2021

CENTRAL COMMUNITIES HEALTH ACCESS NETWORK

ANNUAL REPORT

Covering January 1, 2021 through December 31, 2021

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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

1. Number of providers by name and panel size affiliated with CCHAN.

There were twenty-five (25) providers affiliated with CCHAN as of December 31, 2021. 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 PCPs for 2021

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, 2021: 168**	**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** **Hoffman, Ashley, APRN** **Karr, 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, 2021: 801**
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, 2021: 1362**	**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, 2021: 455**

Table 1: CCHAN Affiliated PCPs for 2021 (cont'd)	
Variety Care @ Yukon Pediatrics 9070E Pediatrics, 0-18 years of age 508 W. Vandament Ave. Ste 210 Yukon, OK (405) 632-6688 **Deebs, Mouziane, PA** **Hopkins, Stephanie, NP** **Martin, Alexandra, CNP** **Miller, Rebecca, NP** **Mirossay, Jennifer, LPC** **Tomichen, Regina, MD** **Panel size for December 31, 2021: 986**	

Table 2 presents a snapshot by comparing provider panel sizes December 31, 2019, 2020 and 2021. There is a pronounced increase between 2019 and 2021. It may be due to the Emergency Public Health Declaration providing no member receiving Medicaid shall be denied benefits during this period. The overall decline between 2020 and 2021 is concerning given Medicaid expansion during this period.

Table 2: CCHAN Benefit Enrollment Counts			
PCP	**2019**	**2020**	**2021**
Variety Care @ Yukon	719	732	986
Flores Pediatrics	1309	1527	1362
Canadian Valley Family Care	660	832	801
Mustang Family Physicians	355	468	455
Mustang Urgent Care	217	217	168
Total Count	**3260**	**3776**	**3772**

