Annual Report

July 1 - December 31, 2016

TABLE OF CONTENTS

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.

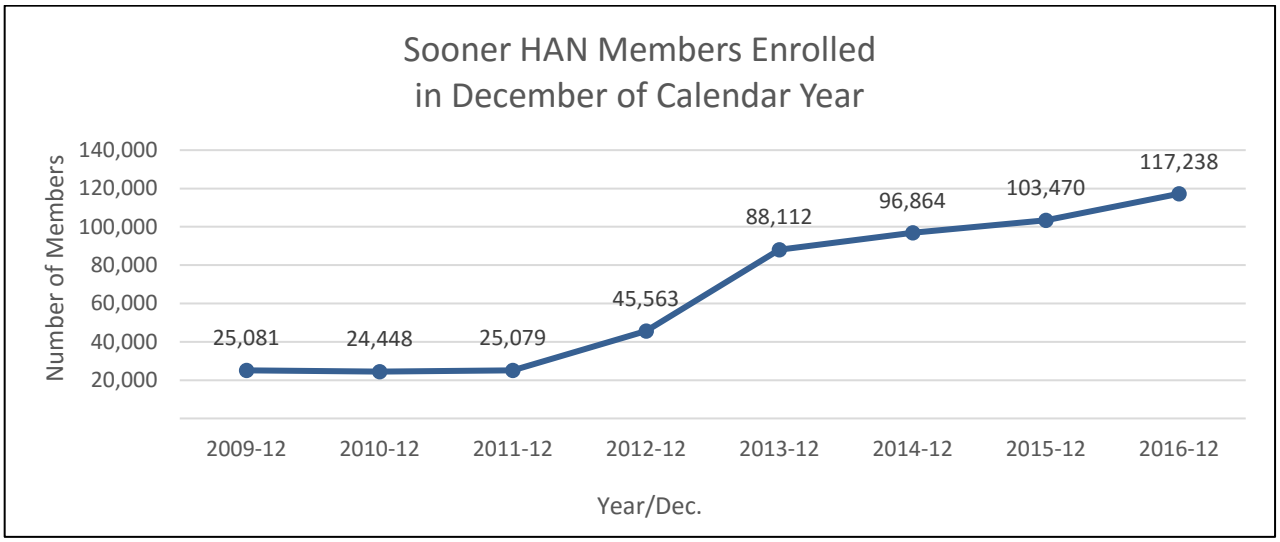
Provider Recruitment

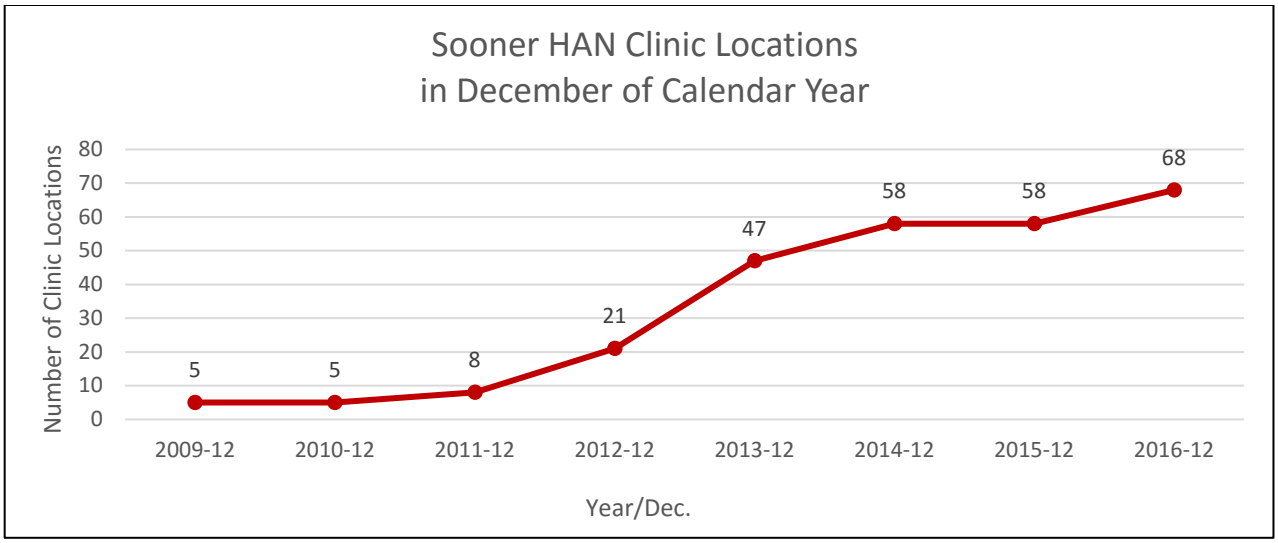
The Sooner HAN began its program with 25,081 members in December of 2009 and one contracted provider group, OU Physicians-Tulsa. Since the inception of the Sooner HAN, Sooner HAN staff have reached out to providers to share the services available and the benefits to both providers and members. Like many 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

