2017

CENTRAL COMMUNITIES HEALTH ACCESS NETWORK

MILESTONES AND REPORTING MEASURES

Covering January 1, 2017 through December 31, 2017

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Affiliated Providers and Access to Care (Article 4.2 and 4.3)

Reporting: To analyze the HANs effectiveness in reducing costs, improving access, improving the quality and coordination of health care services and improving the SoonerCare patient-centered medical home, the CENTRAL COMMUNITIES HAN will provide the following data in an Annual Report. In addition, periodic reports with data supporting the HAN's effectiveness will be submitted to appropriate OHCA staff at meetings throughout the year.

1. Number of Primary Care Physicians (PCP) by name and panel size affiliated with CC-HAN

There were 23 (unduplicated) PCPs affiliated with the HAN as of 12/31/2017. Three of the 23 are associated with two of the participating group practices; they are James M. Brown, DO, Aaron P. Wilbanks, DO, and Andrea L. Krittenbrink, PA-C; each is associated with both Canadian Valley Family Care and Mustang Urgent Care. Names and panel sizes for December, 2017 are presented in Table 1. Dr. Vladimir Holy retired June 30, 2017. Recruitment efforts have been unsuccessful to add new providers.

Table 1: CC-HAN Affiliated PCPs for 2017

Yukon Pediatrics 9070E Pediatrics, 0-18 years of age 508 W. Vandament Ave. Ste 210 Yukon, Ok (405) 350-0200 **Fulmer, Jennifer J., ARNP** **Green, Katrin, PA** **Hanes, Alecia A., MD** **Martin, Alexandra, CNP** **Stutzman, Tiffany B, PA** **Panel size for December 2017: 689**	**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., ARNP** **Krittenbrink, Andrea L., PA-C** **Roof, Lindsay K., APRN** **Siems, Ami L., MD** **Wilbanks, Aaron P., DO** **Panel size for December 2017: 627**
Flores Pediatrics 7440B Pediatrics, 8-21 years of age 415 E. Main, Building B Yukon, OK (405) 350-8017 **Javier A. Flores, MD** **Catherine B. Flores, MD** **Panel size for December 2017: 1324**	**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** **Stephanie R. Sims, CNP** **Panel size for December 2017: 417**

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** **Kelly, Shelly A., ARNP** **Krittenbrink, Andrea L., PA** **James McGinn, ARNP** **Mathew, Rohit, PA** **Medgaarden, Alex E., PA** **Ricks, Jacinda R., ARNP** **Wilbanks, Aaron P., DO** **Panel size for December 2017: 217**	

Table 2 presents a "snapshot survey" by comparing Provider panel sizes in the last month of 2015, 2016, and 2017. The slight upward trend in total enrollments for 2016 is important considering that the change to remove members from SoonerCare who had other insurance was a major reason for the decline in 2015. However, the significant decline in one PCP's enrollment, seen over the three-year period, is of note. It should also be noted the three other providers who saw a decline in 2015, saw significant growth in 2016, exceeding their 2014 numbers. In 2017, there was a statewide downward trend in SoonerCare enrollment, plus the CC-HAN lost one provider to retirement. That provider accounted for seven percent (7%) of the total enrollment.

Table 2: CC-HAN Benefit Enrollment Counts

PCP	December 2015	December 2016	December 2017
Vladimir Holy, MD	307	275	0
Yukon Pediatrics	687	758	689
Flores Pediatrics	1384	1450	1324
Canadian Valley Family Care	577	638	627
Mustang Family Physicians	442	513	417
Mustang Urgent Care	131	228	217
Total Count	3528	3862	3274

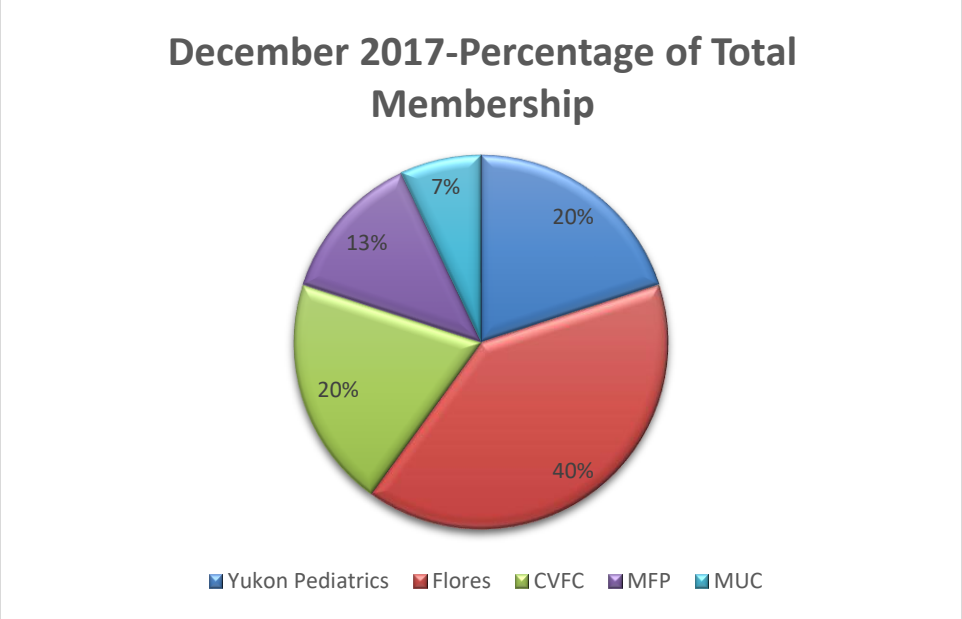
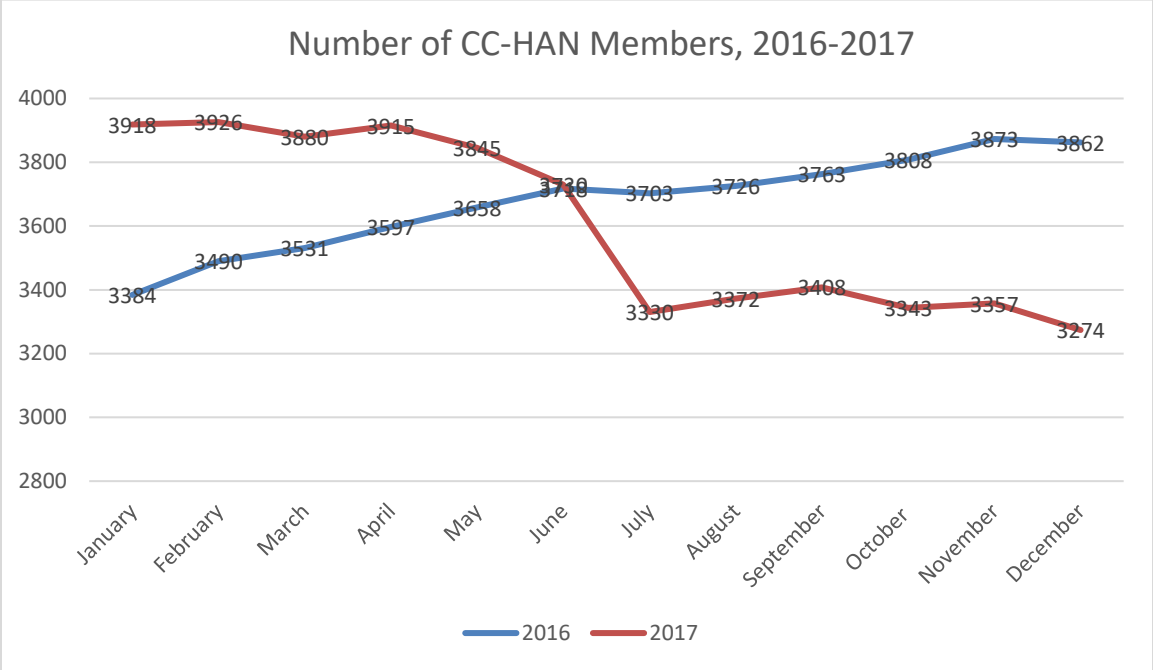


