

## C. Report on Stakeholder Engagement and Design Process Deliberations

### INTRODUCTION

This section of the State Health System Innovation Plan (SHSIP) describes the stakeholder engagement and design deliberations for the Oklahoma State Innovation Model (SIM) project. This report reviews all stakeholder activities as of the close of the project on March 31, 2016. The purpose of this section is to present details of the SIM stakeholder engagement activities, including collaborative efforts between the Oklahoma SIM project staff and stakeholders, identification of relevant aspects of the 2014 Oklahoma State Department of Health (OSDH) Wellness Business Survey Report, and analysis and interpretation of key findings on collected data. Stakeholder engagement aimed at bringing subject matter experts together to facilitate discourse and consensus on critical areas of the SIM design.

#### Stakeholder Engagement Foundation

The OSDH, the fiduciary agent of the Oklahoma SIM grant, understands that broad stakeholder engagement is essential for effective and sustainable health system transformation. In 2008, five years prior to the SIM design and testing opportunities provided by federal law, the State convened a broad-based group of stakeholders, called the Oklahoma Health Improvement Planning (OHIP) Coalition. The goal of this coalition was to develop a comprehensive health improvement plan for Oklahoma. The OHIP team consisted of influential stakeholders representing providers, payers, state and local governments, tribal sovereign nations, academic institutions, private institutions, businesses, and community organizations. Under the OHIP Coalition's leadership, the State produced two state health improvement plans: the Oklahoma Health Care Improvement Plan (OHIP) 2014, for 2010 to 2014, and the OHIP Plan 2020, for 2015 to 2020. OHIP 2014 and OHIP 2020 identified the state's flagship population health issues (tobacco use, obesity, children's health, behavioral health); infrastructure goals (public health finance, workforce development, access to care, health systems effectiveness); and societal and policy integration goals (social determinants of health, health equity).

#### Oklahoma SIM and OHIP Alignment

The State has used the governance structure and stakeholder base of the OHIP Coalition to lead the Oklahoma SIM project. OHIP workgroups were organized around four distinct focus areas, Health Efficiency and Effectiveness, Health Workforce, Health Finance, and Health Information Technology (IT). These same focus areas were used for the SIM design. The alignment of the vision and goals of the Oklahoma SIM project and OHIP Coalition has been actualized through the incorporation of the OHIP Coalition, Tribal Public Health Advisory Committee, and OHIP Workgroups into the Oklahoma SIM governance structure. As with OHIP 2014 and OHIP 2020, the SHSIP will be a product of collaboration across diverse stakeholder groups.

While the OHIP plans presented a comprehensive assessment of Oklahoma's population health successes, challenges, and improvement strategies, the Oklahoma SIM project takes OHIP to the next level by designing a feasible and sustainable model for healthcare delivery and payment reform to advance the population health improvement goals identified by the OHIP Coalition. Furthermore, the Oklahoma SIM project team has expanded OHIP's stakeholder base to include additional consumers, businesses, public

health coalitions, healthcare associations, and the state’s top payers and organizations at the forefront of healthcare innovation.

## STAKEHOLDER ENGAGEMENT PLAN UPDATE

The Oklahoma SIM project team devised a Stakeholder Engagement Plan to address the value of healthcare delivery and payment reform. The aim of the stakeholder engagement plan was to encourage collaboration and discourse that would ensure incorporation of stakeholder input and facilitate agreement and ultimately buy-in necessary to shape the design of the state’s model. The project team has utilized a multi-pronged approach to ensure broad and diverse stakeholder engagement across the state.

At a high-level, the strategies to this Oklahoma SIM Stakeholder Engagement Plan include:

1. Leveraging the OHIP governance structure and workgroups to ensure representatives with the appropriate subject matter expertise and practical experience facilitate, monitor, and evaluate the various activities and deliverables of the Oklahoma SIM project.
2. Utilizing the Tribal Public Health Advisory Committee to seek feedback and recommendations for the model design from Oklahoma’s tribal nations and partners.
3. Deploying Oklahoma SIM staff and a Stakeholder Engagement Facilitator to work together in the field to engage new communities and stakeholders throughout Oklahoma to solicit more interest, support, and subject matter expertise for the Oklahoma SIM project.

Below is a diagram of the four phases of Oklahoma SIM Stakeholder Engagement Plan. Using extensive stakeholder input, the Oklahoma SIM project team created the conceptual design of the “Oklahoma Model”, and drafted the SHSIP, the final product of the Oklahoma project. The project team conducted a statewide public comment period on the SHSIP from February 2016 to March 2016. Now at the end of March 2016, the project team has completed all four phases of the plan and is submitting the SHSIP.

**Figure 17: Phases of the Engagement Plan**



The Oklahoma SIM project team has implemented the strategies contained in the Stakeholder Engagement Plan. The table below details successes and future opportunities for each strategy.

**Table 13: Stakeholder Engagement Plan High-Level Strategies**

Strategy	Successes	Opportunities
<p><b>Leverage the OHIP governance structure and workgroups to ensure representatives with the appropriate subject matter expertise and practical experience facilitate, monitor, and evaluate the various activities and deliverables of the Oklahoma SIM project.</b></p>	<ul style="list-style-type: none"> <li>• Held 3 Executive Steering Committee Meetings</li> <li>• Held regular leadership calls to discuss and refine Stakeholder Engagement Plan strategies</li> <li>• Held 33 workgroup meetings, including 3 All Workgroup meetings</li> <li>• Drafted, reviewed, and completed 15 workgroup deliverables</li> <li>• Completed 9 technical assistance deliverables</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage further focused stakeholder input on workgroup deliverables via the workgroup online public comment boxes</li> <li>• Recruit additional members from underrepresented communities to serve as workgroup members</li> </ul>
<p><b>Utilize the Tribal Public Health Advisory Committee (incorporated as part of the OKLAHOMA SIM governance structure) to seek feedback and recommendations for the model design from Oklahoma’s Tribal nations and partners.</b></p>	<ul style="list-style-type: none"> <li>• Had active participation from various tribal nations and associations on the workgroups</li> <li>• Had representation of an industry expert and hospital executive from the Cherokee Nation in the Executive Steering Committee</li> <li>• Presented twice to the Tribal Public Health Advisory Committee</li> <li>• Held two tribal consultations</li> </ul>	<ul style="list-style-type: none"> <li>• Continue working with the Tribal Liaison to establish and coordinate meetings between the committee, workgroups, staff, and leadership to keep the committee apprised of the project’s status and seek their input into the SHSIP</li> </ul>
<p><b>Deploy Oklahoma SIM staff and a Stakeholder Engagement Facilitator to work together in the field to engage new communities and stakeholders throughout Oklahoma to solicit more interest, support, and subject matter expertise for Oklahoma SIM.</b></p>	<ul style="list-style-type: none"> <li>• Held 90 stakeholder meetings and presentations, 2 Statewide Webinars, and 1 All Payer Meeting to inform and engage stakeholders</li> <li>• Held meetings in 14 cities and counties across urban and rural Oklahoma, representing all four quadrants</li> <li>• Prepared agendas, scalable educational materials, supporting document, and summary notes</li> </ul>	<ul style="list-style-type: none"> <li>• Secure buy-in and consensus from the state’s top payers on the proposed model design</li> <li>• Continue reaching out to the business community to align vision for health system transformation, recruit new workgroup members, and secure buy-in for the model design</li> </ul>

The Oklahoma SIM project team leveraged OSDH’s existing outreach network of community coalitions, educators, and specialists embedded throughout Oklahoma to disseminate information about project goals and objectives, assemble stakeholders, and provide regional and community logistics and support to host stakeholder meetings. In particular, the project team leveraged the Turning Point program and

Partnerships for Health Improvement Program. The project team incorporated information about community-based health initiatives into the SHSIP.

