2020

CENTRAL COMMUNITIES HEALTH ACCESS NETWORK

MILESTONES AND REPORTING MEASURES
Covering January 1, 2020 through December 31, 2020

TABLE OF CONTENTS

To analyze Central Communities Health Access Network's (CCHAN) effectiveness in reducing costs, improving access, improving the quality and coordination of health care services and improving the SoonerCare Choice patient-centered medical home, the CCHAN will provide the following data in a semi-annual and annual report. In addition, periodic reports with data supporting CCHAN's effectiveness will be submitted to appropriate OHCA staff at meetings throughout the year.

Affiliated Providers and Access to Care

Number of providers by name and panel size affiliated with CCHAN

There were twenty-four (24) providers affiliated with CCHAN as of 12/31/2020. Four (4) of the twenty-four are associated with two of the participating group practices; they are James M. Brown, DO, Aaron P. Wilbanks, DO, Alex Medgaarden, PA-C, and Andrea L. Krittenbrink, PA-C; all are associated with both Canadian Valley Family Care and Mustang Urgent Care. July 1, 2020 Variety Care purchased Yukon Pediatrics, thus the name change.

Table 1 CCHAN Affiliated PCPs

Mustang Urgent Care 0840A Family Practice, 0-18 years of age 115 N. Mustang Rd. Mustang, OK (405) 256-5595 **Baker, Dustin R., MD** **Broome, Joseph C., MD** **Brown, James M., DO** **Bryant, L'Tora, APRN** **Davis, Henry, APRN** **Krittenbrink, Andrea L., PA-C** **McGinn, James, APRN** **Medgaarden, Alex E., PA-C** **Pittman, Bradley D., PA-C** **Ricks, Jacinda R., APRN** **Wilbanks, Aaron P., DO** **Panel size for December 31, 2020: 217**	**Canadian Valley Family Care 4470A** Family Practice, 0-18 years of age 1491 Health Center Pkwy. Yukon, OK (405) 806-2200 **Brown, Curtis L., MD** **Brown, James M., DO** **Dorris, Nicholas A., APRN** **Krittenbrink, Andrea L., PA-C** **Medgaarden, Alex E., PA-C** **Roof, Lindsay K., APRN** **Siems, Ami L., MD** **Spence, Lisa, APRN** **Wilbanks, Aaron P., DO** **Panel size for December 31, 2020: 832**
Flores Pediatrics 7440B Pediatrics, 8-21 years of age 415 E. Main, Building B Yukon, OK (405) 350-8017 **Flores, Catherine B., MD** **Flores, Javier A., MD** **Panel size for December 31, 2020: 1527**	**Mustang Family Physicians, PC 8780A** Family Practice, 0-14 years of age 200 S. Castlerock Lane Mustang, OK (405) 256-6000 **Amundsen II, Gerald A., MD** **Crystal Kinzzalow-Hardimon, APRN-CNP** **Panel size for December 31, 2020: 468**

Table 1 CCHAN Affiliated PCPs (cont'd)	
Variety Care at Yukon Pediatrics 9070E Pediatrics, 0-18 years of age 508 W. Vandament Ave. Ste 210 Yukon, OK (405) 350-0200 **Fulmer, Jennifer J., APRN** **Martin, Alexandra, CNP** **Tomichen, Regina, MD** **Nsa,Musheni, MD** **Panel size for December 31, 2020: 732**	

Table 2 presents a snapshot by comparing provider panel sizes in the last month of 2018, 2019 and 2020. There were several factors contributing to the increase in enrollment. First is the effort to update contact information before benefits are suspended. Being able to gather this information before the member being dropped from the panel has proven successful. Secondly, the continued COVID-19 pandemic emergency order has kept members from losing benefits. The dip in numbers in September is due to Variety Care's acquisition of Yukon Pediatrics July 1. When VC@ Yukon was added to as a new provider to OHCA, the clinic was not listed as a medical home, therefore did not show as a member of our HAN. This was corrected for October.

Table 2 CCHAN Benefit Enrollment Counts			
PCP	**December 2018**	**December 2019**	**December 2020**
Variety Care @ Yukon Pediatrics	778	719	732
Flores Pediatrics	1292	1309	1527
Canadian Valley Family Care	670	660	832
Mustang Family Physicians	395	355	468
Mustang Urgent Care	224	217	217
Total Count	**3359**	**3260**	**3776**

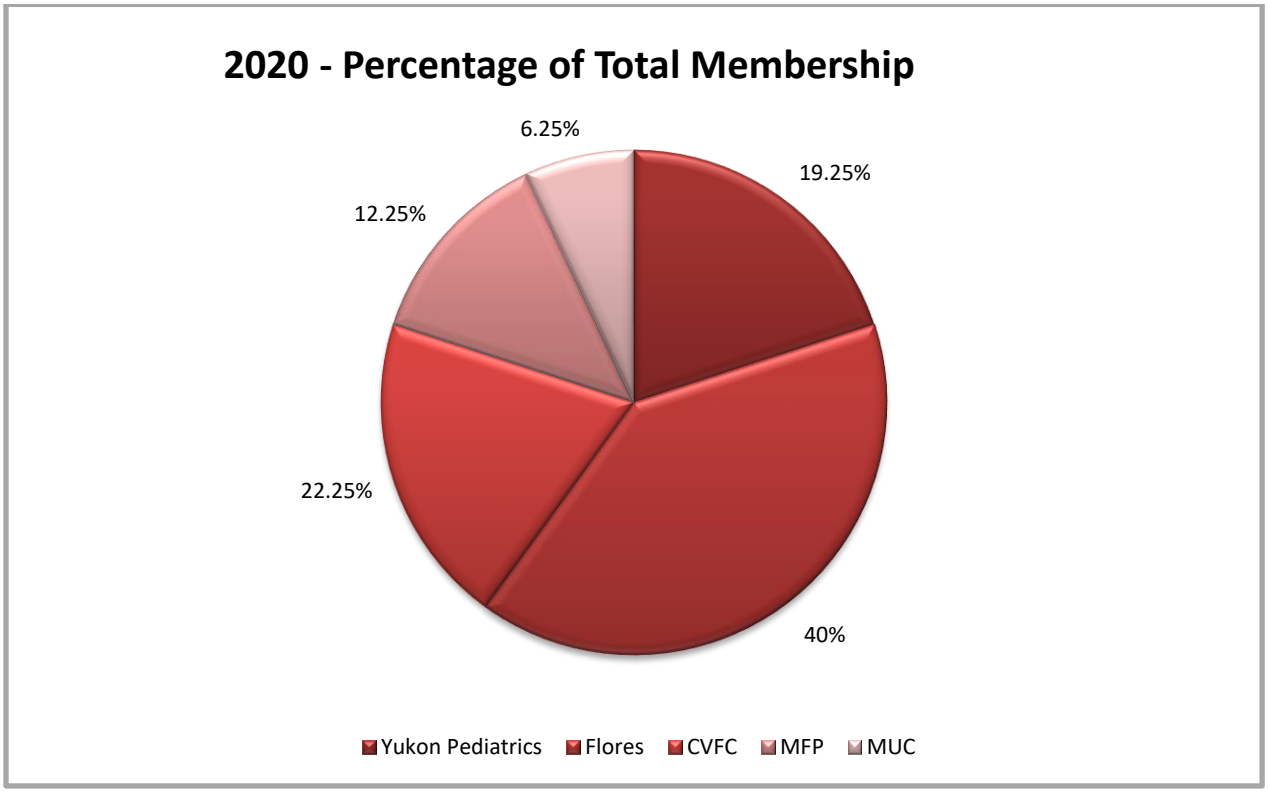
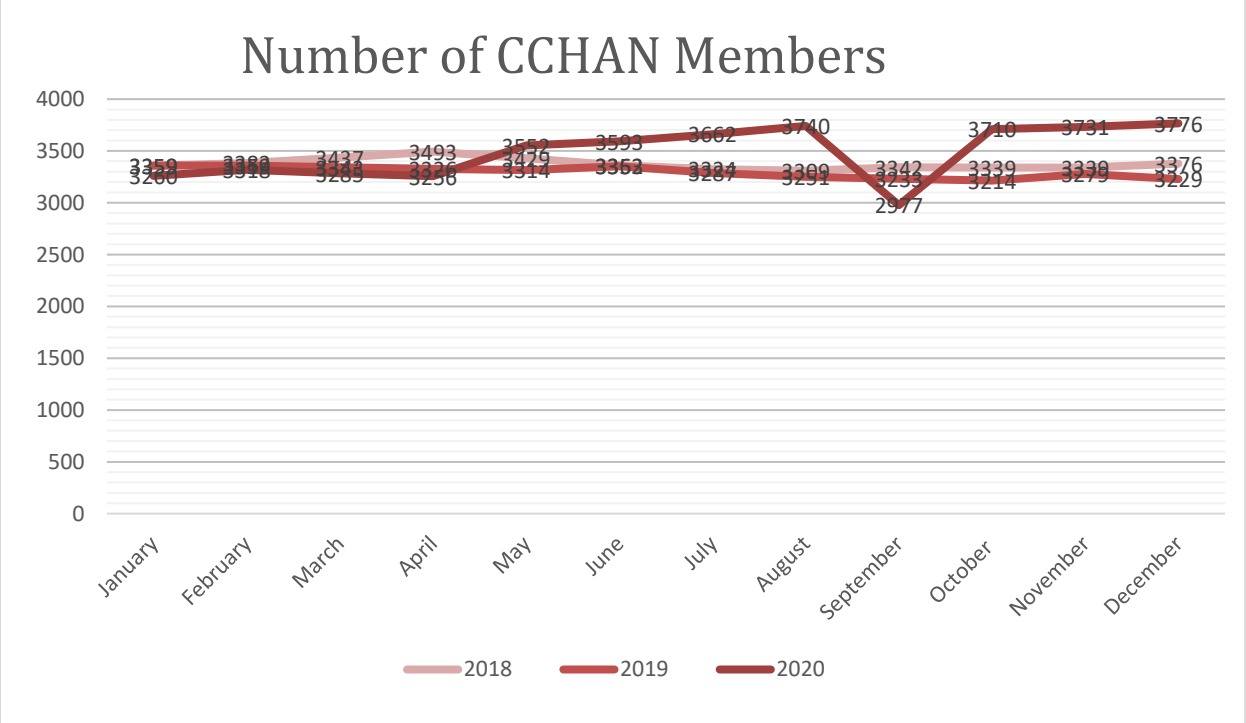


