

MASTER PLAN

FOR

OKLAHOMA COUNTY COMMUNITY HEALTH NETWORK

A TRANSFORMATIONAL SYSTEM OF CARE
FOR THE LOW-INCOME, UNINSURED

JULY 2012

PRODUCED BY

COMMISSION TO TRANSFORM THE HEALTH CARE SAFETY NET IN OKLAHOMA COUNTY
CO-CHAIRS: STANLEY F. HUPFELD, FACHE, AND D. ROBERT McCAFFREE, MD

TECHNICAL ASSISTANCE PROVIDED BY

MARK R. CRUISE, PRINCIPAL
FREE CLINIC SOLUTIONS

INTRODUCTION

Oklahoma County is believed to have more community-based and faith-based health care safety net providers per square mile than any other major metropolitan county or region in the U.S. Oklahomans care about their neighbors in need, particularly when health care is involved. Over the past decade hospitals, doctors, and nurses, as well as public agencies, churches, private funders, and community-minded leaders in Oklahoma County have rallied to make health care more accessible to vulnerable populations. Numerous clinics and health centers have been established. Health professionals have volunteered their time and talents. Hospitals have generously provided in-kind services. Foundations have awarded millions of dollars of grants. Churches have rediscovered their spiritual roots in healing the sick. As a result of all of this, hundreds of lives have undoubtedly been saved and thousands more have been improved. Much good has been done, and there are many hopeful signs.

However, despite all the progress and accomplishments, the health care safety net in Oklahoma County remains largely fragmented, disorganized, and ill-equipped to address systemic issues or deliver meaningful improvements in population health. Serious problems and deficiencies, if left unaddressed, will continue to threaten the viability and effectiveness of this important community resource. This Master Plan, the result of months of work by the Commission to Transform the Health Care Safety Net in Oklahoma County (hereinafter referred to as “Commission”), is a blueprint for revamping and organizing the health care safety net into a coherent, rational system that delivers real results and value to patients, providers, funders, and the community at large.

ABOUT THE COMMISSION

The idea of forming a Commission, composed of a group of community leaders from in and around the health care safety net in Oklahoma County, was the brainchild of a few individuals who recognized significant deficits in the safety net – the insufficiency of specialty care services being the most prominent - and wanted to fix them. Stanley Hupfeld, FACHE, retired CEO of INTEGRIS Health, took the lead in marshaling community resources and leadership to launch the Commission. He recruited D. Robert McCaffree, MD,

from the OU Health Sciences Center to Co-Chair the Commission with him. A \$50,000 grant was awarded by the Oklahoma City Community Foundation to cover the Commission's expenses. The Health Alliance for the Uninsured is serving as fiscal agent for this grant. Mark Cruise, Principal of Free Clinic Solutions, a national consulting firm that had just completed a strategic planning project for Butterfield Memorial Foundation, was engaged to serve as consultant to the Commission. Pam Cross, Executive Director of the Health Alliance for the Uninsured, was recruited to serve as staff to the Commission.

COMMISSION TO TRANSFORM THE HEALTH CARE SAFETY NET IN OKLAHOMA COUNTY

Co-Chairs: Stanley F. Hupfeld, FACHE, President, INTEGRIS Family of Foundations
D. Robert McCaffree, MD, Faculty, OU Health Sciences Center

Nancy Anthony, Executive Director, Oklahoma City Community Foundation
Beverly Binkowski, Director, Public Affairs, Blue Cross Blue Shield of Oklahoma
Lou Carmichael, CEO, Variety Care
Terry Cline, PhD, Oklahoma Secretary of Health, Commissioner, Oklahoma State Department of Health
Evan Collins, President, Butterfield Memorial Foundation
Robert Cooke, MD, General Surgeon, President, Oklahoma County Medical Society
Gary Cox, Director, Oklahoma City-County Health Department
Patricia Fennell, CEO, Latino Community Development Agency
Mike Fogarty, CEO, Oklahoma Health Care Authority
Anita Fream, CEO, Planned Parenthood, Board President, Central Oklahoma CareLink (formerly COINS)
Cathryn Hibbs, CEO, Deaconess Hospital
Christi Jernigan, Director, Oklahoma County Social Services
Rosalyn Johnson, CEO, Community Health Centers, Inc.
Craig Jones, President, Oklahoma Hospital Association
Daniel McNeill, PhD, PA-C, Professor & Director, OU Physician Associate Program, Medical Director, Good Shepherd
Terrisa Singleton, Foundation Manager, Delta Dental Oral Health Foundation of Oklahoma
Rhonda Sparks, MD, OU College of Medicine, Faculty, Director of Clinical Skills Education and Training Center
Steve Turner, Executive Director, Crossings Community Center
Terri White, Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services

The charge the Commission gave itself was to assess the current scope and operation of the health care safety net in Oklahoma County, identify areas of challenge and need for all involved, learn about the best practices of other safety net collaboratives around the country, create a master plan for a transformational system of care vetted with key stakeholders, and negotiate the agreements and arrangements necessary to implement the plan. During its kickoff meeting in September 2011, the Commission members were

introduced to each other, a team charter was developed, and an initial work plan was established. Since then the Commission has met six hours each month, with individual and group homework assignments between meetings, and has progressed through a lengthy series of presentations from Commission members, stakeholder representatives, and leaders of successful collaboratives elsewhere. The latter included Project Access Northwest in Washington state, Primary Care Access Network of Orange County (Orlando, FL), Hamilton County Project Access (Chattanooga, TN), and Primary Care Coalition of Montgomery County, MD. Each presentation was followed by Commission discussion and synthesis of ideas, which led to the development of guiding principles and an emerging consensus on a transformational health care “Network” for vulnerable populations in Oklahoma County.

COMMISSION’S GUIDING PRINCIPLES

- ✓ Organize the safety net in Oklahoma County into a rational, coherent system
- ✓ Enhance capacity and quality of care among safety net medical providers
- ✓ Provide value to those that support the Network: hospitals, physicians, and funders
- ✓ Improve the health of vulnerable Oklahoma County residents
- ✓ Make better use of the community’s health care dollars

Small group planning teams were formed to flesh out the details of the various components of the “Network.” These are presented with fuller explanation in later sections. Through it all, the Commission has worked hard, has dealt with a dizzying array of topics and issues, and has maintained a laser focus on addressing the areas of most critical need. There is a significant feeling among the group that it is on the verge of a seismic shift in the health care safety net for Oklahoma County – not just the production of a great plan for major systems change, but the collective community will to act on it.

CURRENT DEMAND AND SAFETY NET CAPACITY

90,469 Oklahoma County residents (12.7%) are uninsured and have household incomes at or below 200% of the federal poverty level. These are the people for whom the safety net exists in large part.

**Oklahoma County
Data on Uninsured (2010)**

County Population – 711,319
 # Uninsured – 138,969
 # Uninsured ≤ 200% Poverty – 90,469

Source: U.S. Census Bureau, 2010 American Community Survey

While not all of these individuals are sick and/or in need of health care, they are a population at risk. A wealth of research indicates that the uninsured are less healthy, suffer higher rates of chronic disease, die younger, and have less access to routine medical care than those who are insured. For low-income, uninsured residents of Oklahoma County, it is no different. The poor health of Oklahomans in general has been well documented, requiring no additional mention here except to emphasize that the health care safety net in our community, as well as in other communities across our state, has a supremely difficult challenge on its hands.

