



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

The OHCA SFY 2007 Performance and Quality Report

*July 2006 – June 2007*





STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY

April 2008

Thank you for your continued interest in the Oklahoma Health Care Authority's annual performance and quality report, *Minding Our P's and Q's*. Providing health care services for hundreds of thousands of **SoonerCare** members every year is a huge responsibility, and we embrace this challenge with the determination to ensure access to quality care in a cost-effective manner.

In addition to regularly scheduled quality assurance efforts, the agency pursues a large number of initiatives designed to improve the services provided. Many of these initiatives are collaborative efforts with stakeholders in other agencies and communities throughout Oklahoma. This year's quality report is filled with examples of such collaboration, including:

- the Perinatal Advisory Task Force, a partnership with the Oklahoma State Department of Health (OSDH) and representatives from several medical and community organizations. We have implemented many suggestions from this task force, including the Perinatal Dental Program and additional obstetrical benefits for members in need of specialized support and treatment services.
- the Child Health Advisory Task Force, another partnership with OSDH with representatives from medical and community organizations. This task force has identified a list of priorities, including utilization of primary care, mental health services for children and childhood obesity.
- **SoonerCare** Tribal Consultation, which involves leaders from Oklahoma's Native American tribes to gain their insight and advice on how our policies and programs impact members who receive services through tribal, Indian urban, and Indian Health Service facilities. Their input will help us improve our programs and move forward with strategic planning and policy development.
- "Oklahoma Cares" Breast and Cervical Cancer Treatment Program, which involves OSDH, the Oklahoma Department of Human Services (DHS), the Kaw Nation and the Cherokee Nation. During state fiscal year 2007, we surpassed the milestone of 10,000 women served by this program.
- Oklahoma Long-Term Living Choice. This program involves a long list of collaborators, with the goal of helping people exercise their options related to home- and community-based care.

Navigating the health care system is daunting for anyone, and we hope these collaborations will help **SoonerCare** members obtain access to services, which are spread out among many agencies and organizations. As you will see throughout this report, the Oklahoma Health Care Authority benefits from our many partners, providers 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  
State Medicaid Director

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# OUR MISSION & VISION



The Oklahoma Health Care Authority (OHCA) serves as Oklahoma's single agency administering the state's Medicaid program, known as **SoonerCare**. 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.

The Quality Assurance and Improvement (QA/I) Department has adopted a **departmental objective**, with greater detail on the work related to the quality initiatives described in this report:

We are dedicated to ensuring access to care and continuity of services; and evaluating and improving the quality of services for **SoonerCare** members. We promote partnerships with providers, helping them to implement best practices for serving our members. Departmental staff members research and develop innovative ways of improving health care delivery and provide support and direction for all departments within the agency. In addition, we promote proper reimbursement of services through provider education, through ongoing research of coding principles and national policy, and through manual claim review. QA/I is a leader in system policy development and safeguards the integrity of the billing system affecting all members and providers.

As a way of taking stock of our work, we are pleased to present the Performance and Quality Report, *Minding Our P's and Q's*, for State Fiscal Year 2007 (July 2006 through June 2007).

This report 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. In recognition of the celebration of Oklahoma's centennial of statehood, the theme of this year's annual report is "Pioneering Health Care Coverage." We hope this quality report will provide readers with a look at the ways we are pioneering to improve health care services for Oklahomans.

# SFY 2007 OVERVIEW

*Minding Our P's and Q's* is divided into several sections. Here is a quick glance at the topics you will find in each section.

## Updates on Quality Initiatives

- We have expanded our outreach to parents of newborns. The goal is to ensure that newborns are aligned with an accessible and appropriate PCP, while informing parents about Child Health Checkups and helping them navigate the health care system.
- Our rates of Child Health Checkups have increased steadily over three years, and we have launched a pilot program to improve the number and quality of these screenings.
- The Perinatal Advisory Task Force's recommendations have led to expanded benefits for pregnant **SoonerCare** members. Among the expanded benefits are the Perinatal Dental Access Program, Lactation Consultant services, Maternal and Infant Health Social Work services, Genetic Counseling, and Prenatal Risk Assessment.
- We added more outreach and educational efforts to reduce the number of members using emergency room services for non-urgent treatment, resulting in thousands of members receiving intervention and millions of dollars in avoided ER costs.
- A mass mailing informed about 180,000 **SoonerCare** members about services available to help them quit smoking.
- A quality initiative to search our claims data and put together medical histories for foster and adoptive children now has become part of our regular work to ensure continuity of care.
- A pilot study on providing care management for children after an in-patient behavioral health stay has become a broader initiative.
- The number of providers of inpatient behavioral health services for members under age 21 has been increased, resulting in a decrease in the use of out-of-state mental health providers.





### New Quality Initiatives

- In collaboration with the Oklahoma State Department of Health and a number of other organizations, we are participating in a Child Health Advisory Task Force, which has set a priority list for issues to be tackled.
- A new Medical Advisory Task Force consisting of 12 physician members also is advising the OHCA on medical issues and recommending program and policy changes.
- We have launched a formal program of consulting Native American tribes on **SoonerCare** issues, such as program development, strategic planning and legislation.
- We have instituted a program of care management as part of expanded benefits for expectant mothers identified as having a high-risk pregnancy.
- The agency participated in a national non-profit organization's initiative to implement a Return on Investment Calculator, which will help us develop more realistic predictions of costs and savings.
- Special analyses of pharmacy data are helping us identify possible quality concerns related to prescribers, pharmacies and members.

### SoonerCare Program Updates

- Oklahoma Cares, the Breast and Cervical Cancer Treatment Program, has passed a milestone of 10,000 women served.
- The SoonerPlan family planning program increased its outreach activities.
- Insure Oklahoma, also known as the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC), expanded to make health insurance premium assistance available to more Oklahomans.
- A program to help children with physical or mental disabilities who cannot obtain other kinds of benefits because of their parent or guardian's income level reached an all-time high in the number of people served.
- The Health Management Program geared up for implementation, with a contract being awarded to a company to provide care management for members with chronic conditions.

