Sooner HAN Annual Report

Calendar Year 2019

SOONER
HEALTH ACCESS NETWORK

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EXECUTIVE SUMMARY

MISSION

The mission of the OU Sooner Health Access Network (Sooner HAN) is to improve the health of SoonerCare Choice members through providing comprehensive, high quality, evidence-based care management and quality improvement services, while leveraging health information technology to boost outcomes and broaden access to care.

VISION

The Vision of the Sooner HAN is to advance the Quadruple 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, lower costs through continuous improvement efforts, and improve the work life of health care providers and staff.

VALUES

The Sooner HAN defines the values it upholds and uses these values to guide daily operations. The first letter of each word, when combined, spell the word INTEGRITY.

- **I**nterest in serving the whole person
- **N**ourish self-care in our employees
- **T**reat all people with dignity and respect
- **E**vidence-based care
- **G**row fierce advocates
- **R**egard for self-determination
- **I**nclusion, diversity, and equity
- **T**ransform healthcare
- **Y**our goals matter

PURPOSE

The purpose of the 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

CORE FUNCTIONS

The Sooner HAN ended calendar year (CY) 2019 with an enrollment of 148,464 SoonerCare Choice members served across 97 primary care practices. During 2019, a total of 213,814 unique members were enrolled.

CARE MANAGEMENT

Throughout 2019, the Sooner HAN has continued to work with the Oklahoma Health Care Authority (OHCA), the Pacific Health Policy Group (PHPG), and the other two Health Access Networks (HAN) on the HAN Redesign. A total of 2,982 unique members received care management throughout 2019, of which 1,829 were attributed to the Aged, Blind, or Disabled (ABD) category. This is a drop from 2018; however, two key factors that have influenced this are 1) Cases remained open 10% longer than in CY2018, 2) Open positions have remained unfilled longer in CY2019.

EDUCATION AND TRAINING

In 2019, 60 providers and staff from Sooner HAN participating clinics attended one of the four care management course offerings. The four-day Fundamentals of Care Management course is built on the framework of the National Committee for Quality Assurance (NCQA) Care

Management standards and is continually updated and refined to ensure the most current delivery of industry knowledge, and best practices based on evidence-based, peer-reviewed studies from medical and social services literature.

The Sooner HAN continued its monthly Lunch and Learn series to provide ongoing learning opportunities for care managers throughout the community. A total of 1,205 participants from more than 50 departments and organizations attended the monthly Lunch and Learn offerings in 2019.

'Just in time' education sessions were conducted by the Sooner HAN Medical Director and the Sooner HAN Behavioral Health Medical Director at the respective biweekly care management team staffing meetings.

The Sooner HAN launched the Asthma Academic Detailing Program in late 2018 and in 2019, 11 practices participated in the program.

REFERRAL MANAGEMENT

The Sooner HAN team continues to focus on expanding the referral network among both primary care and specialty practices. While we experienced overall growth for the year in Doc2Doc utilization, there were five small participating practices that closed this year.

During the course of the year, the Doc2Doc team assisted several practices with projects to increase referral loop closure rates. This included training, follow-up with specialty providers regarding unscheduled referrals, and verifying the report was received to close the referral loop.

The Doc2Doc team worked on system enhancements with the vendor that have increased overall efficiency for user support and customer management.

QUALITY

In 2019, the Sooner HAN developed a customized AIDET training following the findings from the secret shopper program conducted in fall of 2018.

The results from the secret shopper program highlighted the need for increased focus on internal reporting and quality improvement projects, specifically around care management protocols in CY2019.

The Sooner HAN collaborated with the OHCA to host a focus group with providers regarding the proposed Patient Centered Medical Home (PCMH) changes that will occur in the fall of 2020.

GOALS

In 2020, the Sooner HAN will continue to focus on the following goals:

1. Primary Care Provider (PCP) Recruitment- Increase PCP participation to 165,000 covered lives;

2. Expansion of Care Management Services- Target 2%-3% of covered lives in care management;

3. Doc2Doc Utilization for Optimal Referral Loop Closure- Increase PCP participation in Doc2Doc by 10%;

4. Quality Management- Increase provider outreach offerings of quality management by 25%.

PROGRESS AND FUTURE GOALS

Achievement and progress was made on the goals set in 2019. Plans to continue these goals as well as continual improvement for goals that were met are described below:

1. SoonerCare Choice monthly enrollment in 2019 averaged 147,718 members, a 9% increase from the 2018 monthly enrollment average but a little lower of the 155,000 goal. The first tribal practice joined in 2019 as well. In 2020, Sooner HAN staff will continue to recruit primary care providers with a focus on the areas identified by OHCA in the ABD gap analysis.

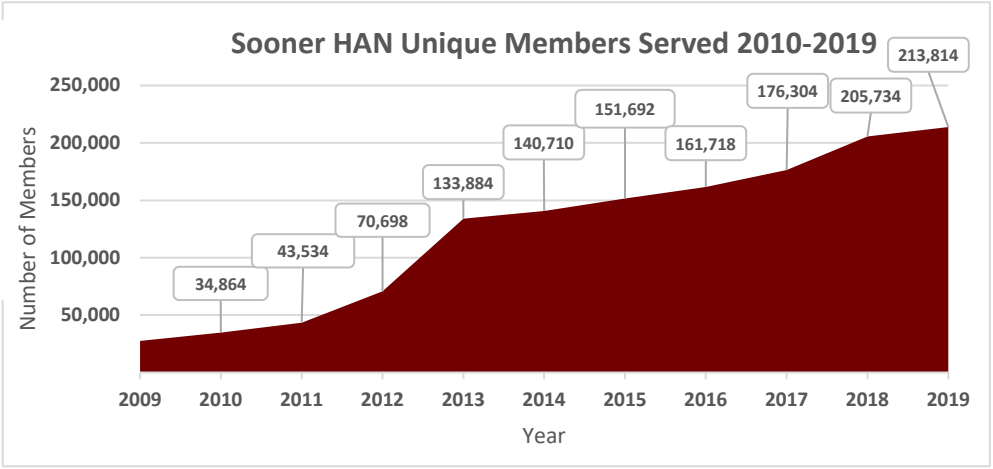
2. The percentage of Sooner HAN members receiving care management services in 2019 was 2% of covered lives. Of the 2,982 members in care management in 2019, 1,829 members were ABD. This was 61% of all care managed members.

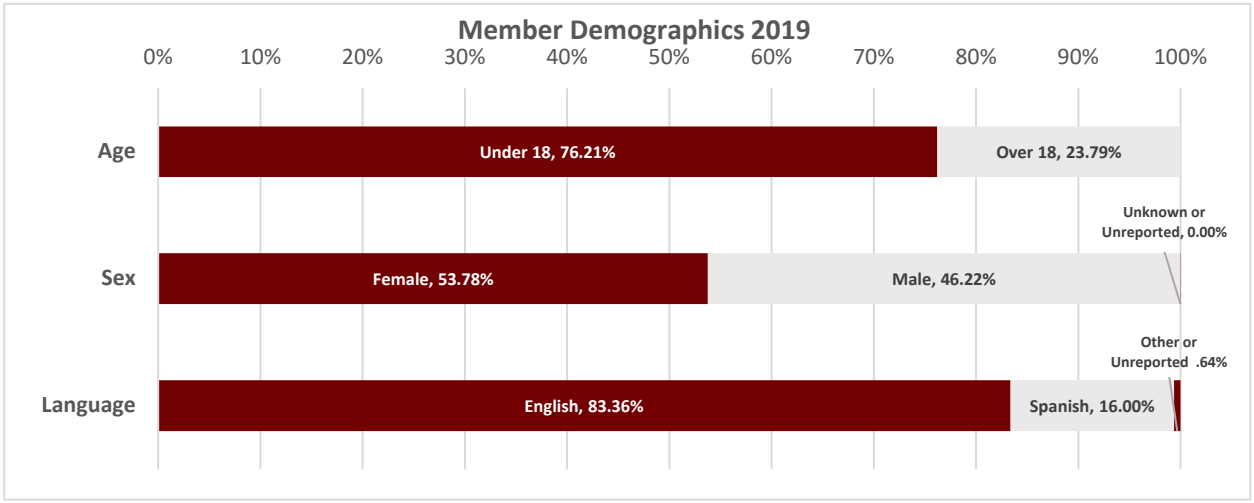
3. In 2019, two new primary care practices were added to the Sooner HAN Doc2Doc services and two were re-engaged, bringing the total number of primary care practices utilizing this service to 32. In 2020, Sooner HAN staff will continue to recruit primary care and specialty providers, particularly in rural areas.

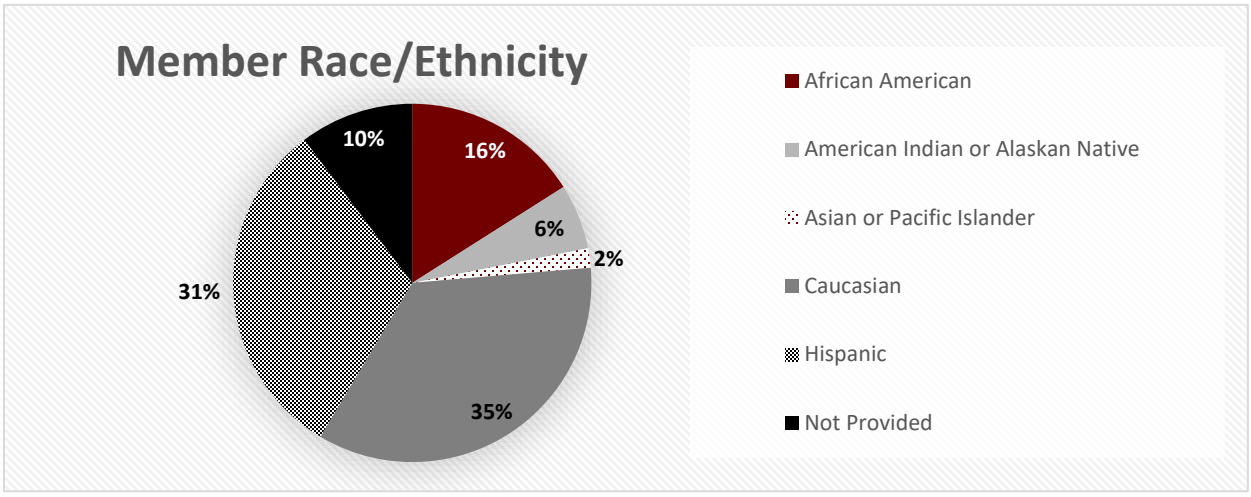
4. The Sooner HAN quality group focused a significant amount of time on internal quality programs. In 2020, the Sooner HAN team will be preparing to help Sooner HAN practices be ready for the Patient Centered Medical Home changes beginning in October 2020.

SOONER HAN ENROLLMENT

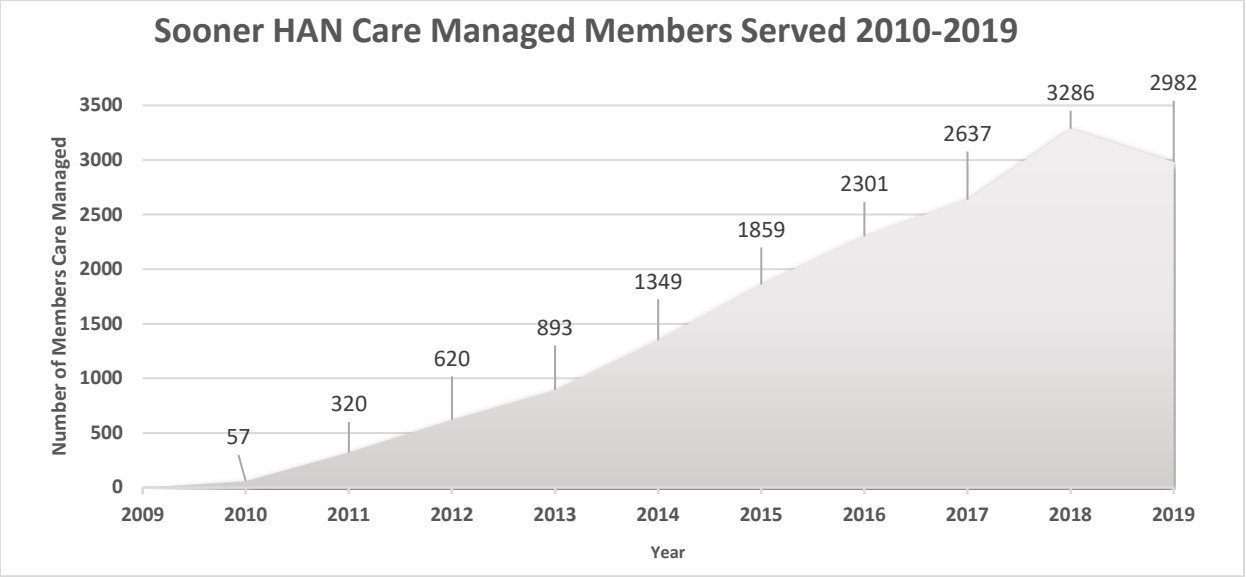
MEMBER DEMOGRAPHICS







The Sooner HAN continues to utilize data to help identify potential new members for care management. Enrollment in these services has increased each year since its commencement in 2010. In 2019, 2,982 cases were opened for care management services.



