2018

CENTRAL COMMUNITIES HEALTH ACCESS NETWORK

MILESTONES AND REPORTING MEASURES
Covering January 1, 2018 through December 31, 2018

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ANNUAL REPORT: 2018

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 an annual report. In addition, periodic reports with data supporting CCHAN's effectiveness will be submitted to appropriate OHCA staff at meetings throughout the year.

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

1. Number of Primary Care Physicians (PCP) by name and panel size affiliated with CCHAN. There were twenty-six (26) PCPs affiliated with CCHAN as of 12/31/2018. Four (4) of the twenty-six are associated with two of the participating group practices; they are James M. Brown, DO, Aaron P. Wilbanks, DO, Alex Medgaarden, PA, and Andrea L. Krittenbrink, PA; all are associated with both Canadian Valley Family Care and Mustang Urgent Care.

Table 1: CCHAN Affiliated PCPs for 2018

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** **Mathew, Rohit, PA** **McGinn, James, ARNP** **Medgaarden, Alex E., PA** **Pittman, Bradley D., PA** **Ricks, Jacinda R., ARNP** **Wilbanks, Aaron P., DO** **Panel size for December 2018: 224**	**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** **Medgaarden, Alex E., PA** **Roof, Lindsay K., APRN** **Siems, Ami L., MD** **Spence, Lisa, APRN** **Wilbanks, Aaron P., DO** **Panel size for December 2018: 670**
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 2018: 1292**	**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** **Marlee Robinson, ARNP** **Sims, Stephanie R., CNP** **Panel size for December 2018: 395**

Table 1: CCHAN Affiliated PCPs for 2018 (cont'd)	
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** **James, Brenda, ARPN** **Martin, Alexandra, CNP** **Panel size for December 2018: 778**	

Table 2 presents a snapshot by comparing provider panel sizes in the last month of 2016, 2017 and 2018. In 2017, there was a statewide downward trend in SoonerCare Choice enrollment**.** Overall, 2018 saw a slight increase in SoonerCare Choice enrollment**.**

Table 2: CCHAN Benefit Enrollment Counts			
PCP	**December 2016**	**December 2017**	**December 2018**
Yukon Pediatrics	758	689	778
Flores Pediatrics	1450	1324	1292
Canadian Valley Family Care	638	627	670
Mustang Family Physicians	513	417	395
Mustang Urgent Care	228	217	224
Total Count	**3862**	**3274**	**3359**

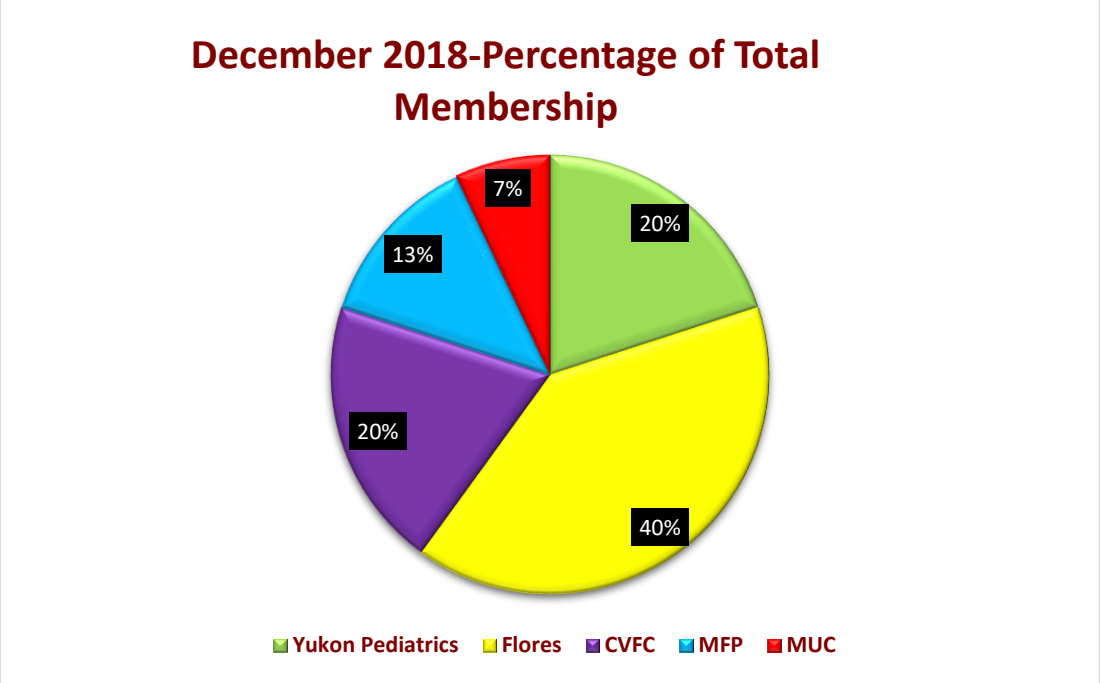
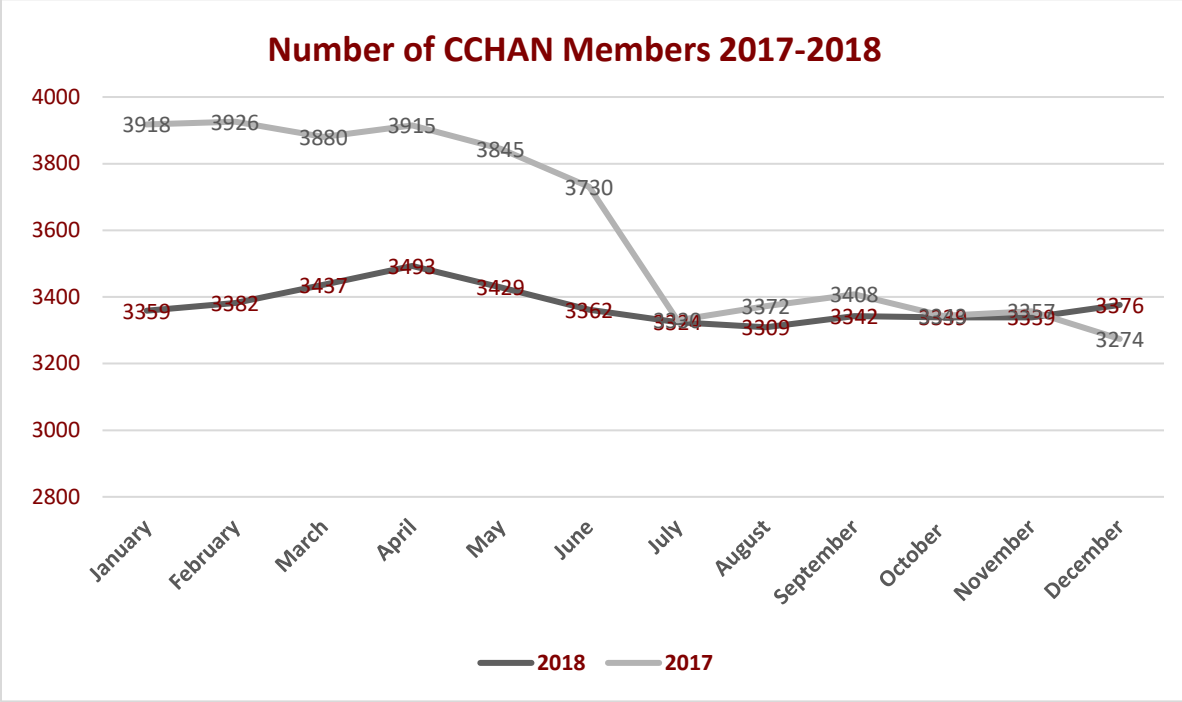


