Health Workforce Subcommittee

Governor's Council for Workforce and Economic Development

June 22, 2017

Health Workforce Subcommittee

Governor's Council on Workforce and Economic Development

June 22, 2017
1:30 p.m.-3:30 p.m.
OSDH
1000 NE 10th Street, Room 1102
Oklahoma City, OK 73117

Section	Time	Presenter
Welcome and Introductions		Shelly Dunham, Co-Chair David Keith, Co-Chair
Research to Recommendations		Jennifer Kellbach
Graduate Medical Education Recruitment and Retention		John Zubialde, MD
Critical Occupations		Jana Castleberry Shelly Dunham
Health Workforce Plan Priorities Discussion		Shelly Dunham, Co-Chair David Keith, Co-Chair
Innovation Waiver/Quality Measures		Buffy Heater
Wrap Up and Next Steps		Shelly Dunham, Co-Chair David Keith, Co-Chair

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Meeting Objectives

- Advance understanding of evaluation process to ensure data-informed and evidence-based recommendations
- Determine support for graduate medical education, recruitment and retention recommendations
- Understand and approve “Critical Healthcare Occupations” list
- Identify priorities in “Health Workforce Action Plan”

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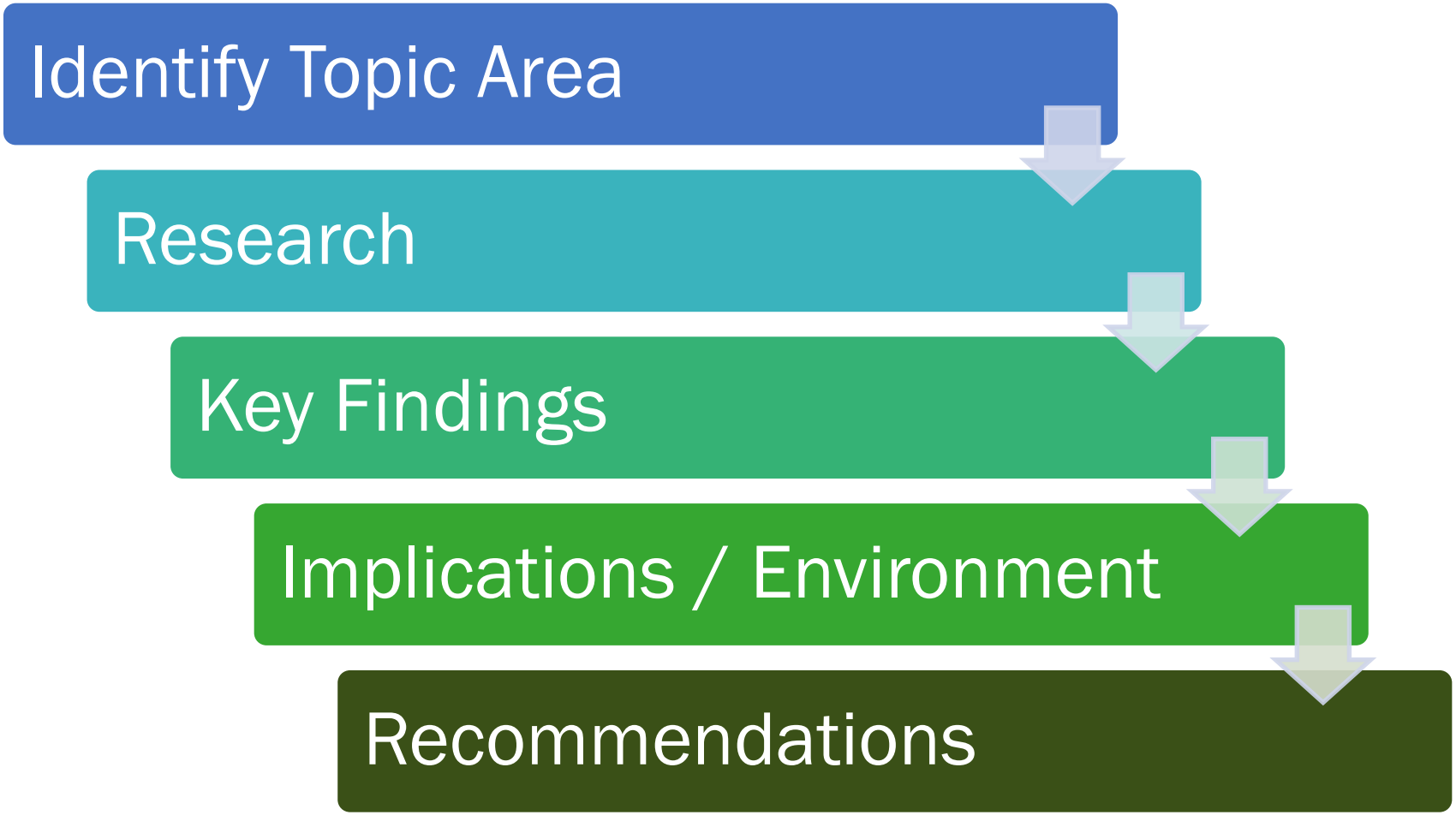
Research to Recommendations



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Sources of Evidence

Scientific Evidence: findings from published research

Organizational Evidence: data, facts, and figures gathered from organizations and experts

Experiential Evidence: the professional experience and judgment of partners and other states

Stakeholder Evidence: The values and concerns of people who may be affected by the decision (implications)

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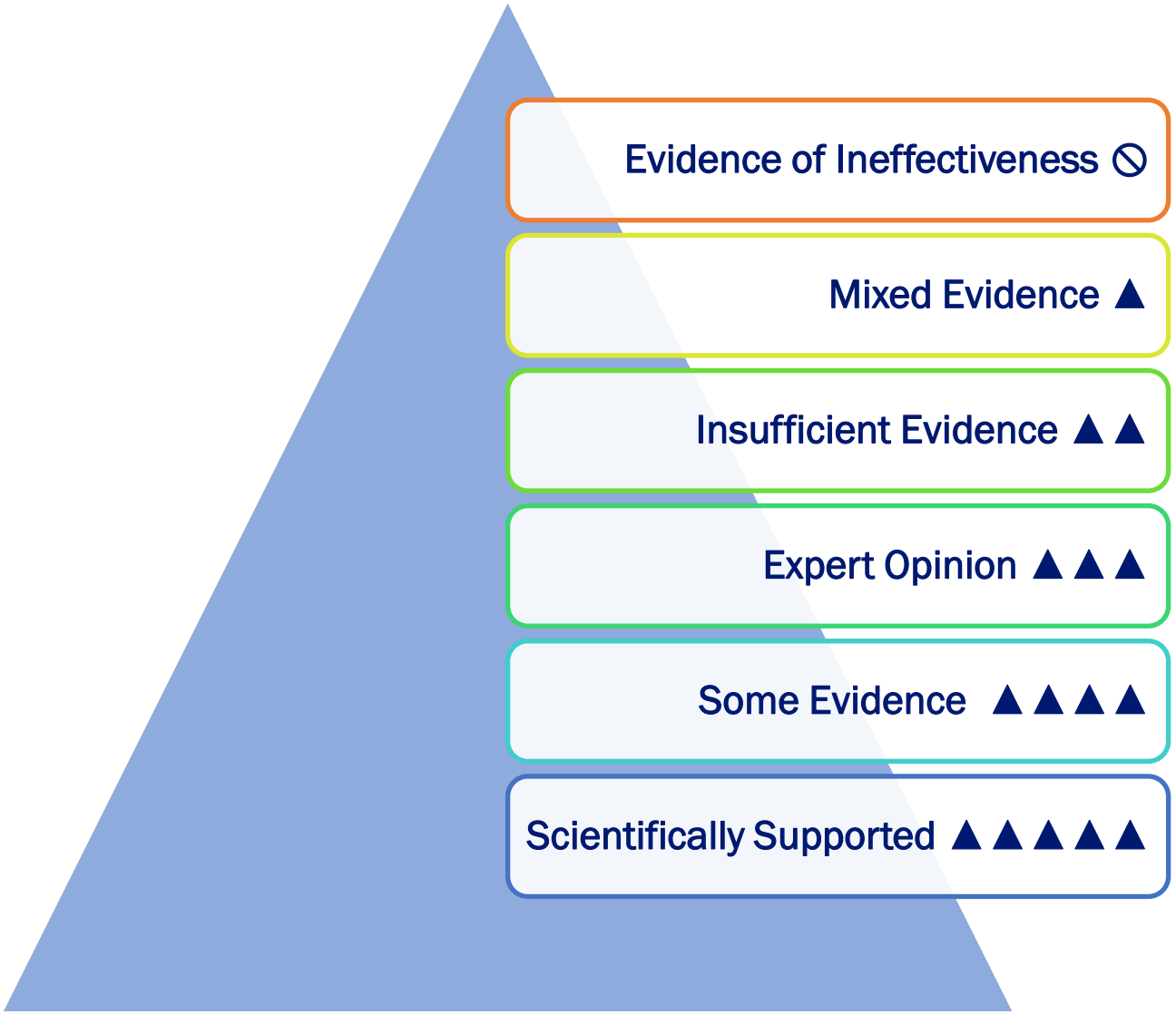
Source: Center for Evidence Based Management. (2014). Evidence-Based Management: The Basic Principles. Retrieved from: https://www.cebma.org/wp-content/uploads/Evidence-Based-Practice-The-Basic-Principles-vs-Dec-2015.pdf.

