ACCREDITED NCQA CASE MANAGEMENT 3 YEARS

2023 ANNUAL REPORT

OU Sooner Health Access Network

SOONER HEALTH ACCESS NETWORK

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

MISSION, VISION, AND VALUES 4

PURPOSE 4

OU SOONER HAN ENROLLMENT 5

PRIMARY CARE NETWORK 6

EMERGENCY ROOM UTILIZATION 6

CARE MANAGEMENT 8

CARE MANAGEMENT BY THE NUMBERS 8

CARE MANAGEMENT TARGETED POPULATIONS 11

AGED, BLIND, DISABLED (ABD) CATEGORY 11

ASTHMA 12

DIABETES 12

ER TIER 1 (10+ VISITS IN 12 MONTHS) 13

ER TIER 2 (2-9 VISITS IN 12 MONTHS) 13

GENERAL HAN 14

HEMOPHILIA, PHARMACY LOCK- IN, SICKLE CELL 14

QUALITY 15

EDUCATIONAL OPPORTUNITIES AND PROVIDER ENGAGEMENT 16

FUNDAMENTALS OF CARE MANAGEMENT COURSE 16

MONTHLY LEARNING SERIES 17

IMPACT STORIES 18

REBUILDING CONFIDENCE & REJOINING THE WORKFORCE 18

TRANSLATION ASSISTANCE FOR ZOMI-SPEAKING MEMBERS 18

ADVOCACY 18

LEGAL SUPPORT 19

COMPLEX CARE THAT LEAD TO A SUCCESSFUL KIDNEY TRANSPLANT 19

RESILIENCE – MEETING GOALS AND FINDING THE RIGHT PROVIDER 20

IMPORTANCE OF MOTIVATIONAL INTERVIEWING & CARE MANAGEMENT 22

HOUSING 22

EXECUTIVE SUMMARY

The OU Sooner Health Access Network (HAN) hit a significant milestone in 2023 by successfully achieving Full National Committee for Quality Assurance (NCQA) Case Management Accreditation. This was the first of its kind in the state of Oklahoma. The OU Sooner HAN underwent the comprehensive evaluation process by NCQA which included a thorough assessment of our organization's structure, processes, and performance against the NCQA Standards. This accreditation serves as a testament to our dedication to excellence in providing the best possible healthcare to our SoonerCare Choice members.

In achieving this Accreditation it highlights our commitment to quality improvement, patient-centered care, evidence-based practices, care coordination and integration, and overall population health. This accreditation was a decade in the making and a reflection of the commitment of the leadership team and care managers.

We managed 3,114 complex care cases, working to ensure that these members received the necessary support and services to improve their chronic health conditions. An annual report favorite, Impact Stories (page 18) highlights just a few of the amazing successes our care managers had while improving their members lives.

OU SOONER HAN HIGHLIGHTS

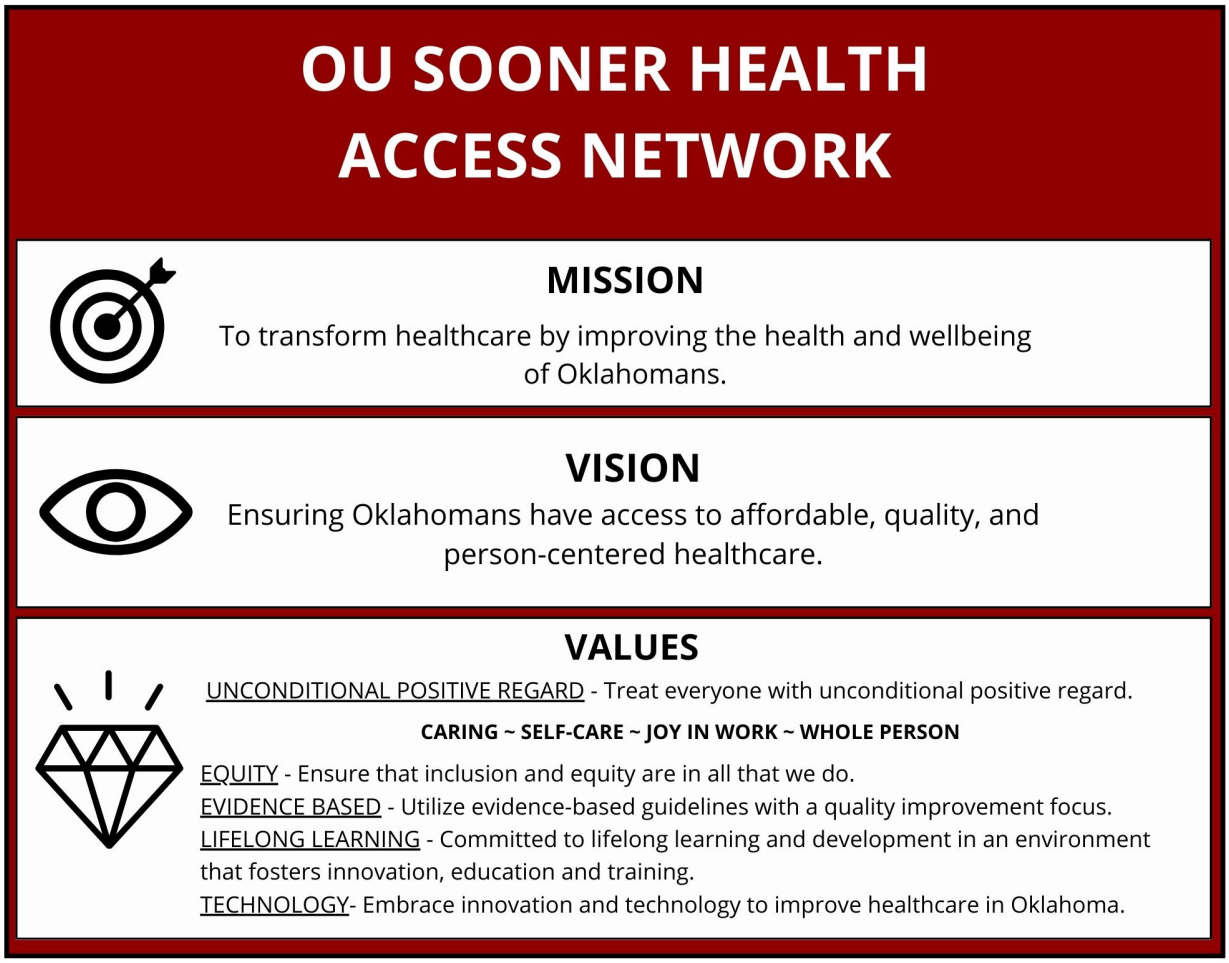
- NCQA Case Management 3-year Accreditation
- 3,114 Complex Care Management Cases
- New care managed members in the Diabetes care group saw an 80% decrease in ER events.