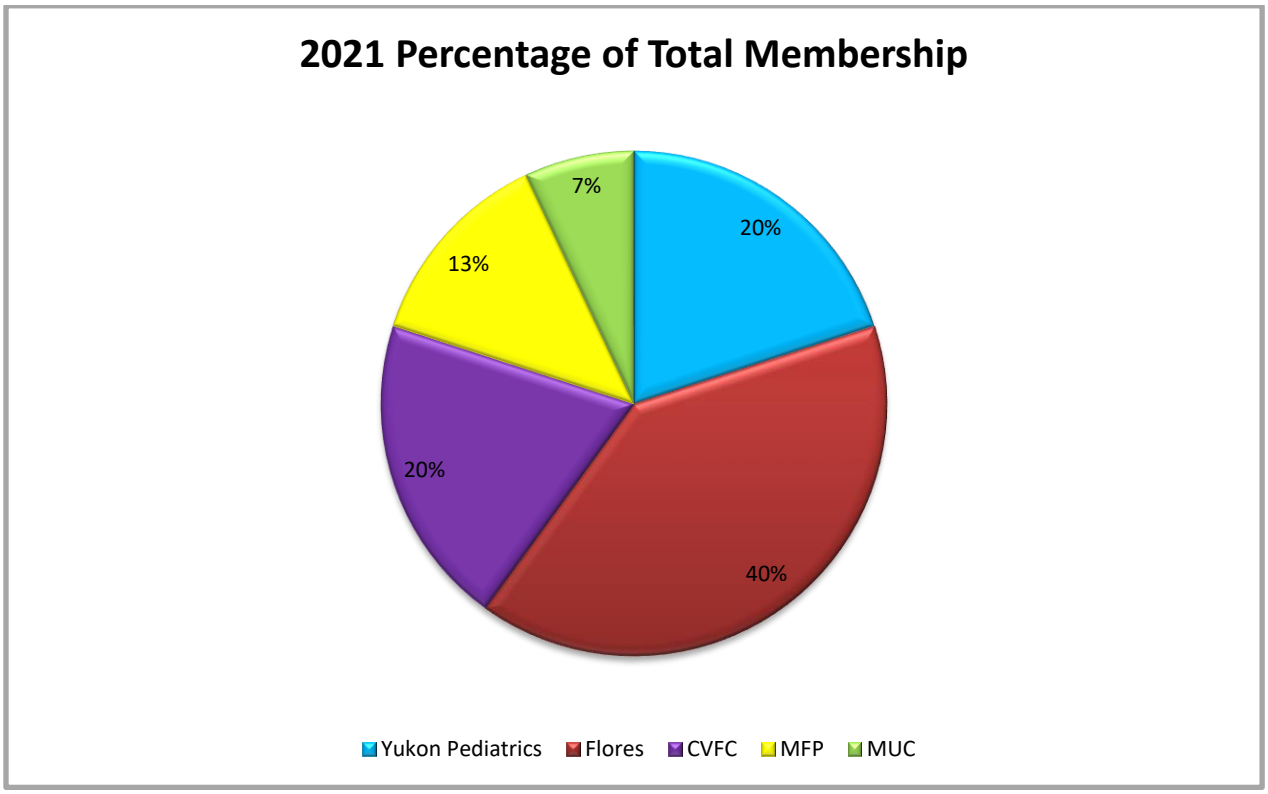

Table 3 shows monthly membership totals for 2021 and the same time periods of 2019 and 2020. Our numbers were trending downward the first half of the year, then began increasing throughout the balance of the year. We ended the year very close to where we started.

	Table 3: CCHAN Monthly Total Members 2019 through 2021		
Month	**2019**	**2020**	**2021**
January	3359	3260	3782
February	3359	3318	3746
March	3343	3285	3775
April	3326	3256	3743
May	3314	3552	3690
June	3353	3593	3690
July	3287	3662	3543
August	3251	3740	3626
September	3233	2977	3660
October	3214	3710	3663
November	3279	3731	3741
December	3229	3776	3772

2. Number of entry level or advanced level PCPs identified by name for assistance with level step up in 2021

NONE

3. Steps taken to assist PCPs in maintaining or advancing their level designation for 2021.

- **Canadian Valley Family Care**: Currently Optimal level.
  Available to staff as needed.
- **Flores Pediatrics**: Currently Optimal level.
  Available to staff as needed.
- **Variety Care at Yukon**: Currently Optimal level.
  Available to staff as needed.
- **Mustang Family Physicians**: Currently Optimal level.
  Available to staff as needed.
- **Mustang Urgent Care**: Currently Advanced level.
  Available for additional support as needed.

For ALL Providers:

Delivery of the following reports and educational materials was ongoing:

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

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

- **4998 referrals** for goods and/or services
- **388 deliveries of goods,** i.e., food, clothing, personal/household goods
- **3234 translator assisted communications,** with the aid of CCHAN Resource & Linguistic clerk.
- **8218 educational resources** were distributed to members.
- **388 behavioral health** resources were provided.
- **3115 community resources were** identified and provided.
- **59 referrals to specialists** were obtained.
- **1436 daily living needs resources** were provided.

4. 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 2019	
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 2021 include:

Asthma	ED Users
Inpatient	ABD
Behavioral Health	Other
Childhood Obesity	

Table 5: CCHAN Summary of Care Management for 2021

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 43 members in January ○ Roster with 43 members in February ○ Roster with 38 members in March ○ Roster with 38 members in April ○ Roster with 38 members in May ○ Roster with 38 members in June ○ Roster with 38 members in July ○ Roster with 37 members in August ○ Roster with 39 members in September ○ Roster with 36 members in October ○ Roster with 37 members in November ○ Roster with 39 member sin December *Note: There were forty-nine (49) individual members involved in the Asthma Improvement Plan throughout 2021.
In-Patient	Two hundred (200) members who had hospital admissions were offered care management services in 2021. One hundred eighty (180) were live births.
Aged, Blind, & Disabled	There was a total of seventy-three (73) members involved in care management in 2021.
Behavioral Health	Forty-six (46) 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: **29**
- Members with 4-14 visits in a 3-month period: **16**
- Members with 15 or more visits in 3-month period (Persistent) **0**
- Members with 3 or more ED visits being actively care managed so far in 2021: **27**

The top three (3) diagnoses for ED visits in 2021 were:

- **Accidental External Injury**
- **Respiratory Illnes**
- **Infections and Parasitic Diseases**

Average report time between emergency department visit and provider follow up visit: **Thirteen (13) days,** which is four (4) 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 2021				
Successful phone call	**Unsuccessful phone call**	**Letters, email & texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
381	70	214	5	**600**

Total Attempts: 670

Asthma Improvement Plan (AIP)

A total of forty-nine (49) individuals participated in the AIP program in 2021. At the end of 2021, 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 2021				
Successful phone call	**Unsuccessful phone call**	**Letters, emails & texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
708	34	122	24	**854**

Total Attempts: 888

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 996 contacts were made to this group, including twenty-four (24) face-face visits. One hundred eighty (180) 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 2021				
Successful phone call	**Unsuccessful phone call**	**Letters / texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
550	106	209 / 213	24	**996**

Total Attempts: 1102

Aged, Blind and Disabled (ABD)

After servings 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 issues 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. Forty-nine (49) members were actively receiving care management services at the end of 2021.