Table 3 shows a slight growth trend in total members for early 2107 over 2016, with a decline in July 2017 continuing throughout the remainder of 2017. Efforts were underway at the end of 2017 to recruit another group to join CC-HAN, which will both strengthen the HAN and add positive support for the (new) providers and additional SoonerCare members.

Table 3: CC-HAN Monthly/Total Members for Calendar Years 2016 & 2017		
Month	**2016**	**2017**
January	3384	3918
February	3490	3926
March	3531	3880
April	3597	3915
May	3658	3845
June	3718	3730
July	3703	3330
August	3726	3372
September	3763	3408
October	3808	3343
November	3873	3357
December	3862	3274



2. Number of Tier 1 or 2 PCPs identified by name for assistance with tier step-up by tier type for 2017.

None

3. Steps taken to assist PCPs in maintaining or advancing their tier designation for 2017.

Canadian Valley Family Care:
Discussed advancing to Tier III, was not interested at this time. May take a look at using the Doc2Doc at a later time. Reviewed Tier II requirements with office manager. Offered to provide SBIRT training to providers.

Flores Pediatrics:
Offered assistance in preparation for SoonerCare audit. Offered SBIRT training to providers. Assisted in blood born pathogens / universal precautions training to staff.

Alecia Hanes, MD DBA Yukon Pediatrics:
Consultation in preparation for Department of Mental Health Accreditation. Offered SBIRT training to all providers. Discussed possibly helping with online Ages & Stages for all providers.

Mustang Family Physicians:
Offered SBIRT training to all providers. Aided in building website to include online scheduling.

Mustang Urgent Care:
Offered SBIRT training.

For ALL Providers:

Delivery of the following Reports and educational materials was ongoing throughout 2017:

- Monthly ER reports
- Monthly Inpatient reports
- EPSDT rosters
- ABD Rosters
- Tobacco Cessation educational materials/resources
- CC-HAN Website Promotional items and brochures
- Canadian County Prescription Dropbox Information/Location flyers
- CC-HAN ER 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.

CC-HAN staff also **provided assistance during 2017** with member issues/needs for all providers. This assistance included the following totals:

- **2169 referrals** for goods and/or services
- **130 deliveries of goods,** i.e., food, clothing, personal/household goods
- **31 back-school supplies** referrals and/or deliveries
- **74 holiday gifts/items** referrals and/or deliveries
- **88 translator assisted communications**, either through Canadian County Department, or with the aid of CC-HAN EPSDT clerk.
- **9 peak flow meters** were provided to members
- **2 coagulator home-test monitors** were provided to members**.**
- **1 custom made weighted blanket** was provided to a member**.**
- **12 nebulizer kits** were provided to members
- **Smoke detector** installation was provided by OKCFD, arranged by care manager

4. Number of PCPs with successful tier advancement by name within designated timeframe

   There were no Tier advancements in 2017.

5. Number of specialty providers:

   Number of specialty providers available for SoonerCare members served by our providers: **108 Specialists and 594 public resources for a total of 702 specialty providers.** Table 4 represents the type and number of providers.

Table 4: CC-HAN Specialty Providers for 2017	
Type of Provider	**Number**
Medical Doctors - all specialties	166
Behavioral Health - Psychologists, therapist, etc	99
Therapy - PT, OT, Speech, Dietician, Home Health	66
Women's Health	31
Community Resources - Housing, Food, Clothing	118
Crisis Intervention / Support Groups	60
Dental	39
Substance Abuse - Counseling / Support	16
DME	7
Labs & Testing	37
Free Clinics	38
Hospitals	20
Medication Assistance	5
TOTAL	**702**

6. Number of PCPs by name and panel size that failed medical home audits.

   There were no medical home audit failures in 2017.

7. Documentation of type of assistance provided (e.g. face to face visits, corrective action plans developed, etc.) to each PCP.

   NA

Care Management (Article 4.4) PR

- Identify all populations for care management, complete implementation timetable for all populations, and complete transition for each population with members on PCP rosters (Article 4.4 a and b).

  The populations for care management throughout 2017 include:

  - Asthma
  - Chronic Care
  - High Risk OB (returned to OHCA in September)
  - ER Users
  - Inpatient
  - Pharmacy Lock-In (returned to OHCA in September)
  - ABD (added in August)
  - Breast & Cervical Cancer (Oklahoma Cares) (returned to OHCA in September)

- Hold at least one Care Management quarterly meeting.

  Four (4) Care Management meetings (via conference call) with OHCA Care Management staff on January 24, April 19, July 19, and October 18, 2017.

  Monthly care management team meetings were held in 2017. The project manager for Red-Rock Systems of Care agreed to become a member of our team to provide much needed behavioral health expertise. In August, when we received our first ABD roster, it was apparent we would need the expertise of our Sooner Success representative, who graciously agreed to become part of our team. We are fortunate to have service providers in our area that are available to come talk with use during our care manager meetings. We have had a therapist that works strictly with children with autism to help us understand this condition and provide helpful information on how to best serve that population.

Reporting: To analyze the HANs effectiveness in reducing costs, improving access, improving the quality and coordination of health care services and improving the SoonerCare patient-centered medical home, the CENTRAL COMMUNITIES HAN will provide Care Management activities and measures on a monthly basis to the following populations:

Table 5: CC-HAN Summary of Care Management for 2017	
Population	**Care Management Members**
High Risk OB	One (1) case in 2017. Returned to OHCA 9/2017
Chronic Care	○ Roster with 37 members (3 other; 34 asthma*) in 1/17 ○ Roster with 35 members (35 asthma*) in 2/17 ○ Roster with 37 members (37 asthma*) in 3/17 ○ Roster with 36 members (36 asthma*) in 4/17 ○ Roster with 37 members (37 asthma*) in 5/17 ○ Roster with 37 members (37 asthma*) in 6/17 ○ Roster with 36 members (36 asthma*) in 7/17 ○ Roster with 33 members (33 asthma*) in 8/17 ○ Roster with 33 members (32 asthma*) in 9/17 ○ Roster with 34 members (34 asthma*) in 10/17 ○ Roster with 32 members (32 asthma*) in 11/17 ○ Roster with 32 members (32 asthma*) in 12/17 *Note: the asthma members are all those engaged in the Asthma Improvement Plan.
Pharmacy Lock-In	No members in 2017. Returned to OHCA 9/2017.
Aged, Blind, & Disabled	The aged, blind and disabled (ABD) population was added in August 2017. Approximately 50% had a psychological disorder identified. One care manager has taken that population and is also accepting referrals from PCP's when behavioral health issues arise. All other ABD members are being care managed, as appropriate, by other care managers. At the end of 2017, 67 members were engaged.
Breast &Cervical Cancer (Oklahoma Cares)	No members in 2017. Returned to OHCA 9/2017.
CM Initiative	Asthma care management initiative, the Asthma Improvement Plan (AIP) initiated in February 2012; a total of 37 members were engaged in January - December 2017 with 32 members engaged as of 12/31/17.

