2022 Annual Report

Covering January 1, 2022, through December 31, 2022

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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-five (25) providers affiliated with CCHAN as of December 31, 2022. Three (3) of the twenty-five 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 2022	
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, PA-C** **McGinn, James, APRN** **Pittman, Bradley D., PA-C** **Wilbanks, Aaron P., DO** **Panel size for December 31, 2022: 139**	**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** **Hoffman, Ashley, APRN** **Krittenbrink, Andrea L., PA-C** **Roof, Lindsay K., APRN** **Siems, Ami L., MD** **Wilbanks, Aaron P., DO** **Panel size for December 31, 2022: 801**

Table 1: CCHAN Affiliated Providers for 2022 (cont'd)	
Variety Care @ Yukon 9070E Pediatrics, 0-18 years of age 508 W. Vandament Ave. Ste 210 Yukon, OK (405) 632-6688 **Hopkins, Nikkie, NP** **Mirossay, Jennifer, LPC** **Tomichen, Regina, MD** **Torres, Amie, PA-C** **Panel size for December 31, 2022: 1793**	**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** **Patricia Pappe, APRN-CNP** **Audrick Ye, APRN-CNP** **Panel size for December 31, 2022: 498**
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, 2022: 1277**	

Table 2 presents a snapshot by comparing provider panel sizes December 31, 2020, 2021 and 2022.

PCP	2020	2021	2022
Variety Care @ Yukon	732	986	1793
Flores Pediatrics	1527	1362	1277
Canadian Valley Family Care	832	801	801
Mustang Family Physicians	468	455	498
Mustang Urgent Care	217	168	139
Total Count	**3776**	**3772**	**4508**

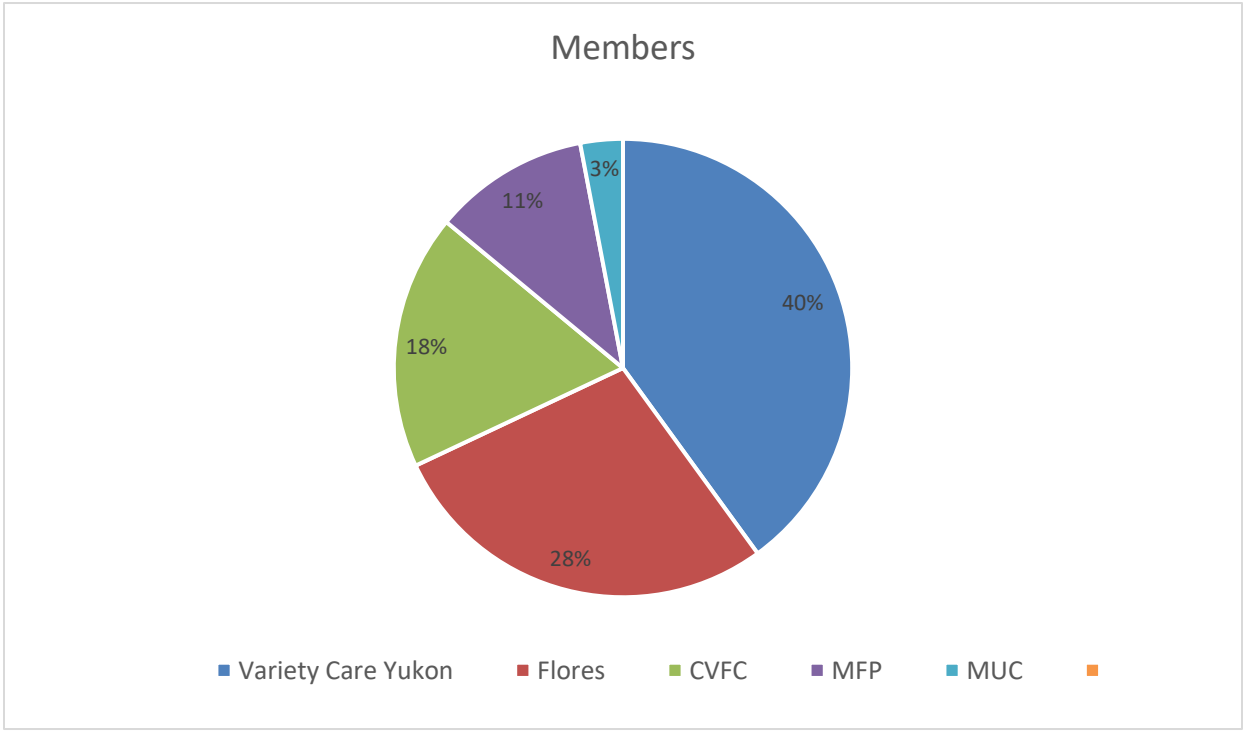


Table 3 shows monthly membership totals for 2022 and the same time periods of 2021 and 2020. Our numbers were trending upward the first three quarters of the year, then began decreasing throughout during the final quarter of the year. We still ended the year with more members than we began. We believe the increase is due, in part, to one of our providers expanding their population to include adult expansion.