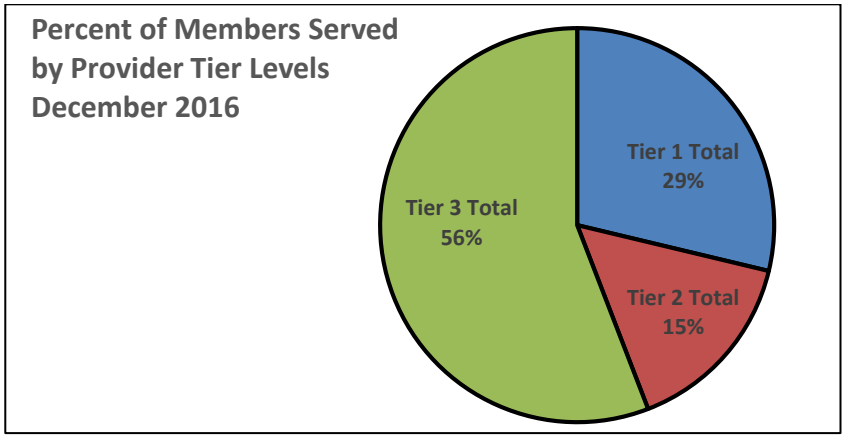
SoonerCare Choice is a managed care model in which each member is linked to a primary care provider who serves as the member's "medical home". Primary care providers manage the basic health care needs, including after-hours care and specialty referral of the members on their panel. PCMH includes three 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.

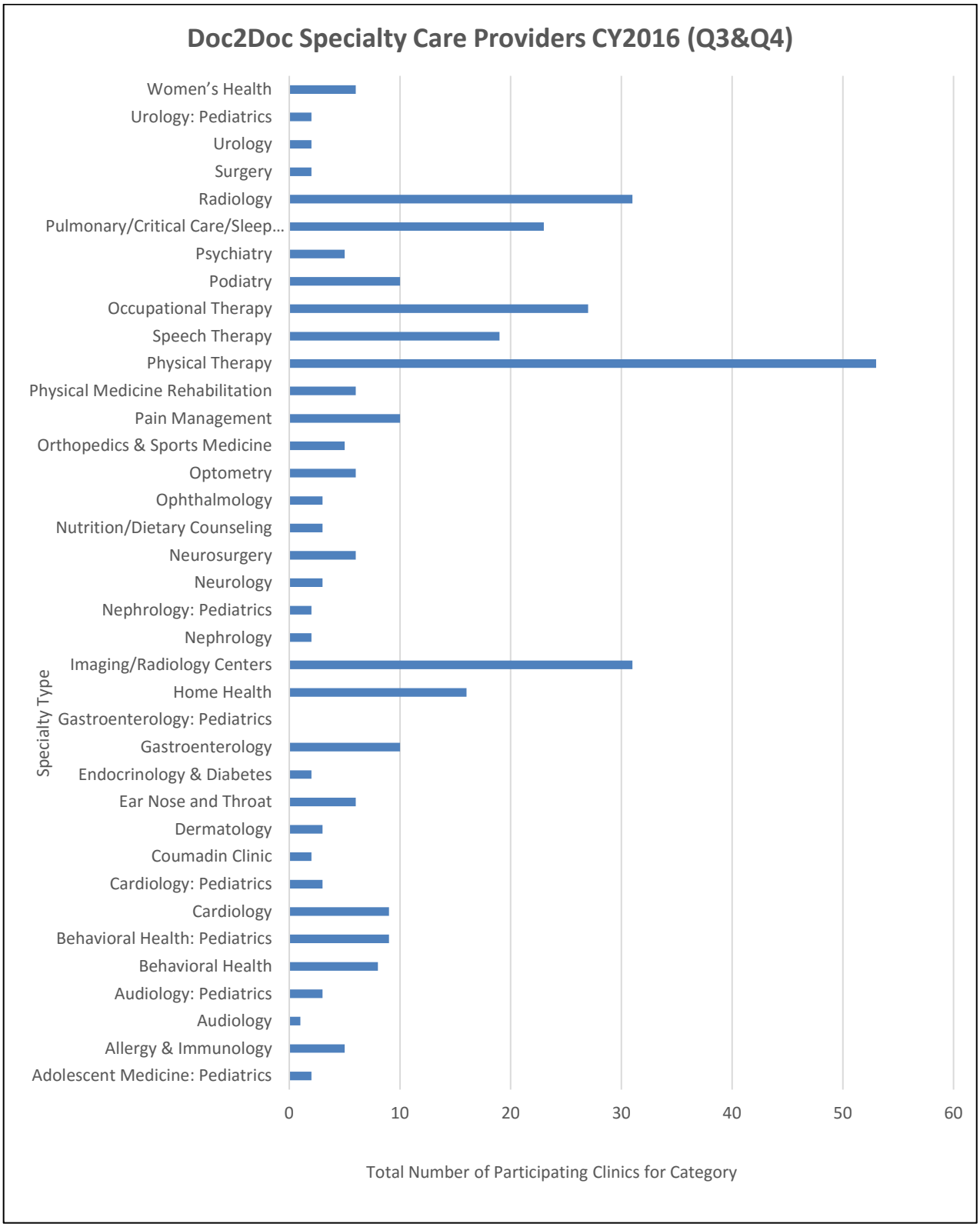
As shown in the table below, providers in the Sooner HAN at the highest PCMH Tier Level III served 56% of the total member population in December 2016. Providers at PCMH Tier Level II served 15% while providers at Tier Level 1 served 29% of the member population.