- We launched a program for rewarding nursing facilities that demonstrate improvement on a wide range of quality measures – the first program of its kind in the nation.
- A federal grant is supporting a wide-ranging collaboration between the OHCA and other stakeholders to help members receive services in their communities so that they might avoid having to move into institutions to receive services.

### Study Results

This section will summarize the results of studies involving a number of topics:

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT, or Child Health Checkups)
- Prenatal care and outcomes
- Comprehensive diabetes care
- Medical management of depression
- Emergency room utilization



### Meeting Standards, Tracking Change

This section will summarize an external review of our quality assurance efforts, our performance on nationally recognized measures of quality and the results of two consumer satisfaction surveys.

### Ongoing Quality Reviews

In addition to new initiatives, we conduct quality reviews as part of our regular work. This section will explain our programs of on-site provider reviews, outreach to providers about access to care, dental provider audits, medical record review and quality of care reviews.

### Looking Ahead

At the end of the report, we will look ahead to programs that we expect to feature in SFY 2008's *Minding Our P's and Q's*, including provider profiles on Child Health Checkups and Women's Cancer Screenings.



Quality assurance and improvement are continuous activities at the OHCA. In this section of the report, we will provide an update on several programs that began in previous fiscal years and continued in SFY 2007. As you will see, many of these programs are aimed at improving the health of children and the services they receive, while other programs are aimed mostly at adult members.

### **Educational Outreach to Parents of Newborns**

A top priority at the OHCA is ensuring access to care, especially for our youngest members. A successful pilot program for reaching out to the families of newborns was expanded during State Fiscal Year (SFY) 2007 to include all newborns covered by **SoonerCare**. The Educational Outreach to Parents of Newborns Program works to ensure that newborns are aligned with an accessible and appropriate PCP, while informing parents about the importance of Child Health Checkups and helping them navigate the health care system.

During SFY 2007 we made phone calls to 17,649 households, reaching 4,404 parents. Each household received a letter, either thanking them for talking with us by phone or, in the case of those we could not reach, explaining why we had tried to reach them and giving them our phone number. Parents who were contacted by phone provided us with information about their experience with PCP selection, appointments with the PCP and feeding method. These phone calls also allow us to give parents information about services available to the family and to let them ask questions about their concerns as parents of a newborn.

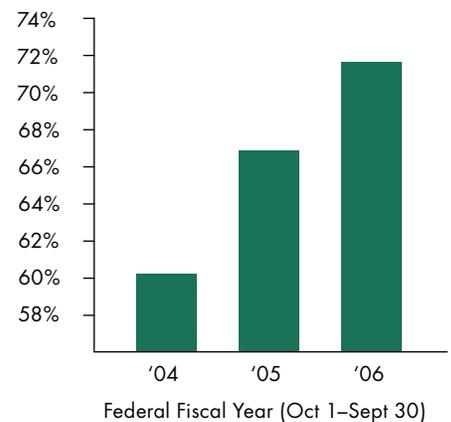
This program was launched in early 2006 as a small pilot project, but during SFY 2007 we expanded the program so that we were contacting all households identified with newborns born in the previous month. The two-month pilot program involved 496 randomly selected parents of newborns; the expanded program places calls to more than twice that number of parents per month.

As we track information about these youngest **SoonerCare** members and their parents, we hope to be able to target future interventions based on information we gather about PCP alignment, referrals, parents' primary languages and parents' satisfaction with the telephone outreach.

## Child Health Checkups

For a number of years the OHCA has had an ongoing focus on improving our rates of Child Health Checkups (also known as Early and Periodic Screening, Diagnosis and Treatment, or EPSDT, exams). A recent analysis revealed that the rates of Child Health Checkups have increased steadily across the three most recent federal fiscal years (FFY). (The FFY, Oct. 1 to Sept. 30, is the review period required for our reports to the Centers for Medicare and Medicaid Services, or CMS.) The number of Child Health Checkups performed in FFY 2006 reached 71.8 percent of the expected number of screens, an increase of more than 10 percent in two years. The rates were 66.9 percent in FFY 2005 and 60.3 percent in FFY 2004. Infants (under 1 year of age) had the highest screening rate, while adolescents had the lowest rates. Yet even those least likely to obtain Child Health Checkups – members ages 15 to 18 years old – have had an increase in rates, from about 31 percent in FFY 2004 to 40.2 percent in FFY 2006.

Percentage of Expected EPSDT Exams Completed



We also are emphasizing the quality of Child Health Checkups. During SFY 2007 we contracted with the University of Oklahoma Health Sciences Center (OUHSC) to help us evaluate and possibly implement a program of supporting practice facilitators (PF) who would help providers make changes in their processes of care. This pilot program began as a local initiative. The Canadian County Sooner SUCCESS Coalition formed a workgroup to look at access to health care. The coalition identified a small amount of money that could be used to match Medicaid funds. Because of this local initiative, the OHCA decided to contract with the OUHSC to conduct our PF pilot program in Canadian County.

Three PFs working in Canadian County had masters-level education and experience in primary health care settings as well as training in practice facilitation. In addition, one part-time case manager was assigned to the project. Five practices were participating at the end of SFY 2007. Each practice agreed to generate patient lists for the PF to perform chart reviews for quality and quantity of Child Health Checkups. The providers also met with the PF once weekly to discuss any necessary changes in care processes.

The Child Health staff is reviewing the results of an evaluation of this project for potential usefulness across Oklahoma. In our next quality report we plan to report on a recent expansion of the program into Garfield County.