Month	2020	2021	2022
January	3260	3782	3828
February	3318	3746	4077
March	3285	3775	4142
April	3256	3743	4242
May	3552	3690	4333
June	3593	3690	4387
July	3662	3543	4441
August	3740	3626	4500
September	2977	3660	4545
October	3710	3663	4512
November	3731	3741	4521
December	3776	3772	4508

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:

6172 referrals for goods and/or services

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

***2234 translator assisted communications,** with the aid of CCHAN Resource & Linguistic clerk.

9964 educational resources were distributed to members.

424 behavioral health resources were provided.

4196 community resources were identified and provided.

52 referrals to specialists were obtained.

1500 daily living needs resources were provided.

46 Thanksgiving food baskets

82 families received Christmas assistance.

*1692 phone calls; 469 text messages; 52 letters; 18 face to face visits

Table 4 shows the number of specialty providers:

Number of specialty providers available for SoonerCare Choice members served by our providers: 260 Primary Care Providers and Specialists (*) and 316 public resources for a total of 576 individual resources. Table 4 represents the type and number of providers.

Table 4: CCHAN Specialty Providers for 2022	
Type of Provider	**Number**
Medical Doctors - all specialties	90
Behavioral Health - Psychologists, therapist, etc.	*85
Therapy - PT, OT, Speech, Dietician, Home Health	*38
Developmental Delay / Disabilities	*20
Community Resources - Housing, Food, Clothing	112
Crisis Intervention / Support Groups	62
Dental	31
Substance Abuse - Counseling / Support	*17
DME	7
Labs & Testing	42
Free Clinics	33
Hospitals	21
Medication Assistance	8
Other Specialties	*10
TOTAL	**576**

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 2022 include:

Asthma	ED Users
Inpatient	ABD
Behavioral Health	Other
Childhood Obesity	

Table 5: CCHAN Summary of Care Management for 2022

Population	Care Management Members
ED Utilization	Forty-nine (49) members who had visited the Emergency Department were offered care management services during in this time period.
Asthma (AIP)	○ Roster with 40 members in January ○ Roster with 37 members in February ○ Roster with 35 members in March ○ Roster with 39 members in April ○ Roster with 34 members in May ○ Roster with 37 members in June ○ Roster with 38 members in July ○ Roster with 40 members in August ○ Roster with 38 members in September ○ Roster with 36 members in October ○ Roster with 38 members in November ○ Roster with 39 members in December *Note: There were fifty-four (54) individual members involved in the Asthma Improvement Plan throughout 2022.
In-Patient	Two hundred thirteen (213) members who had hospital admissions were offered care management services in 2022. One hundred sixty-six (166) were live births.
Aged, Blind, & Disabled	There was a total of sixty-four (64) members involved in care management in 2022.
Behavioral Health	Fifty-eight (58 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: **32**
- Members with 4-14 visits in a 3-month period: **14**
- Members with 15 or more visits in 3-month period: **0**
- Members with 3 or more ED visits currently under care management : **36**

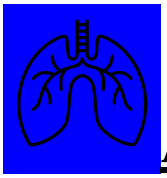
The top three (3) diagnoses for ED visits in 2022 were:

- **Respiratory Illness**
- **Viral Infections including Covid-19**
- **Lacerations and Mental Health equally represented**

Average report time between emergency department visit and provider follow up visit: **Ten (10) days,** which is three (3) less than 2021 and seven (7) 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 2022				
Successful phone call	**Unsuccessful phone call**	**Letters, email & texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
507	145	345	22	**874**

Total Attempts: 1019



Asthma Improvement Plan (AIP)

A total of fifty-four (54) individuals participated in the AIP program in 2022. At the end of 2022, thirty-nine (39) 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 2022				
Successful phone call	**Unsuccessful phone call**	**Letters, emails & texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
620	63	191	22	**833**

Total Attempts: 896

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 742 contacts were made to this group, including two (2) face-face visits. One hundred sixty-six (166) 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.