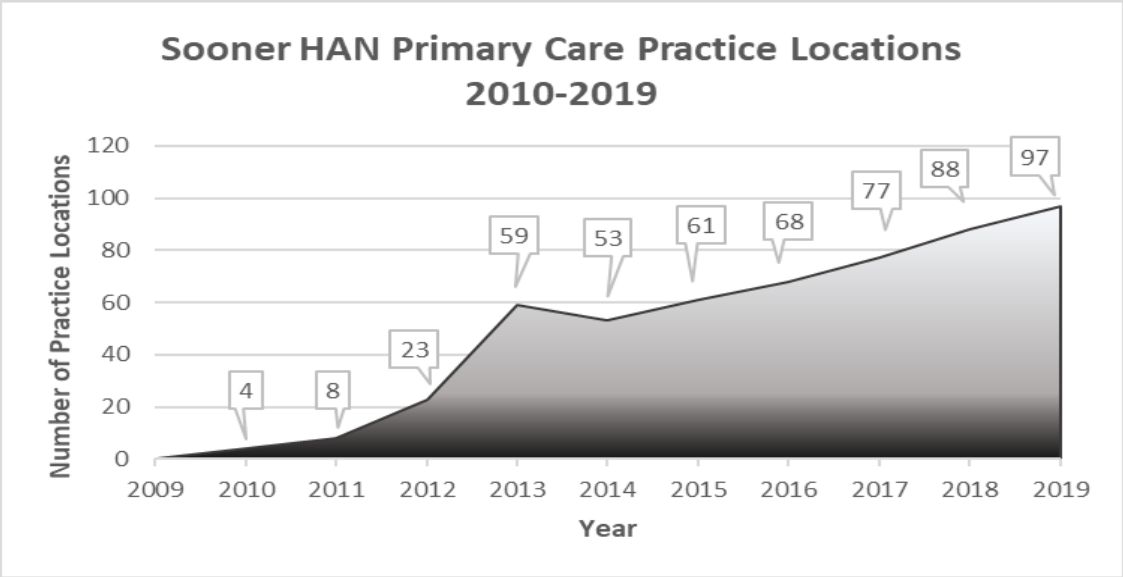
Although we saw a decrease in the number of members served over the past year, we believe we have improved our engagement with members. Several factors contributed to the decrease in the number of cases care managed in 2019, including:

- Cases remained open 10% longer in 2019 when compared with 2018.
- The care management team was down an average of 1 FTE every month in 2019 when compared to 2018.
- In CY2018, the number of contact attempts was decreased from 5 to 3. There was an initial uptake of more cases assigned for approximately 3 months in after this change before case assignments leveled back out.

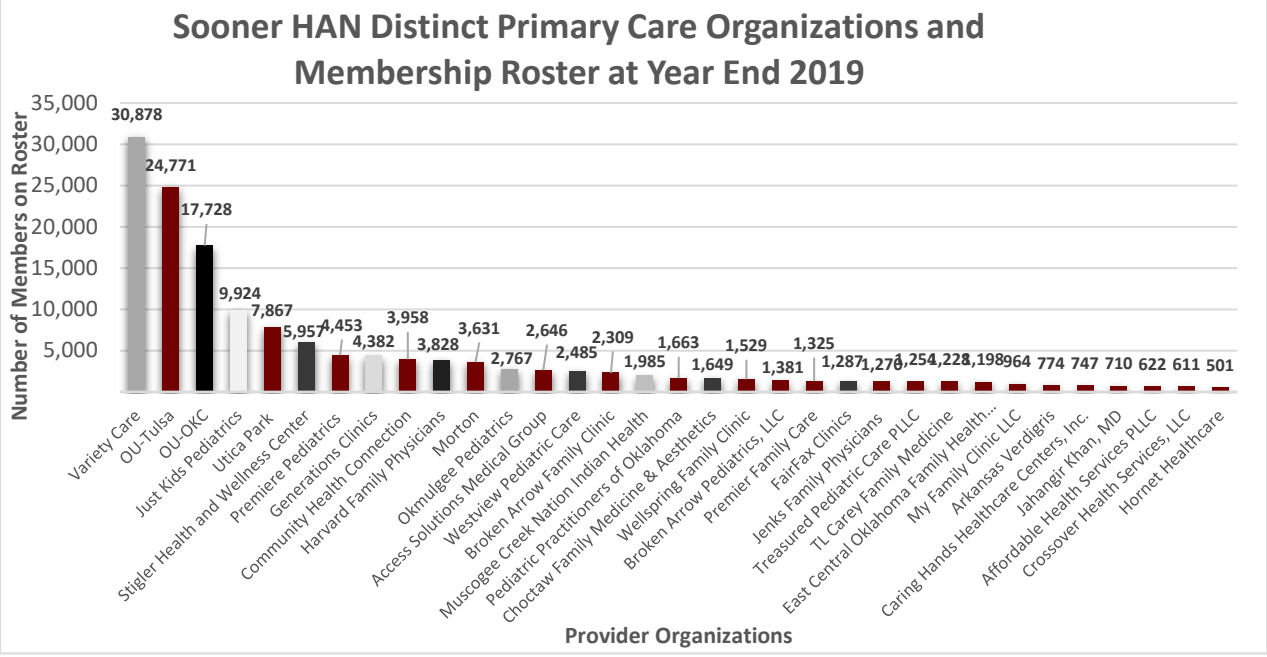
PRIMARY CARE NETWORK

PRACTICE LOCATIONS AND ROSTER SIZE

The Sooner HAN has continued to grow in its partnerships with primary care providers to expand Sooner HAN services to more SoonerCare Choice members. The Sooner HAN partnered with 97 primary care practices serving 148,464 SoonerCare Choice members at the close of 2019.



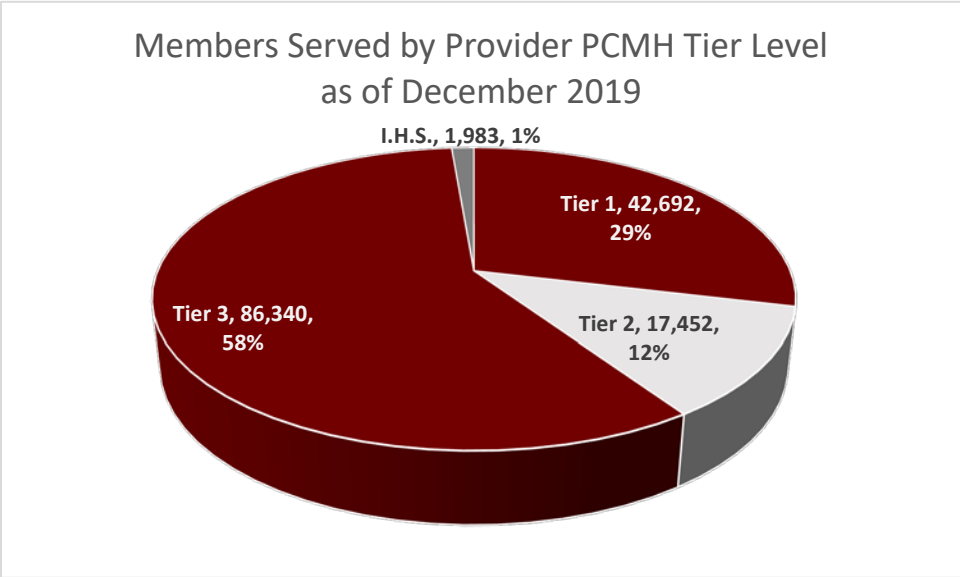
The Sooner HAN is affiliated with 34 distinct Primary Care Organizations. The graph below displays these affiliations and the number of SoonerCare Choice members assigned to those organization's roster.



Three practices (Variety Care, OU Physicians-Tulsa, and OU Physicians-OKC) provided access to care at 26 locations throughout the Tulsa and Oklahoma City metropolitan areas. These large practices represent 49% of the Sooner HAN membership, or 73,377 members. The remaining 75,087 members were served by 71 smaller practices and locations across Oklahoma.

Variety care, an FQHC and the Sooner HAN's largest provider practice, served 30,878 members at the close of 2019 at 13 practice locations in central Oklahoma

PATIENT-CENTERED MEDICAL HOMES (PCMH)



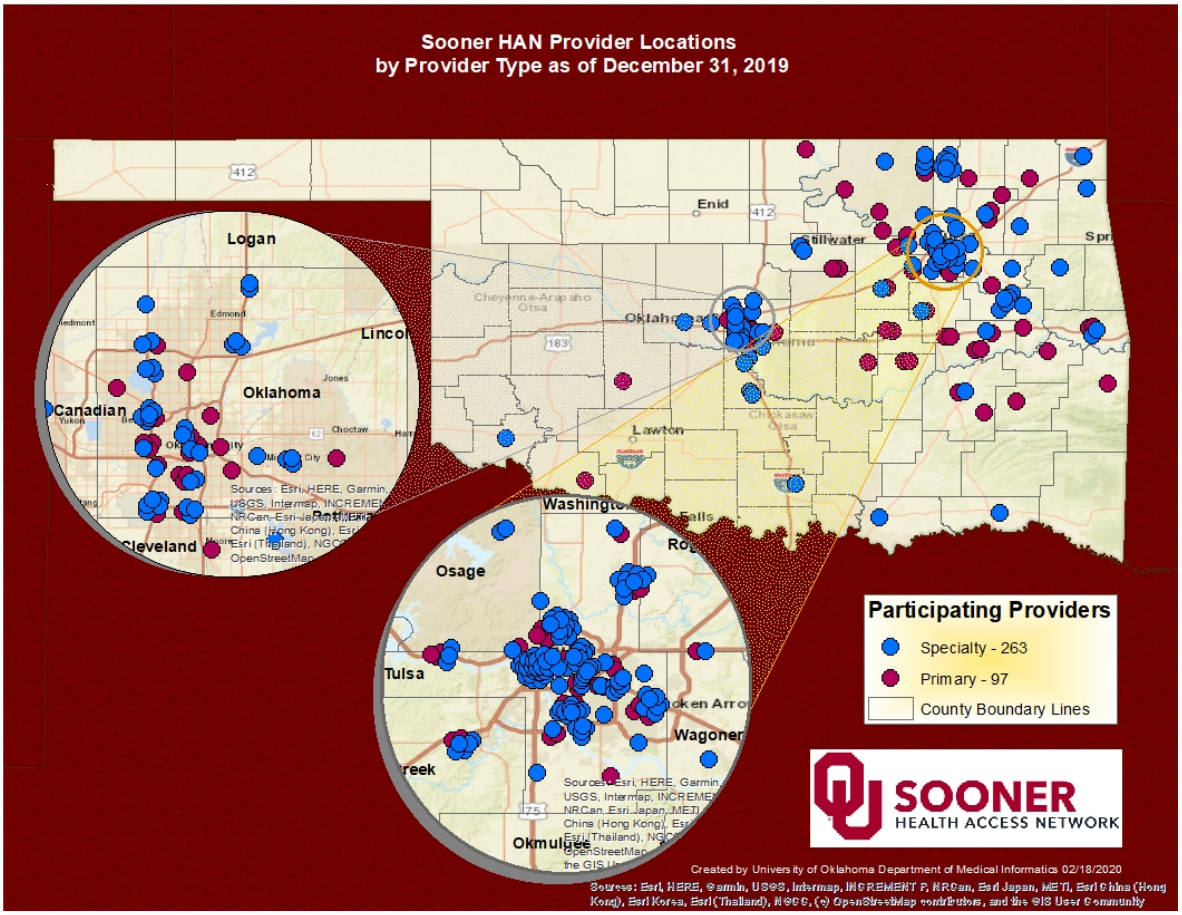
The OHCA is introducing a redesigned PCMH program in October 2020. A key component to the redesign will be the creation of the Health Neighborhoods, which will be established by each HAN. The Sooner HAN has been working closely with the OHCA to learn about the Health Neighborhoods as well as other changes that will affect the Sooner HAN practices.

SPECIALTY CARE NETWORK

In 2019, the Doc2Doc team focused on re-engaging participating specialty practices that were not fully utilizing the Doc2Doc tool. Activities included additional contacts, new training opportunities, and process improvement. Recruiting efforts for specialty practices continued as well, specifically around behavioral health, neurology, pain management, and dermatology.

As of December 2019, 263 specialty practice locations, representing 45 specialties, were active in Doc2Doc, the Sooner HAN referral management tool.

The following map highlights the locations of the Sooner HAN participating providers, by primary or specialty, throughout the state of Oklahoma. Primary care locations are shown with blue dots while specialty care locations are shown with red dots.



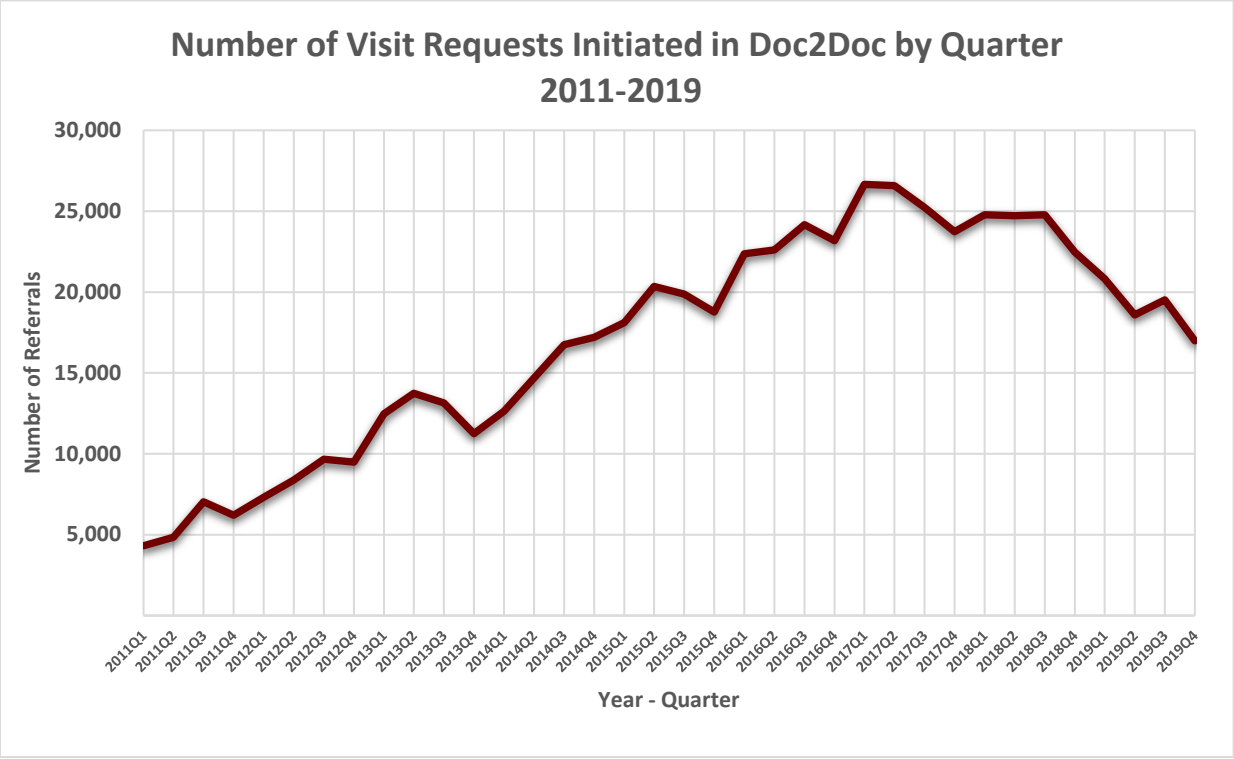
TRANSITIONS OF CARE AND REFERRAL MANAGEMENT

The Doc2Doc referral management tool continues to be marketed to new practices within the Sooner HAN. There were two new primary care practices who began using Doc2Doc in 2019. While utilization of Doc2Doc did decrease in 2019, there are already six practices in the que to begin using Doc2Doc in 2020.