The problem here is not lack of good intentions. Oklahoma County is unique in terms of the sheer number of safety net “access points.” There are presently 19 independent, community-supported, volunteer-driven charitable clinics operating in Oklahoma County. Most of these clinics have opened in the past decade. Many have been started by well-meaning churches, but operate only a few

Oklahoma County Safety Net <u>Medical</u> Provider Data (2010)	
# of Federally Qualified Health Center Sites:	12
2010 Uninsured Patients Served:	21,307
Average of	1,775 patients per site
# of Charitable Clinics:	19
2010 Uninsured Patients Served:	8,788
Average of	462 patients per clinic
<small>Sources: VarietyCare, Inc.; Community Health Centers, Inc.; Health Alliance for the Uninsured</small>	

hours per week and with limited provider capacity. However, several of these clinics have grown into larger operations with significant resources and capacity. In addition to the charitable clinics, there are 12 community health center sites operated by the two large federally qualified health center (FQHC) organizations: Variety Care, Inc. and Community Health Centers, Inc. These federally qualified health centers exist to provide primary and preventive care to all, regardless of insurance status. While these centers serve those who have Medicaid, Medicare, and private insurance, they also play a pivotal role in serving the county’s uninsured.

Together, the health centers and the charitable clinics served more than 30,000 uninsured Oklahoma County residents in 2010. Yet a number of questions remain: How many of those 30,000 saw improvements in their health status, particularly those with one or more chronic illnesses? How much money did it take to serve them, and did the results justify the costs? What impact was made by the safety net in reducing hospitalizations for preventable conditions by the uninsured, and thus lowering

uncompensated care costs? Was care delivery for the uninsured, particularly the chronically ill, organized to serve them in the most appropriate primary care setting and to move them efficiently in and out of specialty care when necessary, so that outcomes can be optimized? On the latter question, the Commission discovered the answer was a resounding “No!” The health safety net in Oklahoma County today does not function as a rational, coherent system of care.

SYSTEMIC ISSUES

The most glaring deficiency in the Oklahoma County safety net is the inability of health centers and charitable clinics to access a broad range of specialty care services for the uninsured in a timely and efficient manner. Specialty care services include not only consults with sub-specialist physicians, but also labs and other diagnostic tests (e.g. x-ray), as well as inpatient and outpatient procedures (e.g. surgery). As much as 25-30% of uninsured patients served by the health centers and clinics require specialty care. Two programs currently exist to try and meet these needs, but the data indicates that health centers and clinics are largely depending on their own efforts to secure specialty care services. The “brother-in-law” system, in which a safety net primary care medical provider is forced to call on his/her relatives, friends or colleagues for a specialty consult or procedure, is common. With so many health centers and clinics in Oklahoma County looking for donated specialty care services, sub-specialist physicians are overwhelmed with requests. Some, thankfully, are doing more than their fair share. Others do what they can. Many do not participate at all. Multiple reasons have been cited for this. Chief among them is the lack of an institutionalized central coordinating structure that effectively brokers hospital and physician participation, assures seamless and clinician-friendly care transitions, and equitably distributes the “burden” of donated care.

MAJOR AREAS OF CONCERN

- ◆ **Lack of robust system to coordinate and manage specialty care services**
- ◆ **No designation of primary care medical homes to treat chronically ill**
- ◆ **Absence of coordinated case management system for high-risk patients**

A second major finding of the Commission is the lack of primary care medical homes to treat the chronically ill. Low-income, uninsured patients are disproportionately represented among the chronically ill, but our safety net is not well organized to ensure that these patients are served in the most appropriate setting. Primary care that meets the medical home model is generally better suited to treat chronically ill patients than urgent care delivery systems organized primarily for treatment of acute and episodic illness. Without an appropriate chronic care provider, chronically ill patients are less likely to get the focused treatment and education needed to control their disease states and more likely to require more intensive, higher cost care (e.g. hospitalization). One of the frustrations of sub-specialist physicians taking referrals has been the lack of a primary care medical home to whom to return the patient for ongoing care that will assure good outcomes and not forfeit the value of the specialty care rendered. Presently Variety Care, Inc. and Community Health Centers, Inc. – which together operate 12 federally qualified health center sites in Oklahoma County – are pursuing medical home recognition from separate certifying bodies. Three of the 19 charitable clinics are pursuing major expansions, with the help of grant funding from Butterfield Memorial Foundation, which will enable them among other things to serve as medical homes for chronically ill patients in addition to those with acute, episodic illness. Thus there is positive momentum. What is needed now is a community-wide consensus both on what defines a medical home and a commitment to using those medical homes to serve chronically ill patients.

The third major cause of concern is that high-risk and very sick uninsured patients continue to run up millions of dollars in uncompensated care costs at area hospitals each year while there is no coordinated system of case management to manage their care and address the underlying conditions and causal factors. The story of Dr. Jeffrey Brenner from Camden, New Jersey – highlighted in a January 2011 article in *The New Yorker*, which was a homework assignment for the Commission – exposes the potential power of combining a strong medical home



model with intensive case management to help dramatically reduce avoidable hospital utilization and costs while substantially improving the health of very sick patients. In addition to contributing to the cost burden of hospitals, high-risk patients also consume substantial amounts of time, energy, and resources in the health centers and clinics, and in so doing prevent them from serving more patients. While some of the health centers and clinics attempt to do case management themselves, there is very little coordination of these efforts across the safety net and most of the activity is focused on coordinating clinical care rather than addressing the patient's needs holistically. The Commission recognizes that without effective case management to facilitate care transitions and address the social determinants of health, the benefits of medical homes and specialty care services for high-risk patients will go largely for naught and expensive hospitalizations costing millions of dollars of unreimbursed health care expenditures each year will continue unabated.

While these three areas of concern rose to the top of the Commission's focus, other issues and needs were included in the Commission's agenda and deserve ongoing attention. They include the following:

- The prevalence of mental illness among the population accessing the safety net, and the shortage of mental health providers and programs to care for them
- The lack of a community-wide consensus and strategy to address oral health needs, and the severe shortage of dental safety net providers and programs
- The absence of a system-wide strategy to capture and use data to track patient demographics and utilization, facilitate care transitions, analyze costs and allocation of resources, and document improvements in population health

Many have asked the Commission about the potential impact of health care reform. The Commission's view is that even if the major coverage expansions provided in the Affordable Care Act remain intact, there will still be plenty of uninsured individuals in Oklahoma County who will fall through the cracks and continue to suffer in part due to the lack of a coherent, organized system of care. While there is clearly a need for substantial health policy reforms at the federal level, we do not expect Washington to transform our health safety net. This is a challenge that is ultimately ours to address.

A SYSTEMIC SOLUTION

The Commission overwhelmingly concluded that the health care safety net in Oklahoma County needs to be transformed into an organized, coordinated system that initially focuses on three core services, specialty care being chief among them. The name of this initiative will be **Oklahoma County Community Health Network** (hereinafter referred to simply as the “Network”). Information about the authority means of accountability, and organizational structure for the Network is treated in a later section. The principal byproduct of the Network will be a rational, coherent system of care for low-income, uninsured populations, especially chronically ill and high-risk patients. This will entail not just a few minor tweaks here and there, but substantial revamping and re-allocation of resources. The improvements envisioned by the Commission will generate transformational change in how and where patients are treated, how they are moved through the system, how their care is managed, and what outcomes they realize. Furthermore, the Network will create greater efficiencies for hospitals, physicians, health centers, and clinics, and lead to better utilization of the community’s health care dollars and resources.