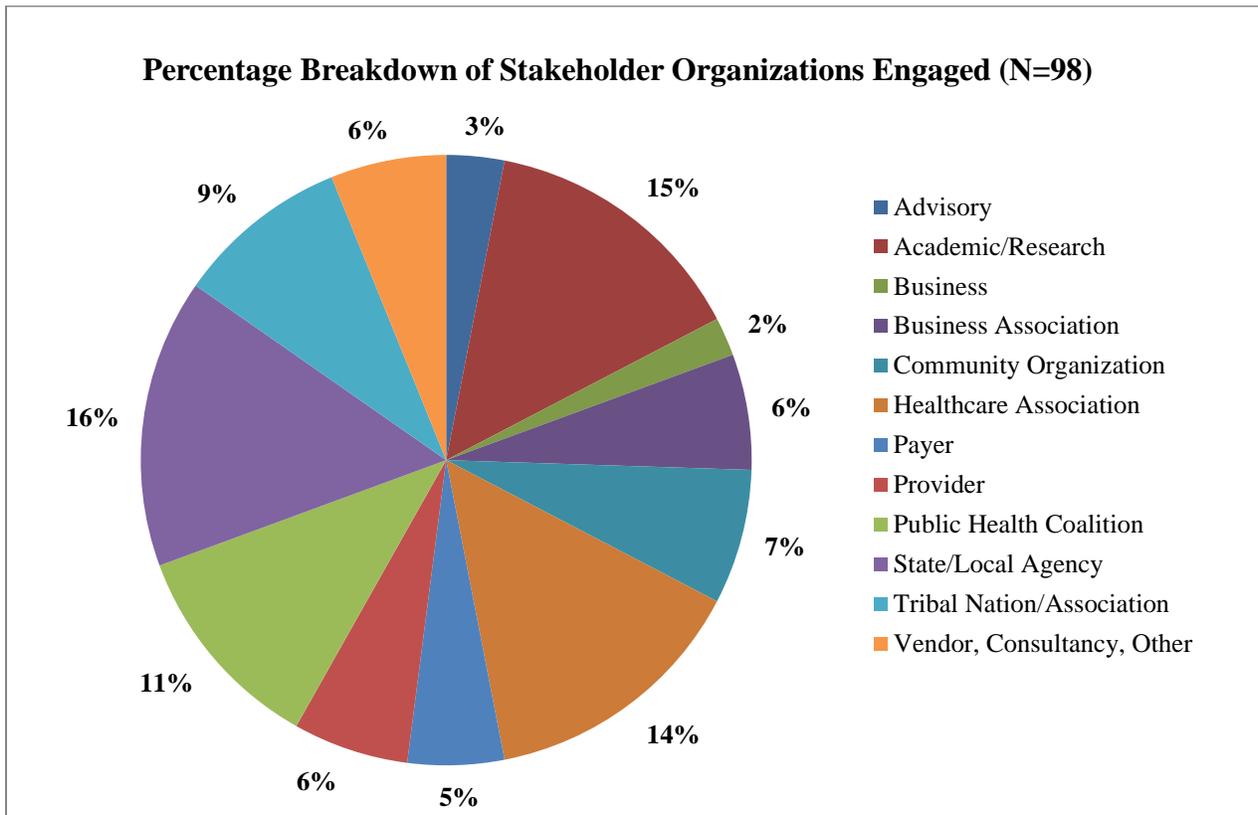
### **Stakeholder Type**

The Oklahoma SIM project engaged with a diverse group of stakeholders as shown in the list below:

- A. Advisory Group/Committee
- B. Academic/Research Institution
- C. Business/Business Association
- D. Community Organization/Consumer Advocate
- E. Healthcare Association
- F. Payer (State-Funded, Commercial, Non-Profit)
- G. Provider
- H. Public Health Association/Coalition
- I. State/Local Agency
- J. Tribal Nation/Association
- K. Vendor, Consultancy, Other

The pie chart below depicts a breakdown of stakeholder organizations, per stakeholder type, with whom the Oklahoma SIM project team has engaged, out of a total of 100 stakeholder organizations.

**Figure 18: Percentage Breakdown of Stakeholder Organizations Engaged**



**Stakeholder Meetings**

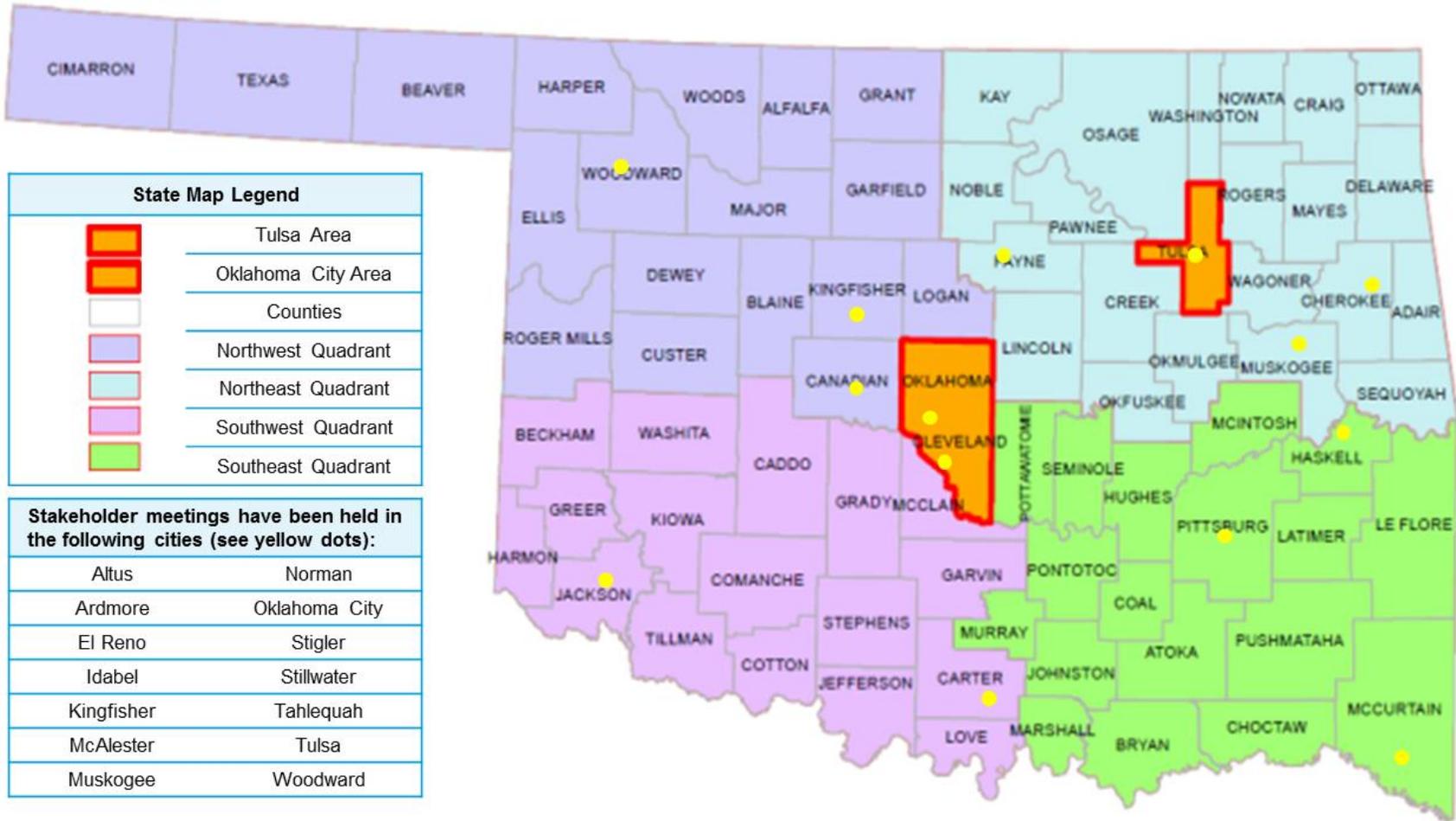
The table and map below show the location of meetings in 14 cities and counties across the state. The Oklahoma SIM leadership divided Oklahoma into four geographic quadrants (Northwest, Northeast, Southwest, and Southeast) and two metropolitan areas (Oklahoma City and Tulsa). The Oklahoma SIM project team has engaged local communities in all of the four quadrants. The majority of meetings outside the Oklahoma City and Tulsa Metropolitan Areas represent meetings with Turning Point Coalitions to learn about community-based initiatives. The project team used OSDH’s Turning Point program to help schedule these meetings.

**Table 14: Stakeholder Engagement Meeting Locations**

City	County	Quadrant
Altus	Jackson County	Southwest
Ardmore	Carter County	Southwest
El Reno	Canadian County	Northwest
Idabel	McCurtain County	Southeast
Kingfisher	Kingfisher County	Northwest
McAlester	Pittsburg County	Southeast

<b>Muskogee</b>	Muskogee County	Northeast
<b>Norman</b>	Cleveland County	Oklahoma City Area
<b>Oklahoma City</b>	Oklahoma County	Oklahoma City Area
<b>Stigler</b>	Haskell County	Southeast
<b>Stillwater</b>	Payne County	Northeast
<b>Tahlequah</b>	Cherokee County	Northeast
<b>Tulsa</b>	Tulsa County	Tulsa Area
<b>Woodward</b>	Woodward County	Northeast