Table 8: CCHAN Inpatient Contacts for 2022				
Successful phone call	**Unsuccessful phone call**	**Letters / texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
419	136	207 / 114	2	**742**

Total Attempts: 878

Aged, Blind and Disabled (ABD)

After serving this population for over five years, one thing remains constant - approximately 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.
Sixty-four (64) members were actively receiving care management services at the end of 2022.

Table 9: CCHAN ABD Contacts for 2022				
Successful phone	**Unsuccessful phone**	**Letters / texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
602	127	7 / 299	3	**911**

Total Attempts: 1038

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. Fifty-eight (58) 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 2022.

Table 10: CCHAN Behavioral Health Contacts for 2022

Successful phone	Unsuccessful Phone	Mailings/ Texts/E-mails	Face-to-Face	TOTAL NO. of CONTACTS
207	257	12 / 345	11	**575**

Total Attempts: 832

Childhood Obesity

At the request of one of our providers we began researching childhood obesity. Data was compiled and used to create an informational brochure to address the subject. We began accepting referrals from our PCPs for care management. It was determined that many issues patients with obesity have also fall in line with behavioral health issues. This new population will be managed by our behavioral health nurse care manager. So far, four (4) referrals have been accepted. Engagement has been difficult to establish, therefore no meaningful data has been collected. CCHAN is committed to see this program succeed.

Other

During this reporting period, forty-one (41) other SoonerCare Choice members were provided with either care management services or referrals. Eight hundred eighty-two (882) contacts were made to these members who were not associated with a particular program within CCHAN. That number includes four hundred forty-four (444) phone calls, twenty-five (25) letters, twenty-three (23) face-to-face visits, and three hundred ninety (390) text messages. Eighty-eight (88) unsuccessful phone calls were made for a total of nine hundred seventy (970) total attempts at contact for 2022.

GRAND TOTAL OF ALL CARE MANAGEMENT CONTACTS AND ATTEMPTS IN 2022:

5,647 Attempts

4,826 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. Sixty-five (65) AHC screenings were completed in 2022.

4. 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 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 use 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 six hundred ninety six (1,696) telephone calls, four hundred sixty-eight (468) text messages, fifty-two (52) 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 two hundred thirty-four (2,234) 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 technology 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. 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 2022, there were a total of 580 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 2022. The estimated level of achievement will be an increase in the total number of claims in 2022 (compared with 2021) 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 2023. Table 11 presents the number/types of EPSDT contacts made in 2022.

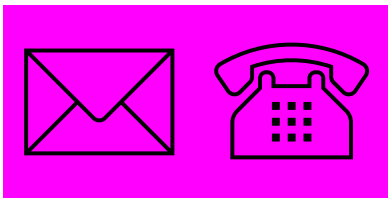


Table 11: EPSDT Contact 2022

EPSDT CONTACTS BY TYPE					
Month	SPC	UPC	Texts	Letters	Total Attempts
January	262	350	101	19	732
February	242	391	126	11	770
March	265	403	153	27	848
April	272	341	123	25	761
May	278	408	109	16	811
June	259	425	118	41	843
July	262	404	121	26	813
August	261	360	140	18	779
September	276	416	109	28	829
October	236	353	150	24	763
November	267	384	121	20	792
December	274	315	131	27	747
TOTALS	**3154**	**4550**	**1502**	**282**	**9488**

Table 12 EPSDT Claims 2021 – 2022

Preventive Code	2021 claims / % change from 2020		2022 claims	% change from 2021
99381	172	-30%	217	+26%
99382	69	-41%	77	+12%
99383	71	-41%	87	+23%
99384	52	-34%	73	+40%
99385	-	-	16	Baseline
99386	-	-	4	Baseline
99391	816	-37%	1018	+25%
99392	889	-18%	1035	+16%
99393	767	-16%	820	+7%
99394	579	-7%	567	-2%
99395	-	-	107	Baseline
99396	-	-	20	Baseline
TOTALS by YEAR	**3415**	**-23%**	**4041**	**+18.5%**

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 2022.**

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	2019	2020	2021	2022
January	85	54	38	41
February	111	41	32	37
March	107	39	34	69
April	184	63	64	43
May	92	47	36	26
June	89	42	51	33
July	72	52	38	25
August	59	63	64	48
September	67	56	63	57
October	61	64	47	89
November	49	58	46	52
December	36	53	47	60

Total views 580

People from twenty-seven (27) states have visited www.cc-han.com in 2022.