OKLAHOMA COUNTY COMMUNITY HEALTH NETWORK

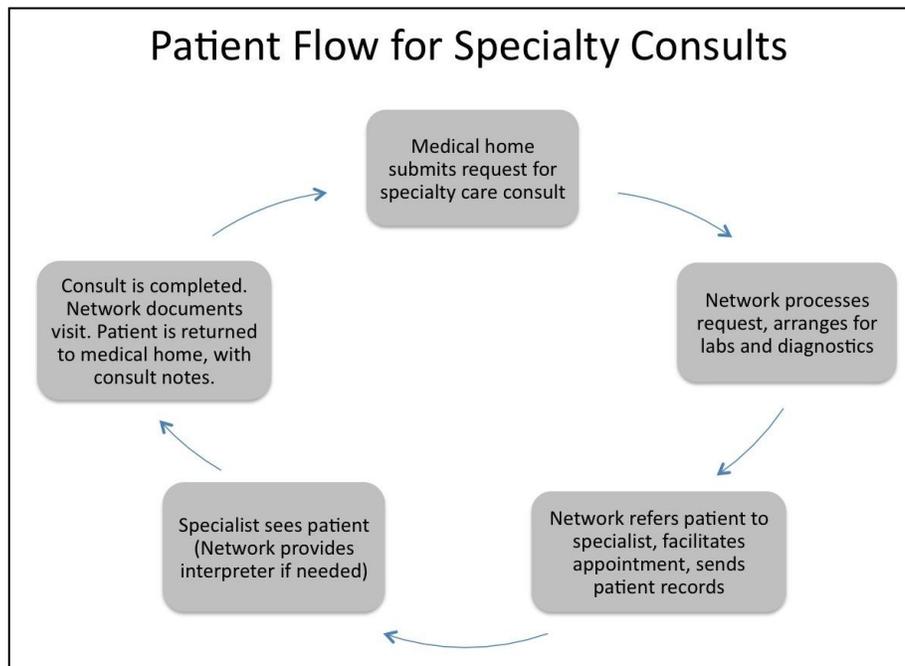
PROGRAM COMPONENTS

A. SPECIALTY CARE

Intent – The purpose of this component is to establish a single robust system for receiving, managing, and distributing requests for donated specialty care. Specialty care services include not only consults with sub-specialist physicians, but also labs and other diagnostic tests (e.g. x-ray), inpatient and outpatient procedures (e.g. surgery), referrals to behavioral health agencies/professionals, and access to certain medically-necessary equipment and supplies (e.g. prosthetics). This will be a program that everyone salutes and that works for all who use it. Getting this component up and running and functioning at a high level is the most important programmatic priority for the Network.

Design Features – Eligibility for Network specialty care services will be uninsured patients who have household incomes at or below 200% of the federal poverty level AND who are patients of Network designated medical homes. Network participating hospitals, physicians and other providers, and community mental health centers may also refer patients for Network specialty care services; in such cases, the Network will first place the patient with a designated medical home to ensure continuity and quality of care. Specialty care services will be provided free of charge. The Network will focus initially on facilitating access to the most commonly requested specialty care services, including lab tests and diagnostics (e.g. X-rays, ultrasounds, CTs, and MRIs). Consults in high demand presently include gastroenterology, general surgery, ophthalmology, orthopedics, gynecology, cardiology, ENT, and urology. The Network will ensure that physicians have all the necessary documentation and lab/diagnostic work completed BEFORE the patient arrives for the exam or procedure. Pre-visit protocols for specific specialty consults will be developed in consultation with relevant physicians (as Project Access Northwest in King County, Washington has done).

The Network will also ensure that patients are returned to their medical home for ongoing care following specialty care services, so that specialists are not expected to take the place of primary care. Network designated medical home providers will be trained in how to make judicious use of specialty care services; use of full scope of primary care will emphasize intent to control and manage the volume of specialty care referrals. The Network will employ staff to receive and manage the requests to completion, keeping wait times as low as possible and ensuring fluid communications with the patient, the medical home, and the specialty care provider(s) at all times. The Network will have strict guidelines for appointment compliance, including restrictions on cancellations and termination in the event of no-shows. The Network will ensure that meaningful recognition and appreciation are accorded to all participating specialty care providers on at least an annual basis.



Hospitals – The Network will seek to work with all full-service hospitals, specialty hospitals, and surgical centers located in Oklahoma County, whether public or private, for-profit or not-for-profit. The Network will discuss and mutually agree upon an annual allocation of donated specialty care services with each hospital and/or system, with the goal of distributing specialty care in an equitable manner relative to the market share of the hospital. The hospitals and systems will be asked to help formulate the definition of market share. The Network will work with hospitals and systems to establish an efficient decision-making process for approving Network requests for specialty care at their facility. Network specialty care services will be restricted to patients of Network designated medical homes. In order to preserve the integrity of the system, it is preferred that the hospitals and systems prioritize the delivery of donated specialty care through the Network; nevertheless, hospitals and systems reserve the right to provide donated specialty care services outside of this mechanism. The Network will develop a patient identification card system for eligible medical home patients to help facilitate patient identification, intake, and processing.

Physicians - Providers of specialty care services will also include sub-specialist physicians, both independents as well as those employed by hospitals or group practices.

It is recognized that the physician community has an extremely vital role to play in the success of the Network. Because there are hundreds of physicians and dozens of group practices in Oklahoma County (as opposed to a half dozen or so hospitals), it may be more challenging to rally sub-specialist physician support and participation in a charitable care program such as Oklahoma County Community Health Network. Nevertheless, recruiting and signing up significant numbers of active practicing and retired (and still licensed) sub-specialist physicians, not to mention involving physicians in program design and strategic decisions, is essential for the Network specialty care services to deliver on its stated goal. For this reason, the leadership of Oklahoma County Medical Society is crucial.



The presence on the Commission of OCMS Immediate Past President, Robert Cooke, MD, along with long-time OCMS member and Past President D. Robert McCaffree, MD, has provided hope for a broad commitment of support from the physician community. In any case, membership in OCMS will not be required in order for a physician to become a participating Network specialty care provider. Concerns about the extent of the state law providing immunity from liability still linger for some physicians who would like to donate their services. The Commission is in the process of securing a legal brief to help put these concerns to rest. Similar to the arrangements with hospitals, the Network will negotiate with each physician or group practice to accept a specific number of Network specialty care referrals each year; however, any number will be graciously welcomed. As noted earlier, the Network will assure that all lab and diagnostic work is completed BEFORE the patient sees the specialist. In most cases, the specialist will see the patient in his/her own office, but there may be instances where a specialist sees patients in a Network designated medical home or another setting, because he/she is already seeing patients there and wishes to use that setting. No provider will be compensated for care.

Community Mental Health Centers and Other Health Partners – Another important group of specialty care providers in the Network will be community mental

health centers and private behavioral health professionals (e.g. professional counselors, psychologists, licensed clinical social workers, etc.). The prevalence of mental illness and high rates of substance abuse requires that the Network form and maintain a strong referral base among these behavioral health providers. The Network will also partner with organizations focused on oral health access, such as D-DENT (Dentists for the Disabled and Elderly in Need of Treatment). Finally, the Network will form partnerships with suppliers of medically necessary equipment and supplies, so that, for example, when a surgeon needs to implant a device or a patient needs prosthetics, those tangible goods will be donated as well.