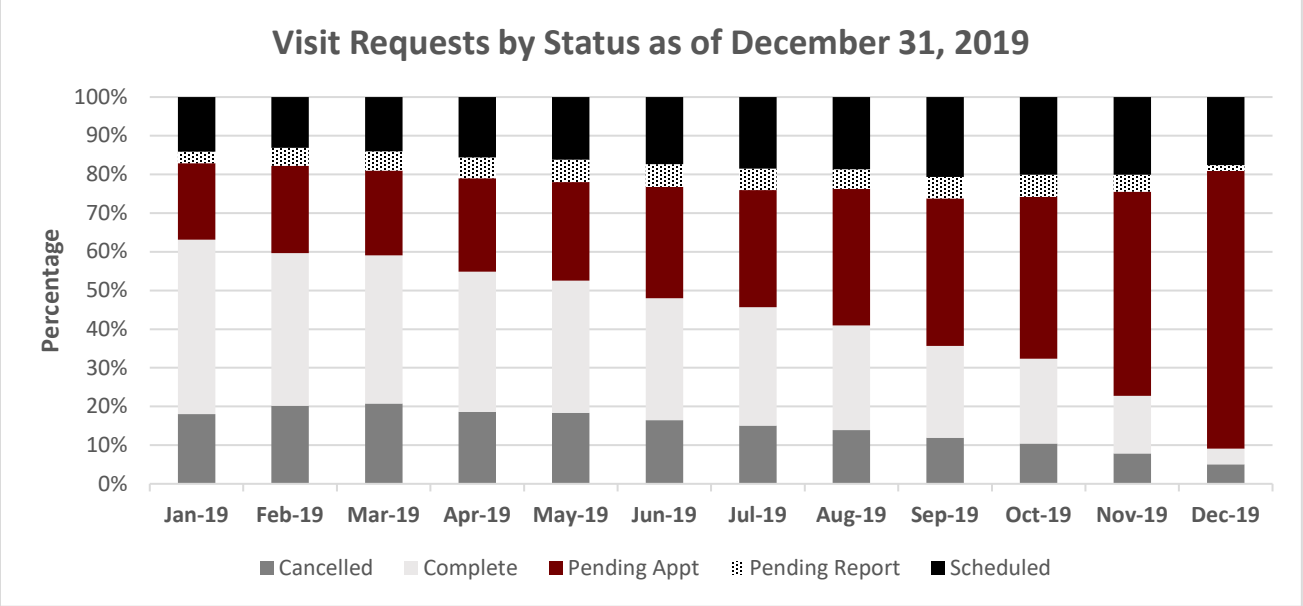
In 2019, 75,917 referrals were initiated in Doc2Doc. The following graph shows the number of referrals (visit requests) initiated by calendar quarter since 2011. In 2011, 22,411 referrals were initiated.

75,917 Referrals were initiated in 2019

Doc2Doc account specialists have noticed an increase in referral staff turnover and lack of a technology interface with Doc2Doc as being the primary issues around the decrease in Doc2Doc utilization.



The graph below outlines the classifications of the referral statuses initiated in 2019 at the close of the year by month initiated. At the end of the fourth quarter of 2019, 68% of referrals initiated in 2019 were cancelled, scheduled, or completed.

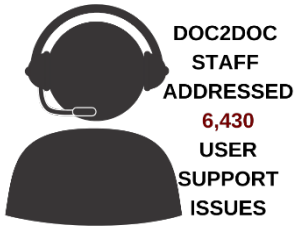


The Sooner HAN Doc2Doc staff focused on three training areas in 2019. First, Doc2Doc staff worked with clinic managers to identify additional staff that could participate in a piece of the referral workflow process, such as a front desk staff member verifying receipt of a report. Second, education was given on how every member of the care team could utilize Doc2Doc to impact referrals and ensure referral loop closure. Third, Doc2Doc staff trained the new staff to improve the quality of the information within the referral sent to the specialist.

In 2019, the Sooner HAN Doc2Doc staff initiated referral improvement projects with two primary care practices when new managers were hired. The projects included, creating new reports for monitoring referral loop closure and staff productivity and retraining referral staff.

TRANSITIONS OF CARE AND REFERRAL MANAGEMENT, USER ACCOUNTS AND SUPPORT ISSUES

The Sooner HAN provides user support for the Doc2Doc referral management tool via telephone support, email support, and remote online support. Doc2Doc user support is available Monday-Friday 7AM to 7PM. The team also provides support for the OU Physicians Tulsa EMR interface.

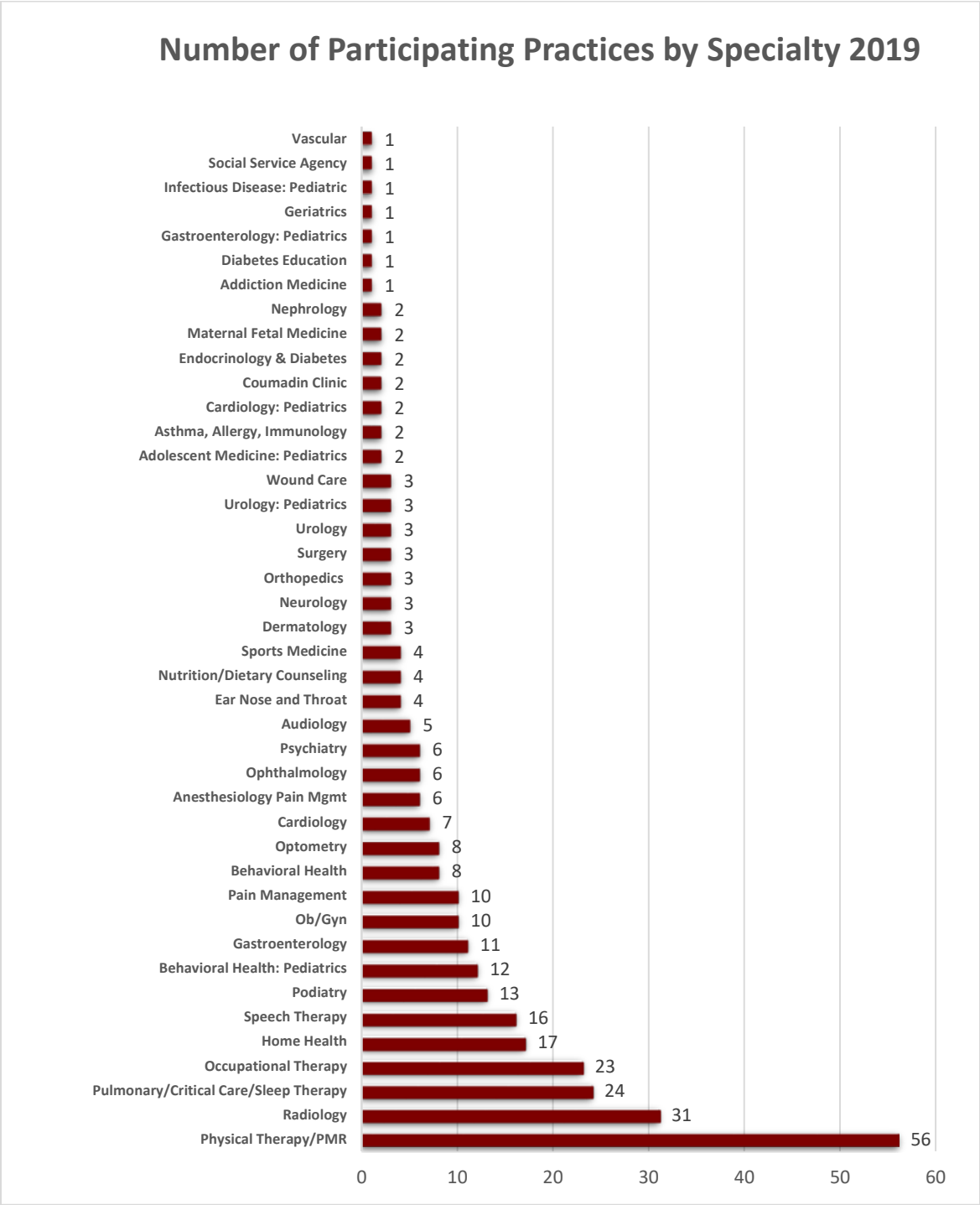


MOST COMMON SUPPORT ISSUES IN 2019

1. Claims Reports for Care Management Staff (1,483 support tickets)
2. Addressing EMR Interface Alerts (1,155 support tickets)
3. Updates to Clinic Profiles (770 support tickets)

PARTICIPATING SPECIALTIES

The graph below highlights the many different specialties utilizing the Doc2Doc referral management tool.



CARE MANAGEMENT

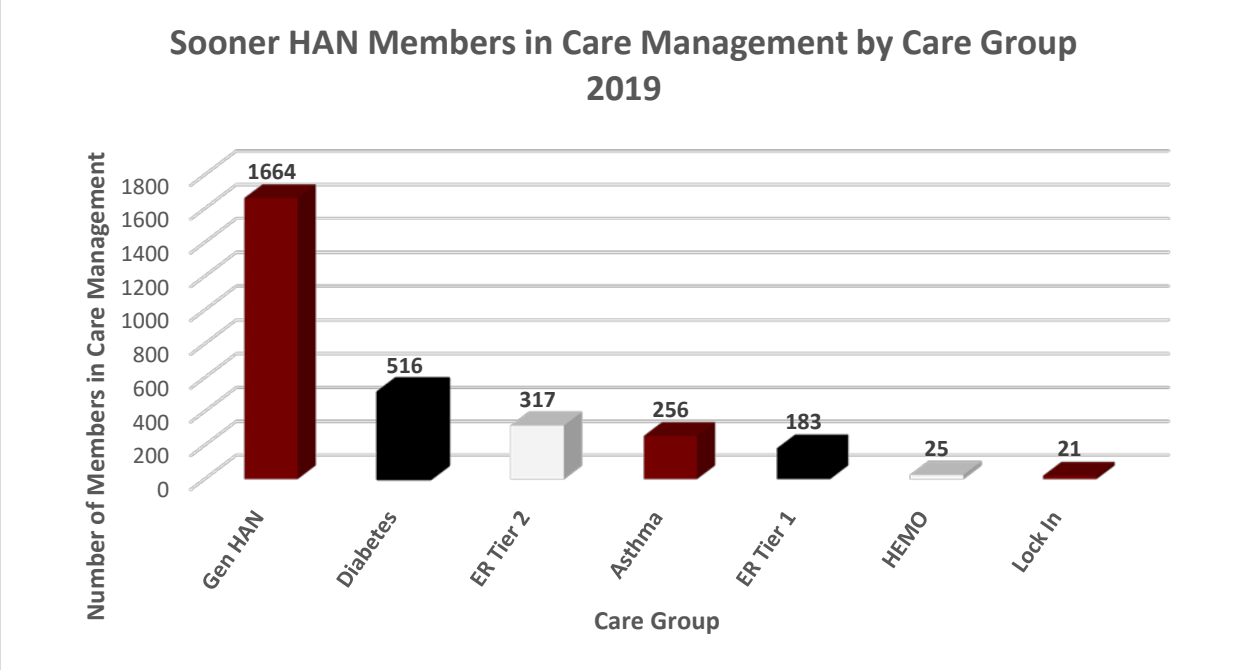
The number of unique members served has grown significantly from 58 in 2010 to 2,982 in 2019. There was a decrease in members served in CY2019. Review of the data found three key factors contributing to this finding, including:

- Cases remained open 10% longer than in CY2018, while average case load size has not significantly changed;
- Open positions have remained unfilled for longer periods of time. The care management team was down an average of 1 FTE every month in CY2019 compared to CY2018;
- In CY2018, the number of contact attempts was decreased from 5 to 3. There was an initial uptake of more cases assigned for approximately 3 months in CY2018 after this change before case assignments leveled back out;

The Sooner HAN leadership will continue to monitor case assignments to ensure the right people are being identified and as many SoonerCare Choice members are engaged into care management.

The Sooner HAN plans to increase the number of care managers in 2020 to support the overall increase in the Sooner HAN membership, in addition to filling the current open positions. At the end of 2019, the Sooner HAN employed twelve registered nurse care mangers (three bilingual in Spanish and English, and a certified diabetes educator), four master's prepared licensed clinical social workers and three open positions.

The graph below shows a summary of the number of unique members receiving care management by care group.



CARE GROUP ASSIGNMENT AND PRIORITIZATION

The Sooner HAN utilizes data from sources such as MEDai data and claims to identify and prioritize potential members for care management intervention as outlined below.