Throughout this report you can see the influence of being part of the OU School of Community Medicine and the impact providing personalized, member-centered care has on improving health outcomes. As Dr. Jacob O'Meilia, the OU Sooner HAN Behavioral Health Medical Director stated, "Sooner HAN embodies the core values of community medicine, doing good work for the most vulnerable in our community."

As we look ahead to 2024, we are excited about the opportunities to partner with the Managed Medicaid Organizations (MCO's), and we are confident that when these MCO's work with the OU Sooner HAN they will see the benefits of such a strong partner. While our program may look different in the coming years, I can say with confidence that the OU Sooner HAN will continue to provide excellent care to the people of Oklahoma.

Rachel Mix, MBA, BSN
Director
OU Sooner Health Access Network

MISSION, VISION, AND VALUES



PURPOSE

The purpose of the OU Sooner HAN is to:

- Support comprehensive, coordinated healthcare centered around the wants and needs of the **member**
- Improve member **access** to care and social services
- Improve member **health** and **healthcare** one network connection at a time

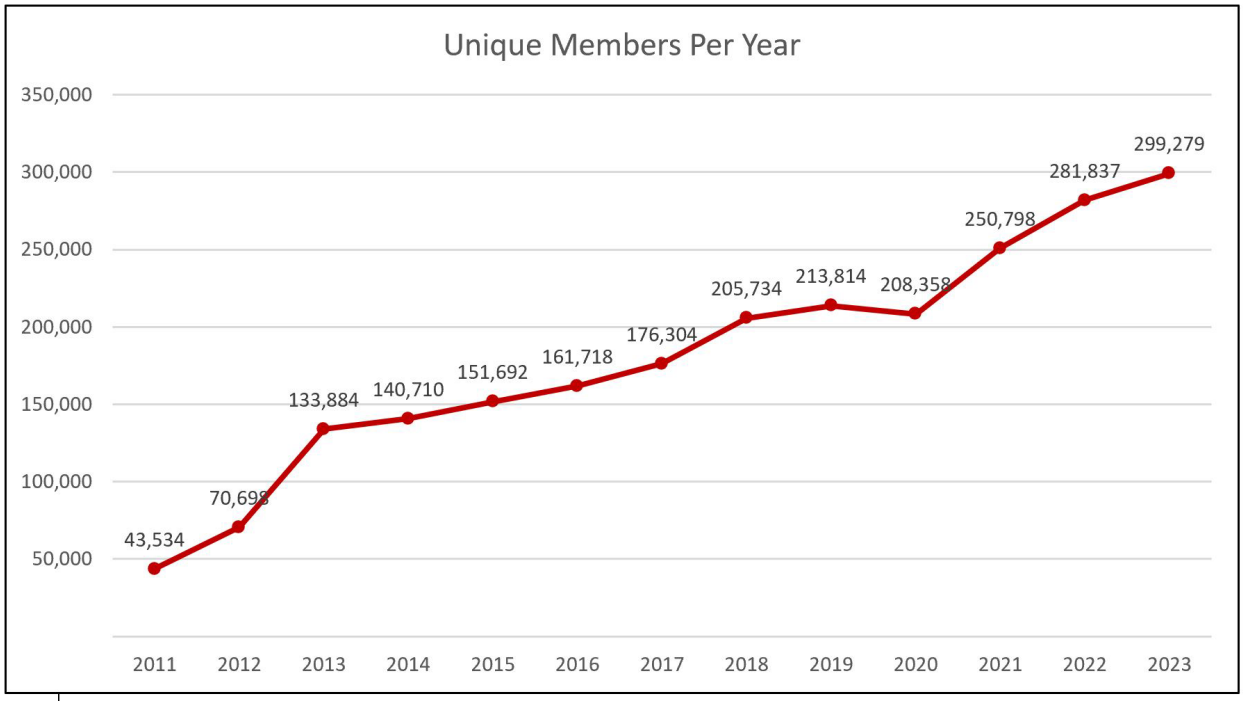
OU SOONER HAN ENROLLMENT

OU SOONER HAN

Member Demographics

CY 2023

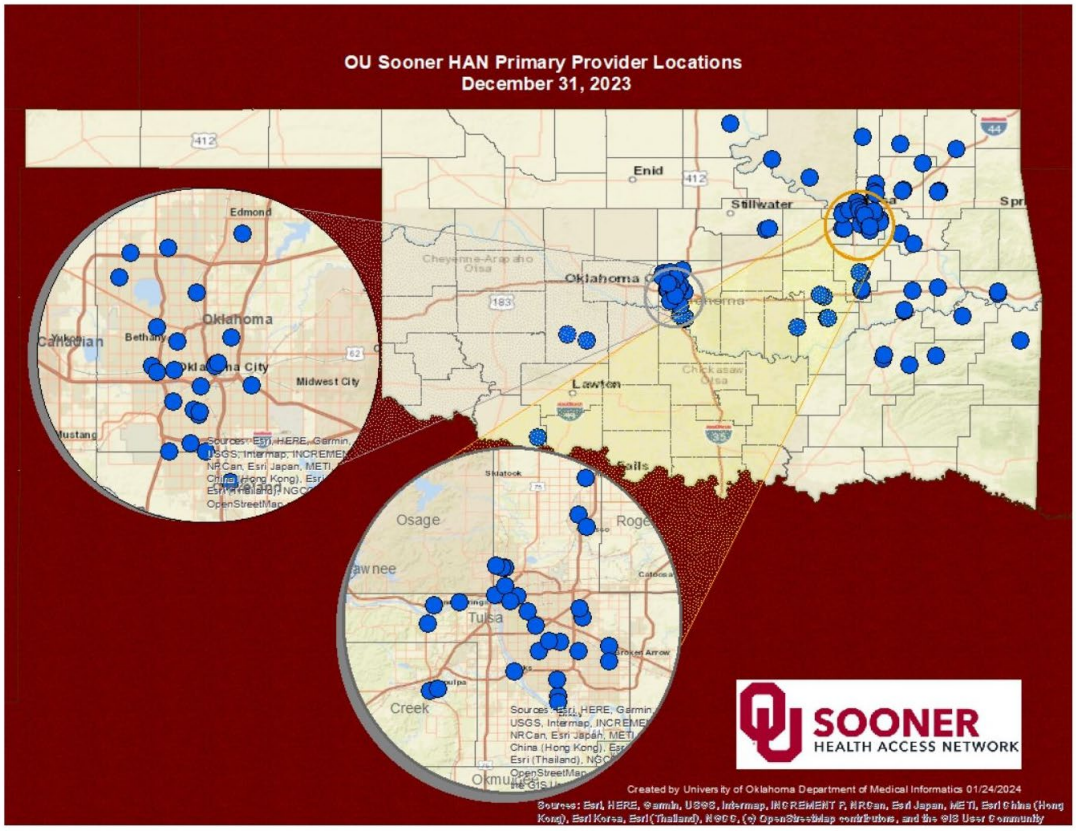
299,279 Unique Members Served	
	6.19% Growth in Roster
55% Members Age 18+ 45% Members Age Under 18	
	84% English Preferred Language 15% Spanish Preferred Language <1% Unreported



