



G. Plan for Improving Population Health

INTRODUCTION

This section of the State Health System Innovation Plan (SHSIP) discusses how overall population health will be improved through current statewide health initiatives and the proposed Oklahoma Model. Certain aspects of population health differentiate it from the traditional clinical perspective. For example, improving population health outcomes involves addressing social determinants of health and not just clinical health needs.¹³³ This plan uses the Oklahoma Health Improvement Plan (OHIP), State of the State's Health Report, Population Health Needs Assessment, and Community Health Improvement Plans (CHIP) to examine statewide data and set a baseline and framework for population health improvement. This plan also outlines how the Oklahoma Model will incorporate current statewide initiatives or otherwise use best practices and lessons learned to promote the health of all Oklahomans. Other areas of the plan describe how community members will actively participate, provide direction, and make decisions regarding how community health initiatives will be determined and managed through the Regional Care Organization (RCO). The goal of the Oklahoma State Innovation Model (SIM) project is to provide statewide solutions to Oklahoma's healthcare challenges. The Oklahoma SIM project will help drive vital improvements by integrating primary prevention strategies for the Oklahoma SIM population health flagship issues into the state healthcare delivery system.

LEVERAGING STATE HEALTH REPORTS AND ASSESSMENTS

Several reports were used to establish the baseline population health status in Oklahoma, including:

- The State of the State's Health Report (SOS);
- The Oklahoma Health Improvement Plan (OHIP),
- The Population Health Needs Assessment (PHNA), and
- Community Health Improvement Plans (CHIPs).

The 2014 SOS provides data on the leading causes of death, disease rates, risk factors and behaviors, and socioeconomic factors. It also outlines outcomes by county, providing a snapshot of how each county's health compares to national health outcomes. The OHIP is a plan for improvement of the physical, social, and mental well-being of all Oklahomans.¹³⁴ Both the OHIP and SOS were used to select criteria for the Oklahoma SIM flagship issues of: tobacco use, diabetes, hypertension, obesity, and behavioral health. All five issues are also identified as OHIP flagship issues or otherwise as key health indicators leading to poor health outcomes. The PHNA, which identifies populations that experience adverse health outcomes and account for a large part of state healthcare costs, was used to pinpoint what disparities exist and what resources are needed to address those disparities. Data from various sources including the SOS and the OHIP 2020 were used to complete the PHNA, and it was written to help with the development of the Oklahoma SIM. The CHIPs, which identify community health issues and prepare a strategic plan of action, will be used to ensure that community health needs across the state are addressed in the most

efficient and effective way. The poor health outcomes that were identified within each CHIP were used as a rationale for the selection of certain statewide quality metrics and population health targets for the Oklahoma Model and for regional health outcome improvement. The Description of the State Healthcare Environment profiled the CHIPs for Beaver County, Oklahoma County, McCurtain County, and Tulsa County. Though some common health issues existed across the counties, each county had a unique set of population health issues due to factors such as rural versus urban context, geography, wealth, resources, and other factors. This demonstrates that Oklahoma will have to be flexible in its approach to healthcare transformation to ensure that appropriate solutions are found for each county and region. The proposed RCO within the Oklahoma Model allow for this flexibility to address issues within the CHIP in ways that are unique to the region and populations served.

The Oklahoma SIM project aims to use research from these past reports and assessments to guide the development of multi-payer quality metrics and episodes of care for the Oklahoma Model. Together these reports will continue to be leveraged through the Oklahoma SIM process. Goals from OHIP and population level statistics from the SOS will be used to establish baseline and population health goals for the RCO to meet or improve. The RCO will also be involved in CHIPs across the state as active participants in community health improvement.

ADDRESSING AREAS OF HIGH BURDEN AND COST

Oklahomans face serious health challenges, as highlighted by the state’s health ranking of 45th in the nation in 2015 by the United Health Foundation’s *America’s Health Rankings*. Unhealthy behaviors such as tobacco use, physical inactivity, and low fruit and vegetable consumption contribute to the high prevalence of diseases such as cancer, heart disease, and diabetes. All of these health issues factor into Oklahoma’s poor health outcomes and low national ranking. In order to improve the health of the state’s population, the areas of highest cost and disease burden must be identified and included in the state’s plan for healthcare transformation. It is important for the state not only to address primary healthcare delivery strategies but also to focus on prevention strategies and the social determinants of health to improve population health.

The Oklahoma SIM project specifically looked at these high-cost conditions, as described in Section B, the Description of the State Healthcare Environment, and the associated burden to guide the selection of multi-payer quality metrics and episodes of care that would make the most impact on health outcomes, cost, and quality under the Oklahoma Model. The tables below detail the prevalence of major health conditions by insurance payer as well as the costliest conditions on a national level.

