PHPG

Population Care Management Department Evaluation

Oklahoma Health Care Authority Project Request 14-2

Conducted by:

The Pacific Health Policy Group

On behalf of:

State of Oklahoma
Oklahoma Health Care Authority
Population Care Management Department

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Table of Contents

EXECUTIVE SUMMARY

Introduction

The Population Care Management (PCM) Unit was formed in 2000 by a decision of the OHCA Executive Staff to coordinate the needs of SoonerCare members with complex medical needs. The goals of the PCM Department are to achieve better health care, better health, and reduced costs by facilitating and coordinating the delivery of quality health care to SoonerCare members. The PCM Department houses three distinct departments and programs to provide care management and coordination services for SoonerCare members: Health Management Program, Chronic Care Unit, and Case Management Unit.

The SoonerCare Health Management Program (HMP) is directed to address the needs of chronically ill SoonerCare members through practice facilitation for providers and health coaching for members that takes place at provider practices. Nurses in the Chronic Care Unit (CCU), called Exceptional Needs Coordinators (ENCs), provide telephonic case management to targeted members with conditions who are not in a practice with an HMP health coach. The Case Management Unit (CMU) provides episodic or event-based case management services and certain supportive eligibility determinations and utilization management functions to other areas of the OHCA.

The Pacific Health Policy Group (PHPG) was retained to analyze the history, analytical framework, and value of the OHCA's Population Care Management (PCM) Unit. It should be noted that although PHPG's analysis was limited to programs and services within the CMU, the overarching program area was the PCM Department; therefore, PCM Department terminology is used interchangeably throughout this report.

Evaluation Scope and Methodology

The OHCA's Population Care Management (PCM) Unit Evaluation report focuses on a select group of PCM programs. Each program chapter is organized into sections that include a program history and overview, program eligibility, program process and flowchart(s), evaluation methodology, and evaluation results. Each program chapter examines a unique set of measures that are specific to a particular program and agreed upon by the OHCA PCM Department representatives.

The evaluation measures may fall into two categories, depending on a particular program:

- *Process Measures* that evaluate program enrollment, demographics and case management activities

- *Outcome Measures* that evaluate the program's impact on service utilization and expenditures and achieving high levels of member satisfaction.

PHPG collected data for the evaluation through a variety of methods. These included data sets from the Atlantes care management system, analysis of eligibility, and paid claims data and surveys of members who were enrolled in the PCM Department's obstetric and pediatric programs. A summary of findings is presented below for each PCM program that PHPG evaluated.

High Risk Obstetrics Case Management Program

Overview

The High Risk OB (HROB) case management program was implemented on December 1, 2007. The program offers SoonerCare members who are pregnant an enhanced benefit package (e.g., increased ultrasounds, non-stress tests, biophysical profiles) and the opportunity for co-management by both an OB/GYN provider as well as a Maternal Fetal Specialist to reduce potential complications. To qualify, SoonerCare members must meet certain qualifying maternal or fetal conditions.

Evaluation Findings

Analysis of HROB Enrollment and ENC Activities

From SFY 2008 through SFY 2013 there were 5,946 HROB members that the PCM Department case managed. Sixty percent of HROB members resided in the urban counties of Cleveland, Oklahoma, and Tulsa. Over 70 percent of HROB members fell into the age range of 21 to 34 years of age. Seventy-three percent of HROB members were enrolled fewer than three months, with 30 percent enrolled five to eight weeks in duration.

Member contact rates varied by SFY and ranged from 37 to 74 percent. The average contact rate across all SFYs was 58.5 percent. The average number of member contacts across all SFYs was 6.6 contacts per member. From SFY 2008 through 2013, ENCs spent an average of 1.4 to 2.6 hours per case across all activities. Average ENC hours per case and equivalent FTEs decreased in SFY 2012 and 2013. The number of FTEs required for the HROB Program varied from a high of around 1.6 FTEs in SFY 2011, decreasing to 1.0 FTE in SFY 2013. The initial assessment rate increased by 25 percent from SFY 2012 through SFY 2013 when there was a 77 percent compliance rate. From SFY 2008 through 2013, ENCs mailed an average of 2.7 to 3.9 letters per member.

HROB Utilization and Cost Outcomes

The four-year average rate of early gestation and low birth weight deliveries was nearly 20 percent. From SFY 2010 through SFY 2013, the percentage of early gestation and low birth weight deliveries declined by 25 percent. From SFY 2010 through SFY 2013, NICU admission rates remained relatively constant. On average, 13 percent of HROB deliveries resulted in a NICU admission.

The four-year average for cesarean section rates was 12 percent. The percent of HROB members who received pre-term labor pharmaceuticals was fairly low with an average of 0.8 to 2.7 percent over the four-year period. Readmission rates within 30 and 60 days of the mother's delivery declined steadily from SFY 2011 through SFY 2013, though the rates were higher at 60 days compared to 30 days. Similarly, ER visits declined from SFY 2011 through SFY 2013 at both the 30- and 60-day mark, though the rates were again higher at the 60-day mark. Inpatient admission rates per 1,000 children remained relatively steady over each SFY. ER visit rates per 1,000 children increased from SFY 2012 to SFY 2013.

Between SFY 2011 and 2013, total HROB program expenditures and expenditures per case for both mother and child increased steadily. Total expenditures for both mother and child were $57.4 million, which were equally divided between both cohorts. HROB benefits comprised approximately three percent of the total expenditures for the mother.

HROB Member Survey Findings

Overall, 73.2 percent of respondents were very satisfied with the help they received from their case manager. Overall satisfaction with the HROB program (72.9 percent) closely tracked to the case manager satisfaction ratings. The overwhelming majority of surveyed participants (93.2 percent) would recommend the HROB program to a friend with similar health care needs.

OB Outreach Program/At Risk OB Program

Overview

The OHCA's OB Outreach (OBOR) Program was implemented in the OHCA's Member Services Department on July 1, 2008. The OHCA's OB Outreach Program provides targeted outreach for SoonerCare pregnant members to connect them with benefits and resources, to ensure they are linked with an obstetric provider for prenatal care, and to identify women who are at risk for poor birth outcomes who may benefit from case management services.

The PCM Department has an At Risk OB (AROB) Case Management Program to assess At Risk OB members and to provide them with education, linkage to resources, and routine follow-up in an effort to reduce potential complications. Members are identified for the program through outreach letters and subsequent positive screenings by the OHCA Member Services Department as part of the OB Outreach Program. The AROB Program was implemented February 1, 2008.

Evaluation Findings

At the OHCA's request, PHPG performed an evaluation of both programs. The following sections describe the history and overview of the two programs, as well as evaluation findings.

OB Outreach Program Process Measures Summary

Since its inception on July 1, 2008, through SFY 2013, Member Services mailed 97,700 Pat Brown letters. Member Services has received calls and completed OBOR screenings for 40,217 members (40 percent) who responded to the Pat Brown letter. Since July 2008, Member Services has answered 99 percent of all the inbound phone calls presented to them, the highest rate of any OHCA or OHCA-contracted call center. Of the 40,217 members who called in response to their letter and received an OBOR screening, 4,632 (11.5 percent) had a positive screening and were subsequently referred to the PCM Department for evaluation for the AROB program.

Analysis of At Risk OB Enrollment and ENC Activities

From SFY 2008 through SFY 2013, there were 2,016 AROB members that the PCM Department case managed. Nearly 90 percent of AROB enrollment was split between urban and rural counties. The vast majority of AROB members (73 percent) fell into the age range of 21 to 34 years of age. Over 60 percent of members were enrolled three months or less in the AROB program, with 30 percent enrolled only one to four weeks in duration.

The average contact rate across all SFYs was 55.7 percent. The average number of member contacts across all SFYs was 6.1 contacts per member. From SFY 2008 through 2013, ENCs spent an average of 1.2 to 3.5 hours per case across all activities, and FTEs ranged from 0.01 in SFY 2008 to 0.5 in SFY 2010. The initial assessment rate increased by nine percent from SFY 2012 to SFY 2013 when there was a 55.1 percent compliance rate. From SFY 2008 through 2013, ENCs mailed an average 2.4 to 4.2 letters per member.

AROB Utilization and Cost Outcomes

The four-year average rate of early gestation and low birth weight deliveries was 12.5 percent. From SFY 2010 through SFY 2013, NICU admission rates remained relatively constant. On average, 10.4 percent of AROB deliveries resulted in a NICU admission. The four-year average for AROB cesarean section rates was 10.2 percent.

Readmission rates within 30 days and 60 days of the mother's delivery declined steadily from SFY 2012 through SFY 2013. Similarly, ER visits declined at both the 30- and 60-day mark. Inpatient admission rates per 1,000 for newborns through the first year of life remained relatively steady over each SFY. ER Visit rates decreased from SFY 2012 through SFY 2013.

Between SFY 2011 and 2013, total AROB program expenditures and expenditures per case for the mother and child increased substantially. Total expenditures for both mother and child were $8.9 million. Children comprised a third greater proportion of total expenditures than did the mother in this program.

AROB Member Survey Findings

Overall, 81.5 percent of respondents were very satisfied with the help they received from their case manager. Overall, 71.4 percent of respondents were very satisfied with the AROB program. The overwhelming majority of surveyed participants (97.1 percent) would recommend the AROB program to a friend with similar health care needs.

Fetal Infant Mortality Reduction Mom Program

Overview

The Fetal Infant Mortality Reduction (FIMR) Mom case management program was implemented on March 21, 2011. The program provides case management services to SoonerCare pregnant members who reside in one of the top ten counties with the highest fetal Infant Mortality Rates (IMRs). Upon enrollment into SoonerCare, FIMR members are automatically provided case management services to reduce potential complications.

Evaluation Findings

Analysis of FIMR Mom Enrollment and ENC Activities

From SFY 2011 through SFY 2013 there were 4,370 FIMR Mom members that the PCM Department case managed. Nearly two-thirds of FIMR Moms fell into the age range of 21 to 34 years of age. Fifty-seven percent of members were enrolled four to nine months. Nearly 40 percent of FIMR Mom members were enrolled three months or less.

The average contact rate across all SFYs was 58.7 percent. The average number of member contacts across all SFYs was 8.5 contacts per member. From SFY 2011 through 2013, ENCs spent an average of 2.0 to 3.7 hours per case across all activities. In total, the FTEs required for the FIMR Mom program ranged from 1.2 to 2.5 FTEs. From SFY 2011 through 2013, ENCs mailed an average of 4.3 to 4.8 letters per member.

FIMR Mom Utilization and Cost Outcomes

This section highlights FIMR Mom utilization and cost trends by SFY using claims and eligibility data for SFY 2011 through SFY 2013. For each measure, a comparison of outcomes was performed for FIMR Mom members who reside in the ten FIMR counties to individuals who reside in ten comparison counties and who were not enrolled in the FIMR Mom program. The ten comparison counties provided by OHCA had IMRs similar to the ten FIMR counties.

The three-year average for cesarean section rates was 9.9 percent compared to 1.8 percent in the comparison group. Readmission rates within 30 and 60 days of the mother's delivery were higher in the comparison group than in the FIMR Mom population (1.4 and 1.9 percent compared to 4.9 and 5.3 percent). ER visits within 30 and 60 days were higher in the FIMR Mom population at both intervals (8.6 and 12.5 percent compared to 6.5 and 10.6 percent).

While total program expenditures were higher in the comparison group ($9.8 million) compared to the FIMR Mom population ($8.1 million), total expenditures per case were 39 percent higher in the FIMR Mom cohort ($4,566.18 compared to $2,764.39). This is likely attributable to a lower acuity mix in the non-FIMR counties and selection bias among individuals who were enrolled in FIMR Mom and who were truly high need.

FIMR Mom Member Survey Findings

Overall, 73.2 percent of respondents were very satisfied with the help they received from their case manager. Overall, 68.3 percent of respondents were very satisfied with FIMR Mom program. The overwhelming majority of surveyed participants (88.3 percent) would recommend the FIMR Mom program to a friend with similar health care needs.

Interconception Care Program

Overview

The Interconception Care (ICC) case management program was implemented on July 1, 2013. The program provides case management services to FIMR moms age 18 or under (teen mothers) who reside in one of the top ten counties with the highest fetal Infant Mortality Rates (IMRs). Upon enrollment, ICC members are identified, and a trigger for automatic referral to case management is made in order to reduce potential birth complications.

Evaluation Findings

The following section details the process and outcome measures that were evaluated for the ICC program. As a reminder, the program was implemented on July 1, 2013 (SFY 2014), so there is currently no trend data for annual comparisons. Caution should be used in interpreting the findings for this program due to the small caseload for ICC (average of 50 members) and the subsequent potential for swings in the findings due to any potential outliers.

Analysis of ICC Enrollment and ENC Activities

During the first half of SFY 2014, there were 38 ICC members that the PCM Department case managed. Nearly 95 percent of ICC Moms fell into the age range of 14-17 years. Over 40 percent of ICC members were enrolled more than one year. This is consistent with the program goal of case managing ICC members for one year postpartum.

Forty-seven percent of ICC members were contacted within three business days. The average number of contacts per member for the first half of SFY 2014 was 6.9. For SFY 2014, ENCs spent 1.9 hours per case across all activities, with an average of 0.03 FTEs. ENCs mailed an average of 3.2 letters per member.

ICC Utilization and Cost Outcomes

The average rate of early gestation and low birth weight deliveries was 24 percent, which exceeded the rate of all other programs that evaluated this measure. The NICU admission rate for ICC members was 17.4 percent. The ICC cesarean section rate was 8 percent.

There were no inpatient readmission claims for ICC participants within 30 and 60 days of delivery. The ER visit rate at 30 days was 16 percent and 20 percent at 60 days. An evaluation was performed of hospitalizations and ER visits for newborns through the first year of life. The ICC inpatient admission rate per 1,000 was 1,043. The ICC ER Visit rate per child was 957.

Total ICC program expenditures and expenditures for both mother and child were nearly $700,000, for which the child's expenditures comprised 56.7 percent of the total. Expenditures per case were $27,987.

ICC Member Survey Findings

Overall, 73 percent of respondents were very satisfied with the help they received from their case manager. Overall, 72 percent of respondents were very satisfied with ICC program. Seventy-five percent of respondents would recommend the ICC program to a friend with similar health care needs.

Prenatal and Postpartum Depression Screening and Referrals

Overview

The OHCA's Behavioral Health Unit (BHU) is an independent unit co-located within the Oklahoma Health Care Authority. The BHU is made up of Licensed Behavioral Healthcare Professionals (LBHPs) who perform intake and connect SoonerCare members with behavioral health resources. Members are referred to the BHU from the PCM Department's case management programs, Health Management Program, and the Chronic Care Unit. Prenatal and postpartum SoonerCare members who have a positive behavioral health screening are eligible; however, members must consent to a referral to the BHU.

Evaluation Findings

For this evaluation, PHPG analyzed the prenatal and postpartum depression screenings performed by the PCM Department and subsequent referrals that were made to the BHU. While a number of members reported receiving a behavioral health screening, there were only a handful of members who said they were referred to the OHCA's BHU. There was considerable variance in prenatal and postpartum behavioral health screening rates across programs.

Only a small percentage had a positive EPDS screening. Of those members, only a few were referred to the BHU. As indicated, these members must consent to a referral to the BHU. Additionally, some members already had existing behavioral health services in place at the time of the EPDS screening. The gaps in data may be the result of cases that were not included in the study but remained open at the time of the analysis. The incomplete data for a particular program or SFY may also be the result of changes over time to the technical and business processes for assessments in the case management software.

Private Duty Nursing Program

Overview

The Private Duty Nursing (PDN) case management program was implemented on April 1, 2004. The program provides components of community-based alternatives to institutional care for children up to 21 years of age who have complex medical needs. Specifically, the program provides in-home skilled nursing care which can be provided safely outside of an institutional setting, to qualified SoonerCare members. The program supports members and their families who assume a portion of the member's care.

Evaluation Findings

Analysis of PDN Enrollment and ENC Activities

From SFY 2004 through SFY 2013 there were 339 PDN members that the PCM Department case managed. There was a decline in enrollment after SFY 2010, which is likely attributable to additional prior authorization requirements and procedures for the PDN services in light of the escalating increase in growth and expenditures. Nearly 90 percent of PDN enrollment was split between urban and rural counties.

Among PDN members, 50 percent reside in urban areas while 40 percent reside in rural areas. The majority of PDN members fell into the birth-to-7 years range (69.9 percent), followed by 18.9 percent of members who were 8 to 14 years of age. Over half of PDN members (53.1 percent) were enrolled less than one year. Nearly 25 percent of members (24.5 percent) were enrolled between one to two years.

Member reach rates varied over the ten SFYs and ranged from 28.6 to 90 percent. Of note is that contact rates exceeded 60 percent for all but three SFYs. The average contact rate across all SFYs was 66.4 percent. ENCs averaged 18.8 to 55.6 contacts per PDN member across the ten fiscal years. The average number of member contacts across all SFYs was 28.6 contacts per member. From SFY 2004 through 2013, ENCs spent an average of 18.4 to 60.5 hours per case across all activities. The total FTEs required for the PDN program ranged from 0.2 to 1.0 FTEs. From SFY 2004 through 2013, ENCs mailed an average of 0.9 to 2.2 letters per member.

PDN Utilization and Cost Outcomes

The four-year average for ER visits per 1,000 was 239. Inpatient admissions fluctuated year over year but averaged 112 per 1,000 members. Readmission rates within 30 days of hospitalization declined from SFY 2011 to SFY 2013 and averaged 26 over the four-year period. Total PDN expenditures declined considerably from SFY 2010 to SFY 2013. Total PDN expenditures were nearly 37 million, and the average expenditures per case were $118,085. Total PMPM expenditures dropped considerably year over year and averaged $9,840.

At Risk Newborn Program

Overview

The OHCA Newborn Outreach Program provides targeted outreach for SoonerCare newborns to identify those who may be at risk and/or have medical conditions, with the goal of automatically enrolling them in the PCM At Risk Newborn Program.

The OHCA's At Risk Newborn (ARNB) Program was implemented on August 1, 2009. The goal of the program is to assess at-risk newborn members and provide them with education, linkage to resources, and follow up in an effort to improve health outcomes and reduce infant mortality. Since August 1, 2009, the PCM Department has collaborated with OHCA's Member Services Department on newborn outreach activities.

Evaluation Findings

Analysis of ARNB Enrollment and ENC Activities

From SFY 2010 through SFY 2013 there were 169 ARNB members that the PCM Department case managed. Over half of the ARNB membership was concentrated in urban counties, and another 35.5 percent resided in rural counties. The vast majority of ARNB members (89 percent) fell into the age range of zero to four weeks. The majority of ARNB members (88.2 percent) were enrolled three months or less, of which 46.2 percent were enrolled for only one to four weeks, and 33.7 percent were enrolled for five to eight weeks.

Compliance rates for contacting members within three business days were extremely high, ranging from 56.4 to 84.6 percent. The average contact rate across all SFYs was 64.5 percent. ENCs averaged 3.5 to 5.2 contacts per member across the four fiscal years. From SFY 2010 through 2013, ENCs spent an average of 1 to 1.6 hours per case across all activities. In total, the FTEs required for the ARNB Program ranged from 0.01 to 0.03 FTEs. The initial assessment rate increased on an annual basis from SFY 2011, with a 49.1 percent compliance rate achieved in SFY 2013. From SFY 2010 through 2013, ENCs mailed an average 0.8 to 4.2 letters per member.

ARNB Utilization and Cost Outcomes

For ARNB, inpatient admissions declined dramatically during the four-year period. Inpatient admissions per 1,000 during the child's first year of life averaged 1,935 per member. ER visits per 1,000 declined in both SFY 2011 and SFY 2013 and averaged 1,634 per 1,000 over the four-year period.

PHPG was able to analyze immunization rates at the two-, three-, and five-month intervals. Two-month rates declined from SFY 2010 to SFY 2011 before experiencing increases through SFY 2013, with a four-year average of only 41.1 percent. Rates at the three-month interval were again low and declined from SFY 2011 to SFY 2013. The four-year average rate was only 27.7 percent. Rates at the five-month interval showed more promise with 50 percent compliance in 2013.

Total ARNB expenditures and expenditures per case increased from SFY 2011 through SFY 2013. Total ARNB expenditures were $2.1 million and average PMPM expenditures were $7,163.

ARNB Member Survey Findings

Overall, 80 percent of respondents were very satisfied with the help they received from their child's case manager. The vast majority of respondents (90 percent) were very satisfied with ARNB program. One hundred percent of respondents would recommend the ARNB program to a friend with similar health care needs.

Synagis Program

Overview

The Synagis Case Management Program provides case management services to children who are prescribed the Synagis antibody when there are concerns about dosage compliance in order to reduce the rate of hospitalization and poor outcomes that result from Respiratory Syncytial Virus (RSV). The program was implemented on December 1, 2010.

Evaluation Findings

Analysis of Synagis Enrollment and ENC Activities

From SFY 2011 through SFY 2013 there were 110 Synagis members that the PCM Department case managed. Over 60 percent of the Synagis membership (61.8 percent) was concentrated in urban counties and 34.5 percent in rural counties. Over 50 percent of Synagis members fell into the age range of zero to six months from SFY 2011 through SFY 2013.

Over 30 percent of members were in the seven-to-twelve-month age range. Nearly all Synagis members (97.3 percent) were enrolled three months or less, of which 69 percent were enrolled only one to four weeks in duration. The short duration in case management aligns with the Synagis desktop procedures; that is, if there are no other case management needs, the ENC provides the member with PCM's toll-free number and closes the case. If additional needs exist, the case is kept open only until those needs are addressed.

Member contact rates ranged from 40.5 to 66.7 percent. The average contact rate across all SFYs was 42.7 percent. ENCs averaged 0.7 to 8.7 contacts per member across the three fiscal years. From SFY 2011 through 2013, ENCs spent an average of 1.0 to 1.5 hours per case across all activities. In total, the FTEs required for the Synagis program ranged from 0.01 to 0.04 FTEs. This low number is attributed to the small membership and short duration members are in the Synagis program. Synagis assessment rates have remained low across all SFYs, which may be attributable to the omission by ENCs of the "assessment completion date" entry in the member's record. From SFY 2011 through 2013, ENCs mailed an average 1.0 to 3.3 letters per member.

Synagis Utilization and Cost Outcomes

On average, 73.1 percent of Synagis program members received Synagis treatment. The percentage who received a full course of treatment when compared to a partial course of treatment was equally split in SFY 2012. The difference in the number of Synagis doses could be related to the time when it was prescribed during the specified month and/or due to compliance factors.

Despite Synagis treatment, the percentage of members hospitalized for RSV averaged 55.7 percent across all SFYs. Ironically, members who received a full course of Synagis treatment had higher hospitalization rates for RSV than did members who received a partial course of treatment (62.5 percent compared to 48.7 percent).

ER utilization fluctuated each year, as did the number of program participants. The three-year average for ER visits per 1,000 was 96. Inpatient admissions fluctuated for SFY 2012 and 2013 but averaged 32 per 1,000 per members. The readmission rate per 1,000 within 30 days for SFY 2012 was 59. No data were found for SFYs 2011 and 2013. It should be noted that utilization was pulled for all diagnoses and not just RSV-related diagnoses.

Total Synagis expenditures and PMPM expenditures declined considerably from SFY 2011 to SFY 2013. Participation counts were small in some SFYs. Total expenditures were $421,407, and PMPM expenditures were $2,701.

Synagis Member Survey Findings

Overall, 75 percent of respondents were very satisfied with the help they received from their child's case manager. One hundred percent of respondents were very satisfied with the Synagis program. One hundred percent of respondents would recommend the Synagis program to a friend with similar health care needs.

Fetal Infant Mortality Reduction Baby Program

Overview

The FIMR Baby case management program provides case management services to all children born to mothers in FIMR counties with the highest fetal Infant Mortality Rates (IMRs). The goal of the FIMR Baby Program is to ensure the child has a healthy start and access to resources in FIMR counties. The program was implemented on August 24, 2011.

Evaluation Findings

Analysis of FIMR Baby Enrollment and ENC Activities

From SFY 2012 through SFY 2013, there were 3,063 FIMR Baby members that the PCM Department case managed. The vast majority from SFY 2012 through SFY 2013 fell into the age range of 0-4 weeks. Seventy-eight percent of FIMR Baby members were enrolled ten to twelve months in duration. The longevity in the program aligns with the goal of providing case management services through the first year of life.

From SFY 2012 through 2013, ENCs spent an average of 2.2 to 2.8 hours per case across all activities. In total, the FTEs required for the FIMR baby program ranged from 1.6 to 2.2 FTEs. From SFY 2012 through 2013, ENCs mailed an average 5.0 to 5.4 letters per member.

FIMR Baby Utilization and Cost Outcomes

The two-year average rate of early gestation and low birth weight deliveries was 13.5 percent. From SFY 2012 through SFY 2013, the percentage of early gestation and low birth weight deliveries increased by 9.9 percent. On average, 2.3 percent of FIMR Baby deliveries resulted in a NICU admission.

For FIMR Baby, inpatient admissions declined between SFY 2012 and SFY 2013, which is likely attributable to the decline in NICU cases over this same time period. Inpatient admissions per 1,000 averaged 145.61. ER visits per 1,000 declined nearly 15 percent from SFY 2012 to SFY 2013. ER visits per 1,000 averaged 1,246 over the two-year term.

PHPG was able to analyze immunization rates at the two-, three-, five-, seven-, ten-, and 12-month intervals. Two-month rates were most favorable and averaged 87.8 percent over the two-year period. Compliance rates at other intervals ranged from 46.0 to 53.8 percent with the exception of the 12-month rate, which averaged only 13 percent. Compliance rates for four immunizations (DTaP, Hepatitis B, IPV, and Pneumococcal Conjugate) were nearly 60 percent; rotavirus compliance rate was 48.9 percent, while the influenza vaccine had only a 10.4 percent compliance rate.

Total FIMR Baby expenditures decreased from SFY 2012 through SFY 2013 by 7 percent. PMPM expenditures decreased over the same time period. Total FIMR Baby expenditures were $6.5 million, and average PMPM expenditures were $229.

FIMR Baby Member Survey Findings

Overall, 84 percent of respondents were very satisfied with the help they received from their child's case manager. Seventy-five percent of respondents were very satisfied with FIMR Baby program. The vast majority of respondents (93 percent) would recommend the FIMR Baby program to a friend with similar health care needs.

Conclusion - Obstetric and Pediatric Programs

The PCM's OB and pediatric programs offer a number of helpful services and interventions to support pregnant SoonerCare members and their children. Each program's purpose meets a specific need that was identified, researched, and collaborated among the OHCA and a number of external stakeholders. Data suggests that the PCM Department has been successful with enrolling and case managing a significant number of members despite staffing challenges. There have been refinements to program procedures, ENC training, assessments, and services to address gaps.

Administrative Referrals Program

Overview

The Oklahoma Health Care Authority (OHCA) performs retrospective and prospective administrative referrals for a select number of SoonerCare members who cannot get access to their medical home for a specialty referral (e.g., the primary care provider (PCP) is unable to see the member prior to a needed specialty visit). The OHCA decides whether the referral is urgent or non-urgent. If the referral is urgent, the OHCA performs the determination and bypasses the regular referral process.

Evaluation Findings

Analysis of Administrative Referral Enrollment and ENC Activities

The PCM Department handles approximately 12 referrals per month, and thus volume is small. From SFY 2010 through SFY 2013 there were 559 referrals that the PCM Department handled. Over half of these referrals originated in urban areas of the state. Thirty-seven percent of administrative referrals fell into the age range of 18 and under. Member contact rates across all SFYs were 17.2 percent, though contact attempts are sometimes relaxed in times of staffing crisis.

The average number of contacts per member across all SFYs was 3.5. From SFY 2010 through 2013, ENCs spent an average of 1.0 to 4.1 hours per referral across all activities. The FTEs required for administrative referrals ranged from 0.02 FTEs in SFY 2010 to 0.11 FTEs in SFY 2013. From SFY 2010 through 2013, ENCs mailed an average of 0.4 to 1.1 letters per referral.

Conclusions

The PCM Department has a solid process in place for clinical reviews for both types of referrals. If there are PCP access or continuity-of-care issues, the PCM Department engages the OHCA Provider Services Department. Considerations for the future should referral volume increase would be to further educate members on the PCP referral process and the importance of PCP selection, as well as to assist members in selecting a PCP as needed. Referral reports should continue to be monitored to assess the reason for the referral and to monitor provider network accessibility and compliance with the referral processes the OHCA has in place.

Meals and/or Lodging Program

Overview

The OHCA's Meals and Lodging Program was implemented in the PCM Department in SFY 2012. The OHCA's Meals and/or Lodging Program provides meals and/or lodging assistance, after medical necessity review by a nurse, for SoonerCare members who have medical appointments greater than 100 miles from member's home or whose condition discourages traveling.

Evaluation Findings

Analysis of Meals and/or Lodging and ENC Activities

From SFY 2012 through SFY 2013 there were 698 meals and/or lodging referrals that the PCM Department handled. Over 70 percent of these referrals originated in rural areas of the state. Over 74 percent of referrals fell into the age range of 18 and under.

Member contact rates across all SFYs averaged 72.1 percent, which ranked higher than in most programs. The average number of contacts per member across all SFYs was 8.2. From SFY 2012 through 2013, ENCs/SSCs spent an average of 4.0 to 4.4 hours per member across all activities. The FTEs required for meals and/or lodging ranged from 0.22 FTEs in SFY 2012 to 0.90 FTEs in SFY 2013. From SFY 2012 through 2013, ENCs mailed an average of 2.1 to 2.3 letters per referral.

Conclusions

The PCM Department has processes in place for meals and/or lodging referrals and reimbursement. Considerations for the future would be to continue to monitor rural provider networks for adequacy issues. While PHPG did not perform an audit of meals and/or lodging cases, the OHCA may want to consider a review of a sample of cases to ensure that all of the criteria were met during the authorization and reimbursement processes.

Out of State Services

Overview

The OHCA's Out of State Services Program has been a significant activity in the PCM Department since the SoonerCare Plus transition in January 2004. The OHCA's Out of State Services Program provides case management for members requiring medically necessary services that are not available in Oklahoma.

Evaluation Findings

Analysis of Out of State Enrollment and ENC Activities

From 2009 through SFY 2013 there were 1,459 out of state requests that the PCM Department handled. Nearly 65 percent of out-of-state services were provided to members who resided in rural counties. Over 70 percent of referrals fell into the age range of 18 and under.

Member contact rates across all SFYs were 82.9 percent, which likely relates to the member's need for the service and willingness to work with the PCM Department on arranging the service. The average number of contacts per member across all SFYs was 11.1. Since out-of-state services referrals have been a significant activity in the PCM Department, it is not unusual that hours per member and FTE time were higher for this program.

From SFY 2009 through 2013, ENCs spent an average of 3.4 to 5.3 hours per member across all activities. The FTEs required for out-of-state services ranged from 0.03 FTEs in SFY 2009 to 1.20 FTEs in SFY 2012. From SFY 2012 through 2013, ENCs mailed an average of 0.7 to 1.5 letters per referral.

Out-of-State Utilization and Cost Outcomes

Between SFY 2010 through SFY 2013, there was an average of 696 members who received out-of-state services with an average cost of $16,679 per member. Between SFY 2010 through SFY 2013, there were $60,676 in meals and/or lodging expenditures and 47 members who received meals and/or lodging services. The average cost per member was $1,291 over the four-year period.

From SFY 2010 through SFY 2013, there were $46,206,679 in out-of-state service expenditures with an average PMPM of $890. Forty percent of out-of-state expenditures were incurred in Texas, 27.6 percent were incurred in Arkansas, and 17.5 percent were incurred in Missouri.

Conclusions

The PCM Department has processes in place for out-of-state services referrals and reimbursement. An algorithm designates whether out-of-state cases must be reviewed by a physician from the Medical Professional Services Unit. To the extent that out-of-state services are approved, the PCM Department has processes in place with Provider Contracting and Finance who perform network contracting and reimbursement activities. If out-of-state services are denied, the PCM Department notifies all providers, as well as the member and/or the member's family, of the decision and how to appeal.

Considerations for the future would be to continue to monitor provider networks for adequacy and contracting issues. While PHPG did not perform an audit of out-of-state services cases, the OHCA may want to consider a review of a sample of cases to ensure that all of the criteria were met during the authorization, provider contracting, and reimbursement processes.

Emergency Room Utilization Program

Overview

The Emergency Room (ER) Utilization Program was implemented on September 1, 2004. The first level of intervention is provided by the OHCA's Member Services department, which provides outreach to SoonerCare members identified with high ER utilization. As Member Services identifies care gaps or issues that are beyond its scope, the member is referred to the PCM Department for clinical follow-up.

Providers can also make referrals to the PCM Department for follow-up if they have a concern about their patients' ER usage. ENCs work with Primary Care Providers (PCPs) and members to coordinate services and to overcome barriers that may lead to frequent ER utilization.

Evaluation Findings

Analysis of ER Utilization Enrollment and ENC Activities

From SFY 2006 through SFY 2013 there were 2,277 members that had ER utilization records associated with the PCM Department. The percentage of ER utilization cases is fairly even among members who resided in urban and rural counties. Nearly half of members who were enrolled in case management fell into the age range of 18 and under.

Member contact rates varied by SFY and ranged from 1.2 to 52.3 percent. The average contact rate across all SFYs was 21.7 percent. The average number of member contacts across all SFYs was one contact per member. From SFY 2006 through SFY 2013, ENCs spent an average of 0.4 to 3.3 hours per member across all activities. The FTEs required for ER utilization activities ranged from 0.05 FTEs to 0.15 FTEs. From SFY 2006 through 2011, ENCs mailed an average of 0.04 to 0.27 letters per member.

ER Utilization and Cost Outcomes

ER utilization records for members who received an ER intervention letter (i.e., 4-14 ER visits letter and 15-or-greater ER visits letter) were extracted from the Member Services' ER utilization database for the period of SFY 2010 through the first quarter of SFY 2013. PHPG analyzed claims for ER visits 12 months before and 12 months after the letter date to see if there was any change in utilization as a result of the ER intervention letter.

As it relates to the 4-14 ER visit letter, there was a difference of 3.43 ER visits per member 12 months prior to the 4-14 ER visit letter and 12 months after the 4-14 ER visit letters were sent. This reduction resulted in a 41.8 percentage reduction in ER visits per member and a $496 reduction in ER visit expenditures per member. Regarding the impact of the 15-or-greater ER visit letter, there was a difference of 8.98 ER visits per member 12 months prior to the 15-or-greater ER visit letter and 12 months after the 15-or-greater ER visit letter was sent. This reduction resulted in a 35.9 percentage reduction in ER visits per member and a $1939 reduction in ER visit expenditures per member.

For all members who received either a 4-14 ER visit letter or a 15-or-greater ER visit letter, there was a difference of 4.63 ER visits per member 12 months prior to an ER visit letter and 12 months after an ER visit letter was sent. This reduction resulted in a 39.1 percentage reduction in ER visits per member and an $809 reduction in ER visit expenditures per member. In summary, it appears the mailing of ER letters to members and their PCPs had a sizeable impact on the reduction of ER services for the members who were evaluated.

Conclusions

The Emergency Room (ER) Utilization Program involves both the OHCA Member Services Department and the PCM Department. The first level of intervention is provided by the OHCA's Member Services department, which provides outreach to SoonerCare members identified with high ER utilization. As Member Services identifies care gaps or issues that are beyond its scope, the member is referred to the PCM Department for clinical follow-up. Providers can also make referrals to the PCM Department for follow-up if they have a concern about their patients' ER usage. ENCs work with PCPs and members to coordinate services and to overcome barriers that may lead to frequent ER utilization.

Considerations for the future would be to continue to send ER visit letters to members and their PCPs at varying intervals and to monitor the number of member calls back to the OHCA, as well as PCP intervention to reduce unnecessary ER visits. More aggressive interventions could include face-to-face member and provider education, provider profiling, and collaborating with high volume ERs to address non-compliance issues for members that have more than five ER visits in any given quarter.

Care Manager Training Program

Overview

As the PCM Department expanded its program oversight, programs, and training curriculum, methods for educating nurses (ENCs) evolved to meet the needs of members and to engage members in conversations about their care. While researching best practices for the SoonerCare HMP, the concept of motivational interviewing became of high interest.

In 2011, the SoonerCare HMP added a senior nurse analyst to work on clinical topics and quality assurance and to develop motivational interviewing skills for other PCM programs. To educate and enable staff to perform in the role as quickly as possible, the PCM Program Education Manager position was then developed. The person in this role is responsible for clinical content training, systems training, organizational history/agency guidelines training, and skills-based training in motivational interviewing.

Evaluation Findings

PHPG interviewed the PCM Program Education Manager to learn about the successes and challenges PCM Department staff have had with the transition to and application of motivational interviewing. While the OHCA has not conducted any formal evaluations with its nurses or members about their satisfaction and the effectiveness of motivational interviewing, the PCM Program Education Manager reported success stories of reaching and actively engaging members using this method.

Conclusions

The transition to and application of motivational interviewing skills among ENCs in the PCM Department is still in progress. A curriculum has been developed and implemented for new and existing PCM Department staff. Inbound and outbound phone calls are recorded (archived) and evaluated to facilitate motivational interviewing proficiency. Surveys/evaluations of motivational interviewing from the perspectives of nurses and members may prove beneficial. Although survey responses may be subjective, they may serve to inspire other PCM staff of the value of motivational interviewing skills and help to refine the curriculum if/when needed.

Another way to engage staff would be to consider an incentive or certificate program (e.g., offer CEU credits) for nurses who complete the training. The OHCA may want to consider involving PCM staff in curriculum development to make the curriculum more interactive and inspire more interest.

Pharmacy Lock-in Program

Overview

The OHCA Pharmacy Lock-In Program promotes appropriate utilization of health care resources by monitoring potential abuse or inappropriate utilization of prescription medications by SoonerCare members. Members are monitored for excessive use of medications considered to have a high abuse potential, the use of multiple physicians and pharmacies, and for diagnoses that raise concern for prescription drug abuse. When warranted, a member may be "locked-in," and therefore required to fill all prescriptions at a single designated pharmacy in order to manage his or her medication utilization.

The OHCA has contracts with the University of Oklahoma College of Pharmacy (OU COP) to provide operational, consultant, and educational services to support the administration of pharmacy benefits for Oklahoma SoonerCare members. Among their many functions as the Pharmacy Benefit Manager for the OHCA, OU COP has operated the OHCA Pharmacy Lock-in Program since 2006. OU COP conducts in-depth analysis to determine if a SoonerCare member's pharmacy utilization is inappropriate and meets Lock-in Program criteria.

Evaluation Findings

<u>Analysis of Pharmacy Lock-in Enrollment and ENC Activities</u>

The number of cases varied considerably across fiscal years, from a low of 17 in SFY 2010 to a high of 94 in SFY 2011. However, the average age of the cases reviewed was relatively consistent across fiscal years (from age 36 to 43), as was the fact that the majority of cases were females. In SFY 2011 through SFY 2013, the total hours spent by the Senior ENC for the Pharmacy Lock-in Program across all activities has

ranged between 35 and 58 hours. This equates to approximately two to three percent of an FTE each year, with the remaining time available to support other care management functions within the PCM Department.

Conclusions

This program evaluation has a narrow scope due to the limited role of the PCM Department within the overall Pharmacy Lock-in Program. That said, the relatively small amount of time (approximately two to three percent of an FTE) spent on this Program appears to be extremely valuable in terms of claims review to ensure that appropriate SoonerCare members are referred for possible lock-in to one pharmacy due to inappropriate pharmacy utilization. The current process for the program as a whole is somewhat complex, with information transfers between multiple entities. The OHCA has indicated that staff is examining the current operations to identify possible areas for streamlining the processes and information transfers within the program.

Another area for program improvement is clarification of the working definitions for activity types in Atlantes in order to obtain more consistent data entry by the Pharmacy Lock-in Program ENC. The OHCA began standardizing activity types in the Atlantes menu in the summer of 2014; this will benefit data analyses and program reports for all care management functions in the future. In addition, the OHCA Desktop Procedure Guide for the PCM Department could be improved to clearly distinguish the ENC's role regarding all three referral paths. The Pharmacy Lock-in Program has changed over time, and the guide does not clearly portray the current program operations from the perspective of an external reader. Improvements to the guide would be especially important if the ENC who is the Unit designee to the Pharmacy Lock-in Program changes over time.

Waiver Operations Programs

Overview

The OHCA Long Term Care (LTC) Waiver Operations Division (Waiver Division) oversees the development and implementation of initiatives to support the long-term service and support needs of Oklahoma citizens. The OHCA has received federal approval from the Centers for Medicare and Medicaid Services (CMS) for a variety of Home and Community-based Services (HCBS) Programs, including programs to support elders and/or those beneficiaries who have disabilities needing long-term services and supports and individuals who are medically fragile. These include a LTC Demonstration Program (the Living Choice Program), three Home and Community-Based Services (HCBS) Waivers (the My Life, My Choice Program; the Sooner Seniors Program; and the Medically Fragile Program), and one comprehensive capitated LTC program that serves the frail elderly and adults with physical disabilities (Program of All Inclusive Care for the Elderly (PACE)).

Evaluation Findings

Number and description of LTC Program cases with PCM Department involvement by Fiscal Year

For each Program, the number of cases varied considerably across fiscal years. The number of Living Choice assessments decreased each year, from a high of 290 in SFY 2011 to a low of 183 in SFY 2013. The number of clinical reviews and LOC determinations for the Medically Fragile Program also decreased each year, with a high of 31 in SFY 2011 to a low of 17 in SFY 2013. The number of clinical reviews and LOC determinations conducted for the My Life My Choice program and the Sooner Seniors Programs in SFY 2011 is lower than in SFY 2012, but the SFY 2011 data only reflect a partial year due to the date that the PCM Department began involvement with these Programs. However, the number of clinical reviews and LOC determinations conducted in SFY 2012 is higher than in the following SFY 2013.

The number of critical incident reviews conducted by ENCs for the Living Choice and LTC Waiver Programs is relatively similar for the two years of full PCM Department involvement (i.e., 56 in SFY 2012 and 46 in SFY 2013). The number of TEFRA home visit assessments conducted by ENCs was relatively similar in SFY 2011 and SFY 2012 (i.e., 68 and 65), but increased to 81 in SFY 2013. The number of PACE Level of Care Determinations has increased since OHCA involvement began in June 2011, rising from 86 Determinations in SFY 2012 to 124 in SFY 2013. There are minimal variations in gender, with males representing a slightly higher number of cases than females in SFY 2011 and SFY 2013.

PCM Department ENC time, FTEs, and hours per case spent on LTC Program activities

The total hours spent by the ENCs across all LTC Programs has been relatively consistent for each SFY, ranging from 2,270 to 2,868 hours per year. This equates to a little more than one FTE each year, with the remaining time available to support other care management functions within the PCM Department. Upon closer examination, a majority of the ENC hours were spent on Living Choice Program onsite assessments. These assessments accounted for 80 percent, 72 percent, and 57 percent of the ENC hours in SFY 2011, SFY 2012, and SFY 2013 respectively.

Conclusions

This program evaluation has a narrow scope due to the limited role of the PCM Department within the overall Long Term Care and Waiver Programs. However, the qualitative value of the clinical functions provided by the PCM Department for these Programs cannot be underestimated. The on-site and home visit assessments, critical incident report reviews, authorization of treatment plan services, and level-of-care determinations are all critical functions that ensure that these Programs are serving the intended Members and that the Members receive the clinical services needed to successfully live outside of institutional care.

Oklahoma Cares Breast and Cervical Cancer Program

Overview

Oklahoma Cares was implemented on January 1, 2005, under the authority of the National Breast and Cervical Cancer Prevention and Treatment Act of 2000. Oklahoma Cares provides diagnostic and treatment services for eligible women with abnormal breast or cervical cancer (BCC) screenings. Oklahoma Cares members also receive full SoonerCare (Oklahoma Medicaid) benefits for the duration of their cancer treatment, including transportation to their medical appointments through the SoonerRide transportation program. Oklahoma Cares is a partnership among the Oklahoma Health Care Authority (OHCA), Oklahoma State Department of Health (OSDH), Cherokee Nation, Kaw Nation of Oklahoma, and Oklahoma Department of Human Services (OKDHS).

Evaluation Findings

Analysis of Oklahoma Cares Enrollment and ENC Activities

The result of Oklahoma Cares program development efforts can be seen in both administrative metrics and in the utilization and cost data. Specifically, the administrative data available from Atlantes shows that the introduction of web-based care management tools in late calendar year 2008 and 2009 was met with a corresponding decrease in the volume of null data values in the level-of-care end-date fields. Null values decreased from a high of 91 percent in 2006 to a low of five percent in 2012. Along these lines, the use of the Atlantes web-based care management system allowed the OHCA to create clear and consistent protocols, schedules, and ENC care management expectations for assigned staff.

Another notable change in program operations occurred in State Fiscal Year 2011 when the OHCA shifted enrollment authorizations away from field-based screening in community programs across the state to the use of Senior ENC's (Nurse Reviewers) employed within the Population Care Management Department. Specifically, information submitted by community-based screeners was reviewed against criteria with requests to providers or screeners as needed for further information or pathology reports.

This change, initiated on January 1, 2011, was followed by the promulgation of rules in April 2011 related to program eligibility, administrative timelines, and redeterminations of need and appeals. Approximately one year later the OHCA adopted written Clinical Guidelines and definitions of clinical care management for both cancer and cancer-related abnormalities.

Changes in these enrollment review processes and guidelines were followed by a 78 percent decrease in enrollment, shortened length of stay in the Oklahoma Cares program, and more efficient use of the OHCA staff resources and services. The overall decrease in enrollment can be seen in the "related conditions" category, suggesting that women with a cancer diagnosis are receiving necessary care, while those with more ambiguous abnormalities are receiving additional diagnostics and physician consults

that ultimately rule out the need for pre-cancer or cancer-related care offered as part of the Oklahoma Cares program.

Post-2011 decreases can also be seen in the overall use of supervisory time for case review, and fewer ENC resources overall, in that the latter moved from a high of 8.4 FTEs in 2009 to approximately 1.7 FTEs in 2013. This decrease may also be attributed to the use of Senior ENC staff with a greater level of work experience and clinical knowledge.

Oklahoma Cares Utilization and Cost Outcomes

Overall, total payments for Oklahoma Cares program expenditures show a high of $32.5 million in SFY 2009 and a low of $14.4 million in SFY 2013. Across all state fiscal years, breast cancer treatment accounted for the largest proportion of total spending as compared to total spending by the cervical cancer and related conditions groups.

Along with the implementation of clinical enrollment standards, the OHCA ENCs also review claims and outreach to providers to gather information on services provided and ensure the need for continued program eligibility. These changes overall may have contributed to the finding that expenditures for women enrolled in Oklahoma Cares increasingly have been linked to cancer-related care during the five-year study period.

Furthermore, women enrolled in Oklahoma Cares have an average of 22 percent lower claims costs, and more spending can be linked to their breast and cervical cancer diagnosis than is the case for a comparison group of women with these diagnoses who are not enrolled in the Oklahoma Cares program. A discrete analysis of claims for persons with the breast and cervical cancer diagnosis enrolled in overall SoonerCare programs (Choice and Traditional), but not part of the Oklahoma Cares program, showed that non-Oklahoma Cares members have little evidence in the claims system of treatment related to their diagnosis. In addition, those members not part of the Oklahoma Cares program received fewer physician and outpatient-related services and more in Inpatient, Nursing Facility, Targeted Case Management, Pharmacy, and Home Health-related services.

Conclusions

Without a full medical records review it is difficult to determine if the non-Oklahoma Cares group includes persons with more complex psychiatric and disability-related conditions, and/or more medically fragile physical health-related conditions, that could be contributing to their higher costs. Regardless, the data indicate that women enrolled in Oklahoma Cares are using this program to access needed treatment for their cancer conditions, and they are doing so more readily than other SoonerCare members who have a breast or cervical cancer-related diagnosis.

In summary, it appears that the Oklahoma Cares program is succeeding in its mission of supporting women with breast, cervical cancer, and related diagnoses to access care that they otherwise might not be able to afford. Data also suggests that the OHCA and its Population Management Unit have been successful at designing and implementing effective strategies to manage operations, clinical care, and expense for persons who qualify for breast and cervical cancer-related treatment funding. Future program consideration could be given to understanding if any of the design elements in use in the Oklahoma Cares program could be adopted in other areas for the management of non- Oklahoma Cares SoonerCare members with breast or cervical cancer.

Organ and Tissue Transplant Program

Overview

The OHCA Organ and Tissue Transplant Program (OTTP), which was implemented in the PCM Department in SFY 2003, provides for solid organ and bone marrow/stem cell transplants for SoonerCare members. Organ and tissue transplant procedures are subject to both medical appropriateness and medical necessity review by the OHCA's Medical Authorization Unit (MAU) Transplant Coordinator and a Medical Consultant.

Evaluation Findings

Analysis of Organ and Tissue Transplant Enrollment and Demographics

From SFY 2010 through SFY 2013 there were 186 members who had an organ or tissue transplants. Nearly half of transplant referrals originated in rural counties. Participation in the age ranges of 18 and under, 26 to 34, and 35 to 49 differed by less than eight percent and accounted for nearly 75 percent of organ and tissue transplants.

Conclusions

The OTTP provides for solid organ and bone marrow/stem cell transplants for SoonerCare members. OTTP services are subject to prior authorization and require procedures to be medically appropriate and medically necessary. Care coordination for members is managed by the PCM Department pre- and post-transplant, and authorization is managed by the MAU through the use of medical consultants. Both departments have processes in place for OTTP case management, authorization, and referral to OTTP providers and facilities.

Considerations for the future would be to continue to monitor OTTP networks for adequacy and contracting issues. While PHPG did not perform an audit of OTTP cases, the OHCA may want to consider a review of a sample of cases to ensure that all of the criteria were met during the authorization,

provider contracting, and reimbursement processes. It is recommended that clinical and program outcomes be monitored via the generation of OTTP reports in an effort to adjust case management intensity, if needed, and to monitor cost and member outcomes (e.g., clinical, satisfaction with provider or facility).

Hemophilia Outreach

Overview

The Hemophilia Outreach Case Management Program is dedicated to encouraging compliance and good health to members with a diagnosis of hemophilia and their families. The program is administered by the CCU within the PCM Department. ENCs provide ongoing education and support to members and their families. ENCs collaborate with pediatric hematologists and provide stress compliance education and depression screening. Members with three or more emergency room visits and/or medical utilization costs greater than $50,000 per rolling year are identified as eligible for case management participation by CCU staff, which includes members with hemophilia.

Evaluation Findings

Analysis of Hemophilia Enrollment and ENC Activities

Between SFY 2010 through SFY 2013 there were 113 members who received hemophilia case management assistance. Forty percent of members remained in the program longer than 24 months. Nearly 64 percent of members had “Hemophilia Diagnosed” listed as their First Level of Care in Atlantes. Approximately 16 percent had “Hemophilia High Cost” listed as their First Level of Care.

Hemophilia Utilization and Cost Outcomes

There were a total of $12,775,819 in aggregate expenditures related to hemophilia and $14,718.69 in PMPM expenditures.

Conclusions

Considerations for the future would be to have a focus group or to survey parents/guardians and members with hemophilia to see what they find useful about the case management program. Other interventions to consider, in addition to the monthly calls and assessments, are onsite collaboration with members and providers, multidisciplinary care team conferences with the ENCs and providers, and/or face-to-face visits with members if the need arises. These interventions may be beneficial for high cost cases where the ENC is unable to contact the member.

To the extent members and hemophilia providers have an established relationship and there are no case management needs, an evaluation of case closure criteria could be performed. More direct contact and coordination between the CCU ENCs and the Health Access Network (HAN) case managers to coordinate care when the member returns to the CCU would be advantageous.

Large Transitional Events

Overview

A large transitional event is a large-scale situation that potentially could affect SoonerCare members' access to care. When an event influences a large number of members, the OHCA reaches out to impacted members to determine care needs and facilitate transition of care, if applicable. To do so, the PCM Department has procedures in place for documenting and tracking all member outreach activities.

Evaluation Findings

Upon a review of a sample of call tracking logs, PHPG noted that outreach efforts (contact date, level of contact achieved, disposition, and comments) are summarized for each impacted member. Available call tracking logs indicate that all members were either contacted successfully or sent a letter when unable to be reached.

Conclusions

Since the events are fairly infrequent, and the OHCA seems to have solid procedures and a tracking system in place, no changes are recommended at this time.

Behavioral Health Inspection of Care

Overview

The OHCA conducts onsite service quality reviews of facilities providing inpatient behavioral health services to SoonerCare members pursuant to federal and state regulations. The audited facilities include providers of acute psychiatric care (freestanding hospitals and units of larger facilities), Psychiatric Residential Treatment Facilities (PRTFs), Residential Treatment Centers (RTCs), Cognitive Behavioral Therapy (CBT) units, and Therapeutic Foster Care (TPC) agencies.

The overarching purpose of the audits is to verify that facilities are safe for residents, as verified through physical inspections, and that they provide medically necessary care, as documented through patient records. Safety issues and other areas of non-compliance are subject to corrective action plans or, in extreme cases, termination; services not shown to be medically necessary are subject to recoupment.

Evaluation Findings

It is important to note that seven of the 15 facilities "failed" on three or fewer elements, and only one facility failed on a majority of elements. This is consistent with other evidence that the OHCA's audits are having a positive impact on facility performance and quality.

PHPG evaluated the impact of the audits by examining recoupment amounts in SFY 2013 and SFY 2014. Since the audit process was as comprehensive in SFY 2014 as in the previous year, a decline in recoupments would signify improved performance. Recoupments did in fact decline among the facilities examined by PHPG.

PHPG also analyzed the OHCA's SFY 2014 findings with regard to implementation of SFY 2013 Corrective Action Plans. While this data was available for only a subset of the facilities, the results were encouraging. The great majority of CAP items imposed in SFY 2013 were found to have been resolved by the time of the SFY 2014 audit.

Conclusions

The OHCA's behavioral health service quality review process is comprehensive and well structured. The process appears to be contributing to improved performance on the part of audited facilities. It also has allowed the agency to recoup funds for services not demonstrated to meet medical necessity or other payment criteria.

Starting in SFY 2015, the OHCA will be undertaking enhanced audits of facilities with recurring CAP issues, a step that appropriately focuses agency resources where the need is greatest. Going forward, audit findings also can be used to inform provider education and quality improvement activities in areas where significant numbers of providers fail to meet audit standards.

POPULATION CARE MANAGEMENT DEPARTMENT INTRODUCTION AND OVERVIEW

The Oklahoma Health Care Authority (OHCA) serves as the managed care organization for SoonerCare Choice. The OHCA is responsible for providing care management services and coordination to SoonerCare members and outreach to targeted populations based on the mandates in the established legislation that created the OHCA, 63 O.S. Section 5003. The Population Care Management (PCM) Unit was formed in 2000 by a decision of the OHCA Executive Staff to coordinate the needs of SoonerCare members with complex medical needs.

In 2004, when HMO contracts ended, the number of members with care coordination needs grew substantially. The PCM Department expanded as a result of this change and has continued to grow as the SoonerCare population has grown, and the responsibilities of the department have continued to evolve. The OHCA leadership acknowledges the needs of the populations served and continues to guide the work of the PCM Department.

The PCM Department enhances the SoonerCare program with the provision of care management and coordination, offering these important services to any SoonerCare member or provider, as well as targeted populations, through well-trained and clinically skilled staff. The goals of the PCM Department are to achieve better health care, better health, and reduced costs by facilitating and coordinating the delivery of quality health care to SoonerCare members. To do so, the PCM Department works with members, providers, and other OHCA units, including but not limited to the Medical Authorization Unit, Quality Assurance/Quality Improvement, Legal, Member Services, Medical Professional Services, Provider Services, Information Services, Electronic Health Operations, Health Policy & Waiver Development & Reporting, and Behavioral Health Operations.

The PCM Department also collaborates with various public and private partners to bridge common interests for members and providers. Some of these partnerships include, but are not limited to, the following entities:

- SoonerCare Patient-Centered Medical Home providers;
- Oklahoma State Department of Health;
- Oklahoma Cares partners;
- Oklahoma Aging Division Services;
- All advisory task forces that OHCA oversees;
- Health Access Networks;
- Child Study Center/Sooner Success;
- University of Oklahoma; and
- Strong Start partners.

PCM Department Overview

The PCM Department houses three distinct departments and programs to provide care management and coordination services for SoonerCare members: Health Management Program, Chronic Care Unit and Case Management Unit. An overview of each department is provided below. It should be noted that although PHPG's analysis was limited to programs and services within the Case Management Unit, the overarching program area was the PCM Department; therefore, PCM Department terminology is used interchangeably throughout this report.

SoonerCare Health Management Program

Under the Oklahoma Medicaid Reform Act of 2006 (HB2842), the Legislature directed the OHCA to develop and implement a management program for chronic diseases, including, but not limited to, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes, and renal disease. The SoonerCare Health Management Program (HMP) would address the health needs of chronically ill SoonerCare members while reducing unnecessary medical expenditures at a time of significant fiscal constraints.

The OHCA contracted with a vendor through a competitive bid process to implement and operate the SoonerCare HMP. The program mainly provides practice-based, chronic disease-focused supports to SoonerCare members and primary care providers. The HMP provides specially trained process improvement support, known as practice facilitators, to practices with a significant burden of SoonerCare members with chronic illness. The practice facilitators work with practices to identify opportunities for team-based care, implement evidence-based guidelines, teach process and quality improvement principles, and maximize the use of electronic medical records and/or incorporation of a disease registry.

The HMP also provides specially trained nurses, known as health coaches, to high-target primary care practices, to work directly with high-risk members with chronic conditions or members at risk for chronic conditions. These health coaches are embedded in the practices and focus on health literacy and improvement of self-management skills. Health coaches are trained in motivational interviewing and have case management experience. The health coaches collaborate with practices in managing the care of patients enrolled in the SoonerCare HMP.

Chronic Care Unit

SoonerCare HMP members who require care management (based on diagnosis, risk score, and care management needs) and who are not in a practice with an HMP health coach are contacted by the OHCA's Chronic Care Unit (CCU) and offered telephonic care management outside of the SoonerCare HMP Program. The CCU was implemented in January 2013. At-risk and high-risk SoonerCare members are identified through self-referral, provider referral, data mining, and transfer from the HMP. Through

health coaching, members are assisted with the improvement of self-management of their chronic disease(s).

Nurses in the CCU, called Exceptional Needs Coordinators (ENCs), provide telephonic case management to targeted members with conditions such as sickle cell disease and hemophilia (with high ER utilization and evidence of uncontrolled care,) hepatitis C (receiving specific treatment), and morbid obesity (authorized for the bariatric surgery process.) ENCs also provide outreach to members with certain at-risk profiles on health risk assessments. ENCs assess and address the health status, health literacy, behavioral health, and prescription drug utilization of SoonerCare members through care coordination, self-management principles, and behavior modification techniques. Their primary focus is on self-management skills, member education, and resource support.

Case Management Unit

The Case Management Unit (CMU) provides episodic or event-based case management services and certain supportive eligibility determinations and utilization management functions to other areas of the OHCA, such as the Long-Term Care Waiver Operations division and the TEFRA Eligibility unit. Services are provided by a team of ENCs and social services coordinators and include, but are not limited to, assessment, care planning, patient education, appointment reminders, care coordination, and case management. The CMU is organized into geographical areas to assist ENCs in becoming familiar with the resources and unique qualities of a particular region of the state.

ENCs work with members identified through various programs or those who are in need of episodic or event-based health care. Supports provided by this unit are directed toward, but not limited to, at-risk and high-risk obstetrical populations, at-risk and high-risk pediatric populations, members in the Oklahoma Cares breast and cervical cancer treatment program, and members in need of out-of-state care coordination. Members are identified through data mining, self-referral, provider referral, community agency/state partner agency referral, legislative referral, and intra-agency (OHCA) referrals.

The HMP and CCU work in tandem with the CMU to provide member and provider supports for members who are high-risk or at-risk for chronic conditions. Together these units coordinate and facilitate the delivery of health care to SoonerCare members through the most appropriate resources, providers, and facilities within the scope of the SoonerCare program. The enhanced benefits of PCM offer members and providers more ways to help control complex conditions and improve quality of life. PCM Department case management services are provided at no cost to SoonerCare members or providers.

Health Access Networks

There are three Health Access Networks (HAN) the PCM Department collaborates with — The Central Communities HAN (formerly known as Canadian County HAN), the Oklahoma State University Center for Health Sciences Health Access Network (OSU HAN), and the University of Oklahoma (OU Sooner HAN).

Under contract with the OHCA, the HANs have responsibility for case managing members in the following programs: Breast and Cervical Cancer, Hemophilia, High Risk OB, Pharmacy Lock-In, and High ER Utilization.

Member enrollment in a HAN is determined by the PCP to whom a member has been assigned. If a member is enrolled in a HAN PCP's panel, that member is a part of the HAN. HAN case managers provide telephonic and face-to-face care management. They meet with their PCPs and work on strategies for improving member compliance and quality of care. PCM involvement with the HANs is primarily related to coordinating care as member's transition to and from the HANs.

All contacts with the HAN are documented in Atlantes. On a monthly basis, HAN rosters are reconciled to see if a member is enrolled with a HAN PCP in order to prepare for the member's transition to a HAN. Should a HAN member change to a non-HAN PCP, that member's case is transferred back to the PCM Department who then assumes responsibility for case management. It should be noted that there was a separate evaluation of the HANs, and therefore an analysis of the HANs is not part of this report.

PCM Department Staff and Organizational Structure

As noted previously, the PCM Department has three distinct departments and programs to provide care management and coordination services for SoonerCare members. A Director is responsible for oversight of the entire PCM Department. The Director initiates, supervises, develops, administers, and directs health professionals and paraprofessionals in all three departments and oversees and monitors all programs and services offered within the PCM Department to ensure they operate in accordance with agency and division policy, goals, and objectives.

An Assistant Director assists with the direction and oversight of licensed health professionals and paraprofessionals to coordinate activities within the PCM Department. The Assistant Director serves as a clinical specialist resource to develop, coordinate, and supervise staff to work with identified members to ensure necessary access to providers and medical services in accordance with the Oklahoma Medicaid State Plan. The Assistant Director also coordinates staff interface with SoonerCare members, providers, advocacy groups, legislative representatives, and the OHCA staff to facilitate medically necessary services for individuals with complex/medically diverse needs.

Case management supervisors support the Assistant Director and oversee the day-to-day supervision and activities of licensed health professionals and paraprofessionals within their assigned care management teams. Supervisors also support the Assistant Director by organizing and directing the interface of care management staff with members, providers, and other entities. They oversee documentation of the individual care management needs of identified members and activities performed by care management staff to meet those needs. Supervisors are responsible for interviewing and training internal care management staff; planning, assigning, and monitoring work/referrals; appraising staff work performance; providing disciplinary measures; addressing staff complaints; and resolving personnel issues.

Senior ENCs assist care management supervisors and the Assistant Director in identifying members with medically complex/special health care needs appropriate for care management. They act as the "lead" of a care management team by directing, coordinating, and facilitating care management referrals as required. Senior ENCs personally facilitate the more complex referrals assigned to a care management team.

Supervisors and Senior ENCs must have a current Registered Nurse (RN) license, at least two years of full- time clinical experience in an acute setting, and at least one year of experience as an ENC, Nurse Case Manager, or Quality Assurance/Utilization Review Nurse. In some cases, a supervisor or Senior ENC may have a Bachelor of Science in Nursing (BSN) or advanced nursing degree, management/supervisory experience, and other professional certifications.

ENCs are nurses who are assigned to SoonerCare members in a particular geographic area and provide case management and oversight to a caseload of members. They are responsible for coordinating and facilitating access to medical care to address the medically complex/special health care needs of members. ENCs interface with providers, advocacy groups, legislative representatives, other state agencies, and the OHCA staff to facilitate care management for those members and are responsible for documenting all case management activities for their assigned members. ENCs must have a minimum of two years full-time professional clinical experience with at least one year in a medical/surgical acute care setting.

Social Services Coordinators focus on the social and/or behavioral aspects of case management referrals. They offer proactive outreach to identified SoonerCare members as necessary and support the activities of ENCs. Social Service Coordinators must have a Bachelor's degree in social work, behavioral or medical science, or health-related field and a minimum of one year of full-time social work or medical experience in an acute medical setting.

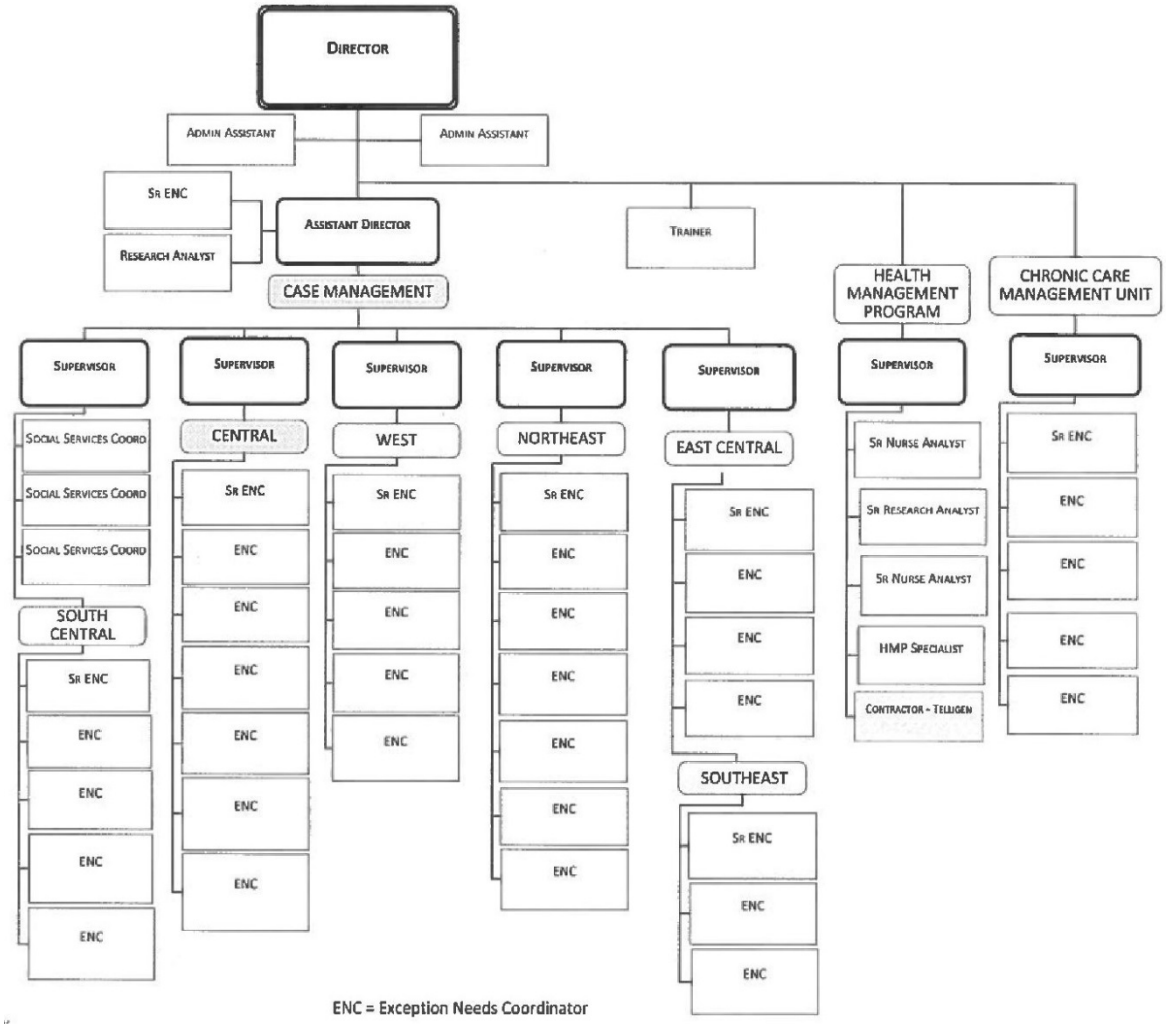
The Research Analyst position is responsible for completing and producing identified data projects and reports associated with PCM Department activities. The Research Analyst collects, analyzes, and validates the data for all PCM Department projects and reports and assists in the coordination of all

reporting activities within PCM Department. The analyst also prepares reports for review and/or presentations to internal and external entities.

The PCM Program Education Manager ("trainer") serves as the lead clinical education specialist by developing, directing, and coordinating all training for PCM Department staff. The trainer independently researches, develops, coordinates, and facilitates the clinical educational curriculum and initial and ongoing training programs for PCM Department staff. The trainer must have a current RN license and at least five years of full-time professional clinical experience in an acute care setting and at least two years of full-time experience as an ENC, nurse case manager, or clinical nurse educator.

Exhibit 1-1 below provides an organization chart of the PCM Department structure.

Exhibit 1-1 – OHCA PCM Department Organizational Chart



PCM Department Independent Evaluation

The Pacific Health Policy Group (PHPG) was retained to analyze the history, analytical framework, and value of the OHCA's Population Care Management (PCM) Department. Evaluation findings are presented by program on the forthcoming pages. Each program is organized into a specific chapter of this report. Each chapter provides a program overview and findings section. Where applicable, PHPG provides a conclusion and summary of future considerations for planning purposes. The report also contains a series of appendices with supporting documentation. The appendices are identified in the body of the report. The following programs are part of PHPG's evaluation:

- High Risk Obstetrics Program;
- OB Outreach Program/At Risk OB Program;
- Fetal Infant Mortality Reduction Mom Program;
- Interconception Care Program;
- Prenatal and Postpartum Depression Screenings and Referrals;
- Private Duty Nursing Program;
- At Risk Newborn Program;
- Synagis Program;
- Fetal Infant Mortality Reduction Baby Program;
- Administrative Referrals Program;
- Meals and/or Lodging Program;
- Out of State Services;
- Emergency Room Utilization Program;
- Behavioral Health Discharge Planning Program;
- Care Manager Training;
- Pharmacy Lock-in Program;
- Waiver Programs;
- Breast and Cervical Care Program;
- Transplants Program;
- Hemophilia Program;
- Large Transitional Events; and
- Behavioral Health Inspection of Care.

OBSTETRICAL AND PEDIATRIC PROGRAMS INTRODUCTION AND OVERVIEW

The following report provides an overview and evaluation of the eight PCM Obstetric and Pediatric Case Management Programs, as well as prenatal and postpartum screenings and referrals to the OHCA's Behavioral Health Unit (BHU). The program summaries and findings are followed by a "Conclusions and Considerations" section, which contains discussion trends, factors associated with them, and considerations for the future. PHPG collaborated with representatives from the OHCA's PCM Department as part of this process.

The OHCA PCM Department offers four obstetrical and four pediatric case management programs to SoonerCare members who qualify. Exhibit 2-1 below provides a summary of these programs and the corresponding start dates on which they became available to qualifying members.

Exhibit 2-1 – OHCA PCM Department Obstetrical and Pediatric Programs

Obstetrical Programs	Program Start Date
1. High Risk OB Program	December 1, 2007
2. OB Outreach/At Risk OB Program	February 1, 2008
3. Fetal Infant Mortality Reduction (FIMR) Mom Program	March 21, 2011
4. Interconception Care (ICC) Program	July 1, 2013
Pediatric Programs	**Program Start Date**
1. Private Duty Nursing Program	April 1, 2004
2. At Risk Newborn Program	August 1, 2009
3. Synagis Program	December 1, 2010
4. Fetal Infant Mortality Reduction (FIMR) Baby Program	August 24, 2011

HIGH RISK OB PROGRAM INTRODUCTION AND PROGRAM OVERVIEW

High Risk OB Program Objective

The High Risk OB (HROB) case management program was implemented on December 1, 2007. The program offers SoonerCare members who are pregnant an enhanced benefit package and opportunity for co-management by both an OB/GYN provider as well as a Maternal Fetal Specialist to reduce potential complications.

Program History and Overview

In 2005, the OHCA initiated a partnership with the Oklahoma State Department of Health (OSDH) to develop a statewide Perinatal Advisory Task Force (PATF). The PATF, subsequently renamed the Oklahoma Perinatal Quality Improvement Collaborative task force, is composed of more than 20 agencies and organizations involved with perinatal care and was developed to focus on issues concerning pregnant women covered by SoonerCare or other public health sources for their prenatal care. Since its first meeting in May 2005, the PATF has made several recommendations to the OHCA regarding expansion of benefits and services to pregnant women.

In December 1, 2007, the PCM HROB Case Management Program was implemented within the PCM Department because of the PAFT's recommendation to expand benefits and covered services for SoonerCare pregnant members who meet the OHCA's high-risk pregnancy criteria. Providers of obstetrical care may seek medical authorization for additional reimbursement when caring for medically high-risk pregnant women and for medically necessary fetal non-stress tests (NSTs), biophysical profiles (BPPs), and additional prenatal ultrasounds (in addition to the standard SoonerCare benefit).

NSTs are generally performed after 28 weeks of gestation. Before 28 weeks, the fetus is not developed enough to respond to the test protocol. The primary goal of the test is to measure the heart rate of the fetus in response to its own movements. Healthy babies will respond with an increased heart rate during times of movement, and the heart rate will decrease at rest. The concept behind a non-stress test is that adequate oxygen is required for fetal activity and heart rate to be within normal ranges. When oxygen levels are low, the fetus may not respond normally. Low oxygen levels can often be caused by problems with the placenta or umbilical cord.

A BPP Test measures the health of one's baby during pregnancy. A BPP test may include an NST with electronic fetal heart monitoring and a fetal ultrasound. The BPP measures a baby's heart rate, muscle tone, movement, breathing, and the amount of amniotic fluid around the baby. A BPP is commonly performed in the last trimester of pregnancy; however, for high-risk pregnancies, this may be done earlier and more frequently.

A prenatal ultrasound (also called a sonogram) is a non-invasive diagnostic test that uses sound waves to create a visual image of the baby, amniotic sac, placenta, and ovaries, as well as other pelvic organs. It allows a health care practitioner to gather valuable information about the progress of a pregnancy and about a baby's health. Major anatomical abnormalities or birth defects are often visible on an ultrasound.

Members enrolled in the HROB Program are also able to receive services by both an OB/GYN provider and a Maternal Fetal Specialist. The average membership in the PCM HROB Case Management Program is approximately 250 members at any given point in time.

Program Eligibility

A list of qualifying maternal and fetal conditions was developed by the PATF for the HROB Program. The criteria consist of a series of qualified HROB diagnosis codes as identified in Attachment A. If an OB/GYN provider determines that a member is high-risk, as defined in the list of qualifying conditions for the HROB Program, then the OB/GYN provider can refer the member to a Maternal Fetal Medicine (MFM) specialist for an additional assessment.

If the MFM or OB provider determines that a member is high-risk, the provider completes and signs the HROB Assessment and the OHCA's Prior Authorization Request form. The provider then obtains the member's signature and forwards the forms to the OHCA's Medical Authorization Unit (MAU) for review to determine if the member qualifies for the HROB Program.

Upon verification of high-risk status, MAU staff review the member's case records against clinical criteria. If a member qualifies for the HROB Program, MAU staff sends an automatic referral to the PCM Department for enrollment into the HROB case management program.

HROB Case Management Process

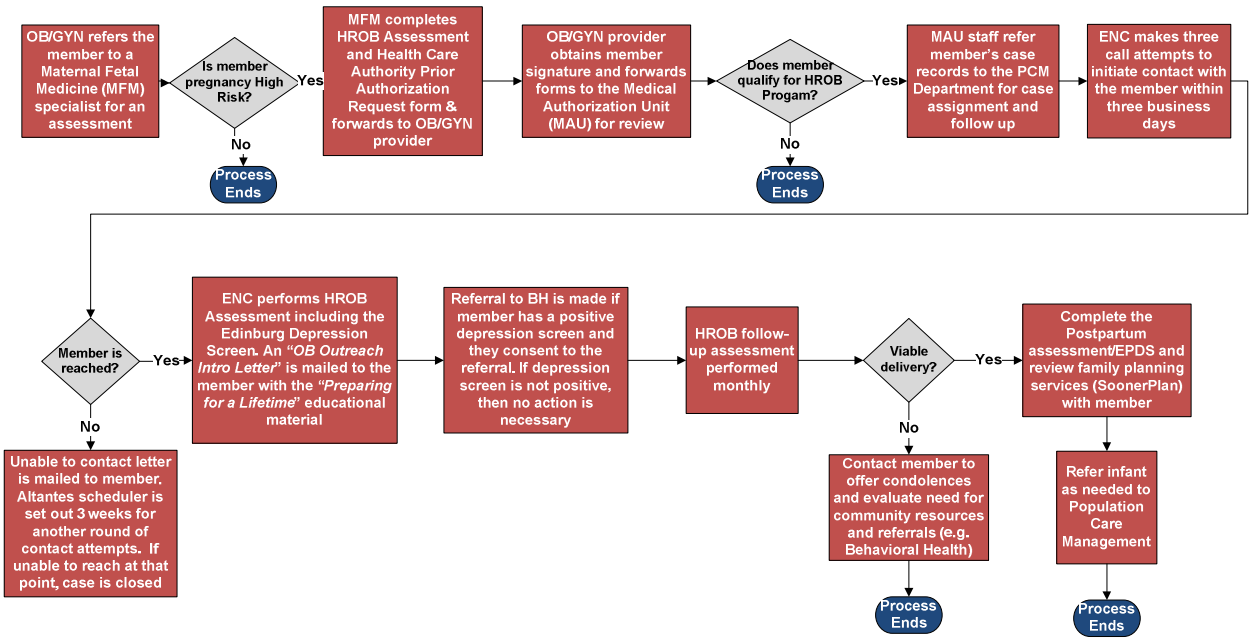
The HROB member is assigned to an Exceptional Needs Coordinator (ENC), a registered nurse who conducts member assessments and provides ongoing case management based on a member's needs. Assignment for the HROB Program is not limited to the geographic location of the ENC. A member is assigned to any available ENC in any region at the time the assignment is made. This prevents regional ENC teams from being assigned too many HROB case types in regions where prevalence rates may run high.

The assigned ENC then initiates contact with the member within three business days. Once the member is reached via telephone, the ENC performs the HROB Initial Assessment, which includes the Edinburgh Postnatal Depression Screening (EPDS) Tool. If a member has a positive EPDS, a referral to the OHCA Behavioral Health Unit (BHU) is made, if the member consents (see Prenatal and Postpartum Depression Screening and Referral section for more information).

The ENC educates the member on program benefits and pregnancy-related concerns and issues and provides monthly follow-up contacts throughout the duration of the pregnancy. The HROB/OB Outreach Monthly follow-up assessment is then completed with each successful telephone contact. If the member has a viable delivery, a postpartum assessment, which includes the EPDS Tool, is completed two weeks after delivery. The ENC assists the member's child to enroll in SoonerCare and in choosing a provider. Assistance in accessing resources and services for the newborn is also offered.

Exhibit 3-1 below provides a flow chart of the PCM Department's HROB Case Management Program authorization and case management process.

Exhibit 3-1: High Risk OB Case Management Program Authorization and Case Management Process



Changes/Revisions to the Project

During the period of 2008 through February 2011, every member in other Obstetric Case Management Programs was screened for qualifying maternal or fetal conditions to determine if she were a candidate for the HROB Program. If the member had a diagnosis that would make her eligible for the HROB Program, an OB Outreach Provider Letter was mailed or faxed to the member's prenatal care provider. The purpose of the letter was to inform the provider that the member may qualify for the HROB Program and to provide program authorization procedures and required forms.

From inception of the HROB program, PCM sent letters to related providers upon member enrollment into one of the other OB case management programs. The letter contained information about the HROB program in an effort to educate providers about the program benefits. Due to the extensive provider outreach and resulting MFM familiarity with the OHCA's HROB Program, PCM discontinued provider notification regarding the program in March 2011.

HIGH RISK OB PROGRAM FINDINGS

Methodology

PHPG obtained two datasets from the OHCA to conduct our analyses – HROB data from the care management system (Atlantes) and claims and eligibility data. The Atlantes system is a proprietary care management system operated by Hewlett-Packard and is used by the PCM Department to store all HROB member records, program activities, assessments, and program letters that are generated. HROB member records were extracted from Atlantes for the period of December 1, 2007 (SFY 2008), through June 30, 2013 (SFY 2013). Claims and eligibility data were pulled for dates of services in state fiscal years (SFY) 2010 through 2013.

The Atlantes dataset was treated as the authority for identifying HROB members. To do so, the dataset was "cleaned" to ensure a member was accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates), as well as removing member records that had null end dates. Thus, only members who completed a case management cycle were included in this analysis. Members who had been enrolled in the program less than one week were also removed. Thus, only members who had actively engaged in the program for greater than one week were included in the analysis.

For programs where the participant was a mother, some measures could be calculated by analyzing only the participant's claims history. For other measures (e.g., percentage of deliveries admitted to the NICU), the analysis required a review of the child's claims history, as certain procedure and diagnosis codes are billed under the child's recipient ID (RID) number, rather than the mother's.

In order to identify the children of participants for the purposes of this analysis, PHPG first identified the date of the delivery billed under the mother's RID by reviewing claims with any diagnosis code of V27 ("outcome of delivery"). PHPG limited delivery dates to dates of service between 30 days prior through 30 days after disenrollment from the program, according to data contained in the Atlantes system.

Second, PHPG identified children in the recipient dataset with the same street address and zip code as the mother, and with a date of birth equal to the delivery date identified above. PHPG was able to successfully match approximately 60 percent or more of deliveries, depending on the program.

A member survey instrument was developed specifically for the PCM Department's obstetric and pediatric programs. A copy of the survey instrument is contained in Attachment B. Surveys were administered via telephone to a sample of obstetric and pediatric members, including HROB members. Prior to conducting the survey, a letter was mailed to all members informing them of the survey and what to expect.

As part of the sampling methodology, members were interviewed only about their current or most recent prenatal program and current or most recent pediatric program, as applicable. Members were also interviewed about the Synagis program, if applicable. For example, a member who initially was enrolled in the OB Outreach/At Risk OB program but later was elevated to the HROB program was interviewed about the HROB program. If the same member had a child enrolled in the FIMR Baby program, they were interviewed about that program as well.

Survey results were entered into a proprietary database and then analyzed on a per-program basis. A total of 59 HROB member surveys were collected. Findings for the HROB survey interviews are reported in the HROB Member Survey section.

Results

The following program enrollment and ENC activities were analyzed for the HROB program by using the Atlantes dataset:

- Total enrolled in the HROB program by SFY;
- Breakdown of HROB participants by county geography (i.e., rural, urban, suburban, mixed, out of state);
- HROB enrollment in the top ten counties;
- Total HROB participants by age range;
- Total HROB participants by CDC age range;
- Average length of time in program;
- Percentage of members contacted within three business days of receiving a referral to the HROB program by SFY;
- Total number of contacts per member per SFY;
- Total ENC time spent per member by SFY;
- Total ENC FTE time per SFY;
- Initial HROB/OB Outreach assessment rates by SFY; and
- Total number of HROB letters sent per member by SFY.

The following utilization and cost measures were evaluated for the HROB program by using claims and eligibility data:

- Early gestation and low birth weight percentages of HROB deliveries by SFY;
- Neonatal Intensive Care Unit (NICU) admissions in the HROB sample by SFY;
- The ratio of cesarean section deliveries to vaginal deliveries in the HROB sample by SFY;
- Utilization of pre-term labor medication for HROB members by SFY;
- HROB moms who were readmitted to the hospital within 30 days postpartum (i.e., postpartum readmission) by SFY;
- HROB moms who were readmitted to the hospital within 60 days postpartum (i.e., postpartum readmission) by SFY;

- Emergency Room visits for HROB moms within 30 days postpartum by SFY;
- Emergency Room visits for HROB moms within 60 days postpartum by SFY;
- Hospital admissions for HROB newborns during the first year of life by SFY;
- Emergency Room visits for HROB newborns during the first year of life by SFY; and
- Summary of expenditures for HROB moms and newborns by SFY.

The following member survey metrics were evaluated for the HROB program by using results from the HROB member surveys:

- Survey demographics (e.g., member age, ethnicity, education level);
- Services received through HROB and their helpfulness;
- ENC correspondence;
- ENC activities and member satisfaction rates;
- Overall member satisfaction with the assigned ENC and the HROB program; and
- Behavioral health screenings and referrals.

Analysis of HROB Enrollment and ENC Activities

This section describes program enrollment and ENC activities by SFY using data contained in Atlantes. It should be noted that as the program matured and web-based care management tools became available to the PCM Department in SFY 2009, the data became more complete and reliable.

Total Enrollment

Exhibit 3-2 below summarizes total HROB enrollment from SFY 2008 through SFY 2013. Total enrolled by SFY was calculated based on a member having a level-of-care start date in that fiscal year. Enrollment increased dramatically between SFY 2009 and 2013.

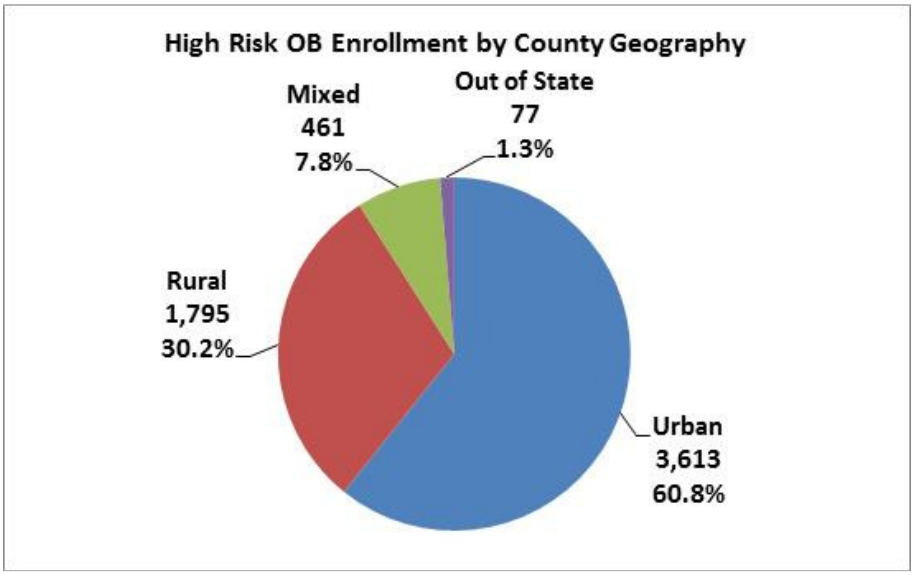
Exhibit 3-2: High Risk OB Enrollment by State Fiscal Year

SFY	Members
2008	58
2009	680
2010	1,176
2011	1,264
2012	1,345
2013	1,423
Total	**5,946**

Enrollment by County Geography

Exhibit 3-3 below summarizes the breakdown of HROB enrollment by county geography from SFY 2008 through SFY 2013. Sixty percent of HROB members resided in the urban counties of Cleveland, Oklahoma, and Tulsa. Thirty percent of HROB members resided in rural counties, with the balance of members having resided in mixed counties. A small percentage of 1.3 percent resided out of state at the time of the data analyses, though these members resided in Oklahoma when they were initially enrolled in the HROB program.

Exhibit 3-3: High Risk OB Enrollment by County Geography



Enrollment by Top Ten Counties

A review of county codes, based on county of residence in Atlantes, shows that the largest numbers of members (74 percent) resided in ten Oklahoma Counties from SFY 2008 through SFY 2013 (see Exhibit 3-4 on the following page).

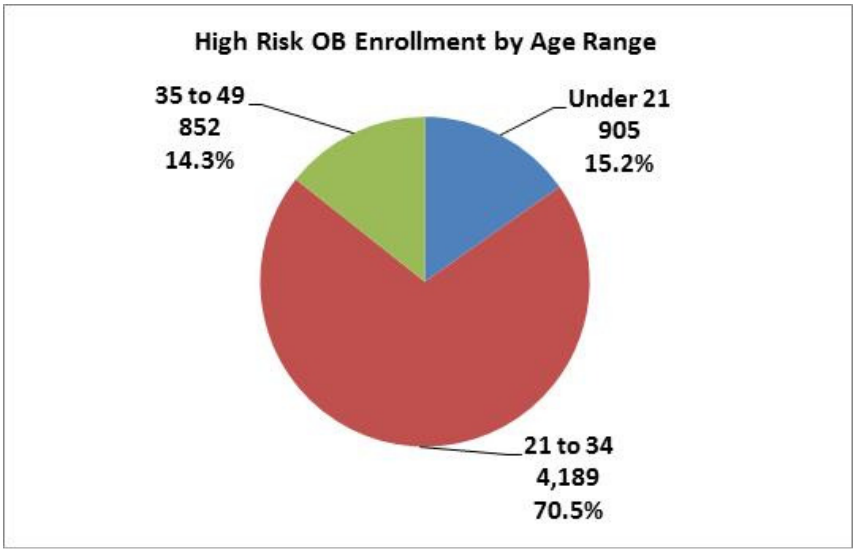
Exhibit 3-4: High Risk OB Enrollment by County

County	Total Members 2008-2013
Tulsa	1,907
Oklahoma	1,387
Cleveland	263
Creek	171
Okmulgee	121
Muskogee	119
Payne	114
Wagoner	112
Canadian	92
Cherokee	88
All other counties	1,572
Grand Total	**5,946**

Age Range of HROB Members

Over 70 percent of HROB members fell into the age range of 21 to 34 from SFY 2008 through SFY 2013, with the remaining 30 percent fairly evenly split between ages 35 to 49 and under 21 (see Exhibit 3-5 below).

Exhibit 3-5: High Risk OB Enrollment by Age Range



CDC Age Range of HROB Members

The Centers for Disease Control and Prevention (CDC) monitor pregnancy rates and rates of pregnancy outcomes using pre-defined age ranges. Exhibit 3-6 below provides a breakdown of HROB enrollment for the nine CDC age ranges from SFY 2008 through SFY 2103.

Over 75 percent of HROB members fell into the age ranges of 20 to 24 years, 25 to 29, and 30 to 34. Eleven percent of members fell into the age range of 35 to 39, and seven percent fell into the age range of 18 to 19.

Exhibit 3-6: High Risk OB Enrollment by CDC Age Range

CDC Age Range	Members	CDC Age Range	Members
Under 15	16	30 - 34	1,187
15 - 17	169	35 – 39	672
18 – 19	419	40 – 44	171
20 – 24	1,652	Over 44	9
25 - 29	1,651	**Total**	**5,946**

Length of Stay

Exhibit 3-7 on the following page summarizes the average length of stay from SFY 2008 through SFY 2013 Length of stay was calculated by subtracting a member's level-of-care end date from their level-of-care start date.

Seventy-three percent of HROB members were enrolled three or fewer months, of which 30 percent were enrolled five to eight weeks in duration. Twenty-four percent of members were enrolled four to six months, of which 12 percent were enrolled 13-16 weeks in duration. Approximately three percent of members were enrolled in HROB more than six months.

Exhibit 3-7: High Risk OB Length of Stay

Length of Stay (weeks)	Duration Classification	# Members	% Members
1-4	Three or Fewer Months	1,336	22.5%
5-8		1,807	30.4%
9-12		1,199	20.2%
	Total	***4,342***	**73.0%**
13-16	Four to Six Months	730	12.3%
17-20		480	8.1%
21-24		222	3.7%
	Total	***1,432***	**24.1%**
25-28	Seven to Nine Months	78	1.3%
29-32		36	0.6%
33-36		17	0.3%
	Total	***131***	**2.2%**
37-40	Ten to Twelve Months	7	0.1%
41-44		2	0.0%
45-48		3	0.0%
49-52		1	0.0%
	Total	***13***	**0.2%**
53+	More than One Year	28	0.4%
	Total	***28***	**0.5%**

ENC Activity Time

Initial Outreach

Once a member is assigned to an ENC, the ENC attempts to make an initial telephone contact within three business days of receiving the referral. Three attempts are made on three different days at different times to contact the member via telephone. To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes HROB Activity Report. The review was limited to only those cases where the data indicated that an ENC performed initial telephone outreach (e.g., member contact attempts 1, 2 and 3, phone calls to and from) within three business days of a referral to case management. Time spent performing each outreach attempt had to be more than five minutes in duration.

Exhibit 3-8 on the following page highlights member contacts made within three business days from SFY 2008 through SFY 2013. Member contact rates varied by SFY and ranged from 37 to 74 percent. The average contact rate across all SFYs was 58.5 percent. The involvement of both an OB and MFM provider in the member's authorization process, as well as the enhanced HROB benefit package for the member, may have played a role in the higher reach rates for members in this program.

Exhibit 3-8: High Risk OB Contacts within Three Business Days

Measure	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Members Contacted within Three Business Days	35	429	869	929	693	526
Total HROB Enrollment	58	680	1,176	1,264	1,345	1,423
Contact Rate	**60.3%**	**63.1%**	**73.9%**	**73.5%**	**51.5%**	**37.0%**

Total Contacts

All contacts for members in the HROB program are documented in Atlantes. To determine the number of contacts, a count was performed of all activity actions contained in the Atlantes HROB Activity Report. Time spent performing member activities had to be more than five minutes in duration.

Exhibit 3-9 below contains the average number of contacts per member from SFY 2008 through SFY 2013. ENCs had an average of 5.4 to 7.6 contacts across the six fiscal years. The average number of member contacts across all SFYs was 6.6 contacts per member. Contacts decreased by 29 percent from SFY 2011 to SFY 2013. This number may have declined when the PCM Department implemented additional case management programs, and, as a result, staff caseloads increased. It should be noted that contact attempts are sometimes relaxed in times of staffing crises.

Exhibit 3-9: High Risk OB Total Contacts per Member

Measure	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Count of Contacts	344	4,047	8,962	9,567	8,754	7,688
Total HROB Enrollment	58	680	1,176	1,264	1,345	1,423
Total Contacts Per Member	**5.9**	**6.0**	**7.6**	**7.6**	**6.5**	**5.4**

ENC Time Spent Managing Enrollees

For HROB cases, if there was a previous ENC assigned to the member for a prior level of care, then attempts are made to re-assign the member to the same ENC. If there is no prior history with an ENC, assignment to HROB is based on ENC caseload at the time of member activation. ENC assignment is then performed using a round-robin approach.

To assess the time spent by ENCs on the HROB program, PHPG used the Atlantes activity data and limited our review to only those cases where an ENC performed activities related to women who were assigned to HROB. In each fiscal year, a large majority of ENC time was dedicated to assessments, ongoing member correspondence and care management for enrolled members, and provider outreach. These activities are consistent with the primary functions of ENCs.

From SFY 2008 through 2013, ENCs spent an average of 1.4 to 2.6 hours per case across all activities. Average ENC hours per case and equivalent FTEs decreased in SFY 2012 and 2013. The FTEs required for the HROB Program reached a high of around 1.6 FTEs in SFY 2011, decreasing to 1.0 FTE in SFY 2013 (see Exhibit 3-10 below). The decrease may be attributed to the widening scope and volume of ENC duties and subsequent contact standard adjustments during times of staffing crises.

The electronic HROB/OB Outreach Assessment Tool went into production in Atlantes in September 2011 along other automated processes. As a result, there were changes to processes and challenges in the way ENCs captured their time (i.e., some ENCs under-reported their time) while performing the assessment.

Exhibit 3-10: High Risk OB ENC Time per Member and ENC FTE Time

Measure	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Total Members	58	680	1,176	1,264	1,345	1,423
Sum of HROB Activity (Hours)	142.1	1,411.9	3,070	3,268.6	2,964.3	2,061.4
ENC Time Per Enrolled Member (Hours)	**2.5**	**2.1**	**2.6**	**2.6**	**2.0**	**1.4**
Total ENC FTE Time	**0.1**	**0.7**	**1.5**	**1.6**	**1.3**	**1.0**

HROB Assessment Rates

Initial HROB/OB Outreach Assessment

Upon successful contact with a HROB member, the HROB/OB Outreach Initial Call Assessment is completed. The assessment includes talking points and the Edinburgh Postnatal Depression Scale (EPDS) screening tool. The assessment is located in Atlantes. An analysis of the HROB/OB Outreach Initial Call Assessment rates was performed using the Atlantes HROB Assessment Report. A count of all initial assessments was performed by SFY, and these totals were divided by the number of unique members served in each SFY from SFY 12 (when the HROB/OB Outreach Assessment was available in Atlantes) through SFY 2013. The initial assessment rate increased by 25 percent from SFY 2012 through SFY 2013, when there was a 77 percent compliance rate (see Exhibit 3-11 below).

Exhibit 3-11: Initial HROB/OB Outreach Assessment Rates

Measure	SFY2012	SFY2013
Initial Assessments Performed	828	1,095
Total HROB Enrollment	1,345	1,423
Initial Assessment Rate	**61.6%**	**77.0%**

HROB Letters

ENCs generate and mail a number of letters to members and providers for the HROB program, including but not limited to, introductory letters, unable-to-contact letters, provider notification, and case closure letters. An analysis was performed for the number of HROB letters sent by SFY. From SFY 2008 through 2013, ENCs mailed an average of 2.7 to 3.9 letters per member (see Exhibit 3-12 below).

Exhibit 3-12: High Risk OB Letters Sent by State Fiscal Year

Measure	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Total Letters Sent	162	1,834	4,429	4,901	4,385	4,880
Total HROB Enrollment	58	680	1,176	1,264	1,345	1,423
Total Letters Per Member	**2.8**	**2.7**	**3.8**	**3.9**	**3.3**	**3.4**

HROB Utilization and Cost Outcomes

This section highlights HROB utilization and cost trends by SFY using claims and eligibility data for dates of services in SFY 2010 through 2013. It should be noted that exhibits are presented based on date/SFY of the delivery and not the actual claims incurred during each SFY.

Early Gestation/Low Birth Weight

Early gestation and low birth weight diagnosis codes were evaluated separately. The two populations were essentially the same. For the vast majority of cases, pre-term deliveries were coded as both early gestation and low birth weight. Therefore, a combined rate was calculated based on the number of participants with these codes out of the total number of identifiable deliveries.

The four-year average rate of early gestation and low birth weight deliveries was nearly 20 percent. From SFY 2010 through SFY 2013, the percentage of early gestation and low birth weight deliveries declined by 25 percent. While there are multiple factors that play a role in early gestation and low birth weight deliveries, one cannot rule out the positive impact of ongoing case management to encourage members to access prenatal care (see Exhibit 3-13 on the following page).

Exhibit 3-13: Percentage of Early Gestation and Low Birth Weight Deliveries among HROB Participants

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	1,244	1,348	1,536	1,712	5,840
Deliveries Identified	1,161	1,141	1,181	1,237	4,720
Participants Early Gestation/Low Birth Weight	251	254	227	201	933
Percent of Early Gestation/Low Birth Weight Deliveries	**21.6%**	**22.3%**	**19.2%**	**16.2%**	**19.8%**

Neonatal Intensive Care Unit Admissions

From SFY 2010 through SFY 2013, NICU admission rates remained relatively constant (see Exhibit 3-14 below). On average, 13.1 percent of HROB deliveries resulted in a NICU admission. NICU rates are highly correlated to the percent of early gestation/low birth weight deliveries. Therefore, continued efforts should be made to improve early access to prenatal care and to educate mothers in a timely manner.

Exhibit 3-14: Percentage of NICU Admissions among HROB Participants

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	1,244	1,348	1,536	1,712	5,840
Deliveries Paired with Child in Claims	**577**	**590**	**686**	**805**	**2,658**
NICU Cases	80	74	90	105	349
Percent of Deliveries Admitted to NICU	**13.9%**	**12.5%**	**13.1%**	**13.0%**	**13.1%**

Cesarean Section vs. Vaginal Delivery

Vaginal delivery rates for HROB members remained fairly constant year over year. The four-year average for cesarean section rates was 12.0 percent, which is not alarming in a higher acuity OB population (see Exhibit 3-15 on the following page).

Exhibit 3-15: Cesarean Section vs. Vaginal Delivery Comparison among HROB Participants

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	1,244	1,348	1,536	1,712	5,840
Deliveries Identified	1,161	1,141	1,181	1,237	4,720
Vaginal Deliveries	1,033	973	1,038	1,111	4,155
Percent of Vaginal Deliveries	**89.0%**	**85.3%**	**87.9%**	**89.8%**	**88.0%**
Cesarean Section Deliveries	128	168	143	126	565
Percent of Cesarean Section Deliveries	**11.0%**	**14.7%**	**12.1%**	**10.2%**	**12.0%**

Utilization of Pre-Term Labor Pharmaceuticals

PHPG analyzed pharmacy claims for pre-term labor pharmaceuticals commonly used. The OHCA supplied 11 NDC plus four procedure codes (J1725, J2675, Q2042, S5000) as part of the analysis. The percent of HROB members who received pre-term labor pharmaceuticals was fairly low, with an average of 0.8 to 2.7 percent over the four-year period (see Exhibit 3-16 below).

Exhibit 3-16: Utilization of Pre-Term Labor Pharmaceuticals among HROB Participants

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	1,244	1,348	1,536	1,712	5,840
Deliveries Identified	1,161	1,141	1,181	1,237	4,720
Received Pre-term Labor Pharmaceuticals	16	31	9	18	74
Percent Received Pre-term Labor Pharmaceuticals	**1.4%**	**2.7%**	**0.8%**	**1.5%**	**1.6%**

Utilization Rates

PHPG evaluated the percentage of mothers that were readmitted as inpatients, as well as ER visits within 30 and 60 days of delivery. All claims were evaluated for this time period, not just OB-related claims. Readmission rates within 30 and 60 days of the mother's delivery declined steadily from SFY 2011 through SFY 2013, though the rates were higher at 60 days as compared to 30 days. Similarly, ER visits declined from SFY 2011 through SFY 2013 at both the 30- and 60-day mark, though the rates were again higher at the 60-day mark.

An evaluation was performed of hospitalizations and ER visits for newborns through the first year of life. The analysis did not include delivery-related inpatient claims. Inpatient admission rates per 1,000 remained relatively steady over each SFY. ER visit rates per 1,000 increased from SFY 2012 through SFY 2013 (see Exhibit 3-17 below).

Exhibit 3-17: Utilization among HROB Participants and their Newborns

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Inpatient Admissions – Mother					
Any Within 30 Days of Delivery	40	52	31	28	151
Percent Readmitted within 30 days	**3.4%**	**4.6%**	**2.6%**	**2.3%**	**3.2%**
Any Within 60 Days of Delivery	45	61	34	35	175
Percent Readmitted within 60 days	**3.9%**	**5.3%**	**2.9%**	**2.8%**	**3.7%**
Inpatient Admissions – Child					
Total	632	587	654	792	2,665
Per 1,000 Children	**1,095.32**	**994.92**	**953.35**	**983.85**	**1002.63**
Emergency Room Visits – Mother					
Any Within 30 Days of Delivery	132	152	129	110	523
Percent of ER Visits within 30 Days	**11.4%**	**13.3%**	**10.9%**	**8.9%**	**11.1%**
Any Within 60 Days of Delivery	176	199	190	158	723
Percent of ER Visits within 60 Days	**15.2%**	**17.4%**	**16.1%**	**12.8%**	**15.3%**
Emergency Room Visits – Child					
Total	306	648	734	946	2,634
Per 1,000 Children	**530.33**	**1,098.31**	**1,069.97**	**1,175.16**	**990.97**

Expenditures

Between SFY 2011 and 2013, total HROB program expenditures and expenditures per case for both mother and child increased steadily. Total expenditures for both mother and child were $57.4 million, which were equally divided between both cohorts. HROB benefits comprised approximately three percent of the total expenditures for the mother (see Exhibit 3-18 below).

Exhibit 3-18: Summary of Expenditures for HROB Participants and their Newborns

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Total Expenditures (paired deliveries only)					
Mother	**$6,517,664**	**$6,466,824**	**$7,724,470**	**$9,312,196**	**$30,021,154**
HROB Benefits	$213,314	$202,961	$254,502	$274,271	**$945,048**
-Fetal Non-Stress Tests and Biophysical Profiles	$190,587	$185,821	$240,933	$249,846	**$867,187**
-Prenatal At-Risk Ante Partum Management	$12,906	$10,303	$6,110	$8,107	**$37,426**
-Ultrasounds	$9,822	$6,838	$7,459	$16,318	**$40,437**
HROB Pharmaceuticals	$893	$1,280	$352	$163,345	**$165,870**
Child	**$5,511,444**	**$4,428,909**	**$6,756,173**	**$10,707,790**	**$27,404,316**
TOTAL	**$12,029,108**	**$10,895,733**	**$14,480,643**	**$20,019,986**	**$57,425,470**
Expenditures per Case (paired deliveries only)					
Mother	**$11,295.78**	**$10,960.72**	**$11,260.16**	**$11,567.95**	**$11,294.64**
HROB OB Benefits	$369.70	$344.00	$370.99	$340.71	$355.55
-Fetal Non-Stress Tests and Biophysical Profiles	$330.31	$314.95	$351.21	$310.37	$326.26
-Prenatal At-Risk Ante Partum Management	$22.37	$17.46	$8.91	$10.07	$14.08
-Ultrasounds	$17.02	$11.59	$10.87	$20.27	$15.21
HROB Pharmaceuticals	$1.55	$2.17	$0.51	$202.91	$62.40
Child	**$9,551.90**	**$7,506.63**	**$9,848.65**	**$13,301.60**	**$10,310.13**
TOTAL	**$20,847.67**	**$18,467.34**	**$21,108.81**	**$24,869.55**	**$21,604.77**

HROB Member Survey Findings

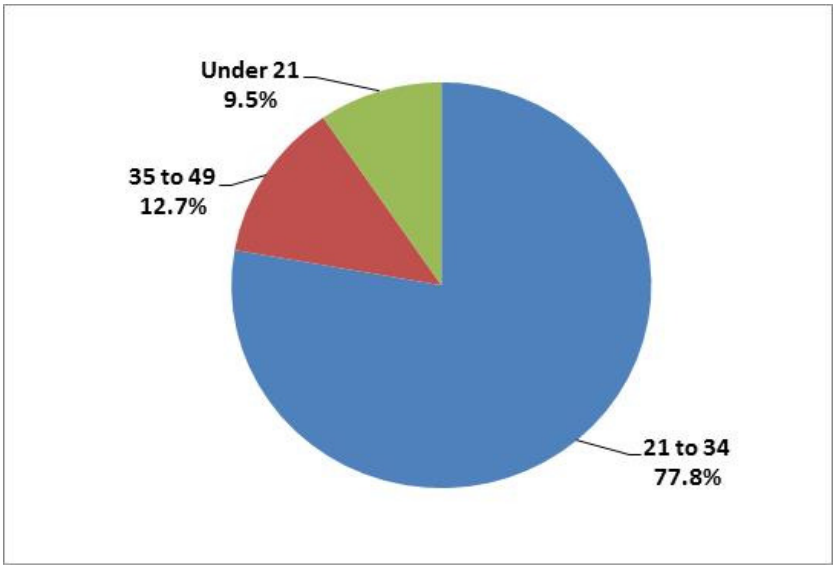
This section describes key findings from the HROB member survey using data collected from 59 survey interviews.

Survey Demographics

Age Range

Nearly 78 percent of respondents fell into the age range of 21 to 34. Over 12 percent were between 35 and 49, and nearly ten percent were under 21 (see Exhibit 3-19 below).

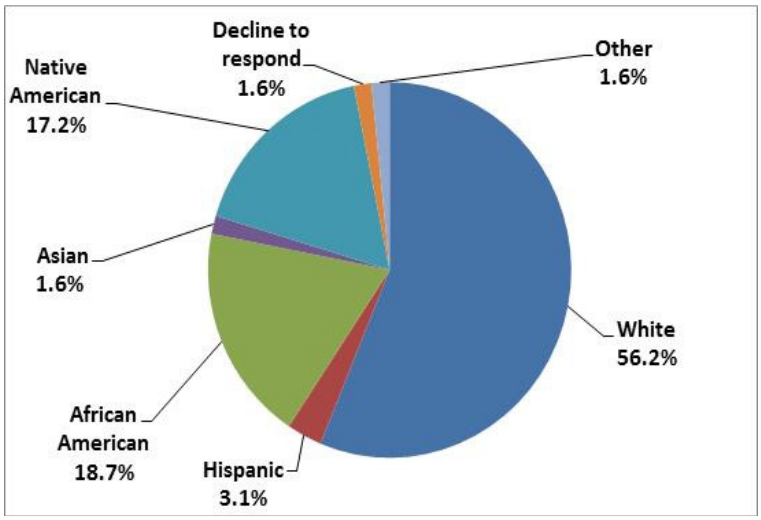
Exhibit 3-19: Age Range



Ethnicity

Over half of respondents (56.2 percent) reported their ethnicity as white (see Exhibit 3-20 below).

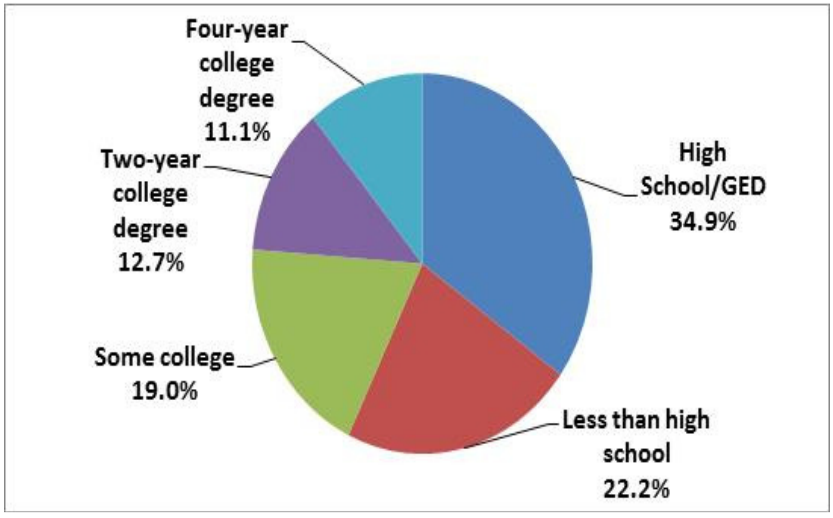
Exhibit 3-20: Ethnicity



Highest Level of Education Completed

Over one-third of respondents (34.9 percent) said they completed high school/GED (see Exhibit 3-21 below). Another 19 percent reported completing some college education. Slightly more participants completed a two-year college degree (12.7 percent) than a four-year college degree (11.1 percent). Over 20 percent reported not completing high school.