Table 3 shows a slight growth trend in total members for early 2018 over 2017, with a decline in June 2018 continuing through August 2018. Small gains have been made to end 2018 slightly higher than January 2018. Efforts remain ongoing to recruit new providers.

Table 3: CCHAN Monthly Total Members for 2017 and 2018		
Month	**2017**	**2018**
January	3918	3359
February	3926	3382
March	3880	3437
April	3915	3493
May	3845	3429
June	3730	3362
July	3330	3324
August	3372	3309
September	3408	3342
October	3343	3339
November	3357	3339
December	3274	3376



2. Number of entry level or advanced level PCPs identified by name for assistance with level step up in 2018.

One - Canadian Valley Family Care was an entry level, child-only practice. Steps were completed to become an Optimal level practice.

All PCP's, except for one, Mustang Urgent Care, are at Optimal level. Offer to help advancement remains.

3. Steps taken to assist PCPs in maintaining or advancing their level designation for 2018.

- **Canadian Valley Family Care**: Advanced to Optimal level in 2018.
  Helped in preparing for level advancement. Aided in preparing for SoonerCare audit and provided support during audit. Provided blood borne pathogens / universal precautions training to staff.
- **Flores Pediatrics**: Currently Optimal level.
  Helped in preparation for SoonerCare audit. Provided support during audit. Assisted in blood borne pathogens / universal precautions training to staff.
- **Alecia Hanes, MD DBA Yukon Pediatrics**: Currently Optimal level.
  Offered help whenever needed.
- **Mustang Family Physicians**: Currently Optimal level.
  Helped as needed.
- **Mustang Urgent Care**: Currently Advanced level.
  Was available for support as needed.

For ALL Providers:

Delivery of the following reports and educational materials was ongoing throughout 2018:

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

CCHAN staff also provided assistance during 2018 with member issues/needs for all providers. This assistance included the following totals:

- **2617 referrals** for goods and/or services
- **267 deliveries of goods,** i.e., food, clothing, personal/household goods
- **26 back-school supplies** referrals and/or deliveries
- **16 peak flow meters** were distributed to AIP members.
- **75 holiday gifts/items** referrals and/or deliveries
- **1628 translator assisted communications,** with the aid of CCHAN Resource & Linguistic clerk.

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

- There was one level advancement in 2018 by Canadian Valley Family Care, advanced from Entry level to Optimal level.

5. Number of specialty providers:

- Number of specialty providers available for SoonerCare members served by our providers**:** 160 Specialists and 555 public resources for a total of 715 specialty providers. Table 4 represents the type and number of providers.

Table 4: CCHAN Specialty Providers for 2018	
Type of Provider	**Number**
Medical Doctors - all specialties	160
Behavioral Health - Psychologists, therapist, etc.	85
Therapy - PT, OT, Speech, Dietician, Home Health	61
Women's Health	32
Community Resources - Housing, Food, Clothing	164
Crisis Intervention / Support Groups	63
Dental	37
Substance Abuse - Counseling / Support	19
DME	7
Labs & Testing	29
Free Clinics	24
Hospitals	20
Medication Assistance	7
Other Specialties	6
TOTAL	**715**

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

- There were no medical home audit failures in 2018.

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)

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, complete implementation timetable for all populations, and complete transition for each population with members on PCP rosters (Article 4.4 a and b).
2. The populations for care management throughout 2018 include:
    - Asthma
    - ED Users
    - Inpatient
    - ABD
    - Behavioral Health

Table 5: CCHAN Summary of Care Management for 2018

Population	Care Management Members
ED Utilization	239 members who had visited the Emergency Department were provided care management services during 2018
Asthma (AIP)	○ Roster with 42 members in 1/18 ○ Roster with 43 members in 2/18 ○ Roster with 43 members in 3/18 ○ Roster with 44 members in 4/18 ○ Roster with 43 members in 5/18 ○ Roster with 43 members in 6/18 ○ Roster with 39 members in 7/18 ○ Roster with 35 members in 8/18 ○ Roster with 32 members in 9/18 ○ Roster with 31 members in 10/18 ○ Roster with 38 members in 11/18 ○ Roster with 47 members in 12/18 *Note: There were 53 individual members involved in the Asthma Improvement Plan throughout 2018.
In-Patient	182 members who had hospital admissions were provided care management services in 2018.
Aged, Blind, & Disabled	There was a total of 102 members involved in care management throughout 2018.
CM Initiative Behavioral Health	25 members have been provided care management that were not identified as ABD.