Table 36: Condition Prevalence by Insurance Payer in Oklahoma¹³⁵

Condition	Commercial Insurance	Medicare	Medicaid
Obesity	29.9%	28.9%	28.9%
Diabetes	5.2%	25.9%	4.5%
Hypertension	14.2%	70.6%	9.8%
Tobacco Use	23.7%	9.9%	36.7%

Table 37: National Costliest Conditions, 2010

Condition	Cost (in millions)	Highest Cost Service
Heart Disease	\$107,186.40	In-patient hospital
Trauma	\$82,303.57	Out-patient hospital
Cancer	\$81,734.62	Out-patient hospital
Mental Health Disorders	\$73,060.24	Prescription Medication
COPD/Asthma	\$63,782.99	Prescription Medication
Osteoarthritis	\$62,362.98	Out-patient hospital
Diabetes	\$51,310.57	Prescription Medication
Hypertension	\$42,943.38	Prescription Medication
<i>Source: Agency for Healthcare Research and Quality, 2010 Medical Expenditure Panel Survey</i>		

Heart Disease

Heart disease is the primary driver of healthcare costs in Oklahoma, with over \$2 billion (\$2,133,719,629) in total charges for all payers in 2012.¹³⁶ Heart disease-related inpatient hospital costs were the highest cost condition among patients covered by Medicare, commercial insurance, Veterans Affairs and military insurance, and other payers, as well as patients that were uninsured/self-pay.¹³⁶ Congestive heart failure was the second leading cause of all 30-day hospital readmissions in 2012. Combined with coronary atherosclerosis and other heart disease, this made up 6.8 percent of all 30-day readmissions.¹³⁶

Hypertension

Hypertension, or high blood pressure, increases the risk for heart disease and stroke and can typically be controlled through medications, medical care, and lifestyle management. In Oklahoma, 37.5 percent of adults have hypertension, compared to the national rate of 31.4 percent.¹³⁷ Like other chronic conditions, hypertension can be controlled, but when it is not, a person can face serious health consequences. One of the most common consequences of uncontrolled hypertension is preventable hospitalization. In 2013, there was an estimated 1,275 blood pressure related preventable hospitalizations in the state.¹³⁷ If a 20 percent reduction in preventable hospitalizations for hypertension were achieved, there would be a healthcare cost savings of \$1.8 million.¹³⁸

Cancer

Oklahoma faces poorer health outcomes related to cancer compared to most other states and the nation. Overall, Oklahoma has the twelfth highest rate of death due to cancer. And while the national rates of cancer deaths decreased 16 percent between 1999 and 2010, Oklahoma’s rate of death due to cancer decreased only seven percent during the same period.¹³⁸ It is also necessary to include tobacco cessation measures as a way to reduce the burden of cancer in the state. In Oklahoma, the leading cause of cancer deaths is from lung and bronchus cancers (cause for 30 percent of deaths).¹³⁸ In 2012, there were 11,300 hospital inpatient discharges for cancer (malignant neoplasm) for all insurance payers at a total cost of \$714 million.¹³⁶ Cancer was also the primary driver of average healthcare costs at \$61,094 per discharge.¹³⁷

Stroke

Much like heart disease, stroke – or cerebrovascular disease – is a prevalent and costly condition among Oklahomans that is impacted by other chronic conditions and lifestyle factors. Overall, Oklahoma has the fourth highest rate of stroke in the nation.¹³⁸ In 2012, there were 12,068 hospital inpatient discharges for cerebrovascular diseases (all payers) at a total cost of over \$437.7 million (\$437,740,360).¹³⁶

Chronic Lower Respiratory Diseases

In 2012, Chronic Lower Respiratory Diseases, which include both Chronic Obstructive Pulmonary Disease (COPD) and asthma, was the fifth leading cause of 30-day hospital readmissions in Oklahoma.¹³⁷ Nationally, Oklahoma has the highest death rate due to COPD. In 2013, an estimated 10,817 hospitalizations for COPD could have been prevented through outpatient care and community services. If even 10 percent of these hospitalizations had been prevented, an estimated \$9,019,282 could have been saved.¹³⁷

Diabetes

Many complications from diabetes can be reduced through proper disease management. In Oklahoma, 11 percent of the population has diabetes, giving the state the ninth highest rate in the nation.¹³⁷ In 2012, 7,007 inpatient hospital discharges were attributed to diabetes diagnoses at a total cost of over \$206.6 million (\$206,662,251).¹³⁶

Behavioral Health

Mental health and substance abuse are a growing concern facing the health of Oklahomans. In 2014, 21.9 percent of adults in the state reported a mental health issue and 12 percent reported having a substance abuse issue.¹³⁷ Data from the 2014 SOS ranked Oklahoma 42nd in average number of poor mental health days each month reported by adults.¹³⁸ The rate of suicide in Oklahoma is 36 percent higher than the national rate and suicide is the ninth leading cause of death in Oklahoma.¹³⁷ For each suicide prevented, Oklahoma could save an average of \$1,097,763 total in medical expenses (\$3,545) and lost productivity (\$1,094,218).¹³⁸