Quality of Evidence



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Evidence Rating Scale

Rating	Evidence Criteria: Amount & Type	Evidence Criteria: Quality
Scientifically Supported ▲▲▲▲▲	• 1 or more systematic review(s), or at least: • 3 experimental studies, or • 3 quasi-experimental studies with matched concurrent comparisons	Studies have: • Strong designs • Statistically significant positive findings
Some Evidence ▲▲▲▲	• 1 or more systematic review(s), or at least: • 2 experimental studies, or • 2 quasi-experimental studies with matched concurrent comparisons, or • 3 studies with unmatched comparisons or pre-post measures	Studies have statistically significant positive findings Compared to 'Scientifically Supported', studies have: • Less rigorous designs • Limited effect(s)
Expert Opinion ▲▲▲	• Generally no more than 1 experimental or quasi-experimental study with a matched concurrent comparison, or • 2 or fewer studies with unmatched comparisons or pre-post measures	• Expert recommendation supported by theory, but study limited • Study quality varies, but is often low • Study findings vary, but are often inconclusive

Source: University of Wisconsin Population Health Institute. What Works for Health: Policies and Programs to Improve Wisconsin's Health. http://whatworksforhealth.wisc.edu/rating-scales.php

Evidence Rating Scale, continued

Rating	Evidence Criteria: Amount & Type	Evidence Criteria: Quality
Insufficient Evidence ▲▲	• Generally no more than 1 experimental or quasi-experimental study with a matched concurrent comparison, or • 2 or fewer studies with unmatched comparisons or pre-post measures	• Study quality varies, but is often low • Study findings vary, but are often inconclusive
Mixed Evidence ▲	• 1 or more systematic review(s), or at least: • 2 experimental studies, or • 2 quasi-experimental studies with matched concurrent comparisons, or • 3 studies with unmatched comparisons or pre-post measures	• Studies have statistically significant findings • Body of evidence inconclusive, or • Body of evidence mixed leaning negative
Evidence of Ineffectiveness ⃠	• 1 or more systematic review(s), or at least: • 3 experimental studies, or • 3 quasi-experimental studies with matched concurrent comparisons	Studies have: • Strong designs • Significant negative or ineffective findings, or • Strong evidence of harm

Source: University of Wisconsin Population Health Institute. What Works for Health: Policies and Programs to Improve Wisconsin's Health. http://whatworksforhealth.wisc.edu/rating-scales.php

Impact Rating

Direction and Extent of Impact	
↑↑↑↑ or ↓↓↓↓	significant impact on many
↑↑↑ or ↓↓↓	significant impact for few or small impact on many
↑↑ or ↓↓	moderate impact on medium number
↑ or ↓	small impact on few
?	uncertain
None	no impact

- Direction of the arrow indicates positive impact (increase or improvement) or negative impact (decrease or makes worse)
- Number of arrows represents the level of impact (highest to none)

Additional Evaluation Criteria

Cost/Benefit Return on Investment	Is there a defined cost/benefit? Is there demonstrated ROI?	Positive Negative N/A or Unknown
Sustainability	Is there evidence for sustainability?	Long-term Short-term N/A or Unknown
Impact Distribution	Are one or more subpopulations impacted more?	Examples: geographic; ethnicity or race; sub-populations

Evaluation Example – Tort Reform

IMPACT AREA	Quality of Evidence	Cost/Benefit ROI Positive Negative N/A or Unknown	Sustainability Short-Term Long-Term N/A or Unknown	Impact: ↑ or ↓ Direction and level of impact	Impact Distribution: Rural, Regional, Sub-Pop.
Economic ➢ Wealth Generation ➢ Employment Growth ➢ Wages/Poverty	▲ Mixed evidence on direct reduction in health care spending as a result of tort reform efforts	Positive, but minimal reductions found in some studies; Congressional Budget Office calls for national reforms in order to reduce overall healthcare spending by 0.5%	N/A*	↓ litigation time can takeaway from provision of health care services	N/A
Health ➢ Health Outcomes ➢ Access to Care	▲ No conclusive evidence to show tort reform improves health outcomes	no conclusive evidence that reforms increase or decrease "defensive medicine" – even for higher risk specialty like OB	N/A*	↑ Some evidence to suggest greater access through marginal increases in practicing physicians	N/A
Workforce ➢ Team-Based Care ➢ Scope and Roles ➢ Systems Transformation	▲ No conclusive evidence to show tort reform increases or decreases the physician workforce	Lower caps may lead to lower malpractice insurance premiums which may lower consumer health insurance premiums – but does not impact workforce	N/A* *enacted legislation/regulation will allow for long term sustainability, but there is no direct evidence for sustained impact on any of the identified impact areas	↑↑ Modest impact in increasing physician workforce	Some reforms may impact rural providers and some specialty (emergency and OB/GYN)

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BACKGROUND – GME ISSUE BRIEF

The GME Committee has worked on a draft issue brief providing recommendations related to the supply of physicians in Oklahoma.

OSDH staff supported research/writing; GME workgroup provided input on additions/changes which were incorporated since the April meeting.

Working Title: "Physician Supply Key to Oklahoma's Health and Wealth"

Purpose of the Brief:

- Provide evidence on Oklahoma's challenges in physician training, recruitment and retention
- Highlight current state-specific training, recruitment and retention initiatives in Oklahoma.
- Recommend strategies for addressing physician supply challenges.
- Inform the overall subcommittee on the issue to help coordinate planning and future communications.

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STABILIZE AND IMPROVE FUNDING FOR PHYSICIAN TRAINING

- Oklahoma has 110+ GME programs with nearly 1,200 residents (2016-2017).
- Innovative programs are already in place in Oklahoma..
- Peer-reviewed evidence shows that residency location is a key influence on where physicians eventually practice.
- New funding strategies will be needed to help improve supply of doctors in critical specialties – improving supply can have short-term and lasting impact.

BUILD CAPACITY FOR DATA-DRIVEN HEALTH WORKFORCE RECOMMENDATIONS

- Identifying the state's critical shortage areas requires quality health workforce data.
- Aligning data collection efforts of multiple agencies and stakeholders is a "best practice" endorsed by experts (NGA) and the Health Workforce Action Plan.
- **Examples:** Coordination with licensure boards, state agencies on data, examining proposals for AAMC Center for Health Workforce Studies

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ROBUST RECRUITMENT AND RETENTION STRATEGIES

- PMTC has existing authority to obligate and match funds (OHCA) for the purpose of recruiting health professionals.
- PMTC is continuing to develop new ways to create options for leveraging public/private funding in collaborative ventures which support the rural health workforce.
- **Examples:** Community Partnerships for Loan Repayment and Placement

IDENTIFY KEY ECONOMIC FACTORS FOR SUCCESSFUL PRACTICES THROUGH RESEARCH TO INFORM POLICY CHANGE

- Closure of rural hospitals and medical practices is a top issue for the health and economic livelihood of rural areas.
- Research insights toward the specific barriers faced by rural areas will assist the state in both economic development and health workforce development.
- **Examples:** Proposals for a ‘rural practice fragility’ index and Dept. of Commerce ‘Key Economic Networks’ are examples of supportive, locally-focused research.

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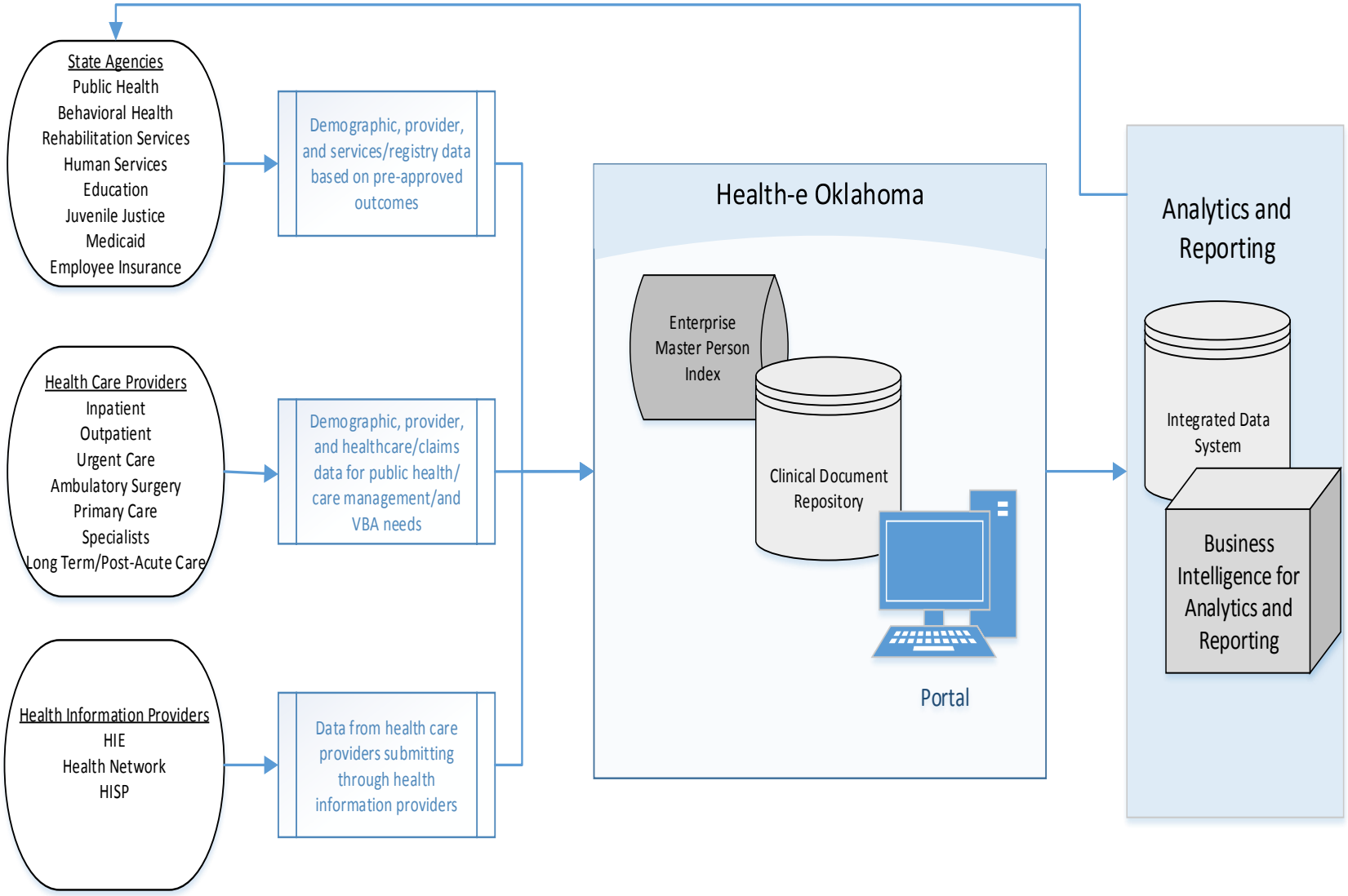
Oklahoma HHS Interoperability System

- Purpose
  - Identification
    - Shared clients
    - Shared providers
    - Provider certification/licensure
    - Relationships
  - Reporting
    - Public Health
    - Care Management
  - Integrated Data Systems
    - Multi- agency initiatives
    - Population health
    - Predictive analytics
    - Value-based analytics

- Data
  - HHS agency data systems
  - Healthcare and claims
  - Social determinants of health
  - Community-based

- Supporting Infrastructure
  - DISCUSS Governance
    - Data governance
    - Multi-agency MOU
  - Public Health Informatics
  - State-of-the-art technology