Emergency Department Utilization

- Members with 3 visits in a 3-month period during report period: **58**.
- Members with 4-14 visits in a 3-month period: **21.**
- Members with 15 or more visits in 3-month period (Persistent) **0**
- Members with 3 or more ED visits being actively care managed at the end of 2018: **10**

The top three (3) diagnoses for ED visits in 2018 were:

- **Upper Respiratory Infection**
- **Fever**
- **Nausea and Vomiting**

The top three diagnoses for ED visits have also been top diagnoses for previous years. ED brochures had been developed for these diagnoses and are currently used as educational tools in the care management process. The evidence that CCHAN developed ED brochures add value to the care management efforts is based upon member and provider feedback that the brochures are helpful. These brochures are available in Spanish as well.

811 referrals for assistance with identified needs in conjunction with daily living were provided to SoonerCare Choice members that had been in the emergency department at least twice in a ninety-day period.

Average report time between emergency department visit and successful follow up PCP visit: **10 days**

Table 6: CCHAN Emergency Department Utilization contacts for 2018				
Successful phone call	**Unsuccessful phone call**	**Letters, email & texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
239	408	229	9	**448**

Asthma Improvement Plan (AIP)

A total of fifty-three (53) individuals participated in the AIP program in 2018. At the end of 2018, forty-seven (47) members were actively involved. Sixteen (16) peak flow meters had been given to members during this period, along with education on how to use them. The majority of referrals for this program are received from participating PCPs. Some come from rosters of members who have had contact with the emergency department or have had an inpatient stay in the hospital. OHCA provides those rosters monthly. All AIPs are developed and implemented collaborating with the member, PCP, and care manager. Copies of each AIP are provided not only to the provider, but to the member as well. In many cases, Spanish copies are provided along with the English copy. The Spanish copy remains in the Spanish speaking homes, while the English copy is provided, by the parent, to the school in which the member attends, along with the rescue inhaler. We have received positive feedback from school nurses for having this information available on the student.

Table 7: CCHAN AIP contacts for 2018				
Successful phone call	**Unsuccessful phone call**	**Letters, emails & texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
254	246	21	23	**298**

In-patient

Monthly reports of members that have been hospitalized and discharged, have been provided by OHCA to CCHAN throughout 2018. Care management services provided for this group are included in Table 8. As the table shows, a total of 354 contacts were made to this group, including twenty-two (22) face-face visits. Many of these hospitalizations are for new births. We are able to follow-up with new parents and provide needed resources and support at such a vulnerable time. This also provides an opportunity to educate on the importance of well-child checks. Other hospitalizations are for varied reasons. It has been determined that if we were able to receive this roster closer to real time, we may have even more success with this population.

Table 8: CCHAN Inpatient Contacts for 2018				
Successful phone call	**Unsuccessful phone call**	**Letters, email & texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
247	281	85	22	**354**

Aged, Blind and Disabled (ABD)

The CCHAN began serving this population in late August 2017. 2018 was the first full year of providing care management services to these folks. Approximately 50% of this roster had a psychological disorder identified. In preparation for this, one nurse care manager was trained in serving the behavioral health issues within this population. This 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. In 2018, 1047 referrals for goods / services have been made on behalf of these ABD members. This population certainly comes with a new set of challenges, which so far, we have been successful in meeting.

Table 9: CCHAN ABD Contacts for 2018				
Successful phone	**Unsuccessful phone**	**Letters, emails, texts**	**Face-to-Face visits**	**TOTAL CONTACTS**
829	775	387	58	**1274**

CCHAN Case Management Initiative - Behavioral Health

Members who experience behavioral / mental health conditions that are of concern to their PCP are being referred for Behavioral Health Care Management. Members who appear on our ED or Inpatient rosters with a Behavioral Health diagnosis are also followed up with an offer of care management. Twenty-five (25) members have been provided behavioral health care management that were not identified as ABD. Of those twenty-five (25) members, twenty-one (21) had been hospitalized prior to care management services. After care management engagement, only one (1) member has been hospitalized. Of course, those members were referred from the in-patient roster provided by OHCA. The numbers next year are likely to be much lower. There were nineteen (19) members receiving care management services at the end of 2018.

Table 10: CCHAN Behavioral Health: Care Management Contacts for 2018				
Successful phone	**Unsuccessful Phone**	**Mailings/ Texts/E-mails**	**Face-to-Face**	**TOTAL NO. of CONTACTS**
48	50	13	3	**64**

Throughout 2018, twenty (20) other SoonerCare Choice members were provided with either care management services, or referrals. These members were not associated with a particular program within CCHAN.

3. AHC screening tools have been successfully assimilated into each program within CCHAN. This tool is being used to determine level of care for each member referred to CCHAN. It may lead to a member needing full care management, or simply a referral or educational materials provided. In 2018, a total of ninety-four (94) screens have been completed. 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. Hold at least one Care Management quarterly meeting. (amended)

Three (3) Care Management meetings (via conference call) with OHCA Care Management staff on January 24, April 18, and July 17, 2018. It was determined by OHCA staff that with recent restructuring at the agency level, there was no longer a need for quarterly meetings. Needs would be addressed as they occur and OHCA staff would be available for consultation.

Monthly care management team meetings were held in 2018. 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 2017, 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. She continues to provide priceless support for our care 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.

Health Information Technology (Article 4.5)

1. PCPs assisted with qualifying for federal EHR incentives–education, outreach, etc. (Article 4.5 c): None in 2018.

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

   Benchmark and milestones regarding EMR:

   A. Number of PCPs with existing EMRs as a benchmark: Twenty-four.
   B. Number of PCPs with existing EMRs which are functional and operational: Twenty-four.
   C. Number that have operability between PCPs: None.

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

   CCHAN 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.

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. A new database has been developed by the author of the previous CCHAN database. We were able to replicate the ACH screening tool to enable care managers to enter the data directly onto the database in the ACH screen format. From that, a care plan is generated with fields populated with data from the ACH screen. Both databases are connected resulting in less data entry and more options for reporting.

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

Quality Assurance (Article 4.6)

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 2018. The estimated level of achievement will be an increase in the total number of claims in 2018 (compared with 2017) 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 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 care management services.
   - To submit monthly reports to the Project Manager outlining the numbers and types of contacts made.