PRIORITIZATION MATRIX SUMMARY			
Group 1 **Aged, Blind, Disabled**	**Group 2** **Claim Based**	**Group 3** **Clinic Panel Reports** **(OU Tulsa Clinics Only)**	**Provider Referrals are inserted at any time they are received**
High Acute Impact Score and High Chronic Impact Score and High Forecasted Costs	10 or more ER visits for any reason ***and ABD***	A1C>9	
High Forecasted Costs	10 or more ER visits for any reason	Uncontrolled Blood Pressure	
High Chronic Impact Score	4 or more ER events with Diabetes or Asthma as one of the top three diagnosis ***and ABD***	High Risk by EMR Criteria	
High Acute Impact Score	4 or more ER events with Diabetes or Asthma as one of the top three diagnosis		

The Sooner HAN had a comprehensive review of all the General HAN cases open in June 2019 to identify any target populations that would benefit from being separated from the General HAN group. A total of 568 cases were reviewed. Two key findings resulted from this review. First, the creation of a Sickle Cell group and second, the creation of a cardiovascular flag. For the sickle cell group, there was a Sooner HAN care manager who was very interested in serving this population. It also corresponded with the OHCA's sickle cell education initiative. The Sooner HAN care manager is working with the Sooner HAN clinical manager to create an evidence-based assessment and interventions that will be introduced in 2020.

The review also indicated that many of the General HAN care managed members had multiple co-morbidities making it difficult to identify one primary intervention group. Specifically, many had cardiovascular illnesses along with asthma or diabetes. The decision was not to create a separate group, but create a flag that would be added to the cases to indicate the presence of cardiovascular illnesses. The General HAN group will continue to be monitored to ensure evidence-based interventions are being applied when applicable.

The Sooner HAN has also continued to see a rise in provider referrals for care management. This is a key element in ensuring that the proper members are being targeted for care management. Research supports that provider judgement is one of the best indicators that a person could benefit from care management. The Sooner HAN received 211 referrals from providers for care management services in 2019.

CONTACT HISTORY

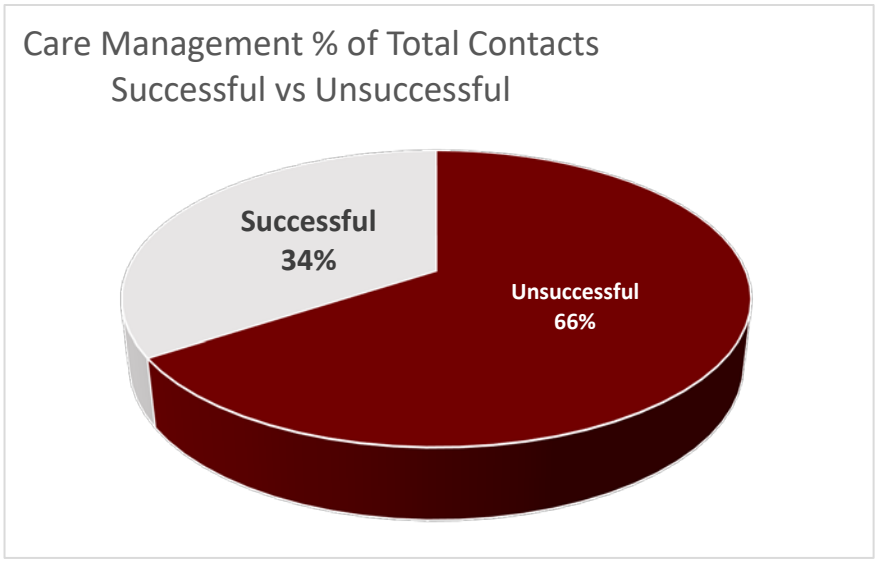
In 2019, the Sooner HAN care managers documented 54,115 contacts with members, or with others on behalf of members enrolled in care management. Successful contacts accounted for thirty-four percent (34%) of all contacts. Sixty-six percent (66%) of attempted contacts were unsuccessful. The total number of care management contact hours documented in 2019 was 15,160. Successful contacts totaled 8,807 hours (58%) while the hours documented for unsuccessful contact attempts totaled 6,353 hours (42%). Total contact hours documented increased 6% from CY2018.

54,115 Contacts
15,160 Hours

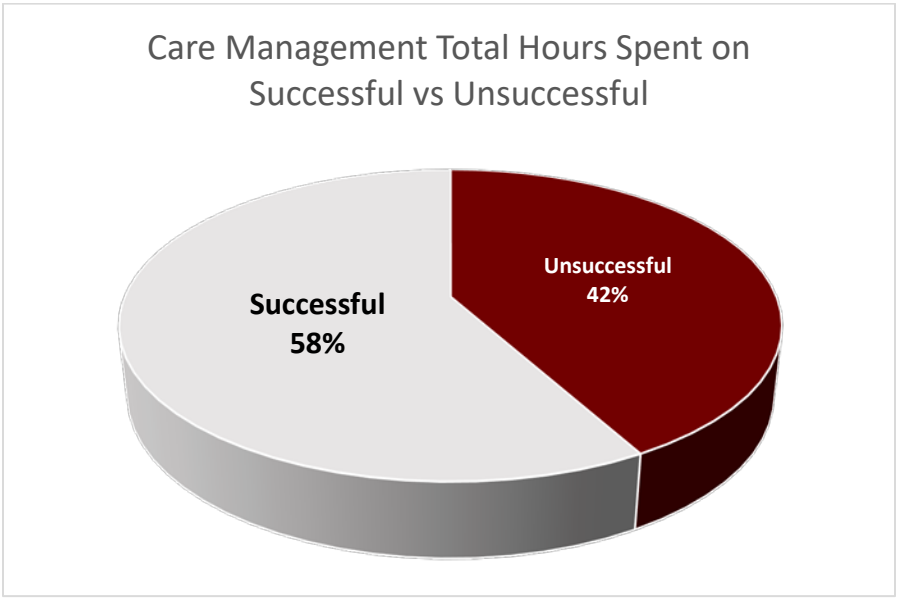
Although there are more unsuccessful contact attempts, the majority of care managers' time is spent on successful contacts. Contacts are reported in two groups; members or their representatives (including caregiver, guardian, power of attorney (POA), parent of minor child, spouse/partner, relative-father, relative-mother, relative-grandmother, and relative-grandfather) and others on behalf of members (including specialist, primary care provider, case worker, pharmacies, clinics, hospitals, nurses, DHS, OHCA, and others).

The distribution of contact attempts, with members, their representatives or with others on behalf of members, both successful and unsuccessful, are highlighted in the following chart.

Contacts and Hours	Direct Contact with Member or Member Representative		Contact with Others on Behalf of Member	
Contact Outcome	**# Contacts**	**# Hours**	**# Contacts**	**# Hours**
Successful Contact	13,746	7,322	5,045	1,485
Unsuccessful Contact	16,538	2,457	19,319	3,896
Grand Total	**30,284**	**9,779**	**24,364**	**5,381**



Although 66% of contact attempts were unsuccessful, more hours were spent on successful contacts with members or on a member's behalf



CLOSURE REASON

When a case is closed, a closure reason is documented for the member's case. In 2019, three closure reasons accounted for 82% of all case closures. "Never able to contact" was the most cited closure reason with 29% of case closures citing this reason, down from 35% in CY2018. The second and third most cited reasons were voluntary withdrawal with 28% and unable to make contact (after making initial contact) with 25% of closures.

Most Frequent Closure Reasons

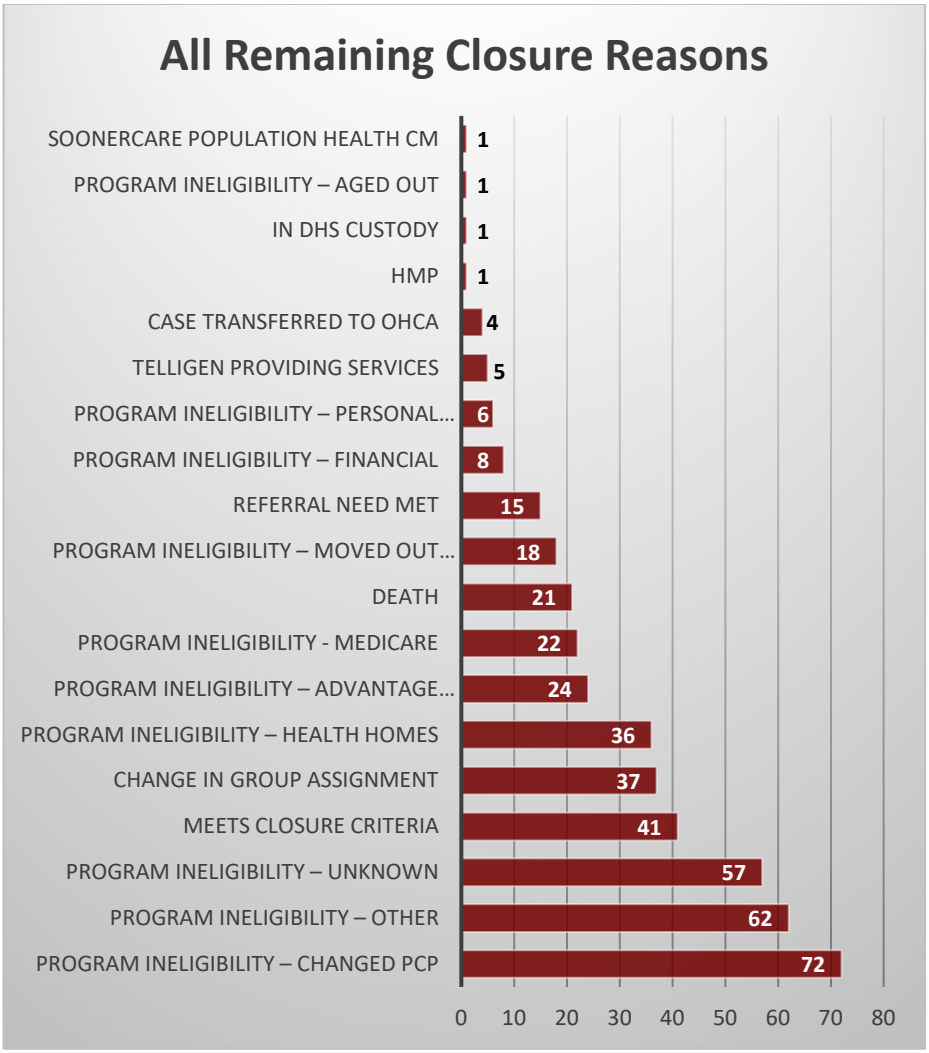
1. **Never Able to Contact, 29%**
2. **Voluntary Withdrawal, 28%**
3. **Unable to Contact (after making initial contact), 25%**

"NEVER ABLE TO CONTACT"

was the most frequently cited for case closure

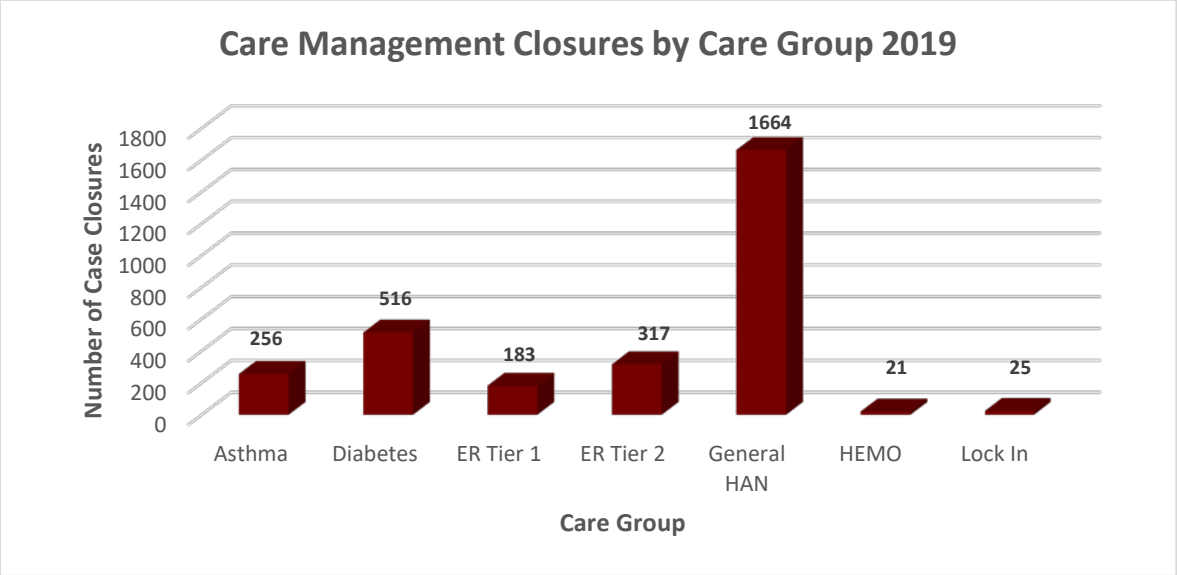
Specific closure criteria is created for each care group in order to guide care managers through an appropriate closure. Examples of closure criteria might include decreased or no ER visits in a certain period of time, moving from uncontrolled to controlled asthma, A1C goal achieved over a certain amount of months, seeing their PCP on a regular basis, etc. Closing cases for meeting closure criteria is a growing reason, in large part due to the care managers having readily available reports that make identifying cases that meet closure criteria simpler but also due to the success they are having working with their members. This increased success could be attributed to many factors including continuing education and training for the care managers on disease processes, motivational interviewing training, and increased partnerships with the practices.

All remaining closure reasons make up 18% of all closure reasons



These additional closure reasons are frequently related to program ineligibility. While different types of ineligibility can often be identified, there are many cases when the cause may not be available to the Sooner HAN from the member or from OHCA.

The graph below highlights the number of closures for the year, broken down by care group. The largest number of closures was seen in the largest care group, General HAN.

