REBECCA PASTERNIK-IKARD
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Shanna Janu, Project Officer
Centers for Medicare and Medicaid Services
Division of State Demonstrations and Waivers
750 Security Blvd., Mail Stop S2-01-16
Baltimore, MD 21244-1850

RE: Request to Amend the SoonerCare Demonstration, 2017

Waiver No. 11-W-00048/6

Dear Ms. Janu:

The Oklahoma Health Care Authority (OHCA) as the single State Medicaid Agency request the approval of the Centers for Medicare and Medicaid Services to amend the currently approved SoonerCare $1115(a) Research and Demonstration Waiver, approved from January 1, 2017 until December 31, 2017.

The state is requesting that the request submitted August 2, 2017 be processed by CMS as an amendment to the SoonerCare Choice and Insure Oklahoma programs under the currently approved authority with updates to the Special Terms and Conditions regarding Workforce Development Supplemental Payments to State Teaching Universities. It is the intent of the OHCA to maintain the current waiver list and update the expenditure authorities to include Workforce Development, while sustaining budget neutrality.

Sincerely,

[redacted]

Tywanda Cox,
Chief of State and Federal Policy

Mary Fallin
Office of the Governor
State of Oklahoma

August 1, 2017

Shanna Janu, Project Officer
Centers for Medicare and Medicaid Services
Division of State Demonstrations and Waivers
7500 Security Blvd., Mail Stop S2-0l-16
Baltimore, MD 21244-1850

RE: Request to Extend SoonerCare Demonstration, 2018

Waiver No. 11-W-00048/6

Dear Mrs. Janu:

The Single State Medicaid Agency and The Oklahoma Health Care Authority request the approval of the Centers for Medicare and Medicaid Services to extend the SoonerCare §1115(a) Research and Demonstration Waiver from January 1, 2018 to December 31, 2018. The current waiver is approved through December 31, 2017.

The State is requesting an extension of the SoonerCare Choice and Insure Oklahoma programs under the current approved authority with updates to the Special Terms and Conditions regarding Workforce Development Supplemental Payments to State Teaching Universities. For the 2018 extension period, it is the intent of the OHCA to maintain the current waiver list and update the expenditure authorities to include workforce development, while sustaining budget neutrality. The waiver evaluation hypotheses will remain the same through the extension period along with the proposed objectives and evaluation measures.

Following the above one year extension, I intend to request a permanent approval of the Insure OK Program. I also intend to aggressively pursue the approval of the Sponsor's Choice amendment which was submitted March 7, 2016 and is pending authorization.

If you have any questions, please contact Tywanda Cox, Chief of Federal and State Policy, at (405) 522-7153.

Sincerely,

Mary Fallin
Governor

Oklahoma Health Care Authority

SoonerCare Choice and Insure Oklahoma §1115(a) Demonstration 11-W-00048/6

Application for Extension of the Demonstration, 01/01/18-12/31/18

Submitted to the Centers for Medicare and Medicaid Services

August 2, 2017

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I. HISTORICAL NARRATIVE SUMMARY

Demonstration Background

In 1993, the State of Oklahoma was in the process of reforming the Medicaid program in order to improve access to care, quality of care, and cost effectiveness. During the 1993 legislative session, Oklahoma state leadership passed legislation[1] that directed the Oklahoma Health Care Authority (OHCA), as the state entity designated by law, to assume the responsibilities for the preparation and development for converting the present delivery of the Oklahoma Medicaid Program to a managed care system.

The OHCA worked collaboratively with state leadership, providers and stakeholders to propose a program that was innovative and unique to Oklahoma. The Oklahoma SoonerCare Choice demonstration was approved by the Health Care Financing Administration in January 1995 under a 1915(b) managed care waiver. The managed care program was subsumed under a Section 1115(a) Research and Demonstration Waiver on January1, 1996. The SoonerCare Choice program began as a partially-capitated, primary care case management (PCCM) pilot program in four rural areas of Oklahoma and, in 1997 became a statewide program for all rural areas. In contrast, the SoonerCare Plus program was offered as a fully-capitated managed care program in urban areas of the state, and relied on contracted managed care organizations as providers. While the program initially enrolled children, pregnant women and Temporary Assistance for Needy Families (TANF) populations, over the years, the success of the program led state leadership to enlarge the program to serve the Aged, Blind and Disabled, as well as additional populations. In December 2003, the fully capitated managed care program, SoonerCare Plus was ended, and in January 2004, SoonerCare Choice PCCM was expanded statewide as the single managed care delivery system, for both urban and rural areas.

In addition to the PCCM delivery system, in January 2009, the OHCA implemented the patient-centered medical home in order to furnish each member with a primary care provider (PCP), otherwise known as "Medical Home". The OHCA continues to use this model today.

In the current SoonerCare Choice medical home model, members actively choose their medical home from a network of contracted SoonerCare providers. Members can change PCPs with no delay in the enrollment effective date. SoonerCare Choice providers are paid monthly care coordination payments for each member on their panel in amounts that vary depending on the level of medical home services provided and the mix of adults and children the provider accepts. Providers also qualify for performance incentive payments when they meet certain quality improvement goals defined by the state.

Outside of care coordination, all other services provided in the medical home, as well as by specialist, hospitals or other providers, are reimbursed on a fee-for-service basis. Members receive primary care services from their medical home PCP without a referral. For certain specialty services provided outside of the medical home, members are required to obtain a referral from their PCP.

[1] Title 63,§63-5009 of the Oklahoma Statutes.

SoonerCare Choice members receive SoonerCare benefits, which are State Plan benefits. The SoonerCare benefits plan does provide the enhanced benefit of unlimited physician visits (as medically necessary with the PCP) as compared to the State Plan, which limits physician services to four visits per month, including specialty visits for adults.

The SoonerCare Choice demonstration serves individuals who qualify for the Mandatory and Optional State Plan groups. Refer to Appendix A for a list of the SoonerCare Choice eligibility groups.

In accordance with Title 56 of the Oklahoma Statutes, the 1115(a) demonstration also serves individuals not qualified for SoonerCare Choice, but who qualify for the Insure Oklahoma program. The Insure Oklahoma program, enabled by State Legislation in April 2004, includes the Employer Sponsored Insurance (ESI) program and the Individual Plan (IP). Refer to Appendix A to review a list of Insure Oklahoma populations. Individuals in ESI receive assistance with payment for their premiums based on the Insure Oklahoma qualifying health plan[2] they choose. The employers also contribute a portion of premiums. Individuals who do not qualify for ESI may qualify for IP. Individuals who qualify for the IP program receive premium assistance and cost sharing for benefits that meet the essential health benefit requirements that would be applicable to alternative benefit plans under federal regulations found in 42 Code of Federal Regulations (CFR) Section 440.347.

Refer to Appendix B for a detailed history of the SoonerCare Choice and Insure Oklahoma programs and the corresponding program amendments.

Objectives Approved for the 2016-2017 Demonstration

The OHCA's objectives for the SoonerCare Choice demonstration are representative of the goals of the agency and the state. The OHCA was approved by the Centers for Medicare & Medicaid Services (CMS) on November 30, 2016, for the following objectives for the 2016-2017 extension period.

- Waiver Objective 1: To improve access to preventive and primary care services;
- Waiver Objective 2: To provide each member with a medical home;
- Waiver Objective 3: To integrate Indian Health Services (IHS) eligible beneficiaries and IHS and tribal providers into the SoonerCare delivery system;
- Waiver Objective 4: To expand access to affordable health insurance for low income working adults and their spouses; and
- Waiver Objective 5: To optimize quality of care through effective care management

Evaluation of 2016-2017 Objective Measures

In order to ensure that the OHCA is successfully meeting the stated objectives, the agency evaluates the SoonerCare Choice program through evaluation measures that assess each of the waiver objectives. The OHCA's progress in meeting the 2016-2017 objectives are outlined below.

[2] Insure Oklahoma qualified health plan requirements can be found at Oklahoma Administrative Code 317:45-5-1.

Waiver Objective 1: Access to Care (Hypos 1, 2, 4 & 5)
Through the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Health Plan Surveys (CAHPS®), the OHCA's SoonerCare Choice program has shown effectiveness in providing access to care. Results from HEDIS® and CAHPS® surveys indicate:

- The percentage of children ages 0-15months that had at least one or more checkups each year has maintained consistently above 90 percent since HEDIS® year 2011.
- More than 50 percent of children ages 3-6 years old had at least one or more checkups each year.
- Adolescents' ages 12-19 years old have maintained their percentage of health checkup rates. Although Oklahoma remains below the national average, there was an increase of 0.3 percent in health checkups for this population for HEDIS® year 2015 to HEDIS® 2016.
- The percentage of adults ages 20-44 years old who had at least one or more PCP visits per year has historically maintained at or above 80 percent since HEDIS® 2009, but, saw a slight decrease of 2.1 percent in HEDIS® year 2016.
- Adults ages 45- 64 years old who had at least one or more PCP visits a year saw a 0.1 percent increase and continues to maintain at a little more than 90 percent in HEDIS® year 2016.
- Some 82 percent of adults CAHPS® survey respondents indicated that they are "Usually" or "Always" satisfied with the time it takes to get an appointment with their PCP, while 92 percent of child CAHPS® survey respondents indicated their satisfaction with appointment times.

Waiver Objective 2: Medical Home (Hypos 3 & 4)
The OHCA continues to increase the number of SoonerCare providers and to ensure that each member has a medical home.

- The number of SoonerCare contracted providers has continued to increase. The OHCA began tracking Insure Oklahoma PCP providers which totaled 2,196 by December 2016 which has increased 45 percent since the January 2013 baseline total of 1,514.
- SoonerCare Choice PCP providers increased to 2,689 contracted providers as of December 2016. This is a capacity increase of 30 percent from the baseline year of December 2013. The average member per PCP continues to fluctuate.

Waiver Objective 3: Integration of IHS Beneficiaries and Providers (Hypo 6)
The OHCA continues to integrate Indian health members and providers into the SoonerCare Choice program.

- As of December 2016, nearly 85 percent of Native American SoonerCare members had an I/T/U PCP with SoonerCare Choice, while 15 percent of Native American SoonerCare members have an I/T/U PCP only.

Wavier Objective 4: Providing Access to Affordable Health Insurance (Hypos 3 & 5)
The OHCA believes that the number of Insure Oklahoma PCPs will continue to be maintained throughout the 2016 extension period. There was a total 2,196.

- The 2016 CAHPS ® survey indicate the majority of survey respondents for both the Adult and Child surveys had satisfactory responses for scheduling and appointment as soon as needed.

Waiver Objective 5: Care Management (Hypos 7, 8 & 9)
The OHCA provides comprehensive care management to individuals with chronic conditions in the Health Management Program (HMP), as well as individuals with complex health care needs in the Health Access Network (HAN) pilot program.

- The OHCA has increased the number of individuals engaged in nurse care management in an active HMP practice that have undergone practice facilitation by seven percent as of December 2016.
- In SFY 2015, the comparison group which is the General SoonerCare population had an 84.1 percent compliance rate and the Health Coach Participant group had a 96.1 percent compliance rate which indicates members visited their PCP more times within 12 months.
- Nearly 75 percent of the participant population also has both a physical and behavioral health condition. The HMP staff was able to identify members to participate in the program. The health coaching participant compliance rate improved in 10 of 22 measures (45.5 percent increase) from SFY2014 to SFY2015, although typically by small amounts.
- As of June 2016, some 117,750 SoonerCare Choice members with complex health care needs are receiving care management through one of the Demonstration's three pilot HANs.
- In SFY 2016, the Per Member Per Month (PMPM) average for HAN members was $285.30 while the PMPM average for non-HAN members was $313.33 PMPM. Expenditures continue to be lower for SoonerCare Choice members enrolled with a HAN PCP, than for SoonerCare Choice members who are not enrolled with a HAN PCP.

To review the evaluation measures in their entirety, refer to Section VI *Demonstration Evaluation*

<u>Demonstration Hypotheses</u>
The state will test the demonstration hypotheses listed in Section XIV, Evaluation of the Demonstration

<u>Proposed Objectives for the 2018 Extension</u>
The State proposes to continue the main objectives for the 2018 extension.

- Waiver Objective 1: To improve access to preventive and primary care services;

- Waiver Objective 2: To provide each member with a medical home;
- Waiver Objective 3: To integrate Indian Health Services (IHS) eligible beneficiaries and IHS and tribal providers into the SoonerCare delivery system;
- Waiver Objective 4: To expand access to affordable health insurance for low income working adults and their spouses; and
- Waiver Objective 5: To optimize quality of care through effective care management

II. REQUESTED CHANGES FOR THE 2018 DEMONSTRATION

The SoonerCare Choice and Insure Oklahoma § 1115(a) Research and Demonstration Waiver is currently approved through December 31, 2017. Oklahoma is aware that the SoonerCare/Insure Oklahoma Demonstration Waiver will need to be amended in order to include the provision of changes to the program (s) noted within the waiver extension. Oklahoma requests an extension of the program for the period of January 1, 2018 through December 31, 2018. At this time the state is requesting extension of this wavier with the following amended changes:

The State requests amendment to the expenditure authority and special terms and conditions to the waiver for the extension period to add the following program.

Work Force Development Supplemental Payments to State Teaching Universities

The OHCA makes supplemental payments to state teaching universities to grow and improve the healthcare workforce in the state of Oklahoma. These payments offer longitudinal options for training, development and placement of critical healthcare workers that offer flexible components that can be easily adapted to address specific healthcare needs that achieve certain goals. State universities can receive payments for programs that reach defined metrics such as percentage of graduating medical students entering residency programs in Oklahoma, number of medical students in qualified training programs, percentage of registered nurse students with clinical experience to Medicaid patients in a Medicaid contracted hospital/facility and percentage of licensed physical therapist in Oklahoma five (5) years post- graduation. This list of metrics is not exhaustive but serves as an example of required metrics for payments. The federal estimated impact is $115,000,000.

History:

Oklahoma has poor rankings in many health indicators. According to the Commonwealth Fund (December 2015), Oklahoma ranked in the bottom quartile for Access & Affordability (50th), Prevention & Treatment (48th), Avoidable Hospital Use & Cost (46th), Healthy Living (46th) and Equity (49th). These statistics are alarming and indicative of the need for a plan of action to improve the overall health within the state which has a 20% Medicaid health insurance coverage of non-elderly 0-64 population (source Kaiser Foundation 2015).

In late 2016, Governor Mary Fallin, appointed a committee to address both workforce development and health improvement through a request to the National Governors Association for a program called "Connecting Medicaid and Health Workforce: How

States Can Use Medicaid Funds to Address Workforce Needs in Rural and Other Underserved Areas." The program was selected for technical assistance support through the National Governors Association Center for Best Practices.

The committee identified the following recommendations for addressing two critically important issues of workforce development and health improvement.

- Improve funding to Training Institutions;
- Improve data collection and analysis related to workforce demand and critical shortages;
- Develop a collaborative program with communities to recruit and retain physicians and other health professionals across the state; and
- Engage in research to identify the critical success factors required to stabilize health care entities, sustain physicians and health care workers in communities, and enable care systems to effectively address the health needs of our citizens.

The committee concluded that the state is currently experiencing a serious physician workforce shortage and it is likely only to get worse without some type of intervention. The fact that Oklahoma is not alone in a physician shortage, as it is a national problem, affects the ability of Oklahoma to retain physicians who are targeted by the recruitment efforts of other states across the country. Stabilizing and improving the physician pipeline is absolutely imperative for both patients' wellbeing and insurers (Medicare and Medicaid) needs for access.

In addition, Oklahoma has high percentages of unfilled health professions as indicated in an excerpt of the Oklahoma's Critical Occupation for Ecosystems table below.

2017 Oklahoma[3] Health Professions			
Description	**2016 Jobs**	**Openings**	**Percentage of Unfilled Positions**
Surgeons	626	265	42%
Physicians (D.O. M.D.) & Surgeons, All Other	3,387	1,301	38%
Physical Therapists	1,795	1,144	64%
Registered Nurses	27,577	10,577	38%
Nurse Practitioners	1,104	625	57%

Solution:

The OHCA makes payments, under Section 1115(a) authority, to teaching universities to recruit, train and retain medical professionals to address the healthcare workforce shortage in Oklahoma. Specifically, Oklahoma has two primary physician training institutions, the University of Oklahoma and Oklahoma State University, which provide the vast majority of training to medical students, residents and fellows in both primary care and sub-specialty

[3] Source: Oklahoma Works, 2016.

medical care. These two institutions, as well as other academic institutions, are also working to address the workforce needs of the state with training of health profession workers such as registered nurses, advanced practice registered nurses, and physical therapists.

Eligibility Participation:

To be eligible to participate in the program schools must: (1) be a four year public university, (2) request funding for students enrolled in academic programs that result in licensure eligibility for the following healthcare workers: physician (D.O. & M.D.), registered nurse, advanced practice registered nurse or physical therapist, (3) provide an intergovernmental transfer (IGT) for the non-federal share, and (4) meet or exceed defined metrics for payment. Eligible programs must provide face to face onsite classes resulting in 100% online programs being prohibited from participation.

Payment Metrics: ** Some of the wording in this section may have been modified from the original state public comment posting due to receipt of information during the comment period. Changes were made to page 10.

Workforce Development for Physicians

- Number of medical students in qualified training programs
- Percentage of graduating medical students entering residency programs in Oklahoma
- Percentage of graduates of Oklahoma post graduate training (residency/fellowship) programs who remain in Oklahoma two years
- Percentage of graduates of Oklahoma post graduate training (residency/fellowship) who remain in Oklahoma 5 years with an active Medicaid contract
- Number of critical specialty graduates of an Oklahoma public universities in an accredited residency/fellowship program including, but not limited to, Psychiatrist, Neurologist, Dermatologist, Rheumatologist, Hepatologist

Workforce Development for Registered Nurses (RN)

- Total number of full-time enrolled equivalent RN students
- Percentage of RN students with clinical rotation experience in Medicaid contracted facilities
- Percentage of RN graduates from an Oklahoma public university who are licensed RNs in Oklahoma 2 years post-graduation.

Workforce Development for Advanced Practice Registered Nurse (APRN)

- Total number of full-time enrolled equivalent APRN students
- Percentage of APRN students with clinical rotation experience in Medicaid contracted facilities
- Percentage of graduates from an Oklahoma public university who are licensed APRNs in Oklahoma 2 years post-graduation.
- Percentage of APRN graduates from an Oklahoma public university who have an active Medicaid contract 2 years post-graduation.

Workforce Development for Physical Therapist (PT)

- Total number of full-time enrolled equivalent PT students
- Percentage of PT students with clinical rotation experience in Medicaid contracted

facilities

- Percentage of graduates from an Oklahoma public university who are licensed PT in Oklahoma 2 years post-graduation.
- Percentage of PT graduates from an Oklahoma public university who have an active Medicaid contract 2 years post-graduation.

Workforce Development for Resident Rural Scholarship

- Scholarships are paid to enrolled students in an accredited Oklahoma Family Practice/Family Medicine Program and agreement to match with an approved rural community and spend one month during the 3rd year of residency on elective rotation in the selected community and return to the community upon completion of residency training, one month for each month the loan was received.

Workforce Development for Nursing Student Assistance Loan Program

- Loans are made to Registered Nurses and Advanced Practice Registered Nurses who are unconditionally enrolled as a student in a four-year public university program, a legal resident of Oklahoma and a United States citizen. Loans are forgiven if the nurse fulfills work obligation of one year for each year of financial assistance at an approved health institution.

Workforce Development for Physician Loan Program

- Loans are made to provide financial assistance to the primary care physician in setting up a practice in a selected community in Oklahoma, in exchange for a service obligation to a rural community with a population of 10,000 or less.

Workforce Development for Loan Repayment Program

- Educational loan repayment assistance is made to Oklahoma licensed primary care physicians who agree to establish a practice in a community located in Oklahoma to provide medical care and services to Oklahoma citizens in rural and underserved areas with special emphasis to Medicaid members as authorized by the Oklahoma Health Care Authority. Participating physicians must agree to a minimum of two years practice in rural or underserved areas.

Workforce Development for Resident Retention

- Assistance is provided for resident salaries to assist with retention and faculty to promote and support the retention and training of primary care physicians for the state of Oklahoma. Payment assistance is made to pay a portion the salaries of individuals in residency programs in Oklahoma. Qualified expenditures will also include a percentage of the total amount of salary and benefits paid by each qualifying health training program for faculty and support staff and other indirect cost of running the residency program at qualifying employers.

III. 2018 WAIVER LIST, EXPENDITURE AUTHORITIES AND COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS

The State requests the following waiver list and expenditure authorities for the 2018 extension period. Additionally, the State complies with the current Special Terms and Conditions (STCs).

Waiver List

The State requests the following Waiver List as approved in the 2017 SoonerCare Choice

demonstration.

1. *Statewideness/Uniformity Section 902(a)(1)*
   To enable the state to provide Health Access Networks (HANs) only in certain geographical areas of the State.
2. *Freedom of Choice Section 1902(a)(23)(A)*
   To enable the state to restrict beneficiaries' freedom of choice of care management providers and to use selective contracting that limits freedom of choice of certain provider groups to the extent that the selective contracting is consistent with beneficiary access to quality services. No waiver of freedom of choice is authorized for family planning providers.
3. *Retroactive Eligibility Section 1902(a)(34)*
   To enable the state to waive retroactive eligibility for demonstration participants with the exception of Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind and Disabled populations.

Expenditure Authorities

The State requests the following Expenditure Authorities for the 2018 demonstration extension.

1. *Demonstration Population 5.*
   Expenditures for health benefits coverage for individuals who are "Non-Disabled Low-Income Workers" ages 19-64 years old, who work for a qualifying employer, and have income up to 200 percent of the federal poverty level (FPL) and their spouses.

2. *Demonstration Population 6.*
   Expenditures for health benefit coverage for individuals who are "Working Disabled Adults ages 19-64 years of age, who work for a qualifying employer and have income up to 200 percent of the FPL.

3. *Demonstration Population 8.*
   Expenditures for health benefit coverage for no more than 3,000 individuals at any one time who are full-time college students ages 19-22 and have income up to 200 percent of the FPL, who have no creditable health insurance coverage and work for a qualifying employer.

4. *Demonstration Population 10.*
   Expenditures for health benefit coverage for foster parents who work for a qualified employer and their spouses with household incomes up to 200 percent of the FPL.

5. *Demonstration Population 11.*
   Expenditures for health benefit coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees, work for a qualifying employer and with household incomes up to 200 percent of the FPL.

6. *Demonstration Population 12.*
   Expenditures for health benefit coverage for individuals who are "Non-Disabled Low-Income Workers" 19-64 years of age, whose employer elects not to participate in the

Premium Assistance Employer Coverage Plan, as well as those who are self-employed or unemployed (and seeking work) and who have income up to 100 percent of the FPL and their spouses.

7. *Demonstration Population 13.*
   Expenditures for health benefits coverage for individuals who are "Working Disabled Adults" 19-64 years of age, whose employer elects not to participate in the Premium Assistance Employer Coverage Plan, as well as those who are self-employed or unemployed (and seeking work) and who have income up to 100 percent of the FPL.

8. *Demonstration Population 14.*
   Expenditures for health benefit coverage for no more than 3,000 individuals at any one time who are full-time college students ages 19-22 and have income up to 100 percent of the FPL, who have no creditable health insurance coverage and do not have access to the Premium Assistance Employer Coverage Plan.

9. *Demonstration Population15.*
   Expenditures for health benefit coverage for individuals who are working foster parents, whose employer elects not to participate in the Premium Assistance Employer Coverage Plan and their spouses, who have household incomes up to 100 percent of the FPL.

10. *Demonstration Population16.*
    Expenditures for health benefit coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes up to 100 percent of the FPL, and do not have access to the Premium Assistance Employer Coverage Plan.

11. *Health Access Networks Expenditures.*
    Expenditures for Per Member Per Month payments made to the Health Access Networks for case management activities.

12. *Premium Assistance Beneficiary Reimbursement.*
    Expenditures for reimbursement of costs incurred by individuals enrolled in the Premium Assistance Employer Coverage Plan and in the Premium Assistance Individual Plan that are in the excess of five percent of annual gross family income.

13. *Health Management Program.*
    Expenditures for other non-covered costs to provide health coaches and practice facilitation services through the Health Management Program.

14. *Work Force Development Supplemental Payments to State Teaching Universities.*
    Expenditures for reimbursement to state teaching universities to grow and improve the healthcare workforce in Oklahoma.

Title XIX Requirements Not Applicable to the Demonstration Expenditure Authorities

Not applicable to Demonstration Populations: 5,6,8,10,11,12,13,14, 15, and16.

1. *Comparability; Section 1902(a)(10)(B) and 1902(a)(17)*
   To permit the State to provide different benefit packages to individuals in demonstration populations 5,6, 8, 10 and 11who are enrolled in the Premium Assistance Employer Coverage Plan that may vary by individual.

2. *Cost Sharing Requirements; Section 1902(a)(14) insofar as it incorporates Section 1916*
   To permit the State to impose premiums, deductions, cost sharing and similar charges that exceed the statutory limitations to individuals in populations 5, 6, 8, 10 and 11 who are enrolled in the Premium Assistance Employer Coverage Plan.

3. *Freedom of Choice; Section 1902(a)(23)(A)*
   To permit the State to restrict the choice of provider for beneficiaries qualified under populations 5, 6,8, 10 and 11 enrolled in the Premium Assistance Employer Coverage Plan. No waiver of freedom of choice is authorized for family planning providers.

4. *Retroactive Eligibility; Section 1902(a)(34)*
   To enable the State to not provide retroactive eligibility for demonstration participants in populations 5, 6, 8, 10, 11, 12, 13, 14, 15 and 16.

5. *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services; Section 1902(a)(4)(B); 1902(a)(10)(A); and 1902(a)(43)*
   To exempt the State from furnishing or arranging for EPSDT services for full-time college students age 19 through age 22 who are defined in populations 8, 13 and 14.

6. *Assurance of Transportation; Sections 1902(a)(4); and 1902(a)(19); 42 CFR 431.53*
   To permit the State not to provide transportation benefits to individuals in populations 12, 13, 14, 15 and 16 enrolled in the Insure Oklahoma Premium Assistance Individual Plan

<u>Compliance with Special Terms and Conditions</u>

1. *Compliance with Federal Non-Discrimination Statutes.*
   The State complies with all applicable state and federal statutes relating to non-discrimination, including but not limited to, the American with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age of Discrimination Act of 1975.

2. *Compliance with Medicaid and Children's Health insurance Program (CHIP) Law, Regulation and Policy.*
   The State complies with all Medicaid and CHIP program requirements in law, regulation and policy statement that are not expressly waived or identified as not applicable in the wavier and expenditure authority documents received from the Centers for Medicare and Medicaid Services (CMS) of which these terms and conditions are a part, including protections for Indians pursuant to Section 5006 of the American Recovery Reinvestment Act of 2009.

3. *Compliance with Changes in Medicaid and CHIP Law, Regulation and Policy (e.g. CHIPRA)*
   Within the timeframes specified by law, regulation or policy statement, the State brings the Demonstration into compliance with changes in Federal and State law, regulations or policy that affect the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision change is expressly waived or identified as not applicable to the Demonstration.

4. *Impact on Demonstration of Changes in Federal Law, Regulation and Policy.*
   a) If change in federal law, regulation or policy results in a change in Federal Financial Participation (FFP) for expenditures made under the Demonstration, the State submits modified budget neutrality and allotment neutrality agreements for CMS approval. The State recognizes that the modified agreements referred to in this subparagraph do not involve changes to trend rates for the budget neutrality agreement, and that modified agreements take effect on the date the relevant change (s) is implemented.

   b) The State complies with mandated changes in federal law that requires state legislation. Any mandatory changes will take effect the day the State law becomes effective or the last effective day required by the federal law.

5. *State Plan Amendments*
   The State submits State Plan amendments if changes to the Demonstration affect populations qualified through the Medicaid or CHIP State Plans.

6. *Changes Subject to the Amendment Process.*
   The State agrees to not implement changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality or other comparable program elements without submission of an amendment request and receipt of prior approval by CMS. Amendments are not retroactive, and the State recognizes that FFP is not available for changes to the Demonstration that have not been approved through the proper amendment process.

7. *Amendment Process.*
   The State submits amendment requests to CMS no later than 120 days prior to the planned implementation date and the requests are not implemented until receipt of CMS approval. Amendment requests include all required elements, as outlined in (a)- (e) of this section, for CMS review.

8. *Extension of the Demonstration.*
   a) The State submits its extension request per CMS guidance.

   b) The State submits this application as documentation of compliance with the transparency requirements in 42 CFR section 431.412 and the required supporting documentation outlined in (i)-(vii) of this section, as well as the public notice requirements outlined in paragraph 16 of STCs.

9. *Demonstration Phase-Out*
   In the event that the State elects to suspend or terminate the Demonstration in whole or in part, the State agrees to promptly notify CMS in writing and submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. The State agrees to comply with all phase-out requirements set forth in (a)-(d) of this section.

10. *Expiring Demonstration Authority.*
    In the event that CMS elects to expire demonstration authority prior to the Demonstration's expiration date, the State agrees to submit a demonstration Transition and Expiration Plan to CMS at least six months prior to the Demonstration authority's expiration date. The State agrees to include in the Expiration Plan, the requirements as outlined in (a)-(d) of this section.

11. *CMS Right to Terminate or Suspend.*
    The State understands that CMS may suspend or terminate the Demonstration in whole or in part whenever it determines, after a hearing that the State has materially failed to comply with the terms of the Demonstration.

12. *Federal Financial Participation.*
    The State understands that federal financial funds for Medicaid expenditures will not be available until the effective date of the demonstration approval letter.

13. *Finding of Non-Compliance.*
    The State understands its right to challenge a CMS finding that the State materially failed to comply with the terms of the Demonstration.

14. *Withdrawal of Waiver or Expenditure Authority.*
    The State understands that CMS reserves the right to withdraw waiver or expenditure authorities and that the State may request a hearing prior to the effective date to challenge CMS' determination that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX and/or Title XXI.

15. Adequacy of Infrastructure.
    The State ensures the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach and enrollment; maintenance of eligibility systems; compliance with cost sharing requirements and reporting on financial and other demonstration components.

16. Public Notice, Tribal Consultation, and Consultation with Interested Parties.
    The State complies with the State Notice Procedures set forth in 59 Federal Register 49249, as well as the tribal consultation requirements pursuant to Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act of 2009. The State also complies with the tribal consultation requirements contained in the State's approved State Plan. The State submits evidence to CMS regarding solicitation of advice from federally recognized Indian tribes, Indian health programs and Urban Indian Organizations prior to submission of

any waiver proposal, amendment or renewal of the Demonstration. Documentation of compliance with these requirements is provided in Section VII, *Public Notice.*

17. Post Award Forum.

The State complies with the requirement to afford the public an opportunity to provide comment on the progress of the Demonstration through a Post Award Forum. Documentation of compliance with these requirements is provided in Section VII, *Public Notice*.

18. Compliance with Managed Care Regulations.

State complies with all managed care regulations at 42 CFR section 438 *et. seq.*, that are applicable to the Demonstration.

19. Use of Modified Adjusted Gross Income (MAGI) Based Methodologies for Demonstration Groups.

The State derives the SoonerCare Choice Mandatory and Optional State Plan groups' eligibility from the Medicaid State Plan, which are subject to all applicable Medicaid laws and regulations, except as expressly waived in the Demonstration. The State understands that Medicaid State Plan amendments apply to the eligibility standards and methodologies for the Mandatory and Optional SoonerCare Choice State Plan groups. This includes the conversion to MAGI for the SoonerCare Choice population on October 1, 2013 (State Plan 13-0018 S10).

20. State Plan Populations Affected -

The Demonstration includes Title XIX and Title XXI populations. The State maintains the Mandatory and Optional State Plan groups outlined in the Special Terms and Conditions. Refer to Appendix A, *SoonerCare Choice and Insure Oklahoma Eligibility Chart*. The State does not request any changes.

21. Demonstration Eligibility.

The State maintains the eligibility groups in the Individual Plan program as outlined in the Special Terms and Conditions. The State does not request any changes.

22. Eligibility Exclusions.

The State maintains the eligibility exclusion rules outlined in the STCs and is not requesting any changes to the populations not qualified to participate in the Demonstration.

23. TEFRA Children, Population 7.

The State maintains the rules for eligibility in the TEFRA category and is not requesting any changes in the definition of the population or the eligibility for the Demonstration.

24. TEFRA Children Retroactive Eligibility.

The State agrees that the waiver of retroactive eligibility does not apply to TEFRA children. TEFRA parents or guardians choose an appropriate PCP/case manager. The State is not requesting any changes to these rules.

25. Eligibility Conditions for Full-Time College Students, Populations 8 and 14

The State complies with the requirements of the income eligibility documentation. The State maintains an enrollment cap of 3,000 full-time college students for the Insure Oklahoma program. The State received authorization for a waiting list from CMS on April 25, 2011. As of December 2016, there are 114 students enrolled in ESI and 187 students enrolled in IP for a total of 301 college students currently enrolled in the Insure Oklahoma program. A waiting list is currently not in place. The State does not expect to implement a waiting list for the 2018 extension period but understands that a minimum of 60-day notifications to CMS is required prior to implementing a waiting list.

26. SoonerCare Benefits.

The State agrees that SoonerCare Choice benefits are Title XIX State Plan benefits with one exception, the SoonerCare Choice waiver package allows unlimited, medically necessary PCP visits and up to four specialty visits per month. The State is not requesting any changes to the SoonerCare benefits. Insure Oklahoma Employer Sponsored Insurance benefits can be found under section VI in paragraph 29, of the STCs. Insure Oklahoma Individual Plan benefits can be found in paragraph 31 of the STCs.

27. SoonerCare Cost Sharing

The State agrees that under the current SoonerCare program, American Indians with an I/T/U provider, pregnant women, and children (including TEFRA children) up to and including age 18, individuals in the Breast and Cervical Cancer program, emergency room services and family planning services are not subject to cost sharing. Cost sharing for non-pregnant adults enrolled in SoonerCare is the same as the cost sharing assessed under the Title XIX State Plan. The State is not requesting any changes to cost sharing.

Insure Oklahoma premium assistance benefits and cost sharing is referred to in Section VI of the STCs.

28. Insure Oklahoma: Premium Assistance Employer Coverage.

The State maintains all other definitions, eligibility rules for premium assistance employer coverage, as well as the employer requirements outlined in (a)-(f) of this section.

29. Insure Oklahoma: Premium Assistance Employer Coverage IO Qualifying Plans.

The State maintains the required criteria for the Insure Oklahoma qualified health plans as defined in Oklahoma Administrative Code 317:45-5-1. All Insure Oklahoma employer sponsored insurance health plans are approved by the Oklahoma Insurance Department. The State is not requesting any changes to the maximum allowed copayment amounts at this time, and continues to comply with paragraph 33 of the STCs.

30. Insure Oklahoma: Premium Assistance Individual Plan.

The State complies with the Insure Oklahoma Individual Plan definition and eligibility criteria. The State also maintains the Individual Plan benefits, under paragraph 31 of the STCs. Additionally, the State is not requesting any changes to the process requirements, as outlined in (a)-(f) of this section.

31. Premium Assistance Individual Plan (Insure Oklahoma) Benefit.

The State maintains the Individual Plan benefit package. The benefit package meets the essential health benefit requirements that would be applicable to alternative benefit plans under federal regulations found in 42 CFR Section 440.347. In the future, the State agrees to submit all changes covered and non-covered services and benefits to CMS for prior approval.

32. Insure Oklahoma Cost Sharing.

The State agrees to not exceed the cost sharing amounts for the Employer Sponsored Insurance program, as outlined in paragraphs 33 and 34 of the STCs. For the Individual Plan, the State agrees to not exceed cost sharing amounts as defined under federal regulation 42 CFR Section 447. One exception to this is that the State maintains a $30 copayment for emergency services, unless the individual is admitted to the hospital. The State understands that copayments may be lowered at any time by notifying CMS in writing at least 30 days prior to the effective date. The State also maintains the annual out-of-pocket cost sharing to not exceed five percent of a family's gross income.

33. Premium Assistance Employer Coverage Copayments and Deductibles.

The State maintains that Insure Oklahoma ESI copayments continue to be the copayments required by the enrollee's specific health plan, as defined in paragraph 29 of the STCs. The State also maintains the copayment and deductible requirements as outlined in (a)-(d) of this section.

34. Premium Assistance Employer Coverage Plan Premiums.

The State maintains that individuals and families participating in employer coverage will be responsible for up to 15 percent of the total health insurance premium not to exceed three percent out of the five percent annual gross household income cap. The State maintains the reimbursement and premium responsibilities as outlined in (a)-(b) of this section.

35. Premium Assistance Individual Plan Premiums.

The State maintains the Individual Plan premiums as imposed in (a)-(d) of this section.

36. Compliance with Managed Care Regulations.

The State complies with all managed care regulations at 42 CFR Section 438 et. seq. that are applicable to the Demonstration.

37. Access and Service Delivery

The State maintains the access and service delivery language as outlined in this section. In accordance with the provider type chart, the State adds the following

underlined language to the "Medical Resident" requirement, in order to comply with current OHCA rules[4] and business practices.

Medical Resident: Must be licensed by the State in which s/he practices**.** Must be at least at the Post Graduate 2 level and may serve as a PCP/CM only within his/her continuity clinic setting and must work under the supervision of a licensed attending physician.

38. Care Coordination Payments.

The State maintains the definition for the monthly care coordination payments, the monthly schedule of care coordination payments, the changes to monthly care coordination payments and the monthly care management payments as outlined in (a) – (d). The State understands the requirement to notify CMS at least 60 days prior to changing the fees paid to PCPs and to include a revised budget neutrality assessment with such a notification.

39. Other Medical Services.

It continues to be the case that all other SoonerCare Choice benefits, (with the exception of non-emergency transportation and PACE, which are paid though a capitated contract) are paid through the State's FFS system. The State is not requesting any changes to this arrangement.

40. Health Access Networks.

The State understands that it may pilot up to four Health Access Networks (HANs). The State maintains all other definitions, rules and requirements for the HANs as outlined in this section inclusive of care management/care coordination responsibilities. The State understands that duplicative payments for services offered under the State Plan are not to be made to HANs. The State also recognizes the requirements to notify CMS 60 days prior to any change to the HAN PMPM payment and to include a revised budget neutrality assessment with the notification.

41. Provider Performance.

The State maintains incentive payments for the performance program, SoonerExcel, outlined in this paragraph and maintains a 60-day CMS notice requirement if the State wishes to make changes.

42. Services for American Indians.

The State agrees that qualified American Indian SoonerCare Choice members may continue to enroll with I/T/Us as their PCP. This enrollment is voluntary. I/T/U providers enrolled as SoonerCare PCPs receive the care coordination payments as outlined in paragraph 38. The State maintains that Oklahoma's I/T/Us must have a SoonerCare American Indian PCCM contract. All of the OHCA's I/T/U SoonerCare providers have a SoonerCare American Indian PCCM contract.

43. *Contracts.*

[4] Oklahoma Administrative Code 317:25-7-5.

The State understands that procurement and subsequent final contracts that implement selective contracting by the State with any provider group must be approved by CMS prior to implementation. The State maintains existing contracts with Federally Qualified Health Centers.

44. TEFRA Children.

The State maintains the arrangements for service delivery for TEFRA children, as defined in paragraph 23, outlined in this paragraph and is not requesting that any changes be made.

45. Health Management Program Defined.

The State complies with the definition and eligibility requirements outlined for the Health Management program. The State reports on the HMP in the Quarterly Reports, which are submitted no later than 60 days after the last day of each calendar quarter.

46. Health Management Program Services.

The State maintains the services provided through the HMP as defined in this paragraph, in (a)-(b) of this section. The State is not requesting that any changes be made.

47. Changes to the HMP Program.

The State understands that it must submit notification to CMS 60 days prior to any requested change in HMP services, as well as submit a revised budget neutrality assessment. The State is not requesting that any changes be made.

48. Monitoring Aggregate Costs for Eligibles in the Premium Assistance Program.

The State monitors the aggregate costs for the Insure Oklahoma ESI and IP programs. On a quarterly basis, the State compares the average monthly premium assistance contribution per employer coverage enrollee to the cost per member per month of the Individual Plan population. On an annual basis, the State calculates the total cost per enrollee per month for individuals receiving subsidies under the ESI program, including reimbursement made to enrollees whose out-of-pocket costs exceed their income stop loss threshold (or five percent income). The State compares the cost to the 'per enrollee per month' cost of individuals enrolled in the Individual Plan. Documentation of compliance with these requirements is provided in Appendix C, *Insure Oklahoma Monitoring.*

49. Monitoring Employer Sponsored Insurance.

The State monitors the aggregate level of contributions made by participating employers, requires that participating employers report annually their total contributions for employees, prepares an aggregate analysis across all participating employers summarizing the total statewide employer contribution and monitors changes in covered benefits and cost-sharing requirements of employer-sponsored health plans and documents any trends. Documentation of compliance with these requirements is provided in Appendix C, *Insure Oklahoma Monitoring.*

50. General Financial Requirements.

The State complies with all General Financial Requirements under Title XIX, set forth in the STCs, Section XI, as well as the General Financial Requirements under Title XXI, set forth in Section XII of the STCs. Refer to Section V of this document for compliance with budget neutrality.

51. Reporting Requirements Related to Budget Neutrality.

The State complies with all reporting requirements for Monitoring Budget Neutrality, as set forth in Section XIII of the STCs. Refer to Section V of this document for compliance with budget neutrality.

52. Monthly Calls.

The State participates in monthly calls with CMS as outlined in this paragraph of the STCs.

53. Quarterly Operational Reports.

The State submits quarterly operational reports on the Demonstration to CMS in the format specified in Attachment A of the STCs, no later than 60 days following the end of the quarter. The reports include all of the following elements outlined in (a)-(e) of this section of the STCs

54. Annual Report.

The State submits a draft Annual Report to CMS within 120 days after the close of each demonstration year; the State submits the final Annual Report to CMS 30 days after receiving comments from CMS. The State includes in the report the requirements set forth in this paragraph.

55. Title XXI Enrollment Reporting.

The State complies with Title XXI enrollment reporting requirements.

56. Quarterly Expenditure Reports

The State complies with the quarterly expenditure report requirements outlined in this section. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

57. Reporting Expenditures Under the Demonstration

The State reports demonstration expenditures through the SoonerCare and CHIP program budget and Expenditure System, following routine CMS-64 reporting instructions. The State complies with all reporting expenditure requirements outlined in (a)-(j) of this section. Refer to Section V of this document and attachments one and two for compliance with the Budget Neutrality Cap.

58. Reporting Member Months.

The State complies with the member months reporting requirements, as outlined in (a)-(d) of this paragraph. Refer to Section V of this document for compliance with the Budget Neutrality.

59. Standard Medicaid Funding Process.

The State reports to CMS its best estimate of matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure agreement, and separately reports these expenditures by quarter for each federal fiscal year on the CMS-37 form for the Medical Assistance Payments and state and local administration costs. The State submits to CMS the CMS-64 quarterly Medicaid expenditure report 30 days after the end of each quarter. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

60. Extent of Federal Financial Participation for the Demonstration

The State understands CMS's provision of FFP for applicable federal matching rates for the Demonstration, as outlined in (a)-(d) of this section. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

61. Sources of Non-Federal Share.

The State certifies that the matching non-federal share of funds for the Demonstration are state/local monies. The State also certifies that such funds shall not be used as the match for any other federal grant or contract except as permitted by law. The State certifies that all sources of non-federal funding are compliant with Section 1903(w) of the Act and applicable regulations, and are subject to CMS approval. In addition, the State complies with the requirements set forth in (a)-(b) of this paragraph. The State submits certifications of financial matters quarterly through the CMS-64. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

The State also agrees that health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. The State understands that no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments.

62. State Certification of Funding Conditions

The State complies with the non-federal share requirements of demonstration expenditures, as outlined in (a)-(d) of this section. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

63. Monitoring the Demonstration.

The State agrees to provide CMS all of the requested information in a timely manner in order to effectively monitor the Demonstration.

64. Quarterly Expenditure Reports.

The State complies with submission of reports quarterly under this demonstration expenditure through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in Section 2115 and 2500 of the State Medicaid Manual. The State submits all Title XXI expenditures through the CMS- 64.21U and/or the CMS-64.21UP. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

65. Claiming Period.

The State complies with the claiming period requirements outlined in this section (a) – (b). Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

66. Limitation on Title XXI Funding.

The State understands that there is a limit on the amount of federal Title XXI funds that it may receive for demonstration expenditures during the demonstration period. The State also understands that no further enhanced federal matching funds will be available for costs of the Demonstration if the State expends its available allotment. If Title XXI funds are exhausted, the State agrees to continue to provide coverage to Medicaid expansion children (Demonstration Population 9) through Title XIX funds until further Title XXI funds become available. Refer to Section V of this document and attachments one and two of this document for compliance with budget neutrality.

67. Limit on Title XIX Funding.

The State understands that there is a limit on the amount of Title XIX funds that the State may receive for selected Medicaid expenditures during the period of approval for the Demonstration. Refer to Section V of this document for compliance with budget neutrality.

68. Risk.

The State understands that it is at risk for the per capita cost for demonstration enrollees under the budget neutrality agreement. The State understands, however, that it is not at risk for the number of demonstration enrollees in each of the groups, as well as for changing economic conditions, which might impact enrollment levels. Refer to Section V of this document for compliance with budget neutrality.

69. Demonstration Populations Subject to the Budget Neutrality Agreement

The State agrees that the demonstration populations outlined in (a)-(e) of this section are subject to the budget neutrality agreement and are incorporated into the demonstration eligibility groups used to calculate budget neutrality. Refer to Section V of this document for compliance with budget neutrality.

70. Budget Neutrality Expenditure Limit.

The State complies with the method used to calculate the budget neutrality expenditure limit, as outlined in (a)-(b) of this section. Refer to Section V of this

document and attachment one and two of this document for compliance with budget neutrality.

71. Enforcement of Budget Neutrality

The State agrees to submit a corrective action plan to CMS if the State exceeds the calculated cumulative budget neutrality expenditure limit. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

72. Exceeding Budget Neutrality

The State agrees that if the budget neutrality limit has been exceeded at the end of the demonstration period, the State will return all excess federal funds to CMS. Refer to Section V of this document and attachments one and two for compliance with budget neutrality.

73. Submission of Draft Evaluation Design.

The State submits to CMS a draft Evaluation Design no later than 120 days after the award of the Demonstration. The State agrees to include in the draft Evaluation Design the requirements set forth in (a)-(g) of this section.

The OHCA submitted to CMS the proposed SoonerCare Choice 2015-2016 Evaluation Design on November 9, 2015 and submitted the final document to CMS on (December 15, 2016) which included the extension for the 2017 demonstration year. To review the final Evaluation Design, refer to attachment three.

74. Identify the Evaluator.

The State identifies in the Evaluation Design the agency or contractor who will conduct the Evaluation report.

The State identified the 2016-2017 evaluator(s) for the SoonerCare Choice Evaluation report within the proposed 2015-2016 Evaluation Design that was submitted to CMS on November 9, 2015, and again on December 15, 2016 when the OHCA submitted the final document to CMS which included the extension for the 2017 demonstration year.

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75. Demonstration Hypotheses.

The State tests the demonstration hypotheses that are approved by the State and CMS.

The OHCA submitted the proposed SoonerCare Choice demonstration hypotheses in the 2015-2016 Evaluation Design submitted to CMS on November 9, 20015, and submitted the final document to CMS on December 15, 2016 which included the extension for the 2017 demonstration year. For the 2015-2016 findings from the Evaluation Design, refer to Section VI of this document.

The OHCA proposes the 2018 demonstration hypotheses to remain the same as those proposed for the 2016-2017 Evaluation Design submission.

76. Evaluation of Health Access Networks.

The State submits to CMS a draft Evaluation Design for the Health Access Network pilot program as required under paragraph 73. Within the Evaluation Design, the State includes the requirements set forth in (a)-(d) of this section.

The OHCA submitted the draft HAN Evaluation Design with the HAN reporting requirements outlined in (a)-(d) of this section within the 2015-2016 SoonerCare Choice Evaluation Design, which was submitted to CMS on November 9, 2015, and submitted the final document to CMS on December 15, 2016, Refer to Section VI of this document for the Evaluation Design findings.

For the 2018 demonstration extension, the OHCA would like to retain the changes that were included in the submission of the 2016 - 2017 Evaluation Design, which included an analysis of the HANs effectiveness in:

a. Improving access to health care services to SoonerCare members served by the HANs;
b. Improving coordination of health care services through health information technology; and
c. Enhancing the State's patient-centered medical home program.

77. Evaluation of the Health Management Program.

The State submits to CMS a draft Evaluation Design for the Health Management Program as required under paragraph 73. Within the Evaluation Design, the State includes the requirements set forth in (a)–(h) of this section.

The OHCA submitted the draft HMP Evaluation Design with the HMP hypothesis listed within the 2015-2016 SoonerCare Choice Evaluation Design, which was submitted to CMS on November 9, 2015, and submitted the final document to CMS on (December 15, 2016), Refer to Section VI of this document for the Evaluation Design findings.

The OHCA proposes the HMP hypotheses for the 2018 demonstration extension to remain the same.

78. Evaluation of Eligibility and Enrollment Systems.

The OHCA evaluates the State's eligibility and enrollment system, as indicated in (a)-(g) of this section, during an interim evaluation report, which documents the State's systems performance between Medicaid, CHIP and the Exchange.

79. Interim Evaluation Reports.

The State submits to CMS an interim evaluation report in the event that the State requests to extend the Demonstration beyond the current approval period. Refer to Section VI of this document for the current 2015-2016 Evaluation Design findings.

80. Final Evaluation Plan and Implementation.

The State provides the final Evaluation Design to CMS within 60 days of receiving CMS's comments. The State agrees to implement the Evaluation Design and include progress reports within the SoonerCare Quarterly Reports. The State also

submits to CMS a draft Evaluation of the Demonstration 120 days after the expiration of the current Demonstration. The State agrees to provide a final Evaluation of the Demonstration to CMS within 60 days of receiving CMS's comments. The State agrees to include in the Evaluation the requirements set forth in (a)-(g) of this section.

The OHCA submitted to CMS the proposed 2015-2016 SoonerCare Choice Evaluation Design on November 9, 2015, and again as a final report on December 15, 2016, after receipt of CMS's comments. The OHCA will report on the progress of two or more hypotheses within each Quarterly report as it relates to progress of each evaluation measure.

81. *Cooperation with CMS Evaluators.*
The State agrees to fully cooperate with CMS, or an independent evaluator of CMS, for the evaluation of the Demonstration.

IV QUALITY

Quality Assurance Monitoring

The OHCA is contracted with an outside vendor Telligen who works with, Morpace to conduct the State Fiscal Year (SFY) 2016 *CAHPS® Adult Medicaid Member Services Satisfaction Surveys, and SFY 2016 CAHPS® Child Medicaid with Child Chronic Condition (CCC) Member Satisfaction Surveys.* The OHCA received these reports in June 2016. The objective of the survey is to capture accurate and complete information about consumer-reported experiences with SoonerCare Choice by:

- Measuring satisfaction levels, health plan and socio-demographic characteristics of members;
- Identifying factors that affect the level of satisfaction;
- Providing a tool that can be used by plan management to identify opportunities for quality improvement; and
- Providing plans with data for HEDIS® and National Committee for Quality Assurance (NCQA) accreditation.

The outcome conclusion of the child and adult survey is noted in Appendix D. Please see attachments four and five for full detailed information.

Quality Initiatives

Community Relations

The office of Health Promotion expanded the SoonerQuit Engagement Grant in 2016. There are two branches of the grant with SoonerQuit, Health Promotion and SoonerQuit Provider Engagement. The OHCA partnered with Oklahoma's Tobacco Settlement Endowment Trust (TSET) fund and the Oklahoma State Department of Health (OSDH) to administer the Provider Engagement program.

In 2016, the SoonerQuit Provider Engagement program utilized practice facilitation to educate providers on tobacco cessation best practice methodology in 24 clinics. Sixty-six providers

participated in the program in 2016.

The OHCA has more than 589 public, private and nonprofit entities within Oklahoma's 77 counties who are considered OHCA's community partners. Community partners are engaged in outreach, enrollment and retention activities for SoonerCare eligible and enrolled children.

Executive Council

The Governor appointed members to the Blue Ribbon Panel for Developmental Disabilities in response to the significant number of Oklahoma's men, women and children with intellectual disabilities that were on a waiting list for services. Before its expiration, the Blue Ribbon Panel commissioned an Executive Council, which was formed to improve the range and quality of services accessible to Oklahomans with developmental disabilities. There are four objectives that have been created by the Council:

- Provide for the regular, periodic dissemination of information about resources to individuals on the wavier services request list;
- Develop and implement resources training programs that are designed both for state employees to employ at the point of intake and for families and self -advocates to access;
- Improve the ease-of-use and prominence of information on state agency websites concerning resources, including the potential creation of a uniform disability information web portal; and
- Analyze how to best prioritize the waiver services request list.

During 2016, the Executive Council initiated and continues to work toward implementation of a web portal to provide a streamlined application, allowing users to access multiple state systems without having to enter information multiple times. It will also be used to coordinate supports and services, and provide prescreening for Medicaid applicants.

Applied Behavior Analysis Report

According to the Centers for Disease Control, one in 68 children has an autism spectrum diagnosis (ASD), higher than previous years[5]. House Bill 2962 (HB 2962), passed during the 2nd regular session of the 55th Legislature, authored by Representative Jason Nelson and Senator AJ Griffin, directed the OHCA and partnering state agencies Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma State Department of Education (OSDE), and the Oklahoma State Department of Health (OSDH) to study and prepare a report concentrating on the use of applied behavior analysis therapy treatment for children with ASD within the state's Medicaid program. The data referenced throughout the final report includes information from SFY2010 through SFY2016.

The report took into account various states' cost analysis of services to this population. Variance exists with a probability of new members being added for services, which are not counted in the State of Oklahoma final calculation in addition to other limitations inclusive of provider access and funding. Since ABA therapy is individualized and a clinical cannot

[5] Centers for Disease Control and Prevention (March 27, 2014); Autism Spectrum Disorder

uniformly apply the interventions to all persons with an ASD diagnosis, an assumption of 10 percent of the population was applied; however, the percentage of members with ASD that could benefit from ABA therapy is undeterminable. To review the report in its entirety, please visit 2016 - HB 2962 Legislative Report 2016 HB 2962 Legislative Report (located under Studies and Evaluations)

Medical Home Audits

The OHCA's Quality Assurance Compliance department conducts an on-location evaluation of medical home requirements for contracted providers. As of CY 2016, the OHCA review team conducted 258 reviews with "quality review "to determine success of "pass compliance" This means those who PASSED every component of the review would be 162 of the 397. Below are the findings of the review:

Total compliance reviews performed = 258

- Tier ONE: 115, of these 18 were FQHC facilities
- Tier TWO: 50, of these 6 were FQHC facilities
- Tier THREE: 60, of these 3 were FQHC facilities

Primary Audit- Non-Compliant = 225

- Tier ONE: 100, of these 17 were FQHC facilities (99 with a score + & 1 invalid = 100)
- Tier TWO: 44, of these 4 were FQHC facilities
- Tier THREE: 56, of these 3 were FQHC facilities with one being invalid and two failed.

Primary Audit-PASSED ALL = 19

- Tier ONE: 10
- Tier TWO: 6
- Tier THREE: 3

Corrective Action Plan Audit – Follow-ups = 14(these are medical record reviews only and validation for those who failed a primary audit and would like to have their PCMH contract reinstate and out of the corrective action plan status)

- Provider with Panel (PWP) status: (scored at Tier ONE requirements) = 5, this allows the provider to continue to provide care coordination for these members and offer referrals, but at this time cannot accept new membership. This happens after receiving a score on medical records audit below 75 percent. This status allows the provider to work at Tier ONE for the next 12 months and receive education from the OHCA provider services unit to help with reinstatement of a higher tier level.
- Tier ONE: 5, of which 1 was an FQHC facility
- Tier TWO: 2 both were FQHC/RHC facilities
- Tier THREE: 1

INVALID Audit: This means that the contact was active, but the records were not valid to determine compliance.

- Tier ONE: Invalid Record
- FQHC Tier THREE: Invalid records
- (41%) which is 107 of the 258 audits, had at least one previous compliance review
- (59%) which is 151 of the 258 audits was first time compliance reviews.

PCP Compliance with 24-Hour Access Requirements

The OHCA requires providers give member 24-hour access and ensure members receive

appropriate and timely services. The data below is from CY 2016.

- Average number of providers called each quarter: 892
- Average percentage of PCPs providing after-hours access each quarter: 93%
- Percent of Providers Educated for compliance: 7%

HEDIS ® Quality Measures

The OHCA's Quality Assurance department began compiling the data in 2010. The services were contracted out to Pacific Health Policy Group (PHPG) in 2013. PHPG recalculated the 2013 rates and changed the methodology, which meant that some of the rates may not be comparable to previous years' rates. The table below presents the HEDIS ® year measures using the new methodology.

HEDIS® Measures 2013-2016	HEDIS® 2013	HEDIS® 2014	HEDIS® 2015	HEDIS® 2016
Annual Dental Visit				
Aged 2-3 years	40..4%	39.5%	Not Available	Not Available
Aged 4-6 years	67.k7%	63.4%	Not Available	Not Available
Aged 7-10 years	70.9%	68.8%	Not Available	Not Available
Aged 11-14 years	68.7%	66.9%	Not Available	Not Available
Aged 15-18 years	62.0%	59.9%	Not Available	Not Available
Aged 19-21 years	40.6%	38.2%	Not Available	Not Available
Children and Adolescents' Access to PCP				
Aged 12-24 months	96.3%	96.2%	96.1%	96.1%
Aged 25 months – 6 years	90.2%	89.0%	87.6%	89.6%
Aged 7-11 years	92.2%	90.9%	91.8%	91.8%
Aged 12-19 years	92.8%	92.7%	92.9%	92.9%
Adults' Access to Preventive/Ambulatory Health				
Aged 20-44 years	83.4%	82.4%	81.0%	80.3%
Aged 45-64 years	89.8%	89.9%	90.1%	90.0%
Aged 65+ years	83.5%	78.2%	77.4%	77.4%
Well-Child Visits				
Aged <15 months 1+ visits	97.3%	96.3%	94.3%	96.4%

Aged <15 months 6+ visits	59.6%	55.8%	68.5%	68.1%
Aged 3-6 years 1+ visits	57.6%	58.5%	57.1%	56.7%

HEDIS® Measures 2013-2016	HEDIS®	HEDIS® 2014	HEDIS® 2015	HEDIS® 2016
Appropriate Medications for the Treatment of Asthma (Change in HEDIS® 2012)				
Aged 5-11 years	91.5%	89.7%	90.2%	90.3%
Aged 12-18 years	86.4%	82.6%	82.5%	82.3%
Aged 19-50 years	63.2%	61.7%	61.9%	62.0%
Aged 51-64 years	67.3%	62.5%	61.8%	62.0%
Comprehensive Diabetes Care (Aged 18-75 years)				
Hemoglobin A1C Testing	71.6%	71.9%	72.1%	72.2%
Eye Exam (Retinal)	32.0%	26.3%	27.3%	27.6%
LDL-C Screen	63.1%	63.4%	63.9%	64.2%
Medical Attention for Nephropathy	58.7%	53.4%	52.4%	52.5%
Screening Rates				
Lead Screening in Children (by 2 years of age)	48.2%	47.6%	Not Available	Not Available
Appropriate Treatment for Children with URI (aged 3 months to 18 years)	73.1%	72.5%	Not Available	Not Available
Appropriate Testing for Children with Pharyngitis (aged 2 to 18 years)	53.2%	51.6%	Not Available	Not Available
Breast Cancer Screening (aged 42-74 years)	36.5%	Not Available	Not Available	Not Available
Chlamydia Screening in Women (CHL) (aged 16-24 years)	49.3%	48.0%	56.8%	57.2%
Cervical Cancer Screening (aged 21-64 years)	46.0%	47.5%	37.7%	41.2%
Cholesterol Management for Patients with Cardiovascular Conditions (aged 18-75)	49.9%	45.2%	Not Available	Not Available

Program Integrity

In accordance with the Improper Payments Information Act of 2002, federal agencies review

Medicaid and CHIP programs for improper payments every three years, this is known as the Payment Error Rate Measurement (PERM) program. The consistent application of eligibility rules also has enabled Oklahoma to achieve one of the lowest processing error rates in the nation. Under the federal PERM initiative, states must audit the accuracy of their eligibility processes every three years. In 2015, the most recent audit, Oklahoma's error rate was 3.82% versus the national average of 5.70%. To continue ensuring proper payments, the OHCA annually conducts a payment accuracy review. This review is similar to the PERM initiative review.

V. BUDGET NEUTRALITY

Compliance with Budget Neutrality Cap

As of December 2016, the State has $5.6 billion savings over the life of the Demonstration. Actuarial analysis of the Demonstration projects indicates that the State will maintain compliance with the budget neutrality cap through 2018. It is projected that the state will have 3.75 billion in savings by the end of 2018. To review the Budget Neutrality in its entirety, refer to Attachments one and two.

Standard CMS Financial Management Questions

1. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved State Plan.
    a. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local government entity or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e. general fund, medical services account, etc.)

    Answer: Yes, SoonerCare providers retain 100 percent of the payments.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services available under the plan.
    a. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded.

    Answer: The non-federal (NFS) of the medical home care coordination payments and HAN payments are funded by appropriations from the legislature to the Medicaid Agency. The NFS for Insure Oklahoma is funded by tobacco tax. The NFS payments to academic medical centers are funded through Intergovernmental Transfers (IGTs) from appropriations from the legislature.

    b. Please describe whether the state share is from appropriations from the legislature

to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs) provider taxes or any other mechanism used by the State to provide state share.

Answer: The state share is from appropriations from the legislature to the Medicaid agency and through IGTs.

c. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Answer: funds are appropriated to OU and OSU medical Schools, manpower Training Commission for the Graduate Education (GME) payments and the Tobacco Settlement Endowment Trust

d. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment.

Type	Total	NFS
Care Coordination fees and SoonerExcel	$29,227,899	$11,632,704
HAN Payments[6]	$3,000,000	$1,194,000
GME Payments	$106,969,897	$42,574,019
Insure Oklahoma	$85,617,321	$34,075,694

e. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds.

Answer: The State receives the transferred amounts prior to making the payments.

f. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b).

Answer: Not applicable.

g. For any payment funded by CPEs or IGTs, please provide the following:

i. A complete list of the names of entities transferring or certifying funds:

Answer: OU and OSU medical schools and Physician Manpower Training Commission

ii. The operational nature of the entity (state, county, city, other):

Answer: State medical schools and State Commission

[6] Numbers are estimates based on the SFY 2017 budget and SFY Blended 2017 FMAP (60.20%).

iii. The total amounts transferred or certified by each entity:
Answer: $42,574,019

iv. Clarify whether the certifying or transferring entity has general taxing authority:
Answer: No general taxing authority

v. Whether the certifying or transferring entity receives appropriations (identify level of appropriations):
Answer: Yes, they receive appropriations.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.
Answer: Supplemental payments include SoonerExcel bonus payments to medical homes. Total amount budgeted annually $3,000,000 with annual average payment for last two years of $2.84 million.

4. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.
Answer: The upper payment limit demonstration is not applicable.

Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the federal share of the excess to CMS on the quarterly expenditures report?
Answer: No

VI. DEMONSTRATION EVALUATION

Demonstration Evaluation Introduction

This portion of the application has three sections. The Program Evaluation portion provides current reports related to SoonerCare Choice, the Health Management Program, and statewide insurance and access. A summary of the 2015-2016 evaluation findings is also included, followed by the details of the report. Finally, the Hypotheses proposed for 2018 are requested to remain the same as those for the 2016-2017 requested demonstration term year.

Program Evaluation

The OHCA uses multiple contractors to evaluate the SoonerCare program. The OHCA uses an independent outside contractor Pacific Health Policy Group (PHPG) to evaluate the SoonerCare Choice program and the Health Management Program. PHPG uses paid claims data, member and provider survey results and OHCA's enrollment and expenditure data to evaluate the

programs' effectiveness in access, quality of care and cost savings.

Access Monitoring Review Plan 2016

On November 2, 2015, CMS issued the final rule with comment period: Methods for Assuring Access to Covered Medical Services (CMS-2328-FC). The final rule requires states to develop an Access Monitoring Review Plan (AMRP) which includes an analysis of access to covered services under their Fee-For-Service (FFS) programs, consistent with section 1902(a)(30)(A) of the Social Security Act. Certain categories of services will be reviewed every three years and additional services will be reviewed and monitored as states reduce (or restructure) provider payment rates. Through this report, the State addresses access to care by measuring the following enrollee needs, the ability of care and providers; and the utilization of services.

Access:

- The OHCA continues to have a service capacity for the 1 million Oklahomans that it serves. This is about 26 percent of the state's population.
- Provider contracts, provider networks and beneficiary access to primary care services remain stable in spite of the significant rate decreases of July 2014 and January 2016.

Quality:

- The outcomes of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey indicate satisfaction with services from children and adults of SoonerCare.
- Services under state plan are available to beneficiaries to the extent that those are available to the general population.
- In accordance with 42 CFR 447.203, the Oklahoma Health Care Authority developed an access review monitoring plan for the defined service categories provided under a Fee-for-Service arrangement.

Cost Effectiveness:

- Per the OHCA Annual Report, total expenditures for the SoonerCare program in State Fiscal Year 2015 were approximately $5.1 billion.

To review the Access Monitoring Review Plan 2016 report in its entirety, refer to the OHCA public website at 2016 Access Monitoring Review Plan and view *Access Monitoring Review Plan 2016* under Studies and Evaluations.

Health Management Program Evaluation

The OHCA's evaluator for the HMP program, the Pacific Health Policy Group (PHPG), collaborated with Telligen to conduct the SoonerCare HMP's annual evaluation for SFY 2015. During SFY 2014, the OHCA and Telligen executed a contract amendment to modify and expand operations starting in SFY 2015. The amendment included three components: intervention quality enhancement; chronic pain and opioid drug utilization initiative and staff increase. The OHCA received the final SFY 2015 report in July 2016.

PHPG collected data for the evaluation through a variety of methods. These included an

audit of Telligen, analysis of paid claims data and surveys/in-depth interviews of nurse care management and practice facilitation participants.

Nearly all of the initial survey respondents (99 percent) indicated that their health coach asked questions about health problems or concerns, and the great majority stated their coach also provided answers and instructions for taking care of their health problems or concerns (91 percent); answered questions about their health (88 percent); and helped with management of medications (77 percent). Over 30 percent stated that their nurse helped to identify changes in health that might be an early sign of a problem and helped them to talk to and work with their regular doctor and his/her staff.

Respondents were asked to rate their satisfaction with each "yes" activity. Except for one activity, the overwhelming majority reported being very satisfied with the help they received, with the portion ranging from 91 to 94 percent, depending on the item. This attitude carried over to the members' overall satisfaction with their health coaches; 87 percent reported being very satisfied. Results for the follow-up survey were closely aligned to the initial survey.

Health coaching employs motivational interviewing to identify lifestyle changes that members would like to make. Once identified, it is the health coach's responsibility to collaborate with the member in developing an action plan with goals to be pursued by the member with his/her coach's assistance. Seventy-six percent of initial survey respondents confirmed that their health coach asked them what change in their life would make the biggest difference in their health. Eighty-four percent of this subset (or 63 percent of total) stated that they actually selected an area to make a change.

PHPG examined the program's return on investment (ROI) through SFY 2015, by comparing health coaching and practice facilitation administrative expenditures to medical savings. Both program components have achieved a positive ROI, with the program as a whole generating net savings of $41.2 million and a return on investment of 249 percent. Put another way, the second generation SoonerCare HMP generated nearly $2.50 in net medical savings for every dollar in administrative expenditures.

To review the HMP Evaluation report in its entirety, go to the OHCA public website at 2016 SoonerCare Health Management Program Evaluation SFY 2015 and view *SoonerCare Health Management State Fiscal Year 2015 Evaluation* under Studies and Evaluations.

Evaluation Findings from the 2016 - 2017 Hypotheses

Hypotheses	**Do the outcomes of the 2016 Demonstration confirm the hypotheses?**
1A. Child Health checkup rates for children age Zero to 15 months old will be maintained at or above 95 percent over the life of the extension period.	Yes
1B. Child Health checkup rates for children Three through Six years old will increase by one percentage point over the life of the extension period.	No. The OHCA will continue to track this data associated with this hypothesis over the extension period.
1C. Adolescent child health checkup rates will maintain over the life of the extension period.	Yes
2. The rate of adult members who have one or more preventative health visits with a primary care provider in a year will improve by one percentage point as a measure of access to primary care in accordance with HEDIS guidelines between 2015-2016.	No. The OHCA will continue to track this data associated with this hypothesis over the extension period.
3. The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data between 2015-2016.	Yes
3b. The number of Insure Oklahoma practitioners enrolled as PCPs will maintain at or above the baseline data between 2015 - 2016.	Yes
4. There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period.	Yes

Hypotheses	Do the outcomes of the 2016 Demonstration confirm the hypotheses?
5. There will be adequate PCP capacity to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. As perceived by the member, the time it takes for the member to schedule an appointment should	Yes
6. The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal, or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will improve during the 2015 - 2016 waiver period.	No – The OHCA has not yet met this measure. The OHCA will continue to track this data associated with this hypothesis over the extension period.
7A. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015-2016. Decrease asthma related ER visits for HAN members with an Asthma diagnosis identified in the medical record.	Yes
7B. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015-2016. Decrease 90-day readmissions for related asthma conditions for HAN members with an Asthma diagnosis identified in their medical record.	Yes
7C. Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015-2016. Decrease overall ER use for HAN members.	Yes

8. Average per member per month expenditures for members belonging to a HAN affiliated PCP will continue to be less than those members enrolled with non-Han affiliated PCPs during the period of 2015-2016.	Yes
9a. The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will maintain enrollment and active participation in the program.	Yes
9b. The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members for preventive/ambulatory care.	Yes
9c. The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase in average complexity of need within the nurse care managed population.	Yes
9d. Health Coaches will improve quality measures for members who are engaged.	Yes
9e. Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention.	Yes
9f. Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention.	Yes
9g. Nurse care managed members will report high levels of satisfaction with their care.	Yes
9h. Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.	Yes

The OHCA reports the most current data and analysis for the SoonerCare Choice program's hypotheses. The data for hypotheses one and two, as well as 9b- 9h, are taken from the PHPG (2016) Reporting Year 2015 Measurement Year 2014 Quality of Care in the SoonerCare Program Report**.** ** Some of the wording in this section may have been modified from the original state public comment posting due to receipt of information during the comment period. Changes were made to hypotheses 9a, 9b, 9c, 9d, 9e, and 9f which are on pages 48 - 58.

Hypothesis 1- Child Health Checkup Rates: This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #2 of CMS's Three Part Aim.
The rate age-appropriate well-child and adolescent visits will improve between 2015-2016.

A. Child health check-up rates for children 0 to 15 months old will be maintained at or above 95 percent over the life of the extension period.
B. Child health checkup rates for children 3 through 6 years old will increase by one percentage points over the life of the extension period.
C. Adolescent child health checkup rates will maintain over the life of the extension period.

Well-Child Adolescent Visits	**Baseline HEDIS® 2014 CY2013**	**Baseline HEDIS® 2015 CY2014**	**Baseline HEDIS® 2016 CY2015**
0 - 15 months	96.3%	94.3%	96.4%
3-6 years	58.5%	57.1%	56.7%
12-21 years	21.8%	22.1%	22.4%

Hypothesis 1A Results:

This hypothesis specifies that checkup rates for children 0 to 15 months will be maintained at or above 95 percent over the course of the extension period.

Children 0 to 15 months old saw an increase in child checkup rates for HEDIS® year 2016. In HEDIS® year 2015 the child checkup rate fell slightly below 95 percent to 94.3 percent. The data shows that the child health checkup rates fluctuate throughout the years, but has maintained above 90 percent consistently. In HEDIS® year 2016 OHCA met the measure when the percentage of child visits increased to 96.4 percent. The OHCA will continue to monitor this group during the 2017 extension period.

Hypothesis 1B Results:

In accordance with the hypothesis, the checkup rates for children ages 3 to 6 years will increase by one percentage point over the extension period 2015-2016.

Children 3 to 6 years old saw a 1.8 percent decrease in child health checkup rates from HEDIS® year 2014 to HEDIS® year 2016. For HEDIS® year 2015 to HEDIS® year 2016 there was a .4 percent decrease in health checkups for this population. The OHCA has not yet met the measure; the OHCA will continue to track the measure over the extension period to monitor for significant changes in rates for this age group during the 2017 extension period.

Hypothesis 1C Results:

The evaluation measure hypothesizes that the checkup rate for adolescent's ages 12 to 21 years will maintain over the life of the extension period.

Adolescent's ages 12 to 21 years of age saw a slight increase in health checkup rates for HEDIS® year 2016. There was a .3 percent increase in health checkup rates from HEDIS® year 2014 to HEDIS® year 2015. For HEDIS® year 2015 to HEDIS® 2016 there was an increase of .3 percent in health checkups for this population. The adolescents ages 12 to 21 have maintained their percentage for health checkup rates. The OHCA will continue to monitor this group during the 2017 extension period.

PCP Visits: This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #2 of CMS's Three Part Aim:

The rate of adult members who have one or more preventive health visits with a primary care provider in a year will improve by one percentage point as a measure of access to primary care in accordance with HEDIS® guidelines between 2015-2016.

Access to PCP/Ambulatory HealthCare: HEDIS® Measures	Baseline HEDIS® 2014 CY2013	HEDIS® 2015 CY2014	HEDIS® 2016 CY2015
20-44 years	82.4%	81.0%	80.3%
45-64 years	89.9%	90.1%	90.0%

Hypothesis 2 Results:

This hypothesis suggests that adults' rate of access to primary care providers will improve by one percentage point as a measure of access to primary care in accordance with HEDIS® guidelines between 2015-2016.

SoonerCare adults ages 20 to 44 saw a 2.1 percent decrease with access to PCP or ambulatory health care in HEDIS® year 2016 compared to HEDIS® year 2014. SoonerCare adults ages 45 to 64 saw a .1 percent increase with access to PCP or ambulatory health care in HEDIS® year 2016 compared to HEDIS® year 2014. The OHCA has not yet met the measure; the OHCA will continue to track the adult access rates over the extension period to monitor for significant changes in rates for these age groups.

Hypothesis 3 - PCP Enrollments: This hypothesis directly relates to SoonerCare Choice waiver objective #2 and #1 of CMS's Three Part Aim:

The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data (2,067 providers) between 2015-2016.

	Base line Dec 2013	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16
Number of SoonerCare Choice PCPs	2,067	2,663	2,588	2,613	2,637	2,659	2,661	2,701	2,738	2,759	2,655	2,681	2,689

Hypothesis 3 Results:

This hypothesis measures the State's access to care by tracking the number of SoonerCare primary care providers (PCP) enrolled as medical home PCPs. The OHCA exceeded the baseline data during the first month of 2016 and has continued to exceed baseline. The OHCA exceeded the baseline data by 30 percent at the end of 2016. The OHCA believes that the number of Choice PCPs will continue to be maintained throughout the 2017extension period.

Hypothesis 3b - PCP Enrollments Insure Oklahoma: This hypothesis directly relates to SoonerCare Choice waiver objective #2 and #1 of CMS's Three Part Aim:

The number of Insure Oklahoma practitioners enrolled as PCPs will maintain at or above the baseline data between 2015-2016.

2016 PCP Enrollments	Baseline Jan-Mar 2013	Jan-Mar 2016	Apr-Jun 2016	Jul-Sep 2016	Oct-Dec 2016
Number of SoonerCare Choice PCPs	1,514	2,149	2,127	2,216	2,196

Hypothesis 3b Results:

This hypothesis tracks the number of Insure Oklahoma primary care providers (PCP) enrolled as PCPs. The OHCA exceeded the baseline data during the first month of 2016 and has continued to exceed baseline. The OHCA exceeded the baseline data by 45 percent at the beginning of 2016. The OHCA believes that the number of Insure Oklahoma PCPs will continue to be maintained throughout the 2017 extension period

Hypothesis 4 - PCP Capacity Available: This hypothesis directly relates to SoonerCare Choice waiver objectives #1, #2 and #1 of CMS's Three Part Aim:

There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2015-2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015-2016. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period.

SoonerCare Choice PCP Capacity	PCP Capacity December 2013	PCP Capacity December 2014	PCP Capacity December 2015	PCP Capacity December 2016
SoonerCare Choice Enrollment	555,436	539,647	528,202	549,184
Number of SoonerCare Choice PCPs	2,067	2,454	2,642	2,689
SoonerCare Choice PCP Capacity	1,149,541	1,155,455	1,146,767	1,176,817
Average Members per PCP	268.72	219.91	199.93	204.23

Hypothesis 4 Results:
This hypothesis suggests that OHCA will equal or exceed the baseline capacity data (1,149,541; average of 269 members per PCP) over the duration of the extension period. The OHCA exceeded the baseline capacity in the beginning of 2016.

Additionally, the number of SoonerCare Choice PCP providers has increased over the course of the year. There are 2,689 contracted SoonerCare Choice providers who serve SoonerCare members as of December 2016. This is a 30 percent increase from the number of providers in December 2013 the baseline year. In 2016, SoonerCare Choice providers served an average of 204 members per provider. As the number of SoonerCare Choice PCPs increases, the average members per PCP fluctuate. The OHCA believes that the available capacity will equal or exceed the baseline capacity over the duration of the 2017 extension period.

Hypothesis 5 - PCP Availability: This hypothesis directly relates to SoonerCare Choice waiver objectives #1, #2 and #1 of CMS's Three Part Aim.

There will be adequate PCP capacity to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016.

CAHPS® Adult Survey Results	Baseline Data: 2013 CAHPS® Survey Response	2014 CAHPS® Survey Response	2015 CAHPS® Survey Response	2016 CAHPS® Survey Response
Positive Responses from the Survey Question: *"In the last 6*	80% Responded "Usually" or	82% Responded "Usually" or	87% Responded "Usually" or	82% Responded "Usually" or

CAHPS® Adult Survey Results	Baseline Data: 2013 CAHPS® Survey Response	2014 CAHPS® Survey Response	2015 CAHPS® Survey Response	2016 CAHPS® Survey Response
months, how often did you get an appointment for a check- up or routine care at a doctor's office or clinic as soon as you needed?"	"Always"	"Always"	"Always	"Always

CAHPS® Child Survey Results	Baseline Data: 2013 CAHPS® Survey Response	2014 CAHPS® Survey Response	2015 CAHPS® Survey Response	2016 CAHPS® Survey Response
Positive Responses from the Survey Question: *"In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?"*	90% Responded "Usually" or "Always"	91% Responded "Usually" or "Always"	93% Responded "Usually" or "Always"	92% Responded "Usually" or "Always"

Hypothesis 5 Results:

This hypothesis theorizes that the member's response to the time it takes to schedule an appointment should exceed the baseline data. The OHCA's contracted External Quality Review Organization (EQRO) Morpace, conducted the Consumer Assessment of Healthcare Providers & Systems (CAHPS®) survey for the period 2016. Results from the CAHPS® survey indicate that the majority of survey respondents for both the Adult and Child surveys had satisfactory responses for scheduling an appointment as soon as needed. In review of the adult respondents, 82 percent felt satisfied in the time it took to schedule an appointment with their PCP, while 92 percent of child survey respondents indicated they were "Usually" or "Always" satisfied. More than 800 combined adult and child survey respondents that had a positive response about the time it takes to get an appointment with their PCP; the OHCA saw an increase in the number of positive responses in SFY16 for both the adult and children composite responses compared to the baseline data. The OHCA believes that the survey responses will continue to improve throughout the 2017 extension period.

Hypothesis 6 - Integration of Indian Health Services, Tribal Clinics, and Urban Indian Clinic Providers: This hypothesis directly relates to SoonerCare Choice waiver objective #4 and #1 of CMS's Three Part Aim:

The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal, or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will improve during the 2015 - 2016 waiver period.

	Base line Dec 2013	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016
Total AI/AN Members with SC Choice and I/T/U PCP	94,142	81,240	82,544	82,935	82,273	82,721	84,465	87,237	87,512	88,750	88,737	90,001	90,232
AI/AN Members with I/T/U PCP	21,165	12,702	13,016	12,767	12,501	12,464	12,725	14,406	12,969	13,293	13,590	13,856	13,885
Percent of AI/AN Members with I/T/U PCP	22.48%	15.64%	15.77%	15.39%	15.19%	15.07%	15.07%	16.51%	14.82%	14.98%	15.31%	15.40%	15.39%
Percent of American Indian members in SC Choice	77.52%	84.36%	84.23%	84.61%	84.81%	84.93%	84.93%	83.49%	85.18%	85.02%	84.69%	84.60%	84.61%
I/T/U Capacity	99,400	96,999	96,999	96,466	99,499	99,499	99,499	99,499	99,499	99,499	99,499	99,499	99,499

Hypothesis 6 Results:

This hypothesis postulates that the percentage of American Indian members who are enrolled with an I/T/U with a SoonerCare American Indian primary care case management contract will improve during the extension period. The proportion of American Indian members with an I/T/U PCP has decreased 7.09 percentage points when comparing December 2013 to December 2016. At this time, the OHCA expects the percentage of IHS members who are enrolled with an I/T/U PCP will continue to be maintained throughout the extension period. The OHCA has not yet met the measure; the OHCA will continue to track the data associated with this hypothesis over the extension period to monitor for significant changes in rates for these eligibility groups.

Hypothesis 7 – Impact of Health Access Networks on Quality of Care: This hypothesis directly relates to the SoonerCare Choice waiver objective #3 and #2 of CMS' Three Part Aim:

Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2015–2016.

A. Decrease asthma-related ER visits for HAN members with an asthma diagnosis identified in their medical record.
B. Decrease 90-day readmissions for related asthma conditions for HAN members with an asthma diagnosis identified in their medical record.
C. Decrease overall ER use for HAN members.

Hypothesis 7 Results:

This hypothesis posits that the percentage of HAN members with asthma who visit the ER will decrease, 90-day readmission for asthma conditions will decrease and percent of ER use for HAN members will decrease.

Hypothesis 7A Results: The health access networks continue to move forward with reporting. The HANs are on track in decreasing percent asthma related ER visits. In comparing 2015 to 2016 each network had a decrease. The OU Sooner HAN had a 1 percent decrease, the PHCC HAN had a 3 percent decrease and the OSU Network HAN had a 2 percent decrease.

A. **2015** Asthma Related ER Visits	HAN members with an Asthma diagnosis in their medical record	All HAN members with ER visit in a calendar year	Percent of HAN members with an Asthma diagnosis who visited the ER
OU Sooner HAN	5,888	64,958	9%
PHCC HAN	41	858	5%
OSU Network HAN	560	7,390	8%
A. **2016** Asthma Related ER Visits	HAN members with an Asthma diagnosis in their medical record	All HAN members with ER visit in a calendar year	Percent of HAN members with an Asthma diagnosis who visited the ER
OU Sooner HAN	4,987	59,643	8%
PHCC HAN	42	2,679	2%
OSU Network HAN	412	6,767	6%

Hypothesis 7B Results: The HANs are on track in decreasing 90-day re-admissions for HAN members with asthma. In comparing 2015 to 2016 each network had a decrease. The OU Sooner HAN had a 3 percent decrease and the PHCC HAN had a 22 percent. Although the OSU HAN Network had an increase in enrollment; therefore a three percent increase in re-admissions resulted in comparison to the previous year 2015.

B. **2015** 90-Day Re-admissions for HAN members with Asthma	HAN members with Asthma who were Re- admitted to the Hospital 90-days after previous asthma-related hospitalization	HAN members with Asthma identified in their medical record and having at least one inpatient stay related to Asthma	Percent of HAN members with Asthma who had a 90-Day re-admission for Asthma related Condition(s)
OU Sooner HAN	44	469	9%
PHCC HAN	2	9	22%
OSU Network HAN	2	71	3%

B. **2016** 90-Day Re-admissions for HAN members with Asthma	HAN members with Asthma who were Re- admitted to the Hospital 90-days after previous asthma-related hospitalization	HAN members with Asthma identified in their medical record and having at least one inpatient stay related to Asthma	Percent of HAN members with Asthma who had a 90-Day re-admission for Asthma related Condition(s)
OU Sooner HAN	17	268	6%
PHCC HAN	0	2	0%
OSU Network HAN	5	80	6%

Hypothesis 7C Results: The HANs are on track in decreasing ER use for HAN members. In comparing 2015 to 2016 each network had a decrease. The OU Sooner HAN had a 6 percent decrease, the PHCC HAN had a 36 percent decrease and the OSU Network HAN had a 9 percent decrease.

C. **2015** ER Use for HAN Members	Total number of ER visits for HAN members	Total number of HAN members	Percent of ER Use for HAN Members
OU Sooner HAN	64,958	136,679	48%
PHCC HAN	2,256	5,137	44%
OSU Network HAN	9,937	57,895	17%

C. **2016** ER Use for HAN Members	Total number of ER visits for HAN members	Total number of HAN members	Percent of ER Use for HAN Members
OU Sooner HAN	59,643	143,032	42%
PHCC HAN	1,397	16,441	8%
OSU Network HAN	5,339	68,385	8%

The health access networks continue to move forward with reporting. The HANs are on track in decreasing percent of ER utilization, 90-day re-admission for asthma conditions and HAN members with asthma who visit the ER.

Hypothesis 8 - Impact of Health Access Networks on Effectiveness of Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #3 of CMS's Three Part Aim. Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs.

Average per member per month expenditures for members belonging to a HAN affiliated PCP will continue to be less than those members enrolled with non-HAN affiliated PCPs during the period of 2015-2016.

Hypothesis 8 Results:

This hypothesis indicates that the average per member per month (PMPM) expenditure for HAN members will be less than the PMPM expenditure for Non-HAN members. In SFY 2016, the PMPM average for HAN members was $285.30 while the PMPM average for non-HAN members was $313.33. Per member per month expenditures, continue to be lower for SoonerCare Choice members enrolled with a HAN PCP, than for SoonerCare Choice members who are not enrolled with a HAN PCP.

The OHCA has met the measure and expects this trend to continue. The evaluation design gathers the data for this hypothesis on a state fiscal year basis. In order to allow for claims lag data to be reported, the analysis of the information is done in conjunction with the evaluation design reporting frequency within three to four month window following the state fiscal year. The information reported in the hypothesis is the most current available.

HAN PMP SFY 2016	**Jul 15**	**Aug 15**	**Sep 15**	**Oct 15**	**Nov 15**	**Dec 15**	**Jan 16**	**Feb 16**	**Mar 16**	**Apr 16**	**May 16**	**Jun 16**
HAN Members	$262.02	$272.14	$276.49	$295.14	$279.74	$273.40	$292.92	$307.84	$311.22	$286.52	$286.16	$282.66
Non-HAN Members	$300.11	$308.40	$308.49	$320.62	$302.99	$306.00	$325.82	$335.40	$342.86	$313.22	$306.21	$293.45

The OHCA has retained the Pacific Health Policy Group (PHPG) to conduct an independent evaluation of the SoonerCare HMP. PHPG is evaluating the program's impact on participants and the health care system as a whole. The information in hypotheses 9b – 9h are taken from the PHPG (2016) evaluation in totality. For additional information on the HMP program, please refer to attachment six HMP SoonerCare Health Management Program Evaluation SFY2015.

Hypothesis 9a - Health Management Program (HMP) Impact on Enrollment Figures: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3 and #1 of CMS's Three Part Aim.

The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse

care management and practice facilitation, has resulted in maintained enrollment and active participation in the program.

Hypothesis 9a Results: The results show the total number of HMP members actively engaged in nurse care management; and it shows the number of SoonerCare Choice members in an active HMP practice that have undergone practice facilitation.

SoonerCare HMP Members in Nurse Care Management	Engaged in Nurse Care Management
Jan-16	4,595
Feb-16	4,792
Mar-16	4,999
Apr-16	5,020
May-16	4,766
Jun-16	4,544
Jul-16	4,300
Aug-16	3,968
Sep-16	3,771
Oct-16	3,580
Nov-16	3,300
Dec-16	3,147

	SoonerCare Choice Members in an active HMP practice
Jan-16	75,258
Feb-16	70,689
Mar-16	70,228
Apr-16	75,066
May-16	74,168
Jun-16	75,816
Jul-16	72,417
Aug-16	71,757
Sep-16	71,058
Oct-16	79,129
Nov-16	81,923
Dec-16	80,985

The OHCA will continue to track and trend this hypothesis over the extension period to monitor for significant changes in results. The results show the total number of HMP members actively engaged in nurse care management and it shows the number of SoonerCare Choice members in an active HMP practice that have undergone practice facilitation.

Hypothesis 9b - Health Management Program (HMP); Impact on Access to Care: This

hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2 and #1 of CMS's Three Part Aim.

The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members for preventive/ambulatory care.

Hypothesis 9b Results:
The HMP measures access to care for health coaching participants and members aligned with a practice facilitation provider through the following three clinical measures:

- Adult Access to Preventive/Ambulatory Care: Percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year;
- Child Access to PCP: Percentage of children 12 months to 19 years old who visited a primary care practitioner (PCP) during the measurement year, or if seven years or older, in the measurement year or year prior; and
- Adult BMI: Percentage of adults 18 to 75 years old who had an outpatient visit where his/her BMI was documented, either during the measurement year or year prior to the measurement year. The compliance rate for the health coaching population exceeded the comparison group rate on the two measures having a comparison group percentage. The difference was statistically significant in both cases.

The compliance rate is the percentage of participants engaged in health coaching or members aligned with a practice facilitation provider that meet the measure criteria. The comparison group is the general SoonerCare population.

Measures for Members Engaged in Health Coaching	SFY2014		SFY2015	
	Percent Compliant	Comparison Group - Compliance Rate	Percent Compliant	Comparison Group – Compliance Rate
1. Adult Access to Preventive/Ambulatory Care	96.3%	84.7%	96.1%	84.1%
2. Child Access to PCP	98.4%	91.2%	98.7%	91.7%
3. Adult BMI	14.3%	N/A	14.2%	10.7%

In SFY 2014, the comparison group for the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year had an 84.7 percent compliance rate and the Health Coach Participants group had a 96.3 percent compliance rate. The compliance rate for the health coaching population exceeded the comparison group rate on the two measures having a comparison group percentage. The difference was statistically significant in both cases.

In SFY 15, the comparison group for the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year had an 84.1 percent compliance rate and the Health Coach Participants group had a 96.1 percent compliance rate. The compliance rate for the health coaching population exceeded the comparison group rate on all there measures. The difference was statistically significant for all three.

The same three measures are utilized to determine access to care for members aligned with a

practice facilitation provider.

Measures for Members Aligned with a Practice Facilitation Provider	SFY2014		SFY2015	
	Percent Compliant	Comparison Group - Compliance Rate	Percent Compliant	Comparison Group – Compliance Rate
3. Adult Access to Preventive/Ambulatory Care	96.5%	84.7%	96.6%	84.1%
4. Child Access to PCP	98.9%	91.2%	99.1%	91.7%
3. Adult BMI	9.2%	N/A	9.0%	10.7%

In SFY 2014, the comparison group for the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year had an 84.7 percent compliance rate and the Health Coach Participants group had a 96.5 percent compliance rate. The compliance rate for the members aligned with a practice facilitation provider exceeded the comparison group rate on the two measures having a comparison group percentage. The difference was statistically significant in both cases.

In SFY 15, the comparison group for the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year had an 84.1 percent compliance rate and the members aligned with a practice facilitation provider had a 96.6 percent compliance rate. The compliance rate for the members aligned with a practice facilitation provider exceeded the comparison group rate on two of the three measures and the difference was statistically significant in both cases.

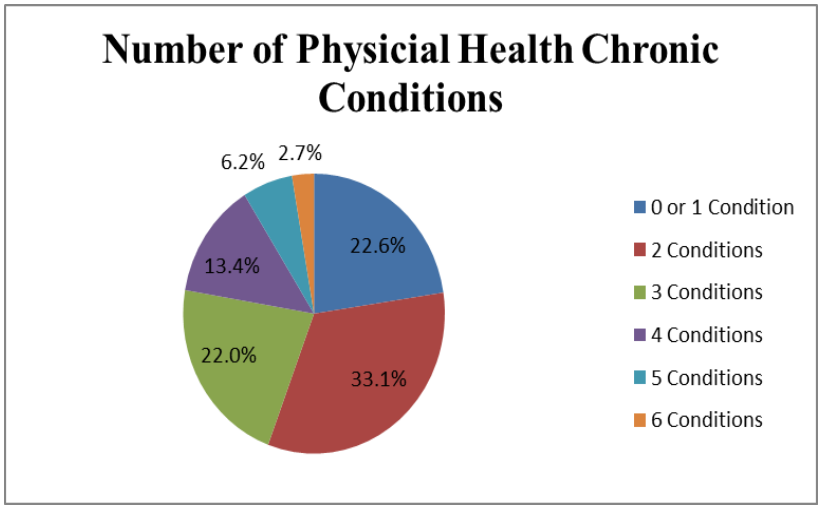
The above findings suggest that the health coaching and practice facilitation are both having a positive impact on access to care.

Hypothesis 9c - Health Management Program (HMP); Impact on Identifying Appropriate Target Population: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2, and #2 of CMS's Three Part Aim.

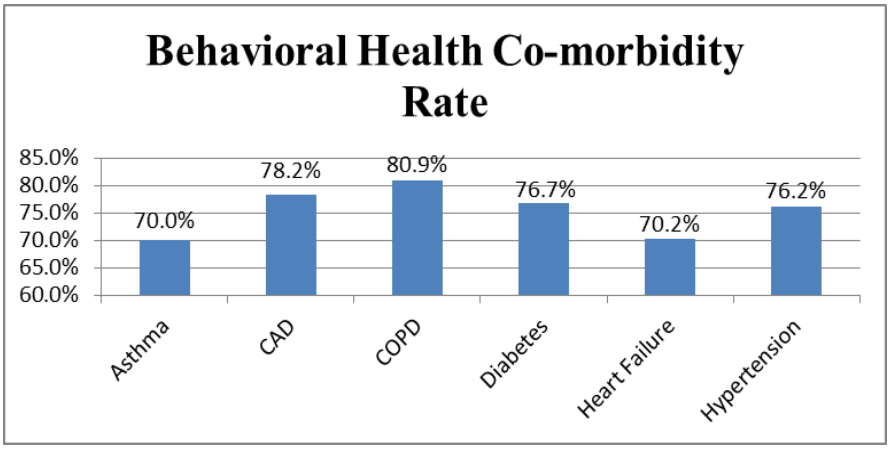
The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase in average complexity of need within the nurse care managed population.

Hypothesis 9c Results:

The SoonerCare HMPs' focus on holistic care rather than management of a single disease is appropriate given the prevalence of co-morbidities in the participating population. Independent research conducted by Pacific Health Policy Group (PHPG) examined the number of physical chronic conditions per participant and found that nearly 80 percent in SFY 2015 had at least two of six high priority chronic physical conditions (asthma, COPD, coronary artery disease, diabetes, heart failure and hypertension) as demonstrated in the chart below. The SFY 2015 distribution was very similar to the distribution in SFY 2014.



Nearly 75 percent of the participant population also has both a physical and behavioral health condition. Among the six priority physical health conditions, the co-morbidity prevalence in SFY 2015 ranged from approximately 81 percent in the case of persons with COPD to 70 percent among persons with asthma. The percentage distributions were almost unchanged from SFY 2014.



Overall, health coaching participants demonstrate the characteristics expected of a population that could benefit from care management. Most have two or more chronic physical health conditions, often coupled with serious acute conditions. The population also has significant behavioral health needs that can complicate adherence to guidelines for self-management of physical health conditions and maintaining a healthy lifestyle.

Hypothesis 9d - Health Management Program (HMP); Impact on Health Outcomes: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim. Health coaches will improve quality measures for members who

are engaged.

Hypothesis 9d Results:

In SFY 2015 the health coaching participant compliance rate exceeded the comparison group rate on 12 of 17 measures for which there was a comparison group percentage (70.6 percent). The difference was statistically significant for 10 of the 12 measures (83.3 percent). Conversely, the comparison group achieved a higher rate on five of the 17 measures (29.4 percent), including three for which the difference was statistically significant (60 percent). The health coaching participant compliance rate improved on 10 of 22 measures (45.5 percent) from SFY 2014 to SFY 2015, although typically by small amounts. Twelve of 22 measures (54.5 percent) experienced a slight decline from SFY 2014 to SFY 2015. The most impressive results, relative to the comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care.

While it is still early in the evaluation process, the above findings suggest that health coaching is having a positive impact on the quality of care for program participants. The long term benefit to participants will continue to be measured through the quality of care longitudinal analysis and through the utilization and expenditure analysis.

HMP Health Coaching Members' Compliance Rates	**SFY 2014**	**SFY 2015**
	Percent Compliant	**Percent Compliant**
Asthma	**SFY2014**	**SFY 2015**
Use of Appropriate Medications for People with Asthma	95.3%	93.5%
Medication Management for People with Asthma - 50 Percent	98.3%	68.2%
Medication Management for People with Asthma - 50 Percent	26.8%	27.3%
Cardiovascular Disease	**SFY2014**	**SFY 2015**
Persistence of Beta Blocker Treatment after Heart Attack	50.0%	46.2%
LDL-C Screening	76.0%	76.8%
COPD	**SFY2014**	**SFY 2015**
Use of Spirometry Testing in the Assessment/Diagnosis of COPD	31.5%	31.8%
Pharmacotherapy Management of COPD Exacerbation-14 days	49.5%	50.4%
Pharmacotherapy Management of COPD Exacerbation-14 days	73.9%	76.5%
Diabetes	**SFY2014**	**SFY 2015**
LDL-C Screening	77.0%	78.3%
Retinal Eye Exam	37.8%	38.1%
HbA1c Test	86.7%	87.2%
Medical Attention for Nephropathy	77.1%	77.0%
ACE/ARB Therapy	66.8%	66.5%
Hypertension	**SFY2014**	**SFY 2015**
LDL-C Screening	67.3%	67.8%
ACE/ARB Therapy	66.5%	65.8%
Diuretics	45.1%	44.9%

Annual Monitoring for Patients Prescribed ACE/ARB or Diuretics	84.2%	83.7%
Mental Health	**SFY2014**	**SFY 2015**
Follow-up after Hospitalization for Mental Illness – Seven Days	34.8%	34.3%
Follow-up after Hospitalization for Mental Illness – 30 Days	67.4%	67.2%
Prevention	**SFY2014**	**SFY 2015**
Adult Access to Preventive/Ambulatory Care	96.3%	96.1%
Child Access to PCP	98.4%	98.7%
Adult BMI	14.3%	14.2%

The practice facilitation participant compliance rate exceeded the comparison group rate on eight of 17 measures for which there was a comparison group percentage (47.1 percent). The difference was statistically significant for five of the eight measures (62.5 percent). Conversely, the comparison group achieved a higher rate on nine of the 17 measures (52.9 percent), including five for which the difference was statistically significant (55.6 percent). The practice facilitation participant compliance rate improved on 14 of 22 measures (63.6 percent) from SFY 2014 to SFY 2015, although typically by small amounts. Eight of 22 measures (36.4 percent) experienced a slight decline from SFY 2014 to SFY 2015. The most impressive results, relative to the comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care.

Similar to the health coaching quality outcomes, the above findings suggest that practice facilitation is having a positive impact on the quality of care for program participants. The long term benefit to participants will continue to be measured through the quality of care longitudinal analysis.

Hypothesis 9e – Health Management Program (HMP); Impact on Cost/Utilization of Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.

Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention.

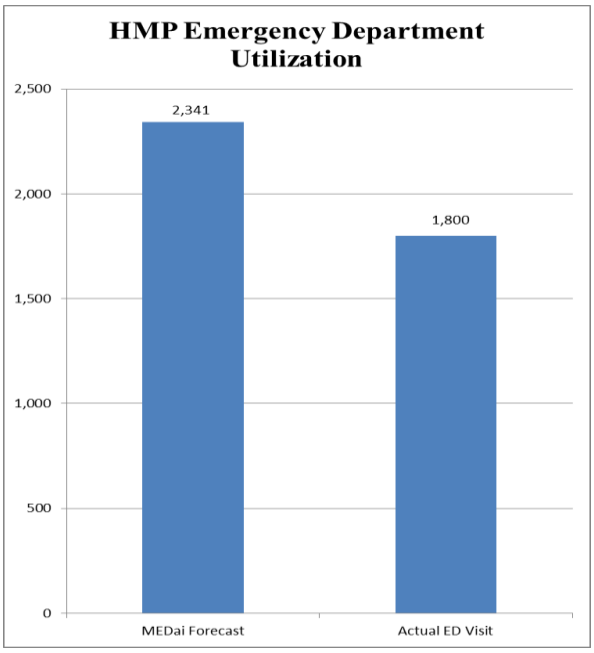
Hypothesis 9e Results:

Health coaching, if effective, should have an observable impact on participant service utilization and expenditures. Practice facilitation, like health coaching, should demonstrate its effectiveness through an observable impact on member service utilization and expenditures. Improvement in -quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care costs.

Most potential SoonerCare HMP participants are identified based on MEDai data, which includes a 12-month forecast of emergency department visits, hospitalizations and total expenditures. MEDai's advanced predictive modeling, as opposed to extrapolating historical trends, accounts for participants' risk factors and recent clinical experience. The resulting

forecasts serve as an accurate depiction of what participant utilization would have been like in the absence of health coaching. They serve as benchmarks against which each member's actual utilization and expenditures, post HMP enrollment, can be compared.

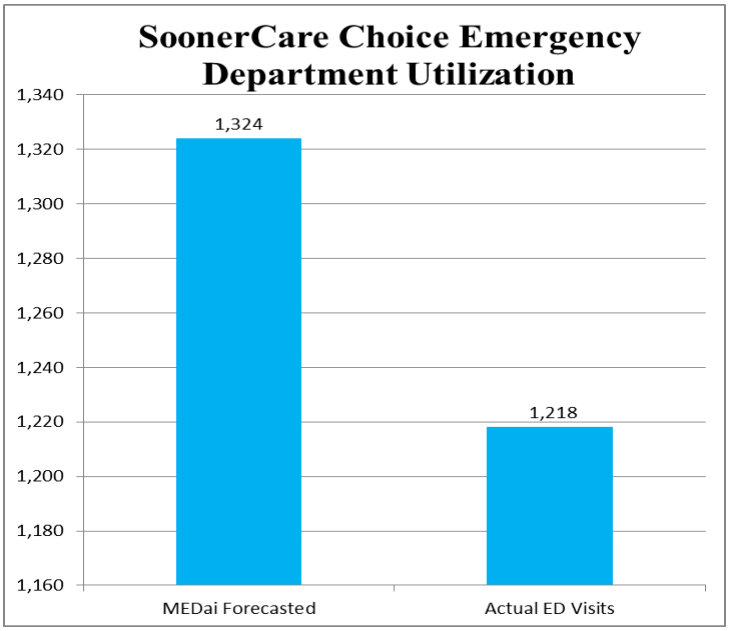
In SFY 2015 MEDai forecasted that HMP health coaching participants as a group would incur 2,341 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,800 or 77 percent of forecast.



Practice facilitation, like health coaching, should demonstrate its effectiveness through and observable impact on member service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care cost.

PHPG conducted the practice facilitation utilization and expenditure evaluation by comparing the actual claims experience of members aligned with Patient Centered Medical Home (PCMH) practice facilitation providers to MEDai forecasts. To be included in the analysis, members had to have been aligned with a PCMH provider who underwent practice facilitation. They also had to have been seen by a PCMH provider at least once following their own PCMH provider's initiation into practice facilitation. Members participating in the health coaching portion of the SoonerCare HMP were excluded from the analysis. This was done to avoid double counting the impact of the program.

In SFY 2015, MEDai projected members aligned with a practice facilitation provider in total would incur 1,324 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 1,218, or 92 percent of forecast.



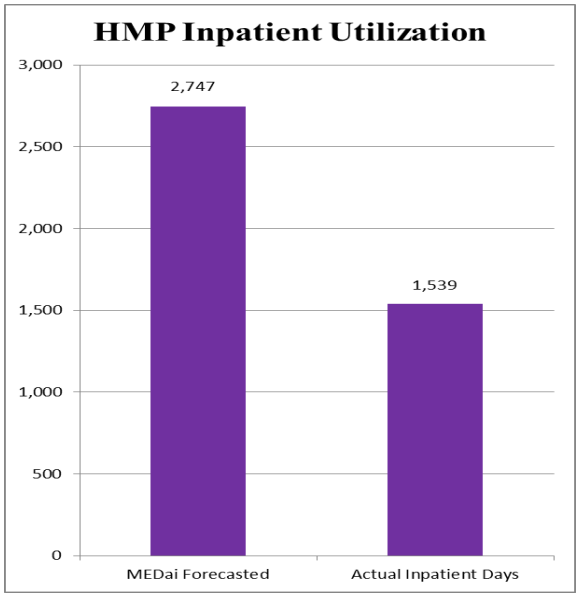
Hypothesis 9f – Health Management Program (HMP); Impact on Cost/Utilization of Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1 and #2 of CMS's Three Part Aim.

Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention.

Hypothesis 9f Results:

Health coaching, if effective, should have an observable impact on participant service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care costs. Most potential SoonerCare HMP participants are identified based on MEDai data, which includes a 12-month forecast of emergency department visits, hospitalizations and total expenditures. MEDai's advanced predictive modeling, as opposed to extrapolating historical trends, account for participants' risk factors and recent clinical experience. The resulting forecasts serve as an accurate depiction of what participant utilization would have been like in the absence of health coaching. They serve as benchmarks against which each member's actual utilization and expenditures, post HMP enrollment, can be compared.

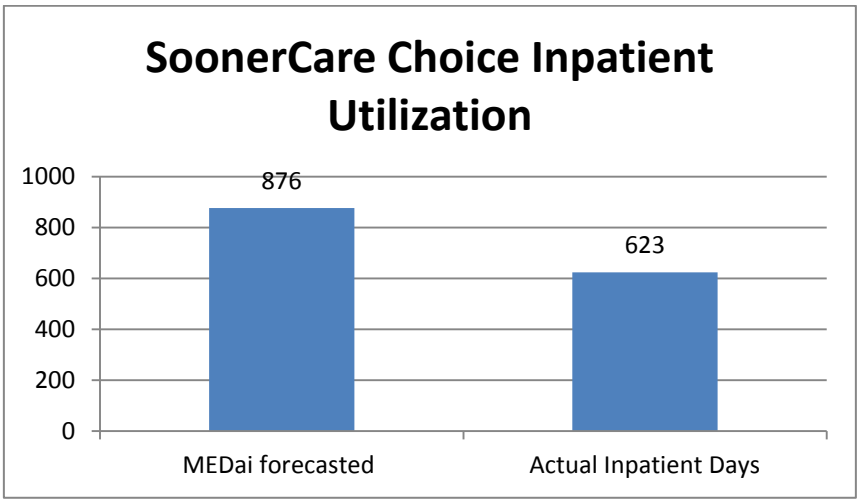
In SFY 2015, MEDai forecasted that SoonerCare HMP participants as a group would incur 2,747 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 1,539, or 56 percent of forecast.



Practice facilitation, like health coaching, should demonstrate its effectiveness through and observable impact on member service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care cost.

PHPG conducted the practice facilitation utilization and expenditure evaluation by comparing the actual claims experience of members aligned with Patient Centered Medical Home (PCMH) practice facilitation providers to MEDai forecasts. To be included in the analysis, members had have to have been aligned with a PCMH provider who underwent practice facilitation. They also had to have been seen by a PCMH provider at least once following their own PCMH provider's initiation into practice facilitation. Members participating in the health coaching portion of the

SoonerCare HMP were excluded from the analysis. This was done to avoid double counting the impact of the program.
In SFY 2015, MEDai projected members aligned with a practice facilitation provider in total would incur 876 inpatient days per 1,000 over the 12-month forecast period. The actual rate was 623, or 71 percent of forecast.



The OHCA will continue to monitor the program for he impact of reducing medical cost of the population served.

Hypothesis 9g - Health Management Program (HMP); Impact on Satisfaction /Experience with Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3, and #2 of CMS's Three Part Aim.

Nurse care managed members will report higher levels of satisfaction with their care.

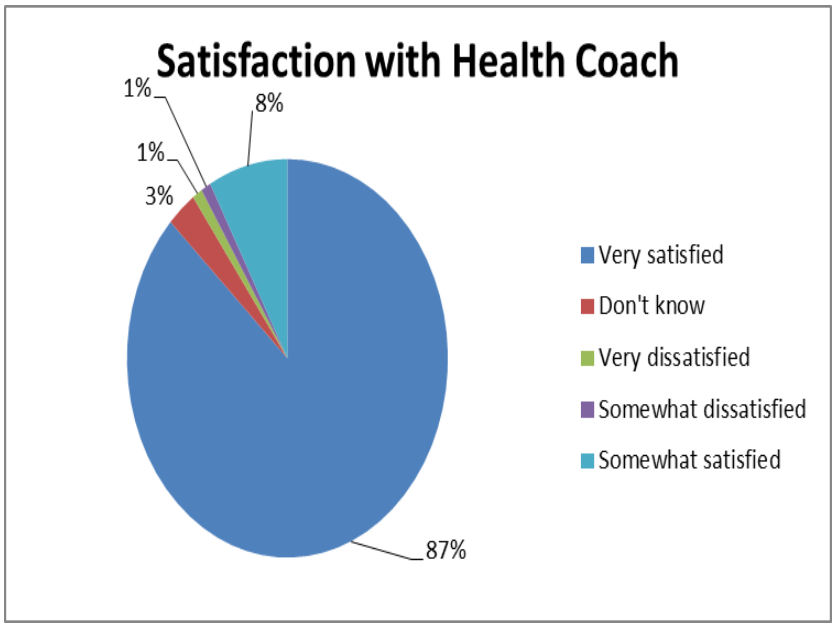
Hypothesis 9g Results:
Member satisfaction is a key component of SoonerCare HMP performance. If members are satisfied with their experience and value its worth, they are likely to remain engaged and focused on improving their self-management skills and adopting a healthier lifestyle. Conversely, if members do not see a lasting value to the experience, they are likely to lose interest and lack the necessary motivation to follow coaching recommendations.

PHPG completed 758 initial surveys with SoonerCare HMP participants, as well as 133 six-month follow-up surveys with participants who previously completed an initial survey. The purpose of the follow-up survey was to identify changes in attitudes and health status over time.

Health coaches are expected to help participants build their self-management skills and improve their health through a variety of activities. Respondents were read a list of activities

and asked, for each, whether it had occurred and, if so, how satisfied they were with the interaction or help they received.

Respondents were asked to rate their satisfaction with each "yes" activity. The overwhelming majority reported being very satisfied with the help they received, with the portion ranging from 91 to 94 percent, depending on the item. This attitude carried over to the members' overall satisfaction with their health coaches; 87 percent reported being very satisfied. Results for the follow-up survey were closely aligned to the initial survey.
Survey respondents reported very high levels of satisfaction with the SoonerCare HMP overall, consistent with their opinion of the health coach, who serves as their point of contact with the program. Eighty-seven percent of initial survey respondents and 90 percent of follow-up survey respondents stated they were very satisfied. Nearly all respondents (93 percent of initial survey and 97 percent of follow-up survey) said they would recommend the program to a friend with health care needs like theirs.



The OHCA will continue to track and trend this hypothesis over the extension period to monitor for significant changes in results.

Hypothesis 9h - Health Management Program (HMP); Impact of HMP on Effectiveness of Care: This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #3 of CMS's Three Part Aim.

Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.

Hypothesis 9h Results:

The value of the SoonerCare HMP is measurable on multiple axes, including participant

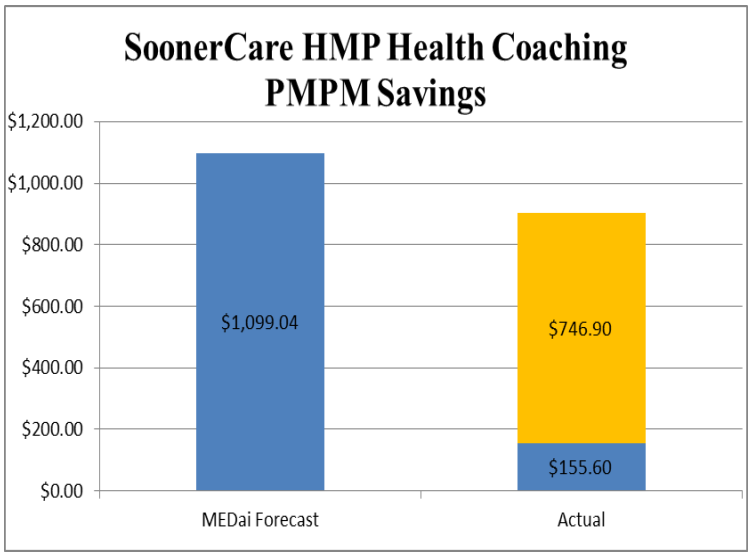
satisfaction and change in behavior, quality of care, improvement in service utilization and overall impact on medical expenditures. The last criterion is arguably the most important, as progress in other areas ultimately result in medical expenditures remaining below the level that would have occurred absent the program.

PHPG examined the program's return on investment (ROI) through SFY 2015, by comparing health coaching and practice facilitation administrative expenditures to medical savings.

Both program components have achieved a positive ROI, with the program as a whole generating net savings of $41.2 million and a return on investment of 249 percent. Put another way, the second generation SoonerCare HMP generated nearly $2.50 in net medical savings for every dollar in administrative expenditures.

PHPG performed a cost effectiveness test by comparing forecasted costs to actual costs during SFY 2014 and SFY 2015, inclusive of SoonerCare HMP health coaching administrative expenses.

The SoonerCare HMP health coaching participants as a group were forecasted to incur average medical costs of $1,099.04. Their actual average PMPM medical costs were $746.90. With the addition of $155.60 in average PMPM administrative expenses, total actual costs were $902.50. Medical expenses accounted for 83 percent of the total and administrative expenses for the other 17 percent. Overall, SoonerCare HMP health coaching participant PMPM expenses, inclusive of administrative costs were 82.1 percent of forecast.

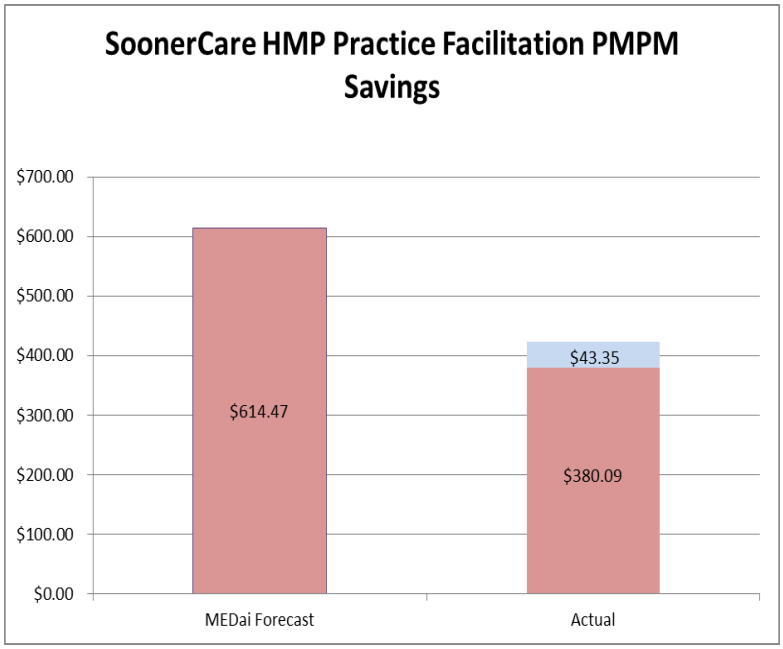


On an aggregate basis, the health coaching portion of the SoonerCare HMP achieved net savings during its initial 24 months of operation (July 2013 through June 2015) of nearly $12.8 million, up from only $3.4 million in its first 12. These results appear in line with the nurse care management component of the first generation SoonerCare HMP, which generated cumulative net savings of $5.5 million through its initial 17 months of operation (February

2008 implementation through June 2009) and $14.9 million in cumulative net savings through its initial 29 months of operation (February 2008 through June 2010).

PHPG performed a cost effectiveness test by comparing forecasted costs to actual costs during SFY 2014 and SFY 2015, inclusive of SoonerCare HMP practice facilitation administrative expenses.

SoonerCare HMP members aligned with a practice facilitation provider and included in the expenditure analysis were forecasted to incur average medical costs of $614.47. Their actual average PMPM medical costs were $380.09. With the addition of $43.35 in average PMPM administrative expenses, total actual costs were $423.44. Medical expenses accounted for 90 percent of the total and administrative expenses for the other 10 percent. Overall, net SoonerCare HMP practice facilitation-related PMPM expenses were 61.9 percent of forecast.



On an aggregate basis, the practice facilitation portion of the SoonerCare HMP achieved net savings in excess of $28.4 million. These net savings compare favorably to the practice facilitation component of the first generation SoonerCare HMP, which generated cumulative net savings of $3.5 million through its initial 17 months of operation (February 2008 implementation through June 2009) and $19.2 million in cumulative net savings through its initial 29 months of operation (February 2008 through June 2010). The OHCA will continue to track and trend this hypothesis over the extension period to monitor for significant changes in results.

Proposed 2018 SoonerCare Choice and Insure Oklahoma Hypotheses

The OHCA is requesting that these remain the same as the 2017 approved hypotheses submitted (December 15, 2016)

Hypothesis 1 – Child Health Checkup Rates.

The rate for age-appropriate well-child and adolescent visits will improve between 2016-2018.

Hypothesis 2 – PCP Visits.

The rate of adult members who have one or more preventive health visits with a primary care provider in a year will improve as a measure of access to primary care in accordance with HEDIS® guidelines between 2016- 2017.

Hypothesis 3 – PCP Enrollments.

The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data between 2016-2018.

Hypothesis 3b: PCP Enrollments Insure Oklahoma.

The number of Insure Oklahoma practitioners enrolled as PCPs will maintain at or above the baseline data between 2016-2018

Hypothesis 4 – PCP Capacity Available.

There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2016- 2018. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2016-2018.

Hypothesis 5 – PCP Availability.

There will be adequate PCP capacity to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between 2016-2018. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2016 - 2018.

Hypothesis 6 - Integration of Indian Health Services, Tribal Clinics, and Urban Indian Clinic Providers.

The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal, or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will improve during the 2016-2018 waiver period.

Hypothesis 7 – Impact of Health Access Networks on Quality of Care.

Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2016-2018.

Hypothesis 8 – Impact of Health Access Networks on Effectiveness of Care.

Average per member per month expenditures for members belonging to a HAN affiliated PCP will continue to be less than those members enrolled with non-HAN affiliated PCPs during the period of 2016-2018.

Hypothesis 9 – Health Management Program (HMP). Impact on Enrollment Figures

Health outcomes for chronic diseases will improve between 2017-2018 as a result of participation in the HMP. Total expenditures for members enrolled in HMP will decrease.

(a) The implementation of phase two of the SoonerCare HMP, including introduction of physician office- based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will maintain enrollment and active participation in the program.
(b) The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members for preventive/ambulatory care.
(c) The implementation of phase two of the SoonerCare HMP, including introduction of physician office- based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase in average complexity of need within the nurse care managed population.
(d) Health Coaches will improve quality measures for members who are engaged.
(e) Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention
(f) Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention.
(g) Nurse care managed members will report high levels of satisfaction with their care.
(h) Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management

VII. PUBLIC NOTICE PROCESS

Post Award Forum

In accordance with STC #17, the OHCA has the Post Award Forum scheduled for September 20, 2017 for the 2017 extension period in order to afford the public an opportunity to provide meaningful comment on the progress of the demonstration. Any oral or written comments will be provided to CMS accordingly.

Public Meetings

In accordance with 42 CFR Section 431.408, the OHCA held three public meetings to inform the public of constant and consistent transparency and feedback for the public regarding the waiver. Two of the public meetings are to be considered as part of the requirements for the public notice process for the 2018 demonstration extension. Some of the comments resulted in an update to language as indicated in the application from original posting. Please refer to Attachment 22.

The OHCA held a public meeting on April 11, 2017; five months after CMS approved the 2017 demonstration extension[7]. The meeting was held at the OHCA in Oklahoma City; the meeting included teleconferencing by the Go To Meeting feature. The meeting time and location was published beforehand in accordance with Oklahoma's Open Meeting Act[8]. During the forum/ public

[7] Refer to attachments 15 and 16 for The Children's Health Group Quarterly Meeting agenda and SoonerCare Choice Insure Oklahoma Post Award Forum PowerPoint for April 2017.

[8] Refer to attachment 17 for the Post Award Forum Newspaper Publication Notice April 2017.

meeting, the OHCA Waiver Development & Reporting Coordinator provided education on the 1115 waiver authority, the use of medical homes and the programs within the 1115 authority, as well as discussed the benefits, services and main program goals of the SoonerCare Choice program. The Coordinator also explained the process by which the OHCA evaluates the Demonstration, and the modifications on the Demonstration for the 2016-2017 extension periods as outlined in Section II of the STCs. Due to posting requirements, the agency counted this as a public meeting for informational purposes for the public.

Comments during this meeting included:

1. One comment was provided in the form of a verbal request by those in attendance of how to be more involved in the decision making process and offer input.

   The OHCA responded: An email response was provided. The OHCA appreciates your attendance, April 11, 2017, at the 2017 Post Award Forum meeting. Part of our public notice process is to follow up on questions and comments to us by the attendees. As mentioned in the discussion, you requested information on how your agency could be more involved with ensuring that the agency is aware of the significance of the services you provide and your ability to have greater input.

On May 18, 2017, the state conducted it first public meeting at the OHCA during the Medical Advisory Committee (MAC) Meeting in Oklahoma City, OK. The State provided updated information of its plan to submit an extension application for the SoonerCare Choice and Insure Oklahoma 1115(a) waiver to the Centers for Medicare and Medicaid Services (CMS) for the period January 1 2018, to December 31, 2018. The State also introduced Supplemental Payment Methodology information regarding Workforce Development for Teaching Universities during this meeting. The state reported an anticipated application date of August 1, 2017.

Comments during this meeting included:

1. One of the MAC members asked if the Physicians Manpower organization had been involved with the development of the matrix for the Work Force development of the 2018 extension.
   The OHCA responded: "Yes."
2. Would the extension request be impacted with the status of the Aged Blinded & Disabled (ABD)
   The OHCA responded: This was an extension request to continue the waiver without including ABD or without ABD being impacted. If we were to do anything that would impact the ABD, we would have to amend the demonstration to add a new program.

On May 25, 2017, the State conducted its second meeting at the Cleveland County Health Department in Norman, OK during the Child Health Workgroup. Information regarding programs covered under the demonstration waiver inclusive of the Health Management Program, Health Access Networks and Workforce Development for Teaching Universities was discussed.

It was mentioned that the state has introduced Supplemental Payment Methodology information regarding Workforce Development for Teaching Universities in the 2018 extension request during this meeting. The extension application requires approval from our federal partners, CMS, to continue services provided under the 1115(a) demonstration waiver. This information was also explained during this meeting.
Comments during this meeting included:

1. Since the current administration, has it caused the State to have any problems with getting authority to operate Medicaid or waivers described today?

The OHCA responded: The State has always utilized transparence and seeks public comment on any changes that are made to any policy and/or waiver decisions before proceeding. Our federal partners have supported the authority to continue to process demonstration waiver request this way.

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Documentation of Compliance with Public Notice Requirements

In compliance with public notice requirements of the agency and regulations at 42 CFR §431.408, the OHCA provided meaningful notice of the State's intent to renew the SoonerCare demonstration to the Native American Tribes and to the general public.

The OHCA made use of the methods listed below to inform the public of the State's intent to renew the Demonstration and to solicit feedback from the public. All dates reflected are 2017.

May 17 • **Newspaper notification** to announce meeting location(s) intent to request an extension in the newspapers of widest circulation in each city with a population of 100,000, or more persons (Attachments 8 and 8a)

May 18 • **OHCA Banners** Place a banner and extension request documents on OHCA's public site for public comment period to run through June 30, 2017, (Attachments 7 and 7a.)

May 18 • **1st Public meeting Medical Advisory Meeting (MAC):** regarding Waiver Extension request and modifications Workforce Development supplemental payments to Waiver (Attachment 20).

May 23 • **Tribal Consultation:** regarding Waiver Extension request and modifications Workforce development supplemental payments. (Attachments 9 and 9a)

May 24 • **2nd Public meeting Child Health Workgroup:** regarding Waiver Extension request and modifications Workforce Development supplemental payments to Waiver. (Attachment 19)

June 30 • OHCA's Comment Period ends: regarding Waiver Extension request and modifications Workforce Development to Waiver.

August 1 • Receive Cover Letter from Governor's Office for Renewal

(Attachment 21)

August 2 • Submit Renewal Application to CMS

APPENDICES

Appendix A: 2018 SoonerCare Choice and Insure Oklahoma Eligibility Chart

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (Waiver List summary)	Demonstration Population (STC# 57)
Pregnant women and infants under age 1 1902(a)(10)(A)(i)(IV)	Up to and including 133 % FPL	Freedom of Choice, Retroactive Eligibility	Populations 1,2,3,4
Children 1-5 1902(a)(10)(A)(i)(VI)	Up to and including 133 % FPL	As Above	Populations 1,2,3,4
Children 6-18 1902(a)(10)(A)(i)(VII)	Up to and including 133	As Above	Populations 1,2,3,4
IV-E Foster Care or Adoption Assistance Children	Automatic Medicaid	As Above	Populations 1,2,3,4
1931 low-income families	73% of the AFDC standard of need.	As above	Populations 1,2,3,4
SSI recipients	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Pickle amendment	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Early widows/widowers	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Disabled Adult Children (DACs)	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
~~1619~~ 1916(b)	SSI for unearned income and earned income limit is the ~~1619~~ 1916(b) threshold amount for Disabled SSI members, as updated annually by the SSA.	Freedom of Choice	Populations 1,2,3,4

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (Waiver List summary)	Demonstration Population (STC# 57)
Targeted Low-Income Child	Up to and including 185% FPL	As Above	Population 9
Infants under age 1 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the	As Above	Population 9
Children 1-5 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the	As Above	Population 9
Children 6-18 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the	As Above	Populations 9
Non-IV-E foster care children under age 21 in State or Tribal	AFDC limits as of 7/16/1996	As above	Populations 1,2,3,4
Aged, Blind and Disabled	From SSI up to and including 100% FPL	Freedom of Choice	Populations 1,2,3,4
Eligible but not receiving cash assistance	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Individuals receiving only optional State supplements	100% SSI FBR + $41 (SSP)	Freedom of Choice	Populations 1,2,3,4
Breast and Cervical Cancer Prevention and Treatment	Up to and including 185% FPL	Freedom of Choice, Counting Income and Comparability of Eligibility	Populations 1,2,3,4
Optional State Plan Groups	**FPL and/or Other Qualifying Criteria**	**Applicable Waivers and CNOMs (Waiver List summary)**	**Demonstration Population (STC# 57)**
TEFRA Children (under 19 years of age) without	Must be disabled according to	Freedom of Choice, Counting Income and Comparability of Eligibility	Population 7

Demonstration Expansion Groups	Authority	FPL and/or Other Qualifying Criteria
Non-Disabled Low-Income Workers and Spouse (ages 19-64) (Employer Sponsored Plan)	Oklahoma Senate Bill 1546	Up to and including 200 percent FPL, who work for a qualified employer with 200 or fewer employees. Spouses who do not work are also qualified to enroll on their working spouse's coverage.
Full-Time College Students (ages 19-22) (Employer Sponsored Plan)	Oklahoma House Bill 2842	Full-time college students with FPL not to exceed 200 percent (limited to 3,000 participants), who have no creditable health insurance coverage, work for a qualifying employer.
Foster Parents (ages 19-64) (Employer Sponsored Plan)	Oklahoma House Bill 2713	Up to and including 200 percent FPL, who work full-time or part-time for a qualified employer. Spouses who do not work are also qualified to enroll on their working spouse's coverage. No limit on employer
Qualified Employees of Not-for-Profit Businesses (ages 19-64) (Employer Sponsored Plan)	Oklahoma Senate Bill 1404	Up to and including 200 percent FPL, who work for a qualified employer with access to an ESI with 500 or fewer employees. Spouses who do not work are also qualified to enroll on their working
Non-Disabled Low-Income Workers and Spouse (ages 19-64) (Individual Plan)	Oklahoma Senate Bill 1546	Individuals up to and including 100 percent FPL, who are self-employed, or unemployed. Spouses who do not work are also qualified to enroll on their spouse's coverage.
Working Disabled Adults (ages 19-64) (Individual Plan)	Oklahoma Senate Bill 1546	Individuals up to and including 100 percent FPL, who are not qualified for Medicaid due to employment earnings, and who otherwise, except for earned income, would be qualified to receive

Demonstration Expansion Groups	Authority	FPL and/or Other Qualifying Criteria
		benefits.
Full-Time College Students (ages 19-22) (Individual Plan)	Oklahoma House Bill 2842	Full-time college students with FPL not to exceed 100 percent FPL (limited to 3,000 participants), who do not have access to employer sponsored insurance and do not have creditable
Foster Parents (ages 19-64) (Individual Plan)	Oklahoma House Bill 2713	Individuals up to and including 200 percent FPL, who work full-time or part- time. Spouses who do not work are also qualified to enroll on their working spouse's coverage.

Qualified Employees of Not-for-Profit Businesses (ages 19-64) (Individual Plan)	Oklahoma Senate Bill 1404	Individuals up to and including 200 percent FPL, who work for a not-for- profit with 500 or fewer employees. Spouses who do not work are also qualified

Appendix B: A Historical Timeline of the SoonerCare Choice Program	
July 1, 1993	State leadership passes Title 63 of the Oklahoma Statute directing the Oklahoma Health Care Authority as the single-state Medicaid agency, and to convert the Medicaid program to managed care.
January 1995	The Health Care Financing Administration approved operating SoonerCare under a Section 1915(b) managed care waiver
January 1, 1996	The SoonerCare program is subsumed under a Section 1115(a) demonstration waiver.
July 1996	The State implements SoonerCare Choice, a partially capitated model for specific rural areas of the State utilizing primary care case management, and SoonerCare Plus, a capitated model in urban areas utilizing fee-for-service.
1997	The SoonerCare Choice program is taken statewide in rural areas.
December 31, 2002	The State terminates the SoonerCare Plus [9] program and transitions managed care enrollees to the SoonerCare Choice primary care case management model statewide.
January 1, 2004	CMS approved extending the program from January 1, 2004 through December 31, 2006.
January 2005	CMS approved the Breast and Cervical Cancer population for SoonerCare Choice.
September 30, 2005	CMS approved adding coverage for TEFRA children
December 21, 2006	CMS approved extending the program from January 1, 2007 through December 31, 2009
January 3, 2009	a) CMS approved changing the service delivery model from a Prepaid Ambulatory Health Plan (PAHP) to an exclusive Primary Care Case Management (PCCM) model. The patient-centered medical home was implemented b) CMS approved expanding the description of qualified PCPs to permit County Health Departments to serve as medical homes for members who choose those providers. c) CMS approved the option for the voluntary enrollment of children in State or Tribal custody in the Demonstration. d) CMS approved the SoonerExcel incentive payment program for PCPs to build upon the EPSDT and Fourth DTaP Bonus program.

[9] The SoonerCare Plus program contracted with health maintenance organizations for individuals in urban communities.

Appendix B: A Historical Timeline of the SoonerCare Choice Program	
	e) CMS approved adding $1 copay for non-pregnant adults in SoonerCare.
December 30, 2009	a) CMS approved extending the program from January 1, 2010 to December 31, 2012. b) CMS approved the Health Access Network (HAN) pilot program.
December 31, 2012	a) CMS approved extending the program from January 1, 2013 to December 31, 2015. b) CMS approved removal of the waiver authority that allowed the State to exclude parental income in determining eligibility for children with disabilities who are qualified for the TEFRA category because the State has this authority under the State Plan. c) CMS approved the Health Management Program, as reflected in Section VII to rename nurse care managers as health coaches and to increase face-to-face care management by embedding health coaches within physician practices with the highest concentration of members with chronic illnesses.
July 23, 2013	CMS approved the early adoption of the Systems Simplification Implementation.
September 6, 2013	a) CMS approved adding the mandatory Title XXI Targeted Low-Income Child eligibility group for children ages 0-18. b) CMS approved adding to the SoonerCare Eligibility Exclusions list individuals in the Former Foster Care group and pregnant women with incomes between 134 percent and 185 percent FPL. c) CMS approved referencing the calculation of Modified Adjusted Gross Income (MAGI) for determination of SoonerCare eligibility.
August 13, 2014	CMS approved removal of individuals with other creditable health insurance coverage from the SoonerCare Choice demonstration. Other technical changes were made to clarify language in the STCs.
July 9, 2015	CMS approved extending the program from January 1, 2016 to December 31, 2016
January 2016	The SoonerCare Pain Management program was implemented
June 29, 2016	Leon Bragg, DDS, Chief Dental Officer for the OHCA was recognized by Delta Dental of Oklahoma for his service as President of the Medicaid Medicare Children's Health Insurance Program (CHIP) Services Dental Association (MSDA)
July 11, 2016	Text4Baby (T4b) enrolled its 1 millionth participant the largest mobile health initiative in the nation
August 22, 2016	Dr. Mike Herndon named Chief Medical Officer of the OHCA.
August 29, 2016	Nico Gomez announced he was stepping down as Chief Executive Officer of the OHCA. His last day was September 30, 2016.
September 9, 2016	State Medicaid Director Becky Pasternik-Ikard accepted position of Chief Executive Officer of the OHCA.
November 30,	The Oklahoma Office of Management and Enterprise Services (OMES)

Appendix B: A Historical Timeline of the SoonerCare Choice Program	
2016	released the RFP for SoonerHealth+, The fully capitated, statewide model of care coordinated that is being developed for Oklahoma Medicaid's ABD population. CMS approved extending the program from January 1, 2017 to December 31, 2017
December 12, 2016	The OHCA comes in at number ten of Workplace Dynamic's "Top Workplaces," a list of the best places to work in Oklahoma. The OHCA was included, for the second year in a row.

A Historical Timeline of the Insure Oklahoma Program	
August 2001	President Bush approved the Health Insurance Flexibility and Accountability waiver policy.
April 20, 2004	State legislators pass Senate Bill 1546 authorizing OHCA to develop an assistance program for employees of small businesses (25 or fewer) and individuals to purchase state-sponsored health plans under the state Medicaid program.
September 30, 2005	CMS approved OHCA's Health Insurance Flexibility and Accountability waiver amendment providing insurance coverage to adults employed by small employers and working disabled adults. Originally named the Oklahoma Employers/Employees Partnership for Insurance Coverage (O-EPIC), the program was included in the 1115(a) SoonerCare Choice Research and Demonstration waiver.
December 21, 2006	CMS approved increasing the Insure Oklahoma ESI employer size to 50 or fewer employees.
February 21, 2007	Oklahoma Senate passes Senate bill 424, the All Kids Act.
March 1, 2007	CMS approved the Insure Oklahoma IP program, which was created to serve those individuals who did not have access to ESI coverage
January 3, 2009	a) CMS approved increasing the Insure Oklahoma ESI employer size to 250 or fewer employees. b) CMS approved the Insure Oklahoma eligibility group of full-time college students ages 19 to 22 up to 200 percent of the FPL, with a cap of 3,000 members. c) CMS approved amending cost sharing requirements for the Insure Oklahoma program.
June 22, 2009	CMS approved the Title XXI stand-alone CHIP State Plan amendment for children in the Insure Oklahoma program with incomes from 186 percent to 300 percent FPL.
December 30, 2009	a) CMS approved to expand eligibility under the Insure Oklahoma program for non- disabled working adults and their spouses, disabled wording adults and full-time college students, from 200 percent FPL up to and including 250 percent FPL.

	b) CMS approved the Insure Oklahoma eligibility group of foster parents up to 250 percent of the FPL. c) CMS approved the Insure Oklahoma eligibility group of employees of not-for-profit businesses having fewer than 500 employees, up to and including 250 percent of the FPL.
August 1, 2011	CMS approved elimination of the $10 copay for the initial prenatal visit under the Insure Oklahoma Individual Plan program.
December 31, 2012	a) CMS reduced the financial eligibility under the Insure Oklahoma program for all populations from up to and including 250 percent FPL to up to and including 200 percent FPL. While OHCA continues to have authority up to 250 percent FPL, this programmatic change indicates the current FPL utilization. b) CMS approved limiting the adult outpatient behavioral health benefit in the Insure Oklahoma Individual Plan program by limiting the number of visits to 48 per year consistent with the limitation for behavioral health visits for children. This benefit is limited to individual licensed behavioral health professionals (LBHPs).
September 6, 2013	a) CMS approved eligibility under the Insure Oklahoma program for populations qualified for the Individual Plan from up to and including 200 percent FPL to be reduced to up to and including 100 percent FPL. New demonstration populations were separately defined for the Individual Plan coverage populations. The new demonstration populations were added to the Expenditure Authorities and the Demonstration Expansion Groups in the eligibility chart. CMS approved extending the ESI and IP programs through December 31, 2014. b) CMS approved deleting the Individual Plan benefits and cost-sharing charts from the Special Terms and Conditions in order to add language to reference the State changing the benefits and cost sharing for the Insure Oklahoma Individual Plan in order to align with federal regulations.
June 27, 2014	CMS approved extending the Insure Oklahoma program through December 31, 2015.
July 9, 2015	CMS approved extending the program from January 1, 2016 to December 31, 2016
March 2016	Insure Oklahoma completed its online enrollment systems project

March 4, 2016	The OHCA submitted an amendment to the 1115(a) demonstration waiver for a third component to the Insure Oklahoma Program named Sponsor's Choice.
November 30, 2016	CMS approved extending the program from January 1, 2017 to December 31, 2017

Appendix C: Insure Oklahoma Monitoring

The OHCA began work on a new system migration for online enrollment of the IO program which includes the enrollment numbers for Insure Oklahoma. Therefore, none of the Insure Oklahoma table data was reported during the first quarter of the 2016 year.

Average Monthly Premium Assistance Contribution per ESI Member and Cost PMPM for IP Member

Quarter	ESI Monthly Average Premium Contribution	IP Average Cost PMPM
Jan-March 2008	$228.74	$283.97
April-June 2008	$229.21	$273.04
July-Sept 2008	$234.35	$290.24
Oct-Dec 2008	$236.91	$328.70
Jan-March 2009	$240.07	$278.30
April-June 2009	$244.32	$311.81
July-Sept 2009	$246.23	$321.29
Oct-Dec 2009	$249.63	$339.70
Jan-March 2010	$254.34	$313.84
April-June 2010	$257.48	$309.93
July-Sept 2010	$260.57	$325.33
Oct-Dec 2010	$270.44	$313.32
Jan-March 2011	$273.20	$318.01
April-June 2011	$277.39	$336.42
July-Sept 2011	$280.06	$337.36
Oct-Dec 2011	$281.78	$352.93
Jan-March 2012	$285.85	$325.56
April-June 2012	$286.12	$357.86
July-Sept 2012	$285.55	$338.17
Oct-Dec 2012	$288.47	$331.11
Jan-March 2013	$287.29	$346.71
April-June 2013	$289.40	$336.85
July-Sept 2013	$293.11	$364.26
Oct-Dec 2013	$298.93	$408.05
Jan-March 2014	$299.71	$621.16
Apr-June 2014	$292.21	$480.66
July-Sept 2014	$295.84	$443.06
Oct-Dec 2014	$297.94	$450.62
Jan-March 2015	$302.81	$419.92

Apr-June 2015	$307.08	$460.93
July-Sept 2015	$311.68	$473.49
Oct-Dec 2015	$313.51	$438.17
Jan-March 2016	Unavailable	Unavailable[10]
Apr-June 2016	Unavailable	Unavailable
July-Sept 2016	$340.52	Unavailable
Oct-Dec 2016	$336.26	$373.43

ESI Average PMPM Total Cost for 2016: $308.68 (OHCA separates the employee, spouse, student and dependent categories).

IP Average PMPM Total Cost for 2016: $ 441.06

In 2016 the OHCA implemented an online system for enrollment of employers/businesses and members. This created a delay in the way in which numbers were gathered for the reporting documentation. This was reported each month to CMS and the methodology changed around May 2016 moving forward. The numbers may appear inconsistent from previous years for this reason.

Contributions by Employers Pre- and Post- Participation in ESI

Total annual employer premiums pre-implementation: $13,636,335

Total annual amount paid by employers toward subsidized employees' premiums 2016: $14,650,644.10

Total Costs PMPM for ESI and IP Members Including Reimbursements of Out-of-Pocket Expenses over Five Percent of Gross Income.

Year	Total Average Cost PMPM, IP	Total Average Cost
2008	$234.82	$299.62
2009	$248.40	$317.69
2010	$265.57	$315.97
2011	$287.01	$336.76
2012	$294.16	$337.91
2013	$302.91	$363.34
2014	$305.26	$501.55
2015	$318.53	$447.69
2016	$346.05	$419.60

[10] Due to delays in the enrollment migration these numbers were not reported in the quarter indicated.

This table below includes total cost of out of pocket expenses of all eligible member and employer expenses prior to meeting their 5 percent threshold. The numbers in this table were reconfigured due to a refinement in methodology in 2016.

Year	Total Employer Contribution
2008	$6,371,915.40
2009	$11,303,340.57
2010	$15,092,287.60
2011	$15,749,806.23
2012	$14,900,847.59
2013	$14,051,782.26
2014	$12,251,882.15
2015	$13,248,870,.04
2016	$14,650,644.10

ESI Health Plan Monitoring

Insure Oklahoma program staff monitor ESI qualified health plans as they are submitted for each year and ensure that the benefits covered and cost-sharing requirements meet OHCA rules and standards. Due to federal mandates, staff has noted that newer health plans have more expenses that accumulate toward the out-of-pocket maximums. Some of the older plans' costs, such as copays, do not apply to out-of-pocket, while in newer plans they do.

Appendix D: Recent Quality Assurance Monitoring for the SoonerCare Choice Program

Year	Survey	Time Period of Data Collected	EQRO
2016	2016 Child CAHPS® Medicaid Survey 5.0H	February 2015 to June 2016	Telligen / Morpace
2016	2016 Adult CAHPS® Medicaid Survey 5.0H	February 2015 to June 2016	Telligen / Morpace

Appendix E: CAHPS® Medicaid Child Member Satisfaction Survey Results

The OHCA annually conducts the Consumer Assessment of Health Provider and Systems (CAHPS) survey designed for children. The sample is from members enrolled via the Children's Health Insurance Program (CHIP).

CAHPS® Child Survey (CHIP) 2016 Key Measure	2014 Summary Rate	2015 Summary Rate	2016 Summary Rate
Getting Needed Care	89%	85%	89%
Getting Care Quickly	92%	92%	93%
How Well Doctors Communicate	97%	96%	97%
Customer Service	88%	86%	86%
Shared Decision Making	Not Applicable	78%	78%
Rating of Health Care	85%	87%	88%
Rating of Personal Doctor	88%	89%	89%
Rating of Specialist	89%	88%	83%
Rating of Health Plan	86%	87%	86%

CAHPS® adult member satisfaction survey shows improvement compared to SFY 2015, SoonerCare Adult member satisfaction rates held steady or increased slightly in all key measures other than Rating of Specialist.

CAHPS® Adult Survey 2016 Key Measure	2014 Summary Rate	2015 Summary Rate	2016 Summary Rate
Getting Needed Care	82%	85%	85%
Getting Care Quickly	82%	82%	84%
How Well Doctors Communicate	90%	90%	91%
Customer Service	82%	92%	87%
Shared Decision Making	Not Applicable	77%	77%
Rating of Health Care	68%	72%	74%
Rating of Personal Doctor	79%	80%	81%
Rating of Specialist	83%	78%	83%
Rating of Health Plan	73%	73%	67%

For comprehensive CAHPS® survey results, please visit CAHPS under Member Satisfaction Surveys.

Oklahoma Health Care Authority

SOONERCARE
§1115(a) Research and Demonstration Waiver
Demonstration Project No. 11-W-0048/6

Proposed Extension through
December 31, 2018

Attachment B, BUDGET NEUTRALITY
July 2016

Budget Neutrality

This chapter contains updated enrollment and expenditure projections for the ***SoonerCare*** program through the remainder of the current extension period, which runs through calendar year 2018. There are 24 exhibits, as delineated below and described in greater detail in this document. The exhibits also have been provided in their original worksheet format, with additional information concerning the OHCA's methodology.

The exhibits incorporate full-year enrollment and expenditure data through calendar year 2015 (demonstration year 20). Expenditures reflect C-Report amounts.

Projections for the remainder of the current extension period are based on Medicaid Eligibility Group (MEG) specific assumptions, as described in detail throughout the chapter. Updates to worksheets previously submitted are described in text boxes included at the top of each worksheet (where applicable).

Budget Neutrality Data for Individual MEGs

The ***SoonerCare*** program includes four traditional MEGs that in combination provide the "without waiver" expenditure estimates for calculation of the budget neutrality cap. They are:

- TANF – Urban
- TANF – Rural
- ABD – Urban
- ABD – Rural

The "with waiver" expenditure estimates also include the following demonstration populations[1]:

- Non-Disabled Working Adults (NDWA) – Employer Sponsored Insurance (ESI)
- Working Disabled Adults (WDA) – ESI
- TEFRA Children
- Full-Time College Students – ESI
- Foster Parents – ESI
- Not-for-Profit Employees – ESI
- Sponsor's Choice Insurance (SCI)
- Non-Disabled Working Adults – Individual Plan (IP)
- Working Disabled Adults – IP
- Full-Time College Students – IP
- Foster Parents – IP
- Not-for-Profit Employees – IP
- Demonstration Expenses 1 – Health Access Network (HAN) Expenditures
- Demonstration Expenses 2 – Health Management Program (HMP) Expenditures

[1] One additional population, CHIP Medicaid Expansion, is reported separately.

Traditional MEGs

Budget neutrality exhibits for the four traditional MEGs are presented starting on page 6. Each exhibit includes enrollment, expenditure and budget neutrality data. Expenditures consist of both paid claims and non-claim medical expenses.

The exhibits include complete historical enrollment and expenditure data for calendar year 2004 through 2015. (MEG-specific data was not produced prior to 2004.)

Member months for the remainder of the current extension period are based on the 2010 – 2015 historical member month growth trend for each MEG, as shown in exhibit 1 on the second following page.

Calendar year per member per month (PMPM) expenditures are trended forward using OMB trend factors of 4.40 percent for the TANF MEGs and 4.20 percent for the ABD MEGs, as shown in exhibit 2 on the second following page. The 2016 – 2018 PMPM values for the four traditional MEGs and the TEFRA MEG also are adjusted to reflect a three percent across-the-board provider rate reduction that took effect in January 2016.

"Demonstration Expenses 2 – HMP" expenditures are included within the four traditional MEGs. Expenditures are prorated based on each MEG's percentage of total enrollment.

Budget neutrality data for the traditional MEGs is presented in exhibits 3 – 6.

Demonstration MEGs

Budget neutrality data for the additional demonstration populations and for HAN and HMP expenditures is presented in exhibits 7 – 23. Member month and expenditure data for all MEGs has been prepared using the same methodology as for the traditional MEGs, with the following exceptions:

- "Demonstration Expenses 1 – HAN Expenditures" and "Demonstration Expenses 2 – HMP Expenditures" relate to allowable expenditures for populations enrolled in the traditional MEGs. Treatment of these expenditures is described in more detail within their respective worksheets.

- The OHCA began to report separately ESI and IP expenditures for the NDWA, WDA and Full Time College Student populations in 2014. The budget neutrality tables for these populations present aggregated data through 2013, followed by separate historical and projected data for 2014 – 2018.

- The ESI component of Insure OK was opened to employers between 100 and 250 workers in size in 2015, which has resulted in enrollment growth in the program after an extended period of decline. Enrollment counts for 2016 – 2018 are based on the trend from 2014 – 2015, rather than the longer look back used for other MEGs.

- Enrollment in the WDA MEG has declined to a small number of member months and is expected to remain at the current low level through 2018. Historically, all WDA MEG enrollment has been within the IP component of the program. The OHCA has requested discontinuation of the WDA-ESI MEG, although it continues to be shown pending approval from CMS.

- Enrollment in the Foster Parents and Not-for-Profit Employees MEGs has not begun and is not expected to occur during the extension period. ESI and IP tables are included for these MEGs but with zero enrollment or expenditures.

- Enrollment in the Sponsor's Choice Insurance (SCI) MEG is projected to begin in January 2017 and to reach 10,000 members by December 2017 and 50,000 members by December 2018. Projected PMPM costs have been set equal to projections for the closest equivalent IOK MEG: NDWA-ESI.

Aggregate Budget Neutrality Data

Exhibit 24 on the last page provides updated aggregate budget neutrality projections through calendar year 2018. As the exhibit illustrates, the ***SoonerCare*** demonstration is projected to continue generating savings throughout the remainder of the current waiver extension period.

Exhibit 1 – Enrollment Trends by MEG

MEG	2010	2011	2012	2013	2014	2015	Annual Trend	Trending Years
TANF - Urban	3,333,170	3,357,000	3,620,263	3,741,817	4,001,208	4,101,736	4.24%	*2010 - 2015*
TANF - Rural	2,429,264	2,433,324	2,565,123	2,618,683	2,745,120	2,807,836	2.94%	*2010 - 2015*
ABD - Urban	327,267	344,575	348,935	360,205	365,630	362,810	2.08%	*2010 - 2015*
ABD - Rural	278,093	285,113	285,622	290,965	291,806	287,250	0.65%	*2010 - 2015*
NDWA - ESI							0.73%	*See IOK_ESI-IP Tab*
NDWA - IP							-16.69%	*See IOK_ESI-IP Tab*
WDA	90	114	66	42	-	-	-100.00%	*2010 - 2015*
TEFRA	4,018	4,514	4,978	5,326	6,148	6,771	11.00%	*2010 - 2015*
College - ESI							-3.81%	*See IOK_ESI-IP Tab*
College - IP							0.56%	*See IOK_ESI-IP Tab*

Exhibit 2 – PMPM Expenditure Trends by MEG

Year	TANF – Urban	TANF – Rural	ABD-Urban	ABD – Rural	NDWA	WDA	TEFRA	College Students
2015	4.40%	4.40%	4.20%	4.20%	4.40%	4.20%	4.20%	4.40%
2016	4.40%	4.40%	4.20%	4.20%	4.40%	4.20%	4.20%	4.40%
2017	4.40%	4.40%	4.20%	4.20%	4.40%	4.20%	4.20%	4.40%

Exhibit 3 – Budget Neutrality for TANF-Urban MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical	1	1996	1,248,591	$ 121.60	$ 151,828,666				
	2	1997	1,201,538	$ 129.52	$ 155,618,588				
	3	1998	1,299,675	$ 137.95	$ 179,287,128				
	4	1999	1,489,962	$ 146.93	$ 218,917,218				
	5	2000	1,575,250	$ 156.49	$ 246,515,710				
	6	2001	1,988,010	$ 166.68	$ 331,363,038				
	7	2002	2,159,002	$ 177.53	$ 383,291,270				
	8	2003	2,319,441	$ 189.09	$ 438,580,782				
	9	2004	2,426,341	$ 201.40	$ 488,661,911	$ 136.70	$ 331,669,473	$ 156,992,438	$ 156,992,438
	10	2005	2,528,654	$ 214.51	$ 542,420,938	$ 188.11	$ 475,653,511	$ 66,767,427	$ 223,759,865
	11	2006	2,643,157	$ 228.47	$ 603,893,538	$ 213.25	$ 563,645,766	$ 40,247,772	$ 264,007,637
	12	2007	2,808,278	$ 240.19	$ 674,520,293	$ 217.74	$ 611,465,158	$ 63,055,135	$ 327,062,772
	13	2008	2,772,622	$ 252.51	$ 700,119,625	$ 237.40	$ 658,219,711	$ 41,899,914	$ 368,962,686
	14	2009	3,029,870	$ 265.47	$ 804,339,589	$ 249.71	$ 756,593,334	$ 47,746,255	$ 416,708,941
	15	2010	3,333,170	$ 279.09	$ 930,249,786	$ 234.68	$ 782,242,482	$ 148,007,304	$ 564,716,244
	16	2011	3,357,000	$ 293.41	$ 984,968,363	$ 252.31	$ 847,000,007	$ 137,968,356	$ 702,684,600
	17	2012	3,620,263	$ 308.46	$ 1,116,703,111	$ 251.66	$ 911,062,393	$ 205,640,718	$ 908,325,319
Current	18	2013	3,741,817	$ 322.03	$ 1,204,977,329	$ 260.87	$ 976,119,115	$ 228,858,214	$ 1,137,183,532
	19	2014	4,001,208	$ 336.20	$ 1,345,206,130	$ 254.89	$ 1,019,875,339	$ 325,330,791	$ 1,462,514,323
	20	2015	4,101,736	$ 350.99	$ 1,439,668,319	$ 264.45	$ 1,084,707,551	$ 354,960,768	$ 1,817,475,091
Extension	21	2016 (proj)	4,275,528	$ 366.44	$ 1,566,724,471	$ 268.76	$ 1,149,110,893	$ 417,613,578	$ 2,235,088,669
	22	2017 (proj)	4,456,684	$ 382.56	$ 1,704,963,844	$ 281.55	$ 1,254,761,717	$ 450,202,127	$ 2,685,290,796
	23	2018 (proj)	4,645,515	$ 399.40	$ 1,855,400,718	$ 294.88	$ 1,369,892,310	$ 485,508,408	$ 3,170,799,204

See Exhibit 24 (Aggregate)

Exhibit 4 – Budget Neutrality for TANF-Rural MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996	1,088,941	$ 123.34	$ 134,309,983				
	2	1997	1,081,206	$ 131.37	$ 142,037,420				
	3	1998	1,250,830	$ 139.92	$ 175,018,115				
	4	1999	1,510,946	$ 149.03	$ 225,177,007				
	5	2000	1,522,229	$ 158.73	$ 241,627,007				
	6	2001	1,915,864	$ 169.07	$ 323,907,157				
	7	2002	2,014,674	$ 180.07	$ 362,786,430				
	8	2003	1,941,227	$ 191.79	$ 372,317,080				
	9	2004	1,984,722	$ 204.28	$ 405,440,105	$ 149.19	$ 296,093,830	$ 109,346,275	$ 109,346,275
	10	2005	2,015,932	$ 217.58	$ 438,624,903	$ 159.74	$ 322,029,702	$ 116,595,201	$ 225,941,475
	11	2006	2,036,491	$ 231.74	$ 471,943,801	$ 190.64	$ 388,233,610	$ 83,710,191	$ 309,651,667
	12	2007	2,130,548	$ 243.63	$ 519,065,409	$ 195.93	$ 417,441,223	$ 101,624,186	$ 411,275,853
	13	2008	2,078,460	$ 256.13	$ 532,352,258	$ 208.78	$ 433,930,540	$ 98,421,718	$ 509,697,571
	14	2009	2,246,021	$ 269.27	$ 604,780,677	$ 220.17	$ 494,500,235	$ 110,280,442	$ 619,978,012
	15	2010	2,429,264	$ 283.08	$ 687,678,542	$ 213.70	$ 519,126,643	$ 168,551,899	$ 788,529,911
	16	2011	2,433,324	$ 297.60	$ 724,164,719	$ 224.38	$ 545,999,493	$ 178,165,226	$ 966,695,137
	17	2012	2,565,123	$ 312.87	$ 802,550,338	$ 230.22	$ 590,533,873	$ 212,016,465	$ 1,178,711,602
	18	2013	2,618,683	$ 326.64	$ 855,366,615	$ 230.12	$ 602,610,415	$ 252,756,200	$ 1,431,467,803
	19	2014	2,745,120	$ 341.01	$ 936,113,371	$ 229.99	$ 631,345,478	$ 304,767,893	$ 1,736,235,696
	20	2015	2,807,836	$ 356.01	$ 999,617,694	$ 210.86	$ 592,057,993	$ 407,559,702	$ 2,143,795,398
Extension	21	2016 (proj)	2,890,355	$ 371.67	$ 1,074,258,133	$ 214.49	$ 619,962,204	$ 454,295,929	$ 2,598,091,326
	22	2017 (proj)	2,975,299	$ 388.02	$ 1,154,485,689	$ 224.89	$ 669,105,727	$ 485,379,962	$ 3,083,471,288
	23	2018 (proj)	3,062,739	$ 405.10	$ 1,240,704,785	$ 235.73	$ 721,987,938	$ 518,716,847	$ 3,602,188,136

See Exhibit 24 (Aggregate)

Exhibit 5 – Budget Neutrality for ABD-Urban MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999	96,785	$ 536.14	$ 51,889,826				
	5	2000	190,315	$ 567.55	$ 108,013,756				
	6	2001	279,689	$ 600.81	$ 168,040,252				
	7	2002	306,526	$ 636.02	$ 194,956,243				
	8	2003	233,742	$ 673.29	$ 157,375,990				
	9	2004	244,590	$ 712.74	$ 174,330,070	$ 489.16	$ 119,644,174	$ 54,685,896	$ 54,685,896
	10	2005	255,066	$ 754.51	$ 192,450,068	$ 668.41	$ 170,487,472	$ 21,962,596	$ 76,648,492
	11	2006	259,473	$ 798.73	$ 207,247,624	$ 858.00	$ 222,627,081	$ (15,379,457)	$ 61,269,036
	12	2007	268,332	$ 840.26	$ 225,468,646	$ 894.55	$ 240,036,203	$ (14,567,557)	$ 46,701,479
	13	2008	283,834	$ 883.96	$ 250,898,901	$ 962.43	$ 273,171,226	$ (22,272,325)	$ 24,429,154
	14	2009	301,034	$ 929.92	$ 279,937,423	$ 1,003.30	$ 302,026,587	$ (22,089,164)	$ 2,339,990
	15	2010	327,267	$ 978.28	$ 320,157,269	$ 960.84	$ 314,450,856	$ 5,706,413	$ 8,046,403
	16	2011	344,575	$ 1,029.15	$ 354,617,902	$ 931.12	$ 320,839,827	$ 33,778,075	$ 41,824,478
	17	2012	348,935	$ 1,082.66	$ 377,778,436	$ 932.40	$ 325,345,676	$ 52,432,760	$ 94,257,239
	18	2013	360,205	$ 1,128.13	$ 406,358,067	$ 974.58	$ 351,048,325	$ 55,309,742	$ 149,566,981
	19	2014	365,630	$ 1,175.51	$ 429,801,721	$ 1,055.90	$ 386,068,587	$ 43,733,135	$ 193,300,115
	20	2015	362,810	$ 1,224.89	$ 444,402,341	$ 1,089.26	$ 395,192,726	$ 49,209,615	$ 242,509,730
Extension	21	2016 (proj)	370,369	$ 1,276.34	$ 472,716,798	$ 1,101.91	$ 408,115,006	$ 64,601,792	$ 307,111,523
	22	2017 (proj)	$ 378,086	$ 1,329.95	$ 502,833,451	$ 1,149.15	$ 434,477,249	$ 68,356,202	$ 375,467,725
	23	2018 (proj)	$ 385,963	$ 1,385.80	$ 534,868,827	$ 1,198.37	$ 462,524,659	$ 72,344,168	$ 447,811,893

See Exhibit 24 (Aggregate)

Exhibit 6 – Budget Neutrality for ABD-Rural MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999	103,533	$ 427.26	$ 44,235,510				
	5	2000	209,188	$ 452.30	$ 94,615,196				
	6	2001	329,747	$ 478.80	$ 157,883,545				
	7	2002	343,627	$ 506.86	$ 174,170,735				
	8	2003	222,348	$ 536.56	$ 119,303,455				
	9	2004	231,151	$ 568.00	$ 131,294,780	$ 599.10	$ 138,481,478	$ (7,186,698)	$ (7,186,698)
	10	2005	238,426	$ 601.29	$ 143,363,035	$ 639.45	$ 152,460,934	$ (9,097,899)	$ (16,284,596)
	11	2006	241,661	$ 636.52	$ 153,823,267	$ 793.03	$ 191,644,246	$ (37,820,979)	$ (54,105,575)
	12	2007	244,220	$ 669.62	$ 163,534,596	$ 834.57	$ 203,819,587	$ (40,284,991)	$ (94,390,566)
	13	2008	251,088	$ 704.44	$ 176,876,491	$ 871.89	$ 218,920,196	$ (42,043,705)	$ (136,434,272)
	14	2009	262,857	$ 741.07	$ 194,795,734	$ 930.09	$ 244,480,172	$ (49,684,438)	$ (186,118,709)
	15	2010	278,093	$ 779.61	$ 216,803,202	$ 943.82	$ 262,470,486	$ (45,667,284)	$ (231,785,993)
	16	2011	285,113	$ 820.15	$ 233,834,396	$ 958.77	$ 273,358,100	$ (39,523,704)	$ (271,309,697)
	17	2012	285,622	$ 862.79	$ 246,432,947	$ 938.53	$ 268,063,880	$ (21,630,933)	$ (292,940,630)
	18	2013	290,965	$ 899.03	$ 261,586,264	$ 970.21	$ 282,298,187	$ (20,711,923)	$ (313,652,553)
	19	2014	291,806	$ 936.79	$ 273,360,943	$ 1,011.24	$ 295,085,785	$ (21,724,842)	$ (335,377,395)
	20	2015	287,250	$ 976.14	$ 280,396,215	$ 1,031.19	$ 296,210,205	$ (15,813,990)	$ (351,191,386)
Extension	21	2016 (proj)	289,117	$ 1,019.09	$ 294,636,518	$ 1,043.23	$ 301,615,423	$ (6,978,905)	$ (358,170,290)
	22	2017 (proj)	290,997	$ 1,061.89	$ 309,006,979	$ 1,088.00	$ 316,604,387	$ (7,597,408)	$ (365,767,698)
	23	2018 (proj)	292,888	$ 1,106.49	$ 324,078,338	$ 1,134.65	$ 332,324,788	$ (8,246,450)	$ (374,014,148)

See Exhibit 24 (Aggregate)

Exhibit 7 – Budget Neutrality for NDWA MEG: ESI and IP Combined through 2013

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006	9,744			$ 198.81	$ 1,937,239	$ (1,937,239)	$ (1,937,239)
	12	2007	38,417			$ 204.54	$ 7,857,843	$ (7,857,843)	$ (9,795,082)
	13	2008	139,822			$ 239.38	$ 33,470,013	$ (33,470,013)	$ (43,265,095)
	14	2009	172,594			$ 437.73	$ 75,549,419	$ (75,549,419)	$ (118,814,514)
	15	2010	392,065			$ 284.10	$ 111,386,167	$ (111,386,167)	$ (230,200,681)
	16	2011	392,772			$ 314.00	$ 123,330,328	$ (123,330,328)	$ (353,531,009)
	17	2012	391,031			$ 309.32	$ 120,952,327	$ (120,952,327)	$ (474,483,336)
	18	2013	388,005			$ 297.14	$ 115,291,324	$ (115,291,324)	$ (589,774,660)
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

See Exhibit 8 for ESI 2014 and later
See Exhibit 17 for IP 2014 and later

Exhibit 8 – Budget Neutrality for NDWA MEG: ESI – 2014 to 2018

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014	273,146			$ 72.50	$ 19,802,018	$ (19,802,018)	$ (379,039,071)
	20	2015	158,543			$ 277.93	$ 44,063,972	$ (44,063,972)	$ (423,103,043)
Extension	21	2016 (proj)	159,699			$ 290.16	$ 46,338,191	$ (46,338,191)	$ (469,441,234)
	22	2017 (proj)	160,863			$ 302.93	$ 48,729,786	$ (48,729,786)	$ (518,171,021)
	23	2018 (proj)	162,036			$ 316.26	$ 51,244,816	$ (51,244,816)	$ (569,415,837)

Exhibit 9 – Budget Neutrality for WDA MEG: ESI and IP Combined through 2013

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006	-				$ -	$ -	$ -
	12	2007	-				$ 24	$ (24)	$ (24)
	13	2008	-				$ 34,024	$ (34,024)	$ (34,048)
	14	2009	110			$ 1,175.11	$ 129,262	$ (129,262)	$ (163,310)
	15	2010	90			$ 1,517.03	$ 136,533	$ (136,533)	$ (299,843)
	16	2011	114			$ 907.56	$ 103,462	$ (103,462)	$ (403,305)
	17	2012	66			$ 1,429.38	$ 94,339	$ (94,339)	$ (497,644)
	18	2013	42			$ 1,243.31	$ 52,219	$ (52,219)	$ (549,863)
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

See Exhibit 10 for ESI 2014 and later
See Exhibit 18 for IP 2014 and later

Exhibit 10 – Budget Neutrality for WDA MEG: ESI – 2014 to 2018[2]

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015	-			$ -	$ -	$ -	$ -
Extension	21	2016 (proj)	-			$ -	$ -	$ -	$ -
	22	2017 (proj)	-			$ -	$ -	$ -	$ -
	23	2018 (proj)	-			$ -	$ -	$ -	$ -

[2] All WDA enrollment has occurred within the IP component of the program.

Exhibit 11 – TEFRA Children MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005					$ 5,427	$ (5,427)	$ (5,427)
	11	2006	931			$ 943.85	$ 878,723	$ (878,723)	$ (884,150)
	12	2007	1,813			$ 1,055.94	$ 1,914,413	$ (1,914,413)	$ (2,798,563)
	13	2008	2,515			$ 914.81	$ 2,300,738	$ (2,300,738)	$ (5,099,301)
	14	2009	3,299			$ 1,393.11	$ 4,595,873	$ (4,595,873)	$ (9,695,174)
	15	2010	4,018			$ 1,128.02	$ 4,532,385	$ (4,532,385)	$ (14,227,559)
	16	2011	4,514			$ 1,007.97	$ 4,549,994	$ (4,549,994)	$ (18,777,553)
	17	2012	4,978			$ 1,209.69	$ 6,021,818	$ (6,021,818)	$ (24,799,371)
	18	2013	5,326			$ 1,038.85	$ 5,532,926	$ (5,532,926)	$ (30,332,297)
	19	2014	6,148			$ 1,018.70	$ 6,262,962	$ (6,262,962)	$ (36,595,259)
	20	2015	6,771			$ 1,061.48	$ 5,999,400	$ (5,999,400)	$ (42,594,659)
Extension	21	2016 (proj)	7,516			$ 1,072.88	$ 8,063,702	$ (8,063,702)	$ (50,658,362)
	22	2017 (proj)	8,343			$ 1,117.95	$ 9,326,759	$ (9,326,759)	$ (59,985,121)
	23	2018 (proj)	9,261			$ 1,164.90	$ 10,787,656	$ (10,787,656)	$ (70,772,777)

Exhibit 12 – Budget Neutrality for Full-Time College Student MEG: ESI and IP Combined through 2013

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009	873			$ 65.14	$ 56,867	$ (56,867)	$ (56,867)
	15	2010	3,972			$ 150.85	$ 599,168	$ (599,168)	$ (656,035)
	16	2011	5,493			$ 147.65	$ 811,060	$ (811,060)	$ (1,467,095)
	17	2012	6,724			$ 162.45	$ 1,092,335	$ (1,092,335)	$ (2,559,430)
	18	2013	5,630			$ 191.36	$ 1,077,362	$ (1,077,362)	$ (3,636,792)
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

See Exhibit 13 for ESI 2014 and later
See Exhibit 19 for IP 2014 and later

Exhibit 13– Budget Neutrality for Full-Time College Student MEG: ESI – 2014 to 2018

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014	3,182			$ 74.14	$ 235,903	$ (235,903)	$ (1,853,302)
	20	2015	1,217			$ 251.98	$ 306,659	$ (306,659)	$ (2,159,961)
Extension	21	2016 (proj)	1,171			$ 263.07	$ 307,956	$ (307,956)	$ (2,467,917)
	22	2017 (proj)	1,126			$ 274.64	$ 309,258	$ (309,258)	$ (2,777,175)
	23	2018 (proj)	1,083			$ 286.73	$ 310,566	$ (310,566)	$ (3,087,741)

Exhibit 14– Budget Neutrality for Foster Parent MEG: ESI[3]

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

[3] The OHCA is not projecting any enrollment for this MEG during the extension period.

Exhibit 15– Not-for-Profit Employees MEG: ESI[4]

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

[4] The OHCA is not projecting any enrollment for this MEG during the extension period.

Exhibit 16 – Sponsor's Choice Insurance (SCI) MEG – 2017 to 2018

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)	65,000			$ 302.93	$ 19,690,236	$ (19,690,236)	$ (19,690,236)
	23	2018 (proj)	380,000			$ 316.26	$ 120,177,084	$ (120,177,084)	$ (139,867,321)

Exhibit 17 – NDWA MEG: IP – 2014 to 2018

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014	12,712			$ 4,478.15	$ 56,926,254	$ (56,926,254)	$ (287,463,861)
	20	2015	48,088			$ 588.04	$ 28,277,714	$ (28,277,714)	$ (315,741,575)
Extension	21	2016 (proj)	40,062			$ 613.91	$ 24,594,710	$ (24,594,710)	$ (340,336,285)
	22	2017 (proj)	33,376			$ 640.93	$ 21,391,396	$ (21,391,396)	$ (361,727,681)
	23	2018 (proj)	27,805			$ 669.13	$ 18,605,294	$ (18,605,294)	$ (380,332,975)

Exhibit 18 – WDA MEG: IP – 2014 to 2018

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014	4			$ 1,560.75	$ 6,243	$ (6,243)	$ (556,106)
	20	2015	11			$ 4,187.27	$ 46,060	$ (46,060)	$ (602,166)
Extension	21	2016 (proj)	12			$ 4,363.14	$ 52,358	$ (52,358)	$ (654,524)
	22	2017 (proj)	12			$ 4,546.39	$ 54,557	$ (54,557)	$ (709,080)
	23	2018 (proj)	12			$ 4,737.34	$ 56,848	$ (56,848)	$ (765,928)

Exhibit 19 – Full-Time College Students MEG: IP – 2014 to 2018

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014	-			#DIV/0!	$ 293,200	$ (293,200)	$ (2,312,593)
	20	2015	2,126			$ 180.09	$ 382,877	$ (382,877)	$ (2,695,470)
Extension	21	2016 (proj)	2,126			$ -	$ -	$ -	$ (2,695,470)
	22	2017 (proj)	2,126			$ -	$ -	$ -	$ (2,695,470)
	23	2018 (proj)	2,126			$ -	$ -	$ -	$ (2,695,470)

Exhibit 20 – Budget Neutrality for Foster Parent MEG: IP[5]

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

[5] The OHCA is not projecting any enrollment for this MEG during the extension period.

Exhibit 21 – Not-for-Profit Employees MEG: IP[6]

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010							
	16	2011							
	17	2012							
	18	2013							
	19	2014							
	20	2015							
Extension	21	2016 (proj)							
	22	2017 (proj)							
	23	2018 (proj)							

[6] The OHCA is not projecting any enrollment for this MEG during the extension period.

Exhibit 22 – Health Access Network Expenditures

	DY	CY	Client Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009							
	15	2010 (6 mos)	149,104			$ 5.00	$ 745,520	$ (745,520)	$ (745,520)
	16	2011	428,898			$ 5.00	$ 2,144,490	$ (2,144,490)	$ (2,890,010)
	17	2012	542,657			$ 5.00	$ 2,713,285	$ (2,713,285)	$ (5,603,295)
	18	2013	1,010,286			$ 5.00	$ 5,051,430	$ (5,051,430)	$ (10,654,725)
	19	2014	1,396,342			$ 5.00	$ 6,981,710	$ (6,981,710)	$ (17,636,435)
	20	2015	1,455,505			$ 5.00	$ 7,133,940	$ (7,133,940)	$ (24,770,375)
Extension	21	2016 (proj)	1,517,176			$ 5.00	$ 7,585,879	$ (7,585,879)	$ (32,356,254)
	22	2017 (proj)	1,581,459			$ 5.00	$ 7,907,295	$ (7,907,295)	$ (40,263,549)
	23	2018 (proj)	1,648,466			$ 5.00	$ 8,242,330	$ (8,242,330)	$ (48,505,879)

Exhibit 23 – Health Management Program Expenditures[7]

	DY	CY	Traditional MEG Client Months					HMP Expenditures (Prorated across MEGs based on Client Months)				
			TANF-U	TANF-R	ABD-U	ABD-R	Total Client Months	TANF-U	TANF-R	ABD-U	ABD-R	Total Expenditures
Historical	1	1996										
	2	1997										
	3	1998										
	4	1999										
	5	2000										
	6	2001										
	7	2002										
	8	2003										
	9	2004										
	10	2005										
	11	2006										
	12	2007										
	13	2008										
	14	2009										
	15	2010										
	16	2011										
	17	2012										
	18	2013	3,741,817	2,618,683	360,205	290,965	7,011,670	$ 3,118,501	$ 2,182,460	$ 300,202	$ 242,496	$ 5,843,658
	19	2014	4,001,208	2,745,120	365,630	291,806	7,403,764	$ 8,334,149	$ 5,717,833	$ 761,574	$ 607,805	$ 15,421,361
	20	2015	4,101,736	2,807,836	362,810	287,250	7,559,632	$ 3,959,816	$ 2,710,685	$ 350,257	$ 277,311	$ 7,298,068
Extension	21	2016 (proj)	4,275,528	2,890,355	370,369	289,117	7,825,369	$ 4,107,051	$ 2,776,460	$ 355,775	$ 277,725	$ 7,517,010
	22	2017 (proj)	4,456,684	2,975,299	378,086	290,997	8,101,064	$ 4,259,436	$ 2,843,615	$ 361,352	$ 278,117	$ 7,742,520
	23	2018 (proj)	4,645,515	3,062,739	385,963	292,888	8,387,105	$ 4,417,142	$ 2,912,175	$ 366,989	$ 278,490	$ 7,974,796

[7] Presented for informational purposes only. Expenditures are included within the four traditional MEG exhibits.

Exhibit 24 – Aggregate Budget Neutrality (All MEGs)

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Historical and Current	1	1996	2,337,532	$ 122.41	$ 286,138,649	$ 170.69	$ 398,999,423	$ (112,860,774)	$ (112,860,774)
	2	1997	2,282,744	$ 130.39	$ 297,656,008	$ 134.54	$ 307,126,525	$ (9,470,517)	$ (122,331,291)
	3	1998	2,550,505	$ 138.92	$ 354,305,243	$ 106.62	$ 271,927,279	$ 82,377,964	$ (39,953,328)
	4	1999	3,201,226	$ 168.75	$ 540,219,561	$ 144.65	$ 463,050,620	$ 77,168,941	$ 37,215,613
	5	2000	3,496,982	$ 197.53	$ 690,771,669	$ 171.75	$ 600,600,099	$ 90,171,570	$ 127,387,183
	6	2001	4,513,310	$ 217.40	$ 981,193,992	$ 129.19	$ 583,054,043	$ 398,139,949	$ 525,527,133
	7	2002	4,823,829	$ 231.19	$ 1,115,204,678	$ 176.23	$ 850,117,611	$ 265,087,067	$ 790,614,200
	8	2003	4,716,758	$ 230.58	$ 1,087,577,307	$ 194.45	$ 917,157,855	$ 170,419,452	$ 961,033,652
	9	2004	4,886,804	$ 245.50	$ 1,199,726,867	$ 181.28	$ 885,888,955	$ 313,837,912	$ 1,274,871,564
	10	2005	5,038,078	$ 261.38	$ 1,316,858,944	$ 222.43	$ 1,120,637,046	$ 196,221,898	$ 1,471,093,461
	11	2006	5,180,782	$ 277.35	$ 1,436,908,230	$ 264.24	$ 1,368,966,665	$ 67,941,565	$ 1,539,035,027
	12	2007	5,451,378	$ 290.31	$ 1,582,588,944	$ 271.96	$ 1,482,534,451	$ 100,054,493	$ 1,639,089,520
	13	2008	5,386,004	$ 308.25	$ 1,660,247,275	$ 300.79	$ 1,620,046,448	$ 40,200,827	$ 1,679,290,347
	14	2009	5,839,782	$ 322.59	$ 1,883,853,423	$ 321.58	$ 1,877,931,749	$ 5,921,674	$ 1,685,212,021
	15	2010	6,367,794	$ 338.40	$ 2,154,888,798	$ 313.40	$ 1,995,690,240	$ 159,198,558	$ 1,844,410,579
	16	2011	6,420,012	$ 357.88	$ 2,297,585,380	$ 329.93	$ 2,118,136,761	$ 179,448,619	$ 2,023,859,198
	17	2012	6,819,943	$ 372.95	$ 2,543,464,833	$ 326.38	$ 2,225,879,926	$ 317,584,907	$ 2,341,444,105
	18	2013	7,011,670	$ 389.11	$ 2,728,288,274	$ 333.60	$ 2,339,081,302	$ 389,206,972	$ 2,730,651,077
	19	2014	7,403,764	$ 403.10	$ 2,984,482,165	$ 327.25	$ 2,422,883,479	$ 561,598,686	$ 3,292,249,763
	20	2015	7,559,632	$ 418.55	$ 3,164,084,569	$ 324.67	$ 2,454,379,096	$ 709,705,473	$ 4,001,955,236
Extension	21	2016 (proj)	7,825,369	$ 435.55	$ 3,408,335,921	$ 327.88	$ 2,565,746,322	$ 842,589,599	$ 4,844,544,835
	22	2017 (proj)	8,101,064	$ 453.19	$ 3,671,289,963	$ 343.46	$ 2,782,358,367	$ 888,931,595	$ 5,733,476,431
	23	2018 (proj)	8,387,105	$ 471.56	$ 3,955,052,668	$ 369.16	$ 3,096,154,289	$ 858,898,379	$ 6,592,374,809

1115a SoonerCare Choice and Insure Oklahoma 2018 Extension Application Comments

DATE	FROM	COMMENT	AGENCY RESPONSE / MISC. FOLLOW UP
6/08/17	Anonymous	**1)** Workforce development for APRN and PT are in the proposal. How about workforce development for Physician Assistants (PAs). **2)** Under workforce development for Physicians can a metric of telemedicine services to rural communities or ECHO programs be included as well?	Thank you for your feedback. OHCA considers all input seriously and will take your comments under advisement.
6/12/17	Anonymous	Consider change under Payment Metrics for Workforce Development of Physicians: Delete under bullet #5 "Primarily." Will now read ...program with training linked to a Level I Trauma Center...	Thank you for your feedback. OHCA considers all input seriously and will take your comments under advisement.
6/14/17	Anonymous	**1)** Under the payment metrics for physicians- what are "critical" specialty graduates? Is it just graduates in an accredited specialty residency/fellowship program? **2)** Based on the current waiver, the amount is $101,680,000 for OU/OSU/PMTC...This proposal is to go to ~$115,000,000 with additions of RN/APRN/PT programs. Should the amount be increased more to allow program growth for all?	Thank you for your feedback. OHCA considers all input seriously and will take your comments under advisement.
6/16/17	Della Gregg	I reviewed the HMP hypothesis sections of the 1115 renewal. I have suggestions for considered changes and updates to sections inclusive of: • Charts and tables; • Health coaching outcomes; and • Practice facilitation outcomes In order to provide a more clear picture of the work in the HMP program.	Thank you so very much for taking the time to thoroughly go through our 2018 demonstration waiver extension application. We will take this feedback under consideration and make sure to include your feedback in our final document to CMS. We take all feedback seriously and appreciate when our co-workers contribute to our work. * This comment required updated language to the original application document posted for public comment pg. 48 – 58.
6/20/17	Anonymous	Can a metric for physicians be: # or & of instate	Thank you for your feedback. OHCA considers

		medical students in a class?	all input seriously and will take your comments under advisement.
6/21/17	Anonymous	Number or Percentage of Oklahoma residents in each program (physician, nurse, PT, and other) should be a potential variable for each program. That would encourage schools to recruit from Oklahoma for Oklahoma.	Thank you for your feedback. OHCA considers all input seriously and will take your comments under advisement.
6/27/17	Jason Sanders	Request to re-write some of the measures Workforce Development for Physicians: Suggestions for inclusion of additional specialty groups: General Surgery, Oncology"; Obstetrics & Gynecology instead of Dermatology Suggestion for clarification of terminology from clinical rotation exposure to clinical rotation experience for Registered Nurses: Advance Practice Registered Nurses: Physical Therapist:	Written response not provided. * This comment required updated language to the original application document posted for public comment pg. 10.
6/29/17	Jana Castleberry	The OSDH feedback includes the suggestion to add the following: 1.Eligibility Section - (1) be a four year public university, we suggest expanding eligibility to two year colleges 2.Add Workforce Development Loan Program for Physician Assistants	Thank you for your feedback. OHCA considers all input seriously and will take your comments under advisement.
6/29/17	Adrienne Rollins	The OSDH team did a quick review in addition to their feedback and would like to offer two additional suggestions. The OSDH feedback includes the suggestion to add the following: 1. Eligibility Section - *(1) be a four year public university,* we suggest expanding eligibility to two year colleges 2. Add Workforce Development Loan Program for Physician Assistants	Your suggestions are consistent with other comments .What we have communicated to others is that we listed all of the healthcare providers that were included in the critical occupation list from the Oklahomaworks.gov page and that we are not opposed to adding them (PAs) once we have an approved program. When we were developing the program, we

			specifically wanted to exclude 2 year colleges because of the potential to greatly expand the program. However, all suggestions that we are receiving during the comment period that are not addressed in 2018 will be considered for the 2019-2021 renewal application.
6/29/17	Adrienne Rollins / Governor's Health Workforce Subcommittee Critical Occupations Workgroup	For the next submission, I want to make mention that the Governor's Health Workforce Subcommittee Critical Occupations Workgroup has decided to add Physicians Assistants to the Critical Occupations List, as well as two emerging occupations for the purpose of supply and demand forecasting. We are also looking at the methodology currently being finalized by OK Works to better determine health workforce needs throughout Oklahoma. Once we are able to get the HealthCare Industry Report completed, we will all be able to make better resource allocation decisions. Thus, we appreciate your hard work to sustain the resources we do have currently. As always, please do not hesitate to ask if there is anything we can assist you all with.	Thanks so much Adrienne for the information. Since we are using the work the Governor's Health Workforce Subcommittee has done as one our foundations for the Workforce Development Program.