Contributing Lifestyle Factors

Many lifestyle factors can contribute to the development or exacerbation of chronic conditions that add to the overall disease burden for both patients and society. For example, healthcare costs associated with smoking in Oklahoma are approximately \$1.62 billion per year, with \$264 million covered by state Medicaid. Data from the 2014 SOS states tobacco use, obesity, physical inactivity, and poor diet are some of the most common behavioral and lifestyle factors driving poor health outcomes in the state.¹³⁸ Many other factors are discussed in Section B. There are a number of reasons for the lack of physical activity and low consumption of healthy foods, and many of them are related to the social determinants of health – like access to healthy foods and safe places to exercise; transportation; and health literacy and education about proper nutrition and exercise. Because of the complex nature of all of these factors that contribute to risky lifestyle behaviors, the RCO will be encouraged to utilize their community boards and resources to help bridge the gap to accessing healthy food, transportation, places to exercise, and other social factors in order to improve the health of the members they serve.

EXISTING CAPACITY AND EFFORTS AIMED AT POPULATION HEALTH

This section will review initiatives that are currently in place to address the health of the population. This is not meant to be an exhaustive list of resources. However, this does demonstrate the community partners that the RCO will look to partner with to and existing efforts to be leveraged to improve population health in Oklahoma.

Federal, State, and Local Healthcare Initiatives

The Oklahoma Model will leverage and build upon the many innovative payment, delivery, and public health models that are already in existence across the state. Most initiatives to date have been targeted at the Medicare population. These initiatives have aimed to improve population health through the innovative use of payment and reporting to incent coordination and proper screening and tests. A greater emphasis on multi-payer collaboration in recent years has produced a large enough revenue share to make the pursuit of healthcare transformation relevant for providers. The Oklahoma Model must complement existing models in the state and allow for new ones to emerge by creating the necessary infrastructure. Currently, the Oklahoma SIM project has identified the following models and resources operating within Oklahoma to advance population health.

Table 38: Federal, State, and Local Healthcare Initiatives

Name of Initiative	Incorporation into the RCO Model
Accountable Care Organizations (ACO)	Provide a foundation for RCOs on quality metric reporting, coordination of care, provider networks, etc.; a RCO may want to implement an ACO alternative payment arrangement for specific populations and/or may want to continue existing ACOs to meet Medicare requirements and qualify for Medicare incentive payments.
Bundled Payments for Care Improvement Initiative	Provide results and lessons learned to assist RCOs in adapting business and healthcare delivery practices for episodes of care, alternative payment arrangements, and bundled payments
Comprehensive Primary Care Initiative	Risk stratification, practice transformation, care coordination, shared savings (value-based purchasing)
Healthy Hearts for Oklahoma	Serve as an excellent model and potential partner as the RCO adapts a higher level of reliance on HIT, develops connections with community, implements care coordination, changes process to match value-based purchasing practices, and works with providers to transform practice to improve health outcomes, lower costs, and increase patient satisfaction.
Federally-Qualified Health Centers	Serve as valued partners that can provide needed guidance on the integration of primary care and behavioral health and how to approach and implement necessary practice transformations
Free/Charitable Clinics and Pharmacy Programs	Provide critical healthcare access in communities, and with better coordination of community resources, potentially enable better - continuity of care for members who over utilize public programs.
Oklahoma Department of Mental Health and	Provide a foundation from which RCOs can build upon, including lessons learned, care coordination, network development, and

Substance Abuse Services (ODMHSAS) Health Homes	adaptation to value-based payment
State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke (CDC 1422 Grant)	Work with RCOs to identify evidence-based interventions, as RCOs and 1422 organizations share core goals for improving Oklahoma health outcomes

Accountable Care Organizations (ACOs)

As described in Section B, ACOs are groups of doctors, hospitals, and other healthcare providers who voluntarily collaborate and accept collective accountability for the cost and quality of care delivered to a population of patients. Under the Oklahoma Model, the ACO model has laid the foundation for several of the components of the RCO. The ACO has influenced the decision to report of quality metrics, include care coordination, and develop provider networks. It has also introduced many providers to value-based purchasing. Additionally, RCOs may want to implement an ACO as an APA for specific populations to allow for risk/gain sharing with providers. RCOs may also need to continue ACOs that include dual eligibles to meet CMS requirements and to qualify for Medicare incentive payments from CMS.

Bundled Payments for Care Improvement Initiative

As described in Section B, bundled payments are a reimbursement methodology in which providers receive payment for the expected costs of an episode of care to promote care coordination and integration and better outcomes. In Oklahoma, 39 sites are currently participating in the Bundled Payments for Care Improvement (BPCBPCI) Initiative. Under the Oklahoma Model, bundled payments will be an alternative payment arrangement option that can be used by hospitals within a RCO.