Table 3 shows monthly membership totals for 2018, 2019 and 2020.

	Table 3 CCHAN Monthly Total Members		
Month	**2018**	**2019**	**2020**
January	3359	3359	3260
February	3382	3359	3318
March	3437	3343	3285
April	3493	3326	3256
May	3363	3314	3552
June	3324	3353	3593
July	3309	3287	3662
August	3309	3251	3740
September	3342	3233	2977
October	3339	3214	3710
November	3339	3279	3731
December	3376	3229	3776



Number of entry level or advanced level PCPs identified by name for assistance with level step up in 2020

NONE

Steps taken to assist PCPs in maintaining or advancing their level designation for 2020.

- **Canadian Valley Family Care**: Currently Optimal level.
  Available to staff as needed.
- **Flores Pediatrics**: Currently Optimal level.
  Available to staff as needed.
- **Variety Care at Yukon Pediatrics**: Currently Optimal level.
  Available to staff as needed.
- **Mustang Family Physicians**: Currently Optimal level.
  Available to staff as needed.
- **Mustang Urgent Care**: Currently Advanced level.
  Provided aid with SoonerCare Choice audit and available for additional support as needed.

Delivery of the following reports and educational materials to all providers was ongoing:

- Monthly ED and inpatient reports, EPSDT and periodic ABD rosters
- Tobacco Cessation educational materials/resources
- CCHAN Website Promotional items and brochures
- Canadian County Prescription Dropbox Information/Location flyers
- CCHAN brochures for office distribution in English and Spanish
- Specific educational materials upon request (e.g., Spanish materials on flu immunizations and asthma)
- Flyers on upcoming community wide events that impact members and trainings for professionals.
- Children's Crisis Line information
- Prescription medication lockboxes and disposal bags for members

CCHAN staff also provided assistance during this reporting period with member issues/needs for all providers. This assistance included the following totals:

- **4921 referrals** for goods and/or services
- **210 deliveries of goods,** i.e., food, clothing, personal/household goods
- **10 peak flow meters** were distributed to AIP members.
- **2548 translator assisted communications,** with the aid of CCHAN Resource & Linguistic clerk.
- **7229 educational resources** were distributed to members.
- **343 behavioral health** resources were provided.
- **3226 community resources** were identified and provided to members.
- **45 referrals to specialists** were obtained.
- **1307 daily living needs resources** were provided.

Number of specialty providers:

Number of specialty providers available for SoonerCare Choice members served by our providers: 225 Specialists and 329 public resources for a total of 554 individual resources. Table 4 represents the type and number of providers.

Table 4 CCHAN Specialty Providers	
Type of Provider	**Number**
Medical Doctors - all specialties	63
Behavioral Health - Psychologists, therapist, etc.	66
Therapy - PT, OT, Speech, Dietician, Home Health	52
Developmental Delay / Disabilities	21
Community Resources - Housing, Food, Clothing	117
Crisis Intervention / Support Groups	54
Dental	30
Substance Abuse - Counseling / Support	16
DME	8
Labs & Testing	41
Free Clinics	45
Hospitals	20
Medication Assistance	7
Other Specialties	14
TOTAL	**554**

Care Management

To analyze Central Communities Health Access Network's (CCHAN) effectiveness in reducing costs, improving access, improving the quality and coordination of health care services and improving the SoonerCare Choice patient-centered medical home, the CCHAN provides care management activities and measures on a monthly basis to the following populations:

Asthma
Inpatient
Behavioral Health
ED Users
ABD

Table 5 CCHAN Summary of Care Management

Population	Care Management Members
ED Utilization	One hundred sixty-seven (167) members who had visited the Emergency Department were offered care management services in throughout 2020.
Asthma (AIP)	○ Roster with 55 members in January ○ Roster with 55 members in February ○ Roster with 55 members in March ○ Roster with 55 members in April ○ Roster with 54 members in May ○ Roster with 48 members in June ○ Roster with 49 members in July ○ Roster with 44 members in August ○ Roster with 44 members in September ○ Roster with 45 members in October ○ Roster with 45 members in November ○ Roster with 43 members in December *Note: There were sixty-five (65) individual members involved in the Asthma Improvement Plan throughout 2020.
In-Patient	Two hundred forty-one (241) members who had hospital admissions were provided care management services in 2020. Two hundred thirteen (213) were live births.
Aged, Blind, & Disabled	There was a total of seventy-five (75) members involved in care management in 2020.
Behavioral Health	Forty-seven (47) members have been provided care management for behavioral health issues not identified in the ABD roster.