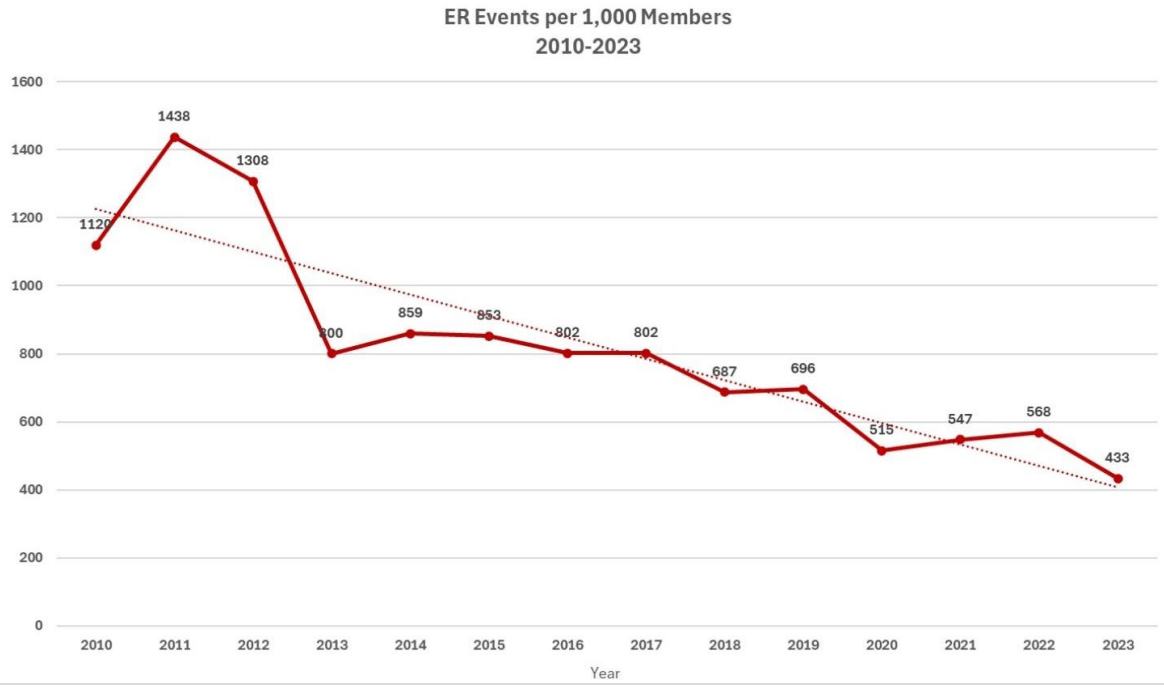
PRIMARY CARE NETWORK

As of December 2023

99 Primary Care Locations



EMERGENCY ROOM UTILIZATION



Top Three ICD-10 from ER Events in 2023

- J06.9 - Acute upper respiratory infection, unspecified
- B34.9 - Viral infection, unspecified
- R11.2 - Nausea with vomiting, unspecified

Most Common ER Events

Day of the Week
Monday 15.13%

Age Group
19-44 (38.91%)

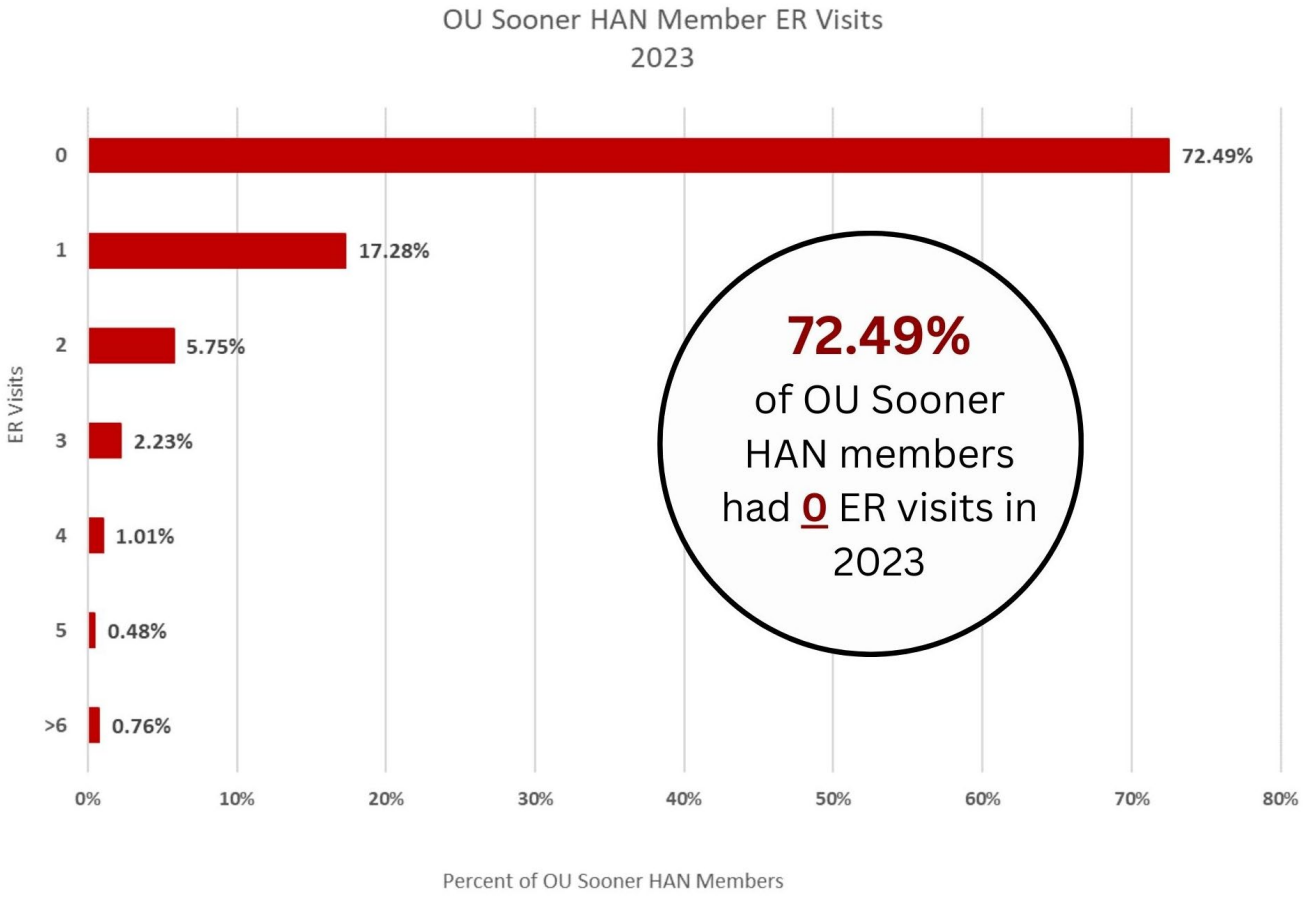
Race
Caucasian (40.99%)