Comprehensive Primary Care Initiative

As described in Section B, the Comprehensive Primary Care (CPC) Initiative aims to support primary care practices with innovative payment models to implement, on a broader scale, a core set of five comprehensive primary care functions identified by CMS and stakeholders. Under the Oklahoma Model, the CPC Initiative will serve as a foundational model for the RCO in terms of risk stratification efforts and strategies, practice transformation, care coordination and adapting to value based purchasing practices, such as the shared savings employed by the CPC Initiative.

Federally Qualified Health Centers

As described in Section B, Federally-Qualified Health Centers (FQHCs) are designated by the Health Resources and Services Administration (HRSA) to provide healthcare services to medically underserved populations, regardless of ability to pay. Under the Oklahoma Model, RCOs must incorporate FQHCs into their model if they exist within the RCO’s region. The RCOs will have the flexibility of determining how to incorporate FQHCs. FQHCs will also be incorporated into the Oklahoma Model’s Practice Transformation Center. FQHCs will also serve as an important role model to the RCOs in terms of integration of primary and behavioral healthcare.

Free/Charitable Clinics and Pharmacy Programs’

As described in Section B, a total of 40 licensed charitable pharmacies and over 80 free clinics exist in Oklahoma. Examples include clinics supported by the Health Alliance for the Uninsured, the Sandy Park Clinic in Tulsa, and the Good Shepherd Community Clinic in McAlester County. Under the Oklahoma Model, the State will include these resources as part of the RCOs inventory of community resources that providers can access and reference for patient referrals.

Healthy Hearts for Oklahoma

As described in Section B, the Healthy Hearts for Oklahoma (H2O) initiative is a four-year statewide cooperative, using a \$15 million grant from the Agency for Healthcare Research and Quality (AHRQ), to test if a learning cooperative can improve the care of cardiovascular patients. Under the Oklahoma Model, H2O will serve as an excellent role model and could become a valuable partner as the RCO adapts a higher level of reliance on HIT, develops connections with community, implementations care coordination, changes process to match value-based purchasing practices and works with providers to transform their practice to improve health outcomes, lower cost and increase patient satisfaction.

Health Homes

As described in Section B, Health Homes are an optional Medicaid State Plan benefit through a collaboration of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and Oklahoma Health Care Authority (OHCA). Health Homes provide an opportunity to build a person-centered system of care that achieves improved outcomes and better services and value for the Oklahoma SoonerCare program for individuals with complex needs. Under the Oklahoma Model, RCOs will use best practices and lessons learned from the Health Homes initiative for behavioral and physical healthcare integration. RCOs will learn from the health homes experiences with care coordination and quality improvement efforts

State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke (Centers for Disease Control and Prevention 1422 Grant)

As described in Section B, the Chronic Disease Service and the Center for the Advancement of Wellness located within the OSDH are collaborating with local county health departments to develop and implement evidence-based interventions to combat obesity, diabetes, heart disease, and stroke. Local county health departments are currently performing care coordination related to these health conditions. The State will examine findings and best practices from these initiatives to determine how best to incorporate local health departments into the Oklahoma Model and incorporate appropriate representation of local health departments in the RCO governance and community board.

Oklahoma Health Care Authority (OHCA) Programs

As described in Section B, the OHCA, Oklahoma's state Medicaid Agency, serves over 818,000 adults and children through its plans.¹³ The OHCA has implemented several initiatives aimed at improving the health of their member population to decrease costs. The Oklahoma Model will incorporate aspects of these initiatives and lessons learned into the RCOs, as described below.

Table 39: Oklahoma Health Care Authority Initiatives

Name of Initiative	Incorporation into the RCO Model
Health Access Networks	Provide lessons learned and possibly contract with RCOs for care coordination, practice transformation, or other tasks.
Primary Care Medical Homes	Provide lessons learned for care coordination and quality improvement
SoonerExcel Program	Serve as a foundational model for the RCO in terms of how to implement and operationalize value based purchasing

Health Access Networks

As described in Section B, Health Access Networks (HANs) are designed to increase access to care, quality of care, and cost effectiveness by providing a higher degree of care coordination support to HAN-affiliated Patient Centered Medical Home providers. Under the Oklahoma Model, HANs will be able to contract with RCOs to offer services for care coordination, practice transformation, and other needed resources that they offer in the current healthcare environment. RCOs will have the flexibility to determine how they will collaborate with HANs.

Primary Care Medical Homes

As described in Section B, SoonerCare Choice is a Primary Care Case Management (PCCM) program in which each member is assigned to a primary care medical home. Under the Oklahoma Model, the PCMH model will serve as a foundational model for RCOs in terms of care coordination strategies, provider network building, and quality improvement efforts.

SoonerExcel Program

As described in Section B, SoonerExcel is a performance-based reimbursement component of SoonerCare Choice where providers are eligible for incentive payments if they meet certain quality-of-care benchmarks.¹³⁹ This program will be considered as an APA option for the RCOs. The measures that are used in the SoonerExcel Program are currently being reviewed by the Oklahoma SIM project team and will be required for use in the RCOs. RCOs will have the flexibility to determine the specific payment methodologies associated with this program for their region.