Emergency Department Utilization

- Members with 3 visits in a 3-month period during report period: **24**
- Members with 4-14 visits in a 3-month period: **12**
- Members with 15 or more visits in 3-month period (Persistent) **0**
- Members with 3 or more ED visits being actively care managed at any time in 2020: **167**

The top three (3) diagnoses for ED visits in 2020 were:

- **Viral Infections including COVID 19**
- **Laceration of Head / Scalp**
- **Abdominal Pain / Acute URI (tied)**

For many years the top three had been fever, URI, and nausea and vomiting. ED brochures had been developed for these diagnoses and are currently used as educational tools in the care management process. The evidence that CCHAN developed ED brochures add value to the care management efforts is based upon member and provider feedback that the brochures are helpful. We have been using a brochure provided by the CDC for flu patients. These brochures are available in Spanish as well. Cough was often a secondary symptom with these diagnoses.

Average report time between emergency department visit and successful provider follow up visit: **17 days .** This number reflects a two day decrease from 2019**.** This includes any follow-up appointment after ED visits, regardless of specialty or primary care.

Table 6 CCHAN Emergency Department Utilization Contacts				
Successful phone call	**Unsuccessful phone call**	**Letters, email & texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
253	162	206	12	**471**

Asthma Improvement Plan (AIP)

A total of sixty-five (65) individuals participated in the AIP program in 2020. At the end of December 2020, forty-three (43) members were actively involved. Ten (10) peak flow meters had been given to members during this period, along with education on how to use them. The majority of referrals for this program are received from participating PCPs. Some come from rosters of members who have had contact with the emergency department or have had an inpatient stay in the hospital. OHCA provides those rosters monthly. All AIPs are developed and implemented collaborating with the member, PCP, and care manager. Copies of each AIP are provided not only to the provider, but to the member as well. In many cases, Spanish copies are provided along with the English copy. The Spanish copy remains in the Spanish speaking homes, while the English copy is provided, by the parent, to the school in which the member attends, along with the rescue inhaler. We have received positive feedback from school nurses for having this information available on the student. Although we stress the importance of receiving the flu shot annually, we target this population. We have a goal of 80% vaccination of these members. Of the sixty-five (65) members served in 2020, thirty-seven (37) received flu shots for a total of 57%, a bit short of our goal. One reason for lack of flu shots of some members is the fear of catching COVID19 if they go to their provider for the shot. We continue to educate and stress the importance of the flu vaccine, especially during the pandemic. No member participating in the AIP have gone to the ED or have been admitted to the hospital since being placed on the Asthma Improvement Program in 2020.

Table 7 CCHAN AIP Contacts				
Successful phone call	**Unsuccessful phone call**	**Letters, emails & texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
735	315	54	27	**816**

In-patient

Monthly reports of members that have been hospitalized and discharged, have been provided by OHCA to CCHAN throughout 2020. Care management services provided for this group are included in Table 8. As the table shows, a total of one thousand one hundred eighty-two (1182) contacts were made to this group, including fifty-four (54) face-to-face visits. Two hundred thirteen (213) of these hospitalizations are for new births. We are able to follow-up with new parents and provide needed resources and support at such a vulnerable time. This also provides an opportunity to educate on the importance of well-child checks. Other hospitalizations are for varied reasons. It has been determined that if we were able to receive this roster closer to real time, we may have even more success with this population, especially with members with behavioral health issues.

Table 8 CCHAN Inpatient Contacts				
Successful phone call	**Unsuccessful phone call**	**Letters & Texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
595	253	254 / 279	54	**1182**

Aged, Blind and Disabled (ABD)

This is our third year to serve this population. The one thing that remains constant is that approximately fifty percent (50%) of this roster has a psychological disorder identified. CCHAN not only provides this benefit to those identified ABD members, but are able to take referrals from our providers for members with psychological disorders as well. All these members are receiving services from the same Nurse Care Manager. All other ABD members are being care managed, as appropriate, by other care managers.

Table 9 CCHAN ABD Contacts				
Successful phone	**Unsuccessful phone**	**Letters, emails, texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
635	204	69 / 170	27	**901**

CCHAN Case Management Initiative - Behavioral Health

Members who experience behavioral / mental health conditions that are of concern to their PCP are being referred for Behavioral Health Care Management. Members who appear on our ED or Inpatient rosters with a Behavioral Health diagnosis are also followed up with an offer of care management. These numbers do not include those on the ABD roster. Forty-seven (47) members have been provided behavioral health care management that were not identified as ABD. Of those forty-seven (47) members, six (6) had been hospitalized prior to care management services. After care management engagement, only two (2) members have been hospitalized.

Table 10 CCHAN Behavioral Health Contacts				
Successful phone	**Unsuccessful Phone**	**Mailings/ Texts/E-mails**	**Face-to-Face**	**TOTAL CONTACTS**
489	187	37 / 57	13	**596**

OTHER

During this reporting period, thirty-seven (37) other SoonerCare Choice members were provided either care management services or referrals. Two hundred sixty (260) contacts were made to these members who were not associated with a particular target population within CCHAN.

The AHC screening tool is being used to determine level of care for each member referred to CCHAN. It may lead to a member needing full care management, or simply a referral or educational materials provided. A total of twenty-six (26) screens were completed in 2020. The Nurse Care Managers have found this tool to be extremely helpful in building relationships with our members. This is also used to develop care plans.

Monthly Care Management Team meetings were held. The project manager for Red-Rock Systems of Care is a member of our team to provide much needed behavioral health expertise. Our Sooner Success representative, Janet Wilson, continues to provide priceless support for our care team when issues arise with our ABD members. We are fortunate to have service providers in our area that are available to come talk with us during our care manager meetings. Due to the emergency mandates in regards to the COVID19 pandemic, our monthly meetings have mostly been electronic. We did meet in person in January, February, May and June keeping social distancing. All other monthly meetings were conducted virtually.

Health Information Technology

The Access database used to document and maintain records of care management contacts is considered a technology strength for CCHAN. The database also provides for aggregation of data by member name/ID, program, type of contact, and date of contact as well as maintaining nursing notes. We were able to replicate the AHC screening tool to enable care managers to enter the data directly onto the database in the AHC screen format. From that, a care plan is generated with fields populated with data from the AHC screen. Both databases are connected resulting in less data entry and more options for reporting.

CC-HAN Website (http://CC-HAN.com/): The Central Communities Health Access Network website continues to provide health preventive/management information and resources for members and the public at large. Information about CCHAN participating Providers and staff is also available through our website with linkage to the provider's websites. In addition, a specialist list with contact information is housed on the website, although password protected for provider access only. A list of community resources is available to the general public. This website is also available in Spanish.

We receive a number of requests from outside agencies / programs requesting linkage on our site. These requests are carefully reviewed and added when appropriate. We never want to appear to endorse a product or program through association. We are able to collect data on where people are from that visit our site. Most are from Oklahoma, but an increasing number are coming from other states within the boundaries of the United States of America. A small percentage are international visits. In 2020, there were a total of 643 visits to our CC-HAN web site.

Quality Assurance

To improve quality and access to healthcare services and to reduce costs, CCHAN:

Continued strategies to increase the number of SoonerCare Choice children in CCHAN contracted Medical Home practices who receive well-child visits with appropriate health screenings, in accordance with EPSDT guidelines. The estimated level of achievement will be an increase in the total number of claims from 2019 for each Preventive Code.

The primary strategy to increase the number of well-child visits is ongoing. EPSDT reports provided monthly by OHCA facilitate contacts with members' families to remind them of the upcoming well-child check. This correlates directly with the following efforts:

- To facilitate attainment of CCHAN quality measure to increase the number of SoonerCare Choice children in CCHAN Medical Home practices who receive well-child visits with appropriate health screenings.
- To contact SoonerCare Choice members to encourage compliance with well-child/EPSDT visit schedule(s); communications will also include contacts to provider offices for contact information updates as needed.
- To refer members needing additional information/clarification or with health-related questions/concerns to Project Manager who will assign to nurse care management if needed.
- To assist members in identifying resources to address obstacles to access of care.

