

# Oklahoma State Department of Health



Oklahoma State Innovation Model (OSIM)

OSIM Health Information Technology  
07/29/2015 Workgroup Meeting



# Agenda



	Section		Presenter	
<b>Introductions</b>	<b>5 min</b>	<b>10:00</b>	<b>I. Lutz / A. Miley</b>	
<b>Final Deliverable Review &amp; Discussion: Electronic Health Record</b>	<b>15 min</b>	<b>10:05</b>	<b>Oklahoma Foundation for Medical Quality (OFMQ)</b>	
<b>Final Deliverable Review &amp; Discussion: Health Information Exchange</b>	<b>45 min</b>	<b>10:20</b>	<b>A. Miley</b>	
<b>Payment Models: Overview</b>	<b>45 min</b>	<b>11:05</b>	<b>I. Lutz</b>	
<b>Wrap-Up</b>	<b>10 min</b>	<b>11:50</b>	<b>I. Lutz / A. Miley</b>	



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# EHR Survey: Considerations & Discussion Questions

## Considerations

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- 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

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- 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



# Health Information Exchange (HIE) Environmental Scan: Final Review

## Current Oklahoma HIE Features (updated)

Feature	Coordinated Care Oklahoma	MyHealth Access Network
Organization Structure	Not-for-profit	Not-for-profit
Revenue Model	Fee and subscription	Fee and subscription
Board Composition	Hospital systems and providers	Community- and member-based
Patient Lives (est.)	4,700,000	4,000,000
Provider Locations (est.)	455	800
Data Model	Hybrid	Hybrid
CCD	Yes	Yes
Population Management Tools	Yes (Pentaho)	Yes (Pentaho)
Analytics	Not at this time	Yes (IndiGo)
Patient Participation Model	Opt-out	Opt-out
ONC Certifications	Advanced directives	Patient portal
Training Model	Train the trainer	Train the trainer
Demographic Data	Yes (centralized)	Yes (centralized)
Clinical Data	Yes (centralized)	Yes (centralized)
Claims Data	Not at this time	Yes (selected payers)
Major Funding Grants	None	Beacon Community Grant



# Health Information Exchange (HIE) Environmental Scan: Final Review

## **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

**Claims/Clinical Analytics Support**

**Clinical Decision Support**

**Point-of-Care Support**



# 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



# Health Information Exchange (HIE) Environmental Scan: Final Review

## **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



# Health Information Exchange (HIE) Environmental Scan: Final Review

## **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



# Health Information Exchange (HIE) Environmental Scan: Final Review

## Consideration 2: Governance Model

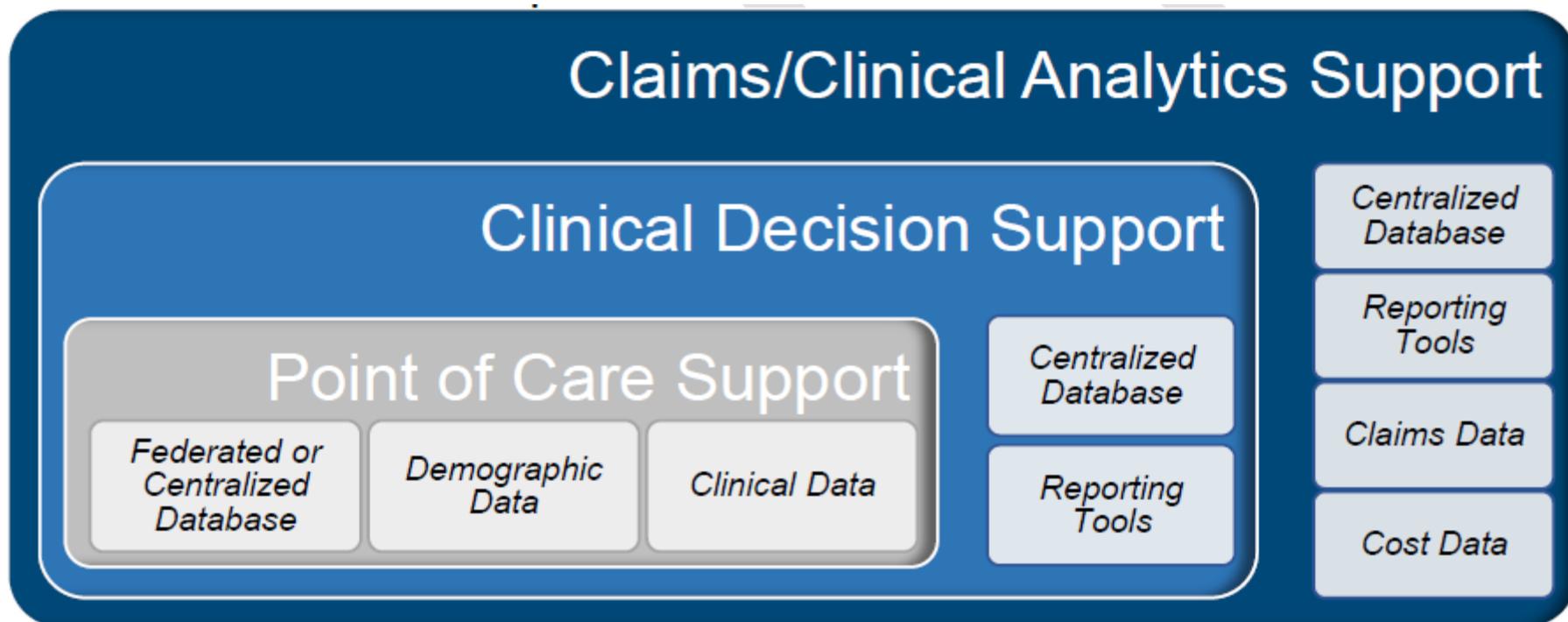
Experience gained from other HIE initiatives nationally suggests that agreeing upon or legislating what information is shared and when and to whom it is accessible are key determinants for the utility of an exchange or network of exchanges. Important decisions that need to be made about the exchange's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