   The estimated level of achievement was met in 2018 with a 12% gain (overall) in well-child visits from 2017, although slightly lower than 2015 and 2016. It is possible the increase in numbers for 2018 may be due to our bilingual staff making contacts with members and families enabling better communications.

   Importantly, CCHAN PCPs continue to share support for the contacts made to increase well-child visits. 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 even more visits for 2019. Tables 11 and 12 present the number/types of EPSDT contacts throughout 2018.

Table 11: EPSDT Claims 2018								
Preventive Code	**FY 15 EPSDT claims**		**July - December 2016 EPSDT claims**		**2017 EPSDT claims**	**% change**	**2018 EPSDT claims**	**% change**
New Patients:								
99381	301	-9%	141	-53%	99	-30%	117	15%
99382	119	-27%	80	-33%	73	-8%	80	9%
99383	146	-24%	128	-12%	94	-27%	112	16%
99384	63	2%	60	-5%	42	-30%	67	37%
Established Patients								
99391	1536	4%	1256	-18%	1004	-20%	1004	NC
99392	1189	20%	1032	-13%	960	-7	860	-10%
99393	947	4%	848	-10%	787	-7	1032	24%
99394	466	22%	447	-4%	434	-3	699	38%
TOTALS by YEAR	**4767**	**6%**	**3992**	**-16%**	**3493**	**-12**	**3971**	**12%**

Table 12: EPSDT Contacts 2018					
Month	**SPC**	**UPC**	**Texts**	**Letters**	**Total Attempts**
January	152	185	45	25	**407**
February	135	206	51	27	**419**
March	155	191	42	32	**420**
April	145	219	31	32	**427**
May	135	200	46	38	**419**
June	122	222	49	36	**429**
July	147	228	58	30	**463**
August	184	251	55	25	**515**
September	162	219	51	9	**441**
October	154	186	44	13	**397**
November	176	212	41	20	**449**
December	142	188	42	13	**385**
TOTALS	**1809**	**2507**	**555**	**300**	**5171**

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 2018.

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

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

A website review program provides site statistics which are reviewed at least 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 April - June 2016. 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. The lower numbers in July and August 2017 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 CCHAN 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 CCHAN website in 2017.

Numbers for 2018 still were not as high as we had hoped. 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, along with pens and memo pads.

Table 13: CCHAN Web Site Views

Number of Views per Month	2015	2016	2017	2018
January	387	37	115	46
February	315	38	82	49
March	317	44	103	23
April	174	71	135	51
May	161	50	97	25
June	167	65	138	48
July	176	83	69	39
August	154	122	35	37
September	158	117	68	31
October	74	86	65	54
November	86	115	45	63
December	15	83	17	62

B. The second major strategy for achieving quality measure 2 is the utilization of ED brochures and one flyer for member education. The brochures/flyer are based on the top diagnoses for ED visits in 2012-2018. The top three diagnoses for ED visits in 2018 were upper respiratory infection, fever, and nausea and vomiting. Previously developed brochures/flyer were reviewed for accuracy and relevance and will continue to be used for member and general public education related to the following diagnoses:

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

The distribution process for the ED brochures/flyer 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 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 CCHAN website.

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. Monitor the number of hospitalizations for each member engaged with CCHAN's Asthma Improvement Plan throughout 2018. 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 80% annual flu immunization level for all AIP members in 2018.

At of the end of 2018, 23 of the 53 AIP members who were engaged in the AIP (at some point throughout the year) were known to have been immunized for flu, which is a 43% 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 14: CCHAN AIP Evaluative Data 2018

	Totals for FY 2014	Totals for FY 2015	Totals for July – December 2016	Totals for 2017	Totals for 2018
Total No. AIP Members	39	40	34	40	53
Total No. of Hospitalizations prior to AIP Engagement	1	3	4	1	1
Total No. of Hospitalizations for Asthma Related DX after AIP Engagement	0	1	0	0	1
Total No. of ED Visits for Asthma Related DX prior to AIP Engagement	8	14	17	26	34
Total No. of ED Visits for Asthma Related DX after AIP Engagement	2	2	3	2	13
Total No. of Urgent Care Visits for AIP Members	5	22	1	0	0
Total No./Percentage of AIP Members who received flu vaccination	30 for 77%	27 for 68%	21 for 58%	21 for 53%	23 for 43%

Care management 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.

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

As Table 14 shows, the number of ED visits (with asthma-related diagnosis) by CCHAN members who have asthma identified in their problem list (claims data) remains relatively low with a downward trend. The trend 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 2018 is noted to be significantly lower than the numbers in previous years. The data is supportive of the following CCHAN efforts to reduce overall ED use:

- Care management contacts to all members with ED visits in the previous month and also identified through quarterly claims review by CCHAN IT staff;
- Varied types of care management contacts include phone, letter, and face-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: Hypothesis 7: 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.	**CY14**	**CY15**	**CY16**	**2017**	**2018**
1224Numerator: Total number of ED visits by CCHAN members with asthma identified in their problem list for an asthma-related diagnosis.	72	41	42	26	57
Denominator: All CCHAN members with an asthma diagnosis identified in their medical claims record.	885	858	670	651	1224
Dividend for Performance Measure A:	.08	.05	.06	.04	.05
Performance Measure B: Decrease 90-day readmissions for related asthma conditions for CCHAN members with an asthma diagnosis identified in their medical claims record.	**2014**	**2015**	**2016**	**2017**	**2018**
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	2	0	0	0
Denominator: All CCHAN members with an asthma diagnosis identified in their medical claims record and having at least one inpatient stay related to asthma.	4	9	2	2	3
Dividend for Performance Measure B:	0	.22	0	0	0
Performance Measure C: Decrease overall ED use for CCHAN members.	**2014**	**2015**	**2016**	**2017**	**2018**
Numerator: Total number of ED visits for CCHAN members.	1938	2256	1397	1500	1234
Denominator: All CCHAN members.	5273	5137	4110	3915	3359
Dividend for Performance Measure C:	.38	.44	.34	.38	.37

Other CCHAN Distinctives

The CCHAN continues to have distinctive characteristics that are considered important to highlight in the Annual 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. Further information may be found in the bi-monthly project manager reports from 2018, which are readily available upon request.

