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EHR Survey: Considerations & Discussion Questions

Considerations

- Limitations generalizing survey results
  - Especially low response rate among physicians who identify as independent practice associations (IPAs)
  - Respondents are concentrated, geographically and by provider type

- Implications of developing innovative model with a focus on institutional providers
  - Integration with surrounding urban/rural areas

Discussion Questions

- How do we quantify overall EHR adoption rates in Oklahoma? Perhaps more relevant information is how many providers are unsupported and how EHR capabilities are actually being used.

- How do unsupported provider numbers differ when FQHCs are omitted?

- How do we assist unsupported providers?
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Health Information Exchange (HIE) Environmental Scan: Final Review

Oklahoma Health Improvement Plan: Health IT

**Goal:** Improve quality, safety, effectiveness, and efficiency of health services through the use of interoperable health information technology

**Objective:** By 2020, ensure that each Oklahoman’s safety, quality, and convenience of care is improved by ensuring that providers access a multi-sourced comprehensive medical record on 30% of patients they treat

**Strategies:**

1. Facilitate secure Health Information Exchange (HIE) adoption and implementation
2. Enhance communication among healthcare stakeholders (including patients and families) with respect to the use of health IT
3. Establish training programs to increase provider knowledge and abilities in clinical informatics and health IT
Health Information Exchange (HIE) Environmental Scan: Final Review

Overview

OSDH engaged Milliman to:

- perform a statewide environmental scan of existing health information exchanges (HIE)
- describe the status of health information exchanges within the state
- develop a proposal to implement a statewide interoperable health information network

The report presents findings identified during the interviews and from review of HIE initiatives in Oklahoma and other states

This project is not complete; information presented here may change significantly based on subsequent discussion and analysis
## Current Oklahoma HIE Features (updated)

<table>
<thead>
<tr>
<th>Feature</th>
<th>Coordinated Care Oklahoma</th>
<th>MyHealth Access Network</th>
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<tbody>
<tr>
<td>Organization Structure</td>
<td>Not-for-profit</td>
<td>Not-for-profit</td>
</tr>
<tr>
<td>Revenue Model</td>
<td>Fee and subscription</td>
<td>Fee and subscription</td>
</tr>
<tr>
<td>Board Composition</td>
<td>Hospital systems and providers</td>
<td>Community- and member-based</td>
</tr>
<tr>
<td>Patient Lives (est.)</td>
<td>4,700,000</td>
<td>4,000,000</td>
</tr>
<tr>
<td>Provider Locations (est.)</td>
<td>455</td>
<td>800</td>
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<tr>
<td>Data Model</td>
<td>Hybrid</td>
<td>Hybrid</td>
</tr>
<tr>
<td>CCD</td>
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<td>Yes</td>
</tr>
<tr>
<td>Population Management Tools</td>
<td>Yes (Pentaho)</td>
<td>Yes (Pentaho)</td>
</tr>
<tr>
<td>Analytics</td>
<td>Not at this time</td>
<td>Yes (IndiGo)</td>
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<tr>
<td>Patient Participation Model</td>
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<td>ONC Certifications</td>
<td>Advanced directives</td>
<td>Patient portal</td>
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<td>Training Model</td>
<td>Train the trainer</td>
<td>Train the trainer</td>
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<tr>
<td>Demographic Data</td>
<td>Yes (centralized)</td>
<td>Yes (centralized)</td>
</tr>
<tr>
<td>Clinical Data</td>
<td>Yes (centralized)</td>
<td>Yes (centralized)</td>
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<tr>
<td>Claims Data</td>
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<td>Major Funding Grants</td>
<td>None</td>
<td>Beacon Community Grant</td>
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Statewide Interoperable Health Information Network Options
Consideration 1: Intended Use

Three general scenarios exist for the intended use of the Oklahoma Health Information Network:

1. Point-of-care support
2. Clinical decision support
3. Claims/clinical analytics support
Health Information Exchange (HIE) Environmental Scan: Final Review

Statewide Interoperable Health Information Network Options
Consideration 1: Intended Use
Health Information Exchange (HIE) Environmental Scan: Final Review

Intended Use: Point-of-Care Support

Under this scenario, information is exchanged among clinical locations for use in the patient visit. The content of the transmitted data must include basic demographic information for patient matching and relevant clinical information, such as that which is found in a CCD.