Oklahoma Health Care Authority

2015-2016 Evaluation Design for the SoonerCare §1115(a) Waiver Demonstration 11-W-00048/6

November 9, 2015

I. OVERVIEW

The Oklahoma Health Care Authority (OHCA), Oklahoma's single-state Medicaid agency, administers the 1115(a) SoonerCare Choice Research and Demonstration waiver. The waiver is currently in its twentieth year of operations and has been renewed by the Centers for Medicare and Medicaid Services (CMS) seven times.

OHCA recently received CMS's approval for the 2015 - 2016 demonstration extension period on July 9, 2015, with the State acknowledging the approval of the renewal application and the Special Terms and Conditions (STC) on August 6, 2015.

The State operates the SoonerCare Choice program as a means to address Oklahoman's health care needs by providing quality care, as well as increasing access to care. OHCA identifies five objectives for the Choice demonstration in which to support program goals. The SoonerCare Choice program objectives include:

- To improve access to preventive and primary care services;
- Increase the number of participating primary care providers, and overall primary care capacity, in both urban and rural areas;
- To optimize quality of care through effective care management;
- To integrate Indian Health Service (IHS) qualified members and IHS and tribal providers into the SoonerCare delivery system;
- To provide access to affordable health insurance for qualified low-income working adults, their spouses and college students.

In accordance with section XIV of the STC, OHCA proposes this SoonerCare Choice Evaluation Design for the 2015 - 2016 extension period to outline the hypotheses and reporting methodologies the State will use to evaluate the demonstration as it relates to the program's objectives, as well as CMS's Three-Part Aim.

II. OVERVIEW OF SOONERCARE CHOICE PROGRAM

SoonerCare Choice

The SoonerCare Choice demonstration operates under a Primary Care Case Management (PCCM) model in which the OHCA contracts directly with primary care providers throughout the state who serve as Primary Care Medical Homes (PCMH) for SoonerCare Choice members. PCMHs are paid monthly care coordination payments for each member on their panels. Payments vary depending on the PCMH tier level services provided and the mix of adults and children on the provider's panel. Providers may qualify for performance incentive payments when certain quality improvement goals, defined by the State, are met. Aside from care coordination, all other services provided in the medical home or by specialists, hospitals, or other providers, are reimbursed on a fee-for-service basis.

The SoonerCare Choice demonstration serves children in mandatory state plan groups, pregnant women and Aged, Blind and Disabled (ABD) members as well as, state plan populations including 1931 low-income families, IV-E foster care or adoption assistance children; the latter with voluntary enrollment. In accordance with Senate Bill 741, OHCA serves individuals in need of breast or cervical cancer treatment and children with disabilities in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The SoonerCare Choice program currently serves approximately 540,000[1] members.

Insure Oklahoma Premium Assistance Program

The OHCA operates the Insure Oklahoma premium assistance program under the 1115(a) SoonerCare Choice Research and Demonstration waiver. The Insure Oklahoma program provides two avenues for individuals to receive premium assistance – the Employer Sponsored Insurance (ESI) and the Individual Plan (IP) programs. Individuals in ESI enroll in an Insure Oklahoma private health plan and pay up to 15 percent of the premium, with costs also divided among the employee and the state and federal governments. Individuals in the IP program are responsible for health plan premiums up to four percent of their monthly gross household income[2].

The Insure Oklahoma program serves non-disabled, low-income working adults, and their spouses, who work for an employer with 250 or fewer employees; working disabled adults, and their spouses (ages 19-64); foster parents, and their spouses; qualified employees of not-for-profit businesses, and their spouses, who work for an employer with 500 or fewer employees; full-time college students (ages 19-22); and (dependent children of parents in the Insure Oklahoma program). The Insure Oklahoma program currently serves 13,518[3] individuals enrolled in the ESI program and 3,920[3] individuals enrolled in the IP program for a total of 17,438[3] individuals.

[1] September 2015, SoonerCare Choice Fast Facts.
[2] In accordance with Oklahoma Administrative Code 317:45-9-4 & 317:45-11-24, American Indians providing documentation of ethnicity are exempt from premium payments.
[3] October 2015, Insure Oklahoma Fast Facts.

Health Access Networks (HANs)

OHCA has three health access network pilot programs under the 1115(a) SoonerCare Choice Research and Demonstration waiver – the University of Oklahoma (OU) Sooner HAN, the Partnership for a Healthy Canadian County (PHCC) HAN, and the Oklahoma State University (OSU) Network HAN. Each HAN is a non-profit, administrative entity that works with affiliated providers to coordinate and improve the quality of care provided to SoonerCare Choice members. Health Access Networks receive a nominal $5 per member per month payment (PMPM).

The HANs offer care management and care coordination to SoonerCare Choice members with complex health care needs and co-manage individuals enrolled in the Health Management Program. The HANs also work to establish new initiatives to address complex medical, social and behavioral health issues. An asthma specific protocol as defined by evidence based guidelines, is one initiative that has been implemented by the HANs to assist members who have uncontrolled asthma to move to controlled status. The OU Sooner HAN, the PHCC HAN and the OSU HAN currently serves approximately 103,030[4] individuals, 3,380[4] individuals, and 13,112[4] respectively.

Health Management Program (HMP)

The Health Management Program (HMP) is a statewide program under the 1115(a) SoonerCare Choice Research and Demonstration waiver developed to manage SoonerCare Choice members most at-risk for chronic disease and other adverse health care concerns. The program is administered by the OHCA and is managed by a vendor obtained through competitive bid.

The SoonerCare HMP serves SoonerCare Choice beneficiaries ages 4 through 63 with chronic illness who are at highest risk for adverse outcomes and increased health care expenditures. The chronic illness for which the program provides care coordination includes, but is not limited to asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and renal disease.

The SoonerCare HMP program refocused their efforts after a process of examining the program to see if the program could be enhanced to better benefit the members and the providers. They moved from telephonic case management and decided to centralize the nurse care management services in the physician practices. The new generation of HMP would work closely with the practice staff to provide coaching services to members and practice facilitation to the providers. The telephonic members were offered an opportunity to work on the Chronic Care Unit (CCU) operated directly by the OHCA.

Through embedded health coaches into the Primary Care Practices (PCP) practices, the HMP program is able to assist members to become more invested in their health outcomes and improve self-management of chronic disease. Health coaches coordinate closely with the providers on health-related goals, as well as allow providers to easily refer members to the health coaches. With health coaches embedded in PCP practices more one-on-one care management is possible.

[4] Oklahoma Medicaid Management Information System data as of October 2015.

In addition to embedded health coaches, the HMP program also incorporates Practice Facilitation in each HMP participating practice. A Practice facilitator (PF) is assigned to each practice participating in the program. Some of the essential functions and core components of the PFs include; Practice Facilitator and Health Coach Integration, Foundation Intervention and Academic Detailing. Practice facilitators have health coach training and certification. Additionally, PFs work with the health coaches to coordinate efforts within the practices. There are four tiers of practice facilitation: Tier 1 practices need full practice facilitation services before deployment of a health coach; Tier 2 practices have received prior practice facilitation but require additional training before deployment of a health coach; Tier 3 practices have received full practice facilitation, are high-functioning practices and are ready for deployment of a health coach. Tier 4 is for a High-functioning practice, but the practice still requests inclusion in academic detailing and other educational services.

III. EVALUATION DESIGN PLAN

Since the program's inception, OHCA has provided a set of waiver objectives for the demonstration that establish the purpose and the goals of the SoonerCare Choice program. The following Evaluation Design waiver objectives refer back to the still-relevant goals from the program's inception, as well as taking into consideration the program's populations and goals for the 2015 - 2016 extension period, and CMS's three-part aim.

2015 - 2016 SoonerCare Choice Waiver Objectives:

1. To improve access to preventive and primary care services;
2. Increase the number of participating primary care providers, and overall primary care capacity, in both urban and rural areas;
3. To optimize quality of care through effective care management;
4. To integrate Indian Health Service (IHS) qualified members and IHS and tribal providers into the SoonerCare delivery system;
5. To provide access to affordable health insurance for qualified low-income working adults, their spouses and college students.

CMS's Three Part Aim:

1. Improving access to and experience of care;
2. Improving quality of health care; and
3. Decreasing per capita costs.

All data reported will be based on the entire universe of SoonerCare Choice members being evaluated within each hypothesis, unless a sample of the larger population is specified.

Each of the hypotheses targets a SoonerCare initiative for which there is no parallel initiative whose effect must be isolated as part of the analysis. Therefore, OHCA did not deem it necessary to develop specific steps to isolate the effects of the SoonerCare program from others in the state.

OHCA and the state's External Quality Review Organization will be responsible for evaluation and reporting on the hypotheses. OHCA will report interim evaluation findings and hypothesis data in the quarterly operational reports.

In accordance with the Special Terms and Conditions, the State will submit to CMS a draft evaluation plan 120 days after the award of the 2015 - 2016 extension.

Hypothesis 1
Hypothesis 1: Child Health Checkup Rates *This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #2 of CMS's Three Part Aim.* The rate for age-appropriate well-child and adolescent visits will improve between 2015 - 2016. A. Child health checkup rates for children 0 to 15 months old will be maintained at or above 95 percent over the life of the extension period. B. Child health checkup rates for children 3 through 6 years old will increase by one percentage point over the life of the extension period. C. Adolescent child health checkup rates will maintain over the life of the extension period.
Research Methodology: The visit rates will be calculated separately for each of the age cohorts (0 to 15 months, 3 to 6 years, and 12 to 21 years) in accordance with each year's HEDIS® guidelines, using administrative data (paid claims and encounters).
Population Studied: SoonerCare Choice members ages 0 to 15 months, 3 to 6 years, and 12 to 21 years.
Numerators: A. The number of SoonerCare Choice members ages 0-15 months old during the measurement year and who received one or more well-child visits with a primary care provider during their first 15 months of life. B. The number of SoonerCare Choice members who were three, four, five, or six years of age during the calendar year and who received one or more well-child visits with a primary care provider during the calendar year. C. The number of SoonerCare Choice members who were twelve to twenty-one years of age during the calendar year and who were due to receive one or more well-child visits with a primary care provider during the calendar year. The following primary care provider types are recognized under SoonerCare Choice: - Physicians - Family Medicine Practitioner - General Practitioner - General Pediatrician - General Internist - Clinics - EPSDT Clinic - Family Planning Clinic - FQHC/RHC - Medical Clinic - Nurse Practitioner Clinic - Pediatric Clinic - Other - Family Nurse Practitioner - Other Nurse Practitioner - Pediatric Nurse Practitioner - Physician Assistant

Hypothesis 1
Denominators: A. Number of children enrolled in SoonerCare Choice continuously from their date-of-birth (DOB) + 31 days to their DOB + 15 months, allowing for a gap of one month, and who are enrolled in SoonerCare on their "anchor date" (DOB + 15 months). B. Number of children enrolled in SoonerCare Choice for 11 or 12 months in the measurement year, including on the anchor date (December 31 of measurement year), with no more than one gap in enrollment of up to 45 days during the continuous enrollment period. C. Number of adolescents enrolled in SoonerCare Choice for 11 or 12 months in the measurement year, including on the anchor date (December 31 of measurement year), with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: Demonstration year 2013 well-child visit rate.
Reporting Frequency: OHCA compiles HEDIS® data on a calendar year basis and reports data six to nine months after the close of the calendar year.
Statistical Analysis OHCA will determine whether a change (increase or decrease) from one year to the following year is statistically significant. The HEDIS® data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 2
Hypothesis 2: PCP Visits *This hypothesis directly relates to SoonerCare Choice waiver objective #1 and #2 of CMS's Three Part Aim.* The rate of adult members who have one or more preventive health visits with a primary care provider in a year will improve by one percentage point as a measure of access to primary care in accordance with HEDIS® guidelines between 2015 - 2016.
Research Methodology: Health visits will be calculated separately for each of the age cohorts (20-44 years and 45-64 years) in accordance with HEDIS® guidelines, using administrative data (paid claims and encounters).
Population Studied: SoonerCare Choice members ages 20-44 years and 45-64 years.
Numerator: The number of SoonerCare Choice members ages 20 years through 44 years and 45 years through 64 years continuously enrolled during the measurement year that have had one or more preventive health visits during the year. The only exclusions will be for inpatient procedures, hospitalizations, emergency room visits, and visits primarily related to mental health and/or chemical dependency. The following primary care provider types are recognized under SoonerCare Choice: - Physicians - Family Medicine Practitioner - General Practitioner - General Pediatrician - General Internist - Clinics - EPSDT Clinic - Family Planning Clinic - FQHC/RHC - Medical Clinic - Nurse Practitioner Clinic - Pediatric Clinic - Other - Family Nurse Practitioner - Other Nurse Practitioner - Pediatric Nurse Practitioner - Physician Assistant
Denominator: The number of adults ages 20 through 44 and 45 through 64 enrolled in SoonerCare Choice for 11 or 12 months of the calendar year, including on the "anchor date" (December 31 of the calendar year), with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: Demonstration year 2013 preventive health access rate for adult age cohorts.
Reporting Frequency: OHCA compiles HEDIS® data on a calendar year basis and reports data six to nine months after the close of the calendar year.
Statistical Analysis: OHCA will determine whether a change (increase or decrease) from one year to the following year is statistically significant. The HEDIS® data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 3
Hypothesis 3: PCP Enrollments *This hypothesis directly relates to SoonerCare Choice waiver objective #2 and #1 of CMS's Three Part Aim.* The number of SoonerCare primary care practitioners enrolled as medical home PCPs will maintain at or above the baseline data between 2015 - 2016.
Research Methodology: SoonerCare Choice PCPs are calculated by counting the number of service locations of individual providers who are contracted as Choice PCPs and the number of members of group practices that are contracted as Choice PCPs.
Population Studied: Contracted SoonerCare Choice PCPs.
Data Source: Provider Fast Facts
Baseline Data: Demonstration year 2013. (December 2013 – 2,067)
Reporting Frequency: The OHCA Reporting and Statistics unit compiles the Provider Fast Facts on a monthly basis.

Hypothesis 3b
Hypothesis 3b: PCP Enrollments Insure Oklahoma *This hypothesis directly relates to SoonerCare Choice waiver objective #2 and #1 of CMS's Three Part Aim.* The number of Insure Oklahoma practitioners enrolled as PCPs will maintain at or above the baseline data between 2015 - 2016.
Research Methodology: Insure Oklahoma PCPs are calculated by counting the number of service locations of individual providers who are contracted as Insure Oklahoma PCPs and the number of members of group practices that are contracted as Insure Oklahoma PCPs.
Population Studied: Contracted Insure Oklahoma PCPs.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: Demonstration year 2013. (January-March 2013 – 1,514)
Reporting Frequency: The OHCA Reporting and Statistics unit compiles the data report from the Oklahoma Medicaid Management Information System on a quarterly basis.

Hypothesis 4
Hypothesis 4: PCP Capacity Available *This hypothesis directly relates to SoonerCare Choice waiver objectives #1 and #2, and #1 of CMS's Three Part Aim.* There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. The available capacity will equal or exceed the baseline capacity data over the duration of the waiver extension period.
Research Methodology: Capacity will be calculated in terms of total capacity and the average number of SoonerCare Choice members per PCP.
Population Studied: SoonerCare Choice members.
Numerators: The total number of SoonerCare Choice members in each measurement month.
Denominators: The total contracted capacity across SoonerCare Choice PCPs, as recorded in the provider subsystem of the Medicaid Management Information System.
Data Resources: The total contracted capacity, as recorded in the Medicaid Management Information System, as derived from PCP contract data; and the average number of members per PCP, calculated by dividing the total number of members in the measurement month by the total number of contracted PCPs in that same month.
Data Sources: Oklahoma Medicaid Management Information System.
Baseline Data: December 2013 total contracted capacity (1,149,541) and average members per PCP (268.72).
Reporting Frequency: The OHCA Reporting and Statistics unit compiles the Provider Fast Facts on a monthly basis.
Statistical Analysis: The data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 5
Hypothesis 5: PCP Availability *This hypothesis directly relates to SoonerCare Choice waiver objectives #1 and #2, and #1 of CMS's Three Part Aim.* There will be adequate PCP capacity to meet the health care needs of the SoonerCare members with Children's Health Insurance Program (CHIP) eligibility between 2015 - 2016. Also, as perceived by the member, the time it takes to schedule an appointment should improve between 2015 - 2016. As perceived by the member, the time it takes for the member to schedule an appointment should exceed the baseline data between 2015 - 2016.
Research Methodology: The member's perception of timeliness to schedule an appointment will be calculated using OHCA's External Quality Review contractor who will conduct a CAHPS® member survey, and include a question relating to the time it takes to schedule an appointment.
Population Studied: A. SoonerCare Choice members. B. A sample group from the SoonerCare Choice population, who meet certain eligibility criteria.
Numerators: The total number of qualified members who give a positive response to the CAHPS® survey question relating to the time it takes to schedule an appointment.
Denominators: The total number of qualified members who complete the CAHPS® survey question relating to the time it takes to schedule an appointment.
Data Resources: Survey responses collected through mail and telephone will be systematically entered into a central database. Once the survey collection period ends, the statistical analysis software SAS® will be used with the CAHPS® Analysis Program to complete the necessary cleaning and preparation of the data as well as the analysis. The survey responses will be recorded in order to perform the necessary calculations using assigned numeric values from the CAHPS® Survey and Reporting Kit.
Data Sources: A. Oklahoma Medicaid Management Information System. B. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0 Medicaid Adult or Child Member Satisfaction Surveys
Baseline Data: CAHPS® survey, July 2013
Reporting Frequency: A. The OHCA receives the data quarterly, no later than 90 days after close of the measurement period. B. The CAHPS® survey is reported annually on a state fiscal year basis.

Hypothesis 5
Statistical Analysis: OHCA's vendor for the CAHPS® member survey will determine whether a change (increase or decrease) from one year to the following year is statistically significant. The data will be analyzed using a statistical procedure called the test of two independent proportions, or a z-test. The z-test determines the value of the number of standard deviations between the two proportions.

Hypothesis 6
Hypothesis 6: Integration of Indian Health Services, Tribal Clinics, and Urban Indian Clinic Providers *This hypothesis directly relates to SoonerCare Choice waiver objective #4, and #1 of CMS's Three Part Aim.* The percentage of American Indian members who are enrolled with an Indian Health Services, Tribal, or Urban Indian Clinic (I/T/U) with a SoonerCare Choice American Indian primary care case management contract will improve during the 2015 - 2016 waiver period.
Research Methodology: The American Indian SoonerCare Choice enrollment percentage will be calculated based on PCP assignment data.
Population Studied: American Indian SoonerCare Choice members who are enrolled with an Indian Health Services, Tribal or Urban Indian Clinic (I/T/U) with a SoonerCare American Indian primary care case management contract.
Numerator: The total number of SoonerCare Indian Health Services enrollees in December of each measurement year who have an I/T/U PCP.
Denominator: The total number of SoonerCare Indian Health Service's enrollees in December of each measurement year.
Data Resource: The total I/T/U contracted capacity, as recorded in the MMIS from PCP contract data. The member PCP alignment data, as recorded in the eligibility subsystem of the MMIS.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: Total contracted I/T/U capacity in December 2013 (99,400) and percentage of SoonerCare IHS enrollees with an I/T/U PCP in December 2013 (22.48 percent).
Reporting Frequency: The OHCA Reporting and Statistics unit compiles the Provider Fast Facts on a monthly basis as well as data report from the Oklahoma Medicaid Management Information System on a quarterly basis.

Hypothesis 7
Hypothesis 7: Impact of Health Access Networks on Quality of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #2 of CMS's Three Part Aim.* Key quality performance measures, asthma and Emergency Room (ER) utilization, tracked for PCPs participating in the HANs will improve between 2013-2015. A. Decrease asthma-related ER visits for HAN members with an asthma diagnosis identified in their medical record. B. Decrease 90-day readmissions for related asthma conditions for HAN members with an asthma diagnosis identified in their medical record. C. Decrease overall ER use for HAN members.
Research Methodology: A. ER visits will be reviewed to identify ER visits related to an asthma diagnosis and compared to HAN members with asthma identified as a problem in their medical records. ER visits for unrelated illnesses will not be included in the measure. B. Readmissions that occurred within 90 days of first admission will be reviewed to identify readmissions related to an asthma diagnosis and compared to HAN members with asthma identified as a problem in their medical records. Readmissions for unrelated illnesses will not be included in the measure. C. ER visits will be reviewed for all HAN members regardless of reason.
Population Studied: Members in the HAN.
Numerator: A. Total number of ER visits by HAN members with asthma identified in their problem list for an asthma-related diagnosis. B. Total number 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. C. Total number of ER visits for HAN members.
Denominator: A. All HAN members with an asthma diagnosis identified in their medical record. B. All HAN members with an asthma diagnosis identified in their medical record and having at least one inpatient stay related to asthma. C. All HAN members.
Data Resource: Claims data as recorded in the claims subsystem of the Medicaid Management Information System. Patient data recorded in electronic medical records, community Health Information Exchange (HIE), medical record or self-report by providers.
Data Source: Oklahoma Medicaid Management Information System. Provider electronic medical record, medical record, HIE, and self-report by providers in absence of access to EMR or HIE.
Baseline Data: A. The number of ER visits for HAN members continuously enrolled in the HAN for at least 90 days with a related diagnosis of asthma for CY2013 will serve as the numerator for baseline

Hypothesis 7
data. The number of ER visits for HAN members continuously enrolled in the HAN for at least 90 days for CY2013 will serve as the denominator for baseline data. B. The number of HAN members continuously enrolled in the HAN for at least 90 days 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 for CY 2013 will serve as the numerator for baseline data. The number of HAN members continuously enrolled in the HAN for at least 90 days with an asthma diagnosis identified in their medical record and having at least one inpatient stay related to asthma for CY 2013 will serve as the denominator for baseline data. C. The number of ER Visits for any cause for HAN members continuously enrolled in the HAN for at least 90 days for CY 2013 will serve as the numerator for baseline data. The number of ER Visits for any cause for HAN members continuously enrolled in the HAN for at least 90 days for CY 2013 will serve as the denominator for baseline data.
Reporting Frequency: The HANs will perform and submit quarterly data during each calendar year as well as evaluate results annually.

In addition to the hypothesis, the HANs will include in their annual report an analysis of the HANs effectiveness in:

- Improving access to and the availability of health care services to SoonerCare beneficiaries served by the HAN;
- Improving the quality and coordination of health care services to SoonerCare beneficiaries served by the HAN with specific focus on the populations at greatest risk including those with multiple chronic illnesses; and
- Enhancing the state's patient-centered medical home program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance, and cost.

Hypothesis 8
Hypothesis 8: Impact of Health Access Networks on Effectiveness of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3 and #3 of CMS's Three Part Aim.* Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HANs. Average per member per month expenditures for members belonging to a HAN affiliated PCP will continue to be less than those members enrolled with non-HAN affiliated PCPs during the period of 2013-2015.
Research Methodology: A PMPM comparison will be calculated between Choice members' whose PCPs are in a HAN and those members PCPs who do not participate in a HAN.
Population Studied: SoonerCare Choice members' whose PCPs are in a HAN and SoonerCare Choice members PCPs not participating in a HAN.
Numerator: A. The monthly total of paid claims, care coordination payments, HAN network payments, and Sooner Excel payments for members whose PCPs belong to a HAN. B. The monthly total of paid claims, care coordination payments, and Sooner Excel payments for members whose PCPs do not belong to a HAN.
Denominator: A. Member months for all PCPs in a HAN. B. Member months for all PCPs not in a HAN.
Data Source: Oklahoma Medicaid Management Information System.
Baseline Data: PMPM comparison for SFY 2012.
Reporting Frequency: Completed on a yearly basis three to four months after the end of each state fiscal year.

Evaluation of the Health Management Program
OHCA discusses the goals, objectives, and specific hypotheses that are being tested through the Health Management (HMP) program.

OHCA and the HMP contractor will partner together to evaluate the effectiveness of the HMP program as it relates to the HMP program goals and CMS's three-part aim.

2016 HMP program Objectives:

- Improving health outcomes and reducing medical costs of the population served;
- Reducing the incidence and severity of chronic disease in the member population;
- Encouraging and enabling members to better manage their own health;
- Improving the effectiveness of providers in caring for members with chronic disease or at risk for such disease; and
- Having the ability to provide services to providers and members in any area of the state, urban or rural.

CMS's Three Part Aim:

- Improving access to and experience of care;
- Improving quality of health care; and
- Decreasing per capita costs.

Hypothesis 9a
Hypothesis 9a: Health Management Program (HMP); Impact on Enrollment Figures *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3, and #1 of CMS's Three Part Aim.* The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will maintain enrollment and active participation in the program.
Research Methodology: The number for population item A will be calculated using data provided by the program contractor (Telligen) on the number of members identified as engaged in nurse care management. The number for population item B will be calculated using data provided by overall PCP assignment data provided by the OHCA.
Population Studied: A. SoonerCare Choice members identified as engaged in nurse care management. B. SoonerCare Choice members whose PCP has undergone practice facilitation.
Population Studied: The number of members actively engaged in nurse care management.
Data Resource: SoonerCare HMP contractor (Telligen) and OHCA.
Data Source: Monthly rosters denoting PCP panel assignment and members engaged in nurse care management.
Baseline Data: Participation data for SFY2013 (Phase II of the SoonerCare HMP began).
Reporting Frequency: Telligen will submit monthly reports to the OHCA and the OHCA will prepare quarterly PCP assignment reports.

Hypothesis 9b
Hypothesis 9b: Health Management Program (HMP); Impact on Access to Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2, and #1 of CMS's Three Part Aim.* The incorporation of Health Coaches into primary care practices will result in increased PCP contact with nurse care managed members for preventive/ambulatory care.
Research Methodology: The contact rates will be calculated through analysis of visit activity, as derived from paid claims data, for members identified by the program contractor (Telligen) as engaged in nurse care management.
Population Studied: SoonerCare Choice members who receive nurse care management.
Numerator: SoonerCare Choice members who receive nurse care management and are 20 years old and older who had an ambulatory or preventive care visit during the measurement year.
Denominator: SoonerCare Choice members who receive nurse care management and are 20 years old and older.
Data Resource: SoonerCare HMP contractor (Telligen) and MMIS contractor (HP).
Data Source: Monthly roster of members engaged in nurse care management. Monthly paid claims extract.
Baseline Data: SoonerCare Choice members who receive nurse care management and are 20 years old and older who had an ambulatory or preventive care visit in SFY14.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9c
Hypothesis 9c: Health Management Program (HMP); Impact on Identifying Appropriate Target Population *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #2, and #2 of CMS's Three Part Aim.* The implementation of phase two of the SoonerCare HMP, including introduction of physician office-based Health Coaches for nurse care managed members and closer alignment of nurse care management and practice facilitation will improve the process for identifying qualified members and result in an increase in average complexity of need within the nurse care managed population.
Research Methodology: The type and number of physical and behavioral health chronic conditions for engaged members will be analyzed using diagnosis codes from paid claims data.
Population Studied: SoonerCare Choice members in nurse care management.
Numerator: A. Number of members engaged in nurse care management at any time in a 12-month period with 2, 3, 4, etc. chronic physical health conditions. B. Number of members engaged in nurse care management at any time in a 12-month period with at least one chronic physical health condition and one behavioral health condition.
Denominator: A. Total members engaged in nurse care management for the 12-month period. B. Total members engaged in nurse care management for the 12-month period.
Data Resource: SoonerCare HMP contractor (Telligen) and MMIS contractor (HP).
Data Source: Monthly rosters denoting members engaged in nurse care management and monthly paid claims extracts.
Baseline Data: Same metrics for nurse care managed population in SFY2013.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9d
Hypothesis 9d: Health Management Program (HMP); Impact on Health Outcomes *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.* Health Coaches will improve quality measures for members who are engaged.
Research Methodology: The percentage of engaged members documented as compliant on diagnosis-specific quality measures and preventive health measures will be analyzed and trended over time. Measures will be derived from the Initial Set of Health Care Quality Measures for Medicaid-Qualified Adults and CHIPRA Core Set of Children's Healthcare Quality Measures.
Population Studied: SoonerCare Choice members who receive nurse care management.
Numerator: Sum of measures across all reporting practices documented as compliant on each quality measure (separate analysis for each measure).
Denominator: Sum of members across all reporting practices.
Data Resource: SoonerCare HMP contractor (Telligen), MEDai and MMIS contractor (HP).
Data Source: Monthly extract from claims data.
Baseline Data: Same metrics for nurse care managed population in SFY2013 for measures reported that year. SFY2014 metrics for new measures.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports, MEDai and MMIS data runs will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9e
Hypothesis 9e: Health Management Program (HMP); Impact on Cost/Utilization of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.* Nurse care managed members will utilize the emergency room at a lower rate than forecasted without nurse care management intervention.
Research Methodology: Emergency room utilization rates will be calculated through analysis of paid claims data as reported on a per 1,000 member basis.
Population Studied: SoonerCare Choice members who receive nurse care management (actual vs. forecasted).
Numerator: Total emergency room visits over a 12-month period for members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY2014 (actual).
Denominator: Total emergency room visits over a 12-month period for members engaged in nurse care management for at least a 3 month continuous period within the 12 months. Starting in SFY 2014 (forecasted).
Data Resource: SoonerCare HMP contractor (Telligen), MEDai and MMIS contractor (HP).
Data Source: Monthly rosters of members engaged in nurse care management. Monthly paid claims extract and MEDai data runs.
Baseline Data: Emergency room visit rate per 1,000 engaged members (actual vs. forecasted) group members in SFY2014.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports, MEDai and MMIS data runs will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9f
Hypothesis 9f: Health Management Program (HMP); Impact on Cost/Utilization of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #2 of CMS's Three Part Aim.* Nurse care managed members will have fewer hospital admissions than forecasted without nurse care management intervention.
Research Methodology: Hospital admission rates will be calculated through analysis of paid claims data and reported on a per 1,000 member basis.
Population Studied: SoonerCare Choice members who receive nurse care management (forecasted vs. actual).
Numerator: Total hospital admissions in a 12-month period for members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY2015 (actual).
Denominator: Total hospital admissions in a 12-month period for members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY 2014 (forecasted).
Data Resource: SoonerCare HMP contractor (Telligen), MEDai and MMIS contractor (HP).
Data Source: Monthly rosters of members engaged in nurse care management. Monthly paid claims extract and MEDai data runs.
Baseline Data: Hospital admission rate per 1,000 engaged members (actual vs. forecasted) in SFY2014.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports, MEDai and MMIS data runs will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9g
Hypothesis 9g: Health Management Program (HMP); Impact on Satisfaction/Experience with Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #3, and #2 of CMS's Three Part Aim.* Nurse care managed members will report high levels of satisfaction with their care.
Research Methodology: Nurse care managed members will be surveyed regarding their satisfaction with their personal provider and overall health care. The survey will include validated questions derived from the CAHPS® instrument.
Population Studied: SoonerCare Choice members who receive nurse care management.
Numerator: Nurse care managed members surveyed in a 12-month period and reporting positive satisfaction levels.
Denominator: Total nurse care managed members surveyed in a 12-month period.
Data Resource: SoonerCare HMP contractor (Telligen) and independent evaluator.
Data Source: Monthly rosters denoting members engaged in nurse care management. Survey data collected by independent evaluator.
Baseline Data: Satisfaction rates for engaged members SFY2014.
Reporting Frequency: Telligen will provide monthly rosters to the independent evaluator for use in contacting survey respondents. Findings will be presented in the annual progress report prepared by the evaluator.

Hypothesis 9h
Hypothesis 9h: Health Management Program (HMP); Impact of HMP on Effectiveness of Care *This hypothesis directly relates to SoonerCare Choice waiver objective #3, HMP objective #1, and #3 of CMS's Three Part Aim.* Total and PMPM expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.
Research Methodology: Actual expenditures for nurse care managed members will be calculated and compared to forecasted expenditures as derived through MEDai predictive modeling software. In order to measure the program's true cost effectiveness, the actual expenditures will include both paid claims and administrative expenses (vendor payments and OHCA salary/overhead expenses) associated with the nurse care management portion of the HMP.
Population Studied: SoonerCare Choice members who receive nurse care management (actual vs. forecasted).
Numerator: Total and PMPM expenditures incurred over a 12-month period by members engaged in nurse care management for at least a 3-month continuous period within the 12 months, starting in SFY2014 (actual).
Denominator: Total and PMPM projected health expenditures in the initial 12-month period for nurse care managed members, as calculated by MEDai predictive modeling software (forecasted).
Data Source: Monthly rosters of members engaged in nurse care management. Monthly MEDai expenditure forecasts for the same population. Monthly paid claims extract. Vendor payment and OHCA administrative expense data.
Baseline Data: Total projected health expenditures in the initial 12-month period for nurse care managed members.
Reporting Frequency: Telligen will submit monthly reports to the OHCA. The Telligen reports, MEDai data runs and paid claims extracts will be provided to the SoonerCare HMP independent evaluator. Findings will be presented in the annual progress report prepared by the evaluator.

Creative Minds. Intelligent Solutions.

morpace Market Research & Consulting

2016 CAHPS® Child Medicaid Survey Executive Summary

Oklahoma Health Care Authority

June 2016

Oklahoma HealthCare Authority

Morpace research is completed in compliance with ISO 20252

Table of Contents

Executive Summary

Background and Protocol

Background

- CAHPS® measures health care consumers' satisfaction with the quality of care and customer service provided by their health plan. Plans which are collecting HEDIS® (Healthcare Effectiveness Data and Information Set) data for NCQA accreditation are required to field the CAHPS® survey among their eligible populations.

Protocol

- For CAHPS® results to be considered in HEDIS® results, the CAHPS® 5.0H survey must be fielded by an NCQA (National Committee for Quality Assurance)-certified survey vendor using an NCQA-approved protocol of administration in order to ensure that results are collected in a standardized way and can be compared across plans. Standard NCQA protocols for administering CAHPS® 5.0H include a mixed-mode mail/telephone protocol and a mail-only protocol.

- The protocol includes the following:

Pre-notification postcard mailed (optional)

Questionnaire with cover letter and business reply envelope (BRE) mailed

Internet link included on cover letter (optional)

1st reminder postcard mailed

Replacement questionnaire with cover letter and BRE to all non-responders

Internet link included on cover letter (optional)

2nd reminder postcard mailed

Telephone interviews conducted with non-responders (min of 3/max of 6 attempts)

- Oklahoma Health Care Authority chose the mail/telephone/Internet protocol.

Executive Summary

Sample

- NCQA originally designed this protocol with the goal of achieving a total response rate of at least 45%. In 2015, the average response rate for all Child Medicaid plans reporting to NCQA was 27%, which is lower than the 2014 average (28%).
- In February, 2073 Oklahoma Health Care Authority members were randomly selected to participate in the 2016 CAHPS® 5.0H Child Medicaid Survey. The survey results presented in this report are compiled from the 441 Oklahoma Health Care Authority members who responded to the survey.

	Sample Size	Total Completes	English Completes	Spanish Completes
Oklahoma Health Care Authority	2073	441	410	31

Executive Summary

Disposition Summary and Response Rate

- A response rate is calculated for those members who were eligible and able to respond.
- A completed questionnaire is defined as a respondent who completed three of the five required questions that all respondents are eligible to answer (question # 3, 15, 27, 31, 36).
- According to NCQA protocol, ineligible members include those who are deceased, do not meet eligible criteria, have a language barrier, are either mentally or physically incapacitated, or duplicate household to another member selected in the sample.
- Non-responders include those members who refuse to participate in the current year's survey, could not be reached due to a bad address or telephone number, members that reached a maximum attempt threshold without a response, or members that did not meet the completed survey definition.
- The table below shows the total number of members in the sample that fell into each of the various disposition categories.

Oklahoma Health Care Authority
2016 Disposition Summary

Ineligible	Number
Deceased (M20/T20)	0
Does not meet criteria (M21/T21/I21)	21
Language barrier (M22/T22)	13
Mentally/physically incapacitated (M24/T24)	0
Sample duplicates (IDI/ID2)	10
Total Ineligible	**44**

Non-response	Number
Bad address/phone (M23/T23)	144
Partial complete (M31/T31/I31)	7
Refusal (M32/T32)	78
Maximum attempts made (M33/T33)	1359
Total Non-response	**1588**

- Ineligible surveys are subtracted from the sample size when computing a response rate (see below):

$$\frac{\textit{Completed mail, telephone and Internet surveys}}{\textit{Sample size - Ineligible surveys}} = \textit{Response Rate}$$

- Using the final figures from Oklahoma Health Care Authority's Child Medicaid survey, the 2016 response rate is calculated using the equation below:

$$\frac{\textit{Mail completes } (247) + \textit{Phone completes } (167) + \textit{Internet completes } (27)}{\textit{Total Sample } (2073) - \textit{Total Ineligible } (44)} = \frac{441}{2029} = \textit{Response Rate} = \mathbf{22\%}$$

Executive Summary
Summary of Key Measures

- For purposes of reporting the CAHPS® results, the National Committee for Quality Assurance (NCQA) uses 5 composite measures and 4 rating questions from the survey.
- Each of the composite measures is the average of 2 - 4 questions on the survey, depending on the measure, while each rating score is based on a single question. CAHPS® scores are most commonly shown using Summary Rate scores (percentage of positive responses).

Oklahoma Health Care Authority				
	Trended Data			
Composite Measures	**2013**	**2014**	**2015**	**2016**
Getting Care Quickly	93%	92%	92%	93%
Shared Decision Making	NT	NT	78%	78%
How Well Doctors Communicate	93%	97%	96%	97%
Getting Needed Care	89%	89%	85%	89%
Customer Service	84%	88%	86%	86%
Overall Rating Measures				
Health Care	82%	85%	87%	88%
Personal Doctor	85%	88%	89%	89%
Specialist	89%	89%	88%	83%
Health Plan	84%	86%	86%	86%
Health Promotion & Education	68%	69%	67%	70%
Coordination of Care	77%	82%	86%	89%
Sample Size	*1650*	*1650*	*1980*	*2073*
# of Completes	*549*	*357*	*500*	*441*
Response Rate	*34%*	*22%*	*25%*	*22%*

Legend: ↑/↓ Statistically higher/lower compared to prior year results.
NT=Data not trendable

Executive Summary

Scoring for NCQA Accreditation (Includes How Well Doctors Communicate)

				2016 NCQA National Accreditation Comparisons*					
				Below 25th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l	
			Accreditation Points	***0.33***	***0.65***	***1.11***	***1.43***	***1.63***	
Composite Scores	**Sample Size**	**Mean**	**Approximate Percentile Threshold**						***Approximate Score***
Getting Care Quickly	(n=237)	**2.662**	75th		2.54	2.61	2.66	2.69	***1.43***
How Well Doctors Communicate	(n=305)	**2.783**	90th		2.63	2.68	2.72	2.75	***1.63***
Getting Needed Care	(n=213)	**2.554**	75th		2.39	2.47	2.53	2.58	***1.43***
Customer Service	(n=121)	**2.424**	Below 25th		2.50	2.53	2.58	2.63	***0.33***
Overall Ratings Scores									
Q13 Health Care	(n=340)	**2.591**	90th		2.49	2.52	2.57	2.59	***1.63***
Q26 Personal Doctor	(n=389)	**2.697**	90th		2.58	2.62	2.65	2.69	***1.63***
Q30 Specialist***	(n=83)	**0.000**	NA		2.53	2.59	2.62	2.66	***NA***
			Accreditation Points	***0.65***	***1.30***	***2.21***	***2.86***	***3.25***	
Q36 Health Plan	(n=434)	**2.622**	75th		2.51	2.57	2.62	2.67	***2.86***
								Estimated Overall CAHPS® Score:	**10.94**

NOTE: NCQA begins their calculation with an unadjusted raw score showing six digits after the decimal and then compares the adjusted score to their benchmarks and thresholds (also calculated to the sixth decimal place). Starting in 2015, NCQA will no longer use an adjusted score. This report displays accreditation points and scores with only two digits after the decimal. Therefore, the estimated overall CAHPS® score may differ from the sum of the individual scores due to rounding and could differ slightly from official scores provided by NCQA. The CAHPS® measures account for 13 points towards accreditation.

*Data Source: **NCQA Memorandum of January 21, 2016**. Subject: 2016 Accreditation Benchmarks and Thresholds.

*** Not reportable due to insufficient sample size.

Executive Summary

Scoring for NCQA Accreditation (Includes Care Coordination)

				2016 NCQA National Accreditation Comparisons*					
					Below 25th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l
			Accreditation Points	***0.33***	***0.65***	***1.11***	***1.43***	***1.63***	
Composite Scores	**Sample Size**	**Mean**	**Approximate Percentile Threshold**						***Approximate Score***
Getting Care Quickly	(n=237)	**2.662**	75th		2.54	2.61	2.66	2.69	***1.43***
Getting Needed Care	(n=213)	**2.554**	75th		2.39	2.47	2.53	2.58	***1.43***
Customer Service	(n=121)	**2.424**	Below 25th		2.50	2.53	2.58	2.63	***0.33***
Care Coordination	(n=136)	**2.463**	75th		2.36	2.41	2.46	2.51	***1.43***
Overall Ratings Scores									
Q13 Health Care	(n=340)	**2.591**	90th		2.49	2.52	2.57	2.59	***1.63***
Q26 Personal Doctor	(n=389)	**2.697**	90th		2.58	2.62	2.65	2.69	***1.63***
Q30 Specialist***	(n=83)	**0.000**	NA		2.53	2.59	2.62	2.66	***NA***
			Accreditation Points	***0.65***	***1.30***	***2.21***	***2.86***	***3.25***	
Q36 Health Plan	(n=434)	**2.622**	75th		2.51	2.57	2.62	2.67	***2.86***
								Estimated Overall CAHPS® Score:	**10.74**

NOTE: NCQA begins their calculation with an unadjusted raw score showing six digits after the decimal and then compares the adjusted score to their benchmarks and thresholds (also calculated to the sixth decimal place). Starting in 2015, NCQA will no longer use an adjusted score. This report displays accreditation points and scores with only two digits after the decimal. Therefore, the estimated overall CAHPS® score may differ from the sum of the individual scores due to rounding and could differ slightly from official scores provided by NCQA. The CAHPS® measures account for 13 points towards accreditation.

*Data Source: **NCQA Memorandum of January 21, 2016**. Subject: 2016 Accreditation Benchmarks and Thresholds.

*** Not reportable due to insufficient sample size.

Executive Summary
Comparison to Quality Compass®

	Oklahoma Health Care Authority	2015 Child Medicaid Quality Compass® Comparisons*						
		5th Nat'l	10th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l	95th Nat'l
Composite Scores		%	%	%	%	%	%	%
Getting Care Quickly *(% Always/Usually)*	**93.01%**	**79.93**	**82.51**	**85.94**	**89.61**	**92.30**	**93.65**	**94.33**
Shared Decision Making *(% Yes)*	**78.41%**	**68.18**	**72.77**	**75.76**	**78.91**	**80.88**	**82.61**	**83.50**
How Well Doctors Communicate *(% Always/Usually)*	**97.14%**	**89.33**	**89.91**	**91.84**	**93.53**	**94.64**	**95.65**	**96.02**
Getting Needed Care *(% Always/Usually)*	**89.28%**	**76.72**	**78.92**	**81.38**	**85.01**	**87.83**	**89.67**	**90.65**
Customer Service *(% Always/Usually)*	**86.03%**	**82.09**	**83.31**	**85.96**	**87.67**	**89.43**	**91.06**	**91.63**
Overall Ratings Scores								
Q13 Rating of Health Care (% 8, 9, 10)	**87.94%**	**80.94**	**81.55**	**83.39**	**85.39**	**87.02**	**88.07**	**88.69**
Q26 Rating of Personal Doctor (% 8, 9, 10)	**88.95%**	**84.21**	**84.91**	**86.89**	**88.34**	**89.66**	**90.78**	**92.16**
Q30 Rating of Specialist (% 8, 9, 10)	**83.13%**	**79.29**	**80.95**	**82.91**	**84.81**	**87.27**	**90.00**	**90.76**
Q36 Rating of Health Plan (% 8, 9, 10)	**85.71%**	**76.85**	**79.57**	**81.95**	**84.79**	**87.05**	**89.22**	**90.06**

*Data Source: 2015 Child Medicaid Quality Compass®. Scores above based on 95 public and non-public reporting health plan products (All Lines of Business excluding PPOs).

= Plan score falls below 5th Percentile

Executive Summary

Action Plan – Rating of Health Plan

A Key Driver Analysis is conducted to understand the impact that different aspects of plan service and provider care have on members' overall satisfaction with their health plan, their personal doctor, their specialist, and health care in general. Two specific scores are assessed both individually and in relation to each other. These are:

1. The relative importance of the individual issues (Correlation to overall measures)
2. The current levels of performance on each issue (Percentile group in Quality Compass®)

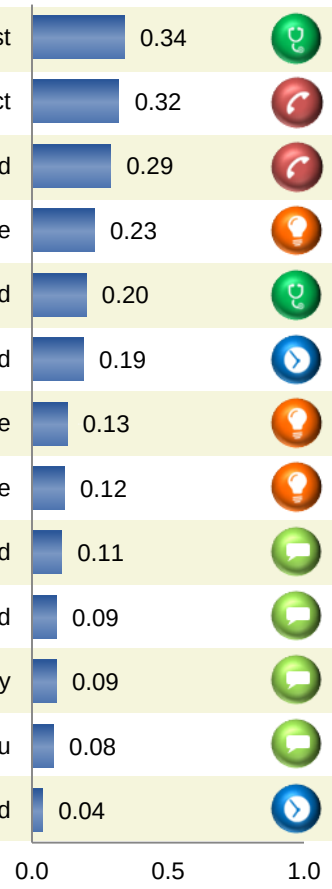
Items that are a High Priority for Improvement are those measures that are highly correlated to the overall measure, and the plan's scores are below the 50th percentile of Quality Compass®. Below is a list of items that are considered a High Priority for Improvement to the Overall Rating of Health Plan as well as the Primary Recommendation for improving this measure. For more ideas on how to improve your scores, please see the *Action Plans for Improving CAHPS® Scores* section of this report.

High Priority for Improvement (High correlation/Relatively low performance)	
Overall Rating of Health Plan	**Primary Recommendation**
Q33 - Treated You with Courtesy and Respect	Operationally define customer service behaviors for Call Center representatives as well as all staff throughout the organization. Train staff on these behaviors.
Q32 - Got Information or Help Needed	On a monthly basis study Call Center reports for reasons of incoming calls and identify the primary drivers of calls. Bring together Call Center representatives and key staff from related operational departments to design interventions to decrease call volume and/or improve member satisfaction with the health plan.

Executive Summary

Key Driver Analysis – Health Plan

Q36. Rating of Health Plan	Composite	Sample Size	Health Plan's Score	Plan's Percentile
Q28. Easy to Get Appointment for Child with Specialist	0.34	87	86.21%	85th
Q33. Treated You with Courtesy and Respect	0.32	121	90.91%	17th
Q32. Got Information or Help Needed	0.29	122	81.15%	41st
Q12. Asked Preference for Medicine	0.23	105	75.24%	23rd
Q14. Easy to Get Care Believed Necessary for Child	0.20	340	92.35%	78th
Q6. Getting Appointment for Child as Soon as Needed	0.19	300	92.33%	88th
Q10. Discussed Reasons to Take Medicine	0.13	105	93.33%	60th
Q11. Discussed Reasons Not to Take Medicine	0.12	105	66.67%	57th
Q22. Spend Enough Time with Child	0.11	306	94.77%	99th
Q17. Explain Things in a Way You Could Understand	0.09	305	98.69%	100th
Q19. Show Respect for What You Had to Say	0.09	306	98.37%	98th
Q18. Listen Carefully to You	0.08	306	96.73%	88th
Q4. Getting Care for Child as Soon as Needed	0.04	174	93.68%	73rd



High Priority for Improvement
(High Correlation/
Lower Quality Compass® Group

Q33 - Treated You with Courtesy and Respect
Q32 - Got Information or Help Needed

Continue to Target Efforts
(High Correlation/
Higher Quality Compass® Group

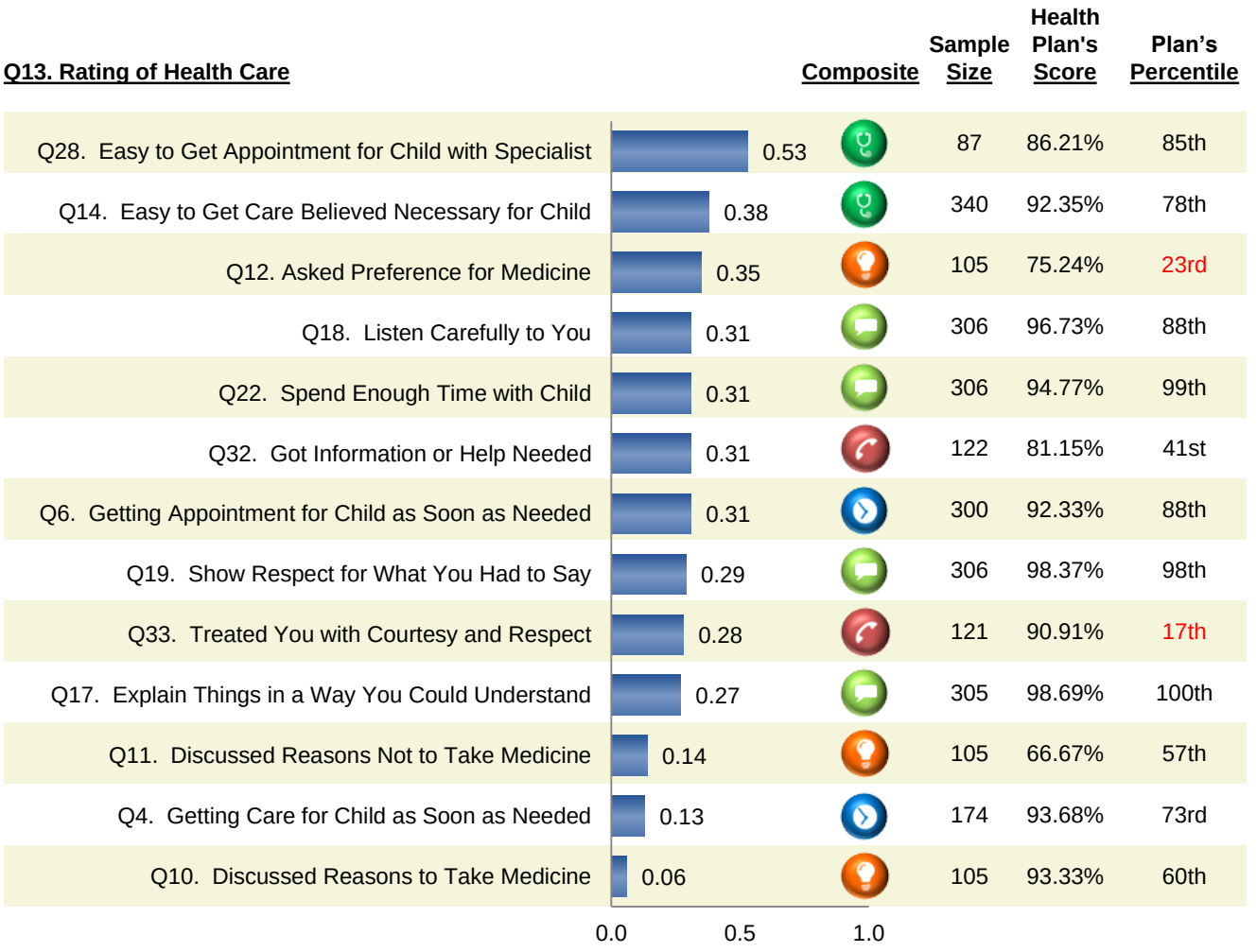
Q28 - Easy to Get Appointment for Child with Specialist

Getting Care Quickly | Shared Decision Making | How Well Doctors Communicate | Getting Needed Care | Customer Service

Use caution when reviewing scores with sample sizes less than 25.
"Health Plan's Score" is the percent of respondents that answered "Always", "Usually"; "Yes"

Executive Summary

Key Driver Analysis – Health Care



High Priority for Improvement
(High Correlation/
Lower Quality Compass® Group

Q12 - Asked Preference for Medicine

Continue to Target Efforts
(High Correlation/
Higher Quality Compass® Group

Q28 - Easy to Get Appointment for Child with Specialist

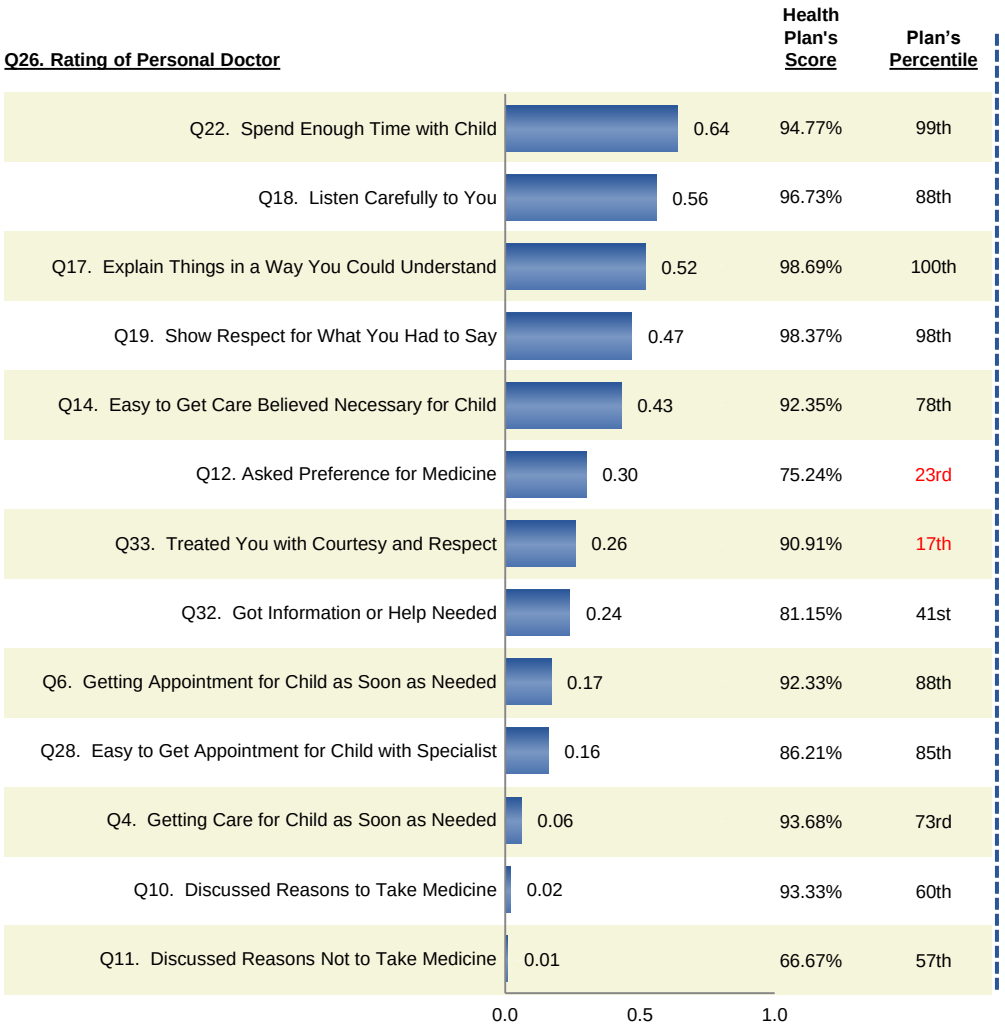
Q14 - Easy to Get Care Believed Necessary for Child

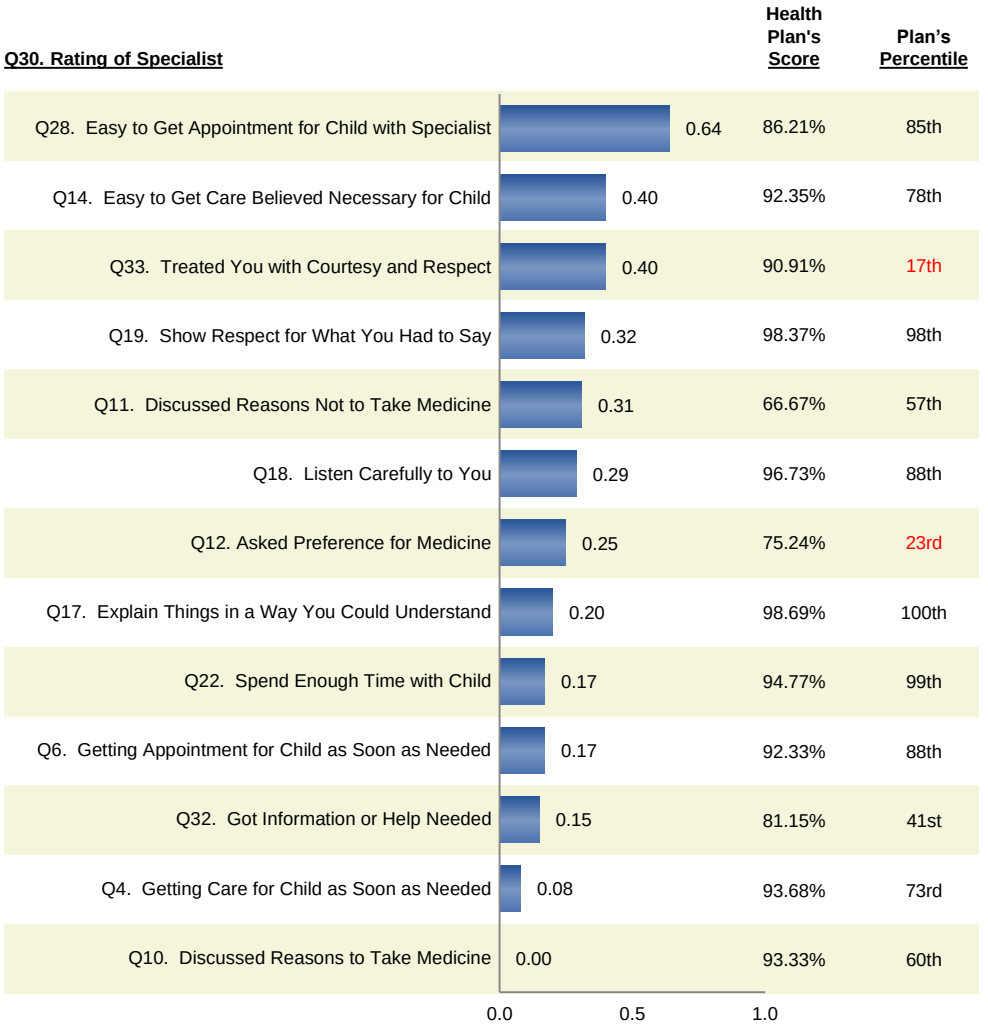
Use caution when reviewing scores with sample sizes less than 25.
"Health Plan's Score" is the percent of respondents that answered "Always", "Usually"; "Yes"

Getting Care Quickly | Shared Decision Making | How Well Doctors Communicate | Getting Needed Care | Customer Service

Executive Summary

Key Driver Analysis – Doctor and Specialist





"Health Plan's Score" is the percent of respondents that answered "Always", "Usually"; "Yes"

Executive Summary

Action Plans for Improving CAHPS® Scores

Morpace has consulted with numerous clients on ways to improve CAHPS® scores. Even though each health plan is unique and faces different challenges, many of the improvement strategies discussed on the next few pages can be applied by most plans with appropriate modifications.

In addition to the strategies suggested below, we suggest reviewing AHRQ's CAHPS® Improvement Guide, an online resource located on the Agency for Healthcare Research and Quality website at:

www.cahps.ahrq.gov/quality-improvement/index.html

Getting Needed Care

- Ease of obtaining appointment with specialist
  - Review panel of specialists to assure that there are an adequate number of specialists and that they are disbursed geographically to meet the needs of your members.
  - Conduct an Access to Care survey with either or both of 2 audiences: physician's office and/or among members.
  - Conduct a CG-CAHPS survey including specialists in the sample to identify the specialists with whom members are having a problem obtaining an appointment.
  - Include supplemental questions on the CAHPS® survey to determine whether the difficulty is in obtaining the initial consult or subsequent appointments.
  - Include a supplemental question on the CAHPS® survey to determine with which type of specialist members have difficulty making an appointment.
  - Utilize Provider Relations staff to question PCP office staff when making a regular visit to determine with which types of specialists they have the most problems scheduling appointments.
  - Develop materials to promote your specialist network and encourage the PCPs to develop new referral patterns that align with the network.

Getting Needed Care

- Ease of obtaining care, tests, or treatment you needed through your health plan
  - Include a supplemental question on the CAHPS® survey to identify the type of care, test or treatment for which the member has a problem obtaining.
  - Review complaints received by Customer Service regarding inability to receive care, tests or treatments.
  - Evaluate pre-certification, authorization, and appeals processes. Of even more importance is to evaluate the manner in which the policies and procedures are delivered to the member, whether the delivery of the information is directly to the member or through their provider. Members may be hearing that they cannot receive the care, tests, or treatment, but are not hearing why.
  - When care or treatment is denied, care should be taken to ensure that the message is understood by both the provider and the member.

Executive Summary

Action Plans for Improving CAHPS® Scores (cont'd)

Getting Care Quickly

- Obtaining care for urgent care (illness, injury or condition that needed care right away) as soon as you needed
- Obtaining an appointment for routine care/check-ups
  - Conduct a CG-CAHPS survey to identify offices with scheduling issues.
  - Conduct an Access to Care Study
    - Calls to physician office - unblinded
    - Calls to physician office – blinded (Secret Shopper)
    - Calls to members with recent claims
    - Desk audit by provider relations staff
  - Develop seminars for physicians' office staff that could include telephone skills (answering, placing a person on hold, taking messages from patients, dealing with irate patients over the phone, etc.) as well as scheduling advice. Use this time to obtain feedback concerning what issues members have shared with the office staff concerning interactions with the plan.
    - These seminars could be offered early morning, lunch times or evenings so as to be convenient for the office staff. Most physicians would be appreciative of having this type of training for their staff as they do not have the time or talents to train their employees in customer service and practice management.

How Well Doctors Communicate

- Doctor explained things in a way that was easy to understand
- Doctor listened carefully
- Doctor showed respect for what member had to say
- Doctor spent enough time with member
  - Conduct a CG-CAHPS survey to identify lower performing physicians for whom improvement plans should be developed.
  - Conduct focus group of members to identify examples of behaviors identified in the questions. Video the groups to show physicians how patients characterize excellent and poor physician performance.
  - Include supplemental questions from the Item Set for Addressing Health Literacy to better identify communication issues.
  - Develop "Questions Checklists" on specific diseases to be used by members when speaking to doctors. Have these available in office waiting rooms.
  - Offer in-service programs with CMEs for physicians on improving communication with patients. This could be couched in terms of motivating patients to comply with medication regimens or to incorporate healthy life-style habits. Research has shown that such small changes as having physicians sit down instead of stand when talking with a patient leads the patient to think that the doctor has spent more time with them.
  - Provide the physicians with patient education materials, which the physician will then give to the patient. These materials could reinforce that the physician has heard the concerns of the patient or that they are interested in the well-being of the patient. The materials might also speak to a healthy habit that the physician wants the patient to adopt, thereby reinforcing the communication and increasing the chances for compliance.
  - Provide communication tips in the provider newsletters. Often, these are better accepted if presented as a testimonial from a patient.

Executive Summary

Action Plans for Improving CAHPS® Scores (cont'd)

Shared Decision Making

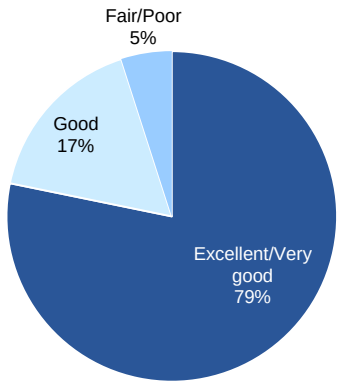
- Doctor talked about reasons you might want to take a medicine
- Doctor talked about reasons you might not want to take a medicine
- Doctor asked you what you thought was best
  - Conduct a CG-CAHPS survey and include the Shared Decision Making Composite as supplemental questions.
  - Develop patient education materials on common medicines described for your members explaining pros and cons of each medicine. Examples: asthma medications, high blood pressure medications, statins.
  - Develop audio recordings and/or videos of patient/doctor dialogues/vignettes on common medications. Distribute to provider panel via podcast or other method.

Health Plan Customer Service

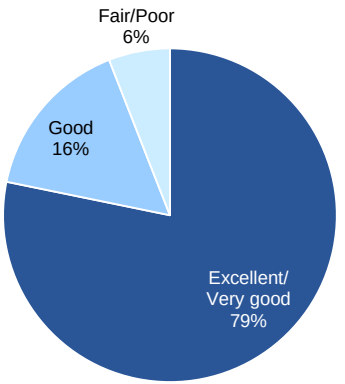
- Customer service gave the information or help needed
- Customer service treated member with courtesy and respect
  - Conduct Call Center Satisfaction Survey. Implement a short IVR survey to members within days of their calling customer service to explore/assess their recent experience.
  - At the end of each Customer Service call, have your representative enter/post the reason for the call. At the end of a month, synthesize the information to discern the major reasons for a call. Have the customer service representatives and other appropriate staff discuss ways to address the reason for the majority of the calls and design interventions so that the reason for the call no longer exists.

Executive Summary
Demographics

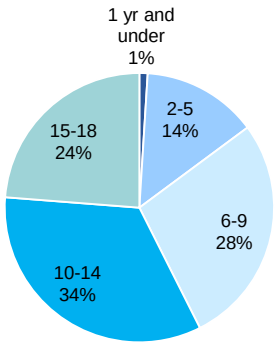
CHILD'S HEALTH STATUS



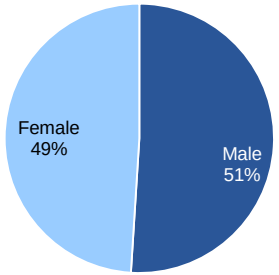
CHILD'S MENTAL/EMOTIONAL HEALTH STATUS



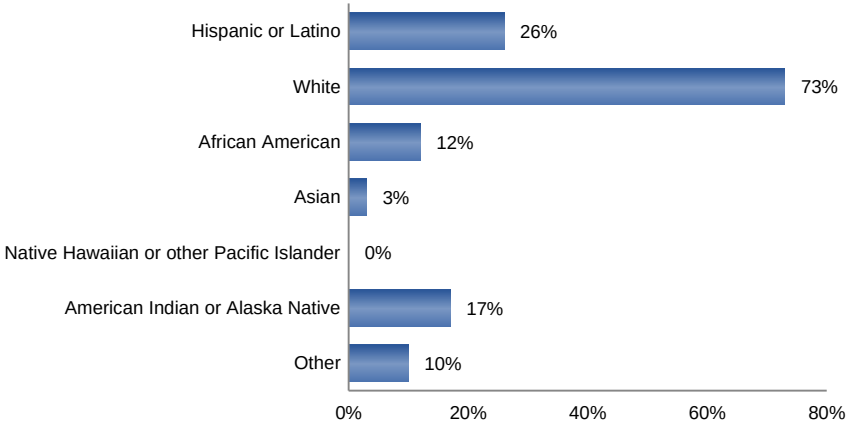
CHILD'S AGE



CHILD'S GENDER



CHILD'S RACE / ETHNICITY



Data shown are self reported.

Executive Summary
Child Demographics

	2013	2014	2015	2016	2015 Quality Compass®
Q37. Child's Health Status					
Excellent/Very good	80%	77%	79%	79%	75%
Good	17%	20%	18%	17%	20%
Fair/Poor	3%	3%	3%	5%	5%
Q38. Child's Mental/Emotional Health Status					
Excellent/Very good	79%	77%	79%	79%	73%
Good	16%	16%	15%	16%	18%
Fair/Poor	5%	7%	6%	6%	9%
Q39. Child's Age					
1 yr and under	2%	1%	3%	1%	NA
2-5	15%	11%	14%	14%	NA
6-9	27%	24%	26%	28%	NA
10-14	33%	39%	34%	34%	NA
15-18	23%	26%	23%	24%	NA
Q40. Child's Gender					
Male	52%	54%	50%	51%	52%
Female	48%	46%	50%	49%	48%
Q41/42. Child's Race/Ethnicity					
Hispanic or Latino	21%	17%	21%	26%	29%
White	68%	71%	73%	73%	44%
African American	11%	9%	12%	12%	19%
Asian	5%	3%	5%	3%	5%
Native Hawaiian or other Pacific Islander	1%	2%	1%	0%	2%
American Indian or Alaska Native	22%	23%	19%	17%	3%
Other	10%	6%	9%	10%	11%

Data shown are self reported.
NA = Data not available

Executive Summary

Respondent Demographics

	2013	2014	2015	2016	2015 Quality Compass®
Q7. Number of Times Going to Doctor's Office/Clinic for Care					
None	23%	23%	23%	21%	24%
1 time	26%	26%	30%	29%	26%
2 times	24%	21%	24%	23%	23%
3 times	13%	14%	13%	13%	12%
4 times	6%	7%	5%	7%	6%
5-9 times	6%	8%	4%	7%	6%
10 or more times	1%	2%	1%	0%	2%
Q16. Number of Times Visited Personal Doctor to Get Care					
None	22%	24%	23%	21%	20%
1 time	31%	30%	36%	36%	32%
2 times	23%	21%	21%	21%	23%
3 times	13%	13%	11%	12%	12%
4 times	4%	6%	5%	4%	6%
5-9 times	5%	6%	4%	5%	6%
10 or more times	1%	1%	1%	1%	1%
Q43. Respondent's Age					
Under 18	5%	7%	3%	4%	8%
18 to 24	5%	1%	3%	2%	7%
25 to 34	35%	27%	33%	32%	32%
35 to 44	33%	41%	38%	43%	31%
45 to 54	18%	17%	14%	14%	15%
55 to 64	4%	7%	6%	3%	5%
65 or older	1%	1%	1%	2%	2%
Q44. Respondent's Gender					
Male	12%	15%	16%	15%	12%
Female	88%	85%	84%	85%	88%
Q45. Respondent's Education					
Did not graduate high school	15%	14%	15%	17%	20%
High school graduate or GED	34%	34%	30%	32%	33%
Some college or 2-year degree	37%	36%	40%	34%	33%
4-year college graduate	10%	11%	10%	11%	9%
More than 4-year college degree	5%	5%	5%	6%	5%

Data shown are self reported.

Executive Summary

General Knowledge about Demographic Differences

The commentary below is based on generally recognized industry knowledge per various published sources:

Age	Older respondents tend to be more satisfied than younger respondents.
Health Status	People who rate their health status as 'Excellent' or 'Very good' tend to be more satisfied than people who rate their health status lower.
Education	More educated respondents tend to be less satisfied.
Race and ethnicity effects are independent of education and income. Lower income generally predicts lower satisfaction with coverage and care.	
Race	Whites give the highest ratings to both rating and composite questions. In general, Asian/Pacific Islanders and American Indian/Alaska Natives give the lowest ratings. Growing evidence that lower satisfaction ratings from Asian Americans are partially attributable to cultural differences in their response tendencies. Therefore, their lower scores might not reflect an accurate comparison of their experience with health care.
Ethnicity	Hispanics tend to give lower ratings than non-Hispanics. Non-English speaking Hispanics tend to give lower ratings than English-speaking Hispanics.

Note: If a health plan's population differs from Quality Compass® in any of the demographic groups, these differences could account for the plan's score when compared to Quality Compass® . For example, if a plan's population rates themselves in better health than the Quality Compass® population, this could impact a plan's score positively. Conversely, if a plan's population rates themselves in poorer health than the Quality Compass® population, the plan's scores could be negatively impacted.

Executive Summary

Composite & Rating Scores by Demographics

Demographic	Child's Age					Child's Race			Child's Ethnicity		Respondent's Educational Level		Child's Health Status		
	1 yr and under	2-5 yrs	6-9 yrs	10-14 yrs	15-18 yrs	White	African American	All other	Hispanic	Non-Hispanic	HS Grad or Less	Some College+	Excellent/ Very Good	Good	Fair/ Poor
Sample size	(n=4)	(n=59)	(n=120)	(n=150)	(n=103)	(n=324)	(n=54)	(n=134)	(n=113)	(n=321)	(n=211)	(n=226)	(n=345)	(n=73)	(n=21)
Composites *(% Always/Usually)*															
Getting Care Quickly	100	86	95	91	99	94	96	89	85	96	91	94	93	90	98
Shared Decision Making *(% Yes)*	100	64	73	79	84	80	67	80	75	79	77	79	75	84	81
How Well Doctors Communicate	88	100	98	96	97	97	98	98	95	98	97	97	98	96	84
Getting Needed Care	100	94	91	85	92	92	92	84	86	91	90	90	93	83	81
Customer Service	0	88	79	87	91	86	97	80	80	89	85	88	87	78	95
Overall Ratings *(% 8,9,10)*															
Health Care	100	86	93	88	84	89	89	84	92	87	91	86	89	89	81
Personal Doctor	100	87	87	89	92	89	89	82	91	88	93	85	89	92	71
Specialist	100	50	96	76	88	83	86	83	100	80	89	80	85	84	80
Health Plan	100	85	88	87	81	87	83	79	95	82	88	83	87	82	81

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morpace Market Research & Consulting

2016 CAHPS® Adult Medicaid Survey Executive Summary

Oklahoma Health Care Authority

June 2016

Oklahoma HealthCare Authority

Morpace research is completed in compliance with ISO 20252

Table of Contents

Executive Summary

Background and Protocol

Background

- CAHPS® measures health care consumers' satisfaction with the quality of care and customer service provided by their health plan. Plans which are collecting HEDIS® (Healthcare Effectiveness Data and Information Set) data for NCQA accreditation are required to field the CAHPS® survey among their eligible populations.

Protocol

- For CAHPS® results to be considered in HEDIS® results, the CAHPS® 5.0H survey must be fielded by an NCQA (National Committee for Quality Assurance)-certified survey vendor using an NCQA-approved protocol of administration in order to ensure that results are collected in a standardized way and can be compared across plans. Standard NCQA protocols for administering CAHPS® 5.0H include a mixed-mode mail/telephone protocol and a mail-only protocol.

- The protocol includes the following:

Pre-notification postcard mailed (optional)

Questionnaire with cover letter and business reply envelope (BRE) mailed

Internet link included on cover letter (optional)

1st reminder postcard mailed

Replacement questionnaire with cover letter and BRE to all non-responders

Internet link included on cover letter (optional)

2nd reminder postcard mailed

Telephone interviews conducted with non-responders (min of 3/max of 6 attempts)

- Oklahoma Health Care Authority chose the mail/telephone/Internet protocol.

Executive Summary

Sample

- NCQA originally designed this protocol with the goal of achieving a total response rate of at least 45%. In 2015, the average response rate for all Adult Medicaid plans reporting to NCQA was 27%, which is lower than the 2014 average (29%).
- In February, 1823 Oklahoma Health Care Authority members were randomly selected to participate in the 2016 CAHPS® 5.0H Adult Medicaid Survey. The survey results presented in this report are compiled from the 474 Oklahoma Health Care Authority members who responded to the survey.

	Sample Size	Total Completes	English Completes	Spanish Completes
Oklahoma Health Care Authority	1823	474	471	3

Executive Summary

Disposition Summary and Response Rate

- A response rate is calculated for those members who were eligible and able to respond.
- A completed questionnaire is defined as a respondent who completed three of the five required questions that all respondents are eligible to answer (question #3,15, 24, 28, 35).
- According to NCQA protocol, ineligible members include those who are deceased, do not meet eligible criteria, have a language barrier, are either mentally physically incapacitated, or duplicate household to another member selected in the sample.
- Non-responders include those members who refuse to participate in the current year's survey, could not be reached due to a bad address or telephone number, members that reached a maximum attempt threshold without a response, or members that did not meet the completed survey definition.
- The table below shows the total number of members in the sample that fell into each of the various disposition categories.

Oklahoma Health Care Authority
2016 Disposition Summary

Ineligible	Number
Deceased (M20/T20)	16
Does not meet criteria (M21/T21/I21)	14
Language barrier (M22/T22)	4
Mentally/physically incapacitated (M24/T24)	21
Sample duplicates (ID1/ID2)	0
Total Ineligible	**55**

Non-response	Number
Bad address/phone (M23/T23)	155
Partial complete (M31/T31/I31)	16
Refusal (M32/T32)	62
Maximum attempts made (M33/T33)	1061
Total Non-response	**1294**

- Ineligible surveys are subtracted from the sample size when computing a response rate (see below):

$$\frac{\textit{Completed mail, telephone and Internet surveys}}{\textit{Sample size - Ineligible surveys}} = \textit{Response Rate}$$

- Using the final figures from Oklahoma Health Care Authority's Adult Medicaid survey, the 2016 response rate is calculated using the equation below:

$$\frac{\textit{Mail completes (344) + Phone completes (112) + Internet completes (18)}}{\textit{Total Sample (1823) - Total Ineligible (55)}} = \frac{474}{1768} = \textit{Response Rate} = \mathbf{27\%}$$

Executive Summary
Summary of Key Measures

- For purposes of reporting the CAHPS® results in HEDIS® (Healthcare Effectiveness Data and Information Set) and for scoring for health plan accreditation, the National Committee for Quality Assurance (NCQA) uses 5 composite measures and 4 rating questions from the survey.
- Each of the composite measures is the average of 2 - 4 questions on the survey, depending on the measure, while each rating score is based on a single question. CAHPS® scores are most commonly shown using Summary Rate scores (percentage of positive responses).

Oklahoma Health Care Authority				
	Trended Data			
Composite Measures	**2013**	**2014**	**2015**	**2016**
Getting Care Quickly	79%	82%	86%	84%
Shared Decision Making	NT	NT	77%	77%
How Well Doctors Communicate	87%	90%	90%	91%
Getting Needed Care	80%	82%	85%	85%
Customer Service	90%	82%	92%	87%
Overall Rating Measures				
Health Care	64%	68%	72%	74%
Personal Doctor	71%	79%↑	80%	81%
Specialist	75%	83%	78%	83%
Health Plan	61%	73%↑	73%	67%
HEDIS® Measures				
Flu Vaccinations***	NA	45%	46%	43%
Advising Smokers and Tobacco Users to Quit*	76%	75%	74%	76%
Discussing Cessation Medications*	45%	48%	49%	50%
Discussing Cessation Strategies*	42%	44%	46%	48%
Aspirin Use**	NR	NR	NR	NR
Discussing Aspirin Risks and Benefits**	NR	NR	NR	NR
Health Promotion & Education	70%	71%	71%	70%
Coordination of Care	77%	83%	79%	79%
Sample Size	*1350*	*1350*	*1823*	*1823*
# of Completes	*414*	*309*	*426*	*474*
Response Rate	*32%*	*23%*	*24%*	*27%*

Legend: ↑/↓ Statistically higher/lower compared to prior year results.
NA=Data not available NT=Data not trendable NR=Data not reportable

*Measure is reported using a Rolling Average Methodology. The score shown is the reportable score for the corresponding year.
**Measure is reported using a Rolling Average Methodology and is not reportable in 2016.
***Question text and age range changed in 2014. This is a single year measure.

Executive Summary

Scoring for NCQA Accreditation (Includes How Well Doctors Communicate)

				2016 NCQA National Accreditation Comparisons*				
				Below 25th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l
			Accreditation Points	***0.29***	***0.58***	***0.98***	***1.27***	***1.44***
Composite Scores	**Sample Size**	**Mean**	**Approximate Percentile Threshold**					***Approximate Score***
Getting Care Quickly	(n=305)	**2.458**	50th		2.36	2.42	2.46	2.49	***0.98***
How Well Doctors Communicate	(n=357)	**2.634**	75th		2.48	2.54	2.58	2.64	***1.27***
Getting Needed Care	(n=312)	**2.391**	50th		2.31	2.37	2.42	2.45	***0.98***
Customer Service	(n=106)	**2.509**	25th		2.48	2.54	2.58	2.61	***0.58***
Overall Ratings Scores									
Q13 Health Care	(n=383)	**2.366**	50th		2.31	2.36	2.42	2.45	***0.98***
Q23 Personal Doctor	(n=407)	**2.548**	75th		2.43	2.50	2.53	2.57	***1.27***
Q27 Specialist	(n=225)	**2.573**	75th		2.48	2.51	2.56	2.59	***1.27***
			Accreditation Points	***0.58***	***1.16***	***1.96***	***2.54***	***2.89***	
Q35 Health Plan	(n=458)	**2.293**	Below 25th		2.37	2.43	2.49	2.55	***0.58***
								Estimated Overall CAHPS® Score:	**7.91**

NOTE: NCQA begins their calculation with an unadjusted raw score showing six digits after the decimal and then compares the adjusted score to their benchmarks and thresholds (also calculated to the sixth decimal place). Starting in 2015, NCQA will no longer use an adjusted score. This report displays accreditation points and scores with only two digits after the decimal. Therefore, the estimated overall CAHPS® score may differ from the sum of the individual scores due to rounding and could differ slightly from official scores provided by NCQA. The CAHPS® measures account for 13 points towards accreditation.

*Data Source: **NCQA Memorandum of January 21, 2016.** Subject: 2016 Accreditation Benchmarks and Thresholds.

*** Not reportable due to insufficient sample size.

Executive Summary

Scoring for NCQA Accreditation (Includes Care Coordination)

				2016 NCQA National Accreditation Comparisons*				
				Below 25th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l
			Accreditation Points	***0.29***	***0.58***	***0.98***	***1.27***	***1.44***
Composite Scores	**Sample Size**	**Mean**	**Approximate Percentile Threshold**					***Approximate Score***
Getting Care Quickly	(n=305)	**2.458**	50th		2.36	2.42	2.46	2.49	***0.98***
Getting Needed Care	(n=312)	**2.391**	50th		2.31	2.37	2.42	2.45	***0.98***
Customer Service	(n=106)	**2.509**	25th		2.48	2.54	2.58	2.61	***0.58***
Care Coordination	(n=221)	**2.321**	Below 25th		2.33	2.39	2.43	2.49	***0.29***
Overall Ratings Scores									
Q13 Health Care	(n=383)	**2.366**	50th		2.31	2.36	2.42	2.45	***0.98***
Q23 Personal Doctor	(n=407)	**2.548**	75th		2.43	2.50	2.53	2.57	***1.27***
Q27 Specialist	(n=225)	**2.573**	75th		2.48	2.51	2.56	2.59	***1.27***
			Accreditation Points	***0.58***	***1.16***	***1.96***	***2.54***	***2.89***	
Q35 Health Plan	(n=458)	**2.293**	Below 25th		2.37	2.43	2.49	2.55	***0.58***
							Estimated Overall CAHPS® Score:		**6.93**

NOTE: NCQA begins their calculation with an unadjusted raw score showing six digits after the decimal and then compares the adjusted score to their benchmarks and thresholds (also calculated to the sixth decimal place). Starting in 2015, NCQA will no longer use an adjusted score. This report displays accreditation points and scores with only two digits after the decimal. Therefore, the estimated overall CAHPS® score may differ from the sum of the individual scores due to rounding and could differ slightly from official scores provided by NCQA. The CAHPS® measures account for 13 points towards accreditation.

*Data Source: **NCQA Memorandum of January 21, 2016.** Subject: 2016 Accreditation Benchmarks and Thresholds.

*** Not reportable due to insufficient sample size.

Executive Summary
Comparison to Quality Compass®

	Oklahoma Health Care Authority	2015 Adult Medicaid Quality Compass® Comparisons*						
		5th Nat'l	10th Nat'l	25th Nat'l	50th Nat'l	75th Nat'l	90th Nat'l	95th Nat'l
Composite Scores		%	%	%	%	%	%	%
Getting Care Quickly *(% Always/Usually)*	**84.22%**	**72.32**	**73.99**	**78.73**	**81.55**	**83.48**	**85.26**	**86.61**
Shared Decision Making *(% Yes)*	**76.64%**	**74.21**	**74.93**	**76.65**	**78.56**	**80.41**	**82.28**	**83.94**
How Well Doctors Communicate *(% Always/Usually)*	**90.82%**	**86.99**	**88.13**	**89.21**	**90.70**	**92.17**	**93.29**	**94.23**
Getting Needed Care *(% Always/Usually)*	**84.53%**	**72.97**	**74.95**	**77.94**	**81.35**	**84.18**	**85.41**	**86.46**
Customer Service *(% Always/Usually)*	**87.22%**	**82.77**	**83.25**	**85.32**	**87.34**	**88.70**	**90.56**	**91.67**
Overall Ratings Scores								
Q13 Rating of Health Care (% 8, 9, 10)	**73.89%**	**63.55**	**66.67**	**70.15**	**72.82**	**75.50**	**77.68**	**79.00**
Q23 Rating of Personal Doctor (% 8, 9, 10)	**81.33%**	**73.07**	**75.00**	**77.69**	**80.00**	**82.06**	**84.17**	**86.28**
Q27 Rating of Specialist (% 8, 9, 10)	**83.11%**	**73.95**	**75.14**	**78.05**	**80.67**	**82.82**	**85.34**	**86.19**
Q35 Rating of Health Plan (% 8, 9, 10)	**67.25%**	**65.23**	**67.85**	**72.44**	**76.15**	**78.65**	**81.16**	**83.25**

*Data Source: 2015 Adult Medicaid Quality Compass®. Scores above based on 155 public and non-public reporting health plan products (All Lines of Business excluding PPOs).

= Plan score falls below 5th Percentile

Executive Summary

Action Plan – Rating of Health Plan

A Key Driver Analysis is conducted to understand the impact that different aspects of plan service and provider care have on members' overall satisfaction with their health plan, their personal doctor, their specialist, and health care in general. Two specific scores are assessed both individually and in relation to each other. These are:

1. The relative importance of the individual issues (Correlation to overall measures)
2. The current levels of performance on each issue (Percentile group in Quality Compass®)

Items that are a High Priority for Improvement are those measures that are highly correlated to the overall measure, and the plan's scores are below the 50th percentile of Quality Compass®. Below is a list of items that are considered a High Priority for Improvement to the Overall Rating of Health Plan as well as the Primary Recommendation for improving this measure. For more ideas on how to improve your scores, please see the *Action Plans for Improving CAHPS® Scores* section of this report.

High Priority for Improvement
(High correlation/Relatively low performance)

Overall Rating of Health Plan	Primary Recommendation
Q32 - Treated You with Courtesy and Respect	Operationally define customer service behaviors for Call Center representatives as well as all staff throughout the organization. Train staff on these behaviors.
Q19 - Show Respect for What You Had to Say	Conduct focus group of members to identify examples of behaviors identified in the questions. Video the groups to show physicians how patients characterize excellent and poor physician performance.
Q14 - Easy to Get Care Believed Necessary	Evaluate pre-certification, authorization, and appeals processes. Of even more importance is to evaluate the manner in which the decisions are communicated to the member. Members may be told that the health plan has not approved specific care, tests, or treatment, but are not being told why. The health plan should go the extra step to ensure that the member understands the decision and hears directly from them.
Q18 - Listen Carefully to You	Provide the physicians with patient education materials. These materials could reinforce that the physician has heard the concerns of the patient and/or that they are interested in the well-being of the patient. The materials might also speak to a healthy habit that the physician wants the patient to adopt, thereby reinforcing the communication and increasing the chances for compliance. Materials should be available in appropriate/relevant languages and reading levels for the population.

Executive Summary

Key Driver Analysis – Health Plan

Use caution when reviewing scores with sample sizes less than 25.

"Health Plan's Score" is the percent of respondents that answered “Always”, “Usually”; “Yes”

High Priority for Improvement
(High Correlation/
Lower Quality Compass® Group)

Q32 - Treated You with Courtesy and Respect
Q19 - Show Respect for What You Had to Say
Q14 - Easy to Get Care Believed Necessary
Q18 - Listen Carefully to You

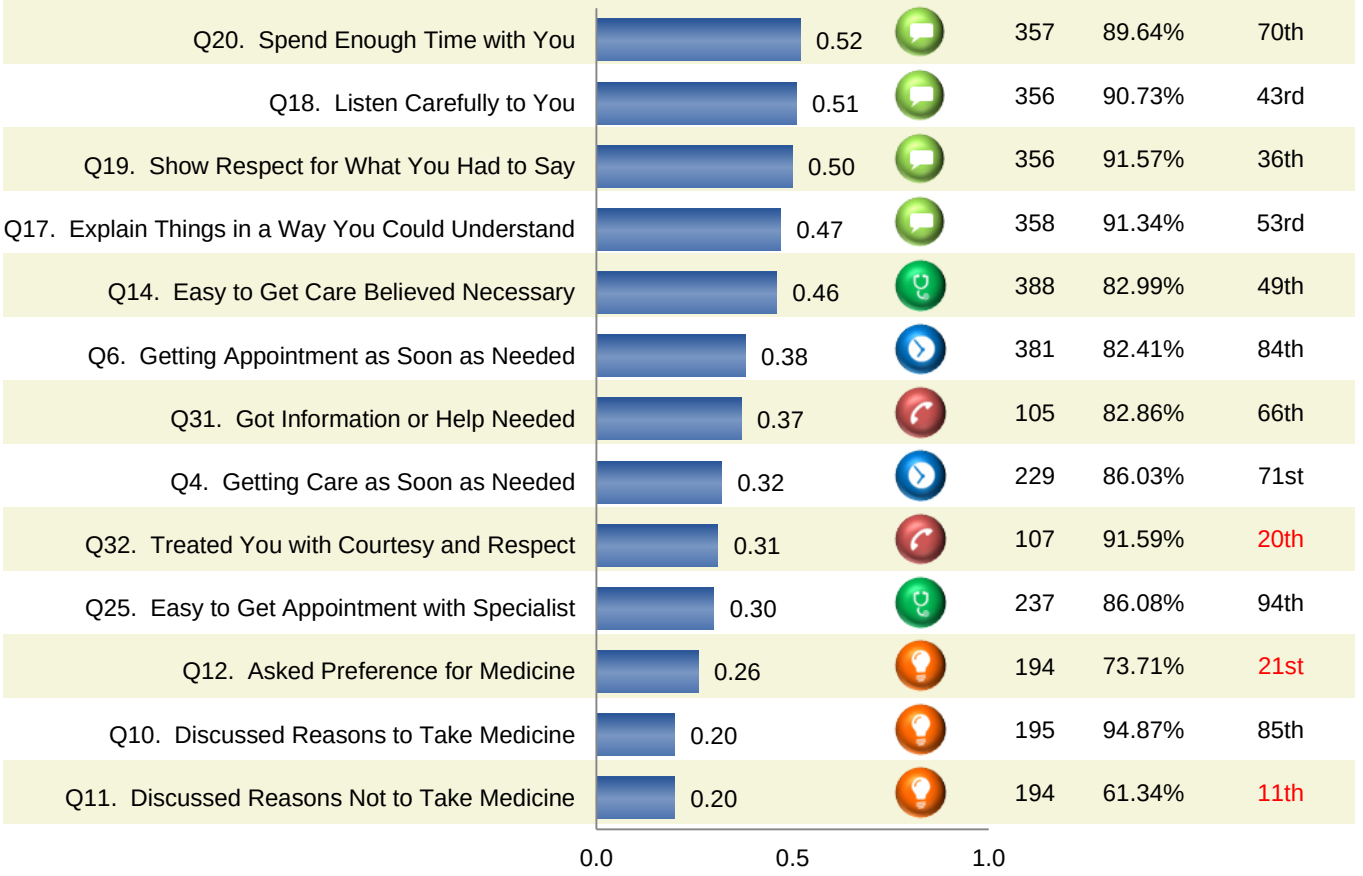
Continue to Target Efforts
(High Correlation/
Higher Quality Compass® Group)

Q20 - Spend Enough Time with You
Q4 - Getting Care as Soon as Needed

Getting Care Quickly | Shared Decision Making | How Well Doctors Communicate | Getting Needed Care | Customer Service

Executive Summary

Key Driver Analysis – Health Care



Use caution when reviewing scores with sample sizes less than 25.

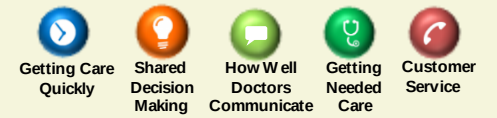
"Health Plan's Score" is the percent of respondents that answered “Always”, “Usually”; “Yes”

High Priority for Improvement
(High Correlation/
Lower Quality Compass® Group)

Q18 - Listen Carefully to You
Q19 - Show Respect for What You Had to Say
Q14 - Easy to Get Care Believed Necessary

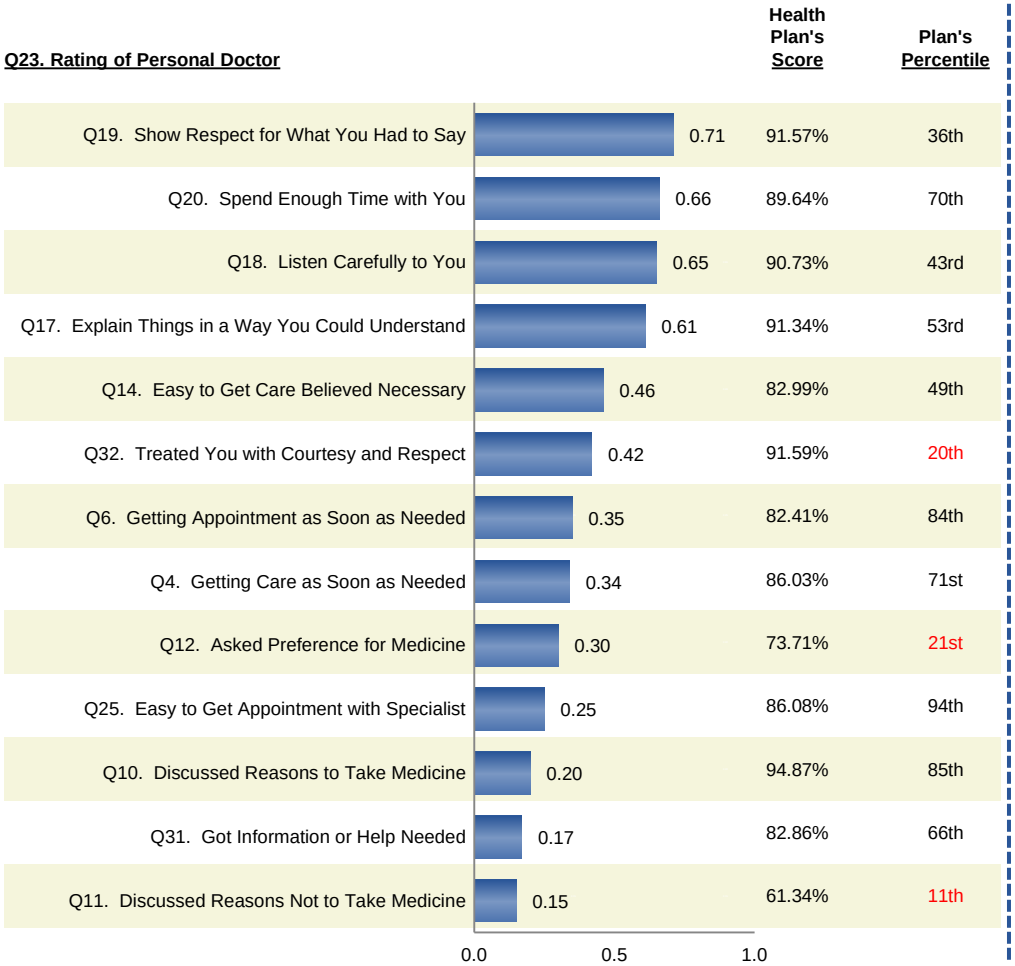
Continue to Target Efforts
(High Correlation/
Higher Quality Compass® Group)

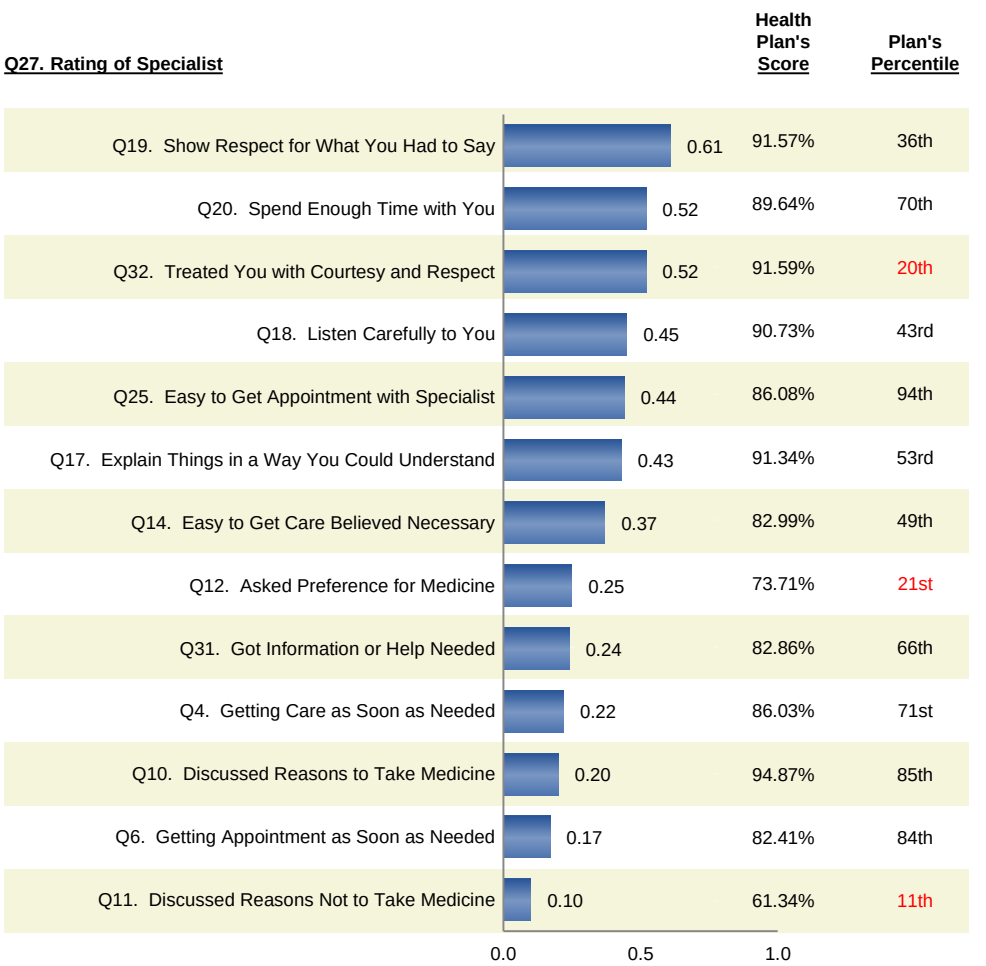
Q20 - Spend Enough Time with You
Q17 - Explain Things in a Way You Could Understand



Executive Summary

Key Driver Analysis – Doctor and Specialist





"Health Plan's Score" is the percent of respondents that answered “Always”, “Usually”; “Yes”

Executive Summary

Action Plans for Improving CAHPS® Scores

Morpace has consulted with numerous clients on ways to improve CAHPS® scores. Even though each health plan is unique and faces different challenges, many of the improvement strategies discussed on the next few pages can be applied by most plans with appropriate modifications.

In addition to the strategies suggested below, we suggest reviewing AHRQ's CAHPS® Improvement Guide, an online resource located on the Agency for Healthcare Research and Quality website at:

www.cahps.ahrq.gov/quality-improvement/index.html

Getting Needed Care

- Ease of obtaining appointment with specialist
  - Review panel of specialists to assure that there are an adequate number of specialists and that they are disbursed geographically to meet the needs of your members.
  - Conduct an Access to Care survey with either or both of 2 audiences: physician's office and/or among members.
  - Conduct a CG-CAHPS survey including specialists in the sample to identify the specialists with whom members are having a problem obtaining an appointment.
  - Include supplemental questions on the CAHPS® survey to determine whether the difficulty is in obtaining the initial consult or subsequent appointments.
  - Include a supplemental question on the CAHPS® survey to determine with which type of specialist members have difficulty making an appointment.
  - Utilize Provider Relations staff to question PCP office staff when making a regular visit to determine with which types of specialists they have the most problems scheduling appointments.
  - Develop materials to promote your specialist network and encourage the PCPs to develop new referral patterns that align with the network.

Getting Needed Care

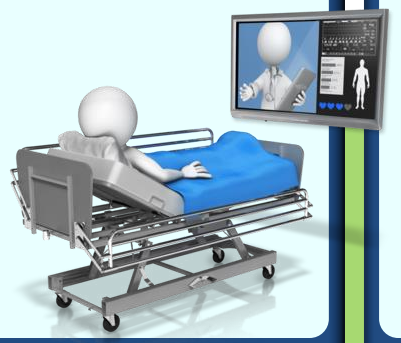
- Ease of obtaining care, tests, or treatment you needed through your health plan
  - Include a supplemental question on the CAHPS® survey to identify the type of care, test or treatment for which the member has a problem obtaining.
  - Review complaints received by Customer Service regarding inability to receive care, tests or treatments.
  - Evaluate pre-certification, authorization, and appeals processes. Of even more importance is to evaluate the manner in which the policies and procedures are delivered to the member, whether the delivery of the information is directly to the member or through their provider. Members may be hearing that they cannot receive the care, tests, or treatment, but are not hearing why.
  - When care or treatment is denied, care should be taken to ensure that the message is understood by both the provider and the member.

Executive Summary

Action Plans for Improving CAHPS® Scores (cont'd)

Getting Care Quickly

- Obtaining care for urgent care (illness, injury or condition that needed care right away) as soon as you needed
- Obtaining an appointment for routine care/check-ups
  - Conduct a CG-CAHPS survey to identify offices with scheduling issues.
  - Conduct an Access to Care Study
    - Calls to physician office - unblinded
    - Calls to physician office – blinded (Secret Shopper)
    - Calls to members with recent claims
    - Desk audit by provider relations staff
  - Develop seminars for physicians' office staff that could include telephone skills (answering, placing a person on hold, taking messages from patients, dealing with irate patients over the phone, etc.) as well as scheduling advice. Use this time to obtain feedback concerning what issues members have shared with the office staff concerning interactions with the plan.
    - These seminars could be offered early morning, lunch times or evenings so as to be convenient for the office staff. Most physicians would be appreciative of having this type of training for their staff as they do not have the time or talents to train their employees in customer service and practice management.



How Well Doctors Communicate

- Doctor explained things in a way that was easy to understand
- Doctor listened carefully
- Doctor showed respect for what member had to say
- Doctor spent enough time with member
  - Conduct a CG-CAHPS survey to identify lower performing physicians for whom improvement plans should be developed.
  - Conduct focus group of members to identify examples of behaviors identified in the questions. Video the groups to show physicians how patients characterize excellent and poor physician performance.
  - Include supplemental questions from the Item Set for Addressing Health Literacy to better identify communication issues.
  - Develop "Questions Checklists" on specific diseases to be used by members when speaking to doctors. Have these available in office waiting rooms.
  - Offer in-service programs with CMEs for physicians on improving communication with patients. This could be couched in terms of motivating patients to comply with medication regimens or to incorporate healthy life-style habits. Research has shown that such small changes as having physicians sit down instead of stand when talking with a patient leads the patient to think that the doctor has spent more time with them.
  - Provide the physicians with patient education materials, which the physician will then give to the patient. These materials could reinforce that the physician has heard the concerns of the patient or that they are interested in the well-being of the patient. The materials might also speak to a healthy habit that the physician wants the patient to adopt, thereby reinforcing the communication and increasing the chances for compliance.
  - Provide communication tips in the provider newsletters. Often, these are better accepted if presented as a testimonial from a patient.

Executive Summary

Action Plans for Improving CAHPS® Scores (cont'd)

Shared Decision Making

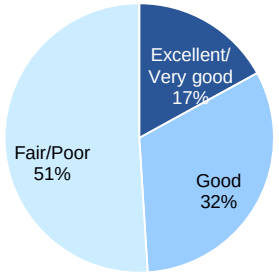
- Doctor talked about reasons you might want to take a medicine
- Doctor talked about reasons you might not want to take a medicine
- Doctor asked you what you thought was best
  - Conduct a CG-CAHPS survey and include the Shared Decision Making Composite as supplemental questions.
  - Develop patient education materials on common medicines described for your members explaining pros and cons of each medicine. Examples: asthma medications, high blood pressure medications, statins.
  - Develop audio recordings and/or videos of patient/doctor dialogues/vignettes on common medications. Distribute to provider panel via podcast or other method.

Health Plan Customer Service

- Customer service gave the information or help needed
- Customer service treated member with courtesy and respect
  - Conduct Call Center Satisfaction Survey. Implement a short IVR survey to members within days of their calling customer service to explore/assess their recent experience.
  - At the end of each Customer Service call, have your representative enter/post the reason for the call. At the end of a month, synthesize the information to discern the major reasons for a call. Have the customer service representatives and other appropriate staff discuss ways to address the reason for the majority of the calls and design interventions so that the reason for the call no longer exists.

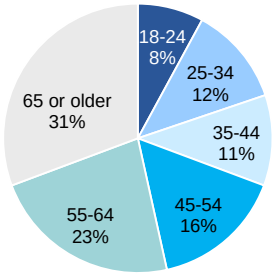
Executive Summary
Demographics

HEALTH STATUS

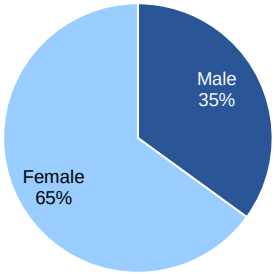


MENTAL/EMOTIONAL HEALTH STATUS

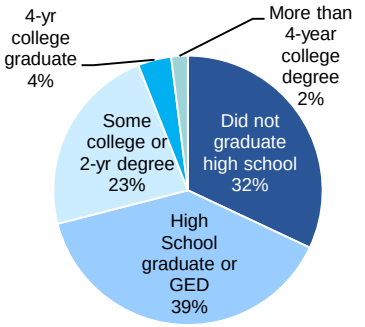
MEMBER'S AGE



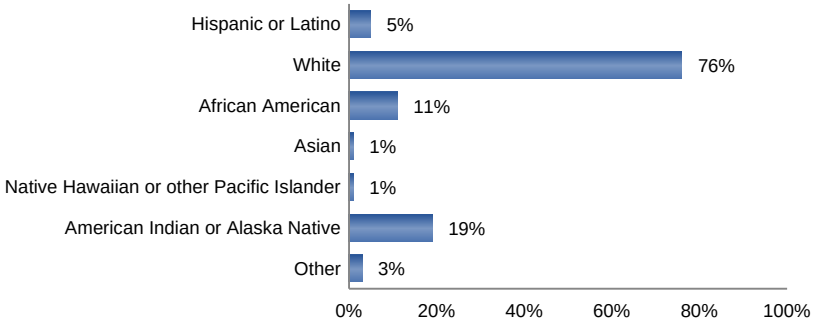
GENDER



EDUCATION



RACE / ETHNICITY



Data shown are self reported.

Executive Summary
Demographics

	2013	2014	2015	2016	2015 Quality Compass®
Q36. Health Status					
Excellent/Very good	25%	24%	20%	17%	34%
Good	27%	30%	27%	32%	33%
Fair/Poor	48%	46%	52%	51%	33%
Q37. Mental/Emotional Health Status					
Excellent/Very good	32%	35%	30%	31%	44%
Good	28%	26%	37%	30%	28%
Fair/Poor	40%	39%	33%	39%	28%
Q52. Member's Age					
18 to 24	18%	18%	7%	8%	15%
25 to 34	21%	15%	11%	12%	20%
35 to 44	15%	16%	12%	11%	17%
45 to 54	24%	25%	17%	16%	20%
55 to 64	21%	24%	23%	23%	22%
65 or older	1%	2%	30%	31%	6%
Q53. Gender					
Male	32%	32%	33%	35%	35%
Female	68%	68%	67%	65%	65%
Q54. Education					
Did not graduate high school	32%	30%	31%	32%	25%
High school graduate or GED	46%	46%	41%	39%	38%
Some college or 2-year degree	19%	20%	22%	23%	28%
4-year college graduate	2%	3%	2%	4%	6%
More than 4-year college degree	1%	1%	3%	2%	3%
Q55/56. Race/Ethnicity					
Hispanic or Latino	6%	7%	5%	5%	17%
White	74%	71%	71%	76%	53%
African American	15%	14%	13%	11%	23%
Asian	1%	1%	2%	1%	5%
Native Hawaiian or other Pacific Islander	0%	1%	0%	1%	2%
American Indian or Alaska Native	18%	18%	21%	19%	4%
Other	5%	6%	4%	3%	9%

Data shown are self reported.

Executive Summary

General Knowledge about Demographic Differences

The commentary below is based on generally recognized industry knowledge per various published sources:

Age	Older respondents tend to be more satisfied than younger respondents.
Health Status	People who rate their health status as 'Excellent' or 'Very good' tend to be more satisfied than people who rate their health status lower.
Education	More educated respondents tend to be less satisfied.
Race and ethnicity effects are independent of education and income. Lower income generally predicts lower satisfaction with coverage and care.	
Race	Whites give the highest ratings to both rating and composite questions. In general, Asian/Pacific Islanders and American Indian/Alaska Natives give the lowest ratings. Growing evidence that lower satisfaction ratings from Asian Americans are partially attributable to cultural differences in their response tendencies. Therefore, their lower scores might not reflect an accurate comparison of their experience with health care.
Ethnicity	Hispanics tend to give lower ratings than non-Hispanics. Non-English speaking Hispanics tend to give lower ratings than English-speaking Hispanics.

Note: If a health plan's population differs from Quality Compass® in any of the demographic groups, these differences could account for the plan's score when compared to Quality Compass®. For example, if a plan's population rates themselves in better health than the Quality Compass® population, this could impact a plan's score positively. Conversely, if a plan's population rates themselves in poorer health than the Quality Compass® population, the plan's scores could be negatively impacted.

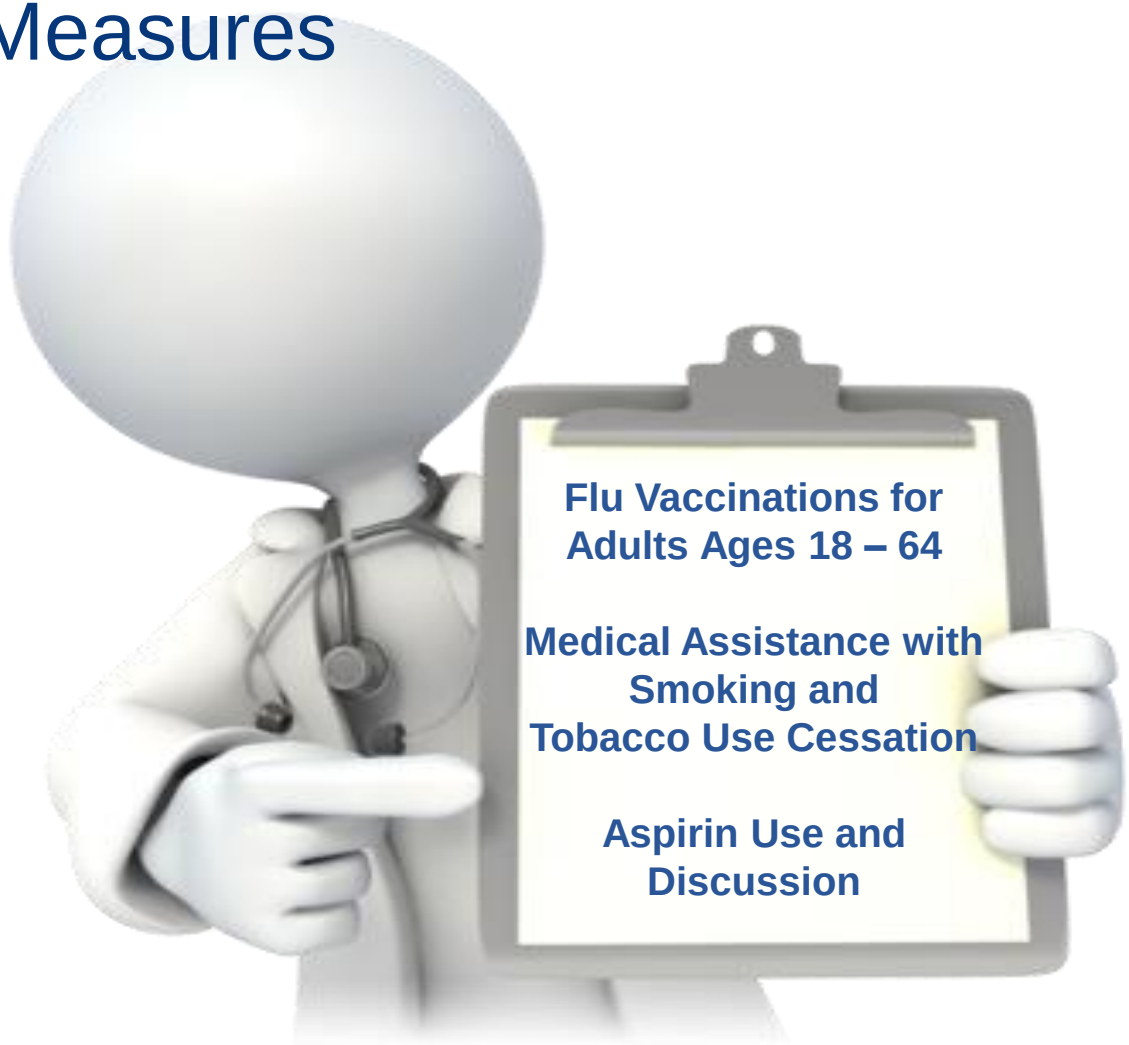
Executive Summary

Composite & Rating Scores by Demographics

Demographic	Age				Race			Ethnicity		Educational Level		Health Status		
	18-24	25-34	35-44	45+	White	African American	All other	Hispanic	Non-Hispanic	HS Grad or Less	Some College+	Excellent/ Very Good	Good	Fair/ Poor
	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Sample size	(n=36)	(n=56)	(n=51)	(n=327)	(n=360)	(n=53)	(n=114)	(n=23)	(n=427)	(n=335)	(n=131)	(n=80)	(n=149)	(n=234)
Composites *(% Always/Usually)*														
Getting Care Quickly	76	83	81	86	86	78	82	83	85	84	85	87	84	84
Shared Decision Making *(% Yes)*	80	81	81	75	76	76	78	80	76	76	79	82	73	77
How Well Doctors Communicate	93	86	92	91	92	90	90	88	91	90	92	93	92	90
Getting Needed Care	85	79	78	86	87G	79	78	77	86	83	87	91	86	82
Customer Service	63	89	81	91A	87	86	90	83	88	86	90	95	85	87
Overall Ratings *(% 8,9,10)*														
Health Care	61	66	67	77	75	67	67	78	74	74	74	87MN	73	72
Personal Doctor	78	76	79	83	83	80	78	79	82	82	81	87	81	80
Specialist	75	71	83	85	86	80	85	64	84	85	80	83	83	84
Health Plan	50	59	60	72A	68	63	64	61	68	68	66	76M	61	68

Significance is noted by UPPERCASE letters for columns significantly HIGHER at 95% confidence level

HEDIS® Measures



Flu Vaccinations for Adults Ages 18 – 64

- In 2014, the Flu Vaccinations for Adults Ages 18-64 Measure (FVA) was added to the Medicaid product line.
- The Flu Vaccinations for Adults Ages 18-64 Measure is designed to report the percent of members:
  - who are between the ages of 18-64 as of July 1st of the measurement year
  - who were continuously enrolled during the measurement year, and
  - who received an influenza vaccination or flu spray between July of the measurement year and the date on which the survey was completed
- Results for this measure are calculated using data collected during the measurement year.
- All members in the sample are asked to answer this question but only the members that meet the age criteria will be included in the results for this measure. Below are the 2016 Reported Results. See Technical Notes for Accreditation Scoring.

Q38. Have you had either a flu shot or flu spray in the nose since July 1, 2015?	2016 Reported Results*
Members that meet age criteria (results are not reportable if less than 100)	316
Members that meet age criteria and received a flu vaccination	137
Flu Vaccinations for Adults Rate	***43%***

2015 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
39.49	27.42	30.04	35.14	39.04	44.83	48.96	50.52

Plan Score: 70th Percentile

** The 2016 Reported Result is calculated using results collected during the measurement year. There must be a total of 100 or more respondents eligible for calculation in the measurement year for the rate to be reportable. This measure became eligible for public reporting in 2015.*

Medical Assistance with Smoking & Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit

- In 2010, the Medical Assistance with Smoking Cessation measure was revised and is now called the Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure. The scope of the measure was expanded to include smokeless tobacco use and revised the question response choices. This measure consists of the following components that assess different facets of providing medical assistance with smoking and tobacco use cessation:
  - Advising Smokers and Tobacco Users to Quit
  - Discussing Cessation Medications
  - Discussing Cessation Strategies
- Criteria for inclusion in this measure are members who are at least 18 years old, who were either current smokers, tobacco users, or recent quitters, who were seen by an MCO practitioner during the measurement year, and who received advice on quitting smoking/tobacco use.

Q40. Advising Smokers and Tobacco Users to Quit	2015	2016	2016 Reported Results*
Members that meet criteria (results are not reportable if less than 100)	148	160	308
Members that meet criteria and were advised to quit smoking or using tobacco	110	125	235
Advising Smokers and Tobacco Users to Quit Rate	***74%***	***78%***	***76%***

2015 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
75.79	65.20	67.57	73.60	76.74	79.41	81.91	84.18

Plan Score:
43rd Percentile

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Reported Results were calculated for the first time in 2011.*

Medical Assistance with Smoking & Tobacco Use Cessation
Discussing Cessation Medications

- Criteria for inclusion in this measure are members who are at least 18 years old, who were either current smokers, tobacco users, or recent quitters, who were seen by an MCO practitioner during the measurement year, and who discussed smoking/tobacco use cessation medications.

Q41. Discussing Cessation Medications	2015	2016	2016 Reported Results*
Members that meet criteria (results are not reportable if less than 100)	146	159	305
Members that meet criteria and discussed medications to quit smoking or using tobacco	69	82	151
Discussing Cessation Medications Rate	***47%***	***52%***	***50%***

2015 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
46.75	34.29	36.31	41.76	46.70	51.91	57.45	58.61

Plan Score:
60th Percentile

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Reported Results were calculated for the first time in 2011.*

Medical Assistance with Smoking & Tobacco Use Cessation
Discussing Cessation Strategies

- Criteria for inclusion in this measure are members who are at least 18 years old, who were either current smokers, tobacco users, or recent quitters, who were seen by an MCO practitioner during the measurement year, and who discussed smoking/tobacco use cessation medications or strategies with their doctor.

Q42. Discussing Cessation Strategies	2015	2016	2016 Reported Results*
Members that meet criteria (results are not reportable if less than 100)	149	158	307
Members that meet criteria and discussed methods & strategies to quit smoking or using tobacco	66	80	146
Discussing Cessation Strategies Rate	***44%***	***51%***	***48%***

2015 Quality Compass®							
Mean	5th	10th	25th	50th	75th	90th	95th
42.46	29.79	33.59	38.18	42.50	47.60	51.21	53.27

Plan Score: 74th Percentile

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Reported Results were calculated for the first time in 2011.*

Aspirin Use and Discussion (ASP)

- In 2010, Aspirin Use and Discussion (ASP) was added to assess different facets of managing aspirin use for the primary prevention of cardiovascular disease.
- This measure is not yet approved to be publicly reported for Adult Medicaid plans. The Aspirin results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection.
- Criteria for inclusion in the Aspirin Use measure are:
  - Women 56-79 years of age with at least two risk factors for cardiovascular disease
  - Men 46-65 years of age with at least one risk factor for cardiovascular disease
  - Men 66-79 years of age, regardless of risk factors
- Criteria for the Discussing Aspirin Risks/Benefits measure are:
  - Women 56-79 years of age
  - Men 46-79 years of age

	2015	2016	2016 Rolling Average Results*
Q43. Aspirin Use			
Members that meet criteria (results are not reportable in 2016)	44	40	84
Members that meet criteria and use aspirin for preventative measures	21	10	31
Aspirin Use Rate	***48%***	***25%***	***37%***
Q45. Discussing Aspirin Risks and Benefits			
Members that meet criteria (results are not reportable in 2016)	87	98	185
Members that meet criteria and provider discussed risks/benefits of aspirin use for preventative measures	46	40	86
Discussing Aspirin Risks and Benefits Rate	***53%***	***41%***	***46%***

**The Reported Results are calculated using a rolling average methodology, using results collected during two consecutive years of data collection. The Rolling Average was calculated for the first time in 2011 and is not yet approved for public reporting.*

State Fiscal Year 2015

ANNUAL REPORT

SoonerCare Health Management Program Evaluation

Prepared for:

State of Oklahoma
Oklahoma Health Care Authority

July 2016

PHPG

SoonerCare
Oklahoma Health Care Authority

READER NOTE

The Pacific Health Policy Group (PHPG) has been retained to conduct a multi-year independent evaluation of the SoonerCare Health Management Program (HMP) and SoonerCare Chronic Care Unit (CCU). This report contains SFY 2015 evaluation findings for the SoonerCare HMP evaluation; CCU evaluation findings have been issued in a companion report.

PHPG wishes to acknowledge the cooperation of the Oklahoma Health Care Authority (OHCA) and Telligen in providing the information necessary for the evaluation.

Questions or comments about this report should be directed to:

Andrew Cohen, Principal Investigator
The Pacific Health Policy Group
1550 South Coast Highway, Suite 204
Laguna Beach, CA 92651
949/494-5420
acohen@phpg.com

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EXECUTIVE SUMMARY

Introduction

Chronic diseases are the leading causes of death and disability in the United States. According to the Centers for Disease Control and Prevention, in 2012 about half of all adults—117 million people—had one or more chronic health conditions such as diabetes or heart disease. More than one in four Americans has multiple chronic conditions, those that last a year or more and require ongoing medical attention or that limit activities of daily living.

The per capita impact of chronic disease is even greater in Oklahoma than for the nation as a whole. In 2013, 1,269 Oklahomans died due to complications from diabetes. This equated to a diabetes-related mortality rate of 29.9 persons per 100,000 residents, versus the national rate of 21.2. The mortality rate for other chronic conditions, such as heart disease and hypertension, is similarly higher in Oklahoma than in the nation overall.

Under the Oklahoma Medicaid Reform Act of 2006 (HB2842), the Legislature directed the Oklahoma Health Care Authority (OHCA) to develop and implement a management program for chronic diseases, including, but not limited to, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure and diabetes. The program would address the health needs of chronically ill SoonerCare members while reducing unnecessary medical expenditures at a time of significant fiscal constraints.

In response, the OHCA developed the SoonerCare Health Management Program (HMP), which offered nurse care management to qualifying members with one or more chronic conditions. The program also offered practice facilitation and education to primary care providers treating the chronically ill.

First Generation SoonerCare HMP

The OHCA contracted with a vendor through a competitive bid process to implement and operate the SoonerCare HMP. Telligen was selected to administer the SoonerCare HMP in accordance with the OHCA's specifications. Telligen is a national quality improvement and medical management firm specializing in care, quality and information management services. Telligen staff members provided nurse care management to SoonerCare HMP participants and practice facilitation to OHCA-designated primary care providers.

Medical Artificial Intelligence (MEDai) was already serving as a subcontractor to Hewlett Packard Enterprises (HPE), the OHCA's Medicaid fiscal agent, at the time of the SoonerCare HMP's development. The OHCA capitalized on this existing relationship by utilizing MEDai to assist in identifying candidates for enrollment in the SoonerCare HMP based on historical and

predicted service utilization, as well as their potential for improvement through care management[1].

The first generation model of the SoonerCare HMP operated from February 2008 through June 2013. PHPG conducted a five-year evaluation of the first generation program, focusing on the program's impact on member behavior (e.g., self-management of chronic conditions), quality of care, service utilization and cost. PHPG documented significant positive outcomes attributable to both program components.

Second Generation SoonerCare HMP

As the contractual period for the first generation SoonerCare HMP was nearing its end, the OHCA began the process of examining how the program could be enhanced for the benefit of both members and providers. To improve member identification and participation, as well as coordination with primary care providers, the OHCA elected to replace centralized nurse care management services with health coaches embedded at primary care practice sites.

The health coaches would work closely with practice staff and provide coaching services to participating members. Practice facilitation would continue in the second generation HMP but would become more diverse, encompassing both traditional full practice facilitation and more targeted services such as academic detailing focused on specific topics and preparing practices for health coaches. In order to participate in the second SoonerCare HMP at its outset, members would have to be receiving primary care from a practice with an embedded health coach.

Transition from First Generation HMP

At the time of the transition from the first to second generation HMP, participants in nurse care management receiving care in a qualifying practice were offered the opportunity to transition to a health coach. Participants not aligned with a qualifying practice were given the opportunity to work with a new telephonic Chronic Care Unit (CCU) operated directly by the OHCA.

Post-Transition HMP and CCU Enrollment

Post-transition, Telligen continues to identify HMP candidates from the SoonerCare Choice population through analysis of MEDai data. Providers also refer patients to Telligen, for review and possible enrollment into the SoonerCare HMP.
SoonerCare Choice and SoonerCare Traditional members both are eligible for participation in the SoonerCare CCU. The SoonerCare CCU works with members who self refer or are referred by a provider or another area within the OHCA, such as care management, member services or provider services.

[1] MEDai calculates "chronic impact" scores that quantify the likelihood that a member's projected utilization/expenditures can be influenced through care management, based on his/her profile.

The CCU also is responsible for:

- Members with hemophilia or sickle cell anemia, even if the member otherwise would be enrolled in the SoonerCare HMP.
- Members identified as high utilizers of the emergency department.
- Members undergoing bariatric surgery.
- Members with Hepatitis-C receiving treatment and whose treating provider has referred for case management.
- Members identified through a Health Risk Assessment (HRA), which SoonerCare applicants are given the option of completing as part of the online enrollment process. Based on responses to the HRA, members can be referred to different programs for assistance or case management, including the SoonerCare CCU.

The OHCA sends weekly updates of newly-opened CCU cases to Telligen. This ensures that there is no duplication in enrollment.

Second Generation SoonerCare HMP

Program Implementation

Implementation of the second generation program began with identification and recruitment of patient centered medical home (PCMH) providers (primary care providers). Every SoonerCare Choice member is aligned with one of the 800+ PCMH providers throughout the State. The OHCA analyzed the MEDai and chronic disease profiles of members at each PCMH site and provided the information to Telligen.

Telligen segmented the practices by size (large, medium and small) and location (urban and rural) and targeted the most promising within each category based on patient mix and ability to support a health coach. The purpose of the segmentation was to ensure diversity in the group ultimately selected.

Providers who previously had undergone practice facilitation were evaluated for the second generation HMP but were not automatically offered a health coach. Telligen initially trained and deployed 26 health coaches at the program's outset to work full time at participating practices. Most were assigned to a single practice, although five health coaches divided their time across two or more smaller practices with insufficient caseloads to support a full time coach on their own.

Telligen also initially deployed eight practice facilitators, to work in collaboration with health coaches. Forty-one providers across 32 sites participated in the program for at least a portion of

SFY 2014[2]. Ten additional providers across 11 sites joined in SFY 2015 (one provider practices at two locations, both of which are part of the program).

The health coach, practice facilitator and provider form the core team for the program. The team focuses first on assessing the practice's operations and determining how the health coach can best be integrated into the office's routine. The practice facilitator then addresses opportunities for enhancing process flows, while the health coach begins reviewing patient rosters to identify coaching candidates based on MEDai chronic impact scores and disease states.

Once established in a practice, a health coach on a typical day may see both existing SoonerCare HMP members scheduled for a medical appointment and potential new members identified by the coach as enrolled in SoonerCare and eligible for the program. Depending on the preference of the practice, health coaches meet with members either before or after the member's visit with the provider.

Health coaches also may schedule sessions with members outside of the medical appointment process. On such occasions, members come to the office specifically to meet with their coach. Health coaches apply motivational interviewing and other components of the coaching model throughout their workday.

Telligen also has two community resource specialists available to help members with non-clinical programs, such as obtaining food or housing assistance. Health coaches are able to make referrals to the specialists when needs are identified and help is desired.

Telligen receives monthly payments specific to its health coaching and practice facilitation field activities, as well as payments for "centralized operations" costs.

The OHCA oversees SoonerCare HMP activities through a dedicated unit whose medical director is an Oklahoma-licensed physician.

SFY 2015 Contract Amendment

During SFY 2014, the OHCA and Telligen executed a contract amendment to modify and expand operations starting in SFY 2015. The amendment included three components: intervention quality enhancement; chronic pain and opioid drug utilization initiative and staff increase. Specifically:

- Intervention Quality Enhancement. The OHCA authorized Telligen to begin providing telephonic case management (health coaching) in addition to face-to-face (embedded) case management. Telephonic health coaches would focus their efforts on engaging

[2] Throughout the report, "practice" refers to the office hosting a practice facilitator/health coach, while "provider" refers to individual clinicians.

new members, actively pursuing members needing assistance with care transitions and serving high risk members not assigned to a primary care provider with an embedded coach.

- Chronic Pain and Opioid Drug Utilization. The OHCA authorized Telligen to hire practice facilitators and substance use resource specialists dedicated to improving the effectiveness of providers caring for members with chronic pain and opioid drug use. The new staff would assist providers with implementation of a chronic pain management tool kit and principles of proper prescribing.

- Staff Increase. The OHCA authorized Telligen to expand outreach to a greater number of providers and members and implement the chronic pain and opioid drug utilization initiative. As a result, Telligen added nine health coaches, five embedded in provider offices (also able to perform telephonic coaching) and four telephonic only, bringing the total number to 37. Telligen also hired a substance use resource specialist in SFY 2015 to support the chronic pain and opioid drug utilization initiative.

(The chronic pain and opioid drug utilization initiative is outside the scope of the core health management program and is not part of the evaluation activities addressed in this report.)

SoonerCare HMP Independent Evaluation

The OHCA has retained the Pacific Health Policy Group (PHPG) to conduct an independent evaluation of the SoonerCare HMP. PHPG is evaluating the program's impact on participants and the health care system as a whole with respect to:

1. Health coaching participant satisfaction and perceived health status;

2. Health coaching participant self-management of chronic conditions;

3. Impact of health coaching on quality of care, as measured by participant utilization of preventive and chronic care management services and adherence to national, evidence-based disease management practice guidelines;

4. Health coaching cost effectiveness, as measured by avoidance of unnecessary service utilization (e.g., inpatient days, emergency department visits) and associated expenditures, while taking into account program administrative costs;

5. Practice facilitation participant satisfaction;

6. Impact of practice facilitation on quality of care, as measured by patient adherence to national, evidence-based disease management practice guidelines; and

7. Practice facilitation cost effectiveness, as measured by avoidance of unnecessary service utilization (e.g., inpatient days, emergency department visits) and associated expenditures, while taking into account program administrative costs.

PHPG is presenting evaluation findings in a series of annual reports issued over a five-year period. This is the second Annual Evaluation report addressing progress toward achievement of program objectives. (PHPG also is evaluating the SoonerCare CCU; findings have been issued in a separate report[3].)

[3] See SoonerCare CCU SFY 2015 Evaluation Report, June 2016.

Evaluation Findings

Health Coaching Participant Satisfaction and Perceived Health Status

Member satisfaction is a key component of SoonerCare HMP performance. If members are satisfied with their experience and value its worth, they are likely to remain engaged and focused on improving their self-management skills and adopting a healthier lifestyle. Conversely, if members do not see a lasting value to the experience, they are likely to lose interest and lack the necessary motivation to follow coaching recommendations.

PHPG completed 758 initial surveys with SoonerCare HMP participants, as well as 133 six-month follow-up surveys with participants who previously completed an initial survey. The purpose of the follow-up survey was to identify changes in attitudes and health status over time.

Health coaches are expected to help participants build their self-management skills and improve their health through a variety of activities. Respondents were read a list of activities and asked, for each, whether it had occurred and, if so, how satisfied they were with the interaction or help they received.

Nearly all of the initial survey respondents (99 percent) indicated that their health coach asked questions about health problems or concerns, and the great majority stated their coach also provided answers and instructions for taking care of their health problems or concerns (91 percent); answered questions about their health (88 percent); and helped with management of medications (77 percent). Over 30 percent stated that their nurse helped to identify changes in health that might be an early sign of a problem and helped them to talk to and work with their regular doctor and his/her staff.

Respondents were asked to rate their satisfaction with each "yes" activity. Except for one activity[4], the overwhelming majority reported being very satisfied with the help they received, with the portion ranging from 91 to 94 percent, depending on the item. This attitude carried over to the members' overall satisfaction with their health coaches; 87 percent reported being very satisfied. Results for the follow-up survey were closely aligned to the initial survey.

Health coaching employs motivational interviewing to identify lifestyle changes that members would like to make. Once identified, it is the health coach's responsibility to collaborate with the member in developing an action plan with goals to be pursued by the member with his/her coach's assistance.

[4] The outlier activity was helping to make and keep health care appointments for mental health or substance abuse problems. Seventy percent of "yes" respondents reported they were very satisfied with the help they received; another 28 percent reported they were somewhat satisfied.

Seventy-six percent of initial survey respondents confirmed that their health coach asked them what change in their life would make the biggest difference in their health. Eighty-four percent of this subset (or 63 percent of total) stated that they actually selected an area to make a change.

The most common choice involved some combination of weight loss or gain, improved diet and exercise. This was followed by tobacco use cessation and management of a chronic physical health condition, such as asthma, diabetes or hypertension.

A large majority of the respondents (84 percent) who selected an area stated that they went on to develop an action plan with goals. Among those with an action plan, 74 percent reported achieving one or more goals. Among the members who reported having a goal but not yet achieving it, 64 percent stated they were "very confident" they would ultimately accomplish it. Results for the follow-up survey were very similar.

In a related line of questioning, members also were asked whether their health coach had tried to help them improve their health by changing behaviors and, if so, whether they had in fact made a change. Respondents were asked whether their coach discussed behavior changes with respect to: smoking, exercise, diet, medication management, water intake, and alcohol/substance consumption. If yes, respondents were asked about the impact of the coach's intervention on their behavior (no change, temporary change or continuing change).

A majority of respondents reported discussing each of the activities with their health coach. A significant percentage also reported continuing to make changes with respect to exercise, diet, water intake and medication management. Smaller percentages reported working to reduce tobacco, alcohol or other substance use.

Thirty-eight percent of initial survey respondents and 37 percent of follow-up survey respondents stated they were aware of the resource specialists. Only a small portion 33 in total, reported using a community resource specialist to help resolve a problem. The nature of the help included housing/rental assistance, food assistance and arranging transportation to medical appointments, all consistent with the specialists' defined mission.

Survey respondents reported very high levels of satisfaction with the SoonerCare HMP overall, consistent with their opinion of the health coach, who serves as their point of contact with the program. Eighty-seven percent of initial survey respondents and 90 percent of follow-up survey respondents stated they were very satisfied. Nearly all respondents (93 percent of initial survey and 97 percent of follow-up survey) said they would recommend the program to a friend with health care needs like theirs.

The ultimate objectives of the SoonerCare HMP are to assist members in adopting healthier lifestyles and improving their overall health. When asked to rate their current health status, the largest segment of initial survey respondents (42 percent) said "fair", while 37 percent said "good" and 19 percent said "poor".

When next asked if their health status had changed since enrolling in the SoonerCare HMP, 43 percent said it was "better" and 49 percent said it was "about the same"; only eight percent said it was "worse". Among those members who reported a positive change, nearly all (96 percent) credited the SoonerCare HMP with contributing to their improved health.

The results were even more encouraging among follow-up survey respondents. A larger segment (41 percent) reported their current health status as "good", equal to the 41 percent who said "fair". Forty-eight percent of respondents reported that their health had improved, with 91 percent crediting this improvement to the program.

Impact of Health Coaching on Quality of Care

SoonerCare HMP health coaches devote much of their time to improving the quality of care for program participants. This includes educating participants about adherence to clinical guidelines for preventive care and for treatment of chronic conditions.

PHPG evaluated the impact of SoonerCare HMP health coaching on quality of care through calculation of Healthcare Effectiveness Data and Information Set (HEDIS®) measures applicable to the SoonerCare HMP population. The evaluation included 19 diagnosis-specific measures and three population-wide preventive measures (22 in total). For example, the quality of care for participants with asthma was analyzed with respect to their use of appropriate medications and their overall medication management.

PHPG determined the total number of participants in each measurement category, the number meeting the clinical standard and the resultant "percent compliant". The findings were evaluated against two comparison data sets. The first data set contained compliance rates for the general SoonerCare population. The second data set contained national compliance rates for Medicaid MCOs. The national rates were used when data for the general SoonerCare population was not available but a national rate was.

The health coaching participant compliance rate exceeded the comparison group rate on 12 of 17 measures for which there was a comparison group percentage. The difference was statistically significant for 10 of the 12, suggesting that the program is having a positive effect on quality of care, although there is room for continued improvement.

The most impressive results, relative to the comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care. These categories also showed the greatest strength in the SFY 2014 evaluation.

PHPG also compared SFY 2015 compliance rates for health coaching participants to SFY 2014 compliance rates to document year-over-year trends. The compliance rate improved for 10 measures and declined for 12, but the movement up or down generally was very slight.

Health Coaching Cost Effectiveness

Health coaching, if effective, should have an observable impact on participant service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care costs.

Most potential SoonerCare HMP participants are identified based on MEDai data, which includes a 12-month forecast of emergency department visits, hospitalizations and total expenditures. MEDai's advanced predictive modeling, as opposed to extrapolating historical trends, accounts for participants' risk factors and recent clinical experience.

Members also can be identified and referred to the program by providers with embedded health coaches at their sites. This includes members whose MEDai scores are relatively low, but are determined by the provider and health coach to be "at risk" based on the individual's total profile.

PHPG conducted the utilization and expenditure evaluation by comparing participants' actual claims experience to MEDai forecasts absent health coaching. PHPG performed the analysis for selected chronic conditions[5] and for the participant population as a whole.

MEDai forecasted that health coaching participants as a group would incur 2,747 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 1,539, or 56 percent of forecast.

MEDai forecasted that health coaching participants as a group would incur 2,341 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,800, or 77 percent of forecast.

PHPG documented total per member per month (PMPM) medical expenditures for all health coaching participants as a group and compared actual medical expenditures to forecast for the first 24 months of engagement. MEDai forecasts for the first 12 months were trended in months 13 to 24 based on the PMPM trend rate of a comparison group comprised of SoonerCare members found eligible for the SoonerCare HMP who declined to enroll ("eligible but not engaged population")[6].

The trended MEDai forecast projected that the participant population would incur an average of $1,099 in PMPM expenditures in the first 24 months of engagement. The actual amount was $747, or 68 percent of forecast.

[5] The conditions evaluated were asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes, heart failure and hypertension. Condition-specific findings are presented in chapter four.
[6] MEDai forecasts extend only 12 months.

PHPG calculated an aggregate dollar impact for all health coaching participants by multiplying total months of engagement through SFY 2015 by average PMPM savings. The resultant medical savings were approximately $22.9 million.

PHPG then performed a net cost effectiveness test by comparing forecasted costs to actual costs during SFY 2014 and SFY 2015, inclusive of the health coaching portion of SoonerCare HMP administrative expenses. SoonerCare HMP administrative expenses include Telligen invoiced amounts plus salary, benefit and overhead costs for persons working in the OHCA's SoonerCare HMP unit. Aggregate administrative expenses for the health coaching portion of the SoonerCare HMP were approximately $10.1 million.

The SoonerCare HMP health coaching component registered net savings of nearly $12.8 million. These results appear in line with the nurse care management component of the first generation SoonerCare HMP, which generated cumulative net savings of $5.5 million through its initial 17 months of operation (February 2008 implementation through June 2009) and $14.9 million in cumulative net savings through its initial 29 months of operation (February 2008 through June 2010).

The $12.8 million savings figure is noteworthy given the inclusion in health coaching of "at risk" members referred by providers, a group that was not part of the first generation SoonerCare HMP. These members have lower projected costs, and therefore lower documentable savings under the MEDai methodology, even though by intervening at an early stage, the health coach may help to avert significant future health costs.

Finally, it is encouraging that average PMPM savings increased from the initial 12-month engagement period to engagement months 13 – 24. This suggests that the impact of health coaching increases over time, which if the trend continues, bodes well for the program's long term success.

Practice Facilitation Participant Satisfaction

Practice facilitation is integral to the performance of the SoonerCare HMP. PHPG conducts a survey of participating providers at practice facilitation sites that inquires about awareness of SoonerCare HMP objectives and components; interactions with Telligen health coaches and practice facilitators; and the program's impact with respect to patient management and outcomes. PHPG has surveyed 16 providers since the start of the program.

Providers who have completed the onsite portion of practice facilitation view the SoonerCare HMP favorably. The most common reason cited for participating was to improve care management of patients with chronic conditions. Eighty-one percent of the surveyed practices reported making changes in the management of their patients with chronic conditions as a result of participating in practice facilitation. Similarly, 88 percent of the providers credited the program with improving their management of patients with chronic conditions.

Overall, 75 percent of the providers described themselves as "very satisfied" with the experience and another 13 percent as "somewhat satisfied". Eighty-one percent of those surveyed would recommend the program to a colleague.

Providers also were asked for their perceptions of the health coaching model. Respondents first were asked to rate the importance of the activities performed by the health coach assigned to their practice (e.g., learning about patients and their health needs; giving easy to understand instructions about taking care of health problems/concerns; helping patients to identify changes in their health; helping patients to talk to and work with the provider and his/her staff etc.). A majority rated each of the activities as "very important".

Respondents next were asked to rate their satisfaction with health coaching activities, in terms of assistance provided to their patients. The level of satisfaction was extremely high across all activities, with at least 14 out of 16 respondents describing themselves as "very satisfied" on each item. The providers' enthusiasm was further reflected in their overall satisfaction with having a health coach assigned to their practice (93 percent "very satisfied").

Impact of Practice Facilitation on Quality of Care

SoonerCare HMP practice facilitation is intended to improve quality of care by educating practices on effective treatment of patients with chronic conditions and adoption of clinical best practices.

PHPG evaluated the impact of SoonerCare HMP practice facilitation on quality of care through calculation of HEDIS measures applicable to the SoonerCare HMP population. The evaluation included the same 19 diagnosis-specific measures and three population-wide preventive measures examined to measure the impact of health coaching on quality of care.

The quality of care analysis targeted members aligned with practice facilitation providers who were not participating in health coaching. PHPG determined the total number of members in each measurement category, the number meeting the clinical standard and the resultant "percent compliant".

The results were evaluated against the same two comparison data sets as used in the health coaching evaluation. The first data set contained compliance rates for the general SoonerCare population. The second data set contained national compliance rates for Medicaid MCOs. The national rates were used when data for the general SoonerCare population was not available but a national rate was.

The practice facilitation population compliance rate exceeded the comparison group rate on eight of 17 measures for which there was a comparison group percentage. The difference was statistically significant for five of the eight. This is almost identical to the results documented in the SFY 2014 evaluation.

Conversely, the comparison group performed slightly better by achieving a higher rate on nine of the 17 measures, including five for which the difference was statistically significant.

PHPG also compared SFY 2015 compliance rates for the practice facilitation population to SFY 2014 compliance rates to document year-over-year trends. The compliance rate improved for 14 of 22 measures and declined for eight. As with the health coaching analysis, the movement up or down generally was small.

It is still relatively early in the evaluation cycle and quality outcomes may improve in subsequent years. However, the impact of practice facilitation on quality after two years remains ambiguous.

Practice Facilitation Cost Effectiveness

Practice facilitation, like health coaching, should demonstrate its effectiveness through an observable impact on member service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care costs.

PHPG conducted the practice facilitation utilization and expenditure evaluation by comparing the actual claims experience of members aligned with PCMH practice facilitation providers to MEDai forecasts. The practice facilitation dataset was developed from the complete Medicaid claims and eligibility extract provided by the OHCA.

To be included in the analysis, members had to have been aligned with a PCMH provider who underwent practice facilitation. They also had to have been seen by a PCMH provider at least once following their own PCMH provider's initiation into practice facilitation. Members

participating in the health coaching portion of the SoonerCare HMP were excluded from the analysis. This was done to avoid double counting the impact of the program.

MEDai projected that members aligned with PCMH practice facilitation providers as a group would incur 876 inpatient days per 1,000 participants over the 12-month forecast period. The actual rate was 623, or 71 percent of forecast.

MEDai projected that members aligned with PCMH practice facilitation providers as a group would incur 1,324 emergency department visits per 1,000 participants over the 12-month forecast period. The actual rate was 1,218, or 92 percent of forecast.

PHPG documented total per member per month (PMPM) medical expenditures for all members aligned with PCMH providers as a group and compared actual medical expenditures to forecast for the first 24 months of the program. MEDai forecasts for the first 12 months were trended in months 13 to 24 using the same methodology as applied in the health coaching cost effectiveness analysis.

The trended MEDai forecast projected that the members would incur an average of $614.47 in PMPM expenditures in the first 24 months of the program. The actual amount was $380.09, or 62 percent of forecast.

PHPG calculated an aggregate dollar impact for members in total by multiplying total months of enrollment, following practice facilitation initiation and member interaction with a provider, by average PMPM savings. The resultant savings equaled approximately $34.9 million.

PHPG then performed a net cost effectiveness test by comparing forecasted costs to actual costs, inclusive of the practice facilitation portion of SoonerCare HMP administrative expenses. SoonerCare HMP administrative expenses include Telligen invoiced amounts plus salary, benefit and overhead costs for persons working in the OHCA's SoonerCare HMP unit. SFY 2014 and SFY 2015 aggregate administrative expenses for the practice facilitation portion of the SoonerCare HMP were approximately $6.5 million.

The SoonerCare HMP practice facilitation component registered net savings of approximately $28.4 million. These net savings compare favorably to the practice facilitation component of the first generation SoonerCare HMP, which generated cumulative net savings of $3.5 million through its initial 17 months of operation (February 2008 implementation through June 2009) and $19.2 million in cumulative net savings through its initial 29 months of operation (February 2008 through June 2010).

SoonerCare HMP Return on Investment

The value of the SoonerCare HMP is measurable on multiple axes, including participant satisfaction and change in behavior, quality of care, improvement in service utilization and overall impact on medical expenditures. The last criterion is arguably the most important, as

progress in other areas should ultimately result in medical expenditures remaining below the level that would have occurred absent the program.

PHPG examined the program's return on investment (ROI) through SFY 2015, by comparing health coaching and practice facilitation administrative expenditures to medical savings. Both program components have achieved a positive ROI, with the program as a whole generating net savings of $41.2 million and a return on investment of 249 percent. Put another way, **the second generation SoonerCare HMP generated nearly $2.50 in net medical savings for every dollar in administrative expenditures.**

CHAPTER 1 – INTRODUCTION

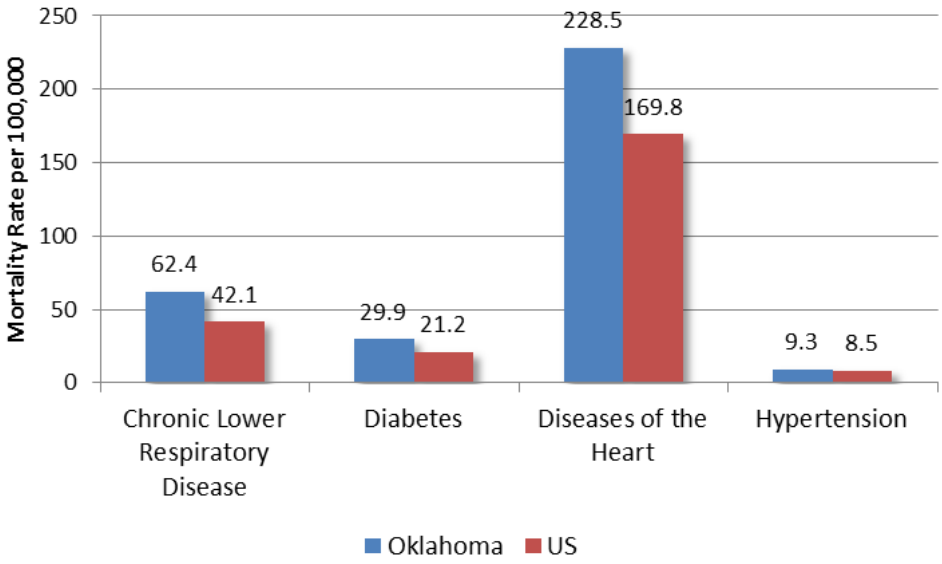
Chronic Disease Management

Chronic diseases are the leading causes of death and disability in the United States. According to the Centers for Disease Control and Prevention, in 2012 about half of all adults—117 million people—had one or more chronic health conditions such as diabetes or heart disease. More than one in four Americans has multiple chronic conditions, those that last a year or more and require ongoing medical attention or that limit activities of daily living[7].

The per capita impact of chronic disease is even greater in Oklahoma than for the nation as a whole. In 2013, 1,269 Oklahomans died due to complications from diabetes. This equated to a diabetes-related mortality rate of 29.9 persons per 100,000 residents, versus the national rate of 21.2[8].

The mortality rate for other chronic conditions, such as heart disease and hypertension, is similarly higher in Oklahoma than in the nation overall (Exhibit 1-1).

Exhibit 1-1 **– Chronic Disease Mortality Rates, 2013 – OK and US (Selected Conditions)[9]**



[7] http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf.
[8] http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf. Age adjusted rates.
[9] Ibid. Rate for chronic lower respiratory disease, also known as chronic obstructive pulmonary disease, includes asthma, chronic bronchitis and emphysema. Hypertension rate includes essential hypertension and hypertensive renal disease.

Chronic diseases also are among the most costly of all health problems. Persons with multiple chronic conditions account for over 70 percent of health spending nationally[10]. Providing care to individuals with chronic diseases, many of whom meet the federal disability standard, has placed a significant burden on state Medicaid budgets.

In Oklahoma, the CDC estimates that total expenditures related to treating selected major chronic conditions will surpass $8.6 billion in 2016 and will reach nearly $10.5 billion in 2020. The estimated portion attributable to SoonerCare members will be approximately $1.0 billion (state and federal) in 2016 and more than $1.2 billion in 2020[11] (Exhibit 1-2).

***Exhibit 1-2* – Estimated/Projected Chronic Disease Expenditures (Millions)**

Chronic Condition	OK All Payers		SoonerCare	
	2016	2020	2016	2020
Asthma	$452	$538	$153	$182
Cardiovascular Diseases (heart diseases, stroke and hypertension)	$5,793	$7,076	$622	$760
Diabetes	$2,359	$2,869	$263	$319
TOTAL FOR SELECTED CONDITIONS	**$8,604**	**$10,483**	**$1,038**	**$1,260**

The costs associated with chronic conditions are typically calculated by individual disease, as shown in the above exhibit. Traditional case and disease management programs similarly target single episodes of care or disease systems, but do not take into account the entire social, educational, behavioral and physical health needs of persons with chronic conditions. Research into holistic models has shown that sustained improvement requires the engagement of the member, provider, the member's support system and community resources to address total needs.

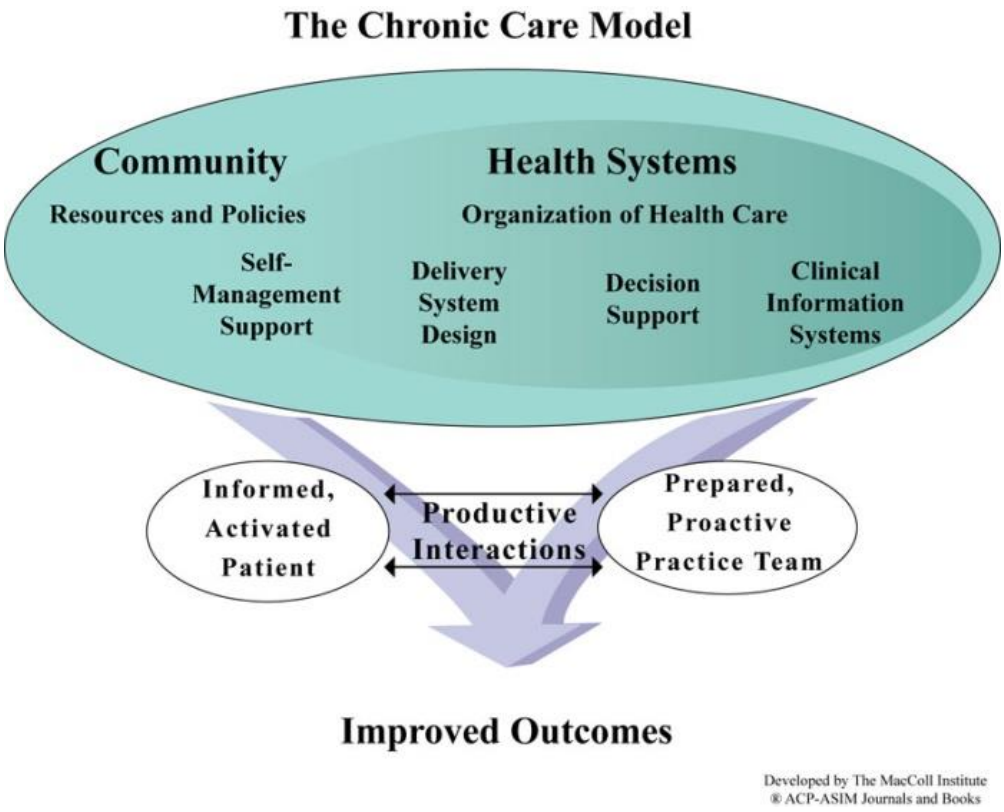
Holistic programs seek to address proactively the individual needs of patients through planned, ongoing follow-up, assessment and education. [12] Under the Chronic Care Model, as first developed by Dr. Edward H. Wagner, community providers collaborate to effect positive changes for health care recipients with chronic diseases.

[10] http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf
[11] Expenditure estimates developed using CDC Chronic Disease Cost Calculator.
[12] Wagner, E.H., "Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?," *Effective Clinical Practice*, 1:2-4 (1998).

These interactions include systematic assessments, attention to treatment guidelines and support to empower patients to become self-managers of their own care. Continuous follow-up care and the establishment of clinical information systems to track patient care are also components vital to improving chronic illness management.

Exhibit 1-3 illustrates the basic components and interrelationships of the Chronic Care Model.

Exhibit 1-3 **– The Chronic Care Model**



Development of a Strategy for Holistic Chronic Care

Under the Oklahoma Medicaid Reform Act of 2006 (HB2842), the Oklahoma Legislature directed the Oklahoma Health Care Authority (OHCA) to develop and implement a management program for persons with chronic diseases, including, but not limited to, asthma, chronic obstructive pulmonary disease, congestive heart failure and diabetes. The program would address the health needs of chronically ill SoonerCare members while reducing unnecessary medical expenditures at a time of significant fiscal constraints.

In response, the OHCA developed the SoonerCare Health Management Program, with the stated goals of:

- Evaluating and managing participants with chronic conditions;
- Improving participants' health status and medical adherence;
- Increasing participant disease literacy and self-management skills;
- Coordinating and reducing unnecessary or inappropriate medication usage by participants;
- Reducing hospital admissions and emergency department use by participants;
- Improving primary care provider adherence to evidence-based guidelines and best practices measures;
- Coordinating participant care, including the establishment of coordination between providers, participants and community resources;
- Regularly reporting clinical performance and outcome measures;
- Regularly reporting SoonerCare health care expenditures of participants; and
- Measuring provider and participant satisfaction with the program.

"First Generation" SoonerCare HMP

The OHCA moved from concept to reality by creating a program that offered nurse care management to qualifying members with one or more chronic conditions. The program also offered practice facilitation and education to primary care providers treating the chronically ill.

The OHCA contracted with a vendor through a competitive bid process to implement and operate the SoonerCare HMP. Telligen[13] was selected to administer the SoonerCare HMP in accordance with the OHCA's specifications. Telligen is a national quality improvement and medical management firm specializing in care, quality and information management services. Telligen staff members provided nurse care management to SoonerCare HMP participants and practice facilitation to OHCA-designated primary care providers.

Medical Artificial Intelligence (MEDai), was already serving as a subcontractor to Hewlett Packard Enterprise (HPE), the OHCA's Medicaid fiscal agent, at the time of the SoonerCare HMP's development. The OHCA capitalized on this existing relationship by utilizing MEDai to assist in identifying candidates for enrollment in the SoonerCare HMP based on historical and predicted service utilization, as well as their potential for improvement through care management.

[13] Prior to August 2011, Telligen was known as the Iowa Foundation for Medical Care.

Nurse Care Management

Nurse care management targeted SoonerCare members with chronic conditions identified as being at high risk for both adverse outcomes and significant future medical costs. The members were stratified into two levels of care, with the highest-risk segment placed in "Tier 1" and the remainder in "Tier 2."

Prospective participants were contacted and "enrolled" in their appropriate tier. After enrollment, participants were "engaged" through initiation of care management activities.

Tier 1 participants received face-to-face nurse care management while Tier 2 participants received telephonic nurse care management. The OHCA sought to provide services at any given time to about 1,000 members in Tier 1 and about 4,000 members in Tier 2.

Practice Facilitation and Provider Education

Selected participating providers received practice facilitation through the SoonerCare HMP. Practice facilitators collaborated with providers and office staff to improve the quality of care through implementation of enhanced disease management and improved patient tracking and reporting systems.

The provider education component targeted primary care providers throughout the State who were treating patients with chronic illnesses. The program incorporated elements of the Chronic Care Model by inviting primary care practices to engage in collaboratives focused on health management and evidence-based guidelines.

Program Performance

The first generation model of the SoonerCare HMP operated from February 2008 through June 2013. PHPG conducted a five-year evaluation of the first generation program, focusing on the program's impact on member behavior (e.g., self-management of chronic conditions), quality of care, service utilization and cost. PHPG documented significant positive outcomes attributable to both program components.

In the final evaluation report issued in 2014, PHPG concluded that the program had achieved high levels of satisfaction among participants, both members and providers; had improved quality of care; reduced inpatient and emergency department utilization versus what would have occurred absent the program; and saved $182 million over five years, even after accounting for program administrative costs. PHPG also concluded that, "the OHCA has laid a strong foundation for the program's second generation model, which is designed to further enhance care for members with complex/chronic conditions and to generate additional savings in the form of avoided hospital days, emergency department visits and other chronic care service costs."

"Second Generation" SoonerCare HMP & OHCA Chronic Care Unit (CCU)

As the contractual period for the first generation SoonerCare HMP was nearing its end, the OHCA began the process of examining how the program could be enhanced for the benefit of both members and providers. The OHCA and Telligen observed that a significant amount of the nurse care managers' time was being spent on outreach and scheduling activities, particularly for Tier 1 participants. The OHCA also observed that nurse care managers tended to work in isolation from primary care providers, although coordination did improve somewhat in the program's later years, as documented in provider survey results.

To enhance member identification and participation, as well as coordination with primary care providers, the OHCA elected to replace centralized nurse care management services with registered nurse health coaches embedded at primary care practice sites. The health coaches would work closely with practice staff and provide coaching services to participating members. Health coaches could either be dedicated to a single practice with one or more providers or shared between multiple practice sites within a geographic area[14].

Health coaches would use evidence-based concepts such as motivational interviewing and member-driven action planning principles to impart changes in behaviors that impact chronic disease care.

Practice facilitation would continue in the second generation HMP but would become more diverse, encompassing both traditional full practice facilitation and more targeted services such as academic detailing focused on specific topics and preparing practices for health coaches.

Health coaches would only be embedded at practices that had first undergone practice facilitation[15]. In order to participate in the second generation SoonerCare HMP at its outset, members would have to be receiving primary care from a practice with an embedded health coach.

The OHCA conducted a competitive procurement to select a vendor to administer the second generation HMP. Telligen was awarded the contract.

Health Coaching Model – Design and Principles

As administered by Telligen, the health coach, practice facilitator and provider form the core team for the program. The team focuses first on assessing the practice's operations and determining how the health coach can best be integrated into the office's routine. The practice facilitator then addresses opportunities for enhancing process flows, while the health coach

[14] The description of Health Coaching and second generation Practice Facilitation are taken from the OHCA's October 2012 RFP for a second generation Health Management Program contractor.

[15] The health coaching model has since undergone some refinements, as described later in the chapter.

begins reviewing patient rosters to identify coaching candidates based on MEDai chronic impact scores and disease states. (Providers also can refer members for health coaching. This includes members whose MEDai scores are relatively low, but are determined by the provider and health coach to be "at risk" based on the individual's total profile.)

Once established in a practice, a health coach on a typical day may see both existing SoonerCare HMP members scheduled for a medical appointment and potential new members identified by the coach as enrolled in SoonerCare and eligible for the program. Depending on the preference of the practice, health coaches meet with members either before or after the member's visit with the provider.

Some providers prefer that the health coach meet with a member before his or her medical appointment, to help prepare the member for the appointment, including identifying important information the member should share with the provider. Others prefer that the coach meet with the member after the appointment to review instructions the member may have received from the provider. Occasionally, a provider may ask a health coach to attend the medical appointment; this tends to be limited to appointments with members who have difficulty understanding the provider's instructions.

Health coaches also may schedule sessions with members outside of the medical appointment process. On such occasions, members come to the office specifically to meet with their coach.

Health coaches apply motivational interviewing and other components of the coaching model throughout their workday. The narrative below in italics is excerpted from Telligen's training manual for health coaches and summarizes its health coaching model, as well as its approach to integration of health coaching and practice facilitation activities[16].

> *The Health Coach (HC) will utilize the principles and health coaching framework from the Miller and Rollnick model (2012). This is a SoonerCare Choice Member-centered, evidence-based approach that takes practice, feedback and time to master. An abbreviated summary of the Motivational Interview (MI) approach is provided below.*
>
> *As presented by Miller & Rollnick (2012)[17], there are four major principles that form the 'spirit' of MI: Partnership, Acceptance, Compassion and Evocation.*
>
> - *Partnership: Unlike the traditional medical model, where the practitioner is the expert, in the MI approach, the HC and the member will form a partnership. Together, they will identify the member's priorities, readiness to change and health goals. The practitioner will guide the member and help him/her to work through ambivalence to change by selectively reinforcing and evoking the member's motivation to change.*

[16] Telligen Health Coach Training Manual – OK HMP, June 2013. The manual was developed and training was conducted in partnership with HealthSciences Institute.
[17] Motivational Interviewing, Third Edition, W Miller & S Rollnick, 2012

- *Acceptance: In the MI model, the HC looks at the member through a SoonerCare Choice Member-centered and empathetic lens. Acceptance includes believing in the absolute worth of the member, affirming the member's strengths and efforts, supporting the member's autonomy or choice, and providing reflections that show accurate empathy.*
- *Compassion: Without a deep underlying compassion for members, their circumstances, and their challenges, it is nearly impossible to employ the important skill of empathic listening. And without empathic listening, it is difficult to establish rapport and engage the SoonerCare Choice Member in a discussion about behavior change.*
- *Evocation: Evocation is perhaps the most important principle because it sets the MI-based health coaching approach apart from all others and is linked to clinical outcome. By evoking change talk – desire, ability, reasons and need to change, commitment for change, activation towards change, and steps already take towards change – the HC creates the best case scenario in health coaching.*

Miller & Rollnick (2012) also present a health coaching framework. The sequence and length of time spent in each phase will vary depending on the member's readiness to change, the complexity of chronic illness, their understanding of the disease and any behavioral or social limitations.

1) *<u>Engaging</u> the SoonerCare Choice Member sets the foundation for the health coaching encounter. The ability to consistently build and maintain rapport is a significant skill for a HC. This is especially important when working with SoonerCare Choice Members who are less motivated and less ready to make changes in their health. The HC should strive to explore with the member their motivations, priorities, self-management efforts and challenges they have faced with their health.*
2) *<u>Focusing</u> sets the agenda for the HC and member encounter. As there is limited time with these appointments, it is important to utilize your time effectively and efficiently with the member. By eliciting what is important to the SoonerCare Choice Member and using clinical judgment, the HC can selectively guide the SoonerCare Choice Member into a productive discussion about how he or she can improve their health or change an unhealthy habit. The treatment plan suggested by the PCP may be a starting place; however, the agenda should be SoonerCare Choice Member-centered.*
3) *<u>Evoking</u> draws out what is important to the SoonerCare Choice Member. The goal here is to evoke change talk from the SoonerCare Choice Member. This is the most important phase as it is linked to clinical outcomes, but is often skipped due to our need to want to diagnose and provide answers. After member is engaged, the HC should look for opportunities to evoke change talk throughout and during each session.*
4) *<u>Planning</u> helps develop next steps and/or health goals. If the other three phases have been done well, the member's goals most likely have already been shared with the HC. As the session closes, the HC can summarize these goals and then ask the member for a realistic plan or next step.*

The HC collaborates with the Practice Facilitator (PF) on the Four Phases of facilitation; Assess, Analyze, Implement and Evaluate. It is imperative that the HC works in partnership with the PF and Medical Home to improve the health and outcomes of the Oklahoma SoonerCare population. The four phases of facilitation are defined as follows:

1) *Assess the practice and SoonerCare Choice Member population. Conduct an assessment of current staff, practice flow and data collection systems. Assess population, culture and chronic disease of members (SoonerCare Choice Members). The Health Management Program Practice Facilitators will be instrumental in implementing a registry during the HC preparation phase but the use of the registry would likely be a shared responsibility between practice staff and the HC.*
2) *Analyze assessment findings. Work in collaboration with the practice in the management and maintenance of a registry. Organize direction, gather coaching tools and use meaningful feedback on trends and findings of medical record review. Contact member (SoonerCare Choice Member) and gather information using best practice guidelines.*
3) *Implement positive activities towards managing chronic illness. Partner with members to set short term and long term goals for self-management of chronic disease. Engage with member and family using the evidence-based health coaching approach of Motivational Interviewing (MI). Address barriers to following through on treatment plan and health goals. In addition to using the MI approach, as needed, use educational materials regarding specific health care conditions and assist with referrals.*
4) *Evaluate progress and improvements with ongoing collaboration with member and family with follow up appointments. Collaborate with PCP for continuation of care. Support members with getting their needs met. Coordinate with PMCH staff to identify members overdue for visit, labs or referral and arrange follow-up services. Determine the ability of PMCH staff and clinicians to access reports, implement satisfaction evaluations and analyze the effectiveness of the data system in place. (Care Measures®).*

Telligen also has community resource specialists available to help members with non-clinical programs, such as obtaining food or housing assistance. Health coaches are able to make referrals to the specialists when needs are identified and help is desired.

Implementation and Evolution of the Second Generation HMP

Identification and Recruitment of Practices

Implementation of the second generation program began with identification and recruitment of PCMH providers (primary care providers). Every SoonerCare Choice member is aligned with one of the 800+ PCMH providers throughout the State. The OHCA analyzed the MEDai and chronic disease profiles of members at each PCMH site and provided the information to Telligen.

Telligen segmented the practices by size (large, medium and small) and location (urban and rural) and targeted the most promising within each category based on patient mix and ability to support a health coach. The purpose of the segmentation was to ensure diversity in the group ultimately selected.

Providers who previously had undergone practice facilitation were evaluated for the second generation HMP but were not automatically offered a health coach. Providers already participating in two other care management programs, Health Access Networks and the Comprehensive Primary Care Initiative (CPCI) were excluded from the process.

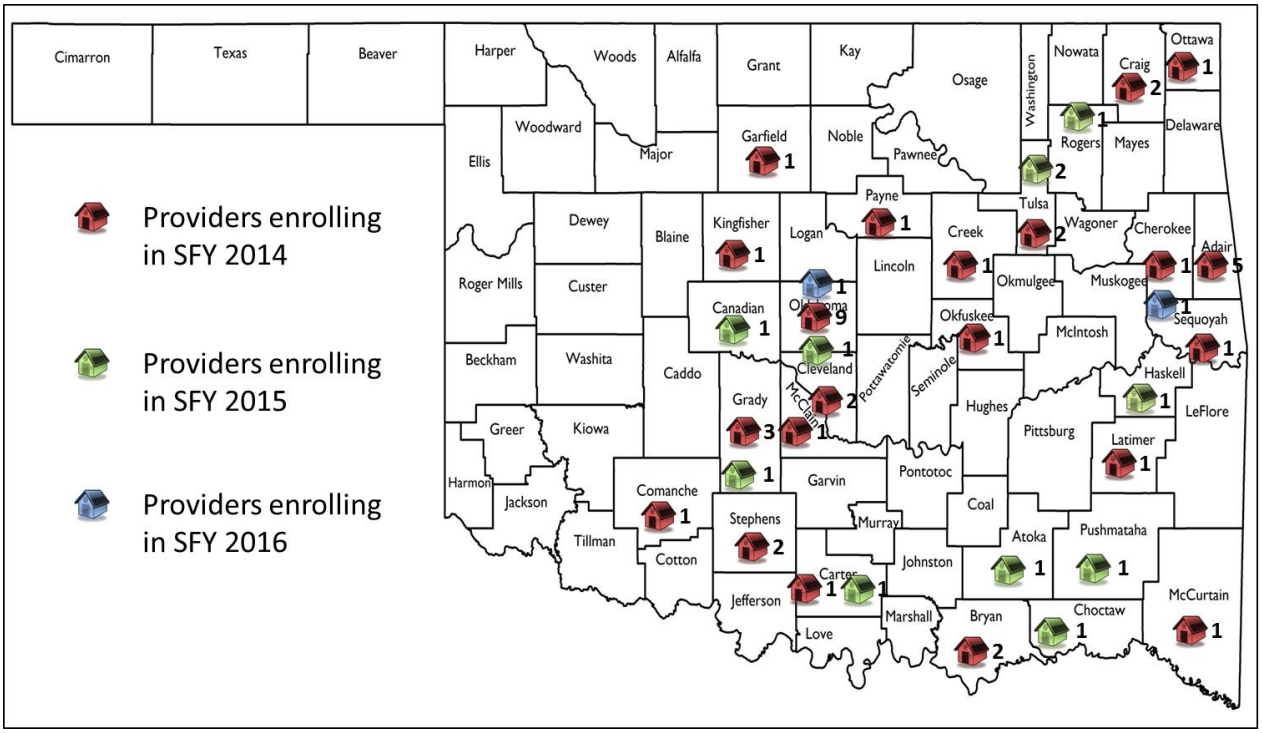
Telligen initially trained and deployed 26 health coaches at the program's outset to work full time at participating practices. Most were assigned to a single practice, although five health coaches divided their time across two or more smaller practices with insufficient caseloads to support a full time coach on their own.

Telligen also initially deployed eight practice facilitators to work in collaboration with health coaches. Forty-one providers across 32 sites participated in the program for at least a portion of SFY 2014. Ten additional providers across 11 sites joined in SFY 2015 (one provider practices at two locations, both of which are part of the program). One provider to date has joined in SFY 2016 while a provider who joined in SFY 2015 added a practice facilitation location in SFY 2016. This brings the total to 52 providers across 45 sites[18] (Exhibit 1-4 on the following page).

Except for the survey component, the SFY 2015 evaluation was limited to the 51 providers participating for at least a portion of that year. The providers enrolling in SFY 2016 will be included in the SFY 2016 evaluation.

[18] Fifteen of the providers previously underwent practice facilitation in the first generation program . The 15 providers underwent a new round of practice facilitation for the second generation program; for many of these providers, it had been several years since their previous experience.

Exhibit 1-4 – Practice Facilitation/Health Coach Sites



Initial Transition of Members

At the time of the transition from the first to second generation HMP, participants in nurse care management receiving care in a qualifying practice were offered the opportunity to transition to a health coach. Participants not aligned with a qualifying practice were given the opportunity to work with a new telephonic Chronic Care Unit (CCU) operated directly by the OHCA.

Post-Transition HMP Enrollment

Post-transition, Telligen continues to identify HMP candidates from the SoonerCare Choice population through analysis of MEDai data. Providers also refer patients to Telligen, for review and possible enrollment into the SoonerCare HMP.

Expansion of HMP and Introduction of Telephonic Health Coaching – SFY 2015

During SFY 2014, the OHCA and Telligen executed a contract amendment to modify and expand operations starting in SFY 2015[19]. The amendment included three components: intervention quality enhancement; chronic pain and opioid drug utilization initiative and staff increase. Specifically:

[19] Amendment Four to the Contract between Oklahoma Health Care Authority and Telligen.

- Intervention Quality Enhancement. The OHCA authorized Telligen to begin providing telephonic case management (health coaching) in addition to face-to-face (embedded) case management. Telephonic health coaches would focus their efforts on engaging new members, actively pursuing members needing assistance with care transitions and serving high risk members not assigned to a primary care provider with an embedded coach.

- Chronic Pain and Opioid Drug Utilization. The OHCA authorized Telligen to hire practice facilitators and substance use resource specialists dedicated to improving the effectiveness of providers caring for members with chronic pain and opioid drug use. The new staff would assist providers with implementation of a chronic pain management tool kit and principles of proper prescribing.

- Staff Increase. The OHCA authorized Telligen to expand outreach to a greater number of providers and members and implement the chronic pain and opioid drug utilization initiative. As a result, Telligen added nine health coaches, five embedded in provider offices (also able to perform telephonic coaching) and four telephonic only, bringing the total number to 37. Telligen also hired a substance use resource specialist in SFY 2015 to support the chronic pain and opioid drug utilization initiative.

(The chronic pain and opioid drug utilization initiative is outside the scope of the core health management program and is not part of the evaluation activities addressed in this report. Expenditures associated with the initiative have not been included in the cost effectiveness analyses presented in chapters four and seven.)

SoonerCare HMP Operations

Telligen receives monthly payments specific to its health coaching and practice facilitation field activities, as well as payments for "centralized operations" costs. Telligen also has two community resource specialists available to help members with non-clinical programs, such as obtaining food or housing assistance. Health coaches are able to make referrals to the specialists when needs are identified and help is desired.

The OHCA oversees SoonerCare HMP activities through a dedicated unit whose medical director is an Oklahoma-licensed physician.

Telligen payments and OHCA administrative costs are presented in greater detail in the SoonerCare HMP cost effectiveness sections of the report.

SoonerCare Chronic Care Unit

SoonerCare Choice and SoonerCare Traditional members both are eligible for participation in the SoonerCare CCU. The SoonerCare CCU works with members who self-refer or are referred by a provider or another area within the OHCA, such as care management, member services, or provider services.

The CCU also is responsible for:

- Members with hemophilia or sickle cell anemia, even if the member otherwise would be enrolled in the SoonerCare HMP.
- Members identified as high utilizers of the emergency department.
- Members undergoing bariatric surgery.
- Members with Hepatitis-C receiving treatment and whose treating provider has referred for case management.
- Members identified through a Health Risk Assessment (HRA), which SoonerCare applicants are given the option of completing as part of the online enrollment process. Based on responses to the HRA, members can be referred to different programs for assistance or case management, including the SoonerCare CCU.

The OHCA sends weekly updates of newly-opened CCU cases to Telligen. This ensures that there is no duplication in enrollment.

Characteristics of Health Coaching Participants

During SFY 2015, a total of 6,990 members were enrolled in the SoonerCare HMP for at least part of one month. PHPG, in consultation with the OHCA, removed certain groups from the utilization, expenditure and quality of care portions of the evaluation, to improve the integrity of the results. Specifically:

- Members who were enrolled for fewer than three months in SFY 2015.
- Members who were enrolled for three months or longer, but who also were enrolled in the CCU for a portion of SFY 2015, if their CCU tenure exceeded their HMP tenure.
- Members receiving disease management through Oklahoma University's Harold Hamm Diabetes Center, to isolate the impact of the SoonerCare HMP from activities occurring at the center[20].
- Members enrolled in a Health Access Network for three months or longer, to isolate the impact of the SoonerCare HMP from HAN care management activities[21].

The revised evaluation dataset included 5,447 SoonerCare HMP participants, up from 4,914 in the SFY 2014 evaluation. Demographic and health data for these members is presented starting on the next page.

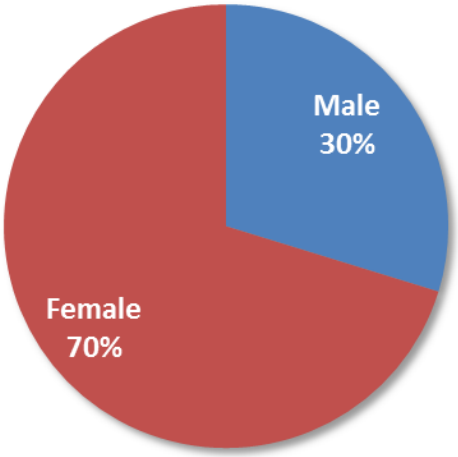
[20] There were 16 members who received services from the center and who also were enrolled in either the SoonerCare HMP or CCU.

