2023 Annual Report

Covering January 1, 2023, through December 31, 2023

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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.

Affiliated Providers and Access to Care

Table 1 illustrates the number of providers by name and panel size affiliated with CCHAN.

There were twenty-three (23) providers affiliated with CCHAN as of December 31, 2023. Three (3) of the twenty-three are associated with two participating group practices. Those are James M. Brown, DO, Aaron P. Wilbanks, DO, and Andrea L. Krittenbrink, PA-C; all are associated with both Canadian Valley Family Care and Mustang Urgent Care.

Table 1: CCHAN Affiliated Providers for 2023	
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** **Hard, Jennifer, APRN** **Krittenbrink, Andrea, PA-C** **Morgan, Garrett, APRN** **Patel, Urvashi, APRN** **Wilbanks, Aaron P., DO** **Panel size for December 31, 2023: 92**	**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** **Heskett, Hannah, PA-C** **Krittenbrink, Andrea L., PA-C** **Roof, Lindsay K., APRN** **Siems, Ami L., MD** **Wilbanks, Aaron P., DO** **Panel size for December 31, 2023: 552**

Table 1: CCHAN Affiliated Providers for 2023 (cont'd)	
Variety Care @ Yukon 9070E Family Practice – all ages 508 W. Vandament Ave. Ste 210 Yukon, OK (405) 632-6688 **Hopkins, Nikkie, CPNP-PC** **Mirossay, Jennifer, LPC** **Tomichen, Regina, MD, FAAP** **Torres, Amie, PA-C** **Khalili, Rahil, APRN-CNP, PMHNP-BC** **Panel size for December 31, 2023: 1430**	**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, 2023: 332**
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, 2023: 961**	

Table 2 presents a snapshot by comparing provider panel sizes December 31, 2021, 2022 and 2023.

PCP	2021	2022	2023
Variety Care @ Yukon	986	1793	1430
Flores Pediatrics	1362	1277	961
Canadian Valley Family Care	801	801	552
Mustang Family Physicians	455	498	332
Mustang Urgent Care	168	139	92
Total Count	**3772**	**4508**	**3367**

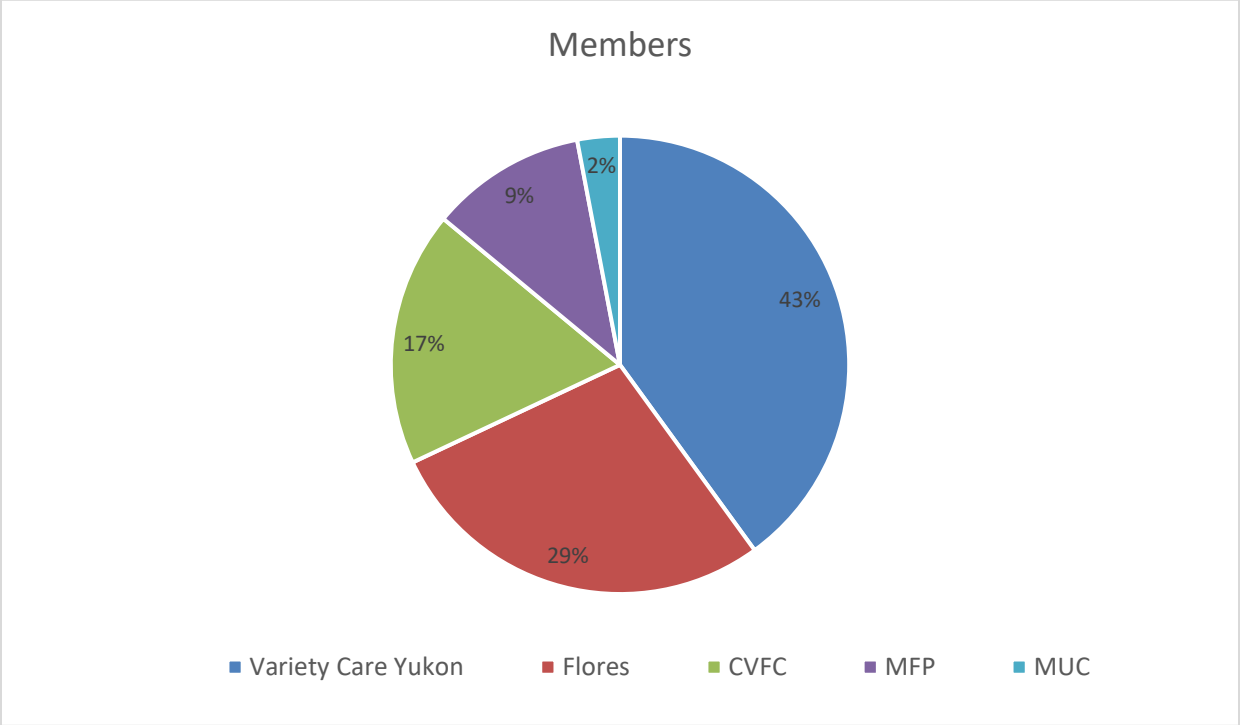


Table 3 shows monthly membership totals for 2021, 2022 and 2023. Our numbers were trending downward throughout the year. This is due to the public health emergency (PHE) from COVID unwinding and members losing their benefits.