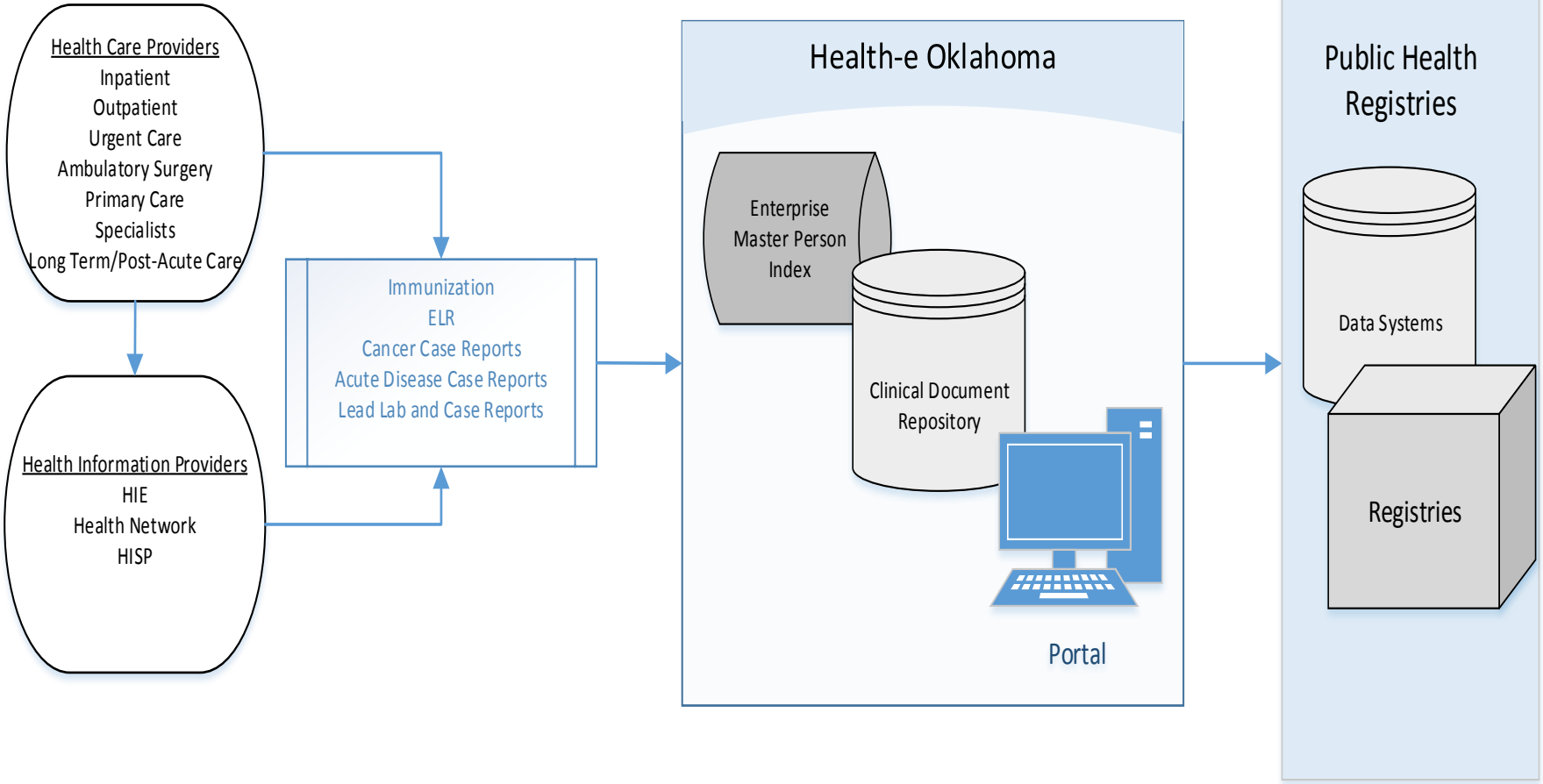
Health-e Oklahoma

Health-e Oklahoma Supporting Public Health

- Unique Client Identification
  - Within existing data systems
  - Across registries
  - Death clearance notification
- Unique Provider Identification
  - Common provider identifier
  - Licensure and certification
- Meaningful Use Reporting
  - Immunization
  - Electronic laboratory reports
  - Cancer case reporting
  - Acute disease case reporting
  - Lead case reporting

- Public Health Informatics
  - System administration
    - Product Owner
    - MPI manager and data stewards
  - Centralized Meaningful Use registration and onboarding
  - Data governance
  - HIPAA privacy and security

Public Health Reporting



Data Governance

HIPAA Privacy and Security

Centralized Support

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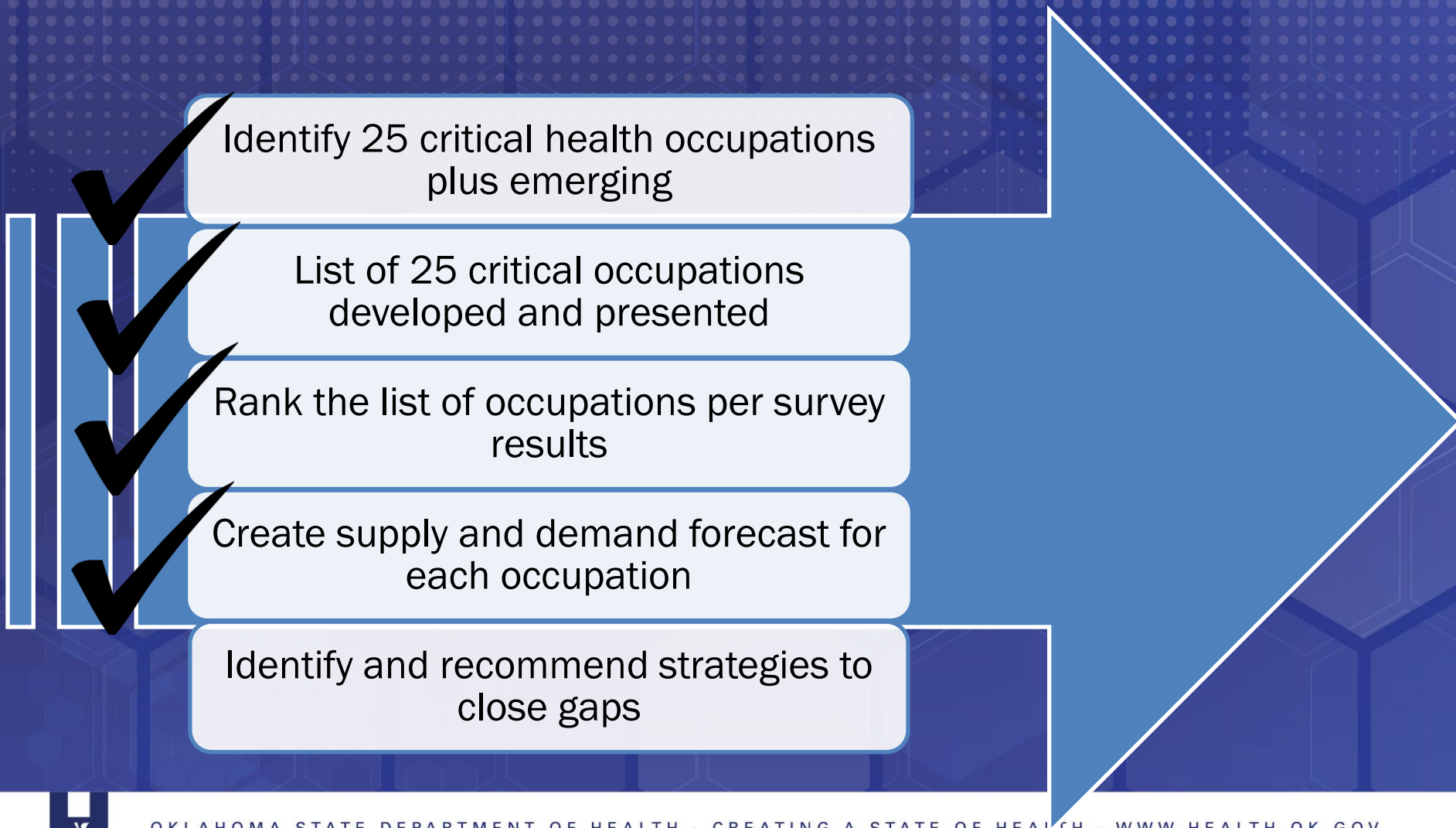
Critical Healthcare Occupations List

Process



Ranked Order Critical Occupations List	
1. Registered Nurses	15. Respiratory Therapists
2. Licensed Practical and Licensed Vocational Nurses	16. Dentists, General
3. Physicians and Surgeons, All Other	17. Pediatricians, General
4. Medical and Health Services Managers	18. Optometrists
5. Physical Therapists	19. Physician Assistants
6. Emergency Medical Technicians and Paramedics	20. Internists, General
7. Pharmacists	21. Phlebotomists
8. Medical and Clinical Laboratory Technologists	22. Diagnostic Medical Sonographers
9. Medical Records and Health Information Technicians	23. Community Health Workers
10. Radiologic Technologists	24. Anesthesiologists
11. Mental Health Counselors	25. Nurse Anesthetists
12. Family and General Practitioners	26. Surgeons
13. Nurse Practitioners	27. Magnetic Resonance Imaging Technologists
14. Medical and Clinical Laboratory Technicians	28. Psychiatrists

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Ranking Methodology

- Survey sent to Critical Occupations workgroup to rank the importance of occupational variables
- Variables weighted based on survey answers
- Sandi Wright, Labor Analyst at Office of Workforce Development, ranked list based on survey results

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Ranking Decisions by OSDH

- Assign numeric values to age groups

- Assigning a numeric value to level of education required to enter a field

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Critical Healthcare Occupations List Limitations/Solutions

- List created in 2015; Due to Office of Workforce staff turnover, exact methodology not replicable

- New methodology for revised list of statewide Critical Occupations methodology currently under review; tentatively scheduled for approval by Governor's Council July 28

- When new methodology is approved, current healthcare occupations list can be developed using approved methodology; can be used to identify and integrate newly identified critical health care occupations if needed

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Ranking List: Why?