Specialty Care Network

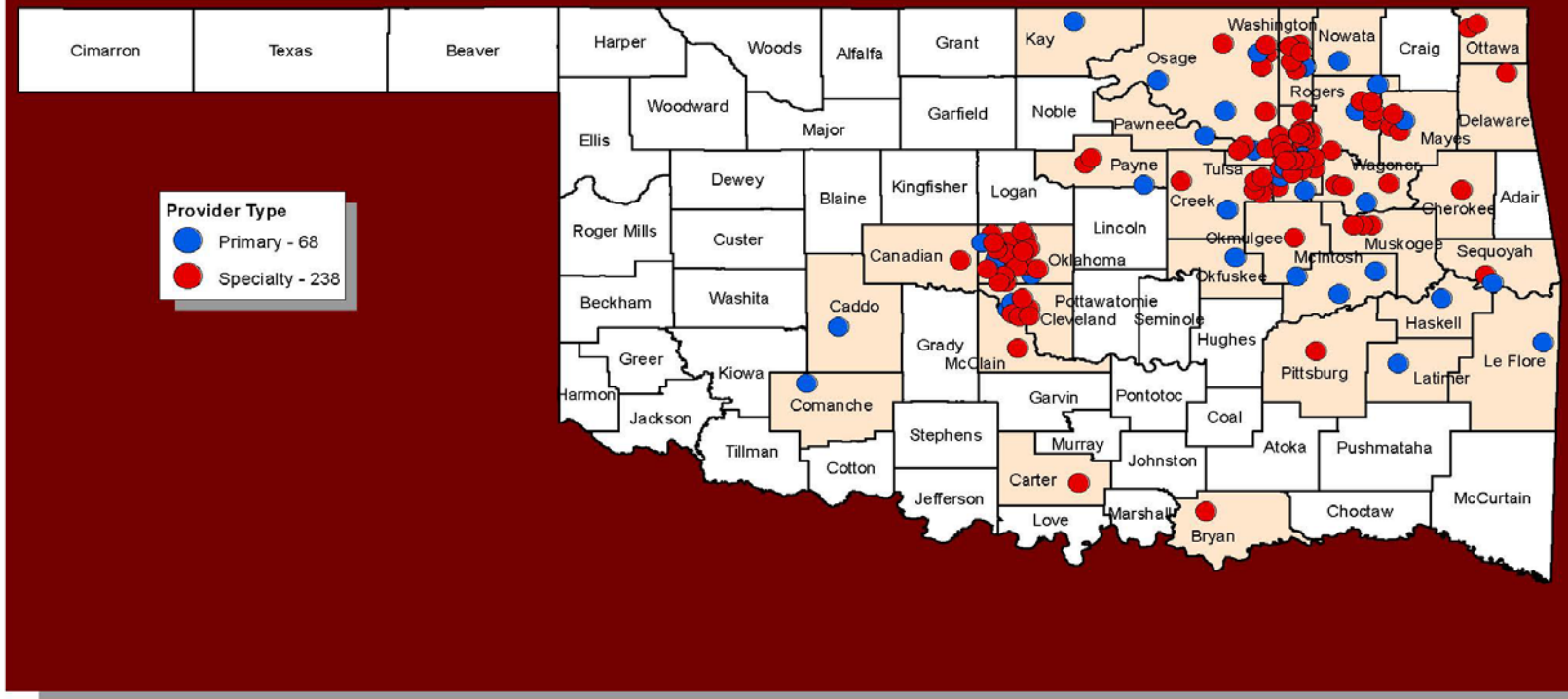
The Sooner HAN continues to focus on the recruitment of specialty providers for enrollment into the Sooner HAN. Targeted recruitment in the Oklahoma City and Tulsa areas will continue throughout CY 2017. As of December 2016, there were 258 specialty clinics participating in Doc2Doc, offering access to 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