Option 1 “Network of Exchanges”	Option 2 Select an Existing HIE	Option 3 State Sponsored HIE
<ul style="list-style-type: none"><li>• Least robust statewide capability</li><li>• Moderate response to market needs; maximum stakeholder input</li><li>• Moderate time to market</li></ul>	<ul style="list-style-type: none"><li>• Adoption of existing capability</li><li>• Responsive to market needs; moderate stakeholder input</li><li>• Shortest time to market</li></ul>	<ul style="list-style-type: none"><li>• Ability to customize statewide capability</li><li>• Slow response to market needs; limited stakeholder input</li><li>• Longest time to market</li></ul>



# 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



# Health Information Exchange (HIE) Environmental Scan: Final Review

## 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

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- 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

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- 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



# Agenda



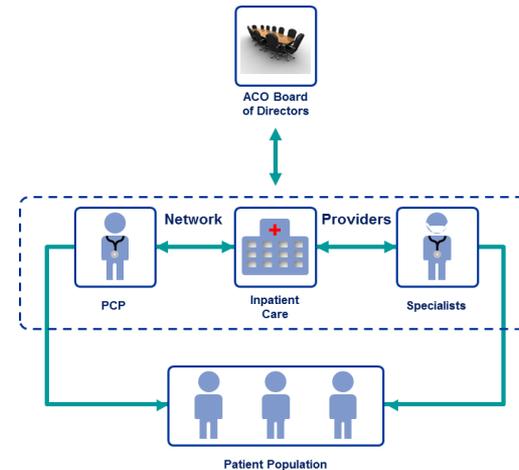
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# Accountable Care Organizations

<b>Overview</b>	<ul style="list-style-type: none"> <li>▪ Networks of providers that collectively accept accountability for the cost and quality of a patient's care</li> <li>▪ Emphasizes coordination of care</li> </ul>
<b>Scope</b>	<ul style="list-style-type: none"> <li>▪ Provider organizations including hospitals, primary care, specialists, and other supportive care institutions and services</li> </ul>
<b>Care Model</b>	<ul style="list-style-type: none"> <li>▪ Integrated care delivery efforts on behalf of networked providers             <ul style="list-style-type: none"> <li>– ACO assumed primary accountability for overall outcomes and costs for a patient's care</li> </ul> </li> <li>▪ Patients are not limited to providers within the ACO network</li> </ul>
<b>Payment Model</b>	<ul style="list-style-type: none"> <li>▪ ACOs can operate through a variety of payment models</li> <li>▪ Their networked nature positions them well to handle episodes of care and bundled payments designs</li> </ul>
<b>Attribution</b>	<ul style="list-style-type: none"> <li>▪ Patients are attributed prospectively based on prior claims information and retroactively based on volume of contacts             <ul style="list-style-type: none"> <li>– Provider must notify patients that it is an ACO</li> </ul> </li> </ul>