**Figure 19: Stakeholder Meeting Map**

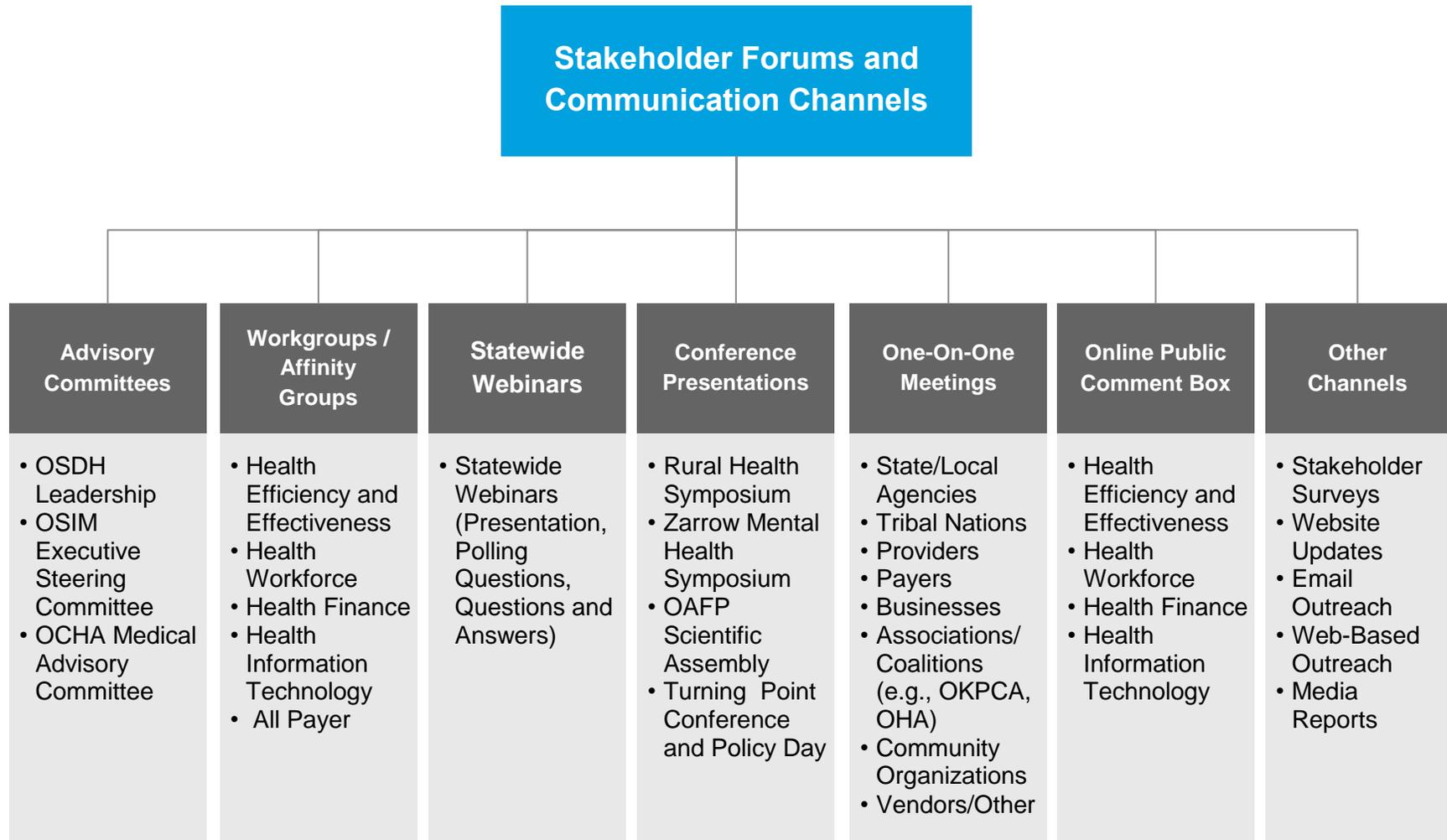


## **NARRATIVE OF STAKEHOLDER ENGAGEMENT ACTIVITIES**

The Oklahoma SIM project team has benefited from the use of multiple forums and communication channels for stakeholder engagement. Executive Steering Committee meetings focused on providing project leadership with high-level updates to the project and driving critical decision-making on key aspects of the SHSIP development. This was coupled with meetings of the OSDH leadership and Oklahoma Health Care Authority (OHCA) Medicaid Advisory Committee to provide advisory guidance for the project. Workgroup meetings allowed stakeholders to offer focused feedback to Oklahoma SIM deliverables as well as on the SHSIP sections. Statewide Webinars focused on providing quarterly updates on project meetings, activities, and deliverables. Affinity group based meetings, in this case the All Payer Meeting, focused on determining areas of alignment between these similar entities and building consensus on a model for the state. One-on-one meetings focused on conducting key informant interviews and informing stakeholders about the project and stakeholder opportunities, determining areas of alignment between the project and stakeholder organizations, and collecting data on organizational activities, particularly with regards to healthcare innovation. These meetings also enabled the project team to receive focused feedback on the model for the state. Presentations at stakeholder board meetings and conferences focused on informing potential stakeholders about the project, leading discussions, providing answers to questions from the public, and soliciting participation in workgroups. Additionally, the project team used a public comment box located on the Oklahoma SIM website and other channels, such as stakeholder surveys, website updates, and direct email outreach, to engage stakeholders virtually.

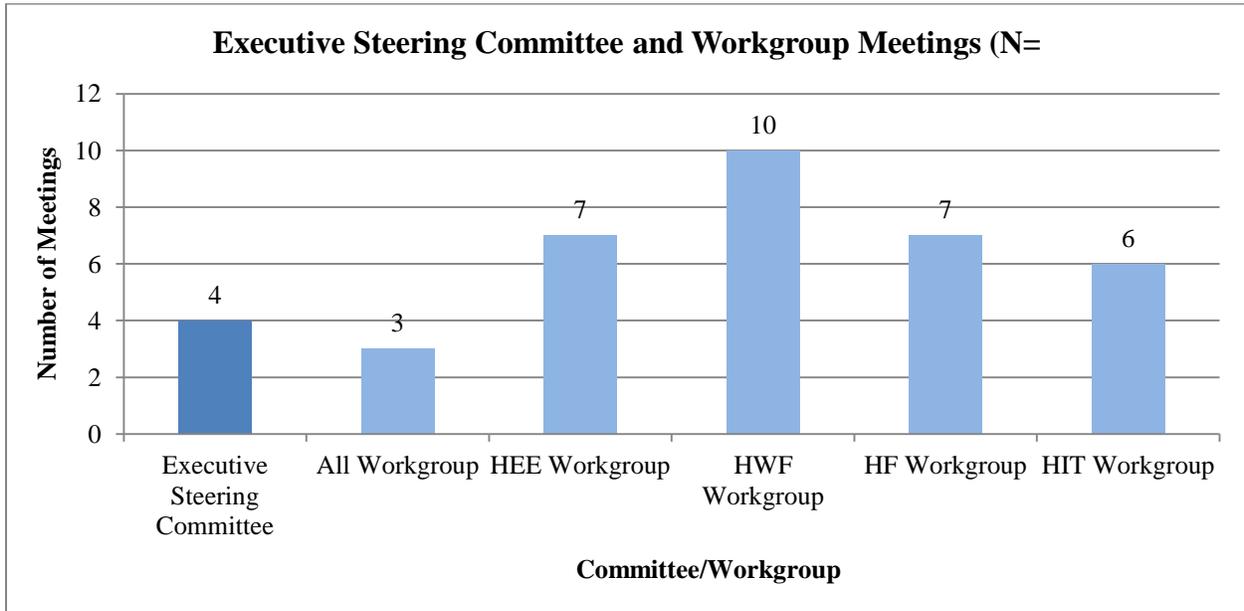
The figure below displays the various forums and communication channels used throughout the Oklahoma SIM project period to engage stakeholders in developing project deliverables and the SHSIP.

**Figure 20: Oklahoma SIM Stakeholder Forums and Communication Channels**



As a representation of the constant meeting activity during the Oklahoma SIM project period, the graphs below show a breakdown of Executive Steering Committee meetings, workgroup meetings, statewide webinars, affinity group meetings, and general stakeholder meetings as of the close of the project period. In total, the project team held four Executive Steering Committee meetings, 33 workgroup meetings, two statewide webinars, and a range of other stakeholder meetings and presentations.

**Figure 21: Executive Steering Committee and Workgroup Meetings**



**Figure 22: External Stakeholder Meetings**



## Executive Steering Committee Meetings

The Oklahoma SIM project team held four Executive Steering Committee Meetings on June 11, 2015; September 16, 2015; January 13, 2016; and February 23, 2016. Table 15 shows the list of the 12 committee members.