### Perinatal Advisory Task Force

Benefits for pregnant **SoonerCare** members have been expanded in response to recommendations from the Perinatal Advisory Task Force (PATF), a collaborative effort between the OHCA and the Oklahoma State Department of Health (OSDH).

Members of the PATF represent many stakeholders – university obstetrics departments, professional organizations, medical professionals, and community organizations. Created two years ago, the PATF studied ways of improving care to the medically high risk; improving intervention, support and treatment for members with psychosocial risks that can impact pregnancy outcomes; and increasing breastfeeding initiation and duration.

Among the expanded benefits for pregnant **SoonerCare** members are the Perinatal Dental Access Program, Lactation Consultant, Maternal and Infant Health Social Work, Genetic Counseling and Prenatal Risk Assessment. (In addition, the section on New Quality Initiatives outlines a new program that emerges from the PATF's recommendations, care management for high-risk pregnancy.)

The task force recommended dental services for pregnant women and new mothers because research indicates a possible relationship between gingivitis/periodontal disease during pregnancy and the incidence of premature and low birth weight babies. The Perinatal Dental Access Program was launched in May 2007, and during the last two months of SFY 2007, 586 members received services from 139 contracted dental providers across Oklahoma.

In the upcoming year the PATF will focus on ways to improve the quality of prenatal care within the public arena and workforce concerns. With increased malpractice insurance costs and fewer people entering the obstetrical specialty, the number of physicians and other practitioners providing obstetrical care is thought to be decreasing in parts of Oklahoma. The PATF will examine this issue, discuss its impact on our members, and make recommendations to the OHCA and OSDH.

## Emergency Room Utilization

SFY 2007 marked the OHCA's third year of tracking emergency room (ER) services, focusing this year on **SoonerCare** members with four or more visits in a quarter. To reduce inappropriate utilization of the ER and help align members with a PCP for routine health care needs, the OHCA has expanded its outreach and educational efforts, with 6,730 people identified for intervention in SFY 2007.



An administrative workgroup meets throughout the year to coordinate efforts on this project. This year the workgroup modified the member interventions and added targeted provider engagement activities. We identify members with four or more visits in the previous quarter, then stratify them into two groups: members with four to nine visits in the quarter and members with 10 or more ER visits. The intervention process was modified so that now all identified members receive an initial letter. For the children who are identified, letters to parents/guardians are prepared. A separate letter was customized for adult members with high ER use.

Member Services staff telephone the identified members to educate them about appropriate ER use and how to access primary care services. Some members cannot be reached by phone, so a letter is sent, requesting that the member call a specific member services coordinator. All member contacts about this project are logged in a database so the impact of the interventions can be measured.

During SFY 2007, we successfully contacted 96 percent of the members identified with high ER use. Of the members contacted by phone in six quarters reviewed, an average of 80 percent knew their PCP's name. In another review of six quarters of data, an average of 82 percent reduced their usage of the ER, so that they had fewer than four ER visits in the following quarter.

Members with persistently high ER utilization also are identified for special intervention efforts. These "persistent utilizers" had 10 or more ER visits per quarter for three consecutive quarters. These members receive an



educational letter about their use and are invited to a face-to-face meeting with staff members from our Care Management and Member Services units. Health histories are gathered, including behavioral health, general health and psychosocial health. Education and community resources are provided to the members, who receive Care Management services after the meeting. If the member is unable to attend an in-person meeting, our staff members arrange to meet by phone with the member.

We identified 35 “persistent utilizers” with a total of 3,528 ER visits during SFY 2007. Eighteen of those members met in person with our two-member team, seven others participated in phone conferences, and the rest received letters but did not meet with our team for various reasons. Most of the persistent utilizers had serious health issues, so our focus was on helping them obtain the care they needed in the most appropriate setting. After receiving intervention, the persistent utilizers had a 42 percent decrease in ER visits.

We also provided outreach to **SoonerCare** Choice providers who had patients with high ER utilization rates. We sent about 1,300 letters to PCPs in SFY 2007, detailing each of these members’ high ER use and top three diagnoses. A new intervention involved personally contacting these PCPs to discuss the high ER utilizers’ health issues and to assist them in creating strategies for helping these members.

We compared the ER costs before and after the interventions, and for SFY 2007 we estimate that these interventions led to about \$5.8 million in avoided costs. In other words, these costs were avoided because the members involved in the interventions did not continue with the same ER utilization pattern.

During SFY 2007 we continued our effort to inform PCPs about all their members’ ER utilization rates through the twice-yearly mailing of provider profiles. These profiles give providers information on the ratio of ER visits to office visits. We sent 952 profiles to providers with sufficient data for statistical analysis and 147 letters to providers with insufficient data.

As we continue to coordinate efforts across many units within the OHCA, we hope to reduce inappropriate ER utilization and reinforce members’ relationships with PCPs.

## QUIT NOW Smoking Cessation

About one in four adult Oklahomans smokes, making Oklahoma's rate one of the highest in the nation, according to the Centers for Disease Control and Prevention. The OHCA is committed to helping members who want to stop smoking, and we recently mailed fliers to about 180,000 members to tell them about smoking cessation benefits available through **SoonerCare**. And hundreds of **SoonerCare** members appeared to respond.

The fliers told **SoonerCare** members about smoking cessation benefits and the support available to them through the Oklahoma Tobacco Helpline at 1-800-QUIT-NOW. On average, between 100 and 150 **SoonerCare** members accessed the Helpline each month prior to the mailing; after the mailing this figure increased by about 1,000 callers in one month. In the same month we noted a 28 percent increase in members seeking smoking cessation products and a 29 percent increase in pharmacy claims for such products.

We also began paying providers for conducting a smoking cessation assessment with their patients using the "5 A's" for brief intervention, which has received the endorsement of a number of leading health care organizations. The "5 A's" are:

- Ask the patient to describe their tobacco use;
- Advise the patient to quit;
- Assess their willingness to quit;
- Assist with referrals and "quit plans;" and
- Arrange for follow-up.