Using an HIE in this manner has the potential to improve the quality of care:

- Better patient outcomes may be achieved by reducing errors and providing a more informed treatment plan.
- Combined clinical information can improve decisions made in-visit about testing, diagnosis, and treatment. This type of interchange can also be augmented with value-added services.
Intended Use: Clinical Decision Support

In a clinical decision support role, HIEs aggregate patient information for reporting. This reporting typically takes two forms:

- “Within-visit” analytics to identify risk factors and potential testing
- Population-level analytics independent of a single patient visit to assist with population management

Using an HIE to assist with clinical decision support typically aggregates a patient’s information from all locations within the HIE
Intended Use: Claims/Clinical Analytics Support

Using data in this manner for analytics typically combines information from payers and providers to evaluate care outcomes based on the entirety of a patient’s clinical care. There are generally two progressive stages to a claims/clinical analytics:

- The first stage is a shared measurement framework in which performance is measured by one entity that all parties agree is the “trusted source”

- The second step is to pair the combined claims and clinical data with cost information to draw conclusions about care outcomes and treatment protocol value, given the cost of providing these services
Consideration 2: Governance Model

Experience gained from other HIE initiatives nationally suggests that agreeing upon or legislating what information is shared and when and to whom it is accessible are key determinants for the utility of an exchange or network of exchanges. Important decisions that need to be made about the exchange’s governance structure should include:

- How the exchange is funded
- Who operates it
- Who owns it
- Whether participation will be optional or required for healthcare organizations in the state
Health Information Exchange (HIE) Environmental Scan: Final Review

Consideration 3: Databased Design and Data Model
Health Information Exchange (HIE) Environmental Scan: Final Review

Statewide Health Information Network Options

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
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<tr>
<td>“Network of Exchanges”</td>
<td>Select an Existing HIE</td>
<td>State Sponsored HIE</td>
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<tr>
<td>• Least robust statewide capability</td>
<td>• Adoption of existing capability</td>
<td>• Ability to customize statewide capability</td>
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<tr>
<td>• Moderate response to market needs; maximum stakeholder input</td>
<td>• Responsive to market needs; moderate stakeholder input</td>
<td>• Slow response to market needs; limited stakeholder input</td>
</tr>
<tr>
<td>• Moderate time to market</td>
<td>• Shortest time to market</td>
<td>• Longest time to market</td>
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Health Information Exchange (HIE) Environmental Scan: Final Review

Option 1: “Network of Exchanges”

Considerations

- Because participation is voluntary, this approach has the advantage of not unduly disrupting business processes within the state and integration can be done gradually, as it makes sense for HIEs to join.

- The voluntary nature of participation means that connections will undoubtedly be established on uncertain time frames.

- As connections to the “network of exchanges” are federated, data passed through eHealth Exchange could not easily be used for analytics, population management, or value-based purchasing decisions.

- Rural and small independent providers may require a subsidy to afford the costs of HIE membership.
Health Information Exchange (HIE) Environmental Scan: Final Review

Option 2: Select an Existing HIE

Considerations

- The overall setup time for connecting the state should be reduced as participants would need to map their data to a single entity and that entity would not need to do any further transformation or data exchange with a third party

- Development needs would depend on the capabilities of the selected HIE

- Rural and small independent providers may require a subsidy to afford the costs of even a single HIE

- This approach would disrupt Oklahoma’s business environment by creating a potential “winner” through direct state action
Option 3: State-Sponsored HIE

Considerations

- Oklahoma has already declared the intent to develop a shared-services state agency HIE under OSDH that could be expanded for this purpose, or Oklahoma could construct an HIE

- State sponsorship would let the state provide a uniform experience and functionality suite that exactly matches the desired system capabilities

- Discretion around the funding and fee structure could enable rural and small provider groups to afford any fees for connections

- Development of such a software solution is certain to be a long, challenging process that could delay information access across the state
HIE Scan Considerations & Discussion Questions