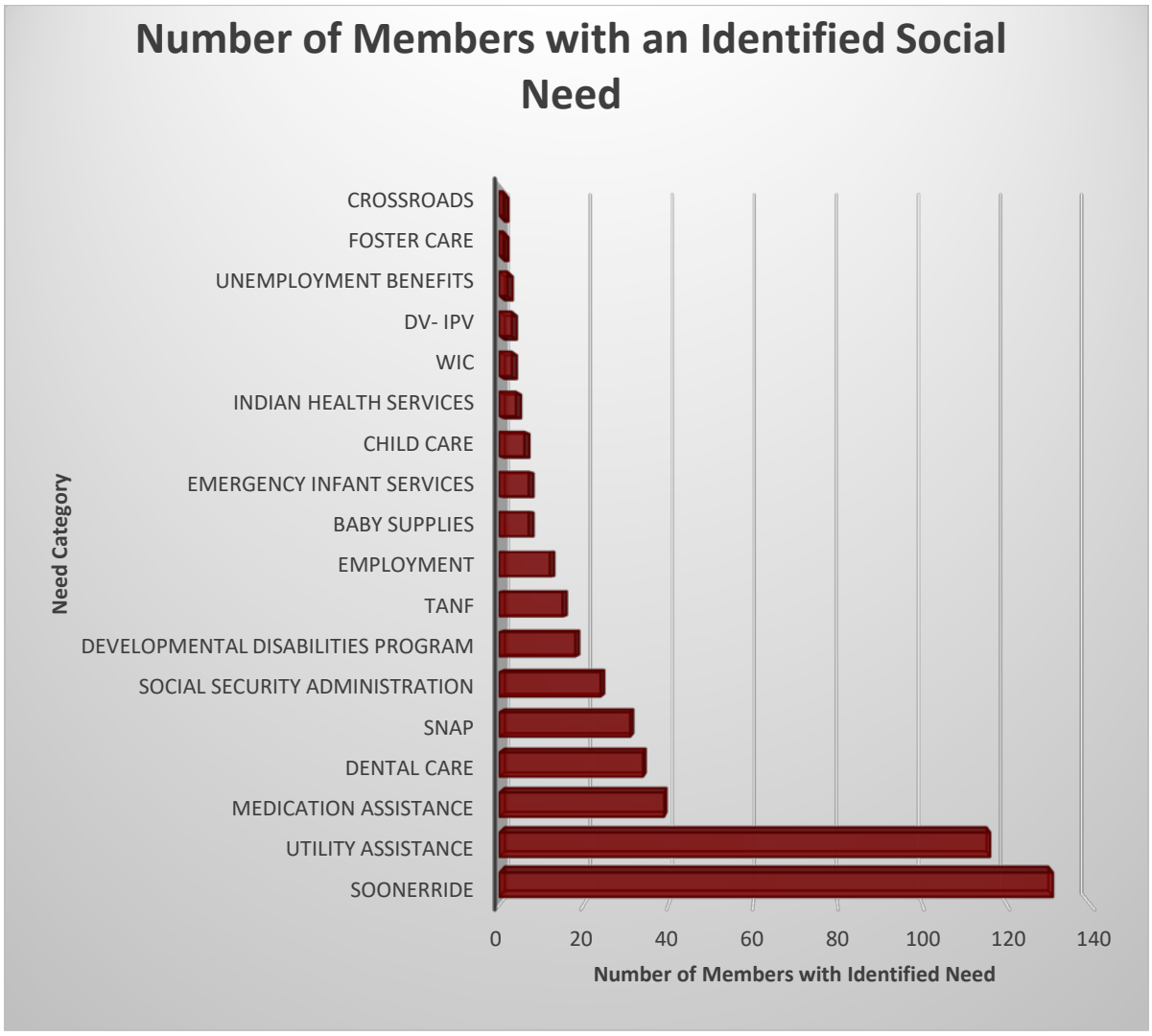


SOCIAL NEEDS SCREENINGS

Screening for social needs of care managed members remained a priority in 2019. In total, 697 members were screened or rescreened with the Accountable Health Communities tool. Of these members, the data gathered from the social needs screening tool is vital to properly identifying care management interventions.

Due to this importance, the completion of the social needs screening tool had been identified as a ProForma measure for 2019 and will continue for 2020.

Among the most frequently identified social needs were help with SoonerRide, utility assistance, and assistance with SNAP benefits.



CARE MANAGEMENT MONITORING

The Sooner HAN added two new monitoring reports in 2019. In addition to medication reconciliation completion and member contact reports, care managers began to receive reports regarding open referrals and aging social needs screenings.

Medication Reconciliation and open referral tracking were included on the 2019 ProForma and will continue on the 2020 ProForma. These are both important elements in the care management process. At the end of CY2018, 76% of eligible members had a medication reconciliation on file. At the end of CY2019, this measure had increased to 89%.

In addition, care managers continued to receive a monthly member contact history report. The report was expanded to include additional elements, such as the last successful contact. Care Managers have reported that this report significantly helps them manage and monitor their case load contacts and ensure compliance with established protocols. In January of 2019, 5% of cases went 35 or more days before a contact attempt. In December of 2019, that percentage had improved to 2%. Additionally, cases that stayed open longer than 45 days without a successful contact decreased from 12% in January 2019 to 2% in December 2019. These reports ensure that members who need contact follow-up are completed in line with Sooner HAN protocols and that cases where a member cannot be reached are closed so new members can enter care management.

SUCCESS STORIES

The stories highlighted below are told from care managers' and from providers' perspectives. The member names have been changed to protect member privacy and confidentiality.

The Sooner HAN members have had many successes throughout the year. The stories below serve as reminders of the impact care management services can have on individuals.

TEAM SUPORT AND SUCCESS: A CARE MANAGER'S PERSPECTIVE

I am boasting about my great co-workers. They are always willing to go above and beyond to help our families in need.

MS. M.

During Christmas break, Ms. M. verbalized being "depressed" because she has been unable to buy her five granddaughters ages 19, 13, 10, 1, and 2 months, Christmas gifts for several years. She expressed embarrassment when the girls asked in the past, "What did you get us grandma M.?" Ms. M. is a 52-year-old member who is in care management services for diabetes. She receives SSI benefits monthly. However, her check is being decreased due to an overpayment.

With Ms. M.'s permission, I solicited help from Sooner HAN and clinic care managers. Of course, they responded immediately and donated cash, gift cards, clothing, and toys. The items were bagged separately for each girl and presented from Ms. M.

When I followed up with Ms. M. at her PCP visit, she was quick to tell me how one of her granddaughters who received a purse asked, "Grandma, how did you know this is what I wanted?"

"Grandma, how did you know what I wanted?"

THANKSGIVING GENEROSITY

Before the Thanksgiving holiday, a Sooner HAN care manager's church announced their desire to bless at least twenty families within their church and the local community, with Thanksgiving baskets. The Sooner HAN Care Managers presented four families for consideration. Family #1 had eleven members, family #2 was a grandmother caring for her daughter and two younger grandchildren, family #3 consisted of a grandmother who has custody of her grandchildren, but due to her age, she does not qualify for "grandparent assistance" from local agencies, and family #4 was a single mother of three.

Each family was chosen and blessed with turkeys with all the fixings. The astonishing part of this story was the generosity of a Sooner HAN care manager. She unselfishly donated $100 to ensure that every family presented to the HAN received a basket.

Each family was blessed with turkeys and all the fixings

MEMBER SUCCESS STORIES

TOBY

Toby is a 6 year old member with thyroid cancer and possible metastasis to his lungs. He was referred to the Sooner HAN for care management services by a pediatric endocrinology clinic. Over the course of seven days there was a whirlwind of activity to try and get Toby the treatment he needed. When I received Toby's case, the care team struggled trying to find a specialist within the State of Oklahoma that provided the radioactive iodine therapy as in-patient and as soon as possible. The specialist referred them to MD Anderson. Additionally, Toby had just changed primary care providers (PCP) and would need to establish care with the new PCP before any referrals could be made for treatment. I contacted the Care Coordination Supervisor at the Oklahoma Health Care Authority (OHCA) for information regarding out of state referrals, as the process had recently changed. I learned that 1) the new PCP would need to submit the referral, 2) we would need to submit documentation that there was no place in Oklahoma that could complete the procedure, and 3) find an out of state specialist that would be willing to contract with Oklahoma Medicaid. I confirmed that the OU Children's hospital was not currently set up to accommodate this procedure and would need time to get everything set up and staff trained. MD Anderson was also not a viable option, as they did not accept out of state Medicaid. I began the long process of contacting multiple facilities in-state and out-of-state with little success; either they did not do this procedure or did not take Oklahoma Medicaid. During this process Toby was scheduled for a meeting with the PCP. I attended the appointment and met with

Toby's dad and aunt. During this time, I learned that Toby had been having an issue with bedwetting while in his mother's custody, probably due to anxiety, but it had since resolved once his dad regained custody.

Meanwhile, the pediatric endocrinologist had also reached out to the Medical Director at OHCA and were exploring additional options at the University of Colorado. Another meeting was scheduled with myself, the family, the pediatric endocrinologist, the medical director of Nuclear Medicine at OU Children's Hospital, the safety officer for OU Children's Hospital, and the charge nurse to discuss options. It was at this meeting that it was identified that one of the barriers to Toby receiving the treatment at OU Children's Hospital was the bedwetting that had been occurring when Toby was with his mother. Now that it had resolved, the team felt confident that they could create a treatment plan that could be safely delivered and Toby would now be able to stay in Oklahoma for his treatment.

Ultimately, Toby did receive the needed treatment. Toby's cancer is a rare and especially aggressive form. I'm continuing to work with Toby and has family as he continues to have surgeries and treatments for his cancer.

HENRY

Henry is an 11 year old boy who was referred for care management due to frequent ER visits. Henry had recently been diagnosed with seizures and the majority of the ER visits were for these seizures. Henry's seizures have been changing and increasing in intensity. One of mom's worries was maintaining his normalcy in school. Henry did not start having seizures until he was 8 years old and had been a very active boy involved with sports and friends. Recently, he began having partial seizures that included him walking around dazed without any recognition of what he was doing. After an episode occurred at school, the school asked her to pick him up for his safety and expressed concern about him returning to the classroom. Mom was very frustrated with the school especially after the basketball coach also said he could not play because he might "hit his head". I asked mom if it would be okay for me to reach out to the school and offer to work with them to see what we could do to make the best of the situation and keep Henry safe.

The school is a small rural school with minimal resources. They do not have a school nurse and the entire school (K-12) is on one small campus. The principal often takes on the role of the healthcare provider. The nearest ambulance support comes from the next town over. The principle agreed to meet with me and I offered to put together a program to talk about seizures and present it to Henry's 5th grade class and teachers. I sent him a draft of the presentation and he ended up requesting that I present to the entire 5th grade, all the teachers and other staff that have daily interaction with Henry.

We gathered everyone in a classroom and I did my presentation, talking about how the brain works, and how seizures occur. We talked about why seizures happen, what happens inside the brain during a seizure, and the 'normal' timeframe for them. Most importantly, we talked about when a seizure is a medical emergency, and what everyone can do to help the person experiencing this lightning storm inside his or her brain. I utilized lots of bright colors to capture the kids' attention, a short video showing the electrical impulses of a normal brain vs. a brain during a seizures, and finally, a video showing a child having a seizure in a school setting and what everyone did to help the child be safe. I never referred to Henry specifically, but talked about how lots of different people could have seizures. We talked about how scary seizures are to witness, and how even as a trained nurse, I was terrified the first time I saw one of my patients have a seizure. I had the kids tell me what they could do if they saw someone fall down and start to convulse on the playground and they did a marvelous job listing what to do to keep the person safe. We talked about what would happen if they were at WalMart and saw a person fall down and start to have a seizure. They all said they would call a grown up. We then talked about the fact that most grow-ups have never had to learn what to do, so they, the kids, might be the only ones to know what to do! They were all very excited about their potential roles as heroes and I could quickly see the change in their ideas about someone having a seizure as someone who is "weird" or "strange" to someone that is a friend that they could help and protect.

After the program, Henry's teacher came up to me and quietly thanked me. She said she had been very nervous before today, but now felt very confident in knowing what she needed to do if it happened again. The principal discussed having a "helper" keep an eye on my member if he were to again start wandering around during a focal seizure, and thanked me again for helping them all to understand not only their roles, but also when to act on them; and for enabling all the kids to step up in their community and help when they could with this unique situation. He also asked if I would be willing to come and talk to the entire faculty at some point in the future to help train them on what steps to take if faced with a student having a seizure.

This has to be one of the best parts of my job, and one of the most important roles as Care Manager to be able to identify ways to help make our member's lives easier and make it happen.

MARY

Mary is a 40 year old single mother to a child with special needs. Mary has diabetes, anxiety, hypothyroidism, and obesity. As soon as I began working with Mary she identified that she wanted to weigh less than 200 pounds by her 40th birthday in 2019 and get off some of her prescribed medications. I helped Mary apply for a free membership at the local YMCA, which she received. There, Mary started participating in water aerobics, weight training, walking, Zumba, and yoga. Mary and I discussed other things she could do to improve her health and lose weight, like drinking more water and

eliminating soda. Mary also committed to keeping a food journal, eliminating processed foods and trying to follow a 1500 calorie diet. Mary was also accepted to participate in the "Produce Drop Program" through her Primary Care Provider and will receive weekly home delivery of fruits and vegetables for nine months. November was Mary's birthday month and she now has an A1C of 6.9 and has lost 35 pounds in less than 13 months. She has set a short term goal of exploring certification to become a substitute group fitness instructor through the YMCA and a long term goal to become a certified personal trainer. Mary is well on her way of getting below 200 pounds and controlling her diabetes through diet and exercise.

"November was Mary's birthday month and she now has an A1C of 6.9 and has lost 35 pounds in less than 13 months."

GEORGE

George has a history of using methamphetamines for over ten years and uncontrolled diabetes. Additionally, in 2013, George had a stroke, causing paralysis to his complete left side. In 2016, he had a traumatic brain injury after falling out of a semi. In 2018, he had a partial right great toe amputation (still has an open wound). George was referred for care management in October 2019. After reviewing George's case information I was worried. As a new care manager, I wasn't sure how I was going to help George.