Month	2021	2022	2023
January	3782	3828	4524
February	3746	4077	4512
March	3775	4142	4519
April	3743	4242	4561
May	3690	4333	4476
June	3690	4387	4339
July	3543	4441	4098
August	3626	4500	3974
September	3660	4545	3850
October	3663	4512	3602
November	3741	4521	3427
December	3772	4508	3367

CC-HAN provides the following for ALL Providers:

- 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
- Medication disposal bags for members
- Staff trainings on certain topics upon request

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

6309 referrals for goods and/or services

57 deliveries of goods, i.e., food, clothing, personal/household goods

***2378 translator assisted communications,** with the aid of CCHAN Resource & Linguistic clerk.

9375 educational resources were distributed to members.

388 behavioral health resources were provided.

4560 community resources were identified and provided.

143 referrals to specialists were obtained.

1213 daily living needs resources were provided.

30 Thanksgiving food baskets

24 families received Christmas assistance.

*1860 phone calls; 459 text messages; 41 letters; 18 face-to-face visits

Table 4 shows the number of specialty providers:

We have identified 670 specialty providers available for SoonerCare Choice members served by our network. Table 4 represents the type and number of providers.

Table 4: CCHAN Specialty Providers for 2023	
Type of Provider	**Number**
Medical Doctors - all specialties	149
Behavioral Health - Psychologists, therapist, etc.	99
Therapy - PT, OT, Speech, Dietician, Home Health	35
Developmental Delay / Disabilities	22
Community Resources - Housing, Food, Clothing	120
Crisis Intervention / Support Groups	59
Dental	36
DME	6
Labs & Testing	16
Free Clinics	34
Hospitals	21
Medication Assistance	7
Other Specialties	68
TOTAL	**670**

Care Management

Reporting: 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 care management activities and measures on a monthly basis to the following populations:

1. Identify all populations for care management and complete transition for each population with members on PCP rosters.
2. The populations for care management throughout 2023 include:

Asthma	ED Utilization
Inpatient	ABD
Behavioral Health	Other

Table 5: CCHAN Summary of Care Management for 2023

Population	Care Management Members
ED Utilization	Two hundred ninety (290) members visited the Emergency Department in 2023. Six (6) of those were provided care management services during this time. All others were offered education and/or resources.
Asthma (AIP)	○ Roster with 38 members in January ○ Roster with 39 members in February ○ Roster with 35 members in March ○ Roster with 35 members in April ○ Roster with 35 members in May ○ Roster with 34 members in June ○ Roster with 34 members in July ○ Roster with 36 members in August ○ Roster with 34 members in September ○ Roster with 37 members in October ○ Roster with 31 members in November ○ Roster with 30 members in December *Note: There were forty-five (45) individual members involved in the Asthma Improvement Plan throughout 2023.
In-Patient	One hundred nineteen (195) members who had hospital admissions were offered care management services in 2023. One hundred forty-nine (149) were live births.
Aged, Blind, & Disabled	There was a total of eighty-eight (88) members involved in care management in 2023.
Behavioral Health	Sixty-seven (67) members have been provided care management for behavioral health issues not identified in the ABD roster.

Emergency Department Utilization

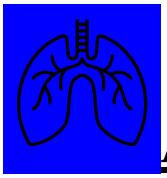
- Members with 3 visits in a 3-month period during report period: **25**
- Members with 4-14 visits in a 3-month period: **16**
- Members with 15 or more visits in 3-month period: **0**
- Members with 3 or more ED visits currently under care management : **6**

The top three (3) diagnoses for ED visits in 2023 were:

- **Viral Infections including Covid-19**
- **Otitis Media**
- **Nausea w/ Vomiting**

Average report time between emergency department visit and provider follow up visit: **Twelve (12) days,** which is two (2) more than 2022 and five (5) days less than 2020 at seventeen (17) days. This includes any follow-up appointment after ED visits, regardless of specialty or primary care.

Table 6: CCHAN Emergency Department Utilization contacts for 2023				
Phone call, texts, letters, face-to-face	**Unsuccessful phone call**	**Total Attempts**		**TOTAL CONTACTS**
799	99	898		**799**



Asthma Improvement Plan (AIP)

A total of forty-five (45) individuals participated in the AIP program in 2023. At the end of 2023, thirty (30) members were actively involved. 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 for the student. Members are provided peak flow meters along with educational materials regarding their condition.