- **Follow-up on needs and concerns of PCPs** remain priorities for the CCHAN staff. Examples include assistance with Medical Home requirements and audits and availability to assist with matters as varied as billing questions, possible rate cuts, prior authorization matters, OHCA requirements on various matters, and need for specialists. CCHAN staff provides educational presentations for participating PCPs and staff. In 2018, some specific examples include:
    - Communicable Diseases/Infection Control training for three (3) practices.
    - The PHCC Board approved funding to purchase twelve (12) additional peak flow meters to distribute to AIP members.
    - PHCC Board approved funding to purchase coag test strips 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. Essence Robinson, Red-Rock Behavioral Health, provided information regarding Systems of Care. Finally, Janet Wilson with Sooner Success spoke regarding services she can provide families with members with special needs.
    - Throughout 2018, CCHAN staff members have worked closely with all providers to coordinate care through care management and to implement the AIP. A total of twenty (20) other members were provided care management services throughout the year, demonstrating the collaborative relationships between CCHAN, providers, and staff.

- **Collaborative work between CCHAN providers and staff** was ongoing through 2018 to improve coordination of care and increased quality of care for members. CCHAN care management staff have provided face-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 384 deliveries of goods were made by CCHAN care management staff.

- **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 and phone contacts. One formal meeting was held on June 13, 2018. Melody Anthony, Deputy State Medical Director, provided OHCA updates, and addressed provider concerns and questions.

- **402 Provider contacts** made in 2018. Contacts are as varied as deliveries of rosters (e.g., EPSDT, Inpatient, or ED visits), 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** continue to include acceptance of referrals of other members who need educational or other assistance. A total of 155 contacts were made to this group.

- **Care Management Teleconferences** with OHCA staff were held on 1/24, 4/18, 7/17, 2018. CCHAN staff maintains open communication with liaisons at OHCA, therefore the quarterly teleconferences were concluded after the July, 2018 meeting.

- **Monthly CC-HAN Care Management Team meetings** for 2018 were held on 1/24, 2/21, 3/26, 4/18, 5/14, 6/18, 7/17, 8/21, 9/24, 10/22, 11/26, and 12/18/2018. 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. One example of this was a representative of Logicare met with us to discuss SoonerRide and how to access it for our members.

- **Community Involvement** continues to be a priority with CCHAN. The following activities are examples of that.

- Project Manager and one care manager participated in the Infant Mental Health and Trauma Resource Team. The project for 2018 was to provide the opportunity for as many professionals and lay-people who deal with children to view the documentary "Resilience: The Biology of Stress and the Science of Hope". This film focuses on the ACES (adverse childhood experiences survey) and how childhood trauma can lead to adverse physical and mental health issues into adulthood. Ten (10) showings of this documentary were held throughout Canadian County reaching approximately 330 teachers, law enforcement officers, child care workers, mental health professionals, foster

parents, biological parents, faith community members, and children's justice professionals. A panel of professionals were available after each showing to discuss how this affects all aspects of our community. Ongoing efforts remain to educate as many people as possible to the effects of childhood trauma.

- Participation by CCHAN Nurse Care Manager in Canadian County Health Department Baby Expo.
- Project Manager CCHAN staff participated in OG&E Community Round Table, where community health, social services, and educational agency representatives share information and updates.
- CCHAN staff participate in the Infant Mortality Alliance meetings whenever possible.
- CCHAN staff attended the Rare Disease Day at the Oklahoma State Capitol.
- Participation by CCHAN staff in key community health related organizations and activities throughout 2018, including:
    - Canadian County Coalition for Children and Families (project manager serves as chair and one care manager serves as treasurer; all other staff attend regularly). Medical Director also attends this monthly meeting.
    - Infant Mental Health and Trauma Resource Team (project manager and one nurse care manager attend along with our Medical Director)
    - Canadian County Healthy Living Grant
    - Partnership for Healthy Central Communities Board
    - Participated in a career fair at Redlands Community College.
    - All CCHAN staff attended the Infant Crisis Services partners luncheon.
    - Nurse Care Manager attended the Infant Mortality Alliance Summit 10/25/2018.
    - Project Manager helped set pinwheels at Canadian County CART house for Child Abuse Awareness month in April.
    - Nurse Care Managers participated in the Mustang Community Wellness Fair.
    - Project Manager attend bi-monthly meetings with OHCA Administration.
    - Nurse Care Managers attends staffing with Red-Rock Systems of Care for updates on mutual members / clients.
- Infrastructure, including IT services, promotional materials, and support personnel were augmented in the report year. Examples include additional care management hours; EPSDT Clerk position transitioned to Linguistic and Resource Specialist due to her increasing role in translating for the nurse care managers and taking the responsibility of updating our resource data bank; increasing hours for IT support; and ongoing development of CCHAN website and use of the ED diagnoses' brochures including website development promotional efforts.
- Ongoing implementation of the Asthma Improvement Plan (AIP) with growth in number of members served and positive outcomes;
- Ongoing utilization and additions to the searchable specialist 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;
- Ongoing development of web-site, www.cc-han.com.
- 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 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 CCHAN 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 2019 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:
Karen McKeever, RN, Nurse Care Manager
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Johns Paul, RN, Nurse Care Manager
Mary Cuevas, Linguistics & Resource Specialist

Appendix A

Emergency Department Utilization Table for 2018

ED Utilization 2018					
	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	**257**	**448**	**1234**	**267**	**10**

Appendix B

Emergency Department Aggregate Data 2018

AGGREGATE NUMBERS FOR ED VISITS 2018				
Three (3) visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
6	**24**	**17**	**11**	**58**
45% decrease from previous quarter.	37% increase from previous quarter	45% increase from previous quarter	Baseline data.	**OVERALL 45% DECREASE**
Four (4) Visits in Quarter				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
7	**6**	**8**	**6**	**27**
14% increase from previous quarter.	25% decrease from previous quarter.	25% increase from previous quarter.	Baseline data.	**OVERALL 14% 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**
46	**39**	**38**	**55**	**178**
15% increase from previous quarter.	3% decrease from previous quarter.	31% decrease from previous quarter.	Baseline data	**OVERALL 17% DECREASE**
Total Contacts 2018				
Q4	**Q3**	**Q2**	**Q1**	**TOTAL**
101	**129**	**110**	**108**	**448**