Public Health and Community Organizations

In addition to the healthcare models and initiatives going on across the state that were described in Section B, RCOs will include and leverage regional public health programs in order to best address health outside of the healthcare setting and to start addressing social factors that affect health. Although regions will differ in services available, RCOs will need to attest to how they will incorporate these ongoing efforts into their care delivery and payment design. The efforts listed below give an overview of some of the broader public and community health efforts occurring across Oklahoma.

Table 40: Public Health and Community Organizations

Name of Organization	Incorporation into the RCO Model
Alliance for Healthier Generation – Healthy Schools Program	Serve as a community partner to address and prevent childhood obesity
County Health Department Accreditation	State will leverage this accreditation process to incorporate the CHIPs and community health needs assessments as part of the RCOs in each region
Department of Human Services Aging Services Division	Work in partnership with RCO to address social determinants and environmental concerns for RCO members age 65 and old
Health Equity Campaign	Serve as a State partner to provide resources to RCOs regarding health equity and the social determinants of health
Mental Health Association of Oklahoma	Serve as a community partner to address and provide resources for mental illness and homelessness
Schools for Healthy Lifestyles	Serve as a community partner to address and prevent childhood obesity
Regional Food Bank	Serve as a community partner to address social determinants related to nutrition and food insecurity
Tobacco Settlement Endowment Trust	Serve as a State partner to support the mutual goal to lower the rate of tobacco by 2020 by 2%
Tulsa Area United Way	Serve as a community partner to provide resources to address social determinants of health
Turning Point Partnerships	Continue to provide services and potentially expand to serve as partners with the State Governing Body and RCO on practice transformation
United Way of Central Oklahoma	Serve as a community partner to provide resources to address social determinants of health

Alliance for Healthier Generation – Healthy Schools Program

As described in Section B, the Alliance for Healthier Generation Healthy Schools Program includes strategies to improve snack policies, add physical activity breaks in the classroom, start active afterschool programs, and start employee wellness programs. Under the Oklahoma Model, the alliance will serve as community partner of the RCOs to help address childhood nutrition and obesity.

County Health Department Accreditation

As described in Section B, the OSDH is currently accredited through the Public Health Accreditation Board (PHAB) and 32 of 68 county health departments are participating in some part of the accreditation process. Under the Oklahoma Model, the State will leverage this accreditation process to incorporate the CHIPs and community health needs assessments as part of the RCOs in each region.

Department of Human Services Aging Services Division

As described in Section B, the Department of Human Services (DHS) Aging Services Division contracts with 11 Area Agencies to provide services to residents age 60 and older. Under the Oklahoma Model, the division will serve as a community partner.

Health Equity Campaign

As described in Section B, the Health Equity Campaign (OHEC) is a statewide campaign alerting state and community leaders to socioeconomic and ethnic inequities in health and engaging leaders in conversations that result in actions to fight the effects of these inequities in Oklahoma. Under the Oklahoma Model, the State will incorporate the OHEC as a partner to the State Governing Body to provide resources to RCOs regarding health equity.

Mental Health Association Oklahoma

As described in Section B, Mental Health Association Oklahoma is an advocacy voice representing people impacted by mental illness and homelessness in communities throughout Oklahoma. Under the Oklahoma Model, the association will serve as a community partner of the RCOs to provide services and resources to address mental illness and homelessness.

Regional Food Bank

As described in Section B, the Regional Food Bank distributes food and other products through a network of more than 1,100 charitable feeding programs, including food pantries, homeless shelters, church pantries, soup kitchens, Food Resource Centers, and schools. Under the Oklahoma Model, the food bank will serve as community partners of the RCO.

Schools for Healthy Lifestyles

As described in Section B, Schools for Healthy Lifestyles is a program that provides health education to Oklahoma elementary students in five key areas: physical activity and fitness, nutrition education and awareness, tobacco use prevention, safety and injury prevention, and oral health. Under the Oklahoma Model, the program will serve as a community partner of the RCOs to help address childhood nutrition and obesity.

Tobacco Settlement Endowment Trust

As described in Section B, the Tobacco Settlement Endowment Trust (TSET) is a grant-making state agency that focuses on preventing tobacco use, reducing tobacco use, and preventing obesity. Under the Oklahoma Model, both the State Governing Body and the RCO will need to work in partnership with TSET to meet the SHSIP goal of lowering Oklahoma's smoking rate by two percent by 2020.

Turning Point Partnerships

As described in Section B, Turning Point works as an independent statewide consortium focused on policy issues aimed at improving Oklahoma's health⁶ and has partnered with communities all across Oklahoma to work on local innovations to transform public health in Oklahoma. Under the Oklahoma Model, the State Governing Body and the RCO will need to build upon and potentially expand this effort in order to make the strides in practice transformation that will support the new RCO model.