Least Common ER Events

Day of the Week
Saturday 13.33%

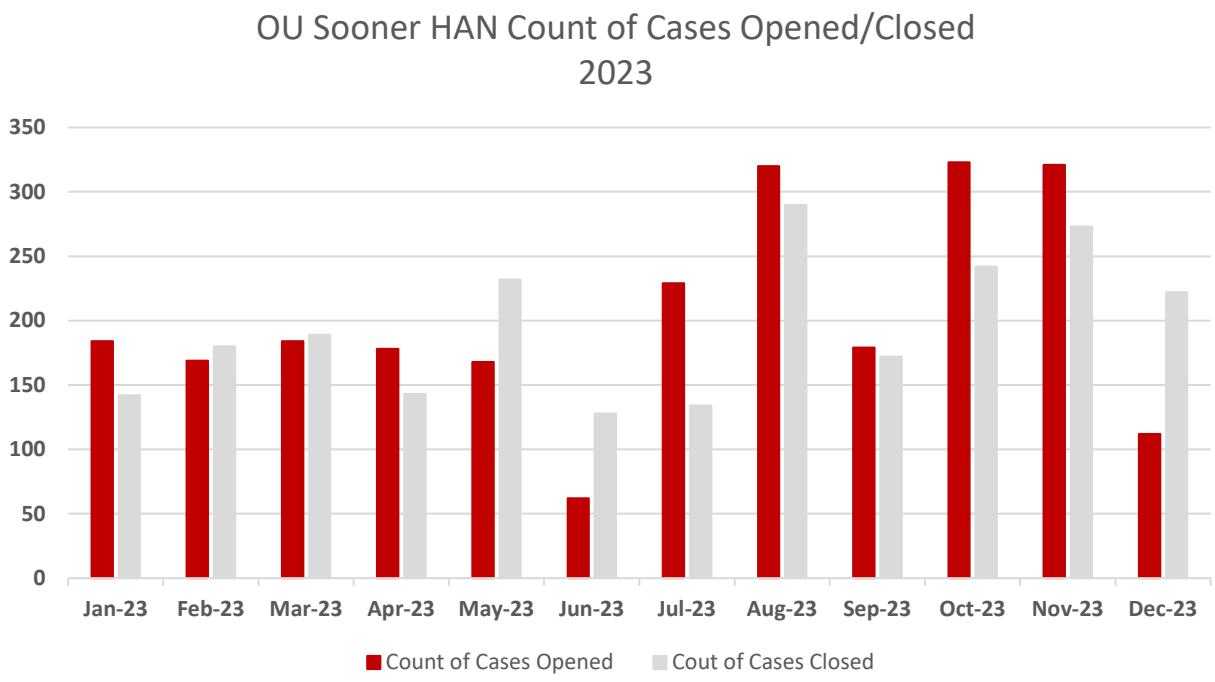
Age Group
65+/Unknown (1.02%)

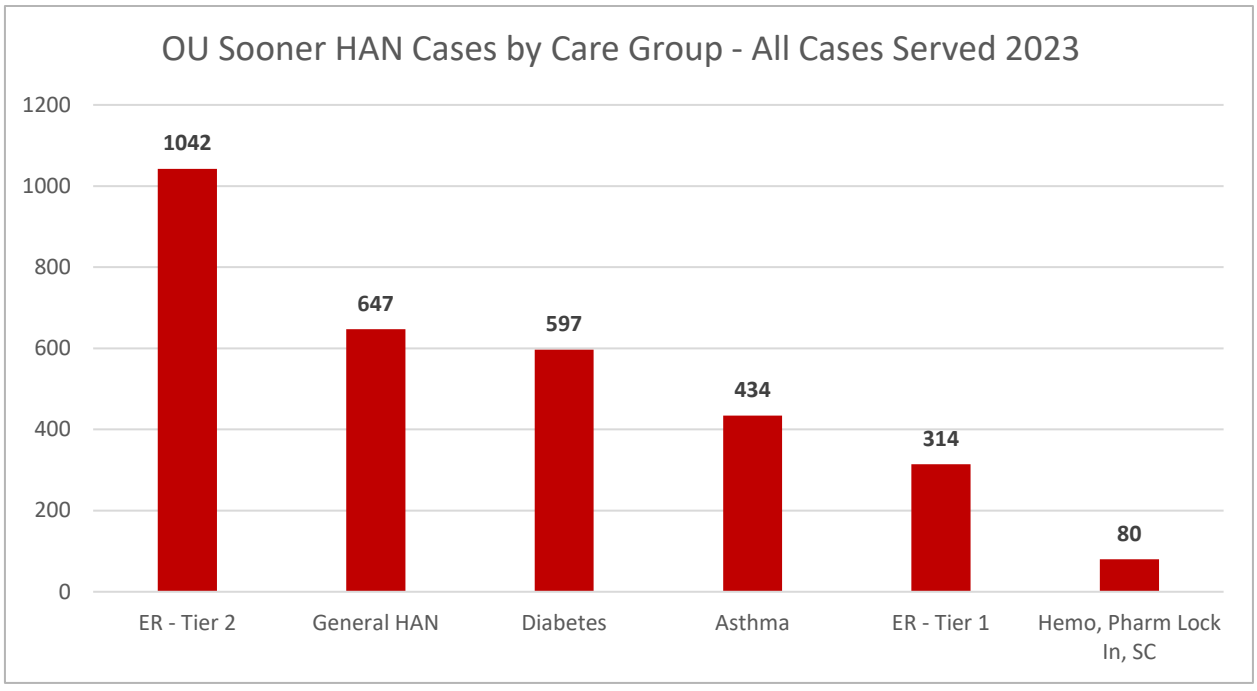
Race
Asian/PI/Unknown (1.27%)



CARE MANAGEMENT

CARE MANAGEMENT BY THE NUMBERS





3,114
Care Management Cases Served

43%
Participation Rate

192
Average number of days in care management

13,949
Completed Contacts with Member or Member-Related Individual

1,204
In Person Visits Completed
(Home, PCP, Specialist, Hospital, Other)

13,962
Documented Hours of Completed Contacts and Activities

OU Sooner HAN Care Managers spent
68%
of their time providing direct contact to their members.