## Accountable Care Organizations

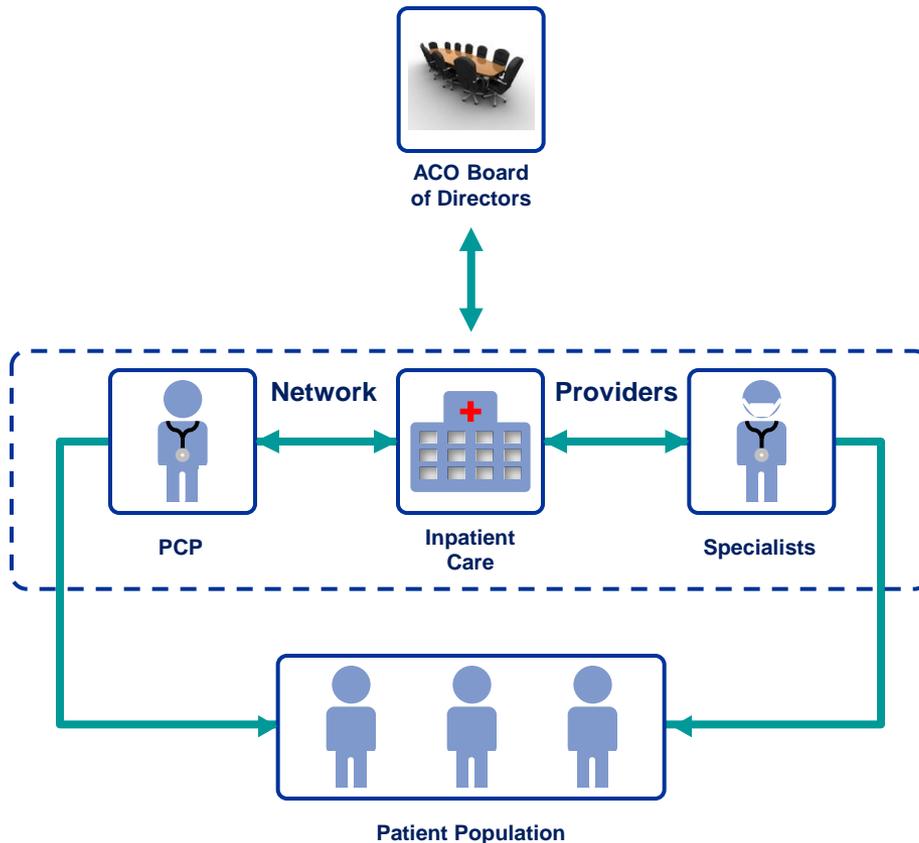


## Results & Considerations

- 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

# Accountable Care Organizations – Care Model Design

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

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- Preliminary results from the 243 Medicare ACOs indicate that 25% achieved significant cost savings
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- All participating providers need to have some level of access to HIT in order to best coordinate patient care
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## Discussion Questions

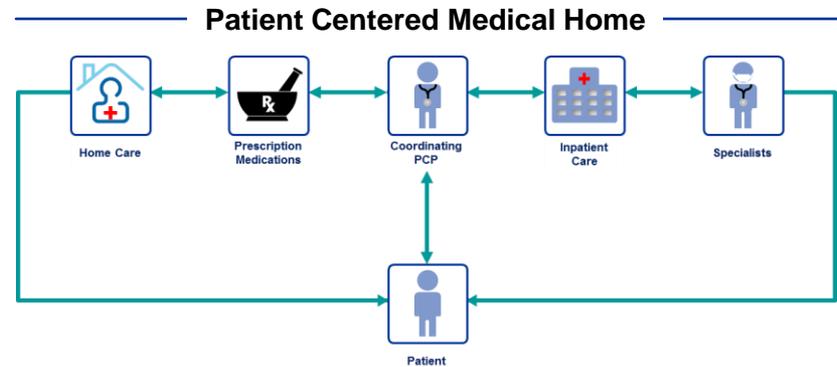
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- What information technology considerations would wider adoption have for Oklahoma? What information and systems must come together?
  - EHR adoption rate and interoperability?
  - Quality metrics tracking for evaluation and reimbursement?
- What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