DESIRED OUTCOMES OF SPECIALTY CARE
<ul style="list-style-type: none"> ▪ INCREASING NUMBER OF COMPLETED SPECIALTY CARE CONSULTS (STRETCH GOAL IS 10,000 PER YEAR): 1,000 IN YEAR 1, 2,500 IN YEAR 2 ▪ PATIENT NOTIFICATION OF SPECIALTY CARE APPOINTMENT AVERAGES 7 DAYS OR LESS ▪ ACHIEVING PARTICIPATION RATE AMONG SUB-SPECIALIST PHYSICIANS: 15% IN YEAR 1, 30% IN YEAR 2 ▪ ALL HOSPITALS PARTICIPATING AND AT RATES EQUIVALENT TO MARKET SHARE ▪ HIGH PROGRAM SATISFACTION RATES (AVERAGE OF 4 OR HIGHER ON A SCALE OF 1-5) AMONG PARTICIPANTS (PHYSICIANS, HOSPITALS, MEDICAL HOMES)

B. CASE MANAGEMENT

Intent – The purpose of this component is to improve the overall health and well being of high-risk patients by enhancing their ability to utilize the health care system appropriately and take better care of themselves. In turn, various “system benefits” will be realized, including lowering the use of hospital emergency rooms for primary care among the uninsured, reducing uncompensated care costs attributed to hospitalizations for primary care sensitive (i.e. avoidable, preventable) conditions, and freeing up additional capacity at Network participating hospitals and designated medical homes by providing intensive case management for their “super-utilizer” patients. The Network will build and maintain a robust, effective case management system that utilizes in-house staff and

coordinates efforts with case managers, care coordinators, and discharge planners in Network medical homes and hospitals.

Scope of Services - Case management will be customized to the unique needs of the patient. For some patients, this will mean working with them for period of time as they progress through a particular health issue or set of health issues; for others, this will be an ongoing need, depending upon the patient's ability to maintain his/her own health. It is recognized that some patients, for reasons of mental ability, health literacy levels, or other factors, may need more intensive or continuous service. Network case management will be focused primarily on coordinating the patient's utilization of medical services; however, a broader range of health care services, including behavioral health, dental, vision, and/or other services, may be addressed as appropriate. Additionally, services will go beyond "medical" case management to include broader "social" case management, addressing the social determinants of the patient's poor health, thus serving the patient more holistically. This could even include things like paying for, or arranging payment or service for, transportation to a medical appointment, a minor home modification, the purchase of a medical device or supplies, etc., which could make a vital difference in the patient's health improvement and/or health care.

The ultimate objective of the Network is to impact the wellness of patients in a meaningful way. Thus, attention will be paid to the level of service, cost to achieve these impacts, and likelihood of successful outcomes. A costly service with very little potential for positive health impact will not be an efficient or effective utilization of resources. Furthermore, instances in which a patient's own persistent non-compliance (whether by reason of willingness or ability) negates any positive impact of services will be taken into consideration. Evaluation will include a patient's ability to understand instructions and treatment. It will be expected that a patient is able to manage his/her health and that he/she cares about maintaining his/her health whenever possible. For example, a person waiting for a procedure but not following doctor's instructions may not be considered a candidate. The post-procedure regimens are often critical and require diligence; a patient's ability to follow the pre-procedure regimen will be considered an indication of self-care after the procedure. Additionally, patients whose care is under another "umbrella" such as those with access to tribal-provided health care or persons who are incarcerated will not

be deemed appropriate. Resources are to be allocated to achieve maximum impact for each patient, as well as for patients served in the aggregate, understanding that some patients may not succeed but that most will.

Target population - Case management will be restricted to patients referred by Network designated medical homes, and participating hospitals and sub-specialist physicians. For patients referred by hospitals and sub-specialist physicians, Network case management will ensure that they are placed in a designated medical home for primary care. Referrals can go “up, down, or sideways” among participants in the Network. However, for the purpose of achieving the greatest amount of cost avoidance for preventable conditions, the highest priority for Network case management will be given to “super-utilizer” self-pay patients referred from participating hospitals. Patients accepted into Network case management must be uninsured individuals with household incomes at or below 200% of federal poverty level and eligible for or enrolled in a Network designated medical home. It is understood that designated medical homes may have patient eligibility criteria that differ from the target population for Network case management, but patients referred for case management must meet the requirements above.

2012 Federal Poverty Income Guidelines

Household size	100%	133%	150%	200%
1	\$11,170	\$14,856	\$16,755	\$22,340
2	15,130	20,123	22,695	30,260
3	19,090	25,390	28,635	38,180
4	23,050	30,657	34,575	46,100
5	27,010	35,923	40,515	54,020
6	30,970	41,190	46,455	61,940
7	34,930	46,457	52,395	69,860
8	38,890	51,724	58,335	77,780

Personnel and Process – The central point of intake for Network case management will be an Intake Coordinator who is a nurse with a background in holistic case management, who will receive pertinent information from the referring source and contact the patient to make an initial assessment of need. This function determines whether the

case management need is likely to be limited to short-term, solution focused assistance or to more intensive case management to address multiple, complex, or on-going issues. The Intake Coordinator will have the breadth and depth of knowledge to triage effectively but will not have deep involvement in the cases. If the need is for short-term assistance only, the patient will be assigned to a Case Manager designated for less intensive case management. The Case Manager will be a liaison who has strong relationships with the various health care and human service providers in the community. The Case Manager will handle the majority of contacts with these entities, and connect the patient to the services. Patients needing longer term or more intensive case management will be assigned to both a Case Manager (designated for more intensive cases) and a Health Coach.

The Health Coach will have training similar to a community health worker, and the ability to interact effectively with patients, develop trust, and maintain accountability. The majority of contact for these patients will be with the Health Coach. This leaves the intensive Case Manager free to handle the more complex issues that arise in their caseload without having to respond to more routine issues. All Case Managers will establish and maintain close working relationships with their counterparts at Network participating hospitals and designated medical homes. Some of the case management staff will be bilingual to ensure fluent communications with Spanish-speaking patients. The Network will convene quarterly meetings of case management staff, internally and externally, to facilitate the sharing of pertinent information, troubleshoot system issues, and discuss cases.

DESIRED OUTCOMES OF CASE MANAGEMENT
<ul style="list-style-type: none"> ▪ INCREASING NUMBER OF PATIENTS RECEIVING NETWORK CASE MANAGEMENT: 75 IN YEAR 1; 125 IN YEAR 2 ▪ MARKED IMPROVEMENT IN HEALTH STATUS AND SOCIAL DETERMINANTS OF HEALTH FOR CASE MANAGEMENT PATIENTS <u>IN THE AGGREGATE</u> FOLLOWING ONE YEAR OF SERVICE ▪ DOCUMENTED REDUCTIONS IN INCIDENCES AND COST OF HOSPITALIZATIONS AND EMERGENCY DEPARTMENT USE FOR PRIMARY CARE SENSITIVE CONDITIONS

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| <ul style="list-style-type: none"> ▪ DEMONSTRATED COST-BENEFIT TO HOSPITALS WHEN COMPARING COST OF PROGRAM TO PATIENT-SPECIFIC HOSPITAL COST AVOIDANCES ACHIEVED ▪ HIGH PROGRAM SATISFACTION RATES (AVERAGE OF 4 OR HIGHER ON A SCALE OF 1-5) AMONG CASE MANAGEMENT PATIENTS |
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C. MEDICAL HOMES

Intent – The purpose of this component is to institutionalize the use of designated primary care medical homes as the preferred providers of care to uninsured, chronically ill patients in Oklahoma County. As patient centered medical homes are fast becoming the model for how primary care is organized and delivered across the nation, the health care safety net in Oklahoma County must embrace and adopt this approach. The two large FQHCs (with 12 health center sites between them) and some of the charitable clinics have already begun to take steps in this direction. In any case, the Network will provide an equal opportunity for all FQHCs and charitable clinics in Oklahoma County to become designated medical homes if they wish.