High Risk OB With the addition of the ABD members, it should be noted, this population will no longer be care managed by CC-HAN.

1. Number of members received for HAN care management program January - December 2017: **Zero (0)**
2. Number of existing members still being care managed at end of December 2017: **Zero (0).**
3. Number of attempted contacts with outcomes (successful or unsuccessful) and contact method (face-to-face, telephonic, letter, etc.) for each attempt: **44 total**
   17 successful phone calls; 25 unsuccessful phone calls; 2 letters.
4. Indicate type of provider (family practice, OB/GYN, clinic, etc.): **Member was seen by OB/GYN Provider.**
5. Pregnancy outcomes: **Twin live births in May, 2017**
6. Number of depression screenings completed with results: **One depression screening was performed with negative results. Member denied depression each month up to final contact on June 12m 2017.**

Hemophilia With the addition of the ABD members, it should be noted population will not be served by CC-HAN.

There were no members served in the CC-HAN Hemophilia program in 2017.

Chronic Care Unit:

1. Number of members received for HAN care management program for January-December 2017: **One (1)**

2. Number of contacts - one successful telephone call. Member was thought to have cystic fibrosis, but that was ruled out. Mother did not want care management services.

ER Utilization (co-manage)

- Members with 3 visits in a 3 month period during report period: **38**.
- Members with 4-14 visits in a 3 month period: **7.**
- Members with 15 or more visits in 3 month period (Persistent) **0**
- Members with 3 or more ER visits being actively care managed: **13**

1. The top three (3) diagnoses for ER visits in 2017 were:
   - **Upper Respiratory Infection**
   - **Fever**
   - **Laceration without foreign body (various body parts)**

   Two of the top three diagnoses for ER visits have also been top diagnoses for previous years. ER brochures had been developed for these two diagnoses and are currently used as educational tools in the care management process. The evidence that the CC-HAN developed ER brochures add value to the care management efforts is based upon member and provider feedback that the brochures are helpful. These brochures are now available in Spanish as well. It is unclear at this time what might be provided to reduce the number of ER visits for lacerations.

2. Number of medical referrals generated.

    a. Assistance with identified needs in conjunction with daily living, members were provided with **1087 referrals made on behalf of SoonerCare Choice members.**

    b. Report time between ER visit and successful follow up PCP visit: **29.48 days**

A review of data related to the total number of members with 3 visits/quarter and with 4-14 visits/quarter since the HAN's implementation shows an upward trend in FY16. It is also noted that the HAN total enrollment for FY16 was up (nearly) 10% over FY15, accounting for some of the trend. Overall enrollment has declined in 2017, including the loss of one provider, equaling approximately 7% of the total membership.

Data will be continuously monitored and evaluated to be reported in the 2018 annual report using the calendar year time frame.

Pharmacy Lock-in. With the addition of the ABD members, it should be noted this program will no longer be implemented by CC-HAN.

There were no pharmacy lock-in members provided with care management services in 2017.

B&C Cancer (Oklahoma Cares Program) With the addition of the ABD members, it should be noted this program will no longer be implemented by CC-HAN.

No members participated in this program in 2017.

Aged, Blind & Disabled (ABD) - The CC-HAN began serving this population in late August, 2017. In preparation for this, one nurse care manager was trained in serving the behavioral health issues within this population. She will be care managing the psychological disorders on this list, which average 50% of total members on the list. Since August, 2017, 137 total contacts have been made, with a total of 262 attempts. This population has been found to be quite needy, therefore an additional nurse care manager was hired to help serve our members.

HAN CM Initiative

The Asthma Initiative was fully implemented in the spring of 2013. A total of 39 members were engaged in the Asthma Improvement Plan (AIP) in 2017. During 2017, 39 AIP members have been referred from CC-HAN participating PCPs. The number and types of contacts, including successful and unsuccessful phone contacts, mailings, electronic communications (requested by members), and face-to-face visits are reported in Table 6. A grand total of 604 care management contacts were made in 2017, including forty-seven (47) face to face visits.

Table 6: CC-HAN AIP: Care Management Contacts for 2017

Successful Phone	Unsuccessful Phone	Mailings/ Texts/E-mails	Face-to-Face	TOTAL NO. of CONTACTS
456	435	101	47	**604**

In-patient Contacts

Monthly reports have been provided by OHCA to CC-HAN throughout 2017, including in-patient reports for recently hospitalized members. Care management services provided for this group are included in Table 7. As the Table shows, a total of 272 contacts were made to this group, including ten (10) face-face visits.

Table 7: CC-HAN Inpatient Contacts for 2017				
Successful. Phone	**Unsuccessful Phone**	**Letters**	**Face-to-Face**	**TOTAL NO. OF CONTACTS**
203	31	59	10	**245**

AHC screening tools have been successfully assimilated into each program within the CC-HAN. This tool is being used to determine level of care for each member entering the CC-HAN. It may lead to a member needing full care management, or simply a referral or educational materials provided. In 2017, a total of 32 screens have been completed. The Nurse Care Managers have found this tool to be extremely helpful in building relationships with our members.

Health Information Technology (Article 4.5)

1. PCPs assisted with qualifying for federal EHR incentives–education, outreach, etc. (Article 4.5 c): None in 2017.

Milestones for electronic health records being met (Article 4.5 b):
All twenty-three PCPs in CC-HAN have EHRs; milestone is met.

Reporting: To analyze the HANs effectiveness in reducing costs, improving access, improving the quality and coordination of health care services and improving the SoonerCare patient-centered medical home, the Central Communities HAN will provide the following data quarterly:

Benchmark and milestones regarding EMR:

1. **Number of PCPs with existing EMRs as a benchmark:** Twenty-three.

2. **Number of PCPs with existing EMRs which are functional and operational:** Twenty-three.

3. **Number that have operability between PCPs:** None.

All twenty-three HAN PCPs (five practices) have and are utilizing EMRs. None have operability with other PCPs.

Doc2Doc:

CC-HAN Providers continue to have many questions/concerns related to implementation of Doc2Doc and share primary interest in the development of the online consultation component of Doc2Doc. The PCP staff have gained familiarity with the OHCA referral system so that incentive (using Doc2Doc for referrals) no longer exists. In addition, the EMRs for most work well enough to facilitate management of referrals, including tickler systems or other ways to ensure "closing the loop" for referrals.

The CC-HAN Project Manager met in spring 2016 with Lyn Denny from the Sooner Health Access Network's Department of Medical Informatics to learn about Doc2Doc updates. Ms. Denny then participated in the June 2016 PCP meeting to share updates and information about Doc2Doc. Three (3) providers have been trained in the Doc2Doc program. One provider reports being extremely happy with the outcomes, but still would like a larger group of specialists to choose from. The other provider is reluctant to give up the old method but was trained regardless.