Top 3 Case Closure Reasons

1. Never Able to Contact
2. Voluntary Withdrawal
3. Unable to Contact (After Making Contact)

OU SOONER HAN

Social Determinates

CY 2023

16% of Care Managed members reported having utilities shut off or at risk.

40% Caucasian
23% African American
15% Children ages 0-18

34% of Care Managed members reported in the last 12 months to have had a shortage of food and lacked money to buy more.

48% Caucasian
18% African American or Hispanic
24% Children ages 0-18

31% of Care Managed members reported that a lack of reliable transportation kept them from attending medical appointments, meetings, work, or from getting to things needed for daily living.

49% Caucasian
23% African American
18% Children ages 0-18

2,645 Referrals Initiated in 2023

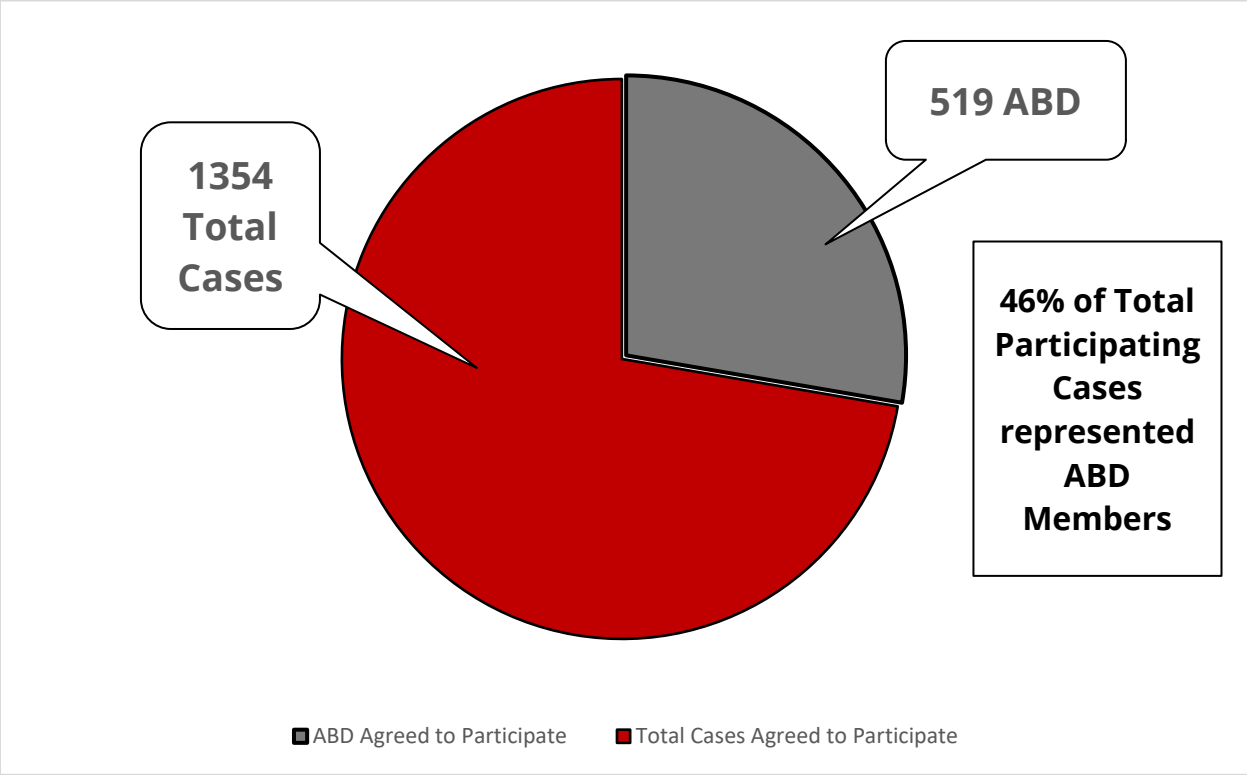
2,164 Referrals Closed in 2023

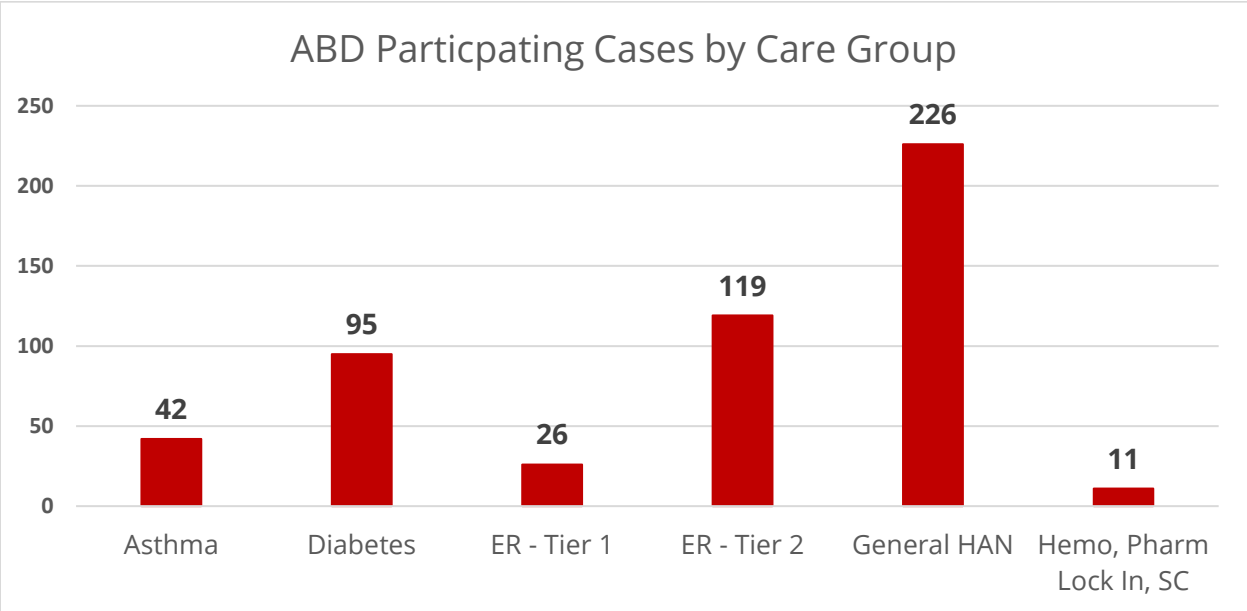
Top Referral Categories

- Identification Resources
- Utility Assistance
- Healthcare
- Counseling Therapy Resources
- Disability Related Resources