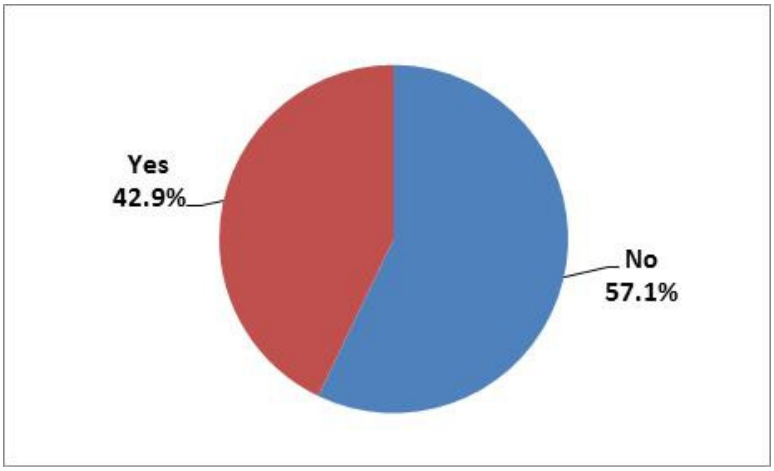
Exhibit 3-21: Education Level



Miscarriages

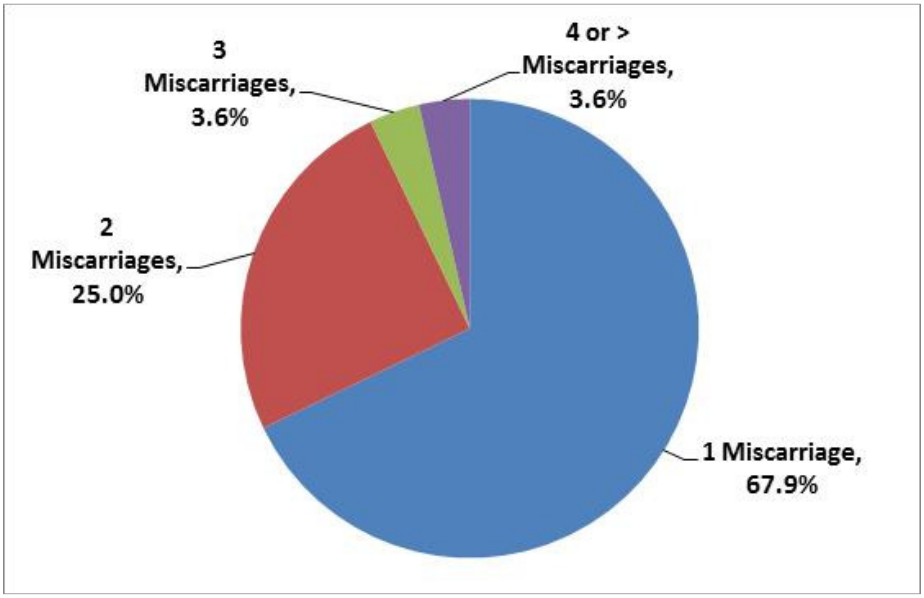
Among all respondents, 57.1 percent denied having a miscarriage. Another 42.9 percent reported having a miscarriage (see Exhibit 3-22 below).

Exhibit 3-22: Miscarriages



Among those who reported having a miscarriage, 67.9 percent said they had one miscarriage. Twenty-five percent reported having two miscarriages (see Exhibit 3-23 below). Over seven percent had three or more miscarriages.

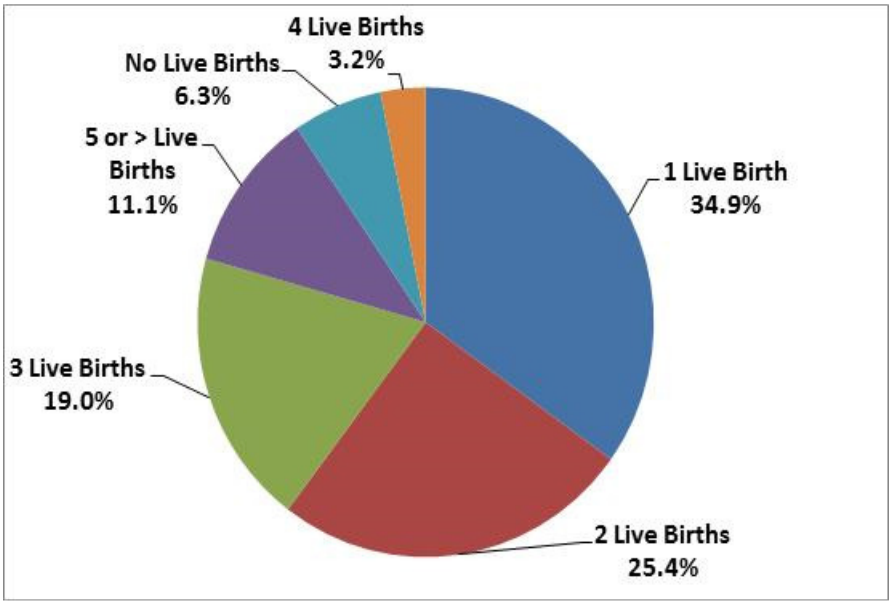
Exhibit 3-23: Number of Miscarriages



Number of Live Births

Among all respondents, over one-third (34.9 percent) reported having one live birth. Another 25.4 percent reported having two live births. Nineteen percent reported having three live births (see Exhibit 3-24 below). Over six percent reported no live births, which is attributable to pregnancy status at the time of the survey or due to miscarriage(s).

Exhibit 3-24: Number of Live Births



HROB Program Services

There are a number of services available to members in the HROB program. Nearly all respondents said they received the enhanced benefit package. Over 81 percent said they received monthly phone calls, and nearly 75 percent reported having assessments performed. Over 62 percent reported obtaining referrals to programs and services. Over 50 percent reported they received training and education services, as well as family planning services (see Exhibit 3-25 on the following page).

Exhibit 3-25: High Risk OB Program Services

Service		Respondents answering "yes" to service				
	Yes	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Unsure/N/A
Assessment	**74.6%**	52.5%	22.0%	5.1%	0.0%	20.3%
Enhanced Benefit Package	**93.2%**	84.7%	8.5%	1.7%	0.0%	5.1%
Training and Education	**57.6%**	35.6%	22.0%	0.0%	0.0%	42.4%
Educational Materials	**49.2%**	37.3%	13.6%	1.7%	0.0%	47.5%
Postpartum Depression Screening	**30.5%**	23.7%	5.1%	0.0%	0.0%	71.2%
Referrals to Programs and Services	**62.7%**	45.8%	16.9%	1.7%	0.0%	35.6%
Appointment Scheduling	**23.7%**	18.6%	8.5%	0.0%	0.0%	72.9%
Family Planning	**52.5%**	30.5%	23.7%	0.0%	0.0%	45.8%
Monthly Phone Calls	**81.4%**	55.9%	22.0%	3.4%	0.0%	18.6%
Home Visitation	**00.0%**	0.0%	0.0%	0.0%	0.0%	0.0%

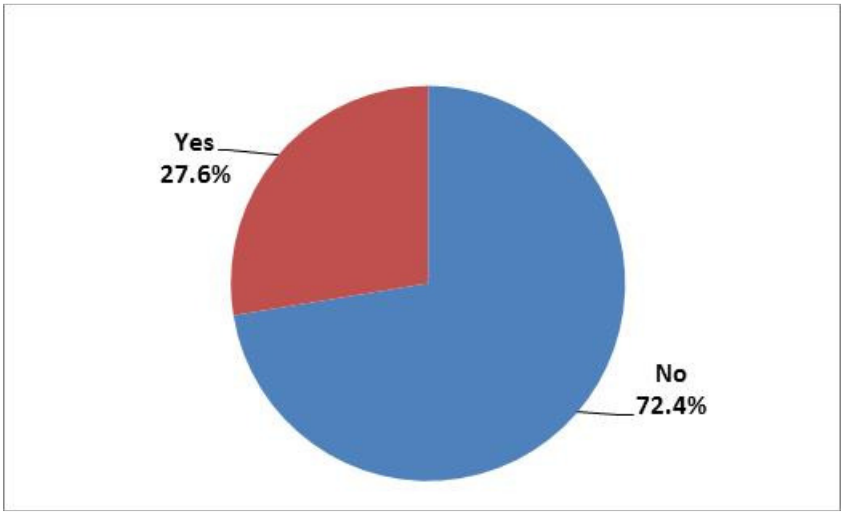
Respondents were asked to rate the helpfulness of each “yes” service. Nearly 85 percent of respondents reported the enhanced benefit package was very helpful. Over half reported the assessments and monthly phone calls were very helpful. Nearly half reported referrals to programs and services were very helpful. Over one-third of respondents reported training and education was very helpful.

ENC Correspondence

Name of Case Manager

Among all respondents, only 27.6 percent could recall the name of their case manager (see Exhibit 3-26 below).

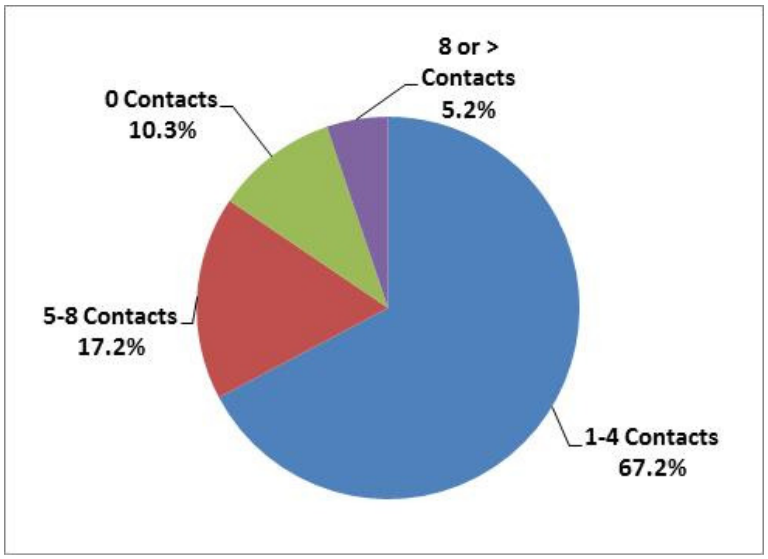
Exhibit 3-26: Identified the Name of Case Manager



Number of Times Spoke with Case Manager

Over two-thirds (67.2 percent) of respondents said they spoke with their case manager from one to four times since they started the program (see Exhibit 3-27 below). Ten percent said they had no contact with their case manager.

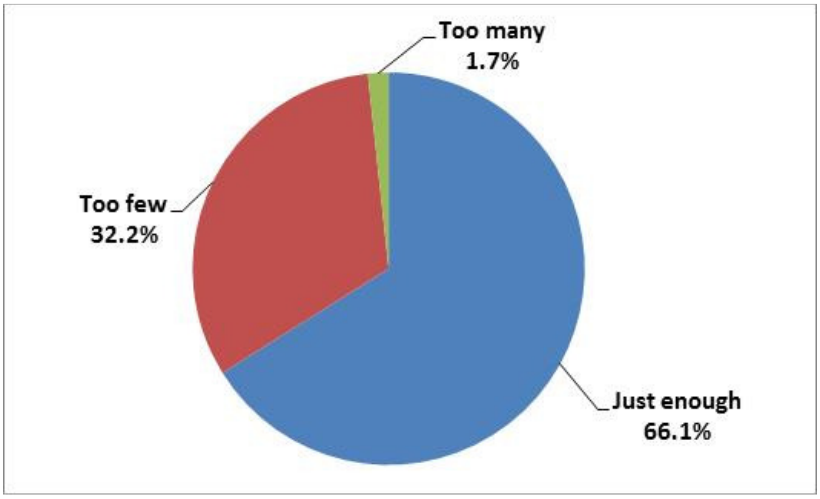
Exhibit 3-27: Number of Times Spoke with Case Manager



Rating of Case Manager Contacts

Nearly two-thirds (66.1 percent) of respondents felt the number of times their case manager contacted them was just enough (see Exhibit 3-28 below).

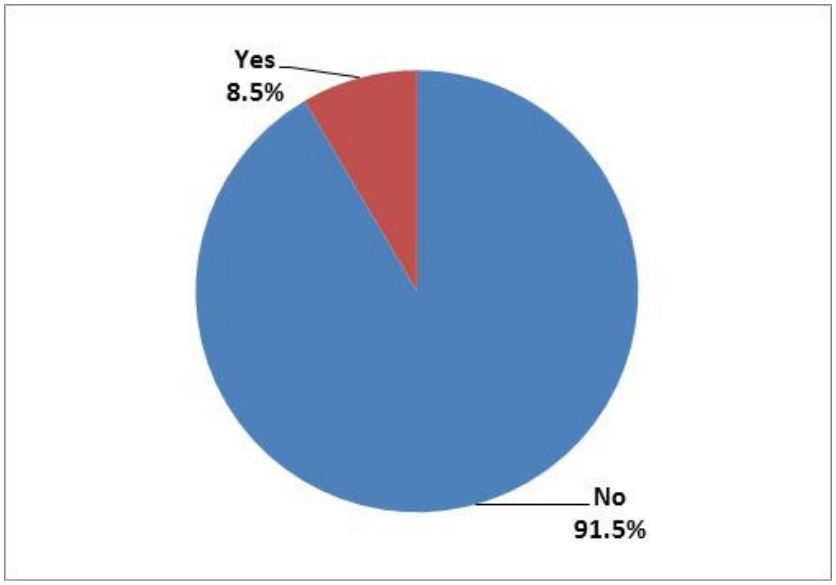
Exhibit 3-28: Rating of Case Manager Contacts



Member Calls to Case Manager

The majority of respondents (91.5 percent) said they had not called their case manager (see Exhibit 3-29 below).

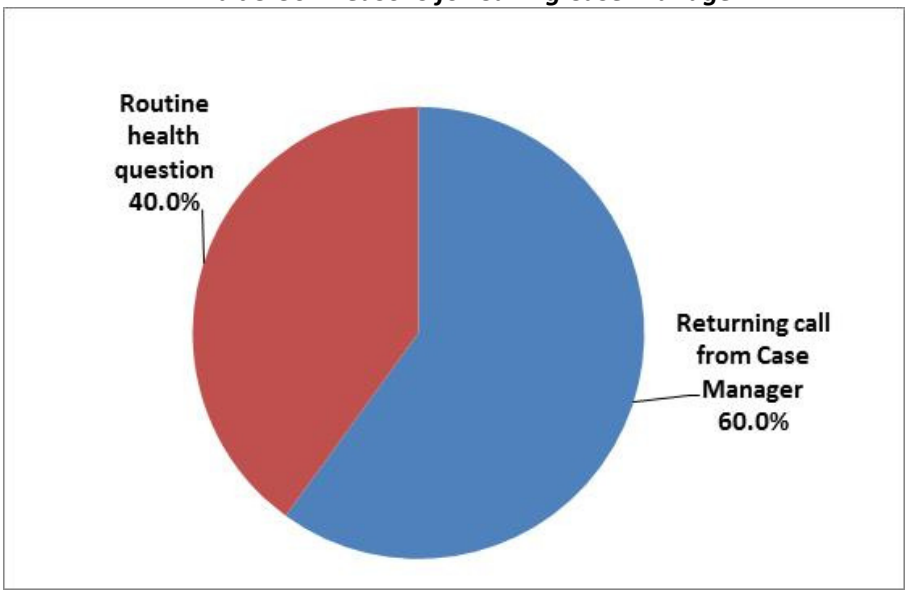
Exhibit 3-29: Have Called Their Case Manager



Reason for Calling Case Manager

Of the respondents who called their case manager, 60 percent said they were returning phone calls from their case manager, and another 40 percent called with a routine health question (see Exhibit 3-30 below).

Exhibit 3-30: Reasons for Calling Case Manager



ENC Activities

Case managers are expected to help participants build their self-management skills. Nearly 90 percent of respondents indicated that their nurse care manager asked questions about their health problems or concerns (see Exhibit 3-31). Over two-thirds said their case manager provided answers and instructions for taking care of their health. Over 55 percent said their case manager referred them to programs and services.

Exhibit 3-31: Case Manager Activity Ratings

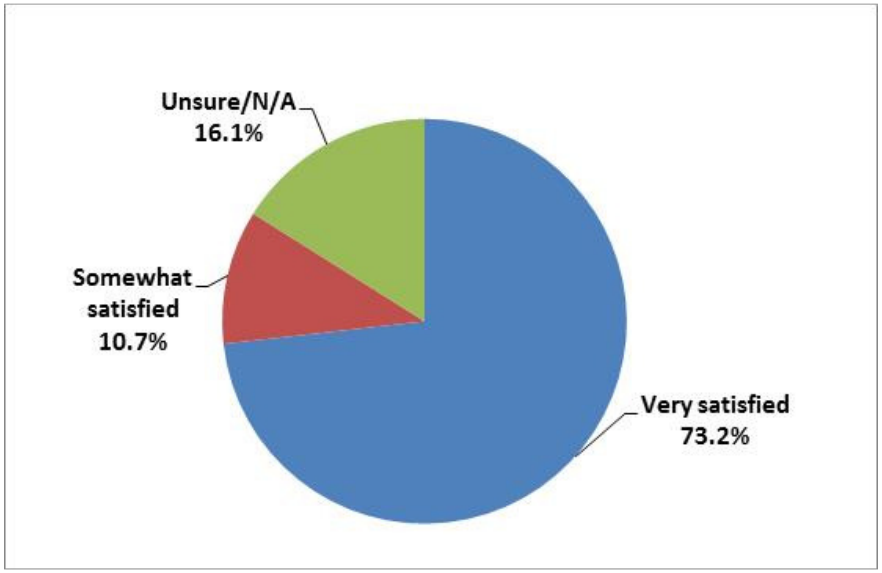
Activity		Respondents answering "yes" to activity				
	Yes	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Unsure/N/A
Asked questions about your health or concerns	**89.8%**	76.3%	13.6%	0.0%	0.0%	10.2%
Provided instructions about taking care of your health	**69.5%**	66.1%	3.4%	0.0%	0.0%	30.5%
Helped you to identify changes in your health that might be an early sign of a problem	**20.3%**	23.7%	0.0%	0.0%	0.0%	76.3%
Answered questions about your health care needs	**67.8%**	67.2%	0.0%	0.0%	0.0%	32.8%
Helped you to make and keep health care appointments for medical problems	**18.6%**	22.0%	0.0%	0.0%	0.0%	78.0%
Helped you to make and keep health care appointments for mental health or substance abuse problems	**3.4%**	3.4%	0.0%	0.0%	0.0%	96.6%
Referred you to programs and services	**55.9%**	53.4%	0.0%	0.0%	0.0%	46.6%
Helped you to stop smoking or stop using tobacco products	**6.8%**	6.8%	0.0%	0.0%	0.0%	93.2%

Respondents were asked to rate their satisfaction with each “yes” activity. Nearly 90 percent reported being very satisfied when their case manager asked questions about their health or concerns. Over two-thirds said they were very satisfied with how their case manager provided answers and instructions for taking care of their health. Over 50 percent reported being very satisfied when their case manager referred them to programs and services.

Satisfaction with ENC and High Risk OB Program

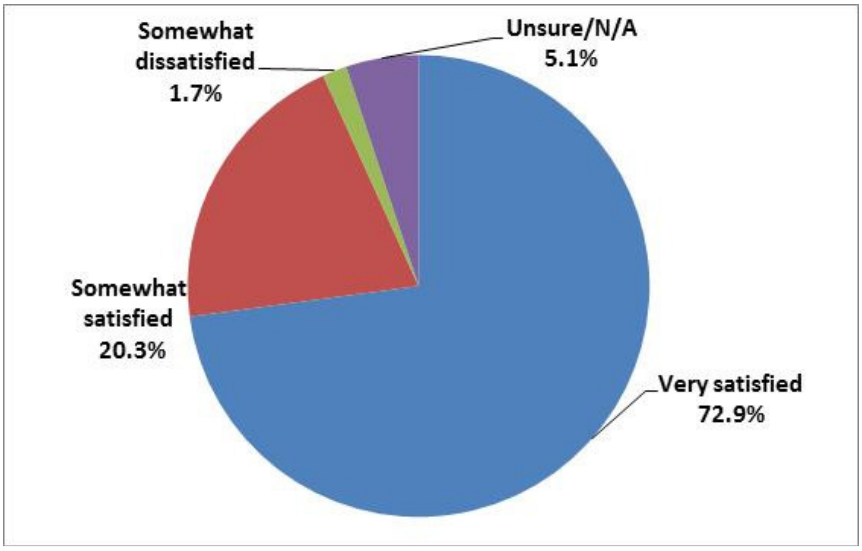
Overall, 73.2 percent of respondents were very satisfied with the help they received from their case manager (see Exhibit 3-32 on the following page).

Exhibit 3-32: Overall Satisfaction with Case Manager



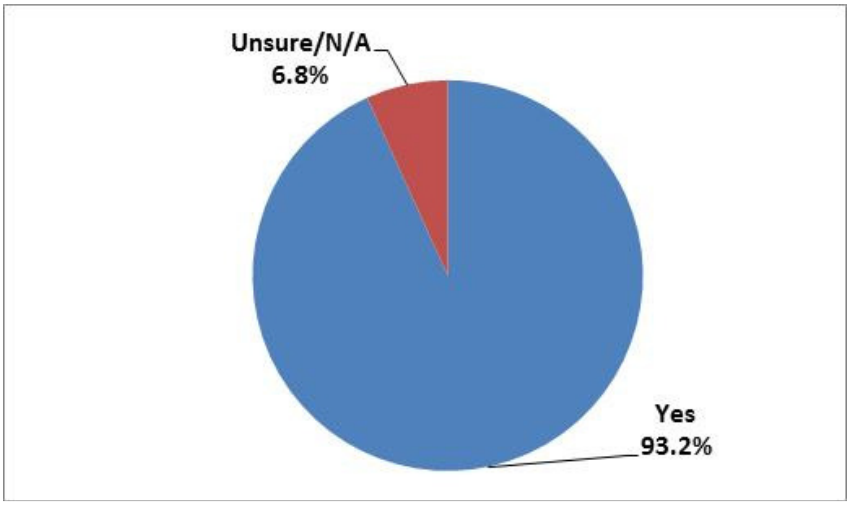
Overall satisfaction with the HROB program (72.9 percent) closely tracked to the case manager satisfaction ratings (see Exhibit 3-33 below).

Exhibit 3-33: Overall Satisfaction with High Risk OB Program



The overwhelming majority of surveyed participants (93.2 percent) would recommend the HROB program to a friend with similar health care needs (see Exhibit 3-34 on the following page).

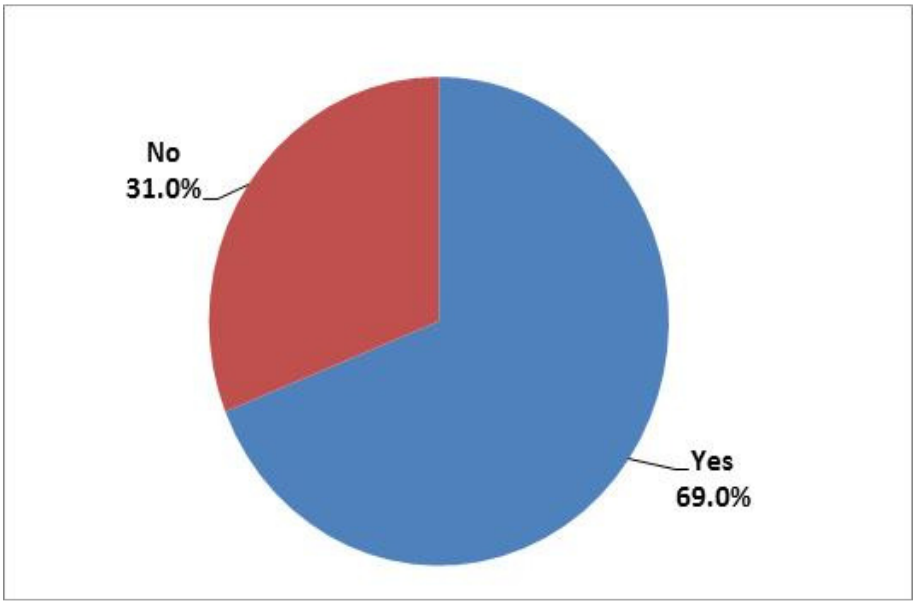
Exhibit 3-34: Would Recommend High Risk OB Program



Completed Behavioral Health Screening

Overall, 69 percent of respondents reported completing a behavioral health screening with someone at the OHCA (see Exhibit 3-35).

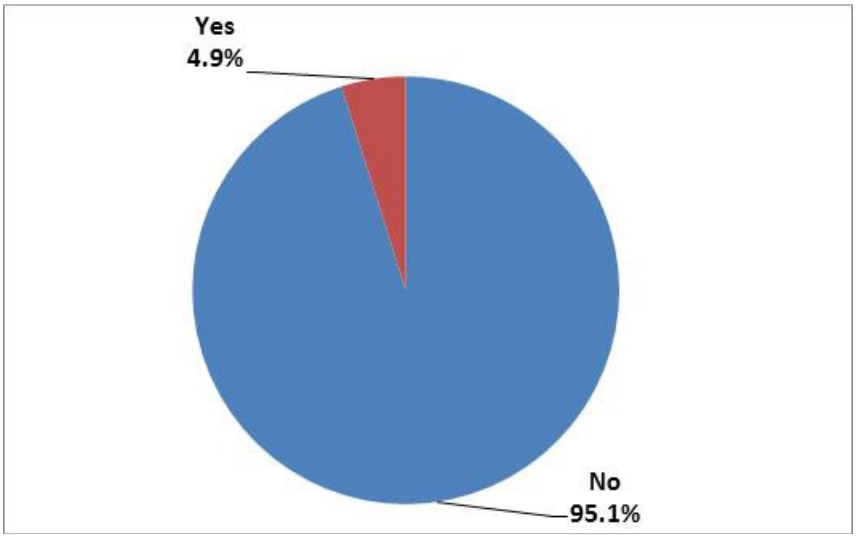
Exhibit 3-35: Completed Behavioral Health Screening



Referred to the OHCA's Behavioral Health Unit (BHU)

One respondent (4.9 percent) was referred to the OHCA's BHU (see Exhibit 3-36). Although members may have had a positive behavioral health screening, they must consent to a referral to the BHU.

Exhibit 3-36: Referred to OHCA's Behavioral Health Unit



Outpatient Behavioral Health Referrals

Only one member reported obtaining a referral to an outpatient behavioral health agency.

Overall Satisfaction with the BHU

The one respondent who was referred to the OHCA's BHU reported being very satisfied with the help received.

OB OUTREACH/AT RISK OB PROGRAM INTRODUCTION AND PROGRAM OVERVIEW

OB Outreach Program/At Risk OB Program Objective

The OHCA's OB Outreach (OBOR) Program was implemented in the OHCA's Member Services Department on July 1, 2008. The OHCA's OB Outreach Program provides targeted outreach for SoonerCare pregnant members to connect them with benefits and resources, to ensure they are linked with an obstetric provider for prenatal care, and to identify women who are at risk for poor birth outcomes and who may benefit from case management services.

The PCM Department has an At Risk OB (AROB) Case Management Program to assess At Risk OB members and to provide them with education, linkage to resources, and routine follow-up in an effort to reduce potential complications. Members are identified for the program through outreach letters and subsequent positive screenings by the OHCA Member Services Department as part of the OB Outreach Program. The At Risk OB Program was implemented February 1, 2008.

At the OHCA's request, PHPG performed an evaluation of both programs. The following sections describe the history and overview of the two programs, as well as evaluation findings.

Program History and Overview

Since February 1, 2008, the OHCA's Case Management Unit (CMU) has collaborated with OHCA's Member Services Department on OB outreach activities.

OB Outreach Program History

There is a critical need for pregnant women to begin receiving prenatal care during the first trimester of their pregnancy in order to promote the best possible health outcomes for both a mother and her baby. A complex birth under SoonerCare costs taxpayers about 14 times that of a healthy birth. According to an OHCA report, in SFY 2007, only eight percent of SoonerCare births were complex; however, they accounted for more than half of the OHCA's newborn costs[1].

Many women do not learn that they are pregnant until halfway into their first trimester. Even then, it takes time for them to apply for SoonerCare benefits, obtain medical coverage, and receive notifications from the OHCA. As a result, SoonerCare pregnant members are often at the beginning of their second trimester before they begin to access prenatal care.

[1] Rupe, K. Quality Team Day abstract for the OHCA OB Outreach Project. May 6, 2010.

To help provide SoonerCare pregnant members with early access to prenatal care, the OHCA initiated an outbound calling campaign with the goal of speaking directly to these members. When a member was reached, the OHCA could immediately begin the process of connecting the member with an available prenatal care provider, assist the member to schedule the initial appointment, explain the reason for the call, and answer any questions a member may have about the medical benefits. It was the OHCA's belief that babies not only could obtain a healthy beginning to life– a worthy goal by itself– but that they could also save taxpayer funds if even one complex birth could be averted.

Unfortunately, the OHCA was only able to reach 20 percent of pregnant members through this initiative. Due to computerized call tracking requirements, Member Services Coordinators (MSCs) could not make outbound calls and receive inbound calls at the same time. This then led to the division of MSC so that some could perform outbound calls and some could receive inbound calls from pregnant members, thereby reducing the number of inbound calls that could be answered. The OHCA began to consider alternative ways to increase contact rates for pregnant members.

In June 2008, the OBOR Program began as a pilot project to test what method of outreach worked best for SoonerCare pregnant members. Member Services, with the assistance of the OHCA Waiver Reporting personnel, participated in the project to test different styles and lengths of letters directed at pregnant members. Up until that time, all new members received outreach calls upon enrollment into SoonerCare, but nothing was targeted specifically to pregnant women.

Results of the member responses for each type of letter were recorded and compared. When the OHCA could not reach a member through outbound calling, and no answering machine was available to leave a message, they sent a letter asking the member to call back at her convenience. The call volume resulting from this letter was 20 times greater than that from the other letters trialed as part of this initiative.

The letter subsequently became the model letter that is currently used for the OBOR Program ("Pat Brown Letter"). The letter, a short, four-sentence message, informs the member about important pregnancy-related updates and the importance of calling the OHCA by a certain date to ask for "Pat Brown" so that an OB screening can be performed. The combination of these elements proved an immediate success. Within two weeks, the OHCA received calls from 38 percent of the members to whom they had mailed letters, resulting in a 90 percent increase over the previous outbound call contact rate (20 percent to 38 percent).

The pilot resulted in the achievement of better contact rates from targeted mailings to SoonerCare pregnant members than from direct phone outreach to pregnant members. Beginning February 1, 2008, all pregnant members who were identified on the initial enrollment file received a letter requesting they contact Member Services.

The OHCA entered into a sharing agreement with the Oklahoma State Department of Health (OSDH) when the OBOR Program began. Each week a CD-ROM containing an updated list of pregnant members

is sent to the OSDH to ensure they obtain timely leads for participants in their Children First project. This project is aimed at first-time pregnant women prior to their 28th week of pregnancy.

At Risk OB Program History

A case management program was implemented for pregnant members who may be at risk for poor outcomes absent any intervention. Members are identified for the AROB Program through outreach letters ("Pat Brown Letters") and subsequent positive screenings performed by the Member Services Department. A full assessment is then performed by an ENC, and, if needed, additional follow-up and case management services are provided to members. The average membership in the AROB Program is approximately 100 members at any given point in time.

Program Eligibility

As part of the Member Services screening, the member is asked: Do you have diabetes? Have you had problems with a previous pregnancy? If the member responds with a "yes" to either of these questions, a referral is sent to the PCM Department for enrollment into the AROB Program via an automatic notification from Member Services to the PCM Department. If the member indicates she has pregnancy-related health issues, the information is documented in Atlantes, and the member remains in the AROB program until the issues are resolved.

OB Outreach Program/At Risk OB Program Process

OB Outreach Program

Each month Member Services mails every new pregnant member a letter signed by "Pat Brown," which requests that she call the SoonerCare Helpline to receive important information concerning her benefits. If the member calls back and asks for "Pat Brown," her member information is validated, and the call is then immediately routed to an MSC. The MSC conducts an OB screening to identify high-risk pregnancies and provides information about SoonerCare benefits.

Results from the screening are entered into a Microsoft Access database available to Member Services employees. All of the talking points needed by the MSC to conduct the OB outreach, the questions used to identify potential high-risk pregnancies, and the ability to record the member's responses are on the survey tool. By making the process electronic, the OHCA reduced talk times with pregnant members from an average of 13 minutes to five minutes.

At Risk OB Program

Members are identified for the AROB Program through the "Pat Brown" outreach letter and a subsequent positive OB screening performed by the Member Services Department. A referral from

Member Services is sent to the PCM Department for ENC assignment. Referrals may also come in from providers and members.

For the AROB Program, ENC assignment is based on the geographic location (case management team region) in which the member resides. The assigned ENC then initiates contact with the member within three business days. Once the member is reached via telephone, the ENC performs the HROB/OB Outreach Initial Assessment, which includes the Edinburgh Postnatal Depression Screening (EPDS) Tool. If a member has a positive EPDS, a referral to the OHCA BHU is made, if the member consents (see Prenatal and Postpartum Depression Screening and Referral section for more information).

If the member denies any problems with the pregnancy or indicates she is no longer pregnant, the member is offered the appropriate referrals, as necessary, and the case is closed. If the member states that she has pregnancy-related health issues, she remains in the AROB Program, and the case remains open for monthly follow-up assessments and education throughout the member's pregnancy.

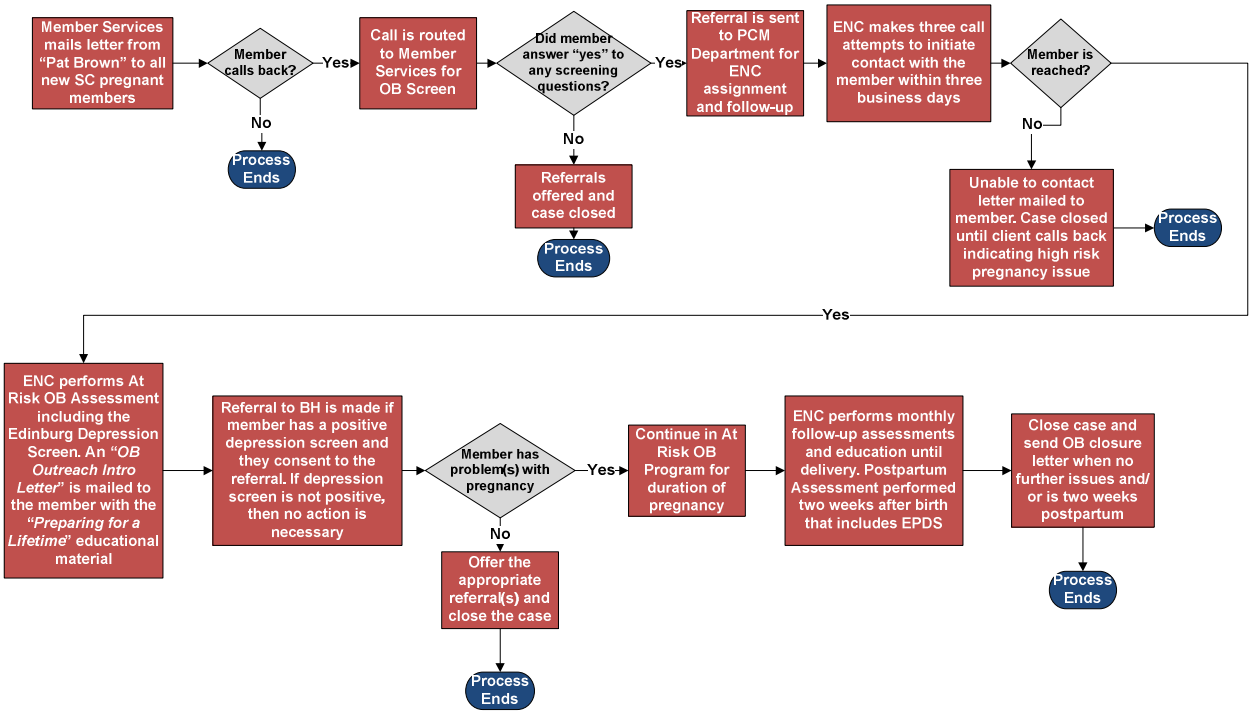
During the prenatal period for this and all OB-related case management programs, the ENC performs the following activities:

- Discusses and educates the member on her benefits;
- Educates the member on relevant prenatal and postpartum topics (e.g., exercise, nutrition, breastfeeding, infant safety);
- Stresses compliance with the member's prescribed medical regimen, including prenatal appointments;
- Assists with any barriers to access to medical care, including transportation and specialty care;
- Offers assistance in accessing resources and services for both the member and the newborn;
- Discusses the importance of regular and consistent communication between the member and her provider(s); and
- Discusses important issues related to a healthy birth outcome including but not limited to: tobacco cessation, depression screening, and home safety.

A postpartum assessment, which includes the EPDS Tool, is completed two weeks after delivery. During the postpartum period, if a member has a positive EPDS, a referral to the BHU is made if the member consents. From there, the BHU provides assistance with referrals to services as necessary.

Exhibit 4-1 on the following page provides a flow chart of the OBOR and AROB process.

Exhibit 4-1 – OB Outreach Program/At Risk OB Program Process



OB OUTREACH PROGRAM/AT RISK OB PROGRAM FINDINGS

Methodology

PHPG obtained three datasets from the OHCA to conduct our analyses – OBOR data from the OHCA's Member Services Department for the OBOR Program, data from the AROB care management system (Atlantes), and claims and eligibility data.

OBOR member records were extracted from the Member Services' OBOR database for the period of SFY 2008 through June 30, 2013 (SFY 2013). AROB member records were extracted from Atlantes for the period of February 1, 2008 (SFY 2008), through June 30, 2013 (SFY 2013). Claims and eligibility data were pulled for dates of services in SFY 2010 through 2013.

The Atlantes dataset was treated as the authority for identifying AROB members. To do so, the dataset was "cleaned" to ensure a member was accurately included in the analyses. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates), as well as removing member records that had null end dates. Thus, only members who completed a case management cycle were included in this analysis. Members who had been enrolled in the program less than one week were also removed. Thus, only members who had actively engaged in the program for greater than one week were included in the analysis.

Member surveys were administered via telephone to a sample of obstetric and pediatric members, including AROB members. Prior to conducting the survey, a letter was mailed to all members informing them of the survey and what to expect.

Survey results were entered into a proprietary database and then analyzed on a per-program basis. A total of 35 AROB member surveys were collected. Findings for the AROB survey interviews are reported in the AROB Member Survey section.

Results

OB Outreach Program

The following OBOR program process measures were analyzed by evaluating member records within the OBOR Member Services database:

- Total number of "Pat Brown" letters mailed by SFY;
- Total number and rate of member OB screenings performed as a result of the "Pat Brown" letter by SFY;
- Total number and rate of members who were referred to the PCM Department for evaluation for the AROB program by SFY; and
- Total number and rate of members enrolled in the AROB program who were referred from the OBOR program.

At Risk OB Program

The following program enrollment and ENC activities were analyzed for the AROB program by using the Atlantes dataset:

- Total enrolled in the AROB program by SFY;
- Breakdown of AROB participants by county geography (i.e., rural, urban, suburban, mixed, out of state);
- AROB enrollment in the top ten counties;
- Total AROB participants by age range;
- Total AROB participants by CDC age range;
- Average length of time in program;
- Percentage of members contacted within three business days of receiving a referral to the AROB program by SFY;
- Total number of contacts per member per SFY;
- Total ENC time spent per member by SFY;
- Total ENC FTE time per SFY;
- Initial HROB/OB Outreach assessment rates by SFY; and
- Total number of AROB letters sent per member by SFY.

The following utilization and cost measures were evaluated for the AROB program by using claims and eligibility data:

- Early gestation and low birth weight percentages of AROB deliveries by SFY;
- Neonatal Intensive Care Unit (NICU) admissions in the AROB sample by SFY;
- The ratio of cesarean section deliveries to vaginal deliveries in the AROB sample by SFY;
- AROB moms who were readmitted to the hospital within 30 days postpartum (i.e., postpartum readmission) by SFY;
- AROB moms who were readmitted to the hospital within 60 days postpartum (i.e., postpartum readmission) by SFY;
- Emergency Room visits for AROB moms within 30 days postpartum by SFY;
- Emergency Room visits for AROB moms within 60 days postpartum by SFY;
- Hospital admissions for AROB newborns during the first year of life by SFY;
- Emergency Room visits for AROB newborns during the first year of life by SFY; and
- Summary of expenditures for AROB moms and newborns by SFY.

The following member survey metrics were evaluated for the AROB program by using results from the AROB member surveys:

- Survey demographics (e.g., member age, ethnicity, education level);
- Services received through AROB and their helpfulness;
- ENC correspondence;
- ENC activities and member satisfaction rates;
- Overall member satisfaction with the assigned ENC and the AROB program; and
- Behavioral health screenings and referrals.

OB Outreach Program Process Measures Summary

This section describes OBOR program process measures by SFY using data contained in the OBOR Member Services database.

Pat Brown Letters Mailed

Since its inception on July 1, 2008, through SFY 2013, Member Services mailed 97,700 Pat Brown letters (see Exhibit 4-2 on the following page).

Exhibit 4-2: OB Outreach Program Pat Brown Letters Mailed

SFY	Pat Brown Letters Mailed
2008	921
2009	23,779
2010	16,448
2011	13,755
2012	22,728
2013	20,069
Total	**97,700**

OBOR Screenings

Member Services has received calls and completed OBOR screenings for 40,217 members (40 percent) who responded to the Pat Brown letter. During the first week of November 2009, an even shorter letter was sent to pregnant members. The contact rate from that letter increased by 19.5 percent from SFY 2009 to SFY 2010. Since that time, contact rates have remained above 40 percent (see Exhibit 4-3 below).

Since July 2008, Member Services has answered 99 percent of all the inbound phone calls presented to them, the highest rate of any OHCA or OHCA-contracted call center. One of the direct benefits of adopting this outreach method is the overall improvement in efficiency and effectiveness of the call center. In turn, it has also had a positive effect on all of the OHCA and OHCA-contracted call centers as they strive to match the Member Services call center statistics[2].

Exhibit 4-3: OB Outreach Screenings Performed

SFY	# of OBOR Screenings Performed	Screening Rate
2008	297	32.2%
2009	9,037	38.0%
2010	7,463	45.4%
2011	5,596	40.7%
2012	9,641	42.4%
2013	8,183	40.8%
Total	**40,217**	**41.2%**

[2] Rupe, K. Quality Team Day abstract for the OHCA OB Outreach Project. May 6, 2010.

OBOR Members Referred to the PCM Department

Of the 40,217 members who called in response to their letter and received an OBOR screening, a total of 4,632 (11.5 percent) had a positive screening and were subsequently referred to the PCM Department for evaluation for the AROB program (see Exhibit 4-4 below).

Exhibit 4-4: OB Outreach Members Referred to the PCM Department

SFY	# of Positive OBOR Screenings	Referral Rate to PCM Department
2008	4	1.3%
2009	1,266	14.0%
2010	791	10.6%
2011	558	10.0%
2012	956	9.9%
2013	1,057	12.9%
Total	**4,632**	**11.5%**

OBOR Members Enrolled in the AROB Program

Of the 4,632 members who were referred to the PCM Department for evaluation for the AROB program, 2,938 (63.4 percent) were identified as having pregnancy-related health issues (see Exhibit 4-5 below) and were subsequently enrolled in the AROB program. As a reminder, SoonerCare members are often at the beginning of their second trimester before they access prenatal care. As a result, the need for timely intervention by the assigned ENC is critical to assist members to gain immediate access to prenatal care. Since over 60 percent of OBOR members were enrolled in the AROB program, an opportunity exists to have considerable impact on the chances for positive birth outcomes.

Exhibit 4-5: OB Outreach Members Enrolled in the At Risk OB Program

SFY	# of Positive OBOR Screenings	Referral Rate to PCM Department
2008	4	100.0%
2009	849	67.1%
2010	556	70.3%
2011	355	63.6%
2012	603	63.1%
2013	571	54.0%
Total	**2,938**	**63.4%**

Analysis of At Risk OB Enrollment and ENC Activities

This section describes program enrollment and ENC activities by SFY using data contained in Atlantes. It should be noted the Atlantes dataset was treated as the authority for identifying AROB members. To do so, the dataset was "cleaned" to ensure a member was accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates) as well as removing member records that had null end dates. Members who had been enrolled in the program less than one week were also removed.

As a result of the above data mining, while the number of members referred to AROB from the OBOR program was 2,938, PHPG identified a total of 2,016 unique AROB member records for evaluation purposes. In addition, the OHCA advised that while some members were referred from Member Services due to a positive OBOR screening, some of these members already had an open OB case and were receiving case management from the PCM Department (e.g., HROB program or FIMR).

Total Enrollment

Exhibit 4-6 below summarizes total AROB enrollment from SFY 2008 through SFY 2013. Total enrollment by SFY was calculated based on a member's having a level-of-care start date in that fiscal year. Enrollment increased 59.3 percent between SFY 2011 and 2012 and then remained fairly constant in SFY 2013.

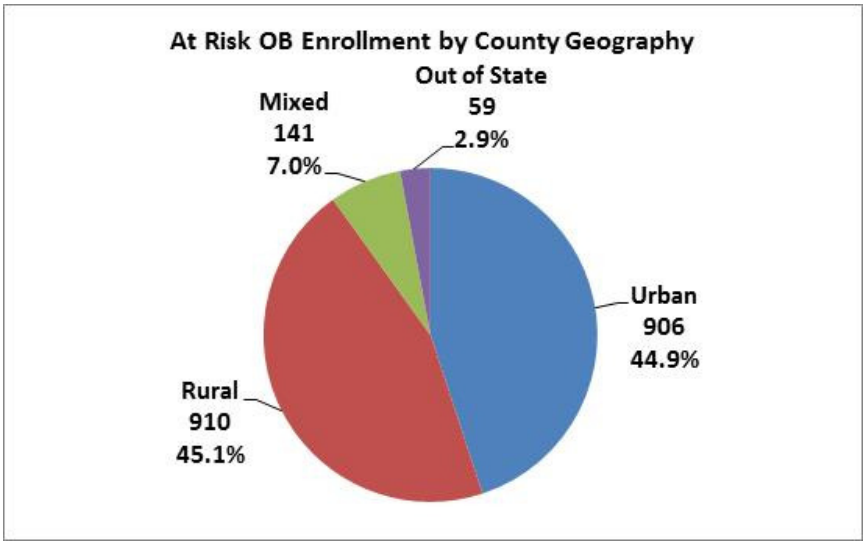
Exhibit 4-6: At Risk OB Enrollment by State Fiscal Year

SFY	Members
2008	6
2009	400
2010	406
2011	297
2012	473
2013	434
Total	**2,016**

Enrollment by County Geography

Exhibit 4-7 on the following page summarizes the breakdown of AROB enrollment by county geography from SFY 2008 through SFY 2013. Nearly 90 percent of AROB enrollment was split between urban and rural counties. Nearly 45 percent of AROB members resided in the urban counties of Cleveland, Oklahoma, and Tulsa. Forty-five percent of AROB members resided in rural counties and 7 percent of members resided in mixed counties. A small percentage of 2.9 percent of AROB members resided out of state, though these members resided in Oklahoma when they were initially enrolled in AROB program.

Exhibit 4-7: At Risk OB Enrollment by County Geography



Enrollment by Top Ten Counties

A review of county codes, based on county of residence in Atlantes, shows that nearly 60 percent of AROB members (56.9 percent) resided in ten Oklahoma Counties from SFY 2008 through SFY 2013 (see Exhibit 4-8 below).

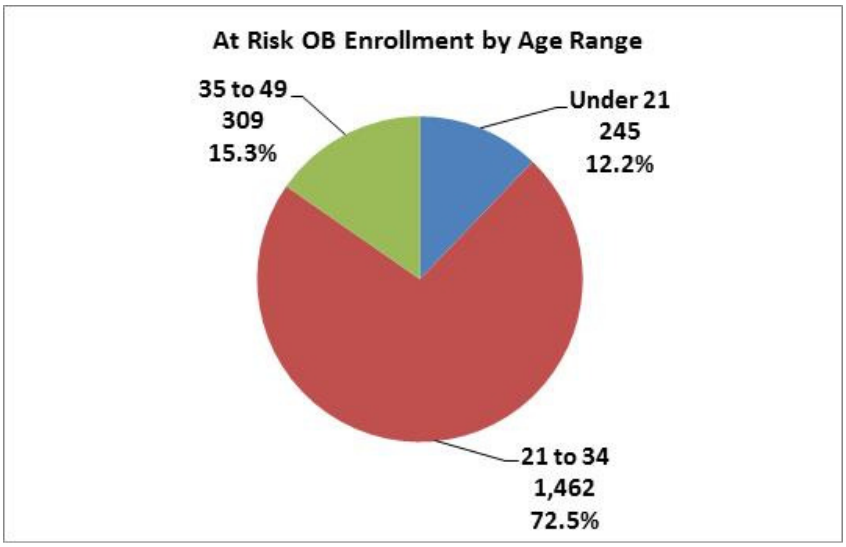
Exhibit 4-8: At Risk OB Enrollment by County

County	Total Members 2008-2013
Oklahoma	439
Tulsa	309
Cleveland	108
Comanche	50
Muskogee	49
Creek	41
Rogers	41
Pottawatomie	40
Payne	37
Canadian	34
All other counties	868
Grand Total	**2,016**

Age Range of AROB Members

The vast majority of AROB members (73 percent) fell into the age range of 21 to 34 from SFY 2008 through SFY 2013. Fifteen percent of AROB members fell into the age range of 35 to 39, while the remaining 12 percent fell in the under 21 (see Exhibit 4-9 below).

Exhibit 4-9: At Risk OB Enrollment by Age Range



CDC Age Range of AROB Members

The Centers for Disease Control and Prevention (CDC) monitor pregnancy rates and rates of pregnancy outcomes using pre-defined age ranges. Exhibit 4-10 below provides a breakdown of AROB enrollment for the nine CDC age ranges from SFY 2008 through SFY 2103.

Over 77 percent of AROB members fell into the age ranges of 20 to 24, 25 to 29, and 30 to 34. Twelve percent of members fell into the age range of 35 to 39, and six percent fell into the age range of 18 to 19.

Exhibit 4-10: At Risk OB Enrollment by CDC Age Range

CDC Age Range	Members	CDC Age Range	Members
Under 15	3	30 - 34	404
15 - 17	22	35 – 39	241
18 – 19	125	40 – 44	65
20 – 24	554	Over 44	3
25 - 29	599	**Total**	**2,016**

Length of Stay

Exhibit 4-11 below summarizes the average length of stay from SFY 2008 through SFY 2013. Length of stay was calculated by subtracting a member's level-of-care end date from the level-of-care start date. Over 60 percent of members were enrolled three or fewer months in the AROB program, of which 30 percent were only enrolled one to four weeks in duration. Twenty-three percent of members were enrolled four to six months, and 15 percent of members were enrolled in AROB seven to nine months.

Exhibit 4-11: At Risk OB Length of Stay

Length of Stay (weeks)	Duration Classification	# Members	% Members
1-4	Three or Fewer Months	595	29.5%
5-8		407	20.2%
9-12		227	11.3%
	Total	***1,229***	**61.0%**
13-16	Four to Six Months	186	9.2%
17-20		146	7.2%
21-24		135	6.7%
	Total	***467***	**23.2%**
25-28	Seven to Nine Months	118	5.9%
29-32		130	6.4%
33-36		62	3.1%
	Total	***310***	**15.4%**
37-40	Ten to Twelve Months	6	0.3%
41-44		2	0.1%
45-48		1	0.05%
49-52		0	0.0%
	Total	***9***	**0.4%**
53+	More than One Year	1	0.05%
	Total	***1***	**0.05%**

ENC Activity Time

Initial Outreach

Once a member is assigned to an ENC, the ENC attempts to make an initial telephone contact within three business days of receiving the referral. Three attempts are made on three different days at different times to contact the member via telephone. To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes AROB Activity Report.

The review was limited to only those cases where the data indicated that an ENC performed initial telephone outreach (e.g., member contact attempts 1, 2 and 3, phone calls to and from) within three business days of a referral to case management. Time spent performing each outreach attempt had to be more than five minutes in duration.

Exhibit 4-12 below highlights member contacts made within three business days from SFY 2008 through SFY 2013. Compliance rates for contacting members within three business days ranged from 36.2 to 100 percent, with a sharp decline from 71.4 percent in SFY 2011 to 36.2 percent in SFY 2013. The decline was the result of relaxed contact efforts as caseloads increased and the scope of ENC duties widened (49.2 percent reduction). The average contact rate across all SFYs was 55.7 percent.

Exhibit 4-12: At Risk OB Member Contacts within Three Business Days

Measure	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Members Contacted within Three Business Days	6	242	273	212	233	157
Total AROB Enrollment	6	400	406	297	473	434
Contact Rate	**100.0%**	**60.5%**	**67.2%**	**71.4%**	**49.2%**	**36.2%**

Total Contacts

After successfully contacting a member and completing the initial assessment, the member is placed on a monthly contact schedule if she meets clinical criteria to remain in the program. All contacts for members are documented in Atlantes. To determine the number of contacts, a count was performed of all activity actions contained in the Atlantes AROB Activity Report. Time spent performing member activities had to more than five minutes in duration.

Exhibit 4-13 below contains the average number of contacts per member from SFY 2008 through SFY 2013. ENCs averaged 4.4 to 10.3 contacts per member across the six fiscal years. The average number of member contacts across all SFYs was 6.1 contacts per member. There was a 44.3 percentage decline in contacts made from SFY 2011 to SFY 2013 though membership increased 31.6 percent. This number may have declined when the PCM Department implemented additional case management programs and, as a result, staff caseloads increased. It should be noted that contact attempts are sometimes relaxed in times of staffing crises.

Exhibit 4-13: At Risk OB Total Contacts per Member

Measure	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Count of Contacts	62	2,357	3,064	2,361	2,489	1,898
Total AROB Enrollment	6	400	406	297	473	434
Total Contacts Per Member	**10.3**	**5.9**	**7.5**	**7.9**	**5.3**	**4.4**

ENC Time Spent Managing Enrollees

For AROB cases, if there was a previous ENC assigned to the member for a prior level of care, attempts are made to re-assign the member to the same ENC. If there is no prior history with an ENC, assignment to AROB cases is based on the geographic location in which the member resides. ENC assignment is then performed using a round-robin approach within a particular geographic location.

To assess the time spent by ENCs for the AROB program, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to women who were assigned to AROB. In each fiscal year, a large majority of ENC time was dedicated to assessments, ongoing member correspondence and care management for enrolled members, and provider outreach. These activities are consistent with the primary functions of ENCs.

Exhibit 4-14 below highlights ENC time spent per member and ENC FTE time. From SFY 2008 through 2013, ENCs spent an average of 1.2 to 3.5 hours per case across all activities, and FTEs ranged from 0.01 in SFY 2008 to 0.5 in SFY 2010. Average ENC hours per case and equivalent FTEs have decreased each fiscal year starting with SFY 2011. The decrease may be attributed to the widening scope and volume of ENC duties and subsequent contact standard adjustments during times of staffing crises.

The electronic HROB/OB Outreach Assessment Tool went into production in Atlantes in September 2011 along with other automated processes. As a result, there were changes to processes, as well as challenges in the way ENCs captured their time (i.e., some ENCs under-reported their time) while performing the assessment.

Exhibit 4-14: At Risk OB ENC Time per Member and ENC FTE Time

Measure	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Total Members	6	400	406	297	473	434
Sum of AROB Activity (Hours)	21.10	792.2	1033.0	794.4	725.8	500.2
ENC Time Per Enrolled Member (Hours)	**3.5**	**2.0**	**2.5**	**2.7**	**1.5**	**1.2**
Total ENC FTE Time	**0.01**	**0.4**	**0.5**	**0.4**	**0.3**	**0.2**

AROB Assessment Rates

Initial HROB/OB Outreach Assessment

Upon successful contact with an AROB member, the HROB/OB Outreach Initial Call Assessment is completed. The assessment includes talking points and the Edinburgh Postnatal Depression Scale (EPDS) screening tool. The assessment is located in Atlantes.

An analysis of the HROB/OB Outreach Initial Call Assessment rates was performed using the Atlantes AROB Assessment Report. A count of all initial assessments was performed by SFY, and these totals were divided by the number of unique members served in each SFY from SFY 12 (when the HROB/OB Outreach Assessment was available in Atlantes) through SFY 2013. The initial assessment rate increased by nine percent from SFY 2012 through SFY 2013, when there was a 55.1 percent compliance rate (see Exhibit 4-15 below).

Exhibit 4-15: Initial HROB/OB Outreach Assessment Rates

Measure	SFY2012	SFY2013
Initial Assessments Performed	240	239
Total AROB Enrollment	473	434
Initial Assessment Rate	**50.6%**	**55.1%**

AROB Letters

ENCs generate and mail a number of letters to members and providers for the AROB program, including but not limited to introductory letters, unable-to-contact letters, provider notification, and case closure letters. An analysis was performed for the number of AROB letters sent by SFY. From SFY 2008 through 2013, ENCs mailed an average 2.4 to 4.2 letters per member (see Exhibit 4-16 below). There was a 29 percent reduction in the number of letters sent from SFY 2011 to SFY 2013.

Exhibit 4-16: At Risk OB Letters Sent by State Fiscal Year

Measure	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Total Letters Sent	18	973	1,423	1,258	1,321	1,297
Total AROB Enrollment	6	400	406	297	473	434
Total Letters Per Member	**3.0**	**2.4**	**3.5**	**4.2**	**2.8**	**3.0**

AROB Utilization and Cost Outcomes

This section highlights AROB utilization and cost trends by SFY using claims and eligibility data for dates of services in SFY 2010 through 2013.

Early Gestation/Low Birth Weight

The four-year average rate of early gestation and low birth weight deliveries was 12.5 percent. Rates increased from SFY 2010 through SFY 2012 but declined in 2013 by 11.0 percent. Early gestation and low birth weight delivery rates were 37 percent lower in the AROB population when compared to HROB, which one would expect to see due to the higher acuity among HROB participants (see Exhibit 4-17 below).

Exhibit 4-17: Percentage of Early Gestation and Low Birth Weight Deliveries among AROB Participants

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	474	347	582	511	1,635
Deliveries Identified	172	113	185	146	616
Participants Early Gestation/Low Birth Weight	17	14	27	19	77
Percent of Early Gestation/Low Birth Weight Deliveries	**9.9%**	**12.4%**	**14.6%**	**13.0%**	**12.5%**

Neonatal Intensive Care Unit Admissions

From SFY 2010 through SFY 2012, the percentage of AROB deliveries admitted to the NICU increased. The rate subsequently declined in SFY 2013 (see Exhibit 4-18 below). NICU admission rates in the AROB population were 21 percent lower when compared to the HROB population. Continued program efforts should be made to improve early access to prenatal care and to educate mothers in a timely manner.

Exhibit 4-18: Percentage of NICU Admissions among AROB Participants

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	474	347	582	511	1,635
Deliveries Paired with Child in Claims	94	72	120	126	412
NICU Cases	5	7	16	15	43
Percent of Deliveries Admitted to NICU	**5.3%**	**9.7%**	**13.3%**	**11.9%**	**10.4%**

Cesarean Section vs. Vaginal Delivery

The four-year average for AROB vaginal deliveries was 89.8 percent. Rates have remained relatively constant year-over-year. The four-year average for AROB cesarean section rates was 10.2 percent (see Exhibit 4-19 below) compared to 12.0 percent in the HROB population.

Exhibit 4-19: Cesarean Section vs. Vaginal Delivery Comparison among AROB Participants

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	474	347	582	511	1,635
Deliveries Identified	172	113	185	146	616
Vaginal Deliveries	143	105	170	135	553
Percent of Vaginal Deliveries	**83.1%**	**92.9%**	**91.9%**	**92.5%**	**89.8%**
Cesarean Section Deliveries	29	8	15	11	63
Percent of Cesarean Section Deliveries	**16.9%**	**7.1%**	**8.1%**	**7.5%**	**10.2%**

Utilization Rates

PHPG evaluated the percentage of AROB mothers that were readmitted as inpatients, as well as ER visits within 30 and 60 days of delivery. All claims were evaluated for this time period. Readmission rates within 30 days and 60 days of the mother's delivery declined steadily from SFY 2012 through SFY 2013. Similarly, ER visits declined at both the 30- and 60-day mark. Readmission rates and ER visit rates at the 60-day mark were considerably higher than the rates at 30 days.

An evaluation was performed of hospitalizations and ER visits for newborns through the first year of life. The analysis did not include delivery-related inpatient claims. Inpatient admission rates per 1,000 and ER visit rates remained relatively steady over each SFY (see Exhibit 4-20 on the following page).

Exhibit 4-20: Utilization among AROB Participants and their Newborns

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Inpatient Admissions - Mother					
Any Within 30 Days of Delivery	8	-	9	2	19
Percent Readmitted Within 30 days of Delivery	**4.7%**	**0.0%**	**4.9%**	**1.4%**	**3.1%**
Any Within 60 Days of Delivery	11	-	10	2	23
Percent Readmitted Within 60 days of Delivery	**6.4%**	**0.0%**	**5.4%**	**1.4%**	**3.7%**
Inpatient Admissions – Child					
Total	100	74	133	129	436
Per 1,000 Children	**1,063.83**	**1,027.78**	**1,108.33**	**1,023.81**	**1,058.25**
Emergency Room Visits – Mother					
Any Within 30 Days of Delivery	29	10	25	16	80
Percent of ER Visits Within 30 Days of Delivery	**16.9%**	**8.8%**	**13.5%**	**11.0%**	**13.0%**
Any Within 60 Days of Delivery	40	13	28	19	100
Percent of ER Visits Within 60 Days of Delivery	**23.3%**	**11.5%**	**15.1%**	**13.0%**	**16.2%**
Emergency Room Visits – Child					
Total	114	70	173	175	532
Per 1,000 Children	**1,212.77**	**972.22**	**1,441.67**	**1,388.89**	**1,291.26**

Expenditures

Between SFY 2011 and 2013, total AROB program expenditures and expenditures per case for the mother and child increased substantially. Total expenditures for both mother and child were $9 million. Children comprised a much greater proportion of total expenditures than did the mother in this program (see Exhibit 4-21 on the following page).

Exhibit 4-21: Summary of Expenditures for AROB Participants and their Newborns

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Total Expenditures (paired deliveries only)					
Mother	$851,326	$600,472	$972,407	$1,369,137	$3,793,342
Child	$528,765	$681,617	$1,445,965	$2,437,850	$5,094,197
TOTAL	$1,380,091	$1,282,088	$2,418,373	$3,806,988	$8,887,539
Expenditures per Case (paired deliveries only)					
Mother	$9,056.66	$8,339.88	$8,103.39	$10,866.17	$9,207.14
Child	$5,625.16	$9,466.90	$12,049.71	$19,348.02	$12,364.56
TOTAL	$14,681.82	$17,806.78	$20,153.11	$30,214.19	$21,571.70

AROB Member Survey Findings

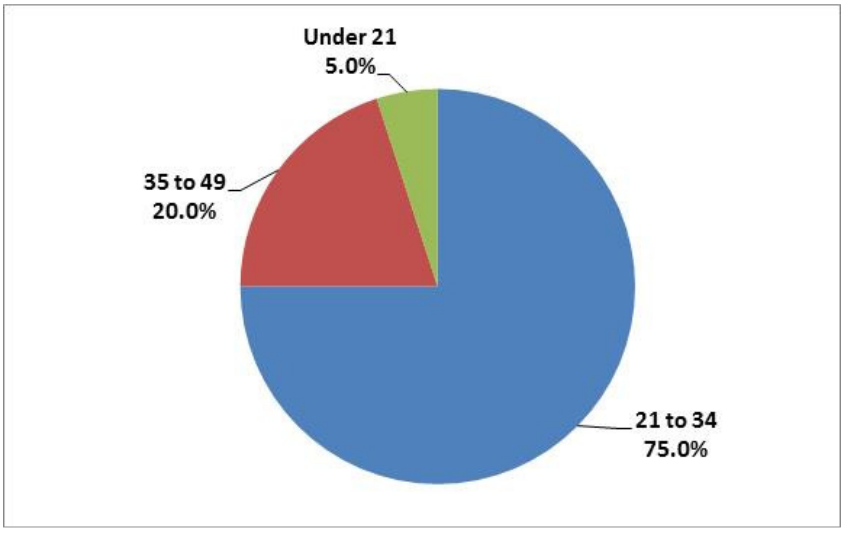
This section describes key findings from the AROB member survey using data collected from 35 survey interviews.

Survey Demographics

Age Range

Seventy-five percent of respondents fell into the age range of 21 to 34. Twenty percent were between 35 to 49 years of age. Five percent were under 21 years of age (see Exhibit 4-22 below).

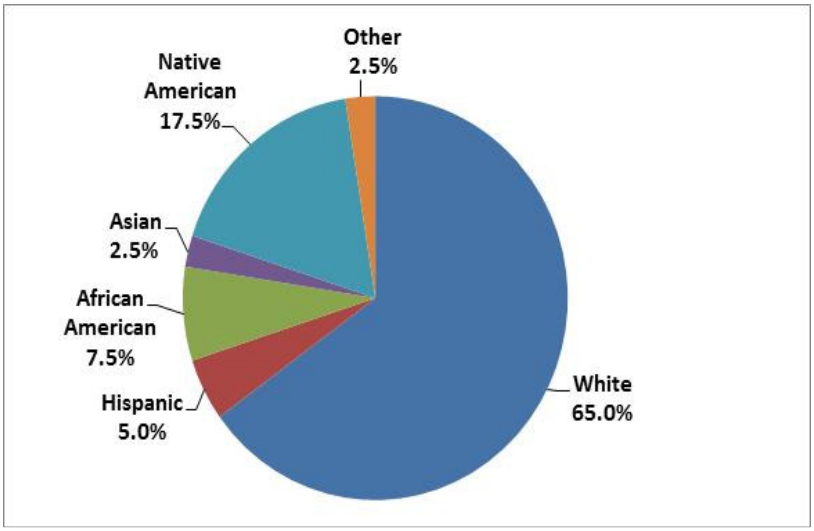
Exhibit 4-22: Age Range



Ethnicity

Nearly two-thirds (65 percent) reported their ethnicity as white (see Exhibit 4-23 below). Over 17 percent said they were of Native American descent.

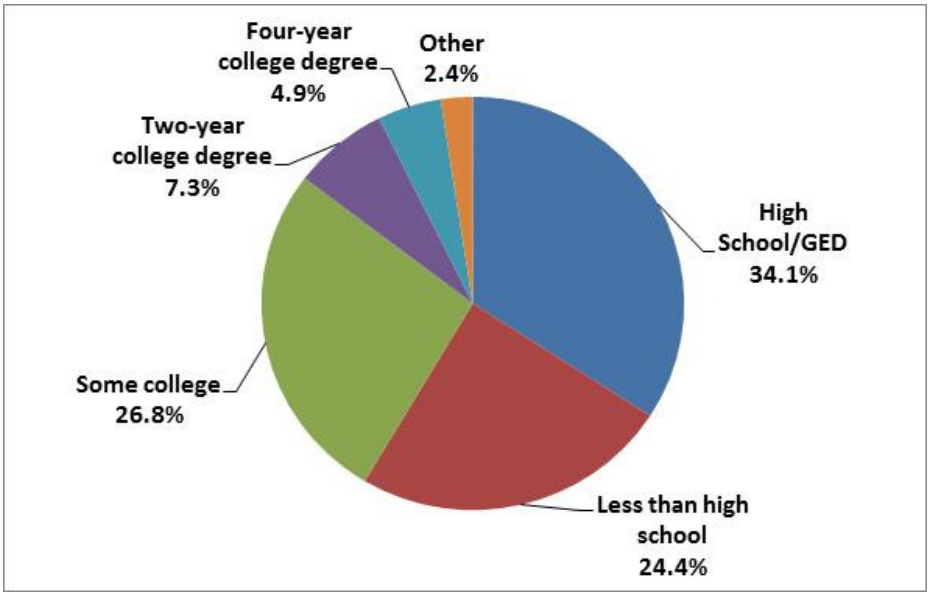
Exhibit 4-23: Ethnicity



Highest Level of Education Completed

Over one-third of respondents (34.1 percent) said they completed high school/GED. Nearly 27 percent reported completing some college education. Over seven percent completed a two-year college degree, while 4.9 percent completed a four-year college degree. Nearly one-quarter (24.4 percent) reported not completing high school. One respondent (2.4 percent) had a doctorate (see Exhibit 4-24 below).

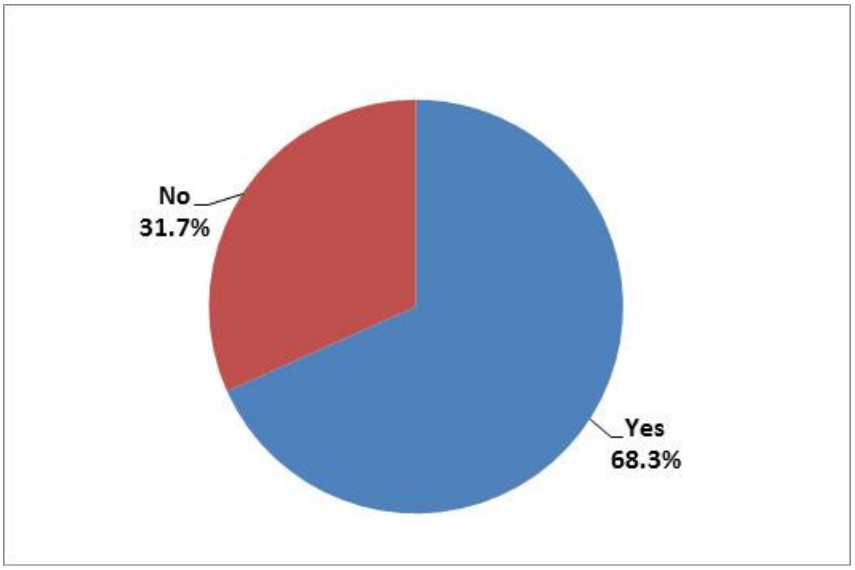
Exhibit 4-24: Education Level



Miscarriages

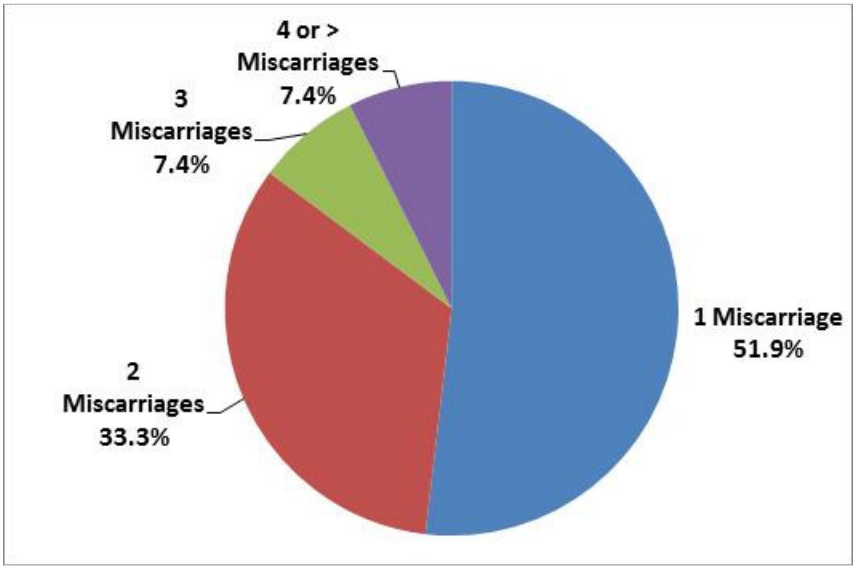
Among all respondents, 68.3 percent reported having a miscarriage. Just under one-third (31.7 percent) denied having a miscarriage (see Exhibit 4-25 below).

Exhibit 4-25: Miscarriages



Among those who reported having a miscarriage, just over half (51.9 percent) said they had one miscarriage. One-third reported having two miscarriages (see Exhibit 4-26 below). Over 7 percent had three miscarriages, and over seven percent had four or more miscarriages.

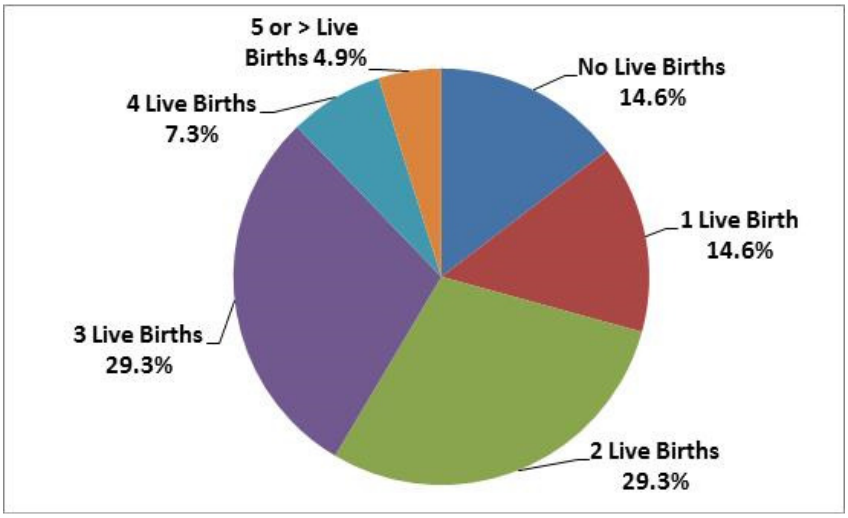
Exhibit 4-26: Number of Miscarriages



Number of Live Births

Nearly 30 percent reported having two live births. Another 29.3 percent reported having three live births (see Exhibit 4-27 below). Nearly 15 percent reported one live birth. Another 15 percent reported no live births, which is attributable to pregnancy status at the time of the survey or due to miscarriage(s).

Exhibit 4-27: Number of Live Births



AROB Program Services

There are a number of services available to members in the AROB program. Nearly all respondents (91.4 percent) said they received monthly phone calls. Seventy-seven percent reported having assessments. Over 65 percent reported obtaining referrals to programs and services (see Exhibit 4-28 below).

Exhibit 4-28: At Risk OB Program Services

Service		Respondents answering "yes" to the service				
	Yes	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Unsure/N/A
Assessment	**77.1%**	55.9%	23.5%	2.9%	0.0%	17.6%
Training and Education	**48.6%**	34.3%	11.4%	2.9%	0.0%	51.4%
Educational Materials	**45.7%**	31.4%	11.4%	2.9%	0.0%	54.3%
Postpartum Depression Screening	**8.6%**	2.9%	0.0%	2.9%	0.0%	94.1%
Referrals to Programs and Services	**65.7%**	48.6%	14.3%	0.0%	0.0%	37.1%
Appointment Scheduling	**22.9%**	14.3%	8.6%	0.0%	0.0%	77.1%
Family Planning	**25.7%**	11.4%	14.3%	0.0%	0.0%	74.3%
Monthly Phone Calls	**91.4%**	58.8%	29.4%	5.9%	0.0%	5.9%

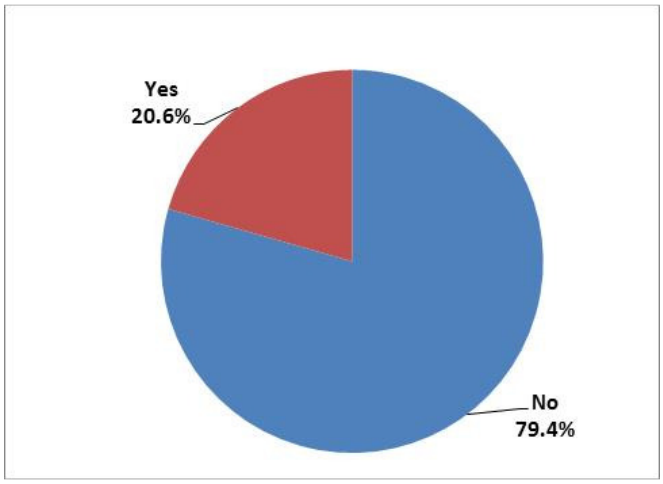
Respondents were asked to rate the helpfulness of each "yes" service. Nearly 60 percent of respondents reported the monthly phone calls were very helpful. Over half of respondents reported the assessments were very helpful. Nearly half reported referrals to programs and services were very helpful. Over one-third of respondents reported training and education were very helpful.

ENC Correspondence

Name of Case Manager

Only 20.6 percent of respondents could recall the name of their case manager (see Exhibit 4-29 below).

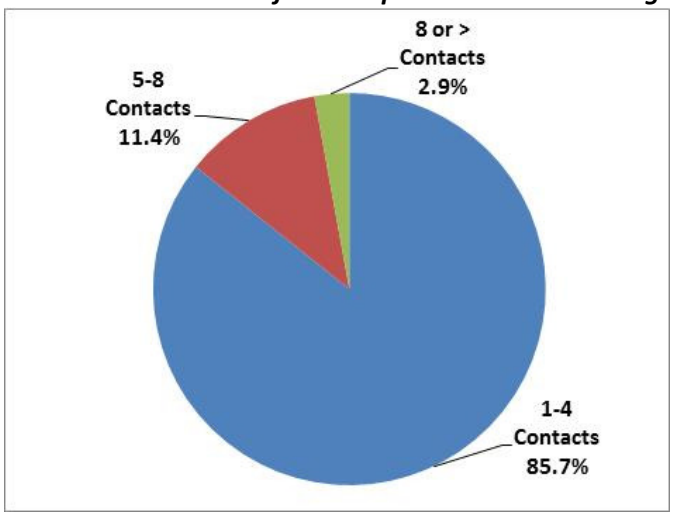
Exhibit 4-29: Identified the Name of Case Manager



Number of Times Spoke with Case Manager

Over eighty-five percent of respondents said they spoke with their case manager between one to four times since they started the program (see Exhibit 4-30 below). Eleven percent reported 5-8 contacts.

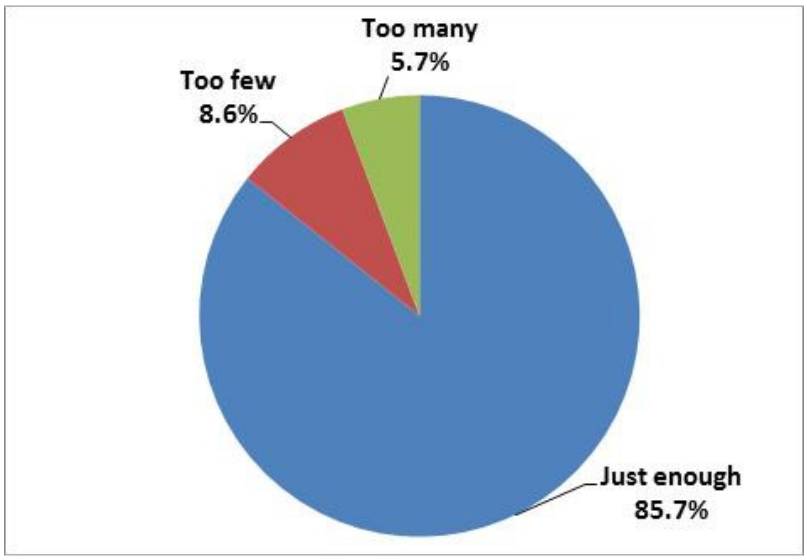
Exhibit 4-30: Number of Times Spoke with Case Manager



Rating of Case Manager Contacts

The majority of respondents (85.7 percent) felt the number of times their case manager contacted them was just enough (see Exhibit 4-31 below).

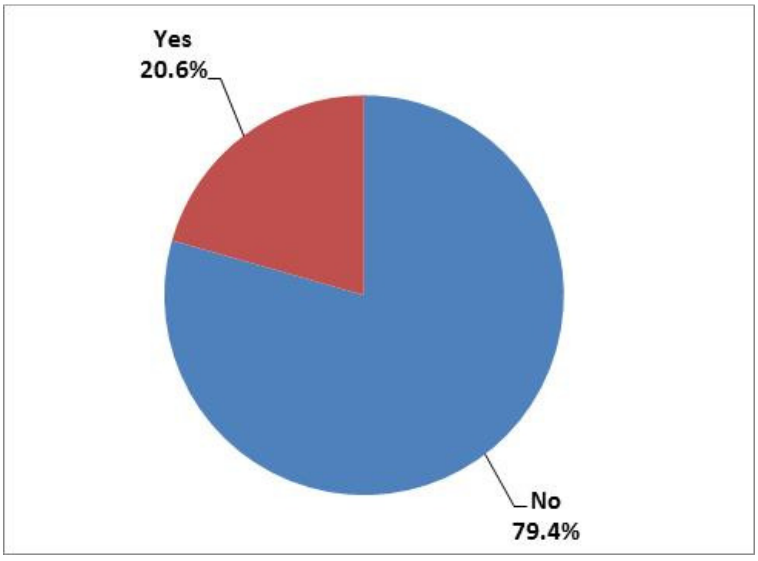
Exhibit 4-31: Rating of Case Manager Contacts



Member Calls to Case Manager

Nearly 80 percent of respondents said they had not called their case manager (see Exhibit 4-32 below).

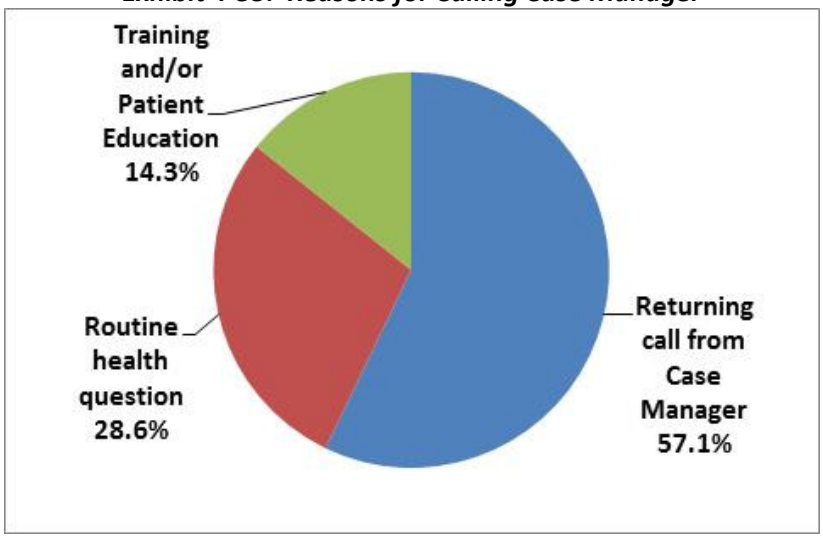
Exhibit 4-32: Have Called Their Case Manager



Reason for Calling Case Manager

Of the respondents that called their case manager, 57.1 percent said they were returning phone calls from their case manager. Nearly 30 percent called with a routine health question, and 14 percent called for training and/or education purposes (see Exhibit 4-33 below).

Exhibit 4-33: Reasons for Calling Case Manager



ENC Activities

Case managers are expected to help participants build their self-management skills. All respondents indicated that their nurse care manager asked questions about their health or concerns (see Exhibit 4-34 on the following page). The vast majority (82.9 percent) said their case manager provided instructions for taking care of their health. Nearly 70 percent said their case manager answered questions about their health care needs.

Exhibit 4-34: Case Manager Activity Ratings

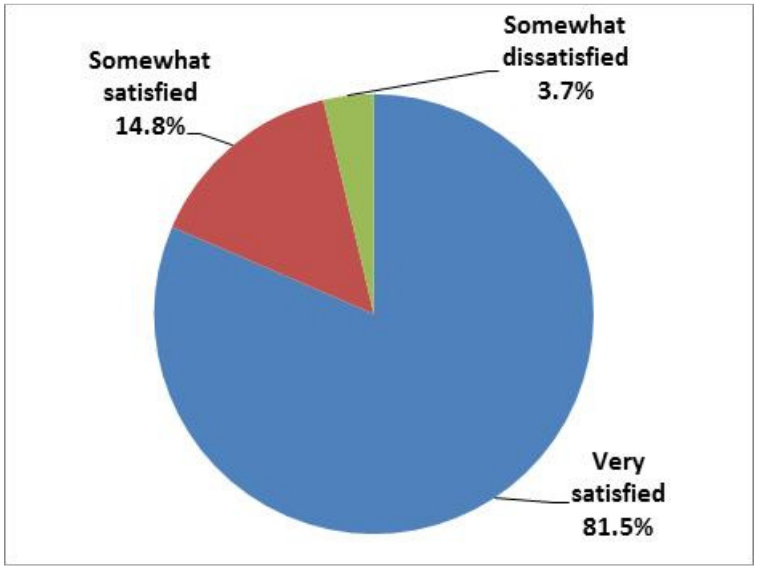
Activity		Respondents answering "yes" to the activity				
	Yes	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Unsure/N/A
Asked questions about your health or concerns	**100.0%**	82.4%	14.7%	2.9%	0.0%	0.0%
Provided instructions about taking care of your health	**82.9%**	65.7%	14.3%	2.9%	0.0%	17.1%
Helped you to identify changes in your health that might be an early sign of a problem	**11.4%**	11.4%	0.0%	0.0%	0.0%	88.6%
Answered questions about your health care needs	**68.6%**	65.7%	0.0%	0.0%	0.0%	34.3%
Helped you to make and keep health care appointments for medical problems	**20.0%**	20.0%	0.0%	0.0%	0.0%	80.0%
Helped you to make and keep health care appointments for mental health or substance abuse problems	**8.6%**	0.0%	0.0%	0.0%	0.0%	100.0%
Referred you to programs and services	**8.6%**	54.3%	2.9%	2.9%	2.9%	37.1%
Helped you to stop smoking or stop using tobacco products	**9.4%**	5.7%	0.0%	2.9%	0.0%	91.4%

Respondents were asked to rate their satisfaction with each “yes” activity. Over 80 percent reported being very satisfied when their case manager asked questions about their health or concerns. Nearly two-thirds said they were very satisfied with how their case manager provided answers and instructions for taking care of their health. Over 50 percent reported being very satisfied when their case manager referred them to programs and services.

Satisfaction with ENC and At Risk OB Program

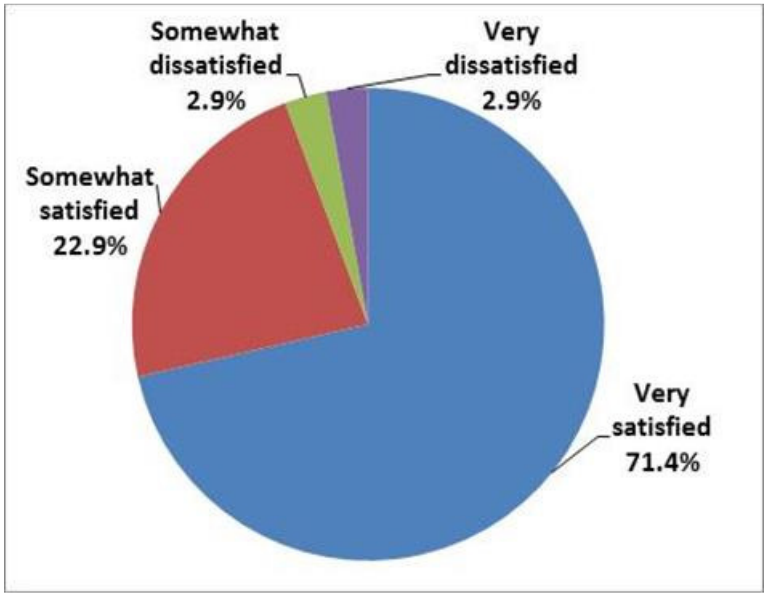
Overall, 81.5 percent of respondents were very satisfied with the help they received from their case manager (see Exhibit 4-35 on the following page).

Exhibit 4-35: Overall Satisfaction with Case Manager



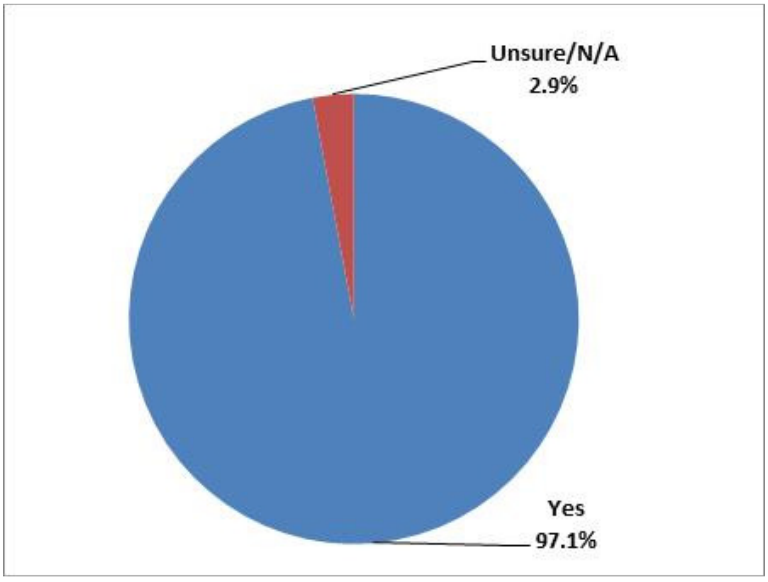
Overall, 71.4 percent of respondents were very satisfied with AROB program (see Exhibit 4-36).

Exhibit 4-36: Overall Satisfaction with At Risk OB Program



The overwhelming majority of surveyed participants (97.1 percent) would recommend the AROB program to a friend with similar health care needs (see Exhibit 4-37 on the following page).

Exhibit 4-37: Would Recommend At Risk OB Program

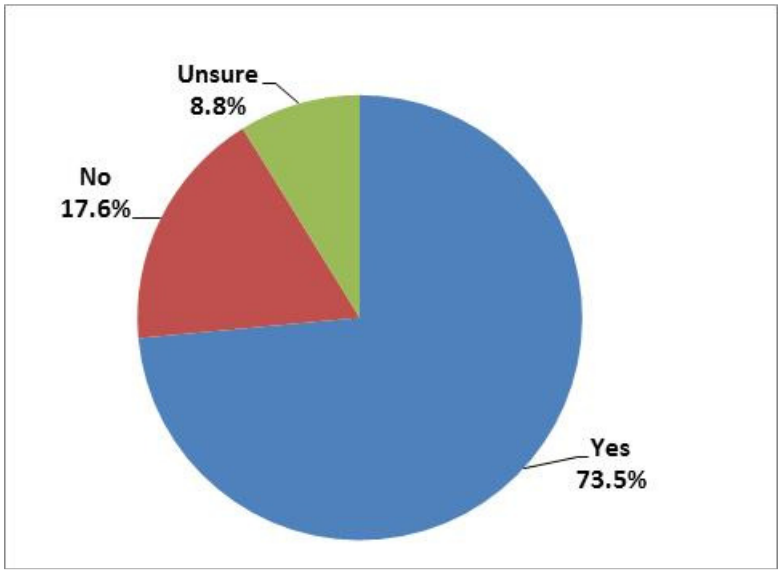


AROB Behavioral Health Screening and Referral

Completed Behavioral Health Screening

Overall, 73.5 percent of respondents reported completing a behavioral health screening with someone at the OHCA (see Exhibit 4-38).

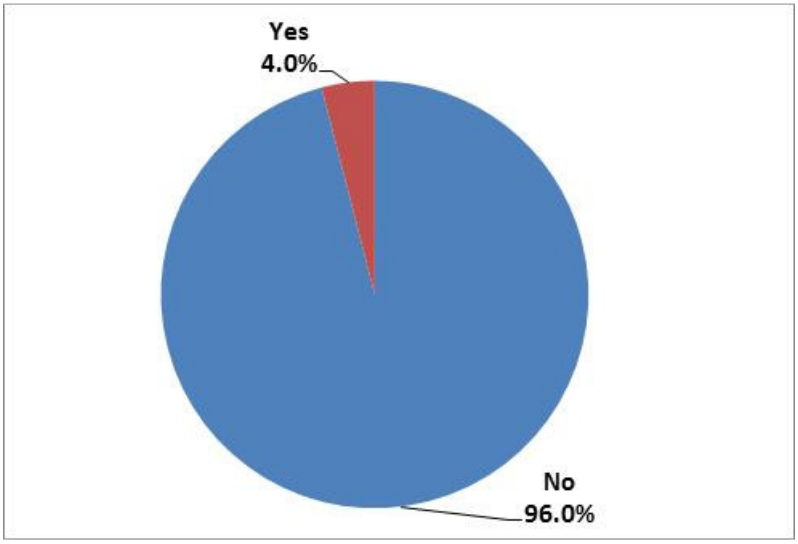
Exhibit 4-38: Completed Behavioral Health Screening



Referred to the OHCA's Behavioral Health Unit (BHU)

Only one member reported a referral to the OHCA's BHU (see Exhibit 4-39). Although members may have had a positive behavioral health screening, they must consent to a referral to the BHU.

Exhibit 4-39: Referred to OHCA's Behavioral Health Unit



Outpatient Behavioral Health Referrals

Only one member reported obtaining a referral to a support group.

Overall Satisfaction with the BHU

The one member who was referred to the OHCA's BHU reported being very satisfied with the help received.

FETAL INFANT MORTALITY REDUCTION (FIMR) MOM PROGRAM INTRODUCTION AND PROGRAM OVERVIEW

FIMR Mom Program Objective

The Fetal Infant Mortality Reduction (FIMR) Mom case management program was implemented on March 21, 2011. The program provides case management services to SoonerCare pregnant members who reside in one of the top ten counties with the highest fetal Infant Mortality Rates (IMRs). Upon enrollment in SoonerCare, FIMR members are automatically provided case management services to reduce potential complications.

Program History and Overview

Infant mortality is defined as the death of an infant in the first year of life. Any time an infant dies during the first year of life, the death is tracked in IMR statistics. Oklahoma's IMR has consistently remained above the national rate since 1992. The top five related causes to infant mortality are: (1) congenital malformations, deformations, and chromosomal abnormalities, (2) disorders due to short gestation and low birth weight, (3) SIDS, (4) accidents (unintentional injuries), and (5) bacterial sepsis of newborn.

According to the Oklahoma State Department of Health and the National Center for Health Statistics, Oklahoma ranked 41st in the U.S. with an Infant Mortality Rate (IMR) of 8.0 compared to 6.6 nationally in 2006. In 2007, the Oklahoma State Department of Health (OSDH) Commissioner's Action Team on Reduction of Infant Mortality was convened with the overarching goal of reducing infant mortality in Oklahoma.

This statewide collaborative was charged with developing a strategic plan outlining specific steps to be taken to reduce infant mortality and other adverse birth outcomes, as well as reducing racial disparities for such outcomes. Members of the Action Team include representatives from professional associations, the Oklahoma Hospital Association, universities, the March of Dimes, Chambers of Commerce, local health departments, Indian Health Services, and child advocacy organizations.

Over the next two years, internal and external partnerships expanded as work progressed in collecting and analyzing data, as well as identifying priorities and strategies to impact infant mortality and racial disparities. Interventions were targeted to focus on both maternal health and infant health. Maternal health encompasses behaviors before and during pregnancy, maternal infections, prematurity, postpartum depression, and tobacco use. Infant health efforts focus on infant safe sleep, breastfeeding, and childhood injury.

In September 2009, the Action Team expanded to include external partners in a collaborative initiative, "Preparing for A Lifetime, It's Everyone's Responsibility," to reduce infant mortality and other adverse birth outcomes and to reduce racial disparities. The statewide initiative focuses on identifying priority areas for improving the health status of mothers and infants: preconception/interconception health, prematurity, postpartum depression, tobacco use, breastfeeding, infant safe sleep, and infant injury prevention.

In 2010, Oklahoma ranked 43rd in the U.S. with an IMR of 7.59 compared to 6.15 nationally. While some improvements had been observed, there was still much work to do. Representatives from the OHCA PCM Department began gathering data on how PCM could best address the IMR for the SoonerCare Population. The PCM Department reviewed the IMR data provided by OSDH and decided to focus efforts on the top ten counties with the poorest outcomes.

In response to this need, the OHCA launched the FIMR Mom Case Management Program on March 21, 2011. This effort was a collaborative effort between OSDH and the OHCA's PCM, Child Health, and Behavioral Health Units. Working with the OSDH, the PCM Department identified the top ten counties with the highest fetal IMRs and developed a case management program to trigger automatic referral to case management for any SoonerCare pregnant women residing in one of those counties.

Exhibit 5-1 below displays the ten counties that were selected for the FIMR Program, which are shaded in blue.

Exhibit 5-1: Fetal Infant Mortality Reduction Program Counties

There are approximately 200 new members enrolled in the FIMR Mom Program each month.

Program Eligibility

Pregnant SoonerCare members who reside in one of the ten FIMR counties are automatically enrolled into FIMR Mom Case Management Program.

FIMR Mom Case Management Program Process

Identification of a pregnant member in one of the ten counties is performed on a weekly basis. A report is generated for all new pregnant members by the OHCA data warehouse. From there, the PCM Department manually enters data into Atlantes using an algorithm. A report is then generated of all new pregnant moms who reside in FIMR counties. These members are automatically enrolled in case management.

ENC assignment for the FIMR Mom Program is not limited to the geographic location of the ENC. A member is assigned to any available ENC in any region at the time the assignment is made to prevent regional ENC teams from being assigned too many FIMR cases.

The member is then contacted the week after her enrollment into SoonerCare to review benefits, encourage member/provider communication and compliance with the prescribed medical regimen, and to schedule follow-up assessments. The ENC also communicates with the member's obstetrical provider to determine if there is any information that he or she would like the PCM Department to review with the member.

There are three tiered FIMR assessments that are completed in one-month intervals. Each FIMR Mom assessment is unique and addresses different educational topics. The initial FIMR assessment includes the EPDS Tool so that a baseline can be established (see Prenatal and Postpartum Depression Screening and Referral section for more information).

After the three assessments are completed, the member moves to a monthly follow-up assessment call, which includes a referral to an appropriate home visitation agency. The following questions are asked during each monthly follow-up call:

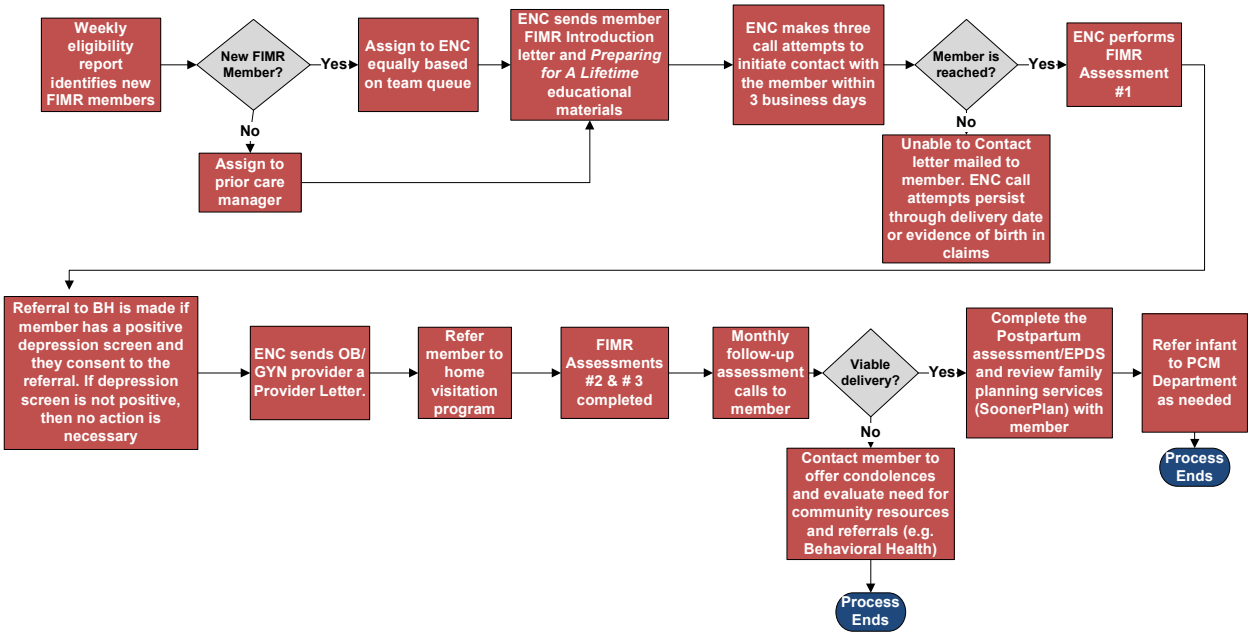
- When was your last doctor appointment?
- Were you able to make your appointment?
- Did your doctor talk about any problems?
- Did he/she give you any new medications?
- Are you taking your prenatal vitamins?
- Have you been to the ER since we last talked?
- If you are on a special diet – how are you doing?
- If you are a smoker – are you attempting to quit / how are you doing?
- Is there anything that I can do to assist you at this time?

The ENC assesses and discusses the member's dietary concerns, diabetes, blood pressure problems, and any other health issues. The ENC educates on tobacco usage in the home (either the pregnant member or another person in the home) and gives resources for smoking cessation. The ENC performs a brief screen for domestic violence and gives the member information on WIC, car seat resources, safe sleep, breastfeeding, and choosing a primary care provider for her new baby.

Case management follow-up during the prenatal period includes assistance with transportation and scheduling appointments, reminder calls about follow-up appointments, medication and appointment compliance, education about pregnancy-related issues, and member and provider communication. Members are then managed through the end of their pregnancy and for two weeks' postpartum. A postpartum assessment is completed two weeks postpartum and includes the EPDS.

Exhibit 5-2 below provides a flow chart of the FIMR case management process.

Exhibit 5-2 – FIMR Mom Program Case Management Process



FIMR MOM PROGRAM FINDINGS

Methodology

PHPG obtained two datasets from the OHCA to conduct the analysis –data from Atlantes and claims and eligibility data. FIMR member records were extracted from Atlantes for the period of March 21, 2011 (SFY 2011), through June 30, 2013 (SFY 2013). Claims and eligibility data were pulled for dates of services in SFY 2011 through 2013.

The Atlantes dataset was treated as the authority for identifying FIMR members. To do so, the dataset was "cleaned" to ensure that a member was accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of- Care Start and End dates), as well as removing member records that had null end dates. Thus, only members who completed a case management cycle were included in this analysis. Members who had been enrolled in the program less than one week were also removed. Thus, only members who had actively engaged in the program for greater than one week were included in the analysis.

Member surveys were administered via telephone to a sample of obstetric and pediatric members, including FIMR members. Prior to conducting the survey, a letter was mailed to all members informing them of the survey and what to expect. Survey results were entered into a proprietary database and then analyzed on a per-program basis. A total of 63 FIMR Mom member surveys were collected. Findings for the FIMR Mom survey interviews are reported in the FIMR Mom Member Survey section.

Results

The following program enrollment and ENC activities were analyzed for the FIMR Mom program by using the Atlantes dataset:

- Total enrolled in the FIMR Mom program by SFY;
- Breakdown of FIMR Mom participants by county geography (i.e., rural, urban, suburban, mixed, out of state);
- FIMR Mom enrollment in FIMR;
- Total FIMR Mom participants by age range;
- Total FIMR Mom participants by CDC age range;
- Average length of time in program;
- Percentage of members contacted within three business days of receiving a referral to the FIMR Mom program by SFY;
- Total number of contact attempts per member per SFY;
- Total ENC time spent per enrollee by SFY;
- Total ENC FTE time per SFY; and
- Total number of FIMR Mom letters sent per enrollee by SFY.

The utilization and cost measures listed below were evaluated for the FIMR Mom program by using claims and eligibility data. For each measure, a comparison of outcomes was performed for FIMR Mom members who reside in the ten FIMR counties and individuals who reside in ten comparison counties and who were not enrolled in the FIMR Mom program. The ten comparison counties provided by OHCA had similar IMRs as the ten FIMR counties.

The following utilization and cost measures were evaluated for the FIMR program by using claims and eligibility data:

- The ratio of cesarean section deliveries to vaginal deliveries in the ICC sample by SFY;
- FIMR Moms who were readmitted to the hospital within 30 days postpartum (i.e., postpartum readmission) by SFY;
- FIMR Moms who were readmitted to the hospital within 60 days postpartum (i.e., postpartum readmission) by SFY;
- Emergency Room visits for FIMR Moms within 30 days postpartum by SFY;
- Emergency Room visits for FIMR Moms within 60 days postpartum by SFY; and
- Summary of expenditures (FIMR Moms) by SFY.

The following member survey metrics were evaluated for the FIMR Mom program by using results from the FIMR Mom member surveys:

- Survey demographics (e.g., member age, ethnicity, education level);
- Services received through FIMR Mom and their helpfulness;
- ENC correspondence;
- ENC activities and member satisfaction rates;
- Overall member satisfaction with the assigned ENC and the FIMR Mom program; and
- Behavioral health screenings and referrals.

Analysis of FIMR Mom Enrollment and ENC Activities

This section describes program enrollment and ENC activities by SFY using data contained in Atlantes.

Total Enrollment

Exhibit 5-3 below summarizes total FIMR Mom enrollment from SFY 2011 through SFY 2013. Total enrolled by SFY was calculated based on a member having a level-of-care start date in that fiscal year. In SFY 2012, enrollment increased more than 2.5 times SFY 2011 enrollment and then only slightly declined by 5.4 percent in SFY 2013.

Keep in mind that SFY 2012 was the first full year of program operations since the program was implemented approximately three months before the close of SFY 2011.

Exhibit 5-3: FIMR Mom Enrollment by State Fiscal Year

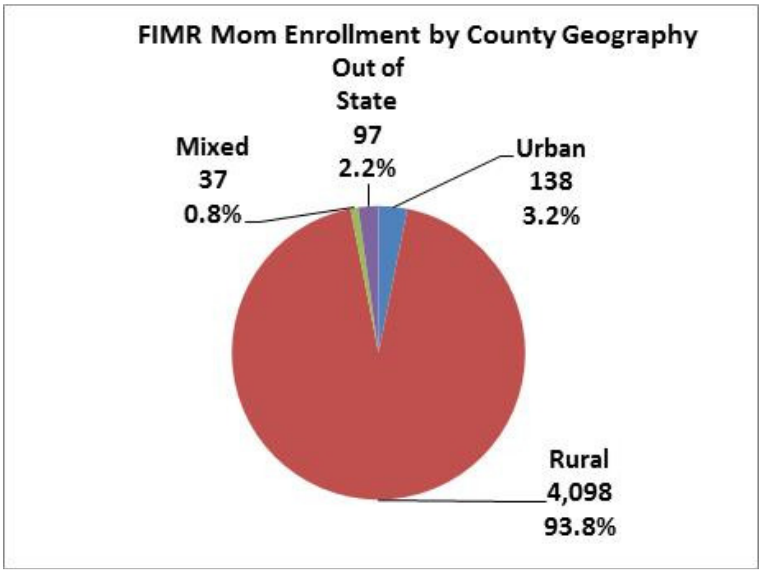
SFY	Members
2011	692
2012	1,880
2013	1,798
Total	**4,370**

Enrollment by County Geography

All ten FIMR counties are classified as rural counties. While 94 percent of FIMR members resided in rural counties, only 85 percent of them resided in one of the FIMR rural counties; another nine percent resided in non-FIMR rural counties. PHPG identified members with a FIMR level of care that had a county of record other than the ten FIMR counties, including out of state (15 percent of FIMR members).

The OHCA reviewed a sample of member records and confirmed that these members moved from a FIMR to a non-FIMR county or out of state sometime after their case record was opened in Atlantes. When this occurs, the PCM Department generally leaves the case open and continues to case manage the FIMR Mom until the end of her pregnancy. Exhibit 5-4 below summarizes the breakdown of FIMR Mom enrollment by county geography from SFY 2011 through SFY 2013.

Exhibit 5-4: FIMR Mom Enrollment by County Geography



FIMR Enrollment in FIMR and Non-FIMR Counties

Exhibit 5-5 on the following page highlights the breakdown of FIMR enrollment in FIMR counties as well as FIMR enrollment in non-FIMR counties and out of state from SFY 2011 through SFY 2013.

Exhibit 5-5: FIMR Mom Enrollment Breakdown in FIMR and Non-FIMR Counties

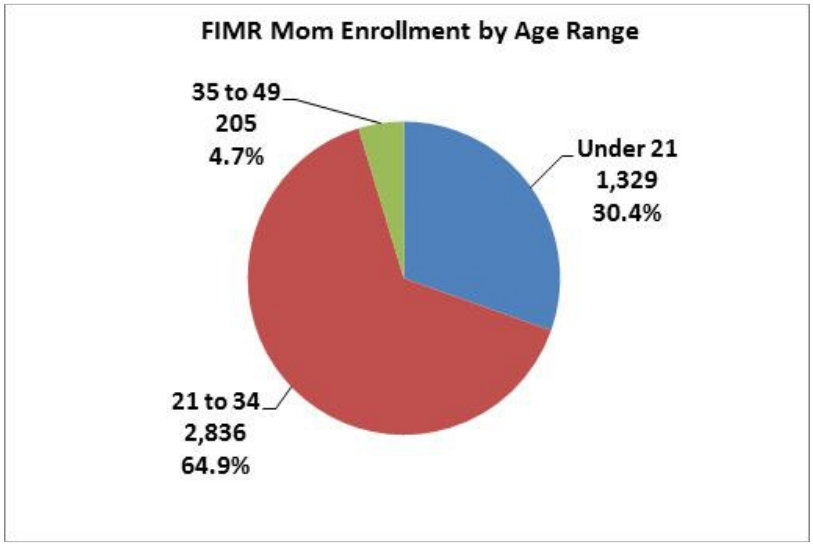
County	Total Members 2011-2013	Percent of FIMR Enrollment
Garfield	1,150	31.0%
Jackson	528	14.2%
Lincoln	521	14.1%
McIntosh	345	9.3%
Choctaw	333	9.0%
Atoka	248	6.7%
Latimer	211	5.7%
Tillman	166	4.5%
Greer	122	3.3%
Coal	82	2.2%
Enrollment in Non-FIMR Counties and Out of State	664	
Grand Total	**4,370**	

Age Range of FIMR Mom Members

Nearly two-thirds of FIMR Moms fell into the age range of 21 to 34 from SFY 2011 through SFY 2013. Thirty percent of members were under 21, while the remaining 4.7 percent were 35 to 49 years of age (see Exhibit 5-6 on the following page) range.

The number of members who were under 21 years of age was considerably higher in this program when compared to the HROB and AROB case management programs. Note that members who were 18 and under with a FIMR level of care had a program start date before 7/1/2013, when the Interconception Care (ICC) program was implemented, and so it makes sense that they would be in the FIMR Mom Atlantes dataset. For background, ICC is a case management program for FIMR moms who are age 18 or under (teen mothers).

Exhibit 5-6: FIMR Mom Enrollment by Age Range



CDC Age Range of FIMR Mom Members

The Centers for Disease Control and Prevention (CDC) monitor pregnancy rates and rates of pregnancy outcomes using pre-defined age ranges. Exhibit 5-7 below provides a breakdown of FIMR Mom enrollment for the nine CDC age ranges from SFY 2011 through SFY 2013.

The top age range for FIMR Mom members was 20 to 24 years of age (39.8 percent) followed by members who fell into the 25 to 29 age range (23.1 percent). Nearly 17 percent of members fell into the age range of 18 to 19 years of age, and ten percent fell into the age range of 30 to 34 years of age.

Exhibit 5-7: FIMR Mom Enrollment by CDC Age Range

CDC Age Range	Members	CDC Age Range	Members
Under 15	8	30 - 34	452
15 - 17	220	35 – 39	167
18 – 19	735	40 – 44	36
20 – 24	1,739	Over 44	2
25 - 29	1,011	**Total**	**4,370**

Length of Stay

Exhibit 5-8 on the following page summarizes the average length of stay from SFY 2011 through SFY 2013. Length of stay was calculated by subtracting a member's level-of-care end date from their level-of-care start date. Nearly 40 percent of FIMR Mom members were enrolled three or fewer months. Fifty-seven percent of members were enrolled four to nine months. The length of stay for members in this program is much longer when compared to the HROB and AROB case management programs.

Exhibit 5-8: FIMR Mom Length of Stay

Length of Stay (weeks)	Duration Classification	# Members	% Members
1-4	Three or Fewer Months	406	9.3%
5-8		558	12.8%
9-12		750	17.2%
	Total	**1,714**	**39.2%**
13-16	Four to Six Months	519	11.9%
17-20		367	8.4%
21-24		315	7.2%
	Total	**1,201**	**27.5%**
25-28	Seven to Nine Months	302	6.9%
29-32		402	9.2%
33-36		583	13.3%
	Total	**1,287**	**29.5%**
37-40	Ten to Twelve Months	151	3.5%
41-44		7	0.2%
45-48		2	0.0%
49-52		0	0.0%
	Total	**160**	**3.7%**
53+	More than One Year	8	0.2%
	Total	**8**	**0.2%**

ENC Activity Time

Initial Outreach

Once a member is assigned to an ENC, the ENC attempts to make an initial telephone contact within three business days of receiving the referral. Three attempts are made on three different days at different times to contact the member via telephone. To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes FIMR Mom Activity Report.