Table 9: CCHAN ABD Contacts for 2021				
Successful phone	**Unsuccessful phone**	**Letters / texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
893	223	42 / 219	34	**1188**

Total Attempts: 1411

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. Forty-six (46) members have been provided behavioral health care management that were not identified as ABD. Of those forty-six (46) members, only three (3) members have been hospitalized. There were thirty-five (35) members with active care management services at the end of 2021.

Table 10: CCHAN Behavioral Health Contacts for 2021				
Successful phone	**Unsuccessful Phone**	**Mailings/ Texts/E-mails**	**Face-to-Face**	**TOTAL NO. of CONTACTS**
403	230	6 / 58	10	**477**

Total Attempts: 707

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, two referrals have been accepted.

Other

During this reporting period, forty-seven (47) other SoonerCare Choice members were provided with either care management services or referrals. Six hundred eleven (611) contacts were made to these members who were not associated with a particular program within CCHAN. That number includes two hundred seventy-eight (278) phone calls, twelve (12) letters, twenty-nine (29) face-to-face visits, and two hundred ninety-two (292) text messages. Ninety-one (91) unsuccessful phone calls were made for a total of seven hundred two (702) total attempts at contact for 2021.

GRAND TOTAL OF ALL CARE MANAGEMENT CONTACTS AND ATTEMPTS IN 2021:

5480 Attempts 4726 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.

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. Linquistic and Resource Specialist allows CCHAN to communicate with our Spanish speaking members, eliminating the language barrier to care. For this reporting period, 3,234 calls, text messages, letters, and face-to-face visits were made with the assistance of our Linquistic Specialist. 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 L&R 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 hair cuts are passed on to our members, as well as holiday assist programs.

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-four 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-four.
B. Number of providers with existing EMRs which are functional and operational: Twenty-four.
C. Number that have operability between providers: None.

All twenty-four 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/ID, program, type of contact, and date of contact as well as maintaining nursing notes. We were able to replicate the AHC screening tool to enable care managers to enter the data directly onto the database in the AHC screen format. From that, a care plan is generated with fields populated with data from the AHC screen. Both databases are connected resulting in less data entry and more options for reporting.

3. CHAN Website (http://CCHAN.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. Our latest addition to the website is a link 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 2021, there were a total of 538 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 2021. The estimated level of achievement will be an increase in the total number of claims in 2021 (compared with 2020) 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 borns 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 2022. Table 11 presents the number/types of EPSDT contacts made in 2021.

Table 11: EPSDT Contact 2021

EPSDT CONTACTS BY TYPE					
Month	**SPC**	**UPC**	**Texts**	**Letters**	**Total Attempts**
January	280	331	104	25	740
February	271	294	90	19	674
March	272	353	122	8	755
April	265	307	100	24	696
May	243	301	107	20	671
June	255	377	120	42	794
July	236	304	98	25	663
August	266	290	99	11	666
September	257	315	129	16	717
October	272	365	101	32	770
November	273	305	87	26	691
December	287	335	77	31	730
TOTALS	**3177**	**2877**	**1234**	**279**	**8567**

Table 12 EPSDT Claims 2020 - 2021

Preventive Code	2020 claims / % change from 2019		2021 claims	% change from 2020
99381	245	189%	172	-30%
99382	117	170%	69	-41%
99383	128	131%	71	-41%
99384	78	128%	52	-34%
99391	1230	125%	816	-37%
99392	1082	122%	889	-18%
99393	914	106%	767	-16%
99394	622	113%	579	-7%
TOTALS by YEAR	**4416**	**121%**	**3415**	**-23%**

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 2021.**

The first strategy to achieve the quality measure is the CCHAN website, http://CCHAN.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 CCHAN.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 slightly higher numbers. Our hope is the numbers will continue to increase. Other promotional items are being utilized to promote the webpage, to include personal thermometers, hand sanitizer, and lip balm with the web address and logo imprinted.