Table 7: CCHAN AIP contacts for 2023

Phone call, texts, letters, face-to-face	Unsuccessful phone call	Total Attempts		TOTAL CONTACTS
798	85	883		**798**

In-patient

Monthly reports of members that have been hospitalized and discharged, are provided by OHCA to CCHAN. Care management services provided for this group are included in Table 8. As the table shows, a total of 773 contacts were made to this group. One hundred forty-nine (149) of these hospitalizations are for new births. We 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.

Table 8: CCHAN Inpatient Contacts for 2023				
Phone call, texts, letters, face-to-face	**Unsuccessful phone call**	**Total Attempts**		**TOTAL CONTACTS**
773	126	899		**773**

Aged, Blind and Disabled (ABD)

After serving this population for over five years, one thing remains constant – well over 50% of the members on this roster have been identified with a psychological disorder. CCHAN is fortunate to be able to provide one nurse care manager with specialized training in behavioral health to provide care management to this population. CCHAN not only provides this benefit to those identified ABD members but are able to take referrals from our providers as well. All other ABD members are being care managed, as appropriate, by other care managers.
Eighty-eight (88) members were actively receiving care management services at the end of 2023.

Table 9: CCHAN ABD Contacts for 2023				
Phone call, texts, letters, face-to-face	**Unsuccessful phone**	**Total Attempts**		**TOTAL CONTACTS**
1478	310	1788		**1478**

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. Sixty-seven (67) members have been provided behavioral health care management that were not identified as ABD. There were thirty-five (35) members with active care management services at the end of 2023.

Table 10: CCHAN Behavioral Health Contacts for 2023

Phone call, texts, letters, face-to-face	Unsuccessful Phone	Total Attempts		TOTAL CONTACTS
1387	336	1723		**1387**

Other

During this reporting period, forty (40) other SoonerCare Choice members were provided with either care management services or referrals. One thousand one hundred seventy-seven (1177) contacts were made to these members who were not associated with a particular program within CCHAN. One hundred four (104) unsuccessful phone calls were made for a total of one thousand two hundred eighty-one (1281) attempts at contact for 2023.

GRAND TOTAL OF ALL CARE MANAGEMENT CONTACTS AND ATTEMPTS IN 2023:

7,472 Attempts

6,412 Successful Contacts

3. The AHC screening tool is being used to determine the 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. 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. Thirty-six (36) AHC screenings were completed in 2023.

4. Monthly Care Management Team meetings were held. The project manager for Red-Rock Systems of Care is a member of our team that provides much needed behavioral health expertise. Our Sooner Success representative 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 talk with us during our care manager meetings.

5. Linguistic and Resource Specialist allows CCHAN to communicate with our Spanish speaking members, eliminating the language barrier to care. For this reporting period, one thousand eight hundred sixty (1,860) telephone calls, four hundred fifty-nine (459) text messages, forty-one (41) letters, and eighteen (18) face-to-face visits were made with the assistance of our Linguistic Specialist. This equates to a total of two thousand three hundred seventy-eight (2,378) contacts made to members in their native language. This has increased our ability to connect with our members.

6. CCHAN keeps an updated list of community resources and providers that is available to anyone on our website. Our Resource Specialist stays up to date with all events locally that might be of interest to our members. Back to school events, such as free backpacks full of supplies, groceries and free haircuts are passed on to our members, as well as holiday-assist programs. We are also given access to an invitation only sensory friendly night at the OKC Zoo for our qualified members.

Health Information Technology

1. Providers assisted with qualifying for federal EHR incentives–education, outreach, etc. None

   Milestones for electronic health records being met:

   All twenty-five providers in CC- HAN have EHRs; milestone is met.

   Benchmark and milestones regarding EMR:

   A. Number of providers with existing EMRs as a benchmark: Twenty-five.

   B. Number of providers with existing EMRs which are functional and operational: Twenty-five.

   C. Number that has operability between providers: None.

   All twenty-five CCHAN PCPs (five practices) have and are utilizing EMRs. None are compatible with other providers.

2. The Access database used to document and maintain records of care management contacts is considered a technological strength for CCHAN. The database also provides for aggregation of data by member name, RID, 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.

3. CCHAN 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. We also have links for updated COVID-19 information and to OHCA for enrollment for the expanded Medicaid population and upcoming managed care transition. 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 2023, there were a total of 647 (six hundred forty-seven) visits to our CC-HAN web site.

Quality Assurance

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

1. Develop and implement 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) in 2023. The estimated level of achievement will be an increase in the total number of claims in 2023 (compared with 2022) 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 provide information regarding the importance of well child checks to parents of new-born babies who are referred through In-Patient rosters provided by OHCA.