The review was limited to only those cases where the data indicated that an ENC performed initial telephone outreach (e.g., member contact attempts 1, 2 and 3, phone calls to and from) within three business days of a referral to case management. Time spent performing each outreach attempt had to be more than five minutes in duration. Exhibit 5-9 on the following page highlights member contacts made within three business days from SFY 2011 through SFY 2013. Contact rates within three business days ranged from 43.9 to 82.5 percent. The decline from SFY 2011 to SFY 2013 was the result of relaxed contact efforts as caseloads increased and the scope of ENC duties widened (46.8 percent reduction). The average contact rate across all SFYs was 58.7 percent.

Exhibit 5-9: FIMR Mom Contact Rates within Three Business Days

Measure	SFY2011	SFY2012	SFY2013
Members Contacted within Three Business Days	571	1,203	790
Total FIMR Mom Enrollment	692	1,880	1,798
Contact Rate	**82.5%**	**64.0%**	**43.9%**

Total Contacts

After successfully contacting a member and completing the initial assessment, the member is placed on a monthly contact schedule. All contacts for members are documented in Atlantes. To determine the number of contacts, a count was performed of all activity actions contained in the Atlantes FIMR Mom Activity Report. Time spent performing member activities had to more than five minutes in duration.

Exhibit 5-10 below contains the average number of contacts per member from SFY 2011 through SFY 2013. ENCs averaged 6.8 to 11.2 contacts per member across the three fiscal years. The average number of member contacts across all SFYs was 8.5 contacts per member. Contacts decreased by 39.2 percent from SFY 2011 to SFY 2013. It should be noted that contact attempts are sometimes relaxed in times of staffing crises. This number may have declined when the PCM Department implemented additional case management programs, and, as a result, staff caseloads increased.

Exhibit 5-10 FIMR Mom Total Contacts per Member

Measure	SFY2011	SFY2012	SFY2013
Count of Contacts	7,771	17,206	12,304
Total FIMR Mom Enrollment	692	1,880	1,798
Total Contacts Per Member	**11.2**	**9.2**	**6.8**

ENC Time Spent Managing Enrollees

For FIMR Mom cases, if there was a previous ENC assigned to the member for a prior level of care, attempts are made to re-assign the member to the same ENC. If there is no prior history with an ENC, then assignment to FIMR Mom cases is based on ENC caseload at the time of member activation. ENC assignment is then performed using a round-robin approach.

To assess the time spent by ENCs for the FIMR Mom program, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to women who were assigned to FIMR Mom. In each fiscal year, a large majority of ENC time was dedicated to assessments,

ongoing member correspondence and care management for enrolled members, and provider outreach. These activities are consistent with the primary functions of ENCs.

From SFY 2011 through 2013, ENCs spent an average of 2.0 to 3.7 hours per case across all activities. The number of required FTEs increased from SFY 2011 and 2012, but decreased to 1.7 in SFY 2013. The decrease could be attributed to the implementation of the electronic HROB/OB Outreach Assessment Tool that went into production in Atlantes in September 2011 along other automated processes. As a result, there were changes to processes, as well as challenges in the way ENCs captured their time (i.e. some ENCs under-reported their time) while performing the assessment. In total, the FTEs required for the FIMR Mom program ranged from 1.2 to 2.5 FTEs (see Exhibit 5-11 below).

Exhibit 5-11: FIMR Mom ENC Time per Member and ENC FTE Time

Measure	SFY2011	SFY2012	SFY2013
Total Members	692	1,880	1,798
Sum of FIMR Mom Activity (Hours)	2,582.2	5,181.5	3,536.4
ENC Time Per Enrolled Member (Hours)	**3.7**	**2.8**	**2.0**
Total ENC FTE Time	**1.2**	**2.5**	**1.7**

FIMR Mom Letters

ENCs generate and mail a number of letters to members and providers for the FIMR program, including but not limited to introductory letters, unable-to-contact letters, provider notification, and case closure letters. An analysis was performed of the number of FIMR Mom letters sent by SFY. From SFY 2011 through 2013, ENCs mailed an average of 4.3 to 4.8 letters per member (see Exhibit 5-12 below).

Exhibit 5-12: FIMR Mom Letters Sent by State Fiscal Year

Measure	SFY2011	SFY2012	SFY2013
Total Letters Sent	3,338	8,052	8,579
Total FIMR Mom Enrollment	692	1,880	1,798
Total Letters Per Member	**4.8**	**4.3**	**4.8**

FIMR Mom Utilization and Cost Outcomes

This section highlights FIMR Mom utilization and cost trends by SFY using claims and eligibility data for SFY 2011 through SFY 2013. It should be noted that exhibits are presented based on date/SFY of the delivery and not the actual claims incurred during each SFY. For each measure, a comparison of

outcomes was performed for FIMR Mom members who reside in the ten FIMR counties to individuals who reside in ten comparison counties and who were not enrolled in the FIMR Mom program.

Cesarean Section vs. Vaginal Delivery

The three-year average for vaginal deliveries in the FIMR Mom cohort was 90.1 percent compared to 98.2 percent in the comparison group. The three-year average for cesarean section rates was 9.9 percent compared to 1.8 percent in the comparison group (see Exhibit 5-13 below).

Exhibit 5-13: Cesarean Section vs. Vaginal Delivery Rates between FIMR Mom and Comparison Group

Measure	State Fiscal Year			Total
	2011	2012	2013	
FIMR Mom Participants				
Deliveries Identified	73	864	843	1,780
Vaginal Deliveries	67	783	754	1,604
Percent of Vaginal Deliveries	**91.8%**	**90.6%**	**89.4%**	**90.1%**
Cesarean Section Deliveries	6	81	89	176
Percent of Cesarean Section Deliveries	**8.2%**	**9.4%**	**10.6%**	**9.9%**
Comparison Group				
Deliveries Identified	1,094	1,167	1,291	3,552
Vaginal Deliveries	1,071	1,149	1,268	3,488
Percent of Vaginal Deliveries	**97.9%**	**98.5%**	**98.2%**	**98.2%**
Cesarean Section Deliveries	23	18	23	64
Percent of Cesarean Section Deliveries	**2.1%**	**1.5%**	**1.8%**	**1.8%**

Utilization Rates

Exhibit 5-14 on the following page highlights findings for FIMR Mom and comparison group participants who had a readmission and ER visit within 30 and 60 days of delivery. Readmission rates within 30 and 60 days of the mother's delivery were higher in the comparison group than in the FIMR Mom population (1.4 percent and 1.9 percent compared to 4.9 and 5.3 percent). ER visits within 30 and 60 days were higher in the FIMR Mom population at both intervals (8.6 and 12.5 compared to 6.5 and 10.6).

Exhibit 5-14: Utilization among FIMR Mom Participants and Comparison Group

Measure	State Fiscal Year			Total
	2011	2012	2013	
Inpatient Admissions – FIMR Mom Participants				
Any Within 30 Days of Delivery	-	17	8	25
Percent Readmitted Within 30 days of Delivery	**0.0%**	**2.0%**	**0.9%**	**1.4%**
Any Within 60 Days of Delivery	-	25	9	34
Percent Readmitted Within 60 days of Delivery	**0.0%**	**2.9%**	**1.1%**	**1.9%**
Inpatient Admissions – Comparison Group				
Any Within 30 Days of Delivery	85	61	28	174
Percent Readmitted within 30 days of Delivery	**7.8%**	**5.2%**	**2.2%**	**4.9%**
Any Within 60 Days of Delivery	88	66	36	190
Percent Readmitted Within 60 days of Delivery	**8.0%**	**5.7%**	**2.8%**	**5.3%**
Emergency Room Visits - FIMR Mom Participants				
Any Within 30 Days of Delivery	3	84	66	153
Percent of ER Visits Within 30 Days of Delivery	**4.1%**	**9.7%**	**7.8%**	**8.6%**
Any Within 60 Days of Delivery	4	120	99	223
Percent of ER Visits Within 60 Days of Delivery	**5.5%**	**13.9%**	**11.7%**	**12.5%**
Emergency Room Visits - Comparison Group				
Any Within 30 Days of Delivery	60	70	102	232
Percent of ER Visits Within 30 Days of Delivery	**5.5%**	**6.0%**	**7.9%**	**6.5%**
Any Within 60 Days of Delivery	93	123	159	375
Percent of ER Visits Within 60 Days of Delivery	**8.5%**	**10.5%**	**12.3%**	**10.6%**

Expenditures

Total program expenditures increased from SFY 2011 through SFY 2013 as the FIMR Mom program enrolled more participants (see Exhibit 5-15 on the following page). While total program expenditures were higher in the comparison group ($9.8 million) compared to the FIMR Mom population ($8.1 million), total expenditures per case were 39 percent higher in the FIMR Mom cohort ($4,566.18 compared to $2,764.39). This is likely attributable to a lower acuity mix in the non-FIMR counties and selection bias among individuals who were enrolled in FIMR Mom and who are truly high need.

Exhibit 5-15: Expenditures among FIMR Mom Participants and Comparison Group

Measure	State Fiscal Year				Total
	2011	2012	2013	2014	
FIMR Mom Participants					
Participants	545	2,165	2,501	1,173	3,661
Total Expenditures	**$281,745**	**$3,670,678**	**$4,175,370**	**$3,582,133**	**$8,127,793**
Expenditures per Case	**$3,859.52**	**$4,248.47**	**$4,952.99**	**$6,536.74**	**$4,566.18**
Comparison Group					
Participants					
Total Expenditures	**$2,688,585**	**$3,168,242**	**$3,962,299**	**$4,021,086**	**$9,819,212**
Expenditures per Case	**$2,457.57**	**$2,714.86**	**$3,069.17**	**$3,314.99**	**$2,764.39**

FIMR Mom Member Survey Findings

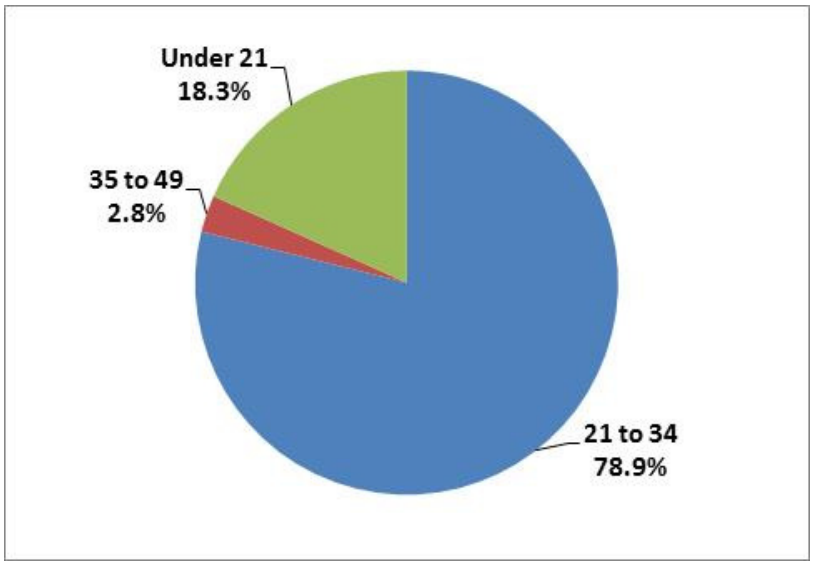
This section describes key findings from the FIMR Mom member survey using data collected from 63 survey interviews.

Survey Demographics

Age Range

Nearly 80 percent of respondents (78.9 percent) fell into the age range of 21 to 34. Only 2.8 percent were between 35 to 49 years of age. Eighteen percent were under 21 years of age (see Exhibit 5-16 below).

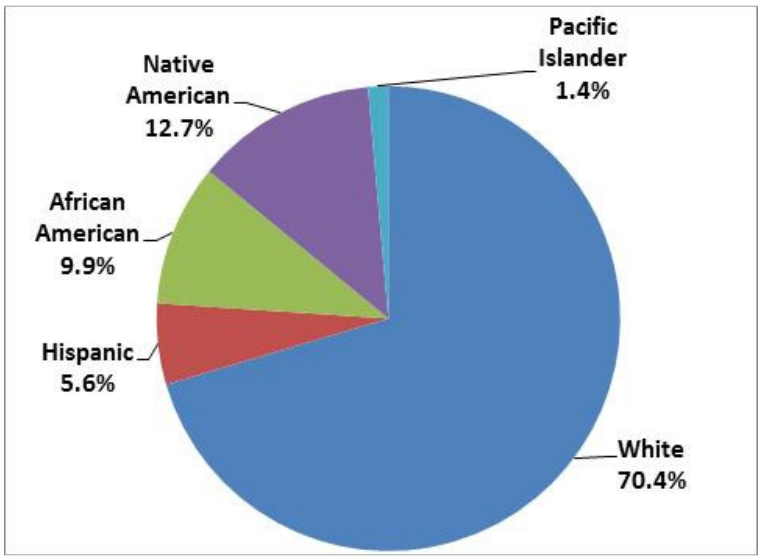
Exhibit 5-16: Age Range



Ethnicity

Seventy percent reported their ethnicity as white (see Exhibit 5-17 below). Over 12 percent said they were of Native American descent.

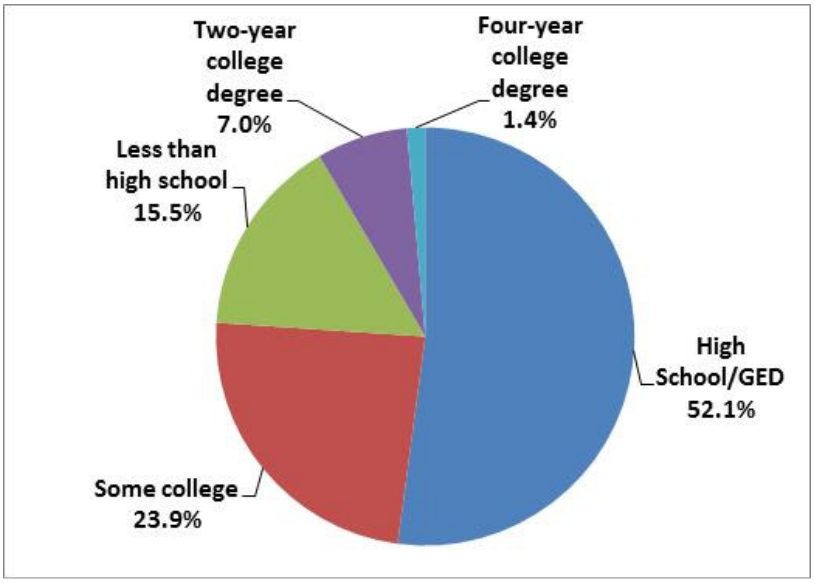
Exhibit 5-17: Ethnicity



Highest Level of Education Completed

Over half of respondents (52.1 percent) said they completed high school/GED. Nearly 24 percent reported completing some college education. Seven percent completed a two-year college degree while 1.4 percent a four-year college degree. Another 15.5 percent reported not completing high school (see Exhibit 5-18 below).

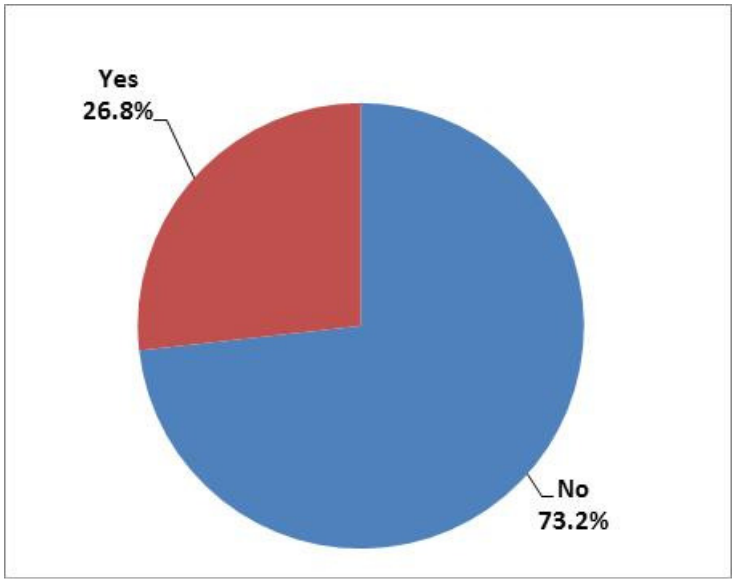
Exhibit 5-18: Education Level



Miscarriages

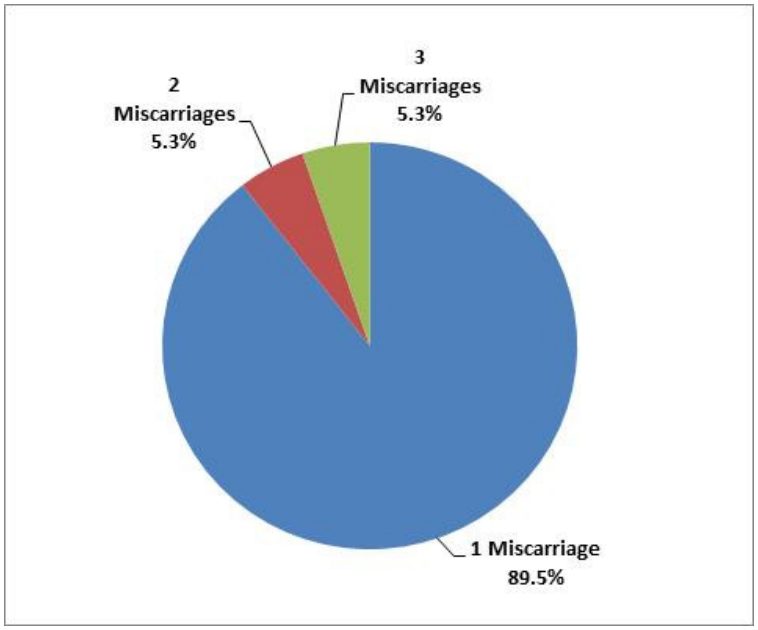
Seventy-three percent denied having a miscarriage. Among all respondents, 26.8 percent reported having a miscarriage, which is considerably lower than that of respondents in the HROB and AROB programs. (see Exhibit 5-19 below).

Exhibit 5-19: Miscarriages



The majority of respondents reported having one miscarriage (89.5 percent). Five percent reported having two miscarriages and another five percent had three miscarriages (see Exhibit 5-20 below).

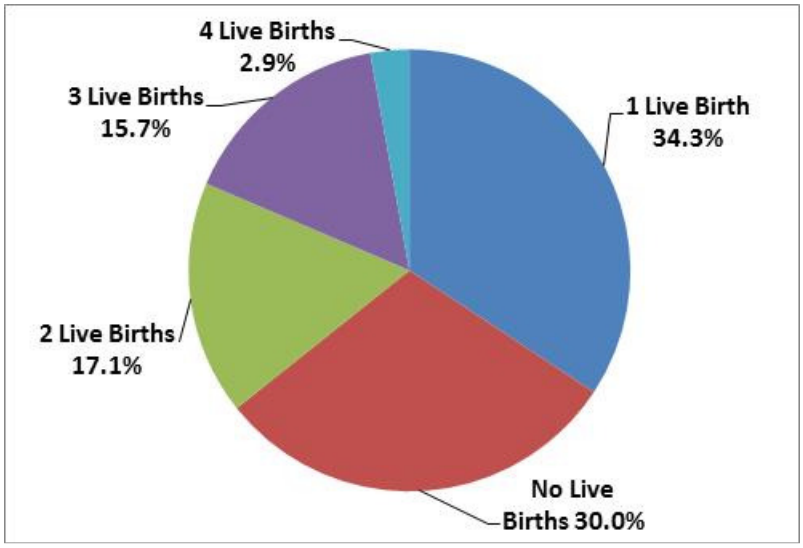
Exhibit 5-20: Number of Miscarriages



Number of Live Births

Thirty-four percent reported having one live birth. Thirty percent reported having no live births, which is attributable to pregnancy status at the time of the survey or due to miscarriage(s). Seventeen percent had two live births (see Exhibit 5-21 below).

Exhibit 5-21: Number of Live Births



FIMR Mom Program Services

There are a number of services available to members in the FIMR Mom program. Nearly all respondents (95.1 percent) said they received monthly phone calls. Eighty percent reported having assessments performed. Over 65 percent said they received training and education, while over 50 percent received referrals to programs and services (see Exhibit 5-22 below).

Exhibit 5-22: FIMR Mom Program Services

Service		Respondents answering "yes" to the service				
	Yes	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Unsure / N/A
Assessment	80.3%	54.1%	24.6%	3.3%	1.6%	16.4%
Training and Education	65.6%	50.8%	13.1%	1.6%	0.0%	34.4%
Educational Materials	44.3%	34.4%	8.2%	1.6%	0.0%	55.7%
Postpartum Depression Screening	14.8%	8.2%	3.3%	1.6%	0.0%	86.9%
Referrals to Programs and Services	56.7%	41.0%	13.1%	1.6%	0.0%	44.3%
Appointment Scheduling	14.8%	11.5%	3.3%	0.0%	0.0%	85.2%
Family Planning	45.9%	31.1%	13.1%	1.6%	0.0%	54.1%
Monthly Phone Calls	95.1%	95.1%	0.0%	0.0%	0.0%	1.6%
Home Visitation	4.9%	55.9%	22.0%	3.4%	0.0%	18.6%

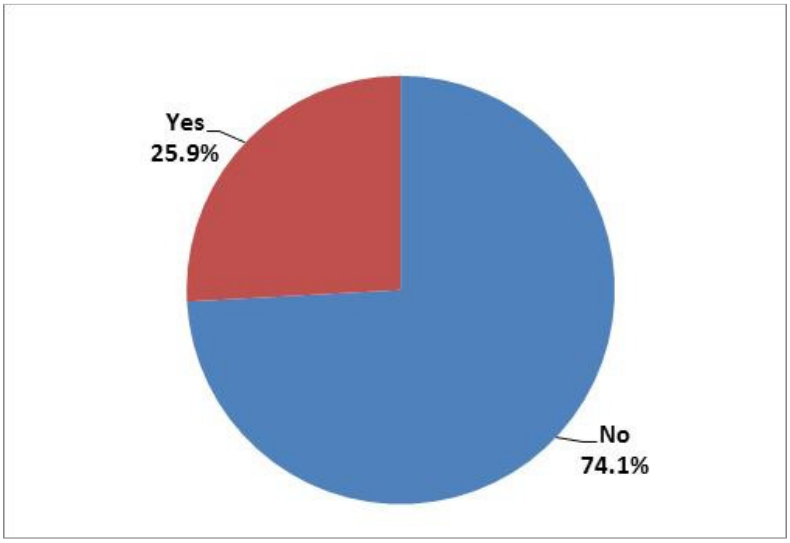
Respondents were asked to rate the helpfulness of each "yes" service. Nearly all respondents (95.1 percent) reported the monthly phone calls were very helpful. Over half of respondents reported the assessments, training and education, and home visitation services were very helpful. Note that the OHCA attempts to refer all FIMR Mom members to home visit programs, though only five percent of FIMR Mom members reported having received this service when interviewed. This may have been due to member refusal and/or a failure of the member to recall the home visit.

ENC Correspondence

Name of Case Manager

Approximately 26 percent of respondents could recall the name of their case manager (see Exhibit 5-23 below).

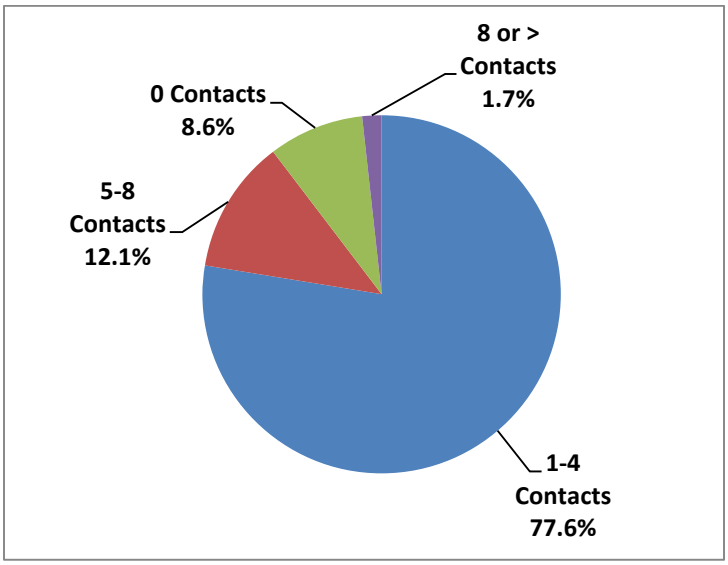
Exhibit 5-23: Identified the Name of Case Manager



Number of Times Spoke with Case Manager

Over 77 percent of respondents said they spoke with their case manager between one and four times since they started the program (see Exhibit 5-24 on the following page). Twelve percent reported 5-8 contacts. Another 8.6 percent reported no contact with their case manager.

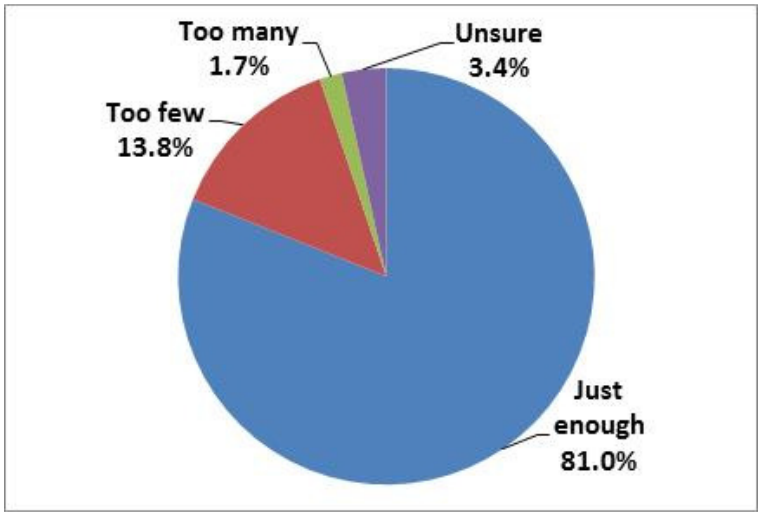
Exhibit 5-24: Number of Times Spoke with Case Manager



Rating of Case Manager Contacts

Eighty-one percent of respondents felt the number of times their case manager contacted them was just enough (see Exhibit 5-25 below).

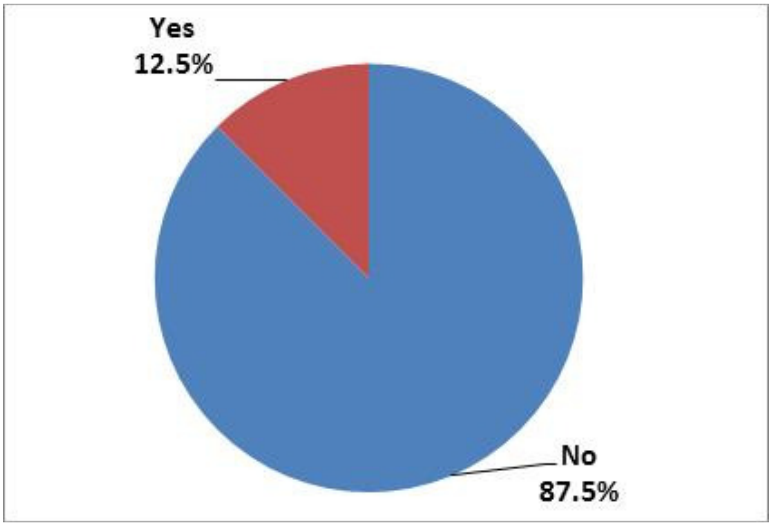
Exhibit 5-25: Rating of Case Manager Contacts



Member Calls to Case Manager

The majority of respondents (87.5 percent) said they had not called their case manager (see Exhibit 5-26 on the following page).

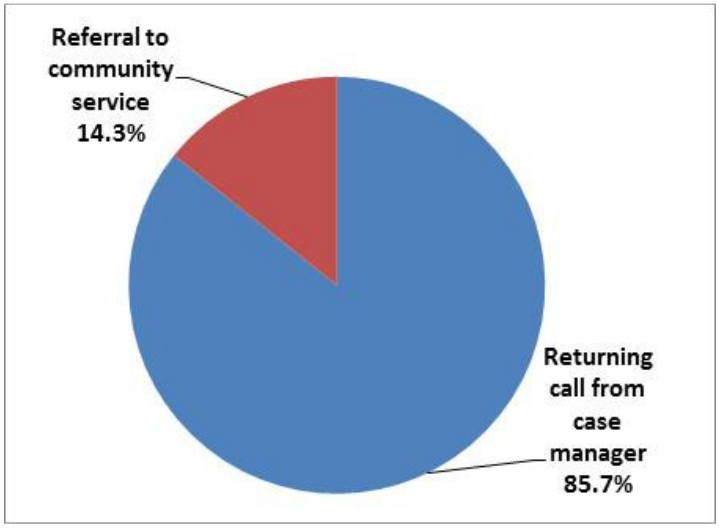
Exhibit 5-26: Have Called Their Case Manager



Reason for Calling Case Manager

Of the respondents that called their case manager, 85.7 percent said returned phone calls from their case manager. Fourteen percent called for a referral to a community service (see Exhibit 5-27 on the following page).

Exhibit 5-27: Reasons for Calling Case Manager



ENC Activities

Case managers are expected to help participants build their self-management skills. The majority of respondents (88.5 percent) indicated that their nurse care manager asked questions about their health or concerns (see Exhibit 5-28 on the following page). Over three quarters said their case manager

answered questions about their health care needs and provided instructions for taking care of their health. Fifty-four percent were referred to programs and services.

Exhibit 5-28: Case Manager Activity Ratings

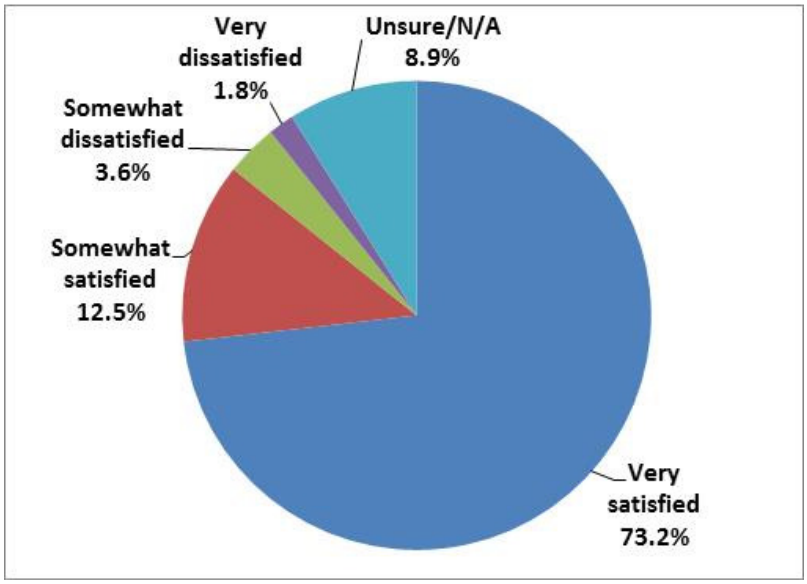
Activity		Respondents answering "yes" to the activity				
	Yes	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Unsure/N/A
Asked questions about your health or concerns	**88.5%**	75.4%	11.5%	1.6%	0.0%	11.5%
Provided instructions about taking care of your health	**75.4%**	70.0%	6.7%	0.0%	0.0%	23.3%
Helped you to identify changes in your health that might be an early sign of a problem	**18.0%**	16.4%	0.0%	0.0%	0.0%	83.6%
Answered questions about your health care needs	**77.0%**	70.5%	3.3%	0.0%	0.0%	26.2%
Helped you to make and keep health care appointments for medical problems	**11.5%**	11.5%	0.0%	0.0%	0.0%	88.5%
Helped you to make and keep health care appointments for mental health or substance abuse problems	**6.6%**	6.6%	0.0%	0.0%	0.0%	93.4%
Referred you to programs and services	**54.1%**	50.8%	3.3%	0.0%	0.0%	45.9%
Helped you to stop smoking or stop using tobacco products	**9.8%**	8.2%	1.6%	0.0%	0.0%	90.2%

Respondents were asked to rate their satisfaction with each “yes” activity. Seventy-five percent reported being very satisfied when their case manager asked questions about their health or concerns. Seventy percent were very satisfied with how their case manager provided answers and instructions for taking care of their health. Over 50 percent reported being very satisfied when their case manager referred them to programs and services.

Satisfaction with ENC and FIMR Mom Program

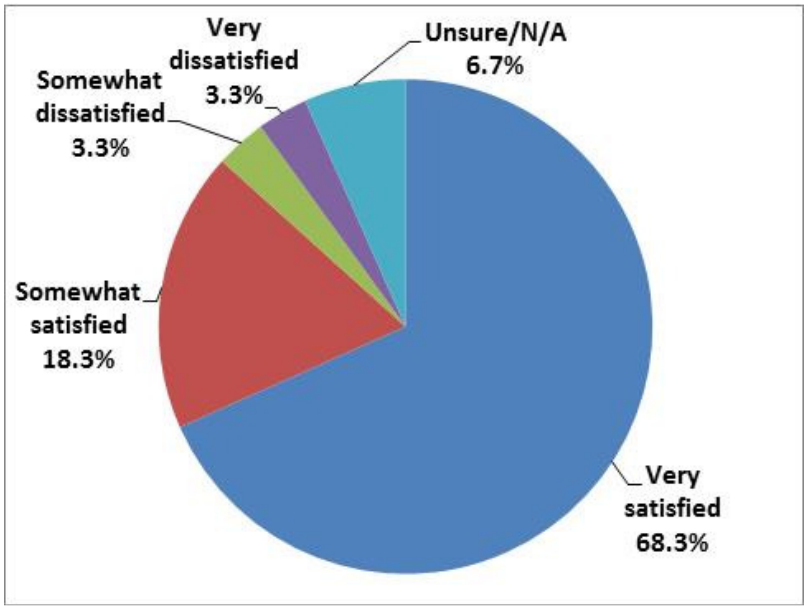
Overall, 73.2 percent of respondents were very satisfied with the help they received from their case manager (see Exhibit 5-29 on the following page).

Exhibit 5-29: Overall Satisfaction with Case Manager



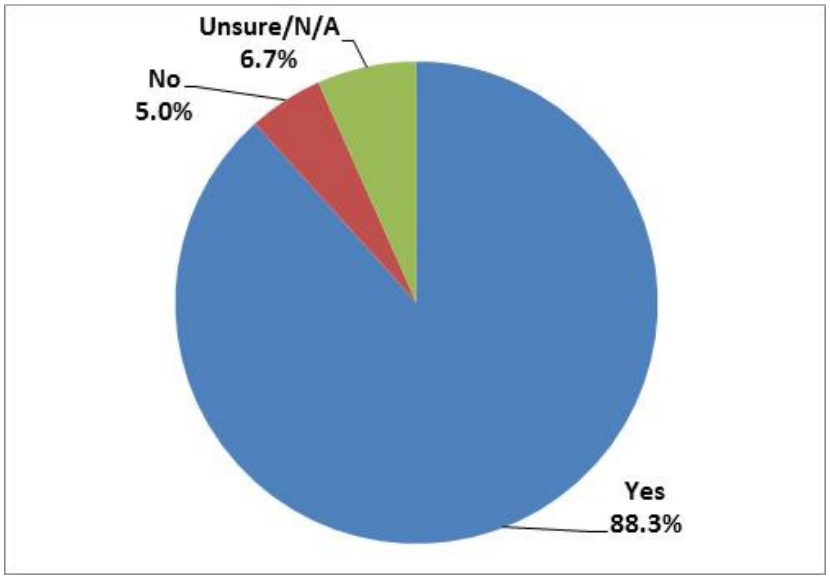
Overall, 68.3 percent of respondents were very satisfied with FIMR Mom program (see Exhibit 5-30 below).

Exhibit 5-30: Overall Satisfaction with FIMR Mom Program



The overwhelming majority of surveyed participants (88.3 percent) would recommend the FIMR Mom program to a friend with similar health care needs (see Exhibit 5-31 below).

Exhibit 5-31: Would Recommend FIMR Mom Program

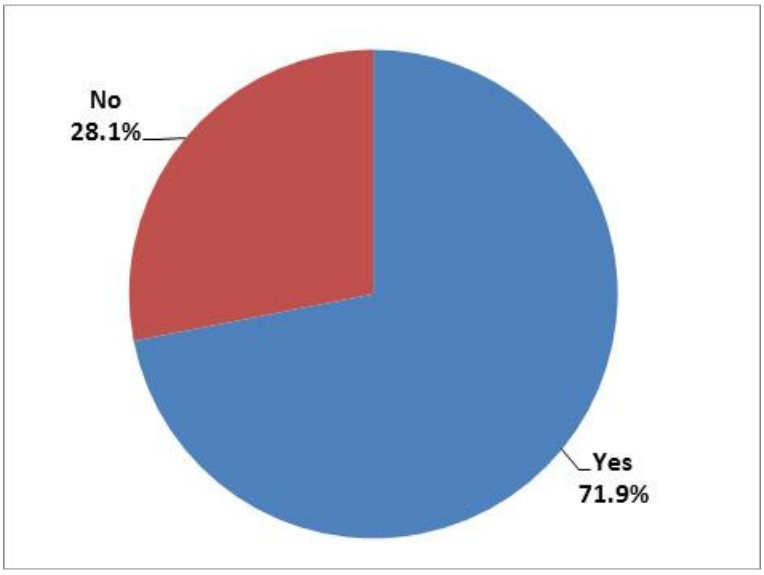


FIMR Mom Behavioral Health Screening and Referral

Completed Behavioral Health Screening

Overall, 71.9 percent of respondents reported completing a behavioral health screening with someone at the OHCA (see Exhibit 5-32 below).

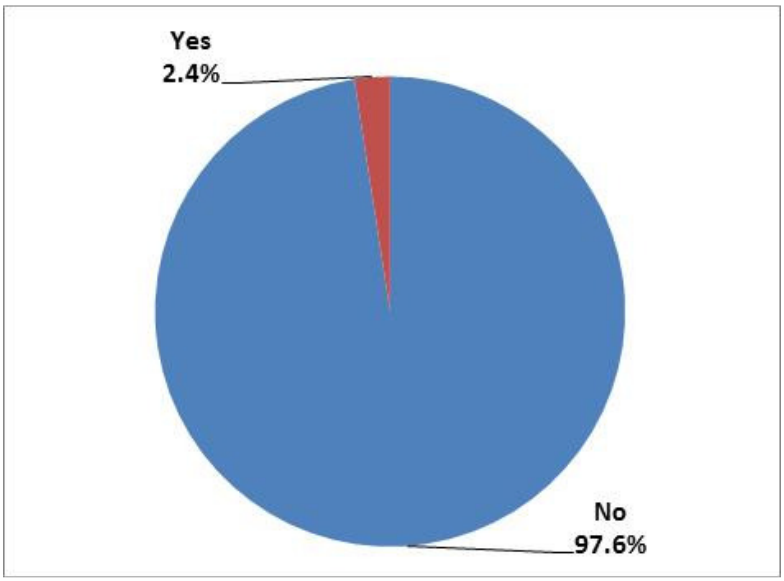
Exhibit 5-32: Completed Behavioral Health Screening



Referred to the OHCA's Behavioral Health Unit (BHU)

Only 2.4 percent (1 member) was referred to the OHCA's BHU (see Exhibit 5-33 below). Although members may have had a positive behavioral health screening, they must consent to a referral to the BHU.

Exhibit 5-33: Referred to OHCA's Behavioral Health Unit



Outpatient Behavioral Health Referrals

There were no outpatient behavioral health referrals reported.

Overall Satisfaction with the BHU

The one respondent who was referred to the OHCA's BHU reported being very satisfied with the help received.

INTERCONCEPTION CARE (ICC) PROGRAM INTRODUCTION AND PROGRAM OVERVIEW

ICC Program Objective

The Interconception Care (ICC) case management program was implemented on July 1, 2013. The program provides case management services to FIMR moms age 18 or under (teen mothers) who reside in one of the top ten counties with the highest fetal Infant Mortality Rates (IMRs). Upon enrollment, ICC members are identified, and a trigger for automatic referral to case management is made in order to reduce potential birth complications.

Program History and Overview

The Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality is a combined Health Resources and Services Administration (HRSA)/Centers for Medicare and Medicaid Services (CMS) and private partnership to reduce infant mortality and improve birth outcomes. Participants learn from one another and national experts, share best practices and lessons learned, and track progress toward shared benchmarks. The goal is to improve access to and financing of postpartum visits and ICC for women who have had an adverse pregnancy outcome while enrolled in Medicaid.

The CoIIN builds on the success of multiple public and private investments to improve birth outcomes in various states. Oklahoma is a participating state and falls into Region VI CoIIN.

In Region IV and Region VI, following the January 2012 Infant Mortality Summit, five priorities to reduce infant mortality and improve birth outcomes were selected:

- Reduce elective delivery at less than 39 weeks of pregnancy;
- Expand access to interconception care (between pregnancies) through Medicaid;
- Promote smoking cessation among pregnant women;
- Promote infant safe sleep practices; and
- Improve perinatal regionalization (a geographically-targeted approach to assure risk-appropriate care for mothers and infants).

On November 30, 2012, the PCM Department participated in meetings with CoIIN representatives, Oklahoma State Department of Health (OSDH) staff, and other OHCA staff in an effort to address Oklahoma's high IMR. It was recommended for Oklahoma to focus on a subgroup of women who retain SoonerCare eligibility after delivery, in this case adolescent FIMR moms (ages 13 to 18), for interventions to promote better ICC. Interconception is the time between the end of one pregnancy and the beginning of the next one, when the mother (and father) should make sure they are in good health before becoming pregnant again. This program would focus on this in an effort to influence outcomes.

Oklahoma was tasked with developing either an ICC case management program or an ICC waiver program. Due to the short window of time to develop such a program, the PCM Department made the decision to develop an ICC case management program. As a result, representatives from PCM began to develop the program in December 2012. Oklahoma is one of only two states that have developed such a program; the other state is Louisiana.

The ICC Program was implemented on July 1, 2013. The ICC Program is a subset of the FIMR Program. The program provides case management to FIMR moms age 18 or under (teen mothers). The program was developed due to the high rates of repeat pregnancies among teen mothers coupled with the high IMRs in FIMR counties.

Exhibit 6-1 below displays the ten counties that were selected for the FIMR and ICC programs, which are shaded in blue.

Exhibit 6-1: Fetal Infant Mortality Reduction Program Counties

As a result of the CoIIN Initiative, case management of ICC members was extended in FIMR counties for one additional year post-delivery. Normally, cases would close at six weeks postpartum, but the intent is to work with teen mothers on family planning and education. As a result, the CMU developed program logic for the identification of members for case management purposes. Additionally, business rules were created for extending case management services for the additional one-year duration, as long as the member maintains SoonerCare eligibility.

The average membership in the ICC Program is approximately 50 members at any given point in time.

Program Eligibility

Pregnant SoonerCare members age 18 and under who reside in one of the ten FIMR counties are automatically enrolled into ICC Case Management Program.

ICC Case Management Program Process

Similar to the FIMR Mom program, identification of a pregnant member in one of the ten counties is performed on a weekly basis. A report is generated for all new pregnant members by the data warehouse. From there, the PCM Department enters data into Atlantes using an algorithm for the member's birth date for the ICC Program. A report is then generated of all new pregnant moms who reside in FIMR/ICC counties. ICC members are automatically enrolled in case management.

ENC assignment for the ICC Program is not limited to the geographic location of the ENC. A member is assigned to any available ENC in any region at the time the assignment is made to prevent regional ENC teams from being overburdened with ICC cases. The member is then contacted by the assigned ENC one week after enrollment into SoonerCare to encourage member/provider communication and compliance with the prescribed medical regimen, review benefits, and schedule follow-up assessments. The ENC also communicates with the member's obstetrical provider to determine if there is any information that the provider would like the ENC to review with the member.

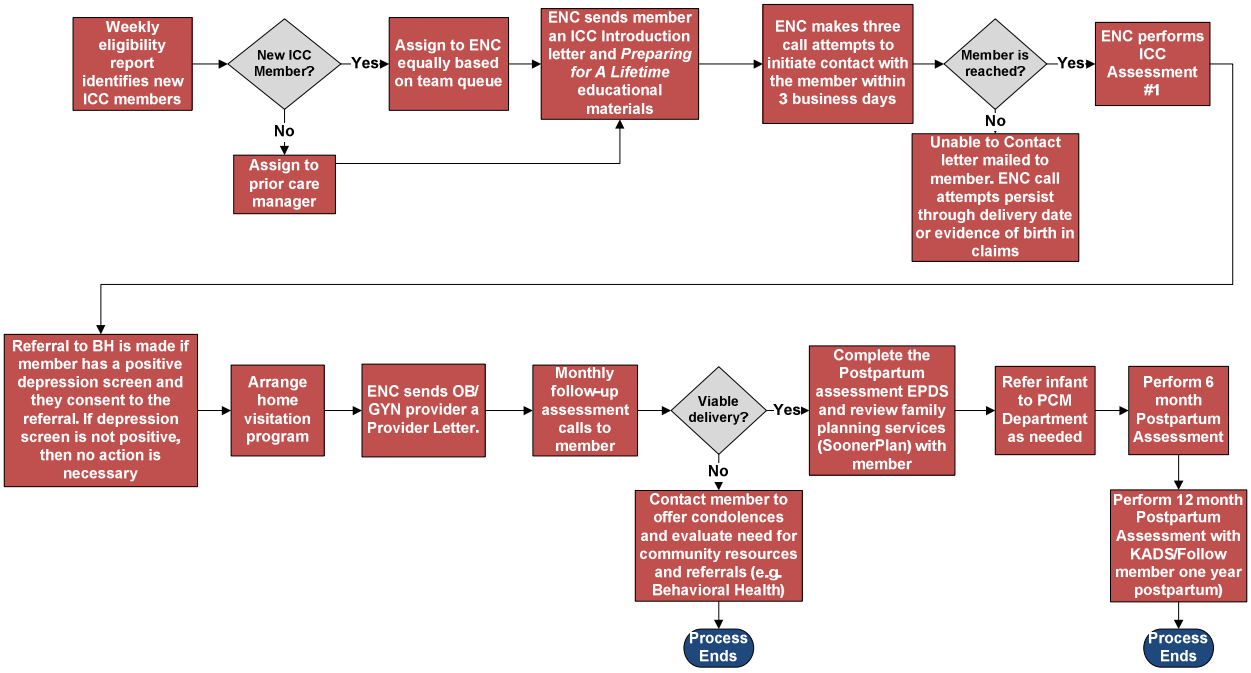
There are three tiered FIMR/ICC assessments that are completed in one-month intervals. Each FIMR/ICC assessment is unique and addresses different educational topics. The initial FIMR/ICC assessment includes the EPDS Tool so that a baseline can be established (see Prenatal and Postpartum Depression Screening and Referral section for more information). After the three assessments are completed, the member moves to a monthly follow-up assessment call, which includes a referral to an appropriate home visitation agency.

Case management follow-up during the prenatal period includes assistance with transportation and scheduling appointments, reminder calls about follow-up appointments, education about pregnancy-related issues (e.g., regular medical care, smoking cessation, breastfeeding), medication and appointment compliance, and member and provider communication. For ICC, the ENC focuses specifically on contraception utilization, medical and dental well-checks (for the ICC woman), return to school/graduation and/or vocational training, and increasing primary care provider visits.

The ENC outreach also incorporates a postpartum assessment performed two weeks post-delivery, which includes the EPDS screening. Two additional assessments are dedicated to the ICC Program: the ICC 6-Month Postpartum Assessment and the ICC 12-Month Postpartum Assessment. At the 12-month Postpartum Assessment, the Kutcher Adolescent Depression Screening (KADS) is completed. The KADS is an assessment instrument used to identify young people at risk for depression.

ENCs also have the option to do the depression screen at any time they feel it may be necessary with the member. Exhibit 6-2 below provides a flow chart of the ICC case management process.

Exhibit 6-2 – ICC Program Case Management Process



ICC PROGRAM FINDINGS

Methodology

PHPG obtained two datasets from the OHCA to conduct the analysis, data from Atlantes and claims and eligibility data. ICC member records were extracted from Atlantes for the period of July 1, 2013, through December 31, 2013 (first half of SFY 2014). Claims and eligibility data were pulled for dates of services in SFY 2014. Caution should be exercised in interpreting trended data, given the partial year results for SFY 2014.

The Atlantes dataset was treated as the authority for identifying ICC members. To do so, the dataset was "cleaned" to ensure a member was accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates). Members who had been enrolled in the program less than one week were also removed. Thus, only members who had actively engaged in the program for greater than one week were included in the analysis. Members who were still enrolled at the time of the analysis were also included (i.e., no LOC end date) due to the lack of historical data and the low sample size for this program.

Member surveys were administered via telephone to a sample of obstetric and pediatric members, including ICC members. Prior to conducting the survey, a letter was mailed to all members informing them of the survey and what to expect.

Survey results were entered into a proprietary database and then analyzed on a per-program basis. A total of 14 ICC member surveys were collected. Due to the small respondent pool surveyed, the results should be treated as qualitative in nature. Additionally, membership in the ICC program is similarly small, and the survey sample accounts for approximately 28 percent of the average ICC caseload reported by the OHCA. Findings for the ICC survey interviews are reported in the ICC Member Survey section.

Results

The following section details the process and outcome measures that were evaluated for the ICC program. As a reminder, the program was implemented on July 1, 2013 (SFY 2014), so there is currently no trend data for annual comparisons. Caution should be used in interpreting the findings for this program due to the small caseload for ICC (average of 50 members) and the subsequent potential for swings in the findings due to any potential outliers. Where applicable, conclusions will be drawn based on the findings.

The following program enrollment and ENC activities were analyzed for the ICC program by using the Atlantes dataset:

- Total enrolled in the ICC program by SFY;
- Breakdown of ICC participants by county geography (i.e., rural, urban, suburban, mixed, out of state);
- ICC enrollment in FIMR and Non-FIMR counties;
- Total ICC participants by age range;
- Total ICC participants by CDC age range;
- Average length of time in program;
- Percentage of members contacted within three business days of receiving a referral to the ICC program by SFY;
- Total number of contact attempts per member per SFY;
- Total ENC time spent per enrollee by SFY;
- Total ENC FTE time per SFY; and
- Total number of FIMR ICC letters sent per enrollee by SFY.

The following utilization and cost measures were evaluated for the ICC program by using claims and eligibility data:

- Early gestation and low birth weight percentages of ICC deliveries by SFY;
- Neonatal Intensive Care Unit (NICU) admissions in the ICC sample by SFY;
- The ratio of cesarean section deliveries to vaginal deliveries in the ICC sample by SFY;
- ICC moms who were readmitted to the hospital within 30 days postpartum (i.e., postpartum readmission) by SFY;
- ICC moms who were readmitted to the hospital within 60 days postpartum (i.e., postpartum readmission) by SFY;
- Emergency Room visits for ICC moms within 30 days postpartum by SFY;
- Emergency Room visits for ICC moms within 60 days postpartum by SFY;
- Hospital admissions for ICC newborns during the first year of life by SFY;
- Emergency Room visits for ICC newborns during the first year of life by SFY; and
- Summary of expenditures for ICC moms and newborns by SFY.

The following member survey metrics were evaluated for the ICC program by using results from the ICC member surveys:

- Survey demographics (e.g., member age, ethnicity, education level);
- Services received through ICC and their helpfulness;
- ENC correspondence;
- ENC activities and member satisfaction rates;
- Overall member satisfaction with the assigned ENC and the ICC program; and
- Behavioral health screenings and referrals.

Analysis of ICC Enrollment and ENC Activities

This section describes ICC program enrollment and ENC activities by SFY using Atlantes data.

Total Enrollment

Exhibit 6-3 below summarizes total ICC enrollment in the first half of SFY 2014. Total enrolled by SFY was calculated based on a member having a level-of-care start date in that fiscal year.

Exhibit 6-3: ICC Enrollment SFY 2014

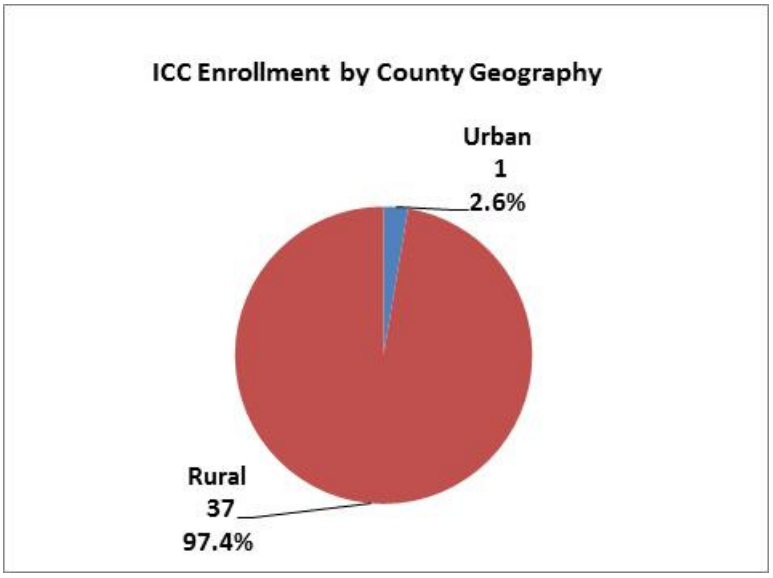
SFY	Members
2014–1st half	**38**

Enrollment by County Geography

All ten ICC counties are classified as rural counties. While 97.4 percent of ICC members resided in rural counties, 94.7 percent of them resided in one of the FIMR rural counties; another 2.6 percent resided in non-FIMR rural counties. PHPG identified two members with an ICC level of care that had a county of record other than the ten FIMR counties, including one member who resided in Oklahoma County.

Similar to FIMR Mom, this is likely attributable to members moving from an ICC to a non-ICC county after their case record was opened in Atlantes. When this occurs, the PCM Department generally leaves the case open and continues to case manage the ICC Mom through the 12-month postpartum period. Exhibit 6-4 below summarizes the breakdown of FIMR Mom enrollment by county geography for SFY 2014.

Exhibit 6-4: ICC Enrollment by County Geography



ICC Enrollment in FIMR and Non-FIMR Counties

Exhibit 6-5 on the following page highlights the breakdown of ICC enrollment in FIMR counties, as well as ICC enrollment in non-FIMR counties for SFY 2014. There were no ICC members in Greer County, another FIMR county.

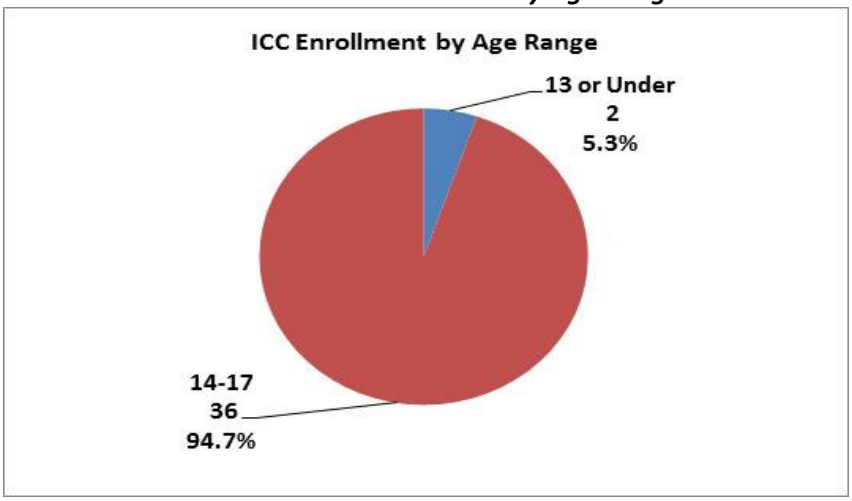
Exhibit 6-5: ICC Enrollment Breakdown in FIMR and Non-FIMR Counties

County	Total Members 2014– 1st half	Percent of ICC Enrollment
Garfield	11	28.9%
Jackson	8	21.1%
Lincoln	4	10.5%
McIntosh	4	10.5%
Latimer	3	7.9%
Atoka	2	5.3%
Coal	2	5.3%
Choctaw	1	2.6%
Tillman	1	2.6%
Enrollment in Non-FIMR Counties	2	
Grand Total	**38**	

Age Range of ICC Members

Nearly 95 percent of ICC Moms fell into the age range of 14-17for the first half of SFY 2014. The remaining five percent were 13 and under (see Exhibit 6-6 below).

Exhibit 6-6: ICC Enrollment by Age Range



Length of Stay

Exhibit 6-7 below summarizes the average length of stay for ICC members. Length of stay was calculated by subtracting a member's level-of-care end date from their level-of-care start date. It should be noted that the OHCA provided PHPG with updated level-of-care end dates for ICC members in March 2015 to allow for the evaluation of this measure.

Over 40 percent of ICC members were enrolled more than one year. This is consistent with the program goal of case managing ICC members for one year postpartum. The remaining members were enrolled less than one year: 25 percent of members were enrolled for a period of four to nine months, 21.9 percent were enrolled for three or fewer months, and 9.4 percent were enrolled 10-12 months in duration. There were six ICC members who remain enrolled in the ICC program as of the date this report was written.

Exhibit 6-7: ICC Length of Stay

Length of Stay (weeks)	Duration Classification	# Members	% Members
1-4	Three or Fewer Months	4	12.5%
5-8		3	9.4%
9-12		0	0.0%
	Total	***7***	**21.9%**
13-16	Four to Six Months	1	3.1%
17-20		1	3.1%
21-24		2	6.3%
	Total	***4***	**12.5%**
25-28	Seven to Nine Months	0	0.0%
29-32		1	3.1%
33-36		3	9.4%
	Total	***4***	**12.5%**
37-40	Ten to Twelve Months	1	3.1%
41-44		0	0.0%
45-48		1	3.1%
49-52		1	3.1%
	Total	***3***	**9.4%**
53+	More than One Year	14	43.8%
	Total	***14***	**43.8%**

ENC Activity Time

Initial Outreach

Once a member is assigned to an ENC, the ENC attempts to make an initial telephone contact within three business days of receiving the referral. Three attempts are made on three different days at different times to contact the member via telephone.

To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes ICC Activity Report. The review was limited to only those cases where the data indicated that an ENC performed initial telephone outreach (e.g., member contact attempts 1, 2 and 3, phone calls to and from) within three business days of a referral to case management. Time spent performing each outreach attempt had to be more than five minutes in duration. Forty-seven percent of ICC members were contacted within three business days (Exhibit 6-8 below).

Exhibit 6-8: ICC Contacts within Three Business Days

Measure	SFY2014–1st half
Members Contacted within Three Business Days	18
Total ICC Enrollment	38
Contact Rate	**47.4%**

Total Contacts

After successfully contacting a member and completing the initial assessment, the member is placed on a monthly contact schedule. All contacts for members are documented in Atlantes. To determine the number of contacts, a count was performed of all activity actions contained in the Atlantes ICC Activity Report. Time spent performing member activities had to be more than five minutes in duration. Exhibit 6-9 below shows the average number of contacts per member for the first half of SFY 2014 was 6.9.

Exhibit 6-9: ICC Total Contacts per Member

Measure	SFY2014–1st half
Count of Contacts	261
Total ICC Enrollment	38
Total Contacts Per Member	**6.9**

ENC Time Spent Managing Enrollees

For ICC cases, if there was a previous ENC assigned to the member for a prior level of care, attempts are made to re-assign the member to the same ENC. If there is no prior history with an ENC, assignment to ICC cases is based on ENC caseload at the time of member activation. ENC assignment is then performed using a round-robin approach.

To assess the time spent by ENCs for the ICC program, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to women who were assigned to ICC. In each fiscal year, a large majority of ENC time was dedicated to assessments, ongoing member correspondence and care management for enrolled members and provider outreach. These activities are consistent with the primary functions of ENCs.

For SFY 2014, ENCs spent 1.9 hours per case across all activities. The FTEs time required was 0.03 FTEs, which appears to be lower compared to the other OB programs (see Exhibit 6-10 below), but caution should be used in interpreting these results since the time period was only the first half of SFY 2014.

Exhibit 6-10: ICC ENC Time per Member and ENC FTE Time

Measure	SFY2014–1st half
Total Members	38
Sum of ICC Activity (Hours)	71.9
ENC Time Per Enrolled Member (Hours)	**1.9**
Total ENC FTE Time	**0.03**

ICC Letters

ENCs generate and mail a number of letters to members and providers for the ICC program, including but not limited to introductory letters, unable-to-contact letters, provider notification, and case closure letters. An analysis was performed for the number of ICC letters sent by SFY. In SFY 2014, ENCs mailed an average of 3.2 letters per member (see Exhibit 6-11 below).

Exhibit 6-11: ICC Letters Sent by State Fiscal Year

Measure	SFY2014–1st half
Total Letters Sent	123
Total ICC Enrollment	38
Total Letters Per Member	**3.2**

ICC Utilization and Cost Outcomes

This section highlights ICC utilization and cost trends by SFY using claims and eligibility data for dates of services in SFY 2014. It should be noted that exhibits are presented based on date/SFY of the delivery and not the actual claims incurred during each SFY.

Early Gestation/Low Birth Weight

Early gestation and low birth weight diagnosis codes were evaluated separately. The two populations were essentially the same. For the vast majority of cases, pre-term deliveries were coded as both early gestation and low birth weight. Therefore, a combined rate was calculated based on the number of participants with these codes out of the total number of identifiable deliveries.

The average rate of early gestation and low birth weight deliveries was 24 percent, which exceeded the rate of all other programs that evaluated this measure. Multiple factors play a role in early gestation and low birth weight deliveries. Note that findings should be interpreted with caution due to the small sample size (see Exhibit 6-12 below).

Exhibit 6-12: Percentage of Early Gestation and Low Birth Weight Deliveries among ICC Participants

Measure	SFY2014– 1st half
Participants	40
Deliveries Identified	25
Participants Early Gestation/Low Birth Weight	6
Percent of Early Gestation/Low Birth Weight Deliveries	**24.0%**

Neonatal Intensive Care Unit Admissions

The NICU admission rate for ICC members was 17.4 percent (see Exhibit 6-13 below). NICU rates are highly correlated to the percent of early gestation/low birth weight deliveries. Therefore, continued efforts should be made to improve early access to prenatal care and to educate mothers.

Exhibit 6-13: Percentage of NICU Admissions among ICC Participants

Measure	SFY2014– 1st half
Participants	40
Deliveries Paired with Child in Claims	25
NICU Cases	4
Percent of Deliveries Admitted to NICU	**17.4%**

Cesarean Section vs. Vaginal Delivery

The vaginal delivery rate for ICC members was 92 percent compared to the cesarean section rate of 8 percent (see Exhibit 6-14 below).

Exhibit 6-14: Cesarean Section vs. Vaginal Delivery Comparison among ICC Participants

Measure	SFY2014– 1st half
Participants	40
Deliveries Identified	25
Vaginal Deliveries	23
Percent of Vaginal Deliveries	**92.0%**
Cesarean Section Deliveries	2
Percent of Cesarean Section Deliveries	**8.0%**

Utilization Rates

There were no inpatient readmission claims for ICC participants within 30 and 60 days of delivery. The ER visit rate at 30 days was 16 percent and 20 percent at 60 days (see Exhibit 6-15 on the following page). An evaluation was performed of hospitalizations and ER visits for newborns through the first year of life. The ICC inpatient admission rate per 1,000 was 1,043. The ICC ER Visit rate per child was 957.

Exhibit 6-15: Utilization among ICC Participants and their Newborns

Measure	SFY2014– 1st half
Inpatient Admissions - Mother	
Any Within 30 Days of Delivery	-
Percent Readmitted within 30 days of Delivery	0.0%
Any Within 60 Days of Delivery	-
Percent Readmitted within 60 days of Delivery	0.0%
Inpatient Admissions - Child	
Total	24
Per 1,000 Children	1,043.48
Emergency Room Visits - Mother	
Any Within 30 Days of Delivery	4
Percent of ER Visits within 30 Days of Delivery	16.0%
Any Within 60 Days of Delivery	5
Percent of ER Visits within 60 Days of Delivery	20.0%
Emergency Room Visits - Child	
Total	22
Per Child	956.52

Expenditures

Total ICC program expenditures and expenditures per case for both mother and child were nearly $700,000 for which the child's expenditures comprised 56.7 percent of the total. Expenditures per case were $27,987 (see Exhibit 6-16 below).

Exhibit 6-16: Summary of Expenditures for ICC Participants and their Newborns

Measure	SFY2014– 1st half
Total Expenditures (paired deliveries only)	
Mother	**$303,176**
Child	**$396,500**
TOTAL	**$699,676**
Expenditures per Case (paired deliveries only)	
Mother	**$12,127.06**
Child	**$15,860.00**
TOTAL	**$27,987.05**

ICC Member Survey Findings

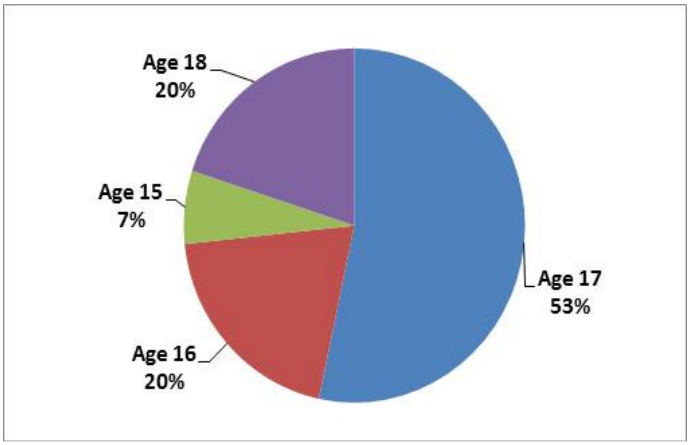
This section describes key findings from the ICC member survey using data collected from 14 survey interviews.

Survey Demographics

Age Range

Over half of respondents (53 percent) were 17 years of age. Twenty percent were 16 years of age and 18 years of age respectively (see Exhibit 6-17 below).

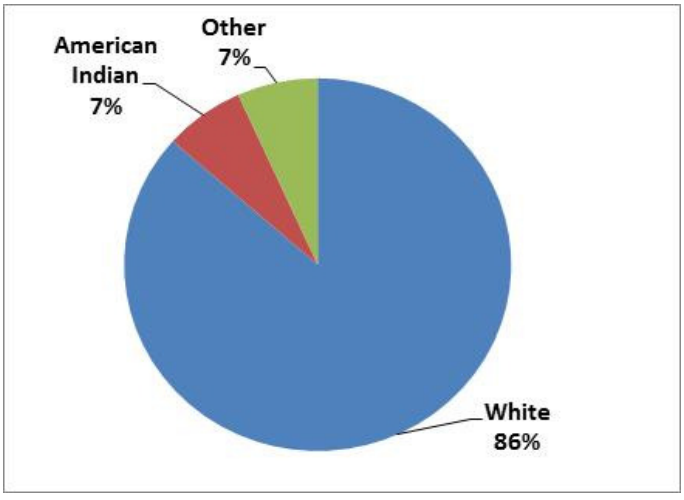
Exhibit 6-17: Age Range



Ethnicity

Eighty-six percent of respondents reported their ethnicity as white (see Exhibit 6-18 below).

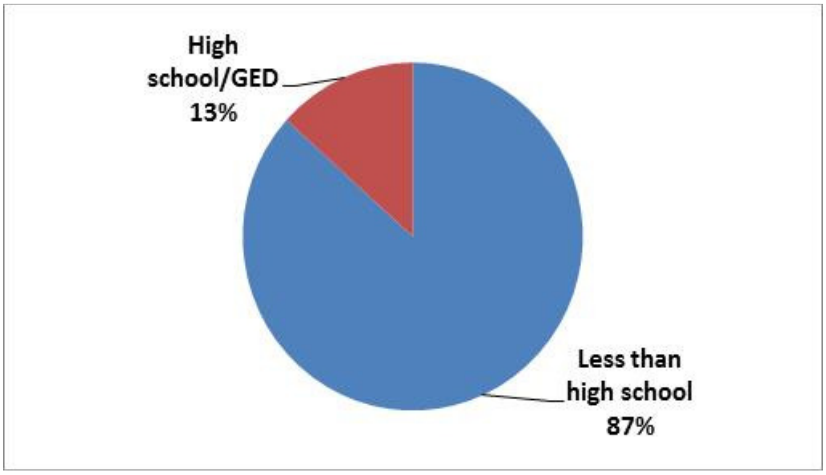
Exhibit 6-18: Ethnicity



Highest Level of Education Completed

As expected, the vast majority of respondents (87 percent) reported not completing high school (see Exhibit 6-19 below) since the ICC program is only eligible to members who are 18 years of age or younger.

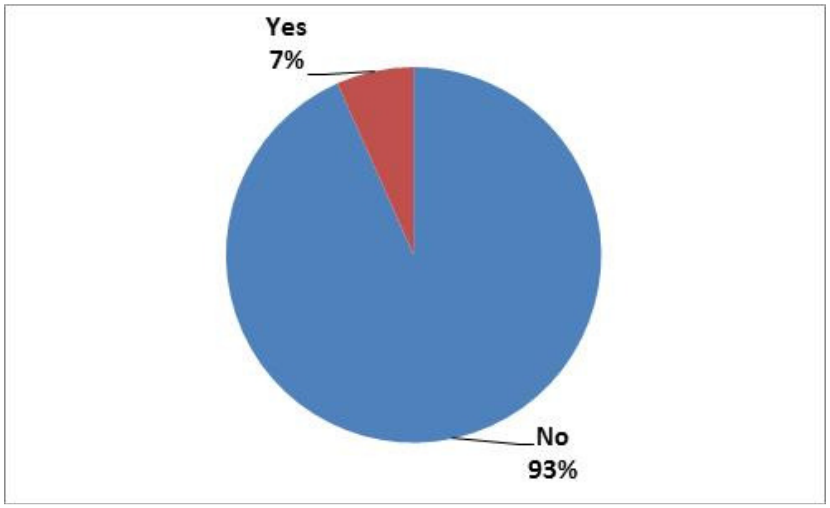
Exhibit 6-19: Education Level



Miscarriages

The majority of respondents (93 percent) denied having a miscarriage (see Exhibit 6-20 below). The age of ICC members plays a key factor in these findings. The average number of miscarriages in the ICC sample was one miscarriage.

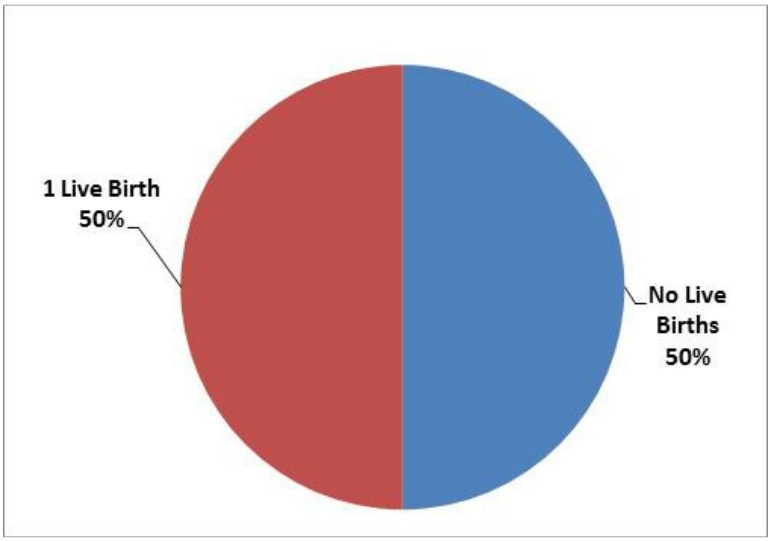
Exhibit 6-20: Miscarriages



Number of Live Births

Fifty percent reported having no live births, which is attributable to pregnancy status at the time of the survey or due to miscarriage(s). Fifty percent had one live birth (Exhibit 6-21 below).

Exhibit 6-21: Number of Live Births



ICC Program Services

There are a number of services available to members in the ICC program. Nearly all respondents (92.9 percent) said they received monthly phone calls. Seventy-nine percent reported having assessments performed. Sixty-four percent said they received training and education, while 57 percent received referrals to programs and services (see Exhibit 6-22 below).

Exhibit 6-22: ICC Program Services

Service		Respondents answering "yes" to the service				
	Yes	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Unsure/N/A
Assessment	78.6%	50.0%	28.6%	0.0%	0.0%	21.4%
Training and Education	64.3%	57.1%	7.1%	0.0%	0.0%	35.7%
Educational Materials	28.6%	35.7%	0.0%	0.0%	0.0%	64.3%
Postpartum Depression Screening	35.7%	21.4%	14.3%	0.0%	0.0%	64.3%
Referrals to Programs and Services	57.1%	42.9%	14.3%	0.0%	0.0%	42.9%
Appointment Scheduling	21.4%	21.4%	0.0%	0.0%	0.0%	78.6%
Family Planning	50.0%	42.9%	0.0%	7.1%	0.0%	50.0%
Monthly Phone Calls	92.9%	64.3%	21.4%	0.0%	0.0%	14.3%
Home Visitation	14.3%	7.1%	7.1%	0.0%	0.0%	85.7%

Respondents were asked to rate the helpfulness of each "yes" service. Sixty-four percent reported the monthly phone calls were very helpful. Of the respondents who received training and education, 57.1 percent said it was very helpful. Fifty percent reported the assessment was very helpful.

ENC Correspondence

Name of Case Manager

None of the ICC respondents could recall the name of their case manager.

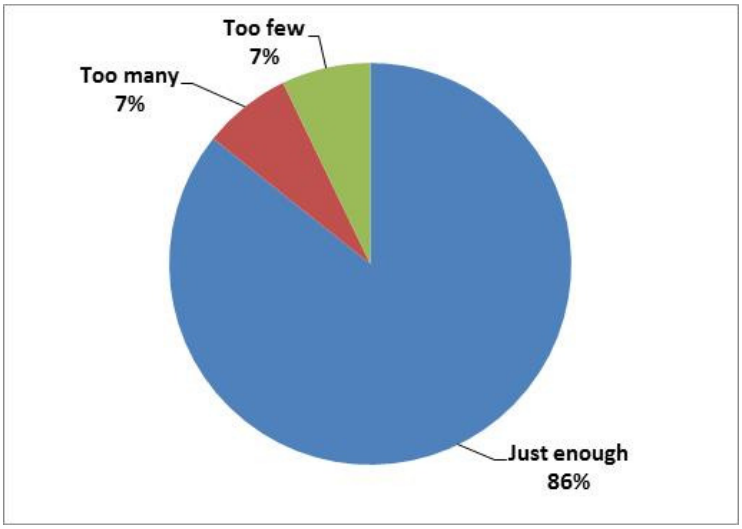
Number of Times Spoke with Case Manager

On average, respondents spoke with their case manager 4.2 times since they started the ICC program.

Rating of Case Manager Contacts

Eight-six percent of respondents felt the number of times their case manager contacted them was just enough (see Exhibit 6-23 below).

Exhibit 6-23: Rating of Case Manager Contacts



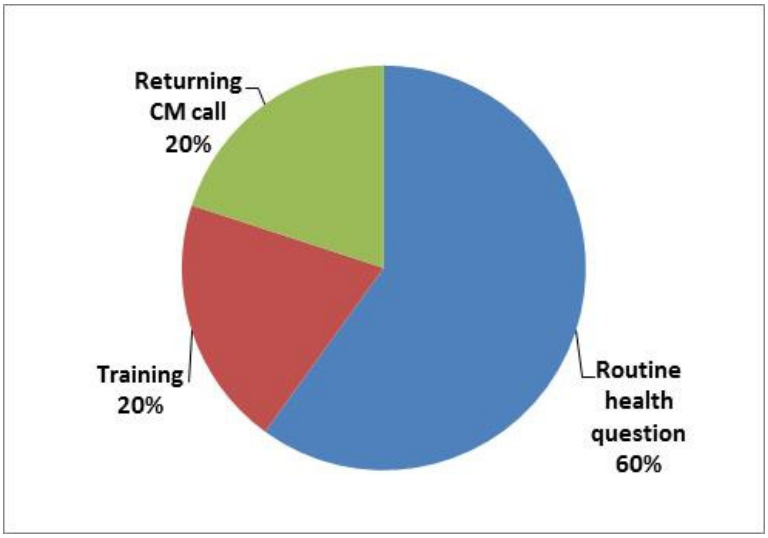
Member Calls to Case Manager

One hundred percent of respondents said they had called their case manager during the course of their enrollment in the ICC program.

Reason for Calling Case Manager

Of the respondents that called their case manager, 60 percent said they called about a routine health question (see Exhibit 6-24 below).

Exhibit 6-24: Reasons for Calling Case Manager



ENC Activities

Case managers are expected to help participants build their self-management skills. The majority of respondents (92.9 percent) indicated that their nurse care manager asked questions about their health or concerns (see Exhibit 6-25 on the following page). Seventy-nine percent said their case manager answered questions about their health care needs. Nearly 65 percent were referred to programs and services.

Exhibit 6-25: Case Manager Activity Ratings

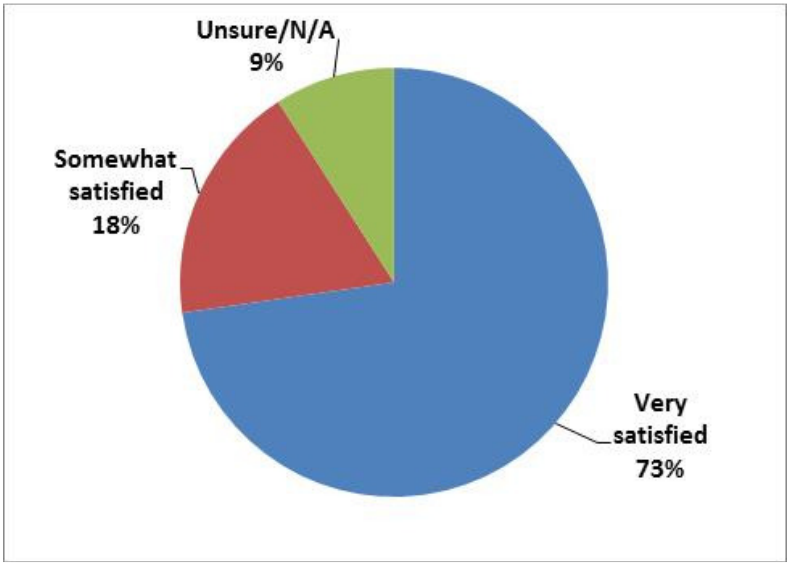
Activity		Respondents answering "yes" to the activity				
	Yes	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Unsure/N/A
Asked questions about your health or concerns	**92.9%**	78.6%	14.3%	0.0%	7.1%	0.0%
Provided instructions about taking care of your health	**23.1%**	64.3%	0.0%	0.0%	0.0%	35.7%
Helped you to identify changes in your health that might be an early sign of a problem	**14.3%**	14.3%	0.0%	0.0%	0.0%	85.7%
Answered questions about your health care needs	**78.6%**	69.2%	7.7%	0.0%	0.0%	23.1%
Helped you to make and keep health care appointments for medical problems	**28.6%**	21.4%	7.1%	0.0%	0.0%	71.4%
Helped you to make and keep health care appointments for mental health or substance abuse problems	**0.0%**	0.0%	0.0%	0.0%	0.0%	100.0%
Referred you to programs and services	**64.3%**	57.1%	7.1%	0.0%	0.0%	35.7%
Helped you to stop smoking or stop using tobacco products	**21.4%**	21.4%	0.0%	0.0%	0.0%	78.6%

Respondents were asked to rate their satisfaction with each “yes” activity. Seventy-nine percent reported being very satisfied when their case manager asked questions about their health or concerns. Nearly seventy percent were very satisfied with how their case manager provided answers to health related questions. Sixty-four percent were very satisfied with how the case manager provided instructions for taking care of their health. Fifty-seven percent said they were very satisfied when their case manager referred them to programs and services.

Satisfaction with ENC and ICC Program

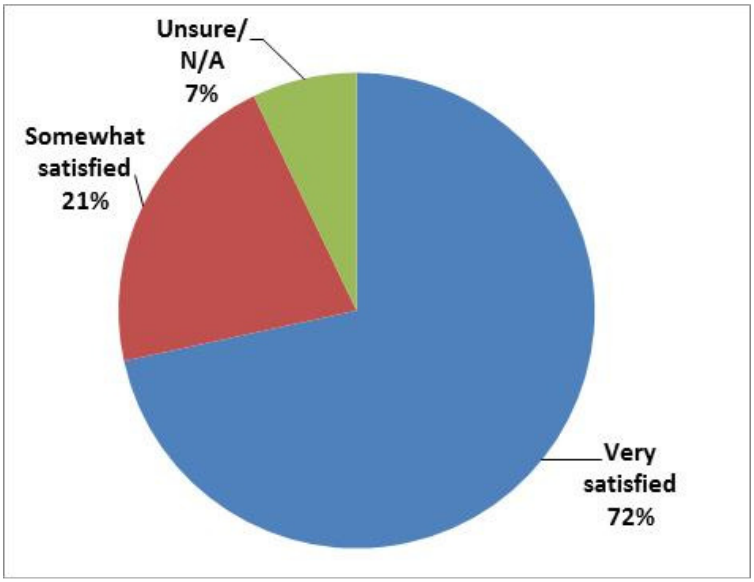
Overall, 73 percent of respondents were very satisfied with the help they received from their case manager (see Exhibit 6-26 below).

Exhibit 6-26: Overall Satisfaction with Case Manager



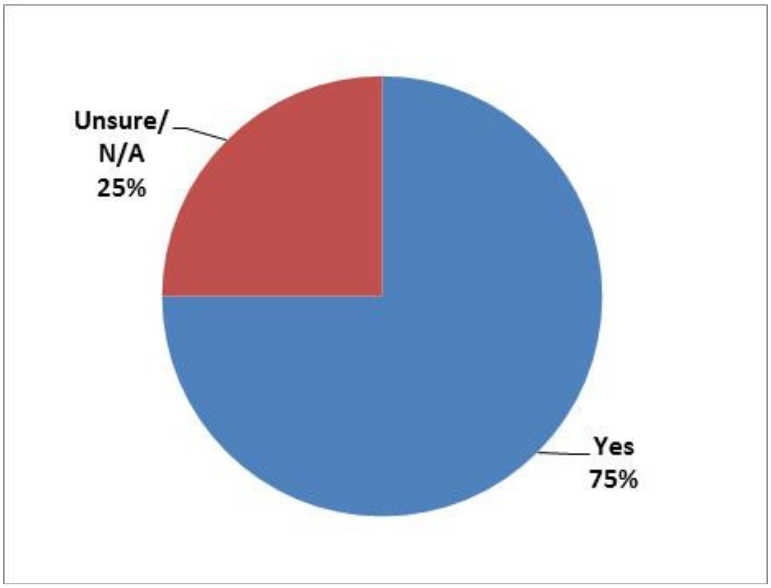
Overall, 72 percent of respondents were very satisfied with the ICC program (see Exhibit 6-27 below).

Exhibit 6-27: Overall Satisfaction with ICC Program



Seventy-five percent of respondents would recommend the ICC program to a friend with similar health care needs (see Exhibit 6-28 on the following page).

Exhibit 6-28: Would Recommend ICC Program

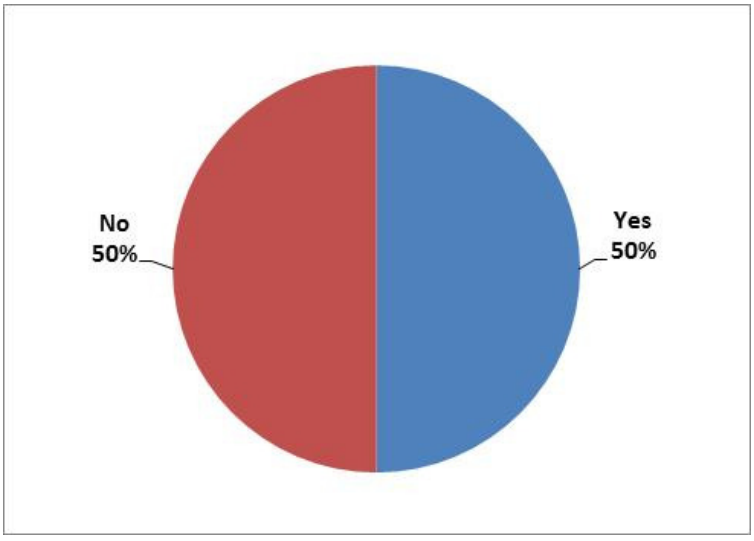


ICC Behavioral Health Screening and Referral

Completed Behavioral Health Screening

Fifty percent of respondents reported completing a behavioral health screening with someone at the OHCA (see Exhibit 6-29 below). No respondents were referred to the OHCA's BHU.

Exhibit 6-29: Completed Behavioral Health Screening



PRENATAL AND POSTPARTUM DEPRESSION SCREENING AND REFERRAL

Behavioral Health Unit Program Objective

The OHCA's Behavioral Health Unit (BHU) is an independent unit co-located within the OHCA. The BHU is made up of Licensed Behavioral Healthcare Professionals (LBHPs) who perform intake and connect SoonerCare members with behavioral health resources. Members are referred to the BHU from the PCM Department's case management programs, Health Management Program, and the Chronic Care Unit.

Program History and Overview

When a member is referred to the BHU by Population Care Management, primary case management is performed through the PCM Department. Staff located in the BHU in turn provides behavioral health case management in order to address the member's behavioral health needs.

For this evaluation, PHPG analyzed the prenatal and postpartum depression screenings performed by the PCM Department and subsequent referrals made to the BHU. For background, each of the OB case management programs uses specific assessment tools (e.g., High Risk OB (HROB), At Risk OB (AROB), FIMR Mom, and ICC). All assessment tools include the Edinburgh Postnatal Depression Scale (EPDS) screening tool, which is performed with the member during the initial prenatal assessment and at two weeks postpartum.

The EPDS is a ten-item questionnaire developed to identify women who have Postpartum Depression. Items of the scale correspond to various clinical depression symptoms, such as guilt feelings, sleep disturbance, low energy, and suicidal ideation. Overall assessment is done by total score, which is determined by adding together the scores for each of the ten items. Higher scores indicate more depressive symptoms.

One additional behavioral health assessment is dedicated to the ICC Program at the 12-month postpartum point. At the 12-month Postpartum Assessment, the six-Item Kutcher Adolescent Depression Screening (KADS) is completed. The KADS is an assessment instrument used to identify young people at risk for depression.

Both the EPDS and KADS screening tools are located in Atlantes. Referrals to the BHU are based on the scores received on either the EPDS or KADS screening tools.

Program Eligibility

Prenatal and postpartum SoonerCare members who have a positive behavioral health screening are eligible for BHU services; however, members must consent to a referral to the BHU.

BHU Case Management Program Process

If the overall EPDS score is 10 or greater, or if the KADS score is six or above, a referral to the BHU is discussed with the member. A referral is then made with the member's consent. If the member does not consent, a note is entered into the member's record in Atlantes indicating the member's decline of a referral for behavioral health services.

If a member consents to a referral, the BHU inquires as to whether or not the member is currently receiving behavioral health services from a counselor or psychiatrist. If the member is receiving services, the member is asked if she wants additional services or if she wants to change providers. If the member declines both options, a note to that effect is entered into the member's record.

If the member requests additional services or would like to change providers, the member is contacted by a LBHP to receive a referral to a behavioral health provider in her geographic area.

If a member is not currently receiving services, the member is asked if she wants to speak with a LBHP about receiving a referral to a behavioral health provider in her area. If the member declines, a note indicating her decline of services is entered into the member's record. If the member wishes to speak with a LBHP, the member is informed that she will be contacted by the BHU to receive a referral to a provider in her area.

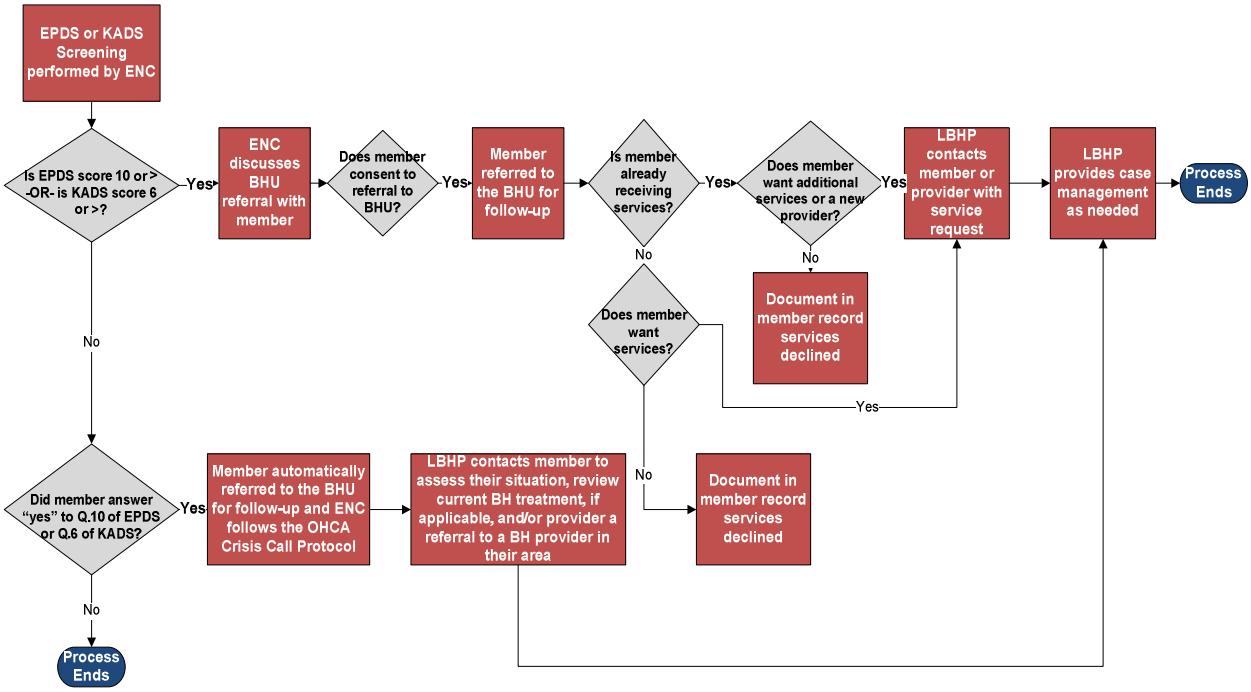
Members who respond to Question #10 of the EDPS, "*The thought of harming myself has occurred to me*" with a "1-Hardly Ever, 2-Sometimes or 3-Yes, quite often," or to question 6 of the KADS, "*Thoughts, plans or actions about suicide or self-harm,*" are automatically referred to the BHU regardless of their total score on either the EPDS or the KADs.

A LBHP then contacts these members to further assess their situation, review the appropriateness of their current mental health treatment if they are receiving MH services, and/or provide them with a referral to a mental health provider in their area.

An LBHP then provides ongoing follow-up with the member to address her behavioral health issues until they are resolved and/or the member is referred to the necessary resource to assist with her behavioral health need(s).

Exhibit 7-1 on the following page provides a flow chart of the BHU screening and referral process.

Exhibit 7-1 – Prenatal and Postpartum Depression Screening and Referral Process



BHU SCREENING AND REFERRAL FINDINGS

Methodology

PHPG obtained behavioral health and referral screening data from the OHCA, which was generated from Atlantes. Member records were extracted from Atlantes for the period of SFY 2011 through June 30, 2013 (SFY 2013). The Atlantes dataset was treated as the authority for identifying members who were in one of the four PCM OB case management programs (HROB, AROB, FIMR Mom, and ICC), who had an EPDS screening, and who were subsequently referred to the BHU.

The dataset was "cleaned" to ensure that a member from one of the four OB programs was accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of- Care Start and End dates), as well as removing member records that had null end dates. Thus, only members who completed a case management cycle were included in this analysis. Members who had been enrolled in the program less than one week were also removed. Thus, only members who had actively engaged in the program for more than one week were included in the analysis.

Results

The following measures were evaluated for BHU screenings and referrals by using Atlantes data, as data were available:

- Prenatal EPDS screening rates by OB program by SFY;
- Postpartum EPDS screening rates by OB program by SFY;
- Total prenatal and postpartum EPDS screening rates by OB program by SFY;
- Percentage scoring 10 or greater on the EPDS by OB program by SFY;
- Percentage with a positive response to Q#10, "Thought of harming oneself" by OB program by SFY;
- Percentage scoring 10 or Greater and the percentage with a positive response to Q#10, "Thought of harming oneself"; and
- Referral rates for members who had a positive EPDS screening by program by SFY.

Findings for the above measures will be reported for each OB program separately in the following section. To calculate screening rates for each of the four programs, PHPG filtered the assessment titles for prenatal EPDS screenings (e.g., first assessments) and postpartum assessments by program type and SFY. Gaps are noted in the tables that proceed below. These gaps may be the result of cases that were not included in the study secondary to remaining open at the time of the analysis. The incomplete data for a particular program or SFY may also be the result of changes over time to the technical and business processes for assessments in the case management software.

Analysis of HROB Behavioral Health Screenings and Referrals

This section describes findings for the HROB behavioral health screenings and referrals by SFY using data contained in Atlantes.

EPDS Screening Rates

Prenatal screening data were only available for SFY 2014 and therefore not part of this analysis. Postpartum screening rates increased from 0.6 percent in SFY 2011 to 33 percent in SFY 2013 (see Exhibit 7-2 on the following page). Factors that may have played a role in the low screening rates include member refusal at the time of assessment, PCM Department staffing levels, Atlantes data entry errors and/or omissions, the inability to reach a member for a screening, and the fact that the analysis only includes cases that have closed. Regarding the latter, some cases may have closed due to the ENC's inability to reach and engage the member.

Exhibit 7-2: High Risk OB EPDS Screening Rates

Measure	State Fiscal Year		
	2011	2012	2013
Prenatal EPDS Screening Rates			
# Screened	-	-	-
# Members	-	-	-
Prenatal EPDS Screening Rates	-	-	-
Postpartum EPDS Screening Rates			
# Screened	8	370	469
# Members	1,264	1,345	1,423
Postpartum EPDS Screening Rates	**0.6%**	**27.5%**	**33.0%**
Total Prenatal and Postpartum EPDS Screening Rates			
# Screened	8	370	469
# Members	1,264	1,345	1,423
Combined Prenatal and Postpartum Screening Rates	**0.6%**	**27.5%**	**33.0%**

Positive Screenings

Exhibit 7-3 below highlights the HROB participants who had a positive EPDS postpartum screening from SFY 2012 through SFY 2013. The number of members scoring a 10 or greater on the EPDS was 1.6 percent in SFY 2013. Only a small percentage (0.1 percent to 0.2 percent) of HROB members had a positive response to Question #10 on the EPDS. The same holds true for members who scored a 10 or > and had a positive response to Question #10 on the EPDS.

Exhibit 7-3: High Risk OB Participants with Positive EPDS Screenings

Measure	State Fiscal Year	
	SFY2012	SFY2013
# Scored 10 or > on the EPDS	14	23
# Members	1,345	1,423
Percentage Scoring 10 or > on EPDS	**1.0%**	**1.6%**
# with a Positive Response to Question #10 on the EPDS	1	3
# Members	1,345	1,423
Percentage with a Positive Response to Questions #10 on the EPDS	**0.1%**	**0.2%**
# Scoring 10 or > -and- who had a Positive Response to Questions #10 on the EPDS	1	3
# Members	1,345	1,423
Percentage Scoring 10 or > and who had a Positive Response to Question #10 on the EPDS	**0.1%**	**0.2%**

Referrals to the BHU

The HROB referral rate increased from SFY 2011 through SFY 2013 and ranged from 0.8 percent to 2.6 percent (see Exhibit 7-4 below). Keep in mind that if the member has a positive EPDS screening, she then needs to consent to a referral to the BHU. In addition, a subset of members with a positive EPDS screening may already be seeing a BH provider and/or accessing BH services at the time of screening and therefore do not require a referral to the BHU.

Exhibit 7-4: High Risk OB Referrals to the BHU

Measure	State Fiscal Year		
	2011	2012	2013
# Referred to the BHU	10	35	34
# Members	1,264	1,345	1,423
Percentage Referred to the BHU	**0.8%**	**2.6%**	**2.6%**

Analysis of At Risk OB Behavioral Health Screenings and Referrals

EPDS Screening Rates

Prenatal screening data were only available for SFY 2012 through SFY 2013. Prenatal screening rates were 0.2 percent in SFY 2012 and 0.9 in SFY 2013. Postpartum screening rates increased from SFY 2011 to SFY 2013 (3.7 percent to 15.9 percent). The combined prenatal and postpartum screening rates were nearly 17 percent in SFY 2013 (see Exhibit 7-5 on the following page).

Factors that may have played a role in the low screening rates include member refusal at the time of assessment, PCM Department staffing levels, Atlantes data entry errors and/or omissions, the inability to reach a member for a screening, and the fact that the analysis only includes cases that have closed. Regarding the latter, some cases may have closed due to the ENC's inability to reach and engage the member.

Exhibit 7-5: At Risk OB EPDS Screening Rates

Measure	State Fiscal Year		
	2011	2012	2013
Prenatal EPDS Screening Rates			
# Screened	-	1	4
# Members	-	467	434
Prenatal EPDS Screening Rates	-	**0.2%**	**0.9%**
Postpartum EPDS Screening Rates			
# Screened	11	62	69
# Members	296	467	434
Postpartum EPDS Screening Rates	**3.7%**	**13.3%**	**15.9%**
Total Prenatal and Postpartum EPDS Screening Rates			
# Screened	11	63	73
# Members	296	467	434
Combined Prenatal and Postpartum Screening Rates	**3.7%**	**13.5%**	**16.8%**

Positive Screenings

Exhibit 7-6 below highlights the AROB participants who had a positive EPDS screening from SFY 2012 through SFY 2013. The number of members scoring a 10 or greater on the EPDS ranged from 0.2 percent to 1.4 percent in SFY 2013. Only a small percentage (0.2 percent) of AROB members had a positive response to Question #10 on the EPDS, and this was limited to SFY 2013 only. The same is true for members who scored a 10 or > and had a positive response to Question #10 on the EPDS.

Exhibit 7-6: At Risk OB Participants with Positive EPDS Screenings

Measure	State Fiscal Year	
	SFY2012	SFY2013
# Scored 10 or > on the EPDS	1	6
# Members	467	434
Percentage Scoring 10 or > on EPDS	**0.2%**	**1.4%**
# with a Positive Response to Question #10 on the EPDS	-	1
# Members		434
Percentage with a Positive Response to Questions #10 on the EPDS	-	**0.2%**
# Scoring 10 or > -and- who had a Positive Response to Questions #10 on the EPDS		1
# Members		434
Percentage Scoring 10 or > and who had a Positive Response to Question #10 on the EPDS		**0.2%**

Referrals to the BHU

The AROB referral rate increased from SFY 2011 to SFY 2013 and ranged from 1.4 percent to 4.1 percent (see Exhibit 7-7 below).

Exhibit 7-7: At Risk OB Referrals to the BHU

Measure	State Fiscal Year		
	2011	2012	2013
# Referred to the BHU	4	9	18
# Members	296	467	434
Percentage Referred to the BHU	**1.4%**	**1.9%**	**4.1%**

Analysis of FIMR Mom Behavioral Health Screenings and Referrals

EPDS Screening Rates

The FIMR Mom prenatal screening rate was 58.5 percent in SFY 2012 before declining to 48.9 percent in SFY 2013. Postpartum screening rates increased from SFY 2011 to SFY 2012 and then declined modestly in SFY 2013. The combined prenatal and postpartum screening rates ranged from 72 percent to 84 percent (see Exhibit 7-8 on the following page).

Factors that may have played a role in the low postpartum screening rates include: member refusal at the time of assessment, PCM Department staffing levels, Atlantes data entry errors and/or omissions, the inability to reach a member for a screening, and the fact that the analysis only includes cases that have closed. Regarding the latter, some cases may have closed due to the ENC's inability to reach and engage the member.

Exhibit 7-8: FIMR Mom EPDS Screening Rates

Measure	State Fiscal Year		
	2011	2012	2013
Prenatal EPDS Screening Rates			
# Screened	391	1,099	879
# Members	692	1,880	1,798
Prenatal EPDS Screening Rates	**56.5%**	**58.5%**	**48.9%**
Postpartum EPDS Screening Rates			
# Screened	107	478	412
# Members	692	1,880	1,798
Postpartum EPDS Screening Rates	**15.5%**	**25.4%**	**22.9%**
Total Prenatal and Postpartum EPDS Screening Rates			
# Screened	498	1,577	1,291
# Members	692	1,880	1,798
Combined Prenatal and Postpartum Screening Rates	**72.0%**	**83.9%**	**71.8%**

Positive Screenings

Exhibit 7-9 on the following page highlights the FIMR Mom participants who had a positive EPDS screening from SFY 2011 through SFY 2013. The number of members scoring a 10 or greater on the EPDS ranged from 4.5 percent to 7.7 percent.

Only a small percentage (0.2 percent) of FIMR Mom participants either had a positive response to Question #10 on the EPDS (0.9 percent to 1.6 percent) or scored a 10 or > and had a positive response to Question #10 on the EPDS (ranging from 0.7 percent to 1.1 percent).

Exhibit 7-9: FIMR Mom Participants with Positive EPDS Screenings

Measure	State Fiscal Year		
	2011	2012	2013
# Scored 10 or > on the EPDS	53	110	81
# Members	692	1,880	1,798
Percentage Scoring 10 or > on EPDS	**7.7%**	**5.9%**	**4.5%**
# with a Positive Response to Question #10 on the EPDS	6	28	28
# Members	692	1,880	1,798
Percentage with a Positive Response to Questions #10 on the EPDS	**0.9%**	**1.5%**	**1.6%**
# Scoring 10 or > -and- who had a Positive Response to Questions #10 on the EPDS	6	13	19
# Members	692	1,880	1,798
Percentage Scoring 10 or > and who had a Positive Response to Question #10 on the EPDS	**0.9%**	**0.7%**	**1.1%**

Referrals to the BHU

The FIMR Mom referral rate increased from SFY 2011 to SFY 2013 and ranged from 1.3 percent to 1.9 percent (see Exhibit 7-10 below).

Exhibit 7-10: FIMR Mom Referrals to the BHU

Measure	State Fiscal Year		
	2011	2012	2013
# Referred to the BHU	9	24	34
# Members	692	1,880	1,798
Percentage Referred to the BHU	**1.3%**	**1.3%**	**1.9%**

Analysis of ICC Behavioral Health Screenings and Referrals

As a reminder, the program was implemented on July 1, 2013 (SFY 2014), so there are currently no trend data for annual comparisons. Caution should be exercised in interpreting data, given the partial year results for SFY 2014.

EPDS Screening Rates

The ICC prenatal screening rate was 60.5 percent in SFY 2014, which was the highest compliance rate achieved among the four OB programs, followed by FIMR Mom. The postpartum screening rate was 10.5 percent in SFY 2014. The combined prenatal and postpartum screening rate was 71.1 percent (see Exhibit 7-11 below).

Exhibit 7-11: ICC EPDS Screening Rates

Measure	SFY2014– 1st half
Prenatal EPDS Screening Rates	
# Screened	**23**
# Members	**38**
Prenatal EPDS Screening Rates	**60.5%**
Postpartum EPDS Screening Rates	
# Screened	**4**
# Members	**38**
Postpartum EPDS Screening Rates	**10.5%**
Total Prenatal and Postpartum EPDS Screening Rates	
# Screened	**27**
# Members	**38**
Combined Prenatal and Postpartum Screening Rates	**71.1%**

Positive Screenings

Exhibit 7-12 on the following page highlights the ICC participants who had a positive EPDS screening in SFY 2014 (10.5 percent). There were no data on the number of members scoring a 10 or greater on the EPDS or for members who scored a 10 or > and had a positive response to Question #10 on the EPDS.

Exhibit 7-12: ICC Participants with Positive EPDS Screenings

Measure	SFY2014– 1st half
# Scored 10 or > on the EPDS	4
# Members	38
Percentage Scoring 10 or > on EPDS	**10.5%**
# with a Positive Response to Question #10 on the EPDS	-
# Members	-
Percentage with a Positive Response to Questions #10 on the EPDS	-
# Scoring 10 or > -and- who had a Positive Response to Questions #10 on the EPDS	-
# Members	-
Percentage Scoring 10 or > -and- who had a Positive Response to Questions #10 on the EPDS	-

Referrals to the BHU

There were no referrals to the BHU found in the Atlantes data for the ICC program.

PRIVATE DUTY NURSING PROGRAM INTRODUCTION AND PROGRAM OVERVIEW

Private Duty Nursing Program Objective

The Private Duty Nursing (PDN) case management program was implemented on April 1, 2004. The program provides components of community-based alternatives to institutional care for children up to 21 years of age who have complex medical needs. Specifically, the program provides in-home skilled nursing care, which can be provided safely outside of an institutional setting, to qualified SoonerCare members. The program supports members and their families who assume a portion of the member's care.

Program History and Overview

PDN is medically necessary care provided on a regular basis by a Licensed Practical Nurse (LPN) or Registered Nurse (RN). The care is provided in the member's primary residence or assists outside the home during transport to medical appointments and Emergency Room visits in lieu of transport by ambulance.

SoonerCare children up to age 21 who have complex special health care needs may qualify for in-home nursing service as part of the SoonerCare PDN benefit package. Members are identified for the program through the prior authorization process in the Medical Authorization Unit (MAU.) Informal inquirers who contact PCM directly are also educated on the referral/authorization process.

In 2003, PCM facilitated intra-agency meetings to develop a PDN acuity tool. PDN services were previously authorized by the MAU without the application of formal, objective criteria and without clinical review. In April 2004, PCM developed a PDN Acuity Grid, modeled after the State of Oregon's Private Duty Nursing Acuity Grid. Development took place shortly after the SoonerCare Plus transition. Simultaneously, the PCM Department began to implement in-home PDN reviews, utilizing the PDN Acuity Grid, which includes both a physical and psychosocial assessment, to monitor the utilization of PDN services. The number of hours of private duty nursing that a particular member may receive is determined by the score on the PDN Acuity Grid, obtained through clinical assessment and record review.

In March 2005, the tool was reformatted to improve usability by the ENCs. During the transition to the new model, in order to assure consistent results between the former and new version of the tool, the PCM Department sought feedback on the appropriateness of the PDN Acuity Grid from an array of pediatric physician advisors from across the state, including a pediatric pulmonologist. These providers evaluated the tool to ensure members would not lose or gain benefits based on the changes that were

made to the criteria. Additionally, the OHCA QA/QI team assisted in the development of an inter-rater reliability study to further ensure consistency in application of the tool.

The average caseload in the PDN Program is approximately 200 members at any given point in time. There are approximately 10 new members enrolled in the program each month.

Program Eligibility

The PDN program is available to qualifying SoonerCare children up to 21 years of age who have complex special health care need and who require community-based alternatives to institutional care. Members are determined to be eligible for PDN through the medical authorization process as determined by their scores on the PDN Acuity Grid.

PDN Case Management Program Process

To initiate PDN services, a pediatrician or hospital contacts a home health care agency (HHA) to evaluate the SoonerCare member. The HHA then performs an in-home assessment and completes a 485-Plan of Care. The HHA sends the PDN service request along with the 485-Plan of Care to the OHCA MAU. If the documentation is complete, the MAU refers the member's case records to the PCM Department for case assignment and follow-up.

The PCM Department has various responsibilities for the PDN program. ENCs in the PCM Department complete a preliminary review of medical records and a telephonic assessment to obtain a preliminary PDN Acuity Grid score. This includes both a physical need score and a psychosocial need score. If the preliminary physical score is 35 or greater, and the psychosocial score is less than 24, or if the physical score is 30 – 39, and the psychosocial score is greater than 24, a home visit is completed within 3 business days or as directed by the Supervisor. The ENC completes the formal PDN Acuity Grid upon conducting the face-to-face clinical assessment.

If the preliminary score does not warrant a home visit for formal review, the review is forwarded to physician consultant for a determination. If the request for services is denied, and the member appeals, a home visit is performed in order to conduct a face-to-face review. This step was implemented to assure that members fit the most basic criteria for skilled nursing services before staff resources are used to conduct a review. Prior to the implementation of this step, it was common to receive requests for which only custodial care needs existed, and the member was not a valid candidate for PDN services, yet personnel and travel expenses were incurred only to determine that the member did not qualify.

Upon conducting the face-to-face visit, if warranted by the preliminary review, the results are forwarded to the physician consultant. If the physician consultant approves services, generally based on a physical grid score of 40 or over, the authorization request is returned to the MAU with

the number of PDN hours to be authorized. If the physician consultant denies services, the member and requesting agency are notified. If after 30 days there is no appeal filed, the case is closed. For cases where services are approved, routine follow-up and home visits are then performed for ongoing qualification for service and re-certification, and referral to and coordination of related services and benefits.

Upon subsequent review, if a child has received PDN services but now has a score of 30-39 on the physical score portion of PDN Acuity Grid, and the PDN Psychosocial grid score is less than 24, he or she may receive up to eight hours of PDN per day for five days per week. This benefit is authorized for a maximum of 90 days to allow the member a referral into the State Plan Personal Care Services, or an alternative service/program.

If a child has received PDN services in the past and has a score of 30-39 on the physical portion of the PDN Acuity Grid, and the PDN Psychosocial grid score is 24 or greater, he or she may receive up to 12 hours of PDN per day for five days each week.

Any child scoring 25-30 on the physical portion of the PDN Acuity Grid is referred for OHCA's Intra-Agency Case Staffing. For cases where there is a significant hardship to the member's primary caregiver, but the PDN Acuity Grid score does not support medical necessity, consideration by an internal committee may be given to allowing brief PDN services.