Table 13: Web Site Views

Number of Views per Month	2018	2019	2020	2021
January	46	85	54	38
February	49	111	41	32
March	23	107	39	34
April	51	184	63	64
May	25	92	47	36
June	48	89	42	51
July	39	72	52	38
August	37	59	63	64
September	31	67	56	63
October	54	61	64	47
November	63	49	58	46
December	62	36	53	47

Total views 538

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, PCPs (who approved the content of each), and other health care professionals in the communities served.

3. We monitored the number of hospitalizations for each member engaged with CCHAN's Asthma Improvement Plan throughout 2021. The estimated level of achievement for this quality measure will be a reduction in number (or zero) annual hospitalizations (asthma related diagnoses) for each engaged member, comparing to pre-AIP participation.

4. Achieve at least an 90% annual flu immunization level for all AIP members in 2021. For Q1 and Q2 2021, we exceeded that goal. Thirty-five (35) of the thirty-eight (38) AIP members who were engaged in the AIP were known to have been immunized for flu, which is an 92% level. We reset our count in September. At the end of 2021, with our new timeline and goal, we reached an 82% of current AIP members vaccinated for flu. Forty (40) of forty-nine (49) members had received the vaccination. This is higher than our previous goal of 80%, but still falls short of our new goal of 90%. Educational efforts will continue.

Table 14 CCHAN AIP Evaluative Data

	Totals for 2019	Totals for 2020	Totals for 2021
Total No. AIP Members	85	65	49
Total No. of Hospitalizations prior to AIP Engagement	2	5	2
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	27	25	18
Total No. of ED Visits for Asthma Related DX after AIP Engagement	2	0	0
Total No./Percentage of AIP Members who received flu vaccination	59 for 83%	37 for 57%	40 for 82%

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

Impact of Health Access Networks on Quality of Care

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

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

The data related to overall use of the ED for CCHAN members in 2021 shows a rather large increase. One thousand forty-five (1045) members were responsible for one thousand six hundred seventy-six (1676) 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.

- Care management contacts to all members with ED visits in the previous month and also identified through quarterly claims review by CCHAN IT staff.
- Varied types of care management contacts include phone, letter, and face-to-face meetings.
- Educational materials including the CCHAN ED Diagnoses brochures and/or other educational resources are provided to members with ED visits.
- Referrals for daily living needs or other resources are made as indicated.
- Follow-up for all members with asthma-related diagnoses in either ED or inpatient reports to determine if participation in AIP is indicated.
- Deliveries of monthly ED reports to each CCHAN provider with requests for latest member contact information as well as date of last office visit and next scheduled.
- Care management encouragement to follow-up with PCP for all members who have ED visits or inpatient stays.
- 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.	**2018**	**2019**	**2020**	**2021**
Numerator: Total number of ED visits by CCHAN members with asthma identified in their problem list for an asthma-related diagnosis.	57	27	25	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.	**2018**	**2019**	**2020**	**2021**
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.	**2018**	**2019**	**2020**	**2021**
Numerator: Total number of ED visits for CCHAN members.	1234	1200	787	1676
Denominator: All CCHAN members.	3359	3260	3776	3703
Dividend for Performance Measure C:	.37	.37	.21	.45

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 about available services.

Efforts to develop broad community relationships and expand the information about available services for individuals in need of health care continues. Highlights of activities and accomplishments which illustrate the unique characteristics of CCHAN are presented below.

- **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, and the need for specialists. CCHAN staff provides educational presentations for participating PCPs and staff. In 2021, some specific examples include:

    - The PHCC Board approved funding to purchase additional peak flow meters to distribute to AIP members.
    - Throughout 2021 CCHAN staff members have worked closely with all providers to coordinate care through care management and to implement the AIP. A total of six (6) 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, including obesity. Two (2) were new babies with complex medical needs with the remaining three (3) for non-compliance with medications. Nurse Care Managers were able to make contact and determine what the needs were to improve outcomes.

- **Collaborative work between CCHAN providers and staff** was ongoing through 2021 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 three hundred eighty-eight (388) deliveries of goods were made by CCHAN care management staff. One hundred eighty (180) 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.

- **236 Provider contacts** made in 2021. 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 resources 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 So far in 2021 all meetings have been via zoom technology.