**Table 15: Executive Steering Committee Membership**

Name	Title and Organization	Committee Role
<b>Julie Cox-Kain</b>	Deputy Secretary for Health and Human Services, OSDH	Leadership Chair
<b>Rebecca Pasternik-Ikard</b>	State Medicaid Director, Oklahoma Health Care Authority (OHCA)	Health Efficiency and Effectiveness Workgroup Vice Chair
<b>Deidre Meyers</b>	Deputy Secretary of Workforce Development, Office of Workforce Development	Health Workforce Workgroup Vice Chair
<b>Joseph Cunningham</b>	Vice President of Health Care Management and Chief Medical Officer, Blue Cross Blue Shield (BCBS) of Oklahoma	Health Finance Workgroup Vice Chair
<b>Bo Reese</b>	State Chief Information Officer, Office of Management and Enterprise Services (OMES)	HIT Workgroup Vice Chair
<b>Mitchell Thornbrugh</b>	Chief Operating Officer, Cherokee Nation W.W. Hastings Hospital	Tribal Leadership Advisor
<b>David Kendrick</b>	Chair of Medical Informatics, University of Oklahoma (OU) College of Medicine; Founder and Chief Executive Officer (CEO), MyHealth Access Network	Committee Member
<b>Brian Yeaman</b>	Chief Administrative Officer, Coordinated Care Oklahoma	Committee Member
<b>Bill Hancock</b>	Vice President, CommunityCare of Oklahoma Health Insurance Plans	Committee Member
<b>David Hadley</b>	Managing Director and Chief Financial Officer, INTEGRIS Health	Committee Member
<b>Debby Hampton</b>	President and CEO, United Way of Central Oklahoma	Committee Member
<b>Michael Brose</b>	Executive Director, Mental Health Association Oklahoma	Committee Member

Executive Steering Committee meetings solicited critical feedback from committee members on the development of the Oklahoma SIM project, the model design, and the SHSIP sections. The first meeting focused on the following objectives: 1) Increasing committee membership to reflect the business community, health systems, behavioral health providers, and safety net providers; and 2) strategies to conduct research and evaluation on alternative payment models in Arkansas, Ohio, Colorado, Oregon and Tennessee with the aim of identifying practices that could be replicated in Oklahoma’s model design.

The second meeting allowed the committee to review all stakeholder feedback and considerations on options for the state’s model design. After deliberation, the committee directed the Oklahoma SIM project team to draft a model similar to the Oregon Care Coordination, with a focus on integrating the social

determinants of health and mental health and substance abuse. The committee also deliberated on the HIT plan to support the state’s model and statewide interoperability.

The third meeting allowed the committee to review an update on the model design as well as the working assumptions for the financial analysis of the model. The committee suggested ideas for strengthening the governance of the model and achieved agreement on the working assumptions for the financial analysis.

The four meeting allows the committee to review feedback on the model design and review and executive summary of the SHSIP.

### Workgroup Meetings

The Oklahoma SIM project had four workgroups that were responsible for producing, reviewing, and finalizing a range of deliverables that were used to produce the SHSIP, as outlined in Table 16.

**Table 16: Oklahoma SIM Workgroups**

Workgroup	Function
<b>Health Efficiency and Effectiveness</b>	Provide guidance in the design of an evaluation plan that identifies specific quality metrics in coordination with healthcare delivery models identified for Oklahoma with a focus on three key outcomes: (1) strengthening population health; (2) transforming the health care delivery system; and (3) decreasing per capita healthcare spending
<b>Health Workforce</b>	Develop a health workforce data catalog, identify data gaps, and assess state capacity for meeting current and future healthcare demands; provide a policy prospectus for health workforce redesign and training, recruitment, and retention
<b>Health Information Technology</b>	Increase the adoption of Electronic Health Records (EHR) and attainment of meaningful use (MU), incentive adoption among non-EHR providers and connect them to existing Health Information Exchanges (HIEs), foster interoperable health systems, and plan the development of a value-based analytics (VBA) tool
<b>Health Finance</b>	Work with the actuarial contractor to integrate a new value based payment model based on pay-for-success and perform actuarial analysis of Oklahoma interventions and evaluations

The Oklahoma SIM project team held 33 workgroup meetings. At meetings, workgroup leaders and members reviewed and vetted contractor deliverables for inclusion in the SHSIP. Once deliverables were fully vetted and finalized, they were posted on the Oklahoma SIM website so that stakeholders could review and deliver feedback through the public comment box for each workgroup. Members were able to join meetings in person or virtually. Workgroups successfully vetted and completed 15 deliverables.

Three All Workgroup meetings brought stakeholders from all workgroups together on September 9 and 11, 2015 and again on January 13, 2016. The purpose of the All Workgroup Meetings was to review and discuss pivotal aspects of the Oklahoma SIM project to move the entire project forward based on overall stakeholder consensus at the conclusion of these meetings. At the September meetings, the workgroups discussed the Value-Based Analytics Roadmap and evaluated three conceptual model design options for the state. Workgroup members evaluated the strengths and weaknesses of a conceptual model for patient-

centered medical homes, accountable care organizations, and care coordination organizations, based on a pre-determined set of criteria that aligned to the objectives of the Oklahoma SIM project and the Triple Aim. Based on feedback from these meetings, the project team devised the key conceptual design tenets of the Oklahoma Model. At the January meeting, the Oklahoma SIM actuarial contractor reviewed the process of creating the working assumptions for the state's model based on standard actuarial analysis, the model components, and experiences in other states with similar models. Workgroup members discussed assumptions used to estimate enrollment into the RCOs and the use of models from other states as a baseline for Oklahoma. Concerns were addressed and the plan design was modified accordingly.

The section below details the activities conducted by each workgroup during the project period.

### ***Health Efficiency and Effectiveness Workgroup***

At Health Efficiency and Effectiveness Workgroup meetings, members reviewed and provided comments on the following deliverables:

- Population Health Needs Assessment
- Population Health Driver Diagrams
- Current Healthcare Transformation Initiatives
- Care Delivery Model Analysis
- High Cost Delivery Services

Additionally, members discussed funding opportunities and the sustainability of provider organizations such as federally-qualified health centers.

### ***Health Workforce Workgroup***

At Health Workforce Workgroup meetings, members reviewed and provided comments on the following deliverables:

- Health Workforce Data Catalog
- Health Workforce Assessment: Provider Organizations
- Health Workforce Assessment: Providers
- Health Workforce Assessment: Gap Analysis
- Health Workforce Assessment: Environmental Scan
- Health Workforce Assessment: Emerging Trends

Additionally, members discussed critical health occupations and the National Governor's Association Health Workforce Action Plan.

### ***Health Finance Workgroup***

At the Health Finance Meetings, members reviewed and provided comments on the following deliverables:

- Market Effects on Healthcare Transformation
- Oklahoma Care Delivery Model Analysis
- High-Cost Delivery Services

Additionally, members discussed guidelines for the financial analysis of the state’s model.

***Health Information Technology Workgroup***

At HIT Workgroup Meetings, members reviewed and provided comments on the following deliverables:

- Health Information Exchange Environmental Scan
- Electronic Health Records Adoption Analysis Survey Report
- Value-Based Analytics Tool Roadmap and Discussion

Additionally, members discussed funding opportunities such as the Office of the National Coordinator’s grant for interoperability, which the workgroup applied for but was not awarded. Members also discussed the outline of the HIT plan and delivery and payment models.

**Statewide Webinars**

The Oklahoma SIM project team held two statewide webinars on June 11, 2015 and August 13, 2015. The first webinar was an introduction to the project, including goals and objectives, timeline, workgroups, and stakeholder engagement opportunities. The second webinar presented a comprehensive review of deliverables from each workgroup, presented by the workgroup project managers. The first webinar had twice as many attendees as the second webinar (110 attendees compared to 55 attendees). The majority of webinar attendees represented state and local agencies, providers, healthcare associations, and payers.

The following characteristics about stakeholders were determined from webinar polling questions:

- Stakeholders reported that the Oklahoma SIM goal of improving population health outcomes most aligns with their organization’s priorities (61.8 percent of respondents, Webinar 1).
- Stakeholders reported that a shared vision across payers is the greatest barrier to participating in multi-payer value-based purchasing (41.9 percent of respondents, Webinar 1).
- Stakeholders reported that behavioral health was the population health issue that was the most difficult to tackle (56 percent of respondents, Webinar 2). The majority of respondents stated that this was due to insufficient resources (58 percent of respondents, Webinar 2).
- Stakeholders reported that the greatest barrier to ensuring a well-trained health workforce was difficulty with recruitment and retention of providers (60 percent of respondents, Webinar 2).

Below are stakeholder evaluations of the two webinars.

**Table 17: Statewide Webinar Evaluation Answer Key**

Rating Category	Rating Value
Strongly Agree	5

Agree	4
Neutral	3
Disagree	2
Strongly Disagree	1
Did Not Attend	N/A

**Table 18: Statewide Webinar Evaluation Responses (Average)**

Meeting Evaluation Statement	Webinar 1	Webinar 2
The meeting leaders effectively moderated the meeting.	4.0	3.9
The meeting content was useful for my organization's goals.	3.3	3.9
The meeting was the appropriate length of time.	4.1	3.9
The speakers were easily heard.	4.3	3.4
The presentation was easily seen.	3.8	3.8
I feel comfortable asking questions during a statewide meeting.	3.7	4.3

### Affinity Group Meetings

The Oklahoma SIM project team held an All Payer Meeting on August 5, 2015. Payer organization stakeholders include the OHCA, State Employees Group Insurance Division (EGID), Blue Cross Blue Shield of Oklahoma, CommunityCare of Oklahoma Health Insurance Plans, and GlobalHealth, Inc. HMO.