Another part of our work toward helping **SoonerCare** members quit using tobacco products involved a collaboration with the University of Oklahoma (OU) College of Pharmacy. This collaboration involves additional phone support to members who received a smoking cessation product for the first time in at least a year. Each member who fills a prescription for a smoking-cessation product is called and encouraged to become involved in a quit-smoking program, such as the coaching available from the Oklahoma Tobacco Helpline. **SoonerCare** members also can obtain up to eight stop-smoking counseling sessions from many kinds of medical professionals contracted with the OHCA. The telephone call is followed by a mailing,



and more phone calls are made after two, six and 12 months. We hope these interventions will help reduce the smoking rate in Oklahoma and improve the health of our members.



### **Medical Histories for Foster and Adoptive Children**

Children who are placed in foster care or are in the process of being adopted sometimes are caught in a situation of not having medical records. The OHCA Child Health Unit has been collaborating with DHS to improve the health history information available to foster parents, physicians and others who are attempting to care for children in custody or adoption status. We have implemented a process that allows our Child Health staff to share information with the DHS Child Welfare staff about children recently taken into custody. The Child Health staff searches our claims data to determine whether these children have had their required immunizations and to establish a record of past health care services, including surgeries and mental health treatment. The claims information also can tell providers and foster/adoptive parents about past and current medications, known diagnoses, hospitalizations, the most recent dental visit, and the most recent vision and hearing screenings. The Child Health staff sends this information to DHS, where it is entered into the Child Welfare computer system and follows the child if a placement changes.

We receive requests for medical histories for 500 to 600 children a month, and we are able to supply information for 80 percent of them. What began as a quality improvement initiative is now part of our routine efforts to assure greater continuity of care.

## Care Management for Young Members After Inpatient Behavioral Health Services

The OHCA's Behavioral Health Department is expanding its care management efforts for young members with the highest use of inpatient mental health services. Care management can help members obtain outpatient therapy and medical management, which can be crucial to avoiding readmission.

During SFY 2006 we conducted an intervention with 50 **SoonerCare** members under 21 years old who had the highest number of inpatient days for behavioral health treatment. Behavioral health care coordinators contacted each member's parent/guardian, obtained a brief clinical history, and determined which behavioral health services already were in place. The care coordinator 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. We estimated that these care management efforts resulted in a 40 percent reduction in the number of inpatient days for behavioral health treatment and a savings of about \$1.1 million.

During SFY 2007 we increased to 150 the number of members in care management. Members with the highest number of inpatient days now can include those in state custody; the pilot study excluded such members. An external contractor provides care coordination to members during their inpatient behavioral health hospitalizations by ensuring each member has an adequate plan for follow-up care upon discharge, including specific appointment dates and times. The OHCA has two behavioral health care coordinators who contact each member's family and provider monthly for a year following discharge.

This intervention is conducted in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services, who will provide care management to those receiving behavioral health services paid for by that agency. We expect this intervention to continue to improve the lives of members receiving behavioral health services, with the added benefit of saving taxpayer funds.





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

Children needing inpatient treatment for behavioral disorders now can find help without having to resort to out-of-state providers. In late 2004 we noticed an increase in requests from members and out-of-state providers of inpatient behavioral health treatment for children. Upon investigation we determined that Oklahoma did not have enough of the right kind of treatment facilities for children with pervasive developmental disorders, reactive attachment disorders, autism and other serious conditions. Additionally, the need for services for children with both mental retardation and mental health challenges became apparent.

With the help of private providers, stakeholders, DHS and other concerned parties, we set to work on alleviating the problem. 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 high levels of clinical quality.

We are pleased to report that these efforts have been successful. During SFY 2007 one facility opened 104 new psychiatric treatment beds, and its new state-of-the-art neurobehavioral unit now is fully operational. Another provider opened a 36-bed facility for children with autism-related challenges. A third facility has eight new beds for treatment of autism and reactive attachment disorder. At press time a fourth provider was building onto an existing facility to expand its program for reactive detachment disorder.

The effect of these efforts has been immeasurable in the lives of 62 children who needed residential psychiatric treatment. These children were able to stay in Oklahoma, rather than having to travel to another state where their families might not have been able to visit. This has relieved some of the emotional and financial burden on these children and families, and their in-state treatment most likely has saved taxpayers' money.

Cooperation and support from many organizations and stakeholders made the difference in these children's lives. We will continue to work with these partners to make sure we have a comprehensive continuum of care in our state so that **SoonerCare** members receive appropriate and quality treatment closer to their homes.

# NEW QUALITY INITIATIVES

Our work toward improving the quality of health care for our members does not occur in a vacuum. We read and respond to national studies and contribute to other national reports about the state of health care in Oklahoma. We study our data so that our quality efforts and policy decisions can be based on the most current information possible. Our work often entails collaborations with other agencies and stakeholders who want to improve Oklahomans' health, as well as the quality of health care services. So although the OHCA's name is on this report, the accomplishments are not ours alone. This section describes several new quality initiatives, many of which involve collaborations.



## **Child Health Advisory Task Force**

The OHCA benefits from partnerships with many other agencies, organizations and individuals as we work together to find the best ways to serve our members. This year we collaborated with the Oklahoma State Department of Health (OSDH) to establish a Child Health Advisory Task Force to help these two agencies develop improved benefits and services for low-income families.

This ongoing committee will advise the OHCA and OSDH on children's health issues. These issues include improving the quality and quantity of Child Health Checkups and follow-up care, and identifying better ways to address widespread children's health problems in Oklahoma. The task force will help us develop better policies and services for children and will provide advocacy as we work toward implementing the group's recommendations.

Created in SFY 2007, the task force developed a list of 13 concerns to be addressed. The top three topics identified by the task force were utilization of primary care, mental health services for children and childhood obesity.