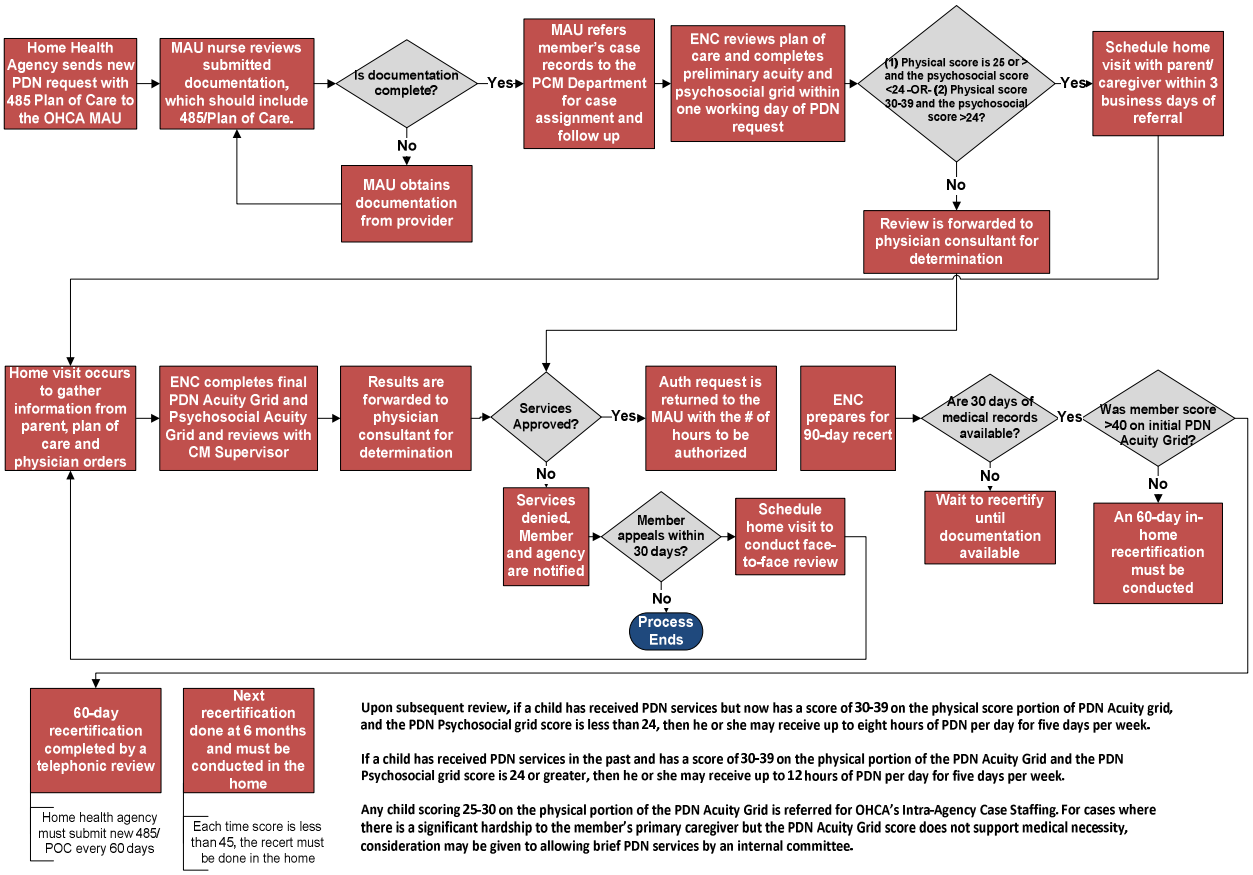
The PDN committee includes at least one physician medical consultant, at least one attorney from the OHCA Legal department, the PCM Department Director or his/her designee, the ENC Supervisor involved with the PDN prior authorization request, and the Health Policy Director or his/her designee. Representatives from the OHCA's Developmental Disabilities Services Division *(*DDSD*)* and the Oklahoma Department of Human Services (OKDHS) may be included. The committee meets on an as-need basis, and a majority determines the OHCA's final decision. Examples of hardship cases that are referred to the committee include the following:

- Single parent/provider household where the parent/provider is dependent upon employment to meet the basic needs of the family;
- A household where there is more than one child or dependent with significant ongoing health care needs, resulting in an unrealistic expectation that one caregiver can meet the needs of both/all dependents requiring intervention; and
- A parent/caregiver with a significant permanent medical disability.

On the member's 21st birthday, the PDN benefit terminates, but the member may be eligible for services through the OHCA's Medically Fragile (MF) waiver. The OHCA begins working on transition planning for the MF waiver when the member approaches age 19 to ensure ample time for the application process.

Exhibit 8-1 on the following page provides a flow chart of the PDN case management process.

Exhibit 8-1 – PDN Program Case Management Process



Changes/Revisions to the Project

The following changes were made to the PDN program since PCM began case management in 2004:

- Revised the PDN Acuity Grid to include an adjustment in the clinical criteria as well as more descriptive information for consistency in scoring;
- Implemented a parental notification process to advise parents about the authorization process;
- Provided outreach and education for home health care agencies, providers, hospital social workers, and discharge planners about the PDN benefit and revised Acuity Grid;
- Implemented a step-down process in late 2009 so that children could be transitioned off services when they no longer qualify;
- Clarified the grid specific to nebulizer, chest PT, assessment, and metabolic scoring needs in July 2012; and
- Initiated physician consultant reviews for all cases in September 2014.

PDN PROGRAM FINDINGS

Methodology

PHPG obtained two datasets from the OHCA to conduct the analysis, data from Atlantes and claims and eligibility data. PDN member records were extracted from Atlantes for the period of April 1, 2004 (SFY 2004), through June 30, 2013 (SFY 2013). Claims and eligibility data were pulled for dates of services in SFY 2010 through 2013.

The Atlantes dataset was treated as the authority for identifying PDN members. The dataset was "cleaned" to ensure that a member was accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates), as well as removing member records that had null end dates. Thus, only members who completed a case management cycle were included in this analysis. Members who had been enrolled in the program less than one week were also removed. Thus, only members who had actively engaged in the program for greater than one week were included in the analysis.

Results

The following program enrollment and ENC activities were analyzed for the PDN program by using the Atlantes dataset:

- Total enrolled in the PDN program by SFY;
- Breakdown of PDN participants by county geography (i.e., rural, urban, mixed, out of state);
- PDN enrollment in the top five counties;
- Total PDN participants by age range;
- Average length of time in the PDN program;
- Percentage of members contacted within three business days of receiving a referral to the PDN program by SFY;
- Total number of contact attempts per member per SFY;
- Total ENC time spent per enrollee by SFY;
- Total ENC FTE time per SFY; and
- Total number of PDN letters sent per enrollee by SFY.

The following utilization and cost measures were evaluated for the PDN program by using claims and eligibility data:

- Summary of utilization rates (i.e., Emergency Room Visits, Hospitalizations, and Readmission rates) for PDN members by SFY; and
- Summary of expenditures for the PDN Program by SFY.

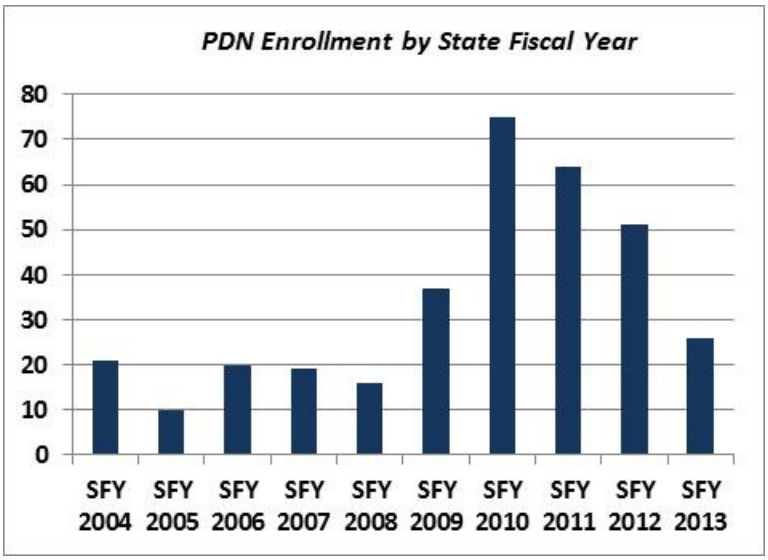
Analysis of PDN Enrollment and ENC Activities

This section describes program enrollment and ENC activities by SFY using data contained in Atlantes.

Total Enrollment

Exhibit 8-2 below summarizes total PDN enrollment from SFY 2004 through SFY 2013. Total enrolled by SFY was calculated based on a member's having a level-of-care start date in that fiscal year (i.e., newly enrolled in the SFY). Enrollment more than doubled from SFY 2008 to SFY 2009 and then nearly doubled from SFY 2009 to SFY 2010 before declining year over year thereafter. The decline is likely attributable to additional prior authorization requirements and procedures for the PDN services in light of the escalating increase in growth and expenditures.

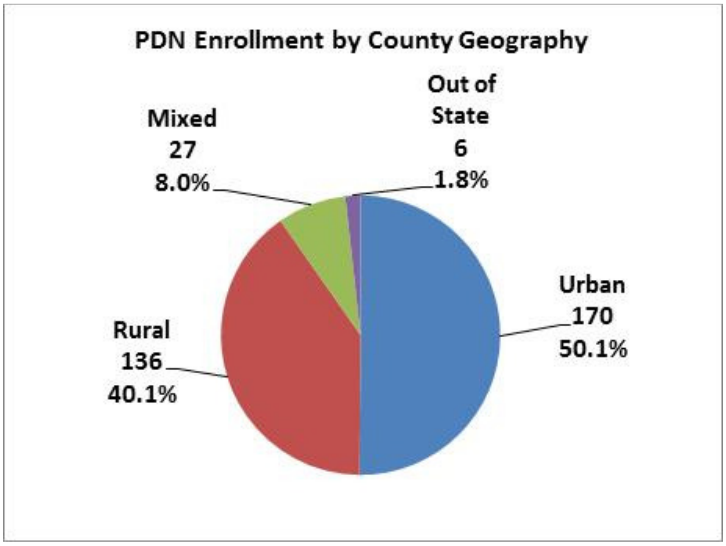
Exhibit 8-2: PDN Enrollment by State Fiscal Year



Enrollment by County Geography

Exhibit 8-3 on the following page summarizes the breakdown of PDN enrollment by county geography from SFY 2004 through SFY 2013. Among PDN members, 50 percent reside in urban areas, while 40 percent reside in rural areas. The urban portions of the state include the greater Oklahoma City and Tulsa metropolitan areas. Less than ten percent of members resided in mixed counties and out of state.

Exhibit 8-3: PDN Enrollment by County Geography



Enrollment by Top Five Counties

A review of county codes shows that 60 percent of PDN members resided in six Oklahoma counties from SFY 2004 through SFY 2013 (Exhibit 8-4 below). Three of the counties were urban (Cleveland, Oklahoma, and Tulsa), one county mixed (Canadian), and two counties rural (Muskogee, Okmulgee).

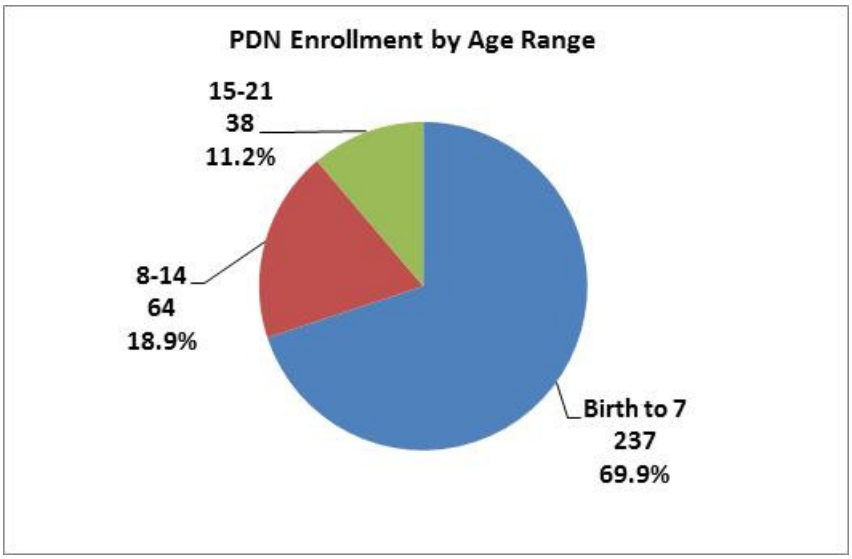
Exhibit 8-4: PDN Enrollment by County

County	Total Members 2008-2013
Tulsa	83
Oklahoma	63
Cleveland	18
Muskogee	14
Okmulgee	12
Canadian	11
All other counties	136
Grand Total	**337**

Age Range of PDN Members

The majority of PDN members fell into the birth-to -7 years range (69.9 percent), followed by 18.9 percent of members who were 8 to 14 years of age. Only 11.2 percent of PDN members were 15 to 21 years of age (see Exhibit 8-5 on the following page).

Exhibit 8-5: PDN Enrollment by Age Range



Length of Stay

Exhibit 8-6 below summarizes the average length of stay in case management from SFY 2004 through SFY 2013. Length of stay was calculated by subtracting a member's level-of-care end date from their level-of-care start date. The length of stay for members in this program ranged from less than one year to more than eight years, which is much longer than the other PCM programs. Over half of PDN members (53.1 percent) were enrolled less than one year. Nearly 25 percent of members (24.5 percent) were enrolled between one to two years.

Exhibit 8-6: PDN Length of Stay

Length of Stay	# Members	% Members
Less than One Year	180	53.1%
1 – 2 Years	83	24.5%
3 – 4 Years	33	9.7%
5 – 6 Years	31	9.1%
7 – 8 Years	9	2.7%
Greater than 8 Years	3	0.9%

ENC Activity Time

Initial Outreach

Once a member is assigned to an ENC, the ENC attempts to make an initial telephone contact within three business days of receiving the referral. Three attempts are made on three different days at different times to contact the member via telephone.

To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes PDN Activity Report. The review was limited to only those cases where the data indicated that an ENC performed initial telephone outreach (e.g., member contact attempts 1, 2 and 3, phone calls to and from) within three business days of a referral to case management. Time spent performing each outreach attempt had to be more than five minutes in duration.

Exhibit 8-7 below highlights member contacts made within three business days from SFY 2004 through SFY 2013. Member reach rates varied over the ten SFYs and ranged from 28.6 to 90 percent. Note that contact rates exceeded 60 percent for all but three SFYs. The average contact rate across all SFYs was 66.4 percent.

Exhibit 8-7: PDN Contacts within Three Business Days

SFY	Members Contacted Within 3 Business Days	Total PDN Enrollment	Contact Rate
2004	6	21	**28.6%**
2005	9	10	**90.0%**
2006	6	20	**30.0%**
2007	8	19	**42.1%**
2008	14	16	**87.5%**
2009	23	37	**62.2%**
2010	57	75	**76.0%**
2011	47	64	**73.4%**
2012	39	51	**76.5%**
2013	16	26	**61.5%**

Total Contacts

After successfully contacting a member and completing the initial assessment, the member is placed on a monthly contact schedule. All contacts for members are documented in Atlantes. To determine the

number of contacts, a count was performed of all activity actions contained in the Atlantes PDN Activity Report. Time spent performing member activities had to more than five minutes in duration.

Exhibit 8-8 below contains the total contacts per member from SFY 2004 through SFY 2013. ENCs averaged 18.8 to 55.6 contacts per PDN member across the ten fiscal years. The average number of member contacts across all SFYs was 28.6 contacts per member. Contact rates for this program far exceed those of other PCM OB and pediatric programs most likely due to the complexity of this member population.

Exhibit 8-8: PDN Total Contacts per Member

SFY	Count of Contacts	Total PDN Enrollment	Total Contacts Per Member
2004	1,141	21	**54.3**
2005	556	10	**55.6**
2006	934	20	**46.7**
2007	699	19	**36.8**
2008	592	16	**37.0**
2009	883	37	**23.9**
2010	1,843	75	**24.6**
2011	1,201	64	**18.8**
2012	1,253	51	**24.6**
2013	591	26	**22.7**

ENC Time Spent Managing Enrollees

For PDN cases, if there was a previous ENC assigned to the member for a prior level of care, attempts are made to re-assign the member to the same ENC. If there is no prior history with an ENC, assignment to PDN cases is based on the geographic location in which the member resides. ENC assignment is then performed using a round-robin approach within a particular geographic location.

To assess the time spent by ENCs for the PDN program, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to children who were assigned to PDN. In each fiscal year, a large majority of ENC time has been dedicated to assessments, ongoing member correspondence and care management for enrolled members, and provider outreach. These activities are consistent with the primary functions of ENCs. From SFY 2004 through 2013, ENCs spent an average of 18.4 to 60.5 hours per case across all activities. ENC hours per case have declined since SFY 2007.

The decrease in hours could be the result of more automated clinical tools and processes, as well as more telephone versus face-to-face time. The total FTEs required for the PDN program ranged from 0.3 to 1.0 FTEs (see Exhibit 8-9 below). Caution should be exercised in interpreting this data since these findings are based on cases that were closed at the time the data was pulled and therefore only represents a fraction of the PDN work that is performed. PDN cases tend to be much longer in duration than any of the other PCM Department programs.

Exhibit 8-9: PDN ENC Time per Member and ENC FTE Time

SFY	Total Members	Sum of PDN Activity (Hours)	ENC Time Per Enrolled Member (Hours)	Total ENC FTE Time
2004	21	1,208.9	**57.6**	**0.6**
2005	10	604.8	**60.5**	**0.3**
2006	20	1,070.8	**53.5**	**0.5**
2007	19	683.9	**36.0**	**0.3**
2008	16	538.4	**33.7**	**0.3**
2009	37	851.7	**23.0**	**0.4**
2010	75	2,082.1	**27.8**	**1.0**
2011	64	1,177.9	**18.4**	**0.6**
2012	51	1,073.3	**21.0**	**0.5**
2013	26	529.3	**20.4**	**0.3**

PDN Letters

ENCs generate and mail a number of letters to members and providers for the PDN program, including but not limited to, introductory letters, unable-to-contact letters, provider notification, and case closure letters. An analysis was performed for the number of PDN letters sent by SFY. From SFY 2004 through 2013, ENCs mailed an average of 0.9 to 2.2 letters per member (see Exhibit 8-10 on the following page).

Exhibit 8-10: PDN Letters Sent by State Fiscal Year

SFY	Total Letters Sent	Total Members	Total Letters Per Member
2004	33	21	**1.6**
2005	22	10	**2.2**
2006	18	20	**0.9**
2007	26	19	**1.4**
2008	18	16	**1.1**
2009	63	37	**1.7**
2010	95	75	**1.3**
2011	61	64	**1.0**
2012	65	51	**1.3**
2013	38	26	**1.5**

PDN Utilization and Cost Outcomes

This section highlights PDN utilization and cost trends by SFY using claims and eligibility data for dates of services in SFY 2010 through 2013.

Utilization Rates

For PDN, the trend in ER utilization remained relatively constant year over year. The four-year average for ER visits per 1,000 was 239 (see Exhibit 8-11). Inpatient admissions fluctuated year over year but averaged 112 per 1,000 per members. Readmission rates within 30 days of hospitalization declined from SFY 2011 to SFY 2013 and averaged 26 over the four-year period.

Exhibit 8-11: PDN Utilization

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	155	162	133	102	277
Participation Months	1,164	1,001	882	690	3,737
ER Visits per 1,000 per member	**225**	**232**	**244**	**267**	**239**
IP Admissions per 1,000 per member	**107**	**127**	**94**	**120**	**112**
Readmissions (within 30 days)	**31**	**42**	**14**	**13**	**26**

Expenditures

Total PDN expenditures declined considerably from SFY 2010 to SFY 2013. PMPM expenditures declined as well from SFY 2010 through SFY 2013. This is likely a result of additional prior authorization requirements and procedures that were implemented to address the escalating growth and expenses associated with the program in earlier years. Total PDN expenditures were nearly 37 million, and the average expenditures per case were $118,085 (see Exhibit 8-12).

Exhibit 8-12: PDN Total Expenditures and Expenditures per Case

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	155	162	133	102	277
Participation Months	1,164	1,001	882	690	3,737
Total Expenditures	**$12,048,122**	**$9,988,867**	**$8,559,103**	**$6,177,515**	**$36,773,608**
Total PMPM Expenditures	**$10,350.62**	**$9,978.89**	**$9,704.20**	**$8,952.92**	**$9,840.41**

Total PMPM expenditures dropped considerably year over year and averaged $9,840. Over the four-year period, home health and home care accounted for over 50 percent of PDN expenditures. Additional cost drivers included inpatient services averaging 15.3 percent of PMPM, medical supplies and orthotics averaging 10.5 percent of PMPM, prescription drugs averaging 9.9 percent of PMPM, and physician services averaging 6.8 percent of PMPM (see Exhibit 8-13 on the following page).

Exhibit 8-13: PDN Total PMPM Expenditures and Percent of PMPM

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	155	162	133	102	277
Total PMPM Expenditures	**$10,350.62**	**$9,978.89**	**$9,704.20**	**$8,952.92**	**$9,840.41**
Home Health and Home Care	$5,482.88	$5,546.59	$5,076.95	$4,297.51	$5,185.27
Percent of PMPM	**53.0%**	**55.6%**	**52.3%**	**48.0%**	**52.7%**
Inpatient	$1,781.01	$1,178.29	$1,423.60	$1,641.63	$1,509.48
Percent of PMPM	**17.2%**	**11.8%**	**14.7%**	**18.3%**	**15.3%**
Medical Supplies & Orthotics	$1,136.69	$1,076.32	$949.85	$917.04	$1,035.87
Percent of PMPM	**11.0%**	**10.8%**	**9.8%**	**10.2%**	**10.5%**
Prescribed Drugs	$826.91	$975.05	$1,136.94	$1,002.88	$972.25
Percent of PMPM	**8.0%**	**9.8%**	**11.7%**	**11.2%**	**9.9%**
Physician Services	$676.78	$735.33	$623.52	$606.84	$666.98
Percent of PMPM	**6.5%**	**7.4%**	**6.4%**	**6.8%**	**6.8%**
Outpatient Services	$119.69	$135.61	$135.26	$149.27	$133.09
Percent of PMPM	**1.2%**	**1.4%**	**1.4%**	**1.7%**	**1.4%**
All Other*	$152.45	$140.57	$180.94	$175.45	$152.10
Percent of PMPM	**1.5%**	**1.4%**	**1.9%**	**2.0%**	**1.6%**

***The category "All Other" includes the following expenditures: other institutional, other practitioner, lab and x-ray, nursing facility, and other expenses.*

AT RISK NEWBORN PROGRAM INTRODUCTION AND PROGRAM OVERVIEW

At Risk Newborn Program Objective

The OHCA's Newborn Outreach Program provides targeted outreach for SoonerCare newborns to identify those who may be at risk and/or have medical conditions with the goal of automatically enrolling them in the PCM At Risk Newborn Program.

The OHCA's At Risk Newborn (ARNB) Program was implemented on August 1, 2009. The goal of the program is to assess at-risk newborn members and provide their parents with education, linkage to resources, and follow-up in an effort to improve health outcomes and reduce infant mortality. Since August 1, 2009, the PCM Department has collaborated with OHCA's Member Services Department on newborn outreach activities.

Program History and Overview

Newborn Outreach Program

The Newborn Outreach Program was developed out of the need to identify newborns that were at risk post-delivery. Up until August 2009, there was not a specific program in place to identify, reach out to parents, or case manage newborns who were at risk for complications and/or who had a complex condition identified at birth.

Every Friday, the OHCA Member Services Department mails a letter to all households that have a newborn indicator on the enrollment file. The letter requests that someone from the household call "Jean Tucker" (SoonerCare Helpline) to discuss benefits and services for their newborn. If the parent calls back to speak to Jean Tucker, the SoonerCare Helpline transfers the call to a Member Services representative who provides information about the newborn's SoonerCare benefits and asks a series of questions about the newborn. Certain key questions in the Member Services call scripts automatically trigger a referral to the PCM Department for follow-up by a care manager. Triggers include situations such as the newborn had a hospital stay of >14 days, has more than one doctor, and/or has a chronic condition.

At Risk Newborn Program

When the Newborn Outreach referral is sent from Members Services to the PCM Department, an ENC contacts the parent for additional information on any of the trigger questions. If medical conditions are confirmed, or other issues are identified that may influence the newborn's health, the ENC places the

newborn into active case management until the issue at hand is resolved. The ENC conducts a postpartum screen on the new mother, forwarding any positive screens to OHCA's BHU.
The average caseload in the ARNB program is approximately 25 members at any given point in time. There are approximately 10 new members enrolled in the program each month.

Program Eligibility

As part of the Member Services screening, the newborn's parent is asked: "Has the newborn had a hospital stay of >14 days?"; "Has the newborn been seen by more than one doctor?" and/or "Does the newborn have a chronic condition?" If the member responds with a "yes" to any of these questions, a referral is sent to the PCM Department for enrollment into the ARNB Program via an automatic notification from Member Services to the PCM Department.

At Risk Newborn Program Process

When a newborn referral is received by from Member Services or another referral source, an ENC is assigned to the member based on the geographic location (case management team region) in which the member resides. The ENC then contacts the parent within three business days of receipt of the referral in order to obtain additional information about any of the trigger questions.

The purpose of this contact is to determine what types of services or assistance the family needs. The CM Newborn Outreach Assessment, which includes the EPDS Tool, is performed with the mom of the newborn. Any positive screens are forwarded to the OHCA BHU staff for follow-up and referral (see Prenatal and Postpartum Depression Screening and Referral section for more information).

If any medical conditions are confirmed, or other issues are identified that may affect the newborn's health, the ENC places the newborn member into active case management.

If the newborn is still in the hospital, the ENC documents the status of "following" in the member's record and calls once each month until the newborn is home (The Newborn Outreach Assessment cannot be completed until the newborn is in the home).

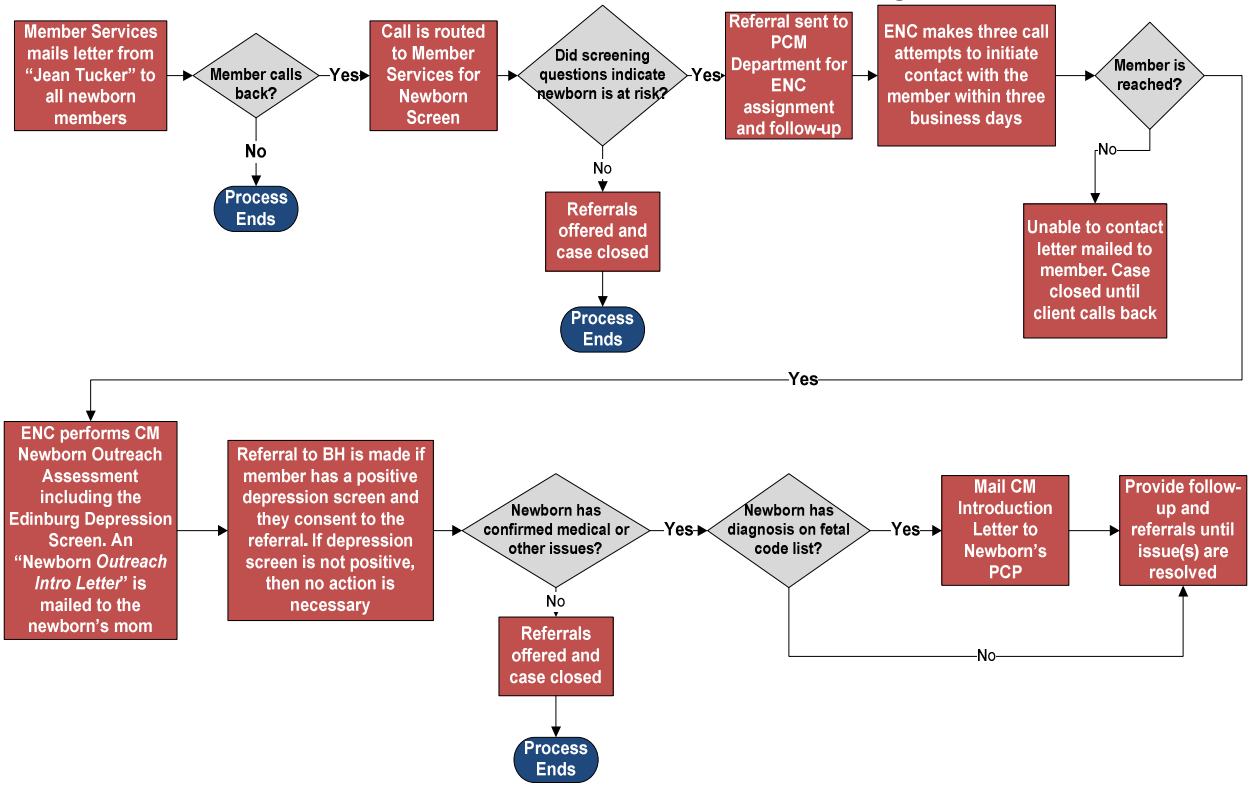
During the case management period, activity notes are entered into both the newborn's and the mother's records in Atlantes. The newborn note must indicate when the ENC completed the CM Newborn Outreach assessment and any additional referrals made for the newborn. The mother's note must include completion of the EPDS and any referrals made for her.

If the newborn or mother requires additional referrals and/or information, the ENC leaves the case open to follow the member and newborn until the issue(s) are resolved. If additional follow-up is not needed, the case status is closed, and an end date is then entered in both the newborn's and the mom's record in Atlantes.

During the course of case management, the ENC also emphasizes the importance of postpartum follow-up. As it relates to the newborn, the ENC ensures enrollment in SoonerCare, educates the mother regarding safe sleep, tobacco use in the home, immunizations, and well-child visits, and provides referrals to other programs as needed.

Through June 2012, if the newborn had a diagnosis contained on the list of fetal codes associated with HROB qualifications, a Case Management Introduction letter was mailed to the newborn's Primary Care Provider to inform the Provider of the HROB program. Exhibit 9-1 below provides an overview of the Newborn Outreach and At Risk Newborn case management process.

Exhibit 9-1 – Newborn Outreach and At Risk Newborn Program Process



AT RISK NEWBORN PROGRAM FINDINGS

Methodology

PHPG obtained two datasets from the OHCA to conduct the analysis, data from the ARNB care management system (Atlantes) and claims and eligibility data. ARNB member records were extracted from Atlantes for the period of August 1, 2009 (SFY 2010), through June 30, 2013 (SFY 2013). Claims and eligibility data were pulled for dates of services in SFY 2010 through 2013.

The Atlantes dataset was treated as the authority for identifying ARNB members. The dataset was "cleaned" to ensure a member was accurately included in the analyses. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates), as well as removing member records that had null end dates. Thus, only members who completed a case management cycle were included in this analysis. Members who had been enrolled in the program less than one week were also removed. Thus, only members who had actively engaged in the program for more than one week were included in the analysis.

Member surveys were administered via telephone to a sample of obstetric and pediatric members, including ARNB members. Prior to conducting the survey, a letter was mailed to all members informing them of the survey and what to expect. Survey results were entered into a proprietary database and then analyzed on a per-program basis.

A total of ten ARNB member surveys were collected. Findings for the ARNB survey interviews are reported in the ARNB Member Survey. Due to the small respondent pool surveyed, the results should be treated as qualitative in nature. Additionally, membership in the ARNB program is similarly small, and the survey sample accounts for approximately 24 percent of the average ARNB caseload for the last four state fiscal years.

Results

The following program enrollment and ENC activities were analyzed for the ARNB program by using the Atlantes dataset:

- Total enrolled in the ARNB program by SFY;
- Breakdown of ARNB participants by county geography (i.e., rural, urban, suburban, mixed, out of state);
- ARNB enrollment in the top ten counties;
- Total ARNB participants by age range;
- Average length of time in program;
- Percentage of members contacted within three business days of receiving a referral to the ARNB program by SFY;
- Total number of contact attempts per member per SFY;
- Total ENC time spent per enrollee by SFY;
- Total ENC FTE time per SFY;
- Initial CM Newborn Outreach assessment rates by SFY; and
- Total number of ARNB letters sent per enrollee by SFY.

The following utilization and cost measures were evaluated for the ARNB program by using claims and eligibility data:

- Hospital admissions for ARNB newborns during the first year of life by SFY;
- Emergency Room visits for ARNB newborns during the first year of life by SFY;
- Well-Child visit rates; and
- Summary of expenditures for the ARNB Program by SFY.

The following member survey metrics were evaluated for the ARNB program by using results from the ARNB member surveys:

- Survey demographics (e.g., member age, ethnicity, education level);
- Services received through ARNB and their helpfulness;
- ENC correspondence;
- ENC activities and member satisfaction rates;
- Overall member satisfaction with the assigned ENC and the ARNB program; and
- Behavioral health screenings and referrals.

Analysis of At Risk Newborn Enrollment and ENC Activities

This section describes ARNB program enrollment and ENC activities by SFY using Atlantes data.

Total Enrollment

Exhibit 9-2 below summarizes total ARNB enrollment from SFY 2010 through SFY 2013. Total enrolled by SFY was calculated based on a member's having a level-of-care start date in that fiscal year. Enrollment in SFY 2011 declined but then enrollment increased in SFY 2012 and remained constant through SFY 2013.

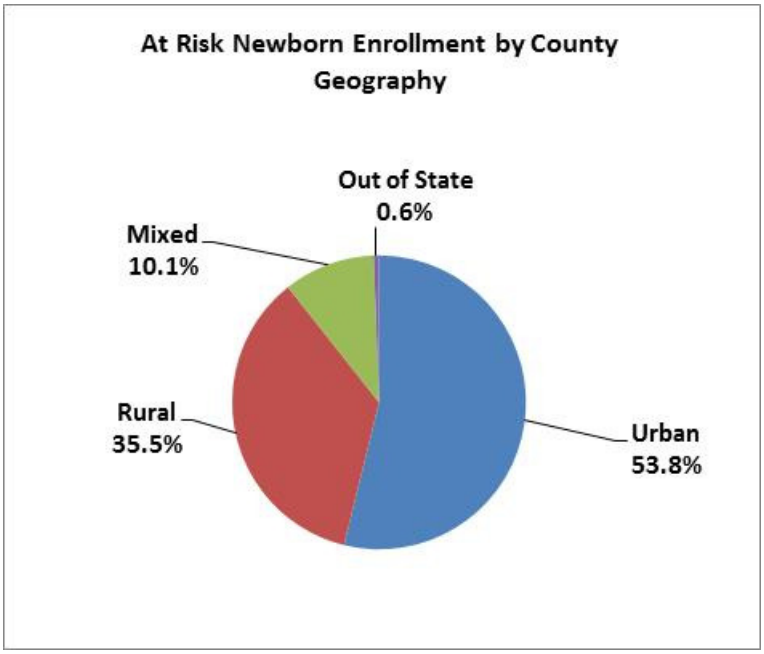
Exhibit 9-2: At Risk Newborn Enrollment by State Fiscal Year

SFY	Members
2010	45
2011	13
2012	56
2013	55
Total	**169**

Enrollment by County Geography

Exhibit 9-3 below summarizes the breakdown of ARNB enrollment by county geography from SFY 2010 through SFY 2013. Over half of the ARNB membership was concentrated in urban counties and another 35.5 percent resided in rural counties.

Exhibit 9-3: At Risk Newborn Enrollment by County Geography



Enrollment by Top Three Counties

A review of county codes, based on county of residence in Atlantes, shows that just over 50 percent of ARNB members (86 members) resided in the three urban Oklahoma counties of Cleveland, Oklahoma, and Tulsa from SFY 2010 through SFY 2013 (see Exhibit 9-4 below).

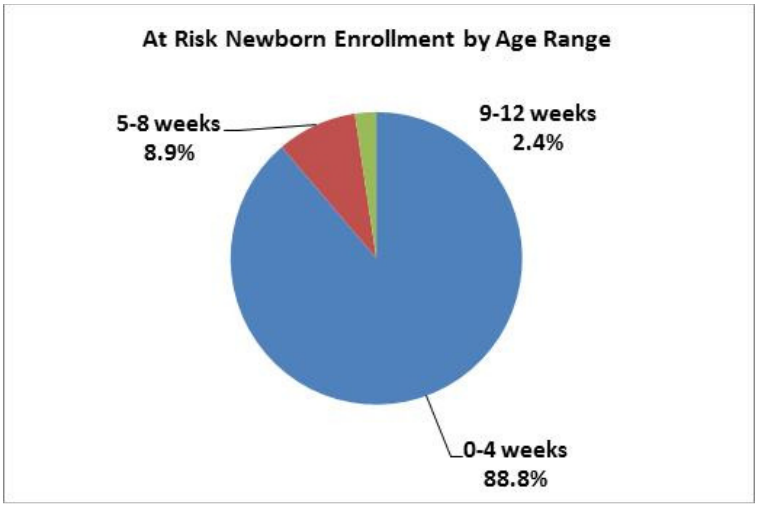
Exhibit 9-4: At Risk Newborn Enrollment by County

County	Total Members 2010-2013
Oklahoma	41
Tulsa	38
Cleveland	7
All other counties	99
Grand Total	**169**

Age Range of ARNB Members

The vast majority of ARNB members (89 percent) fell into the age range of zero to four weeks. Another nine percent of ARNB members fell into the age range of five to eight weeks, while the remaining two percent fell into the age range of nine to twelve week (see Exhibit 9-5 below) range.

Exhibit 9-5: At Risk Newborn Enrollment by Age Range



Length of Stay

Exhibit 9-6 below summarizes the average length of stay from SFY 2010 through SFY 2013. The majority of ARNB members (88.2 percent) were enrolled three or fewer months, of which 46.2 percent were only enrolled one to four weeks in duration, with 33.7 percent enrolled for five to eight weeks. Only 11 percent of members were enrolled four to six months.

Exhibit 9-6: At Risk Newborn Length of Stay

Length of Stay (weeks)	Duration Classification	# Members	% Members
1-4	Three or Fewer Months	78	46.2%
5-8		57	33.7%
9-12		14	8.3%
	Total	***149***	**88.2%**
13-16	Four to Six Months	13	7.7%
17-20		4	2.4%
21-24		2	1.2%
	Total	***19***	**11.2%**
25-28	Seven to Nine Months	1	0.6%
	Total	***1***	**0.6%**

ENC Activity Time

Initial Outreach

Once a member is assigned to an ENC, the ENC attempts to make an initial telephone contact within three business days of receiving the referral. Three attempts are made on three different days at different times to contact the member via telephone. To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes ARNB Activity Report.

The review was limited to only those cases where the data indicated that an ENC performed activities related to ARNB. The review was limited to only those cases where the data indicated that an ENC performed initial telephone outreach (e.g., member contact attempts 1, 2 and 3, phone calls to and from) within three business days of a referral to case management. Time spent performing each outreach attempt had to be more than five minutes in duration.

Exhibit 9-7 below highlights member contact rates within three business days from SFY 2010 through SFY 2013. Compliance rates for contacting members within three business days were extremely high, ranging from 56.4 to 84.6 percent. The average contact rate across all SFYs was 64.5 percent. This may be the result of the initial "Jean Tucker" letter that Member Services mails to the moms of newborns in an attempt to obtain a response that would lead to the initial newborn screening.

Exhibit 9-7: At Risk Newborn Member Contacts within Three Business Days

Measure	SFY2010	SFY2011	SFY2012	SFY2013
Members Contacted within Three Business Days	31	11	36	31
Total ARNB Enrollment	45	13	56	55
Contact Rate	**68.9%**	**84.6%**	**64.3%**	**56.4%**

Total Contacts

After successfully contacting a member and completing the initial assessment, the member is placed on a monthly contact schedule. All contacts for members are documented in Atlantes. To determine the number of contacts, a count was performed of all activity actions contained in the Atlantes ARNB Activity Report. Time spent performing member activities had to be more than five minutes in duration. Exhibit 9-8 on the following page contains the total contact attempts per member from SFY 2010 through SFY 2013. ENCs ranged from 3.5 to 5.2 contacts per member across the four fiscal years. There was a 32.7 percent decline in contact attempts made from SFY 2011 to SFY 2013. This number may have declined when the PCM Department implemented additional case management programs and, as a result, increased staff caseloads.

Exhibit 9-8: At Risk Newborn Total Contacts per Member

Measure	SFY2010	SFY2011	SFY2012	SFY2013
Count of Contacts	189	68	242	194
Total ARNB Enrollment	45	13	56	55
Total Contacts Per Member	**4.2**	**5.2**	**4.3**	**3.5**

ENC Time Spent Managing Enrollees

For ARNB cases, if there was a previous ENC assigned to the member for a prior level of care, attempts are made to re-assign the member to the same ENC. If there is no prior history with an ENC, assignment of ARNB cases is based on the geographic location in which the member resides. ENC assignment is then performed using a round-robin approach within a particular geographic location.

To assess the time spent by ENCs for the ARNB program, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to newborns who were assigned to ARNB. In each fiscal year, a large majority of ENC time has been dedicated to assessments, ongoing member correspondence and care management for enrolled members, and provider outreach. These activities are consistent with the primary functions of ENCs.

From SFY 2010 through 2013, ENCs spent an average of 1 to 1.6 hours per case across all activities. Average ENC hours per case have decreased slightly each fiscal year starting with SFY 2011. The decrease could be attributed to the implementation the electronic HROB/OB Outreach Assessment Tool in Atlantes in September 2011. As a result, there were changes to processes, as well as challenges in the way ENCs captured their time (i.e., some ENCs under-reported their time) while performing the assessment. In total, the FTEs required for the AROB Program ranged from 0.01 to 0.03 FTEs (see Exhibit 9-9 below).

Exhibit 9-9: At Risk Newborn ENC Time per Member and ENC FTE Time

Measure	SFY2010	SFY2011	SFY2012	SFY2013
Total Members	45	13	56	55
Sum of ARNB Activity (Hours)	57.6	21.3	70.1	53.7
ENC Time Per Enrolled Member (Hours)	**1.3**	**1.6**	**1.3**	**1.0**
Total ENC FTE Time	**0.03**	**0.01**	**0.03**	**0.03**

ARNB Assessment Rates

Upon successful contact with an ARNB member, the Initial CM Newborn Outreach Assessment is completed with the newborn's mom. The assessment includes talking points and the Edinburgh Postnatal Depression Scale (EPDS) screening tool. The assessment is located in Atlantes.
An analysis of the Initial CM Newborn Outreach Assessment rates was performed using the Atlantes ARNB Assessment Report.

A count of all initial assessments was performed by SFY, and these totals were divided by the number of unique members served in each SFY from SFY 2010 through SFY 2013. The initial assessment rate has increased on an annual basis since SFY 2011, with a 49.1 percent compliance rate achieved in SFY 2013 (see Exhibit 9-10 below).

Exhibit 9-10: Initial CM Newborn Outreach Assessment Rates

Measure	SFY2010	SFY2011	SFY2012	SFY2013
Initial Assessments Performed	7	1	14	27
Total ARNB Enrollment	45	13	56	55
Initial Assessment Rate	**15.6%**	**7.7%**	**25.0%**	**49.1%**

ARNB Letters

ENCs generate and mail a number of letters to members and providers for the ARNB program, including but not limited to, introductory letters, unable-to-contact letters, provider notification, and case closure letters. An analysis was performed for the number of ARNB letters sent by SFY. From SFY 2010 through 2013, ENCs mailed an average 0.8 to 4.2 letters per member (see Exhibit 9-11 below).

Exhibit 9-11: At Risk Newborn Letters Sent by State Fiscal Year

Measure	SFY2010	SFY2011	SFY2012	SFY2013
Total Letters Sent	191	47	142	171
Total ARNB Enrollment	45	13	56	55
Total Letters Per Member	**4.2**	**3.6**	**0.8**	**0.9**

At Risk Newborn Utilization and Cost Outcomes

This section highlights the ARNB utilization and cost trends by SFY using claims and eligibility data for dates of services in SFY 2010 through 2013. It should be noted that exhibits are presented based on date/SFY of the delivery and not the actual claims incurred during each SFY.

Utilization Rates

For ARNB, inpatient admissions declined dramatically during the four-year period. Inpatient admissions per 1,000 during the child's first year of life averaged 1,935 per member. ER visits per 1,000 declined in SFY 2011 and averaged 1,634 per 1,000 over the four-year period (see Exhibit 9-12 below).

Exhibit 9-12: At Risk Newborn Utilization

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	40	18	57	65	164
IP Admissions Total	**180**	**41**	**85**	**21**	**327**
IP Admissions per 1,000	**4,000.00**	**3,153.85**	**1,517.86**	**381.82**	**1,934.91**
ER Visits Total	**83**	**17**	**79**	**89**	**268**
ER Visits per 1,000	**2,075.00**	**944.44**	**1,385.96**	**1,369.23**	**1,634.15**

Well-Child Visit Rates

ARNB well-child visit rates were evaluated for the duration of time that participants were in the program. PHPG was able to analyze well-child visit rates at two-, three-, and five-month intervals. Two-month rates declined from SFY 2010 to SFY 2011 before experiencing increases through SFY 2013, with a four-year average of only 41.1 percent.

Rates at the three-month interval were again low and experienced declines from SFY 2011 to SFY 2013. The four-year average rate was only 27.7 percent. Rates at the five-month interval showed more promise with 50 percent compliance in 2013. Continued education and outreach is needed to stress the importance of well-child visits for ARNB participants (see Exhibit 9-13 on the following page).

Exhibit 9-13: At Risk Newborn Well-Child Visits

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	40	18	57	65	164
Rate					
2-months	**53.3%**	**27.3%**	**34.4%**	**41.7%**	**41.1%**
3-months	**30.0%**	**33.3%**	**29.0%**	**22.2%**	**27.7%**
5-months	**100.0%**	**0.0%**	**75.0%**	**50.0%**	**66.7%**
Denominator					
2-months	45	11	64	72	192
3-months	30	6	31	27	94
5-months	4	1	4	6	15
Numerator					
2-months	24	3	22	30	79
3-months	9	2	9	6	26
5-months	4	-	3	3	10

Expenditures

Total ARNB expenditures and expenditures per case increased from SFY 2011 through SFY 2013. Total ARNB expenditures were $2.1 million, and average PMPM expenditures were $7,163.49 (see Exhibit 9-14).

Exhibit 9-14: At Risk Newborn Total Expenditures and Expenditures per Case

Measure	State Fiscal Year				Total
	2010	2011	2012	2013	
Participants	40	18	57	65	164
Participation Months	61	29	101	102	293
Total Expenditures	**$636,068**	**$141,984**	**$646,261**	**$671,590**	**$2,098,903**
PMPM Expenditures	**$10,427.34**	**$4,896.00**	**$6,428.33**	**$6,584.22**	**$7,163.49**

ARNB Member Survey Findings

This section describes key findings from the ARNB member survey using data collected from ten survey interviews.

ARNB Program Services

There are a number of services available to children in the ARNB program. Eighty percent of respondents said they received an assessment, as well as training and education for their child. Seventy percent reported having received monthly phone calls (see Exhibit 9-15 below). Respondents were asked to rate the helpfulness of each "yes" service. Seventy percent reported training and education related to their child was very helpful. Sixty percent reported the assessments and monthly phone calls were very helpful.

Exhibit 9-15: ARNB Program Services

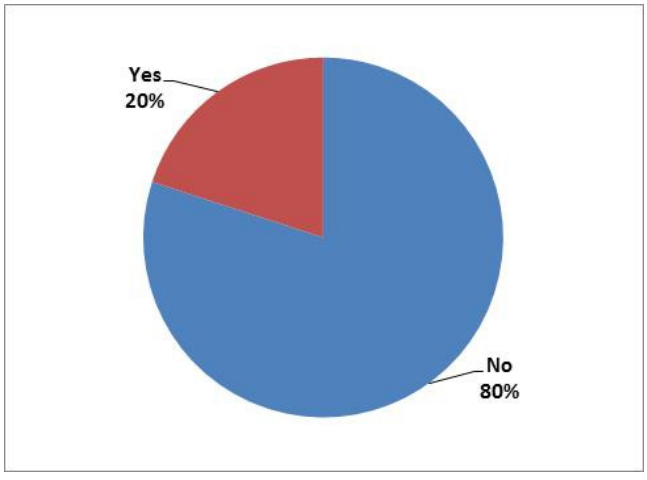
Service		Respondents answering "yes" to the service				
	Yes	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Unsure/ N/A
Assessment	80.0%	60.0%	20.0%	0.0%	0.0%	20.0%
Training and Education	80.0%	70.0%	10.0%	0.0%	0.0%	20.0%
Educational Materials	40.0%	40.0%	0.0%	0.0%	0.0%	60.0%
Postpartum Depression Screening	0.0%	10.0%	0.0%	0.0%	0.0%	90.0%
Referrals to Programs and Services	44.4%	33.3%	0.0%	0.0%	0.0%	66.7%
Appointment Scheduling	40.0%	40.0%	0.0%	0.0%	0.0%	60.0%
Family Planning	0.0%	40.0%	20.0%	0.0%	0.0%	40.0%
Monthly Phone Calls	70.0%	60.0%	10.0%	0.0%	0.0%	30.0%

ENC Correspondence

Name of Case Manager

Approximately 20 percent of respondents recalled the name of their child's case manager (Exhibit 9-16).

Exhibit 9-16: Identified the Name of Case Manager



Number of Times Spoke with Case Manager

On average, respondents spoke with their child's case manager 2.8 times since they started the ARNB program.

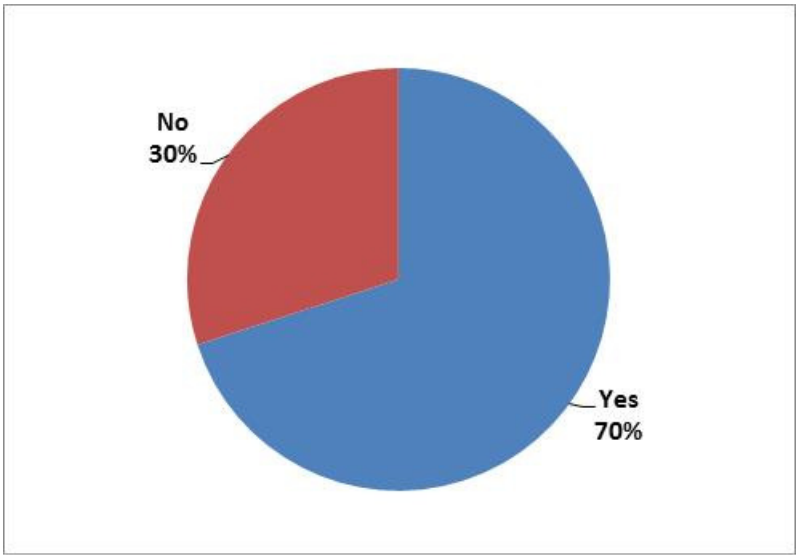
Rating of Case Manager Contacts

Eight-nine percent of respondents felt the number of times their child's case manager contacted them was just enough.

Member Calls to Case Manager

The majority of respondents (70 percent) said they had called their child's case manager (see Exhibit 9-17 below).

Exhibit 9-17: Have Called Their Case Manager



Reason for Calling Case Manager

The top three reasons for respondents' calling their case manager were to return phone calls from their case manager (33 percent), to request a referral to a community service for their child (33 percent), and to ask a routine health question about their child (33 percent).

ENC Activities

Case managers are expected to help build self-management skills so that moms/parents can render the appropriate care to their children enrolled in the ARNB program. The majority of respondents (80 percent) indicated that their child's case manager asked questions about their child's health or their concerns (see Exhibit 9-18 on the following page). Sixty percent said their child's case manager

answered questions about their child's health care needs. Forty percent were provided with referrals to programs and services for their child.

Exhibit 9-18: Case Manager Activity Ratings

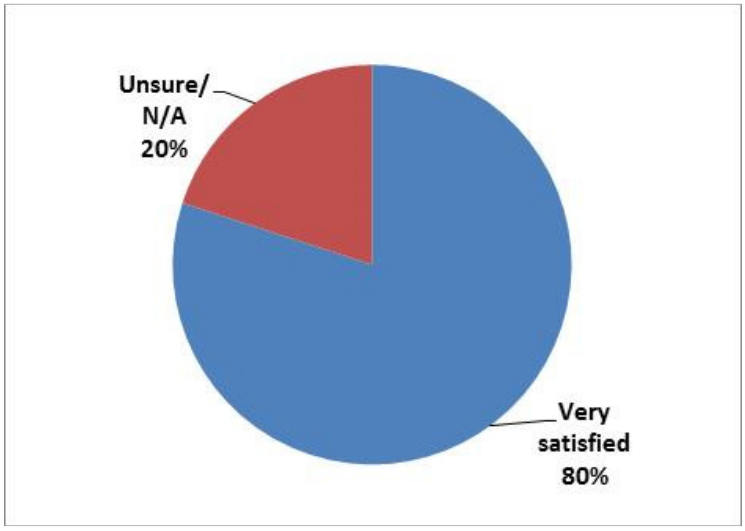
Activity		Respondents answering "yes" to the activity				
	Yes	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Unsure/N/A
Asked questions about your child's health or your concerns	**80.0%**	80.0%	0.0%	0.0%	0.0%	20.0%
Provided instructions about taking care of your child's health	**20.0%**	70.0%	0.0%	0.0%	0.0%	30.0%
Helped you to identify changes in your child's health that might be an early sign of a problem	**20.0%**	20.0%	0.0%	0.0%	0.0%	80.0%
Answered questions about your child's health care needs	**60.0%**	60.0%	0.0%	0.0%	0.0%	40.0%
Helped you to make and keep health care appointments for medical problems	**20.0%**	20.0%	0.0%	0.0%	0.0%	80.0%
Referred you to programs and services	**40.0%**	50.0%	0.0%	0.0%	0.0%	50.0%

Respondents were asked to rate their satisfaction with each "yes" activity. Eighty percent were very satisfied when the case manager asked questions about their child's health or concerns. Seventy percent were very satisfied with the instructions they received about taking care of their child's health. Sixty percent were very satisfied with how the case manager answered questions about their child's health care needs. Fifty percent said they were very satisfied when the case manager referred them to programs and services for their child.

Satisfaction with ENC and ARNB Program

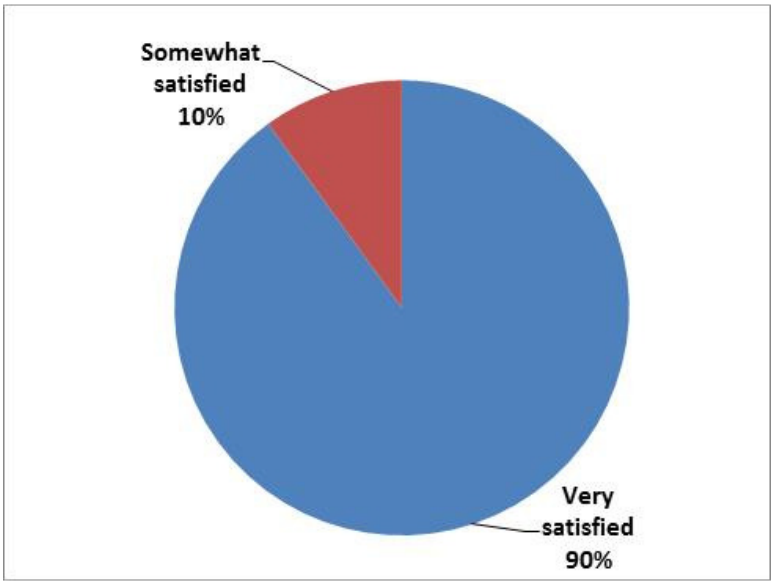
Overall, 80 percent of respondents were very satisfied with the help they received from their child's case manager (see Exhibit 9-19 on the following page).

Exhibit 9-19: Overall Satisfaction with Case Manager



The vast majority of respondents (90 percent) were very satisfied with the ARNB program (see Exhibit 9-20). One hundred percent of respondents would recommend the ARNB program to a friend with similar health care needs.

Exhibit 9-20: Overall Satisfaction with At Risk Newborn Program



SYNAGIS PROGRAM INTRODUCTION AND PROGRAM OVERVIEW

Synagis Program Objective

The Synagis Case Management Program provides case management services to children who are prescribed the Synagis antibody when there are concerns about dosage compliance in order to reduce the rate of hospitalization and poor outcomes that result from Respiratory Syncytial Virus (RSV). The program was implemented on December 1, 2010.

Program History and Overview

RSV is an airborne respiratory virus that infects the lungs and airways. RSV is transmitted through nose and throat secretions, either by direct contact or through air particles from coughs and sneezes. In adults and older children, it causes mild, cold-like symptoms. However, RSV can cause serious breathing problems, including pneumonia and, in few instances, death in premature infants and in children with certain pre-existing medical conditions. RSV is the most common cause of bronchiolitis and pneumonia in children under one year of age in the United States.

During RSV season, which is November through the end of March in Oklahoma, these high-risk children are treated with monthly injections of Synagis. Synagis is an antibody given to reduce the rate of hospitalization from infection with RSV among high-risk children. The OHCA requires prior authorization for Synagis. All requests are processed through the Oklahoma University College of Pharmacy. The OHCA begins accepting prior authorizations for Synagis in mid-October and approves drug administration from November through the end of March.

Because of their fragile health status and the short time of effectiveness of the medication (22 days), it is important that these children receive all of their prescribed Synagis doses during the RSV season (usually five doses). The Oklahoma University (OU) College of Pharmacy (COP) and the OHCA pharmacy consultants were concerned about dosage compliance for SoonerCare members who were prescribed this seasonal pharmaceutical regimen.

In October 2010, the PCM Department, along with OHCA's Chief Medical Officer, OU College of Pharmacy staff, and OHCA Pharmacy operations staff, developed the Synagis Case Management Program for infants who are prescribed the Synagis antibody.

If a provider has concerns about an infant's receiving all of the prescribed Synagis doses, a referral can be made to the PCM Department. The PCM Department then provides monthly follow-up by an ENC throughout RSV season. The program can be initiated at any time during RSV season.

Specific criteria were developed for Synagis Program inclusion. Members must be in one of the following age groups at the beginning of the RSV season:

- Infants and children less than 24 months old with Chronic Lung Disease (CLD) (formerly Bronchopulmonary dysplasia) who have required medical treatment (e.g., oxygen, bronchodilator, corticosteroid, or diuretic therapy) for CLD in the 6 months prior to RSV season;
- Infants up to 24 months old with moderate to severe pulmonary hypertension, cyanotic heart disease, or those on medications to control congestive heart failure;
- Infants less than 12 months of age, born at 28 weeks' gestation or earlier;
- Infants less than 6 months of age, born at 29-31 weeks' gestation;
- Infants less than 12 months of age, with congenital abnormalities of the airway;
- Infants less than 12 months of age, with severe neuromuscular disease; and
- Infants up to 3 months old at the start of RSV season, born at 32-34 weeks' gestation, who have one of the following risk factors: (up to three doses only)
    - Child care attendance; or
    - Siblings younger than 5 years of age.

Most children receive at least three to five injections of the medication during the time of year when RSV is most likely to be prevalent. The three to five injections are considered a full course of treatment. Children who only receive a partial course of treatment (1-2 injections) may also reap the benefit of the medication. By providing this series of medications to infants and young children who meet criteria for its use, hospitalization and other severe complications of RSV can be avoided in this vulnerable population. Criteria for receiving the injections of Synagis are based on the American Academy of Pediatrics (AAP) guidelines for Synagis use, which are released annually.

Since SFY 2011, there have been 110 members who were case managed in the Synagis Program.

Program Eligibility

If a provider has concerns about an infant's receiving all of the prescribed Synagis doses, a referral can be made to the PCM Department. The PCM Department then provides monthly follow-up by an ENC throughout RSV season. The COP also refers Synagis cases to the PCM Department.

Synagis Program Process

When a referral for the Synagis Program is received by the PCM Department, it is sent to the geographical team queue for assignment to an ENC based on the geographic location (case management team region) in which the member resides. The PCM Administrative Assistant documents in Atlantes whether the referral is from the COP or from a provider. If the referral is from a provider, the ENC contacts the provider to discuss the referral and to see if the provider would like information on the case over time.

Once an ENC is assigned to the member, a call is made to the child's parent in order to complete a Synagis phone assessment (Synagis Talking Points). During this time, the parent is educated about the RSV season, as well as measures to prevent illness, including but not limited to the following:

- Review of PCP and specialist;
- Knowledge of infant's health conditions;
- Knowledge of Synagis vs. immunizations;
- Compliance with prescribed regimen;
- SoonerCare benefits review;
- Tobacco usage in the home (mom and/or another person);
- ER utilization;
- Low literacy assessment–caregiver's preferred way to learn medical information;
- Prevention; and
- What to do when child is sick with a fever and cough.

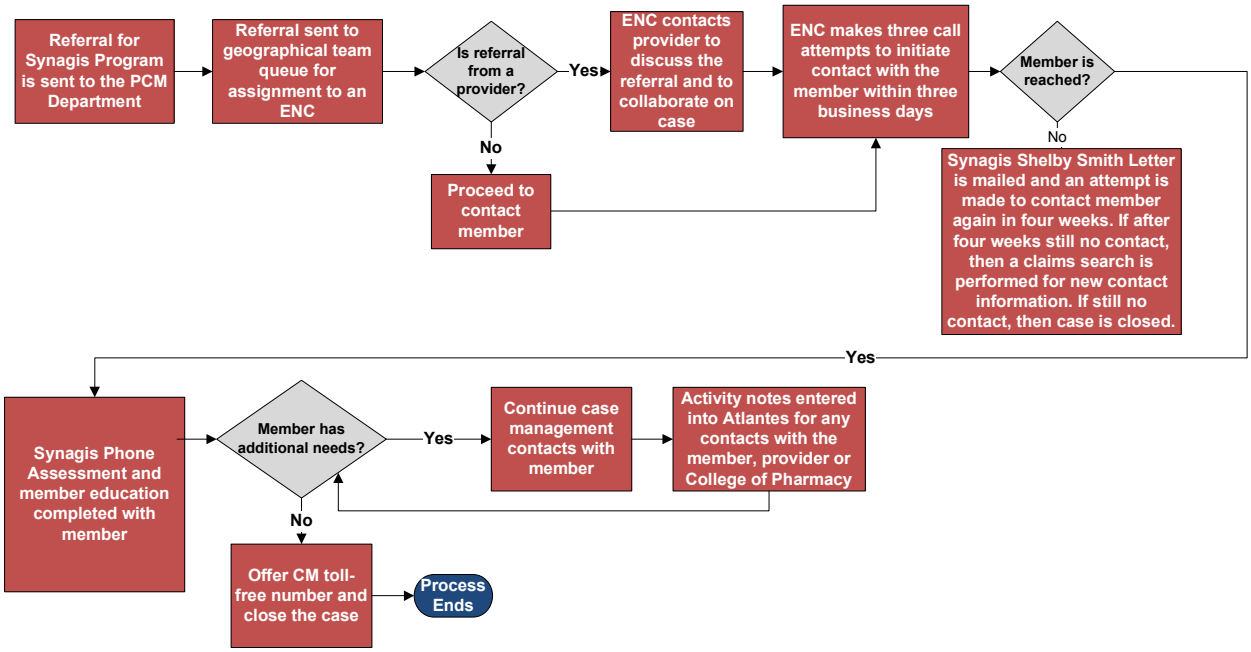
After completion of the Synagis assessment, if there are no other care management needs, the ENC provides the member with PCM's toll-free number and closes the case. If additional needs exist, the case is kept open until these are addressed.

If the ENC is unable to reach the member, a letter (Synagis Shelby Smith Letter) is mailed to the member, and an activity note is entered into Atlantes to contact the member again in four weeks. If after four weeks the call back is unsuccessful, the ENC performs a claims search to determine if there are pharmacy claims or other providers who may have new contact information for the member. If no other information is available or if the parent/guardian does not call back, the case is closed.

During the case management period, activity notes are entered into Atlantes for any contacts with the member, provider, or COP. The program has realized significant growth since its inception in 2010.

Exhibit 10-1 on the following page provides an overview of the Synagis case management process.

Exhibit 10-1 – Synagis Program Case Management Process



SYNAGIS PROGRAM FINDINGS

Methodology

PHPG obtained two datasets from the OHCA to conduct the analysis, data from the Synagis care management system (Atlantes) and claims and eligibility data. Synagis member records were extracted from Atlantes for the period of August 1, 2010 (SFY 2011), through June 30, 2013 (SFY 2013). Claims and eligibility data were pulled for dates of services in SFY 2011 through 2013.

The Atlantes dataset was treated as the authority for identifying Synagis members. The dataset was "cleaned" to ensure a member was accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates), as well as removing member records that had null end dates. Thus, only members who completed a case management cycle were included in this analysis. Members who had been enrolled in the program less than one week were also removed. Thus, only members who had actively engaged in the program for more than one week were included in the analysis.

Member surveys were administered via telephone to a sample of obstetric and pediatric members, including Synagis members. Prior to conducting the survey, a letter was mailed to all members informing them of the survey and what to expect.

Survey results were entered into a proprietary database and then analyzed on a per-program basis. Nine Synagis member surveys were collected. Findings for the Synagis survey interviews are reported in the Synagis Member Survey section. Due to the small respondent pool surveyed, the results should be treated as qualitative in nature. Additionally, membership in the Synagis program is similarly small, and the survey sample accounts for approximately 13 percent of the average Synagis caseload for the last three state fiscal years.

Results

The following program enrollment and ENC activities were analyzed for the Synagis program by using the Atlantes dataset:

- Total enrolled in the Synagis program by SFY;
- Breakdown of Synagis participants by county geography (i.e., rural, urban, suburban, mixed, out of state);
- Synagis enrollment in the top ten counties;
- Total Synagis participants by age range;
- Average length of time in program;
- Percentage of members contacted within three business days of receiving a referral to the Synagis program by SFY;
- Total number of contact attempts per member per SFY;
- Total ENC time spent per enrollee by SFY;
- Total ENC FTE time per SFY;
- Initial Synagis assessment rates by SFY; and
- Total number of Synagis letters sent per enrollee by SFY.

The following utilization and cost measures were evaluated for the Synagis program by using claims and eligibility data:

- Percentage of members who received at least a partial course of Synagis treatment;
- Percentage of members who received a full course of Synagis treatment (5 treatments or greater);
- Percentage of members who received a partial course of treatment (1-4 treatments total) and were subsequently hospitalized with RSV infection;
- Percentage members who received a full course of treatment and were subsequently hospitalized with RSV infection;
- Summary of utilization rates (i.e., Emergency Room Visits, Hospitalizations, and Readmission rates) for Synagis members by SFY; and
- Summary of expenditures for the Synagis Program by SFY.

The following member survey metrics were evaluated for the Synagis program by using results from the Synagis member surveys:

- Survey demographics (e.g., member age, ethnicity, education level);
- Services received through Synagis and their helpfulness;
- ENC correspondence;
- ENC activities and member satisfaction rates; and
- Overall member satisfaction with the assigned ENC and the Synagis program.

Analysis of Synagis Enrollment and ENC Activities

This section highlights Synagis utilization and cost trends by SFY using claims and eligibility data for dates of services in SFY 2011 through 2013.

Total Enrollment

Exhibit 10-2 below summarizes total Synagis Case Management enrollment from SFY 2011 through SFY 2013. Total enrolled by SFY was calculated based on a member's having a level-of-care start date in that fiscal year. Enrollment has increased since SFY 2011.

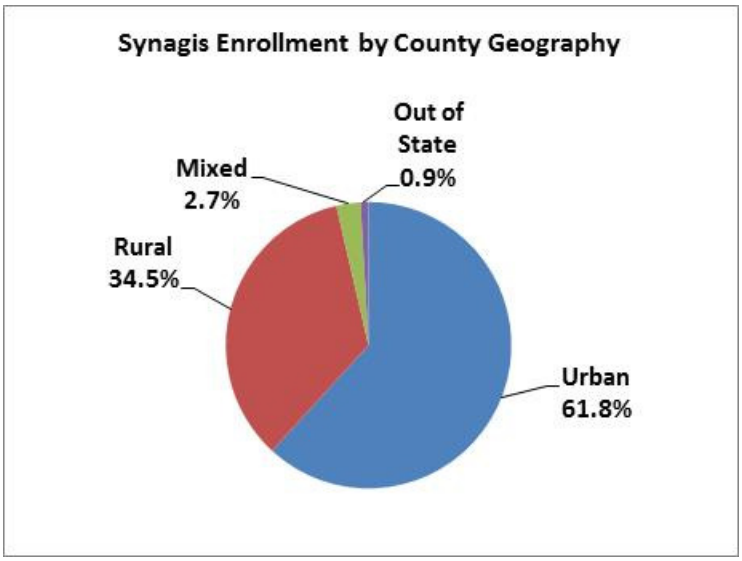
Exhibit 10-2: Synagis Enrollment by State Fiscal Year

SFY	Members
2011	6
2012	25
2013	79
Total	**110**

Enrollment by County Geography

Exhibit 10-3 on the following page summarizes the breakdown of Synagis enrollment by county geography from SFY 2011 through SFY 2013. Over 60 percent of the Synagis membership (61.8 percent) was concentrated in urban counties, and 34.5 percent resided in rural counties.

Exhibit 10-3: Synagis Enrollment by County Geography



Enrollment by Top Three Counties

A review of county codes, based on county of residence in Atlantes, shows that 60 percent of Synagis members (66 members) resided in the three urban Oklahoma counties of Cleveland, Oklahoma, and Tulsa from SFY 2011 through SFY 2013 (see Exhibit 10-4 below).

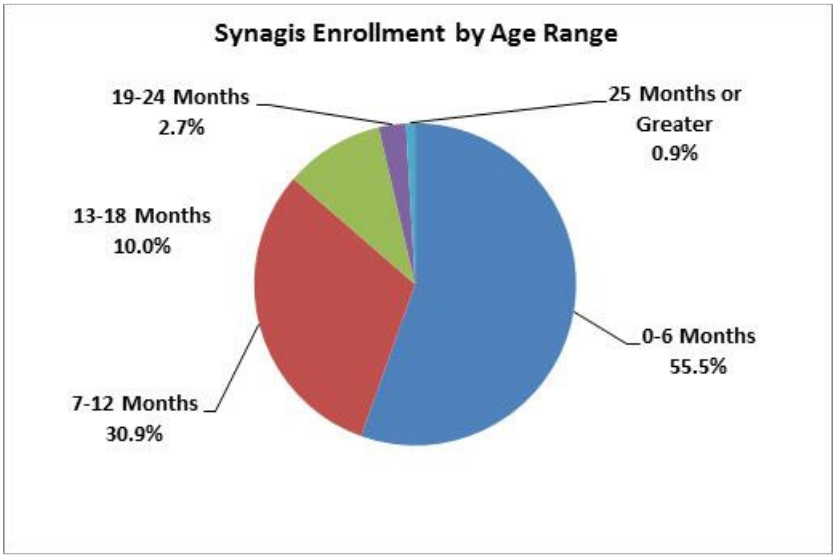
Exhibit 10-4: Synagis Enrollment by County

County	Total Members 2011-2013
Tulsa	36
Oklahoma	25
Cleveland	5
All other counties	44
Grand Total	**110**

Age Range of Synagis members

Over 50 percent of Synagis members fell into the age range of zero to six months from SFY 2011 through SFY 2013. Over 30 percent were in the seven-to twelve-month range (see Exhibit 10-5 on the following page).

Exhibit 10-5: Synagis Enrollment by Age Range



Length of Stay

Exhibit 10-6 below summarizes the average length of stay from SFY 2011 through SFY 2013. Length of stay in case management was calculated by subtracting a member's level-of-care end date from their level-of-care start date. Nearly all Synagis members (97.3 percent) were enrolled three or fewer months, of which 69 percent were only enrolled one to four weeks.

The short duration in case management aligns with the Synagis desktop procedures; that is, if there are no other case management needs, the ENC provides the member with PCM's toll-free number and closes the case. If additional needs exist, the case is only kept open until those needs are addressed.

Exhibit 10-6: Synagis Length of Stay

Length of Stay (weeks)	Duration Classification	# Members	% Members
1-4	Three or Fewer Months	76	69.1%
5-8		26	23.6%
9-12		5	4.5%
	Total	***107***	**97.3%**
13-16	Four to Six Months	0	0.0%
17-20		2	1.8%
21-24		0	0.0%
	Total	***2***	**1.8%**
25-28	More than Six Months	1	0.9%
	Total	***1***	**0.9%**

ENC Activity Time

Initial Outreach

Once a member is assigned to an ENC, the ENC attempts to make an initial telephone contact within three business days of receiving the referral. Three attempts are made on three different days at different times to contact the member via telephone. To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes Synagis Activity Report.

The review was limited to only those cases where the data indicated that an ENC performed initial telephone outreach (e.g., member contact attempts 1, 2 and 3, phone calls to and from) within three business days of a referral to case management. Time spent performing each outreach attempt had to be more than five minutes in duration.

Exhibit 10-7 below highlights member contact rates within three business days from SFY 2011 through SFY 2013. Member contact rates ranged from 40.5 to 66.7 percent. The average contact rate across all SFYs was 42.7 percent.

Exhibit 10-7: Synagis Member Contacts within Three Business Days

	SFY2011	SFY2012	SFY2013
Members Contacted within Three Business Days	4	11	32
Total Synagis Enrollment	6	25	79
Contact Rate	**66.7%**	**44.0%**	**40.5%**

Total Contacts

All contacts for members in the Synagis program are documented in Atlantes. To determine the number of contacts, a count was performed of all activity actions contained in the Atlantes Synagis Activity Report. Time spent performing member activities had to more than five minutes in duration.

Exhibit 10-8 on the following page contains the average number of contacts per member from SFY 2011 through SFY 2013. ENCs averaged 0.7 to 8.7 contacts per member across the three fiscal years. There was a 76 percent decline in contact attempts made from SFY 2011 to SFY 2012. This decline may have occurred when the PCM Department implemented additional case management programs, and, as a result, staff caseloads increased. It should be noted that contact attempts are sometimes relaxed in times of staffing crises. The average number of member contacts across all SFYs was 4.6 contacts per member.

Exhibit 10-8: Synagis Total Contacts per Member

	SFY2011	SFY2012	SFY2013
Count of Contacts	52	144	310
Total Synagis Enrollment	6	25	79
Total Contacts Per Member	**8.7**	**2.1**	**0.7**

ENC Time Spent Managing Enrollees

For Synagis cases, if there was a previous ENC assigned to the member for a prior level of care, attempts are made to re-assign the member to the same ENC. If there is no prior history with an ENC, assignment to Synagis cases is based on the geographic location in which the member resides. ENC assignment is then performed using a round-robin approach within a particular geographic location.

To assess the time spent by ENCs for the Synagis program, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to newborns who were assigned to Synagis.

In each fiscal year, a large majority of ENC time has been dedicated to assessments, ongoing member correspondence and care management for enrolled members, and provider outreach. These activities are consistent with the primary functions of ENCs.

From SFY 2011 through 2013, ENCs spent an average of 1.0 to 3.8 hours per case across all activities. Average ENC hours per case have fluctuated each fiscal year but have averaged one hour. In total, the FTEs required for the Synagis program ranged from 0.01 to 0.04 FTEs (see Exhibit 10-9 below). This low number is attributed to the small membership and short duration that members are in the Synagis program.

Exhibit 10-9: Synagis ENC Time per Member and ENC FTE Time

	SFY2011	SFY2012	SFY2013
Total Members	6	25	79
Sum of Synagis Activity (Hours)	22.9	38.2	81.2
ENC Time Per Enrolled Member (Hours)	**3.8**	**1.5**	**1.0**
Total ENC FTE Time	**0.01**	**0.02**	**0.04**

Synagis Assessment Rates

Upon successful contact with a Synagis member, one of two Synagis assessments is completed, depending on the referral source. If the referral source is the COP, the “Synagis Talking Point – referral from COP assessment” is completed. If the referral source is a provider, the “Synagis Talking Point – referral from provider” is completed. The assessments are located in Atlantes.

An analysis of assessment rates for both Synagis assessments was performed using the Atlantes Synagis Assessment Report. Records were queried that had an assessment completion date entered. A count of all initial assessments was performed by SFY, and these totals were divided by the number of unique members served in each SFY from SFY 2011 through SFY 2013.

Synagis assessment rates have remained low across all SFYs (see Exhibit 10-10 below). This may be attributable to ENC’s omitting of the "assessment completion date" entry in the member’s record.

Exhibit 10-10: Synagis Assessment Rates

	SFY2011	SFY2012	SFY2013
Initial Assessments Performed	4	5	11
Total Synagis Enrollment	6	25	79
Initial Assessment Rate	**66.7%**	**20.0%**	**13.9%**

Synagis Letters

ENCs generate and mail a number of letters to members and providers for the Synagis program, including but not limited to, introductory letters, unable-to-contact letters, provider notification, and case closure letters. An analysis was performed for the number of Synagis letters sent by SFY. From SFY 2011 through 2013, ENCs mailed an average 1.3 to 3.3 letters per member (see Exhibit 10-11 below).

Exhibit 10-11: Synagis Letters Sent by State Fiscal Year

	SFY2011	SFY2012	SFY2013
Total Letters Sent	20	42	102
Total Synagis Enrollment	6	25	79
Total Letters Per Member	**3.3**	**1.7**	**1.3**

Synagis Utilization and Cost Outcomes

This section highlights the Synagis utilization and cost trends by SFY using claims and eligibility data for dates of services in SFY 2011 through 2013. Note the SFY 2011 findings should be interpreted with caution given the small sample sizes.

Synagis Treatment

On average, 73.1 percent of Synagis program members received Synagis treatment. The percentage who received a full course of treatment when compared to a partial course of treatment was almost equally split in SFY 2012 (see Exhibit 10-12 below). The difference in the number of Synagis doses could be related to the time when it was prescribed during the specified month and/or due to compliance factors.

Despite Synagis treatment, the percentage of members hospitalized for RSV averaged 55.7 percent across all SFYs. Ironically, members who received a full course of Synagis treatment had higher hospitalization rates for RSV than did members who received a partial course of treatment (62.5 percent compared to 48.7 percent).

Exhibit 10-12: Synagis Treatment and Subsequent Hospitalization for RSV

Measures	State Fiscal Year			Total
	2011	2012	2013	
Participants	6	26	79	108
Synagis Prescription Claims Data Not Available	2	8	22	32
Synagis Prescription Claims Data Available	4	18	57	79
Percent of Participants, Any Dosage	**66.7%**	**69.2%**	**72.2%**	**73.1%**
Full Course (3 to 5 doses)	4	9	27	40
Percent of Participants, Full Course	**100.0%**	**50.0%**	**47.4%**	**50.6%**
Partial (1 to 2 doses)	0	9	30	39
Percent of Participants, Partial Course	**0.0%**	**50.0%**	**52.6%**	**49.4%**
Subsequently Hospitalized for RSV	3	10	31	44
Percent Hospitalized, Any Dosage	**75.0%**	**55.6%**	**54.4%**	**55.7%**
Full Course (3 to 5 doses)	3	6	16	25
Percent Hospitalized, Full Dosage	**75.0%**	**66.7%**	**59.3%**	**62.5%**
Partial (1 to 2 doses)	0	4	15	19
Percent Hospitalized, Partial Dosage	**0.0%**	**44.4%**	**50.0%**	**48.7%**

Utilization Rates

ER utilization fluctuated each year, as did the number of program participants. The three-year average for ER visits per 1,000 was 96 (see Exhibit 10-13 below). Inpatient admissions fluctuated for SFY 2012 and 2013 but averaged 32 per 1,000 per members. The readmission rate per 1,000 within 30 days for SFY 2012 was 59. No data were found for SFYs 2011 and 2013. It should be noted that utilization was pulled for all diagnoses and not just RSV-related diagnoses.

Exhibit 10-13: Synagis Utilization

Measures	State Fiscal Year			Total
	2011	2012	2013	
Participants	6	26	79	108
Participation Months	15	34	107	156
ER Visits per 1,000	**133**	**176**	**65**	**96**
IP Admissions per 1,000	-	**88**	**19**	**32**
Readmissions per 1,000 (within 30 days)	-	**59**	-	**13**

Summary of Expenditures

Total Synagis expenditures and PMPM expenditures declined considerably from SFY 2011 to SFY 2013. Participation counts were small in some SFY's. Total PMPM expenditures were $421,407 and PMPM expenditures were $2,701.33 (see Exhibit 10-14 below).

Exhibit 10-14: Synagis Total Expenditures and Expenditures per Case

Measures	State Fiscal Year			Total
	2011	2012	2013	
Participants	6	26	79	108
Participation Months	15	34	107	156
Total Expenditures	**$129,968**	**$163,395**	**$128,045**	**$421,407**
Total PMPM Expenditures	**$8,664.50**	**$4,805.73**	**$1,196.68**	**$2,701.33**

Over the three-year period, Synagis injections accounted for 25 percent of total PMPM expenditures. Additionally, inpatient services accounted for 26.4 percent of total expenditures (see Exhibit 10-15 on the following page).

Exhibit 10-15: Synagis Total PMPM Expenditures and Percent of PMPM

Measures	State Fiscal Year			Total
	2011	2012	2013	
Participants	6	26	79	213
Total PMPM Expenditures	**$8,664.50**	**$4,805.73**	**$1,196.68**	**$2701.33**
Prescribed Drugs	$1,192.30	$512.78	$714.67	$716.60
-Synagis Only-	$1,187.25	$476.73	$675.71	$681.53
Percent of PMPM, Synagis	**83.1%**	**10.2%**	**56.5%**	**25.2%**
Inpatient Services	$ -	$3,145.48	$40.72	$713.49
Percent of PMPM	**0.0%**	**67.4%**	**3.4%**	**26.4%**
Physician Services	$261.08	$793.71	$203.00	$337.33
Percent of PMPM	**18.3%**	**17.0%**	**17.0%**	**12.5%**
Outpatient Services	$9.96	$31.50	$105.88	$80.45
Percent of PMPM	**0.7%**	**0.7%**	**8.8%**	**3.0%**
All Other*	$162.96	$322.26	$132.40	$176.72
Percent of PMPM	**11.4%**	**6.9%**	**11.1%**	**6.5%**

***The category "All Other" includes the following expenditures: medical supplies and orthotics, lab and x-ray, home health and home care, transportation, other practitioner, other institutional, and targeted case management.*

Synagis Member Survey Findings

This section describes key findings from the Synagis member survey using data collected from nine survey interviews.

Synagis Program Services

There is a select set of services available to children in the Synagis program. Nearly 80 percent of respondents received help scheduling and rescheduling injection appointments for their children. Two-thirds received training and education, as well as follow-up calls by their child's case manager (see Exhibit 10-16 on the following page). Over 50 percent said they received educational materials and letters, as well as referrals to programs and services for their children.

Exhibit 10-16: Synagis Program Services

Service		Respondents answering "yes" to the service				
	Yes	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Unsure/ N/A
Training and Education	**66.7%**	55.6%	11.1%	0.0%	0.0%	33.3%
Educational materials and letters	**55.6%**	55.6%	0.0%	0.0%	0.0%	44.4%
Scheduling and rescheduling injection appointments	**77.8%**	66.7%	11.1%	0.0%	0.0%	22.2%
Follow-up phone calls by case manager	**66.7%**	66.7%	0.0%	0.0%	0.0%	33.3%
Referrals to programs and services	**55.6%**	44.4%	11.1%	0.0%	0.0%	44.4%

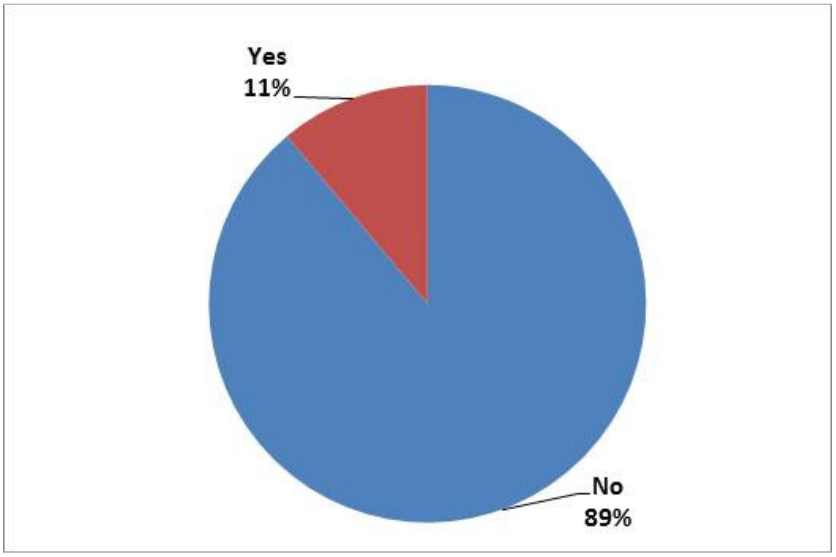
Respondents were asked to rate the helpfulness of each "yes" service. Two-thirds reported the scheduling and rescheduling injection appointments, as well as the follow-up phone calls by their child's case manager, were very helpful. Over 50 percent said educational materials and letters and training and education were very helpful.

ENC Correspondence

Name of Case Manager

Approximately 11 percent of respondents could recall the name of their child's case manager (see Exhibit 10-17 below).

Exhibit 10-17: Identified the Name of Case Manager



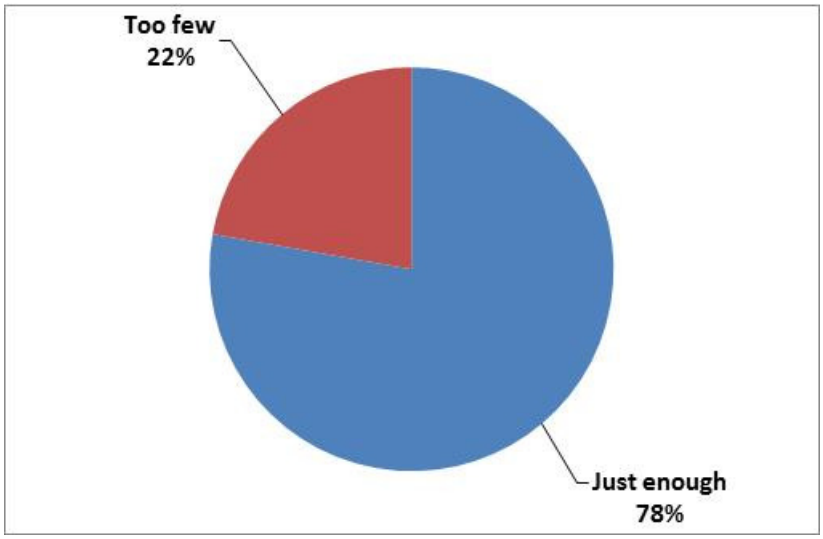
Number of Times Spoke with Case Manager

On average, respondents spoke with their child's case manager 1.3 times since they started the Synagis program.

Rating of Case Manager Contacts

Seventy-eight percent of respondents felt the number of times their child's case manager contacted them was just enough (see Exhibit 10-18 below).

Exhibit 10-18: Rating of Case Manager Contacts



Member Calls to Case Manager

All respondents denied ever having called their child's case manager.

ENC Activities

Case managers are expected to help build self-management skills so that moms/parents can render the appropriate care for their children enrolled in the Synagis program. Nearly 80 percent of respondents indicated that their child's case manager asked questions about their child's health or their concerns. One-third said their child's case manager answered questions about their child's health care needs. Over 55 percent were provided help in making and keeping health care appointments for their children (see Exhibit 10-19 on the following page).

Exhibit 10-19: Case Manager Activity Ratings

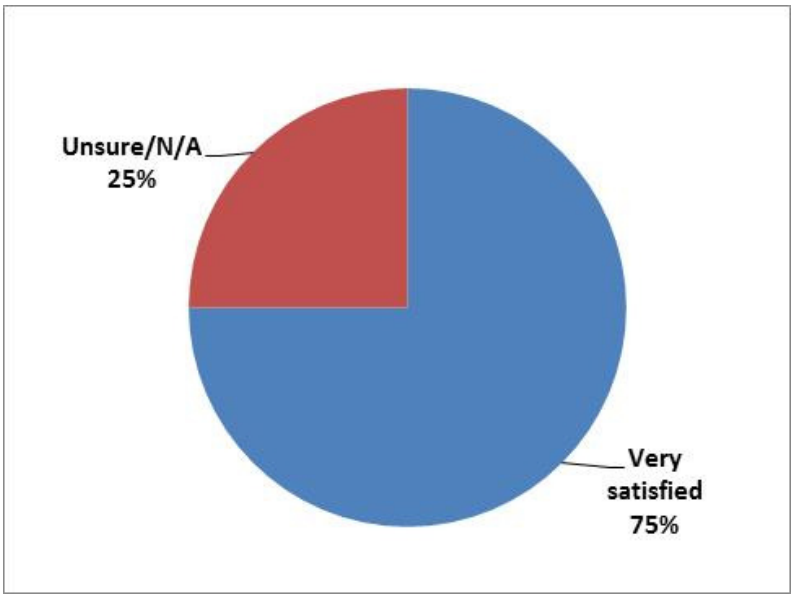
Activity		Respondents answering "yes" to the activity				
	Yes	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Unsure/N/A
Asked questions about your child's health or your concerns	**77.8%**	77.8%	0.0%	0.0%	0.0%	22.2%
Provided instructions about taking care of your child's health	**44.4%**	66.7%	0.0%	0.0%	0.0%	33.3%
Helped you to identify changes in your child's health that might be an early sign of a problem	**12.5%**	11.1%	0.0%	0.0%	0.0%	88.9%
Answered questions about your child's health care needs	**66.7%**	66.7%	0.0%	0.0%	0.0%	33.3%
Helped you to make and keep health care appointments for medical problems	**55.6%**	55.6%	0.0%	0.0%	0.0%	44.4%
Referred you to programs and services	**33.3%**	33.3%	0.0%	0.0%	0.0%	66.7%

Respondents were asked to rate their satisfaction with each "yes" activity. Nearly 80 percent were very satisfied when the case manager asked questions about their child's health or concerns. One-third said they were very satisfied with the instructions they received about taking care of their child's health as well as how the case manager answered questions about their child's health care needs. Over 55 percent said they were very satisfied with the help in making and keeping health care appointments for their children.

Satisfaction with ENC and Synagis Program

Overall, 75 percent of respondents were very satisfied with the help they received from their child's case manager (see Exhibit 10-20 on the following page).

Exhibit 10-20: Overall Satisfaction with Case Manager



One hundred percent of respondents were very satisfied with Synagis program.

One hundred percent of respondents would recommend the Synagis program to a friend with similar health care needs.

FETAL INFANT MORTALITY REDUCTION (FIMR) BABY PROGRAM INTRODUCTION AND PROGRAM OVERVIEW

FIMR Baby Program Objective

The FIMR Baby case management program provides case management services to all children born to mothers in FIMR counties with the highest fetal Infant Mortality Rates (IMRs). The goal of the FIMR Baby Program is to ensure the child has a healthy start and access to resources in FIMR counties. The program was implemented on August 24, 2011.

Program History and Overview

After a viable delivery, all children who are born to mothers in FIMR counties receive care management services. During this time, the mother is educated about the postpartum phase and the child's first year of life. The ENC provides regular follow-up with the new parent to ensure that her newborn has been enrolled in SoonerCare and that a primary care provider (PCP) has been selected for this new SoonerCare member.

As stated earlier, the FIMR Baby phase was implemented in August 2011. The OHCA's desired goal it to positively affect the poor infant outcomes in the target counties by ensuring adequate prenatal care.

In August 2012, a program refinement was made to the FIMR Baby Program. The PCM Department implemented an extension of care management services to any child who has ongoing medical problems at the time of his/her first birthday. If an ENC identifies a need based on the child's medical status during the 12-month follow-up call, he/she will leave the case open and continue to provide case management as long as the need is present.

The average caseload in the FIMR Baby Program is approximately 1,600-1,800 members at any given point in time. There are approximately 200 new members enrolled in the program each month.

Program Eligibility

Newborns of FIMR moms who reside in one of the ten FIMR counties are automatically enrolled into FIMR Baby case management program.

FIMR Baby Program Process

The identification of a FIMR baby is performed on a daily basis. A report is generated for all new moms and babies by the OHCA Data Warehouse. From there, an automated report is generated in Atlantes of all new FIMR babies.

The FIMR baby is assigned to the same ENC as the FIMR mom. The ENC then sends a FIMR Baby Introduction Letter to the member in Atlantes, which counts as the "first contact." The ENC ensures that the child is automatically enrolled in SoonerCare and that his/her mother has chosen a provider to care for the child. The ENC also ensures that the member's mother is taking him/her to see that provider for Well-Child Checks, as well as immunizations.

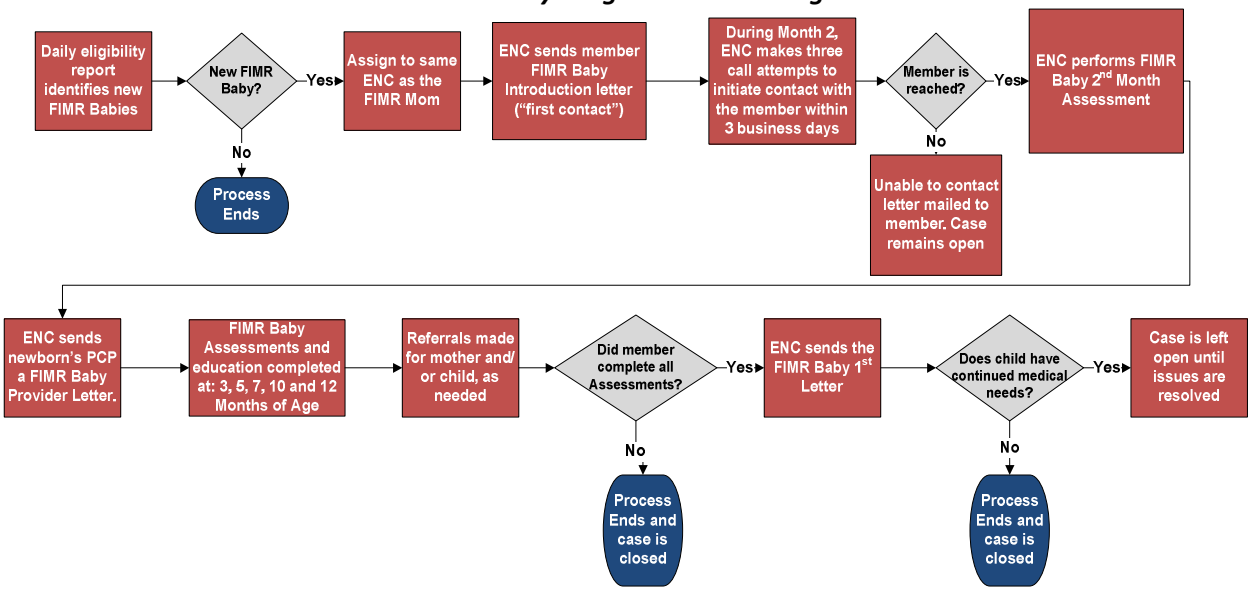
There are six FIMR Baby assessments that need to be completed at the appropriate month of the child's life: Two Months, Three Months, Five Months, Seven Months, Ten Months, and 12 Months. During these follow-up calls, the ENC continues educational discussions with the mother that include important health-related topics, such as safe sleep, tobacco use in the home, immunizations and well-child visits, and referrals to other programs. The ENC also sends the newborn's PCP a FIMR Baby Provider Letter.

The ENC conducts a postpartum EPDS on the new mother within two weeks of delivery. If the screen is positive, the ENC makes a referral to the BHU, upon member consent, for appropriate follow-up. If additional or specialty services are indicated, the ENC assists with coordination to ensure timely access.

If the ENC is able to complete the entire year of assessments with the child's mother, the ENC sends the FIMR Baby 1st Birthday Letter. If the child has medical needs extending beyond his/her first birthday, the ENC will leave the case open and continue to provide care management as long as the need is present.

Exhibit 11-1 on the following page provides an overview of the FIMR Baby case management process.

Exhibit 11-1 – FIMR Baby Program Case Management Process



FIMR BABY PROGRAM FINDINGS

Methodology

PHPG obtained two datasets from the OHCA to conduct the analysis, data from Atlantes and claims and eligibility data. FIMR Baby member records were extracted from Atlantes for the period of August 24, 2011 (SFY 2012), through June 30, 2013 (SFY 2013). Claims and eligibility data were pulled for dates of services in SFY 2012 through 2013.

The Atlantes dataset was treated as the authority for identifying FIMR Baby members. The dataset was "cleaned" to ensure a member was accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates), as well as removing member records that had null end dates. Thus, only members who completed a case management cycle were included in this analysis. Members who had been enrolled in the program less than one week were also removed. Thus, only members who had actively engaged in the program for more than one week were included in the analysis.

Member surveys were administered via telephone to a sample of obstetric and pediatric members, including FIMR Baby members. Prior to conducting the survey, a letter was mailed to all members informing them of the survey and what to expect.

Survey results were entered into a proprietary database and then analyzed on a per-program basis. A total of 57 FIMR Baby member surveys were collected. Findings for the FIMR Baby survey interviews are reported in the FIMR Baby Member Survey section.

Results

The following program enrollment and ENC activities were analyzed for the FIMR Baby program by using the Atlantes dataset:

- Total enrolled in the FIMR Baby program by SFY;
- Breakdown of FIMR Baby participants by county geography (i.e., rural, urban, suburban, mixed, out of state);
- FIMR Baby enrollment in FIMR and Non-FIMR counties;
- Total FIMR Baby participants by age range;
- Average length of time in program;
- Percentage of members contacted within three business days of receiving a referral to the FIMR Baby program by SFY;
- Total number of contact attempts per member per SFY;
- ENC time spent per enrollee by SFY;
- Total ENC FTE time per SFY; and
- Total number of FIMR Baby letters sent per enrollee by SFY.

The following utilization and cost measures were evaluated for the FIMR Baby program by using claims and eligibility data:

- Early gestation and low birth weight percentages of FIMR Baby deliveries by SFY;
- Neonatal Intensive Care Unit (NICU) admissions in the FIMR Baby sample by SFY;
- Well-Child and Immunization visit rates in the FIMR Baby sample by SFY;
- Hospital admissions during the first year of life by SFY;
- Emergency Room visits during the first year of life by SFY; and
- Summary of expenditures for FIMR Baby participants by SFY.

The following member survey metrics were evaluated for the FIMR Baby program by using results from the FIMR Baby member surveys:

- Survey demographics (e.g., member age, ethnicity, education level);
- Services received through FIMR Baby and their helpfulness;
- ENC correspondence;
- ENC activities and member satisfaction rates; and
- Overall member satisfaction with the assigned ENC and the FIMR Baby program.

Analysis of FIMR Baby Enrollment and ENC Activities

This section describes FIMR Baby program enrollment and ENC activities by SFY using Atlantes data.

Total Enrollment

Exhibit 11-2 below summarizes total FIMR baby enrollment from SFY 2012 through SFY 2013. Total enrolled by SFY was calculated based on a member's having a level-of-care start date in that fiscal year. Enrollment remained fairly constant between SFY 2012 and SFY 2013, with only an 11.5 percent decline.

Exhibit 11-2: FIMR Baby Enrollment by State Fiscal Year

SFY	Members
2012	1,625
2013	1,438
Total	**3,063**

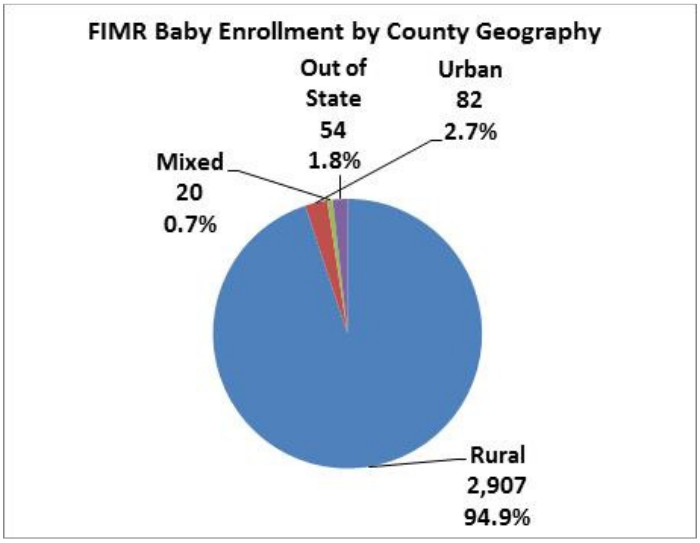
Enrollment by County Geography

All ten FIMR counties are classified as rural counties. While 94.9 percent of FIMR Baby members resided in rural counties, 88 percent of them resided in one of the FIMR rural counties, with another 12 percent residing in non-FIMR rural counties. PHPG identified members with a FIMR Baby level of care that had a county of record other than the ten FIMR counties, including mixed, urban, and out of state.

The OHCA reviewed a sample of FIMR mom member records and confirmed that these members moved from a FIMR to a non-FIMR county or out of state sometime after their case record was opened in Atlantes. When this occurs, the PCM Department generally leaves the case open and continues to case manage the FIMR Baby. However, in the instance of an out-of-state move, this generally results in loss of SoonerCare benefits, and the case would subsequently close.

Exhibit 11-3 on the following page summarizes the breakdown of FIMR Baby enrollment by county geography from SFY 2012 through SFY 2013.

Exhibit 11-3: FIMR Baby Enrollment by County Geography



FIMR Baby Enrollment in FIMR and Non-FIMR Counties

Exhibit 11-4 below highlights the breakdown of FIMR Baby enrollment in FIMR counties, as well as FIMR enrollment in non-FIMR counties and out of state from SFY 2012 through SFY 2013.

Exhibit 11-4: FIMR Baby Enrollment Breakdown in FIMR and Non-FIMR Counties

County	Total Members 2012-2013	Percent of FIMR Enrollment
Garfield	914	29.8%
Jackson	377	12.3%
Lincoln	371	12.1%
Choctaw	246	8.0%
McIntosh	218	7.1%
Atoka	173	5.6%
Latimer	142	4.6%
Tillman	111	3.6%
Greer	81	2.6%
Coal	62	2.0%
Enrollment in Non-FIMR Counties and Out of State	368	
Grand Total	**3,063**	

Age Range of FIMR Baby members

The vast majority fell into the age range of 0-4 weeks from SFY 2012 through SFY 2013 (see Exhibit 11-5 below). This is in line with program enrollment, which begins once a FIMR mom has a viable delivery.

Exhibit 11-5: FIMR Baby Enrollment by Age Range

Age Range	# Members	% Members
0-4 weeks	2,943	96.1%
5-8 weeks	108	3.5%
9-12 weeks	2	0.1%
13 weeks or Greater	10	0.3%

Length of Stay

Exhibit 11-6 below summarizes the average length of stay from SFY 2012 through SFY 2013. Seventy-eight percent of FIMR Baby members were enrolled ten to twelve months in duration. The length of time in the program aligns with the goal of providing case management services through the first year of life.

Exhibit 11-6: FIMR Baby Length of Stay

Length of Stay (weeks)	Duration Classification	# Members	% Members
1-4	Three or Fewer Months	24	0.8%
5-8		81	2.6%
9-12		77	2.5%
	Total	***182***	**5.9%**
13-16	Four to Six Months	45	1.5%
17-20		45	1.5%
21-24		56	1.8%
	Total	***146***	**4.8%**
25-28	Seven to Nine Months	37	1.2%
29-32		59	1.9%
33-36		10	0.3%
	Total	***106***	**3.5%**
37-40	Ten to Twelve Months	21	0.7%
41-44		93	3.0%
45-48		116	3.8%
49-52		2,163	70.6%
	Total	***2,393***	**78.1%**
53+	More than One Year	236	7.7%
	Total	***236***	**7.5%**

ENC Activity Time

Initial Member Outreach

Once a member is assigned to an ENC, the ENC makes an initial telephone contact within three business days of receiving the referral. Three attempts are made on three different days at different times to contact the member via telephone.

To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes FIMR Baby Activity Report. The review was limited to only those cases where the data indicated that an ENC performed activities related to FIMR Baby.

Exhibit 11-7 below highlights member contact rates within three business days from SFY 2012 through SFY 2013. Compliance rates for contacting members within three business days exceeded 80 percent across both SFYs.

Exhibit 11-7: FIMR Baby Contact Rates within Three Business Days

Member Contact Rates within Three Business Days-	SFY2012	SFY2013
Members Contacted within Three Business Days	1,319	1,182
Total FIMR Baby Enrollment	1,625	1,438
Contact Rate	**81.2%**	**82.2%**

Total Contacts

All contacts for members in the FIMR Baby program are documented in Atlantes. To determine the number of contacts, a count was performed of all activity actions contained in the Atlantes Synagis Activity Report. Time spent performing member activities had to more than five minutes in duration.

Exhibit 11-8 on the following page contains the average number of contacts per member for SFY 2012 and SFY 2013. ENCs averaged 8.0 to 9.6 contacts per member across the two fiscal years. There was a 17 percent decline in contact attempts made from SFY 2012 to SFY 2013. The decline may have resulted from the PCM Department's implementation of additional case management programs, and, as a result, staff caseloads increased. It should be noted that contact attempts are sometimes relaxed in times of staffing crises. The average number of member contacts across both SFYs was 8.7 contacts per member.

Exhibit 11-8: FIMR Baby Total Contact Attempts per Member

	SFY2012	SFY2013
Count of Contacts	1,625	1,438
Total FIMR Baby Enrollment	15,642	11,477
Total Contacts Per Member	**9.6**	**8.0**

ENC Time Spent Managing Enrollees

The FIMR baby is assigned to the same ENC as the FIMR mom. To assess the time spent by ENCs for the FIMR Baby program, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to newborns who were assigned to FIMR Baby.

In each fiscal year, a large majority of ENC time has been dedicated to assessments, ongoing member correspondence and care management for enrolled members, and provider outreach. These activities are consistent with the primary functions of ENCs.

From SFY 2012 through 2013, ENCs spent an average of 2.2 to 2.8 hours per case across all activities. Average ENC hours per case and equivalent FTEs decreased from SFY 2012 to SFY 2013. The decrease may be attributed to the widening scope and volume of ENC duties and subsequent contact standard adjustments during times of staffing crises. In total, the FTEs required for the FIMR baby program ranged from 1.6 to 2.2 FTEs (see Exhibit 11-9).

Exhibit 11-9: FIMR Baby Time per Member and ENC FTE Time

	SFY2012	SFY2013
Total Members	1,625	1,438
Sum of FIMR Baby Activity (Hours)	4,620.7	3,233.9
ENC Time Per Enrolled Member (Hours)	**2.8**	**2.2**
Total ENC FTE Time	**2.2**	**1.6**

<u>FIMR Baby Letters</u>

ENCs generate and mail a number of letters to members and providers for the FIMR Baby program, including but not limited to, introductory letters, unable-to-contact letters, provider notification, and case closure letters. An analysis was performed for the number of FIMR Baby letters sent by SFY. From SFY 2012 through 2013, ENCs mailed an average 5.0 to 5.4 letters per member (see Exhibit 11-10 on the following page). There was an increase (8 percent) in letter generation from SFY 2012 to SFY 2013.

Exhibit 11-10: FIMR Baby Letters Sent by State Fiscal Year

	SFY2012	SFY2013
Total Letters Sent	8,200	7,722
Total FIMR Baby Enrollment	1,625	1,438
Total Letters Per Member	**5.0**	**5.4**

Utilization and Cost Outcomes

This section highlights the FIMR Baby utilization and cost trends by SFY using claims and eligibility data for dates of services in SFY 2012 through 2013. It should be noted that exhibits are presented based on date/SFY of the delivery and not the actual claims incurred during each SFY.

Early Gestation/Low Birth Weight

Early gestation and low birth weight diagnosis codes were evaluated separately. The two populations were essentially the same. For the vast majority of cases, pre-term deliveries were coded as both early gestation and low birth weight. Therefore, a combined rate was calculated based on the number of participants with these codes out of the total number of identifiable deliveries.

The two-year average rate of early gestation and low birth weight deliveries was 13.5 percent. From SFY 2012 through SFY 2013, the percentage of early gestation and low birth weight deliveries increased by 9.9 percent. (see Exhibit 11-11 below).

Exhibit 11-11: Percentage of Early Gestation and Low Birth Weight Deliveries FIMR Baby Participants

	State Fiscal Year		Total
	2012	2013	
Participants	1,554	2,909	1,912
Deliveries Identified	334	318	652
Participants Early Gestation/Low Birth Weight	43	45	88
Percent of Early Gestation/Low Birth Weight Deliveries	**12.9%**	**14.2%**	**13.5%**

Neonatal Intensive Care Unit Admissions

On average, 2.3 percent of FIMR Baby deliveries resulted in a NICU admission (see Exhibit 11-12 on the following page). NICU rates are highly correlated to the percent of early gestation/low birth weight deliveries. Therefore, continued efforts should be made to improve early access to prenatal care and to educate mothers in a timely manner.

Exhibit 11-12: Percentage of NICU Admissions among FIMR Baby Participants

	State Fiscal Year		Total
	2012	2013	
Participants	1,554	2,909	1,912
Deliveries Paired with Child in Claims	334	318	652
NICU Cases	8	7	15
Percent of Deliveries Admitted to NICU	**2.4%**	**2.2%**	**2.3%**

Utilization Rates

For FIMR Baby, inpatient admissions declined between SFY 2012 and SFY 2013, which is likely attributable to the decline in NICU cases over this same time period. Inpatient admissions per 1,000 averaged 145.61 per member. ER visits per 1,000 declined nearly 15 percent from SFY 2012 and SFY 2013. ER visits per 1,000 averaged 1,246 per 1,000 over the two-year term (see Exhibit 11-13 below).

Exhibit 11-13: FIMR Baby Utilization

	State Fiscal Year		Total
	2012	2013	
Participants	1,554	2,909	1,912
IP Admissions Total	266	180	446
IP Admissions per 1,000	**163.69**	**125.17**	**145.61**
ER Visits Total	2,058	1,758	3,816
ER Visits per 1,000	**1,266.46**	**1,222.53**	**1,245.84**

Well-Child Visit Rates

FIMR Baby well-child immunization rates were evaluated for the duration of time that participants were in the program. PHPG was able to analyze immunization rates at the two-, three-, five-, seven-, ten-, and 12-month intervals (see Exhibit 11-14 on the following page). Two-month rates were most favorable and averaged 87.8 percent over the two-year period. Compliance rates at other intervals ranged from 46.0 to 53.8 percent with the exception of the 12-month rate, which averaged only 13 percent. Continued education and outreach is needed to stress the importance of well-child visits for FIMR Baby participants.

Exhibit 11-14: FIMR Baby Well-Child Visits

	State Fiscal Year		Total
	2012	2013	
Participants	1,554	2,909	1,912
Rate			
2-months	93.4%	82.4%	87.8%
3-months	48.5%	43.6%	46.0%
5-months	58.3%	49.5%	53.8%
7-months	51.9%	46.5%	49.2%
10-months	53.6%	47.0%	50.3%
12-months	14.6%	11.3%	13.0%
Denominator			
2-months	1,954	2,052	4,006
3-months	1,942	2,035	3,977
5-months	1,834	1,911	3,745
7-months	1,801	1,805	3,606
10-months	1,754	1,708	3,462
12-months	1,714	1,610	3,324
Numerator			
2-months	1,826	1,690	3,516
3-months	942	887	1,829
5-months	1,069	945	2,014
7-months	934	839	1,773
10-months	941	802	1,743
12-months	250	182	432

Immunization Rates

The OHCA supplied PHPG with the 2015 Recommended Immunization Schedule. PHPG pulled claims for those members enrolled in FIMR Baby who had received the recommended doses during the first year of life. Exhibit 11-15 on the following page highlights compliance rates for seven immunizations that were administered within the first year of life to FIMR Baby participants. Compliance rates for four immunizations (DTaP, Hepatitis B, IPV, and Pneumococcal Conjugate) were nearly 60 percent; rotavirus compliance rate was 48.9 percent, while the influenza vaccine only had a 10.4 percent compliance rate.

Exhibit 11-15: FIMR Baby Immunization Rates

	State Fiscal Year		Total
	2012	2013	
Participants	1,554	2,909	1,912
Rate			
DTaP	57.6%	59.3%	58.4%
Hepatitis B	57.4%	58.4%	57.9%
HiB	54.6%	47.7%	51.3%
Influenza	11.7%	9.1%	10.4%
IPV	57.4%	59.4%	58.3%
Pneumococcal Conjugate	56.7%	58.8%	57.7%
Rotavirus	46.8%	51.1%	48.9%
Denominator			
12-months	1,714	1,610	3,324
Numerator			
DTaP	988	954	1,942
Hepatitis B	983	941	1,924
HiB	936	768	1,704
Influenza	200	146	346
IPV	983	956	1,939
Pneumococcal Conjugate	972	946	1,918
Rotavirus	803	823	1,626

Summary of Expenditures

Total FIMR Baby expenditures decreased from SFY 2012 through SFY 2013 by 7 percent. PMPM expenditures decreased over the same time period. Total FIMR Baby expenditures were $6.5 million, and average PMPM expenditures were $229 (see Exhibit 11-16 on the following page). A large portion of the expenditures was likely related to the high costs of the NICU admissions.