New Jersey


Kentucky


Virginia


Arizona


Idaho

Kansas


Maine


Connecticut


Ohio


New York

Oregon


Delaware


Florida


Minnesota

North Carolina


Missouri


Indiana


Pennsylvania


Washington


Nevada

California

Illinois

Arkansas


Texas


Georgia


Colorado

Oklahoma

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


India


Brazil


Kenya


Russia


Canada


Singapore


Pakistan


China


New Zealand


Philippines


Ireland


Norway


Armenia

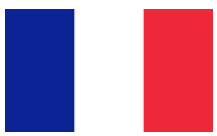

Denmark


Panama


Bangladesh


Germany


South Africa


France

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 2022. 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, comparing to pre-AIP participation. We had zero (0) hospitalizations for asthma related diagnoses in 2022 among the AIP participants.

4. We fell short of our goal of at least 90% annual flu immunization level for all AIP members in 2022. For the first quarter of 2022 we had 74% of our AIP members immunized for the flu. The second quarter was 72%. The third quarter saw no more members being vaccinated. The count was reset at the beginning of the fourth quarter and by the end of that quarter, 72% of members involved with the AIP had received the flu shot. Overall for 2022, this is much less than we had hoped for and our educational efforts will continue.

Table 14 CCHAN AIP Evaluative Data

	Totals for 2020	Totals for 2021	Totals for 2022
Total No. AIP Members	65	49	54
Total No. of Hospitalizations prior to AIP Engagement	5	2	0
Total No. of Hospitalizations for Asthma Related DX after AIP Engagement	0	0	0
Total No. of ED Visits for Asthma Related DX prior to AIP Engagement	25	18	4
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	37 for 57%	40 for 82%	39 for 72%

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 continues to drop since 2019. 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.

The data related to overall use of the ED for CCHAN members in 2021 shows a rather large increase. One thousand forty-five (1045) members were responsible for one thousand six hundred fifty-seven (1657) ED visits and two thousand one hundred seventy-two (2172) claims.
It is unclear why there was such a large increase in ED visits this year, but our goal to decrease ED usage remains the same. It may be speculated that the increased use of ED facilities may be related to Medicaid Expansion.

- 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.	**2019**	**2020**	**2021**	**2022**
Numerator: Total number of ED visits by CCHAN members with asthma identified in their problem list for an asthma-related diagnosis.	27	25	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.	**2019**	**2020**	**2021**	**2022**
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.	**2019**	**2020**	**2021**	**2022**
Numerator: Total number of ED visits for CCHAN members.	1200	787	1676	1657
Denominator: All CCHAN members.	3260	3776	3703	4508
Dividend for Performance Measure C:	.37	.21	.45	.37

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.

- **<u>Follow-up on needs and concerns of PCPs</u>** 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, and the need for specialists. CCHAN staff provides educational presentations for participating PCPs and staff.

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

    - Throughout 2022 CCHAN staff members have worked closely with all providers to coordinate care through care management and to implement the AIP. A total of nine (9) 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. Three (3) of these members were referred for behavioral health concerns. Three (3) were new babies with complex medical needs or concerns over care-giver health. One (1) was referred for general resources, one (1) for frequent no-shows for appointments and the remaining one (1) for non-compliance with medications. Nurse Care Managers were able to make contact and determine what the needs were to improve outcomes.

- **<u>Collaborative work between CCHAN providers and staff</u>** was ongoing through 2022 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-three (53) deliveries of goods were made by CCHAN care management staff. One hundred sixty-six (166) 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.

- **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.

- **196 Provider contacts** made in 2022. 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 we were able to meet in person in on several occasions.

- **Community Involvement** continues to be a priority with CCHAN. Project Manager participated in the Infant Mental Health Team, a subcommittee 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 committee, 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 a 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

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, 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 2023 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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Mary Cuevas, Linguistics & Resource Specialist

Appendix A

Emergency Department Utilization Table for 2022

ED Utilization 2022					
	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	**4545**	**874**	**1657**	**1291**	**10 days**

Appendix B

AGGREGATE NUMBERS FOR ED VISITS in 2022				
Two (2) visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
60	**69**	**33**	**37**	**199**
13% decrease from previous quarter	101% increase from previous quarter	10% decrease from previous quarter	Baseline data.	
Three (3) Visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
12	**10**	**8**	**2**	**32**
20 % increase from previous quarter	25% increase from previous quarter	300 % increase from previous quarter	Baseline data.	
Four (4) or more Visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
5	**5**	**3**	**1**	**14**
No change from previous quarter	67% increase from previous quarter	200 % increase from previous quarter	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 2021				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
274	**196**	**172**	**219**	**861**