- List will guide work of critical occupations workgroup and larger Subcommittee
- Develop strategies and recommendations to close the supply gap
- Forecast shortages and surplus
- List will determine what occupations will be included in the Healthcare Industry Report

Ranking: 2016 Employment

SOC	Description	Ranked by 2016 Employment
29-1141	Registered Nurses	1
29-2061	Licensed Practical and Licensed Vocational Nurses	2
11-9111	Medical and Health Services Managers	3
29-1062	Family and General Practitioners	4
29-2071	Medical Records and Health Information Technicians	5
29-1051	Pharmacists	6
29-2041	Emergency Medical Technicians and Paramedics	7
29-1069	Physicians and Surgeons, All Other	8
29-2012	Medical and Clinical Laboratory Technicians	9
29-2034	Radiologic Technologists	10
29-2011	Medical and Clinical Laboratory Technologists	11
21-1014	Mental Health Counselors	12
29-1123	Physical Therapists	13
29-1021	Dentists, General	14
29-1071	Physician Assistants	15
31-9097	Phlebotomists	16
21-1094	Community Health Workers	17
29-1126	Respiratory Therapists	18
29-1171	Nurse Practitioners	19
29-2032	Diagnostic Medical Sonographers	20
29-1041	Optometrists	21
29-1067	Surgeons	22
29-2035	Magnetic Resonance Imaging Technologists	23
29-1151	Nurse Anesthetists	24
29-1063	Internists, General	25
29-1066	Psychiatrists	26
29-1061	Anesthesiologists	27
29-1065	Pediatricians, General	28

Ranking: 2016-2026 Employment Growth

SOC	Description	Ranked by 2016-2026 Employment Growth
29-1141	Registered Nurses	1
29-2041	Emergency Medical Technicians and Paramedics	2
29-1123	Physical Therapists	3
29-2061	Licensed Practical and Licensed Vocational Nurses	4
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29-1063	Internists, General	27
29-1065	Pediatricians, General	28

Ranking: 2016-2026 Openings

SOC	Description	Ranked by Total 2016-2026 Openings
29-1141	Registered Nurses	1
29-2061	Licensed Practical and Licensed Vocational Nurses	2
11-9111	Medical and Health Services Managers	3
29-2041	Emergency Medical Technicians and Paramedics	4
29-1069	Physicians and Surgeons, All Other	5
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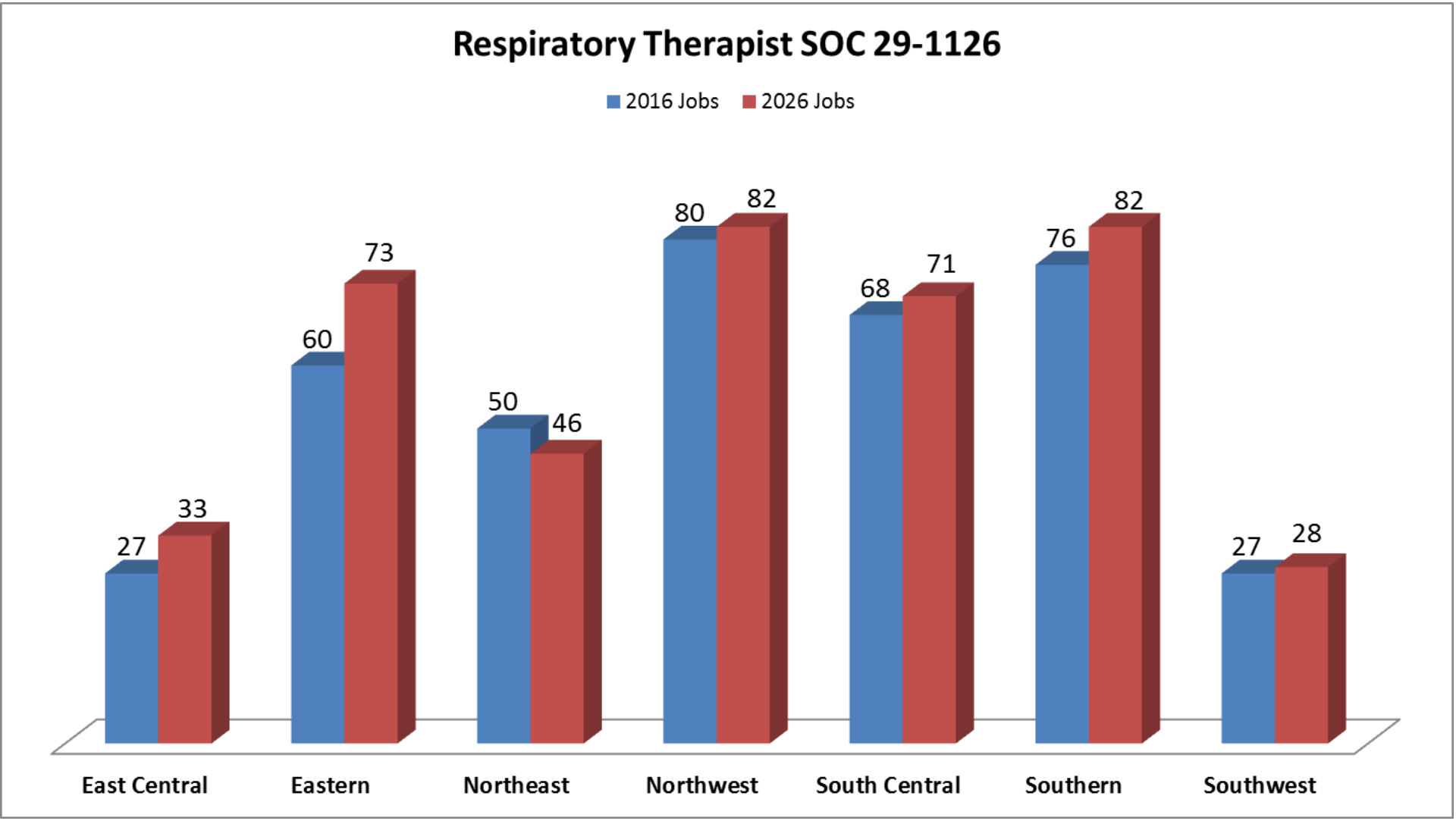
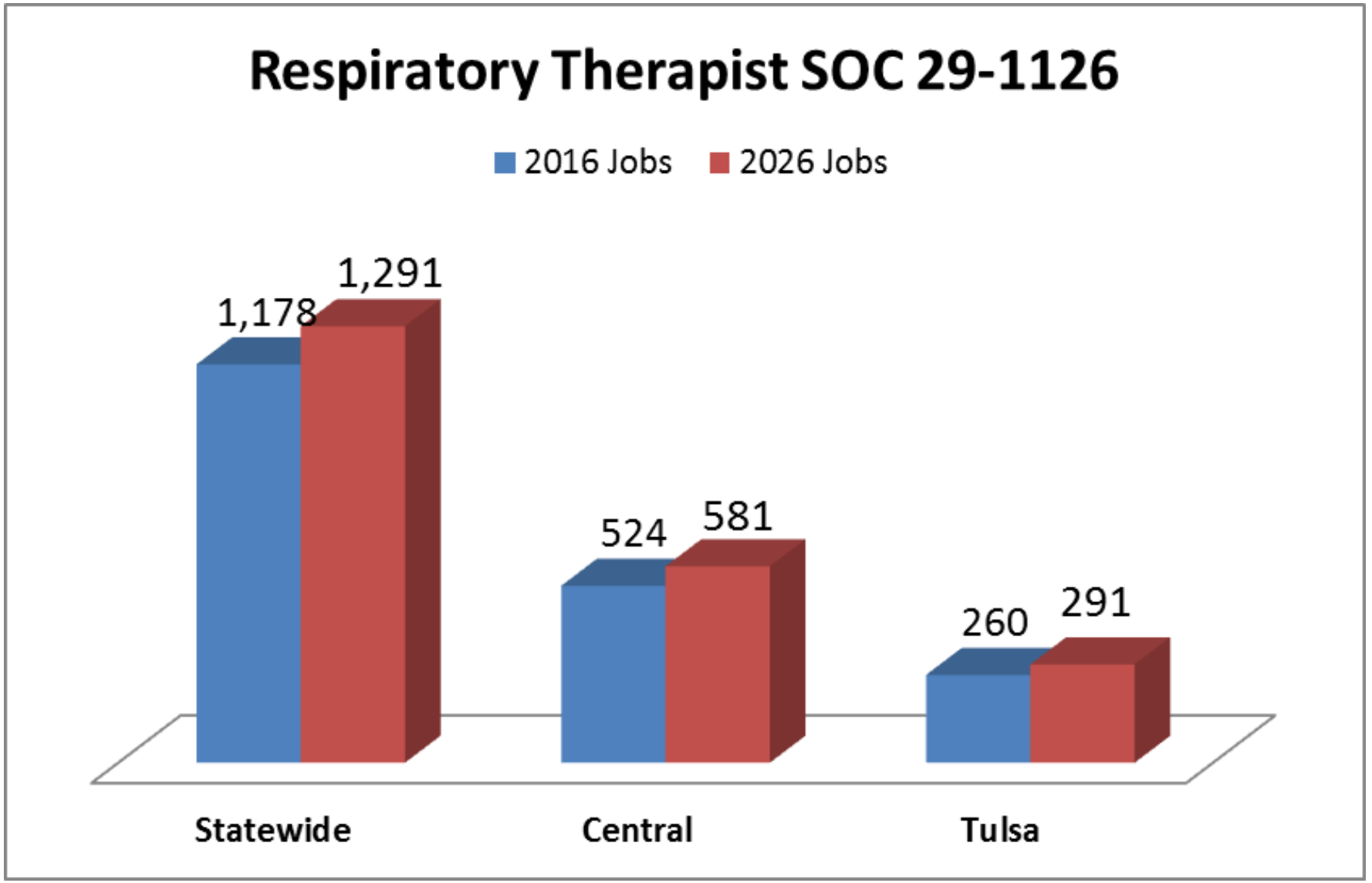
Supply and Demand

- Projections are under the assumption of **no** delivery or payment system changes
- Includes Key Economic Network (KEN) regions and Statewide
- The model modifications will come later, once the assumptions of the changes are determined
- Any occupation with <10 will be suppressed
- Include self-employed estimates, QCEW, and non-QCEW employment, which are important factors for possessing the most complete employment numbers available

