

Minding Our *P's* and *Q's*

The OHCA SFY 2006 Performance and Quality Report

July 2005 – June 2006



STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

May 2007

Thank you for your continued interest in the Oklahoma Health Care Authority's annual quality report, *Minding Our P's and Q's*. Here at the OHCA, we take seriously our role in helping to provide quality health care services for our Oklahoma **SoonerCare** members. We are also serious about providing these services in a cost-effective manner.

Every day the OHCA works to ensure that quality health care is being provided to its members. In addition to regularly scheduled quality assurance efforts, the agency also conducts projects to improve the services provided. This report will summarize these initiatives. A few examples of how our efforts have resulted in improvements include:

- Increased the screening rates for adult Native American members with diabetes;
- Increased the EPSDT screening rates for eligible members 0-21 years of age; and
- Decreased the utilization of emergency room services for non-emergent needs for eligible members identified as frequent users of these services.

SoonerCare programs cover the entire lifespan as do our quality assurance and improvement efforts. The Newborn Outreach Initiative was designed to provide structured educational outreach for **SoonerCare's** youngest members and their moms. Our behavioral health initiatives were designed to improve care for children in need of specialized behavioral health services. The system of focused care management for women with breast or cervical cancer was designed to assure that these adult members receive prompt diagnostic tests and appropriate treatment. We look forward to telling you in future reports about new initiatives under development, including the implementation of our Health Management Program designed to provide focused care management for high-risk members of all ages and a program called "The Money Follows the Person," which is a federal grant the OHCA just received to help individuals with disabilities and senior citizens remain in their own homes.

As you will see throughout this report, the Oklahoma Health Care Authority is committed to our many partners and members. Every quality initiative begins with an idea. Do you have an idea for improving the health care services provided to **SoonerCare** members? Please feel free to contact us and share your suggestions.

Respectfully,

A handwritten signature in cursive script that reads "Lynn V. Mitchell, M.D., MPH".

Lynn V. Mitchell, MD, MPH
Medical Director and
State Medicaid Director

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OUR MISSION & VISION



For more than a decade, the Oklahoma Health Care Authority (OHCA) has served as Oklahoma's single agency administering the state's Medicaid program, known as **SoonerCare**. We take our responsibility seriously and our work is guided by the following mission statement and vision.

Mission:

To purchase state and federally funded health care in the most efficient and comprehensive manner possible and to study and recommend strategies for optimizing the accessibility and quality of health care.

Vision:

Our vision is for Oklahomans to enjoy optimal health status through having access to quality health care, regardless of their ability to pay.

Flowing from these statements are our agency values, which include a **dedication to using qualitative and quantitative data to guide and evaluate our actions and improve our performance in a purposeful way over time**. To provide an update on the OHCA's Quality Improvement/Quality Assurance programs and initiatives, we are pleased to present the Performance and Quality Report, *Minding Our P's and Q's*, for State Fiscal Year 2006 (July 2005 through June 2006).

Minding Our P's and Q's is a supplement to the OHCA's Annual Report, which gives greater detail on all of our programs and provides information on our management of taxpayer funds. This year's theme is "Building Bridges to Health Care for Oklahomans." We hope this report will provide readers with a detailed look at the ways our quality initiatives and programs serve as bridges to improved health care services for all Oklahomans.

SFY 2006 HIGHLIGHTS

Minding Our P's and Q's is divided into several sections: Updates on Quality Initiatives, New Quality Initiatives, **SoonerCare** Program Updates, Results of Research Projects and Ongoing Quality Reviews. The following is a quick glance at what you will find in these sections.

Updates on Quality Initiatives:

From year to year, some projects are ongoing, while a few reach an end. This section will update the reader on these initiatives:

- The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program has received attention on a number of fronts. Among other actions, a new periodicity schedule has been implemented, manuals have been revised and forms have been made available for providers.
- Several activities have targeted the inappropriate use of emergency rooms, including educational outreach to members and profiles sent to **SoonerCare** providers.
- We concluded our participation in the Center for Health Care Strategies' Best Clinical and Administrative Practices project, in which we focused on diabetes among Native Americans. The project demonstrated improvement on measures of diabetes management by **SoonerCare** members who participated in the study.
- Mailing fliers to **SoonerCare** members to tell them about our QUIT NOW Smoking Cessation program led to a jump in the number of calls to the toll-free help line.





New Quality Initiatives:

In this section we will describe several initiatives that aim to improve services for babies and children:

- We discuss the work of the Perinatal Task Force, which suggested ways of improving perinatal services for pregnant women statewide.
- Follow-up care for newborns and their parents is the main focus of another initiative, in which hundreds of phone calls have been made to women with new babies.
- Continuity of care is important for all children, and it is sometimes compromised when foster and adoptive children are moved from one home to another. Supporting continuity of care for these children is the focus of another new quality initiative.
- High utilization of inpatient behavioral health services by **SoonerCare** children led the OHCA behavioral health care coordinators to develop a quality initiative targeting these members. This project explores how intensive care management of these children might affect the length of hospitalization for these services.
- Access to services within the state of Oklahoma is an area of great importance to the OHCA. We address the use of out-of-state mental health providers by children who are **SoonerCare** members, so that they have better access to the services they need.

SoonerCare Program Updates:

At the OHCA, we look for new ways to serve our members, furthering our mission and vision of access to quality health care. This section of the report will describe progress on four fronts:

- SoonerPlan is a special program for providing family planning services to **SoonerCare** members as well as Oklahomans who might not otherwise qualify for our services.
- The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) is new to Oklahoma. Through this program, home care can be offered for children with physical or mental disabilities who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parent or guardian's income or resources. Many children benefited from this program in SFY 2006.
- The OHCA's Care Management Division made thousands of phone calls to women to let them know about Oklahoma Cares, the Breast and Cervical Cancer Prevention and Treatment Program. We will detail the number of women directly affected by this program.
- As SFY 2006 was drawing to a close, Governor Brad Henry signed legislation for the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC). This program will help increase the number of Oklahomans with health insurance.

Toward the end of this report we describe the results of studies that the OHCA has conducted to support quality improvement efforts, as well as to inform the development of programs and future studies. We also report on trends across the last five years based on the Health Plan Employer Data and Information Set (HEDIS®), a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Finally, we summarize the results of year-round quality reviews and look ahead to new and expanded programs that we expect to feature in SFY 2007's *Minding Our P's and Q's*.



UPDATES



As a supplement to the OHCA annual report, *Minding Our P's and Q's* provides a summary of activities related to quality initiatives that continue from year to year. This section of the report will focus on the following topics that are involved in ongoing quality improvement and assurance efforts: the EPSDT program, appropriate use of emergency room services, an intervention with Native Americans diagnosed with diabetes and smoking cessation.

Early and Periodic Screening, Diagnosis and Treatment

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program has been the focus of a number of activities. An EPSDT Periodicity Advisory Workgroup was created and studied three main areas: timing of well-child screenings, content of services, and documentation and reporting issues. The workgroup consisted of representatives from 33 organizations, including the OHCA, other state agencies, provider organizations and health sciences colleges (medical and dental).

After numerous meetings and public hearings, a new periodicity schedule was implemented. Changes included:

- a newborn visit, to be performed in the hospital, was added;
- a one-week visit was added, although it is optional in certain cases;
- the 15-month visit was made optional; and
- visits after the age of 6 years are to be performed during the even years (ages 8, 10, 12, etc.), with visits during the odd years being optional.