Appendix C

Care Management Highlights

This member came to us as an ED follow up asthma patient and ended up having autism and other medical issues related to allergies. Mom reports their provider has encouraged her to apply for SSI for many years, but she just could not grasp or accept her son needing SSI. Mom cannot work due to son's multiple needs, and he only goes to school for a few hours a day. Therefore, the family has been relying on grandma to fund their extra expenses. Nurse Care Manager gradually built a relationship and encouraged her to apply for son's SSI, encouraged to reapply for SNAP benefits since income goes up and down depending on husband ability to work overtime. She became discouraged at the first attempt applying because she was overwhelmed. NCM encouraged her to go ahead and give it another try, and she completed the process. She did talk to someone at Social Security, and they told her they see no reason he would not be approved. She sent me a message of what a blessing we have been to her and was tearful on phone call. The family also took advantage of the holiday food boxes which were greatly needed.

Female member was accepted into a day treatment program in January. By February, her mother took her out stating that she wasn't getting any benefit from it and that member was lonely and needed to be around kids her age of fourteen (14). Mother stated that while at day treatment, member was discouraged from making friends. She is a very lonely teenager at this time and Mother believes with help and the ability to make friends at a regular school, she will be all right. Since then, member began cutting herself. Her mother attributes it to seeing a fifteen-year-old friend that drives her grandmother's car without a license, smokes weed, and does not attend school. Member's mother took member to Baptist and became incredibly angry when they did not admit member stating that she is in no real danger at that time. The family was in the ED for twelve (12) hours by the time they saw someone for an evaluation. It was our member who made the statement "I need to be inpatient because I don't know what I'm going to do or how far I will go." At that point she was admitted to Integris Spencer.

Family with several children with behavioral health concerns. Our main concern currently is the only female child. She continues to have behavioral problems at day treatment. After therapy, medication changes, and school changes member continues to be a concern. She tries to run away, break things, and have outbursts. It does appear that things are not getting better after multiple changes throughout the years. This family is involved with Red-Rock Systems of Care out of Clinton. Nurse Care Manager and SOC Case Manager can only go off what the mother tells us.

Member's mother was released from prison and reunited with member and older sibling. There are two younger children who have now been brought back into the home as well. Mother is upset that she did not qualify for food stamps because of the increased number of children in the home. They are struggling food wise. Mom was given resources on local food pantries. We are working with the family on finding a counselor. With all the changes and being back as a family, behavior problems have presented. There is yelling, threats between siblings and general chaos. Mother is feeling worn down but does have hope they can all get pass this hump.

Member was in-patient for almost two months because of her aggressive behavior towards her younger brother and suicidal ideation with a plan. Member has been home since for some time and has had behavior problems trying to adjust back to her life before being hospitalized. She is now doing well. She is attending a day treatment program and receives therapy during school and outside of school.

Member is fifteen-year-old female with Down's Syndrome on our ABD roster. Tragically, her father died by suicide in 2018 after a long struggle with mental health issues. Member's Spanish-speaking mother has a job, but they rely heavily on member's Social Security payments from her father being deceased, to make ends meet. Member's Social Security based on her being a child of a deceased parent is higher than what she would receive from SSI due to her disability. In December, the mother received a letter saying that member was overpaid in benefits in the amount of $5,300 and would have to be repaid. The overpayments were dated back to at least a year before the member was born. Payment was due within 30 days, or they would withhold member's full benefit payment beginning March 2022. Mother was helped in contacting Legal Aide and filling out the application for assistance, but they were denied. Assistance was provided by translating many calls to the Social Security office and filling out numerous appeal forms. In February, the mother received a letter saying they were going to start withholding member's Social Security income. Assistance with several more calls to the Social Security office and different appeal forms was also provided. On March 5, we received word that the appeal had been accepted and member's checks would continue to arrive as before.

Six-month-old baby boy came to our attention when he had several ED visits in a two-month period (Covid, pneumonia and bronchiolitis). The family is getting by on a small income from the father. The mother stays home to care for member and his two older sisters. We explained that member should qualify for SSI benefits. She had never heard of this. Since mother is Spanish-speaking, translator has an appointment with the mother to call SSA. It was also explained that after member applies for SSI, he can sign up for the DDS waiver and the Family Support Assistance Program, which will help the family with an additional $250/month. The family needed baby clothes and diapers. Nurse Care Manager picked up clothing from a local church and delivered diapers, wipes, laundry detergent and hand soap to the family. We also provided additional resources, including Infant Crisis Services, Willow Pregnancy Center and 2-1-1. Due to recent digestive issues, member has had to switch from the Gerber formulas provided by WIC to Enfamil. He is doing well on Enfamil, but this is an added expense to the family. Resources were provided to help with the formula.