Prior to the meeting, the project team conducted a survey to capture insight from the payer organizations into alternative payment models, including models currently in use, models of interest, and barriers to implementation of new models. The project team also captured responses on the population health issues that had the greatest impact on payer organizations and beneficiaries.

The table below details responses from payers.

**Table 19: Alternative Payment Arrangements**

APAs Currently In Use	APAs Interested In Using	Greatest Barrier to APAs
<ul style="list-style-type: none"> <li>• <b>Bundled Payments</b></li> <li>• <b>Capitation</b></li> <li>• <b>Pay for Coordination</b></li> <li>• <b>Pay for Performance</b></li> <li>• <b>Shared Savings</b></li> </ul>	<ul style="list-style-type: none"> <li>• Bundled Payments</li> <li>• Capitation</li> <li>• Comprehensive Care/ Total Cost of Care Payment</li> <li>• Pay for Coordination</li> </ul>	<ul style="list-style-type: none"> <li>• Market Readiness <ul style="list-style-type: none"> <li>○ Insurance Market</li> <li>○ Health Workforce</li> <li>○ Providers</li> <li>○ Patients</li> </ul> </li> </ul>

- Pay for Performance
- Shared Savings (Shared Risk)

**Table 20: Population Health Target Issues in Order of Greatest Impact**

Population Health Flagship Issue	Ranking
<b>Behavioral Health</b>	1
<b>Diabetes</b>	2
<b>Obesity</b>	3
<b>Hypertension</b>	4
<b>Tobacco Use</b>	5

The outcomes of the meeting included several useful recommendations on the model design with regards to quality measures, data and analytics, health information technology, and implementation. The project team followed-up with payers to receive one-on-one feedback and present a draft of the healthcare delivery and payment model for the state.

### **One-On-One Meetings and Presentations**

The Oklahoma SIM project team held over 90 one-on-one meetings and presentations with stakeholders from March 2015 to March 2016. These meetings reflect engagement with academic and research institutions, businesses, business associations, community organizations and consumer advocates, healthcare associations, payers, providers, public health coalitions, state and local agencies, and vendors and consultancies.

From March 2015 to November 2015, the meetings focused on an overview of the Oklahoma SIM project and opportunities for stakeholder engagement and discussion. From December 2015 to March 2016, the meetings focused on an overview of the Oklahoma Model. These meetings were an opportunity to educate stakeholders about the Oklahoma SIM project and Oklahoma Model, answer clarifying questions, and at times, clear up misunderstandings.

Stakeholders expressed varying levels of support for the model, from strong enthusiasm and support, to acceptance with reservations, to non-acceptance with strong concerns. Overall, the model received strong support from academic institutions, the business community, community organizations, public health coalitions, and state public health agencies. The model received some support but overall mixed reactions from healthcare associations, payers, providers, and health information exchange vendors. The meetings provided the opportunity for dialogue aimed at gathering input and useful information on strategies to strengthen aspects of the Oklahoma Model, align the model with pre-existing initiatives and resources in the state, or otherwise better engage stakeholders in the initiative.

A complete list of stakeholder organizations engaged for the OHIP and Oklahoma SIM initiatives can be found in Appendix C.

### ***Academic and Research Institutions***

The project team met with the following stakeholder entities:

- Oklahoma State University, Center for Health Systems Innovation

- Oklahoma State University, Center for Healthcare Improvement
- University of Oklahoma College of Medicine, Department of Family and Preventive Medicine
- University of Oklahoma College of Pharmacy, Pharmacy Management Consultants
- University of Oklahoma College of Medicine, OU Physicians
- University of Oklahoma, Oklahoma Tobacco Research Center

### ***Businesses***

The project team met with the following stakeholder entities:

- Dewberry Architects
- QuikTrip

### ***Business Associations***

The project team met with the following stakeholder entities:

- Greater Oklahoma City Chamber
- State Chamber of Oklahoma
- Oklahoma Association of Health Underwriters
- Oklahoma Restaurant Association
- Tulsa City Chamber of Commerce
- WellOK (Northeastern Business Coalition on Health)

### ***Community Organizations and Patient and Consumer Advocates***

The project team met with the following stakeholder entities:

- Homeless Alliance
- Health Alliance for the Uninsured
- Hospitality House
- Oklahoma Healthy Aging Initiative
- Tobacco Settlement Endowment Trust
- United Way of Central Oklahoma

### ***Healthcare Associations***

The project team met with the following stakeholder entities:

- Central Communities Health Access Network
- Healthcare Financial Management Association
- Mental Health Association Oklahoma
- Oklahoma Academy of Family Physicians
- Oklahoma Association of Health Plans
- Oklahoma Care Coordination Alliance
- Oklahoma Hospital Association
- Oklahoma Primary Care Association
- Association of Family Physicians
- Rural Health Association
- Oklahoma Medical Association
- Oklahoma Nursing Association
- Oklahoma Primary Care Association
- Oklahoma State Medical Association
- Oklahoma Osteopathic Association
- Sooner Care Health Access Network

### ***Payers***

The project team met with the following payers:

- Oklahoma Health Care Authority
- State Employees Group Insurance Division
- Blue Cross Blue Shield of Oklahoma
- CommunityCare of Oklahoma Health Insurance Plans
- GlobalHealth, Inc. HMO

### ***Providers***

The project team met with the following providers:

- Hillcrest Healthcare System
- INTEGRIS Health
- St. Anthony's Health System
- St. John's Health System
- Variety Care FQHC (Federally-Qualified Health Center)

### ***Public Health Coalitions and Associations***

The project team met with the following coalitions:

- Turning Point Regional Consultants
- Turning Point Conference and Policy Day
- North Dyad of Regional Health Educators
- South Dyad of Regional Health Educators
- Cherokee County Community Health Coalition
- Cleveland County Coalition
- Haskell County Turning Point
- Jackson County Community Health Action Team
- Kingfisher Turning Point
- McCurtain County Coalition for Change
- Muskogee Turning Point
- Pittsburgh County Local Services Coalition
- Tulsa City County Health Department
- Oklahoma City County Health Department

### ***State Agencies***

The project team met with the following state agencies:

- Oklahoma Department of Mental Health and Substance Abuse Services
- Oklahoma Health Care Authority
- Oklahoma Employees Group Insurance Division
- Oklahoma State Department of Health
- Oregon Health Authority
- Arkansas Health Care Payment Improvement Initiative

### *Tribal Nations and Associations*

The project team met with the following tribal nation entities:

- Chickasaw Nation Department of Health
- Tribal Public Health Advisory Committee
- Tribal Consultation

### *Vendors and Consultancies*

The project team met with the following stakeholder entities:

- Coordinated Care Oklahoma
- MyHealth Access Network
- National Committee for Quality Assurance
- Oklahoma Foundation for Medical Quality

## **OSDH WELLNESS BUSINESS SURVEY REPORT (2014) FINDINGS**

Businesses play a vital role in healthcare transformation. As employers and major sponsors of health plans, businesses have a direct stake in the expansion of value-based initiatives in healthcare.

For businesses, value-based initiatives and population health improvement mean:

- A healthier, more productive workforce
- Less healthcare spending from a decreased burden of chronic diseases and cost of medical care
- Greater value from health plans through innovation and health information technology
- Greater transparency about employee health information to guide healthcare decision-making

The Oklahoma State Department of Health, in cooperation with Governor Mary Fallin, the Oklahoma Department of Commerce, the State Chamber of Oklahoma Research Foundation, Insure Oklahoma, and the Oklahoma Employment Security Commission enlisted a contractor to conduct a survey to inform the State on how to partner with businesses on strategies for improving workforce readiness and productivity. Study findings were used to support preparation of OHIP 2020 and inform policy makers. Oklahoma SIM Stakeholders were asked to review and provide input on how to incorporate findings from the survey into the Oklahoma Model.

### **Research Objectives**

This project gathered Oklahoma employer perspectives on health insurance and wellness programs as they relate to workforce costs, productivity, and returning value on investment. The project sought to answer three research questions:

1. How does the health of the Oklahoma workforce affect business?
2. What impact does access or lack of access to healthcare have on the bottom line?
3. What barriers and challenges do employers face in providing health and wellness benefits?

### **Research Methods**

The information collection campaign for the project included an online survey, phone polling, and in-depth interviews. Data collection began July 28, 2014 and ended August 21, 2014. The survey and phone polling questions often allowed Oklahoma employers to select more than one option if they were applicable.