Criteria – In order to establish criteria for medical homes that would make the most sense for the Network, the Commission reviewed the medical home criteria promulgated by the National Committee for Quality Assurance (NCQA) and the American Academy of Family Practice (AAFP). Medicaid’s new “health home” option was also considered, as was the Butterfield Memorial Foundation’s 15 criteria for defining their soon-to-be-funded primary care centers of excellence. The Commission determined the Network "medical home" criteria using components of all of the above.

NETWORK CRITERIA FOR DESIGNATED MEDICAL HOMES

- Be located in Oklahoma County
- Have an intentional presence in a purposefully selected location that takes into account existing safety net providers and demonstrated needs
- Serve medically vulnerable populations, including but not limited to those who meet the Network’s criteria for specialty care services: uninsured individuals with household income at or below 200% federal poverty level
- Utilize and adhere to evidence-based protocols for the treatment of common chronic diseases

- Be open at least 30 hours per week for primary care medical visits
- Provide at least 4,000 primary care medical visits annually
- Have adequate clinical space, including a minimum of 2 exam rooms per provider present and an on-site lab for CLIA waived testing
- Provide medications on-site through the use of pharmaceutical company patient assistance programs, dispensing donated or discounted medications and samples, or other means
- Facilitate after hours call for patients
- Have a well-defined process and policies for incoming calls, patient intake process, appointment scheduling, patient records management, and referral tracking and follow up
- Utilize the Network for accessing all or most specialty care services, with a designated referral coordinator on staff
- Document patient's household income, if referred for Network specialty care services
- Conduct a comprehensive health screening for all patients upon enrollment
- Serve patients referred for medical care from the Network, participating hospitals, and community mental health centers
- Have case manager(s) or care coordinator(s) that interact with the Network case management program
- Have well developed human resource practices and policies, including credentialing and privileging for all health care professionals, criminal background checks, and volunteer handbook
- Facilitate access to lifestyle interventions, such as weight loss and fitness programs, nutrition counseling, and smoking cessation
- Provide comprehensive multi-disciplinary holistic care components on-site or by written referral for the following: dental services, behavioral health, and women's health (OB and GYN)
- Have a defined process for measuring patient satisfaction at least annually
- Assess and address patient transportation needs
- Possess a well-defined effective governance system including Bylaws, an impartial and independent Board of Directors and Board-approved policies that provide medical oversight, assure proper control of finances, and ensure a continuous quality improvement plan based on outcomes and efficiency

The medical home may also have a spiritual care component (e.g. chaplains, pastoral counselors, etc.) that is integrated into the clinical operation. Medical homes will be encouraged to foster a culture that invites, encourages, and acknowledges student involvement and training in a variety of community health disciplines. In addition, volunteerism among active and retired health care professionals, as well as laypeople, will

be strongly encouraged, with adequate provisions for background checks, orientation, training, supervision, and recognition.

Designation and Support – The Network will create an ongoing program to support the development, designation, and strengthening of medical homes that excel in serving the needs of chronically ill patients. Training and technical assistance will be provided to health centers and charitable clinics that wish to pursue medical home designation. Special emphasis will be given to this area during the formation and early years of the Network. With the attention that the medical home model is receiving these days, the Network may be in a strong position to secure funds that would go to the health centers and clinics as they pursue this designation.

Health centers and clinics that organize and meet the medical home designation criteria will complete an application for this status and provide supporting documentation. The Network will convene a committee, composed of existing designated medical homes and other subject matter experts, to review applications, conduct site visits, and make recommendations to the Network for medical home designation. This committee will function much like a peer review team. It is expected that, by the time entities apply for medical home designation, their condition and circumstances will already be well known to the Network, and they will meet the criteria for approval.

The Network will also convene regular meetings of the designated medical homes and develop programming and resources that support their ongoing improvement and strengthening. To facilitate patient identification, intake, and processing through Network participating hospitals and other health care organizations, the Network will develop and coordinate a patient identification card system in conjunction with designated medical homes. A future hope is that the Network will become an effective mechanism for raising major funds earmarked to support special projects and/or ongoing operations in designated medical homes.

Network “Neighborhood Clinics” - It is understood that a number of charitable clinics will not be able to meet the medical home designation criteria in the near future or long term, due to capacity constraints or other factors, but still want to improve their standard of care, strengthen their operation, and perhaps even continue serving

chronically ill patients. The Network will thereby establish a “neighborhood clinic” designation in order to provide a formal mechanism to provide support to these clinics while also ensuring the integrity of Network services and the effective and efficient use of safety net resources, such as specialty care. In order to achieve neighborhood clinic designation, the clinic must meet minimum operational standards and agree to comply with rules of engagement, both to be established by the Network. In return, the designated neighborhood clinics will be eligible to access Network specialty care services, limited case management slots, educational opportunities, and possibly even funding. This designation is not intended to dilute the emphasis on medical homes or to dissuade clinics from pursuing medical home designation; rather, it reflects the reality that a number of charitable clinics (perhaps 6-8 altogether) are not likely to achieve medical home status anytime in the near future, but nevertheless want to grow and raise their level of care. The Commission believes that these clinics will still have a meaningful role to play in serving the chronically ill after the Network begins and therefore should receive some attention and support from the Network. The possibility exists for a “hub and spoke” arrangement whereby several Network designated neighborhood clinics (spokes) are linked to a Network designated medical home (hub) in their proximity, creating a “mini-collaborative” that the Network can use to facilitate effective use of services and resources.

Options for Charitable Clinics Not Pursuing Medical Home Designation or Neighborhood Clinic Status – Some charitable clinics may elect not to pursue either medical home designation or neighborhood clinic status. The Network will respect the prerogative of such clinics, and will encourage them to consider the following options for care delivery:

1. Continue to serve patients with acute, episodic conditions, thus filling important immediate needs for vulnerable populations;
2. Refer chronically ill patients to a designated medical home, which will free up more capacity to serve those with acute, episodic needs and also ensure that chronically ill patients benefit from the provision of care in a medical home;
3. Refer patients who need specialty care services to a designated medical home, which in turn will place the patient in the specialty care “queue” through the Network (in these cases, the referring clinic and designated

medical home will discuss and decide which one will assume responsibility for ongoing care following the specialty care service); and,

4. Consider joining forces and/or merging with one or more neighboring clinics and thereby achieve the capacity requirements and other infrastructure criteria necessary to be a Network designated medical home or neighborhood clinic.