In establishing the task force, we sought input from a number of professional associations and advocacy groups who have an interest in children's health. Among the organizations represented on the task force are the Oklahoma State Medical Association, Smart Start Oklahoma, the physicians of the University of Oklahoma and Oklahoma State University, and the Oklahoma Academy of Pediatrics. We expect to report on the work of this task force in future issues of this quality report.



### Medical Advisory Task Force

The OHCA relies upon input from **SoonerCare** providers on ways to improve our programs for all members. In addition to the Medical Advisory Committee and task forces described elsewhere in this report, we have established the Medical Advisory Task Force, a dozen physicians from urban and rural areas representing a range of specialties. Two meetings were held during SFY 2007, during which the physicians discussed and recommended changes in agency programs and policies.

The task force developed a list of issues for its initial focus:

- A possible change from a system of paying a capitation fee per **SoonerCare** member assigned to a PCP to a new system of paying a case management fee only;
- Development of a medical home model of health care delivery;
- Enhancement of the credentialing process for providers; and
- The possible creation of an option for members to choose a provider at the outset of eligibility, instead of being auto-assigned to a provider.

Working with our Provider Services department, the Medical Advisory Task Force is a welcome addition to the many collaborators giving their time to improve **SoonerCare** and health care for thousands of Oklahomans.

### Tribal Consultation

Many **SoonerCare** providers serve Native American members through tribal, Indian urban, and Indian Health Service clinics and hospitals. In SFY 2007 we implemented a formal tribal consultation policy. The goal of the policy is to maximize partnerships with sovereign tribal governments by consulting them on **SoonerCare** issues, such as program development, strategic planning and legislation.

The first OHCA **SoonerCare** Tribal Consultation meeting was held June 20, 2007, with 152 tribal leaders and their designees representing 15 tribes. The meeting focused on OHCA policy and program development, and participants seemed to react positively to the cooperative approach. We look forward to making the gathering an annual event to help us improve policies and services impacting Native American members and their providers.

### Care Management for High-Risk Pregnancy

Pregnancy can be a difficult time for **SoonerCare** members, especially those at high risk for complications. In response to recommendations from the Perinatal Advisory Task Force, the OHCA is starting a program of care management and expanded benefits for expectant mothers identified with high-risk pregnancies.

Care Management and Medical Authorization Unit staff met frequently during SFY 2007 to outline the process for coordinating the new program of care management for high-risk pregnancy. Members who are verified as having a high-risk pregnancy will be referred to a Care Management nurse for regular follow-up during the pregnancy. The expanded benefits include fetal non-stress tests, biophysical profiles, more ultrasounds (beyond the number available to other pregnant **SoonerCare** members), and additional payment to practitioners for the management of the high-risk pregnancy.

We will keep you updated in future quality reports about the work of this new program on behalf of mothers and babies.

### Return on Investment Calculator

The OHCA and seven other Medicaid agencies participated in a national project to test a web-based calculator for predicting whether an intervention intended to improve people's health care will save more money than it costs. The Center for Health Care Strategies (CHCS) chose the OHCA in February 2007 for the Return on Investment Purchasing Institute (ROI-PI), which will be completed during SFY 2008.

The ROI-PI was well timed because the OHCA simultaneously was planning the implementation of its new Health Management Program (HMP). When people with chronic conditions are guided in the management of their health and receive appropriate medical tests and prescriptions, such costs tend to increase. But research has shown that other services are used less, such as emergency rooms, leading to overall savings.

The ROI Forecasting Calculator is a web-based program that allows us to enter data on existing rates of utilization costs – inpatient, outpatient, ER, lab, and so forth. The software is linked to a literature base of high-quality research articles about interventions that already have been tested by other organizations. Estimates of increases or decreases in utilization are



grounded in evidence from these studies. The Forecasting Calculator also accounts for the cost of implementing an intervention and allows us to specify a range of values, so the worst- and best-case scenarios can be estimated.

The OHCA's costs for participating in the ROI-PI are paid by the CHCS, a nonprofit organization dedicated to improving the quality and cost effectiveness of publicly financed health care. The OHCA will benefit from using the calculator by being able to make informed estimates on how much money we might expect to save by investing in interventions such as the HMP.



### Prescribing Patterns

The OHCA has contracts with thousands of providers serving more than half a million members, many of whom must fill prescriptions for necessary medications. But the potential for abuse – and for provider education – should not be overlooked, and the OHCA has a number of ways of checking to make sure prescriptions are being written and filled appropriately. During SFY 2007 we initiated several new processes of analyzing pharmacy claims and made 161 referrals to our Pharmacy Department for further investigation.

With the assistance of an external quality improvement organization, we designed several algorithms for searching pharmacy claims to find answers to the following questions:

- Are any prescribers writing more than a typical proportion of prescriptions for controlled substances, compared with other providers in the same specialty?
- Are some providers writing prescriptions for more than a usual proportion of brand-name medicines, at times when a generic alternative is available?
- Do some providers write a higher-than-average number of prescriptions per client, compared with other providers in the same specialty?

We have instituted a schedule of analyzing pharmacy claims on a regular basis to look for potential quality issues, possible abuse, opportunities for educating prescribers, and ways of saving taxpayer funds.

# SOONERCARE UPDATES

A program like **SoonerCare** must remain flexible to accommodate the changing needs of its members. This section provides an update on several programs, some intended to help people with specific health concerns and others aimed at improving the quality of life for people with multiple issues.



## **“Oklahoma Cares” Breast and Cervical Cancer Treatment Program**

In SFY 2007 the “Oklahoma Cares” Breast and Cervical Cancer Treatment Program reached a milestone of 10,000 members served. An interagency collaboration comprised of the OHCA, OSDH, DHS, the Kaw Nation of Oklahoma and the Cherokee Nation, the program identifies and resolves issues related to these two types of cancer.

