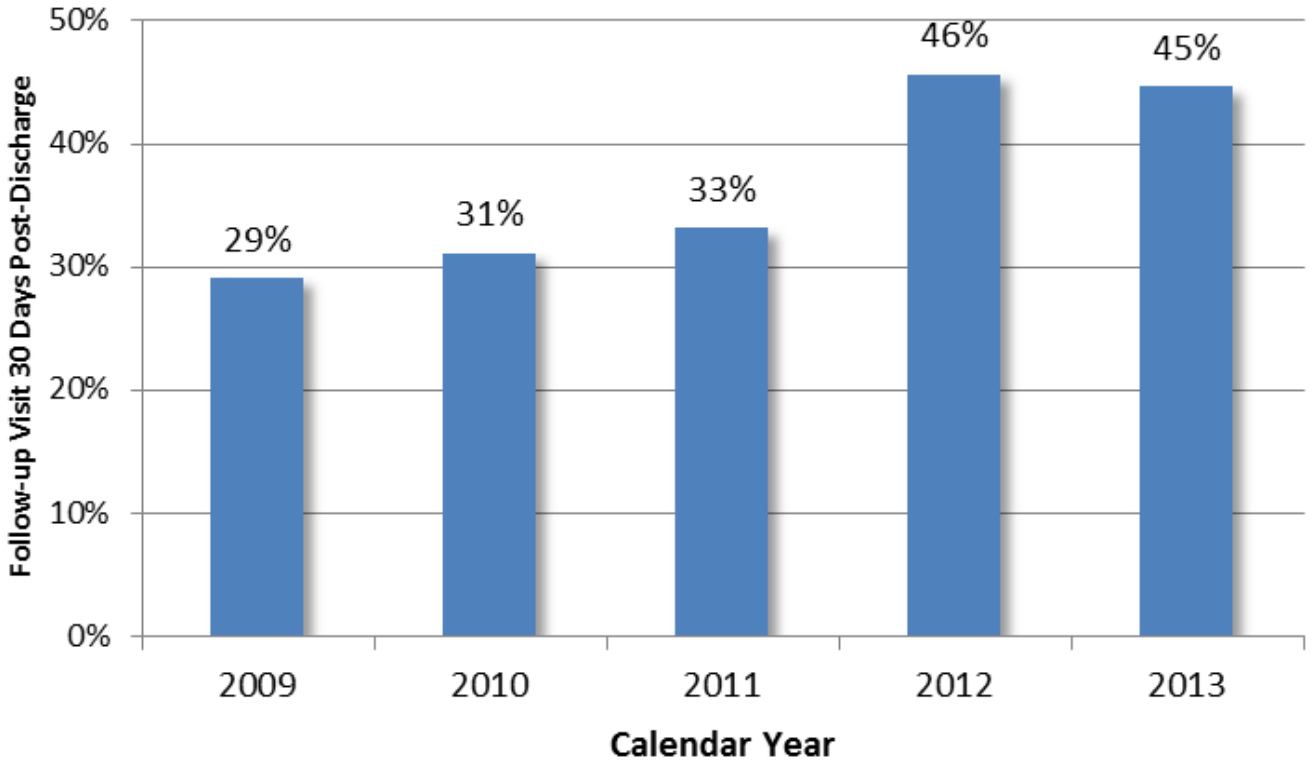
*Combined results for Health Coaching and Practice Facilitation.
**CCU trend line suggests that net savings are likely to have been achieved in SFY 2015.

PCM BEHAVIORAL HEALTH EVALUATION

- Areas Evaluated
  - Follow-up visits with behavioral health provider post-discharge
  - Inpatient readmission rates (hospitals and residential treatment facilities)

BEHAVIORAL HEALTH EVALUATION RESULTS

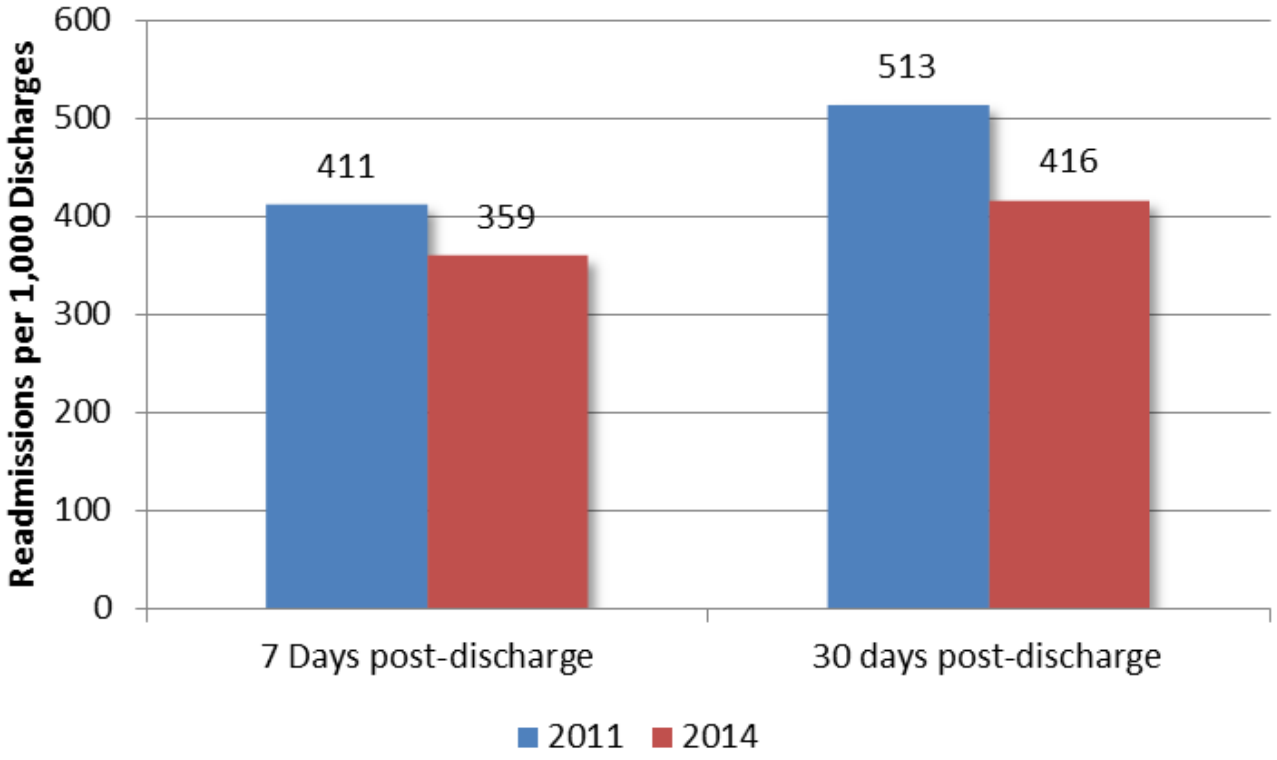
*Follow-up Visit w/BH Provider – 30 Days Post-Discharge**



* 2009 – 2011 rates are for SoonerCare Choice. 2012 - 2013 rates are for all SoonerCare. 2013 Rate for members under age 21 was 48%. 2013 National Medicaid MCO rate for members under 21 was 61%.

BEHAVIORAL HEALTH EVALUATION RESULTS

*Readmission Rates for Members under Age 21**



* Actual re-admissions in SFY 2014 equaled 6,273. ER visit rates were up slightly over the same period but totaled only 157 visits in SFY 2014.

THURSDAY: SESSION 10

Interactive Planning Session

Prescription Drug Abuse

THURSDAY: SESSION 10

Prescription Drug Abuse

Facilitator:

- Burl Beasley, Pharmacist, OHCA

THURSDAY: SESSION 10

Prescription Drug Abuse

Subject Matter Experts:

- Mike Herndon, Medical Director, OHCA Medicaid Operations
- Nancy Nesser, Director, Pharmacy Operations, OHCA
- Jessica Hawkins, Director of Prevention, OKDMHSAS
- Sheryll Brown, Injury Prevention Services, OSDH
- Ashley Teel, Lock-in Program Administrator, PMC

AGENDA

Introductions

Presentation

- State of Rx Drug Abuse in Oklahoma

Panel Discussion

Action Items - Next Steps

Questions – Open discussion

PANELISTS

Mike Herndon, D.O., Medical Director, OHCA Medicaid Operations

Nancy Nesser, Pharm.D, J.D. Director Pharmacy Operations OHCA

Jessica Hawkins, Director of Prevention Services, OK Dept. of Mental Health & Substance Abuse Services

Sheryll Brown, M.P.H., Director, Injury Prevention Services, OK State Dept. of Health.

Claire Nguyen, Injury Prevention Services, OK State Dept. of Health

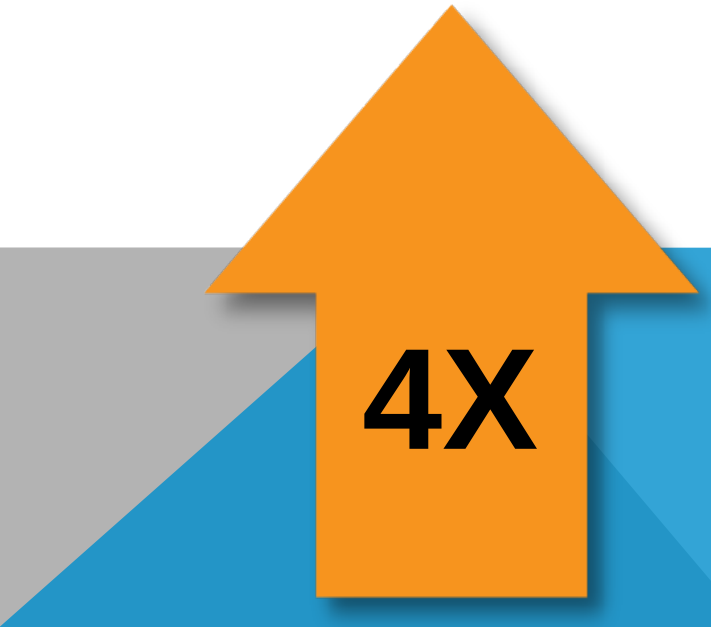
Teel, Ashley J Pharm.D, Lock-in program administrator, Pharmacy Management Consultants

Facilitator

Burl Beasley, BS Pharm, MPH, MS Pharm, Pharmacist OHCA

PRESCRIPTION DRUG ABUSE IS A PUBLIC HEALTH EPIDEMIC

Prescription opioids are potentially dangerous drugs – overdoses have claimed more than 145,000 lives over the past decade



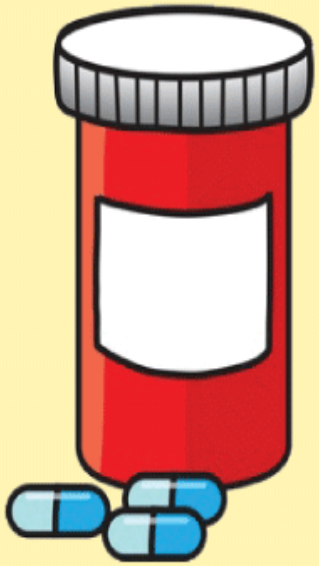
The more than 4-fold increase in opioid overdose deaths parallels the 4-fold increase in sales since 1999