The third primary care practice had three employees trained in 2017. Very little work is being done with this program. There seems to be a consensus among the CC-HAN providers who are trained in the Doc2Doc referral program, is specialists in the referring area are not signed up and in the program. It has been requested that the providers prepare a list of specialists they would like to be included, and to date, it is unclear that that has occurred. Efforts are ongoing to find a way to make the Doc2Doc program work.

The CC-HAN Providers have also expressed a lack of willingness to invest funds for a Health Information Exchange when the Oklahoma City area data continues (in general) to be split between MyHealthAccess and Coordinated Care of Oklahoma. There is a general agreement that access to health information through an HIE is a future goal all support when there is a reliable single source of data that will facilitate coordination of care for members. Ongoing reports from MyHealthAccess are promising to support utilization in the near future.

The Access database used to document and maintain records of care management contacts is considered a technology strength for the CC-HAN. 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. It remains a goal to utilize the database for aggregating referrals made, although another strategy is in place (and working well) as care managers report referrals monthly.

CC-HAN Website (http://cc-han.com/):

The Central Communities HAN website continues to provide health preventive/management information and resources for members and the public at large. Information about the HAN, participating Providers, and staff is also available through the website. In addition, a Specialist List with contact information is housed on the website although password protected for Provider access only. A list of community resources is available to the general public. This website is also available in Spanish.

QI/QA (Article 4.6)

To improve quality and access to healthcare services and to reduce costs, the CC-HAN will:

1. **Develop and implement strategies to increase the number of SoonerCare children in CC-HAN contracted Medical Home practices who receive well-child visits with appropriate health screenings (in accordance with EPSDT guidelines) in 2017. The estimated level of achievement will be an increase in the total number of claims in 2017 (compared with 2016) for each Preventive Code.**

   The primary strategy to increase the number of well-child visits is ongoing through the EPSDT Clerk position; the EPSDT Reports provided monthly by OHCA facilitate the contacts. Specific purposes and responsibilities of the Clerk position are:

   - To facilitate attainment of the HAN Quality Measure to increase the number of SoonerCare Children in HAN Medical Home practices who receive well-child visits with appropriate health screenings.
   - To contact SoonerCare members to encourage compliance with well-child/EPSDT visit schedule(s); communications will also include contacts to PCP 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 provide (or assign) care management services.
   - To submit monthly reports (or more often if needed) to the Project Manager outlining the numbers and types of contacts made.

   In February 2015, OHCA approved the CC-HAN Quality Measure and plan. The position was filled in March 2015, and implementation was initiated in April 2015. The position has been ongoing since that date. In September 2016, a new, bilingual clerk was hired.

   The estimated level of achievement was met in 2015 with a 6% gain (overall) in well-child visits. For 2016, there is an 11% loss from the totals in 2015. One possible contributing factor to the decline is based upon conversations with PCPs, who share that often children come in for well-child visits with complaints of other "problems." The priority of the visit shifts to assessment, diagnosis, and treatment of the problem. Since the provider can bill for only one code per visit, they typically submit the claim for the illness. CC-HAN providers have also shared concerns that it is often "very difficult and close to impossible" to get the child re-scheduled for a well-child visit, resulting in a common decision to include the well-child exam "without reimbursement."

   Importantly, CC-HAN PCPs continue to share support for the contacts made to increase well-child visits; continuation of the position of EPSDT clerk with assigned responsibilities will continue through 2018. With a bi-lingual clerk coordinating the contacts due to the number of Spanish-speaking families served, it is hoped that improvements in communication may result in more visits for 2018. Tables 8-9 present the number/types of EPSDT contacts throughout 2017.

Table 8: CC-HAN Quality Measure Report: EPSDT Claims Data							
Preventive Code	**FY 14 # of Claims**	**FY 15 # of Claims**		**July - December 2016 # of Claims**		**2017 # of claims**	
New Patients:							
99381	332	301	-9%	141	-53%	99	-30%
99382	164	119	-27%	80	-33%	73	-8%
99383	193	146	-24%	128	-12%	94	-27%
99384	62	63	2%	60	-5%	42	-30%
Established Patients:							
99391	1477	1536	4%	1256	-18%	1004	-20%
99392	993	1189	20%	1032	-13%	960	-7%
99393	912	947	4%	848	-10%	787	-7%
99394	382	466	22%	447	-4%	434	-3%
TOTALS by YEAR	**4515**	**4767**	**6%**	**3992**	**-16%**	**3493**	**-12%**

Table 9: EPSDT Contacts 2017					
Month	**SPC**	**UPC**	**Texts**	**Letters**	**Total Attempts**
January	168	228	78	35	**509**
February	154	285	89	34	**562**
March	135	199	55	33	**422**
April	157	232	53	42	**484**
May	151	195	47	35	**428**
June	173	224	54	37	**488**
July	153	184	38	43	**418**
August	130	171	34	36	**371**
September	128	194	46	32	**400**
October	140	196	45	32	**413**
November	154	228	54	27	**463**
December	112	158	31	33	**334**

TOTALS	1766	2494	624	419	5303

2. Develop, implement, and/or strengthen at least two strategies to facilitate increased access and delivery of preventive health care services for SoonerCare members in. 2017

The first strategy to achieve the QM is the CC-HAN 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 monthly for assessment and planning purposes. In general, the stats showed upward trend in views in 2014, with a downward trend in starting in spring/summer/fall 2015 which continued until a slight upward trend in Apr-Jun 2016. Efforts to promote use of the website for preventive health services as well as general information about the HAN and Providers have been ongoing.

The utilization of site stats has been found to be very useful in guiding HAN efforts to promote access and delivery of preventive health services. Table 10 presents information and trends on CC-HAN website views. The lower numbers in July and August can be attributed to this being a period of time the website was down for upgrades and updates. The site stat program was inadvertently turned off during this period, not counting any visitors. It was also discovered that HAN employees whose computers had the webpage set as their homepage were also being counted. This is no longer the case. Numbers from September 2017 are believed to be a bit more reliable. It should also be noted, two out-of-state agencies requested to be linked to the CC-HAN website in 2017.

Table 10: CC-HAN Website Stats				
Number of Views per Month	**2014**	**2015**	**2016**	**2017**
January	261	387	37	115
February	223	315	38	82
March	232	317	44	103
April	176	174	71	135
May	365	161	50	97
June	321	167	65	138
July	373	176	83	69
August	386	154	122	35
September	593	158	117	68
October	unknown	74	86	65
November	unknown	86	115	45
December	unknown	15	83	17

The second major strategy for achieving QM 2 is the utilization of ER brochures and one flyer for member education throughout 2017. The brochures/flyer are based on the "top diagnoses" for ER visits in 2012-2016. The top three diagnoses for ER visits in 2017 were upper respiratory infection, fever, and lacerations. Two of the three were among the top diagnoses in previous years (fever & URI). Previously developed brochures/flyer were reviewed (again) for accuracy and relevance and will continue to be used for member and general public education related to the following diagnoses:

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

The distribution process for the ER brochures/flyer includes:

- PCP offices are provided copies of the brochures to assist with patient education;
- All SC members with related ER visits are provided (appropriate) brochure(s) as a part of the care management process;
- The brochures are also provided other members with (related) health concerns.
- Brochures are provided to four area County Health Departments (Canadian, Custer, Kingfisher, and Logan) 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 CC-HAN website.

