Feedback from VBA/Care Model Stakeholder Meetings
September 9 and 11

VBA Discussion

Feedback related to the VBA was primarily focused on three issues: 1) data privacy and trust, 2) data inputs, and 3) infrastructure and governance.

Data Privacy and Trust

- Quality data and transparent governance are essential to building trust
- Is all of the data, claims, and clinical, stored in the Health Information Network (HIN)?
    - No, clinical data is stored in the HIN but not claims information. The storing of clinical information enables the most complete clinical view of the patient for the provider which is essential for clinical decision support, quality, and cost reductions. Claims information is paired with clinical in the MPI and then scrubbed of patient identifiers as it goes to the VBA for analysis.
- When is data de-identified?
    - Before it is taken in to the VBA Tool for analysis

Data Inputs

- Not all data sources have been identified within the conceptual framework

Missing Inputs Identified by Stakeholders:

- Tribal Data
- Sensitive data (i.e. behavioral health)
- Nonprofit providers
- Public health
- Might need to include "one – offs" from EHR systems not connected to HIE

Infrastructure and Governance

- MPI – there needs to be a master patient index and master provider index

    - Is now indicated on the conceptual model
  - Need to move HIEs to the center and remove HIN
    - This would not allow for interoperability with the multiple HIEs now available
- Model has similar vision and mission of an existing HIE
    - VBA anticipates more complete but de-identified data
    - VBA allows for all operable HIEs and providers to participate
    - The VBA has different end uses than current HIE functions in the state

Accountable Care Organizations Model Discussion

General Feedback

Appeal/Strengths of the Model

- Comprehensive, includes aspects of the other models (CCO and PCMH)
- Payment alignment promotes opt-in
- This model works well where networks are already defined
- Model will be more successful/appealing in urban areas
- There is the potential for meaningful savings for high utilizers
- This model can improve care coordination and promote preventive care
- Comprehensive with long-term potential to address population health
- Potential for payment negotiations among providers
- Potential for use of telemedicine (rural areas especially)
- Currently, St. John is assisting with paying for EHR/HIE waivers under the ACO. Other models may be able to do the same
- Patient experience will likely see improvement
- Improve/decrease wait times for specialist visits
- May be too large of a model to be realizable in Oklahoma
- Seen as limiting patient choice

Challenges of Model

- May be too large of a model to be realizable in Oklahoma on a statewide basis
- May be perceived as limiting patient choice; patients will push back if access to providers is limited
- Easier to implement in private insurance, may be more difficult for public
- May be geographically limited - not as feasible in rural settings where attaining volume needed (5,000) may be a big challenge
- Comprehensiveness of the network will be a challenge, especially in rural areas

- Success of this model working beyond urban areas is limited
- It may be difficult to risk stratify patients to avoid providers "cherry picking"
- May be difficult to link county health departments, mental health, and DHS
- Who decides governance?
- HIE infrastructure needs will be a challenge for this model to work in an ideal fashion; needs robust HIE
- Provider independence, especially older or rural providers who do not want to be incorporated into a model/system
- Providers using different EHRs within the system will make this model difficult to succeed
- Technology infrastructure, especially in rural areas
- May be challenging to address social determinants with this model

Feedback Related to Specific Aspects

Patient Experience

- Will face short-term struggles as patients may lose choice of provider (or want to opt-out if they feel they are losing choice)
- Long-term experience should improve
- Can improve patient experience to the extent that it can be fully implemented and helps patients move through the system faster – especially when getting referrals and visits scheduled with specialists

Population Health

- ACO can improve population health in the long-term, but it may be a challenge to determine how to incorporate social determinants and effectively measure outcomes to incentivize providers in the shorter term
- St. John has seen this model incentivize providers to make sure that more members attend wellness visits – this not only helps their health, but also keeps them attributed to the system

Per Capita Cost Reduction

- This model is designed for savings, but data needs to be shareable in order to see the most savings through care coordination
- Will have a positive impact if implemented effectively