A great deal of effort went into the creation and distribution of materials to support the implementation of the new EPSDT periodicity schedule, as well as increase awareness of the need for these important assessments of children's development. New educational and training materials, provider manual, fliers, easy-to-read booklets for parents/guardians (English and Spanish versions), and forms that providers can use for EPSDT visits were created and distributed to providers. The materials are available online at www.okhca.org/providers/childhealthcheckup.

Emergency Room Utilization

The inappropriate utilization of emergency room (ER) services is an ongoing quality of health care issue for Medicaid programs around the country. The OHCA has been tracking ER utilization rates of **SoonerCare** members for about three years and has created interventions to educate members about appropriate ER use.

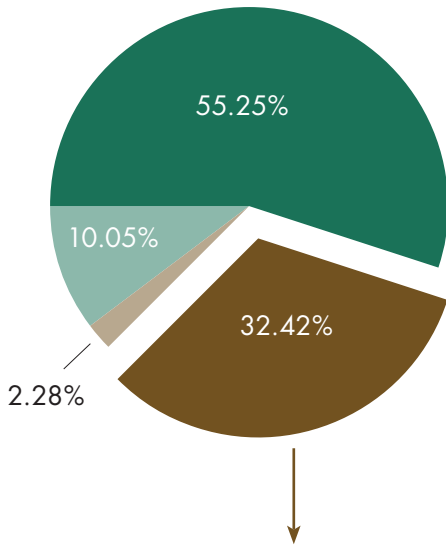
An administrative workgroup was established with participants from Quality Assurance/Improvement, Care Management, Member Services, Provider Services, Data and Reporting, and Medical Management. The workgroup refined the intervention database to capture useful information for monitoring project status, workflow and developing interventions. The administrative workgroup analyzed the data to identify the proportion of children versus adult high utilizers, pharmacy lock-in patterns, ER diagnoses with seasonal fluctuation, provider hospital utilization patterns, primary care provider trends, member aid categories and members with high utilization of medications from drug classifications associated with potential for substance abuse.

Our initial educational outreach, conducted by the Care Management Division, targeted members with six or more ER visits during a three-month period. At the beginning of SFY 2006 we lowered the threshold to five visits per quarter, and then we decreased it to four ER visits per quarter. Lowering the threshold nearly doubled the number of members being called, so we transitioned the responsibility from Care Management to Member Services, a move deemed to be the most appropriate allocation of human resources.

The Member Services staff focused on educating and assisting these members with access to care and coordination of health care services. Here is an example to illustrate the impact of this outreach and education: During the first quarter of SFY 2006, 1,549 members were contacted. Out of this pool of high ER utilizers, 88 percent of them remained in **SoonerCare** during the second quarter; and out of these members, 89 percent had lower ER utilization. This decrease represented 3,379 fewer ER visits than these members made in the first quarter.



CY 2003



Out of all the providers still being tracked whose panels had the highest ER utilization in CY2003, 25% of these providers now are in the lowest ER utilization category.

Chosen to participate in the Quality Improvement and Performance Measurement in Medicaid Care Management Learning Network sponsored by the Agency for Healthcare Research and Quality (AHRQ), the OHCA participated in a series of workshops. We highlighted the successful transition of the responsibility for the first-tier calls to high ER utilizers by Member Services staff during one of these workshops.

Another facet of the ER utilization initiative involves notifying providers about members assigned to their practices with high ER utilization based on an analysis of paid claims and encounters. This outreach to providers also includes information related to the development and implementation of strategies to assist them.

In addition to notifying providers about specific members with high ER utilization, the OHCA sends ER utilization profiles and letters twice a year to many **SoonerCare** Choice Primary Care Providers (PCPs). These letters and profiles show how many office visits and ER visits were made by the members assigned to the PCP. The results are risk-adjusted so that the analysis takes into account the fact that people with more serious illnesses tend to use the ER more often. This method of risk adjustment creates a more level playing field so that comparisons can be made between providers. As we look back at the data from the first profiles sent to providers for calendar year 2003, we have identified the providers whose members had the highest ER utilization rates. Among those providers still being tracked, 25 percent of those providers have reduced their members' ER utilization to the lowest category of usage.

The ER utilization provider profiles have been well-received. This success has prompted the OHCA to create similar profiles on other important services. We expect to provide details of these new profiles in future issues of *Minding Our P's and Q's*.

This program is one of the first in the nation to encompass such a comprehensive approach to reducing inappropriate ER utilization. By educating providers and members, the decreased ER utilization is estimated to have saved approximately \$2 million. In recognition of our success in decreasing inappropriate ER utilization, Governor Brad Henry presented a Quality Team Day Commendation Award to the OHCA.

Best Clinical and Administrative Practices: Native Americans and Diabetes

This year the OHCA completed its participation in a project with the Center for Health Care Strategies (CHCS), a nonprofit organization dedicated to improving the quality and cost effectiveness of publicly financed health care for people with chronic health needs, the elderly, and racially and ethnically diverse populations. Oklahoma was one of 12 participants in the collaborative workgroup on Best Clinical and Administrative Practices (BCAP) from 2004-2006. We targeted specific diabetic screenings (blood tests and eye exams) of American Indians, who represent about 12% of our members. This population tends to have higher prevalence for the disease and we wanted to increase the number of screenings for this population as well as identify best practices used in clinics with high screening rates.

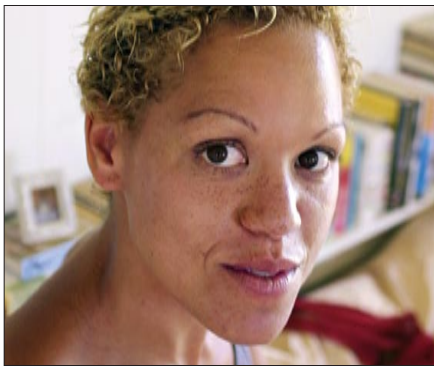
We used claims data to identify 1,020 eligible Native American adults with diabetes and targeted interventions toward this group from January 2005 through September 2005.

Outreach efforts included letters, one-on-one outreach and on-site clinic visits. The letters informed members about the importance of screenings, diabetes management and benefits available to them. Nurses from the Care Management team contacted members to assess why screenings were missed and to help them schedule appointments and obtain transportation for scheduled screenings. We also notified hundreds of providers about screening needs for these members. These outreach efforts resulted in an 18 percent increase in screening rates for members contacted through a phone/letter campaign and 10 percent for those who received letters only.

As a way of identifying the best clinical and administrative practices, we visited high-performing facilities to determine the types of operational procedures that could be applied at the clinic level to improve compliance. BCAP team members interviewed medical teams to assess their day-to-day diabetes care management: how they identify and register patients, how they schedule visits, how they organize care, and the skill level of personnel. The results of those assessments have guided the development of education sessions for low-performing practice sites.



After concluding the BCAP project, we collaborated with the University of Oklahoma (OU) College of Pharmacy and expanded the initiative to include all adults diagnosed with diabetes. Members at high risk for diabetes received direct written and verbal communication from the agency at specified intervals. Although the BCAP project has been completed, we expect to continue to use what we learned from the study as the OHCA implements a Health Management Program. This major addition to the OHCA's efforts to bring quality care to our members is discussed in the *Looking Ahead* section of this report.