- **Community Involvement** continues to be a priority with CCHAN. Project Manager participated in the Infant Mental Health and Trauma Resource Team, a subcommittee of the Canadian County Coalition for Children and Families. Continuation of education and support of ACES awareness remains a priority for this group.

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

CCHAN staff participate in the Canadian County Coalition for Children and Families. Medical Director also attends this monthly meeting.

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

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

Ongoing implementation of the Asthma Improvement Plan (AIP) with positive outcomes.

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

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

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

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

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

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

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

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

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

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

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

The Partnership for Healthy Central Communities Board as well as the Central Communities Health Access Network staff believes the Core Strengths continue to describe the current status of the Network and serve well as a framework for future planning. We look forward to ongoing efforts in 2022 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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Amanda Perks, RN, Nurse Care Manager
Kim Johnson, RN, Nurse Care Manager
Mary Cuevas, Linguistics & Resource Specialist

Appendix A

Emergency Department Utilization Table for 2021

ED Utilization 2021					
	Total number of Members	**Number of Contacts**	**Number of ED Visits (claims)**	**Number of PCP Visits**	**Average Time (days) Between ED Visit-PCP Visit**
Totals	**1045**	**600**	**1676**	**181**	**13**

Appendix B

AGGREGATE NUMBERS FOR ED VISITS				
Two (2) visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
57	**30**	**13**	**11**	**111**
90% increase from previous quarter	131% increase from previous quarter	18 % increase from previous quarter	Baseline data.	
Three (3) Visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
23	**5**	**4**	**3**	**35**
360 % increase from previous quarter	25% increase from previous quarter	33 % increase from previous quarter	Baseline data.	
Four (4) or more Visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
7	**9**	**6**	**0**	**22**
22% decrease from previous quarter	50% increase from previous quarter	600 % 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**
178	**206**	**114**	**98**	**596**

Appendix C

Care Management Highlights

Twelve-year-old boy is on our ABD roster due to intellectual disability. His mother shared that he has grown taller lately and he very much needed some pants. We were able to pick up two new pair of athletic pants and a pair of jeans from donors at Sourth Yukon Church of Christ. Nurse Care Manager delivered them and the mother was so excited.

Family with three small children who constantly struggle with putting food on the table and clothing the family. In February, their home burned down, and they barely escaped. Everything was lost. The mother reached out to us for help and using the South Yukon Church of Christ's resources, were able to deliver many bags of clothing and other needed items. We will continue to work with this family as they try to get back on their feet.

Member's new baby sister brought us into contact. We contacted the family to follow up on how the new baby and mother were doing and became aware of member. She is a beautiful seven-year-old girl with microcephaly. Her mother shared that buying pull-ups for her were causing a strain on the family budget and asked if we could help. We were able to pick up a large quantity of pull ups from the South Yukon Church of Christ clothing rooms. Additionally, information was provided on the SoonerCare Program administered by People First Industries, which will provide the family with all the pull-ups and wipes that she will need. When I dropped off the pull ups, the mother, older sister, member, and baby came to the door. They expressed appreciation, and member gave a huge smile and said thank you as well.

Family with two members we are working with. First is 17-year-old male who continues to have problems in school. The hope is for him to finish this year and then move in with his grandmother so he can attend vocational training. He recently had a problem lashing out at home to the point Mom called CRMS (Crisis Response Mobile System), who informed her they could do a welfare check, or she could take him to the ER. By the time he was at the ER, Mom stated he was fine. Education was provided to Mom on the use of ER, CRMS and use of their support group. Seven-year-old sister is starting to misbehave at school. She is biting herself and teachers and running away. We are currently working with Mom to schedule a psychological evaluation, family behavior trends, open communication with all involved, and appropriate use of support systems.

Fourteen-year-old member who has had increased behavioral problems. She has gained a boyfriend a few months ago and the parents are very concern because he is seventeen and has dropped out of school. They are concerned with, among other things, the age difference as member is so young. They are relating the behavior and the drop in grades to her dating. Assisted family with counselors and reading materials that goes with situation.

Member is paraplegic and his mother recently had a baby. She needed a baby bouncy seat to keep baby safely by her side and move from room to room while caring for her teenage disabled son. We were able to provide a baby bouncy seat so mom is able to keep the baby close while she cooks meals, feeds her disabled teenage son, and provides care for him.