Appendix C

Highlights

Baby boy is a newborn on our Inpatient roster. When we spoke with his mother, utilizing our translator, it was determined the family had quite a few needs. The mother had suffered gestational diabetes. Some dietary instruction was provided, as she is more likely to develop Type 2 Diabetes. She shared that only her husband is working at this time, and his job is a very low paying construction job. They were very low on groceries and diapers for the baby and the toddler. We were able to deliver a box of groceries along with a bag of household/ personal supplies and diapers provided by South Yukon Church of Church. We provided them with contact information to local resources (2-1-1, Infant Crisis Center, and many others) which should be able to help them in the future. The mother also shared that she has a large abdominal hernia which was causing a lot of pain. When I met with the family, I was able to see that the hernia was extremely large. She said, "It looks like I am still pregnant". She shared that she experiences a great deal of pain from the hernia, especially when she holds the children or breastfeeds the baby. She said that she knows she needs surgery, but they have no insurance and have no money. We were able to provide instruction so that she would know if the hernia has become strangulated, requiring immediate attention. We were also able to provide medical resources including free clinics and clinics which charge on a sliding scale. We will continue to follow-up with this family.

An adorable two-year-old boy on our ABD roster has Down's Syndrome and a cardiac condition. His mother shared that while the social security payments they receive are helping, they "still run out of groceries sometimes". Since they now receive social security payments, they do not qualify for SNAP. Mom stays home to care for the baby and the father works as a bricklayer, but his job is dependent on good weather. After a spell of inclement weather, Maria shared that they were out of groceries as well as diapers. We delivered a box of groceries, diapers, wipes and a bag of household/personal supplies. We also provided other resources for future needs (including 2-1-1 and Infant Crisis Center among others). It was such a pleasure to meet this little guy! We will continue to follow this family.

ABD member's aunt is high risk pregnancy due in April. She had minimal baby items and what she did have was destroyed when the storage building, she was using leaked. Member's one-year old cousin was sleeping in a baby bed tied together with rope as the side had broken off. Member's caregiver contacted care manager and requested assistance. Through the Baby Room at Mustang Heights Baptist Church care managers obtained and delivered a full-sized baby bed for the one-year old, crib and changing table for the new baby as well as clothes, diapers, blankets and various other baby items. Family was also referred to Infant Crisis Center Services where they are receiving help with food and diapers for the one-year old.

Former adult AIP member who is also diagnosed with borderline mental functioning, was experiencing conflict with her guardian. She felt that she was being treated unfairly and had no ability to make her own decisions. Member had no means of transportation; minimal

communication with others, all income was controlled by her guardian and she felt her privacy was being violated. Member's guardian "had taken away" her car, computer and cell phone due to poor choices she had made in the past. She was given a "land line" at her home in the event of an emergency. Member was not able to attend a psychiatric or medical appointment, including invasive physical testing, unless the guardian was present in the room. Member received a referral to the Oklahoma Disabilities Law Center where she was assisted with obtaining her independence. Member's guardianship was relinquished on February 8, 2018. Guardian returned member's car, computer and cell phone. Member is now able to drive herself to appointments and do her own grocery shopping. During last conversation with care manager, member stated, "I finally feel alive again." Member currently manages her own finances, maintains her home, drives herself to appointments, attends church regularly, makes her own medical decisions, volunteers at a Senior Citizen Meal Program and participates in a mental health support group. She attends weekly mental health sessions with her therapist and verbalizes the need to continue to do so to remain at her optimal mental health. She continues to have regular contact with Care Manager and at times does face obstacles however she is able to process the situation and seek appropriate solutions and outcomes.

Member is a 4-year-old boy on our ABD program. He is currently in the application process to receive Social Security Disability. He was referred to us by a family member (uncle) who also has a child in the ABD program. Member was diagnosed with autism last year. His parents, who speak Spanish, expressed an interest in learning more about autism, and resources available to their son. With the assistance of our translator, we encouraged him to contact the bilingual coordinator for Sooner Success. I explained that she will be able to help him find many educational resources and resources in the treatment of autism. I also suggested he contact the **Oklahoma Autism Network**. This family lives on a very limited income. The father works in a restaurant. They shared that they were having a difficult time affording diapers for this child. We explained that SoonerCare has a diaper program, and information was provided. They worked through their PCP's office and are now on the program to receive diapers. He explained that transportation to appointments was becoming a burdensome expense. We provided him with information on Sooner Ride. They also shared that they are expecting a new baby in May. They had no furniture, clothing or supplies for the new baby and were also in need of summer clothing for the member and his 1 ½ yr. old sister. Working with Mustang Heights Baptist Church and South Yukon Church of Christ, we were able to locate a bassinet, pack-n-play, high chair, diapers, wipes, blankets and clothing for the new baby as well as the older children. I met with member's father, to deliver the clothing, furniture and supplies. He expressed a great deal of appreciation for our help.

We were able to assist Mustang Urgent Care in finding a dermatologist for one of their SoonerCare Choice members. Office staff shared that they were finding it difficult to find a dermatologist who could see one of their SoonerCare patients. We contacted OHCA liaison that day, received a list of Dermatologists that accept SoonerCare, and sent the list to the PCP. She reported that they were excited to find a dermatologist for their patient and were able to make an appointment that day.
ABD patient whose mom has been concerned about him having a condition called PANDAS. Care manager was able to consult with Sooner Success resource person, who provided referral information as well as possible labs needed to relay to this mom. Mom was very grateful for the information.