CCHAN providers continue to share 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 even more visits for 2024. Table 11 presents the number/types of EPSDT contacts made in 2023.

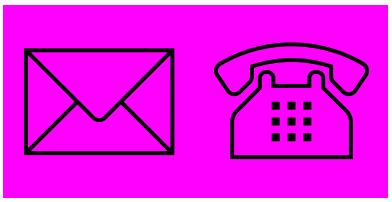


Table 11: EPSDT Contact 2023

EPSDT CONTACTS BY TYPE					
Month	**SPC**	**UPC**	**Texts**	**Letters**	**Total Attempts**
January	232	315	98	23	668
February	272	355	104	29	760
March	239	384	129	42	794
April	247	368	121	28	764
May	241	363	127	14	745
June	242	344	103	38	727
July	214	346	115	37	712
August	250	282	76	38	646
September	230	285	84	26	625
October	225	268	87	8	588
November	234	270	84	13	601
December	217	252	92	14	575
TOTALS	**2843**	**3832**	**1220**	**310**	**8205**

Table 12 EPSDT Claims 2022 - 2023

Preventive Code	2022 claims	% change from 2021	2023 claims	% change from 2022
99381	217	+26%	167	-24%
99382	77	+12%	73	-6%
99383	87	+23%	88	+2%
99384	73	+40%	52	-29%
99385	16	Baseline	17	+6%
99386	4	Baseline	3	-25%
99391	1018	+25%	790	-23%
99392	1035	+16%	931	-21%
99393	820	+7%	748	-8%
99394	567	-2%	546	-4%
99395	107	Baseline	91	-15%
99396	20	Baseline	14	-30%
TOTALS by YEAR	**4041**	**+18.5%**	**3520**	**-13%**

It should be noted that there was a 25% drop in enrollment in SoonerCare Choice in 2023. This was mainly due to the rollback of the Public Health Emergency mandates.

2. **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 2023.**

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. Using several search engines to locate the webpage, we were less than successful in locating it. Revisions have been made, and CCHAN has moved up the list on several search engines, resulting in higher numbers. Our hope is the numbers will continue to increase. Other promotional items are being utilized to promote the webpage, to include personal medication organizers, hand sanitizer, liquid medication dosage cups, and lip balm with the web address and logo imprinted.

Table 13: Web Site Views

Number of Views per Month	2020	2021	2022	2023
January	54	38	41	41
February	41	32	37	37
March	39	34	69	40
April	63	64	43	49
May	47	36	26	45
June	42	51	33	72
July	52	38	25	44
August	63	64	48	54
September	56	63	57	49
October	64	47	89	64
November	58	46	52	91
December	53	47	60	70
TOTAL	632	560	580	656

People from thirty-four (34) states visited www.cc-han.com in 2023.

Alabama

Arizona

Arkansas

California

Colorado

Connecticut

Delaware

Florida

Georgia

Idaho

Illinois

Iowa

Kansas

Kentucky

Louisiana

Massachusetts

Minnesota

Missouri

Nebraska

Nevada

New Jersey

New York

North Carolina

Oklahoma

Pennsylvania

South Carolina

Tennessee

Texas

Utah

Virginia

Washington

West Virginia

Wisconsin

Wyoming

And people from nineteen (19) countries outside the United States visited our website.

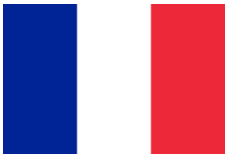

Armenia


Australia


Bangladesh


China


Croatia


France


Germany


Hong Kong


India


Israel


Japan


Mexico


Nigeria


Pakistan


Panama


Philippines


Poland


Romania


Russia


Slovakia


South Korea


United Kingdom


Venezuela

The second major strategy for achieving quality measure 2 is the utilization of educational brochures. These brochures are based on top historical diagnoses for emergency department visits. Provider input also influences the topics of new brochures. Previously developed brochures 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
- Upper Respiratory Infections
- Back Pain
- Children with Fever
- UTIs
- Asthma
- Diabetes
- Childhood Obesity
- Otitis Media (Ear Infection)
- Abdominal Pain
- Cellulitis
- Headaches
- Tobacco Use Disorder
- Hypertension
- 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 provided to area County Health Departments for distribution.
- Brochures are shared through various community events and sites such as Health Fairs, 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, Physicians, and other health care professionals in the communities served.

3. We monitored the number of hospitalizations for each engaged Asthma Improvement Plan (AIP) member throughout 2023. The estimated level of achievement for this quality measure will be a reduction in number (or zero) annual hospitalizations with an asthma related diagnosis for each engaged member, compared to pre-AIP participation. We had one (1) hospitalization for asthma related diagnoses in 2023 among the AIP participants.