Below are the aspects of each research method:

1. An online survey sent through multiple channels was completed by 665 employers from 20 industries, across 63 counties
2. A phone poll was conducted with 78 employees from a randomized list of Oklahoma employers.
3. In-depth, face-to-face interviews were conducted with eight employers who sponsor worksite wellness programs

### **Key Findings**

Findings reflect the importance of healthcare improvement for the business community. Key findings include stakeholder feedback on the effect of health status on business, health insurance, wellness programs and activities, and advice regarding health-related programs for employees.

#### ***Effect of Employee Health Status on Business***

Nearly half of survey respondents reported that employee health affects their business. High medical costs and frequent leave requests represent top challenges. Most respondents had 10 percent or less, on average, lost productive work days due to employee health issues. Polled employers, who answered an open-ended question about health-related challenges, did not articulate issues regarding employee health status.

**Figure 23: Employee Health Challenges Reported by Survey Respondents**

Challenge	Percentage
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<b>Making positive healthy lifestyle choices</b>	82%
<b>Losing weight</b>	69%
<b>Seeing doctor for preventive care</b>	48%
<b>Quitting tobacco</b>	46%
<b>Reducing stress</b>	46%
<b>Access to healthcare</b>	30%
<b>Caring for sick children/spouse</b>	24%
<b>Substance abuse and addiction</b>	22%
<b>Caring for elderly or sick parents</b>	21%
<b>Mental health issues</b>	14%
<b>Prenatal care</b>	2%

### *Health Insurance*

The majority of study participants (85 percent of survey participants and 91 percent of phone poll participants) offer health insurance coverage to employees. More than half (64 percent) of survey respondents who provided employee health insurance offered coverage to eligible family members – though this was less common for small business employers with fewer than 50 full-time workers. When responding to why they offer health insurance, the majority of respondents (over 80 percent) says they do it because it is the right thing to do. Additionally, most survey respondents believed that health insurance was very important in recruiting and retaining top-quality employees. Still, cost of health insurance was a significant concern.

**Figure 24: Impact of Healthcare Costs on Survey Respondents**

<b>Impact</b>	<b>Percentage</b>
<b>Less profit available for general business growth</b>	43%
<b>Held off on salary increases for employees</b>	39%
<b>Increased medical plan deductible</b>	31%
<b>Increased employee share of medical premiums</b>	26%
<b>Held off on hiring new employees</b>	22%
<b>Increased prices</b>	17%
<b>Hired more part-time vs. full-time employees</b>	17%
<b>Switched health insurance carriers</b>	17%
<b>Delayed purchase of new equipment</b>	17%
<b>Held off on implementing growth strategies</b>	13%
<b>Reduced employee benefits</b>	12%

<b>Reduced hours of existing employees</b>	6%
<b>Reduced workforce/laid off employees</b>	3%

**Figure 25: Response to Rising Healthcare Costs Reported by Survey Respondents**

<b>Impact</b>	<b>Percentage</b>
<b>Increased employee cost-sharing</b>	38%
<b>Added a high deductible health plan</b>	37%
<b>Started wellness programs or activities</b>	33%
<b>Changed insurance companies</b>	23%
<b>Reduced benefits</b>	23%
<b>Tightened pharmacy benefit design</b>	12%
<b>Put in a narrow provider network</b>	8%
<b>Introduced disease and/or care management programs</b>	7%
<b>Dropped coverage and gave money directly to employees to purchase insurance themselves</b>	1%

*Wellness*

Almost all survey respondents with 500 or more full-time employees offer some kind of wellness program or activity. In contrast, at least half of small business employers from this group do not currently offer wellness programs. The most common wellness initiative was a tobacco-free workplace. The most prevalent reason for providing wellness initiatives was an altruistic desire for employees to be healthy and happy, but also increase worker productivity. Other reasons included controlling rising healthcare costs; managing sick leave, reducing absenteeism, and reducing workers’ compensation claims and costs, and positive impact on recruitment and retention. During the in-depth interviews, some participants noted the dire state of Oklahoma’s health as a motivating factor. Among survey respondents who promote wellness, about half report healthier behaviors and positive impact on the business. This includes: a reduction in tobacco use, weight loss, increased productivity, increased morale, and stronger recruitment.

**Figure 26: Top 10 Wellness Programs/Activities Offered by Survey Respondents**

<b>Impact</b>	<b>Percentage</b>
<b>Tobacco-free workplace</b>	47%
<b>Smoking/tobacco cessation programs</b>	28%
<b>Employee Assistance programs</b>	27%
<b>Biometric screenings</b>	22%
<b>Company participation in charity walks/runs</b>	20%
<b>Health education</b>	20%
<b>Gym membership subsidies</b>	18%
<b>Stress management</b>	16%
<b>Health coaching</b>	16%

Businesses that promoted wellness activities and initiatives saw other positive outcomes, including:

- Favorable image in the community for marketing
- Attractive company culture for recruiting
- More productive, focused employees
- Healthier lifestyle choices and more informed healthcare decisions for benefits.

### ***Summary***

Findings from this survey demonstrate that most Oklahoma business, regardless of size, view offering health insurance as a key component of employee recruitment and retention and as “the right thing to do” for employees and their families. Aligned with this feedback, almost all large employers that responded to the survey (96 percent) sponsor some kind of wellness project or activity for their employees.

Businesses can take advantage of their role as key stakeholders in health system transformation by:

- Encouraging a “value agenda” in health plans by endorsing value-based plans that align to the Triple Aim of better health, better care, and lower costs
- Going beyond their traditional role as sponsors of health plans to spearhead initiatives that increase quality and affordability of healthcare
- Championing prevention and wellness programs to encourage employees to play a more active role in their health and wellness
- Working with their local chambers of commerce to endorse legislation that supports members’ business interests aligned to higher quality health plans at lower costs

## **ANALYSIS AND INTERPRETATION OF KEY FINDINGS ON COLLECTED DATA**

The Oklahoma SIM project team has used various channels to collect input from stakeholders on the best formation of a healthcare delivery and payment model for Oklahoma. This included polling questions during statewide webinars, post-webinar stakeholder surveys, and All Workgroup Meeting activities. Statewide webinar polling questions identified likely priority areas for the state’s model, including population health improvement, behavioral healthcare, and multi-payer alignment. Post-webinar stakeholder surveys identified suggested components and characteristics of the model, including enhanced primary care services, behavioral healthcare services, and health education and prevention services; as well as social determinants of health and a variance of the model based on urban or rural locations. The All Workgroup Meetings further helped to narrow down a model selection for the state. Ultimately, based on this collective stakeholder feedback, in particular consensus drawn from the All Workgroup Meetings, the Oklahoma SIM project team proposed a care coordination model design for the state, which was then affirmed by the Executive Steering Committee, as aforementioned.

## Statewide Webinar Polling Questions

From early in the project period, the project team saw that stakeholders were strongly aligned to population health improvement being a major part of the state’s focus on health system transformation. During the first statewide webinar, when asked “what Oklahoma SIM goal most aligns with your organization’s priorities?” stakeholders primarily selected “improve population health outcomes”.

**Table 21: “What Oklahoma SIM goal most aligns with your organization’s priorities?”**

Multiple Choice Selections	Respondents
<b>Improve population health outcomes</b>	61.8%
<b>Achieve health equity (rural, socioeconomic, race/ethnicity, behavioral health)</b>	17.6%
<b>Coordinate public health and healthcare services and goals</b>	14.7%
<b>Achieve savings from multi-payer value-based purchasing</b>	5.9%
<b>Align clinical population health measures</b>	0%

Furthermore, the project team received insight that aligning payers would be a major barrier and needed to be prioritized to achieve multi-payer value-based purchasing. During the first statewide webinar, when asked “what is your organization’s greatest barrier to participating in multi-payer value-based purchasing?” stakeholders primarily selected “shared vision across payers”.

**Table 22: “What is your organization’s greatest barrier to participating in multi-payer value-based purchasing?”**

Multiple Choice Selections	Respondents
<b>Shared vision across payers</b>	41.9%
<b>Adequate HIT infrastructure</b>	22.6%
<b>Financial resources</b>	12.9%
<b>Workforce resources (staff and/or time)</b>	9.7%
<b>Leadership buy-in</b>	9.7%
<b>Cultural attitudes</b>	3.2%

The project team also found that the model would need to focus heavily on addressing challenges related to behavioral healthcare. During the second statewide webinar, when asked “which of the following population health issues have you found the most difficult to tackle”, selecting among the five Oklahoma SIM flagship issues, stakeholders primarily selected behavioral health. When asked as a follow-up question why this issue was the most difficult to tackle, stakeholders primarily selected “insufficient resources (financial, personal, time)”.