Supply and Demand: Regional



Supply and Demand: Statewide/Central/Tulsa



Factors Affecting Supply and Demand

Supply

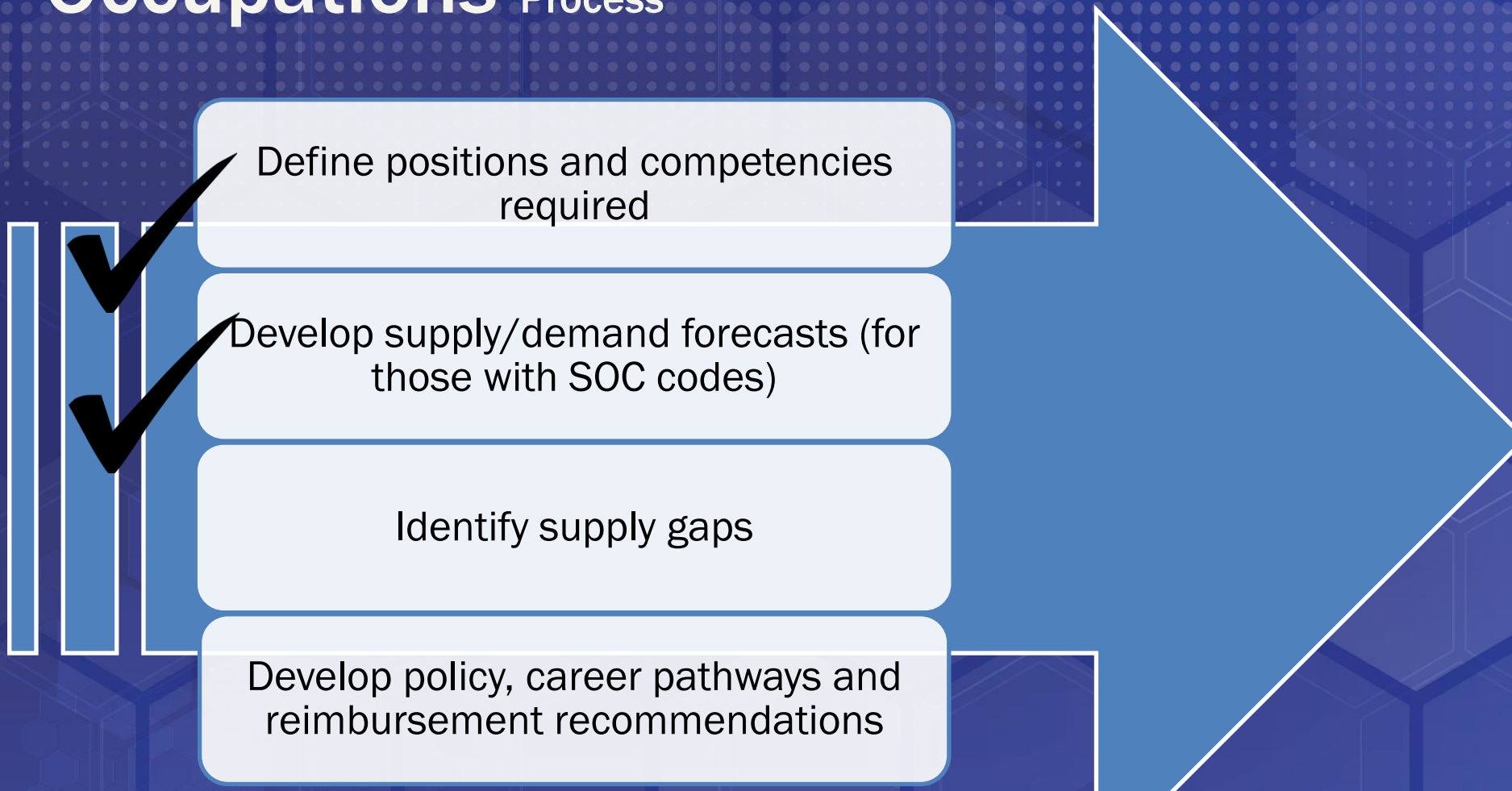
- Educational Capacity
- Geographical distribution
- Job satisfaction
- Economy
- Skills and Education

Demand

- Aging population
- Increase in chronic conditions
- Expanded access to care

Source: http://www.americansentinel.edu/blog/2016/02/02/the-nursing-shortage-factors-affecting-supply-and-demand/

Emerging and Evolving Health Occupations Process



Timeline

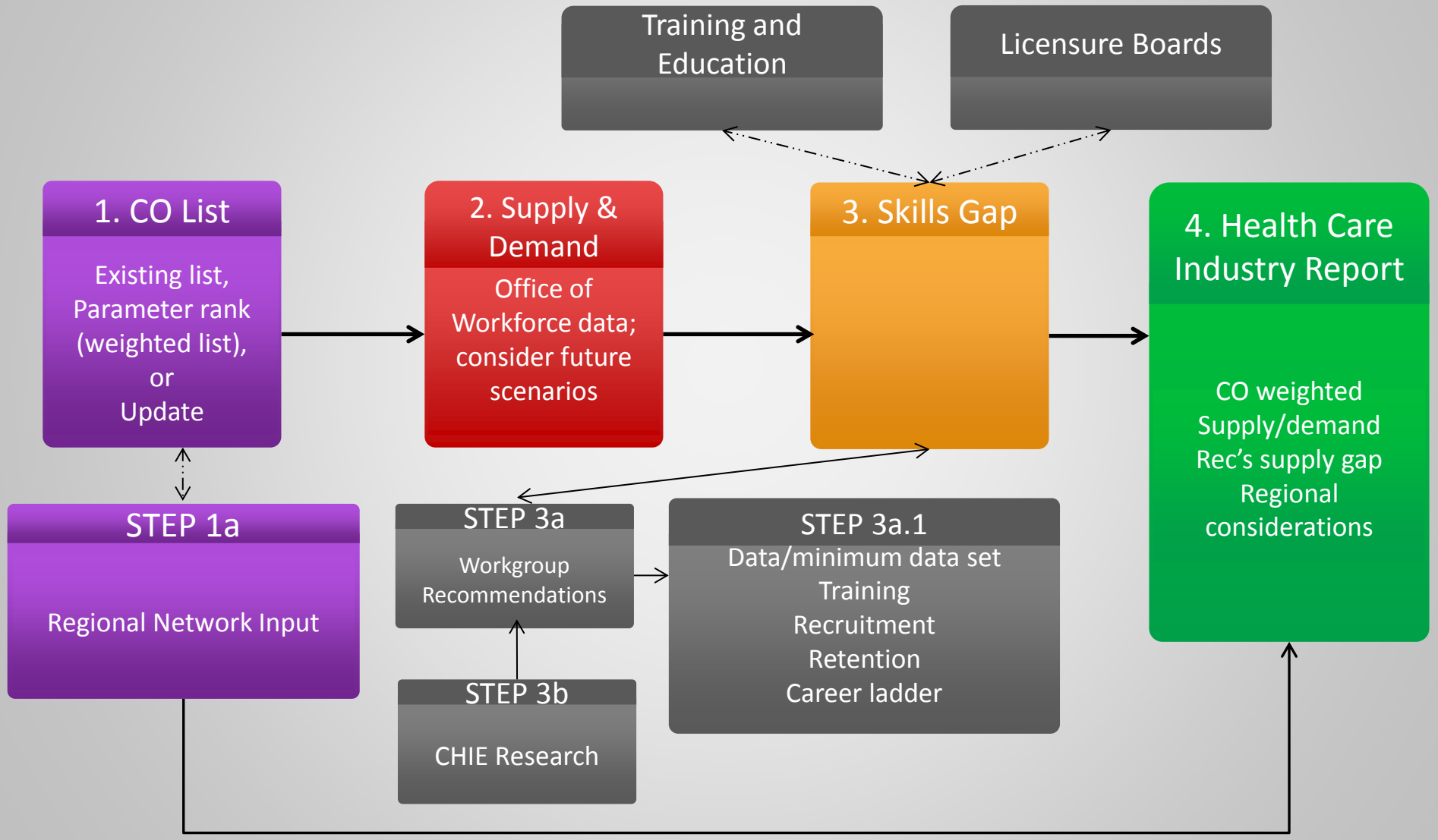
Next Steps

- Supply/demand analysis of all occupations and forecasting
- Utilize partnerships with Regents, Department of Commerce, Employment Security Commission, Licensure Boards, Hospital Association (**July**)
- Engage regional networks

Decision Points for Critical Occupations Workgroup

- Model modifications/value statements to project future changes in supply/demand
- Impact of incorporation of new methodology

Health Care Industry Report Process Diagram



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Health Workforce Action Plan: Subcommittee Priorities

Health System Transformation:
Moving from Workforce Planning to Implementation

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Health Workforce Plan Overview: Core Area Strategies

Coordination of Workforce Efforts

- Integrate health workforce into workforce and economic development efforts
- Leverage efforts and scale successful demonstration projects

Workforce Data Collection and Analysis

- Ensure availability of comprehensive, high quality health workforce data
- Establish centralized health workforce data center

Workforce Redesign

- Achieve collaboration necessary to support team-based health care delivery
- Ensure training and education matches the needs of a redesigned health care system
- Support the utilization of telehealth

Pipeline, Recruitment and Retention

- Facilitate collaboration and achieve consensus on statewide strategies for education, training, and development
- Align and integrate strategies with economic development priorities

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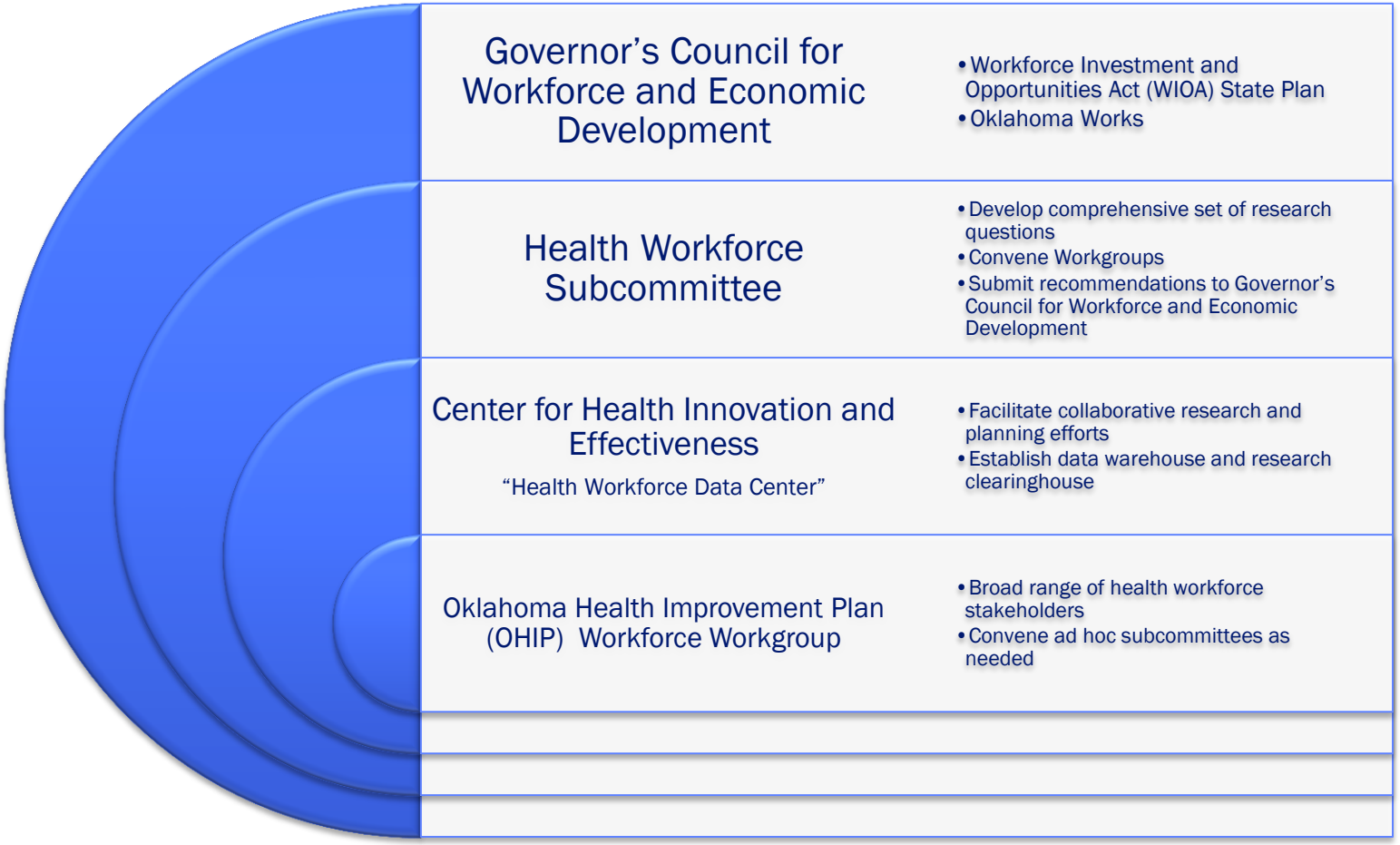