Exhibit 11-16: FIMR Baby Total Expenditures and PMPM Expenditures

	State Fiscal Year		Total
	2012	2013	
Participants	1,554	2,909	1,912
Participation Months	8,168	20,185	28,353
Total Expenditures	**$3,362,807**	**$3,138,614**	**$6,501,421**
PMPM Expenditures	**$411.71**	**$155.49**	**$229.30**

FIMR Baby Member Survey Findings

This section describes key findings from the FIMR Baby member survey using data collected from 57 survey interviews.

FIMR Baby Program Services

There is a select set of services available to children in the FIMR Baby program. The vast majority of respondents (94.7 percent) received phone calls from their child's case manager. Seventy-five percent received assessments. Over 60 percent said they received training and education, while over 50 percent received educational materials for their child (see Exhibit 11-17 below).

Exhibit 11-17: FIMR Baby Program Services

Service		Respondents answering "yes" to the service				
	Yes	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Unsure/ N/A
Assessments	75.4%	64.9%	14.0%	3.5%	14.0%	17.5%
Training and Education	62.5%	56.1%	10.5%	1.8%	0.0%	31.6%
Educational Materials	50.9%	43.9%	5.3%	1.8%	0.0%	49.1%
Postpartum Depression Screening	45.6%	31.6%	7.0%	1.8%	1.8%	57.9%
Referrals to Programs and Services	42.1%	31.6%	12.3%	0.0%	0.0%	56.1%
Appointment Scheduling	25.0%	22.8%	3.5%	0.0%	1.8%	1.8%
Family Planning	52.6%	33.3%	15.8%	1.8%	1.8%	47.4%
Monthly Phone Calls	94.7%	73.7%	17.5%	0.0%	1.8%	7.0%

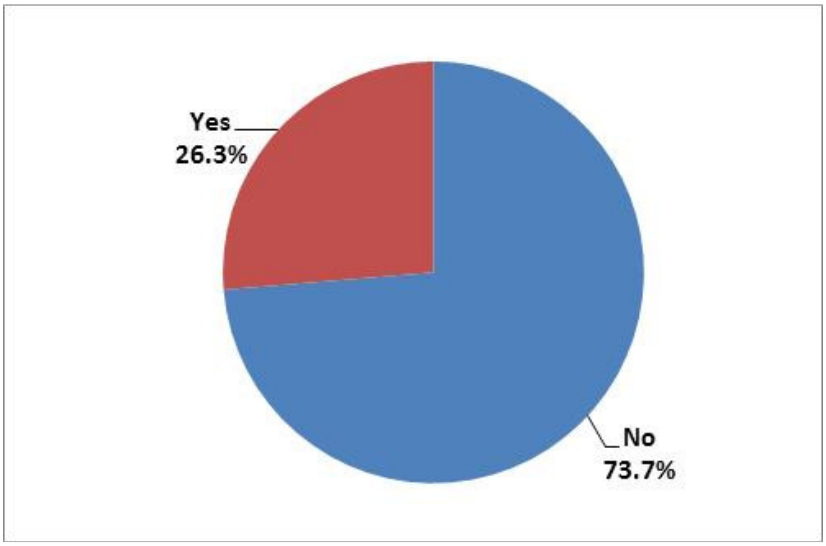
Respondents were asked to rate the helpfulness of each "yes" service. Over 70 percent reported the monthly follow-up phone calls placed by their child's case manager were very helpful. Nearly 65 percent said the assessments were very helpful. Over 55 percent of respondents felt the training and education were very helpful.

ENC Correspondence

Name of Case Manager

Twenty-six percent of respondents could recall the name of their child's case manager (see Exhibit 11-18 below).

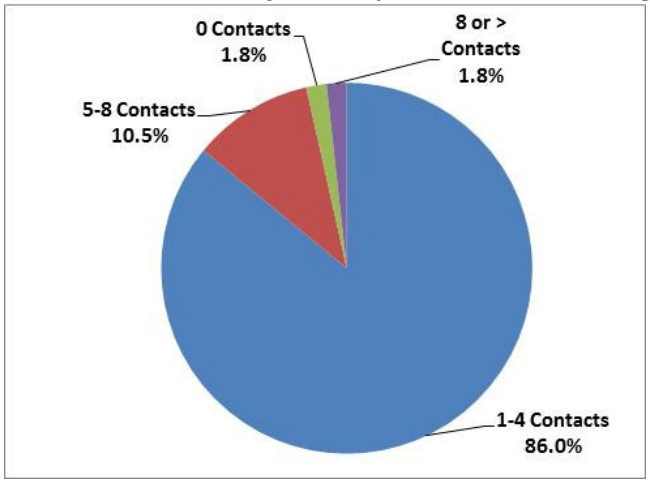
Exhibit 11-18: Identified the Name of Case Manager



Number of Times Spoke with Case Manager

Eighty-six percent of respondents said they spoke with their case manager between one and four times since they started the program (see Exhibit 11-19 below). Eleven percent reported 5-8 contacts.

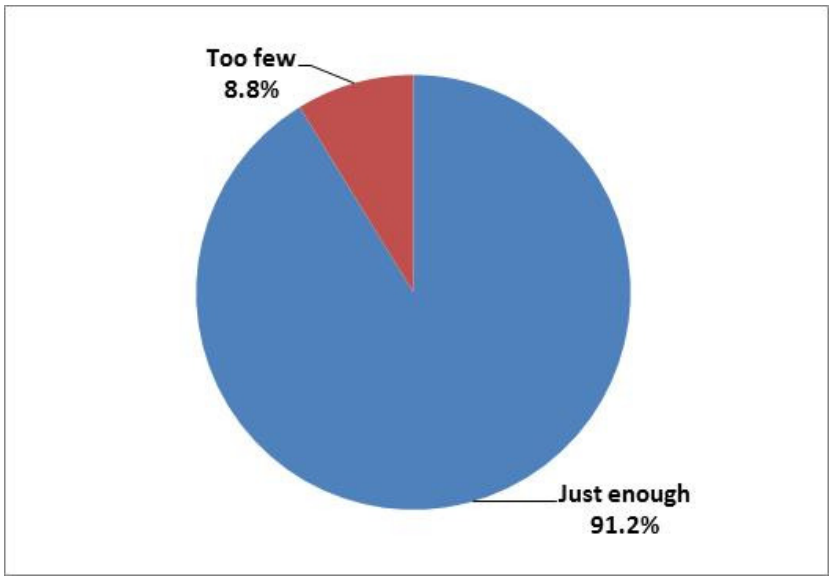
Exhibit 11-19: Number of Times Spoke with Case Manager



Rating of Case Manager Contacts

The vast majority of respondents (91.2 percent) felt the number of times their child's case manager contacted them was just enough (see Exhibit 11-20 below).

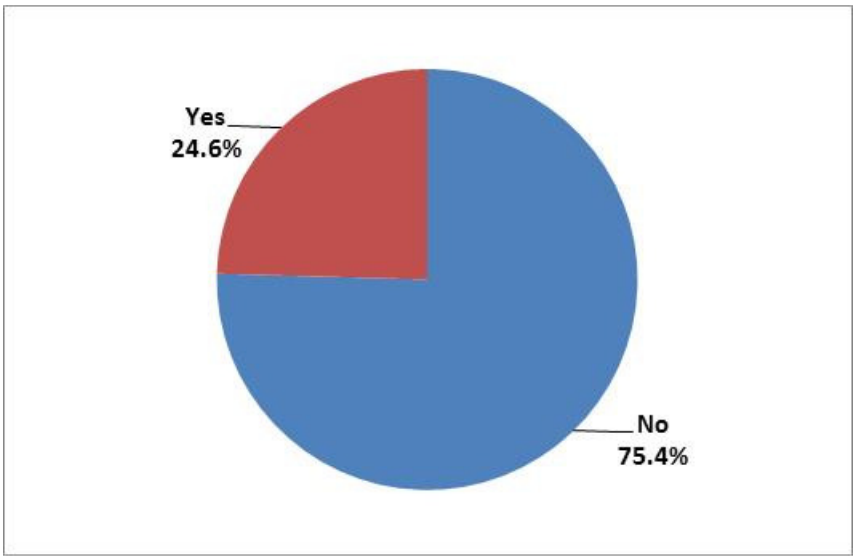
Exhibit 11-20: Rating of Case Manager Contacts



Member Calls to Case Manager

Nearly 25 percent of respondents said they had called their case manager (see Exhibit 11-21 below).

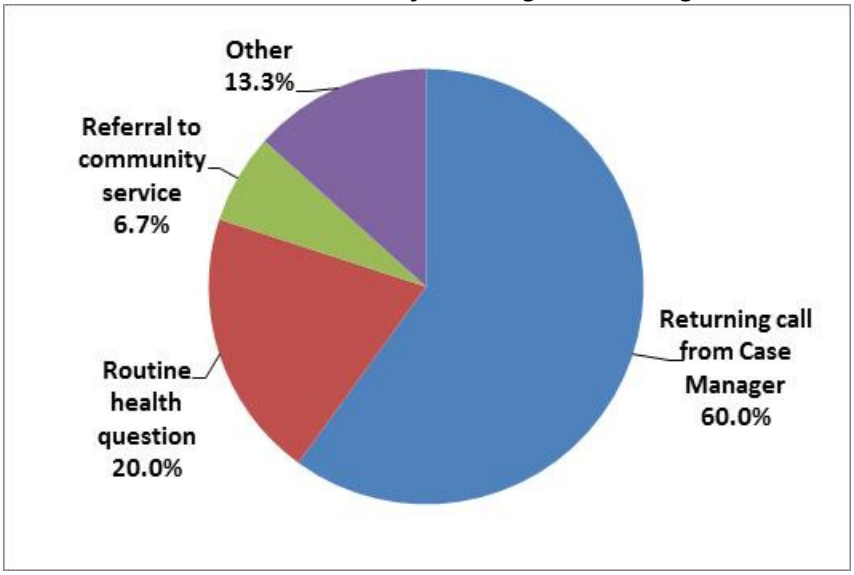
Exhibit 11-21: Have Called Their Case Manager



Reason for Calling Case Manager

Of the respondents that called their case manager, 60 percent said they were returning phone calls from their case manager. Twenty percent called with a routine health question about their child (see Exhibit-11-22 below).

Exhibit 11-22: Reasons for Calling Case Manager



ENC Activities

Case managers are expected to help build self-management skills so that moms/parents can render the appropriate care to their children enrolled in the FIMR Baby program. Nearly all respondents (98.2 percent) indicated that their child's case manager asked questions about their child's health or their concerns. Over 87 percent said their child's case manager provided instructions about taking care of their child's health. Eighty-three percent reported the case manager answered questions about their child's health care needs (see Exhibit 11-23 on the following page).

Exhibit 11-23: Case Manager Activity Ratings

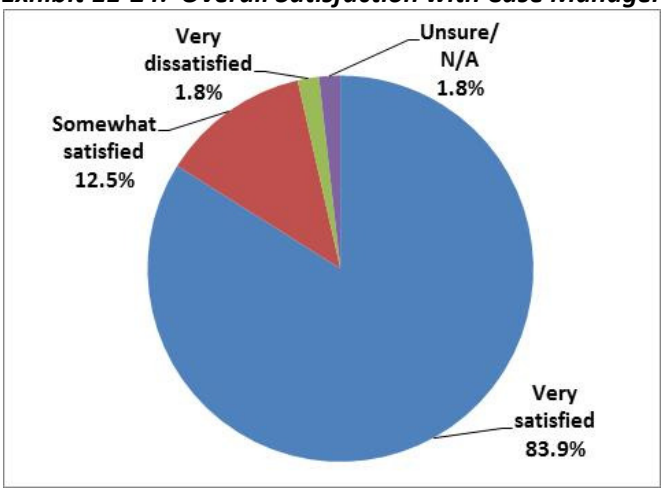
Activity		Respondents Answering "Yes" to the Service				
	Yes	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Unsure/N/A
Asked questions about your child's health or your concerns	**98.2%**	84.2%	12.3%	0.0%	1.8%	1.8%
Provided instructions about taking care of your child's health	**87.7%**	80.7%	7.0%	0.0%	0.0%	12.3%
Helped you to identify changes in your child's health that might be an early sign of a problem	**17.5%**	19.3%	1.8%	0.0%	0.0%	78.9%
Answered questions about your child's health care needs	**82.5%**	77.2%	5.3%	0.0%	0.0%	17.5%
Helped you to make and keep health care appointments for medical problems	**33.3%**	33.3%	0.0%	0.0%	0.0%	66.7%
Referred you to programs and services	**47.4%**	43.9%	3.5%	0.0%	0.0%	52.6%

Respondents were asked to rate their satisfaction with each "yes" activity. Eighty-four percent were very satisfied when the case manager asked questions about their child's health or concerns. Over 80 percent were very satisfied with the instructions they received about taking care of their child's health. Seventy-seven percent were very satisfied that the case manager answered questions about their child's health care needs.

Satisfaction with ENC and FIMR Baby Program

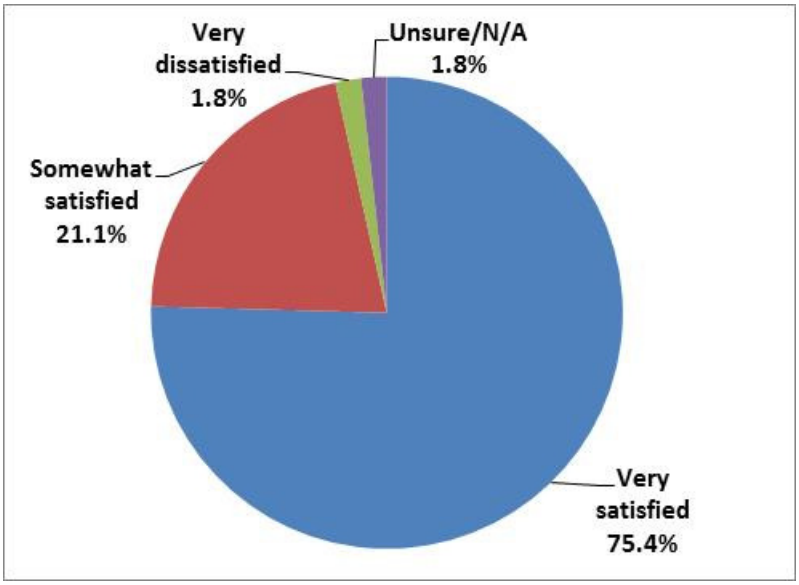
Overall, 84 percent of respondents were very satisfied with the help they received from their child's case manager (see Exhibit 11-24 below).

Exhibit 11-24: Overall Satisfaction with Case Manager



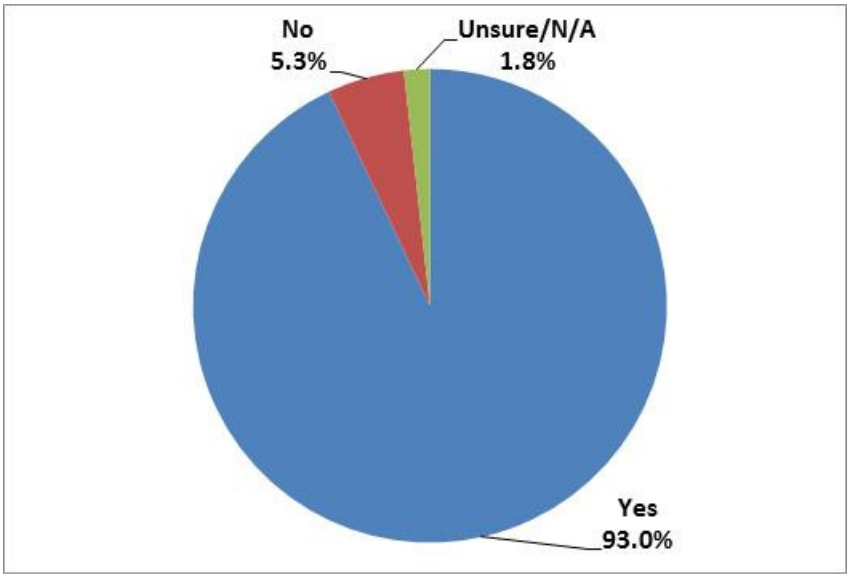
Seventy-five percent of respondents were very satisfied with FIMR Baby program (see Exhibit 11-25 below).

Exhibit 11-25: Overall Satisfaction with FIMR Baby Program



The vast majority of respondents (93 percent) would recommend the FIMR Baby program to a friend with similar health care needs (see Exhibit 11-26 below).

Exhibit 11-26: Would Recommend FIMR Baby Program



OBSTETRICAL AND PEDIATRIC PROGRAMS - CONCLUSIONS AND FUTURE CONSIDERATIONS

OB Programs

The OHCA's PCM Department offers four OB case management programs to SoonerCare women. The primary distinction among these programs is member eligibility. A member must have a positive OB screening to qualify for the AROB program. To be eligible for HROB, a member must be screened by an MFM and meet clinical criteria for the high-risk definition. For FIMR Mom, a member must reside in a designated FIMR county (defined as those counties with the highest infant mortality rates). Finally, for ICC, a member must reside in a FIMR county and be 18 years of age or younger.

An analysis of enrollment in the OB programs revealed that enrollment counts vary by program with the bulk of members enrolled in HROB, followed by FIMR Mom, then AROB, and finally ICC, which is a unique program since it is offered to a pre-determined age cohort. On average, members enrolled in these programs have a length of stay that is three months or less. Most participants are between 21 and 24 years of age, are Caucasian, and reside in a combination of rural and urban Oklahoma counties (with the exception of FIMR and ICC programs that operate in select counties).

An evaluation of ENC activities using Atlantes data indicated a downward trend in the some of the process measures that PHPG evaluated, including reach rates for member calls within three business days, the number of attempts to contact members, ENC hours per case and FTE time, and the amount of correspondence mailed to members. PHPG participated in interviews with representatives of the PCM Department to identify the etiology behind some of these trends. In doing so, a number of factors were identified by the OHCA that warrant mention.

The PCM Department experienced a large influx of new members in SFY 2011 with the addition of the FIMR Mom and FIMR Baby programs. Thousands of new members were onboarded for these case management programs, though staffing did not keep pace with the demand. Specifically, two FTEs were added for these programs, but they also had responsibilities to the long-term care waiver programs. With a maximum caseload of 150 members, the two FTEs were not sufficient to keep up with FIMR caseload demand.

There was significant staff turnover in the PCM Department in SFY 2013. The OHCA added nursing positions in other work units with clinical functions. Several PCM-trained staff with the skills and background to fulfill these duties applied for and were awarded these higher-grade positions. As a result of the PCM Department operating with fewer staff, the standards outlined in the desktop procedures had to be relaxed to meet member demand. For example, instead of three initial attempts to reach members via telephone, at times there were two attempts and then a grace period until the third

attempt was made. This enabled the PCM Department to maintain its basic level of service during these staff fluctuations.

When new ENCs are hired to fill the gaps, they are generally entry-level registered nurses (RNs) who came from a hospital or another care delivery setting. The RNs therefore require an extensive amount of training on Medicaid, case management, PCM Department operational protocols and processes, the Atlantes clinical system, member assessments, member populations, and motivational interviewing, to name a few. The training takes a significant amount of time before the ENC can perform duties independently.

The OHCA provided feedback on member behaviors related to ENC outreach. A good portion of members are difficult to reach by telephone, since the Medicaid population in general is a challenging audience to reach. Additionally, a number of members refuse the ENC telephone calls and/or do not have time to take the call(s). Feedback is often received indicating a member's lack of desire to have a second assessment. As it relates to FIMR, Garfield County has a substantial number of Marshallese-speaking members. They have a number of dialects, but the OHCA's language line is only able to accommodate one dialect, which results in a language barrier for some members. It should be noted that caregivers do not always call on behalf of members in these circumstances.

A review of OB outcomes, utilization, and expenditures was performed via a claims analysis for each program for which findings are noted throughout the report. In summary, early gestation and low birth weight deliveries rates ranged from 19.8 to 24 percent of program members, depending on the program. NICU admission rates ranged from two percent to 17.4 percent of program members. The percent of vaginal deliveries ranged from 88.0 to 92 percent; the bottom of the range was comprised of HROB members. The percent of HROB members who received pre-term labor pharmaceuticals was fairly low with an average of 0.8 to 2.7 percent over the four-year period.

Inpatient admissions for the mother at 30 days ranged from 1.4 to 3.2 percent compared to 1.9 to 3.7 percent at 60 days. ER visits for the mother at 30 days ranged from 8.6 to 16 percent compared to 12.5 to 20 percent at 60 days. Inpatient admissions per 1,000 children during the first year of life ranged from 146 to 1,934.91. ER visits per 1,000 children during the first year of life ranged from 957 to 1,634.

For programs where the participant was a mother, some measures could be calculated by analyzing only the participant's claims history. For other measures (e.g., percentage of deliveries admitted to the NICU), the analysis required a review of the child's claims history, as certain procedure and diagnosis codes are billed under the child's recipient ID (RID) number, rather than the mother's. This required a pairing exercise that was discussed previously in the report. As a result, total expenditures were calculated for paired deliveries only and are highlighted in Exhibit 12-1 on the following page.

Exhibit 12-1: PCM Department OB Programs Total Expenditures and Expenditures per Case

Measure	PCM Department OB Program				Total
	HROB	AROB	FIMR Mom*	ICC	
Total expenditures (paired deliveries only)					
Mother	$30,021,154	$3,793,342	$8,127,793	$303,176	**$42,245,465**
Child	$27,404,316	$5,094,197	-	$396,500	**$32,895,013**
				Total	**$75,140,478**
Expenditures per Case (paired deliveries only)					
Mother	$11,294.64	$9,207.14	$4,566.18	$12,127.06	**$37,195.02**
Child	$10,310.13	$12,364.56	-	$15,860.00	**$38,534.69**
				Total	**$75,729.71**

- *Expenditures for FIMR Mom are contained within the FIMR Baby program analysis and not FIMR Mom*

A review of member survey data showed high levels of satisfaction with the OB case management programs and with the ENCs. In fact, the overwhelming majority of respondents would recommend the case management programs to a friend with similar health care needs.

The enhanced benefit package was the most attractive service to HROB members. For AROB members, monthly phone calls, assessments, and referrals to programs and services were very helpful. FIMR members reported monthly phone calls, assessments, training and education, and home visitation services were very helpful. As it relates to the ICC program, training and education, as well as assessments, were the most desirable program services.

Very few members called their assigned ENCs; rather, the expectation is that the ENCs will call members. For the calls that are placed by a member, the primary reasons are to return calls to their ENC or to ask a routine health question. The majority of members are very satisfied when their ENCs ask questions about health or concerns, provide instructions on taking care of their health, answer health-related questions, and assist with referrals to programs and services.

While a number of members reported receiving a behavioral health screening, there were only a handful of members who said they were referred to the OHCA's BHU. There was considerable variance in prenatal and postpartum behavioral health screening rates across programs. Only a small percentage had a positive EPDS screening. Of those members, only a handful of members were referred to the BHU. As indicated, these members must consent to a referral to the BHU. Additionally, some members already have existing behavioral health services in place at the time of the EPDS screening.

Pediatric Programs

The OHCA's PCM Department offers four pediatric case management programs to SoonerCare children who qualify: PDN, Synagis, FIMR Baby and ARNB. Similar to the OB programs, the primary distinction among these programs is member eligibility. The PDN program is available to SoonerCare children up to 21 years of age who have complex special health care needs and who require community-based alternatives to institutional care. Members are deemed eligible via a medical authorization and assessment process.

The Synagis program is available to children when a provider has concerns about the child's receiving all of the prescribed Synagis doses. The ARNB program is available to newborns that have a positive newborn screening. The FIMR Baby program is available to newborns of FIMR moms who reside in one of the ten FIMR counties. It is also available to SoonerCare newborns in those 10 counties whose mother was not followed as a FIMR Mom (e.g., mother just moved to a FIMR county).

An analysis of enrollment in the pediatric programs revealed that enrollment counts vary by program but are much smaller in number than the OB programs with the exception of FIMR Baby, which averages approximately 1,600-1,800 members. On average, members enrolled in the PDN and FIMR Baby programs have a length of stay that is ten to 12 months in duration. Synagis and ARNB programs have a length of stay that is three or fewer months. Age varies by program: ARNB and FIMR Baby members average 0-4 weeks, Synagis 0-6 months, and PDN birth to seven years. Members reside in a combination of rural and urban Oklahoma counties (with the exception of FIMR Baby that operates in select counties).

Similar to the OB Programs, an evaluation of ENC activities using Atlantes data indicated a downward trend in the some of the process measures that PHPG evaluated. The same factors that the OHCA identified in the OB section also apply to the pediatric programs.

A review of newborn outcomes, utilization, and expenditures was performed via a claims analysis for each program for which findings are noted throughout the report. A summary of utilization and expenditures is highlighted in Exhibits 12-2 below and in Exhibit 12-3 on the following page.

Exhibit 12-2: PCM Department Pediatric Programs Total Expenditures and Expenditures per Case

Measure	PCM Department Pediatric Program				Total
	PDN	ARNB	Synagis	FIMR Baby	
Total Expenditures	**$36,773,608**	**$2,098,903**	**$421,407**	**$6,501,421**	**$47,046,113**
Total PMPM Expenditures	**$9,840.41**	**$7,163.49**	**$2,701.33**	**$229.30**	**$19,934.53**

Exhibit 12-3: PCM Department Pediatric Programs Utilization

Measure	PCM Department Pediatric Program			
	PDN	ARNB	Synagis	FIMR Baby
ER Visits per 1,000 per member	**239**	**1,634**	**76**	**1,246**
IP Admissions per 1,000 per member	**112**	**1,935**	**29**	**146**

A review of member survey data showed high levels of satisfaction with the pediatric case management programs and with the ENCs. In fact, the overwhelming majority of respondents would recommend the case management programs to a friend with similar health care needs.

For ARNB members, training and education, assessments, and monthly phone calls were very helpful. For Synagis, scheduling and rescheduling injection appointments, as well as the follow-up phone calls by their child's case manager were very helpful. For FIMR Baby participants, scheduled follow-up phone calls, assessments, and training and education were found to be most helpful.

Very few members called their assigned ENCs; rather, the expectation is that the ENCs will call members. For the calls that are placed by a member, the primary reasons are to return calls to their ENC, to request a referral, or to ask a routine health question. The majority of members were very satisfied when their ENCs asked questions about their child's health or concerns, provided instructions on taking care of their child's health, answered questions about their child's health care needs, made appointments for their children, and assisted with referrals to programs and services.

OHCA Refinements

The OHCA has made a number of refinements to the programs to address some of the challenges. Between SFY 2012 and SFY 2013 all assessments moved to electronic format in Atlantes. This saved time from having to complete paper assessments and enabled the PCM Department to capture detailed clinical data in the member's record in Atlantes. There were also two FTEs that were added during that time to support the FIMR programs.

The curriculum for ENC training has been revised and is now more comprehensive in scope, covering such topics as Medicaid, case management process, Atlantes, assessments, and motivational interviewing. The latter has been the focus of much of the curriculum refinement over the past SFY as ENCs are trained on a variety of motivational interviewing techniques to better capture the member's attention during the assessment process.

In addition to its predictive modeling capabilities, MEDai is used by the ENCs to review member profiles in order to get a clinical snapshot of the member (e.g., risk, medications, and providers). Desktop procedures have also been revised for each of the programs and are reviewed with existing and new staff.

Considerations for the Future

The PCM Department has been involved with a number of OB and pediatric initiatives that have led to the development of the eight case management programs. Since the eight programs have evolved, much work has been done to develop desktop procedures, training curricula, individual program assessments, authorization criteria, benefits packages, refinements to the Atlantes case management system, case management services, and activities to engage members.

The growth of these programs over the years has been steady, though staffing to support the programs has not kept pace with the demand. In 2011, the OHCA onboarded thousands of women and children into the FIMR Mom and Baby programs with very few additional resources. Consideration should be given to increasing staff to ensure compliance with caseload ratios and program procedures, as well as to support members who may have higher acuity and/or who may require face-to-face intervention. This could improve clinical outcomes for members by adding resources to educate and answer questions, locate referrals, assist with making prenatal and other appointments, and, of course, to provide ongoing contact and case management.

As it relates to the OB programs, consideration should be given to increasing member reach rates and subsequent member retention past the three-month mark. This would help to ensure that education occurs throughout the course of a member's pregnancy, as well as to assist with efforts to increase compliance with prenatal visit rates. A feature that works well in other OB programs is the use of an incentive (e.g., Babies R Us gift card, stroller, cell phone to call the ENC or provider) to achieve longer enrollment in case management and compliance with prenatal visits.

While providers are sent introductory letters about the program, additional outreach methods should be investigated. The degree of provider involvement once a member is enrolled is uncertain since this was not apparent in reviewing the desktop procedures or in reviewing the Atlantes data. Providers and their staff are in a unique position to collaborate with ENCs to address member compliance with prenatal, well-child, and immunization visits, as well as to educate them about the importance of recurring follow-up care.

Since the majority of members surveyed could not recall the name of their ENC, it may be helpful to consider including a refrigerator magnet or some laminated card that contains the ENC name and telephone number as part of the program introductory letters. This may serve to increase incoming call volume to the ENCs as well.

Throughout this project, a considerable amount of data mining had to be performed due to incomplete or miscoded Atlantes data. Note that there are system design limitations that make the data entry process complex for ENCs and the data collection difficult. At the same time, the Atlantes system had to evolve to meet the data needs of the new and rapidly changing PCM Department programs. While data entry errors are inevitable, additional training and reinforcement of staff should be considered, as well

as efforts to streamline the number of drop downs and codes used in Atlantes. PHPG understands that the OHCA is involved in a larger project to evaluate alternative case management systems. Consideration should be given to the clinical and reporting capabilities (e.g., care plans) of a new clinical system in order to weigh the return on investment.

Both the FIMR Baby and FIMR Mom programs are opt-out programs in that members are auto enrolled based on the county in which they reside and their status as a pregnant woman or a newborn of a FIMR mom. One option would be to offer the AROB, ARNB, and Synagis case management programs to members who qualify as an “opt-out” rather than as an “opt-in” program. This may increase volume and earlier intervention for members who need it.

In summary, the PCM’s OB and pediatric programs offer a number of helpful services and interventions to support pregnant SoonerCare members and their children. Each program serves the purpose of meeting a specific need that was identified, researched, and collaborated among the OHCA and a number of external stakeholders. Data suggests that the PCM Department has been successful with enrolling and case managing a significant number of members despite staffing challenges. There have been refinements to program procedures, ENC training, assessments, and services to address gaps.

ADMINISTRATIVE REFERRALS INTRODUCTION AND OVERVIEW

Administrative Referrals Objective

The Oklahoma Health Care Authority (OHCA) performs retrospective and prospective administrative referrals for a select number of SoonerCare members who cannot get access to their medical home for a specialty referral (e.g., primary care provider (PCP) is unable to see the member prior to a needed specialty visit). The OHCA decides whether the referral is urgent or non-urgent. If the referral is urgent, the OHCA performs the determination and bypasses the regular referral process.

Program History and Overview

From the period of September 2005 through September 2010, the OHCA's Population Care Management (PCM) Unit performed all prospective administrative referrals, and the OHCA's Provider Services department performed all retrospective administrative referrals. Retrospective referrals are defined as those referrals that are made after the requested service or procedure has occurred. For example, when a child breaks an arm and has a new PCP whom the child has not yet seen, a retrospective referral may be required. The child seeks care in the Emergency Room (ER) for the broken arm and then needs to see an orthopedic surgeon for follow-up. Prospective referrals are conducted prior to the delivery of the requested services.

Effective October 2010, a new agency policy was established to reduce the number of retrospective administrative referrals. As of that time, if a clinical review was necessary to determine the appropriateness of a retrospective referral, a Provider Services representative sent the referral to the PCM Department for the clinical review. This same process is in place today for administrative retrospective referrals.

All prospective referrals, around 12 referrals per month, are handled by the PCM Department. Common referral types processed by the PCM Department are orthopedics, cardiology, and neurology. If a referral is received for a dental procedure, the referral is submitted to the OHCA's Dental Services department to process.

Program Eligibility

Administrative referrals are processed only when they contain the necessary documentation to substantiate medically necessity for the referral. The PCM Department denies all Administrative Referrals that lack the necessary documentation to substantiate medically necessity (i.e., if the services of the specialist were not a medical emergency, and the services could have waited until after a PCP referral was obtained).

Administrative Referrals Process

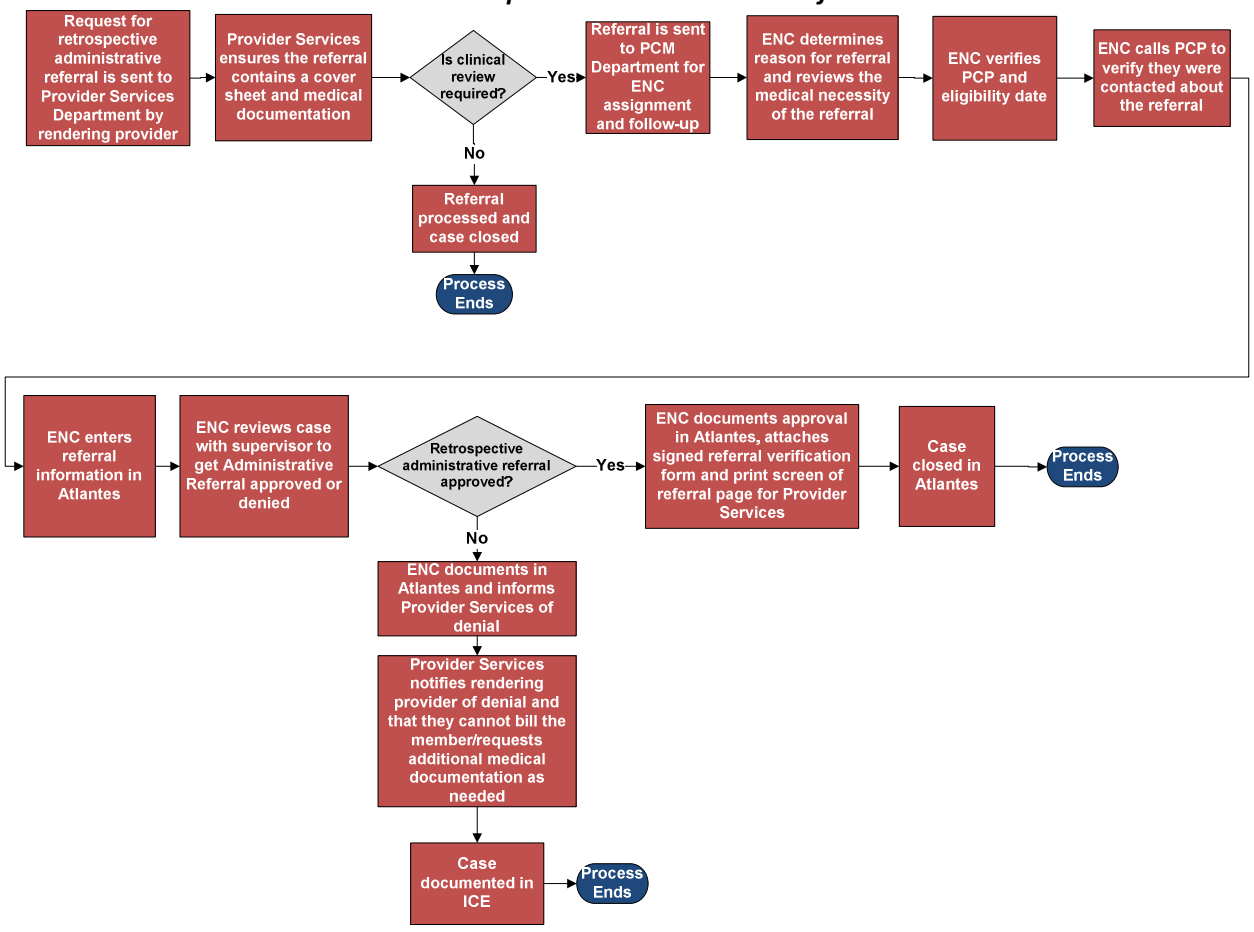
Retrospective Administrative Referrals

Provider Services processes all retrospective administrative referrals as allowed by policy. All retrospective administrative referral requests that require a clinical review are sent to the PCM Department. An Exceptional Needs Coordinator (ENC) is assigned to the referral and ensures that the referral contains the necessary medical information.

The ENC contacts the member's PCP to verify whether the PCP was contacted about the referral. The ENC enters the required referral information into Atlantes. The referral is reviewed by a PCM Department supervisor who approves or denies the referral request. The ENC documents the outcome of the referral, and this information is communicated to the Provider Services department. Provider Services then communicates the outcome of the referral to the rendering provider.

Exhibit 13-1 below provides a flow chart of the retrospective administrative referral process.

Exhibit 13-1: Retrospective Administrative Referral Process



Prospective Administrative Referrals

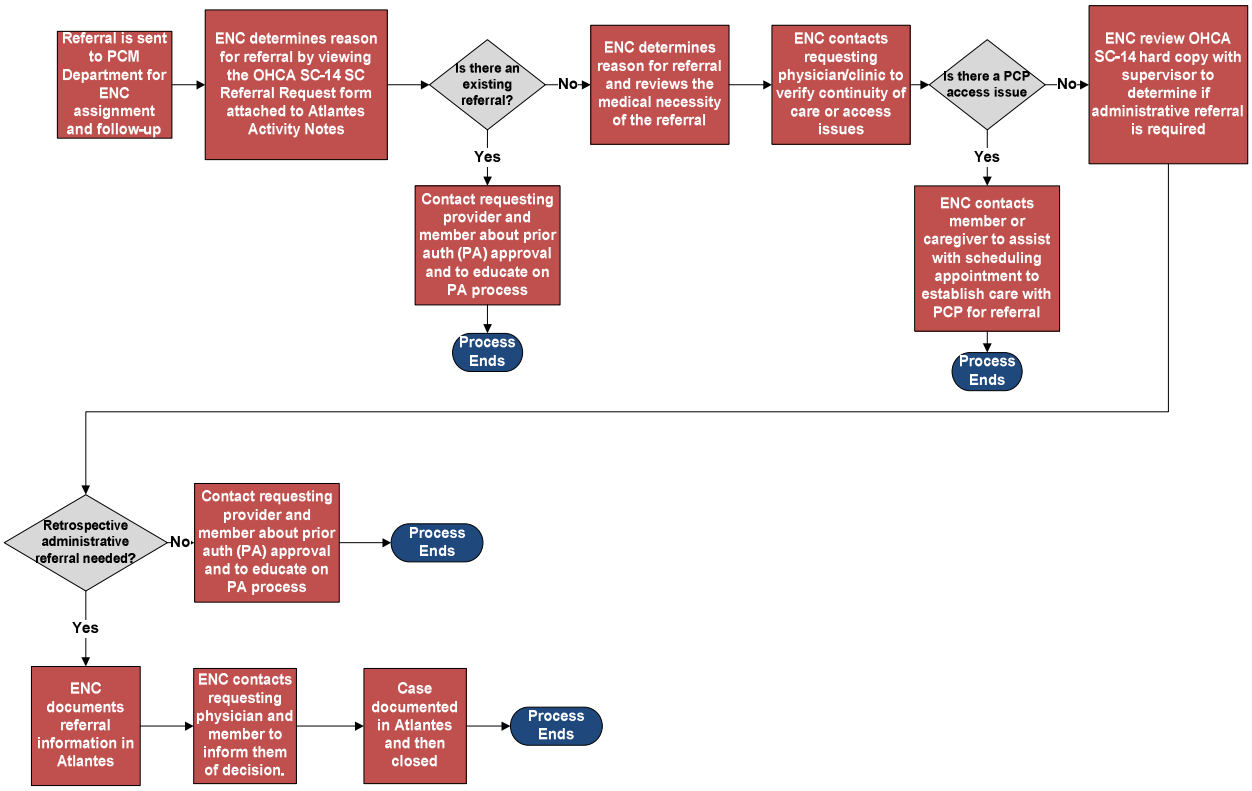
All prospective administrative referral requests are sent to the PCM Department. An Exceptional Needs Coordinator (ENC) is assigned to the referral. The ENC determines the reason for the referral by viewing the OHCA SC-14 SC Referral Request form. If there is an existing referral, the ENC contacts the requesting provider and member about the prior authorization approval and process. If there is not an existing referral, the ENC ensures that the referral contains the necessary medical information.

The ENC contacts the member's PCP to verify whether there are continuity of care or access issues. To the extent there are issues, the ENC works with the member to schedule a PCP appointment to establish care with the PCP for a referral. If there are no issues, the ENC reviews the referral form with a PCM Department supervisor to determine if a prospective administrative referral is required.

If a referral is needed, the ENC documents the necessary information in Atlantes and contacts the requesting physician and member to inform them of the decision. The case is documented in Atlantes and then closed. If a referral is not needed, the ENC contacts the requesting provider and member about the prior authorization approval and process.

Exhibit 13-2 below provides a flow chart of the prospective administrative referral process.

Exhibit 13- 2 – Prospective Administrative Referral Process



ADMINISTRATIVE REFERRALS PROGRAM FINDINGS

Methodology

To conduct the analysis, PHPG obtained data from the OHCA's care management system (Atlantes). The Atlantes system is a proprietary care management system operated by Hewlett-Packard and is used by the PCM Department to store all member records, program activities, assessments, and program letters that are generated. Administrative referral records were extracted from Atlantes for the period of July 1, 2009 (SFY 2010), through June 30, 2013 (SFY 2013).

The Atlantes dataset was treated as the authority for identifying administrative referrals activity. The dataset was "cleaned" to ensure that a referral was accurately included in the analyses. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates) as well as removing records that had null end dates.

Results

The following program enrollment and ENC activities were analyzed for administrative referrals by using the Atlantes dataset:

- Total administrative referrals by SFY;
- Breakdown of administrative referrals by county geography (i.e., rural, urban, suburban, mixed, out of state);
- Total administrative referrals by age range;
- Percentage of members contacted within three business days of receiving an administrative referral by SFY;
- Total number of contacts per administrative referral per SFY;
- Total ENC time spent per administrative referral by SFY;
- Total ENC FTE time per SFY; and
- Total number of administrative referral letters sent by SFY.

Analysis of Administrative Referral Enrollment and ENC Activities

This section describes program enrollment and ENC activities by SFY using data contained in Atlantes. It should be noted that as the program matured and web-based care management tools became available to the PCM Department in SFY 2009, the data became more complete and reliable.

Total Administrative Referrals

Exhibit 13-3 below summarizes the number of administrative referrals from SFY 2010 through SFY 2013. The total number of members having administrative referrals by SFY was calculated based on a member's having a level-of-care start date in that fiscal year. There were steady increases in administrative referral activity between SFY 2010 and 2013.

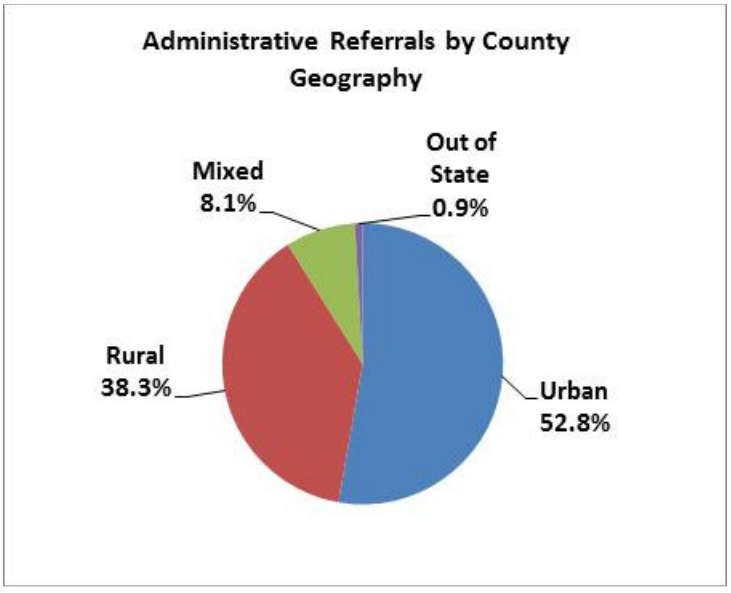
Exhibit 13-3: Administrative Referrals by State Fiscal Year

SFY	Referrals
2010	8
2011	164
2012	187
2013	200
Total	**559**

Administrative Referrals by County Geography

Exhibit 13-4 below summarizes the breakdown of administrative referrals by county geography from SFY 2010 through SFY 2013. Over 50 percent of administrative referrals originated in the urban counties of Cleveland, Oklahoma, and Tulsa. Nearly forty percent of referrals originated in rural counties with the balance of members having resided in mixed counties. A small percentage, 0.9 percent, resided out of state at the time of the data analyses, though these members resided in Oklahoma when they were enrolled in SoonerCare.

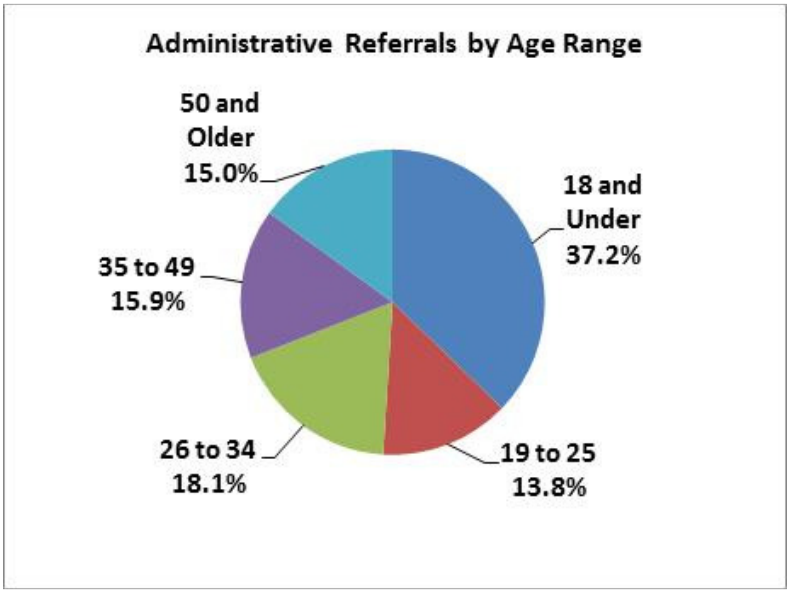
Exhibit 13-4: Administrative Referrals by County Geography



Age Range of Administrative Referrals

Thirty-seven percent of administrative referrals fell into the age range of 18 and under from SFY 2010 through SFY 2013, with the remaining fairly evenly split among the other age ranges (see Exhibit 13-5 below).

Exhibit 13-5: Administrative Referrals by Age Range



ENC Activity Time

Initial Outreach

Once a referral is assigned to an ENC, the ENC begins gathering information by contacting the requesting physician, PCP, and the member, if applicable, to verify continuity of care and/or any access issues. To determine the percentage of administrative referral contacts made within three business days, the level-of-care start date was subtracted from the initial activity date in the Atlantes Administrative Referral Activity Report.

The review was limited to those cases where the data indicated that an ENC performed initial outreach activities related to administrative referrals (e.g., telephone calls, faxes, letters, etc.) within three business days of obtaining a referral. Time spent performing initial outreach activities had to be more than five minutes in duration.

Exhibit 13-6 on the following page highlights member contacts within three business days from SFY 2010 through SFY 2013. Contact rates within three business days ranged from 10.7 percent to 50 percent. The member contact rate across all SFYs was 17.2 percent. Contact for this program is brief and is generally limited to obtaining the rationale for a referral.

Exhibit 13-6: Administrative Referral Contacts within Three Business Days

Measure	SFY2010	SFY2011	SFY2012	SFY2013	Total
Members Contacted within Three Business Days	4	33	20	39	96
Total Administrative Referrals	8	164	187	200	559
Contact Rate	**50.0%**	**20.1%**	**10.7%**	**19.5%**	**17.2%**

Total Contacts

All contacts related to administrative referrals are documented in Atlantes. To determine the number of contacts for each referral, a count was performed of all activity actions contained in the Atlantes Administrative Referral Activity Report. Time spent performing member activities had to be more than five minutes in duration.

Exhibit 13-7 below contains the total number of contacts per member from SFY 2010 through SFY 2013. ENCs have had an average of 2.8 to 11.3 contacts across the four fiscal years. The average number of contacts per member across all SFYs was 3.5 contacts.

Exhibit 13-7: Administrative Referral Total Contacts per Referral

Measure	SFY2010	SFY2011	SFY2012	SFY2013	Total
Count of Contacts	90	462	729	703	1,984
Total Members	8	164	187	200	559
Total Contacts	**11.3**	**2.8**	**3.9**	**3.5**	**3.5**

ENC Time Spent Managing Enrollees

To assess the time spent by ENCs on administrative referrals, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to members who were assigned to administrative referrals.

From SFY 2010 through 2013, ENCs spent an average of 1.0 to 4.1 hours per referral across all activities. Average ENC hours per case have remained relatively stable since SFY 2011. The FTEs required for administrative referrals ranged from 0.02 FTE in SFY 2010 to 0.11 FTE in SFY 2013 (see Exhibit 13-8 on the following page).

Exhibit 13-8: Administrative Referral ENC Time per Referral and ENC FTE Time

Measure	SFY2010	SFY2011	SFY2012	SFY2013
Total Referrals	8	164	187	200
Sum of Administrative Referral Activity (Hours)	32.7	171.6	231.1	229.3
ENC Time Per Referral (Hours)	**4.1**	**1.0**	**1.2**	**1.1**
Total ENC FTE Time	**0.02**	**0.08**	**0.11**	**0.11**

Administrative Referral Letters

ENCs generate and mail referral letters to members and providers for the Administrative Referral program. An analysis was performed for the number of administrative referral letters sent by SFY. From SFY 2010 through 2013, ENCs mailed an average of 0.4 to 1.1 letters per referral (see Exhibit 13-9 below).

Exhibit 13-9: Administrative Referral Letters Sent by State Fiscal Year

Measure	SFY2010	SFY2011	SFY2012	SFY2013
Total Letters Sent	9	68	135	161
Total Referrals	8	164	187	200
Total Letters Per Referral	**1.1**	**0.4**	**0.7**	**0.8**

Summary and Considerations for the Future

The OHCA's PCM Department performs clinical reviews to determine the appropriateness of a retrospective referral when necessary. All prospective referrals are handled by the PCM Department. The PCM Department handles approximately 12 referrals per month, and thus volume is small. From SFY 2010 through SFY 2013 there were 559 referrals that the PCM Department processed. Over half of these referrals originated in urban areas of the state.

Thirty-seven percent of administrative referrals fell into the member age range of 18 and under. Member contact rates across all SFYs averaged 17.2 percent, though contact attempts are sometimes relaxed in times of staffing crises. The average number of contacts per member across all SFYs was 3.5 contacts.

From SFY 2010 through 2013, ENCs spent an average of 1.0 to 4.1 hours per referral across all activities. The FTEs required for administrative referrals ranged from 0.02 FTE in SFY 2010 to 0.11 FTE in SFY 2013. ENCs mailed an average of 0.4 to 1.1 letters per referral.

The PCM Department has a solid process in place for clinical reviews. If there are PCP access or continuity of care issues, PCM engages the OHCA Provider Services Department. Considerations for the future would be to further educate members on the PCP selection and referral processes. Referral reports should continue to be monitored to assess the reason for the referral and to monitor provider network accessibility and compliance with OHCA's referral processes.

MEALS AND/OR LODGING INTRODUCTION AND PROGRAM OVERVIEW

Meals and/or Lodging Program Objective

The OHCA's Meals and Lodging Program was implemented in the PCM Department in SFY 2012. The OHCA's Meals and/or Lodging Program provides meals and/or lodging assistance, after medical necessity review by a nurse, for SoonerCare members who have medical appointments more than 100 miles from the member's home or whose condition discourages traveling.

Program History and Overview

In addition to clinical staff, the PCM Department also has Social Service Coordinators (SSCs) to assist SoonerCare members with any social issues that may impact their medical issues. As SoonerCare members cope with their medical issues, it is sometimes difficult to focus on making lifestyle changes when they are struggling to meet their most basic of needs, such as food and shelter.

An unmet social need can significantly impact a member's medical condition. The SSCs assist with meals and/or lodging for medical appointments and work with the ENC's to ensure these benefits meet medical necessity and other authorization criteria. SSCs also work with providers, members, and lodging and meal vendors to coordinate these benefits.

The OHCA has established codes for reimbursement of meals and/or lodging, as well as contracted meal and lodging providers. Lodging is billed at $52.25 per night (code A0180), and meals are billed at $20.32 per person per day (code A0200). Meals and/or lodging are only offered if the trip for the medical appointment is not completed during normal SoonerRide operating hours of 6:00 a.m. – 7:00 p.m. Central Standard Time (CST).

Program Eligibility

Members who are Title XIX eligible and who are eligible for SoonerRide Non-Emergency Transportation (NET) benefits are eligible for meals and/or lodging assistance. The criteria below are used to determine general program eligibility.

- The medical service is a SoonerCare Medicaid compensated service;
- The travel is to obtain specialty care;
- The medical facility or specialist is the nearest provider available to provide the necessary care required for the member's medical conditions;

- The member does not have active private insurance with major medical coverage listed under Third Party Liability;
- Meals will be reimbursable only if the duration of the trip is 18 hours or more; and
- Payment for meals and/or lodging is limited to a period of up to 24 hours prior to the start of the member's medical service(s) and up to 24 hours after the service(s) end.

Additional eligibility criteria are required for a medical escort to accompany the member as outlined below. A medical escort can be a family member, legal guardian, or a volunteer.

- For the member to qualify for medical escort services, the member must be a child under the age of 18 or an adult member with a health condition or disability that does not permit traveling alone;
- An escort must be an adult age 18 years of age or older who is capable of assisting the member;
- Only one escort may be authorized; and
- For NICU, the medical escort must meet a six-hour minimum visitation per day to be eligible for voucher extension. If one person can room in with the member, no lodging is authorized. If the escort receives meals from the medical facility, no meals services are authorized.

Meals and/or Lodging Program Process

When a request for meals and/or lodging assistance is made, an ENC is assigned to the case to verify eligibility. If the member is eligible for meals and/or lodging, the ENC then determines if the member meets the criteria for medical necessity. If the ENC approves meals and/or lodging, a referral is sent to a Social Services Coordinator (SSC) queue for SSC case assignment.

The SSC addresses any additional eligibility questions/concerns and then determines whether meals and/or lodging will be provided through a contracted provider, direct reimbursement to the member and/or escort, or a combination of both. The SSC communicates approval to the referral source or to the member and/or escort and then follows the procedure for completing reimbursement, whether to the lodging provider, member, or to both.

If a member is not eligible for meals and/or lodging, the ENC communicates the denial to the member and referral source, offers alternative charitable resources, if available, and documents the case notes in Atlantes. The case is then closed in Atlantes.

Exhibits 14-1 and 14-2 on the following page provide a flow chart of the meals and/or lodging program and the voucher to lodging provider reimbursement process. Exhibit 14-3 on page 241 provides a flow chart of the reimbursement process to the member or escort.

Exhibit 14-1 –Meals and/or Lodging Program Process

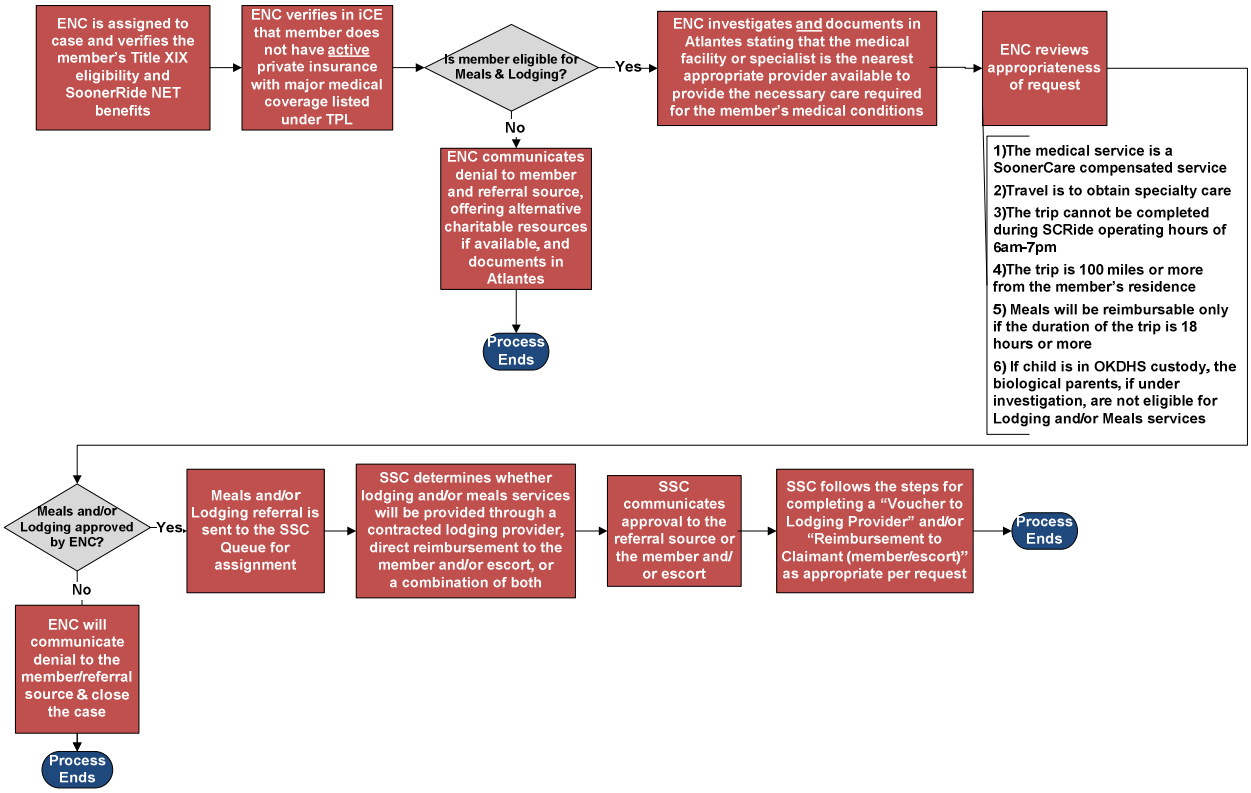


Exhibit 14-2 –Voucher to Lodging Provider Reimbursement Process

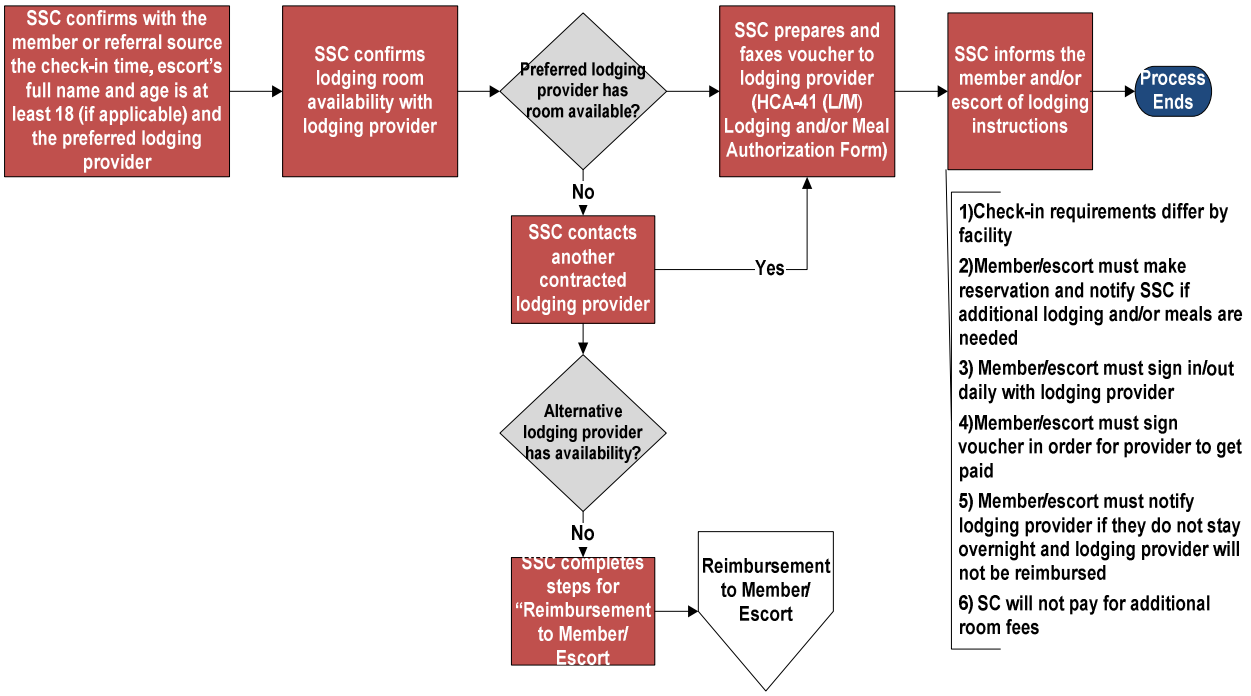
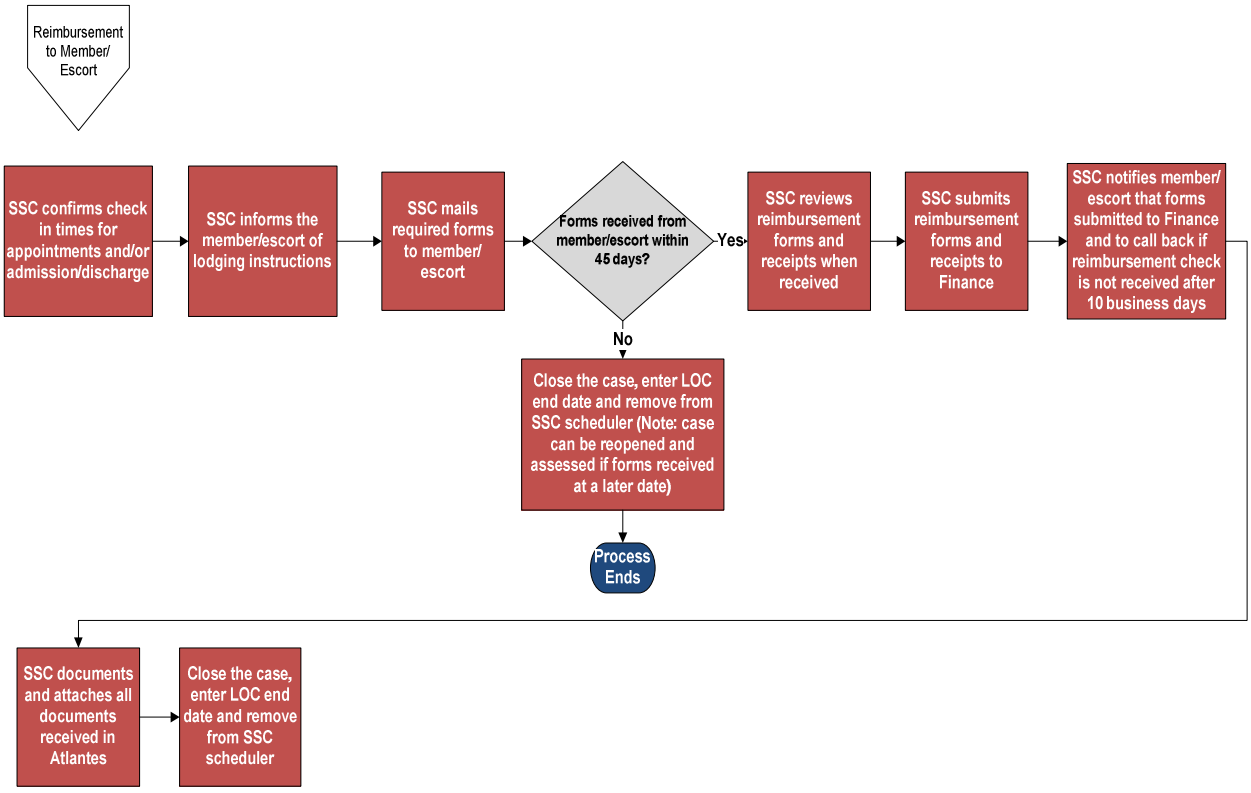


Exhibit 14-3 –Reimbursement to Member/Escort Process



MEALS AND/OR LODGING PROGRAM FINDINGS

Methodology

To conduct the analysis, PHPG obtained data from the OHCA's care management system (Atlantes). The Atlantes system is a proprietary care management system operated by Hewlett-Packard and is used by the PCM Department to store all member records, program activities, assessments, and program letters that are generated. Meals and/or lodging records were extracted from Atlantes for the period of July 1, 2011 (SFY 2012), through June 30, 2013 (SFY 2013).

The Atlantes dataset was treated as the authority for identifying meals and/or lodging activity. The dataset was "cleaned" to ensure meals and/or lodging records were accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates), as well as removing records that had null end dates.

Results

The following PCM program enrollment and ENC activities were analyzed for meals and/or lodging activity by using the Atlantes dataset:

- Total members with meals and/or lodging assistance by SFY;
- Breakdown of members with meals and/or lodging assistance by county geography (i.e., rural, urban, suburban, mixed, out of state);
- Total meals and/or lodging members by age range;
- Percentage of members contacted within three business days of receiving a meals and/or lodging request by SFY;
- Total number of contacts per meals and/or lodging request per SFY;
- Total ENC and Social Service Coordinator (SSC) time spent per meals and/or lodging request by SFY;
- Total ENC and SSC FTE time per SFY; and
- Total number of meals and/or lodging letters sent by SFY.

Analysis of Meals and/or Lodging and ENC Activities

This section describes program enrollment and ENC/SSC activities by SFY using data contained in Atlantes. It should be noted that as the program matured and web-based care management tools became available to the PCM Department in SFY 2009, the data became more complete and reliable.

Members with Meals and/or Lodging Assistance

Exhibit 14-4 below summarizes the number of members with meals and/or lodging assistance from SFY 2012 through SFY 2013. The total number of members having meals and/or lodging assistance by SFY was calculated based on a member's having a level-of-care start date in that fiscal year.

Meals and/or lodging activity increased considerably between SFY 2012 and 2013. It should be noted that new desktop procedures and a new Meals and/or Lodging Letter Authorization form were put in place for meals and/or lodging benefits in SFY 2013.

Exhibit 14-4: Members with Meals and/or Lodging Assistance by State Fiscal Year

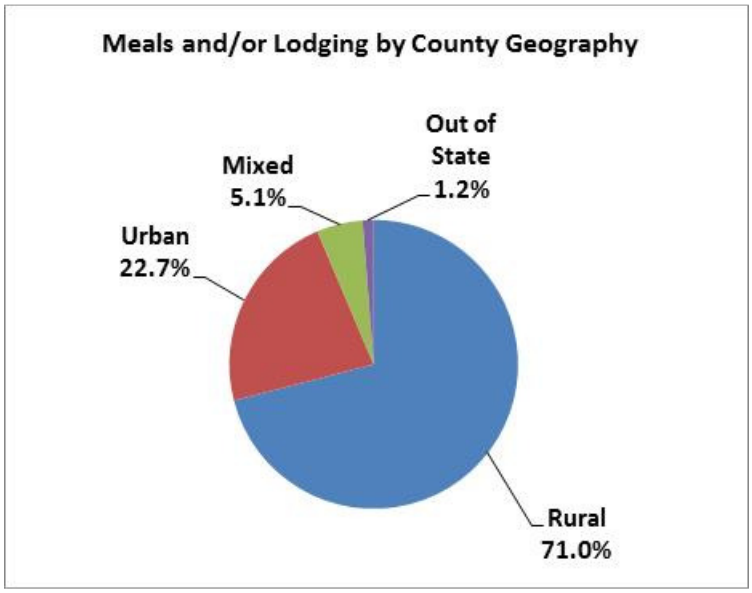
SFY	# of Members
2012	105
2013	462
Total	**698**

Meals and/or Lodging Benefits by County Geography

Exhibit 14-5 below summarizes the breakdown of meals and/or lodging assistance by county geography from SFY 2012 through SFY 2013. Over 70 percent of meals and/or lodging assistance was provided to members who resided in rural counties.

Slightly more than 22 percent of meals and/or lodging assistance was provided to members who resided in urban counties, with the balance of members having resided in mixed counties. A small percentage, 1.2 percent, resided out of state at the time of the data analyses, though these members resided in Oklahoma when they were enrolled in the meals and/or lodging program.

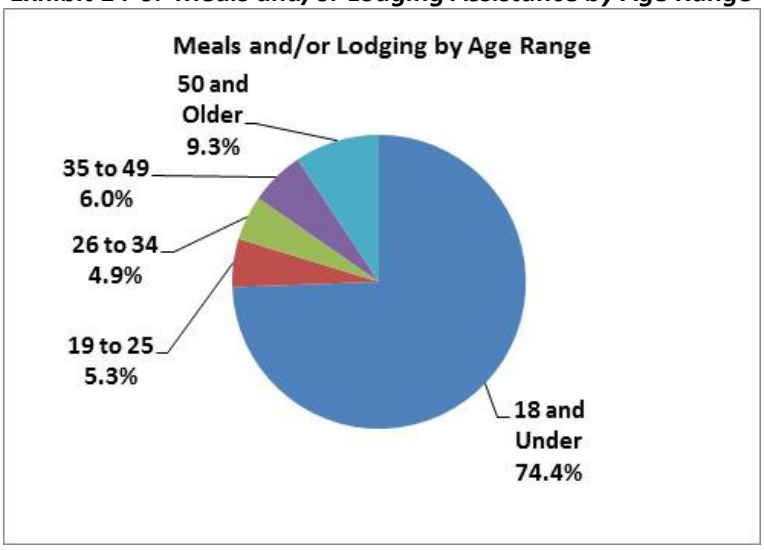
Exhibit 14-5: Meals and/or Lodging Assistance by County Geography



Age Range of Members with Meals and/or Lodging Assistance

Over 74 percent of members who received meals and/or lodging assistance fell into the age range of 18 and under from SFY 2012 through SFY 2013. Nine percent of members fell into the age range of 50 or older with the remaining evenly split among the other age ranges (see Exhibit 14-6 on the following page).

Exhibit 14-6: Meals and/or Lodging Assistance by Age Range



ENC/SSC Activity Time

Initial Outreach

Once a request for meals and/or lodging is received, it is assigned to an ENC or SSC. The ENC or SSC begin gathering information by contacting the provider, facility, lodging provider, and the member, if applicable, to verify the service(s) and the need for meals and/or lodging. To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes Meals and/or Lodging Activity Report.

The review was limited to only those cases where the data indicated that an ENC performed initial telephone outreach (e.g., member contact attempts 1, 2 and 3; phone calls to and from) within three business days of a meals and/or lodging request. Time spent performing each outreach attempt had to be more than five minutes in duration.

Exhibit 14-7 below highlights member contacts within three business days from SFY 2012 through SFY 2013; contacts increased by 20.4 percent from SFY 2012 to SFY 2013. The average member contact rate across both SFYs was 72.1 percent.

Exhibit 14-7: Meals and/or Lodging Contacts within Three Business Days

Measure	SFY2012	SFY2013	Total
Contacts within Three Business Days	65	344	409
Total Members	105	462	567
Contact Rate	**61.9%**	**74.5%**	**72.1%**

Total Contacts

All contacts related to meals and/or lodging are documented in Atlantes. To determine the number of contacts for each meals and/or lodging request, a count was performed of all activity actions contained in the Atlantes Meals and/or Lodging Activity Report. Time spent performing meals and/or lodging activities had to be more than five minutes in duration. Exhibit 14-8 below contains the total number of contacts per member from SFY 2012 through SFY 2013. The average number of contacts per member across both SFYs was 8.2 contacts.

Exhibit 14-8: Meals and/or Lodging Total Contacts per Member

Measure	SFY2012	SFY2013	Total
Count of Contacts	980	3,685	4,665
Total Members	105	462	567
Total Contacts	**9.3**	**8.0**	**8.2**

ENC Time Spent Managing Enrollees

To assess the time spent by ENCs/SSCs on meals and/or lodging cases, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC/SSC performed activities related to members who were assigned to meals and/or lodging. From SFY 2012 through 2013, ENCs/SSCs spent an average of 4.0 to 4.4 hours per member across all activities. The FTEs required for meals and/or lodging ranged from 0.22 FTE in SFY 2012 to 0.90 FTE in SFY 2013 (see Exhibit 14-9 below).

Exhibit 14-9: Meals and/or Lodging ENC/SSC Time per Member and FTE Time

Measure	SFY2012	SFY2013
Total Members	105	462
Sum of Meals and/or Lodging Activity (Hours)	457.5	1.870.0
ENC/SSC Time Per Enrolled Member (Hours)	**4.4**	**4.0**
ENC/SSC FTE Time	**0.22**	**0.90**

<u>Meals and/or Lodging Letters</u>

ENCs/SSCs generate and mail meals and/or lodging letters to members and providers. An analysis was performed for the number of meals and/or lodging letters sent by fiscal year. From SFY 2012 through 2013, ENCs/SSCs mailed an average of 2.1 to 2.3 letters per member (see Exhibit 14-10 on the following page).

Exhibit 14-10: Meals and/or Lodging Letters Sent by State Fiscal Year

Measure	SFY2012	SFY2013
Total Letters Sent	222	1,062
Total Members	105	462
Total Letters Per Member	**2.1**	**2.3**

Summary and Considerations for the Future

The OHCA's PCM Department assists with arranging meals and/or lodging for medical appointments and ensures that these benefits meet medical necessity. From SFY 2012 through SFY 2013 there were 698 meals and/or lodging referrals processed by the PCM Department. Over 70 percent of these referrals originated in rural areas of the state. Over 74 percent of referrals fell into the member age range of 18 and under.

Member contact rates within three days across all SFYs averaged 72.1 percent, which ranked higher than most programs. The average number of contacts per member across all SFYs was 8.2 contacts. From SFY 2012 through 2013, ENCs/SSCs spent an average of 4.0 to 4.4 hours per member across all activities. The FTEs required for meals and/or lodging ranged from 0.22 FTE in SFY 2012 to 0.90 FTE in SFY 2013. From SFY 2012 through 2013, ENCs mailed an average of 2.1 to 2.3 letters per referral.

The PCM Department has processes in place for meals and/or lodging referrals and reimbursement. Considerations for the future would be to continue to monitor rural provider networks for adequacy issues. While PHPG did not perform an audit of meals and/or lodging cases, the OHCA may want to consider a review of a sample of cases to ensure that all criteria were met during the authorization and reimbursement processes.

OUT OF STATE SERVICES PROGRAM INTRODUCTION AND PROGRAM OVERVIEW

Out of State Services Program Objective

The OHCA's Out of State Services Program has been a significant activity in the PCM Department since the SoonerCare Plus transition in January 2004. The OHCA's Out of State Services Program provides case management for members requiring medically necessary services that are not available in Oklahoma.

Program History and Overview

The PCM Department coordinates all requests for out-of-state services. ENCs review all services, perform service authorizations, arrange for travel and lodging for an adult and/or spouse to accompany the member, and coordinate any follow-up services needed for SoonerCare members who qualify for out-of-state services. This work is done in collaboration with the OHCA's SSCs and the OHCA Medical Directors. All out-of-state services must be pre-approved by clinical staff, which is a time-consuming process.

There are a variety of factors that result in services being requested out of state. Some examples of out-of-state service requests include, but are not limited to: services that are not available within Oklahoma (e.g., small bowel transplants for pediatric members), services that are/were not available for a period of time (e.g. a pediatric subspecialist has an extended illness or moves out of state and has to be replaced), and services that are available on the state border and are more cost effective to access across state lines.

Historically, the process for authorization of out-of-state services was not well established or consistent, which resulted in increased costs to the OHCA. Staff from the PCM Department then worked with the OHCA Medical Directors to implement guidelines and incorporate case management into the out-of-state authorization process. In June 2008, the process was further refined, and a documented flow established among three departments: the PCM Department for medical necessity determination, Finance for fiscal authorization, and Provider Enrollment for the contracting process. In 2010, medical necessity criteria and processes were further refined for the PCM Department by the OHCA Medical Directors.

Currently, PCM clinical staff processes all out-of-state service determinations in an effort to streamline and closely monitor the process. Upon receiving a request for out-of-state services, an ENC must validate that there is no in-state option, or, if there is an in-state option, that it is more cost effective to cover the service outside the state. From an institutional perspective, the decision to render services in- or out-of-state depends on whether an institutional provider will accept Oklahoma Medicaid rates or requests a special rate. The former is more cost effective for the OHCA, and the contracts are already

configured within the claims system. On average, there are 50 to 70 new out-of-state service requests, which are prioritized as they come in to the PCM Department, in any given month.

Program Eligibility

Out-of-state services are subject to the non-availability of the same service in the state. Documentation must be submitted from the requesting provider to support the medical necessity of the out-of-state service. Documentation must include a letter of medical necessity from the appropriate provider(s), a recent history and physical, if available, and any other pertinent information to justify the need for out-of-state care.

The requestor must provide the name, address, and contact phone number for the receiving providers. If this information is not received with the initial out-of-state service request, the ENC must determine a priority timeline for the case and then take appropriate action to secure the information as quickly as possible. A medical review form and out-of-state request form must be completed by the ENC to secure Supervisor and Medical Director approval.

Out of State Services Program Process

All out-of-state services referrals are sent to the PCM Department. An ENC is assigned to the referral. The ENC reviews documentation from the requesting provider and confirms non-availability of the same service in Oklahoma. Out-of-state requests are evaluated by an algorithm to determine whether the case must be reviewed by a physician from the Medical Professional Services Unit (MPSU) or whether approval authority remains with a PCM Supervisor. Part of this review is an MMIS/ICE search of provider files to determine if the provider has an active contract. If MPSU review is necessary, the ENC completes an Out of State Medical Review form and forwards this and all documentation to MPSU for approval or denial.

If out-of-state services are approved, and the provider does not have a contract, the ENC refers the provider to OHCA's provider enrollment page on the public website. If the provider is interested, he or she completes the required process, and the contract is entered into the Provider Contracting system. If the provider is not interested in a contract with OHCA, it may become necessary for OHCA's Finance Department to negotiate rates and complete a single case agreement. That information is then routed back to Provider Enrollment to enter into the Provider Contracting system.

If out-of-state services are denied, the ENC adds the Out of State Medical Review Form to Atlantes and notifies all providers, as well as the member and/or the member's family, of the decision and how to appeal.

Exhibit 15-1 and Exhibit 15-2 on the following pages provide flow charts of the out-of-state services program process and the out-of-state services provider contracting process.

Exhibit 15-1 –Out of State Services Program Process

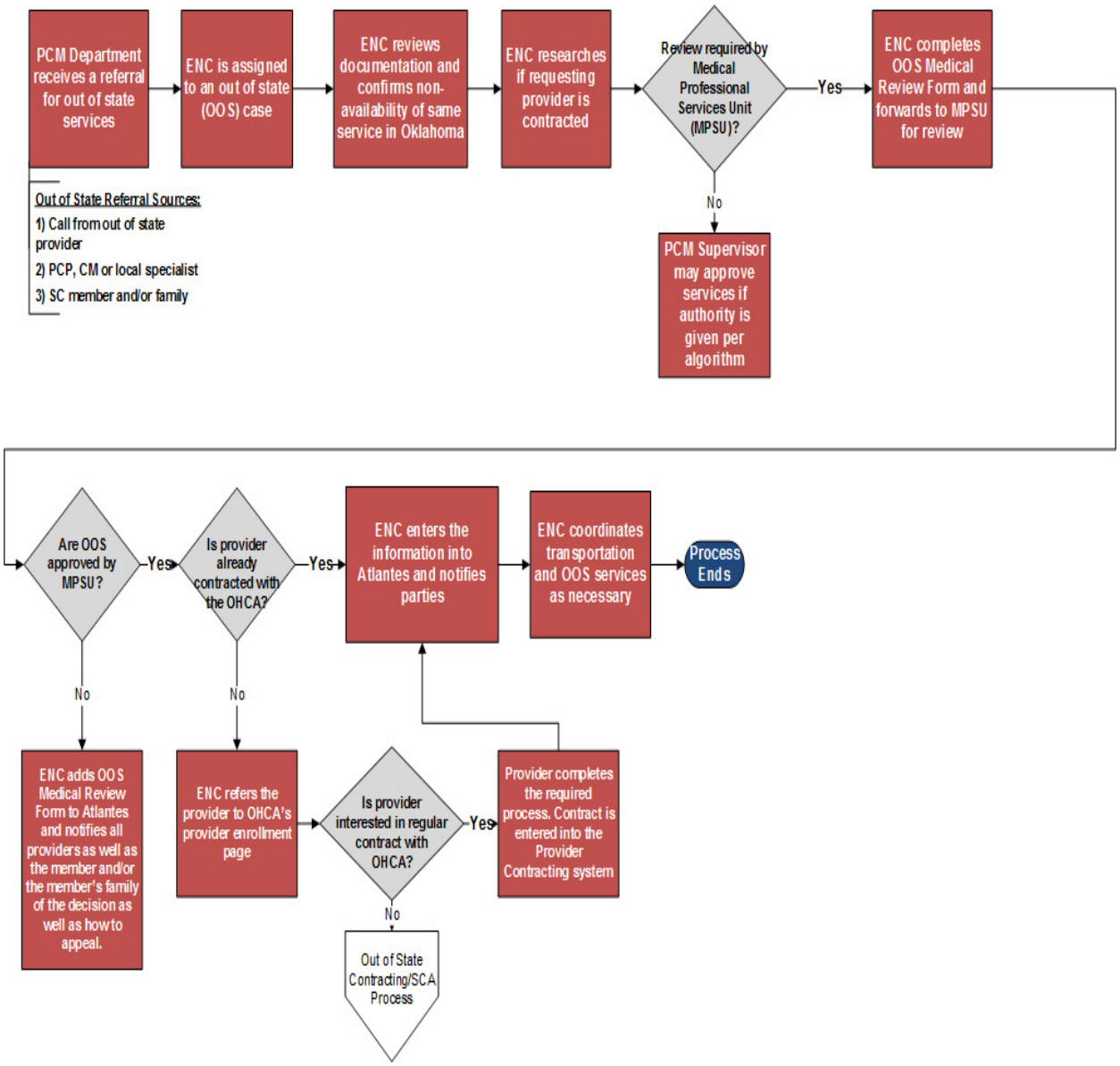
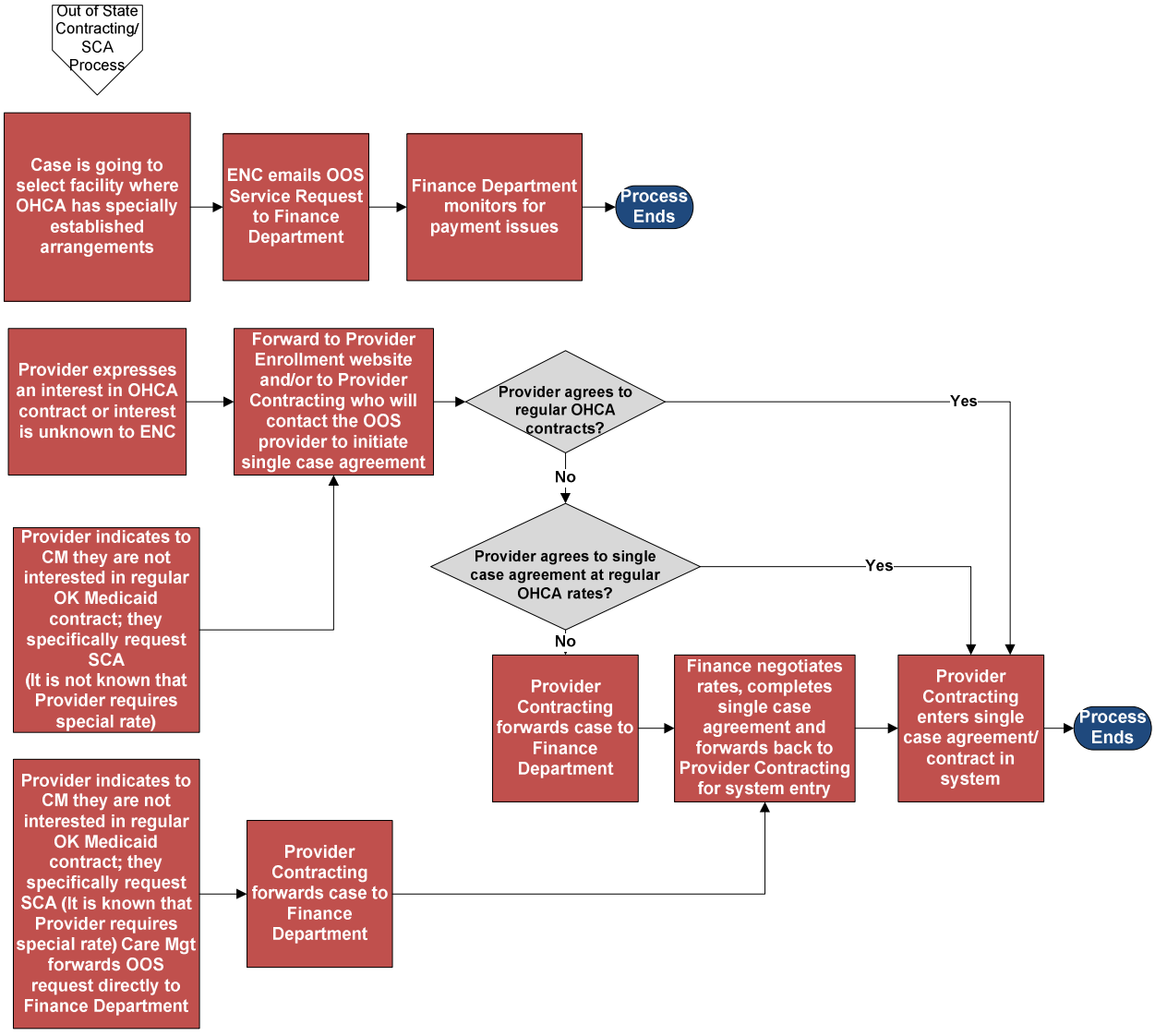


Exhibit 15-2 –Out of State Services Provider Contracting Process



OUT OF STATE SERVICES PROGRAM FINDINGS

Methodology

To conduct the analysis, PHPG obtained data from the OHCA's care management system (Atlantes). The Atlantes system is a proprietary care management system operated by Hewlett-Packard and is used by the PCM Department to store all member records, program activities, assessments, and program letters that are generated. Out-of-state services records were extracted from Atlantes for the period of July 1, 2008 (SFY 2009), through June 30, 2013 (SFY 2013). Claims and eligibility data were pulled for dates of services in SFY 2010 through SFY 2013.

The Atlantes dataset was treated as the authority for identifying out of state services activity. The dataset was "cleaned" to ensure out-of-state records were accurately included in the analyses. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates), as well as removing records that had null end dates.

Results

The following PCM program enrollment and ENC activities were analyzed for out-of-state services by using the Atlantes dataset:

- Total members with out-of-state services by SFY;
- Breakdown of members with out-of-state services by county geography;
- Total out-of-state service participants by age range;
- Percentage of members contacted within three business days of receiving an out-of-state request by SFY;
- Total number of contacts for each out-of-state case per SFY;
- Total ENC time spent on out-of-state services activities by SFY;
- Total ENC FTE time per SFY; and
- Total number of out-of-state services letters sent by SFY.

The following utilization and cost measures were evaluated for out-of-state services by using claims and eligibility data:

- Number of members that had out-of-state services;
- Age breakdown of members that received out-of-state services;
- The type of out-of-state services utilized by state (note that border states are separated from all other states identified in this analysis);
- The number and percentage of members that had meals and/or lodging services associated with their out-of-state claims; and
- The total cost of out-of-state services.

Analysis of Out of State Enrollment and ENC Activities

This section describes program enrollment and ENC activities by SFY using data contained in Atlantes. It should be noted that as the program matured and web-based care management tools became available to the PCM Department in SFY 2009, the data became more complete and reliable.

Members with Out-of-State Services Managed by the PCM Department

Exhibit 15-3 below summarizes the number of members with out-of-state services from SFY 2009 through SFY 2013. It should be noted that these totals only include members with out-of-state services that were managed by the PCM Department. The total number of members having out-of-state services by SFY was calculated based on a member's having a level-of-care start date in that fiscal year. Out-of-state services activity increased from SFY 2009 to 2012 before leveling off in SFY 2013.

Exhibit 15-3: Members with Out-of-State Services Managed by PCM by State Fiscal Year

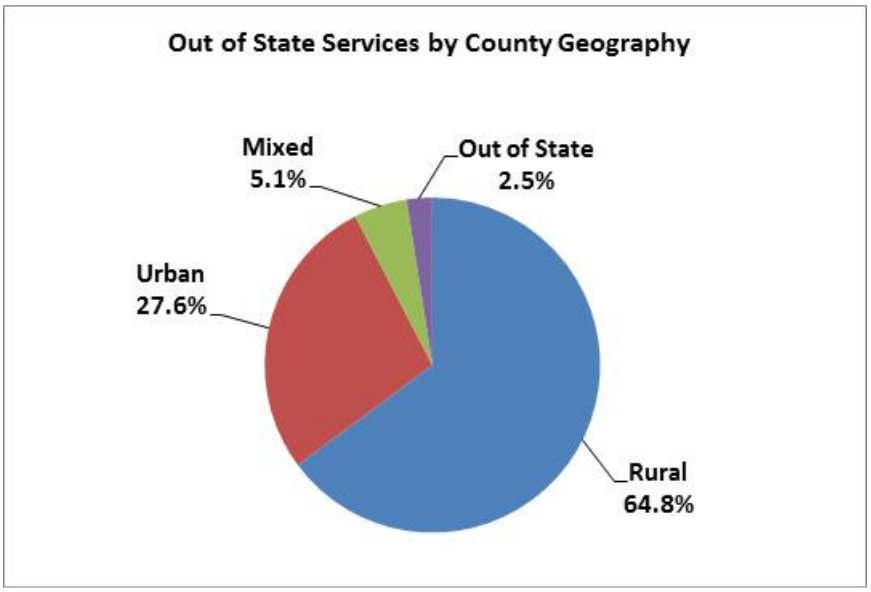
SFY	# of Members
2009	13
2010	96
2011	297
2012	545
2013	508
Total	**1,459**

Out-of-State Services by County Geography

Exhibit 15-4 on the following page summarizes the breakdown of out-of-state services by county geography from SFY 2009 through SFY 2013 that were managed by the PCM Department. Nearly 65 percent of out-of-state services were provided to members who resided in rural counties. This may be related to the lack of certain specialists in some of the rural Oklahoma counties.

Twenty-eight percent of out-of-state services were provided to members who resided in urban counties, and five percent to members residing in mixed counties. A small percentage, 2.5 percent, originated out of state, which is likely attributed to members who were in the program and subsequently relocated to another state.

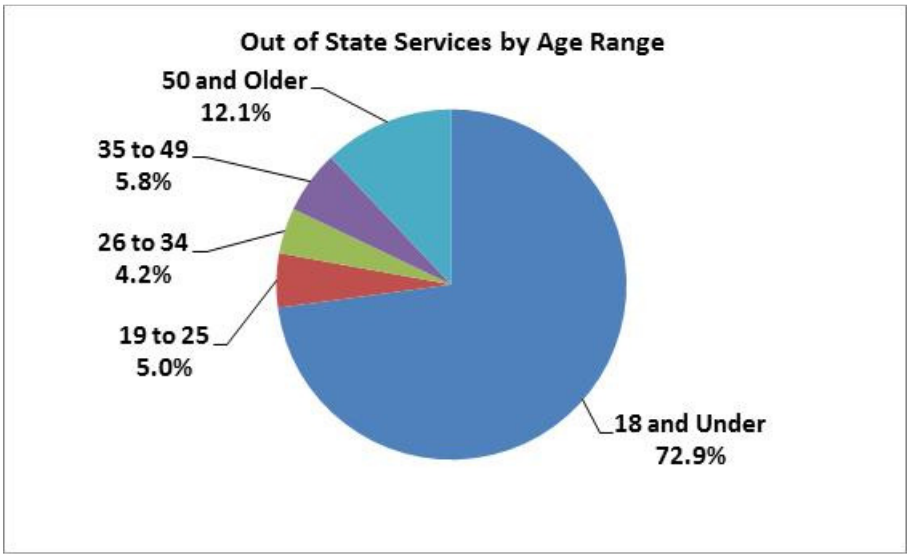
Exhibit 15-4: Out-of-State Services by County Geography



Age Range of Members with Out-of-State Services

Over 70 percent of members who received out-of-state services fell into the age range of 18 and under from SFY 2009 through SFY 2013. Twelve percent of members fell into the age range of 50 or older, with the remaining evenly split among the other age ranges (see Exhibit 15-5 below).

Exhibit 15-5: Out of State Services by Age Range



ENC Activity Time

Initial Outreach

Once an out-of-state referral is assigned to an ENC, the ENC begins gathering information by contacting the requesting and receiving provider and facility, as well as the member and/or family member to confirm the non-availability of the same service in Oklahoma. To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes Out of State Services Activity Report.

The review was limited to only those cases where the data indicated that an ENC performed initial telephone outreach (e.g., member contact attempts 1, 2 and 3; phone calls to and from) within three business days of a referral for out-of-state services. Time spent performing each outreach attempt had to be more than five minutes in duration.

Exhibit 15-6 below highlights member contacts made within three business days from SFY 2009 through SFY 2013; contacts increased from SFY 2009 to SFY 2010 and then remained steady through SFY 2013. The average member contact rate across all SFYs was 82.9 percent.

Exhibit 15-6: Out of State Services Contacts within Three Business Days

Measure	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013	Total
Contacts within Three Business Days	8	85	261	456	400	1,210
Total Members	13	96	297	545	508	1,459
Contact Rate	**61.5%**	**88.5%**	**87.9%**	**83.7%**	**78.7%**	**82.9%**

Total Contacts

All contacts related to out-of-state services are documented in Atlantes. To determine the number of contacts per an out-of-state member referral, a count was performed of all activity actions contained in the Atlantes Out of State Services Activity Report. Time spent performing referral activities had to be more than five minutes in duration.

Exhibit 15-7 on the following page contains the total number of contacts per member from SFY 2009 through SFY 2013. ENCs had an average of 9.1 to 13.3 contacts across the five fiscal years. The average number of contacts per member across all SFYs was 11.1 contacts.

Exhibit 15-7: Out of State Services Total Contacts per Member

Measure	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013	Total
Count of Contacts	173	1,278	3,786	6,296	4,598	16,131
Total Members	13	96	297	545	508	1,459
Total Contacts	**13.3**	**13.3**	**12.7**	**11.6**	**9.1**	**11.1**

ENC Time Spent Managing Enrollees

To assess the time spent by ENCs on out-of-state services cases, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to members who were assigned to out-of-state services.

From SFY 2009 through 2013, ENCs spent an average of 3.4 to 5.3 hours per member across all activities. The FTEs required for out-of-state services ranged from 0.03 FTE in SFY 2009 to 1.20 FTEs in SFY 2012 (see Exhibit 15-8 below).

Exhibit 15-8: Out of State Services ENC Time per Member and FTE Time

Measure	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Total Members	13	96	297	545	508
Sum of Out of State Services Activity (Hours)	56.0	459.3	1,577.9	2,503.5	1,736.3
ENC Time Per Enrolled Member (Hours)	**4.3**	**4.8**	**5.3**	**4.6**	**3.4**
Total ENC FTE Time	**0.03**	**0.22**	**0.76**	**1.20**	**0.83**

Out-of-State Services Letters

ENCs generate and mail out-of-state services letters to members and providers. An analysis was performed for the number of out-of-state services letters sent by fiscal year. From SFY 2009 through 2013, ENCs mailed an average of 0.7 to 1.5 letters per member (see Exhibit 15-9 below).

Exhibit 15-9: Out of State Services Letter Sent by State Fiscal Year

Measure	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Total Letters Sent	19	104	205	577	676
Total Members	13	96	297	545	508
Total Letters Per Member	**1.5**	**1.1**	**0.7**	**1.1**	**1.3**

Utilization and Cost Outcomes

This section highlights utilization and cost trends for out-of-state services by SFY using claims and eligibility data for dates of services in SFY 2010 through 2013. Note that this section contains out-of-state claims data for both members managed by the PCM Department and members not managed by PCM but who received out-of-state services.

Members with Out-of-State Services

Exhibit 15-10 below summarizes the number of unique members that received out-of-state services by the major categories of service (i.e., inpatient, outpatient, and all other) based on all out-of-state service claims. Between SFY 2010 through SFY 2013, there was an average of 639 members who received out-of-state services, with an average cost of $16,679 per member served.

Exhibit 15-10: Unique Members Receiving Out-of-State Services and Costs per Member

Measure	SFY2010	SFY2011	SFY2012	SFY2013	4-Year Average
Unique Members - Inpatient	122	228	232	229	203
Inpatient Cost per Member Served	$48,003.11	$63,451.22	$37,460.41	$38,032.33	$46,737.77
Unique Members - Outpatient	267	363	442	451	381
Outpatient Cost per Member Served	$999.78	$849.04	$885.98	$1,347.89	$1,020.67
Unique Members – All Other	490	636	740	690	639
All Other Cost per Member Served	$2,629.75	$3,467.36	$2,518.08	$2,248.35	$2,715.89
Total Unique Members Served	519	683	809	774	696
All Other Cost per Member Served	$14,281.11	$24,861.38	$13,530.03	$14,042.20	16,678.68

Meals and/or Lodging Expenditures Associated with Out-of-State Claims

Exhibit 15-11 on the following page highlights the meals and/or lodging expenditures associated with out-of-state claims. Between SFY 2010 through SFY 2013, there were $60,676 in meals and/or lodging expenditures and 47 members who received meals and/or lodging services. The average cost per member was $1,291 over the four-year period.

Exhibit 15-11: Meals and/or Lodging Expenditures Associated with Out-of-State Claims

Procedure Code	SFY2010	SFY2011	SFY2012	SFY2013	4-Year Total
A0180	$7,352.00	$9,796.75	$1,731.50	$7,030.00	$25,910.25
A0200	$12,861.00	$10,504.80	$11,347.25	$52.25	$34,765.30
Total Meals and/or Lodging Expenditures	**$20,213.00**	**$20,301.55**	**$13,078.75**	**$7,082.25**	**$60,675.55**
Total Members	**13**	**16**	**16**	**2**	**47**
Meals and/or Lodging Average Cost Per Member	**$1,554.85**	**$1,268.85**	**$817.42**	**$3,541.13**	**$1,290.97**

Out-of-State Service Expenditures by Category of Service and SFY

Exhibit 15-12 below contains out-of-state service expenditures by category of services and SFY. Between SFY 2010 through SFY 2013, there were $46,206,679 in out-of-state service expenditures with an average PMPM of $890.

Exhibit 15-12: Out-of-State Service Expenditures by Category of Service and SFY

Category of Service	SFY2010	SFY2011	SFY2012	SFY2013	4-Year Total
Dental Services	$22,275.06	$17,002.53	$23,494.75	$23,990.09	**$86,762.43**
Home Health and Home Care	$70,160.64	$47,985.98	$40,154.35	$66,614.20	**$224,915.17**
Inpatient Services	$5,856,379.31	$14,466,877.78	$8,690,814.62	$8,709,404.51	**$37,723,476.22**
Lab and X-Ray	$35,015.35	$45,803.09	$60,237.30	$54,994.44	**$196,050.18**
Medical Supplies and Orthotics	$172,766.11	$181,592.42	$176,316.73	$232,221.77	**$762,897.03**
Other	$7,151.70	$35,689.24	$47,438.45	$67,591.20	**$157,870.59**
Other Institutional	$33,191.11	$38,182.59	$16,858.78	$13,332.49	**$101,564.97**
Other Practitioner	$18,057.54	$1,774.92	$2,572.72	$3,155.56	**$25,560.74**
Outpatient Services	$266,941.37	$308,202.93	$391,601.74	$607,896.51	**$1,574,642.55**
Physician Services	$787,606.68	$1,604,192.28	$1,115,042.67	$874,160.72	**$4,381,002.35**
Prescribed Drugs	-	-	-	-	-
Psychiatric Services	$1,912.96	$12,125.09	$75,055.11	$23,628.52	**$112,721.68**
Transportation	$140,439.11	$220,892.51	$306,209.06	$191,675.33	**$859,216.01**
Total out of state Expenditures	**$7,411,896.94**	**$16,980,321.36**	**$10,945,796.28**	**$10,868,665.34**	**$46,206,679.92**
Total Unique Members Served	**519**	**683**	**809**	**774**	**696**
Average Cost per Member Served	**$14,281.11**	**$24,861.38**	**$13,530.03**	**$14,042.20**	**16,678.68**
PMPM	**$712.68**	**$1,372.26**	**$759.33**	**$736.46**	**$889.50**

Out of State Service Expenditures by State and SFY

Exhibit 15-13 below contains out-of-state service expenditures by state and SFY. Forty percent of out-of-state expenditures were incurred in Texas, 27.6 percent were incurred in Arkansas, and 17.5 percent were incurred in Missouri.

Exhibit 15-13: Out of State Service Expenditures by State and SFY

State	2010	2011	2012	2013	4-Year Total
AR	$462,107.49	$5,024,454.82	$4,692,897.62	$2,571,548.93	**$12,751,008.86**
AZ	$25.10	$10.48	$10.19	$119,368.00	**$119,413.77**
CA	$14,524.47	$6,534.40	$6,565.72	$10,493.16	**$38,117.75**
CO	$2,387.73	$6,213.83	$4,259.88	$315.64	**$13,177.08**
DC			$299.45	$367.52	**$666.97**
FL	$13,355.30	$21,038.98	$21,412.46	$25,361.85	**$81,168.59**
GA	$9.91	$2,993.50	$3,159.30	$3,965.73	**$10,128.44**
HI		$21.18			**$21.18**
IA		$7,757.32	$9,999.75		**$17,757.07**
IL	$11,896.15	$2,907.41	$1,874.43	$3,314.54	**$19,992.53**
IN	$9,119.05	$214.45	$585.02	$572.33	**$10,490.85**
KS	$123,612.40	$73,240.27	$70,134.27	$79,221.16	**$346,208.10**
KY	$583.94				**$583.94**
LA			$3,990.41	$4,714.09	**$8,704.50**
MA	$97,812.48	$9,939.20	$74,392.35	$117,357.02	**$299,501.05**
MD	$60.43	$629.97	$445.45	$858.21	**$1,994.06**
MI	$159.81	$113.14	$1,779.96	$86.43	**$2,139.34**
MN	$350.79	$21,625.03	$8,199.07	$21,579.70	**$51,754.59**
MO	$1,498,514.70	$1,846,073.13	$1,425,344.24	$3,316,936.46	**$8,086,868.53**
MS			$15,299.86		**$15,299.86**
NC	$13,802.26	$3,944.42	$9,235.89	$7,181.74	**$34,164.31**
NE	$922,507.74	$745,530.83	$252,456.15	$49,194.68	**$1,969,689.40**
NJ	$1,930.90	$1,303.71	$2,190.07	$1,640.38	**$7,065.06**
NM	$426.56			$9,097.70	**$9,524.26**
NV		$172.80	$27.37	$11.95	**$212.12**
NY			$20,820.18	$39.20	**$20,859.38**
OH	$87,803.69	$872,222.92	$701,719.87	$160,969.13	**$1,822,715.61**
OR			$7,239.38		**$7,239.38**
PA	$6,464.57	$18,807.40	$126,205.00	$29,071.12	**$180,548.09**
SC				$260.91	**$260.91**
SD					**$0.00**
TN	$97,880.07	$353,052.25	$338,224.50	$924,140.48	**$1,713,297.30**
TX	$4,038,163.49	$7,941,913.85	$3,144,490.65	$3,341,591.08	**$18,466,159.07**
UT	$17.61			$66,845.86	**$66,863.47**
VA	$455.81	$401.66	$883.72	$725.24	**$2,466.43**
WA	$7,522.02	$19,204.41	$1,654.07	$695.44	**$29,075.94**
WI	$402.47				**$402.47**
WY				$1,139.66	**$1,139.66**
Total	**$7,411,896.94**	**$16,980,321.36**	**$10,945,796.28**	**$10,868,665.34**	**$46,206,679.92**

Summary and Considerations for the Future

The OHCA's PCM Department coordinates all requests for out-of-state services. In an effort to streamline and closely monitor the process, ENCs review all services, perform service authorizations, arrange for travel and lodging for an adult and/or spouse to accompany the member, and coordinate any follow-up services needed for SoonerCare members who qualify for out-of-state services. From SFY 2009 through SFY 2013, there were 1,459 out-of-state requests processed by the PCM Department. Nearly 65 percent of out-of-state services were provided to members who resided in rural counties. Over 70 percent of referrals fell into the member age range of 18 and under.

Member contact rates within three days across all SFYs was 82.9 percent, which likely relates to the member's need for the service and willingness to work with the PCM Department on arranging the service. The average number of contacts per member across all SFYs was 11.1 contacts. Out-of-state services referrals have been a significant activity in the PCM Department and so it is not unusual that hours per member and FTE time were higher for this program than for other programs. From SFY 2009 through 2013, ENCs spent an average of 3.4 to 5.3 hours per member across all activities. The FTEs required for out-of-state services ranged from 0.03 FTE in SFY 2009 to 1.20 FTEs in SFY 2012. From SFY 2012 through 2013, ENCs mailed an average of 0.7 to 1.5 letters per referral.

From SFY 2010 through SFY 2013, there was an average of 696 members who received out-of-state services, with an average cost of $16,679 per member served. From SFY 2010 through SFY 2013, there were $60,676 in meals and/or lodging expenditures and 47 members who received meals and/or lodging services. The average cost per member was $1,291 over the four-year period. From SFY 2010 through SFY 2013, there were $46,206,679 in out-of-state service expenditures with an average PMPM of $890. Forty percent of out-of-state expenditures were incurred in Texas, 27.6 percent were incurred in Arkansas, and 17.5 percent were incurred in Missouri.

The PCM Department has processes in place for out-of-state services referrals and reimbursement. An algorithm designates whether an out-of-state case must be reviewed by a physician from the Medical Professional Services Unit. To the extent that out-of-state services are approved, the PCM Department has processes in place with Provider Contracting and Finance who perform network contracting and reimbursement activities. If out-of-state services are denied, the PCM Department notifies all providers, as well as the member and/or the member's family of the decision and how to appeal.

Considerations for the future would be to continue to monitor provide networks for adequacy and contracting issues. While PHPG did not perform an audit of out-of-state services cases, the OHCA may want to consider a review of a sample of cases to ensure all criteria were met during the authorization, provider contracting, and reimbursement processes.

EMERGENCY ROOM UTILIZATION INTRODUCTION AND PROGRAM OVERVIEW

Emergency Room Utilization Program Objective

The Emergency Room (ER) Utilization Program was implemented on September 1, 2004. The first level of intervention is provided by the OHCA's Member Services department, which provides outreach to SoonerCare members identified with high ER utilization. As Member Services identifies care gaps or issues that are beyond their scope, the member is referred to the PCM Department for clinical follow-up. Providers can also make referrals to the PCM Department for follow-up if they have a concern about their patients' ER usage. ENCs work with Primary Care Providers (PCPs) and members to coordinate services and to overcome barriers that may lead to frequent ER utilization.

Program History and Overview

The ER Utilization Program was implemented on September 1, 2004, by the OHCA's Quality Assurance (QA) Department. The QA Department identified ER claims in the data warehouse and created an ER utilization database. The QA Department subsequently used this database to identify and refer members who had six ER visits in one quarter to the PCM Department. An ENC in the PCM Department then reviewed the member's claims history (i.e., ER visits) and made three attempts to contact the member via telephone and using a telephone script to discuss their ER utilization. The three attempts were made on three different days and at different times of the day.

If the ENC was unable to reach the member or the minor member's guardian, a letter was generated from the ER utilization database the QA Department created. All activities related to ER Utilization case management were documented in Atlantes. The ENC closed the case after the case was documented in Atlantes and a letter had been sent. If the member called back, the ENC would add that information to the case.

On March 1, 2006, the initial ER intervention was transitioned from the PCM Department to the OHCA's Member Services Department. Instead of placing outbound telephone calls to high ER utilizers, Member Services instead performs a series of member and provider mailings. The role of the PCM Department has transitioned from performing outreach calls to accepting case management referrals for high ER utilizers identified by Member Services, PCPs, and other providers.

The Member Services department generates quarterly reports from an Access database (constructed by the QA Department using ER claims from the data warehouse) containing members who have had two or more ER visits in a quarter. The data is pulled 45 days after the close of the quarter. Provider and member letters are then generated based on the ER visit range. Within two to three weeks the first batch of letters is sent. The provider letter is sent to the member's PCP first to inform the PCP of the member's activity. The member letters are divided into four equal batches for mailing purposes. The

"two weeks later" letters are sent two weeks after the mailing of each batch. It takes a total of six weeks to mail all the letters for the quarter.

The number of ER visits that trigger a letter and the type of letter has changed over time. Regardless, the letter varies according to the ER visit range and is stratified based on whether the member is an adult (21 year of age or older) or a child (under age 21). Presently, there are three tiers of intervention performed by Member Services based on the number of ER visits as detailed below:

- 2-3 ER visits in a three-month period: Members receive an informational letter from Member Services advising them of the ER visits and the need to contact their PCP for follow-up;
- 4-14 ER visits in a three-month period: Members receive an "Ethel Rayburn" letter requesting that they contact Member Services for education according to ER guidelines. Appropriate members are referred to the PCM Department for case management if Member Services identifies care gaps or issues beyond their scope. Then, a second letter is generated to members with 4-14 ER visits two weeks after the initial letter, using the same process as the initial letter; and
- 15 or more ER visits (Persistent Members): The member is assigned to an ER Intervention Team, which consists of a Member Services Coordinator, Member Services Supervisor, and a Provider Services Specialist. A Member Services Coordinator forwards a "persistent member" list to the Pharmacy Department to be considered for Pharmacy Lock-In. A Provider Services Specialist contacts the member's PCP regarding the member and then e-mails this information to the Member Services Coordinator and logs the information into a call tracking system. Persistent members may be referred to the PCM Department for case management. Members who remain at very high ER utilization levels are referred to the OHCA Legal department for possible sanctioning, which may include the sanctioning of benefits for six months.

Program Eligibility

Members who have two or greater ER visits within a three-month period are eligible for one of three tiers of intervention performed by Member Services. Members who are referred to the PCM Department as having high ER utilization are eligible to receive case management services.

PCM Department ER Utilization Program Process

Historically, the PCM Department has been involved in varying degrees in the ER Utilization case management process. For approximately four years, from February 2007 and concluding with SFY11, a Senior ENC was assigned to the ER Utilization program, focusing exclusively on high and persistent ER Utilizers. That process is outlined in 16-1, 16-2, and 16-3. As of today, the PCM Department's ENCs receive referrals as Member Services staff identifies the need.