The educational value of the brochures has received support through anecdotal evidence, including inclusion in the July 2015 External Evaluation Report. 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.

N. **Monitor the number of hospitalizations for each member engaged in the CC-HAN Asthma Improvement Plan throughout 2017. The estimated level of achievement for this QA Measure will be a reduction in number (or zero) annual hospitalizations (asthma related diagnoses) for each engaged member, comparing to pre-AIP participation**.

In 2017, thirty-nine (unique) SoonerCare Choice members were engaged in the Asthma Improvement Plan (AIP).

O. **Achieve at least an 80% annual flu immunization level for all AIP members in 2017.**

As of the end of 2017, 21 of the 40 AIP members who were engaged in the AIP (at some point) were known to have been immunized for flu, which is a 53% level. The outcome is significantly lower than the goal of 80%; it is accounted for largely by parental distrust of vaccinations, particularly fears of negative side effects. Media coverage about the vaccine's effectiveness has also influenced the outcome. However, the 80% level will remain the CC-HAN benchmark because of sound evidence that immunization is the best way to prevent the complications associated with flu and because of the higher risks for flu complications for individuals with asthma. Educational efforts will also continue.

Table 11: CC-HAN AIP Evaluative Data, CY 13-2017					
	Totals for CY 13	Totals for RY 14	Totals for RY 15	Totals for July - December 2016	Totals for 2017
Total No. AIP Members	39	39	40	34	40
Total No. of Hospitalizations prior to AIP Engagement	1	1	3	4	1
Total No. of Hospitalizations for Asthma Related DX after AIP Engagement	0	0	1	0	0
Total No. of ER Visits for Asthma Related DX prior to AIP Engagement	12	8	14	17	26
Total No. of ER Visits for Asthma Related DX after AIP Engagement	2	2	2	3	2
Total No. of Urgent Care Visits for AIP Members	2	5	22	1	0
Total No./Percentage of AIP Members who received flu vaccination	21 for 54%	30 for 77%	27 for 68%	21 for 58.22%	21 for 53%

Care management encouragement to utilize urgent care facilities rather than hospital ERs (when appropriate) will continue along with education about symptom control and recognition of the symptoms which are true emergencies.

Hypothesis 7 Report: Impact of Health Access Networks on Quality of Care: Performance Measure A: Decrease asthma-related ER visits for HAN members with an asthma related diagnosis identified in their medical record.

As Table 12 shows, the number of ER visits (with asthma-related diagnosis) by HAN members who have asthma identified in their problem list (PCP EMRs) remains low with a downward trend since CY 13. The trend is positive support of the CC-HAN work although opportunities for improvement continue. Staff members monitor closely all ER 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 ER for HAN members in 2017 is noted to be significantly lower than the numbers in previous years. The data is supportive of the following CC-HAN efforts to reduce overall ER use:

- Care management contacts to all members with ER visits in the previous month and also identified through quarterly claims review by CC-HAN IT staff;
- Varied types of care management contacts include phone, letter, and face-face meetings;
- Educational materials including the CC-HAN ER Diagnoses brochures and/or other educational resources are provided to members with ER visits;
- Referrals for daily living needs or other resources are made as indicated;
- Follow-up for all members with asthma-related diagnoses in either ER or inpatient reports to determine if participation in AIP is indicated;
- Deliveries of Monthly ER Reports to each CC-HAN Provider with requests for latest member contact information as well as date of last office visit and next (if any) scheduled;
- Care management encouragement to follow-up with PCP visit(s) for all members who have ER visits or inpatient stays.

Table 12: Hypothesis 7: Key Quality Performance Measures					
Performance Measure A: Decrease asthma – related ER visits for HAN members with an asthma related diagnosis identified in their medical record.	**CY 13**	**CY14**	**CY15**	**CY16**	**2017**
Numerator: Total no. of ER visits by HAN members with asthma identified in their problem list for an asthma-related diagnosis.	86	72	41	42	26
Denominator: All HAN members with an asthma diagnosis identified in their medical record.	839	885	858	670	651
Dividend for PM A:	.10	.08	.05	.06	.04
Performance Measure B: Decrease 90-day readmissions for related asthma conditions for HAN members with an asthma diagnosis identified in their medical record.	**2013**	**2014**	**2015**	**2016**	**2017**
Numerator: Total no. of HAN 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	2	0	0
Denominator: All HAN members with an asthma diagnosis identified in their medical record and having at least one inpatient stay related to asthma.	7	4	9	2	2
Dividend for PM B:	0	0	.22	0	0
Performance Measure C: Decrease overall ER use for HAN members.	**2013**	**2014**	**2015**	**2016**	**2017**
Numerator: Total number of ER visits for HAN members.	2153	1938	2256	1397	1500
Denominator: All HAN members.	5192	5273	5137	4110	3915
Dividend for PM C:	.41	.38	.44	.34	.38

Other CC-HAN Distinctives

The CC-HAN continues to have distinctive characteristics that are considered important to highlight in the Annual Report. From the earliest planning stages for the CC HAN, 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 the HAN 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 members will benefit, providers will benefit, and the communities served will also benefit. Another important expectation is that the HAN 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 the CC HAN are presented below. Further information may be found in the bi-monthly Project/Care Manager Reports from 2017, which are readily available upon request.

- **Follow-up on needs and concerns of PCPs** remain priorities for the CC-HAN staff. Examples include assistance with Medical Home requirements and audits and availability to assist with matters as varied as billing questions, possible rate cuts, prior authorizations matters, OHCA requirements on various matters (e.g., Behavioral Health Screening requirements, Allergy Testing program changes), EMR implementation challenges, and need for specialists or other community resources for patients (counseling resources, transportation services, ADHD testing, etc.). In addition, the HAN staff provides educational presentations for participating PCPs and staff. In 2017, some specific examples include:
    - Communicable Diseases/Infection Control for Flores' Pediatrics on 1/25/17.
    - In March, the PHCC Board approved funding to purchase 12 additional Peak Flow Meters to distribute to AIP members.
    - In May, PHCC Board approved funding to purchase two coagulator meters for providers with members that were having difficulty getting to a lab to have their blood checked. PCP's provided patient education as needed.
    - In June, PCP meeting was held with Melody Anthony, Deputy State Medicaid Director, answering questions concerning providers regarding upcoming budget shortfalls, among other topics. Lauren Greenfield, Red-Rock Area Preventionists, provided information regarding the safe disposal of prescription medications, along with several prevention programs ongoing in our communities. Finally, Nicole Sukenis, Infant Crisis Services spoke on the services offered at their Oklahoma City location and with the baby-mobile that frequents Canadian County.
    - Throughout 2017, CC-HAN staff members have worked closely with all Providers to coordinate care through care management and to implement the AIP. A total of 43 "other" members were provided care management services throughout the Report Year, demonstrating the collaborative relationships between HAN providers and staff.

- **Collaborative work between HAN Providers and staff** was ongoing through 2017 to improve coordination of care and increased quality of care for members, as evidenced in part by CC-HAN care management staff have provided face-face contacts with members since the HAN's inception, including the 78 face to face visits. 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.
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    - A total of 259 deliveries of goods as varied as clothing, food, household supplies or Peak Flow Meters were made by CC-HAN care management staff.