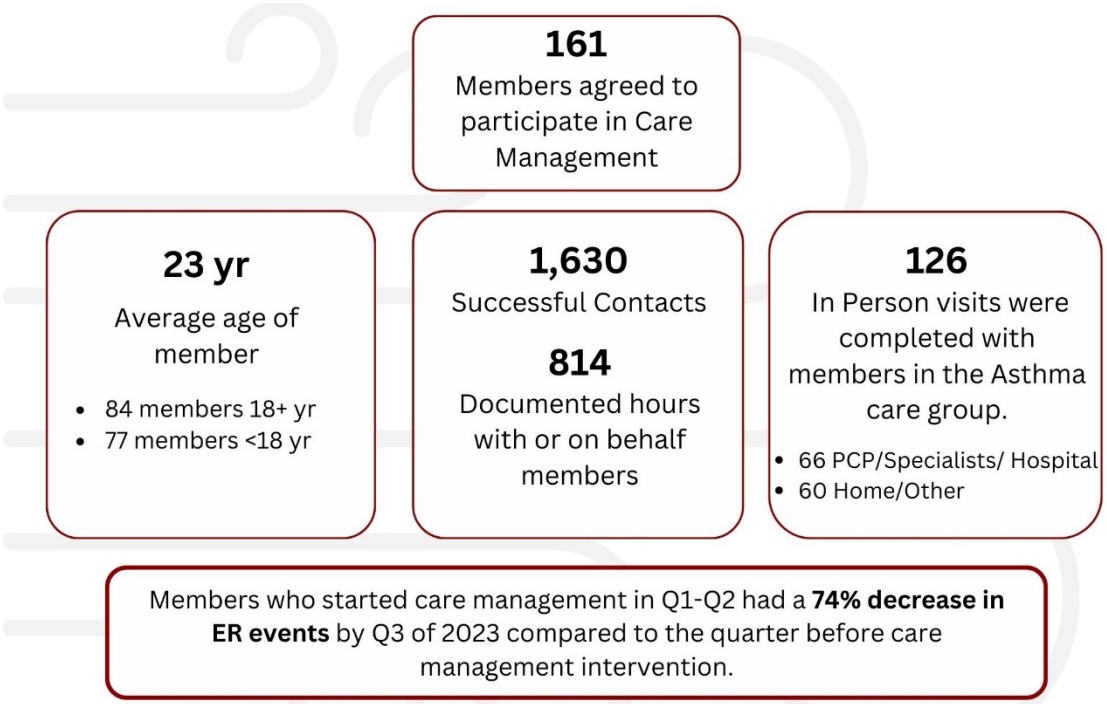
CARE MANAGEMENT TARGETED POPULATIONS

AGED, BLIND, DISABLED (ABD) CATEGORY





ASTHMA



DIABETES

222 Members agreed to participate in Care Management	**4,086** Successful Contacts **2,356** Documented hours with or on behalf of members in the Diabetes care group.
45 Average Age • 209 members 18+ yr • 13 members <18 yr	**372** In Person visits completed with members in the Diabetes care group. • 215 PCP/Specialist/Hospital • 157 Home/Other

Members who started care management in Q1-Q2 had an
80% decrease in ER events
by Q3 2023 compared to the quarter before care management intervention.

ER TIER 1 (10+ VISITS IN 12 MONTHS)

115
Members agreed to participate in care management

35
Average Age
- 92 members 18+yr
- 23 members <18 yr

432
Documented hours with or on behalf of the member.

887 Successful Contacts

43 In person visits completed
- 34 PCP/ Specialist/ Hospital
- 9 Home/Other

Members who started care management in Q1-Q2 had a **74% decrease in ER events** by Q3 2023 compared to the quarter before care management intervention.

ER TIER 2 (2-9 VISITS IN 12 MONTHS)

347
Members agreed to participate in care management

32
Average Age
- 232 members 18+yr
- 115 members <18 yr

1,503
Documented hours with or on behalf of the member.

2,936 Successful Contacts

181 In person visits completed
- 110 PCP/ Specialist/ Hospital
- 71 Home/Other

Members who started care management in Q1-Q2 had a **84% decrease in ER events** by Q3 2023 compared to the quarter before care management intervention.

GENERAL HAN

481
Members agreed to participate in care management.

5,861
Successful Contacts

3,185
Documented hours with or on behalf of the member.

30
Average Age

281 Members 18+ yr
115 Members <18 yr

605
In Person visits completed

- 314 PCP/Specialist/Hospital
- 291 Home/Other

Members who started care management in Q1-Q2 had a **75% decrease in ER events** by Q3 2023 compared to the quarter before care management intervention.

HEMOPHILIA, PHARMACY LOCK- IN, SICKLE CELL

28 Members agreed to participate in care management.

27 Average Age

- 17 Members 18+ yr
- 11 Members <18 yr

166 Successful Contacts

80 Documented hours with or on behalf of the member.

3 In Person visits completed

- 2 PCP/Specialist
- 1 Home Visit

QUALITY

On June 1, 2023, the OU Sooner HAN achieved Full Case Management Accreditation from the National Committee for Quality Assurance (NCQA). This Accreditation, awarded for a 3-year term, represents the highest level of recognition. Additionally, the OU Sooner HAN was the first of its kind in the state to achieve such Accreditation.

82 quality improvement initiatives open.

Care managers completed **85** chart audits in 2023

9 Quality Newsletters written and distributed to the department.

2023 Quality Committee

- Yonna Creason
- Katie Yokum
- Rachel Mix
- Kristin Steuck
- Monica Molina

11 Quality Committee Meetings in 2023

Population Assessment Initiatives

Spanish Language Utilization

Zomi Language Utilization

FUNDAMENTALS OF CARE MANAGEMENT COURSE

Course Topics

- Healthcare in Oklahoma
- Foundations of Care Management
- Trauma Informed Care
- Ethics
- Intr. to Behavioral Health
- Suicide Risk
- Crisis Management
- Cultural Consciousness
- Chronic Disease Management
- Motivational Interviewing
- Community Resources

3 Sessions

44 Total Attendees
11 Network Practices and Partners

"I loved how interactive the sessions were."

