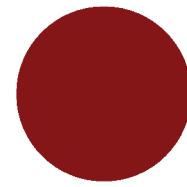




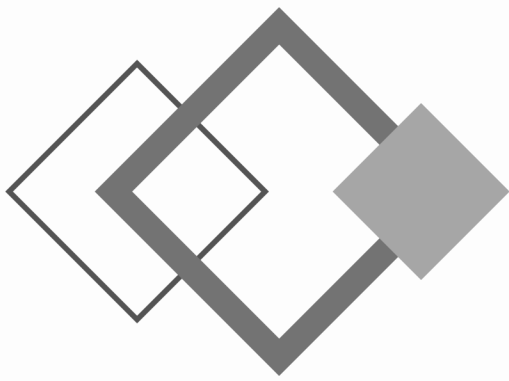
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# 2025 ANNUAL REPORT

# Table of Contents



03	Executive Summary	13	Social Drivers of Health
04	Organizational Overview	17	Emergency Department Utilization
07	Program Reach & Engagement	20	Quality & Compliance Performance
09	Care Management Activities	22	Program Stability & Workforce Sustainability



# EXECUTIVE SUMMARY

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In 2025, the OU Sooner Health Access Network (HAN) continued its mission to deliver high-quality member-centered care management across multiple Medicaid programs. This year marked ongoing operational growth, expanded partnerships, and strengthened alignment with Oklahoma's evolving SoonerCare and SoonerSelect landscape. Across all contracted entities, OU Sooner HAN supported members through care management, outreach, and referrals - ensuring access to primary care, addressing social drivers of health, and improving continuity across settings.

Care managers maintained a strong emphasis on meaningful member engagement, with the majority of care-management time spent directly supporting members and caregivers. New member experience surveys demonstrated consistently high satisfaction, reinforcing the impact of relationship-based care. Multi-year trends revealed persistent community-level disparities, guiding continued focus on food, transportation, utilities, and housing support.

Program performance remained strong, supported by a stable workforce and ongoing training through the 2025 Learning Series. Quality and compliance indicators demonstrated adherence to state and accreditation standards, positioning the program well for 2026 NCQA reaccreditation activities. As OU Sooner HAN expands services and continues to refine its processes across entities, the network remains committed to delivering high-quality, coordinated, and data-informed care to Oklahoma's Medicaid Members.

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

# ORGANIZATIONAL OVERVIEW

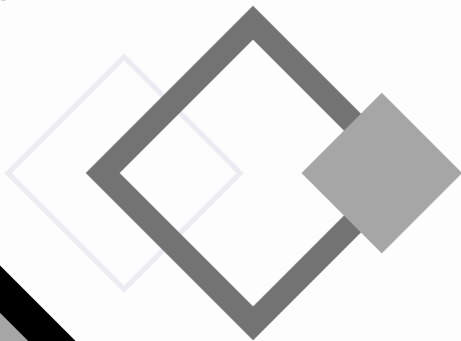
The OU Sooner Health Access Network (HAN) started as part of Oklahoma's 1115 Medicaid Waiver designed to support the Patient-Centered Medical Home model serving SoonerCare Choice members.

The OU Sooner HAN has spent over a decade building a comprehensive and complex care management system to support primary care practices and their members across the state of Oklahoma.

In June 2023, the OU Sooner HAN received National Committee for Quality Assurance (NCQA) accreditation for its Complex Case Management Program. Accreditation was awarded for a three year period and represented the first Complex Case Management *accreditation of its kind in Oklahoma.*

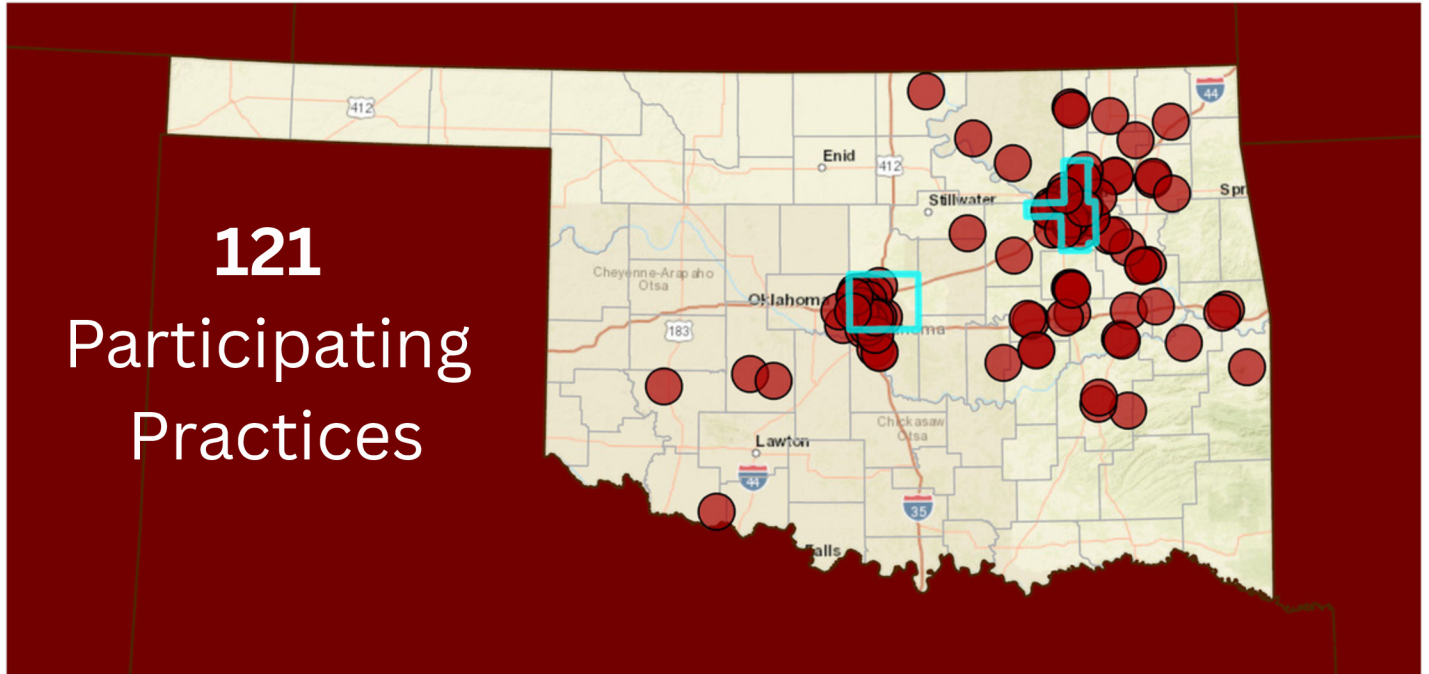
In April 2024, the OU Sooner HAN expanded services to include SoonerSelect members and providers enrolled with Aetna Better Health of Oklahoma. Beginning in 2025, the OU Sooner HAN further expanded to serve SoonerSelect members with Oklahoma Complete.