QUIT NOW Smoking Cessation

The OHCA's Child Health staff developed and coordinated the mailing of 148,681 fliers to adult members in last quarter of SFY 2006. The flier promoted 1-800-QUIT NOW, also known as the Oklahoma Tobacco Helpline. Prior to the mailing, about 10 percent of calls each month were reported to be from **SoonerCare** members. In the weeks after the fliers were mailed, 40 percent of calls were reported to be from **SoonerCare** members.

Developed by the Tobacco Settlement Endowment Trust, the Oklahoma Tobacco Helpline is a free service for all Oklahomans with a desire to stop smoking or using other tobacco products. Callers receive one-on-one "quit coaching," specialized materials and referrals to community resources. Callers interested in receiving follow-up can enroll in the Helpline's multiple call program, in which they will receive telephone-based coaching sessions with the same "Quit Coach" throughout their quitting process. Participants in the multiple call program also may receive free nicotine patches or gum, or they may be referred to their health insurance plan or health care professional for additional treatment. The Helpline operates every day from 7 a.m. to 11 p.m.

NEW QUALITY INITIATIVES

Many of the new initiatives described in this section involve issues that are crucially important to Oklahomans, including pregnant women, new parents, children who are in foster care or recently have been adopted, and children with serious behavioral health concerns. The following pages summarize efforts to improve perinatal care, help parents of newborns, assure continuity of care to children in foster care or newly adopted homes, and provide appropriate services to children with serious behavioral health issues.

Perinatal Task Force

Through a partnership with the Oklahoma State Department of Health (OSDH), the OHCA's Child Health Unit formed a Perinatal Task Force to study issues concerning pregnant women covered by **SoonerCare** and other public funding sources. The goal of the task force was to determine the issues in which the task force could make a positive difference and to develop programs and plans to target those issues.

Among the stakeholders and organizations involved in the Perinatal Task Force are the OU obstetrics department (Oklahoma City and Tulsa); the Oklahoma State University (OSU) obstetrics department; community agencies and organizations; the American College of Nurse Midwives; and contracted **SoonerCare** obstetric and family practice physicians.

After months of review, surveys and discussions, the task force narrowed its focus to the following four areas of concern:

- High-risk pregnancy: The task force examined the management of high-risk pregnancies, as well as the potential for a separate payment structure for these services.
- Lifestyle risk behavior: Among the many issues that can affect pregnant women are domestic violence, smoking, substance abuse and mental illness.
- Undocumented residents' access to care during pregnancy: The OHCA currently does not pay for prenatal care in this population, but does pay for emergency services, including delivery.
- Alternative pregnancy models of care: "Centering Pregnancy" is one example of alternative pregnancy models of care that the task force examined. This model provides complete prenatal assessment, education and support throughout pregnancy in a group setting.



Based on the input, advice and advocacy provided by this group, the OHCA prepared proposed rules to enhance and improve benefits to pregnant members. More specifically, the OHCA has proposed expanding the number and types of ultrasounds available as medically indicated; and establishing payment for assessment that includes medical and obstetrical risk factors, as well as critical psychosocial risk factors. This group is also evaluating the potential of providing certain dental services for pregnant women due to the possible relationship between periodontal disease and pre-term babies. Offering dental services also will provide an educational opportunity for the mothers in which they can receive information on the importance of taking care of their children's teeth. The Perinatal Task Force will continue meeting and focusing on positive outcomes in the upcoming State Fiscal Year.



Educational Outreach to Parents of Newborns

The **SoonerCare** Program Operations & Benefits Member Services team initiated an educational calling campaign to households with newborns, focusing on PCP alignment and follow-up care for both the mother and the baby. The pilot project in early January 2006 was targeted to 496 households randomly selected from the **SoonerCare** population. Initiated in Child Health, the program later transitioned to the Member Services department. As the pilot program unfolded, we refined the script being used by the OHCA staff members making the phone calls to mothers of newborns. The mothers were asked whether they had chosen a pediatrician, whether they were breast-feeding, whether their baby had seen a doctor since leaving the hospital, and so forth. The Member Services team assists members with obtaining appropriate medical services and, when appropriate, refers members to other sources of assistance. Informal feedback from the mothers indicates that they appreciate the outreach.

In addition to the calling campaign, the OHCA provides the *Healthy Start, Grow Smart* magazine series to all families with newborns. The magazine includes important health and safety information and resources for parents and families. Health information and tips range from breast- and bottle-feeding to check-ups and car seat safety. The magazine also outlines activities designed to stimulate infants' brain development and build skills that children will need once they start school. Ideas are included for fun, age-appropriate activities that center on reading, language and learning.

The OHCA has partnered with the U.S. Department of Health and Human Services to distribute these English and Spanish magazines to Oklahoma **SoonerCare** members with newborn babies. Mothers receive a packet of three magazines each quarter of their baby's first year.

Medical Histories for Foster and Adoptive Children

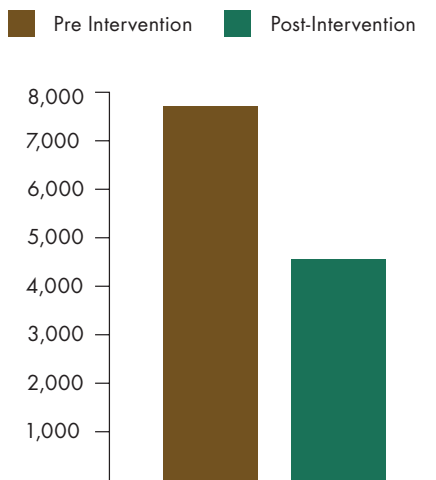
Children in custody situations may move to various placements, which can jeopardize continuity of care and make it difficult for medical professionals to obtain the information they need about the children's medical histories. Through a relationship with the Oklahoma Department of Human Services (OKDHS), the OHCA Child Health Unit is promoting continuity of care for foster and adoptive children in Oklahoma.

The OHCA has begun to provide medical histories to OKDHS for new foster and adoptive parents. Representatives of OKDHS say the OHCA's service has saved them a great deal of time and has given needed medical information to foster parents and adoptive families who are eager to receive it.

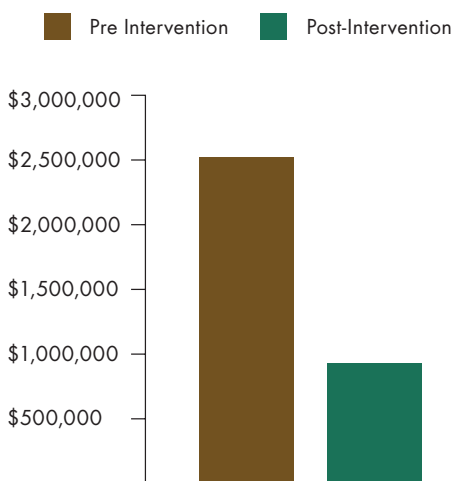
To gather the needed information, the OHCA completes a retrospective review of claims information on custody and adoption-subsidy children. Through an examination of claims data, we determine whether these children have had their required immunizations as well as establish a record of past health care services, including surgeries and mental health treatment. The comprehensive history lists past and current medications, known diagnoses, hospitalizations, the most recent dental visit, and the most recent vision and hearing screenings. This information assists providers in providing the needed well-child examinations. The OHCA sends the information to OKDHS, where the information is entered into the OKDHS Child Welfare computer system and follows the child if a placement changes. When a child is placed with a new foster family, a copy of the medical information is provided to the family for continued coordination of services.