Exhibit 16-1: ER Utilization Program Process for High Cost Members

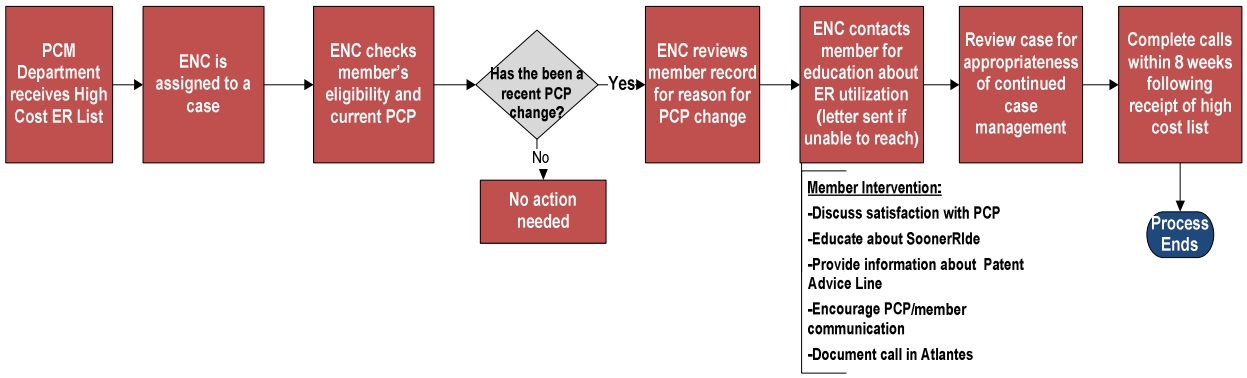


Exhibit 16-2 below highlights the process for pre-persistent members.

Exhibit 16-2: ER Utilization Program Process for Pre-Persistent Members (20-29 ER Visits)

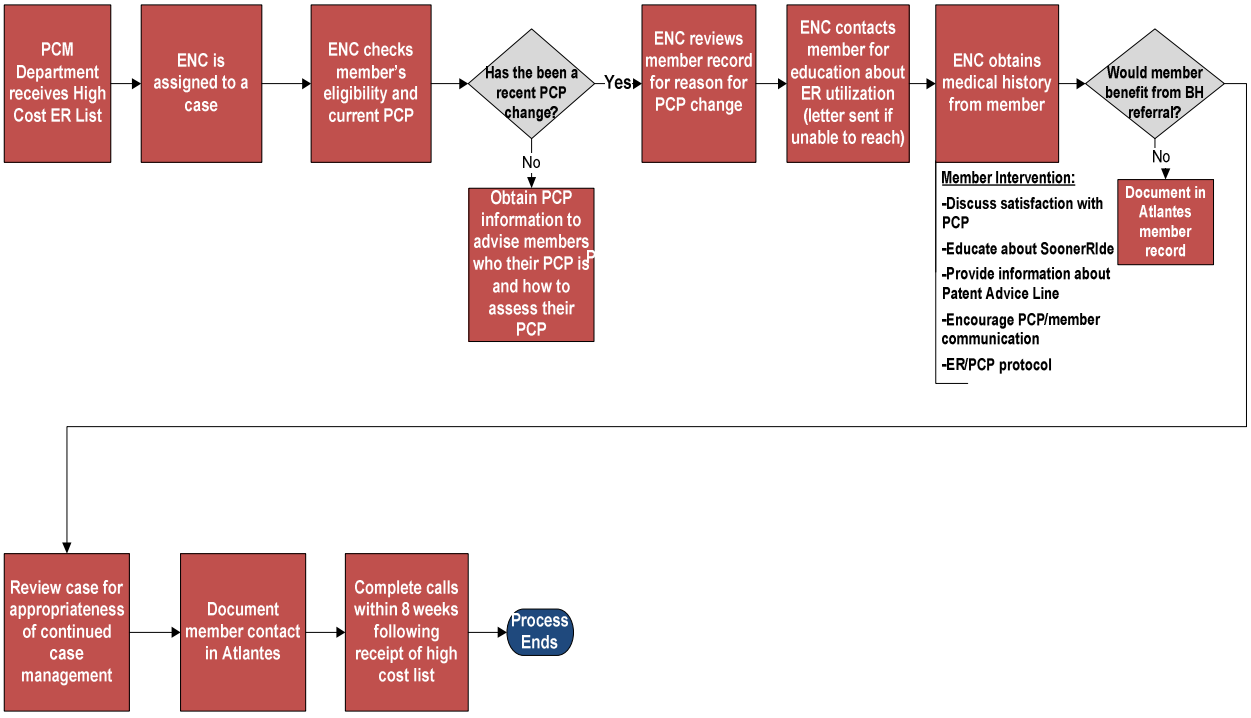
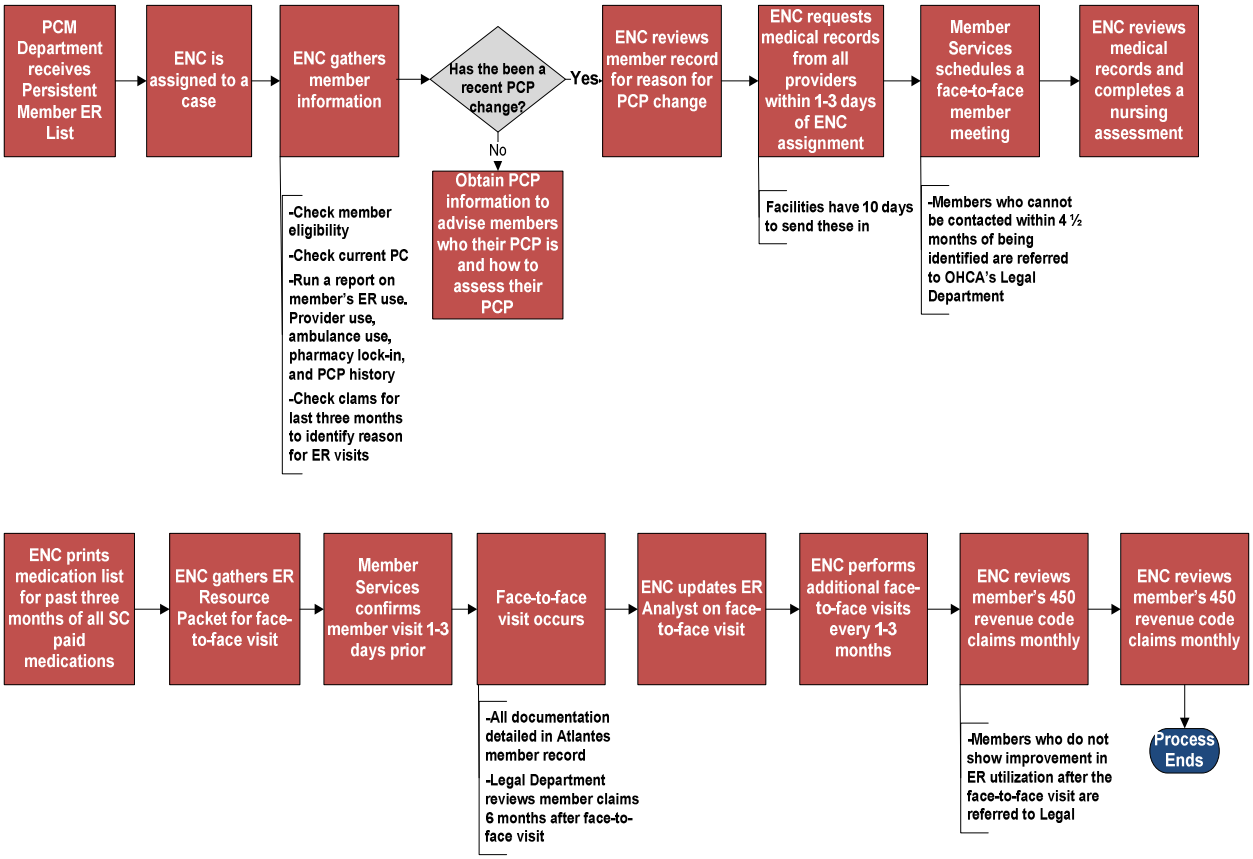


Exhibit 16-3 on the following page highlights the process for persistent members. As it relates to the PCM Department, a persistent member is any member having 30 or more paid ER visits in a nine-month (or less) period.

Exhibit 16-3: ER Utilization Program Process for Persistent Members



NOTE: Contact attempts by the ENC cease once the member is identified as a Legal referral

ER UTILIZATION PROGRAM FINDINGS

Methodology

To conduct the analyses, PHPG obtained data from the OHCA's care management system (Atlantes). The Atlantes system is a proprietary care management system operated by Hewlett-Packard and is used by the PCM Department to store all member records, program activities, assessments, and program letters that are generated. ER records were extracted from Atlantes for the period of July 1, 2005 (SFY 2006), through June 30, 2013 (SFY 2013).

The Atlantes dataset was treated as the authority for identifying ER utilization activity. The dataset was "cleaned" to ensure ER utilization records were accurately included in the analyses. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level-of-Care Start and End dates), as well as removing records that had null end dates.

Claims and eligibility data were pulled for dates of services in SFY 2010 through SFY 2013. ER utilization records for members who received an ER intervention letter were extracted from the Member Services' ER utilization database for the period of SFY 2010 through SFY 2013.

Results

The following PCM program enrollment and ENC activities were analyzed for ER utilization by using the Atlantes dataset:

- Total members with ER utilization records by SFY;
- Breakdown of members with ER utilization records by county geography (i.e., rural, urban, suburban, mixed, out of state);
- Total ER utilization records by age range;
- Percentage of members contacted within three business days of receiving an ER utilization record by SFY;
- Total number of contacts per ER utilization case per SFY;
- Total ENC time spent on ER utilization activities by SFY;
- Total ENC FTE time per SFY; and
- Total number of ER utilization letters sent by SFY.

The following utilization and cost measures were evaluated for ER utilization by using claims and eligibility data:

- Number of members that had high ER utilization letters (4-14 visits in a quarter and greater than 15 visits in a quarter);
- Age breakdown of members that had high ER utilization (4-14 visits in a quarter and more than 15 visits in a quarter);
- The number and percentage of members that had ER visits 12 months before and 12 months after a letter was sent to them by Member Services; and
- The total cost of ER utilization before and after the Member Services intervention (i.e., letter).

Analysis of ER Utilization Enrollment and ENC Activities

This section describes PCM program enrollment and ENC activities by SFY using data contained in Atlantes. It should be noted that as the program matured and web-based care management tools became available to the PCM Department in SFY 2009, the data became more complete and reliable.

Members with ER Utilization Records

Exhibit 16-4 below summarizes the number of members with ER utilization records from SFY 2006 through SFY 2013. The total number of members having ER utilization records by SFY was calculated based on a member's having a level-of-care start date in that fiscal year.

The number of members that had ER utilization records associated with the PCM Department varied by SFY. The variation is likely attributable to the fact that ER cases often involve a combination of Member Services staff and PCM Department staff working on the case during the time it is open. At times, the PCM Department may defer the case to Member Services to start up the ER intervention (i.e., letter) before active PCM involvement if and when a member is referred for case management. In addition, a member may be enrolled in case management for another problem (e.g., Breast and Cervical Cancer, OB) but then subsequently be identified as having an ER utilization issue, at which time the member is referred to Member Services.

Exhibit 16-4: Members with ER Utilization Records by State Fiscal Year

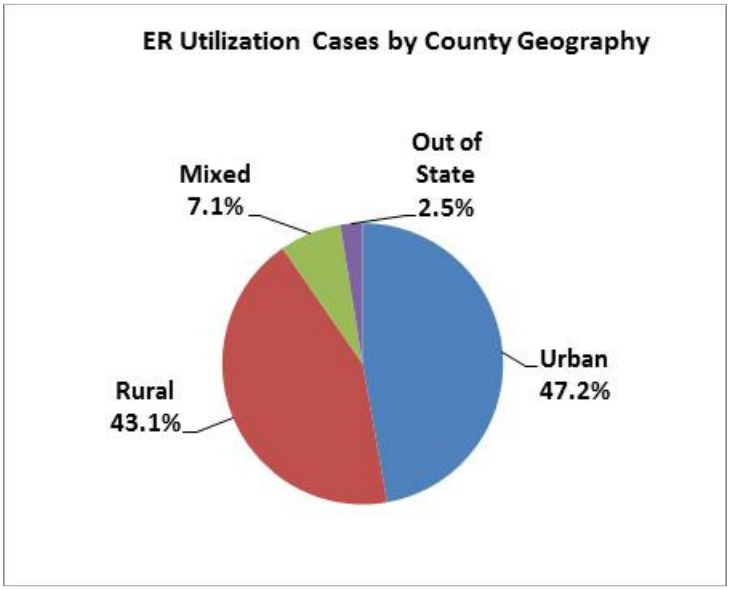
SFY	# of Members
2006	665
2007	548
2008	329
2009	68
2010	101
2011	305
2012	99
2013	162
Total	**2,277**

ER Utilization Cases by County Geography

Exhibit 16-5 on the following page summarizes the breakdown of ER utilization cases by county geography from SFY 2006 through SFY 2013. The percentage of ER utilization cases in rural and urban counties is fairly even among members.

Seven percent of ER utilization cases were provided to members who resided in mixed counties. A small percentage of cases, 2.5 percent, resided out of state at the time of the data analysis, though these members resided in Oklahoma when they were enrolled in the ER utilization program.

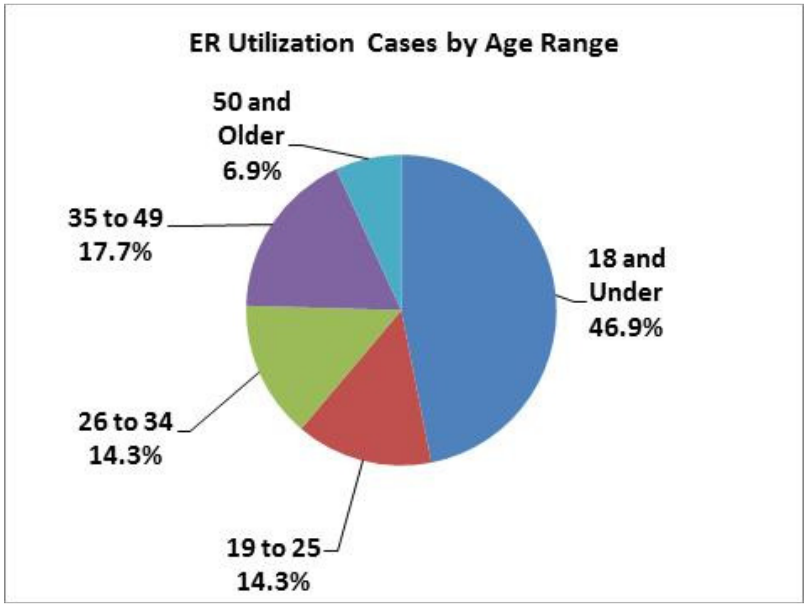
Exhibit 16-5: ER Utilization Cases by County Geography



Age Range of ER Utilization Cases

Nearly half of members who were enrolled in case management fell into the age range of 18 and under from SFY 2006 through SFY 2013. Nearly 18 percent of members fell into the age range of 35 to 49. Fourteen percent of members fell into the age ranges of 19 to 25 and 26 to 34. Seven percent of members fell into the age range of 50 or older (see Exhibit 16-6 below).

Exhibit 16-6: ER Utilization Cases by Age Range



ENC Activity Time

Initial Outreach

To determine the percentage of members who were contacted within three business days, the level-of-care start date was subtracted from the initial member activity date in the Atlantes ER Utilization Activity Report. The review was limited to only those cases where the data indicated that an ENC performed initial telephone outreach (e.g., member contact attempts 1, 2 and 3; phone calls to and from) within three business days of a referral to case management. Time spent performing each outreach attempt had to be more than five minutes in duration.

Exhibit 16-7 below highlights member contacts made within three business days from SFY 2006 through SFY 2013. Member contact rates varied by SFY and ranged from 1.2 to 52.3 percent. The average contact rate across all SFYs was 21.7 percent. It should be noted that contact attempts are sometimes relaxed in times of staffing crises.

Exhibit 16-7: ER Utilization Contacts within Three Business Days

Measure	SFY2006	SFY2007	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Contacts within Three Business Days	170	88	172	8	17	22	16	2
Total Members	665	548	329	68	101	305	99	162
Contact Rate	**25.6%**	**16.1%**	**52.3%**	**11.8%**	**16.8%**	**7.2%**	**16.2%**	**1.2%**

Total Contacts

All contacts related to ER utilization are documented in Atlantes. To determine the number of contacts, a count was performed of all activity actions contained in the Atlantes ER Utilization Activity Report. Time spent performing member activities had to more than five minutes in duration.

Exhibit 16-8 below contains the average number of contacts per member from SFY 2006 through SFY 2013. ENCs had an average of 0.4 to 2.0 contacts across the eight fiscal years. The average number of member contacts across all SFYs was one contact per member.

Exhibit 16-8: ER Utilization Total Contacts per Member

Measure	SFY2006	SFY2007	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Count of Contacts	456	205	575	107	188	201	197	259
Total Members	665	548	329	68	101	305	99	162
Average Contacts Per Member	**0.7**	**0.4**	**1.7**	**1.6**	**1.9**	**0.7**	**2.0**	**1.6**

ENC Time Spent Managing Enrollees

To assess the time spent by ENCs on ER utilization cases, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to members who were assigned to ER utilization.

From SFY 2006 through SFY 2013, ENCs spent an average of 0.4 to 3.3 hours per member across all activities. The FTEs required for ER utilization activities ranged from 0.05 FTE to 0.15 FTE (see Exhibit 16-9 below).

Exhibit 16-9: ER Utilization ENC Time per Member and FTE Time

Measure	SFY2006	SFY2007	SFY2008	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Total Members	665	548	329	68	101	305	99	162
Sum of ER Utilization Activity (Hours)	202.8	105.3	317.0	223.6	285.2	122.0	74.2	97.4
ENC Time Per Enrolled Member (Hours)	**0.3**	**0.2**	**1.0**	**3.3**	**2.8**	**0.4**	**0.7**	**0.6**
Total ENC FTE Time	**0.10**	**0.05**	**0.15**	**0.11**	**0.14**	**0.06**	**0.04**	**0.05**

ER Utilization Letters

ENCs generate and mail letters to members and providers for the ER utilization program, including but not limited to introductory letters, unable-to-contact letters, provider notification, and case closure letters. An analysis was performed for the number of ER letters sent by SFY. From SFY 2006 through 2011, ENCs mailed an average of 0.04 to 0.27 letters per member (see Exhibit 16-10 below). There were no letters noted in the Atlantes data for SFY 2012 or SFY 2013, and so these two years were not included in our findings. Only letters related to ER utilization were included in this analysis.

Exhibit 16-10: ER Utilization Letters Sent by State Fiscal Year

Measure	SFY2006	SFY2007	SFY2008	SFY2009	SFY2010	SFY2011
Total Letters Sent	8	21	89	14	11	4
Total Members	665	548	329	68	101	305
Total Letters Per Member	**0.01**	**0.04**	**0.27**	**0.21**	**0.11**	**0.01**

Utilization and Cost Outcomes

ER utilization records for members who received an ER intervention letter (i.e., 4-14 ER visits letter and 15 or greater ER visits letter) were extracted from the Member Services' ER utilization database for the period of SFY 2010 through the first quarter of SFY 2013. PHPG analyzed claims for ER visits 12 months before and 12 months after the letter date to see if there was any change in utilization as a result of the

ER intervention letter. Participants were included in the analysis only if they were fully eligible for SoonerCare 12 months before and 12 months after the letter date. This section highlights the ER utilization and cost trends using claims and eligibility data.

ER Utilization and Expenditures Prior to 4-14 ER Visit Letters Sent – All Years

There were 2,457 members who were eligible and who had claims for ER visits 12 months prior to receiving their 4-14 visit letters. There were 20,139 ER visits that took place 12 months prior to the issuance of a 4-14 visit letter, with an average ER visit rate of 8.20 per member. Total ER visit expenditures incurred for all members at 12 months prior to receiving the 4-14 visit letter were $3,228,968, and average expenditures per member were $1,314 (see Exhibit 16-11).

Exhibit 16-11: ER Utilization and Expenditures Prior to 4-14 ER Visit Letters Sent – All Years

Age (Years)	Members	Total Visits	Average Visits	Total Expenditures	Average Expenditures
< 3	382	2,808	7.35	$327,351.63	$856.94
3 to 12	389	2,657	6.83	$327,949.44	$843.06
13 to 20	313	2,517	8.04	$382,664.71	$1,222.57
21 to 34	534	4,790	8.97	$856,073.18	$1,603.13
35 to 44	354	3,139	8.87	$546,249.11	$1,543.08
45 to 64	482	4,207	8.73	$786,240.36	$1,631.20
65 +	3	21	7.00	$2,439.13	$813.04
Total	**2,457**	**20,139**	**8.20**	**$3,228,967.56**	**$1,314.19**

ER Utilization and Expenditures after 4-14 ER Visit Letters Sent– All Years

There were 2,457 members who were eligible and who had claims for ER visits 12 months after receiving their 4-14 visit letters. There were 11,721 ER visits that took place 12 months after a 4-14 visit letter was sent with an average ER visit rate of 4.77 per member. Total ER visit expenditures incurred for all members at 12 months after receiving the 4-14 visit letter were $2,009,718 and average expenditures per member were $818 (see Exhibit 16-12 on the following page).

Exhibit 16-12: ER Utilization and Expenditures after 4-14 ER Visit Letters Sent – All Years

Age (Years)	Members	Total Visits	Average Visits	Total Expenditures	Average Expenditures
< 3	382	1,216	3.18	$145,855.40	$381.82
3 to 12	389	1,107	2.85	$142,407.01	$366.08
13 to 20	313	1,424	4.55	$221,413.20	$707.39
21 to 34	534	3,393	6.35	$612,919.49	$1,147.79
35 to 44	354	1,998	5.64	$378,787.68	$1,070.02
45 to 64	482	2,574	5.34	$508,325.27	$1,054.62
65 +	3	9	3.00	$9.54	$3.18
Total	**2,457**	**11,721**	**4.77**	**$2,009,717.59**	**$817.96**

ER Utilization and Expenditures Trends 4-14 ER Visit Letters – All Years

There was a difference of 3.43 ER visits per member 12 months prior to the 4-14 ER visit letter and 12 months after the 4-14 ER visit letter was sent, a 41.8 percentage reduction in ER visits per member. As a result of the change in utilization, there was a $496 reduction in ER visit expenditures per member, a 37.8 percentage change in ER visit expenditures per member. Of the 2,457 members, 21.7 percent fell into the age range of 21 to 34, followed by 19.6 percent of members who fell into the age range of 45 to 64 (see Exhibit 16-13 below).

Exhibit 16-13: ER Utilization and Expenditures Trends 4-14 ER Visit Letters – All Years

Age (Years)	Members	Actual ER Visits	% Change in ER Visits	Actual Expenditures	% Change in ER Visit Expenditures
< 3	382	4.17	-56.7%	($475.12)	-55.4%
3 to 12	389	3.98	-58.3%	($476.97)	-56.6%
13 to 20	313	3.49	-43.4%	($515.18)	-42.1%
21 to 34	534	2.62	-29.2%	($455.34)	-28.4%
35 to 44	354	3.22	-36.3%	($473.05)	-30.7%
45 to 64	482	3.39	-38.8%	($576.59)	-35.3%
65 +	3	4.00	-57.1%	($809.86)	-99.6%
Total	**2,457**	**3.43**	**-41.8%**	**($496.24)**	**-37.8%**

ER Utilization and Expenditures Prior to 15-or-More Visits Letter Sent – All Years

There were 681 members who were eligible and who had claims for ER visits 12 months prior to receiving their 15-or-more ER visit letter. There were 17,058 ER visits that took place 12 months prior to a 15-or-more visit letter being sent, with an average ER visit rate of 25.05 per member. Total ER visit expenditures incurred for all members at 12 months prior to receiving the 15-or-more ER visit letter were $4,016,306, and average expenditures per member were $5,898 (see Exhibit 16-14 below).

Exhibit 16-14: ER Utilization and Expenditures Prior to 15-or-More ER Visit Letters Sent – All Years

Age (Years)	Members	Total Visits	Average Visits	Total Expenditures	Average Expenditures
< 3	16	325	20.31	$59,812.78	$3,738.30
3 to 12	19	355	18.68	$54,576.23	$2,872.43
13 to 20	34	704	20.71	$123,194.78	$3,623.38
21 to 34	261	6,449	24.71	$1,441,381.22	$5,522.53
35 to 44	146	4,095	28.05	$1,064,997.04	$7,294.50
45 to 64	204	5,114	25.07	$1,269,489.24	$6,222.99
65 +	1	16	16.00	$2,854.66	$2,854.66
Total	**681**	**17,058**	**25.05**	**$4,016,305.95**	**$5,897.66**

ER Utilization and Expenditures after 15 or Greater Visits Letter Sent– All Years

There were 681 members who were eligible and who had claims for ER visits 12 months after receiving their 15-or-more ER visit letter. There were 10,942 ER visits that took place 12 months after a 15-or-more visit letter was sent with an average ER visit rate of 16.07 per member. Total ER visit expenditures incurred for all members at 12 months after receiving the 15-or-more ER visit letter were $2,695,977 and average expenditures per member were $3,959 (see Exhibit 16-15 below).

Exhibit 16-15: ER Utilization and Expenditures after 15-or-More ER Visit Letters Sent – All Years

Age (Years)	Members	Total Visits	Average Visits	Total Expenditures	Average Expenditures
< 3	16	156	9.75	$38,334.61	$2,395.91
3 to 12	19	146	7.68	$26,085.38	$1,372.91
13 to 20	34	425	12.50	$76,467.63	$2,249.05
21 to 34	261	3,902	14.95	$921,472.06	$3,530.54
35 to 44	146	3,105	21.27	$847,092.66	$5,802.00
45 to 64	204	3,194	15.66	$784,688.61	$3,846.51
65 +	1	14	14.00	$1,835.86	$1,835.86
Total	**681**	**10,942**	**16.07**	**$2,695,976.81**	**$3,958.85**

ER Utilization and Expenditures Trends 15-or-More Visits Letter – All Years

There was a difference of 8.98 ER visits per member 12 months prior to the 15-or-more ER visit letter and 12 months after the 15-or-more ER visit letter was sent, a 35.9 percentage reduction in ER visits per member. As a result of the change in utilization, there was a $1939 reduction in ER visit expenditures per member, a 32.9 percentage change in ER visit expenditures per member. Of the 681 members, 38.3 percent fell into the age range of 21 to 34, followed by 30 percent of members who fell into the age range of 45 to 64 (see Exhibit 16-16 below).

Exhibit 16-16: ER Utilization and Expenditures Trends 15-or-More ER Visit Letters – All Years

Age (Years)	Members	Actual ER Visits	% Change in ER Visits	Actual Expenditures	% Change in ER Visit Expenditures
< 3	16	10.56	-52.0%	($1,342.39)	-35.9%
3 to 12	19	11.00	-58.9%	($1,499.52)	-52.2%
13 to 20	34	8.21	-39.6%	($1,374.33)	-37.9%
21 to 34	261	9.76	-39.5%	($1,991.99)	-36.1%
35 to 44	146	6.78	-24.2%	($1,492.50)	-20.5%
45 to 64	204	9.41	-37.5%	($2,376.47)	-38.2%
65 +	1	2.00	-12.5%	($1,018.80)	-35.7%
Total	**681**	**8.98**	**-35.9%**	**($1,938.81)**	**-32.9%**

ER Utilization and Expenditures Prior to any ER Visit Letters Sent – All Years

There were 3,138 members who were eligible and who had claims for ER visits 12 months prior to receiving any ER visit letters. There were 37,197 ER visits that took place 12 months prior to the issuance of a letter, with an average ER visit rate of 11.85 per member. Total ER visit expenditures incurred for all members at 12 months prior to receiving an ER visit letter were $7,245,274, and average expenditures per member were $2,309 (see Exhibit 16-17 on the following page).

Exhibit 16-17: ER Utilization and Expenditures Prior to Any ER Visit Letter Sent – All Years

Age (Years)	Members	Total Visits	Average Visits	Total Expenditures	Average Expenditures
< 3	398	3,133	7.87	387,164.41	972.77
3 to 12	408	3,012	7.38	382,525.67	937.56
13 to 20	347	3,221	9.28	505,859.49	1,457.81
21 to 34	795	11,239	14.14	2,297,454.40	2,889.88
35 to 44	500	7,234	14.47	1,611,246.15	3,222.49
45 to 64	686	9,321	13.59	2,055,729.60	2,996.69
65 +	4	37	9.25	5,293.79	1,323.45
Total	**3,138**	**37,197**	**11.85**	**7,245,273.51**	**2,308.88**

ER Utilization and Expenditures after ER Visit Letters Sent– All Years

There were 3,138 members who were eligible and who had claims for ER visits 12 months after receiving an ER visit letter. There were 22,663 ER visits that took place 12 months after an ER visit letter was sent, with an average ER visit rate of 7.22 per member. Total ER visit expenditures incurred for all members at 12 months after receiving an ER visit letter were $4,705,964, and average expenditures per member were $1,500 (see Exhibit 16-18).

Exhibit 16-18: ER Utilization and Expenditures after Any ER Visit Letters Sent – All Years

Age (Years)	Members	Total Visits	Average Visits	Total Expenditures	Average Expenditures
< 3	398	1,372	3.45	184,190.01	462.79
3 to 12	408	1,253	3.07	168,492.39	412.97
13 to 20	347	1,849	5.33	297,880.83	858.45
21 to 34	795	7,295	9.18	1,534,391.55	1,930.05
35 to 44	500	5,103	10.21	1,225,880.34	2,451.76
45 to 64	686	5,768	8.41	1,293,013.88	1,884.86
65 +	4	23	5.75	1,845.40	461.35
Total	**3,138**	**22,663**	**7.22**	**4,705,694.40**	**1,499.58**

ER Utilization and Expenditures Trends All ER Letters – All Years

There was a difference of 4.63 ER visits per member 12 months prior to an ER visit letter and 12 months after an ER visit letter was sent, a 39.1 percentage reduction in ER visits per member. As a result of the change in utilization, there was an $809 reduction in ER visit expenditures per member, a 35.1 percentage change in ER visit expenditures per member. Of the 3,138 members, 25.3 percent fell into the age range of 21 to 34, followed by 21.9 percent of members who fell into the age range of 45 to 64 (see Exhibit 16-19 below).

Exhibit 16-19: ER Utilization and Expenditures Trends Any ER Visit Letters – All Years

Age (Years)	Members	Actual ER Visits	% Change in ER Visits	Actual Expenditures	% Change in ER Visit Expenditures
< 3	398	4.42	-56.2%	($509.99)	-52.4%
3 to 12	408	4.31	-58.4%	($524.59)	-56.0%
13 to 20	347	3.95	-42.6%	($599.36)	-41.1%
21 to 34	795	4.96	-35.1%	($959.83)	-33.2%
35 to 44	500	4.26	-29.5%	($770.73)	-23.9%
45 to 64	686	5.18	-38.1%	($1,111.83)	-37.1%
65 +	4	3.50	-37.8%	($862.10)	-65.1%
Total	**3,138**	**4.63**	**-39.1%**	**($809.30)**	**-35.1%**

Summary and Considerations for the Future

The Emergency Room (ER) Utilization Program involves both the OHCA Member Services Department and the PCM Department. The first level of intervention is provided by the OHCA's Member Services department, which provides outreach to SoonerCare members identified with high ER utilization. As Member Services identifies care gaps or issues that are beyond their scope, the member is referred to the PCM Department for clinical follow-up. Providers can also make referrals to the PCM Department for follow-up if they have a concern about their patients' ER usage. ENCs work with PCPs and members to coordinate services and to overcome barriers that may lead to frequent ER utilization.

Between SFY 2006 through SFY 2013 there were 2,277 members that had ER utilization records associated with the PCM Department. The percentage of ER utilization cases in rural and urban counties is fairly even among members. Nearly half of members who were enrolled in case management fell into the age range of 18 and under. Member contact rates varied by SFY and ranged from 1.2 to 52.3 percent. The average contact rate across all SFYs was 21.7 percent. The average number of member contacts across all SFYs was one contact per member.

From SFY 2006 through SFY 2013, ENCs spent an average of 0.4 to 3.3 hours per member across all activities. The FTEs required for ER utilization activities ranged from 0.05 FTE to 0.15 FTE. From SFY 2006 through 2011, ENCs mailed an average of 0.04 to 0.27 letters per member.

ER utilization records for members who received an ER intervention letter (i.e., 4-14 ER visits letter and 15-or-more ER visits letter) were extracted from the Member Services' ER utilization database for the period of SFY 2010 through the first quarter of SFY 2013. PHPG analyzed claims for ER visits 12 months before and 12 months after the letter date to see if there was any change in utilization as a result of the ER intervention letter.

As it relates to the 4-14 ER visit letter, there was a difference of 3.43 ER visits per member 12 months prior to the 4-14 ER visit letter and 12 months after the 4-14 ER visit letters were sent. This reduction represented a 41.8 percentage reduction in ER visits per member and a $496 reduction in ER visit expenditures per member. Regarding the impact of the 15-or-more ER visit letter, there was a difference of 8.98 ER visits per member 12 months prior to the 15-or-more ER visit letter and 12 months after the 15 or greater ER visit letter was sent. This represents a reduction of 35.9 percent in ER visits per member and a $1939 reduction in ER visit expenditures per member.

For all members who received either a 4-14 ER visit letter or a 15-or-greater ER visit letter, there was a difference of 4.63 ER visits per member 12 months prior to an ER visit letter and 12 months after an ER visit letter was sent, a 39.1 percentage reduction in ER visits per member and an $809 reduction in ER visit expenditures per member. In summary, it appears the mailing of ER letters to members and their PCPs had a sizeable impact on the reduction of ER services for the members who were evaluated.

Considerations for the future would be to continue to send ER visit letters to members and their PCPs at varying intervals and to monitor the degree of member calls back to the OHCA, as well as PCP intervention to reduce unnecessary ER visits. More aggressive interventions could include face-to-face member and provider education, provider profiling, and partnering with high-volume ERs to address non-compliance issues for members that have more than five ER visits in any given quarter.

CARE MANAGER TRAINING INTRODUCTION AND PROGRAM OVERVIEW

Care Management Training Objective

As the PCM Department expanded its program oversight for case management, the SoonerCare Health Management Program (HMP), and the Chronic Care Unit (CCU), the training curriculum and methods for educating nurses (ENCs) have evolved to meet the needs of members and to actively engage members in conversations about their care.

Program History and Overview

When the SoonerCare Plus program transitioned to the SoonerCare Choice program in 2004, the PCM Department increased its staffing substantially (from seven FTEs to 30 FTEs). Following this transition, the immediate goal was to model some of the programs that had been implemented by the SoonerCare Plus care managers under the former managed care model.

During the first few years following the transition, the PCM Department added new programs such as Breast and Cervical Cancer, ER Utilization, OB Outreach, and High Risk OB. Practices were put into place for new staff to be routinely trained by the Senior ENC and team Supervisor. Desktop procedures were developed and implemented. To orient new staff, PCM representatives used a combination of literature review, systems training, and desktop procedures review.

In addition, new staff received hands-on training. Phone training was conducted by observation through a two-way headset, and ENCs accompanied more experienced nurses on home visits to learn the Private Duty nursing review process. The PCM Department managed training predominantly in this way through calendar year 2012.

While researching best practices for the SoonerCare HMP, the concept of motivational interviewing became of high interest. Motivational interviewing is a counseling approach developed by William R. Miller, PhD, and Stephen Rollnick, PhD, that emphasizes a patient-centered, driven approach for eliciting behavior change. In 2011, the SoonerCare HMP added a senior nurse analyst to work with Telligen[3] on clinical topics and quality assurance. The senior nurse analyst sought to develop motivational interviewing skills for other PCM programs.

[3] Telligen is the vendor administering the SoonerCare HMP.

In late 2011 to early 2012, several OHCA agency staff received Health Coach training through the Iowa Chronic Care Consortium. The training was offered through the grant project, "Reducing Disparities in the Practice Site," a Center for Health Care Strategies initiative.[4] The information gained from the training was used to help the OHCA staff develop ideas for the next generation of the SoonerCare HMP, as well as for use in all the PCM case management programs.

ENCs primarily provide case management for members specifically identified through programs, episodes, or events, such as obstetrics and pediatric case management. The CCU was added to partner with the SoonerCare HMP in managing members who are high-risk or at-high risk for chronic conditions. Given the differences in population needs, PCM leadership recognized that staff needed to have very specific education to make them successful in their individual roles. Due to the PCM Department's positioning in the agency with more entry level nursing positions than other departments, the Department experienced relatively high turnover in staffing.

To educate and enable staff to successfully perform in the role as quickly as possible, the PCM Program Education Manager position was developed. The person in this role would be responsible for clinical content training, systems training, organizational history/agency guidelines training, and skills-based training in motivational interviewing. An internal candidate who served as the HMP Senior Nurse Analyst was awarded this position and assumed the role in early 2013. This PCM Program Education Manager continues to develop the clinical training content and fosters motivational interviewing in PCM staff.

The PCM Program Education Manager has achieved Registered Health Coach III status through the Health Sciences Institute (HSI) and is one of only three Motivational Interviewing Network of Training (MINT) trainers in Oklahoma. The following list details the clinical positions that receive training from the education manager:

- 29 care management nurses (including 6 seniors);
- 5 care management supervisors;
- 5 CCU nurses (including 1 senior);
- 1 Chronic Care supervisor; and
- 1 HMP nurse.

Care Management Training Processes

PCM offers staff classes on:

- Health literacy;
- MEDai training;

[4] The OHCA designed its Reducing Disparities at the Practice Site initiative within the SoonerCare HMP framework. The initiative focused on small practices with high volume of racially and ethnically diverse SoonerCare members with certain chronic conditions (e.g., diabetes).

- Orientation for new hires;
- Individual classes on motivational interviewing spirit; and
- Motivational interviewing processes (i.e., Engaging, Focusing, Evoking, and Planning).

All PCM staff undergoes a two-day motivational interviewing training class. The class focuses on:

- Motivational interviewing spirit;
- OARS (open-ended questions, affirmation, reflective listening, summaries);
- Righting reflex;
- Worst and best case scenario when counseling members about change; and
- The four processes of motivational interviewing.

The class incorporates interactive activities to practice these skills. Classes on reflective listening practice also are offered. Two groups of about ten staff members also meet weekly to discuss motivational interviewing and continue to practice together. Staff also has access to clinical training modules. Clinical training modules have been converted into Microsoft OneNote modules. Information is organized into sections, such as in a notebook or binder. Available modules include:

- Diabetes;
- Smoking cessation;
- Healthy eating and weight management;
- Hypertension;
- Depression;
- Congestive heart failure;
- Coronary artery disease;
- Chronic obstructive pulmonary disease (COPD);
- Asthma;
- Hepatitis C;
- Newborn care;
- Pregnancy;
- Sickle cell disease;
- Pain management;
- Contraceptives;
- Pre-conception;
- Physical activity; and
- Motivational interviewing.

Inbound and outbound phone calls are recorded (archived) and evaluated to facilitate motivational interviewing proficiency. (See below for more information on the evaluation process.)

CARE MANAGEMENT TRAINING FINDINGS

Methodology

PHPG interviewed the PCM clinical nurse educator to learn about the successes and challenges that PCM Department staff have had with the transition to and application of motivational interviewing.

Results

The transition to and application of motivational interviewing skills among ENCs in the PCM Department is still in progress. ENCs' phone conversations with members are archived so that the PCM Program Education Manager can review and code the calls. The PCM Department uses the Motivational Interviewing Integrity (MITI 3.1.1) coding system. This system measures an interaction from two perspectives: globally and behaviorally. There are five global dimensions: evocation, collaboration, autonomy/support, direction, and empathy.

A behavior count requires the coder to tally instances of particular interview behaviors, such as open-ended versus closed-ended questions, complex versus simple reflections, information giving, and adherent versus non-adherent statements[5]. In March 2015, the coding system was modified. To date, the PCM Program Education Manager has coded 90 calls. Of the 35 nurses (ENCs) and seven supervisors, four care management staff, two chronic care staff, and two supervisors have achieved Beginning Motivational Interviewing Competency.[6]

As reported by the PCM Program Education Manager, a major challenge is resistance to change. For many staff, the traditional approach to managing patients is to assess and educate. The premise is that the patient lacks motivation, knowledge, or skills, and it is the nurse's job to supply it. The PCM Program Education Manager reported that the interaction between nurses and members under this approach seemed "scripted." For example, if members could not reach their nurses, the members leave a voice message.

Messages often would contain the same type of information in a reporting format; that is, whether the member saw the doctor that month and what medications they currently are taking. As a whole, nurses were not engaging in conversations with their members and asking what could be done to improve their health. Although motivational interviewing incorporates assessment and education as part of the process, it is a form of collaborative conversation for strengthening a person's own motivation and commitment to change. As described by the PCM clinical nurse educator:

[5] Motivational interviewing adherent behaviors include offering supportive statements, affirmations, emphasizing autonomy, and asking permission before providing information. Non-adherent behaviors consist of providing information or advice without permission, disagreeing, confronting, and directing.
[6] There are three levels for motivational interviewing competency: beginning, proficient, and advanced.

> [Motivational interviewing is a] person-centered counseling style for addressing the common problem of ambivalence about change by paying particular attention to the language of change called "change talk." It is designed to strengthen a person's own motivation for change by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. [It] includes understanding the patient's perspective, accepting a patient's motivation or lack of motivation for change, helping people find their own solutions to problems instead of telling them what to do, discovering their own internal motivation to change, and affirming their own freedom to change.

Motivational interviewing uses open-ended questions, affirmations, reflections, and summaries to guide the conversation. To be able to engage the member in these more personal discussions, the nurse has to develop a relationship in order to have open conversations with the member. This approach often takes more time and patience on the part of the nurse to gain the member's trust.

While the OHCA has not conducted any formal evaluations with its nurses or members about their satisfaction and the effectiveness of motivational interviewing, the PCM Program Education Manager reported success stories of reaching and actively engaging members using this method. For example, nurses reported challenges in engaging pregnant teenagers due to trust issues and assumptions that their babies will be taken away from them. Using the assessment and educational approach to pregnancy care, one nurse reported the member initially would not talk with or would only provide brief responses to the questions being asked.

The PCM Program Education Manager and nurse began to evaluate methods for getting the member to open up about herself and her baby. From a member-centered perspective, teenagers want to talk about themselves. The focus had to be on the member, and by applying the correct questions, the nurse could learn about the baby's health. The nurse started to ask the member what her summer plans were and what she liked to do with her friends. Slowly, the member started to open up and feel comfortable talking with her nurse. The nurse was then able to solicit health status information on both the member and her baby.

The goal of the PCM Department is to have all CCU staff receive Chronic Care Professional Certification through the HealthSciences Institute (HSI)[7], and all Care Management Supervisors are required to pursue Certified Case Manager status through the Commission for Case Management Certification[8]. To date, two CCU staff members have received Chronic Care Professional Certification and four supervisors have achieved Certified Case Manager status.

[7] The HealthSciences Institute (HSI) provides chronic care and motivational interviewing health coaching training, certification, and quality improvement services.
[8] The Commission for Case Management Certification is a nationally accredited organization that certifies case managers.

Application of motivational interviewing has been slow among PCM Department staff as leadership is still attempting to train and encourage nurse case managers on the techniques. However, since the PCM Program Education Manager is a member of the Motivational Interviewing Network of Trainers, the OHCA refers cases when there are inquiries about patient-centered care and motivational interviewing.

The PCM Program Education Manager has provided training on patient-centered communication to Insure Oklahoma, the OHCA Member Services Department, Centering Pregnancy, and Comprehensive Primary Care Initiative (CPCI) providers. She has also provided training in a two-day workshop and in monthly meetings for five consecutive months to discuss and practice motivational interviewing to OU and OSU Health Access Network nurse case managers. She has been involved in facilitating community education related to Health Literacy.

Summary and Considerations for the Future

As the PCM Department expanded its program oversight and programs, the training curriculum and methods for educating nurses (ENCs) have evolved to meet the needs of members and to actively engage members in conversations about their care. While researching best practices for the SoonerCare HMP, the concept of motivational interviewing became of high interest.

In 2011, the SoonerCare HMP added a senior nurse analyst to work on clinical topics, quality assurance, and to develop motivational interviewing skills for other PCM programs. To educate and enable staff to successfully perform in the role as quickly as possible, the PCM Program Education Manager position was then developed. The person in this role is responsible for clinical content training, systems training, organizational history/agency guidelines training, and skills-based training in motivational interviewing.

PHPG interviewed the PCM Program Education Manager to learn about the successes and challenges that PCM Department staff have had with the transition to and application of motivational interviewing. While the OHCA has not conducted any formal evaluations with its nurses or members about their satisfaction and the effectiveness of motivational interviewing, the clinical nurse educator reported success stories of reaching and actively engaging members using this method.

Surveys/evaluations of motivational interviewing from the perspectives of nurses and members may prove beneficial. Although survey responses may be anecdotal, they may serve to inspire other PCM staff of the value of motivational interviewing and help to refine the curriculum if/when needed. Another way to get staff more engaged would be to consider an incentive or certificate program (e.g., offer CEU credits) for nurses who complete the training. The OHCA may want to consider the types of training to make the curriculum more interactive in order to better inspire interest, and may also want to consider involving PCM staff in curriculum development.

PHARMACY LOCK-IN INTRODUCTION AND PROGRAM OVERVIEW

Pharmacy Lock-In Program Description

The OHCA Pharmacy Lock-In Program promotes appropriate utilization of health care resources by monitoring potential abuse or inappropriate utilization of prescription medications by SoonerCare members. Members are monitored for excessive use of medications considered to have a high abuse potential, the use of multiple physicians and pharmacies, and the use of medications for diagnoses that raise concern for prescription drug abuse. When warranted, a member may be "locked-in," and therefore required to fill all prescriptions at a single designated pharmacy in order to better manage his or her medication utilization.

Role of the University of Oklahoma College of Pharmacy

The OHCA has contracts with the University of Oklahoma College of Pharmacy (OU COP) to provide operational, consultant, and educational services to support the administration of pharmacy benefits for Oklahoma SoonerCare members. Among their many functions as the Pharmacy Benefit Manager for the OHCA, OU COP has operated the OHCA Pharmacy Lock-in Program since 2006. OU COP conducts in-depth analysis to determine if a SoonerCare member's pharmacy utilization is inappropriate and meets Lock-in Program criteria, locks eligible members into one pharmacy using OHCA's Medicaid Management Information System (MMIS), monitors and conducts reviews of pharmacy utilization by locked-in members and other members who merit concern, performs case closure activities, and manages all lock-in program correspondence with members. The functions are described in more detail below.

Pharmacy Lock-in Program Eligibility and Referral Processes

In order to qualify for lock-in review, an individual must currently be enrolled in SoonerCare or the Insure Oklahoma Individual Plan. Dual-eligible individuals who are enrolled in both SoonerCare and Medicare do not qualify for the Lock-In Program, as their pharmacy benefits are administered by a Medicare Part D drug plan.

Referrals of SoonerCare members for evaluation of the need for lock-in to one pharmacy come via phone or written requests from several sources, including physicians, pharmacies, case workers, OHCA staff members including the OHCA Patient Dismissal Committee (described below), and outside agencies. Referrals can be made using any of the following three paths: 1) direct referral to the Pharmacy Lock-in Unit, operated by OU COP; 2) referral via the OHCA Care Management Unit; or 3) provider submission of a SoonerCare Dismissal Request Form to the OHCA Patient Dismissal Committee. The three paths, and PCM Department staff roles associated with each, are explained below.

Direct Referrals to the Pharmacy Lock-in Unit at the Oklahoma University College of Pharmacy

The OHCA website offers a Pharmacy Lock-In Referral Form (Pharm-16) that provides both the telephone and fax numbers of the OHCA Pharmacy Lock-in Unit, which is located at and administered by the Oklahoma University College of Pharmacy (OU COP). The Pharm-16 Form, which is provided as Attachment C, requests information about the referral source (i.e., Health Care Provider, Emergency Room (ER) Department, Pharmacy, Caseworker, Other) and contact information, identifying information about the member being referred, and the reason for referral (i.e., multiple pharmacies, multiple ER visits, multiple prescribers, concern for member safety, other).

Once a referral is received, the OU COP reviews details of the member's SoonerCare utilization history to determine whether the member qualifies for the Pharmacy Lock-in Program. To be locked-in, the member must meet at least three of the following criteria:

- Number of ER visits (3)
- Number of different pharmacies (3)
- Number of different prescribers/physicians (5) (combined)
- Number of days' supply of controlled substances
- Diagnosis of drug dependency/ other diagnosis
- Number of hospital discharges (3)
- Other information from past reviews
- Safety concerns noted in the profile.

If the OHCA PCM Department receives a phone or fax referral using the Pharm-16 Form, the caller/referral source/fax is directed to the OU College of Pharmacy. The OHCA PCM Department does not perform any other activities regarding these direct referrals to OU COP.

Referral via the OHCA Care Management Unit or Member Services

Providers, case workers, community agency staff, and others can refer SoonerCare members for the OHCA care management services via a Care Management Referral Form (HCA-24) that can be submitted by phone or fax. Similar to the Pharm-16 Form, the Care Management Referral Form, which is provided as Attachment D, requests information about the referral source and contact information and identifying information about the member being referred. However, the reasons for referral on the HCA-24 Form are much broader than those on the Pharm-16, which is focused specifically on indicators of inappropriate pharmaceutical utilization. The reasons for member referral for care management services on the HCA-24 Form include: coordinate complex case, multiple ER visits, education needs related to benefits, education needs related to condition, access to primary care services, access to community resources, multiple inpatient admissions, follow-up of complex inpatient admission, complex discharge needs, poly-pharmacy, transplant evaluation notification, and other.

If the referral reason indicated on the HCA-24 is multiple ER visits and/or poly-pharmacy, the Senior Exceptional Needs Coordinator (ENC) Lock-in Program designee in the PCM Department forwards the referral form to the OHCA Member Services. Member Services also may receive referrals through their toll-free number. Once Member Services receives a referral either from the PCM Department Senior ENC or through the toll-free number, Member Services conducts a claims analysis to determine if the referral meets high-level criteria for the Emergency Room Utilization Care Management Program and/or for the Pharmacy Lock-in Program. If the latter, Member Services forwards the referral to OU COP, which runs a report to identify medications the member has been prescribed during the past six months. This report lists: member's name and identification number, dispensed date, provider name, prescribing provider name, National Drug Classification (NDC) description, claim status, days' supply, quantity dispensed, and drug strength.

Once completed by OU COP, the member's six-month prescription history report is sent to the Senior ENC Lock-in designee in the PCM Department. At this point, the Senior ENC enters member information and the Program referral source into an Excel "Lock-in Log."

The Senior ENC formats and then reviews the six-month pharmacy utilization report against claims data to determine if the member potentially qualifies for the Lock-in Program by examining the following:

- Scheduled medications in paid status, or multiple denied attempts by member (excludes retries from the pharmacy within two days)
- Number of prescribers/pharmacies related to scheduled medications received
- Scheduled medication dates for a six-month timeframe
- Scheduled medication amounts.

Using the above information, the Senior ENC reviews the data for the following:

- Greater than three pharmacies used for scheduled medications in six months
- Same scheduled medication obtained from different providers and pharmacies with overlapping dates
- Quantities received are greater than normal (cumulative during specified timeframe)
- Report of illegal activity has been received related to scheduled medication (e.g., forgery, selling medication).

If any of these conditions have been met, the Senior ENC completes the "Criteria" and "Date Referred to COP" fields in the Excel Lock-in Log and then faxes the report log to OU COP. This report alerts OU COP to conduct more in-depth analyses to determine if the member meets criteria to initiate the Pharmacy Lock-in Program, as previously described in the section on "Direct Referrals to the Pharmacy Lock-in Unit at the Oklahoma University College of Pharmacy."

The Senior ENC also enters information into Atlantes for those members referred to OU COP, including the fact that the member's status is "evaluating" due to "referral for lock-in (status reason) and an activity note that indicates the date the Senior ENC conducted the claims review and referral source.

Referral via the OHCA Patient Dismissal Committee

Primary care providers (PCPs) can request to have SoonerCare members dismissed from their patient panel using the SoonerCare Dismissal Request Form HCA-42. Dismissal request reasons on the Form include: rude/disruptive behavior, non-compliance with medical regime, deterioration of provider/patient relationship, and/or no shows (see Attachment E).

The OHCA has a Patient Dismissal Committee that meets every other week to review the PCP requests to determine if patient dismissal is appropriate. The Committee is composed of OHCA representatives from the Medical Professional Services Unit, Member Services, Care Management (the Pharmacy Lock-in Program designated Senior ENC), Provider Services, Behavioral Health, and Quality Assurance/Quality Improvement. Prior to each Patient Dismissal Committee meeting, the Member Services designee compiles the list of specific members who have been referred to the Patient Dismissal Committee and sends it to the OU COP for evaluation of prescription drug utilization concerns.

OU COP runs a report to identify medications the member has been prescribed for the past six months. This report lists: member's name and identification number, dispensed date, provider name, prescribing provider name, National Drug Classification (NDC) description, claim status, days' supply, quantity dispensed, and drug strength.

Once completed by OU COP, the member's six-month prescription history report is sent to the Senior ENC Lock-in designee in the PCM Department. The Senior ENC formats and then reviews the report against claims data using the same criteria and process as that previously described in the "Referral via the OHCA Care Management Unit" section. The Senior ENC attends the bi-weekly Patient Dismissal Committee meeting to provide the report results as they consider each request for member dismissal.

After the Dismissal Committee meeting, the Senior ENC enters the appropriate information into the Excel Lock-in Log and then faxes the report log to OU COP, alerting OU COP to the need for more in-depth review for possible initiation into the Pharmacy Lock-in Program. The Senior ENC also enters information into Atlantes for those members referred to OU COP, as described in the "Referral via the OHCA Care Management Unit" section.

Pharmacy Lock-in Program Initiation, Monitoring, and Closure

For each member identified through the above three referral mechanisms, the OU COP conducts more in-depth analysis to determine if the member's pharmacy utilization is inappropriate and meets Lock-in Program criteria. If the member meets program criteria, the OU COP will "Lock" them using OHCA's Medicaid Management Information System (MMIS). This MMIS entry notifies the PCM Department Senior ENC to change the Atlantes Level of Care Detail: Case Information for the member to "Lock-In Enrolled."

OU COP manages all lock-in program functions. When the lock-in process is started, the member is required to fill all prescriptions at a single pharmacy. The member is given the opportunity to choose a designated pharmacy; the pharmacy is then given the option to accept or decline serving as the member's designated lock-in pharmacy. Once a pharmacy is assigned to that member, the eligibility file is updated to pay claims only for that pharmacy.

If a lock-in member's designated pharmacy is unable to fill the member's prescription, requests to temporarily override the lock-in status may be initiated by contacting the Pharmacy Help Desk. For example, exceptions may be permitted if the designated lock-in pharmacy confirms that it is currently unable to fill the needed prescription because the medication is currently out of stock.

Members are locked-in for two years, which can be extended one year if warranted by an OU COP review. OU COP conducts all correspondence with members regarding their Lock-in Program status. If at any point in the above process it is determined that the member definitely does not meet the Lock-in Program criteria, the OU COP indicates the member's closure from the Program through an entry into the OHCA MMIS. The PCM Department Senior ENC then enters this information into Atlantes with the closure date.

Referrals that Do Not Meet Lock-In Program Criteria

An individual whose utilization merits concern, but does not fully meet the criteria for lock-in, is typically warned and/or monitored by OU COP. If a decision is made to monitor without a warning, the case is reviewed again in three months, and a decision is made based on recent utilization patterns. In cases where a warning is warranted, a letter is sent to the member explaining that he or she is being monitored and the reasons for which the warning has been issued.

Members who receive warnings are reviewed again in six months to evaluate recent utilization. If there is no improvement in utilization patterns, the member is entered into the Lock-in Program. If recent utilization has improved, the cases are closed. PCM Department staff members are not involved in on-going care management, monitoring, communication, or case closure activities for Pharmacy Lock-In enrollees or referrals; these activities are performed by OU COP.

Significant Changes/Revisions to the Pharmacy Lock-In Program

2001 - 2005: The earliest records of referrals to the Pharmacy Lock-in Program are from 2001. Care Management staff received referrals for lock-in from a variety of external sources, such as individual providers and Emergency Room staff, as well as from internal OHCA departments, including Provider Services, Member Services, and Quality Assurance. Similar to the current process, the referrals were screened by Care Management. If the screening was positive based on similar criteria to what is used present-day, the member's case was referred to the OHCA Surveillance Utilization and Review Services Unit (SURS) for Lock-in management. SURS would notify the member, give the member a choice of pharmacy, and monitor utilization over time. If the screening was borderline, the member would receive a warning letter and be monitored by SURS for six months to observe utilization patterns. When members were locked-in, they would be locked in for one year. At the end of one year, service utilization would be re-evaluated for extension or discontinuation.

At the beginning of the Lock-in Program, members were assigned to a lock-in provider in addition to a lock-in pharmacy. This option was discontinued after a few years due to difficulty in finding providers willing to serve as a lock-in prescriber.

2006: In January 2006, the administration of the Lock-In Program was transferred from the OHCA Surveillance Utilization and Review Services (SURS) Unit to an outside contractor, the OU COP. At the same time, Medicare Part D was implemented requiring that all dual eligibles (members who qualify for Medicare and Medicaid) obtain their drugs through Medicare.

2014: The practice of assigning the member a lock-in prescriber as well as a lock-in pharmacy was re-implemented.

Summary of OHCA Care Management Unit Functions for the Pharmacy Lock-in Program

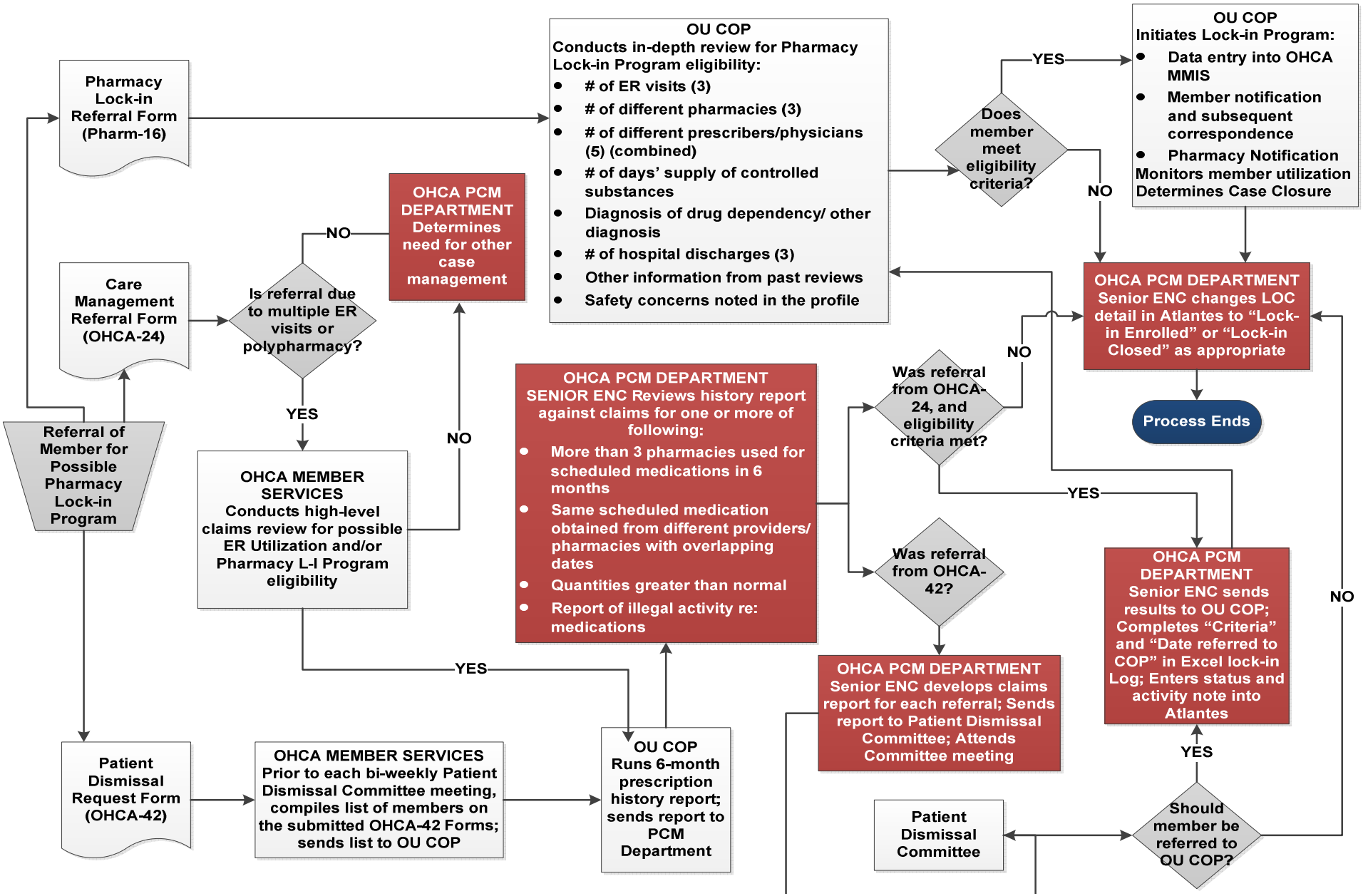
In summary, the PCM Department Senior ENC designated to the Pharmacy Lock-in Program performs the following functions:

- For members referred for the Lock-in Program via the Care Management Referral Form or Member Services:
    - Reviews pharmacy utilization six-month history reports (provided by OU COP) against claims data to see if the member potentially qualifies for the Lock-in Program
    - If the claims data indicate that any of the program conditions have been met, forwards the findings to the OU COP for more in-depth analyses and potential Lock-in Program initiation.

- For members referred via the Patient Dismissal Committee:
    - Reviews pharmacy utilization six-month history reports (provided by OU COP) against claims data to see if the member potentially qualifies for the Lock-in Program
    - Prepares a report to be reviewed by the Patient Dismissal Committee
    - Serves as the Care Management representative on the OHCA Patient Dismissal Committee and attends each meeting to discuss the member's pharmacy utilization report
    - For those members that the Patient Dismissal Committee deems warranted, forwards the findings to the OU COP for more in-depth analyses and potential Lock-in Program initiation.
- Coordinates with OU COP regarding member reports and Lock-in Program status
- Manages all data entries into Atlantes regarding the member's Lock-in Program status.

Exhibit 17-1 on the following page provides a flow chart of the Pharmacy Lock-in Program referral processes and the related functions performed by the designated ENC in the PCM Department.

Exhibit 17-1: PCM Department Involvement in Pharmacy Lock-in Program Process



PHARMACY LOCK-IN PROGRAM FINDINGS

Methodology

PHPG utilized data from the OHCA care management system (Atlantes) to conduct the analysis of the Pharmacy Lock-in Program. The Atlantes system is a propriety care management system operated by Hewlett-Packard and is used by the PCM Department to record Pharmacy Lock-in Program member referrals and status and related ENC activities. PCM Department activities are not consistently reflected in the Atlantes system until SFY 2010. Thus, PHPG data analysis reflects SFY 2010 through SFY 2013.

Pharmacy Lock-in members were identified in Atlantes through their assignment to the Pharmacy Lock-in Program. The Atlantes dataset was "cleaned" to ensure a member's program assignment and eligibility were accurately reflected for the analysis. This included removing duplicate entries.

Results

The PCM Department's responsibilities related to the Pharmacy Lock-in Program are primarily focused on claims analyses and reporting regarding potential Program eligibility; once this activity is completed, the Unit's Senior ENC responsibilities are minimal (i.e., changing member status in Atlantes when warranted). As such, the OHCA and PHPG jointly agreed that a full evaluation of the Program was not warranted, and that a brief analysis of basic demographics regarding the cases and time spent by the Senior ENC would suffice. The following metrics related to the Pharmacy Lock-in Program were analyzed for this Report:

- Cases reviewed by the PCM Department designated Senior ENC by Fiscal Year, Average Age, and Gender;
- PCM Department Senior ENC Time spent on Pharmacy Lock-in Program activities; and
- Total PCM Senior ENC FTEs for the Pharmacy Lock-in Program.

Number and Description of Pharmacy Lock-in Program Cases Reviewed by the PCM Department

The number of cases reviewed by the PCM Department for possible Pharmacy Lock-in Program eligibility, and the demographics of these cases, are presented in Exhibit 17-2 on the following page. The number of cases varied considerably across fiscal years, from a low of 17 in SFY 2010 to a high of 94 in SFY 2011. However, the average age of the cases reviewed was relatively consistent across fiscal years (from age 36 to 43), as was the fact that the majority of cases were females.

Exhibit 17-2: PCM ENC Reviewed Pharmacy Lock-in Program Cases by Fiscal Year, Average Age, and Gender

SFY	Cases Reviewed	Average Age	Gender	
			Male	Female
2010	17	43	42%	58%
2011	94	39	32%	68%
2012	82	38	30%	70%
2013	42	39	20%	80%

ENC Time Spent on Pharmacy Lock-in Program Activities

Unlike many of the other programs within the PCM Department where ENCs share responsibility across all programs, a Senior ENC is assigned to work on the Pharmacy Lock-in Program in addition to the other functions that Senior ENCs perform. To assess the time spent by the Senior ENC for the Pharmacy Lock-in Program, PHPG used the Atlantes activity data and limited the review to only those cases where the data indicated that an ENC performed activities related to Pharmacy Lock-in.

During SFY 2010 through SFY 2013, the ENC recorded time in ten different activity types; however, 92 percent of the time was recorded as one of the following three activities: Care Evaluation, Other CM Contact, and Referral (see Exhibit 17-3 on the following page). This would be expected since the primary functions of the ENC for the Pharmacy Lock-in Program relate to these categories (i.e., reviewing claims data to see if the member potentially qualifies for the Lock-in Program, coordinating with member Services and the Patient Dismissal Committee, and referring to the OU COP).

In SFY 2011 through SFY 2013, the total hours spent by the Senior ENC for the Pharmacy Lock-in Program across all activities has ranged between 36 and 58 hours (see Exhibit 17-3 below). This equates to approximately two to three percent of an FTE each year, with the remaining time available to support other care management functions within the PCM Department.

Exhibit 17-3: ENC Time Spent on Pharmacy Lock-In Program Activities

	SFY2010	SFY2011	SFY2012	SFY2013
Total Minutes	**246**	**2145**	**3455**	**2375**
Total Hours	**4.1**	**35.8**	**57.6**	**39.6**
Total ENC FTE Time	**0.002**	**0.02**	**0.03**	**0.02**

Summary and Considerations for the Future

This program evaluation has a narrow scope due to the limited role of the PCM Department within the overall Pharmacy Lock-in Program. That said, the relatively small amount of time (approximately two to three percent of an FTE) spent on this Program appears to be extremely valuable in terms of claims review to ensure that appropriate SoonerCare members are referred for possible lock-in to one pharmacy due to inappropriate pharmacy utilization. As can be seen in Exhibit 17-1, the current process for the program as a whole is somewhat complex, with information transfers among multiple entities. The OHCA has indicated that staff is examining the current operations to identify possible areas for streamlining the processes and information transfers within the program.

Another area for program improvement is clarification of the working definitions for activity types in Atlantes in order to obtain more consistent data entry by the Pharmacy Lock-in Program ENC. The OHCA began standardizing activity types in the Atlantes menu in the summer of 2014; this will benefit data analyses and program reports for all care management functions in the future.

In addition, the OHCA Desktop Procedure Guide for the PCM Department could be improved to more clearly distinguish the ENC role regarding the three referral paths. The Pharmacy Lock-in Program has changed over time, and the guide does not clearly portray the current program operations from the perspective of an external reader. Improvements to the guide would be especially important if the ENC who is the Unit designee to the Pharmacy Lock-in Program changes over time.

WAIVER OPERATIONS PROGRAM INTRODUCTION AND OVERVIEW

The OHCA Long Term Care (LTC) Waiver Operations Division (Waiver Division) oversees the development and implementation of initiatives to support the long-term service and support needs of Oklahoma citizens. The OHCA has received federal approval from the Centers for Medicare and Medicaid Services (CMS) for a variety of Home and Community-based Services (HCBS) Programs, including programs to support elders and/or those beneficiaries who have disabilities needing long-term services and supports, and individuals who are medically fragile. These include a LTC Demonstration Program (the Living Choice Program), three Home and Community-Based Services (HCBS) Waivers (the My Life, My Choice Program; the Sooner Seniors Program; and the Medically Fragile Program) and one comprehensive capitated LTC program that serves the frail elderly and adults with physical disabilities (Program of All Inclusive Care for the Elderly (PACE)).

The OHCA PCM Department works in partnership with the Waiver Division to provide clinical expertise and oversight for these five programs. These duties are conducted by Registered Nurses and are assigned according to experience and expertise. Senior-level Exceptional Needs Coordinators (ENCs) review level-of-care determinations, critical incident reports, treatment plans, and prior authorize services for plans of care. The Exceptional Needs Coordinators also conduct on-site assessments for Living Choice Program eligibility.

In addition, the OHCA makes Medicaid benefits available to children with physical or intellectual disabilities who would not ordinarily qualify for Supplemental Security Income (SSI) benefits because of their parents' income or resources. This option, which is allowed under the Tax Equity and Fiscal Regulation Act of 1982 (TEFRA), gives states the option to allow children who are eligible for institutional services to be cared for in their homes. The Level of Care Eligibility Unit (LOC-EU) within the OHCA Member Services Division is responsible for TEFRA eligibility determinations. PCM Department ENCs conduct safety inspections for home-based care prior to final TEFRA eligibility approval and also conduct home visits for any application that was denied TEFRA eligibility by the LOC-EU in order to assure the denial was appropriate.

The Waiver Division and PCM Department partnership started in State Fiscal Year (SFY) 2006 with the PCM Department involvement in the TEFRA eligibility process. Each of these OHCA LTC Programs and the PCM Department staff roles associated with the Programs are described on the following pages.

Long-term Care Demonstration Program

The PCM Department is integrally involved with the Living Choice Program, which is the LTC Demonstration program administered by the OHCA Waiver Division.

Oklahoma Living Choice (Money Follows the Person)

The OHCA Living Choice Program, which began in November 2009, is supported as a CMS approved Money Follows the Person (MFP) Rebalancing Demonstration. This CMS opportunity was made available to states to rebalance their Medicaid long-term care systems, which have traditionally been focused on institutional care. The Oklahoma Program is designed to transition individuals with disabilities and long-term illnesses from the institution back into their home in the community.

The Living Choice Program serves three populations: individuals age 19 years to 64 years who are physically disabled, individuals who are age 65 years and older, and individuals age 19 years or older with an intellectual disability. Individuals in any of these three populations are eligible for transition out of institutional level of care to home and community-based services, as long as they have resided in a qualified institution for at least ninety days prior to their proposed transition date and have had one day of their institutional stay paid by Medicaid. Qualified institutions include nursing facilities and intermediate care facilities. Applicants for the Living Choice Program must want to transition back into the community and be willing to play an active role in their transition.

The Living Choice application process begins in the field and relies on field nurses known as Transition Coordinators to facilitate applications and enrollments. Transition Coordinators are employees of Home Health Agencies that are under contract with the OHCA to serve as the point of contact and provide oversight for all Living Choice transitions. Anyone can make a referral to the Living Choice Program and can do so by phone, fax, mail, or online to the transition agency (Home Health Agency) in their region.

Living Choice Program Initial Assessment

Note: PCM Department involvement in the initial assessment phase for the Living Choice Program was eliminated as of August 1, 2014, when the OHCA began contracting with the Oklahoma University (OU) College of Nursing to perform the first-level assessment. However, this Evaluation Report covers the time period prior to this procedural change (i.e., State Fiscal Years 2009 to 2013). As such, the following description describes the process in place during the evaluation period, but uses past tense to remind the reader that the process has since changed.

During the time period of this Evaluation Report, the Transition Coordinator reviewed applications and used the OHCA Care Management Referral Form (HCA-24) to request a Living Choice assessment by a PCM Department Exceptional Needs Coordinator (ENC) for those who meet Program criteria. Once received in the PCM Department, the HCA-24 information was used by administrative staff to create a

case within Atlantes; the case was added to the queue for a senior PCM Department staff member to assign the case to a regional ENC to review the referral and contact the Transition Coordinator for any additional information. After this initial discussion with the Transition Coordinator, the ENC contacted the facility directly (and if possible, the member) to schedule a visit. During the facility visit the ENC completed a chart review, met with any necessary facility staff, interviewed the applicant to complete the Living Choice Nursing Assessment, and, if not already completed by the Transition Coordinator, completed the Quality of Life Survey.

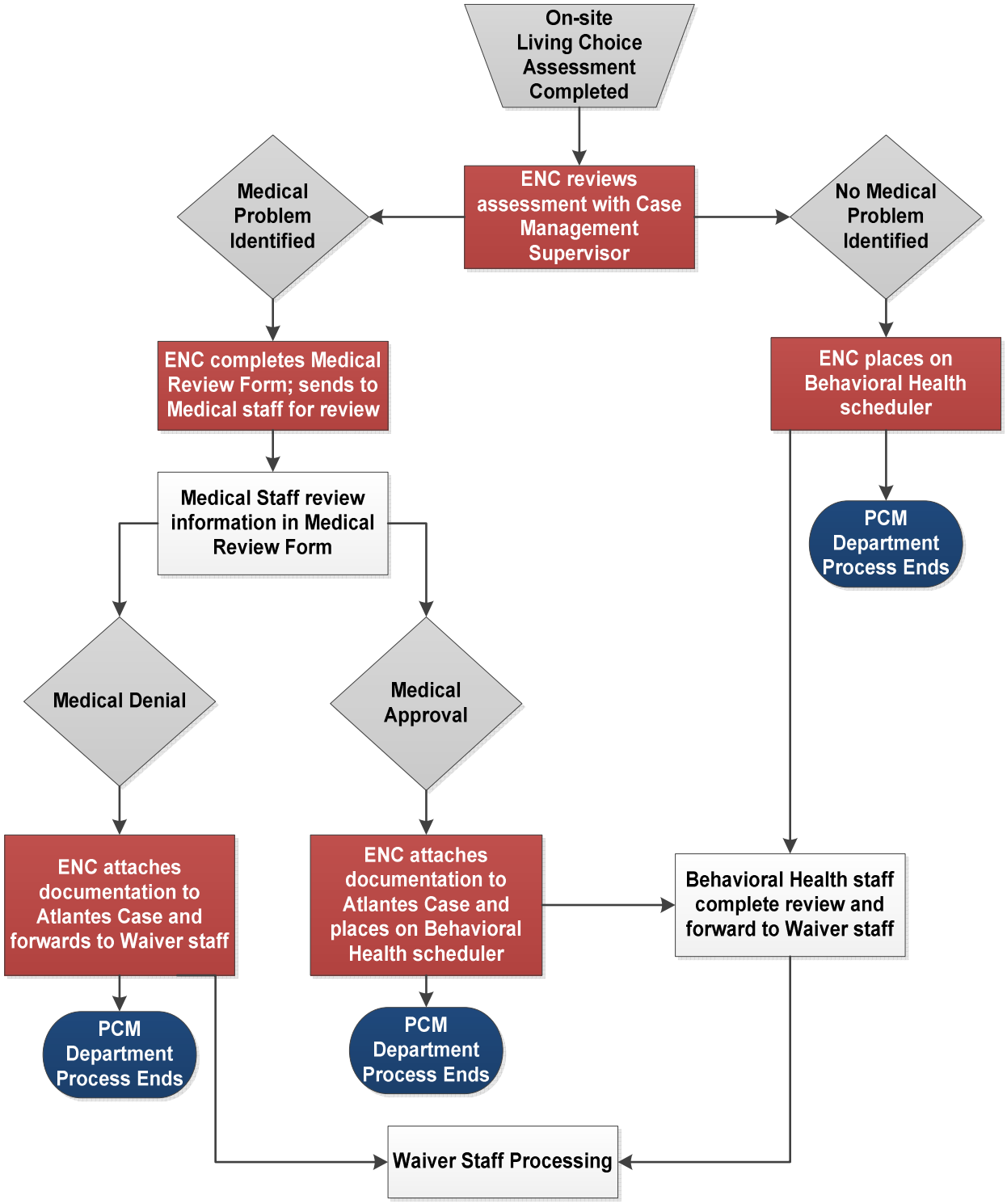
The Living Choice Nursing Assessment includes diagnostic information; practitioner and specialist information, specialized equipment use, skilled care needs (wound care, catheter, labs, medication management, foot care, etc.), and service utilization over the past six months such as hospital stays, emergency room use, and behavioral health services. During the assessment process the ENC gathered information on chronic health conditions across several domains (i.e., neurological/psychological, integumentary, cardio-pulmonary, gastrointestinal, and musculoskeletal). The ENC also reviewed medication needs, requirements for activities of daily living (ADLs) and instrumental ADLs, safety and other needs, health benefits, and other agencies' involvement in the individual's care.

If the Quality of Life Survey was not already conducted by the Transition Coordinator, the ENC interviewed the applicant to complete the survey. The Quality of Life Survey is an instrument sponsored by CMS and is used in the evaluation of the Money Follows the Person Programs. The survey asks individual applicants to answer questions related to their satisfaction with their living conditions, their choice and autonomy in everyday decision making (e.g., food, sleep, and recreation), their caregivers, and caregiving routines. The survey also asks individuals to rate their satisfaction with their level of community access and social integration, health status, and feelings of safety and well-being. The Quality of Life Survey is then repeated at one year after transitioning to home.

PCM Department Review of Assessment regarding Medical Appropriateness

After the assessment is completed, the PCM Department ENC discusses the results of the assessment with a supervisor within two business days of the facility visit. If they determine that the member is appropriate for the Living Choice Program, the supervisor and ENC will sign the appropriate documentation. However, if for any reason the ENC and/or supervisor feel that the referral is not appropriate for the Living Choice Program, the ENC will complete a Medical Review Form and request that a Medical Doctor from the OHCA Medical and Professional Services Unit make the final medical appropriateness decision. Beginning in November 2013, all Living Choice cases that are approved are then referred for clinical review by the OHCA Behavioral Health Staff. Upon completion of all reviews, documentation and determinations are forwarded to the Waiver staff responsible for the creation of notifications of approval or denial and follow-up with applicants. Please see Exhibit 18-1 on the following page for a flow chart of the PCM Department's involvement in the Living Choice Program assessment review process.

Exhibit 18-1: Living Choice Assessment Review Process



PCM Clinical Review and Prior Authorizations

Once accepted into the Living Choice Program, the PCM Department continues to play a clinical oversight role by reviewing in-depth assessments, treatment plans, subsequent requests for treatment plan changes, and prior authorizing services. (From 2009-2011, OHCA ENCs performed the on-site assessment only, and all transition process activities for the programs were managed by the Oklahoma Long-Term Care Authority.)

The Transition Coordinators are responsible for completing the Uniform Comprehensive Assessment, Part III Medical Level of Care (UCAT-III) upon the member's initial enrollment in Living Choice, at the end of the 365-day period, and anytime in between when there is a change in the member's needs. The UCAT Part III is a comprehensive assessment used across all OHCA LTC Programs to determine a person's potential to remain or live in a community-based care setting and to assist with development of a plan of care. The results are scored to determine whether someone meets nursing facility, skilled, or hospital level of care in order to determine waiver eligibility, as well as to provide the basis for treatment planning and subsequent prior authorizations for services.

Living Choice treatment and support plans must address all areas identified in the UCAT III assessment process. The Transition Coordinators fax all requests for new service plans and/or changes to plans to the Waiver Division. The Waiver staff creates a prior authorization request in the Integration of the Interchange (iCE), the Medicaid claims processing system and places the PA on "evaluation status." Waiver staff then attaches the UCAT /UCAT update, service plans, and service plan addendums to the PA request and puts the case in the Atlantes scheduler for PCM Department review.

Senior ENCs are assigned reviews of all UCAT III and treatment plan information and must complete the review within three business days of receiving the request. All requests must be supported by written plan goals, and the requested service amount and duration must match plan activities. The Senior ENC reviews the information for adherence to these guidelines and for medical necessity, and then approves or denies the request.

PCM Critical Incident Review and Investigation

PCM Department staff review all Living Choice critical incident reports submitted to the Waiver Division by local Transition Coordinators to determine if there is a need for clinical follow-up or adjustments in the treatment plan. In all cases, the PCM staff will follow the report through to resolution, including obtaining additional information, contacting providers, and/or requiring changes in treatment plans and support services. Reportable incidents are classified into three levels, each with specific reporting timeframes as noted in Exhibit 18-2 on the following page.

Exhibit 18-2: Critical Incident Report Categorization and Required PCM Department Follow-up

Level	Type of incident	Reporting Timeline	OHCA Follow-up Requirements
I – Urgent	Sexual abuse; lost or missing person; questionable, unexpected, or preventable death; suicide attempt; neglect, physical abuse; exploitation	Within 1 working day	Investigation and written report.
II – Serious	Criminal justice system involvement; restraint use; medication error with adverse effects; falls with injury	Within 2 working days	Evaluation required. May require investigation and written report.
III - Significant	Verbal abuse; hospitalizations; emergency room visits	Within 2 working days	Evaluation required. May require investigation and written report.

The Living Choice Program is limited to 365 days, in that each individual who transitions to a home in the community receives a range of medical and home and community-based services for one year after moving from the institution. At the end of their 365 days in the community, those with physical disabilities and older persons graduate into one of the two waivers offered as part of Oklahoma's LTC system: The My Life, My Choice Program for people's ages 19 through 64 and the Sooner Seniors Program for persons 65 and older. These are described below and on the following page.

OHCA Home and Community-Based Waiver Programs

The PCM Department is involved with three Home and Community-Based Services (HCBS) Waivers, which are administered by the OHCA Waiver Division: the My Life, My Choice Program; the Sooner Seniors Program; and the Medically Fragile Program. Each is briefly described below, followed by the role of the PCM Department, which is consistent across all three.

My Life, My Choice Program

My Life, My Choice is a Home and Community-based Waiver Program that was approved by CMS in September of 2010. Services began in November of 2010, when the first member transitioned from the Living Choice/MFP demonstration described above. This Program offers the same services received through the Living Choice demonstration for individuals who are ages 19 through 64 with physical disabilities and who meet nursing facility level of care. Medicaid expenditures for services rendered under the My Life, My Choice Program must be lower than the costs of the Medicaid-funded institutional services that would have been incurred had the individual been served in a nursing facility.

To be eligible for the My Life; My Choice Program an individual must:

- Have transitioned to the community through the Living Choice Demonstration;
- Be between 20 and 64 years of age with a physical disability;
- Meet nursing facility level of care; and
- Meet SoonerCare financial eligibility.

Sooner Seniors Program

Sooner Seniors is a Home and Community-based Waiver Program that was approved by CMS in 2010. Services began in March of 2011, when the first member transitioned from the Living Choice/MFP demonstration described above. This Program offers persons 65 and older with long-term illnesses the same services they received through the Living Choice demonstration in a residential setting of their choice. Medicaid expenditures for services rendered under the Sooner Seniors Program must be less than the Medicaid-funded institutional services the individual would have received in a nursing facility.

To be eligible for the Sooner Seniors Program individuals must:

- Have transitioned to the community through the Living Choice Demonstration;
- Be 65 years of age or older with a long-term illness;
- Meet nursing facility level of care; and
- Meet SoonerCare financial eligibility.

Medically Fragile Program

The Medically Fragile Program, which began in July 2010, is a home and community-based alternative to placement in a hospital and/or skilled nursing unit of a nursing facility. The goal of this Program is to provide services that allow Medicaid-eligible persons who meet hospital and/or skilled nursing level of care to remain at home or in the residential setting of their choosing while receiving the necessary care. A medically fragile condition is defined as a chronic physical condition that results in prolonged dependency on medical care and for which daily skilled (nursing) intervention is medically necessary and is characterized by one or more of the following:

- There is a life-threatening condition characterized by reasonably frequent periods of acute exacerbation that requires frequent medical supervision and/or physician consultation, and which, in the absence of such supervision or consultation, would require hospitalization;
- The individual requires frequent, time-consuming administration of specialized treatments that are medically necessary; and/or
- The individual is dependent on medical technology such that without the technology a reasonable level of health could not be maintained. Examples include, but are not limited to, dependence on ventilators, dialysis machines, enteral or parenteral nutrition support, or continuous oxygen.

To be eligible for the Medically Fragile Program individuals must:

- Be at least 19 years of age;
- Meet hospital and/or skilled nursing level of care;
- Meet SoonerCare financial eligibility; and
- Must be living at home or a residential setting.

Population Care Management Department Role in HCBS Waiver Programs

Once a member has completed the 365 days in the Living Choice Demonstration, the member is eligible to apply for the My Life, My Choice or Sooner Senior Programs. If requirements are met, the member will continue to receive the same level of service provided in the Living Choice demonstration. Entry into the Medically Fragile Program may be through involvement with the Living Choice/Money Follows the Person Program or through direct referral to the Medically Fragile Program.

Waiver Level-of-Care Determinations

For the My Life, My Choice and the Sooner Senior Programs, PCM Department Senior ENCs are responsible for reviewing applicants after they have completed 365 days in the Living Choice Program. Assessment of Program eligibility is based on the results of the scoring matrix from the Uniform Comprehensive Assessment, Part III Medical Level of Care (UCAT-III). As previously described in the section on the Living Choices Program, the UCAT Part III is a comprehensive assessment used to determine a person's potential to remain or live in a community-based care setting and to assist with development of a plan of care. The results are scored to determine whether the person meets nursing facility, skilled, or hospital level of care in order to determine waiver eligibility, as well as to provide the basis for treatment planning and subsequent prior authorizations for services.

For the My Life, My Choice and Sooner Seniors Programs, a member must meet the Nursing Facility level of care on the UCAT III. The Medically Fragile waiver requires a Skilled or Hospital Level of Care to qualify. In all cases the PCM Department lead nurse will receive a request for the level-of-care determination and assign the case to a Senior ENC staff. The Senior ENC will review the UCAT III content, score each section, and compile an overall score to determine level of care. The score is determined by a mechanism developed by the Oklahoma Department of Human Services and is used statewide for multiple long-term care programs. The result of this scoring is communicated to the Waiver staff. The accumulated time spent in the activity, the final score, and a note are placed in the Atlantes system by the Senior ENC.

Clinical Review and Prior Authorizations

Once accepted into one of the three waiver Programs described above, the PCM Department continues to play a clinical oversight role by reviewing in-depth assessments, treatment plans, and subsequent requests for treatment plan changes, and by prior authorizing services. (Note: From 2009-2011, OHCA ENCs performed the on-site assessment only, and all transition process activities for the programs were managed by the Oklahoma Long-Term Care Authority.) Waiver case managers are responsible for completing any necessary updates to the UCAT-III no less than annually, and treatment and support plans must address all areas identified in the UCAT III assessment process.

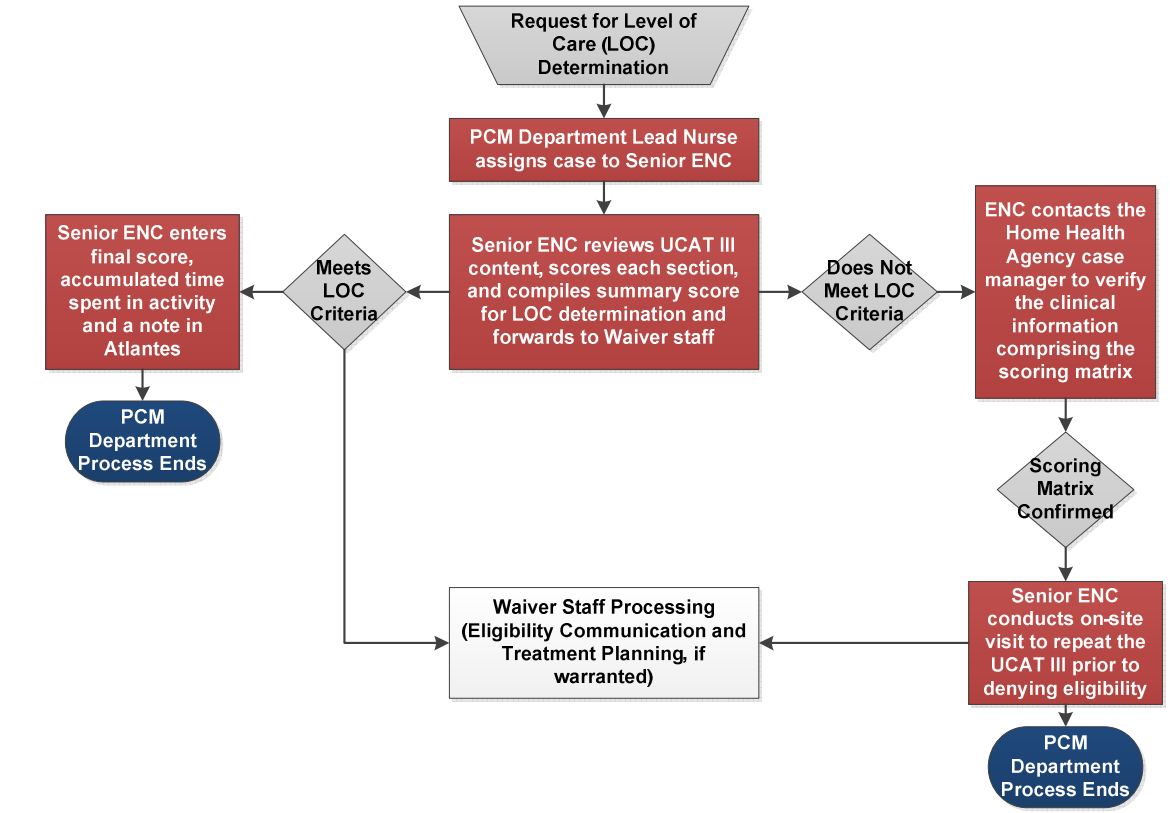
Case managers fax all requests for new service plans and/or changes to plans to the Waiver Division. The Waiver staff creates a prior authorization request in the iCE and places the PA on “evaluation status.” Waiver staff will then attach the UCAT /UCAT update, service plans, and service plans addendums to the PA request and put the case in the Atlantes scheduler for PCM Department review.

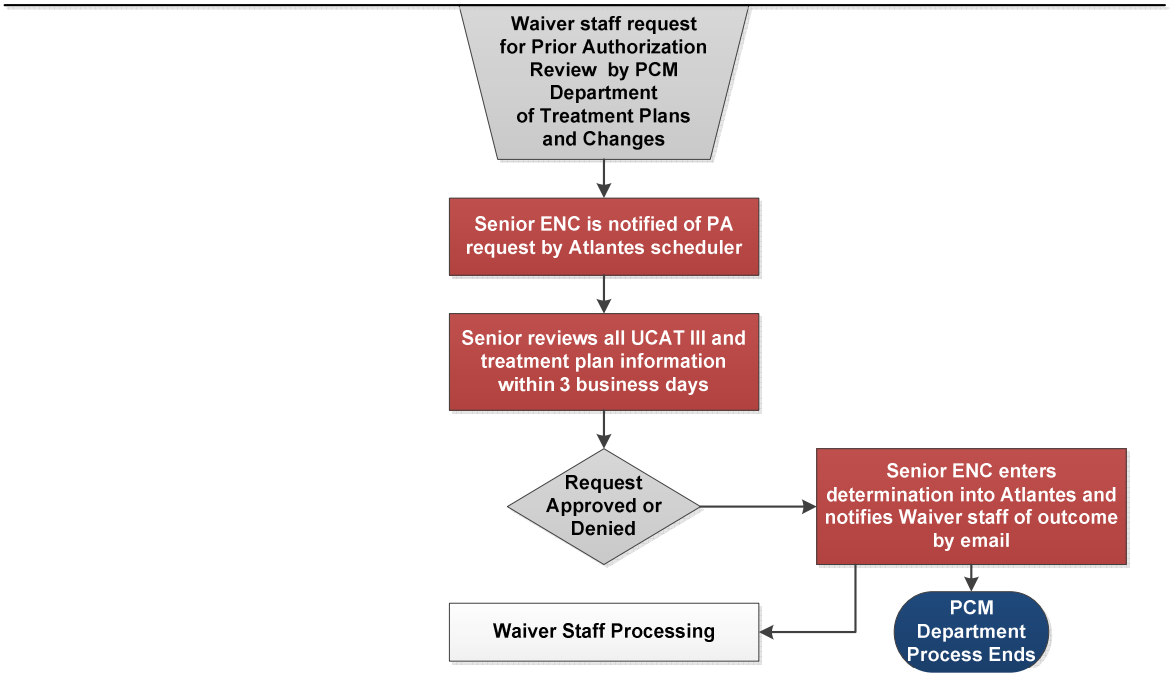
Senior ENC’s are assigned reviews of all UCAT III and treatment plan information and must complete the review within three business days of receiving the request. All requests must be supported by written plan goals, and the requested service amount and duration must match plan activities. Senior ENCs review the information for adherence to these guidelines and for medical necessity and then approve or deny the request.

If the member does not meet a qualifying level of care upon review of the UCAT III score, the ENC contacts the case manager at the home health agency to verify the clinical information comprising the scoring matrix. If this is confirmed, the Senior ENC does an on-site visit to repeat the UCAT III prior to denying eligibility.

Exhibit 18-3 on the following page provides an overview of the PCM Department’s involvement in the eligibility determination and prior authorization processes for the HCBS Waiver Programs.

Exhibit 18-3: PCM Department Involvement in HCBS Waiver Program Eligibility and Prior Authorization Reviews (My Life, My Choice, Sooner Seniors and Medically Fragile Programs)





PCM Critical Incident Review and Investigation

PCM Department staff review all critical incident reports submitted to the OHCA Waiver Division by local waiver case managers to determine if there is a need for clinical follow-up or adjustments in the treatment plan. In all cases, the PCM Department staff will follow the report through to resolution, including obtaining additional information, contacting providers, and/or requiring changes in treatment plans and support services. Waiver Programs use the same reportable incidents classification and reporting timeframes as noted for the Living Choice Program.

Oklahoma LTCS Eligibility Processes (PACE and TEFRA)

TEFRA Eligibility Home Care Assessments

The Tax Equity and Fiscal Regulation Act of 1982 (TEFRA) gives states the option to make Medicaid benefits available to children with physical or intellectual disabilities who would not ordinarily qualify for Supplemental Security Income (SSI) benefits because of their parents' income or resources. This option allows children who are eligible for institutional services to be cared for in their homes. Oklahoma TEFRA eligibility requests are reviewed, and level-of-care determinations are completed, by the Level of Care Eligibility Unit (LOC-EU) in the OHCA Member Services Division. As part of the application process for home care, the PCM Department staff conducts an in-home assessment to determine that the home environment is safe and adequately prepared to deliver necessary in-home care and support to TEFRA-eligible children.

TEFRA applications are sent to the PCM Department by the OHCA LOC-EU, and a case is created in Atlantes. TEFRA cases are assigned to ENCs based on the geographical region of the home-care request. Within three business days of assignment, the ENC schedules an appointment with the parent to meet the child and conduct a home assessment.

During the home visit the ENC completes the TEFRA Home Care Evaluation Assessment form. This instrument collects information on household size, ages of occupants and their relationships to the TEFRA applicant, the primary caregiver's health status and work schedule, the child's schedule and/or school routines, who is available to care for the child in the event the primary caregiver is sick or otherwise unable to provide care, family structure and stability, and the risks and obstacles for care to be appropriately provided in the home setting. TEFRA risk areas include medication management, caregiver availability, wage earner considerations for the caregiver, family structure, family problem solving skills, compliance with medical regime, availability of support systems, stressors, financial considerations, resource availability and utilization, environmental safety, and ADL considerations.

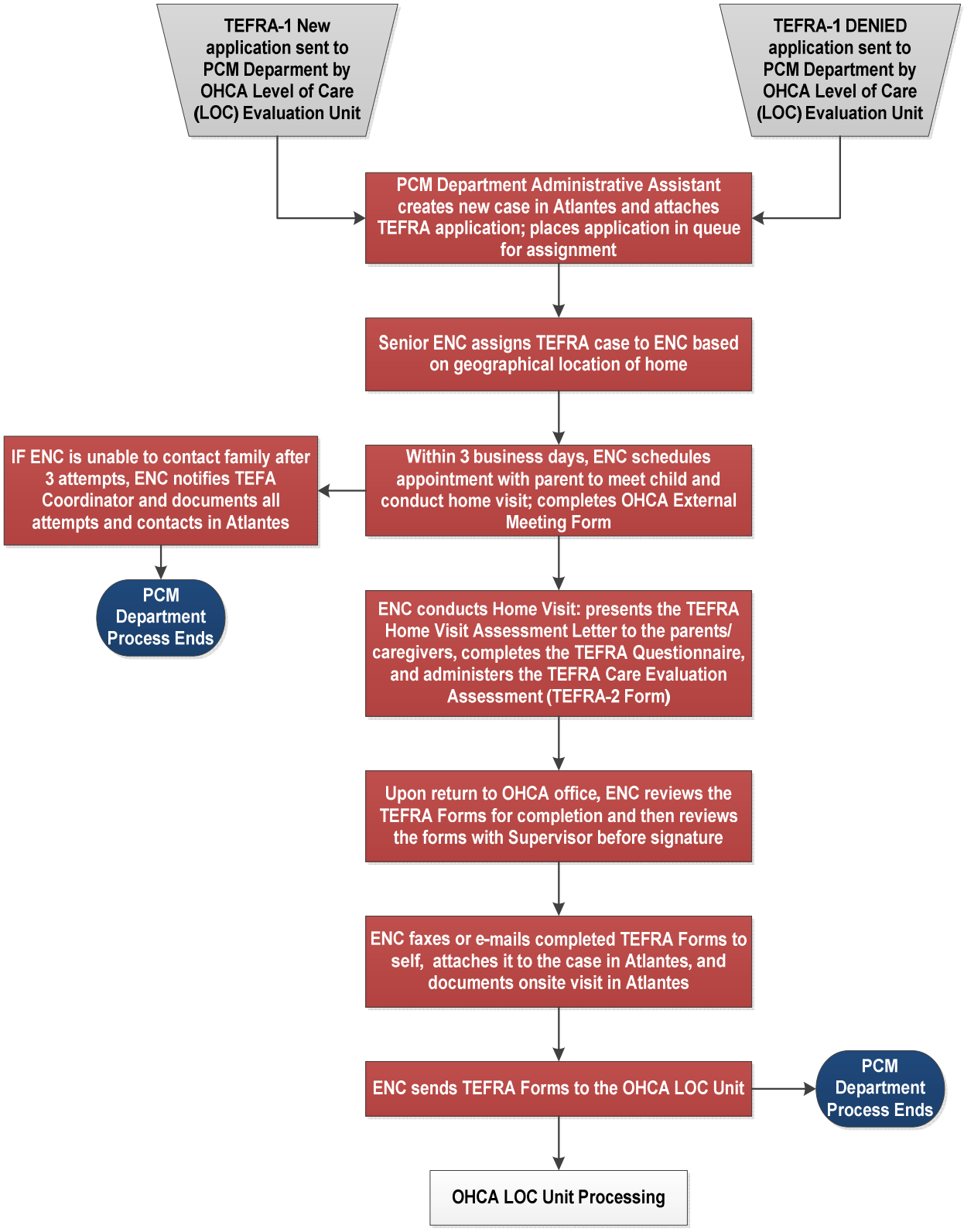
Upon completion of the assessment, the ENC reviews the information with the supervisor, and they discuss whether or not TEFRA benefits are sufficient to meet the child's level-of-care needs safely in the home. The results of the home visit and supporting information are returned the TEFRA Coordinator and LOC-EU staff, and the PCM Department has no further role in TEFRA eligibility or ongoing services.

To ensure internal quality control for the TEFRA LOC-EU determinations, the PCM Department ENCs also review all cases where the LOC-EU denied TEFRA eligibility. Completed TEFRA applications that have been denied are sent to the PCM Department by the OHCA LOC-EU, and a case is created in Atlantes. TEFRA cases are assigned to ENCs based on the geographical region of the home-care request. Within three business days of assignment, the ENC will schedule an appointment with the parent to meet the child and conduct a home assessment.

During the home visit the ENC completes the same Home Care Assessment Evaluation Form noted above and a TEFRA Questionnaire. The latter includes diagnostic, weight, height, and developmental information related to any noted speech, vision, and/or hearing deficits. The ENC documents how these deficits have been identified (e.g., parental report, Bright Futures tools, medical documentation, etc.). The questionnaire also inventories medication and intravenous therapy (IV) delivery needs, feeding needs, elimination needs, seizure activity, sleep patterns, mobility, and the overall developmental status of the child. All information collected during the home visit is reviewed by the ENC with the supervisor. The results of the home visit and supporting information are returned to the TEFRA Coordinator and LOC-EU staff. The PCM Department has no further role in TEFRA eligibility or ongoing services.

Exhibit 18-4 on the following page provides an overview of the PCM Department's involvement in TEFRA home care assessments and review of eligibility denials.

Exhibit 18-4: PCM Department Involvement in TEFRA Home Visit and Eligibility Denial Processes



Program of All Inclusive Care for the Elderly (PACE)

Program of All Inclusive Care for the Elderly (PACE) is a unique, capitated, one-stop, Home and Community-based Program. PACE is a Medicare program. States can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit, and it becomes the sole source of Medicaid and Medicare benefits for PACE participants and is responsible for meeting the full range of their needs. The OHCA PACE, which started in August 2008, provides an array of necessary medical and social services for frail and elderly members within the home or at the Cherokee Elder Care Center in Tahlequah. It is the first Native American-sponsored program in the United States and is available to those living within specific zip codes of the pilot area. Persons must be age 55 or older, qualify for nursing facility level of care, be safely cared for in community setting, and meet SoonerCare financial qualifications.

The PCM Department became involved with PACE in June 2011. The PCM Department reviews all PACE eligibility assessments and annual re-assessments for determination of nursing facility level of care. Eligibility is based on the results of the scoring matrix from the UCAT-III. As described previously, the UCAT Part III is a comprehensive assessment used to collect data about the member to determine a person's potential to remain or live in a community-based care setting and to assist with development of a plan of care. In order to qualify for PACE services, a member must meet the Nursing Facility level of care on the UCAT III. The score is determined by a mechanism developed by the Oklahoma Department of Human Services and is used statewide for multiple long-term care programs.

PCM Department staff receive referrals directly from the PACE facility nurse. The PACE nurse will complete the UCAT III and send the assessment for review to the PCM administrative staff who then create a case in Atlantes. The lead PCM nurse will assign the case to a Senior ENC for review of UCAT III information and scoring of the UCAT III assessment or reassessment. The level-of-care determination is then forwarded via secure email to the PACE facility nurse and to the designated Waiver Division staff. The PCM Department has no further role in PACE eligibility or ongoing services. [9]

Summary of Population Care Management Department Functions for the Long Term Care Services

A summary of the PCM Department roles and responsibilities across each of the Long-Term Care waiver and eligibility Programs is provided in Exhibit 18-5 on the following page.

[9] Beginning in August 2014, if there is a conflict of interest between the local PACE reviewer and the applicant (i.e., family members), the OHCA staff conduct the UCAT. This process change is beyond the timeframe of this Evaluation Report.

Exhibit 18-5: Summary of PCM Department Long-term Care Services Activities

LTC Program	Brief Description of PCM Department Role
Living Choice Demonstration Program - Money Follows the Person	• Conduct initial on-site assessment for MFP program participation • Review and follow up on critical incident reports • Prior authorize Treatment Plan services • After 365 days in LC/MFP program, review UCAT/Level of Care for persons moving from LC/MFP to My Life, My Choice or Sooner Seniors waiver
My Life, My Choice Waiver Program	• Complete level -of-care determinations for waiver services after one year in Living Choice/MFP • Review and follow up on critical incident reports • Prior authorize Treatment Plan services
Sooner Seniors Waiver Program	• Complete level-of-care determinations for waiver services after one year in Living Choice/MFP • Review and follow up on critical incident reports • Prior authorize Treatment Plan services
Medically Fragile Waiver Program	• Complete initial UCAT III assessment • Complete level-of-care determinations for waiver services • Review and follow up on critical incident reports • Prior authorize Treatment Plan services
Eligibility (TEFRA)	• Complete Safety Home Visits for: - Applications approved by Level of Care Eligibility Unit - Review of TEFRA applications denied by Level of Care Eligibility Unit
Eligibility (PACE)	• Score Uniform Comprehensive Assessment, Part III Medical Level of Care (UCAT-III) to determine PACE eligibility • Recertify annually participant level-of-care needs

Significant Changes/Revisions to the OHCA Population Care Management Role in Long-Term Care Services

Living Choice/Money Follows the Person and Long-Term Care Waiver Programs

2005: The Oklahoma Living Choice program is created to promote community living for members with disabilities or long-term illnesses and is authorized by Section 6071 of Public Law 109-71, the Deficit Reduction Act of 2005.

2009: The Living Choice Program began in November 2009. PCM Department involvement began upon program initiation.

2010: The Medically Fragile Waiver Program began in July 2010. PCM Department involvement began upon program initiation.

2010: The My Life, My Choice waiver was approved by the Centers for Medicare and Medicaid Services (CMS) on September 22, 2010. The program began operation in November 2010 when the first member transitioned from the Living Choice demonstration. PCM Department involvement began upon program initiation.

2010: The Sooner Seniors waiver was approved by CMS on October 7, 2010. The program began operation in March of 2011 when the first member transitioned from the Living Choice demonstration. PCM Department involvement began upon initiation of the Program's operation.

2011: The PCM Department began involvement with the transition process for all programs, including follow-up planning activities and communication with the Transition Coordinator. (From 2009 - 2011, OHCA ENCs performed the on-site assessment only, and all transition process activities for the programs were managed by the Oklahoma Long-Term Care Authority.)

2013: In November of 2013 the PCM Department instituted the new process of referring all approved Living Choice applications to the OHCA Behavioral Health Staff for further clinical review.

2014: As of August 1, 2014, the OHCA contracts with the Oklahoma University (OU) College of Nursing to perform the first-level assessment. (This procedural change is beyond the timeframe of this Evaluation Report.)

Tax Equity and Fiscal Regulation Act (TEFRA)

2006: TEFRA program begins, and PCM begins working with the Level of Care Eligibility Unit to assist in the TEFRA eligibility determination process by conducting home visits and safety inspections.

Program All Inclusive Care for the Elderly (PACE)

2008: PACE was implemented in August 2008 to manage all aspects of member care through an interdisciplinary center-based program.

2011: PCM Department involvement with PACE began in June 2011.

2014: Beginning in August 2014, if there is a conflict of interest between the local PACE reviewer and the applicant (i.e., they are family members), the OHCA staff conducts the Uniform Comprehensive Assessment (UCAT). (This procedural change is beyond the timeframe of this Evaluation Report.)

WAIVER OPERATIONS PROGRAM FINDINGS

Methodology

PHPG utilized data from the Oklahoma Cares care management system (Atlantes) to conduct the analysis of the Population Care Management (PCM) Unit staff roles within the Long-Term Care Services programs. The Atlantes system is a propriety care management system operated by Hewlett-Packard and is used by the PCM Department to record member referrals, activities, status, and related Exceptional Needs Coordinators (ENCs) activities. PCM Department utilization of Atlantes became more consistent when the application was transformed to a web-based system in SFY 2010. Thus, PHPG's data analysis reflects SFY 2010 through SFY 2013, although fiscal years vary by Program due to the start date for PCM Department involvement with each Program.

Long-term care cases with PCM Department involvement were derived from two subsystems of Atlantes: The Case Management Care subsystem and the Waiver Management subsystem. Since the PCM Department shares files with Waiver staff on certain case types but are independent in their work on other case types, there are LTC cases/work/activities found in each of these two sections of Atlantes. The data were combined for purposes of this report in order to obtain a comprehensive dataset for PCM Department involvement.

Results

The PCM Department's responsibilities related to the LTC programs are primarily focused on level-of-care determinations, review of treatment plans, prior authorizations, safety home visits, and clinical review of critical incident reports. Once these activities are completed, the PCM Department's ENC responsibilities are minimal. As such, the OHCA and PHPG jointly agreed that a full evaluation of these programs was not warranted, and that a brief analysis of basic demographics regarding the cases and time spent by the ENC would suffice. The following metrics related to the LTC Programs were analyzed for this Report:

- Number and description of LTC Program cases with PCM Department involvement by Fiscal Year; and
- PCM Department ENC time, FTEs, and hours per case spent on LTC Program activities.

Number and Description of LTC Program Cases with PCM Department Involvement by Fiscal Year

Exhibit 18-6 on the following page presents the number of:

- Assessments conducted for the Living Choice Program;
- Clinical reviews and Level-of-Care (LOC) determinations for the three LTC Waiver Programs;
- Critical Incident Report reviews conducted across these four Programs;

- Home visit assessments conducted for the TEFRA Program; and
- Level-of-Care Determinations conducted for PACE.

For each Program, the number of cases varied considerably across fiscal years. The number of Living Choice assessments decreased each year, from a high of 290 in SFY 2011 to a low of 183 in SFY 2013. The number of clinical reviews and LOC determinations for the Medically Fragile Program also decreased each year, with a high of 31 in SFY 2011 to a low of 17 in SFY 2013.

The number of clinical reviews and LOC determinations conducted for the My Life, My Choice program and the Sooner Seniors Programs in SFY 2011 is lower than in SFY 2012, but the SFY 2011 data only reflect a partial year due to the date that the PCM Department began involvement with these Programs. However, the number of clinical reviews and LOC determinations conducted in SFY 2012 is higher than in the following SFY 2013.

The number of critical incident reviews conducted by ENCs for the Living Choice and LTC Waiver Programs is relatively similar for the two years of full PCM Department involvement (i.e., 56 in SFY 2012 and 46 in SFY 2013).

The number of TEFRA home visit assessments conducted by ENCs was relatively similar in SFY 2011 and SFY 2012 (i.e., 68 and 65), but increased to 81 in SFY 2013.

The number of PACE Level-of-Care Determinations has increased since OHCA involvement began in June 2011, rising from 86 Determinations in SFY 2012 to 124 in SFY 2013.

Exhibit 18-6: Number of LTC Program Cases with PCM Department Involvement by Fiscal Year

LTC Program	PCM Department Start Date	SFY 2011 Portion	Number of Cases		
			SFY 2011	SFY 2012	SFY 2013
Living Choice Assessments	Nov 2009	Full year	290	233	183
My Life, My Choice Clinical Reviews and Level-of-Care Determinations	Nov 2010	8 months	15	51	36
Sooner Seniors Clinical Reviews and Level-of-Care Determinations	Mar 2011	4 months	8	28	25
Medically Fragile Clinical Reviews and Level-of-Care Determinations	July 2010	Full year	31	23	17
Critical Incident Report Reviews (across four Programs listed above)	See above	See above	3	56	46
TEFRA Home Visit Assessments	2006	Full year	68	65	81
PACE Level-of-Care Determinations	June 2011	None	NA	86	124

Exhibit 18-7 below presents the gender of the cases in which the PCM Department was involved by SFY, across all LTC Programs. There are minimal variations in gender, with males representing slightly more cases than females in SFY 2011 and SFY 2013.

Exhibit 18-7: Gender of LTC Program Cases with PCM Department Involvement by Fiscal Year

SFY	Cases Reviewed	Gender	
		Male	Female
2011	415	56%	44%
2012	542	49%	51%
2013	512	51%	49%

Senior ENC and ENC Time Spent on LTC Program Activities

ENCs are assigned to work on the LTC Programs in addition to other functions performed. To assess the time spent by ENCs for the LTC Programs, PHPG used the Atlantes activity data in the combined two Atlantes subsections and limited the review to only those cases where the data indicated that an ENC performed activities related to LTC.

Exhibit 18-8 on the following page presents the hours spent by ENCS for each of the LTC Programs, and the total hours and FTEs across all LTC Programs, by fiscal year. The total hours spent by the ENCs across all LTC Programs have been relatively consistent for each SFY, ranging from 2,270 to 2,868 hours per year. This equates to a little more than one FTE each year, with the remaining time available to support other care management functions within the PCM Department.