All services and outcomes described in this report are presented at an aggregate level and reflect the OU Sooner HAN's ongoing commitment to equity, access, regulatory compliance, and member privacy.

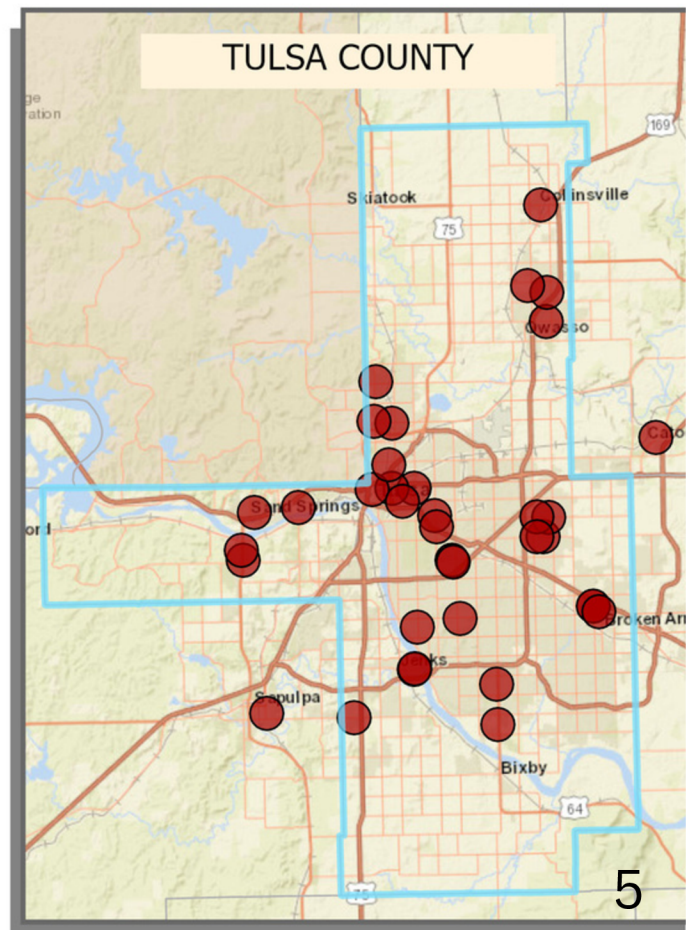
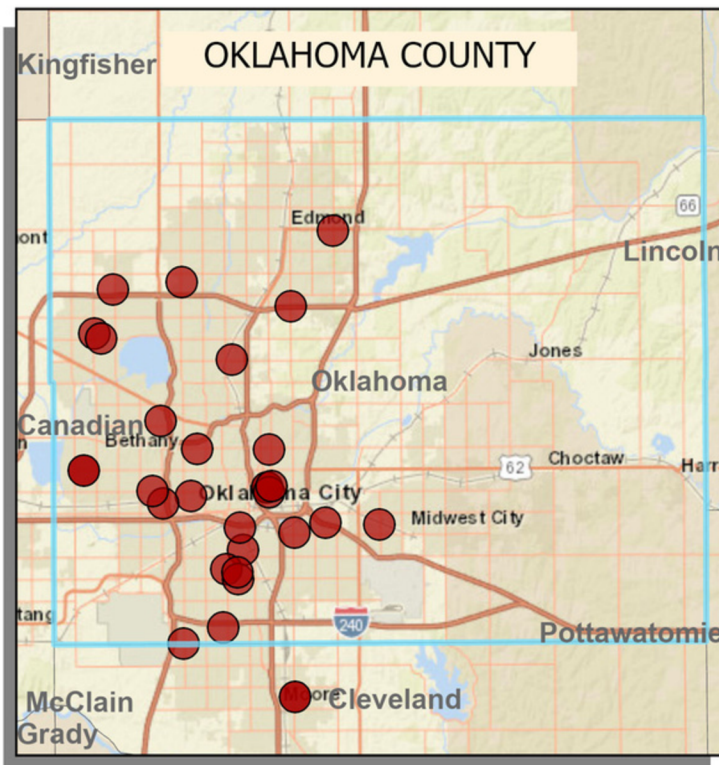


The OU Sooner Health Access Network's work is guided by a commitment to coordinated, member-centered care that improves outcomes, strengthens primary care practices, and promotes equitable access across Oklahoma.