Tulsa Area United Way

As described in Section B, Tulsa Area United Way serves 505,000 people through 60 partner agencies in six counties of the Tulsa region: Tulsa, Creek, Okmulgee, Osage, Rogers, and Wagoner counties. Under the Oklahoma Model, the organization will serve as a community partner of the RCOs to address social determinants of health.

United Way of Central Oklahoma

As described in Section B, United Way of Central Oklahoma works to provide access and critical funding to over 127 results-oriented programs at 61 accountable nonprofits across central Oklahoma. Under the Oklahoma Model, the organization will serve as a community partner of the RCOs to address social determinants of health.

SIM POPULATION HEALTH STRATEGIES AND ACTIVITIES

The Oklahoma Model will begin upon strategies and activities employed by SIM to advance population health improvement goals, namely the workgroup structure, focus on social determinants of health, and multi-payer quality alignment.

Workgroup Structure

As described in Section B, the Oklahoma SIM project leveraged the workgroup structure that was established by the OHIP Coalition as a vehicle to accomplish the goals of the initiative. The workgroups participated in the planning and development of the SHSIP. The four workgroups included the:

- Health Efficiency and Effectiveness Workgroup;
- Health Workforce Workgroup;
- Health Information Technology (HIT) Workgroup; and
- Health Finance Workgroup.

Moving forward, the Oklahoma Model will retain some aspects of this workgroup structure for the State Governing Body to advise the body on population health matters for the RCOs. This may be done by infusing aspects of the Oklahoma SIM workgroups into the State Governing Body committees or by standing by new committees or subcommittees for the State Governing Body. For instance, aspects of the HIT Workgroup may be infused into the HIT Committee and aspects of the Health Workforce Workgroup may be infused into the Provider Advisory Committee. The current proposed workgroup structure of the State Governing Body is displayed below. It is envisioned that other workgroups will be added.

Figure 39: State Governing Body Advisory Committees



Social Determinants of Health

The Oklahoma SIM project aimed to highlight health disparities and the impact of social determinants on health status. RCOs will play an important role in addressing the social determinants of health that impact poor health outcomes. As stated in Section B, the social determinants of health that most impact Oklahomans are: access to care, affordable housing, access to fresh and affordable produce, walkability or access to a place to be physically active, literacy, employment, and transportation.¹³⁴ RCOs will work with community members to address these barriers to promote the health of the population they serve, and in turn, meet the cost and quality targets required of the RCO.

RCOs will formally identify and incorporate community resources in their region through their Community Advisory Board. The Community Advisory Board will assist with voicing concerns about barriers that members of the region face in achieving better health outcomes. This board will also bring knowledge of the resources that are available to address the issues that are inhibiting healthy behaviors and lifestyle. RCOs will be encouraged to use these boards and resources to help bridge the gap to accessing healthy foods, transportation, places to exercise, and other social factors in order to improve the health of their attributed members. Through this feedback, the RCO can determine the most effective way to support members and providers in promoting health. In light of the diverse needs and varying levels of resources in counties across the state, specific methods to address the social determinants of health will be left to the RCO. This will provide RCOs the flexibility to find best fit solutions for their region. RCOs will have to demonstrate how they have the necessary partnerships and community board membership to address the social determinants of health that impact healthcare costs. Once the RCO is operational, it will be a part of the CHIP process at the community level. RCOs will work with county coalitions and the RCO governing board to revise and develop the CHIP.

RCOs will also use “flexible spending” to address social determinants of health and improve health. Flexible spending refers to allowing the use of RCO funds for non-clinical services that are medically necessary. Historically, federal funds for Medicaid could not be used for anything besides direct patient care at the time of service. However, many states have been able to negotiate spending for services outside of the clinical setting that directly affect the health outcomes of patients. The scope of services that will be allowed with these funds will be determined through the state plan and waiver negotiation process with CMS. This will be a direct way that the RCO can support the provider and community to address the social determinants of health.

Multi-Payer Quality Alignment

The Oklahoma SIM project aims to strategically align population-based health outcomes with clinical quality measures using National Quality Forum (NQF) Measures and Clinical Quality Measures (CQM) for the targeted areas of tobacco use, obesity, diabetes, hypertension, and behavioral health.

According to the PHNA, the state's mortality rate (941.9 per 100,000, age-adjusted) is 23 percent higher than the national rate.¹³⁷ Several factors contribute to this high rate; the Oklahoma SIM flagship issues (tobacco use, diabetes, hypertension, obesity, and behavioral health) are some of the most influential factors. Oklahoma exceeds the national average in all areas of the flagship issues. Assigning and linking measures to incentive payments and penalties based on the flagship issues will ensure that providers are taking a more active role in screening patients for diseases, assisting patients with health improvement, and following up with patients. Adopting multi-payer quality measures will help to lower healthcare costs and improve quality, patient experience, and population health.