# Patient-Centered Medical Home (PCMH)

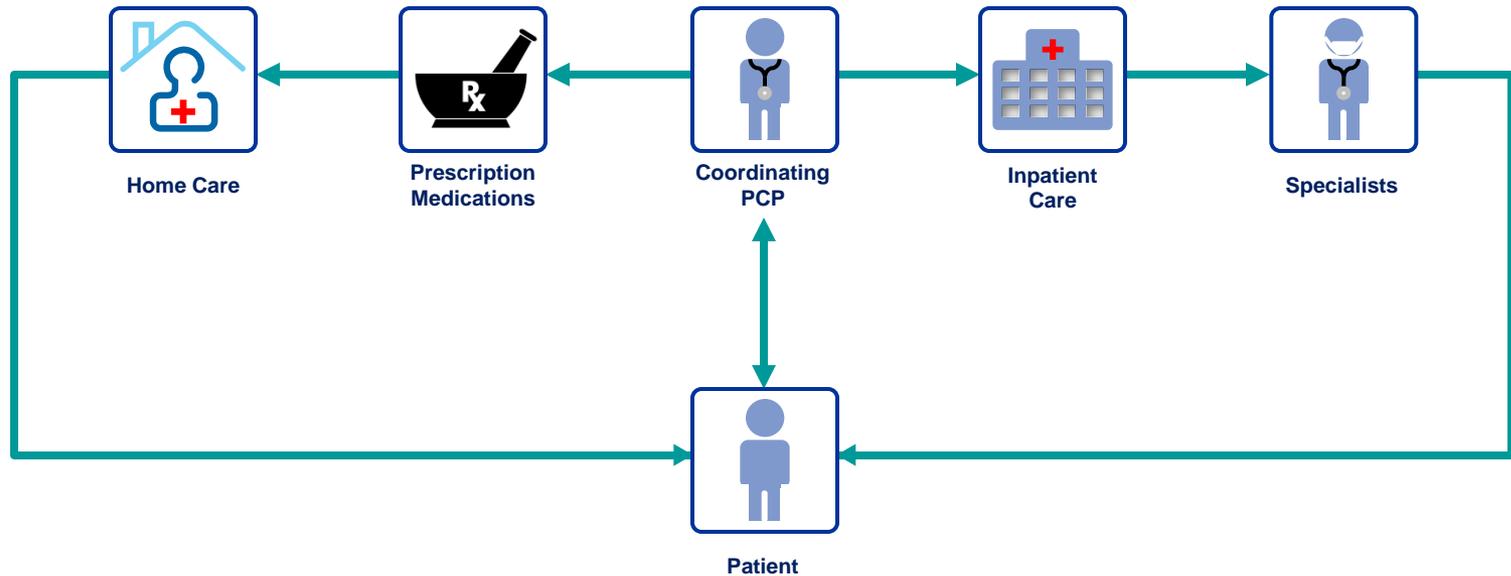
<b>Overview</b>	<ul style="list-style-type: none"> <li>Primary care delivery model that focuses on care coordination, communication, and the patient experience</li> </ul>
<b>Scope</b>	<ul style="list-style-type: none"> <li>Single primary care provider</li> <li>Appropriate patients vary by program</li> </ul>
<b>Care Model</b>	<ul style="list-style-type: none"> <li>One primary care physician serves as the first point of contact for the patient and provides comprehensive, coordinated care</li> <li>The PCMH encompasses five attributes:             <ul style="list-style-type: none"> <li>Comprehensive, team-based care</li> <li>Patient-centered care</li> <li>Coordinated care</li> <li>Accessible services</li> <li>Quality and safety</li> </ul> </li> </ul>
<b>Payment Model</b>	<ul style="list-style-type: none"> <li>Payment can include fee-for-service (FFS), with a modest additional per member per month payment for coordinating care</li> </ul>
<b>Attribution</b>	<ul style="list-style-type: none"> <li>Patient eligibility determined by payer organization</li> </ul>



## 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

# Patient-Centered Medical Home (PCMH) – Care Model Design



- 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

# Patient-Centered Medical Home (PCMH) – Model Implications Discussion

## Considerations

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- 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
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## Discussion Questions

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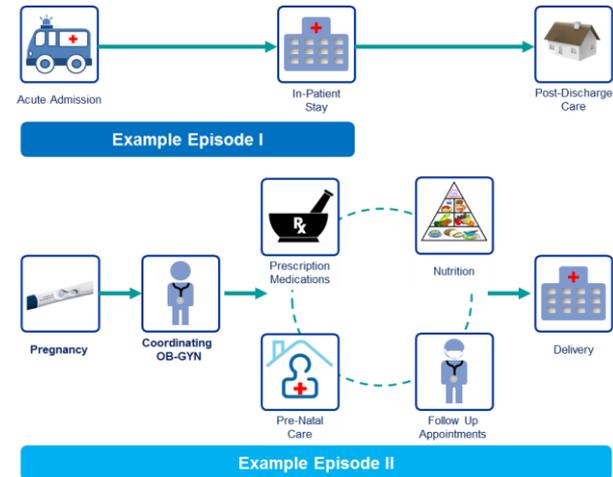
- What information technology considerations would wider adoption have for Oklahoma? What information and systems must come together?
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# Episodes of Care

<b>Overview</b>	<ul style="list-style-type: none"> <li>Payment model in which services related to a condition or procedure are grouped into “episodes” that provide benchmarks for appropriate costs of care</li> </ul>
<b>Scope</b>	<ul style="list-style-type: none"> <li>Single provider</li> <li>Episodes may be designed for any patient population</li> </ul>
<b>Care Model</b>	<ul style="list-style-type: none"> <li>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</li> </ul>
<b>Payment Model</b>	<ul style="list-style-type: none"> <li>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</li> <li>PAPs are rewarded with a percentage of savings or charged a portion of costs in excess of the benchmarks</li> </ul>
<b>Attribution</b>	<ul style="list-style-type: none"> <li>Patient has a triggering event or certain number of claims related to an episode with a participating provider</li> </ul>