Since its start in January 2005, the program has served more than 11,500 women, with 7,818 enrolling during SFY 2007. The milestone of 10,000 women served was marked by television coverage featuring women who had received help through Oklahoma Cares and news articles showing how patients were linked with treatment resources promptly.

After receiving an abnormal result on a cancer screen, women meeting program requirements for these cancers are enrolled in the program. Our Care Management staff or one of the Tribal partners follows these members to provide support for navigating the health care system. Close to 90 percent of women enrolled are successfully contacted by Care Management for program education and care coordination. Of these, almost 94 percent received negative results following further diagnostic tests provided through the program. Out of the 369 women identified with a confirmed diagnosis of cancer, 296 had breast cancer, 67 had cervical cancer, and 6 had both breast and cervical cancer. Treatment was available to the members through the program. In SFY 2007, the Oklahoma Cares Program benefit package was enhanced by an increase in coverage for mammograms and the inclusion of external breast prostheses. Further, breast MRIs are now compensable with prior authorization.

In our next issue we plan to report the results of a satisfaction survey administered to members served by Oklahoma Cares.



### SoonerPlan

The SoonerPlan family planning program is another example of interagency collaboration. SoonerPlan has completed its second full fiscal year in operation, with a total of 43,984 men and women qualifying for services. This program helps adults who are ineligible for **SoonerCare** to receive family planning services. During the last month of SFY 2007 we had 20,253 people (19,394 women, 859 men) enrolled in the program.

SFY 2007 began with an on-site review of SoonerPlan by representatives from the CMS Central and Regional offices. The goal of the review was to assure compliance with laws and regulations and with the specifications of our agreement with CMS regarding this program. Among the areas reviewed were program coordination, eligibility screening and enrollment, access and service delivery, and provider education and billing. Overall, CMS found that the OHCA is effectively administering the program and commended the state for its efficient administration and service delivery. The OHCA also was recognized for utilizing “best practices” on two facets of the reviewed processes.

Aggressive outreach efforts to **SoonerCare** enrollees whose eligibility might be ending were enhanced during SFY 2007. A refinement in identifying pregnant women potentially eligible for SoonerPlan after they complete the post-partum period allowed us to target 54,030 individuals for outreach. This figure is more than twice the number identified for outreach in SFY 2006.

We also conducted provider education about SoonerPlan during multiple sessions statewide, with 982 providers attending. In addition, OSDH addressed the SoonerPlan program during its regional training sessions for county health department staff.

An administrative workgroup with representatives from OSDH, DHS and OHCA collaborated on access to care, the provider network, program development and monitoring, and outreach to potential enrollees. The workgroup met regularly through SFY 2007 to address the concern about the program enrollment falling below projections. In response the workgroup developed a strategic marketing campaign in collaboration with the OHCA Communication Services Division. The campaign included news releases to all print media outlets, including college newspapers; and posters and

fliers, which were distributed to DHS and OSDH county offices, as well as other stakeholders. **SoonerCare** provider representatives gave fliers to PCP offices during on-site visits, and SoonerPlan information was increased on the OHCA website.

This multidimensional marketing campaign's effects will be studied during SFY 2008, in hopes of finding that the uptick in enrollment in the last quarter of SFY 2007 was a first sign of the campaign's impact on participation in SoonerPlan.

### **Insure Oklahoma: Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)**

A program to help employed Oklahomans pay for health insurance continued to grow during SFY 2007. Insure Oklahoma, also known as the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC), began accepting applications during SFY 2006. This program started as a premium assistance program for Oklahomans working for small businesses with 25 or fewer employees, expanding to 50 or fewer employees in October 2006. We expanded Insure Oklahoma during SFY 2007 to offer health coverage to individuals.



By the end of SFY 2007, about 1,030 small businesses had signed up for premium subsidies, impacting about 2,000 low-income employees and their families. The program provided an average monthly premium assistance payment of about \$240 per employee, with the benefits being supported by tobacco tax revenue and federal matching funds. Companies participating in Insure Oklahoma pay 25 percent of the employee's premium, the employee pays 15 percent, and Insure Oklahoma pays the rest of the premium. Employees are responsible for the copayments and deductibles as required by the participating health plan, although Insure Oklahoma reimburses members for some qualified out-of-pocket expenses.

The Insure Oklahoma program instituted a number of changes this year. Applicants now may apply by using either paper forms or the internet. An income adjustment was implemented, helping more applicants establish eligibility. Rules were changed to specify how businesses would count part-time workers and full-time-equivalent positions and still qualify for Insure Oklahoma. By the end of SFY 2007, a total of 16 health plans with multiple coverage options were available for participants.



The Insure Oklahoma/O-EPIC Individual Plan (IP) is designed to provide Oklahomans with health coverage if they do not have access to Insure Oklahoma through their employer. These individuals must work for an Oklahoma business with 50 or fewer employees; or they may be temporarily unemployed adults who are eligible for unemployment benefits through the Oklahoma Employment Security Commission. Adults with a disability who work for any size of employer and who have a “ticket to work” also are eligible if low-income eligibility guidelines must be met.

Enrollment for the Individual Plan began in January, and by the end of SFY 2007, 302 employees and 101 spouses were covered. IP members pay premiums, copayments and deductibles and have a limited benefit package. Premiums are based on a sliding scale, depending on the member’s income; the average IP member premium in June 2007 was \$29.58. Each member selected a primary care provider from a network of 416 providers statewide. In addition, enrollees had access to covered hospitals, medications, durable medical equipment and other services.

Toward the end of SFY 2007 we awarded a contract to a marketing company to increase Oklahomans’ awareness of Insure Oklahoma. We expect to report on continued expansion of Insure Oklahoma in future issues of this quality report, as new laws allow us to expand to businesses with up to 250 employees and workers earning up to 250 percent of the poverty level. The OHCA has received federal approval for eligibility up to the 200 percent level, so applications were being prepared at press time to request federal approval to the 250 percent level.