US opioid prescribing in 2012

259M

259M prescriptions

18B



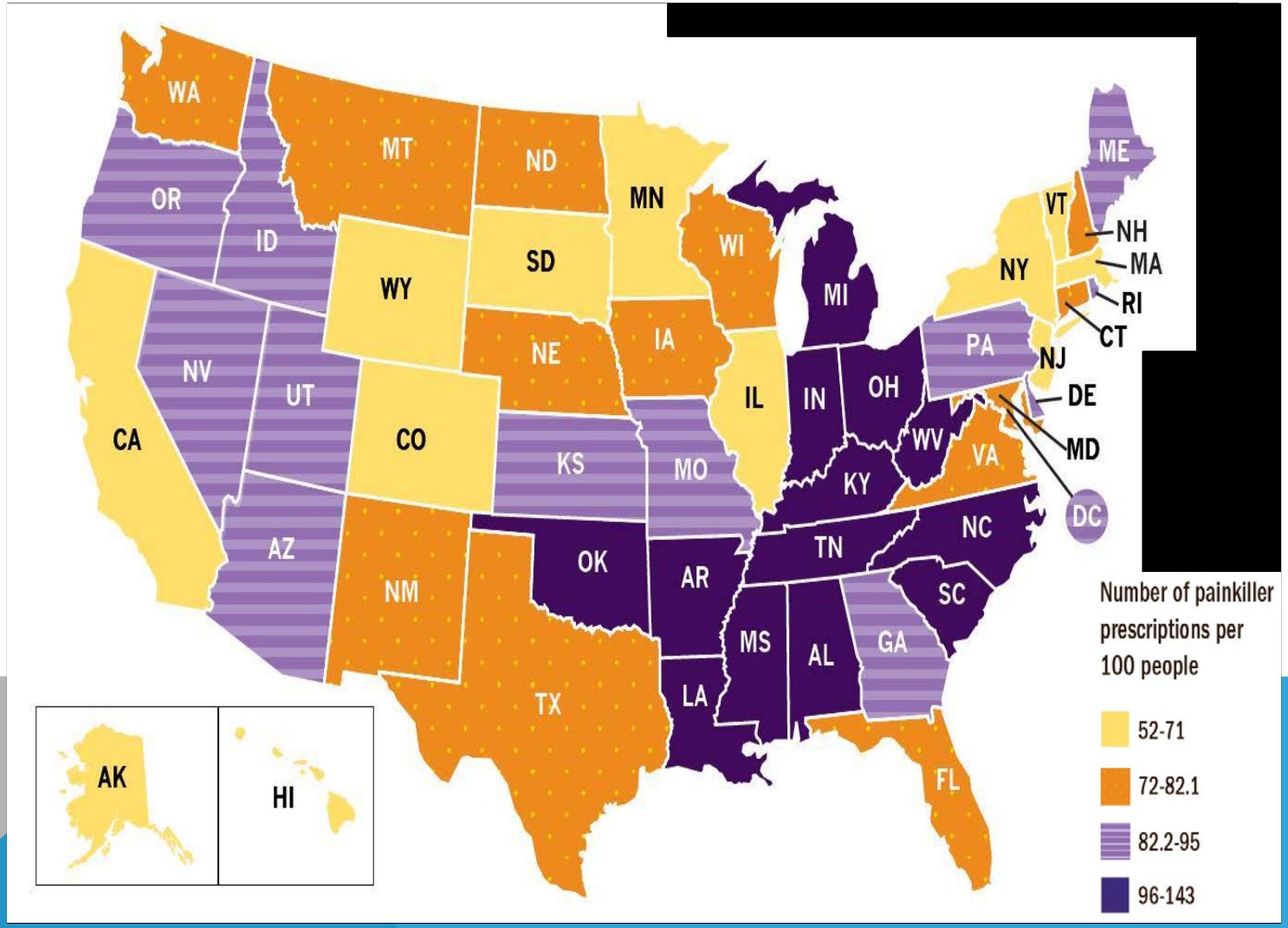
18 billion opioid pills

75

Enough pills to give every American 18 years or older 75 opioid pills in 2012

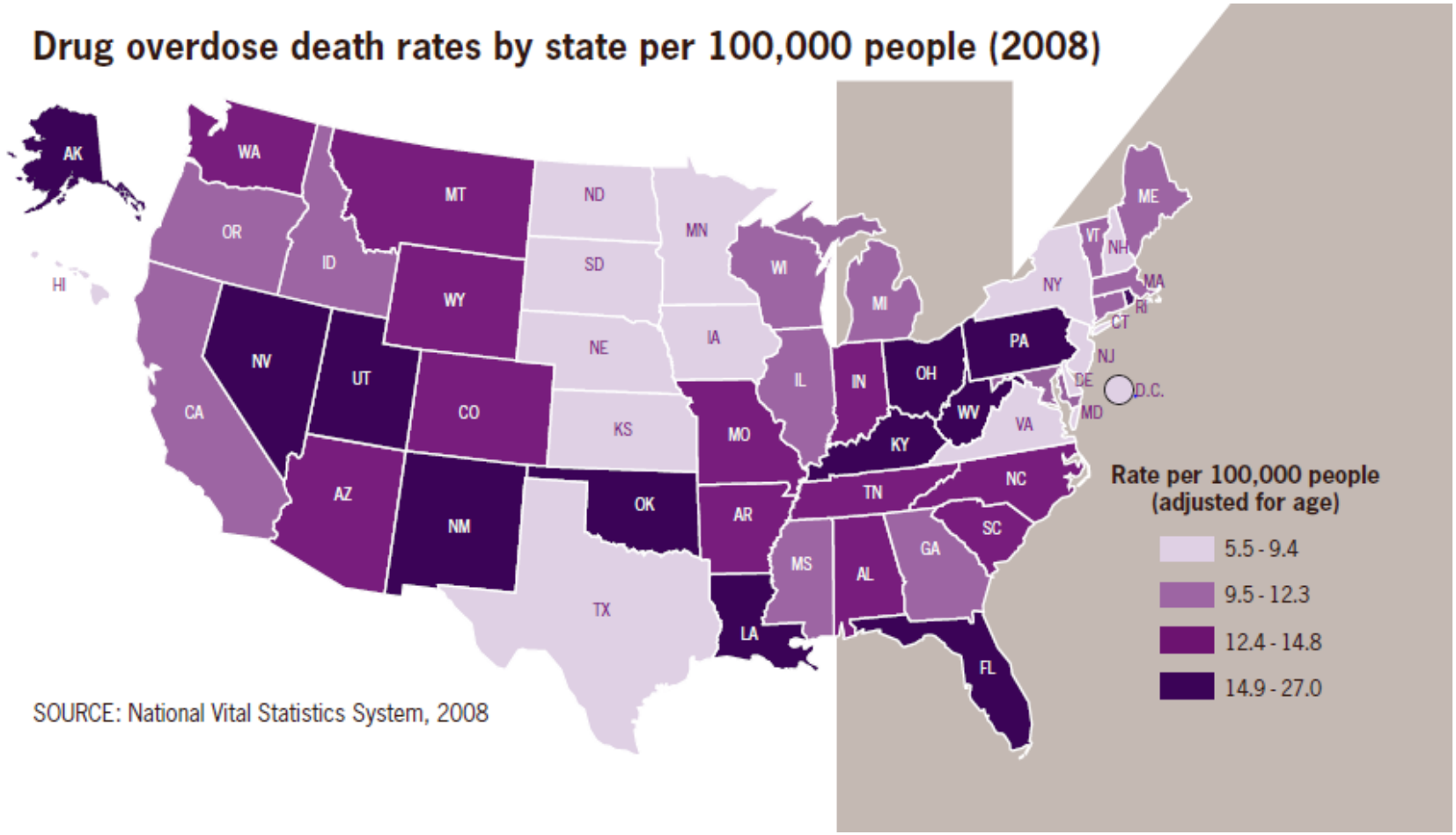
IMS Health, National Prescription Audit, 2012.

OPIOID PRESCRIBING RATES ARE 3X HIGHER IN OKLAHOMA THAN OTHER STATES



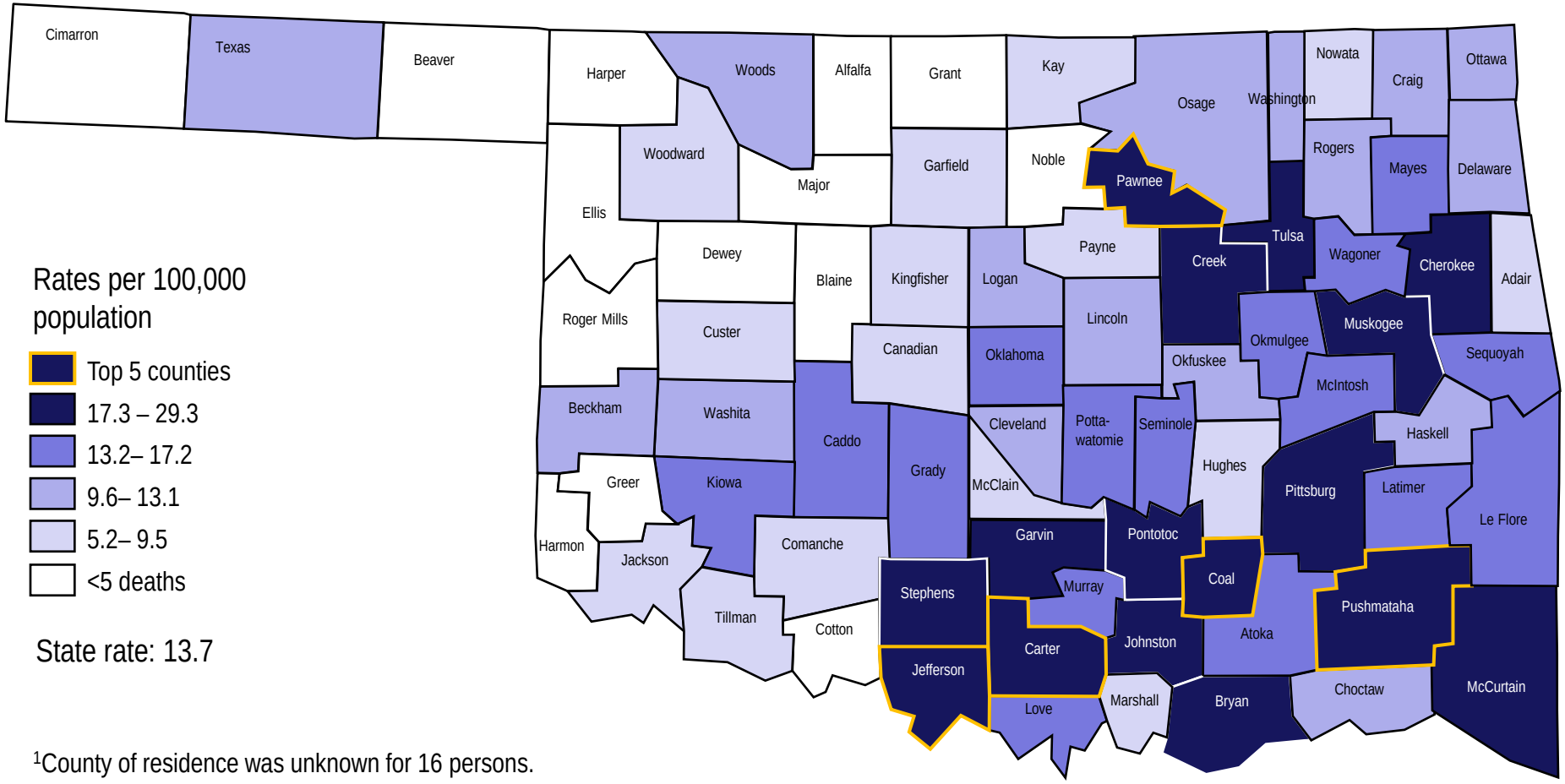
MMWR Vital Signs, July 2014. Source: IMS, National Prescription Audit (NPATM), 2012.