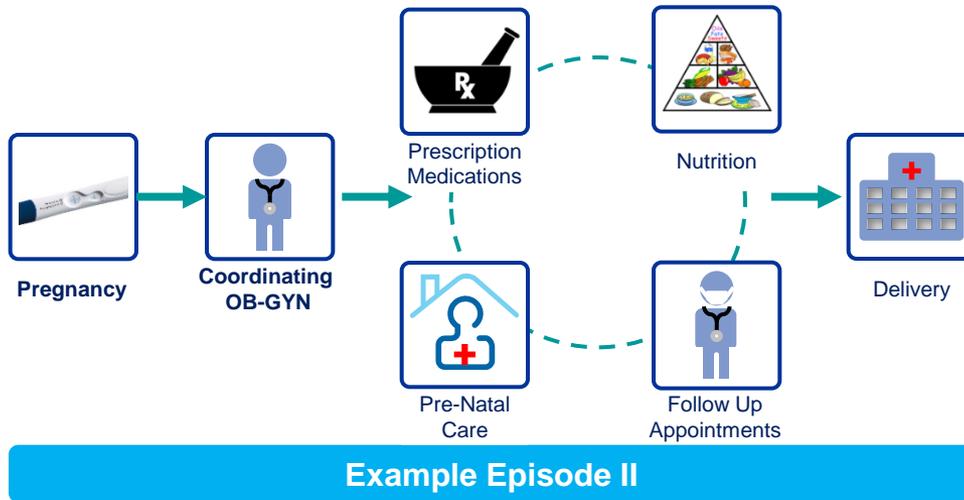
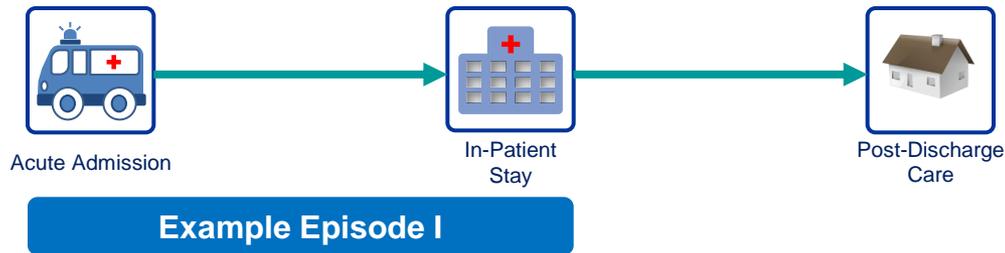
## Example Episodes of Care



## 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

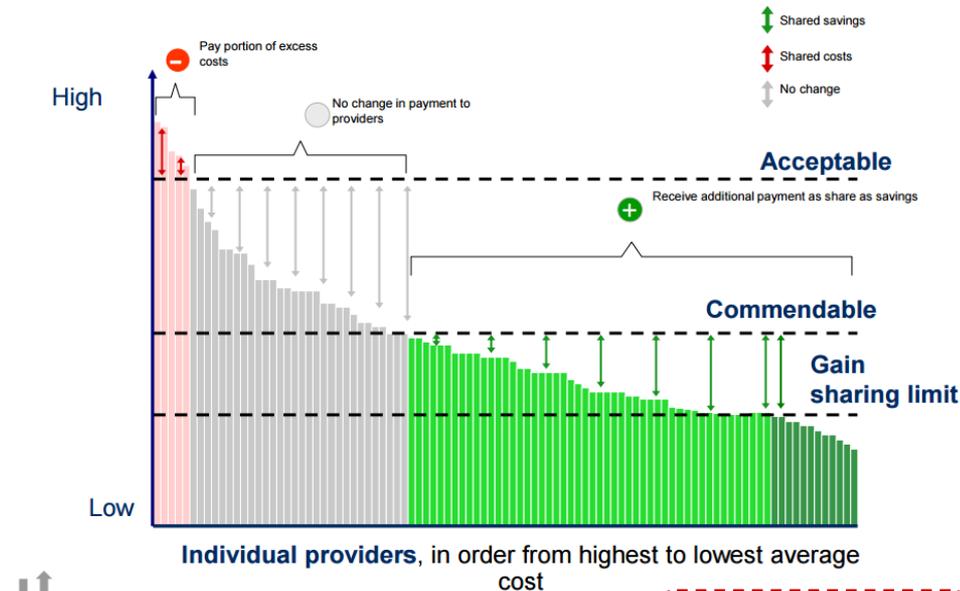
# Episodes of Care – Payment Model Design



- 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)

PAPs that meet quality standards and have average costs below the commendable threshold will share in savings up to a limit