Number of Inpatient Days, Before and After Care Coordination



Paid Claims for Top Utilizers of Inpatient Behavioral Health Services



Care Management and Children’s Inpatient Behavioral Health Services

The OHCA’s Behavioral Health Department conducted a quality improvement study during SFY 2006 to explore how the length of inpatient stays by **SoonerCare** members under the age of 21 years might be impacted by care management.

The study focused on 50 members identified as having the highest use of inpatient behavioral health services (excluding persons in state custody), with 47 members completing the study. Behavioral health care coordinators contacted each member’s guardian/parent and provided follow-up calls as well. A brief clinical history was obtained. We also determined which behavioral health services were already in place. The care coordinator then worked with the family to determine any areas of concern and made referrals as appropriate, including review of medications, psychological testing, therapy and substance abuse services.

If the member was receiving inpatient behavioral health services at the time of initial contact with the family, the care coordinator worked with a contracted external reviewer to ensure adequate discharge planning. The contracted reviewer communicated regularly with the treating facility, which helped members being discharged make appointments for follow-up outpatient care.

An analysis of paid claims indicated that the participants experienced a markedly lower number of inpatient days for behavioral health services. Before the intervention, the sample had 7,607 inpatient days from October 2004 through September 2005. For the period of October 2005 through September 2006, the total number of inpatient days for these members was 4,546, a reduction of 40 percent. We estimate that this reduction

saved \$1.1 million. The intervention also resulted in a greater rate of follow-up care for patients upon discharge, which often is crucial to avoiding readmission.

The positive results of this project led us to add care coordination services to our contract with our external review organization. Now, all members who receive inpatient behavioral health services are provided care coordination services. OHCA Behavioral Health staff members plan to meet weekly with our contracted reviewers to discuss complex cases and make clinical recommendations to assure the most appropriate, least restrictive care is made possible.

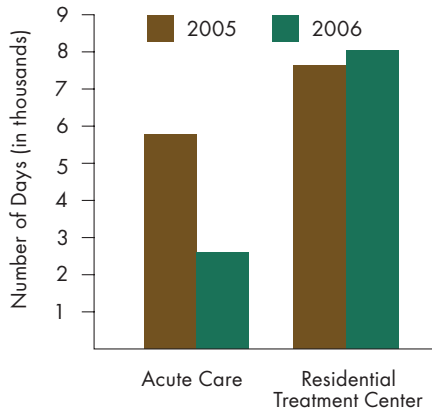
Addressing the Use of Out-of-State Mental Health Providers for Children

In late 2004, the OHCA found it was receiving an increasing number of requests from providers and members for children's behavioral health inpatient treatment outside the State of Oklahoma. These requests seemed to be related to a lack of sufficient treatment beds in the state that would meet the clinical needs of children. Upon investigation with assistance from private providers, stakeholders, the Department of Human Services (DHS), the Oklahoma Foundation for Medical Quality (OFMQ), and independent clinicians and physicians across the state, the OHCA determined that adequate services did not exist for certain specialty mental health services. The collaborative group identified a need for more treatment beds for children with pervasive developmental disorders and reactive attachment disorders, among other mental health diagnoses. Additionally, the need for services for children with both mental retardation and mental health challenges became apparent.

The sheer number of children placed in treatment made this issue a high priority for us. Expenditures for residential treatment exceeded \$31 million annually for both SFY 2005 and 2006. The goal of this initiative became the



Comparison of 2005 & 2006: Number of Inpatient Days According to Treatment Type



development of new and expanded clinical programs within Oklahoma to meet the children's needs and reduce the number of out-of-state placements. In mid-2005, specific job functions were created within the Behavioral Health Division to focus on recruiting providers with the needed specialties. Additionally, we refined the prior authorization and care management processes to ensure children were placed in facilities that specifically met their clinical needs.

Claims data for mental health services for children in **SoonerCare** were analyzed to determine highest priority needs. National provider organizations and behavioral health companies were contacted and invited to collaborate in this effort. Work groups were initiated to develop criteria for these specialty services and further define the expectations to ensure the highest levels of clinical quality.

Out-of-State Behavioral Health Treatment for Children

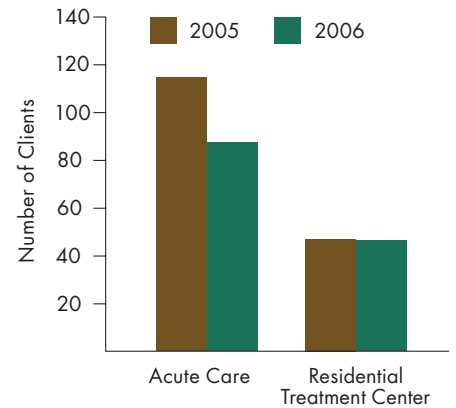
Year	Acute Care			Residential Treatment Centers		
	Client Count*	Covered Days	Paid Amount	Client Count*	Covered Days	Paid Amount
2005	116	5,735	\$2,834,929	47	7,688	\$2,262,424
2006	90	2,644	\$1,249,711	46	8,007	\$2,402,813
Difference (2006-2005)	-26	-3,091	-\$1,585,218	-1	+319	+\$140,389

*unduplicated

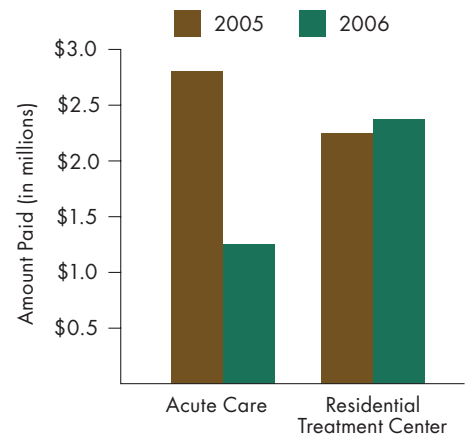
In 2006, three new state-of-the-art specialty programs opened in Tulsa with a total of 32 beds for children with developmental disorders, reactive attachment disorders, or co-existing mental retardation and mental illness. A new provider opened 104 treatment beds for **SoonerCare** children and adolescents, with 12 beds set aside for children with neurobehavioral disorders. Seriously autistic children and children with highly aggressive behavior will have access to an additional 32 beds in a facility that a nationally known provider is constructing in Oklahoma City.

Even before the new beds became available, out-of-state placements for acute care began to decline. The chart shows patient volume and patient days in out-of-state treatment for SFY 2005 and SFY 2006. Out-of-state treatment costs (acute and residential treatment centers) dropped by \$1.4 million in SFY 2006, compared with the previous year. We expect that as these new treatment beds become available, children in **SoonerCare** will have access to clinically appropriate treatment closer to home, with the added benefit of saving taxpayer dollars.

Comparison of 2005 & 2006: Number of Clients According to Treatment Type



Comparison of 2005 & 2006: Costs According to Treatment Type



SOONERCARE UPDATES



The OHCA continually looks for ways of improving our services and programs. This section of *Minding Our P's and Q's* details programs to provide family planning services to men and women; home care for children with physical or mental challenges; tests and treatment for women with breast or cervical cancer; and health care for employees of small businesses in Oklahoma.

SoonerPlan

The SoonerPlan family planning program has been operational since the program's inception in April 2005. Since then, 30,255 men and women have qualified for services, with the vast majority of these members signing up during SFY 2006. Enrollment for June 2006 totaled 21,466 (1,013 men, 20,453 women).