PAINKILLER BACKGROUND - OKLAHOMA



Oklahoma HealthCare Authority

Unintentional Prescription Drug Overdose Death Rates by County of Residence[1], Oklahoma, 2007-2013



Rates per 100,000 population

- Top 5 counties
- 17.3 – 29.3
- 13.2– 17.2
- 9.6– 13.1
- 5.2– 9.5
- <5 deaths

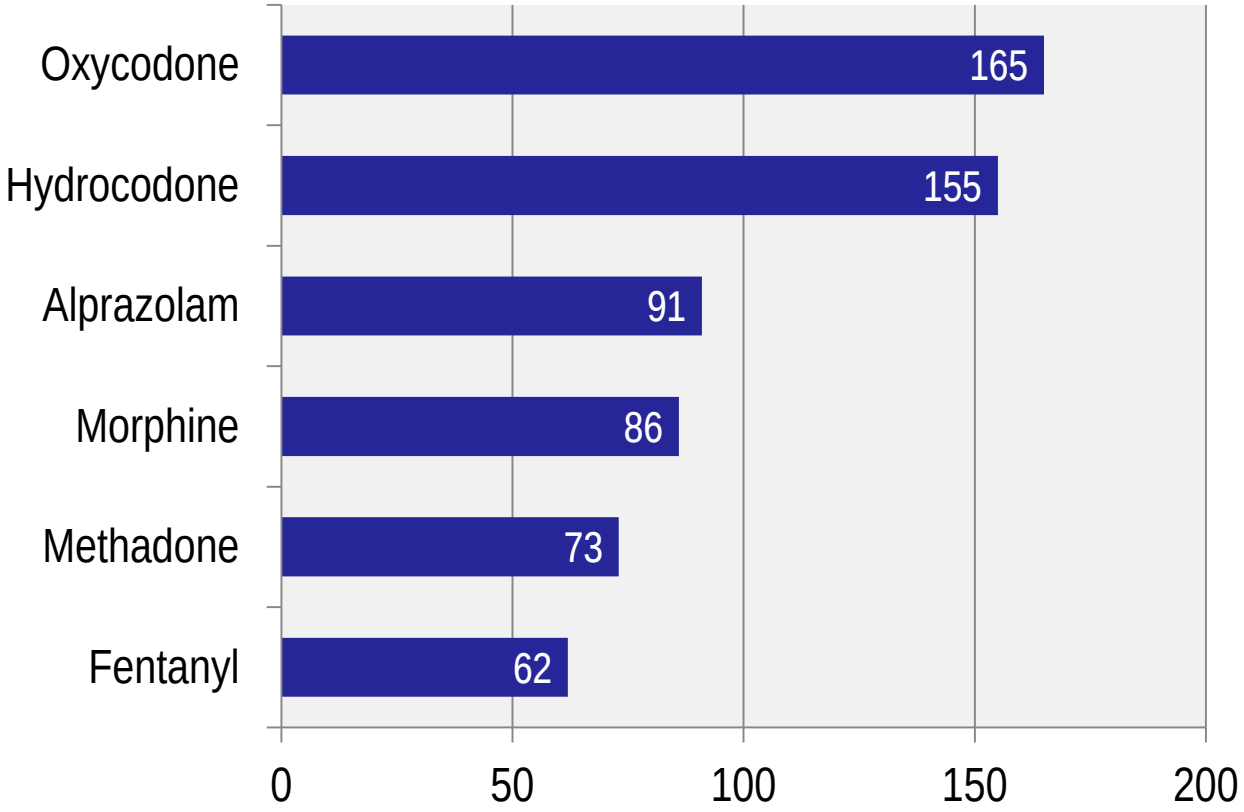
State rate: 13.7

[1]County of residence was unknown for 16 persons.

Source: OSDH, Injury Prevention Service, Unintentional Poisonings Database
(Abstracted from Medical Examiner reports)

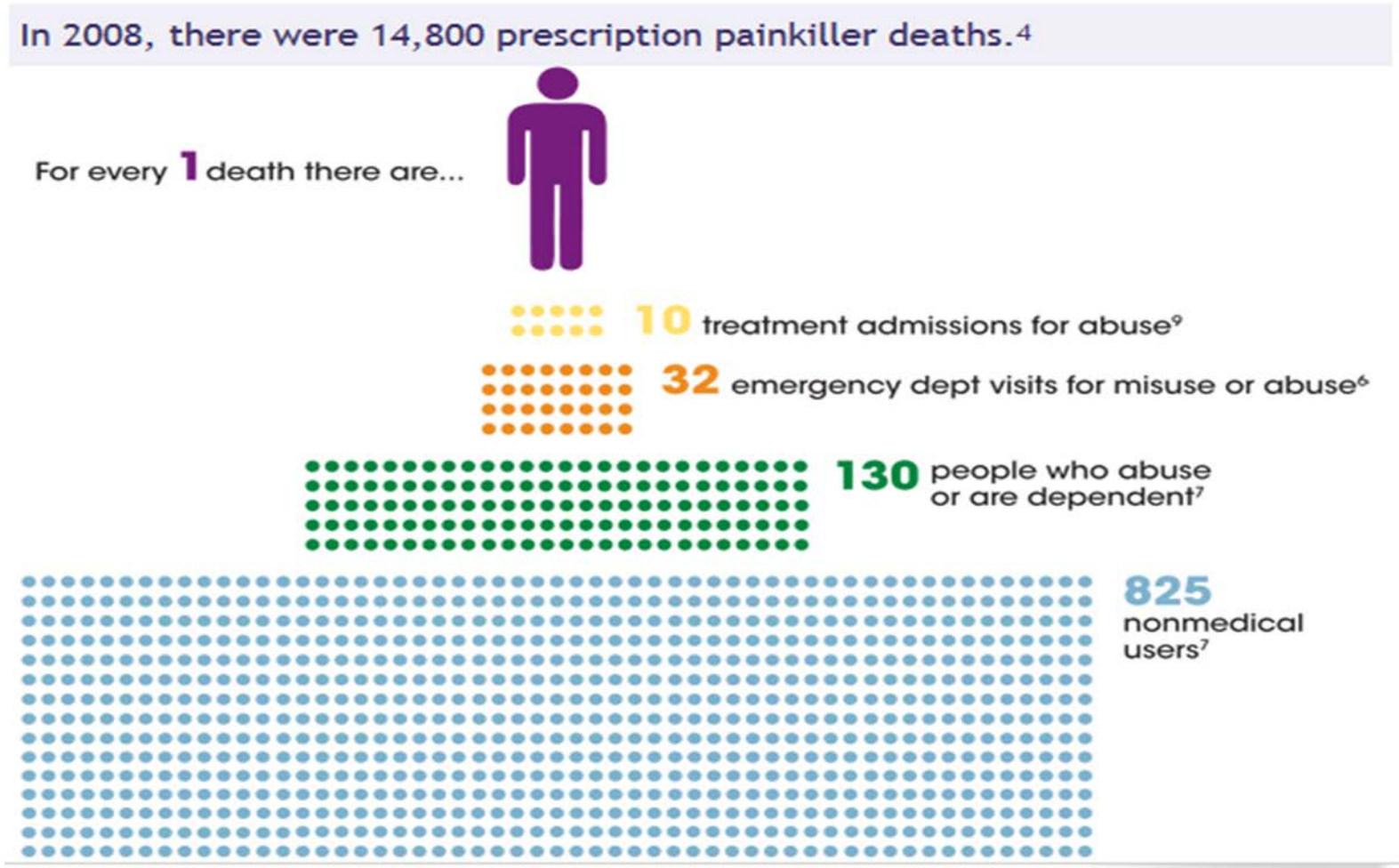
Injury Prevention Service
Oklahoma State Department of Health

Most Common Prescription Drugs in Unintentional PDO Deaths, Oklahoma, 2013



Source: OSDH, Injury Prevention Service, Unintentional Poisonings Database
(Abstracted from Medical Examiner reports)

Injury Prevention Service
Oklahoma State Department of Health



Source:
http://www.cdc.gov/homeandrecreationalsafety/rxbrief/

Oklahoma HealthCare Authority

Table C. Deaths and percentage of total deaths for the 10 leading causes of death: United States, 2009–2010

[An asterisk (*) preceding a cause-of-death code indicates that the code is not included in the *International Classification of Diseases, Tenth Revision* (ICD–10), Second Edition; see Technical Notes]

Cause of death (based on ICD–10, 2004)	Rank[1]	2010		2009	
		Deaths	Percent of total deaths	Deaths	Percent of total deaths
All causes	...	2,468,435	100.0	2,437,163	100.0
Diseases of heart (I00–I09,I11,I13,I20–I51)	1	597,689	24.2	599,413	24.6
Malignant neoplasms (C00–C97)	2	574,743	23.3	567,628	23.3
Chronic lower respiratory diseases (J40–J47)	3	138,080	5.6	137,353	5.6
Cerebrovascular diseases (I60–I69)	4	129,476	5.2	128,842	5.3
Accidents (unintentional injuries) (V01–X59,Y85–Y86)	5	120,859	4.9	118,021	4.8
Alzheimer's disease (G30)	6	83,494	3.4	79,003	3.2
Diabetes mellitus (E10–E14)	7	69,071	2.8	68,705	2.8
Nephritis, nephrotic syndrome and nephrosis (N00–N07,N17–N19,N25–N27)	8	50,476	2.0	48,935	2.0
Influenza and pneumonia (J09–J18)	9	50,097	2.0	53,692	2.2
Intentional self-harm (suicide) (*U03,X60–X84,Y87.0)	10	38,364	1.6	36,909	1.5

... Category not applicable.

[1]Based on number of deaths.

http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_06.pdf

Source: National Vital Statistics Reports: Volume 62, No 6. December 20, 2013. Accessed July 7th 2015.

U.S. CAUSE OF DEATH 2010

10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2010

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Unintentional Suffocation 905	Unintentional Drowning 436	Unintentional MV Traffic 354	Unintentional MV Traffic 452	Unintentional MV Traffic 7,024	Unintentional Poisoning 6,767	Unintentional Poisoning 7,476	Unintentional Poisoning 9,662	Unintentional Poisoning 4,451	Unintentional Fall 21,649	Unintentional MV Traffic 33,687
2	Homicide Unspecified 154	Unintentional MV Traffic 343	Unintentional Drowning 134	Suicide Suffocation 168	Homicide Firearm 3,889	Unintentional MV Traffic 5,558	Unintentional MV Traffic 4,552	Unintentional MV Traffic 5,154	Unintentional MV Traffic 4,134	Unintentional MV Traffic 6,037	Unintentional Poisoning 33,041
3	Homicide Other Spec., classifiable 82	Homicide Unspecified 163	Unintentional Fire/Burn 89	Unintentional Drowning 117	Unintentional Poisoning 3,183	Homicide Firearm 3,331	Suicide Firearm 2,914	Suicide Firearm 4,092	Suicide Firearm 3,387	Unintentional Unspecified 4,596	Unintentional Fall 26,009
4	Unintentional MV Traffic 76	Unintentional Fire/Burn 151	Homicide Firearm 58	Homicide Firearm 107	Suicide Firearm 2,046	Suicide Firearm 2,594	Suicide Suffocation 1,839	Suicide Poisoning 2,061	Unintentional Fall 2,011	Suicide Firearm 4,276	Suicide Firearm 19,392
5	Undetermined Suffocation 39	Unintentional Suffocation 134	Unintentional Suffocation 31	Suicide Firearm 80	Suicide Suffocation 1,824	Suicide Suffocation 1,910	Homicide Firearm 1,673	Suicide Suffocation 1,965	Suicide Poisoning 1,382	Unintentional Suffocation 3,400	Homicide Firearm 11,078
6	Unintentional Drowning	Unintentional Pedestrian, Other	Unintentional Other Land Transport	Unintentional Suffocation	Unintentional Drowning	Suicide Poisoning	Suicide Poisoning	Unintentional Fall	Suicide Suffocation	Adverse Effects	Suicide Suffocation

http://www.cdc.gov/injury/wisqars/pdf/10lcid_unintentional_deaths_2010-a.pdf Source: 10 leading causes of death by age group 2010