CCHAN providers continue to show support for the contacts made to increase well-child visits. With a bilingual clerk coordinating the contacts due to the number of Spanish-speaking families served, it is hoped that improvements in communication may result in continued increase in visits for 2021. Accessing information from our provider panels gives additional support for contacting members. Tables 11 and 12 present the number/types of EPSDT contacts. The ability to use telehealth for well-child checks during the pandemic has contributed to the increase in the numbers of claims for this reporting period. Providers have shared that people are unwilling to come into the office unless absolutely necessary.

Table 11 EPSDT Claims 2018-2020

Preventive Code	2018 claims / % change from 2017		2019 claims / % change from 2018		2020 claims	% change from 2019
99381	117	15%	130	10%	245	189%
99382	80	9%	69	-16%	117	170%
99383	112	16%	98	-14%	128	131%
99384	67	37%	61	-10%	78	128%
99391	1004	NC	987	-2%	1230	125%
99392	860	-10%	887	3%	1082	122%
99393	1032	24%	859	-17%	914	106%
99394	699	38%	551	-27%	622	113%
TOTALS by YEAR	**3971**	**12%**	**3642**	**-8%**	**4416**	**121%**

EPSDT CONTACTS BY TYPE 2020					
Month	**SPC**	**UPC**	**Texts**	**Letters**	**Total Attempts**
January	232	336	93	1	**662**
February	247	334	92	10	**683**
March	237	326	106	5	**674**
April	248	320	92	0	**660**
May	253	338	105	1	**697**
June	291	383	109	0	**783**
July	269	381	115	2	**767**
August	288	362	116	2	**768**
September	319	425	122	16	**882**
October	260	324	103	31	**718**
November	234	312	101	21	**668**
December	281	358	146	29	**814**
TOTALS	**3159**	**4199**	**1300**	**118**	**8776**

Develop, implement, and/or strengthen at least two strategies to facilitate increased access and delivery of preventive health care services for SoonerCare Choice members in 2020.

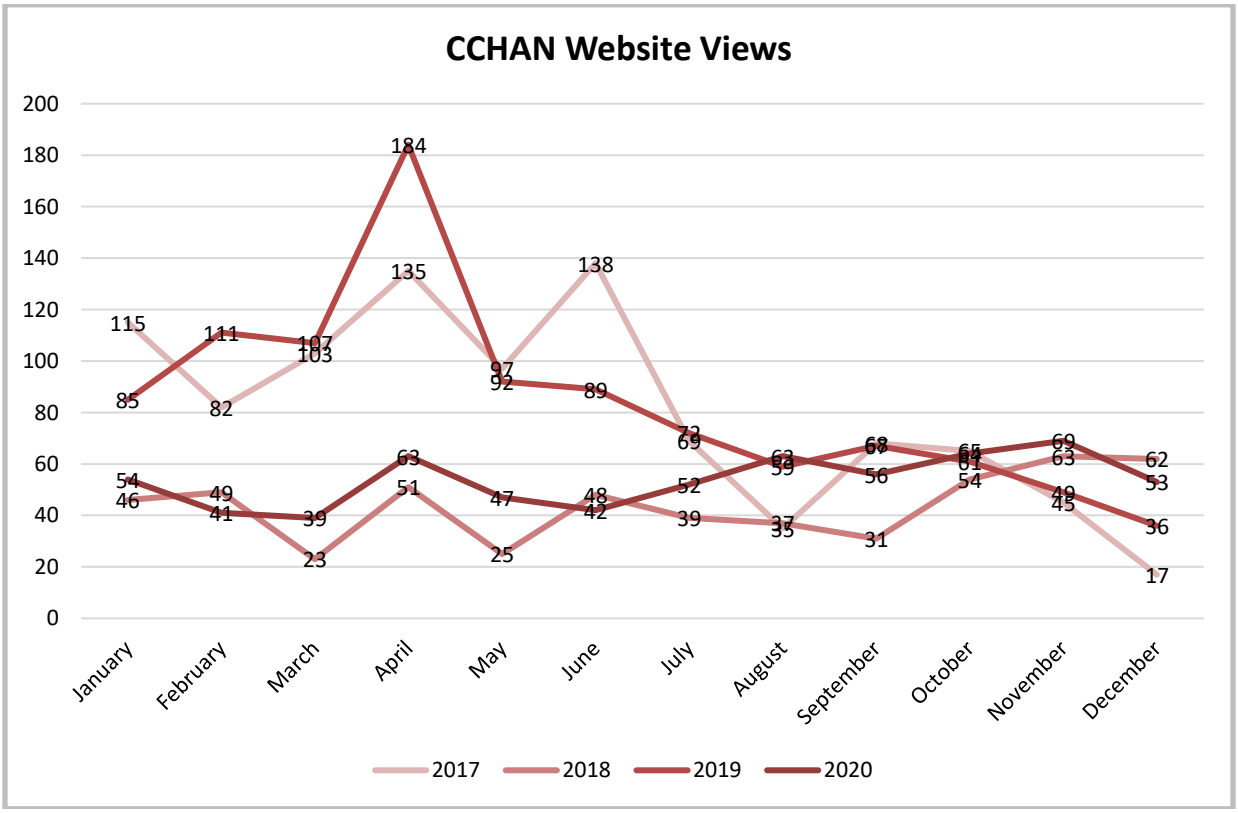
The first strategy to achieve the quality measure is the CCHAN website, http://CC-HAN.com. Varied sources of input are utilized to guide content decisions for the website, including the Health Management Resources. The intent is to provide appropriate and accurate content which is also considered relevant to the individuals and communities served. Content decisions are obtained from SoonerCare members and families; care management contacts and needs; Providers and their staff; and general input/suggestions obtained from other interested parties (e.g., County Health Department staff, Sooner Success program staff, health and public educators). Content sources include varied evidence-based clinical resources. The project manager also identifies special topics to be featured through the Home Page, depending on current health issues or seasonal health concerns. Examples include mental health awareness emphases or flu season information.

Two primary methods are used to promote website use. First, promotional items imprinted with the message **"*Health Questions?* Go to CC-HAN.com for help"** are widely distributed through PCP offices, Youth and Family Services of Canadian, Blaine & Kingfisher counties, various health promotion events (i.e., health fairs and back-to-school events), community meetings of health professionals and social services personnel, and at public sites including community libraries and county health departments in Canadian, Custer, Blaine, Kingfisher and Logan counties (central Oklahoma). In addition, a professional commercial artist assisted with development of a web-site promotion brochure entitled **"Questions About Your Health Care?"** which is also widely distributed (through sites and events as above). The website is now available in Spanish as well.

A website review program provides site statistics which are reviewed at least quarterly for assessment and planning purposes. Efforts to promote use of the website for preventive health services as well as general information about CCHAN and Providers have been ongoing.

The utilization of site stats has been found to be very useful in guiding CCHAN efforts to promote access and delivery of preventive health services. Table 13 presents information and trends on CCHAN website views. Numbers for 2020 were not as high as we had hoped. Revisions have been made, and CCHAN has moved up the list on several search engines, resulting in slightly higher numbers. Our hope is the numbers will continue to increase. Other promotional items are being utilized to promote the webpage, to include personal thermometers, hand sanitizer, and lip balm with the web address and logo imprinted.