**Table 23: “Which of the following population health issues have you found the most difficult to tackle?”**

Multiple Choice Selections	Respondents
<b>Behavioral Health</b>	56%
<b>Obesity</b>	22%
<b>Diabetes</b>	11%
<b>Tobacco Use</b>	11%
<b>Hypertension</b>	0%

### Post-Webinar Stakeholder Surveys

The project team also conducted two stakeholder surveys to capture feedback on the first and second statewide webinars as well as stakeholder perspectives on a model for the state. Stakeholders responded to various survey questions, including:

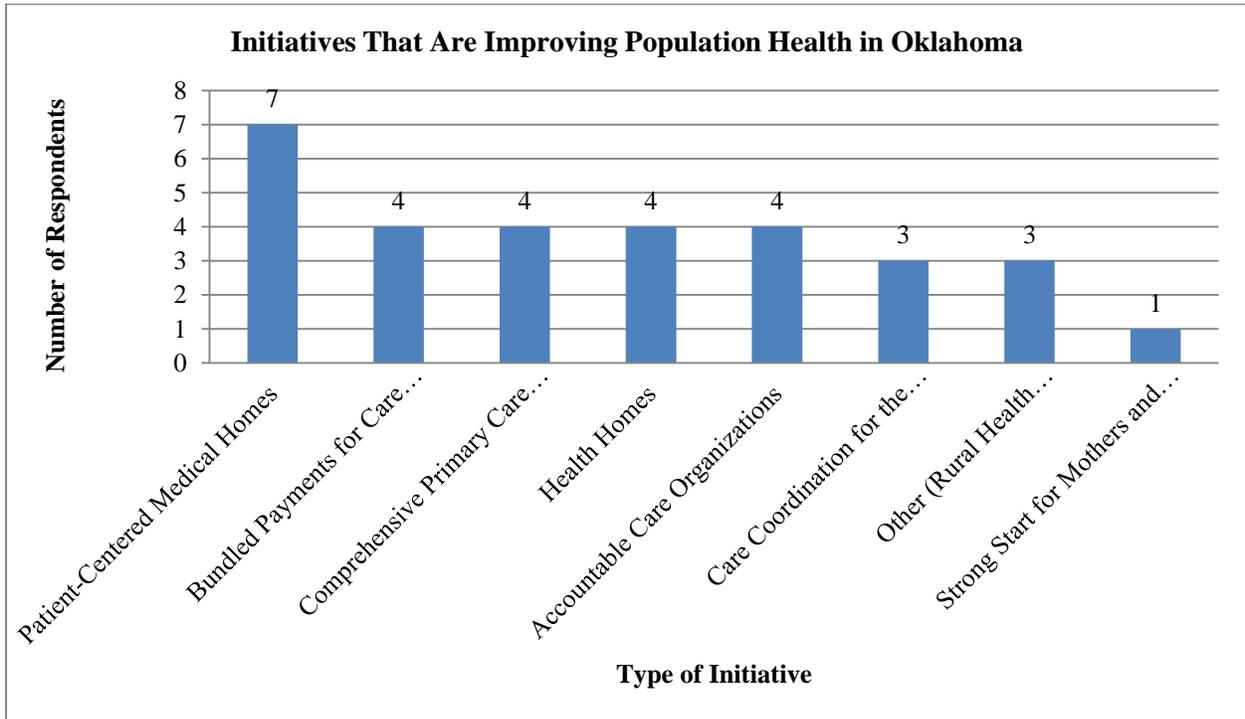
- What role do you play in the healthcare industry?
- What initiatives are making an impact in population health improvement in Oklahoma?
- What care delivery models are addressing your population health improvement goals?
- What social determinant of health has the greatest impact on your organization?
- Should the model vary based on an urban vs. rural context?

Overall, stakeholder respondents reported that an ideal model for the state would address primary care services, behavioral health services, and health education and prevention services; and would also vary based on an urban versus rural context. The tables below display results from these two surveys.

**Table 24: Stakeholder Surveys**

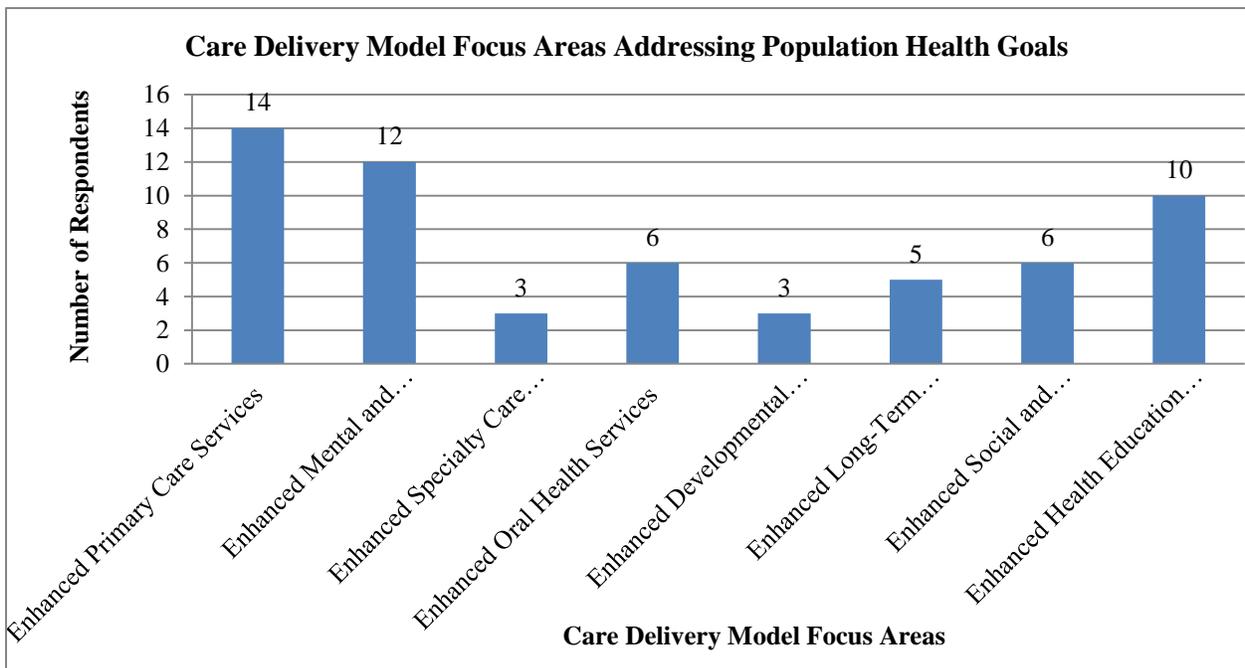
Survey Name	Open Date	Close Date	Respondents (#)
<b>First Stakeholder Survey</b>	6/23/2015	7/11/2015	13
<b>Second Stakeholder Survey</b>	8/28/2015	9/3/2015	17

**Figure 27: What Initiatives Are Improving Population Health in Oklahoma?**



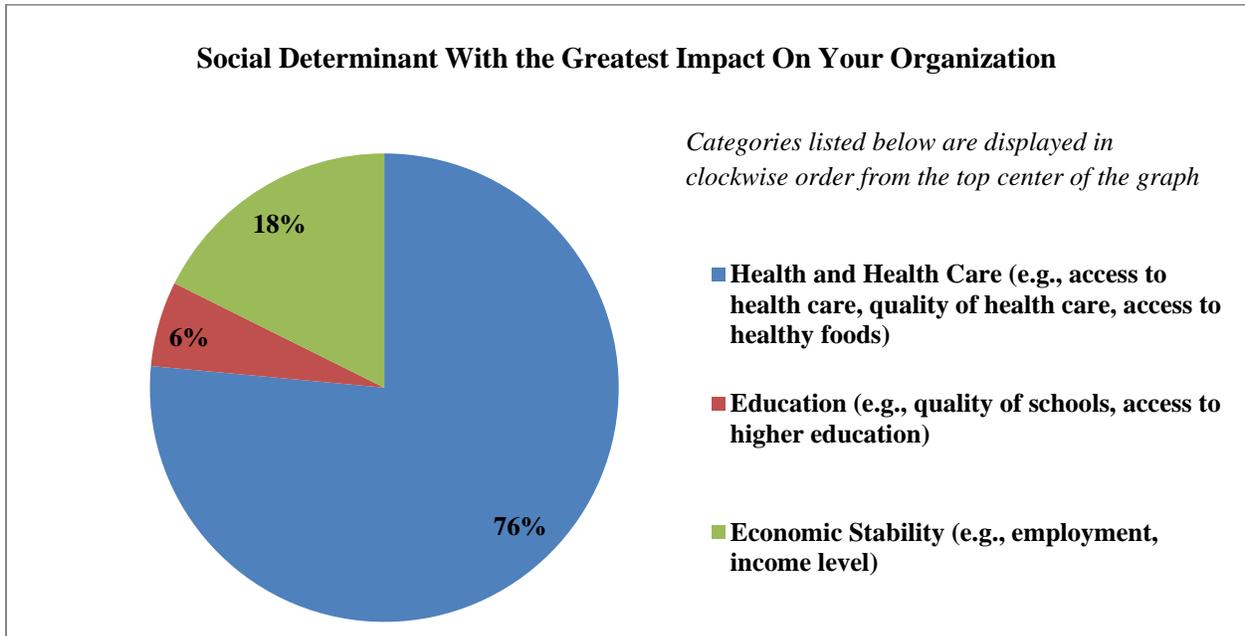
Stakeholders reported that a number of initiatives are making an impact on population health improvement, including patient-centered medical homes, bundled payments, health homes, accountable care organizations, and the Comprehensive Primary Care Initiative.