# OU Sooner HAN Primary Care Practices



*Geographic distribution of primary care practices participating in the OU Sooner Health Access Network*



# Partnerships & Collaboration

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- Hosted statewide Managed Medicaid convenings in April and November 2025 in partnership with the **George Kaiser Family Foundation (GKFF)**, supporting cross-system alignment among state agencies, payors, and community partners.
- Strengthened relationships with primary care practices through targeted operational support, including workflow troubleshooting, scheduling coordination, and care management integration.
- Continued collaboration with community organizations and provider groups to promote equitable access, support transition readiness and reinforce coordinated care delivery statewide.

*These partnerships expand HAN's statewide reach and strengthen coordinated, equitable care delivery for SoonerCare Choice and SoonerSelect members.*



# PROGRAM REACH & ENGAGEMENT



**OKLAHOMA**  
Health Care Authority

## Member Population Overview

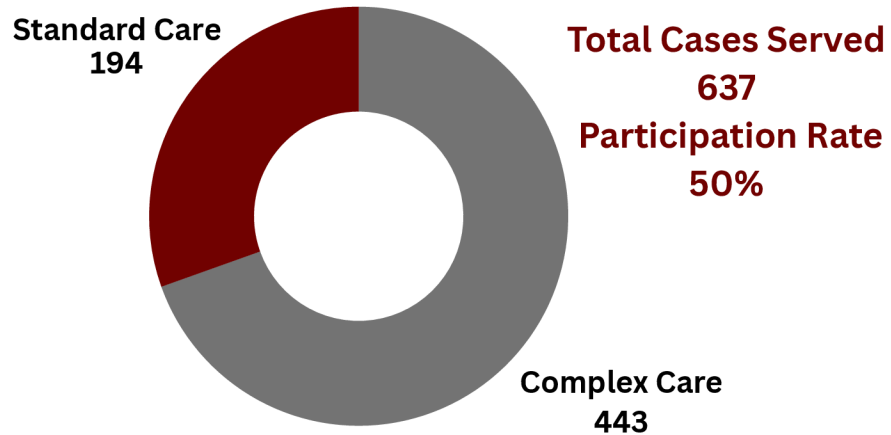
In 2025, the OU Sooner Health Access Network provided care management services to members attributed to Oklahoma Health Care Authority (OHCA). The following summarizes the distribution of members served during 2025.

## Unique Members

**47,496**

Represents all distinct members who appeared on the roster at any point during the year.

## Care Group Distribution



Language	Distinct Members	Percentage
English	46,708	98.3%
Spanish	498	1%
Unknown	290	0.6%

Age Group	Distinct Members	Percentage
Under 18	23,358	49.2%
18 and Over	23,836	50.2%

# PROGRAM REACH & ENGAGEMENT



Aetna Better Health® of Oklahoma

## Member Population Overview

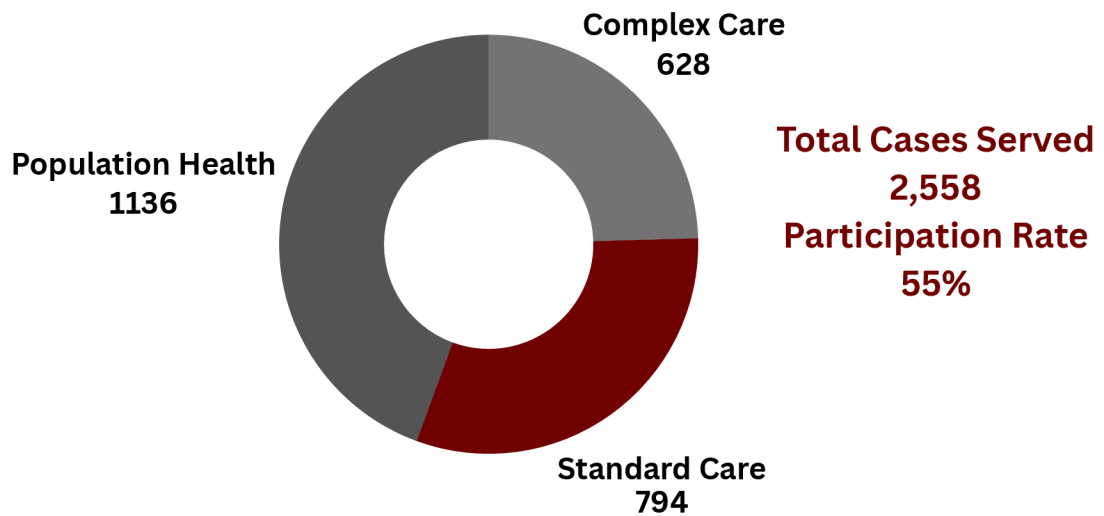
In 2025, the OU Sooner Health Access Network provided care management services to members attributed to Aetna Better Health of Oklahoma (ABHOK). The following summarizes the distribution of members served during 2025.