Two and a half-year-old boy was hospitalized with UTI, stage 4 chronic kidney disease. He is on the inactive kidney transplant list needing to gain thirty pounds. His mother was having to pay an extra $75 a month for his prescriptions. She was encouraged to contact member's neurologist for a prior authorization. Only the father works, and they live on a small income. Mother was encouraged to apply for SSI for our member and was given information on the DDS waiver and the Family Support Assistance in case member meets the developmental delay requirements.

Female member on our ABD roster has a history of severe drug abuse and HIV infection. Her home situation has been very insecure. She is currently staying with her mother. She arrived at her mother's house with only the clothes on her back. We were able to pick up a large assortment of clothing from a local church and deliver them to the home. Several outpatient drug therapy programs have been recommended and we continue to encourage her to become involved with one of these. She was recently approved for Section 8 housing. She asked that we help her with resources for her apartment. We have already located some nice pieces of furniture, sheets, and a television. A local church member had a garage sale and offered anything they could use at no cost.

Member is a five-month-old baby boy. He was hospitalized with a life-threatening skin infection. He was sent home on several medications and lotions that had to be applied regularly. The mother is a single mom with a two-year-old in addition to the baby. The only income they have is a small amount from DHS and child support. They all live with the mother's sister. Information was provided on Section 8 housing. Resources for baby needs were provided. In a conversation with the mother, she shared that she was feeling depressed. I strongly encouraged her to speak with her obstetrician and gave her information on Red Rock Behavioral Health. Out of concern for her well-being, Nurse Care Manager tried repeatedly to contact her with no success. Three months later, the mother contacted the Nurse Care Manager sharing that she was feeling overwhelmed. She denies any thoughts of harming herself or others. She shared that she has no support for the children. She says she begged the father and his family for help but was refused. Because of member's infectious skin condition, she cannot leave him at daycare, making it impossible for her to work. She asked for resources for respite or temporary custody for the children. Despite calling DHS, Youth and Family Services, OKC Infant Crisis Nursery and many other resources, we were unsuccessful in finding such a resource due to the infectious nature of member's condition. Nurse Care Manager has spoken almost daily with the mother and has also talked to member's PCP and the mother's PCP. The mother has an appointment scheduled with her PCP to discuss her depression, suspected anemia and need for birth control. Member's PCP is working with specialists to find a treatment to help with his condition so that he won't have open sores and will be able to go to daycare. PCP is also working on a referral for home health care for member. An update on our little one with the terrible skin condition. Although the family continues to struggle, his skin is much better. He has been cleared to go to daycare and is on the waiting list to get into the facility that his brother attends. This will allow the mother to get a job. She is extremely excited about this prospect.

One of our community partners supplies bicycles for boys and girls. They take donations of old bicycles and parts and transforms them into wonderful toys. Over the holidays they were overwhelmed with generous community members to the point they had too many bicycles left after all needs and desires were filled. They offered the community a free bike give-away. We were able to notify our members of this event and some of them were gifted with a new bicycle. Again, in the spring, they found themselves with too many bicycles and sponsored a community event to give these bicycles to deserving children. Several of our members were able to take advantage of this opportunity.

Member and two sisters live with their single mother. We received a text from their mother that everyone in the family was ill with Covid. She shared that they were almost out of food, especially milk for the children and were out of diapers and wipes for member. We offered several resources for both food and diapers, but the mother explained that she was too ill to drive anywhere to pick them up. We agreed to deliver a food box provided by a local church as well as diapers, wipes, and laundry detergent. Items were delivered to the home. By the tone of her response, you could tell that she was relieved to receive the food and diapers. She was effusive in her thanks. In one text message she thanked us four times!

Female member was inpatient for almost two (2) months. Upon discharge, she returned to her previous therapist for outpatient treatment. The first couple of weeks of being home was rough, but she did get better. Family is incorporating things that were learned from inpatient and things are going well for now.

Member states mother "yells a lot". Mother has multiple chronic conditions including chronic kidney disease, nephrolithiasis, high blood pressure, thyroid disease, depression, anxiety, COPD, and eosinophilic asthma. There are four children within the household with this single parent. She is highly stressed. Within the last few months, she has moved from her brother's residence to a two-bedroom apartment. We were able to assist with furnishing of home through Focus on Home, medication lock box, education about handling stress, and food pantry.

Female member has had problems with redundancy and object fixation. We are working with family to have member use notebooks and a calendar to help ease some of these problematic situations. Example: member will be focus on a date for an event, appointment, or tv show. A big calendar in her room and a hand-held calendar have been used so she can remind herself of events.