Table 13 CCHAN Web Site Views				
Number of Views per Month	**2017**	**2018**	**2019**	**2020**
January	115	46	85	54
February	82	49	111	41
March	103	23	107	39
April	135	51	184	63
May	97	25	92	47
June	138	48	89	42
July	69	39	72	52
August	35	37	59	63
September	68	31	67	56
October	65	54	61	64
November	45	63	49	69
December	17	62	36	53



The second major strategy for achieving quality measure 2 is the utilization of educational brochures. The brochures/flyer are based on top historical diagnoses for emergency department visits. Previously developed brochures/flyers were reviewed for accuracy and relevance and will continue to be used for member and general public education related to the following diagnoses:

Nausea and Vomiting	Otitis Media (Ear Infection)
Upper Respiratory Infections	Abdominal Pain
Back Pain	Cellulitis
Children with Fever	Headaches
UTIs	Tobacco Use Disorder
Asthma	Hypertension
Diabetes	PTSD & ADHD

The distribution process for the brochures includes:

- PCP offices are provided copies of the brochures to assist with patient education
- All SoonerCare Choice members with related ED visits are provided (appropriate) brochure(s) as a part of their care management
- The brochures are also provided to other members with (related) health concerns
- Brochures are shared through various community events and sites such as Health Fairs, Community Baby Showers, educational seminars, Coalition meetings, and educational settings
- Web flyers are created for each topic and made available via the CCHAN website
- Electronic versions on flash drives were made available to all providers

The educational value of the brochures has received support through anecdotal evidence. The brochures are well received by PCPs, and other health care professionals in the communities served. Though challenging to provide directly linked, data-driven evidence to support the value of the brochures, their use as educational tools will continue as they are well-received by members, PCPs (who approved the content of each), and other health care professionals in the communities served.

We monitored the number of hospitalizations for each member engaged with CCHAN's Asthma Improvement Plan throughout 2020. The estimated level of achievement for this quality measure will be a reduction in number (or zero) annual hospitalizations (asthma related diagnoses) for each engaged member, comparing to pre-AIP participation. Overall, the total number of members engaged in the AIP has increased while all other measures have remained the same or decreased.

A goal of at least 80% annual flu immunization level for all AIP members in 2020. We fell a bit short of that goal this year. Thirty-seven (37) of the sixty-five (65) AIP members who were engaged in the AIP were known to have been immunized for flu, which is 57% of this population. The 80% level will remain the CCHAN benchmark because of sound evidence that immunization is the best way to prevent the complications associated with flu and because of the higher risks for flu complications for individuals with asthma. Educational efforts will continue.

Table 14 CCHAN AIP Evaluative Data

	Totals for 2018	Totals for 2019	Totals for 2020
Total No. AIP Members	53	85	65
Total No. of Hospitalizations prior to AIP Engagement	2	2	5
Total No. of Hospitalizations for Asthma Related DX after AIP Engagement	1	0	0
Total No. of ED Visits for Asthma Related DX prior to AIP Engagement	34	27	25
Total No. of ED Visits for Asthma Related DX after AIP Engagement	13	2	0
Total No./Percentage of AIP Members who received flu vaccination	39 for 78%	50 for 83%	37 for 57%

Care manager encouragement to utilize urgent care facilities rather than hospital EDs (when appropriate) will continue along with education about symptom control and recognition of the symptoms which are true emergencies. Education stresses the importance of maintenance medications, to keep from having a crisis situation.

Impact of Health Access Networks on Quality of Care

Decrease asthma-related ED visits for CCHAN members with an asthma related diagnosis identified in their medical record.

As Table 15 shows, the number of ED visits (with asthma-related diagnosis) by CCHAN members who have asthma identified in their problem list (claims data) dropped dramatically from 2018. This is positive support of CCHAN work although opportunities for improvement continue. Staff members monitor closely all ED visits for asthma diagnoses, discussing possible referrals with PCPs and/or members as follow-up to those visits.

The data related to overall use of the ED for CCHAN members in 2020 shows continued decline over previous years. The data is supportive of the following CCHAN efforts to reduce overall ED use:

- Care management contacts to all members with ED visits in the previous month
- Care management contacts include phone, letter, and face-to-face meetings
- Educational materials including the CCHAN ED Diagnoses brochures and/or other educational resources are provided to members with ED visits
- Referrals for daily living needs or other resources are made as indicated
- Follow-up for all members with asthma-related diagnoses in either ED or inpatient reports to determine if participation in AIP is indicated
- Deliveries of monthly ED reports to each CCHAN provider with requests for latest member contact information as well as date of last office visit and next scheduled
- Care management encouragement to follow-up with PCP for all members who have ED visits or inpatient stays
- Reminders of PCP office hours and 24/7 availability via telephone
- Services and materials are available in Spanish

TABLE 15 KEY QUALITY PERFORMANCE MEASURES

Decrease asthma related ED visits for CCHAN members with an asthma related diagnosis identified in their medical claims record.	**2017**	**2018**	**2019**	**2020**
Total number of ED visits by CCHAN members with asthma identified in their problem list for an asthma-related diagnosis.	26	57	27	25
Decrease 90-day readmissions for asthma related conditions for members with an asthma diagnosis identified in their medical claims record.	**2017**	**2018**	**2019**	**2020**
Total number of CCHAN members with asthma identified in their problem list who were readmitted to the hospital for an asthma-related illness within 90 days of a previous asthma-related hospitalization.	0	0	0	0
Performance Measure C: Decrease overall ED use for CCHAN members.	**2017**	**2018**	**2019**	**2020**
Numerator: Total number of ED visits for CCHAN members.	1500	1234	1200	787
Denominator: All CCHAN members.	3915	3359	3260	3776
Dividend for Performance Measure C:	.38	.37	.37	.21

Other CCHAN Distinctives

The CCHAN continues to have distinctive characteristics that are considered important to highlight. From the earliest planning stages for CCHAN, it has remained the intention of the parent non-profit organization, the Partnership for Healthy Central Communities, to develop a network that improves health care for SoonerCare Choice members and addresses the challenges of the underserved populations in central Oklahoma communities. The vision includes CCHAN serving as the central hub to coordinate information and referrals for members, providers, and other community residents. Underlying assumptions are that healthcare costs can be reduced while access to coordinated care is enhanced through HAN services. SoonerCare Choice members will benefit, providers will benefit, and the communities served will also benefit. Another important expectation is that CCHAN will contribute to improved utilization of community based behavioral and social health resources by improved education for providers, members, and other community residents about available services.

Efforts to develop broad community relationships and expand the information about available services for individuals in need of health care continues. Highlights of activities and accomplishments which illustrate the unique characteristics of CCHAN are presented below. Further information may be found in the bi-monthly project manager reports from 2020, which are readily available upon request.

- **Follow-up on needs and concerns of PCPs** remain priorities for the CCHAN staff. Examples include assistance with Medical Home requirements and audits and availability to assist with matters as varied as billing questions, possible rate cuts, prior authorization matters, OHCA requirements on various matters, and need for specialists. CCHAN staff provides educational presentations for participating PCPs and staff. In 2020, some specific examples include:

    - The PHCC Board approved funding to purchase additional peak flow meters to distribute to AIP members.
    - Throughout 2019 CCHAN staff members have worked closely with all providers to coordinate care through care management and to implement the AIP. A total of ninety-two (92) members who were not a part of one of our targeted populations were provided care management services throughout the year, demonstrating the collaborative relationships between CCHAN, providers, and staff. Fifty-five (55) of these members were referred for behavioral health concerns. Thirty-seven (37) referrals were received from providers to follow-up with members where there were concerns. Many had missed more than three appointments; others were non-compliant with their medications. Nurse Care Managers were able to make contact and determine what the needs were to improve outcomes.

- **Collaborative work between CCHAN providers and staff** was ongoing through 2020 to improve coordination of care and increased quality of care for members. CCHAN care management staff have provided face-to-face contacts with members since the CCHAN's inception. Reasons for home visits have been varied but include home safety assessments, deliveries of food, clothing or household supplies, deliveries of peak flow meters and asthma educational packets, and providing education/support, particularly with child development and care. A total of 210 deliveries of goods were made by CCHAN care management staff. New baby packets were also developed and mailed to 213 new mom's that appear on our in-patient rosters.