4. We fell short of our goal of at least 90% annual flu immunization level for all AIP members in 2023. We only had nineteen (19) of our forty-five (45) AIP members receive the flu shot. Overall, this is much less than we had hoped for and our educational efforts will continue.

Table 14 CCHAN AIP Evaluative Data

	Totals for 2021	Totals for 2022	Totals for 2023
Total No. AIP Members	49	54	45
Total No. of Hospitalizations prior to AIP Engagement	2	0	4
Total No. of Hospitalizations for Asthma Related DX after AIP Engagement	0	0	1
Total No. of ED Visits for Asthma Related DX prior to AIP Engagement	18	4	18
Total No. of ED Visits for Asthma Related DX after AIP Engagement	0	0	0
Total No./Percentage of AIP Members who received flu vaccination	40 for 82%	39 for 72%	19 for 42%

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.

Table 15 shows the number of ED visits with asthma related diagnosis by CCHAN members who have asthma identified in their problem list has maintained since the last drop in 2020. This is positive support of CCHAN work, even though 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. Efforts to decrease ED utilization include:

- Care management contacts to all members with ED visits in the previous month and identified through quarterly claims review.
- Varied types of care management contacts include phone, letter, text messaging, 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.
- Services and materials are available in Spanish.

TABLE 15: KEY QUALITY PERFORMANCE MEASURES

Performance Measure A: Decrease asthma –related ED visits for CCHAN members with an asthma related diagnosis identified in their medical claims record.	**2020**	**2021**	**2022**	**2023**
Numerator: Total number of ED visits by CCHAN members with asthma identified in their problem list for an asthma-related diagnosis.	25	18	18	18
Performance Measure B: Decrease 90-day readmissions for related asthma conditions for CCHAN members with an asthma diagnosis identified in their medical claims record.	**2020**	**2021**	**2022**	**2023**
Numerator: 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.	**2020**	**2021**	**2022**	**2023**
Numerator: Total number of ED visits for CCHAN members.	787	1676	1657	1493
Denominator: All CCHAN members.	3776	3703	4508	3367
Dividend for Performance Measure C:	.21	.45	.37	.44

Other CCHAN Distinctives

The CCHAN continues to have distinctive characteristics that are considered important to highlight in this report. 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 regarding 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.

Ensure CCHAN staff maintain high quality education in topics that affect our clients, providers, and members of the community. This year training has been completed on the following topics: DDSD wait list, Planning for Waivers, Life Course Planning, Fentynal, OK STABLE, OK SHINE, Child & Adolescent Trama Screening, Youth Mental Health First Aid, Care Coordination, Healthcare Inequities, Sooner Quit, Sooner Select, SoonerRide, and Collaborative Assessment and Management of Suicidality for Teens (CAMS 4 Teens).

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 changes, prior authorization matters, OHCA requirements on various matters, updates on Medicaid expansion, managed care, and the need for specialists. CCHAN staff provides educational presentations for participating PCPs and staff at their request.

- The PHCC Board approved funding to purchase additional peak flow meters to distribute to AIP members.

- Throughout 2023 CCHAN staff members have worked closely with all providers to coordinate care through care management and to implement the AIP. A total of seventeen (17) 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. 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 2023 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 fifty-seven (57) deliveries of goods were made by CCHAN care management staff. One hundred forty-nine (149) new baby packets were delivered to new mom's that appeared on our in-patient rosters. For those who did not have working smoke detectors in their homes, referrals were made to local fire departments, who provide and install smoke detectors free of charge. Food baskets were provided to thirty (30) families for Thanksgiving and twenty-four (24) families were helped with Christmas gifts and/or meals.

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.

264 Provider contacts made in 2023. 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.

Monthly CCHAN Care Management Team meetings These meetings provide an opportunity for CCHAN staff to meet with others on the team to discuss challenges and celebrations. Guest speakers come periodically to inform the group of new programs or resources available in the community. Most meetings were via zoom, but face-to-face meetings were held quarterly.

Community Involvement continues to be a priority with CCHAN. All CCHAN Staff attend monthly meetings of the Canadian County Coalition for Children and Families. Continuation of education and support of ACES awareness remains a priority for this group. As a result of the work of this Coalition, legislation is being considered to provide guidance for all public schools to implement the "Handle with Care" initiative. This program was designed to aid school personnel in dealing with the needs of students who had recent contact with law enforcement. Law enforcement officers contact designated staff members at the school the child attends to inform them of prior contact. This then triggers someone at that child's school to check on that child throughout the day, to ensure the child is OK and to offer resources as needed.

CCHAN continues to provide SoonerCare members and other community members medication disposal bags.