[21] There were 344 members aligned with a HAN PCMH provider for three months or longer who also were enrolled in either the SoonerCare HMP or CCU at some point during the year.

Participants by Gender and Age

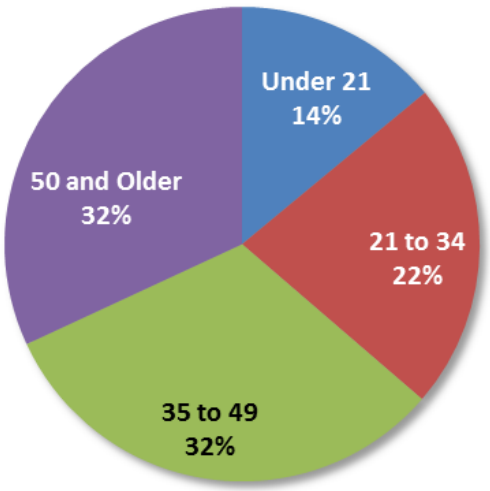
Most SoonerCare HMP participants are women, with females outnumbering males by more than two to one (Exhibit 1-5).

Exhibit 1-5 – Gender Mix for SoonerCare HMP Participants



Not surprisingly, SoonerCare HMP participants are older than the general Medicaid population. Only 14 percent of SoonerCare HMP participants are under the age of 21, compared to approximately 62 percent of the general SoonerCare population (Exhibit 1-6).[22]

Exhibit 1-6 – Age Distribution for SoonerCare HMP Participants



[22] Source for total SoonerCare percentage: OHCA SFY 2015 Annual Report.

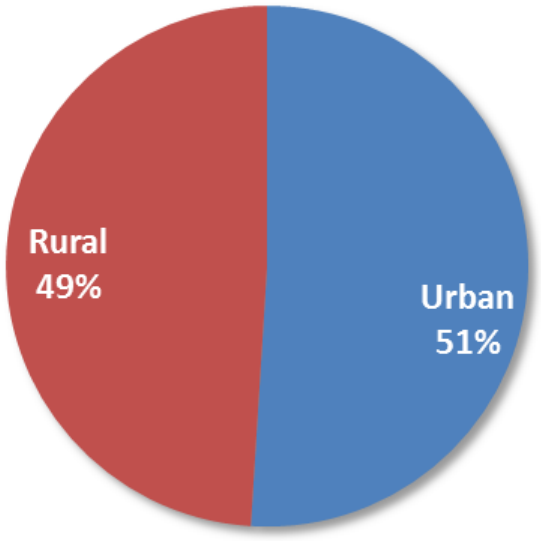
Participants by Place of Residence

Forty-nine percent of SoonerCare HMP participants resided in rural Oklahoma in SFY 2015, while 51 percent resided in urban counties comprising the greater Oklahoma City, Tulsa and Lawton metropolitan areas (Exhibit 1-7). The rural/urban split was much closer in SFY 2015 than SFY 2014, when rural participants made-up 58 percent of the SoonerCare HMP population and urban participants only 42 percent.

The high rural percentage in SFY 2014 was attributable to the placement of SoonerCare HMP participating practices. At the OHCA's request, Telligen recruited practices throughout most of the State, including rural counties in northeast, southeast and southwest Oklahoma. This was done to ensure diversity among participants.

The SFY 2015 mix was close to that of the general SoonerCare population, approximately 47 percent of whom resided in rural counties and 52 percent in urban counties in SFY 2015[23].

Exhibit 1-7 – SoonerCare HMP Participants by Location: Urban/Rural Mix



[23] Source: OHCA SFY 2015 Annual Report. Urban counties include Canadian, Cleveland, Comanche, Creek, Logan, McClain, Oklahoma, Osage, Rogers, Tulsa and Wagoner. Slightly under one percent was classified as "out-of-state" or "other" (e.g., in state custody).

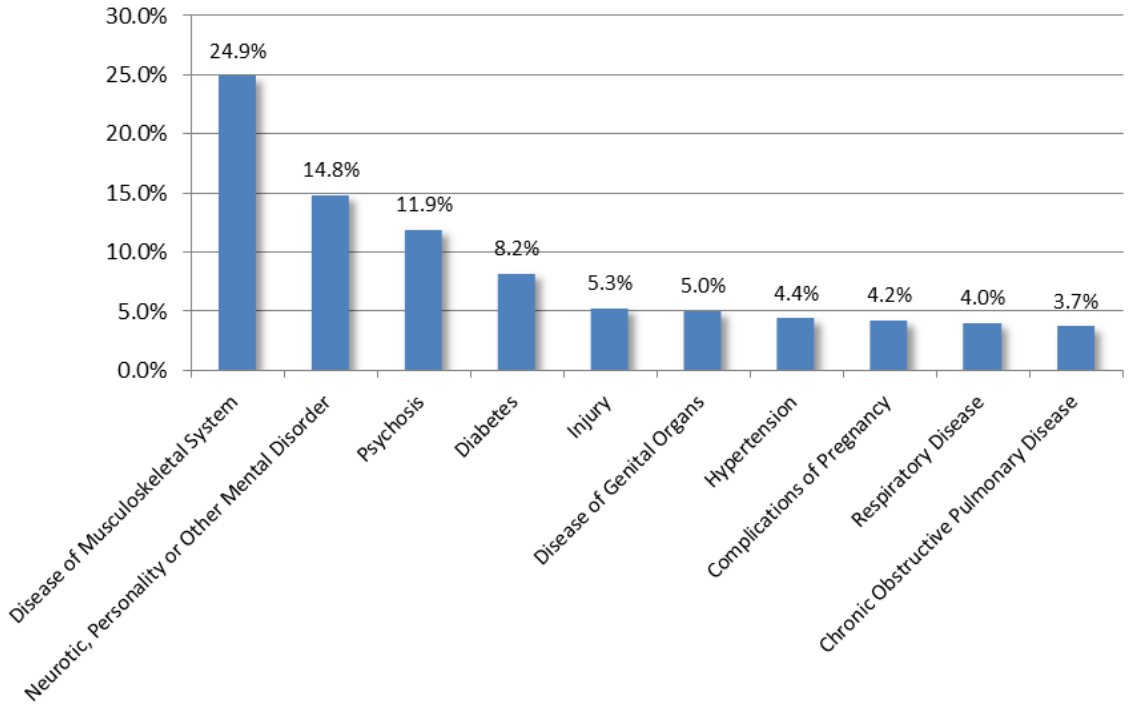
Participants by Most Common Diagnostic Categories[24]

Program participants are treated for numerous chronic and acute physical conditions. The most common diagnostic category among participants in SFY 2015 was disease of the musculoskeletal system, which includes osteoarthritis, other types of arthritis, backbone disease, rheumatism and other bone and cartilage diseases and deformities (Exhibit 1-8).

Two behavioral health categories were included among the top five, along with diabetes and injuries, while the remaining five categories include a mix of chronic and acute conditions. The top ten categories accounted for 86 percent of the SoonerCare HMP population.

The composition of the top 10 categories was unchanged from SFY 2014. The percentages also were nearly identical, with conditions shifting in most cases by no more than one-tenth of a percentage point.

Exhibit 1-8 – Most Common Diagnostic Categories for Health Coaching Participants[25]

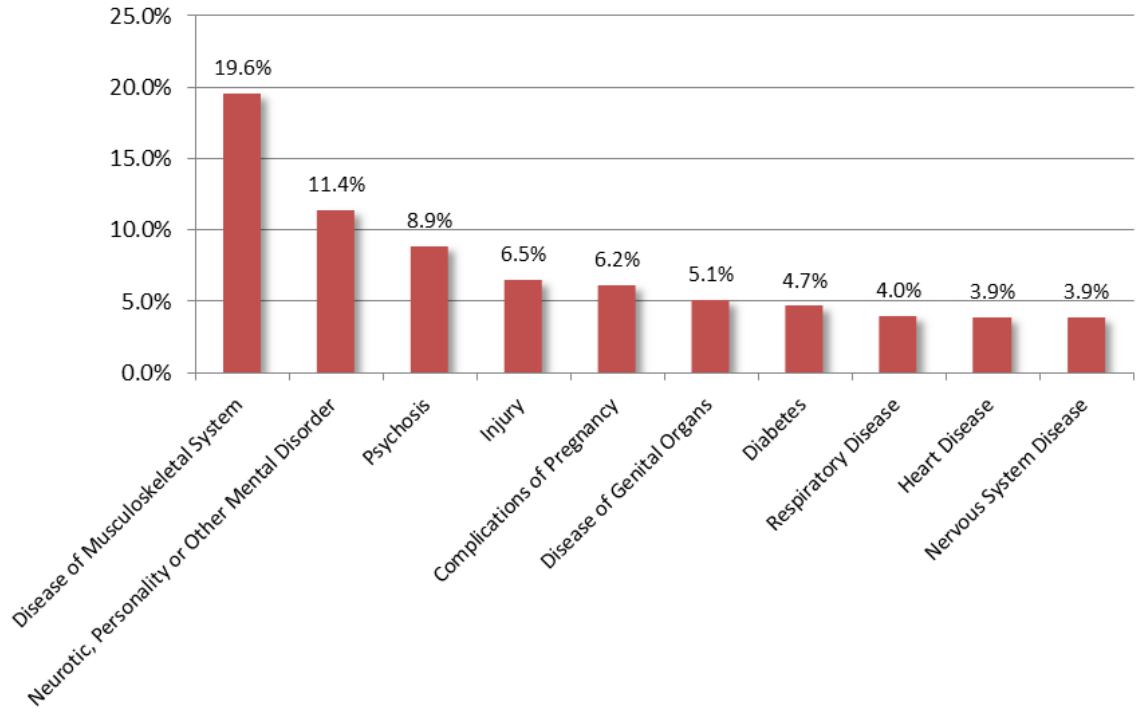


[24] Ranking of most common diagnoses calculated using primary diagnosis code from paid claims.
[25] It is the OHCA's policy not to enroll pregnant members in the SoonerCare HMP, and to disenroll those who become pregnant. The "complications of pregnancy" group may represent members not yet disenrolled, post partum members being treated for a complication and/or members who have had miscarriages.

Participants by Most Expensive Diagnostic Categories[26]

Disease of the musculoskeletal system also was the most expensive diagnostic category in SFY 2015 based on paid claim amounts, followed by seven of the same nine categories from the prior exhibit, although in slightly different order (Exhibit 1-9). The top ten most expensive disease categories accounted for 74 percent of the population. The ranking and percentages were again nearly identical to those reported for SFY 2014.

Exhibit 1-9 – Most Expensive Diagnostic Categories for Health Coaching Participants



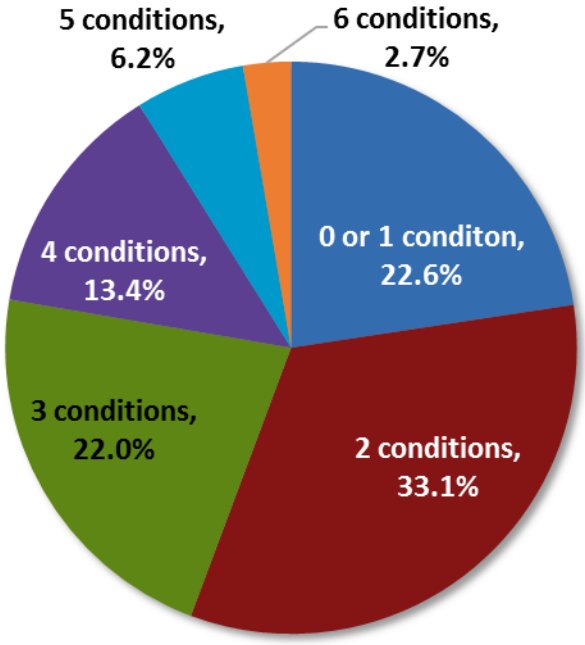
[26] Ranking of most costly diagnoses calculated using primary diagnosis code from paid claims.

Co-morbidities among Participants

The SoonerCare HMP's focus on holistic care rather than management of a single disease is appropriate given the prevalence of co-morbidities in the participating population.

PHPG examined the number of physical chronic conditions per participant and found that nearly 80 percent in SFY 2015 had at least two of six high priority chronic physical conditions[27] (asthma, COPD, coronary artery disease, diabetes, heart failure and hypertension) (Exhibit 1-10). The SFY 2015 distribution was very similar to the distribution in SFY 2014.

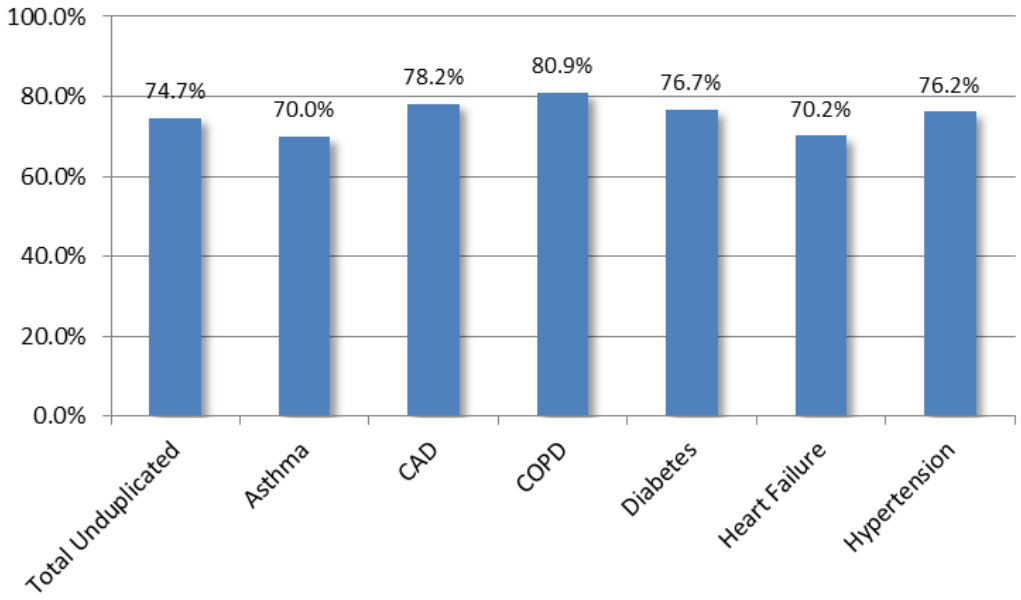
Exhibit 1-10 – Number of Physical Health Chronic Conditions



[27] These conditions are used by MEDai as part of its calculation of chronic impact scores.

Nearly 75 percent of the participant population also has both a physical and behavioral health condition. Among the six priority physical health conditions, the co-morbidity prevalence in SFY 2015 ranged from approximately 81 percent in the case of persons with COPD to 70 percent among persons with asthma (Exhibit 1-11).[28] The percentages once again were almost unchanged from SFY 2014.

Exhibit 1-11 – Behavioral Health Co-morbidity Rate



Conclusion

Overall, health coaching participants demonstrate the characteristics expected of a population that could benefit from care management. Most have two or more chronic physical health conditions, often coupled with serious acute conditions. The population also has significant behavioral health needs that can complicate adherence to guidelines for self-management of physical health conditions and maintaining a healthy lifestyle.

[28] Behavioral health comorbidity defined as diagnosis codes 290-319 being one of the participant's top three most common or most expensive diagnosis, by claim count and paid amount, respectively.

SoonerCare HMP Independent Evaluation

The OHCA has retained the Pacific Health Policy Group (PHPG) to conduct an independent evaluation of the SoonerCare HMP. PHPG is evaluating the program's impact on participants and the health care system as a whole with respect to:

1. Health coaching participant satisfaction and perceived health status;

2. Health coaching participant self-management of chronic conditions;

3. Impact of health coaching on quality of care, as measured by participant utilization of preventive and chronic care management services and adherence to national, evidence-based disease management practice guidelines;

4. Health coaching cost effectiveness, as measured by avoidance of unnecessary service utilization (e.g., inpatient days, emergency department visits) and associated expenditures, while taking into account program administrative costs;

5. Practice facilitation participant satisfaction;

6. Impact of practice facilitation on quality of care, as measured by provider adherence to national, evidence-based disease management practice guidelines; and

7. Practice facilitation cost effectiveness, as measured by avoidance of unnecessary service utilization (e.g., inpatient days, emergency department visits) and associated expenditures, while taking into account program administrative costs.

PHPG is presenting evaluation findings in a series of annual reports to be issued over a five-year period. This is the second Annual Evaluation report addressing progress toward achievement of program objectives.

The specific methodologies employed and time periods addressed are described within each chapter of the evaluation. In general, utilization and expenditure findings are for years one and two of the program, covering July 2013 to June 2015 (State Fiscal Years 2014 and 2015).

Member and provider survey data is being collected on a continuous basis. Findings in this report are for surveys conducted from February 2015 to April 2016.

PHPG did not modify the evaluation methodology in response to the contract modifications executed in SFY 2015. Any impact associated with the introduction of telephonic health coaching will be captured through the existing evaluation methods. The OHCA and PHPG may develop a targeted methodology for evaluating the impact of the chronic pain and opioid drug utilization initiative. Findings from any such evaluation would be included in the SFY 2016 evaluation report.

CHAPTER 2 – HEALTH COACHING – PARTICIPANT SATISFACTION

Introduction

Participant satisfaction is a key component of SoonerCare HMP performance. If participants are satisfied with their experience and value its worth, they are likely to remain engaged and focused on improving their self-management skills and adopting a healthier lifestyle. Conversely, if participants do not see a lasting value to the experience, they are likely to lose interest and lack the necessary motivation to follow coaching recommendations.

Satisfaction is measured through participant telephone surveys. PHPG conducts initial surveys on a sample of SoonerCare HMP participants drawn from rosters furnished by the OHCA. PHPG attempts to re-survey all participants who complete an initial survey after six months, to identify any changes in perceptions over time.

Initial Survey

Initial survey data collection began in late February 2015. At that time, the OHCA provided a roster of all participants dating back to the start of the program in July 2013. The OHCA periodically updates the roster and, as of April 2016, has provided contact information for 10,902 individuals.

PHPG mails introductory letters to a sample of participants, informing them that they have been selected to participate in an evaluation of the SoonerCare HMP and will be contacted by telephone to complete a survey asking their opinions of the program. Surveyors make multiple call attempts at different times of the day and different days of the week before closing a case. PHPG seeks to complete 50 surveys per month, or 600 per year.

The survey is written at a sixth-grade reading level and includes questions designed to garner meaningful information on participant perceptions and satisfaction. The areas explored include:

- Program awareness and engagement status
- Decision to enroll in the SoonerCare HMP
- Experience with health coaching and satisfaction with health coach
- Experience with community resource specialists and satisfaction (if applicable)
- Overall satisfaction with the SoonerCare HMP
- Health status and lifestyle

Six-month Follow-up Survey

Six-month follow-up survey data collection activities began in early September 2015. The follow-up survey covers the same areas as the initial survey, to allow for comparison of participant responses across the two surveys.

The survey also includes questions for respondents who report having voluntarily disenrolled from the SoonerCare HMP since their initial survey. Respondents are asked to discuss the reason(s) for their decision to disenroll.

Survey Population Size, Margin of Error and Confidence Levels

The SFY 2014 evaluation report included data from 139 initial surveys conducted during a ten week period, from late February through April 2015. The SFY 2015 evaluation includes data from an additional 619 initial surveys conducted from May 2015 through April 2016, for a total of 758 responses. The SFY 2015 evaluation also includes data from 133 six-month follow-up surveys.

The member survey results are based on a sample of the total SoonerCare HMP population and therefore contain a margin of error. The margin of error (or confidence interval), is usually expressed as a "plus or minus" percentage range (e.g., "+/- 10 percent"). The margin of error for any survey is a factor of the absolute sample size, its relationship to the total population and the desired confidence level for survey results.

The confidence level for the survey was set at 95 percent, the most commonly used standard. The confidence level represents the degree of certainty that a statistical prediction (i.e., survey result) is accurate. That is, it quantifies the probability that a confidence interval (margin of error) will include the true population value.

The 95 percent confidence level means that, if repeated 100 times, the survey results will fall within the margin of error 95 out of 100 times. The other five times the results will be outside of the range.

Exhibit 2-1 presents the sample size and margin of error for each of the surveys. The margin of error is for the total survey population, based on the average distribution of responses to individual questions. The margin can vary by question to some degree, upward or downward, depending on the number of respondents and distribution of responses.

Exhibit 2-1 – Survey Sample Size and Margin of Error

Survey	Sample Size	Confidence Level	Margin of Error
Initial	758	95%	+/- 3.43%
Six-month Follow-up	133	95%	+/- 8.45%

SoonerCare HMP Participant Survey Findings

Respondent Demographics

Initial Survey Respondents

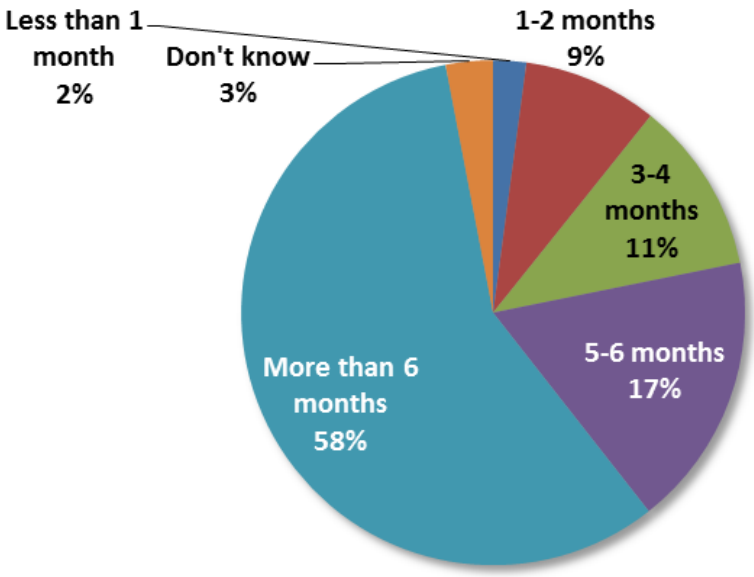
The SoonerCare HMP initial survey respondents in aggregate included 489 females (65 percent) and 269 males (35 percent).

The majority of surveys (595 out of 758, or 78 percent) were conducted with the actual SoonerCare HMP participant. The remaining surveys were conducted with a relative of the participant, primarily parents/guardians of minors, but also a small number of spouses, siblings and adult children of members.

The initial survey targeted members who were still active participants in the SoonerCare HMP. After screening out persons no longer participating in the program, the initial survey respondent sample included 660 persons.

Respondent tenure in the program among the 660 active participants ranged from less than one month to more than six months (Exhibit 2-2).

Exhibit 2-2 – Respondent Tenure in SoonerCare HMP – Initial Survey



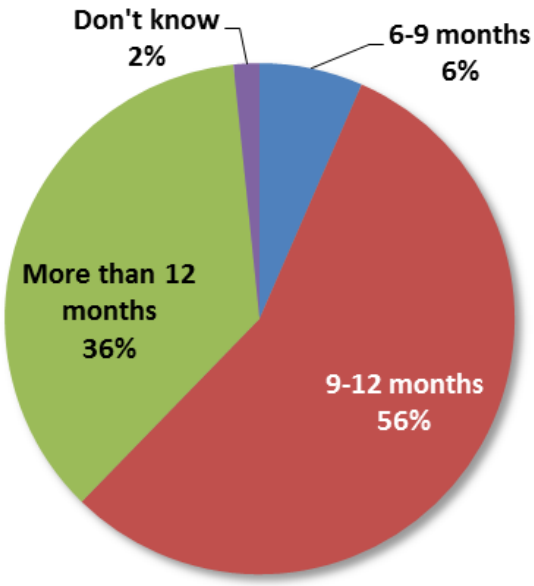
Follow-up Survey Respondents

The demographics of the follow-up survey population were very similar to the initial survey group. The SoonerCare HMP follow-up survey respondents included 87 females (65 percent) and 46 males (35 percent).

The follow-up survey included both 122 active participants and eight persons who reported having disenrolled and who were asked about their disenrollment decision. (Three others were uncertain of their current enrollment status and were not asked additional questions.)

Respondent tenure in the program among the 122 active participants was at least six months and in a majority of cases was nine to twelve months in duration (Exhibit 2-3).

Exhibit 2-3 – Respondent Tenure in SoonerCare HMP – Follow-up Survey



Key findings for the initial and follow-up surveys are discussed below. Findings are presented in aggregate for the 660 initial survey respondents interviewed since February 2015. The aggregate initial survey results also are broken-out into two subgroups: February 2015 – April 2015 respondents, data for which was originally included in the SFY 2014 evaluation report, and May 2015 – April 2016 respondents. This segmentation allows for identification of any emerging trends with respect to new participant perceptions.

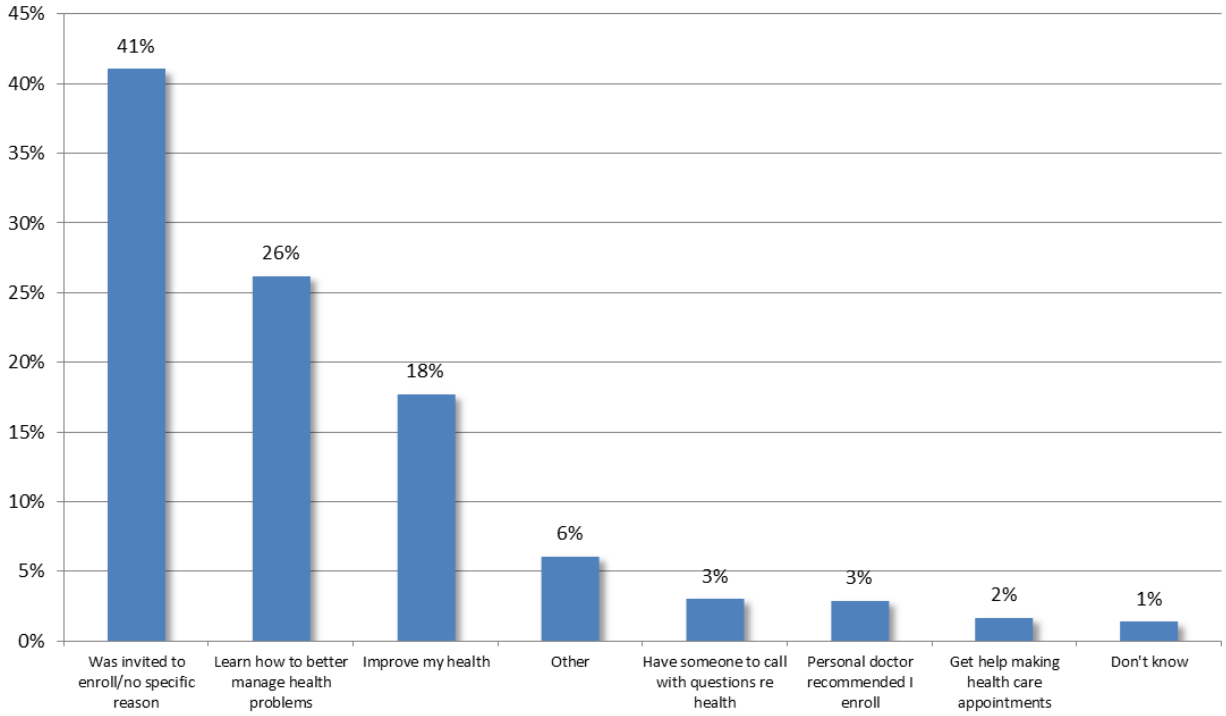
Follow-up survey data is presented alongside initial survey data as applicable. This allows for comparison of program perceptions between participants based on their tenure.

Copies of the survey instruments are included in Appendix A. The full set of responses is presented in Appendix B.

Primary Reason for Enrolling

The SoonerCare HMP seeks to teach participants how to better manage their chronic conditions and improve their health. These were the primary reasons cited by participants who had a goal in mind when enrolling. However, the largest segment, at 41 percent, enrolled simply because they were asked (Exhibit 2-4).

Exhibit 2-4 – Primary Reason for Enrolling in SoonerCare HMP – Initial Survey (Aggregate)[29]



[29] This question was not asked on the follow-up survey.

Although the percentages varied somewhat, the top three reasons given for enrolling were consistent across time periods and accounted for approximately 85 percent of the responses (Exhibit 2-5).

The fourth highest category, "other", included getting help making lifestyle changes (e.g., losing weight and stopping tobacco use) and getting help with mental health or emotional issues.

Exhibit 2-5 – Primary Reason for Enrolling in SoonerCare HMP – Initial Survey (Longitudinal)

	Primary Reason for Enrolling (Percent Naming) February 2015 – April 2016		
Reason	**Feb – Apr 2015**	**May 2015 – Apr 2016**	**Aggregate**
1. Was invited to enroll/no specific reason	35.6%	43.0%	***41.1%***
2. Learn how to better manage health problems	26.3%	26.7%	***26.2%***
3. Improve my health	23.7%	16.7%	***17.7%***
4. Other	4.2%	6.6%	***6.1%***
5. Have someone to call with questions regarding health	2.5%	3.2%	***3.0%***
6. Personal doctor recommended I enroll	1.7%	3.2%	***2.9%***
7. Get help making personal health care appointments	3.4%	1.3%	***1.7%***
8. Don't know/not sure	2.5%	1.1%	***1.4%***

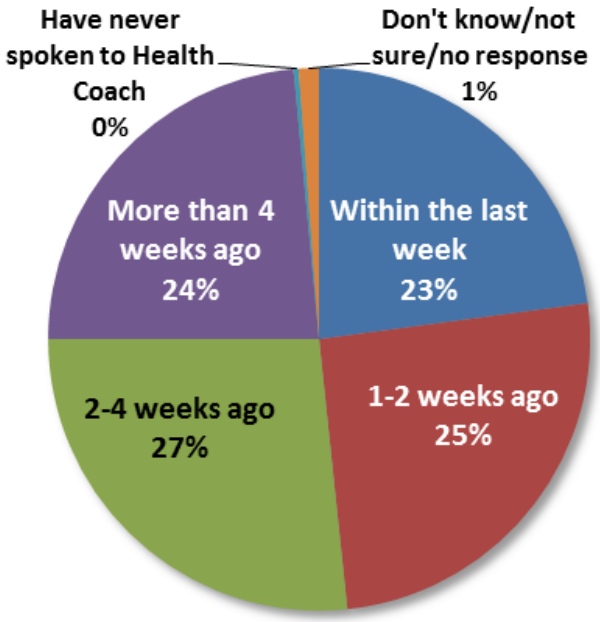
Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Health Coach Contact

The health coach is the "face" of the SoonerCare HMP for most participants. Survey respondents were asked a series of questions about their interaction with the health coach, starting with their most recent contact.

Slightly less than 50 percent of initial survey respondents reported speaking to their health coach within the previous two weeks (Exhibit 2-6).

Exhibit 2-6 – Most Recent Contact with Health Coach – Initial Survey (Aggregate)[30]



[30] "Have never spoken to health coach" segment is 0.3% (rounded down to 0% in exhibit).

The percentage reporting contact within the past two weeks was consistent across time periods for the initial survey. However, follow-up survey respondents were more likely to report that their most recent contact occurred more than four weeks ago. The longer interval may reflect a reduced need for very frequent contacts with participants who have been enrolled for a significant period of time (Exhibit 2-7).

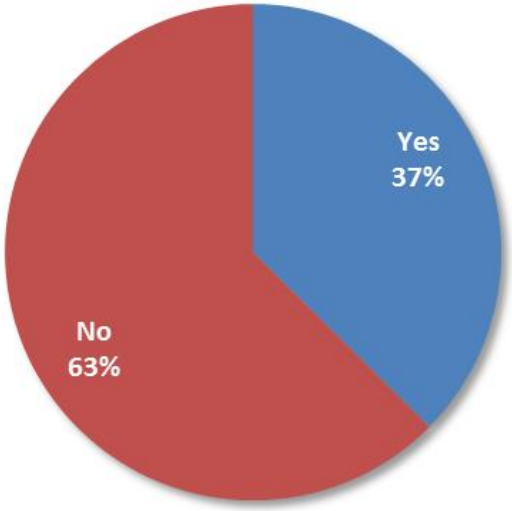
Exhibit 2-7 – Most Recent Contact with Health Coach – Initial Survey (Longitudinal) & Follow-up

	Last Time Spoke with Health Coach			
	Initial Survey			Follow-up Survey
Time Elapsed	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate	
Within last week	24.1%	22.6%	***22.9%***	***24.6%***
1 to 2 weeks ago	35.3%	23.3%	***25.5%***	***14.8%***
2 to 4 weeks ago	23.3%	27.4%	***26.7%***	***20.5%***
More than 4 weeks ago	16.4%	25.0%	***23.5%***	***38.5%***
Have never spoken to health coach	0.9%	0.2%	***0.3%***	***0.8%***
Don't know/not sure/no response	0.0%	1.5%	***1.2%***	***0.8%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Although a majority of initial survey respondents had spoken to their health coach within the past four weeks, fewer than 40 percent were able to provide the name of their health coach[31] (Exhibit 2-8).

Exhibit 2-8 – Able to Name Health Coach – Initial Survey (Aggregate)



The portion able to name their health coach was consistent across initial survey time periods and between the initial survey and follow-up survey (Exhibit 2-9).

Exhibit 2-9 – Able to Name Health Coach – Initial Survey (Longitudinal) & Follow-up

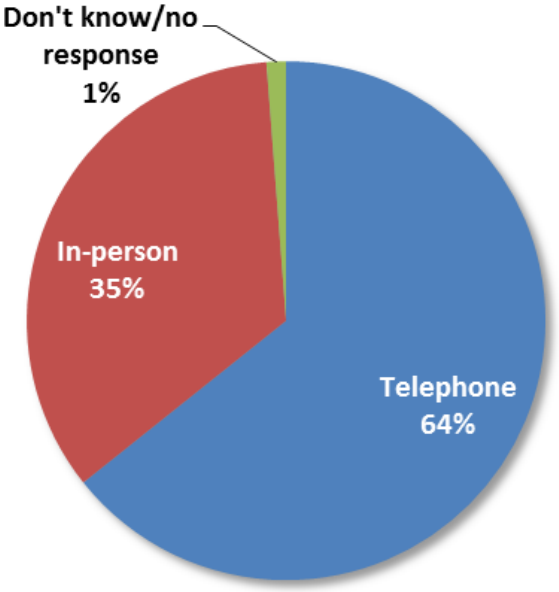
	Able to Name Health Coach			
Response	Initial Survey			Follow-up Survey
	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate	
Yes	39.3%	37.0%	***37.4%***	***34.4%***
No	60.7%	63.0%	***62.6%***	***65.6%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

[31] Respondents were asked for a name but PHPG did not verify the accuracy of the information.

The majority of initial survey respondents reported that their most recent contact occurred by telephone rather than face-to-face (Exhibit 2-10).

Exhibit 2-10 – Most Recent Contact Method – Initial Survey (Aggregate)



The percentage reporting a telephone rather than in-person contact increased from the first to second initial survey periods and was higher for follow-up than initial survey respondents (Exhibit 2-11). The rise in telephone contacts may be due at least in part to the introduction of telephonic health coaching in SFY 2015.

Exhibit 2-11 – Health Coach Contact Method – Initial Survey (Longitudinal) & Follow-up

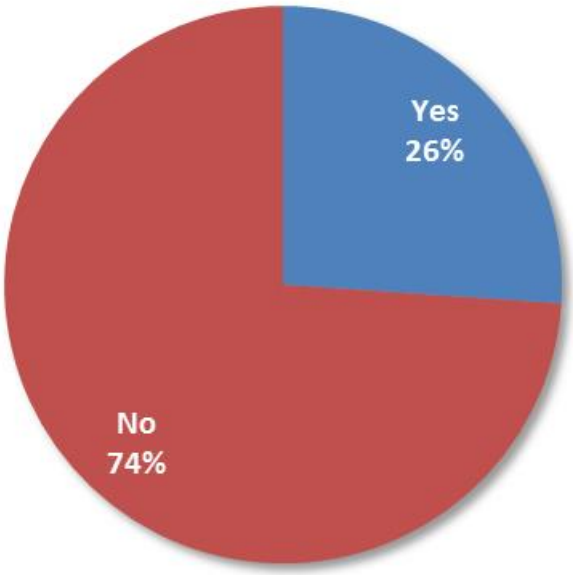
Response	Health Coach Contact Method				
	Initial Survey				Follow-up Survey
	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate		
Telephone	50.9%	66.9%	***64.1%***		***81.1%***
In-person	49.1%	31.3%	***34.4%***		***18.9%***
Don't know/no response	0.0%	1.8%	***1.5%***		***0.0%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Health coaches are required to provide a contact telephone number to their members. Approximately 90 percent of respondents, both initial and follow-up, confirmed that they were given a number.

Only 26 percent of the initial survey respondents who remembered being given a number stated they had ever tried to call their health coach (Exhibit 2-12).

Exhibit 2-12 – Tried to Call Health Coach – Initial Survey (Aggregate)



The percentage increased from the first to second initial survey groups. The follow-up survey group percentage nearly matched the first initial survey group (Exhibit 2-13).

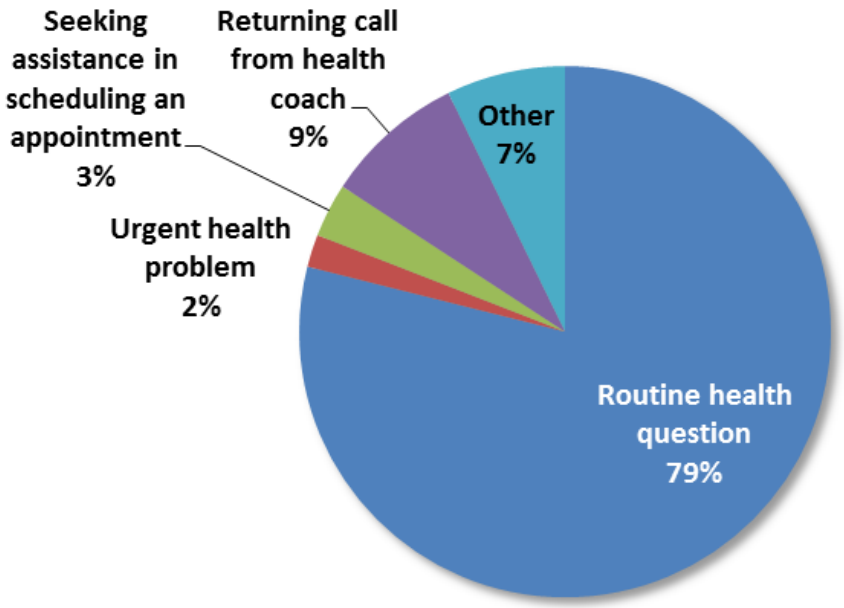
Exhibit 2-13 – Tried to Call Health Coach –
Initial Survey (Longitudinal) & Follow-up

Response	Tried to Call Health Coach			
	Initial Survey			Follow-up Survey
	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate	
Yes	16.0%	28.3%	***26.1%***	***16.4%***
No	84.0%	71.7%	***73.9%***	***83.6%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Among those who had tried calling, a majority (79 percent of initial survey respondents) reported their most recent call concerned a routine health question (Exhibit 2-14).

Exhibit 2-14 – Reason for Most Recent Call – Initial Survey (Aggregate)



A majority of follow-up survey respondents also called with a routine health question, although a larger percentage reported returning a call from the health coach (Exhibit 2-15).

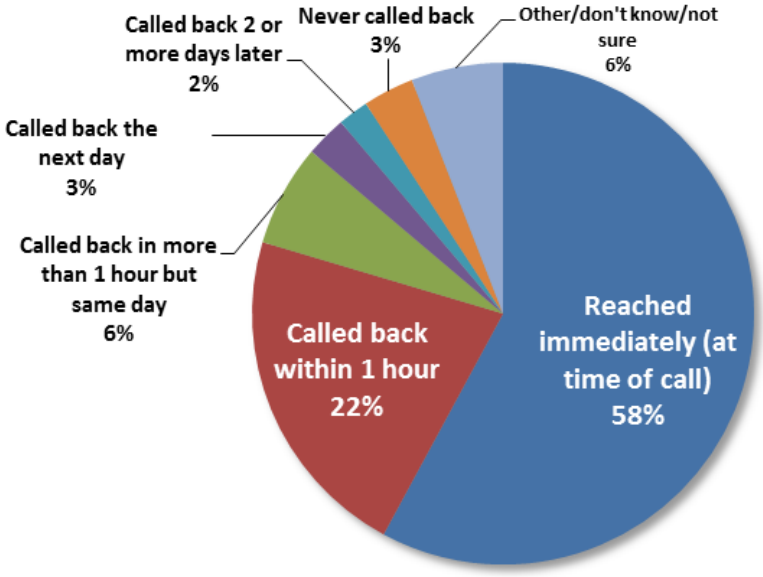
Exhibit 2-15 – Reason for Most Recent Call – Initial Survey (Longitudinal) & Follow-up

	Reason for Most Recent Call to Health Coach			
Reason	Initial Survey			Follow-up Survey
	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate	
Routine health question	64.7%	80.7%	***78.9%***	***61.1%***
Urgent health problem	0.0%	2.2%	***2.0%***	***5.6%***
Seeking assistance in scheduling an appointment	11.8%	2.2%	***3.3%***	***0.0%***
Returning call from health coach	0.0%	9.6%	***8.6%***	***22.2%***
Other	23.5%	5.2%	***7.2%***	***11.1%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Eighty-six percent of initial survey respondents who called the number reached their coach immediately or heard back later the same day. Over 95 percent reported eventually getting a call back (Exhibit 2-16).

Exhibit 2-16 – Health Coach Call-Back Time – Initial Survey (Aggregate)



A large majority of follow-up survey respondents reported being called back the same day, although a higher percentage stated they were called back the next day (Exhibit 2-17).

Exhibit 2-17 – Health Coach Call-Back Time – Initial Survey (Longitudinal) & Follow-up

Response	Health Coach Call-Back Time			
	Initial Survey			Follow-up Survey
	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate	
Reached immediately (at time of call)	47.1%	59.3%	***57.9%***	***61.1%***
Called back within 1 hour	23.5%	21.5%	***21.7%***	***11.1%***
Called back in more than 1 hour but same day	17.6%	5.2%	***6.6%***	***5.6%***
Called back the next day	5.9%	2.2%	***2.6%***	***16.7%***
Called back 2 or more days later	5.9%	1.5%	***2.0%***	***0.0%***
Never called back	0.0%	3.7%	***3.3%***	***5.6%***
Other/don't know/not sure	0.0%	6.6%	***5.9%***	***0.0%***

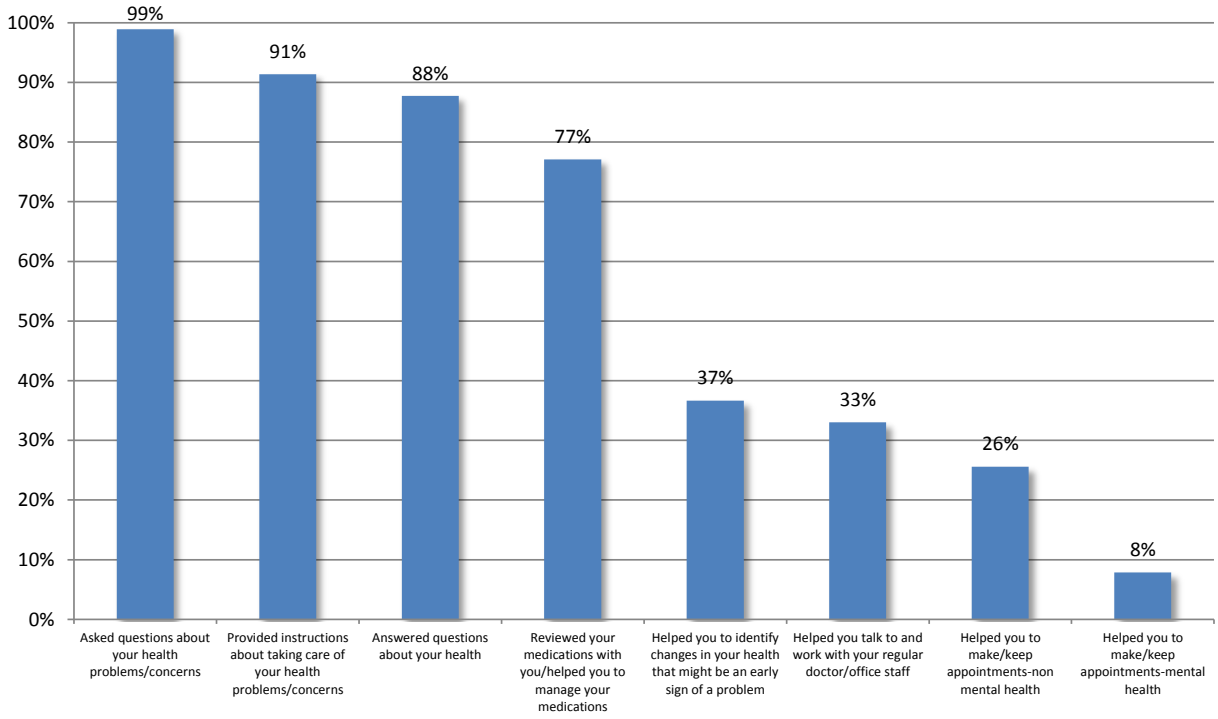
Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Health Coaching Activities

Health coaches are expected to help participants build their self-management skills and improve their health through a variety of activities. Respondents were read a list of activities and asked, for each, whether it had occurred and, if so, how satisfied they were with the interaction or help they received.

Nearly all of the initial survey respondents stated that their health coach asked questions about health problems or concerns, and the great majority stated their health coach also provided answers and instructions for taking care of their health problems or concerns, answered questions about their health and assisted with medications (Exhibit 2-18). Respondents reported that other activities occurred with less frequency.

Exhibit 2-18 – Health Coach Activity – Initial Survey (Aggregate)



The rate at which activities occurred was generally consistent across initial survey time periods and between the initial and follow-up surveys (Exhibit 2-19). One notable change from the first to second initial survey groups was an increase of 21 percentage points in the number of respondents stating they received medication management assistance.

Exhibit 2-19 – Health Coach Activity – Initial Survey (Longitudinal) & Follow-up

Activity	Health Coach Activity Occurrence			
	Initial Survey (% "yes")			Follow-up Survey (% "yes")
	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate	
1. Asked questions about your health problems or concerns	98.3%	99.1%	***98.9%***	***98.3%***
2. Provided instructions about taking care of your health problems or concerns	83.9%	93.0%	***91.4%***	***95.0%***
3. Helped you to identify changes in your health that might be an early sign of a problem	24.6%	39.3%	***36.7%***	***24.8%***
4. Answered questions about your health	78.8%	89.7%	***87.7%***	***90.9%***
5. Helped you talk to and work with your regular doctor and your regular doctor's staff	44.9%	30.4%	***33.0%***	***25.6%***
6. Helped you to make and keep health care appointments with other doctors, such as specialists, for medical problems	27.1%	25.3%	***25.6%***	***22.3%***
7. Helped you to make and keep health care appointments for mental health or substance abuse problems	14.4%	6.5%	***7.9%***	***5.0%***
8. Reviewed your medications with you and helped you to manage your medications	59.3%	81.0%	***77.1%***	***80.2%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Respondents were asked to rate their satisfaction with each "yes" activity. The overwhelming majority across all survey groups reported being very satisfied with the help they received (Exhibit 2-20). The only activity registering somewhat lower "very satisfied" ratings was assistance with mental health/substance abuse problems, particularly among initial survey respondents in the second time period. However, nearly all respondents rating this activity reported being either very or somewhat satisfied.

Exhibit 2-20 – Satisfaction with Health Coach Activity ("Very Satisfied")[32] – Initial Survey (Longitudinal) & Follow-up

Activity	Health Coach Activity Satisfaction (Very Satisfied)			
	Initial Survey (% "very satisfied")			Follow-up Survey (% "very satisfied")
	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate	
1. Asked questions about your health problems or concerns	84.3%	91.0%	***89.8%***	***94.1%***
2. Provided instructions about taking care of your health problems or concerns	86.7%	93.1%	***92.1%***	***93.9%***
3. Helped you to identify changes in your health that might be an early sign of a problem	87.9%	95.3%	***94.3%***	***100.0%***
4. Answered questions about your health	90.3%	93.6%	***93.1%***	***95.5%***
5. Helped you talk to and work with your regular doctor and your regular doctor's staff	98.1%	90.9%	***92.5%***	***96.9%***
6. Helped you to make and keep health care appointments with other doctors, such as specialists, for medical problems	93.8%	87.0%	***88.2%***	***100.0%***
7. Helped you to make and keep health care appointments for mental health or substance abuse problems	93.8%	62.3%	***69.6%***	***80.0%***
8. Reviewed your medications with you and helped you to manage your medications	84.7%	92.4%	***91.3%***	***95.9%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

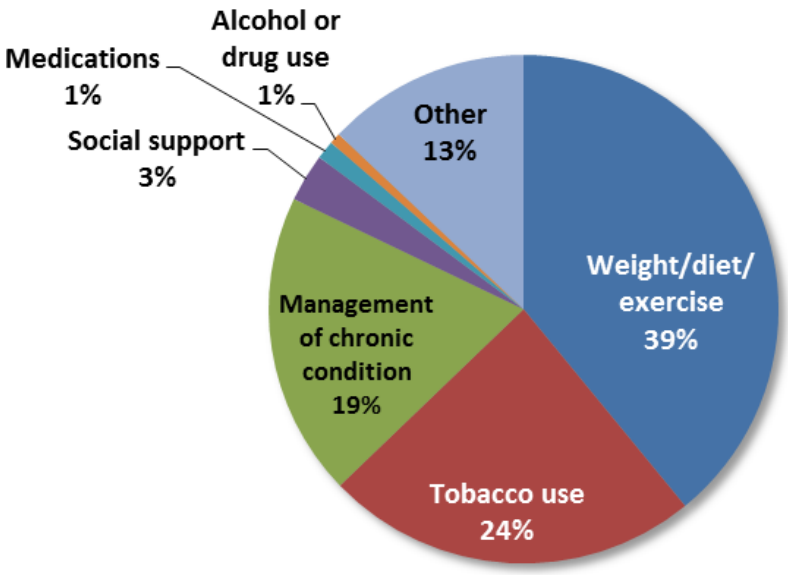
[32] Satisfaction percentages shown in Appendix B for this and later tables are for all survey respondents, rather than the subset answering "yes" to an activity. The two data sets therefore do not match for these questions.

Health coaching employs motivational interviewing to identify lifestyle changes that members would like to make. Once identified, it is the health coach's responsibility to collaborate with the member in developing an action plan with goals to be pursued by the member with his/her coach's assistance.

Seventy-six percent of initial survey respondents and 77 percent of follow-up survey respondents confirmed that their health coach asked them what change in their life would make the biggest difference in their health. Eighty-four percent of the initial survey group subset that answered "yes" (or 63 percent of total) stated that they actually selected an area to make a change. Among follow-up survey respondents, 73 percent of the subset that answered "yes" (or 56 percent of total) reported selecting an area to make a change.

The most common choice among initial survey respondents involved some combination of weight loss or gain, improved diet and exercise (Exhibit 2-21). This was followed by tobacco use cessation and management of a chronic physical health condition, such as asthma, diabetes or hypertension. The "other" category included recovery from acute conditions, improved medication management, general health improvement and doing a better job of keeping doctor's appointments.

Exhibit 2-21 – Area Selected for Development of Action Plan – Initial Survey (Aggregate)



The area selected for making a change was generally consistent across initial survey time periods and between the initial and follow-up surveys. The exceptions were "other", which declined over time, and tobacco use, which nearly doubled in frequency from the first to second initial survey time periods and remained at the higher level in the follow-up survey (Exhibit 2-22).

Exhibit 2-22 – Area Selected for Development of Action Plan – Initial Survey (Longitudinal) & Follow-up

	Action Plan			
	Initial Survey (% selecting)			Follow-up Survey (% selecting)
Action Plan Area	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate	
1. Management of chronic condition	21.5%	18.7%	***19.3%***	***18.8%***
2. Weight/diet/exercise	36.5%	39.7%	***39.0%***	***44.9%***
3. Tobacco use	14.0%	26.5%	***23.8%***	***23.2%***
4. Medications	0.0%	1.5%	***1.2%***	***2.9%***
5. Alcohol or drug use	0.0%	0.9%	***0.7%***	***0.0%***
6. Social support	0.0.%	3.9%	***3.1%***	***2.9%***
7. Other	28.0%	8.7%	***12.9%***	***7.2%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

A large majority who selected an area for change stated that they went on to develop an action plan with goals (84 percent of initial survey respondents and 78 percent of follow-up survey respondents). Among those with an action plan, 74 percent of initial survey respondents and 77 percent of follow-up survey respondents reporting achieving one or more goals. Exhibit 2-23 provides examples of the goals members reported achieving.

Exhibit 2-23 – Examples of Achieved Goals

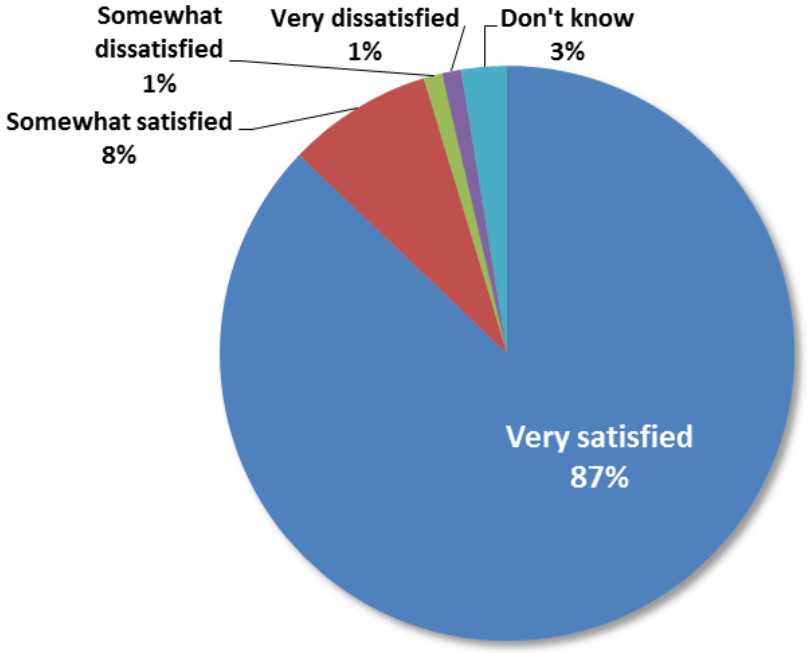
Action Plan Area	Goals Achieved
Weight/Diet/Exercise	• **Eating better, including more fruits/vegetables and less sugar** • **Exercising more; enrolling in an exercise class** • **Walking more** • **Learning portion control**
Management of chronic physical health condition	• **Better control of asthma with medications; using inhaler properly** • **Enrolling in diabetes education program** • **Eating better to control blood sugar** • **Seeing pain specialist**
Management of mental health condition	• **Starting counseling** • **Adhering to medication to address condition** • **Controlling weight while taking ADHD medications** • **Controlling anxiety; communicating with people outside of immediate family** • **Learning relaxation techniques** • **Learning how to say "no" to people**
Tobacco use	• **Cutting back on number of packs smoked per day** • **Converting to electronic cigarettes** • **Using nicotine patch** • **Calling SoonerQuit line** • **Putting cigarettes in hard to reach/inconvenient places**

Among the members who reported having a goal but not yet achieving it, 64 percent of initial survey respondents and 75 percent of follow-up survey respondents stated they were "very confident" they would ultimately accomplish it.

Regardless of their status, members were overwhelmingly positive about the role of the health coach, with 93 percent of initial survey respondents and 100 percent of follow-up survey respondents stating that their coach had been "very helpful" to them in achieving their goal.

This positive attitude carried over to the members' overall satisfaction with their health coaches. Eighty-seven percent of initial survey respondents stated they were "very satisfied" with their coach (Exhibit 2-24).

Exhibit 2-24 – Satisfaction with Health Coach – Initial Survey (Aggregate)



The high level of satisfaction was consistent across initial survey time periods and between the initial and follow-up surveys (Exhibit 2-25).

Exhibit 2-25– Satisfaction with Health Coach – Initial Survey (Longitudinal) & Follow-up

Response	Satisfaction with Health Coach				
	Initial Survey				Follow-up Survey
	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate		
Very satisfied	84.3%	87.7%	***87.1%***		***85.1%***
Somewhat satisfied	11.3%	7.5%	***8.2%***		***7.4%***
Somewhat dissatisfied	0.0%	1.3%	***1.1%***		***1.7%***
Very dissatisfied	1.7%	0.9%	***1.1%***		***0.8%***
Don't know/not sure/no response	2.6%	2.6%	***2.6%***		***5.0%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Community Resource Specialists

Telligen has community resource specialists available to help members with non-clinical issues, such as obtaining food or housing assistance. Health coaches are able to make referrals to the specialists when needs are identified and help is desired.

Thirty-eight percent of initial survey respondents and 37 percent of follow-up survey respondents stated they were aware of the resource specialists. Only a small portion – 30 initial survey respondents and three follow-up survey respondents – reported using the resource specialists to help resolve a problem (Exhibit 2-26). The nature of the help included housing/rental assistance, food assistance and arranging child care and transportation to medical appointments, all consistent with the specialists' defined mission.

Exhibit 2-26 – Community Resource Specialist Awareness & Use – Initial Survey (Longitudinal) & Follow-up

	Satisfaction with Health Coach				
	Initial Survey				Follow-up Survey
Awareness & Use	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate		
Yes - aware	35.9%	38.9%	***38.3%***		***37.2%***
No – not aware	63.2%	51.2%	***53.3%***		***54.5%***
Don't know/not sure/no response	0.9%	9.9%	***8.3%***		***8.3%***
If aware:					
Yes – have used	19.0%	10.4%	***11.9%***		***6.7%***
No – have not used	81.0%	89.1%	***87.7%***		***93.3%***
Don't know/not sure/no response	0.0%	0.5%	***0.4%***		***0.0%***

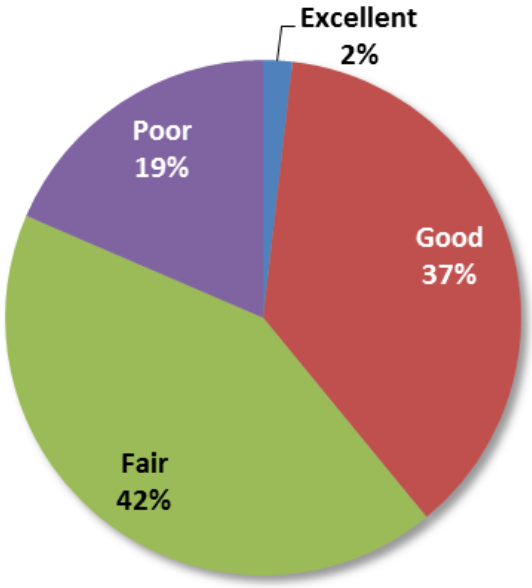
Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Twenty-two of the 30 initial survey respondents and all three follow-up survey respondents stated that the community resource specialist was "very helpful" in resolving their problem. A common complaint among the few respondents who found the resource specialist not to be helpful was that the member was given a referral telephone number (e.g., to a housing agency) but no other assistance.

Health Status and Lifestyle

The ultimate objectives of health coaching are to assist members in adopting healthier lifestyles and improving their overall health. When asked to rate their current health status, the largest segment of initial survey respondents said "fair" (Exhibit 2-27).

Exhibit 2-27 – Current Health Status – Initial Survey (Aggregate)



The self-reported health status profile was consistent across initial survey time periods and between the initial and follow-up surveys (Exhibit 2-28).

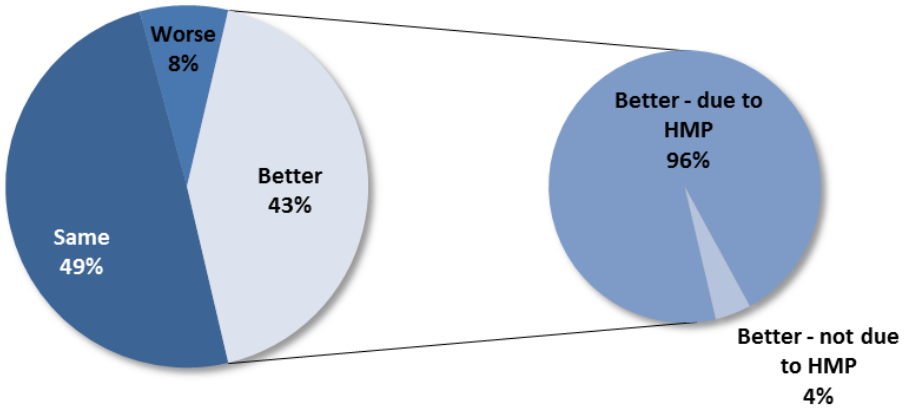
Exhibit 2-28 – Current Health Status –
Initial Survey (Longitudinal) & Follow-up

	Health Status			
	Initial Survey			Follow-up Survey
Response	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate	
Excellent	3.4%	1.5%	***1.8%***	***1.7%***
Good	31.4%	38.4%	***37.2%***	***40.5%***
Fair	46.6%	41.4%	***42.3%***	***40.5%***
Poor	18.6%	18.5%	***18.5%***	***17.4%***
Don't know/not sure/no response	0.0%	0.2%	***0.2%***	***0.0%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

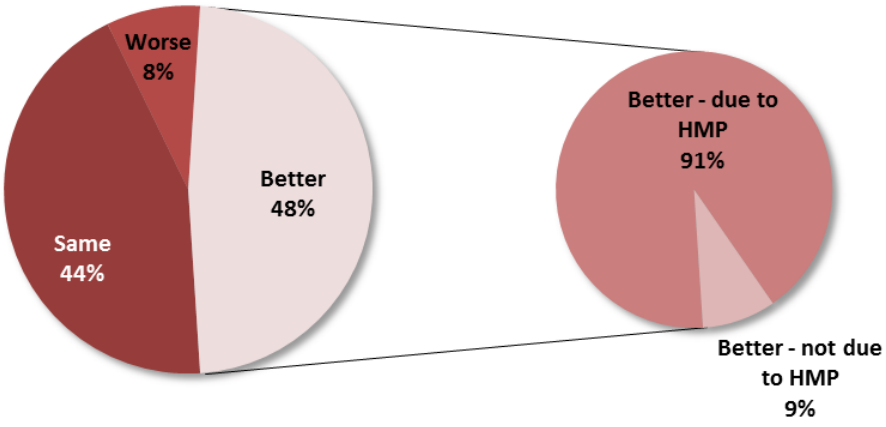
When next asked if their health status had changed since enrolling in the SoonerCare HMP, the largest segment of initial survey respondents (49 percent) said it was "about the same". However, nearly as many (43 percent) said their health was "better" and only eight percent said it was "worse". Among those respondents who reported a positive change, nearly all (96 percent) credited the SoonerCare HMP with contributing to their improved health (Exhibit 2-29).

Exhibit 2-29 – Health Status as Compared to Pre-HMP Enrollment – Initial Survey (Aggregate)



The results were even more encouraging among follow-up survey respondents. The largest segment reported improved health, with over 90 percent crediting this improvement to the program (Exhibit 2-30).

Exhibit 2-30 – Health Status as Compared to Pre-HMP Enrollment – Follow-up Survey



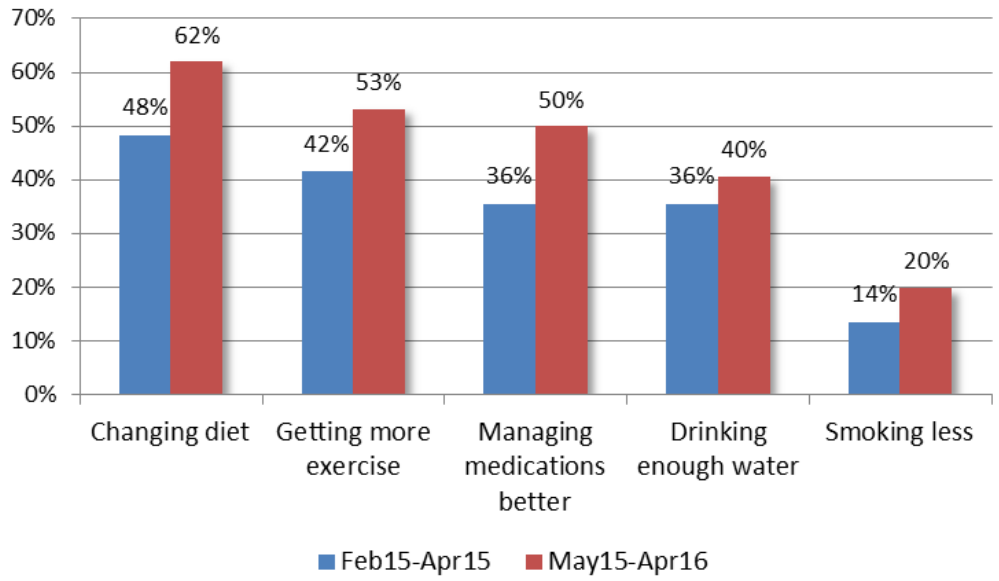
Respondents in the follow-up survey who stated that the SoonerCare HMP contributed to their improvement in health were asked to provide examples of the program's impact. The answers generally mirrored the achieved goals shown in Exhibit 2-23.

Respondents also were asked whether their health coach had tried to help them improve their health by changing behaviors and, if so, whether they had in fact made a change[33]. Respondents were asked whether their health coach discussed behavior changes with respect to: smoking, exercise, diet, medication management, water intake and alcohol/substance consumption. If yes, respondents were asked about the impact of the health coach's intervention on their behavior (no change, temporary change or continuing change).

A majority of respondents in both the initial and follow-up survey groups reported discussing each of the activities with their health coach. A significant percentage also reported continuing to make changes with respect to exercise, diet, water intake and medication management. Smaller percentages reported working to reduce tobacco, alcohol or other substance use.

The percentage that reported continuing change increased from the first to second initial survey groups for five of the six behavior areas; the sole exception was drinking/using other substances less, which was the same for both time periods (Exhibit 2 – 31).

Exhibit 2-31 – Changes in Behavior – "Continuing Change" – Initial Survey Groups[34]



[33] The areas of inquiry overlap somewhat with the content of action plans adopted by members. However, the questions in this section were asked of all members, regardless of what they reported with respect to having an action plan.

[34] The sixth behavior, drinking or using other substances less, was identified as an area of continuing change by 1.7 percent of both survey groups. It is omitted from the exhibit due to the difference in scale versus the other behavior items.

The results for the initial survey, in aggregate, and the follow-up survey were very similar across the six behaviors (Exhibit 2-32).

Exhibit 2-32– Changes in Behavior – Initial Survey (Aggregate) & Follow-up

Behavior	Survey	Discussion and Change in Behavior					
		N/A – Not Discussed[35]	Discussed – No Change	Discussed – Temporary Change	Discussed – Continuing Change	Discussed – But Not Applicable	Unsure/ No Response
1. Smoking less or using other tobacco products less	Initial	14.0%	5.3%	2.1%	18.5%	56.0%	4.1%
	Follow-up	9.2%	8.4%	0.0%	13.4%	65.5%	3.4%
2. Moving around more or getting more exercise	Initial	15.5%	7.1%	1.7%	51.0%	20.9%	3.8%
	Follow-up	12.6%	5.9%	1.7%	56.3%	21.0%	2.5%
3. Changing your diet	Initial	15.5%	6.4%	2.0%	59.3%	13.2%	3.6%
	Follow-up	12.6%	6.7%	1.7%	61.3%	16.0%	1.7%
4. Managing and taking your medications better	Initial	16.1%	3.2%	0.0%	47.2%	29.9%	3.6%
	Follow-up	16.0%	0.0%	0.0%	47.9%	33.6%	2.5%
5. Making sure to drink enough water throughout the day	Initial	37.8%	3.3%	0.6%	39.5%	14.4%	4.4%
	Follow-up	35.3%	5.0%	0.0%	37.0%	16.8%	5.9%
6. Drinking or using other substances less	Initial	29.3%	1.4%	0.0%	1.7%	63.6%	4.1%
	Follow-up	32.8%	0.0%	0.0%	0.8%	62.2%	4.2%

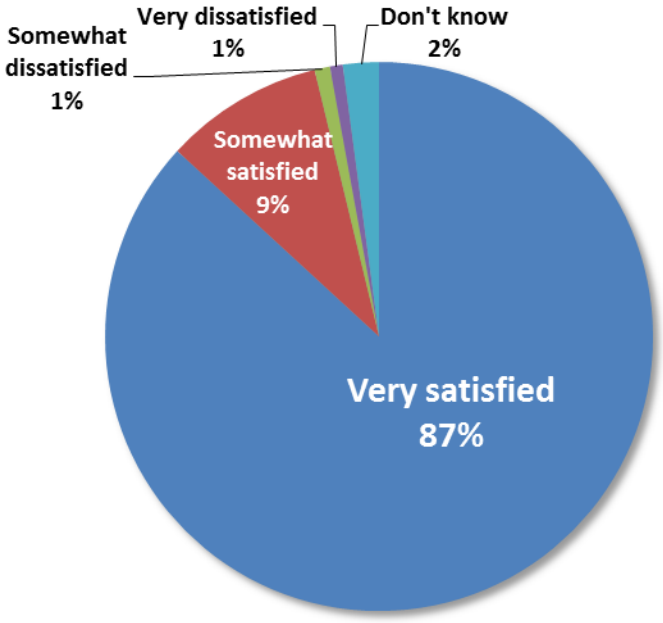
Note: Percentages on this and other tables may not total to 100 percent due to rounding.

[35] "N/A – not discussed" includes members for whom no inquiry was made. "Discussed but not applicable" column refers to members for whom an inquiry was made but the category did not apply (e.g., non-tobacco users).

Overall Satisfaction

Survey respondents reported very high levels of satisfaction with the SoonerCare HMP overall, consistent with their opinion of the health coach, who serves as the face of the program. Eighty-seven percent of initial survey respondents reported being "very satisfied" (Exhibit 2-33). An even higher percentage (93 percent) said they would recommend the program to a friend with health care needs like theirs.

Exhibit 2-33 – Overall Satisfaction with SoonerCare HMP – Initial Survey (Aggregate)



The "very satisfied" percentage increased from the first to second initial survey periods and was higher still among follow-up survey respondents (Exhibit 2-34).

Exhibit 2-34 – Overall Satisfaction with SoonerCare HMP – Initial Survey (Longitudinal) & Follow-up

	Satisfaction with SoonerCare HMP			
	Initial Survey			Follow-up Survey
Response	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate	
Very satisfied	81.9%	87.9%	***86.8%***	***89.9%***
Somewhat satisfied	12.9%	8.6%	***9.4%***	***8.4%***
Somewhat dissatisfied	0.9%	0.9%	***0.9%***	***0.8%***

Response	Satisfaction with SoonerCare HMP				
	Initial Survey				Follow-up Survey
	Feb – Apr 2015	May 2015 – Apr 2016	Aggregate		
Very dissatisfied	1.7%	0.6%	***0.8%***		***0.0%***
Don't know/not sure/no response	2.6%	2.0%	***2.1%***		***0.8%***

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Participant appreciation of the health coach and SoonerCare HMP overall is further reflected in the types of comments made during the survey. While not all of the comments were positive, the great majority were. For example:

> *"My nurse is great. She makes me comfortable enough that I can talk to her about anything. She tells me if I have any problem to just call her and she will help make appointments, or anything else that I may need. I appreciate her and the whole SoonerCare program a lot."*

> *"(My health coach) has been wonderful. Not only has she helped me with my physical help but she provides great emotional support too. My depression and anxiety is so much better now that I have her to talk to. She has even helped me improve the relationship with my daughter. I can't say enough good things about her and the program."*

> *"My physical health has not changed much since I got my Health Coach but my attitude sure has. Some days she calls and I am really down because of the chronic pain I have. She listens to me and it really helps. She has also helped educate me on my medications and how to take them the right way."*

> *"My health coach is wonderful. She has been very supportive with my diet. She has even offered to go work out with me."*

> *"I love (my health coach), please don't take her away from me. She has been a big help, whatever I need, she gets right on it. She helped me get a ride to the Rheumatologist, which is far away. I don't know how I would have gotten there otherwise."*

> *"I did not know (she) was a Health Coach. She just came into the room during my doctor appointment and offered to help me to eat better and exercise more to control my diabetes and with stress. She has given me a lot of support and encouragement to eat better and walk more. I think of her as more of a counselor than a health nurse. It is a great program, don't stop it."*

> *"I do not normally do these surveys, but as soon as you told me it was about (my health coach), I knew that I had to do it. She is so wonderful and has helped me so much. She is always there at my doctor appointments and has been very motivational in helping me lose weight. The loss of weight has greatly improved my knee and back pain."*

Voluntary Disenrollments

Six respondents in the follow-up survey stated that they had voluntarily disenrolled from the SoonerCare HMP. When asked why they disenrolled, they gave the following reasons:

- Not aware of the program/did not know had been enrolled (two respondents)
- Did not wish to self-manage care/receive health education (two respondents)
- Have no health needs at this time (one respondent)
- Satisfied with current doctor/health access without the program (one respondent)
- Changed doctors (two respondents)[36]
- Health coach stopped calling (two respondents)

Two of the reasons cited – changing doctors and loss of contact with the health coach – were arguably not voluntary disenrollments, although they were considered such by the respondents.

Summary Findings

SoonerCare HMP members report being very satisfied with their experience in the program and value highly their relationship with the health coach. This was true both at the time of the initial survey and when participants were re-contacted six months later for the follow-up survey.

[36] Going forward, this will no longer be a cause for disenrollment, due to the introduction of telephonic health coaching.

CHAPTER 3 – HEALTH COACHING QUALITY OF CARE ANALYSIS

Introduction

SoonerCare HMP health coaches devote much of their time to improving the quality of care for program participants. This includes educating participants about adherence to clinical guidelines for preventive care and for treatment of chronic conditions.

PHPG evaluated the impact of SoonerCare HMP health coaching on quality of care through calculation of Healthcare Effectiveness Data and Information Set (HEDIS®) and HEDIS®-like measures applicable to the SoonerCare HMP population. The evaluation included 19 diagnosis-specific measures and three population-wide preventive measures:

- Asthma measures
  - Use of appropriate medications for people with asthma
  - Medication management for people with asthma – 50 percent
  - Medication management for people with asthma – 75 percent

- Cardiovascular (CAD and heart failure) measures
  - Persistence of beta-blocker treatment after a heart attack
  - Cholesterol management for patients with cardiovascular conditions – LDL-C screening

- COPD measures
  - Use of spirometry testing in the assessment and diagnosis of COPD
  - Pharmacotherapy management of COPD exacerbation – 14 days
  - Pharmacotherapy management of COPD exacerbation – 30 days

- Diabetes measures
  - Percentage of members who had LDL-C screening
  - Percentage of members who had retinal eye exam performed
  - Percentage of members who had Hemoglobin A1c (HbA1c) testing
  - Percentage of members who received medical attention for nephropathy
  - Percentage of members prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACE/ARB therapy)

- Hypertension measures
  - Percentage of members who had LDL-C screening
  - Percentage of members prescribed ACE/ARB therapy
  - Percentage of members prescribed diuretics
  - Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring

- Mental Health measures
  - Follow-up after hospitalization for mental illness – 7 days
  - Follow-up after hospitalization for mental illness – 30 days

- Preventive health measures
  - Adult access to preventive/ambulatory health services
  - Children and adolescents' access to PCPs
  - Adult body mass index (BMI) assessment

The specifications for each measure are presented in the applicable section.

Methodology

The quality of care analysis targeted SoonerCare HMP health coaching participants meeting the criteria outlined in chapter one. The analysis was performed in accordance with HEDIS specifications. PHPG used administrative (claims) data to develop findings for the measures.

PHPG determined the total number of members to be evaluated for each measure (denominator), the number meeting the clinical standard (numerator) and the resultant "percent compliant". The results were compared to compliance rates for the general SoonerCare population (SFY 2015 reporting year), where available, and to national Medicaid MCO benchmarks where SoonerCare data was not available. (SoonerCare rates are shown in black font; national rates, when used, are shown in blue font. In a few instances, neither source was available, as denoted by dash lines.)

PHPG also compared SFY 2014 SoonerCare health coaching population compliance rates to SFY 2015 compliance rates to examine year-over-year trends.

For each measure, the first exhibit displayed presents SoonerCare health coaching participants and a comparison group (general SoonerCare population or national Medicaid MCO benchmark). The second exhibit presents SoonerCare health coaching year-over-year compliance percentages.

Statistically significant differences between members aligned with health coaching and the comparison group at a 95 percent confidence interval are noted in the exhibits through bold face type of the value shown in the "% point difference" column. However, disease-specific results should be interpreted with caution where there are small sample sizes.

There were no statistically significant differences at the 95 percent confidence interval identified in the health coaching participant year-over-year analysis.

Asthma

The quality of care for health coaching participants with asthma (ages 5 to 64) was evaluated through three clinical measures:

- *Use of Appropriate Medications for People with Asthma*: Percent with persistent asthma who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylaxanthines.
- *Medication Management for People with Asthma – 50 Percent*: Percentage of members receiving at least one asthma medication who had an active prescription for an asthma controller medication for at least 50 percent (50 percent compliance rate) of the year, starting with the first date of receiving such a prescription.
- *Medication Management for People with Asthma – 75 Percent*: Percentage of members receiving at least one asthma medication who had an active prescription at least 75 percent (75 percent compliance rate) of the year, starting with the first date of receiving such a prescription.

The compliance rate for the health coaching population exceeded the comparison group rate on two of three measures (Exhibit 3-1[37]). The difference was statistically significant for one measure.

Exhibit 3-1– Asthma Clinical Measures - Health Coaching Participants vs. Comparison Group

Measure	Health Coaching Participants			HC Participants versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	HC - Comparison: % Point Difference
1. Use of Appropriate Medications for People with Asthma	46	43	93.5%	81.2%	**12.3%**
2. Medication Management for People with Asthma – 50 Percent	44	30	68.2%	61.3%	6.9%
3. Medication Management for People with Asthma – 75 Percent	44	12	27.3%	38.6%	(11.3%)

Results for this diagnosis should be interpreted with caution given the small size of the population.

[37] In the interest of space, the population size for the comparison group is not presented in the tables. However, in all instances, it was many multiples of the health coaching population, as would be expected for a total program number. For example, the denominator for asthma measures was 16,230.

There was a small decline in the compliance rate for individuals with asthma who were appropriately prescribed medications from SFY 2014 to SFY 2015, although the compliance rate was still very high at 93.5 percent (Exhibit 3-2). The compliance rate for asthma medication management at the 50th and 75th percentiles was nearly unchanged.

Exhibit 3-2 – Asthma Clinical Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. Use of Appropriate Medications for People with Asthma	95.3%	93.5%	(1.8%)
2. Medication Management for People with Asthma – 50 Percent	68.3%	68.2%	(0.1%)
3. Medication Management for People with Asthma – 75 Percent	26.8%	27.3%	0.5%

Results for this diagnosis should be interpreted with caution given the small size of the population.

Cardiovascular Disease

The quality of care for health coaching participants with cardiovascular disease (coronary artery disease and/or heart failure) was evaluated through two clinical measures:

- *Persistence of Beta Blocker Treatment after Heart Attack*: Percentage of members 18 and older with prior MI prescribed beta-blocker therapy.
- *LDL-C Screening*: Percentage of members 18 to 75 who received at least one LDL-C screening in previous twelve months.

The compliance rate for the comparison group exceeded the health coaching population rate for beta blocker treatment after a heart attack (Exhibit 3-3). The difference was statistically significant, although this result should be viewed with caution given the small health coaching population.

Over 75 percent of the health coaching population received at least one LDL-C screening. A comparison group was not identified for this measure in SFY 2015.

Exhibit 3-3 – Cardiovascular Disease Clinical Measures - Health Coaching Participants vs. Comparison Group

Measure	Health Coaching Participants			HC Participants versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	HC - Comparison: % Point Difference
1. Persistence of Beta Blocker Treatment after Heart Attack	13	6	46.2%	83.3%	**(37.1%)**
2. LDL-C Screening	276	212	76.8%	---	---

Results for beta blocker treatment measure should be interpreted with caution given the small size of the population.

There was a slight decline in beta blocker treatment and a slight increase in LDL-C screening from SFY 2014 to SFY 2015 (Exhibit 3-4).

Exhibit 3-4 – Cardiovascular Disease Clinical Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. Persistence of Beta Blocker Treatment after Heart Attack	50.0%	46.2%	(3.8%)
2. LDL-C Screening	76.0%	76.8%	0.8%

Results for beta blocker treatment measure should be interpreted with caution given the small size of the population.

COPD

The quality of care for health coaching participants with COPD (ages 40 and older) was evaluated through three clinical measures:

- *Use of Spirometry Testing in the Assessment/Diagnosis of COPD*: Percentage of members who received spirometry screening.
- *Pharmacotherapy Management of COPD Exacerbation – 14 Days*: Percentage of COPD exacerbations for members who had an acute inpatient discharge or ED visit and who were dispensed systemic corticosteroid within 14 days.
- *Pharmacotherapy Management of COPD Exacerbation – 30 Days*: Percentage of COPD exacerbations for members who had an acute inpatient discharge or ED visit and who were dispensed a bronchodilator within 30 days.

The compliance rate for the comparison group exceeded the health coaching rate on two of three measures (Exhibit 3-5). The difference was statistically significant for one measure.

Exhibit 3-5– COPD Clinical Measures - Health Coaching Participants vs. Comparison Group

Measure	Health Coaching Participants			HC Participants versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	HC - Comparison: % Point Difference
1. Use of Spirometry Testing in the Assessment/Diagnosis of COPD	157	50	31.8%	31.0%	0.8%
2. Pharmacotherapy Management of COPD Exacerbation – 14 Days	119	60	50.4%	65.3%	**(14.9%)**
3. Pharmacotherapy Management of COPD Exacerbation – 30 Days	119	91	76.5%	79.0%	(2.5%)

The compliance rates for all three COPD measures increased slightly from SFY 2014 to SFY 2015 (Exhibit 3-6).

Exhibit 3-6 – COPD Clinical Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. Use of Spirometry Testing in the Assessment/Diagnosis of COPD	31.5%	31.8%	0.3%
2. Pharmacotherapy Management of COPD Exacerbation – 14 Days	49.5%	50.4%	0.9%
3. Pharmacotherapy Management of COPD Exacerbation – 30 Days	73.9%	76.5%	2.6%

Diabetes

The quality of care for health coaching participants (ages 18 to 75) with diabetes was evaluated through five clinical measures:

- *LDL-C Screening:* Percentage of members who received at least one LDL-C screening in previous twelve months.
- *Retinal Eye Exam*: Percentage of members who received at least one dilated retinal eye exam in previous twelve months.
- *HbA1c Test*: Percentage of members who received at least one HbA1C test in previous twelve months.
- *Medical Attention for Nephropathy*: Percentage of members who received medical attention for nephropathy in previous twelve months.
- *ACE/ARB Therapy*: Percentage of members who received ACE/ARB therapy in previous twelve months.

The compliance rate for the health coaching population exceeded the comparison group rate on the four measures having a comparison group percentage (Exhibit 3-7). The difference was statistically significant for all four measures.

Exhibit 3-7 – Diabetes Clinical Measures – Health Coaching Participants vs. Comparison Group

Measure	Health Coaching Participants			HC Participants versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	HC - Comparison: % Point Difference
1. LDL-C Screening	838	656	78.3%	63.9%	**14.4%**
2. Retinal Eye Exam	838	319	38.1%	27.3%	**10.8%**
3. HbA1c Test	838	731	87.2%	72.1%	**15.1%**
4. Medical Attention for Nephropathy	838	645	77.0%	52.4%	**24.6%**
5. ACE/ARB Therapy	838	557	66.5%	---	---

The compliance rates for three measures increased from SFY 2014 to SFY 2015 (Exhibit 3-8). There was a marginal decline in the compliance rates for two measures in SFY 2015; however, the ACE/ARB therapy compliance rate remained above 65 percent and the medical attention for nephropathy rate remained above 75 percent.

Exhibit 3-8 – Diabetes Clinical Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. LDL-C Screening	77.0%	78.3%	1.3%
2. Retinal Eye Exam	37.8%	38.1%	0.3%
3. HbA1c Test	86.7%	87.2%	0.5%
4. Medical Attention for Nephropathy	77.1%	77.0%	(0.1%)
5. ACE/ARB Therapy	66.8%	66.5%	(0.3%)

Hypertension

The quality of care for health coaching participants with hypertension (ages 18 and older) was evaluated through four clinical measures:

- *LDL-C Screening*: Percentage of members who received at least one LDL-C screening in previous twelve months.
- *ACE/ARB Therapy*: Percentage of members who received ACE/ARB therapy in previous twelve months.
- *Diuretics*: Percentage of members who received diuretic in previous twelve months.
- *Annual Monitoring for Patients Prescribed ACE/ARB or Diuretics*: Percentage of members prescribed ACE/ARB therapy or diuretic who received annual medication monitoring.

The compliance rate for the comparison group exceeded the health coaching population rate on the one measure having a comparison group percentage (Exhibit 3-9). The difference was statistically significant.

Exhibit 3-9 – Hypertension Clinical Measures – Health Coaching Participants vs. Comparison Group

Measure	Health Coaching Participants			HC Participants versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	HC - Comparison: % Point Difference
1. LDL-C Screening	1,855	1,257	67.8%	---	---
2. ACE/ARB Therapy	1,855	1,221	65.8%	---	---
3. Diuretics	1,855	833	44.9%	---	---
4. Annual Monitoring for Patients Prescribed ACE/ARB or Diuretics[38]	1,018	852	83.7%	86.8%	**(3.1%)**

[38] Denominator for measure 4 is smaller than numerator for measure 2 because numerator for measure 2 is defined as having at least one prescription active during the year. Denominator 4 is defined as having a prescription active for at least 180 days during the year.

The compliance rate for the health coaching population who received at least one LDL-C screening increased from SFY 2014 to SFY 2015 (Exhibit 3-10).

There was a small decline in the other three rates; however, over 65 percent of the health coaching population with hypertension received ACE/ARB therapy and over 80 percent received annual medication monitoring. The rate for diuretics was somewhat lower at just under 45 percent.

Exhibit 3-10 – Hypertension Clinical Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. LDL-C Screening	67.3%	67.8%	0.5%
2. ACE/ARB Therapy	66.5%	65.8%	(0.7%)
3. Diuretics	45.1%	44.9%	(0.2%)
4. Annual Monitoring for Patients Prescribed ACE/ARB or Diuretics	84.2%	83.7%	(0.5%)

Mental Health

The quality of care for health coaching participants with mental illness (ages six and older) was evaluated through two clinical measures:

- *Follow-up after Hospitalization for Mental Illness – Seven Days*: Percentage of members who were hospitalized during the measurement year for the treatment of selected mental health diagnoses who had a follow up visit with a mental health practitioner within seven days.
- *Follow-up after Hospitalization for Mental Illness – 30 Days*: Percentage of members who were hospitalized during the measurement year for the treatment of selected mental health diagnoses who had a follow up visit with a mental health practitioner within 30 days.

The compliance rate for the health coaching population exceeded the comparison group rate on both measures (Exhibit 3-11). The difference was statistically significant in both cases.

Exhibit 3-11 – Mental Health Measures – Health Coaching Participants vs. Comparison Group

Measure	Health Coaching Participants			HC Participants versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	HC - Comparison: % Point Difference
1. Follow-up after Hospitalization for Mental Illness – Seven Days	137	47	34.3%	21.9%	**12.4%**
2. Follow-up after Hospitalization for Mental Illness – 30 Days	137	92	67.2%	44.1%	**23.1%**

There was a slight decline in the compliance rates for both measures from SFY 2014 to SFY 2015 (Exhibit 3-12).

Exhibit 3-12 – Mental Health Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. Follow-up after Hospitalization for Mental Illness – Seven Days	34.8%	34.3%	(0.5%)
2. Follow-up after Hospitalization for Mental Illness – 30 Days	67.4%	67.2%	(0.2%)

Prevention

The quality of preventive care for health coaching participants was evaluated through three clinical measures:

- *Adult Access to Preventive/Ambulatory Care*: Percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.
- *Child Access to PCP*: Percentage of children 12 months to 19 years old who visited a primary care practitioner (PCP) during the measurement year, or if seven years or older, in the measurement year or year prior.
- *Adult BMI*: Percentage of adults 18 to 75 years old who had an outpatient visit where his/her BMI was documented, either during the measurement year or year prior to the measurement year.

The compliance rate for the health coaching population exceeded the comparison group rate on all three measures (Exhibit 3-13). The difference was statistically significant for all three measures.

Exhibit 3-13 – Preventive Measures – Health Coaching Participants vs. Comparison Group

Measure	Health Coaching Participants			HC Participants versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	HC - Comparison: % Point Difference
1. Adult Access to Preventive/Ambulatory Care	4,015	3,859	96.1%	84.1%	**12.0%**
2. Child Access to PCP	628	620	98.7%	91.7%	**7.0%**
3. Adult BMI	3,057	434	14.2%	10.7%	**3.5%**

There was a small increase in the compliance rate for the measure of child access to PCP from SFY 2014 to SFY 2015 (Exhibit 3-14). There was a slight decline in the compliance rates for the remaining two measures in SFY 2015 when compared to SFY 2014; however, the compliance rate for adult access to preventive/ambulatory care remained very high at 95 percent. The adult BMI compliance rate remained low at 14.2 percent.

Exhibit 3-14 – Preventive Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. Adult Access to Preventive/Ambulatory Care	96.3%	96.1%	(0.2%)
2. Child Access to PCP	98.4%	98.7%	0.3%
3. Adult BMI	14.3%	14.2%	(0.1%)

Summary of Key Findings

The health coaching participant compliance rate exceeded the comparison group rate on 12 of 17 measures for which there was a comparison group percentage (70.6 percent). The difference was statistically significant for 10 of the 12 measures (83.3 percent).

Conversely, the comparison group achieved a higher rate on five of the 17 measures (29.4 percent), including three for which the difference was statistically significant (60.0 percent).

The health coaching participant compliance rate improved on 10 of 22 measures (45.5 percent) from SFY 2014 to SFY 2015, although typically by small amounts. Twelve of 22 measures (54.5 percent) experienced a slight decline from SFY 2014 to SFY 2015. The most impressive results, relative to the comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care.

While it is still early in the evaluation process, the above findings suggest that health coaching is having a positive impact on the quality of care for program participants. The long term benefit to participants will continue to be measured through the quality of care longitudinal analysis and through the utilization and expenditure analysis presented in the next chapter.

CHAPTER 4 – HEALTH COACHING – UTILIZATION, EXPENDITURE & COST EFFECTIVENESS ANALYSIS

Introduction

Health coaching, if effective, should have an observable impact on participant service utilization and expenditures. Improvement in quality of care should yield better outcomes in the form of fewer emergency department visits and hospitalizations, and lower acute care costs.

Most SoonerCare HMP participants are identified based on MEDai data, which includes a 12-month forecast of emergency department visits, hospitalizations and total expenditures . MEDai's advanced predictive modeling, as opposed to extrapolating historical trends, accounts for participants' risk factors and recent clinical experience[39].

The resulting forecasts serve as an accurate depiction of what participant utilization would have been like in the absence of health coaching. They serve as benchmarks against which each member's actual utilization and expenditures, post HMP enrollment, can be compared.

At the program level, the expenditure test also must take into account SoonerCare HMP administrative expenses. To be cost effective, actual expenditures must be sufficiently below forecast to cover administrative expenses and yield some level of net savings.

Methodology

PHPG conducted the utilization and expenditure evaluation by comparing SoonerCare HMP participants' actual claims experience to MEDai forecasts for the period following the start date of engagement up to 24 months. Data includes both active participants and persons who have graduated or otherwise disenrolled from the program.

MEDai forecasts only extend to the first 12 months of engagement. For months 13 to 24, PHPG applied a trend rate to the MEDai data to calculate an estimated PMPM absent SoonerCare HMP enrollment. The trend rate was set equal to the actual PMPM trend in SFY 2015 for a comparison group comprised of SoonerCare members who were determined to be eligible for the SoonerCare HMP but who declined the opportunity to enroll ("eligible but not engaged").

The trend rate was calculated using a roster of "eligible but not engaged" members dating back to the start of the second generation SoonerCare HMP in SFY 2014. Before calculating the trend, PHPG analyzed the roster data and removed members without at least one chronic condition, as well as members with no or very low claims activity. This was done to ensure the comparison group accurately reflected the engaged population.

[39] Providers also can refer members for health coaching. This includes members whose MEDai scores are relatively low, but are determined by the provider and health coach to be "at risk" based on the individual's total profile.

The trend rate for the eligible but not engaged comparison group was three percent. This trend was applied to the MEDai forecast PMPM for months 1 – 12 to establish a PMPM for months 13 – 24 absent enrollment in the SoonerCare HMP.

The subsequent evaluation examined participants in six priority diagnostic categories used by MEDai as part of its calculation of the chronic impact score for potential SoonerCare HMP participants: asthma, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), heart failure, diabetes mellitus and hypertension[40]. The evaluation also examined the SoonerCare HMP population as a whole.

Participants in each diagnostic category were included in the analysis only if it was their most expensive at the time of engagement. A member's most expensive diagnostic category at the time of engagement was defined as the diagnostic category associated with the greatest medical expenditures during the pre-engaged (1-12 months) and engaged periods. As participants have significant rates of physical co-morbidities, categorizing them in this manner allows for a targeted analysis of both the absolute and relative impact of health coaching on the various chronic impact conditions driving participant utilization.

PHPG developed utilization/expenditure rates using claims with dates of service from SFY 2013 through SFY 2015. (The SFY 2013 data was used for calculation of pre-engagement activity.) The OHCA and HPE (the state's Medicaid fiscal agent) prepared a claims file employing the same extraction methodology used by the OHCA on a monthly basis to provide updated claims files to MEDai.

The initial file contained individual eligibility records and complete claims for the Medicaid eligible. PHPG created a dataset that identified each individual's eligibility and claims experience during the evaluation period.

Participants were included in the analysis only if they had three months or more of engagement experience as of June 30, 2015, and had MEDai forecast data available at the time of engagement.[41]

The following data is provided for each of the six diagnoses:

1. Number of participants having the diagnosis and portion for which the diagnosis is their most expensive condition;
2. Comorbidity rates with other targeted conditions;
3. Inpatient days – forecast versus actual;
4. Emergency department visits – forecast versus actual;

[40] MEDai examines diagnoses beyond the six listed, but these six are among the most common found among SoonerCare HMP and CCU participants and are significant contributors to member utilization and expenditures.
[41] See chapter one for information on other exclusions made prior to the utilization/expenditure analysis.

5. PMPM medical expenditures – forecast versus actual;
6. Medical expenditures by category of service – pre- and post-engagement; and
7. Aggregate medical expenditure impact of SoonerCare HMP participation.

Items 3 through 7 also are presented for the SoonerCare HMP population as a whole. Appendix C contains detailed expenditure exhibits.

Asthma Population Utilization and Expenditure Evaluation

The SoonerCare HMP in SFY 2015 included 1,346 health coaching participants with an asthma diagnosis[42]. Asthma was the most expensive diagnosis at the time of engagement for 56 percent of participants with this diagnosis (Exhibit 4-1).

Exhibit 4-1 – Participants with Asthma as Most Expensive Diagnosis

Participants w/Asthma	Number Most Expensive	Percent Most Expensive
1,346	748	56%

A significant portion of participants with asthma also were diagnosed with another chronic impact condition, the most common being hypertension and COPD (Exhibit 4-2).

Exhibit 4-2 – Participants with Asthma Co-morbidity with Chronic Impact Conditions

Condition	Percent w/Comorbidity
Asthma	---
Coronary Artery Disease	11%
COPD	44%
Diabetes	24%
Heart Failure	9%
Hypertension	49%

[42] All participation and expenditure data in the chapter is for the portion of the SoonerCare HMP population remaining after application of the exclusions described in chapter one.

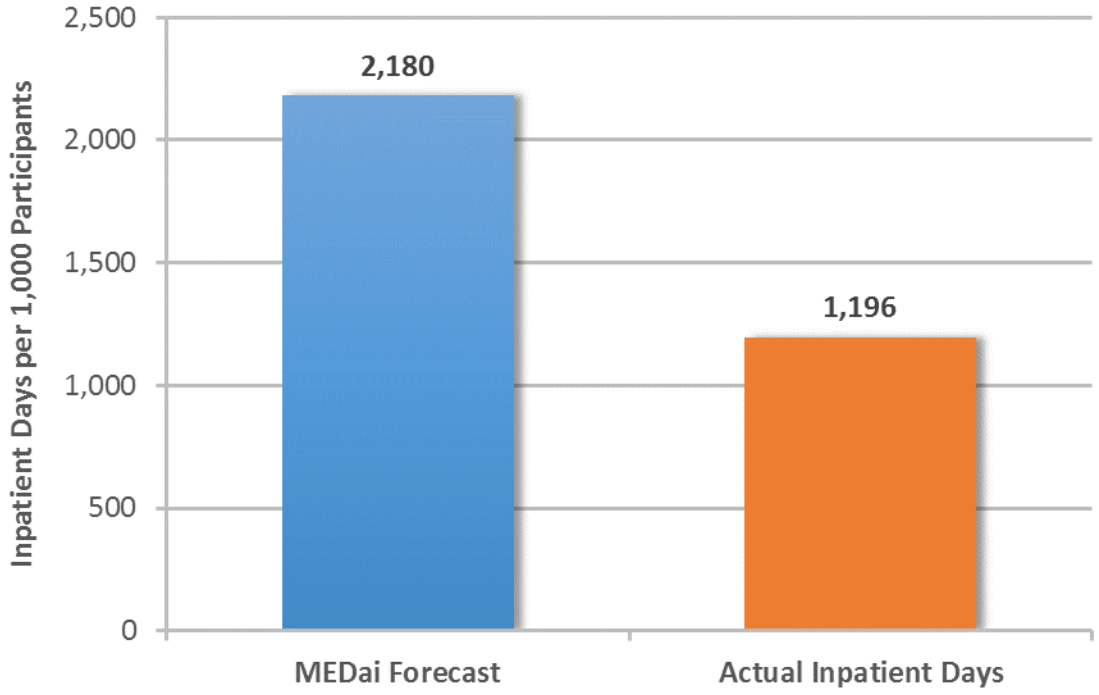
Utilization

PHPG analyzed inpatient hospital and emergency department utilization rates by comparing MEDai forecasts to actual utilization. Hospital utilization was measured by number of inpatient days and emergency department utilization by number of visits per 1,000 participants with asthma as their most expensive diagnosis at the time of engagement.

The purpose of this analysis was to determine if enrollment in the SoonerCare HMP had an impact on avoidable and expensive acute care episodes. All hospitalizations and emergency department visits for a participant were included in the calculations, regardless of the primary admitting/presenting diagnosis. The SoonerCare HMP is intended to be holistic and not limited in its impact to a member's particular chronic condition.

MEDai forecasted that participants with asthma would incur 2,180 inpatient days per 1,000 participants in the first 12 months of engagement[43]. The actual rate was 1,196, or 55 percent of forecast (Exhibit 4-3). (As a point of comparison, the rate for all Oklahomans in 2014, across all diagnoses, was 560 days per 1,000.[44])

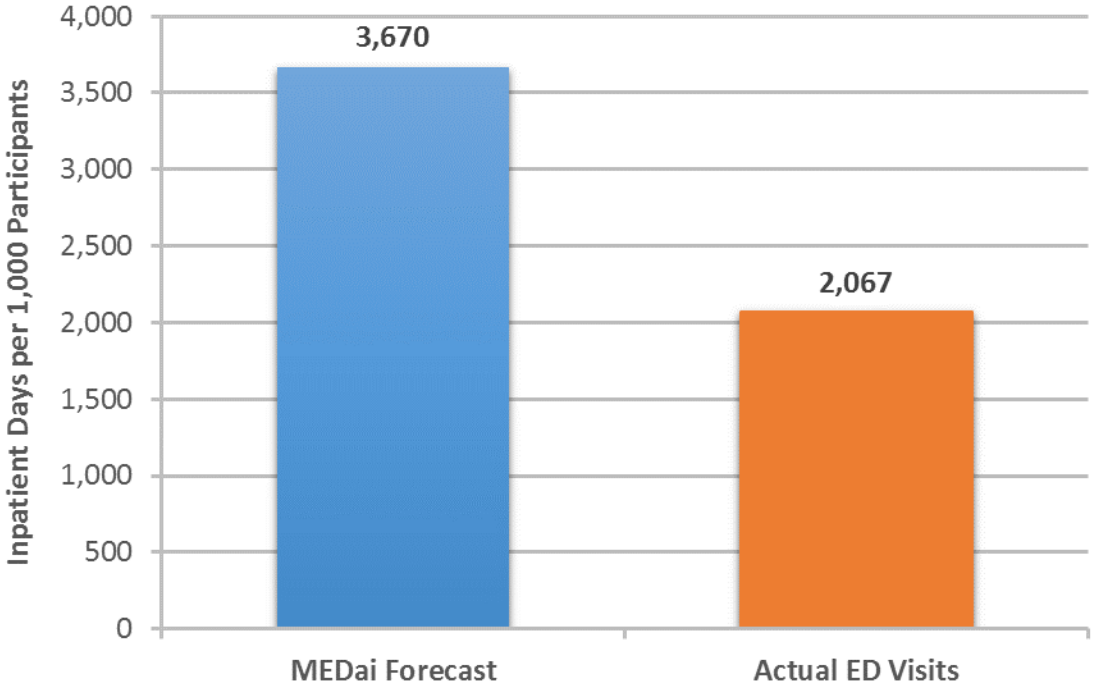
Exhibit 4-3 – Participants with Asthma as Most Expensive Diagnosis
Inpatient Utilization - First 12 Months Following Engagement, per 1,000 Participants



[43] All MEDai forecasts assume no intervention in terms of care management. Rate calculated for portion of year that each participant was engaged in program.
[44] Source: http://kff.org/other/state-indicator/inpatient-days-by-ownership/ 2014 is the most recent year available.

MEDai forecasted that participants with asthma would incur 3,670 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 2,067, or 56 percent of forecast (Exhibit 4-4). (As a point of comparison, the rate for all Oklahomans in 2013, across all diagnoses, was 479 visits per 1,000.[45])

Exhibit 4-4 – Participants with Asthma as Most Expensive Diagnosis
Emergency Department Utilization - First 12 Months Following Engagement, per 1,000 Participants



[45] Source: http://kff.org/other/state-indicator/emergency-room-visits-by-ownership/ 2013 is the most recent year available.

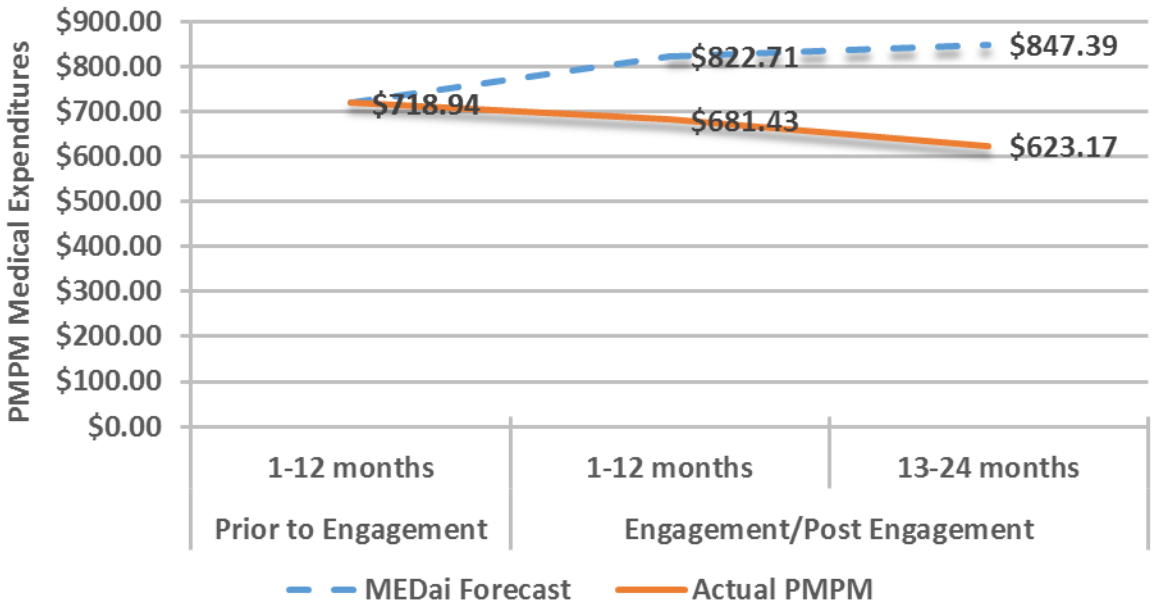
Medical Expenditures – Total and by Category of Service

PHPG documented total per PMPM medical expenditures for participants with asthma during the 12 months prior to engagement and compared actual medical expenditures to forecast for the first 24 months of engagement[46].

MEDai forecasted that participants with asthma would incur an average of $823 in PMPM expenditures in the first 12 months of engagement. The actual amount was $681, or 83 percent of forecast.

For months 13 to 24, the MEDai forecast with trend applied was $847 in PMPM expenditures. The actual amount was $623, or 74 percent of forecast (Exhibit 4-5).

Exhibit 4-5 – Participants with Asthma as Most Expensive Diagnosis
Total PMPM Expenditures



[46] PMPM rate calculated for portion of year that each participant was engaged in program.

At the category-of-service level, the most significant declines in the first 12 months of engagement occurred within hospital and behavioral health expenditures (Exhibit 4-6).

Exhibit 4-6 – Participants with Asthma as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$116.67	$103.53	($13.14)	(11%)
Outpatient Hospital	$117.18	$97.86	($19.32)	(16%)
Physician	$168.40	$170.47	$2.07	1%
Pharmacy	$138.29	$147.88	$9.59	6%
Behavioral Health	$90.21	$79.92	($10.29)	(11%)
All Other	$88.08	$81.75	($6.33)	(7%)
Total	$718.94	$681.43	($37.51)	(5%)

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for SoonerCare HMP participants with asthma as their most expensive diagnosis by multiplying total months of engagement by average PMPM savings. The resultant savings equaled approximately $1.3 million (Exhibit 4-7).

Exhibit 4-7 – Participants with Asthma as Most Expensive Diagnosis
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	6,069	$141.28	$857,428
Months 13 - 24	2,038	$224.22	$456,960
Total	**8,107**	**$162.13**	**$1,314,389**

Coronary Artery Disease Population Utilization and Expenditure Evaluation

The SoonerCare HMP in SFY 2015 included 572 health coaching participants with a coronary artery disease diagnosis (CAD) . Coronary artery disease was the most expensive diagnosis at the time of engagement for 23 percent of participants with this diagnosis (Exhibit 4-8).

Exhibit 4-8 – Participants with CAD as Most Expensive Diagnosis

Participants w/CAD	Number Most Expensive	Percent Most Expensive
572	132	23%

The majority of participants with coronary artery disease also were diagnosed with another chronic impact condition, the most common being hypertension and COPD (Exhibit 4-9).

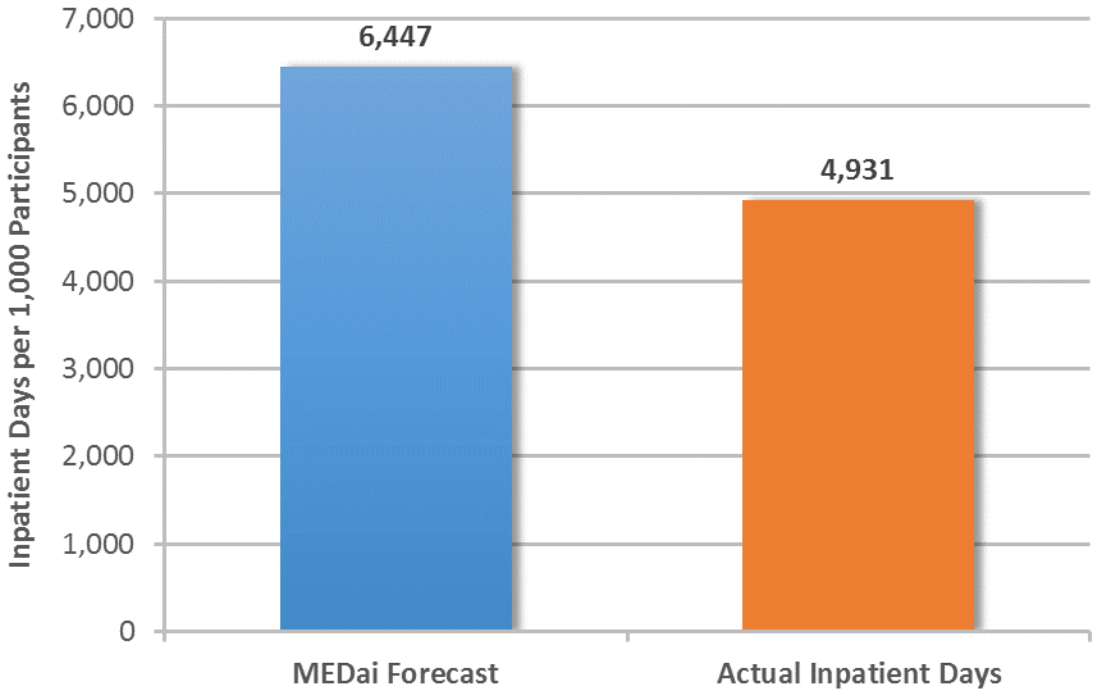
Exhibit 4-9 – Participants with CAD
Co-morbidity with Chronic Impact Conditions

Condition	Percent w/Comorbidity
Asthma	26%
Coronary Artery Disease	---
COPD	60%
Diabetes	48%
Heart Failure	33%
Hypertension	90%

Utilization

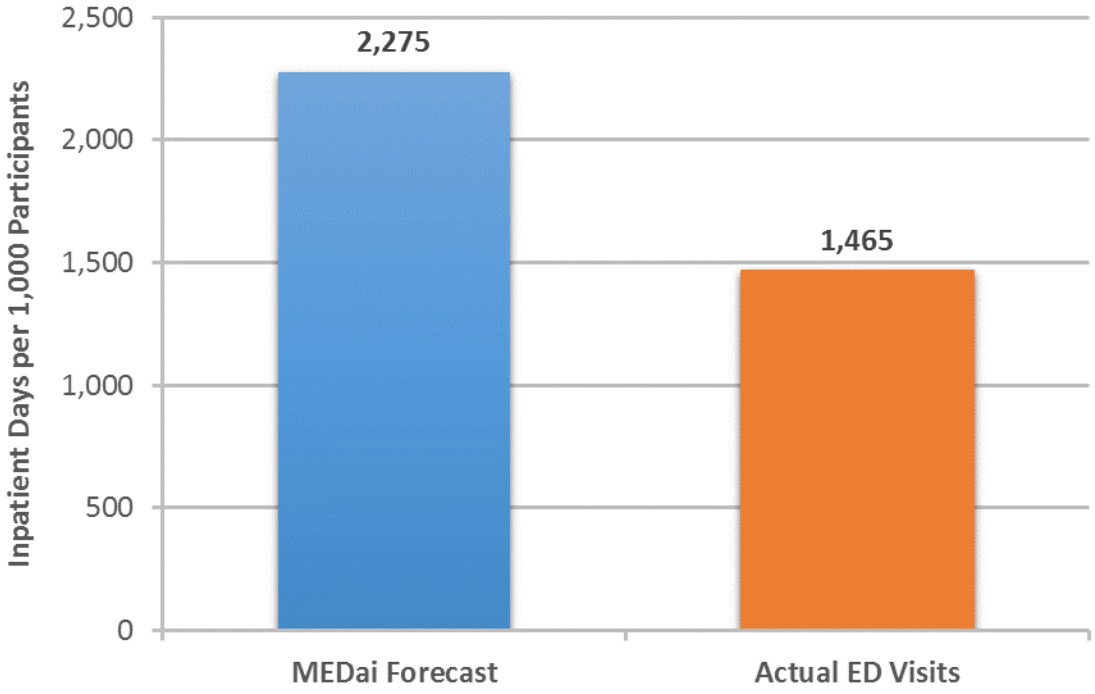
MEDai forecasted that participants with coronary artery disease would incur 6,447 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 4,931, or 76 percent of forecast (Exhibit 4-10).

Exhibit 4-10 – Participants with CAD as Most Expensive Diagnosis
Inpatient Utilization - First 12 Months Following Engagement, per 1,000 Participants



MEDai forecasted that participants with coronary artery disease would incur 2,275 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,465, or 64 percent of forecast (Exhibit 4-11).

Exhibit 4-11 – Participants with CAD as Most Expensive Diagnosis
Emergency Department Utilization - First 12 Months Following Engagement, per 1,000 Participants



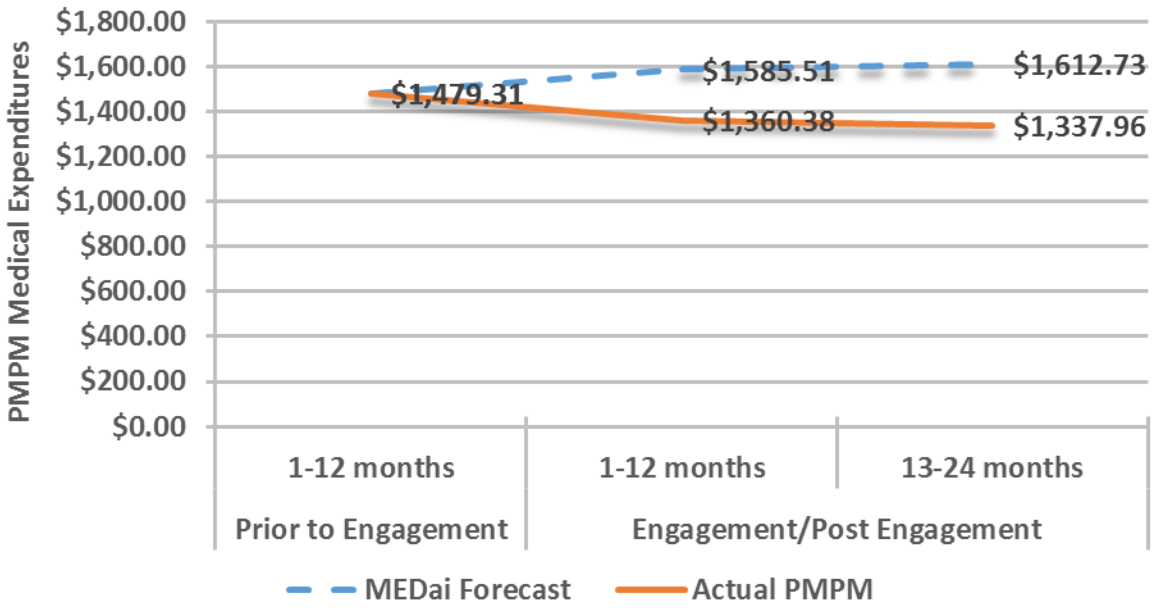
Medical Expenditures – Total and by Category of Service

PHPG documented total PMPM medical expenditures for participants with coronary artery disease during the 12 months prior to engagement and compared actual medical expenditures to forecast for the first 24 months of engagement.

MEDai forecasted that participants with coronary artery disease would incur an average of $1,586 in PMPM expenditures in the first 12 months of engagement. The actual amount was $1,360, or 86 percent of forecast.

For months 13 to 24, the MEDai forecast with trend applied was $1,613 in PMPM expenditures. The actual amount was $1,338, or 83 percent of forecast (Exhibit 4-12).

Exhibit 4-12 – Participants with CAD as Most Expensive Diagnosis
Total PMPM Expenditures



At the category-of-service level, the most significant declines in the first 12 months of engagement occurred within hospital and physician expenditures (Exhibit 4-13).

Exhibit 4-13 – Participants with CAD as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$618.64	$561.48	($57.16)	(9%)
Outpatient Hospital	$180.34	$147.48	($32.86)	(18%)
Physician	$296.40	$260.48	($35.92)	(12%)
Pharmacy	$195.22	$199.19	$3.97	2%
Behavioral Health	$27.50	$27.93	$0.43	2%
All Other	$161.21	$163.34	$2.13	1%
Total	$1,479.31	$1,359.90	($119.41)	(8%)

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for SoonerCare HMP participants with coronary artery disease as their most expensive diagnosis by multiplying total months of engagement in SFY 2014 by average PMPM savings. The resultant savings equaled approximately $419,000 (Exhibit 4-14).

Exhibit 4-14 – Participants with CAD as Most Expensive Diagnosis
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	1,341	$225.13	$301,899
Months 13 - 24	427	$274.77	$117,327
Total	**1,768**	**$237.19**	**$419,352**

COPD Population Utilization and Expenditure Evaluation

The SoonerCare HMP in SFY 2015 included 1,440 health coaching participants with a chronic obstructive pulmonary disease (COPD) diagnosis. COPD was the most expensive diagnosis at the time of engagement for 36 percent of participants with this diagnosis (Exhibit 4-15).

Exhibit 4-15 – Participants with COPD as Most Expensive Diagnosis

Participants w/COPD	Number Most Expensive	Percent Most Expensive
1,440	515	36%

The majority of participants with COPD also were diagnosed with another chronic impact condition, the most common being hypertension and asthma (Exhibit 4-16).

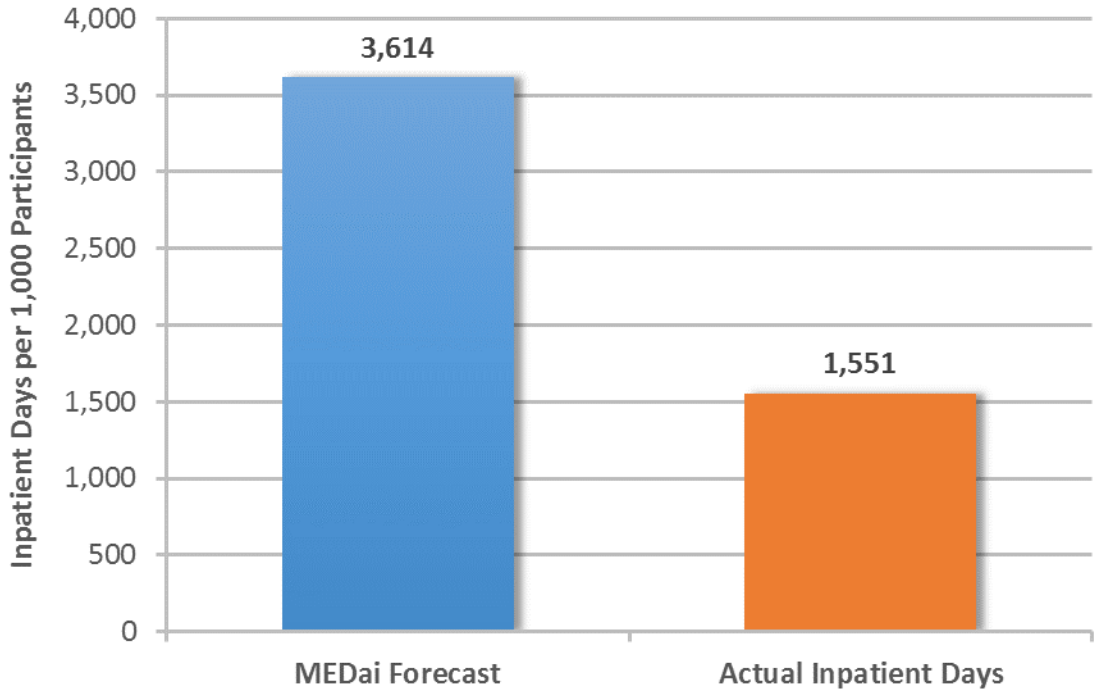
Exhibit 4-16 – Participants with COPD Co-morbidity with Chronic Impact Conditions

Condition	Percent w/Comorbidity
Asthma	37%
Coronary Artery Disease	25%
COPD	---
Diabetes	33%
Heart Failure	14%
Hypertension	71%

Utilization

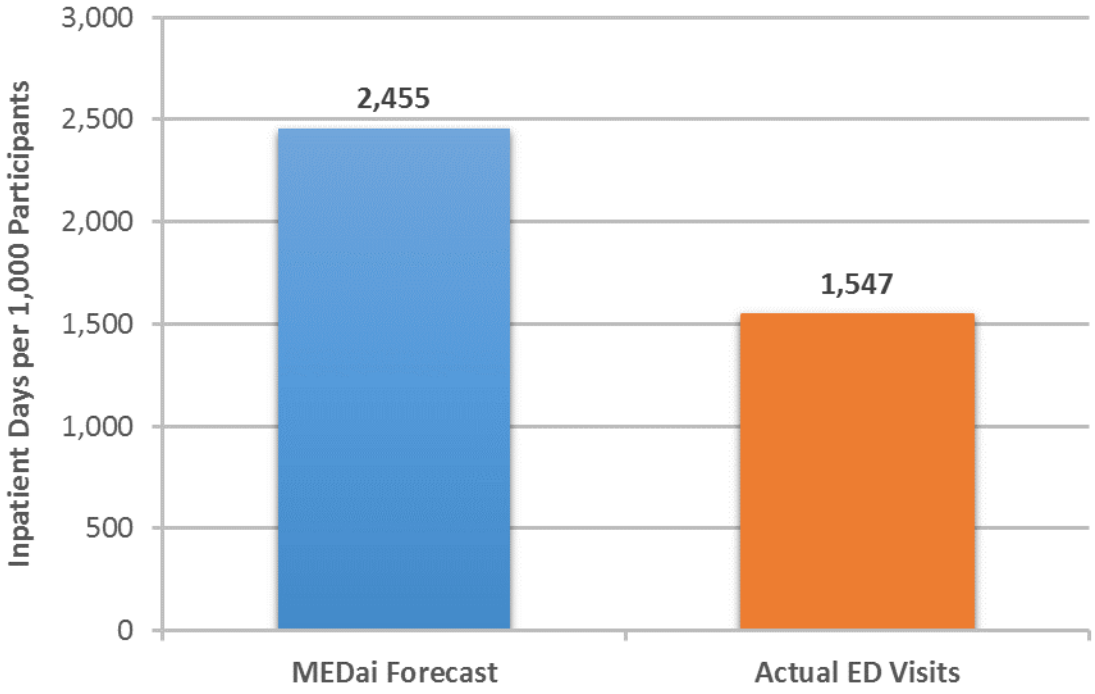
MEDai forecasted that participants with COPD would incur 3,614 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 1,551, or 43 percent of forecast (Exhibit 4-17).

Exhibit 4-17 – Participants with COPD as Most Expensive Diagnosis
Inpatient Utilization - First 12 Months Following Engagement, per 1,000 Participants



MEDai forecasted that participants with COPD would incur 2,455 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,547, or 63 percent of forecast (Exhibit 4-18).

Exhibit 4-18 – Participants with COPD as Most Expensive Diagnosis
Emergency Department Utilization - First 12 Months Following Engagement, per 1,000 Participants



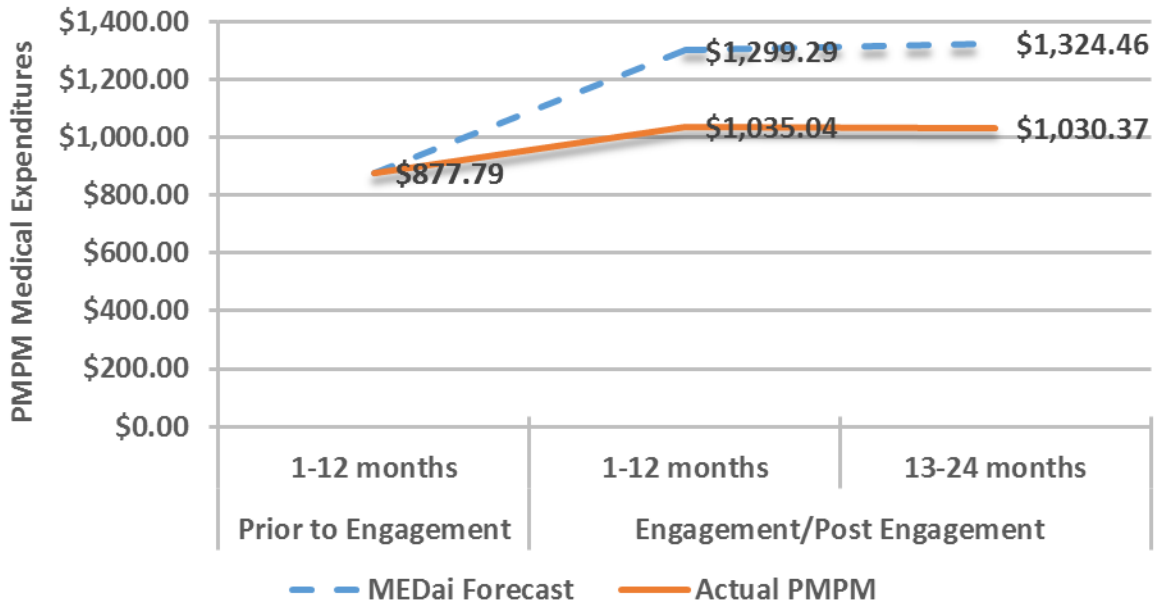
Medical Expenditures – Total and by Category of Service

PHPG documented total PMPM medical expenditures for participants with COPD during the 12 months prior to engagement and compared actual medical expenditures to forecast for the first 24 months of engagement.

MEDai forecasted that participants with COPD would incur an average of $1,299 in PMPM expenditures in the first 12 months of engagement. The actual amount was $1,035, or 80 percent of forecast.

For months 13 to 24, the MEDai forecast with trend applied was $1,324 in PMPM expenditures. The actual amount was $1,030, or 78 percent of forecast (Exhibit 4-19).

Exhibit 4-19 – Participants with COPD as Most Expensive Diagnosis
Total PMPM Expenditures



At the category-of-service level in the first 12 months of engagement, inpatient hospital expenditures declined slightly, while other service costs increased, with pharmacy costs experiencing the most significant growth (Exhibit 4-20).

Exhibit 4-20 – Participants with COPD as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$193.58	$190.00	($3.58)	(2%)
Outpatient Hospital	$100.36	$115.33	$14.97	13%
Physician	$174.19	$180.38	$6.19	3%
Pharmacy	$213.48	$331.19	$117.71	55%
Behavioral Health	$73.55	$77.75	$4.73	5%
All Other	$122.63	$140.41	$18.64	14%
Total	$877.79	$1,035.06	$157.27	18%

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for SoonerCare HMP participants with COPD as their most expensive diagnosis by multiplying total months of engagement by average PMPM savings. The resultant savings equaled approximately $1.8 million (Exhibit 4-21).

Exhibit 4-21 – Participants with COPD as Most Expensive Diagnosis
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	5,010	$264.25	$1,323,893
Months 13 - 24	1,574	$294.09	$462,898
Total	**6,584**	**$271.38**	**$1,786,766**

Diabetes Population Utilization and Expenditure Evaluation

The SoonerCare HMP in SFY 2015 included 1,195 health coaching participants with a diabetes diagnosis. Diabetes was the most expensive diagnosis at the time of engagement for 66 percent of participants with this diagnosis (Exhibit 4-22).

Exhibit 4-22 – Participants with Diabetes as Most Expensive Diagnosis

Participants w/Diabetes	Number Most Expensive	Percent Most Expensive
1,195	783	66%

The majority of participants with diabetes also were diagnosed with another chronic impact condition, the most common being hypertension and COPD (Exhibit 4-23).

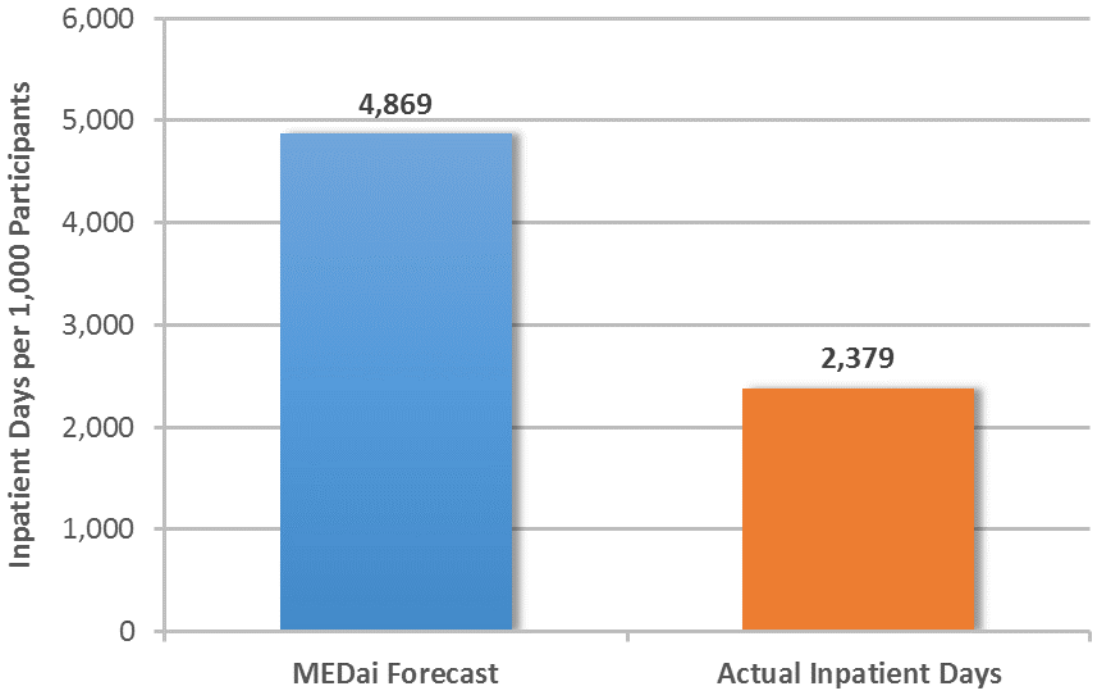
Exhibit 4-23 – Participants with Diabetes Co-morbidity with Chronic Impact Conditions

Condition	Percent w/Comorbidity
Asthma	26%
Coronary Artery Disease	23%
COPD	40%
Diabetes	---
Heart Failure	12%
Hypertension	81%

Utilization

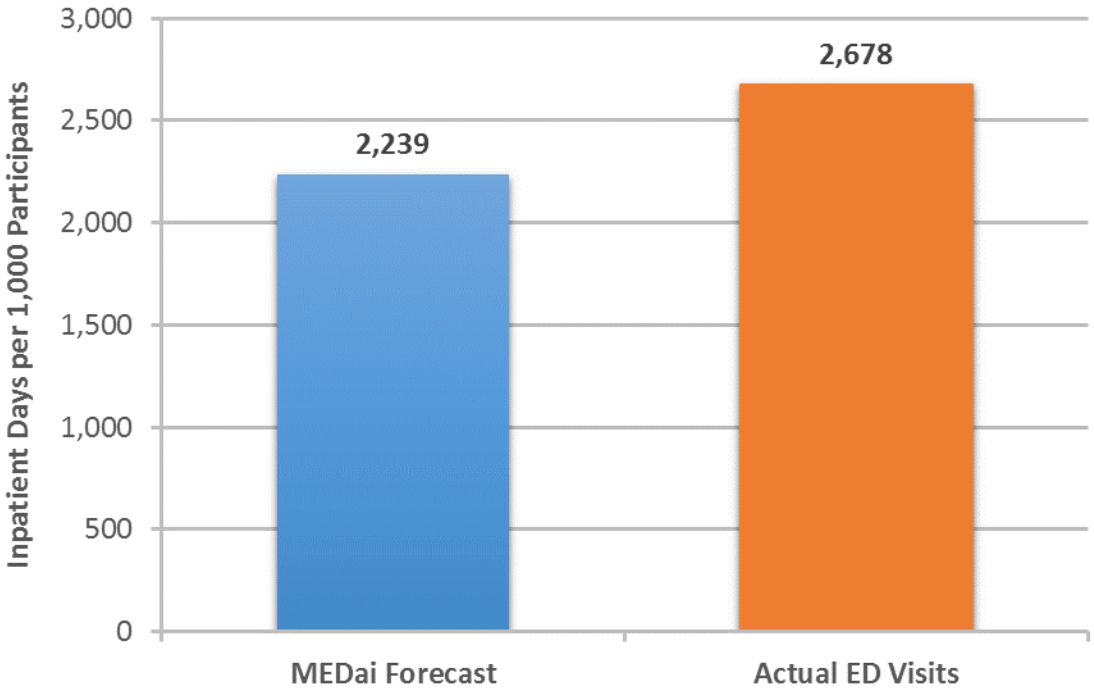
MEDai forecasted that participants with diabetes would incur 4,869 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 2,379, or 49 percent of forecast (Exhibit 4-24).

Exhibit 4-24 – Participants with Diabetes as Most Expensive Diagnosis
Inpatient Utilization - First 12 Months Following Engagement, per 1,000 Participants



MEDai forecasted that participants with diabetes would incur 2,239 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 2,678, or 119 percent of forecast (Exhibit 4-25).

Exhibit 4-25 – Participants with Diabetes as Most Expensive Diagnosis
Emergency Department Utilization - First 12 Months Following Engagement, per 1,000 Participants



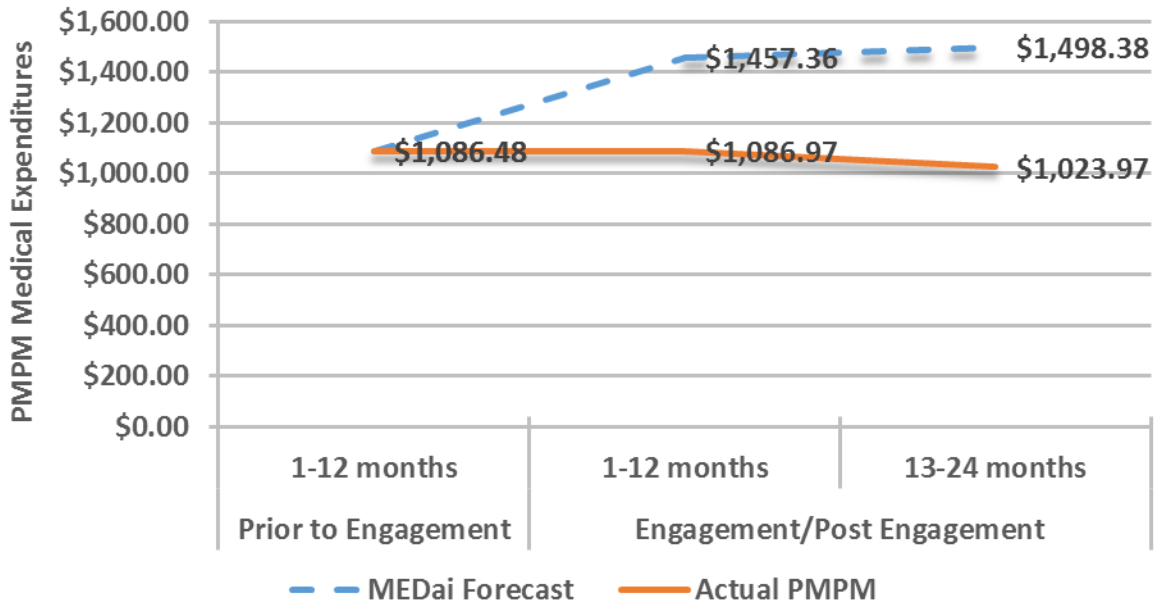
Medical Expenditures – Total and by Category of Service

PHPG documented total PMPM medical expenditures for participants with diabetes during the 12 months prior to engagement and compared actual medical expenditures to forecast for the first 24 months of engagement.

MEDai forecasted that participants with diabetes would incur an average of $1,457 in PMPM expenditures in the first 24 months of engagement. The actual amount was $1,087, or 75 percent of forecast.

For months 13 to 24, the MEDai forecast with trend applied was $1,498 in PMPM expenditures. The actual amount was $1,024, or 68 percent of forecast (Exhibit 4-26).

Exhibit 4-26 – Participants with Diabetes as Most Expensive Diagnosis
Total PMPM Expenditures



At the category-of-service level in the first 12 months of engagement, inpatient hospital and physician service expenditures declined, nearly offsetting increases in other service categories (Exhibit 4-27).

Exhibit 4-27 – Participants with Diabetes as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$288.41	$259.27	($29.14)	(10%)
Outpatient Hospital	$122.13	$135.31	$13.18	11%
Physician	$213.03	$197.22	($15.81)	(7%)
Pharmacy	$269.87	$295.06	$25.19	9%
Behavioral Health	$56.46	$63.21	$6.75	12%
All Other	$136.57	$136.91	$0.34	<1%
Total	$1,086.47	$1,086.98	$0.51	<1%

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for SoonerCare HMP participants with diabetes as their most expensive diagnosis by multiplying total months of engagement by average PMPM savings. The resultant savings equaled approximately $4.2 million (Exhibit 4-28).

Exhibit 4-28 – Participants with Diabetes as Most Expensive Diagnosis
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	7,676	$370.39	$2,843,114
Months 13 - 24	2,822	$474.41	$1,338,785
Total	**10,498**	**$398.35**	**$4,181,878**

Heart Failure Population Utilization and Expenditure Evaluation

The SoonerCare HMP in SFY 2015 included 310 health coaching participants with a heart failure diagnosis. Heart failure was the most expensive diagnosis at the time of engagement for 16 percent of participants with this diagnosis (Exhibit 4-29). Results for this diagnosis should be interpreted with caution given the small size of the population.

Exhibit 4-29 – Participants with Heart Failure as Most Expensive Diagnosis

Participants w/Heart Failure	Number Most Expensive	Percent Most Expensive
310	51	16%

The majority of participants with heart failure also were diagnosed with another chronic impact condition, the most common being hypertension and COPD (Exhibit 4-30).

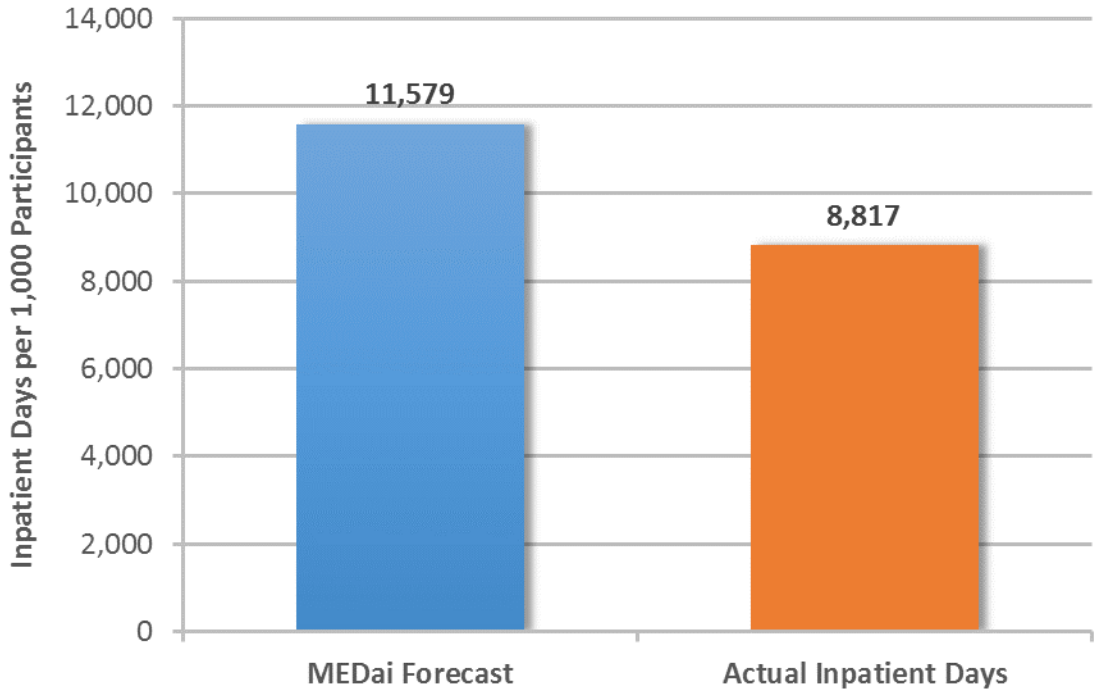
Exhibit 4-30 – Participants with Heart Failure Co-morbidity with Chronic Impact Conditions

Condition	Percent w/Comorbidity
Asthma	30%
Coronary Artery Disease	59%
COPD	64%
Diabetes	50%
Heart Failure	---
Hypertension	94%

Utilization

MEDai forecasted that participants with heart failure would incur 11,579 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 8,817, or 76 percent of forecast (Exhibit 4-31).

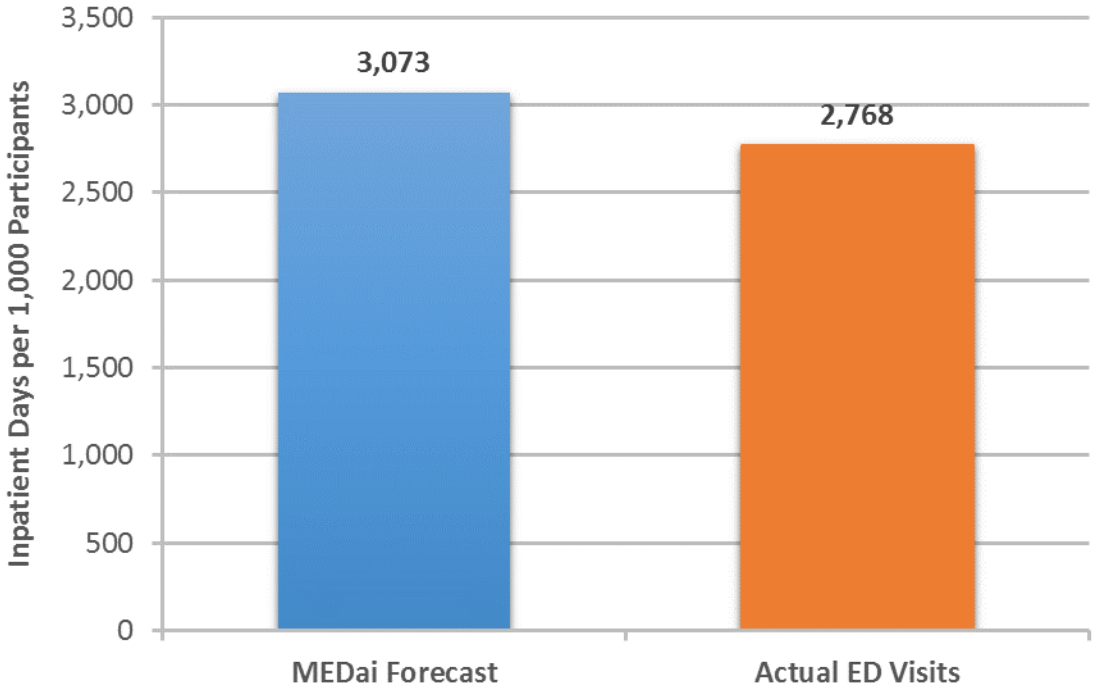
Exhibit 4-31 – Participants with Heart Failure as Most Expensive Diagnosis
Inpatient Utilization - First 12 Months Following Engagement, per 1,000 Participants



Results for this diagnosis should be interpreted with caution given the small size of the population.

MEDai forecasted that participants with heart failure would incur 3,073 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 2,768, or 90 percent of forecast (Exhibit 4-32).

Exhibit 4-32 – Participants with Heart Failure as Most Expensive Diagnosis
Emergency Department Utilization - First 12 Months Following Engagement, per 1,000 Participants



Results for this diagnosis should be interpreted with caution given the small size of the population.

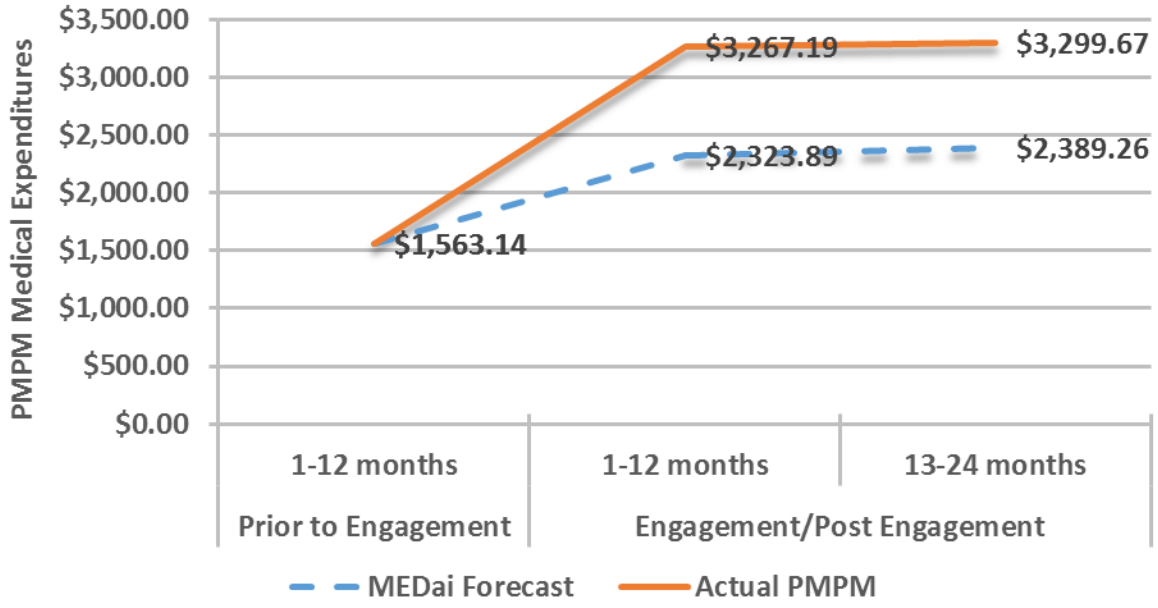
Medical Expenditures – Total and by Category of Service

PHPG documented total PMPM medical expenditures for participants with heart failure during the 12 months prior to engagement and compared actual medical expenditures to forecast for the first 24 months of engagement.

MEDai forecasted that participants with heart failure would incur an average of $2,324 in PMPM expenditures in the first 12 months of engagement. The actual amount was $3,267, or 140 percent of forecast.

For months 13 to 24, the MEDai forecast with trend applied was $2,389 in PMPM expenditures. The actual amount was $3,300, or 138 percent of forecast (Exhibit 4-33). Results for this diagnosis should be interpreted with caution given the small size of the population.

Exhibit 4-33 – Participants with Heart Failure as Most Expensive Diagnosis
Total PMPM Expenditures



Results for this diagnosis should be interpreted with caution given the small size of the population.

At the category-of-service level, the most significant increases in the first 12 months of engagement occurred within hospital and physician expenditures (Exhibit 4-34).

Exhibit 4-34 – Participants with Heart Failure as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$675.82	$2,088.28	$1,412.46	209%
Outpatient Hospital	$164.37	$253.84	$89.47	54%
Physician	$241.69	$398.92	$157.23	65%
Pharmacy	$210.47	$240.18	$29.71	14%
Behavioral Health	$51.37	$64.92	$13.55	26%
All Other	$219.42	$221.05	$1.63	1%
Total	$1,563.14	$3,267.19	$1,704.05	109%

Results for this diagnosis should be interpreted with caution given the small size of the population.

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for SoonerCare HMP participants with heart failure as their most expensive diagnosis by multiplying total months of engagement by average PMPM savings. The resultant deficit equaled ($564,000) (Exhibit 4-35).

Exhibit 4-35 – Participants with Heart Failure as Most Expensive Diagnosis
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	459	($943.30)	($432,975)
Months 13 - 24	144	($910.41)	($131,099)
Total	**603**	**($935.11)**	**($563,871)**

Results for this diagnosis should be interpreted with caution given the small size of the population.

Hypertension Population Utilization and Expenditure Evaluation

The SoonerCare HMP in SFY 2015 included 2,581 health coaching participants with a hypertension diagnosis. Hypertension was the most expensive diagnosis at the time of engagement for 55 percent of participants with this diagnosis (Exhibit 4-36).

Exhibit 4-36 – Participants with Hypertension as Most Expensive Diagnosis

Participants w/Hypertension	Number Most Expensive	Percent Most Expensive
2,581	1,412	55%

A significant portion of participants with hypertension also were diagnosed with another chronic impact condition, although the comorbidity rate lagged that of the other diagnosis groups, which may have contributed to the relatively high percentage of hypertensive participants for whom hypertension was the most expensive condition (Exhibit 4-37).

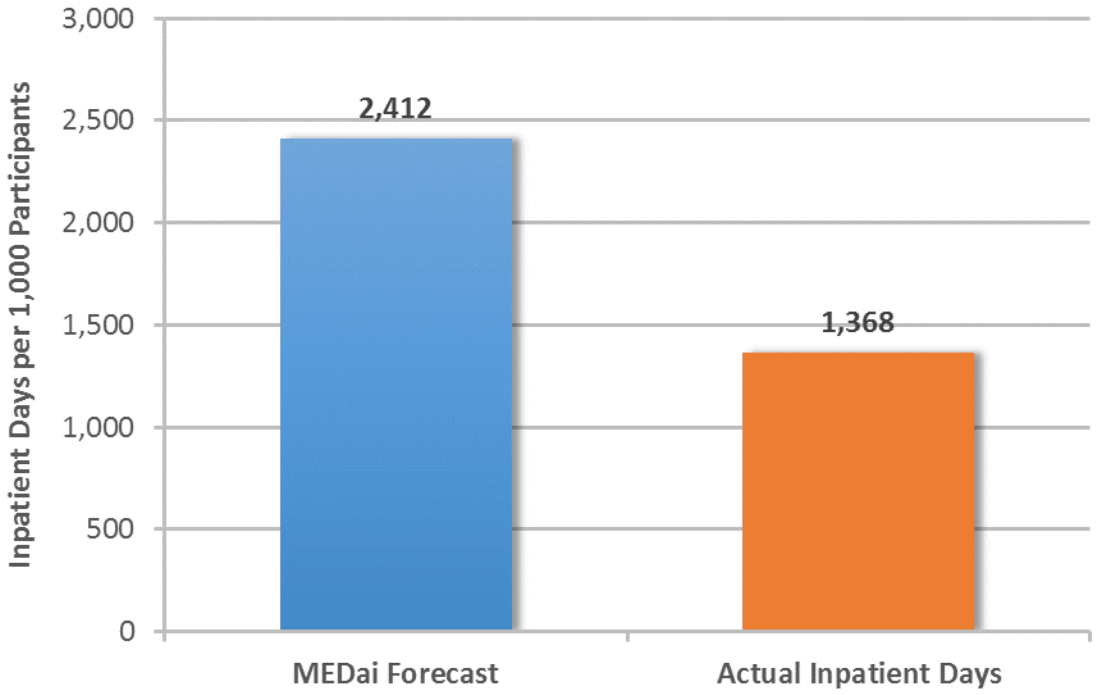
Exhibit 4-37 – Participants with Hypertension Co-morbidity with Chronic Impact Conditions

Condition	Percent w/Comorbidity
Asthma	25%
Coronary Artery Disease	20%
COPD	41%
Diabetes	39%
Heart Failure	11%
Hypertension	---

Utilization

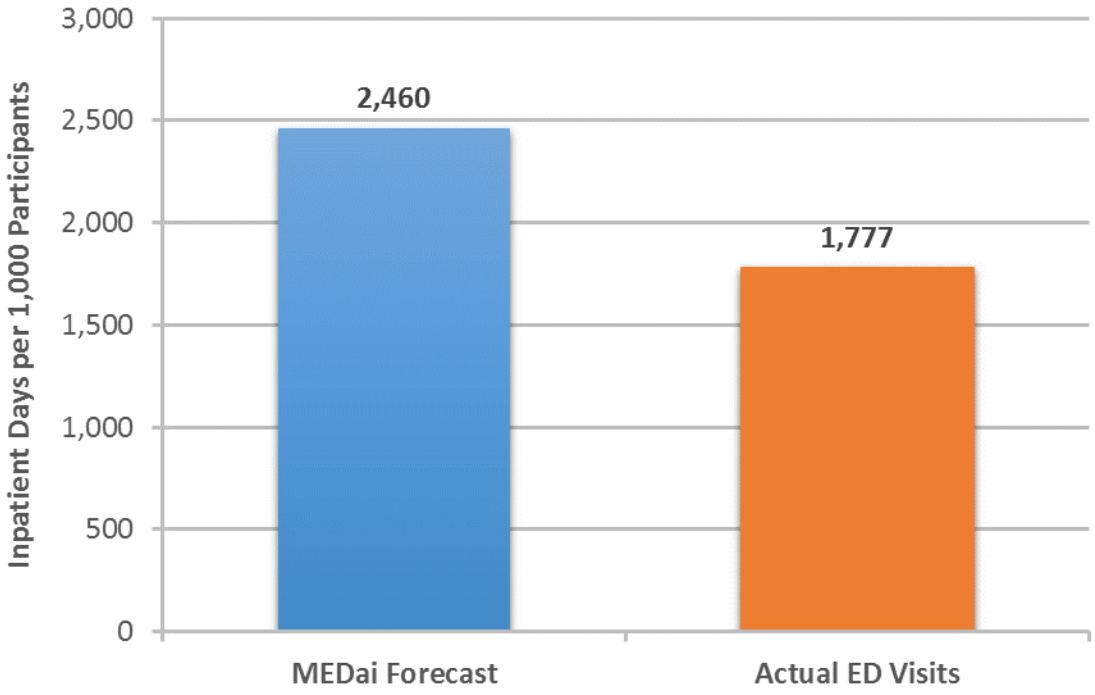
MEDai forecasted that participants with hypertension would incur 2,412 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 1,368, or 57 percent of forecast (Exhibit 4-38).

Exhibit 4-38 – Participants with Hypertension as Most Expensive Diagnosis
Inpatient Utilization - First 12 Months Following Engagement, per 1,000 Participants



MEDai forecasted that participants with hypertension would incur 2,460 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,777, or 72 percent of forecast (Exhibit 4-39).

Exhibit 4-39 – Participants with Hypertension as Most Expensive Diagnosis
Emergency Department Utilization - First 12 Months Following Engagement, per 1,000 Participants



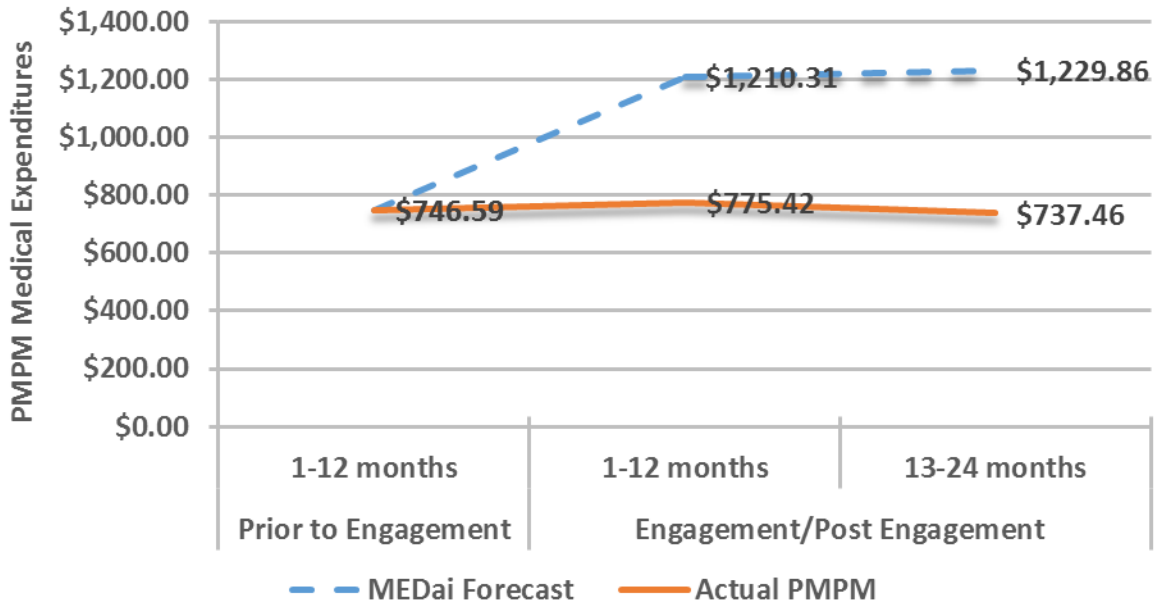
Medical Expenditures – Total and by Category of Service

PHPG documented total PMPM medical expenditures for participants with hypertension during the 12 months prior to engagement and compared actual medical expenditures to forecast for the first 24 months of engagement.

MEDai forecasted that participants with hypertension would incur an average of $1,210 in PMPM expenditures in the first 12 months of engagement. The actual amount was $775, or 64 percent of forecast.

For months 13 to 24, the MEDai forecast with trend applied was $1,230 in PMPM expenditures. The actual amount was $737, or 60 percent of forecast (Exhibit 4-40).

Exhibit 4-40 – Participants with Hypertension as Most Expensive Diagnosis
Total PMPM Expenditures



At the category-of-service level in the first 12 months of engagement, inpatient hospital and behavioral health expenditures declined, while other service costs increased, with pharmacy costs experiencing the most significant growth (Exhibit 4-41).

Exhibit 4-41 – Participants with Hypertension as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$174.59	$124.11	($50.48)	(29%)
Outpatient Hospital	$106.82	$114.23	$7.41	7%
Physician	$170.53	$172.60	$2.07	1%
Pharmacy	$149.54	$216.03	$66.49	44%
Behavioral Health	$52.62	$52.48	($0.14)	(<1%)
All Other	$92.50	$95.97	$3.47	4%
Total	$746.60	$775.42	$28.82	4%

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for SoonerCare HMP participants with hypertension as their most expensive diagnosis by multiplying total months of engagement by average PMPM savings. The resultant savings equaled approximately $8.1 million (Exhibit 4-42).

Exhibit 4-42 – Participants with Hypertension as Most Expensive Diagnosis
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	13,605	$434.89	$5,916,678
Months 13 - 24	4,446	$492.40	$2,189,210
Total	**18,051**	**$449.05**	**$8,105,802**

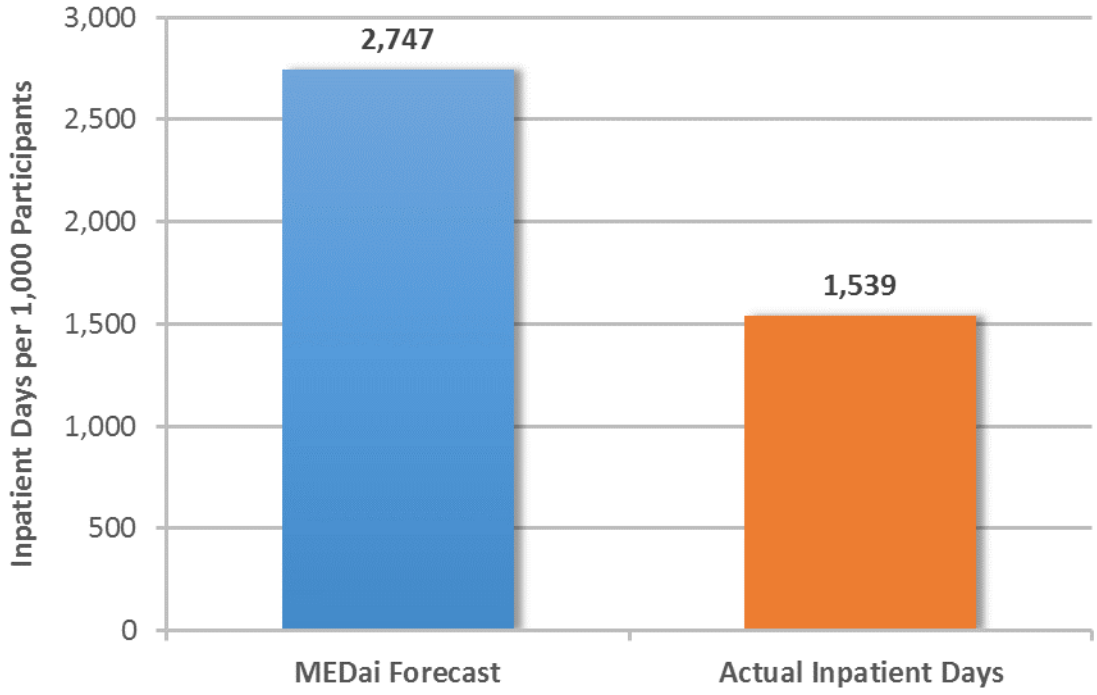
Utilization and Expenditure Evaluation – All Participants

This section presents consolidated trend data across all 5,447 SoonerCare HMP health coaching participants, regardless of diagnosis. For approximately 71 percent of participants, the most expensive diagnosis at the time of engagement was one of the six target chronic impact conditions.

Utilization

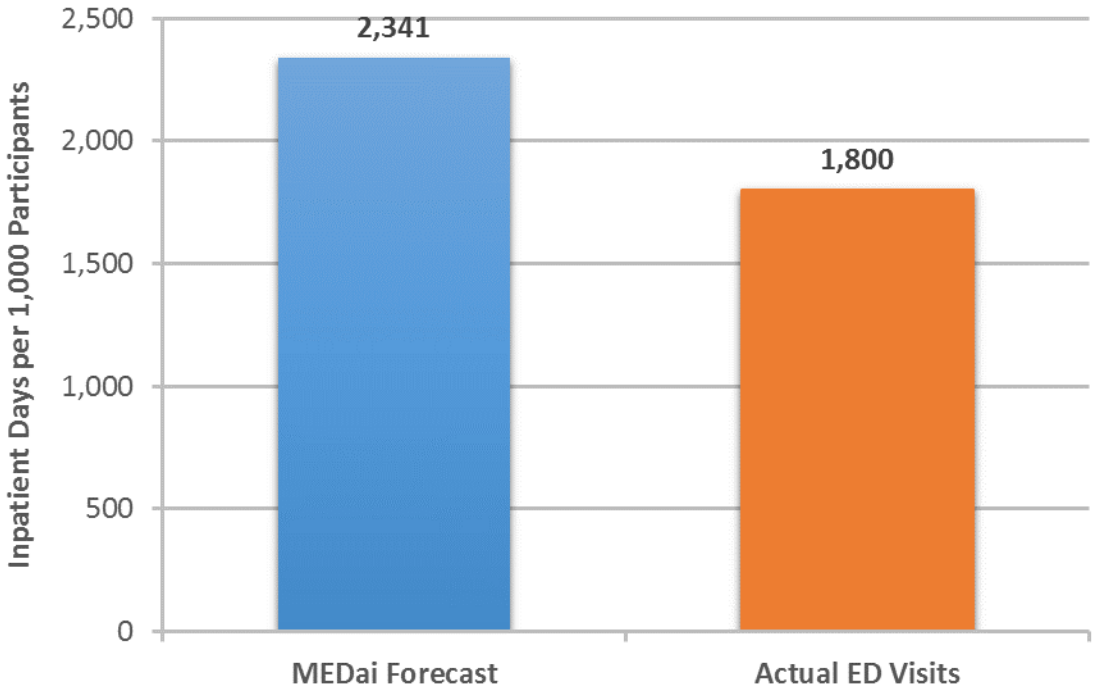
MEDai forecasted that SoonerCare HMP participants as a group would incur 2,747 inpatient days per 1,000 participants in the first 12 months of engagement. The actual rate was 1,539, or 56 percent of forecast (Exhibit 4-43).

Exhibit 4-43 – All SoonerCare HMP Health Coaching Participants
Inpatient Utilization - First 12 Months Following Engagement, per 1,000 Participants



MEDai forecasted that SoonerCare HMP participants as a group would incur 2,341 emergency department visits per 1,000 participants in the first 12 months of engagement. The actual rate was 1,800, or 77 percent of forecast (Exhibit 4-44).

Exhibit 4-44 – All SoonerCare HMP Health Coaching Participants
Emergency Department Utilization - First 12 Months Following Engagement, per 1,000 Participants



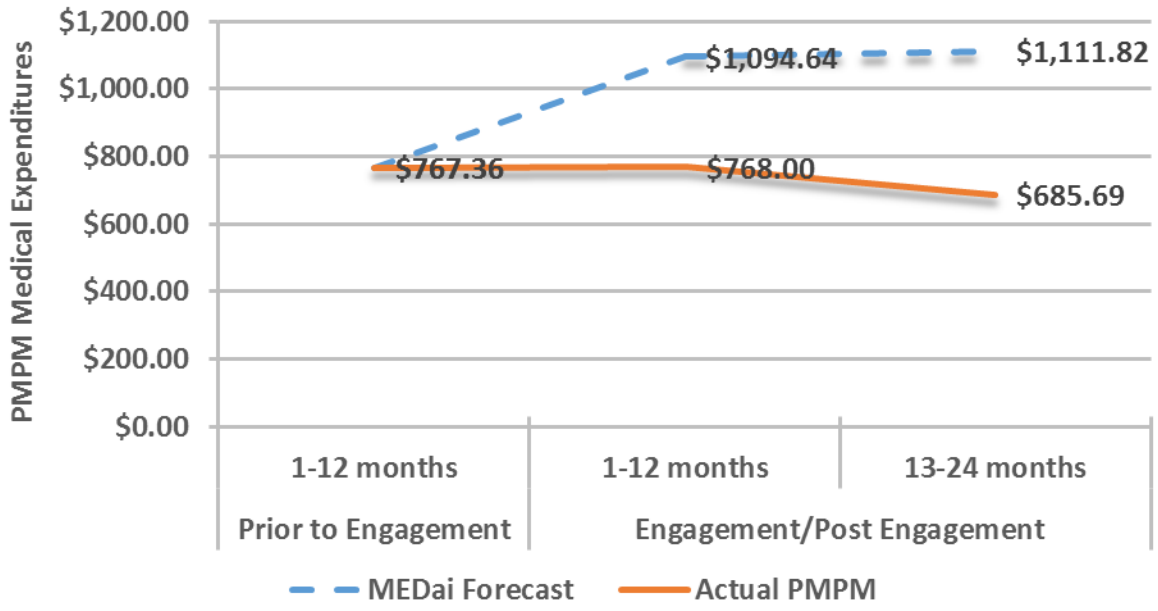
Medical Expenditures – Total and by Category of Service

PHPG documented total PMPM medical expenditures for all SoonerCare HMP participants as a group and compared actual medical expenditures to forecast for the first 24 months of engagement.

MEDai forecasted that the participant population would incur an average of $1,095 in PMPM expenditures in the first 12 months of engagement. The actual amount was $768, or 70 percent of forecast.

For months 13 to 24, the MEDai forecast with trend applied was $1,112 in PMPM expenditures. The actual amount was $686, or 62 percent of forecast (Exhibit 4-45).

Exhibit 4-45 – All SoonerCare HMP Health Coaching Participants
Total PMPM Expenditures



At the category-of-service level in the first 12 months of engagement, hospital, physician, and other expenditures declined while other costs increased, with pharmacy experiencing the strongest growth (Exhibit 4-46).

Exhibit 4-46 – All SoonerCare HMP Health Coaching Participants
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$176.06	$156.15	($19.91)	(11%)
Outpatient Hospital	$104.52	$104.51	($.01)	(<1%)
Physician	$171.08	$159.85	($11.23)	(7%)
Pharmacy	$158.24	$194.28	$36.04	23%
Behavioral Health	$60.10	$57.47	$2.63	4%
All Other	$97.36	$95.74	($1.62)	(2%)
Total	$767.36	$786.00	$18.64	2%

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for all SoonerCare HMP participants by multiplying total months of engagement by average PMPM savings. The resultant savings equaled nearly $23 million (Exhibit 4-47).

Exhibit 4-47 – All SoonerCare HMP Health Coaching Participants
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	48,280	$326.64	$15,770,179
Months 13 - 24	16,641	$426.13	$7,091,229
Total	**64,921**	**$352.14**	**$22,861,281**

This was a noteworthy outcome given that the program is still only in its second year. It also is noteworthy given the inclusion in health coaching of “at risk” members referred by providers. These members have lower projected costs, and therefore lower documentable savings under

the MEDai methodology, even though by intervening at an early stage, the health coach may help to avert significant future health costs.

Finally, it is encouraging that average PMPM savings increased from the initial 12-month engagement period to engagement months 13 – 24. This suggests that the impact of health coaching increases over time, which if the trend continues, bodes well for the program's long term success.

SoonerCare HMP Health Coaching Cost Effectiveness Analysis

Over time, the SoonerCare HMP should demonstrate its efficacy through a reduction in the relative PMPM and aggregate costs of engaged members versus what would have occurred absent health coaching. PHPG performed a cost effectiveness analysis by carrying forward and expanding the medical expenditure impact findings from the previous section and adding program administrative expenses to the analysis. To be cost effective, health coaching must demonstrate lower expenditures even after factoring-in the program's administrative component.[47]

Administrative Expenses

SoonerCare HMP administrative expenses include salary, benefits and overhead costs for persons working in the SoonerCare HMP unit, plus Telligen vendor payments. The OHCA provided PHPG with detailed information on administrative expenditures during SFY 2014 and SFY 2015 for use in performing the cost effectiveness test.

OHCA salary and benefit costs were included for staff assigned to the SoonerCare HMP unit. Costs were prorated for employees working less than full time on the SoonerCare HMP.

Overhead expenses (rent, travel, etc.) were allocated based on the unit's share of total OHCA salary/benefit expenses in each fiscal year (0.60 percent in SFY 2014 and 0.46 percent in SFY 2015)[48]. No specific allocation was made for MEDai activities, as these are occurring under a pre-existing contract.

OHCA HMP administrative expenses were divided equally between the health coaching and practice facilitation. (The practice facilitation portion is included in the practice facilitation cost effectiveness analysis presented in chapter seven.)

Telligen receives monthly payments for centralized operations, as well as payments specific to health coaching and practice facilitation activities. Health coach and practice facilitator payments are based on salary and benefit costs for the two departments.

Health coaching payments were combined with 50 percent of the payment amounts for centralized operations[49] to arrive at a total amount for this portion of the analysis. (The remaining dollars for centralized operations are included in the practice facilitation cost effectiveness analysis presented in chapter seven.)

[47] For the purposes of the cost effectiveness analysis only, PHPG altered MEDai forecasts for members whose cost for the year prior to engagement exceeded $144,000, as MEDai forecasts have an upper limit of $144,000. To ensure they would not skew the cost effectiveness test results, PHPG set the forecasts for these members equal to prior year costs, assuming no increase or decrease in medical costs.
[48] Portion of unit devoted to administration/oversight of health coaching activities.
[49] PHPG also included miscellaneous expenses, such as continuing medical education costs, in this line item.

SFY 2014 and SFY 2015 aggregate administrative expenses for health coaching were approximately $10.1 million (Exhibit 4-48). This equated to $155.60 on a PMPM basis. The PMPM calculation was performed using total member months (64,921) for health coaching participants meeting the criteria outlined in chapter one (e.g., enrolled for at least three months)[50].

Exhibit 4-48 – SoonerCare HMP Health Coaching Administrative Expense

Cost Component	SFY 2014 - 2015 Aggregate Dollars	PMPM
OHCA SoonerCare HMP unit salaries and benefits (50% allocation)	$420,514	$6.48
OHCA SoonerCare HMP overhead (50% allocation)	$53,008	$0.82
Telligen health coaches	$7,744,675	$119.29
Telligen Central Operations (50% allocation)	$1,883,528	$29.01
Total Administrative Expense	**$10,101,726**	**$155.60**

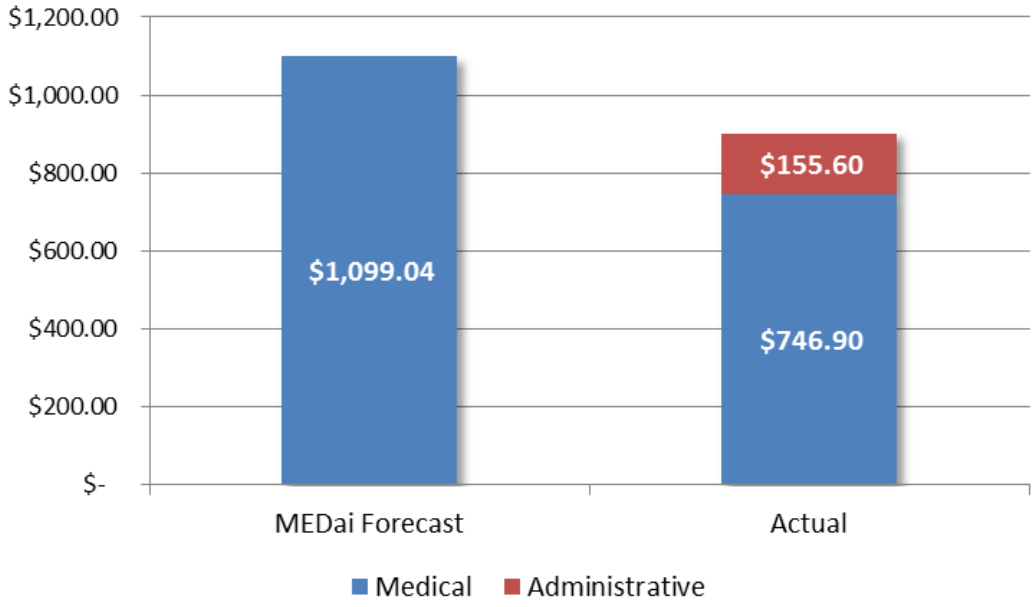
[50] This methodology overstates the PMPM amount, in that it excludes member months for participants who did not meet the analysis criteria. However, it is the appropriate for determining cost effectiveness, as it accounts for all administrative expenses.

Cost Effectiveness Calculation[51]

PHPG performed a cost effectiveness test by comparing forecasted costs to actual costs during SFY 2014 and SFY 2015, inclusive of SoonerCare HMP health coaching administrative expenses.

SoonerCare HMP health coaching participants as a group were forecasted to incur average medical costs of $1,099.04[52]. Their actual average PMPM medical costs were $746.90. With the addition of $155.60 in average PMPM administrative expenses, total actual costs were $902.50. Medical expenses accounted for 83 percent of the total and administrative expenses for the other 17 percent. Overall, SoonerCare HMP health coaching participant PMPM expenses, inclusive of administrative costs were 82.1 percent of forecast (Exhibit 4-49).

Exhibit 4-49 – SoonerCare HMP Health Coaching PMPM Savings



On an aggregate basis, the health coaching portion of the SoonerCare HMP achieved net savings during its initial 24 months of operation (July 2013 through June 2015) of nearly $12.8 million, up from only $3.4 million in its first 12 months (Exhibit 4-50 on the following page). These results appear in line with the nurse care management component of the first generation SoonerCare HMP, which generated cumulative net savings of $5.5 million through its initial 17 months of operation (February 2008 implementation through June 2009) and $14.9 million in cumulative net savings through its initial 29 months of operation (February 2008 through June 2010)[53].

[51] PMPM and aggregate values differ slightly due to rounding.
[52] This represents a weighted average (by member months) of the forecasted PMPM values for the first 12 months and months 13 – 24, as shown in exhibit 4-45.
[53] SoonerCare HMP Comprehensive Evaluation Report, May 2014, page 92.

If the previous program's trends are repeated, savings should continue to increase significantly in future years as the long term impact of health coaching on participants' health is realized. The SFY 2015 modifications to the health coaching model described in chapter one also may further improve outcomes.

Exhibit 4-50 – All SoonerCare HMP Health Coaching Participants
Aggregate Savings – Net of Administrative Expenses

Medical Savings	Administrative Costs	Net Savings
$22,861,281	($10,101,726)	**$12,759,555**

CHAPTER 5 – PRACTICE FACILITATION – PROVIDER SATISFACTION

Introduction

Providers are an integral component of the SoonerCare HMP and the practice-based health coaching model. Prior to the initiation of health coaching within a practice, the provider and his or her staff participate in practice facilitation, to document existing process flows and devise a plan for enhancing care management of patients with chronic conditions.

PHPG attempts to survey all provider offices that participate in practice facilitation to gather information on provider perceptions and satisfaction with the experience. The OHCA provides to PHPG the names of primary care practices and providers who have completed the initial onsite portion of practice facilitation.

PHPG or the OHCA informs providers in advance that they will be contacted by telephone to complete a survey. Providers also are given the option of completing and returning a paper version of the survey by mail, fax or email.

The survey instrument consists of 19 questions in four areas:

- Decision to participate in the SoonerCare HMP
- Practice facilitation activities
- Practice facilitation outcomes
- Health coaching activities

Survey responses can be furnished by providers and/or members of the practice staff. Only practice staff members with direct experience and knowledge of the program are permitted to respond to the survey in lieu of the provider. PHPG screens non-physician respondents to verify their involvement with the program before conducting the survey. A copy of the survey instrument is included in Appendix D.

Survey Population Size

PHPG initially conducted surveys during a ten week period, from late February through April 2015. PHPG obtained completed surveys from 12 of the 47 practices that had undergone some phase of practice facilitation prior to April 2015.

In April and May 2016, PHPG conducted surveys with four additional practices that had begun practice facilitation after April 2015, bringing the total number of completed surveys to 16. Due to the small total sample size, findings are presented for all 16 practices, including the 12 previously discussed in the SFY 2014 annual report.

Readers should exercise caution when reviewing survey results, given the small sample size. Although percentages are presented, the findings should be treated as qualitative, offering a general sense of the attitudes of the provider population.

Practice Facilitation Survey Findings

Decision to Participate in the SoonerCare HMP

Eight of the 16 surveys were completed by the individual in the practice who actually made the decision to participate. All eight gave as their primary reason "improving care management of patients with chronic conditions/improving outcomes".

Secondary reasons cited by one or more respondents included:

- Gaining access to practice facilitator and/or embedded health coach (four respondents)
- Continuing education (two respondents)
- Receiving assistance in redesigning practice workflows (one respondent)
- Increasing income (one respondent)

Practice Facilitation Activities

Respondents were asked to rate the importance of the specific activities typically performed by practice facilitators. Respondents were asked to rate their importance regardless of the practice's actual experience.

Each of the activities was rated "very important" by a majority of the respondents (Exhibit 5-1 on the following page). The highest rated item was "receiving focused training in evidence-based practice guidelines for chronic conditions".

Exhibit 5-1 – Importance of Practice Facilitation Components

Practice Facilitation Component	Level of Importance			
	Very Important	Somewhat Important	Not too Important	Not at all Important/ N/A
1. Receiving information on the prevalence of chronic diseases among your patients	68.8%	31.3%	0.0%	0.0%
2. Receiving a baseline assessment of how well you have been managing the care of your patients with chronic diseases	75.0%	25.0%	0.0%	0.0%
3. Receiving focused training in evidence-based practice guidelines for chronic conditions	87.5%	12.5%	0.0%	0.0%
4. Receiving assistance in redesigning office workflows and policies and procedures for management of patients with chronic diseases	68.8%	31.3%	0.0%	0.0%
5. Identifying performance measures to track your improvement in managing the care of your patients with chronic diseases	62.5%	37.5%	0.0%	0.0%
6. Having a Practice Facilitator on-site to work with you and your staff	56.3%	31.3%	6.3%	6.3%
7. Receiving quarterly reports on your progress with respect to identified performance measures	62.5%	37.5%	0.0%	0.0%
8. Receiving ongoing education and assistance after conclusion of the initial on-site activities	68.8%	31.3%	0.0%	0.0%

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Helpfulness of Program Components

Respondents next were asked to rate the helpfulness of the same practice facilitation components in terms of improving their management of patients with chronic conditions. The overall level of satisfaction was high, with six of the eight activities rated as "very helpful" by a majority of practices (Exhibit 5-2).