SoonerPlan Highlights

3,062	<i>Calls handled</i>
17,017	<i>Welcome packets mailed</i>
22,523	<i>Office visits</i>
15,136	<i>Enrollees supplied with contraceptive products during office visits</i>
3,126	<i>Enrollees receiving contraceptive products from pharmacies</i>
573	<i>Tubal ligations</i>
166	<i>Vasectomies</i>

An administrative workgroup with representatives from OSDH, OKDHS and the OHCA collaborated on access to care, the provider network, program development and monitoring, and outreach to potential enrollees. During SFY 2006 we conducted outreach to 21,560 individuals whose **SoonerCare** eligibility might be ending to encourage enrollment in SoonerPlan. In addition, a process was developed to assist members desiring services not covered in SoonerPlan.

As part of the Child Health Unit's outreach to new mothers, calls were made in early 2006 to 496 randomly selected members with newborns between four and six weeks of age, with part of the phone call devoted to SoonerPlan. While these calls gave the new mothers an opportunity to obtain answers about any aspect of their **SoonerCare** coverage, many members indicated they were likely to take advantage of SoonerPlan services.

Outreach to providers took a number of forms, including a letter mailed at the beginning of the fiscal year to clarify that any **SoonerCare** provider is eligible to provide services to SoonerPlan members. The network increased nearly 15 percent among private sector providers, from 3,612 to 4,138 participating providers in SFY 2006. The public sector provider network

remains stable, and 12 more federally qualified health centers became SoonerPlan providers. Further, the workgroup established and refined procedures for closing cases of people no longer eligible for the program following sterilization procedures.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

SFY 2006 brought the implementation of a new program to help more children with physical or mental disabilities to receive home care. Oklahoma is one of the states taking advantage of a special federal law allowing Medicaid agencies to offer benefits to children with physical or mental disabilities who cannot obtain other kinds of benefits because of their parent or guardian's income level. This federal law is called the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).



TEFRA provides help to children in the home so that they don't have to be institutionalized if they can be cared for appropriately and affordably at home. Children under 19 years of age who meet the definition of disability used by the Supplemental Security Income (SSI) program and meet an institutional level of care can receive TEFRA assistance if their own income and assets – not a parent or guardian's income and assets – meet criteria. Services include regular EPSDT screenings, dental care, emergency and non-emergency transportation, physical or occupational therapy, medications and other services available to **SoonerCare** members.

In addition, children in the TEFRA program receive assistance from a registered nurse who works as an exceptional needs coordinator in the Care Management Unit, which helps to link children with an appropriate primary care provider and other services.

Starting in January 2005, a new tax on tobacco funded Oklahoma's TEFRA program and the program has grown steadily since it began enrolling members in the fall of 2005. By the end of SFY 2006, the TEFRA program had 80 children receiving services.

Oklahoma Cares Highlights

- 17,964 *Successful calls completed to Oklahoma Cares members*
- 290 *Enrollment calls from Member Services to Oklahoma Cares women confirmed with cancer*
- 2,945 *Incoming Oklahoma Cares calls*

Oklahoma Cares

Like many state programs involving the OHCA, the Oklahoma Cares Breast and Cervical Cancer Treatment Program is an interagency collaboration. Working with representatives from OSDH, OKDHS, the Kaw Nation of Oklahoma and the Cherokee Nation, we help women obtain access to care and screening related to these two kinds of cancer.

Oklahoma Cares was implemented in January 2005. During SFY 2006, the OHCA received 4,776 members into Care Management through the Oklahoma Cares program. Almost 92% of these women received a negative diagnosis following further diagnostic tests provided through the program. Out of the 385 women identified with cancerous or precancerous conditions, 303 had breast cancer, 75 had cervical cancer, and 7 had both breast and cervical cancer. As of the end of SFY 2006, a total of 2,831 women were enrolled in Oklahoma Cares.

To keep members from falling out of eligibility, the OHCA and OKDHS began a new outreach initiative to help assure continuity of care for women in Oklahoma Cares. OKDHS generates a list of women who have not returned paperwork. OHCA's Member Services calls these women to remind them to complete their renewal applications. This proactive approach has resulted in assuring continuous care for dozens of women with cancer.

Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)

The OHCA is pleased to administer a new program to help small businesses and self-employed Oklahomans obtain health care. The Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) began November 1, 2005, and operates under the **SoonerCare** umbrella. O-EPIC consists of two branches: small business and individual plans. By the end of state fiscal year 2006, only the small business branch had been established and 420 businesses with 25 or fewer employees had been approved for the program. A total of 762 employees and spouses were approved for coverage under O-EPIC by the end of SFY 2006, and \$167,013 in premium assistance had been paid. We will be tracking the success of this program as it grows over the next few years.



STUDY RESULTS

The OHCA's continuous quality efforts are supported by studies of OHCA programs and services. Often these studies provide insight into opportunities for future quality initiatives or new programs, while also serving as a measurement of success and effectiveness for past and present programs. Important studies from SFY 2006 addressed issues related to ER utilization, prenatal care, EPSDT screenings, diabetes and behavioral health.

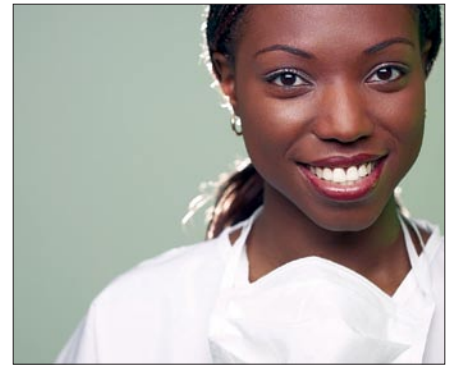
How Our Research is Conducted

When a provider submits a claim to the OHCA for payment, or when a PCP reports an encounter with a **SoonerCare** member, the information becomes part of a large and complex database of information. Much of our research involves data from these claims and encounters. We can analyze data from thousands of members for different time periods, specifying various diagnoses or age groups, depending on the questions we are trying to answer. The studies described in this section emerged from careful examination of patterns in the claims and encounter data.

Prenatal Care

The OHCA and OFMQ collaborated on a baseline study of factors associated with increased risk for delivery of low birth weight (LBW) or very low birth weight (VLBW) infants. The results of this baseline study are helping us understand the variables related to the incidence of LBW and VLBW infants in Oklahoma and will help us create initiatives to decrease these risks.

The study involved data from 7,757 births between April 1, 2004, and September 30, 2004. Many maternal demographic factors were examined in connection with LBW or VLBW infants, including age at the time of delivery, race, ethnicity, kind of program eligibility, education and tobacco use. Multivariate analyses considered whether each of these factors remained significantly related to birth weight when controlling for the other demographic variables. The study showed that babies with less than normal birth weight were more likely to be female and born before the 38th week of gestation. Additionally, mothers of these infants were more likely to be African American, have less than a high school education and use tobacco.



The data showed that almost 96% of normal-weight babies received some prenatal care. This figure was lower for LBW infants (91%) and VLBW infants (85%). The study cautioned, however, that many of the lowest-weight babies were premature, reducing the opportunities for the mothers to obtain prenatal services. For the mothers who received prenatal care, birth weight was unrelated to the trimester that the prenatal care occurred. Results from this study demonstrate that some prenatal care, regardless of when it began, promotes the birth of infants of normal weight.