CCHAN staff participate in the Canadian County Coalition for Children and Families.

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

Nurse Care Manager is a member of the Canadian County Health Department's TSET/HLP Collaborative Group.

Ongoing utilization and additions to the searchable specialists and resource list that is hosted on the website.

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

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 Independent 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, text messaging and mail contacts with the ability to communicate in Spanish and English
- Extending care management services beyond those contractually required to include others outside our target populations who are referred by providers

The Partnership for Healthy Central Communities Board of Directors 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. In this ever-changing healthcare environment, we look forward to ongoing efforts in 2024 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*.**

Respectfully submitted by Cindy Bacon, Project Manager with assistance of:
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Appendix A

Emergency Department Utilization Table for 2023

ED Utilization 2023					
	Total number of Members	**Number of Contacts**	**Number of ED Visits (claims)**	**Number of PCP Visits after ER visit**	**Average Time (days) Between ED Visit-PCP Visit**
Totals	**4524**	**799**	**1493**	**254**	**12 days**

Appendix C

Care Management Highlights

This member is a fifty-five-year-old man with COPD, Heart Disease and Hypertension. His health is frail. He is on continuous oxygen. He is staying with a friend in a very isolated area in a house that has only partial heat in one room. The member has no income, and his friend has only his Social Security check. His friend's vehicle broke down, so they had no transportation. We worked to decide for SoonerRide to transport him to appointments, but they had trouble locating him and he missed appointments. We encouraged him to ask for Tele visits and provided him with information on some of the local churches, who might help him get to his medical appointments. His prescriptions ran out and he could not get refills until he saw his medical providers. He applied for disability, but still has no income. While working with him to get the resources he needs, he became unreachable by phone. As we were concerned about his safety, the local sheriff's office was contacted to do a welfare check. They reported back that he is safe, but his phone has been disconnected.

It took several weeks before I was able to reach him by phone. His roommate had procured a working vehicle and was able to take him to appointments. He was approved for disability and started receiving checks. He was appreciative that we had requested the welfare check and said, "No one has ever cared enough for me in my life to do something like that". Our member has now used his disability money to rent a room in OKC that is more accessible to healthcare.

This member is a very sweet gentleman on our ABD roster. He has cerebral palsy and lived with his mother until her recent death. He shared that he has been having problems dealing with her loss. He says, "I miss her so much that I cry almost every day". We were able to locate a GriefShare Program that is near his home and that will be starting soon. He seemed excited about joining this group and shared that he has a friend who recently lost someone and may also want to attend.

Member is a twenty-year-old young man with severe autism, seizure disorder and brain damage. He is non-verbal, unable to toilet himself or do most activities of normal daily living. The mother was not sure if our member was on the DDSD waiver wait list. We provided her with the appropriate phone number to call and it was confirmed that he has been on the wait list for about two years and should receive services in about a year. The member's parents did not have guardianship of the adult member. They shared that they do not have the money to hire an attorney. We were able to provide them with the guardianship packet for adults and they are now working on getting legal guardianship for their son.

This family continues to use the emergency department excessively. Female member has gotten in trouble with school because of non-attendance and has been assigned a truancy officer. She now must do community service along with summer school and will be held back next year. Mother is relaxed when it comes to school, she didn't graduate high school nor obtain a GED. Since having to deal with the truancy officer Mom has been pushing the member more to go to school.

This member lives with his maternal grandmother, mother and three siblings. Mother now has a full-time job. Mother is working to save enough money to make a down payment on a place for her and the four children. We were able to help them receive items from Infant Crisis Center for the newest baby applying to FOCUS on HOMES for furniture.

Female teen-age member was obese and led a very sedentary lifestyle. We assisted with getting started on physical activity and nutrition with the help of a Registered Dietician. We were also able to assist with getting her parents home health help Valir Pace.

This member's father is incarcerated. We assisted in going over the Oklahoma Children of Incarcerated Parents Toolkit. We also helped with Ok Messages getting a book recorded by member's father so member could hear his dad read him a story.

Elderly female member who lives with her son, who is her main caregiver. We worked on building a medical history folder with the aid of her son. Member has had some emergency department visits due to falls. We reviewed fall safety and preventative measures, and provided education on diabetes, hypothyroidism, and nutrition. We worked with a registered dietician for nutrition and with DME Oklahoma Able Tech to obtain a rolling walker. Valir Pace is helping with home health.

The member's mother was having car problems and was having to "bum rides" from people to get to work. On a follow-up call she told us she was unable to make it to work the past two days because of car issues. Her car was in the shop getting fixed, but she was unsure how she was going to gather up the money to pay for the $300 repair. It was determined that this family was eligible to apply for Ashbrooke Grant funds. Ashbrooke Grant application was submitted, approved and payment made to mechanic. Mom was extremely thankful to have transportation to get back and forth to work. (Nurse comment – It is a real eye opener when $300 can make a life changing difference for a family to keep surviving.)