**Figure 28: What Care Delivery Model Focus Areas Are Addressing Your Population Health Goals?**



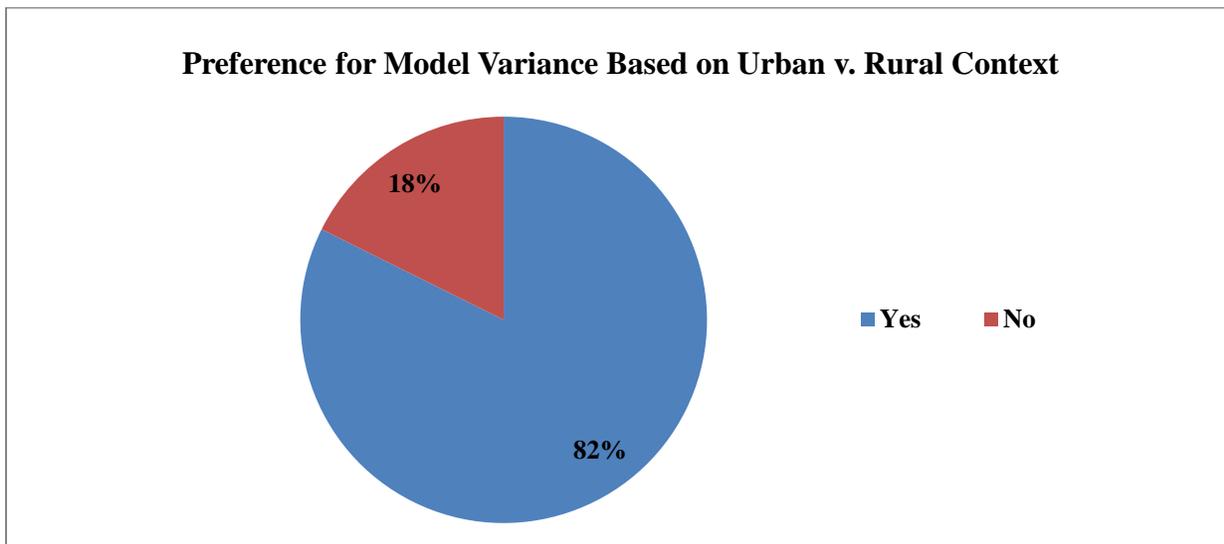
Stakeholders reported that enhanced primary care services, mental and behavioral health services, and health education and prevention services will best address their population health goals.

**Figure 29: What Social Determinant of Health Has the Greatest Impact on Your Organization?**



Stakeholders overwhelmingly reported that health and healthcare has the greatest impact on their beneficiary population.

**Figure 30: Should the Model Vary Based on an Urban vs. Rural Context?**



Stakeholders overwhelmingly reported that a model for Oklahoma should vary based on an urban or rural context.

## All Workgroup Meeting Activities

At the All Workgroup Meetings in September 2015, the project team led an interactive activity with workgroup members to rate the effectiveness of three conceptual model designs based on the aims of the Oklahoma SIM project and Triple Aim. The aim of the activity was to generate and report on robust stakeholder discussion on model components that best serve the needs of the state. Based on previous stakeholder survey findings regarding initiatives that were improving population health in the state, as well as model designs being currently employed in other states with a similar healthcare landscape as Oklahoma, the project team used the following conceptual model designs for the workgroup activity: patient-centered medical home, accountable care organization, and care coordination organization.

Criteria for the model design discussions included the following:

- Improves the patient experience of care
- Improve population health
- Reduces the per capita cost of care
- Addresses the social determinants of health
- Has the workforce resources needed for implementation
- Has the technological resources needed for implementation
- Has the political will to support implementation
- Has the cultural will to support implementation

Based on cumulative stakeholder feedback, the project team determined the following:

- The model needs to address urban and rural scalability, which can be addressed over time through a multi-phased rollout
- The model needs to acknowledge patient choice
- The model needs to incorporate a direct connection between clinical care and social determinants
- The model needs to incorporate telehealth as a way to augment the existing workforce
- The model needs to incorporate a diverse workforce, including non-traditional healthcare workers such as community health workers
- The model needs to address potential roadblocks with HIT infrastructure in the state

**Table 25: Stakeholder Feedback on Pros and Cons of Conceptual Model Designs**

Model Design	Pros of Model Design	Cons of Model Design
<b>Patient-Centered Medical Homes</b>	<ul style="list-style-type: none"> <li>• Would integrate behavioral health within primary care</li> <li>• Would not need extensive HIT to be extensive</li> </ul>	<ul style="list-style-type: none"> <li>• Does not have a strong enough linkage to social determinants of health; would need to expand healthcare team</li> </ul>

	<ul style="list-style-type: none"> <li>• Could leverage telehealth for co-location of services</li> <li>• Has infrastructure needed for implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Does not have workforce resources for implementation</li> <li>• Does not have HIT infrastructure for implementation</li> </ul>
<b>Accountable Care Organization</b>	<ul style="list-style-type: none"> <li>• Would be able to address all aspects of a patient’s health needs</li> <li>• Creates opportunity for potential savings</li> <li>• Supported by current workforce availability in urban areas</li> </ul>	<ul style="list-style-type: none"> <li>• Has the potential to limit patient choice</li> <li>• Is not feasible in rural areas</li> <li>• Is politically unfeasible as the model would require too much centralization</li> <li>• Would need a strong value-based insurance design</li> </ul>
<b>Care Coordination Organization</b>	<ul style="list-style-type: none"> <li>• Has a direct link to social determinants of health</li> <li>• Would be scalable in rural and urban environments</li> <li>• Has preexisting resources at the community level to aid implementation (e.g., public health, social services)</li> </ul>	<ul style="list-style-type: none"> <li>• Would need to strengthen the linkage to providers</li> <li>• Would need to enhance HIT infrastructure</li> <li>• Would need to implement workforce training and standards</li> <li>• Would require extensive education on the model structure</li> </ul>

Based on this stakeholder feedback, the project team recommended creating a model for the state akin to a care coordination organization that had a robust primary care environment, integrated physical and behavioral healthcare, and a linkage between clinical care and social determinants of health. Furthermore, this model would use multi-payer engagement, quality measures, and a value-based purchasing strategy.

## CONCLUSION

The Oklahoma SIM project team has now completed all four phases of the Stakeholder Engagement Plan. In Phase One (March to June 2015), the project team began holding regular workgroup meetings to begin producing project deliverables and introducing stakeholders to the project in order to solicit their idea and feedback and secure their buy-in on a new model for the state. The project team also held the first Executive Steering Committee Meeting and Statewide Webinar. In Phase Two (July to October 2015), the project team continued engaging stakeholders and held the Second Statewide Webinar. Workgroups completed the review of the majority of project deliverables. The project team also developed the conceptual tenets of the Oklahoma Model and received buy-in from the Executive Steering Committee to create a new model for the state based on the care coordination model, called Regional Care Organizations. In Phase Three (November 2015 to January 2016), the project team engaged key stakeholders and workgroups to receive focused feedback on the proposed Oklahoma Model. The project team also completed drafting the SHSIP. In Phase Four (February to March 2016), the project team held a statewide public comment period for the SHSIP and finalized the plan, which is now being submitted.

With advice and input from the OHIP and SIM Executive Steering Committee, the Grantee Project Director for SIM and Deputy Secretary of Health and Human Services has authorized the Oklahoma SHSIP. Each of the stakeholder meetings that have occurred have been directly used to influence the design of the final Oklahoma Model and SHSIP, including consensus gained and disagreement remaining. Disagreements have been taken to the Executive Steering Committee and resolved by the committee.

chair, the Deputy Secretary of Health and Human Services. As the initiative continues, stakeholders will continue to meet in workgroups to operationalize each component of the SIM. As the Oklahoma Model is formed, stakeholders and workgroups may reorganize to serve in the necessary governing functions of the state's new model.

Each section of the SHSIP will continue to highlight how stakeholder engagement contributed to the development of each aspect of the Oklahoma SIM project and Oklahoma Model. The next section describes the Health System Design and Performance Objectives that the Oklahoma SIM project team used to guide the development of the new model for the State.