Quality measures will be aligned across payers and focus on addressing the leading causes of disease and disability within their patient population. All payers will be asked to use these common measures as reporting tools, and where possible, to improve health outcomes and evaluate them with these agreed upon measures. Multi-payer alignment of quality measures prevents an unnecessary workload from being placed on providers due to multiple measure sets from different payers. This alignment also helps to ensure that providers have a clear understanding of their responsibilities with regard to achieving high-quality patient health outcomes. Sophisticated analytics are the most common way providers (and payers) are able to determine how well they are doing in meeting quality measure targets. EHRs and tools within their EHR systems help providers identify where they need to improve. Many EHR systems also have clinical decision support tools that guide providers in referring patients to outside resources. Some EHR systems lack these resources for provider guidance and reporting. In such cases, the provider must have knowledge of what resources are available and how the patient can gain access to those resources.

Under the Oklahoma Model, the Board of Accountable Providers will advise RCOs on how to address traditional clinical approaches to meet quality metrics guidelines for attributed patients in their region.

ADDITIONAL OPPORTUNITIES UNDER SIM

Coordination with Tribal Public Health Efforts

Oklahoma is home to 38 federally recognized tribal nations¹⁴⁰ and has an American Indian population of almost 350,000 persons, comprising nine percent of the state's population.¹⁴¹ Along with being citizens of the state, tribal members are also citizens of their respective tribal nation that has its own inalienable self-governance of its citizens and territories, and possess unique culture, beliefs, value systems, and history as a sovereign nation. American Indian people suffer greater health disparities than other populations and have higher rates of heart disease and diabetes than other Oklahomans. Due to the high rates of chronic disease and other health issues, it is important for the state to address the health needs of the American Indian population, but it must be done within the context of the tribal nation's sovereignty. As part of the Oklahoma Model, the State Governing Body will include representation from tribal nations. The RCO governance and advisory boards for each region will also include representation from tribal nations, as determined by the population of tribal nations in the region. As described in Section B, the OSDH has utilized two outlets for respectfully communicating and collaborating with the 38 federally-recognized tribal nations in Oklahoma to address public health issues: the Office of the Tribal Liaison and Tribal Public Health Advisory Committee.

ROADMAP TO IMPROVE POPULATION HEALTH

The Centers for Disease Control and Prevention (CDC) has identified three approaches to improving population health: traditional clinical approaches, innovative patient-centered care and community linkages, and community-wide strategies. This section will review the Oklahoma SIM model components within each of these categories. These interventions leverage current initiatives to give a roadmap to population health improvement.

Traditional Clinical Approaches

The healthcare environment is rapidly changing. Providers now have to meet quality standards in order to receive their payments from some health plans. Quality measures give providers a guideline/best practice to follow that is shown to improve the overall health of their panel or population. Sophisticated analytics are the most common way providers are able to determine how well they are doing on meeting quality measures. Table 37 details lists the multi-payer quality measures suggested for the Oklahoma Model. By converging on a set of multi-payer quality metrics, there would be a synergy of effort to perform well on these evidence-based metrics. Through this traditional clinical approach, there would be the potential to show improvement in the related population health issue.^{139,140,141,142} All clinical approaches and suggested best practices were adapted from the American College of Physicians, National Committee for Quality Assurance, National Quality Forum, and United States Preventive Services Task Force.^{142,143,144,145}

Table 41: Multi-Payer Quality Measures

Measure	Health Condition
NQF 0028	Tobacco Use: Screening and Cessation Intervention
NQF 0059	Diabetes: Poor Control of Hemoglobin A1c
NQF 0018	Hypertension: Controlling High Blood Pressure
NQF 0421	Obesity: BMI Screening and Follow-Up
NQF 0418	Behavioral Health: Depression Screening
NQF 0105	Medication Adherence: Anti-Depressant Medication Management
NQF 1932	Behavioral Health: Diabetes Screening for People with Schizophrenia or Bipolar Disorder
USPTF	Abnormal Blood Glucose and Type 2 Diabetes – Adults Aged 40-70 Years Who Are Overweight or Obese
NQF 0024	Children’s Health: Weight Assessment and Counseling for Nutrition and Physical Activity

Innovative Patient-Centered Care and Community Linkages

In addition to addressing traditional clinical approaches for healthcare, RCOs will focus on how to incorporate innovative clinical approaches to meet quality measure targets and improve population health. RCOs will furthermore go beyond the provider’s office for solutions to improving population health. For

real healthcare transformation to occur in Oklahoma, healthcare strategies and interventions need not only to occur in traditional healthcare settings but also in the places where people live, work, and learn.

The Oklahoma Model will incorporate patient-centered care and community-based linkages to transform healthcare delivery by focusing on a more holistic approach to population health improvement. More specifically, RCOs will integrate physical and behavioral healthcare delivery; use care coordination to direct patients to the appropriate healthcare settings and resources once they leave the provider's office; and refer patients to community resources that address social needs that impact health. RCOs will also adhere to quality measures that align to the Oklahoma SIM flagship issues.