Insurance agents and brokers play a vital role in educating businesses about Insure Oklahoma. During spring 2007, agent partners were added to provide personalized attention to Oklahoma’s health insurance agents and brokers. These positions – two in the Oklahoma Insurance Department, two in a company contracted with the OHCA – were created as a dedicated resource for agents and brokers. The agent partners provide personalized education and support to agents and brokers who currently market Insure Oklahoma and they also travel throughout the state to recruit new agents and brokers. Agent partners often go on-site to businesses to assist the agent or broker with group enrollment of the employees.

In the next issue of *Minding Our P’s and Q’s* we look forward to reporting on the results of a survey of participating business owners, telling us how they benefit from Insure Oklahoma.

## Tax Equity and Fiscal Responsibility

### Act of 1982 (TEFRA)

Children with physical or mental disabilities who are not eligible for other **SoonerCare** benefits because of a parent's income or resources may qualify for services under a federal law called the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). This is the second year that children under age 19 have been served under this law, which helps them obtain the services they need to be cared for at home instead of in an institution.

TEFRA assistance is based on the child's income and assets, not those of a parent. A child qualifies for TEFRA by meeting the definition of disability used by the Supplemental Security Income (SSI) program and an institutional level of care. Services include regular well-child screenings, dental care, emergency and non-emergency transportation, physical or occupational therapy, medications and other services available to **SoonerCare** members.

Since the OHCA began the program in October 2005, 184 children have qualified to receive services in the home. Enrollment reached a program high in June 2007 with 150 children enrolled. Automatically enrolled in the OHCA's Care Management program, these members are aligned with a nurse exceptional needs coordinator to assist them and their families with access to primary and specialty care. In addition, an OHCA Member Services coordinator contacts the families to facilitate selection and enrollment with an appropriate and accessible primary care provider, as well as to provide information on navigating the health care system.

In the final quarter of SFY 2007 representatives from the CMS Regional office conducted a comprehensive on-site review of the TEFRA program. The evaluation focused on the eligibility criteria and determination, level of care assessment, in-home analysis, and targeted medical records and claims review. Although the final CMS report will not be received until next fiscal year, positive feedback was received at the conclusion of the on-site review.





### Health Management Program

One of the most potentially life-changing programs we have created for our members is the new Health Management Program (HMP). This program is designed to target **SoonerCare** members at high risk for health problems that may be improved through the HMP intervention. The goals are to improve the health status of these members, increase their ability to manage multiple chronic conditions and save money in the long run.

The HMP is not the agency's first foray into helping people with serious conditions. In addition to the daily work of our Care Management Unit, we completed a pilot program in SFY 2006 to help Native Americans with diabetes and to learn about the best ways that their providers help them manage their illness. We expanded this program by establishing a collaboration with the University of Oklahoma (OU) College of Pharmacy, which conducted outreach to members with diabetes. About 1,100 members received educational mailings and multiple comprehensive phone calls in which they were interviewed about their diabetes management. We also have worked with the OU Pediatric Endocrinology Department on educating children with diabetes and tracking their progress.

Members with asthma also have received assistance. The OU College of Pharmacy and the OHCA's Drug Utilization Review (DUR) committee worked together to conduct an asthma education program for members who had emergency room visits related to their asthma. About 3,500 members received mailings about the proper use of asthma prevention (controller) medications.

The HMP represents the next step: treating the whole person, not just a person's specific disease. Many members have comorbid conditions that are difficult to manage without additional assistance. At the end of SFY 2006 Governor Brad Henry signed legislation to create this kind of program for **SoonerCare** members, and during SFY 2007 many OHCA employees were preparing for the implementation of the HMP early in calendar year 2008. Ramping up for the program's launch included the work involved in studying potential vendors' proposals for administering the HMP.

One facet of our work this year was investigating predictive modeling software. We wanted to find the best software for identifying members whose lives could be impacted the most by participation in the HMP. The software, which has been obtained with the assistance of an existing contractor, will allow us to analyze administrative data (diagnoses, procedures, prescriptions, and so forth) to identify members at highest health risk whose conditions may be improved through intervention.

Once we have identified members for the HMP, we will determine who needs the most assistance with managing their health conditions. About 1,000 members at any given time will be in Tier 1, which will involve monthly face-to-face nurse care management. They will be interviewed about their health history and understanding of their medical conditions, and they will be coached on ways they can improve their health and manage chronic conditions, such as asthma, diabetes, depression, and others. About 4,000 members will be identified for Tier 2 intervention, which will involve monthly phone calls from a nurse care manager, who will conduct similar interviews with members and provide support for their medical self-management. All members in the HMP will be screened for depression, often an underlying condition that decreases people's ability to manage their other medical conditions and reduces their quality of life. The nurses will help members learn about their specific illnesses, understand and follow regimens of medication, and keep regular PCP visits. Members also will set medical self-management goals, which they will pursue with their nurse care manager's help.

In addition to nurse care management, the HMP will include Practice Facilitators, who will be placed strategically around the state in **SoonerCare** PCP offices. The Practice Facilitators will assist these practices with following evidence-based guidelines, developing patient registries and improving efficiency. In our next issue of this report, we expect to report on the implementation of the HMP and plans for tracking its impact.





### Focus on Excellence: Tiered Reimbursement for Nursing Facilities

Evidence-based quality improvement, demonstrated value, consumer education – these are facets of a new program designed to increase the quality of nursing facilities in Oklahoma. On June 9, 2006, Governor Brad Henry signed House Bill 2842, creating the Focus on Excellence Program, the first incentive-based rate plan of its kind in the nation. The Focus on Excellence Program will use a tiered reimbursement system to reward participating nursing homes that demonstrate improvement in the quality of life, care and services. The program also will provide consumers with frequently updated information by which to compare and choose nursing homes.