Members were referred to us by the Nurse Practitioner at Mustang Family Physicians. The children, ages 4 and 5, have been involved in a custody dispute between parents and grandparents for over a year, with allegations of kidnapping. The parents are now going through a divorce. The mother shared that she felt the children had been traumatized by all that they had gone through and were displaying anger issues and defiant behaviors. We were able to make a referral to Red Rock Systems of Care. The family was also experiencing issues with food, and resources including Loaves and Fishes, 1st Baptist Church Food Pantry, Kiwanis Food Program, 2-1-1, were provided. It was also recommended that they talk to their DHS caseworker about applying for TANF, now that the main income earner is no longer in the home.

59-year-old gentleman on our ABD roster, on disability due to back pain and cardiac issues as well as a history of stroke. About a year ago, his house caught on fire. He moved into the garage while the house was being re-built. His hospital bed was ruined. Member is now back in his home but was sleeping on the floor as he had no bed. We were able to network with South Yukon Church of Christ members and located an electric bed, which was delivered to our member. He expressed a great deal of appreciation and has shared that this has made his life much easier, as "it was all I could do to get up off of the floor in the morning when I was sleeping on the floor".

The family of a six-week-old baby on our inpatient roster includes parents, seven-year-old girl, and a six-year-old boy in addition to the baby. The family speaks only Spanish, so we utilized our translator in making this contact. During our contact, it was determined that the family was in need of infant supplies (diapers/wipes), clothing, and food. They were provided with contact information for the Infant Crisis Services, BabyMobile, 2-1-1 and Oklahoma Food Bank. Additionally, we agreed to meet the family at a local church that has a clothing room and a food room. There were able to shop for clothing for all family members and were provided with a box of food, bag of household/personal supplies, diapers and wipes.

Care manager received a call from Community Action of Canadian County with request for assistance with obtaining SoonerCare benefits for a client. The client did not understand the on-line application process and had no success with completing the application. The agency was unable to assist her. Care manager contacted the client and directed her to the Canadian County Health Department for application assistance.

ABD/BH members and families received invitations to Oklahoma City Zoo Dream Night. (Total of 31 members received the special invitations). The OKC Zoo closed early to the public on this date for these families to have the entire venue for their kids with special needs. Families were served dinner, received family photos and all zoo activities and rides were free of charge. Several

parents commented on the wonderful time their families were able to experience. Comments received following the event include: * "It felt so good to be out in public with my child and not be judged for his behavior, no one paid attention when he became aggressive and started hitting himself or screamed and yelled for no reason. I was able to relax and enjoy watching him have fun which is something we don't get to do very often". *"My daughter yells out when we are at the store or out to eat and other people stare or yell at me to shut her up, they don't understand that she does not understand what she is doing. She was able to be around others like her and no one yelled at her or said anything to her". *"We are not able to afford to do things like this with my family, my kids really had a great time".

One-year-old boy was on our care management roster after his birth in June of 2017. His mother is a single parent and he has a 12-year- old brother with Autism. Mom recently contacted us explaining that she was "in a tight spot" and needed help. Her father, a veteran, with serious medical issues including diabetes, was living in a mobile home in Texas, which developed black mold. He became very ill from inhaling the spores and was hospitalized for a lengthy period. Upon release, he was taken directly to Oklahoma to be with his daughter. He had only the clothes on his back and moved into a pop-up camper. Using the South Yukon Church of Christ, we were able to locate clothing, including shirts, pants, a jacket and appropriate shoes and diabetic socks. We were also able to obtain donated bedding and a small chest of drawers as he had no place to store the clothing we provided. We were able to provide numerous resources for needs of daily living, including several clothing rooms and Veteran Support Services. He is now in the process of moving to a small apartment. He was tickled to receive the clothing and other goods and sent his appreciation to all. While working with this family, we learned that the mother had not had a break from her children for a long time. She shared she has very little family or support in the community. She was excited to hear about sib shops and other resources for her disabled son. She was given contact information for Sooner Success and assured me that she would call them right away. She gave the biggest hug and had tears in her eyes as she thanked us repeatedly for the assistance/resources.

Care manager received a call from member's grandmother with request for wound care supplies. Grandmother informed that member would need wound care for several weeks and the cost of the supplies was more than the family budget could cover. Care manager contacted the PCP office for list of supplies needed and then was able to obtain supplies through anonymous donation.

Former ABD with low mental functioning and anger management issues was hospitalized in March 2018 after becoming violent in the home he shared with his grandparents, father and siblings. As his discharge time approached, father was told that member could not return to the home due to the grandparent's fear of his violent behavior. Due to financial constraints, father

was not able to move his family from the grandparent's home. As member was only 17 years old, long term placement options were sparse. Care manager spoke with member's therapist at the hospital several times and researched possible available options for placement with no success. Sooner Success became involved and it was determined that options for placement were not available until member turned 18. At one point, father decided to relinquish his parental rights so placement could be made. Father had been told by the therapist "just don't show up to pick him up when he is discharged". Care manager provided information for legal assistance through "Lawyer for a Day" and the Oklahoma Disabilities Law Center. Father was informed that he could be charged with abandonment if he followed therapist's advice. Father shared that he felt this was his last option however he was very conflicted as this would keep him from having any decisions in member's care. Care manager was contacted on a regular basis by father and informed of member's progress.

Member continued to have aggressive episodes in the hospital where he would strike out at staff members. Discharge plans were made numerous times; however, member was not able to meet his goals for dismissal. Care manager provided father with housing assistance options and the Oklahoma Regional Food Bank Program in the event he could obtain housing with assistance and bring member home. Contact with father continued routinely with care manager providing emotional support and active listening. Updates on member's progress toward long term placement continued to look bleak. Eventually the following text was received.

> *I just wanted to let you know that I got [redacted] into [redacted] Group Home in [redacted] Now he is doing fine and he has a little job that he goes to in their workshop every day. Also, he gets paid a little bit of money for working. Just from talking to him he sounds pretty happy to be there he is making friends and getting to go out with them on the town once in a while.*

Contact continues with member's father. Most recent text informed that member is now working at a community business and adjusting to the Group Home setting.

Member is a 59-year-old gentleman on our ABD roster. He has been dealing with congestive heart failure, arthritis and depression for years. He lived with his mother, who had Alzheimer's Disease until she died a few months ago. In April, he was diagnosed with lung cancer. He admitted that he finds it difficult to cook nutritious meals for himself and was "living on bologna sandwiches". We connected him with Yukon Mobile Meals and he now receives nutritious lunches daily. We have endeavored to provide him with moral support as he has started his chemotherapy. Behavioral health resources were also offered.