- **Meetings with all PCPs and their key staff** to address common concerns and to determine ways CCHAN can facilitate their practices occurred primarily through office visits, emails, text messages, and phone contacts. Due to Covid 19, office visits have been limited. We do plan to have informational meetins with all providers when we are able to gather in person once again.

  250 Provider contacts made 2020. Contacts are as varied as deliveries of rosters (e.g., EPSDT, Inpatient, or ED visits) and addressing specific questions providers may have about billing or member concerns. We also receive their referrals for other members for whom they request care management contacts. Thirty-seven (37) referrals of this type were received.

- **PCP and member support** continue to include acceptance of referrals of other members who need educational or other assistance. A total of 260 contacts were made to this group.

- **Monthly CCHAN Care Management Team meetings** for 2020 were held on 1/27, 2/24, 5/19, and 6/24 in person. The remaining months were met via google meet or zoom. These meetings provide an opportunity for CCHAN staff to meet with the team to discuss challenges and celebrations. Guest speakers come periodically to inform the group of new programs or resources available in the community.

- **Community Involvement** continues to be a priority with CCHAN. Project Manager participated in the Infant Mental Health and Trauma Resource Team, a subcommittee of the Canadian County Coalition for Children and Families. The project for 2020 was to promote and provide support to local law enforcement and public schools with their implementation of "Handle with Care". This program allows law enforcement to connect with the school of a child they may have had contact with. They only alert the school counselor, or designated person, that contact with that child and/or family was made. The school official can then simply check in with the child to ensure things are ok. If not, then appropriate referrals can be made.

  In partnership with Red Rock Prevention Services, CCHAN was provided medication lock boxes and medication disposal bags to distribute to our members. We continue to be able to provide these lock boxes and medication disposal bags to our members.

CCHAN staff participate in the Canadian County Coalition for Children and Families (project manager serves as chair). Medical Director also attends this monthly meeting.

Infant Mental Health and Trauma Resource Team (project manager and Medical Director)

Partnership for Healthy Central Communities Board of Directors

Project Manager attend bi-monthly meetings with OHCA Administration.

Nurse Care Managers attends staffing with Red-Rock Systems of Care for updates on mutual members / clients.

Ongoing implementation of the Asthma Improvement Plan (AIP) with growth in number of members served and positive outcomes.

Ongoing utilization and additions to the searchable specialist and resource list that is hosted on the web-site

Ongoing development/implementation of database for oversight of care management responsibilities and communications

Ongoing implementation of HIPAA compliant instant messaging system for facilitating CCHAN staff communications

Periodic discussions with Medical Director (both face-to-face, phone, electronic communications) about CCHAN implementation and future goals.

The Core Strengths continue to serve as directives for administrative decisions and day to day activities.

Core Strength #1: Community Integration for the Medical Home Model, including

- Relationship building
- Strengthening the Medical Home concept
- Area wide services

Core Strength #2: Practice Independence Enhancement for Providers, including

- Offering Providers ways to improve cost effectiveness and time efficiency by providing staff who are readily accessible when assistance is needed
- Assisting Providers in complying with CMS/OHCA requirements

Core Strength #3: Providing a Safety Net for Members and Providers, including

- Care management services, including face to face, home visits, phone, and mailing contacts with the ability to communicate in Spanish and English
- Extending care management services beyond those contractually required to include others referred by providers

The Partnership for Healthy Central Communities Board as well as the Central Communities Health Access Network staff believes the Core Strengths continue to describe the current status of the Network and serve well as a framework for future planning. We look forward to ongoing efforts in 2021 as we continue work to demonstrate success in meeting both OHCA/CMS expectations and CCHAN Mission: ***To improve health care for SoonerCare Choice members and to address the challenges of the underserved populations in Central Oklahoma Communities*.**

The success of the CC-HAN would not be possible if not for our community partners. The following have made a difference in the lives of our members.

Red-Rock Systems of Care
Youth & Family Services
Sooner Success
Infant Crisis Services
Ashbrook Foundation
Mustang Heights Baptist Church
El Reno Community Action
Blessing Baskets of El Reno
Able Tech DME
Bethleham Star Church
Willow Pregnancy Support
Catholic Charities
Urban / Skyline Ministries
Toys for Tots
Epiphany of the Lord Church
OK Bikes for Kids
Alameda Church of Christ
OKFD Smoke Alarm Program
Red-Rock RPC
Redlands Community College
Canadian County Health Department
Manna Pantry – Yukon
South Yukon Church of Christ
Mustang Christian Church
Oklahoma Family Network
Sunbeam Family Services
Mustang Kiwanis
Love of the Children – El Reno
Sharing Tree – Moore
Coat – a – Kid
Salvation Army
360 Family Support
The Lord's Harvest
St. Vincent DePaul
Cleveland County Community Action

Respectfully submitted by Cindy Bacon, Project Manager with assistance of:
Karen McKeever, RN, Nurse Care Manager
Rhonda Chronister, RN, Nurse Care Manager
Kim Johnson, RN, Nurse Care Manager
Amanda Perks, RN, Nurse Care Manager
Mary Cuevas, Linguistics & Resource Specialist

Appendix A

Emergency Department Utilization Table for 2020

ED Utilization					
	Total number of Members	**Number of Contacts**	**Number of ED Visits (claims)**	**Number of PCP Visits**	**Average Time (days) Between ED Visit-PCP Visit**
Totals	**426**	**225**	**448**	**95**	**18**

Appendix B

AGGREGATE NUMBERS FOR ED VISITS				
Two (2) visits in Quarter				
Q4	Q3	Q2	Q1	TOTAL
19	19	11	49	98
NC	72% increase from previous quarter	22% decrease from previous quarter	Baseline data.	Overall decrease from baseline data.
Three (3) Visits in Quarter				
Q4	Q3	Q2	Q1	TOTAL
7	2	1	14	24
250% increase from previous quarter.	100 % increase from previous quarter.	7% decrease from previous quarter.	Baseline data.	Overall decrease from baseline data.
Four (4) or more Visits in Quarter				
Q4	Q3	Q2	Q1	TOTAL
4	2	1	5	12
100% increase from previous quarter.	100% increase from previous quarter.	80 % decrease from previous quarter.	Baseline data	Overall decrease from baseline data.
FIFTEEN (15) Visits in Quarter				
Q4	Q3	Q2	Q1	TOTAL
0	0	0	0	0
No change from previous quarter.	No change from previous quarter.	No change from previous quarter.	Baseline data	NO CHANGE
Total Contacts 2019				
Q4	Q3	Q2	Q1	TOTAL
82	145	127	98	452

Appendix C

Care Management Highlights

Five-month-old is on our roster for three or more ER visits in a three-month time period. She has an older sister, who has Down's Syndrome and is on our ABD roster. In January, the five-month-old went to the ER with a high fever and tachycardia. She was diagnosed with pneumonia and sepsis and sent by ambulance to Children's Hospital where she was admitted. I spoke with her mother while she was in the hospital. Mom shared that the baby's heart rate was 230 when she was admitted, and that they were having trouble getting it down to a normal rate. I asked about her respiratory symptoms, and she told me that member was still experiencing congestion and coughing. She said that no breathing treatments had been administered while she was in the hospital, but she planned on bringing the nebulizer and Albuterol from home and giving her a treatment. It was explained that one of the side effects of Albuterol is increased heart rate and that giving it without the doctor's order could have extremely serious side effects. She was instructed to talk to the doctor when he makes rounds about her continued respiratory symptoms and what treatments are available. It was also explained that if she feels her daughter's condition requires immediate attention, she should call a nurse and ask that the doctor be notified. After discharge, she was seen for follow-up by Dr. Flores, who changed her medication from Albuterol to a different drug which has less impact on heart rate.