"I can use the tools provided immediately."

On average, attendee's post assessment scores increased **35%** after course completion.

"This course really helped me as a new care manager to see all the resources that I was not aware of."

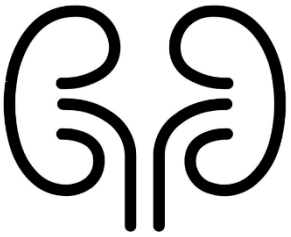
2023 LEARNING SERIES

JANUARY *Self-Care* Presented by: Julia Reed, MSW 88 Attendees	**FEBRUARY** *Housing & Homelessness* Presented by: Becky Gligo, Shandi Campbell & Laura Evanoff 92 Attendees	**MARCH** *LGBTQ+ Health* Presented by: Laura Arrowsmith, MD 97 Attendees
APRIL *Motivational Interviewing* Presented by: Helen Farrar, PhD, RN, BC, CNE 43 – In Person Attendees 91 - Online Attendees	**MAY** *Children's Behavioral Health* Presented by: Tara R. Buck, MD 83 Attendees	**JUNE** *Telemedicine* Presented by: Blake Lesselroth, MD, MBI 18 – In Person Attendees 51 – Online Attendees
JULY *Allied Health Services – OT & PT* *Rescheduled*	**AUGUST** *Allied Health Services – OT & PT* Presented by: Tara Klinedinst, PhD, OTR/L & Carolyn Cheema, PT, DSc, OCS, FAAOMPT 72 Attendees	**SEPTEMBER** *Suicide Prevention* Presented by: Matthew Crum, MS LPC 77 Attendees
OCTOBER *Women's Health* *Cancelled*	**NOVEMBER** *Men's Health* Presented by: Jacob O'Meilia MD, FAPA & Ryan Yarnall, MD 49 Attendees	**DECEMBER** *Grief* Presented by: Traci Owen, RN & Audrey McCraw 54 Attendees

IMPACT STORIES

The stories highlighted below are just a few examples of how care management makes a difference. The stories are told from the care managers' perspectives. The member names have been changed to protect member privacy and confidentiality.

REBUILDING CONFIDENCE & REJOINING THE WORKFORCE	TRANSLATION ASSISTANCE FOR ZOMI-SPEAKING MEMBERS	ADVOCACY
Martha is in her mid-50's and was referred for care management due to ongoing mental health issues. When the care manager first began to work with Martha she was living with her mother and sister who suffers from bipolar disorder and was unemployed. The initial goals identified by Martha were to obtain hearing aids and dentures. The care manager worked with her to track her progress of following through with her provider appointments. They were able to get her a full set of dentures, which she contributed to providing her confidence to seek out employment. She began with a temporary seasonal job, which ended but built her confidence for the work force. Martha is living independently and has been able to obtain private insurance through her now permanent employer and the care manager was able to close her care management case.	 Pau and Chin are brothers, ages 6 and 3 respectively, who both have autism spectrum disorder level 3, developmental delays, and speech delays. Additionally, Chin also has a seizure disorder. Their mother does not speak English and accessing services has been difficult due to the language barrier. The family speaks Zomi and the mother understands very little English. The mother had initiated the social security process utilizing services at The Arc Foundation but had difficulty understanding how to complete the social security interview. The care manager for Pau and Chin offered to attend the interview, where they learned that Social Security does not have access to a Zomi translator. The care manager was able to access our translation service and the interview was successfully completed. The Social Security case worker worked with the care manager to finalize the process and as of now, one of the members has been approved with social security which will greatly help the family with accessing services to meet their needs.	Mary is 60 years old and has COPD. Her care manager has accompanied her to many appointments and encouraged her to regularly go to her PCP appointments. During a COPD exacerbation, the care manager convinced Mary to make a PCP appointment. The care manager met Mary there and noticed her behavior was not normal. The provider was not her regular provider and had not met Mary before, so the care manager advocated for Mary and explained that this was not normal behavior, and something appeared very wrong. The provider checked Mary's oxygen level which was only 87% and she was hypoxic. Mary was immediately sent to the hospital. The care manager educated both Mary and her daughter on signs to look for in a COPD exacerbation and what steps to take in the future. 

LEGAL SUPPORT	COMPLEX CARE THAT LEAD TO A SUCCESSFUL KIDNEY TRANSPLANT
Yvonne is 61 and lives in Section 8 housing. Yvonne has chronic pain issues, is legally blind, and extremely hard of hearing. Over the summer, Yvonne received a letter from her apartment complex that she owed back rent from an increase that had occurred. There had been confusion over a rent increase and if it was her responsibility or Tulsa Housing Authority (THA). Now, three months later the apartment complex was saying she owed $250 in back rent with another $100 in late fees. Yvonne was given a week to pay $100 but did not have access to that much money. The care manager began to call around trying to find resources. Restore Hope could help but needed an eviction notice first, which we were trying to avoid. In talking with Restore Hope they directed the care manager to reach out to Legal Aid and see if they could assist. After talking with Legal Aid's attorney, they waited for the eviction notice. The care manager helped pull all the documentation together and Yvonne won her case with the attorney's assistance since the landlord filed for bankruptcy before issuing the eviction notice. Restore Hope helped with the payments that were allowed and Yvonne was able to stay in her apartment. 	 Isabella was barely one when the care manager first started working with her in 2018. She was born with congenital nephrotic syndrome. When the care manager first met this family, the mother was managing her peritoneal dialysis at home as well as G-tube feeds and numerous medications. Isabella has undergone several procedures and surgeries over the years. There have been many barriers to overcome before Isabella could be approved for a transplant including, low income, single parent, undocumented parent, transportation concerns at times, Spanish speaking, domestic violence, immigration concerns, school/IEP issues, sibling resources, housing, and food resources. The care manager has been helping Isabella's mother advocate for her, empowering her to ask questions and obtaining clarification, and learning to navigate the health care system. They have worked closely with the transplant team for the last few years. Finally, after all of mom's hard work they received news in November that Isabella would be actively listed on the kidney transplant list, she received a kidney the first week of December.