Mother reported member's psychiatrist is no longer accepting SoonerCare. Member is eligible to receive services through Indian Health Services but has been unable to get an appointment any time soon. Continuity of medications is our main concern right now. Member suffers from multiple behavioral and mood disorders. Mother stated that they went to the ER when he was having an outburst and became physically aggressive. ER staff informed them that since they had been in the ER twice within a month, if they come again with the same issues, they will have to make a DHS referral, leaving Mom feeling very distraught and helpless. Nurse Care Manager gave CMRS number, introduced North Care Wrap Around Program, and provided a list of local Psychiatrists.

Member with developmental delays is over eighteen years old but is functionally much younger. He lives with his grandparents and younger sister. Grandmother became concerned when member began acting out sexually. She feared for her younger granddaughter as well as her grandson. He had been sneaking out of the house and peeping through neighbors' windows. It has been difficult to find a therapist to work with him as he is legally an adult, but not eligible for any adult programs. Plus, juvenile programs required a court finding, which is what we are trying to avoid. With much time and effort, he has been approved for DDS waiver. Family has been able to obtain cameras and tracking system to monitor member and he has started a new therapy program.

Member is a 52-year-old woman that first came into our care management through the Inpatient Program. She had been hospitalized with a myocardial infarction. She shared that this was her fourth heart attack. She also suffers from mental health issues, which are largely controlled through medication, and poorly controlled diabetes. Member has custody of her two young grandchildren, ages two and five. She shared that she and the children live out of her car. She got an interview with Section 8 housing shortly after our first conversation. When she did not hear back from them, I encouraged her to contact them again and to make sure they understand that her two young grandchildren live with her. She did this and shared that she is now approved and has received housing vouchers. She shared that while she should have enough money to pay her share of the monthly rent, she does not have enough to pay deposits on utilities. After making many calls (many charities are out of money), we were able to refer her to several community partners who should be able to help her. When we learned that her grandchildren were living with her, we were genuinely concerned. We spoke with the children's PCP who shared that they were aware of the living situation with the children, but that the children appear to be doing well. Member says that if there is a real need, her mother can keep the children for short times in her home. She assured me that they can keep cool in the heat.

Member is one of our long-term ABD members. He is a 54-year-old man with cerebral palsy. He had lost many of his teeth and was experiencing tooth pain. He visited one of our providing dentists, who advised him to have the remainder of his teeth pulled and to get full dentures. Member was reluctant to part with his remaining teeth and asked if SoonerCare would pay for a second opinion. After conferring with the OHCA, it was determined that SoonerCare will not pay for a second opinion, although they do not discourage him getting a second opinion on his own. I spoke with his dental office, and they assured me that his remaining teeth were unstable and in poor condition. We were able to provide him with the resource of a no-cost dental service so that if he decided to do so, he could get a second opinion. It was explained that since the extraction/denture prior authorization was approved, he has 6 months from time of approval to make the decision.

Member is an eight-year-old little boy with severe brain abnormalities, tumors, and seizures. He has a nine-year-old sister. The family stretches a small income to take care of their family. They needed assistance with school supplies, but member was hospitalized at the time of most of the school supply events. We contacted some churches that had put on school supply events. A local church agreed to provide school supplies for both children. The family was also struggling with getting adequate food and were provided information on the Regional Food Bank, 2-1-1 and a local church.

Upon engagement with this family, they were dumpster diving for food and their home was in horrible disrepair. Family is no longer dumpster diving for food. They continue to have the home worked on. We went through Unite US to assist with some home repairs. Home Repairs needed: Electricity (only has electricity through half of the home), bug infestation, non-working refrigerator, leaking roof, no air condition/heat. Wound on member's foot is getting better and we continue education on food to help wound healing and diabetes. The family has a new refrigerator, the roof is fixed, and they continue to work on living space.

For the past few months, member's behavior in her home has spiraled out of control. She states that she is hearing voices. She is emotionally abusive towards her single parent. Member is on medication and seeing a therapist. Nurse Care Manager is working with mother to be more active in the therapy sessions. Mother believes that member is not telling the therapist what is truly going on. Member has threatened her mother and talks down to her. Member tells her mother what she can or cannot do when it comes to her (member). Example: Not talking to her therapist. During our last call (twenty minutes) member called her mother three times while in school. Mother is working on setting boundaries and working with the therapist.