Nine-year-old girl, born at 26-week gestation and 1 lb. 9 oz. Her mother speaks only Spanish. She was receiving SSI because of her developmental delays. Recently, member made such good progress that she no longer qualified for SSI (or our ABD program). Following removal from the ABD program, I spoke with her mother and found that she no longer had SoonerCare. The mother thought that if the child did not qualify for SSI, she would not qualify for SoonerCare. The family had been paying out-of-pocket for medical care and therapy. It was explained that if they qualify by income, member could get back on SoonerCare. They were encouraged to re-apply as soon as possible. Member is now back on our SoonerCare roster and her medical therapy needs are covered.

Nineteen-year-old ABD member with autism received training for a community job last year. Mother contacted the training facility to find out the status of member's job placement and was told now that member was of age, they were unable to provide any information to her as she was not member's legal guardian. Mother had attempted to obtain guardianship. Provided mother with information and contact numbers for Legal Aid of Oklahoma and Oklahoma Disability Law Center. Also, provided contact number for Oklahoma Family Network and advised that they provided advocacy and support for families of children with disabilities. At last contact with mother, translator and care manager were told that member had met that day with job placement services and will begin training from 8 a.m. to 3 p.m. weekdays, washing articles, and then in August will be assigned a job in the community. Mother verbalized her gratitude for information and support translator and care manager had provided.

Member is a twenty-two-year-old female with a history of bi-polar disorder. While providing care management services initially, member was frequently non-compliant with her medication regimen, did not attend therapeutic appointments and experienced lapses in her SoonerCare benefits. As rapport was eventually established between care manger and member, member became more comfortable with sharing her issues and concerns with care manager. Numerous referrals were provided for mental health professionals. Member has now become engaged with the mental health system, attends therapeutic appointments, is compliant with her medication regimen and verbalizes a more stable mood. Member began working in the community and has been successful as an employee and has been placed in a position of responsibility. Care Manager was recently contacted by member who informed that she has been attending college and had received a B+ for a final grade in her first class. When asked what she was focusing on, member replied, "I am getting my bachelor's degree for science in psychology, I want to be a counselor in trauma to help people the way I didn't get help".

Member has an extremely weak immune system due to her spinal muscular atrophy. Her mother was unable to find masks to protect her and the other family members from Covid-19. We were able to find and deliver several masks, both fabric and paper, and deliver to the home. The mother is only able to work 3 days/week, and they were low on groceries and toiletries. We were able to provide some of these as well by accessing food pantry at South Yukon Church of Christ. The mother shared that she is feeling a great deal of stress but does not feel comfortable leaving the home for counseling. Information was provided regarding telehealth sessions that are available through Red Rock Behavioral Health. Contact information was provided. She was also encouraged to utilize Community Action and Blessing Basket. She was encouraged to apply for SNAP, and translator was able to help with letters from SNAP requesting additional information.

We called to follow up with a high-risk family (children in the custody of grandmother) and were told that they had almost nothing to eat. We provided resources for food and delivered a box of food to the home from South Yukon Church of Christ. The grandmother complained that she had a tooth that was "terribly decayed and breaking apart". We provided resources for free dental clinics.

Six-month-old twin brothers were hospitalized with extreme weight loss. While following up with this family, they shared that the family needed food, clothing, and diapers. Resources were provided and we were able to deliver clothing from Mustang Heights Baptist Church, diapers obtained through private donations, and food from South Yukon Church of Christ.

Care Manager was notified by PCP office with request for assistance obtaining information from DHS. Member was a six-day-old infant who had been placed in emergency foster care. PCP staff reported they were unable to obtain any information on the infant as DHS had not returned foster mother's or PCP staff's phone calls. Project Manager was notified of the situation and sent an email to the DHS Supervisor. DHS Supervisor immediately responded to the situation. Within a short amount of time, foster mother was contacted by two DHS case workers as well as the DHS Supervisor and information was obtained which allowed PCP to obtain birth and family history and provide care needed to the infant. Care Manager was contacted by the foster mother and was told that she is also fostering the baby's siblings (3-year-old and 18-month-old). She reports that when the children arrived at her home, she was not provided any formula, diapers, or clothing other that what the children were wearing. (Per foster mother, the 3-year-old was in a t-shirt and underwear and the 18-month-old was wearing a diaper only) Foster mother reports that she was initially told that baby was two months old. Prior to receiving the children, foster mother had purchased diapers for a two-month-old not a six-day-old baby. Foster mother shared that she had tried to return the diapers for an exchange and was told that due to the pandemic, exchanges were not occurring. Foster mother requested assistance with diapers if possible. When asked if she had formula for the baby, was told that PCP's office had provided a supply of formula. Inquired about clothing for the children, was told that friends had provided clothing. Care Manager received approval from Project Manager to utilize Ashbrook Foundation funds to obtain diapers and wipes for both the infant and 18-month-old sibling. Porch delivery of diapers and wipes was made to foster mother's home. Foster mother was provided information and contact number for Mustang Heights Baptist Church baby room for clothing and baby items if needed.

Newborn girl whose parents were contacted by phone to follow-up and mailed a New Baby Packet. The contact seemed unremarkable, we confirmed that baby and mother were doing well and that needs were being met. Several days after the call, baby's grandmother from North Carolina called. She said that she wanted to send us a big thank-you for providing information, resources and caring for the baby and her parents. She said that the packet we provided, and the phone call were much appreciated, and that her son expressed so much appreciation that we were able to be there for them. She said that her son and his family have only recently moved to our area and did not know what was available to them.

Newborn babies in a Spanish speaking home were experiencing digestive issues. The PCP ordered Similac Sensitive and gave the family some samples. The formula was very effective, and the babies did well with it. They took their prescription to WIC, but an alternative formula was offered, as they do not routinely provide Similac products. The mother did not understand that the offered formula should be very similar to Similac Sensitive, so she declined it. We were able to locate 4 tubs of the Similac Sensitive formula from Willow Pregnancy and Mustang Heights Baptist Church, which were delivered to the family along with needed diapers and wipes. RN spoke with the WIC representative and was able to relay to the mother, with translator's assistance, that the offered formula was very similar to Similac Sensitive and should not cause constipation, which was the mother's main concern. We encouraged her to get a canister of the formula and try it, which she did. There have been no more concerns with the formula. This family was very excited to receive back-to-school socks and underwear for the older children.

Twin brothers were born at 31-week gestation. They were put on our roster in May, after they had both been hospitalized for failure to thrive. The mother, who is Spanish speaking, explained that both babies had developed "a lot of phlegm" and it had become difficult to eat. Following the treatment, both babies gained significant amounts of weight. She shared that the family needed food and diapers. They were given several food resources and told about Infant Crisis Services. We also delivered a box of food (provided by SYCOC), diapers and wipes. In June, both babies tested positive for Covid-19, as did their father.

In July, one of the twins was hospitalized and an NG feeding tube was inserted due to his inability to take in adequate nutrition. At this time, he had dropped down to eleven pounds and was nine months old. He was sent home with the feeding tube and a pump. The parents did not receive adequate home care instructions and were turning off the pump because they were afraid that he was getting too much. Mom said that while in the hospital, the baby was receiving one ounce of formula per hour and that at home, the pump was set at two ounces per hour. It was determined the baby was not experiencing distention, vomiting or diarrhea. We advised her that the recommended rate is a reasonable amount of formula and advised her to continue the feedings 24 hours per day. They were also running out of feeding bags and tubing because they were disposing them after each feeding as opposed to daily. They were also running out of formula. The mother was advised to contact the hospital, her discharging physician, and Dr. Flores to confirm proper discharge care. She was urged to call WIC about increasing the amount of formula provided. She said that she tried to do these things but was unable to receive the information needed and she shared that her inability to speak English was making things more difficult. She was able to talk to WIC and get the amount of formula increased.