Considerations

- Potential future HIE market environment shifts
  - Publication and adoption of standard protocol for HIE interoperability
  - Emergence or disappearance of exchange players
- Ongoing development of shared services of health information at state agencies

Discussion Questions

- Are the characterizations of the health information environment accurate in accord with your personal experience?
  - Areas for expansion, elaboration, or color commentary?
- What are the relative merits and drawbacks of the vendor’s proposed options for developing an interoperable health information network?
  - Option 1: “Network of Exchanges”
  - Option 2: Select an Existing HIE
  - Option 3: State-Sponsored HIE
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Accountable Care Organizations

Overview
- Networks of providers that collectively accept accountability for the cost and quality of a patient’s care
- Emphasizes coordination of care

Scope
- Provider organizations including hospitals, primary care, specialists, and other supportive care institutions and services

Care Model
- Integrated care delivery efforts on behalf of networked providers
  - ACO assumed primary accountability for overall outcomes and costs for a patient’s care
- Patients are not limited to providers within the ACO network

Payment Model
- ACOs can operate through a variety of payment models
- Their networked nature positions them well to handle episodes of care and bundled payments designs

Attribution
- Patients are attributed prospectively based on prior claims information and retroactively based on volume of contacts
  - Provider must notify patients that it is an ACO

Results & Considerations
- Preliminary results from the 243 Medicare ACOs indicate that 25% achieved significant cost savings
  - Total of $817M in 2014 (.2% of total Medicare A&B budget)
- Patients are not limited to in-network physicians, which complicates provider coordination and outcomes
- All participating providers need to have some level of access to HIT in order to best coordinate patient care
  - Health IT interoperability is a critical component of high level care coordination
ACOs help to shift the emphasis from volume to value in care delivery by networking the providers together to facilitate care coordination and financial incentive realignment.

- Board of directors develops treatment and care coordination protocols
- ACO governing body recruits providers and institutions to be involved in the network
- The ACO assumes full accountability for the patient
  - Care delivered
  - Clinical outcomes
  - Cost expenditures
- Providers coordinate to optimize the care delivered and costs incurred for patient care
- Note: Patients can see any provider, not necessarily just those in network
Accountable Care Organizations –
Model Implications Discussion

Considerations

- Preliminary results from the 243 Medicare ACOs indicate that 25% achieved significant cost savings
  - Total of $817M in 2014 (.2% of total Medicare A&B budget)

- Patients are not limited to in-network physicians, which complicates provider coordination and outcomes

- All participating providers need to have some level of access to HIT in order to best coordinate patient care
  - Health IT interoperability is a critical component of high level care coordination

Discussion Questions

- What information technology considerations would wider adoption have for Oklahoma? What information and systems must come together?
  - EHR adoption rate and interoperability?
  - Quality metrics tracking for evaluation and reimbursement?

- What preconditions are necessary for successful adoption and implementation?
Patient-Centered Medical Home (PCMH)

| Overview | Primary care delivery model that focuses on care coordination, communication, and the patient experience |
| Scope | Single primary care provider  
| | Appropriate patients vary by program |
| Care Model | One primary care physician serves as the first point of contact for the patient and provides comprehensive, coordinated care  
| | The PCMH encompasses five attributes:  
| | - Comprehensive, team-based care  
| | - Patient-centered care  
| | - Coordinated care  
| | - Accessible services  
| | - Quality and safety |
| Payment Model | Payment can include fee-for-service (FFS), with a modest additional per member per month payment for coordinating care |
| Attribution | Patient eligibility determined by payer organization |

**Patient Centered Medical Home**

- Home Care
- Prescription Medications
- Coordinating PCP
- Inpatient Care
- Specialist

**Results & Considerations**

- All participating providers need to have some level of access to HIT in order to best coordinate patient care  
  - Health IT interoperability is a critical component of high level care coordination  
- Management of PCMH, at its ideal level, can place a significant burden on an individual practitioner. Providers may require additional IT systems, support, or personnel to succeed
One primary care physician serves as the first point of contact for the patient and provides comprehensive, coordinated care
- Helps to ensure that patients understand and execute their medical instructions, referrals, and follow up appointments