DESIRED OUTCOMES OF MEDICAL HOMES
<ul style="list-style-type: none"> ▪ NETWORK DESIGNATION OF MEDICAL HOMES: 7 FQHC SITES BY YEAR 1 AND 10 FQHC SITES CUMULATIVELY BY YEAR 2; 3 CHARITABLE CLINICS BY YEAR 1; 4 CHARITABLE CLINICS CUMULATIVELY BY YEAR 2 ▪ AGGREGATE IMPROVEMENTS IN DISEASE MANAGEMENT BY MEDICAL HOMES: <ul style="list-style-type: none"> ○ DIABETICS: HGA1C CONTROL (≤ 7) – REDUCE THE PROPORTION OF PATIENTS WITH HGA1C GREATER THAN 9% BY 35% IN YEAR 1, AND 50% IN YEAR 2 ○ HYPERTENSIVES: BP CONTROL - INCREASE THE PROPORTION OF PATIENTS WITH BP $\leq 140/90$ TO 50% IN YEAR 1, AND 75% IN YEAR 2 ▪ MEDICAL HOMES REFER 75% SPECIALTY CARE SERVICE REQUESTS TO NETWORK BY YEAR 2 ▪ HIGH RATES OF PATIENT SATISFACTION WITH OVERALL CARE RECEIVED IN MEDICAL HOMES (AVERAGE OF 4 OR HIGHER ON A SCALE OF 1-5)

MEDICATION ACCESS

Medications are an integral component of effective treatment regimens, especially for the chronically ill. Many patients require ongoing medication therapies to manage their chronic diseases. Robust access to a wide range of prescription medicines, not to mention efficient delivery systems and medication counseling for patients are essential for the Network to achieve positive outcomes with the target population. The designated medical homes, as indicated in the criteria, will be expected to dispense medications on-site through a licensed pharmacy. The Network will help develop and promote strategies that enable the medical homes to acquire and provide high-quality medications at the lowest

possible cost. Some medication access programs, such as Rx Oklahoma and the Cooperative Central Pharmacy, already exist to help these needs. Given that the universe of free and low-cost medications is constantly shifting and evolving, the Network will continually look for promising solutions that can benefit medical homes and the patients they serve.

NETWORK STRUCTURE

Coordinating Council – Effective governance of the Network is absolutely critical. The Commission considered a number of governance models during its review of leading health care safety nets across the country. Given the unique circumstances of Oklahoma County and the Commission’s desire to move the **Oklahoma County Community Health Network** from concept to reality, the Commission proposes the formation of a 9-15 member Coordinating Council to serve as a “bridge” from the Commission to the launch and early operation of the Network. The Commission will disband when the Coordinating Council begins to function. Ultimately, the Board of the Administering Organization will govern the Network and be accountable to funders, partners, providers and the community at large. The Coordinating Council will exist to create a smooth transition to that end.

The Coordinating Council will conduct a Request for Proposals process to give all interested, eligible organizations an opportunity to apply to become the Administering Organization. In addition, it will advocate for start-up and first year funding commitments for the Network, and in so doing will act as an endorsing mechanism for the funders. During the period prior to the selection of the Administering Organization, the Health Alliance for the Uninsured will serve as a temporary fiscal agent for the receipt of any grants and other funds raised for the Network, as well as any funds necessary to support the Coordinating Council’s work. These funds will be held in an escrow account separate from the operating accounts of the Health Alliance for the Uninsured. Once the Administering Organization is selected, the funds dedicated to the Network will be transferred to the operating accounts of the selected organization. The authority and responsibilities for these arrangements will be codified in formal agreements between the Coordinating Council, the Health Alliance for the Uninsured, and the funders.

Bylaws governing the composition and functions of the Coordinating Council will be drafted and approved by the Commission. Many of the Coordinating Council’s members will be individuals who served on the Commission. The Commission will select the initial members of the Coordinating Council. In addition, each of the following major stakeholder groups will have a standing seat: hospitals, physicians, charitable clinics, FQHCs, community mental health centers, and funders of health interests. “At large” members will also have a seat and these may include representatives of other key constituencies for the Network, such as Oklahoma City-County Health Department, Latino Community Development Association, and others. The Coordinating Council will remain in existence for at least two years following the selection of the Administering Organization, and until the Network is firmly institutionalized as viable, sustainable enterprise. By agreement with the major funders of the Network, the Coordinating Council will help monitor the performance of the Administering Organization to ensure that the Commission’s vision for a transformation system of care for Oklahoma County’s uninsured is fully realized. If the Administering Organization fails to meet expectations and/or decides it does not want to administer the Network any longer, the Coordinating Council will work to find another Administering Organization or create a new one.

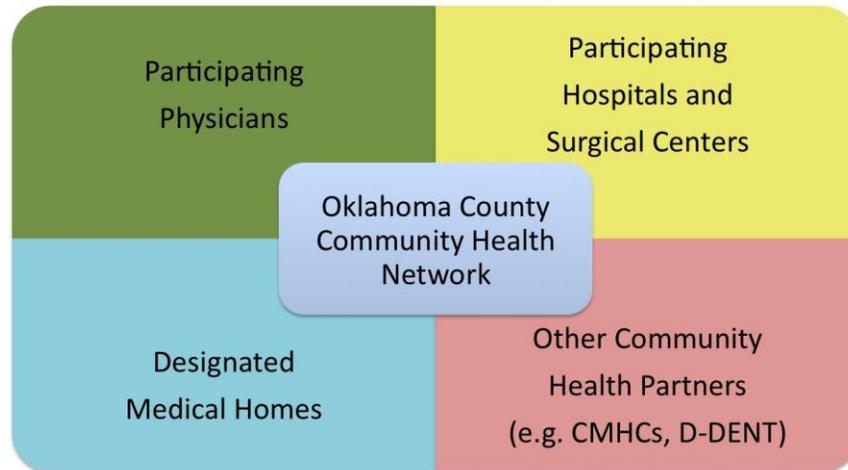
Oklahoma County Community Health Network



Letters of Intent and Proposals – The Commission believes that a nonprofit organization with 501(c)3 tax-exempt status is best suited to serve as the Administering Organization for the Network. A Request for Letters of Intent will be drafted by the

Coordinating Council and publicized to all organizations in Oklahoma County that may be interested in administering the Network. The Request for Letters of Intent will set forth the criteria for eligible organizations, broad aims for the Network, expected funding, and desired outcomes. Letters of Intent will be reviewed and organizations that meet the eligibility criteria will be asked to prepare a full proposal. For purposes of assessing performance and providing an appropriate amount of time for the Administering Organization to produce meaningful results, full proposals will cover a two-year period of activity. Proposals from applicant organizations will contain detailed plans for Network start-up, service delivery, and production of desired outcomes, as well as evidence of leadership, management, and financial capability to administer the Network. Assuming one or more applications meet all the criteria and requirements, the Coordinating Council will select one to be the Administering Organization and will arrange for Network funds to be transferred to it.

Administering Organization – The responsibility for building the necessary infrastructure and service delivery systems for the Network will belong to the Administering Organization. The Administering Organization will receive the major funding that is dedicated to the Network, hire staff, build necessary infrastructure, and develop the three core services of the Network: a robust specialty care services operation; a coordinated system of case management targeting high-risk patients; and, designation and support for primary care medical homes treating the chronically ill. While specialty care is the highest priority, the other two services must not be given short shrift as all three core services are interdependent and form an integrated system. The Administering Organization will coordinate efforts with the participating partners of the Network – hospitals, physicians, designated medical homes, and other community health partners that will contribute to a transformational system of care. Ideally, the Administering Organization will have, or plan to hire, a seasoned, dynamic manager who is a systems thinker with a strong background in community health and collaborative networks, proven skills in rallying diverse interests, and a successful track record with start-ups.