Exhibit 5-2 – Helpfulness of Practice Facilitation Components

Practice Facilitation Component	Level of Helpfulness				
	Very Helpful	Somewhat Helpful	Not too Helpful	Not at all Helpful	Don't know
1. Receiving information on the prevalence of chronic diseases among your patients	62.5%	31.3%	6.3%	0.0%	0.0%
2. Receiving a baseline assessment of how well you have been managing the care of your patients with chronic diseases	68.8%	25.0%	6.3%	0.0%	0.0%
3. Receiving focused training in evidence-based practice guidelines for chronic conditions	75.0%	25.0%	0.0%	0.0%	0.0%
4. Receiving assistance in redesigning office workflows and policies and procedures for management of patients with chronic diseases	43.8%	37.5%	6.3%	0.0%	12.5%
5. Identifying performance measures to track your improvement in managing the care of your patients with chronic diseases	56.3%	43.8%	0%	0.0%	0.0%
6. Having a practice facilitator on-site to work with you and your staff	62.5%	25.0%	6.3%	6.3%	0%
7. Receiving quarterly reports on your progress with respect to identified performance measures	43.8%	50.0%	6.3%	0.0%	0.0%
8. Receiving ongoing education and assistance after conclusion of the initial on-site activities	56.3%	37.5%	0.0%	0.0%	6.3%

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

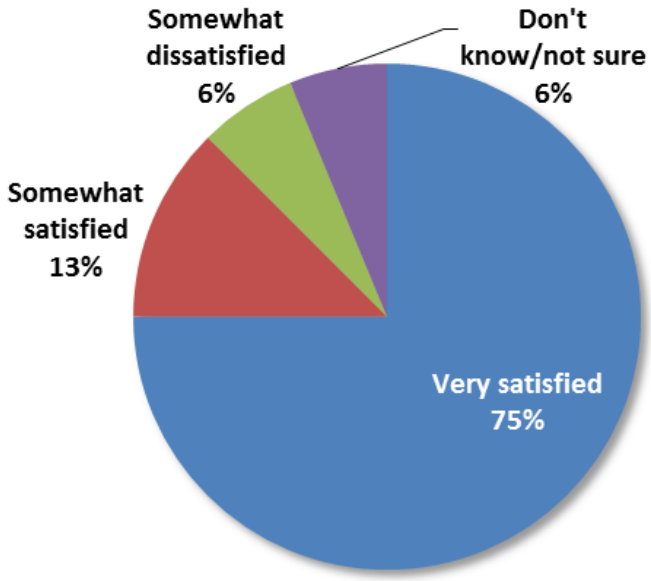
Practice Facilitation Outcomes

Eighty-one percent of the surveyed practices reported making changes in the management of their patients with chronic conditions as a result of participating in practice facilitation. The types of changes made included:

- More frequent foot/eye exams and/or HbA1c testing of diabetic patients (seven respondents)
- Improved documentation (seven respondents)
- Identification of tests/exams to manage chronic conditions (six respondents)
- Better education of patients with chronic conditions, including provision of educational materials (five respondents)
- Increased staff involvement in chronic care workups (four respondents)
- Use of flow sheets/forms provided by the practice facilitator or created through CareMeasures (two respondents)
- Better office organization overall (two respondents)

Fourteen of the 16 respondents (87.5 percent) stated that their practice had become more effective in managing patients with chronic conditions as a result of their participation in practice facilitation. This translated into a high level of satisfaction with the overall practice facilitation experience (Exhibit 5-3).

Exhibit 5-3 – Overall Satisfaction with Practice Facilitation Experience



Consistent with this result, 81 percent of respondents said they would recommend the practice facilitation program to other physicians caring for patients with chronic conditions. The other 19 percent did not know/were not sure.

Health Coach Activities

Fourteen of the 16 respondents stated they had a health coach currently assigned to their practice. The 14 respondents were asked to rate the importance of the activities performed by the health coach. A majority rated each of the activities as "very important" (Exhibit 5-4).

Exhibit 5-4 **– Importance of Health Coaching Activities**

Health Coaching Activity	Level of Importance			
	Very Important	Somewhat Important	Not Very Important	Not at all Important
1. Learning about your patients and their health care needs	100.0%	0.0%	0.0%	0.0%
2. Giving easy to understand instructions about taking care of health problems or concerns	92.9%	7.1%	0.0%	0.0%
3. Helping patients to identify changes in their health that might be an early sign of a problem	100.0%	0.0%	0.0%	0.0%
4. Answering patient questions about their health	100.0%	0.0%	0.0%	0.0%
5. Helping patients to talk to and work with you and practice staff	85.7%	14.3%	0.0%	0.0%
6. Helping patients make and keep health care appointments with other doctors, such as specialists, for medical problems	71.4%	28.6%	0.0%	0.0%
7. Helping patients make and keep health care appointments for mental health or substance abuse problems	57.1%	42.9%	0.0%	0.0%
8. Reviewing patient medications and helping patients to manage their medications	85.7%	14.3%	0.0%	0.0%

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

Respondents next were asked to rate their satisfaction with health coaching activities, in terms of assistance provided to their patients. The level of satisfaction was extremely high across all activities (Exhibit 5-5).

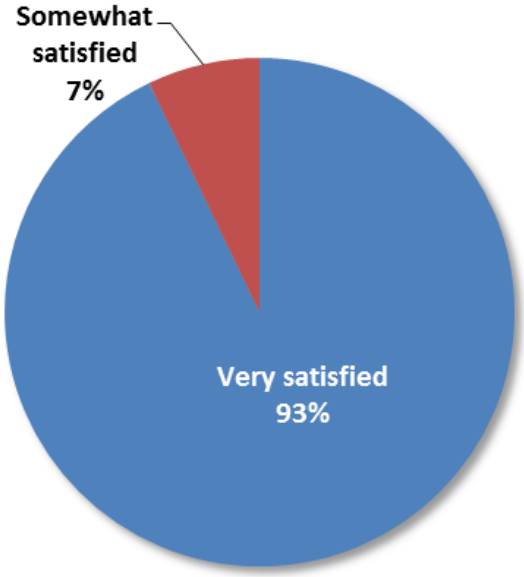
***Exhibit 5-5* – Satisfaction with Health Coaching Activities**

Health Coaching Activity	Level of Satisfaction				
	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Not Sure
1. Learning about your patients and their health care needs	100.0%	0.0%	0.0%	0.0%	0.0%
2. Giving easy to understand instructions about taking care of health problems or concerns	100.0%	0.0%	0.0%	0.0%	0.0%
3. Helping patients to identify changes in their health that might be an early sign of a problem	100.0%	0.0%	0.0%	0.0%	0.0%
4. Answering patient questions about their health	100.0%	0.0%	0.0%	0.0%	0.0%
5. Helping patients to talk to and work with you and practice staff	100.0%	0.0%	0.0%	0.0%	0.0%
6. Helping patients make and keep health care appointments with other doctors, such as specialists, for medical problems	85.7%	7.1%	0.0%	0.0%	7.1%
7. Helping patients make and keep health care appointments for mental health or substance abuse problems	85.7%	7.1%	0.0%	0.0%	7.1%
8. Reviewing patient medications and helping patients to manage their medications	92.9%	7.1%	0.0%	0.0%	0%

Note: Percentages on this and other tables may not total to 100 percent due to rounding.

The providers' enthusiasm was further reflected in their overall satisfaction with having a health coach assigned to their practice (Exhibit 5-6).

***Exhibit 5-6* – Overall Satisfaction with Health Coach**



It also carried over to the types of comments made when asked to suggest ways to improve the program:

- "Doing a great job!"
- "Clone Diane" (health coach)
- "Let us keep them – we love them!"

In terms of suggestions, one provider questioned the OHCA's methodology for identifying health coaching participants. In this provider's opinion, the criteria can result in the enrollment of patients with fewer needs than other patients who do not qualify. Another provider recommended that the OHCA not impose limits on which patients can be referred to the health coach. A third recommended more frequent assessments of member needs.

Summary of Key Findings

Providers who have completed the onsite portion of practice facilitation view the SoonerCare HMP very favorably. The most common reason cited for participating was to improve care management of patients with chronic conditions. Eighty-one percent of respondents (13 out of 16) credited the program with helping them to achieve this objective.

Overall, 91 percent of providers described themselves as very or somewhat satisfied with their practice facilitation experience. One hundred percent described themselves as very or somewhat satisfied with having a health coach assigned to their practice.

CHAPTER 6 – PRACTICE FACILITATION – QUALITY OF CARE ANALYSIS

Introduction

SoonerCare HMP practice facilitation is intended to improve quality of care by educating practices on effective treatment of patients with chronic conditions and adoption of clinical best practices.

PHPG evaluated the impact of SoonerCare HMP practice facilitation on quality of care through calculation of Healthcare Effectiveness Data and Information Set (HEDIS®) and HEDIS®-like measures applicable to the SoonerCare HMP population. The evaluation included the same 19 diagnosis-specific measures and three population-wide preventive measures presented in chapter three:

- Asthma measures
  - Use of appropriate medications for people with asthma
  - Medication management for people with asthma – 50 percent
  - Medication management for people with asthma – 75 percent

- Cardiovascular (CAD and heart failure) measures
  - Persistence of beta-blocker treatment after a heart attack
  - Cholesterol management for patients with cardiovascular conditions – LDL-C screening

- COPD measures
  - Use of spirometry testing in the assessment and diagnosis of COPD
  - Pharmacotherapy management of COPD exacerbation – 14 days
  - Pharmacotherapy management of COPD exacerbation – 30 days

- Diabetes measures
  - Percentage of members who had LDL-C screening
  - Percentage of members who had retinal eye exam performed
  - Percentage of members who had Hemoglobin A1c (HbA1c) testing
  - Percentage of members who received medical attention for nephropathy
  - Percentage of members prescribed angiotensin converting enzyme inhibitors or angiotensin receptor blockers (ACE/ARB therapy)

- Hypertension measures
  - Percentage of members who had LDL-C screening
  - Percentage of members prescribed ACE/ARB therapy
  - Percentage of members prescribed diuretics
  - Percentage of members prescribed ACE/ARB therapy or diuretics with annual medication monitoring

- Mental Health measures
  - Follow-up after hospitalization for mental illness – 7 days
  - Follow-up after hospitalization for mental illness – 30 days

- Preventive health measures
  - Adult access to preventive/ambulatory health services
  - Children and adolescents' access to PCPs
  - Adult body mass index (BMI) assessment

The specifications for each measure are presented in the applicable section.

Methodology

The quality of care analysis dataset was developed from the complete Medicaid claims and eligibility extract provided by the OHCA. To be included in the analysis, members had to have been aligned with a PCMH provider who underwent practice facilitation. They also had to have been seen by a PCMH provider at least once following their own PCMH provider's initiation into practice facilitation. Members participating in the health coaching portion of the SoonerCare HMP were excluded from the analysis. This was done to avoid double counting the impact of the program.

PHPG determined the total number of members to be evaluated for each measure (denominator), the number meeting the clinical standard (numerator) and the resultant "percent compliant". As in chapter three, the results were compared to compliance rates for the general SoonerCare population (SFY 2014 reporting year), where available, and to national Medicaid MCO benchmarks where SoonerCare data was not available. (SoonerCare rates are shown in black font; national rates, when used, are shown in blue font. In a few instances, neither source was available, as denoted by dash lines.)

PHPG also compared SFY 2014 practice facilitation site patient compliance rates to SFY 2015 compliance rates to examine year-over-year trends.

For each measure, the first exhibit displayed presents SoonerCare practice facilitation site patients and a comparison group (general SoonerCare population or national Medicaid MCO benchmark). The second exhibit presents SoonerCare practice facilitation site patient year-over-year compliance percentages.

Statistically significant differences between members aligned with practice facilitation providers and the comparison group at a 95 percent confidence interval are noted in the exhibits through bold face type of the value shown in the "% point difference" column. However, disease-specific results should be interpreted with caution where there are small sample sizes.
There were no statistically significant differences at the 95 percent confidence interval identified in the practice facilitation participant year-over-year analysis.

Asthma

The quality of care for members with asthma (ages 5 to 64) was evaluated through three clinical measures:

- *Use of Appropriate Medications for People with Asthma*: Percent with persistent asthma who had at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, leukotriene modifiers or methylaxanthines.
- *Medication Management for People with Asthma – 50 Percent*: Percentage of members receiving at least one asthma medication who had an active prescription for an asthma controller medication for at least 50 percent (50 percent compliance rate) of the year, starting with the first date of receiving such a prescription.
- *Medication Management for People with Asthma – 75 Percent*: Percentage of members receiving at least one asthma medication who had an active prescription at least 75 percent (75 percent compliance rate) of the year, starting with the first date of receiving such a prescription.

The compliance rate for the practice facilitation population exceeded the comparison group rate on one of three measures (Exhibit 6-1). The difference was not statistically significant.

Exhibit 6-1– Asthma Clinical Measures – Practice Facilitation Members vs. Comparison Group

Measure	Practice Facilitation Members			PF Members versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	PF - Comparison: % Point Difference
1. Use of Appropriate Medications for People with Asthma	40	36	90.0%	81.2%	8.8%
2. Medication Management for People with Asthma – 50 Percent	37	21	56.8%	61.3%	(4.5%)
3. Medication Management for People with Asthma – 75 Percent	37	9	24.3%	38.6%	(14.3%)

Results for this diagnosis should be interpreted with caution given the small size of the population.

There were slight increases in both of the asthma medication management measures from SFY 2014 to SFY 2015 (Exhibit 6-2). There was a small decline in the compliance rate for individuals with asthma who were appropriately prescribed medications; however, the compliance rate remained very high at 90 percent.

Exhibit 6-2 – Asthma Clinical Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. Use of Appropriate Medications for People with Asthma	91.9%	90.0%	(1.9%)
2. Medication Management for People with Asthma – 50 Percent	55.9%	56.8%	0.9%
3. Medication Management for People with Asthma – 75 Percent	23.5%	24.3%	0.8%

Results for this diagnosis should be interpreted with caution given the small size of the population.

Cardiovascular Disease

The quality of care for members with cardiovascular disease (coronary artery disease and/or heart failure) was evaluated through two clinical measures:

- *Persistence of Beta Blocker Treatment after Heart Attack*: Percentage of members 18 and older with prior MI prescribed beta-blocker therapy.
- *LDL-C Screening*: Percentage of members 18 to 75 who received at least one LDL-C screening in previous twelve months.

The compliance rate for the comparison group exceeded the practice facilitation population rate on the one measure having a comparison group percentage (Exhibit 6-3). The difference was statistically significant, although this result should be viewed with caution given the small practice facilitation population.

Exhibit 6-3 – Cardiovascular Disease Clinical Measures – Practice Facilitation Members vs. Comparison Group

Measure	Practice Facilitation Members			PF Members versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	PF - Comparison: % Point Difference
1. Persistence of Beta Blocker Treatment after Heart Attack	6	2	33.3%	83.3%	**(50.0%)**
2. LDL-C Screening	50	38	76.0%	---	---

Results for this diagnosis should be interpreted with caution given the small size of the population.

The compliance rates for both cardiovascular measures increased from SFY 2014 to SFY 2015 SFY 2014 (Exhibit 6-4).

Exhibit 6-4 – Cardiovascular Disease Clinical Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. Persistence of Beta Blocker Treatment after Heart Attack	20.0%	33.3%	13.3%
2. LDL-C Screening	74.5%	76.0%	1.5%

Results for this diagnosis should be interpreted with caution given the small size of the population.

COPD

The quality of care for members with COPD (ages 40 and older) was evaluated through three clinical measures:

- *Use of Spirometry Testing in the Assessment/Diagnosis of COPD*: Percentage of members who received spirometry screening.
- *Pharmacotherapy Management of COPD Exacerbation – 14 Days*: Percentage of COPD exacerbations for members who had an acute inpatient discharge or ED visit and who were dispensed systemic corticosteroid within 14 days.
- *Pharmacotherapy Management of COPD Exacerbation – 30 Days*: Percentage of COPD exacerbations for members who had an acute inpatient discharge or ED visit and who were dispensed a bronchodilator within 30 days.

The compliance rate for the comparison group exceeded the practice facilitation population rate on all three measures (Exhibit 6-5). The difference was statistically significant for two of the three measures.

Exhibit 6-5 – COPD Clinical Measures – Practice Facilitation Members vs. Comparison Group

Measure	Practice Facilitation Members			PF Members versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	PF - Comparison: % Point Difference
1. Use of Spirometry Testing in the Assessment/Diagnosis of COPD	86	9	10.5%	31.0%	**(20.5%)**
2. Pharmacotherapy Management of COPD Exacerbation – 14 Days	40	12	30.0%	65.3%	**(35.3%)**
3. Pharmacotherapy Management of COPD Exacerbation – 30 Days	40	27	67.5%	79.0%	(11.5%)

Results for this diagnosis should be interpreted with caution given the small size of the population.

The compliance rate for the practice facilitation population who received spirometry screening increased slightly from SFY 2014 to SFY 2015 (Exhibit 6-6).

There was a small decline in the rates for the pharmacotherapy management of COPD exacerbation measures during SFY 2015 when compared to SFY 2014. Despite this, nearly one-third of the practice facilitation population with COPD was dispensed systemic corticosteroids within 14 days of an acute inpatient discharge or ED visit, and over 65 percent received systemic corticosteroids within 30 days.

Exhibit 6-6 – COPD Clinical Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. Use of Spirometry Testing in the Assessment/Diagnosis of COPD	9.9%	10.5%	0.6%
2. Pharmacotherapy Management of COPD Exacerbation – 14 Days	30.6%	30.0%	(0.6%)
3. Pharmacotherapy Management of COPD Exacerbation – 30 Days	69.4%	67.5%	(1.9%)

Results for this diagnosis should be interpreted with caution given the small size of the population.

Diabetes

The quality of care for members (ages 18 to 75) with diabetes was evaluated through five clinical measures:

- *LDL-C Screening*: Percentage of members who received at least one LDL-C in previous twelve months.
- *Retinal Eye Exam*: Percentage of members who received at least one dilated retinal eye exam in previous twelve months.
- *HbA1c Test*: Percentage of members who received at least one HbA1C test in previous twelve months.
- *Medical Attention for Nephropathy*: Percentage of members who received medical attention for nephropathy in previous twelve months.
- *ACE/ARB Therapy*: Percentage of members who received ACE/ARB therapy in previous twelve months.

The compliance rate for the practice facilitation population exceeded the comparison group rate on three of the four measures having a comparison group percentage (Exhibit 6-7). The difference was statistically significant for one measure, medical attention for nephropathy.

Exhibit 6-7 – Diabetes Clinical Measures – Practice Facilitation Members vs. Comparison Group

Measure	Practice Facilitation Members			PF Members versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	PF - Comparison: % Point Difference
1. LDL-C Screening	253	168	66.4%	63.9%	2.5%
2. Retinal Eye Exam	253	67	26.5%	27.3%	(0.8%)
3. HbA1c Test	253	185	73.1%	72.1%	1.0%
4. Medical Attention for Nephropathy	253	183	72.3%	52.4%	**19.9%**
5. ACE/ARB Therapy	253	146	57.7%	---	---

The compliance rate for all diabetes clinical measures increased from SFY 2014 to SFY 2015 (Exhibit 6-8).

Exhibit 6-8 – Diabetes Clinical Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. LDL-C Screening	64.8%	66.4%	1.6%
2. Retinal Eye Exam	25.2%	26.5%	1.3%
3. HbA1c Test	72.2%	73.1%	0.9%
4. Medical Attention for Nephropathy	72.2%	72.3%	0.1%
5. ACE/ARB Therapy	57.4%	57.7%	0.3%

Hypertension

The quality of care for members with hypertension (ages 18 and older) was evaluated through four clinical measures:

- *LDL-C Screening*: Percentage of members who received at least one LDL-C in previous twelve months.
- *ACE/ARB Therapy*: Percentage of members who received ACE/ARB therapy in previous twelve months.
- *Diuretics*: Percentage of members who received diuretic in previous twelve months.
- *Annual Monitoring for Patients Prescribed ACE/ARB or Diuretics*: Percentage of members prescribed ACE/ARB therapy or diuretic who received annual medication monitoring.

The compliance rate for the comparison group exceeded the practice facilitation population rate on the one measure having a comparison group percentage (Exhibit 6-9). The difference was statistically significant.

Exhibit 6-9 – Hypertension Clinical Measures – Practice Facilitation Members vs. Comparison Group

Measure	Practice Facilitation Members			PF Members versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	PF - Comparison: % Point Difference
1. LDL-C Screening	594	346	58.2%	---	---
2. ACE/ARB Therapy	594	357	60.1%	---	---
3. Diuretics	594	246	41.4%	---	---
4. Annual Monitoring for Patients Prescribed ACE/ARB or Diuretics[54]	254	201	79.1%	86.8%	**(7.7%)**

[54] Denominator for measure 4 is smaller than numerator for measure 2 because numerator for measure 2 is defined as having at least one prescription active during the year. Denominator 4 is defined as having a prescription active for at least 180 days during the year.

The compliance rates for two measures increased slightly from SFY 2014 to SFY 2015, while the rates for the other two declined slightly (Exhibit 6-10).

Exhibit 6-10 – Hypertension Clinical Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. LDL-C Screening	57.0%	58.2%	1.2%
2. ACE/ARB Therapy	60.5%	60.1%	(0.4%)
3. Diuretics	41.3%	41.4%	0.1%
4. Annual Monitoring for Patients Prescribed ACE/ARB or Diuretics	79.9%	79.1%	(0.8%)

Mental Health

The quality of care for members with mental illness (ages six and older) was evaluated through two clinical measures:

- *Follow-up after Hospitalization for Mental Illness – Seven Days*: Percentage of members who were hospitalized during the measurement year for the treatment of selected mental health diagnoses who had a follow up visit with a mental health practitioner within seven days.
- *Follow-up after Hospitalization for Mental Illness – 30 Days*: Percentage of members who were hospitalized during the measurement year for the treatment of selected mental health diagnoses who had a follow up visit with a mental health practitioner within 30 days.

The compliance rate for the practice facilitation population exceeded the comparison group rate on both measures (Exhibit 6-11). The difference was statistically significant in both cases.

Exhibit 6-11 – Mental Health Measures – Practice Facilitation Members vs. Comparison Group

Measure	Practice Facilitation Members			PF Members versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	PF - Comparison: % Point Difference
1. Follow-up after Hospitalization for Mental Illness – Seven Days	165	69	41.8%	21.9%	**19.9%**
2. Follow-up after Hospitalization for Mental Illness – 30 Days	165	117	70.9%	44.1%	**26.8%**

The compliance rates for both mental health measures declined slightly from SFY 2014 to SFY 2015 (Exhibit 6-12).

Exhibit 6-12 – Mental Health Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. Follow-up after Hospitalization for Mental Illness – Seven Days	42.1%	41.8%	(0.3%)
2. Follow-up after Hospitalization for Mental Illness – 30 Days	71.7%	70.9%	(0.8%)

Prevention

The quality of preventive care for members aligned with a practice facilitation provider was evaluated through three clinical measures:

- *Adult Access to Preventive/Ambulatory Care*: Percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.
- *Child Access to PCP*: Percentage of children 12 months to 19 years old who visited a primary care practitioner (PCP) during the measurement year, or if seven years or older, in the measurement year or year prior.
- *Adult BMI*: Percentage of adults 18 to 75 years old who had an outpatient visit where his/her BMI was documented, either during the measurement year or year prior to the measurement year.

The compliance rate for the practice facilitation population exceeded the comparison group rate on two of the three measures having a comparison group percentage (Exhibit 6-13). The difference was statistically significant in both cases.

Exhibit 6-13 – Preventive Measures – Practice Facilitation Members vs. Comparison Group

Measure	Practice Facilitation Members			PF Members versus Comparison Group	
	Total Members	Members Compliant	Percent Compliant	Comparison Group - Compliance Rate	PF - Comparison: % Point Difference
1. Adult Access to Preventive/Ambulatory Care	1,980	1,912	96.6%	84.1%	**12.5%**
2. Child Access to PCP	6,113	6,059	99.1%	91.7%	**7.4%**
3. Adult BMI	1,540	139	9.0%	10.7%	**(1.7%)**

The compliance rates for two measures increased slightly from SFY 2014 to SFY 2015 and declined slightly for the third measure (Exhibit 6-14).

Exhibit 6-14 – Preventive Measures - 2014 - 2015

Measure	Percent Compliant		2014-2015 Comparison % Point Change
	June 2014 Findings	June 2015 Findings	
1. Adult Access to Preventive/Ambulatory Care	96.5%	96.6%	0.1%
2. Child Access to PCP	98.9%	99.1%	0.2%
3. Adult BMI	9.2%	9.0%	(0.2%)

Summary of Key Findings

The practice facilitation participant compliance rate exceeded the comparison group rate on eight of 17 measures for which there was a comparison group percentage (47.1 percent). The difference was statistically significant for five of the eight measures (62.5 percent).

Conversely, the comparison group achieved a higher rate on nine of the 17 measures (52.9 percent), including five for which the difference was statistically significant (55.6 percent).

The practice facilitation participant compliance rate improved on 14 of 22 measures (63.6 percent) from SFY 2014 to SFY 2015, although typically by small amounts. Eight of 22 measures (36.4 percent) experienced a slight decline from SFY 2014 to SFY 2015. The most impressive results, relative to the comparison group, were observed for participants with diabetes and mental illness, and with respect to access to preventive care.

Similar to the health coaching quality outcomes, the above findings suggest that practice facilitation is having a positive impact on the quality of care for program participants. The long term benefit to participants will continue to be measured through the quality of care longitudinal analysis and through the utilization and expenditure analysis presented in the next chapter.

CHAPTER 7 – PRACTICE FACILITATION – EXPENDITURE & COST EFFECTIVENESS ANALYSIS

Introduction

Practice facilitation, if effective, should have an observable impact on service utilization and expenditures for patients with chronic conditions. Improvement in the quality of care should yield better outcomes in the form of lower acute care costs.

This section presents information for members with chronic conditions treated at practice facilitation sites. The analysis includes detailed findings for the same six chronic impact conditions evaluated in the health coaching expenditure evaluation: asthma, coronary artery disease, COPD, diabetes, heart failure and hypertension. It also includes findings for other members aligned with practice facilitation providers (i.e., outside of the chronic impact group) and for members aligned with practice facilitation providers in total.

Similar to the method used for the health coaching evaluation, PHPG calculated aggregate and PMPM medical expenditures for members treated during the evaluation period. PHPG then compared actual expenditures to trended MEDai forecasts.

Methodology for Creation of Expenditure Dataset

The practice facilitation dataset was developed from the complete Medicaid claims and eligibility extract provided by the OHCA.

To be included in the analysis, members had to have been aligned with a PCMH provider who underwent practice facilitation. They also had to have been seen by a PCMH provider at least once following their own PCMH provider's initiation into practice facilitation. Members participating in the health coaching portion of the SoonerCare HMP were excluded from the analysis. This was done to avoid double counting the impact of the program.

Members with more than one diagnosis were included in their diagnostic category with the greatest expenditures during the post-initiation period.

Findings are presented starting on the following page in similar format to the health coaching data presented in chapter four. Actual hospital days, ED visits and PMPM expenditures are compared to MEDai forecasts. Appendix E contains detailed expenditure exhibits.

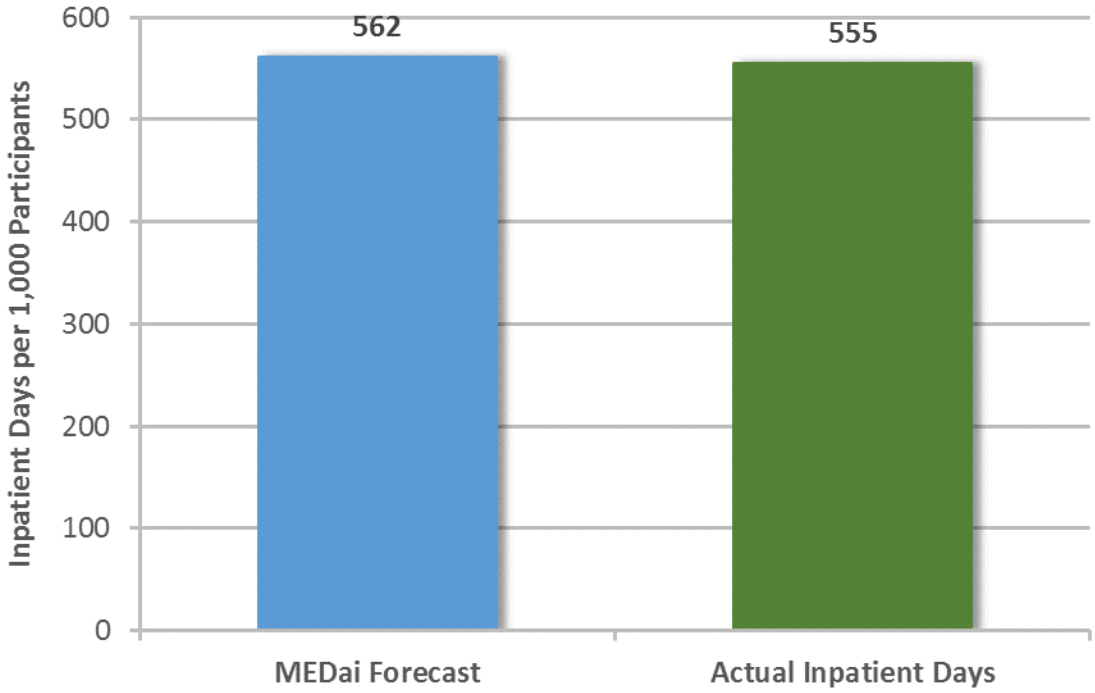
Asthma Population Utilization and Expenditure Evaluation

The SoonerCare HMP practice facilitation sites in SFY 2015 included 1,475 members who were not participating in health coaching and for whom asthma was the most expensive diagnosis.

Utilization

MEDai projected that members with asthma would incur 562 inpatient days per 1,000 over the 12 month forecast period[55]. The actual rate was 555, or 99 percent of forecast (Exhibit 7-1). (As noted in chapter four, the rate for all Oklahomans in 2014 was 560 days per 1,000.)

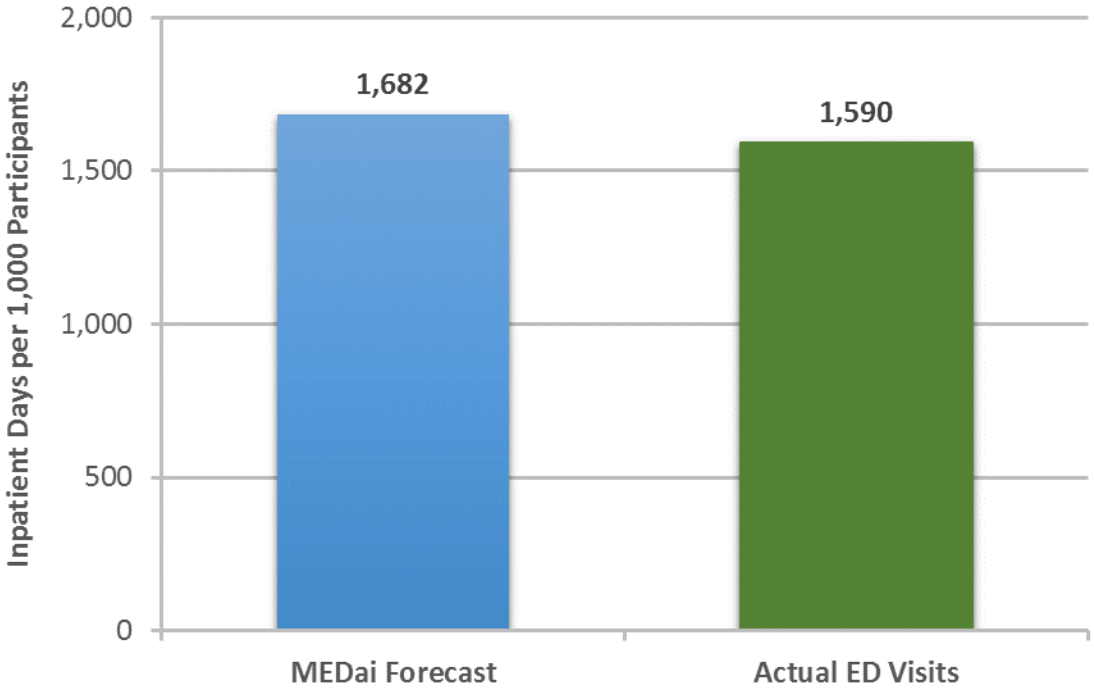
Exhibit 7-1 – Members with Asthma as Most Expensive Diagnosis
Inpatient Utilization – 12-Month Projection, per 1,000 Participants



[55] As with the health coaching analysis, all MEDai forecasts assume no intervention in terms of care management. PMPM rate calculated for portion of year that each participant was engaged in program.

MEDai projected that members with asthma would incur 1,682 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 1,590, or 95 percent of forecast (Exhibit 7-2). (As noted in chapter four, the rate for all Oklahomans in 2014 was 479 visits per 1,000.)

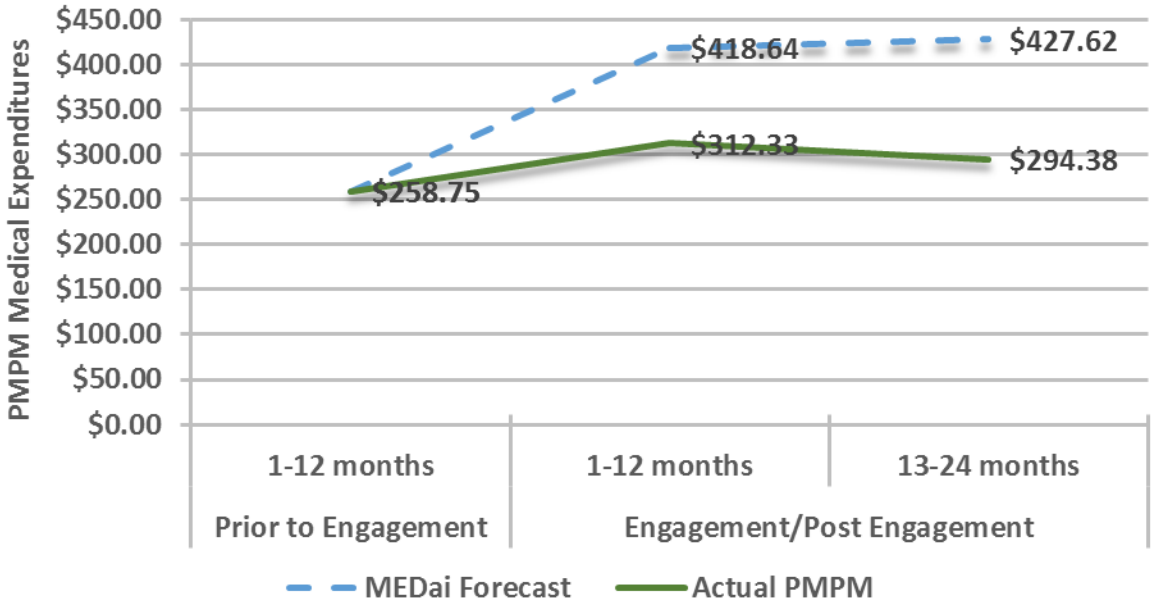
Exhibit 7-2 – Members with Asthma as Most Expensive Diagnosis
Emergency Department Utilization – 12-Month Projection, per 1,000 Participants



Medical Expenditures – Total and by Category of Service

MEDai projected that members with asthma would incur an average of $419 in PMPM expenditures over the 12-month forecast period. The actual amount was $312, or 74 percent of forecast. For months 13 to 24, the MEDai forecast with trend applied was $428 in PMPM expenditures. The actual amount was $294, or 69 percent of forecast (Exhibit 7-3).

Exhibit 7-3 – Members with Asthma as Most Expensive Diagnosis
Total PMPM Expenditures



At the category-of-service level in the first 12 months, expenditures increased for nearly all services (Exhibit 7-4).

Exhibit 7-4 – Members with Asthma as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$40.42	$48.43	$8.01	20%
Outpatient Hospital	$40.46	$55.35	$14.89	37%
Physician	$88.16	$105.15	$16.99	19%
Pharmacy	$47.04	$63.03	$15.99	34%
Behavioral Health	$1.22	$1.69	$0.47	39%
All Other	$41.45	$38.68	($2.77)	(7%)
Total	$258.75	$312.33	$53.58	21%

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for members with asthma by multiplying total months of enrollment following practice facilitation initiation and member interaction with a provider by average PMPM savings. The resultant savings equaled approximately $1.6 million (Exhibit 7-5).

Exhibit 7-5 – Members with Asthma as Most Expensive Diagnosis
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	10,884	$106.31	$1,157,078
Months 13 - 24	3,536	$133.24	$471,137
Total	**14,420**	**$112.91**	**$1,628,162**

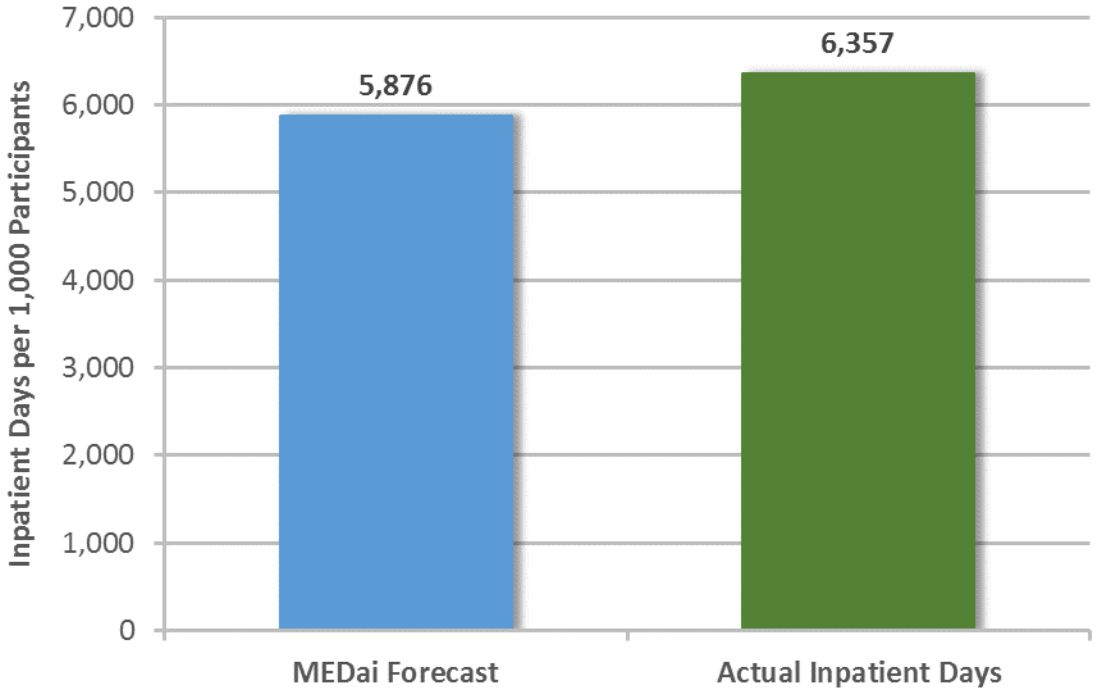
Coronary Artery Disease Population Utilization and Expenditure Evaluation

The SoonerCare HMP practice facilitation sites in SFY 2015 included 35 members who were not participating in health coaching and for whom coronary artery disease (CAD) was the most expensive diagnosis. Results for this diagnosis should be interpreted with caution given the small size of the population.

Utilization

MEDai projected that members with coronary artery disease would incur 5,876 inpatient days per 1,000 over the 12 month forecast period. The actual rate was 6,357, or 108 percent of forecast (Exhibit 7-6).

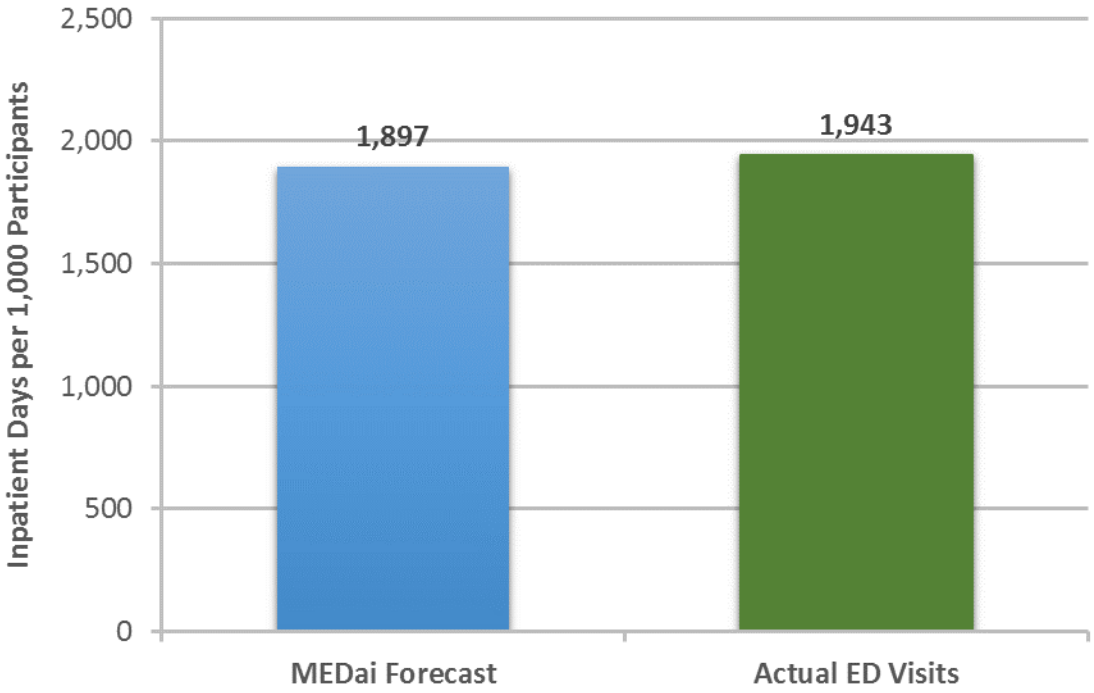
Exhibit 7-6 – Members with CAD as Most Expensive Diagnosis
Inpatient Utilization – 12-Month Projection, per 1,000 Participants



Results for this diagnosis should be interpreted with caution given the small size of the population.

MEDai projected that members with coronary artery disease would incur 1,897 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 1,943, or 102 percent of forecast (Exhibit 7-7).

Exhibit 7-7 – Members with CAD as Most Expensive Diagnosis
Emergency Department Utilization – 12-Month Projection, per 1,000 Participants

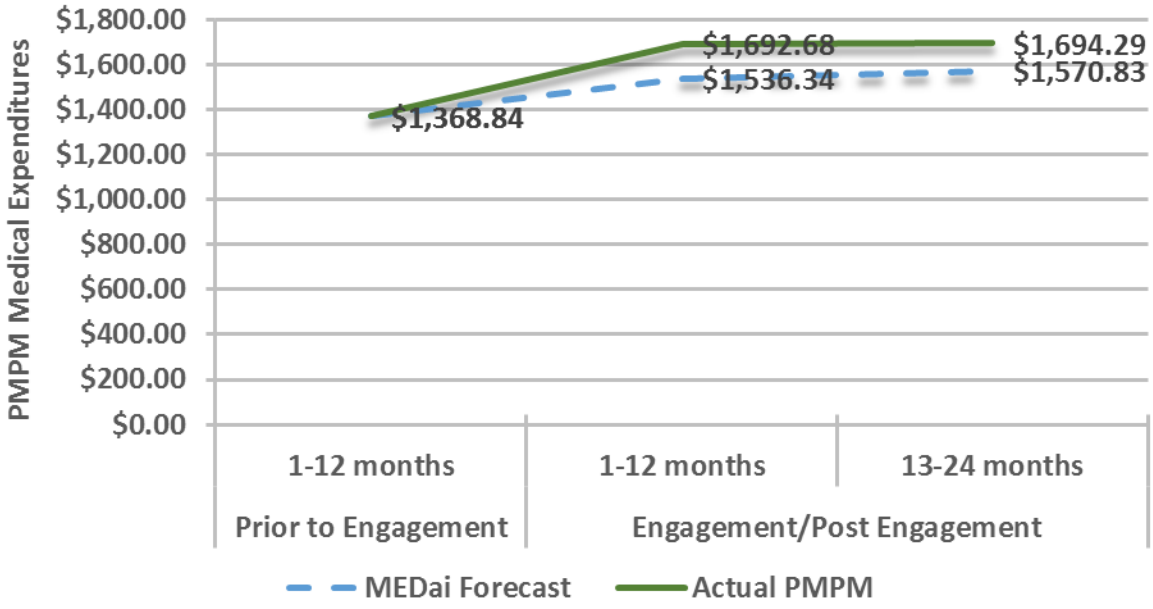


Results for this diagnosis should be interpreted with caution given the small size of the population.

Medical Expenditures – Total and by Category of Service

MEDai projected that members with coronary artery disease would incur an average of $1,536 in PMPM expenditures over the 12-month forecast period. The actual amount was $1,693, or 110 percent of forecast. For months 13 to 24, the MEDai forecast with trend applied was $1,571 in PMPM expenditures. The actual amount was $1,694, or 108 percent of forecast (Exhibit 7-8).

Exhibit 7-8 – Members with CAD as Most Expensive Diagnosis
Total PMPM Expenditures



Results for this diagnosis should be interpreted with caution given the small size of the population.

At the category-of-service level in the first 12 months, expenditures increased for nearly all services except inpatient hospital (Exhibit 7-9).

Exhibit 7-9 – Members with CAD as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$754.14	$752.61	($1.53)	(<1%)
Outpatient Hospital	$83.66	$283.76	$199.49	238%
Physician	$215.18	$275.26	$60.77	28%
Pharmacy	$220.32	$225.34	$5.99	3%
Behavioral Health	$0.21	$0.55	$0.34	162%
All Other	$95.33	$155.16	$59.83	63%
Total	$1,368.84	$1,692.68	$323.84	24%

Results for this diagnosis should be interpreted with caution given the small size of the population.

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for members with coronary artery disease by multiplying total months of enrollment following practice facilitation initiation and member interaction with a provider by average PMPM savings. The resultant deficit equaled approximately ($68,000) (Exhibit 7-10).

Exhibit 7-10 – Members with CAD as Most Expensive Diagnosis
Aggregate Deficit

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	348	($156.34)	($54,406)
Months 13 - 24	109	($123.46)	($13,457)
Total	**457**	**($148.68)**	**($67,947)**

Results for this diagnosis should be interpreted with caution given the small size of the population.

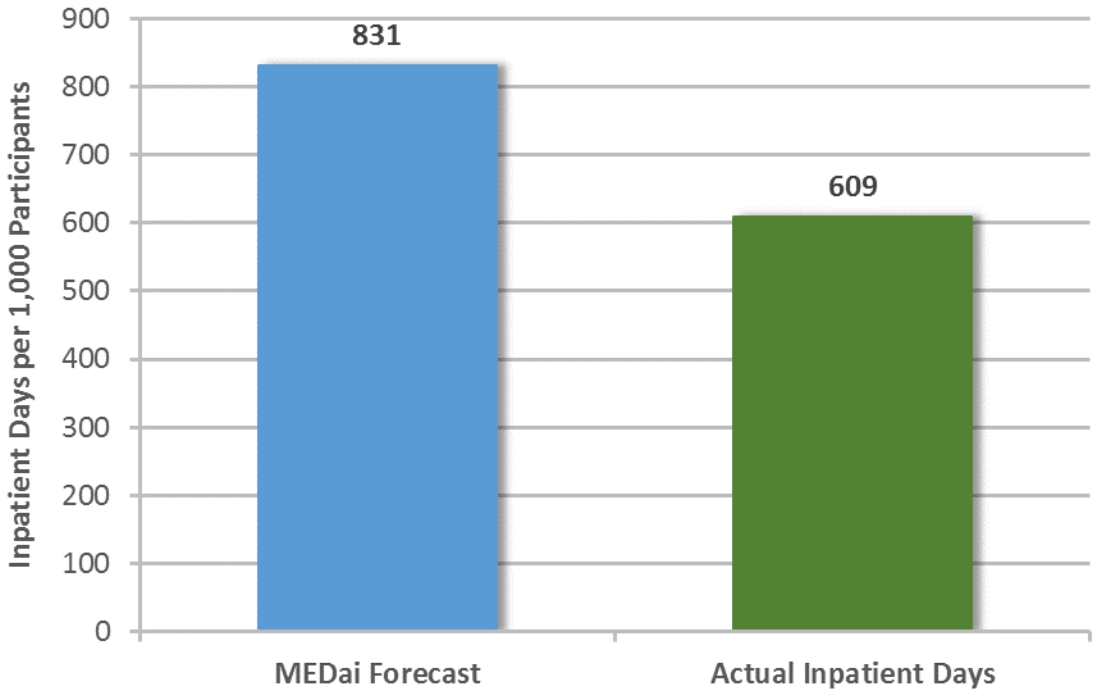
COPD Population Utilization and Expenditure Evaluation

The SoonerCare HMP practice facilitation sites in SFY 2015 included 690 members who were not participating in health coaching and for whom COPD was the most expensive diagnosis.

Utilization

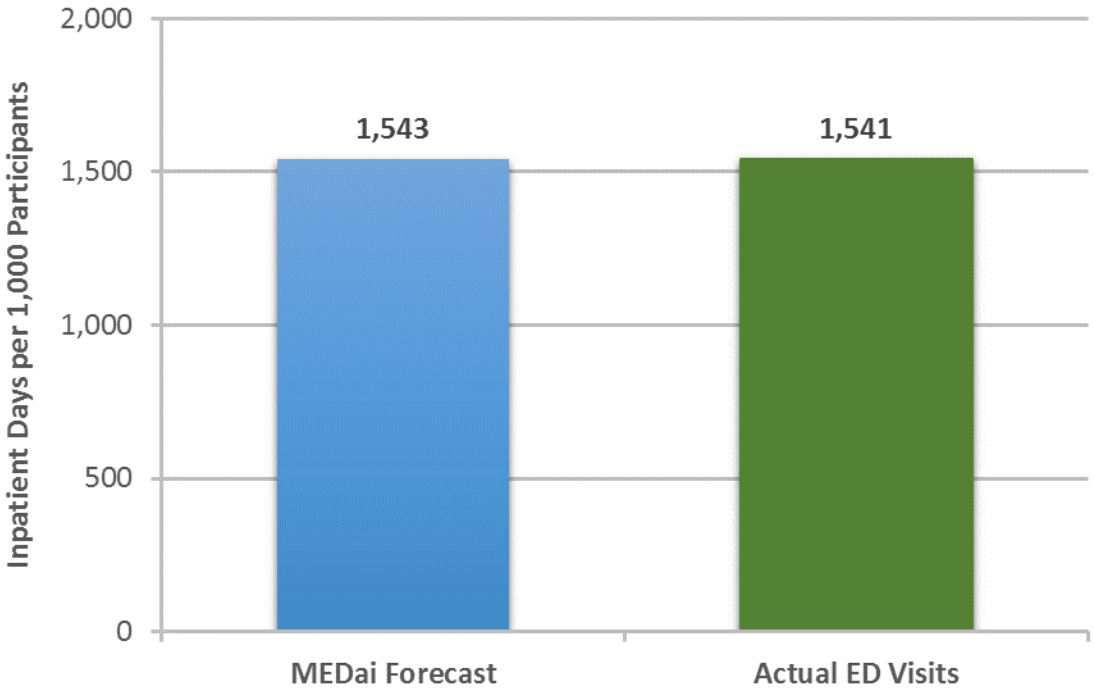
MEDai projected that members with COPD would incur 831 inpatient days per 1,000 over the 12 month forecast period. The actual rate was 609, or 73 percent of forecast (Exhibit 7-11).

Exhibit 7-11 – Members with COPD as Most Expensive Diagnosis
Inpatient Utilization – 12-Month Projection, per 1,000 Participants



MEDai projected that members with COPD would incur 1,543 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 1,541, or 100 percent of forecast (Exhibit 7-12).

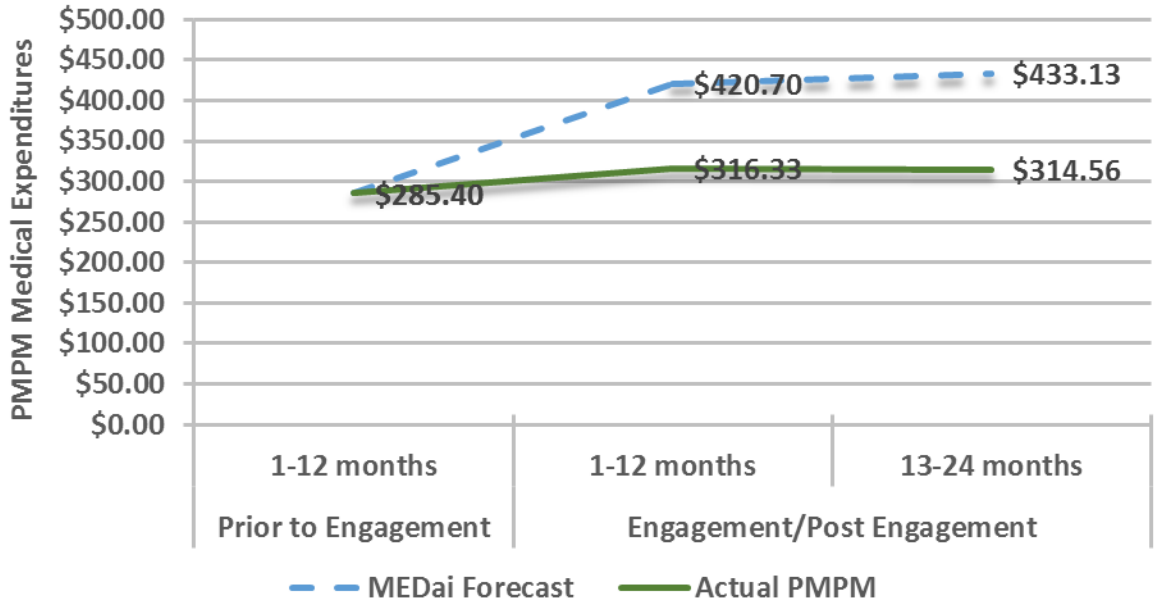
Exhibit 7-12 – Members with COPD as Most Expensive Diagnosis
Emergency Department Utilization – 12-Month Projection, per 1,000 Participants



Medical Expenditures – Total and by Category of Service

MEDai projected that members with COPD would incur an average of $421 in PMPM expenditures over the 12-month forecast period. The actual amount was $316, or 75 percent of forecast. For months 13 to 24, the MEDai forecast with trend applied was $433 in PMPM expenditures. The actual amount was $315, or 73 percent of forecast (Exhibit 7-13).

Exhibit 7-13 – Members with COPD as Most Expensive Diagnosis
Total PMPM Expenditures



At the category-of-service level in the first 12 months, expenditures increased for nearly all services, although physician costs declined slightly (Exhibit 7-14).

Exhibit 7-14 – Members with COPD as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$51.74	$55.78	$4.04	8%
Outpatient Hospital	$39.07	$54.95	$15.88	41%
Physician	$100.82	$99.89	($0.93)	(<1%)
Pharmacy	$53.44	$59.86	$6.42	12%
Behavioral Health	$0.39	$0.61	$0.22	56%
All Other	$39.93	$45.23	$5.30	13%
Total	$285.39	$316.32	$30.93	11%

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for members with COPD by multiplying total months of enrollment following practice facilitation initiation and member interaction with a provider by average PMPM savings. The resultant savings equaled approximately $800,000 (Exhibit 7-15).

Exhibit 7-15 – Members with COPD as Most Expensive Diagnosis
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	5,649	$104.37	$589,586
Months 13 - 24	1,761	$118.57	$208,802
Total	**7,410**	**$108.02**	**$800,428**

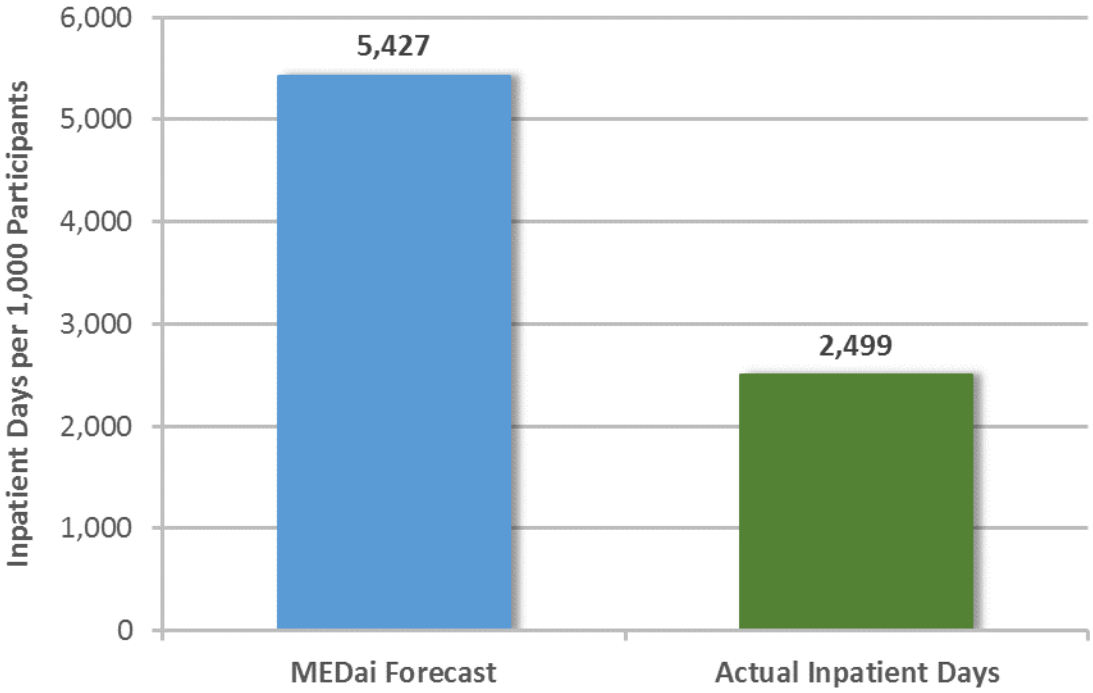
Diabetes Population Utilization and Expenditure Evaluation

The SoonerCare HMP practice facilitation sites in SFY 2015 included 296 members who were not participating in health coaching and for whom diabetes was the most expensive diagnosis.

Utilization

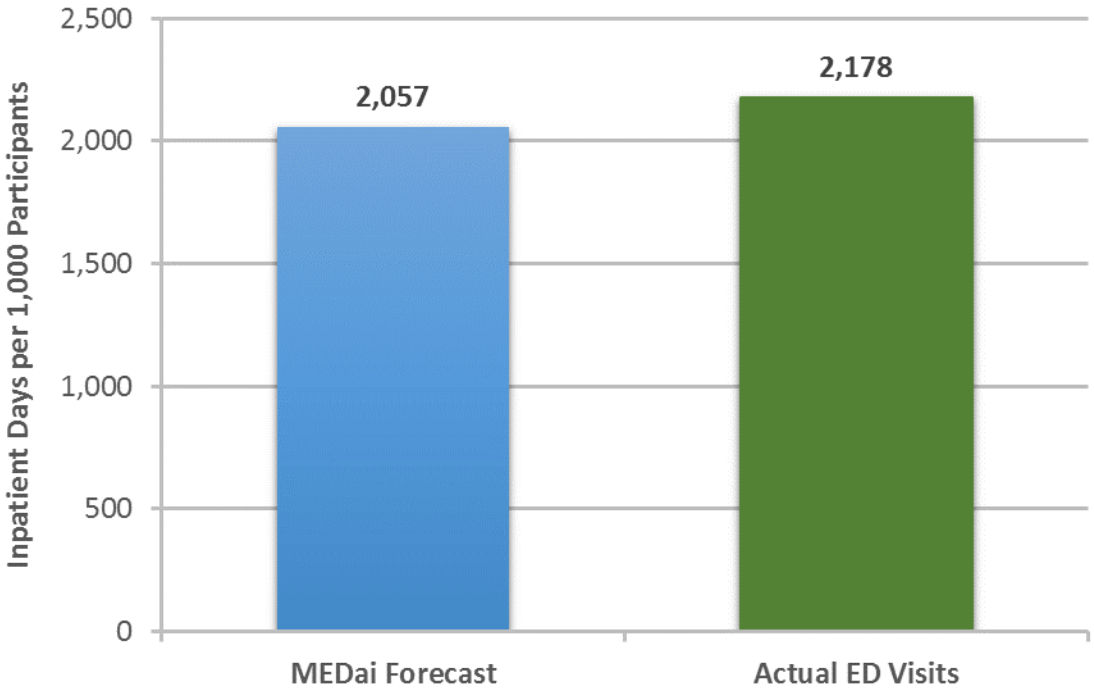
MEDai projected that members with diabetes would incur 5,427 inpatient days per 1,000 over the 12 month forecast period. The actual rate was 2,499, or 46 percent of forecast (Exhibit 7-16).

Exhibit 7-16 – Members with Diabetes as Most Expensive Diagnosis
Inpatient Utilization – 12-Month Projection, per 1,000 Participants



MEDai projected that members with diabetes would incur 2,057 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 2,178, or 106 percent of forecast (Exhibit 7-17).

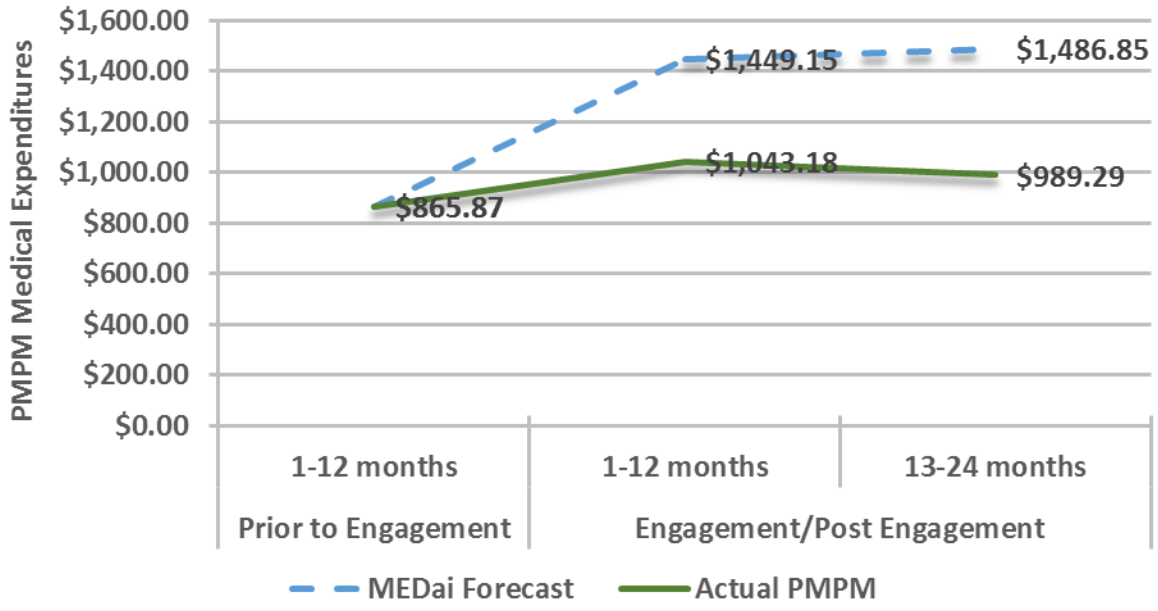
Exhibit 7-17 – Members with Diabetes as Most Expensive Diagnosis
Emergency Department Utilization – 12-Month Projection, per 1,000 Participants



Medical Expenditures – Total and by Category of Service

MEDai projected that members with diabetes would incur an average of $1,449 in PMPM expenditures over the 12-month forecast period. The actual amount was $1,043, or 72 percent of forecast. For months 13 to 24, the MEDai forecast with trend applied was $1,487 in PMPM expenditures. The actual amount was $989, or 67 percent of forecast (Exhibit 7-18).

Exhibit 7-18 – Members with Diabetes as Most Expensive Diagnosis
Total PMPM Expenditures



At the category-of-service level in the first 12 months, expenditures increased for nearly all services (Exhibit 7-19).

Exhibit 7-19 – Members with Diabetes as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$192.77	$285.52	$92.75	48%
Outpatient Hospital	$143.53	$144.51	$0.98	<1%
Physician	$190.52	$215.72	$25.20	13%
Pharmacy	$198.15	$232.18	$34.03	17%
Behavioral Health	$13.81	$4.90	($8.91)	(65%)
All Other	$127.09	$160.35	$33.26	26%
Total	$865.87	$1,043.18	$177.31	20%

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for members with diabetes by multiplying total months of enrollment following practice facilitation initiation and member interaction with a provider by average PMPM savings. The resultant savings equaled approximately $1.3 million (Exhibit 7-20).

Exhibit 7-20 – Members with Diabetes as Most Expensive Diagnosis
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	2,291	$405.97	$930,077
Months 13 - 24	737	$497.56	$366,702
Total	**3,028**	**$428.26**	**$1,296,771**

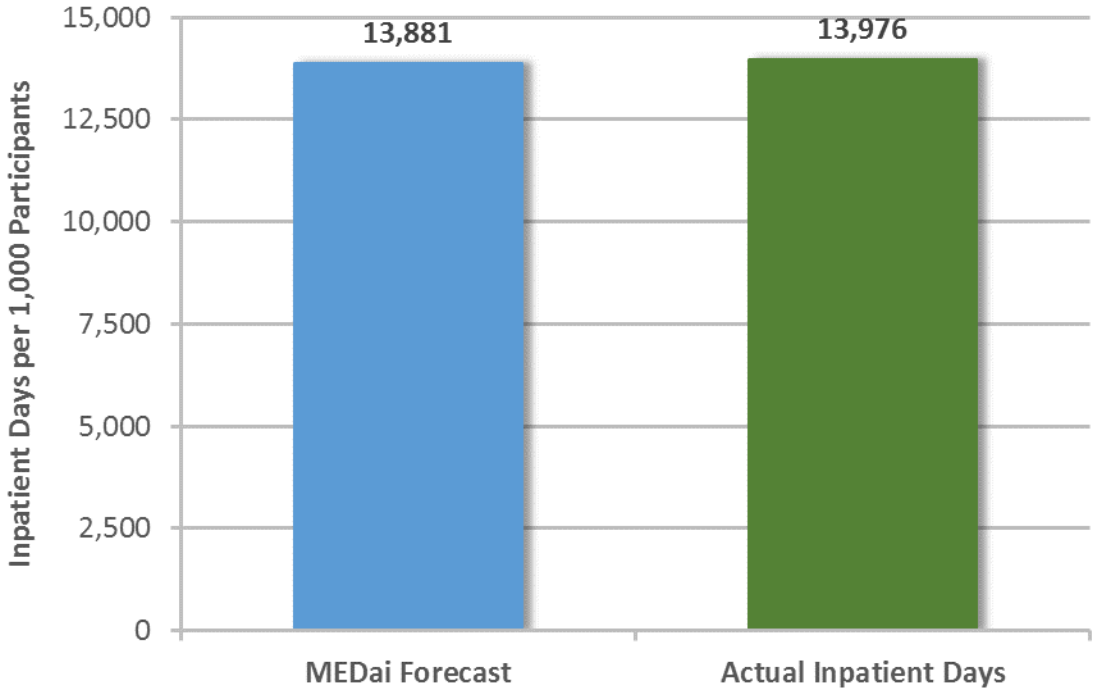
Heart Failure Population Utilization and Expenditure Evaluation

The SoonerCare HMP practice facilitation sites in SFY 2015 included 22 members who were not participating in health coaching and for whom heart failure was the most expensive diagnosis. Results for this diagnosis should be interpreted with caution given the small size of the population.

Utilization

MEDai projected that members with heart failure would incur 13,881 inpatient days per 1,000 over the 12 month forecast period. The actual rate was exactly 13,976, or 101 percent of forecast (Exhibit 7-21).

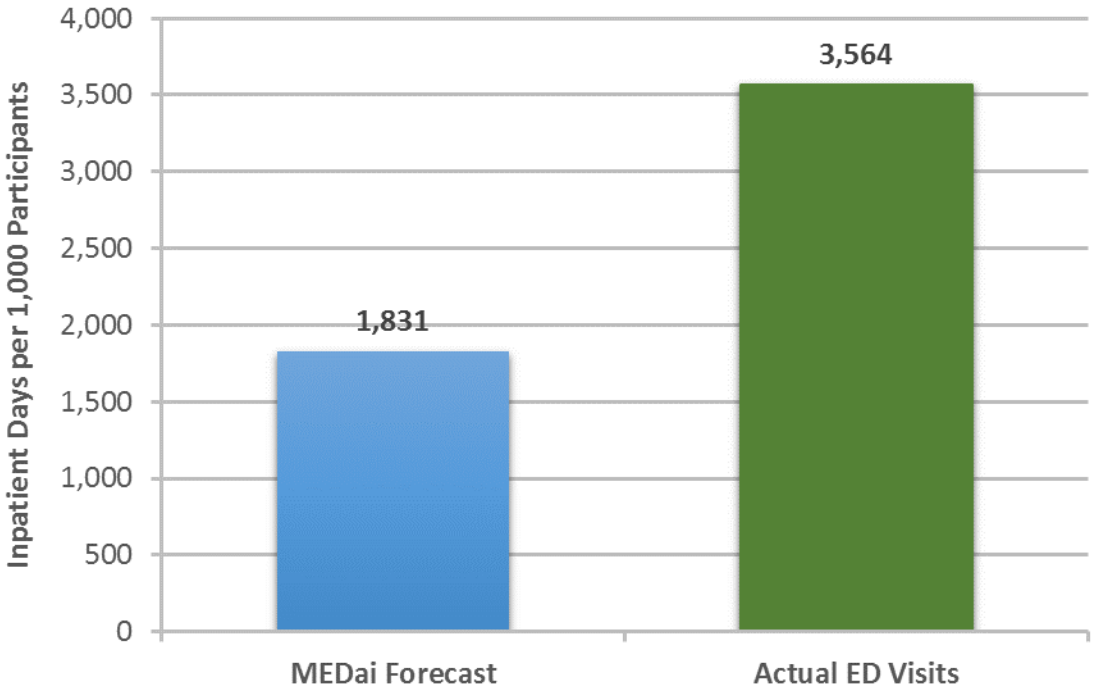
Exhibit 7-21 – Members with Heart Failure as Most Expensive Diagnosis
Inpatient Utilization – 12-Month Projection, per 1,000 Participants



Results for this diagnosis should be interpreted with caution given the small size of the population.

MEDai projected that members with heart failure would incur 1,831 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 3,564, or 195 percent of forecast (Exhibit 7-22).

Exhibit 7-22 – Members with Heart Failure as Most Expensive Diagnosis
Emergency Department Utilization – 12-Month Projection, per 1,000 Participants

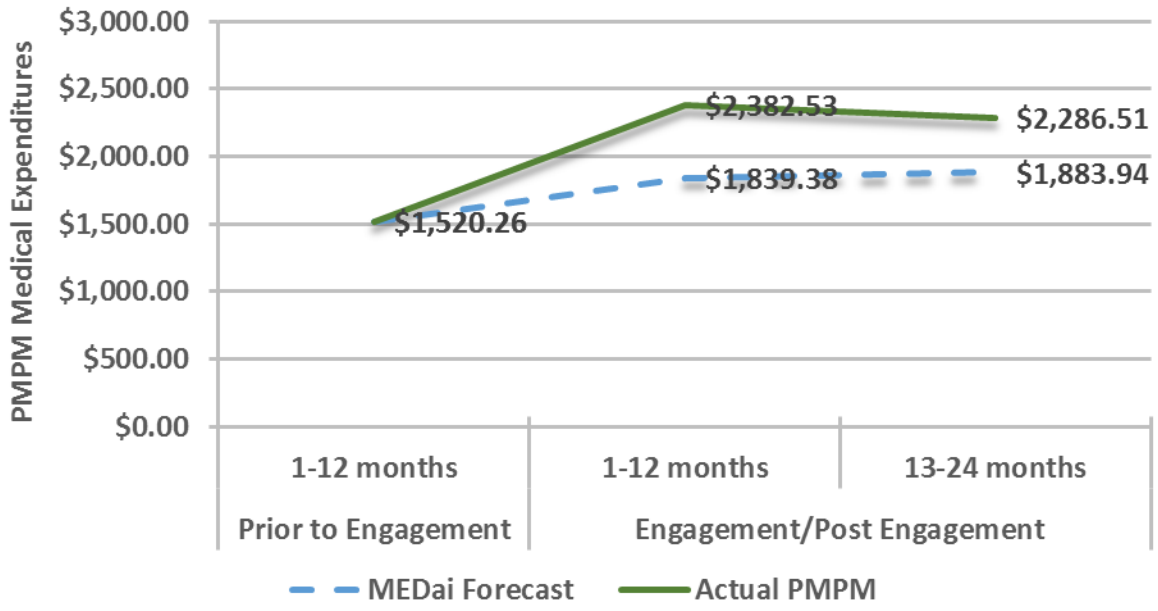


Results for this diagnosis should be interpreted with caution given the small size of the population.

Medical Expenditures – Total and by Category of Service

MEDai projected that members with heart failure would incur an average of $1,839 in PMPM expenditures over the 12-month forecast period. The actual amount was $2,383, or 130 percent of forecast. For months 13 to 24, the MEDai forecast with trend applied was $1,884 in PMPM expenditures. The actual amount was $2,287, or 121 percent of forecast (Exhibit 7-23).

Exhibit 7-23 – Members with Heart Failure as Most Expensive Diagnosis
Total PMPM Expenditures



Results for this diagnosis should be interpreted with caution given the small size of the population.

At the category-of-service level in the first 12 months, expenditures increased for nearly all services (Exhibit 7-24).

Exhibit 7-24 – Members with Heart Failure as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$659.07	$1,246.82	$587.75	89%
Outpatient Hospital	$323.98	$462.19	$138.21	43%
Physician	$251.11	$400.15	$149.04	59%
Pharmacy	$118.93	$86.77	($32.16)	(27%)
Behavioral Health	$0.00	$0.00	$0.00	--
All Other	$167.17	$186.59	$19.42	12%
Total	$1,520.26	$2,382.52	$862.26	57%

Results for this diagnosis should be interpreted with caution given the small size of the population.

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for members with heart failure by multiplying total months of enrollment following practice facilitation initiation and member interaction with a provider by average PMPM savings. The resultant deficit equaled approximately ($113,000) (Exhibit 7-25).

Exhibit 7-25 – Members with Heart Failure as Most Expensive Diagnosis
Aggregate Deficit

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	168	($543.15)	($91,249)
Months 13 - 24	54	($402.57)	($21,739)
Total	**222**	**($508.95)**	**($112,987)**

Results for this diagnosis should be interpreted with caution given the small size of the population.

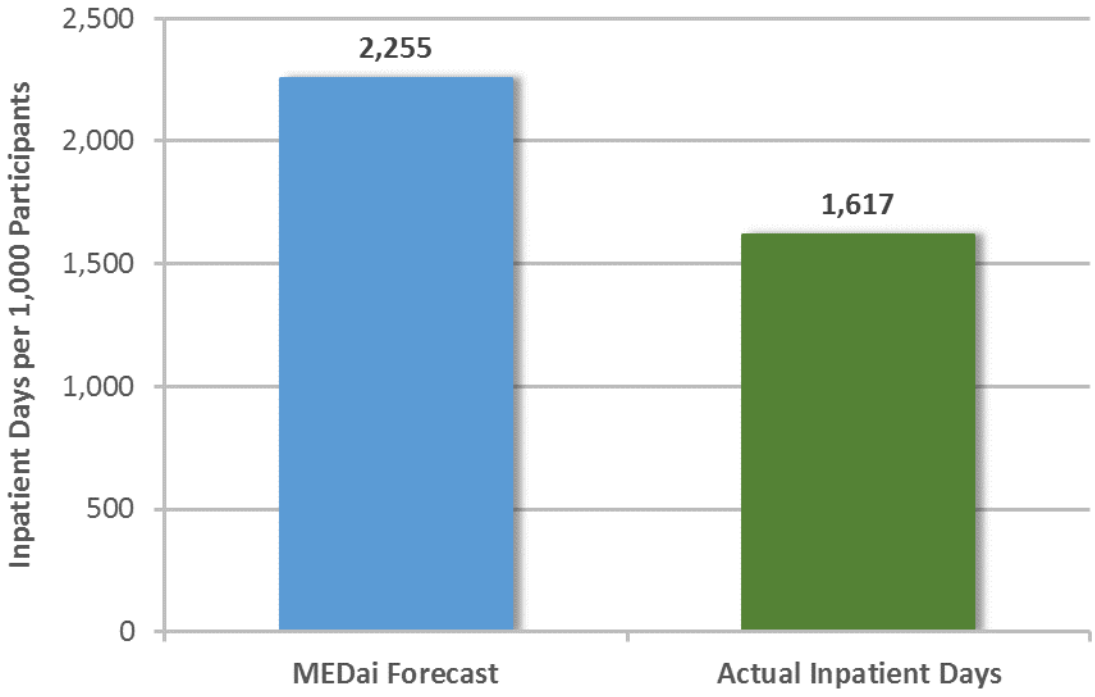
Hypertension Population Utilization and Expenditure Evaluation

The SoonerCare HMP practice facilitation sites in SFY 2015 included 677 members who were not participating in health coaching and for whom hypertension was the most expensive diagnosis.

Utilization

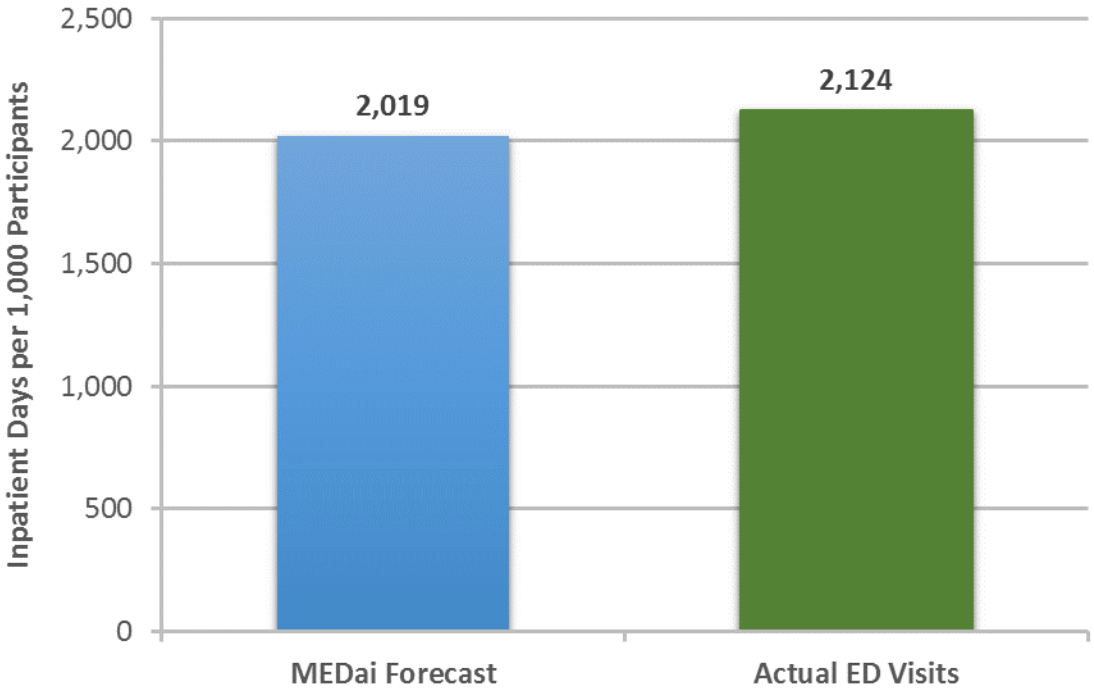
MEDai projected that members with hypertension would incur 2,255 inpatient days per 1,000 over the 12 month forecast period. The actual rate was 1,617, or 72 percent of forecast (Exhibit 7-26).

Exhibit 7-26 – Members with Hypertension as Most Expensive Diagnosis
Inpatient Utilization – 12-Month Projection, per 1,000 Participants



MEDai projected that members with hypertension would incur 2,019 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 2,124, or 105 percent of forecast (Exhibit 7-27).

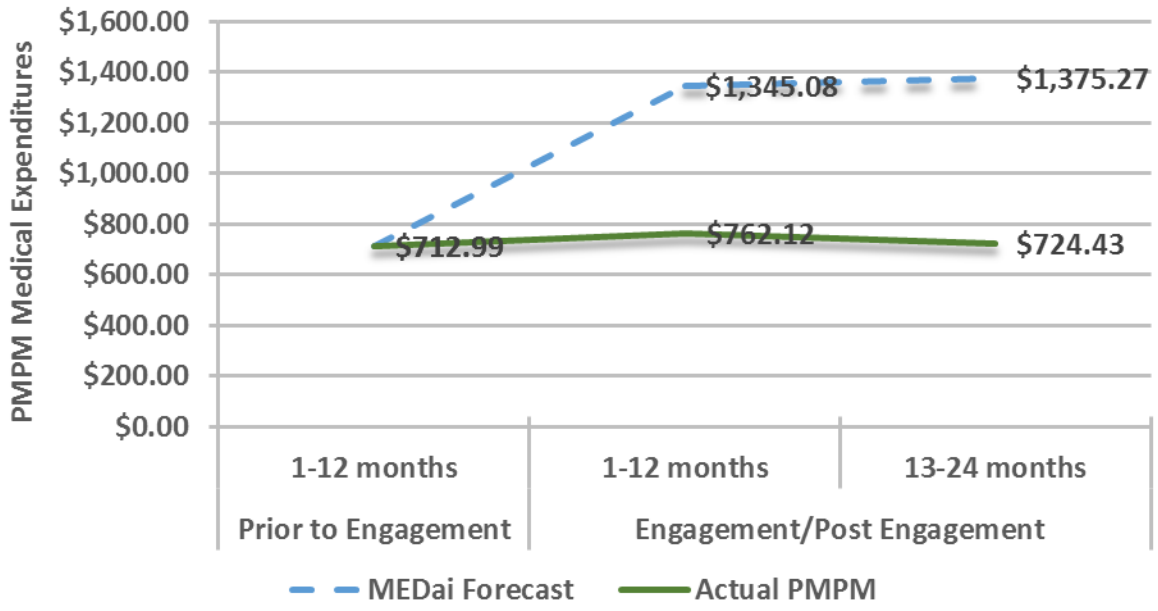
Exhibit 7-27 – Members with Hypertension as Most Expensive Diagnosis
Emergency Department Utilization – 12-Month Projection, per 1,000 Participants



Medical Expenditures – Total and by Category of Service

MEDai projected that members with hypertension would incur an average of $1,345 in PMPM expenditures over the 12-month forecast period. The actual amount was $762, or 57 percent of forecast. For months 13 to 24, the MEDai forecast with trend applied was $1,375 in PMPM expenditures. The actual amount was $724, or 53 percent of forecast (Exhibit 7-28).

Exhibit 7-28 – Members with Hypertension as Most Expensive Diagnosis
Total PMPM Expenditures



At the category-of-service level in the first 12 months, expenditures decreased for several services, with physician costs declining by the greatest amount (Exhibit 7-29).

Exhibit 7-29 – Members with Hypertension as Most Expensive Diagnosis
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$232.71	$222.83	($9.88)	(4%)
Outpatient Hospital	$104.13	$115.03	$10.90	10%
Physician	$189.68	$167.52	($22.16)	(12%)
Pharmacy	$111.88	$168.89	$57.01	51%
Behavioral Health	$4.24	$3.57	($0.67)	(16%)
All Other	$70.34	$84.29	$13.95	20%
Total	$712.98	$762.13	$49.15	7%

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for members with hypertension by multiplying total months of enrollment following practice facilitation initiation and member interaction with a provider by average PMPM savings. The resultant savings equaled approximately $3.3 million (Exhibit 7-30).

Exhibit 7-30 – Members with Hypertension as Most Expensive Diagnosis
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	4,256	$582.96	$2,481,078
Months 13 - 24	1,368	$650.84	$890,349
Total	**5,624**	**$599.47**	**$3,371,419**

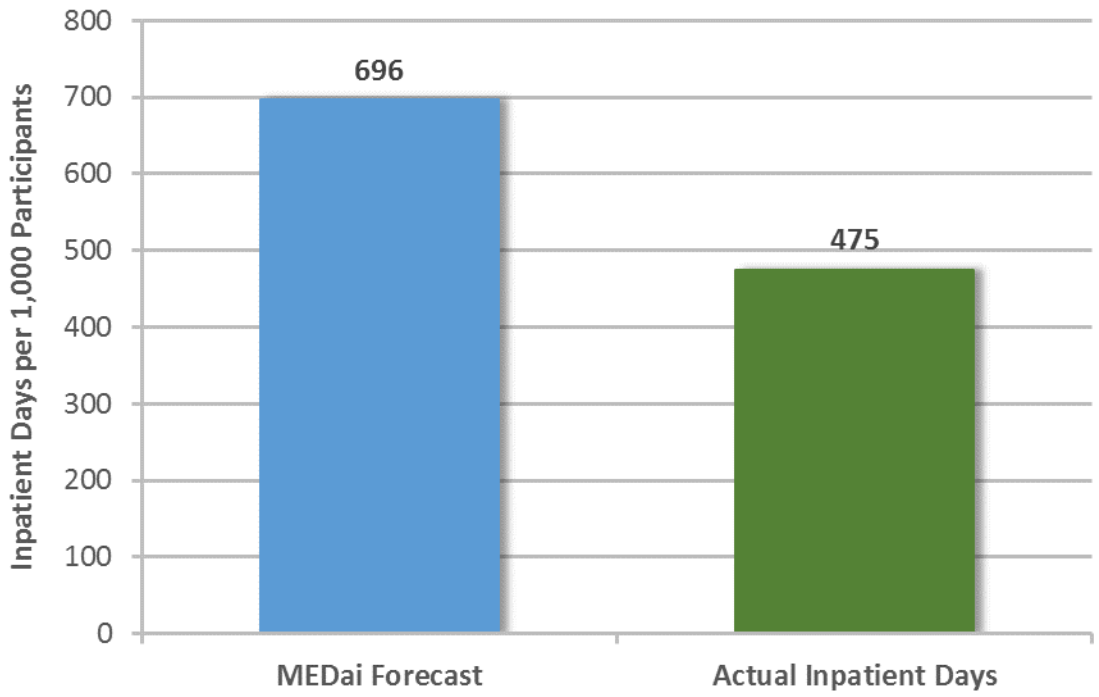
Utilization and Expenditure Evaluation – All Others

The SoonerCare HMP practice facilitation sites in SFY 2015 included 6,677 members who did not fall into one of the six priority diagnostic categories and who were not participating in health coaching. Although these members fell outside the universe of the six conditions, the holistic nature of the SoonerCare HMP suggests they also should have benefited from practice improvements undertaken at the participating sites.

Utilization

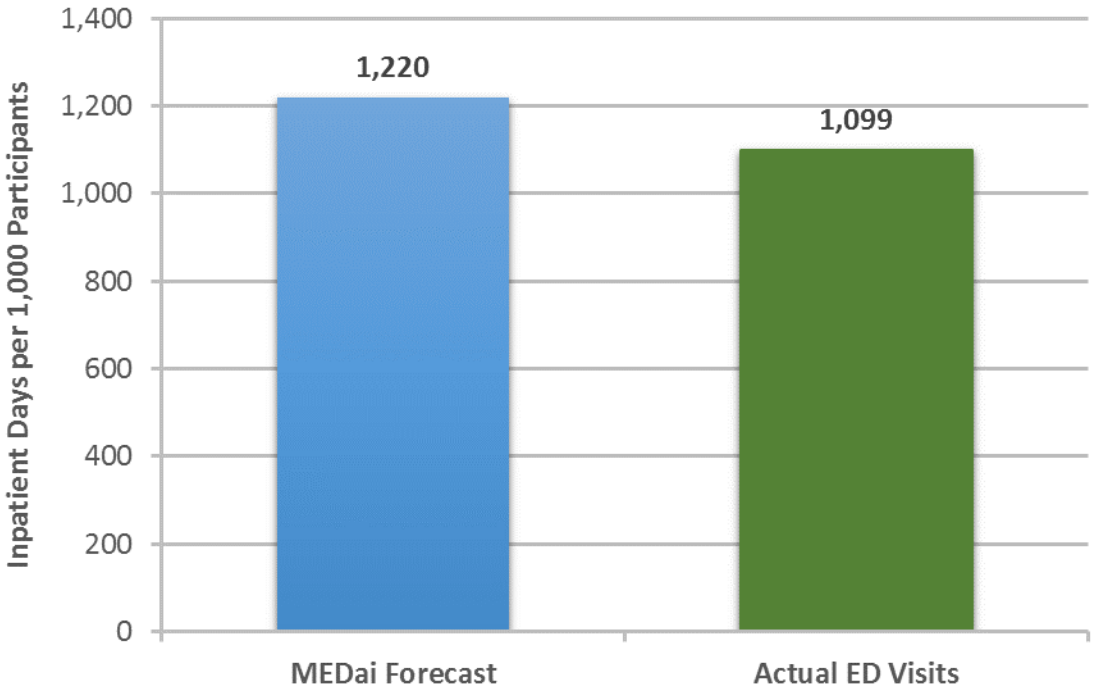
MEDai projected members in the "all others" group would incur 696 inpatient days per 1,000 over the 12 month forecast period. The actual rate was 475, or 68 percent of forecast (Exhibit 7-31).

Exhibit 7-31 – All Other Members
Inpatient Utilization – 12-Month Projection, per 1,000 Participants



MEDai projected members in the "all others" group would incur 1,220 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 1,099, or 90 percent of forecast (Exhibit 7-32).

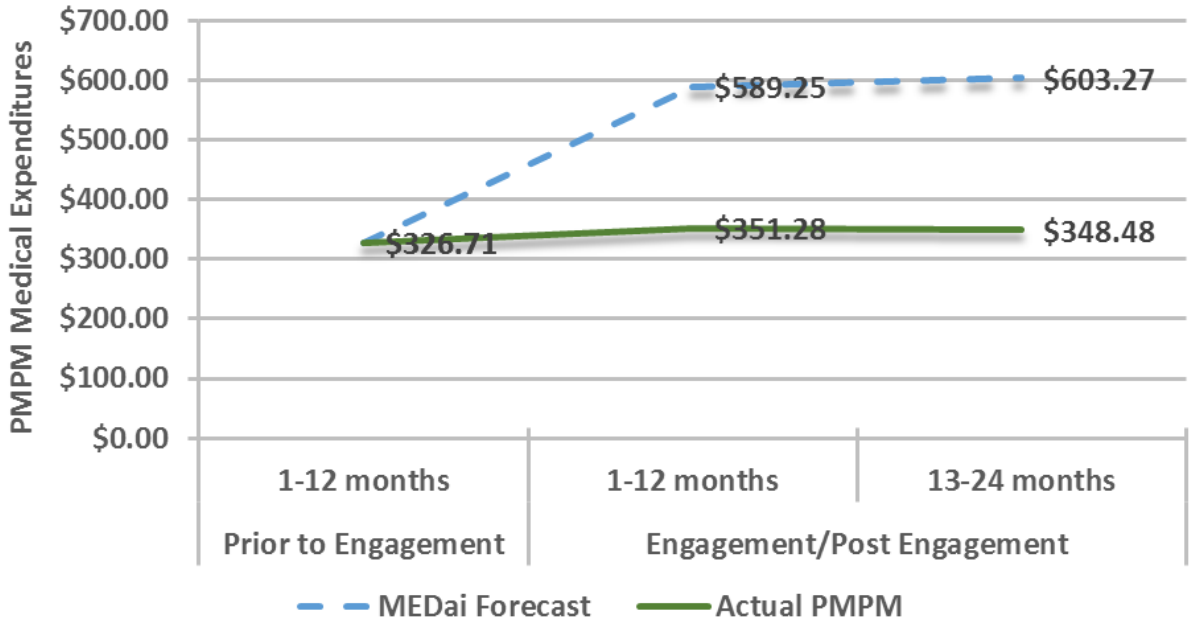
Exhibit 7-32 – All Other Members
Emergency Department Utilization – 12-Month Projection, per 1,000 Participants



Medical Expenditures – Total and by Category of Service

MEDai projected that members in the "all others" group would incur an average of $589 in PMPM expenditures over the 12-month forecast period. The actual amount was $351, or 60 percent of forecast. For months 13 to 24, the MEDai forecast with trend applied was $603 in PMPM expenditures. The actual amount was $348, or 58 percent of forecast (Exhibit 7-33).

Exhibit 7-33 – All Other Members
Total PMPM Expenditures



At the category-of-service level in the first 12 months, expenditures increased for most services, although the overall rate of increase was in single digits (Exhibit 7-34).

Exhibit 7-34 – All Other Members
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$36.96	$41.85	$4.89	13%
Outpatient Hospital	$36.36	$42.18	$5.81	16%
Physician	$73.18	$81.85	$8.67	12%
Pharmacy	$52.61	$60.53	$7.92	15%
Behavioral Health	$78.00	$75.62	($2.38)	(3%)
All Other	$49.59	$49.25	($0.34)	(1%)
Total	$326.70	$351.28	$24.58	8%

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for members in the "all others" group by multiplying total months of enrollment following practice facilitation initiation and member interaction with a provider by average PMPM savings. The resultant savings equaled approximately $28.5 million (Exhibit 7-35).

Exhibit 7-35 – All Other Members
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	89,436	$237.97	$21,261,668
Months 13 - 24	28,052	$254.79	$7,147,369
Total	**117,488**	**$242.30**	**$28,467,342**

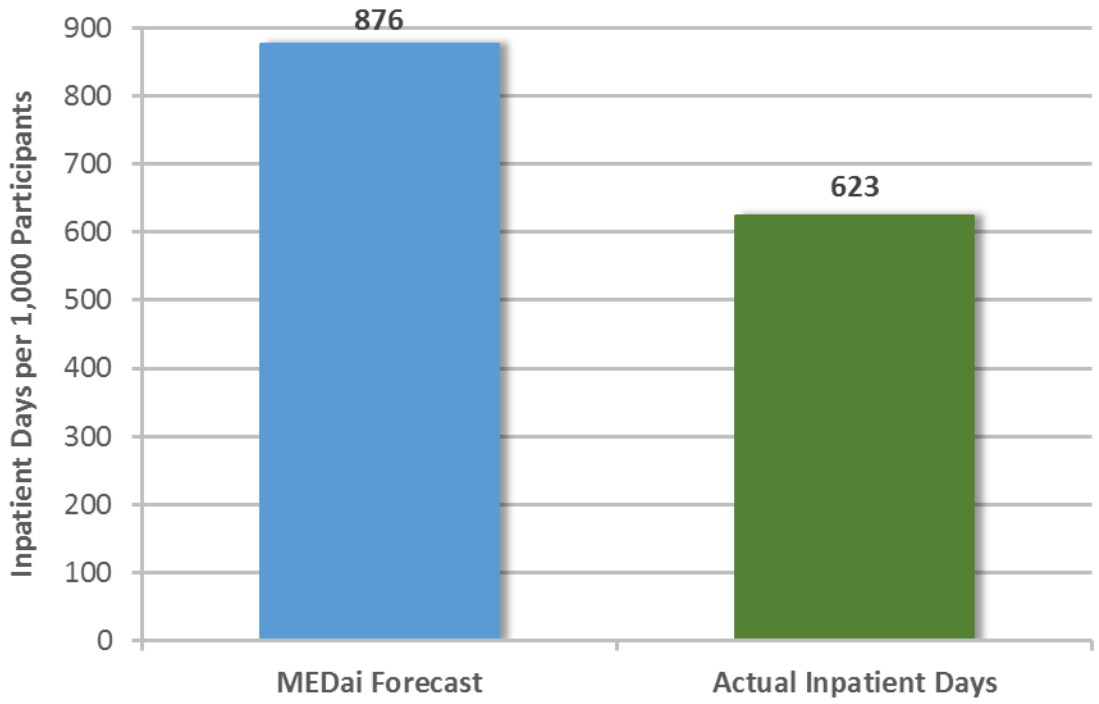
Utilization and Expenditure Evaluation – All Members

This section presents consolidated trend data across all 9,872 members aligned with a practice facilitation provider who did not participate in health coaching but met the other criteria for inclusion in the analysis.

Utilization

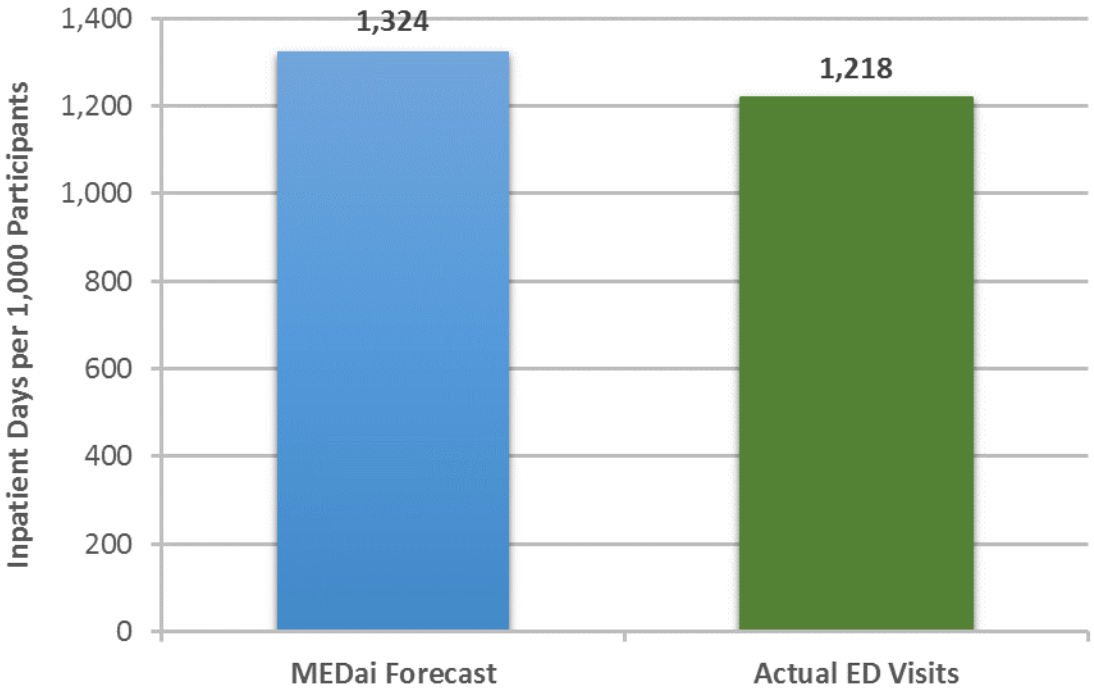
MEDai projected members in total would incur 876 inpatient days per 1,000 over the 12 month forecast period. The actual rate was 623, or 71 percent of forecast (Exhibit 7-36).

Exhibit 7-36 – All Members
Inpatient Utilization – 12-Month Projection, per 1,000 Participants



MEDai projected members in total would incur 1,324 emergency department visits per 1,000 over the 12-month forecast period. The actual rate was 1,218, or 92 percent of forecast (Exhibit 7-37).

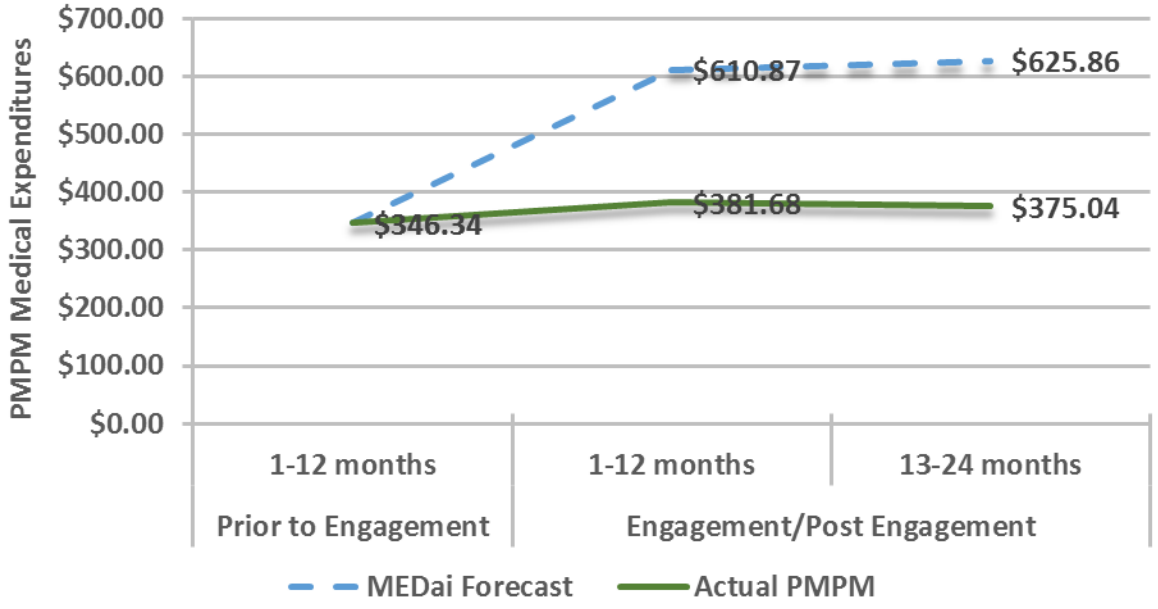
Exhibit 7-37 – All Members
Emergency Department Utilization – 12-Month Projection, per 1,000 Participants



Medical Expenditures – Total and by Category of Service

MEDai projected that members in total would incur an average of $611 in PMPM expenditures over the 12-month forecast period. The actual amount was $382, or 63 percent of forecast. For months 13 to 24, the MEDai forecast with trend applied was $626 in PMPM expenditures. The actual amount was $375, or 60 percent of forecast (Exhibit 7-38).

Exhibit 7-38 – All Members
Total PMPM Expenditures



At the category-of-service level in the first 12 months, expenditures increased for all services except behavioral health (Exhibit 7-39).

Exhibit 7-39 – All Members
PMPM Expenditures by Category of Service

Category of Service	PMPM 12 Months Prior to Engagement	PMPM First 12 Months of Engagement	Dollar Change (Engaged minus Prior to Engagement)	Percent Change (As Percent of PMPM Prior to Engagement)
Inpatient Hospital	$50.89	$58.84	$7.95	16%
Outpatient Hospital	$41.88	$50.19	$8.31	20%
Physician	$82.97	$91.84	$8.87	11%
Pharmacy	$57.49	$68.67	$11.18	19%
Behavioral Health	$62.32	$60.10	($2.22)	(4%)
All Other	$50.80	$52.04	$1.24	2%
Total	$346.35	$381.68	$35.33	10%

Aggregate Dollar Impact

PHPG calculated an aggregate dollar impact for all members included in the analysis by multiplying total months of enrollment following practice facilitation initiation and member interaction with a provider by average PMPM savings. The resultant savings equaled nearly $34.9 million (Exhibit 7-40).

Exhibit 7-40 – All Members
Aggregate Savings

Engagement Period	Member Months	PMPM Savings (Forecast – Actual)	Aggregate Savings / (Deficit)
First 12 Months	113,148	$229.19	$25,932,390
Months 13 - 24	35,727	$250.82	$8,961,046
Total	**148,875**	**$234.38**	**$34,893,323**

Practice Facilitation Cost Effectiveness Analysis

PHPG conducted a formal cost effectiveness analysis of practice facilitation by adding SoonerCare HMP administrative expenses to the medical expenditure data presented in the summary portion of the previous section. The combined medical and administrative expenses represent the appropriate values for measuring the overall cost effectiveness of the practice facilitation program.

Administrative Expenses

SoonerCare HMP administrative expenses were calculated using the same methodology as described in chapter four for health coaching. SFY 2014 – SFY 2015 aggregate administrative expenses for practice facilitation were approximately $6.5 million (Exhibit 7-41). This equated to $43.35 on a PMPM basis. The PMPM calculation was performed using total member months (148,875) for members included in the expenditure analysis.

Exhibit 7-41 – SoonerCare HMP - Practice Facilitation Administrative Expense

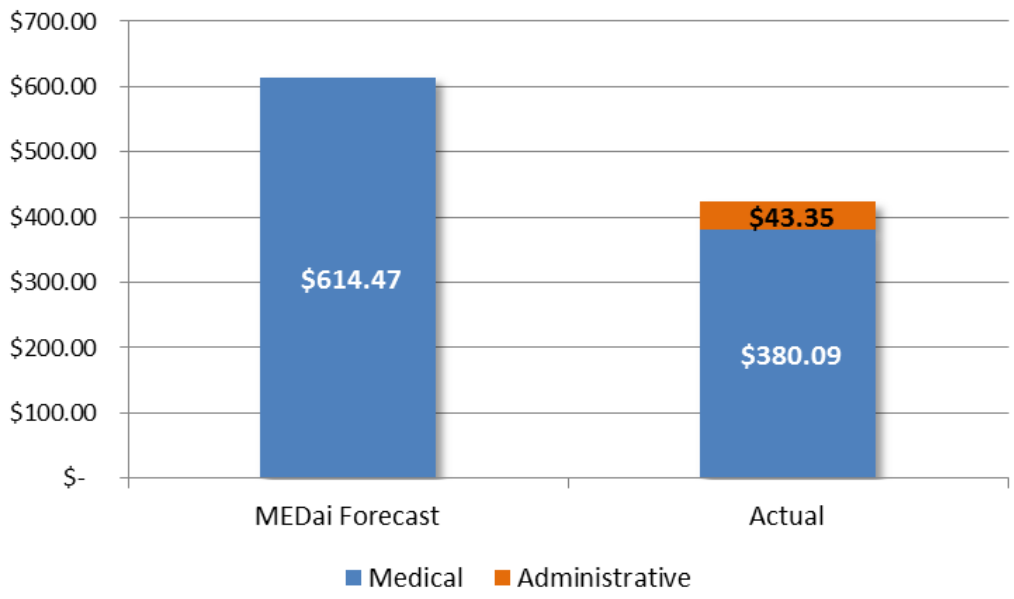
Cost Component	SFY 2014 - 2015 Aggregate Dollars	PMPM
OHCA SoonerCare HMP unit salaries and benefits (50% allocation)	$420,514	$2.82
OHCA SoonerCare HMP overhead (50% allocation)	$53,008	$0.36
Telligen practice facilitators	$4,097,336	$27.52
Telligen Central Operations (50% allocation)	$1,883,302	$12.65
Total Administrative Expense	**$6,454,160**	**$43.35**

Cost Effectiveness Calculation[56]

PHPG performed a cost effectiveness test by comparing forecasted costs to actual costs during SFY 2014 and SFY 2015, inclusive of SoonerCare HMP practice facilitation administrative expenses.

SoonerCare HMP members aligned with a practice facilitation provider and included in the expenditure analysis were forecasted to incur average medical costs of $614.47[57]. Their actual average PMPM medical costs were $380.09. With the addition of $43.35 in average PMPM administrative expenses, total actual costs were $423.44. Medical expenses accounted for 90 percent of the total and administrative expenses for the other 10 percent. Overall, net SoonerCare HMP practice facilitation-related PMPM expenses were 61.9 percent of forecast (Exhibit 7-42).

Exhibit 7-42 – SoonerCare HMP - Practice Facilitation PMPM Savings



On an aggregate basis, the practice facilitation portion of the SoonerCare HMP achieved net savings in excess of $28.4 million (Exhibit 7-43 on the following page). These net savings compare favorably to the practice facilitation component of the first generation SoonerCare HMP, which generated cumulative net savings of $3.5 million through its initial 17 months of operation (February 2008 implementation through June 2009) and $19.2 million in cumulative net savings through its initial 29 months of operation (February 2008 through June 2010).[58]

[56] PMPM and aggregate values differ slightly due to rounding.
[57] This represents a weighted average (by member months) of the forecasted PMPM values for the first 12 months and months 13 – 24, as shown in exhibit 7-38.
[58] SoonerCare HMP Comprehensive Evaluation Report, May 2014, page 94.

Exhibit 7-43 – SoonerCare HMP - Practice Facilitation
Aggregate Savings – Net of Administrative Expenses

Medical Savings	Administrative Costs	Net Savings
$34,893,323	($6,454,160)	**$28,439,163**

CHAPTER 8 – SOONERCARE HMP RETURN ON INVESTMENT

Introduction

The value of the SoonerCare HMP is measurable on multiple axes, including participant satisfaction and change in behavior, quality of care, improvement in service utilization and overall impact on medical expenditures. The last criterion is arguably the most important, as progress in other areas should ultimately result in medical expenditures remaining below the level that would have occurred absent the program.

ROI Results

PHPG examined the program's return on investment (ROI) through SFY 2015, by comparing health coaching and practice facilitation administrative expenditures to medical savings. The results are presented in Exhibit 8-1 below.

As the exhibit illustrates, both program components have achieved a positive ROI, with the program as a whole generating a return on investment of just under 250 percent. Put another way, the second generation ***SoonerCare HMP generated nearly $2.50 in net medical savings for every dollar in administrative expenditures.***

Exhibit 8-1 – SoonerCare HMP ROI (State and Federal Dollars)

Component	Medical Savings	Administrative Costs	Net Savings	Return on Investment
Health Coaching	$22,861,281	($10,101,726)	$12,759,555	126.3%
Practice Facilitation	$34,893,323	($6,454,160)	$28,439,163	440.6%
TOTAL	**$57,754,604**	**($16,555,886)**	**$41,198,718**	**248.8%**

APPENDIX A – HEALTH COACHING PARTICIPANT SURVEY INSTRUMENT

Appendix A includes the advance letter sent to SoonerCare HMP participants and survey instrument. The instrument is annotated to flag questions that have been discontinued or are asked of follow-up survey respondents only.

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

<First> <Last>
<Street Address 1>
<Street Address 2>
<City>, <State> <Zip>

The Oklahoma Health Care Authority is conducting a survey of SoonerCare members. You were selected for the survey because you may have received help from the SoonerCare Health Management Program. We are interested in learning about your experience and how we can make these services better.

The survey will be over the phone and should take about 15 minutes of your time. In the next few days, someone will be calling you to conduct the survey.

THE SURVEY IS VOLUNTARY. If you decide not to complete the survey, it will NOT affect your SoonerCare enrollment or the enrollment of anyone else in your family.

However, we want to hear from you and hope you will agree to help. The survey will be conducted by the Pacific Health Policy Group (PHPG), an outside company. All of your answers will be kept confidential.

If you have any questions about the survey, you can reach PHPG toll-free at 1-888-941-9358. If you would like to take the survey right away, you may call the same number any time between the hours of 9 a.m. and 4 p.m. If you have any questions for the Oklahoma Health Care Authority, please call the toll-free number 1-877-252-6002.

We look forward to speaking with you soon.

SoonerCare
Oklahoma Health Care Authority

SOONERCARE HMP MEMBER SURVEY

INTRODUCTION & CONSENT

Hello, my name is _____ and I am calling on behalf of the Oklahoma SoonerCare program. May I please speak to {RESPONDENT NAME}?

INTRO1. We are conducting a short survey to find out about where SoonerCare members get their health care and about their participation in the health management program. The survey takes about 10 minutes.

[ANSWER ANY QUESTIONS AND PROCEED TO QUESTION 1]

INTRO2. [If need to leave a message] We are conducting a short survey to find out about where SoonerCare members get their health care and about their participation in the health management program. We can be reached toll-free at 1-888-941-9358.

1. The SoonerCare program is a health insurance program offered by the state. Are you currently participating in SoonerCare?[59]
    a. Yes
    b. No → [ASK IF ENROLLED IN MEDICAID. IF NO, END CALL]
    c. Don't Know/Not Sure → [ASK IF ENROLLED IN MEDICAID. IF NO, END CALL]

2. Some SoonerCare members with health needs receive help through a special program known as the SoonerCare Health Management Program. Have you heard of it? [IF RESPONDENT SAYS 'NO' OR 'NOT SURE'] The program includes Health Coaches in doctors' offices who help members with their care. Does that sound familiar?
    a. Yes
    b. No
    c. Don't Know/Not Sure

3. Were you contacted and offered a chance to participate in the SoonerCare Health Management Program?
    a. Yes
    b. No → [END CALL]
    c. Don't Know/Not Sure → [END CALL]

4. Did you decide to participate?
    a. Yes
    b. No → [GO TO Q50]
    c. Not yet, but still considering → [INFORM THAT WE MAY CALL BACK AT A LATER DATE AND END CALL]
    d. Don't Know/Not Sure → [END CALL]

[59] All questions include a "don't know/not sure" or similar option which is unprompted by the surveyor; this response is listed on the instrument to allow surveyors to document such a response. Questions are reworded for parents/guardians completing the survey on behalf of program participants.

5. Are you still participating today in the SoonerCare Health Management Program?
    a. Yes
    b. No → [GO TO Q48]
    c. Don't Know/Not Sure → [END CALL]

6. How long have you been participating in the SoonerCare Health Management Program?
    a. Less than 1 month
    b. One to two months
    c. Three to four months
    d. Four to six months
    e. More than six months
    f. Don't Know/Not Sure

Now I want to ask about your decision to enroll in the SoonerCare Health Management Program.

7. How did you learn about the SoonerCare Health Management Program?
    a. Received information in the mail
    b. Received a call from my Health Coach
    c. Received a call from someone else SPECIFY _____
    d. Doctor referred me while I was in his/her office
    e. Other. SPECIFY: _____
    f. Don't Know/Not Sure

8. What were your reasons for deciding to participate in the SoonerCare Health Management Program? [CHECK ALL THAT APPLY]
    a. Learn how to better manage health problems
    b. Learn how to identify changes in health
    c. Have someone to call with questions about health
    d. Get help making health care appointments
    e. Personal doctor recommended I enroll
    f. Improve my health
    g. Was invited to enroll/no specific reason
    h. Other. SPECIFY: _____
    i. Don't Know/Not Sure

9. Among the reasons you gave, what was your most important reason for deciding to participate?
    a. Learn how to better manage health problems
    b. Learn how to identify changes in health
    c. Have someone to call with questions about health
    d. Get help making health care appointments
    e. Personal doctor recommended I enroll
    f. Improve my health
    g. Was invited to enroll/no specific reason
    h. Other. SPECIFY: _____
    i. Don't Know/Not Sure

Now I'm going to ask you a few questions about your experience in the SoonerCare Health Management Program, starting with your Health Coach.

HEALTH COACH

10. How soon after you started participating in the SoonerCare Health Management Program were you contacted by your Health Coach?
    a. Contacted at time of enrollment in the doctor's office
    b. Less than one week
    c. One to two weeks
    d. More than two weeks
    e. Have not been contacted – enrolled two weeks ago or less
    f. Have not been contacted – enrolled two to four weeks ago
    g. Have not been contacted – enrolled more than four weeks ago
    h. Don't Know/Not Sure

11. Can you tell me the name of your Health Coach?
    a. Yes. RECORD: _____
    b. No
12. About when was the last time you spoke to your Health Coach?
    a. Within the last week
    b. One to two weeks ago
    c. Two to four weeks ago
    d. More than four weeks ago
    e. Have never spoken to Health Coach → [GO TO Q14]
    f. Don't know/Not Sure → [GO TO Q14]

13. Did you speak to your Health Coach over the telephone or in person at your doctor's office?
    a. Telephone
    b. In-person
    c. Don't Know/Not Sure

14. Did your Health Coach give you a telephone number to call if you needed help with your care?
    a. Yes
    b. No → [GO TO Q18]
    c. Don't Know/Not Sure → [GO TO Q18]

15. Have you tried to call your Health Coach at the number you were given?
    a. Yes
    b. No → [GO TO Q18]
    c. Don't Know/Not Sure → [GO TO Q18]

16. Thinking about the last time you called your Health Coach, what was the reason for your call?
    a. Routine health question
    b. Urgent health problem
    c. Seeking assistance in scheduling appointment
    d. Returning call from Health Coach
    e. Other. SPECIFY: _____
    f. Don't Know/Not Sure

17. Did you reach your Health Coach immediately? [IF NO] How quickly did you get a call back?
    a. Reached immediately (at time of call)
    b. Called back within one hour
    c. Called back in more than one hour but same day
    d. Called back the next day
    e. Called back two or more days later
    f. Never called back
    g. Other. SPECIFY: _____
    h. Don't Know/Not Sure

18. [ASK QUESTION EVEN IF RESPONDENT STATES S/HE HAS NOT SPOKEN TO THE HEALTH COACH. IF RESPONDENT REPEATS S/HE IS UNABLE TO ANSWER DUE TO LACK OF CONTACT, GO TO Q32 (RESOURCE CENTER)] I am going to mention some things your Health Coach may have done for you. Has your Health Coach:

	Yes	No	DK
a. Asked questions about your health problems or concerns			
b. Provided instructions about taking care of your health problems or concerns			
c. Helped you to identify changes in your health that might be an early sign of a problem			
d. Answered questions about your health			
e. Helped you talk to and work with your regular doctor and your regular doctor's office staff			
f. Helped you to make and keep health care appointments with other doctors, such as specialists, for medical problems			
g. Helped you to make and keep health care appointments for mental health or substance abuse problems			
h. Reviewed your medications with you and helped you to manage your medications			

19. [ASK FOR EACH "YES" ACTIVITY IN Q18] Thinking about what your Health Coach has done for you, please tell me how satisfied you are with the help you received. Tell me if you are very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied.

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	DK	N/A
a. Learning about you and your health care needs						
b. Getting easy to understand instructions about taking care of health problems or concerns						
c. Getting help identifying changes in your health that might be an early sign of a problem						
d. Answering questions about your health						
e. Helping you to talk to and work with your regular doctor and your regular doctor's staff						
f. Helping you make and keep health care appointments with other doctors, such as specialists, for medical problems						
g. Helping you make and keep health care appointments for mental health or substance abuse problems						
h. Reviewing your medications and helping you to manage your medications						

[IF ANSWERED YES TO Q18a, ASK QUESTION 20. IF ANSWERED 'NO' OR 'DK', GO TO Q31.]

20. You said a moment ago that your Health Coach asked questions about your health problems and concerns. Did your Health Coach ask your thoughts on what change in your life would make the biggest difference to your health?
    a. Yes
    b. No → [GO TO Q31]
    c. Don't Know/Not Sure → [GO TO Q31]

21. Did you select an area where you would like to make a change?
    a. Yes
    b. No → [GO TO Q31]
    c. Don't Know/Not Sure → [GO TO Q31]

22. What did you select?
    a. Management of chronic condition. SPECIFY: _____
    b. Weight
    c. Diet
    d. Tobacco use
    e. Medications
    f. Alcohol or drug use
    g. Social support
    h. Other. SPECIFY: _____
    i. Don't Know/Not Sure

23. Did you and your Health Coach develop an Action Plan with Goals?
    a. Yes
    b. No → [GO TO Q31]
    c. Don't Know/Not Sure → [GO TO Q31]

24. Have you achieved one or more Goals in your Action Plan?
    a. Yes
    b. No → [GO TO Q31]
    c. Don't Know/Not Sure → [GO TO Q31]

25. What was the Goal you achieved?
    a. RECORD RESPONSE. _____
    b. Don't Know/Not Sure

26. Do you have a Goal you are currently trying to achieve?
    a. Yes
    b. No → [GO TO Q29]
    c. Don't Know/Not Sure → [GO TO Q29]

27. What is the Goal you're trying to achieve?
    a. RECORD RESPONSE _____
    b. Don't Know/Not Sure → [GO TO Q29]

28. How confident are you that you will be able to achieve this Goal? Would you say you are very confident, somewhat confident, not very confident or not at all confident?
    a. Very confident
    b. Somewhat confident
    c. Not very confident
    d. Not at all confident
    e. Don't Know/Not Sure

29. How helpful has your Health Coach been in helping you to achieve your Goals? Would you say your Health Coach has been very helpful, somewhat helpful, not very helpful or not at all helpful?
    a. Very helpful
    b. Somewhat helpful
    c. Not very helpful
    d. Not at all helpful
    e. Don't Know/Not Sure

30. Do you have any suggestions for how your Health Coach could be more helpful to you in achieving your Goals? RECORD.

    _____

    _____

    _____

31. Overall, how satisfied are you with your Health Coach? Would you say you are very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Not Sure

RESOURCE CENTER(COMMUNITY RESOURCE SPECIALISTS)

32. Did you know that the SoonerCare Health Management Program has a Resource Center to help members deal with non-medical problems? For example, help with eligibility issues or community resources like food, help with lights, etc.
    a. Yes
    b. No → [GO TO Q37]
    c. Don't Know/Not Sure → [GO TO Q37]

33. Have you or your Health Coach used the Resource Center to help you with a problem?
    a. Yes
    b. No → [GO TO Q37]
    c. Don't Know/Note Sure → [GO TO Q37]

34. Thinking about the last time you used the Resource Center, what problem did you or your Health Coach ask for help in resolving?
    a. Housing/rent
    b. Food
    c. Child care
    d. Transportation. SPECIFY DESTINATION:_____
    e. Don't Know/Not Sure
    f. Other. SPECIFY: _____

35. How helpful was the Resource Center in resolving the problem? Would you say it was very helpful, somewhat helpful, not very helpful or not at all helpful?
    a. Very helpful
    b. Somewhat helpful
    c. Not very helpful
    d. Not at all helpful
    e. Don't Know/Not Sure

36. What did the Resource Center do?
    a. RECORD: _____
    b. Don't Know/Not Sure

OVERALL SATISFACTION

37. Overall, how satisfied are you with your whole experience in the Health Management Program?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Not Sure

38. Would you recommend the SoonerCare Health Management Program to a friend who has health care needs like yours?
    a. Yes
    b. No
    c. Don't Know/Not Sure

39. Do you have any suggestions for improving the SoonerCare Health Management Program?

    _____

    _____

    _____

HEALTH STATUS & LIFESTYLE

40. Overall, how would you rate your health today? Would you say it is excellent, good, fair or poor?
    a. Excellent
    b. Good
    c. Fair
    d. Poor
    e. Don't Know/Not Sure

41. Compared to before you participated in the SoonerCare Health Management Program, how has your health changed? Would you say your health is better, worse or about the same?
    a. Better
    b. Worse → [GO TO Q43]
    c. About the same → [GO TO Q43]

42. Do you think the SoonerCare Health Management Program has contributed to your improvement in health?
    a. Yes
    b. No
    c. Don't Know/Not Sure

43. I am going to mention a few areas where Health Coaches sometimes try to help members to improve their health by changing behaviors. For each, please tell me if your Health Coach spoke to you, and if so, whether you changed your behavior as a result. [IF BEHAVIOR WAS CHANGED, ASK IF CHANGE WAS TEMPORARY OR IS CONTINUING]

	N/A – Not Discussed	Discussed – No Change	Discussed – Temporary Change	Discussed – Continuing Change	DK	Not Applicable
a. Smoking less or using other tobacco products less						
b. Moving around more or getting more exercise						
c. Changing your diet						
d. Managing and taking your medications better						
e. Making sure to drink enough water throughout the day						
f. Drinking or using other substances less						

Questions 44 to 47 have been discontinued

~~44. [IF RESPONDENT'S RECORD SHOWS ENROLLMENT DATE PRIOR TO JULY 2013, ASK THIS QUESTION] We're almost done. Before July 2013, the SoonerCare Health Management Program included Nurse Care Managers who visited members in their homes or called them each month on the phone. Did you have a Nurse Care Manager under the previous program? [IF YES, ASK WHETHER NCM VISITED THEIR HOME OR CALLED ON PHONE. IF RESPONDENT SAYS "BOTH", RECORD AS VISITED IN THEIR HOME.]~~

~~a. Yes, visited in home~~

~~b. Yes, called on phone~~

~~c. No → [GO TO Q52]~~

~~d. Don't Know/Not Sure → [GO TO Q52]~~

~~45. I am going to ask about different kinds of help that you may have received from your Nurse Care Manager in the previous program and that you may be receiving today from your Health Coach. For each, please tell me who was more helpful, your Nurse Care Manager you had before July 2013 under the previous program or your current Health Coach [REVERSE ORDER FROM PREVIOUS SURVEY]. [RECORD "SAME" IF VOLUNTEERED BY RESPONDENT; DO NOT OFFER AS OPTION.]~~

	~~NCM More Helpful~~	~~HC More Helpful~~	~~About the Same Help~~	~~N/A~~	~~Don't Know/Not Sure~~
~~a. Providing instructions about taking care of your health problems or concerns~~					

	NCM More Helpful	HC More Helpful	About the Same Help	N/A	Don't Know/Not Sure
b. Helping you to identify changes in your health that might be an early sign of a problem					
c. Answering questions about your health					
d. Helping you talk to and work with your regular doctor and your regular doctor's office staff					
e. Helping you to make and keep health care appointments with other doctors, such as specialists, for medical problems					
f. Helping you to make and keep health care appointments for mental health or substance abuse problems					
g. Helping you manage your medications					

46. Overall, what do you prefer – the program as it was before July 2013 with a Nurse Care Manager or the program as it is today, with a Health Coach in the doctor's office? [REVERSE ORDER FROM PREVIOUS SURVEY.] [RECORD "NO PREFERENCE/SAME" IF VOLUNTEERED BY RESPONDENT; DO NOT OFFER AS OPTION.]
    a. Program before, with Nurse Care Manager
    b. Program today, with Health Coach
    c. No preference/programs are about the same → [GO TO Q52]
    d. Don't Know/Not Sure → [GO TO Q52]

47. Why do you prefer [MEMBER'S CHOICE]? [RECORD ANSWER AND GO TO Q52]

    _____
    _____
    _____
    _____

Questions 48 and 49 are asked of follow-up survey respondents only

48. [IF RESPONDENT ANSWERED "NO" TO Q5] About when did you decide to no longer participate?
    a. Month/Year [SPECIFY] _____
    b. Don't Know/Not Sure

49. Why did you decide to no longer participate in the program [RECORD ANSWER & SKIP TO Q52]?
    a. Not aware of program/did not know was enrolled

b. Did not understand purpose of the program
c. Satisfied with doctor/current health care access without program
d. Doctor recommended I not participate
e. Do not wish to self-manage care/receive health education/receive health coaching
f. Do not want to be evaluated by Nurse Care Manager/Health Coach
g. Dislike Nurse Care Manager/Health Coach
h. Have no health needs at this time
i. Nurse Care Manager/Health Coach stopped calling or visiting
j. Did not like change from Nurse Care Management to Health Coaching
k. Other. SPECIFY: _____
l. Don't Know/Not Sure

Questions 50 and 51 have been discontinued

~~50. [IF RESPONDENT ANSWERED "NO" TO Q4] About when did you decide to not participate?~~

~~a. Month/Year [SPECIFY] _____~~
~~b. Don't Know/Not Sure~~

~~51. Why did you decide not to participate in the program?~~

~~a. Not aware of program/did not know was enrolled~~
~~b. Did not understand purpose of the program~~
~~c. Satisfied with doctor/current health care access without program~~
~~d. Doctor recommended I not participate~~
~~e. Do not wish to self-manage care/receive health education/receive health coaching~~
~~f. Do not want to be evaluated by Nurse Care Manager/Health Coach~~
~~g. Dislike Nurse Care Manager/Health Coach~~
~~h. Have no health needs at this time~~
~~i. Nurse Care Manager/Health Coach stopped calling or visiting~~
~~j. Did not like change from Nurse Care Management to Health Coaching~~
~~k. Other. SPECIFY: _____~~
~~l. Don't Know/Not Sure~~

DEMOGRAPHICS

52. I'm now going to ask about your race. I will read you a list of choices. You may choose 1 or more. This question is being used for demographic purposes only and you may also choose not to respond.

    a. White or Caucasian
    b. Black or African-American
    c. Asian
    d. Native Hawaiian or other Pacific Islander
    e. American Indian
    f. Hispanic or Latino
    g. Other. SPECIFY: _____

Those are all the questions I have today. We may contact you again in the future to follow-up and learn if anything about your health care has changed. Thank you for your help.

APPENDIX B – DETAILED HEALTH COACHING PARTICIPANT SURVEY RESULTS

Appendix B includes active participant responses to all survey questions. Data is presented for both the initial and follow-up surveys.

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
1) Are you currently enrolled in SoonerCare?				
A. Yes	**138** *99.3%*	**602** *97.3%*	**740** *97.6%*	**133** *98.5%*
B. No	**1** *0.7%*	**17** *2.7%*	**18** *2.4%*	**2** *1.5%*
2) Have you heard of the Health Management Program (HMP)?				
A. Yes	**121** *87.7%*	**554** *92.0%*	**675** *91.2%*	*N/A - not asked*
B. No	**16** *11.6%*	**47** *7.8%*	**63** *8.5%*	
C. Don't know/not sure	**1** *0.7%*	**1** *0.2%*	**2** *0.3%*	
3) Were you contacted and offered a chance to enroll in the HMP?				
A. Yes	**122** *89.7%*	**553** *91.6%*	**675** *91.2%*	*N/A - not asked*
B. No	**7** *5.1%*	**47** *7.8%*	**54** *7.3%*	
C. Don't know/not sure	**9** *6.6%*	**2** *0.3%*	**11** *1.5%*	
4) Did you decide to participate?				
A. Yes	**120** *95.2%*	**552** *99.8%*	**672** *99.0%*	*N/A - not asked*
B. No	**6** *4.8%*	**1** *0.2%*	**7** *1.0%*	

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
5) Are you still participating today in the SoonerCare HMP?				
A. Yes	**118** *98.3%*	**542** *98.2%*	**660** *98.2%*	**122** *93.8%*
B. No/Don't know	**2** *1.7%*	**10** *1.8%*	**12** *1.8%*	**11** *8.5%*
6) How long have you been participating in the SoonerCare HMP?				
A. Less than 1 month	**9** *7.6%*	**5** *0.9%*	**14** *2.1%*	**0** *0.0%*
B. 1 to 2 months	**39** *33.1%*	**18** *3.3%*	**57** *8.6%*	**0** *0.0%*
C. 3 to 4 months	**33** *28.0%*	**40** *7.4%*	**73** *11.1%*	**0** *0.0%*
D. 5 to 6 months	**7** *5.9%*	**109** *20.1%*	**116** *17.6%*	**0** *0.0%*
E. More than 6 months	**28** *23.7%*	**352** *64.9%*	**380** *57.6%*	*See below*
F. 6 to 9 months	*For initial survey, tenures greater than six months are not further stratified*			**8** *6.6%*
G. 9 to 12 months				**68** *55.7%*
H. More than 12 months				**44** *36.1%*
I. Don't know/not sure	**2** *1.7%*	**18** *3.3%*	**20** *3.0%*	**2** *1.6%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
7) How did you learn about the SoonerCare HMP?				
A. Received information in the mail	**10** *8.5%*	**17** *3.1%*	**27** *4.1%*	*N/A - not asked*
B. Received a call from my Health Coach	**37** *31.4%*	**191** *35.2%*	**228** *34.5%*	
C. Received a call from someone else	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	
D. Doctor referred me while I was in his/her office	**67** *56.8%*	**305** *56.3%*	**372** *56.4%*	
E. Other	**0** *0.0%*	**8** *1.5%*	**8** *1.2%*	
F. Don't know/not sure	**4** *3.4%*	**21** *3.9%*	**25** *3.8%*	
8) What were your reasons for deciding to participate in the SoonerCare HMP? (Multiple answers allowed.)				
A. Learn how to better manage health problems	**30** *25.4%*	**143** *26.4%*	**173** *26.2%*	*N/A - not asked*
B. Learn how to identify changes in health	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	
C. Have someone to call with questions about health	**3** *2.5%*	**17** *3.1%*	**20** *3.0%*	
D. Get help making health care appointments	**4** *3.4%*	**7** *1.3%*	**11** *1.7%*	
E. Personal doctor recommended I enroll	**2** *1.7%*	**18** *3.3%*	**20** *3.0%*	
F. Improve my health	**28** *23.7%*	**89** *16.4%*	**117** *17.7%*	

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
G. Was invited to enroll/no specific reason	**43** *36.4%*	**229** *42.3%*	**272** *41.2%*	
H. Other	**5** *4.2%*	**35** *6.5%*	**40** *6.1%*	
I. Don't know/not sure	**3** *2.5%*	**6** *1.1%*	**9** *1.4%*	
9) Among the reasons you gave, what was your most important reason for deciding to participate?				
A. Learn how to better manage health problems	**31** *26.3%*	**142** *26.2%*	**173** *26.2%*	
B. Learn how to identify changes in health	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	
C. Have someone to call with questions about health	**3** *2.5%*	**17** *3.1%*	**20** *3.0%*	
D. Get help making health care appointments	**4** *3.4%*	**7** *1.3%*	**11** *1.7%*	
E. Personal doctor recommended I enroll	**2** *1.7%*	**17** *3.1%*	**19** *2.9%*	*N/A - not asked*
F. Improve my health	**28** *23.7%*	**89** *16.4%*	**117** *17.7%*	
G. Was invited to enroll/no specific reason	**42** *35.6%*	**229** *42.3%*	**271** *41.1%*	
H. Other	**5** *4.2%*	**35** *6.5%*	**40** *6.1%*	
I. Don't know/not sure	**3** *2.5%*	**6** *1.1%*	**9** *1.4%*	

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
10) How soon after you started participating in the SoonerCare HMP were you contacted by your Health Coach?				
A. Contacted at time of enrollment	**67** *56.8%*	**498** *91.9%*	**565** *85.6%*	*N/A - not asked*
B. Less than 1 week	**34** *28.8%*	**14** *2.6%*	**48** *7.3%*	
C. 1 to 2 weeks	**2** *1.7%*	**2** *0.4%*	**4** *0.6%*	
D. More than 2 weeks	**0** *0.0%*	**2** *0.4%*	**2** *0.3%*	
E. Have not been contacted - enrolled 2 weeks ago or less	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	
F. Have not been contacted - enrolled 2 to 4 weeks ago	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	
G. Have not been contacted - enrolled more than 4 weeks ago	**1** *0.8%*	**2** *0.4%*	**3** *0.5%*	
H. Don't know/not sure	**14** *11.9%*	**24** *4.4%*	**38** *5.8%*	
11) Can you tell me the name of your Health Coach?				
A. Yes	**46** *39.3%*	**201** *37.0%*	**247** *37.4%*	**42** *34.4%*
B. No	**71** *60.7%*	**342** *63.0%*	**413** *62.6%*	**80** *65.6%*
12) About when was the last time you spoke to your Health Coach?				
A. Within last week	**28** *24.1%*	**123** *22.6%*	**151** *22.9%*	**30** *24.6%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
B. 1 to 2 weeks ago	**41** *35.3%*	**127** *23.3%*	**168** *25.5%*	**18** *14.8%*
C. 2 to 4 weeks ago	**27** *23.3%*	**149** *27.4%*	**176** *26.7%*	**25** *20.5%*
D. More than 4 weeks ago	**19** *16.4%*	**136** *25.0%*	**155** *23.5%*	**47** *38.5%*
E. Have never spoken to Health Coach	**1** *0.9%*	**1** *0.2%*	**2** *0.3%*	**1** *0.8%*
F. Don't know/not sure/no response	**0** *0.0%*	**8** *1.5%*	**8** *1.2%*	**1** *0.8%*
13) Did you speak to your Health Coach over the telephone or in person at your doctor's office?				
A. Telephone	**59** *50.9%*	**364** *66.9%*	**423** *64.1%*	**99** *81.1%*
B. In person	**57** *49.1%*	**170** *31.3%*	**227** *34.4%*	**23** *18.9%*
C. Don't know/not sure/no response	**0** *0.0%*	**10** *1.8%*	**10** *1.5%*	**0** *0.0%*
14) Did your Health Coach give you a telephone number to call if you needed help with your care?				
A. Yes	**106** *90.6%*	**477** *87.8%*	**583** *88.3%*	**110** *90.2%*
B. No	**5** *4.3%*	**38** *7.0%*	**43** *6.5%*	**10** *8.2%*
C. Don't know/not sure/no response	**6** *5.1%*	**28** *5.2%*	**34** *5.2%*	**2** *1.6%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
15) Have you tried to call your Health Coach at the number you were given?				
A. Yes	**17** *16.0%*	**135** *28.3%*	**152** *26.1%*	**18** *16.4%*
B. No	**89** *84.0%*	**342** *71.7%*	**431** *73.9%*	**92** *83.6%*
C. Don't know/not sure	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*
16) Thinking about the last time you called your Health Coach, what was the reason for your call?				
A. Routine health question	**11** *64.7%*	**109** *80.7%*	**120** *78.9%*	**11** *61.1%*
B. Urgent health problem	**0** *0.0%*	**3** *2.2%*	**3** *2.0%*	**1** *5.6%*
C. Seeking assistance in scheduling an appointment	**2** *11.8%*	**3** *2.2%*	**5** *3.3%*	**0** *0.0%*
D. Returning call from Health Coach	**0** *0.0%*	**13** *9.6%*	**13** *8.6%*	**4** *22.2%*
E. Other	**4** *23.5%*	**7** *5.2%*	**11** *7.2%*	**2** *11.1%*
F. Don't know/not sure	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*
17) Did you reach your Health Coach immediately? If no, how quickly did you get a call back?				
A. Reached immediately (at time of call)	**8** *47.1%*	**80** *59.3%*	**88** *57.9%*	**11** *61.1%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
B. Called back within 1 hour	**4** *23.5%*	**29** *21.5%*	**33** *21.7%*	**2** *11.1%*
C. Called back in more than 1 hour but same day	**3** *17.6%*	**7** *5.2%*	**10** *6.6%*	**1** *5.6%*
D. Called back the next day	**1** *5.9%*	**3** *2.2%*	**4** *2.6%*	**3** *16.7%*
E. Called back 2 or more days later	**1** *5.9%*	**2** *1.5%*	**3** *2.0%*	**0** *0.0%*
F. Never called back	**0** *0.0%*	**5** *3.7%*	**5** *3.3%*	**1** *5.6%*
G. Other	**0** *0.0%*	**3** *2.2%*	**3** *2.0%*	**0** *0.0%*
H. Don't know/not sure	**0** *0.0%*	**6** *4.4%*	**6** *3.9%*	**0** *0.0%*
18) I'm going to mention some things your Health Coach may have done for you. Has your Health Coach:				
(a) Asked questions about your health problems or concerns				
A. Yes	**116** *98.3%*	**537** *99.1%*	**653** *98.9%*	**119** *98.3%*
B. No	**2** *1.7%*	**4** *0.7%*	**6** *0.9%*	**2** *1.7%*
C. Don't know/not sure	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
(b) Provided instructions about taking care of your health problems or concerns				
A. Yes	**99** *83.9%*	**504** *93.0%*	**603** *91.4%*	**115** *95.0%*
B. No	**18** *15.3%*	**34** *6.3%*	**52** *7.9%*	**6** *5.0%*
C. Don't know/not sure	**1** *0.8%*	**4** *0.7%*	**5** *0.8%*	**0** *0.0%*
(c) Helped you to identify changes in your health that might be an early sign of a problem				
A. Yes	**29** *24.6%*	**213** *39.3%*	**242** *36.7%*	**30** *24.8%*
B. No	**89** *75.4%*	**325** *60.0%*	**414** *62.7%*	**91** *75.2%*
C. Don't know/not sure	**0** *0.0%*	**4** *0.7%*	**4** *0.6%*	**0** *0.0%*
(d) Answered questions about your health				
A. Yes	**93** *78.8%*	**486** *89.7%*	**579** *87.7%*	**110** *90.9%*
B. No	**23** *19.5%*	**52** *9.6%*	**75** *11.4%*	**11** *9.1%*
C. Don't know/not sure	**1** *0.8%*	**5** *0.9%*	**6** *0.9%*	**0** *0.0%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
(e) Helped you talk to and work with your regular doctor and your regular doctor's office staff				
A. Yes	**53** *44.9%*	**165** *30.4%*	**218** *33.0%*	**31** *25.6%*
B. No	**64** *54.2%*	**374** *69.0%*	**438** *66.4%*	**90** *74.4%*
C. Don't know/not sure	**1** *0.8%*	**3** *0.6%*	**4** *0.6%*	**0** *0.0%*
(f) Helped you to make and keep health care appointments with other doctors, such as specialists, for medical problems?				
A. Yes	**32** *27.1%*	**137** *25.3%*	**169** *25.6%*	**27** *22.3%*
B. No	**86** *72.9%*	**404** *74.5%*	**490** *74.2%*	**94** *77.7%*
C. Don't know/not sure	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*
(g) Helped you to make and keep health care appointments for mental health or substance abuse problems				
A. Yes	**17** *14.4%*	**35** *6.5%*	**52** *7.9%*	**6** *5.0%*
B. No	**101** *85.6%*	**506** *93.4%*	**607** *92.0%*	**115** *95.0%*
C. Don't know/not sure	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
(h) Reviewed your medications with you and helped you to manage your medications				
A. Yes	**70** *59.3%*	**439** *81.0%*	**509** *77.1%*	**97** *80.2%*
B. No	**46** *39.0%*	**90** *16.6%*	**136** *20.6%*	**22** *18.2%*
C. Don't know/not sure	**2** *1.7%*	**13** *2.4%*	**15** *2.3%*	**2** *1.7%*
19) (For each activity performed) How satisfied are you with the help you received?				
(a) Asked questions about your health problems or concerns				
A. Very satisfied	**97** *82.2%*	**487** *89.9%*	**584** *88.5%*	**111** *91.7%*
B. Somewhat satisfied	**16** *13.6%*	**40** *7.4%*	**56** *8.5%*	**5** *4.1%*
C. Somewhat dissatisfied	**1** *0.8%*	**4** *0.7%*	**5** *0.8%*	**2** *1.7%*
D. Very dissatisfied	**1** *0.8%*	**4** *0.7%*	**5** *0.8%*	**1** *0.8%*
E. Don't know/Not Applicable	**3** *2.5%*	**7** *1.3%*	**10** *1.5%*	**3** *2.5%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
(b) Provided instructions about taking care of your health problems or concerns				
A. Very satisfied	**85** *72.0%*	**471** *86.9%*	**556** *84.2%*	**108** *89.3%*
B. Somewhat satisfied	**11** *9.3%*	**30** *5.5%*	**41** *6.2%*	**4** *3.3%*
C. Somewhat dissatisfied	**1** *0.8%*	**1** *0.2%*	**2** *0.3%*	**2** *1.7%*
D. Very dissatisfied	**1** *0.8%*	**4** *0.7%*	**5** *0.8%*	**1** *0.8%*
E. Don't know/Not Applicable	**20** *16.9%*	**36** *6.6%*	**56** *8.5%*	**6** *5.0%*
(c) Helped you to identify changes in your health that might be an early sign of a problem				
A. Very satisfied	**29** *24.6%*	**203** *37.5%*	**232** *35.2%*	**29** *24.0%*
B. Somewhat satisfied	**4** *3.4%*	**8** *1.5%*	**12** *1.8%*	**0** *0.0%*
C. Somewhat dissatisfied	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*
D. Very dissatisfied	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*
E. Don't know/Not Applicable	**85** *72.0%*	**329** *60.7%*	**414** *62.7%*	**92** *76.0%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
(d) Answered questions about your health				
A. Very satisfied	**84** *71.2%*	**452** *83.4%*	**536** *81.2%*	**105** *86.8%*
B. Somewhat satisfied	**9** *7.6%*	**26** *4.8%*	**35** *5.3%*	**3** *2.5%*
C. Somewhat dissatisfied	**0** *0.0%*	**2** *0.4%*	**2** *0.3%*	**2** *1.7%*
D. Very dissatisfied	**0** *0.0%*	**3** *0.6%*	**3** *0.5%*	**0** *0.0%*
E. Don't know/Not Applicable	**25** *21.2%*	**59** *10.9%*	**84** *12.7%*	**11** *9.1%*
(e) Helped you talk to and work with your regular doctor and your regular doctor's office staff				
A. Very satisfied	**52** *44.1%*	**159** *29.3%*	**211** *32.0%*	**31** *25.6%*
B. Somewhat satisfied	**1** *0.8%*	**13** *2.4%*	**14** *2.1%*	**1** *0.8%*
C. Somewhat dissatisfied	**0** *0.0%*	**2** *0.4%*	**2** *0.3%*	**0** *0.0%*
D. Very dissatisfied	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*
E. Don't know/Not Applicable	**65** *55.1%*	**367** *67.7%*	**432** *65.5%*	**89** *73.6%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
(f) Helped you to make and keep health care appointments with other doctors, such as specialists, for medical problems?				
A. Very satisfied	**30** *25.4%*	**127** *23.4%*	**157** *23.8%*	**27** *22.3%*
B. Somewhat satisfied	**2** *1.7%*	**17** *3.1%*	**19** *2.9%*	**0** *0.0%*
C. Somewhat dissatisfied	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*
D. Very dissatisfied	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*
E. Don't know/Not Applicable	**86** *72.9%*	**396** *73.1%*	**482** *73.0%*	**94** *77.7%*
(g) Helped you to make and keep health care appointments for mental health or substance abuse problems				
A. Very satisfied	**15** *12.7%*	**33** *6.1%*	**48** *7.3%*	**4** *3.3%*
B. Somewhat satisfied	**1** *0.8%*	**18** *3.3%*	**19** *2.9%*	**1** *0.8%*
C. Somewhat dissatisfied	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*
D. Very dissatisfied	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*
E. Don't know/Not Applicable	**102** *86.4%*	**489** *90.2%*	**591** *89.5%*	**116** *95.9%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
(h) Reviewed your medications with you and helped you to manage your medications				
A. Very satisfied	**61** *51.7%*	**412** *76.0%*	**473** *71.7%*	**93** *76.9%*
B. Somewhat satisfied	**7** *5.9%*	**32** *5.9%*	**39** *5.9%*	**3** *2.5%*
C. Somewhat dissatisfied	**0** *0.0%*	**4** *0.7%*	**4** *0.6%*	**1** *0.8%*
D. Very dissatisfied	**1** *0.8%*	**1** *0.2%*	**2** *0.3%*	**0** *0.0%*
E. Don't know/Not Applicable	**46** *39.0%*	**96** *17.7%*	**142** *21.5%*	**24** *19.8%*
20) Did your Health Coach ask your thoughts on what change in your life would make the biggest difference to your health?				
A. Yes	**91** *77.1%*	**409** *75.5%*	**500** *75.8%*	**93** *76.9%*
B. No	**24** *20.3%*	**94** *17.3%*	**118** *17.9%*	**20** *16.5%*
C. Don't know/not sure	**3** *2.5%*	**39** *7.2%*	**42** *6.4%*	**8** *6.6%*
21) Did you select an area where you would like to make a change?				
A. Yes	**79** *86.8%*	**339** *82.9%*	**418** *83.6%*	**68** *73.1%*
B. No	**11** *12.1%*	**70** *17.1%*	**81** *16.2%*	**25** *26.9%*
C. Don't know/not sure	**1** *1.1%*	**0** *0.0%*	**1** *0.2%*	**0** *0.0%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
22) What did you select? (Multiple categories allowed.)				
A. Management of chronic condition	**20** *21.5%*	**62** *18.7%*	**82** *19.3%*	**13** *18.8%*
B. Weight	**23** *24.7%*	**94** *28.3%*	**117** *27.5%*	**17** *24.6%*
C. Diet	**11** *11.8%*	**38** *11.4%*	**49** *11.5%*	**14** *20.3%*
D. Tobacco use	**13** *14.0%*	**88** *26.5%*	**101** *23.8%*	**16** *23.2%*
E. Medications	**0** *0.0%*	**5** *1.5%*	**5** *1.2%*	**2** *2.9%*
F. Alcohol or drug use	**0** *0.0%*	**3** *0.9%*	**3** *0.7%*	**0** *0.0%*
G. Social support	**0** *0.0%*	**13** *3.9%*	**13** *3.1%*	**2** *2.9%*
H. Other	**26** *28.0%*	**29** *8.7%*	**55** *12.9%*	**5** *7.2%*
23) Did you and your Health Coach develop an Action Plan with goals?				
A. Yes	**76** *96.2%*	**275** *81.1%*	**351** *84.0%*	**53** *77.9%*
B. No	**3** *3.8%*	**61** *18.0%*	**64** *15.3%*	**15** *22.1%*
C. Don't know/not sure	**0** *0.0%*	**3** *0.9%*	**3** *0.7%*	**0** *0.0%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
24) Have you achieved one or more goals in your Action Plan?				
A. Yes	**38** *50.0%*	**221** *80.4%*	**259** *73.8%*	**41** *77.4%*
B. No	**38** *50.0%*	**54** *19.6%*	**92** *26.2%*	**12** *22.6%*
C. Don't know/not sure	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*
25) What was the goal you achieved?	*(Member-specific data)*	*(Member-specific data)*	*(Member-specific data)*	*(Member-specific data)*
26) Do you have a goal you are currently trying to achieve?				
A. Yes	**22** *56.4%*	**78** *35.9%*	**100** *39.1%*	**8** *19.5%*
B. No	**17** *43.6%*	**139** *64.1%*	**156** *60.9%*	**33** *80.5%*
C. Don't know/not sure	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*
27) What is the goal you're trying to achieve?	*(Member-specific data)*	*(Member-specific data)*	*(Member-specific data)*	*(Member-specific data)*
28) How confident are you that you will be able to achieve this goal?				
A. Very confident	**15** *71.4%*	**49** *62.0%*	**64** *64.0%*	**6** *75.0%*
B. Somewhat confident	**4** *19.0%*	**24** *30.4%*	**28** *28.0%*	**2** *25.0%*
C. Not very confident	**2** *9.5%*	**3** *3.8%*	**5** *5.0%*	**0** *0.0%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
D. Not at all confident	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*
E. Don't know/not sure	**0** *0.0%*	**3** *3.8%*	**3** *3.0%*	**0** *0.0%*
29) How helpful has your Health Coach been in helping you to achieve your goals?				
A. Very helpful	**33** *94.3%*	**208** *92.9%*	**241** *93.1%*	**41** *100.0%*
B. Somewhat helpful	**2** *5.7%*	**3** *1.3%*	**5** *1.9%*	**0** *0.0%*
C. Not very helpful	**0** *0.0%*	**1** *0.4%*	**1** *0.4%*	**0** *0.0%*
D. Not at all helpful	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*
E. Don't know/not sure/no response	**0** *0.0%*	**12** *5.4%*	**12** *4.6%*	**0** *0.0%*
30) Do you have any suggestions for how your Health Coach could be more helpful to you in achieving your goals?	*(Member-specific data)*	*(Member-specific data)*	*(Member-specific data)*	*(Member-specific data)*
31) Overall, how satisfied are you with your Health Coach?				
A. Very satisfied	**97** *84.3%*	**478** *87.7%*	**575** *87.1%*	**103** *85.1%*
B. Somewhat satisfied	**13** *11.3%*	**41** *7.5%*	**54** *8.2%*	**9** *7.4%*
C. Somewhat dissatisfied	**0** *0.0%*	**7** *1.3%*	**7** *1.1%*	**2** *1.7%*
D. Very dissatisfied	**2** *1.7%*	**5** *0.9%*	**7** *1.1%*	**1** *0.8%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
E. Don't know/not sure/no response	**3** *2.6%*	**14** *2.6%*	**17** *2.6%*	**6** *5.0%*
32) Did you know that the SoonerCare HMP has a Resource Center to help members deal with non-medical problems?				
A. Yes	**42** *35.9%*	**211** *38.9%*	**253** *38.3%*	**45** *37.2%*
B. No	**74** *63.2%*	**278** *51.2%*	**352** *53.3%*	**66** *54.5%*
C. Don't know/not sure/no response	**1** *0.9%*	**54** *9.9%*	**55** *8.3%*	**10** *8.3%*
33) Have you or your Health Coach used the Resource Center to help you with a problem?				
A. Yes	**8** *19.0%*	**22** *10.4%*	**30** *11.9%*	**3** *6.7%*
B. No	**34** *81.0%*	**188** *89.1%*	**222** *87.7%*	**42** *93.3%*
C. Don't know/not sure	**0** *0.0%*	**1** *0.5%*	**1** *0.4%*	**0** *0.0%*
34) Thinking about the last time you used the Resource Center, what problem did you or your Health Coach ask for help in resolving?				
A. Housing/rent	**2** *25.0%*	**1** *4.5%*	**3** *10.0%*	**0** *0.0%*
B. Food	**2** *25.0%*	**4** *18.2%*	**6** *20.0%*	**0** *0.0%*
C. Child care	**0** *0.0%*	**1** *4.5%*	**1** *3.3%*	**0** *0.0%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
D. Transportation	**3** *37.5%*	**4** *18.2%*	**7** *23.3%*	**2** *66.7%*
E. Don't know/not sure	**1** *12.5%*	**0** *0.0%*	**1** *3.3%*	**0** *0.0%*
F. Other	**0** *0.0%*	**12** *54.5%*	**12** *40.0%*	**1** *33.3%*
35) How helpful was the Resource Center in resolving the problem?				
A. Very helpful	**6** *75.0%*	**16** *76.2%*	**22** *75.9%*	**3** *100.0%*
B. Somewhat helpful	**0** *0.0%*	**2** *9.5%*	**2** *6.9%*	**0** *0.0%*
C. Not very helpful	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*
D. Not at all helpful	**1** *12.5%*	**2** *9.5%*	**3** *10.3%*	**0** *0.0%*
E. Don't know/not sure	**1** *12.5%*	**1** *4.8%*	**2** *6.9%*	**0** *0.0%*
36) What did the Resource Center do?	*(Member-specific data)*	*(Member-specific data)*	*(Member-specific data)*	*(Member-specific data)*
37) Overall, how satisfied are you with your whole experience in the HMP?				
A. Very satisfied	**95** *81.9%*	**478** *87.9%*	**573** *86.8%*	**107** *89.9%*
B. Somewhat satisfied	**15** *12.9%*	**47** *8.6%*	**62** *9.4%*	**10** *8.4%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
C. Somewhat dissatisfied	**1** *0.9%*	**5** *0.9%*	**6** *0.9%*	**1** *0.8%*
D. Very dissatisfied	**2** *1.7%*	**3** *0.6%*	**5** *0.8%*	**0** *0.0%*
E. Don't know/not sure/no response	**3** *2.6%*	**11** *2.0%*	**14** *2.1%*	**1** *0.8%*
38) Would you recommend the SoonerCare HMP to a friend who has health care needs like yours?				
A. Yes	**106** *91.4%*	**510** *93.8%*	**616** *93.3%*	**117** *96.7%*
B. No	**2** *1.7%*	**5** *0.9%*	**7** *1.1%*	**2** *1.7%*
C. Don't know/not sure/no response	**8** *6.9%*	**29** *5.3%*	**37** *5.6%*	**2** *1.7%*
35) Do you have any suggestions for improving the SoonerCare HMP?				
A. Yes *(member-specific responses documented)*	**12** *10.3%*	**47** *8.6%*	**59** *8.9%*	**10** *8.3%*
B. No/no response	**104** *89.7%*	**497** *91.4%*	**601** *91.1%*	**111** *91.7%*
40) Overall, how would you rate your health today?				
A. Excellent	**4** *3.4%*	**8** *1.5%*	**12** *1.8%*	**2** *1.7%*
B. Good	**37** *31.4%*	**208** *38.4%*	**245** *37.2%*	**49** *40.5%*
C. Fair	**55** *46.6%*	**224** *41.4%*	**279** *42.3%*	**49** *40.5%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
D. Poor	**22** *18.6%*	**100** *18.5%*	**122** *18.5%*	**21** *17.4%*
E. Don't know/not sure	**0** *0.0%*	**1** *0.2%*	**1** *0.2%*	**0** *0.0%*
41) Compared to before you enrolled in the SoonerCare HMP, how has your health changed?				
A. Better	**46** *39.0%*	**235** *43.4%*	**281** *42.6%*	**58** *47.9%*
B. Worse	**4** *3.4%*	**48** *8.9%*	**52** *7.9%*	**10** *8.3%*
C. About the same	**68** *57.6%*	**258** *47.7%*	**326** *49.5%*	**53** *43.8%*
42) (If better) Do you think the SoonerCare HMP has contributed to your improvement in health?				
A. Yes	**44** *95.7%*	**225** *95.7%*	**269** *95.7%*	**53** *91.4%*
B. No	**2** *4.3%*	**10** *4.3%*	**12** *4.3%*	**4** *6.9%*
C. Don't know/not sure	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	**1** *1.7%*
43) I'm going to mention a few areas where Health Coaches sometimes try to help members improve their health by changing behaviors. For each, tell me if your Health Coach spoke to you, and if so, whether you changed your behavior as a result.				

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
(a) Smoking less or using other tobacco products less				
A. N/A - not discussed	**28** *23.7%*	**64** *11.8%*	**92** *14.0%*	**11** *9.2%*
B. Discussed - no change	**9** *7.6%*	**26** *4.8%*	**35** *5.3%*	**10** *8.4%*
C. Discussed - temporary change	**3** *2.5%*	**11** *2.0%*	**14** *2.1%*	**0** *0.0%*
D. Discussed - continuing change	**16** *13.6%*	**106** *19.6%*	**122** *18.5%*	**16** *13.4%*
E. Don't know/not sure	**3** *2.5%*	**24** *4.4%*	**27** *4.1%*	**4** *3.4%*
F. Not applicable	**59** *50.0%*	**310** *57.3%*	**369** *56.0%*	**78** *65.5%*
(b) Moving around more or getting more exercise				
A. N/A - not discussed	**20** *16.9%*	**82** *15.2%*	**102** *15.5%*	**15** *12.6%*
B. Discussed - no change	**12** *10.2%*	**35** *6.5%*	**47** *7.1%*	**7** *5.9%*
C. Discussed - temporary change	**4** *3.4%*	**7** *1.3%*	**11** *1.7%*	**2** *1.7%*
D. Discussed - continuing change	**49** *41.5%*	**287** *53.0%*	**336** *51.0%*	**67** *56.3%*
E. Don't know/not sure	**4** *3.4%*	**21** *3.9%*	**25** *3.8%*	**3** *2.5%*
F. Not applicable	**29** *24.6%*	**109** *20.1%*	**138** *20.9%*	**25** *21.0%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
(c) Changing your diet				
A. N/A - not discussed	**19** *16.1%*	**83** *15.3%*	**102** *15.5%*	**15** *12.6%*
B. Discussed - no change	**15** *12.7%*	**27** *5.0%*	**42** *6.4%*	**8** *6.7%*
C. Discussed - temporary change	**2** *1.7%*	**11** *2.0%*	**13** *2.0%*	**2** *1.7%*
D. Discussed - continuing change	**57** *48.3%*	**334** *61.7%*	**391** *59.3%*	**73** *61.3%*
E. Don't know/not sure	**3** *2.5%*	**21** *3.9%*	**24** *3.6%*	**2** *1.7%*
F. Not applicable	**22** *18.6%*	**65** *12.0%*	**87** *13.2%*	**19** *16.0%*
(d) Managing and taking your medications better				
A. N/A - not discussed	**18** *15.3%*	**88** *16.3%*	**106** *16.1%*	**19** *16.0%*
B. Discussed - no change	**18** *15.3%*	**3** *0.6%*	**21** *3.2%*	**0** *0.0%*
C. Discussed - temporary change	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*
D. Discussed - continuing change	**42** *35.6%*	**269** *49.7%*	**311** *47.2%*	**57** *47.9%*
E. Don't know/not sure	**3** *2.5%*	**21** *3.9%*	**24** *3.6%*	**3** *2.5%*
F. Not applicable	**37** *31.4%*	**160** *29.6%*	**197** *29.9%*	**40** *33.6%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
(e) Making sure to drink enough water throughout the day				
A. N/A - not discussed	**51** *43.2%*	**198** *36.6%*	**249** *37.8%*	**42** *35.3%*
B. Discussed - no change	**7** *5.9%*	**15** *2.8%*	**22** *3.3%*	**6** *5.0%*
C. Discussed - temporary change	**1** *0.8%*	**3** *0.6%*	**4** *0.6%*	**0** *0.0%*
D. Discussed - continuing change	**42** *35.6%*	**218** *40.3%*	**260** *39.5%*	**44** *37.0%*
E. Don't know/not sure	**3** *2.5%*	**26** *4.8%*	**29** *4.4%*	**7** *5.9%*
F. Not applicable	**14** *11.9%*	**81** *15.0%*	**95** *14.4%*	**20** *16.8%*
(f) Drinking or using other substances less				
A. N/A - not discussed	**33** *28.0%*	**160** *29.6%*	**193** *29.3%*	**39** *32.8%*
B. Discussed - no change	**6** *5.1%*	**3** *0.6%*	**9** *1.4%*	**0** *0.0%*
C. Discussed - temporary change	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*
D. Discussed - continuing change	**2** *1.7%*	**9** *1.7%*	**11** *1.7%*	**1** *0.8%*
E. Don't know/not sure	**3** *2.5%*	**24** *4.4%*	**27** *4.1%*	**5** *4.2%*
F. Not applicable	**74** *62.7%*	**345** *63.8%*	**419** *63.6%*	**74** *62.2%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
44 - 47) Comparison to NCM program	*(Insufficient data to report)*	*(Question discontinued)*	*(Question discontinued)*	*(Question discontinued)*
48 - 49) Dropouts (question 3 on follow-up survey) - Why did you decide to disenroll from the SoonerCare HMP?	*(Insufficient data to report)*	*(Question moved to follow-up survey)*	*(Question moved to follow-up survey)*	
A. Not aware of program/did not know was enrolled	*N/A - follow-up survey only*			**2** *20.0%*
B. Did not understand purpose of the program				**0** *0.0%*
C. Did not wish to self-manage care/receive health education				**2** *20.0%*
D. Satisfied with doctor/current health care access without program				**1** *10.0%*
E. Dislike nurse care manager				**0** *0.0%*
F Changed doctors				**2** *20.0%*
G. Disenrolled by doctor				**0** *0.0%*
H. Disenrolled by nurse care manager				**0** *0.0%*
I. Disenrolled by other				**0** *0.0%*
J. Have not health needs at this time				**1** *10.0%*
K. Other				**2** *20.0%*
L. Don't know/not sure				**0** *0.0%*

Survey Questions (numbering based on initial survey)	Initial Survey			Six-Month Follow-up
	2/15 - 4/15	5/15 - 4/16	Aggregate	
50 - 51) Opt outs	*(Insufficient data to report)*	*(Question discontinued)*	*(Question discontinued)*	*(Question discontinued)*
52) Race (multiple categories allowed)				
A. White or Caucasian	**77** *61.6%*	**334** *61.7%*	**411** *61.7%*	*N/A - not asked*
B. Black or African American	**18** *14.4%*	**117** *21.6%*	**135** *20.3%*	
C. Asian	**1** *0.8%*	**10** *1.8%*	**11** *1.7%*	
D. Native Hawaiian or other Pacific Islander	**0** *0.0%*	**0** *0.0%*	**0** *0.0%*	
E. American Indian	**10** *8.0%*	**52** *9.6%*	**62** *9.3%*	
F. Hispanic or Latino	**15** *12.0%*	**27** *5.0%*	**42** *6.3%*	
G. Other	**4** *3.2%*	**1** *0.2%*	**5** *0.8%*	

APPENDIX C – DETAILED HEALTH COACHING PARTICIPANT EXPENDITURE DATA

Appendix C includes detailed expenditure data for SoonerCare HMP health coaching participants. The exhibits are listed below.

Exhibit	***Description***
C-1	All Participants
C-2	Participants with Asthma as most Expensive Diagnosis
C-3	Participants with CAD as most Expensive Diagnosis
C-4	Participants with COPD as most Expensive Diagnosis
C-5	Participants with Diabetes as most Expensive Diagnosis
C-6	Participants with Heart Failure as most Expensive Diagnosis
C-7	Participants with Hypertension as most Expensive Diagnosis

Exhibit C-1 – Detailed Expenditure Data – All SoonerCare HMP Participants

	HMP Detail - All Health Coaching Participants							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Pre Accum/ Engage Accum)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	81,475	28,711	48,280	18,765	16,641			
Aggregrate Expenditures								
Inpatient Services	$14,344,100	$5,125,349	$7,538,918	$2,697,060	$2,319,366			
Outpatient Services	$8,515,892	$3,042,848	$5,045,981	$1,805,208	$1,552,408			
Physician Services	$13,938,791	$4,982,052	$7,717,430	$2,758,729	$2,375,337			
Prescribed Drugs	$12,892,902	$4,608,791	$9,379,822	$3,353,390	$2,886,806			
Psychiatric Services	$4,896,427	$1,750,098	$2,774,668	$991,914	$853,982			
Dental Services	$986,176	$352,461	$408,899	$146,168	$125,854			
Lab and X-Ray	$2,953,056	$1,055,492	$2,077,233	$742,588	$639,327			
Medical Supplies and Orthotics	$1,049,455	$375,077	$567,349	$202,821	$174,618			
Home Health and Home Care	$750,476	$268,238	$445,785	$159,334	$137,217			
Nursing Facility	$97,172	$34,734	$66,824	$23,886	$20,568			
Targeted Case Management	$57,970	$20,725	$50,200	$17,947	$15,450			
Transportation	$1,183,758	$423,051	$614,405	$219,603	$189,120			
Other Practitioner	$339,896	$121,494	$190,420	$68,069	$58,609			
Other Institutional	$2,021	$722	$6,806	$2,433	$2,095			
Other	$512,430	$183,166	$194,323	$69,460	$59,812			
Total	**$62,520,521**	**$22,344,297**	**$37,079,062**	**$13,258,609**	**$11,410,569**			
PMPM Expenditures								
Inpatient Services	$176.06	$178.52	$156.15	$143.73	$139.38	-11.3%	-19.5%	-3.0%
Outpatient Services	$104.52	$105.98	$104.51	$96.20	$93.29	0.0%	-9.2%	-3.0%
Physician Services	$171.08	$173.52	$159.85	$147.01	$142.74	-6.6%	-15.3%	-2.9%
Prescribed Drugs	$158.24	$160.52	$194.28	$178.70	$173.48	18.5%	11.3%	-2.9%
Psychiatric Services	$60.10	$60.96	$57.47	$52.86	$51.32	-4.4%	-13.3%	-2.9%
Dental Services	$12.10	$12.28	$8.47	$7.79	$7.56	-30.0%	-36.5%	-2.9%
Lab and X-Ray	$36.24	$36.76	$43.02	$39.57	$38.42	15.8%	7.6%	-2.9%
Medical Supplies and Orthotics	$12.88	$13.06	$11.75	$10.81	$10.49	-8.8%	-17.3%	-2.9%
Home Health and Home Care	$9.21	$9.34	$9.23	$8.49	$8.25	0.2%	-9.1%	-2.9%
Nursing Facility	$1.19	$1.21	$1.38	$1.27	$1.24	16.1%	5.2%	-2.9%
Targeted Case Management	$0.71	$0.72	$1.04	$0.96	$0.93	46.1%	32.5%	-2.9%
Transportation	$14.53	$14.73	$12.73	$11.70	$11.36	-12.4%	-20.6%	-2.9%
Other Practitioner	$4.17	$4.23	$3.94	$3.63	$3.52	-5.5%	-14.3%	-2.9%
Other Institutional	$0.02	$0.03	$0.14	$0.13	$0.13	82.4%	415.3%	-2.9%
Other	$6.29	$6.38	$4.02	$3.70	$3.59	-36.0%	-42.0%	-2.9%
Total	**$767.36**	**$778.25**	**$768.00**	**$706.56**	**$685.69**	**0.1%**	**-9.2%**	**-3.0%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$1,094.64**	**70.1%**
Months 13-24	**$1,111.82**	**61.7%**

Exhibit C-2 – Detailed Expenditure Data – Participants w/Asthma as Most Expensive Diagnosis

	HMP Health Coaching Detail - Asthma							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	11,880	4,333	6,069	2,299	2,038			
Aggregrate Expenditures								
Inpatient Services	$1,387,208	$496,882	$628,319	$224,507	$193,018			
Outpatient Services	$1,392,124	$498,947	$593,932	$212,311	$182,555			
Physician Services	$2,000,638	$716,169	$1,034,612	$369,817	$317,828			
Prescribed Drugs	$1,642,855	$587,339	$897,512	$320,831	$275,377			
Psychiatric Services	$1,071,754	$383,890	$485,064	$173,352	$148,702			
Dental Services	$243,258	$87,026	$82,562	$29,499	$25,398			
Lab and X-Ray	$378,532	$135,321	$233,492	$83,440	$71,794			
Medical Supplies and Orthotics	$73,246	$26,183	$29,557	$10,562	$9,079			
Home Health and Home Care	$27,486	$9,824	$17,962	$6,418	$5,510			
Nursing Facility	-	-	-	-	-			
Targeted Case Management	$6,992	$2,500	$9,268	$3,312	$2,850			
Transportation	$134,927	$48,235	$52,818	$18,870	$16,238			
Other Practitioner	$92,692	$33,128	$37,013	$13,228	$11,370			
Other Institutional	-	-	$727	$260	$223			
Other	$89,264	$31,954	$32,768	$11,709	$10,076			
Total	**$8,540,975**	**$3,057,397**	**$4,135,606**	**$1,478,116**	**$1,270,019**			
PMPM Expenditures								
Inpatient Services	$116.77	$114.67	$103.53	$97.65	$94.71	-11.3%	-14.8%	-3.0%
Outpatient Services	$117.18	$115.15	$97.86	$92.35	$89.58	-16.5%	-19.8%	-3.0%
Physician Services	$168.40	$165.28	$170.47	$160.86	$155.95	1.2%	-2.7%	-3.1%
Prescribed Drugs	$138.29	$135.55	$147.88	$139.55	$135.12	6.9%	3.0%	-3.2%
Psychiatric Services	$90.21	$88.60	$79.92	$75.40	$72.96	-11.4%	-14.9%	-3.2%
Dental Services	$20.48	$20.08	$13.60	$12.83	$12.46	-33.6%	-36.1%	-2.9%
Lab and X-Ray	$31.86	$31.23	$38.47	$36.29	$35.23	20.7%	16.2%	-2.9%
Medical Supplies and Orthotics	$6.17	$6.04	$4.87	$4.59	$4.46	-21.0%	-24.0%	-3.0%
Home Health and Home Care	$2.31	$2.27	$2.96	$2.79	$2.70	27.9%	23.1%	-3.1%
Nursing Facility	-	-	-	-	-	-	-	-
Targeted Case Management	$0.59	$0.58	$1.53	$1.44	$1.40	159.5%	149.7%	-2.9%
Transportation	$11.36	$11.13	$8.70	$8.21	$7.97	-23.4%	-26.3%	-2.9%
Other Practitioner	$7.80	$7.65	$6.10	$5.75	$5.58	-21.8%	-24.7%	-3.0%
Other Institutional	-	-	$0.12	$0.11	$0.11	-	-	-2.9%
Other	$7.51	$7.37	$5.40	$5.09	$4.94	-28.1%	-30.9%	-2.9%
Total	**$718.94**	**$705.61**	**$681.43**	**$642.94**	**$623.17**	**-5.2%**	**-8.9%**	**-3.1%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$822.71**	**82.8%**
Months 13-24	**$847.39**	**73.5%**

Exhibit C-3 – Detailed Expenditure Data – Participants w/CAD as Most Expensive Diagnosis

	HMP Health Coaching Detail - CAD							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	2,254	793	1,341	482	427			
Aggregrate Expenditures								
Inpatient Services	$1,394,412	$498,518	$752,941	$269,135	$235,575			
Outpatient Services	$406,486	$145,323	$197,769	$70,687	$61,891			
Physician Services	$668,078	$238,787	$349,303	$124,849	$109,481			
Prescribed Drugs	$440,024	$157,294	$267,119	$95,469	$83,830			
Psychiatric Services	$61,985	$22,152	$38,104	$13,615	$11,913			
Dental Services	$17,498	$6,252	$4,451	$1,590	$1,394			
Lab and X-Ray	$94,197	$33,668	$68,568	$24,500	$21,497			
Medical Supplies and Orthotics	$42,797	$15,296	$14,932	$5,336	$4,673			
Home Health and Home Care	$51,678	$18,465	$41,255	$14,743	$12,907			
Nursing Facility	-	-	-	-	-			
Targeted Case Management	$3,103	$1,109	$1,873	$669	$587			
Transportation	$97,118	$34,704	$55,226	$19,733	$17,294			
Other Practitioner	$5,087	$1,818	$3,203	$1,145	$1,003			
Other Institutional	$156	$56	$0	$0	$0			
Other	$51,739	$18,493	$29,527	$10,551	$9,267			
Total	**$3,334,357**	**$1,191,934**	**$1,824,273**	**$652,024**	**$571,310**			
PMPM Expenditures								
Inpatient Services	$618.64	$628.65	$561.48	$558.37	$551.70	-9.2%	-11.2%	-1.2%
Outpatient Services	$180.34	$183.26	$147.48	$146.65	$144.94	-18.2%	-20.0%	-1.2%
Physician Services	$296.40	$301.12	$260.48	$259.02	$256.40	-12.1%	-14.0%	-1.0%
Prescribed Drugs	$195.22	$198.35	$199.19	$198.07	$196.32	2.0%	-0.1%	-0.9%
Psychiatric Services	$27.50	$27.93	$28.41	$28.25	$27.90	3.3%	1.1%	-1.2%
Dental Services	$7.76	$7.88	$3.32	$3.30	$3.26	-57.2%	-58.1%	-1.1%
Lab and X-Ray	$41.79	$42.46	$51.13	$50.83	$50.34	22.4%	19.7%	-1.0%
Medical Supplies and Orthotics	$18.99	$19.29	$11.14	$11.07	$10.94	-41.4%	-42.6%	-1.1%
Home Health and Home Care	$22.93	$23.29	$30.76	$30.59	$30.23	34.2%	31.4%	-1.2%
Nursing Facility	-	-	-	-	-	-	-	-
Targeted Case Management	$1.38	$1.40	$1.40	$1.39	$1.37	1.5%	-0.7%	-1.0%
Transportation	$43.09	$43.76	$41.18	$40.94	$40.50	-4.4%	-6.4%	-1.1%
Other Practitioner	$2.26	$2.29	$2.39	$2.37	$2.35	5.8%	3.6%	-1.1%
Other Institutional	$0.07	$0.07	$0.00	$0.00	$0.00	-100.0%	-	-
Other	$22.95	$23.32	$22.02	$21.89	$21.70	-4.1%	-6.1%	-0.9%
Total	**$1,479.31**	**$1,503.07**	**$1,360.38**	**$1,352.75**	**$1,337.96**	**-8.0%**	**-10.0%**	**-1.1%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$1,585.51**	**85.8%**
Months 13-24	**$1,612.73**	**82.9%**

Exhibit C-4 – Detailed Expenditure Data – Participants w/COPD as Most Expensive Diagnosis

	HMP Health Coaching Detail - COPD							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	8898	3106	5010	1774	1574			
Aggregrate Expenditures								
Inpatient Services	$1,722,474	$615,728	$951,879	$340,224	$297,597			
Outpatient Services	$893,019	$319,264	$577,803	$206,508	$180,634			
Physician Services	$1,549,967	$553,927	$903,681	$322,918	$282,567			
Prescribed Drugs	$1,899,513	$679,014	$1,659,254	$593,020	$518,920			
Psychiatric Services	$654,491	$233,945	$389,506	$139,227	$121,854			
Dental Services	$68,551	$24,508	$50,043	$17,890	$15,662			
Lab and X-Ray	$386,348	$138,090	$292,232	$104,425	$91,526			
Medical Supplies and Orthotics	$258,412	$92,340	$152,179	$54,379	$47,630			
Home Health and Home Care	$134,734	$48,148	$97,606	$34,880	$30,531			
Nursing Facility	$8,904	$3,182	$9,665	$3,454	$3,026			
Targeted Case Management	$8,348	$2,983	$6,296	$2,250	$1,970			
Transportation	$162,041	$57,914	$68,823	$24,593	$21,551			
Other Practitioner	$29,772	$10,640	$13,040	$4,660	$4,080			
Other Institutional	-	-	$370	$132	$116			
Other	$34,030	$12,161	$13,194	$4,715	$4,133			
Total	**$7,810,602**	**$2,791,842**	**$5,185,571**	**$1,853,275**	**$1,621,796**			
PMPM Expenditures								
Inpatient Services	$193.58	$198.24	$190.00	$191.78	$189.07	-1.9%	-3.3%	-1.4%
Outpatient Services	$100.36	$102.79	$115.33	$116.41	$114.76	14.9%	13.2%	-1.4%
Physician Services	$174.19	$178.34	$180.38	$182.03	$179.52	3.5%	2.1%	-1.4%
Prescribed Drugs	$213.48	$218.61	$331.19	$334.28	$329.68	55.1%	52.9%	-1.4%
Psychiatric Services	$73.55	$75.32	$77.75	$78.48	$77.42	5.7%	4.2%	-1.4%
Dental Services	$7.70	$7.89	$9.99	$10.08	$9.95	29.7%	27.8%	-1.3%
Lab and X-Ray	$43.42	$44.46	$58.33	$58.86	$58.15	34.3%	32.4%	-1.2%
Medical Supplies and Orthotics	$29.04	$29.73	$30.38	$30.65	$30.26	4.6%	3.1%	-1.3%
Home Health and Home Care	$15.14	$15.50	$19.48	$19.66	$19.40	28.7%	26.8%	-1.3%
Nursing Facility	$1.00	$1.02	$1.93	$1.95	$1.92	92.8%	90.1%	-1.3%
Targeted Case Management	$0.94	$0.96	$1.26	$1.27	$1.25	33.9%	32.0%	-1.3%
Transportation	$18.21	$18.65	$13.74	$13.86	$13.69	-24.6%	-25.7%	-1.2%
Other Practitioner	$3.35	$3.43	$2.60	$2.63	$2.59	-22.2%	-23.3%	-1.3%
Other Institutional	-	-	$0.07	$0.07	$0.07	-	-	-1.4%
Other	$3.82	$3.92	$2.63	$2.66	$2.63	-31.1%	-32.1%	-1.2%
Total	**$877.79**	**$898.85**	**$1,035.04**	**$1,044.69**	**$1,030.37**	**17.9%**	**16.2%**	**-1.4%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$1,299.29**	**79.7%**
Months 13-24	**$1,324.46**	**77.8%**

Exhibit C-5 – Detailed Expenditure Data – Participants w/Diabetes as Most Expensive Diagnosis

	HMP Health Coaching Detail - Diabetes							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	12,494	4,497	7,676	2,822	2,502			
Aggregrate Expenditures								
Inpatient Services	$3,603,399	$1,288,255	$1,990,130	$711,363	$611,358			
Outpatient Services	$1,525,882	$545,553	$1,038,649	$371,283	$318,712			
Physician Services	$2,661,578	$951,427	$1,513,856	$541,088	$465,065			
Prescribed Drugs	$3,371,770	$1,205,371	$2,264,851	$809,511	$695,296			
Psychiatric Services	$705,454	$252,161	$485,182	$173,426	$148,855			
Dental Services	$97,231	$34,759	$42,501	$15,189	$13,060			
Lab and X-Ray	$488,865	$174,732	$372,014	$132,942	$114,263			
Medical Supplies and Orthotics	$407,127	$145,508	$239,182	$85,484	$73,481			
Home Health and Home Care	$228,244	$81,565	$134,565	$48,076	$41,243			
Nursing Facility	-	-	$17,881	$6,391	$5,490			
Targeted Case Management	$15,598	$5,576	$8,337	$2,979	$2,561			
Transportation	$255,623	$91,377	$148,720	$53,146	$45,670			
Other Practitioner	$72,088	$25,761	$48,410	$17,292	$14,871			
Other Institutional	$1,866	$667	$596	$213	$183			
Other	$139,694	$49,942	$38,699	$13,830	$11,875			
Total	**$13,574,419**	**$4,852,654**	**$8,343,574**	**$2,982,214**	**$2,561,983**			
PMPM Expenditures								
Inpatient Services	$288.41	$286.47	$259.27	$252.08	$244.35	-10.1%	-12.0%	-3.1%
Outpatient Services	$122.13	$121.31	$135.31	$131.57	$127.38	10.8%	8.5%	-3.2%
Physician Services	$213.03	$211.57	$197.22	$191.74	$185.88	-7.4%	-9.4%	-3.1%
Prescribed Drugs	$269.87	$268.04	$295.06	$286.86	$277.90	9.3%	7.0%	-3.1%
Psychiatric Services	$56.46	$56.07	$63.21	$61.46	$59.49	11.9%	9.6%	-3.2%
Dental Services	$7.78	$7.73	$5.54	$5.38	$5.22	-28.9%	-30.4%	-3.0%
Lab and X-Ray	$39.13	$38.86	$48.46	$47.11	$45.67	23.9%	21.2%	-3.1%
Medical Supplies and Orthotics	$32.59	$32.36	$31.16	$30.29	$29.37	-4.4%	-6.4%	-3.0%
Home Health and Home Care	$18.27	$18.14	$17.53	$17.04	$16.48	-4.0%	-6.1%	-3.2%
Nursing Facility	-	-	$2.33	$2.26	$2.19	-	-	-3.1%
Targeted Case Management	$1.25	$1.24	$1.09	$1.06	$1.02	-13.0%	-14.9%	-3.0%
Transportation	$20.46	$20.32	$19.37	$18.83	$18.25	-5.3%	-7.3%	-3.1%
Other Practitioner	$5.77	$5.73	$6.31	$6.13	$5.94	9.3%	7.0%	-3.0%
Other Institutional	$0.15	$0.15	$0.08	$0.08	$0.07	-48.0%	-49.1%	-3.0%
Other	$11.18	$11.11	$5.04	$4.90	$4.75	-54.9%	-55.9%	-3.2%
Total	**$1,086.48**	**$1,079.09**	**$1,086.97**	**$1,056.77**	**$1,023.97**	**0.0%**	**-2.1%**	**-3.1%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$1,457.36**	**74.6%**
Months 13-24	**$1,498.38**	**68.3%**

Exhibit C-6 – Detailed Expenditure Data – Participants w/Heart Failure as Most Expensive Diagnosis

	HMP Health Coaching Detail - Heart Failure							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	864	303	459	162	144			
Aggregrate Expenditures								
Inpatient Services	$583,906	$208,702	$958,519	$342,639	$303,705			
Outpatient Services	$142,016	$50,757	$116,512	$41,647	$36,914			
Physician Services	$208,823	$74,652	$183,105	$65,458	$58,015			
Prescribed Drugs	$181,843	$64,991	$110,242	$39,408	$34,940			
Psychiatric Services	$44,384	$15,865	$29,798	$10,651	$9,439			
Dental Services	$22,410	$8,010	$1,717	$614	$544			
Lab and X-Ray	$25,855	$9,240	$23,689	$8,467	$7,504			
Medical Supplies and Orthotics	$47,775	$17,072	$15,786	$5,642	$5,002			
Home Health and Home Care	$43,827	$15,663	$26,906	$9,616	$8,521			
Nursing Facility	-	-	$7,193	$2,571	$2,278			
Targeted Case Management	$7,043	$2,517	$3,178	$1,136	$1,007			
Transportation	$30,686	$10,968	$14,344	$5,128	$4,542			
Other Practitioner	$3,892	$1,391	$2,712	$969	$859			
Other Institutional	-	-	$5,112	$1,827	$1,620			
Other	$8,091	$2,892	$825	$295	$261			
Total	**$1,350,549**	**$482,718**	**$1,499,638**	**$536,068**	**$475,152**			
PMPM Expenditures								
Inpatient Services	$675.82	$688.78	$2,088.28	$2,115.06	$2,109.06	209.0%	207.1%	-0.3%
Outpatient Services	$164.37	$167.51	$253.84	$257.08	$256.35	54.4%	53.5%	-0.3%
Physician Services	$241.69	$246.38	$398.92	$404.06	$402.88	65.1%	64.0%	-0.3%
Prescribed Drugs	$210.47	$214.49	$240.18	$243.26	$242.64	14.1%	13.4%	-0.3%
Psychiatric Services	$51.37	$52.36	$64.92	$65.75	$65.55	26.4%	25.6%	-0.3%
Dental Services	$25.94	$26.43	$3.74	$3.79	$3.77	-85.6%	-85.7%	-0.3%
Lab and X-Ray	$29.92	$30.50	$51.61	$52.27	$52.11	72.5%	71.4%	-0.3%
Medical Supplies and Orthotics	$55.29	$56.34	$34.39	$34.83	$34.74	-37.8%	-38.2%	-0.3%
Home Health and Home Care	$50.73	$51.69	$58.62	$59.36	$59.18	15.6%	14.8%	-0.3%
Nursing Facility	-	-	$15.67	$15.87	$15.82	-	-	-0.3%
Targeted Case Management	$8.15	$8.31	$6.92	$7.01	$6.99	-15.1%	-15.6%	-0.3%
Transportation	$35.52	$36.20	$31.25	$31.65	$31.54	-12.0%	-12.6%	-0.3%
Other Practitioner	$4.50	$4.59	$5.91	$5.98	$5.97	31.2%	30.4%	-0.3%
Other Institutional	-	-	$11.14	$11.28	$11.25	-	-	-0.3%
Other	$9.36	$9.55	$1.80	$1.82	$1.81	-80.8%	-80.9%	-0.3%
Total	**$1,563.14**	**$1,593.13**	**$3,267.19**	**$3,309.06**	**$3,299.67**	**109.0%**	**107.7%**	**-0.3%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$2,323.89**	**140.6%**
Months 13-24	**$2,389.26**	**138.1%**

Exhibit C-7 – Detailed Expenditure Data – Participants w/Hypertension as Most Expensive Diagnosis

	HMP Health Coaching Detail - Hypertension							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	23,239	8,408	13,605	5,014	4,446			
Aggregrate Expenditures								
Inpatient Services	$4,057,212	$1,450,498	$1,688,466	$603,645	$524,754			
Outpatient Services	$2,482,413	$888,087	$1,554,067	$555,630	$482,921			
Physician Services	$3,962,866	$1,416,682	$2,348,174	$839,498	$729,783			
Prescribed Drugs	$3,475,067	$1,242,223	$2,939,066	$1,050,684	$913,722			
Psychiatric Services	$1,222,872	$437,137	$714,050	$255,218	$221,883			
Dental Services	$190,714	$68,178	$104,549	$37,368	$32,472			
Lab and X-Ray	$911,165	$325,692	$635,502	$227,171	$197,462			
Medical Supplies and Orthotics	$190,787	$68,192	$93,125	$33,285	$28,946			
Home Health and Home Care	$215,966	$77,201	$109,484	$39,137	$34,009			
Nursing Facility	$88,266	$31,550	$32,082	$11,467	$9,967			
Targeted Case Management	$15,629	$5,586	$20,307	$7,258	$6,310			
Transportation	$353,899	$126,484	$228,432	$81,642	$70,971			
Other Practitioner	$60,301	$21,554	$43,791	$15,650	$13,607			
Other Institutional	-	-	-	-	-			
Other	$122,779	$43,892	$38,456	$13,745	$11,951			
Total	**$17,349,936**	**$6,202,956**	**$10,549,554**	**$3,771,401**	**$3,278,758**			
PMPM Expenditures								
Inpatient Services	$174.59	$172.51	$124.11	$120.39	$118.03	-28.9%	-30.2%	-2.0%
Outpatient Services	$106.82	$105.62	$114.23	$110.82	$108.62	6.9%	4.9%	-2.0%
Physician Services	$170.53	$168.49	$172.60	$167.43	$164.14	1.2%	-0.6%	-2.0%
Prescribed Drugs	$149.54	$147.74	$216.03	$209.55	$205.52	44.5%	41.8%	-1.9%
Psychiatric Services	$52.62	$51.99	$52.48	$50.90	$49.91	-0.3%	-2.1%	-2.0%
Dental Services	$8.21	$8.11	$7.68	$7.45	$7.30	-6.4%	-8.1%	-2.0%
Lab and X-Ray	$39.21	$38.74	$46.71	$45.31	$44.41	19.1%	17.0%	-2.0%
Medical Supplies and Orthotics	$8.21	$8.11	$6.84	$6.64	$6.51	-16.6%	-18.1%	-1.9%
Home Health and Home Care	$9.29	$9.18	$8.05	$7.81	$7.65	-13.4%	-15.0%	-2.0%
Nursing Facility	$3.80	$3.75	$2.36	$2.29	$2.24	-37.9%	-39.1%	-2.0%
Targeted Case Management	$0.67	$0.66	$1.49	$1.45	$1.42	121.9%	117.9%	-2.0%
Transportation	$15.23	$15.04	$16.79	$16.28	$15.96	10.3%	8.2%	-2.0%
Other Practitioner	$2.59	$2.56	$3.22	$3.12	$3.06	24.0%	21.8%	-1.9%
Other Institutional	-	-	-	-	-	-	-	-
Other	$5.28	$5.22	$2.83	$2.74	$2.69	-46.5%	-47.5%	-1.9%
Total	**$746.59**	**$737.74**	**$775.42**	**$752.17**	**$737.46**	**3.9%**	**2.0%**	**-2.0%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$1,210.31**	**64.1%**
Months 13-24	**$1,229.86**	**60.0%**

APPENDIX D – PRACTICE FACILITATION SITE SURVEY MATERIALS

Appendix D includes the advance letter sent to practice facilitation sites and practice facilitation survey instrument (mail version).