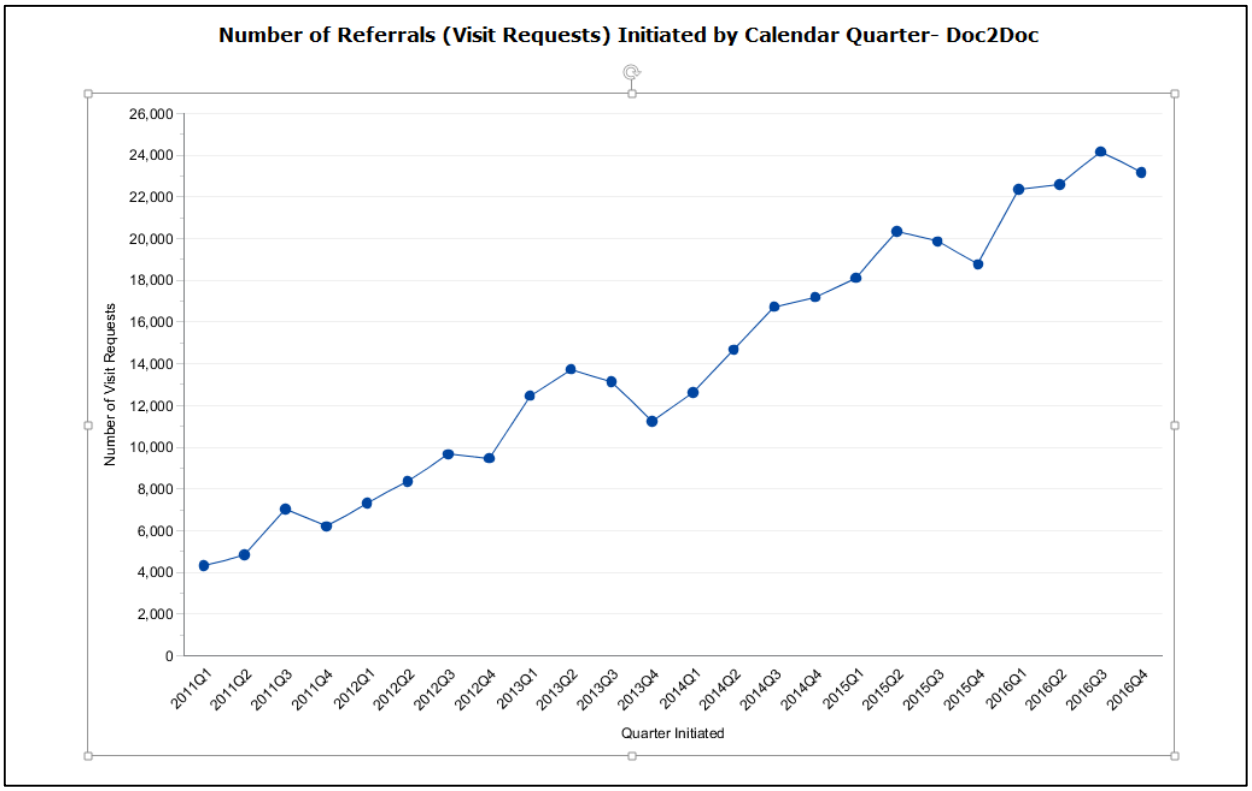


SOONER HEALTH ACCESS NETWORK

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.

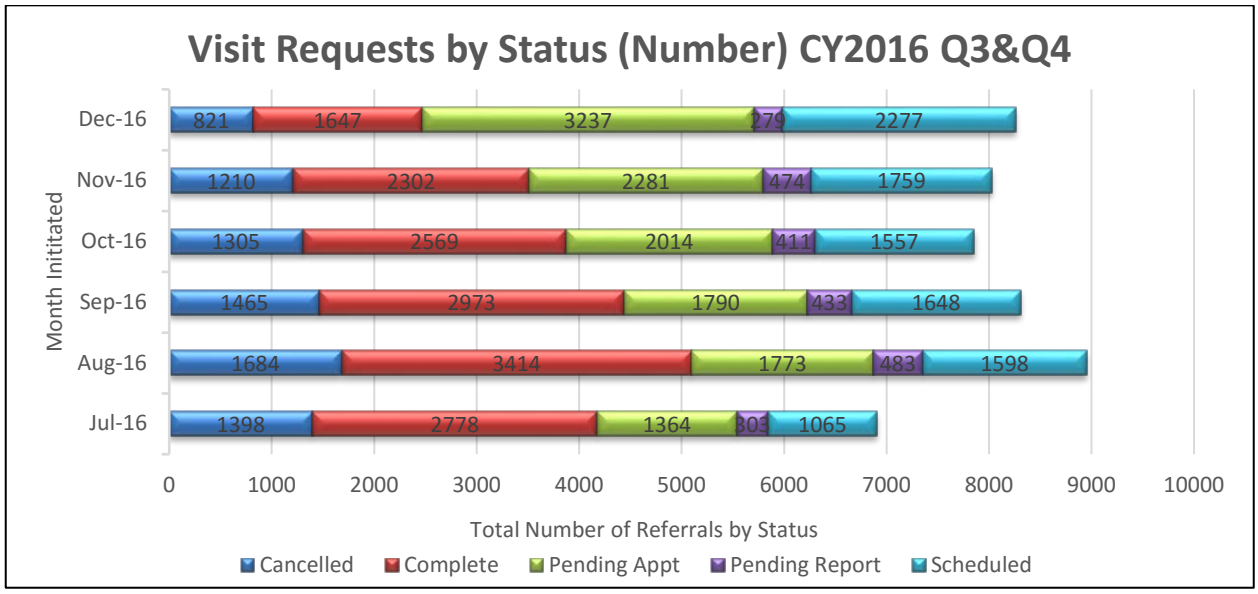


The table below outlines the total number of visit requests in Doc2Doc and a breakdown of the statuses of these requests at the conclusion of December 2016.

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.