The first thing we worked on was getting George established with a new primary care provider (PCP), after being "let go" by the previous one. I attended his first appointment with him and was able to ensure that George received a referral for wound care. George seemed to respond well to the new PCP. George was very grateful and expressed how he was ready for a change and really needed help. A few days after the PCP appointment I accompanied George to his first wound care appointment. Over the next six weeks, George completed daily wound care, but complications required further surgery and a PICC line placed with antibiotics three times a day. George is continuing with the daily wound care, but is also seeing an infectious disease provider, behavioral health provider, and started substance abuse counseling. George has been clean for over 43 days, his fasting blood sugars are 90-105 verses 200-300, and his family is helping with dressing changes and antibiotics. In order for George's wound to heal and avoid amputation of his entire foot, it was critical that he follow a "no weight bearing" order from the surgeon. Luckily, I was able to find him a wheelchair so he could stay off his foot. George's brain injury makes him forgetful and he lacks impulse control. I have worked with George and his family to develop routines and schedules to keep his care on track. George calls me on a daily basis, even on weekends and leaves me a message "checking in" and letting me know his blood sugar. He says this helps to keep him accountable and lets me know he is okay.

"George is sober, his blood sugars are in control, and his foot is healing."

It has been a lot of work educating him, his family, attending appointments, and so much more, but George is sober, his blood sugars are in control, and his foot is healing. George continues to work to improve his own mental health and repair his strained family relations. His family tells me they have never seen him this engaged, this sober, or working on his health so much.

ANNA

I received Anna's case back in December 2018. Anna was 3 at the time and had a history of epilepsy and has a mickey button for nutrition. When I first started working with Anna, her mother was very frustrated and overwhelmed with all the appointments, treatments, medications and supplies for Anna. One of the first things I did with Anna's mother was help her create a calendar to organize all the appointments. Anna has a lot of providers including, a neurologist, primary care, gastroenterologist, and a surgeon for her mickey button. I assisted Anna's mom in calling each one and scheduling new appointments and recording them on the calendar. We also contacted the medical equipment provider and clarified the supply orders and delivery dates. After months of Anna's mother following up with all the specialist appointments, Anna stopped having seizures and was getting the proper amount of nutrition through her mickey button. Then, I worked with Anna's mother in the process of getting Anna into the Little Light House, it took a year but we were able to get Anna in. Anna's mother no longer feels frustrated and overwhelmed and is able to prioritize and organize Anna's care. I will actually be closing Anna's case now that her mother is doing so well in meeting her needs. It gives me so much joy to be able to guide and teach my member's families to navigate the health system as well as giving them resources to navigate life in stressful situations, especially when the language is a big barrier. I am so thankful for everything we are able to do with our members to better their lives.

BOB

Bob was assigned to me from the General HAN group and has been in care management for several years. When I first started working with him, he frequented the ER and had uncontrolled COPD, Asthma, and diabetes. Bob was still smoking and struggling to communicate effectively with his primary care provider (PCP), as well. With Bob's approval and cooperation I worked with him to strengthen his relationship with his PCP and his specialists. Our first goal was to get Bob's blood sugar levels under control so he could have a knee replacement. We worked hard together and he was finally able to have the knee surgery. After getting his blood sugars controlled and his new knee he was able to start losing weight through diet and exercise. He completed the required physical therapy earlier than expected. As he

continued to meet his health goals I could see a positive change in his life. In the beginning, I had to initiate all communication to Bob, and he was very aggravated and frustrated with his health. Over time this changed. Bob often is now calling me to report his newest achievements related to his health. Bob quit smoking, lost approximately 65 pounds, and his last reported A1C was 4. He went from three medications for his diabetes to none. Bob also started to be more social. Eventually he met someone and married. They recently moved to Arizona to live. In our last conversation, Bob let me know he is planning on returning to school to finish a degree and pursue a career in music or teaching.

SUCCESSFUL INTERACTIONS

Care Coordination

"Her parents expressed feeling glad about having a care manager to assist in the complicated referral and medical care process"

Second Chances

"He agreed to the terms at the new clinic and was able to get his pain controlled for the first time in 2 years"

DME Assistance

The member received a new bed and reports that she sleeps "much better"

NEW BEGINNINGS

"She has consistently met her exercise goals, getting a scholarship to the Y, working with a personal trainer, and attending every appointment with her doctor and calling her care manager to update"

Goal Setting

"He is drinking more water, getting more exercise, getting his own apartment, getting a service dog, and he will begin a new experimental sickle cell medication next month"

Progress

"The member is more active and is on the growth chart now.

She went from 30 pounds in July 2018 to 45 pounds in October 2019"

Overcoming Obstacles

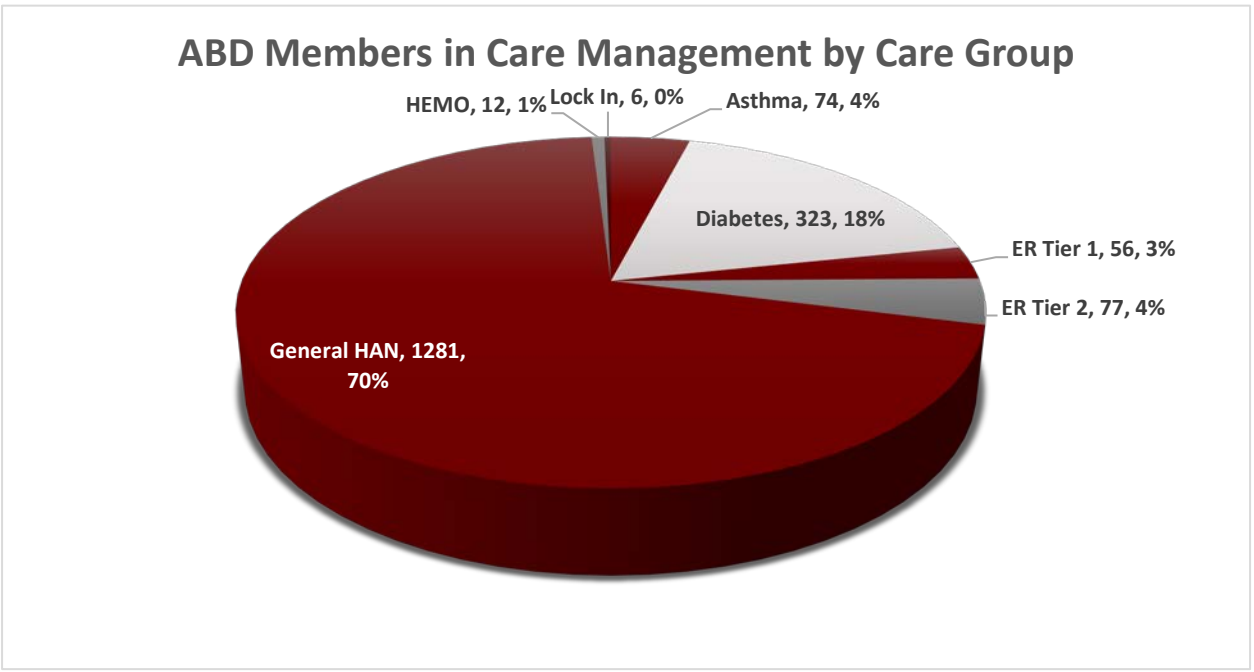
Care management support helped the member obtain a wagon to carry the twins' car seats and travel to appointments

CARE MANAGEMENT TARGETED POPULATIONS

AGED, BLIND, AND DISABLED (ABD) CATEGORY

The Sooner HAN continues to prioritize the ABD population for engagement into care management services.

13,639 SOONER HAN MEMBERS WERE ATTRIBUTED TO THE ABD CATEGORY IN 2019



ASTHMA

The Sooner HAN served 256 member cases for asthma care management in 2019. Care managers monitored member's asthma control, asthma action plan, and use of long-term controller and short-term rescue medications.

Care managers made 4,599 contacts and documented a total of 1,318 hours in 2019 with or on behalf of members in the asthma care group

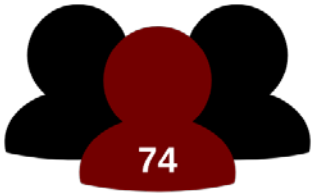
256 members attributed to the asthma care group received care management services in 2019

At the time of their most recent asthma assessment,

64% of care managed members reported having a written **Asthma Action Plan**

And of screened members

77% reported using an **Asthma Controller Medication**



ABD Members

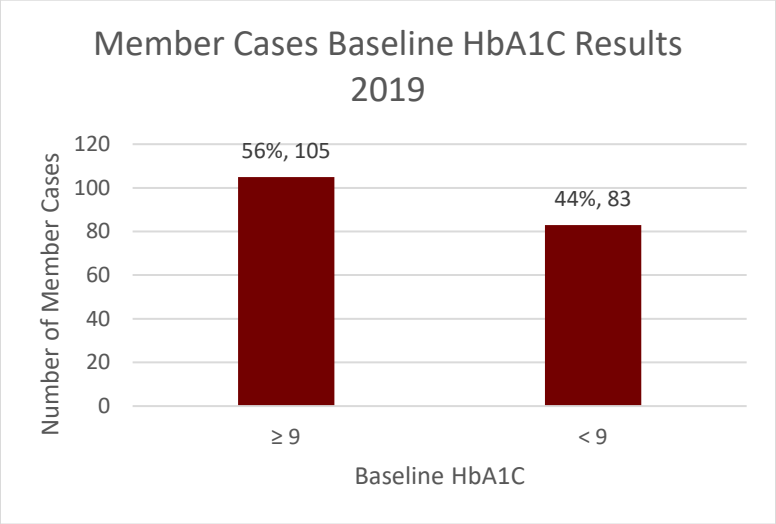
Asthma

A 43% decrease in ER events was seen between 2018 and 2019 for members that had at least one year of care management services

***based on current claims data**

DIABETES

In 2019, the Sooner HAN served 516 distinct members in diabetes care management. This continues to be a growing population and was an area of focus in 2019, with a specific HbA1c measure reported on the 2019 ProForma.



DIABETES

516 MEMBERS RECEIVED CARE MANAGEMENT SERVICES DURING 2019

Care managers made *9,984* contacts and documented a total of 2,780 hours in 2019 with or on behalf of diabetes management

Of members with a baseline HbA1C greater than 9, that have documented follow-up HbA1C results,

68% have a decrease between their baseline and most recent HbA1C.

323

ABD Members

386 NEW MEMBERS ADDED TO THE DIABETES CARE GROUP IN 2019

ER TIER 1 (10+ VISITS IN 12 MONTHS)

During 2019, the Sooner HAN provided care management to a total of 183 ER Tier 1 members. ER Tier 1 members are automatically placed into the High Touch care management group and receive a more intensive level of intervention.

183 members attributed to the ER Tier 1 care group received care management services in 2019

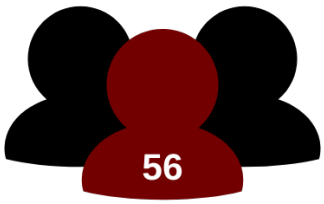
Care managers made an average of 14 contacts and provided 36 hours of assistance to each member in the ER Tier 1 group in 2019

ER Tier 1

Care managers made 2,558 contacts and documented a total of 658 hours in 2019 with or on behalf of members to assist with better management of their health conditions and decrease ER usage

This care group saw a **55% decrease in ER events** between 2018 & 2019, for members with at least one year of care management services

**based on current claims data

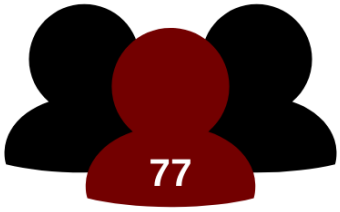


ABD Members

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

The Sooner HAN provided care management services to 317 ER Tier 2 members who had between 2-9 ER visits in a 12 month period. This group continues to be challenging, with the top three closure reasons mirroring the overall program closure reasons of voluntary withdrawal, never unable to contact, and unable to contact after making contact.

317 members attributed to the ER Tier 2 care group received care management services in 2019



ABD Members

ER TIER 2 Care managers made an average of **12 contacts** and provided **3 hours** of assistance to each group member in 2019

ER Tier 2

Care managers made 3,911 contacts and documented a total of 1,052 hours in 2019 with or on behalf of members to assist with better management of their health conditions and decrease ER usage

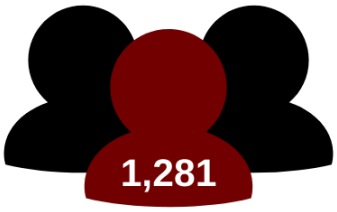
Between 2018 and 2019, there was a 36% decrease in the number of ER events for members of this care group that received at least a year of care management services

GENERAL HAN

The General HAN category continues to be the fastest growing care management group, with 1,644 members served in 2019.

1,664 members received care management services in the Sooner HAN's largest care group

56% of all care managed members belong to the General HAN care group



ABD Members

Care managers made an average of 18 contacts and provided 5 hours of assistance to each General HAN care managed member in 2019

GENERAL HAN

Care managers made 32,416 contacts and documented a total of 9,203 hours in 2019 with or on behalf of members to assist them in management of their health and treatment goals

GENERAL HAN MEMBERS WITH AT LEAST ONE YEAR OF CARE MANAGEMENT SERVICES BY THE END OF 2019 SAW A DECREASE IN ER EVENTS BETWEEN 2018 AND 2019 OF

23%

HEMOPHILIA

The Sooner HAN provided care management services to 25 members in 2019. In an effort to best serve this population, one Sooner HAN Care Manager was identified to act as the main care manager.