- **Meetings with all PCPs and their key staff** to address common concerns and to determine ways the HAN can facilitate their practices occurred primarily through office visits and phone contacts. One formal meeting was held on June 21, 2017. Melody Anthony, MS, Director of Provider Services, provided OHCA updates, and addressed provider concerns and questions.

- **313 Provider contacts** made in 2017. Contacts are as varied as deliveries of rosters (e.g., EPSDT or latest ER), assistance with mental health audits, educational presentations, 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.

- **PCP and member support** continues to include acceptance of referrals of "other" members who need educational or other assistance. A total of 150 contacts were made to this group.
- One Nurse Care Manager spent one week in training in order to learn best to work with the psychological needs of the ABD population.
- Care Management Teleconferences with OHCA staff were held on 1/24, 4/19, 7/29, and 12/13/2017.
- Monthly CC-HAN Care Management Team meetings for 2017 were held on 1/30, 2/27, 30/20, 4/24, 5/15, 6/19, 7/17, 8/21, 9/11, 10/16, 11/8, and 12/13/2017.

- **Community Involvement** continues to be a priority with the CC-HAN. The following activities are examples of that.
- Leadership by Project Manager of Canadian County Coalition for Families and Children in a successful blanket collection campaign for the Canadian County Sheriff's Office to place a blanket in every deputy's vehicle in case they pick up a child to be removed from the home.
- Project Manager participated in Infant Mental Health Committee, associated with Coalition for Families and Children throughout 2017. Training for mental health first aid was also offered to the community. A toy drive was held for kids involved in Systems of Care along with CART house in El Reno, OK.
- Participation by CC-HAN Nurse Care Manager in Canadian County Health Department Baby Expo on 9/22/2017.

- Project Manager and all Nurse Care Managers participated in OG&E Community Round Table October 19 2017, where community health, social services, and educational agency representatives share information and updates.
- Participation by CC-HAN staff in key community health related organizations and activities throughout 2017, including:
  - Canadian County Coalition for Children and Families (project manager serves as chair and one care manager serves as treasurer; all care managers attend regularly).
  - Infant Mental Health Committee (project manager and one nurse care manager)
  - Canadian County Healthy Living Grant (care managers)
  - Partnership for Healthy Central Communities Board (project and care managers are participants)
  - Participated in a career fair at Redlands Community College 4/5/2017.
  - Project Manager and Nurse Care Managers attended the Infant Crisis Services partners luncheon and followed with a tour of the facility.
  - Project Manager and Nurse Care Managers attended the Infant Mortality Alliance Summit 10/24/2017. The focus was on poverty and infant mortality.
  - Project Manager met with State House Representative Rhonda Baker regarding the challenges in healthcare in Oklahoma. Explained the HAN to her.
  - Project Manager attended two day OHCA Strategy Forum.
- Two Nurse Care Managers were interviewed and highlighted, along with the CC-HAN, in two separate issues of Oklahoma Nursing Times.
- Infrastructure (including IT services, phone services, accountant services, post office services, promotional materials and additional personnel support) were augmented in the Report Year. Examples include additional care management hours; EPSDT Clerk position; increasing hours for IT support; and ongoing development of CC-HAN website and use of the ER diagnoses' brochures including website development promotional efforts; and the addition of one more part-time nurse care manager.
- Ongoing implementation of the Asthma Improvement Plan (AIP) in Report Year, with growth in number of members served and positive outcomes;
- Ongoing utilization and additions to the searchable Specialist 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 CC-HAN staff communications;
- Ongoing development of web-site, www.cc-han.com.
- Periodic meetings with Medical Director (both face-to-face, phone, electronic communications) about HAN implementation and future goals.

Several changes occurred in 2017 for CC-HAN. First was the addition of the Aged, Blind & Disabled (ABD) population for care management. This more than doubled our population being care managed. For that reason, a third part-time care manager was hired. Also, one provider retired as of June 30, 2017, decreasing our total population approximately 7%.

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 requirement

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
- Extending care management services beyond those contractually required to include others referred by PCPs
- Community presentations and events that reach beyond CC-HAN members to other SoonerCare members and individuals/families in the communities at large

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 RY 2018 as we continue work to demonstrate success in meeting both OHCA/CMS expectations and the CC-HAN Mission: *To improve health care for SoonerCare Choice members and to address the challenges of the underserved populations in Central Oklahoma Communities*.

Appendix A

ER Utilization Table for 2017

ER Utilization 2017					
	Members	Number of Contacts	No. of ER Visits	No. of PCP Visits	Average Time (days) Between ER Visit-PCP Visit
Totals	**38**	**408**	**140**	**92**	**29.48**

Appendix B
ER Aggregate Data 2017

AGGREGATE NUMBERS FOR ER VISITS 2017				
Three (3) visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
47	**41**	**45**	**66**	**199**
13% increase from previous quarter.	9% decrease from previous quarter	32% decrease from previous quarter	Baseline data.	**OVERALL 29% DECREASE**
Four (4) Visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
8	**19**	**19**	**27**	**73**
58% decrease from previous quarter.	No change from previous quarter.	30% decrease from previous quarter.	Baseline data.	**OVERALL 61% DECREASE**
Fifteen (15) or more 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	
Two (2) Visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
75	**89**	**122**	**126**	**412**
16% decrease from previous quarter.	29% decrease from previous quarter.	3% decrease from previous quarter.	Baseline data	**OVERALL 40% DECREASE**

Total Contacts-2017				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
172	**161**	**96**	**100**	**529**

Appendix C

Highlights

An eighteen-year-old mother expressed her desire to be a good mother, and to better her life and the life of her new baby. She expressed a strong desire to further her education. I encouraged her to speak to her DHS caseworker to see if she qualifies for TANF. I also provided her with information on the GOALS program through Redlands Community College. Since she is Native American, I encouraged her to contact Indian Services to see if they might also have programs which would assist her with her education. The member also shared that she is finding it difficult to make ends meet when it comes to affording groceries. She was already receiving food stamps, but was not on WIC. I encouraged her to apply for WIC, and let her know that since she is breastfeeding, more healthy foods are available. She shared that she would like to find a free parenting class. We were able to provide a couple of options, including Chris Jarko at Child Guidance at the Canadian County Health Department.

Thee-year-old boy and his family have recently gone through a great tragedy, as his little sister died in November as a result of abuse received from her childcare provider. Of course, the mother is overwhelmed with grief. She also feels that the three-year-old would benefit from counseling. We were able to provide numerous counseling resources for him, including several that focus on trauma in childhood. We also provided contact information and counseling resources and grief support groups for the parents.

Received call from member's mother that his nebulizer had quit working. She had contacted the PCP and was told it was too soon to get another nebulizer (SoonerCare will only cover nebulizers every 5 years). Was able to deliver member a new nebulizer that had been donated by DME provider. Member would have had to go to the ER for treatments if nebulizer had not been available.

Provided a peak flow meter (PFM) and education on use to an adult AIP member. When speaking with her a few weeks later, she was asked if she was using the PFM and if she was able to see how it was helping her. She related that she was, indeed using the PFM twice a day and had noticed her numbers were not where they should be. She shared that she then contacted the PCP where she was prescribed antibiotics. She reports that had she not been using the PFM she might not have noticed she wasn't doing well and might have become much more ill before seeking treatment.