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

<Title> <First> <Last>
<Practice Name>
<Street Address 1>
<Street Address 2>
<City>, <State> <Zip>

Dear Provider,

The Oklahoma Health Care Authority would like to hear about your experiences with the Practice Facilitation initiative being carried out by Telligen. These services support providers caring for SoonerCare members. Pacific Health Policy Group (PHPG), an outside company, has been contracted by the Oklahoma Health Care Authority to survey providers and practices that have participated in this initiative.

The purpose of the survey is to gather information on the initiative's value and how it can be improved from a provider's perspective. The survey will be over the phone and should take about 15 minutes of your time.

In the next few days, someone will be calling you to conduct the survey. We look forward to your input and hope you will agree to help.

The survey is voluntary, and all of your answers will be kept confidential. Your answers will be combined with those of other providers being surveyed and will not be reported individually to the Oklahoma Health Care Authority.

If you have any questions about the survey, you can reach PHPG toll-free at 1-888-941-9358. If you would like to take the survey right away, you may call the same number any time between the hours of 9 a.m. and 4 p.m. If you have any questions for the Oklahoma Health Care Authority, please call the toll-free number 1-877-252-6002.

Thank you for your time.

SoonerCare
Oklahoma Health Care Authority

HEALTH MANAGEMENT PROGRAM PROVIDER SURVEY

The Oklahoma Health Care Authority would like to hear about your experiences with the Health Management Program being carried out by Telligen. These services support providers caring for SoonerCare members. Pacific Health Policy Group (PHPG), an outside company, has been contracted by the Oklahoma Health Care Authority to survey providers and practices that have participated in the program's Practice Facilitation and/or Health Coaching programs. The purpose of the survey is to gather information on the program's value and how it can be improved from a provider's perspective.

Decision to Participate in the Health Management Program

1. Were you the person who made the decision to participate in the Health Management Program?
    a. Yes
    b. No. If your answer is "no," please proceed to Question 4.
2. What were your reasons for deciding to participate?
    a. Improve care management of patients with chronic conditions/improve outcomes
    b. Gain access to Practice Facilitator and/or embedded Health Coach
    c. Obtain information on patient utilization and costs
    d. Receive assistance in redesigning practice workflows
    e. Reduce costs
    f. Increase income
    g. Continuing education
    h. Other. Please specify: _____
    i. Don't know/not sure
3. Among the reasons you cited, what was the most important reason for deciding to participate?
    a. Improve care management of patients with chronic conditions/improve outcomes
    b. Gain access to Practice Facilitator and/or embedded Health Coach
    c. Obtain information on patient utilization and costs
    d. Receive assistance in redesigning practice workflows
    e. Reduce costs
    f. Increase income
    g. Continuing education
    h. Other. Please specify: _____

Practice Facilitation Activities

A practice facilitator initially asses the practice and acts as a practice management consultant by assisting the practice with quality improvement initiatives that enhance quality of care; enhance proactive, preventive disease management; and enhance efficiencies in the office.

4. The following are a list of activities that typically are part of Practice Facilitation. Regardless of your actual experience, **please rate how important you think** each one is in preparing a practice to better manage patients with chronic medical conditions.

	Very Important	Somewhat Important	Not Too Important	Not At All Important	Not Sure
a. Receiving information on the prevalence of chronic diseases among your patients					
b. Receiving a baseline assessment of how well you have been managing the care of your patients with chronic diseases					
c. Receiving focused training in evidence-based practice guidelines for chronic conditions					
d. Receiving assistance in redesigning office workflows and policies and procedures for management of patients with chronic diseases					
e. Identifying performance measures to track your improvement in managing the care of your patients with chronic diseases					
f. Having a Practice Facilitator on-site to work with you and practice staff					
g. Receiving quarterly reports on your progress with respect to identified performance measures					
h. Receiving ongoing education and assistance after conclusion of the initial onsite activities					

5. The following are a list of activities that typically are part of Practice Facilitation. For each one, **please rate how helpful it was to you** in improving your management of patients with chronic medical conditions.

	Very Helpful	Somewhat Helpful	Not Too Helpful	Not At All Helpful	Not Sure
a. Receiving information on the prevalence of chronic diseases among your patients					
b. Receiving a baseline assessment of how well you have been managing the care of your patients with chronic diseases					
c. Receiving focused training in evidence-based practice guidelines for chronic conditions					
d. Receiving assistance in redesigning office workflows and policies and procedures for management of patients with chronic diseases					
e. Identifying performance measures to track your improvement in managing the care of your patients with chronic diseases					
f. Having a Practice Facilitator on-site to work with you and practice staff					
g. Receiving quarterly reports on your progress with respect to identified performance measures					
h. Receiving ongoing education and assistance after conclusion of the initial onsite activities					

Practice Facilitation Outcomes

6. Have you made changes in the management of your patients with chronic conditions as the result of participating in Practice Facilitation?
    a. Yes
    b. No. If your answer is "no," please proceed to Question 9.
    c. Don't know/not sure. (Please proceed to Question 9.)

7. What are the changes you made?
    a. Identification of tests/exams to manage chronic conditions
    b. Increased attention and diligence/use of alerts
    c. More frequent foot/eye exams and/or HbA1c testing of diabetic patients
    d. Use of flow sheets/forms provided by Practice Facilitator or created through CareMeasures
    e. Improved documentation
    f. Better education of patients with chronic conditions, including provision of materials
    g. Increased staff involvement in chronic care workups
    h. Other. Please specify: _____
    i. Don't know/not sure

8. What is the most important change you made?

    _____

    _____

    _____

9. Has your practice become more effective in managing patients with chronic conditions as a result of your participation in Practice Facilitation?
    a. Yes
    b. No
    c. Don't know/not sure

10. Overall, how satisfied are you with your experience in Practice Facilitation? Would you say you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't know/not sure

11. Would you recommend Practice Facilitation to other providers and practices caring for patients with chronic conditions?
    a. Yes
    b. No
    c. Don't know/not sure

12. Do you have any suggestions for improving Practice Facilitation?

_____

_____

_____

Health Coach Activities

SoonerCare Choice members with or at risk for developing chronic disease(s) will be targeted for care management through the SoonerCare Health Management Program (HMP). Once enrolled, HMP members receive intervention from an assigned Health Coach. Health Coaches are embedded in providers' practices.

13. Do you have a Health Coach assigned to your practice?
    a. Yes
    b. No. If your answer is "no," please proceed to Question 19.
    c. Don't know/not sure. (Please proceed to Question 19.)

14. What is the name of the Health Coach currently assigned to your practice?
    a. If known, please provide name: _____
    b. Don't know/not sure

15. The following is a list of activities that Health Coaches can perform to assist patients. Regardless of your actual experience, **please rate how important you think** it is that the Health Coach in your practice provides this assistance to your patients.

	Very Important	Somewhat Important	Not Very Important	Not at all Important	Not Appropriate	Not Sure
a. Learning about your patients and their health care needs						
b. Giving easy to understand instructions about taking care of health problems or concerns						
c. Helping patients to identify changes in their health that might be an early sign of a problem						
d. Answering patient questions about their health						
e. Helping patients to talk to and work with you and practice staff						
f. Helping patients make and keep health care appointments with other doctors, such as specialists, for medical problems						
g. Helping patients make and keep health care appointments for mental health or substance abuse problems						
h. Reviewing patient medications and helping patients to manage their medications						

16. The following is a list of activities that Health Coaches can perform to assist patients. Thinking about the current Health Coach assigned to your practice, **please rate me how satisfied you** are with the assistance she provides to your patients.

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Not Sure/ NA
a. Learning about your patients and their health care needs					
b. Giving easy to understand instructions about taking care of health problems or concerns					
c. Helping patients to identify changes in their health that might be an early sign of a problem					
d. Answering patient questions about their health					
e. Helping patients to talk to and work with you and practice staff					
f. Helping patients make and keep health care appointments with other doctors, such as specialists, for medical problems					
g. Helping patients make and keep health care appointments for mental health or substance abuse problems					
h. Reviewing patient medications and helping patients to manage their medications					

17. Overall, how satisfied are you with your experience having a Telligen Health Coach assigned to your practice?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't know/not sure

18. Do you have any suggestions for improving the Health Coaching position?

_____

_____

_____

19. Do you have any other comments or suggestions you would like to share today?

_____

_____

_____

Your survey answers will remain confidential and will be combined with those of other providers being surveyed.

Please list the name and position of the individual completing the Provider Survey:

_____

Please list the name of the practice and address:

_____

Please return your completed survey to:

OHCA Practice Facilitation Survey
1725 North McGovern Street
Suite 201
Highland Park, Illinois 60035
FAX: (847) 433-1461

If you have any questions, you can reach us toll-free at 1-888-941-9358.

Thank you for your help.

APPENDIX E – DETAILED PRACTICE FACILITATION EXPENDITURE DATA

Appendix E includes detailed expenditure data for SoonerCare HMP members aligned with PCMH practice facilitation providers. The exhibits are listed below.

Exhibit	***Description***
E-1	All Members
E-2	Members with Asthma as most Expensive Diagnosis
E-3	Members with CAD as most Expensive Diagnosis
E-4	Members with COPD as most Expensive Diagnosis
E-5	Members with Diabetes as most Expensive Diagnosis
E-6	Members with Heart Failure as most Expensive Diagnosis
E-7	Members with Hypertension as most Expensive Diagnosis
E-8	All Other Members

Exhibit E-1 – Detailed Expenditure Data – All Members

Category of Service	HMP Practice Facilitation Detail - All Members							
	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Pre Accum/ Engage Accum)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	129,793	46,006	113,148	40,287	35,727			
Aggregate Expenditures								
Inpatient Services	$6,604,926	$2,359,599	$6,657,549	$2,368,170	$2,066,812			
Outpatient Services	$5,435,915	$1,942,091	$5,679,386	$2,021,600	$1,764,201			
Physician Services	$10,768,549	$3,847,754	$10,392,076	$3,699,329	$3,224,860			
Prescribed Drugs	$7,461,853	$2,666,552	$7,769,959	$2,763,013	$2,410,214			
Psychiatric Services	$8,088,500	$2,891,020	$6,799,844	$2,418,487	$2,107,012			
Dental Services	$2,499,554	$893,345	$1,936,263	$688,624	$601,167			
Lab and X-Ray	$1,291,151	$461,488	$1,591,350	$566,692	$493,244			
Medical Supplies and Orthotics	$389,494	$139,206	$354,178	$125,962	$109,750			
Home Health and Home Care	$200,028	$71,495	$199,672	$71,061	$61,608			
Nursing Facility	-	-	$13,722	$4,883	$4,247			
Targeted Case Management	$65,389	$23,377	$61,103	$21,724	$18,938			
Transportation	$690,859	$246,899	$645,679	$229,619	$200,320			
Other Practitioner	$866,085	$309,578	$653,193	$232,334	$202,452			
Other Institutional	$14,009	$5,007	$34,166	$12,151	$10,546			
Other	$576,493	$206,065	$398,372	$141,609	$123,599			
Total	**$44,952,804**	**$16,063,475**	**$43,186,514**	**$15,365,260**	**$13,398,968**			
PMPM Expenditures								
Inpatient Services	$50.89	$51.29	$58.84	$58.78	$57.85	15.6%	14.6%	-1.6%
Outpatient Services	$41.88	$42.21	$50.19	$50.18	$49.38	19.8%	18.9%	-1.6%
Physician Services	$82.97	$83.64	$91.84	$91.82	$90.26	10.7%	9.8%	-1.7%
Prescribed Drugs	$57.49	$57.96	$68.67	$68.58	$67.46	16.3%	18.3%	-1.6%
Psychiatric Services	$62.32	$62.84	$60.10	$60.03	$58.98	-3.6%	-4.5%	-1.8%
Dental Services	$19.26	$19.42	$17.11	$17.09	$16.83	-11.1%	-12.0%	-1.6%
Lab and X-Ray	$9.95	$10.03	$14.06	$14.07	$13.81	29.3%	40.2%	-1.9%
Medical Supplies and Orthotics	$3.00	$3.03	$3.13	$3.13	$3.07	4.3%	3.3%	-1.7%
Home Health and Home Care	$1.54	$1.55	$1.76	$1.76	$1.72	14.5%	13.5%	-2.2%
Nursing Facility	-	-	$0.12	$0.12	$0.12	-	-	-1.9%
Targeted Case Management	$0.50	$0.51	$0.54	$0.54	$0.53	7.2%	6.1%	-1.7%
Transportation	$5.32	$5.37	$5.71	$5.70	$5.61	7.2%	6.2%	-1.6%
Other Practitioner	$6.67	$6.73	$5.77	$5.77	$5.67	-13.5%	-14.3%	-1.7%
Other Institutional	$0.11	$0.11	$0.30	$0.30	$0.30	64.3%	177.1%	-2.1%
Other	$4.44	$4.48	$3.52	$3.52	$3.46	-20.7%	-21.5%	-1.6%
Total	**$346.34**	**$349.16**	**$381.68**	**$381.39**	**$375.04**	**10.2%**	**9.2%**	**-1.7%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$610.87**	**62.4%**
Months 13-24	**$625.86**	**59.9%**

Exhibit E-2 – Detailed Expenditure Data – Members w/Asthma as Most Expensive Diagnosis

	HMP Practice Facilitation Detail - Asthma							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	12,805	4,602	10,884	3,987	3,536			
Aggregate Expenditures								
Inpatient Services	$517,575	$184,767	$527,126	$187,714	$160,640			
Outpatient Services	$518,111	$185,015	$602,441	$214,335	$184,562			
Physician Services	$1,128,928	$402,739	$1,144,493	$407,538	$350,941			
Prescribed Drugs	$602,309	$214,804	$685,977	$244,342	$210,059			
Psychiatric Services	$15,574	$5,558	$18,399	$6,554	$5,651			
Dental Services	$276,311	$98,615	$173,410	$61,699	$53,260			
Lab and X-Ray	$85,620	$30,552	$105,421	$37,548	$32,283			
Medical Supplies and Orthotics	$38,192	$13,625	$29,667	$10,564	$9,095			
Home Health and Home Care	$2,185	$780	$2,472	$881	$759			
Nursing Facility	-	-	-	-	-			
Targeted Case Management	$532	$190	$1,222	$435	$374			
Transportation	$52,095	$18,578	$42,519	$15,135	$13,021			
Other Practitioner	$71,437	$25,485	$64,061	$22,825	$19,615			
Other Institutional	$156	$56	$0	$0	$0			
Other	$4,300	$1,536	$2,200	$784	$672			
Total	**$3,313,322**	**$1,182,297**	**$3,399,408**	**$1,210,354**	**$1,040,934**			
PMPM Expenditures								
Inpatient Services	$40.42	$40.15	$48.43	$47.08	$45.43	19.8%	17.3%	-3.5%
Outpatient Services	$40.46	$40.20	$55.35	$53.76	$52.20	36.8%	33.7%	-2.9%
Physician Services	$88.16	$87.51	$105.15	$102.22	$99.25	19.3%	16.8%	-2.9%
Prescribed Drugs	$47.04	$46.68	$63.03	$61.28	$59.41	34.0%	31.3%	-3.1%
Psychiatric Services	$1.22	$1.21	$1.69	$1.64	$1.60	39.0%	36.1%	-2.8%
Dental Services	$21.58	$21.43	$15.93	$15.48	$15.06	-26.2%	-27.8%	-2.7%
Lab and X-Ray	$6.69	$6.64	$9.69	$9.42	$9.13	44.9%	41.9%	-3.1%
Medical Supplies and Orthotics	$2.98	$2.96	$2.73	$2.65	$2.57	-8.6%	-10.5%	-2.9%
Home Health and Home Care	$0.17	$0.17	$0.23	$0.22	$0.21	33.1%	30.3%	-2.8%
Nursing Facility	-	-	-	-	-	-	-	-
Targeted Case Management	$0.04	$0.04	$0.11	$0.11	$0.11	170.2%	164.1%	-3.2%
Transportation	$4.07	$4.04	$3.91	$3.80	$3.68	-4.0%	-6.0%	-3.0%
Other Practitioner	$5.58	$5.54	$5.89	$5.72	$5.55	5.5%	3.4%	-3.1%
Other Institutional	$0.01	$0.01	$0.00	$0.00	$0.00	-100.0%	-100.0%	-
Other	$0.34	$0.33	$0.20	$0.20	$0.19	-39.8%	-41.1%	-3.3%
Total	**$258.75**	**$256.91**	**$312.33**	**$303.58**	**$294.38**	**20.7%**	**18.2%**	**-3.0%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$418.64**	**74.6%**
Months 13-24	**$427.62**	**68.8%**

Exhibit E-3 – Detailed Expenditure Data – Members w/CAD as Most Expensive Diagnosis

	HMP Practice Facilitation Detail - CAD							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	361	127	348	123	109			
Aggregrate Expenditures								
Inpatient Services	$272,243	$97,330	$261,908	$93,463	$82,019			
Outpatient Services	$30,201	$10,811	$98,750	$35,220	$30,940			
Physician Services	$77,682	$27,791	$95,792	$34,146	$30,069			
Prescribed Drugs	$79,536	$28,454	$78,418	$27,953	$24,646			
Psychiatric Services	$76	$27	$191	$68	$60			
Dental Services	$1,088	$389	$50	$18	$16			
Lab and X-Ray	$8,858	$3,165	$10,509	$3,741	$3,302			
Medical Supplies and Orthotics	$4,847	$1,735	$12,077	$4,302	$3,786			
Home Health and Home Care	$1,271	$454	$1,144	$407	$359			
Nursing Facility	-	-	-	-	-			
Targeted Case Management	-	-	-	-	-			
Transportation	$16,964	$6,065	$27,501	$9,790	$8,630			
Other Practitioner	$1,385	$495	$2,715	$966	$853			
Other Institutional	-	-	-	-	-			
Other	-	-	-	-	-			
Total	**$494,152**	**$176,717**	**$589,054**	**$210,073**	**$184,678**			
PMPM Expenditures								
Inpatient Services	$754.14	$766.38	$752.61	$759.86	$752.47	-0.2%	-0.9%	-1.0%
Outpatient Services	$83.66	$85.13	$283.76	$286.34	$283.85	239.2%	236.4%	-0.9%
Physician Services	$215.18	$218.83	$275.26	$277.61	$275.86	27.9%	26.9%	-0.6%
Prescribed Drugs	$220.32	$224.05	$225.34	$227.26	$226.11	2.3%	1.4%	-0.5%
Psychiatric Services	$0.21	$0.21	$0.55	$0.55	$0.55	160.0%	157.9%	-0.8%
Dental Services	$3.01	$3.06	$0.14	$0.14	$0.14	-95.3%	-95.3%	-0.7%
Lab and X-Ray	$24.54	$24.92	$30.20	$30.42	$30.29	23.1%	22.0%	-0.4%
Medical Supplies and Orthotics	$13.43	$13.66	$34.70	$34.98	$34.74	158.5%	156.0%	-0.7%
Home Health and Home Care	$3.52	$3.58	$3.29	$3.31	$3.29	-6.6%	-7.4%	-0.6%
Nursing Facility	-	-	-	-	-	-	-	-
Targeted Case Management	-	-	-	-	-	-	-	-
Transportation	$46.99	$47.75	$79.02	$79.59	$79.17	68.2%	66.7%	-0.5%
Other Practitioner	$3.84	$3.90	$7.80	$7.85	$7.82	103.3%	101.4%	-0.4%
Other Institutional	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-
Total	**$1,368.84**	**$1,391.47**	**$1,692.68**	**$1,707.91**	**$1,694.29**	**23.7%**	**22.7%**	**-0.8%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$1,536.34**	**110.2%**
Months 13-24	**$1,570.83**	**107.9%**

Exhibit E-4 – Detailed Expenditure Data – Members w/COPD as Most Expensive Diagnosis

	HMP Practice Facilitation Detail - COPD							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	6,375	2,237	5,649	1,986	1,761			
Aggregate Expenditures								
Inpatient Services	$329,851	$118,113	$315,086	$112,343	$97,690			
Outpatient Services	$249,090	$89,134	$310,424	$110,742	$96,206			
Physician Services	$642,716	$230,087	$564,305	$201,399	$174,864			
Prescribed Drugs	$340,675	$121,758	$338,173	$120,493	$104,918			
Psychiatric Services	$2,513	$899	$3,427	$1,221	$1,064			
Dental Services	$79,030	$28,287	$72,282	$25,777	$22,434			
Lab and X-Ray	$69,798	$24,987	$68,918	$24,551	$21,413			
Medical Supplies and Orthotics	$30,108	$10,772	$30,282	$10,781	$9,406			
Home Health and Home Care	$23,604	$8,456	$38,630	$13,788	$11,975			
Nursing Facility	-	-	-	-	-			
Targeted Case Management	-	-	$2,189	$780	$679			
Transportation	$28,715	$10,261	$25,289	$9,009	$7,779			
Other Practitioner	$20,522	$7,337	$17,455	$6,225	$5,361			
Other Institutional	-	-	-	-	-			
Other	$2,784	$995	$471	$168	$146			
Total	**$1,819,404**	**$651,084**	**$1,786,932**	**$637,278**	**$553,937**			
PMPM Expenditures								
Inpatient Services	$51.74	$52.80	$55.78	$56.57	$55.47	7.8%	7.1%	-1.9%
Outpatient Services	$39.07	$39.85	$54.95	$55.76	$54.63	40.6%	39.9%	-2.0%
Physician Services	$100.82	$102.86	$99.89	$101.41	$99.30	-0.9%	-1.4%	-2.1%
Prescribed Drugs	$53.44	$54.43	$59.86	$60.67	$59.58	12.0%	11.5%	-1.8%
Psychiatric Services	$0.39	$0.40	$0.61	$0.61	$0.60	53.9%	53.1%	-1.8%
Dental Services	$12.40	$12.65	$12.80	$12.98	$12.74	3.2%	2.6%	-1.8%
Lab and X-Ray	$10.95	$11.17	$12.20	$12.36	$12.16	11.4%	10.7%	-1.6%
Medical Supplies and Orthotics	$4.72	$4.82	$5.36	$5.43	$5.34	13.5%	12.7%	-1.6%
Home Health and Home Care	$3.70	$3.78	$6.84	$6.94	$6.80	84.7%	83.7%	-2.1%
Nursing Facility	-	-	-	-	-	-	-	-
Targeted Case Management	-	-	$0.39	$0.39	$0.39	-	-	-1.8%
Transportation	$4.50	$4.59	$4.48	$4.54	$4.42	-0.6%	-1.1%	-2.6%
Other Practitioner	$3.22	$3.28	$3.09	$3.13	$3.04	-4.0%	-4.4%	-2.9%
Other Institutional	-	-	-	-	-	-	-	-
Other	$0.44	$0.44	$0.08	$0.08	$0.08	-80.9%	-81.0%	-1.7%
Total	**$285.40**	**$291.05**	**$316.33**	**$320.88**	**$314.56**	**10.8%**	**10.2%**	**-2.0%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$420.70**	**75.2%**
Months 13-24	**$433.13**	**72.6%**

Exhibit E-5 – Detailed Expenditure Data – Members w/Diabetes as Most Expensive Diagnosis

	HMP Practice Facilitation Detail - Diabetes							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	2,492	893	2,291	832	737			
Aggregrate Expenditures								
Inpatient Services	$480,373	$171,707	$654,134	$232,381	$199,651			
Outpatient Services	$357,667	$127,878	$331,072	$117,715	$100,889			
Physician Services	$474,779	$169,697	$494,207	$175,665	$150,793			
Prescribed Drugs	$493,798	$176,495	$531,919	$188,835	$162,298			
Psychiatric Services	$34,422	$12,304	$11,230	$3,992	$3,422			
Dental Services	$24,747	$8,844	$18,156	$6,457	$5,539			
Lab and X-Ray	$89,088	$31,836	$114,157	$40,544	$34,837			
Medical Supplies and Orthotics	$64,880	$23,188	$63,040	$22,392	$19,242			
Home Health and Home Care	$16,057	$5,737	$28,739	$10,217	$8,745			
Nursing Facility	-	-	-	-	-			
Targeted Case Management	-	-	-	-	-			
Transportation	$41,648	$14,883	$50,427	$17,921	$15,380			
Other Practitioner	$17,667	$6,311	$21,084	$7,499	$6,428			
Other Institutional	$556	$199	$599	$213	$185			
Other	$62,076	$22,185	$71,163	$25,276	$21,696			
Total	**$2,157,758**	**$771,264**	**$2,389,927**	**$849,107**	**$729,106**			
PMPM Expenditures								
Inpatient Services	$192.77	$192.28	$285.52	$279.30	$270.90	48.1%	45.3%	-3.0%
Outpatient Services	$143.53	$143.20	$144.51	$141.48	$136.89	0.7%	-1.2%	-3.2%
Physician Services	$190.52	$190.03	$215.72	$211.14	$204.60	13.2%	11.1%	-3.1%
Prescribed Drugs	$198.15	$197.64	$232.18	$226.97	$220.21	17.2%	14.8%	-3.0%
Psychiatric Services	$13.81	$13.78	$4.90	$4.80	$4.64	-64.5%	-65.2%	-3.2%
Dental Services	$9.93	$9.90	$7.92	$7.76	$7.52	-20.2%	-21.6%	-3.1%
Lab and X-Ray	$35.75	$35.65	$49.83	$48.73	$47.27	39.4%	36.7%	-3.0%
Medical Supplies and Orthotics	$26.04	$25.97	$27.52	$26.91	$26.11	5.7%	3.6%	-3.0%
Home Health and Home Care	$6.44	$6.42	$12.54	$12.28	$11.87	94.7%	91.2%	-3.4%
Nursing Facility	-	-	-	-	-	-	-	-
Targeted Case Management	-	-	-	-	-	-	-	-
Transportation	$16.71	$16.67	$22.01	$21.54	$20.87	31.7%	29.2%	-3.1%
Other Practitioner	$7.09	$7.07	$9.20	$9.01	$8.72	29.8%	27.5%	-3.2%
Other Institutional	$0.22	$0.22	$0.26	$0.26	$0.25	17.3%	15.2%	-2.2%
Other	$24.91	$24.84	$31.06	$30.38	$29.44	24.7%	22.3%	-3.1%
Total	**$865.87**	**$863.68**	**$1,043.18**	**$1,020.56**	**$989.29**	**20.5%**	**18.2%**	**-3.1%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$1,449.15**	**72.0%**
Months 13-24	**$1,486.85**	**66.5%**

Exhibit E-6 – Detailed Expenditure Data – Members w/Heart Failure as Most Expensive Diagnosis

	HMP Practice Facilitation Detail - Heart Failure							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	210	74	168	60	54			
Aggregrate Expenditures								
Inpatient Services	$138,405	$49,596	$209,466	$73,675	$64,588			
Outpatient Services	$68,036	$24,349	$77,647	$27,274	$23,936			
Physician Services	$52,733	$18,886	$67,226	$23,632	$20,735			
Prescribed Drugs	$24,974	$8,938	$14,578	$5,121	$4,511			
Psychiatric Services	-	-	-	-	-			
Dental Services	$3,293	$1,179	$258	$91	$80			
Lab and X-Ray	$10,060	$3,600	$12,407	$4,358	$3,855			
Medical Supplies and Orthotics	$12,244	$4,379	$4,401	$1,545	$1,358			
Home Health and Home Care	$3,837	$1,374	$4,084	$1,435	$1,265			
Nursing Facility	-	-	-	-	-			
Targeted Case Management	$0	$0	$617	$218	$190			
Transportation	$4,623	$1,655	$9,200	$3,232	$2,838			
Other Practitioner	$1,049	$375	$382	$135	$116			
Other Institutional	-	-	-	-	-			
Other	-	-	-	-	-			
Total	**$319,254**	**$114,331**	**$400,265**	**$140,715**	**$123,471**			
PMPM Expenditures								
Inpatient Services	$659.07	$670.22	$1,246.82	$1,227.92	$1,196.07	89.2%	83.2%	-2.6%
Outpatient Services	$323.98	$329.04	$462.19	$454.57	$443.25	42.7%	38.2%	-2.5%
Physician Services	$251.11	$255.22	$400.15	$393.86	$383.98	59.4%	54.3%	-2.5%
Prescribed Drugs	$118.93	$120.79	$86.77	$85.35	$83.55	-27.0%	-29.3%	-2.1%
Psychiatric Services	-	-	-	-	-	-	-	-
Dental Services	$15.68	$15.94	$1.53	$1.51	$1.47	-90.2%	-90.5%	-2.3%
Lab and X-Ray	$47.91	$48.65	$73.85	$72.63	$71.39	54.2%	49.3%	-1.7%
Medical Supplies and Orthotics	$58.30	$59.18	$26.19	$25.75	$25.16	-55.1%	-56.5%	-2.3%
Home Health and Home Care	$18.27	$18.56	$24.31	$23.92	$23.43	33.1%	28.9%	-2.1%
Nursing Facility	-	-	-	-	-	-	-	-
Targeted Case Management	$0.00	$0.00	$3.67	$3.63	$3.51	-	-	-3.2%
Transportation	$22.01	$22.36	$54.76	$53.87	$52.55	148.8%	140.9%	-2.4%
Other Practitioner	$4.99	$5.07	$2.27	$2.25	$2.15	-54.5%	-55.7%	-4.2%
Other Institutional	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-
Total	**$1,520.26**	**$1,545.02**	**$2,382.53**	**$2,345.24**	**$2,286.51**	**56.7%**	**51.8%**	**-2.5%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$1,839.38**	**129.5%**
Months 13-24	**$1,883.94**	**121.3%**

Exhibit E-7 – Detailed Expenditure Data – Participants w/Hypertension as Most Expensive Diagnosis

	HMP Practice Facilitation Detail - Hypertension							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	4,598	1,650	4,256	1,543	1,368			
Aggregrate Expenditures								
Inpatient Services	$1,070,017	$382,543	$948,379	$336,556	$290,202			
Outpatient Services	$478,811	$171,191	$489,564	$173,853	$149,734			
Physician Services	$872,144	$311,801	$712,948	$252,850	$217,587			
Prescribed Drugs	$514,422	$183,900	$718,809	$254,913	$219,448			
Psychiatric Services	$19,517	$6,976	$15,173	$5,390	$4,634			
Dental Services	$50,852	$18,176	$40,301	$14,325	$12,287			
Lab and X-Ray	$132,796	$47,470	$165,259	$58,639	$50,407			
Medical Supplies and Orthotics	$26,580	$9,500	$17,546	$6,229	$5,352			
Home Health and Home Care	$16,454	$5,882	$27,916	$9,899	$8,532			
Nursing Facility	-	-	$0	$0	$0			
Targeted Case Management	-	-	$2,821	$1,002	$860			
Transportation	$63,346	$22,640	$67,822	$24,061	$20,664			
Other Practitioner	$27,889	$9,967	$24,720	$8,758	$7,546			
Other Institutional	-	-	$288	$102	##############			
Other	$5,512	$1,970	$12,048	$4,280	$3,673			
Total	**$3,278,340**	**$1,172,016**	**$3,243,594**	**$1,150,857**	**$991,015**			
PMPM Expenditures								
Inpatient Services	$232.71	$231.84	$222.83	$218.12	$212.14	-4.2%	-5.9%	-2.7%
Outpatient Services	$104.13	$103.75	$115.03	$112.67	$109.46	10.5%	8.6%	-2.9%
Physician Services	$189.68	$188.97	$167.52	$163.87	$159.05	-11.7%	-13.3%	-2.9%
Prescribed Drugs	$111.88	$111.45	$168.89	$165.21	$160.42	51.0%	48.2%	-2.9%
Psychiatric Services	$4.24	$4.23	$3.57	$3.49	$3.39	-16.0%	-17.4%	-3.0%
Dental Services	$11.06	$11.02	$9.47	$9.28	$8.98	-14.4%	-15.7%	-3.3%
Lab and X-Ray	$28.88	$28.77	$38.83	$38.00	$36.85	34.4%	32.1%	-3.0%
Medical Supplies and Orthotics	$5.78	$5.76	$4.12	$4.04	$3.91	-28.7%	-29.9%	-3.1%
Home Health and Home Care	$3.58	$3.56	$6.56	$6.42	$6.24	83.3%	80.0%	-2.8%
Nursing Facility	-	-	-	-	-	-	-	-
Targeted Case Management	-	-	$0.66	$0.65	$0.63	-	-	-3.2%
Transportation	$13.78	$13.72	$15.94	$15.59	$15.11	15.7%	13.6%	-3.1%
Other Practitioner	$6.07	$6.04	$5.81	$5.68	$5.52	-4.2%	-6.0%	-2.8%
Other Institutional	-	-	$0.07	$0.07	$0.06	-	-	-3.5%
Other	$1.20	$1.19	$2.83	$2.77	$2.68	136.1%	132.3%	-3.2%
Total	**$712.99**	**$710.31**	**$762.12**	**$745.86**	**$724.43**	**6.9%**	**5.0%**	**-2.9%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$1,345.08**	**56.7%**
Months 13-24	**$1,375.27**	**52.7%**

Exhibit E-8 – Detailed Expenditure Data – All Other Members

	HMP Practice Facilitation Detail - All Others							
Category of Service	Pre-Engagement: 1-12 Months (Accumulated Total)	Pre-Engagement: 1-12 Months (FY15 Total)	Engaged Period: 3 to 12 Months (Accumulated Total)	Engaged Period: 3 to 12 Months (FY15 Total)	Engaged Period: 13 to 24 Months (FY15 Total)	Percent Change (Accumulated/ Accumulated)	Percent Change (FY15 Pre Engage/FY 3-12 Engaged)	Percent Change (FY15 3-12 Engage/FY15 13-24 Engage)
Member Months	102,769	36,240	89,436	31,640	28,052			
Aggregrate Expenditures								
Inpatient Services	$3,798,126	$1,357,207	$3,742,716	$1,333,304	$1,165,490			
Outpatient Services	$3,736,808	$1,336,522	$3,772,009	$1,344,981	$1,173,898			
Physician Services	$7,520,740	$2,687,925	$7,320,582	$2,611,577	$2,277,859			
Prescribed Drugs	$5,406,261	$1,932,325	$5,413,141	$1,932,413	$1,684,202			
Psychiatric Services	$8,016,389	$2,865,246	$6,762,959	$2,412,796	$2,103,665			
Dental Services	$2,063,803	$737,426	$1,634,841	$583,292	$508,264			
Lab and X-Ray	$894,979	$319,926	$1,115,709	$398,341	$346,907			
Medical Supplies and Orthotics	$212,648	$76,010	$197,406	$70,389	$61,441			
Home Health and Home Care	$136,658	$48,851	$96,755	$34,502	$30,096			
Nursing Facility	-	-	$13,732	$4,893	$4,274			
Targeted Case Management	$64,848	$23,178	$54,357	$19,393	$16,906			
Transportation	$483,431	$172,779	$423,404	$150,954	$131,727			
Other Practitioner	$725,979	$259,450	$523,466	$186,617	$162,879			
Other Institutional	$13,297	$4,752	$33,323	$11,880	$10,574			
Other	$501,797	$179,354	$313,085	$111,698	$97,397			
Total	**$33,575,764**	**$12,000,951**	**$31,417,484**	**$11,207,029**	**$9,775,578**			
PMPM Expenditures								
Inpatient Services	$36.96	$37.45	$41.85	$42.14	$41.55	13.2%	12.5%	-1.4%
Outpatient Services	$36.36	$36.88	$42.18	$42.51	$41.85	16.0%	15.3%	-1.6%
Physician Services	$73.18	$74.17	$81.85	$82.54	$81.20	11.8%	11.3%	-1.6%
Prescribed Drugs	$52.61	$53.32	$60.53	$61.08	$60.04	15.1%	14.5%	-1.7%
Psychiatric Services	$78.00	$79.06	$75.62	$76.26	$74.99	-3.1%	-3.5%	-1.7%
Dental Services	$20.08	$20.35	$18.28	$18.44	$18.12	-9.0%	-9.4%	-1.7%
Lab and X-Ray	$8.71	$8.83	$12.47	$12.59	$12.37	43.2%	42.6%	-1.8%
Medical Supplies and Orthotics	$2.07	$2.10	$2.21	$2.22	$2.19	6.7%	6.1%	-1.5%
Home Health and Home Care	$1.33	$1.35	$1.08	$1.09	$1.07	-18.6%	-19.1%	-1.6%
Nursing Facility	-	-	$0.15	$0.15	$0.15	-	-	-1.5%
Targeted Case Management	$0.63	$0.64	$0.61	$0.61	$0.60	-3.7%	-4.2%	-1.7%
Transportation	$4.70	$4.77	$4.73	$4.77	$4.70	0.6%	0.1%	-1.6%
Other Practitioner	$7.06	$7.16	$5.85	$5.90	$5.81	-17.1%	-17.6%	-1.6%
Other Institutional	$0.13	$0.13	$0.37	$0.38	$0.38	188.0%	186.3%	0.4%
Other	$4.88	$4.95	$3.50	$3.53	$3.47	-28.3%	-28.7%	-1.7%
Total	**$326.71**	**$331.15**	**$351.28**	**$354.20**	**$348.48**	**7.5%**	**7.0%**	**-1.6%**

	Forecasted (FC) Costs	Actual % of FC
First 12 Months	**$589.25**	**59.6%**
Months 13-24	**$603.27**	**57.8%**

2016

CENTRAL COMMUNITIES HEALTH ACCESS NETWORK

MILESTONES AND REPORTING MEASURES

Report Year 2016 (July 2015-June 2016)

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ANNUAL REPORT: 2016

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, due September 30 annually. In addition, periodic reports with data supporting the HANs effectiveness will be reported at administrative meetings with OHCA staff throughout the Report Year.

1. **Number of PCPs by name and panel size affiliated with the HAN for the current month.**

There were 24 (unduplicated) PCPs affiliated with the HAN as of 6/30/2016. Three of the 24 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 June 2016 are presented in Table 1.

Table 1: CC-HAN Affiliated PCPs for RY 16

Yukon Pediatrics [redacted] 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 May, Julie D., ARNP Sherry, Alex, PA Panel size for June 2016: 726	Canadian Valley Family Care [redacted] Family Practice, 0-18 years of age 1491 Health Center Pkwy. Yukon, Ok (405) 806-2200 Brown, Curtis L., MD Brown, James M., DO (also associated with Mustang Urgent Care) Krittenbrink, Andrea L., PA-C (also associated with Mustang Urgent Care) Roof, Lindsay K., APRN Siems, Ami L., MD Wilbanks, Aaron P., DO (also associated with Mustang Urgent Care) Panel size for June 2016: 614
Flores Pediatrics LLC [redacted] Pediatrics, 0-18 years of age 415 E. Main St. Ste B2 Yukon, Ok (405) 350-3000 Flores, Catherine B., MD Flores, Javier A., MD Panel size for June 2016: 1442	Vladimir Holy, MD PC [redacted] No age restrictions 2315 Park View Dr El Reno, OK (405) 422-6337 Vladimir Holy, MD Karen Kyte, PA

	Panel size for June 2016: 287
Mustang Family Physicians, PC [redacted] Family Practice, 0-14 years of age 206 N. Mustang Mall Terr. Mustang, Ok (405) 256-6000 Amundsen II, Gerald A., MD Halcomb, Monica L., CNP Panel size for June 2016: 469	Mustang Urgent Care [redacted] 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 (also associated with Canadian Valley Family Care) Kelly, Shelly A., ARNP Laflan, Tylor R., PA Mathew, Rohit, PA Medgaarden, Alex E., PA Sturlin, Candace L., PA Krittenbrink, Andrea L., PA (also associated with Canadian Valley Family Care) Wilbanks, Aaron P., DO (also associated with Canadian Valley Family Care) Panel size for June 2016: 179

Table 2: CC-HAN Benefit Enrollment Counts for June 14 - June 16

PCP	June 2014	June 2015	June 2016
Vladimir Holy, MD	503	422	288
Yukon Pediatrics	570	560	726
Flores Pediatrics	1621	1486	1442
Canadian Valley Family Care	417	526	614
Mustang Family Physicians	606	490	469
Mustang Urgent Care	139	153	179
Total Count	3,856	3,637	3,718

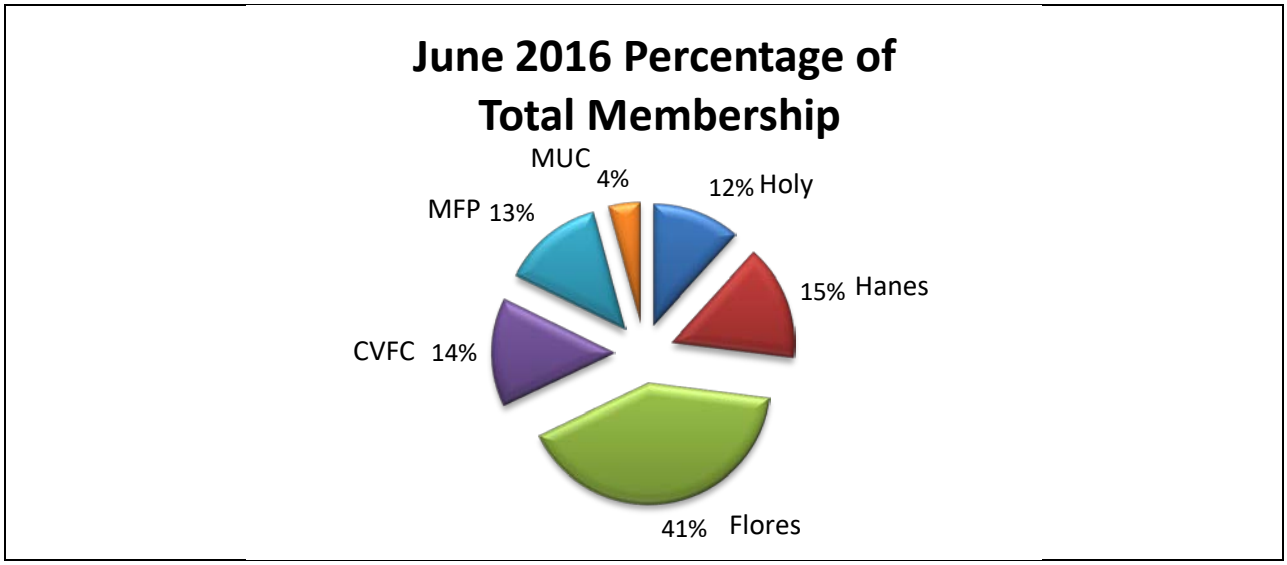

Table 3: CC-HAN Monthly/Total Members for RY 15 and RY 16		
Month	RY 15	RY 16
Jul	3376	3582
Aug	3387	3559
Sep	3379	3457
Oct	3402	3380
Nov	3486	3485
Dec	3449	3528
Jan	3478	3384
Feb	3514	3490
Mar	3524	3531
Apr	3499	3597
May	3655	3658
June	3637	3718
TOTAL CC-HAN Members	41,786	42,369

Table 2 presents a "snapshot survey" by comparing Provider panel sizes in the last month of RYs 14, 15, and 16. The slight upward trend in total enrollments for June FY 16 is important considering that the change to remove members from SoonerCare who had other insurance was a major reason for the decline in RY 15. However, the significant decline in one PCP's enrollment, seen over the three year period, is of note.

Table 3 also shows a slight growth trend in total members for RY 16 over RY 15. Efforts were underway at the end of RY 16 to recruit another group to join CC-HAN, which will both strengthen the HAN and add positive support for the (new) Providers and additional SC members.

2. Number of Tier 1 or 2 PCPs identified by name for assistance with tier step-up by tier type for RY 2016.

Canadian Valley Family Care was assisted in attaining Tier 2 status in fall 2014; CC-HAN support is ongoing. As of 6/30/2016, CVFC chooses to maintain Tier 2 status.

Dr. Alecia Hanes (now Yukon Pediatrics) was provided assistance with step-up to Tier 3 status in summer/fall of 2012 and has remained Tier 3 since. CC-HAN support is ongoing.

Flores Pediatrics maintains Tier 3 status; CC-HAN support is ongoing.

Dr. Vladimir Holy was provided assistance with moving from Tier 2 status to Tier 3 status in 2013; ongoing CC-HAN support continues.

Mustang Family Physicians maintains Tier 3 status; CC-HAN support is ongoing.

Mustang Urgent Care was provided assistance with meeting Tier 2 status requirements in December 2013/early spring 2014; CC-HAN support is ongoing, including assistance with a July 2016 Medical Home Performance Audit**.**

3. Documentation of steps taken to assist PCPs in maintaining or advancing their tier designation for RY 2015.

Canadian Valley Family Care:

- **July 2015:**
  - Informed re: August OHCA Board Retreat panel presentation, asking for input on members who might participate.
  - Sent PHPG SC Annual Evaluation Report results, thanking them for participation and support through providing Medical Home.
  - Obtained updated contact info for ER3 user.
- **August 2015:**
  - Contact made with OHCA Provider Educator to assist with question about PT billing.
  - Contact made requesting consideration of member (from ER user list) for AIP; approval received.
  - Information on upcoming community Baby Shower was provided, included delivery (both sites) of brochures for their clientele.
  - CC-HAN website promotion brochures delivered (both sites).
  - Updated contact info obtained for (3) ER3 users and (1) ER2 user.
- **September 2015:**
  - Communications with Dr. Jim Brown about Canadian County Board of Health responsibilities/meeting; project manager recommended him for CCHD Board of Health Physician position.

  - Clarified with CVFC staff that we are contacting members to encourage EPSDT visits.
  - Worked with staff to obtain office visits made in past RY by ER users.
  - Delivered ER3 roster for Q2 and also picked up business cards for distribution at upcoming Baby Shower.
- **October 2015:**
  - F/u provided to ensure billing question had been resolved with assistance of Provider Educator.
- **November 2015:**
  - Information provided re: care management support of their members as requested.
  - Office visit to pick up current contact info and appointment schedules for members receiving care management services.
- **December 2015:**
  - Sent request to office manager for list of members with asthma from their EMR by 1/29/16.
  - Delivery of holiday baskets (both sites) from CC-HAN staff.
- **January 2016:**
  - Confirmed CC-HAN role in contacting members due for EPSDT visits.
  - Received list of members with asthma diagnosis(es) in EMR for completion of CY 15 Hypothesis 7 report.
- **February 2016:**
  - Received "concerns" from Provider re: OHCA attempting to "recoup" funds from allergy testing "after 2 years" and possible repercussions; encouraged to continue contract with OHCA to provide Medical Home.
  - Clarified Behavioral Health screening requirements, sending information including screening tools.
  - Also clarified reimbursement for Behavioral Health screenings, sent information on how to submit claims.
  - Confirmed Tier 2 level for CVFC and requirements.
  - Assisted referral nurse who had received request for "facility referral" for member; called facility (CV Integris) and learned that the request was an error on their part; reported same back to referral nurse.
- **March 2016:**
  - Clarified incentive payment denials (delays) for Behavioral Health screenings after receiving question about "denials" and consulting with M. Anthony.
  - Discussed questions about PT billing using CVFC Provider ID; referred to Provider Helpline for assistance.
- **April 2016**:
  - Hypothesis 7 Report sent, including a request for current list of members with asthma diagnoses (Q1 16).
  - Received current list (Q1 2016) of members with asthma diagnoses.
  - Information requested about intent to continue with Medical Home contract; received info that final decision was pending but they are "closed to new members." Responded encouraging them to continue with contract.
  - Information provided about Doc2Doc online referral/consult system and requested time to schedule Lyn Denny from OU HAN to demonstrate/explain.
  - Information sent about upcoming Provider meeting, 6/16/16.

- **May 2016**:
  - Provided info on sources for educational/training materials as they plan on purchasing DVDs for training new employees.
  - Sent Provider Education: CC-HAN AIP document, outlining positive outcomes of AIP; received feedback from Dr. Jim Brown about allergies and asthma, also positive feedback about AIP.
  - Tentative agenda for PCP meeting in June sent, asking for input.
- **June 2016:**
  - Two reminders sent about 6/16/2016 PCP meeting with agenda attached.
  - Sent request for Q2 16 list of members with asthma diagnoses for Hypothesis 7 interim report.

Flores Pediatrics:

- **July 2015:**
  - Informed re: August OHCA Board Retreat panel presentation, asking for input on members who might participate.
  - Sent PHPG SC Annual Evaluation Report results, thanking them for participation and support through providing Medical Home.
  - Consults for three AIP members, incl. pick-up of plans for two new members.
  - Obtained SC RID for 2 "other" members referred for care management support.
  - Delivered latest EPSDT (paper) roster.
- **August 2015:**
  - Information on upcoming community Baby Shower was provided, included delivery of brochures for their clientele.
  - Accepted referral to assist adolescent member find drug counseling resources; f/u with member occurred with options provided. F/u information provided to Provider.
  - Phone consult re: possible new AIP member (from ER list) and for updated info on 2 other AIP members.
  - Updated contact and latest appointment info requested for recent ER users.
  - Delivered latest EPSDT list.
  - Delivered CC-HAN website promotion brochures.
- **September 2015:**
  - Care manager delivered groceries/personal/household care items to parent of member at office.
  - Worked with staff to obtain office visits made in past RY by ER users.
  - Obtained current contact and appointment info for AIP member.
  - Contact and appointment info obtained for member from Inpt report.
  - Delivered ER3 user roster for Q2 2015 and picked up business cards for Baby Shower distribution.
  - Contact and appointment info obtained for members on ER 3 roster.
  - Delivered latest EPSDT list.
- **October 2015:**
  - Office visit to work with staff re: referrals for AIP and other "member needs."
  - Delivered monthly (Sep) ER/Inpt rosters and request current contact info/appointment schedules for each member on rosters.

  - Office visit by AIP care manager to pick up info on AIP member; also confirmed flu vaccine availability.
- **November 2015:**
  - Information provided office manager about ICD 10 training opportunities.
  - Current contact info requested for AIP member.
  - Current contact info and appointment schedules requested for ER users.
  - Office visit to pick up member contact/appointment schedules for ER users.
- **December 2015:**
  - Sent request to office manager for list of members with asthma from their EMR by 1/29/16.
  - Delivery of holiday baskets from CC-HAN staff.
  - Scheduled Communicable Diseases training for Jan 16.
- **January 2016:**
  - Received list of members with asthma diagnoses in EMR for completion of CY 15 Hypothesis 7 report.
  - Communicable Diseases training provided by project manager.
- **February 2016:**
  - Follow-up on member needs upon request.
  - Pick-up of AIP member progress notes.
  - Requested consideration of a new member for AIP participation.
  - Requested consideration of ENT referral for AIP member.
- **March 2016:**
  - Assistance provided referral nurse in locating a room for special event.
  - AIP care manager conferred re: possible AIP participation for 3 members with recent ER visits for asthma.
- **April 2016:**
  - CY 15 Hypothesis 7 Report sent; also requesting Q1 16 list of members with asthma diagnoses for interim report.
  - Received current list (Q1 2016) of members with asthma diagnoses.
  - Information provided about Doc2Doc online referral/consult system and requested time to schedule Lyn Denny from OU HAN to demonstrate/explain.
  - Information sent about upcoming Provider meeting, 6/16/16.
  - AIP care manager requested consideration of member for engagement based on ER visit (asthma diagnosis).
- **May 2016:**
  - Sent Provider Education: CC-HAN AIP document, outlining positive outcomes of AIP.
  - Tentative agenda for PCP meeting in June sent, asking for input.
  - AIP participation requested for member who has upcoming appointment.
- **June 2016:**
  - Two PCP meeting reminders sent with agenda attached.
  - PCP meeting with Kristi Maddox representing Flores' Pediatrics.
  - Sent request for Q2 list of members with asthma diagnoses for interim Hypothesis 7 report.

Alecia Hanes, MD:

- **July 2015:**
  - Informed re: August OHCA Board Retreat panel presentation, asking for input on members who might participate.
  - Sent PHPG SC Annual Evaluation Report results, thanking them for participation and support through providing Medical Home.
  - Updated contact info obtained for 1 ER 3 user; 1 Inpatient; 1 "other" member.
  - Staffed with PA re: 3 "other" members, 1 ER 3 user.
- **August 2015:**
  - Sent congratulatory e-mail for 30th anniversary of Dr. Hanes' pediatric practice in Yukon as well as confirmation that CC-HAN would participate in Open House.
  - Information on upcoming community Baby Shower was provided, including delivery of brochures for their clientele.
  - Confirmation of (current) Provider information was requested and received for AR 15.
  - Updated contact/appointment info obtained for ER2 members.
  - Delivered CC-HAN website promotion brochures.
  - Referral process to SOC completed for two members.
  - Contacted and received approval to engage recent ER user in AIP; process completed.
  - Updated contact and appointment info obtained for recent ER2 users.
- **September 2015:**
  - Facilitated transfer of AIP member to Dr. Hanes' roster to ensure continuity of care.
  - CC-HAN staff participated in 30th Anniversary Celebration/Community Event for Dr. Hanes' practice.
  - CC-HAN care manager addressed needs (including TEFRA and DLN) for four other members.
  - CC-HAN staff assisted with transportation needs of mother with two small children.
  - Worked with staff to obtain office visits made in past RY by ER users.
  - Contacted/obtained approval to engage member with ER visit in AIP.
- **October 2015:**
  - Received and f/u provided for "other" member in need of care management support.
  - Researched and reported on speech and OT services available in Ada area, where member was moving.
  - Received questions/concerns re: Health Home MOU from Red Rock; project manager coordinated planning for meeting to address concerns/educate Provider re: Health Home vs. Medical Home.
  - Referral completed to SOC for one member.
  - Received referral of "other" member for care management services; care manager picked up info from office.
- **November 2015:**
  - Meeting held at Dr. Hanes' office to discuss with Red Rock administrative staff Health Home info/other services available for members; questions addressed, concerns resolved.
  - Reports provided on 2 "other" members referred for care management.
  - Received referral for food needs for one "other" member/family; groceries delivered to office; family also needed clothing so care manager met them at church clothing resource.
  - Completed SOC referral for one member.

- Provided contact info for SOC personnel at Provider's request; also reported that one member referred for SOC lives in OK County and is not eligible for services from Canadian County.

- **December 2015:**
  - Sent request to office manager for list of members with asthma from their EMR by 1/29/16.
  - Delivery of holiday baskets from CC-HAN staff.
  - Follow-up on needs/support provided to "other" members.
- **January 2016:**
  - Received list of members with asthma diagnoses in EMR for completion of Hypothesis 7 report.
  - Provided care management support for 5 "other" member referrals.
  - Care manager provided assistance for referral to SOC (another county) for member.
- **February 2016:**
  - CC-HAN staff facilitated Systems of Care referral for member as well as providing parent of member referral for Oklahoma Family Network.
  - Provided care management support for 7 "other" members.
  - Clarified with Provider error on ER Monthly Report r/t diagnosis of "accidental alcohol poisoning"; error was a result of switch to ICD 10; actual diagnosis was gastroenteritis.
  - Provided DVD on HIPAA training for new staff.
  - Care manager facilitated transfer of AIP member to Dr. Hanes' roster to provide evening appointments to fit parent's work schedule.
  - Three phone consults about AIP members, including discussion re: flu immunizations.
  - One request for new AIP member based on Risk Assessment data.
- **March 2016:**
  - Provided care management support for 3 "other" members.
  - Assisted with speech therapy referral for member.
  - CC-HAN provided training materials on HIPAA and Breach Notification for new office staff.
  - Care manager reported back on SOC referral; SOC staff reported no contact was made with parent.
  - AIP care manager requested referral for AIP of member with ER visit, asthma diagnosis.
- **April 2016:**
  - Hypothesis 7 Report sent; also requesting current list of members with asthma diagnoses.
  - Received list of Q1 members with asthma diagnosis.
  - Information provided about Doc2Doc online referral/consult system and requested time to schedule Lyn Denny from OU HAN to demonstrate/explain.
  - Information sent about upcoming Provider meeting, 6/16/16.
  - Continued care management support for 4 "other" members.
  - At request of Provider, sent copy of PHCC Personnel Policies for their review.
- **May 2016:**
  - Sent Provider Education: CC-HAN AIP document, outlining positive outcomes of AIP.

- Tentative agenda for PCP meeting in June sent, asking for input.
- Care manager consult re: SOC referral for three members; f/u referrals completed for two members.

- **June 2016:**
  - Two PCP meeting reminders sent, including agenda.
  - PCP meeting with Dr. Hanes and three office staff personnel present.
  - Sent request for Q2 list of members with asthma diagnoses for interim Hypothesis 7 report.

Vladimir Holy, MD:

- **July 2015:**
  - Informed re: August OHCA Board Retreat panel presentation, asking for input on members who might participate.
  - Sent PHPG SC Annual Evaluation Report results (pertinent to HAN), thanking them for participation.
  - Facilitated communications between MFP and Dr. Holy's office r/t staffing matter.
  - Consult with office staff about "other" member receiving care management support.
  - Delivered latest EPSDT list.
- **August 2015:**
  - Provided information on upcoming community Baby Shower, including delivery of brochures for their clientele.
  - Researched and developed written guidelines for how to request accompaniment for member through SoonerRide; delivered to office with f/u verbal instructions.
  - Assisted in finding opthamology specialist referral option for member.
  - Addressed referral "issues" with staff, asking them to provide information on specialists who "do not accept online referrals" so that Provider Educator services can be requested.
  - Provided (copied) EPSDT list for August, explaining how CC-HAN has incorporated contacting members for Quality Measure.
- **September 2015:**
  - Worked with staff, OHCA personnel, and parent of member to develop plan for continuation of services for parent who "forgot" or "did not receive notice" to renew SC benefits.
  - Coordination of care for Pharmacy LI members occurred, incl. review of OBN reports.
  - Met with new staff RN to explain/review Tier 3 requirements.
  - Worked with staff to obtain office visits made in past RY by ER users.
  - Obtained current contact info and appointment dates for current ER users.
  - Current contact info and appointment dates for member with Inpatient stay.
- **October 2015:**
  - Ongoing work with Dr. Holy r/t his desire to add Behavioral Health services to his practice; efforts made to coordinate meeting.

- Facilitated resolution of concerns from Dr. Holy and staff re: medical records requests from Red Rock for member who remains on their roster.
- Care manager contacted Provider with concerns re: member (ER user).
- Office visit to deliver monthly (September) ER/Inpt rosters and request information.
- Office visit to pick up info (current contact and appointment schedules) for ER/Inpt roster members.
- Two phone consultations re: AIP member recently hospitalized.

- **November 2015:**
  - Resolved concerns r/t care for Pharmacy LI member.
  - Current contact info and appointment schedule requested for ER 3 user; obtained by phone.
- **December 2015:**
  - Sent request to office manager for list of members with asthma from their EMR by 1/29/16.
  - Delivery of holiday baskets from CC-HAN staff.
- **January 2016:**
  - Received list of members with asthma diagnoses in EMR for completion of Hypothesis 7 report.
  - Project manager met with Dr. Holy to provide information on Tier requirements (1-3) for his review/consideration for future. Provided subsequent clarification to office manager.
  - Provided Communicable Diseases training for office staff.
  - Provided f/u care management support to adult member at Dr. Holy's request (diabetes supplies).
  - Reviewed with new staff member requirements for Behavioral Health Screenings.
  - Clarified with new staff member referral requirements for member with Title 19 benefits.
  - Delivered (hard) copy of EPSDT rosters for past 3 months, reminding staff that CC-HAN has clerk who contacts these members' parent/guardian.
- **February 2016**
  - Clarified (post consulting with M. Anthony) OHCA position on documenting PMP review in medical records.
  - Project manager met with Red Rock Behavioral Health administrative staff to determine possibility of their placing staff in Dr. Holy's office "few hours" monthly for behavioral health screenings/services; reported their willingness to consider and meet with Dr. Holy for further discussion; attempted (several times) to schedule meeting with Dr. Holy.
  - F/u care management support provided to parent of three members who made appointments for well-child visits and were no-call, no-show.
  - Assisted new staff member with use of online referral system to find pain management specialist for member.
  - AIP care manager conferred about hospitalizations of AIP member.
  - Delivery of CC-HAN website promotion brochures and pens.

- **March 2016:**
  - Received "complaint" about proposed "25% rate cut for Providers"; provided support/info that this was "proposal only and reflects worst case scenario."

- Continued efforts to schedule time for Dr. Holy to meet with Red Rock staff; confirmed through in-person meeting with Dr. Holy that he wanted to "proceed with this plan."
- Received e-mail with attachment of Dr. Holy's referrals that have not been read through online referral system; forwarded attachment to M. Anthony for Provider Educator support.
- Clarified with Dr. Holy's staff that letter of intent to be a Health Home Provider signed (over a year ago) with Red Rock was no longer valid; Dr. Holy was paid x1.

- **April 2016:**
  - Consult on member issues (x3), decision to drug test; consulted M. Anthony re: reimbursement options, received code; provided info. Also encouraged referral to Red Rock for BHS for member.
  - Sent Dr. Holy invitation to join Qliqsoft, a HIPAA certified (and free) instant messaging system; office manager stated they would participate after explaining how system would facilitate communications.
  - F/u communications with office manager about proposed rate cuts, explaining that "hopefully" legislature would find other ways to avoid cuts to OHCA, noting time framework of budgeting process (late May before we may know for sure).
  - Hypothesis 7 Report sent for CY 15; also requested current list of members with asthma diagnoses for Q1 16 interim report.
  - Information provided about Doc2Doc online referral/consult system and requested time to schedule Lyn Denny from OU HAN to demonstrate/explain.
  - Information sent about upcoming Provider meeting, 6/16/16.
  - Received Q1 16 list of members with asthma diagnoses.
- **May 2016:**
  - Notified on 5/4/16 that "Medicaid Performance Audit" was occurring on this date; project manager agreed to participate in (6 hour) process.
  - Prepared a policy on use of EMR and sent to office manager on 5/4/16.
  - Received request for assisting a member with diabetes supplies; f/u care management support provided. Learned of "issues" at specialist's office and referred to M. Anthony, requesting Provider Educator to assist specialist's staff with prior auth process.
  - Sent Provider Education: CC-HAN AIP document, outlining positive outcomes of AIP.
  - Tentative agenda for PCP meeting in June sent, asking for input.
- **June 2016:**
  - Two reminders sent about PCP meeting on 6/16/16, agenda attached.
  - Notified that Dr. Holy would be in attendance (but was unable to make).
  - Sent request for Q2 16 list of members with asthma diagnoses for interim Hypothesis 7 report.

Mustang Family Physicians:

- **July 2015:**
  - Informed re: August OHCA Board Retreat panel presentation, asking for input on members who might participate.

- Sent PHPG SC Annual Evaluation Report results, thanking them for participation and support through providing Medical Home.
- Facilitated communications between MFP and Dr. Holy's office r/t staffing matter.
- Updated contact info obtained on Inpatient member.
- Phone update by care manager on ER3 user.
- In-office staffing on ER3 user.
- Delivered latest EPSDT list.

- **August 2015:**
  - Information on upcoming community Baby Shower was provided, included delivery of brochures for their clientele.
  - Sent all Providers PowerPoint presentation (OHCA Board Retreat presentation) on AIP outcomes, thanking them for referring members.
  - Contacted re: possible AIP participation for recent ER user.
- **September 2015:**
  - Worked with staff to obtain office visits made in past RY by ER users for AR 15.
  - Delivered ER Q2 2015 roster and obtained current contact info and appointment schedules for (roster) members.
  - Delivered latest EPSDT list and agreed that need no longer exists to provide these as they have access to same.
  - Contacted Provider to determine if 2 members with recent ER visits were appropriate for AIP; neither was referred.
  - Picked up business cards to distribute through Baby Shower.
- **October 2015:**
  - Delivered monthly (September) ER and Inpt rosters with request for current contact info and appointment schedules.
  - Requested current contact info for ER3 user.
  - Requested current contact info for ER 2 user.
  - Office visit to pick-up member information.
- **December 2015:**
  - Sent request to office manager for list of members with asthma from their EMR by 1/29/16.
  - Delivery of holiday baskets from CC-HAN staff.
- **January 2016:**
  - Received list of members with asthma diagnoses in EMR for completion of Hypothesis 7 report.
  - Collaborated with staff re: new HROB member; never seen by MFP though on roster now.
- **March 2016:**
  - AIP care manager requested consideration of member with ER visit (asthma diagnosis) for AIP; received info member was no longer seen at MFP.
- **April 2016:**
  - CY 15 Hypothesis 7 Report sent; also requested current list of members with asthma diagnoses for Q1 16 interim report.
  - Received Q1 16 list of members with asthma.
  - Information provided about Doc2Doc online referral/consult system and requested time to schedule Lyn Denny from OU HAN to demonstrate/explain.
  - Information sent about upcoming Provider meeting, 6/16/16.

  - Communicable Diseases presentation on 4/26/16; also discussed proposed rate cuts, "how OHCA might cut costs", and other input r/t AIP.
  - Notified that Dr. Amundsen would be out of country on date of PCP meeting; encouraged to send Monica and Rebecca.
- **May 2016:**
  - Sent Provider Education: CC-HAN AIP document, outlining positive outcomes of AIP.
  - Tentative agenda for PCP meeting in June sent, asking for input.
  - Communications with office manager about meeting to discuss MU reimbursement options; meeting requested with from OMFQ rep.
  - AIP referral requested for one member based on ER visit (asthma diagnosis).
- **June 2016:**
  - Two PCP meeting reminders sent with attached agenda.
  - PCP meeting on 6/16/16 with Monica Halcomb, CNP and Rebecca representing practice.
  - Sent request for Q2 16 list of members with asthma diagnoses for Hypothesis 7 report.

Mustang Urgent Care:

- **July 2015:**
  - Informed re: August OHCA Board Retreat panel presentation, asking for input on members who might participate.
  - Sent PHPG SC Annual Evaluation Report results, thanking them for participation and support through providing Medical Home.
  - Delivered latest EPSDT list.
- **August 2015:**
  - Information on upcoming community Baby Shower was provided along with included delivery of brochures for their clientele.
  - Addressed a question re: billing for a well-child visit when two occurred in less than a year; f/u question sent to M. Anthony; correct info then relayed to MUC staff.
  - Requested current list of Providers for MUC; f/u info sent to office manager sharing importance of providing current information (changes) to OHCA.
  - Sent all Providers PowerPoint presentation (OHCA Board Retreat presentation) on AIP outcomes, thanking them for referring members.
- **September 2015:**
  - Worked with staff to obtain office visits made in past RY by ER users.
  - Delivered Q2 2015 ER roster and picked up business cards to distribute through Baby Shower.
  - Obtained current contact info/appointments for Q2 ER roster.
- **October 2015:**
  - Worked with office manager to resolve issues with age restrictions for SC members as they are "getting calls from adults who say they are on our roster…we don't see adults." Matter was resolved.

  - Office visit to deliver monthly (September) ER and Inpt rosters and to request current contact info/appointment schedules for members.
- **November 2015:**
  - Received photos of Providers for CC-HAN website.
  - Verified resolution of age restrictions matter.
- **December 2015:**
  - Sent request to office manager for list of members with asthma from their EMR by 1/29/16.
  - Delivery of holiday baskets from CC-HAN staff.
- **January 2016:**
  - Received list of members with asthma diagnoses in EMR for completion of Hypothesis 7 report.
  - Consulted with staff re: DHS hotline for Child Abuse reporting.
  - Project manager developed individual education plans for MUC staff to complete annual Communicable Diseases training; plans included tests, handout with current links for further information, and DVD provided by CC-HAN.
  - Provided information on Medical Home Agreements as well as sending current copy of suggested Agreement. Recommended plan of annual updates.
- **March 2016:**
  - Communicable Diseases training DVD picked up; verified all staff had successfully completed educational requirements.
- **April 2016:**
  - CY 15 Hypothesis 7 Report sent; also requesting current list of members with asthma diagnoses for Q1 16 interim report.
  - List of members with asthma diagnoses for Q1 16 received.
  - Information provided about Doc2Doc online referral/consult system and requested time to schedule Lyn Denny from OU HAN to demonstrate/explain.
  - Information sent about upcoming Provider meeting, 6/16/16.
- **May 2016:**
  - Reminder about 6/16 PCP meeting sent with agenda.
- **June 2016:**
  - Two reminders re: 6/16/16 PCP meeting on 6/16/16 sent with agenda attached.
  - PCP meeting (6/16/16) with Gretchen McFarland, office manager, and Siera, referral nurse, attending.

For ALL Providers:

Delivery of the following Reports and educational materials was ongoing throughout RY 2016:

- Monthly ER reports
- Monthly Inpatient reports
- EPSDT rosters (upon request, along with education about availability of same)
- Tobacco Cessation educational materials/resources
- CC-HAN Website Promotional brochures and pens
- Canadian County Prescription Dropbox Information/Location flyers
- Social Host Laws flyers
- CC-HAN ER Brochures for office distribution

- Specific educational materials upon request (e.g., Spanish materials on flu immunizations and asthma)

CC-HAN staff also provided assistance throughout RY 16 with member issues/other member issues/needs for all Providers. This assistance included the following RY 16 totals:

- **1594 referrals**
- **68 deliveries of goods, i.e., food, clothing, personal/household goods (add May-June)**
- **20 back-school supplies referrals and/or deliveries**
- **53 holiday gifts/items referrals and/or deliveries**

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

There were no Tier advancements in RY 16.

Support provided throughout RY 16 in support of Dr. Holy's advancement to tier 3 to help ensure ongoing compliance through several staff changes. Other assistance in maintaining Tier status was provided through Communicable Diseases training (Flores Pediatrics, Vladimir Holy, Mustang Family Physicians, and Mustang Urgent Care). Additional training sessions and/or CC-HAN resources were also provided (specified in previous "Steps taken to assist Providers section).

5. **Number of specialty providers by specialty type:**
   a. **Number of specialty providers available for SoonerCare members served by our providers.**
   b. **Number of SoonerCare members receiving specialty care (note: Delayed effective date until Doc2Doc program or other effective tracking method is in place).**

   The total number of specialty providers (and resources) by specialty type for RY 16 is **686.** Table 4 presents the type and number of Providers (by type).

Table 4: CC-HAN Specialty Providers for RY 16	
Allergy:	4
Attention Deficit Disorder:	10
Audiology:	18
Autism:	8
Behavioral Health:	60
Birth Control:	2
Boys Homes:	2
Cardiology:	5
Chiropractic:	1
Community Resources:	38
Crisis Lines:	19
Death, Dying, Grief Resources:	4
Dental Care:	37
Dermatology:	17
Developmental Delays:	10

Dieticians:	6
Domestic Abuse:	5
Drug Treatment/Rehab:	16
Durable Medical Equipment:	6
Ear, Nose, Throat Doctors:	15
Education:	1
Electroencephalograms:	3
Electrocardiographs:	4
Endocrinologists:	10
Family Planning Services:	(under Birth Control)
Formula Providers:	4
Formula Reps:	3
Free Clinics:	38
Gastroenterology:	7
Genetics:	2
(County) Health Departments:	8
Hematology/Oncology:	3
Holiday Resources	3
Home Health Resources:	11
Homeless Resources:	1
Hospice:	2
Hospitals:	20
Housing Resources:	4
Immunology:	1
Infant Resources:	9
Infectious Diseases:	4
Labs:	10
Lactation Specialists:	8
Latino Resources:	3
Learning Disabilities:	4
Legal Assistance:	2
Liceology:	2
Litholink-Kidney Stone Prevention:	1
Mammograms:	1
Maxillofacial:	1
Medical Assistance Resources	3
Military Assistance Programs:	3
Nephrology:	2
Neurology:	7
Obstetrics/Gynecology:	8
Occupational Therapy:	1
Ophthalmology:	7
Optometry:	9
Oral/Maxilla Surgery:	2
Orthopedics:	13
“Other Resources”:	6
Oxygen Resources:	1
Pain Management:	3
Parent Education Resources:	1
Pediatrics Special Care Center	1
Pharmacy:	1
Physical Therapy:	14

Plastic Surgeons:	1
Podiatry:	4
Pregnancy Care Center:	1
Prescription Drug Assistance	2
Psychiatry:	15
Psychology	11
Pulmonology:	3
Radiology/Imaging Services:	15
Residential Programs:	4
Rheumatology:	5
Sleep Studies:	5
SoonerCare: 1	1
Special Needs Resources:	3
Special Schools:	2
Speech Therapy:	20
Support Groups:	15
Surgery:	4
Thoracic Surgery:	1
Transportation Resources:	6
Urology:	7
WIC/Nutrition Resources:	4

The number of members receiving specialty care is unknown/delayed until implementation of Doc2Doc (or another tracking method).

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

There were no medical home audit failures in RY 16.

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

There have been no medical home audits for CC-HAN participating Medical Home Providers in RY 16. There was one Medical Performance Audit for Dr. Vladimir Holy in May, 2016. The Project Manager participated by developing an EMR Policy and Procedure document for Dr. Holy's review/approval. The Project Manager was also present for the audit, assisting with locating and printing required documents for the review team. There was no corrective action plan required as records for all billed services were provided.

Other ways the Project Manager has assisted CC-HAN PCPs are outlined on pages 5-16. In addition, prior to the end of RY 16, Mustang Urgent Care was scheduled for a Medical Home Performance Audit for 7/14/16. The Project Manager participated in the process by meeting with the office manager and key staff prior to the audit to review the process, providing assistance for preparations, and was also present for the audit on 7/14/16.

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 RY 16 include:

  - Asthma
  - Chronic Care
  - High Risk OB
  - ER Users
  - Inpatient
  - Pharmacy Lock-In

- **Hold at least one Care Management quarterly meeting.**

  Three Care Management meetings (via conference calls) with OHCA Care Management staff in RY 16; meeting dates were 7/21/15; 1/17/16; and 4/21/16.

  Eleven CC-HAN Care Management Team meetings in RY 16; meeting dates were 7/27/15; 8/24/15; 9/28/15; 10/26/15; 12/7/15; 1/11/16; 2/8/16; 3/7/16; 4/4/16; 5/2/16; and 6/20/16.

Table 5: CC-HAN Summary of Care Management for RY 16

Population	Care Management Members
High Risk OB	Five cases managed in RY 16.
Hemophilia	No cases managed in RY 16.
Chronic Care	o Roster with 34 members (1 other; 33 asthma*) in 7/15 o Roster with 31 members (1 other; 30 asthma*) in 8/15 o Roster with 32 members (1 other; 31 asthma*) in 9/15 o Roster with 34 members (1 other; 33 asthma*) in 10/15. o Roster with 34 members (1 other; 33 asthma*) in 11/15. o Roster with 33 members (33 asthma*) in 12/15. o Roster with 33 members (1 other; 32 asthma*) in 1/16. o Roster with 33 members (1 other; 32 asthma*) in 2/16. o Roster with 33 members (1 other; 32 asthma*) in 3/16. o Roster with 34 members (1 other; 33 asthma*) in 4/16. o Roster with 32 members (1 other; 31 asthma*) in 5/16. o Roster with 35 members (1 other; 34 asthma*) in 6/16.

Table 5: CC-HAN Summary of Care Management for RY 16	
Population	**Care Management Members**
	*Note: the asthma members are all those engaged in the Asthma Improvement Plan.
Pharmacy Lock-In	One member rcvd in 7/15 for Pharmacy Lock-In, to extend through 7/17. Member was not on HAN PCP roster for 2/16, 3/16, 4/16, and 5/16; care management was temporarily suspended until member returned to CC-HAN Medical Home in 6/16.
Breast &Cervical Cancer (Oklahoma Cares)	No members in RY 16.
CM Initiative	Asthma care management initiative, the Asthma Improvement Plan (AIP) initiated in February 2012; a total of 40 (individual) members were engaged in RY 2016 with 34 members engaged as of 6/30/16.

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 Care Management activities and measures monthly:

High Risk OB (fully manage) (The following information should be submitted by RID number.)

1. Number of members received for HAN care management program in RY 2016: **Five.**
2. Number of existing members still being care managed at end of RY 2016: **None.**
3. Number of attempted contacts by member with outcomes (successful or unsuccessful) and contact method (face-to-face, telephonic, letter, etc.) for each attempt:
   - **RID [redacted] 17 total contacts (6 spc; 8 upc; 3 letters)**
   - **RID [redacted] 20 total contacts (7 spc; 8 upc; 5 letters)**
   - **RID [redacted] 8 total contacts (4 spc; 2 upc; 2 letters)**
   - **RID [redacted] 16 total contacts (2 spc; 11 upc; 3 letters)**
   - **RID [redacted] 11 total contacts (6 spc; 3 upc; 2 letters)**
4. Indicate type of provider (family practice, OB/GYN, clinic, etc.): **All members were seen by OB/GYN Providers.**
5. Estimated due date:
   - **RID [redacted] 10/19/2015**
   - **RID [redacted] 9/14/2015**
   - **RID [redacted] 9/21/2015**

RID [redacted] 3/19/2016
RID [redacted] 3/1/2016

6. Delivery date:
RID [redacted] 10/1/2015
RID [redacted] 9/2/2015
RID [redacted] 9/11/2015
RID [redacted] 3/18/2016
RID [redacted] 2/8/2016

7. Length of hospital stay for the newborn in the newborn nursery:
RID [redacted] 1 day
RID [redacted] 2 days
RID [redacted] 2 days
RID [redacted] 2 days
RID [redacted] 7 days

8. Was there a NICU admission?
RID [redacted] no
RID [redacted] no
RID [redacted] no
RID [redacted] no
RID [redacted] yes (Special Care Unit at CV Integris)

9. Length of NICU stay for the newborn: **7 days in "Special Care" for infant born to RID [redacted]**

10. Number of depression screenings completed with results (number that require referral and number that do not require referral):
RID [redacted] 2 (both "negative")
RID [redacted] 2 (prenatal score indicated need for referral, which was made; postnatal "negative")
RID [redacted] 1 (prenatal score indicated need for referral, which was made; member declined postpartum screening saying she had adequate support)
RID [redacted] 1 (prenatal score indicated need for referral which was offered and also discussed with Provider); no postnatal screening (member did not respond to contacts)
RID [redacted] 2 (both negative)

11. Number of women who accepted a referral to behavioral health as a result of depression screening: **One reported she was receiving services.**
    a. Number of women who kept a behavioral health appointment: **One reported regular appointments (non-billable agency).**
12. Pregnancy outcome (viable vs. demise): **Viable for all members listed.**
13. Report the following indicators that assist in identifying at-risk newborns:
    a. Birth weight of the newborn: **none.**
    b. Newborns that are discharged from the hospital on oxygen: **none.**

c. Newborns that are discharged from the hospital on any type of monitor or medications (indicate the type of monitor, e.g. apnea, pulse oximeter, etc. or type of medication): **none.**
d. Newborns that had surgery while in the hospital, excluding circumcision (indicate the type of surgery): **none.**
e. Newborns that had a failed hearing screen: **none.**

Hemophilia (fully manage) (The following information should be submitted by RID number.)

1. Number of members received for HAN care management program for the FY 2016: **None.**
   a. Number of existing members still being care managed: **N/A.**
   b. Number of members HAN care management program is actively working with: **NA.**
2. Number of attempted contacts by member with outcomes (successful or unsuccessful) and contact method (face-to-face, telephonic, letter, etc.) for each attempt: **N/A.**
3. Number of kept appointments (provider, specialist, etc.): **N/A.**
4. Number of missed appointments (provider, specialist, etc. excluding cancelled or rescheduled appointments): **N/A.**
5. Number of treatment logs submitted to provider monthly (notify provider timely of a bleed and receive timely treatment): **N/A.**
   a. Indicate whether log is complete or incomplete: **N/A.**
6. Number of members compliant with prescribed treatment: **N/A.**
   a. Indicate the provider prescribing treatment**:** **N/A.**
   b. Number of ER visits**:** **N/A.**
   c. Number of hospitalizations: **N/A.**
   d. Lengths of stay for each admission: **N/A.**

Chronic Care Unit:

1. Number of members received for HAN care management program for RY 2016: **One**, **RID [redacted] (other than members engaged in CC-HAN AIP, reported on separately). Appendix A.2 presents information r/t contacts and referrals for member [redacted] A summary of the contacts for the non-AIP Chronic Care member follows.**
   a. Letters sent to Chronic Care program member:
      RID [redacted] 5
   b. Phone contacts to Chronic Care program members:
      RID [redacted] 16 successful; 17 unsuccessful
   c. Number/type of community resource referrals:
      RID [redacted] 6 (Disability Related Services); 3 (Legal Aid resources); 13 (Daily Living Needs)
   d. Other miscellaneous case related contacts:
      RID [redacted] 1 face-face
   e. Facilitation of PCP/NCM written communication for care coordination (includes care plan exchanges, medical treatment plan exchanges):
      RID [redacted] 2

ER Utilization (co-manage)

Categories:

- Members with 3 visits in a 3 month period during Report Year: **42** is total of members reported as having 3 visits in Report Year 16 (Q1 –Q4 2015).
- Members with 4-14 visits in a 3 month period: **19** is total number of members reported as having 4-14 visits in Report Year 16 (Q1-Q4 15).
- Members with 15 or more visits in 3 month period (Persistent) **0**

The following information should be submitted by Category and RID number.

1. Number of members received for HAN care management program for the Report Year stopped here on 9/3/16 (for ER rosters, Q1-Q4 2015). The total number of members received for the Report Year (with 3 or more visits per quarter) is **61. See Appendix B, Table 1.**

2. Number of existing members still being care managed: **One from the Q2 2016 roster.**

   A significant change in the methodology ER rosters are provided from OHCA occurred in RY 16. CC-HAN now receives monthly ER user reports. Staff continue to "group" members by quarterly use to determine those with 3 or more visits in a 3 month period. For Q1 2016 (Jan-Mar 16), there were 9 members with 3 or more ER visits reported through monthly reports; care management contacts were made for this group through July 2016. There were also 28 members (Q1 16) with 2 visits (reported through monthly reports), each of whom received at least one care management contact.

   For Q2 2016 (Apr-Jun 16), there was one member with 3 ER visits (reported through monthly reports). This member remained in the care management program through the end of RY 16 (June 30, 2016). There were 17 members (Q2) who had 2 visits; each received one care management contact to determine if PCP follow-up has occurred and if further care management support is indicated.

   Due to the current method of ER roster receipt from OHCA, it is significant to highlight that all CC-HAN members reported through the monthly reports are contacted at least once to assess care management needs, and in a more timely way than was previously possible. Those with 3 or more in a Quarter are routinely contacted by a care manager weekly until the completion of the next (subsequent) Quarter. In addition, it is also important to note that claims searches are done for ER visits every 3 months now by CC-HAN IT staff to ensure that all members who were seen in ERs are identified for care management purposes.

   The data reported in Appendix B, Table 1 is for members who had ER visits between Jan 1 2015 through Dec 31 2015 to be consistent with prior years' reporting. The CC-HAN's Completion Report for 2016 will include those members with ER visits in Q1- Q4 of (calendar year) 2016.

3. Total number of members HAN care management program is actively working with: **There are 17 members (Q2 16 roster to date) that will receive at least one contact.**

4. Number of attempted contacts by member (Q1-Q4 2015) with outcomes (successful or unsuccessful) and contact method (face-to-face, telephonic, letter, etc.): **See Appendix B, Table 2.**

5. Number of PCP visits per member (Q1-Q4 2015): **See Appendix B, Table 2.**

6. Number of ER visits per member: (Q1-Q4 2015) **See Appendix B, Table 2.**

7. Top 3 diagnoses and date service for ER visits: The top 3 diagnoses for ER visits in (Q1-Q4 2015, and in order of frequency) are:
   - **Fever (41 visits)**
   - **Otitis media (40 visits)**
   - **Upper Respiratory Infection (18 visits)**

   Each of the top three diagnoses for RY 16 ER visits have also been top diagnoses for previous years. ER brochures were previously developed for each of these diagnoses and are currently used as educational tools in the care management process. The "evidence" that the CCHAN developed ER brochures add value to the care management efforts is based upon member and Provider feedback that they are "helpful." Of note, the brochures were included in the SoonerCare Choice Program Independent Evaluation (2015) as examples of strategies developed by the CC-HAN Providers and staff to help reduce ER visits.

   Review of the outcomes r/t the top ER diagnoses is a process involving the CCHAN CM team, PCPs, and PHCC Board members. Recommendations are utilized by care management staff to help ensure ongoing improvements in care management efforts.

   From the dates for ER visits reported on (which was calendar year 2015), the date with the highest number of visits was **Sunday, 2/22/15, with 9 visits.** An additional date **(Saturday, 1/24/15) had 8 visits.** The third date (**with 7 visits**) **was Saturday, 2/14/15.** It is noted that each of the dates with the highest number of visits is a week-end date, which would be an expected outcome since only one practice includes (routinely) week-end hours.

   An analysis of the top dates for ER visits (as previously noted, calendar year 2015) was utilized to review the days of the week most used (from the top dates); Table 5 presents the data. It is noted that Thursday has the highest number of ER visits for the second year in a row, which is a challenge to explain since all CC-HAN practices are open on Thursdays as well as Fridays. However, the amount of variance in the numbers for each of the days of the week is (relatively) small, with a range of 28 (on Saturdays) to 34 (Thursday).

   The care management process includes reminders to all members with ER visits that same day appointments with their PCP are available.

Table 6: CC-HAN 16: Days of ER Visits							
Day of the Week	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
No. of Visits	**29**	**29**	**29**	**26**	**34**	**30**	**28**

8. Number of medical referrals generated, indicate whether ER or CM (behavioral health, pain management, specialists, community resources, etc.)**.**
   a. Number of identified needs in conjunction with daily living members are assisted with (e.g. community resources, food pantry, and housing). **See Appendix B, Table 2.**
9. Report time between:
   b. ER visit and HAN care manager contact. **See Appendix B, Table 2.**
   c. ER visit and successful follow up PCP visit if appropriate. **See Appendix B, Table 2.**

10. Type and date of intervention with HAN care manager (e.g. crisis intervention, education provided, follow up care scheduled, follow up care received, etc.) **See Appendix B, Table 2.**

11. Number of members removed from persistent category due to decrease in ER usage: **None in RY 16 (none in persistent category in RY 15 or in RY 16).**

12. Supply aggregate number of ER visits by category for the quarter; show percent of change for the aggregate number of visits from quarter to quarter for the year (Jan 2015 to Dec 2015) in a table format using the following calculation. [(new quarter # minus previous quarter #) divided by previous quarter #.] **See Appendix C.**

13. Supply aggregate number of total visits for all categories; show percent of change from quarter to quarter for the year (Jan 2015 to Dec 2015) using the same calculation supplied above. **See Appendix C.**

14. Provide the average length of time between each ER visit. Indicate whether there was a successful contact (telephonic or face-to-face) during the quarter. Identify the type of contact made including the date. **See Appendix B, Table 2.**

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 RY 16. It is also noted that the HAN total enrollment for RY 16 was up (nearly) 10% over RY 15, accounting for some of the trend. However, staff will continue efforts to address ER utilization through care management strategies and work with PCPs.

Table 7: CC-HAN ER Utilization Data		
RY	**Total No. Members with 3 Visits/Quarter**	**Total No. Members with 4-12 Visits/Quarter**
12*	27	11
13	49 (a 45% increase from RY 12, 3 quarters)	25 (a 44% increase from RY 12, 3 quarters)
14	55 (a 11% increase from RY 13)	28 (a 11% increase from RY 13)
15	38 (a 31% decrease from RY 14)	18 (a 53% decrease from RY 14)
16	42 (a 11% increase from RY 15)	19 (a 5% increase from RY 15)

*FY 12 included 3 quarters of ER users only due to date of HAN implementation.

<u>Pharmacy Lock-in</u> (fully manage) (The following information should be submitted by RID number.)

1. Number of members received for the HAN care management program for the current month: **<u>1 RID</u>** [redacted]
   - Number of existing members still being care managed: **<u>1</u>**

2. **Number of attempted contacts by member's RID in lock-in and monitor status with outcomes (successful or unsuccessful) and contact method (face-to-face, telephonic, letter, etc.) for each attempt.**

   <u>RID</u> [redacted]**:** rcvd as Pharmacy Lock-In member on 8/6/2015; member changed PCPs in spring 2016 so CC-HAN care management case for this member was closed for a short time; member was back on CC-HAN Provider roster for 6/16, with continuation of care management support.

   For RY 16, HAN CM has provided:
   - Care coordination/consultation with PCP on 5 dates;
   - 37 unsuccessful phone contacts with member;
   - 4 successful phone contacts with member; referral to behavioral health offered in 1.
   - 7 letters and 1 text message to member; behavioral health referral offered in 4 letters.
   - Referral (verbal) to SoonerCare Helpline on 11/17/15 for assistance locating another Provider.
   - Consultation with OHCA care management team occurred 1/27/16; recommendations followed.

3. **Number of members in monitoring status that were prevented from being placed in the lock-in program:** None.

4. **Number and name of physicians lock-in and monitoring status members' have seen.** From OBN Patient History Report, a total of 3 Providers who prescribed controlled substances for RID [redacted] were seen (6/21/15-6/30/16):

   Ann M Burkle, NP, Healthcare One, El Reno, OK
   Dawn R Davis, DO, Yukon, OK
   Vladimir Holy, MD, El Reno, OK

5. **Number of ER visits by lock-in and monitoring status members shown by ER Category (e.g. 3, 4 or more, pre-persistent, persistent).**
   <u>RID</u> [redacted] None in RY 16

6. **Number and name of pharmacies filling prescriptions for members in monitoring status.**
   <u>RID</u> [redacted]

Total of 2 pharmacies filling prescriptions for member:

Walgreens #04066
Walgreens #12027

7. **Number of referrals to pain management specialists for lock-in and monitoring status members that are experiencing unrelieved pain.** None were considered medically indicated.

8. **Number of controlled substance prescriptions filled for each lock-in and monitoring status member.**
   RID [redacted]
   Total of 7 controlled substance prescriptions filled for member.

9. **Number of lock-in members discharged from the lock-in program.** None.

B&C Cancer (Oklahoma Cares Program) (fully manage) (The following information should be submitted by RID number.)

1. Number of women received for HAN care management for the Report Year: **N/A**.
   Designate by breast or cervical cancer diagnosis categories for list of women received: **N/A.**
2. Number of existing members still being care managed**: N/A.**
3. Specify the stage at which each woman initially entered the Oklahoma Cares program. (e.g. abnormality, precancerous condition or cancer diagnosis): N/A.
4. Number of attempted contacts by member with outcomes (successful or unsuccessful) and contact method (face-to-face, telephonic, letter, etc.) for each attempt for Report Year: **N/A.**
5. Number of appointments/treatments as specified: **N/A.**
6. Number of missed provider or treatment appointments (excluding cancellations or rescheduled appointments): **N/A.**
7. Number of kept provider or treatment appointments: **N/A**.
   i. Radiation Treatment related: **N/A**.
   ii. Lab: **N/A**.
   iii. Radiology (CT, MRI, PET, X-Ray): **N/A**.
   iv. Office Visits: **N/A**.
   v. Chemo Treatment**: N/A**.
8. Number of women contacted and/or assisted with recertification process
   a. Number of women who recertified eligibility: **N/A**.
   b. Number of women who required more than one contact to assist with recertification: **N/A**.
   c. Number of women who did not complete the recertification process**: N/A**.
   d. Number of Oklahoma Cares cases closed and reason (lost eligibility, death, cured, etc.): **N/A**.
   e. Number of women reentering the BCC program to due recurrence of cancer: **N/A**.

f. Number of women prescribed a hormone therapy drug for breast cancer diagnosis: **N/A**.
   1). Number of women who were non-compliant with filling the prescription: **N/A**.
g. Number of women with breast cancer that undergo mastectomy: **N/A**.
h. Number of women with reconstructive surgery: **N/A**.
i. Time period between the date of mastectomy and reconstructive surgery: **N/A**.

HAN CM Initiative (fully manage)

The Asthma Initiative was fully implemented in the spring of 2013. A total of 40 members were engaged in the Asthma Improvement Plan (AIP) in FY 15. Appendix A.1 presents care management information for each member, including each engaged member's RID. Outcomes data for the AIP is reported in the QI/QM section, Table 16, page 38.

During RY 16, 40 (unique) 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 7. A grand total of 1187 care management contacts were made in FY 16, including twenty-four face-face visits.

Table 8: CC-HAN AIP: Care Management Contacts for RY 16

Successful Phone	Unsuccessful Phone	Mailings/ Texts/E-mails	Face-to-Face	GRAND TOTAL of CONTACTS
479	583	101	24	**1187**

Inpatient Contacts

Monthly reports have been provided by OHCA to CC-HAN throughout RY 16, including Inpatient Reports for recently hospitalized members. Care management services provided for this group are included, by member, in Table 9. As the Table shows, a total of 227 visits were made to this group, including six face-face visits.

Table 9: CC-HAN Inpatient Contacts for RY 16

Successful. Phone	Unsuccessful Phone	Letters	Face-to-Face	GRAND TOTAL OF CONTACTS
70	129	22	**6**	**227**

Health Information Technology (Article 4.5)

1. PCPs assisted with qualifying for federal EHR incentives–education, outreach, etc. (Article 4.5 c): None in RY 16.

Milestones for electronic health records being met (Article 4.5 b):
All twenty-four PCPs in 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-four.

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

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

All twenty-four HAN PCPs (six 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; one CC-HAN practice subsequently (prior to end of June 2016) expressed interest in scheduling in-office training, and work was ongoing to coordinate schedules at the end of RY 16.

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.

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 RY 16. The ELA will be an increase in the total number of claims in RY 16 (compared with RY 15) 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.

As data in Table 10 demonstrates, evidence (to date) is somewhat ambivalent about the effectiveness of the primary strategy to increase the number of well-child visits. Claims searches done in spring of 2015 were found (subsequent to submission of AR 15) to include some duplicate claims; Table 10 presents the correct data for 2015 as well as for 2016.

The ELA was met in RY 15 with a 6% gain (overall) in well-child visits. For RY 16, there is an 11% loss from the totals in RY 15. 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 RY 17. Recently a bi-lingual clerk was employed to coordinate the contacts due to the number of Spanish-speaking families served; it is hoped that improvements in communications may result in more visits for RY 17. Tables 11-14 present the number/types of EPSDT contacts throughout RY 16.

Table 10: CC-HAN Quality Measure Report: EPSDT Claims Data

Preventive Code	FY 14 # of Claims	FY 15 # of Claims		FY 16 # of Claims	
New Patients:					
99381	332	301	-9%	185	-39%
99382	164	119	-27%	95	-20%
99383	193	146	-24%	132	-10%
99384	62	63	2%	65	3%
Established Patients:					
99391	1477	1536	4%	1376	-10%
99392	993	1189	20%	1092	-8%
99393	912	947	4%	836	-12%
99394	382	466	22%	474	2%
TOTALS by FY	**4515**	**4767**	**6%**	**4255**	**-11%**

Table 11: EPSDT Contacts Q1 RY 16

	Jul 15			Aug 15			Sep 15			TOTAL Contacts (all types) for 2015
	Letters/ Texts	SPC	UPC	Letters/ Texts	SPC	UPC	Letters/ Texts	SPC	UPC	
Canadian Valley Family Care	0	0	0	2 letters	1	2	5 letters	31	5	46
Flores Pediatrics	29 texts; 21 letters	2	60	19 letters	24	19	18 letters	73	18	283
Alecia Hanes	5 texts; 2 letters	5	7	2 texts; 4 letters	6	6	14 letters	42	14	107
Vladimir Holy	4 texts	5	4	3 letters	4	3	3 letters	11	3	40
Mustang Family	6 texts; 3	5	9	3 texts	3	3	6 texts	31	6	75

Physicians	letters									
Mustang Urgent Care	1 text	0	1	2 letters	1	2	0	3	0	10
Total No. of (All Types) Contacts to Increase EPSDT (Well-Child) Visits for Q1 RY 2016										563

Table 12: EPSDT Contacts Q2 RY 16

	Oct 15			Nov 15			Dec 15			TOTAL Contacts (all types) for Q2 RY 16
	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	
Canadian Valley Family Care	15	3	15/3	42	4	0/0	35	9	7/2	135
Flores Pediatrics	79	40	17/24	69	43	23/20	44	36	15/22	432
Alecia Hanes	31	9	0/9	30	27	20/7	20	12	5/7	177
Vladimir Holy	13	8	6/8	5	4	0/4	11	1	0/1	61
Mustang Family Physicians	19	16	7/9	18	16	11/7	18	9	6/3	139
Mustang Urgent Care	5	3	0/3	2	1	0/1	0	0	0/0	15
Total No. of (All Types) Contacts to Increase EPSDT (Well-Child) Visits for Q2 RY 16										959

Table 13: EPSDT Contacts Q3 RY 16

	Jan 16			Feb 16			Mar 16			TOTAL Contacts (all types) for Q3 2016
	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	
Canadian Valley Family Care	39	11	5/6	32	9	5/4	33	13	11/1	169
Flores Pediatrics	69	21	0/19	62	36	14/20	77	16	6/10	350
Alecia Hanes	32	20	16/5	44	6	0/6	52	6	0/5	192
Vladimir Holy	6	7	2/5	9	9	4/5	5	3	0/3	58
Mustang Family Physicians	21	2	0/2	20	10	5/5	24	6	0/6	101
Mustang Urgent Care	4	0	0/0	4	1	0/1	6	6	0/0	22
Total No. of (All Types) Contacts to Increase EPSDT (Well-Child) Visits for Q3 RY 16										892

Table 14: EPSDT Contacts Q4 RY 16										
	Apr 16			May 16			Jun 16			TOTAL Contacts (all types) for Q2 2016
	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	
Canadian Valley Family Care	34	5	0/0	33	6	5	25	3	0/3	114
Flores Pediatrics	86	27	19/9	70	35	23/12	68	24	21/3	397
Alecia Hanes	39	11	5/6	43	9	6/3	62	3	0/2	189
Vladimir Holy	9	1	1/0	6	1	0/1	6	1	0/1	27
Mustang Family Physicians	25	6	0/6	19	10	7/4	25	9	8/1	120
Mustang Urgent Care	5	0	0/0	4	0	0/0	10	0	0/0	19
Total No. of (All Types) Contacts to Increase EPSDT (Well-Child) Visits for Q4 RY 16										866

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 RY 2016.

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, SmartStart 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.

Efforts to ensure the website presents current and accurate information are anchored in a process conducted by PHCC Board volunteers who utilize guides to evaluate:

- Lay-out for reader appeal and for user friendliness, including visual appeal of materials or content "guides."
- Level of reading, focusing on (approximate) 5th grade or lower to maximize "effectiveness" for users.

- Content relevancy for general public, specifically HAN members and PCP "patients." E.g., is the content relevant for different age groups and populations, including ethnicities, who might use the website.
- Content appropriateness. E.g., are there content areas that are either "dated" or otherwise considered inappropriate? Are there content gaps in terms of information or materials which should be included? Is there content that might be considered culturally or otherwise inappropriate? Are there any specific content suggestions that you would like to see included or presented OR that you believe should be omitted?
- Accuracy. Content accuracy and "workability" of the links.
- Ease of use.

The project manager compiles the quarterly evaluation results and presents the information to the PHCC Board for review and comment. Subsequently, results and comments are provided to the IT professional who manages the website for implementation. Periodic meetings with the web designer combined with the evaluation findings and recommendations provide an ongoing quality improvement process.

Two primary methods are used to promote website use. First, promotional pens (with stylus) imprinted with the message ***"Health Questions?* Go to cc-han.com for help"** are widely distributed through PCP offices, Youth and Family Services of El Reno, 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, 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).

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 15 presents information and trends on CC-HAN website views.

Table 15: CC-HAN Website Stats

Number of Views per Month	2014	2015	2016
January	261	387	37
February	223	315	38
March	232	317	44

April	176	174	71
May	365	161	50
June	321	167	65
July	373	176	
August	386	154	
September	593	158	
October	unknown	74	
November	unknown	86	
December	unknown	15	

The second major strategy for achieving QM 2 is the development and utilization of ER brochures and one flyer for member education throughout RY 16. The brochures/flyer are based on the "top diagnoses" for ER visits in RYs 12-16. The top 3 diagnoses for ER visits in RY 16 were Fever, Otitis Media (Ear Infection) and Upper Respiratory Infection; each was among the top diagnoses in previous years. 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

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. As data presented in Table 17 indicates, additional evidence includes a significant decrease in the total number of ER visits (to date) in CY 16 as compared to calendar years 13, 14, and 15. 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 FY 2016. The ELA 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 FY 16, forty (unique) SC Choice members were engaged in the Asthma Improvement Plan (AIP). Information about hospitalizations includes:

- There were two hospitalizations (asthma related diagnoses) for member [redacted] (9/15 and 10/15). The member is a special needs adult whose caregiver is an elderly mother. The member has been engaged in the AIP since 2013 with no records available about hospitalizations prior to engagement. Subsequent to the fall 2015 hospitalizations, member was referred to a pulmonologist by PCP, and changes in asthma management plan have resulted in much better symptom control. Member has no additional hospitalizations since 10/15, which includes the (most recent) seasonal months in which flu/respiratory infections are common. Clearly, improvement in management of asthma symptoms has been attained.
- Member [redacted] was hospitalized for asthma twice in1/15 prior to being engaged in AIP later in the same month. Subsequently he was hospitalized one time (8/15) for bronchitis. There have been no additional hospitalizations for asthma related diagnoses, including the most recent seasonal months for respiratory illnesses (9/15-4/16). With the reduction from two hospitalizations in 1/15 to one in 8/15 (post engagement in AIP), the ELA is considered met.
- Member [redacted] was engaged in the AIP after hospitalization for an asthma related diagnosis in 1/16. Since engagement, parent reports "better control," and no additional hospitalizations (or ER visits) have occurred. Because this member has been in AIP for only 5 months, there is insufficient data to say the ELA is met. However, improvement in symptom control has been attained.

O. **Achieve at least an 80% annual flu immunization level for all AIP members in RY 2016.**

As of the end of RY 16, 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 ELA; it is accounted for largely by parental distrust of vaccinations, particularly fears of "traumatizing" a child or of "negative side effects,"

including autism. 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. To better understand the variables associated with vaccination refusals, the CC-HAN care management staff recently reviewed the Medscape Vaccine Acceptance Report for 2016 as well as other EBP resources; specific strategies were identified for better educating parents who are vaccine resistant.

Table 16: CC-HAN AIP Evaluative Data, CY 13-RY 16

	Totals for CY 13	Totals for RY 14	Totals for RY 15	Totals for RY 16
Total No. AIP Members	39	39	40	40
Total No. of Hospitalizations prior to AIP Engagement	1	1	3	7
Total No. of Hospitalizations for Asthma Related DX after AIP Engagement	0	0	1	2 (for one member)
Total No. of ER Visits for Asthma Related DX prior to AIP Engagement	12	8 (5 separate members)	14	9
Total No. of ER Visits for Asthma Related DX after AIP Engagement	2 (2 separate members)	2 (2 separate members)	2	7
Total No. of Urgent Care Visits for AIP Members	2	5	22	7
Total No. of Unscheduled PCP Visits for AIP Members	12	29	22	22

Table 16: CC-HAN AIP Evaluative Data, CY 13-RY 16				
	Totals for CY 13	Totals for RY 14	Totals for RY 15	Totals for RY 16
Total No./Percentage of AIP Members who received flu vaccination	21 for 54%	30 for 77% (2 members lost SC benefits, so lack of PCP verification for FY immunization; however, parental intent and history was to immunize children; parent did not respond to attempts to verify)	27 for 68% (3 members were discharged prior to flu immunization season; 1 lost SC benefits; 2 changed PCPs. Parents of 7 other members declined to immunize d/t publicity r/t lack of efficacy evidence for expected viral strains).	21 for 53% (5 unknown due to no response or no longer in AIP. Parents of 8 report lack of evidence that vaccine is beneficial; parents of 2 did not want child "traumatized" by injection; parents of 4 refused on basis of undesirable "side effects."

Of some concern with the outcomes reported in Table 16 is the 350% increase in ER visits in RY 16 over RY 15, although the actual numbers remain relatively small (from 2 visits to 7 visits). In addition, the total number of Urgent Care visits is significantly down in RY 16 as compared with RY 15, which may be a contributing factor to the increase in ER visits. The trend is challenging to explain; Providers share they continue to refer members to Urgent Care when after-hours calls are received reporting symptoms that "need quick but not urgent" professional evaluation. 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 17 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. In early May 2016 an educational document entitled "Provider Education: CC-HAN Asthma Improvement Plan" was shared with all CC-HAN Providers to demonstrate value of the AIP and encourage more referrals. Upon receipt of ER rosters in May and June 2016, three members with asthma related diagnoses were added to the AIP (2 in May, 1 in June).

As of completion of Quarters 1 and 2 (CY 16), there were no 90 day readmissions for members with an asthma diagnosis (in their medical record).

The data related to overall use of the ER for HAN members in Q1 16 is noted to be (significantly) lower than the numbers in Calendar Years 13, 14, and 15. 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 17: Hypothesis 7:
Key Quality Performance Measures
Report for CC-HAN

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, Q1	CY16 Q2
Numerator: Total no. of ER visits by HAN members with asthma identified in their problem list for an asthma-related diagnosis.	86	72	41	6	13
Denominator: All HAN members with an asthma diagnosis identified in their medical record.	839	885	858	595	729
Dividend for PM A:	.10	.08	.05	.01	.02
Performance Measure B: Decrease 90 day readmissions for related asthma conditions for HAN members with an asthma diagnosis identified in their medical record.	CY 13	CY 14	CY 15	CY 16, Q1	CY16, Q2
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	7	4	9	0	1

inpatient stay related to asthma.					
Dividend for PM B:	0	0	.22	0	0
Performance Measure C: Decrease overall ER use for HAN members.	CY 13	CY 14	CY 15	CY 16, Q1	CY16, Q2
Numerator: Total number of ER visits for HAN members.	2153	1938	2256	436	346
Denominator: All HAN members.	5192	5273	5137	3990	4091
Dividend for PM C:	.41	.38	.44	.11	.08

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 continued in the fifth year of implementation. 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 July 2015-June 2016 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 (project manager was present for one audit and planned corrective action steps as needed in RY 16); assistance with Self-Evaluation process required for annual contract for one PCP; 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 (e.g., counseling resources, transportation services, ADHD testing, and/or ADL needs). In addition, the HAN staff provides educational presentations for participating PCPs and staff. In RY 16, some specific examples include:

- Orientation to HAN services provided to new staff, including review of all Medical Home Tier 2 requirements with (new) office manager for Mustang Urgent Care, 7/24/15.
- Project manager coordinated meeting with Dr. Hanes and Red Rock Behavioral Health administrative staff on 11/3/15; purpose/outcomes were clarification of Health Home and Medical Home roles as well as collaborative opportunities for Dr. Hanes and Red Rock staff to benefit children/families.
- Communicable Diseases/Infection Control for Mustang Family Physicians, 12/9/15.
- Project manager developed/presented plan for individualized Communicable Diseases/Infection Control education, including resources and outcomes assessment, for Mustang Urgent Care staff in 1/16.
- Communicable Diseases/Infection Control for Vladimir Holy, MD on 1/26/16; also reviewed Behavioral Health Screening requirements with staff.
- Communicable Diseases/Infection Control for Flores' Pediatrics on 1/27/16.
- In February and March 2016, project manager worked with Dr. Holy and Red Rock staff to develop collaborative model for behavioral health services available at Dr. Holy's office site. Outcome was a contractual relationship established between Dr. Holy and a behavioral health provider.
- In 3/16, the PHCC Board approved funding to purchase 15 additional Peak Flow Meters to distribute to AIP members.
- Project manager worked with Canadian Valley Family Care staff in 3/16 to clarify requirements for behavioral health screenings as well as questions about reimbursement for same.
- On-site assistance/support provided for Dr. Holy's Medicaid Performance Audit on 5/4/16.
- PCP meeting was held 6/16/16 with participation from four of the six Provider groups in CC-HAN as well as outgoing Medical Director, Dr. Judith Frasier, and incoming Medical Director, Dr. Alecia Hanes. OHCA administrative staff also participated, including Melody Anthony, Deputy Director of Medicaid, and Burl Beasley, R. Ph. A representative from Sooner HAN's Medical Informatics also presented updates on Doc2Doc. One practice requested additional training/support through Doc2Doc.
- Throughout RY 16, 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 the Report Year 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 28 home visits following established guidelines. 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 r/t child development and care.
  - In RY 16, 28 home visits were made.

  - In RY 16, 48 face-face visits occurred, some in PCP offices and some in other sites (such as public libraries or what are called "curbside" deliveries of resources).
  - A total of 68 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 6/16/16. Melody Anthony, MS, Director of Provider Services, provided OHCA updates, and Burl Beasley, R.Ph addressed Agency updates including prior authorizations/changes made to improve safety/ensure proper use of funds for pharmaceuticals.

- **707 Provider contacts** made in RY 2016. Contacts are as varied as deliveries of rosters (e.g., EPSDT or latest ER), assistance with MH 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 43 SoonerCare members not engaged in other care management programs were served in RY 16. In addition, one "other" member was contacted at PCP request for support/education purposes including how to apply for SoonerCare benefits. A total of 228 contacts were made to this group.
- Quarterly Care Management Teleconferences with OHCA staff were held on 7/21/15; 1/17/16; and 4/21/16.
- Monthly CC-HAN Care Management Committee meetings for RY 16 were held on 7/29/15; 8/24/15; 9/28/15; 10/26/15; 12/7/15; 1/11/16; 2/8/16; 3/7/16; 4/4/16; 5/2/16; and 6/20/16.
- Participation by parent of five CC-HAN members (all engaged in AIP) in OHCA Strategic Planning Retreat, 8/13/15. Project Manager and AIP care manager also attended.
- Leadership by Project Manager of Canadian County Coalition for Families and Children Schools Support Project throughout summer and fall of 2015; funds were raised and distributed to elementary schools throughout the County to support school supplies and activities of needy children.
- Project Manager participated in Infant Mental Health Committee, associated with Coalition for Families and Children throughout RY 16. A Tip Sheet was developed to share with law enforcement throughout Canadian County, providing information on identifying s/s of child trauma as well as community support and treatment resources. The Tip Sheets, in both English and Spanish, have been distributed throughout the County.
- Participation by CC-HAN care management staff in Canadian County Health Department Baby Shower on 9/5/15.
- CC-HAN Project Manager coordinated meetings with Red Rock Behavioral Health staff and CC-HAN Providers to clarify Health Home project and the interface with Medical Homes in fall 2015.

- Project Manager was invited to participate in community planning meeting coordinated by Canadian County Extension Services in fall 2015 and subsequently became a member of Advisory Committee.
- Project Manager participated in OG&E Community Round Table in fall 2015, 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 FY 16, including:
  - Canadian County Coalition for Children and Families (project manager and both care managers)
  - Infant Mental Health Committee (project manager)
  - Canadian County Healthy Living Grant (care managers)
  - Canadian County Board of Health (project manager)
  - Partnership for Healthy Central Communities Board (project and care managers are participants)
  - SmartStart Leadership Team (project manager)
  - Canadian County SPF-SIG Project participation (project manager and one care manager)
- 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;
- Ongoing implementation of the Asthma Improvement Plan (AIP) in Report Year, with growth in number of members served and positive outcomes (Appendix A.1);
- Ongoing utilization and additions the (searchable) Specialist List that is hosted on web-site;
- Ongoing development/implementation of database for managing care management responsibilities and communications;
- Ongoing implementation of instant messaging system (HIPAA compliant) 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.

In January 2014, the following core strengths of the CC-HAN were identified in preparation for the external evaluation process. 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 2017 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.1

Asthma Improvement Plan Report - RY 16

Asthma Improvement Plan - RY16

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
RID [redacted]	Jul 2015	3 succ phone contacts 1 unsucc phone contact 4 text messages			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Aug 2015	1 succ phone contact 1 unsucc phone contact 1 face to face w/ Mom 1 text			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Sep 2015	3 succ phone contacts 2 text messages	Referred to OHCA for out of area family member case management for asthma		Offered information for daily living resources, mental and behavioral health resources and smoking cessation Contacted DLO via phone and fax re: lab testing requirements
RID [redacted]	Oct 2015	2 succ phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	2 succ phone contacts			
RID [redacted]	Dec 2015	1 succ phone contact 2 unsucc phone contacts 1 mailing 1 text message			Provided CDC flu vaccine and holiday safety tips info via mailing
RID [redacted]	Jan 2016	2 unsucc phone contacts			
RID [redacted]	Feb 2016	1 succ phone contact 3 unsucc phone contacts 1 text message	Referred to Child Development @CC Health Department-Chris Jarko		Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	2 succ phone contacts 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 succ phone contact 1 mailing	Referred to okhca.org for behavioral health care providers – Provided printed information for 21 SoonerCare Providers in the Yukon /OKC area		Offered smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 succ phone contact			Offered mental and behavioral health

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		1 unsucc phone contact			resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	3 succ phone contacts 1 unsucc phone contact 4 text messages			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Aug 2015	1 succ phone contact 1 unsucc phone contact 1 face to face 1 text			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Sep 2015	3 succ phone contacts 2 text messages	Referred to OHCA Care Management for out of area family member Care Management for asthma		Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Oct 2015	2 succ phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	2 succ phone contacts			
RID [redacted]	Dec 2015	1 succ phone contact 2 unsucc phone contacts 1 mailing			Provided CDC flu vaccine and holiday safety tips info via mailing
RID [redacted]	Jan 2016	2 unsucc phone contacts			
RID [redacted]	Feb 2016	1 succ phone contact 3 unsucc phone contacts			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	2 succ phone contacts 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 succ phone contact 1 unsucc phone			Offered mental and behavioral health resources, smoking

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		contact			cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	3 succ phone contacts 1 unsucc phone contact 4 text messages			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Aug 2015	1 succ phone contact 1 unsucc phone contact 1 face to face 1 text			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Sep 2015	3 succ phone contacts 2 text messages	Referred to OHCA Care Management for out of area family member Care Management for asthma		Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Oct 2015	2 succ phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	2 succ phone contacts			
RID [redacted]	Dec 2015	1 succ phone contact 2 unsucc phone contacts 1 mailing			Provided CDC flu vaccine and holiday safety tips info via mailing
RID [redacted]	Jan 2016	2 unsucc phone contacts			
RID [redacted]	Feb 2016	1 succ phone contact 3 unsucc phone contacts			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	2 succ phone contacts 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	3 succ phone			Offered information

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		contacts 1 unsucc phone contact 4 text messages			for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Aug 2015	1 succ phone contact 1 unsucc phone contact 1 face to face 1 text			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Sep 2015	3 succ phone contacts 2 text messages	Referred to OHCA Care Management for out of area family member Care Management for asthma		Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Oct 2015	2 succ phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	2 succ phone contacts			
RID [redacted]	Dec 2015	1 succ phone contact 2 unsucc phone contacts 1 mailing			Provided CDC flu vaccine and holiday safety tips info via mailing
RID [redacted]	Jan 2016	2 unsucc phone contacts			
RID [redacted]	Feb 2016	1 succ phone contact 3 unsucc phone contacts			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	2 succ phone contacts 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	3 succ phone contacts 1 unsucc phone contact 4 text messages			Offered information for daily living resources, mental and behavioral health resources and

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					smoking cessation
RID [redacted]	Aug 2015	1 succ phone contact 1 unsucc phone contact 1 face to face 1 text			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Sep 2015	3 succ phone contacts 2 text messages	Referred to OHCA Care Management for out of area family member Care Management for asthma		Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Oct 2015	2 succ phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	2 succ phone contacts			
RID [redacted]	Dec 2015	1 succ phone contact 2 unsucc phone contacts 1 mailing			Provided CDC flu vaccine and holiday safety tips info via mailing
RID [redacted]	Jan 2016	2 unsucc phone contacts			
RID [redacted]	Feb 2016	1 succ phone contact 3 unsucc phone contacts			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	2 succ phone contacts 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	1 succ phone contact 1 unsucc phone contact			
RID [redacted]	Aug 2015	1 succ phone			

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		contact 3 unsucc phone contacts			
RID [redacted]	Sep 2015	1 succ phone contact 1 unsucc phone contact		Referred to DHS Case Worker for assist with child support options	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Oct 2015	2 unsucc phone contacts 1 mailing		Referred to Legal Aid Services of OKC (2 offices), Oklahoma Legal Service Center, Oklahoma Lawyers for Children, Trinity Legal Clinic and website www.legalaid.org via mailing	
RID [redacted]	Nov 2015	3 unsucc phone contacts			
RID [redacted]	Dec 2015	5 succ phone contacts 4 unsucc phone contacts 2 text messages 1 mailing		Referred to Mustang Heights Baptist Church Toy and Clothing Closet, South Yukon Church of Christ Toy Event and CANADIAN COUNTY HEALTH DEPARTMENT for flu vaccine information	Provided CDC flu vaccine and holiday safety tips info via mailing
RID [redacted]	Jan 2016	1 unsucc phone contact		Mission of Mercy Dental Clinic in OKC via voicemail message	
RID [redacted]	Feb 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	2 unsucc phone contacts			
RID [redacted]	Apr 2016	4 unsucc phone contacts			
RID [redacted]	May 2016	2 unsucc phone contacts			
RID [redacted]	Jun 2016	1 succ phone contact 1 mailing	www.cdc.gov CDC Asthma Educational Booklet via mailing		Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted] (referred to AIP)	May 2016	4 succ phone contacts 1 unsucc phone contact 1 mailing		CC-HAN website, *Important Information for patients with Upper Respiratory Infections* and *Important Information for Parents of a Child with Fever* brochures via mailing	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jun 2016	4 succ phone contacts 5 unsucc phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jul 2015	4 succ phone contacts 4 unsucc phone contacts		SNAP, Food Stamp Hotline, 211, Gods Helping Hands, Manna Pantry, Lord's Harvest, DHS	
RID [redacted]	Aug 2015	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Sep 2015	2 unsucc phone contacts			
RID [redacted]	Oct 2015	1 succ phone		South Yukon Church of Christ	Offered information

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		contact 1 unsucc phone contact		Thanksgiving Resources, DHS office for assist in change in income guidelines	for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	2 succ phone contacts 9 unsucc phone contacts 1 face to face		Delivered Thanksgiving basket supplied by South Yukon Church of Christ	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Dec 2015	3 succ phone contacts 1 mailing		Mustang Heights Baptist Church Clothing and Toy Closet, South Yukon Church of Christ Toy Event	Provided CDC holiday safety tips info via mailing. Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jan 2016	1 succ phone contact 1 unsucc phone contact 1 email		Mission of Mercy Dental Clinic in OKC	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Feb 2016	1 succ phone contact 1 mailing	TSA website and mailing with requirements for overseas travel		Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Mar 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	May 2016	2 unsucc phone contacts 1 mailing			
RID [redacted]	Jun 2016	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
End of Mustang Family Physician's Members					
RID [redacted]	Jul 2015	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Aug 2015	1 succ phone contact 1 unsucc phone contact			
RID [redacted]	Sep 2015	4 succ phone contacts 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					smoking cessation
RID [redacted]	Oct 2015	2 succ phone contacts 1 face to face		CC-HAN website Delivered Household, food and clothing resources provided by South Yukon Church of Christ and Mustang Heights Baptist Church	Delivered Peak Flow Meter (Provided by PHCC funding)and Asthma/PFM educational
RID [redacted]	Nov 2015	2 succ phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Dec 2015	7 succ phone contacts 2 unsucc phone contacts 1 face to face		Mustang Heights Baptist Church Toy and Clothing Closet Delivered coats for family members, household supplies and food resources provided by South Yukon Church of Christ	
RID [redacted]	Jan 2016	1 unsucc phone contact			
RID [redacted]	Feb 2016	2 succ phone contacts 1 face to face		Delivered food and household resources provided by South Yukon Church of Christ	
RID [redacted]	Mar 2016	1 succ phone contact			
RID [redacted]	Apr 2016	1 unsucc phone contact			
RID [redacted]	May 2016	3 succ phone contacts 1 unsucc phone contact 1 face to face		Delivered summer clothing for member and family provided by South Yukon Church of Christ	Offered mental and behavioral health and smoking cessation information
RID [redacted]	June 2016	2 succ phone contacts			Offered information for household and food resources, mental and behavioral health and smoking cessation information
RID [redacted]	Jul 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Aug 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Sep 2015	2 unsucc phone contacts			
RID [redacted]	Oct 2015	3 unsucc phone contacts			
RID [redacted]	Nov 2015	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Dec 2015	3 unsucc phone contacts			
RID [redacted]	Jan 2016	3 unsucc phone contacts			
RID [redacted]	Feb 2016	3 succ phone		CC-HAN brochure *Important*	Offered mental and

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		contacts 1 mailing		*Information for Patients with Upper Respiratory Infections* via mailing	behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	2 unsucc phone contacts 1 mailing	www.cdc.gov CDC Asthma Educational Booklet via mailing		
RID [redacted]	Jun 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Aug 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Sep 2015	2 unsucc phone contacts			
RID [redacted]	Oct 2015	3 unsucc phone contacts			
RID [redacted]	Nov 2015	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Dec 2015	3 unsucc phone contacts			
RID [redacted]	Jan 2016	3 unsucc phone contacts			
RID [redacted]	Feb 2016	2 succ phone contacts 1 mailing			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact			Offered mental and behavioral health

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		1 unsucc phone contact			resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	2 unsucc phone contacts 1 mailing	www.cdc.gov CDC Asthma Educational Booklet via mailing		
RID [redacted]	June 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Aug 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Sep 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Oct 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Nov 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Dec 2015	1 succ phone contact			
RID [redacted]	Jan 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Feb 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact 2 unsucc phone contacts			Offered mental and behavioral health resources, smoking cessation resources and resources for

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					daily living needs
RID [redacted]	May 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	3 succ phone contacts 1 face to face		Delivered food and household resources provided by South Yukon Church of Christ	Offered mental and behavioral health information and smoking cessation resources
RID [redacted]	Aug 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Sep 2015	1 unsucc phone contact			
RID [redacted]	Oct 2015	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Nov 2015	1 succ phone contact			Offered holiday resource information
RID [redacted]	Dec 2015	1 unsucc phone contact 1 mailing			Holiday safety tips info via mailing
RID [redacted]	Jan 2016	2 unsucc phone contacts			
RID [redacted]	Feb 2016	1 succ phone contact 1 mailing		CC-HAN *Important Information for Children with Ear Infections (Otitis Media)* brochure via mailing	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 unsucc phone contact			
RID [redacted]	May 2016	2 succ phone contacts 1 unsucc phone contact 1 face to face		Delivered food and household resources provided by South Yukon Church of Christ	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 unsucc phone contact			

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
RID [redacted]	Jul 2015	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Aug 2015	2 unsucc phone contacts			
RID [redacted]	Sep 2015	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Oct 2015	1 succ phone contact 1 unsucc phone contact			
RID [redacted]	Nov 2015	1 unsucc phone contact			
RID [redacted]	Dec 2016	2 succ phone contacts 3 unsucc phone contacts 2 text messages 1 mailing		South Yukon Church of Christ Toy Event	Holiday Safety Tips via mailing
RID [redacted]	Jan 2015	2 unsucc phone contacts			
RID [redacted]	Jul 2015	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Aug 2015	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Sep 2015	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Oct 2015	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	1 succ phone contact			
RID [redacted]	Dec 2015	1 succ phone contact			
RID [redacted]	Jan 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					resources and smoking cessation
RID [redacted]	Feb 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Mar 2016	1 succ phone contact			
RID [redacted]	Apr 2016	1 succ phone contact			
RID [redacted]	May 2016	1 succ phone contact			
RID [redacted]	Jun 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jul 2015	3 unsucc phone contacts			
RID [redacted]	Aug 2015	3 unsucc phone contacts			
RID [redacted]	Sep 2015	2 unsucc phone contacts			
RID [redacted]	Oct 2015	4 unsucc phone contacts			
RID [redacted]	Nov 2015	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Dec 2015	3 unsucc phone contacts			
RID [redacted]	Jan 2016	1 unsucc phone contact			
RID [redacted]	Feb 2016	3 unsucc phone contacts 1 mailing		CC-HAN brochure *Important Information for Patients with Upper Respiratory Infections* via mailing	
RID [redacted]	Mar 2016	2 unsucc phone contacts			
RID [redacted]	Apr 2016	2 unsucc phone contacts			
RID [redacted]	May 2016	2 unsucc phone contacts			
RID [redacted]	Jun 2016	2 unsucc phone contacts			
RID [redacted]	Jul 2015	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					daily living needs
RID [redacted]	Aug 2015	2 succ phone contacts		OG & E Customer Service	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Sep 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Oct 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Nov 2015	3 succ phone contacts			Offered Holiday resources and resources for daily living needs
RID [redacted]	Dec 2015	3 unsucc phone contacts 1 mailing			Holiday Safety Tips via mailing
RID [redacted]	Jan 2016	1 unsucc phone contact			
RID [redacted]	Feb 2016	1 succ phone contact 2 unsucc phone contacts			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 unsucc phone contact			
RID [redacted]	Jun 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	3 succ phone contacts 4 unsucc phone contacts		Calls conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Aug 2015	1 succ phone contact 2 unsucc phone		Calls conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		contacts			cessation resources and resources for daily living needs
RID [redacted]	Sep 2015	1 succ phone contact 1 unsucc phone contact		Calls conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Oct 2015	4 unsucc phone contacts		Calls conducted via translator at Canadian County Health Department	
RID [redacted]	Nov 2015	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Dec 2015	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jan 2016	1 succ phone contact 1 unsucc phone contact		Calls conducted via translator at Canadian County Health Department Mission of Mercy Dental Clinic	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Feb 2016	1 succ phone contact 2 unsucc phone contacts		Calls conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 succ phone contact 1 mailing	www.cdc.gov CDC Asthma Educational Booklet via mailing MedlinePlus –US National Library of Medicine website http://www.nim.gov/medlineplus	Call conducted via translator at Canadian County Health Department Bethany Library, Warr Acres Library, RT Williams Library and Belle Isle Library	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 succ phone contact 1 mailing		Call conducted via translator at Canadian County Health Department SafeKids Oklahoma, Christian Services Center, All Things Baby, Crib/Car Seat Foundation, Evany Clinic	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
RID [redacted]	Jul 15	3 succ phone contacts 11 unsucc phone contacts	Child Development at Canadian County Health Department -Chris Jarko	Russell Murray Hospice Grief Support Group, Trinity Baptist Church School Supply Event, Lord's Harvest School Supply Event	Offered resources for daily living needs, smoking cessation and mental and behavioral health resource information
RID [redacted]	Aug 2015	5 unsucc phone contacts			
RID [redacted]	Sep 2015	1 succ phone contact 10 unsucc phone contacts 1 mailing 1 home delivery	Grandparents Raising Grandchildren Program-Sunbeam Family Services	CC-HAN website brochure, *Important Information for patients with Upper Respiratory Infections* brochure	Delivered Peak Flow Meter (Provided by PHCC funding)and Asthma/PFM educational Offered resources for daily living needs, smoking cessation and mental/ behavioral health resource information
RID [redacted]	Oct 2015	5 succ phone contacts 1 home delivery		Delivered Household, food and clothing resources provided by South Yukon Church of Christ	Offered smoking cessation and mental and behavioral health resource information CDC Flu Information brochure
RID [redacted]	Nov 2015	3 succ phone contacts 2 unsucc phone contacts 1 mailing 1 face to face		Blessing Baskets, Elks Lodge Turkey Giveaway Delivered Thanksgiving Basket provided by South Yukon Church of Christ	
RID [redacted]	Dec 2015	1 succ phone contact 3 unsucc phone contacts 1 mailing	Andrea Sneed-Sunbeam Family Services	South Yukon Church of Christ Toy Event	Holiday safety tips info via mailing- Offered resources for daily living needs, smoking cessation and mental and behavioral health resource information
RID [redacted]	Jan 2016	3 unsucc phone contacts			
RID [redacted]	Feb 2016	3 unsucc phone contacts			
RID [redacted]	Mar 2016	1 succ phone contact 2 unsucc phone contacts			Offered resources for daily living needs, smoking cessation and mental and behavioral health resource information
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact	Red Rock Behavioral Health		Offered resources for daily living needs and smoking cessation
RID [redacted]	May 2016	1 unsucc phone contact			
RID [redacted]	Jun 2016	3 unsucc phone contacts			
RID [redacted]	Jul 15	2 succ phone contacts 9 unsucc phone contacts	Child Development at Canadian County Health Department -Chris Jarko	Russell Murray Hospice Grief Support Group, Trinity Baptist Church School Supply Event, Lord's Harvest School Supply Event	Offered resources for daily living needs, smoking cessation and mental and behavioral health resource information
RID [redacted]	Aug 2015	5 unsucc phone			

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		contacts			
RID [redacted]	Sep 2015	1 succ phone contact 10 unsucc phone contacts	Grandparents Raising Grandchildren Program-Sunbeam Family Services	CC-HAN website	Offered resources for daily living needs, smoking cessation and mental/ behavioral health resource information
RID [redacted]	Oct 2015	5 succ phone contacts 1 home delivery		Delivered Household and food resources provided by South Yukon Church of Christ, CDC Flu Information brochure	Offered smoking cessation and mental and behavioral health resource information
RID [redacted]	Nov 2015	3 succ phone contacts 2 unsucc phone contacts 1 mailing 1 face to face		Blessing Baskets, Elks Lodge Turkey Giveaway Delivered Thanksgiving Basket provided by South Yukon Church of Christ	
RID [redacted]	Dec 2015	1 succ phone contact 3 unsucc phone contacts 1 mailing	Andrea Sneed-Sunbeam Family Services	South Yukon Church of Christ Toy Event	Holiday safety tips info via mailing-Offered resources for daily living needs, smoking cessation and mental and behavioral health resource information
RID [redacted]	Jan 2016	3 unsucc phone contacts			
RID [redacted]	Feb 2016	3 unsucc phone contacts			
RID [redacted]	Mar 2016	1 succ phone contact 2 unsucc phone contacts			Offered resources for daily living needs, smoking cessation and mental and behavioral health resource information
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact	Red Rock Behavioral Health		Offered resources for daily living needs and smoking cessation
RID [redacted]	May 2016	1 unsucc phone contact			
RID [redacted]	Jun 2016	3 unsucc phone contacts			
RID [redacted]	Jul 15	2 succ phone contacts 3 unsucc phone contacts		Calls conducted via translator at Canadian County Health Department Warr Acres Library for Summer Programs for Children	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Aug 2015	2 succ phone contacts 1 mailing		Calls conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Sep 2015	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Oct 2015	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					cessation resources and resources for daily living needs
RID [redacted]	Nov 2015	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Dec 2015	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jan 2016	1 succ phone contact		Call conducted via translator at Canadian County Health Department Mission of Mercy Dental Clinic	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Feb 2016	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact		Call conducted via translator at Canadian County Health Department T	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 succ phone contact	www.cdc.gov CDC Asthma Educational Booklet *Help Your Child Gain Control Over Asthma* and *Asthma and Outdoor Air Pollution* flyer via mailing	Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 succ phone contact		Call conducted via translator at Canadian County Health Department	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted] (referred to AIP)	Oct 2015	3 succ phone contacts 3 unsucc phone contacts 1 face to face		Delivered food and household resources provided by South Yukon Church of Christ Mustang Heights Baptist Church Clothing Closet, South Yukon Church of Christ Clothing Closet, 2011, CC-HAN website, South Yukon Church of Christ Thanksgiving Resources, For Medical Care: Open Arms, Southeast Health center, Lighthouse Medical Ministries, Mei Del Community Health Center, OKC-County Health Department, Mary Mahoney Memorial Health Center, Hope Center Health Clinic, Little Flower Clinic, Good Shepherd Clinic, Variety Health	Delivered Peak Flow Meter (Provided by PHCC funding)and Asthma/PFM educational Offered mental and behavioral health resources and smoking cessation information

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
				Center, CC-HAN brochure *Important Information for Patients with Upper Respiratory Infections*	
RID [redacted]	Nov 2015	3 succ phone contacts 1 mailing 1 face to face	Systems of Care	Delivered Thanksgiving basket provided by South Yukon Church of Christ Elks Lodge Turkey Giveaway Christmas resources: Santa's Toy Shop Applications, Yukon's Christmas With A Cop, Yukon Sharing, Tapestry Toy Store	Offered mental and behavioral health resources, smoking cessation information
RID [redacted]	Dec 2015	3 succ phone contacts 2 unsucc phone contacts 7 text messages 1 mailing		Mustang Heights Baptist Church Toy and Clothing Closet South Yukon Church of Christ Toy Event Gift Event Sponsored by Yukon Churches	Provided CDC flu vaccine and holiday safety tips info via mailing Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jan 2016	1 succ phone contact 1 unsucc phone contact			
RID [redacted]	Feb 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	1 succ phone contact 2 unsucc phone contacts			
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 succ phone contact 1 unsucc phone contact			
RID [redacted]	Jun 2016	1 succ phone contact 1 unsucc phone contact		Mustang Heights Baptist Church Clothing Closet South Yukon Church of Christ Clothing Closet	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted] (referred to AIP)	Jun 2016	4 succ phone contacts			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
End of Flores Pediatrics Members					
RID [redacted]	Feb 2016	2 succ phone contacts 1 unsucc phone contact 1 mailing 2 text messages		Oklahoma Mission of Mercy Dental Clinic	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Mar 2016	1 unsucc phone contact 1 mailing	okdhs.org	Kids Campus Learning and Fitness, Kingdom Kids Pre School, Rockwell Plaza YMCA,	

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		2 test messages		Tomorrow's Future, Zavions, Leadership Academy, Beautiful Journey Child Development Center, Child Care network Inc., Child Time, LCIS TuLakes, Children's Lighthouse, Church of the Savior, Northwest KinderCare, Teaching Little Hands, Camp SOAR, Future Stars Learning Center, God's Little Treasures	
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	May 2016	2 unsucc phone contacts			
RID [redacted]	Jun 2016	2 unsucc phone contacts			
RID [redacted]	Jul 2015	3 succ phone contacts 1 unsucc phone contact		211, Compassionate Hands, Trinity Baptist Church School Supply Event, Lord's Harvest School Supply Event	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Aug 2015	4 unsucc phone contacts			
RID [redacted]	Sep 2015	4 succ phone contacts 3 unsucc phone contacts			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Oct 2015	2 succ phone contacts 1 unsucc phone contact		South Yukon Church of Christ Thanksgiving Resource List	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Nov 2015	5 succ phone contacts 1 unsucc phone contact 1 mailing 1 face to face		South Yukon Church of Christ Thanksgiving and Christmas Resources, Delivered Thanksgiving Basket provided by South Yukon Church of Christ, Santa's Toy Shop Applications, Yukon's Christmas With a Cop, Yukon Sharing, Tapestry Toy Store, Elks Lodge Turkey Giveaway	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Dec 2015	5 succ phone contacts 2 unsucc phone contacts 2 emails 1 mailing		South Yukon Church of Christ Toy Event, Mustang Heights Baptist Church Toy and Clothing Closet, Gift Event Sponsored by Yukon Churches	Holiday Safety Tips via mailing, Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jan 2016	3 succ phone contacts 1 email		Mission of Mercy Dental Clinic, Trinity Baptist Church Free Eye Clinic, Women's Resource Center	
RID [redacted]	Feb 2016	1 succ phone contact			Offered mental and behavioral health

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	2 unsucc phone contacts			
RID [redacted]	Apr 2016	4 succ phone contacts 1 face to face		Delivered food and household resources provided by South Yukon Church of Christ	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 succ phone contact		Mustang Heights Baptist Church Clothing Closet	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 succ phone contact 1 face to face	Oklahoma Parent Center	Delivered food and household resources provided by South Yukon Church of Christ	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	2 succ phone contacts 3 unsucc phone contacts	Citizens Potawatomie Health Services, Carl Albert Indian Hospital	Trinity Baptist Church School Supply Event, Lord's Harvest School Supply Event	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Aug 2015	7 unsucc phone contacts			
RID [redacted]	Sep 2015	2 succ phone contacts 3 unsucc phone contacts			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Oct 2015	2 unsucc phone contacts			
RID [redacted]	Nov 2015	1 unsucc phone contact			
RID [redacted]	Dec 2015	5 unsucc phone contacts			
RID [redacted]	Jan 2015	5 unsucc phone contacts 1 mailing			
RID [redacted]	Feb 2015	5 unsucc phone contacts			
RID [redacted]	Mar 2015	3 unsucc phone contacts			
RID [redacted]	Jul 2015	3 succ phone contacts 3 unsucc phone contacts 7 texts	Ashley Dues, LLC, Oklahoma Family Counseling Center, Dr. Richard Zielinski, Inner Peace Pastoral Counseling	Women's Resource Center, 211, WWJD, Bread of Life Project, Salvation Army, El Reno On-Line Garage Sale Site, Trinity Baptist Church School Supply Event, Lord's Harvest School Supply Event	Offered smoking cessation resources
RID [redacted]	Aug 2015	1 succ phone contact			Offered assistance with educational and resource information
RID [redacted]	Jul 2015	3 succ phone	Ashley Dues, LLC, Oklahoma Family Counseling	Women's Resource Center, 211,	Offered smoking

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		contacts 3 unsucc phone contacts 7 texts	Center, Dr. Richard Zielinski, Inner Peace Pastoral Counseling	WWJD, Bread of Life Project, Salvation Army, El Reno On-Line Garage Sale Site, Trinity Baptist Church School Supply Event, Lord's Harvest School Supply Event	cessation resources
RID [redacted]	Aug 2015	1 succ phone contact			Offered assistance with educational and resource information
RID [redacted]	Jul 2015	1 succ phone contact	SoonerCare Helpline		Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Aug 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Sep 2015	2 succ phone contacts			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Oct 2015	1 unsucc phone contact			
RID [redacted]	Nov 2015	8 succ phone contacts 1 unsucc phone contact 1 mailing 1 face to face		Thanksgiving Resources South Yukon Church of Christ, Food and household resources provided by South Yukon Church of Christ, 211 (brochure provided) Delivered Thanksgiving Basket provided by South Yukon Church of Christ,	Offered mental and behavioral health resources, smoking cessation resources
RID [redacted]	Dec 2015	5 succ phone contacts 2 unsucc phone contacts 5 text messages 1 mailing	Andrea Sneed, Sunbeam Family Services	South Yukon Church of Christ Toy Event, Mustang Heights Baptist Church Toy and Clothing Closet	Holiday Safety Tips via mailing Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jan 2016	1 succ phone contact 1 unsucc phone contact 5 text messages		Trinity Baptist Church Free Eye Clinic, Mission of Mercy Dental Clinic	
RID [redacted]	Feb 2016	1 succ phone contact		Integris Canadian Valley Hospital Diabetes Classes	Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Mar 2016	1 unsucc phone contact			
RID [redacted]	Apr 2016	2 succ phone contacts 2 unsucc phone contacts			
RID [redacted]	May 2016	1 succ phone contact 5 unsucc phone contacts	www.cdc.gov CDC Asthma Educational Booklet via mailing		Offered mental and behavioral health resources, smoking cessation resources

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
		1 mailing			and resources for daily living needs
RID [redacted]	Jun 2016	2 unsucc phone contacts			
RID [redacted]	Jul 2015	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Aug 2015	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Sep 2015	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Oct 2015	1 unsucc phone contact			
RID [redacted]	Nov 2015	2 succ phone contacts 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Dec 2015	1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jan 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Feb 2016	2 unsucc phone contacts			
RID [redacted]	Mar 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Apr 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	May 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted]	Jun 2016	1 succ phone contact			Offered mental and behavioral health resources, smoking

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					cessation resources and resources for daily living needs
RID [redacted]	Jul 2015	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Aug 2015	2 unsucc phone contacts			
RID [redacted]	Sep 2015	1 succ phone contact 1 text		Yukon Health Department, Gateway Women's Resource Center, Minco Police Department, La Petite Child Care-Jen Duclos for car seat resources	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Oct 2015	2 unsucc phone contacts			
RID [redacted]	Nov 2015	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Dec 2015	1 unsucc phone contact			
RID [redacted]	Jan 2016	1 succ phone contact 3 unsucc phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Feb 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Mar 2016	1 unsucc phone contact			
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	May 2016	1 succ phone contact 1 mailing		CC-HAN brochure *Important Information for Parents of a Child with Fever*	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jun 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					smoking cessation
RID [redacted] (referred to AIP)	Sep 2015	3 succ phone contacts 1 unsucc phone contact			
RID [redacted]	Oct 2015	3 succ phone contacts 2 unsucc phone contacts 1 mailing	Oklahoma Parent Center	211 www.211oklahoma.org CC-HAN website South Yukon Church of Christ Thanksgiving Resource List	Offered information for mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	4 succ phone contacts 2 unsucc phone contacts 1 mailing 1 home delivery	Oklahoma Parent Center website www.oklahomaparentcenter.org	Delivered Thanksgiving Basket provided by South Yukon Church of Christ	Offered information for mental and behavioral health resources and smoking cessation
RID [redacted]	Dec 2015	1 succ phone contact 5 unsucc phone contacts	SoonerCare Helpline		Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jan 2016	1 succ phone contact 2 unsucc phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Feb 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Mar 2016	2 succ phone contacts 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Apr 2016	3 succ phone contacts 1 unsucc phone contact 2 text messages		211, Restore Hope Ministries, Salvation Army of Muskogee County, Gospel Rescue Mission for Utility Assistance	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	May 2016	1 succ phone contact 1 face to face		Delivered Summer Clothing for member and sibling provided by South Yukon Church of Christ CC-HAN website brochure	Delivered Peak Flow Meter (Provided by PHCC funding)and Asthma/PFM educational Offered information for mental and behavioral health resources and smoking cessation
RID [redacted]	Jun 2016	3 succ phone contact 3 unsucc phone contacts 2 text messages 1 mailing 1 face to face	Cherokee Nation website www.cherokee.org Cherokee Food Distribution Guidelines and locations	Delivered food, household resources and summer clothing provided by South Yukon Church of Christ and Mustang Heights Baptist Church	Offered information for mental and behavioral health resources and smoking cessation
RID [redacted] (referred to AIP)	Mar 2016	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					smoking cessation
RID [redacted]	Apr 2016	3 succ phone contacts 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	May 2016	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jun 2016	1 succ phone contact 1 unsucc phone contact			Offered mental and behavioral health resources, smoking cessation resources and resources for daily living needs
RID [redacted] (referred to AIP)	May 2016	3 succ phone contacts 4 unsucc phone contacts	Systems of Care		Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jun 2016	5 unsucc phone contacts			
End of Yukon Pediatrics Member's					
RID [redacted]	Jul 2015	3 succ phone contacts 3 unsucc phone contacts 1 text message 2 face to face	SNAP, Food Stamp HotLine, Gods Helping Hands,	Delivered food and household resources provided by South Yukon Church of Christ x 2 Trinity Baptist Church for School Supply Event, Lord's Harvest for School supply Event	Offered mental and behavioral health resources and smoking cessation resources
RID [redacted]	Aug 2015	1 succ phone contact 1 unsucc phone contact		Russell Murray Hospice Grief Support Group	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Sep 2015	3 succ phone contacts 3 unsucc phone contacts 1 home delivery		Delivered food and household resources provided by South Yukon Church of Christ	Offered mental and behavioral health resources and smoking cessation resources
RID [redacted]	Oct 2015	2 unsucc phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	2 succ phone contacts 1 mailing		Elks Lodge for Turkey Giveaway, Blessing Baskets	
RID [redacted]	Dec 2015	3 succ phone contacts 5 unsucc phone contacts 1 text 1 mailing		South Yukon Church of Christ Toy Event, Gift Event sponsored by Yukon Churches	Holiday Safety Tips via mailing
RID [redacted]	Jan 2016	1 succ phone contact 2 unsucc phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
RID [redacted]	Feb 2016	2 succ phone contacts 1 unsucc phone contact 1 home delivery		Delivered food and household resources provided by South Yukon Church of Christ	
RID [redacted]	Mar 2016	2 unsucc phone contacts			
RID [redacted]	Apr 2016	2 succ phone contacts 1 face to face		Delivered food and household resources provided by South Yukon Church of Christ	Offered mental and behavioral health resources and smoking cessation resources
RID [redacted]	May 2016	1 unsucc phone contact			
RID [redacted]	Jun 2016	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jul 2015	2 unsucc phone contacts			
RID [redacted]	Aug 2015	1 unsucc phone contact			
RID [redacted]	Jul 2015	1 succ phone contact 1 unsucc phone contact		Trinity Baptist Church School Supply Event, Lord's Harvest School Supply Event	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Aug 2015	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Sep 2015	2 unsucc phone contacts			
RID [redacted]	Oct 2015	2 succ phone contacts 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	1 succ phone contact		Elks Lodge Turkey Giveaway, Blessing Baskets	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Dec 2015	1 succ phone contact 2 unsucc phone contacts		Mustang Heights Baptist Church Toy and Clothing Closet	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jan 2016	2 unsucc phone contacts			
RID [redacted]	Feb 2016	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					smoking cessation
RID [redacted]	Mar 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Apr 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	May 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jun 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
End of Dr. Holy's Members					
RID [redacted]	Jul 2015	1 succ phone contact 5 unsucc phone contacts			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Aug 2015	6 unsucc phone contact			
RID [redacted]	Sep 2015	6 unsucc phone contact			
RID [redacted]	Oct 2015	5 unsucc phone contact			
RID [redacted]	Nov 2015	4 unsucc phone contact			
RID [redacted]	Dec 2015	3 unsucc phone contact 1 mailing			
RID [redacted]	Jan 2106	1 succ phone contact 3 unsucc phone contacts 2 text messages	Neighborhood Service Organization	211	
RID [redacted]	Feb 2016	1 unsucc phone contact			
RID [redacted]	Mar 2016	1 succ phone contact 3 unsucc phone contacts	Neighborhood Service Organization	211	
RID [redacted]	Apr 2016	2 unsucc phone contacts			
RID [redacted]	May 2016	4 unsucc phone contacts			
RID [redacted]	Jun 2016	4 unsucc phone contacts 1 mailing	www.cdc.gov CDC Asthma Educational Booklet via mailing		
RID [redacted] Riot	Jul 2015	2 succ phone contacts 5 unsucc phone contact			
RID [redacted]	Aug 2015	1 succ phone contact 4 unsucc phone contacts			

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
RID [redacted]	Sep 2015	2 unsucc phone contacts 1 mailing	SoonerCare Helpline via mailing		
RID [redacted]	Oct 2015	4 unsucc phone contacts			
RID [redacted]	Nov 2015	3 unsucc phone contacts			
RID [redacted]	Dec 2015	1 unsucc phone contact			
RID [redacted]	Jan 2016	1 mailing		CC-HAN website brochure via mailing	
RID [redacted]	Jul 2015	7 unsucc phone contacts			
RID [redacted]	Aug 2015	2 succ phone contacts 1 unsucc phone contact			
RID [redacted]	Sep 2015	1 succ phone contact 4 unsucc phone contacts	SoonerCare Helpline		
RID [redacted]	Oct 2015	1 succ phone contact 1 unsucc phone contact			
RID [redacted]	Nov 2015	2 succ phone contacts 1 unsucc phone contact			
RID [redacted]	Dec 2015	1 succ phone contact 1 unsucc phone contact 1 mailing		Mustang Heights Baptist Church Toy and Clothing Closet	
RID [redacted]	Jan 2016	1 succ phone contact		Mission of Mercy Dental Clinic Trinity Baptist Church Free Eye Clinic	
RID [redacted]	Feb 2016	1 unsucc phone contact			
RID [redacted]	Mar 2016	2 succ phone contacts 1 unsucc phone contact 2 text messages		Jen Duclos –La Petite Child Care, Minco Police Department, Teresa Minnik-Gateway Women's Resources, Yukon Health Department for Car and Crib Resources	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Apr 2016	1 succ phone contact 1 unsucc phone contact 1 mailing			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	May 2016	1 unsucc phone contact			
RID [redacted] (referred to AIP)	Aug 2015	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Sep 2015	6 succ phone contacts 2 unsucc phone contacts			Offered information for daily living resources, mental and behavioral health resources and

Member RID	Month	Type of Contact(s)	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
					smoking cessation
RID [redacted]	Oct 2015	3 succ phone contacts 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Nov 2015	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Dec 2015	1 succ phone contact 2 unsucc phone contacts 1 mailing			Holiday safety tips info via mailing, Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Jan 2016	1 succ phone contact 1 unsucc phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Feb 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Mar 2016	2 succ phone contacts 1 unsucc phone contact 1 face to face		Delivered food and household resources provided by South Yukon Church of Christ	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	Apr 2016	1 succ phone contact			Offered information for daily living resources, mental and behavioral health resources and smoking cessation
RID [redacted]	May 2016	2 unsucc phone contacts			
RID [redacted]	Jun 2016	1 succ phone contact 1 unsucc phone contact 1 mailing	www.cdc.gov CDC Asthma Educational Booklet via mailing	Custer County Rural Water District # 4 for utility assistance	Offered information for daily living resources, mental and behavioral health resources and smoking cessation
End of CVFC Members					

Appendix A.2
Chronic Care Program Report - RY 16

Chronic Care Program Report RY 16

Member RID	Month	Type of Contact	Care Management Referrals	Community Resource Referrals	Other Misc. Contacts
RID [redacted]	July 15	4 succ phone contacts (spc) 1 face-to-face 1 letter	Confirmed neurology appointments every 2 wks	11-provided clothing and groceries at face-to-face at SYCOC; contact info SYCOC, Manna Pantry, Compassionate Hands, Yukon Sharing, St. Francis De Paul, Jacob's Cupboard, 2-1-1. Also resources for school supplies-Trinity Baptist Church and Canadian Co. Democrats	0
RID [redacted]	Aug 15	3 upc 1 letter	0	0	Mailed CCHAN website brochure
RID [redacted]	Sep 15	1 spc 1upc	Confirmed neurology apt for Sept 14	0	0
RID [redacted]	Oct 15	1 spc	0	2-Legal Aide and Trinity Legal	0
RID [redacted]	Nov 15	1 spc 1 upc		Offered Christmas resources for children	0
RID [redacted]	Dec 15	2 spc 1upc	0	Offered Christmas resources for children	Obtained medical records from Flores Pediatrics; Support provided for getting SoonerCare benefits reinstated
RID [redacted]	Jan 16	2 spc 1 letter	0	4-Legal Aide, Trinity Legal phone number and website, OFN (Needed help w/guardianship issues now that he has turned 18)	0.
RID [redacted]	Feb 16	2 spc 1 upc	0	6-Resources for transitioning out of highschool-OK Foundation for Disabled, Dynasty Care Service, Dale Rogers Training Center, OFN, Sooner Success, DHS caseworker re: State Personal Care Aide Program	0
RID [redacted]	Mar 16	6 upc 1 letter	0	6-Following provided in letter: OK Foundation for Disabled, Dynasty Care Service, Dale Rogers Training Center, OFN, Sooner Success, DHS caseworker re: State Personal Care Aide Program	0
RID [redacted]	Apr 16	4 upc 1 letter	0	0	Requested medical records from Flores Pediatrics
RID [redacted]	May 16	1 spc	Confirmed neurology appointment for June	0	0
RID [redacted]	Jun 16	2 spc	Confirmed neurology appointment for July	0	Picked up medical records from Flores Pediatrics

Appendix B

ER Utilization Tables for Q1-Q4 2015

Table 1

ER Utilization 2015			Total # of Contacts	No. of ER Visits	No of PCP Visits	Average Time (days) Between ER Visit-PCP Visit	Average Time (days) Between ER and 1st CM Contact	Average Days Between ER Visits
Year	Quarter	Members						
2015	Q1	22	575	83	39	15.73	106.37	11.53
2015	Q2	23	597	82	34	34.71	80.33	13.01
2015	Q3	11	393	36	12	19.83	107.61	9.2
2015	Q4	5	138	17	13	151.82	17.18	18.42
FY 2015 Statistics:		61	1703	218	98	55.52	77.87	13.04

Table 2

		ER Utilization 2015-Qtr 1	January, February, March of 2015																										
			Care Manager Contacts					Medical				ER Visits					Intervention		Referrals										
			Telephonic		Other		Total # of Contacts	No. of ER Visits	ER Visits (Date)	PCP visit (Date)	No. of PCP Visits in Q2	Time(days)Between ER-PCP	ER Date	1st CM Date	Time (days)	Time between ER Visits	Average Between ER Visits			CM					Behav Hlth, Other CM	Comm. Res., Other CM	DLN Assist, Other CM
Year	Quarter	Member RID	Successful	Unsuccessful	Letters	Face to Face												Type CMI	Int. Date	Behav Hlth	Pain Mgmt.	Specialist	Comm. Res.	DLN Assist.			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/24/2015				1/24/2015	1/5/2015	-19		7.57	SPC	4/21/2015	0	0	0	1	1			
									1/26/2015				1/26/2015	1/5/2015	-21	2		letter	5/27/2015	1	0	0	0	0			
									2/7/2015				2/7/2015	1/5/2015	-33	12		SPC	6/3/2015	0	9	0	2	0			
									2/7/2015				2/7/2015	1/5/2015	-33	0		SPC	6/15/2015	0	0	1	0	0			
									2/21/2015				2/21/2015	1/5/2015	-47	14		letter	6/17/2015	1	0	0	0	0			
									2/28/2015	3/9/2015		9	2/28/2015	1/5/2015	-54	7		letter	6/26/2015	0	0	0	1	0			
									3/18/2015		1		3/18/2015	1/5/2015	-72	18		letter	7/2/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/16/2015	3/17/2015		60	1/16/2015	6/10/2015	145		8.50	letter	6/17/2015	0	0	0	0	0			
									1/26/2015				1/26/2015	6/10/2015	135	10		SPC	7/13/2015	0	0	0	0	0			
									2/19/2015				2/19/2015	6/10/2015	111	24		letter	7/23/2015	0	0	0	0	0			
									2/19/2015		1		2/19/2015	6/10/2015	111	0		letter	7/29/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/10/2015	1/2/2015		-39	2/10/2015	6/10/2015	120		2.50	SPC	6/10/2015	0	0	0	1	0			
									2/12/2015				2/12/2015	6/10/2015	118	2		SPC	6/17/2015	0	0	0	0	1			
									2/20/2015	3/2/2015		10	2/20/2015	6/10/2015	110	8		letter	6/17/2015	1	0	0	1	0			
									3/9/2015		2		3/9/2015	6/10/2015	93	17		SPC	6/29/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/22/2015	3/17/2015		23	2/22/2015	6/10/2015	108		9.67	letter	6/17/2015	1	0	0	0	0			
									2/23/2015				2/23/2015	6/10/2015	107	1		SPC	6/22/2015	1	0	0	1	1			
									3/23/2015		1		3/23/2015	6/10/2015	79	28		SPC	7/7/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/16/2015	3/18/2015		61	1/16/2015	6/10/2015	145		24.33	SPC	6/10/2015	0	0	0	0	0			
									1/18/2015				1/18/2015	6/10/2015	143	2		SPC	7/13/2015	0	0	0	0	0			
									3/30/2015		1		3/30/2015	6/10/2015	72	71		SPC	7/27/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/13/2015				1/13/2015	6/10/2015	148		5.60	UPC	6/10/2015	0	0	0	0	0			
6/23/15-rcvd from OHCA "Now enrolled non HAN PCP"									1/19/2015				1/19/2015	6/10/2015	142	6		UPC	6/15/2015	0	0	0	0	0			
									2/10/2015				2/10/2015	6/10/2015	120	22		UPC	6/16/2015	0	0	0	0	0			
									2/11/2015				2/11/2015	6/10/2015		1		letter	6/17/2015	0	0	0	0	0			
									2/16/2015		0		2/16/2015	6/10/2015	114	5		UPC	6/22/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/9/2015				1/9/2015	6/10/2015	152		6.00	SPC	6/10/2015	0	0	0	0	0			
6/10/15-Mom reports no longer on SoonerCare									1/18/2015				1/18/2015	6/10/2015	143	9											
									1/27/2015		0		1/27/2015	6/10/[redacted]	[redacted]	[redacted]											
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/29/2015				1/29/2015	6/10/2015	132	2	8.67	UPC	6/10/2015	0	0	0	0	0			
6/23/15-rcvd from OHCA "Enrolled w non HAN PCP									2/18/2015				2/18/2015	6/10/2015	112	20		UPC	6/15/2015	0	0	0	0	0			
									2/24/2015		0		2/24/2015	6/10/2015	106	6		letter	6/21/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/6/2015	1/9/2015		3	1/6/2015	6/10/2015	155		20.25	SPC	6/22/2015	0	0	0	3	0			
7/24/15-rcvd from OHCA "PCP chg 4/2/15" "no longer HAN PCP"									2/12/2015				2/12/2015	6/10/2015	118	37		SPC	6/29/2015	0	0	0	1	1			
									2/13/2015				2/13/2015	6/10/2015	117	1		SPC	7/7/2015	0	0	0	1	0			
									3/28/2015		1		3/28/2015	6/10/2015	74	43		SPC	7/13/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/18/2015				1/18/2015	6/10/2015	143		15.33	SPC	6/30/2015	2	0	0	1	1			
									2/23/2015	3/9/2015		14	2/23/2015	6/10/2015	107	36		face-to-face	7/1/2016	2	0	0	2	5			
									3/5/2015	4/16/2015	2	42	3/5/2015	6/10/2015	97	10		SPC	7/6/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/20/2015	1/12/2015		-8	1/20/2015				21.67	SPC	1/22/2015	0	0	0	0	2			
on AIP									1/24/2015	2/3/2015		10	1/24/2015			4		SPC	2/20/2015	0	0	0	1	0			
									3/26/2015		2		3/26/2015			61		letter	6/23/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/18/2015	1/19/2015		1	1/18/2015	4/13/2016	451		10.67	SPC	4/13/2015	0	0	0	0	0			
									2/17/2015	1/28/2015		-20	2/17/2015	4/13/2016	421	30		SPC	7/7/2015	0	0	0	1	0			
									2/19/2015	3/18/2015	3	27	2/19/2015	4/13/2016	419	2		SPC	7/21/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/9/2015	1/13/2015		4	1/9/2015	6/10/2015	152		13.33	letter	6/26/2015	0	0	0	0	0			
									2/14/2015	1/20/2015		-25	2/14/2015	6/10/2015	116	36		SPC	7/6/2015	0	0	0	1	1			
									2/18/2015	2/3/2015	3	-15	2/18/2015	6/10/2015	112	4		letter	7/23/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	/27/2015				1/27/2015				7.67		1/0/1900								
6/9/2015-rcvd from OHCA "In DHS custody snce 3/11/2015"									1/30/2015				1/30/2015			3			1/0/1900								
									2/2/2015				2/2/2015			3			1/0/1900								
									3/6/2015				3/6/2015			32			1/0/1900								
									3/12/2015				3/12/2015			6			1/0/1900								
									3/14/2015				3/14/2015			2			1/0/1900								

[redacted]					/16/2015	2/2/2015		17	1/16/2015	6/10/2015	145			SPC	6/17/2015	0	0	0	0	2			
					1/18/2015	3/9/2015		50	1/18/2015	6/10/2015	143	2	8.00	SPC	7/14/2015	0	0	0	1	2			
					2/9/2015	3/23/2015	3	42	2/9/2015	6/10/2015	121	22		face-to-face	7/15/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]					/11/2015	1/19/2015		8	1/11/2015	4/8/2015	87			SPC	4/8/2015	0	0	0	0	0			
6/11/15-rcvd from OHCA "last day w/SoonerCare 5/12/15"					1/23/2015	2/9/2015		17	1/23/2015	4/8/2015	75	12		SPC	6/10/2015	0	0	0	0	0			
					2/24/2015	3/2/2015		6	2/24/2015	4/8/2015	43	32	14.40										
					2/28/2015	3/5/2015		5	2/28/2015	4/8/2015	39	4											
					3/24/2015	3/17/2015	7	-7	3/24/2015	4/8/[redacted]	[redacted]	[redacted]											
[redacted]					/7/2015				1/7/2015	4/23/2015	106			letter	5/12/2015	0	0	0	0	0			
SoonerCare eligibility ended 5/12/2015					1/7/2015				1/7/2015	4/23/2015	106	0	13.67	letter	6/17/2015	0	0	0	0	0			
					2/17/2015		0		2/17/2015	4/23/2015	65	41		letter	6/26/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]					/12/2015	6/4/2015		112	2/12/2015	6/10/2015	118			UPC	6/10/2015	0	0	0	0	0			
					2/14/2015				2/14/2015	6/10/2015	116	2	5.00	letter	7/16/2015	0	0	0	0	0			
					2/27/2015		0		2/27/2015	6/10/2015	103	13		SPC	8/19/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]					/1/2015	1/13/2015		12	1/1/2015	6/10/2015	160			letter	6/17/2015	0	0	0	0	0			
7/22/15-rcvd from OHCA SC eligibility ended 7/4/15					1/4/2015				1/4/2015	6/10/2015	157	3		SPC	6/22/2015	0	0	0	1	0			
					2/22/2015	2/25/2015		3	2/22/2015	6/10/2015	108	49	14.00	SPC	6/29/2015	0	0	0	2	0			
					2/27/2015	3/9/2015		10	2/27/2015	6/10/2015	103	5		SPC	7/7/2015	0	0	0	0	0			
					3/12/2015	3/17/2015	4	5	3/12/2015	6/10/2015	90	13		letter	7/15/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]					/5/2015	1/27/2015		22	1/5/2015	6/10/2015	156			SPC	7/6/2015	0	0	0	0	1			
					1/16/2015	3/2/2015		45	1/16/2015	6/10/2015	145	11	16.00	SPC	8/24/2015	0	0	0	1	1			
					2/22/2015	3/31/2015	3	37	2/22/2015	6/10/2015	108	37		face-to-face	8/24/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]					/7/2015				1/7/2015	4/23/2015	106			SPC	6/16/2016	0	0	0	1	0			
					2/1/2015				2/1/2015	4/23/2015	81	25	9.00	letter	7/23/2015	0	0	0	3	0			
					2/3/2015		0		2/3/2015	4/23/2015	79	2		SPC	5/11/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			
[redacted]					/10/2015	1/13/2015		3	1/10/2015	2/26/2015	47			SPC	8/25/2015	0	0	0	0	2			
					1/20/2015	2/12/2015		23	1/20/2015	2/26/2015	37	10	11.75	SPC	9/1/2015	0	0	0	1	0			
					2/23/2015	2/24/2015		1	2/23/2015	2/26/2015	3	34		SPC	9/8/2015	0	0	0	0	4			
					2/26/2015	3/12/2015	5	14	2/26/2015	2/26/2015	0	3		face-to-face	9/8/2015	0	0	0	0	2			
			575	83			39	15.73			106.37		11.53										
			Total # of Contacts	Total # of ER Visits			Total # of PCP Visits	Average Time(days)Between ER-PCP			Average Time between ER and 1st CM contact.		Average Time between ER Visits										

		ER Utilization 2015-Qtr 2	April, May, June 2015																						
			Care Manager Contacts					Medical					ER Visits					Intervention		Referrals CM				
			Telephonic		Other																				
Year	Quarter	Member RID	Successful	Unsuccessful	Letters	Face to Face	Total # of Contacts	No. of ER Visits	ER Visits (Date)	PCP visit (Date)	No. of PCP Visits in Q2	Time(days) Between ER-PCP	ER Date	1st CM Date	Time (days)	Time between ER Visits	Average Between ER Visits	Type CMI	Int. Date	Behav Hlth	Pain Mgmt.	Specialist	Comm. Res.	DLN Assist.
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/6/2015				4/6/2015	4/21/2015	15			SPC	4/21/2015	0	0	0	2	0
									4/7/2015				4/7/2015	4/21/2015	14	1		letter	5/13/2015	1	0	0	0	0
									4/18/2015				4/18/2015	4/21/2015	3	11		letter	5/27/2015	1	0	0	0	0
									4/18/2015				4/18/2015	4/21/2015	3	0		SPC	6/3/2015	0	0	0	2	0
									4/19/2015				4/19/2015	4/21/2015	2	1	7.00	letter	6/26/2015	0	0	0	1	0
									5/11/2015				5/11/2015	4/21/2015	-20	22		letter	7/2/2015	1	0	0	0	0
									5/21/2015				5/21/2015	4/21/2015	-30	10		letter	8/28/2015	1	0	0	0	0
									5/24/2015				5/24/2015	4/21/2015	-33	3		letter	9/17/2015	5	0	0	1	0
									6/8/2015		0		6/8/2015	4/21/2015	-48	15		letter	10/14/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/14/2015				5/14/2015	5/6/2015	-8			UPC	5/6/2015	0	0	0	0	0
									6/4/2015				6/4/2015	5/6/2015	-29	21	8.33	SPC	10/13/2015	1	0	0	0	0
									6/8/2015		0		6/8/2015	5/6/2015	-33	4		SPC	10/20/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/18/2015	6/16/2015		59	4/18/2015	9/14/2015	149			SPC	9/14/2015	0	0	0	0	0
									4/30/2015	6/16/2015		47	4/30/2015	9/14/2015	137	12	5.75	SPC	9/17/2015	0	0	0	0	0
									5/2/2015	6/16/2015		45	5/2/2015	9/14/2015	135	2		letter	9/17/2015	0	0	0	0	0
									5/11/2015	6/16/2015	1	36	5/11/2015	9/14/2015	126	9		SPC	9/23/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/26/2015	6/30/2015		65	4/26/2015	6/10/2015	45			SPC	7/7/2015	0	0	1	1	1
									5/7/2015	6/30/2015		54	5/7/2015	6/10/2015	34	11	16.33	face-to-face	10/27/2015	0	0	0	1	1
									6/14/2015	6/30/2015	1	16	6/14/2015	6/10/2015	-4	38		SPC	11/11/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/20/2015				4/20/2015	8/18/2015	120			SPC	8/18/2015	0	0	0	1	0
									5/3/2015				5/3/2015	8/18/2015	107	13	9.67	SPC	9/21/2015	0	0	0	0	1
									5/19/2015		0		5/19/2015	8/18/2015	91	16		SPC	11/16/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/12/2015				5/12/2015	9/15/2015	126			SPC	9/22/2015	0	0	0	4	0
		last day w/CVFC 10/26/2015							5/15/2015				5/15/2015	9/15/2015	123	3	10.67	SPC	9/30/2015	0	0	0	2	0
									6/13/2015		0		6/13/2015	9/15/2015	94	29		SPC	10/26/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/23/2015	8/19/2015		118	4/23/2015	5/6/2015	13			face-to-face	9/22/2015	1	0	0	3	0
									5/13/2015	8/19/2015		98	5/13/2015	5/6/2015	-7	20	15.75	SPC	9/28/2015	1	0	0	1	0
									5/31/2015	8/19/2015		80	5/31/2015	5/6/2015	-25	18		SPC	10/12/2015	1	0	0	0	1
									6/25/2015	8/19/2015	0	55	6/25/2015	5/6/2015	-50	25		SPC	11/2/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/9/2015	8/12/2015		95	5/9/2015	9/15/2015	129			SPC	9/28/2015	1	0	0	1	1
									5/11/2015	8/12/2015		93	5/11/2015	9/15/2015	127	2		face-to-face	9/29/2015	0	0	0	1	1
									5/11/2015	8/12/2015		93	5/11/2015	9/15/2015	127	0	9.00	face-to-face	10/13/2015	0	0	0	0	7
									6/14/2015	8/12/2015		59	6/14/2015	9/15/2015	93	34		SPC	10/13/2015	0	0	0	2	0
									6/23/2015	8/12/2015	0	50	6/23/2015	9/15/2015	84	9		SPC	10/28/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/6/2015	4/14/2015		8	4/6/2015	4/20/2015	14			letter	5/12/2015	1	0	0	0	0
									5/7/2015	5/5/2015		-2	5/7/2015	4/20/2015	-17	31	26.67	letter	9/18.2015	1	0	0	0	0
									6/25/2015	6/24/2015	3	-1	6/25/2015	4/20/2015	-66	49		letter	10/7/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/10/2015	6/11/2015		62	4/10/2015	7/28/2015	109			letter	9/2/2015	1	0	0	0	0
									6/5/2015				6/5/2015			56	14.75	SPC	9/17/2015	0	0	1	0	0
									6/8/2015				6/8/2015			3		letter	9/17/2015	1	0	0	0	0
									6/8/2015		1		6/8/2015			0		SPC	11/17/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/13/2015				4/13/2015	9/15/2015	155			SPC	9/15/2015	0	0	0	0	
		PCP changed 7/16/15							4/14/2015				4/14/2015	9/15/2015	154	1	0.67		9/15/2015					
									4/15/2015		0		4/15/2015	9/15/2015	153	1			9/15/[redacted]					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/8/2015	5/19/2015		41	4/8/2015	9/15/2015	160			letter	9/17/2015	0	0	0	1	0
									5/22/2015	5/22/2015		0	5/22/2015	9/15/2015	116	44	22.67	SPC	10/6/2015	0	0	0	0	0
									6/15/2015		2		6/15/2015	9/15/2015	92	24		letter	10/22/2015	0	0	0	0	0

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/28/2015	5/6/2015		8	4/28/2015	9/15/2015	140			SPC	9/15/2015	0	0	0	0	0
									5/14/2015	6/1/2015		18	5/14/2015	9/15/2015	124	16	10.67	letter	9/23/2015	0	0	0	1	0
									5/30/2015	6/19/2015	4	20	5/30/2015	9/15/2015	108	16		letter	11/5/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/3/2015				5/3/2015	9/15/2015	135			SPC	9/28/2015	0	0	0	2	0
									5/13/2015				5/13/2015	9/15/2015	125	10	11.67	letter	9/28/2015	0	0	0	2	0
									6/7/2015		0		6/7/2015	9/15/2015	100	25		SPC	11/2/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/18/2015	7/30/2015		73	5/18/2015	9/15/2015	120			SPC	9/16/2015	0	0	0	0	0
									6/11/2015				6/11/2015	9/15/2015	96	24	8.00	UPC	9/21/2015	0	0	0	0	0
									6/11/2015		0		6/11/2015	9/15/2015	96	0		letter	9/23/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/26/2015				5/26/2015	9/15/2015	112			SPC	9/15/2015	0	0	0	0	0
									6/23/2015	6/23/2015		0	6/23/2015	9/15/2015	84	28	10.67	SPC	10/5/2015	0	0	0	0	0
									6/27/2015		1		6/27/2015	9/15/2015	80	4		SPC	11/9/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/7/2015	6/1/2015		55	4/7/2015	6/23/2015	77			SPC	6/25/2015	0	0	0	1	0
									6/8/2015	6/10/2015		2	6/8/2015	6/23/2015	15	62	21.67	SPC	7/23/2015	0	0	0	1	0
									6/11/2015	6/30/2015	3	19	6/11/2015	6/23/2015	12	3		SPC	9/17/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/16/2015	4/13/2015		-3	4/16/2015	9/15/2015	152			SPC	9/15/2015	0	0	0	0	0
									4/18/2015	5/14/2015		26	4/18/2015	9/15/2015	150	2		letter	9/18/2015	0	0	0	0	0
									6/13/2015	6/12/2015		-1	6/13/2015	9/15/2015	94	56	12.20	SPC	10/5/2015	0	0	0	0	0
									6/15/2015	6/15/2015		0	6/15/2015	9/15/2015	92	2		letter	10/22/2015	0	0	0	0	0
									6/16/2015	6/29/2015	5	13	6/16/2015	9/15/2015	91	1		letter	11/5/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/28/2015	6/3/2015		36	4/28/2015	9/15/2015	140			SPC	9/16/2015	1	0	0	0	0
									5/20/2015				5/20/2015	9/15/2015	118	22	8.67	SPC	10/12/2015	0	0	0	0	0
									5/24/2015		0		5/24/2015			4		letter	11/25/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/22/2015				4/22/2015	9/15/2015	146			SPC	9/15/2015	0	0	0	0	0
		9/18/15-received message from J. Laizure, "chgd PCP 7/9/15"							4/26/2015				4/26/2015	9/15/2015	142	4	14.67		9/15/2015					
									6/5/2015		0		6/5/2015	9/15/2015	102	40			9/15/[redacted]					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/11/2015	4/6/2015		-5	4/11/2015	9/15/2015	157			letter	9/18/2015	0	0	0	0	0
									4/12/2015	4/13/2015		1	4/12/2015	9/15/2015	156	1	22.67	SPC	9/21/2015	0	0	0	0	1
									6/18/2015	6/22/2015	5	4	6/18/2015	9/15/2015	89	67		SPC	10/5/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/8/2015	4/8/2015		0	4/8/2015	9/15/2015	160			SPC	9/15/2015	0	0	0	1	0
									5/13/2015	6/2/2015		20	5/13/2015	9/15/2015	125	35	19.00	SPC	9/25/2015	0	0	0	0	0
									6/4/2015	6/5/2015	8	1	6/4/2015	9/15/2015	103	22		letter	10/7/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]/29/2015				4/29/2015	9/15/2015	139			SPC	9/15/2015	0	0	0	0	0
		9/15/15-mom denies SoonerCare coverage							6/4/2015				6/4/2015	9/15/2015	103	36	12.00	letter	9/30/2015	0	0	0	0	0
									6/4/2015		0		6/4/2015	9/15/2015	103	0		letter	10/14/2015	0	0	0	0	0
							597	82			34	34.71			80.33		13.01							
							Total # of Contacts	Total # of ER Visits			Total # of PCP Visits	Average Time(days) Between ER-PCP			Average Time between ER and 1st CM contact.		Average Time between ER Visits							

		ER Utilization 2015-Qtr 3	July, August, September 2015																				
			Care Manager Contacts					Medical					ER Visits					Intervention		CM				
			Telephonic		Other																		
Year	Quarter	Member RID	Successful	Unsuccessful	Letters	Face to Face	Total # of Contacts	No. of ER Visits	ER Visits (Date)	PCP visit (Date)	No. of PCP Visits in Q3	Time(days) Between ER-PCP	ER Date	1st CM Date	Time (days)	Time between ER Visits	Average Between ER Visits	Type CMI	Int. Date	Behav Hlth	Pain Mgmt.	Specialist	Comm. Res.	DLN Assist.
[redacted]		[redacted]							[redacted]/6/2015	7/24/2015		18	7/6/2015	11/5/2015	122			SPC	11/5/2015	0	0	0	1	0
									7/12/2015	8/12/2015		31	7/12/2015	11/5/2015	116	6	16.00	letter	12/4/2016	0	0	0	0	0
									9/5/2015	9/9/2015		4	9/5/2015	11/5/2015	61	55		letter	12/16/2016	0	0	0	0	0
									9/8/2015		3		9/8/2015	11/5/2015	58	3		letter	11/5/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]							[redacted]/8/2015	8/27/2015		-12	9/8/2015	11/24/2015	77			SPC	11/24/2015	0	0	0	1	0
									9/8/2015	9/14/2015		6	9/8/2015	11/24/2015	77	0	3.33	SPC	12/21/2015	0	0	0	1	0
									9/18/2015	10/13/2015	3	25	9/18/2015	11/24/2015	67	10		SPC	12/31/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]							[redacted]/6/2015				7/6/2015	9/29/2015	85			UPC	9/29/2015	0	0	0	0	0
		PCP Suneela Bhoplay effective 12/04/2015							7/8/2015				7/8/2015	9/29/2015	83	2	9.33	letter	11/5/2015	0	0	0	0	0
		(above received 1/13/16)							8/3/2015		0		8/3/2015	9/29/2015	57	26		letter	12/16/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]							[redacted]/7/2015	8/13/2015		6	8/7/2015	10/20/2015	74			SPC	12/3/2016	0	0	0	1	0
		11/10/2015-mother states PCP change to Dr. Hanes							8/8/2015				8/8/2015	10/20/2015	73	1	0.33	SPC	1/17/2016	0	0	0	3	0
									8/8/2015		1		8/8/2015	10/20/2015	73	0		letter	2/17/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]							[redacted]/24/2015	9/25/2015		63	7/24/2015	9/15/2015	53			UPC	9/15/2015	0	0	0	0	0
									7/25/2015				7/25/2015	9/15/2015	52	1	5.00	SPC	9/16/2015	0	0	0	1	0
									7/25/2015				7/25/2015	9/15/2015	52	0		SPC	9/17/2015	1	0	0	2	0
									8/13/2015		1		8/13/2015	9/15/2015	33	19		SPC	11/2/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]							[redacted]/11/2015				7/11/2015	7/25/2015	14			SPC	7/27/2015	0	0	0	2	0
		This member was on AIP							7/23/2015	7/24/2015		1	7/23/2015	7/25/2015	2	12	13.67	SPC	10/29/2015	0	0	0	1	0
									8/21/2015	9/2/2015	2	12	8/21/2015	7/25/2015	-27	29		face to face	11/23/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]							[redacted]/15/2015				7/15/2015	11/24/2016	498			UPC	11/24/2015	0	0	0	0	0
		Flores Pediatrics reports "Patient Dismsissed 9/29/15"							8/22/2015				8/22/2015	11/24/2016	460	38	19.25	UPC	11/25/2015	0	0	0	0	0
		11/30/15-Mother reports change of PCP to Dr. Ferguson							9/28/2015				9/28/2015	11/24/2016	423	37		letter	11/27/2015	0	0	0	0	0
									9/30/2015		0		9/30/2015	11/24/2016	421	2		SPC	11/30/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]							[redacted]/23/2015				8/23/2015	11/24/2015	93			UPC	11/24/2015	0	0	0	0	0
		Flores Pediatrics reports "Patient Dismissed 9/29/15"							9/4/2015				9/4/2015	11/24/2015	81	12	12.00	letter	11/27/2015	0	0	0	0	0
		11/30/15-Mother reports change of PCP to Dr. Ferguson							9/28/2015		0		9/28/2015	11/24/2015	57	24		SPC	11/30/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]							[redacted]/14/2015				7/14/2015	11/24/2015	133			UPC	11/24/2015	0	0	0	0	0
		12/7/15-Received message from Project Manager,							9/6/2015				9/6/2015	11/24/2015	79	54	21.33	letter	11/27/2015	1	0	0	0	0
		"No longer engaged in our HAN..."							9/16/2015		0		9/16/2015	11/24/2015	69	10		letter	12/8/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]							[redacted]/26/2015	10/9/2015		13	9/26/2015	11/24/2015	59			UPC	11/24/2015	0	0	0	0	0
		12/08/15-member states she has changed PCP;							9/27/2015				9/27/2015	11/24/2015	58	1	0.67	SPC	12/7/2015	0	0	0	1	0
		not on Dr. Holy's provider panel							9/28/2015		1		9/28/2015	11/24/2015	57	1		SPC	12/10/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]		[redacted]							[redacted]/19/2015	10/29/2015		71	8/19/2015	10/20/2015	62			UPC	10/20/2015	0	0	0	0	0
									8/20/2015				8/20/2015	10/20/2015	61	1	0.33	SPC	11/12/2015	0	0	0	2	0
									8/20/2015		1		8/20/2015	10/20/2015	61	0		letter	10/20/2015	0	0	0	3	3
							393	36			12	19.83			107.61		9.20							
							Total # of Contacts	Total # of ER Visits			Total # of PCP Visits	Average Time(days) Between ER-PCP			Average Time between ER and 1st CM contact.		Average Time between ER Visits							

		ER Utilization 2015-Qtr 4	October, November, December 2015																				
			Care Manager Contacts					Medical					ER Visits					Intervention		Referrals				
			Telephonic		Other															CM				
Year	Quarter	Member RID	Successful	Unsuccessful	Letters	Face to Face	Total # of Contacts	No. of ER Visits	ER Visits (Date)	PCP visit (Date)	No. of PCP Visits in Q4	Time(days) Between ER-PCP	ER Date	1st CM Date	Time (days)	Time between ER Visits	Average Between ER Visits	Type CMI	Int. Date	Behav Hlth	Pain Mgmt.	Specialist	Comm. Res.	DLN Assist.
[redacted]	[redacted]	[redacted]							[redacted]/26/2015	4/26/2016		183	10/26/2015	1/5/2016	71			SPC	1/5/2016	1	0	0	2	1
1/5/16-Member reported that she had changed her PCP.									11/5/2015				11/5/2015	1/5/2016	61	10		letter	3/17/2016	0	0	0	0	0
In March, she was on the Holy Provider Panel									11/16/2015				11/16/2015	1/5/2016	50	11	11.6	SPC	3/29/2016	0	0	0	0	0
									12/2/2015				12/2/2015	1/5/2016	34	16		SPC	4/11/2016	0	0	0	1	3
									12/23/2015		0		12/23/2015	1/5/2016	13	21		Face-to-Face	4/12/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]							[redacted]/10/2015	10/13/2015		3	10/10/2015	12/8/2015	59			UPC	12/8/2015	0	0	0	0	0
									10/23/2015	10/27/2015		4	10/23/2015	12/8/2015	46	13	21.67	SPC	3/24/2016	0	0	1	1	0
									12/14/2015	12/21/2015	3	7	12/14/2015	12/8/2015	-6	52		SPC	4/18/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]							[redacted]/11/2015	9/16/2015		-25	10/11/2015	10/27/2015	16			UPC	3/15/2016	0	0	0	0	0
									10/31/2015	11/4/2015		4	10/31/2015	10/27/2015	-4	20	18.00	letter	3/17/2016	0	0	0	1	0
									12/4/2015		2		12/4/2015	10/27/2015	-38	34		SPC	3/30/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]							[redacted]/3/2015	10/5/2015		2	10/3/2015	10/27/2015	24			SPC	10/27/2015	0	0	0	0	0
3/23/16-enrolled in AIP									10/4/2015	10/6/2015		2	10/4/2015	10/27/2015	23	1	0.67	UPC	3/15/2016	0	0	0	0	0
									10/5/2015	10/7/2015	5	2	10/5/2015	10/27/2015	22	1		SPC	3/16/[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]							[redacted]/10/2015	10/19/2015		9	10/10/2015	10/5/2015	-5			UPC	10/5/2015	0	0	0	0	0
									11/1/2015	11/19/2019		1479	11/1/2015	10/5/2015	-27	22	14.00	SPC	3/16/2016	0	0	0	0	0
									11/21/2015		3		11/21/2015	10/5/2015	-47	20		SPC	4/13/2016	0	0	0	0	0
							138	17			13	151.82			17.18		13.19							
							Total # of Contacts	Total # of ER Visits			Total # of PCP Visits	Average Time(days) Between ER-PCP			Average Time between ER and 1st CM contact.		Average Time between ER Visits							

Appendix C

ER Aggregate Data Q1-Q4 of RY 2016 (CY 15)

AGGREGATE NUMBERS FOR ER VISITS in Q1 – Q4 of RY 16 (CY 15)
(Most recent quarterly data on left of table)

No. members with 3 visits in Q4 2015: 4 No change from previous quarter.	**No. members with 3 visits in Q3, 2015: 8** 53% decrease from previous quarter.	**No. members with 3 visits in Q2, 2015: 17** 24% decrease from previous quarter.	**No. members with 3 visits in Q1, 2015: 13** Baseline data.	**TOTAL No. for year: Members with 3 visits in a quarter: 42**
No. members with 4-14 visits in Q4 2015: 1 60% decrease from previous quarter.	**No. members with 4-14 visits in Q3, 2015: 3** 50% increase from previous quarter.	**No. members with 4-14 visits in Q2, 2015: 6** 33% decrease from previous quarter.	**No. members with 4-14 visits in Q1, 2015: 9** Baseline data.	**TOTAL for year: Members with 4-14 visits in a quarter: 19**
No. members with 15 or more visits in Q4, 2015: 0 55% decrease from previous quarter.	**No. of members with 15 or more visits in Q3, 2015: 0** 52% decrease from previous quarter.	**No. of members with 15 or more visits in Q2, 2015: 0** No change from previous quarter.	**No. of members with 15 or more visits in Q1, 2015: 0** Baseline data.	**TOTAL for year: Members with 15 or more visits in a quarter: 0**
TOTAL: 5 ER Users (3-15 or more visits) for Q4 2015 55% decrease from previous quarter	**Total: 11 ER Users (3-15 or more visits) for Q3 2015** 52% decrease from previous quarter	**Total: 23 ER Users (3-15 or more visits) for Q2 2015** 4% increase from previous quarter.	**Total: 22 ER Users (3-15 or more visits) for Q1 2015** Baseline data.	**TOTAL: 61 ER Users (3-15 or more visits) for Q1-Q4 2015**
No. members with 2 visits in Q4 2015: 16 64% decrease from previous quarter.	**No. members with 2 visits in Q3 2015: 44** 31% decrease from previous quarter.	**No. members with 2 visits in Q2 2015: 64** 10% decrease from previous quarter.	**No. members with 2 visits in Q1 2015: 71** Baseline data.	**TOTAL for year: 195 Members with 2 visits in a quarter for Q1-Q4 2015**
Total No. Contacts for Q4 2015: 471	**Total No. Contacts for Q3 2015: 551**	**Total No. Contacts for Q2 2015: 724**	**Total No. Contacts for Q1 2015: 686**	**TOTAL no. of all contacts for past year: 2432**

2016

CENTRAL COMMUNITIES HEALTH ACCESS NETWORK

MILESTONES AND REPORTING MEASURES
ADDENDUM Covering July 2016 through December 2016

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ANNUAL REPORT: 2016

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 24 (unduplicated) PCPs affiliated with the HAN as of 12/31/2016. Three of the 24 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, 2016 are presented in Table 1.