As mentioned above, these findings will serve as a baseline for subsequent studies on birth weight. The results also have helped us develop ideas for interventions, such as those being discussed by the new Perinatal Task Force, described in this report under *New Quality Initiatives*.



Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

An important element of childhood health care is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) exam. The OHCA and OFMQ conducted a remeasurement study patterned after the HEDIS® methodology to assess the rate of EPSDT exams provided to **SoonerCare** members under the age of 21 years. The study looked at the rates of well-child visits in four age groups: birth to 15 months, ages 3-6 years, 7-11 years and the adolescent years. For purposes of this study, we counted a visit with a provider as an EPSDT examination if it included the following elements: a comprehensive health and developmental history, a comprehensive unclothed physical examination, and anticipatory guidance/health education.

A combination of claims data and medical records from providers was used in the data analysis. Compliance rates for the 0 to 15 months age group increased significantly when the claims data were used in conjunction with results obtained through medical chart review. For all other age groups, medical chart review did not significantly increase the number of exams counted.

In addition to the screening rates, we wanted to find out whether children were seeing doctors on occasions when an EPSDT exam could have been conducted, but was not. Data analysis revealed multiple missed opportunities. Review of medical charts indicated that some visits included one or two components of an EPSDT exam, but not all three elements that we used as criteria to count as an EPSDT visit.

The OHCA is conducting follow-up studies to compare EPSDT rates across time. In addition, we are planning to give EPSDT providers feedback about their practice in the form of provider profiles, similar to those used in the ER utilization study, with the goal of improving statewide rates of EPSDT exams.

Behavioral Health and Medical Conditions

Quality improvement initiatives often begin with an analysis of claims data. Such is the case with a study we conducted with OFMQ on the co-occurrence of depression and certain medical conditions. This baseline study examined data on **SoonerCare** Choice members to determine which physical ailments most commonly were related with depression.

The study involved data from 2,732 **SoonerCare** Choice members with claims paid between July 1, 2004, and June 30, 2005. Members were included in the sample if they had a primary diagnosis of one of several behavioral health issues, such as depression, anxiety, schizophrenia, or personality disorders. Members also had to have claims during the same year with a primary diagnosis of cancer, lung disease, HIV, cardiovascular disease, diabetes, gastrointestinal disorders, skin infections, or hepatitis.

We found that for most of the physical conditions, adults were less likely to be seen in a behavioral health setting. The exception was diabetes; these members were more likely to be seen in a behavioral health setting versus a medical setting. Children with the co-occurrence of mental illness and lung disease were more likely to be seen in a behavioral health setting, while children with any of the other physical conditions along with a mental health diagnosis were more likely to be seen in a medical setting. These results indicate that medical care providers may need to be alert to co-existing mental health issues.



Depression was significantly more likely to be diagnosed in adult patients with cancer, lung disease, or gastrointestinal disorders, compared with adults without these conditions. (People with HIV were excluded from the analysis because of insufficient numbers.) When each demographic factor was considered in a multivariate analysis, controlling for all other demographic variables, depression was significantly related to the patient being female, having lung disease, or having a gastrointestinal disorder. Among children, gastrointestinal disorders were related with depression.

This study will provide a basis of comparison as we track the co-occurrence of physical and mental illness. Among other things, we are considering the use of predictive modeling to identify those at high risk for depression. The information from this study also will help us provide education to **SoonerCare** members and providers about the diagnosis, treatment and management of such co-morbid conditions.

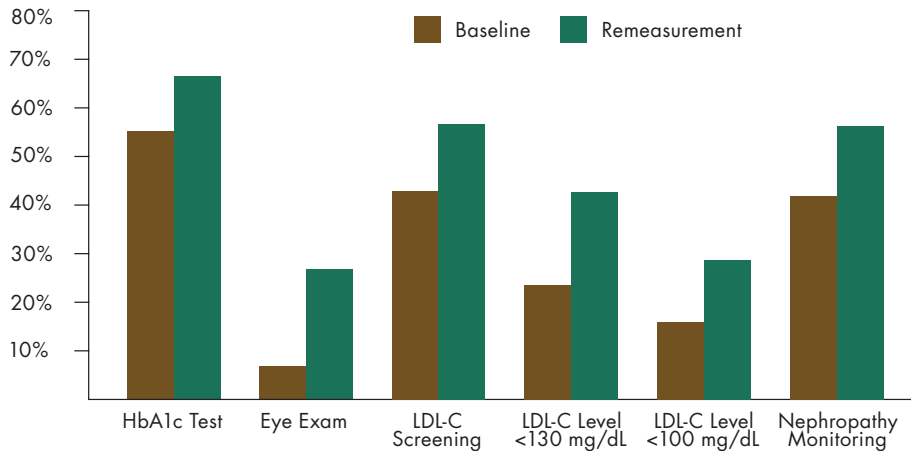


Diabetes Study

Diabetes is an ongoing concern for Oklahomans, contributing to heart attacks, strokes, kidney failure and a number of other problems. Various organizations have ranked the state anywhere from 11th to 15th in the nation in terms of the number of deaths related to this disease. The impact of diabetes on **SoonerCare** members is important to the OHCA, which collaborated with OFMQ on a remeasurement study patterned after the HEDIS® methodology. The study included seven diabetes measures, with the results being compared with findings from the baseline study, conducted the previous year.

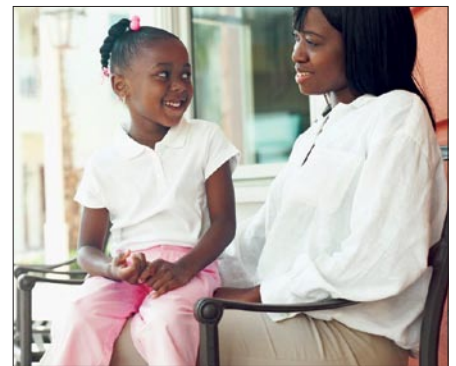
The study involved data from calendar year 2004 for 453 members with diabetes. Data were extracted from claims paid by the OHCA, and medical records were examined to determine whether certain test results were within normal levels. Significant improvement was found on all but one measure. According to the data analysis, 67.8 percent of the participants

Significant Improvements on Six Diabetes Measures



had received at least one HbA1c test in the measurement year, a significant improvement over the baseline year. Retinal eye exams were given to 27.8 percent of participants, a large increase from the baseline figure of 7.1 percent. Cholesterol testing rates improved significantly, as did the observed cholesterol readings. The only measure on which a significant improvement was absent was the percentage of members with poorly controlled HbA1c levels, which was statistically indistinguishable from the baseline rate.

Non-experimental research like this study cannot tell us why improvements occur at a given point in time. It is hoped that interventions such as the outreach to Native Americans with diabetes, which then was widened to include all Oklahomans, may be having an impact. The next issue of this quality report will contain results from the third year of this ongoing study, which is providing valuable information for the OHCA as we work toward the implementation of the Health Management Program.





Emergency Room (ER) Utilization Study

Emergency rooms (ER) are sometimes the source of health care for conditions that may not be emergencies. Because the OHCA is responsible for making sure taxpayer funds are used appropriately and efficiently, we have been tracking ER utilization by **SoonerCare** members. During SFY 2006 we partnered with OFMQ on the second installment of an ongoing study of ER utilization. This study accompanies the provider profiles, member outreach and other activities discussed in the Updates on Quality Initiatives section of this report.