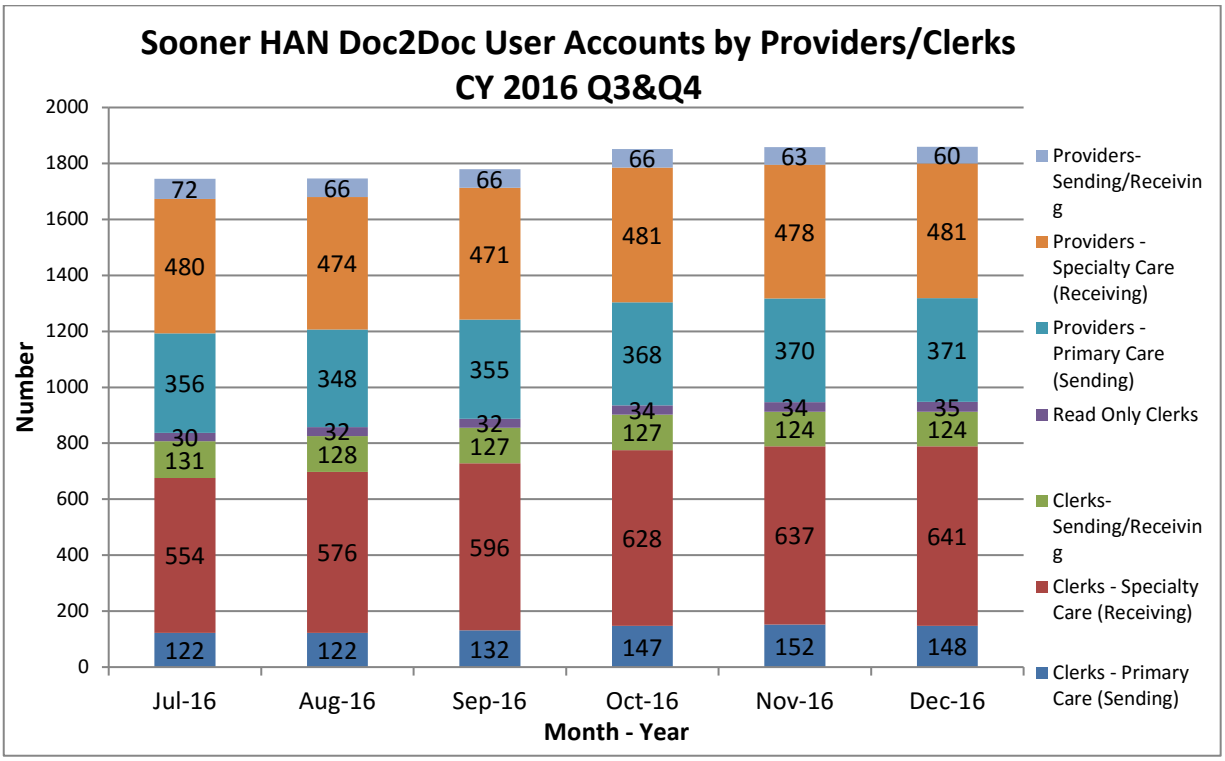


Transitions of Care and Referral Management User Accounts

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