Member's mother canceled all appointments because son lost coverage. Educated mom to call SoonerCare since no cancelations due to covid. She did and everything was reinstated and back on track. Also, client's asthma tubing had a hole and mom reported it took forever to do breathing treatment. Nurse Care Manager took new tubing to home for quicker, more effective breathing treatment.

Member was added to our roster as a new baby. He had a few issues, such as diaper rash, eye infection, and difficulty with his formula. We were able to provide education and refer to his PCP as needed. The family needed assistance with groceries and diapers. Referrals were made to 2-1-1, Infant Crisis Services, and SoonerRide. South Yukon Church of Christ provided a box of groceries and diapers, which we delivered. Recently, the mother contacted us about receiving medical bills for her hospitalization. Staff was able to translate a call with SoonerCare and it was determined that SoonerCare would pay for one of the bills. This was a great relief to the family.

Managing four children of a family, which all have history of behavioral problems. The oldest continues to get into confrontations at school, including his second suspension this year. The only girl child of this family continues to run away from school during recess and at home. The mother has concerns with her daughter's medical problems and sees multiple specialists. Nurse Care Manager has a concern that all providers don't have the opportunity to speak to each other. Specialist includes GI, Urologist, Neurologist and soon to be Dermatologist. The mother continues to use Urgent Care and the ED, even after multiple conversations about proper use and calling the doctor's office after hours. Nurse Care Manager was able to initiate collaboration with Family Support Provider from Red Rock.

Member requesting assistance with childcare application. Contact was made with DHS and application was submitted by telephone for daycare assistance. The agent advised member to answer the phone for daycare interview. Assisted with translation with DHS for childcare interview and member was approved for daycare.

Worked with a family to get member re-established and approved for DDSD benefits to include a referral for IQ testing with psychologist. Member did not contact OHCA and notify them of change of address several years ago and case was filed as inactive due to returned mail. Nurse Care Manager spoke with representative from DDSD office and explained that our member has not heard from DDSD office in regards of IQ testing results. Results of IQ testing were received, and case was approved for benefits. Case was filed and approved BUT was not sent to main office. Case was processed as needed.

Member is a Spanish speaking twelve-year-old girl. In early May, she started feeling fatigued and generally ill. She got on the internet and researched her symptoms. She told her mother that she believed that she had diabetes, but her mother did not think it likely. A few days later, her symptoms worsened, and she was taken to the emergency room. Her blood sugar was over 500 and she was dehydrated. The doctors told her that she was close to a diabetic coma, and she was hospitalized overnight. The parents were overwrought and were crying upon the diagnosis. The member consoled her parents and told them that everything was going to be "OK". When Nurse Care Manager spoke with the mother, she remained extremely upset and was in dire need of education about Type 1 diabetes. We explained the basics of Type 1 diabetes; symptoms and treatment and were able to greatly allay her fears. The importance of following up with her PCP and endocrinologist was stressed. The mother expressed appreciation for our involvement.

This member is one of our new babies. He has an older sister under the age of two. Member's father died from complications of diabetes before he was born. The mother was trying to carry on through the grief. She had started grief counseling on her own and was working full time at a convenience store to provide for her family. She did not know to apply for social security survivor benefits for the children. Information was provided. Because of the situation, we continued to follow-up with the family. In May, she admitted that things were very "tight". She shared that they get SNAP and WIC, so they had no food needs, but asked for help with clothing and diapers. Utilizing South Yukon Church of Christ clothing room, we were able to deliver clothing and diapers for both children. They were also low on formula. Additional resources of Infant Crisis Services, Baby mobile, 2-1-1 and WIC were provided. The mother thanked us for our assistance.

We were able to assist s family in finding furniture for the children's room. The furniture was originally given to them and was completely worn out. Worked with Focus on Homes to get the family approved replacement furniture. Assisted with finding food pantries. Currently working on finding the family another place to live, due to being evicted.

Mother was hesitant on excepting asthma diagnosis for her daughter. Worked with her extensively to have a better understanding of the diagnosis. Provided peak flow meter and education on how to use it.

Due to member's violence toward family members, Nurse Care Manager is working with mother and member's therapist in getting member placed in an inpatient facility. Member has been violent towards multiple members of her family, including having suicidal ideations. Facilities have been at capacity and unable to take member. Nurse Care Manager helped family to implement safety precautions and provided correct contacts to assist in emergencies.