This member is a seven-year-old boy from a Spanish speaking family that is on our ABD roster. He is blind, non-verbal, and not toilet trained. The mother says that she feels that he may also have Autism, but he has never been evaluated. We are helping her to find resources for an Autism Evaluation and encouraging her to follow up on this. We assisted the mother in filling out the DDSD application and sent in the application via e-mail. We also assisted her in filling out an application for the Family Support Assistance Program. They requested IQ testing, which apparently has never been done. She has been encouraged to request this through his school. Information was provided on the People First Industries Diaper Program. The mother then requested this from his PCP, and he is now receiving pull-ups, wipes and pads delivered to the home.

The member is a new baby who was identified from our In-Patient list. He was delivered normally with no complications. When we called, the mother seemed relieved to have someone to ask questions of. The baby was just over a month old at the time of the call. She reported that she had recovered well from the delivery, but wanted to know when she would be able to do household chores such as sweeping the floor, mopping, and driving a car. You can imagine what a relief it was for her to be told that she could do those things if she feels up to it and is not on pain medication! Member has a ten-year-old sister who was born in another country. She has not been receiving health care as she has no insurance and does not qualify for SoonerCare. It was explained that the ten-year-old can receive immunizations at the Health Department. She was also given information on the Christ Community Health Coalition, which provides free Pediatric primary care to uninsured children.

This member is a forty-seven-year-old woman that we first encountered about a year ago, after she developed some health issues and had several emergency department visits. She lives in a travel trailer and works part time at a bakery. She contacted us and explained that the air conditioning in her trailer had quit working. She was able to determine that the problem was the thermostat but had no money to buy one. Temperatures were to get over 100 degrees that day. We were able to establish that she was eligible to utilize Ashbrook Grant funds and met her to pick up the thermostat. Her boyfriend had electrical expertise and was able to install it right away. She texted me that it was working, and she shared her deep appreciation.

The member is a gentleman with very complex and numerous health issues including diabetes, congestive heart failure and end stage kidney disease. He was hospitalized around August 7th at which time he had surgery on his leg. After a week in rehab, he was sent home. On August 28, he received a call from his surgeon telling him that it was urgent he come in on the following day as he risked infection if his stitches were not removed immediately. The member is unable to drive, so he called SoonerRide, but they declined his transportation request as he had not given them the three working day notice. We called SoonerRide and were able to explain the urgency of the appointment. They agreed to provide the needed transportation. He was seen by his doctor, and it was a good thing that he got in when he did as there were concerning problems with his leg.

We started working with this member when he was a baby. He has Down's Syndrome. We helped them access SoonerSuccess and other programs. CCHAN Interpreter helped the family with numerous contacts with the Social Security office, as well as with the DDSD waiver and Family Support Assistance programs. The process was very complicated and there were problems with the Social Security keeping appointments and returning calls. In June the family was informed that the member was approved for SSI, and they were told that they should start receiving payment. He is now receiving monthly SSI payments and they received a back payment check as well.

The member is a four-year-old boy who is a patient at one of our provider's clinic. He was brought to our attention during a well child check reminder call made by CCHAN EPSDT clerk. Mother reported that member uses only 3 words, "runs like a toddler" and is not potty trained. He also has seizures. We contacted the provider with our concerns, and he said he would appreciate our assistance with this family. The provider expressed frustration that the autism evaluation providers they work with are running appointments a year out. We were able to locate a provider that could do the autism evaluation within weeks. The appointment was scheduled, and the member was diagnosed with autism level 2, developmental delays, social communication level 2, language impairment and Intellectual impairment. He is being referred for speech and physical therapy. We are now working with Mom to apply for SSI for the member, after which we will help them apply for the DDSD waiver and Family Support Assistance Payments. We also recommended that she ask member's PCP for a referral to the People First Industries diaper program. This was done and they are now receiving diapers, wipes, and other incontinence supplies.

This member is an adorable two-year-old girl with growth issues and rickets z – she currently wears size nine-month clothing. She has a six-year-old brother with ADHD and a four-year-old that has Pica. The mother is a personal care aide, and the family income is very limited. They received an eviction notice in November that they must be out of their apartment by the end of the year, as the apartments are to be renovated and the rent greatly increased. We were able to use local resources to provide the family with Christmas gifts. Also, food provided by Tyson was delivered. Our member immediately became attached to the cute Christmas wrap when items were delivered to the home. The mother shared that our assistance was "a gift from heaven", as they had planned to skip Christmas gifts so that they could afford to move.