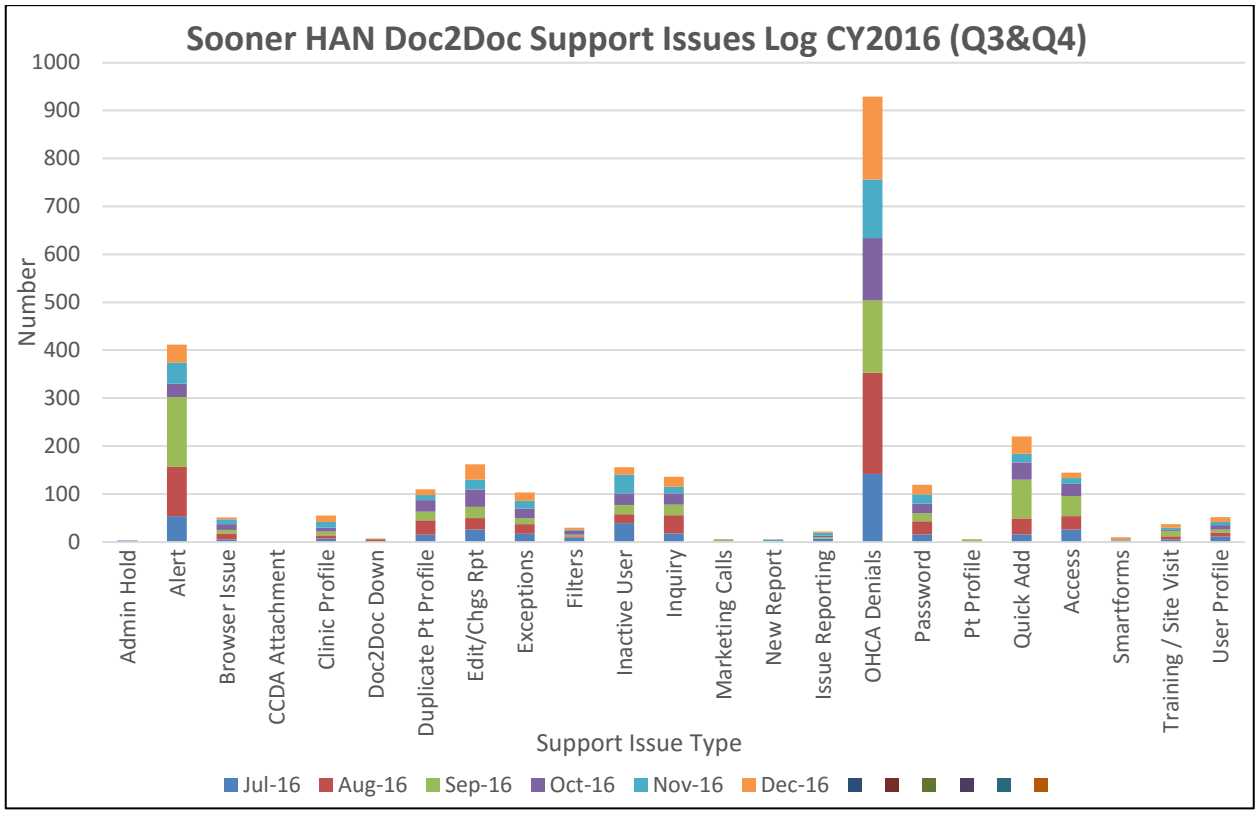
Transitions of Care and Referral Management User Support Issues