New baby girl in a Latino family that includes a 2 ½ year old brother in the home and an 11-year old brother who remains in Guatemala. The family lives on a very limited income but are hesitant to seek assistance. They had a great need for help with infant supplies. We were able to connect them with Infant Crisis Services and the BabyMobile and met her with enough diapers, provided by the South Yukon Church of Christ, to get them by until they could access the other resources. We referred the extended family to the Health Department, where they were able to obtain the flu shot at no cost. Information was provided to the family regarding Head Start so the 2 ½ year old could start school. The family was very appreciative.

Eight-year-old boy was on our emergency room roster with visits for a common cold. We contacted his mother, discussed his ER use and ways to obtain more efficient, wholistic care. The importance of utilizing the PCP for most needs was stressed, as well as the importance of making follow-up appointments with his PCP. This member had been a "no call/no show" for several appointments.

Education and reinforcement were provided to encourage this family to follow through with appointments or to cancel in a timely manner. Education was provided on the importance of immunizations and the flu shot in particular. Resources were provided for the flu shot not only for the child, but for all family members through the Canadian County Health Department. The family was experiencing financial difficulties, as the mother had just started a new job but the paycheck would not be arriving for a while. We delivered a box of groceries to the home for their immediate needs and provided additional resources including the Manna Pantry, Jacob's Cupboard and 211. A family member was pregnant, and we were able to direct her to WIC for assistance with healthy food during her pregnancy and resources after.

We received call from Mustang Heights Baptist Church that strollers were available if needed. Care Manager contacted two2families with infant children. Both families needed strollers. Arrangements were made to deliver strollers to families. The first delivery was for a 10-month-old boy. When delivering the stroller, the mother became tearful and shared that the only stroller she had to use was a two-seated running stroller that she had found. She informed that the stroller was so hard for her to use that she frequently went without, carrying her son. We explained that the stroller had come from the Mustang Heights Baptist Church and that a baby room was available if anything further was needed. The mother informed that the stroller was all she needed at the time and it was "an answer to a prayer". She then stated, "please tell them thank you, thank you so much". The second stroller which included a car seat, was delivered to a family with a 6-month-old girl. Care Manager also obtained a Minnie Mouse walker from MHBC with the possibility that the family could also use this. Delivery was made to the grandmother, who informed that the current stroller the family was using was in poor condition and this one would be "perfect" and there was also a need for the car seat as the one they were using was worn. When asking if there was a need for the walker, a ten-year-old family member stated, "look Nana, she is going to love it, she loves Minnie Mouse". He then explained to Care Manager that when the family had moved into a different trailer a walker had been left behind by the previous tenants. He shared that when they had tried to use the left behind walker it was discovered to be broken. The ten-year-old stated, "and we couldn't get her another one". He and his grandmother both expressed their excitement and gratitude over receiving the items for the 6-month-old.

An adorable ten-year-old on our ABD roster has severe medical/developmental disabilities. Unfortunately, her mother has addiction issues, and guardianship has been granted to her grandparents. Because of the additional financial strain, the family needed groceries, which we were able to deliver. Numerous other local food resources were provided, and we were able to deliver a Thanksgiving meal. Member's PT and OT had been terminated as a result of no-shows, and I encouraged them to speak to her PCP about this. She did and has been referred to the Children's Center for therapy. I encouraged her to apply for the DDSD waiver. She downloaded the application and is working on it. We also connected her with Sunbeam Family Services Grandparents Raising Grandchildren program.

Male patient on inpatient roster as a new baby. He has a four-year-old sister. Their mother is a single parent. The mother's parents both died while she was in high school and she has very little family support. She shared that she was dealing with some depression. The Edinburgh postnatal depression screening was administered, and she scored 15, which indicates possible depression. I

encouraged her to make an appointment as soon as possible with her OB to discuss this. She did and was prescribed antidepressants. The mother shared that she receives a small amount of financial assistance from our member's paternal grandparents but has not yet received any child support and has not yet been able to go back to work. She did receive WIC and SNAP. I encouraged her to talk to her DHS caseworker about applying for TANF and to add the baby to her SNAP so that she can increase her food stamps. Resources were provided to help with infant needs, including the Infant Crisis Services and BabyMobile. A Thanksgiving dinner was provided by the South Yukon Church of Christ, and she was able to sign up for Christmas help with Toys for Tots. The family was evicted from their apartment, but an aunt was able to take the family in. We were able to connect with Mustang Heights Baptist Church to obtain a stroller, baby bed and other infant supplies, which we delivered to the home.

During previous home visits, we have educated members and their families on asthma along with medication instruction and equipment needs, including peak flow meters. It has been noted many times that people do not fully understand asthma and how to use the medications prescribed, so our services are helpful. We continued to assess resource needs and haves worked to get Thanksgiving/Christmas food baskets scheduled as well as give information for parents to have holiday gift options for their children. We also prepare Asthma Education Plans, which are completed by PCP offices. They are then translated to Spanish and mailed both a Spanish and English copy of the plan to the family. We educate them on following the specific instructions for prescribed meds, when to use rescue inhalers and/or nebulizer treatments, as well as when to contact the physician. The parent is instructed to take the English copy to their child's school and give it to the school nurse, along with the rescue inhaler. Many of our parents have not had instructions to give the school and do not understand the importance of having the rescue inhaler at school.

Holidays often are a challenge for some of our families. Our CC-HAN resource specialist works tirelessly to find agencies and groups who are willing to help our families. In 2018, a total of fifty-eight (58) food / gift baskets were arranged for our members for Thanksgiving and Christmas, utilizing eight (8) separate agencies. This represents fifty-eight (58) families receiving these goods. Thirty-four (34) food baskets for Thanksgiving, five (5) food baskets for Christmas, and nineteen (19) toy / gift wishes were filled.

Twenty-six ABD/BH members were contacted with information on free school supply events in their areas. Parents verbalized gratitude and informed that they would not have been able to buy the supplies otherwise.