Five (5) children in one family had been sharing the same nebulizer tubing. All five children were experiencing respiratory symptoms. Mom reported that the only time they received new nebulizer tubing was if a treatment was given in the Dr.'s office or the ER. Was able to contact DME who donated several neb kits.

Member was in need of husky sized jeans. Nurse Care Manager contacted a local church and informed them of the need. As there were no jeans in that size, the church purchased two new pairs of jeans for member. Another local church supplied pants. When clothing was delivered, both member and his mother became tearful when seeing the new jeans. Both were extremely appreciative. Jeans were a perfect fit!

Received information that a local church was assisting with Easter meals. Three (3) AIP members and their families were able to receive the makings for Easter meals. AIP Member's grandmother (who is raising 4 grandchildren) was ill and unable to meet at the church to pick up the meal. CM picked up resources for family for delivery to home. Upon arrival to home CM was met at the door by all 4 children and grandmother. The children were very excited and kept looking through the bags, saying "look what we got Grandma". Grandmother was tearful and shared that during Christmas and Thanksgiving she generally receives some assistance with holiday meals. She then shared that without receiving the Easter basket she would not have been able to provide her grandchildren with an Easter holiday meal.

A 15 year- old boy with rheumatoid arthritis and a rare hip condition, where the hip sockets have deteriorated so that his hips "come out of joint" was in need of assistance. For the most part, the young man is wheelchair bound. He is also obese, which contributes to the debilitating effects of his condition. We were able to connect him with a dietitian, who, according to his mother, was an answer to prayer. She says that the dietitian also worked with them regarding the diet of their 6-year old who had been diagnosed as gluten intolerant. This family has multiple struggles; both parents have health issues and have no insurance. We provided them with contact information for several free clinics and resources for reduced price or no cost medications. They also have needs regarding custody/guardianship of the 15-year-old, as they are actually his aunt and uncle. Since they want to obtain legal custody, we provided contact information to Legal Aide, Trinity Legal, and "Ask an Attorney" on National Attorney Day. The family lives in a very old, narrow, rented mobile home, which is not modified for a wheelchair. The young man lives in the living room, as his wheelchair cannot get down the hall. We provided numerous disability resources which may help them obtain housing which is wheelchair accessible. We also provided resources for them to contact regarding obtaining disability benefits for this member. As this member is to have additional surgery soon, he was referred to the J.D. McCarty Center in Norman as an alternative to home recovery. Information for the Oklahoma Medical Reuse Program was provided so that this member can get a hospital bed with trapeze and a "lazy Susan" for transfer from wheelchair to bed or chair.

An eighteen-year-old woman with many physical and mental health needs was referred to the CC-HAN. She is semi-homeless, as sometimes she stays with her grandmother and sometimes she sleeps in her car. She has been diagnosed with an auto immune disease. She also lives with bipolar disorder and autism. She has a history of behavioral issues. While she was listed as a patient of Yukon Pediatrics, she had not been seen there in two years, and according to the practice, she had moved out of state two years ago. The member said that since she did not have a primary care provider, she could not get her medications and could not receive behavioral health services. We helped her to change her PCP. We also provided contact information to Red Rock Behavioral Health. She quickly made appointments with both. Resources were provided for transitional living. She also shared that she could not get a job because she did not have an original birth certificate or any legal identification. She had been told that it would cost her $600 to get the certified birth certificate from California. We provided her information for free legal services, which she used, and was instructed on how to obtain a certified birth certificate at very little or no cost. We met this member at a local library, where she says she spends most of her days, as she is not allowed in her grandmother's house while the grandmother is at work. Groceries were provided by a local church and other resources for food were also provided. She expressed a great deal of appreciation for our assistance.

Eighteen-year-old young woman expecting her first baby in September. We are care managing her because of her 3 ER visits in the past 3 months. She shared that earlier in her pregnancy she experienced several episodes of severe pain and bleeding, which led her to fear that she was about to miscarry. It was determined that the symptoms were a result of severe urinary tract infections which were treated. She says that her pregnancy is now proceeding smoothly. She is listed as a patient of one of our providers, however, they no longer see patients who are pregnant. We were able to direct her to find a new PCP. Information on how to find an available PCP and how to make the change with SoonerCare was provided. As a young, first-time mother, she indicated that she is eagerly anticipating the new baby, but concerns were addressed regarding her readiness for motherhood, so the Children First Program was recommended. She was provided with the brochure/application. Breastfeeding education was provided along with the recommendation to apply for WIC and to speak with their lactation consultant.

Nine-year-old AIP member underwent open heart surgery. Prior to surgery his prognosis was "guarded' as he has had several surgeries in the past with complications. He is being raised by his grandmother and grandfather and there are limited resources in the home to meet unplanned needs. Grandmother and grandfather have numerous physical problems; however, Grandmother does work at part time job at a convenience store to make ends meet. Grandmother verbalized several concerns about providing member with pre-and post-hospitalization needs. With Grandmother's permission, a local youth group was contacted and made this member their "special project". Prior to hospitalization, member, member's grandmother and cousins met with the youth group leader and a few of their members at McDonalds. Care Managers were also present. Member was provided with new clothing (t-shirts) and numerous items that he could utilize during his recovery to keep him occupied. (Paw Patrol figurines, SpongeBob books, Children's Bible, puzzle books, hand sanitizer and cleaning items) Grandmother received several food gift cards to use for meals while member was hospitalized as well as a Walmart gift card to use for new socks and underwear for member. Many words of thanks were extended to the Youth Group and the HAN for the assistance provided. On the day of surgery, CM received a call that surgery had gone better than expected and member was expected to recover without complications. Grandmother again expressed her appreciation for the supplies provided by the youth group and the CC-HAN staff.

Baby born to a single mother, who also has a ten-year-old son with Autism. The mother was experiencing pain with breastfeeding. Breastfeeding education was provided, as well as contact information for the Breastfeeding consultant with WIC. Mom expressed concern that she was about to lose her SoonerCare coverage. We provided contact information for the Federal Insurance Marketplace, but also made her aware of SoonerPlan and services provided at the health department. Since she did not feel she could purchase insurance, a list of free clinics was also provided. She also expressed a desire to find a pediatrician for her children (their current PCP was general practice). We explained how she could access a list of providers who accept SoonerCare on the SoonerCare website and let her know about the pediatricians that are affiliated with the CC-HAN. Mom also shared that she has no family in the area, and, while she denied any depression, related that she was "very tired". We provided contact information for Sooner Success and the Oklahoma Family Network, to provide resources for the 10-year-old, and some possible respite programs. When asked, she related that all members of the family were in need of clothing, and the baby boy was in need of formula and diapers. We met with Mom and

her children at a local church, where she was able to shop the clothing room. Diapers and formula were also provided. Numerous resources were provided to help with both the new baby and the 10-year-old.