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

Illustrative

- 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

# Episodes of Care – Model Implications Discussion

## Considerations

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## Discussion Questions

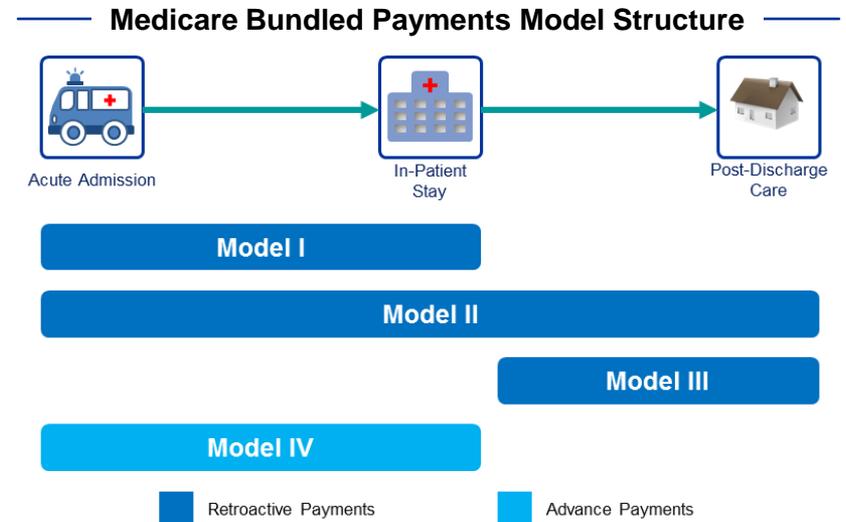
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# Medicare Bundled Payments Care Initiative (BPCI)

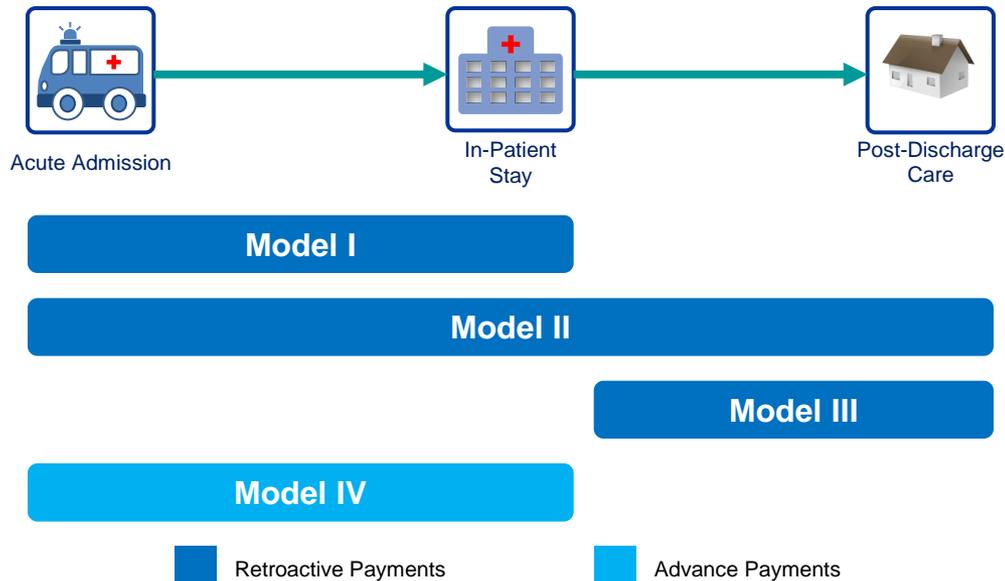
<b>Overview</b>	<ul style="list-style-type: none"> <li>Series of opt-in payment model pilot programs from CMS</li> <li>Designed to align incentives across fee for service providers to improve patient outcomes and decrease costs in tandem</li> </ul>
<b>Scope</b>	<ul style="list-style-type: none"> <li>Networks of providers</li> <li>Programs encompass some or all of a subset of 48 DRGs</li> </ul>
<b>Care Model</b>	<ul style="list-style-type: none"> <li>Care coordination is up to participating provider networks</li> </ul>
<b>Payment Model</b>	<ul style="list-style-type: none"> <li>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</li> <li>All episodes begin with an acute hospitalization by a patient but then vary:             <ul style="list-style-type: none"> <li>Initiation and duration of episode of care</li> <li>Applicable DRG</li> <li>Timing of payments</li> </ul> </li> </ul>
<b>Attribution</b>	<ul style="list-style-type: none"> <li>CMS guidance does not specify attribution protocol, so it is assumed that this can vary by participating institutions</li> </ul>