Coordinating PCP need not have formal or official network or institutional relationships with other care providers involved in the care of the patient

Payment can include fee-for-service (FFS), with a modest additional per member per month payment for coordinating care
Considerations

- All participating providers need to have some level of access to HIT in order to best coordinate patient care
  - Health IT interoperability is a critical component of high level care coordination
- Management of PCMH, at its ideal level, can place a significant burden on an individual practitioner. Providers may require additional IT systems, support, or personnel to succeed

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Episodes of Care

Overview
- Payment model in which services related to a condition or procedure are grouped into “episodes” that provide benchmarks for appropriate costs of care

Scope
- Single provider
- Episodes may be designed for any patient population

Care Model
- Episodes of care payments are applicable to a variety of care models, as long as the model can attribute a single Principle Accountable Provider for payment

Payment Model
- Principle Accountable Providers are initially paid on a fee for service basis and then retroactively evaluated against a set of data-driven benchmarks for the cost of the care delivered
- PAPs are rewarded with a percentage of savings or charged a portion of costs in excess of the benchmarks

Attribution
- Patient has a triggering event or certain number of claims related to an episode with a participating provider

Example Episodes of Care

Results & Considerations
- Episodes can be difficult to define, and changes in best practices or technology can render even well designed episodes obsolete
- Pricing episodes correctly can require significant data
- Costs can vary based on inherent risk within patient population
  - Patient volume considerations to ensure appropriate distribution of risk
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 specified series of events completes, or a pre-determined duration elapses
  - E.g. Discharge from acute care facility
  - E.g. Completion or termination of pregnancy
- Principle Accountable Providers are initially paid on a fee for service basis and then retroactively evaluated against a set of data-driven benchmarks for the average cost of the care delivered per episode
Episodes of Care – Payment Model Design (continued)

- Principle Accountable Providers are initially paid on a fee for service basis and then retroactively evaluated against a set of data-driven benchmarks for the cost of the care delivered.

- PAPs that come in under the cost benchmarks receive a percentage of the savings as a bonus.
  - Bonus percentages may vary, depending on model design as well as whether risk sharing is also involved.

- PAPs that exceed the acceptable level of costs may have to pay a portion of the overrun as a penalty, if the model involves risk sharing.
  - Penalties are capped to ensure provider viability.

Source: [http://www.paymentinitiative.org/](http://www.paymentinitiative.org/)
Episodes of Care – Model Implications Discussion

Considerations

- Episodes can be difficult to define, and changes in best practices or technology can render even well designed episodes obsolete
- Pricing episodes correctly can require significant data
- Costs can vary based on inherent risk within patient population
  - Patient volume considerations to ensure appropriate distribution of risk

Discussion Questions

- What information technology considerations would wider adoption have for Oklahoma? What information and systems must come together?
  - EHR adoption rate and interoperability?
  - Quality metrics tracking for evaluation and reimbursement?
- What preconditions are necessary for successful adoption and implementation?
Medicare Bundled Payments Care Initiative (BPCI)

Overview
- Series of opt-in payment model pilot programs from CMS
- Designed to align incentives across fee for service providers to improve patient outcomes and decrease costs in tandem

Scope
- Networks of providers
- Programs encompass some or all of a subset of 48 DRGs

Care Model
- Care coordination is up to participating provider networks

Payment Model
- Providers receive FFS payments as usual, then at the close of the year, those payments are reconciled with the bundle benchmarks, except for Model IV, which provides proactive payments
- All episodes begin with an acute hospitalization by a patient but then vary:
  - Initiation and duration of episode of care
  - Applicable DRG
  - Timing of payments

Attribution
- CMS guidance does not specify attribution protocol, so it is assumed that this can vary by participating institutions

Medicare Bundled Payments Model Structure

Results & Considerations
- Initial quantitative results are not yet available within the 2014 status report
  - Limited enrollment for the initial 2013 year limits usefulness of any statistics
  - Subsequent reports should contain much more information
- Challenges coordinating across multiple providers can create tension
  - Disparities in the level of quality of various providers across the care delivery chain
  - Patient preference and the desire of the institution to focus on its preferred quality providers can be at odds
- Timing of payments can create cash flow issues
Medicare Bundled Payments Care Initiative (BPCI) – Payment Model Design