This baby boy is the newest member of a family with four older children. While following up on the new baby and mother, it was determined that the family was very low on groceries. Utilizing South Yukon Church of Christ, a box of food was procured and delivered. The children came out and were so excited to see the food that was provided. They were jumping up and down and excitedly thanking us for the food. The mother also said thank you.

One-year-old member of a Spanish speaking family who we first met soon after he was born. He lives with an older sister who is about three years old, and his parents who are Spanish speaking. Recently, we followed up with this family as the baby had several ER visits. We discovered that neither parent had medical insurance. They were encouraged to apply for SoonerCare under the Medicaid expansion. They applied and were accepted. Now everyone in the family has medical insurance.

A baby was born to a Spanish speaking family. During our initial conversation it was discovered that the home had no smoke detectors. Local fire department was contacted and they agreed to install smoke detectors at no charge. We were also able to help this family with resources to help with their utility bills and infant needs. Clothing and diapers provided by South Yukon Church of Christ were delivered to the home.

Family recently found another home due to having difficulty with the mobile home park where they lived in. We were able to refer them to Focus on Homes, who continues to work with family providing bedroom furniture for the children.

Mother of member recently had surgery due to multiple ovarian cysts. The family has decided to keep their school age kids home and on EPIC, due to increasing COVID concerns. Appropriate information was provided to assist in this endeavor.

Member is eighteen years old and is no longer living with her aunt. Members has moved back in with her grandparents who initially lost custody of her and her siblings due to abuse by another family member. Member's aunt continues to need assistance and guidance every month. Assisted family with SoonerCare, medical bills, electric bills, and school supplies.

Member's mother recently had her fifth child and needed assistance with setting up SoonerCare for the baby. She also needed help in obtaining baby items, school supplies and organizations that will help family with clothing and food. All necessary aid and referrals were provided.

Member has been very disruptive and verbally and physically abusive towards mother. Provided mother with emergency resources and things she could do relating to uncomfortable situation. The mother has recently separated from the father who was verbally and physically abusive towards the mother. The father has also been verbally and emotionally abusive towards member. Member has been exhibiting the same characteristics that her father was, all the while refusing to go to therapy. After several attempts of trying to get member into inpatient at multiple different locations, North Care is providing services.

Nurse Care Manager has been working with member's grandmother to get member extra therapy. Member is 19- years old but does not function at that age level. He is acting out sexually. His diagnosis: MR, ADHD, and Autism. There is also four-year-old granddaughter living in the same house. Grandmother she is very aware and concerned of their situation. Member does have a therapist, but the therapist has stated that our member's situation is above his expertise. I have spoken to multiple therapists and facilities, but still having trouble receiving assistance for this family. Obstacles include providers who are qualified do not take SoonerCare and charge more than the family can afford and difficulty in getting calls returned. NCM is currently collaborating with Sooner Success on other options

New female baby is growing and developing well, but her family has very little income. The family speaks Spanish only. We were able to help the family with baby supplies and with resources for baby supplies in the future. We provided the family with information on several free clinics for the older child, including a pediatric clinic for children with no insurance. The family is behind on rent/utilities. Resources were provided. The home had no smoke detectors so staff called the local fire department to request installation of smoke detectors at no charge to the family. During a recent follow-up call, the mother shared that the now one-month old baby was sick with a cough, runny nose, and diarrhea. We encouraged her to make an appointment to get the baby seen right away. The mother said that she called the baby's PCP, and they were unable to see her for two weeks, and no appointments were available before that at any of the clinics. Information was provided to Mom regarding the agreement between SoonerCare Choice providers and OHCA that they need to have open appointments for children with urgent needs. Since she was not able to be seen by her PCP, we encouraged her to take the baby to an Urgent Care. Information was provided for urgent care near their home. Mom took the baby to the Urgent Care where she was diagnosed with RSV; prescriptions were provided, and the mother reported that she could see improvement in baby's symptoms right away. Mom called her PCP to schedule a follow up appointment and again was told that appointments were not available for a couple of weeks. Mom asked about PCP's being required to save some appointment slots for SoonerCare Choice members and the receptionist found an appointment for the baby within two working days.