Social Determinants

- ACO has limited impact on social determinants; there is a need for care coordination and health integration to accurately address social determinants
- Will have a positive impact if implemented effectively

Workforce

- Current workforce does not exist to implement this model, but people are available to be trained to participate (especially community health workers); urban workforce resources will be more readily available than in rural areas
- Some participants disagreed that this model will have the resources necessary, especially with primary care providers and behavioral health provider shortages in the state

Health IT

- Urban areas will have a much easier time implementing this model due to technology infrastructure already being in place
- Serious short comings in rural areas related to the technology needed to fully implement this model – especially if using telemedicine

Political Will

- May be difficult to receive support for this model, many may see it as managed care or as taking away patient choice
- Slightly disagree that political support for this model exists, especially with the current legislature's concerns about "reform"

Sustainability

- Definitely in Medicare; Medicaid and private insurance have higher population turn over and are looking for quicker savings
- Overall funding will be the biggest barrier to sustaining this model

Care Coordination Organization Model Discussion

General Feedback

- Similar to the Health Access Network and Community Health Improvement Organizations
- Addresses the social determinants of health most directly, which was seen to improve health

- Must have a consistent training standard for workforce within CCO
- Need direct patient access to a repository of information on community resources
- Can one CCO service one set of people or type of patient? Should we align patients to certain CCOs based on their health status?
- Reimbursement? What is appropriate?
- Having all payers involved is important
- Where do non-profits fit in? Non-profits could see a boom in patients seeking services, supports for this will be needed
- Without all payers, can it work?
- How do we envision multi-payer buy-in and involvement?
- CCOs have the most potential to address social determinants of health
- Has some strong levers to implement already: County Health Departments, Health Access Networks, community health and social services, community health coalitions

Challenges

- Need closer relationship with primary care physicians than this model is showing to really impact social determinants
- Concern about more governance in the model
- Do not want to have a government entity for the governance structure but rather, prefer a public-private partnership; remove the word "state" in "State Executive Board"

Feedback Related to Specific Aspects

Patient Experience

- Yes, the CCO should improve the patient experience of care but it is compared to what we are doing now, so the improvement will be seen over time and not necessarily immediately
- It is also important to remember the patient directs their own care

Population Health

- Yes, the model will improve population health; however, it will take time and not happen immediately
- The model provides for more people who can work towards improving the patient's health outside of the doctor's office which will eventually lead to improved population health and reduced costs

Per Capita Cost Reduction

- The group was unsure on whether the model would reduce cost per capita in health care
- The model will reduce out of pocket expenses for consumers initially – but some entity may have to make up for these patient savings
- It is hard to measure because of trends and it will take time to see the change in those trends

Social Determinants

- Yes, the model does seem to address the social determinants of health better than the others described by integrating community resources and other patient supports
- Oklahoma already has communities that address social determinants of health so can leverage these preexisting initiatives

Workforce

- Workforce would need consistent training and standards that are not currently in place
- The resources will have to change, will have to look at whom to include for filling in gaps for providers and how to integrate nontraditional healthcare workers

Health IT

- No, the model will not have the technological infrastructure needed for implementation
- We can get most of the data but feeding it back to an HIE is still a problem
- We will need more analytics and communication between the community resource entities
- Rural areas have an environment that is less suitable for HIT; some rural areas do have broadband access, though not very high quality, and other areas have none at all

Political Will

- There was a difference between the Oklahoma City and Tulsa groups. The Oklahoma City group was unsure if the model has the political will to be implemented due to budget shortfalls and constraints. The Tulsa group believed that the political will for population health improvement already exists in the state and it will just be a matter of whether the model has funding and is financially sustainable.
- While reducing health care expenditures is important, it may be difficult to get people on board because saving and health improvements are a long term commitment with implementation costs upfront

Sustainability

- Community involvement is integral for this to be sustainable

- Does seem to be scalable to rural and urban environments
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Patient Centered Medical Home Model Discussion