RESILIENCE – MEETING GOALS AND FINDING THE RIGHT PROVIDER

Sally is a 56-year-old female who was very frustrated with her PCP care when she accepted care management services with the OU Sooner HAN. Sally has a long history of tremor episodes that affect her ability to live life in a way that feels satisfying to her. She described a merry go round of referrals over the last few years, attempting to address these tremors, with no real progress forward. She was deflated and angry. When the care manager asked Sally what mattered to her, she said she wanted to be able to take walks, make grilled cheese, spend time with her grandchildren, but felt stuck. The care manager wanted to help Lisa feel less defeated and more empowered, so the care manager asked her if she had considered changing providers, normalizing the power of choice. Sally immediately asked for help, and we got to work looking at practices in her area. She decided to change her PCP to OU Tisdale Clinic. She was scheduled with a Nurse Practitioner (NP), and Sally and the care manager attended her first visit together. Sally was tearful as she shared her journey, both her victories and defeats. Sally shared her long history with mental illness and the many meds she has been on over the years. Sally shared about her episodic tremors that affect her ability to enjoy simple daily tasks. Sally was honest, and her provider listened. Since that time, this NP has been working with Sally on her tremors, but also addressing her as a whole person. Sally has started seeing a therapist at Family and Childrens. She has started a new medication to assist with the tremors. She has started the process of testing and evaluating the source of these tremors and is on a path to getting better and finding answers. This provider also screens all her new patients for Hep C. Sally was found to be Hep C + and had never been screened before. Sally is beginning the treatment process for this as well, which will hopefully end in a cure. Sally's story is not over, and there is still work to be done, but she keeps showing up and asking for help. She is also taking steps on her own. She told the care manager just two weeks ago that she ordered a smoking cessation kit to help her accomplish her goal of smoking cessation (she was down to one cigarette a day!) but wants to get to zero! The care manager is so proud of Sally, her resilience, and tenacity.

SUCCESSFUL MEDICATION RECONCILIATION

Alice struggles with a rare disease called Myelin oligodendrocyte glycoprotein (MOG), and it has some various neurological symptoms. Alice is prescribed Topamax by her neurologist for these symptoms. While completing a medication reconciliation with Alice she mentioned that the Topamax had been denied by insurance, so she just wasn't going to take it. I reached out to her providers at the OU Neurology clinic and pharmacy to make some changes to the medication order so that it would be covered by SoonerCare. Alice called me to report she was able to get the medication filled and could already tell it was helping with her symptoms.

STAFFING ISSUES

Haily is 3 years old and has a history of nonketotic hyperglycinemia, epilepsy, developmental delay, and is g-tube dependent. Haily lives with her grandmother and has been working with a HAN care manager for just over a year. One of Haily's primary needs is private duty nursing and they have struggled to find an agency that can routinely staff the necessary hours. The care manger was able to research a few new options and they finally found an agency that has been able to meet Haily's needs. So much so, that at the care manager's last follow-up with the grandmother she reported that Haily has been able to go to pre-school twice a week with her private duty nurse.

EDUCATION AROUND TRANSPORTATION	TRANSLATION AND CULTURAL CONSCIOUSNESS WITH A COMPLEX MEMBER
Natasha is 34 years old and has a seizure disorder and asthma. She was referred for care management due to high emergency room utilization. In talking with Natasha, the care manager learned this was primarily due to her not knowing how to access SoonerRide and becoming too overwhelmed when, instead of SoonerRide she was sent bus passes. Natasha would call SoonerRide but get too confused and hang up before scheduling. The care manager worked with Natasha and provided education on how to navigate the scheduling process. Natasha was able to start successfully scheduling her own rides but become scared because they started sending bus passes instead. Due to her seizure disorder, she is too scared to use public transportation. The Care Manager coordinated with her primary care provider to have a letter sent to SoonerRide explaining that Natasha cannot utilize public transportation due to her medical condition. She was able to get uber scheduled for all upcoming appointments and would no longer have to worry about public transportation. 	Mangte is 5 years old and was referred to the HAN for care management after an ER event for a displaced McKey Button and initial provider visit to establish care with OU Pediatrics after relocating from Texas. Mangte has a history of a spontaneous brain bleed at age 3 resulting in quadriplegia, respiratory trach dependent, McKey Button dependent for medication and nutritional supplements and generalized global delay. In addition to the previously stated barriers, her parents are refugees and Zomi or Chin Tedim speaking only. Mangte is the oldest of three children and the parents have no income due to the recent requirements for the father to quit his job to provide care to the member. In the last year, in collaboration with Mangte's parents the care manager has been able to establish and follow up with 14 specialty providers and over 380 documented contacts. Mangte has been to see primary care, dentistry, an orthotic clinic, home health, attend out-patient speech therapy for device and speech therapy for swallowing, physical therapy, occupational therapy, ENT, Pediatric pulmonology, pediatric neurosurgery, pediatric urology, pediatric gastroenterology, neurology, and ophthalmologist. Mangte has progressed physically and cognitively because of the early intervention she has been able to obtain with the HAN's assistance, specifically around enhanced translation services we have been able to provide. The barriers have been big, but the reward has been bigger.

IMPORTANCE OF MOTIVATIONAL INTERVIEWING & CARE MANAGEMENT

The care manager started working with Donna when she changed her PCP to an OU practice. Donna lives alone, has a poor support system and is blind due to diabetic retinopathy. Donna seemed very distant during the care manager's first few conversations with her. After about a month and a half, the care manager offered to attend a PCP visit with her. At first, Donna thought she did something wrong, so the care manager assured her it was just to be an added support and met her in person. After meeting Donna in person, they established a trusting and positive working relationship. One afternoon while checking in with Donna she shared that she felt like God placed the care manager in her life at the right time. Donna shared that when she first started working with the care manager, she was feeling very helpless. She didn't know how much help the care manager would give to her and shared that she was very apprehensive. Donna shared that she feels like the care manager made a positive difference in her life because prior to working with me, she wanted to "give up". She didn't want to see doctors, take medications, or take care of herself. After losing her vision, Donna felt like life wasn't purposeful and all she could focus on was what she was missing out on. Donna shared that building a working relationship with the care manager helped her focus on things she can still enjoy in her life while living visually impaired, such as listening to the TV, going to lunch with friends, and experiencing retail store sales. Donna's new outlook on life improved her mental health and the way she handles stress. Donna has shared that sometimes when she gets upset, she thinks about the care manager telling her "It's going to be alright – where do we go from here?" Donna has been receptive to medication changes, diet modifications, and ways to complete self-care. Donna's story is not only a success for the HAN but a success for the care manager. The care manager feels like knowing I was able to impact someone's life in such a positive way is a reward that she is forever grateful for.

HOUSING

Teri (54) was referred for care management due to a recent stroke, diabetes, hypertension, and depression. At the time the care manager started working with her, her immediate need was securing her housing. Teri had been unable to continue working since the stroke and had no income. She was behind on her rent and was having trouble reaching her case worker with the Tulsa Housing Authority (THA). The care manager was able to help connect Teri with Restore Hope and get her rent payments current. Teri was able to avoid eviction and connected with her THA caseworker to update them on her health and income issues. Teri and the care manager are now working on securing her SSI/SSDI.