Table 1: CC-HAN Affiliated PCPs for 2016

Yukon Pediatrics [redacted] 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 May, Julie D., ARNP Sherry, Alex, PA Panel size for December 2016: 758	Canadian Valley Family Care [redacted] Family Practice, 0-18 years of age 1491 Health Center Pkwy. Yukon, Ok (405) 806-2200 Brown, Curtis L., MD Brown, James M., DO Krittenbrink, Andrea L., PA-C Roof, Lindsay K., APRN Siems, Ami L., MD Wilbanks, Aaron P., DO Panel size for December 2016: 638
Flores Pediatrics [redacted] 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 2016: 1450	Vladamir Holy, MD [redacted] Family Practice, All Ages 2315 Park View Drive El Reno, OK (405) 422-6341 Vladamir Holy, MD Panel size for December 2016: 275
Mustang Family Physicians, PC [redacted] Family Practice, 0-14 years of age 200 S. Castlerock Lane	Mustang Urgent Care [redacted] Family Practice, 0-18 years of age 115 N. Mustang Rd.

Mustang, Ok (405) 256-6000 Amundsen II, Gerald A., MD Halcomb, Monica L., CNP Panel size for December 2016: 513	Mustang, Ok (405) 256-5595 Baker, Dustin R., MD Broome, Joseph C., MD Brown, James M., DO Kelly, Shelly A., ARNP James McGinn, ARNP Mathew, Rohit, PA Medgaarden, Alex E., PA Sturlin, Candace L., PA Krittenbrink, Andrea L., PA Wilbanks, Aaron P., DO Panel size for December 2016: 228

Table 2: CC-HAN Benefit Enrollment Counts

PCP	December 2014	December 2015	December 2016
Vladimir Holy, MD	445	307	275
Yukon Pediatrics	460	687	758
Flores Pediatrics	1466	1384	1450
Canadian Valley Family Care	451	577	638
Mustang Family Physicians	480	442	513
Mustang Urgent Care	142	131	228
Total Count	3444	3528	3862

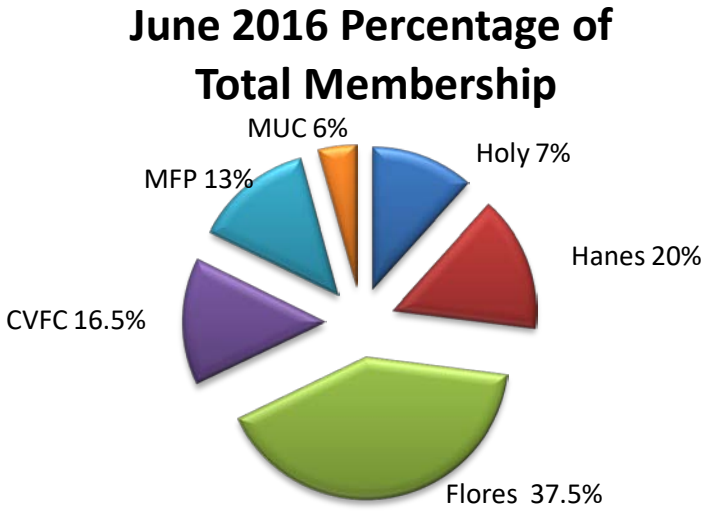


Table 3: CC-HAN Monthly/Total Members for Calendar Years 2015 & 2016		
Month	Calendar Year 15	Calendar Year 16
Jul	3582	3703
Aug	3559	3726
Sep	3457	3763
Oct	3380	3808
Nov	3485	3873
Dec	3528	3862

Table 2 presents a "snapshot survey" by comparing Provider panel sizes in the last month of 2014, 2015, and 2016. 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 that the three other providers who saw a decline in 2015, saw significant growth in 2016, exceeding their 2014 numbers.

Table 3 also shows a slight growth trend in total members for 2016 over 2015. Efforts were underway at the end of 2016 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.

2. Number of Tier 1 or 2 PCPs identified by name for assistance with tier step-up by tier type for 2016.

None

3. Steps taken to assist PCPs in maintaining or advancing their tier designation for July 1, 2016 through December 2016.

Canadian Valley Family Care:

- New Project Manager, Cindy Bacon, was introduced to PCPs and office staff.
- Made contact with office manager to see if they were interested in Doc2Doc training. She was not at this time. Will look at it again in the spring.

Flores Pediatrics:

- Introduced Cindy Bacon as new Project Manager to PCP and office staff
- Assisted in filling out Doc2Doc enrollment information and faxing it to Tulsa.
- Assisted with Doc2Doc training for one office staff.

Alecia Hanes, MD:

- New Project Manager, Cindy Bacon, was introduced to PCPs and office staff.
- Made contact with office manager to see if they were interested in Doc2Doc training. She was not at this time. Will look at it again in the spring.

Vladimir Holy, MD

- Introduced Cindy Bacon as new Project Manager to PCP and office staff.
- Provided requested information to PCP regarding tele-med, licensure of Behavioral Health provider, and billing questions for OHCA.
- Received explanation of audit results to office staff after inquiry from OHCA staff.
- Explained the benefit of Doc2Doc services, when they update their IT equipment for secure transmission of patient information.

Mustang Family Physicians:

Introduced Cindy Bacon as new Project Manager to PCP and office staff.

Mustang Urgent Care:

Introduced Cindy Bacon as new Project Manager to PCPs and office staff.
Assisted in enrollment in and training for Doc2Doc.

For ALL Providers:

Delivery of the following Reports and educational materials was ongoing throughout 2016:

- Monthly ER reports
- Monthly Inpatient reports
- EPSDT rosters (upon request, along with education about availability of same)
- Tobacco Cessation educational materials/resources
- CC-HAN Website Promotional brochures and pens
- Canadian County Prescription Dropbox Information/Location flyers
- Social Host Laws flyers
- CC-HAN ER Brochures for office distribution

- Specific educational materials upon request (e.g., Spanish materials on flu immunizations and asthma)
- Flyers on upcoming community wide events that impact members.

CC-HAN staff also provided assistance during the July 1 through December 31, 2016 reporting period with member issues/needs for all providers. This assistance included the following totals:

- **1087 referrals**
- **68 deliveries of goods, i.e., food, clothing, personal/household goods**
- **24 back-school supplies referrals and/or deliveries**
- **34 holiday gifts/items referrals and/or deliveries**
- **29 translator assisted communications**, arranged through the Health Department

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

There were no Tier advancements in 2016.

5. **Number of specialty providers by specialty type:**
   a. **Number of specialty providers available for SoonerCare members served by our providers.**
   b. **Number of SoonerCare members receiving specialty care (note: Delayed effective date until Doc2Doc program or other effective tracking method is in place).**

   The total number of specialty providers and resources, by specialty type for 2016 is **725.** Table 4 represents the type and number of providers.

Table 4: CC-HAN Specialty Providers for 2016	
Allergy:	4
Attention Deficit Disorder:	10
Audiology:	18
Autism:	8
Behavioral Health:	60
Birth Control:	2
Boys Homes:	2
Cardiology:	5
Chiropractic:	1
Community Resources:	43
Crisis Lines:	19
Death, Dying, Grief Resources:	4
Dental Care:	37
Dermatology:	17
Developmental Delays:	10
Dieticians:	7
Disability Resources:	2
Domestic Abuse:	5

Drug Treatment/Rehab:	16
Durable Medical Equipment:	6
Ear, Nose, Throat Doctors:	15
Education:	2
Electroencephalograms:	3
Electrocardiographs:	4
Endocrinologists:	10
Family Planning Services:	(under Birth Control)
Formula Providers:	4
Formula Reps:	3
Free Clinics:	38
Gastroenterology:	7
Genetics:	2
(County) Health Departments:	8
Hematology/Oncology:	3
Holiday Resources	4
Home Health Resources:	11
Homeless Resources:	8
Hospice:	2
Hospitals:	20
Housing Resources:	10
Housing Resources for families w/ children	1
Immunology:	1
Infant Resources:	11
Infectious Diseases:	4
Labs:	10
Lactation Specialists:	8
Latino Resources:	4
Learning Disabilities:	4
Legal Assistance:	2
Liceology:	2
Litholink-Kidney Stone Prevention:	1
Mammograms:	1
Maxillofacial:	1
Medical Assistance Resources	3
Military Assistance Programs:	3
Nephrology:	2
Neurology:	7
Obstetrics/Gynecology:	8
Occupational Therapy:	1
Ophthalmology:	7
Optometry:	9
Oral/Maxilla Surgery:	2
Orthopedics:	13
“Other Resources”:	5
Oxygen Resources:	1
Pain Management:	3
Parent Education Resources:	1
Parenting Resources	9
Pediatrics Special Care Center	1
Pharmacy:	1
Physical Therapy:	14

Plastic Surgeons:	1
Podiatry:	4
Pregnancy Care Center:	1
Prescription Drug Assistance	2
Psychiatry:	15
Psychology	11
Pulmonology:	3
Radiology/Imaging Services:	15
Residential Programs:	4
Rheumatology:	5
Sleep Studies:	5
SoonerCare: 1	1
Special Needs Resources:	3
Special Schools:	2
Speech Therapy:	20
Support Groups:	15
Surgery:	4
Thoracic Surgery:	1
Transportation Resources:	6
Urology:	7
WIC/Nutrition Resources:	4

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

   There were no medical home audit failures in 2016.

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

There have been no medical home audits for CC-HAN participating Medical Home Providers in 2016. There was one Medical Home Performance Audit for Mustang Urgent Care 7/14/16. The Project Manager participated in the process by meeting with the office manager and key staff prior to the audit to review the process, providing assistance for preparations, and was also present for the audit. Project Manager also assisted in writing the corrective action plan for deficiencies found.

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 RY 16 include:

  - Asthma
  - Chronic Care
  - High Risk OB

- ER Users
- Inpatient
- Pharmacy Lock-In

- **Hold at least one Care Management quarterly meeting.**

  One Care Management meeting (via conference call) with OHCA Care Management staff on July 19, 2016.

  Five (5) care management team meetings were held during this period. One in July, then September 19, October 17, November 21, and December 19, 2016. Our pharmacist resigned from the care management team but agreed to available to us as needed. The project manager for Red-Rock Systems of Care agreed to become a member of our team to provide much needed behavioral health expertise.

Table 5: CC-HAN Summary of Care Management for RY 16

Population	Care Management Members
High Risk OB	Three (3) cases managed July - December 2016.
Hemophilia	No cases managed July - December 2016.
Chronic Care	o Roster with 34 members (1 other; 33 asthma*) in 7/16 o Roster with 36 members (36 asthma*) in 8/16 o Roster with 37 members (1 other; 36 asthma*) in 9/16 o Roster with 36 members (36 asthma*) in 10/16 o Roster with 38 members (38 asthma*) in 11/16 o Roster with 34 members (34 asthma*) in 12/16 *Note: the asthma members are all those engaged in the Asthma Improvement Plan.
Pharmacy Lock-In	No new members were referred to the Pharmacy Lock-In program for this reporting period. One member was identified in August and was subsequently dropped in September due to changing to a PCP who is not a member of the HAN
Breast &Cervical Cancer (Oklahoma Cares)	No members in RY 16
CM Initiative	Asthma care management initiative, the Asthma Improvement Plan (AIP) initiated in February 2012; a total of 36 members were engaged in July - December 2016 with 34 members engaged as of 12/31/16.

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 Care Management activities and measures monthly:

High Risk OB

1. Number of members received for HAN care management program July - December 2016: **Three (3)**
2. Number of existing members still being care managed at end of December 2016: **One.**
3. Number of attempted contacts with outcomes (successful or unsuccessful) and contact method (face-to-face, telephonic, letter, etc.) for each attempt: **45 total**
   11 successful phone calls; 28 unsuccessful phone calls; 5 letters/text messages, 1 face to face visit.
4. Indicate type of provider (family practice, OB/GYN, clinic, etc.): **All members were seen by OB/GYN Providers.**
5. One baby spent **3 weeks in NICU**.
6. Pregnancy outcomes: **2 viable; 1 yet to deliver as of 12/31/2016.**
7. Number of depression screenings completed with results:
   Three (3) screenings were administered, all within the normal range.
8. Report the following indicators that assist in identifying at-risk newborns:
   a. Birth weight of the newborn: **none.**
   b. Newborns that are discharged from the hospital on oxygen: **none.**
   c. Newborns that are discharged from the hospital on any type of monitor or medications (indicate the type of monitor, e.g. apnea, pulse oximeter, etc. or type of medication): **none.**
   d. Newborns that had surgery while in the hospital, excluding circumcision (indicate the type of surgery): **none.**
   e. Newborns that had a failed hearing screen: **none.**

Hemophilia

1. Number of members received for HAN care management program for the FY 2016: **None.**
   a. Number of existing members still being care managed: **N/A.**
   b. Number of members HAN care management program is actively working with: **NA.**
2. Number of attempted contacts by member with outcomes (successful or unsuccessful) and contact method (face-to-face, telephonic, letter, etc.) for each attempt: **N/A.**
3. Number of kept appointments (provider, specialist, etc.): **N/A.**
4. Number of missed appointments (provider, specialist, etc. excluding cancelled or rescheduled appointments): **N/A.**
5. Number of treatment logs submitted to provider monthly (notify provider timely of a bleed and receive timely treatment): **N/A.**
   a. Indicate whether log is complete or incomplete: **N/A.**
6. Number of members compliant with prescribed treatment: **N/A.**
   a. Indicate the provider prescribing treatment**:** **N/A.**
   b. Number of ER visits**:** **N/A.**

c. Number of hospitalizations: **N/A.**
d. Lengths of stay for each admission: **N/A.**

Chronic Care Unit:

1. Number of members received for HAN care management program for July - December 2016: **One (1)**
2. Number of attempted contacts with outcomes (successful or unsuccessful) and contact method (face-to-face, telephonic, letter, etc.) for each attempt: **10 total**
   5 successfully phone calls; 3 unsuccessful phone calls; 1 letter

ER Utilization (co-manage)

Categories:

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. Top 3 diagnoses for ER visits: The top 3 diagnoses for ER visits in July - December 2016 were:
   - **Fever**
   - **Otitis media**
   - **Upper Respiratory Infection**

   Each of the top three diagnoses for ER visits have also been top diagnoses for previous years. ER brochures were previously developed for each of these 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. Of note, the brochures were included in the SoonerCare Choice Program Independent Evaluation (2015) as examples of strategies developed by the CC-HAN Providers and staff to help reduce ER visits. Work began during this reporting period to have all brochures available in Spanish.

2. Number of medical referrals generated, indicate whether ER or CM (behavioral health, pain management, specialists, community resources, etc.)**.**
   a. Number of identified needs in conjunction with daily living, members are assisted with (e.g. community resources, food pantry, and housing). **1087 referrals made on behalf of SoonerCare Choice members.**

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

3. Number of members removed from persistent category due to decrease in ER usage: **None in CY 16 (none in persistent category in RY 15 or in RY 16)**

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 RY 16. It is also noted that the HAN total enrollment for RY 16 was up (nearly) 10% over RY 15, accounting for some of the trend. However, staff will continue efforts to address ER utilization through care management strategies and work with PCPs.

Data will be continuously monitored and evaluated to be reported in the 2017 annual report using the calendar year time frame.

Pharmacy Lock-in.

1. Number of members received for the HAN care management program for the current reporting period: **1**
    - Number of existing members still being care managed: **0**
    - **Number of attempted contacts: 1 face to face.** Member changed PCP to a non-HAN provider.
2. **Number of members in monitoring status that were prevented from being placed in the lock-in program:** None.
3. **Number of ER visits by lock-in and monitoring status members shown by ER Category:** None in RY 16
4. **Number and name of pharmacies filling prescriptions for members in monitoring status.**
   Total of 2 pharmacies filling prescriptions for member:

   Walgreens #04066
   Walgreens #12027
5. **Number of referrals to pain management specialists for lock-in and monitoring status members that are experiencing unrelieved pain.** None were considered medically indicated.
6. **Number of lock-in members discharged from the lock-in program.** One.

B&C Cancer (Oklahoma Cares Program)

1. Number of women received for HAN care management for the Report Year: **N/A**. Designate by breast or cervical cancer diagnosis categories for list of women received: **N/A.**
2. Number of existing members still being care managed**: N/A.**
3. Specify the stage at which each woman initially entered the Oklahoma Cares program. (e.g. abnormality, precancerous condition or cancer diagnosis): N/A.

4. Number of attempted contacts by member with outcomes (successful or unsuccessful) and contact method (face-to-face, telephonic, letter, etc.) for each attempt for Report Year: **N/A.**
5. Number of appointments/treatments as specified: **N/A.**
6. Number of missed provider or treatment appointments (excluding cancellations or rescheduled appointments): **N/A.**
7. Number of kept provider or treatment appointments: **N/A**.
   i. Radiation Treatment related: **N/A**.
   ii. Lab: **N/A**.
   iii. Radiology (CT, MRI, PET, X-Ray): **N/A**.
   iv. Office Visits: **N/A**.
   v. Chemo Treatment**:** **N/A**.
8. Number of women contacted and/or assisted with recertification process
   a. Number of women who recertified eligibility: **N/A**.
   b. Number of women who required more than one contact to assist with recertification: **N/A**.
   c. Number of women who did not complete the recertification process**:** **N/A**.
   d. Number of Oklahoma Cares cases closed and reason (lost eligibility, death, cured, etc.): **N/A**.
   e. Number of women reentering the BCC program to due recurrence of cancer: **N/A**.
   f. Number of women prescribed a hormone therapy drug for breast cancer diagnosis: **N/A**.
      1). Number of women who were non-compliant with filling the prescription: **N/A**.
   g. Number of women with breast cancer that undergo mastectomy: **N/A**.
   h. Number of women with reconstructive surgery: **N/A**.
   i. Time period between the date of mastectomy and reconstructive surgery: **N/A**.

HAN CM Initiative

The Asthma Initiative was fully implemented in the spring of 2013. A total of 34 members were engaged in the Asthma Improvement Plan (AIP) in RP 16. Outcomes data for the AIP is reported in the QI/QM section, Table 14, page 23.

During RP 16, 36 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 651 care management contacts were made from July to December 2016, including thirty face to face visits.

Table 6: CC-HAN AIP: Care Management Contacts for July - December 2016

Successful Phone	Unsuccessful Phone	Mailings/ Texts/E-mails	Face-to-Face	GRAND TOTAL of CONTACTS
245	188	188	30	**651**

In-patient Contacts

Monthly reports have been provided by OHCA to CC-HAN throughout RY 16, 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 245 visits were made to this group, including two face-face visits.

Table 7: CC-HAN Inpatient Contacts for RY 16				
Successful. Phone	**Unsuccessful Phone**	**Letters**	**Face-to-Face**	**GRAND TOTAL OF CONTACTS**
82	130	31	**2**	**245**

Health Information Technology (Article 4.5)

1. PCPs assisted with qualifying for federal EHR incentives–education, outreach, etc. (Article 4.5 c): None in RP 16.

Milestones for electronic health records being met (Article 4.5 b):
All twenty-four PCPs in 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-four.

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

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

All twenty-four HAN PCPs (six 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. Two (2) 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 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.

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 RY 16. The ELA will be an increase in the total number of claims in RY 16 (compared with RY 15) 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 ELA was met in RY 15 with a 6% gain (overall) in well-child visits. For RY 16, there is an 11% loss from the totals in RY 15. 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 RY 17. Recently a bi-lingual clerk was employed to coordinate the contacts due to the number of Spanish-speaking families served; it is

hoped that improvements in communications may result in more visits for RY 17. Tables 8-12 present the number/types of EPSDT contacts throughout RY 16.

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**	
New Patients:					
99381	332	301	-9%	141	-58%
99382	164	119	-27%	80	-51%
99383	193	146	-24%	128	-34%
99384	62	63	2%	60	-3%
Established Patients:					
99391	1477	1536	4%	1256	-15%
99392	993	1189	20%	1032	39%
99393	912	947	4%	848	-7%
99394	382	466	22%	447	142%
TOTALS by FY	**4515**	**4767**	**6%**	**2892**	**-36%**

Table 9: EPSDT Contacts January through March, 2016										
	Jan 16			Feb 16			Mar 16			TOTAL Contacts (all types) for Q3 2016
	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	
Canadian Valley Family Care	39	11	5/6	32	9	5/4	33	13	11/1	169
Flores Pediatrics	69	21	0/19	62	36	14/20	77	16	6/10	350
Alecia Hanes	32	20	16/5	44	6	0/6	52	6	0/5	192
Vladimir Holy	6	7	2/5	9	9	4/5	5	3	0/3	58
Mustang Family Physicians	21	2	0/2	20	10	5/5	24	6	0/6	101
Mustang Urgent Care	4	0	0/0	4	1	0/1	6	6	0/0	22
Total No. of (All Types) Contacts to Increase EPSDT (Well-Child) Visits for Q3 RY 16										892

Table 10: EPSDT Contacts April through June, 2016										
	Apr 16			May 16			Jun 16			TOTAL Contacts (all types) for Q2 2016
	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	
Canadian Valley Family Care	34	5	0/0	33	6	5	25	3	0/3	114
Flores Pediatrics	86	27	19/9	70	35	23/12	68	24	21/3	397
Alecia Hanes	39	11	5/6	43	9	6/3	62	3	0/2	189
Vladimir Holy	9	1	1/0	6	1	0/1	6	1	0/1	27
Mustang Family Physicians	25	6	0/6	19	10	7/4	25	9	8/1	120
Mustang Urgent Care	5	0	0/0	4	0	0/0	10	0	0/0	19
Total No. of (All Types) Contacts to Increase EPSDT (Well-Child) Visits for Q4 RY 16										866

Table 11: Contacts to Increase EPSDT (Well-Child) Visits for July - September 2016										
	July 16			August 16			September 16			TOTAL Contacts (all types) for Q2 2016
	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	SPC	UPC	Texts/ Letters	
Canadian Valley Family Care	19	21	17/3	16	18	15/3	23	15	8/7	165
Flores Pediatrics	52	52	40/11	60	24	18/6	72	28	21/7	391
Alecia Hanes	35	26	17/6	32	28	25/0	30	30	27/2	259
Vladimir Holy	0	5	0	6	3	0/3	6	8	4/4	45
Mustang Family Physicians	20	12	7/5	26	9	6/3	21	19	12/7	147
Mustang Urgent Care	6	4	3/1	4	3	1/2	5	5	5/0	39
Total No. of (All Types) Contacts to Increase EPSDT (Well-Child) Visits for July - September 2016										1046

Table 12: Contacts to Members for Well-Child (EPSDT) Visits October - December, 2016													
	October 16				November 2016				December 2016				Total No. All Contacts
	SPC	UPC	Texts	Letters	SPC	UPC	Texts	Letters	SPC	UPC	Texts	Letters	
Canadian Valley Family Care	32	50	17	4	19	46	17	3	17	48	14	10	277
Flores Pediatrics	76	76	27	3	78	103	30	7	59	60	12	8	539
Yukon Pediatrics	41	52	20	3	30	70	21	4	34	`43	12	3	333
Vladimir Holy	8	13	3	3	6	14	3	3	4	10	3	2	72
Mustang Family Physicians	8	25	7	3	28	50	17	3	15	28	11	2	197
Mustang Urgent Care	3	12	4	2	4	2	1	0	6	10	3	1	48
Total Contacts (Monthly) by Type	168	228	78	18	165	285	89	20	135	199	55	26	1466
Total No. of (All Types) Contacts to Increase EPSDT (Well-Child)Visits for Oct - Dec 2016													1466

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 RY 2016.**

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, SmartStart 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.

Efforts to ensure the website presents current and accurate information are anchored in a process conducted by PHCC Board volunteers who utilize guides to evaluate:

- Lay-out for reader appeal and for user friendliness, including visual appeal of materials or content "guides."

- Level of reading, focusing on (approximate) 5th grade or lower to maximize "effectiveness" for users.
- Content relevancy for general public, specifically HAN members and PCP "patients." E.g., is the content relevant for different age groups and populations, including ethnicities, who might use the website.
- Content appropriateness. E.g., are there content areas that are either "dated" or otherwise considered inappropriate? Are there content gaps in terms of information or materials which should be included? Is there content that might be considered culturally or otherwise inappropriate? Are there any specific content suggestions that you would like to see included or presented OR that you believe should be omitted?
- Accuracy. Content accuracy and "workability" of the links.
- Ease of use.

The project manager compiles the quarterly evaluation results and presents the information to the PHCC Board for review and comment. Subsequently, results and comments are provided to the IT professional who manages the website for implementation. Periodic meetings with the web designer combined with the evaluation findings and recommendations provide an ongoing quality improvement process.

Two primary methods are used to promote website use. First, promotional pens (with stylus) imprinted with the message ***"Health Questions?* Go to cc-han.com for help"** are widely distributed through PCP offices, Youth and Family Services of El Reno, 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, 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).

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 13 presents information and trends on CC-HAN website views.

Table 13: CC-HAN Website Stats

Number of Views per Month	2014	2015	2016
January	261	387	37
February	223	315	38

March	232	317	44
April	176	174	71
May	365	161	50
June	321	167	65
July	373	176	83
August	386	154	122
September	593	158	117
October	unknown	74	86
November	unknown	86	115
December	unknown	15	83

The second major strategy for achieving QM 2 is the development and utilization of ER brochures and one flyer for member education throughout RY 16. The brochures/flyer are based on the "top diagnoses" for ER visits in RYs 12-16. The top 3 diagnoses for ER visits in RY 16 were Fever, Otitis Media (Ear Infection) and Upper Respiratory Infection; each was among the top diagnoses in previous years. 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

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. As data presented in Table 14 indicates, additional evidence includes a significant decrease in the total number of ER visits (to date) in CY 16 as compared to calendar years 13, 14, and 15. 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 FY 2016. The ELA 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 FY 16, forty (unique) SC Choice members were engaged in the Asthma Improvement Plan (AIP). Information about hospitalizations includes:

- There were two hospitalizations (asthma related diagnoses) for member [redacted] (9/15 and 10/15). The member is a special needs adult whose caregiver is an elderly mother. The member has been engaged in the AIP since 2013 with no records available about hospitalizations prior to engagement. Subsequent to the fall 2015 hospitalizations, member was referred to a pulmonologist by PCP, and changes in asthma management plan have resulted in much better symptom control. Member has no additional hospitalizations since 10/15, which includes the (most recent) seasonal months in which flu/respiratory infections are common. Clearly, improvement in management of asthma symptoms has been attained.
- Member [redacted] was hospitalized for asthma twice in1/15 prior to being engaged in AIP later in the same month. Subsequently he was hospitalized one time (8/15) for bronchitis. There have been no additional hospitalizations for asthma related diagnoses, including the most recent seasonal months for respiratory illnesses (9/15-4/16). With the reduction from two hospitalizations in 1/15 to one in 8/15 (post engagement in AIP), the ELA is considered met.
- Member [redacted] was engaged in the AIP after hospitalization for an asthma related diagnosis in 1/16. Since engagement, parent reports "better control," and no additional hospitalizations (or ER visits) have occurred. Because this member has been in AIP for only 5 months, there is insufficient data to say the ELA is met. However, improvement in symptom control has been attained.

O. **Achieve at least an 80% annual flu immunization level for all AIP members in RY 2016.**

As of the end of RY 16, 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 ELA; it is accounted for largely by parental distrust of vaccinations, particularly fears of "traumatizing" a child or of "negative side effects," including autism. 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. To better understand the variables associated with vaccination refusals, the CC-HAN care management staff recently reviewed the Medscape Vaccine Acceptance Report for 2016 as well as other EBP resources; specific strategies were identified for better educating parents who are vaccine resistant.

Table 14: CC-HAN AIP Evaluative Data, CY 13-RY 16

	Totals for CY 13	Totals for RY 14	Totals for RY 15	Totals for July - December 2016
Total No. AIP Members	39	39	40	34
Total No. of Hospitalizations prior to AIP Engagement	1	1	3	4
Total No. of Hospitalizations for Asthma Related DX after AIP Engagement	0	0	1	0
Total No. of ER Visits for Asthma Related DX prior to AIP Engagement	12	8 (5 separate members)	14	17
Total No. of ER Visits for Asthma Related DX after AIP Engagement	2 (2 separate members)	2 (2 separate members)	2	3
Total No. of Urgent Care Visits for AIP Members	2	5	22	1
Total No. of Unscheduled PCP Visits for AIP Members	12	29	22	4

Table 14: CC-HAN AIP Evaluative Data, CY 13-RY 16				
	Totals for CY 13	Totals for RY 14	Totals for RY 15	Totals for July - December 2016
Total No./Percentage of AIP Members who received flu vaccination	21 for 54%	30 for 77% (2 members lost SC benefits, so lack of PCP verification for FY immunization; however, parental intent and history was to immunize children; parent did not respond to attempts to verify)	27 for 68% (3 members were discharged prior to flu immunization season; 1 lost SC benefits; 2 changed PCPs. Parents of 7 other members declined to immunize d/t publicity r/t lack of efficacy evidence for expected viral strains).	21 for 58.22% (Parent of 4 prefers using homeopathic methods. Parents of 8 report lack of evidence that vaccine is beneficial; parents of 2 did not want child "traumatized" by injection; parents of 4 refused on basis of undesirable "side effects."

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 15 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. In early May 2016 an educational document entitled "Provider Education: CC-HAN Asthma Improvement Plan" was shared with all CC-HAN Providers to demonstrate value of the AIP and encourage more referrals. Upon receipt of ER rosters in May and June 2016, three members with asthma related diagnoses were added to the AIP (2 in May, 1 in June).

As of completion of calendar year 2016, there were no 90 day readmissions for members with an asthma diagnosis (in their medical record).

The data related to overall use of the ER for HAN members in 2016 is noted to be significantly lower than the numbers in Calendar Years 13, 14, and 15. 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 15: 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
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
Denominator: All HAN members with an asthma diagnosis identified in their medical record.	839	885	858	670
Dividend for PM A:	.10	.08	.05	.06
Performance Measure B: Decrease 90 day readmissions for related asthma conditions for HAN members with an asthma diagnosis identified in their medical record.	CY 13	CY 14	CY 15	CY 16
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
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
Dividend for PM B:	0	0	.22	0
Performance Measure C: Decrease overall ER use for HAN members.	CY 13	CY 14	CY 15	CY 16
Numerator: Total number of ER visits for HAN members.	2153	1938	2256	1397
Denominator: All HAN members.	5192	5273	5137	4110
Dividend for PM C:	.41	.38	.44	.34

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 continued in the fifth year of implementation. 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 July 2016-December 2016 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 (project manager was present for one audit and planned corrective action steps as needed in RY 16); assistance with Self-Evaluation process required for annual contract for one PCP; 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 (e.g., counseling resources, transportation services, ADHD testing, and/or ADL needs). In addition, the HAN staff provides educational presentations for participating PCPs and staff. In RY 16, some specific examples include:
    - Project manager developed/presented plan for individualized Communicable Diseases/Infection Control education, including resources and outcomes assessment, for Mustang Urgent Care staff in 1/16.
    - Communicable Diseases/Infection Control for Vladimir Holy, MD on 1/26/16; also reviewed Behavioral Health Screening requirements with staff.
    - Communicable Diseases/Infection Control for Flores' Pediatrics on 1/27/16.
    - In February and March 2016, project manager worked with Dr. Holy and Red Rock staff to develop collaborative model for behavioral health services available at Dr. Holy's office site. Outcome was a contractual relationship established between Dr. Holy and a behavioral health provider.
    - In 3/16, the PHCC Board approved funding to purchase 15 additional Peak Flow Meters to distribute to AIP members.
    - Project manager worked with Canadian Valley Family Care staff in 3/16 to clarify requirements for behavioral health screenings as well as questions about reimbursement for same.

- On-site assistance/support provided for Dr. Holy's Medicaid Performance Audit on 5/4/16.
- PCP meeting was held 6/16/16 with participation from four of the six Provider groups in CC-HAN as well as outgoing Medical Director, Dr. Judith Frasier, and incoming Medical Director, Dr. Alecia Hanes. OHCA administrative staff also participated, including Melody Anthony, Deputy Director of Medicaid, and Burl Beasley, R. Ph. A representative from Sooner HAN's Medical Informatics also presented updates on Doc2Doc. One practice requested additional training/support through Doc2Doc.
- Throughout RY 16, 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 the Report Year 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 53 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 r/t child development and care.
  - In RP 16, 8 home visits were made.
  - In RP 16, 48 face-face visits occurred, some in PCP offices and some in other sites (such as public libraries or what are called "curbside" deliveries of resources).
  - A total of 74 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 6/16/16. Melody Anthony, MS, Director of Provider Services, provided OHCA updates, and Burl Beasley, R.Ph addressed Agency updates including prior authorizations/changes made to improve safety/ensure proper use of funds for pharmaceuticals.

- **313 Provider contacts** made in July - December 2016. Contacts are as varied as deliveries of rosters (e.g., EPSDT or latest ER), assistance with MH 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.
- Care Management Teleconference with OHCA staff was held on 7/19/16.

- Monthly CC-HAN Care Management Committee meetings for RY 16 were held on 7/19/16, 9/20/16, 10/17/16, 11/21/16, and 12/19/16.

- 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 RP 16. A Tip Sheet was developed to share with law enforcement throughout Canadian County, providing information on identifying s/s of child trauma as well as community support and treatment resources. The Tip Sheets, in both English and Spanish, have been distributed throughout the County. Training for mental health first aid was also offered to the community.
- Participation by CC-HAN care management staff in Canadian County Health Department Baby Shower on 10/15/16.
- Project Manager participated in OG&E Community Round Table October 20, 2016, 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 FY 16, including:
  - Canadian County Coalition for Children and Families (project manager serves as chair and one care manager serves as treasurer; both care managers attend regularly).
  - Infant Mental Health Committee (project manager)
  - Canadian County Healthy Living Grant (care managers)
  - Partnership for Healthy Central Communities Board (project and care managers are participants)
- 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;
- 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 managing 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.

Two major changes occurred during the reporting period for the CC-HAN. Project Manager, Rosemary Klepper, retired as of September 30, 2016. New Project Manager, Cindy Bacon,

trained with Rosemary during the months of August and September and took over October, 2016. Also of note, office space was acquired in Yukon.

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 2017 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 July - December, 2016

ER Utilization July -December 2016					
	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 Q1-Q4 of RY 2016 (CY 15)

Ending with July - December, 2016

AGGREGATE NUMBERS FOR ER VISITS JULY - DECEMBER 2016 (2 QTRS)

No. members with 3 visits in Q4 2015: 4 No change from previous quarter.	**No. members with 3 visits in Q3, 2015: 8** 53% decrease from previous quarter.	**No. members with 3 visits in Q2, 2015: 17** 24% decrease from previous quarter.	**No. members with 3 visits in Q1, 2015: 13** Baseline data.	**TOTAL No. for report period: Members with 3 visits: 31**
No. members with 4-14 visits in Q4 2015: 1 60% decrease from previous quarter.	**No. members with 4-14 visits in Q3, 2015: 3** 50% increase from previous quarter.	**No. members with 4-14 visits in Q2, 2015: 6** 33% decrease from previous quarter.	**No. members with 4-14 visits in Q1, 2015: 9** Baseline data.	**TOTAL for Members with 4-14 visits in report period: 7**
No. members with 15 or more visits in Q4, 2015: 0 55% decrease from previous quarter.	**No. of members with 15 or more visits in Q3, 2015: 0** 52% decrease from previous quarter.	**No. of members with 15 or more visits in Q2, 2015: 0** No change from previous quarter.	**No. of members with 15 or more visits in Q1, 2015: 0** Baseline data.	**TOTAL : Members with 15 or more visits in report period: 0**
TOTAL: 5 ER Users (3-15 or more visits) for Q4 2015 55% decrease from previous quarter	**Total: 11 ER Users (3-15 or more visits) for Q3 2015** 52% decrease from previous quarter	**Total: 23 ER Users (3-15 or more visits) for Q2 2015** 4% increase from previous quarter.	**Total: 22 ER Users (3-15 or more visits) for Q1 2015** Baseline data.	**TOTAL: 38 ER Users (3-15 or more visits) for report period**
No. members with 2 visits in Q4 2015: 16 64% decrease from previous quarter.	**No. members with 2 visits in Q3 2015: 44** 31% decrease from previous quarter.	**No. members with 2 visits in Q2 2015: 64** 10% decrease from previous quarter.	**No. members with 2 visits in Q1 2015: 71** Baseline data.	**TOTAL: 21 Members with 2 visits in a quarter for reporting period.**
Total No. Contacts for Q4 2015: 471	**Total No. Contacts for Q3 2015: 551**	**Total No. Contacts for Q2 2015: 724**	**Total No. Contacts for Q1 2015: 686**	**TOTAL all contacts for reporting period: 518**

OKLAHOMA STATE UNIVERSITY-HEALTH ACCESS NETWORK

ANNUAL REPORT- JULY 1ST, 2015 TO JUNE 30TH, 2016

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

Annual Report: July 2015-June 2016

Introduction:

The Oklahoma State University-Center for Health Sciences Health Access Network (OSU-CHS HAN) was initially implemented in June, 2011 and currently holds a patient panel size of 15,023 at the end of FY16; June 2016.

The following positions currently contribute to the function of the OSU-HAN:

Financial Reporting Manager- Dr. Johnny Stephens, Pharm D
CFO- Eric Polak
Executive Director/OSU CHSI- Dr. William Paiva
Director/OSU HAN- Matt Maxey
Physician Medical Director: Dr. Scott Shepherd
Behavioral Health Medical Director- Dr. Jason Beaman
Administrative Assistant- Lindsay James
RN Case Managers & LCSW Case Management
Health Information Technology- Heidi Holmes
Medical Informatics/Data Analyst- Shire Sathyanarayanan
Quality Assurance Coordinator- Bruce Pierce

OSU Health Access Network Mission Statement:

The mission of the Oklahoma State University Health Access Network Case Management Program is to empower our members with the ability to manage their health care needs across the care continuum by coordinating quality health care services through an appropriate, cost-effective, and timely care management plan.

Members:

Current OSU HAN Members, June 2016: 15,023

OSU Physicians, Tulsa:

- OSU Internal Medicine- Houston Center
- OSU Internal Medicine, Specialty Services- Houston Center
- OSU Family Medicine- Physician's Office Building (POB), Health Care Center/ Women's Health Center, Eastgate, and North Regional Health and Wellness Center
- OSU OB/GYN- Houston Center, Catholic Charities
- OSU Pediatrics- Houston Center
- OSU Surgery- Physician's Office Building

OSU-Physicians, Muskogee:

- OSU Children's Pediatric Clinic
- OSU Premier Pediatrics Clinic

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

Case Management Program Overview:

Nurse case managers, utilizing motivational interviewing skills; provide outreach, follow-up, health education, care coordination, and management tools to support self-directed care to Sooner Care Choice members living in complex health care needs as identified by the Oklahoma Health Care Authority in the following categories:

- Women enrolled in the High Risk Pregnancy Program
- Members with high Emergency Room utilization
- Women enrolled in the Oklahoma Cares Program (diagnosed with breast/cervical cancer)
- Members enrolled in the Pharmacy Lock-In Program
- Members diagnosed with Hemophilia
- Members with other chronic health conditions referred by their primary care provider or other health care professionals

Additional care management opportunities include:

- Follow up contacts to members discharges from OSU Medical Center
- Chart audits utilizing EMR
- Verifying follow-up appointments with providers-to allow for timely follow-up within 3-5 days from hospital discharge in order to provide care coordination
- Participation in Comprehensive Primary Care (CPC) activities as team member through the OSU-CHS Family Medicine, Health Care Center
- Identification/stratification of members with chronic health conditions
- Data analysis of OHCA claims data

Objective:

The OSU HAN is dedicated to ensuring that Sooner Care Choice Members are adequately supported in reaching their optimal health status and receive the best health care services in the most efficient manner. To accomplish this, the OSU HAN will continue to provide a care coordination system of services; integrating health education, outreach, and access to community resources.

Accomplishments:

Around the start of FY16, Senior members of the OSU HAN sought to strengthen the progress under the direction of Dr. William Paiva, PhD and an appointed interim Director, Michael Shea, MHA took on the challenge of revamping the HAN's focus. During the fiscal year the following positions have been filled;

1. Shantel Bolton, RN- Hired in July 2015
2. Administrative Assistant- Lindsay James- Hired in August 2015
3. HAN Director-Matt Maxey- Hired in September 2015
4. Connie Schadel, RN- Hired in September 2015
5. Leslie Brown, RN- Hired in September 2015
6. Quality Assurance Coordinator- Bruce Pierce- Hired in March 2016
7. Data Analyst- Shrie Sathyanarayanan- Hired in March 2016
8. Paula Wheeler-Ballard, RN- Hired in May 2016
9. Melissa Gantz, LCSW- Hired in June 2016

OSU HAN Highlights

3rd Quarter (July-September)- CY 2015

Operations:

- Aug. 11th- Interim Director and Administrative Assistant met with the University of Oklahoma Health Access Network Administrator to discuss how their current process flows, organizational layout, and overall reporting structure functions.
    - We gained very insightful information as to how their department operates- received documents of OU HAN on reporting structure, organizational charts, and member flow
- Aug. 24th- Departments heads met with Brian Yeaman with Coordinated Care to discuss the possibility of utilizing Coordinated Care EHR
- Sept. 3rd- Department evaluated the use of My Health versus Coordinated Care (after having already met with Coordinated Care) as a possible extension of EPIC in the short term, as well as possibly utilizing Doc to Doc as a referral tool
    - Department heads met with Dr. Kendrick in regard to My Health EHR utilization
- Sept.- OSU Health Access Network department developed an e-mail contact-osuhan@okstate.edu
    - Website creation and implementation was considered during this period of time for the purpose of informing the physicians, residents, and patients about department information, as well as services offered by the OSU Health Access Network Case Management Program.
- Sept.- With the additional of our newly appointed Medical Director, Dr. Koehler, the HAN sought to work with him in order to devise plans of care for such areas as asthmatics, diabetics, high ER utilizers, as well as other high-risk patient populations that we encounter
    - Dr. Koehler was also present on our QA Committee, the many that included our case manager, Shantel Bolton, as well as potential QA Coordinator, Roxanne Sparks (an identified candidate from OSUMC-Mercy)
    - Both HAN Director and Interim Director met with Roxanne to discuss the role in the HAN QA Committee. It was later determined that Roxanne would not be joining the HAN QA Committee due to her current and existing role at the OSU Medical Center
- Sept. The Department was working with two data analytic staff who were data mining the OHCA Claims data
    - Completed a 48 Month Longitudinal survey of the HAN data
    - Pulled top 15 consumers in ER in such areas as; general complaints, Asthma, and diabetes

Departmental Meetings:

- The Health Access Network department has established a weekly departmental meeting to include Dr. Paiva and the Medical Director, Dr. Koehler, every Monday
- The HAN Department has also established a weekly Case Management Update Meeting to occur every Friday

Conference Attendance:

- Aug.- Had departmental presence at the 2015 Strategic Planning Conference in OKC, OK
- Sept. 17th- Received confirmation to setup a HAN exhibit booth at the CME Primary Care Update Conference held at the Double Tree-Tulsa on Nov. 6th & Nov. 7th

- At this conference we were able to provide insight to the HAN and the case management services that we provide
- Marketing materials were produced and distributed during this conference

Departmental Training:

- Aug. 25th, 26th, & 27th- Our Case Manager, Shantel Bolton, attended CM Training at OU-Tulsa

Departmental Hiring Process:

- The HAN has successfully hired for the following positions during the 3rd quarter of CY 2015
  - July 2015- RN Case Manager- Shantel Bolton
  - August 2015- Administrative Assistant- Lindsay James
  - September 2015- HAN Director- Matt Maxey
    - RN Case Manager- Connie Schadel
    - RN Case Manager- Leslie Brown
    - HAN Medical Director- Dr. Duane Koehler
- Also during this time, the HAN was contemplating future interviews for the following positions:
  - LCSW
  - Data Analyst

HAN Clinic Visits:

- Aug. 20th- Conducted a meeting with the Chief Resident from the HCC Family Medicine Clinic to discuss our current referral system/process and consent forms used in the Family Medicine Clinic
  - Discussed the possibility of having a button or drop down embedded in the EPIC system specifically for HAN referrals in order to streamline the referral process and give the physicians and residents the ability to send it directly to the HAN Case Managers within the EHR system
  - HIT decided to utilize e-mail inbox in EPIC for referrals as a temporary solution while our departmental request to have our department and referral drop down was being built in EPIC
- Aug. 21st- Chief Resident of the Family Medicine Health Care Center took the Consent and Referral Form that we presented to him to the weekly HCC Family Medicine Physician Resident Meeting with the premise of implementing the forms into the clinic pods for easy access the following Monday, Aug. 24th
  - Later confirmed by The Oklahoma Health Care Authority that a physical consent form completed with a patient's signature was not required. Verbal consent is sufficient
  - After having re-introduced our program to the residents at the HCC, FM residents began to come directly to the department to refer in-house patients for our case management services
- Aug. 27th- Dr. Paiva, Interim Director Michael Shea, and Administrative Assistant, Lindsay James, met with Lead LPN, Erika Johnson, at the Houston Parke Pediatrics Clinic to discuss the HAN and our Case Management Services
  - Erika is taking our discussion to all of her clinical physicians at their monthly meeting the week of Sept. 14th
    - Erika reported that the discussion at the monthly clinical physicians meeting was very well received and the consensus was that there are a lot of patients in their clinic that would benefit for our CM program
- Aug. 28th- Attended the monthly Family Medicine Physicians meeting of which included the Family Medicine Department Chair, Dr. Thurman, and all FM physicians to discuss the utilization of the HAN in their clinics

- Sept. 16th- HAN Director and Interim Director met with the General Manager of the Muskogee Children's Clinic, Ryan Hardaway, to discuss the case management services that our department offers
    - The meeting went very well and the clinic is eager to begin working with our department and case management services
    - The Muskogee Children's Clinic is also interested in assistance in 'meaningful use' and Tier advancement. We have contacted HIT Director, Heidi Holmes, to discuss meaningful use tactics for their clinic
- Sept. 21st- Looked to schedule a meeting with our Eastgate clinic-reached out to Practice Administrator, Cindy Earnest
- Sept. 30th- HAN Director gave a short introductory presentation of our department and services to the clinical staff at the Houston Parke Internal Medicine and Specialty Services Clinic

Clinic Enrollment:

- Sept. 17th- Department was approached by the Family Medicine Practice Administrator, Cindy Earnest, in regard to enrolling another Family Medicine Clinic- North Regional Health and Wellness Clinic
    - Sept. 18th- Confirmation was received from Melody at OHCA and we successfully enrolled North Regional Health and Wellness Clinic

4th Quarter (October-December)- CY 2015

Operations:

- Oct. 2nd- Department heads, Matt Maxey and Mike Shea, met again with Dr. Kendrick's assistant, Mike Noshay
    - Discussed with Mike Noshay the reporting capabilities of My Health, as well as additional data packages that are available to purchase for immediate utilization
- Oct. 30th- The OSU Health Access Network website went live- osuhan.com

Departmental Meetings:

- The OSU Health Access Network department established weekly departmental meetings to include Dr. Paiva and the HAN Medical Director to occur every Monday
    - Dr. Johnny Stephens also received an open invitation to attend our weekly meetings
        - Oct. 19th- Dr. Stephens attended his first HAN Departmental meeting

Departmental Hiring Process:

- Future interviews were planned by the OSU-CHS staff to include the following positions within OSU HAN:
    - LCSW
    - Data Analyst
    - Quality Assurance Coordinator

Departmental Staff Training:

- Nurse specific EPIC Training completed- Matt Maxey

HAN Clinic visits:

- Oct. 14th- HAN Director, Matt Maxey, and HIT Manager met with Ryan Hardaway at the Muskogee Children's Clinic to discuss meaningful use and My Health EHR Access and Implementation

- Ryan also confirmed that he had submitted the application for Tier II advancement in early October to the Oklahoma Health Care Authority

- Oct. 27th- HAN Director and HAN Administrative Assistant travelled to Muskogee Children's Clinic to re-introduce our department and case management program to the clinical staff, as well as physicians
- Nov. 6th- HAN Director held another departmental re-introduction to the Houston Parke Internal Medicine and Specialty Services that included attending physicians, IM, and Cardio Physicians

1st Quarter (January-March)- CY 2016

Operations:

- Jan. 4th- HAN Director attended a Data analytic meeting with Dr. Paiva and Elvena Fong (Program Manager-Data Analytics-CHSI) to discuss the logistics/departmental responsibilities a data analyst will require for both departments
  - Submitted educational links to OSU Web Manager to be included on our website for patient access and education
- Jan. 5th- OOSU Health Access Network Case Managers conducted monthly Conference Call with Jennifer Laizure
- Feb. 2nd- HAN Director and Case Managers worked to create Asthma Care Plans to include a basic template from which to work. The plan provided the case managers a targeted set of goals that can be individualized for each patient with a chronic condition. This allows a case manager to pick goals for an individual patient that meet the needs of that specific client. This plan allows case managers to track progress toward meeting those goals
  - Feb. 3rd- Case Managers began to utilize the asthma care plan model in order to set goals for existing population of actively managed asthmatics
- Feb. 4th- Received confirmation from our Health Information Technology Department that our HAN department has been built out and completed in EPIC. The ability to receive referrals electronically via the EPIC platform drop down completed
- Feb. 9th- HAN Director and Administrative Assistant met with Jamie Edford, OSU Web Manager, to discuss the stats of our website. We also submitted key words/key phrases to Jamie in an effort to help encourage a higher frequency of website views
- Feb. 16th- HAN Director met with Eric Polak, Dr. Paiva, and Melody Anthony to discuss HAN expansion and the resuming of payments
- Mar. 8th- HAN Director met with Interior Designer of the 810 S. Cincinnati building to discuss layout/logistics and furniture

Departmental Training:

- Mar. 25th- HAN Director and Case Managers, Leslie Brown and Connie Schadel, began Motivational Interviewing training today and continued training for two additional Fridays (4/1 & 4/8)
- Mar. 29th- HAN Director and Case Managers, Connie Schadel and Leslie Brown, attended Case Management training at the University of Oklahoma-Tulsa

Departmental Meetings:

- Jan. 4th- Health Access Network departmental meeting
- Jan. 8th- Health Access Network Case Management Update Meeting
- Jan. 11th- Health Access Network departmental meeting
  - HAN Director attended CHS policy review meeting in order to assist in the revision of policies
- Jan. 15th- Health Access Network departmental meeting

- HAN Director attended the CQI Meeting in order to provide a HAN update
- Jan. 18th- Health Access Network departmental meeting
- Jan. 19th- GME Meeting with Oklahoma Health Care Authority
- Jan. 22nd- Health Access Network departmental meeting
- Jan. 25th- Health Access Network departmental meeting
- Jan. 27th- Monthly meeting with the Oklahoma Health Care Authority
- Feb. 1st- Health Access Network departmental meeting
- Feb. 5th- Health Access Network Case Management Update Meeting
  - HAN Director attended the Continuous Quality Improvement meeting
  - HAN Director met with Dr. Alexopulos to discuss expanding HAN services to other AJ Clinics, as well as other potential partnerships with the Tulsa Health Department
- Feb. 8th- Health Access Network Departmental Meeting
- Feb. 12th- Health Access Network Case Management Update Meeting
- Feb. 15th- Health Access Network Departmental Meeting
- Feb. 19th- Health Access Network Case Management Update Meeting
- Feb. 22nd- Health Access Network Departmental Meeting
- Feb. 23rd- Meeting with Oklahoma Health Care Authority
- Feb. 27th- Health Access Network Case Management Update Meeting
- Mar. 4th- Health Access Network Departmental Meeting
  - Administrative Assistant and Case Managers, Shantel Bolton & Connie Schadel, attended the monthly Continuous Quality Improvement meeting
- Mar. 7th- Health Access Network Departmental Meeting
  - HAN Director attended CHS Policy Review Meeting
- Mar. 8th- HAN Director attended CHSI/HAN Team Meeting
- Mar. 10th- HAN Director and Administrative Assistant joined a conference call with Well Care to discuss their program and how it relates to the Health Access Network Program
- Mar. 11th- Health Access Network Case Management Update Meeting
- Mar. 14th- Health Access Network Departmental Meeting
  - HAN Director attended weekly OSU/CHSI Team Meeting
  - Administrative Assistant met with OSU Web Manager to discuss the design and implementation of a monthly, departmental e-mail blast and Facebook page
- Mar. 21st- Health Access Network Departmental Meeting
- Mar. 28th- Health Access Network Departmental Meeting

HAN Clinic Visits:

- Jan. 11th- HAN Director visited the Eastgate Clinic, Connie followed up with a patient at their appointment
  - Director discussed the HAN and Clinic contract agreements, appointments, and referrals
- Jan. 21st- HAN Director and Case Manager, Leslie Brown, met with residents/attending physicians/nurse practitioners at the North Regional Health and Wellness Clinic
- Jan. 26th- HAN Director visited the Houston Park Pediatrics Clinic to discuss our CM program with their residents and clinical staff
- Feb. 11th- CHSI Director (Marjorie) and HAN Director met with Dr. Stratton at the Muskogee Children's Clinic to further discuss:
  - Case Management Services within the MCC

- Discussed the clinic's Referral Coordinator's retirement at the end of this month

- Feb. 17th- HAN Director and Case Manager, Leslie Brown, met with Houston Park Pediatric providers to re-introduce our program and the services that we offer through our Case Management Program
  - Upon an invitation from the clinic, we have established a monthly Wellness Session meeting to include our Case Managers and the physicians of the clinic
- Feb. 18th- HAN Director and Case Manager, Connie Schadel, travelled to Muskogee Children's Clinic to shadow the current and newly hired referral coordinator in order to become more familiar with their current referral process
  - MCC agreed to begin the new Case Management process on March. 9th
    - Process plan; met at the clinic location weekly and began an implementation of Case Management within the clinic
- Mar. 16th- HAN Director and Kathy Windle travelled to Enid, OK and met with the Practice Managers of several OSU, adjunct clinics in order to introduce our program and the ways in which we could benefit their patient populations

Departmental Hiring Process:

- Jan. 4th- Successfully posted for the position of Quality Assurance Coordinator
  - Feb. 9th- Conducted two interviews
  - Feb. 10th- Conducted two additional interviews
  - Mar. 8th- Offer was extended to one of the candidates, Bruce Pierce, of which he accepted
- Jan. 20th- HAN Director and Elvena Fong (Data Analytic Program Manager- CHSI) conducted multiple interviews (6) for the shared Data Analyst position between the HAN and CHSI
- Feb. 26th- Human Resources has posted two additional Nurse Case Manager positions for the HAN
  - One of the Case Managers that was interviewed, Paula Wheeler-Ballard, accepted the Muskogee Children's Clinic
- Mar. 28th- New Quality Assurance Coordinator, Bruce Pierce, and Data Analyst, Shrie Sathyanarayanan started with the HAN

Departmental Training:

- Mar. 25th- HAN Director and Case Managers, Leslie Brown and Connie Schadel, began Motivational Interviewing training and continued this training for two additional Fridays (4/1 & 4/8)

2nd Quarter (April-June)- CY 2016

Operations:

- Apr. 8th- HAN Director and Case Managers, Connie Schadel and Leslie Brown, attended their final Motivational Interviewing Training
- Apr. 14th- Data Analyst, Shrie, and Quality Assurance Coordinator attended EPIC training to include; Release of Information/Scanning, Telephone Encounters, Cadence 1203, and Referral Training
  - Director, Administrative Assistant, and Case Managers attended the EPCI Cadence 1203 and Referral Training
- April. 28th & 29th- HAN Administrative Assistant and Director hosted an Exhibit Table at the 116th Annual Convention: Medicine's New Frontier in Norman, OK
- May 5th- HAN Director discussed options of Dr. Jason Beaman to act as out Behavioral Health Medical Director
- May 18th- Quality Assurance Coordinator attended the QI Clinic Consultation Project meeting

- Jun. 1st- Collaborative efforts between the HAN and CHSI appointed Dr. Scott Shepherd as the HAN Medical Director

Departmental Meetings:

- Apr. 4th- Health Access Network Departmental Meeting
- Apr. 5th- HAN Director attended weekly CHSI/HAN Team Meeting
- Apr. 11th- Health Access Network Departmental Meeting
  - Director attended Policy Review Committee Meeting
  - Director attended weekly CHSI/HAN Team Meeting
- Apr. 15th- Health Access Network Case Management Update Meeting
- Apr. 18th- Health Access Network Departmental Meeting
- Apr. 19th- HAN Director attended weekly CHSI/HAN Team Meeting
- Apr. 22nd- Health Access Network Case Management Update Meeting
- Apr. 25th- Health Access Network Departmental Meeting
  - Director attended CHSI/HAN Team Meeting
- Apr. 26th- Director attended Supervisor's Meeting
- Apr. 27th- Attended Monthly meeting with the Oklahoma Health Care Authority
- May 2nd- Health Access Network Departmental Meeting
- May 5th- Health Access Network Quality Assurance Meeting
- May 6th- Health Access Network Case Management Update Meeting
- May 9th- Health Access Network Departmental Meeting
- May 10th- HAN Director, QA Coordinator, CM Connie Schadel, and our newest CM Paula Ballard travelled to Muskogee Children's Clinic to attend a clinic cookout and to provide a Meet & Greet opportunity between Paula and the clinic staff
- May 11th- Held Bi-monthly conference call with HIT's Cody Friedan to discuss our current needs and questions
- May 12th- Health Access Network Quality Assurance Meeting
- May 16th- Health Access Network Departmental Meeting
- May 17th- Director attended weekly CHSI/HAN Team Meeting
- May 20th- HAN Quality Assurance Coordinator attended the monthly CQI Meetings in which he spoke about our referral process, as well as attempts to establish monthly meetings with all of our clinics
- Jun. 3rd- HAN Director and QA Coordinator attended the monthly CQI Meeting
- Jun. 6th- Health Access Network Departmental Meeting
  - Director attended weekly CHSI/HAN Team Meeting
- Jun. 7th- Health Access Network Case Management Update Meeting
  - Case Managers attended weekly CHSI/HAN Team Meeting
- Jun. 21st- Health Access Network Case Management Update Meeting
- Jun. 22nd- Held Bi-monthly conference call with Cody Friedan (HIT) to discuss our current needs and questions
- Jun. 27th- Health Access Network Departmental Meeting
- Jun. 28th- Health Access Network Case Management Update Meeting
  - HAN Director attended weekly OSU CHSI/HAN Team Meeting

HAN Clinic Visits:

- Apr. 6th, 13th, & 20th- HAN Director and CM, Connie Schadel, travelled to Muskogee Children's Clinic for their weekly Case Management Meeting

- Case Managers, Leslie Brown and Shantel Bolton, met with physicians at Houston Parke Pediatrics clinic for their standing, monthly case management meeting of which current managed patients were discussed

- May 10th, 17th, & 24th- HAN Director and Case Managers, Connie Schadel and Paula Wheeler-Ballard, travelled to Muskogee Children's Clinic for their weekly Case Management Meeting
  - May 10th- Case Managers, Leslie Brown and Shantel Bolton, met with physicians at the Houston Parke Pediatrics Clinic for their standing, monthly case management meeting
  - HAN Director, Case Manager Connie Schadel, Quality Assurance Coordinator Bruce Pierce, and New Muskogee Children's Clinic Case Manager, Paula Wheeler Ballard attended a clinic cookout at the Muskogee Clinic to introduce Paula to the doctors and clinical staff
- - Jun. 1st, 8th, 15th, 22nd, & 29th- HAN Director and Quality Assurance Coordinator continue to travel to Muskogee Children's Clinic to meet with clinic manager and CM Paula Wheeler Ballard
- Jun. 8th- HAN Director travelled to Premier Pediatrics Clinic in Muskogee and offered an introduction to our Case Management Program. There he successfully obtained a signed contract to join our HAN program
- Jul. 3rd- CM, Leslie Brown, who previously attended the standing, monthly meeting with the Houston Parke Pediatric Clinic took along with her our newest Case Manager, Melissa Gantz, LCSW. As the new Case Manager for the HPP Clinic, Melissa established a schedule where she is in the clinic two days a week, every week to serve as a HAN point of contact

Case Management- All Populations-Interventions

At the end of FY 2016, the OSU HAN provided case management services 608 individual Sooner Care Choice members

Below is a population breakdown of the number of individual Sooner Care Choice members that have benefited from our case management services in FY2016.

OSU HAN Care Management	
Care Management Category	**Unique Members Served in Fiscal Year 2016**
High Risk Obstetrics	53
Diabetes	37
Breast and Cervical Cancer	16
Hemophilia	1
Asthma	28
Pharmacy Lock-in	22
Hospital Follow Up	215
ER Utilizaton	80
Misc.	156
Total for Fiscal Year 2016	**608**

Percentage of Case Managed Patients vs. Entire Clinic Panel Roster

The table below represents the percentage of care managed patients in comparison to the total number of members presented in the clinic panel rosters at the end of FY16; June 2016. According to the table below, at the end of FY16 we were managing 1.28% of the total patient population panel that exists in our enrolled OSU Health Access Network Clinic system.

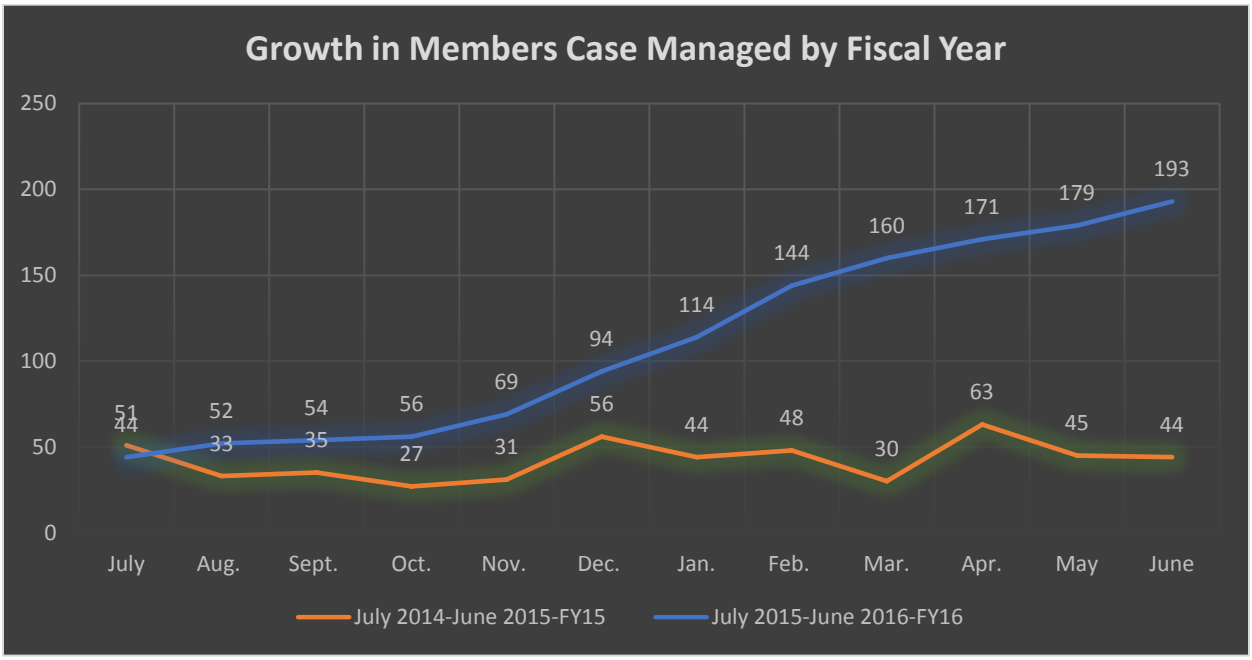
Clinic	Total Members	Care Managed Member	% Care Managed
NORTH REGIONAL HEALTH AND WELLNESS CEN T	410	5	1.22%
OSU EAST GATE	1508	15	0.99%
OSU HCC FM & WHC	2104	66	3.14%
OSU HOUSTON PARKE PEDIATR ICS	4311	30	0.70%
OSU INTERNAL MEDICINE SPE CIALTY CLINIC	360	34	9.44%
OSU POB FAMILY MEDICINE	588	8	1.36%
OSU-AJ CHILDREN'S CLINIC	3937	32	0.81%
OSU-AJ PREMIER PEDIATRICS OF MUSKOGEE	1805	3	0.17%
Grand Total	15023	193	1.28%

FY15 Case Management Patient Population Data

Population	Jul.-14	Aug.-14	Sept.-14	Oct.-14	Nov.-14	Dec.-14	Jan.-14	Feb.-15	Mar.-15	Apr.-15	May.-15	Jun.-15
HROB	8	8	7	8	7	4	5	7	5	5	7	5
Breast/Cervical Cancer	5	5	5	4	4	2	3	4	7	7	7	7
Hemophilia	1	1	1	1	1	1	1	1	1	1	1	1
Hospital F/U	22	14	2	8	13	12	12	20	2	12	14	13
PHARM LOCK IN	3	4	6	6	5	5	5	7	3	2	4	5
ER Utilization	11	1	14	0	1	30	16	6	11	34	12	13
Misc. (Other)	1	0	0	0	0	1	2	3	1	2	0	0
Total Managed Cases per Month:	**51**	**33**	**35**	**27**	**31**	**55**	**44**	**48**	**30**	**63**	**45**	**44**

FY16 Case Management Patient Population Data

Population	Jul.-15	Aug.-15	Sept.-15	Oct.-15	Nov.-15	Dec.-15	Jan.-16	Feb.-16	Mar.-16	Apr.-16	16-May	Jun.-16
HROB	5	9	10	9	11	15	17	18	14	13	15	12
Asthma	0	0	0	0	5	8	11	12	16	14	14	14
Breast/Cervical Cancer	7	8	9	9	10	10	10	12	12	12	12	8
Diabetes	0	4	0	5	11	15	19	23	25	24	23	24
Hemophilia	1	1	1	1	1	1	1	1	1	1	1	1
Hospital F/U	13	14	17	3	0	0	2	3	5	6	6	6
PHARM LOCK IN	5	5	5	5	7	6	7	7	7	8	8	7
ER Utilizaton	13	8	6	19	10	19	20	21	21	19	15	11
Misc. (Other)	0	3	6	5	14	20	27	47	59	74	85	110
Total Managed Cases per Month:	**44**	**52**	**54**	**56**	**69**	**94**	**114**	**48**	**160**	**171**	**179**	**193**

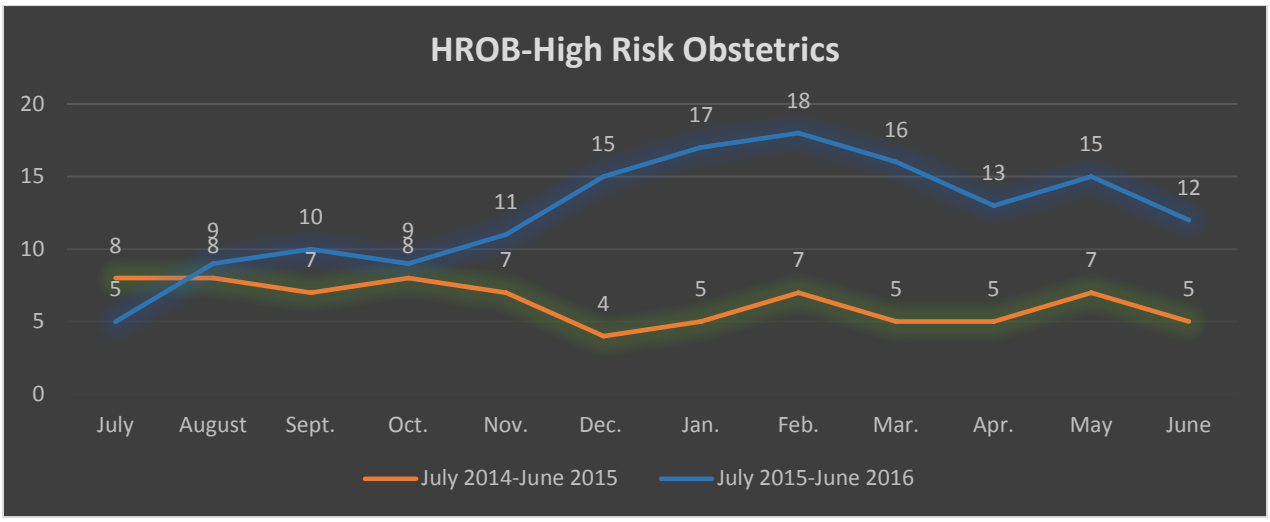


Case Management-Population Specific-Interventions

HROB

HROB- High Risk Obstetrics

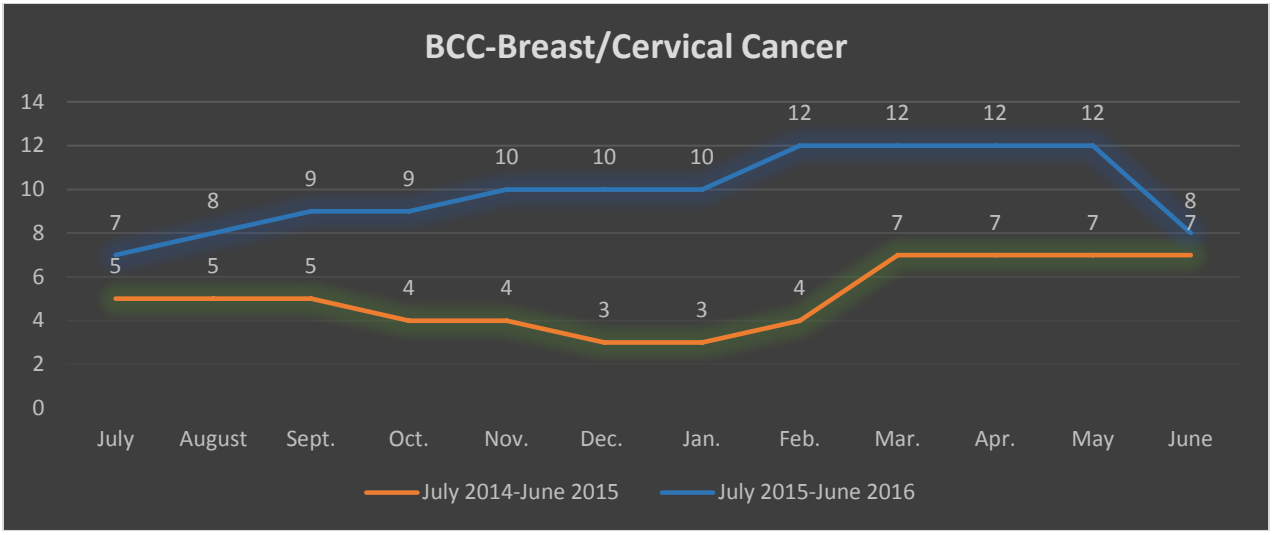
	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
July 2014-June 2015	8	8	7	8	7	4	5	7	5	5	7	5
July 2015-June 2016	5	9	10	9	11	15	17	18	16	13	15	12



BCC-Breast/Cervical Cancer

BCC- Breast/Cervical Cancer

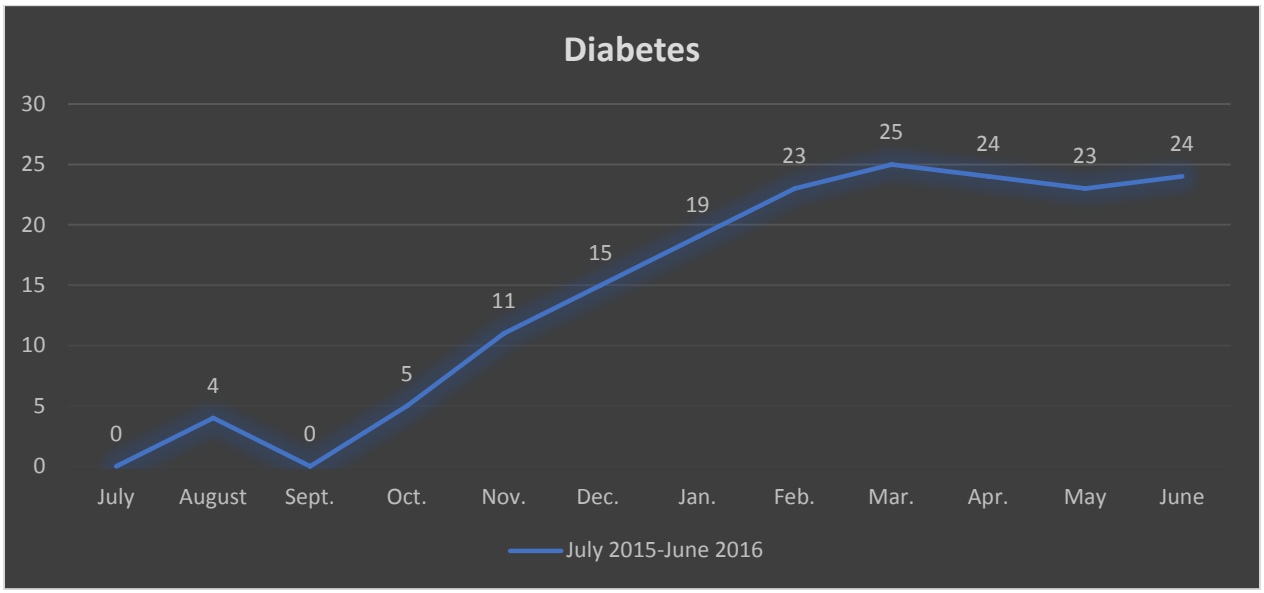
	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
July 2014-June 2015	5	5	5	4	4	3	3	4	7	7	7	7
July 2015-June 2016	7	8	9	9	10	10	10	12	12	12	12	8



Diabetes

DM-Diabetes

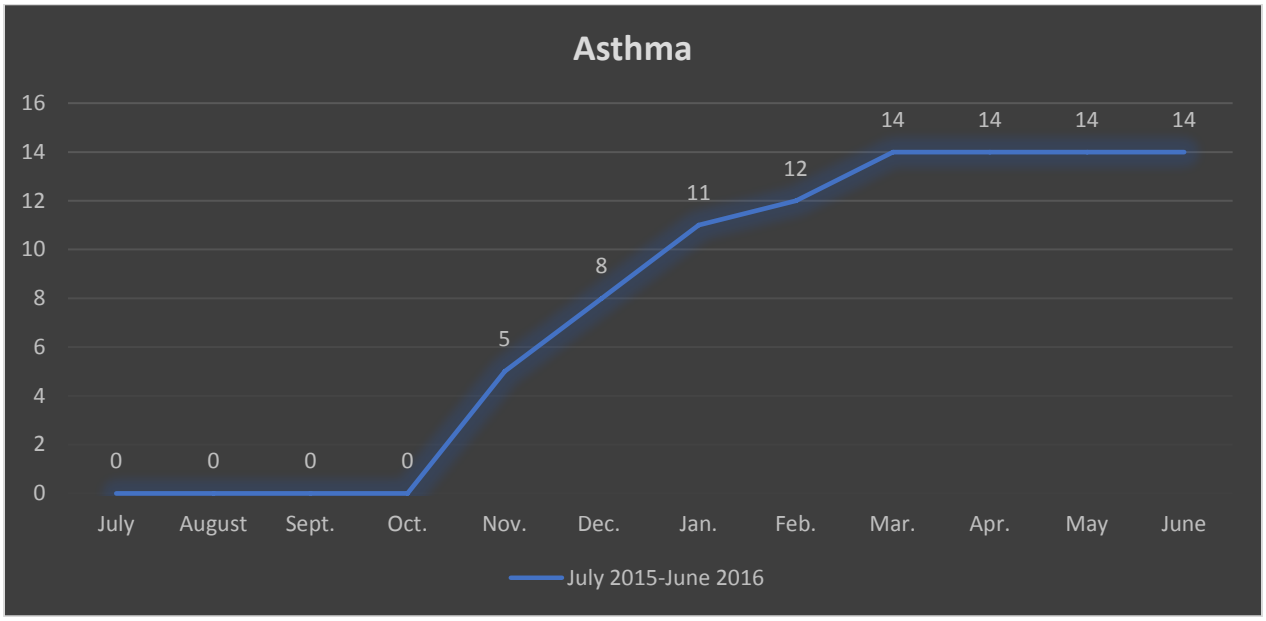
	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
July 2015-June 2016	0	4	0	5	11	15	19	23	25	24	23	24



Asthma

Asthma

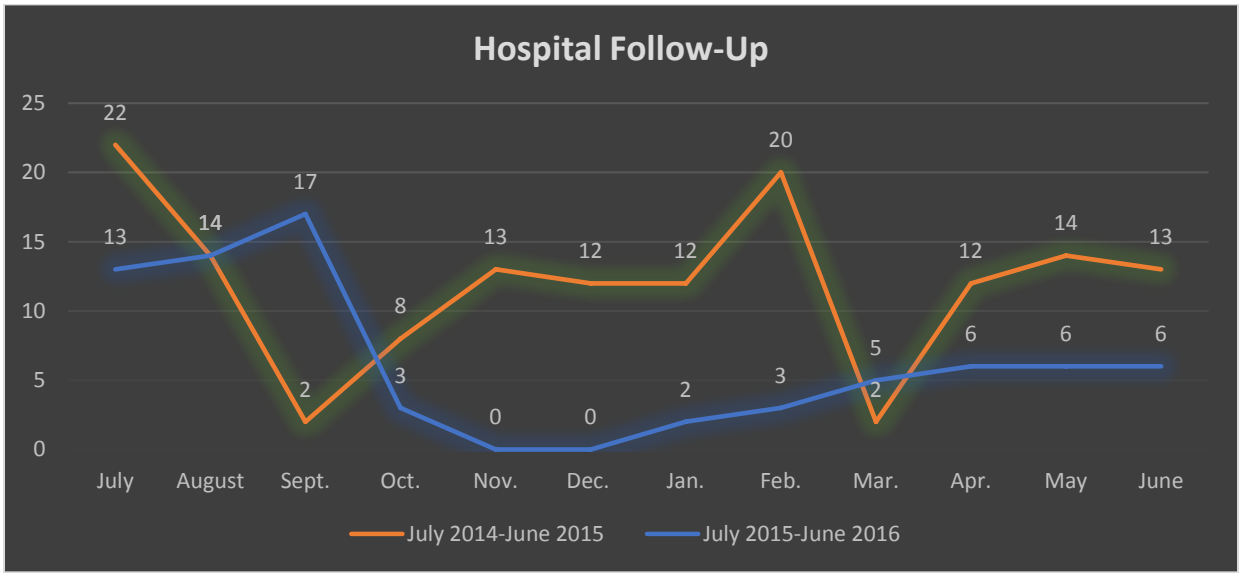
	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
July 2015-June 2016	0	0	0	0	5	8	11	12	14	14	14	14



Hospital Follow-Up

Hospital F/U

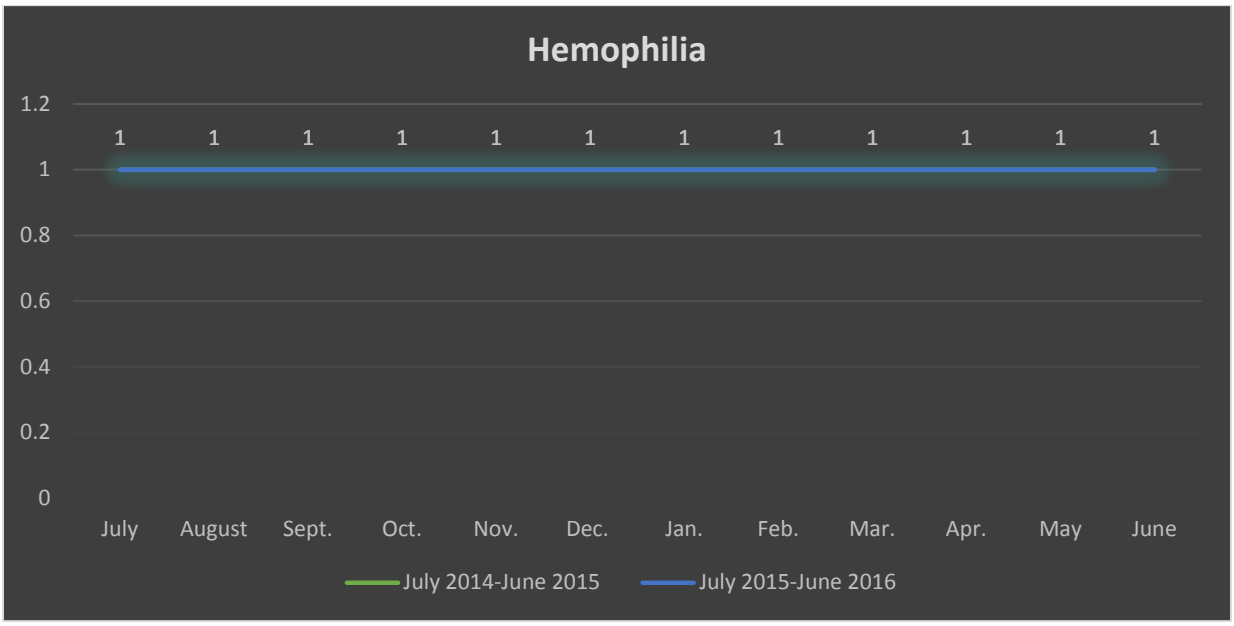
	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
July 2014-June 2015	22	14	2	8	13	12	12	20	2	12	14	13
July 2015-June 2016	13	14	17	3	0	0	2	3	5	6	6	6



Hemophilia

HEMO-Hemophilia

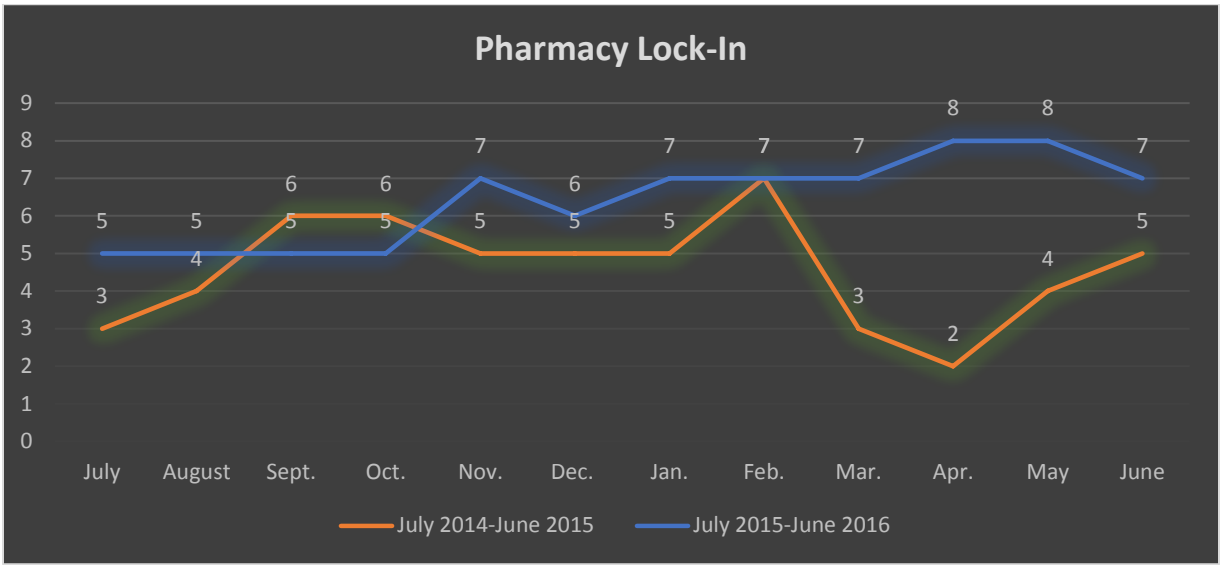
	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
July 2014-June 2015	1	1	1	1	1	1	1	1	1	1	1	1
July 2015-June 2016	1	1	1	1	1	1	1	1	1	1	1	1



Pharmacy Lock-In

Pharmacy Lock-In

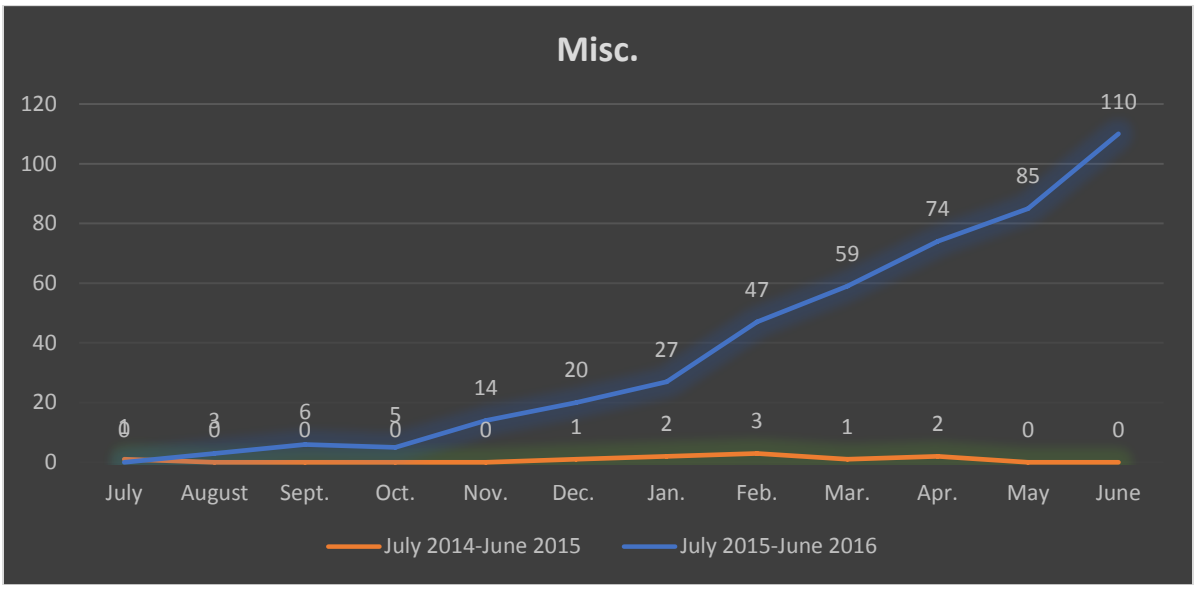
	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
July 2014-June 2015	3	4	6	6	5	5	5	7	3	2	4	5
July 2015-June 2016	5	5	5	5	7	6	7	7	7	8	8	7



Misc.

Misc.

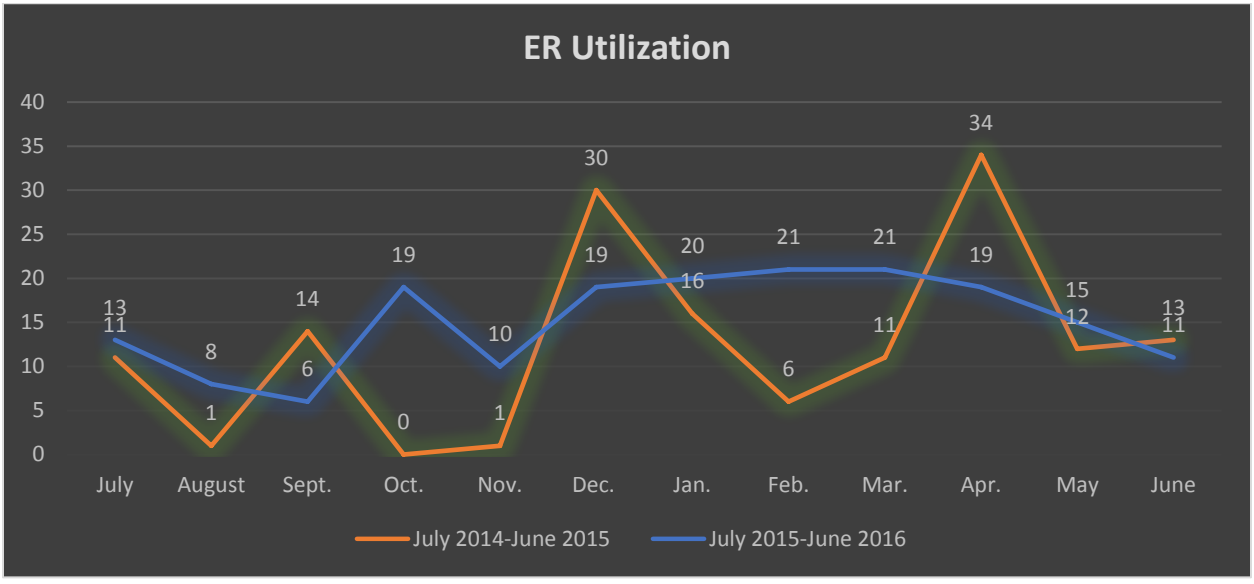
	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
July 2014-June 2015	1	0	0	0	0	1	2	3	1	2	0	0
July 2015-June 2016	0	3	6	5	14	20	27	47	59	74	85	110



ER Utilization

ER Utilization

	July	August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
July 2014-June 2015	11	1	14	0	1	30	16	6	11	34	12	13
July 2015-June 2016	13	8	6	19	10	19	20	21	21	19	15	11



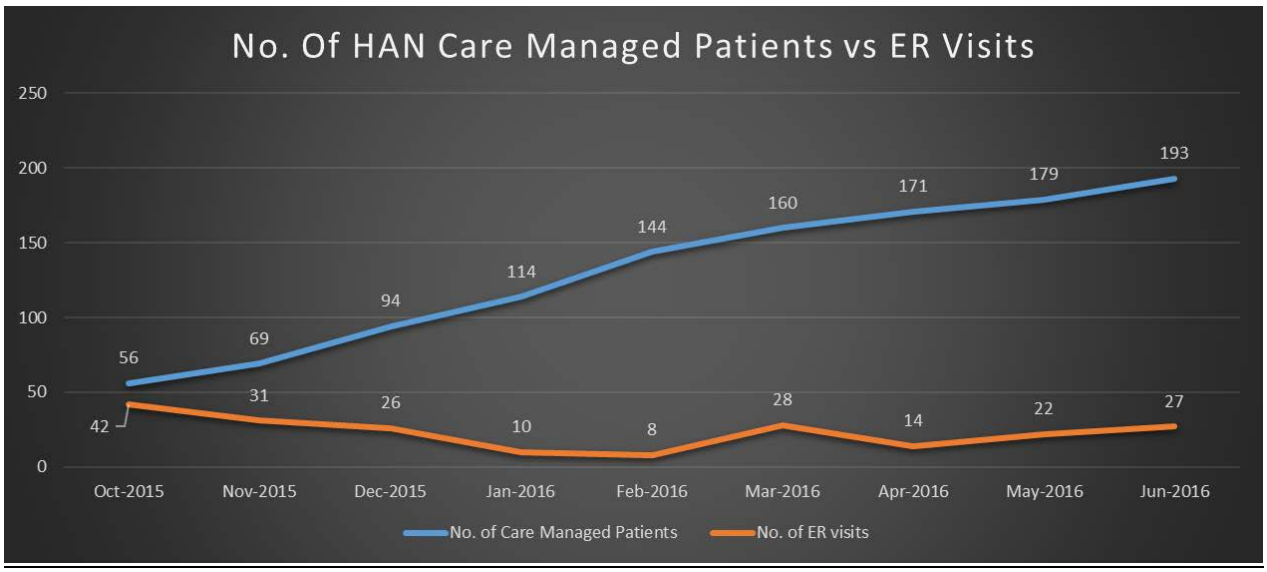
OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

The ER analysis has been conducted from October 2015 until June 2016 in order to estimate the total savings that has been made by HAN. The table below shows the number of members managed each month and their corresponding ER visits for that month. Assuming the trend of October continuing for the rest of the months until June 2016 with an average of .75 visits per member, per month the total estimated savings was $834,741.00 at $1,233 per visit for FY2016. (Average ER cost data pulled from: https://www.google.com/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF8#q=average%20cost%20of%20emergency%20room%20visit%202015)

	Baseline Condition		
Month	OCT	NOV	DEC
No. of Care Managed Patients	56	69	94
Actual ER visit	42	31	26
Proportion of ER visits as a percentage	75.00%	44.93%	28%
Total cost incured for ER Visit (Assuming avg of $1,233/visit)	$ 51,786.00	$ 38,223.00	$ 32,058.00
Estimated ER visits(With baseline as 0.75 visit/member)	42	51.75	70.5
Estimated Savings per Month	$ -	$ 25,584.75	$ 54,868.50

Month	JAN	FEB	MAR	APR	MAY	JUN
No. of Care Managed Patients	114	144	160	171	179	193
Actual ER visit	10	8	28	14	22	27
Proportion of ER visits as a percentage	9%	6%	18%	8%	12%	14%
Total cost incured for ER Visit (Assuming avg of $1,233/visit)	$12,330.00	$ 9,864.00	$ 34,524.00	$ 17,262.00	$ 27,126.00	$ 33,291.00
Estimated ER visits(With baseline as 0.75 visit/member)	85.5	108	120	128.25	134.25	144.75
Estimated Savings per Month	$93,091.50	$123,300.00	$113,436.00	$140,870.25	$138,404.25	$145,185.75

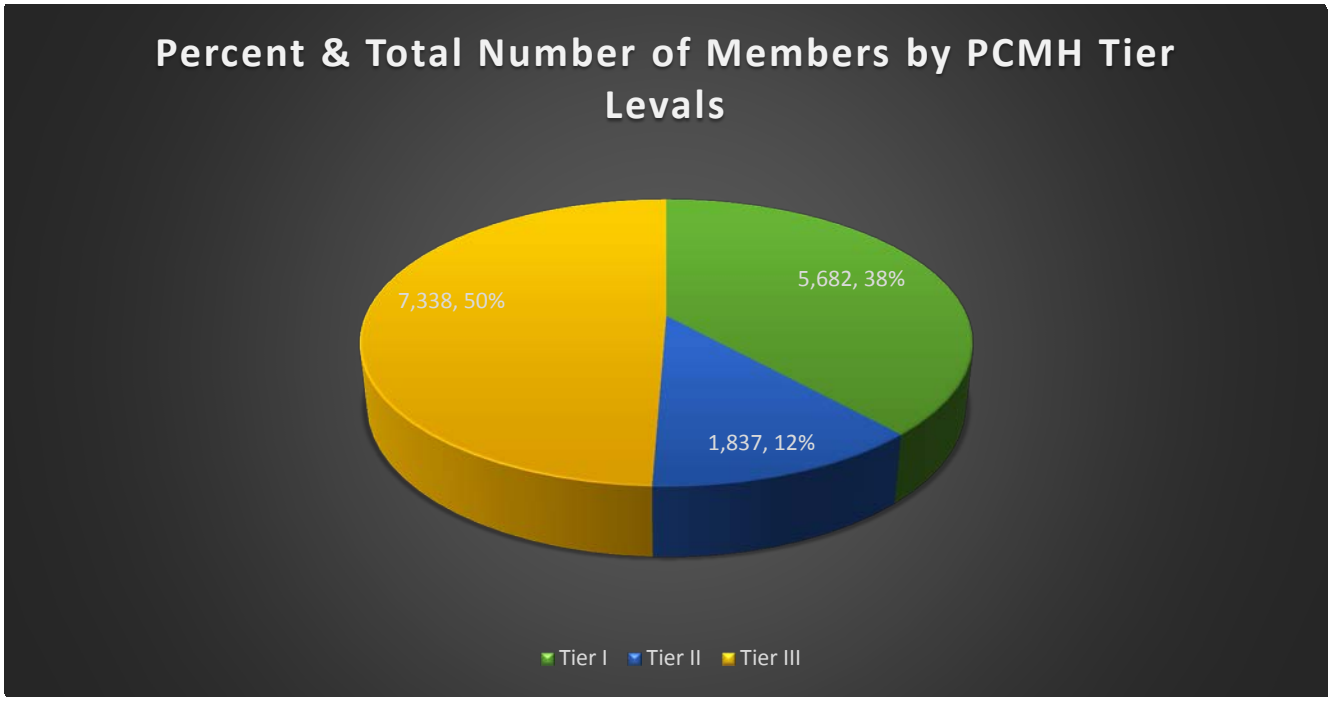
Estimated Total Savings on ER for FY-2016
$834,741.00



OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

Clinic Distribution Per Tier Level

Parent Organization	Clinic Name	Tier Level	Member Count	% of Total
OSU- CHS-HAN	Health Care Center & Women's Health Center- Family Medicine	Tier III	2087	15.00%
	Physician's Office Building (POB)- Family Medicine	Tier III	577	3.00%
	Houston Parke Pediatrics	Tier III	4309	29.00%
	Internal Medicine/ Internal Medicine Speciality Services	Tier III	365	2.41%
	Eastgate	Tier II	1438	9.67%
	North Regional Health and Wellness Center	Tier II	399	2.68%
	Premier Pediatrics Clinic- Muskogee	Tier I	1733	11.66%
	AJ Children's Clinic- Muskogee	Tier I	3949	26.58%
		Grand Total:	**14857**	**100.00%**



Primary Care PCMH Tier Level	# of Members	%
Tier I	5,682	38.24%
Tier II	1,837	12.36%
Tier III	7,338	49.40%
TOTAL	**14,857**	**100.00%**

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

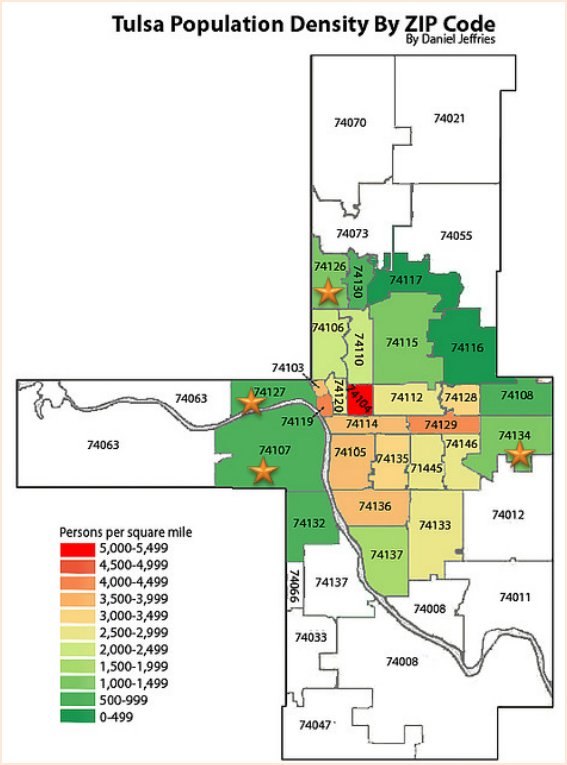
Physician Roster by Clinic

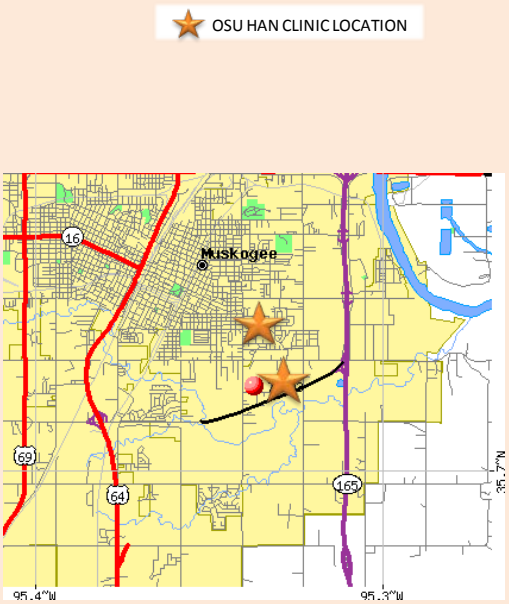
Clinic Name:	Physician List:	Tier Level
Health Care Center- Family Medicine	Dr. Lora Cotton, D.O Dr. Amanda Green, D.O. Dr. Sarah Hall, D.O. Dr. Regina Lewis, D.O. Dr. Andrea McEachern, D.O. Dr. Cornelia Mertz, D.O. Dr. Lana Meyers, D.O. Dr. Christopher Thurman, D.O.	Tier III
Women's Health Center- Family Medicine	Dr. Sarah Hall, D.O. Dr. Regina Lewis, D.O. Dr. Andrea McEachern, D.O. Dr. Lana Meyers, D.O. Dr. Christopher Thurman, D.O.	Tier III
Physician's Office Building (POB)- Family Medicine	Dr. Jenny Alexopulos, D.O. Dr. Lora Cotton, D.O. Dr. Sarah Hall, D.O. Dr. Regina Lewis, D.O. Dr. Lana Meyers, D.O. Dr. Christopher Thurman, D.O. Dr. Jennifer Curran, APRN-CNP Malinda Arrington, APRN-CNP	Tier III
Internal Medicine/ Internal Medicine Specialty Services	Dr. Damon Baker Dr. Jana Baker Dr. Mousumi Som Dr. Kathy Cook Dr. Madhuri Lad Dr. Justin Chronister (Beginning in Oct. 2015)	Tier III
	Dr. D. Matt Wilkett (Cardiology) Dr. Steve Kim (Cardiology) Dr. Brewer (Cardiology) Dr. Daniel Wildes (Cardiology- Beginning Dec. 2015)	
Houston Parke Pediatrics	Dr. Binh Phung, D.O. Dr. Rhonda Jeffries, M.D. Dr. Travis Campbell, D.O. Dr. Rhonda Casey, D.O. Monica Cordero, APRN-CNP Dr. Shawna Duncan, D.O. Dr. Amanda Foster, D.O. Dr. Colony Fugate, D.O. Dr. Jeremy Jones, D.O. Dr. Heather Rector, D.O.	Tier III
Eastgate- Family Medicine	Dr. Traci Carney, D.O. Dr. Amanda Green, D.O. Dr. Sarah Hall, D.O. Dr. Andrea McEachern, D.O.	Tier II
North Regional Health and Wellness Clinic	Dr. Regina Lewis, D.O. Jennifer Curran, APRN-CNP	Tier II
Premier Pediatric Clinic	Dr. Ryan Mundy, M.D. Dr. Tracy Hoos, D.O.	Tier I
AJ Muskogee Children's Clinic	Dr. Michael F. Stratton, D.O. Dr. Jerry D. Whatley, M.D.	Tier I

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

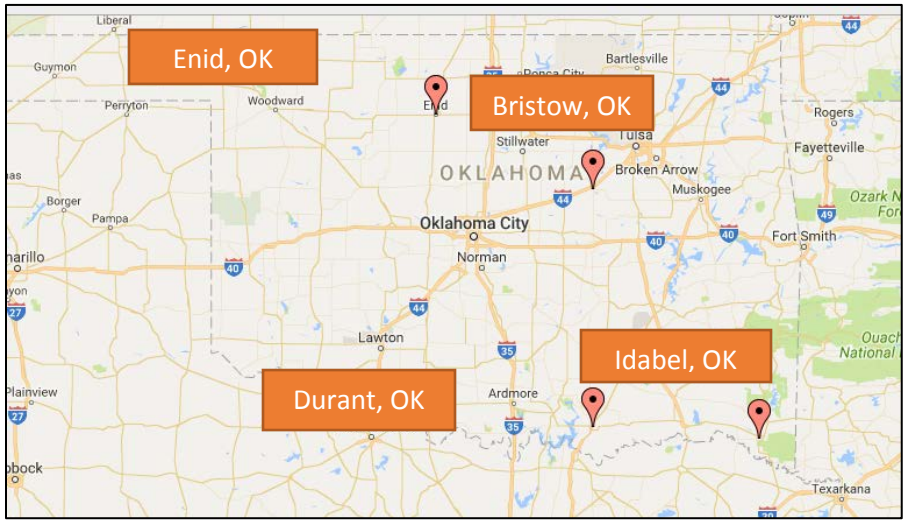
Enrolled OSU HAN Clinic Locations

ENROLLED OSU HAN CLINIC LOCATIONS





Below are a few rural cities in Oklahoma of which we reached out during FY16 as possible, future clinic contracts:



OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

OSU HAN Outreach

Clinical Outreach Initiative:	Clinical Impact:
Aug. 2015	
HAN Director met with Brian Yeaman of Coordinated Care to discuss the possibility of utilizing Coordinated Care as a short term tool	Coordinated Care if a patient demographic and health history tool much like that of My Health. This HIE database would provide our CMs with another avenue for collecting patient-focused data
Sept. 2015	
OSU HAN Department Heads, Matt Maxey and Mike Shea, met with Dr. David Kendrick to discuss the capabilites of My Health	By collaborating with My Health, the OSU HAN was able to gain a valuable resource tool in regard to patient demographics and history. All OSU HAN members gained access to HIE- My Health
Oct. 2015	
The OSU Health Access Network created and implemented a Departmental website on Oct. 30th, 2016. osuhan.com	Physicians can research our program to see if their clinic and patient panel would benefit from our case management program. Patients can gain insight to related events, health education links, and additional information about how our program can benefit their health care goals.
May. 2016	
HAN Director, Quality Assurance Coordinator, CM Shantel Bolton, and Data Analyst, Shrie travelled to OU HAN to meet with their data analytics team and discussed their current usage of the Pentaho Database. Also during this month, the department hosted a conference call with Martie Collin, who created Canadian County's CM Access database.	As the OSU HAN began to build their CM database, we wanted to see what the other HANs have created and were utlizing in an effort to determine which system/method would have been most beneficial to our department/program. We decided to move forward with Marti Collin's Access Database to be implemented post creation.
Community Outreach Initiative:	**Community Impact:**
Nov. 2015	
OSU Health Access Network set up an exhibit booth at the 32rd Annual Primary Care Update Conference on Nov. 6th & 7th at the Warren Double Tree Hotel	By hosting this exhibit table, we were exposed to many Primary Care physicians on both a local and state level. Here they were able to ask us questions about our case management program, as well as ascertain the benefits that we could provide in their own clinics. This conference was also a networking opportunity as well as a way for us to spread the word of our mission
Dec. 2015	
On Dec. 16th, 2015, Director attended at meeting with the OSU Medical Center-Center for Diabetes and Nutritional Education	This meeting was set up in an effort to better address the needs and education of the Sooner Care Choice members that have been diagnosed with diabetes or health nutritional maladies.
May. 2016	
* HAN Director, QA Coordinator, CM Connie Schadel, and Administrative Assistant travelled around Muskogee to the Muskogee Health Department, Bly Sky Behavioral Health Clinic, Muskogee Head State Program, Access to Healthcare Solutions, and the Martin Luther King Community Center * The HAN Department travelled to Durant, OK to attend and volunteer at the Remote Area Medical Event where free dental, vision, and medical exams were given to the general public	* By visiting with these community resource locations and making meaningful contact with the staff involved, we were able to create community relationships that will help tp positively impact our patient population through ways of referrals and general medical need within the community. * As a result of the many clinically trained and general support volunteers that attended and worked the RAM event, there was a total of 529 patients registered and $257, 000 in medical services rendered

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

FY16 HAN Goals

HAN GOALS

1. **Expand the number of Cases Managed**
    a. **Immediate**- 3 mo.- program total of at 90/100 cases (30/33 ea.) DEC/JAN
    b. **Short Term**- 6 mo.-program total of 150 cases (50 cases ea.) MAR/APR
    c. **Long Term-** 1 year-program total of 300 cases (75 ea.) JUN/JUL
2. **Populations**
    a. **Immediate-** Continue teasing out Top 15 (ER users, Asthma, & Diabetes patient populations)
        i. Begin working on teasing out other populations
            1. Rank visit types from claims or Top 15 identified ER utilizers
    b. **Short Term (6 mo.)**- Rank visit types from claims data
        i. Monitor claims for other high-risk patient populations unidentified previously
    c. **Long Term (1 yr.)-** Predictive Analysis to focus on prevention (preventative care)
        i. Clinic referrals to mitigate disease progression in individual patients
        ii. 48 mo. Longitudinal study may provide similar information
3. **HAN DATA GOALS**

    a. **Immediate-**
        i. Finish Longitudinal study
            1. Break down descriptive analytic data
                a. By population
                b. By Clinic
            2. Automate stratification process from ER claims data provided by the Oklahoma Health Care Authority
    b. **Short Term (6 mo.)**
        i. Develop a trend analysis of different populations
        ii. Develop Goal from analysis
            1. Example: Decrease ER utilization in Asthma population by certain %
        iii. IT/DA/Project Manager
        iv. Tableau/Pentaho
    c. **Long Term**
        i. Possible customization reports per clinic request
        ii. Community Comparison- Clinic to Clinic/ Zip to Zip

FY17 HAN Future Focuses

HAN GOALS

1. **Expand the Number of Cases Managed**
    a. **Short Term:** 6 mo.- accumulate cases from Stillwater and Muskogee
    b. **Long Term:** 1 year- reach a program total of 450-600 managed cases (75-100 cases ea.) JUN/JUL
2. **Populations**
    a. **Immediate:** Continue to build out and complete the OSU HAN Disease Registry
    b. **Long Term:** Predictive Analysis in the focus of prevention (preventative care)
        i. Clinic Referrals to mitigate disease progression in individual patients

HAN DATA GOALS

1. **Immediate**
    a. Break down descriptive data
        i. By population
        ii. By Clinic
    b. Automate stratification process for ER claims data from OHCA
    c. Quantify, Return of Investment- ER Data
2. **Short Term:**
    a. Develop a trend analysis of different populations
    b. Develop Goals from analysis
        i. Maintain current ER reduction rate
3. **Long Term:**
    a. Customization of clinic update reports- Currently doing this for Muskogee Children's Clinic but would like to produce for all of our contracted clinics on a monthly basis

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

Health Information Technology

Reporting Period – July 1, 2015 to June 30, 2016

This report provides a summary of Health Information Technology related activities conducted by OSU Health Access Network.

OVERVIEW

Assistance with adoption of Health Information Technology

OSU Physicians

- Help position, grow, and move to other systems. Complete meaningful use stages.
- The HIT team continued efforts to assist OSU Physicians Clinics in supporting and enhancing clinical dashboards as well as building new reports to allow clinical staff to monitor, and provide early intervention strategies on their patients using health management goals, education, primary prevention, behavior modification programs, etc.
- OSU made a decision to move to a new EHR and implementation efforts started in January of 2015. The new EHR system (EPIC) will provide more seamless integration and robust functionality that will allow members of the OSU HAN to track referrals, meet meaningful use, report on clinical quality measures and trend data, etc. The usage of the new EHR system has the same capability of the legacy EHR with added functionality mentioned above, this is to allow providers to also monitor clinical quality measures that have been set for the HAN as well as Behavioral Health, Weight management and Tobacco Cessation counseling needs.
- During the first two quarters of 2015, HIT provided assistance going through the review and selection of a disease management system for the OSU HAN. HIT and the Care management team for the HAN, a couple of system vendors were reviewed however, the main goal for this system is to provide the capability to import data from different sources and create a data warehouse so case managers are able to manage and trend cases through reporting.

Muskogee Children's Clinic

- The OSU HAN engaged with Muskogee Children's clinic during their leadership transition and offered assistance with any HIT related questions to help the clinic continue operating in a smooth manner and help the new leadership with any questions related to services that OSU HAN provides.

HIT Goals for 2015-2016

Reporting Period – July 1, 2015 to June 30, 2016

This report provides a summary of Health Information Technology related activities conducted by OSU Health Access Network.

OVERVIEW

Assistance with adoption of Health Information Technology

- The Health Information Technology department assisted the OSU Health Access Network operations team with the analysis of data warehouse architecture to develop a way to receive structured data from current and future OSU HAN members (XML, CCD's, etc.) and be able to query data and report on clinical outcomes.
- Set up and trained OSU HAN operations team on new Epic workflow of how data would be presented to nursing/case management staff for the purposes of documenting case management interventions in the Epic EHR system implemented at the OSU clinics in August of 2015.
- Trained and conducted transfer knowledge on current delivery of claims data sent by the Oklahoma Healthcare Authority.
- Conducted presentations to all clinic members of the OSU Health Access Network on Meaningful use objectives and final rule changes published in October 6th, 2015. Submitted recommendations and next steps based on the final changes.

Definitions

ADT – Admissions, Discharges and Transfer interface
CCD – Continuity of Care Document
CHS – Center for Health Sciences
CPC – Comprehensive Primary Care
CQI – Continuous Quality Improvement
Convisint – Health Information Exchange software vendor
Doc 2 Doc – Referral Management software
EHR- Electronic Health Record System
Greenway – EHR software Vendor
HIE – Health Information Exchange
HIT – Health Information Technology
My Health – Organization responsible for the implementation of Health Information Exchange between OSU and other participant Health Systems in Tulsa and surrounding areas.
HL7 – Health Level Seven, refers to the set of standards for transferring clinical and administrative data among Health Information systems.
OFMQ – Oklahoma Foundation for Medical Quality
OHCA – Oklahoma Health Care Authority
OSU – Oklahoma State University
OSU HAN – Oklahoma State University Health Access Network
OU – University of Oklahoma Health Access Network
PCMH – Patient Centered Medical Home
REC – Regional Extension Center
FM HCC – OSU Health Care Center Family Medicine clinic
FM POB – OSU Physicians' Office Building Family Medicine clinic
FM Eastgate – OSU Eastgate Family Medicine clinic
HMP- Health Management Program
PCIS – Practice management system used at OSU Physicians clinics
IMSS – OSU Internal Medicine Specialty Services clinic
HP PEDS – OSU Pediatrics clinic

CENTER FOR HEALTH SCIENCES

Health Access Network

ANNUAL REPORT- JULY 1ST, 2015 TO DECEMBER 31ST, 2016

Catina Baker
OKLAHOMA STATE UNIVERSITY | HEALTH ACCESS NETWORK

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

OSU Health Access Network Table of Contents

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

Annual Report: July 2015-December 2016

Introduction:

The Oklahoma State University-Center for Health Sciences Health Access Network (OSU-CHS HAN) was initially implemented in June, 2011 and contained a patient panel size of 21,472 at the end of CY16; December 2016.

The following positions currently contribute to the function of the OSU-HAN:

Financial Reporting Manager- Dr. Johnny Stephens, Pharm D
CFO- Eric Polak
Executive Director/OSU CHSI- Dr. William Paiva
Director/OSU HAN- Matt Maxey
Physician Medical Director: Dr. Scott Shepherd
Behavioral Health Medical Director- Dr. Jason Beaman
Administrative Assistant- Lindsay James-promoted to Program Specialist II in December 2016
RN Case Managers & LCSW Case Management
Health Information Technology- Heidi Holmes
Medical Informatics/Data Analyst- Shire Sathyanarayanan
Quality Assurance Coordinator- Bruce Pierce

OSU Health Access Network Mission Statement:

Providing superior Care Coordination to Sooner Care-Choice members and providers

OSU Health Access Network Vision Statement:

Improving accessibility of comprehensive healthcare in rural Oklahoma.

Members:

Current OSU HAN Members, December 2016: 21,472

OSU Physicians, Tulsa:

- OSU Internal Medicine- Houston Center
- OSU Internal Medicine, Specialty Services- Houston Center
- OSU Family Medicine- Physician's Office Building (POB), Health Care Center/ Women's Health Center, East gate, and North Regional Health and Wellness Center
- OSU OB/GYN- Houston Center, Catholic Charities
- OSU Pediatrics- Houston Center
- OSU Surgery- Physician's Office Building

OSU-Physicians, Muskogee:

- OSU Children's Pediatric Clinic
- OSU Premier Pediatrics Clinic

OSU-Physicians, Stillwater:

- OSU Stillwater Family Care
- OSU Stillwater Pediatrics Clinic

Case Management Program Overview:

Nurse case managers, utilizing motivational interviewing skills; provide outreach, follow-up, health education, care coordination, and management tools to support self-directed care to Sooner Care Choice members living in complex health care needs as identified by the Oklahoma Health Care Authority in the following categories:

- Women enrolled in the High Risk Pregnancy Program
- Members with high Emergency Room utilization
- Women enrolled in the Oklahoma Cares Program (diagnosed with breast/cervical cancer)
- Members enrolled in the Pharmacy Lock-In Program
- Members diagnosed with Hemophilia
- Members with other chronic health conditions referred by their primary care provider or other health care professionals

Additional care management opportunities include:

- Follow up contacts to members discharges from OSU Medical Center
- Chart audits utilizing EMR
- Verifying follow-up appointments with providers-to allow for timely follow-up within 3-5 days from hospital discharge in order to provide care coordination
- Participation in Comprehensive Primary Care (CPC) activities as team member through the OSU-CHS Family Medicine, Health Care Center
- Identification/stratification of members with chronic health conditions
- Data analysis of OHCA claims data

Objective:

The OSU HAN is dedicated to ensuring that Sooner Care Choice Members are adequately supported in reaching their optimal health status and receive the best health care services in the most efficient manner. To accomplish this, the OSU HAN will continue to provide a care coordination system of services; integrating health education, outreach, and access to community resources.

Accomplishments:

Around the start of FY16, Senior members of the OSU HAN sought to strengthen the progress under the direction of Dr. William Paiva, PhD and an appointed interim Director, Michael Shea, MHA, took on the challenge of revamping the HAN's focus. During the fiscal year the following positions vacancies were filled;

1. Shantel Bolton, RN- Hired in July 2015
2. Administrative Assistant- Lindsay James- Hired in August 2015-Promoted to Program Specialist II in Dec. 2016
3. HAN Director-Matt Maxey- Hired in September 2015
4. Connie Schadel, RN- Hired in September 2015
5. Leslie Brown, RN- Hired in September 2015
6. Quality Assurance Coordinator- Bruce Pierce- Hired in March 2016
7. Data Analyst- Shrie Sathyanarayanan- Hired in March 2016
8. Paula Wheeler-Ballard, RN- Hired in May 2016

9. Melissa Gantz, LCSW- Hired in June 2016
10. Rebecca Graham, RN- Hired in October 2016
11. Angie Colborn, RN- Hired in December 2016

OSU HAN Highlights

Third Quarter (July-September) - CY 2015

Operations:

- Aug. 11th- Interim Director and Administrative Assistant met with the University of Oklahoma Health Access Network Administrator to discuss how their current process flows, organizational layout, and overall reporting structures function
  - We gained very insightful information as to how their department operates- received documents of OU HAN on reporting structure, organizational charts, and member flow
- Aug. 24th- Department heads met with Brian Yeaman with Coordinated Care to discuss the possibility of utilizing Coordinated Care EHR
- Sept. 3rd- Department evaluated the use of My Health versus Coordinated Care (after having already met with Coordinated Care) as a possible extension of EPIC in the short term, as well as possibly utilizing Doc to Doc as a referral tool
  - Department heads met with Dr. Kendrick in regard to My Health EHR utilization
- Sept.- OSU Health Access Network department developed an e-mail contact-osuhan@okstate.edu
  - Website creation and implementation was considered during this period for informing the physicians, residents, and patients about department information, as well as services offered by the OSU Health Access Network Case Management Program.
- Sept.- With the addition of our newly appointed Medical Director, Dr. Koehler, the HAN sought to work with him in order to devise plans of care for such areas as asthmatics, diabetics, high ER utilizers, as well as other high-risk patient populations that we encounter
  - Dr. Koehler was also present on our QA Committee, which included our care manager Shantel Bolton, as well as potential QA Coordinator, Roxanne Sparks (an identified candidate from OSUMC-Mercy)
  - Both HAN Director and Interim Director met with Roxanne to discuss the role in the HAN QA Committee. It was later determined that Roxanne would not be joining the HAN QA Committee due to her current and existing role at the OSU Medical Center
- Sept. The Department was working with two data analytic staff who were data mining the OHCA Claims data
  - Completed a 48 Month Longitudinal survey of the HAN data
  - Pulled top 15 consumers in ER in such areas as; general complaints, Asthma, and diabetes

Departmental Meetings:

- The Health Access Network department has established a weekly departmental meeting to include Dr. Paiva and the Medical Director, Dr. Koehler, every Monday
- The HAN Department has also established a weekly Case Management Update Meeting to occur every Friday

Conference Attendance:

- Aug.- Had departmental presence at the 2015 Strategic Planning Conference in OKC, OK

- Sept. 17th- Received confirmation to setup a HAN exhibit booth at the CME Primary Care Update Conference held at the Double Tree-Tulsa on Nov. 6th & Nov. 7th
    - At this conference we were able to provide insight to the HAN and the case management services that we provide
    - Marketing materials were produced and distributed during this conference

Departmental Training:

- Aug. 25th, 26th, & 27th- Our Case Manager, Shantel Bolton, attended CM Training at OU-Tulsa

Departmental Hiring Process:

- The HAN has successfully hired for the following positions during the 3rd quarter of CY 2015
    - July 2015- RN Case Manager- Shantel Bolton
    - August 2015- Administrative Assistant- Lindsay James
    - September 2015- HAN Director- Matt Maxey
        - RN Case Manager- Connie Schadel
        - RN Case Manager- Leslie Brown
        - HAN Medical Director- Dr. Duane Koehler
- Also during this time, the HAN was contemplating future interviews for the following positions:
    - LCSW
    - Data Analyst

HAN Clinic Visits:

- Aug. 20th- Conducted a meeting with the Chief Resident from the HCC Family Medicine Clinic to discuss our current referral system/process and consent forms used in the Family Medicine Clinic
    - Discussed the possibility of having a button or drop down embedded in the EPIC system specifically for HAN referrals in order to streamline the referral process and give the physicians and residents the ability to send it directly to the HAN Case Managers within the EHR system
    - HIT decided to utilize e-mail inbox in EPIC for referrals as a temporary solution while our departmental request to have our department and referral drop down was being built in EPIC
- Aug. 21st- Chief Resident of the Family Medicine Health Care Center took the Consent and Referral Form that we presented to him to the weekly HCC Family Medicine Physician Resident Meeting with the premise of implementing the forms into the clinic pods for easy access the following Monday, Aug. 24th
    - Later confirmed by The Oklahoma Health Care Authority that a physical consent form completed with a patient's signature was not required. Verbal consent is sufficient
    - After having re-introduced our program to the residents at the HCC, FM residents began to come directly to the department to refer in-house patients for our case management services
- Aug. 27th- Dr. Paiva, Interim Director Michael Shea, and Administrative Assistant, Lindsay James, met with Lead LPN, Erika Johnson, at the Houston Parke Pediatrics Clinic to discuss the HAN and our Case Management Services
    - Erika is taking our discussion to all of her clinical physicians at their monthly meeting the week of Sept. 14th
        - Erika reported that the discussion at the monthly clinical physicians meeting was very well received and the consensus was that there are a lot of patients in their clinic that would benefit for our CM program

- Aug. 28th- Attended the monthly Family Medicine Physicians meeting of which included the Family Medicine Department Chair, Dr. Thurman, and all FM physicians to discuss the utilization of the HAN in their clinics
- Sept. 16th- HAN Director and Interim Director met with the General Manager of the Muskogee Children's Clinic, Ryan Hardaway, to discuss the case management services that our department offers
    - The meeting went very well and the clinic is eager to begin working with our department and case management services
    - The Muskogee Children's Clinic is also interested in assistance in 'meaningful use' and Tier advancement. We have contacted HIT Director, Heidi Holmes, to discuss meaningful use tactics for their clinic
- Sept. 21st- Looked to schedule a meeting with our East gate clinic-reached out to Practice Administrator, Cindy Earnest
- Sept. 30th- HAN Director gave a short introductory presentation of our department and services to the clinical staff at the Houston Parke Internal Medicine and Specialty Services Clinic

Clinic Enrollment:

- Sept. 17th- Department was approached by the Family Medicine Practice Administrator, Cindy Earnest, in regard to enrolling another Family Medicine Clinic- North Regional Health and Wellness Clinic
    - Sept. 18th- Confirmation was received from Melody at OHCA and we successfully enrolled North Regional Health and Wellness Clinic

Fourth Quarter (October-December) - CY 2015

Operations:

- Oct. 2nd- Department heads, Matt Maxey and Mike Shea, met again with Dr. Kendrick's assistant, Mike Noshay
    - Discussed with Mike Noshay the reporting capabilities of My Health, as well as additional data packages that are available to purchase for immediate utilization
- Oct. 30th- The OSU Health Access Network website went live- osuhan.com

Departmental Meetings:

- The OSU Health Access Network department established weekly departmental meetings to include Dr. Paiva and the HAN Medical Director to occur every Monday
    - Dr. Johnny Stephens also received an open invitation to attend our weekly meetings
        - Oct. 19th- Dr. Stephens attended his first HAN Departmental meeting

Departmental Hiring Process:

- Future interviews were planned by the OSU-CHS staff to include the following positions within OSU HAN:
    - LCSW
    - Data Analyst
    - Quality Assurance Coordinator

Departmental Staff Training:

- Nurse specific EPIC Training completed- Matt Maxey

HAN Clinic visits:

- Oct. 14th- HAN Director, Matt Maxey, and HIT Manager met with Ryan Hardaway at the Muskogee Children's Clinic to discuss meaningful use and My Health EHR Access and Implementation
    - Ryan also confirmed that he had submitted the application for Tier II advancement in early October to the Oklahoma Health Care Authority
- Oct. 27th- HAN Director and HAN Administrative Assistant travelled to Muskogee Children's Clinic to re-introduce our department and case management program to the clinical staff, as well as physicians
- Nov. 6th- HAN Director held another departmental re-introduction to the Houston Parke Internal Medicine and Specialty Services that included attending physicians, IM, and Cardio Physicians

First Quarter (January-March) - CY 2016

Operations:

- Jan. 4th- HAN Director attended a Data analytic meeting with Dr. Paiva and Elvena Fong (Program Manager-Data Analytics-CHSI) to discuss the logistics/departmental responsibilities a data analyst will require for both departments
    - Submitted educational links to OSU Web Manager to be included on our website for patient access and education
- Jan. 5th- OSU Health Access Network Care Managers conducted monthly Conference Call with Jennifer Laizure
- Feb. 2nd- HAN Director and Case Managers worked to create Asthma Care Plans to include a basic template from which to work. The plan provided the care managers a targeted set of goals that has the ability to be individualized for each patient with a chronic condition. This also allows a care manager to pick goals for an individual patient that meet the needs of that specific client. This plan allows care managers to track progress toward meeting those goals
    - Feb. 3rd- Care Managers began to utilize the asthma care plan model in order to set goals for existing population of actively managed asthmatics
- Feb. 4th- Received confirmation from our Health Information Technology Department that our HAN department has been built out and completed in EPIC. The ability to receive referrals electronically via the EPIC platform drop down is complete
- Feb. 9th- HAN Director and Administrative Assistant met with Jamie Edford, OSU Web Manager, to discuss the stats of our website. We also submitted key words/key phrases to Jamie in an effort to help encourage a higher frequency of website views
- Feb. 16th- HAN Director met with Eric Polak, Dr. Paiva, and Melody Anthony to discuss HAN expansion and the resuming of payments
- Mar. 8th- HAN Director met with Interior Designer of the 810 S. Cincinnati building to discuss layout/logistics and furniture

Departmental Training:

- Mar. 25th- HAN Director and Care Managers, Leslie Brown and Connie Schadel, began Motivational Interviewing training today and continued training for two additional Fridays (4/1 & 4/8)
- Mar. 29th- HAN Director and Care Managers, Connie Schadel and Leslie Brown, attended Case Management training at the University of Oklahoma-Tulsa

Departmental Meetings:

- Jan. 4th- Health Access Network departmental meeting
- Jan. 8th- Health Access Network Care Management Update Meeting

- Jan. 11th- Health Access Network departmental meeting
  - HAN Director attended CHS policy review meeting in order to assist in the revision of policies
- Jan. 15th- Health Access Network departmental meeting
  - HAN Director attended the CQI Meeting in order to provide a HAN update
- Jan. 18th- Health Access Network departmental meeting
- Jan. 19th- GME Meeting with Oklahoma Health Care Authority
- Jan. 22nd- Health Access Network departmental meeting
- Jan. 25th- Health Access Network departmental meeting
- Jan. 27th- Monthly meeting with the Oklahoma Health Care Authority
- Feb. 1st- Health Access Network departmental meeting
- Feb. 5th- Health Access Network Care Management Update Meeting
  - HAN Director attended the Continuous Quality Improvement meeting
  - HAN Director met with Dr. Alexopulos to discuss expanding HAN services to other AJ Clinics, as well as other potential partnerships with the Tulsa Health Department
- Feb. 8th- Health Access Network Departmental Meeting
- Feb. 12th- Health Access Network Care Management Update Meeting
- Feb. 15th- Health Access Network Departmental Meeting
- Feb. 19th- Health Access Network Care Management Update Meeting
- Feb. 22nd- Health Access Network Departmental Meeting
- Feb. 23rd- Meeting with Oklahoma Health Care Authority
- Feb. 27th- Health Access Network Care Management Update Meeting
- Mar. 4th- Health Access Network Departmental Meeting
  - Administrative Assistant and Care Managers, Shantel Bolton & Connie Schadel, attended the monthly Continuous Quality Improvement meeting
- Mar. 7th- Health Access Network Departmental Meeting
  - HAN Director attended CHS Policy Review Meeting
- Mar. 8th- HAN Director attended CHSI/HAN Team Meeting
- Mar. 10th- HAN Director and Administrative Assistant joined a conference call with Well Care to discuss their program and how it relates to the Health Access Network Program
- Mar. 11th- Health Access Network Care Management Update Meeting
- Mar. 14th- Health Access Network Departmental Meeting
  - HAN Director attended weekly OSU/CHSI Team Meeting
  - Administrative Assistant met with OSU Web Manager to discuss the design and implementation of a monthly, departmental e-mail blast and Facebook page
- Mar. 21st- Health Access Network Departmental Meeting
- Mar. 28th- Health Access Network Departmental Meeting

HAN Clinic Visits:

- Jan. 11th- HAN Director visited the East gate Clinic, Connie followed up with a patient at their appointment
  - Director discussed the HAN and Clinic contract agreements, appointments, and referrals
- Jan. 21st- HAN Director and Case Manager, Leslie Brown, met with residents/attending physicians/nurse practitioners at the North Regional Health and Wellness Clinic
- Jan. 26th- HAN Director visited the Houston Park Pediatrics Clinic to discuss our CM program with their residents and clinical staff

- Feb. 11th- CHSI Director (Marjorie) and HAN Director met with Dr. Stratton at the Muskogee Children's Clinic to further discuss:
  - Care Management Services within the MCC
  - Discussed the clinic's Referral Coordinator's retirement at the end of this month
- Feb. 17th- HAN Director and Care Manager, Leslie Brown, met with Houston Park Pediatric providers to re-introduce our program and the services that we offer through our Care Management Program
  - Upon an invitation from the clinic, we have established a monthly Wellness Session meeting to include our Care Managers and the physicians of the clinic
- Feb. 18th- HAN Director and Care Manager, Connie Schadel, travelled to Muskogee Children's Clinic to shadow the current and newly hired referral coordinator in order to become more familiar with their current referral process
  - MCC agreed to begin the new Care Management process on March. 9th
    - Process plan; met at the clinic location weekly and began an implementation of Case Management within the clinic
- Mar. 16th- HAN Director and Kathy Windle travelled to Enid, OK and met with the Practice Managers of several OSU, adjunct clinics in order to introduce our program and the ways in which we could benefit their patient populations

Departmental Hiring Process:

- Jan. 4th- Successfully posted for the position of Quality Assurance Coordinator
  - Feb. 9th- Conducted two interviews
  - Feb. 10th- Conducted two additional interviews
  - Mar. 8th- Offer was extended to one of the candidates, Bruce Pierce, of which he accepted
- Jan. 20th- HAN Director and Elvena Fong (Data Analytic Program Manager- CHSI) conducted multiple interviews (6) for the shared Data Analyst position between the HAN and CHSI
- Feb. 26th- Human Resources has posted two additional Nurse Care Manager positions for the HAN
  - One of the Care Managers that was interviewed, Paula Wheeler-Ballard, accepted the Muskogee Children's Clinic
- Mar. 28th- New Quality Assurance Coordinator, Bruce Pierce, and Data Analyst, Shrie Sathyanarayanan started with the HAN

Departmental Training:

- Mar. 25th- HAN Director and Care Managers, Leslie Brown and Connie Schadel, began Motivational Interviewing training and continued this training for two additional Fridays (4/1 & 4/8)

Second Quarter (April-June) - CY 2016

Operations:

- Apr. 8th- HAN Director and Care Managers, Connie Schadel and Leslie Brown, attended their final Motivational Interviewing Training
- Apr. 14th- Data Analyst, Shrie, and Quality Assurance Coordinator attended EPIC training to include; Release of Information/Scanning, Telephone Encounters, Cadence 1203, and Referral Training
  - Director, Administrative Assistant, and Case Managers attended the EPIC Cadence 1203 and Referral Training

- April. 28th & 29th- HAN Administrative Assistant and Director hosted an Exhibit Table at the 116th Annual Convention: Medicine's New Frontier in Norman, OK
- May 5th- HAN Director discussed options of Dr. Jason Beaman to act as out Behavioral Health Medical Director
- May 18th- Quality Assurance Coordinator attended the QI Clinic Consultation Project meeting
- Jun. 1st- Collaborative efforts between the HAN and CHSI appointed Dr. Scott Shepherd as the HAN Medical Director

Departmental Meetings:

- Apr. 4th- Health Access Network Departmental Meeting
- Apr. 5th- HAN Director attended weekly CHSI/HAN Team Meeting
- Apr. 11th- Health Access Network Departmental Meeting
  - Director attended Policy Review Committee Meeting
  - Director attended weekly CHSI/HAN Team Meeting
- Apr. 15th- Health Access Network Care Management Update Meeting
- Apr. 18th- Health Access Network Departmental Meeting
- Apr. 19th- HAN Director attended weekly CHSI/HAN Team Meeting
- Apr. 22nd- Health Access Network Care Management Update Meeting
- Apr. 25th- Health Access Network Departmental Meeting
  - Director attended CHSI/HAN Team Meeting
- Apr. 26th- Director attended Supervisor's Meeting
- Apr. 27th- Attended Monthly meeting with the Oklahoma Health Care Authority
- May 2nd- Health Access Network Departmental Meeting
- May 5th- Health Access Network Quality Assurance Meeting
- May 6th- Health Access Network Care Management Update Meeting
- May 9th- Health Access Network Departmental Meeting
- May 10th- HAN Director, QA Coordinator, CM Connie Schadel, and our newest CM Paula Ballard travelled to Muskogee Children's Clinic to attend a clinic cookout and to provide a Meet & Greet opportunity between Paula and the clinic staff
- May 11th- Held Bi-monthly conference call with HIT's Cody Friedan to discuss our current needs and questions
- May 12th- Health Access Network Quality Assurance Meeting
- May 16th- Health Access Network Departmental Meeting
- May 17th- Director attended weekly CHSI/HAN Team Meeting
- May 20th- HAN Quality Assurance Coordinator attended the monthly CQI Meetings in which he spoke about our referral process, as well as attempts to establish monthly meetings with all of our clinics
- Jun. 3rd- HAN Director and QA Coordinator attended the monthly CQI Meeting
- Jun. 6th- Health Access Network Departmental Meeting
  - Director attended weekly CHSI/HAN Team Meeting
- Jun. 7th- Health Access Network Case Management Update Meeting
  - Care Managers attended weekly CHSI/HAN Team Meeting
- Jun. 21st- Health Access Network Care Management Update Meeting
- Jun. 22nd- Held Bi-monthly conference call with Cody Friedan (HIT) to discuss our current needs and questions
- Jun. 27th- Health Access Network Departmental Meeting
- Jun. 28th- Health Access Network Care Management Update Meeting
  - HAN Director attended weekly OSU CHSI/HAN Team Meeting

HAN Clinic Visits:

- Apr. 6th, 13th, & 20th- HAN Director and CM, Connie Schadel, travelled to Muskogee Children's Clinic for their weekly Care Management Meeting
    - Care Managers, Leslie Brown and Shantel Bolton, met with physicians at Houston Parke Pediatrics clinic for their standing, monthly care management meeting of which current managed patients were discussed
- May 10th, 17th, & 24th- HAN Director and Care Managers, Connie Schadel and Paula Wheeler-Ballard, travelled to Muskogee Children's Clinic for their weekly Case Management Meeting
    - May 10th- Care Managers, Leslie Brown and Shantel Bolton, met with physicians at the Houston Parke Pediatrics Clinic for their standing, monthly case management meeting
    - HAN Director, Care Manager Connie Schadel, Quality Assurance Coordinator Bruce Pierce, and New Muskogee Children's Clinic Care Manager, Paula Wheeler Ballard attended a clinic cookout at the Muskogee Clinic to introduce Paula to the doctors and clinical staff
- - Jun. 1st, 8th, 15th, 22nd, & 29th- HAN Director and Quality Assurance Coordinator continue to travel to Muskogee Children's Clinic to meet with clinic manager and CM Paula Wheeler Ballard
- Jun. 8th- HAN Director travelled to Premier Pediatrics Clinic in Muskogee and offered an introduction to our Care Management Program. There he successfully obtained a signed contract to join our HAN program
- Jul. 3rd- CM, Leslie Brown, who previously attended the standing, monthly meeting with the Houston Parke Pediatric Clinic, took along with her our newest Care Manager, Melissa Gantz, LCSW. As the new Care Manager for the HPP Clinic, Melissa established a schedule where she is in the clinic two days a week, every week to serve as a HAN point of contact

Third Quarter (July-September) - CY 2016

Operations:

- July 2016:

  Medical Director Highlights:
    - Collaborative efforts between the HAN and CHSI resolved to appoint Dr. Scott Shepherd as the HAN Medical Director

  July Quality Assurance Highlights:
    - Our Quality Assurance Coordinator established a weekly quality assurance meeting to include the HAN Director, Lead Care Manager, Data Analyst, and Program Specialist
        - We have also established a monthly quality assurance meeting with Muskogee Children's Clinic with practice manager, Ryan Hardaway in order to provide the clinic and physicians an update on our current managed patients
    - Quality Assurance Coordinator created an element of measure for all of our managed cases by implementing a case weight mechanism as a guide
    - Our QA Coordinator is currently working on creating a process for the Health Access Network care managers to become CCMs

  July Data Analyst Highlights:
    - HAN Care Management Database deployment: In Final phase of build out and implementation
    - Analyze OHCA Claims data in order to integrate the files for better insights and utilization
    - Working to create new HAN metrics in order to measure impact on the patient by the care management program

- Continue preparing ER utilization reports for the care managers to identify the frequent ER utilizers and manage them

- August 2016:

  Medical Director Highlights:
  - Appointed Dr. Jason Beaman as our Psych Medical Director. Dr. Beaman attends our weekly care management meetings where the care managers can discuss mental health components of their patients and receive feedback and treatment recommendations

  August Quality Assurance Highlights:
  - Our QA Coordinator is working to create HAN Policies and Procedures, training modules for newly hired staff, and the criteria needed for the HAN to possibly become an accredited body in the future
  - Policies and Procedures In Progress:
    - New Hire/Onboarding
    - Conference/Seminar Attendance Approval
    - Transportation Requests/Reservations
    - Attendance
    - Departmental Job Descriptions

  August Data Analyst Highlights:
  - Data Analyst created a manual for the new Care Management access database. A departmental training session occurred on Friday, August 19th for all care managers and office support staff

- September:

  September Quality Assurance Highlights:
  - QA Coordinator is currently working towards developing a satisfaction survey template specific to the HAN in order to gain insights on our involvement both in clinic and on a patient level
  - QA Coordinator is also developing/researching future Community Outreach projects that the HAN can spearhead/become involved in

  September Data Analyst Highlights:
  - Case Management Access Database went live on September 1 2016. Care Managers are currently utilizing the database

Departmental Meetings:

- July 5th- Held Weekly Care Management Update Meeting
  - Care Managers joined monthly OSU HAN conference call with Jennifer Laizure
- July 6th- Attended Bi-Weekly call with HIT/Cody Frieden in order to discuss current HIT challenges/successes
- July 11th- Held Weekly Health Access Network Departmental Meeting
- July 12th- Held Weekly Care Management Update Meeting
  - HAN Director attended the Weekly CHSI/HAN Team Meeting
- July 18th- Held Weekly Health Access Network Departmental Meeting
- August 1st- Held Weekly Health Access Network Departmental Meeting
  - HAN Director attended the Weekly CHSI/HAN Team Meeting
- August 2nd- Held Weekly Care Management Update Meeting of which included Dr. Beaman- our newly appointed Behavioral Health Medical Director
  - Care Managers joined the monthly case manager call with Tina Largent

- August 3rd- HAN Director attended a HAN update meeting with Dr. Stephens, Eric Polak, and William Petit to discuss the current progress of the HAN
- August 5th- HAN Director attended monthly Continuous Quality Improvement Meeting
- August 8th- Held Weekly Health Access Network Departmental Meeting (coined the HAN Huddle)
- August 9th- Held Weekly Care Management Update Meeting
    - HAN Director attended the Weekly CHSI/HAN Team Meeting
    - HAN Director attended the CHS Supervisors/Directors Meeting
- August 15th- Held Weekly Health Access Network Departmental Meeting (HAN Huddle)
- August 22nd- Original, official move-in date to new location: 810 S. Cincinnati Ave., Suite 112
    - HAN staff met at the HCC for a quick HAN Huddle
- August 23rd- Held Weekly Care Management Update Meeting
- August 29th- Held Weekly Care Management Update Meeting
    - Director attend the Weekly CHSI/HAN Team Meeting
- September 2nd- Quality Assurance attended monthly Continuous Quality Improvement Meeting
- September 6th- Held Weekly Care Management Update Meeting
    - HAN Director attended the Weekly CHSI/HAN Team Meeting
- September 7th- Care Managers joined monthly OSU Case Conference call with Tina Largent
- September 12th- Held Weekly Health Access Network Departmental Meeting (HAN Huddle)
    - HAN Director attended the Weekly CHSI/HAN Team Meeting
- September 13th- HAN Director attended the monthly CHS Supervisor/Director Meeting with Dr. Stephens
- September 14th- HAN Director and Quality Assurance Coordinator travelled to Muskogee for the monthly Case Management/Clinic Update Meeting with Practice Manager, Ryan Hardaway
- September 19th- Held Weekly Health Access Network Departmental Meeting (HAN Huddle)
- September 22nd- Held Weekly Care Management Update Meeting
    - HAN Director attended Weekly CHSI/HAN Team Meeting
- September 26th- Held Weekly Health Access Network Departmental Meeting (HAN Huddle)
- September 27th- Held Weekly Care Management Update Meeting
- September 28th- Held Monthly Meeting with the Oklahoma Health Care Authority

HAN Clinic Visits:

- On July 6th, 13th, 20th, & 27th- Care Manager, Paula Wheeler-Ballard, continued to be stationed at the Muskogee Children's Clinic
    - July 6th- Physicians at Houston Parke Pediatrics Clinic confirmed that they would like to hold monthly update meetings with the HAN to discuss their current patients being case managed. Our new Care Manager, Melissa Gantz along with Leslie Brown, attended this meeting in order to introduce Melissa to the physicians and familiarize herself with the patient panel in this clinic as her role will transition into managing the patients of Houston Parke
- July 7th- HAN Director travelled to Stillwater Medical Physicians Clinic in Stillwater to introduce our Case Management Program to their clinic and physicians. We successfully contracted with this clinic on July 16th
- July 8th- Care Manager, Connie Schadel took on the patient panel for Premier Pediatrics Clinic as part of her caseload. The Practice Administrator, Misty Carmack, set a desired expectation to have Connie in the clinic at least once a week to discuss current care managed patients. Both the physicians of the clinic, Dr. Hoos and Dr. Mundy, expressed a need in the future for a full-time care manager stationed in their clinic.

- Wednesday (Aug. 3rd, 10th, 17th, 24th, and 31st), Thursday (Aug. 4th, 11th, 18th, and 25th), and Friday (Aug. 5th, 12th, 19th, and 26th)- Care Manager Paula Wheeler Ballard developed a weekly three-day schedule to be stationed at the Muskogee Children's Clinic on Wednesdays, Thursdays, and Fridays
    - August 3rd- Physicians at Houston Parke Pediatrics Clinic confirmed that they would still like to hold a monthly update meeting with the HAN to discuss their current patients managed.
- On Wednesdays (Aug. 2rd, 17th, 24th, and 31st) and Thursdays (Aug. 4th, 11th, 18th, and 25th) Case Manager Connie Schadel established a weekly two-day work schedule to be stationed at the Premier Pediatrics Clinic in Muskogee
- Wednesday (Sept. 7th, 14th, 21st, and 28th), Thursday (Sept. 1st, 8th, 15th, 22nd, and 29th), and Friday (Sept. 2nd, 9th, 16th, 23rd, and 30th) Care Manager Paula Wheeler-Ballard was stationed at the Muskogee Children's Clinic as a part of her established three-day a week schedule at the clinic
- September 7th- Leslie Brown and Melissa Gantz attended the established Monthly meeting at the Houston Parke Pediatrics Clinic to discuss current patients being managed
- Wednesday (Sept. 7th & 14th) and Thursday (Sept. 8th, 15th, 22nd, and 29th) Care Manager Connie Schadel was stationed at Premier Pediatrics Clinic in Muskogee as part of her established two-day schedule at the clinic
- September 10th- HAN Director and Quality Assurance Coordinator travelled to the Stillwater Family Care Clinic in Stillwater in order to attend a meeting with the Clinic Manager, Stephanie Hindeman, to discuss with the physicians of the clinic some additional questions that they had in regard to our Case Management Program. Successfully contracted this clinic on September 15th
- September 14th- HAN Director and Quality Assurance Coordinator travelled to Muskogee to attend Monthly Care Management Update Meeting with the Practice Administrator in order to provide the clinic with a progress report of the number of members managed out of the clinic
- September 20th- HAN Director met with Dr. Joe Johnson, Department Chair for OSU OB Clinic and the Project ECHO initiative, and discussed the HAN and the OB clinic, but also the HANs future involvement in Project ECHO
    - We plan to send one of our care managers, Shantel Bolton, to New Mexico in October to attend Project ECHO orientation and training in October 2016

Health Access Network Home Visits:

- Earlier this calendar year Dr. Lora Cotton, who is the Program Director for the OSU Family Medicine department, approached our department. Dr. Cotton wanted to collaborate with the OSU Health Access Network about creating a collaborative effort between our Nurse Care Managers and their Family Medicine Residents during this required Community Medicine Rotation of which the Residents must complete. Dr. Cotton set a start date of August 2016.

  On August 15th, a Family Medicine Resident, Dr. Colin Morgan, attended our Weekly Care Management Update Meeting in order to discuss his Community Medicine requirements with the Care Managers and Director, but also to coordinate home visits to include our case managers for some of their already established, care-managed patients.

  Dr. Morgan, in collaboration with our Nurse Care Manager, Connie Schadel, completed one home visit for a shared Sooner Care Choice member.

  The HAN will continue to work together with the HCC Family Medicine Clinic and Dr. Lora Cotton in the coordination of home visits as a community-based collaborative effort between the Resident Doctors and our Case Managers.

Family Medicine Community Medicine Rotation Schedule:

- Below is our Community Medicine rotation schedule for the 2016-2017 Academic Year:

Month	1st-15th	16th-End of Month
July		
August		Dr. Colin Morgan
September		
October	Dr. Shaylea Shebester	
November	Dr. Daniel Tran	Dr. Philp Zrenda
December	Dr. Whitney Engheta	Grisel Quiroz
January		
February	Dr. Aaron Bennett	
March	Dr. Ambreen Sarmast	Dr. Stephanie Letney
April	Dr. Matthew Else	Dr. Tim Bushyhead
May	Dr. Brenton Priest	Dr. Sarah Washatka

Fourth Quarter (October-December) - CY 2016

Operations:

- October 2016:

  October 2016 Operations Highlights

  - On October 19th, one of our newest contracted clinics, Stillwater Medical Physicians Clinic, underwent an audit from the Oklahoma Health Care Authority. For this audit, our HAN Director was present so that he could provide assistance and support to the clinic during the audit. The clinic had two areas of noted interest that required a corrective action plan was submitted. The first was in the area of completing periodic Behavioral Health screenings and having the Medical Home Agreements on file for all patients. The OHCA auditor did mention to our Director that in all of the audits she has done for OHCA, she has not once seen any HAN members present during the clinical audits. She stated that she was very glad to see the OSU HAN so involved

  October Quality Assurance Highlights:

  - Our Quality Assurance Coordinator established a weekly quality assurance meeting to include the HAN Director, Lead Care Manager, Data Analyst, and Program Specialist
    - Have also established a monthly quality assurance meeting with the Muskogee Children's Clinic practice manager, Ryan Hardaway, in order to provide the clinic and physicians an update on the current patients managed out of his clinic

- QA Coordinator has created an element of measure to all of our managed cases by implementing a case weight mechanism and guide
- QA Coordinator is working to create a process for the Health Access Network care managers to become certified CCMs

October Data Analyst Highlights:

- Our Data Analyst, Shrie, is currently working on a few analytic areas for the HAN:
  - OHCA ER- implement Mercy research into HAN data
  - Health Registry- monitoring the status of completion by Care Managers member disease input
  - Database is fully operational- Currently working to improve structure using continuous feedback from the care managers
  - Extracting data from database to produce graphs
  - Planning to produce publication with HAN ER data-indicating impact and savings

- November 2016:

November Operations Highlights

- In response to the OHCA audit that our Director, Matt Maxey, attended on October 19th with one of our newest contracted clinics, Stillwater Medical Physicians Clinics, we took the information gained from that audit and shared it with Ryan Hardaway at our Monthly MCC Case Management meeting that was held on November 9th. The specific areas discussed were the Audit Checklist, the Medical Home Agreements, and the PHQ9 Behavioral Health screening, as these were the areas of high interest in the audit performed in Stillwater. By reviewing the checklist and making Ryan aware of the areas in which OHCA is focusing, we are heling to ensure that the clinic is aware of the expectations during an audit, but also helping to ensure that the audit is successful as a part of our HAN commitment to our contracted clinics

November Medical Director Highlights:

- In November, the HAN invited Dr. Scott Shepherd to attend our weekly HAN Huddle meetings in order to become more involved in the operations side of our department. Dr. Shepherd has already been able to provide very valuable feedback and suggestions on the development and execution of the Community Outreach Project/Health Fair that we plan to hold in late spring/early summer 2017

November Quality Assurance Highlights:

- Our QA Coordinator is working to create HAN policies and procedures, training modules for newly hired staff, and the criteria needed for the HAN to possibly become an accredited body in the future
  - Policies and Procedures Completed:
    - New Hire/Onboarding
    - Conference/Seminar Attendance Approval
    - Transportation Requests/Reservations
    - Attendance
    - Departmental Job Descriptions
  - Policies and Procedures in Progress:
    - HAN House Calls (Resident Program with the HAN)

November Data Analyst Highlights:

- Data Analyst continued to update the database per feedback from the Care Managers

- December 2016:

December Operations Highlights:

- One of our first operational goals for the upcoming year is to distribute patient satisfaction surveys to over 300 of our Sooner Care Choice, care managed members, in order to gain insight on areas that we

might need to improve, as well as areas in which we are performing well. Our survey population will cover members that have been enrolled in the HAN program and care-managed for at least ninety days ranging from September 2015-September 2016. Target date for distribution is January 20th, 2017

December Medical Director Highlights:

- Dr. Shepherd informed our department that he will be presenting at this year's CME Spring Fling conference and will be including information/presentation slides about the HAN Care Management Program, as well as ways in which we are positively impacting our patient population

December Quality Assurance Highlights:

- QA Coordinator completed the patient satisfaction survey template
  - Target distribution date is second week of January 2017
  - Target survey reporting- March 2017
- QA Coordinator is also developing/researching future Community Outreach projects that the HAN can spearhead/become involved in
  - QA Coordinator scheduled several meetings in January with Jennifer Curran and Dr. Regina Lewis at the North Regional Health and Wellness clinic to discuss possible Community Health Fair collaboration
  - QA Team is also in the process of creating a list of possible collaborators for our Health Fair to contact in January; Tulsa Health Department, Community Service Council of Oklahoma, North Regional Health and Wellness Clinic, etc…
  - Policies and Procedures Completed:
    - HAN House Calls (Resident Program with the HAN)
  - Policies and Procedures in Progress:
    - HAN Ride
    - Risk Stratification System
- QA Coordinator assisted in the training and coordination of our newest Nurse Care Manager, Angie, in the Stillwater clinics
- Established a monthly meeting with Premier Pediatrics on the same Wednesdays of the month that the HAN Director and Quality Assurance Coordinator travel to visit with Muskogee Children's Clinic

December Data Analyst Highlights:

- Data Analyst continued to build out Disease Registry
  - Target completion: 2nd Quarter, CY 2017

Departmental Meetings:

- October 3rd- Held Weekly Health Access Network Departmental Meeting (HAN Huddle)
  - HAN Director attended the weekly CHSI/HAN Team Meeting
- October 4th- Held weekly Care Management Update Meeting
- October 6th- Held weekly Quality Assurance Meeting
- October 10th- Held weekly Health Access Network Departmental Meeting (HAN Huddle)
  - Held weekly Care Management Update Meeting
  - HAN Director attended weekly CHSI/HAN Team Meeting
  - HAN Director attended Strategic Planning Meeting with Dr. Stephens
- October 11th- Held weekly Care Management Update Meeting to include Dr. Beaman
  - HAN Director attended Supervisor/Director's meeting
  - HAN Director joined a conference call with Melody Anthony in regard to Project ECHO
  - HAN Director attended a meeting with Eric Polak to discuss HAN finances

- October 13th- Held weekly Quality Assurance Meeting
- October 17th- Held weekly Health Access Network Departmental Meeting (HAN Huddle)
  - Held Monthly departmental Database discussion meeting
- October 18th- Held weekly Care Management Update Meeting
  - HAN Director attended weekly CHSI/HAN Team Meeting
  - HAN Director attended Smartsheet training
- October 20th- Held weekly Quality Assurance Meeting
- October 24th- Held weekly Health Access Network Departmental Meeting (HAN Huddle)
  - Held weekly Care Management Update Meeting
  - HAN Director attended weekly CHSI/HAN Team Meeting
- October 25th- Held weekly Care Management Update Meeting
- October 27th- Held weekly Quality Assurance Meetings
- October 31st- Held weekly Health Access Network Departmental Meeting (HAN Huddle)
- November 1st- Held weekly Care Management Update Meeting
  - HAN Director attended weekly CHSI/HAN Team Meeting
- November 3rd- Held weekly Quality Assurance Meeting
- November 7th- Held weekly Health Access Network Departmental Meeting (HAN Huddle)
  - HAN Director attended weekly CHSI/HAN Team Meeting
- November 8th- Held weekly Care Management Update Meeting
  - HAN Director attended Supervisor/Director's Meeting
- November 10th- Held weekly Quality Assurance Meeting
- November 14th- Held weekly Health Access Network Departmental Meeting (HAN Huddle)
  - Held Monthly Departmental Database Discussion Meeting
- November 15th- Held weekly Care Management Update Meeting
  - Han Director attended weekly CHSI/HAN Team Meeting
- November 17th- Held Weekly Quality Assurance Meeting
- November 21st- Held Weekly Health Access Network Departmental Meeting (HAN Huddle)
  - Quality Assurance Coordinator attended Monthly CQI Meeting
- November 28th- Held weekly Health Access Network Departmental Meeting (HAN Huddle)
- November 29th- Held weekly Care Management Update Meeting
  - Attended November's Monthly meeting with the Oklahoma Health Care Authority in Oklahoma City
- December 1st- Held weekly Quality Assurance Meeting
- December 2nd- HAN Director attended a IPAA Risk Assessment meeting with Michelle Crissup from the OSU Compliance Department
- December 5th- Held weekly Health Access Network Departmental Meeting (HAN Huddle)
  - Community Medicine rotation residents for December; Dr. Engheta and Dr. Quiroz, also attended the HAN Huddle Meeting
  - Today was the first day for our newest Nurse Care Manager, Angie Colborn
  - HAN Director attended weekly CHSI/HAN Team Meeting
- December 6th- Held weekly Care Management Update Meeting
  - Nurse Care Managers attended HAN Case Management Conference Call with Tina Largent
- December 7th- Held weekly Quality Assurance Meeting
- December 12th- Held weekly Health Access Network Departmental Meeting (HAN Huddle)
- December 13th- Held weekly Care Management Update Meeting
  - HAN Director attended weekly CHSI/HAN Team Meeting

- December 15th- Held weekly Quality Assurance Meeting
- December 20th- Held weekly Health Access Network Departmental Meeting (HAN Huddle)
- December 21st- Held weekly Care Management Update Meeting
- December 22nd- Held weekly Quality Assurance Meeting
- December 23rd-January 3rd- Oklahoma State University Holiday Break

HAN Clinic Visits:

- Wednesday October (12th, 19th, 17th, & 26th), Thursday (October 13thand 27th), and Friday (October 21st and 28th)-RN Care Managers Connie Schadel and Rebecca Graham travelled to Premier Pediatrics Clinic in Muskogee in order to full-fill their established weekly clinic schedule. After this month, Rebecca will be independent in Muskogee, as the Premier's designated OSU HAN RN Care Manager
- Wednesday (Oct. 5th, 12th, 19th, & 26th), Thursday (Oct. 6th, 13th, 20th, & 27th), and Friday (Oct. 7th, 14th, 21st, & 28th)- RN Care Manager Paula Wheeler-Ballard was stationed at the Muskogee Children's Clinic as a part of her established three-day a week schedule at the clinic
- On Tuesday afternoon, October 4th, 11th, 18th, & 25th and Thursday, October 6th, 13th, 20th, & 27th- LCSW, Melissa Gantz was stationed at the Houston Parke Pediatrics Clinic as a part of her established weekly schedule
- October 12th- HAN Director and Quality Assurance Coordinator travelled to Muskogee to attend Monthly Case Management Update Meeting with the Practice Administrator of the MCC in order to provide the clinic with a progress report of the number of members managed out of the clinic
- Wednesday (November 2nd, 9th, 16th, 23rd, & 30th), Thursday (November 3rd, 10th, & 17th), and Friday (November 4th, 11th, & 18th)-RN Care Manager, Rebecca Graham travelled to Premier Pediatrics Clinic in Muskogee in order to full-fill her established weekly clinic schedule.
- Wednesday (November 2nd, 9th, 16th, 23rd, & 30th), Thursday (November 3rd, 10th, & 17th), and Friday (November 4th, 11th, & 18th)- RN Care Manager Paula Wheeler-Ballard was stationed at the Muskogee Children's Clinic as a part of her established three-day a week schedule at the clinic
- On Tuesday afternoon (November 1st, 8th, 15th, 22nd, & 29th) and Thursday (November 3rd, 10th, & 17th)- LCSW, Melissa Gantz was stationed at the Houston Parke Pediatrics Clinic as a part of her established weekly schedule
- November 9th- HAN Director and Quality Assurance Coordinator travelled to Muskogee to attend Monthly Case Management Update Meeting with the Practice Administrator of the MCC in order to provide the clinic with a progress report of the number of members managed out of the clinic
- Wednesday (December 7th, 14th, & 21st), Thursday (December 1st, 8th, 15th, & 22nd), and Friday (December 2nd, 9th, & 16th)-RN Care Manager, Rebecca Graham travelled to Premier Pediatrics Clinic in Muskogee in order to full-fill her established weekly clinic schedule.
- Wednesday (December 7th, 14th, & 21st), Thursday (December 1st, 8th, 15th, & 22nd), and Friday (December 2nd, 9th, & 16th)- RN Care Manager Paula Wheeler-Ballard was stationed at the Muskogee Children's Clinic as a part of her established three-day a week schedule at the clinic
- On Tuesday afternoon (December 6th, 13th, & 20th) and all-day Thursday (December 1st, 8th, 15th, & 22nd)- LCSW, Melissa Gantz was stationed at the Houston Parke Pediatrics Clinic as a part of her established weekly schedule
- December 5th- Our newest Nurse Care Manager, Angie Colborn, began with the HAN. She is stationed with the HAN at the Tulsa office until December 19th where she began her regular scheduled stationed at the Stillwater Family Clinic in Stillwater

Health Access Network Home Visits:

- Earlier this year, Dr. Lora Cotton, who is the Program Director for the OSU Family Medicine department approached our department. Dr. Cotton wanted to collaborate with the OSU Health Access Network concerning creating a collaborative effort between our Nurse Care Managers and their Family Medicine Residents during a required Community Medicine rotation of which residents have been expected to complete. Dr. Cotton set a start date of August 2016. During the 4th Quarter of calendar year 2016, the Health Access Network, in collaboration with the Community Medicine residents, completed 12 patient home visits.

  On October 3rd, Dr. Shaylea Shebester, who is a Family Medicine Resident, attended our Weekly Case Management Update Meeting in order to discuss her Community Medicine requirements with the Case Managers and Director, but also to coordinate home visits to include our case managers for some of their already established, care-managed patients. Dr. Shebester, in collaboration with Connie Schadel, RN and Leslie Brown, RN completed four home visits of current members managed.

  On October 31st, Dr. Daniel Tran, who is a Family Medicine Resident, attended our Weekly Health Access Network departmental meeting in order to discuss his Community Medicine requirements with the Case Managers and Director, but also to coordinate home visits to include our case managers for some of their already established, care-managed patients.
  Dr. Tran, in collaboration with Connie Schadel, RN and Leslie Brown, RN completed four home visits of current members managed; two on November 14th and two additional home visits completed on November 15th.

  On December 5th, Dr. Whitney Engheta and Dr. Grisol Quiroz, who are Family Medicine Residents, attended our Weekly Health Access Network departmental meeting in order to discuss their Community Medicine requirements with the Case Managers and Director. During the meeting, we also worked to coordinate their required three-day schedule with the HAN and home visits to include our case managers for some of their already established, care-managed patients.

  Dr. Engheta, in collaboration with Shantel Bolton, RN completed two home visits on Tuesday, December 13th. One of the patients visited was already an active member of the HAN, the other agreed to participate in the program during the conduction of the home visit.
  Dr. Quiroz, in collaboration with Connie Schadel, RN completed two home visits of current members managed on Thursday, December 15th.

  The HAN will continue to work together with the HCC Family Medicine Clinic and Dr. Lora Cotton in the coordination of home visits as a community-based collaborative effort between the Resident Doctors and our Nurse Case Managers.

Case Management- All Populations-Interventions

At the end of FY 2016, the OSU HAN provided case management services 608 individual Sooner Care Choice members

Below is a population breakdown of the number of individual Sooner Care Choice members that have benefited from our case management services in FY2016.

OSU HAN Care Management	
Care Management Category	**Unique Members Served in Fiscal Year 2016**
High Risk Obstetrics	53
Diabetes	37
Breast and Cervical Cancer	16
Hemophilia	1
Asthma	28
Pharmacy Lock-in	22
Hospital Follow Up	215
ER Utilizaton	80
Misc.	156
Total for Fiscal Year 2016	**608**

Percentage of Case Managed Patients vs. Entire Clinic Panel Roster

The table below represents the percentage of care managed patients in comparison to the total number of members presented in the clinic panel rosters at the end of FY16; June 2016. According to the table below, at the end of FY16 we were managing 1.95% of the total patient population panel that exists in our enrolled OSU Health Access Network Clinic system.