An example of how RCOs will deliver patient-centered care and community-based linkages is with diabetes treatment and management. Under the traditional clinical model, if a patient presents to a provider with diabetes complications, the normal clinical approach would be for the provider to modify the patient's medications, provide recommendations for diet and exercise modifications (typically through a pamphlet or health education materials), and schedule routine follow-up. In comparison, under the Oklahoma Model, the patient would receive traditional medical care that would also include care coordination with community programs. These community programs could include a disease self-management program and an in-person health education for nutrition and exercise. If needed, the community programs could include a referral to community resources for access to healthy foods and physical activities, assistance with transportation to medical appointments, and pharmacy resources for purchasing medications. Along with traditional provider reporting on quality measures related to patient health, the RCO would report on how providers' actions impact patient health. In this way, the State will be able to examine both clinical and social outcomes of patient health to determine the priorities to include in future interventions to improve population health the most efficiently and effectively.

Another example of how RCOs will deliver patient-centered care and community-based linkages is with behavioral health treatment. Traditionally, behavioral health is overlooked or undiagnosed outside of mental health or emergent healthcare settings. Under the Oklahoma Model and RCOs, all providers will have to conduct behavioral health screenings for clinical depression and substance abuse disorders. If a patient receives a behavioral health or substance abuse diagnosis, the provider would immediately connect the patient to a care coordinator, who would organize a care plan to address both physical and behavioral healthcare needs. This could include referrals to mental health providers, substance abuse treatment providers and/or facilities, community support groups, and pharmacy support programs.

Overall, under the Oklahoma Model, integrating behavioral and physical healthcare and linking patients to care coordination and community resources will help to reduce health disparities and improve population health.

Community-Wide Strategies

Under the Oklahoma Model, the State will incorporate community-wide strategies into the decision-making process of the State Governing Body and Practice Transformation Center. The State Governing Body itself will serve as a resource for RCOs to disseminate best practices regarding public health practices and serve as an advocate for public health policy. Additionally, the public health sector will be represented in the membership of the State Governing body.

In addition to improving health through clinical care transformation and the incorporation of community initiatives that can address social determinants of health, the State will continue to pursue community wide strategies that aid communities in being healthy. For example, policies related to tobacco-free schools, workplaces, and communities can encourage tobacco users to quit and protect non-smokers from dangerous secondhand smoke. In Oklahoma, organizations like TSET and coalitions like OHIP work to implement policies that help improve population health on a large scale. Both have garnered support from

public and private entities, which has allowed them to saturate the state's health environment with comprehensive health policies.

Tobacco Settlement Endowment Trust Community Grants

As aforementioned, TSET is a state agency that uses earnings from the Master Settlement Agreement to fund community grants through policies related to tobacco, physical activity, and nutrition. Policies related to tobacco include 24/7 tobacco-free schools, businesses, early childhood centers, restaurants, and local communities. Local grantees also work with community stakeholders to pass tobacco policies for smoke-free multi-unit housing and smoke-free local events. Local community coalitions work to pass policies related to obesity through increased physical activity and consumption of healthier foods. Schools, businesses, and communities work to pass policies related to healthy vending options, physical activity breaks, shared-use agreements between cities and schools for spaces to exercise, and promoting biking or walking to school or work. In addition to these local policies, TSET is working with the Free the Night Campaign, a statewide campaign to encourage bars and nightclubs to adopt smoke-free policies.

Certified Healthy Oklahoma Program

As described in Section B, the Certified Healthy Oklahoma Program is a free, voluntary statewide certification for public and private entities that spotlights businesses, campuses, communities, congregations, early childhood programs, restaurants, and schools that are committed to supporting healthy choices through environmental and policy change. These entities are implementing policies and programs that will help Oklahomans eat better, move more, and be tobacco free.

Oklahoma Health Improvement Plan/Community Health Improvement Plan

As aforementioned, the OHIP is a comprehensive plan for improving the physical, social, and mental well-being of all Oklahomans. The OHIP is now in its second installation (OHIP 2020) and fifth year of implementation. At the county-level, the CHIP is a long-term, systematic effort to identify and address public health concerns with the input of community partners. A CHIP is critical for developing policies and defining actions to target efforts that promote health. As the plans are implemented, performance indicators are used to evaluate the effectiveness of the strategies and tactics related to each priority area.

Under the Oklahoma Model, the OHIP and CHIPS will serve as inputs into the State Governing Body for public health policies and goals for the RCOs. The RCOs will use the CHIPS to set priority areas for improving the health of the community served. The priority areas will be aligned with statewide priorities and quality measures to ensure key health issues are being addressed clinically and the communities' overall health improves.

CONCLUSION

(This section of the SHSIP will be updated as a future date).