Coordination of Workforce Efforts

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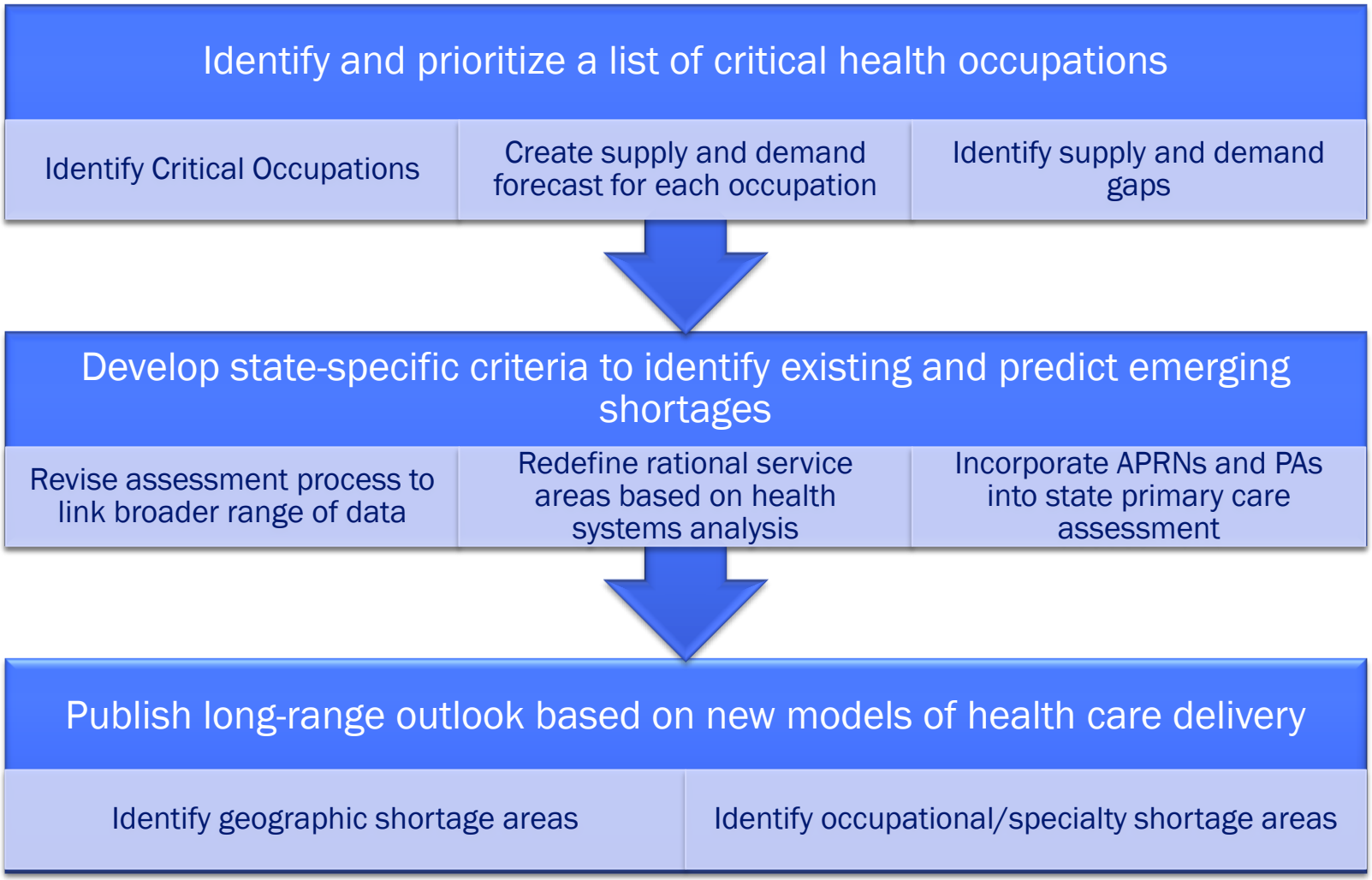

Data Collection and Analysis

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Goal 1: Define Workforce Requirements for a redesigned health system
Goal 2: Develop a process to ensure policy decisions reflect a balanced approach aimed at supporting a high performing, cost effective system of care

#1 Develop a health workforce plan which incorporates care coordination, encourages patient-centered care, and supports the needs of a value-based system of care

- Conduct comprehensive workforce assessment
- Define key competencies and roles for members of community health care teams

#2 Assess, evaluate, and thoughtfully address requirements for physician and ancillary health providers to meet the demands of innovative care delivery models

- Convene interdisciplinary group to guide development of strategy to address regulatory and policy issues that affect health professions
- Assess barriers to health workforce flexibility and optimization
- Utilize findings from demonstration projects (e.g., H2O, Comprehensive Care Initiative, Health Access Networks)
- Develop policy and program recommendations that support health care transformation

#3 Recommend strategies to establish career pathways for new and emerging health professions

- Review and analyze findings from current research and statewide initiatives
- Define positions and competencies required for emerging health professionals, focusing first on community health workers and care coordinators
- Develop training, policy and reimbursement recommendations that support new and emerging health professionals

Workforce Redesign

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Goal 3: Develop an evidence-based plan for optimizing telehealth capabilities

#1 Develop a statewide plan to optimize telehealth and telemedicine capabilities

- Develop a statewide telehealth plan
- Develop statewide policy recommendations.
- Develop recommendations for public/private health education programs for tobacco cessation, diabetes, and other chronic disease management initiatives
- Convene rural telehealth committee to examine and identify potential telehealth innovations to provide robust support to rural hospitals and health care providers

#2 Develop a plan to utilize technology to increase opportunities for training and professional development for health professionals on health transformation and innovation

- Develop statewide training and education plan for the health care transformation
- Develop plan to utilize technology to increase statewide opportunities for training and professional development on health transformation innovation, including practicing goal directed care, using EHR to advance population health, and incorporation of telemedicine
- Create a plan to leverage existing initiatives to create learning networks, virtual communities of practice, and other evidence-based practices
- Develop business plan to secure resources and sustain effort

Workforce Redesign (2)

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Goal 1:	Achieve collaboration and consensus on education, training, and professional development opportunities
Goal 2:	Implement evidence-based initiatives for training, recruitment, and retention strategies in areas identified as geographic or specialty “high need”

#1 Increase the number of physicians trained and retained in Oklahoma

- Sustain and leverage current state Graduate Medical Education (GME)resources
- Expand community-based residencies and rotations
- Maximize impact of pipeline, recruitment and retention efforts
- Address community factors (e.g., economic viability, community support and quality indicators)

#2 Develop recommendations for strategies to address training, recruitment, and retention of nurses, physician assistants, and other ancillary health care providers

- Develop a state plan to address provider shortages and integrate inter-professional education, recruitment and retention strategies
- Increase number of community-based training sites for ancillary providers

#3 Assess and improve distribution and accessibility of training and professional development programs

- Explore shared services for higher education that would increase distribution and availability of health professional training and health professional development programs
- Conduct needs assessment, identify barriers to implementation, and develop recommendations for overcoming barriers

Recruitment and Retention

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June 22, 2017
1:30 p.m.-3:30 p.m.
OSDH
1000 NE 10th Street, Room 1102
Oklahoma City, OK 73117

Section	Time	Presenter
Welcome and Introductions		Shelly Dunham, Co-Chair David Keith, Co-Chair
Research to Recommendations		Jennifer Kellbach
Graduate Medical Education Recruitment and Retention		John Zubialde, MD
Critical Occupations		Jami Vrbenec Jana Castleberry
Health Workforce Plan Priorities Discussion		David Keith, Co-Chair Jana Castleberry
Innovation Waiver/Quality Measures		Buffy Heater
Wrap Up and Next Steps		Shelly Dunham, Co-Chair David Keith, Co-Chair

Oklahoma State Department of Health

OKLAHOMA WORKS

Oklahoma State Innovation Waiver Quality & Evaluation Subcommittee Statewide Quality Measures

Oklahoma State Department of Health

June 22, 2017

Oklahoma State Department of Health

OHIP 2020 - Health Transformation Core Measures

Population Health

Core Measure: Reduce heart disease deaths by 20%.

Quality

Core Measure: Reduce by 20% the rate, per 100,000 population, of potentially preventable hospitalizations.