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

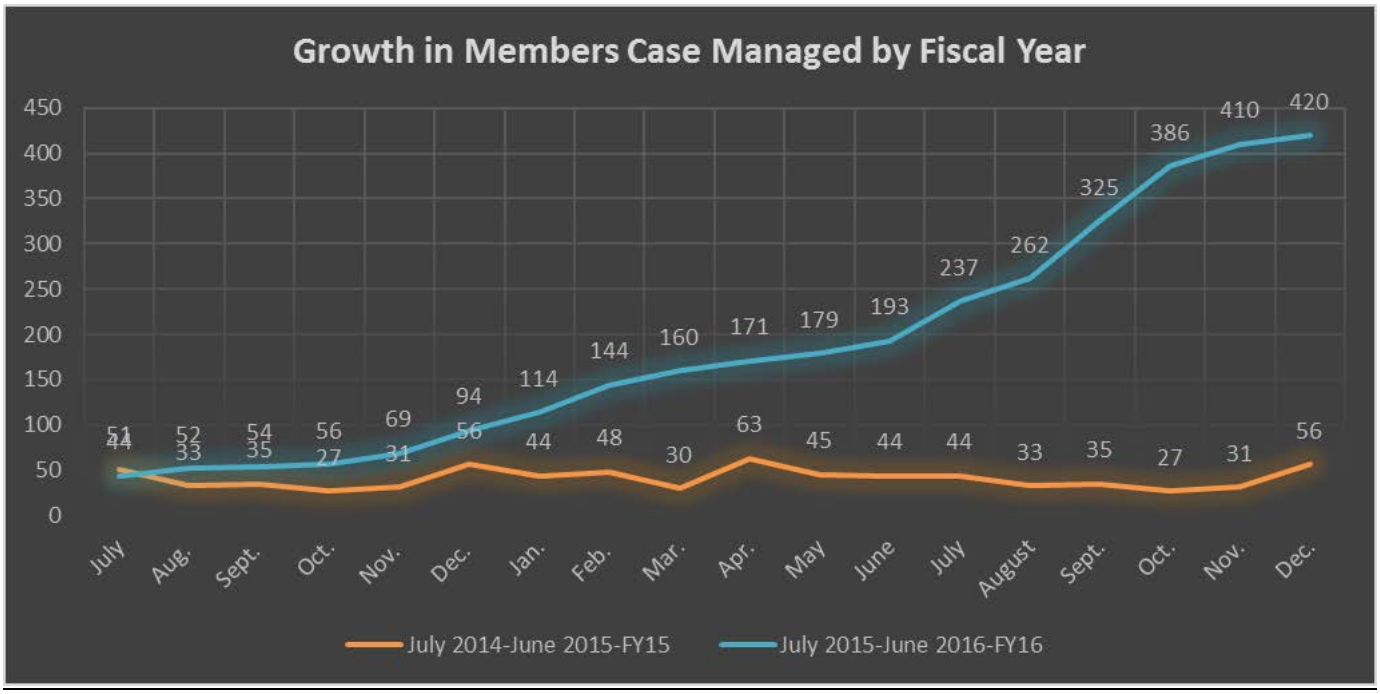
Clinic	Total Members	Care Managed Members	% Care Managed
North Regional Health and Wellness Clinic	500	10	2%
OSU East Gate	1740	25	6%
OSU HCC FM& WHC	2318	78	19%
OSU Houston Parke Pediatrics	4458	82	20%
OSU IMM/IMSS	383	39	9%
OSU POB	610	6	1%
OSU-AJ Children's Clinic	4119	122	29%
OSU-AJ Premier Pediatrics	2179	57	14%
OSU-AJ Stillwater Family Care	879	1	0%
OSU-AJ Stillwater Pediatrics	4286	0	0%
	21472	420	100%

FY15 Case Management Patient Population Data

Population	Jul.-14	Aug.-14	Sept.-14	Oct.-14	Nov.-14	Dec.-14	Jan.-14	Feb.-15	Mar.-15	Apr.-15	May.-15	Jun.-15
HROB	8	8	7	8	7	4	5	7	5	5	7	5
Breast/Cervical Cancer	5	5	5	4	4	2	3	4	7	7	7	7
Hemophilia	1	1	1	1	1	1	1	1	1	1	1	1
Hospital F/U	22	14	2	8	13	12	12	20	2	12	14	13
PHARM LOCK IN	3	4	6	6	5	5	5	7	3	2	4	5
ER Utilization	11	1	14	0	1	30	16	6	11	34	12	13
Misc. (Other)	1	0	0	0	0	1	2	3	1	2	0	0
Total Managed Cases per Month:	**51**	**33**	**35**	**27**	**31**	**55**	**44**	**48**	**30**	**63**	**45**	**44**

CY 15 & CY16 Case Management Patient Population Data

Population	Jul. 2015	Aug. 2015	Sept. 2015	Oct. 2015	Nov. 2015	Dec. 2015	Jan. 2016	Feb. 2016	Mar. 2016	Apr. 2016	May. 2016	Jun. 2016	Jul. 2016	Aug. 2016	Sept. 2016	Oct. 2016	Nov. 2016	Dec. 2016
HROB	5	9	10	9	11	15	17	18	14	13	15	12	7	6	7	5	2	2
Asthma	0	0	0	0	5	8	11	12	16	14	14	14	15	17	21	17	34	37
Breast/Cervical Cancer	7	8	9	9	10	10	10	12	12	12	12	8	8	8	8	8	9	9
Diabetes	0	4	0	5	11	15	19	23	25	24	23	24	21	20	21	22	28	32
Hemophilia	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Hospital F/U	13	14	17	3	0	0	2	3	5	6	6	6	6	5	6	8	3	4
PHARM LOCK IN	5	5	5	5	7	6	7	7	7	8	8	7	7	7	6	11	11	7
ER Utilizaton	13	8	6	19	10	19	20	21	21	19	15	11	12	11	10	9	16	16
Misc. (Other)	0	3	6	5	14	20	27	47	59	74	85	110	160	187	242	305	306	312
Total Managed Cases per Month:	**44**	**52**	**54**	**56**	**69**	**94**	**114**	**48**	**160**	**171**	**179**	**193**	**237**	**262**	**325**	**386**	**410**	**420**

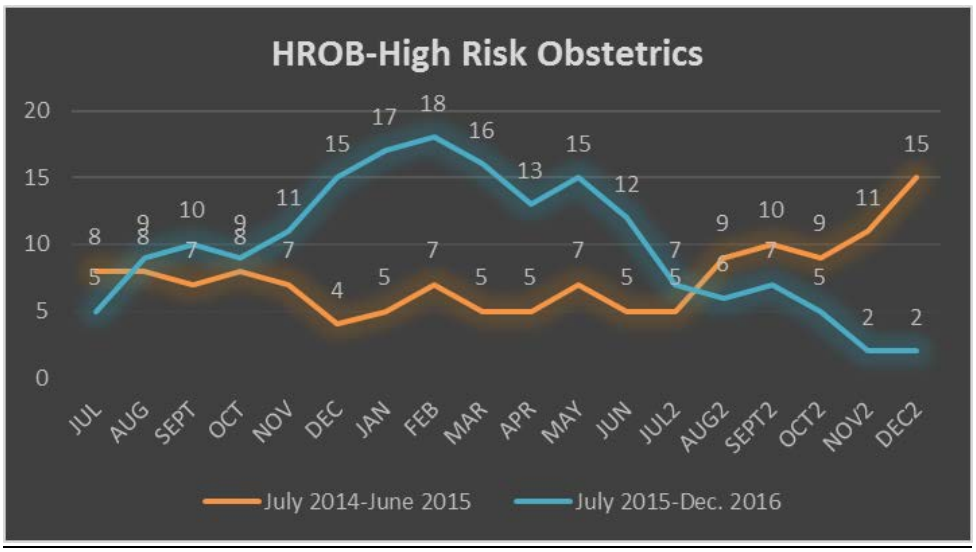


Case Management-Population Specific-Interventions

HROB

HROB- High Risk Obstetrics

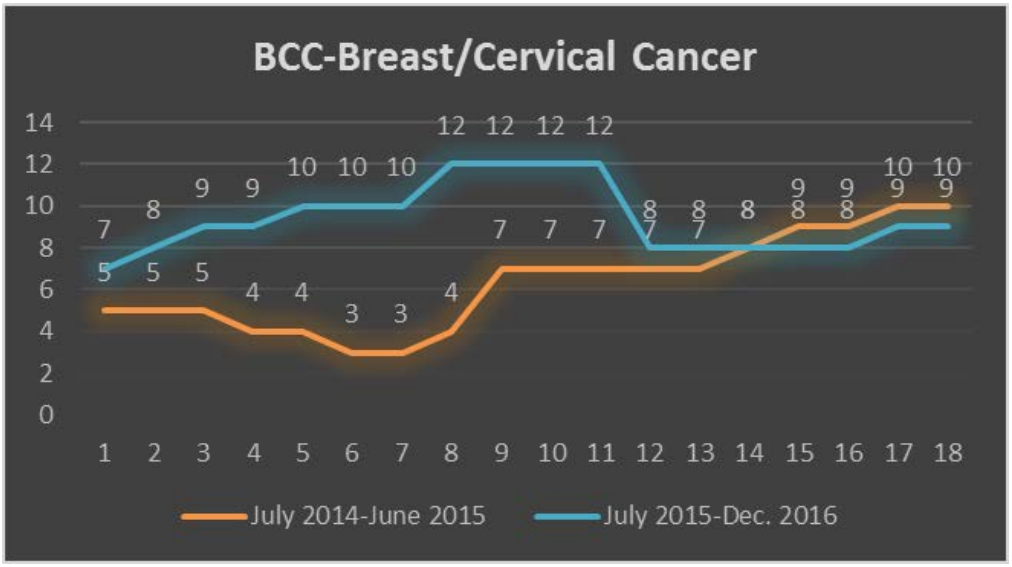
FY	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL2	AUG2	SEPT2	OCT2	NOV2	DEC2
July 2014-June 2015	8	8	7	8	7	4	5	7	5	5	7	5	5	9	10	9	11	15
July 2015-Dec. 2016	5	9	10	9	11	15	17	18	16	13	15	12	7	6	7	5	2	2



BCC-Breast/Cervical Cancer

BCC- Breast/Cervical Cancer

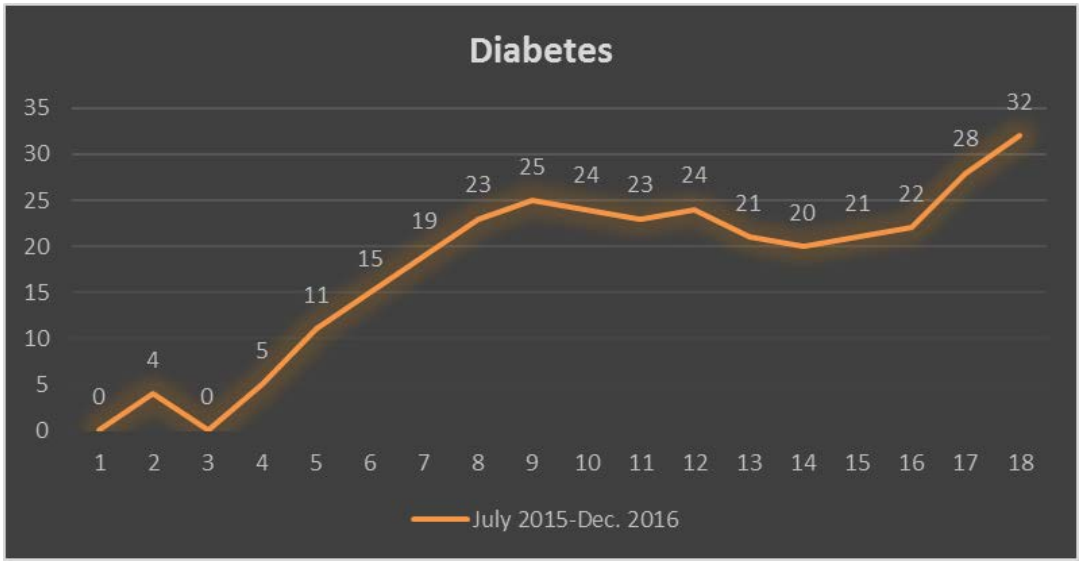
FY	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL2	AUG2	SEPT2	OCT2	NOV2	DEC2
July 2014-June 2015	5	5	5	4	4	3	3	4	7	7	7	7	7	8	9	9	10	10
July 2015-Dec. 2016	7	8	9	9	10	10	10	12	12	12	12	8	8	8	8	8	9	9



Diabetes

DM-Diabetes

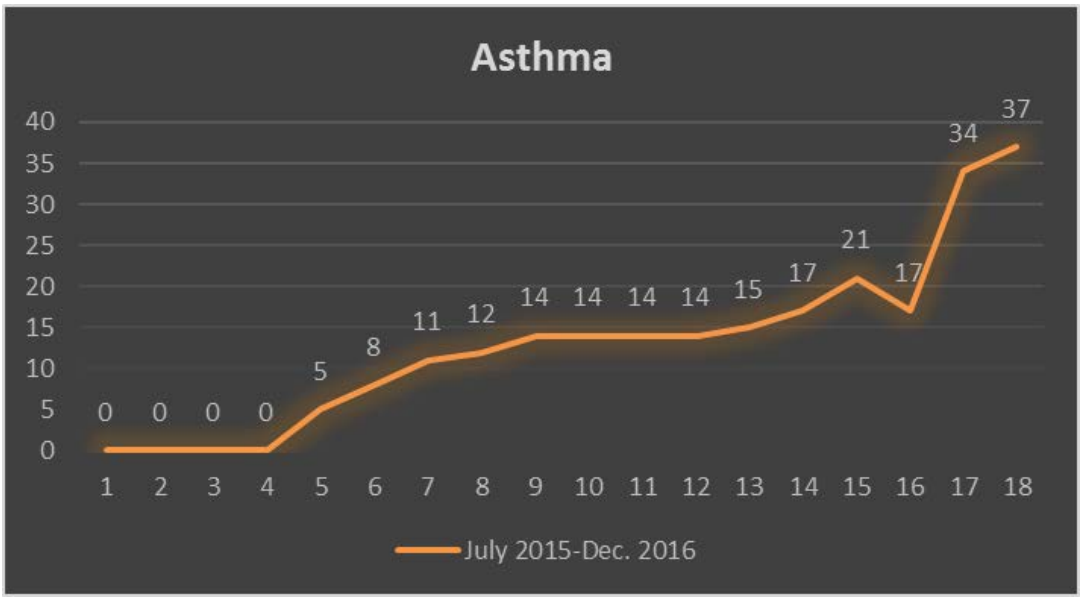
FY	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL2	AUG2	SEPT2	OCT2	NOV2	DEC2
July 2015-Dec. 2016	0	4	0	5	11	15	19	23	25	24	23	24	21	20	21	22	28	32



Asthma

Asthma

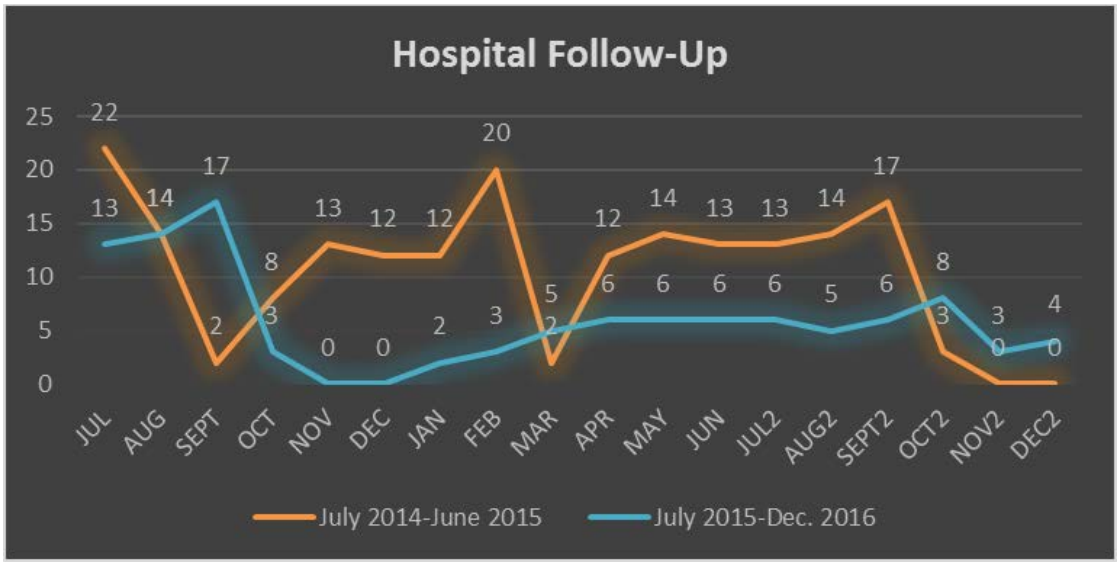
FY	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL2	AUG2	SEPT2	OCT2	NOV2	DEC2
July 2015-Dec. 2016	0	0	0	0	5	8	11	12	14	14	14	14	15	17	21	17	34	37



Hospital Follow-Up

Hospital F/U

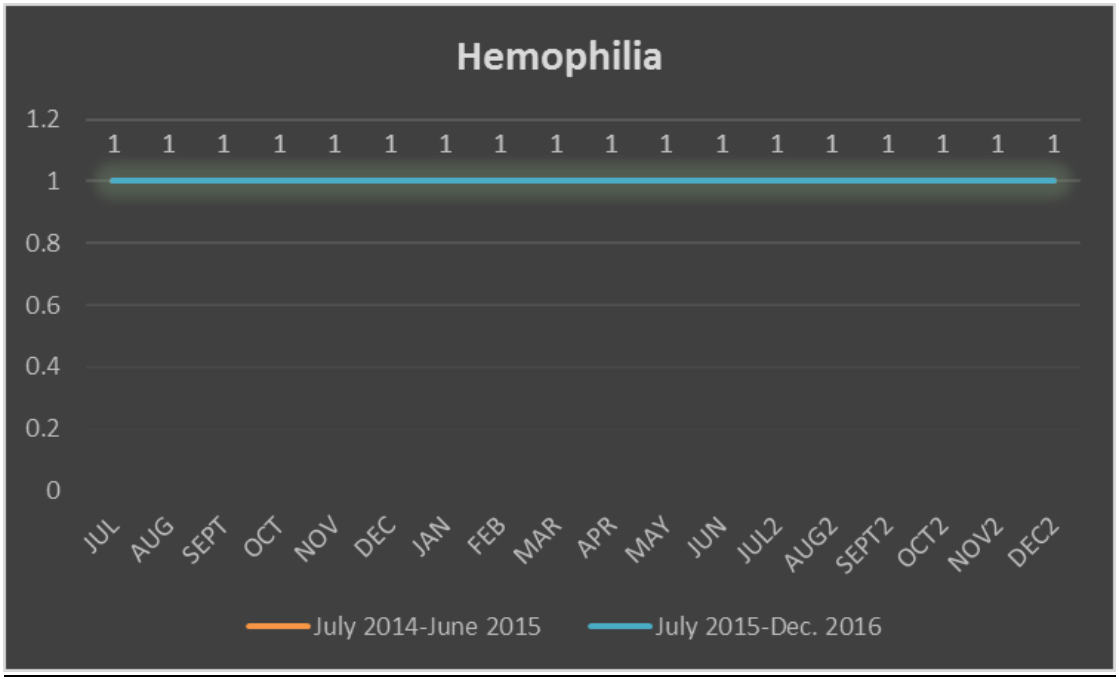
FY	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL2	AUG2	SEPT2	OCT2	NOV2	DEC2
July 2014-June 2015	22	14	2	8	13	12	12	20	2	12	14	13	13	14	17	3	0	0
July 2015-Dec. 2016	13	14	17	3	0	0	2	3	5	6	6	6	6	5	6	8	3	4



Hemophilia

HEMO-Hemophilia

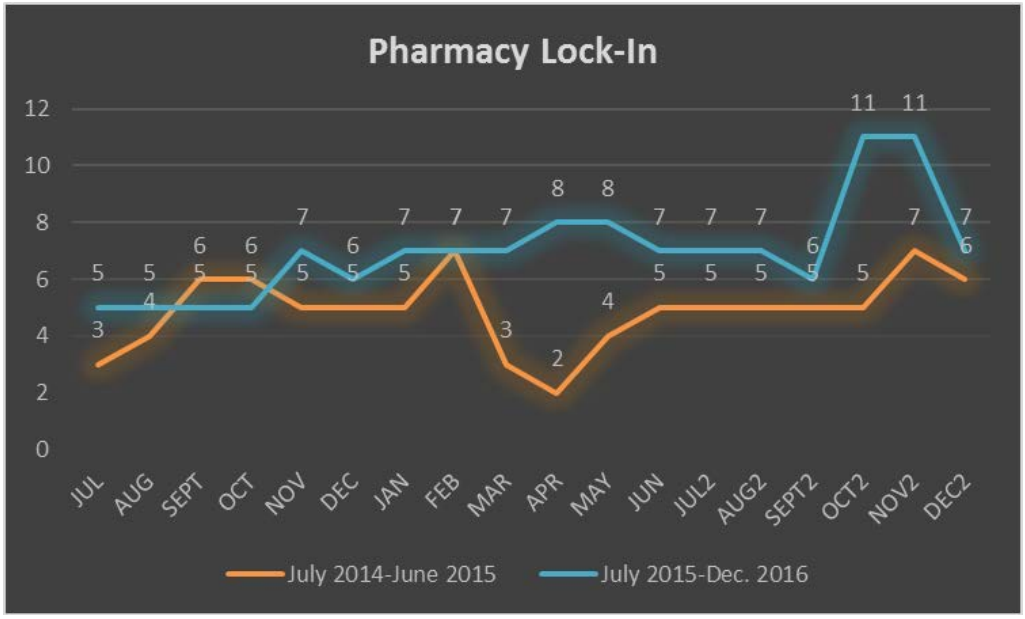
FY	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL2	AUG2	SEPT2	OCT2	NOV2	DEC2
July 2014-June 2015	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
July 2015-Dec. 2016	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1



Pharmacy Lock-In

Pharmacy Lock-In

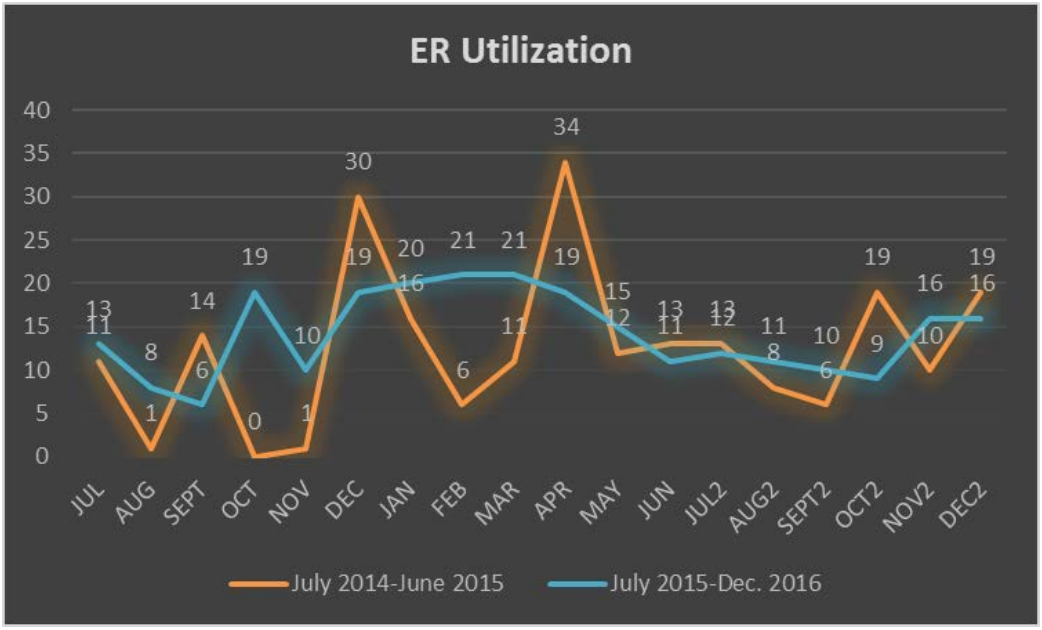
FY	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL2	AUG2	SEPT2	OCT2	NOV2	DEC2
July 2014-June 2015	3	4	6	6	5	5	5	7	3	2	4	5	5	5	5	5	7	6
July 2015-Dec. 2016	5	5	5	5	7	6	7	7	7	8	8	7	7	7	6	11	11	7



ER Utilization

ER Utilization

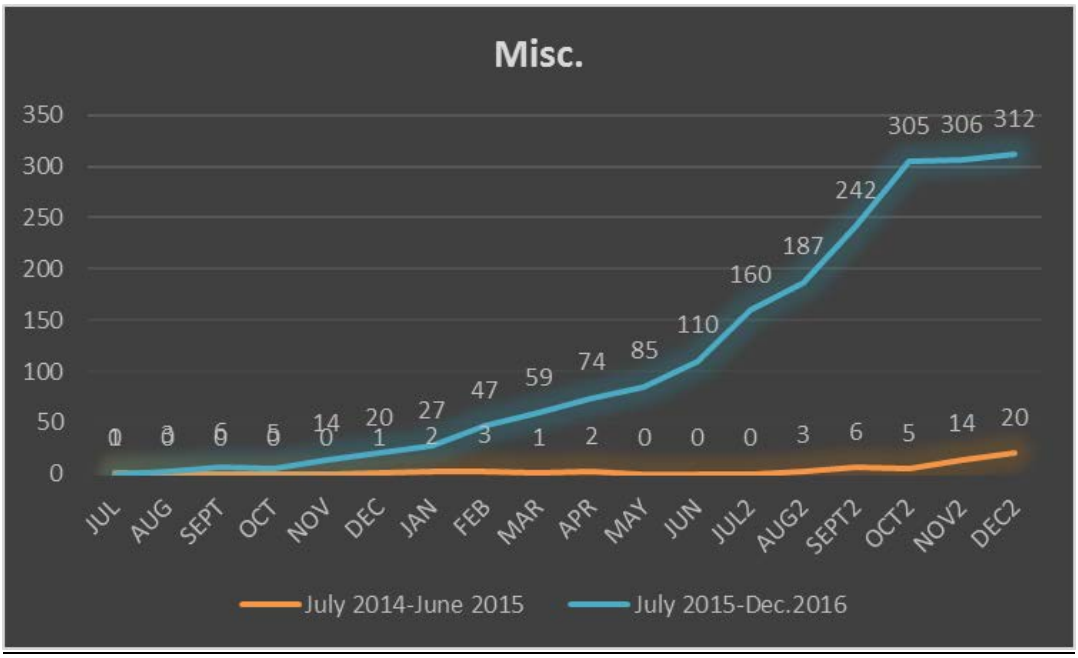
FY	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL2	AUG2	SEPT2	OCT2	NOV2	DEC2
July 2014-June 2015	11	1	14	0	1	30	16	6	11	34	12	13	13	8	6	19	10	19
July 2015-Dec. 2016	13	8	6	19	10	19	20	21	21	19	15	11	12	11	10	9	16	16



Misc.

Misc.

FY	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL2	AUG2	SEPT2	OCT2	NOV2	DEC2
July 2014-June 2015	1	0	0	0	0	1	2	3	1	2	0	0	0	3	6	5	14	20
July 2015-Dec.2016	0	3	6	5	14	20	27	47	59	74	85	110	160	187	242	305	306	312

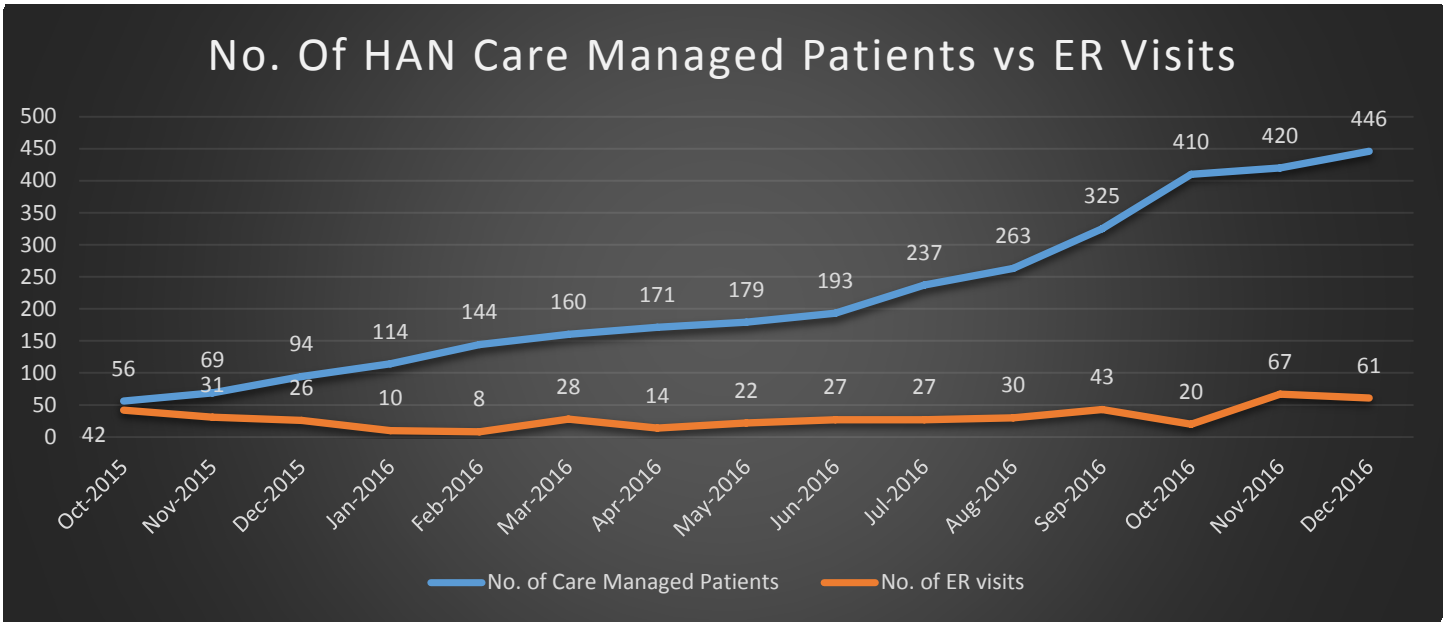


The ER analysis shows data conducted from October 2015 until December 2016 in order to estimate the total savings that was made by HAN interventions. The table below shows the number of members managed each month and their corresponding ER visits for that month. Assuming the trend of October continuing for the rest of the months until June 2016 with an average of .75 visits per member, per month the total estimated savings was $1,635,882.80 at $1,233

per visit for CY2016. (Average ER cost data pulled from: https://www.google.com/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF8#q=average%20cost%20of%20emergency%20room%20visit%202015)

	Baseline Condition							
Month	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
No. of Care Managed Patients	56	69	94	114	144	160	171	179
Actual ER visit	42	31	26	10	8	28	14	22
Proportion of ER visits as a percentage	75.00%	44.93%	28%	9%	6%	18%	8%	12%
Total cost incured for ER Visit (Assuming avg of $1,233/visit)	$ 51,786.00	$ 38,223.00	$ 32,058.00	$12,330.00	$ 9,864.00	$ 34,524.00	$ 17,262.00	$ 27,126.00
Estimated ER visits(With baseline as 0.75 visit/member)	42	51.75	70.5	85.5	108	120	128.25	134.25
		63807.75	86926.5	105421.5	133164	147960	158132.25	165530.25
Estimated Savings per Month	$ -	$ 25,584.75	$ 54,868.50	$93,091.50	$123,300.00	$113,436.00	$140,870.25	$138,404.25

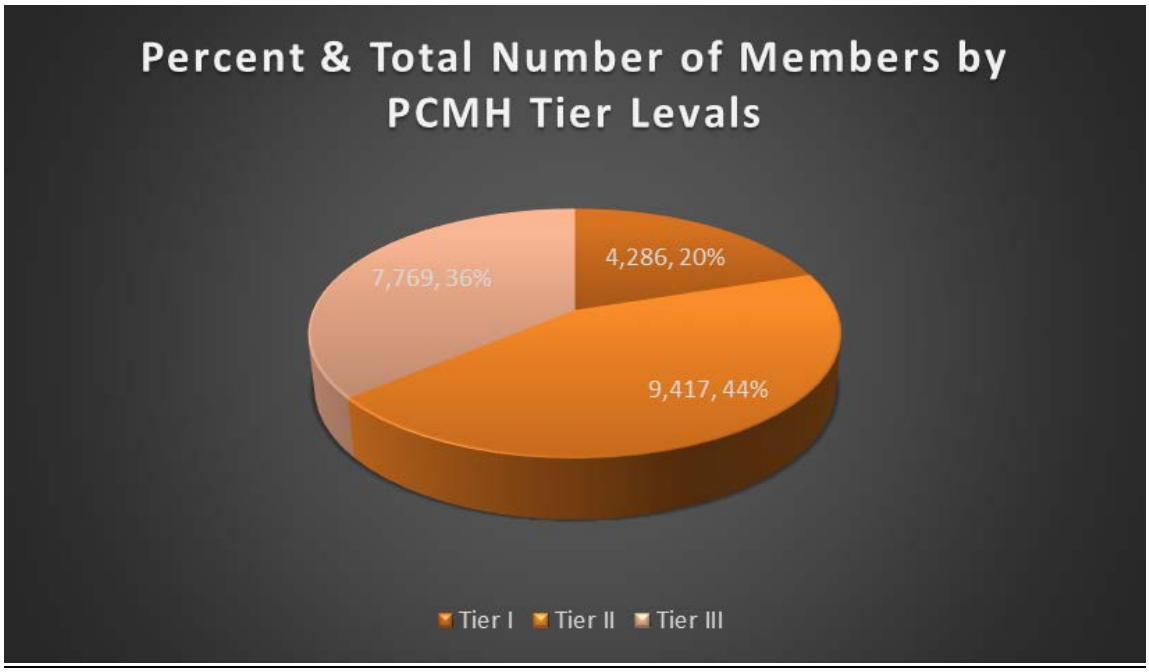
Month	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
No. of Care Managed Patients	193	237	263	325	410	420	446	
Actual ER visit	27	27	30	43	20	68	61	
Proportion of ER visits as a percentage	14%	11%	11%	13%	5%	16%	14%	
Total cost incured for ER Visit (Assuming avg of $1,233/visit)	$ 33,291.00	33291	36990	53019	24660	83844	75213	
Estimated ER visits(With baseline as 0.75 visit/member)	144.75	177.75	197.25	243.75	307.5	315	334.5	
	178476.75							
Estimated Savings per Month	$145,185.75	$185,874.75	$206,219.25	$ 247,524.75	$ 354,487.50	$ 304,551.00	$ 337,225.50	$ 1,635,882.80



Clinic Distribution Per Tier Level

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

Parent Organization	Clinic Name	Tier Level	Member Count	% of Total
OSU- CHS-HAN	Health Care Center & Women's Health Center- Family Medicine	Tier III	2318	10.80%
	Physician's Office Building (POB)- Family Medicine	Tier III	610	2.84%
	Houston Parke Pediatrics	Tier III	4458	20.76%
	Internal Medicine/ Internal Medicine Speciality Services	Tier III	383	1.78%
	Eastgate	Tier II	1740	8.10%
	AJ Muskogee Children's	Tier II	4119	19.18%
	North Regional Health and Wellness Center	Tier II	500	2.33%
	Stillwater Family Care	Tier II	879	4.10%
	SMPC West- Stillwater	Tier II	2179	10.15%
	Premier Pediatrics Clinic- Muskogee	Tier I	4286	19.96%
		Grand Total:	**21472**	**100.00%**



Primary Care PCMH Tier Level	# of Members	%
Tier I	4,286	19.96%
Tier II	9,417	43.86%
Tier III	7,769	36.18%
TOTAL	**21,472**	**100.00%**

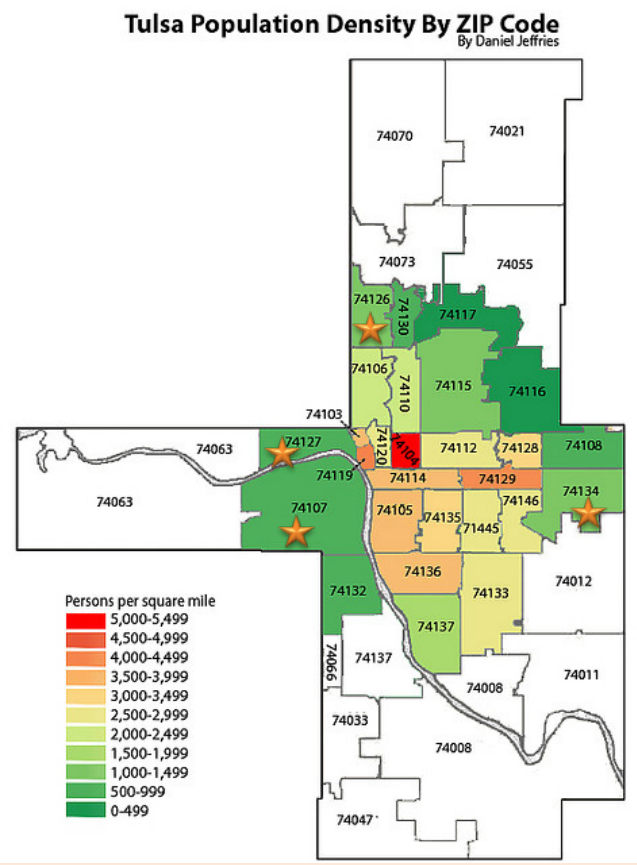
Physician Roster by Clinic

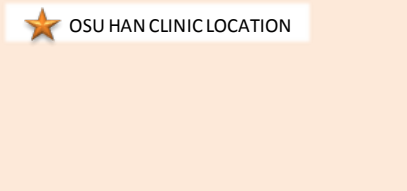
OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

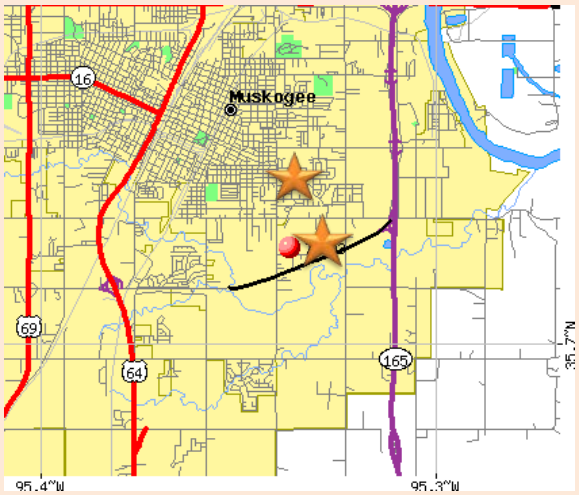
Clinic Name:	Physician List:	Tier Level
Health Care Center- Family Medicine	Dr. Lora Cotton, D.O Dr. Amanda Green, D.O. Dr. Sarah Hall, D.O. Dr. Regina Lewis, D.O. Dr. Andrea McEachern, D.O. Dr. Cornelia Mertz, D.O. Dr. Lana Meyers, D.O. Dr. Christopher Thurman, D.O.	Tier III
Women's Health Center- Family Medicine	Dr. Sarah Hall, D.O. Dr. Regina Lewis, D.O. Dr. Andrea McEachern, D.O. Dr. Lana Meyers, D.O. Dr. Christopher Thurman, D.O.	Tier III
Physician's Office Building (POB)- Family Medicine	Dr. Jenny Alexopulos, D.O. Dr. Lora Cotton, D.O. Dr. Sarah Hall, D.O. Dr. Regina Lewis, D.O. Dr. Lana Meyers, D.O. Dr. Christopher Thurman, D.O. Dr. Jennifer Curran, APRN-CNP Malinda Arrington, APRN-CNP	Tier III
Internal Medicine/ Internal Medicine Specialty Services	Dr. Damon Baker Dr. Jana Baker Dr. Mousumi Som Dr. Kathy Cook Dr. Madhuri Lad Dr. Justin Chronister (Beginning in Oct. 2015)	Tier III
	Dr. D. Matt Wilkett (Cardiology) Dr. Steve Kim (Cardiology) Dr. Brewer (Cardiology) Dr. Daniel Wildes (Cardiology- Beginning Dec. 2015)	
Houston Parke Pediatrics	Dr. Binh Phung, D.O. Dr. Rhonda Jeffries, M.D. Dr. Travis Campbell, D.O. Dr. Rhonda Casey, D.O. Monica Cordero, APRN-CNP Dr. Shawna Duncan, D.O. Dr. Amanda Foster, D.O. Dr. Colony Fugate, D.O. Dr. Jeremy Jones, D.O. Dr. Heather Rector, D.O.	Tier III
Eastgate- Family Medicine	Dr. Traci Carney, D.O. Dr. Amanda Green, D.O. Dr. Sarah Hall, D.O. Dr. Andrea McEachern, D.O.	Tier II
North Regional Health and Wellness Clinic	Dr. Regina Lewis, D.O. Jennifer Curran, APRN-CNP	Tier II
Stillwater Family Care	Dr. Garrick Shreck, D.O. Dr. Colbi Smithton, D.O. Dr. Corby Smithton, D.O. Dr. Frank Evans, D.O. Dr. Kelsey Smith, M.D.	Tier II
AJ SMPC West	Dr. Melinda Webb, M.D. Dr. Dwight Sublett, M.D. Dr. Elisa Davis, M.D. Dr. Krystal Voight, M.D. Dr. Scott Martin, M.D. Dr. Amy Hardin, M.D.	Tier II
AJ Muskogee Children's Clinic	Dr. Michael F. Stratton, D.O. Dr. Jerry D. Whatley, M.D.	Tier II
Premier Pediatric Clinic	Dr. Ryan Mundy, M.D. Dr. Tracy Hoos, D.O.	Tier I

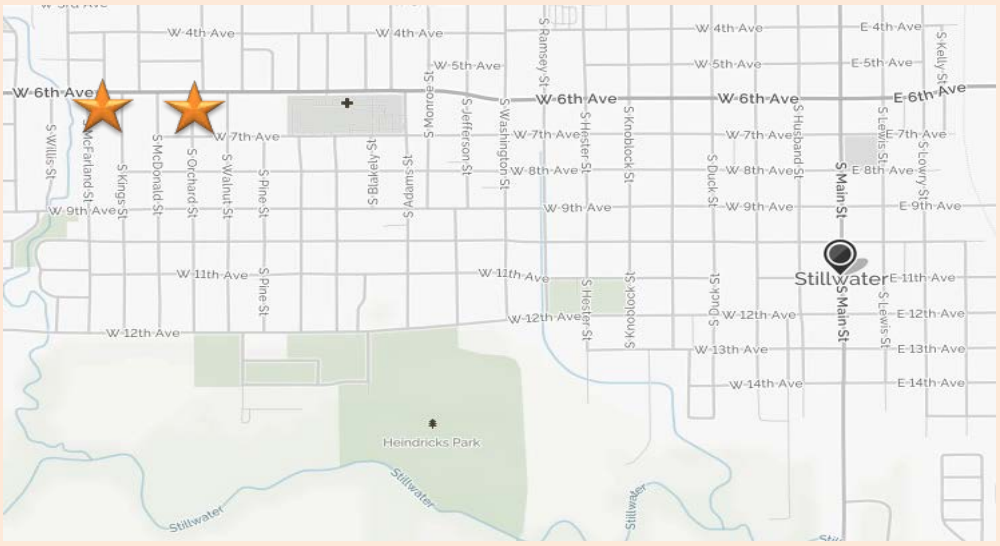
Enrolled OSU HAN Clinic Locations

ENROLLED OSU HAN CLINIC LOCATIONS

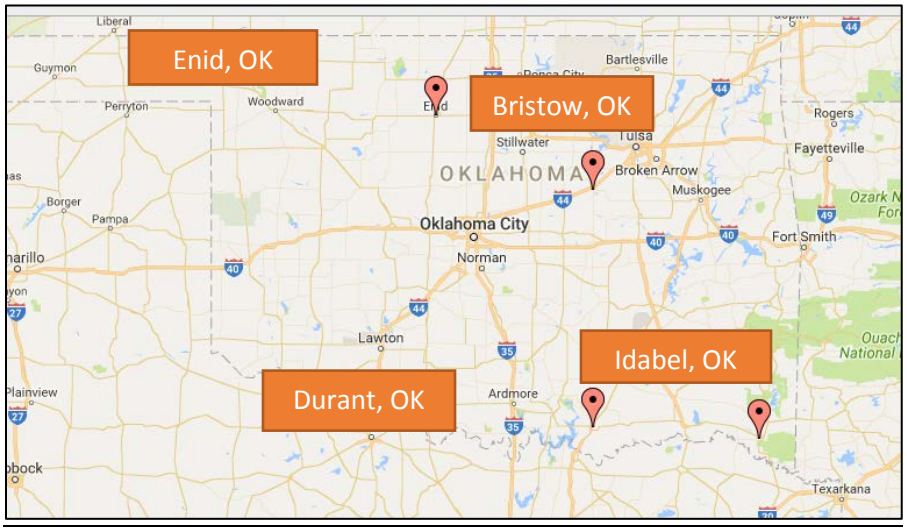








Below are a few rural cities in Oklahoma of which we reached out during FY16 as possible, future clinic contracts:



OSU HAN Outreach

Community Outreach Initiative:	Clinical Impact:
Aug. 2015	
HAN Director met with Brian Yeaman of Coordinated Care to discuss the possibility of utilizing Coordinated Care as a short term tool	Coordinated Care if a patient demographic and health history tool much like that of My Health. This HIE database would provide our CMs with another avenue for collecting patient-focused data
Sept. 2015	
OSU HAN Department Heads, Matt Maxey and Mike Shea, met with Dr. David Kendrick to discuss the capabilites of My Health	By collaborating with My Health, the OSU HAN was able to gain a valuable resource tool in regard to patient demographics and history. All OSU HAN members gained access to HIE- My Health
Oct. 2015	
The OSU Health Access Network created and implemented a Departmental website on Oct. 30th, 2016. osuhan.com	Physicians can research our program to see if their clinic and patient panel would benefit from our case management program. Patients can gain insight to related events, health education links, and additional information about how our program can benefit their health care goals.
May. 2016	
HAN Director, Quality Assurance Coordinator, CM Shantel Bolton, and Data Analyst, Shrie travelled to OU HAN to meet with their data analytics team and discussed their current usage of the Pentaho Database. Also during this month, the department hosted a conference call with Martie Collin, who created Canadian County's CM Access database.	As the OSU HAN began to build their CM database, we wanted to see what the other HANs have created and were utlizing in an effort to determine which system/method would have been most beneficial to our department/program. We decided to move forward with Marti Collin's Access Database to be implemented post creation.
September. 2016	
HAN Director, QA Coordinator, Administrative Assistant, and Care Team attended a Case Management lunch with a representative from Telligen to discuss their program. Lunch and Learn at OU-Tulsa.	By attending this lunch and learn, the OSU Health Access Network can better understand the details of the Telligen mission and thus be able to recognize the differences that exiat between the two similar programs and also how the two can work collaboratively.
Quality Assurance Coordinator, Administrative Assistant, and Data Analyst attended a conference call with representatives from WellCare Health Plans.	Well Care is a healthcare entit that focuses exclusively on providing government-sponsored managed care services, primarily through Medicaid, Medicare, Medicare Advantage, and Prescription drug plans to families, children, seniors, and individuals with complex medical need. We discussed with Well Care in regard to their clinical care plans and aread of which they felt worked and didn't work for them in ways of Case
HAN Director attended a Project ECHO Team meeting to discuss project updates and next steps for implementation.	Project ECHO is a collaborative model of medical education and care management that empowers clinicians everywhere to provide better care to more people, right where they live. Project ECHO is very interested in the involvement of our Care Managers and wants to invest by sending one of our care managers to New MExico in October for training

October. 2016	
The HAN Director, QA Coordinator, and Administrative Assistant met with representatives from Sooner HAN's Doc-to-Doc System, Lyn Denny and Michelle Nunn, and Victoria Parks from OSU Cardiology to discuss possible implementation of the Doc to Doc referral system at OSU-HAN.	The Doc-to-Doc referral database is a something that OU-HAN created of which helps to track referrals in real time. There are many clinics in the Tulsa area that are already contracted with the Doc to Doc system which makes submitting a referral and receiving referrals very easy and trackable at every stage helping to mitigate missed referrals or having a referral sit in the system for too long.
Melissa Foust, from New Century Hospice, visited our office location to provide an in-service presentation on the benefits of earlier admission and what makes New Century Hospice different from other Hospice Facilities.	By receiving this in-service presentation, we were able to take away valuable information on the types of hospice services that they can offer to our Sooner Care Choice member population.
HAN Director and Case Managers travelled to CAPES Tulsa Office and received an in-service presentation. CAPES is an organization that demonstrates through clinic practice and research in a multi-disciplinary, collaborative care team of which provides the most eddective and efficient care for children and adolescents who suffer from complex medical needs.	By receiving this in-service presentation from the CAPES organization, we were able to take away valuable information and resources for our child and adolescent members in terms of pyschological and developmental problems. We now have APES both as an educationa and referral source for our young members.
November. 2016	
The HAN Director, QA Coordinator, Administrative Assistant, and Case Managers met with Wade Hunter, who is the Director of Creoks Behavioral Health Center, for an in-service discussion in regards to their facilities and psychiatric options for our member population.	By receiving this in-service presentation from Wade, we are now more educated on some of the services that Creoks can provide for our member population without it becoming a duplication of services. We are also now more aware of some of the collaborative psychiatric resources that Creoks can offer for some of our members.

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

Community Outreach Initiative:	Community Impact:
Nov. 2015	
OSU Health Access Network set up an exhibit booth at the 32rd Annual Primary Care Update Conference on Nov. 6th & 7th at the Warren Double Tree Hotel	By hosting this exhibit table, we were exposed to many Primary Care physicians on both a local and state level. Here they were able to ask us questions about our case management program, as well as ascertain the benefits that we could provide in their own clinics. This conference was also a networking opportunity as well as a way for us to spread the word of our mission
Dec. 2015	
On Dec. 16th, 2015, Director attended at meeting with the OSU Medical Center-Center for Diabetes and Nutritional Education	This meeting was set up in an effort to better address the needs and education of the Sooner Care Choice members that have been diagnosed with diabetes or health nutritional maladies.
May. 2016	
* HAN Director, QA Coordinator, CM Connie Schadel, and Administrative Assistant travelled around Muskogee to the Muskogee Health Department, Bly Sky Behavioral Health Clinic, Muskogee Head State Program, Access to Healthcare Solutions, and the Martin Luther King Community Center * The HAN Department travelled to Durant, OK to attend and volunteer at the Remote Area Medical Event where free dental, vision, and medical exams were given to the general public	* By visiting with these community resource locations and making meaningful contact with the staff involved, we were able to create community relationships that will help tp positively impact our patient population through ways of referrals and general medical need within the community. * As a result of the many clinically trained and general support volunteers that attended and worked the RAM event, there was a total of 529 patients registered and $257, 000 in medical services rendered
July. 11th, 2016	
During our weekly Health Access Network Departmental Meeting, we met with the Outreach Coordinator, Chelsea Compton, and the Director, Jessica Kelly, of Youthcare of Oklahoma	Youthcare of Oklahoma provides effective, professional behavioral health counseling to children, youth, adults, and families across Oklahoma. We found out during our meeting that this is a Medicad driven program that is an extension of the Home Health Program and even though we cannot really work alongside each other, we can refer patients to each other that meet the specific criteria of each program.
July. 19th, 2016	
HAN Director and Case Managers, Connie Schadel , Leslie Brown, Melissa Gantz, Shantel Bolton, and Paula Ballard met with the Program Director and Medical Director of the Tulsa Methadone Clinic	During this meeting, case managers and director were given an overview of the Tulsa Methadone Clinic and the pipulation that they serve. The Director of the clinic was also able to provide a list of services offered at the clinic and how we would be able to refer patients.
September 20th, 2016	
HAN Director and Care Team hosted a presentation covering the Diabetes Education Program conducted by OSU Medical Center.	By hosting this in-service on Diabetes Education, our Director and HAN Care Team members were able to take away valuable information and resources that they can pass along and educate our patient population.

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

FY16 HAN Goals

HAN GOALS

1. **Expand the number of Cases Managed**
    a. **Immediate**- 3 mo.- program total of at 90/100 cases (30/33 ea.) DEC/JAN
    b. **Short Term**- 6 mo.-program total of 150 cases (50 cases ea.) MAR/APR
    c. **Long Term-** 1 year-program total of 300 cases (75 ea.) JUN/JUL
2. **Populations**
    a. **Immediate-** Continue teasing out Top 15 (ER users, Asthma, & Diabetes patient populations)
        i. Begin working on teasing out other populations
            1. Rank visit types from claims or Top 15 identified ER utilizers
    b. **Short Term (6 mo.)**- Rank visit types from claims data
        i. Monitor claims for other high-risk patient populations unidentified previously
    c. **Long Term (1 yr.)-** Predictive Analysis to focus on prevention (preventative care)
        i. Clinic referrals to mitigate disease progression in individual patients
        ii. 48 mo. Longitudinal study may provide similar information
3. **HAN DATA GOALS**

    a. **Immediate-**
        i. Finish Longitudinal study
            1. Break down descriptive analytic data
                a. By population
                b. By Clinic
            2. Automate stratification process from ER claims data provided by the Oklahoma Health Care Authority
    b. **Short Term (6 mo.)**
        i. Develop a trend analysis of different populations
        ii. Develop Goal from analysis
            1. Example: Decrease ER utilization in Asthma population by certain %
        iii. IT/DA/Project Manager
        iv. Tableau/Pentaho
    c. **Long Term**
        i. Possible customization reports per clinic request
        ii. Community Comparison- Clinic to Clinic/ Zip to Zip

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

FY17 HAN Future Focuses

HAN GOALS

1. **Expand the Number of Cases Managed**
    a. **Short Term:** 6 mo.- accumulate cases from Stillwater and Muskogee
    b. **Long Term:** 1 year- reach a program total of 450-600 managed cases (75-100 cases ea.) JUN/JUL
2. **Populations**
    a. **Immediate:** Continue to build out and complete the OSU HAN Disease Registry
    b. **Long Term:** Predictive Analysis in the focus of prevention (preventative care)
        i. Clinic Referrals to mitigate disease progression in individual patients

HAN DATA GOALS

1. **Immediate**
    a. Break down descriptive data
        i. By population
        ii. By Clinic
    b. Automate stratification process for ER claims data from OHCA
    c. Quantify, Return of Investment- ER Data
2. **Short Term:**
    a. Develop a trend analysis of different populations
    b. Develop Goals from analysis
        i. Maintain current ER reduction rate
3. **Long Term:**
    a. Customization of clinic update reports- Currently doing this for Muskogee Children's Clinic but would like to produce for all of our contracted clinics on a monthly basis

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

Health Information Technology

Reporting Period – July 1st, 2015 to Dec. 30th, 2016

This report provides a summary of Health Information Technology related activities conducted by OSU Health Access Network.

OVERVIEW

Assistance with adoption of Health Information Technology

OSU Physicians

- Help position, grow, and move to other systems. Complete meaningful use stages.
- The HIT team continued efforts to assist OSU Physicians Clinics in supporting and enhancing clinical dashboards as well as building new reports to allow clinical staff to monitor, and provide early intervention strategies on their patients using health management goals, education, primary prevention, behavior modification programs, etc.
- OSU made a decision to move to a new EHR and implementation efforts started in January of 2015. The new EHR system (EPIC) will provide more seamless integration and robust functionality that will allow members of the OSU HAN to track referrals, meet meaningful use, report on clinical quality measures and trend data, etc. The usage of the new EHR system has the same capability of the legacy EHR with added functionality mentioned above, this is to allow providers to also monitor clinical quality measures that have been set for the HAN as well as Behavioral Health, Weight management and Tobacco Cessation counseling needs.
- During the first two quarters of 2015, HIT provided assistance going through the review and selection of a disease management system for the OSU HAN. HIT and the Care management team for the HAN, a couple of system vendors were reviewed however, the main goal for this system is to provide the capability to import data from different sources and create a data warehouse so case managers are able to manage and trend cases through reporting.

Muskogee Children's Clinic

- The OSU HAN engaged with Muskogee Children's clinic during their leadership transition and offered assistance with any HIT related questions to help the clinic continue operating in a smooth manner and help the new leadership with any questions related to services that OSU HAN provides.

OKLAHOMA STATE UNIVERSITY HEALTH ACCESS NETWORK

HIT Goals for 2015-2016

Reporting Period – July 1, 2015 to June 30, 2016

This report provides a summary of Health Information Technology related activities conducted by OSU Health Access Network.

OVERVIEW

Assistance with adoption of Health Information Technology

- The Health Information Technology department assisted the OSU Health Access Network operations team with the analysis of data warehouse architecture to develop a way to receive structured data from current and future OSU HAN members (XML, CCD's, etc.) and be able to query data and report on clinical outcomes.
- Set up and trained OSU HAN operations team on new Epic workflow of how data would be presented to nursing/case management staff for the purposes of documenting case management interventions in the Epic EHR system implemented at the OSU clinics in August of 2015.
- Trained and conducted transfer knowledge on current delivery of claims data sent by the Oklahoma Healthcare Authority.
- Conducted presentations to all clinic members of the OSU Health Access Network on Meaningful use objectives and final rule changes published in October 6th, 2015. Submitted recommendations and next steps based on the final changes.

Definitions

ADT – Admissions, Discharges and Transfer interface
CCD – Continuity of Care Document
CHS – Center for Health Sciences
CPC – Comprehensive Primary Care
CQI – Continuous Quality Improvement
Convisint – Health Information Exchange software vendor
Doc 2 Doc – Referral Management software
EHR- Electronic Health Record System
Greenway – EHR software Vendor
HIE – Health Information Exchange
HIT – Health Information Technology
My Health – Organization responsible for the implementation of Health Information Exchange between OSU and other participant Health Systems in Tulsa and surrounding areas.
HL7 – Health Level Seven, refers to the set of standards for transferring clinical and administrative data among Health Information systems.
OFMQ – Oklahoma Foundation for Medical Quality
OHCA – Oklahoma Health Care Authority
OSU – Oklahoma State University
OSU HAN – Oklahoma State University Health Access Network
OU – University of Oklahoma Health Access Network
PCMH – Patient Centered Medical Home
REC – Regional Extension Center
FM HCC – OSU Health Care Center Family Medicine clinic
FM POB – OSU Physicians' Office Building Family Medicine clinic
FM East gate – OSU East gate Family Medicine clinic
HMP- Health Management Program
PCIS – Practice management system used at OSU Physicians clinics
IMSS – OSU Internal Medicine Specialty Services clinic
HP PEDS – OSU Pediatrics clinic

DRAFT AGENDA

The Children's Health Group (TCHG) Quarterly Meeting
Tuesday, April 11, 2017, 5:00 - 7:00 p.m.

OU Health Sciences Center Campus, Provost's Conference Room, # 223, Bird Library (live video streaming at OU College of Medicine – Tulsa, Room 2B19, Schusterman Campus; NWOSU-Enid Conference Room; and Wilburton)

Welcome and Introductions - Dr. Mary Anne McCaffree/Dr. Marny Dunlap

Updates

- ODMHSAS
  - Legislative/Budget Update – Ellen Buettner
    Group Discussion

- OSDH
  - Legislative/Budget Update – Carter Kimble
    Group Discussion

- OHCA
  - Legislative/Budget Update
    Group Discussion

Presentations

- System of Care: Strengthening our CareNet (SOC^2) Grant: Focus on the Infant and Early Childhood Mental Health Portion of the Grant – *Shannon Lee, Manager, Infant and Early Childhood Services, ODMHSAS*
  Group Discussion

- OHCA 1115a Waiver Post Award Forum – Ivoria Holt
  Group Discussion

- OKAAP Immunization Initiative – Marny Dunlap, MD
  Group Discussion

Announcements/New Business - Mary Anne McCaffree, MD

- Upcoming CY 2017 Meeting Dates: July 11 and October 10

Adjournment

SoonerCare Choice Demonstration Post Award Forum

Sherris Harris-Ososanya
Federal and State Policy
Waiver Reporting Coordinator
April 11, 2017

Oklahoma HealthCare Authority

SOONERCARE CHOICE SECTION 1115 DEMONSTRATION

- Allows flexibility to design and improve Medicaid programs
- Uses innovative service delivery systems that improve care, increase efficiency and reduce costs
- Current SoonerCare Demonstration period is from January 2017 to December 2017

SOONERCARE CHOICE DEMONSTRATION OVERVIEW

- **Current Programs**
  - SoonerCare Choice
  - Insure Oklahoma
- **Looking Forward**

Oklahoma HealthCare Authority

SOONERCARE CHOICE CURRENT PROGRAM

SoonerCare Choice Waiver Objectives:

Access	Medical home
Optimize	Integrate
Health Insurance	

Three-part Aim of Centers for Medicare & Medicaid Services (CMS):

Access	Quality
Decreasing Cost	

Oklahoma HealthCare Authority

SOONERCARE CHOICE WAIVER PROGRAMS

Oklahoma HealthCare Authority

SOONERCARE CHOICE PREMIUM ASSISTANCE WAIVER PROGRAMS

Oklahoma HealthCare Authority

SOONERCARE CHOICE AND INSURE OKLAHOMA

Waiver Administrative Update:

- Extension of the SoonerCare Choice and Insure Oklahoma programs through December 31, 2018

- Clarification language added to the Expenditure Authority and Special Terms and Conditions for Supplemental Payments to the Universities

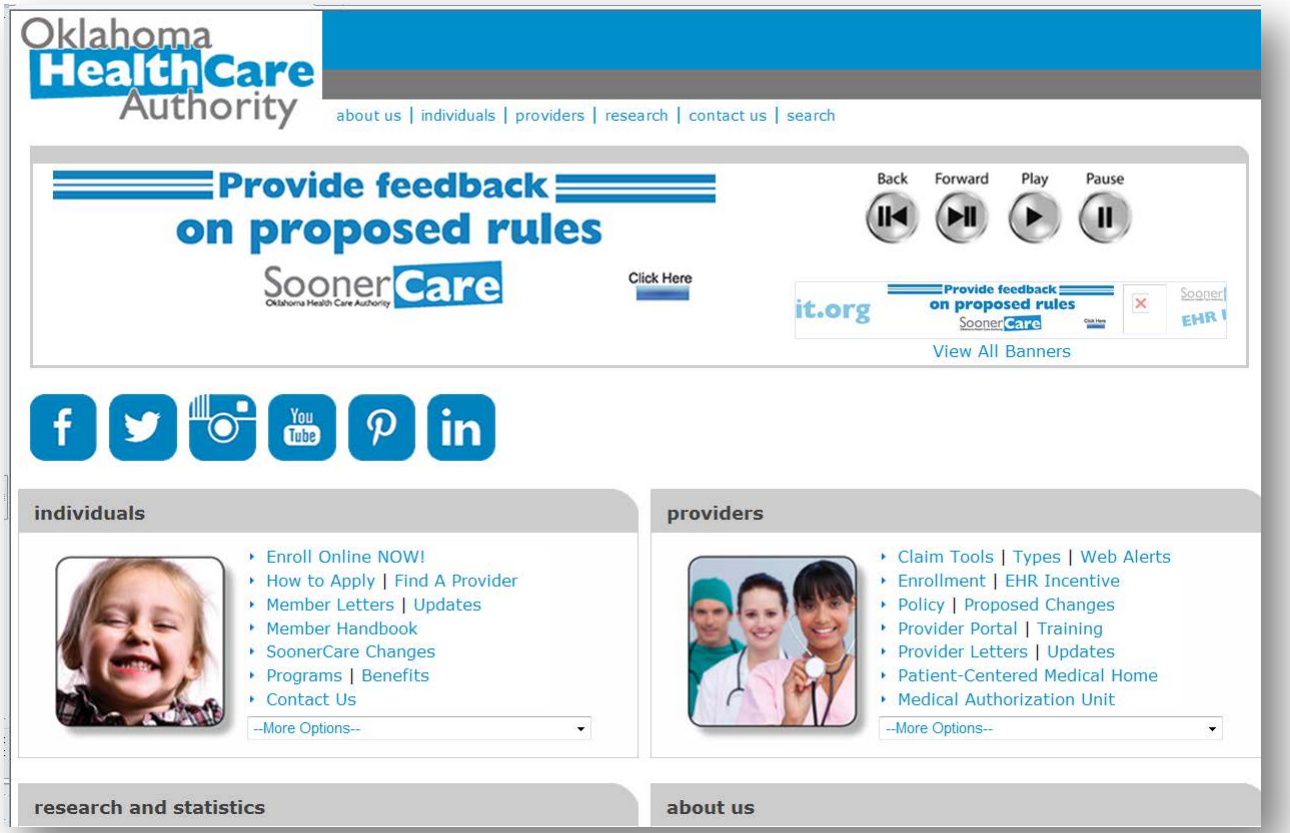
Oklahoma HealthCare Authority

FUTURE OF SOONERCARE CHOICE AND INSURE OKLAHOMA PROGRAMS

- OHCA seeks to extend the SoonerCare Choice and Insure Oklahoma programs through 2021, with an additional SoonerCare Choice renewal application

Oklahoma HealthCare Authority

SOONERCARE CHOICE DEMONSTRATION



For more information, please visit www.okhca.org.

Oklahoma HealthCare Authority

QUESTIONS

Oklahoma HealthCare Authority

CONTACT INFORMATION

Sherris Harris-Ososanya MHR, LPC

Federal and State Policy

Waiver Reporting Coordinator

Phone: 405-522-7507

Fax: 405-530-3273

Sherris.Harris-Ososanya@okhca.org

REFERENCES

- OHCA CMS Special Terms and Conditions

  September 9, 2015

- OHCA Monthly Fast Facts

  (www.okhca.org/research)

- www.Medicaid.gov

Oklahoma HealthCare Authority

Annual Report

Fiscal Year 2016

July 1, 2015 to June 30, 2016

Table of Contents

Executive Summary

Mission

The Mission of the Sooner Health Access Network is to improve the health of SoonerCare Choice members through providing comprehensive, high-quality, evidence-based care management and quality improvement services, while leveraging health information technology to boost outcomes and broaden access to care.

Vision

The Vision of the Sooner Health Access Network is to advance the Triple Aim among both SoonerCare Choice members and their providers. We strive to promote better health care for the population, better experience of care for individuals, and lower costs through continuous improvement efforts.

Summary of Core Functions

The Sooner Health Access Network (Sooner HAN) ended Fiscal Year (FY) 2016 with an enrollment of 101,255 SoonerCare Choice members across 57 primary care practices. During FY 2016, 155,271 unique members were enrolled.

Care Management

The focus of FY 2016 was expansion of care management groups within the Sooner HAN. The Sooner HAN added a new target group, diabetes to the care managed populations. A total of 2,107 unique members received care management throughout FY 2016.

The primary areas of growth within care management resulted from a combination of the continued effort to use claims data to identify and intervene earlier with members who have uncontrolled asthma or high emergency room (ER) utilization and the addition of a diabetes targeted intervention. Care management of members with uncontrolled asthma as defined by evidence-based guidelines grew from 186 in FY 2015 to 265 in FY 2016, representing a 42% increase. Care management of members with high ER utilization decreased from 156 to 77 for Tier 1 (10+ visits in 6 months) and increased from 399 to 545 for Tier 2 (2-9 visits in 6 months), a decrease of 51% and an increase of 37%, respectively. The primary decrease in Tier 1 resulted from the better monitoring of the number of ER visits and adjusting Tier level throughout the year. Additionally, this correlates with the continuing decrease of ER use throughout the entire Sooner HAN population over the past six fiscal years.

The General HAN care management group was created in FY 2014 to address the needs of members who might benefit from care management services but did not fit into any of the existing care management groups. Many of the members in this group have been referred by Sooner HAN providers because they require a higher level of care management than the primary care clinics are able to provide. The General HAN category increased from 95 members served in FY 2015 to 161 members served in FY 2016, an increase of 69%.

The Sooner HAN participated with OU Internal Medicine in a Patient Centered Outcomes Research Institute (PCORI) grant, led by the National Committee of Quality Assurance (NCQA), assessing the impact of a patient centered approach on diabetes outcomes. In this project the Sooner HAN targeted SoonerCare Choice members eligible for the project. A result of this project was the creation of the care management

target group focused around diabetes. At the end of FY 2016 180 unique members had received care management services due to uncontrolled diabetes.

Referral Management

The Sooner HAN Doc2Doc team, in coordination with the Doc2Doc vendor, completed an interface between the Oklahoma Healthcare Authority (OHCA) and the Doc2Doc referral management tool in early 2016. The interface allows users to obtain required visit authorizations from the OHCA Secure Provider Portal in less than one minute to facilitate timely care transitions. Completion of this project allows referral coordinators to work more efficiently, eliminating the need for duplicate entry.

Utilization of the Doc2Doc referral tool by Sooner HAN clinics has increased as a result of the interface with OHCA, marketing efforts, and enhanced reporting capabilities. Increased Doc2Doc utilizations has optimized access to specialty care for up to 8,000+ SoonerCare Choice members.

Quality Management

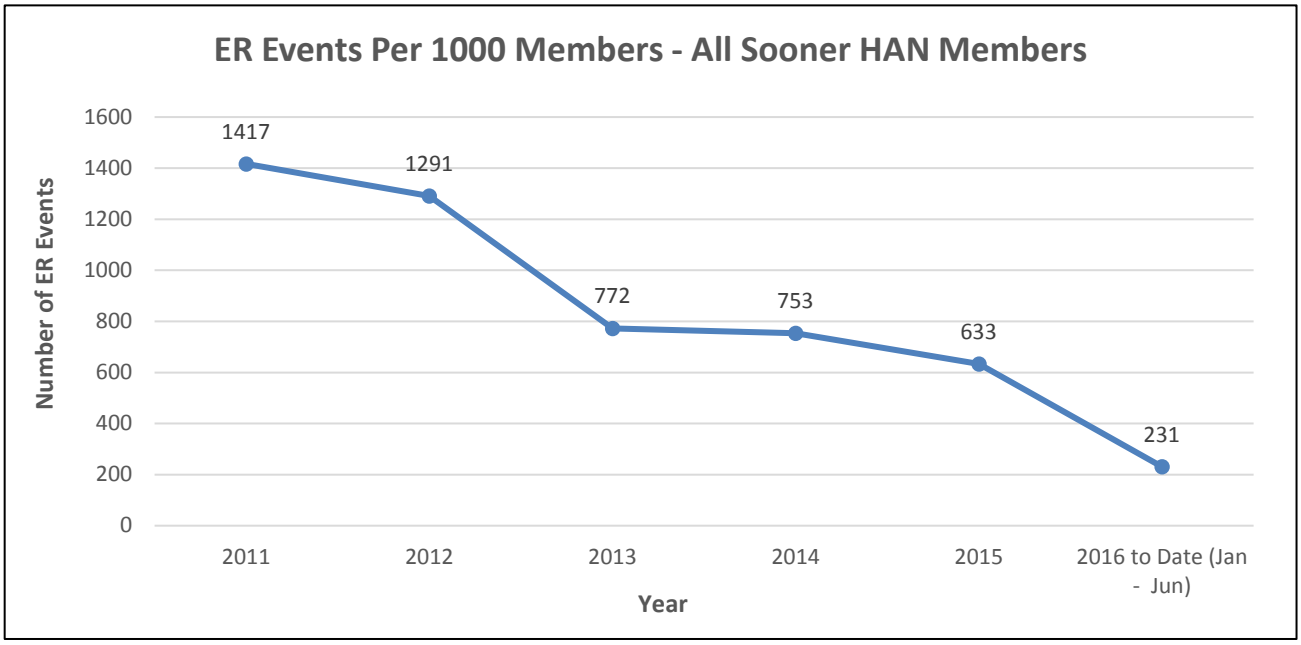
The Sooner HAN continues to provide quality improvement services to Sooner HAN provider practices. In FY 2016, the Sooner HAN assisted a large primary care practice group in Tulsa to redesign clinic workflow and processes to further streamline the patient centered medical home approach. In this same clinic, Sooner HAN staff also participated in implementing diabetes patient centered approaches into the current office visit workflow to evaluate its feasibility. Assistance on these projects will continue into FY 2017.

Sooner HAN staff set up meetings with numerous clinics during FY 2016 to build relationships with new staff, discuss the HAN services of quality improvement, care management, and referral management. In addition, Sooner HAN staff shared examples of reports that can be generated for each clinic for quality improvement monitoring, and discussed clinic issues brought forth by clinic staff. These meetings will continue in FY 2017.

Significant effort was devoted to developing reports for providers based on roster and claims data utilizing the Pentaho business analytics software upgraded in FY 2016. Specifically, numerous providers are currently utilizing the roster reports automatically generated each month that designate new members added to the roster. The roster report includes demographic data such as member address and phone numbers so clinics can conduct outreach activities including welcome phone calls and letters to encourage new members to establish care with the clinic. In addition, practices are using utilization reports showing emergency room visits and hospitalizations. These reports include diagnoses to assist in identifying patterns and trends. Based on provider preferences, reports can be customized to the desired timeframe and include items such as the number of ER and inpatient events, location of facility, day of week, ICD codes, provider specific detail, member specific detail, and care management status.

A significant trend over the past five years has been the decline in ER visits/1000 members. Although ER visits rose from 61,675 in 2011 to 96,031 during 2015, membership grew from 43,534 members served during 2011 to 151,692 members during 2015. Using the calculation of ER Events Per 1000 Members (PTM), ER utilization has decreased significantly from 2011 to 2015, from 1417 PTM to 633 PTM, a 55% decrease.

ER Events - All Sooner HAN Members	2011	2012	2013	2014	2015	2016 (Jan-Jun)
ER Events	61,675	91,300	103,423	105,973	96,031	32,214
Unique Members	43,534	70,698	133,884	140,710	151,692	139,596
ER Events Per 1000 Members	1417	1291	772	753	633	231



Regarding tier advancement, most providers have advanced to the tier level of their preference and are not interested in pursuing further tier advancement at this time. Other providers have been interested in tier advancement and had the internal resources to accomplish tier advancement without assistance from the Sooner HAN. In FY 2016, the Sooner HAN staff began assisting a small primary care clinic that failed an OHCA annual audit and was required to submit a plan of correction. This effort will continue into FY 2017 and is focusing on creating a solid infrastructure and creating policies, procedures, flow charts, and job aids to standardize and streamline key processes. The Sooner HAN quality staff will continue to offer assistance to providers eligible for tier advancement to increase the level of service provided to their members and maximize potential reimbursement.

In addition, a Sooner HAN quality committee was established in July of FY 2016. Members include the HAN Director, Community Analytics Director, Medical Director, Behavioral Health Medical Director, Faculty, Clinical Manager, Quality Manager, and Operations Manager. Additional members will be added as necessary in the future. Meetings are held at least quarterly to review performance measures and discuss opportunities for improvement. Some of the major goals for FY 2017 are highlighted below.

Goals for FY 2017

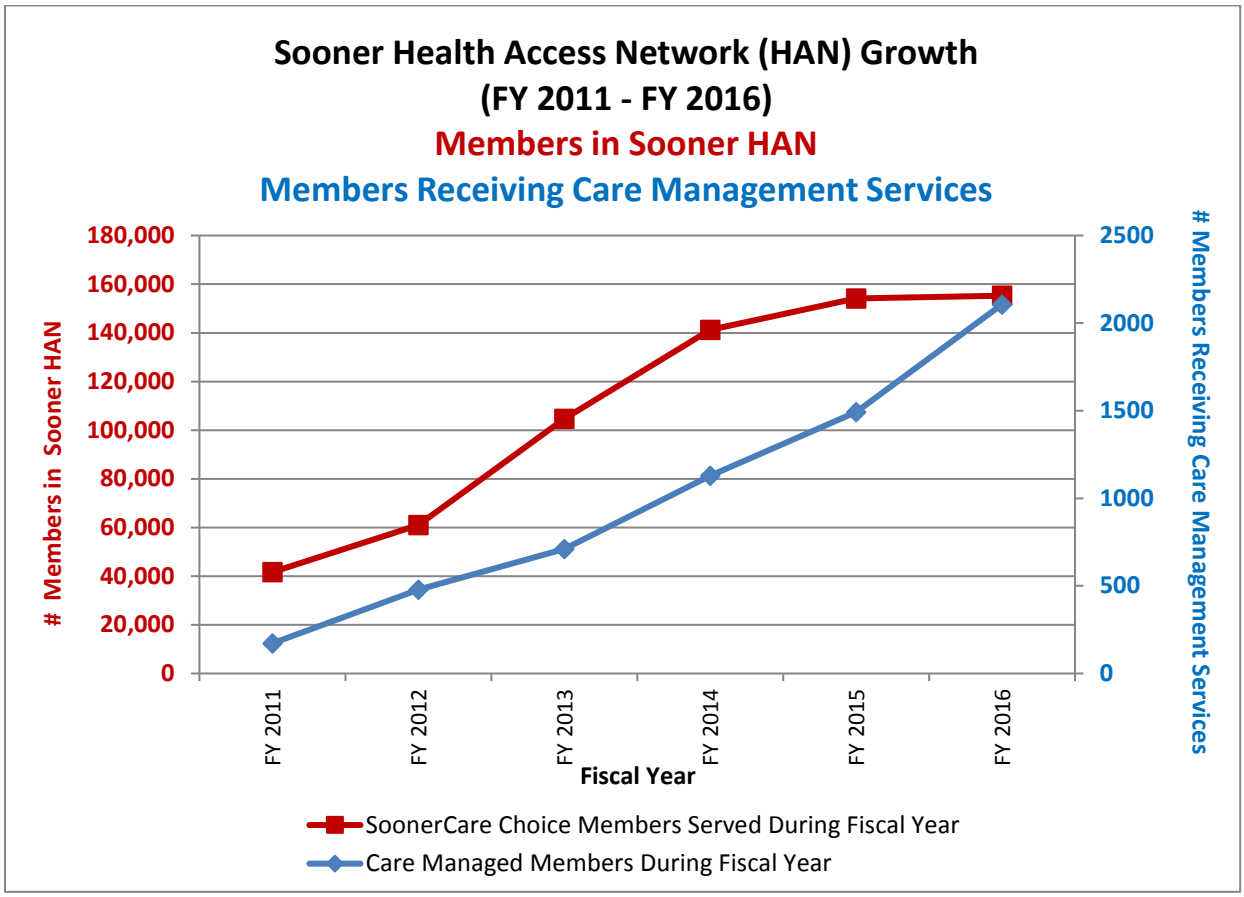
In addition to increasing outcome measurement, the Sooner HAN has identified the following goals for FY 2017.

1. Primary Care Provider (PCP) Recruitment – Increase PCP participation to 150,000 covered lives
2. Expansion of Care Management Services – Reach 2%-3% of covered lives in care management
3. Doc2Doc Utilization for Optimal Referral Loop Closure – Increase primary care participation in Doc2Doc by 25%
4. Quality Management Reporting for Clinics/Providers and Care Managers – Offer quality management reporting to 100% of providers/clinics

Sooner HAN Network

Summary of Sooner HAN Enrollment

	Fiscal Year 2011	Fiscal Year 2012	Fiscal Year 2013	Fiscal Year 2014	Fiscal Year 2015	Fiscal Year 2016
Primary Care Clinics	8	22	50	54	59	57
SoonerCare Choice Members at Fiscal Year End	28,085	43,554	73,516	101,879	114,717	101,255
SoonerCare Choice Members Served During Fiscal Year	41,651	61,063	104,690	141,223	154,111	155,271
Care Managed Members – Total	172	479	711	1,129	1,493	2,107



Affiliated Providers and Access to Care
(Articles 4.2 & 4.3)

At the close of FY 2016 there were 57 provider practice locations representing 101,255 Sooner Care Choice members. The total enrollment has increased significantly since the HAN's inception, however, membership has fluctuated over the past several years, dropping slightly from 114,722 at the close of FY 2015 to 101,255 at the close of FY 2016.

Primary Care Network

The Sooner HAN provides services to 57 provider practice locations, hundreds of primary care providers, and their respective SoonerCare Choice members across the state.

Provider	Clinic	SoonerCare Choice Tier Level	Members Served - June 2016	% of Total HAN Members Served
Access Solutions Medical Group	Access Solutions Medical Group - Catoosa	Tier 3 Child & Adult	915	1%
	Access Solutions Medical Group - Sand Springs	Tier 3 Child & Adult	1,086	1%
	Access Solutions Medical Group - Tulsa	Tier 3 Child & Adult	2,992	3%
Arkansas Verdigris	Arkansas Verdigris	Tier 1 FQHC/RHC	352	0.3%
Community Health Connection	Community Health Connection E 21st St - Tulsa	Tier 2 FQHC/RHC	1,902	2%
	Community Health Connections E 3rd St - Tulsa	Tier 2 FQHC/RHC	1,204	1%
Fairfax Clinics	Fairfax - Hominy	Tier 1 FQHC/RHC	626	1%
	Fairfax - Newkirk Family Health Center	Tier 1 FQHC/RHC	1,002	1%
	Fairfax - Robert Clark Family Health Center	Tier 1 FQHC/RHC	203	0.2%
Generations Clinics	Generations - Bartlesville	Tier 2 Child & Adult	934	1%
	Generations - Chelsea	Tier 1 Child & Adult	757	1%
	Generations - Claremore	Tier 3 Child & Adult	1,784	2%
	Generations - Owasso	Tier 2 Child & Adult	1,298	1%
Jahangir Khan, MD	Jahangir Khan, MD - Bixby	Tier 1 Child & Adult	220	0.2%
	Jahangir Khan, MD - Sand Springs	Tier 1 Child & Adult	658	1%
Jenks Family Physicians	Jenks Family Physicians	Tier 3 Child Only	1,502	1%
Morton	Morton	Tier 2 FQHC/RHC	2,757	3%
	Morton – East	Tier 2 FQHC/RHC	541	1%
	Morton - Nowata	Tier 2 FQHC/RHC	320	0.3%
OU-OKC	OU Adolescent Clinic	Tier 2 Child Only	176	0.2%
	OU Edmond (Family Practice)	Tier 2 Child & Adult	534	1%
	OU Family Medicine Center	Tier 3 Child & Adult	8,067	8%
	OU Latino Clinic	Tier 3 Child Only	2,475	2%
	OU Physicians South OKC Family Practice	Tier 2 Child & Adult	453	0.4%
	OU Sooner Pediatrics Clinic	Tier 3 Child Only	6,279	6%
OU-Tulsa	Community Health	Tier 3 Child & Adult	1,498	1%
	Family Medicine	Tier 3 Child & Adult	5,793	6%
	Internal Medicine	Tier 3 Child & Adult	1,621	2%
	Pediatrics	Tier 3 Child Only	13,004	13%
	Wayman Tisdale Clinic	Tier 3 Child & Adult	1,258	1%
Stigler Health and Wellness Center	Stigler Health & Wellness Ctr - Checotah	Tier 1 FQHC/RHC	690	1%
	Stigler Health & Wellness Ctr - Eufaula	Tier 1 FQHC/RHC	643	1%
	Stigler Health & Wellness Ctr - Poteau	Tier 1 FQHC/RHC	564	1%
	Stigler Health & Wellness Ctr - Stigler	Tier 1 FQHC/RHC	1,739	2%
	Stigler Health & Wellness Ctr Sequoyah - Sallisaw	Tier 1 FQHC/RHC	2,232	2%
Utica Park BA North	Chow MD, Christopher	Tier 3 Child & Adult	43	0.0%

Provider	Clinic	SoonerCare Choice Tier Level	Members Served - June 2016	% of Total HAN Members Served
Utica Park BA South	Crow DO, Tobin	Tier 3 Child & Adult	155	0.2%
	Silas MD, Geeta	Tier 3 Child & Adult	196	0.2%
Utica Park Bristow	Smith DO, Carl R.	Tier 3 Child & Adult	79	0.1%
	Remington DO, Jason D.	Tier 2 Child Only	208	0.2%
	Riffe DO, Jason	Tier 3 Child & Adult	178	0.2%
Utica Park Claremore	Hinkle DO, Brent	Tier 2 Child & Adult	171	0.2%
	Nodine MD, Seth	Tier 2 Child Only	85	0.1%
	Vardey MD, Sheela	Tier 3 Child & Adult	650	1%
	Williams DO, Jeffrey	Tier 2 Child & Adult	184	0.2%
Utica Park Cushing	Jenkins APRN-CNP, Bethany	Tier 3 Child & Adult	556	1%
	McCauley DO, Colm P	Tier 3 Child & Adult	555	1%
	Noe PA, Lisa	Tier 2 Child & Adult	321	0.3%
Utica Park Henryetta	Cain DO, Michael	Tier 1 Child & Adult	95	0.1%
Utica Park Jenks	Koljack MD, Kathleen S	Tier 2 Child & Adult	188	0.2%
	Pollak MD, Charity	Tier 1 Child & Adult	167	0.2%
Utica Park Okemah	Dixon APRN-CNP, Debra	Tier 2 Child & Adult	301	0.3%
Utica Park Owasso	Colpitt MD, Debra	Tier 2 Child Only	16	0.0%
	Horton MD, Theresa	Tier 3 Child & Adult	374	0.4%
	Blesch MD, Lauri	Tier 3 Child & Adult	410	0.4%
	Mickle MD, Laurie	Tier 3 Child & Adult	274	0.3%
	Patterson DO, Keith S.	Tier 3 Child & Adult	143	0.1%
	Galutia DO, Yancy	Tier 3 Child & Adult	159	0.2%
Utica Park Pryor	Battles DO, Paul	Tier 3 Child & Adult	104	0.1%
	Gietzen DO, Michael	Tier 3 Child & Adult	192	0.2%
	Ring DO, David	Tier 1 Child & Adult	118	0.1%
	Suhail MD, Shuaib	Tier 3 Child & Adult	817	1%
Utica Park South Lewis	Choplin PA, Ryan	Tier 2 Child & Adult	572	1%
	Griffin DO, Chelsey	Tier 2 Child & Adult	574	1%
	Hasenpflug DO, Tara Brook	Tier 3 Child & Adult	116	0.1%
	Gordon MD, Richard	Tier 3 Child & Adult	1,012	1%
Utica Park Cleveland	Shipman APRN, Shawna	Tier 2 Child & Adult	190	0.2%
Variety Care	Variety Care - Norman Family Practice	Tier 1 Child & Adult	1,329	1%
	Variety Care - Mid Del	Tier 1 FQHC/RHC	1,687	2%
	Variety Care - Norman Pediatrics	Tier 2 Child & Adult	718	1%
	Variety Care - Fort Cobb	Tier 1 FQHC/RHC	294	0.3%
	Variety Care - Grandfield	Tier 3 FQHC/RHC	178	0.2%
	Variety Care - Lafayette	Tier 1 FQHC/RHC	9,170	9%
	Variety Care - NW 10th Street OKC	Tier 3 FQHC/RHC	2,217	2%
	Variety Care - NW 56th Street OKC	Tier 2 FQHC/RHC	2,493	2%
	Variety Care - Straka	Tier 1 FQHC/RHC	5,877	6%
			101,255	**100%**

Provider Tier Levels

SoonerCare Choice is a managed care model in which each member is linked to a primary care provider who serves as the member's "medical home". Primary care providers manage the basic health care needs, including after hours care and specialty referral of the members on their panel. PCMH includes three tiers with escalating responsibilities and associated per member per month care coordination fees. Providers may serve members in the following panel categories: Child and Adult, Child Only, Adult Only, or Federally Qualified Health Center/Rural Health Center.

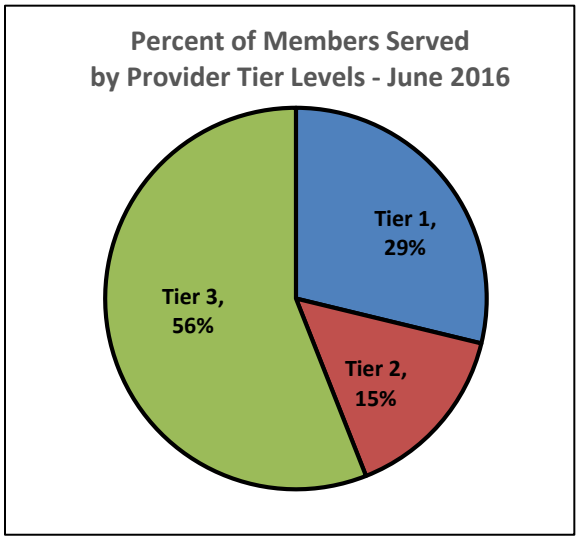
Tier I is considered "entry level" and provides the minimum requirements for OHCA PCMH status and the minimum reimbursement level for incorporating patient centered medical home approaches into the clinic or practice. Tier I has 13 requirements including coordinated primary care and patient education; 24/7 telephone coverage by medical professional; maintaining a system to track tests and referrals; and acceptance of electronic communication from OHCA.

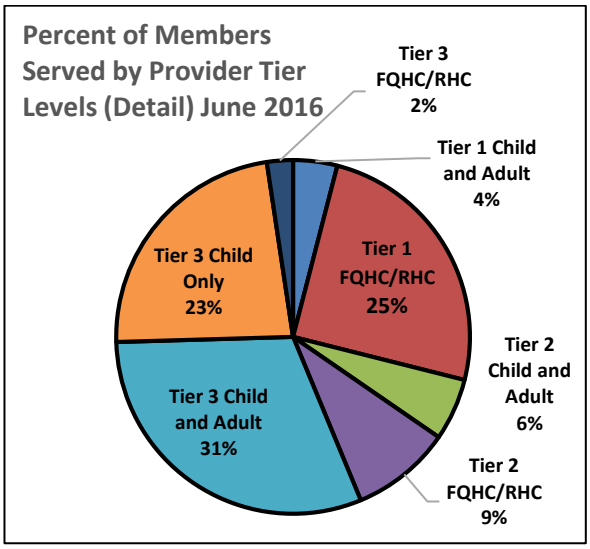
Tier II represents "advanced" medical home approaches and provides a higher reimbursement for the additional requirements. Tier II has 20 requirements, including all Tier I criteria plus full-time practice w/enhanced access/after-hours; inpatient tracking & hospital follow up; and three of five enhanced services - practice healthcare team, after visit follow-up, adoption of evidence-based practice guidelines, and medication reconciliation.

Tier III is the "optimal" level and incorporates additional requirements and additional reimbursement. Tier III has 21 requirements, including all Tier I and Tier II requirements using health assessments tools to characterize patient needs and risks.

As shown in the table below, providers in the Sooner HAN at the highest PCMH Tier Level III served 56,684 members, or 56% of the total member population in June 2016. Providers at PCMH Tier Level II served 15,422 members (15%) and providers at Tier Level 1 served 29,141 members (29%).

Patient Centered Medical Home (PCMH) Tier Levels	Number of Members Served by Tier Level Detail	% of Total Sooner HAN Members Served
Tier 1 – Entry Level		
Tier 1 Child and Adult	4,062	4%
Tier 1 Child Only	0	0%
Tier 1 Adult Only	0	0%
Tier 1 FQHC/RHC	25,079	25%
Tier 1 Total	**29,141**	**29%**
Tier 2 – Advanced		
Tier 2 Child and Adult	5,720	6%
Tier 2 Child Only	485	0%
Tier 2 Adult Only	0	0%
Tier 2 FQHC/RHC	9,217	9%
Tier 2 Total	**15,422**	**15%**
Tier 3 – Optimal		
Tier 3 Child and Adult	31,029	31%
Tier 3 Child Only	23,260	23%
Tier 3 Adult Only	0	0%
Tier 3 FQHC/RHC	2,395	2%
Tier 3 Total	**56,684**	**56%**
Sooner HAN Members Served – June 2016	**101,255**	**100%**

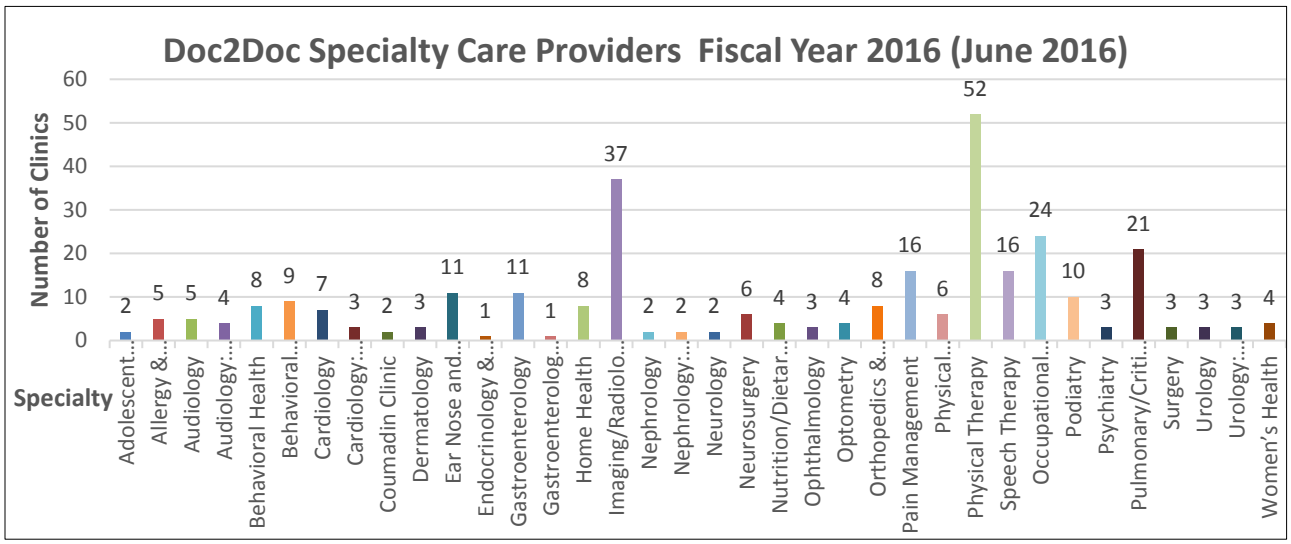




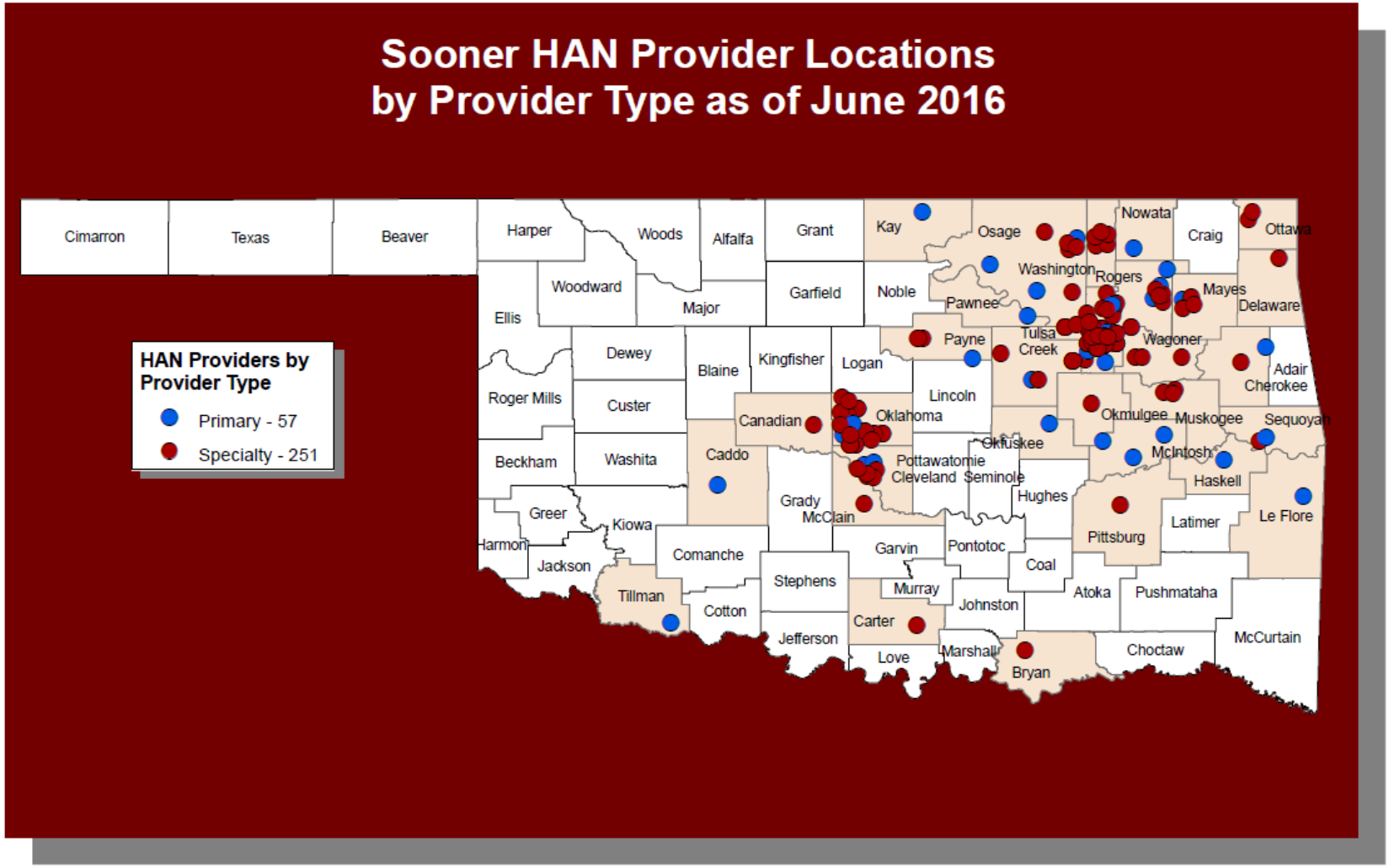
Specialty Care Network

The Sooner HAN continues to focus on the recruitment of specialty providers for enrollment into the Sooner HAN. Targeted recruitment in the Oklahoma City and Tulsa areas will continue throughout FY 2017. As of June 2016, the Sooner HAN had 251 clinics actively enrolled and using the Sooner HAN's electronic care transitions system, Doc2Doc. This use of Doc2Doc provides Sooner HAN members' access to the following 309 specialty types.

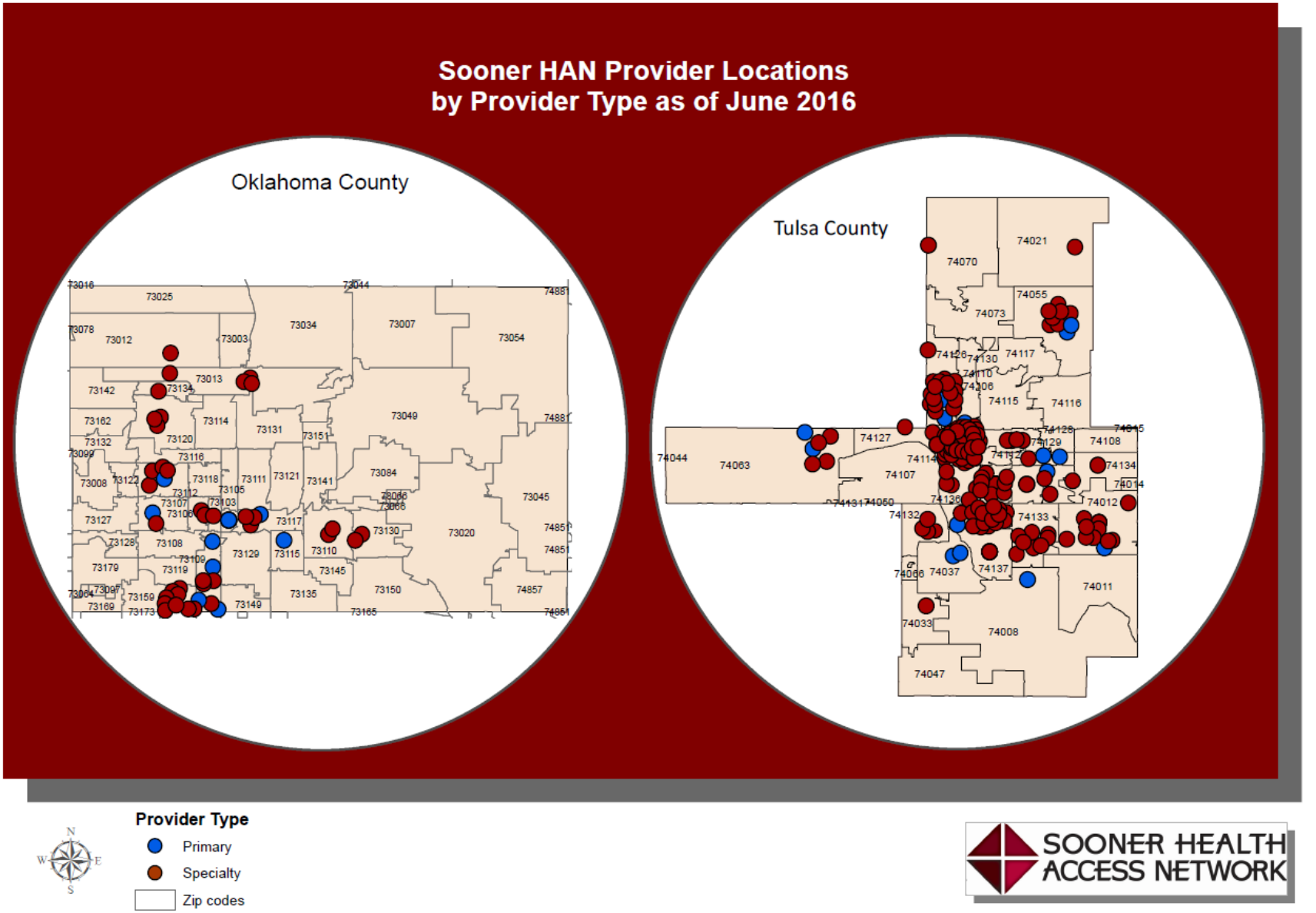
Sooner HAN Specialty Network: Number of Clinics per Specialty			
Specialty	***# Clinics***	***Specialty***	***# Clinics***
Adolescent Medicine: Pediatrics	2	Neurology	2
Allergy & Immunology	5	Neurosurgery	6
Audiology	5	Nutrition/Dietary Counseling	4
Audiology: Pediatrics	4	Ophthalmology	3
Behavioral Health	8	Optometry	4
Behavioral Health: Pediatrics	9	Orthopedics & Sports Medicine	8
Cardiology	7	Pain Management	16
Cardiology: Pediatrics	3	Physical Medicine Rehabilitation	6
Coumadin Clinic	2	Physical Therapy	52
Dermatology	3	Speech Therapy	16
Ear Nose and Throat	11	Occupational Therapy	24
Endocrinology & Diabetes	1	Podiatry	10
Gastroenterology	11	Psychiatry	3
Gastroenterology: Pediatrics	1	Pulmonary/Critical Care/Sleep	21
Home Health	8	Surgery	3
Imaging/Radiology Centers	37	Urology	3
Nephrology	2	Urology: Pediatrics	3
Nephrology: Pediatrics	2	Women's Health	4
		TOTAL	**309**



The maps on the next two pages indicate the locations of the Sooner HAN participating providers. The map highlights each primary and specialty care clinic location.



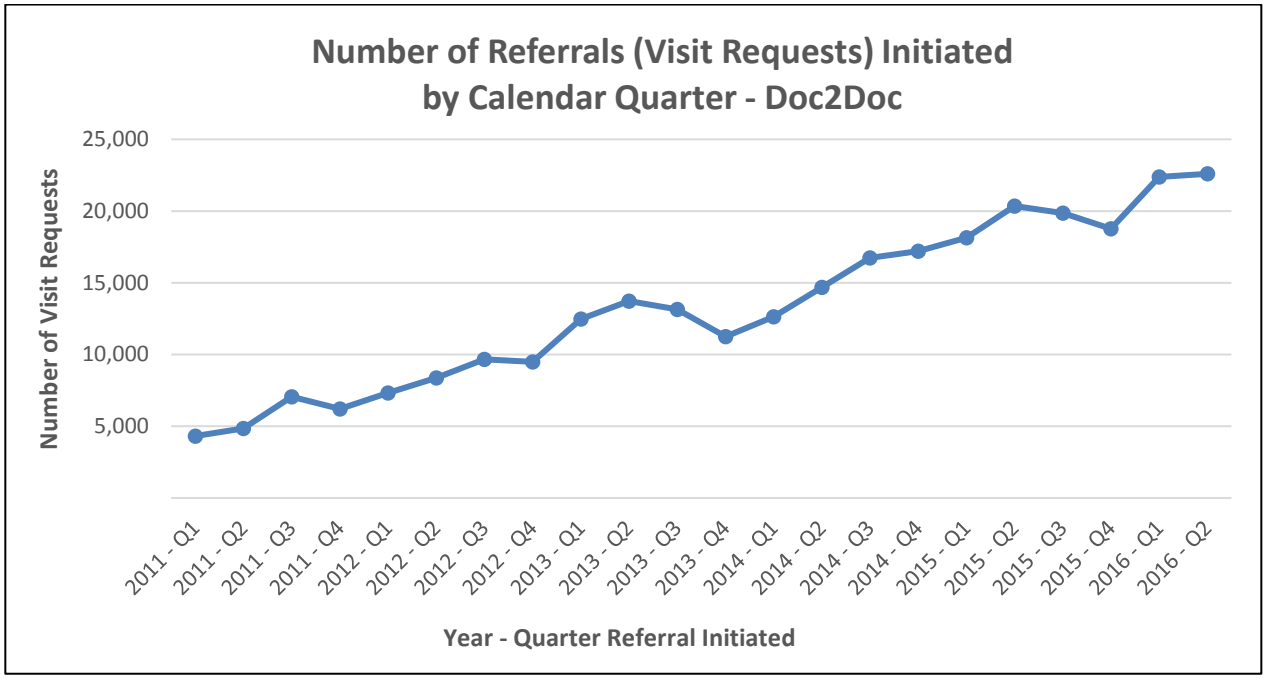
SOONER HEALTH ACCESS NETWORK


Sooner HAN Provider Locations
by Provider Type as of June 2016
Oklahoma County
Tulsa County
Provider Type
Primary
Specialty
Zip codes
SOONER HEALTH ACCESS NETWORK

Transitions of Care and Referral Management

The adoption of the electronic referral management tool, Doc2Doc, continued to grow over FY 2016. In particular, interest has heightened in the Oklahoma City area, as well as southeast Oklahoma. Currently, the Doc2Doc team is especially focused on increasing access to specialty care in Oklahoma's rural areas through the use of Doc2Doc. The interface between Doc2Doc and the OHCA secure portal has generated additional interest in the use of the Doc2Doc tool. The Sooner HAN is currently working with the Doc2Doc vendor to be able to produce reports that will fulfill Meaningful Use Stage 2 requirements regarding transitions of care documents. The Sooner HAN continues to coordinate with MyHealth, a Health Information Exchange in Oklahoma, regarding expanded offerings of the Doc2Doc tool to attract new participating providers.

The following chart shows the number of referrals (visit requests) initiated by calendar quarter since 2011. There continues to be a steady increase in the number of referrals. In the first quarter of 2011, 4.317 referrals were initiated. In comparison, during the second quarter of 2016, 22,595 referrals were initiated in the Doc2Doc system. This represents an increase of 423% over 5 years.



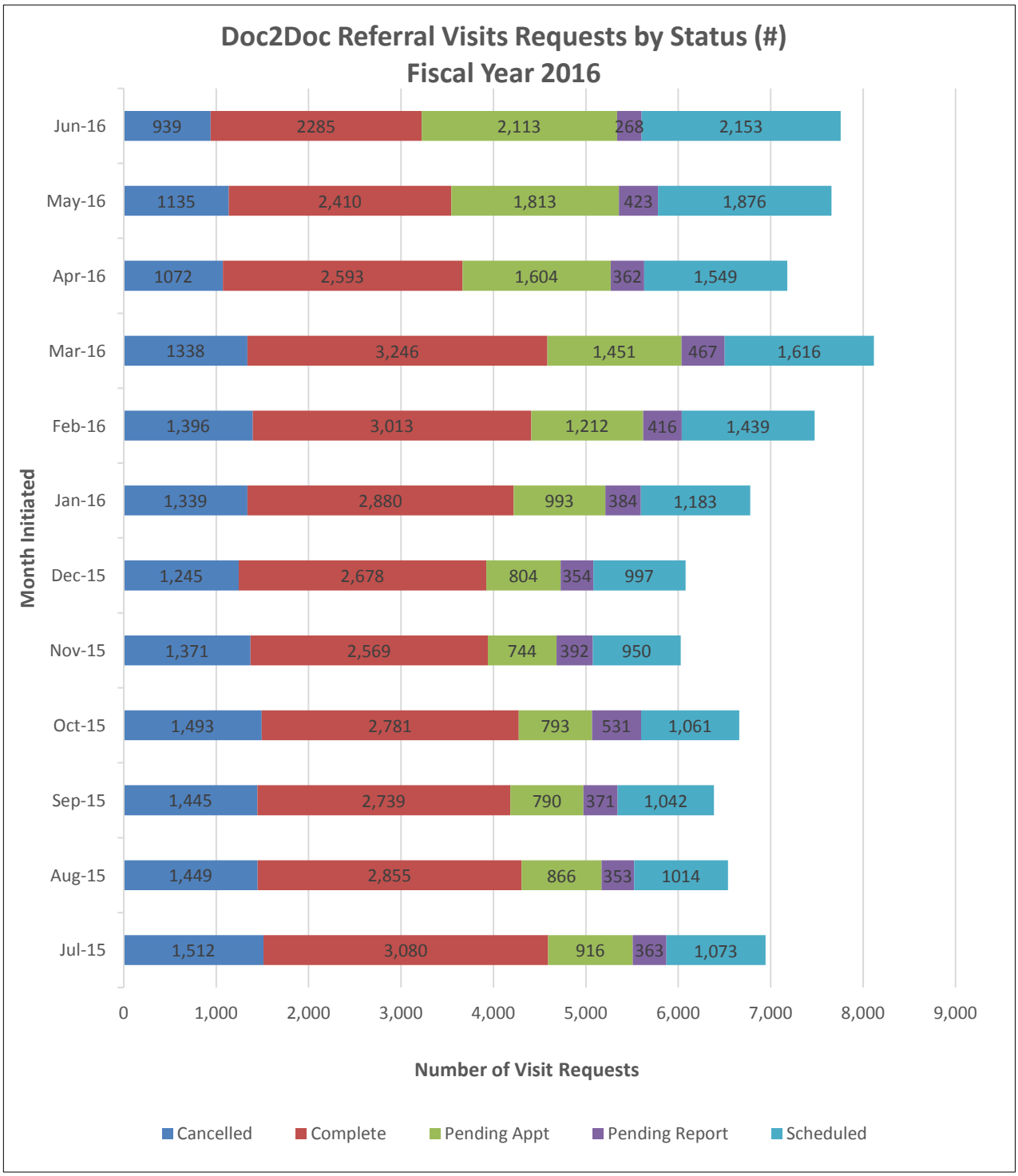
The Sooner HAN Doc2Doc collaborated with OHCA, MyHealth, and MedUnison (Doc2Doc parent company) in the development of an interface between the Doc2Doc tool and the OHCA Provider Portal to integrate the OHCA prior authorization process directly into the Doc2Doc. The interface became operational in March 2016 and was fully implemented in May 2016. The feedback from referral staff using Doc2Doc has generally been positive toward the interface, specifically in the area of increased efficiency in their individual workflows and more timely patient appointments.

The table below outlines the total number of visit requests in Doc2Doc and a breakdown of the statuses of these requests at the conclusion of June 2016.

Sooner HAN Doc2Doc Visit Requests by Status (Number)												
	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Cancelled	1,512	1,449	1,445	1,493	1,371	1,245	1,339	1,396	1338	1072	1135	939
%	22%	22%	23%	22%	23%	20%	20%	19%	16%	15%	15%	12%
Complete	3,080	2,855	2,739	2,781	2,569	2,678	2,880	3,013	3,246	2,593	2,410	2285
%	44%	44%	43%	42%	43%	44%	42%	40%	40%	36%	31%	29%
Pending Appointment	916	866	790	793	744	804	993	1,212	1,451	1,604	1,813	2,113
%	13%	13%	12%	12%	12%	13%	15%	16%	18%	22%	24%	27%
Pending Report	363	353	371	531	392	354	384	416	467	362	423	268
%	5%	5%	6%	8%	7%	6%	6%	6%	6%	5%	6%	3%
Scheduled	1,073	1014	1,042	1,061	950	997	1,183	1,439	1,616	1,549	1,876	2,153
%	15%	16%	16%	16%	16%	16%	17%	19%	20%	22%	25%	28%
Grand Total	6,944	6,537	6,387	6,659	6,026	6,078	6,779	7,476	8,118	7,180	7,657	7,758

In FY 2016, enhanced Doc2Doc training aimed at helping clinics improve referral loop closure included interpreting automated weekly and monthly reports to referral managers, understanding current and upcoming meaningful use requirements, and one-on-one coordinator training to increase workflow efficiency. Efforts were targeted to both primary and specialty care offices to achieve optimal results. As of the submission of this report (9/2016), 85% of referrals initiated in FY 2016 were cancelled, scheduled, or completed, with daily efforts continuing to complete any referrals with which the referral loop has not been completed.

The following graph shows the status of visit requests over time. Ideally, the goal is to see referrals initiated in the past moving to red, i.e., complete. The dark blue represent referrals that have been cancelled. Referrals are cancelled for various reasons including, but not limited to, member requested cancellation or duplicate referral in the system. A reason for cancellation is required to be entered by the referral clerk.



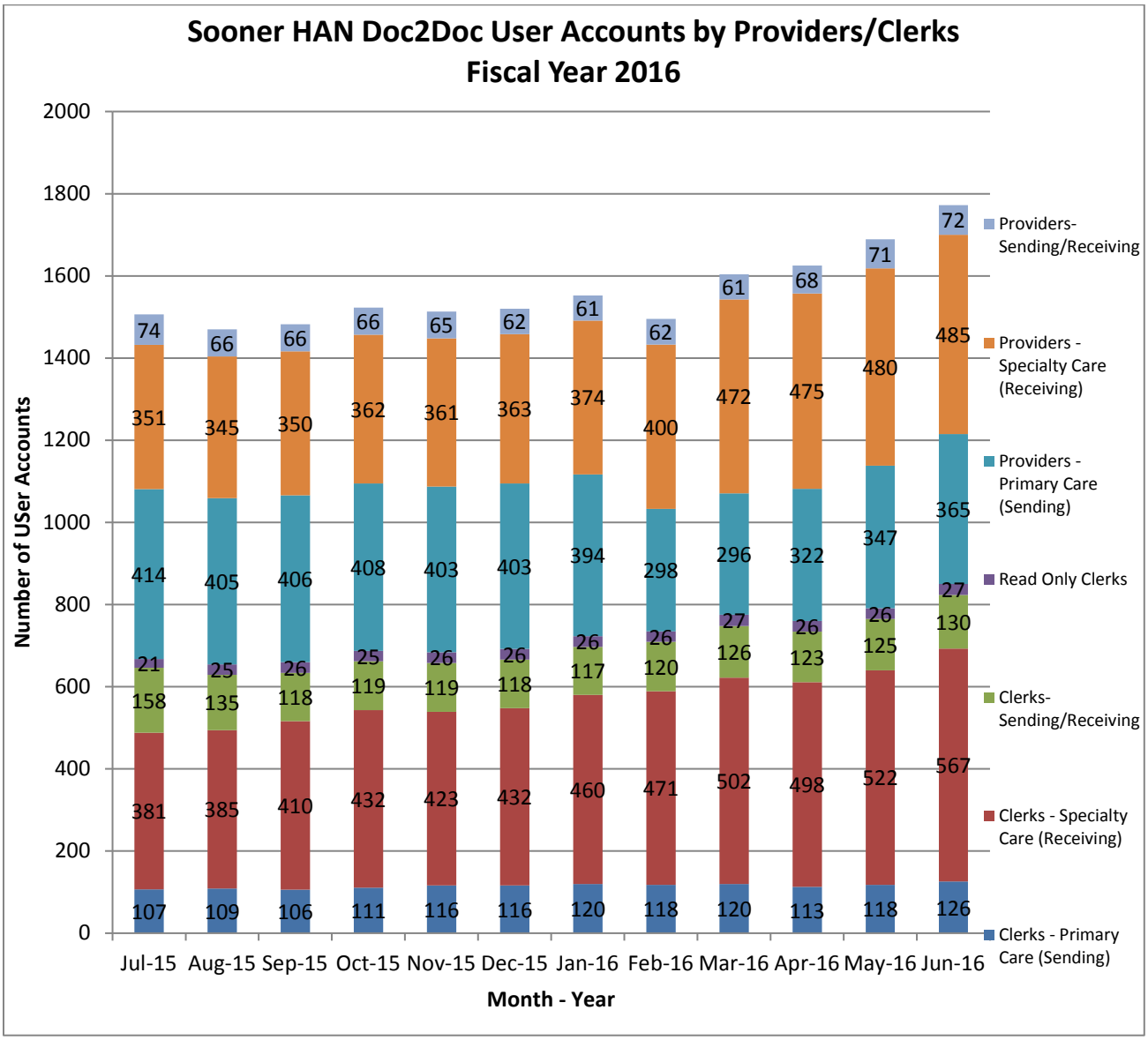
Transitions of Care and Referral Management User Accounts

In FY 2016, the Doc2Doc team observed growth in the number of specialty practices adopting the technology to enhance patient access to care. As a result, over 100 new specialty care providers began using Doc2Doc in FY 2016. Additionally, specialty practices explored new workflows that would allow them to better serve the member, as well as improve their own internal processes. Specialty Clerks were added to the system for the purpose of updating the referral status throughout the process, as well as to perform tasks such as order retrieval that would reduce the number of rescheduled appointments.

Also, three primary care practices implemented the use of Doc2Doc into their clinic workflows in FY 2016, with a total of 7 locations now utilizing the referral management tool. Their onboarding decision was the result of the availability of the OHCA interface and enhancements made to the system to allow for optimal workflows. The Doc2Doc team also performed a database clean up during FY 2016, reconciling and updating inactive accounts. This resulted in a drop in primary care providers midway in the fiscal year, most of whom were residents/students who had graduated. With the recruitment of primary care practices and incoming residents/students, the count of active providers is trending upward.

The following table and graph shows the number of Doc2Doc user accounts by Provider/Clerk Accounts.

Sooner HAN Doc2Doc User Accounts Fiscal Year 2016												
	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Clerks - Primary Care (Sending)	107	109	106	111	116	116	120	118	120	113	118	126
Clerks - Specialty Care (Receiving)	381	385	410	432	423	432	460	471	502	498	522	567
Clerks-Sending/Receiving	158	135	118	119	119	118	117	120	126	123	125	130
Read Only Clerks	21	25	26	25	26	26	26	26	27	26	26	27
Providers - Primary Care (Sending)	414	405	406	408	403	403	394	298	296	322	347	365
Providers - Specialty Care (Receiving)	351	345	350	362	361	363	374	400	472	475	480	485
Providers- Sending/Receiving	74	66	66	66	65	62	61	62	61	68	71	72
Total System Users	**1506**	**1470**	**1482**	**1523**	**1513**	**1520**	**1552**	**1495**	**1604**	**1625**	**1689**	**1772**

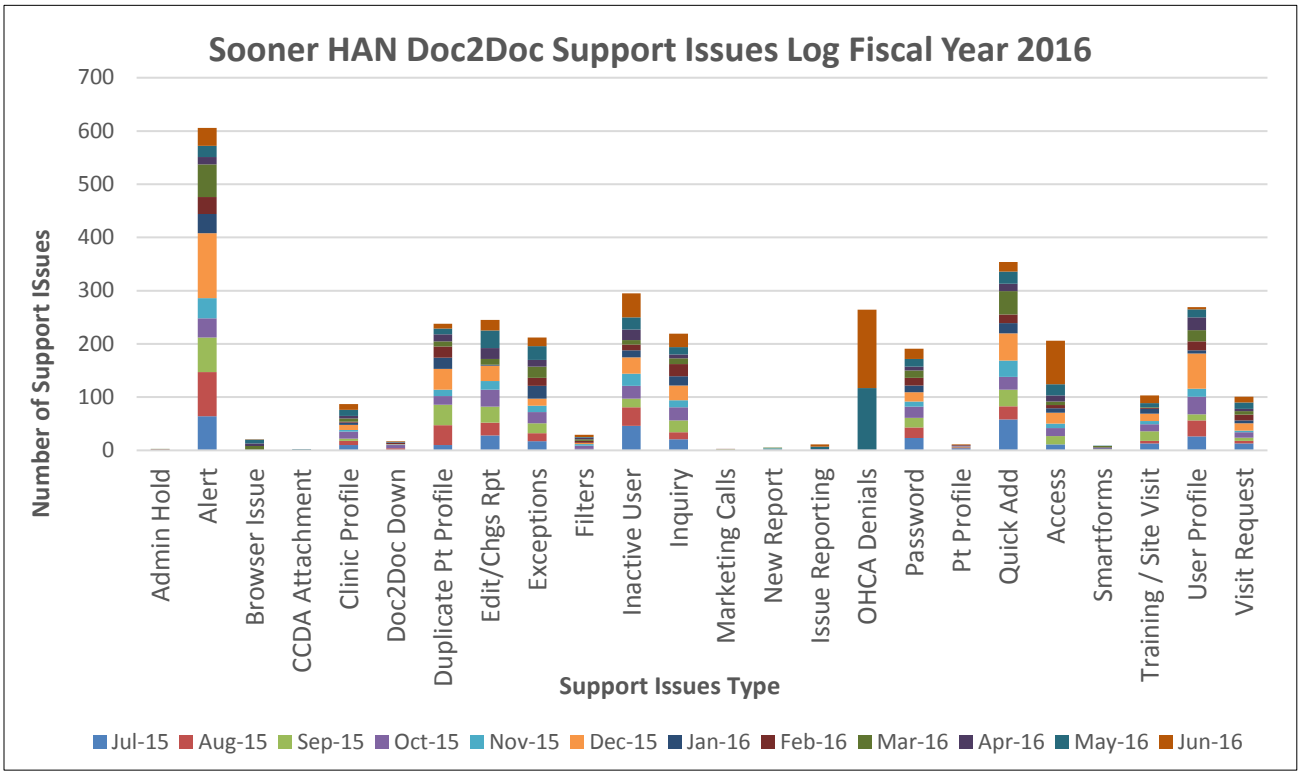

Sooner HAN Doc2Doc User Accounts by Providers/Clerks
Fiscal Year 2016
Number of USer Accounts
2000
1800
1600
1400
1200
1000
800
600
400
200
0
Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16
Month - Year
74 66 66 66 65 62 61 62 61 68 71 72
351 345 350 362 361 363 374 400 472 475 480 485
414 405 406 408 403 403 394 298 296 322 347 365
21 25 26 25 26 26 26 26 27 26 26 27
158 135 118 119 119 118 117 120 126 123 125 130
381 385 410 432 423 432 460 471 502 498 522 567
107 109 106 111 116 116 120 118 120 113 118 126
Providers- Sending/Receiving
Providers - Specialty Care (Receiving)
Providers - Primary Care (Sending)
Read Only Clerks
Clerks- Sending/Receiving
Clerks - Specialty Care (Receiving)
Clerks - Primary Care (Sending)

Transitions of Care and Referral Management User Support Issues

The Sooner HAN provides user support for the Doc2Doc referral management tool via telephonic support, email support, and remote online support. Additionally, the team provides interface support for EMR and OHCA interfaces. Support is available Monday-Friday 7 am to 7 pm.

The following table and graph shows the number of Doc2Doc user support issues logged by month in Fiscal Year 2016.

Sooner HAN Doc2Doc Support Issues Log Fiscal Year 2016													
	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	TOTAL
Admin Hold	0	0	0	0	0	1	0	1	1	0	0	0	3
Alert	64	83	65	36	38	122	36	32	61	14	21	34	606
Browser Issue	0	0	0	0	0	0	0	0	8	5	7	1	21
CCDA Attachment	0	0	0	0	0	0	0	0	0	0	2	0	2
Clinic Profile	10	8	4	13	3	10	4	2	6	5	11	11	87
Doc2Doc Down	0	4	0	6	1	1	0	2	0	1	1	1	17
Duplicate Pt Profile	10	37	39	16	12	39	21	21	10	13	11	9	238
Edit/Changes Report	28	24	30	32	16	29	2	0	11	20	33	20	245
Exceptions	17	15	19	21	12	13	24	15	21	13	26	16	212
Filters	2	1	0	6	3	2	0	4	3	3	1	4	29
Inactive User	46	35	16	24	23	31	13	11	8	20	23	45	295
Inquiry	21	13	22	25	13	28	17	23	11	7	14	25	219
Marketing Calls	0	1	1	0	0	0	0	1	0	0	0	0	3
New Report	2	0	1	0	1	0	0	0	1	0	0	0	5
Issue Reporting	0	0	0	2	0	0	0	0	0	0	5	4	11
OHCA Denials	0	0	0	0	0	0	0	0	0	0	117	147	264
Password	23	20	18	21	10	17	13	14	14	7	15	19	191
Pt Profile	4	2	1	1	0	0	1	1	0	0	0	1	11
Quick Add	58	25	31	24	31	51	19	16	44	14	23	18	354
Access	11	0	16	15	8	21	8	6	7	11	21	82	206
Smartforms	1	0	1	2	0	0	1	1	2	0	1	0	9
Training / Site Visit	13	5	18	13	6	14	9	2	1	0	8	14	103
User Profile	26	30	12	33	15	66	6	17	21	24	15	4	269
Visit Request	13	5	6	10	3	14	5	11	7	4	12	11	101
Total Number of Issues	349	308	300	300	195	459	179	180	237	161	367	466	3501

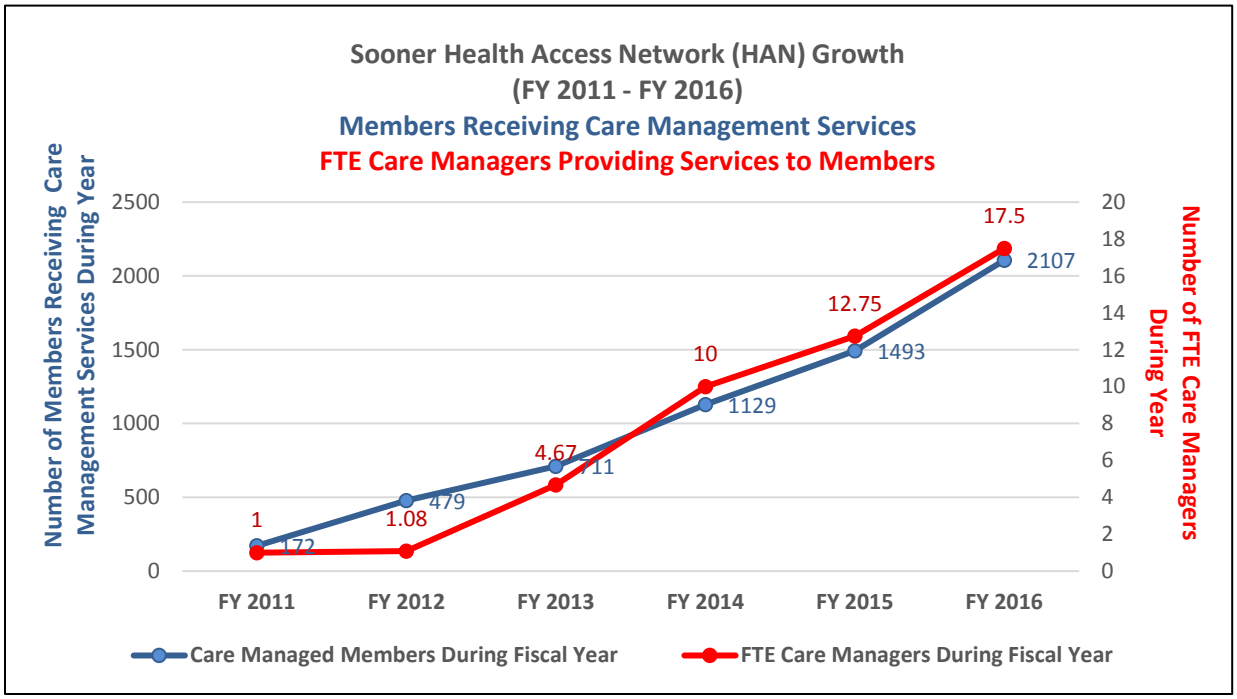


Additionally, the Doc2Doc support team is providing assistance to the Sooner HAN primary care practices by offering assistance in following up on referrals in a pending status. This includes reviewing the EMR record for consultation reports, contacting specialty practices to obtain reports, and updating the referral status to indicate closure. The team communicates with the practice regarding any referrals that require additional processing via Doc2Doc communication tools. This effort has resulted in completing closure of an additional 3317 referrals during the final three months of FY 2016. This project will continue to complete closure on an additional 6100 referrals in FY 2017.

Care Management

Each fiscal year, the Sooner HAN has continued to expand its care management services to SoonerCare Choice members. The number of unique members served has grown from 479 in FY 2012 to 2107 in FY 2016, representing a 340% increase over 5 years. From FY 2015 to FY 2016, members receiving care management services increased from 1493 to 2107, a 41% increase. Likewise, additional care managers were hired in FY 2016 to support the growth in care managed members as shown in the two graphs below.

Each fiscal year the Sooner HAN has continued to expand its care management services to SoonerCare Choice members. The number of unique members served has grown from 479 in FY 2012 to 2107 in FY 2016, representing a 340% increase over 5 years. From FY 2015 to FY 2016, members receiving care management services increased from 1493 to 2107, a 41% increase. To support the growth in membership, additional care managers were hired as needed. During FY 2011, one care manager (1 FTE) served 172 care managed members and in FY 2016, a total of 17.5 FTE care managers served 2107 members.



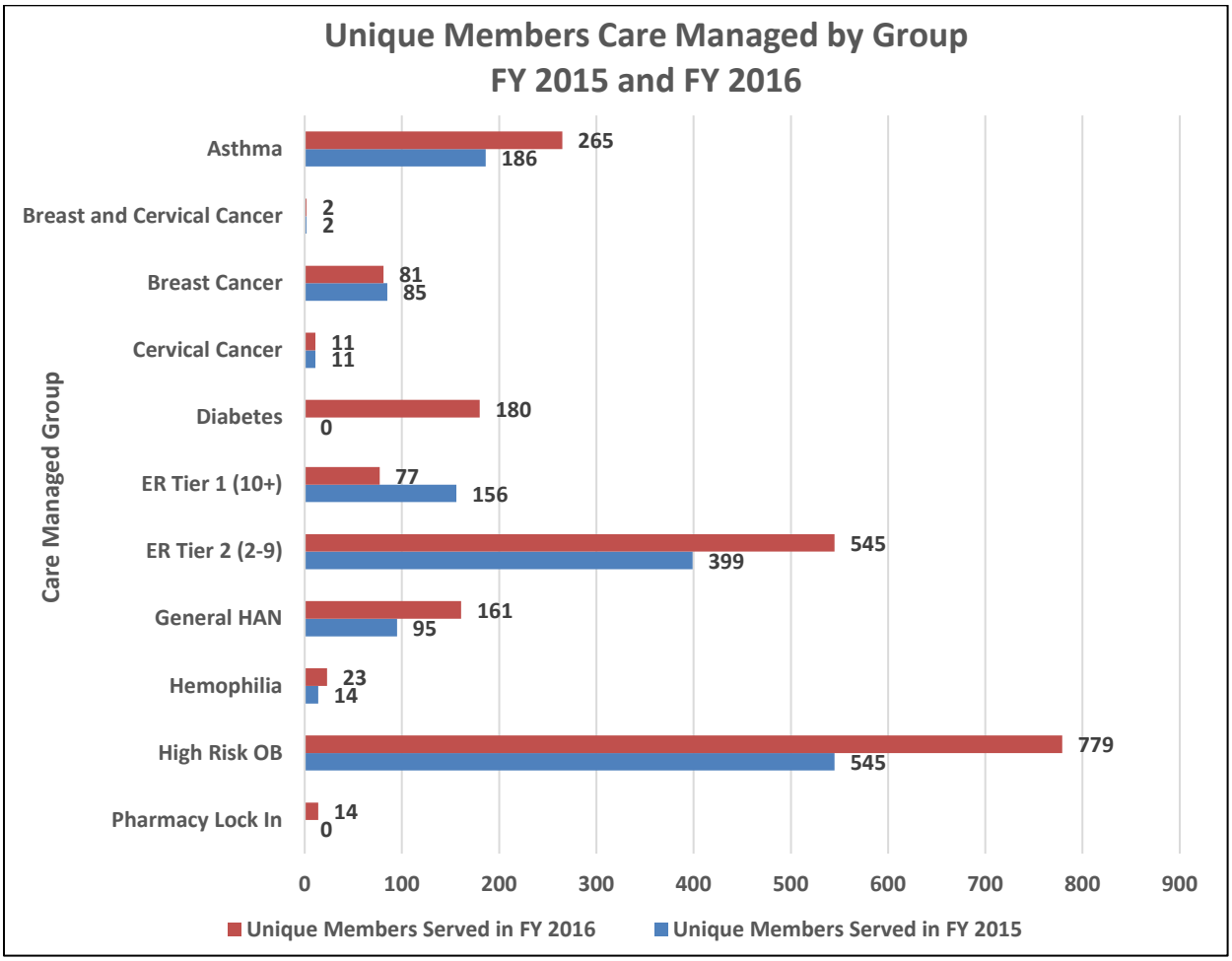
Expanding the reach of care management services to SoonerCare Choice members continues to be a primary focus within the Sooner HAN. At the end of FY 2016 the Sooner HAN had 14 registered nurse care managers, and 5 master's prepared licensed clinical social workers (one of whom is bilingual in Spanish and English). One of the registered nurse care managers is bilingual (in Spanish and English) and is a certified diabetes educator. Engagement of members continues to be one of the main care management challenges—both related to initial contact and ongoing activities.

As a result of recognizing the impact and importance of behavioral health for members with complex medical and social needs, in FY 2016, the Sooner HAN increased screening for depression beyond the Edinburgh Postnatal Depression Scale screenings that were associated with the targeted HROB group. The Sooner HAN chose to use the PHQ9 screening for all members in the HROB and Diabetes care groups as well as for members in other care groups that may benefit from depression screening.

Last year, the Sooner HAN added robust educational opportunities for providers and care managers around behavioral health. This year, the focus was specifically on introducing trauma informed approach to care managers. The results of the Adverse Childhood Events study clearly identified the impact of traumatic events in childhood on a person's health in adulthood. It also identified the need for the health care community to provide services in a different way to people who have experienced trauma. Service providers who are not trauma informed often misinterpret signs and symptoms, have unrealistic behavioral expectations, and thereby inadvertently re-traumatize individuals they serve with labels like "difficult" and "non-compliant". The Sooner HAN created a learning module to provide care managers with the knowledge they would need to provide services with a trauma informed approach. The care managers now have a general understanding of the body's response to stress, how to recognize common traumatic events, the impact of trauma on a person's health and well-being, and the principles of a trauma informed approach.

The table and graph below show a summary of the number of unique members served by care managed category for FY 2015 compared to FY 2016.

Sooner HAN Care Management				
Care Managed Category	**Unique Members Served FY 2015**	**Unique Members Served FY 2016**	**# Increase/ Decrease**	**% Change**
Asthma	186	265	79	42%
Breast Cancer	85	81	-4	-5%
Breast and Cervical Cancer	2	2	0	0
Cervical Cancer	11	11	0	0
Diabetes	0	180	180	
ER Tier 1 (10+)	156	77	-79	-51%
ER Tier 2 (2-9)	399	545	146	37%
General HAN	95	161	66	69%
Hemophilia	14	23	9	64%
High Risk OB	545	779	234	43%
Pharmacy Lock In	0	14	14	
Total	**1,493**	**2,107**	614	41%


Unique Members Care Managed by Group
FY 2015 and FY 2016
Care Managed Group
Asthma
Breast and Cervical Cancer
Breast Cancer
Cervical Cancer
Diabetes
ER Tier 1 (10+)
ER Tier 2 (2-9)
General HAN
Hemophilia
High Risk OB
Pharmacy Lock In
265
186
2
2
81
85
11
11
180
0
77
156
545
399
161
95
23
14
779
545
14
0
0
100
200
300
400
500
600
700
800
900
Unique Members Served in FY 2016
Unique Members Served in FY 2015

Contact History

In FY 2016, the Sooner HAN documented 39,050 contacts with members or on behalf of members enrolled in care management. Successful contacts with member accounted for 21% of all contacts. Twenty eight percent (28%) of attempted contacts with members were unsuccessful due to inability to make contact with the member. Contacts with others involved in the members care included specialists, primary care providers, family members, case workers, pharmacies, clinics, hospitals, nurses, DHS, OHCA, and others, representing 51% percent of contact attempts. The distribution of contact attempts are highlighted below.

Sooner HAN Care Management					
Successful Contacts with Members		**Unsuccessful Contacts with Members**		**Contacts with Others Regarding Member's Care**	
Telephone	6,983	Call Disconnected	106	Telephone	4,736
In Person	966	In Person – No Show	163	In Person	306
Other: Fax, Email, Page	315	Left Message w Person	131	Call Disconnected	89
TOTAL	**8,264**	Left Voice Message	6,238	In Person – No Show	7
		None – No Answer	1,286	Left Message w Person	317
		None – Not Accepting Calls	734	Left Voice Message	1,807
		None – Not in Service	1,267	None – No Answer	323
		None – Wrong Number	156	None – Not Accepting Calls	179
		Posted Mail	751	None – Not in Service	161
		TOTAL	**10,832**	None – Wrong Number	112
				Posted Mail	105
				Case Staffing	260
				Chart Review	8,962
				Team Collaboration	209
				Other: Fax, Email, Page	2,381
				TOTAL	**19,954**
				TOTAL CONTACTS (WITH OR ON BEHALF OF MEMBERS)	**39,050**

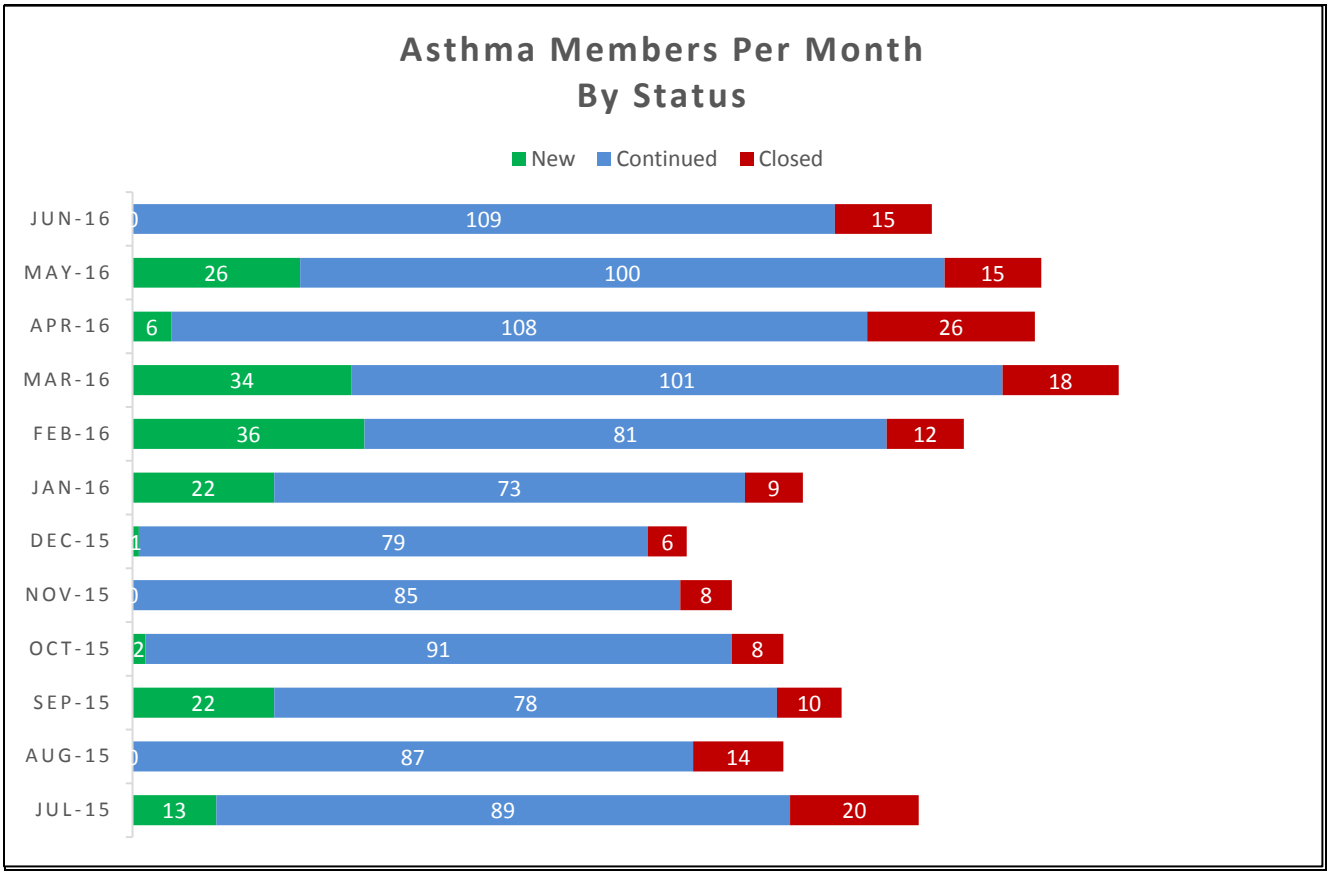
Care Management Targeted Populations

Asthma

The Sooner HAN initiated an asthma specific care management protocol in FY 2014 to assist members who have uncontrolled asthma, as defined by evidence based guidelines, move to controlled status. Members were identified based on having one or more asthma related ER visits or inpatient stays. In FY 2016, 265 members were care managed.

Total Members in Care Management

Summary - Asthma Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	13	0	22	2	0	1	22	36	34	6	26	0
Continued	89	87	78	91	85	79	73	81	101	108	100	109
Closed	20	14	10	8	8	6	9	12	18	26	15	15
New/Closed (in same month)	1	0	1	0	0	0	2	0	2	1	2	0
TOTAL	**121**	**101**	**109**	**101**	**93**	**86**	**102**	**129**	**151**	**139**	**138**	**124**



Closure Reasons and Length of Time in Care Management

Asthma Care Managed Members Continued		
Element	**Total**	
Unique members served throughout the year	265	
Total New Cases	162	
Total Closed Cases	161	
Reasons for Closure	# of Cases	% of Total Cases Closed
Closed in Error	1	1%
Death	1	1%
Health Home	1	1%
Managed by HMP	2	1%
Meets Asthma Closure Criteria	2	1%
Opened in Error	4	2%
Program Ineligibility - Financial	2	1%
Program Ineligibility - Medicare	1	1%
Program Ineligibility - Moved out of state	5	3%
Program Ineligibility - Non HAN PCP	13	8%
Program Ineligibility - Unknown	34	21%
Reopening as General HAN	1	1%
Unable to Contact	70	43%
Voluntary Withdrawal	24	15%
TOTAL	**161**	**100%**

Length of time in Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
0 to 5 weeks	28	17%	0	0%
6 to 10 weeks	34	21%	18	17%
11 to 15 weeks	21	13%	25	23%
16 to 20 weeks	11	7%	19	17%
21 to 25 weeks	11	7%	5	5%
26 plus weeks	56	35%	42	39%
TOTAL	**161**	**100%**	**109**	**100%**

Treatment Summary

Asthma					
Controlled or Uncontrolled Asthma			***Asthma Action Plan***		
Controlled	80	49%	Yes	99	60%
Uncontrolled	70	43%	No	51	31%
Unknown	14	8%	Unknown	14	9
Medication Management – Long Term Chronic			***Medication Management – Short Term Exacerbation***		
Yes	154	94%	Yes	91	56%
No	3	2%	No	62	38%
Unknown	7	4%	Unknown	11	6%

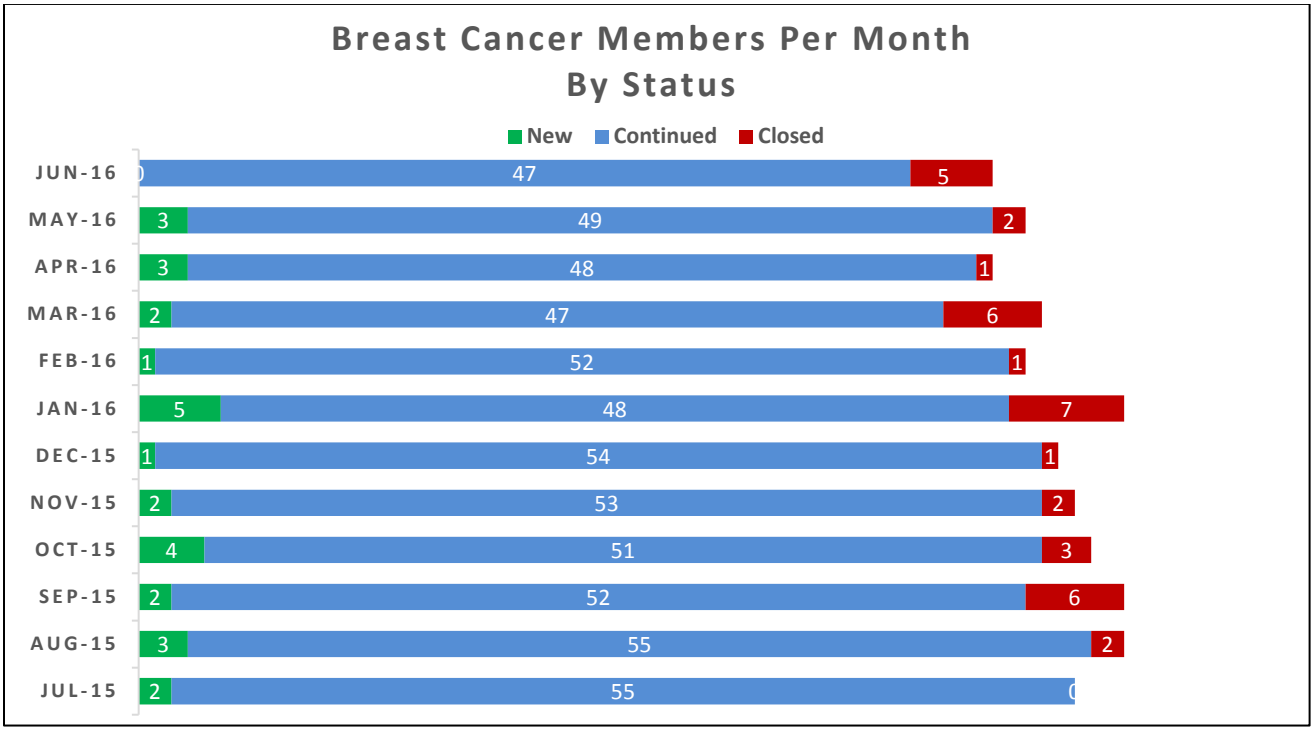
Breast and Cervical Cancer (BCC)

During FY 2016 the Sooner HAN provided care management to 94 women who had either breast cancer, cervical cancer, or both. By group: 86% of the women had breast cancer, 12% had cervical cancer, and 2% had both. The following tables provide details for this care management population.

BCC Members by Category		
Care Group		
Breast Cancer	81	86%
Cervical Cancer	11	12%
Breast and Cervical Cancer	2	2%
Total	98	100%

Total Members in Care Management – Breast Cancer

Summary – Breast Cancer Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	2	3	2	4	2	1	5	1	2	3	3	0
Continued	55	55	52	51	53	54	48	52	47	48	49	47
Closed	0	2	6	3	2	1	7	1	6	1	2	5
New/Closed (in same month)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**57**	**60**	**60**	**58**	**57**	**56**	**60**	**54**	**55**	**52**	**54**	**52**



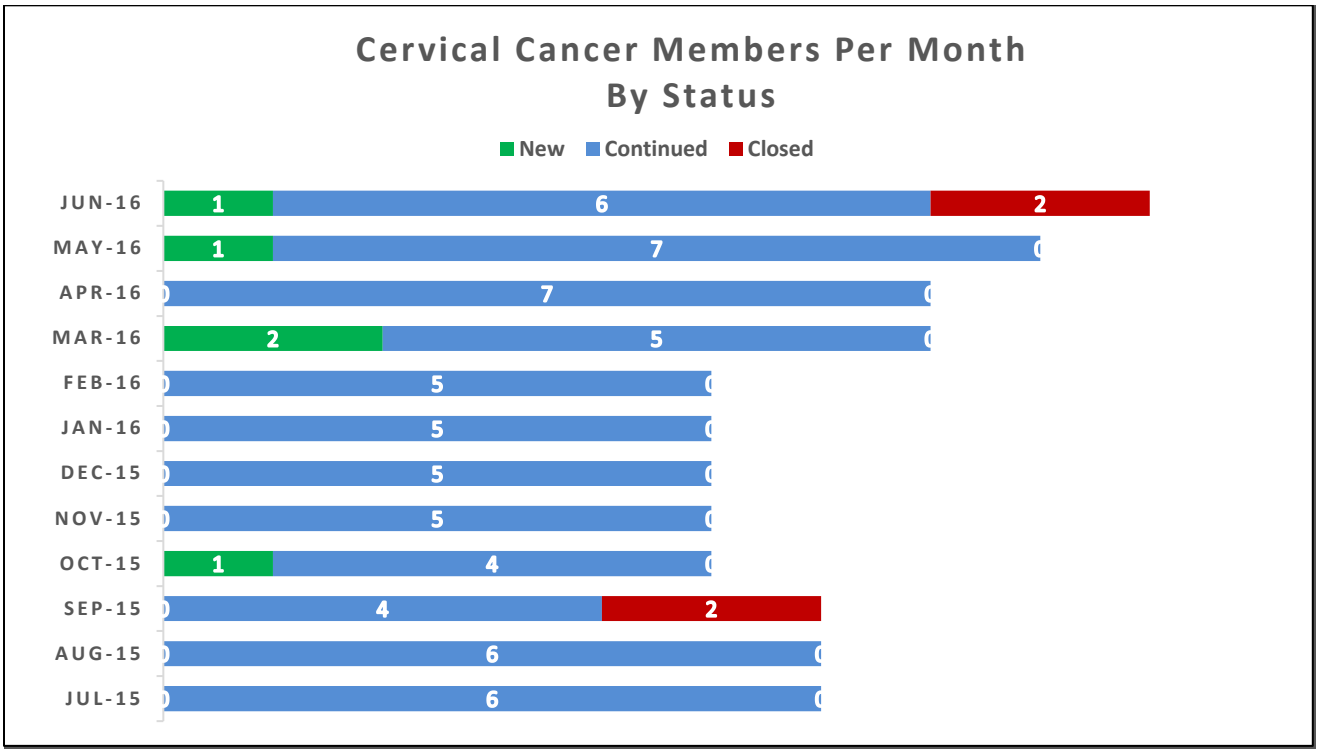
Closure Reasons and Length of Time in Care Management

The chart below highlights breast cancer members by category and case status. The reasons for case closure and length of stay on the care management program are also outlined.

Breast Cancer Care Managed Members				
Element			**Total**	
Unique members served throughout the year			81	
Total New Cases			28	
Total Closed Cases			36	
Reasons for Closure			# of Cases	% of Total Cases Closed
Death			3	8%
Health Home			1	3%
Meets ER Closure Criteria			1	3%
Opened in Error			1	3%
Program Ineligibility - Financial			1	3%
Program Ineligibility - Medicare			3	8%
Program Ineligibility - Non HAN PCP			6	17%
Program Ineligibility - Unknown			19	53%
Treatment Ended			1	3%
TOTAL			**36**	**100%**
Length of time in Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
12 months or less	19	53%	17	36%
13 to 18 months	7	19%	12	26%
19 to 24 months	5	14%	5	11%
25 to 30 months	2	6%	0	0%
31 plus months	3	8%	13	28%
TOTAL	**36**	**100%**	**47**	**100%**

Total Members in Care Management – Cervical Cancer

Summary – Cervical Cancer Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	0	0	0	1	0	0	0	0	2	0	1	1
Continued	6	6	4	4	5	5	5	5	5	7	7	6
Closed	0	0	2	0	0	0	0	0	0	0	0	2
New/Closed (in same month)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**6**	**6**	**6**	**5**	**5**	**5**	**5**	**5**	**7**	**7**	**8**	**9**



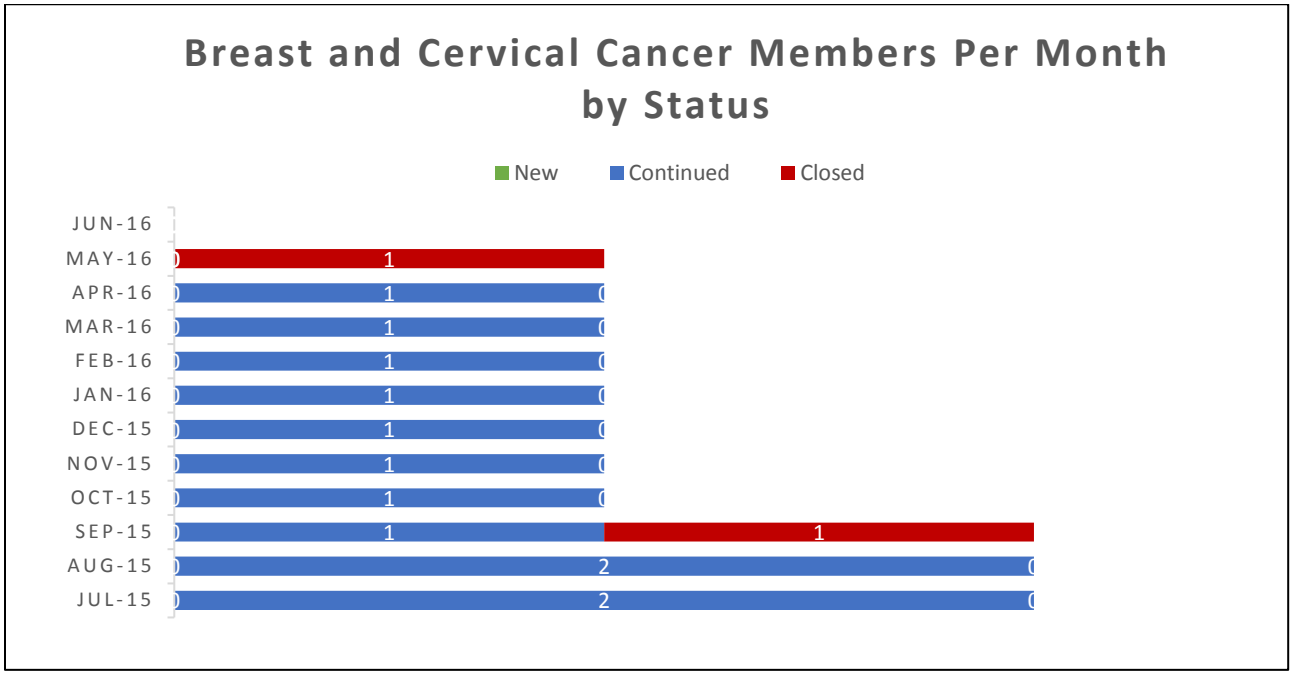
Closure Reasons and Length of Time in Care Management

The chart below highlights cervical cancer members by category and case status. The reasons for case closure and length of stay in the care management program are also outlined.

Cervical Cancer Care Managed Members				
Element			**Total**	
Unique members served throughout the year			11	
Total New Cases			5	
Total Closed Cases			4	
Reasons for Closure			# of Cases	% of Total Cases Closed
Program Ineligibility - Medicare			1	25%
Program Ineligibility - Unknown			2	50%
Treatment Ended			1	25%
TOTAL			**4**	**100%**
Length of time in Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
12 months or less	3	75%	4	57%
12 to 18 months	0	0%	2	29%
19 to 24 months	0	0%	1	14%
25 to 30 months	1	25%	0	0%
31 plus months	0	0%	0	0%
TOTAL	**4**	**100%**	**7**	**100%**

Total Members in Care Management – Both Breast Cancer and Cervical Cancer

Summary – Breast Cancer and Cervical Cancer Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	0	0	0	0	0	0	0	0	0	0	0	0
Continued	2	2	1	1	1	1	1	1	1	1	0	0
Closed	0	0	1	0	0	0	0	0	0	0	1	0
New/Closed (in same month)	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**



Closure Reasons and Length of Time in Care Management

Both Breast and Cervical Cancer Care Managed Members		
Element	**Total**	
Unique members served throughout the year	2	
Total New Cases	0	
Total Closed Cases	2	
Reasons for Closure	# of Cases	% of Total Cases Closed
Program Ineligibility - Personal Insurance	1	50%
Program Ineligibility - Unknown	1	50%
TOTAL	**2**	**100%**

Length of time in Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
12 months or less	0	0%	0	

12 to 18 months	0	0%	0	
19 to 24 months	1	50%	0	
25 to 30 months	0	0%	0	
31 plus months	1	50%	0	
TOTAL	**2**	**100%**	**0**	

Treatment Summary

This section outlines the treatment status of the BCC members during their receipt of care management services. Forty members (53%) had mastectomies and 28 (37%) members had lumpectomies as part of their treatment protocol.

# of Mastectomies		
40	53%	
Mastectomy Details		
Left	11	28%
Right	10	25%
Bilateral	16	40%
Unknown	4	8%

# of Lumpectomies		
28	37%	
Lumpectomy Details		
Left	17	63%
Right	9	33%
Bilateral	0	0%
Unknown	1	4%

Diabetes

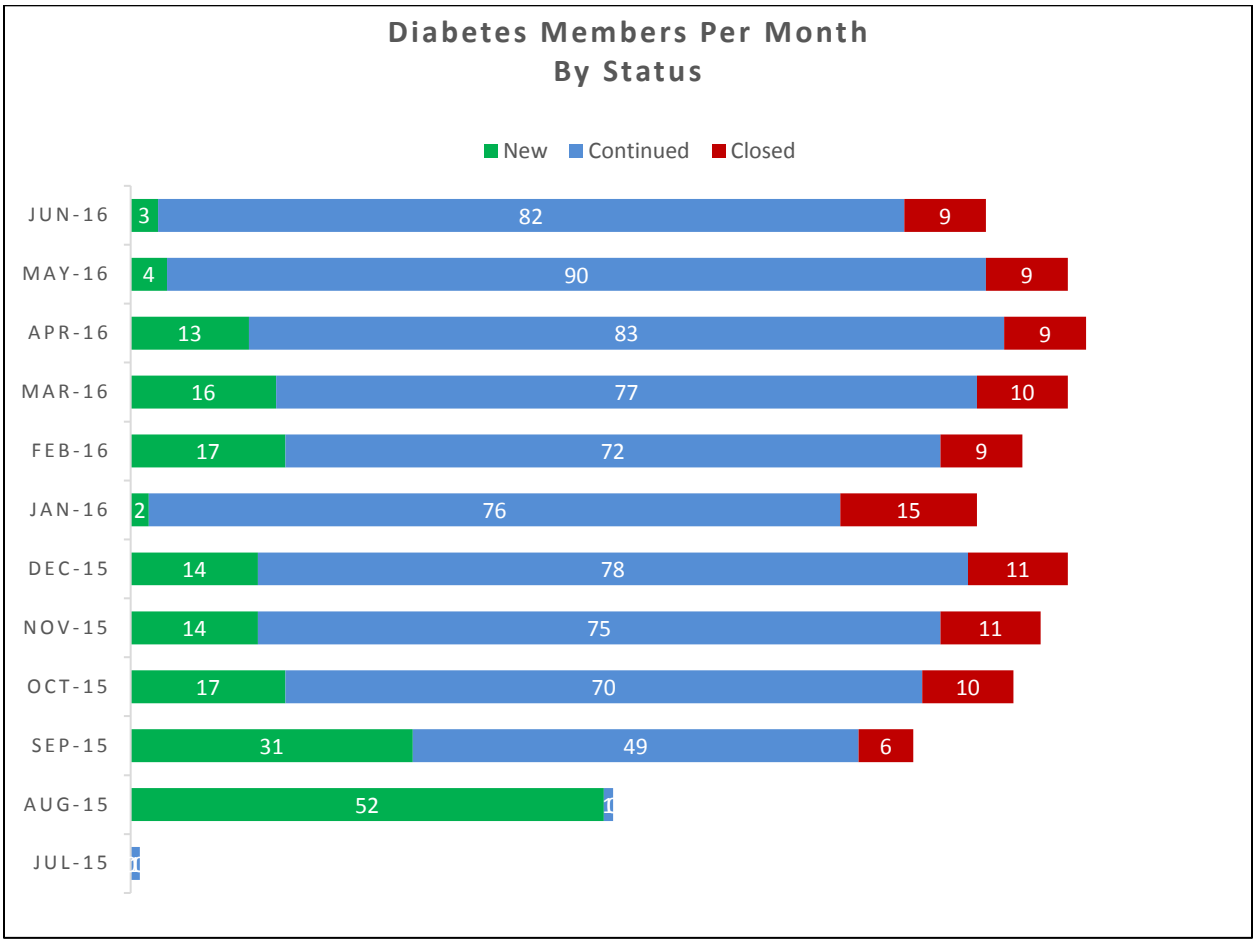
In FY 2016, the Sooner HAN was asked to participate in a project to evaluate the feasibility of implementing patient centered outcome measures (PROMs) into the current office visit workflow. The project was funded by the Patient Centered Outcomes Research Institute (PCORI), led by the National Committee of Quality Assurance (NCQA), and implemented in the OU Physician-Tulsa Internal Medicine Clinic. The Sooner HAN identified care managers to participate in the project to focus on members with diabetes who were interested in completing patient centered outcomes measures (specifically the PROMIS 29), health literacy assessment, goal setting, and diabetes self-efficacy assessment.

Patient centered outcomes approaches were implemented with 95 Sooner HAN SoonerCare Choice members with diabetes. This patient-centered approach with members and integration with the primary care providers was so successful that the Sooner HAN adopted some of the best practices and implemented in its Diabetes Management protocol for all SoonerCare Choice members receiving care management services. This project will continue in FY 2017 with completion expected by 12/31/2016. HAN care managers will continue to provide HAN care management services to these members after the NCQA PCORI project ends.

The Sooner HAN initiated a diabetes specific care management protocol in FY 2016 to assist members who have poorly managed diabetes to move to a controlled status. Members were identified based on having elevated A1C levels, emergency room visits, and hospitalizations related to diabetes and its complications. In FY 2017, members who could benefit from a diabetes specific intervention will be identified based on utilization through claims review as well as through clinical data from MyHealth, a regional Health Information Exchange. In FY 2016, 180 members were care managed.

Total Members in Care Management

Summary – Diabetes Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	0	52	31	17	14	14	2	17	16	13	4	3
Continued	1	1	49	70	75	78	76	72	77	83	90	82
Closed	0	0	6	10	11	11	15	9	10	9	9	9
New/Closed (in same month)	0	0	2	2	1	1	0	3	1	0	3	0
TOTAL	**1**	**53**	**84**	**95**	**99**	**102**	**93**	**95**	**102**	**105**	**100**	**94**



Closure Reasons and Length of Time in Care Management

Diabetes Care Managed Members Continued		
Element	**Total**	
Unique members served throughout the year	180	
Total New Cases	183	
Total Closed Cases	99	
Reasons for Closure	# of Cases	% of Total Cases Closed
Death	1	1%
Managed by HMP	1	1%
Meets Closure Criteria	1	1%
Program Ineligibility - Financial	2	2%
Program Ineligibility - Medicare	7	7%
Program Ineligibility - Non HAN PCP	2	2%
Program Ineligibility - Nursing Facility	1	1%
Program Ineligibility - Unknown	16	16%
Unable to Contact	30	30%
Voluntary Withdrawal	38	38%

TOTAL			99	100%
Length of time in Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
0 to 5 weeks	20	20%	3	4%
6 to 10 weeks	24	24%	7	8%
11 to 15 weeks	16	16%	16	19%
16 to 20 weeks	14	14%	7	8%
21 to 25 weeks	6	6%	6	7%
26 plus weeks	19	19%	46	54%
TOTAL	**99**	**100%**	**85**	**100%**

Depression Screens

The chart below highlights the administration and results of the depression screenings administered by Sooner HAN care management for members care managed for Diabetes. The Sooner HAN began administering the PHQ9 health questionnaire to members with diabetes in FY 2016.

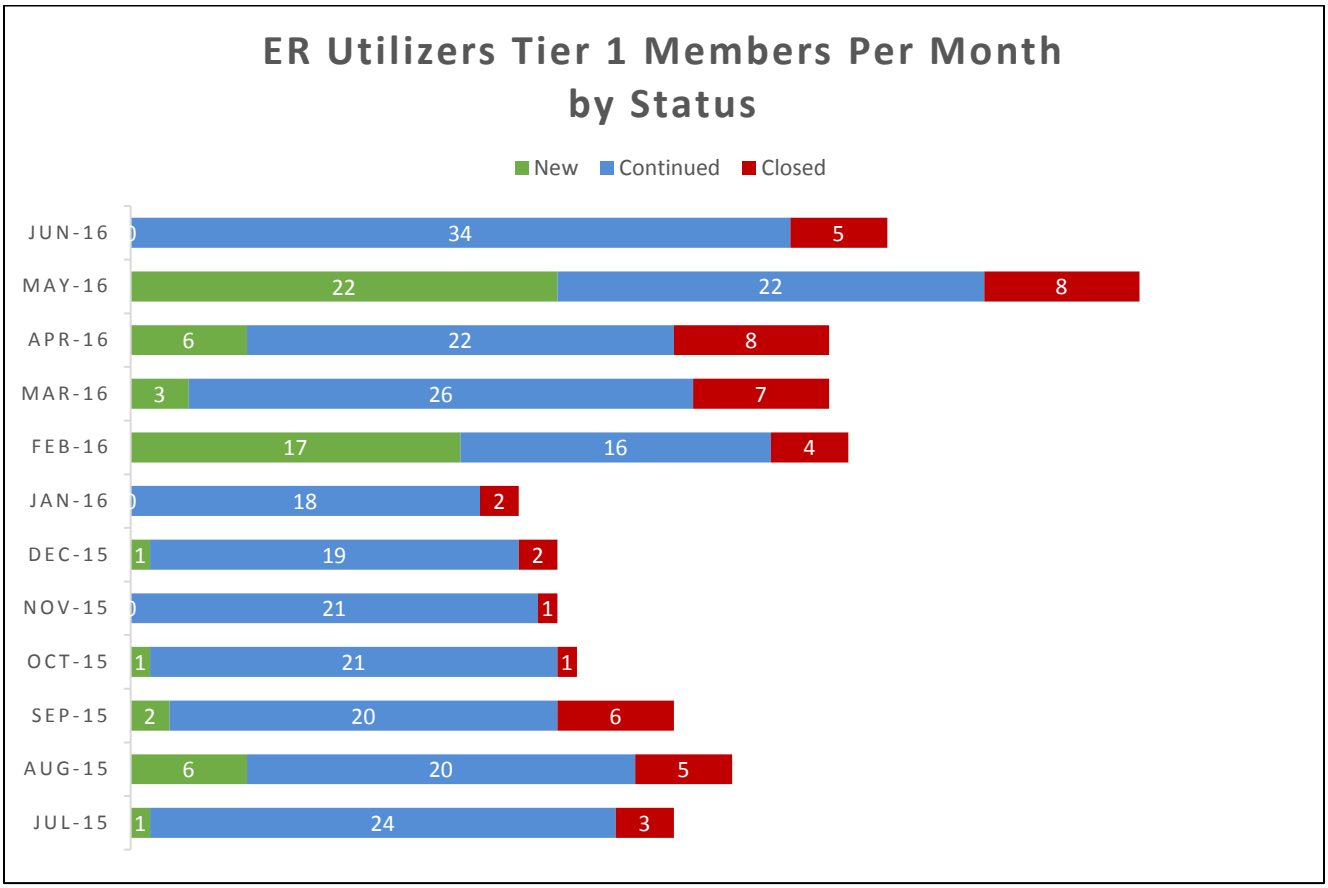
Diabetes - Depression Screens		
Depression Screens		
96%	46	Screened
5%	2	Not Screened
Reason Not Screened		
50%	1	Member does not feel depressed
50%	1	Other
Screening Results		
11%	5	Screenings requiring referral
100%	5	Members accepting BH referral
100%	5	Members keeping BH appointment

ER Tier 1 (10+ visits in 6 months)

During FY 2016, the Sooner HAN provided care management to 77 high ER Tier 1 members. These members are placed immediately into the High Touch Care Management group and receive a higher level of intervention, including home visits and more frequent care management contact than members in the Tier 2 category. The addition of the Behavioral Health Medical Director, the behavioral health case staffings, and the behavioral health lunch and learn sessions have provided a better knowledge base to the care managers to help address the complex behavioral health issues that are often seen in members with high ER utilization.

Total Members in Care Management

Summary – ER Tier 1 (10+ Visits) Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	1	6	2	1	0	1	0	17	3	6	22	0
Continued	24	20	20	21	21	19	18	16	26	22	22	34
Closed	3	5	6	1	1	2	2	4	7	8	8	5
New/Closed (in same month)	0	0	0	0	0	0	0	2	2	3	5	0
TOTAL	**28**	**31**	**28**	**23**	**22**	**22**	**20**	**35**	**34**	**33**	**47**	**39**



Closure Reasons and Length of Time in Care Management

The chart below highlights high ER use by members by case status and length of time in care management.

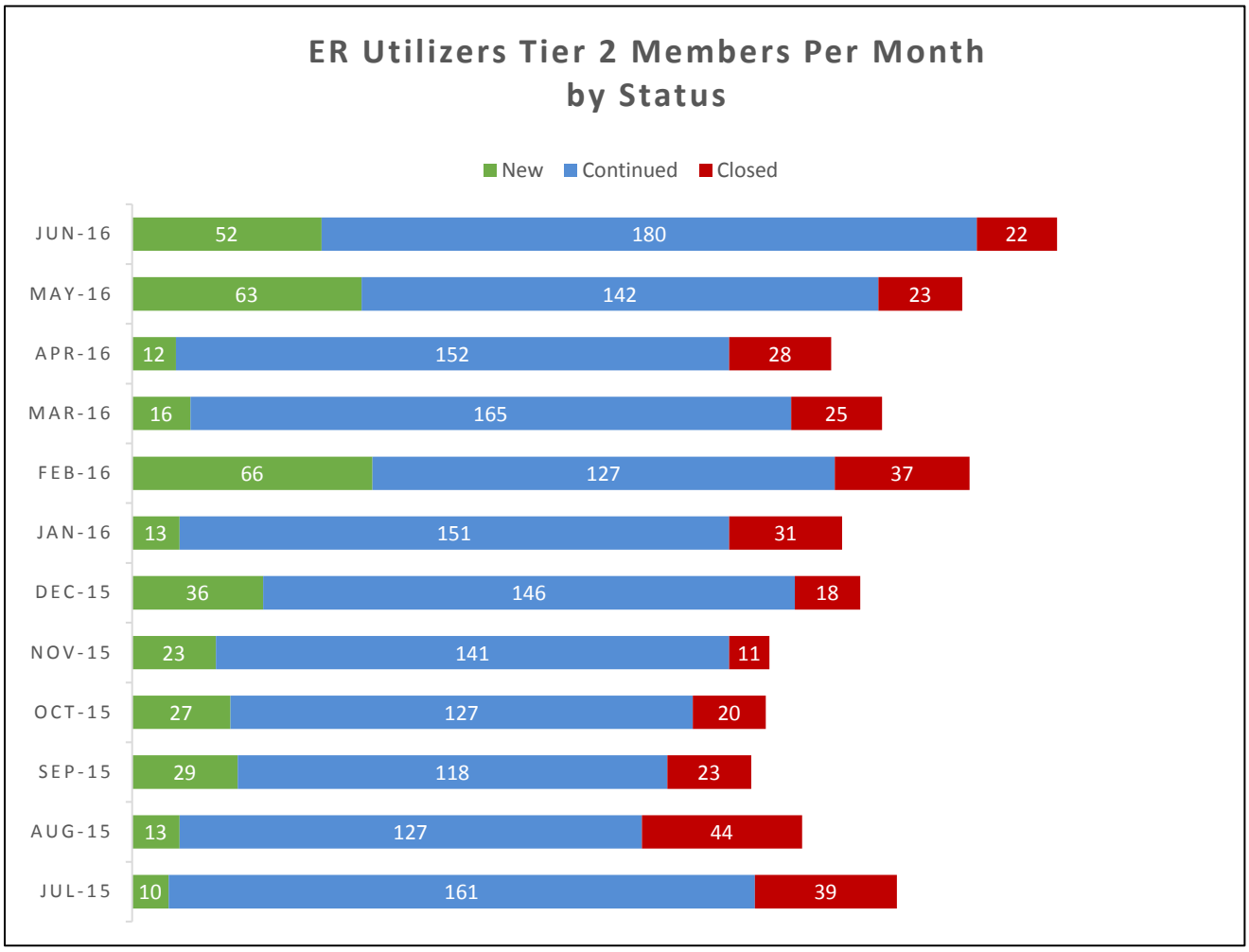
ER Tier 1 Care Managed Members Continued				
Element			**Total**	
Unique members served throughout the year			77	
Total New Cases			59	
Total Closed Cases			52	
Reasons for Closure			# of Cases	% of Total Cases Closed
Closed in Error			7	13%
Death			2	4%
Health Home			1	2%
Meets ER Closure Criteria			4	8%
Opened in Error			2	4%
Program Ineligibility - Financial			2	4%
Program Ineligibility - Moved out of state			1	2%
Program Ineligibility - Non HAN PCP			5	10%
Program Ineligibility - Unknown			3	6%
Unable to Contact			20	38%
Voluntary Withdrawal			5	10%
TOTAL			**52**	**100%**
Length of time in Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
Less than 3 months	24	46%	17	50%
4 to 6 months	7	13%	7	21%
7 to 9 months	5	10%	1	3%
0 to 12 months	5	10%	2	6%
Over 13 months	11	21%	7	21%
TOTAL	**52**	**100%**	**34**	**100%**

ER Tier 2 (2-9 visits in 6 months)

The Sooner HAN provided care management services to 545 ER Tier 2 members (2-9 ER visits in a six month period) in FY 2016. This has been a challenging care management group. Many members who have received notification that care management is available to them either do not call or tend to call outside of traditional office hours. Care managers end up spending multiple hours playing phone tag with members.

Total Members in Care Management

Summary – ER Tier 2 (2-9 Visits) Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	10	13	29	27	23	36	13	66	16	12	63	52
Continued	160	126	118	127	141	146	151	127	165	152	142	180
Closed	39	43	22	23	11	18	31	40	26	27	27	23
New/Closed (in same month)	1	0	1	4	1	1	1	4	2	0	5	2
TOTAL	208	182	168	173	174	199	194	229	205	191	227	253



Closure Reasons and Length of Time in Care Management

The chart below highlights the ER Tier 2 members by status and length of stay in care management.

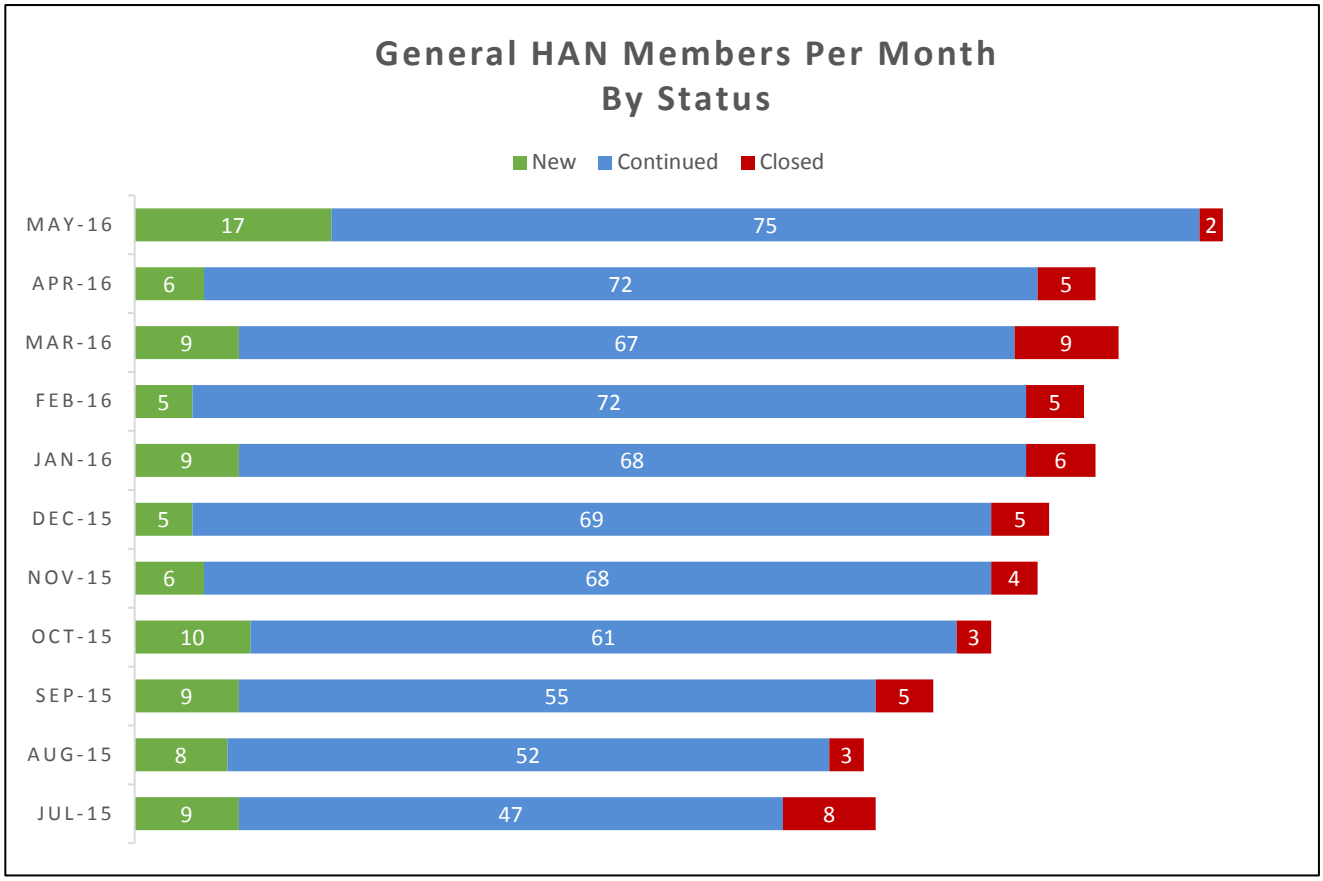
ER Tier 2 Care Managed Members Continued				
Element			**Total**	
Unique members served throughout the year			545	
Total New Cases			360	
Total Closed Cases			330	
Reasons for Closure			# of Cases	% of Total Cases Closed
ADvantage			2	1%
Closed in Error			0	0%
Death			8	2%
Health Home			7	2%
Managed by HMP			3	1%
Meets ER Closure Criteria			31	9%
Opened in Error			3	1%
Program Ineligibility - Medicare			5	2%
Program Ineligibility - Moved out of state			7	2%
Program Ineligibility - Non HAN PCP			23	7%
Program Ineligibility - Personal Insurance			2	1%
Program Ineligibility - Unknown			57	17%
Reopening as Asthma			3	1%
Reopening as Diabetes			2	1%
Reopening as General HAN			1	0%
Unable to Contact			132	40%
Voluntary Withdrawal			44	13%
TOTAL			**330**	**100%**
Length of time on Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
Less than 3 months	120	36%	111	48%
4 to 6 months	78	24%	51	22%
7 to 9 months	60	18%	24	10%
10 to 12 months	22	7%	10	4%
Over 13 months	50	15%	34	15%
TOTAL	**330**	**100%**	**230**	**100%**

General HAN

The General HAN category was created in FY 2014 and continues to grow, mainly from an increased number of referrals from primary care providers. In FY 2016, 161 members were care managed.