We contacted the hospital to confirm discharge instructions and to determine the contract agency that was providing the feeding pump. After numerous calls, additional feeding tubes and bags were delivered, additional formula was procured, and discharge instructions were obtained and provided to the parents. The mother was made aware of follow-up appointments with specialists. The mother continued to seem confused about how to handle the feedings and the pump. We conferred with Dr. Flores' office, and home health was brought in. Baby began to gain significant weight.

Both babies developed severe allergic reactions to most brands of diapers, and the mother shared that the only diapers that she had found that worked for the babies were Huggies. Infant Crisis Services was out of Huggies, so she used the provided brand, and baby developed open blisters for which he had to see the doctor. We contacted Youth and Family Services, who provided Huggies diapers.

Staff made many resource and translations calls, assisting this family. Covid-19 testing centers in the family's neighborhood were located so the mother could be tested and so the other twin could be retested. We continue to maintain contact with this family. Baby will be having surgery next month to have a permanent gastric feeding tube inserted and to have his hypospadias repaired. Because of the father's inability to work the family continues to have needs. Numerous resources have been provided.

Member's father from EPSDT list shared that they had recently been approved for SoonerCare Choice. In doing so they were unable to continue seeing their pediatrician and chose a new physician within our network of providers. One of the children was on medication for ADHD and was finding success with it. They were paying $500 per month out of pocket due to being denied by OHCA for payment. The reason for denial was due to current physician had not prescribed other medication that OHCA wanted them to try first. All those medications had been tried with the prior physician, but apparently that information had not been forwarded to OHCA. Once prior records were received by OHCA and new provider, RX was approved, and member was able to begin taking his meds again.

Member is one of our new babies. His mother, a first-time mom, has no insurance and very low income. She felt that her Cesarean Section incision was not healing properly. She tried to make an appointment with her obstetrician and was told that she would have to pay $185 to be seen. Provider was contacted and was able to clarify issues so that the price would be $73. We then sent her contact information for some free clinics. She followed up with one of these and was seen at no cost. She says she is now doing well and thanked us for our assistance.

Member is a three-year-old boy with neoplasm of the spinal cord. He went through surgery and then a long series of radiation therapy about seven months ago. His cancer has not responded as well as hoped to the treatments and they are now considering chemotherapy. At the same time, his mother started feeling ill and to her despair, discovered that she was pregnant. Over the next couple of months, she came to accept that they would be having an additional member of the family and even embraced the pregnancy with joy. During a recent conversation, she asked if it might be beneficial to save the new baby's cord blood. I encouraged her to ask her son's oncologist if this might help him in the future, and he related that "It could be extremely helpful in treating his cancer". We provided the mother with the names of several companies that provide this service and encouraged her to also speak withher OB about companies that they would recommend. With her OB's assistance, she was able to connect with a company that will store the cord blood for free for five years. The mother shared that she is so excited about the new baby and that this may turn out to be an additional blessing. Baby boy was born and everything went as planned with the cord blood. Mother and family are very happy. Mother reports that baby is nursing well and growing. Member's condition remains unchanged.

Member tested positive for COVID, initial problem was complaints of a sore throat. Medication and nebulizer were given. Member stopped using the nebulizer, stated by members' mother, "…makes her feel like she's suffocating." Education given for the correct use of nebulizer. Member has mostly recovered, but due to having asthma, it is a process. Member does not have a Peak Flow meter, working on continued education and sending a peak flow meter to her.

Family of six, four children being raised by great aunt and great uncle. Children are two sets of siblings, cousins with each other. Members are with us for behavioral health issues and of late, their behaviors have been unremarkable. The family has been going through a bit of tension that involves the incarcerated father of one of the sets of siblings. The father has turned ill since being incarcerated. He was placed in ICU on a ventilator and the members' caregiver has been having a difficult time receiving information. Reached out to Department of Corrections regional Nurse Manager. Information on a prisoner is not to be released until that prisoner signs a release form, no matter who is placed as next of kin or even if the prisoner is incapacitated. Caregiver also stated that her husband recently had an accident at work with a vehicle and may lose his job, they are behind on rent. Nurse Care manager gave her a list of rental assistance resources. Also, informed her to sign up for Sunbeam Family services for grandparents for Holiday assistance.

Seventeen-year-old male was recently seen in the ER for leg pain. He also had trouble standing and walking. Come to find out, he had torn his ACL and meniscus. He has a history of being heavily involved with sports and believes that it happened during football practice. Members mother requested a wheelchair and we were able to provide one. One concern is member is taking narcotics for pain relief and complaining that pain is still present. Educated mother on Pain Management. She was very receptive.

Brothers of a single parent home whose mother recently lost her job. Nurse Care Manager provided information on how to obtain health insurance, where to receive free or low cost flu shot and free/low cost clinics in her area. Due to mom having to go to the doctor for herself and paying out of pocket, she is low on resources. Provided a Thanksgiving meal basket and Food Pantry list in her area.

ABD member is 18 years old with history of seizure disorder and frequent falls. When member falls maximum assistance is needed to get her up again. She becomes incapacitated and unable to walk without assistance from others and assistive devices. Mother requested nursing assistance with daily care due to her inability to lift member if needed. Care Manager contacted local home health agency who assessed member and agreed to provide nursing care as needed. Home Health agency also provided wheelchair, shower chair and bed side commode to be available when needed. Mother identified there was also a need for a portable wheelchair ramp which could be easily removeable due to living in an apartment and there could not be permanent placement. Care Manager completed on-line application with Able Tech Reuse DME program and was contacted by Able Tech technician that ramp would be made available to member after the first of the year.

Six-year-old (6) old boy with Di George Syndrome has been affected by this genetic condition in many ways, experiencing heart problems, developmental issues and speech issues. He and his two siblings were removed from the care of their parents due to drug abuse and were placed with their grandmother. They live on her Social Security payments and his Social Security payments, which makes things pretty tight. We have helped the family numerous times with needs of daily living and have recommended they apply for the DDS waiver and Family Support Assistance, which should increase their monthly income by $250. We also encouraged her to apply through Ability Connections for a free communication device. They now have the device and the grandmother reports that it is making a huge impact on his ability to communicate.

A five-year-old (5) girl and her four-year-old (4) brother were referred to us by Yukon Pediatrics. We made contact just before Christmas and found that they were living in a home with the gas cut off, with little food and no Christmas. Food was delivered, provided by South Yukon Church of Christ (SYCOC), resources for utility assistance were provided, and the SYCOC came together and provided gifts for the family. They were also given information on the Red Andrews Christmas.

Care Manager was contacted by an El Reno community member that a single mother and her two children were not going to be able to celebrate Christmas. Mother and children were victims of a domestic violence situation and had received assistance from a domestic violence program for housing however the family had left their prior home with minimal clothing and household items. With the assistance of the Ashbrook Foundation and the SYCOC, food, clothing, household resources and Christmas gifts were obtained. When items were received, the young mother was extremely tearful and verbalized gratitude numerous times. She expressed that she was most thankful that her children would be able to enjoy Christmas. When seeing the hygiene items and household supplies including dish and laundry soap she stated, “this is the best Christmas gift I could have received, we have been doing without what I use to think were simple things, I don’t look at it that way anymore”.

In addition to normal requests for food and clothing, a local church group reached out to sponsor a back to school mask, socks, and underwear drive for our members. Fifty-one (51) individuals were provided needed items representing twenty-two (22) families.

We were also able to assist members with forty-seven (47) Thanksgiving food baskets and eighty-five (85) Christmas referrals, that included food and gifts. Thanks to our many community partners.