Leading Causes of Death by Age Group, Oklahoma, 2013

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 76	**Unintentional Injury 43**	**Unintentional Injury 28**	**Unintentional Injury 14**	**Unintentional Injury 216**	**Unintentional Injury 271**	**Unintentional Injury 305**	Heart Disease 712	Malignant Neoplasms 1,632	Heart Disease 7,267	Heart Disease 9,721
2	Short Gestation 65	Congenital Anomalies 10	Malignant Neoplasms ---	**Suicide ---**	**Suicide 80**	**Suicide 121**	Heart Disease 224	Malignant Neoplasms 646	Heart Disease 1,448	Malignant Neoplasms 5,509	Malignant Neoplasms 8,039
3	SIDS 30	**Homicide ---**	Chronic Low. Respiratory Disease ---	Congenital Anomalies ---	**Homicide 63**	**Homicide 61**	Malignant Neoplasms 168	**Unintentional Injury 409**	**Unintentional Injury 379**	Chronic Low. Respiratory Disease 2,194	Chronic Low. Respiratory Disease 2,680
4	Maternal Pregnancy Comp. 22	Malignant Neoplasms ---	Congenital Anomalies ---	Malignant Neoplasms ---	Malignant Neoplasms 21	Malignant Neoplasms 48	**Suicide 104**	Liver Disease 163	Chronic Low. Respiratory Disease 354	Cerebro-vascular 1,570	**Unintentional Injury ---**
5	Placenta Cord Membranes 11	Cerebro-vascular ---	**Homicide ---**	Heart Disease ---	Heart Disease 14	Heart Disease 45	Liver Disease 51	**Suicide 135**	Diabetes Mellitus 207	Alzheimer's Disease 1,127	Cerebro-vascular 1,880
6	**Unintentional Injury ---**	Heart Disease ---	Heart Disease ---	**Homicide ---**	Complicated Pregnancy ---	Diabetes Mellitus 17	**Homicide 47**	Diabetes Mellitus 107	Cerebro-vascular 197	Diabetes Mellitus 894	Diabetes Mellitus 1,269
7	Circulatory System Disease ---	Influenza & Pneumonia ---	Meningo-coccal Infection ---	Cerebro-vascular ---	Congenital Anomalies ---	Liver Disease 14	Diabetes Mellitus 42	Chronic Low. Respiratory Disease 100	Liver Disease 189	**Unintentional Injury 800**	Alzheimer's Disease 1,145

Source: CDC WISQARS

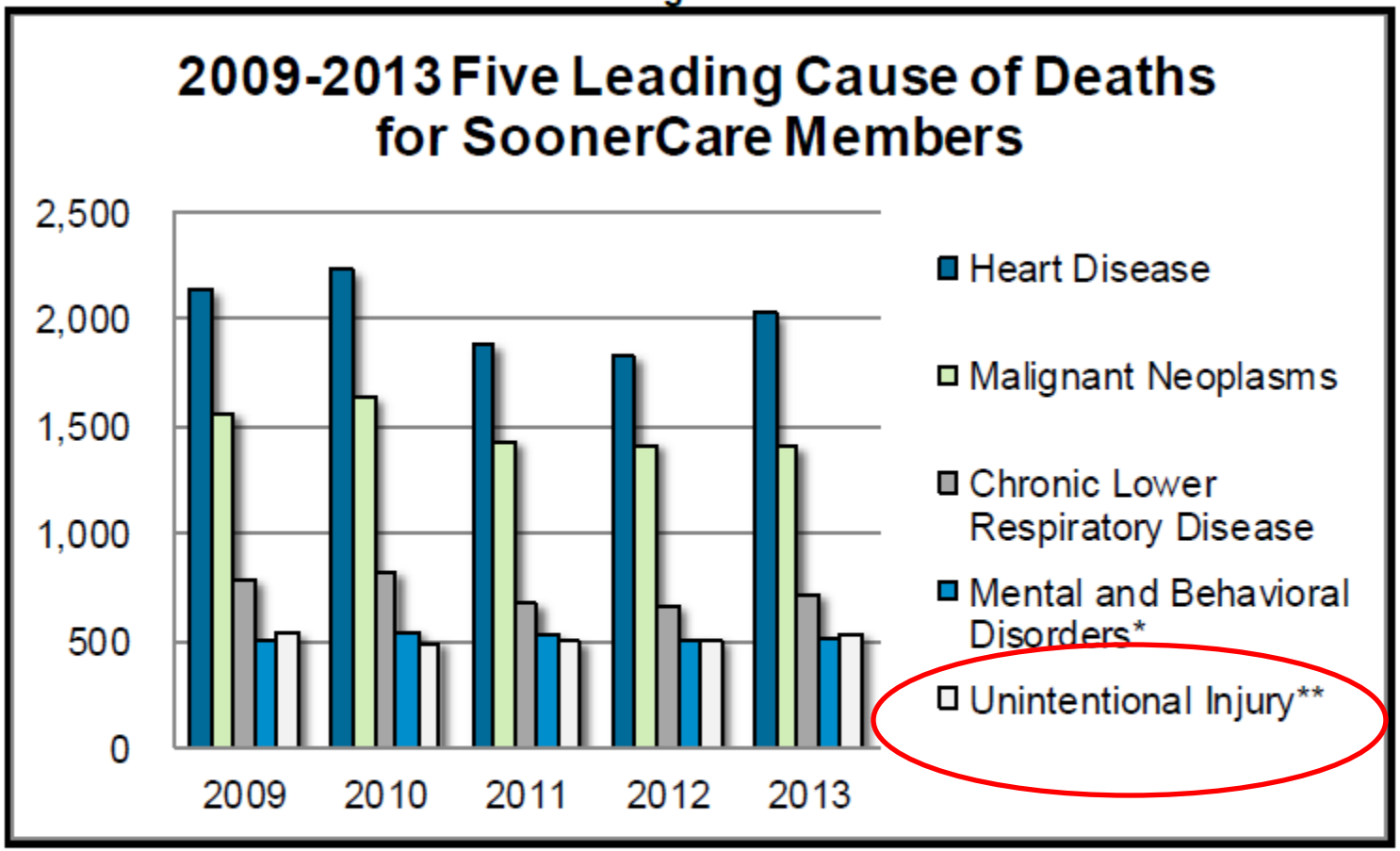
Leading Causes of Injury Death by Age Group, Oklahoma, 2013

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Unintentional Suffocation ---	Unintentional Drowning 14	Unintentional MV Traffic 13	Unintentional MV Traffic ---	Unintentional MV Traffic 118	Unintentional MV Traffic 114	Unintentional Poisoning 150	Unintentional Poisoning 211	Unintentional Poisoning 154	Unintentional Fall 448	Unintentional Poisoning 730
2	Unintentional Natural/ Environment ---	Unintentional MV Traffic 12	Unintentional Natural/ Environment ---	Suicide Firearm ---	Unintentional Poisoning 63	Unintentional Poisoning 110	Unintentional MV Traffic 95	Unintentional MV Traffic 111	Unintentional MV Traffic 112	Unintentional MV Traffic 117	Unintentional MV Traffic 700
3	Homicide Other Spec., classifiable ---	Unintentional Natural/ Environment ---	Unintentional Drowning ---	Unintentional Drowning ---	Homicide Firearm 54	Suicide Firearm 74	Suicide Firearm 57	Suicide Firearm 89	Suicide Firearm 70	Suicide Firearm 88	Unintentional Fall 537
4	Homicide Firearm ---	Unintentional Fire/burn ---	Homicide Fire/burn ---	Suicide Suffocation ---	Suicide Firearm 50	Homicide Firearm 43	Homicide Firearm 35	Homicide Firearm 27	Unintentional Fall 43	Unintentional Unspecified 58	Suicide Firearm 433
5	Homicide Unspecified ---	Unintentional Pedestrian, Other ---	Unintentional Suffocation ---	Seven Tied ---	Suicide Suffocation 25	Suicide Suffocation 33	Suicide Suffocation 33	Unintentional Fall 26	Suicide Poisoning 16	Unintentional Poisoning 39	Homicide Firearm 178
6	Undetermined Poisoning ---	Homicide Other Spec., classifiable ---	Suicide Suffocation ---	Seven Tied ---	Unintentional Drowning 11	Undetermined Poisoning 11	Undetermined Poisoning 15	Suicide Suffocation 21	Undetermined Poisoning 14	Unintentional Suffocation 36	Suicide Suffocation 135
7	Undetermined Suffocation ---	Homicide Unspecified ---	Unintentional Other Land Transport ---	Seven Tied ---	Unintentional Fire/burn ---	Suicide Poisoning 10	Unintentional Other Spec., classifiable 12	Suicide Poisoning 20	Suicide Suffocation 13	Adverse Effects 35	Unintentional Unspecified 78

Source: CDC WISQARS

SOONERCARE CAUSE OF DEATH

Figure 4



*Members whose deaths were attributed to Mental and Behavioral Disorders were further reviewed. The ICD2 field was examined and captured in Appendix B.

**Members whose deaths were attributed to Unintentional Injury were further reviewed. The ICD2 field was examined and captured in Appendix C.