The study examined paid claims for ER services rendered between July 2005 and March 2006, with the results being compared with those from a baseline study for the same period one year earlier. The follow-up study found at least one ER visit by 30.5 percent of the 661,885 unduplicated **SoonerCare** program members with at least one month of eligibility during the study period. This rate was comparable to the baseline study's results.

The most common categories of diagnoses were respiratory problems (19.2 percent of claims) and injury/poisoning (19 percent of claims). This result also was similar to the baseline study. The overall ER utilization rate was 76 visits per 1,000 member months. As a group, adults had a higher ER utilization rate than children and females used the ER more frequently than males. Among racial/ethnic groups, Caucasians had the highest ER utilization rate, while Asians had the lowest rate.

Assessing the medical urgency of an ER visit via examination of claims data is difficult. Some of the procedure codes used on ER claims do indicate greater urgency. Just over half of the claims had a code suggesting moderate to severe medical urgency. Without examination of medical records, however, inferences about the choice to use the ER for less urgent treatment must be made cautiously.

This study has pointed out the need for a better way of exploring whether ER claims involve health concerns that could be treated more appropriately by a PCP, versus claims for true emergencies. The next issue of *Minding Our P's and Q's* will describe the third year of this ongoing study, in which APS Healthcare Inc. will employ an innovative statistical algorithm for identifying emergent and non-emergent cases.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Experience of Care and Health Outcomes (ECHO®) Consumer Surveys

Monitoring the quality of health care services includes consumer satisfaction; therefore members of **SoonerCare** Choice are polled annually using nationally recognized surveys. Each year, one study addresses the experience of adults, while a second survey focuses on children. The Agency for Healthcare Research and Quality (AHRQ) created the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), a family of standardized questionnaires that asks consumers about their experiences with health care services. The Experience of Care and Health Outcomes (ECHO®) survey focuses on consumers' use of behavioral health services. This issue of *Minding Our P's and Q's* reports on the CAHPS® survey on adults and the ECHO® survey on children.

The CAHPS® survey sheds light on a number of aspects of consumer satisfaction, including access to care, timeliness of receiving care, communication with providers, the health plan's customer service, satisfaction with PCPs and specialists, and overall satisfaction with health care.

The most recent CAHPS® study involved adults continuously enrolled in **SoonerCare** Choice for the six months leading up to SFY 2006. An external consultant randomly sampled 880 adult members and made multiple attempts via mailings and telephone calls to obtain their participation. Data were collected from 357 members, or about 41 percent of the random sample, which is a typical response rate for this kind of survey.





Because these surveys are administered repeatedly over time, we can make some comparisons with the previous administration of the adult survey in 2003. The results showed that 69 percent of members who needed care right away were able to receive care always or usually as soon as they wanted, a decline from the previous survey's result of 75.3 percent. The study indicated that 57.4 percent of members who needed care right away received access to care within a day, a figure that was not significantly different from the previous survey's result.

When members were asked to rate their personal doctor or nurse on a scale of 0 (worst) to 10 (best), 77 percent gave ratings of 7 or higher, and more than half of respondents gave a rating of 9 or 10. These results are comparable to the 2003 survey's results. When asked to rate specialists on the same scale, 72.7 percent of members rated their specialist a 7 or higher, with half of the ratings being a 9 or 10, another comparable result to the 2003 survey.

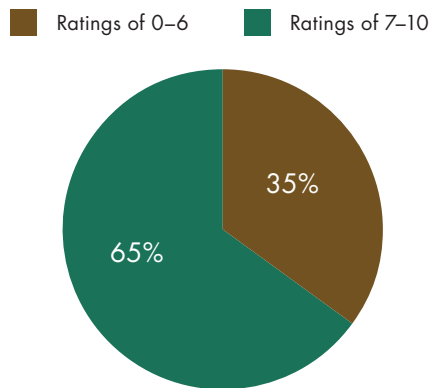
When rating overall satisfaction with the health plan (0 = worst, 10 = best), 65 percent of members gave a rating of 7 or higher to **SoonerCare** Choice. In terms of overall health care, 69 percent responded with a rating of 7 or higher. Getting the care they needed was categorized as no problem or a small problem by 80 percent of members, and 65 percent said they usually or always received care quickly. A total of 80 percent said their doctors always or usually communicated well, and 82 percent said office staff were always or usually courteous, respectful and helpful. Finally, in their experience with **SoonerCare** Choice health plan information, customer service and paperwork, 83 percent of members said they had no problem or a small problem.

The ECHO® survey about children’s experiences of behavioral health care involved a random sample of 1,183 children with continuous eligibility in the months leading up to SFY 2006. An external consultant made numerous attempts via mailings and telephone calls to contact the parents/guardians of each child. Answers were received for 438 children, with an overall 37 percent response rate. Nearly 84% of those surveyed said the clinicians always or usually communicated well. Regarding treatment and information from **SoonerCare**, the survey showed 84.7 percent had no problem or a small problem.

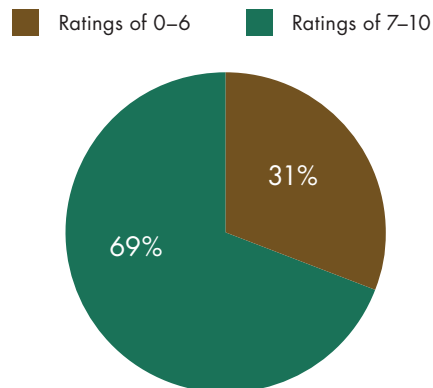
The results of these surveys allow the OHCA to track performance from year to year and we study these results as we plan additional quality improvement efforts.

The following charts display the ratings of the health plan, health care and primary care providers.

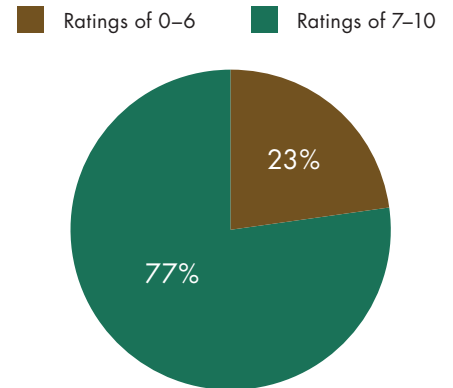
Overall Rating of Health Plan



Overall Rating of Health Care



Overall Rating of Personal Doctor or Nurse





Health Plan Employer Data and Information Set (HEDIS®) Trend Report

The Health Plan Employer Data and Information Set (HEDIS®) is a tool used by most American health plans to measure performance on important dimensions of care and service. The OHCA annually completes a review of HEDIS® measures using administrative (paid claim/encounter) data to determine areas for improvement and monitor effectiveness of performance improvement initiatives. The latest data pertaining to SFY 2006 were collected in CY 2005 and are shown in the last column of the table on the next page. These results have allowed us to track performance across time, a practice we plan to continue.