## Results & Considerations

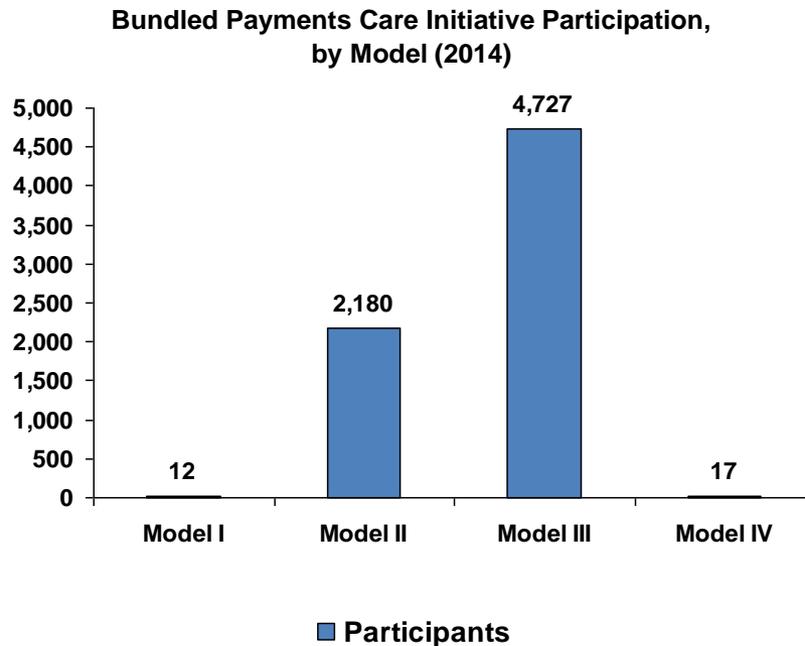
- Initial quantitative results are not yet available within the 2014 status report
  - Limited enrollment for the initial 2013 year limits usefulness of any statistics
  - Subsequent reports should contain much more information
- Challenges coordinating across multiple providers can create tension
  - 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

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- Initial quantitative results are not yet available within the 2014 status report
  - Limited enrollment for the initial 2013 year limits usefulness of any statistics
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## Discussion Questions

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- 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?



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# OSIM – Health Information Technology

## Upcoming Deliverables and Meetings



### 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

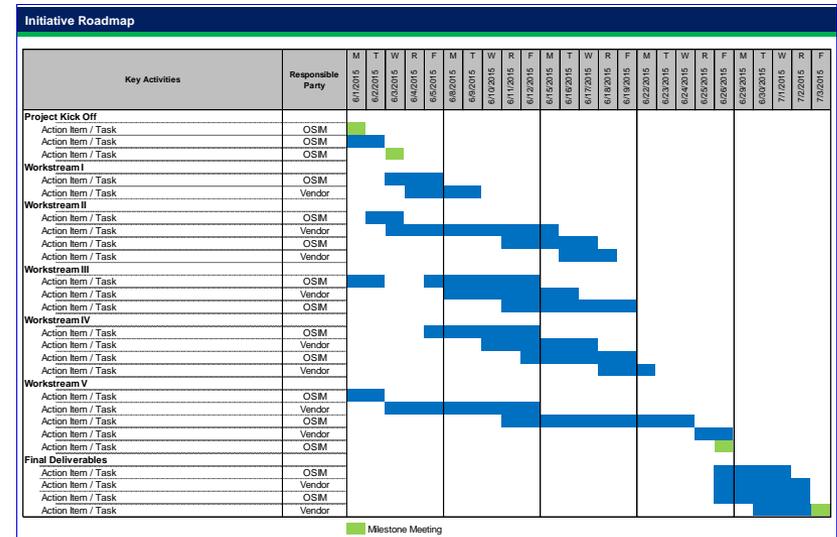
### Health IT Plan: Workbook

Driver Diagram: Health IT Support for Data and Information to achieve state-wide health transformation

Table 1: Health IT Support for Data/Information for Driver Diagram (Workbook Tab 1)