- All episodes begin with acute an hospitalization by a patient but then vary:
  - Initiation and duration of episode of care
  - Applicable DRG
  - Timing of payments; retrospective as usual or prospective

- Payments are reconciled retrospectively for all models, except Model IV
  - Model IV is identical to Model I otherwise

- Participating institutions had to apply to be admitted to the pilot program for these models
  - Participation may continue to grow as the programs evolve and expand
Medicare Bundled Payments Care Initiative (BPCI) – Program Status & Participation

- CMS launched these programs in early 2013, and while each is ongoing with active institutional members, participation numbers vary greatly between programs.
- BPCI participants stand to benefit financially if they provide services within the bundle more efficiently, and they can be at risk if their costs are higher than CMS benchmarks.
- Additionally, each program has reasonably wide geographic coverage, with the notable exception of Model I, which is concentrated primarily in medical centers on the Northeast coast.
### Medicare Bundled Payments Care Initiative (BPCI) – Model Implications Discussion

#### Considerations

- Initial quantitative results are not yet available within the 2014 status report
  - Limited enrollment for the initial 2013 year limits usefulness of any statistics
  - Subsequent reports should contain much more information
- Challenges coordinating across multiple providers can create tension
  - Disparities in the level of quality of various providers across the care delivery chain
  - Patient preference and the desire of the institution to focus on its preferred quality providers can be at odds
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#### Discussion Questions

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  - EHR adoption rate and interoperability?
  - Quality metrics tracking for evaluation and reimbursement?
- What preconditions are necessary for successful adoption and implementation?
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Upcoming Deliverables

- EHR Survey/Adoption Analysis (Wed. 7/10)
- HIE Environmental Scan Key Findings (7/13)
- HIE Environmental Scan (Fri. 7/24)
- Value Based Analytics Roadmap Key Findings (Tues. 8/10)
- Value Based Analytics Roadmap (Tues. 8/25)
- Health Information Technology Plan: Internal Review (Fri. 10/30)
- Health Information Technology Plan: CMS Review (Fri. 11/30)

For more information on workgroup meeting dates and locations, visit the following webpage: [Click Here](#)
HIT Plan Discussion

The ultimate deliverable for the Health Information Technology Workgroup is a detailed plan to support innovative care model design.

CMS Template Example

CMS has provided guidance to support HIT plan development, in the form of detailed templates and supporting documentation.
OHIP/OSIM Meeting Timeline

Health Efficiency & Effectiveness

- 08/20

Health Workforce

- 09/02
- 10/15

Workforce Strategy Session

Health Finance

- 10/28
- 11/3

Health Information Technology

- 07/29
- 08/27

Additional OSIM Meetings

- 08/13 Statewide Webinar
- 09/09 VBA/Model Design Workshops
- 09/11
Value-Based Analytics and Model Design Workshops

Meeting Options:

- September 9 in Oklahoma City
  SAMIS Center, OU Health Sciences Center, 2-5 p.m.

- September 11 in Tulsa
  Tulsa Chamber of Commerce, 1-3 p.m.

Members from all OHIP/OSIM Work Groups are invited.
Health Workforce Redesign

Governor’s Health Workforce Action Plan Strategy Session
September 2nd, 9:00am-3:00pm

- Action Plan contains high level goals and strategies to ensure Oklahoma’s health workforce is able to support the transition to value-based care
- Session will be facilitated by National Governor’s Association Consultants
- Attendees from each workgroup will be invited
- Outcomes will be included in an issue brief that will inform the newly created “Health Workforce Subcommittee” of the Governor’s Council for Workforce and Economic Development

Outcomes:
- Input on the development of a health workforce plan which incorporates a care coordination model, encourages patient-centered care, and supports the needs of a value-based system
- Recommendations for descriptions and core competencies for “emerging health professions” in Oklahoma
- Recommendations that support “Team-Based Care for a Transformed System of Care” in Oklahoma

Contact Jana Castleberry at JanaC@health.ok.gov or at 405-271-9444 ext. 56520.