Upon closer examination, a majority of the ENC hours were spent on Living Choice Program onsite assessments. These assessments accounted for 80 percent, 72 percent, and 57 percent of the ENC hours in SFY 2011, SFY 2012, and SFY 2013 respectively.

Exhibit 18-8: ENC Time Spent on LTC Program Activities

LTC Program	PCM Department Start Date	SFY 2011 Portion	Number of Hours / FTEs		
			SFY 2011	SFY 2012	SFY 2013
Living Choice Assessments	Nov 2009	Full year	1,816	2,052	1,435
My Life My Choice Clinical Reviews and Level-of-Care Determinations	Nov 2010	8 months	19	176	184
Sooner Seniors Clinical Reviews and Level-of-Care Determinations	Mar 2011	4 months	7	76	88
Medically Fragile Clinical Reviews and Level-of-Care Determinations	July 2010	Full year	44	107	226
Critical Incident Report Reviews (across four Programs listed above)	See above	See above	24	23	26
TEFRA Home Visit Assessments	2006	Full year	360	312	401
PACE Level-of-Care Determinations	June 2011	None	-	123	137
Total Hours (across all LTC Programs)			**2,270**	**2,868**	**2,496**
Total ENC FTEs (across all LTC Programs)			**1.09**	**1.38**	**1.20**

Summary and Considerations for the Future

This program evaluation has a narrow scope due to the limited role of the PCM Department within the overall Long-Term Care and Waiver Programs. However, the qualitative value of the clinical functions provided by the PCM Department for these Programs cannot be under-estimated. The on-site and home visit assessments, critical incident report reviews, authorization of treatment plan services, and level-of-care determinations are all critical functions that ensure that these Programs are serving the intended members, and that the members receive the clinical services needed to successfully live outside of institutional care.

It also is interesting to note that number of reported critical incidents was low for these vulnerable populations (i.e., between 23 and 26 per SFY). This suggests that the OHCA staff decisions to enable members to participate in community living were valid and did not jeopardize the members' safety or well-being.[10]

[10] Critical incidents that require reporting include: sexual abuse; lost or missing person; questionable, unexpected or preventable death; suicide attempt; neglect, physical abuse; exploitation; criminal justice system involvement; restraint use; medication error with adverse effects; falls with injury; verbal abuse; hospitalizations; and emergency room visits.

OKLAHOMA CARES BREAST AND CERVICAL CANCER TREATMENT PROGRAM OVERVIEW

Oklahoma Cares Evaluation

Oklahoma Cares was implemented on January 1, 2005, under the authority of the National Breast and Cervical Cancer Prevention and Treatment Act of 2000. Oklahoma Cares provides diagnostic and treatment services for eligible women with abnormal breast or cervical cancer (BCC) screenings. Oklahoma Cares members also receive full SoonerCare (Oklahoma Medicaid) benefits for the duration of their cancer treatment, including transportation to their medical appointments through the SoonerRide transportation program.

Oklahoma Cares is a partnership among the Oklahoma Health Care Authority (OHCA), Oklahoma State Department of Health (OSDH), Cherokee Nation, Kaw Nation of Oklahoma, and Oklahoma Department of Human Services (OKDHS).

Program Eligibility

To be eligible for Oklahoma Cares, a woman must:

- Be screened by a health care provider under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP), administered by the OSDH or Kaw Nation Women's Health Program;
- Have an abnormal screening result, requiring further diagnosis and/or treatment for breast or cervical cancer;
- Be between the ages of 19 and 65;
- Be a US citizen or qualified alien and self-declared Oklahoma resident;
- Declare all household income and have a qualifying low income;
- Be not otherwise eligible for SoonerCare;
- Have no other credible health insurance covering BCC diagnosis or treatment (note: medical care programs of the Indian Health Services (IHS) or tribal organizations are not considered creditable coverage);
- Declare her Social Security number; and
- Assign her medical rights to Third Party Liability.

Program Description

Application and Program Certification Phases

Entry into Oklahoma Cares begins with a breast or cervical abnormality found during a screening conducted by a CDC-certified NBCCEDP physician. The NBCCEDP screener then assists the woman in completing the Oklahoma Cares application and forwards the completed application to the OHCA Population Care Management Department, along with the documentation of clinical findings (i.e., history and physical findings, pathology reports, radiology reports, and other pertinent data). If a woman in treatment for breast or cervical cancer contacts the OKDHS office and has not been through the NBCCEDP screening process, she is referred to the Oklahoma Cares toll-free number for assistance in locating a certified screener.

Senior-level Exceptional Needs Coordinators (ENCs) within the PCM Department review all incoming applications to determine clinical eligibility and "in need of treatment" criteria for Oklahoma Cares. Senior ENCs must have a current Registered Nurse (RN) license, at least two years of full-time clinical experience in an acute setting, and at least one year of experience as an ENC, Nurse Case Manager, or Quality Assurance/Utilization Review Nurse. In some cases, a Senior ENC also may have a Bachelor of Science in Nursing (BSN) or advanced nursing degree, management/supervisory experience, and other professional certifications.

The assigned ENC reviews medical documentation submitted by the NBCCEDP screener and, if needed, may contact the provider to request additional information. The information is reviewed under Oklahoma Cares Clinical Guidelines to verify a finding indicative of a cancerous or precancerous condition. These guidelines provide detailed clinical descriptors to assure consistency in eligibility determination and medical necessity. If the criteria are not met, or the appropriate clinical documentation is not available, the application will be denied, and a notice of ineligibility is sent to the applicant.

Once clinical eligibility is determined, the SoonerCare Eligibility Unit processes the application for review of financial and other eligibility criteria, including verification that the screener is a CDC screener and that the woman is otherwise eligible for SoonerCare. If the woman is found to be eligible under another SoonerCare category, she may be "certified otherwise eligible," which indicates that she came to the attention of the OHCA through the Oklahoma Cares screening process, but may continue in SoonerCare programs following the end of her BCC treatment. If the woman is not otherwise eligible for SoonerCare, she is certified for Oklahoma Cares, and is assigned to an ENC who follows her Oklahoma Cares case until it is closed.

Diagnostic Phase

All women begin in the diagnostic phase of the program. In some cases, a pathology report confirming the cancer diagnosis will accompany the Oklahoma Cares application. In these situations, the stage of care is immediately identified as "treatment," and the woman will receive an introductory letter as outlined below. A member of the Member Services staff will contact the woman and assist with a primary care physician (PCP) assignment. All other women (i.e., without a confirmed pathology) are assigned to the Diagnostic Phase.

Women who are considered in need of treatment due to an abnormality that has not been pathologically confirmed as cancer have 60 days to complete an initial appointment for diagnostic testing, and an additional 60 days to complete any further testing needed to initiate treatment. Women are enrolled in SoonerCare Traditional while in this Diagnostic Phase (i.e., they do not have an OHCA identified Primary Care Physician/Medical Home).

The 120-day period is monitored by the ENC at 30, 60, and 90 days. Members are sent an introductory letter and asked to initiate necessary diagnostic testing within 60 days from the date of their application by completing the initial appointment for a diagnostic procedure to confirm the diagnosis.

The Introductory Letter identifies the ENC as the woman's Oklahoma Cares care manager, introduces the woman to the Oklahoma Cares program, and describes the required actions and timeframes associated with the Diagnostic Phase. The letter also briefly describes her SoonerCare Traditional benefits, noting that her SoonerCare member identification card will arrive in a separate mailing; provides a list of helpful phone numbers; asks that she call the SoonerCare Help Line for information on medical providers in her area, if needed; and states that the ENC will call her soon to answer any questions, while also providing the ENC's number in case the member wishes to initiate contact.

Thirty days after introductory letters are mailed the ENC reviews claims data to determine if testing has occurred. If so, the member is contacted by phone to discuss results, provider information, and next steps. An additional 60 days may be granted if the provider orders additional diagnostic testing prior to the initiation of treatment for a cancerous or pre-cancerous condition. An ENC also may grant an exception to the time limit if there is documented evidence of a lack of diagnostic appointment availability.

Phone contacts are designed to accomplish the following:

- Obtain basic demographic data;
- Collect information regarding any providers the member has seen to date, including date of service, tests/procedures, scheduled follow-up visits, and instructions given to the member by that provider; and
- Answer any questions the member may have about the program, eligibility requirements, and required timelines.

The ENC makes three attempts to reach the member, calling on different days and different times of the day. If the ENC is unable to reach the member after three attempts, s/he tries again in 30 days.
If at any time during the Diagnostic Phase the claims data indicate that a diagnostic procedure is complete or a diagnosis has otherwise been confirmed through a member report, the ENC sends a Provider Decision Letter requesting that information regarding the woman's diagnostic status be submitted within 10 working days (i.e., diagnostics complete – no confirmed cancer, more follow-up needed, or confirmed cancer diagnosis). A pathology report is requested for all confirmed cancer diagnoses.

Upon receipt, medical documentation is reviewed by the ENC to ensure that the member's final diagnosis meets the Oklahoma Cares Clinical Guidelines. Once pathology is confirmed, the member's stage of care is changed from the Diagnostics Phase to the Treatment Phase. If at any time during the Diagnostics Phase the member is found not to have breast or cervical cancer or a related condition that meets program guidelines, the ENC closes the case. Additionally, if a member fails to have diagnostic testing and/or a medical report is not submitted within the required timeframes, or if the woman defers or refuses treatment, the case is closed.

Treatment Phase

The Treatment Phase begins when there is a pathology- or medical records-confirmed diagnosis of cancer or related condition for which the member is in need of treatment. As mentioned above, for some cases a pathology report confirming the cancer diagnosis accompanies the Oklahoma Cares application. In these situations, the member receives an introductory letter (described above) and is contacted by Member Services for PCP assignment.

For women who have moved through the Diagnostic Phase and are now assigned to the Treatment Phase, the ENC contacts the member by phone to discuss her enrollment in SoonerCare Choice and the health care coverage benefits she will receive. ENCs also inform the member that someone from Member Services should be contacting her soon to assist with selecting a PCP.

The ENC must make three attempts, each at a different time on a different day. If the member is not reached, the ENC attempts again in 60 days, at which time the member should have received her SoonerCare Card and been assigned a PCP. If all call attempts are unsuccessful, the member is sent a follow-up letter asking the member to contact the ENC.

During the Treatment Phase, the ENC monitors claims at six-month intervals to verify that the member continues to receive treatment. In addition, a full redetermination of eligibility is required every 12 months. During the 11th month of eligibility, the ENC sends a request for medical records to the member's treatment provider requesting the current plan of care, which is compared against the Oklahoma Cares Clinical Guidelines. At this time, the Oklahoma Cares member also must provide a statement of current household income and is responsible for having her SoonerCare provider complete the statement certifying that she continues to be in need of treatment.

The member receives a call from Member Services when it is time for submission of the yearly review form. As long as a woman meets the guidelines for continued treatment, the ENC continues to monitor claims every six months and requests and reviews medical records annually.

Case Closure

The member's case stays active in the Treatment Phase until any of the following criteria are met, in which case the woman's eligibility is terminated, and her case is closed:

- A medical report necessary to determine continued treatment is not received from the provider within 10 working days after a request is made by the OHCA;
- It is determined at any time by either the woman's treating physician, a SoonerCare Medical Director, or ENC that the woman is no longer in need of treatment for breast or cervical cancer or a precancerous condition;
- Death or voluntary disenrollment from treatment has occurred; or
- It is determined at any time that the woman has creditable health insurance coverage.

When a member's case is closing due to completion of treatment (either during the Diagnostic or Treatment Phase), the ENC notifies the member via a phone call. Closure education includes the recommended follow-up care as prescribed by the member's provider, if the ENC has that information; information on community resources for medical and/or prescription care; and information on the appeals process if the member does not agree with the benefit termination. The member also will receive a brief closure letter from the Oklahoma Cares program, as well as a separate notice from OKDHS regarding the exact date her benefits will end.

Supervisory Review

ENCs refer cases to their Supervisor when they have questions regarding whether medical documentation meets the Oklahoma Cares Clinical Guidelines. In addition, when a woman is refusing any treatment while she is still in need of treatment, the ENC must discuss this case with the Supervisor before the case is closed.

Appeals

Applicants who wish to appeal a denial decision made by the OHCA or OKDHS must submit a specific form to the OHCA within 20 days of receipt of the decision notification. If the form is not received at the OHCA within the required time period, the appeal will not be heard. Reconsiderations to the OHCA also may be requested by a CDC screener if missing documentation that could potentially result in a determination of eligibility has been obtained. The missing documentation must be presented within 30 days of the date of the notice of denial.

Changes/Revisions to the Program

Since its inception in January 2005, the rules governing Oklahoma Cares have been refined, and program operations and tools have been enhanced, to ensure program accountability and effective care management. Both formal rule changes and operational/administrative changes for the Oklahoma Cares program are outlined below, by calendar year.

2006: When Oklahoma Cares was implemented in January 2005, members had unrestricted access to SoonerCare benefits with no time parameters for pursuing or completing diagnostic testing. As such, the program lacked incentives for timely and targeted care. Effective December 1, 2006, Oklahoma Cares program rules were changed to require the initial appointment for diagnostic testing be completed within 60 days of the date of application, with an additional 60 days to complete any further required diagnostic testing. The rules also required the case to be closed if these timeframes were not met (absent evidence to suggest that there was a lack of appointment availability) or if providers did not submit requested medical records within 10 working days. Concurrent with these changes, coverage was expanded to make breast MRIs with prior authorization compensable, and prior authorization for mastectomy and breast reconstructive surgeries was added.

2007: Effective July 1, 2007, the requirements for citizenship/alien status, identity verification, and residency were strengthened. In addition, benefits covered under the program were expanded to include:

- Additional medically necessary mammograms following a screening mammogram; the gender restriction for this benefit also was eliminated.
- Exceptions for the coverage of external breast prostheses and garments in instances where a woman with breast cancer receives reconstruction following a mastectomy, but the breast implant fails or ruptures, and circumstances are such that an implant replacement is not recommended by the surgeon and/or desired by the member.
- Adult physical, occupational, and speech therapy services in outpatient, hospital-based settings (of primary importance to women with lymphedema), effective 2008.

2008: Program data collection and reporting moved from an Excel spreadsheet system to an ACCESS web-based database tool. Member Satisfaction surveys were conducted, and APS Healthcare conducted a Quality Assessment and Performance Improvement Study using SFY 2008 data (report issued in June 2009). The OHCA also began use of the Atlantes web-based tool for care management.

2009: Initial education for new Oklahoma Cares members was transitioned from the OHCA Care Management to the OHCA Member Services. Member Services changed the member contact process from the original practice of calling members to that of sending letters asking members to call Member Services to discuss program benefits (August 2009).

2011: Effective January 1, 2011, the OHCA revised Oklahoma Cares program rules to clarify that women must meet income eligibility guidelines and have breast or cervical cancer or a precancerous condition to qualify for treatment through SoonerCare. The rules also authorized the OHCA to conduct a medical review of breast or cervical cancer screening information prior to the OKDHS eligibility review and determination. Senior ENC nurse reviewers assumed that review role.

These new rules were accompanied by the March 21, 2011, implementation of the Oklahoma Cares Clinical review and treatment guidelines, used by ENCs to review medical eligibility. The OHCA sent a letter to screening providers informing them of the new application review process to better ensure that members meet the intent of the Oklahoma Cares program; the letter included a "Screener's Guide to Eligibility" to help clarify what the OHCA medical staff considers when reviewing documentation.

2012: Cervical cancer review and treatment guidelines were amended on January 1, 2012, and again on March 3, 2012.

2013: Effective July 1, 2013, the rules were amended to clarify that during the annual eligibility redetermination period, the member is responsible for providing any other information necessary to redetermine eligibility, in addition to having her SoonerCare provider complete the statement certifying that she continues to be in need of treatment.

2014: Cervical cancer review and treatment guidelines were changed to incorporate national consensus Clinical Guidelines as the preferred treatment (January 1, 2014).

Summary of BCC Program Care Management Functions

ENCs within the PCM Department perform the following functions for Oklahoma Cares:

- Clinical eligibility review of applications (beginning in 2011);
- Clinical review of initial diagnostic testing results and adherence to Oklahoma Cares Clinical Guidelines;
- Claims review of adherence to required timeframes for testing/treatment initiation;
- Review of medical claims at six-month intervals to ensure continued involvement with treatment;
- Obtaining annual provider recertification of need for treatment;
- Review of denial appeals;
- Telephonic assessment to gather clinical information needed from the member and providers for any of the above; and
- Referral, as needed, to assist members with accessing diagnostic and treatment services and other SoonerCare benefits.

Exhibit 19-1 on the following page provides a flow chart of the Oklahoma Cares clinical application review process performed by the PCM Department. Exhibit 19-2 on the subsequent page provides a flow chart of the activities performed by ENCs once a woman is found eligible for Oklahoma Cares.

Exhibit 19-1 – Breast and Cervical Cancer Program Clinical Application Review Process

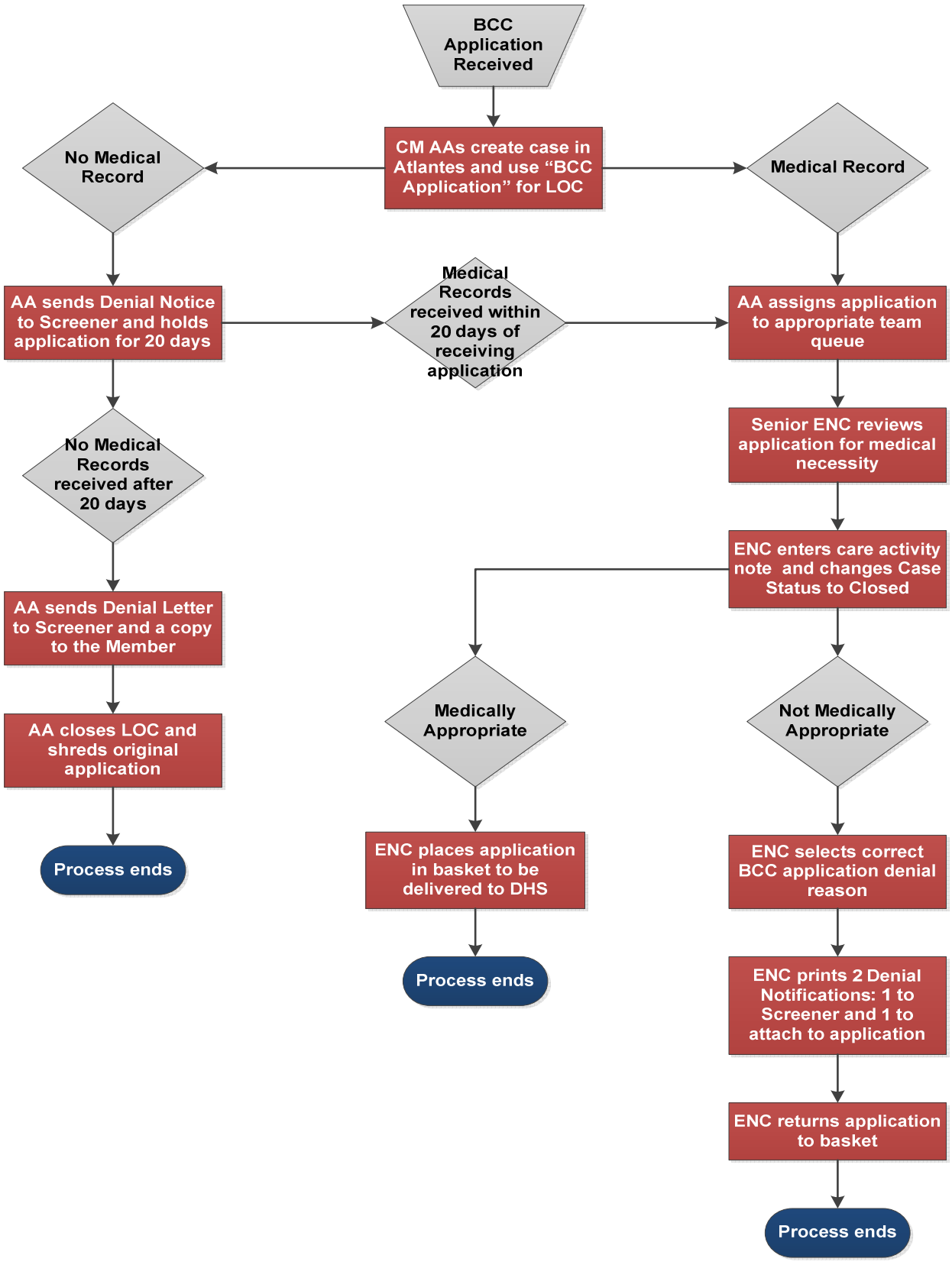
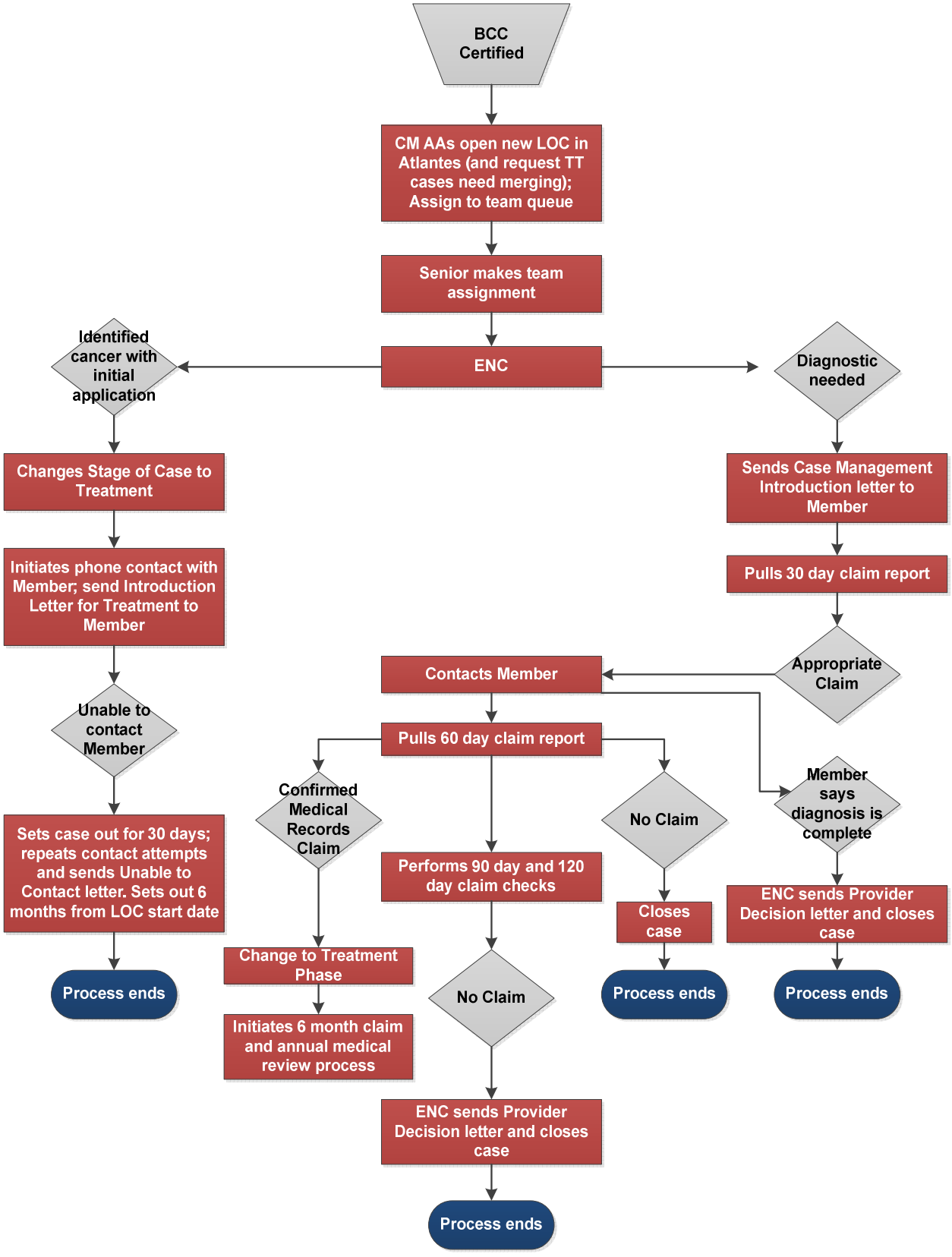


Exhibit 19-2 – Breast and Cervical Cancer Program Senior ENC Care Management Activities



OKLAHOMA CARES FINDINGS

Methodology

PHPG obtained two datasets from the OHCA to conduct the analysis, data from the Oklahoma Cares care management system (Atlantes) and claims and eligibility data for dates of services in state fiscal years (SFY) 2009 through 2013. The Atlantes system is a propriety care management system operated by Hewlett-Packard and is used by the PCM Department to record Oklahoma Cares program referrals and to identify and follow Oklahoma Cares members once they are certified as approved for the program.

The Atlantes dataset was treated as the authority for identifying Oklahoma Cares members. Oklahoma Cares members were defined as those who had moved beyond the application review phase, were determined clinically eligible and in need of treatment, and had been given a program assignment of BCC, Breast Cancer, or Cervical Cancer. The Atlantes dataset was "cleaned" to ensure that a member's eligibility was accurately reflected for the analysis. This included removing duplicate records and combining records that had overlapping dates or dates indicating an interruption in eligibility of less than 90 days.

Members were stratified into the three groups based on ICD-9 diagnosis code, as listed below:

1. Breast Cancer: 174.0 to 174.9;
2. Cervical Cancer: any code from 179 to 189; and
3. BCC Related: All other program participants not having one of the codes listed above.

Claims were analyzed for all recipients who were identified in the Atlantes dataset through SFY2013. Atlantes recipient data represented only a partial year for SFY2014, and therefore these recipients were not included in the claims-based data analysis.

Results

Oklahoma Cares enrollment and ENC program-related activities were analyzed using the following metrics:

- Total number and percent of applicants approved and denied eligibility by a Senior ENC and reason for denials;
- Total enrolled in the Oklahoma Cares program by SFY, diagnostic group, age, and county of residence;
- Oklahoma Cares enrollment trends from SFY 2009 to SFY 2013, highlighting January 1, 2011, when new eligibility guidelines and review procedures were implemented;
- Average length of time in program;
- Total number of cases per year and average ENC FTE time per case; and
- Total ENC time spent by activity type.

Program value and outcomes were measured based on cost and utilization using the following methods:

- Comparisons of annual spending and utilization for BCC-related services and non-BCC related services among Oklahoma Cares members;
- Comparisons of service utilization trends, including inpatient admission/readmission and emergency room (ER) utilization rates;
- Average cost of services per member, by BCC-related and non-related services (e.g., top ten service categories and costs, top ten medication types and costs); and
- Comparison of service utilization and costs for women with a BCC diagnosis who were participating in the Oklahoma Cares program versus those who were not.

Analysis of Oklahoma Cares Enrollment and ENC Activities

This section describes program enrollment and ENC activities by SFY using data contained in Atlantes. It should be noted that as the program matured and web-based care management tools became available to the PCM Department in SFY 2009, the data became more complete and reliable. This is evident by the fact that the number of "null" values, which is the value used to represent an unknown piece of data, significantly decreased in SFY 2009 (see Exhibit 19-3 below).

Exhibit 19-3: Volume of Null End Dates

State Fiscal Year	BCC Atlantes Data		Percent Null
	Total Enrolled (LOC start date in SFY)	Total No LOC End Date	
2005	1,411	1,206	85%
2006	4,997	4,548	91%
2007	5,195	4,622	89%
2008	4,629	3,551	77%
2009	4,608	533	12%
2010	4,229	211	5%
2011	3,238	136	5%
2012	1,716	86	5%
2013	1,043	133	13%

Applicants Approved and Denied Eligibility by Senior ENC

The first phase of Senior ENC involvement with a case is the review of the Oklahoma Cares application and supporting materials to determine if the referral meets the clinical criteria as "in need of treatment." The number of applications reviewed by the PCM Department ENCs and the outcomes of the application reviews are presented in Exhibit 19-4 on the following page.

ENC clinical review of applications began in January 2011, and the number of applications reviewed by the ENCs has steadily decreased each year since this review process began. Similarly, the number of applications determined to be in need of treatment and certified as eligible for Oklahoma Cares has decreased over time, from a high of 83 percent in SFY 2011 to 68 percent in SFY 2013. Both of these trends could be attributed to the implementation of the revised eligibility and clinical review criteria in the second half of SFY 2011 and the subsequent clarifying revisions to the program Clinical Guidelines, which occurred in March and June 2011, January and March 2012, and January 2014.

When examining the reasons for denial, the majority of applications denied in SFY 2011 and SFY 2012 were a result of not meeting the clinical criteria (i.e., no qualifying abnormality); however, this reason for denial decreased in SFY 2013. This may be due to an increased understanding of the clinical requirements by program screeners and applicants as the clinical application review process initiated in 2011 has matured. Correspondingly, three-quarters of the applications denials in SFY 2013 were due to a finding by DHS that the applicant did not meet financial or other eligibility criteria.

Exhibit 19-4: Oklahoma Cares Applications Reviewed BY ENC, Approval and Denial Rates, and Reason for Denial by Fiscal Year

SFY	Total Applications Reviewed by ENCs	Number of Applications Approved by ENCs	Approval Rate	Applications Denied and Denial Reason			
				Total	% No Medical Record	% No Qualifying Abnormality	% Denied by DHS
2011-2nd half	1,865	1,542	83%	323	11%	59%	30%
2012	2,703	2,017	75%	686	3%	51%	46%
2013	1,756	1,198	68%	558	1%	24%	75%

Total Enrollment, Age, and Length of Stay

Exhibit 19-5 on the following page summarizes total enrollment, average age, and length of time in the Oklahoma Cares program from SFY 2009 through 2013. Total enrolled by SFY was calculated based on a member's having a level of care start date in that fiscal year. Enrollment was relatively steady in SFY 2009 and 2010, between approximately 4,200 and 4,600, before decreasing in SFY 2011 by 23 percent. This decrease corresponds with the implementation of the new ENC medical review procedures half way through the year, and the use of the new Clinical Guidelines starting about eight months into the year.

Enrollment decreased further in SFY 2012 and 2013, down 60 percent and 75 percent, respectively, from SFY 2010 levels (the year before medical review procedures and Clinical Guidelines were implemented). The average age of women enrolled in the program has been consistent since 2009, ranging from 35 to 36 years of age. Average length of stay has been steadily declining from a high of seven months in SFY 2009 to not quite five months in SFY 2013.

NOTE: Calculating length of stay in the program using the Atlantes data is confounded by the volume of null values (i.e., unknown data) in the level-of-care end-date field. For determining average length of stay, data prior to 2009 were excluded due to the frequency of "null" values in the data field under review (see Exhibit 3 on a previous page). In addition, the length of time in the program analysis was determined by matching Atlantes data with claims eligibility data indicating BCC eligibility. Specifically, the level-of-- care start date in Atlantes was used to group members by year, and the eligibility data were used to count the number of months the member appeared in the claims data with an active "BC" aid category.

Exhibit 19-5: Oklahoma Cares Enrollments by Fiscal Year, Average Age, and Length of Stay

SFY	Members	Average Age (Years)	Length of Stay (Months)
2009	4,608	36.1	7.01
2010	4,229	36.2	6.38
2011	3,238	36.2	5.92
2012	1,716	35.4	5.60
2013	1,043	36.2	4.87

Enrollment by County

A review of county codes, based on county of residence in Atlantes, shows that the largest numbers of members have resided in Cleveland, Oklahoma, and Tulsa counties (see Exhibit 19-6 below).

Exhibit 19-6: Oklahoma Cares Enrollment by Counties

Enrollees per County 2004-2013	County	Total Enrollees 2004-2013
1,000 or more	Cleveland, Oklahoma, Tulsa	11,451
500 to 999	Canadian, Cherokee, Comanche, Creek, Leflore, Muskogee, Payne, Pittsburg, Pottawatomie, Sequoyah	6,429
200 to 499	Adair, Bryan, Delaware, Garfield, Grady, Jackson, Kay, Lincoln, Logan, McCurtain, Mayes, Okmulgee, Ottawa, Pontotoc, Rogers, Seminole, Stephens, Wagoner, Washington	7,659
199 or fewer	All other counties	5,969
	Grand Total	**31,508**

ENC Activity Time

Application Review

ENCs did not begin medical reviews of Oklahoma Cares applications until January 1, 2011 (i.e., the second half of SFY 2011). As can be seen in the following Exhibit 19-7, since implementing these reviews, ENCs have spent an average of approximately 31 minutes reviewing an application (range of 29 to 32 minutes across the three fiscal years), which is the equivalent of 0.4 to 0.6 FTEs across the three fiscal years.

Exhibit 19-7: ENC Time for Application Review

	SFY2011	SFY2012	SFY2013
Applications Reviewed by ENCs	1,865	2,703	1,756
Average Time Per Application - Minutes	29	29	32
Total ENC FTE Time	0.4	0.6	0.4

Managing Enrollees

ENCs share responsibility across all programs within the PCM Department. As such, there are no dedicated ENCs for the Oklahoma Cares program. Assignment to Oklahoma Cares cases is based on ENC caseload at the time of member activation. To assess the time spent by ENCs for the Oklahoma Cares program, PHPG used the Atlantes activity data and limited the review to only those cases where an ENC performed activities related to women who were assigned to Oklahoma Cares. Activities can fall into 30 different types, ranging from member and provider outreach to resending emails and logging returned mail. PHPG grouped individual activity types into the three general categories described below:

- Intake, Assessment, Care Management – This category included Atlantes-recorded activities such as face-to-face contacts, member contacts, provider contacts, faxing information to/from, initial assessments, intake, legal referrals, letter generation, approving meals and lodging requests, and case research.
- Supervisory Time – This category represented only the Atlantes-recorded activity labeled as supervisory review.
- Miscellaneous Administrative – This category included Atlantes-recorded activities labeled as resending mail, scheduler sent, returned mail, vendor payee/forms, translation, and emails.

In each fiscal year, a large majority of the ENC time has been dedicated to intake, assessment, and care management for enrolled members, with relatively few hours spent on supervisory review or administrative activities (see Exhibit 19-8 on the following page). This is expected since the primary functions of the ENCs fall into this category.

Exhibit 19-8: ENC Time per Enrollee by Activity Type

Activity Type	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Total Members	4,608	4,229	3,238	1,716	1,043
Intake, Assessment, Care Management Activity	3.6	4.13	3.48	2.82	2.47
Supervisory Time	0.20	0.03	0.03	0.01	0.01
Misc. Administrative Activity	0.00	0.04	0.02	0.02	0.02
ENC Time Per Enrolled Member (Hours)	**3.8**	**4.2**	**3.5**	**2.9**	**2.5**
Total ENC FTE Time for Above Activities	**8.4**	**8.5**	**5.5**	**2.4**	**1.3**

From SFY 2009 through 2013, ENCs have spent an average of 2.5 to 4.2 hours per case across all activities. Interestingly, average ENC hours per case and equivalent FTEs have decreased each fiscal year starting with SFY 2011. The number of required FTEs was around 8.5 in SFY 2009 and 2010, but decreased to 5.5, 2.4, and 1.3 FTEs in each subsequent year. This trend can be observed across all activity types.

The decrease could be attributed to the implementation of the revised eligibility and clinical review criteria in the second half of SFY 2011. It also could reflect the use of more senior ENC staff for initial reviews and treatment verifications, thus requiring less time by ENCs once women are enrolled.

In total, when combining time for the application review process and for activities once women are enrolled in the BCC Program, the FTEs required for the BCC Program were a high of around 8.5 FTEs in SFY2009 and 2010, decreasing to 5.9, 3.0, and 1.7 FTEs in subsequent years (see Exhibit 19-9 below).

Exhibit 19-9: Total ENC FTE Time

Activity Type	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013
Application Review	*NA*	*NA*	0.4	0.6	0.4
Managing Enrollees	8.4	8.5	5.5	2.4	1.3
Total ENC FTE Time	**8.4**	**8.5**	**5.9**	**3.0**	**1.7**

Program Value and Outcomes

The following sections provide information regarding the value of the Oklahoma Cares program for the women who are enrolled. Analyses include total payments across five state fiscal years for the program overall, as well as by diagnostic type (Breast, Cervical and Related Conditions). Similar analyses (total and by diagnostic-type) are provided to examine the utilization of BCC-related care versus non-BCC-related care for women enrolled in the program, their top categories of service utilization, pharmacy claims, and hospital utilization (admissions, readmissions, and emergency room visits). In addition, costs and utilization are compared for women with BCC diagnoses who are enrolled in Oklahoma Cares and SoonerCare women who are not enrolled in Oklahoma Cares.

Total Payments: Enrollments and Diagnosis

Trends in total payments corresponded to a decrease in average monthly enrollment of 78 percent, from nearly 3,600 in SFY 2009 to fewer than 800 in SFY 2013. At the same time, the overall PMPM for program participants more than doubled, increasing from $760 to $1,550 (see Exhibit 19-10 below).

These enrollment trends were sharpest in 2010 and 2011, corresponding to the OHCA's implementation of a web-based care management tool in 2009, and new Clinical Guidelines in January 2011 that provided more clarity and detail in the determining the need for treatment and confirming breast and cervical cancer and related diagnoses.

Exhibit 19-10: Trends in Enrollment and Total PMPM for Oklahoma Cares Members

As illustrated above, the decrease in enrollment was attributable primarily to members without a breast or cervical cancer diagnosis (i.e., members with precancerous abnormalities and pathologies). These members also had a PMPM that was 83 percent lower on average than that of members with breast or cervical cancer diagnoses.

Total Payments: BCC- and non-BCC-Related Services for Oklahoma Cares Enrollees

Between SFY 2009 and 2013, total claims payments for program participants dropped by 44 percent, from $32.5 to $14.3 million (see Exhibit 19-11 on the following page).

In order to review whether members were accessing services unrelated to their BCC condition, claims data were stratified into BCC-related care versus non-BCC-related care. Claims that had an associated breast or cervical cancer diagnosis code were included in the analysis as BCC-related care. In addition, procedure codes without a cancer diagnosis were reviewed if they represented $10,000 or more in expenditures. If the procedure could reasonably be associated with breast or cervical cancer treatment (i.e., due to provider type and procedural definition), they also were included as BCC-related care.

Note: BCC-related services were defined as any claim with any of the breast or cervical cancer diagnosis codes, diagnostic and related procedure codes, or related provider specialty codes as identified in Attachment F. However, without conducting a full medical records review, it is difficult to suggest that the other care received by Oklahoma Cares members is unrelated to cancer treatment. Co-morbid conditions arising from cancer treatment may not be coded using a breast or cervical cancer diagnosis, and providers may be inconsistent in their use of diagnosis on claims forms. As such, the expenditures related to cancer in the following Exhibits may be under-represented.

The analysis suggests that overall PMPM spending across all program enrollees has been more directly attributed to cancer-related care as the program has matured, in that cancer-related care accounts for 54 percent of the claims in SFY 2009 versus 65 percent in SFY 2013 (see Exhibit 19-11).

Exhibit 19-11: Total Payments for All Oklahoma Cares Enrollees

SFY	Member Months	Average Monthly Enrollment	Total Payments	PMPM			
				Total	BCC Related	% BCC Related	Non-BCC Related
2009	42,763	3,564	$32,515,302	$760	$413	54%	$348
2010	30,271	2,523	$29,943,759	$989	$546	55%	$443
2011	23,272	1,939	$24,924,333	$1,071	$618	58%	$453
2012	14,454	1,205	$18,890,468	$1,307	$863	66%	$444
2013	9,270	773	$14,364,467	$1,550	$1,007	65%	$542

Note: Payments include both medical and pharmacy claims.

Specific diagnosis-related payments can be seen in Exhibits 19-12 through 19-15 on the following pages. Analysis of the total payments across all categories indicate that breast cancer treatment accounted for the largest proportion of total spending (e.g., in SFY 2013, breast cancer treatment accounted for 76 percent, while cervical cancer and related conditions each accounted for 13 percent of overall spending).

From these more detailed analyses, it appears that the majority of payments for the Breast Cancer Group have been related to cancer, from between 65 percent and 71 percent of payments from SFY 2009 to SFY 2013. This is also true for the Cervical Cancer Group, from between 56 percent and 70 percent of payments from SFY 2009 to SFY 2013. It also appears that the percentage of BCC-related payments for the Breast Cancer Group and for the Cervical Cancer Group is almost twice that of BCC-related payments for the Cancer-Related Group.

Furthermore, while the BCC-related payments for the Breast Cancer Group have remained relatively steady, the BCC-related payments for the Cervical Cancer Group increased from 57 percent in SFY 2009

to 70 percent in SFY 2013, and they increased from 25 percent in SFY 2009 to around 40 percent in SFYs 2013 and 2014 for the Cancer-Related Group.

Exhibit 19-12: Total Payments for Oklahoma Cares Members – Breast Cancer Group

SFY	Member Months	Average Monthly Enrollment	Total Payments	PMPM			
				Total	BCC Related	% BCC Related	Non-BCC Related
2009	7,547	629	$17,509,064	$2,320	$1,589	68%	$731
2010	7,812	651	$17,291,309	$2,213	$1,472	66%	$742
2011	7,032	586	$15,846,804	$2,254	$1,466	65%	$787
2012	5,921	493	$13,220,856	$2,233	$1,590	71%	$643
2013	4,735	395	$10,979,813	$2,319	$1,580	68%	$739

Note: Payments include both medical and pharmacy claims.

Exhibit 19-13: Total Payments for Oklahoma Cares Enrollees – Cervical Cancer Group

SFY	Member Months	Average Monthly Enrollment	Total Payments	PMPM			
				Total	BCC Related	% BCC Related	Non-BCC Related
2009	1,454	121	$4,206,253	$2,893	$1,649	57%	$1,244
2010	1,525	127	$3,617,981	$2,372	$1,322	56%	$1,051
2011	1,573	131	$4,162,668	$2,646	$1,788	68%	$858
2012	889	74	$2,636,872	$2,966	$2,035	69%	$931
2013	568	47	$1,677,201	$2,953	$2,064	70%	$889

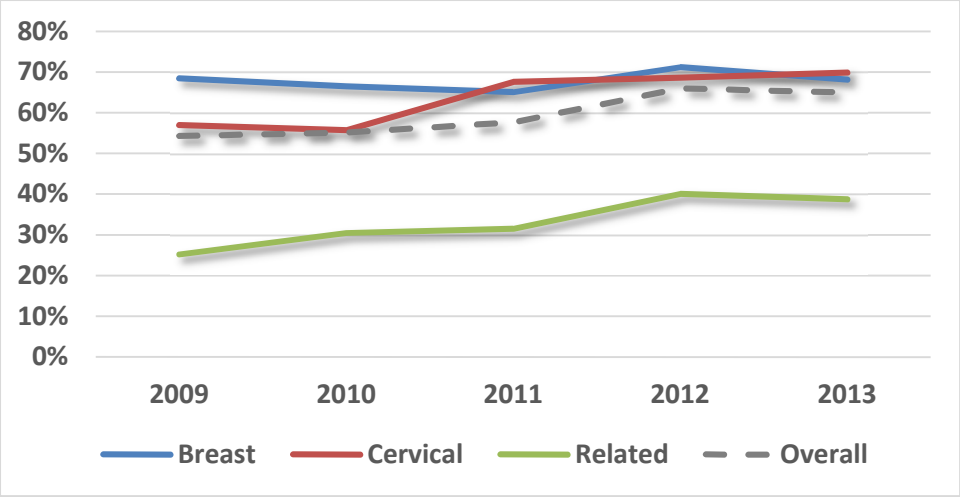
Note: Payments include both medical and pharmacy claims.

Exhibit 19-14: Total Payments for Oklahoma Cares Enrollees – Related Conditions Group

SFY	Member Months (MM)	Average Monthly Enrollment	Total Payments	PMPM			
				Total	BCC Related	% BCC Related	Non-BCC Related
2009	33,852	2,821	$11,011,073	$325	$82	25%	$243
2010	21,099	1,758	$9,505,646	$451	$137	30%	$313
2011	15,262	1,272	$6,369,254	$417	$131	31%	$286
2012	7,780	648	$3,392,999	$436	$175	40%	$261
2013	4,057	338	$1,978,423	$488	$189	39%	$299

Note: Payments include both medical and pharmacy claims.

Exhibit 19-15: Percentage of Claims Payments Attributable to Breast/Cervical Cancer-Related Services



Payments by Category of Service

The top five categories of services utilized by Oklahoma Cares members are similar to those typically utilized by most other health care recipients. These include physician, hospital (inpatient/outpatient), pharmacy, and lab/x-ray services (see Exhibit 19-16 below). All remaining categories of service accounted for less than 10 percent of payments.

Physician payments were approximately 25 percent higher for members with breast cancer than for members with cervical cancer, while the latter group incurred nearly three times the inpatient costs. Pharmacy payments also were slightly higher for members with breast cancer, while both groups utilized outpatient and lab/x-ray services at similar rates.

PMPM payment amounts were lower for members with related conditions. However, when combined, physician and hospital services accounted for 74 percent of total payments for this group, relatively close to the 82 percent observed across the other two groups.

Exhibit 19-16: Claims Payments for Members by Category of Service, Average PMPM SFY 2009 – 2013

Category of Service	Breast Cancer		Cervical Cancer		Related Conditions	
Physician	$1,069	47%	$852	31%	$124	32%
Inpatient	$323	14%	$891	33%	$94	24%
Outpatient	$459	20%	$461	17%	$70	18%
Pharmacy	$237	10%	$196	7%	$35	9%
Lab and X-Ray	$78	3%	$70	3%	$24	6%
Other	$99	4%	$243	9%	$46	12%
Total	**$2,265**	**100%**	**$2,713**	**100%**	**$393**	**100%**

Pharmacy Claims

A review of pharmacy claims shows the majority of all pharmacy expenditures are in the breast cancer group, followed by those with a breast or cervical cancer-related condition (see Exhibit 19-17 below). The breast cancer group showed a high of $2.4 million in SFY 2010 and a low of $1.2 million in SFY2013, while spending in the related condition group has increased slightly in recent years for a high of $1.9 million in SFY2013.

As compared to the expenditures in SFY2009 and 2010, the pharmacy expenditures for women in the breast cancer and cervical cancer groups were reduced in subsequent years, following the implementation of the Senior ENC reviews and clinical care guidelines in mid-fiscal year 2011.

Exhibit 19-17: Total Pharmacy Claims Paid by Fiscal Year 2009-2013

Diagnostic Group	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013	5 Year Total
Breast Cancer	$1,809,335	$2,399,932	$1,724,791	$1,282,342	$1,161,854	$8,378,257
Cervical Cancer	$325,275	$299,926	$233,076	$264,204	$214,644	$1,337,126
Both Cancer Types	$13,129	$74,882	$193,193	$150,385	$167,080	$598,671
Related Condition	$1,568,432	$1,592,456	$1,480,859	$1,733,551	$1,990,635	$8,365,934
Total	**$3,716,172**	**$4,367,197**	**$3,631,921**	**$3,430,484**	**$3,534,214**	**$18,679,990**

Analysis of the top ten expenditures by specific National Drug Codes (NDC) across five years suggests that these top ten NDC expenditures for all program participants can be directly linked to cancer-related care (e.g., medications used to treat early stage breast cancer, cancer, pain, and chemotherapy-induced nausea). The top ten NDCs for SFY 2009 – 2013 are outlined in Exhibit 19-18 below.

Exhibit 19-18: Top Ten National Drug Codes SFY 2009 – 2013

Name	Description
1. Xeloda	Chemotherapeutic agent
2. Femara	Non-steroidal aromatase inhibitor - treatment of early breast cancer
3. Arimidex	Non-steroidal aromatase inhibitor - treatment of early breast cancer
4. Tykerb	Kinase inhibitor - targeted treatment of solid tumors (e.g., breast, lung)
5. Aromasin	Steroidal aromatase inhibitor - treatment of early breast cancer
6. NuvaRing	Pregnancy prevention
7. Emend	Prevention of chemotherapy-induced nausea and vomiting
8. Cymbalta	SNRI - treatment of depression, anxiety, and neuropathy
9. Spiriva	Bronchodilator - treatment of COPD
10.OxyContin	Opioid Agonists

Note: Analysis was conducted by drug code not drug type; as such, drugs produced by other manufacturers in the same class or those administered through a different dosage or delivery system are not included.

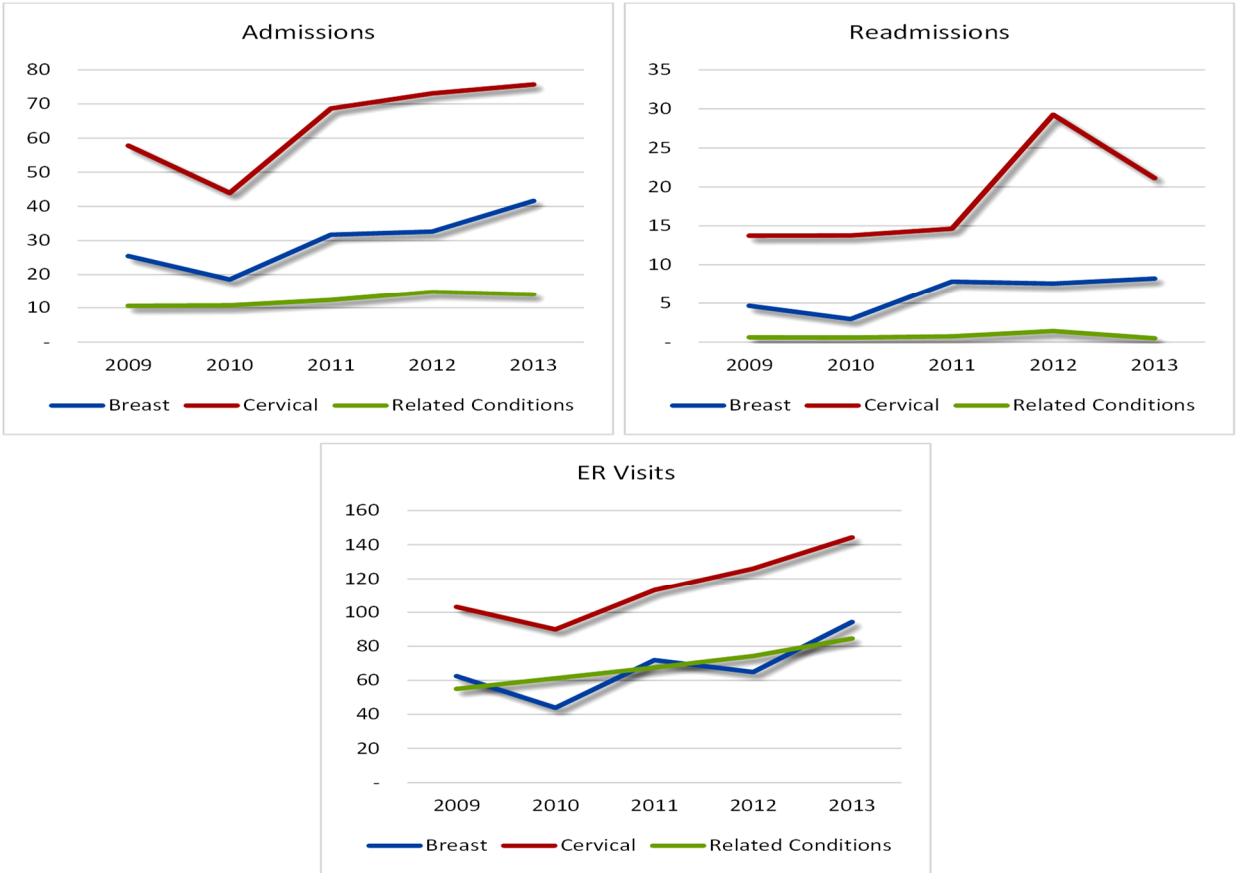
Hospital Utilization (Admissions, Readmissions, and Emergency Room Visits)

On average, members with breast cancer were admitted to the hospital approximately 29 times per 1,000 member months and readmitted within 30 days six times per 1,000 member months, or slightly more than one out of every five admissions. These members also visited the Emergency Room (ER) on average 65 times per 1,000 member months. Between SFY 2009 and 2013, all three rates increased annually at an average rate of between 11 and 15 percent (see Exhibit 19-19 below).

Members with cervical cancer visited the hospital and ER at significantly higher rates. Their admission rate averaged 61 per 1,000 member months, with 16 readmissions, or slightly more than one out of every four admissions. They visited the ER on average nearly 110 times per 1,000 member months. Between SFY 2009 and 2013, all three rates increased annually at an average rate of between seven and 11 percent.

Members with related conditions were admitted just under 12 times per 1,000 member months, and readmitted less than one time per 1,000 member months. The ER visits rate for this group was similar to that of members with breast cancer, at an average of 62 visits per 1,000 member months. Over the last five years, admissions increased at an average annual rate of seven percent and ER visits by 11 percent, while readmissions fell slightly overall, despite a significant spike in 2011 and 2012.

Exhibit 19-19: Hospital Utilization per 1,000 Member Months for Oklahoma Cares Members



Comparison: Women with BCC Diagnoses Enrolled vs. Not Enrolled in Oklahoma Cares

PHPG identified women in the SoonerCare claims data with a breast or cervical cancer diagnosis during each fiscal year who were not enrolled in Oklahoma Cares, and evaluated their service utilization against women enrolled in the program. Utilization data for the comparison group were reviewed for the same five-year period and included claims for SoonerCare programs overall (Choice and Traditional). SoonerCare beneficiaries with Medicare coverage and those under 19 or over 65 years old were excluded from the comparison group. Due to the lack of consistent diagnostic categories for persons in the Oklahoma Cares "related conditions" group, no corresponding comparison data were reviewed for persons without a clear breast or cervical cancer diagnosis.

Exhibits 19-20 and 19-21 below and on the following page illustrate that women enrolled in Oklahoma Cares between SFY 2009 and 2013 with breast or cervical cancer diagnoses incurred 20 to 22 percent less in total claim costs, respectively, than women with these diagnoses who were not enrolled in the program. In addition, women enrolled in Oklahoma Cares generally experienced significantly lower utilization rates compared to women not enrolled, and also utilized significantly more BCC-related services.

Exhibit 19-20: Utilization and PMPM for Women with BCC Diagnoses, Average SFY 2009 - 2013
Women Enrolled vs. Not Enrolled in Oklahoma Cares

	Breast Cancer	Cervical Cancer
Inpatient Admissions per 1,000 Member Months		
Enrolled	35	80
Not Enrolled	70	90
Inpatient Readmissions per 1,000 Member Months		
Enrolled	6	18
Not Enrolled	19	55
ER Visits per 1,000 Member Months		
Enrolled	68	144
Not Enrolled	156	213
BCC Related PMPM		
Enrolled	$1,490	$853
Not Enrolled	$100	$102
Total PMPM		
Enrolled	$2,265	$2,713
Not Enrolled	$2,915	$3,386

Exhibit 19-21: Claims Payments Category of Service for Women with BCC Diagnoses, Average SFY 2009 - 2013
Women Enrolled vs. Not Enrolled in Oklahoma Cares

Category of Service	Breast Cancer		Cervical Cancer	
	Enrolled	NOT Enrolled	Enrolled	NOT Enrolled
Inpatient Services	323	512	891	1,141
Outpatient Services	459	367	461	384
Physician Services	1,069	828	852	803
Prescribed Drugs	237	367	196	488
Psychiatric Services	13	41	25	35
Other Practitioner	7	27	6	17
Dental Services	5	21	10	8
Home Health and Home Care	13	293	28	104
Lab and X-Ray	78	82	70	80
Medical Supplies and Orthotics	13	53	69	60
Nursing Facility	13	100	20	117
Other Institutional	2	53	7	28
Transportation	15	42	37	48
Targeted Case Management	6	80	16	45
Other	11	52	23	28
Total	**$ 2,265**	**$ 2,915**	**$ 2,713**	**$ 3,386**

Summary and Considerations for the Future

The effective date of the Oklahoma Cares authorizing legislation, House bill 2552, "The Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund," was November 1, 2004. The Oklahoma Cares Breast and Cervical Cancer Treatment program began accepting enrollees on January 1, 2005. With very little start-up time, the OHCA staff ensured services to members. Program operations began with limited infrastructure for tracking and monitoring and no written program guidelines. In addition, the Oklahoma Cares program was created approximately one year following the transition of care from private managed care plans in urban areas (SoonerCare Plus) to the OHCA managed SoonerCare Choice model.

In August 2005, six-month post the program start date, the Medical Authorization Unit was brought under the supervisory structure of the Population Care Management Department as part of these overall OHCA reorganization efforts. In February 2009, the Health Management Unit also was transferred from Provider Services to the supervisory structure of the Population Care Management Department. Throughout all these changes, the OHCA staff responsible for Oklahoma Cares took necessary steps to design and implement policies and procedures that ensured clinical best practice, financial and eligibility monitoring, and care management.

The result of these Oklahoma Cares program development efforts can be seen in both administrative metrics and in the utilization and cost data. Specifically, the administrative data available from Atlantes shows that the introduction of web-based care management tools in late calendar year 2008 and 2009 was met with a corresponding decrease in the volume of null data values in the level-of-care end-date fields. Null values decreased from a high of 91 percent in 2006 to a low of five percent in 2012. Along these lines, the use of the Atlantes web-based care management system allowed the OHCA to create clear and consistent protocols, schedules, and ENC care management expectations for assigned staff.

Another notable change in program operations occurred in State Fiscal Year 2011 when the OHCA shifted enrollment authorizations away from field-based screening in community programs across the State to the use of Senior ENC's (Nurse Reviewers) employed within the Population Care Management Department. Specifically, information submitted by community-based screeners was reviewed against criteria with requests to providers or screeners as needed for further information or pathology reports.

This change, initiated on January 1, 2011, was followed by the promulgation of rules in April 2011 related to program eligibility, administrative timelines, and redeterminations of need and appeals. Approximately one year later the OHCA adopted written Clinical Guidelines and definitions of clinical care management for both cancer and cancer-related abnormalities.

Changes in these enrollment review processes and guidelines were followed by a 78 percent decrease in enrollment, shortened length of stay in the Oklahoma Cares program, and efficient use of the OHCA staff resources and services. The overall decrease in enrollment can be seen in the "related conditions" category, suggesting that women with a cancer diagnosis are receiving necessary care, while those with more ambiguous abnormalities are getting additional diagnostics and physician consults that ultimately rule out the need for pre-cancer or cancer-related care offered as part of the Oklahoma Cares program.

Post-2011 decreases can also be seen in the overall use of supervisory time for case review, and fewer ENC resources overall, in that the latter moved from a high of 8.4 FTE time in 2009 to approximately 1.7 FTE time in 2013. This may also be attributed to the use of Senior ENC staff with a greater level of work experience and clinical knowledge.

A similar trend can be seen in claims and cost data. Overall, total payments for Oklahoma Cares program expenditures show a high of $32.5 million in SFY 2009 and a low of $14.4 million in SFY 2013. Across all state fiscal years, breast cancer treatment accounted for the largest proportion of total spending as compared to total spending by the cervical cancer and related conditions groups.

Along with the implementation of clinical enrollment standards, the OHCA ENCs also review claims and outreach to providers to gather information on services provided and ensure the need for continued program eligibility. These changes overall may have contributed to the findings that expenditures for women enrolled in Oklahoma Cares increasingly have been linked to cancer-related care during the five-year study period.

Furthermore, women enrolled in Oklahoma Cares have an average of 22 percent lower claims costs, and more spending can be linked to their breast and cervical cancer diagnosis than for a comparison group of women with these diagnoses who are not enrolled in the Oklahoma Cares program. A discrete analysis of claims for persons with the breast and cervical cancer diagnosis enrolled in overall SoonerCare programs (Choice and Traditional) but not part of the Oklahoma Cares program showed that overall, non-Oklahoma Cares members have little evidence in the claims system of treatment related to their diagnosis. In addition, those members not part of the Oklahoma Cares program received fewer physicians and outpatient-related services and more in Inpatient, Nursing Facility, Targeted Case Management, Pharmacy, and Home Health-related services.

Without a full medical records review it is difficult to determine if the non-Oklahoma Cares group includes persons with more complex, psychiatric, and disability-related conditions and/or more medically fragile physical health related conditions that could be contributing to their higher costs. Regardless, the data indicate that women enrolled in Oklahoma Cares are using this program to access needed treatment for their cancer conditions, and they are doing so more readily than other SoonerCare members who have a breast or cervical cancer-related diagnosis.

In summary, it appears that the Oklahoma Cares program is succeeding in its mission of supporting women with breast and cervical cancer and related diagnoses to access care that they otherwise might not be able to afford. Data also suggest that the OHCA and its Population Management Unit have been successful at designing and implementing effective strategies to manage operations, clinical care, and expense for persons who qualify for breast and cervical cancer-related treatment funding. Future program consideration could be given to understanding if any of the design elements in use in the Oklahoma Cares program could be adopted in other areas for the management of non-Oklahoma Cares SoonerCare members with breast or cervical cancer.

ORGAN AND TISSUE TRANSPLANT INTRODUCTION AND PROGRAM OVERVIEW

Organ and Tissue Transplant Program Objective

The OHCA Organ and Tissue Transplant Program (OTTP), which was implemented in the PCM Department in SFY 2003, provides for solid organ and bone marrow/stem cell transplants for SoonerCare members. Organ and tissue transplant procedures are subject to both medical appropriateness and medical necessity review by the OHCA's Medical Authorization Unit (MAU) Transplant Coordinator and a Medical Consultant.

Program History and Overview

After OTTP implementation with the PCM Department in SFY 2003, transplant authorization and case management guidelines were developed and implemented on March 1, 2004. Prior to this, the process for the authorization of transplants was not consistent. The new guidelines required medical director guidance and review and were created to also incorporate case management into the transplant authorization process, as well as post-transplant management of the member.

On April 1, 2009, the OHCA transferred the OTTP authorization process to the MAU. At that time, the PCM Department retained member record review and pre- and post-transplant case management, and monitoring functions. However, member record review and service monitoring have since transferred to the MAU as of SFY 2011. The PCM Department still performs case management during the transplant evaluation period while the member is awaiting a transplant and post-transplant.

Although OTTP procedures are subject to medical appropriateness and medical necessity review, member transplant evaluation does not require Prior Authorization (PA) when the evaluation is completed at a contracted facility. For SoonerCare Choice members, a Primary Care Provider (PCP) referral for the transplant evaluation is required, consistent with the SoonerCare Choice policy applicable to specialty referrals. With the exception of kidney and cornea transplants, PA is required for all member transplant procedures. The OHCA contracts with both in-state and out-of-state transplant facilities and uses separate processes to distinguish between referrals from non-transplant facilities or physicians to contracted transplant facilities or referrals to non-contracted facilities or providers. The OHCA also provides coverage for transportation services related to member transplant procedures.

Program Eligibility

Members seeking organ or tissue transplants must have the proposed procedure determined both medically appropriate and medically necessary. Members must also be Title XIX eligible to be eligible for the OTTP.

The criteria used to determine general program eligibility for OTTP are listed below:

- The transplant procedures, with the exception of kidney and corneal transplants, must receive PA to be compensable;
- All procedures must be reviewed based on appropriate medical criteria;
- All organ transplants must be performed at a facility that meets hospital protocols and standards for organ procurement agencies contained in Section 1138 of the Social Security Act;
- The procedures are not considered experimental or investigational;
- Donor search and procurement services for organ transplant acquisition costs must be consistent with Medicare program methodology;
- Donor expenses that are incurred as a result of complications are only covered when they are directly and immediately attributable to the donation procedure; and
- Any donor expenses that occur after the 90-day global reimbursement period must be submitted to the OHCA for review.

Organ and Tissue Transplant Program Process

The OHCA Care Management Department is typically notified of potential transplant cases through telephone/facsimile referral from the transplant facility or provider, the member's PCP, case manage, or specialist, or from the member or member's family. When an OTTP referral is made, the PCM Department's administrative assistant assigns the case to an appropriate Senior ENC, who then determines the member's general eligibility and documents both the member and facility contacts in Atlantes.

Once member general eligibility requirements are determined to have been met, the senior ENC attempts to make initial contact with the member. During this exchange, the senior ENC provides information to the member on OTTP benefits and also identifies any immediate care coordination needs. The Senior ENC will also make initial contact with the transplant facility to obtain information on the facility's transplant program and candidate evaluation process.

If the referral proposed is by a non-contracted or out-of-state transplant facility, the Senior ENC will provide the facility with information regarding OHCA's MAU PA criteria. The PA inquiry will make the determination of whether contracted in-state provider services are available. If they are not, the case is referred to OHCA's Provider Enrollment Department, which then contracts with a non-contracted provider or transplant referral facility. If the facility is out of state, the Senior ENC will provide information on OHCA's medical necessity evaluation and coordinate air transport for the member's transplant evaluation.

The transplant referral facility provides the transplant evaluation and supporting documentation to MAU's Transplant Coordinator. If all required information has been received, the MAU Transplant Coordinator and a Medical Consultant collectively decide whether to approve or deny the PA request.

The senior ENC will communicate the decision to the transplant referral facility and the member. If approved, the MAU staff authorizes the transplant procedure and works to coordinate the transplant surgery with the Atlantes Scheduler. The authorization remains valid for a period of twelve months.

During any waiting period, the Senior ENC will maintain monthly contact with the member and facility or more frequently depending upon the complexity of the transplant or the transplant facility's program requirements. Following authorization, the Senior ENC continues to monitor member care coordination needs but may decrease member contact to once every three months pending the transplant procedure. The member is also instructed to contact the MAU in the event of any change in status.

If a member is not eligible or is removed from the transplant listing for any reason, the assigned Senior ENC will determine the member's ongoing care or complex case needs. If necessary, the Senior ENC will assign a new level of care (LOC) to the member and change this to a complex care case as appropriate. After the transplant procedure is completed, the Senior ENC maintains monthly contact for two to three months' post-transplant. Exhibit 20-1 below highlights the OTTP authorization process. Exhibit 20-2 on the following page highlights the OTTP referral process.

Exhibit 20-1: Organ and Tissue Transplant Program Authorization Process

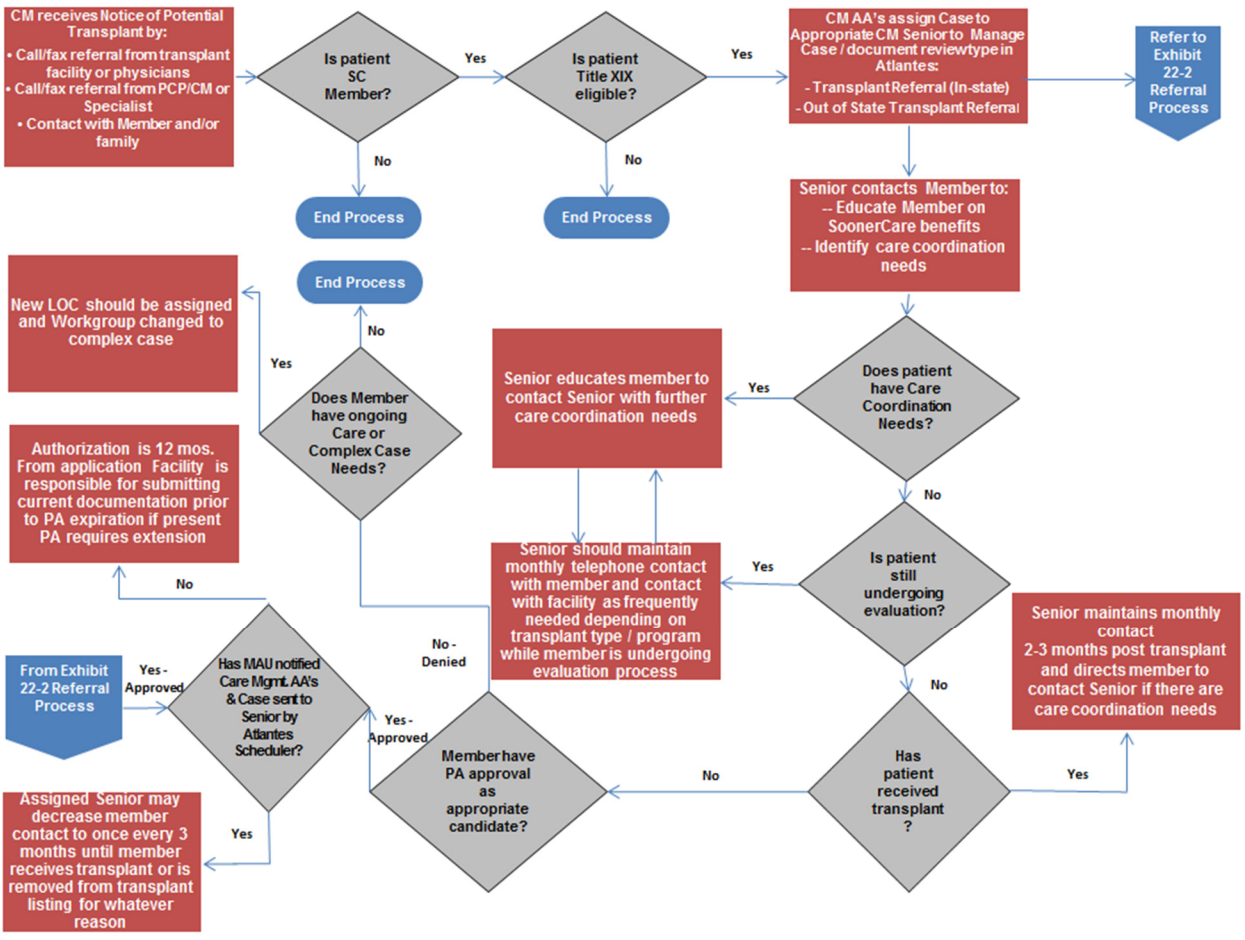
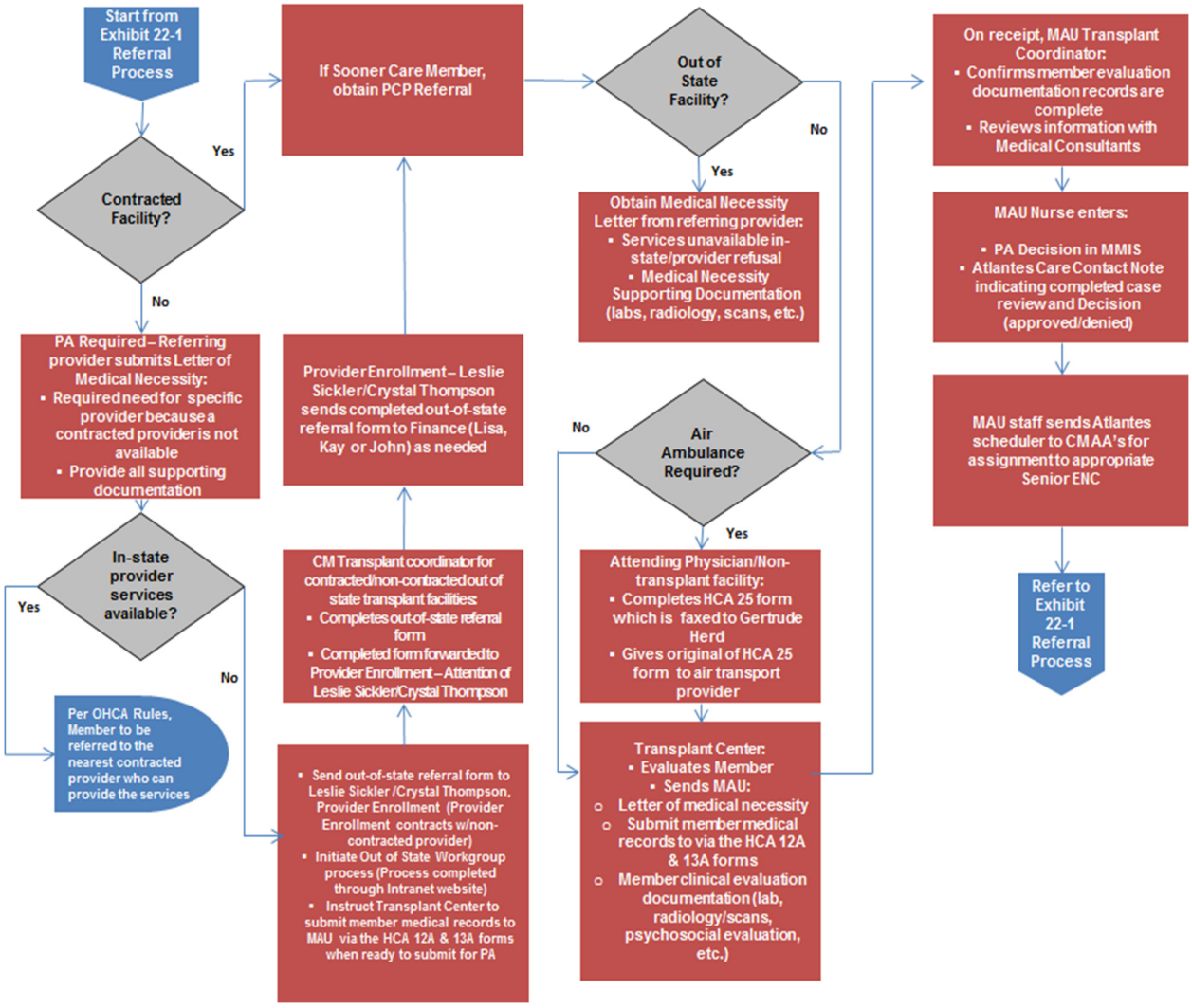


Exhibit 20-2: Organ and Tissue Transplant Program Referral Process



ORGAN AND TISSUE TRANSPLANT PROGRAM FINDINGS

Methodology

To conduct our analysis, PHPG obtained data from the OHCA's care management system (Atlantes). The Atlantes system is a proprietary care management system operated by Hewlett-Packard and is used by the PCM Department to store all member records, program activities, assessments, and program letters that are generated. OTTP records were extracted from Atlantes for the period of July 1, 2009 (SFY 2010), through June 30, 2013 (SFY 2013).

The Atlantes dataset was treated as the authority for identifying OTTP activity. The dataset was "cleaned" to ensure that a referral was accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level of Care Start and End dates) as well as removing records that had null end dates.

Results

The following program enrollment and activities were analyzed for OTTP referrals by using the Atlantes dataset:

- Total organ and tissue transplants by SFY;
- Breakdown of organ and tissue transplants by county geography (i.e., rural, urban, suburban, mixed, out of state); and
- Total organ and tissue transplants by age range.

Analysis of Organ and Tissue Transplant Activities

This section describes program enrollment by SFY using data contained in Atlantes.

Total Organ and Tissue Transplants

Exhibit 20-3 below summarizes the number of organ and tissue transplants from SFY 2010 through SFY 2013. The total number of members having an organ or tissue transplant by SFY was calculated based on a member's having a level-of-care start date in that fiscal year. There were significant decreases in organ and tissue transplant activity between SFY 2010 and 2013, which may be the result of changes in the transplant authorization procedures.

Exhibit 20-3: Organ and Tissue Transplants by State Fiscal Year

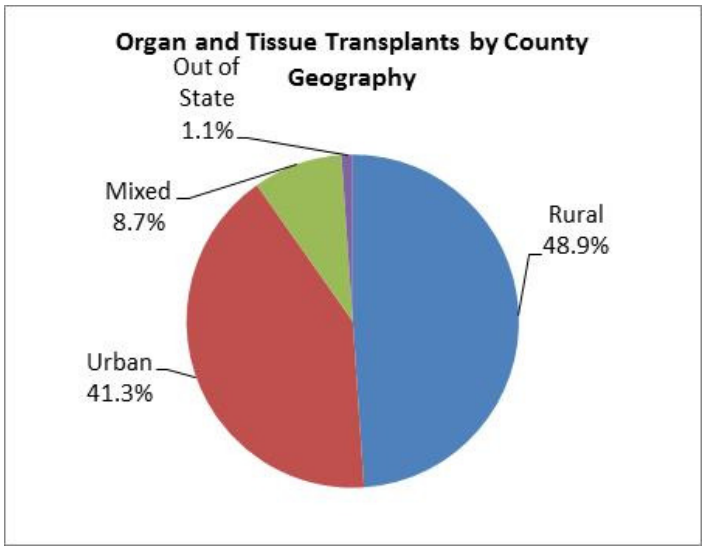
SFY	Referrals
2010	126
2011	43
2012	8
2013	8
Total	**186**

Organ and Tissue Transplants by County Geography

Exhibit 20-4 below summarizes the breakdown of transplant referrals by county geography from SFY 2010 through SFY 2013. Nearly half of transplant referrals originated in rural counties. Slightly more than forty-one percent of referrals originated in the urban counties of Cleveland, Oklahoma, and Tulsa.

The balance of referrals was for members who resided in mixed counties and a small number of members, 1.1 percent, who resided out of state at the time of the data analysis, though these members resided in Oklahoma when they were initially enrolled in the transplant program.

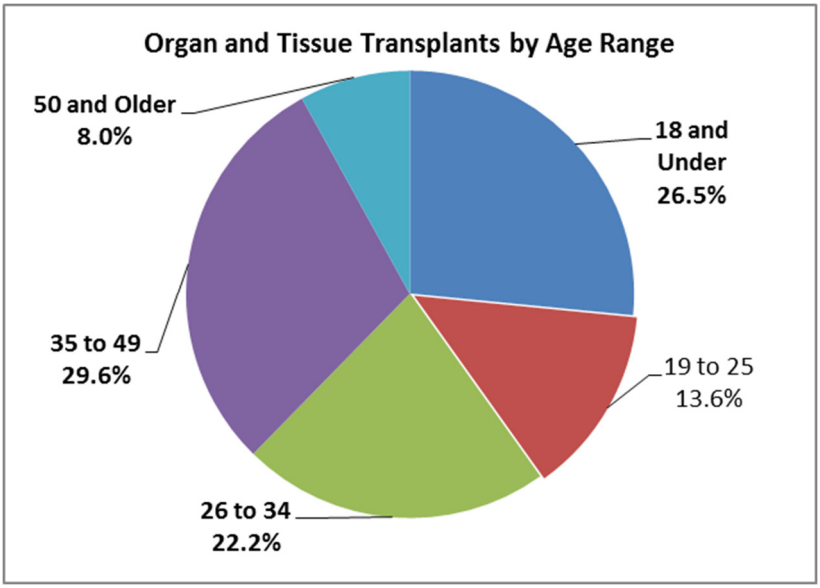
Exhibit 20-4: Organ and Tissue Transplants by County Geography



Age Range of Organ and Tissue Transplant Recipients

The age ranges of 18 and under, 26 to 34 and 35 to 49, which differed by less than eight percent, accounted for nearly seventy-five percent of organ and tissue transplants from SFY 2010 through SFY 2013. Organ and tissue transplants for the remaining age ranges were fairly evenly split (see Exhibit 20-5 on the following page).

Exhibit 20-5: Organ and Tissue Transplant by Age Range



Summary and Considerations for the Future

The OTTP provides for solid organ and bone marrow/stem cell transplants for SoonerCare members. OTTP services are subject to prior authorization and require procedures to be medically appropriate and medically necessary. Care coordination for members is managed by the PCM Department pre- and post-transplant, and authorization is managed by the MAU through the use of medical consultants. Both departments have processes in place for OTTP case management, authorization, and referral to OTTP providers and facilities.

From SFY 2010 through SFY 2013 there were 186 members who had an organ or tissue transplant. Nearly half of transplant referrals originated in rural counties. The age ranges of 18 and under, 26 to 34 and 35 to 49, which differed by less than eight percent, accounted for nearly seventy-five percent of organ and tissue transplants.

Considerations for the future would be to continue to monitor OTTP networks for adequacy and contracting issues. While PHPG did not perform an audit of OTTP cases, the OHCA may want to consider a review of a sample of cases to ensure that all criteria were met during the authorization, provider contracting, and reimbursement processes. It is recommended that clinical and program outcomes be monitored via the generation of OTTP reports in an effort to adjust case management intensity, if needed, and to monitor cost and member outcomes (e.g., clinical, satisfaction with provider or facility).

HEMOPHILIA OUTREACH CASE MANAGEMENT PROGRAM INTRODUCTION AND OVERVIEW

Hemophilia Outreach Case Management Program Objective

The OHCA's Hemophilia Outreach Case Management Program is dedicated to encouraging compliance and good health to members with a diagnosis of hemophilia and their families. Care Management nurses ("Exceptional Needs Coordinators" or "ENCs") provide education and support with ongoing care management outreach.

Program History and Overview

The Hemophilia Outreach Case Management Program began in March 2010. Prior to the Program's transition to the CCU in January 2013, the Program was administered through the Case Management Unit (CMU). In January 2013, the OHCA moved these cases to the Chronic Care Unit (CCU) within the PCM Department.

The CCU provides case management for SoonerCare members that have a diagnosis of hemophilia. ENCs provide ongoing education and support to members and their families. In addition, staff encourages prompt treatment of bleeds and completion and submission of bleed/treatment logs. ENCs collaborate with pediatric hematologists and provide stress compliance education and depression screening.

Program Eligibility

Under the original model, members were identified for program eligibility based on provider referral and/or an OHCA-initiated utilization history referral. The OHCA performed a claims search to identify members with a diagnosis of hemophilia who might benefit from the program's outreach services. Initially, the OHCA placed members in one of two tiers based on their utilization costs. "High Cost" patients had at least $100,000 in medical and/or pharmacy claims per year. "Hemophilia Diagnosed" patients had less than $100,000 in medical and/or pharmacy claims per year. The type of intervention(s) provided depended on the member's tier level.

Following the Program's transition to the CCU in 2013, the OHCA removed the two-tier distinction to create one program. The OHCA also revised its selection criteria. SoonerCare members of all ages with three or more emergency room visits and/or medical utilization costs greater than $50,000 per rolling year are identified as eligible for case management participation by CCU staff. This includes members that have dual eligibility (Medicare/Medicaid). Members on the Advantage Waiver, in the SoonerCare Health Management Program, or living in a nursing facility generally are not followed by the CCU; however, they may be eligible following review by the Senior ENC or Chronic Care Supervisor.

Members currently assigned to a primary care provider (PCP) affiliated with the Health Access Network (HAN) groups are managed through HAN rather than the CCU. When a member's case is closed by the HAN group for any reason, the CCU resumes case management for the member.

Hemophilia Outreach Case Management Program Process

This section provides an overview of the outreach and case management process currently in place for the Hemophilia Outreach Case Management Program. Once a member is confirmed as eligible for and assigned to the program, a Chronic Care Introductory Letter is mailed to the member within three days of case assignment. Members are contacted by phone one week after the letter is mailed. Call attempts are then made on three days at three different times within two weeks.[11]

The initial phone contact allows the CCU to verify the member's demographic and contact information, obtain permission from parents/guardians to speak to minor-aged members, and conduct an initial interview. As part of this process, a Hemophilia Initial Assessment is completed in Atlantes. The Hemophilia Initial Assessment includes questions on:

- Where the member receives his or her care;
- Recent doctor's appointments and scheduling appointments and attendance;
- Frequency of factor treatments;
- Issues with factor treatments;
- Time of last bleed; and
- Tracking/logging infusion and/or bleeds.

Motivational Interviewing techniques are used to engage and connect with members, parents, and/or guardians. Phone contacts are attempted monthly until assessments are completed, and the member or guardian demonstrates the ability to self-manage the disease. The frequency of contact (calls and assessments) depends on the member's need for assistance and engagement as determined by the CCU. Members or guardians who are able to better self-manage health care receive follow-up contact and assessments every two months and gradually transition to every 6 months.

Members who are 12-22 years of age also receive a Behavioral Health Assessment. The OHCA uses the Kutcher Assessment to determine the need for a behavioral health referral. Assessment scores of six or greater or a positive response to question number six ("Thoughts, plans or actions about suicide or self-

[11] During the three-call cycle, the Chronic Care Unit researches members' claims for alternative phone numbers. Providers and pharmacies are contacted for additional phone numbers and to confirm members' addresses. For members receiving care with the OU Hemophilia Group, the OU Nurse Care Manager is contacted for current phone numbers. If an alternative number is not found, an unable-to-contact letter is sent after three call attempts. If an alternative number is provided, the three call attempts are repeated. After two-unable-to contact letters with two claims reviews, if no contact and no response from the member, the case is reviewed with the Senior ENC or CC Supervisor for closure.

harm") trigger a referral to the OHCA's Behavioral Health Unit (BHU). For members under age 18, parental/guardian consent must be obtained to make a referral.

Adult members complete the Patient Health Questionnaire (PHQ-9), which helps assess depression in at-risk populations and the severity of depression. Members with an assessment score of 10 or greater receive a behavioral health referral to the BHU. Members who positively respond to question 9 ("Thoughts that you would be better off dead or of hurting yourself in some way") require immediate intervention.

A Literacy Assessment also is completed with the member. Following completion, members are mailed applicable educational materials. Examples of educational materials include:

- Available resources that will further facilitate the member's care;
- Promotion of emergency room reduction;
- Medication compliance;
- Follow-up care with specialty or primary care provider appointments; and
- Promotion of self-management of hemophilia disease.

The CCU also contacts members' providers to introduce the outreach program. Providers also receive a request to submit members' medical records to the CCU. Members' medical records are reviewed and compared to the members' reported medication list. Claims are reviewed as needed. The CCU creates a partnership with the provider and member to:

- Resolve medication discrepancies;
- Address medication compliance concerns;
- Provide information on the OHCA Rx maintenance medication list;
- Provide resources and/or submit social services referral;
- Provide education on medications using the teach-back method;
- Review gaps of care and coordinate appointments to resolve; and
- Evaluate emergency room visits.

Cases are determined as appropriate for closure when:

- The member does not show on the quarterly report (five or more emergency room visits or a cost greater than $50,000 per rolling year) for four consecutive quarters (one year);
- Assessments have been completed;
- Acute needs have been met;
- Educational information has been sent and reviewed with the member; or
- Member or parent/guardian states they have no further need for contact from the CCU.

The CCU also participates telephonically in quarterly case staffing meetings with the OU Jimmy Everest Center. This provides an opportunity for the OHCA Care Management staff and Hemophilia Center staff to share progress and contacts with members.

Exhibit 21-1 below provides a flow chart of the current Hemophilia Outreach Case Management Program process.

Exhibit 21-1: Hemophilia Care Management Program Process

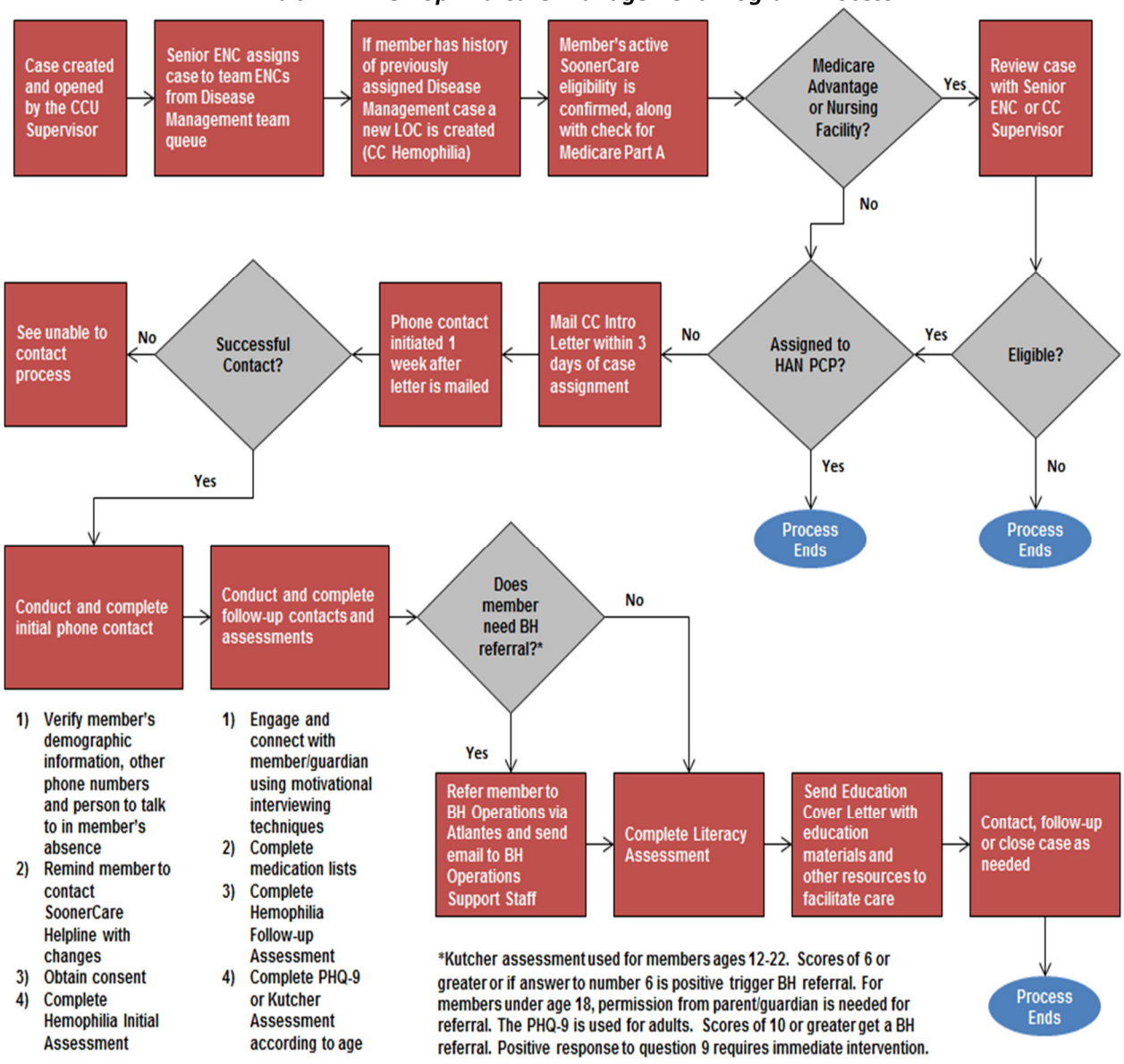
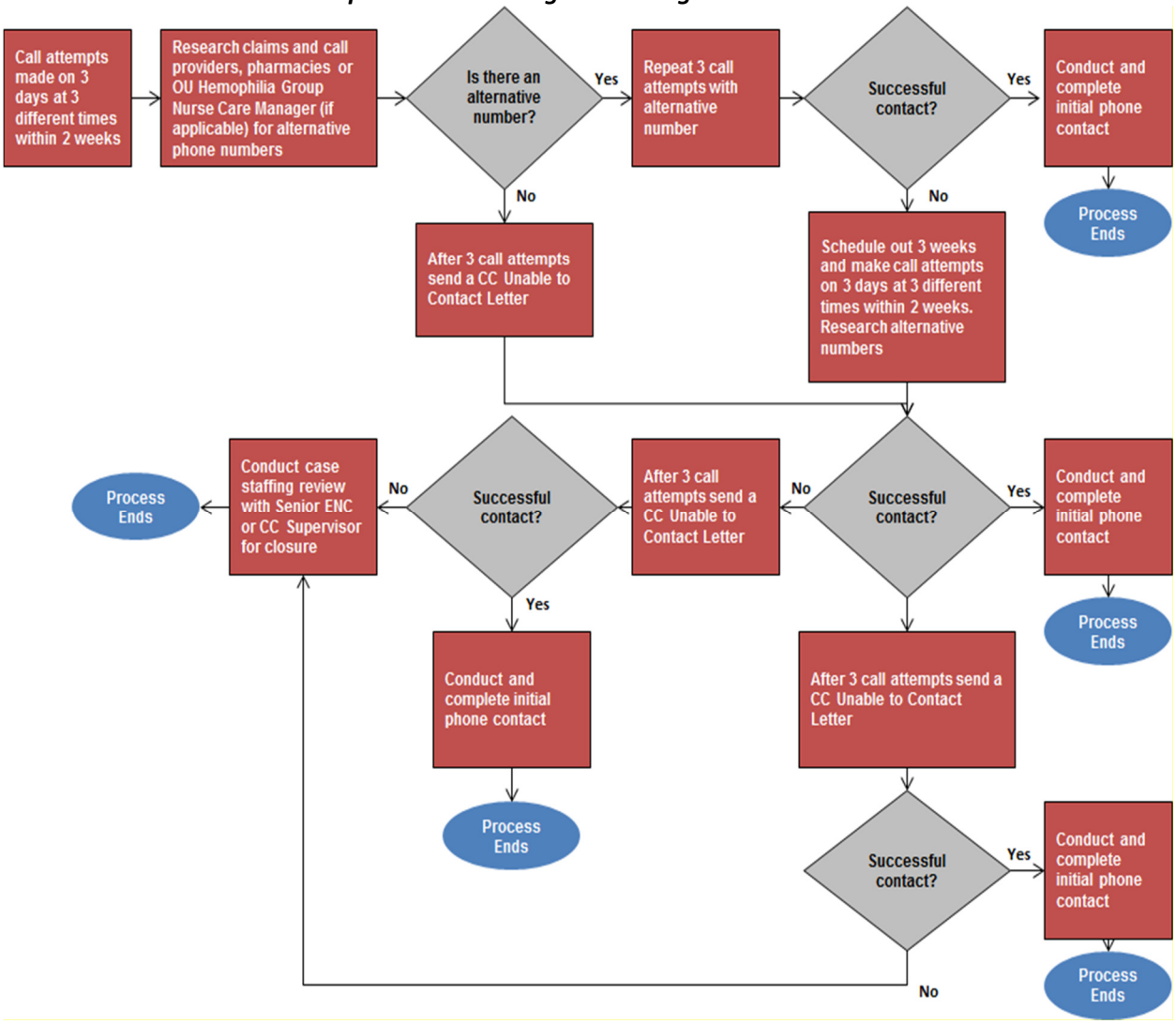


Exhibit 21-2 below provides a flow chart of the unable-to-contact process for the Hemophilia Outreach Case Management Program.

Exhibit 21-2: Hemophilia Care Management Program Unable to Contact Process



HEMOPHILIA CARE MANAGEMENT PROGRAM FINDINGS

Methodology

To conduct our analysis, PHPG obtained data from the OHCA's care management system (Atlantes). The Atlantes system is a proprietary care management system operated by Hewlett-Packard and is used by the PCM Department to store all member records, program activities, assessments, and program letters that are generated. Records were extracted from Atlantes for the period of March 1, 2010 (SFY 2010), through June 30, 2013 (SFY 2013).

The Atlantes dataset was treated as the authority for identifying hemophilia case management activities. The dataset was "cleaned" to ensure activity records were accurately included in the analysis. This included removing duplicate records and combining records that had overlapping dates (i.e., same Level of Care Start and End dates), as well as removing records that had null end dates.

Results

The following PCM program enrollment and activities were analyzed for hemophilia care management by using the Atlantes dataset:

- Initiation of hemophilia care management by SFY;
- Length of program participation;
- Gender and age of program members;
- First level of care in Atlantes; and
- Care management activities.

Analysis of Hemophilia Care Management Activities

This section describes program enrollment and activities by SFY using data contained in Atlantes.

Members with Hemophilia Care Management Assistance

Exhibit 21-3 below summarizes the number of members with hemophilia case management assistance from SFY 2010 through SFY 2013. The total number of members having hemophilia case management assistance by SFY was calculated based on a member's having a level-of-care start date in that fiscal year.

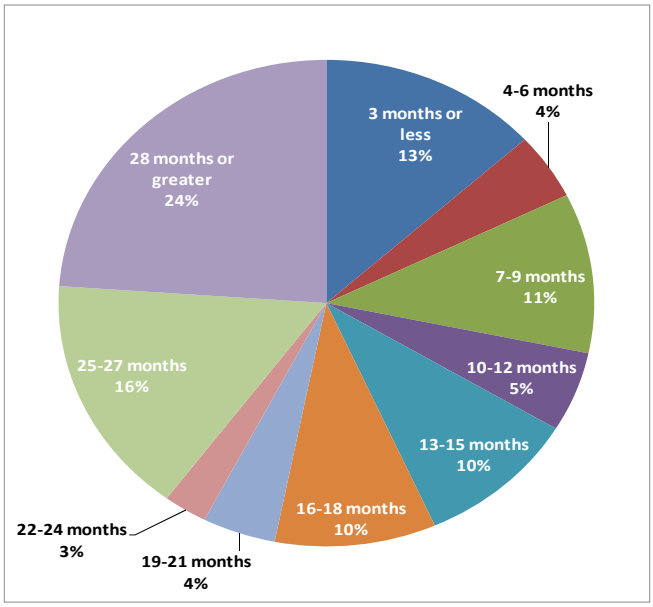
Exhibit 21-3: Members with Hemophilia Care Management Assistance by State Fiscal Year

SFY	# of Members
2010	65
2011	18
2012	25
2013	5
Total	**113**

Average Length of Participation

The average length of hemophilia program engagement was 18 months. Exhibit 21-4 below highlights the breakdown of lengths of engagement by three-month intervals. Forty percent of members remained in the program longer than 24 months.

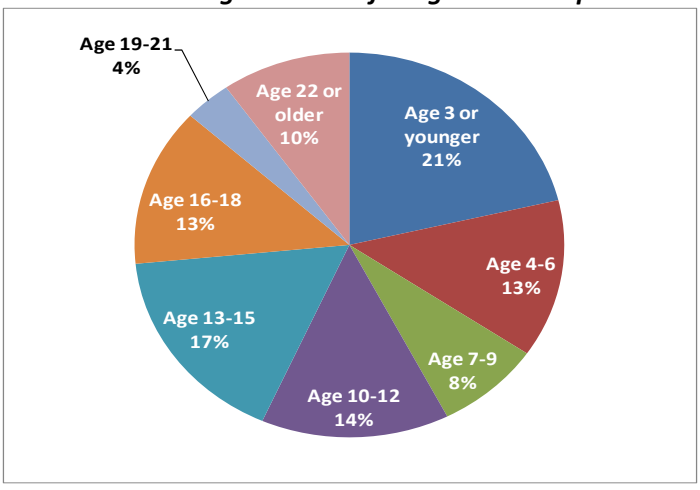
Exhibit 21-4: Length of Program Participation



Gender and Age of Program Members

Eighty-eight percent of program participants were male, and 12 percent were female. The average age of members at the time of program participation was 13 years of age. Exhibit 21-5 below shows the age ranges of members at the time of program participation.

Exhibit 21-5: Age at Time of Program Participation



First Level of Care in Atlantes

As discussed earlier, the program initially placed members in one of two tiers: Hemophilia Diagnosed or Hemophilia High Cost. Nearly 64 percent of members had "Hemophilia Diagnosed" listed as their First Level of Care in Atlantes. Approximately 16 percent had "Hemophilia High Cost" listed as their First Level of Care. Exhibit 21-6 below shows the percentage of members with a hemophilia-related level of care. Eight members were re-classified as Hemophilia High Cost following subsequent assessment by an ENC. The OHCA removed the tier distinctions when the program was moved to the CCU in 2013.

Exhibit 21-6: First Level of Care in Atlantes

Hemophilia Diagnosed	Hemophilia High Cost	Hemophilia and Behavioral Health	Other
63.7%	**15.9%**	**3.5%**	**16.8%**

Care Management Activities

Members received introductory letters. Care Management nurses also performed assessments and follow-up assessments. Contact with members was performed over the phone or face to face. Other activities documented in Atlantes include phone contacts with providers, research, and member record reviews.

Summary and Considerations for the Future

The Hemophilia Outreach Case Management Program is dedicated to encouraging compliance and good health to members with a diagnosis of hemophilia and their families. The program is administered by the CCU within the PCM Department. ENCs provide ongoing education and support to members and their families. ENCs collaborate with pediatric hematologists and provide stress compliance education and depression screening. Members with three or more emergency room visits and/or medical utilization costs greater than $50,000 per rolling year are identified as eligible for case management participation by CCU staff, including members with hemophilia.

Between SFY 2010 through SFY 2013 there were 113 members who received hemophilia case management assistance. Forty percent of members remained in the program longer than 24 months. Nearly 64 percent of members had "Hemophilia Diagnosed" listed as their First Level of Care in Atlantes. Approximately 16 percent had "Hemophilia High Cost" listed as their First Level of Care.

Considerations for the future would be to have a focus group or to survey parents/guardians and members with hemophilia to see what they find useful about the case management program. Other

interventions to consider, in addition to the monthly calls and assessments, are onsite collaboration with members and providers, multidisciplinary care team conferences with the ENCs and providers, and/or face-to-face visits with members if the need arises. This may be beneficial for high-cost cases when the ENC is unable to contact the member. To the extent members and hemophilia providers have an established relationship, and there are no case management needs, an evaluation of case closure criteria could be performed. More direct contact and coordination between the CCU ENCs and the HAN case managers to coordinate care when the member is returned to the CCU would be advantageous.

LARGE TRANSITIONAL EVENTS INTRODUCTION AND OVERVIEW

Large Transitional Events Program Objective

A large transitional event is a large-scale situation that potentially could impact SoonerCare members' access to care. Examples of large transitional events include, but are not limited to:

- Natural disasters, such as tornados or hurricanes;
- Provider disenrollment from SoonerCare participation due to fraud allegations or after the appeals process is exhausted; and
- Program transition, such as moving members from state-subsidized insurance to the Federally Facilitated Marketplace (FFM).

When an event affects a large number of members, the OHCA reaches out to impacted members to determine care needs and facilitate transition of care, if applicable.

Program History and Overview

Natural Disaster (2013 Tornado Outbreaks)

Between May 19th and 20th of 2013, central Oklahoma experienced a tornado outbreak. PCM had 128 members in the affected zip codes. On May 31, 2013, El Reno and south Oklahoma City experienced another series of tornados, which affected 57 members. Outreach calls were made to those members.

Oklahoma State Agencies work together and have disaster response procedures in place to assist members in the event a natural disaster occurs. PCM Department staff conducted outreach efforts to check on the well-being of members and to offer assistance.

Provider Disenrollment

Providers may be terminated from participation in SoonerCare for cause, including allegations of fraud and exhaustion of the appeals process. When this occurs, members may no longer have access to services from the terminated provider.

The PCM Department has desktop procedures in place that describe the outreach process for notifying members of their provider's termination. Impacted members are initially contacted by phone to inform them of the provider's disenrollment from SoonerCare. The calls also provide an opportunity for the ENC to ask if the member needs any assistance in finding another provider or contact information of other available providers. Members who cannot be reached by phone are sent letters.

Program Transition (Insure Oklahoma)

In November 2005, Oklahoma implemented the Insure Oklahoma program to provide premium assistance for health insurance for low-wage working adults in Oklahoma. The program began with Employer Sponsored Insurance (ESI) and expanded to include the Individual Plan (IP) in January 2007 to assist sole proprietors, certain unemployed individuals, and working individuals who did not have access to small group health coverage. Between November 2007 and September 2010, Insure Oklahoma increased its qualifying income guidelines and offered coverage to income-eligible, full-time Oklahoma college students age 19 through 22 and dependent children of Insure Oklahoma members.

Insure Oklahoma decreased its IP-qualifying income guidelines from 200 to 100 percent of the federal poverty level (FPL) in January 2014. Members no longer eligible for IP premium assistance could purchase coverage through the Federally Facilitated Marketplace (FFM).

To prepare for this transition, Insure Oklahoma and the PCM Department worked together to identify and contact potentially impacted members. The desktop procedure outlined the activities that would take place during the months preceding members' eligibility termination.

On September 28, 2013, Insure Oklahoma notified potentially affected members by mail, with a follow-up mailing sent on October 3, 2013 to members slated to lose eligibility. The Insure Oklahoma Nurse and staff from the PCM Department conducted a limited calling campaign targeting the highest-risk members. The calling campaign began the week of October 6, 2013.

Large Transitional Events Processes

Natural Disaster (2013 Tornado Outbreaks)

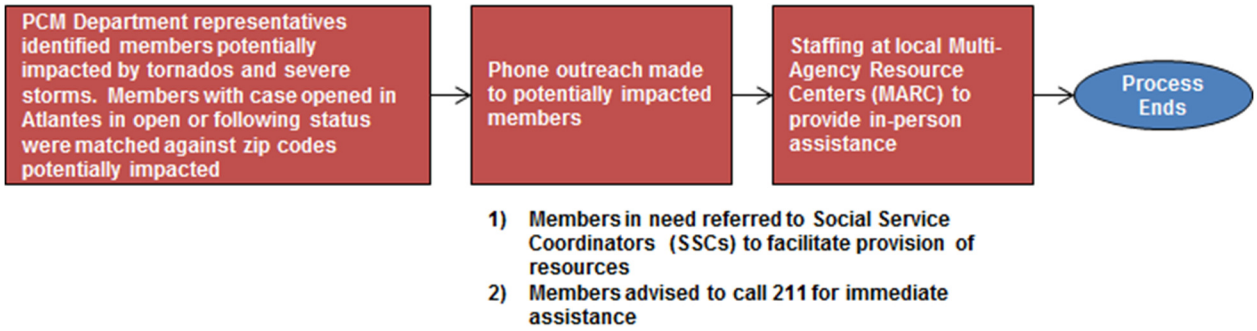
The OHCA identified a list of members who could potentially be in the areas impacted by the tornado outbreak. Members identified as having a case open in Atlantes in either an open or following status were matched against zip codes that were potentially affected by the tornados. ENCs were asked to call their members to check on their welfare and offer assistance.

Calls took place over the weeks following the tornados as different services and methods of contact were restored. Members in need of services were referred to Social Service Coordinators (SSCs) to facilitate the provision of resources. Members were advised to call 211, the statewide information and referral helpline that connects Oklahoma residents with community services and resources seven days a week, 365 days a year.

In addition to making outreach calls, PCM staff also took part in the Multi-Agency Resource Centers (MARC). Individuals impacted by the storms could go to one of five MARC locations to speak with agency representatives to find out more information about available resources.

Exhibit 22-1 below provides an overview of the care transition process used for the May 2013 tornado outbreaks.

Exhibit 22-1: Natural Disaster Care Transition Process



Provider Disenrollment

When a provider is disenrolled from SoonerCare participation due to fraud, the Legal Department Deputy General Counsel notifies Executive Staff and Operations Directors by copy of the provider termination notice. The SoonerCare Provider Services Director reviews the letter and determines the next course of action based on the type of provider.

For Behavioral Health provider types, agency staff is asked to run a Business Objects Query to identify members who have received care from the provider in the past 60 days. For medical specialist or sub-specialists that require further inquiry, the Provider Services Director notifies the PCM Department leadership who will perform a review to determine if an additional provider data query is needed.

Call attempts are made to impacted members. Members are offered assistance with changing providers and are provided with a list of available providers and their contact information. Members who cannot be reached by phone (unsuccessful attempt or phone is disconnected) are sent a letter.

If it is determined that formal notification to affected members is required, a letter is developed using an approved Legal Division template and sent to identified members. The letter notifies members that the provider is terminated and provides a phone number to call if further assistance is needed.

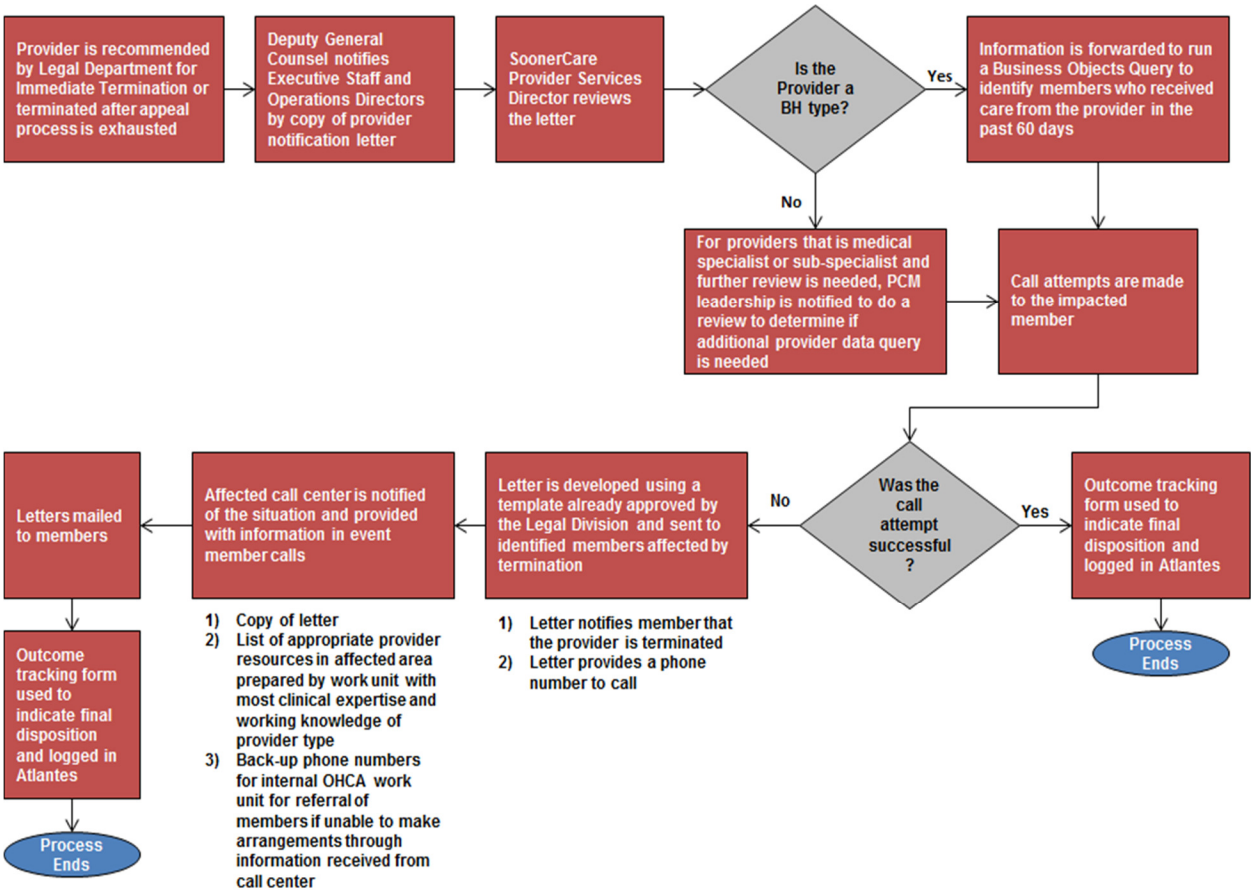
Prior to sending out the letter, the affected call center is notified of the situation and provided with:

- A copy of the letter sent to members;
- List of appropriate provider resources in the affected area; and
- Back-up phone numbers for an internal OHCA work unit for referring members if they are unable to make care arrangements through information received from the call center.

The list of provider resources is prepared by the work unit with the most clinical expertise and working knowledge of the provider type. Individual call attempts and mailings are manually recorded on an outcome tracking form. All outreach efforts are then entered into an Excel tracking log.

Exhibit 22-2 below provides an overview of the provider disenrollment care transition process.

Exhibit 22-2: Provider Disenrollment Care Transition Process



Program Transition (Insure Oklahoma)

On September 28, 2013, Insure Oklahoma mailed general letters to potentially affected Insure Oklahoma members. These letters notified members of various changes to the Insure Oklahoma Program, including a reduction in income limits for participants (from 200 percent of the FPL to 100 percent of the FPL). The letter also notified the member that based on income, the member no longer appeared to qualify to participate; the letter provided information on how to request a review or additional information and appeal rights/processes. Members also received information on how to contact the FFM to apply for coverage and determine eligibility for advance premium tax credits.