25 members with hemophilia received care management services in 2019

ABD Members

Care managers made an average of **13 contacts** and provided **4 hours** of assistance to members in the Hemophilia care group in 2019

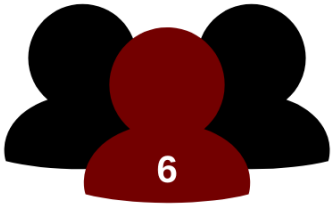
IN 2019, CARE MANAGERS MADE 338 CONTACTS AND DOCUMENTED 99 HOURS WITH OR ON BEHALF OF MEMBERS TO ASSIST IN BETTER MANAGEMENT OF HEMOPHILIA

PHARMACY LOCK IN

In 2019, the number of members in the pharmacy lock in group decreased to 21.

Care Managers made 306 contacts and documented 50 hours during 2019 with or on behalf of members in this group

21 members attributed to the pharmacy lock in care group received care management services in 2019



ABD Members

As a group, members with more than one year of care management services saw a 33% decrease in ER visits between 2018 and 2019

**based on current claims data*

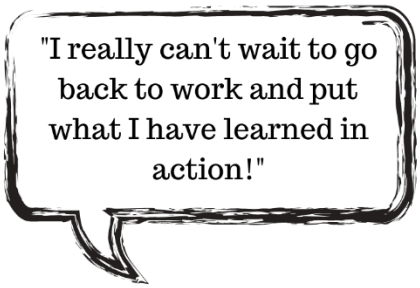
EDUCATIONAL OPPORTUNITIES AND PROVIDER ENGAGEMENT

FUNDAMENTALS OF CARE MANAGEMENT COURSE

The Fundamentals of Care Management course is an intensive training on the delivery of comprehensive care management services to individuals with complex health and social service concerns. It includes approximately four hours of online prerequisite work and four full classroom days.

The Fundamentals of care management course was held four times during 2019 with a total of **60** healthcare professionals in attendance

The training utilizes a multidisciplinary team approach by emphasizing strategies to partner with providers, community agencies, family members, and other stakeholders to co-manage a diverse population of people with high-risk conditions. The course utilizes dual learning mechanisms by incorporating both e-learning and in-class engaging presentations and activities. The small group sessions generate interactive learning and discussion. Many of the teaching modules are case-based and discuss actual events/scenarios that care managers commonly encounter. Supplemental materials and templates are provided electronically in the online learning system.



"It has opened my eyes to so many new ways to move forward and I hope to be more effective and better educated in my approaches with the patients I serve."

More Participant Feedback

- "Very informative. Fun, relaxed atmosphere."
- 'It was presented in a fun and informative/interactive manner."
- "Interaction- making learning fun- speakers were great- such positive attitudes and support."
- "I loved how relaxed the classes were."

On average, post-test scores were 33.5 percentage points higher than pre-test scores (99%: 29.2-37.7)

ASTHMA ACADEMIC DETAILING

In 2018, the Sooner HAN launched the Asthma Academic Detailing program. The goal of this program is to give providers, nurses and patients easy to use, evidenced based asthma tools and education to improve asthma care and outcomes. In August of 2018, the Sooner HAN Clinical Manager and Dr. Nancy Inhofe, OU Pediatrics Asthma Specialist, kicked off the first Asthma Academic Detailing. In 2019, 11 primary care practices participated in the Asthma Academic detailing program.

"She liked the decision support tool for its ease of use and the self-confidence it would give her when recommending specific medications and dosages for her patients with asthma."

Several providers remarked that they did not write prescriptions for spacers because they did not know which spacer to choose from the formulary list on their EMR. Many providers took written notes for the spacer brands I recommended to them

Common observations by the Sooner HAN Clinical Manager when conducting this training included the realization that most nurses were not aware of the need to use spacers. Even those who had asthma or had kids with asthma were not using spacers or they were using them incorrectly. Additionally, providers' inhaler technique skills were poor and none of the providers were aware that the clinical guidelines specify checking patient technique on a regular basis and to schedule preventive visits at least once a year. Provider comments received also reflected what is found in the literature, which is that a lack of confidence in prescribing asthma medications is a major barrier to effective management.

Before training, on a scale of 1 to 10, providers indicated a confidence level of 8.33 in making medication changes based on severity/control classifications

90 days following the training, providers indicated a confidence level of 9

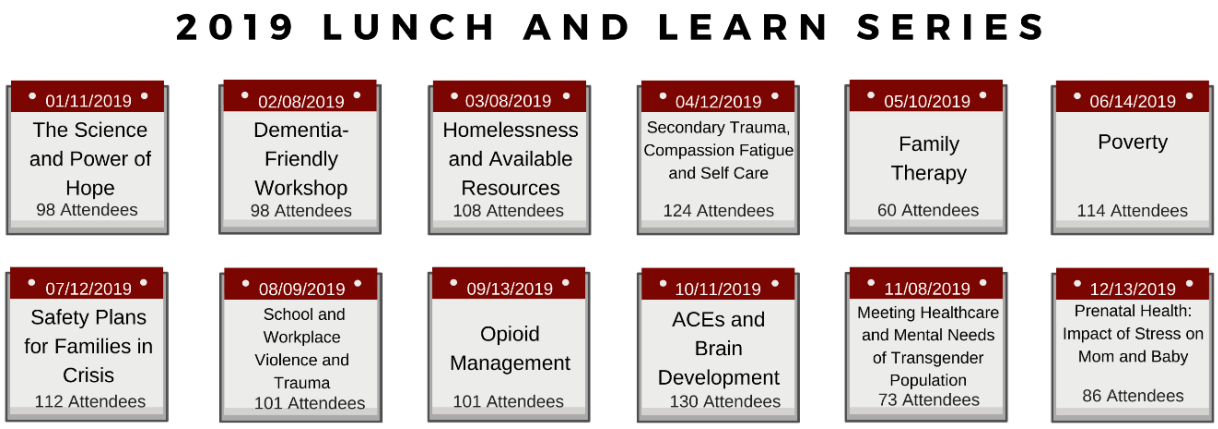
ON A SCALE OF 1 TO 10, PROVIDERS INDICATED AN **8.33** CONFIDENCE LEVEL IN **ACCESSING ASTHMA SEVERITY AND CONTROL** BASED ON GUIDELINES

90 DAYS FOLLOWING TRAINING PROVIDERS INDICATED A CONFIDENCE LEVEL OF **8.66**

LUNCH AND LEARN SERIES

The Lunch and Learn series continued in 2019 with topics identified from past lunch and learn session feedback as well as identified hot-topics within the healthcare landscape. Topics covered and the number of attendees are highlighted below. The Sooner HAN welcomed 1,205 participants during the monthly lunch sessions in 2019. This represents a nearly 10% increase attendance from the 2018 series. Participants included Sooner HAN staff, providers, students, educators, and many more. These offerings are not exclusive, and invitations are sent out to all participating providers and staff monthly. The Sooner HAN values the importance of continuing education and ensuring that resource is available to our practice locations.

1,205 participants attended Sooner HAN Lunch and Learns sessions in 2019



SITE VISITS AND COLLABORATIVE ACTIVITIES

Throughout 2019, the Sooner HAN staff visited provider locations to review the quality improvement, care management, referral management, and education and training services offered. Examples of provider specific reports within the Sooner HANs abilities were also shared during these visits. This was also a time for the organizations to share with the Sooner HAN staff services that would be beneficial to their specific needs.

PROVIDER M

A practice reached out to the Sooner HAN for help with updating their gestational diabetes materials. The current materials were out of date and not at a suitable health literacy level. After review of the materials, the Sooner HAN Clinical Manager and one of the RN care managers, who is also a bilingual certified diabetes educator, went to work to make the handouts evidence-based, at an appropriate health literacy level, and ensured they were translated to Spanish correctly. The Sooner HAN team also provided educational sessions to the practice staff to review all the new materials and answer any questions.

PROVIDER N

In 2018, the Sooner HAN quality team collaborated with a large primary care practice to implement a quality improvement project using secret shoppers to determine the root causes of low patient satisfaction scores. Posing as patients, three Sooner HAN staff called practices to schedule an appointment and one staff member attended a clinical visit at each site.

As a result, the practice senior leaders and the Board of Directors revised their mission and vision statements and aligned their three-year strategic plan around customer service, education, and empowering employees. The plan included customer service training, motivational interviewing, and trauma-informed approach training for all staff. In 2019, the Sooner HAN team implemented the plan over a course of three months.

Employee knowledge of motivational interviewing was measured on an average, post-test cores were 21.4 percentage points higher than pre-test scores. Patient satisfaction survey response rates have increased by 300% over 11 months and the practices nursing staff turnover rate dropped by 50%.

Motivational Interviewing

Post-test scores were 21.4 percentage points higher than pre-test scores

A training focused on the AIDET customer service principles was also developed and delivered during the same three months. The results and feedback from these trainings were compiled and provided to the practice with recommendations for continued improvement opportunities.

The practice's nursing staff turnover rate dropped by 50%

In November of 2019, the practice, along with Sooner HAN staff, presented this project at the “Putting Care at Center” conference hosted by the National Center for Complex Health and Social Needs, an initiative of the Camden Coalition.

ADDITIONAL TRAININGS

In 2019, the Sooner HAN developed a "Person-Centered Communication" training designed for all levels of clinic staff. Person-centered communication uses reflective listening and acceptance of a person's perspective without labeling, judging, or blaming. By learning to recognize language and behaviors that shut communication down, we can begin to remove these barriers and begin to replace these actions with person centered approach that encourages individuals to express themselves and be more open to the possibilities of change.

The Sooner HAN started the 2019 off with conducting a Trauma Informed Approach training for the leadership at the Oklahoma Health Care Authority.

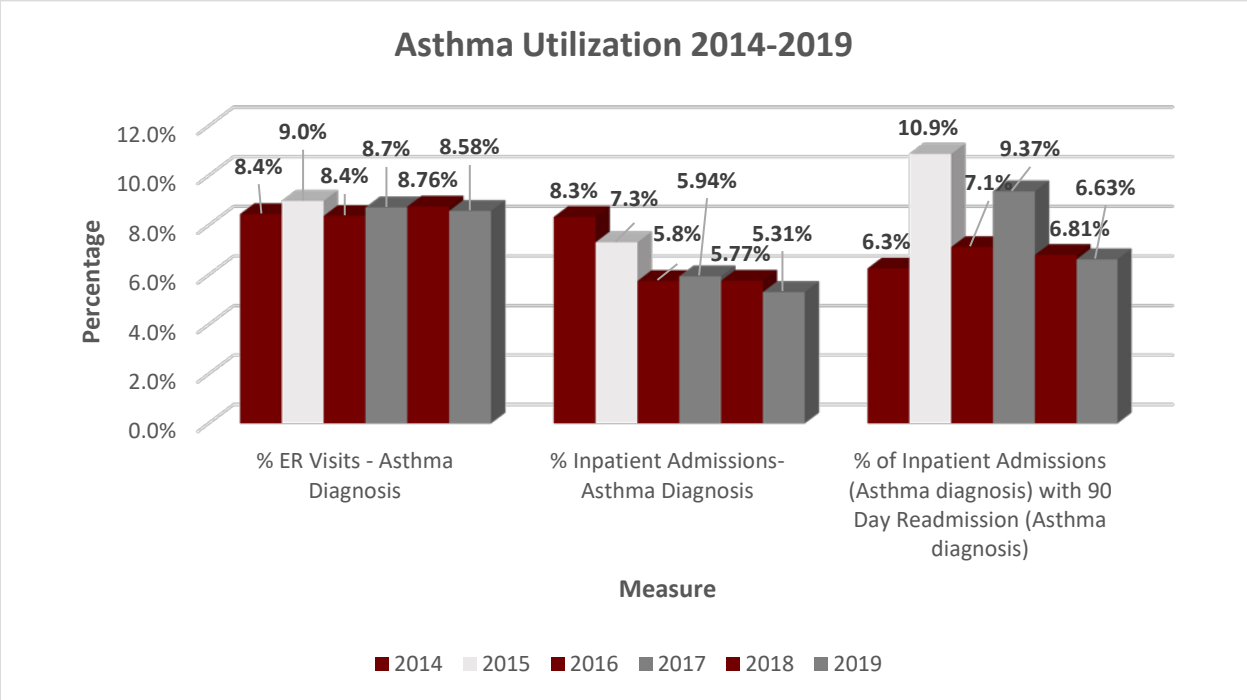
PROVIDER REPORTS

The Sooner HAN offers many standardized and customizable reports to participating clinics. Seventeen provider organizations were receiving reports in 2019. These reports include total roster reports, reports of care managed members, emergency room and inpatient utilization reports.

Clinic	Utilization Reports	15 Month Visit Reports and/or Roster Reports	Doc2Doc Reports	Care Management Reports	Customized Reports
Access Solutions Medical Group	✓	✓	✓		✓
Affordable Health Services				✓	
Broken Arrow Pediatrics	✓				
Broken Arrow Family Medicine	✓		✓		
Caring Hands Healthcare Center	✓	✓		✓	
Community Health Connections	✓	✓	✓	✓	
Choctaw Family Medicine and Aesthetics		✓		✓	✓
Crossover Health Services	✓	✓		✓	
East Central Oklahoma Family Healthcare		✓		✓	
Hornet Healthcare	✓	✓	✓	✓	
Morton Comprehensive Health Services	✓	✓		✓	
My Family Clinic				✓	
Okmulgee Pediatrics		✓	✓	✓	
OU Physicians OKC	✓	✓		✓	
OU Physicians Tulsa	✓	✓	✓	✓	✓
Pediatric Practitioners of Oklahoma	✓	✓		✓	
Stigler Health and Wellness	✓	✓		✓	
Utica Park Clinics		✓		✓	
Variety Care	✓	✓	✓	✓	✓
Westview Pediatrics	✓	✓			

HYPOTHESIS 8 PRO FORMA QUALITY MEASURES

In 2013, the Sooner HAN worked in collaboration with the OHCA and Oklahoma's two other HANs to develop standard measures around Asthma ER use and hospital readmission rates. The Sooner HAN has reported on these measures quarterly since 2014 and now has six calendar years of trended performance data.



The Sooner HAN has a disease specific assessment related to asthma and well defined protocols around the care management of members with this chronic disease. The team also began the development of an Asthma Academic Detailing Program for continuing education and outreach with providers, of which the first training session was held in the summer of 2018.