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.

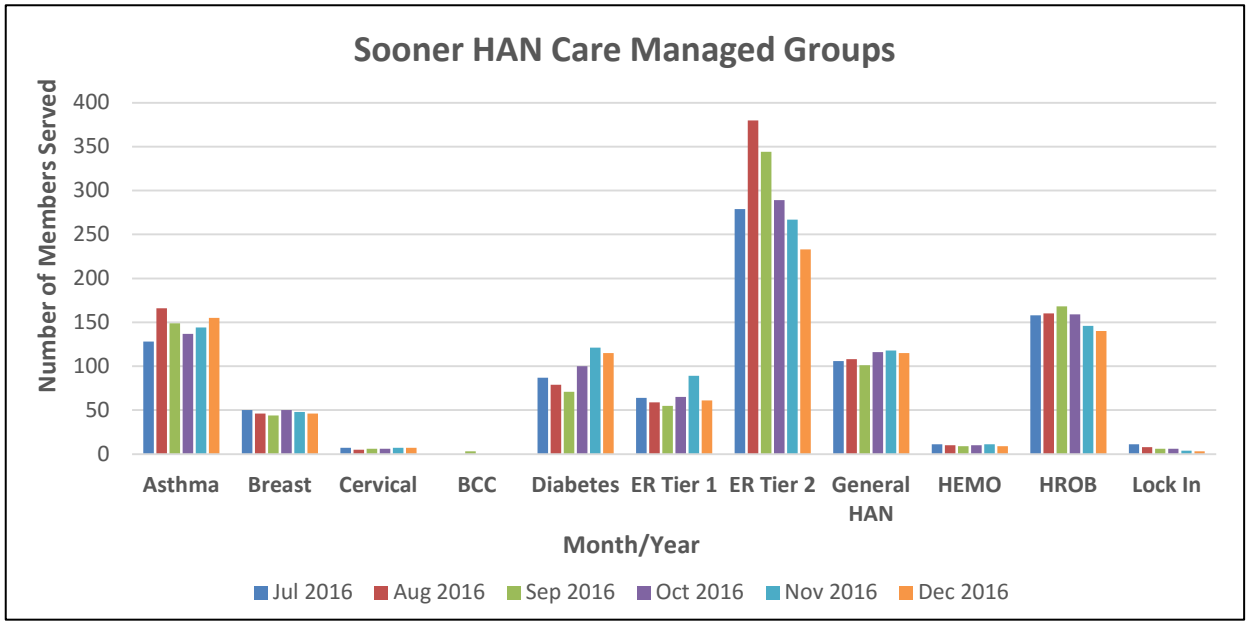
In FY2016 the Sooner HAN chose to implement the use of the PHQ9 screening for all members in the HROB and Diabetes care groups as well as for members in other care groups that may benefit from depression screening. Through reporting in the ProForma in Q3 and Q4 of 2016 it was noted that there was a very 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.

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