## Unique Members

**79,478**

Represents all distinct members who appeared on the roster at any point during the year.

## Care Group Distribution



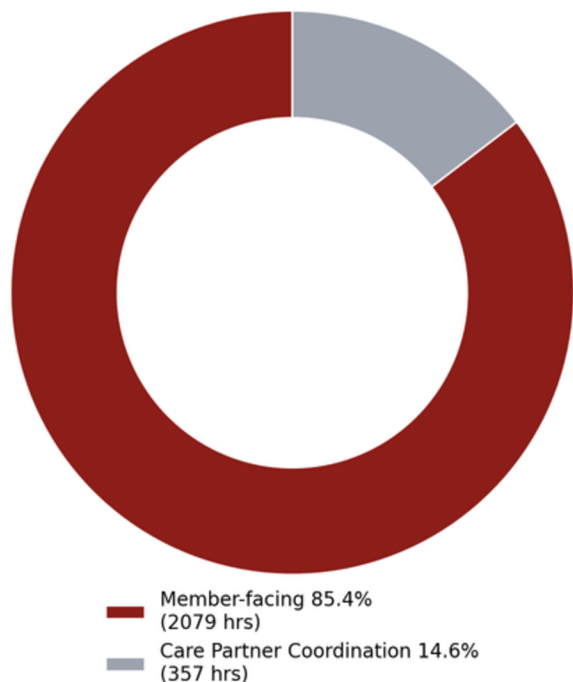
**Total Cases Served**  
2,558  
**Participation Rate**  
55%

Language	Distinct Members	Percentage
English	65,660	82.6%
Spanish	13,816	17.4%
Unknown	2	0%

Age Group	Distinct Members	Percentage
Under 18	49,779	62.6%
18 and Over	29,699	37.4%

# CARE MANAGEMENT ACTIVITIES

OHCA — Time Distribution (CY 2025)



\* Member-facing includes contact with parents/guardians or others acting on behalf of the member.

Total Contacts Completed: 8,030

Member-Facing Time: 85.4%

Visit Modality:

- 7,696 Telephone
- 332 In-Person
- 2 Virtual

In 2025, care managers supported OHCA members through extensive outreach and coordination efforts. Eighty-five percent of care-management time was spent engaging directly with the member or a direct caregiver, demonstrating a strong emphasis on member-facing work. Among those member-facing outreach attempts, 68% resulted in successful connection with the member or their direct caregiver. Engagement focused on supporting members and families, reinforced by collaboration with primary care practices, community agencies, pharmacies, and other care partners.

## Member Experience Survey (NEW in 2025)

All OHCA survey responses selected the highest option for every item.

- 100%** felt they were treated with Dignity/Respect
- 100%** felt the care manager listened to them
- 100%** felt information was explained clearly
- 100%** were satisfied with Care Management Services
- 100%** said their plan of care met expectations

## Top Box Rates

Top box= 'Always' / 'Above Expectation'

# MEMBER SUCCESS STORY

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“**Maria**” had been living with poorly controlled diabetes alongside behavioral health challenges and was referred to OU Sooner HAN when her A1C reached 11.0. Maria shared that she felt overwhelmed and had put off several important preventive care needs.

Through monthly check-ins, Maria’s care manager helped break her health goals into specific, achievable steps with clear timelines. Together, they focused on re-establishing primary care, completing overdue screenings, and building sustainable daily routines.

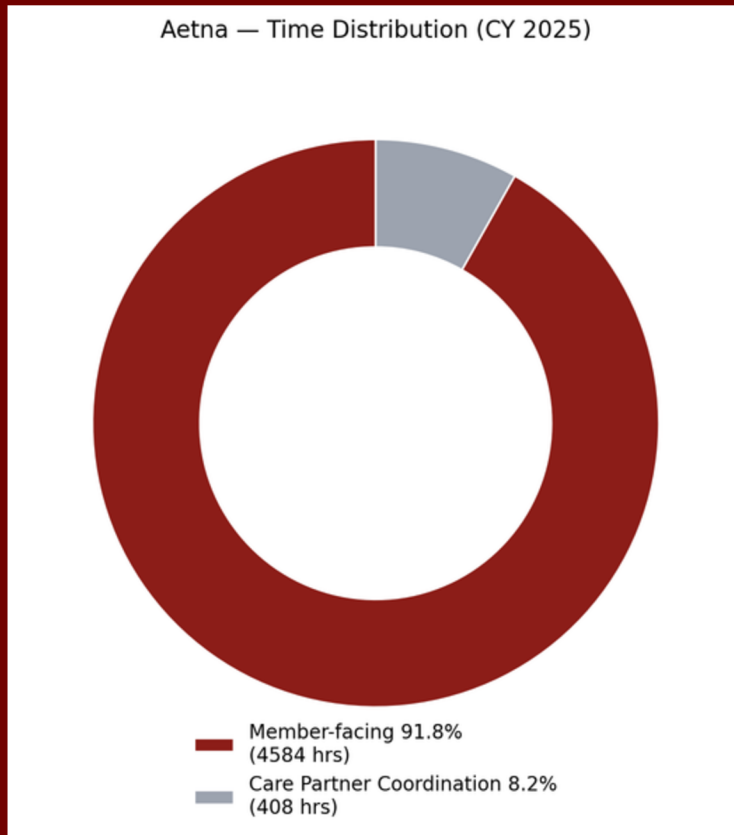
## **Over the following months, Maria:**

- Completed multiple overdue preventive screenings
- Re-established regular visits with primary care
- Increased her daily activity
- Became up-to-date on recommended vaccinations
- Reported feeling more confident and supported in managing her health

Maria’s most recent A1C improved from **11.0 to 7.8**, reflecting a meaningful improvement in her diabetes control. She shared that the consistent support, encouragement, and accountability from her care manager were key in helping her stay motivated and reconnect with her care team.