This member has two older siblings also in the home. Her eleven-year-old sister had received little health care. The mother was provided with information on free clinics for children with no insurance. The family got behind in their rent and were given eviction notice. We referred them to community partners for assistance, but they were out of funds. We stressed the importance of going to the court date, and while there, the landlord agreed to wait on the eviction. They are working on catching up on rent. They have very little income and have needed assistance with baby needs and food. We have found resources for them and have delivered items to their home. Recently, the gas heat in the home was not working, so they were heating the mobile home with their gas cook stove. The dangers of this were stressed. Resources for a carbon monoxide detector were identified and this was delivered to the home. This family also received a Thanksgiving meal from South Yukon Church of Christ.

Four-year-old boy with autism and significant delays is from a single parent home and his mother is unable to work as she cares for the member. The family has very little to live on, but includes member's SSI payment, Family Support Assistance and occasionally some money from the grandfather. This member still uses diapers. We encouraged the mother to talk with their provider about getting on the SoonerCare diaper program through People First Industries. She did and they now receive diapers and wipes at no cost. Housing was a major concern. With our help, she applied for Section 8 housing and was accepted. The mother had no health insurance, so information was provided on the Medicaid Expansion program.

Seven-year-old boy with epilepsy and developmental delays using only single words and a few phrases. The family received word that member would need to have an SSI re-evaluation. They asked for translation assistance and staff was able to meet the family and assist with the interview. DDS/Family Support Assistance applications were also completed earlier in the year. The family did not hear back from the DDS office. Contact was made ti the agency and they are processing the application. Approval for retro-active back pay is being sought since the office misplaced the application. This family was provided a Thanksgiving dinner through the South Yukon Church of Christ. While there, they also shopped the church's clothing room. Member and sibling were very polite and very excited about finding new clothes.

Member recently reunited with biological mother after mother had been incarcerated. Worked with family on receiving furniture from various places. Member has several behavior and physical problems and is currently receiving therapy. Mother is working on gaining custody of her two other children. Member and her older brother are living with her now. Member recently spoke to the couselor about her brother being physical abusive. Working with mother on trying to get the brother assistance and provide a safe place for member before she is removed from the home.

Nine-year-old girl became very sick with Covid in August, which resulted in five Emergency Department visits that month. She suffered from severe congestion and her oxygen levels would dip into the sixties. Since contracting Covid, she has continued to struggle with her health. She is very tired, experiences severe gastric reflux, asthma, headaches, and eye irritation. She has had several episodes of chest pain, shortness of breath and low oxygen levels (dipping into the sixties and seventies) since recovering from Covid, which required ambulance transport to the emergency department. They are working closely with their PCP to help find a resolution for her health issues, but the mother has needed guidance in asking for referrals to specialists and maneuvering the educational system for a child that is falling behind due to her illness. We have attempted to provide this guidance. They have also been a need of clothing and food. South Yukon Church of Christ provided clothing for the family, including new coats for the children. When the children received their new coats, they were bouncing with joy. They were also able to receive a Thanksgiving meal from the same church.

Member with autism and multiple medical issues related to allergies came to us for ED follow-up. Mom reports PCP has encouraged her to apply for SSI for many years but she just couldn't 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, so the family has been relying on grandma to fund their extra expenses. It has become a burden. After months of relationship building, NCM encouraged her to apply for son's SSI, and reapply for SNAP benefits since income goes up and down due to husband working overtime or not. She became discouraged at the first attempt applying because she was overwhelmed. I encouraged her to go ahead and give it another try and she did complete the process. She did talk to someone at social security and they told her they see no reason why 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.

A local television station featured a local organization, OK Bikes for Kids, during the holiday season. This organization accepts donations of used and/or broken bikes and then fixes them to be given to children who otherwise would not have a bicycle. The response was overwhelming. In late January, with an abundance of bicycles, the organization announced another bike giveaway. We were able to notify our members and several of them were able to get new bicycles. The children were thrilled!

Holiday times are always difficult for some of our more vulnerable members. We were able to assist with thirty-five (35) Thanksgiving food baskets and seventy (70) Christmas food baskets. Three (3) families were chosen from a local church for the Angel Tree program. Sixty-two (62) members were assisted by Salvation Army, sixty-three (63) by Toys for Tots and sixty-four (64) by Sharing Tree.

APPENDIX D

Community Partners

360 Family Support
Able Tech DME
Alameda Church of Christ
Ashbrook Foundation
Bethlehem Star Church
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
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