This member was approved for SSI (autistic behavior problems), has been kicked out of school multiple times, and is unable to play with kids at parks or public places. His behavior caused problems with parents being able to work during day-time hours, so one worked during the day and one worked nights because he was so difficult. Dad denied issues but mom wanted help. We were able to assist Mom in getting ABA therapy set up. Initially, the wait was six months, but an opening was found at a different location. Mom was encouraged to get him into ABA therapy as soon as possible. Mom wanted to wait but with the encouragement she decided to take the immediate opening. Mom wanted to put him in all day Kindergarten, but ABA therapist place said he needs continued treatment and do half day kindergarten. We were able to help mom recognize the improvement he made in the past six months. Mom kept him in half day therapy and half day kindergarten. Since starting ABA therapy mom doesn't receive calls to pick him up from school and has not reported that he cannot play with other kids at a park. He continues to improve. Mom applied to SSI and supported mom in the process. Member was approved for SSI and is now on the ABD list.

Member is involved with our Asthma Improvement Plan program. After routine discussions Mom reports autism diagnosis and how the PCP always wanted her to apply for social security to get child long term services, but mom admits denial and reluctance of accepting diagnosis. Over time we encouraged mom to apply for Social Security and child was approved. Child has repeated behavioral issues related to autism and is getting bigger and stronger. During regular follow up calls, we discuss ABA therapy and mom reports how she called a few years ago and they did a mini screening over the phone saying he didn't qualify but was told she could bring him in for a thorough screening to see if it would qualify him. Mom was discouraged, still in some denial and didn't pursue any further behavioral therapy. On most recent call the child's behavior has become increasingly worse at home and school. Mom had to take the child back to PCP a few times for medication changes and the PCP even had to get firm with him so child would behave. I spoke with mom about ABA therapy again, mom repeated how he didn't qualify before, and she didn't seem interested. Knowing how bad the situation was getting, I sent another message the next day reminding mom to consider ABA therapy since the contact I gave her didn't have a waitlist. I also mentioned SoonerRide/SoonerCare will reimburse transportation expenses. Mom replied thirty minutes later that she called and has an appointment set up to get an updated diagnosis of autism from psychologist, then they are going to start the process and hopefully start seeing him at school. ABA therapy can hopefully provide help to this child, the family and school system.

This member has a history of severe asthma that required long term home schooling. Since care management began, I have encouraged mom to make a Pulmonologist appointment. Since seeing a pulmonologist, the child has made great strides in asthma control. Mom would often call PCP for asthma flares up where asthma medication would get changed and child would spiral back into asthma controlling her life. Mom was provided information several times that the Pulmonologist is her specialist for asthma care, and she should always call the pulmonologist when there is an exacerbation of asthma due to her child having a severe case. Since mom finally understood that her daughter's asthma is to be managed by a specialist the daughter no longer misses school, no longer requires anxiety medication and is on a very minimum dose of controller medication. This child is thriving.

When doing monthly follow up call found out family lives in a very poor socioeconomic area and teenagers in home didn't have access to a computer or internet for school assignments. A donated computer was given to the member who had the biggest beaming smile on her face. We discussed Oklahoma's Promise and the need to get signed up as they can use the home computer to complete the process. Assistance was offered if needed. Discussed with the teenager the opportunity to get an education and provide a better future utilizing Oklahoma's Promise.

Community Partners

360 Family Support
Able Tech DME
Alameda Church of Christ
Ashbrook Foundation
Bethany Church of Christ Blessing Baskets of El Reno
Canadian County Coalition for Children & Families
Canadian County Health Department
Cardinal Point
CART House
Catholic Charities Coat – a – Kid
Christ's Closet
Christ Church of Yukon
Cleveland County Community Action
Compassionate Hands Discovery Church Food Pantry
El Reno Community Action
Epiphany of the Lord Church Faith Clinic
Focus on Homes
Infant Crisis Services Jacob's Cupboard
Latino Community Development Agency
Love of the Children – El Reno
Manna Pantry – Yukon
Mustang Christian Church
Mustang Heights Baptist Church
Mustang Kiwanis Mustang United Methodist Church
OKC First Church of the Nazarene OK Bikes for Kids
OKFD Smoke Alarm Program
Oklahoma Family Network Putnam City UMC Food Pantry
Reaching Our City Redlands Community College
Red-Rock Behavioral Health Regional Food Bank
Salvation Army Sharing Tree – Moore
Sooner Success South Yukon Church of Christ
St. Vincent DePaul
Sunbeam Family Services
The Lord's Harvest Toys for Tots
Tulakes Clinic and Food Pantry Tyson Foods
Universal Church Urban / Skyline Ministries
Willow Pregnancy Support
Youth & Family Services
Yukon Sharing