*This story reflects the impact of structured care management in improving chronic disease outcomes and member empowerment.*

# CARE MANAGEMENT ACTIVITIES



Total Contacts Completed: 47,460

Member-Facing Time: 92%

Visit Modality:

- 47,375 Telephone
- 83 In-Person
- 2 Virtual

In 2025, care managers supported Aetna members through a high volume of outreach and coordination activities. Ninety-two percent of care-management time was spent engaging directly with the member or a direct caregiver, reflecting the team’s strong focus on member-facing support. Of those member-facing outreach attempts, 75% resulted in a successful connection with the member or their direct caregiver. Engagement centered on members and families, supported by coordination with primary care providers, pharmacies, and guardians to address both clinical needs and social barriers.

\* Member-facing includes contact with parents/guardians or others acting on behalf of the member.

## Member Experience Survey (NEW in 2025)

Members consistently reported feeling respected, heard, and clearly informed.

<b>100%</b>	felt the care manager listened to them
<b>92%</b>	felt they were treated with Dignity/Respect
<b>92%</b>	felt information was explained clearly
<b>85%</b>	were satisfied with Care Management Services
<b>77%</b>	said their plan of care met expectations

## Top Box Rates

Top box= ‘Always’ / ‘Above Expectation’

# MEMBER SUCCESS STORY

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“Luis” had been living with type 2 diabetes and struggled to manage his health needs due to a significant language barrier. During initial outreach using a language-interpretation service, Luis shared that he had run out of glucose-testing supplies and wasn’t sure how to find the correct replacements. When contacting his primary care provider (PCP), the care manager learned that Luis had not been seen in more than two years, despite believing he had recently completed follow-up after a hospital stay.

The care manager helped Luis schedule a PCP appointment and offered to attend to support communication. At the visit, professional interpretation ensured clear conversation between Luis and his provider. Luis arrived with family members who had been attempting to interpret for him but were uncomfortable doing so, making professional support especially important.

During the appointment, Luis learned that his A1C had improved from **11.6 to 6.2**, but his blood pressure was elevated, requiring him to restart a previous medication. Luis shared that avoiding care, difficulty scheduling appointments, and not knowing how to communicate his needs had kept him from seeking help. The care manager reassured him that she would continue supporting him with care coordination and future appointments. A crucial detail surfaced when the care manager discovered that Luis was still using an insulin pen the provider had not realized he was taking. After the visit, she followed up with the clinic to provide the exact name and dose so that the correct prescriptions could be added to his medication list and ordered through his pharmacy.

*This story demonstrates how OU Sooner HAN Care Managers help bridge communication gaps for members with limited English proficiency—ensuring accurate medication management, restoring continuity of care, and empowering members like Luis to engage confidently in their health.*

# SOCIAL DRIVERS OF HEALTH

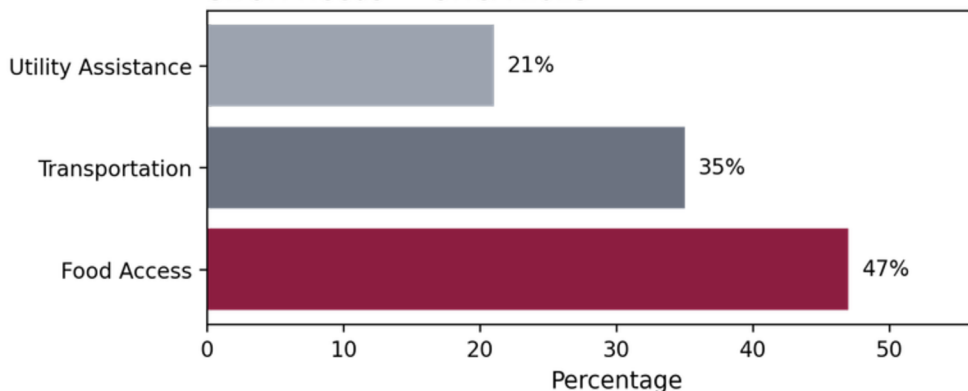


**OKLAHOMA**  
Health Care Authority

SDOH NEED	PERCENTAGE OF MEMBERS INDICATING NEED N=211	PRIMARY ZIP HOT SPOTS
<b>Food</b>	47%	73119, 73107, 73104, 73110, 73127, 74136, 74447, 73114
<b>Transportation</b>	35%	73107, 73117, 74136, 73119, 74106, 73114, 73139, 74110, 74126
<b>Utility Assistance</b>	21%	73107, 74136, 74954, 73117, 74107, 73114

- **Food insecurity (47%)** remains the most reported need, indicating ongoing nutrition vulnerability.
- **Transportation barriers (35%)** and **utility instability (21%)** continue to impact access to care and essential services.
- Persistent ZIP code hot spots (73107, 74106, 74136, 73114, 73117, 73119) appear across multiple SDOH domains, reflecting concentrated geographic disparities.
- Several high-need ZIP codes include pediatric populations, indicating family-level social risk factors affecting children and caregivers.