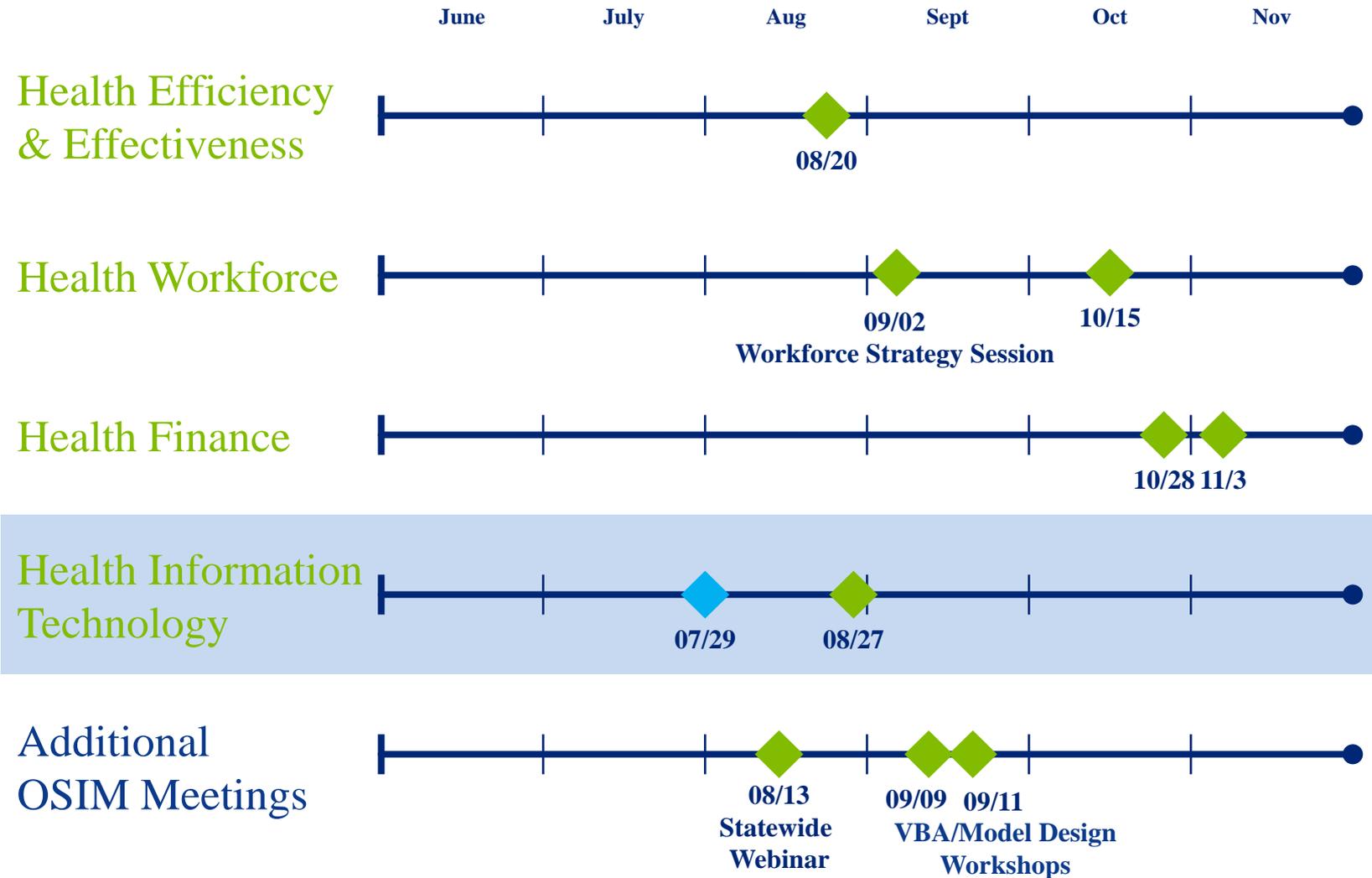
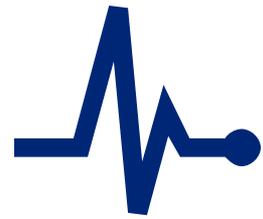
Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) state (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees	What Health IT is needed to support data collection, retention, aggregation, analysis, dissemination? (what and by when)	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable): (1)statutory/regulatory (2) Leveraging State Purchasing - Medicaid (managed care contracting/MMS/MU Program) (3) Leveraging State Purchasing - State Employees (4)Leveraging Private Financing	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item
<i>(Copy from Operational Plan Driver Diagram-Tab 1)</i>	<i>Examples: state - for reporting to state legislature, delivery system - to determine if a change in benefits required; provider - care team for delivery of care; patient - compliance with treatment plan; etc.</i>	<i>Examples: Collection - connectivity between BH, PH and medical providers; Retention - Data Repository, Aggregation - patient matching; Analysis - Data Analytic capability; Dissemination - HIE, etc.</i>	<i>Examples: TA - TA to providers regarding specifications; IT - data analytic software at the state; P - data sharing agreement; O - policies and procedures, etc.</i>	<i>Examples: amendment to state law; contract language in managed care contract; condition of participation; direct or indirect payment; etc.</i>	<i>Examples: P - legislative action; TA - funding; IT - procurement; O - timelines, etc.</i>
1.a.1					
1.a.2					

## Model Roadmap Design

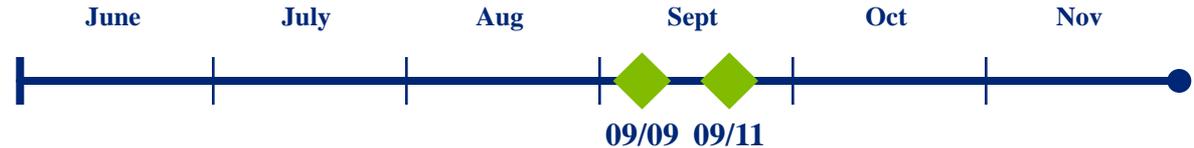


CMS has provided guidance to support HIT plan development, in the form of detailed templates and supporting documentation

# OHIP/OSIM Meeting Timeline



# 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 2<sup>nd</sup>, 9:00am-3:00pm

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- 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

**Contact Jana Castleberry at**  
**[JanaC@health.ok.gov](mailto:JanaC@health.ok.gov) or at**  
**405-271-9444 ext. 56520.**



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### ■ 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