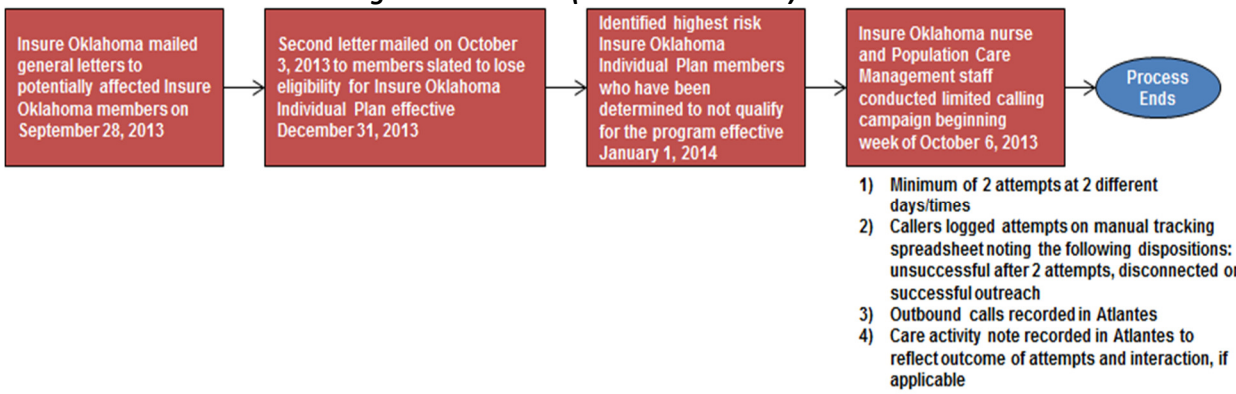
Insure Oklahoma sent a second letter on October 3, 2013 to members determined to be losing their program eligibility at the end of the calendar year. The letter contained information on the termination date (December 31, 2013), how to appeal the decision, and assistance contact information.

The Insure Oklahoma nurse and staff from the PCM Department conducted a limited calling campaign beginning the week of October 6, 2013. Calls were targeted toward the highest-risk Insure Oklahoma Individual Plan members losing coverage. A total of 314 members were identified as highest-risk. Callers used a script to conduct the calls. Callers introduced themselves to the member and asked about the coverage termination letter recently sent to the member, specifically whether the member received the letter and had any questions. Members also were encouraged to visit the Insure Oklahoma website, and callers provided information on the URL and Insure Oklahoma hotline.

Callers made a minimum of two attempts at two different days/times. Callers recorded call attempts using a manual tracking worksheet, noting the following dispositions: unsuccessful after two attempts, disconnected, or successful outreach. Records were turned into the PCM Department Leadership/Analyst upon completion and as requested. Outbound call information also was recorded in Atlantes, as well as a care activity note reflecting the outcome of the attempts and any applicable interaction.

Exhibit 22-3 below provides an overview of the transition process activities.

Exhibit 22-3: Program Transition (Insure Oklahoma) Care Transition Process



LARGE TRANSITIONAL EVENTS FINDINGS

Methodology

To conduct the analysis, PHPG obtained data from the OHCA's care management activity tracking logs. The logs provided information on outreach efforts made for the particular transitional event.

Results

Although some variation may exist depending on the event being tracked, in general, a manual outcome tracking form is completed to document the contact attempt. Information from the tracking form is subsequently entered into an Excel tracking spreadsheet. The spreadsheets summarize the outreach efforts (contact date, level of contact achieved, disposition, and comments) for each impacted member. Available call tracking logs indicate that all members were either contacted successfully or sent a letter when unable to be reached.

Summary and Considerations for the Future

A large transitional event is a large-scale situation that potentially could impact SoonerCare members' access to care. When an event affects a large number of members, the OHCA reaches out to impacted members to determine care needs and facilitate transition of care, if applicable. To do so, the PCM Department has procedures in place for documenting and tracking all member outreach activities.

Upon a review of a sample of call tracking logs, PHPG noted that outreach efforts (contact date, level of contact achieved, disposition, and comments) are summarized for each impacted member. Available call tracking logs indicate that all members were either contacted successfully or sent a letter when unable to be reached. Since the events are fairly infrequent, and the OHCA seems to have solid procedure and a tracking system in place, no changes are recommended at this time.

BEHAVIORAL HEALTH INPATIENT SERVICE QUALITY REVIEWS

Behavioral Health Inpatient Service Quality Review Objective

The OHCA conducts onsite service quality reviews of facilities providing behavioral health services to SoonerCare members. The audited facilities include acute freestanding psychiatric facilities, psychiatric units within acute general care hospitals, psychiatric residential treatment facilities (PRTFs), community based treatment (CBT) units, and therapeutic foster care (TFC) agencies.

The reviews are conducted pursuant to federal regulations requiring the periodic inspection of institutions for mental disease[12] and Oklahoma regulations requiring these facilities to, "maintain all programs and services according to applicable Code of Federal Regulations (CFR) requirements, TJC/AOA standards for Behavioral Health care, State Department of Health's Hospital Standards for Psychiatric Care, and State of Oklahoma Department of Human Services Licensing Standards for Residential Treatment Facilities."[13]

The overarching purpose of these periodic reviews is to verify that facilities are safe for residents, as verified through physical inspections, and that they provide medically necessary care, as documented through patient records. Safety issues and other areas of non-compliance are subject to corrective action plans or, in extreme cases, termination; services not shown to be medically necessary are subject to recoupment.

Program History and Overview

Prior to 2012 the OHCA contracted with a Quality Improvement Organization (QIO) to perform service quality reviews on the agency's behalf. In 2012, the OHCA established an Inspection of Care (IOC) team within the Behavioral Health Department and assumed direct responsibility for conducting the reviews. This IOC team, now known as the Service Quality Review (SQR) unit, is currently comprised of a director, four licensed behavioral health specialists, and one analyst.

In SFY 2014, there were 83 behavioral health facilities subject to the review process. This included a mix of inpatient acute, PRTF, and TFC agencies located in Oklahoma and neighboring states.

The OHCA begins the review process at the start of each state fiscal year (SFY) with the development of a schedule comprised of the facilities that had a SoonerCare member admitted during the prior SFY. These unannounced reviews combine a document review component with an on-site inspection of the facility.

[12] See 42 CFR part 456.
[13] OAC 317:30-5-95.40.

During the document review, the OHCA examines facility policies and procedures (e.g., patient intake policies), member materials (e.g., patient handbook), evidence of licensure/accreditation, staff records, and information on critical incidents/variances. Based on the number of Medicaid admissions, the OHCA also requires the facility to provide medical records for between three and ten patients for evaluation of the appropriateness of the services provided and the facility's billing practices. The OHCA selects the records to be reviewed from the facility's universe of current open Medicaid cases.

OHCA service quality review staff document findings using a variety of worksheets, after which key findings are summarized on a standardized tool. Facilities are rated "yes," "no," or "not applicable" in terms of their compliance with each "key finding" element on the tool. Any "no" finding is supported through a detailed, written description of the OHCA's concern(s), which could include quality issues and/or issues requiring financial recoupment.

The SFY 2015 tool captures key findings across six domains, each of which has between three and nine discrete elements. The domains are:

1. Safety (i.e., safety issues noted during walkthrough);
2. Member Rights (i.e., policies for obtaining consents and notifying members/guardians of their rights);
3. Medical and Clinical Services (i.e., services are provided by appropriately credentialed staff)
4. Medical Records/Charting (i.e., medical records are legible and organized in a manner to allow appropriate accessibility and easily retrievable clinical information)
5. Medical Necessity Criteria (i.e., clinical record reflects substantiated, SoonerCare-compensable diagnosis)
6. Licensing and Accreditation (i.e., hospital has a license, if applicable)

The OHCA applies each facility's own internal standards, as outlined in policies and procedures, when determining whether patient records have been appropriately maintained. If materials should have been included in a record pursuant to the facility's own policies, and were not, this is treated as a deficiency.

Although much of the review focuses on documentation, patient safety and appropriateness of care are given significant attention. Safety issues identified during a facility walk through, such as a shower curtain rod that could pose a suicide risk or an inadequately secured medicine cabinet, are flagged as serious issues requiring immediate remediation. Any use of restraints or seclusion of patients without proper justification is likewise treated as a serious quality-of-care concern.

In addition, staff interviews, incident reports, and grievances are reviewed for patterns of unsafe practices. Staff training and credentials are examined to ensure services are provided safely and by appropriately credentialed staff.

Shortly after the onsite review, the OHCA presents formal written findings to the facility. As applicable, the facility is instructed to prepare a formal corrective action plan (CAP) to address identified deficiencies and failure to comply with applicable federal/state requirements. The OHCA reviews each CAP, and, if indicated, requires revisions before granting final approval for implementation.

Exhibit 23-1 illustrates how findings are translated into CAPs. The exhibit includes examples taken from SFY 2014 inpatient provider audit files. They are presented for information only and are not meant to be representative of all CAP items.

Exhibit 23-1: CAP Examples

OHCA Finding/CAP Directive	Approved CAP Response
Use of Seclusion/Restraints: A restraint was documented where there was no physician order for the intervention. Each seclusion/restraint episode requires an order by a physician or other LIP (licensed independent practitioner).	**Response:** A new Director of Nursing has been hired and is reviewing with the nursing staff all the seclusion and restraint requirements and documentation, including the required order by the physician or other LIP. This re-training was completed on December 6. *(Note: CAP was issued on November 13.)*
Member Grievances: In some records the facility failed to adequately document that patients were informed of the outcome of grievances filed, thus failing to comply with Medicare/Medicaid Patient Rights Conditions of Participation and OHCA rules OAC 317:30-5-95.32 and OAC 317:30-5-95.40.	**Response:** In order to have documentation that the patient is notified of the outcome of grievances, the grievance coordinator will take one of the following actions: 1. Ask the patient to sign the bottom of the grievance to attest that he/she is satisfied with the result of the grievance, 2. If the patient has been discharged, she will send a letter to the home of the patient. A copy will be kept with the original grievance form.
Active Treatment: Inpatient psychiatric programs must provide "Active Treatment." Active Treatment involves a member and the family or guardian from the time of an admission throughout the treatment and discharge process. Family members must attend family therapy weekly for continued SoonerCare reimbursement. OAC 317:30-5-95.34. The facility's documentation of active treatment lacked documentation of required frequency, type of services, and documented overlapping service times. Also, non-SoonerCare compensable services were provided using telephone family therapy. *(Note: The CAP was accompanied by a recoupment for services failing to meet SoonerCare standards.)*	**Response:** Active treatment requirements from OAC 317:30-5-95.34 were reviewed with the clinical staff, and a graph was given to each of the clinicians that outlined a time line for the active treatment requirements. All staff has been instructed to be diligent in their documentation as to the frequency, type of service, and service time. Staff has again been educated that family therapy is a face-to-face service.
Staffing: Title 42: Public Health 482.11 CoP-(c) The hospital must assure the personnel are licensed or meet other applicable standards that are required by state or local laws. OAC 310:667-33-2(a) Personnel (3)	**Response:** Additional staff has been hired to accommodate census fluctuations. A daily review of census on each unit will be conducted to verify appropriate number of staff for each unit.

OHCA Finding/CAP Directive	Approved CAP Response
…at least one (1) RN shall be assigned to care and provide treatment for every 15 patients on each shift, except that if unit census exceeds 15 but does not exceed 20 during the shift, an LPN may be substituted for the second required RN. There were shifts where the required licensed staffing requirement was not met.	
Mixing of Acute and RTC patients: OAC 310:667-33-1(b) Beds should not be co-mingled with acute beds. RTC and Acute levels of care populations are mixed.	**Response:** (Facility), with the support of the division President, has submitted a plan and a request for funds for facility expansion to accommodate an additional unit for children and adolescents. The anticipation of construction is within the next few months.

If the OHCA determines that a recoupment is due for previously reimbursed services not supported by the patient's record, the facility is provided a "Disallowed Services Summary" worksheet that documents the basis for the recoupment.

There are two recoupment types. "Full Day" recoupments are based on the total amount paid to a facility that day for a patient when the reviewer determines that the facility has failed to meet medical necessity criteria for an admission at the level-of-care services provided. A "Partial Recoupment" in the amount of $50 per occurrence is assessed for other issues, such as failure to complete a psychiatric evaluation within the required timeframe.

Facilities are given ten calendar days to submit a written request for reconsideration of some portion or the entire recoupment amount. The reconsideration request is a second level of review by the doctors and possibly the behavioral health supervisory staff who issue a final determination. The request must be supported by documentation not previously reviewed at the time of the audit.

After making any adjustments to the recoupment amount (if applicable) and approving the CAP (if applicable), the OHCA issues a final audit letter to the facility. The CAP items are re-examined at the next audit to verify they have been completed. (Facilities frequently undertake some CAP measures concurrent with submitting the CAP, particularly high-priority items such as safety risks.)

Effective July 2015, the OHCA will be implementing the following new protocols:

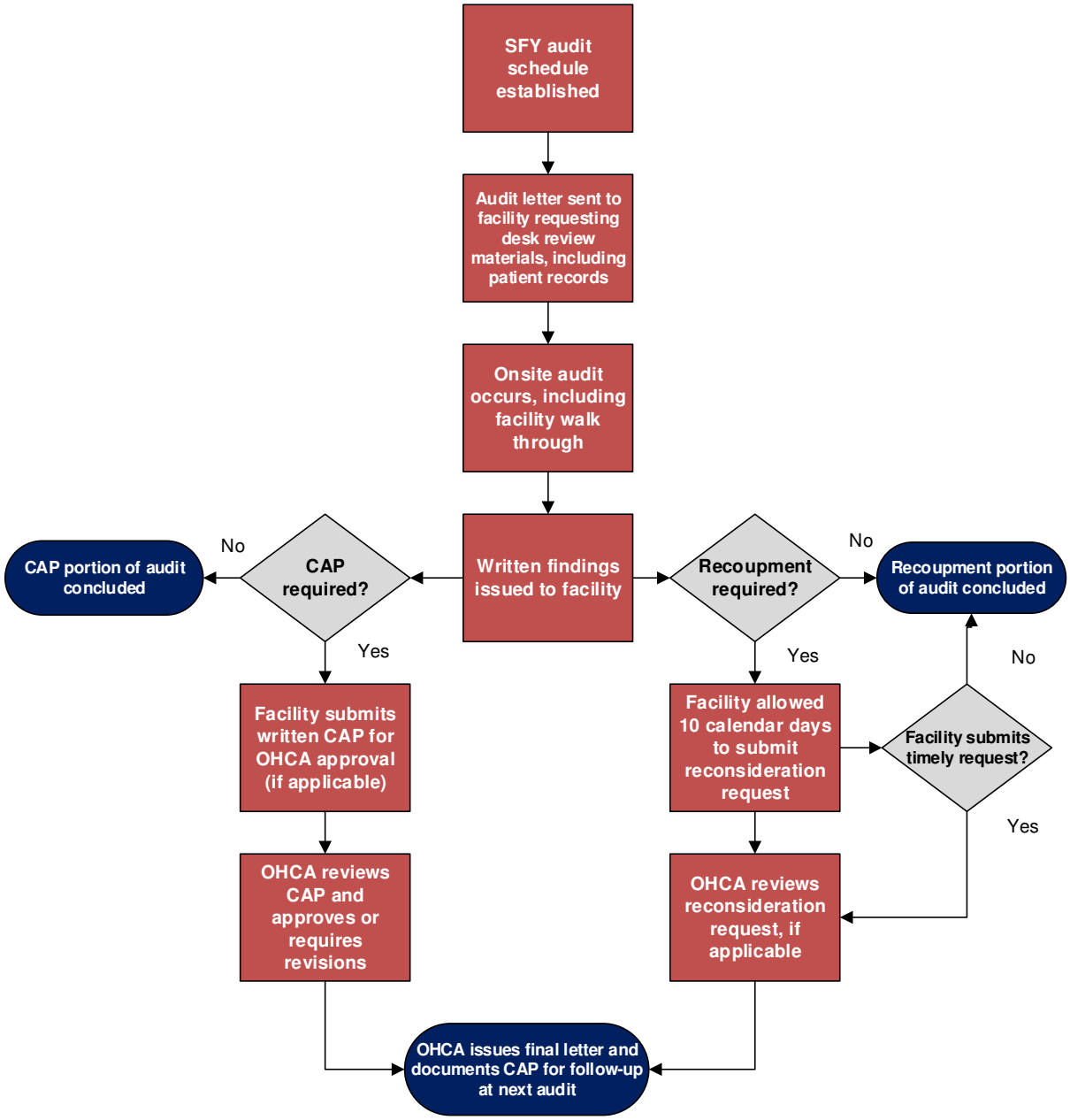
A) In an attempt to decrease or eliminate overnight travel to reduce expenses, the following guidelines will be observed:
   i. Inpatient in-state and border providers will receive annual on-site facility inspections, but the medical records will be reviewed at OHCA office (referred to as a desk review).
   ii. Out-of-state providers with regular admissions will receive an on-site visit the first year they are granted a contract and then once every three years, or on an ad-hoc basis. Again, medical records will be reviewed at OHCA office.

iii. Out-of-state providers with random admissions will receive only desk reviews, and their State's auditing bodies' reports will be used in lieu of an on-site inspection evaluating for quality or safety issues.

B) To address providers that have a CAP for one or more of the same items for two consecutive years or meet one or more of the criteria listed below, the OHCA will supersede the new policy described above and conduct a full on-site audit of the provider at the facility's treatment location:
   i. Failure to adequately document medical necessity criteria in the patient record.
   ii. Non-compliance in one of the four areas considered critical to treatment (psychiatric evaluation, history and physical, psychosocial assessment, and master individual plan of care.
   iii. A significant amount of recoupment due to non-compliance in one or more areas, excluding those already identified in number two above.
   iv. Other serious issues or concerns.

Exhibit 23-2 on the following page presents a flow chart of the service quality review process.

Exhibit 23-2 – Service Quality Review Process



The OHCA shares its oversight responsibility with the facility's accrediting organization, as well as the Oklahoma Department of Human Services and the Oklahoma State Department of Health, which are the licensing agencies for behavioral health facilities. The audit findings are shared with the above mentioned parties.

SERVICE QUALITY REVIEW FINDINGS

Methodology

PHPG evaluated the service quality review process by examining SFY 2014 audit records for 15 inpatient providers selected at random from a list of 65 furnished by the OHCA. The larger list consisted of providers who consistently have Medicaid admissions from one year to the next. The 15 providers included a mix of acute and residential treatment facilities in Oklahoma, Arkansas, and Texas.

PHPG analyzed SFY 2014 audit records to assess the comprehensiveness of the reviews and to document facility performance across the six domains included in the Key Findings tool. Domains and discrete review elements on which fewer than 80 percent of facilities received a passing grade were flagged as potential opportunities for additional education and quality improvement across the provider community.

PHPG also obtained SFY 2013 audit records for the same facilities. The OHCA modified its audit tools in SFY 2014, which limited PHPG's ability to compare across years. However, PHPG was able to examine recoupment trends for all 15 facilities and the status of SFY 2013 CAP items in SFY 2014 for a subset of facilities.

Results

The OHCA's service quality review process is comprehensive in scope, as demonstrated through the completed audit tools, which examine multiple elements within each domain and include detailed auditor notes for any deficiency finding. The process also is consistent across facilities, with the same criteria applied to assess facility compliance with federal/state regulations and internal policies and procedures.

Exhibit 23-3 on the following pages presents average "passing rates" for the six domains included on the Key Findings tool. The average passing rate represents the percentage of discrete elements within the domain on which the facilities reviewed by PHPG received a passing score (typically a "yes" finding, although for some elements a "no" finding equates to passing).

The exhibit also highlights in red the domains and elements within each domain for which fewer than 80 percent of the facilities received a passing rate.

Exhibit 23-3: Audit Key Findings – Pass Rate by Domain and Element

Domain/Element	Pass Rate
Safety Domain	**74%**
1. Staffing levels appropriately address census and acuity	58%
2. Polices are in place to address patient safety issues	100%
3. Policies addressing patient safety appear to be consistently followed	67%
4. Seclusion/restraint (S/R) training updates (including RN post-assessment training, if applicable) completed as required	67%
5. RNs performing post-S/R assessments have appropriate training	100%
6. Incident, Grievance, and/or S/R logs indicate patterns of potential safety issues (no = pass)	67%
7. If yes, is there documentation that this has been addressed by the facility?	25%
8. Seclusions/Restraints are appropriately ordered, monitored, and documented	67%
9. Critical Incidents/Sentinel Events are appropriately tracked through resolution	92%
10. Safety issues noted during unit walk-through/observation (no = pass)	83%
11. CPR training current/updated (annual required for PRTF/RTC; current for acute)	100%
Member Rights Domain	**74%**
12. Policies in place for obtaining consents, notifying member and guardian of member's rights etc.	92%
13. Facility has a Grievance Coordinator and a clear policy for addressing/resolving member grievances	92%
14. Documentation indicates grievances are tracked through resolution	67%
15. Policies are in place addressing other significant patient rights such as mail, visitation, access to belongings, etc. that clearly explain reasons for limitations of these rights (alternate: in place addressing other significant patient rights such as confidentiality)	100%
16. Policies addressing patient rights appear to be followed consistently in an equitable manner	67%
17. Documentation indicates members & guardians were provided with orientation information at admit explaining patient rights	83%
18. Appropriate educational exposure is provided to school-age members who are at the facility more than five days	100%

Domain/Element	Pass Rate
Medical and Clinical Services Domain	74%
19. Treatment team includes required clinical/medical staff	83%
20. Other professional treatment providers and services (pharmacist, dietician, lab, etc.) are available as necessary for patient safety and treatment	100%
21. Medical/clinical departments are staffed adequately to provide required services	100%
22. Required assessments, Plans of Care, & updates are consistently completed, signed, dated, and on the record within the required time frames (alternate: medical record entries are consistently completed, signed, and authenticated in the expected timeframes defined by facility policy/procedure)	100%
23. (Medical records indicate) Active treatment is consistently provided at a frequency meeting OHCA requirements ***and*** active treatment documentation consistently meets required content/quality standards (alternate: included in section 4 of some audits)	27%
24. Clinical documentation indicates appropriate, regular communication between treatment team members	75%
25. Appropriate, ongoing staff development/continuing education is being provided	100%
26. Services are provided by appropriately credentialed staff	75%
27. There is documentation indicating staff training in and implementation of trauma-informed & evidence-based treatment practices	60%
Medical Records/Charting Domain	71%
28. Medical records are (legible and) organized to allow appropriate accessibility of clinical information	50%
29. Documentation policies are in place to insure medical records are accurate, promptly completed, properly filed, & maintained for a period of at least five years	100%
30. Policies are in place addressing patient confidentiality and medical record security (alternate: policies/procedures are in place to address medical record security for hard copy (paper) records)	100%
31. If EMR system is used, policies are in place addressing security and authentication of those records	100%
32. Policies are in place addressing any other significant medical record security/integrity issues	89%
33. There is evidence that documentation/medical record policies are consistently followed	100%
34. Medical record entries are consistently dated, timed, and appropriately authenticated (alternate: consistently completed, signed, and	25%

Domain/Element	Pass Rate
authenticated in the expected time frames defined by facility policy/procedure)	
Medical Necessity Criteria	**100%**
35. The clinical record reflects a substantiated, SoonerCare compensable primary treatment diagnosis	100%
36. Clinical documentation during the intake includes specific behavioral descriptors that support a need for the admission and requested LOC	100%
37. Behavioral descriptors are contained in the clinical record that support ongoing MNC for continued stay	100%
Licensing and Accreditation (as applicable)	**91%**
Hospital (acute program) has a license to operate as a hospital	100%
RTC/PRTF as licensed by DHS	67%
Facility appropriately accredited	100%
Facility maintains separate acute and RTC/PRTF levels of care/programming, including designated staff	100%

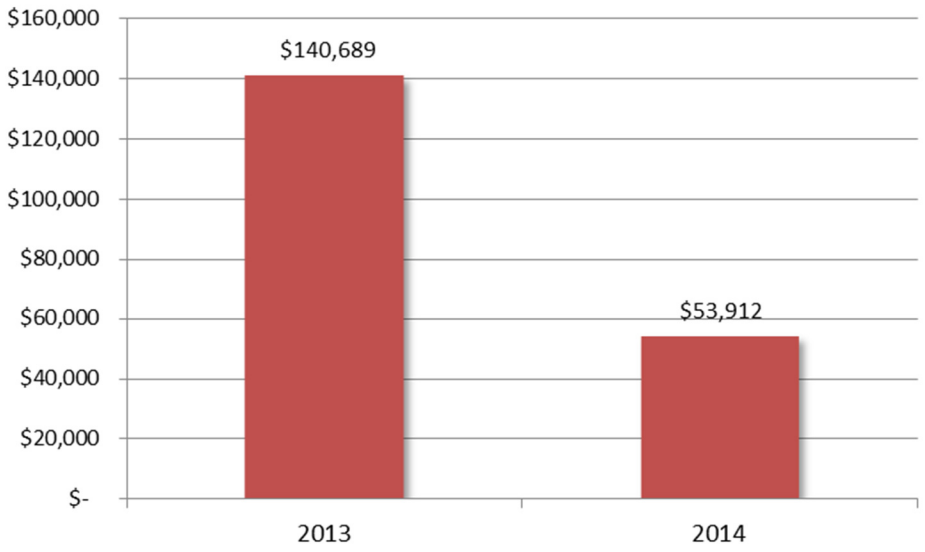
As previously noted, the review elements on which fewer than 80 percent of facilities are passing represent opportunities for additional education on the part of the OHCA. This is especially true for the small number of documentation-related elements on which fewer than 30 percent of facilities are passing.

It is important to note that seven of the 15 facilities "failed" on three or fewer elements, and only one facility failed on a majority of elements. This is consistent with other evidence that the OHCA's audits are having a positive impact on facility performance and quality.

PHPG evaluated the impact of the audits by examining recoupment amounts in SFY 2013 and SFY 2014. Since the audit process was as comprehensive in SFY 2014 as in the previous year, a decline in recoupments would signify improved performance.

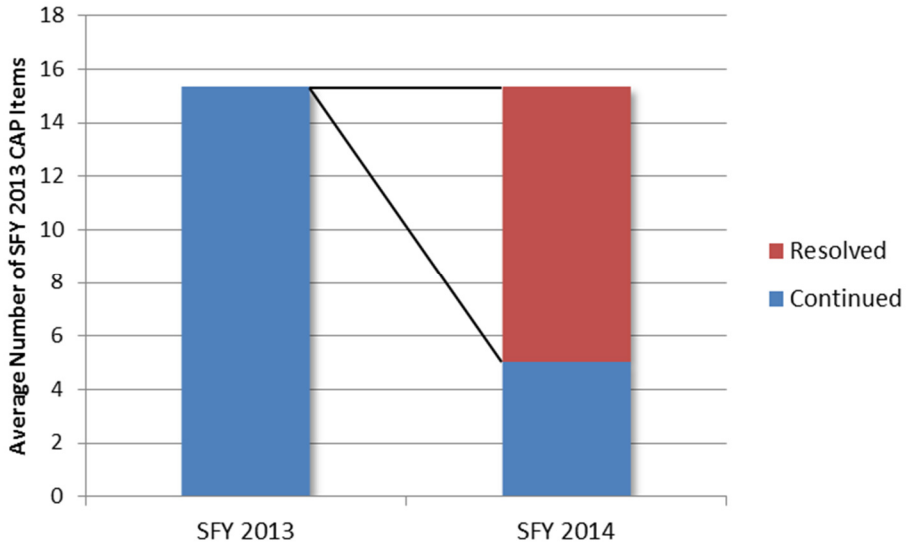
Recoupments did in fact decline among the facilities examined by PHPG. As shown in Exhibit 23-4 below, recoupments in SFY 2014 were only 28 percent of the amount assessed in SFY 2013.

Exhibit 23-4 – Audit Recoupments – SFY 2013 versus SFY 2014



PHPG also analyzed the OHCA's SFY 2014 findings with regard to implementation of SFY 2013 CAPs. While this data was available for only a subset of the facilities, the results were encouraging. As illustrated in Exhibit 23-5, the majority of CAP items imposed in SFY 2013 were found to have been resolved by the time of the SFY 2014 audit.

Exhibit 23-5 – SFY 2013 CAP Items – Status as of SFY 2014 Audit



Summary and Considerations for the Future

The OHCA's behavioral health service quality review process is comprehensive and well-structured. The process appears to be contributing to improved performance on the part of audited facilities. It also has allowed the agency to recoup funds for services not demonstrated to meet medical necessity or other payment criteria.

Starting in SFY 2015, the OHCA will be undertaking enhanced audits of facilities with recurring CAP issues, a step that appropriately focuses agency resources where the need is greatest. Going forward, audit findings also can be used to inform provider education and quality improvement activities in areas where significant numbers of providers fail to meet audit standards.

Attachment A: OHCA Qualified HROB Diagnosis Codes

Oklahoma HealthCare Authority

Medical Authorization Unit

Updated
3/4/2014

OHCA Qualified HROB Diagnosis Codes

282.6	UNSPECIFIED SICKLE-CELL ANEMIA
282.61	HB-S DISEASE WITHOUT MENTION OF CRISIS
282.62	HB-S DISEASE WITH MENTION OF CRISIS
282.63	SICKLE-CELL/HB-C DISEASE
282.64	SICKLE-CELL/HB-C DISEASE WITH CRISIS
282.68	OTHER SICKLE-CELL DISEASE WITHOUT CRISIS
282.69	OTHER SICKLE-CELL ANEMIA
641.03	PLACENTA PREVIA WITHOUT HEMORRHAGE, ANTEPARTUM
641.13	HEMORRHAGE FROM PLACENTA PREVIA, ANTEPARTUM
641.23	PREMATURE SEPARATION OF PLACENTA, ANTEPARTUM
642.03	BENIGN ESSENTIAL HYPERTENSION ANTEPARTUM
642.13	HYPERTENSION SECONDARY TO RENAL DISEASE, ANTEPARTUM
642.43	MILD OR UNSPECIFIED PRE-ECLAMPSIA, ANTEPARTUM
642.53	SEVERE PRE-ECLAMPSIA, ANTEPARTUM
642.63	ECLAMPSIA, ANTEPARTUM
642.73	PRE-ECLAMPSIA OR ECLAMPSIA SUPERIMPOSED ON PRE-EXISTING HYPERTENSION, ANTEPARTUM
644.03	THREATENED PREMATURE LABOR, ANTEPARTUM
648.03	MATERNAL DIABETES MELLITUS, ANTEPARTUM
648.53	MATERNAL CONGENITAL CARDIOVASCULAR DISORDERS, ANTEPARTUM
648.63	OTHER MATERNAL CARDIOVASCULAR DISEASES, ANTEPARTUM
648.80	ABNORMAL MATERNAL GLUCOSE TOLERANCE, COMPLICATING PREGNANCY
648.83	ABNORMAL MATERNAL GLUCOSE TOLERANCE, ANTEPARTUM
649.33	COAGULATION DEFECTS **(specific defect must be documented, such as MTHFR mutation or Leiden mutation-on Lovenox)**
649.73	CERVICAL SHORTENING
651.03	TWIN PREGNANCY, ANTEPARTUM
651.13	TRIPLET PREGNANCY, ANTEPARTUM
651.23	QUADRUPLET PREGNANCY, ANTEPARTUM
651.33	TWIN PREGNANCY WITH FETAL LOSS AND RETENTION OF ONE FETUS, ANTEPARTUM
651.43	TRIPLET PREGNANCY WITH FETAL LOSS AND RETENTION OF ONE OR MORE, ANTEPARTUM
651.53	QUADRUPLET PREGNANCY WITH FETAL LOSS AND RETENTION OF ONE OR MORE, ANTEPARTUM
656.13	RHESUS ISOIMMUNIZATION AFFECTING MANAGEMENT OF MOTHER, ANTEPARTUM CONDITION
656.23	ISOIMMUNIZATION FROM OTHER AND UNSPECIFIED BLOOD-GROUP INCOMPATIBILITY, AFFECTING MANAGE-MENT OF MOTHER, ANTEPARTUM
656.5, 656.50, 656.53	POOR FETAL GROWTH (**EFW <= 10%**), AFFECTING MANAGEMENT OF MOTHER, ANTEPARTUM
656.63	EXCESSIVE FETAL GROWTH AFFECTING MANAGEMENT OF MOTHER **(EFW => 95%)**
657.03	POLYHYDRAMNIOS **(AFI => 95%)**
658.03	OLIGOHYDRAMNIOS, ANTEPARTUM **(AFI <= 10%)**
710.0	SYSTEMIC LUPUS ERYTHEMATOSUS
V23.41	PREGNANCY WITH HISTORY OF PRE-TERM LABOR
V23.5	PREGNANCY WITH OTHER POOR REPRODUCTIVE HISTORY

Attachment B: OHCA PCM Prenatal and Infant Survey

MOTHER

First: _____ Last: _____ Date: _____
SoonerCare ID: _____ PHPG ID: _____
Phone #: _____ Alternative Phone #:_____
Respondent: Self Parent/guardian _____ Other _____

INFANT(S)

(1) First: _____ Last: _____ Date: _____
(1) SoonerCare ID: _____ PHPG ID: _____
(2) First: _____ Last: _____
(2) SoonerCare ID: _____ PHPG ID: _____
Phone #: _____ Alternative Phone #:_____
Respondent: Parent/guardian _____ Other _____

INTRODUCTION & CONSENT

Hello, my name is _____ and I am calling on behalf of the Oklahoma Health Care Authority. May I please speak to [RESPONDENT NAME]?

- [IF SPEAKING WITH RESPONDENT, GO TO INTRO #1.]
- [IF RESPONDENT IS NOT AVAILABLE, GO TO INTRO #2.]

INTRO #1. The Health Care Authority is conducting a survey of SoonerCare Choice members who are pregnant or recently had a baby. You were selected for the survey because you may have received help through one of our programs for expectant moms and infants.

You may choose to do this interview or not. If you do participate, your responses will be kept private. Your decision to do the interview will not affect your participation in any of the programs. The questions should take about ten minutes to answer.

You can ask me any questions during this survey, and you may stop at any time. If you are unsure of an answer, just do your best to choose a response -- there are no right or wrong answers.

I'd like to begin the interview now, but before we begin, do you have any questions about the survey? [ANSWER ANY QUESTIONS AND PROCEED TO QUESTION 1]

INTRO #2. [SCHEDULE TIME TO CALL BACK] **Can you tell me a convenient time to call back to speak with her?** [RECORD CALL BACK TIME] _____

VOICEMAIL MESSAGE. Hello, this message is for [RESPONDENT NAME]. **My name is _____ and I am calling on behalf of the Oklahoma Health Care Authority. We are conducting a survey of SoonerCare Choice members who are pregnant or recently had a baby. We are interested in learning about your experience and how we can make these programs better. If you have any questions about the survey or would like to take it, you can reach us toll-free at 1-888-941-9358. Thank you.**

*****ASK ONLY ABOUT PROGRAMS IDENTIFIED FOR THIS MEMBER/MEMBER'S CHILD*****

OB OUTREACH PROGRAM (AT RISK OB) (Q 1-19; PAGES 2-7)

The SoonerCare OB Outreach Program helps SoonerCare members who are pregnant and have pregnancy-related health issues by providing them with a Care Manager. The Care Manager contacts the member each month to offer education and other assistance to focus on your health and the well-being of your baby.

1. Are you or were you enrolled in the OB Outreach Program (At Risk OB)?
    a. Yes
    b. No [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 19]
    c. Don't Know/Unsure [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 19]

2. Are you still enrolled today in the OB Outreach Program (At Risk OB) Program?
    a. Yes → [GO TO Q 3 AND SKIP Q 4]
    b. No
    c. Don't Know/Unsure → [GO TO Q 3 AND SKIP Q 4]

3. How long have you been (how long were you) enrolled in the OB Outreach Program (At Risk OB) Program?
    a. Less than one month
    b. One to two months
    c. Three to four months
    d. Four to six months
    e. More than six months
    f. Don't Know/Unsure

4. Why are you no longer enrolled in the OB Outreach Program (At Risk OB) Program? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Termination of pregnancy/miscarriage
    b. Completed program goals/graduated from the program
    c. No longer wish to self-manage care/receive health education
    d. No longer want to be evaluated by Case Manager
    e. Relocated to another service area or state
    f. Loss or change in health benefits
    g. Have no additional health needs at this time
    h. Don't Know/Unsure
    i. Other [SPECIFY IN COMMENTS]

    Comments:_____

    _____

5. I'm going to mention some services you may have received through the OB Outreach Program (At Risk OB). Please tell me whether you received the following services as part of the OB Outreach Program (At Risk OB).

	Yes	No	Don't Know	N/A
Assessment				
Training and education (e.g., prenatal care, breastfeeding)				
Educational materials				
Family planning				
Monthly phone calls				
Postpartum depression screening				
Referrals to programs and services				
Appointment scheduling				

Comments: _____

_____

6. [ASK FOR EACH "YES" ACTIVITY IN Q 5] Thinking about the services you received, please tell me how helpful they were. Tell me if they were Very Helpful, Somewhat Helpful, Not Very Helpful or Not at all Helpful.

	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Don't Know	N/A
Assessment						
Training and education (e.g., prenatal care, breastfeeding)						
Educational materials						
Postpartum depression screening						
Referrals to programs and services						
Appointment scheduling						
Family planning						
Monthly phone calls						
Home Visitation						
Other [PLEASE SPECIFY]						

Comments: _____

_____

7. Overall, how satisfied are you with your experience in the OB Outreach Program (At Risk OB)? Would you say are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Unsure

8. Would you recommend the OB Outreach Program (At Risk OB) Program to a friend who has health care needs like yours?
    a. Yes
    b. No
    c. Don't Know/Unsure

9. Do you have any suggestions for improving the services offered through the OB Outreach Program (At Risk OB) Program? [RECORD ALL RECOMMENDATIONS]

    Comments: _____

    _____

Now I'm going to ask you a few questions about your experience with your Case Manager for the OB Outreach Program (At Risk OB).

10. First, can you tell me the name of your current Case Manager, or your most recent Case Manager, if you don't have one today?
    a. Yes [RECORD NAME] _____
    b. No

For the rest of these questions, please think about all of your case managers since you enrolled in the program, if you have had more than one.

11. How many times have you spoken to your Case Manager since you started in the Program? This includes your assessment. [RECORD NUMBER] _____

12. How would you rate the number of times your Case Manager contacted you? [READ CHOICES]
    a. Too many
    b. Too few
    c. Just enough
    d. Don't Know/Unsure

13. Have you called your Case Manager?
    a. Yes
    b. No → [PROCEED TO Q 16]
    c. Don't Know/Unsure → [PROCEED TO Q 16]

14. Thinking about the last time you called your Case Manager, what was the reason for your call?
    a. Routine health question
    b. Urgent health problem
    c. Seeking assistance in scheduling appointment
    d. Training and/or Patient Education
    e. Referral to Community or other service(s)
    f. Returning call from Case Manager
    g. Don't Know/Unsure
    h. Other [SPECIFY IN COMMENTS]
    Comments:_____
    _____

15. Did you reach your Case Manager immediately? [IF NO] How quickly did you get a call back?
    a. Reached immediately (at time of call)
    b. Called back within one hour
    c. Called back in more than one hour but same day
    d. Called back the next day
    e. Called back two or more days later
    f. Never called back
    g. Don't Know/Unsure
    h. Other [SPECIFY IN COMMENTS]
    Comments: _____
    _____

16. Which of the following things has your Case Manager done for you? Has your Case Manager:

	Yes	No	Don't Know	N/A
Asked questions about your health or concerns				
Provided instructions about taking care of your health				
Helped you to identify changes in your health that might be an early sign of a problem				
Answered questions about your health care needs				
Helped you to make and keep health care appointments for medical problems				
Helped you to make and keep health care appointments for mental health or substance abuse problems				
Referred you to programs and services				
Helped you to stop smoking or stop using other tobacco products				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

17. [ASK FOR EACH "YES" ACTIVITY IN Q 16] Thinking about what your Case Manager has done for you, please tell me how satisfied you are with the help you received. Tell me if you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied.

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Don't Know	N/A
Asked questions about your health or concerns						
Provided instructions about taking care of your health						
Helped you to identify changes in your health that might be an early sign of a problem						
Answered questions about your health care needs						
Helped you to make and keep health care appointments for medical problems						
Helped you to make and keep health care appointments for mental health or substance abuse problems						
Referred you to programs and services						
Helped you to stop smoking, or stop using other tobacco products						
Other [SPECIFY IN COMMENTS]						

Comments:_____

_____

18. Overall, how satisfied are you with the help you have received from your Case Manager? Would you say you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very Satisfied
    b. Somewhat Satisfied
    c. Somewhat Dissatisfied
    d. Very Dissatisfied
    e. Don't Know/Unsure

    [AFTER COMPLETING Q 18, SKIP Q 19. CHECK IF MOTHER/CHILD ARE PARTICIPATING IN ANY OTHER PROGRAMS. GO TO NEXT PROGRAM IN WHICH THE MOTHER/CHILD IS ENROLLED. IF THERE IS/ARE NO OTHER PROGRAM(S), GO TO THE BEHAVIORAL HEALTH SCREENING AND REFERRAL QUESTIONS STARTING ON PAGE 50 (Q 156).]

19. You mentioned at the beginning of the survey that you chose not to enroll in the OB Outreach (At Risk OB) Program. Why did you decide not to enroll? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Not aware of program/was not asked to enroll
    b. Did not understand purpose of the program
    c. Was not pregnant
    d. Had a miscarriage
    e. Moved to another location/state
    f. Do not wish to self-manage care/receive health education
    g. Do not want to be evaluated by Case Manager
    h. Have no health needs at this time
    i. Tried to enroll but was unsuccessful [SPECIFY REASON IN COMMENTS]
    j. Don't Know/Unsure
    k. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

    _____

    [CHECK IF MOTHER/CHILD IS/ARE ENROLLED IN ANY OTHER PROGRAMS. IF ENROLLED GO TO ENROLLED PROGRAM QUESTIONS. IF THERE IS/ARE NO OTHER PROGRAM(S), GO TO THE HEALTH STATUS AND DEMOGRAPHICS QUESTIONS STARTING ON PAGE 52 (Q 161).]

HIGH RISK OB PROGRAM (Q 20-38; PAGES 8-13)

The SoonerCare High Risk OB Program helps SoonerCare members who have a high-risk pregnancy by providing them with additional health care benefits, such as increased ultrasounds. In addition, a Care Manager contacts them on the phone each month to offer education and other assistance to focus on your health and the well-being of your baby.

20. Are you or were you enrolled in the High Risk OB Program?
    a. Yes
    b. No [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 38]
    c. Don't Know/Unsure [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 38]

21. Are you still enrolled today in the High Risk OB Program?
    a. Yes → [GO TO Q 22 AND SKIP Q 23]
    b. No
    c. Don't Know/Unsure → [GO TO Q 22 AND SKIP Q 23]

22. How long have you been (how long were you) enrolled in the High Risk OB Program?
    a. Less than one month
    b. One to two months
    c. Three to four months
    d. Four to six months
    e. More than six months
    f. Don't Know/Unsure

23. Why are you no longer enrolled in the High Risk OB Program? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Termination of pregnancy/miscarriage
    b. Completed program goals/graduated from the program
    c. No longer wish to self-manage care/receive health education
    d. No longer want to be evaluated by Case Manager
    e. Relocated to another service area or state
    f. Loss or change in health benefits
    g. Have no additional health needs at this time
    h. Don't Know/Unsure
    i. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

24. I'm going to mention some services you may have received through the High Risk OB Program. Please tell me whether you received the following services as part of the High Risk OB Program.

	Yes	No	Don't Know	N/A
Assessment				
Enhanced benefit package (Ultrasounds, Fetal Non-Stress Tests and Biophysical Profiles)				
Training and education (e.g., prenatal care, breastfeeding)				
Educational materials				
Postpartum depression screening				
Referrals to programs and services				
Appointment scheduling				
Family planning				
Monthly phone calls				
Home Visitation				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

25. [ASK FOR EACH "YES" ACTIVITY IN Q 24] Thinking about the services you received, please tell me how helpful they were. Tell me if they were Very Helpful, Somewhat Helpful, Slightly Helpful or Not at all Helpful.

	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Don't Know	N/A
Assessment						
Enhanced benefit package (Ultrasounds, Fetal Non-Stress Tests and Biophysical Profiles)						
Training and education (e.g., prenatal care, breastfeeding)						
Educational materials						
Postpartum depression screening						
Referrals to programs and services						
Appointment scheduling						
Family planning						
Monthly phone calls						
Home Visitation						
Other [PLEASE SPECIFY]						

Comments: _____

26. Overall, how satisfied are you with your experience in the High Risk OB Program? Would you say are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Unsure

27. Would you recommend the High Risk OB Program to a friend who has health care needs like yours?
    a. Yes
    b. No
    c. Don't Know/Unsure

28. Do you have any suggestions for improving the services offered through the High Risk OB Program? [RECORD ALL RECOMMENDATIONS]

    Comments: _____

    _____

    _____

Now I'm going to ask you a few questions about your experience with your Case Manager for the High Risk OB Program.

29. Can you tell me the name of your current Case Manager, or your most recent Case Manager, if you don't have one today?
    a. Yes [RECORD NAME] _____
    b. No

For the rest of these questions, please think about all of your case managers since you enrolled in the program, if you have had more than one.

30. How many times have you spoken to your Case Manager since you started in the Program? This includes your assessment. [RECORD NUMBER] _____

31. How would you rate the number of times your Case Manager contacted you?
    a. Too many
    b. Too few
    c. Just enough
    d. Don't Know/Unsure

32. Have you called your Case Manager?
    a. Yes
    b. No → [PROCEED TO Q 35]
    c. Don't Know/Unsure → [PROCEED TO Q 35]

33. Thinking about the last time you called your Case Manager, what was the reason for your call?

a. Routine health question
b. Urgent health problem
c. Seeking assistance in scheduling appointment
d. Training and/or Patient Education
e. Referral to Community or other service(s)
f. Returning call from Case Manager
g. Don't Know/Unsure
h. Other [SPECIFY IN COMMENTS]

Comments:_____

_____

34. Did you reach your Case Manager immediately? [IF NO] How quickly did you get a call back?

a. Reached immediately (at time of call)
b. Called back within one hour
c. Called back in more than one hour but same day
d. Called back the next day
e. Called back two or more days later
f. Never called back
g. Don't Know/Unsure
h. Other [SPECIFY IN COMMENTS]

Comments: _____

_____

35. Which of the following things has your Case Manager done for you? Has your Case Manager:

	Yes	No	Don't Know	N/A
Asked questions about your health or concerns				
Provided instructions about taking care of your health				
Helped you to identify changes in your health that might be an early sign of a problem				
Answered questions about your health care needs				
Helped you to make and keep health care appointments for medical problems				
Helped you to make and keep health care appointments for mental health or substance abuse problems				
Referred you to programs and services				
Helped you to stop smoking, or stop using other tobacco products				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

36. [ASK FOR EACH "YES" ACTIVITY IN Q 35] Thinking about what your Case Manager has done for you, please tell me how satisfied you are with the help you received. Tell me if you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied.

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Don't Know	N/A
Asked questions about your health or concerns						
Provided instructions about taking care of your health						
Helped you to identify changes in your health that might be an early sign of a problem						
Answered questions about your health care needs						
Helped you to make and keep health care appointments for medical problems						
Helped you to make and keep health care appointments for mental health or substance abuse problems						
Referred you to programs and services						
Helped you to stop smoking, or stop using other tobacco products						
Other [SPECIFY]						

Comments:_____

_____

37. Overall, how satisfied are you with the help you have received from your Case Manager? Would you say you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very Satisfied
    b. Somewhat Satisfied
    c. Somewhat Dissatisfied
    d. Very Dissatisfied
    e. Don't Know/Unsure

    [AFTER COMPLETING Q 37, SKIP Q 38. CHECK IF MOTHER/CHILD ARE PARTICIPATING IN ANY OTHER PROGRAMS. GO TO NEXT PROGRAM IN WHICH THE MOTHER/CHILD IS ENROLLED. IF THERE IS/ARE NO OTHER PROGRAM(S), GO TO THE BEHAVIORAL HEALTH SCREENING AND REFERRAL QUESTIONS STARTING ON PAGE 50 (Q 156).]

38. You mentioned at the beginning of the survey that you chose not to enroll in the High Risk OB Program. Why did you decide not to enroll? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Not aware of program/was not asked to enroll
    b. Did not understand purpose of the program
    c. Was not pregnant
    d. Had a miscarriage
    e. Moved to another location/state
    f. Do not wish to self-manage care/receive health education
    g. Do not want to be evaluated by Case Manager
    h. Have no health needs at this time
    i. Tried to enroll but was unsuccessful [SPECIFY REASON IN COMMENTS]
    j. Don't Know/Unsure
    k. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

    _____

    [CHECK IF MOTHER/CHILD IS/ARE ENROLLED IN ANY OTHER PROGRAMS. IF ENROLLED GO TO ENROLLED PROGRAM QUESTIONS. IF THERE IS/ARE NO OTHER PROGRAM(S), GO TO THE HEALTH STATUS AND DEMOGRAPHIC QUESTIONS STARTING ON PAGE 52 (Q 161).]

FIMR Mom Program (Q 39-58; PAGES 14-19)

The SoonerCare FIMR Mom Program helps newly enrolled pregnant SoonerCare members who live in certain Oklahoma counties. A Care Manager is assigned who contacts you on the phone each month to offer education and other assistance to focus on your health and the well-being of your baby.

39. Are you or were you enrolled in the FIMR Mom Program?
    a. Yes
    b. No [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 58]
    c. Don't Know/Unsure [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 58]
40. In which county do you reside? [SELECT REPORTED COUNTY]

County	[SELECT]	County	[SELECT]
Atoka		Jackson	
Choctaw		Latimer	
Coal		Lincoln	
Garfield		McIntosh	
Greer		Tillman	

41. Are you still enrolled today in the FIMR Mom Program?
    a. Yes → [GO TO Q 42 AND SKIP Q 43]
    b. No
    c. Don't Know/Unsure → [GO TO Q 42 AND SKIP Q 43]
42. How long have you been (how long were you) a participant in the FIMR Mom Program?
    a. Less than one month
    b. One to two months
    c. Three to four months
    d. Four to six months
    e. More than six months
    f. Don't Know/Unsure
43. Why are you no longer enrolled in the FIMR Mom Program? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Termination of pregnancy/miscarriage
    b. Completed program goals/graduated from the program
    c. No longer wish to self-manage care/receive health education
    d. No longer want to be evaluated by Case Manager
    e. Relocated to another service area or state
    f. Loss or change in health benefits
    g. Have no additional health needs at this time
    h. Don't Know/Unsure
    i. Other [SPECIFY IN COMMENTS]

    Comments:_____

    _____

44. I'm going to mention some services you may have received through the FIMR Mom Program. Please tell me whether you received the following services as part of the FIMR Mom Program.

	Yes	No	Don't Know	N/A
Assessment				
Training and education (e.g., prenatal care, breastfeeding)				
Educational materials				
Postpartum depression screening				
Referrals to programs and services				
Appointment scheduling				
Family planning				
Monthly phone calls				
Home Visitation				
Other [SPECIFY IN COMMENTS]				

Comments: _____

_____

45. [ASK FOR EACH "YES" ACTIVITY IN Q 44] Thinking about the services you received, please tell me how helpful they were. Tell me if they were Very Helpful, Somewhat Helpful, Slightly Helpful or Not at all Helpful.

	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Don't Know	N/A
Assessment						
Training and education (e.g., prenatal care, breastfeeding)						
Educational materials						
Postpartum depression screening						
Referrals to programs and services						
Appointment scheduling						
Family planning						
Monthly phone calls						
Home Visitation						
Other [PLEASE SPECIFY]						

Comments: _____

_____

46. Overall, how satisfied are you with your experience in the FIMR Mom Program? Would you say are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Unsure

47. Would you recommend the FIMR Mom Program to a friend who has health care needs like yours?
    a. Yes
    b. No
    c. Don't Know/Unsure

48. Do you have any suggestions for improving the services offered through the FIMR Mom Program? [RECORD ALL RECOMMENDATIONS]
    Comments: _____
    _____
    _____

Now I'm going to ask you a few questions about your experience with your Case Manager for the FIMR Mom Program.

49. Can you tell me the name of your current Case Manager, or your most recent Case Manager, if you don't have one today?
    a. Yes [RECORD NAME] _____
    b. No

For the rest of these questions, please think about all of your case managers since you enrolled in the program, if you have had more than one.

50. How many times have you spoken to your Case Manager since you started in the Program? This includes your assessment. [RECORD NUMBER] _____

51. How would you rate the number of times your Case Manager contacted you?
    a. Too many
    b. Too few
    c. Just enough
    d. Don't Know/Unsure

52. Have you called your Case Manager?
    a. Yes
    b. No → [PROCEED TO Q 55]
    c. Don't Know/Unsure → [PROCEED TO Q 55]

53. Thinking about the last time you called your Case Manager, what was the reason for your call?

a. Routine health question
b. Urgent health problem
c. Seeking assistance in scheduling appointment
d. Training and/or Patient Education
e. Referral to Community or other service(s)
f. Returning call from Case Manager
g. Don't Know/Unsure
h. Other [SPECIFY IN COMMENTS]

Comments: _____

_____

54. Did you reach your Case Manager immediately? [IF NO] How quickly did you get a call back?

a. Reached immediately (at time of call)
b. Called back within one hour
c. Called back in more than one hour but same day
d. Called back the next day
e. Called back two or more days later
f. Never called back
g. Don't Know/Unsure
h. Other [SPECIFY IN COMMENTS]

Comments: _____

_____

55. Which of the following things has your Case Manager done for you? Has your Case Manager:

	Yes	No	Don't Know	N/A
Asked questions about your health or concerns				
Provided instructions about taking care of your health				
Helped you to identify changes in your health that might be an early sign of a problem				
Answered questions about your health care needs				
Helped you to make and keep health care appointments for medical problems				
Helped you to make and keep health care appointments for mental health or substance abuse problems				
Referred you to programs and services				
Helped you to stop smoking, or stop using other tobacco products				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

56. [ASK FOR EACH "YES" ACTIVITY IN Q 55] Thinking about what your Case Manager has done for you, please tell me how satisfied you are with the help you received. Tell me if you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied.

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Don't Know	N/A
Asked questions about your health or concerns						
Provided instructions about taking care of your health						
Helped you to identify changes in your health that might be an early sign of a problem						
Answered questions about your health care needs						
Helped you to make and keep health care appointments for medical problems						
Helped you to make and keep health care appointments for mental health or substance abuse problems						
Referred you to programs and services						
Helped you to stop smoking, or stop using other tobacco products						
Other [SPECIFY IN COMMENTS]						

Comments:_____

_____

57. Overall, how satisfied are you with the help you have received from your Case Manager? Would you say you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very Satisfied
    b. Somewhat Satisfied
    c. Somewhat Dissatisfied
    d. Very Dissatisfied
    e. Don't Know/Unsure

    [AFTER COMPLETING Q 57, SKIP Q 58. CHECK IF MOTHER/CHILD ARE PARTICIPATING IN ANY OTHER PROGRAMS. GO TO NEXT PROGRAM IN WHICH THE MOTHER/CHILD IS ENROLLED. IF THERE IS/ARE NO OTHER PROGRAM(S), GO TO THE BEHAVIORAL HEALTH SCREENING AND REFERRAL QUESTIONS STARTING ON PAGE 50 (Q 156).]

58. You mentioned at the beginning of the survey that you chose not to enroll in the FIMR Mom Program. Why did you decide not to enroll? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Not aware of program/was not asked to enroll
    b. Did not understand purpose of the program
    c. Was not pregnant
    d. Had a miscarriage
    e. Moved to another location/state
    f. Do not wish to self-manage care/receive health education
    g. Do not want to be evaluated by Case Manager
    h. Have no health needs at this time
    i. Tried to enroll but was unsuccessful [SPECIFY REASON IN COMMENTS]
    j. Don't Know/Unsure
    k. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

    _____

    [CHECK IF MOTHER/CHILD IS/ARE ENROLLED IN ANY OTHER PROGRAMS. IF ENROLLED GO TO ENROLLED PROGRAM QUESTIONS. IF THERE IS/ARE NO OTHER PROGRAM(S), GO TO THE HEALTH STATUS AND DEMOGRAPHICS QUESTIONS STARTING ON PAGE 52 (Q161).]

Interconception Care (ICC) Program (Q 59-78; PAGES 20-25)

The SoonerCare Interconception (ICC) Program helps newly enrolled pregnant SoonerCare members who are 18 and under and who live in certain Oklahoma counties. A Care Manager is assigned who contacts you on the phone each month to offer education and other assistance to focus on your health and the well-being of your baby. The program provides case management for one year postpartum, as long as you maintain SC eligibility

59. Are you or were you enrolled in the Interconception Care (ICC) Program?

    a. Yes
    b. No [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 78]
    c. Don't Know/Unsure [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 78]

60. In which county do you reside in? [SELECT REPORTED COUNTY]

County	[SELECT]	County	[SELECT]
Atoka		Jackson	
Choctaw		Latimer	
Coal		Lincoln	
Garfield		McIntosh	
Greer		Tillman	

61. Are you still enrolled today in the Interconception Care (ICC) Program?

    a. Yes → [GO TO QUESTION 62 AND SKIP Q 63]
    b. No
    c. Don't Know/Unsure → [GO TO QUESTION 62 AND SKIP Q 18]

62. How long have you been (how long were you) a participant in the ICC Program?

    a. Less than one month
    b. One to two months
    c. Three to four months
    d. Four to six months
    e. More than six months
    f. Don't Know/Unsure

63. Why are you no longer enrolled in the Interconception Care (ICC) Program? [RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]

    a. Termination of pregnancy/miscarriage
    b. Completed program goals/graduated from the program
    c. No longer wish to self-manage care/receive health education
    d. No longer want to be evaluated by Case Manager
    e. Relocated to another service area or state
    f. Loss or change in health benefits
    g. Have no additional health needs at this time
    h. Don't Know/Unsure
    i. Other [SPECIFY IN COMMENTS]

    Comments:_____

64. I'm going to mention some services you may have received through the Interconception Care (ICC) Program. Please tell me whether you received the following services as part of the Interconception Care (ICC) Program. Which of the following services did you receive as part of the ICC Program?

	Yes	No	Don't Know	N/A
Assessment				
Training and education (e.g., prenatal care, breastfeeding)				
Educational materials				
Postpartum depression screening				
Referrals to programs and services				
Appointment scheduling				
Family planning				
Monthly phone calls				
Home Visitation				
Other [SPECIFY IN COMMENTS]				

Comments: _____

_____

_____

65. [ASK FOR EACH "YES" ACTIVITY IN Q 64] Thinking about the services you received, please tell me how helpful they were. Tell me if they were Very Helpful, Somewhat Helpful, Slightly Helpful or Not at all Helpful.

	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Don't Know	N/A
Assessment						
Training and education (e.g., prenatal care, breastfeeding)						
Educational materials						
Postpartum depression screening						
Referrals to programs and services						
Appointment scheduling						
Family planning						
Monthly phone calls						
Home Visitation						
Other [PLEASE SPECIFY]						

Comments: _____

_____

66. Overall, how satisfied are you with your experience in the Interconception Care (ICC) Program? Would you say are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Unsure

67. Would you recommend the Interconception Care (ICC) Program to a friend who has health care needs like yours?
    a. Yes
    b. No
    c. Don't Know/Unsure

68. Do you have any suggestions for improving the services offered through the Interconception Care (ICC) Program? [RECORD ALL RECOMMENDATIONS]

    Comments:_____

    _____

Now I'm going to ask you a few questions about your experience with your Case Manager for the Interconception Care (ICC) Program.

69. Can you tell me the name of your current Case Manager, or your most recent Case Manager, if you don't have one today?
    a. Yes [RECORD NAME] _____
    b. No

For the rest of these questions, please think about all of your case managers since you enrolled in the program, if you have had more than one.

70. How many times have you spoken to your Case Manager since you started in the ICC Program? This includes your assessment. [RECORD NUMBER] _____

71. How would you rate the number of times your Case Manager contacted you?
    a. Too many
    b. Too few
    c. Just enough
    d. Don't Know/Unsure

72. Have you called your Case Manager?
    a. Yes
    b. No → [PROCEED TO Q 75]
    c. Don't Know/Unsure → [PROCEED TO Q 75]

73. Thinking about the last time you called your Case Manager, what was the reason for your call?

a. Routine health question
b. Urgent health problem
c. Seeking assistance in scheduling appointment
d. Training and/or Patient Education
e. Referral to Community or other service(s)
f. Returning call from Case Manager
g. Don't Know/Unsure
h. Other [SPECIFY IN COMMENTS]

Comments: _____
_____

74. Did you reach your Case Manager immediately? [IF NO] How quickly did you get a call back?

a. Reached immediately (at time of call)
b. Called back within one hour
c. Called back in more than one hour but same day
d. Called back the next day
e. Called back two or more days later
f. Never called back
g. Don't Know/Unsure
h. Other [SPECIFY IN COMMENTS]

Comments: _____
_____

75. Which of the following things has your Case Manager done for you? Has your Case Manager:

	Yes	No	Don't Know	N/A
Asked questions about your health or concerns				
Provided instructions about taking care of your health				
Helped you to identify changes in your health that might be an early sign of a problem				
Answered questions about your health care needs				
Helped you to make and keep health care appointments for medical problems				
Helped you to make and keep health care appointments for mental health or substance abuse problems				
Referred you to programs and services				
Helped you to stop smoking, or stop using other tobacco products				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

_____

76. [ASK FOR EACH "YES" ACTIVITY IN Q 75] Thinking about what your Case Manager has done for you, please tell me how satisfied you are with the help you received. Tell me if you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied.

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Don't Know	N/A
Asked questions about your health or concerns						
Provided instructions about taking care of your health						
Helped you to identify changes in your health that might be an early sign of a problem						
Answered questions about your health care needs						
Helped you to make and keep health care appointments for medical problems						
Helped you to make and keep health care appointments for mental health or substance abuse problems						
Referred you to programs and services						
Helped you to stop smoking, or stop using other tobacco products						
Other [SPECIFY IN COMMENTS]						

Comments:_____

_____

77. Overall, how satisfied are you with the help you have received from your Case Manager? Would you say you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very Satisfied
    b. Somewhat Satisfied
    c. Somewhat Dissatisfied
    d. Very Dissatisfied
    e. Don't Know/Unsure

    [AFTER COMPLETING Q 77, SKIP Q 78. CHECK IF MOTHER/CHILD ARE PARTICIPATING IN ANY OTHER PROGRAMS. GO TO NEXT PROGRAM IN WHICH THE MOTHER/CHILD IS ENROLLED. IF THERE IS/ARE NO OTHER PROGRAM(S), GO TO THE BEHAVIORAL HEALTH SCREENING AND REFERRAL QUESTIONS STARTING ON PAGE 50 (Q 156).]

78. You mentioned at the beginning of the survey that you chose not to enroll in the Interconception Care (ICC) Program. Why did you decide not to enroll? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASONS.]
    a. Not aware of program/was not asked to enroll
    b. Did not understand purpose of the program
    c. Was not pregnant
    d. Had a miscarriage
    e. Moved to another location/state
    f. Do not wish to self-manage care/receive health education
    g. Do not want to be evaluated by Case Manager
    h. Have no health needs at this time
    i. Tried to enroll but was unsuccessful [SPECIFY REASON IN COMMENTS]
    j. Don't Know/Unsure
    k. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

    _____

    [CHECK IF MOTHER/CHILD IS/ARE ENROLLED IN ANY OTHER PROGRAMS. IF ENROLLED GO TO ENROLLED PROGRAM QUESTIONS. IF THERE IS/ARE NO OTHER PROGRAM(S), GO TO THE HEALTH STATUS AND DEMOGRAPHICS QUESTIONS STARTING ON PAGE 52 (Q 161).]

FIMR Baby Program (Q 79-98; PAGES 26-31)

If you are enrolled in the FIMR Mom Program, then the FIMR Baby Program is offered to your baby immediately after delivery. Each baby is assigned to a Care Manager who assists both the mom and baby through the child's first birthday. During this time, continued education is completed, and the Care Manager works with you to ensure your baby is getting the necessary Well Child Checks as well as immunizations.

79. Is or was your child enrolled in the FIMR Baby Program?
    a. Yes
    b. No [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 98]
    c. Don't Know [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 98]

80. In which county do you reside in? [SELECT REPORTED COUNTY]

County	[SELECT]	County	[SELECT]
Atoka		Jackson	
Choctaw		Latimer	
Coal		Lincoln	
Garfield		McIntosh	
Greer		Tillman	

81. Is your child still enrolled today in the FIMR Baby Program?
    a. Yes → [GO TO QUESTION 82 AND SKIP Q 83
    b. No
    c. Don't Know/Unsure → [GO TO QUESTION 82 AND SKIP Q 83]

82. How long has your child been enrolled (was your child enrolled) in the FIMR Baby Program?
    a. Less than one month
    b. One to two months
    c. Three to four months
    d. Four to six months
    e. More than six months
    f. Don't Know/Unsure

83. Why is your child no longer enrolled in the FIMR Baby Program? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Completed program goals/graduated from the program
    b. No longer wish to self-manage care/receive health education
    c. No longer want to be evaluated by Case Manager
    d. Relocated to another service area or state
    e. Loss or change in health benefits
    f. Have no additional health needs at this time
    g. Don't Know/Unsure

h. Other [SPECIFY IN COMMENTS]

Comments: _____

84. I'm going to mention some services your child may have received through the FIMR Baby Program. Please tell me whether your child received the following services as part of the FIMR Baby Program.

	Yes	No	Don't Know	N/A
Assessments				
Training and education (e.g., safe sleep immunizations, well-child visits)				
Educational materials				
Postpartum depression screening (If yes AND mom isn't in Mom-program, ask BHU questions after Baby-program questions completed!)				
Referrals to programs and services (e.g., SoonerStart, DDSD)				
Appointment scheduling for well-child visits and immunizations				
Family planning				
Monthly phone calls				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

85. [ASK FOR EACH "YES" ACTIVITY IN Q 56] Thinking about the services your child received, please tell me how helpful they were. Tell me if they were Very Helpful, Somewhat Helpful, Slightly Helpful or Not at all Helpful.

	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Don't Know	N/A
Assessments						
Training and education (e.g., safe sleep immunizations, well-child visits)						
Educational materials						
Postpartum depression screening						
Referrals to programs and services (e.g. SoonerStart, DDSD)						
Appointment scheduling for well-child visits and immunizations						
Family planning						
Monthly phone calls						
Other [PLEASE SPECIFY]						

Comments:_____

_____

86. Overall, how satisfied are you with your experience with the FIMR Baby Program? Would you say are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Unsure
87. Would you recommend the FIMR Baby Program to a friend whose child has health care needs like yours?
    a. Yes
    b. No
    c. Don't Know/Unsure

88. Do you have any suggestions for improving the services offered through the FIMR Baby Program? [RECORD ALL RECOMMENDATIONS]

    Comments:_____

    _____

    _____

Now I'm going to ask you a few questions about your experience with your child's Case Manager for the FIMR Baby Program.

89. Can you tell me the name of your child's Case Manager?
    a. Yes [RECORD NAME] _____
    b. No

For the rest of these questions, please think about all of your child's case managers since he or she enrolled in the program, if he or she has had more than one.

90. How many times have you spoken to your child's Case Manager since he or she started in the Program? This includes his or her assessment. [RECORD NUMBER] _____

91. How would you rate the number of times your child's Case Manager contacted you?
    a. Too many
    b. Too few
    c. Just enough
    d. Don't Know/Unsure

92. Have you called your child's Case Manager?
    a. Yes

b. No → [PROCEED TO Q 95]
c. Don't Know/Unsure → [PROCEED TO Q 95]

93. Thinking about the last time you called your child's Case Manager, what was the reason for your call? [DO NOT PROMPT]

a. Routine health question
b. Urgent health problem
c. Seeking assistance in scheduling appointment
d. Training and/or Patient Education
e. Referral to Community or other service(s)
f. Returning call from Case Manager
g. Don't Know/Unsure
h. Other [SPECIFY IN COMMENTS]

Comments: _____

_____

94. Did you reach your child's Case Manager immediately? [IF NO] How quickly did you get a call back?

a. Reached immediately (at time of call)
b. Called back within one hour
c. Called back in more than one hour but same day
d. Called back the next day
e. Called back two or more days later
f. Never called back
g. Don't Know/Unsure
h. Other [SPECIFY IN COMMENTS]

Comments: _____

_____

95. Which of the following things has your child's Case Manager done for you? Has your child's Case Manager:

	Yes	No	Don't Know	N/A
Asked questions about your child's health or your concerns				
Provided instructions about taking care of your child's health				
Helped you to identify changes in your child's health that might be an early sign of a problem				
Answered questions about your child's health care needs				
Helped you to make and keep health care appointments for medical problems				
Referred you to programs and services				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

96. [ASK FOR EACH "YES" ACTIVITY IN Q 95] Thinking about what your child's Case Manager has done for you, please tell me how satisfied you are with the help you received. Tell me if you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied.

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Don't Know	N/A
Asked questions about your child's health or your concerns						
Provided instructions about taking care of your child's health						
Helped you to identify changes in your child's health that might be an early sign of a problem						
Answered questions about your child's health care needs						
Helped you to make and keep health care appointments for medical problems						
Referred you to programs and services						
Other [SPECIFY IN COMMENTS]						

Comments:_____

_____

97. Overall, how satisfied are you with the help you have received from your child's Case Manager? Would you say you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?

a. Very Satisfied
b. Somewhat Satisfied
c. Somewhat Dissatisfied
d. Very Dissatisfied
e. Don't Know/Unsure

[AFTER COMPLETING Q 97, SKIP Q 98. CHECK IF MOTHER/CHILD ARE PARTICIPATING IN ANY OTHER PROGRAMS. GO TO NEXT PROGRAM IN WHICH THE MOTHER/CHILD IS ENROLLED.

IF MOTHER IS ENROLLED IN OB OUTREACH (AT RISK), HIGH-RISK, FIMR MOM OR ICC, MAKE SURE TO COMPLETE THE BEHAVIORAL HEALTH AND DEMOGRAPHIC QUESTIONS STARTING ON PAGE 50 (Q 156).

IF MOTHER ISN'T ENROLLED IN OB OUTREACH (AT RISK), HIGH-RISK, FIMR MOM OR ICC BUT SHE RECEIVED A POSTPARTUM DEPRESSION SCREEN MAKE SURE TO COMPLETE THE BEHAVIORAL HEALTH QUESTIONS STARTING ON PAGE 50 (Q 156). DO NOT ASK DEMOGRAPHIC QUESTIONS.

IF THERE IS/ARE NO OTHER PROGRAM(S), END THE SURVEY**: "THOSE ARE ALL THE QUESTIONS I HAVE TODAY. THANK YOU FOR YOUR HELP! IF YOU HAVE ANY QUESTIONS ABOUT THE SURVEY, YOU CAN REACH PHPG TOLL-FREE AT 1-888-941-9358. IF YOU HAVE ANY QUESTIONS FOR THE HEALTH CARE AUTHORITY, PLEASE CALL THE TOLL-FREE NUMBER 1-877-252-6002."**]

98. You mentioned at the beginning of the survey that you chose not to enroll your child in the FIMR Baby Program. Why did you decide not to enroll him or her? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]

a. Not aware of program/was not asked to enroll
b. Did not understand purpose of the program
c. Was not pregnant
d. Had a miscarriage
e. Moved to another location/state
f. Do not wish to self-manage care/receive health education
g. Do not want to be evaluated by Case Manager
h. Have no health needs at this time
i. Tried to enroll but was unsuccessful [SPECIFY REASON IN COMMENTS]
j. Don't Know/Unsure
k. Other [SPECIFY IN COMMENTS]

Comments: _____

[CHECK IF MOTHER/CHILD IS/ARE ENROLLED IN ANY OTHER PROGRAMS. IF ENROLLED GO TO ENROLLED PROGRAM QUESTIONS. IF THERE IS/ARE NO OTHER PROGRAM(S), END THE SURVEY**: "THOSE ARE ALL THE QUESTIONS I HAVE TODAY. THANK YOU FOR YOUR HELP! IF YOU HAVE ANY QUESTIONS ABOUT THE SURVEY, YOU CAN REACH PHPG TOLL-FREE AT 1-**

888-941-9358. IF YOU HAVE ANY QUESTIONS FOR THE HEALTH CARE AUTHORITY, PLEASE CALL THE TOLL-FREE NUMBER 1-877-252-6002."]

Newborn Outreach Program (Q 99-117; PAGES 32-37)

*****RECORD RESPONSES UNDER BABY'S RID *****

The SoonerCare Newborn Outreach Program is offered to your baby immediately after delivery if your baby was in the hospital for more than 14 days, has a chronic health condition or sees more than one doctor. Each baby is assigned to a Care Manager who assists both the mom and baby to try and determine what types of services or assistance the family needs and how SoonerCare can be of assistance when the hospital is planning the infant's discharge to home.

99. Is or was your child enrolled in the Newborn Outreach Program?

a. Yes
b. No [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 117]
c. Don't Know/Unsure [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 117]

100. Is your child still enrolled today in the Newborn Outreach Program?

a. Yes → [GO TO Q 101 AND SKIP Q 102]
b. No
c. Don't Know/Unsure → [GO TO Q 101 AND SKIP Q 102]

101. How long has your child been (how long was your child) enrolled in the Newborn Outreach Program?

a. Less than one month
b. One to two months
c. Three to four months
d. Four to six months
e. More than six months
f. Don't Know/Unsure

102. Why is your child is no longer enrolled in the Newborn Outreach Program? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]

a. Completed program goals/graduated from the program
b. No longer wish to self-manage care/receive health education
c. No longer want to be evaluated by Case Manager
d. Relocated to another service area or state
e. Loss or change in health benefits
f. Have no additional health needs at this time
g. Don't Know/Unsure
h. Other [SPECIFY IN COMMENTS]

Comments: _____

_____

103. I'm going to mention some services your child may have received through the Newborn Outreach Program. Please tell me whether your child received the following services as part of the Newborn Outreach Program. [CHECK ALL THAT APPLY]

	Yes	No	Don't Know	N/A
Assessments				
Training and education (e.g., safe sleep immunizations, well-child visits)				
Educational materials				
Postpartum depression screening (If yes AND mom isn't in Mom-program, ask BHU questions after Baby-program questions completed!)				
Referrals to programs and services (e.g., SoonerStart, DDSD)				
Appointment scheduling for well-child visits and immunizations				
Family planning				
Monthly phone calls				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

104. [ASK FOR EACH "YES" ACTIVITY IN Q 103] Thinking about the services your child received, please tell me how helpful they were. Tell me if they were Very Helpful, Somewhat Helpful, Slightly Helpful or Not at all Helpful.

	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Don't Know	N/A
Assessments						
Training and education (e.g., safe sleep immunizations, well-child visits)						
Educational materials						
Postpartum depression screening						
Referrals to programs and services (e.g., SoonerStart, DDSD)						
Appointment scheduling for well-child visits and immunizations						
Family planning						
Monthly phone calls						
Other [PLEASE SPECIFY]						

Comments:_____

_____

105. Overall, how satisfied are you with your experience with the Newborn Outreach Program? Would you say are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Unsure

106. Would you recommend the Newborn Outreach Program to a friend whose child has health care needs like yours?
    a. Yes
    b. No
    c. Don't Know/Unsure

107. Do you have any suggestions for improving the services offered through the Newborn Outreach Program? [RECORD ALL RECOMMENDATIONS]

Comments:_____

_____

_____

Now I'm going to ask you a few questions about your experience with your child's Case Manager for the Newborn Outreach Program.

108. Can you tell me the name of your child's Case Manager?
    a. Yes [RECORD NAME] _____
    b. No

109. How many times have you spoken to your child's Case Manager since he or she started in the Program? This includes his or her assessment. [RECORD NUMBER] _____

110. How would you rate the number of times your child's Case Manager contacted you?
    a. Too many
    b. Too few
    c. Just enough
    d. Don't Know/Unsure

111. Have you called your child's Case Manager?
    a. Yes

b. No → [PROCEED TO Q 114]
c. Don't Know/Unsure → [PROCEED TO Q 114]

112. Thinking about the last time you called your child's Case Manager, what was the reason for your call? [DO NOT PROMPT]
    a. Routine health question
    b. Urgent health problem
    c. Seeking assistance in scheduling appointment
    d. Training and/or Patient Education
    e. Referral to Community or other service(s)
    f. Returning call from Case Manager
    g. Don't Know/Unsure
    h. Other [SPECIFY IN COMMENTS]

    Comments:_____

    _____

113. Did you reach your child's Case Manager immediately? [IF NO] How quickly did you get a call back?
    a. Reached immediately (at time of call)
    b. Called back within one hour
    c. Called back in more than one hour but same day
    d. Called back the next day
    e. Called back two or more days later
    f. Never called back
    g. Don't Know/Unsure
    h. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

114. Which of the following things has your child's Case Manager done for you? Has your child's Case Manager:

	Yes	No	Don't Know	N/A
Asked questions about your child's health or your concerns				
Provided instructions about taking care of your child's health				
Helped you to identify changes in your child's health that might be an early sign of a problem				
Answered questions about your child's health care needs				
Helped you to make and keep health care appointments for medical problems				
Referred you to programs and services				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

115. [ASK FOR EACH "YES" ACTIVITY IN Q 114] Thinking about what your child's Case Manager has done for you, please tell me how satisfied you are with the help you received. Tell me if you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied.

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Don't Know	N/A
Asked questions about your child's health or your concerns						
Provided instructions about taking care of your child's health						
Helped you to identify changes in your child's health that might be an early sign of a problem						
Answered questions about your child's health care needs						
Helped you to make and keep health care appointments for medical problems						
Referred you to programs and services						
Other [SPECIFY IN COMMENTS]						

Comments:_____

_____

116. Overall, how satisfied are you with the help you have received from your child's Case Manager? Would you say you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very Satisfied
    b. Somewhat Satisfied
    c. Somewhat Dissatisfied
    d. Very Dissatisfied
    e. Don't Know/Unsure

[AFTER COMPLETING Q 116, SKIP Q 117. CHECK IF MOTHER/CHILD ARE PARTICIPATING IN ANY OTHER PROGRAMS. GO TO NEXT PROGRAM IN WHICH THE MOTHER/CHILD IS ENROLLED.

IF MOTHER IS ENROLLED IN OB OUTREACH (AT RISK), HIGH-RISK, FIMR MOM OR ICC, MAKE SURE TO COMPLETE THE BEHAVIORAL HEALTH AND DEMOGRAPHIC QUESTIONS STARTING ON PAGE 50 (Q 156).

IF MOTHER ISN'T ENROLLED IN OB OUTREACH (AT RISK), HIGH-RISK, FIMR MOM OR ICC BUT SHE RECEIVED A POSTPARTUM DEPRESSION SCREEN MAKE SURE TO COMPLETE THE BEHAVIORAL HEALTH QUESTIONS STARTING ON PAGE 50 (Q 156). DO NOT ASK DEMOGRAPHIC QUESTIONS.

IF THERE IS/ARE NO OTHER PROGRAM(S), END THE SURVEY**: "THOSE ARE ALL THE QUESTIONS I HAVE TODAY. THANK YOU FOR YOUR HELP! IF YOU HAVE ANY QUESTIONS ABOUT THE SURVEY, YOU CAN REACH PHPG TOLL-FREE AT 1-888-941-9358. IF YOU HAVE ANY QUESTIONS FOR THE HEALTH CARE AUTHORITY, PLEASE CALL THE TOLL-FREE NUMBER 1-877-252-6002."**]

117. You mentioned at the beginning of the survey that you chose not to enroll your child in the Newborn Outreach Program. Why did you decide not to enroll him or her? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Not aware of program/was not asked to enroll
    b. Did not understand purpose of the program
    c. Was not pregnant
    d. Had a miscarriage
    e. Moved to another location/state
    f. Do not wish to self-manage care/receive health education
    g. Do not want to be evaluated by Case Manager
    h. Have no health needs at this time
    i. Tried to enroll but was unsuccessful [SPECIFY REASON IN COMMENTS]
    j. Don't Know/Unsure
    k. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

[CHECK IF MOTHER/CHILD IS/ARE ENROLLED IN ANY OTHER PROGRAMS. IF ENROLLED, GO TO ENROLLED PROGRAM QUESTIONS. IF THERE IS/ARE NO OTHER PROGRAM(S), END THE SURVEY: **"THOSE ARE ALL THE QUESTIONS I HAVE TODAY. THANK YOU FOR YOUR HELP! IF YOU HAVE ANY QUESTIONS ABOUT THE SURVEY, YOU CAN REACH PHPG TOLL-FREE AT 1-**

888-941-9358. IF YOU HAVE ANY QUESTIONS FOR THE HEALTH CARE AUTHORITY, PLEASE CALL THE TOLL-FREE NUMBER 1-877-252-6002."]

Seasonal Synagis Program (Q 118-136; PAGES 38-43)

The SoonerCare Seasonal Synagis Program is offered to specific children who are authorized to receive Synagis injections to prevent a serious respiratory disease. A Care Manager is assigned to follow-up with you to ensure injections are given on time and to offer education and other assistance.

118. Is or was your child enrolled in the Seasonal Synagis Program?
    a. Yes
    b. No [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 136]
    c. Don't Know [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 136]

119. Is your child still enrolled today in the Seasonal Synagis Program?
    a. Yes → [GO TO Q 120 AND SKIP Q 121]
    b. No
    c. Don't Know/Unsure → [GO TO Q 120 AND SKIP Q 121]

120. How long has your child been (how long was your child) in the Seasonal Synagis Program?
    a. Less than one month
    b. One to two months
    c. Three to four months
    d. Four to six months
    e. More than six months
    f. Don't Know/Unsure

121. Why is your child no longer enrolled in the Seasonal Synagis Program? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Completed program goals/graduated from the program
    b. No longer wish to self-manage care/receive health education
    c. No longer want to be evaluated by Case Manager
    d. Relocated to another service area or state
    e. Loss or change in health benefits
    f. Have no additional health needs at this time
    g. Don't Know/Unsure
    h. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

122. I'm going to mention some services your child may have received through the Seasonal Synagis Program. Please tell me whether your child received the following services as part of the Seasonal Synagis Program. [CHECK ALL THAT APPLY]

	Yes	No	Don't Know	N/A
Training and education (e.g., medication administration)				
Educational materials and letters				
Scheduling and rescheduling injection appointments				
Follow-up phone calls by Care Manager				
Referrals to programs and services				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

123. [ASK FOR EACH "YES" ACTIVITY IN Q 122] Thinking about the services your child received, please tell me how helpful they were. Tell me if they were Very Helpful, Somewhat Helpful, Slightly Helpful or Not at all Helpful.

	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Don't Know	N/A
Training and education (e.g., medication administration)						
Educational materials and letters						
Scheduling and rescheduling injection appointments						
Follow-up phone calls by Care Manager						
Referrals to programs and services						
Other [PLEASE SPECIFY]						

Comments:_____

_____

124. Overall, how satisfied are you with your experience with the Synagis Program? Would you say are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Unsure

125. Would you recommend the Synagis Program to a friend whose child has health care needs like yours?
    a. Yes
    b. No
    c. Don't Know/Unsure

126. Do you have any suggestions for improving the services offered through the Synagis Program? [RECORD ALL RECOMMENDATIONS]

Comments:_____

_____

_____

Now I'm going to ask you a few questions about your experience with your child's Case Manager for the Seasonal Synagis Program.

127. Can you tell me the name of your child's Case Manager?
    a. Yes [RECORD NAME] _____
    b. No

128. How many times have you spoken to your child's Case Manager since you started in the Program? This includes your assessment. [RECORD NUMBER] _____

129. How would you rate the number of times your child's Case Manager contacted you?
    a. Too many
    b. Too few
    c. Just enough
    d. Don't Know/Unsure

130. Have you called your child's Case Manager?
    a. Yes

b. No → [PROCEED TO Q 133]
c. Don't Know/Unsure → [PROCEED TO Q 133]

131. Thinking about the last time you called your child's Case Manager, what was the reason for your call? [DO NOT PROMPT]
    a. Routine health question
    b. Urgent health problem
    c. Seeking assistance in scheduling appointment
    d. Training and/or Patient Education
    e. Referral to Community or other service(s)
    f. Returning call from Case Manager
    g. Don't Know/Unsure
    h. Other [SPECIFY IN COMMENTS]

    Comments:_____

    _____

132. Did you reach your child's Case Manager immediately? [IF NO] How quickly did you get a call back?
    a. Reached immediately (at time of call)
    b. Called back within one hour
    c. Called back in more than one hour but same day
    d. Called back the next day
    e. Called back two or more days later
    f. Never called back
    g. Don't Know/Unsure
    h. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

133. Which of the following things has your child's Case Manager done for you? Has your child's Case Manager:

	Yes	No	Don't Know	N/A
Asked questions about your child's health or your concerns				
Provided instructions about taking care of your child's health				
Helped you to identify changes in your child's health that might be an early sign of a problem				
Answered questions about your child's health care needs				
Helped you to make and keep health care appointments for medical problems				
Referred you to programs and services				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

134. [ASK FOR EACH "YES" ACTIVITY IN Q 133] Thinking about what your child's Case Manager has done for you, please tell me how satisfied you are with the help you received. Tell me if you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied.

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Don't Know	N/A
Asked questions about your child's health or your concerns						
Provided instructions about taking care of your child's health						
Helped you to identify changes in your child's health that might be an early sign of a problem						
Answered questions about your child's health care needs						
Helped you to make and keep health care appointments for medical problems						
Referred you to programs and services						
Other [SPECIFY IN COMMENTS]						

Comments:_____

_____

135. Overall, how satisfied are you with the help you have received from your child's Case Manager? Would you say you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very Satisfied
    b. Somewhat Satisfied
    c. Somewhat Dissatisfied
    d. Very Dissatisfied
    e. Don't Know/Unsure

[AFTER COMPLETING Q 135, SKIP Q 136. CHECK IF MOTHER/CHILD ARE PARTICIPATING IN ANY OTHER PROGRAMS. GO TO NEXT PROGRAM IN WHICH THE MOTHER/CHILD IS ENROLLED.

IF MOTHER IS ENROLLED IN OB OUTREACH (AT RISK), HIGH-RISK, FIMR MOM OR ICC, MAKE SURE TO COMPLETE THE BEHAVIORAL HEALTH AND DEMOGRAPHIC QUESTIONS STARTING ON PAGE 50 (Q 156).

IF THERE IS/ARE NO OTHER PROGRAM(S), END THE SURVEY**: "THOSE ARE ALL THE QUESTIONS I HAVE TODAY. THANK YOU FOR YOUR HELP! IF YOU HAVE ANY QUESTIONS ABOUT THE SURVEY, YOU CAN REACH PHPG TOLL-FREE AT 1-888-941-9358. IF YOU HAVE ANY QUESTIONS FOR THE HEALTH CARE AUTHORITY, PLEASE CALL THE TOLL-FREE NUMBER 1-877-252-6002."**]

136. You mentioned at the beginning of the survey that you chose not to enroll your child in the Seasonal Synagis Program. Why did you decide not to enroll him or her? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Not aware of program/was not asked to enroll
    b. Did not understand purpose of the program
    c. Was not pregnant
    d. Had a miscarriage
    e. Moved to another location/state
    f. Do not wish to self-manage care/receive health education
    g. Do not want to be evaluated by Case Manager
    h. Have no health needs at this time
    i. Tried to enroll but was unsuccessful [SPECIFY REASON IN COMMENTS]
    j. Don't Know/Unsure
    k. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

[CHECK IF MOTHER/CHILD IS/ARE ENROLLED IN ANY OTHER PROGRAMS. IF ENROLLED GO TO ENROLLED PROGRAM QUESTIONS. IF THERE IS/ARE NO OTHER PROGRAM(S), END THE SURVEY: **"THOSE ARE ALL THE QUESTIONS I HAVE TODAY. THANK YOU FOR YOUR HELP! IF YOU HAVE ANY QUESTIONS ABOUT THE SURVEY, YOU CAN REACH PHPG TOLL-FREE AT 1-888-941-9358. IF YOU HAVE ANY QUESTIONS FOR THE HEALTH CARE AUTHORITY, PLEASE CALL THE TOLL-FREE NUMBER 1-877-252-6002."**]

Private Duty Nursing Program (Q 137-155; PAGES 44-49)

The SoonerCare Private Duty Nursing Program is offered to children with complex special health care needs who qualify for in-home nursing service.

137. Is or was your child enrolled in the Private Duty Nursing Program?
    a. Yes
    b. No [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 155]
    c. Don't Know [PROCEED TO NEXT PROGRAM; IF NO OTHERS, GO TO Q 155]

138. Is your child still enrolled today in the Private Duty Nursing Program?
    a. Yes → [GO TO Q 139 AND SKIP Q 140]
    b. No
    c. Don't Know/Unsure → [GO TO Q 139 AND SKIP Q 140]

139. How long has your child been (how long was your child) enrolled in the Private Duty Nursing Program?
    a. Less than one month
    b. One to two months
    c. Three to four months
    d. Four to six months
    e. More than six months
    f. Don't Know/Unsure

140. Why is your child no longer enrolled in the Private Duty Nursing Program? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]
    a. Completed program goals/graduated from the program
    b. No longer eligible for the program
    c. Relocated to another service area or state
    d. There was no Private Duty Nurse available in my area
    e. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

141. I'm going to mention some services your child may have received through the Private Duty Nursing Program. Please tell me whether your child received the following services as part of the Private Duty Nursing Program. [CHECK ALL THAT APPLY]

	Yes	No	Don't Know	N/A
Training and education about the program and your home health agency				
Educational materials and letters				
Scheduling and rescheduling services and/or appointments				
Follow-up phone calls by the Health Care Authority				
Home visit to determine if your child still qualifies for the program based on their clinical status				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

_____

142. [ASK FOR EACH "YES" ACTIVITY IN Q 141] Thinking about the services your child received, please tell me how helpful they were. Tell me if they were Very Helpful, Somewhat Helpful, Slightly Helpful or Not at all Helpful.

	Very Helpful	Somewhat Helpful	Not Too Helpful	Not at all Helpful	Don't Know	N/A
Training and education about the program and your home health agency						
Educational materials and letters						
Scheduling and rescheduling services and/or appointments						
Follow-up phone calls by the Health Care Authority						
Home visit to determine if your child still qualifies for the program based on their clinical status						
Other [PLEASE SPECIFY]						

Comments:_____

_____

_____

143. Overall, how satisfied are you with your experience with the Private Duty Nursing Program? Would you say are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Unsure

144. Would you recommend the Private Duty Nursing Program to a friend whose child has health care needs like yours?
    a. Yes
    b. No
    c. Don't Know/Unsure

145. Do you have any suggestions for improving the services offered through the Private Duty Nursing Program? [RECORD ALL RECOMMENDATIONS]

Comments:_____

_____

_____

Now I'm going to ask you a few questions about your experience with your child's Case Manager for the Private Duty Nursing Program.

146. Can you tell me the name of your child's Case Manager?
    a. Yes [RECORD NAME] _____
    b. No

147. How many times have you spoken to your child's Case Manager since you started in the Program? This includes your assessment. [RECORD NUMBER] _____

148. How would you rate the number of times your child's Case Manager contacted you?
    a. Too many
    b. Too few
    c. Just enough
    d. Don't Know/Unsure

149. Have you called your child's Case Manager?
    a. Yes
    b. No → [PROCEED TO Q 152]
    c. Don't Know/Unsure → [PROCEED TO Q 152]

150. Thinking about the last time you called your child's Case Manager, what was the reason for your call? [DO NOT PROMPT]
    a. Routine health question
    b. Urgent health problem
    c. Seeking assistance in scheduling appointment
    d. Training and/or Patient Education
    e. Referral to Community or other service(s)
    f. Returning call from Case Manager
    g. Don't Know/Unsure
    h. Other [SPECIFY IN COMMENTS]

    Comments:_____

    _____

151. Did you reach your child's Case Manager immediately? [IF NO] How quickly did you get a call back?
    a. Reached immediately (at time of call)
    b. Called back within one hour
    c. Called back in more than one hour but same day
    d. Called back the next day
    e. Called back two or more days later
    f. Never called back
    g. Don't Know/Unsure
    h. Other [SPECIFY IN COMMENTS]

    Comments: _____

    _____

152. Which of the following things has your child's Case Manager done for you? Has your child's Case Manager:

	Yes	No	Don't Know	N/A
Asked questions about your child's health or your concerns				
Provided instructions about taking care of your child's health				
Helped you to identify changes in your child's health that might be an early sign of a problem				
Answered questions about your child's health care needs				
Helped you to make and keep health care appointments for medical problems				
Referred you to programs and services				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

153. [ASK FOR EACH "YES" ACTIVITY IN Q 152] Thinking about what your child's Case Manager has done for you, please tell me how satisfied you are with the help you received. Tell me if you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied.

	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Don't Know	N/A
Asked questions about your child's health or your concerns						
Provided instructions about taking care of your child's health						
Helped you to identify changes in your child's health that might be an early sign of a problem						
Answered questions about your child's health care needs						
Helped you to make and keep health care appointments for medical problems						
Referred you to programs and services						
Other [SPECIFY IN COMMENTS]						

Comments:_____

_____

154. Overall, how satisfied are you with the help you have received from your child's Case Manager? Would you say you are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?

a. Very Satisfied
b. Somewhat Satisfied
c. Somewhat Dissatisfied
d. Very Dissatisfied
e. Don't Know/Unsure

[AFTER COMPLETING Q 154, SKIP Q 155. CHECK IF MOTHER/CHILD ARE PARTICIPATING IN ANY OTHER PROGRAMS. GO TO NEXT PROGRAM IN WHICH THE MOTHER/CHILD IS ENROLLED.

IF MOTHER IS ENROLLED IN OB OUTREACH (AT RISK), HIGH-RISK, FIMR MOM OR ICC, MAKE SURE TO COMPLETE THE BEHAVIORAL HEALTH AND DEMOGRAPHIC QUESTIONS STARTING ON PAGE 50 (Q 156).

IF THERE IS/ARE NO OTHER PROGRAM(S), END THE SURVEY**: "THOSE ARE ALL THE QUESTIONS I HAVE TODAY. THANK YOU FOR YOUR HELP! IF YOU HAVE ANY QUESTIONS ABOUT THE SURVEY, YOU CAN REACH PHPG TOLL-FREE AT 1-888-941-9358. IF YOU HAVE ANY QUESTIONS FOR THE HEALTH CARE AUTHORITY, PLEASE CALL THE TOLL-FREE NUMBER 1-877-252-6002."**]

155. You mentioned at the beginning of the survey that you chose not to enroll your child in the Private Duty Nursing Program. Why did you decide not to enroll him or her? [DO NOT PROMPT. RECORD ALL REASONS – READ BACK ANSWERS AND ASK TO CHOOSE MOST IMPORTANT REASON]

a. Not aware of program/was not asked to enroll
b. Did not understand purpose of the program
c. Was not pregnant
d. Had a miscarriage
e. Moved to another location/state
f. Do not wish to self-manage care/receive health education
g. Do not want to be evaluated by Case Manager
h. Have no health needs at this time
i. Tried to enroll but was unsuccessful [SPECIFY REASON IN COMMENTS]
j. Don't Know/Unsure
k. Other [SPECIFY IN COMMENTS]

Comments: _____

_____

[CHECK IF MOTHER/CHILD IS/ARE ENROLLED IN ANY OTHER PROGRAMS. IF ENROLLED, GO TO ENROLLED PROGRAM QUESTIONS. IF THERE IS/ARE NO OTHER PROGRAM(S), END THE SURVEY: **"THOSE ARE ALL THE QUESTIONS I HAVE TODAY. THANK YOU FOR YOUR HELP! IF YOU HAVE ANY QUESTIONS ABOUT THE SURVEY, YOU CAN REACH PHPG TOLL-FREE AT 1-888-941-9358. IF YOU HAVE ANY QUESTIONS FOR THE HEALTH CARE AUTHORITY, PLEASE CALL THE TOLL-FREE NUMBER 1-877-252-6002."**]

BEHAVIORAL HEALTH SCREENING AND REFERRAL (Q 156-160; PAGES 50-51)

[NOTE: ONLY ASK THESE QUESTIONS FOR MEMBERS PARTICIPATING IN OB OUTREACH (AT RISK OB), HIGH RISK OB, FIMR MOM AND ICC PROGRAMS. THESE QUESTIONS ARE LIMITED TO THE MOTHER'S EXPERIENCES WITH THE HEALTH CARE AUTHORITY'S BEHAVIORAL HEALTH UNIT.]

156. Have you completed a Behavioral Health Screening with someone at the Health Care Authority?
    a. Yes
    b. No → [GO TO THE HEALTH STATUS AND DEMOGRAPHICS QUESTIONS EXCEPT FOR FIMR BABY-ONLY OR NEWBORN OUTREACH-ONLY WITH MOMS WITH POSTPARTUM DEPRESSION SCREENING]
    c. Don't Know/Unsure → [GO TO THE HEALTH STATUS AND DEMOGRAPHICS QUESTIONS EXCEPT FOR FIMR BABY-ONLY OR NEWBORN OUTREACH-ONLY WITH MOMS WITH POSTPARTUM DEPRESSION SCREENING]

157. Were you referred to the Health Care Authority's Behavioral Health Unit (BHU)?
    a. Yes
    b. No → [GO TO THE HEALTH STATUS AND DEMOGRAPHICS QUESTIONS EXCEPT FOR FIMR BABY-ONLY OR NEWBORN OUTREACH-ONLY WITH MOMS WITH POSTPARTUM DEPRESSION SCREENING]
    c. Don't remember/unsure → [GO TO THE HEALTH STATUS AND DEMOGRAPHICS QUESTIONS EXCEPT FOR FIMR BABY-ONLY OR NEWBORN OUTREACH-ONLY WITH MOMS WITH POSTPARTUM DEPRESSION SCREENING]

158. Were you referred to any of the following outpatient behavioral health services? [READ ALL SERVICES. IF NO TO ALL, GO TO THE HEALTH STATUS AND DEMOGRAPHICS QUESTIONS]

	Yes	No	Don't Know	N/A
Psychiatrist to obtain medication				
Psychologist				
Outpatient Behavioral Health Agency				
Community Mental Health Center				
Individual Licensed Behavioral Health Provider				
Support Group				
Other [SPECIFY IN COMMENTS]				

Comments:_____

_____

_____

159. Overall, how satisfied are you with help you received from the Health Care Authority's Behavioral Health services Unit? Would you say are Very Satisfied, Somewhat Satisfied, Somewhat Dissatisfied or Very Dissatisfied?
    a. Very satisfied
    b. Somewhat satisfied
    c. Somewhat dissatisfied
    d. Very dissatisfied
    e. Don't Know/Unsure
160. Are there ways that the Health Care Authority's Behavioral Health staff could have been more helpful to you? [RECORD ALL RECOMMENDATIONS]

Comments:_____

_____

_____

[GO TO THE HEALTH STATUS AND DEMOGRAPHICS QUESTIONS STARTING ON PAGE 52 (Q 161).]

HEALTH STATUS & DEMOGRAPHICS (Q 161-166; PAGE 52)

[NOTE: ONLY ASK THESE QUESTIONS FOR MEMBERS PARTICIPATING IN OB OUTREACH (AT RISK OB), HIGH RISK OB, FIMR MOM AND ICC PROGRAMS. THESE QUESTIONS ARE LIMITED TO THE MOTHER'S HEALTH STATUS AND DEMOGRAPHICS.]

We're almost done. I just have a few more questions.

161. What is your age? [RECORD AGE] _____

162. I am now going to ask about your ethnicity. I will read you a list of choices. You may choose one or more.
    a. White
    b. Hispanic or Latino origin
    c. Black or African American
    d. Asian
    e. Native Hawaiian or other Pacific Islander
    f. American Indian or Alaska Native
    g. Other
    h. Decline to respond

163. What is the highest level of education you have completed? [RECORD EDUCATION]

    a. Less than high school
    b. High school/GED
    c. Some college
    d. Two-year college degree (Associates)
    e. Four-year college degree (Bachelor's)
    f. Master's Degree
    g. Other [PLEASE SPECIFY] _____

164. Have you had the unfortunate experience of having a miscarriage?

    a. Yes
    b. No → [GO TO Q 166]
    c. Don't Know/Unsure → [GO TO Q 166]

165. How many miscarriages have you had? [RECORD NUMBER] _____

166. How many children of your own have you had? [RECORD NUMBER] _____

Those are all the questions I have today. **Thank you for your help!**

If you have any questions about the survey, you can reach PHPG toll-free at 1-888-941-9358.

If you have any questions for the Health Care Authority, please call the toll-free number 1-877-252-6002.

Attachment C: OHCA Pharmacy Lock-in Referral Form

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
PHARMACY LOCK-IN REFERRAL FORM

LOCK-IN UNIT PHONE: 1-800-522-0114 opt 4 **LOCK-IN UNIT FAX: 1-866-335-3331**

This form is used for referring members with possible medication over utilization to the Lock-in program to evaluate the need for possible lock-in to one pharmacy.

Referral Information

Referral Source: [] Health Care Provider [] ER Department
[] Pharmacy [] Other: _____
[] Caseworker

Referral Name: _____ **Referral Phone**: _____
Date of Referral: _____

Member Information

Member Name: _____

Member ID: _____

Member DOB: _____

Reason for Referral

[] Multiple Pharmacies
[] Multiple Prescribers
[] Other
[] Multiple ER visits
[] Concern for Member Safety

Description of referral reason:

_____

_____

_____

_____

_____

OKLA HCA Issued 04-18-06 Pharm-16

Attachment D: Care Management Referral Form

Oklahoma HealthCare Authority

Care Management Referral Form

Care Management Phone: (877) 252-6002 **Care Management Fax: (405) 530-3217**

Referral Date:	**Date Care Mgmt Referral Received:**
	Received by:
	Referral Source Notified of Receipt: ☐ **Yes**

Referral Information

Referral Source:
☐ Primary Care Provider
☐ Specialty Provider
☐ ER Department
☐ Caseworker/ DC Planner
☐ Community Agency
☐ Other (define):

Referral Name: **Referral Phone:**

Member Information

Member Name: Member ID:

Member DOB: Member Phone:

Contact Name: Contact Phone:

Relationship to Member: ☐ Self ☐ Family ☐ Other (Specify)

Additional information:

Reason for Referral

- ☐ Coordinate complex case
- ☐ Access primary care services
- ☐ Multiple ER visits
- ☐ Access community resources
- ☐ Education needs related to condition
- ☐ Education needs related to benefits
- ☐ Multiple inpatient admissions
- ☐ Follow-up of complex inpatient admission
- ☐ Complex discharge needs
- ☐ Poly-pharmacy
- ☐ Transplant Evaluation Notification
- ☐ Other

Description of referral reason:

OHCA Revised 03/21/2014 HCA - 24

Attachment E: SoonerCare Dismissal Request Form

Oklahoma HealthCare Authority

SoonerCare Dismissal Request Form

Date of Request:
Date Received by OHCA:
FAX Number: 405-530-7243

Name of Provider(s) with Provider ***SoonerCare*** ID#(s):
Point of Contact:
Phone Number:

This serves as a formal request to dismiss the following *SoonerCare* members from our panel:

Name of Member(s):	**Member ID(s):**

Please note dismissal requests from a PCP must be "For Cause". Please provide additional information in the field provided. **Please provide any pertinent chart notes as an attachment to this form.**

I wish to dismiss the member(s) for the following reason:

☐ Rude/Disruptive Behavior (give specific examples):

☐ Non-compliance with medical regime (give specific examples):

☐ Deterioration of provider/patient relationship (give specific examples):

☐ No Shows (give specific dates):

For OHCA Use Only

Dismissal Committee Review Comments:
Provider Representative: _____

Referred To: CM ☐ MS ☐ BH ☐ COP ☐ QA ☐ OTHER ☐

Letter of approval sent to Provider: ☐
Attached copies of dismissal letters: ☐
Disenrolled and locked-out from PCP: ☐
Logged in Excel Database ☐

APPROVED: ☐
DENIED: ☐

_____
Approved By: Date

OHCA Revised 04/10/2014 HCA-42

Attachment F: Procedure and Provider Specialty Codes used to Establish Breast Cancer, Cervical Cancer, and Cancer Related PMPMs when No Diagnosis was Submitted

Procedure Code	Description
40.0	Incision of Lymphatic structures
40.2	Simple Excision of Lymphatic structure
00400	Anesthesia for procedures on the thorax
00790	Anesthesia for procedures on upper abdomen
00840	Anesthesia for intraperitoneal procedures in lower abdomen (hysterectomy and sterilization)
00944	Anesthesia for procedures on perineum
10021	Fine Needle Aspiration (FNA): Without imaging (palpable lump)
10022	Fine Needle Aspiration (FNA): With imaging (non-palpable)
19000	Puncture Aspiration of Breast Cyst: Surgical procedure only
19001	Each Additional Cyst: Use in conjunction with 19000
19081	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; first lesion
19082	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; stereotactic guidance; each additional lesion
19083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; first lesion
19084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous; ultrasound guidance; each additional lesion
19100	Biopsy of breast: No imaging; percutaneous, needle core, not using imaging guidance (separate procedure). Surgical procedure only
19101	Breast biopsy, open, incisional
19102	Biopsy of breast, percutaneous, needle core with imaging guidance
19103	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion
19125	Excision of breast lesion identified by preoperative placement of radiological…
19281	Placement of breast localization device, percutaneous; mammographic guidance; first lesion
19282	Placement of breast localization device, percutaneous; mammographic guidance; each additional lesion
19283	Placement of breast localization device, percutaneous; stereotactic guidance; first lesion

Procedure Code	Description
19284	Placement of breast localization device, percutaneous; stereotactic guidance; each additional lesion
19285	Placement of breast localization device, percutaneous; ultrasound guidance; first lesion
19286	Placement of breast localization device, percutaneous; ultrasound guidance; each additional lesion
19301	Partial mastectomy
19303	Mastectomy, simple, complete
19307	Modified radical mastectomy
19357	Breast Reconstruction procedures
36561	Tunneled central venous catheter with port 5 years of age or older
38500	Sentinel lymph node biopsy
38525	Open, deep axillary node(s)
57452	Colposcopy: Vaginoscopy including upper/adjacent vagina
57454	Colposcopy: With biopsy of the cervix and/or endocervical curettage; surgical procedure
57455	Colposcopy: With biopsy of the cervix
57456	Colposcopy: With endocervical curettage
57460	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix
57461	Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix
57500	Cervical biopsy
57505	ECC
57510	Cervical cauterization
57511	Cervical cauterization
57513	Cervical cauterization
57520	Cervical conization
57520	Conization of cervix, including cold knife or laser
57522	Conization of cervix; loop electrode excision
58100	Endo biopsy for irreg menstruation
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58150	Hysterectomy
58152	Hysterectomy
58260	Hysterectomy
58550	Hysterectomy
58552	Hysterectomy
58563	Hysteroscopy with endometrial ablation
58662	Laparoscopy, surgical, removal of lesions/cysts of ovaries and pelvis.
71010	Radiologic examination, chest; single view, frontal
71020	Radiologic examination, chest, two views, frontal and lateral

Procedure Code	Description
76098	Radiological Examination: Of surgical specimen
76645	Diagnostic Ultrasound: Breast(s) unilateral or bilateral; B-scan and/or real time with image documentation (For determination of fluid or solid mass in breast(s)
76942	Ultrasonic Guidance for Needle Placement: Imaging supervision & interpretation (e.g., biopsy, aspiration, injection, localization device)
77014	CT guidance for placement of radiation therapy fields
77053	Mammary ductogram or galactogram, single duct
77055	Diagnostic, Unilateral Mammogram, Film
77056	Diagnostic, Follow-up Bilateral Mammogram, Film
77057	Screening Mammogram, Film: Bilateral (2 view film study of each breast)
77059	Magnetic resonance imaging, breast, without and/or with contrast
77059	Breast MRI
77263	Therapeutic radiology treatment planning; complex
77280	Therapeutic radiology simulation-aided field setting; simple
77290	Therapeutic Radiology Simulation; complex
77295	3-D Simulation
77300	Basic radiation dosimetry calculation
77301	IMRT Planning
77334	Treatment devices; complex
77336	Continuing medical physics consultation
77338	Multileaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT)
77413	Radiation treatment; 6-10 MV Complex
77414	Radiation treatment; 20 MV or greater
77418	Intensity Modulated Radiation Therapy
77421	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy
77427	Radiation treatment management; five treatments
77470	Spec Trt Procedure
78472	Cardiac blood pool imaging
78815	Positron Emission Tomography (PET) Scan
81211	Genetic testing for hereditary breast and/or cervical cancer
81213	BRCA1, BRCA2 (breast cancer 1 and 2) (e.g. hereditary breast and ovarian cancer)
86300	Tumor Antigen, Immunoassay, CA 15-3 / CA 27.29
87621	Papillomavirus, Human, Amplified Probe • Hybrid Capture II from Digene - HPV Test [High Risk Typing, only] • Cervista HPV HR
88141	Pap Test read by Pathologist: Cytopathology, cervical or vaginal - any reporting system; requiring interpretation by physician.

Procedure Code	Description
88142	Pap Test, Liquid Based (Payable once every 3-5 years as per ASCCP guidelines)
88164	Pap Test reported TBS: Cytopathology, slides, cervical or vaginal - The Bethesda System; manual screening under physician supervision.
88165	Cytopathyology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision)
88172	Evaluation of FNA: Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)
88173	Interpretation of FNA and Report: Cytopathology, interpretation and report
88174	Pap Test, Liquid Based (Payable once every 3-5 years as per ASCCP guidelines)
88175	Pap Test, Liquid Based (Payable once every 3-5 years as per ASCCP guidelines)
88305	Breast or Cervical Biopsy Interpretation: Level IV Surgical pathology, gross & microscopic examination not requiring microscopic examination of margins
88307	Breast Biopsy Interpretation: Excision of Lesion Level V Surgical pathology, gross & microscopic examination requiring microscopic evaluation of surgical margins
88309	Surgical Pathology, gross and microscopic examination
88331	Pathology Consultation During Surgery: With frozen section(s), single specimen
88332	Pathology Consultation During Surgery: Each additional tissue block with frozen section(s)
88342	Immunohistochemistry (including tissue immunoperoxidase), each antibody
88360	Immunohistochemistry-non-computerized advanced morphometric analysis
88361	Immunohistochemistry-morphometric analysis using computer-assisted technology
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour
96367	Additional sequential IV infusion of a new drug/substance, up to 1 hour
96375	Therapeutic, prophylactic or diagnostic injection
96413	Prolonged infusion of chemotherapeutic agents
96417	Chemo each additional sequential infusion
G0202	Screening Mammogram, Digital: Bilateral (2 view film study of each breast)
G0204	Diagnostic Bilateral Mammogram, Digital
G0206	Diagnostic Unilateral Mammogram, Digital
G0339	Robot lin-radsurg com, first
J0897	Injection, denosumab, 1 mg
J1440	Neupogen injection 300 mcg
J1441	Neupogen injection 480 mcg
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J2469	Palonosetron HCl) injection 0.25 mg
J2505	Injection, pegfilgrastim, 6 mg
J3487	Injection, zoledronic acid (zometa), 1 mg
J9070	Cyclophosphamide 100 mg inj

Procedure Code	Description
J9171	Injection, Docetaxel, 1 Mg
J9179	Injection, eribulin mesylate, 0.1 mg
J9201	Injection, gemcitabine hydrochloride, 200 mg
J9207	Injection, ixabepilone, 1 mg
J9264	Injection, paclitaxel protein-bound particles, 1mg
J9265	Injection, paclitaxel, 30 mg
J9355	Injection, trastuzumab, 10 mg
J9395	Injection, fulvestrant, 25 mg
L8030	Breast prosthesis, silicone or equal, without integral adhesive

Provider Specialty Code	Description
195	Oncology Clinic
329	Oncologist
354	Gynecological Oncology