Two groups of people, two different sets of needs

Addicted/Dependent

Need access to services

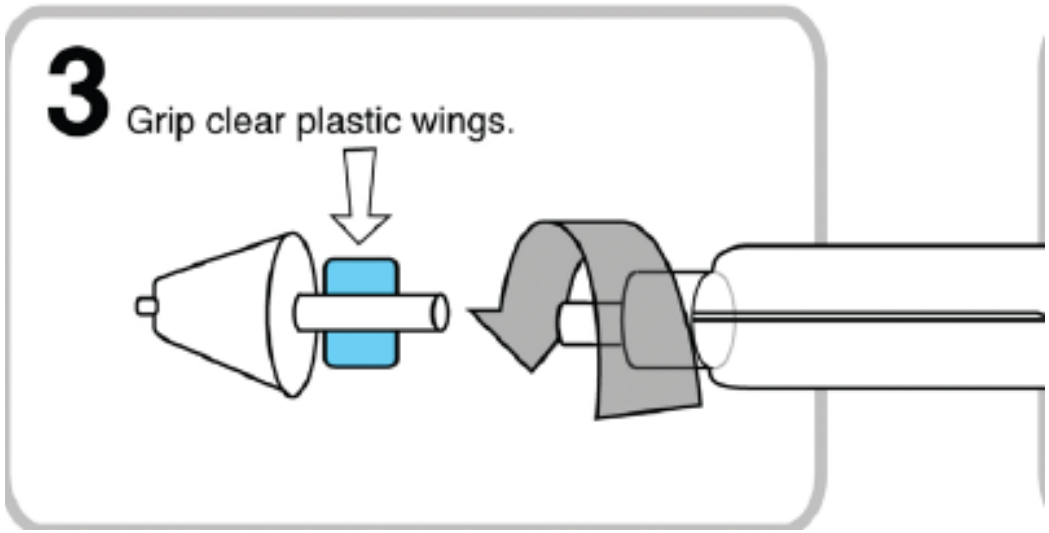
At risk for addiction/dependence

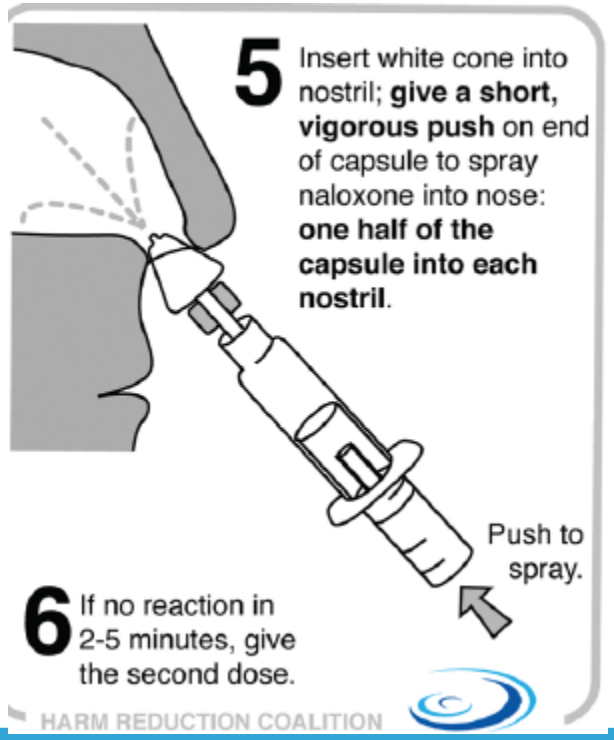
Protect from dangerous drugs

NALOXONE

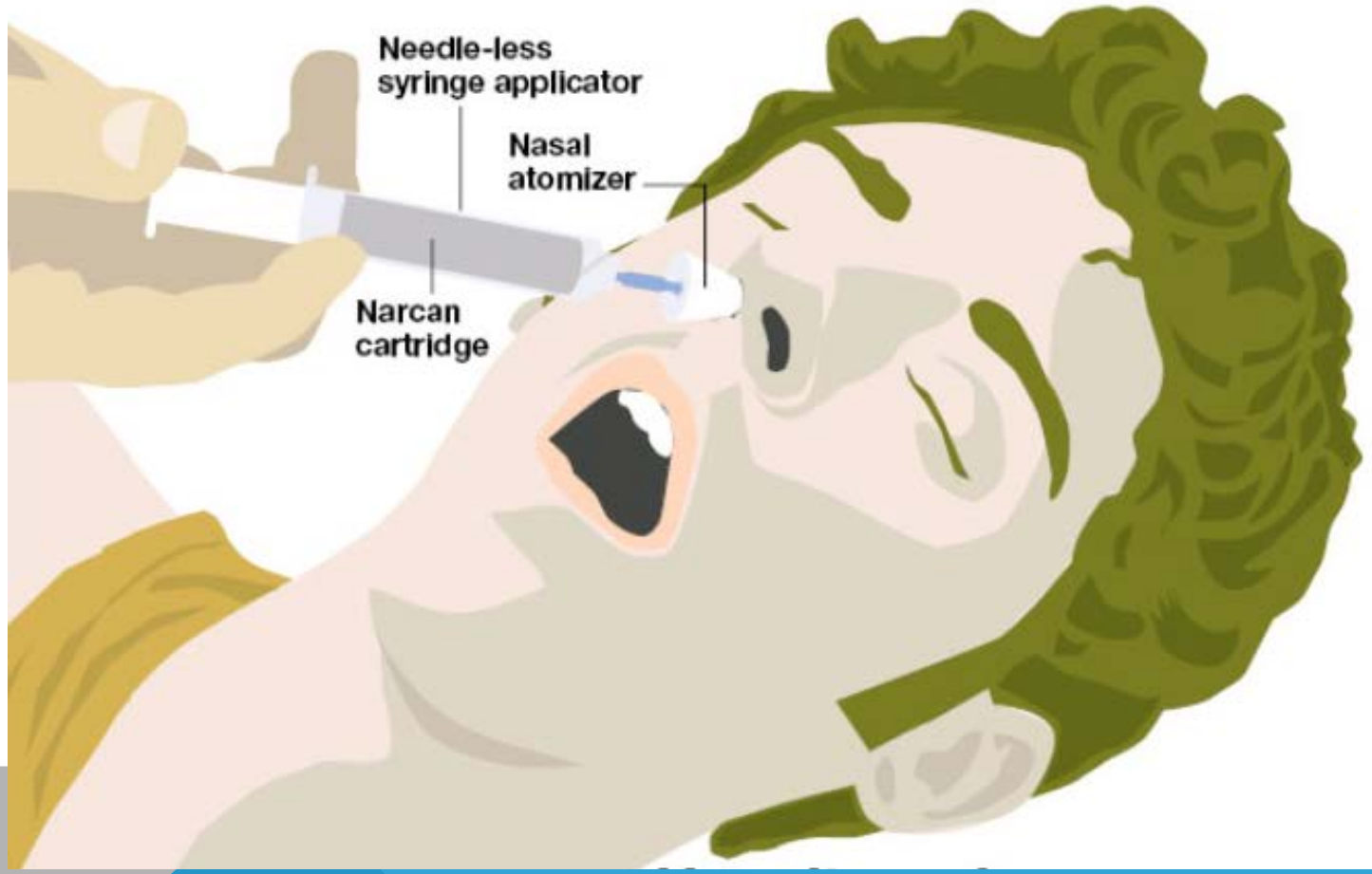
- Opioid Reversal Agent
- Legislation makes naloxone more accessible and allows for expanded use
  - First Responders
  - Family Members and others
  - Pharmacies
  - Different routes of administration
    - Nasal
    - Injection (IM, IV, etc.)

NALOXONE – NASAL ATOMIZER

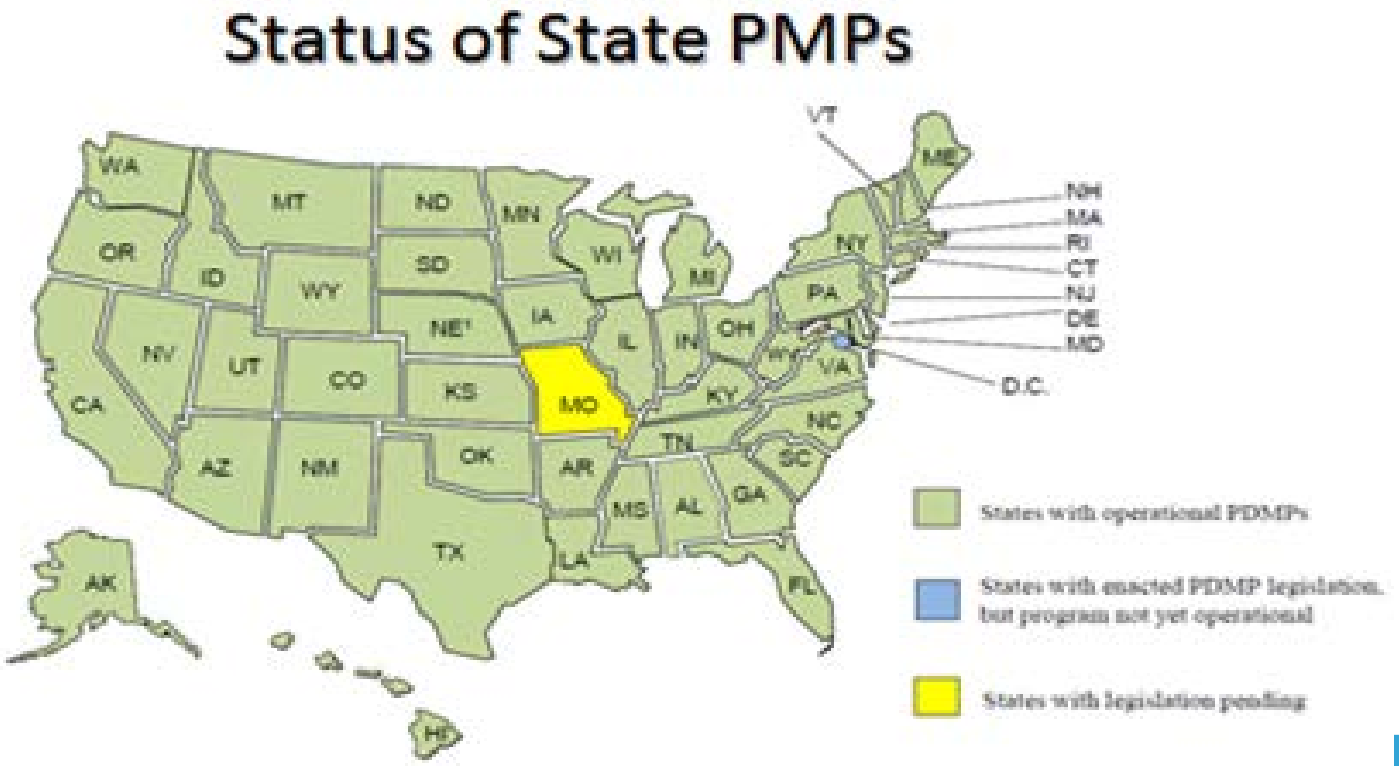




NALOXONE – NASAL ATOMIZER



PRESCRIPTION MONITORING PROGRAMS (PMP - PDMPS)



* The operation of Nebraska's Prescription Monitoring Program is currently being facilitated through the state's Health Information Initiative. Participation by patients, physicians, and other health care providers is voluntary.

PMP EXAMPLE*

Patient History Report

Bookmarks: Page 1 of 2

Prescriptions Customers Prescribers Pharmacies

Date Range: *1/1/2014* -- *7/16/2014*

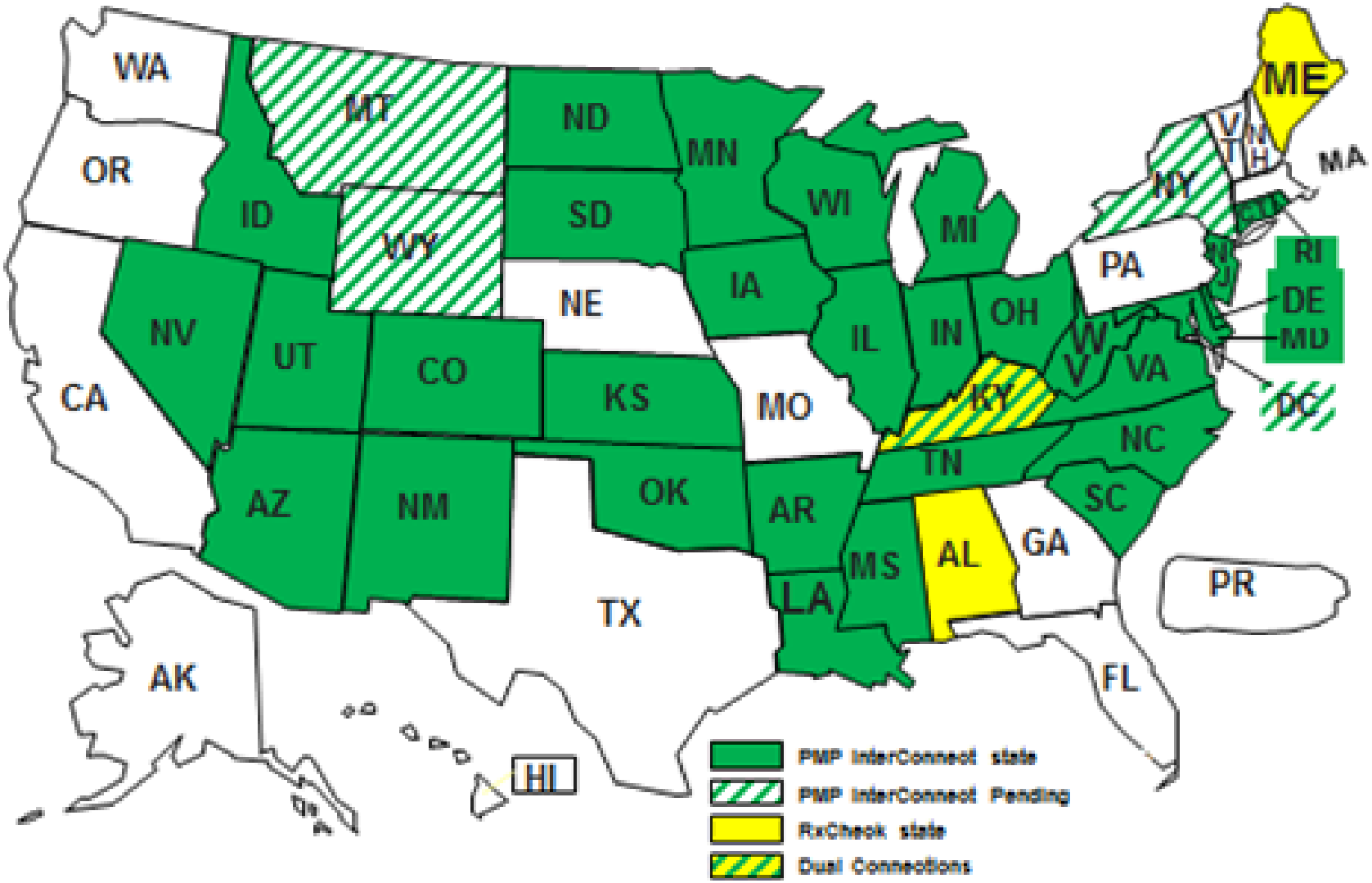
Patient Name: [redacted] **Date of Birth:** [redacted]