SDOH Needs — OHCA 2025



North/Northeast OKC (73114, 73117), South/Southwest OKC (73119, 73107), and South Tulsa (74136) emerge as the primary geographic hotspots, with repeated SDOH needs concentrated across these communities.

Referral trends align closely with identified SDOH needs

## Top Referral Categories

- Food Assistance
- Utility Support
- Housing Resources

# MEMBER SUCCESS STORY

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“**James**” was transitioning out of a sober-living program and needed support to secure stable housing and rebuild daily structure after treatment. James had worked hard in his recovery, but he shared that financial stress and uncertainty about next steps made him fear he might lose progress.

Through regular care-management check-ins, James received support navigating housing resources, maintaining recovery routines, and strengthening natural supports. With consistent encouragement, James completed his sober-living program, secured stable housing, and reconnected with family. He later shared his story as a speaker at one of his former sober-living facilities, offering hope to others working toward recovery.

**Reflecting on this progress**, James expressed deep appreciation for the steady support he received during this transition, noting that having someone walk alongside him eased his stress and helped him stay focused on recovery. As James put it, “life is falling into place.”

*This story highlights the impact of housing stability and care management support in strengthening recovery outcomes.*

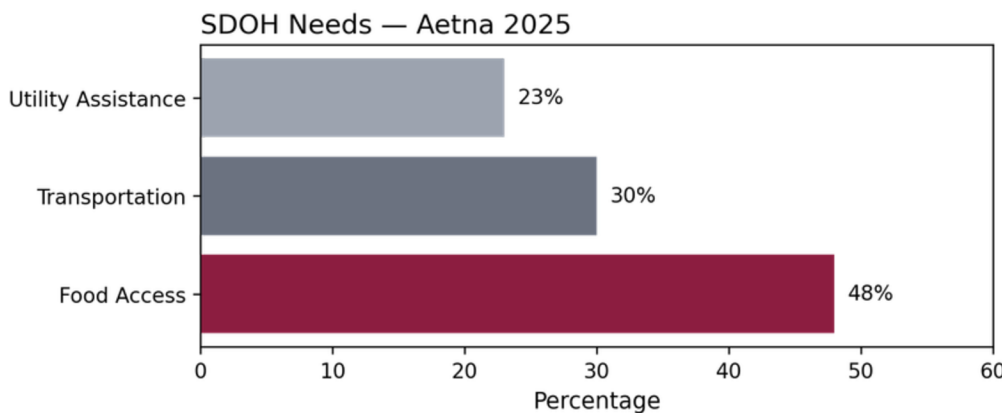
# SOCIAL DRIVERS OF HEALTH



Aetna Better Health® of Oklahoma

SDOH NEED	PERCENTAGE OF MEMBERS INDICATING NEED N=1164	PRIMARY ZIP HOT SPOTS
Food	48%	74106, 74115, 74126, 74135, 74136, 74110
Transportation	30%	74106, 74110, 73142
Utility Assistance	23%	74106, 74012, 73129, 74115

- **Food Insecurity (48%)** remains the most reported need, indicating ongoing nutrition vulnerability.
- **Transportation barriers (30%)** and **utility instability (23%)** continue to impact access to care and essential services.
- Persistent Zip code hot spots (74106,74115,74110) appear across multiple SDOH domains, reflecting concentrated geographic disparities in the North/Northeast Tulsa Region.
- Pediatric populations (0-18) mirror these patterns, suggesting family-level and intergenerational social risk factors.



Multi-year trends (2024-2025) demonstrate recurring concentration in select Tulsa-area Zip codes, indicating sustained needs rather than isolated annual variation.

Referral trends align closely with identified SDOH needs

## Top Referral Categories

- Food Assistance
- Housing Resources
- Transportation & Utility Support

# MEMBER SUCCESS STORY

---

“**Anthony**” had recently completed inpatient treatment for substance use and transitioned to Aetna in hopes of accessing the Short-Term Housing (STH) benefit. After moving into a sober-living home with no income, he worried that the financial strain of paying rent might jeopardize his early recovery. Anthony shared that, despite wanting a fresh start, the uncertainty of how he would maintain stable housing felt overwhelming.

With support from his care manager, Anthony gathered the necessary discharge paperwork and applied for the STH benefit. His application was approved, and the benefit covered his first two months of housing—relieving immediate financial pressure and giving him space to focus on rebuilding his life.

With housing secured, Anthony turned his attention to creating a daily routine and searching for employment. During a follow-up call, he expressed feeling “blessed,” sharing that he had begun working full-time and continued to maintain sobriety. Anthony emphasized that having his rent covered through the STH benefit made a tremendous difference, allowing him to stay grounded in his recovery without the fear of losing stable housing.