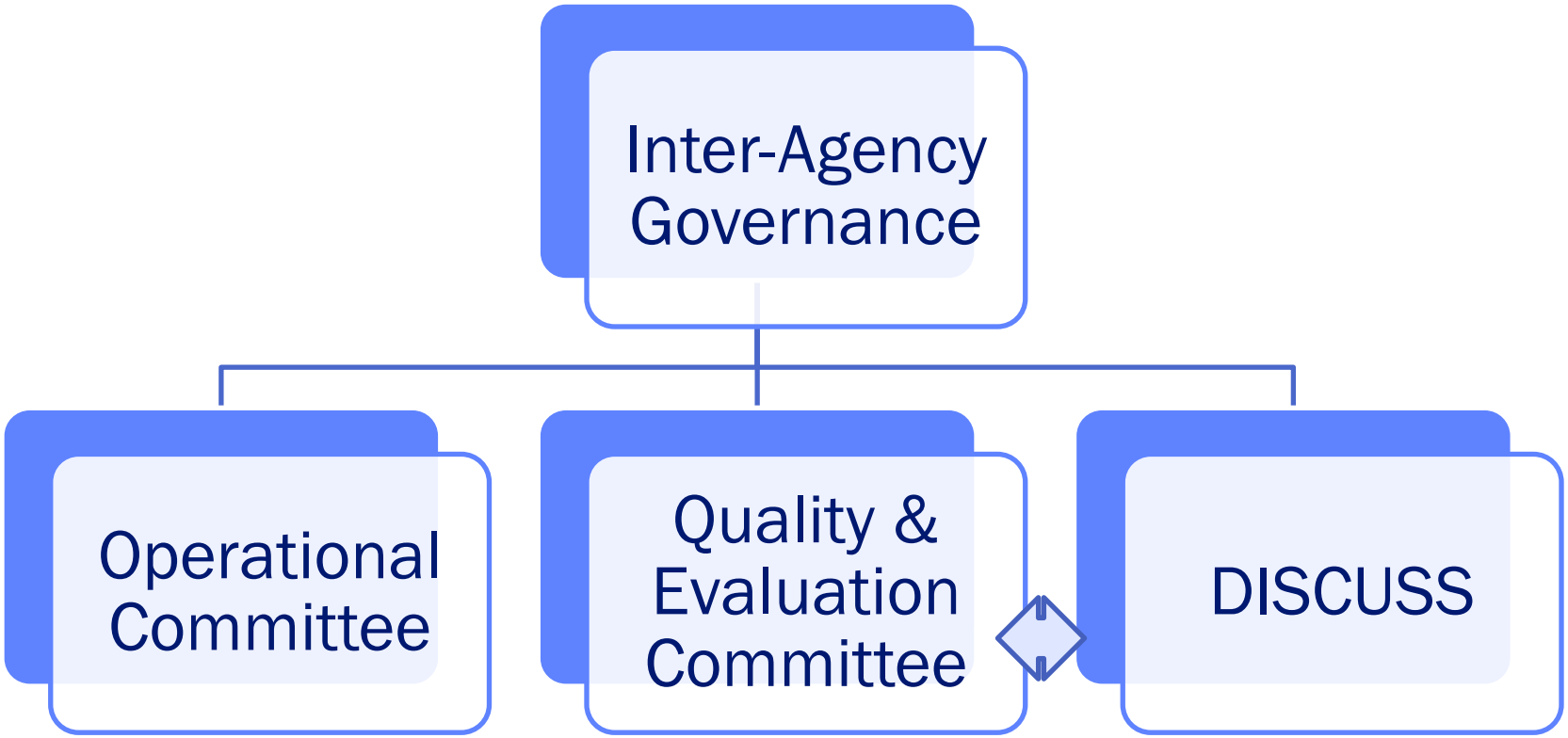
Cost:

Limit annual state-purchased healthcare cost growth, through both Medicaid and EGID, to 2% less than the projected national health expenditures average.

Overall Objective 1: Improve Commonwealth Fund Ranking
Strategy 1 – Promoting and pursuing value-based health models across systems …
Strategy 2 – The State of Oklahoma should lead the health system transformation by evolving existing investments in health to value based models…

Health Finance Objective 2: Limit healthcare cost growth
Strategy 1 – Increase the percentage of healthcare spending in the state that is contracted under value-based payment models that reward providers for quality of care
Strategy 2 - Use payment models that adequately incentivize and support high-quality, team-based care focused on the needs and goals of patients and families
Strategy 3 – Align health system incentives, including payer and provider incentives, to better coordinate care, promote health outcomes and ensure quality measures are achieved which limit health expenditure growth.

State Innovation Waiver
Inter-Agency Governance Structure



Quality & Evaluation Committee Goals

- Identify and recommend common set of outcome measures
  - Agree upon a state quality measure core set
    - Core set applicable to all people
    - Existing agency measures and SIM work provides starting point
    - Potential for add-on measures for certain populations (e.g. children, elderly, disabled, etc)
    - Completed May 2017
- Identify and assess existing quality measures across programs and agencies
- Committee provides existing sources of quality measures, such as:
  - OSDH – SIM, FQHC
  - OHCA – PCMH, HAN, CPC+, HEDIS, CAHPS, ABD
  - ODMHSAS – HH
  - OKDHS – waiver or state-prescribed measures (Advantage, DD)
  - OID – state regulations for private plans

Quality & Evaluation Committee Goals

- Identify and recommend evidence based policy, practices and measures
    - What type of measure is it? Process or Outcome?
    - Who provides the measures? Agency? Payer? Provider?
    - What measures are the same across different sources?
    - What measures/areas of measurement are missing?
    - How often are the measures reported?
    - How are they evidence-based? Tied to OHIP? NQF?
    - Completed June 2017
- Review waivers, RFPs, contracts, etc. for inclusion of meaningful benchmarks for improvement

Quality & Evaluation Committee Goals

- Make recommendations for established programs to include aligned/common outcomes and policy
  - Pursue policy to incorporate the core set of quality measures into programs, contracts, agreements, etc.
    - Identify existing programs, contracts, agreements, etc. and the dates at which they can be modified
    - Completed June 2017
- Identify mechanisms to track performance such as data sets, data collection systems, analytics, dashboards, etc.
  - Agree to adopt and utilize a single state system to report quality measures
    - Tied directly to DISCUSS efforts, development of CDR and dashboards
    - Targeted completion November 2017 for operational system

Statewide Measures – Initial List

- Recommended by the Q&E and Inter-Agency Committees as of May 2017
  - Seeking input and feedback on recommended measures and existing or new systems to capture these data

NQF 24

- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)**
- Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year:
  - Body mass index (BMI) percentile documentation*
  - Education & counseling for nutrition
  - Education & counseling for physical activity

  *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Statewide Measures – Initial List

NQF 28

- **Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention**
- Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation education and counseling intervention if identified as a tobacco user.

NQF 32

- **Cervical Cancer Screening (CCS)**
- Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:
- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Statewide Measures – Initial List

NQF 34

- **Colorectal Cancer Screening (COL)**
- The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer. Appropriate screening includes (per NQF):
- Fecal occult blood test during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

NQF 41

- **Influenza Immunization**
- Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

Statewide Measures – Initial List

NQF 59

- **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)**
- The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.

NQF 418

- **Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan**
- Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

Statewide Measures – Initial List

SBIRT

- **SBIRT Measures (per DMH recommendation)**
- Percent of patients who scored positive on FULL-US-AUDIT/FULL-PHQ9/DAST and received Brief Intervention (BI). Normal Parameters for positive screen: 5 or above on PHQ-9, 8 or above on AUDIT, 1 or above on DAST.

NQF 421

- **Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**
- Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.
- Normal Parameters: Age 65 years and older BMI > or = 23 and < 30
- Age 18 – 64 years BMI > or = 18.5 and < 25

Statewide Measures – Initial List

NQF 59

- **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing**
- The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.

NQF 2372

- **Breast Cancer Screening**
- The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

Statewide Measures – Initial List

NQF 1959

- **HPV for Adolescents**
- Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

NQF 18

- **Controlling High Blood Pressure (CBP)**
- The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Please share your ideas…

- Are these data available, if so how do you collect these data?

- How would you like to use and see the data results?
  - Individually by practice/provider?
  - Aggregated by provider type?
  - By geographic area? County? City/town?

- Some measures are slightly different than the NQF description – what challenge does this pose?
  - NQF28 is >18yrs; proposed is >13 yrs (Tobacco use screening)
  - NQF421 is >18yrs; proposed is >2yrs (BMI screening)
  - NQF2372 is bi-annual screening; proposed is annual screening (Mammogram)
  - NQF1959 is for females only; proposed is for male and females (HPV for adolescents)

Oklahoma 1332 Waiver Update

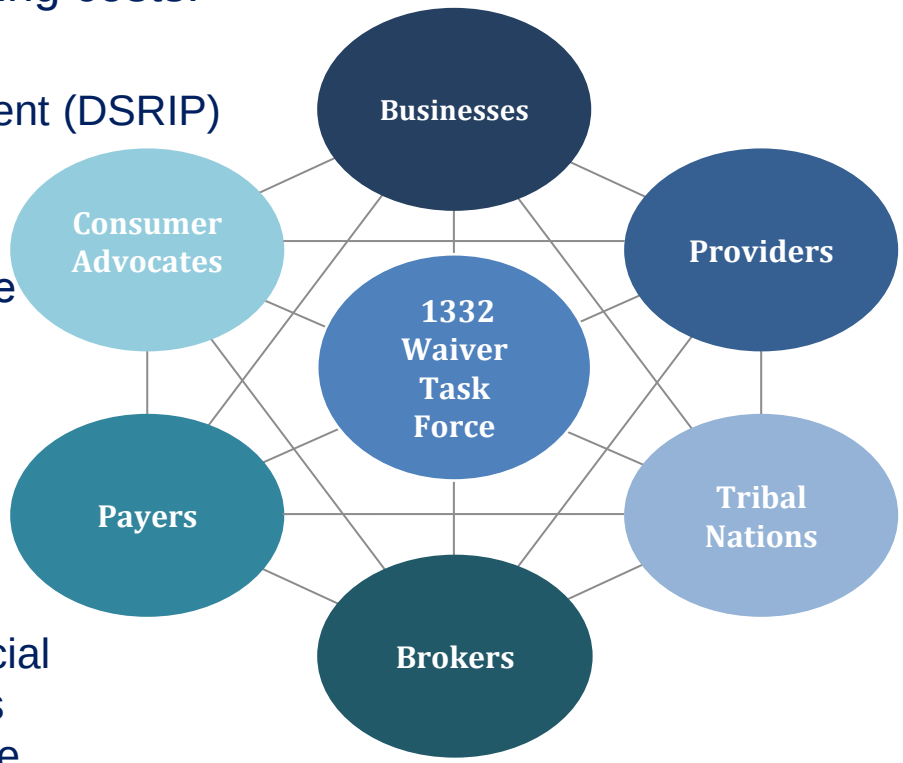
Oklahoma State Department of Health

June 22, 2017

Oklahoma State Department of Health

1332 Waiver Task Force

- **SB1386:** Explore the potential development of new Innovation Waivers for the purpose of creating Oklahoma health insurance products that improve health and healthcare quality while controlling costs:
  - 1332 State Innovation Waiver
  - 1115 Delivery System Reform Incentive Payment (DSRIP)
- **Stakeholder Input:**
  - Advisory Task Force to assist in investigating / analyzing options for an Oklahoma 1332 "State Innovation" Waiver
  - Individual and group meetings
  - Public comment period
  - Transparency requirements
- **Task Force Goals:**
  - Explore potential methods to reduce the financial burden for Oklahoma residents and employers seeking affordable, quality healthcare coverage.
  - Develop innovative, state-based solutions to address its healthcare coverage needs.
  - Promote competition and choice.