Fill Date	Date Written	Prescriber	Product - Strength - Form	Qty	Days	Rx#	Pharmacy	Patient - ID	Refill	Pay
7/8/2014	7/8/2014	[redacted]	OXYCODONE AND ACETAMINOPHEN - 10 MG;325 MG - TABLET	8	2	2002276	[redacted]	[redacted]	new	Medicare
6/24/2014	6/24/2014	[redacted]	ENDOCET - 10 MG;325 MG - TABLET	40	5	2002037	[redacted]	[redacted]	new	Private Pay
6/10/2014	6/5/2014	[redacted]	Unknown - Unkown - Unknown	40	10	2001772	[redacted]	[redacted]	new	insurance
6/5/2014	6/5/2014	[redacted]	Unknown - Unkown - Unknown	40	10	2001772	[redacted]	[redacted]	new	Medicare
5/30/2014	5/29/2014	[redacted]	Unknown - Unkown - Unknown	80	10	2001646	[redacted]	[redacted]	new	insurance
5/19/2014	5/19/2014	[redacted]	OXYCODONE AND ACETAMINOPHEN - 10 MG;325 MG - TABLET	80	10	2001440	[redacted]	[redacted]	new	insurance
5/6/2014	5/5/2014	[redacted]	OXYCODONE AND ACETAMINOPHEN - 10 MG;325 MG - TABLET	80	10	2001207	[redacted]	[redacted]	new	insurance
4/23/2014	4/23/2014	[redacted]	OXYCODONE AND ACETAMINOPHEN - 10 MG;325 MG - TABLET	80	10	2000948	[redacted]	[redacted]	new	insurance
4/14/2014	4/14/2014	[redacted]	OXYCODONE AND ACETAMINOPHEN - 10 MG;325 MG - TABLET	40	10	2000776	[redacted]	[redacted]	new	insurance
4/3/2014	4/3/2014	[redacted]	OXYCODONE AND ACETAMINOPHEN - 10 MG;325 MG - TABLET	40	10	2000600	[redacted]	[redacted]	new	insurance
3/31/2014	3/31/2014	[redacted]	HYDROCODONE BITARTRATE AND ACETAMINOPHEN - 10 MG;325 MG - TABLET	40	5	3001159	[redacted]	[redacted]	new	insurance
3/24/2014	3/24/2014	[redacted]	HYDROCODONE BITARTRATE AND ACETAMINOPHEN - 10 MG;325 MG - TABLET	40	5	3000905	[redacted]	[redacted]	new	Medicare
3/12/2014	3/12/2014	[redacted]	HYDROCODONE BITARTRATE AND ACETAMINOPHEN - 10 MG;325 MG - TABLET	40	5	3000465	[redacted]	[redacted]	new	Private Pay
3/10/2014	3/4/2014	[redacted]	ANDROGEL - 16.2 MG/G - GEL	75	30	3000132	[redacted]	[redacted]	new	Medicaid
3/4/2014	3/4/2014	[redacted]	HYDROCODONE BITARTRATE AND ACETAMINOPHEN - 325 MG;7.5 MG - TABLET	40	10	3000133	[redacted]	[redacted]	new	insurance

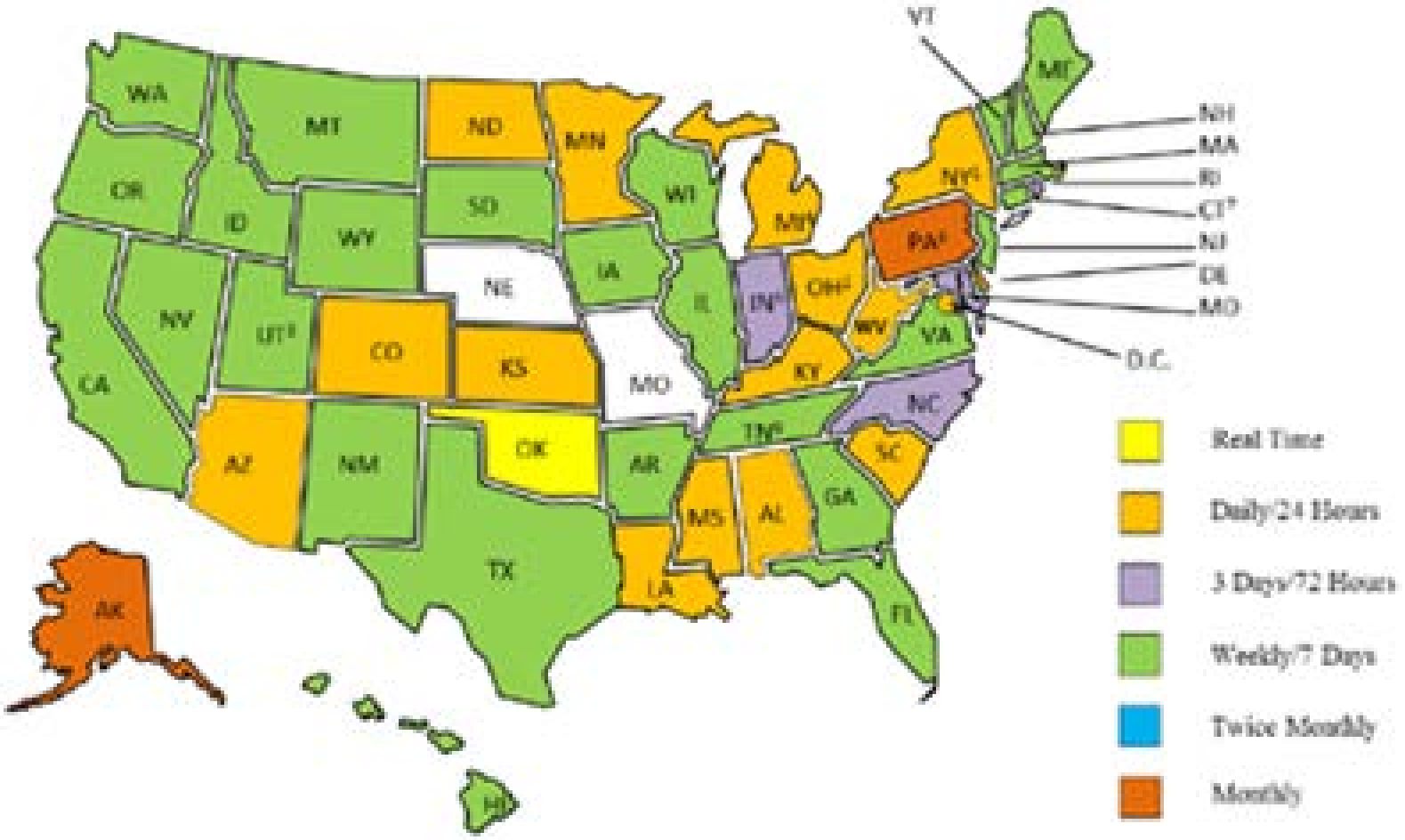
Total Number of Prescriptions 15

*De-identified data

States Sharing Prescription Data With Other States

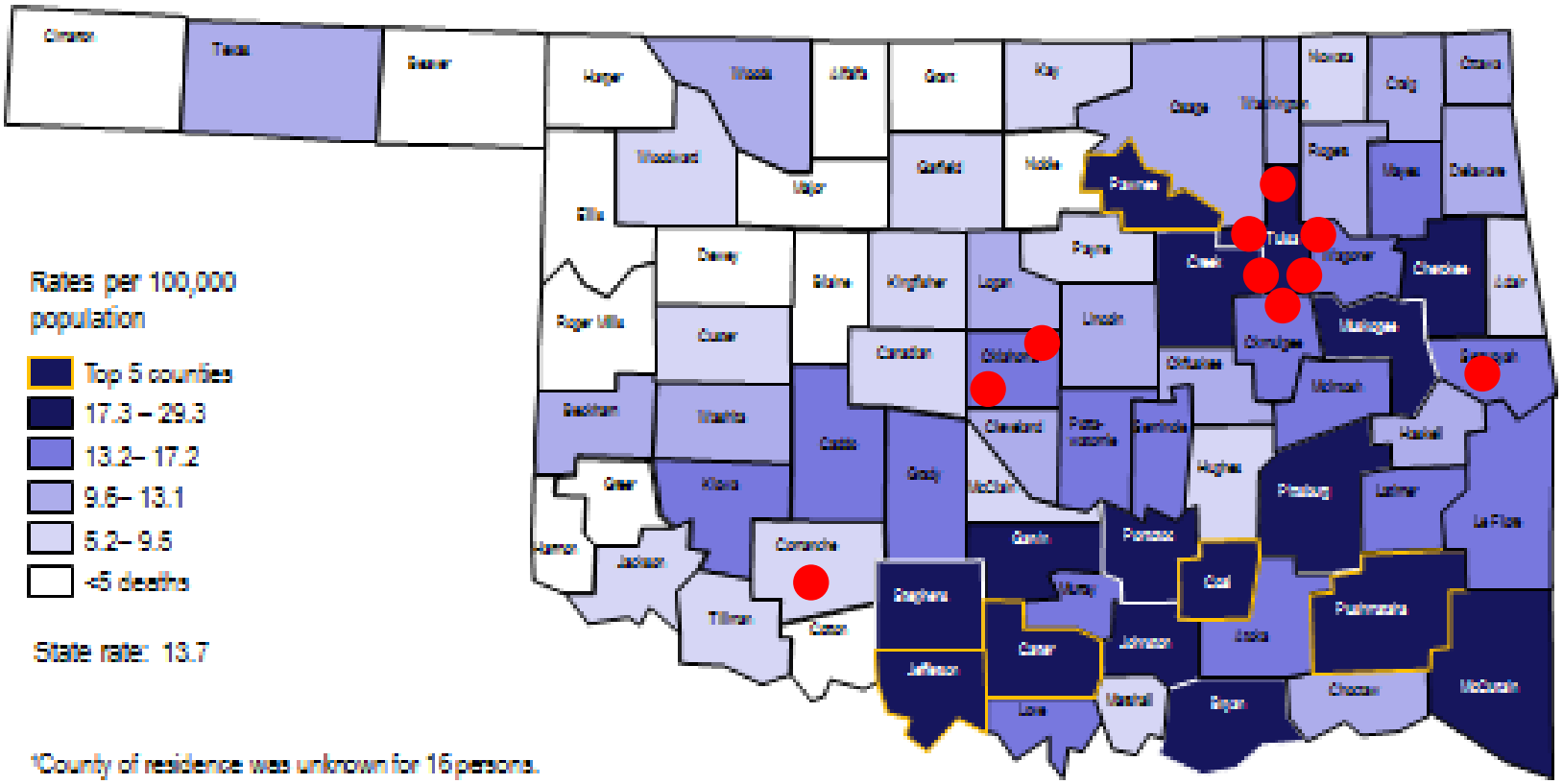


Moving toward "real-time" PDMPs



TOP DISPENSING PHARMACIES – OPIOIDS

Unintentional Prescription Drug Overdose Death Rates by County of Residence[1], Oklahoma, 2007-2013

