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

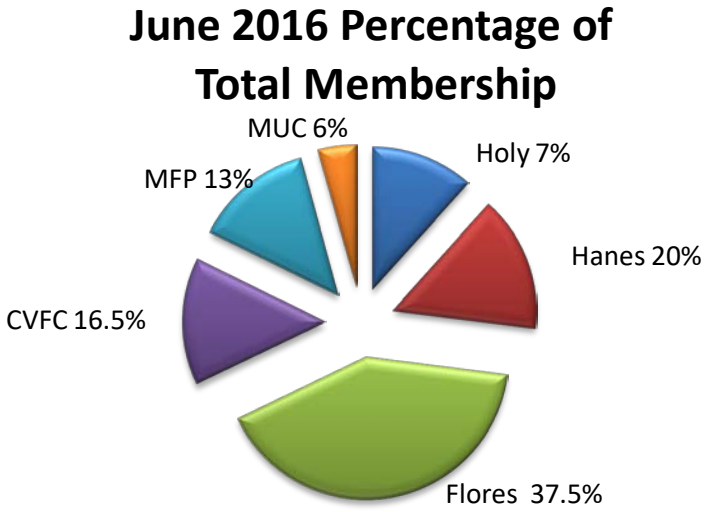

Table 3: CC-HAN Monthly/Total Members for Calendar Years 2015 & 2016		
Month	Calendar Year 15	Calendar Year 16
Jul	3582	3703
Aug	3559	3726
Sep	3457	3763
Oct	3380	3808
Nov	3485	3873
Dec	3528	3862

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**