General Feedback

- Need care coordinators based on the needs of the populations
- Practice Management - managing the various issues can be difficult, several unknowns at once
- Practice Transformation / Facilitation - practices need help to transform and get ready to meet the standards
- Practical because this is already in place in Oklahoma
- Behavioral health integration is key to success
- Would like to see different staff associated to address social determinants of health

Feedback Related to Specific Aspects

Patient Experience

- PCMHs help in that the patient has a consistent relationship with one provider
- Makes providers aware that patient experience affects health outcomes and provides a framework for improving patient experience
- Gives patients a sense of belonging, which can improve patient experience and health outcomes by enhancing patient engagement

Population Health

- Need to effectively use registries
- Needs to be an explicit part of the model
- PCMHs makes PCPs responsible for all patients on their panel, which contributes to population health

Per Capita Cost Reduction

- PCMHs can reduce hospital readmissions and ER use if it's done well
- Hasn't reduced costs in all markets, but there are many iterations of PCMHs
- Definitely reduces the number of people who use ER for primary care
- 24/7 access reduces ER use
- While there are additional costs associated, they could be offset by some of the savings: one hospital admission in a month = one RN's salary within a practice

Social Determinants

- Can increase community resource referrals, which can improve health outcomes
- Non-compliance is often due to a lack of resources
- Behavioral health integration is essential, including early detection and screening
- Model could include behavioral health specialists
- Depression has been shown to increase chronic disease costs significantly
- Need to create framework/protocol for primary care providers on related to how to effectively refer people with behavioral health conditions
- Need to include substance abuse services
- Behavioral health integration – difficult to successfully pull off, uncertainty on what exactly it looks like
- What would be considered the "population" – is it the community (maybe at zip code level) or just the individual PCPs panel?
- The broader team could better address the population health and social determinants of health aspects

<u>Limitations of PCMH + Behavioral Health Integration:</u>

- Severe Mental Illness (SMI) have unique needs that are hard to meet in the "regular" primary care settings
- Behavioral health providers are not traditionally "trained" to integrate; neither are PCPs
- Information sharing is difficult; some confusion about what is allowable related to behavioral health
- Mental health, to some extent, can be less "medically focused" – treatment may involve housing, social services, family caregivers, etc.

Workforce

- Does it translate to rural Oklahoma?
    - The concept does, but there is not enough workforce in rural Oklahoma; it is hard to keep PCPs
    - However, it could translate into more efficient use of providers (such as reducing no-shows)
    - There may be some areas with more specialists than PCPs
    - The available workforce in rural Oklahoma doesn't necessarily have the training to implement certain PCMH aspects
- Telehealth is critical, including behavioral health; however, there are training barriers as well as HIT barriers (see below)
- Need the right training for the workforce
- Ideally the group wanted to consider adding in a workforce that could address the social determinants (community health workers, social workers, etc.)

- Workforce also is a big issue in smaller practices – it's difficult to implement PCMH without a variety of team members
- Many nurses are trained with a focus on hospital care – this model is a bit different than what their training prepares them for
- Significant discussion about the scope – who actually would be allowed to be considered as the PCMH workforce
- Care Coordination in PCMH has to be flexible and account for different types of care. Can all the providers understand one another / work together?

Health IT

- Is adequate in certain parts of the state
- What we need versus what we want – may depend on area (very rural areas may need less)
- Important to include health IT in workforce training
- HIE support and interoperability are major issues
- Telehealth could play an important component (e.g., addressing workforce in rural areas), but there are foundational infrastructure challenges in certain communities (i.e., insufficient internet connectivity to support telehealth)

Political Will

- PCMHs have been around for a long time, but results are mixed
- Requires investment now for savings later
- Is largely politically neutral among non-health care stakeholders (e.g., patients, employers, etc.)—no strong demand or resistance currently

Sustainability

- The model is sustainable in the short-term; long-term is less secure
- Up front, PCMHs can require significant investment and needs funds over the long-term for sustainability; certain practices may need initial kick-starting investments by payers to make PCMH implementation possible
- Currently, the model is used on a large scale by a public payer (Medicaid) – it may need to be adapted/improved for private payers