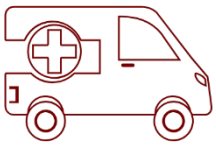
In 2016, the ProForma quality measures were introduced for reporting of quality metrics to OHCA. The 2019 ProForma included metrics around the completion rates for medication reconciliations, social needs screenings, and diabetes assessments as well as referral rate closure for Doc2Doc, as referenced earlier in this report.

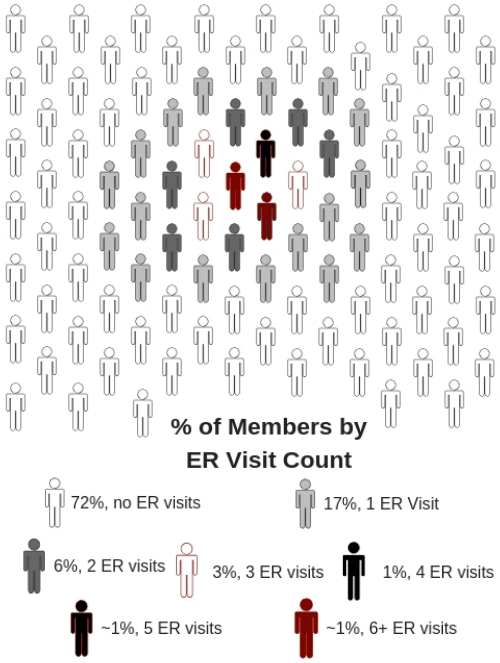
EMERGENCY ROOM UTILIZATION

The Sooner HAN continues to monitor ER use over the past several years. In 2019, there were 113,308 emergency room visits attributed to 60,904 unique members. Of the Sooner HAN's 213,814 unique members in 2019, 152,910 or 72% had no ER visits.

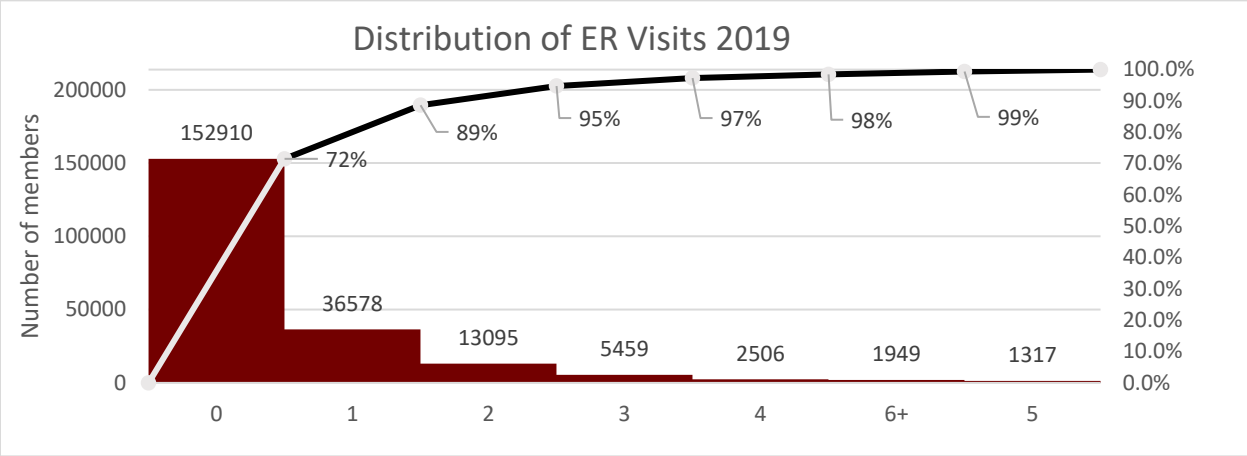
72%

of Sooner HAN Members had no ER visits in 2019

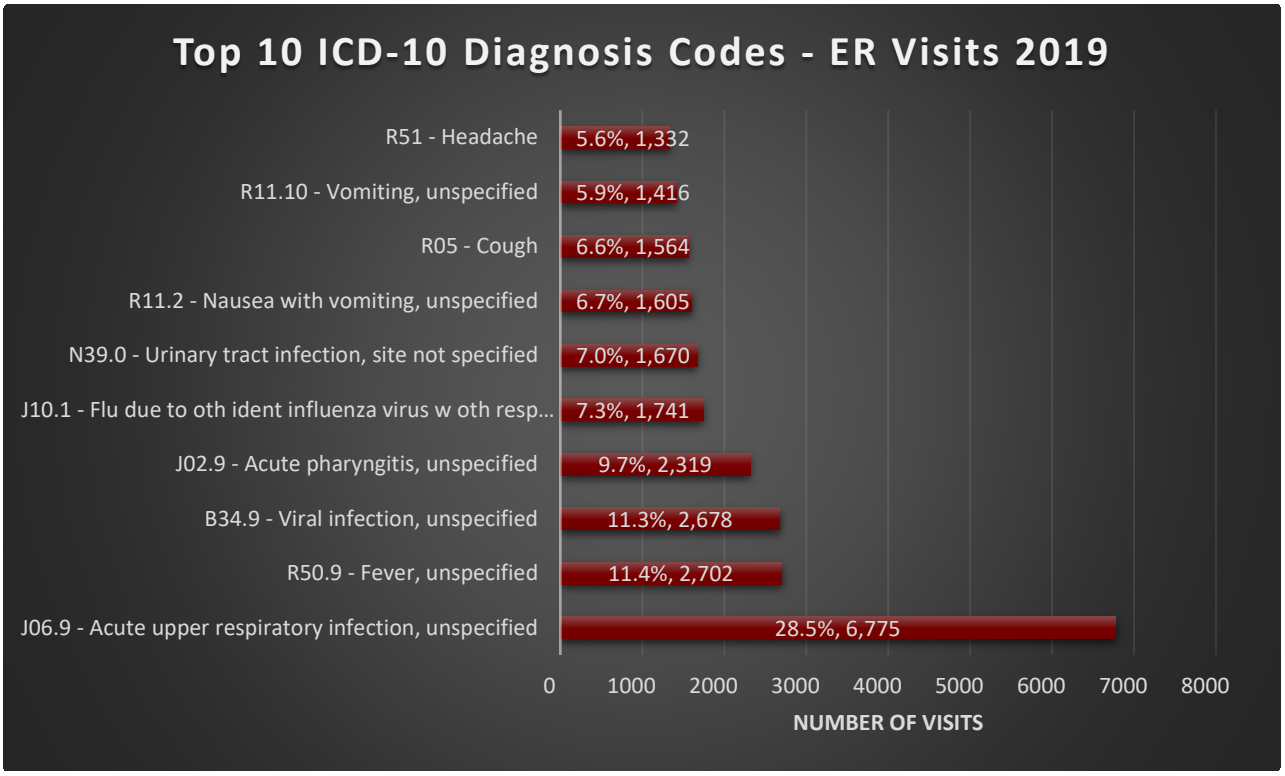




The graph below highlights the distribution in the number of ER visits members had in 2019. As shown below, members with 6 or more ER visits in 2019 accounted for less than 1% of total membership.



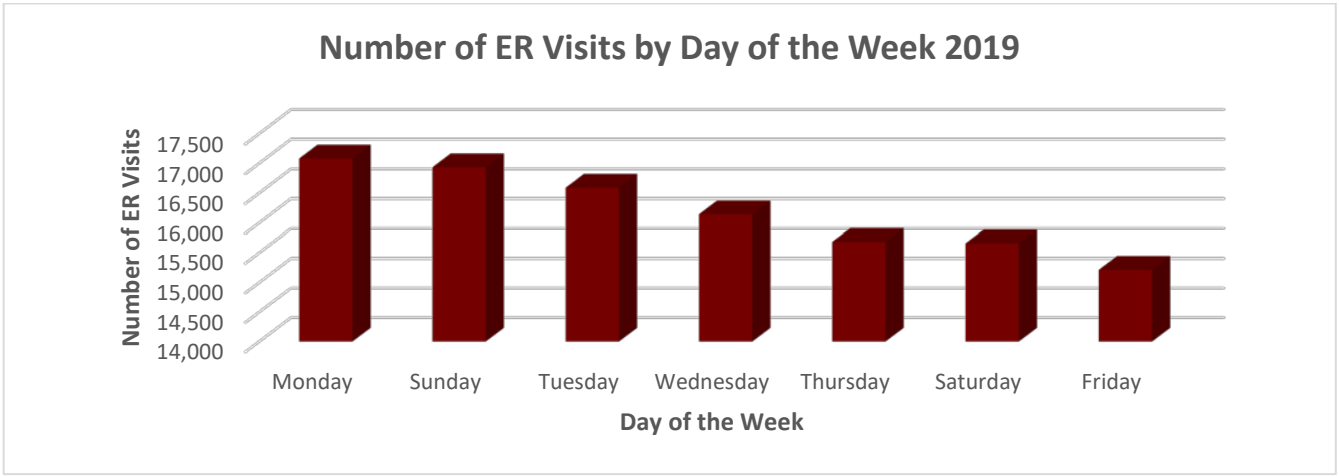
The top ten primary ICD-10 diagnoses codes for ER visits during CY 2019 are shown below.



In 2019, the age groups with the most frequent visits to the ER include 1-5 year olds (30% of total ER visits), followed by 19-44 year olds (24% of total ER visits), and 6-12 year olds (19% of total ER visits).

The most frequent location of ER visits was at OU Medical Center Hospitals, followed by Saint Francis Hospital and Integris Southwest Medical Hospital. These ER's are all located within one of Oklahoma's two metropolitan areas and were the same top three locations for ER visits in 2018.

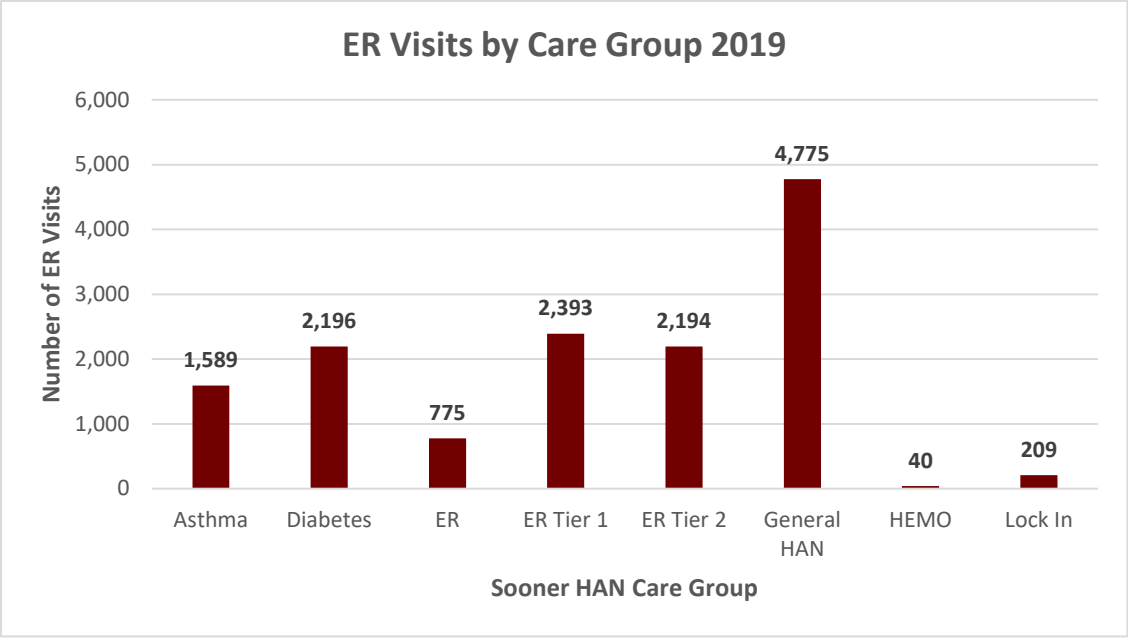
ER visits were distributed evenly throughout the week. Monday was the busiest day of the week with 15.1% of ER visits. Sunday, Tuesday and Wednesday accounted for 14.9%, 14.6% and 14.2% respectively.



The Sooner HAN plans to continue its focus on reducing ER usage throughout 2019 with more targeted interventions in care management. Also, the Sooner HAN will conduct further analysis to determine the degree to which care management services help to decrease overall ER utilization in all care groups. For the OU Tulsa clinics, the Sooner HAN is provided real-time discharge information for local ER and Inpatient utilizations. Upon notification via the EMR, the Sooner HAN care managers are able to follow up with the member to help coordinate their PCP follow up appointment, address any barriers to accessing their PCP, and work on any other identified member goals. In 2019, 95% of Sooner HAN care managed members associated to OU Tulsa clinics had follow up within one week of the ER event. 94% of Sooner HAN care managed members associated to OU Tulsa clinics had follow up within 2 business days of an inpatient event. Improvements were seen in both these areas as ER follow-up and Inpatient follow-up percentages in 2018 were 88% and 81%, respectively.

95% of Sooner HAN care managed members associated with OU Tulsa clinics had follow-up within one week of an ER event

The following graph displays the number of ER visits by members who are currently being care managed, although the members may have begun receiving care management services at any time during the past 5+ years. Thus, the data shows the number of ER visits that occurred for SoonerCare Choice members each year from 2011 through December 31, 2019 regardless of when the member began receiving care management services. The highest number of ER visits were in the General HAN care group. This group accounts for 56% of the Sooner HAN's members. However, the ER Tier 1 and ER Tier 2 groups, when added together account for more ER visits than the General HAN group.



ER visits for Sooner HAN members have risen from 63,205 in 2011 to 113,045 in 2019. Over the same period of time the number of unique members in the Sooner HAN has increased from 43,534 in 2011 to 213,814 in 2019.

Using the calculation of ER Visits per 1,000 Members (PTM), ER utilization has decreased significantly from 2011 to 2019, from 1,432 PTM to 530 PTM, a 63% decrease.