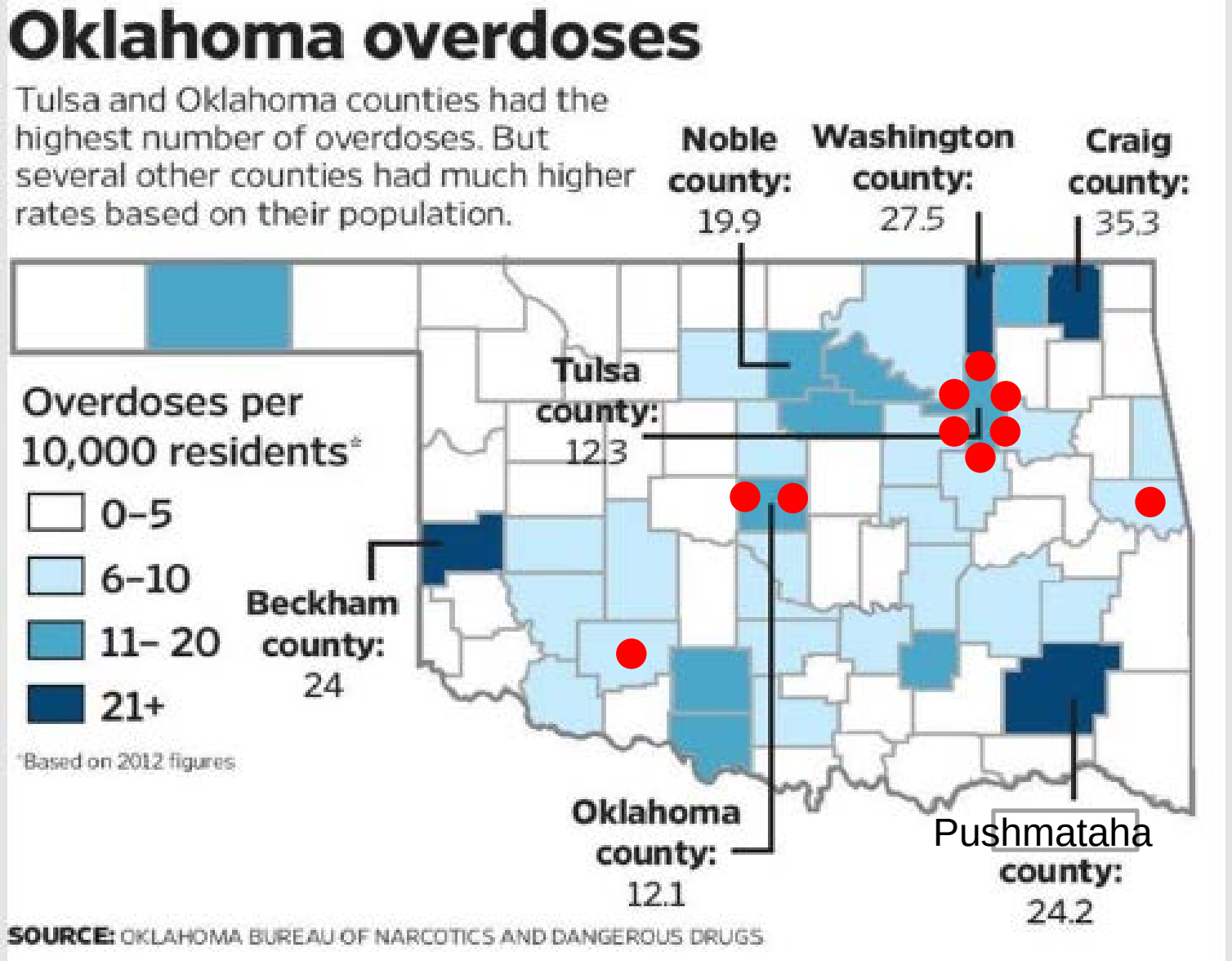


[1]County of residence was unknown for 16 persons.

Source: OSDH, Injury Prevention Service, Unintentional Poisonings Database
(Abstracted from Medical Examiner reports)

Injury Prevention Service
Oklahoma State Department of Health

TOP DISPENSING PHARMACIES – OPIOIDS



ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES (EPCS)

Legal in 49 States and D.C.

- National Average
  - 73% of Pharmacies
  - 1.4% of Prescribers

***Source:** **http://surescripts.com/news-center/national-progress-report-2014#public**

ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES (EPCS)

#17 in readiness

- 84.2% Oklahoma Pharmacies
- 1.18% of Prescribers
- 0.44% of controlled substances*

***Source:** http://surescripts.com/news-center/national-progress-report-2014#public

ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES (EPCS)

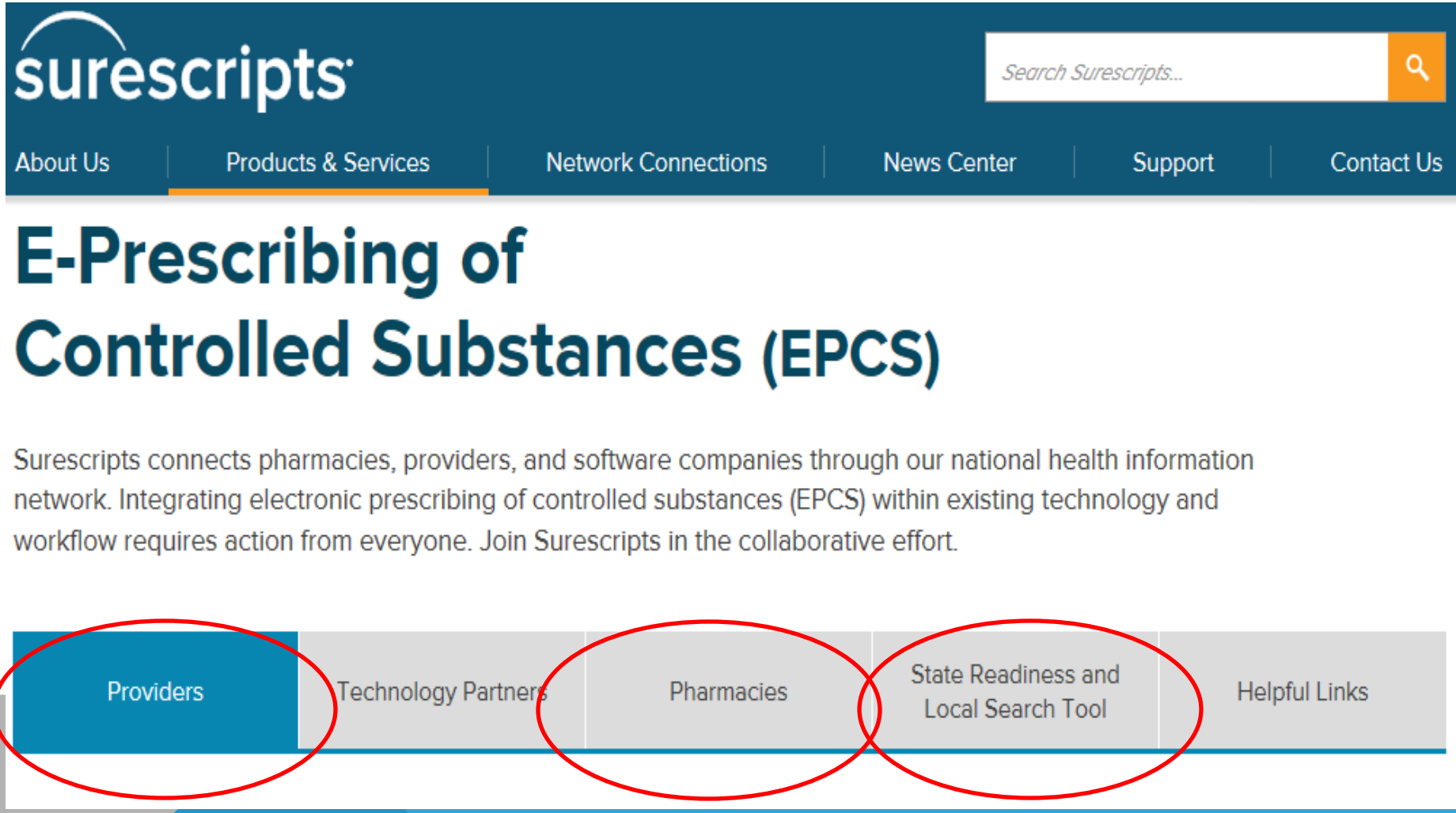
E-PRESCRIBING OF CDS

E-Prescribing of CII and CIII-V is permitted as long as the pharmacy and prescriber are EPCS (E-Prescribing of Controlled Substances) certified. A pharmacy whose software is EPCS certified will recognize other EPCS certified software and will accept CDS prescriptions from those prescribers who are also EPCS certified or reject those who are not.

Faxed prescriptions are not the same as electronic prescriptions. Faxed or written CDS prescriptions must bear the manual signature of the prescriber. They cannot bear a stamped, computer-generated signature, or "electronic signature on file". [11/04/2014]

- E-prescribing of controlled substances permitted in the state of Oklahoma
- Check status of EPCS at: http://surescripts.com/

EPCS…FOR MORE INFORMATION



Source: http://surescripts.com/products-and-services/e-prescribing-of-controlled-substances accessed July 20th 2015.

PHARMACY LOCK-IN PROGRAM – BACKGROUND

Title 42 CRF 431.54 – 1981

Medicaid beneficiaries who abuse their benefits are monitored and controlled

Oklahoma Lock-in Program

Designed to limit abuse of prescription benefits

- Use of multiple doctors prescribing "doctor shopping"
- Use of multiple pharmacies

Promote appropriate use of health resources and limit inappropriate behaviors within the system

Oklahoma HealthCare Authority

PHARMACY LOCK-IN

Initial Lock-in period

24 months

Continued every 12 months if needed

As of July 1st 2014

- Lock-in to:

One provider/prescriber/physician

One Pharmacy

Patient Review and Restriction Program

Oklahoma HealthCare Authority

PANEL DISCUSSION TOPICS

At Risk Prescribers

Naloxone

Patient Review and Restriction Program

Prescription Monitoring Program

Substance Abuse Treatment

Data Match and Mining of Data

Other Agency and State Initiatives

OHCA Initiatives

PANEL DISCUSSION

Mike Herndon, D.O., Medical Director, OHCA Medicaid Operations

Jessica Hawkins, Director of Prevention Services, OK Dept. of Mental Health & Substance Abuse Services

Sheryll Brown, M.P.H., Director, Injury Prevention Services, OK State Dept. of Health.

Claire Nguyen, Injury Prevention Services, OK State Dept. of Health

Teel, Ashley J Pharm.D, Lock-in program administrator, Pharmacy Management Consultants

Nancy Nesser, Pharm.D, J.D. Director Pharmacy Operations OHCA

Facilitator

Burl Beasley, BS Pharm, MPH, MS Pharm, Pharmacist OHCA

DISCUSSION TOPICS & ACTION ITEMS

Changes to PMP

- Effective Nov 1st 2015
- No longer voluntary system

Naloxone initiatives

- Atomizer
- Identify barriers
- Collaborative practice agreements

Outreach to At Risk Prescribers

OHCA SOLUTIONS

OHCA Rx Drug Abuse Workgroup
- Reports To Steering Committee

Review of At Risk Prescribers

Review of Patient Review and Restriction Program

Monitor PMP and effect on opioid prescribers
- November changes to PMP (mandatory)

Collaborate with other state agencies

OHCA SOLUTIONS (CONT.)