Total Members in Care Management

Summary – General HAN Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	9	8	9	10	6	5	9	5	9	6	17	17
Continued	47	52	55	61	68	69	68	72	67	72	75	86
Closed	8	3	5	3	4	5	6	5	9	5	2	7
New/Closed (in same month)	1	0	0	0	1	1	1	1	0	1	0	1
TOTAL	**63**	**63**	**69**	**74**	**77**	**78**	**82**	**81**	**85**	**82**	**94**	**109**



Closure Reasons and Length of Time in Care Management

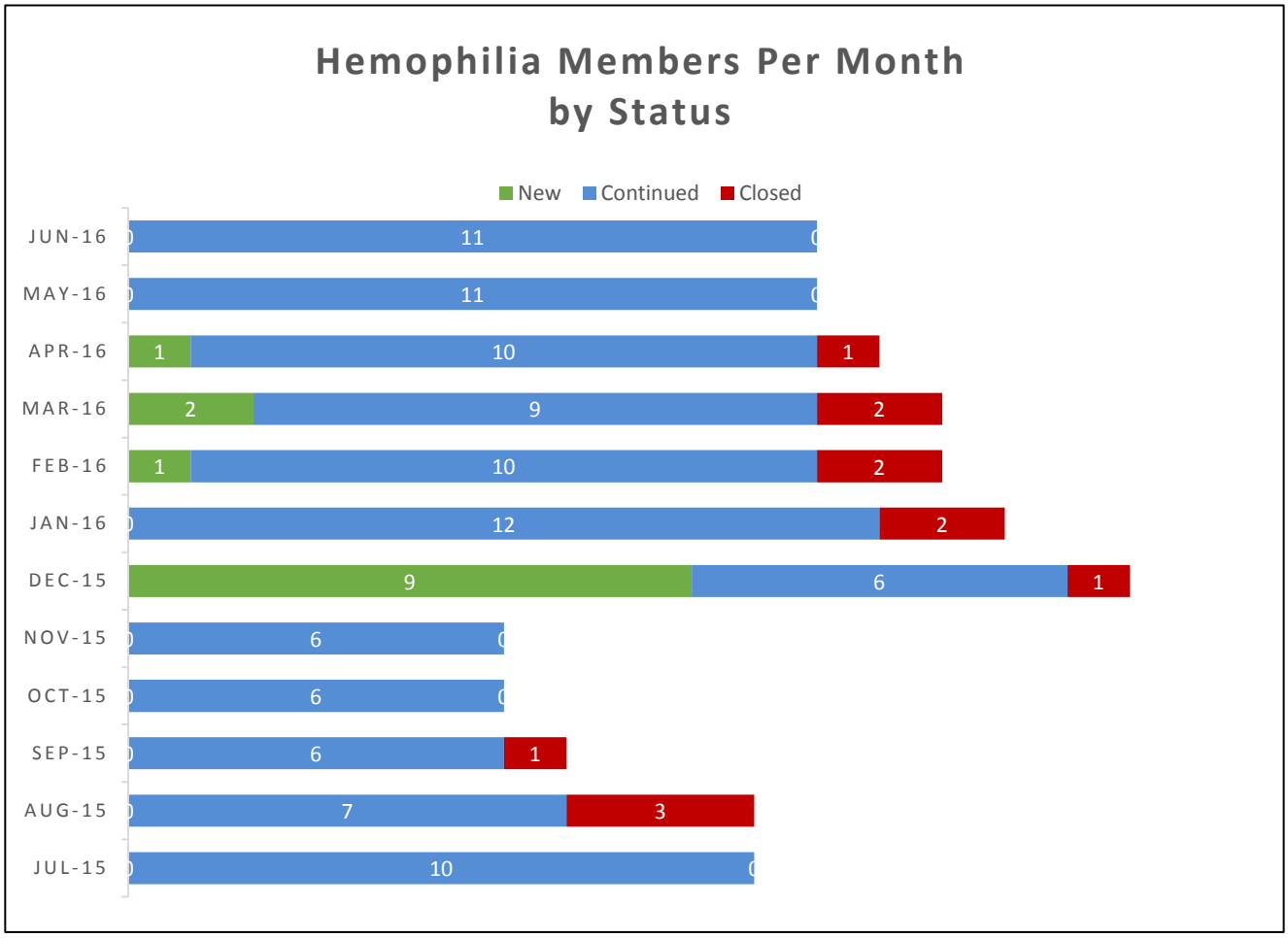
General HAN Care Managed Members Continued				
Element			**Total**	
Unique members served throughout the year			161	
Total New Cases			110	
Total Closed Cases			62	
Reasons for Closure			# of Cases	% of Total Cases Closed
ADvantage			1	2%
Death			2	3%
DHS Custody			1	2%
Health Home			1	2%
Meets Closure Criteria			3	5%
Opened in Error			2	3%
Program Ineligibility - Moved out of state			1	2%
Program Ineligibility - Non HAN PCP			6	10%
Program Ineligibility - Unknown			12	19%
Reopening as Asthma			1	2%
Reopening as Diabetes			3	5%
Unable to Contact			22	35%
Voluntary Withdrawal			7	11%
TOTAL			**62**	**100%**
Length of time on Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
Less than 3 months	23	37%	35	34%
4 to 6 months	10	16%	15	15%
7 to 9 months	8	13%	11	11%
10 to 12 months	4	6%	14	14%
Over 13 months	17	27%	27	26%
TOTAL	**62**	**100%**	**102**	**100%**

Hemophilia

The Sooner HAN has provided care management to 23 members with hemophilia throughout FY 2016.

Total Members in Care Management

Summary – Hemophilia Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	0	0	0	0	0	9	0	1	2	1	0	0
Continued	10	7	6	6	6	6	12	10	9	10	11	11
Closed	0	3	1	0	0	1	2	2	2	1	0	0
New/Closed (in same month)	0	0	0	0	0	1	0	0	0	0	0	0
TOTAL	**10**	**10**	**7**	**6**	**6**	**14**	**14**	**13**	**13**	**12**	**11**	**11**



Closure Reasons and Length of Time in Care Management

Hemophilia Managed Members				
Element			**Total**	
Unique members served throughout the year			23	
Total New Cases			13	
Total Closed Cases			12	
Reasons for Closure			# of Cases	% of Total Cases Closed
Managed by HMP			1	8%
No Hemophilia Diagnosis			1	8%
Program Ineligibility - Non HAN PCP			2	17%
Program Ineligibility - Personal Insurance			1	8%
Program Ineligibility - Unknown			2	17%
Unable to Contact			5	42%
TOTAL			**12**	**100%**
Length of time on Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
Less than 9 months	7	58%	6	55%
9 to 12 months	1	8%	2	18%
13 to 24 months	2	17%	0	0%
25 months plus	2	17%	3	27%
TOTAL	**12**	**100%**	**11**	**100%**

High Risk Obstetrics (HROB)

In FY 2016, the Sooner HAN provided care management services to 779 SoonerCare cases identified as a high risk pregnancy (HROB). This is up 43% from FY 2015. A significant challenge in previous fiscal years has been the late identification of HROB members. OHCA also recognized this as an important issue in need of improvement. During FY 2016, the OHCA began sending new HROB cases as soon as the case was identified in the state system. This resulted in cases being received on a weekly, if not daily basis—a significant improvement from the previous monthly bundle of case notifications. Additionally, at the end of FY 2015 the Sooner HAN embedded a RN Care Manager in the OU Women's Clinic. The collaboration with OU Women's Clinic has led to even more HROB cases being identified early. As a result of the collaboration with the OU Women's Clinic, the Sooner HAN is part of the orientation for new OBGYN residents and has provided just in time learning sessions to faculty and staff.

Length of Time in Care Management

As mentioned earlier, in FY 2016, the Sooner HAN provided services to more high risk OB members and for a longer period of time than in previous fiscal years. By receiving cases earlier in the members' pregnancy, care managers have more of an opportunity to provide services and support to the members prior to birth. It has been the desire of the Sooner HAN to identify and intervene with members as early in the pregnancy as possible to promote the best possible outcome for mother and baby.

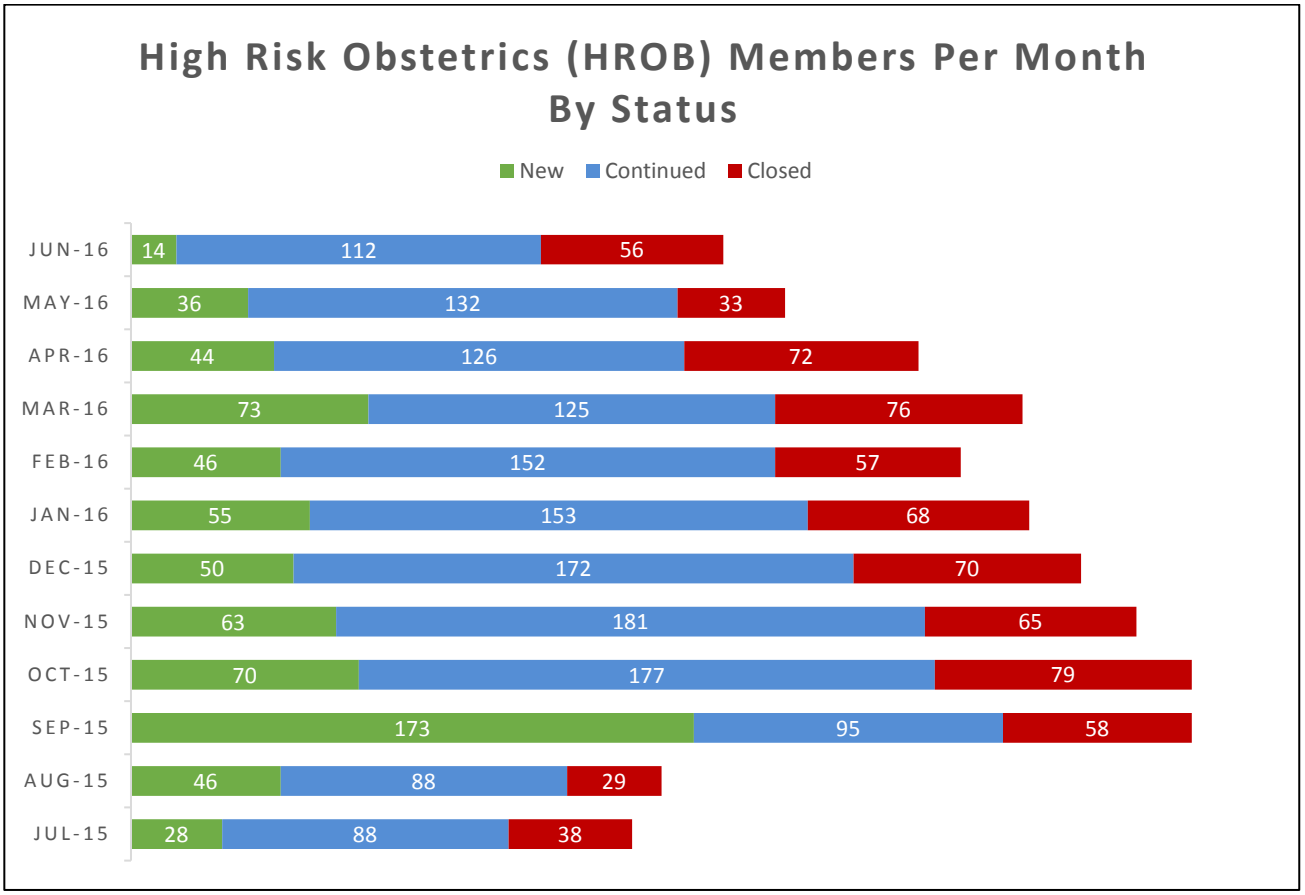
Fiscal Year Comparisons

HROB	**FY 2015**				**FY 2016**			
Length of Time in Care Management	*Closed*	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*	*Closed*	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
0 to 4 weeks	51	12%	66	78%	119	17%	15	12%
5 to 8 weeks	112	26%	9	11%	136	19%	25	20%
9 to 12 weeks	89	20%	5	6%	143	20%	25	20%
13 to 16 weeks	95	22%	1	1%	103	15%	23	18%
17 to 19 weeks	27	6%	2	2%	65	9%	16	13%
20 to 24 weeks	43	10%	1	1%	68	10%	12	10%
25 to 29 weeks	15	3%	0	-	40	6%	3	2%
30 weeks plus	4	1%	1	1%	27	4%	6	5%
	436	**100%**	**85**	**100%**	**701**	**100%**	**125**	**100%**

The following charts provide detail around the care management activities.

Total Members in Care Management

Summary – HROB Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	28	46	173	70	63	50	55	46	73	44	36	14
Continued	88	88	95	177	181	172	153	152	125	126	132	112
Closed	38	29	58	79	65	70	68	57	76	72	33	56
New/Closed (in same month)	1	2	21	7	5	3	2	3	6	6	1	1
Total	153	161	305	319	304	289	274	252	268	236	200	181



Closure Reasons and Length of Time in Care Management

The following chart highlights the number of HROB care managed members, reason for closure, and length of time receiving care management services.

HROB Care Managed Members				
Element			**Total**	
Unique members served throughout the year			779	
Total New Cases			698	
Total Closed Cases			701	
Reasons for Closure			# of Cases	% of Total Cases Closed
Closed in Error			9	1%
Death			1	0%
Death of Infant			0	0%
End of Pregnancy			284	41%
End of Pregnancy - Fetal Demise			2	0%
Opened in Error			19	3%
Program Ineligibility - Financial			2	0%
Program Ineligibility - Moved out of state			6	1%
Program Ineligibility - Non HAN PCP			18	3%
Program Ineligibility - Personal Insurance			2	0%
Program Ineligibility - Unknown			82	12%
Unable to Contact			174	25%
Voluntary Withdrawal			102	15%
TOTAL			**701**	**100%**
Length of time in Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
0 to 4 weeks	119	17%	15	12%
5 to 8 weeks	136	19%	25	20%
9 to 12 weeks	143	20%	25	20%
13 to 16 weeks	103	15%	23	18%
17 to 19 weeks	65	9%	16	13%
20 to 24 weeks	68	10%	12	10%
25 to 29 weeks	40	6%	3	2%
30 weeks plus	27	4%	6	5%
TOTAL	**701**	**100%**	**125**	**100%**

Delivery Data

The chart below highlights delivery data for women who received care management services for HROB. The Sooner HAN had 361 deliveries resulting in 369 viable births. The average weight for the HROB babies was 6.4 lbs. and the average length of hospital stay was 4 days.

HROB - Delivery Data		
Pregnancy Results		
#	%	Category
361	100%	Deliveries/Moms
369	97%	Viable Births
9	2%	Demise
1	<1%	Unknown
379	100%	Total Births
341	94%	Single Births
20	6%	Sets of twins
Birth Type		
#	%	Category
222	61%	Vaginal
139	39%	C Section

Average (Mean)Weight
6.4 lbs.
Median Weight
6.6 lbs.

Average (Mean) Length of Hospital Stay
4 days (mother)
Median Length of Stay
3 days (mother)
Mode Length of Stay
2 days (mother)

Note: Only births that occurred during FY 2016 were counted. Since member cases remain open for approximately 6 weeks after delivery, some members may have still been enrolled in FY 2016, but delivered in the previous fiscal year.

Discharge Data

The chart below highlights information on the status of babies upon hospital discharge. A few babies required oxygen therapy at home or supportive devices or medications. Fewer than 14% of babies required surgery and almost 94% of babies passed their hearing screens.

HROB – Discharge Data					
Sent Home on Oxygen			**Required Surgery**		
>1%	1	Yes	10%	38	Yes
>99%	368	No	0%	0	No
0%	0	Unknown	0%	0	Unknown
Discharged with Supportive Devices or Medications			**Completed Newborn Hearing Screen**		
1%	5	Phototherapy	74%	273	Pass (Left Ear)
5%	20	Medications	2%	8	Fail (Left Ear)
2%	6	Monitor	24%	89	Unknown (Left Ear)
73%	270	None	74%	273	Pass (Right Ear)
18%	67	Unknown	2%	8	Fail (Right Ear)
			24%	89	Unknown (Right Ear)

NICU Information

The chart below highlights information for babies that had a NICU stay. The average NICU stay was 10 days with 27% of the babies having had a NICU stay. The average weight for babies with a NICU stay was 5.6 lbs. In FY 2016, fewer babies required NICU stays and the length of time in the NICU was less than in FY 2015. Likewise, premature births as indicated by the average number of days delivered before the due date dropped significantly, form 24 days in FY 2016 to 13 days in FY 2016, a 46% decrease.

HROB - NICU Information				
Average (Mean) NICU Stay	***Average (Mean) NICU Weight***	***NICU Stays***		
10 days	5.6 lbs.	27%	98	Infants with NICU Stay
Median NICU Stay	***Median NICU Weight***	4%	16	Twins with NICU Stay
5 days	5.8 lbs.	29%	106	Mothers with a baby that had a NICU stay
		20%	20	NICU stays ongoing at time of closure

Prematurity of Babies with NICU Stay	
Average (Mean) - # of days/weeks born before due date	***Average (Mean) - # of days/weeks prior to due date when HROB case was received***
13 days prior	48 days prior
Care Management case received for Babies with NICU stay	
Median - # of days/weeks born before due date	***Median - # of days/weeks prior to due date when HROB case was received***
9 days prior	43 days prior

Twins Data

The chart below highlights data on twins. There were 20 sets of twins born during FY 2016.

HROB - Twins Data		
Average (Mean) Weight	***Average (Mean) - # of weeks prior to due date case was received***	***Average (Mean)- # of days delivered prior to due date***
4.6 lbs.	56 days before	27 days prior
Median Weight	***Median - # of weeks prior to due date case was received***	***Median - # of days delivered prior to due date***
5.0 lbs.	51 days before	27 days prior
Note:	Denominators were adjusted based on ability to gather data from member or medical record	

Depression Screens

The chart below highlights the administration and results of the pre- and post-depression screenings administered by Sooner HAN care management staff. The Sooner HAN administers the PHQ9 health questionnaire.

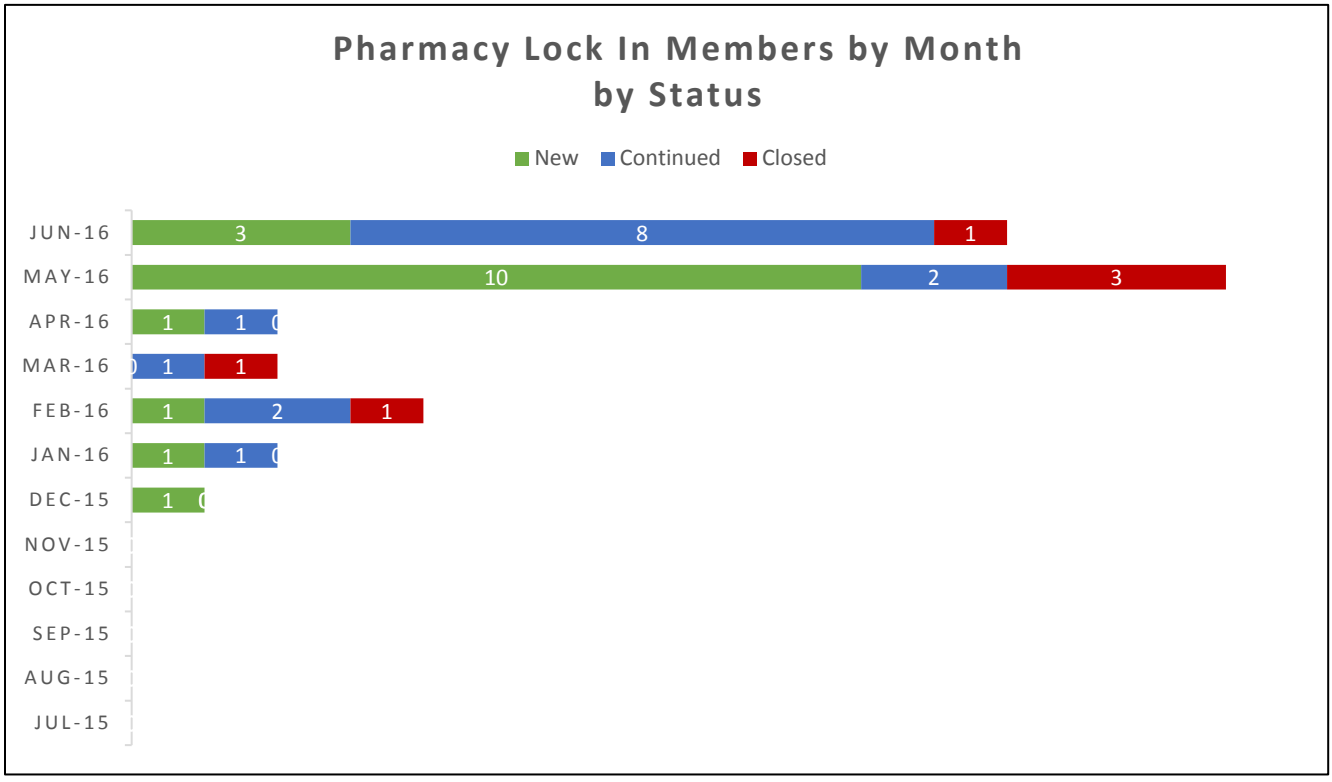
HROB - Depression Screens						
Pre-Depression Screens				**Post-Depression Screens**		
88%	229	Screened		84%	169	Screened
12%	30	Not Screened		16%	32	Not Screened
Reason Not Pre-Screened				**Reason Not Post-Screened**		
37%	11	Recently completed screen		9%	3	Recently completed screen
63%	18	Member does not feel depressed		66%	21	Member does not feel depressed
<1%	1	Other		<1%	2	Currently in treatment for depression
				19%	6	Unknown
Screening Results						
9%	35	Pre/Post screenings requiring referral		34%	12	Women accepting BH referral
				75%	9	Women keeping BH appointment
Additional Recommended Screenings (Not Pre/Post Screens)						
N/A	21	Recommended screenings		100%	4	Women accepting BH referral
19%	4	Recommended screenings requiring referral		75%	3	Women keeping BH appointment

Pharmacy Lock In

In FY 2016 the Sooner HAN began to receive Pharmacy Lock In cases again after a short hiatus, while OHCA modified the program. This group is often challenging for care management as behavioral health and addiction issues require a very specific intervention. In FY 2016, 14 members were care managed.

Total Members in Care Management

Summary – Pharmacy Lock In Care Managed - Member Status												
Month - Year	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
New	0	0	0	0	0	1	1	1	0	1	10	3
Continued	0	0	0	0	0	0	1	2	1	1	2	8
Closed	0	0	0	0	0	0	0	1	1	0	3	1
New/Closed (in same month)	0	0	0	0	0	0	0	1	0	0	3	0
Total	0	0	0	0	0	1	2	3	2	2	12	12



Closure Reasons and Length of Time in Care Management

Pharmacy Lock In Care Managed Members Continued				
Element			**Total**	
Unique members served throughout the year			14	
Total New Cases			17	
Total Closed Cases			6	
Reasons for Closure			# of Cases	% of Total Cases Closed
Closed in Error			3	50%
Unable to Contact			1	17%
Voluntary Withdrawal			2	33%
TOTAL			**6**	**100%**
Length of time on Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
Less than 3 months	6	100%	10	91%
4 to 6 months	0	0%	0	0%
7 to 9 months	0	0%	1	9%
10 to 12 months	0	0%	0	0%
Over 13 months	0	0%	0	0%
TOTAL	**6**	**100%**	**11**	**100%**

Care Management Success Stories

The success stories highlighted below are being told from the care managers' perspectives and in their own words. The members' names have been changed to ensure their privacy and confidentiality. While there were many successes throughout the year, these fourteen stories serve as a reminder of the significant role a care manager plays in each member's life, the value of the providing additional support beyond the primary care office, and the strength of building respectful relationships.

[redacted]
When dealing with a person on a weekly basis you get to know their temperament, what they like, how they communicate, their stressors, and who they believe is part of their support system. I have been working with an ER utilizer for more than a year and it has taken almost that entire year to build a relationship with this member. He was a hit and miss member; I would talk to him for several weeks straight and then he would fall off for several months. He always told me just enough information and never too much for me to figure out his situation. The member has been diagnosed with Hepatitis C, chronic pain and cirrhosis of the liver. he member's ER visits consisted of him having fevers, uncontrollable pain in his body, toxins from his liver, heart palpitations and black stools. The member would go to the ER at least 3 times a month, even if he went to his PCP appointment. As his Care Manager, I continued to just listen to him and let him steer the conversations, whether it was talking about his family that he could not depend on, lack of several medications, lack of treatment for Hepatitis C, to wanting to give up at times due to his diseases. The continued conversations and communication with PCPs about possible treatment options for the member, opened the door to the member, allowing me to assist in many ways. The member mentioned that he has never had anyone to care about his health in the manner that I do, as his Care Manager. Fast forward to almost a year later - this member has had only 3 ER visits in the last 5 months. He has met with the transplant provider again even though his last experience was terrible and he was open and interested in available hospice options. He has made more PCP appointments since care management has been involved and open and accepting to community resources to help with daily needs. Currently, I have talked with the member about the possibility of the ADvantage Program, being one appointment closer to a possible transplant option, his submission to obtain Hepatitis C treatment and how his mental health has improved due to knowing that he is able to manage his diseases with assistance from his PCP team and Sooner HAN Care Manager.

[redacted]
During one of our conversations with the PCP, the member explained her living situation with family members and how this meant she did not have control over her food options because she didn't get to choose her food. Also, food was being purchased for several people so once it was gone, there were even fewer choices. The doctor stated this was really good information because it was something he would not have thought to be a problem. The member said that she felt like, for the first time in a really long time, the doctor actually listened to her and addressed her needs. Action steps included reviewing medications, providing information on other food resources, and referral to pain management clinic.

[redacted]
The member was initially upset when I called her about participating in the (PCORI) project because she didn't think she had ever been diagnosed with diabetes. A diagnosis was in her chart but her blood sugar levels had reduced to a pre-diabetes level; her current lab results showed she had crossed the threshold again for Type II diabetes. Since then, the member has completed the patient reported outcome

measure survey tool (PROM) and identified healthy eating as a goal. I worked with her to create a plan based on modifying old recipes and trying new ones. Her weight has dropped below 300 lbs. for the first time in a year. The member's PCP told her he was "impressed" with her dietary changes and encouraged her to continue. She stated she is very happy with her care at this clinic. The member told the care manager, "It sounds funny, but in a way I'm glad I was diagnosed with diabetes because I've been able to make changes to be healthier."

[redacted]
The member is a single mom with two children who is unemployed, living in homelessness and has a felony on her legal record. She had missed several appointments. I called a few times and the member seemed guarded and mistrustful. I learned that the member's focus was getting a job and finding a place to live so she could regain custody of her youngest child. I started helping her with these concerns and the member said "You really do want to help me, don't you?" Since then, the member has begun asking her questions about diabetes, certain foods, checking her blood sugar and how stress and lack of sleep affect blood sugar levels.

[redacted]
This member has gestational diabetes mellitus (GDM) and speaks Zomi, a dialect of Burmese. I made initial contact with the member and her spouse at the HROB clinic and a Zomi interpreter was used via the language line. Despite increasing meal time insulin doses, respectively, blood sugars remain elevated after her lunch and dinner in the 200s. I reviewed blood sugar log fasting levels that range 60-80s and post one hour breakfast range 65-90mg/dl. Post one hour lunch and dinner range 140-209mg/dl. Upon arrival to clinic her blood sugar level was 44mg/dl. The member was given 15gm CHO (apple juice) and is asymptomatic. In talking to member she is not taking medications as directed. After complete assessments we were able to identify that she is taking both insulins incorrectly, at the wrong time and the wrong dose. This would explain her hypoglycemia episode of upon arrival to the HROB clinic. I also believe the language barrier is a contributing factor to her hypo/hyperglycemia episodes. I discussed the member with the resident. The resident stated that the attending physician would like to admit the member to the hospital for further DM education and glucose control. I staffed the member's case with both resident and attending provider present. We discussed my findings of the language barrier. I am able to provide some DM education via the language line in HROB Clinic. Per attending their recommendation is for the following: Hold on admitting for today, DM education in HROB Clinic, follow up appointment 7/28/2016 for re-evaluation. If hyperglycemia continues will admit to the hospital for glucose control. Recommend a medication change before lunch and dinner. 7/28/2016- Follow up visit in HROB Clinic. Reports she is on NPH 7U/5U after breakfast AND QHS; Novalog 36U / 36U with lunch and dinner (only eats 2 main meals/day). Blood sugar levels have significantly improved. Blood sugar levels after lunch and dinner range 117-149 with one reading 189mg/dl. Per physician no changes at this time she is to continue with the same doses and follow up next week. After staffing the case with both the attending and the resident the member did not need to be admitted for further diabetes education. We were able to identify the barriers and diabetes education could be done in clinic and avoid hospitalization. They both agreed.

[redacted]
I have been in contact with a member to facilitate completion of the PCORI process and to provide care management services. When I made initial telephonic contact with him, prior to his initial clinic visit per the PCORI process, the member agreed to complete the PROMIS-29 survey over the phone and did not consent for me to attend his initial clinic visit; and he agreed for me to follow up via telephone in one

month. While completing this follow-up telephonic encounter, the member said "You're a great sounding wall. I can hear myself talk about things and that helps. I like talking to you." To me, this interaction represents a success, not only because it is apparent how Motivational Interviewing positively affects interactions (and ultimately outcomes) but also because he agreed to meet with me in person at the clinic; and I know this meeting will allow me to build greater rapport with him and allow me to determine ways in which I may provide assistance to the member, to help him meet his health goals.

[redacted]

The member has utilized emergency medical care eighteen times in less than 4 months, for reasons that include back pain, sunburn, and knee pain. At his most recent appointment with his PCP, I facilitated discussion about these ER visits including his stated goal of going to the ER once per month and reasons for his recently increased medical usage. A "success" occurred in the member's case when he verbalized insight that he has been seeking medical care, including through ER and from specialists, in order to obtain emotional support. During our next telephone call following this PCP appointment, he and I were able to further discuss his insight regarding his medical usage: the Member expressed thoughts that because one medical procedure was recently indicated, follow up for an unrelated physical concern was also indicated. This is part of what makes this case challenging. The member and I continue to periodically discuss healthy relationships and coping strategies; and I continue to encourage him to establish and keep short-and long-term goals, including those beyond his physical health that include continued participation with a community volunteer group based at a local community college.

[redacted]

This young man was referred to the Sooner HAN in the Fall of 2015 by a pediatric pulmonologist. He is 9 years old with a history of moderate persistent asthma, recurrent pneumonia and hypoxia, multiple hospitalizations, underweight, and a chromosomal abnormality that affects his neurodevelopment. During the initial telephone call, his mother expressed significant frustration that his breathing problem was not getting better and that it was interfering with his education. His mother and I met face- to-face and discussed his health history, home and family support, challenges and barriers she has encountered and what she hoped to accomplish. The most important thing to her was that his breathing get better. She stated she "is sometimes afraid for his life". Secondly, she wanted to see his attendance in school increase so that he could be there to learn along with the other children. She stated "he cannot learn if he is not there". To accomplish this, she wanted to learn more about asthma and how to respond to early signs of breathing problems. He openly admitted she did not understand asthma very well and felt "lost" in regards to symptoms and steps to take when a problem appeared. She also expressed her lack of confidence in supporting his educational needs due to absences and delayed neurodevelopment. The mother was very open to our meetings; we met by phone, at his appointments, and at my office once a month on one of her days off. We discussed what asthma does to the lungs, possible triggers, his prescribed medications, symptoms, and best response at early sign of flare up. She kept me informed on the outcome of pulmonology appointments, his response to medication changes and called me at the first sign of symptoms to determine whether he needed to be seen. Medication assessment revealed she was using the allergy medication incorrectly and only giving it to him when symptoms appeared. She corrected this and she also has become more alert to coughing/wheezing at night and responded by starting nebulizer treatments promptly. In January she reported he was doing "a little better" and that he was using the rescue inhaler less frequently. Instead of 3-4 times a week she only had to give it to him 2 times in the prior week and once during the week before that. In February she reported he was still doing well and she was able to see a difference in his breathing. In March she happily reported he was doing very well and had had zero ER or urgent care visits since December. In May she was absolutely

thrilled that he had had less sick days and was attending school more regularly. As she begins to express a more positive outlook and less anxiety about his breathing, I am looking for signs that she is ready to move on to the topic of learning more about the educational system and how we can support him. I have gathered some information to get us started, consulted with Sooner Success, and have discussed the steps to get an EIP in place with the school counselor. Now that she has experienced this success with his asthma I am hoping she can build on this for confidence to tackle the next challenge!

[redacted]

The member is identified as having a high risk pregnancy. She is thirty years old and in the final trimester of her sixth pregnancy. She and her husband also have a set of one year old twins, a three year old, a four year old, and one school-aged child. As I talked with the member about her pregnancy; she shared that she had taken an antidepressant in the past, but quit taking that medication during this pregnancy. The Member had discussed her feelings of depression with her OB doctor and was told that she could not take the antidepressant during pregnancy; that counseling was her only option. She receives no mental health services at this time. I asked the member if she was willing to participate in a screening to describe for me, how she had been feeling over the past two weeks. The member agreed and expressed feelings of hopelessness, feeling tired with little energy and as I asked her to describe whether or not she had bad feelings – if she felt she was a failure or had let herself or her family down- she interrupted me. "No one has ever asked me questions like these before. I can't even keep the floors of my house clean, with one year old twins! I get up every day and feel so bad because I cannot look after my house, kids or husband like I want to. I try and try, but there are always messes and I can't keep up". I completed the PHQ-9 screening and the member's score indicated the need for a behavioral health referral, which was discussed with the member and she accepted. The member told me she has no close friends or family in the area to provide support, help in the home, or help with child care. Her husband works long hours every day. I discussed with the member that her husband was probably aware of how she was feeling and he might not know how to help her, since he had to work such long hours. I continued to gather information as we talked and asked if I could call every other week to check in with her and she agreed. On the next scheduled contact, when I asked how she was doing, the member replied, "I am doing so much better! Guess what I did! I told my husband about you calling and asking how I had been feeling and I told him what I told you; how hopeless and frustrated I was- trying to take care of the kids, house and everything". Well, he shared this with a coworker and they arranged for the coworker's wife, who lives just one block over; to take care of my two kids- the three & four year old every day- Monday through Friday from 3:00 PM (when the coworker's wife gets home from work) until 8:00 PM; and then my husband will pick them up and bring them home!" The member then said, "The coworker's wife said she will also come one day a week and help me clean my house and do some of the laundry; and it won't cost us anything! She will just expect my husband to help her husband when he needs another man to help with chores around their house!" The member said she called the Behavioral Health helpline, but thinks this is a better solution for her right now. It sounded like I was talking with another person that day. There was such elation and energy in the member's voice! Then I had another thought. "How might I start a discussion and explore her feelings about her reproductive life plan…?" Another conversation for another day, in the life of a care manager.

[redacted]

The member is a 16 month old, Hispanic male with complex health needs. He was referred to the Sooner HAN because of his frequent emergency room visits. The member was seen in the ER for respiratory issues and he was hospitalized for repeated infections. I was assigned to the member in February while he was hospitalized for RSV. I visited with the member's mother 1-2 times a week in his hospital room

for support until he was discharged. Subsequently, after three weeks, I had established a relationship with his mother and she was accepting of home visits. As his care manager, I coordinated services with the hospital social worker, physicians, and home infusion and I made weekly home visits in conjunction with the infusion nurse. The caregiver was referred to the appropriate resources. I accompanied the member's mother to his PCP and specialty appointments and continue to do so. The member was last hospitalized in April upon the recommendation of his PCP during a clinic visit. He has not been to the ER since being referred to Sooner HAN for care management services.

[redacted]
The member is a two year old, African American male. He was referred to the Sooner HAN in March because of his uncontrolled asthma. He has been hospitalized twice within the last year for asthma exacerbation. He is the second youngest of four children who reside with their single mother. He has had several "cancellations and no shows" with his PCP and is at risk of being discharged from services. I contacted the member's mother and introduced myself and the Sooner HAN Care Management services. She was having transportation problems and was unable to use Sooner Ride because they are only able to transport children with medical appointments. It was the practice of this particular clinic provider to only see two siblings at one time during a visit. I initiated a call to the clinic's Social Worker who in turn spoke with the office manager and providers. The clinic made an exception and all four children were scheduled together. The member's respiratory status was properly assessed and medication changes were made. His mother was given a printed Asthma Action Plan and he has not had any further "no shows and/or cancellations". I continue to contact his caregiver no less than monthly and the member's asthma is well managed. I met the member and his mother at the last clinic appointment and he is thriving.

[redacted]
I was assigned a member with asthma and when I made my first call to the member, she was coughing and wheezing. I asked about her asthma control and she stated that she doesn't do very well with her medications and she doesn't have any refills on her inhalers. I asked her if she uses a nebulizer and she stated that she would if she had one, but she hasn't had one in several years. I asked what her goals would be at this time and she stated she would like to breathe better and live in a better environment. I felt it was necessary to do a home visit to accurately assess her current situation. When I arrived at her home, all of the furniture was covered with plastic. I asked why it was and the member stated that the roaches were so bad that she didn't want her furniture to be soiled with roach droppings. I saw the roaches crawling on the walls and counter tops. The member even kept her purse in a plastic bag as to not carry the roaches to the nursing home when she would visit her mother. We sat and talked about her current situation and what she would like to work on first. She stated that she needed to get into her doctor so that she could get her medications and she needed to get back into pain management. She had been fired for testing positive for other drugs. As I left her apartment, I stated that I would work to help her with her doctor appointments, both for asthma and for pain, and to help with her living arrangements. When I returned to the office, I checked the EMR for her PCP visit information. I called the member and gave her the information and phone number to make an appointment. I stated that if she would make her appointment and attend the visit to get her asthma medications filled, I would try to find a donated nebulizer. I called the Community Medicine department and found that they have a loaner program and printed a contract that the member would have to sign for the nebulizer. The member made and kept her appointment and I delivered the nebulizer. The member and I worked together and found a pain management specialist that she started to see. And then we worked for several weeks on housing, and 3 months later, the member moved into a new apartment that was bug

free. At the current time the member has well controlled asthma and has all her medications under control. She lives in a nice clean apartment and sees her pain management specialist and her PCP on a regular basis. When called, the member rarely has any needs.

[redacted]
I was assigned a member as a HAN referral. Mom is on her own with the member who has multiple diagnosis. These diagnoses include autism, cerebral pseudo tumor, sleep disorders, metabolic disorders and close to 33 others. Mom is overwhelmed with doctor appointments, feeding issues, behavior issues and her own exhaustion. I asked mom what the most important thing that I could help with is at this time. Mom stated that the school has been sending truancy letters and threatening to turn her in to the officials that deal with truancy. Mom is scared that they could do that to her. The member misses school a lot due to vomiting issues and migraines. The member has not missed any assignments, has turned everything in, and has legitimate reasons for missing school. The mom asked for help with the school, therefore the PCP wrote a letter to the school explaining the situation and I would act as an advocate for the member to the school. I called and spoke with the patient facilitator to explain why the member has been missing so much school. This person stated that the PCP's letter was not conclusive enough and that there was no proof that the member's disorders were chronic conditions. She requested more information on the disorders and wanted further explanations as to why he has the problems that he does. As the advocate for the member, the next thing I did was to ask the mothers permission to speak to the principal of the school and the mother stated she would be glad for me to do that. I contacted the principal and explained what was happening with the member and also described what the facilitator had requested. The principal was surprised that the patient facilitator had requested that information and said that he would take it from there. He explained that the member would no longer receive any letters and he could take as much time off that he needs as long as his work was done. The principal then called the member's mother and explained that she did not need to worry anymore about the school and any threats she received about truancy. The next day the mother called me crying with joy that I helped with the school. She was so excited that she would not have to worry anymore about the school and could now concentrate on her son and his medical needs. She could not express her appreciation enough for the effort I made. She didn't expect that a care manager could help with school issues and learned that we can help all other matters in addition to medical needs. With the pressure from the school off of the mother, the member will now have one less thing to keep him from possibly improving.

[redacted]
This morning I assisted one of my HROB members with an appointment. She had her baby 7 weeks ago so today I told her that today would be our last encounter and that she can contact me if she has any questions. Member stated "thank you so much. I don't know what I would have done without all of your help. I really appreciate you and all you did for me." It was an emotional moment for me.

Additional Activities

Educational Opportunities for Providers and Care Managers

Care Management Training

A three day care management training, Fundamentals of Care Management, was held twice in FY 2016. The August 2015 training had 11 participants and the March 2016 training had 12 participants. Both times both Sooner HAN care managers as well as care managers from Sooner HAN participating providers were in attendance. In addition, three care managers from the OSU HAN attended the care management training.

The Fundamentals of Care Management is an intensive training in delivering comprehensive care management services to individuals with complex health and social service concerns. It includes approximately 4 hours of online prerequisite work and 3 days in the classroom. The course is continually updated to reflect current NCQA Care Management standards, industry knowledge, and best practices based on peer-reviewed studies from medical and social service literature. The training emphasizes a multidisciplinary team approach, partnering with providers, community agencies, family members and other stakeholders to co-manage a diverse population of people with high-risk conditions.

This 3 day course incorporates both online e-learning and in-class presentations and activities. The small group sessions generate interactive learning and discussion. Many of the teaching modules are case-based and discuss actual scenarios that Care Managers commonly encounter. Supplemental materials and templates are provided electronically in the online learning system.

Day 1 – Tuesday 8:30 AM to 4:30 PM			
Time	***Topic***	***Description***	***Facilitator(s)***
8:30 – 9:15 *45 Min*	Welcome, Introductions and Icebreaker		ALL
9:25 to 10:55 *1 Hour 30 Min*	Healthcare in Oklahoma	This module describes the health of Oklahomans using a variety of data sources. Emphasis is placed on describing how individual factors, social and community networks, and environmental conditions impact health.	Juell Homco
11:05 to 4:15 *4 Hours 10 Min*	The Nuts and Bolts of Care Management	Nuts and Bolts of Care Management guides care managers through the National Committee for Quality Assurance (NCQA) standards for care management programs. It includes the practical application of core functions of care management with evidenced based guidelines, protocols, and tools that care managers can use in their everyday work life. It also provides care managers with basic knowledge about measurement and quality improvement, patient rights and responsibilities, and patient privacy, security and confidentiality.	Glenda Armstrong / Paula Smith
4:15 – 4:30 *15 Min*	Wrap up and end for the day		Rachel

Day 2 – Wednesday 8:30 AM to 4:30 PM			
Time	***Topic***	***Description***	***Facilitator(s)***
8:30 – 8:45 *15 Min*	Welcome, Review Agenda, and Icebreaker		Glenda Armstrong / Rebeka McRad
8:45 – 10:15 *1 Hour 30 Min*	Introduction to Behavioral Health	All About Behavioral Health introduces care managers to the development of a unique skillset primed to work in emerging models that integrate primary and behavioral health care. It provides a background to the process of basic mental health evaluation, and equips care managers to engage people with behavioral health in a systematic way that results in improved overall health outcomes.	Dr. Erik Vanderlip
10:25 – 12:10 *1 Hour 45 Min*	Motivational Interviewing	Motivational Interviewing teaches basic skills involved in strengthening a person's own desire and ability to make positive behavior changes. Emphasis is on both preventing and managing chronic illness. Participants practice motivational techniques with their peers, while identifying methods that encourage provider alignment and positive reinforcement.	Glenda Armstrong / Dr. Jeffrey Alderman / Rebeka McRad
12:40 – 2:10 *1 Hour 30 Min*	Suicide Prevention	Suicide Prevention teaches participants how to recognize patterns that may suggest suicidal ideation, and introduces basic crisis management skills. Emphasis is on ways to access intervention and treatment if suicidality is suspected.	Rebeka McRad / Brian Timms / Elizabeth Fry
2:20 – 4:15 *1 Hour 45 Min*	Cultural Competency	Cultural Competency challenges health care providers to reflect upon their own values and beliefs, understand the concepts of cultural competency, and develop skills to respond appropriately to culturally diverse populations.	Glenda Armstrong / Dr. Jeffrey Alderman /
4:15 – 4:30 *15 Min*	Wrap up and end for the day		Glenda Armstrong / Dr. Jeffrey Alderman /

Day 3 – Thursday 8:30 AM to 4:30 PM			
Time	***Topic***	***Description***	***Facilitator(s)***
8:30 – 8:45 *15 Min*	Welcome, Review Agenda, and Icebreaker		Glenda
8:45 – 10:15 *1 Hour 30 Min*	Disease Management: Asthma and COPD	Several modules in Disease Management highlight the management of chronic illness including Asthma, COPD, and Diabetes. These courses illustrate ways Care Managers can assist individuals in co-managing their illnesses using self-care techniques. In Disease Management: Asthma and COPD, emphasis is placed on writing Action Plans for those diagnosed with Asthma. The goal is to help build relationships among individuals, caregivers, primary providers, and Care Managers, who will orchestrate care together as a team, tending for an increasingly complex number and variety of illnesses.	Glenda Armstrong / Dr. Jeffrey Alderman
10:25 – 11:55 *1 Hour 30 Min*	Disease Management: Diabetes	Disease Management: Diabetes highlights the management of the chronic illness Diabetes, and illustrates ways Care Managers can assist individuals in co-managing their illness using self-care techniques. Emphasis is placed on Blood Sugar management among people with Diabetes. The goal is to help build relationships among individuals, caregivers, primary providers, and Care Managers, who will orchestrate care together as a team, tending for an increasingly complex number and variety of illnesses.	Glenda Armstrong / Dr. Jeffrey Alderman / Blanca Charles
12:25 – 1:55 *1 Hour 30 Min*	Trauma Informed Approach	Trauma is a prevalent health problem that affects all of us. Introduction to Trauma Informed Approach provides an overview of how traumatic experiences can alter both behavior and physical health. Participants learn to recognize trauma related symptoms, resist re-traumatization, and integrate responses that promote recovery and resilience.	Glenda Armstrong / Alicia Williams
2:05 – 3:05 *1 Hour*	Risk with Dignity	Risk With Dignity explores the dilemma health care providers often face when reconciling a person's risky lifestyle choices with his or her right to choose. Participants learn what truly increases and lowers risk, as well as the importance of self-determination and shared decision making to arrive at common goals.	Glenda Armstrong / Dr. Jeffrey Alderman
3:15 - 3:45 *30 Min*	Community Resources	Know Your Community Resources provides an interactive learning activity where experienced care managers not only share their knowledge of local resources, but also identify how to access services, and explain how to make appropriate referrals.	Rachel Mix / Kristin Steuck
3:45 – 4:15 *30 Min*	Wrap Up and end for the day		ALL

Lunch and Learn Series

Lunch and Learn sessions were held regularly in FY 2016 and focused on areas affecting care managers serving SoonerCare Choice members with complex health and social concerns. Topics covered and the number of attendees are listed below:

DATE	TOPIC	PRESENTERS	ATTENDEES
July 24, 2015	Alcohol Use Disorders	Erik Vanderlip, MD, MPH, FAPA	30
August 28, 2015	Anger and Irritability	Erik Vanderlip, MD, MPH, FAPA	29
September 25, 2015	Smoking Cessation	Erik Vanderlip, MD, MPH, FAPA	30
October 8, 2015	Bridges Out of Poverty	Colleen Ayres Griffin, LPC, LADC	31
December 9, 2015	Sooner Success	Tonda Ames, MS, APR and Erin Strayhorn	16
January 8, 2016	Trauma Informed Approach	Glenda Armstrong, RN and Alicia Williams, MSW	33
February 1, 2016	Post-Traumatic Stress Disorder (PTSD)	Erik Vanderlip, MD, MPH, FAPA	43
March 11, 2016	Personality Disorders	Bryan Touchet, MD	49
April 8, 2016	Recognizing Child Abuse and Neglect	Sarah Passmore, DO	38
May 13, 2016	Cycle of Violence	Norman Simon, MD, FACG	42
June 10, 2016	Substance Use	Erik Vanderlip, MD, MPH, FAPA	56
June 14, 2016	Opioid Use in Oklahoma	Burl Beasley, Pharmacist	36
June 28, 2016	Pain Management Toolkit	Jaclyn Mullen, RN, BSN and Stacy Smith, RN, MSN	41
			354

The response and evaluations from the various lunch and learn sessions throughout FY 2016 has been very positive. The Lunch and Learn sessions will continue in FY 2017 and beyond with topics added to reflect current trends and interests expressed by care managers and providers serving SoonerCare Choice members.

Provider Engagement

Site Visits

The Sooner HAN provided additional support to engage providers who were enrolled in the Sooner HAN. During FY 2016, Sooner HAN staff travelled to the providers' location and met with leadership to build relationships with new staff, discuss the HAN quality improvement services, care management and referral management services, and offer HAN assistance to clinics in these areas. In addition, HAN staff shared examples of reports that can be generated for each clinic for quality improvement monitoring, and discussed clinic issues brought forth by clinic staff. These meetings were beneficial and will continue into FY 2017.

Combined with the site visits and educational offerings, specific investments were made with HAN

providers to increase participation with the Sooner HAN. A few examples include:

Clinic Activities

Utica Park Clinics

The Sooner HAN had designated an RN care manager in the Utica Park main clinic to serve as a resource to clinic providers for SoonerCare Choice members. The care manager worked 2-3 days a week at the clinic, participated in team meetings, and collaborated with clinic providers and staff. In order to better serve Utica Park providers at their twelve locations throughout the region, both an RN care manager and a MSW social work care manager travel to all clinics as needed. The care managers are able to attend members' appointments as needed and collaborate more fully with the care team.

OU Tulsa Internal Medicine

The Sooner HAN began working with this clinic to identify those SoonerCare Choice members who need to be referred for care management through the Sooner HAN. Clinic staff send weekly referrals and also work to identify those who have been admitted to the hospital so that care managers can discharge plan with the member prior to being released home. This has allowed the Sooner HAN and the clinic to meet the needs of members with more complex issues more quickly.

OU Women's Clinic

The Sooner HAN piloted a diabetes education project for HROB SoonerCare Choice members. One of our bilingual care managers who is also a certified diabetes educator attends the OU Women's HROB diabetes clinic on Monday and Thursday mornings. Borrowing from adult learning principles, health literacy concepts, health coaching, and motivational interviewing, the care manager provides ten to fifteen minutes of individualized and focused one-on-one interaction with each member every week.

The pilot began in July of 2015 and data was collected for the entire fiscal year. Baseline data on fasting blood sugar was documented for each member participating in the pilot prior to receiving diabetes education. Additional fasting blood sugar levels were documented throughout the members' pregnancies. Based on the results of 23 members who participated, 16 had improved their fasting blood sugar results (70%) to within normal limits while 7 members were unable to improve to within normal limits (30%).

Another measure widely used for diabetes management is the A1c test because it reflects the average blood sugar level for the past three months. However, not all the pregnant women in this SoonerCare Choice pilot were enrolled in the program long enough to have both a baseline A1c and a follow up A1c test. Despite those challenges, the Sooner HAN was able to collect A1c results both before and after diabetes education for twelve members. Of these twelve members, all showed a decrease in A1c levels, averaging a 2.6% decrease. Because of the success of this pilot, the Sooner HAN will continue the diabetes education project for HROB in FY 2017.

The OU Women's clinic has agreed to engage in this effort and will obtain comparative data from non-SoonerCare Choice members. OU Women's Clinic will provide diabetes education to non-SoonerCare Choice members and collect baseline and follow up A1c levels on this different population. OU Women's will share its results with the Sooner HAN in a de-identified manner so comparisons can be made. This extension phase of the pilot will begin in FY 2017.

Quality Management Activities

Quality Consultation to HAN Providers

OU Physicians-Tulsa Internal Medicine Clinic

Participated on team of NCQA, PCORI and OU Physician-Tulsa Internal medicine staff to evaluate the feasibility of implementing patient centered outcomes approaches into the current office visit workflow. The focus was on members with diabetes who were interested in participating in a project related to health assessment, health literacy, goal setting, and health outcomes. Sooner HAN staff supported quality improvement activities including workflow analysis and PDSA cycles of change while selected care management staff were involved with incorporating patient centered outcomes approaches into the care management of 95 Sooner HAN SoonerCare Choice members with diabetes. This project will continue in FY 2017 with completion expected by 12/31/2016. Sooner HAN care managers will continue to provide HAN care management services after the NCQA PCORI project ends.

OU Physicians-Tulsa Internal Medicine Clinic – Workflow Redesign

Participated on team focused on redesigning OU Physicians-Tulsa clinic workflow and processes to further streamline the patient centered medical home approach. HAN staff assisted with evaluating and documenting the workflow of activities related to a member's clinic visit, from pre-planning activities, the office visit, to after visit activities. Each PCMH team member's role was documented, including the member's interaction. This project will continue in FY 2017 with next steps planned including creation of a value stream map to identify cycle time for an office visit and highlighting value-added and non-value-added steps and time involved. Opportunities for improvement will identified and addressed

Member Experience with Care Management Survey

The Sooner HAN developed a member satisfaction survey tool for members receiving care management services and received approval to proceed from the OU IRB in quarter 2. The surveys are conducted by a master's level student completing a social work or public health practicum. A sample of 150 members in all care groups were identified for the baseline survey. 29 members were contacted during quarter 2, with 14 being unreachable, 7 refusing, 2 deceased, and 6 members who participated and completed the survey. Some of the challenges experienced were: inability to reach members due to incorrect phone numbers or not answering the phone, and members not being able to fully recall events or differentiate who provided services for members. In FY 2017, members will be contacted to participate in the care management satisfaction survey and survey results will be tabulated and reported when the sample size increases. At that time, the Sooner HAN will consult with OHCA regarding feasibility of continuing the survey and next steps.

Sooner HAN Quality Committee

The Sooner HAN formally established a Quality Committee at the beginning of FY 2016. Meetings are held at least quarterly to review performance measures and discuss opportunities for improvement. Quality activities in the planning stage for FY 2017 include the following: 1) determining how the Sooner HAN can assist its providers to improve antibiotic stewardship among Sooner HAN providers related to Upper Respiratory Infections, and 2) evaluating asthma medication adherence and its impact on hospital admissions and readmission rates

HAN Clinic/Provider Reporting

Sooner HAN staff set up meetings with numerous clinics during FY 2016 to build relationships with new staff, discuss the HAN services of quality improvement, care management, and referral management, and offer HAN assistance to clinics in these areas. Onsite meetings were held with the following clinics: Morton Comprehensive Health Services, Stigler Health and Wellness Center, Variety Care, Utica Park and Access Solutions Medical Group. The HAN Director, Quality Manager, and Care Manager attended these meetings with leadership, quality management, and care management staff from the clinic. HAN staff shared examples of reports that can be generated for each clinic for quality improvement monitoring, and discussed clinic issues brought forth by clinic staff.

During FY 2016, the HAN was able to upgrade to a newer version of the Pentaho business analytics software that is used report on roster information and claims data. Providers are utilizing the roster reports that designate new members added to the roster each month. The report includes demographic data that assists clinic staff in conducting outreach activities to new members. Other reports generate for clinics include utilization of emergency rooms and hospitals, including designating members with asthma related ICD codes, to identify patterns and trends. Based on the providers' preferences, reports can be customized to the desired timeframe and include number of ER and Inpatient events, location of facility, day of week, ICD codes, provider specific detail, member specific detail, and care management status.

PCMH Tier Advancement/Corrective Action Plans

Access Solutions Medical Group failed an OHCA PMCH audit and was required to submit a plan of correction. During the 4 quarter of FY 2016, Sooner HAN met with clinic leadership to determine where HAN staff could be of assistance. Efforts related to quality were focused on creating a solid infrastructure and creating policies, procedures, flow charts, and job aids to shore up key processes. Care management staff were engaged to assist with care management of complex members. Doc2Doc staff were involved to help close the referral loop for a backlog of cases. These efforts will continue into FY 2017

Hypothesis 8 and Pro Forma Quality Measures

The Sooner HAN has worked in collaboration with the OHCA and two other Health Access Networks to develop standard measures around Asthma ER use and readmission rates, as well as general ER use by Sooner HAN members. Additional quality measures were added in FY 2016 with the introduction of Pro Forma reporting. These include completion of the PHQ9 behavioral health assessment for new members in the HROB and Diabetes care management groups. Another measure focuses on asthma, evaluating members with persistent asthma who remained on an asthma controller medication during their treatment period. A summary of these measures highlighted below:

Quality Measures (Hypothesis 8 & Pro Forma)		FY 2016 - Sooner HAN			
#	Performance Measure	Qtr 1 %	Qtr 2 %	Qtr 3 %	Qtr 4 %
1	% ER Visits - Asthma Diagnosis	8.8%	9.3%	8.1%	8.2%
2	ER Visits - All Cause Per Roster Member (RATIO)	0.15	0.15	0.16	0.12
3	% Inpatient Admissions-Asthma Diagnosis	6.2%	7.1%	5.8%	4.8%
4	% of Inpatient Admissions (Asthma diagnosis) with 90 Day Readmission (Asthma diagnosis)	14.6%	14.2%	11.8%	3.6%
5	% of new HROB CM members (able to contact) screened for depression using the PHQ9	n/a	n/a	51.9%	45.0%
6	% of new Diabetes CM members (able to contact) screened for depression at least once using the PHQ9	n/a	n/a	0%	55.6%
7	% of patients who remained on an asthma controller medication for at least 50% of their treatment period	n/a	n/a	45.4%	45.0%
8	% of patients who remained on an asthma controller medication for at least 75% of their treatment period	n/a	n/a	21.9%	21.0%

Beginning in the 3rd quarter of FY 2016, the Sooner HAN began reporting on additional quality measures as part of the Pro Forma quarterly reporting to OHCA, numbers 5, 6, 7 and 8. These additional measures were related to depression screening of HROB and Diabetes care managed members and asthma control medication maintenance.

On measure number 6, Diabetes Care Management Depression Screening, the Sooner HAN care managers completed PHQ9 screens for existing members first and then focused on new member screening. Therefore, depression screens for new members were delayed as indicated by 0%. Care Managers were able to catch up and begin focusing on new member screening in the 4th quarter as indicated by rate of 55.6%. Care Managers will continue offer depression screens for all new members in HROB and Diabetes care groups although reaching members due to incorrect phone numbers or unanswered phone calls continues to be a challenge.

Emergency Room Utilization

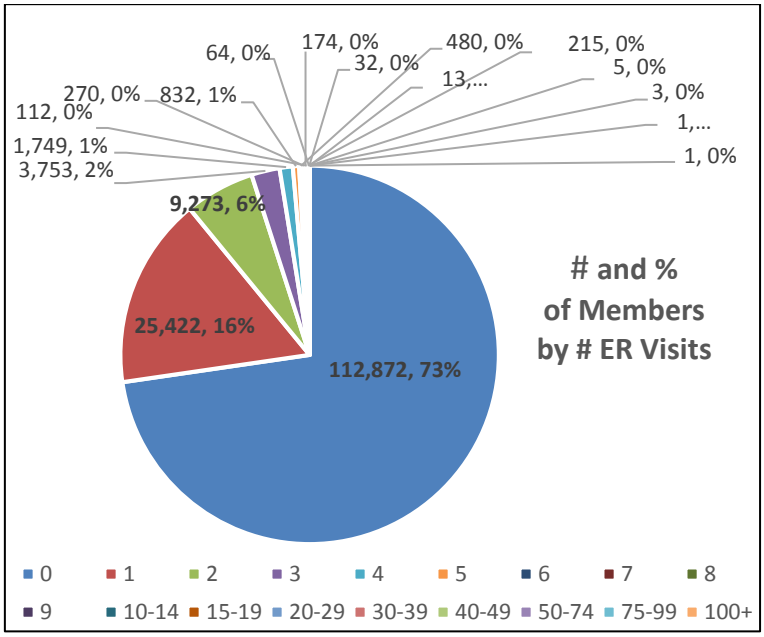
The Sooner HAN has actively monitored ER use over the past several fiscal years. Highlights of FY 2016 data are summarized below:

HAN ER Events per 1000 Members Per Month ranged from a high of 76 ER Events per 1000 members to a low of 61 ER Events per 1000 Members Per Month.

Of the 155,271 unique members served in FY 2016, 112,872 members had no ER visits, representing 73%

of all members. 25,422 members visited the ER on one occasion during the fiscal year which accounts for 16% of unique members' ER visits. 9,273 members visited the ER on two occasions during the fiscal year, representing 6% of unique members' ER visits. However, in total, the percentage of Sooner HAN membership accessing the ER per month was relatively stable, ranging between 6% and 8% each month.

FY 2016 ER Visits		
# ER Events	# Unique Members	% of Total ER Visits
0	112,872	73%
1	25,422	16%
2	9,273	6%
3	3,753	2%
4	1,749	1%
5	832	1%
6	480	0.309%
7	270	0.174%
8	174	0.112%
9	112	0.072%
10-14	215	0.138%
15-19	64	0.041%
0-29	32	0.021%
30-39	13	0.008%
40-49	5	0.003%
50-74	3	0.002%
75-99	1	0.001%
100+	1	0.001%
Total	155,271	100%



The table below show the rate of ER utilization for FY 2016 for Sooner HAN members. Over the course of the fiscal year, variances in ER use are inherent although no significant patterns or trends were noted. Due to the nature of the lag in receipt of claims, data for the most recent months are not complete.

	2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	TOTAL
HAN Unique Mbrs	111,300	108,398	105,553	102,075	103,871	103,478	98,426	98,365	98,453	98,481	98,899	101,255	155,271
ER Events	7,150	7,544	7,631	7,748	7,282	6,728	7,093	7,067	6,499	6,400	5,956	1,199	78,297
ER Events % of HAN Mbrship	6%	7%	7%	8%	7%	7%	7%	7%	7%	6%	6%	1%	
ER Events/ 1000 Mbrs	64	70	72	76	70	65	73	72	67	65	61	12	

The top three primary diagnoses for ER visits during the fiscal year were acute upper respiratory infections, viral infections and otitis media.

ER Events by Top 10 ICD Codes	**2015-07**	**2015-08**	**2015-09**	**2015-10**	**2015-11**	**2015-12**	**2016-01**	**2016-02**	**2016-03**	**2016-04**	**2016-05**	**2016-06**	**Total**	**% of Top 10 Total**
	ICD 9 Codes			ICD 10 Codes										
465.9 - Acute Uri Nos	169	287	362	-	-	-	-	-	-	-	-	-	**818**	**6%**
B34.9 - Viral infection, unspecified	-	-	-	146	158	183	149	156	179	113	108	18	**1,210**	**9%**
H66.91 - Otitis media, unspecified, right ear	-	-	-	68	93	112	109	114	97	77	64	10	**744**	**6%**
J02.9 - Acute pharyngitis, unspecified	-	-	-	151	190	191	182	162	138	158	119	21	**1,312**	**10%**
J06.9 - Acute upper respiratory infection, unspecified	-	-	-	473	577	527	510	511	355	312	250	29	**3,544**	**27%**
J45.901 - Unspecified asthma with (acute) exacerbation	-	-	1	159	128	76	98	81	86	103	87	11	**830**	**6%**
N39.0 - Urinary tract infection, site not specified	-	-	-	170	125	105	112	93	131	94	92	19	**941**	**7%**
R10.9 - Unspecified abdominal pain	-	-	-	113	97	95	100	88	101	115	70	14	**793**	**6%**
R50.9 - Fever, unspecified	-	-	1	145	148	139	142	183	140	155	150	31	**1,234**	**9%**
Z72.0 - Tobacco use	-	-	1	650	496	444	154	-	-	-	-	-	**1,745**	**13%**
Grand Total	**169**	**287**	**365**	**2,075**	**2,012**	**1,872**	**1,556**	**1,388**	**1,227**	**1,127**	**940**	**153**	**13,171**	**100%**

The age groups with the most frequent visits to the ER include the 19-44 year age group (28% of total ER visits), followed by the 1-5 age group (27% of total ER visits), and third by the 6-12 age group (19% of total ER visits).

ER Events by Age Group	2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	Total	% of Total
<1	1	48	116	186	239	336	427	478	481	406	433	99	**3,250**	**4%**
1-5	1,884	1,968	2,011	2,246	2,057	2,047	2,141	2,039	1,651	1,564	1,412	277	**21,297**	**27%**
6-12	1,348	1,474	1,618	1,467	1,424	1,154	1,187	1,341	1,181	1,291	1,216	237	**14,938**	**19%**
13-18	858	988	1,052	1,033	1,022	806	909	915	828	878	785	155	**10,229**	**13%**
19-44	2,396	2,376	2,115	2,140	1,948	1,810	1,845	1,690	1,750	1,692	1,548	326	**21,636**	**28%**
45-64	626	638	670	619	549	548	552	571	582	539	519	100	**6,513**	**8%**
65+	9	14	10	12	6	9	6	3	5	1	1	0	**76**	**0%**
Grand Total	**7,150**	**7,544**	**7,631**	**7,748**	**7,282**	**6,728**	**7,093**	**7,067**	**6,499**	**6,400**	**5,956**	**1,199**	**78,297**	**100%**

The location of ER visits was highest at OU Medical Center Hospitals, followed by Saint Francis Hospital and Integris Southwest Medical Hospital.

ER Event Facility Name	2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	Total	% of Top 10 Total
MEDICAL CENTER HOSPITALS	1,253	1,354	1,357	1,410	1,321	1,325	1,444	1,372	1,195	1,197	1,178	251	**14,657**	**27%**
SAINT FRANCIS HOSPITAL	775	792	841	884	848	775	837	869	846	717	700	156	**9,040**	**17%**
INTEGRIS SW MEDICAL CTR	755	779	762	814	727	672	744	782	692	754	683	1	**8,165**	**15%**
OSU MEDICAL CENTER	458	513	542	473	437	393	425	408	394	389	365	89	**4,886**	**9%**
HILLCREST MEDICAL CTR	408	448	474	437	450	424	397	415	417	419	388	75	**4,752**	**9%**
ST ANTHONY HOSPITAL	358	428	383	413	388	328	352	324	299	303	284	67	**3,927**	**7%**
NORMAN REGIONAL HOSPITAL	216	220	256	272	257	200	234	219	195	189	164	37	**2,459**	**5%**
ST JOHN MED CTR	245	222	240	250	225	195	207	195	226	183	186	37	**2,411**	**4%**
CLAREMORE REG. HOSPITAL	159	178	208	189	176	151	163	149	116	148	139	51	**1,827**	**3%**
INTEGRIS BAPTIST MEDICAL CTR	149	139	142	146	146	146	133	165	136	165	131	4	**1,602**	**3%**
Grand Total	**4,776**	**5,073**	**5,205**	**5,288**	**4,975**	**4,609**	**4,936**	**4,898**	**4,516**	**4,464**	**4,218**	**768**	**53,726**	**100%**

ER visits are distributed fairly equally throughout the week; however, more ER visits occur on Monday than any other day, followed by Sunday and Tuesday. A factor that that may contribute to the higher use on Mondays is that some members may experience symptoms over the weekend but wait until Monday morning to call the PCP office to schedule an urgent care appointment. If members are not able to be seen the same day, they may seek care at the ER.

ER Events by Day of Week	2015 -07	2015 -08	2015 -09	2015 -10	2015 -11	2015-12	2016 -01	2016 -02	2016 -03	2016 -04	2016 -05	2016 -06	Total	% of Total
Monday	962	1,310	1,155	1,140	1,392	904	943	1,344	902	999	1,046	118	**12,215**	**16%**
Sunday	1,028	1,245	1,052	1,026	1,285	893	1,173	1,026	807	867	939	151	**11,492**	**15%**
Tuesday	960	1,002	1,314	1,050	1,020	1,147	898	1,016	1,123	836	952	106	**11,424**	**15%**
Wednesday	1,181	958	1,231	1,052	940	1,134	901	943	1,109	855	816	265	**11,385**	**14%**
Thursday	1,144	991	1,032	1,245	960	986	969	931	1,037	940	806	232	**11,273**	**14%**
Friday	1,058	962	958	1,126	865	806	1,132	933	795	1,034	741	173	**10,583**	**13%**
Saturday	881	1,138	936	1,158	870	910	1,132	908	779	907	703	162	**10,484**	**13%**
Grand Total	**7,150**	**7,544**	**7,631**	**7,748**	**7,282**	**6,728**	**7,148**	**7,101**	**6,552**	**6,438**	**6,003**	**1,207**	**78,532**	**100%**

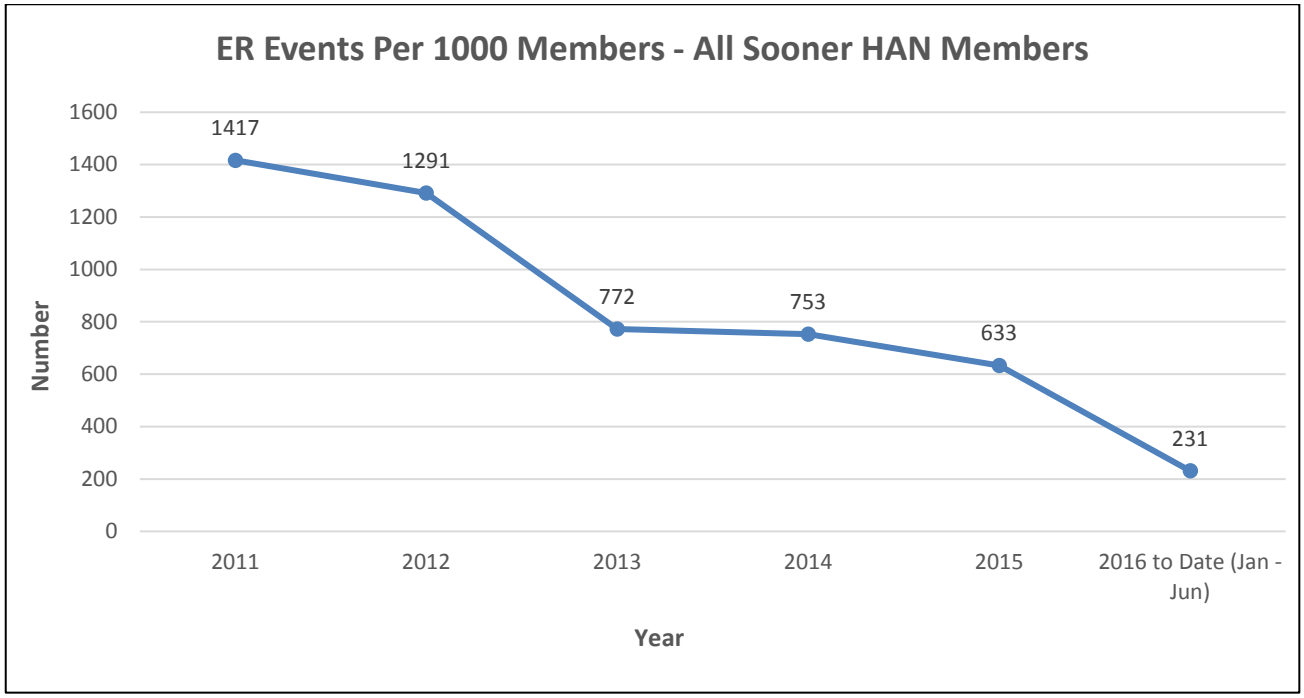
The Sooner HAN plans to continue its focus on reducing ER usage throughout FY 2017 with more targeted interventions in care management. Also, the Sooner HAN will conduct further analysis to determine the degree to which care management services help to decrease overall ER utilization by members receiving care management as well as in the entire Sooner HAN population.

The table below shows the numbers of ER events by members who are currently being care managed, although the members may have begun receiving care management services at any time during the past 5+years. Thus, the data shows the number of ER events that occurred for SoonerCare Choice members each year from 2011 to date regardless of when the member began receiving care management services.

ER Events - Current Care Managed Members							
HAN Care Group / Year	2011	2012	2013	2014	2015	2016 to Date (Jan-Jun)	**Grand Total**
Asthma	100	217	248	389	531	279	**1,764**
BCC - Breast	0	4	11	18	37	13	**83**
BCC - Cervical	-	-	1	4	0	2	**7**
Diabetes	51	98	121	137	151	68	**626**
ER	522	782	1,180	1,483	2,372	1,376	**7,715**
General HAN	83	102	166	137	247	135	**870**
HEMO	2	5	10	6	12	12	**47**
HROB	27	44	97	131	148	114	**561**
Lock In	2	5	13	43	51	13	**127**
Grand Total	**787**	**1,257**	**1,847**	**2,348**	**3,549**	**2,012**	**11,800**

ER events for Sooner HAN members have risen from 61,675 in 2011 to 105,973 in 2014, with a decrease to 96,031 ER events in 2015. Likewise, membership has grown from 43,534 members served during 2011 to 151,692 members during 2015. Using the calculation of ER Events Per 1000 Members (PTM), ER utilization has decreased significantly from 2011 to 2015, from 1417 PTM to 633 PTM, a 55% decrease.

ER Events - All Sooner HAN Members / Year	2011	2012	2013	2014	2015	2016 to Date (Jan-Jun)
ER Events	61,675	91,300	103,423	105,973	96,031	32,214
Unique Members	43,534	70,698	133,884	140,710	151,692	139,596
ER Events Per 1000 Members	1417	1291	772	753	633	231



Annual Report

July 1 - December 31, 2016

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EXECUTIVE SUMMARY

Mission

The Mission of the Sooner Health Access Network is to improve the health of SoonerCare Choice members and support practices through delivering comprehensive, high-quality, evidence-based care management and quality improvement services, while leveraging health information technology to boost outcomes and broaden access to care.

Vision

The Vision of the Sooner Health Access Network is to advance the Triple Aim among both SoonerCare Choice members and their providers. We strive to promote better health care for the population, better experience of care for individuals, and lower costs through continuous improvement efforts.

Summary of Core Functions

The Sooner Health Access Network (Sooner HAN) ended Calendar Year (CY) 2016 with an enrollment of 117,238 SoonerCare Choice members across 68 primary care practices. During Quarters (Q) 3 and 4 of CY 2016, a total of 138,064 unique members were enrolled.

Care Management

The focus of CY 2016 was expansion of care management groups within the Sooner HAN. Identification of members who would benefit from care management services continues to be a priority for the Sooner HAN. Utilization of claims data is the primary way to identify targeted populations for care management, including; emergency room utilization, inpatient admissions, and asthma and diabetes specific ER visits or inpatient stays.

In Q3 and Q4 of CY 2016 the Sooner HAN received 53 referrals for care management from primary care providers. In FY 2016 the Sooner HAN received a total of 55 referrals from primary care providers. This increase in referrals from primary care providers can be attributed to the following three things:

1) Embedding a Sooner HAN care manager in the OU Tulsa Pediatric Practice.
   SoonerCare Choice members account for approximately 90-95% of all members served within the OU Tulsa Pediatrics practice. The Medical Director in this clinic has fully embraced the Sooner HAN and recognizes the valuable services care management can provide.
2) New Sooner HAN providers.
   Care management is no longer a totally foreign concept in primary care. The Sooner HAN has noticed new practices joining the network are more readily accepting care management services.
3) Targeted outreach.
   All the Sooner HAN care managers have been making specific efforts to work closely with the various network practices and at every opportunity reminding the practices about provider referrals for care management and how to send a referral.

Referral Management

The Sooner HAN Doc2Doc staff coordinated with the Doc2Doc vendor to modify the Doc2Doc system to become compliant with the Meaningful Use Stage 2 requirements of sending a transition of care document with all specialty referrals. This document is required to be sent in a specified format, otherwise known as a CCDA, Consolidated Clinical Document Architecture. In Q1 of CY 2017 the Doc2Doc team will be finalizing the reports that will be made available to providers to attest to this specific Meaningful Use requirement.

Targeted efforts were made to both primary and specialty care offices to achieve optimal results in closing the loop on referrals. As of the submission of this report (2/2017), 74.21% of referrals initiated in Q3 and Q4 of CY 2016 were cancelled, scheduled, or completed (report received or pending), with daily efforts continuing to complete any referrals with which the referral loop has not been completed.

Seven new primary care clinics began using Doc2Doc during Q3 and Q4 of 2016. Meeting the goal of increasing primary care utilization of Doc2Doc by 24%, from 25 primary care practices to 31 as of December 31, 2016.

Quality Management

The Sooner HAN continues to provide quality improvement services to Sooner HAN provider practices. During Q3 and Q4 of CY 2016, the Sooner HAN assisted OU Tulsa Internal Medicine to redesign clinic workflow and processes to further streamline the patient centered medical home approach. Assistance on these projects will continue into CY 2017. In this same clinic, Sooner HAN staff also participated in implementing diabetes patient centered approaches into the current office visit workflow to evaluate its feasibility. This project ended at the close of CY 2016.

Sooner HAN staff set up meetings with numerous clinics during CY 2016 to build relationships with new staff, discuss the HAN services of quality improvement, care management, and referral management. In addition, Sooner HAN staff shared examples of reports that can be generated for each clinic for quality improvement monitoring, and discussed clinic issues brought forth by clinic staff. These meetings will continue in CY 2017.

Significant effort was devoted to developing reports for providers based on roster and claims data utilizing the Pentaho business analytics software upgraded in CY 2016. Specifically, numerous providers are currently utilizing the roster reports automatically generated each month that designate new members added to the roster. The roster report includes demographic data such as member address and phone numbers so clinics can conduct outreach activities including welcome phone calls and letters to encourage new members to establish care with the clinic. In addition, practices are using utilization reports showing emergency room visits and hospitalizations. These reports include diagnoses to assist in identifying patterns and trends. Based on provider preferences, reports can be customized to the desired timeframe and include items such as the number of ER and inpatient events, location of facility, day of week, ICD codes, provider specific detail, member specific detail, and care management status.

Regarding tier advancement, most providers have advanced to the tier level of their preference and are not interested in pursuing further tier advancement at this time. Other providers have been interested in tier advancement and had the internal resources to accomplish tier advancement without assistance from the

Sooner HAN. The Sooner HAN quality staff will continue to offer assistance to providers eligible for tier advancement to increase the level of service provided to their members and maximize potential reimbursement.

During Q3 and Q4 of CY 2016, the Sooner HAN staff assisted Access Solutions Medical Group and Crossover Health Services, two primary care clinics that failed an OHCA PCMH annual audit and were required to submit a plan of correction. This effort will continue into CY 2017 and is focusing on creating a solid infrastructure and creating policies, procedures, flow charts, and job aids to standardize and streamline key processes. Both clinics passed their follow up audits in Q4 of CY 2016.

In addition, the Sooner HAN quality committee met at least quarterly during CY 2016 to review performance measures, reports and to discuss opportunities for improvement. Some of the major goals for CY 2017 are highlighted below.

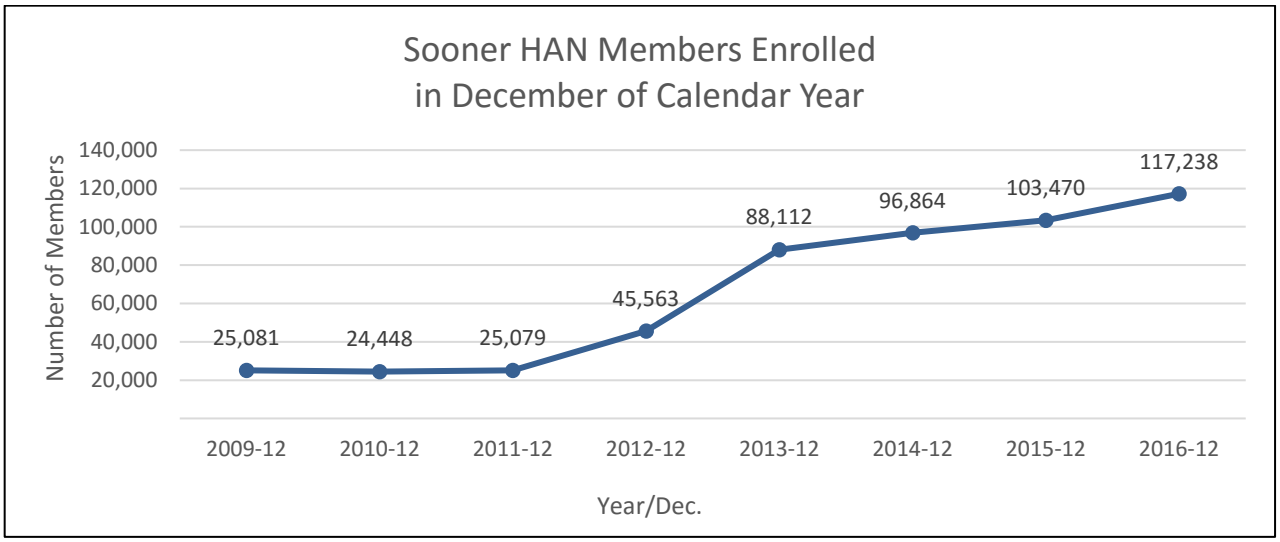
Provider Recruitment

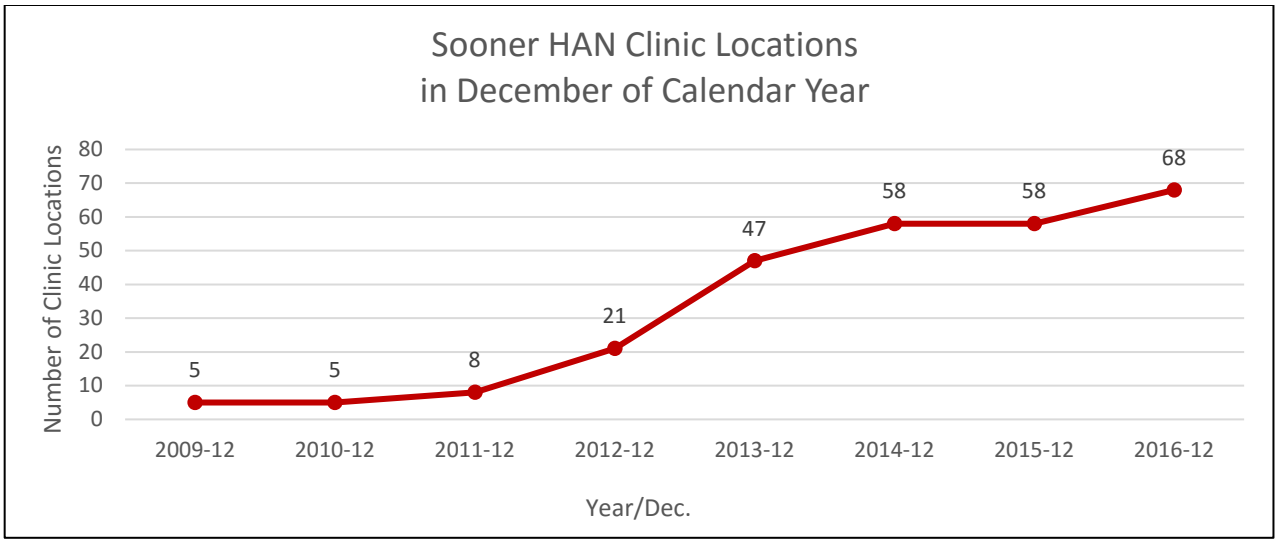
The Sooner HAN began its program with 25,081 members in December of 2009 and one contracted provider group, OU Physicians-Tulsa. Since the inception of the Sooner HAN, Sooner HAN staff have reached out to providers to share the services available and the benefits to both providers and members. Like many new programs, primary care providers were somewhat skeptical at first, but with time the success stories and benefits of the Sooner HAN have become well known and wide spread in the provider community. Providers are now reaching out to the Sooner HAN to learn about and join the network.

At the end of FY 2016 the Sooner HAN set the goal to grow primary care participation to support 150,000 covered lives per month. At the end of CY 2016, the Sooner HAN had grown by 16% from 101,255 to 117,238. It is anticipated that the Sooner HAN will reach 150,000 covered lives per month during CY 2017.

While continuing to focus in CY 2017 on primary care recruitment, extra attention will be given to increasing the specialty provider network utilizing the referral management tool, Doc2Doc, in the rural areas.

The graphs below highlights the growth from July through December of CY 2016 in both the number of members enrolled and the number of clinics available to serve SoonerCare Choice members.





Goals for CY 2017

In addition to increasing outcome measurement, the Sooner HAN has identified the following goals for CY 2017:

1. Primary Care Provider (PCP) Recruitment – Increase PCP participation to 150,000 covered lives
2. Expansion of Care Management Services – Reach 2%-3% of covered lives in care management
3. Doc2Doc Utilization for Optimal Referral Loop Closure – Increase primary care participation in Doc2Doc by 25%
4. Quality Management Reporting for Clinics/Providers and Care Managers – Offer quality management reporting to 100% of providers/clinics

SOONER HAN NETWORK

Summary of Sooner HAN Enrollment

	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016
Sooner HAN Unique Members	102,827	104,907	107,432	113,107	117,081	117,238
Sooner HAN Unique Care Managed Members	901	1,021	956	938	955	884
Sooner HAN Clinic Locations	60	61	62	66	67	68

Primary Care Network

In July of CY 2016, the Sooner HAN provided services to 60 provider practice locations. As a result of primary care recruiting efforts, eight provider locations were added during a 6 month period. By December of CY 2016, 68 provider clinics and hundreds of primary care providers were serving 117,238 SoonerCare Choice members across the state.

Provider	Clinic	Members Served – Dec 2016	% of Total HAN Members Served
Access Solutions Medical Group	Access Solutions Medical Group - Hwy 66	577	0.5%
	Access Solutions Medical Group - SS	1,070	0.9%
	Access Solutions Medical Group - Sheridan	2,586	2.2%
Arkansas Verdigris	Arkansas Verdigris	398	0.3%
Broken Arrow Pediatrics, LLC	Broken Arrow Pediatrics, LLC	745	0.6%
Community Health Connection	Community Health Connection	2,109	1.8%
	Community Health Connections E 3rd St	1,368	1.2%
Crossover Health Services, LLC	Crossover Health Services, LLC	316	0.3%
FairFax Clinics	Fairfax - Hominy	655	0.6%
	Fairfax - Newkirk Family Health Center	1,141	1.0%
	Fairfax - Robert Clark Family Health Center	185	0.2%
Generations Clinics	Generations - Bartlesville	984	0.8%
	Generations - Chelsea	788	0.7%
	Generations - Claremore	1,785	1.5%
	Generations - Owasso	1,344	1.1%
Jahangir Khan, MD	Jahangir Khan, MD - Bixby	246	0.2%
	Jahangir Khan, MD - Sand Springs	716	0.6%
Jenks Family Physicians	Jenks Family Physicians	1,698	1.4%

Provider	Clinic	Members Served – Dec 2016	% of Total HAN Members Served
Morton	Morton	2,769	2.4%
	Morton - Bartlesville	92	0.1%
	Morton - East	815	0.7%
	Morton - Nowata	313	0.3%
OU Physicians - OKC	OU Adolescent Clinic	144	0.1%
	OU Edmond (Family Practice)	591	0.5%
	OU Family Medicine Center	8,408	7.2%
	OU Grand Prairie Pediatrics	1,154	1.0%
	OU Latino Clinic	2,556	2.2%
	OU Physicians South OKC Family Practice	446	0.4%
	OU Sooner Pediatrics Clinic	6,512	5.6%
	OU Southwest Family Medicine	2,571	2.2%
OU Physicians - Tulsa	CM Health	1,637	1.4%
	Family Medicine	6,205	5.3%
	Internal Medicine	1,848	1.6%
	Pediatrics	14,032	12.0%
	Wayman Tisdale Clinic	1,684	1.4%
Pediatric Practitioners of Oklahoma	Pediatric Practitioners of Oklahoma	1,350	1.2%
Stigler Health and Wellness Center	Stigler Health and Wellness Center - Checotah	711	0.6%
	Stigler Health and Wellness Center - Eufaula	705	0.6%
	Stigler Health and Wellness Center - Poteau	562	0.5%
	Stigler Health and Wellness Center - Stigler	1,807	1.5%
	Stigler Health and Wellness Center - Wilburton	342	0.3%
	Stigler Health and Wellness Cnt Sequoyah-Sallisaw	2,389	2.0%
TL Carey Family Medicine	Hutcherson, APRN, Sarah	647	0.6%
	Myers, ARNP, Stephanie	295	0.3%
Utica Park BA North	Chow M.D., Christopher	47	0.0%
Utica Park BA South	Crow D.O., Tobin	139	0.1%
	Silas M.D., Geeta	199	0.2%
Utica Park Bristow	Carl R. Smith, DO	68	0.1%
	Remington D.O., Jason D.	223	0.2%
	Riffe D.O., Jason	154	0.1%
Utica Park Catoosa	Haines PA, Jessica	40	0.0%
Utica Park Claremore	Hinkle D.O., Brent	139	0.1%
	Nodine M.D., Seth	65	0.1%
	Vardey M.D., Sheela	804	0.7%
	Williams D.O., Jeffrey	178	0.2%
Utica Park Cushing	Jenkins APRN-CNP, Bethany	566	0.5%
	McCauley D.O., Colm P	570	0.5%

Provider	Clinic	Members Served – Dec 2016	% of Total HAN Members Served
	Noe P.A., Lisa	340	0.3%
Utica Park Henryetta	Cain D.O., Michael	96	0.1%
Utica Park Jenks	Fowler DO, Matthew B.	96	0.1%
	Koljack M.D., Kathleen S	181	0.2%
Utica Park Okemah	Dixon APRN-CNP, Debra	329	0.3%
Utica Park Owasso	Horton M.D., Theresa	409	0.3%
	Lauri Blesch, MD	397	0.3%
	Laurie Mickle, MD	266	0.2%
	Patterson D.O., Keith S.	136	0.1%
	Yancy Galutia, DO	122	0.1%
Utica Park Pryor	Battles D.O., Paul	89	0.1%
	Gietzen D.O., Michael	186	0.2%
	Johnston APRN, Sarah J.	18	0.0%
	Owens III, DO, John L.	163	0.1%
	Ring D.O., David	129	0.1%
	Suhail M.D., Shuaib	916	0.8%
Utica Park Sapulpa	Bauer APRN, Robert A.	268	0.2%
Utica Park South Lewis	Choplin PA, Ryan	359	0.3%
	Griffin D.O., Chelsey	373	0.3%
	Hasenpflug D.O., Tara Brook	72	0.1%
	Richard Gordon, MD	1,138	1.0%
Utica Park Cleveland	Shipman APRN, Shawna	187	0.2%
Variety Care	Variety Care - Norman Family Practice	1,398	1.2%
	Variety Care at Mid Del	1,965	1.7%
	Variety Care - Norman Pediatrics	1,772	1.5%
	Variety Care at Fort Cobb	304	0.3%
	Variety Care – NW 56th Street	9,876	8.4%
	Variety Care at Lafayette	2,382	2.0%
	Variety Care at NW 10th Street	3,060	2.6%
	Variety Care at Straka	6,189	5.3%
Wellspring Family Clinic	Wellspring Family Clinic	1,128	1.0%
Zoellner Medical Group	Zoellner Medical Group	406	0.3%
Grand Total		**117,238**	**100%**

Provider Tier Levels

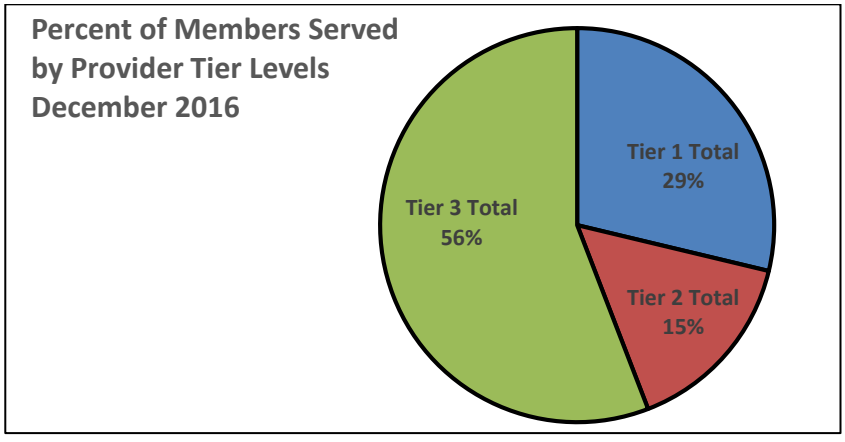
SoonerCare Choice is a managed care model in which each member is linked to a primary care provider who serves as the member's "medical home". Primary care providers manage the basic health care needs, including after-hours care and specialty referral of the members on their panel. PCMH includes three tiers with escalating responsibilities and associated per member per month care coordination fees. Providers may serve members in the following panel categories: Child and Adult, Child Only, Adult Only, or Federally Qualified Health Center/Rural Health Center.

Tier I is considered "entry level" and provides the minimum requirements for OHCA PCMH status and the minimum reimbursement level for incorporating patient centered medical home approaches into the clinic or practice. Tier I has 13 requirements including coordinated primary care and patient education; 24/7 telephone coverage by medical professional; maintaining a system to track tests and referrals; and acceptance of electronic communication from OHCA.

Tier II represents "advanced" medical home approaches and provides a higher reimbursement for the additional requirements. Tier II has 20 requirements, including all Tier I criteria plus full-time practice w/enhanced access/after-hours; inpatient tracking & hospital follow up; and three of five enhanced services - practice healthcare team, after visit follow-up, adoption of evidence-based practice guidelines, and medication reconciliation.

Tier III is the "optimal" level and incorporates additional requirements and additional reimbursement. Tier III has 21 requirements, including all Tier I and Tier II requirements using health assessments tools to characterize patient needs and risks.

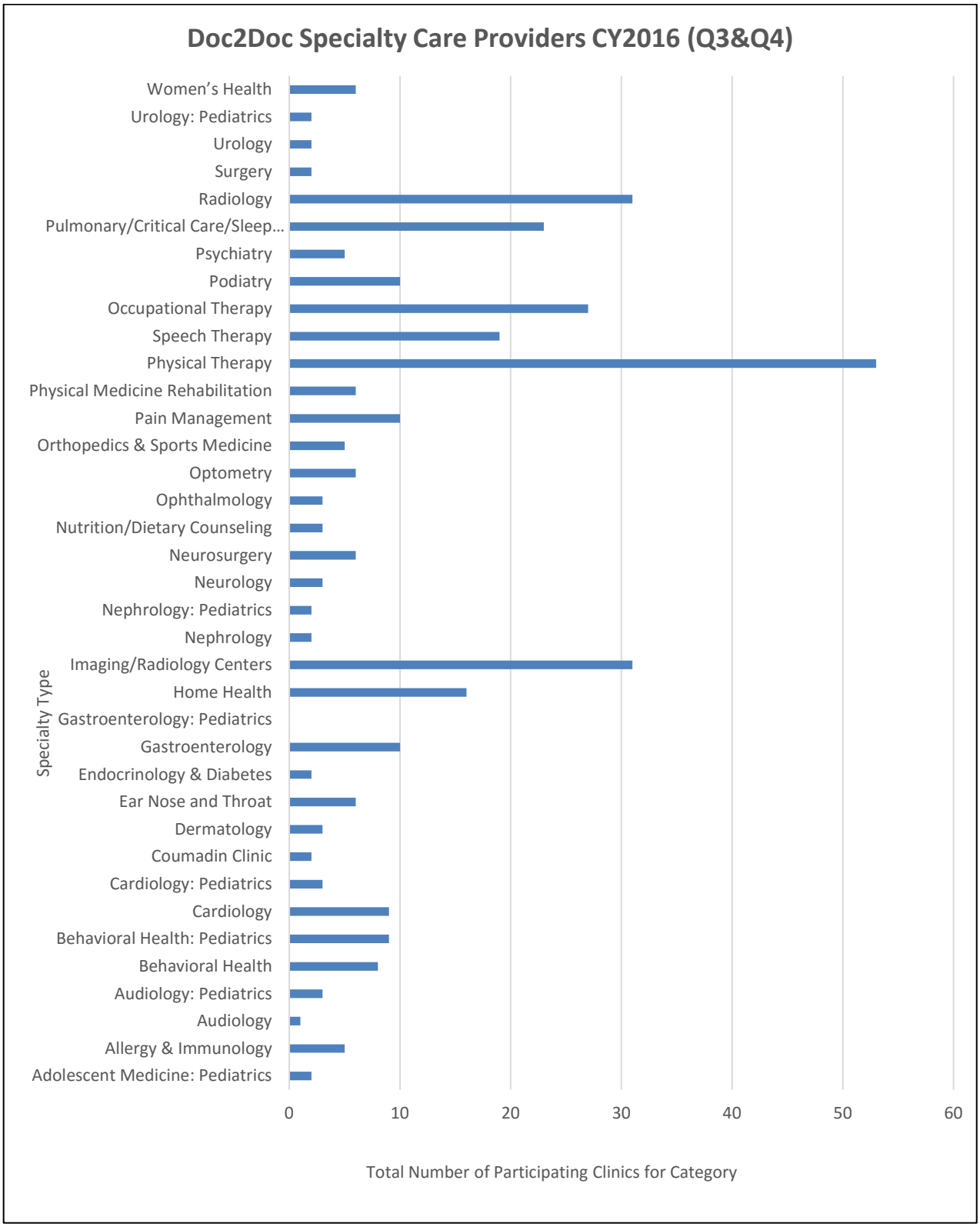
As shown in the table below, providers in the Sooner HAN at the highest PCMH Tier Level III served 56% of the total member population in December 2016. Providers at PCMH Tier Level II served 15% while providers at Tier Level 1 served 29% of the member population.



Specialty Care Network

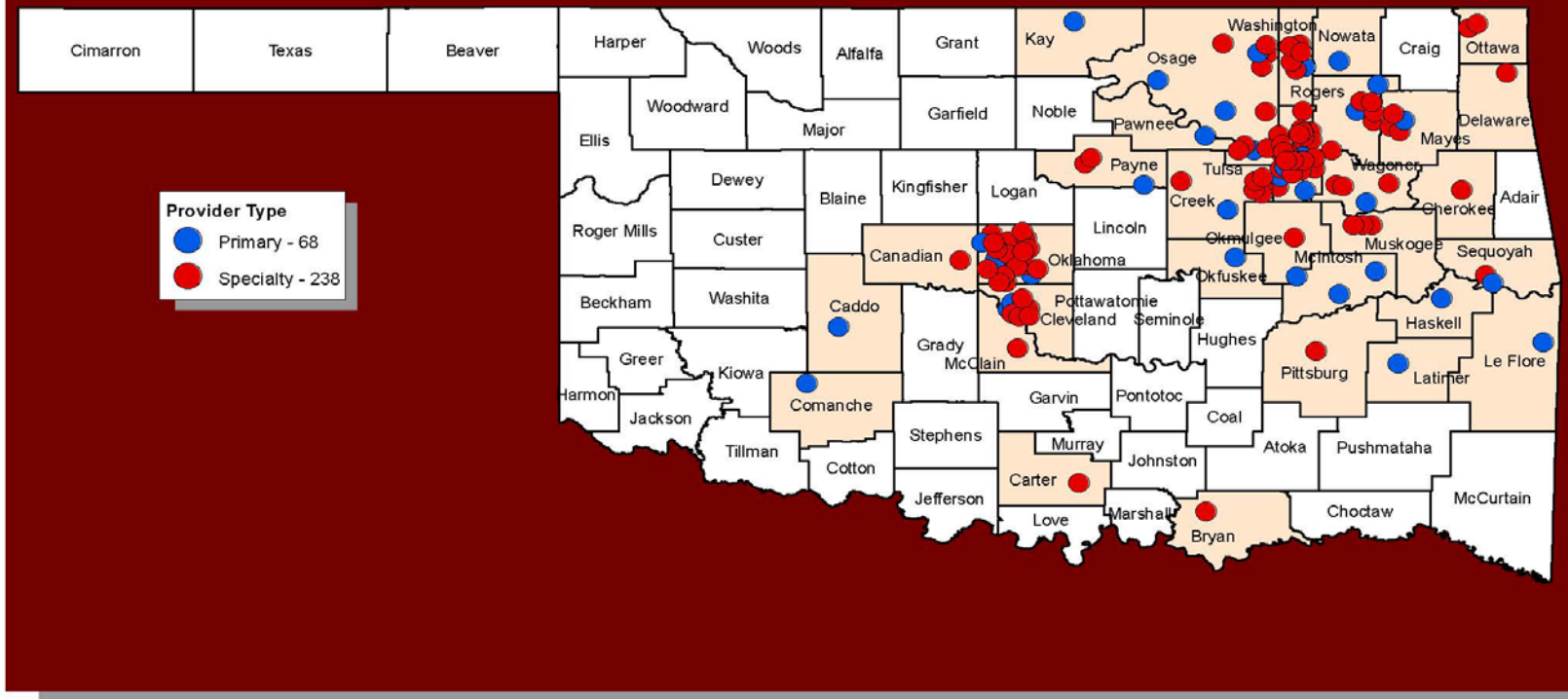
The Sooner HAN continues to focus on the recruitment of specialty providers for enrollment into the Sooner HAN. Targeted recruitment in the Oklahoma City and Tulsa areas will continue throughout CY 2017. As of December 2016, there were 258 specialty clinics participating in Doc2Doc, offering access to care across multiple specialties. The Sooner HAN added 30 new clinic locations: 6 primary care; 16 new specialist service providers, and 8 clinic relocations or expansions.

Sooner HAN Specialty Network: Number of Clinics per Specialty CY 2016			
Specialty	***# Clinics***	***Specialty***	***# Clinics***
Adolescent Medicine: Pediatrics	2	Neurology	3
Allergy & Immunology	5	Neurosurgery	6
Audiology	1	Nutrition/Dietary Counseling	3
Audiology: Pediatrics	3	Ophthalmology	3
Behavioral Health	8	Optometry	6
Behavioral Health: Pediatrics	9	Orthopedics & Sports Medicine	5
Cardiology	9	Pain Management	10
Cardiology: Pediatrics	3	Physical Medicine Rehabilitation	6
Coumadin Clinic	2	Physical Therapy	53
Dermatology	3	Speech Therapy	19
Ear Nose and Throat	6	Occupational Therapy	27
Endocrinology & Diabetes	2	Podiatry	10
Gastroenterology	10	Psychiatry	5
Gastroenterology: Pediatrics	0	Pulmonary/Critical Care/Sleep	23
Home Health	16	Surgery	2
Imaging/Radiology Centers	31	Urology	2
Nephrology	2	Urology: Pediatrics	2
Nephrology: Pediatrics	2	Women's Health	6
		TOTAL	**336**



The maps on the next two pages indicate the locations of the Sooner HAN participating providers. The map highlights each primary and specialty care clinic location.

Sooner HAN Provider Locations
by Provider Type as of December 31, 2016

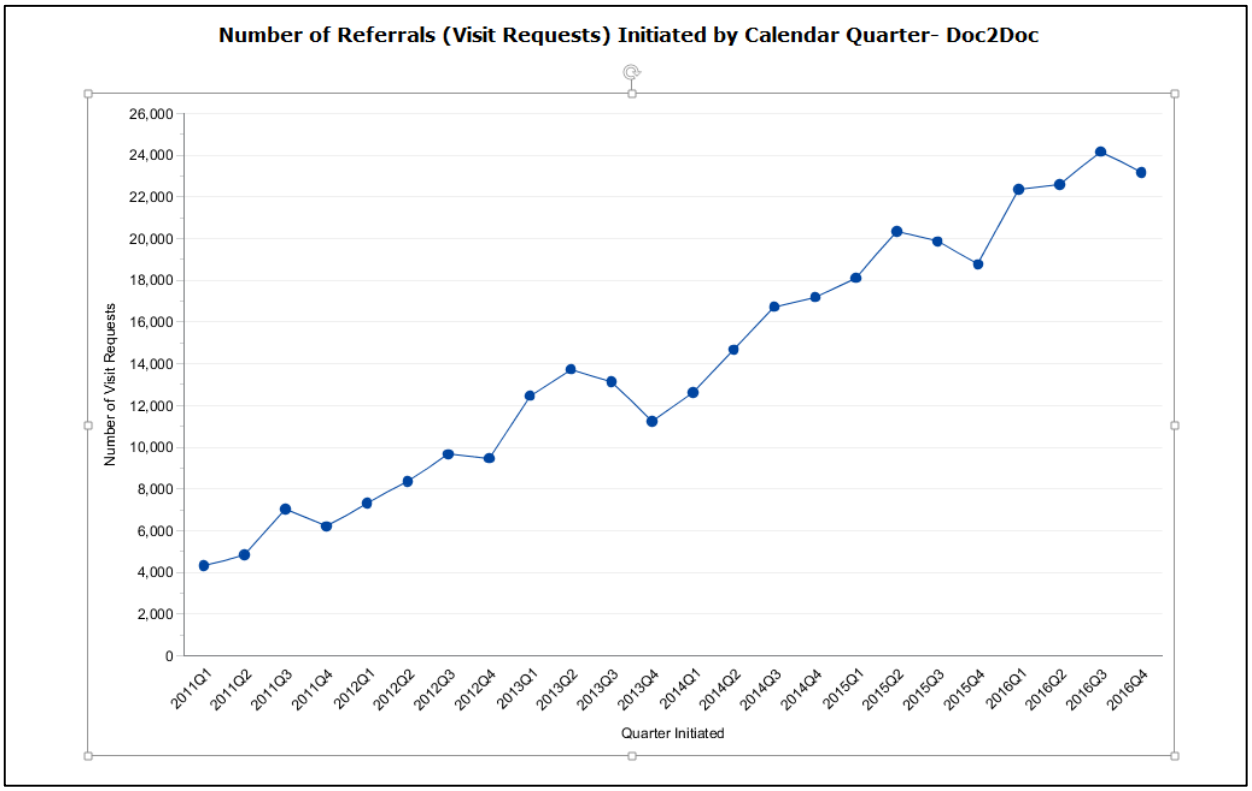


SOONER HEALTH ACCESS NETWORK

Transitions of Care and Referral Management

The adoption of the electronic referral management tool, Doc2Doc, continued to grow over CY 2016. In particular, interest has heightened in the Oklahoma City area, as well as southeast Oklahoma. Currently, the Doc2Doc team is especially focused on increasing access to specialty care in Oklahoma's rural areas through the use of Doc2Doc. The Sooner HAN is currently working with the Doc2Doc vendor to finalize reports that will fulfill Meaningful Use Stage 2 requirements regarding transitions of care documents. The Sooner HAN continues to coordinate with MyHealth, the Health Information Exchange in Oklahoma, regarding expanded offerings of the Doc2Doc tool to attract new participating providers.

The following chart shows the number of referrals (visit requests) initiated by calendar quarter since 2011. There continues to be a steady increase in the number of referrals. In the first quarter of 2011, 4,317 referrals were initiated. In comparison, during Q3 and Q4 of CY 2016, 47,338 referrals were initiated in the Doc2Doc system. This represents an increase of 460% over six years.

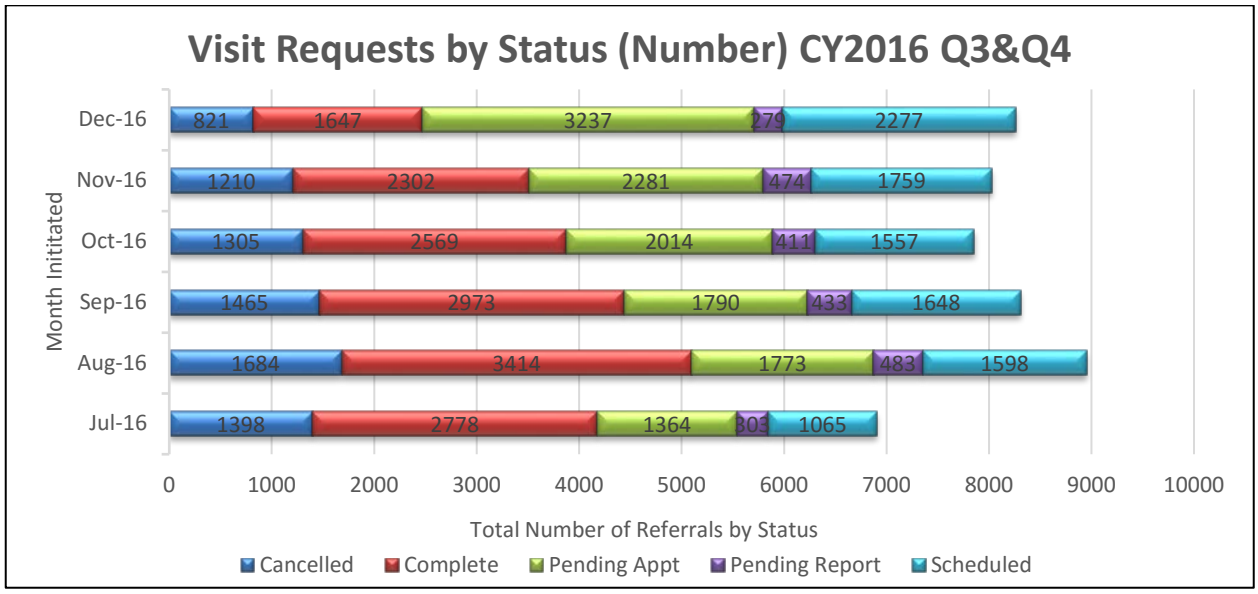


The table below outlines the total number of visit requests in Doc2Doc and a breakdown of the statuses of these requests at the conclusion of December 2016.

Sooner HAN Doc2Doc Status CY 2016							
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	TOTAL
Cancelled	1,398	1,684	1,465	1,305	1,210	821	7,883
%	20	19	18	17	15	10	
Complete	2,778	3,414	2,973	2,569	2,302	1,647	15,683
%	40	38	36	33	29	20	
Pending Appt	1,364	1,773	1,790	2,014	2,281	3,237	12,459
%	20	20	22	26	28	39	
Pending Report	303	483	433	411	474	279	2,383
%	4	5	5	5	6	3	
Scheduled	1,065	1,598	1,648	1,557	1,759	2,277	9,904
%	15	18	20	20	22	28	
Grand Total	6,908	8,952	8,309	7,856	8,026	8,261	48,312

In Q3 and Q4 of CY 2016, enhanced Doc2Doc training aimed at helping participating clinics improve referral loop closure included interpreting automated weekly and monthly reports to referral managers, understanding current and upcoming meaningful use requirements, and one-on-one coordinator training to increase workflow efficiency. Efforts were targeted to both primary and specialty care offices to achieve optimal results. As of the submission of this report (2/2017), 74.21% of referrals initiated in Q3 and Q4 of CY 2016 were cancelled, scheduled, or completed (report received or pending), with daily efforts continuing to complete any referrals with which the referral loop has not been completed.

The following graph shows the status of visit requests over time, based on the month of initiation. Ideally, the goal is to see referrals initiated in the past moving to red, i.e., complete. The dark blue represent referrals that have been cancelled. Referrals are cancelled for various reasons including, but not limited to, member requested cancellation or duplicate referral in the system. A reason for cancellation is required to be entered by the referral clerk.

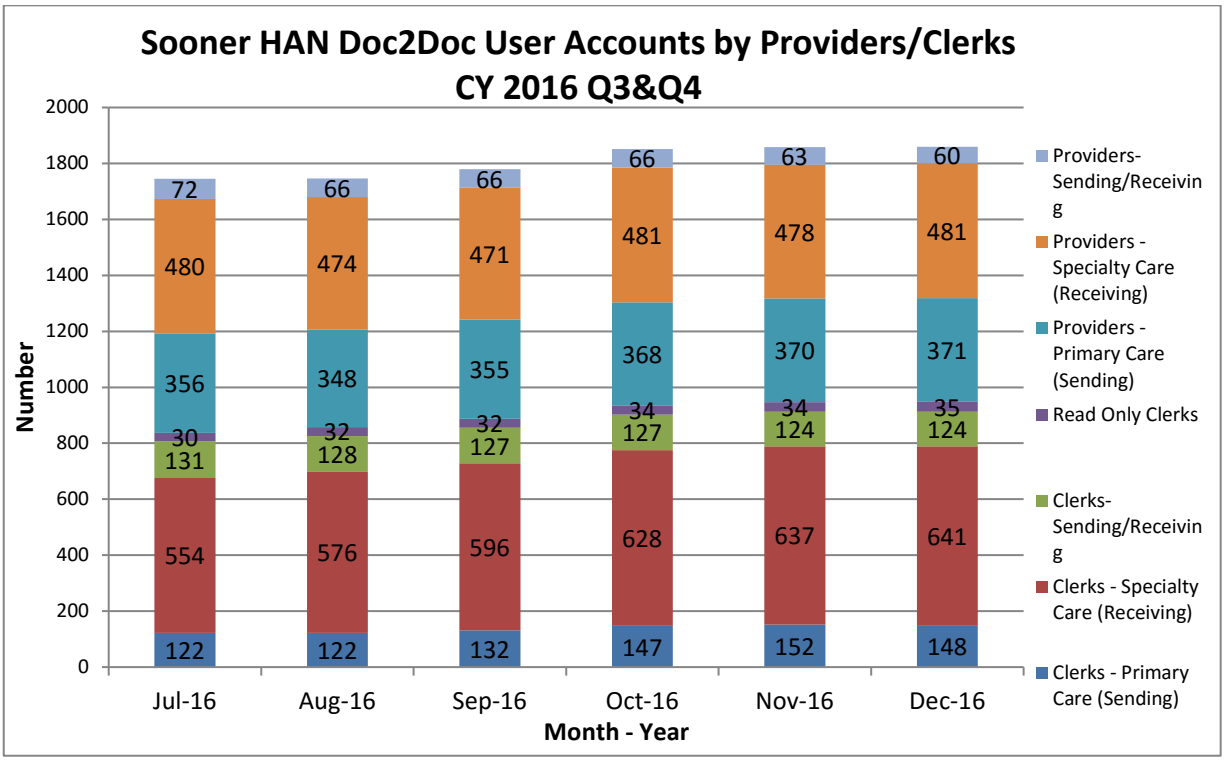


Transitions of Care and Referral Management User Accounts

In Q3 and Q4 of CY 2016, the Doc2Doc team observed growth in the number of specialty practices adopting the technology to enhance patient access to care. As a result, over 16 new specialty care providers began using Doc2Doc in Q3 and Q4 CY 2016. Additionally, specialty practices explored new workflows that would allow them to better serve the member, as well as improve their own internal processes. Specialty Clerks were added to the system for the purpose of updating the referral status throughout the process, as well as to perform tasks such as order retrieval that would reduce the number of rescheduled appointments.

Also, 6 primary care practices implemented the use of Doc2Doc into their clinic workflows in Q3 and Q4 of CY 2016, with a total of 51 locations now utilizing the referral management tool. With the recruitment of primary care practices and incoming residents/students, the count of active providers is trending upward. The following table and graph shows the number of Doc2Doc user accounts by Provider/Clerk Accounts.

Sooner HAN Doc2Doc User Accounts CY 2016							
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	TOTAL
Clerks - Primary Care (Sending)	122	122	132	147	152	148	823
Clerks - Specialty Care (Receiving)	554	576	596	628	637	641	3,632
Clerks-Sending/Receiving	131	128	127	127	124	124	761
Read Only Clerks	30	32	32	34	34	35	197
Providers - Primary Care (Sending)	356	348	355	368	370	371	2,168
Providers - Specialty Care (Receiving)	480	474	471	481	478	481	2,865
Providers- Sending/Receiving	72	66	66	66	63	60	393
Total System Users	1,745	1,746	1,779	1,851	1,858	1,860	10,839



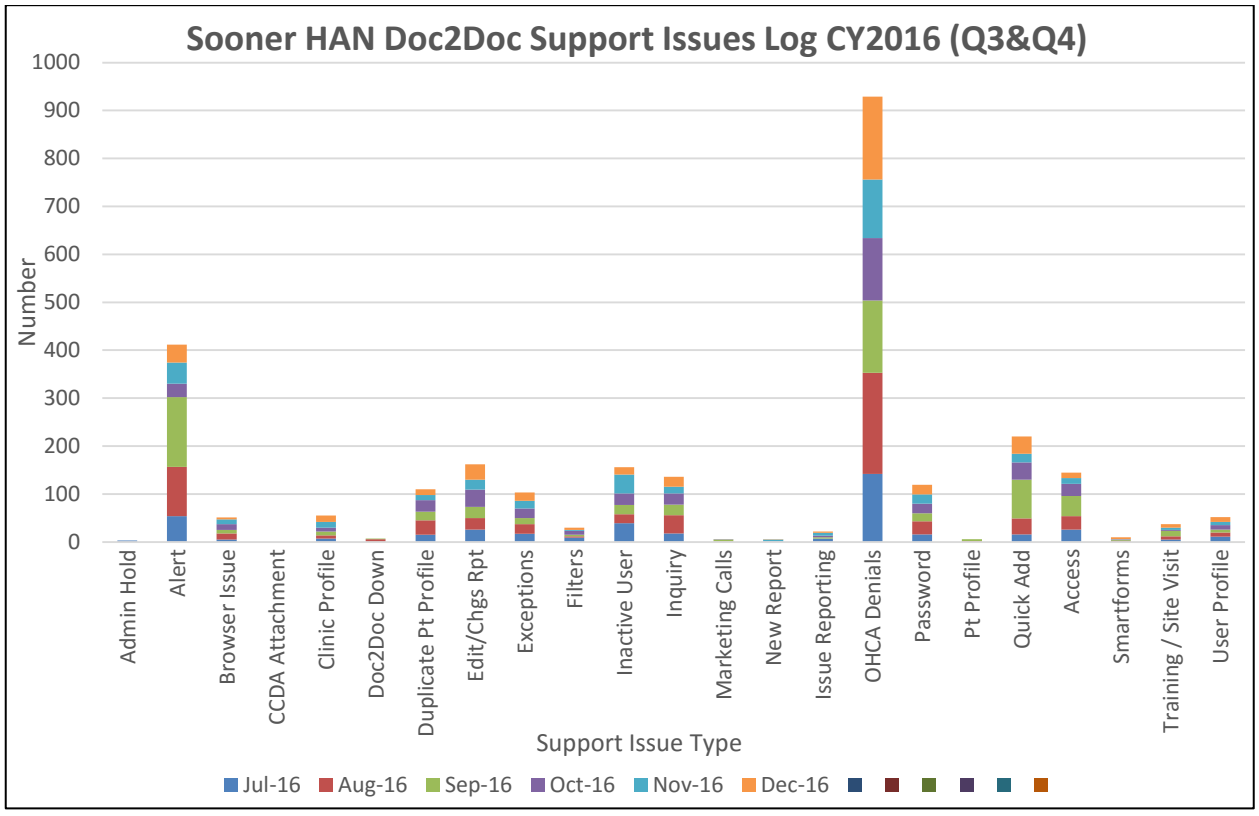
Transitions of Care and Referral Management User Support Issues

The Sooner HAN provides user support for the Doc2Doc referral management tool via telephonic support, email support, and remote online support. Additionally, the team provides interface support for EMR and OHCA interfaces. Support is available Monday-Friday 7 am to 7 pm.

The following table and graph shows the number of Doc2Doc user support issues logged by month in Calendar Year 2016.

Sooner HAN Doc2Doc Support Issues Log CY Year 2016							
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	TOTAL
Add User/Location	1	0	0	0	0	0	1
Admin Hold	3	0	0	0	0	0	3
Alert	54	103	145	28	44	38	412
Browser Issue	5	13	7	12	10	4	51
CCDA Attachment	0	0	0	0	0	0	0
Clinic Profile	7	7	8	8	12	13	55
Doc2Doc Down	0	6	1	0	0	0	7
Duplicate Pt Profile	15	30	18	24	11	12	110
Edit/Chgs Rpt	26	24	23	36	21	32	162

Sooner HAN Doc2Doc Support Issues Log CY Year 2016							
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	TOTAL
Exceptions	17	20	13	20	16	17	103
Filters	9	3	3	8	2	5	30
Inactive User	39	19	19	24	40	15	156
Inquiry	18	38	22	23	14	21	136
Marketing Calls	0	1	4	1	0	0	6
New Report	1	0	0	1	3	1	6
Issue Reporting	7	0	3	3	6	3	22
OHCA Denials	142	211	151	130	122	173	929
Password	16	27	17	20	19	20	119
Pt Profile	0	2	4	0	0	0	6
Quick Add	16	33	81	36	18	36	220
Access	26	28	42	25	12	12	145
Smartforms	0	2	2	1	1	4	10
Training / Site Visit	5	7	11	2	5	7	37
User Profile	11	9	6	9	7	10	52
Visit Request	16	9	16	9	5	7	62
Total Number of Issues	433	592	596	420	368	430	2,839



The Doc2Doc support team is providing assistance to the Sooner HAN primary care practices by offering referral loop closure assistance. This includes reviewing the EMR record for consultation reports, contacting specialty practices to obtain reports, and updating the referral status to indicate closure. The team communicates with the practice regarding any referrals that require additional processing via Doc2Doc communication tools. This effort has resulted in completing closure of an additional 2,118 referrals during Q3 and Q4 of CY 2016. This project will continue to complete closure on a minimum of 2,584 referrals in CY 2017. It is anticipated that this project will be expanded in CY 2017 to continue to support clinics that may need additional staff support to close the loop on open referrals.

Success Stories

In CY2016, the cardiology department at the University of Oklahoma approached the Doc2Doc team to discuss adoption of the e-referral tool. The goal was to increase the number of referrals, gain efficiency in staff process, increase transparency in the referral process, and increase provider satisfaction and productivity. In December 2016, a contract was approved and training completed at the cardiology clinic. Immediately, the clinic began to see an increase in the number of referrals and scheduled appointments. Additionally, the system provided them the transparency to identify staff training needs, resulting in a staff change that has improved the member access to care. The providers in the clinic also provided feedback regarding the increased number of scheduled visits, ultimately leading to retention of a key specialist provider at the clinic. The cardiology department is making recommendations to other departments within the organization to consider Doc2Doc as a referral solution.

In CY 2016, Crossover Health Services partnered with the Sooner Health Access Network to enhance services to SoonerCare Choice members and improve care delivery at the PCMH. Immediate work began to meet the requirements of a Tier I PCMH, as well as improve the referral process. In late 2016, the clinic passed the OHCA audit with a 92%. Additionally, the referral department has successfully adopted Doc2Doc and has defined the process for attaching a care transition summary (CCDA) to each referral. By the close of 2016, the team had confirmed loop closure in just over 50% of referrals and had a plan in place to continue following up on scheduled or pending referrals.

The Orthopaedic Center at the Hillcrest Campus in Tulsa actively sought training for additional users within the clinic to expedite member access to care and provide referral status feedback to referring clinics. As a result of close collaboration with the referral/billing manager, Tiffany Starks, an additional 4 schedulers received training.

The OU-Tulsa Physician Clinics have an increased desired to effect the quality of referrals, member access to care, and referral loop closure. As a result, the Doc2Doc team worked with the quality department to create referral dashboards that would allow the clinic to monitor referral activity as it relates to volume, closure, clerk productivity, and provider performance. The dashboards are actively being utilized by the quality and clinical services teams, as well as have been adopted by each manager in a PCMH, to identify opportunities for process improvement. The dashboards have already resulted in open dialogue between some primary and specialty practices to further enhance referral timeliness and loop closure. The Doc2Doc team will continue to meet at least quarterly with the group in CY 2017 to discuss next steps in quality improvement.

CARE MANAGEMENT

Each fiscal year, the Sooner HAN has continued to expand its care management services to SoonerCare Choice members. The number of unique members served has grown from 172 in FY 2011 to 1518 at the close of December 2016. To support this growth in membership, additional care managers have been hired. During FY 2011, one care manager (1 FTE) served 172 care managed members and in CY 2016 Quarters 3 and 4, 16.75 FTE care managers served 1518 members.

At the end of CY 2016 the Sooner HAN had 12 registered nurse care managers, and 4 master's prepared licensed clinical social workers (one of whom is bilingual in Spanish and English). There were two open RN positions and one open social work position, all expected to be filled in Q1 of CY17. One of the registered nurse care managers is bilingual (in Spanish and English) and is a certified diabetes educator. Engagement of members continues to be one of the main care management challenges—both related to initial contact and ongoing activities.

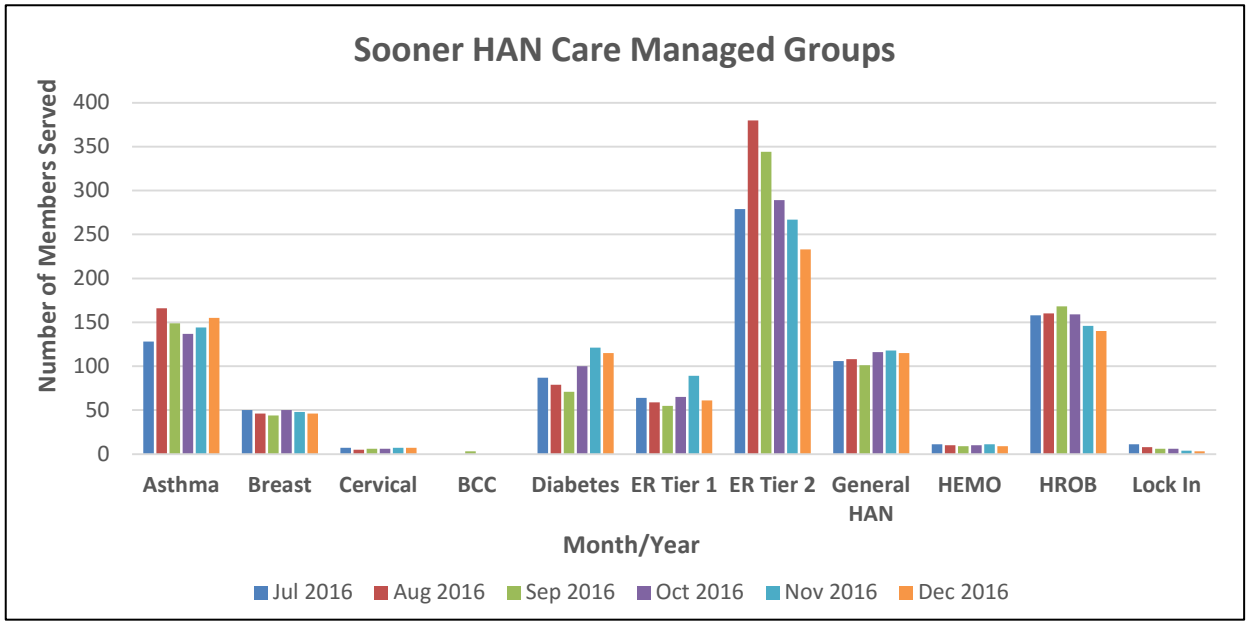
In FY2016 the Sooner HAN chose to implement the use of the PHQ9 screening for all members in the HROB and Diabetes care groups as well as for members in other care groups that may benefit from depression screening. Through reporting in the ProForma in Q3 and Q4 of 2016 it was noted that there was a very low percentage of members in the Diabetes care group successfully receiving the PHQ9 screening. At the end of 2016Q4 with only an 11% screening rate, it has been decided that a PDSA will be conducted to 1) see what the barriers in completing the PHQ9 are and 2) could the PHQ 3 or PHQ4 meet the needs and more easily be administered.

One of the greatest challenges for care managers is identifying and accessing the necessary services for their members. To assist care managers in gathering and reserving some of the necessary resources to use at their immediate disposable, a resource supply area has been created in the care management office. Member education materials regarding chronic disease processes and treatment plans are available in both English and Spanish. Member publications offered by the OHCA, specifically around ER utilization, after hours clinics, and SoonerRide, are also available. The resource area is also stocked with items such as; pill boxes, glucometers, Talking is Teaching Books, nursing covers and boppy pillows. One Sooner HAN care manager also developed a "diaper closet" after the birth of her first child and she had left over diapers.

The table below shows a summary of the number of unique members served by care managed group and the percent of the total care managed members each group represents.

Sooner HAN Care Management		
Care Managed Category	**Unique Members Served CY 2016 Q3&4**	**% of Total Members CY 2016 Q3&4**
Asthma	224	15%
Breast Cancer	55	4%
Breast and Cervical Cancer	0	1%
Cervical Cancer	9	0%
Diabetes	166	11%
ER Tier 1 (10+)	71	5%
ER Tier 2 (2-9)	500	33%
General HAN	140	9%
Hemophilia	14	1%
High Risk OB	326	21%
Pharmacy Lock In	12	1%
Total	1518	100%

The graph below highlights the number of care managed members in each care group from July through December of CY 2016.



Contact History

In FY 2016, the Sooner HAN documented 39,050 contacts with members or on behalf of members enrolled in care management. Successful contacts with member accounted for 21% of all contacts. Twenty eight percent (28%) of attempted contacts with members were unsuccessful due to inability to make contact with the member. Contacts with others involved in the members care included specialists, primary care providers, family members, case workers, pharmacies, clinics, hospitals, nurses, DHS, OHCA, and others, representing 51% percent of contact attempts. The distribution of contact attempts are highlighted below.

Sooner HAN Care Management					
Successful Contacts with Members		**Unsuccessful Contacts with Members**		**Contacts with Others Regarding Member's Care**	
Telephone	6,983	Call Disconnected	39	Telephone	2,803
In Person	966	In Person – No Show	51	In Person	175
Other: Fax, Email, Page	126	Left Message w Person	47	Call Disconnected	42
TOTAL	**8,075**	Left Voice Message	2,703	In Person – No Show	4
		None – No Answer	486	Left Message w Person	190
		None – Not Accepting Calls	480	Left Voice Message	1,066
		None – Not in Service	537	None – No Answer	119
		None – Wrong Number	70	None – Not Accepting Calls	101
		Posted Mail	355	None – Not in Service	105
		TOTAL	**4,768**	None – Wrong Number	68
				Posted Mail	96
				Case Staffing	125
				Chart Review	4,706
				Team Collaboration	214
				Other: Fax, Email, Page	1,120
				TOTAL	**10,934**
				TOTAL CONTACTS (WITH OR ON BEHALF OF MEMBERS)	**23,777**

CARE MANAGEMENT TARGETED POPULATIONS

Asthma

The Sooner HAN initiated an asthma specific care management protocol in FY 2014 to assist members who have uncontrolled asthma, as defined by evidence based guidelines, move to controlled status. Members were identified based on having one or more asthma related ER visits or inpatient stays. The following tables provide details for this care management population in Q3 and Q4 of CY 2016.

Total Members in Care Management

Summary - Asthma Care Managed - Member Status						
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Closed	10	17	16	14	15	19
New	16	47	1	3	19	26
Open	102	102	133	120	110	110
New/Closed (in same month)		1			2	
TOTAL	**128**	**166**	**150**	**137**	**144**	**155**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.						

Closure Reasons

Summary - Asthma Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
Closed In error								
Death								
Health Home			1		1	1	**3**	**3%**
OHCA reason					1		**1**	**1%**
Opened in Error								
Meets Asthma closure criteria	1		1		1	1	**4**	**4%**
Per case review				1			**1**	**1%**
Program Ineligibility - Financial								
Program Ineligibility - Medicare				1			**1**	**1%**
Program Ineligibility - Moved out of State								
Program Ineligibility - Changed PCP		1			1	1	**3**	**3%**
Program Ineligibility - Unknown	2	1	3	1		2	**9**	**10%**
Reopening as General HAN								
Unable to contact	6	9	4	10	11	13	**53**	**58%**
Voluntary Withdrawal	1	6	7	1		1	**16**	**18%**
TOTAL	**10**	**17**	**16**	**14**	**15**	**19**	**91**	**100%**

Treatment Summary

Summary - Asthma Care Managed - Treatment Summary		
	TOTAL	% of TOTAL
ASTHMA CONTROL		
Asthma Controlled	55	43.0%
Asthma Uncontrolled	64	50.0%
Asthma Control Unknown	7	5.5%
N/A (does not have asthma)	2	1.6%
TOTAL	**128**	**100%**
ASTHMA ACTION PLAN		
Action Plan Completed	72	56.3%
Action Plan Not Completed	46	35.9%
Action Plan Not Completion Unknown	8	6.3%
N/A (does not have asthma)	2	1.6%
TOTAL	**128**	**100%**
ASTHMA MEDICATION MANAGEMENT		
Bronchodilator Only	42	32.8%
Bronchodilator and Controller	79	61.7%
Unknown	0	0.0%
Not on Asthma Medications	5	3.9%
N/A (does not have asthma)	2	1.6%
TOTAL	**128**	**100%**

Breast and Cervical Cancer (BCC)

During CY 2016 Q3 and Q4 the Sooner HAN provided care management to women who had either breast cancer or cervical cancer, or both breast cancer and cervical cancer. The following tables provide details for this care management population.

Total Members in Care Management – Breast Cancer

Summary – Breast Cancer Care Managed - Member Status						
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Closed	2	3		2	2	1
New	2		3	2		
Open	46	45	45	46	46	45
New/Closed (in same month)						
TOTAL	**50**	**48**	**48**	**50**	**48**	**46**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.						

Closure Reasons

Summary - Breast Cancer Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
Closed In error								
Death				1			**1**	**9%**
Health Home								
Opened in Error								
Program Ineligibility								
Program Ineligibility - Financial					1		**1**	**9%**
Program Ineligibility - Medicare								
Program Ineligibility - Moved out of State	2						**2**	**18%**
Program Ineligibility - Changed PCP		3		1	1		**5**	**45%**
Program Ineligibility - Unknown						1	**1**	**9%**
Reopening as General HAN								
Unable to contact								
Voluntary Withdrawal								
TOTAL	**2**	**3**	**0**	**2**	**2**	**1**	**11**	**100%**

Treatment Summary

This section outlines the treatment status of the BCC members during their receipt of care management services. Nineteen members (41%) had mastectomies and 14 (30%) members had lumpectomies as part of their treatment protocol.

Summary - Breast Cancer Care Managed - Treatment Summary		
	TOTAL	% of TOTAL
MASTECTOMY		
Left	7	37%
Right	7	37%
Bilateral	5	26%
TOTAL	**19**	**100%**
LUMPECTOMY		
Left	10	71%
Right	4	29%
Bilateral	0	0%
TOTAL	**14**	**100%**

Total Members in Care Management – Cervical Cancer

Cervical Cancer Care Managed Members						
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Closed	2					1
New	1		1		1	
Open	4	5	5	6	6	6
New/Closed (in same month)						
TOTAL	**7**	**5**	**6**	**6**	**7**	**7**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.						

Closure Reasons

Summary - Cervical Cancer Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
Closed In error								
Death								
Health Home								
Opened in Error								

Summary - Cervical Cancer Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
Program Ineligibility - Financial								
Program Ineligibility - Medicare						1	**1**	**33%**
Program Ineligibility - Moved out of State	1						**1**	**33%**
Program Ineligibility - Changed PCP								
Program Ineligibility - Unknown								
Reopening as General HAN								
Unable to contact	1						**1**	**33%**
Voluntary Withdrawal								
TOTAL	**2**	**0**	**0**	**0**	**0**	**1**	**3**	**100%**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.								

Diabetes

The Sooner HAN initiated a diabetes specific care management protocol in FY 2016 to assist members who have poorly managed diabetes to move to a controlled status. Members were identified based on having elevated A1C levels, emergency room visits, and hospitalizations related to diabetes and its complications. In CY 2017, members who could benefit from a diabetes specific intervention will be identified based on utilization through claims review as well as through clinical data from MyHealth, a regional Health Information Exchange.

Total Members in Care Management

Summary – Diabetes Care Managed - Member Status						
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Closed	9	7	7	6	22	14
New	1			36	22	17
Open	77	71	64	58	77	85
New/Closed (in same month)					5	
TOTAL	**87**	**78**	**71**	**100**	**121**	**117**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.						

Closure Reasons

Summary - Diabetes Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
Care managed through OHCA					1		**1**	**2%**
Closed In error								
Death								
Hospice			1			2	**3**	**5%**
Health Home					2		**2**	**3%**
OHCA directed to close					1		**1**	**2%**
Opened in Error					1		**1**	**2%**
Program Ineligibility - Financial								
Program Ineligibility - Medicare						1	**1**	**2%**
Program Ineligibility - Moved out of State				2			**2**	**3%**
Program Ineligibility - Changed PCP				1		2	**3**	**5%**
Program Ineligibility - Unknown		2			4		**6**	**9%**
Reopening as General HAN								
Transferred to Telligen	5	4	6	2	2	4	**23**	**35%**
Unable to contact	4	1		1	4	5	**15**	**23%**
Voluntary Withdrawal					7		**7**	**11%**
TOTAL	**9**	**7**	**7**	**6**	**22**	**14**	**65**	**100%**

Depression Screens

The Sooner HAN began administering the PHQ9 health questionnaire to members with diabetes in FY 2016. The chart below highlights the administration and results of the depression screenings administered by Sooner HAN care management. While the ProForma measures related to depression screening look only at new members in a quarter who had successful contact made and had completed a PHQ9 screening, the numbers below represent the total number of new, continuing and closed members who were screened in a 6 month period, the reasons members were not screened, and the screenings that resulted in a behavioral health referral.

Diabetes - Depression Screens		
Depression Screens		
93%	27	Members Screened
7%	2	Members Not Screened
Reason Not Screened		
100%	2	Other
Screening Results		
24%	6	Members requiring referral
50%	3	Members accepting BH referral
34%	1	Members keeping BH appointment

ER TIER 1 (10+ VISITS IN 6 MONTHS)

During Q3 & Q4 of 2016, the Sooner HAN provided care management to 71 High ER Tier 1 members. These members are placed immediately into the High Touch Care Management group and receive a higher level of intervention, including home visits and more frequent care management contact than members in the Tier 2 category.

Total Members in Care Management

Summary – ER Tier 1 (10+ Visits) - Member Status						
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Closed	2	2	3	1	10	3
New	10	4	0	15	6	4
Open	29	37	38	37	42	45
New/Closed (in same month)	1	0	0	0	0	0
TOTAL	**41**	**43**	**41**	**53**	**58**	**52**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.						

Closure Reasons

Summary - ER Tier 1 Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
Closed as ER reopened as HROB								
Closed In error								
Death								
Health Home								
Meets ER closure criteria								
Opened in Error								
Program Ineligibility - Financial								
Program Ineligibility - Medicare								
Program Ineligibility - Moved out of State					1		**1**	**5%**
Program Ineligibility - Changed PCP			1		1		**2**	**10%**
Program Ineligibility - Unknown			1		2	1	**4**	**19%**
Reopening as General HAN								
Unable to contact	1	2		1	4	2	**10**	**48%**
Voluntary Withdrawal	1		1		2		**4**	**19%**
TOTAL	**2**	**2**	**3**	**1**	**10**	**3**	**21**	**100%**

ER Tier 2 (2-9 visits in 6 months)

The ER Tier 2 (2-9 ER visits in a six month period) has been a challenging care management group due to several reasons. Many members who have received notification that care management is available to them either do not call or tend to call outside of traditional office hours. Care managers spend multiple hours playing phone tag with members, sometimes without ever making a successful contact with the member.

Total Members in Care Management

Summary – ER Tier 2 (2-9 Visits) - Member Status						
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Closed	33	79	58	40	57	46
New	58	110	39	1	16	22
Open	209	197	250	251	195	167
New/Closed (in same month)		9	3	0	0	2
TOTAL	**300**					
Note: Members who were new and then closed within the same month are counted under the "Closed" category.						

Closure Reasons

Summary - ER Tier 2 Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
ADvantage Program			1			1	**2**	**.6%**
Aged out of SoonerCare								
Closed as ER reopened as HROB	1						**1**	**.3%**
Closed In error								
Death	2						**2**	**.6%**
Health Home	1		9	1	1		**12**	**4%**
Incarcerated	1						**1**	**.3%**
Meets ER closure criteria	5	10	3	2	1	2	**23**	**7%**
Opened in Error			1				**1**	**.3%**
Program Ineligibility – Aged out	1						**1**	**.3%**
Program Ineligibility - Financial					1		**1**	**.3%**
Program Ineligibility - Medicare				1			**1**	**.3%**
Program Ineligibility - Moved out of State			1				**1**	**.3%**
Program Ineligibility - Personal Insurance						1	**1**	**.3%**
Program Ineligibility - Changed PCP		3	1	3	5	1	**13**	**4%**
Program Ineligibility - Unknown	2	15	7	5	11	5	**45**	**14%**
Reopening as General HAN						1	**1**	**.3%**
Unable to contact	13	29	20	15	35	29	**141**	**45%**
Voluntary Withdrawal	7	22	15	13	3	6	**66**	**21%**
TOTAL	**33**	**79**	**58**	**40**	**57**	**46**	**313**	**100%**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.								

GENERAL HAN

The General HAN category was created in FY 2014 and continues to grow, with an increased number of referrals from primary care providers.

Total Members in Care Management

Summary – General HAN - Member Status						
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Closed	12	10	8	6	5	6
New	3	13	5	5	8	5
Open	91	84	89	88	88	92
New/Closed (in same month)						2
TOTAL	**106**	**107**	**102**	**99**	**101**	**103**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.						

Closure Reasons

Summary - General HAN Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
Closed In error								
Death	2			1		1	**4**	**9%**
Health Home						1	**1**	**2%**
Issues Resolved				1			**1**	**2%**
Monitoring complete								
Opened in Error								
Program Ineligibility - Financial								
Program Ineligibility - Medicare			2				**2**	**4%**
Program Ineligibility - Moved out of State	2						**2**	**4%**
Program Ineligibility - Changed PCP	1			2	1		**4**	**9%**
Program Ineligibility - Unknown	1				2		**3**	**6%**
Referral needs completed								
Reopening as General HAN	5	5	5	2		2	**19**	**40%**
Unable to contact	1	5	1		2	2	**11**	**23%**
Voluntary Withdrawal								
TOTAL	**12**	**10**	**8**	**6**	**5**	**6**	**47**	**100%**

Hemophilia

The Sooner HAN continues to provide care management to members with hemophilia as highlighted below.

Total Members in Care Management

Summary – Hemophilia - Member Status						
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Closed	2	1			2	2
New		1		1	1	1
Open	9	8	9	9	8	7
New/Closed (in same month)						
TOTAL	**11**	**10**	**9**	**10**	**11**	**10**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.						

Closure Reasons

Summary - Hemophilia Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
Advantage Waiver								
Closed In error								
Death								
Health Home								
OHCA care managing						1	**1**	**14%**
Opened in Error								
Program Ineligibility - Financial								
Program Ineligibility - Medicare								
Program Ineligibility - Moved out of State								
Program Ineligibility - Changed PCP					1		**1**	**14%**
Program Ineligibility - Unknown								
Reopening as General HAN								
Unable to contact	2					1	**3**	**43%**
Voluntary Withdrawal		1					**1**	**14%**
TOTAL	**2**	**1**	**0**	**0**	**2**	**2**	**7**	**100%**

High Risk Obstetrics (HROB)

In Quarters 3 and 4 of CY 2016, the Sooner HAN provided care management services to 326 unique SoonerCare Choice members identified as having a high risk pregnancy (HROB). The change implemented by OHCA to send members identified as high risk weekly verses in a monthly batch, has helped with engaging the members quicker and for longer periods. The Sooner HAN continues to have an embedded a RN Care Manager in the OU Women's Clinic and this collaboration with OU Women's Clinic has led to even more HROB cases being identified early.

Total Members in Care Management

Summary – HROB - Member Status						
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Closed	36	51	29	30	30	45
New	32	39	54	35	16	20
Open	89	70	85	111	117	89
New/Closed (in same month)			5	1	1	1
TOTAL	**157**	**160**	**168**	**176**	**163**	**154**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.						

Closure Reasons

Summary - HROB Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
Closed In error								
Death								
End of Pregnancy	24	27	11	12	9	18	**101**	**46%**
Fetal demise						1	**1**	**0.5%**
Health Home	1						**1**	**0.5%**
Opened in Error					1		**1**	**0.5%**
Program Ineligibility - Financial								
Program Ineligibility - Medicare						2	**2**	**1%**
Program Ineligibility - Moved out of State	1						**1**	**0.5%**
Program Ineligibility - Changed PCP	1	1			2		**4**	**2%**
Program Ineligibility - Personal Insurance	4			5		4	**13**	**6%**
Program Ineligibility - Unknown		3	3		9		**15**	**7%**
Reopening as General HAN	4			10	1		**15**	**7%**
Unable to contact	1	16	8	3	7	18	**53**	**24%**
Voluntary Withdrawal		4	7		1	2	**14**	**6%**
TOTAL	**36**	**51**	**29**	**30**	**30**	**45**	**221**	**100%**

Length of Time in Care Management

By receiving cases earlier in the members' pregnancy, care managers have more of an opportunity to provide services and support to the members prior to birth. It has been the desire of the Sooner HAN to identify and intervene with members as early in the pregnancy as possible to promote the best possible outcome for mother and baby. The table below highlights length of time in care management during Q3 and Q4 of CY 2016.

Summary - HROB Care Managed - Length of time in Care Management				
	Closed	*% of Total Cases Closed*	*Still Open*	*% of Total Cases Still Open*
0 to 4 weeks	20	9%	20	18%
5 to 8 weeks	26	12%	14	13%
9 to 12 weeks	35	16%	20	18%
13 to 16 weeks	32	14%	36	33%
17 to 19 weeks	35	16%	5	5%
20 to 24 weeks	41	19%	7	6%
25 to 29 weeks	18	8%	2	2%
30 weeks plus	14	6%	5	5%
TOTAL	**221**	**100%**	**109**	**100%**

Delivery Data

The chart below highlights delivery data for women who received care management services for HROB. Only births that occurred during Q3 and Q4 of CY 2016 were counted. Since member cases remain open for approximately 6 weeks after delivery, some members may have still been enrolled in Q3 and Q4 of CY 2016, but delivered in the previous reporting period. The Sooner HAN had 147 total births. The chart below highlights pregnancy type, birth type, birth weights and the mother's length of stay in the hospital.

HROB - Delivery Data		
Pregnancy Results		
	#	%
Total Births	147	100%
Viable Births	142	97%
Single Births	121	82%
Sets of twins (12)	24	16%
Demise	2	1%
Unknown	3	1%
Birth Type		
Vaginal	79	54%
C Section	67	46%
Unknown	1	1%
Weight		
Minimum Weight in Lbs./Oz.	1 lb.	8 oz.
Maximum Weight in Lbs./Oz.	9 lb.	8 oz.
Average Weight in Lbs./Oz.	6 lb.	5 oz.
Length of Hospital Stay (mother)		
Minimum Days	1	day
Maximum Days	65	days
Average Days	3.75	days

Discharge Data

The chart below highlights information on the status of babies upon hospital discharge.

HROB - Discharge Data		
Sent Home on Oxygen		
	#	%
Yes	2	1%
No	96	68%
Unknown	44	31%
Discharged with Supportive Devices or Medications		
Phototherapy	3	2%
Medications	1	1%
Monitor	1	1%
Vitamins	1	1%
Unknown	6	4%
None	130	92%
Required Surgery		
Yes	5	4%
No	118	83%
Unknown	19	13%
Completed Newborn Hearing Screen		
Left Ear - Pass	97	68%
Left Ear - Fail	0	0%
Left Ear - Unknown	46	32%
Right Ear - Pass	95	67%
Right Ear - Fail	1	1%
Right Ear - Unknown	46	32%

NICU Information

The chart below highlights information for babies that had a NICU stay.

HROB - NICU Information		
Length of Stay		
Minimum NICU Stay	1	day
Maximum NICU Stay	21	days
Average NICU Stay	9	days
Weight		
Minimum	1 lb.	8 oz.
Maximum	9 lb.	8 oz.
Average	5 lb.	7 oz.
NICU Stays Detail		
Singletons with a NICU Stay	28	23%
Twins with a NICU Stay	9	38%
NICU Stays ongoing at time of closure	8	22%
Prematurity of Infants with a NICU Stay		
Minimum # days/weeks born before due date	4	days after
Maximum # days/weeks born before due date	90	days before
Average # days/weeks born before due date	30	days before
Receipt of HROB Case of Infants with a NICU Stay		
Minimum # days/weeks born prior to due date when HROB case was received	14	days
Maximum # days/weeks born prior to due date when HROB case was received	130	days
Average # days/weeks born prior to due date when HROB case was received	82	days

Twins Data

The chart below highlights data on twins.

HROB - Twins Data		
Weight		
Minimum	4 lbs.	6 oz.
Maximum	7 lbs.	5 oz.
Average	5 lbs.	9 oz.
Prematurity of Twins		
Minimum # days/weeks born before due date	14	days
Maximum # days/weeks born before due date	29	days
Average # days/weeks born before due date	13	days
Receipt of Case of Twins		
Minimum # days/weeks born prior to due date when HROB case was received	14	days
Maximum # days/weeks born prior to due date when HROB case was received	130	days
Average # days/weeks born prior to due date when HROB case was received	76	days

Depression Screens

The chart below highlights the administration and results of the pre- and post-depression screenings administered by Sooner HAN care management staff. The Sooner HAN administers the PHQ9 health questionnaire. While the ProForma measures related to depression screening look only at new members in a quarter who had successful contact made and had completed a PHQ9 screening, the numbers below represent the total number of new, continuing and closed members who were screened in a 6 month period, the reasons members were not screened, and the screenings that resulted in a behavioral health referral.

HROB – Depression Screens		
Pre-Depression Screens		
Screened	68	92%
Not Screened	6	8%
Reason Not Screened: Recently completed screen	3	50%
Reason Not Screened: Member does not feel depressed	3	50%
Screening Required Referral	10	15%
Screening Referrals Accepted	5	50%
Screening Referral Kept	2	40%
Post-Depression Screens		
Screened	59	86%
Not Screened	10	14%
Reason Not Screened: Member does not feel depressed	7	70%
Reason Not Screened: Other	3	30%
Screening Required Referral	21	36%
Screening Referrals Accepted	7	33%
Screening Referral Kept	4	57%
Recommended Depression Screens (not pre or post)		
Recommended screenings	8	89%

Pharmacy Lock In

In FY 2016 the Sooner HAN began to receive Pharmacy Lock In cases again after a short hiatus, while OHCA modified the program. This group is often challenging for care management as behavioral health and addiction issues require a very specific intervention. The table below highlights the members in care management during Q3 and Q4 of CY 2016.

Total Members in Care Management

Summary – HROB - Member Status						
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Closed	3	2			4	
New					1	
Open	8	6	6	6	2	3
New/Closed (in same month)						
TOTAL	**11**	**8**	**6**	**6**	**7**	**3**
Note: Members who were new and then closed within the same month are counted under the "Closed" category.						

Closure Reasons

Summary - Pharmacy Lock In Care Managed - Closure Reasons								
	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16-Dec	TOTAL	% of TOTAL CASES CLOSED
Closed In error					1		**1**	**11%**
Death								
Health Home								
Opened in Error								
No longer lock in eligible					3		**3**	**33%**
Program Ineligibility - Financial								
Program Ineligibility - Medicare								
Program Ineligibility - Moved out of State								
Program Ineligibility - Changed PCP								
Program Ineligibility - Unknown								
Reopening as General HAN	1						**1**	**11%**
Unable to contact	2	2					**4**	**44%**
Voluntary Withdrawal								
TOTAL	**3**	**2**	**0**	**0**	**4**	**0**	**9**	**100%**

CARE MANAGEMENT SUCCESS STORIES

The success stories highlighted below are being told from the care managers' perspectives and in their own words. The members' names have been changed to ensure their privacy and confidentiality. While there were many successes in Q3 and Q4 of CY 2016, the members highlighted below serve as a reminder of the significant role a care manager plays in each member's life, the value of the providing additional support beyond the primary care office, and the strength of building respectful relationships.

[redacted]

Melissa was assigned to me a little over a year ago. Many times throughout the past year, I have wondered if I would be able to reach her again, because she often did not answer the phone. I made time to do some home visits about an hour away to build rapport with her, since she was so hesitant to talk to me on the phone at first.

Melissa talked about feeling suicidal often. We worked together with the psychiatrist and her pain specialist to deal with some of the medical problems, especially aggressive rheumatoid arthritis and secondary gastroparesis from all the pain medications that were driving her depression and resulting suicidal thoughts. She would always tell me she really wanted to live, "but not like this." So I worked to get her a second opinion from another rheumatologist in another city, to give her more confidence in the chosen treatment for RA. We also talked about alternative treatments for pain, including light exercise such as yoga.

We went through the application process for the ADvantage Program twice, but she was denied both times because her husband was unwilling to turn over needed documentation. Then she confided in me that she was living in an abusive relationship with her husband. I knew this from her chart but she had denied the problem when I first started working with her. Eventually she started opening up to me about it, and we talked about her options. She moved in with her mother, and recently got a protective order and in process of getting a divorce due to the continued physical abuse.

Melissa has started going to yoga, and she has tapered off of one of her pain medications. Now she is renting space from some old friends. She continues to have some unresolved health problems, mainly unexplained weight loss, but she thinks it may get better now that she feels safe and her appetite is coming back. Today Melissa thanked me for HAN services and said she is alive today because of my help and persistence. "Sometimes I was in so much pain I could only talk myself into staying alive for 10 more minutes at a time; and now I'm in a better place. You'll never know how much that you mean to me."

[redacted]

When dealing with a person on a weekly basis you get to know their temperament, what they like, how they communicate, their stressors and who they believe is part of their support system. I have been working with Sam for more than a year and it has taken almost a year to build a relationship with this member. He was a hit and miss member, I would talk to him for several weeks straight and then he would fall off for several months. Sam always told me just enough information and never too much for me to figure out his situation.

Sam has been diagnosed with hepatitis C, chronic pain and cirrhosis of the liver. Sam's ER visits consisted of him having fevers, uncontrollable pain in body, toxins from his liver, heart palpations and black stools. Sam would go to the ER at least 3 times a month, even if he went to PCP appointments. As his CM, I continued to

just listen to him and let him steer the conversations, whether it was talking about his family that he could not depend on, lack of several medications, lack of treatment for his hepatitis C, to wanting to give up at times due to his diseases. The continued conversations and communication with PCPs about possible treatment options for Sam, opened the door to Sam allowing me to assist in many ways. Sam mentioned that he has never had anyone to care about his health in the manner that I do as his care manager.

Fast forward to almost a year later, Sam has had only 3 ER visits in the last 5 months. He has met with the transplant provider again even though his last experience was terrible, he was open and interested in available hospice options, Sam has made more PCP appointments since I have been involved and open to accepting community resources to help with daily needs. Currently, as his care manager I have talked with Sam about possibly applying for the Advantage Program, he is one appointment closer to possible transplant option, he has been approved to obtain treatment for his hepatitis C, and his mental health has increased due to knowing that he is able to manage his diseases with assistance from his PCP team and myself.

[redacted]

When I first began care management with my new member, Alice, in October 2016, I was referred by the primary care pediatrician at OU Pediatrics because the member had a chronic health issue and barriers to care. The first item to address for both the PCP, member and mother was assistance obtaining a custom fitting compression garment for her arm and hand. Upon meeting the bright-eyed, slightly shy but smiling eight year old girl, I knew we needed to find a solution for her.

Not many people are familiar with her diagnosis, Proteus Syndrome, but are more familiar with the more common name, the Elephant Man Syndrome. It is a rare congenital disorder causing skin overgrowth, atypical bone development and usually accompanied by tumors on one side of the body. Alice's mother had attempted for eight months to fill the tattered prescription she handed me received from a specialist at Arkansas Children's Hospital without success. The OU Pediatric staff had been unable to find a DME provider that would provide a custom fitting garment and accept SoonerCare. Other barriers included Alice's mother is Spanish-speaking and is the primary caregiver for Alice and her younger brother with Down's syndrome.

Knowing that this rare genetic disorder requires a team approach that includes the geneticist, surgeons, and other specialists in addition to her primary care, I went to work to find a DME provider for the custom glove and sleeve. I consulted Tina Largent at OHCA who gave me names of DME providers in Alice's area that provide compression garments and accept SoonerCare. However, none of those provided custom fitting garments required by the abnormal bone growth and tissue caused by Proteus Syndrome. I consulted with several providers of this service to determine if there was a custom fit provider in Oklahoma that accepted SoonerCare. At one point, I decided to call the sales representative for Medi, known to be the leader in medical compression materials and garments. The representative led me to Asbury Medical in Oklahoma City where Teala Buxton was highly recommended for custom garment fittings. We worked with the family to provide information from her current Occupational therapist, Primary Care, and Specialist at Arkansas Children's to submit for her compression garment. We traveled to OKC for her consultation utilizing the Language Line to explain the procedure to Alice's mother and for any questions. At her fitting, the National Medi Representative attended from North Carolina to ensure all measurements were correct for her specialized vascular condition.

As of February 1st and at almost a year later from being written the prescription, the bright-eyed now nine year old received her very pink custom garment that had the words “Live, Laugh, and Love” in the material. Wearing it, she gave me big smile and a “high five” with her affected limb. She will visit the specialist at Arkansas Children’s for follow up in March to determine next steps in her disease management.

ADDITIONAL ACTIVITIES

Educational Opportunities for Providers and Care Managers

Care Management Training

A four day care management training, Fundamentals of Care Management, was held in November of 2016. The November training had 13 participants. Sooner HAN care managers as well as care managers from Sooner HAN participating providers were in attendance.

The Fundamentals of Care Management is an intensive training in delivering comprehensive care management services to individuals with complex health and social service concerns. It includes approximately 4 hours of online prerequisite work and 4 days in the classroom. The course is continually updated to reflect current NCQA Care Management standards, industry knowledge, and best practices based on peer-reviewed studies from medical and social service literature. The training emphasizes a multidisciplinary team approach, partnering with providers, community agencies, family members and other stakeholders to co-manage a diverse population of people with high-risk conditions.

This 4 day course incorporates both online e-learning and in-class presentations and activities. The small group sessions generate interactive learning and discussion. Many of the teaching modules are case-based and discuss actual scenarios that Care Managers commonly encounter. Supplemental materials and templates are provided electronically in the online learning system.

Fundamentals of Care Management	
Topic	***Description***
Welcome, Introductions and Icebreaker	The Long and Winding Road of Healthcare showcases significant events in each decade from 1930 to current. Particular focus is placed on healthcare related legislation, discoveries, epidemics, technologies, movements and trends that have shaped the current health care delivery system.
Healthcare in Oklahoma	This module describes the health of Oklahomans using a variety of data sources. Emphasis is placed on describing how individual factors, social and community networks, and environmental conditions impact health.
Trauma Informed Approach	Trauma is a prevalent health problem that affects all of us. Introduction to Trauma Informed Approach provides an overview of how traumatic experiences can alter both behavior and physical health. Participants learn to recognize trauma related symptoms, resist re-traumatization, and integrate responses that promote recovery and resilience.
Cultural Competency	Cultural Competency challenges health care providers to reflect upon their own values and beliefs, understand the concepts of cultural competency, and develop skills to respond appropriately to culturally diverse populations.
Ethics	Ethics in Health Care introduces care managers to ethical theories and ethical decision-making. Using real life examples of important and controversial issues encountered in health care organizations, care managers will learn and practice skills needed to analyze the ethical issues, determine possible solutions and identify the best solution for the particular situation.

Fundamentals of Care Management	
Topic	***Description***
Risk with Dignity	Risk With Dignity explores the dilemma health care providers often face when reconciling a person's risky lifestyle choices with his or her right to choose. Participants learn what truly increases and lowers risk, as well as the importance of self-determination and shared decision making to arrive at common goals.
Motivational Interviewing	Motivational Interviewing teaches basic skills involved in strengthening a person's own desire and ability to make positive behavior changes. Emphasis is on both preventing and managing chronic illness. Participants practice motivational techniques with their peers, while identifying methods that encourage provider alignment and positive reinforcement.
Disease Management: Asthma and COPD	Several modules in Disease Management highlight the management of chronic illness including Asthma, COPD, and Diabetes. These courses illustrate ways Care Managers can assist individuals in co-managing their illnesses using self-care techniques. In Disease Management: Asthma and COPD, emphasis is placed on writing Action Plans for those diagnosed with Asthma. The goal is to help build relationships among individuals, caregivers, primary providers, and Care Managers, who will orchestrate care together as a team, tending for an increasingly complex number and variety of illnesses.
Disease Management: Diabetes	Disease Management: Diabetes highlights the management of the chronic illness Diabetes, and illustrates ways Care Managers can assist individuals in co-managing their illness using self-care techniques. Emphasis is placed on Blood Sugar management among people with Diabetes. The goal is to help build relationships among individuals, caregivers, primary providers, and Care Managers, who will orchestrate care together as a team, tending for an increasingly complex number and variety of illnesses.
Introduction to Behavioral Health	All About Behavioral Health introduces care managers to the development of a unique skillset primed to work in emerging models that integrate primary and behavioral health care. It provides a background to the process of basic mental health evaluation, and equips care managers to engage people with behavioral health in a systematic way that results in improved overall health outcomes.
Suicide Prevention	Suicide Prevention teaches participants how to recognize patterns that may suggest suicidal ideation, and introduces basic crisis management skills. Emphasis is on ways to access intervention and treatment if suicidality is suspected.
Documentation	Though it borrows elements from both nursing and social work, care management is a discrete profession that provides distinct services.
Self-Care	Studies show that people working with traumatized populations are at high risk for secondary traumatic stress. Self-care focuses on how to recognize secondary stress in yourself and others, and provides tips and tools to manage it.
Community Resources	Know Your Community Resources provides an interactive learning activity where experienced care managers not only share their knowledge of local resources, but also identify how to access services, and explain how to make appropriate referrals.

Lunch and Learn Series

Lunch and Learn sessions were held regularly in CY 2016 and focused on areas affecting care managers serving SoonerCare Choice members with complex health and social concerns. Topics covered and the number of attendees for Q3 and Q4 2016 are listed below:

DATE	TOPIC	PRESENTERS	ATTENDEES
July	Engaging and Working with Families and School Systems	Sara Coffey, DO	33
August	Diabetes	David Jelley, MD	57
September	Cardiovascular Health	Jeffrey Alderman, MD	63
October	Asthma	Nancy Inhofe, MD	34
November	ADHD	Tara Buck, MD	28
December	Grief and Loss	Ashlie Casey, LCSW	42

The response and evaluations from the various lunch and learn sessions throughout CY 2016 have been very positive. The Lunch and Learn sessions will continue in CY 2017 and beyond with topics added to reflect current trends and interests expressed by care managers and providers serving SoonerCare Choice members.

Provider Engagement

Site Visits

The Sooner HAN provided additional support to engage providers who were enrolled in the Sooner HAN. During FY 2016, Sooner HAN staff travelled to several providers' locations and met with leadership to build relationships with new staff, discuss the HAN quality improvement services, care management and referral management services, and offer HAN assistance to clinics in these areas. In addition, HAN staff shared examples of reports that can be generated for each clinic for quality improvement monitoring, and discussed clinic issues brought forth by clinic staff. These meetings were beneficial and will continue into FY 2017.

Combined with the site visits and educational offerings, specific investments were made with HAN providers to increase participation with the Sooner HAN. A few examples include:

Clinic Activities – At a Glance

Activities in CY 2016 Quarters 3 & 4			
Sooner HAN Practice/Clinic	**Care Management**	**Access to Care (Doc2Doc)**	**Quality Management**
Access Solutions Medical Group	• Care Manager is routinely visiting the various practice locations and has access to	• Referral loop closure project initiated. 1,598 referrals were	• Assisted group to address tier status (PWP) and

Activities in CY 2016 Quarters 3 & 4			
Sooner HAN Practice/Clinic	**Care Management**	**Access to Care (Doc2Doc)**	**Quality Management**
	their EMR to improve communication. • New administrator attended the 4 day Foundations of Care Management Course	closed in 2016, with a goal of closing 2,503 in Q1/Q2 2017. • Providing referral status reports to the clinic manager to enhance oversight of the process.	implement Corrective Action Plan
Broken Arrow Pediatrics, LLC	• Met with nursing team to provide brief overview of care management referral form. Follow up visit to be scheduled.	• Worked closely with the nursing team to develop processes for referral management, subsequently trained front office staff to assist in process. • Provide monthly reports related to open SoonerCare Choice referrals.	• Met with office manager to discuss quality consultation • Created Pentaho monthly monitoring reports
Community Health Connection	• Had meeting to discuss ways to increase referrals for care management with Medical Director and RN Clinical Support Manager • Trained Care Manager to utilize Doc2Doc for referral follow-up as part of care management process	• Assisted clinic in developing a process to attach CCDA documents from EMR to all referrals • Developed processes for referral loop closure. • Worked closely with the quality manager to identify and market the e-referral process to a desired group of specialty practices. This clinic routinely discusses Doc2Doc when building relationships with the community of specialty providers. • Provided reports to the quality manager, who desired to evaluate the referral process, streamline referral follow-up actions, and staffing to ensure efficiency in the process.	• Met with quality manager re: PCMH accreditation • Met with marketing manager to discuss outreach efforts • Created Pentaho monthly monitoring reports
Crossover Health Services, LLC	• The Sooner HAN Clinical Manager has been working with Crossover staff to implement care coordination within their clinic.	• Worked closely with providers and clinic staff to develop referral processes • Assisted clinic in process to implement CCDA transmission with each referral. • Provided reports to referral coordinator to help her refine the process for referral loop closure.	• Met with entire team to discuss PMCH requirements • Assisted group to address tier status (PWP) and implement Corrective Action Plan • Created Pentaho monthly monitoring reports
Morton	• Collaborating with Morton on ways to increase care management utilization. Embedded Care Manager position was open for part of CY16Q4, but will be filled in CY17Q1. • Working on identifying additional training needs for clinic and provider staff.	• Morton has expressed interest in Doc2Doc. The team is scheduled to meet with the clinic leadership in March to review an implementation plan. • Trained the Morton Optometry Group to receive electronic referrals.	• Met with leadership to discuss PMCH requirements • Met with new quality manager regarding quality consultation • Assisted group to address tier status (PWP) and implement Corrective Action Plan

Activities in CY 2016 Quarters 3 & 4			
Sooner HAN Practice/Clinic	**Care Management**	**Access to Care (Doc2Doc)**	**Quality Management**
			• Created Pentaho monthly monitoring reports
OU Physicians – OKC	• Multiple site visits to discuss implementation of care management.		• Created Pentaho monthly monitoring reports
OU Physicians-Tulsa	• OU Tulsa Pediatrics – embedded a Sooner HAN Care Manager in clinic in Q32016. This has resulted in a significant increase in provider referrals. • OU Tulsa Internal Medicine – Collaborating on ways to improve communication between clinic staff and care management utilizing EMR flags. • Meeting held with new Medical Director. • OU Tulsa Family Medicine – • Invited by OU Physicians to participate in team developing plan to implement a Team Based Care Model.	• Assisted the OU-Internal Medicine Clinic in referral loop closure. 8,976 referrals were closed in 2016, as a result. • Created dashboards for the leadership team to monitor the referral closure rates, productivity of staff, and the quality of the care transition. • Provided ongoing training and support, as opportunities were identified to improve the process. • Provided additional training to clinic managers to enhance referral oversight.	• Created Pentaho monthly monitoring reports • Worked with Internal Medicine to support quality activities in the PCORI diabetes project • Worked with Internal Medicine to redesign workflow and streamline processes in office visit check-in to check-out • Worked with Internal Medicine to improve EMR documentation timeliness
Stigler Health and Wellness Center	• Scheduled meeting with nurse care manager administrator to discuss increasing utilization of care management services. • Stigler care managers scheduled to attend Foundations of Care Management Course	• Worked with IT Director to extract CCDA from EMR and transmit via Doc2Doc. • Provided refresher training to referral coordinators.	• Created Pentaho monthly monitoring reports
TL Carey Family Medicine	• Awaiting scheduling for new clinic visit regarding care management services.	• Provided refresher training to referral coordinator.	N/A
Utica Park Clinics	• 1 Nurse Care Manager and 1 LCSW Care Manager are assigned to Utica Park Clinics as primary contacts. They both complete site visits with all the Utica Park clinics quarterly. • All new Utica Park Care Managers attend the 4 day Foundations of Care Management Course; XX attended the November 2016 Course		• Met with new quality manager regarding quality consultation • Created Pentaho monthly monitoring reports
Variety Care	• Completed just in time learning session on gestational diabetes to Medical Assistant staff.	• Provided training and support to centralized referral team.	• Created Pentaho monthly monitoring reports

Activities in CY 2016 Quarters 3 & 4			
Sooner HAN Practice/Clinic	**Care Management**	**Access to Care (Doc2Doc)**	**Quality Management**
	• Multiple site visits completed to review care management processes.	• Provide monthly reports to referral manager, who sets a goal for her team of 75% closure by month end. • Arranged meeting with therapy provider and referral staff to improve process for renewing referrals. • Enrolled specialists, including: obstetrics/gynecology, cardiology, and audiology services to broaden access to care for clinic's members. • Assisted clinic in meeting objective 05, meaningful use, stage II, by providing reports and training on process for CCDA extraction.	• Collaborated with quality director to review draft of Sooner HAN quality curriculum
Wellspring Family Clinic	• Provided care management overview and referral forms. • Assisted MA in identifying and completing referral form for several members.	• Trained and supported Medical Assistant during implementation. • Assisted in process to extract and attach CCDA to all referrals. • Trained front office to assist in referral loop closure during records scanning process.	N/A
Zoellner Medical Group	• Awaiting scheduling for clinic visit regarding care management services.	• Provided training and support on the referral loop closure process. • Assisted clinic in managing OHCA denials and revising process to minimize denials.	N/A
Other Groups			
OU Women's Health	• Embedded Sooner HAN Care Manager who is bi-lingual and a certified diabetes educator		

Quality Management Activities

Quality Improvement Consultation to HAN Providers

OU Physicians-Tulsa Internal Medicine Clinic

Participated on team of NCQA, PCORI and OU Physician-Tulsa Internal medicine staff to evaluate the feasibility of implementing patient centered outcomes approaches into the current office visit workflow. The focus was on members with diabetes who were interested in participating in a project related to health assessment, health literacy, goal setting, and health outcomes. Sooner HAN staff supported quality improvement activities including workflow analysis and PDSA cycles of change while selected care management staff were involved with incorporating patient centered outcomes approaches into the care management of 95 Sooner HAN SoonerCare Choice members with diabetes. This project was completed at the close of CY 2016. Sooner HAN care managers will continue to provide HAN care management services after the NCQA PCORI project ends.

OU Physicians-Tulsa Internal Medicine Clinic – Workflow Redesign

Participated on team focused on redesigning OU Physicians-Tulsa clinic workflow and processes to further streamline the patient centered medical home approach. HAN staff assisted with evaluating and documenting the workflow of activities related to a member's clinic visit, from pre-planning activities, the office visit, to after visit activities. Each PCMH team member's role was documented, including the member's interaction. A value stream map was created to identify cycle time for an office visit and highlighted value-added and non-value-added steps and time involved. The team is increasing efforts to promote member use of the Patient Portal for completing paperwork, receiving lab results, communicating with health care team, etc. Another area of focus of team based care is accountability, teamwork, communication, and working at the top of each team member's license or role. Checklists will be developed to promote standardization as well as comprehensiveness of visits and continuity of care. The team has identified several opportunities for improvement and are testing their ideas using PDSA cycles of change. The team will continue its work in CY 2017 to complete identifying and testing opportunities for improvement in the remaining steps of the value stream map.

OU Physicians – Tulsa (All Clinics) – EMR Documentation Timeliness

Assisting OU Physicians – Tulsa to increase the timeliness of EMR documentation to promote improved patient care and patient satisfaction. An initial survey of providers using the EMR was completed in Q4 of CY 2016. Results of survey indicated changes needed in policy, the EMR system, and in practice redesign. A new policy with tighter documentation timelines was implemented in January of 2017, with a phased in approach. Every two months the timelines will become more stringent, until the desired timeliness is reached. This project will continue into the first 6 months of 2017.

Member Experience with Care Management Survey

The Sooner HAN developed a member satisfaction survey tool for members receiving care management services and received approval to proceed from the OU IRB in quarter 2. The Sooner HAN began contacting members in Q3 to participate in a member satisfaction survey of care management. A sample of 150 members in all care groups were identified for the baseline survey. The surveys were conducted by a master's level student completing a social work or public health practicum. Survey results were entered into REDCap survey database but results have not been tabulated yet.

Some of the challenges experienced were: inability to reach members due to incorrect phone numbers or not answering the phone, and members not being able to fully recall events or differentiate who provided services for members. Staff time was even more limited in Q4 and members were not contacted. The Sooner HAN continue to discuss the feasibility of conducting member satisfaction surveys and consider other methods that may be used to gain feedback from members.

HAN Clinic/Provider Reporting

Sooner HAN staff set up meetings with numerous clinics during CY 2016 to build relationships with new staff, discuss the HAN services of quality improvement, care management, and referral management, and offer HAN assistance to clinics in these areas. Onsite meetings were held and HAN staff shared examples of reports that can be generated for each clinic for quality improvement monitoring, and discussed clinic issues or needs brought forth by clinic staff.

In CY 2016, the Sooner HAN upgraded to a newer version of the Pentaho business analytics software that is used report on roster information and claims data. Providers have responded positively to these monthly reports and many have incorporated the information into their marketing and outreach activities. The roster reports include demographic data on new and continuing members as well as the status of members who are being care managed by the Sooner HAN, including their assigned care manager and care group. Clinics are able to generate letters or phone calls to new members to welcome them and attempt to schedule new members for an upcoming appointment to establish their membership with the clinic and address preventive or other services needed.

Other reports generate for clinics include utilization of emergency rooms and hospitals, including designating members with asthma related ICD codes, to identify patterns and trends. Based on the providers' preferences, reports can be customized to the desired timeframe and include number of ER and Inpatient events, location of facility, day of week, ICD codes, provider specific detail, member specific detail, and care management status.

PCMH Tier Advancement/Corrective Action Plans

Two medical groups, Access Solutions Medical Group and Crossover Health Services failed OHCA PMCH audits and were required to submit plans of correction. Sooner HAN staff met with clinic leadership in Q3 and Q4 to determine where HAN staff could be of assistance. Efforts related to quality were focused on creating a solid infrastructure and creating policies, procedures, flow charts, and job aids to shore up key processes. Care management staff were engaged to assist with care management of complex members. Doc2Doc staff were involved to help close the referral loop for a backlog of cases. Both medical groups passed their most recent follow up audits, however, the Sooner HAN will continue to assist these clinics in CY 2017 to ensure new policies and procedures are firmly practiced and slippage does not occur.

Sooner HAN Quality Committee

The Sooner HAN Quality Committee has met at least quarterly in CY 2016 to review performance measures and discuss opportunities for improvement. Two quality activities in quarters 3 and 4 of CY 2016 included: 1) discussions on how the Sooner HAN can assist its providers to improve antibiotic stewardship among Sooner HAN providers related to Upper Respiratory Infections, and 2) evaluating asthma medication adherence and its impact on hospital admissions and readmission rates.

Hypothesis 8 and Pro Forma Quality Measures

The Sooner HAN has worked in collaboration with the OHCA and two other Health Access Networks in prior to CY 2014 to develop standard measures around Asthma ER use and readmission rates, as well as general ER use by Sooner HAN members.

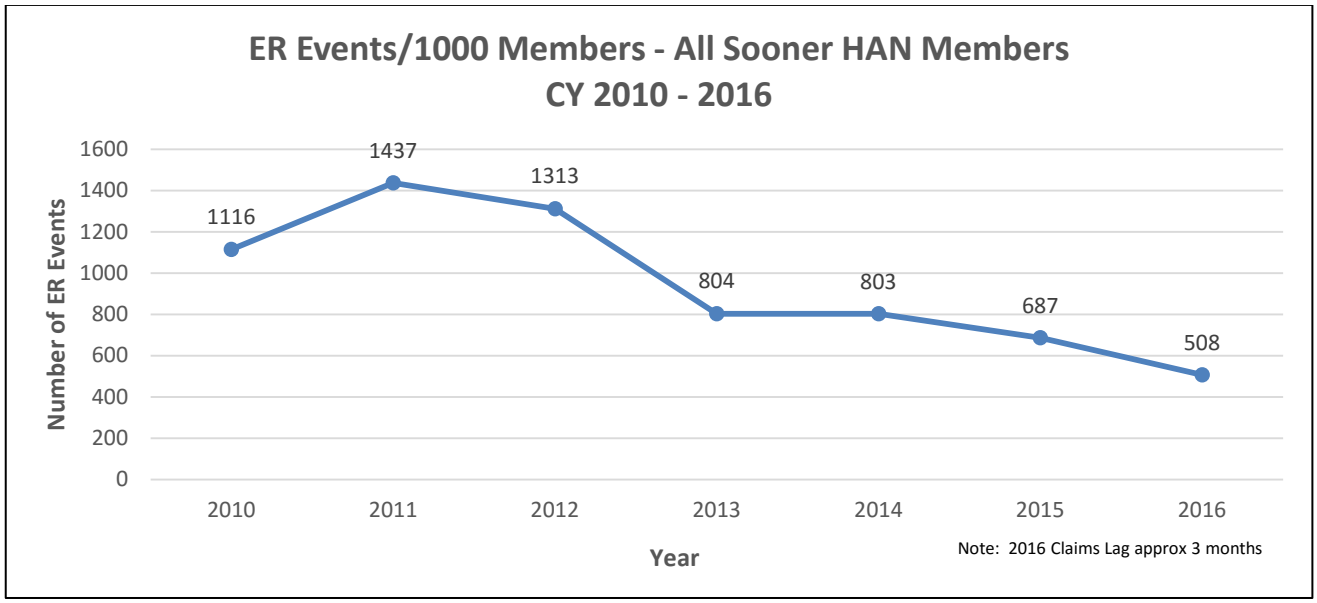
Additional quality measures were added in CY 2016 with the introduction of Pro Forma reporting. These include completion of the PHQ9 behavioral health assessment for new members in the HROB and Diabetes care management groups. Another measure focuses on asthma, evaluating members with persistent asthma who remained on an asthma controller medication during their treatment period. A summary of these measures highlighted below:

Sooner HAN Quality Measures (Hypothesis 8 & Pro Forma)		CY 2016 – Q3&Q4	
#	Performance Measure	Qtr 3 %	Qtr 4 %
1	% ER Visits - Asthma Diagnosis	8.3%	9.1%
2	ER Visits - All Cause Per Roster Member (RATIO)	0.15	0.13
3	% Inpatient Admissions-Asthma Diagnosis	4.3%	7.5%
4	% of Inpatient Admissions (Asthma diagnosis) with 90 Day Readmission (Asthma diagnosis)	4.1%	0.0%
5	% of new HROB CM members (able to contact) screened for depression using the PHQ9	55.4%	56.0%
6	% of new Diabetes CM members (able to contact) screened for depression at least once using the PHQ9	100%	11.1%
7	% of patients who remained on an asthma controller medication for at least 50% of their treatment period	44.61%	43.61%
8	% of patients who remained on an asthma controller medication for at least 75% of their treatment period	21.09%	20.65%

Emergency Room Utilization

The Sooner HAN has actively monitored ER use since CY 2010. A significant trend over the past seven years has been the decline in ER visits/1000 members. While membership grew from 34,864 to 161,718 over seven years (364%), ER visits increased with the additional membership. Although ER visits rose slightly during CY 2011, each subsequent year showed a decline in ER visits. Using the calculation of ER Events per 1000 Members (PTM), ER utilization has decreased significantly from 2010 to 2016, from 1,116 PTM to 508 PTM, a 54% decrease.

ER Events - All Sooner HAN Members	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
ER Events	38,892	62,571	92,796	107,628	113,056	104,164	82,114
Unique Members	34,864	43,534	70,698	133,884	140,710	151,692	161,718
ER Events / 1000 Members	1,116	1,437	1,313	804	803	687	508



Cleveland County Community Health Improvement Plan
Child Health Workgroup

Cleveland County Health Department
250 12th Ave NE, Norman, OK 73071
Wednesday May 24, 2017
3 p.m.

- **Welcome/Introduction**- Corey Burnett
- **Approve April Minutes**
- **OHCA Presentation**
- **Discussion**
    - Well Child Check Strategy
        - Detail work plan for back to school event
- **Action Item Updates**
    - 211
    - Norman Public Schools
    - Resource Navigator Update
- **Upcoming Events/Announcements**
- **Small Wins/Progress update**
- **C4T Campaign**
    - Social Media
    - Progress Report
- **Next Meeting – June 28th**
- **Adjourn**