CM received a call from a former AIP member's grandmother. She shared that member's mother had left him with her as she "needed to get herself together". Grandmother's only legal document was a written note from Mom allowing her to make decisions in the event there was an accident or illness. Grandmother reported member had limited clothes and no shoes. She also shared that she herself was disabled (receiving home health nursing services) due to congestive heart failure. Grandmother reports that member is having asthma issues as he has been exposed to "constant smoking and being in situations that cause him to have asthma problems". Provided information and education on asthma triggers and the importance of controller medications. Grandmother also felt that he was being neglected and had been living in a filthy environment. She reported there was a need for food in her home as she did not have enough to feed them both. She informed that member's mother did receive food stamps, however mother was using the food stamps for herself and her boyfriend. Provided Grandmother with information and contact numbers for CPS, Legal Aid and 211. Grandmother reported member was experiencing "emotional issues with his mother leaving and has severe ADHD" for which he was not being medicated. Informed of SOC wrap around program. Grandmother was receptive to member receiving assistance from SOC and asked that CM complete the referral. With the help of several local churches, clothes, shoes and food were obtained and delivered to the home. Grandmother reported she had contacted CPS and filed a report. Even though member was no longer in the AIP assured Grandmother that she could contact CM if further resources, education or information was needed.

Four-year old boy, ABD member, along with his 8-year-old sister and 6-year-old brother, live with their grandmother. Identified member has DiGeorge syndrome, has had several heart surgeries, is not able to talk, does feed himself, but can't dress himself and is not potty trained. He receives OT and speech therapy. As you can imagine, caring for 3 children, including one with severe special needs is taxing physically, mentally and financially. The grandmother is on SSI Disability, and along with the member's SS check, this is what the family lives on. Grandmother shared that their income is too great to qualify them for SNAP benefits. She recently received cut off notices for her utilities. We were able to connect her with Sunbeam Family Services (as well as other resources). She received help with her utility payment, the children were added to their holiday program (to help with Christmas gifts), and other benefits of the Grandparents Raising Grandchildren Program were made available to her. We were also able to get her on the list for a Thanksgiving dinner provided by a local church.

CM received call from AIP Member's mother. Mother reported that she had recently separated from Member's step-father and was having great difficulty with paying for school lunches and making food resources stretch as most of money was being spent on school meals. She is only working part time. Inquired if Mother knew about the free to low cost meal program at the school where he was attending. Was informed she did not know the process. CM contacted the school and was told that Member automatically qualified for the school lunch program if he met the SoonerCare eligibility requirements. Application was obtained and forwarded to member's mother with instruction to add RID number to application. Member is now receiving both breakfast and lunch at no cost. Member's mother was also referred to the SNAP program where she qualified for benefits

Member is a 12-year old female with Down's Syndrome. Mother speaks primarily Spanish. With the assistance of a translator, needs for food and utility repair were identified and referrals and contact information was given to Mother. When inquiring what other needs CM could assist with, mother shared that member has never had a bicycle as the family has never been able to afford one. Mother informed that receiving a bicycle was member's hope. Informed via translator that CM would inquire and if bicycle became available, mother would be contacted. Inquiries made to a local church and a girl's bicycle was donated. Through a private donation a Barbie Bike Helmet was also obtained. Delivery was arranged, and CM was accompanied by translator. Upon arrival to home and bike being removed from the car, squealing, laughing and clapping was heard. Member came bursting from the home's front door, jumping up and down saying "it's a bike, it's a bike". CM assisted Member with bike helmet and member's brother assisted her with getting on the bike. Member was able to go a few feet her first time trying. All family members present expressed appreciation.

Follow-up: Mother reports member was unable to ride the bike due to inability to keep balance. CM's were able to obtain training wheels to provide to member. Mother reports that with training wheels member rides her bike 5-10 minutes every day (weather permitting)!

Seven-year-old-boy diagnosed with Autism and Depressive Disorder. It was recently determined that he has Celiac Disease as well. His mother shared that she had actually gone into debt to buy him gluten-free foods. We were able to refer this family to a dietitian who offered to help them find acceptable foods that would not "break the bank".

Eleven-year-old boy is one of 11 children, 7 of whom still live at home. Utilizing our translator, we were able to determine that this family was struggling to provide warm clothing for the family. They live on this boy's small disability income, and $365/week that the father brings in through his carpentry work. Utilizing our contacts with the local churches, we were able to locate coats and other winter wear for all of the children. The children were all excited, but especially elated was the nine-year-old brother, who is quite stout. His mother shared that he was so excited because, "I have never had a coat that I could fasten up before!" After inquiring, we learned that the parents were also without coats, and they had no means to provide Christmas for the children. They said, "the older children understand, but if we could at least get something for the younger ones". We asked what each of the children would like, and their requests were simple, such as a doll or hot wheels. One daughter, who is 13, repeatedly said, "I don't need anything, if you can just get something for the little ones". We contacted a local church, who provided gifts for all members of the family. The family expressed a great deal of appreciation. Coats were also provided for the parents. The youngest member of the family was one of our "Inpatient" members due to his recent birth. When we inquired about his birth, and his follow up care, it was revealed that the mother had developed a blood clot in her leg at the time of the baby's birth. She was put on a short-term blood thinner, saw her doctor, who told her that the blood clot was smaller, but that for further follow up she would need to find a different health care provider, since she no longer had insurance. She had made no follow-up appointments, as they "have very little money". We referred her to Variety Care, and she made an appointment to be seen regarding the blood clot. We also referred her for family planning. The mother said she had not been told of any special precautions that she should take with the blood clot. We were able to provide education on the importance of frequent changes in position, avoiding massaging the affected limb, and the importance of discussing this with her care

provider when discussing family planning as some methods of birth control increase the risk of blood clots.

Twelve-year-old member with diagnosis of Down's Syndrome, ADHD and PTSD was having great difficulty at school. Mother was being called from work on a daily basis to pick member up from school for "non-participation". Mother reported she was in jeopardy of losing her job due to missed work hours. Mother also reported that member's IEP was to be re-addressed and member was not to return to school until this was done and until then, his school day would be cut to ½ days. Mother informed that she would not be able to continue employment if this occurs and she is the only support for member and his younger brother. Contacted SoonerSuccess, who provided an advocate. Advocate provided guidance for mother during IEP meeting and member is now attending school for the complete day. SoonerSuccess continues to assist mother with school problems as they arise. In December CM was informed that member had run from the school and had been taken to the police station in handcuffs. Was noted calling the police was a recommendation from member's mother as she felt he would be responsive to the police as he holds law enforcement in high esteem. SoonerSuccess was again notified and continues to provide direction and support to mother on ongoing basis.

Twelve-year-old member with developmental delays and club foot was having a hard time standing in the shower long enough to adequately bath. Mother requested assistance with obtaining a shower chair. Contacted AbleTech several times, without success. CM was able to obtain a shower chair via private donation and deliver to mother. Mother reports improvement in hygiene!

Nine-year-old member with development delays, Anxiety, ADHD and ODD was experiencing frequent periods on uncontrolled anxiety that was interfering with his daily functioning. Mother reports that she was told that a weighted blanket would help, however when she researched purchasing one the cost was too great. (Weighted blankets can cost up to $250.00). Spoke w/Project Manager who arranged for a handmade weighted blanket from a private donation. The blanket included member's favorite cartoon character and colors and was monogramed with his name. Mother reports weighted blanket is working well.

Member needing help getting coag tests done on a regular basis. Transportation was an issue. Sooner Care would not pay for the home test machine and strips. PHCC agreed to buy some of the machines and loan them to the PCP to pass on to the member. Member's mother was beyond grateful upon receiving the meter and strips. She said it was the best Christmas present ever!