Identify - remove barriers to

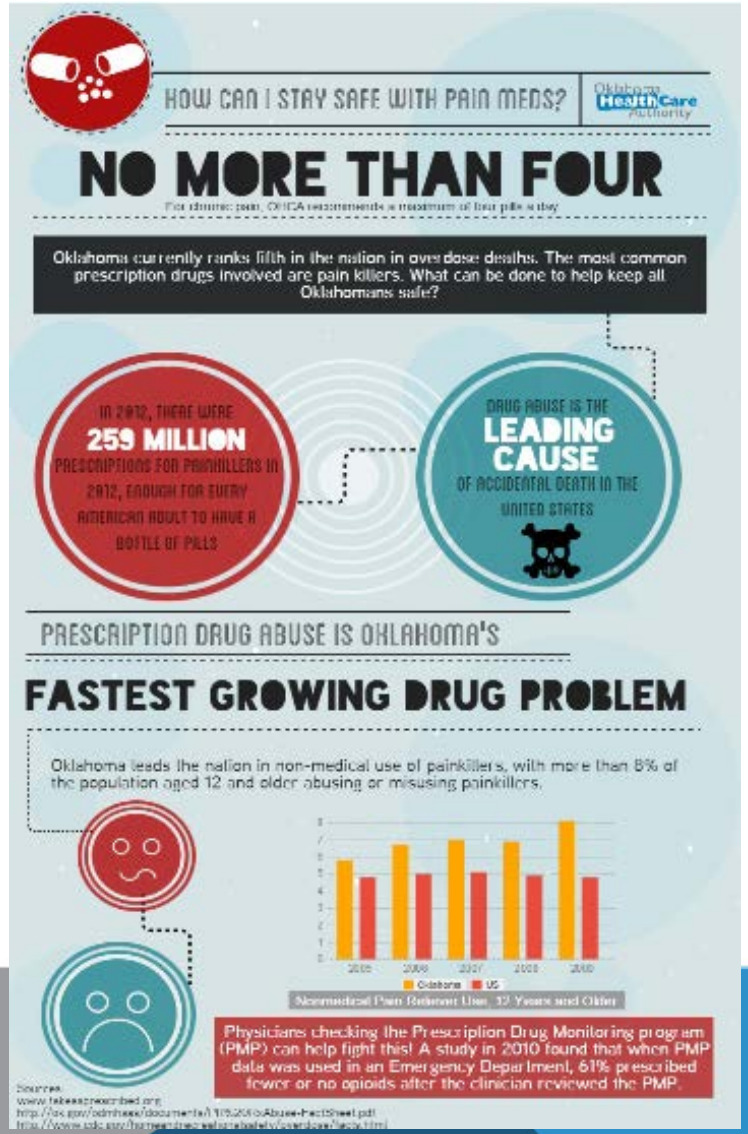
- Electronic Prescribing of Controlled Substances
- Naloxone
- Medication Assistance Treatment(s)
- Quantity Limits on Opioids

OHCA SOLUTIONS CONT.
-QUANTITY LIMITS IMPLEMENTATION

Date of Quantity Limit Implementation	Medications Affected
Phase 1 - November 2014	• Hydromorphone Immediate Release Products • Morphine Immediate Release Products • Codeine and Codeine Combination Products • Oxymorphone Immediate Release Products
Phase 2 - December 2014	• Oxycodone Immediate Release Products • Oxycodone Combination Products
Phase 3 -January 2015	• Hydrocodone Combination Products • Butalbital Combination Products

Oklahoma HealthCare Authority

OHCA SOLUTIONS, CONT.



Updated OHCA website
Opioid Prescribing Guidelines
http://www.okhca.org/providers.aspx?id=15481
Analgesics – Opioids
Analgesics – NSAIDs, Antipyretics
http://www.okhca.org/providers.aspx?id=11146
No More Than 4 Poster
available for printing…

Oklahoma HealthCare Authority

THURSDAY: SESSION II

Interactive Planning Sessions Recap

Moderator

- Buffy Heater, Chief Strategy Officer, OHCA

RECESS

Reconvene Strategic Planning Conference

8:30AM FRIDAY, AUGUST 14, 2015

Registration Open 8:00am

Strategic Planning Conference 2015

Friday, August 14, 2015
Embassy Suites, Oklahoma City, OK

#mysoonercare
#20yearsofcaring

Oklahoma HealthCare Authority

FRIDAY: SESSION 12

Presentation Session

Current Care Delivery Systems for the Aged, Blind, and/or Disabled (ABD)

FRIDAY: SESSION 12

Current Care Delivery Systems for the Aged, Blind, and/or Disabled (ABD)

Facilitators:

- Melinda Thomason, Assistant Division Director, Health Policy, OHCA
- Ivoria Holt, Director of SoonerCare Delivery Systems, PACE, OHCA

FRIDAY: SESSION 12

Subject Matter Experts:

- Megan Haddock, Medical Services Director, OKDHS
- Karen Poteet, ADRC, OKDHS
- JoAnne Goin, Developmental Disabilities Services Director, OKDHS
- Ashley Herron, Waiver Administration Coordinator, OSDH
- Kysha Demas, PACE, OHCA
- Russell Coker, Money Follows the Person – Tribal, Health Policy, OHCA

Oklahoma HealthCare Authority

CURRENT CARE DELIVERY SYSTEMS

August 2015

Current Care Delivery Systems

https://www.youtube.com/watch?v=oHPc4PeN8XM&list=UUh74Rcs2AVfSkwnwW73pqFg

Current Care Delivery Systems

With your hosts: Ivoria Holt and Melinda Thomason
Featuring: Megan Haddock
Karen Poteet
JoAnne Goin
Ashley Herron
Kysha Demas
Russell Coker

Categories of Coverage

Aged (65+)

Blind

Disabled

Physically or Intellectually

Numbers

176,776 SFY 2014

OHCA data valid as of 7/15/2014 and is subject to change.

ABD Population

Aged

- 51,510

Blind/Disabled

- 126,515
- 592 TEFRA children

ABD Population

With Medicare

102,589

SoonerCare Choice

56,031

2,125 with Medicare

Long-term Care

20,344

17,420 with Medicare

Oklahoma HealthCare Authority

PACE

147

136 with Medicare

HCBS Waivers

27,122

21,565 with Medicare

All Others

76,015

62,950 with Medicare

HCBS Waivers

ADvantage

21,312

HCBS Waivers

DDS

5,466

HCBS Waivers

OHCA

472

Waivers

	Total	Dual*
Advantage	21,312	17,982
Community	2,844	1,849
Homeward Bound	690	594
In Home Supports for Adults	1,605	883
In Home Supports for Children	327	0
Living Choice	272	208
Medically Fragile	57	22
My Life My Choice	93	58
Sooner Seniors	50	47

Health Homes for SMI/SED

3,856 Adults – 2,099 dual

3,152 Children – 5 dual

Source: ODMHSAS

Oklahoma HealthCare Authority

PACE

147

136 with Medicare

Oklahoma HealthCare Authority

Money Follows the Person

272 Living Choice

208 with Medicare

Current Care Delivery Systems

And now, a word from our sponsors

HCBS Waivers

ADvantage

21,312

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5,466

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Current Care Delivery Systems

With your hosts: Ivoria Holt and Melinda Thomason
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Kysha Demas
Russell Coker

Current Care Delivery Systems

And now, a word from our sponsors

Link:
https://filetransfer.okdhs.org/?f=3468&fid=355605cf

Current Care Delivery Systems

Audience Participation

FRIDAY: SESSION 13

ABD Care Coordination Stakeholder Meeting

Oklahoma HealthCare Authority

STAKEHOLDERS MEETING

August 2015

Categories of Coverage

Aged (65+)

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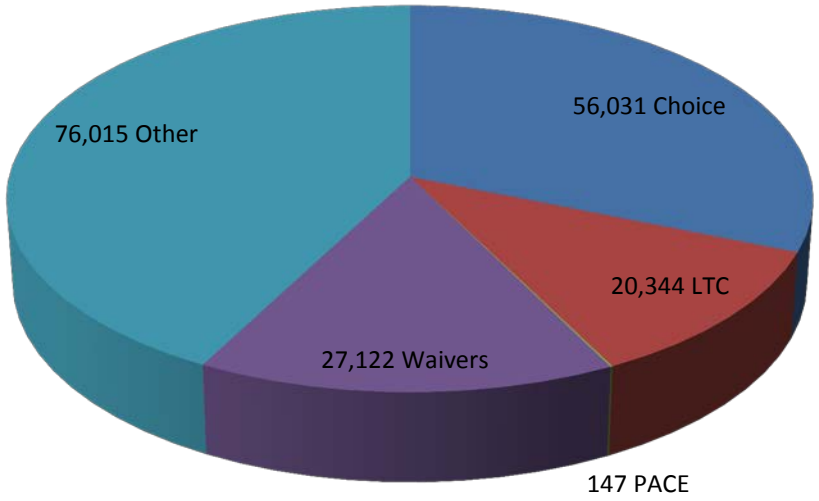
Source: ODMHSAS

Total Population OHCA

ABD SFY 2014



FRIDAY: SESSION 13

Quality Measures:

- Follow-Up After Hospitalization for Mental Illness
- Depression Remission at Six Months
- Hospital Admission and Readmission rates
- ER Usage
- Pneumonia rates
- Hospital-Acquired infection (or MRSA) rates
- Medication Adherence rates
- Asthma
- Diabetes
- Cholesterol management
- Access to preventive/ambulatory health services
- COPD admission rate
- Congestive Heart failure admission rate

FRIDAY: SESSION 13

Quality Measures (cont.):

- Stroke performance
- Osteoarthritis
- Chronic Wound Care
- Age-Related Macular Degeneration (AMD)
- Colorectal Cancer Screening
- Behavioral Health – depression, psychosis
- Social Supports and Services

FRIDAY: SESSION 13

ABD Care Coordination program costs, the savings, the sources of the savings, member satisfaction, health outcomes, clinical care, quality of life, access to services, and the overall status of the program.

Monitor provider network changes
Monitor utilization of services/usage of providers
Member satisfaction survey

Quality of Life and Quality of Care Outcomes that include:
-Enrollee's participation and completion of Health Based Prevention and Improvement Programs
-Enrollee's choice and control over daily living
-attending community activities
-keeping health related appointments
-reducing fall incidents
-requiring fewer emergency room visits
-requiring fewer hospitalizations

FRIDAY: SESSION 13

Quality of Life and Quality of Care Outcomes that include:
-stabilization/improvement of an Enrollee's health condition
-reduction of fall incidents
-keeping medical appointments
-taking medication as prescribed
-Enrollee's choice and control over daily living
-Enrollee's choice over Providers
-Enrollee's attendance to community functions, as medical condition allows
-reduced hospitalizations
-reduced emergency room visits
-Enrollee's goal achievement

Care Management and Transitional Care:
-Lowering readmission rate
-Prescription drug use
-Emergency Room use
-Medication management
-Fall risk management

FRIDAY: SESSION 13

Adult Day Health Services:
-Physical Activity of Older Adults
-Fall risk management
-Comprehensive diabetes care
-Medication management
-Lowering readmission rate
-Controlling high blood pressure

Seniorline Information and Referral:
-Reduction of stress and anxiety
-Effectiveness of care

FRIDAY: SESSION 13

Behavioral Health Assessment and Referral:
-Reduce the number of psychiatric inpatient admissions
-Follow up after hospitalization of mental illness
-Anti-depressant medication management
-Physical activity of Older Adults

Caregiver Support:
-Disease self-management
-Reduction of stress and anxiety
-Effectiveness of care

FRIDAY: SESSION 13

-Assurance of Member Satisfaction
-Involvement of Family Caregivers in Care Plan Development
-Caregiver Training by Providers
-Robust State Oversight to ensure reporting requirements and performance standards are met and reflect improvements in quality and access over the life of the program (not just on paper/contractual, but also through hands-on oversight and monitoring; corrective action when needed)

FRIDAY: SESSION 14

Last Call / Open Forum / Action Plan Review

Moderator

- Buffy Heater, Chief Strategy Officer, OHCA

Wrap Up / Closing Remarks

- Ed McFall, OHCA Board Chairman
- Nico Gomez, CEO, OHCA

New Business

Adjournment