COSTS

Few innovations in health care today can succeed without meaningful outlays of cash for start-up and operating costs. The topic of financing is treated in the next section. Suffice to say, the Commission recommends a budget that will allow the Network to get up and running quickly and achieve at least at a level of productivity that will allow the three inter-related program components to work together, mature, and produce all or most of the Network's desired outcomes by the end of the two years of provisional funding. Some costs may be offset by the availability of in-kind or heavily discounted goods, services, and/or space. In addition, the selected Administering Organization may have certain elements of infrastructure already in place. The budget for the Network reflects a relatively flat organizational structure, so that most of the personnel are "doers" and management/supervisory costs are kept at a minimum. Some of the positions will not be hired until Year 2, giving the Network appropriate time to get started, conduct hiring processes, and develop and stabilize program services.

NETWORK BUDGET	START-UP	YEAR 1	YEAR 2
PERSONNEL (wages and taxes)			
Administrator		\$ 75,000	\$ 75,000
Office Manager		\$ 40,000	\$ 40,000
Health IT Coordinator		\$ 40,000	\$ 40,000
Intake Specialist (for both SC & CM)		\$ 50,000	\$ 50,000
Specialty Care Manager/Recruiter		\$ 60,000	\$ 60,000
Specialty Care Coordinator		\$ 40,000	\$ 40,000
Specialty Care Coordinator		\$ 40,000	\$ 40,000
Specialty Care Coordinator			\$ 40,000
Case Manager II		\$ 55,000	\$ 55,000
Case Manager II			\$ 55,000
Case Manager I		\$ 45,000	\$ 45,000
Health Coach		\$ 35,000	\$ 35,000
Health Coach		\$ 35,000	\$ 35,000
Health Coach			\$ 35,000
Health Coach			\$ 35,000
Medical Homes Quality Specialist		\$ 60,000	\$ 60,000
Medical Interpreting Services		\$ 20,000	\$ 30,000
Ancillary Services and Support to Patients		\$ 15,000	\$ 20,000
Benefits (health insurance, 3% retirement)		\$ 92,000	\$ 118,000
Payroll Taxes		\$ 60,000	\$ 80,000
INFRASTRUCTURE			
Space renovations	\$ 20,000		
Office furniture	\$ 10,000		\$ 3,000
Computer hardware, software, peripherals	\$ 20,000		\$ 5,000
Electronic records system		\$ 50,000	\$ 25,000
Rent and utilities		\$ 40,000	\$ 40,000
Telephone and Internet		\$ 15,000	\$ 20,000
Insurance		\$ 8,000	\$ 8,000
Travel		\$ 5,000	\$ 7,500
Training and conferences		\$ 10,000	\$ 12,000
Office supplies		\$ 3,000	\$ 4,000
Copies and printing		\$ 2,500	\$ 3,500
Miscellaneous	\$ 5,000	\$ 1,000	\$ 1,500
TOTALS	\$ 55,000	\$ 896,500	\$ 1,117,500

FINANCING

With projected start-up and first-year operating costs for the Network estimated at \$950,000, the community must be ready to step up and provide significant seed funding for this effort. Fortunately, an early groundswell of support has emerged. During one of its

meetings, the Commission invited representatives of several of the leading foundations in Oklahoma County with health care interests to participate in a strategic conversation about their views on the present functioning of the health care safety net and their early perceptions of the Commission's vision for a transformational system of care. At the end of the discussion, the foundation leaders overwhelmingly voiced their support and expressed a willingness to carefully consider the Commission's need for funding once a plan was finalized. This gave the Commission a great deal of hope for early funding from some key organizations. Subsequent conversations have reinforced this optimism, while also emphasizing the importance of the Network demonstrating early success and effectiveness.

**TARGET SOURCES AND PERCENTAGES OF EARLY FUNDING FOR
OKLAHOMA COUNTY COMMUNITY HEALTH NETWORK**

55% - Private foundations and trusts with health interests

20% - Hospitals and health systems (including their foundations)

15% - Oklahoma City-County Health Department

10% - Corporations, businesses, and individuals

By the end of the first two years of operation, the Network will hopefully be able to provide strong evidence that it has substantially reduced specific uninsured patients' utilization of hospital services, thus ameliorating some of the uncompensated cost burden borne by area hospitals. Assuming real hospital savings take place that are directly attributable to the Network, hospitals will be asked to contribute a portion of the savings, with the precise formula or methodology developed in close consultation with the hospitals collectively and individually. In addition, other new sources of support might include major grants from national foundations (e.g. Robert Wood Johnson Foundation), federal grants related to health care reform initiatives, membership dues from Network participants (e.g. medical homes, hospitals, and representative organizations like OCMS) to cover overhead expenses, and perhaps even patient fees for administrative costs pertaining to specialty care.

IMPLEMENTATION

No great idea can succeed unless executed effectively. A sound plan based on best practices but implemented poorly will not succeed. The Commission firmly believes that the process is as important as the product, which is partly why the Commission came into existence in the first place. At the same time, there is a bias toward action. Careful homework and good planning must translate into real work and activity. The following timeline illustrates the steps involved in implementing this Master Plan.

- | | |
|------------------------------------|---|
| MARCH - JUNE 2012 | <ul style="list-style-type: none">▪ COMMISSION REVIEWS AND COMMENTS ON INITIAL DRAFT OF MASTER PLAN, AUTHORIZES REVISIONS▪ UPDATED DRAFT OF MASTER PLAN VETTED WITH KEY STAKEHOLDERS (HOSPITALS, PHYSICIANS, SAFETY NET ORGANIZATIONS, FUNDERS, ETC.) |
| 3RD QUARTER 2012 | <ul style="list-style-type: none">▪ COMMISSION RATIFIES MASTER PLAN, BASED ON FEEDBACK FROM KEY STAKEHOLDERS▪ COMMISSION ADOPTS BYLAWS FOR COORDINATING COUNCIL AND ELECTS INITIAL MEMBERS▪ COMMISSION DISBANDS▪ COORDINATING COUNCIL BEGINS▪ PRESS RELEASE IS ISSUED TO ANNOUNCE MASTER PLAN FOR OKLAHOMA COUNTY COMMUNITY HEALTH NETWORK AND RECOGNIZE THE WORK OF THE COMMISSION▪ COORDINATING COUNCIL CIRCULATES REQUEST FOR LETTERS OF INTENT TO ALL ORGANIZATIONS INTERESTED IN BECOMING THE ADMINISTERING ORGANIZATION▪ COORDINATING COUNCIL REVIEWS LETTERS OF INTENT AND SELECTS ORGANIZATION(S) TO BE ASKED FOR FULL PROPOSALS▪ COORDINATING COUNCIL SOLICITS FUNDERS FOR START-UP AND FIRST-YEAR OPERATING COSTS; EXECUTES AGREEMENTS TO SERVE AS AN ENDORSING AND MONITORING MECHANISM FOR THE FUNDERS |
| 4TH QUARTER 2012 | <ul style="list-style-type: none">▪ COORDINATING COUNCIL REVIEWS FULL PROPOSALS AND SELECTS ADMINISTERING ORGANIZATION▪ ADMINISTERING ORGANIZATION COMMENCES NETWORK INFRASTRUCTURE DEVELOPMENT, HIRING STAFF, ETC.▪ RECRUITMENT AND NEGOTIATIONS WITH NETWORK SPECIALTY CARE PROVIDERS AND PARTNERS BEGINS▪ MEDICAL HOME TRAINING AND TECHNICAL ASSISTANCE FOR HEALTH CENTERS AND CHARITABLE CLINICS BEGINS |
| 1ST QUARTER 2013 | <ul style="list-style-type: none">▪ PUBLIC EVENT IS HELD TO CELEBRATE THE LAUNCH OF OKLAHOMA COUNTY COMMUNITY HEALTH NETWORK▪ NETWORK SERVICES ARE OFFICIALLY LAUNCHED▪ ADMINISTERING ORGANIZATION SUBMITS 3-MONTH PROGRESS REPORT TO COORDINATING COUNCIL▪ COORDINATING COUNCIL MEETS WITH ADMINISTERING ORGANIZATION |