*This story reflects the impact of care management and housing stability in supporting recovery and long-term member success.*

# Emergency Department Utilization

**27,047**  
Total ER events

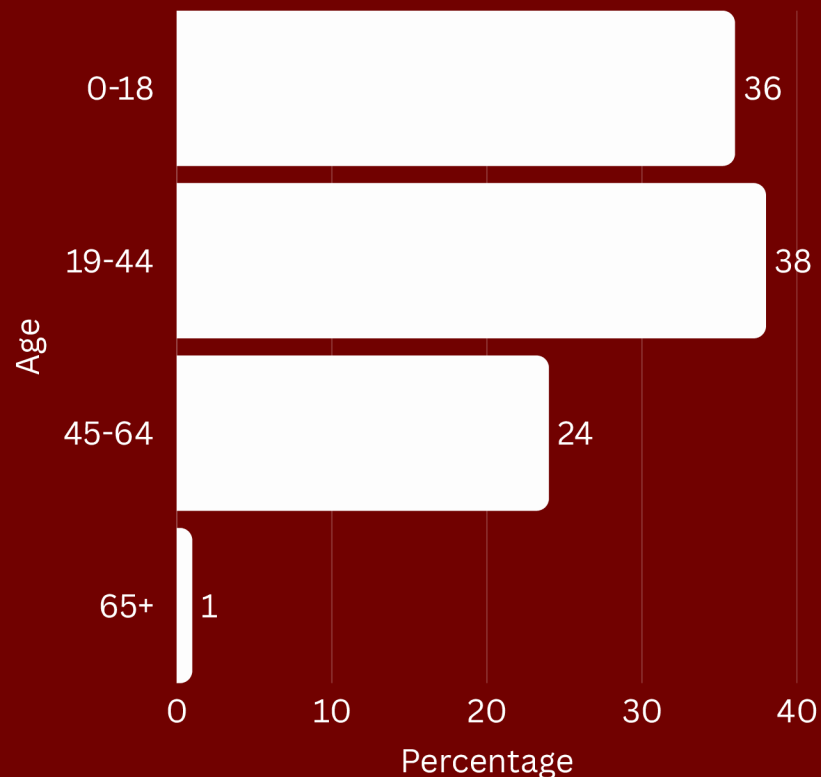
Utilization patterns reflect seasonal respiratory illness trends and a predominantly pediatric and young adult population.

Utilization peaked in January (3,084 visits), consistent with winter respiratory season trends

## Top ER Visit Categories

- Upper respiratory & viral illness (URI, influenza, viral infection)
- Chest pain (R07.9, R07.89)
- Gastrointestinal symptoms (N/V, abdominal pain)
- Urinary tract infection
- Sickle cell crisis

Distribution of ER Events by Age Group  
Percent of total ER events



# Emergency Department Utilization

After a decade of year-over-year declines in ER events per 1,000 SoonerCare Choice members, 2025 marked the first increase. This shift occurred during significant demographic changes within the OU Sooner HAN population: overall membership decreased, while the proportion of Aged, Blind, and Disabled (ABD) members grew. Because the ABD population has higher medical and behavioral complexity, ER utilization naturally rose even as the total member count declined.

To address these trends, OU Sooner HAN continues to strengthen targeted, data-informed strategies. A new weekly Admission, Discharge, and Transfer (ADT) feed provides near-real-time visibility into ER use, allowing care managers to engage members more quickly following an encounter. Additional efforts focus on improving follow-up, strengthening prevention, and coordinating care around the conditions that most often lead members to the emergency department.

Top ER Drivers	Care Management Intervention
Upper respiratory & viral illness	<ul style="list-style-type: none"> <li>• PCP linkage Campaign</li> <li>• Seasonal vaccination campaign</li> </ul>
Chest pain	<ul style="list-style-type: none"> <li>• Targeted member education on prevention, symptom management, and follow-up care</li> </ul>
Gastrointestinal symptoms	<ul style="list-style-type: none"> <li>• PCP linkage campaign</li> <li>• Cologuard screening campaign</li> </ul>
Urinary tract infection	<ul style="list-style-type: none"> <li>• Follow-up care coordination after ER events to ensure timely treatment and symptom resolutions</li> </ul>
Sickle cell crisis	<ul style="list-style-type: none"> <li>• Participation in the state-led Sickle Cell Task Force</li> <li>• Targeted provider education and resource support</li> </ul>

# Emergency Department Utilization

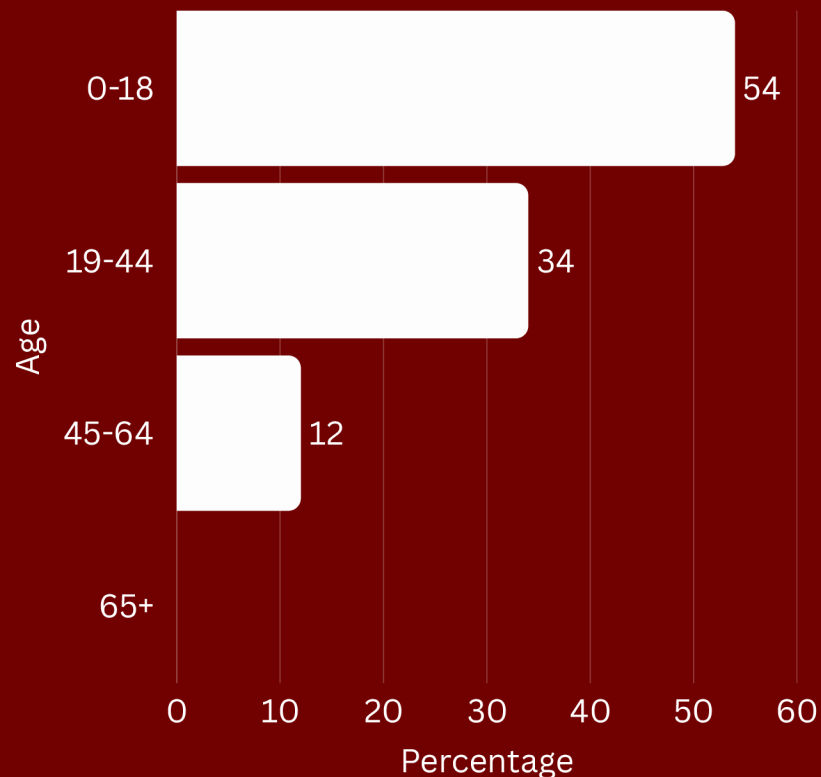
**20,130**  
Total ER events

Utilization patterns reflect seasonal respiratory illness trends and a predominantly pediatric and young adult population.