Performance Tracking Across Time: HEDIS® Results

OHCA Administrative Data	SoonerCare Choice				
	2001 Data	2002 Data	2003 Data	2004 Data	2005 Data
Annual Dental Visit (Combined rate <21 years)	41.6%	46.6%	51.2%	53.6%	56.6%
Cervical Cancer Screening	N/A	N/A	32.6%	34.5%	43.5%
Breast Cancer Screening	N/A	N/A	29.8%	29.8%	31.9%
Well Child Visits					
Well child visits in first 15 mos (1 or more visits)	87.6%	91.4%	92.6%	91.6%	95.2%
Well child visits 3–6 yrs (1 or more visits)	35.3%	40.1%	47.3%	48.6%	54.7%
Well child visits adolescent (1 or more visits)	N/A	N/A	23.7%	23.8%	25.9%
Children's Access to PCP					
12–24 months	88.1%	89.5%	90.8%	91.4%	91.2%
25 months–6 yrs	74.1%	77.0%	79.3%	78.2%	78.0%
7–11 yrs	76.7%	79.0%	79.2%	77.3%	81.2%
12–19 yrs	N/A	N/A	77.4%	77.0%	81.1%
Adult Access to Preventive/Ambulatory Health Services					
20–44 yrs	68.4%	68.8%	69.8%	71.6%	72.0%
45–64 yrs	80.3%	81.5%	81.3%	81.8%	82.8%
Comprehensive Diabetes Care					
HbA1C Screening	N/A	N/A	44.4%	49.2%	64.1%
LDL-C Screening	N/A	N/A	34.7%	39.4%	43.9%
Eye Exam Screening for diabetic retinopathy	N/A	N/A	14.1%	20.7%	27.7%
Nephropathy Screening (for evidence of nephropathy)	N/A	N/A	40.9%	45.3%	49.9%
Appropriate Medications for the Treatment of Asthma					
Age Group 5–9 yrs	N/A	N/A	72.1%	73.9%	93.7%
Age Group 10–17 yrs	N/A	N/A	65.7%	64.2%	88.3%
Age Group 18–56 yrs	N/A	N/A	44.7%	48.6%	64.2%



Quality Improvement System for Managed Care

As a primary care case management (PCCM) program, **SoonerCare** Choice's goal is to enhance the quality, continuity and access of care received by members. We report regularly to the federal Centers for Medicare and Medicaid Services (CMS), which has developed a set of standards to promote the assessment and improvement of quality in programs like **SoonerCare** Choice. These standards are called the Quality Improvement System for Managed Care (QISMC). The OHCA adopted QISMC to help protect and improve the health and satisfaction of its enrollees.

QISMC assesses four domains:

- Quality Assessment and Performance Improvement (QAPI) program: The managed care system is required to meet certain levels of performance; conduct performance improvement projects that are outcome-oriented and achieve demonstrable, sustained improvement in care and services; and take timely action to correct systemic problems that are identified via internal surveillance, complaints, or other mechanisms.
- Enrollee rights: The organization must articulate enrollees' rights, promote the exercise of those rights, and ensure that its staff and affiliated providers are familiar with enrollee rights.
- Health services management: **SoonerCare** Choice is responsible for assuring the availability and accessibility of care; continuity and coordination of care; service authorization; practice guidelines and new technology; provider qualifications and selection; and member health records and communication of clinical information.
- Delegation: **SoonerCare** Choice oversees and is accountable for any functions or responsibilities that are delegated to other entities.

On each of the four domains, a score from 0 (no compliance) to 1.0 (complete compliance) is given. We received scores of 1.0 on all domains except for health services management, for which we received a score of 0.99.

ONGOING QUALITY REVIEWS

The OHCA employs nurses and an outside contractor to conduct routine reviews of medical records and reports of potential quality issues. The following section describes our methods of routinely checking for quality service to our members and investigating reports of possible problems.

Medical Record Review

Each month a sample of medical records from hospital stays is reviewed by an independent medical review organization. These cases are reviewed to ensure that the quality of care meets recognized professional standards of care and that services are medically necessary and appropriate.

During the SFY 2006, Oklahoma Foundation for Medical Quality (OFMQ) was the external quality review organization contracted to complete this work. OFMQ randomly selected a total of 10,800 cases (900 cases per month) for retrospective review. Each monthly sample included both acute medical/surgical cases and psychiatric cases.

Whenever this medical record review process confirms cases in which the quality of care was below recognized standards of practice, we will forward them to the Medical Education and Intervention Committee (MEIC) for review and evaluation. In some cases, we first may monitor and profile the cases for emergence of patterns before forwarding them to the MEIC. This committee is comprised of actively practicing physicians representing various disciplines from both urban and rural areas across Oklahoma. The committee composition is customized according to the nature of the issue. Committee members who practice in the same area of specialty and/or setting as the provider being reviewed are included to provide a peer perspective.





Quality of Care Review

On an ongoing basis, the Quality Assurance/Improvement (QA/I) Department at the OHCA investigates potential quality of care issues that are referred into the department. These referrals may be initiated from **SoonerCare** members, providers or stakeholders. Department staff members conduct a first-level review of each referral and complete the follow-up, trending and analysis of data according to departmental and agency procedures. Cases requiring follow-up are referred to an independent medical review agent for peer review and follow-up of identified issues.

In addition to individual case review, QA/I staff conduct on-site reviews of contracted **SoonerCare** Choice providers. Using standardized audit tools and scoring, the reviews are completed by the unit's compliance analysts and review nurses. During SFY 2006, staff members completed 227 on-site reviews. These reviews impact hundreds of providers and thousands of members. In addition to the review, we provide education about the **SoonerCare** program and OHCA rules, and we make referrals to other OHCA departments as needed. Our goal is to assure that quality health care services are provided through the one-on-one collaboration with contracted providers. What providers may not know, however, is that they help improve the overall quality of services offered by the OHCA and other **SoonerCare** Choice providers. Oftentimes, good ideas come from our providers. These "best practices" are then shared with other **SoonerCare** Choice providers as examples to implement within their practices as desired. This ongoing communication with our providers increases the quality of the **SoonerCare** program, and we look forward to continuing to foster these mutually beneficial relationships in the future.

LOOKING AHEAD

A quality report like *Minding Our P's and Q's* provides the OHCA with the chance to share our progress and accomplishments from the previous fiscal year. But we also take this opportunity to look ahead, and we would like to share news about three programs that we expect to feature in future issues of this report.

Health Management Program

On June 9, 2006, Governor Brad Henry signed legislation for the creation of a disease management program for **SoonerCare** members. This program's focus will be prevention and health management to help **SoonerCare** members maintain or improve their health. As we described in this report, we expanded our outreach from Native Americans with diabetes to all **SoonerCare** members with this disease. The Health Management Program represents the next step: treating the whole person, not just a person's specific disease. The goal is to assist members with one or more serious conditions that can become life-threatening. We expect the next issue of *Minding Our P's and Q's* to report on the implementation of this program.



“The Money Follows the Person”

The OHCA recently was awarded a \$50 million grant for a program titled, “The Money Follows the Person.” This program is intended to help senior citizens and individuals with disabilities take advantage of home-based and community-based services, allowing them to remain in their own homes instead of nursing homes or long-term care facilities. The grant will help the OHCA and the OKDHS to develop a system to provide the elderly and people with disabilities with choices about where they will receive health care and other assistance. We look forward to including more information about this new program in our next issue.

Expanding O-EPIC

This program for assisting small businesses and self-employed Oklahomans obtain health care recently expanded to include larger companies. With the potential of affecting thousands of Oklahomans over the next several years, the growth of O-EPIC is expected to continue to attract media attention. We will be tracking the program's progress and reporting on its growth in future issues of *Minding Our P's and Q's*.

This report is an initiative of the Oklahoma Health Care Authority (www.okhca.org) and APS Healthcare (www.apshealthcare.com).

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