Female member is a very verbal 16-year-old who is wheelchair bound due to Cerebral Palsy. The family lives in an outlying town, but they make many trips weekly to Oklahoma City for therapy and doctor appointments. She has an electric wheelchair, but it is extremely heavy and large. It is exceedingly difficult to load it into their vehicle, and when they do load it and the ramps, there is little room left for passengers. Member's mother shared that a manual wheelchair would make trips much simpler. Resources were provided, such as the Medical Equipment Re-Use Program and the Donna Nigh Foundation, but the mother seemed overwhelmed and did not reach out to these organizations. The CC-HAN had a nice wheelchair in storage. I picked it up and met Member's mother with it. The wheelchair collapsed to a light and manageable size so that one adult could easily load it into the car. The mother was overwhelmed with appreciation and said that this wheelchair will profoundly change their lives.

Member is a nine-month-old baby boy we have care managed as a newborn and then again after he used the ER. The mother called me in a very distraught state, saying that she received a bill of over $1400 for part of one of his ER visits. She explained that the letter said the bill was due in a few days. She did not have the money and was afraid that this would impact her credit score, which she has been working to improve. I assured her that the bill could be resolved and instructed her to call the hospital billing office to discuss the bill. She was told to let them know that the baby is on SoonerCare and that they should pay for the charges. The mother called me back about an hour later, relieved. She said that the hospital admitted they had inadvertently not filed the ER visit with SoonerCare. They agreed to submit the charges to SoonerCare. She was instructed to call the hospital back in a couple of weeks to make sure that the charges were taken care of. She thanked us for our assistance.

Member is a three-year-old boy with a twin brother and a one-year-old sister. Member has a genetic condition which has severely affects his development. He is slowly progressing and is now able to walk with assistance. He is on a feeding tube and requires a lot of therapy. His parents are Spanish speaking. They have been unfamiliar with the resources that are available for member and absolutely overwhelmed by the system. They have often needed resources for food, diapers, and clothing. We have been working with this family since member was a year old. We have been trying to help this family apply for programs such as SSI for member, but the mother has said she just did not feel she could deal with it. With our continued encouragement and assistance, the application for SSI was submitted and approved for benefits. The extra money should allow the family to better care for their special needs child and as a result all the family will benefit.

Grandmother has custody of three (3) kids due to incarcerated parent. All the kids went back to in person school this school year because online school in her district was no longer available. Grandmother reports it has been exceedingly difficult for the oldest teen to make it to school and to complete schoolwork, her grades were poor, and she was withdrawing because she hated going to school. The teen told the grandmother she was going to drop out of school and just go to work. Nurse Care manager gave information for EPIC online school program. On follow up phone call Grandmother reports that the teen started EPIC online school and loves it. She said the EPIC teacher even made accommodations so the teen could work on one subject at a time and complete it before moving forward. Grandmother reports she is making excellent progress, her grades are fantastic, and she is so happy doing school online.

Female patient with cerebral palsy is wheelchair dependent and attends public high school. The family recently moved to a different home that did not have a wheelchair ramp. Because there was not a wheelchair ramp, member was unable to get to the bus to go to school, so she had to be schooled online. The family could not afford to have one built. A local church was contacted, and they built the ramp for our member. This will allow her to return to public school and live a much more normal life.

Ten-year-old member was to have a cardiac catheterization done but was notified that the procedure was denied due to no CPT 10 code being included with the prior authorization request. The mother was advised to contact her doctor's office and have them send the CPT 10 code ASAP. The code was provided, the authorization went through, and she received the cardiac catheterization.

Fifty-six-year-old member has numerous medical issues. She lives in a 20-foot camper. She shared that she had run out of propane, which runs her camper, including heat, hot water, and stove. She said that she has a small electric heater, but it is not working well as it will only heat on the low setting. She said that she was cold and was worried as frigid weather is to come in within the next few days. We were able to access funds, refilled her two (2) propane tanks and purchased her a small electric heater. She expressed a great deal of appreciation.

Community Partners

360 Family Support
Able Tech DME
Alameda Church of Christ
Ashbrook Foundation
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
Cleveland County Community Action
Compassionate Hands
El Reno Community Action
Epiphany of the Lord Church
Focus on Homes
Infant Crisis Services
Latino Community Development Agency
Love of the Children – El Reno
Manna Pantry – Yukon
Mustang Christian Church
Mustang Heights Baptist Church
Mustang Kiwanis
OK Bikes for Kids
OKFD Smoke Alarm Program
Oklahoma Family Network
Redlands Community College
Red-Rock Behavioral Health
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
Urban / Skyline Ministries
Willow Pregnancy Support
Youth & Family Services
Yukon Sharing