## Top ER Visit Categories

- Upper respiratory infections & symptoms
- Trauma-Head Injury & Lacerations
- Dermatologic-Rash/Skin Conditions

Distribution of ER Events by Age Group  
Percent of total ER events



# QUALITY AND COMPLIANCE PERFORMANCE

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## Key Indicators

- **94.02%** of completed social needs referrals.
- **91.11%** of new members screened for social drivers of health.
- **100%** of members in the complex diabetes care group had a documented A1C in 2025.

## Hepatitis C Quality Initiative (Continuation from 2024)

OU Sooner HAN continued the Hepatitis C identification and outreach project begun in 2024. In 2025, efforts focused on identifying members with known Hep C diagnoses who lacked documented treatment completion, coordinating follow-up with primary care, and addressing engagement barriers to support linkage to care.

## NCQA Reaccreditation (2026)

OU Sooner HAN enters the NCQA Complex Case Management reaccreditation window in 2026. Quality monitoring in 2025—including documentation audits, performance reviews, and internal compliance checks supported readiness and continuous improvement.



**OKLAHOMA**  
Health Care Authority

# QUALITY AND COMPLIANCE PERFORMANCE

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## Key Indicators

- **100%** of comprehensive assessments and reassessments completed on time.
- **100%** of members in the Intensive Diabetes care group had a documented A1C in 2025.

## Summary

In 2025, OU Sooner HAN maintained strong alignment with OHCA quality and compliance expectations through routine documentation audits and timeliness monitoring. The program achieved 100% compliance with Aetna delegated audits and KFMC reviews, reinforcing strengths in documentation completeness and adherence to care management standards.

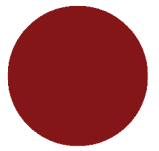
## NCQA Reaccreditation (2026)

OU Sooner HAN enters the NCQA Complex Case Management reaccreditation window in 2026. Quality monitoring in 2025—including documentation audits, performance reviews, and internal compliance checks supported readiness and continuous improvement.



Aetna Better Health® of Oklahoma

# Program Stability & Workforce Sustainability



In 2025, the OU Sooner Health Access Network maintained a stable, multidisciplinary workforce supporting coordinated care delivery across contracted entities. Workforce continuity contributed to consistent member engagement, reliable documentation practices, and sustained quality performance.

## Stability Indicators

- Minimal clinical turnover during 2025
- All newly created positions successfully recruited and onboarded
- Continued alignment with NCQA Complex Case Management standards
- Successful completion of external and contractual audits

## Workforce Development & Professional Excellence

The program continued its structured Learning Series in 2025 to support professional development and promote consistency in care management practices. Monthly sessions were offered at no cost, with Continuing Education Units (CEUs) available through the University of Oklahoma School of Social Work. Trainings strengthened clinical knowledge, reinforced member-centered care delivery, and supported collaboration across OU Sooner HAN staff and contracted primary care practices.

## Participation Snapshot

- **Over 900 attendees** across the 2025 Learning Series

In addition, pre- and post-test results from the Fundamentals of Care Management training demonstrated measurable improvement in participant understanding.

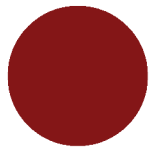
- **February: 49.4% → 92%**
- **May: 54.9% → 96%**
- **September: 53.6% → 89%**

### Participant Perspective

*“The training applied concepts to real-life scenarios and welcomed participant feedback and shared experiences.”*

The Fundamentals of Care Management program strengthens core competencies and ensures consistency in care management practices. This structured training reinforces clinical knowledge, supports accurate documentation, and sustains high-quality, member-centered care aligned with accreditation expectations.

# Looking Forward 2026 Priorities



As OU Sooner HAN enters 2026, the network continues to build on a **year of transition, stabilization, and expanded responsibilities under the SoonerSelect model**. With operations spanning multiple contracted entities, the focus remains on reliable, member-centered care coordination and strong collaboration with primary care practices and community partners.

## Key Areas of Focus

- **Care management workflow excellence** — strengthen assessment timeliness, follow-up reliability, and documentation consistency across all entities
- **Cross-system collaboration** — deepen coordination with state agencies, payors, and community organizations to address social drivers of health and streamline service navigation
- **Primary care partner support** — enhance operational guidance (scheduling, handoffs, post-ED/transition workflows) to reduce access barriers and improve continuity
- **Data & reporting** — advance integration, performance monitoring, and actionable dashboards to support decision-making and evaluation of member outcomes
- **Workforce development** — expand training, case consultation, and accreditation-aligned education for care managers and partner clinics
- **NCQA readiness** — sustain compliance and quality oversight activities as the Complex Case Management program enters the reaccreditation window in 2026

OU Sooner HAN remains committed to delivering **high-quality, equitable, and person-centered care**—supporting members, families, and providers as Oklahoma’s Medicaid landscape continues to evolve.



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