- **Required Legislative Review**

1332 Waiver Scope

- 1332 waivers allow states to apply for a waiver to pursue innovative strategies for providing state residents access to high quality, affordable health insurance.

- These renewable five-year waivers may propose modifications to certain provisions of the ACA that alter the way healthcare coverage is provided in a state.

- 1332 Waivers can begin on or after January 1, 2017. There is no deadline for waiver applications. States must draft an application and provide opportunities for public review and input prior to submission.

- Medicaid program changes are not included as part of any 1332 waiver changes. Instead, 1332 waivers focus on the state's commercial health insurance market, allowing some modifications to the insurance regulations imposed by the ACA rather than Medicaid reform.

1332 Waivers: Four Areas of Innovation

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

1 ***Individual Mandate***

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

2 ***Employer Mandate***

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

3 ***Benefits and Subsidies***

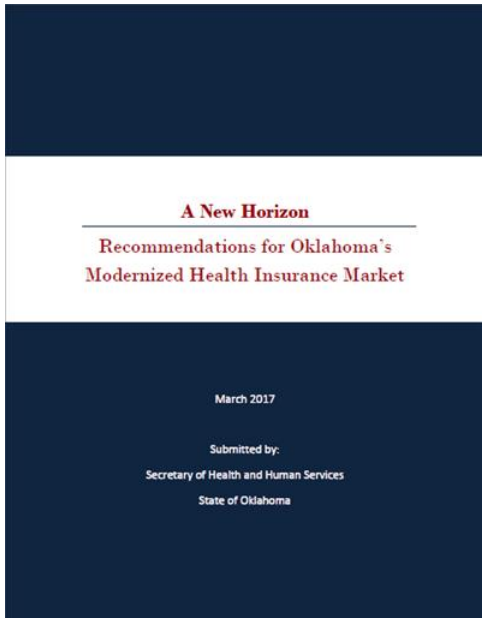
States can modify the rules governing what benefits and subsidies must be provided within the constraints of section 1332's coverage requirements.

4 ***Exchanges and QHPs***

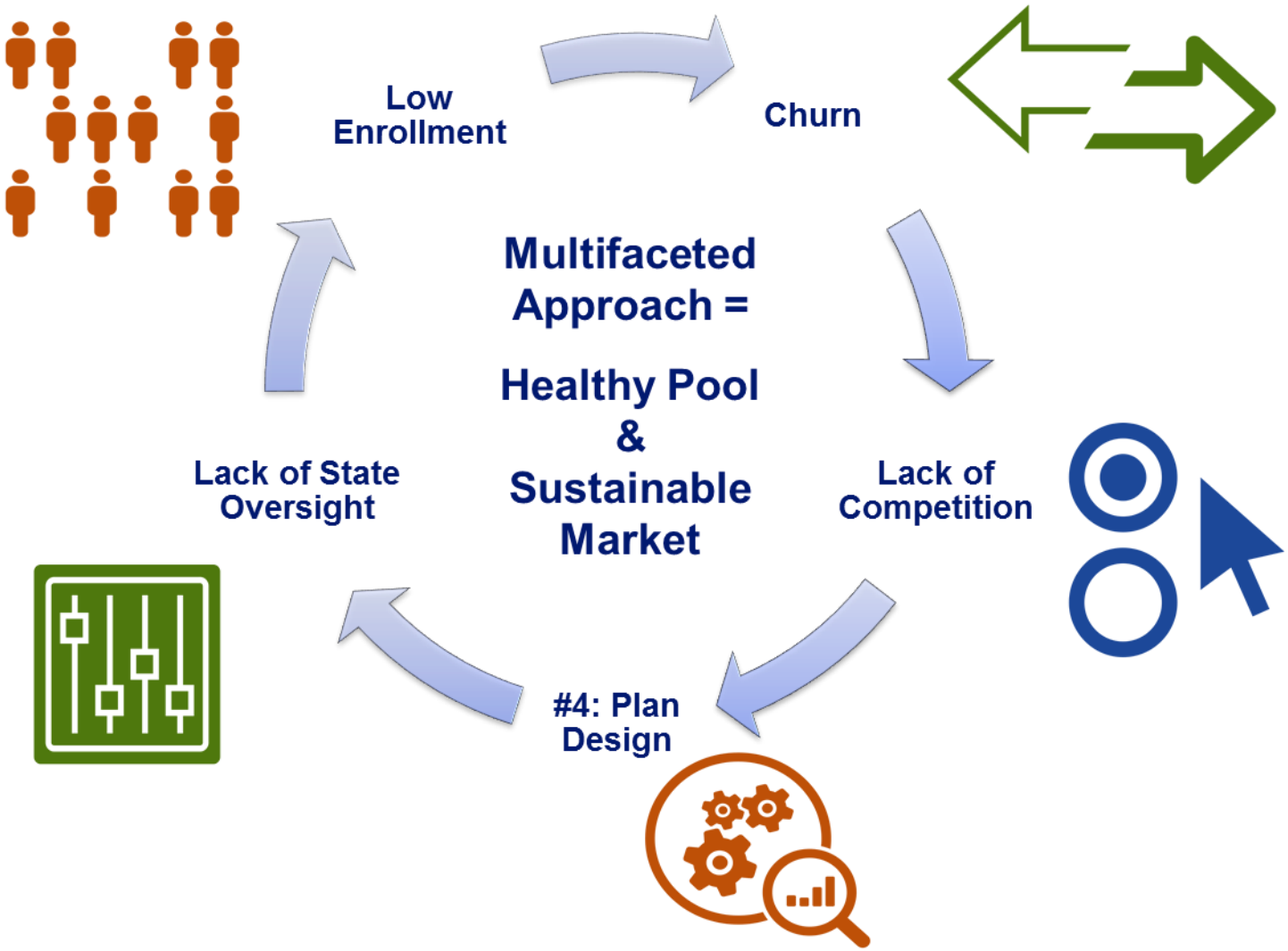
States can modify or eliminate QHP certification and the Exchanges as the vehicle for determining eligibility for subsidies and enrolling consumers in coverage.

Concept Paper Development

- A State Innovation Waiver Task Force has met monthly since August 2016
- The 17 member Task Force has representatives from health plans, business, health providers, tribes, brokers and consumers.
- Workgroups with broader membership convened to provide data and information
- The Task Force reviewed data and identified five major pain points for Oklahoma's individual market
- 62 potential solutions related to the pain points were compiled and ranked by survey
- The majority of the identified solutions in the concept paper are those with the highest rankings from the Task Force/workgroups
- Additional solutions from other state/national plans were included, as well as those that will complement solutions identified by the Task Force/workgroups
- A draft concept paper was released on December 29, 2016 followed by a 30 day public comment period
- The final concept paper was released on March 1, 2017 after incorporating public comments received earlier this year



Market Pain Points



Oklahoma Marketplace Data

- Enrollment in the FFM is Low and Relatively Unhealthy
  - In 2016, only 31% of Oklahoma's eligible population was enrolled in the Federally Facilitated Marketplace (FFM)
- Competition and Consumer Choices are Shrinking
  - The FFM has gone from 5 insurance companies offering plans in Oklahoma in 2014 to 1 in 2017
  - There has been a 67% reduction in plan options (consumer choices) between 2015 – 2017
- Premiums are Increasing, as are subsidies
  - As the FFM dropped to one insurer in 2017, premium rate increases of 75% were requested and granted by HHS
  - Between 2015 and 2017, premiums for all ages, individuals and families have roughly doubled in price
  -

Covered Individuals	2015 Monthly Premium Rate	2017 Monthly Premium Rate
Individual Aged 27	$ 227	$ 454
Individual Aged 50	$ 387	$ 775
Family (Aged 30) with 2 kids (Aged 10)	$ 766	$ 1,535

  - Premiums due (after subsidy) from Oklahoman's has increased by 7% between 2014 and 2016
  - Approx. 87% of the 130,000 enrolled receive tax credits and 62% receive cost sharing reductions
- Deductibles are High
  - Average deductibles for an individual ranges from $1,125 to $19,200
  - Average deductibles for a family ranges from $3,375 to $41,357
- Some individuals are not remaining insured throughout the course of the year
  - In 2016, 15,000 Oklahomans (10% of enrollees) selected a plan but did not pay their premiums
- Of the uninsured, 39% have incomes below 100% of FPL and are ineligible for FFM subsidies

Sequential Approach to Recommendations

2017: Planning and Authorization

- ✓ Engage federal partners
- ✓ Secure actuarial expertise
- ✓ Submit initial 1332 Waiver
- ✓ OID operational planning

2018: State Regulation and Federal Flexibility

- ✓ Market Stabilization via Reinsurance
- ✓ State Regulatory Control
- ✓ Health Outcomes Focus
- ✓ Broaden Age Ratios

2019+: Oklahoma's Modernized Marketplace

- ✓ Change Subsidy Eligibility & Calculation
- ✓ Simplify Plans
- ✓ Create Consumer Health Accounts
- ✓ Leverage Insure Oklahoma

State-based reinsurance and risk pooling programs can improve insurance affordability.

- In reinsurance programs, insurance carriers are paid part of a high-cost and/or high-need individual's claims over a specified amount. The individuals remain in the total pool.
- A high-risk pool offers high-cost individuals coverage in a separate pool. Taking high-risk people out of the conventional market can help keep premiums lower for those remaining in the market.
- A hybrid approach combines features of both reinsurance and high-risk pool programs, identifying high cost and high-needs individuals remaining in a single pool.

State-based reinsurance or risk pooling programs could help to stabilize the Oklahoma insurance market.

- Leavitt Partners modeled the potential influence of such a reinsurance program with annual budget amounts between $50 million and $200 million. At these varied amounts of program funding, it is believed that Oklahoma's state-wide insurance premiums could be reduced by 5% and 22%, respectively.
- Such a reduction in premiums would also support enrollment gains in the range of 3% to 11%.
- **HB 2406** Creates the Oklahoma Individual Health Insurance Market Stabilization Act, establishes the authority for a reinsurance program as early as 2018

Health Workforce Subcommittee

Governor's Council on Workforce and Economic Development

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