- 2ND QUARTER 2013**

 - CEO, DISCUSSES REPORT
 - ADMINISTERING ORGANIZATION SUBMITS 6-MONTH PROGRESS REPORT (WITH FINANCIALS) TO COORDINATING COUNCIL AND FUNDERS
 - COORDINATING COUNCIL MEETS WITH ADMINISTERING ORGANIZATION CEO, DISCUSSES REPORT
- 4TH QUARTER 2013**

 - NETWORK CONTINUES OPERATIONS
 - ADMINISTERING ORGANIZATION SUBMITS 12-MONTH PROGRESS REPORT (WITH FINANCIALS) TO COORDINATING COUNCIL
 - COORDINATING COUNCIL MEETS WITH ADMINISTERING ORGANIZATION CEO, DISCUSSES REPORT
 - COORDINATING COUNCIL ENDORSES YEAR 2 FUNDING FOR ADMINISTERING ORGANIZATION, SUBJECT TO SATISFACTORY PERFORMANCE, AND RENEWS AGREEMENTS WITH FUNDERS
- 2ND QUARTER 2014**

 - ADMINISTERING ORGANIZATION SUBMITS YEAR 2 6-MONTH PROGRESS REPORT (WITH FINANCIALS) TO COORDINATING COUNCIL AND FUNDERS
 - COORDINATING COUNCIL MEETS WITH ADMINISTERING ORGANIZATION CEO, DISCUSSES REPORT
- 4TH QUARTER 2014**

 - ADMINISTERING ORGANIZATION SUBMITS YEAR 2 12-MONTH PROGRESS REPORT (WITH FINANCIALS) TO COORDINATING COUNCIL AND FUNDERS
 - COORDINATING COUNCIL MEETS WITH ADMINISTERING ORGANIZATION CEO, DISCUSSES REPORT
 - COORDINATING COUNCIL EVALUATES 2-YEAR PERFORMANCE OF ADMINISTERING ORGANIZATION AND DECIDES WHETHER IT SHOULD CONTINUE ADMINISTERING NETWORK
 - IF YES, COORDINATING COUNCIL ENDORSES CONTINUED SUPPORT FROM MAJOR FUNDERS AND MONITORS NETWORK PERFORMANCE AT LEAST SEMI-ANNUALLY
 - IF NO, COORDINATING COUNCIL COMMENCES SELECTING OR DEVELOPING ANOTHER ADMINISTERING ORGANIZATION

RISKS

While the Commission is optimistic about this opportunity to transform the health care safety net, we acknowledge that there are risk factors that could derail the implementation and ultimate effectiveness of this Master Plan. Some are cited below. By naming these threats, we become better able to guard against them and respond to them when they surface.

The primacy of the status quo – As with any effort that involves innovation and a significant change in business as usual, there will be those who want to recede back into the comfort and familiarity of the status quo. However, the safety net in its current form is unsustainable. What is needed is a rational, coherent system that is organized and

coordinated to enhance the patient experience of care, improve health, and reduce avoidable costs.

“We tried that before, and it didn’t work” – Some attempts have already been made to address certain deficiencies in the safety net cited in this document. Just because a proposed solution may have failed previously does not mean that the problem is no longer worth fixing. Programs based on great ideas can fail on account of poor design, ineffective execution, or other reasons. This Plan is based on months of analysis, careful consideration of best practices, and collective strategizing by informed and visionary people. Moreover, there will be a strong mechanism in place (i.e. Coordinating Council) to provide ongoing monitoring and assure successful performance. Success is not a guarantee, but the chances are very good.

Lack/loss of fidelity to the Network model – The three core services to be provided by the Network are interdependent and make up an integrated whole. They must all be kept intact. Specialty care services are wasted unless quality medical homes exist to provide ongoing care. The resources of medical homes, hospitals, and physicians will continue to be wasted if good case management is not available for high-risk patients. A strong group of medical homes is critical to providing quality care to thousands of chronically ill patients. Forfeiting or discontinuing any one or more of these components will cause the model to break down and fail to deliver its intended results.

Insufficient funding – The Network will require start-up funding as well as operational funding for at least two years in order to build infrastructure and test the efficacy of the model. Attention has been given to creating enough capacity to produce real effectiveness, without extravagance. Nevertheless the price tag is significant. If local funders cannot provide the requested amount of funding for whatever reason, this could seriously jeopardize the Network. Meanwhile, the Commission (and the Coordinating Council later) will continue to maintain a close dialogue with funders to ensure buy-in and support.

Providers squeezed – Hospitals and physicians alike today are facing increasing downward pressure on reimbursements and revenues, which threatens their financial viability. If these pressures become too great, some of these providers may have to pull back from providing the level of charitable care that is needed by the Network. The

Administering Organization as well as the Coordinating Council will work closely with providers to stay abreast of their projections and concerns about present and future participation.

THE TIME FOR ACTION IS NOW

The creation of this Master Plan marks the beginning of a critical turning point in care for the uninsured in Oklahoma County. Some of the best and brightest minds in health care in our community came together to craft this plan. This Plan is the result of the Commission becoming a learning organization, developing creative solutions, and achieving the consensus and collective will to tackle the most daunting problems facing our safety net today. Whatever becomes of health care reform, we know that there will continue to be people who fall through the cracks and lack access to care. We in Oklahoma County have what it takes to organize and deliver excellent health care to our low-income, uninsured neighbors in need. In doing so, we will improve the health of this population, make better use of our health care dollars and resources, and provide value to those who will make the Network possible.

The time has come to act. We have studied the issues and done our homework. We know what is not working, we have learned from successful programs elsewhere, and we have come up with a set of strategies that makes sense for Oklahoma County. Failing to act is not an option. Successful execution is critical; we have a system of accountability and we will stay with it. We will not be deterred in our quest to build a best-in-class health care system for our neighbors in need. The very survival of many of them depends on it.

**COMMISSION TO TRANSFORM
THE HEALTH CARE SAFETY NET IN CENTRAL OKLAHOMA**

By my signature below, I approve the ratification of the Master Plan for Oklahoma County Community Health Network:

Stanley F. Hupfeld, FACHE

Anita Fream

D. Robert McCaffree, MD

Cathryn Hibbs

Nancy Anthony

Christi Jernigan

Beverly Binkowski

Rosalyn Johnson

Lou Carmichael

Craig Jones

Terry Cline

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Terrisa Singleton

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Steve Turner

Patricia Fennell

Terri White

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