An external contractor was hired during SFY 2007 to manage the measurement of a comprehensive list of quality measures that will serve as the basis of the tiered reimbursement. These measures include:

- Resident, family and employee satisfaction;
- Quality of life;
- Retention rates for certified nurse aides and nurses, with attention to the ratio of residents and staff;
- State regulatory compliance and certification as reported by the Oklahoma State Department of Health;
- Direct care hours, based on monthly reports that the participating facilities make to the OHCA;
- Clinical outcomes;
- **SoonerCare** occupancy and Medicare utilization; and
- System-wide culture change

Among many other facets of the program, Focus on Excellence will pay attention to cultural change, including the decision-making process in the facility; the facility's actions supporting consistent assignments of staff members to residents; the effect of organizational design on communication between front-line staff and the facility's leadership; and the physical environment of the nursing home.

The program is optional and by the end of SFY 2007, 269 nursing homes (85 percent of those eligible for the program) had joined the program. On July 1, 2007 participating facilities were awarded a bonus point and started earning an additional \$1.09 per patient day for each day of Medicaid service rendered. When the tiered reimbursement bonus payments begin during SFY 2008, each facility may earn an additional \$1.09 per day to \$4.36 per day (which can total an additional 1 percent to 4.5 percent rate adjustment).

Consumers will have access to a website where they can obtain information about all nursing homes under **SoonerCare** contract, with more complete information available about the facilities participating in the Focus on Excellence Program. These providers can contribute digital photos, descriptions of their programs and other information for consumers to use. A separate system for providers will allow them to submit information to the OHCA monthly and to check their latest results on the quality measures.

The scope of this program goes beyond this brief description, and its impact surely will mean an improvement in the quality of life for many **SoonerCare** members and their families. The progress of this important and innovative program will be tracked in future issues of *Minding Our P's and Q's*.

### **Oklahoma Long-Term Living Choice**

Supporting Oklahomans' choice of where they will receive medical and social services – in the home or in an institution – and rebalancing Oklahoma's home- and community-based long-term care system are the goals of a new program called Oklahoma Long-Term Living Choice. The OHCA was awarded a Money Follows the Person federal grant of \$41.8 million in January 2007 to coordinate the efforts of many agencies to pursue these goals. In recognition of this accomplishment, the OHCA received the Governor's Award for Excellence during Oklahoma Quality Team Day in May 2007.

The Opportunities for Living Life Advisory Council and the Money Follows the Person Committee collaborated with representatives of state agencies and community organizations to apply for the grant, also called the Oklahoma Long-Term Living Choice Project.





Awarded by the Centers for Medicare and Medicaid Services (CMS), the grant will be used to help more older Oklahomans and people with disabilities to obtain home- and community-based services so that they don't have to be institutionalized to receive the services. The collaboration is a defining aspect of the program; the goal is to make sure all available sources of assistance are working together to help Oklahomans.

Cassell Lawson, director of the OHCA's Opportunities for Living Life unit, says the partners are creating "a model wherein communication is effective, resources are shared, and care is person-centered. The outcome is true systemic reform."

In addition to helping people exercise their options related to home- and community-based care, the program also will assist people who want to move from an institution back into the community so that they have access to the services they need. Developing affordable and accessible housing is another issue to be addressed by the various collaborators on the grant.

Partners in the project include the DHS's Aging Services and Developmental Disabilities Service divisions, the Long Term Care Authority, Progressive Independence, Oklahomans for Independent Living and Ability Resources. Other organizations are contracting with the OHCA to implement aspects of the program.

We have begun spreading the word about this program, adopting the tag line, "Making Community Living a Reality," which will be used in informational fliers. By reducing the barriers on the Medicaid funds, we hope to provide continuous quality assurance and improvement of services for those who receive long-term care services.

Every year we conduct a number of studies to support our continuous quality efforts. We agree with Margaret E. O’Kane, president of the National Committee for Quality Assurance (NCQA), who said in the NCQA’s 2007 report *The State of Health Care Quality*, “The stakes are too high to allow quality to be left to projections, assumptions or guesswork.” The studies discussed in this section illuminate new areas to be targeted for improvement or demonstrate the effect of completed quality improvement activities.

### How Our Research is Conducted

When a provider submits a claim to the OHCA for payment, or when a provider submits a claim/encounter for a **SoonerCare** member, the information becomes part of a large and complex database of information. We use the information on these claims to conduct much of our research. Data from thousands of members can be compared with data from different time periods and various diagnoses, age groups, or medical services, depending on the questions we want to answer. The studies described in this section emerged from careful examination of patterns in the claims and encounter data. Non-experimental research cannot point to the causes of improvements, especially because we often are pursuing several initiatives at once in conjunction with other agencies and organizations. The results of these studies nonetheless are extremely valuable in providing greater understanding of how well we are fulfilling our agency’s mission.

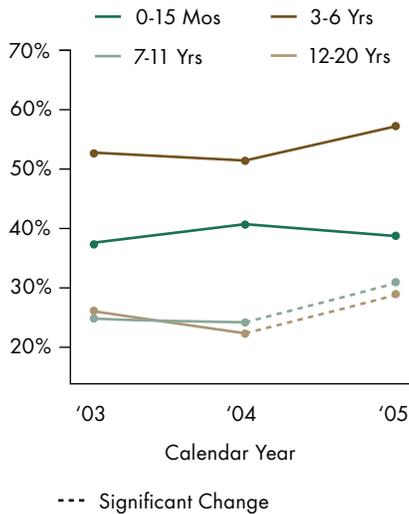
### Child Health Checkups

Child Health Checkups, also known as Early and Periodic Screening, Diagnosis and Treatment visits (EPSDT), allow providers to check children’s development, detecting potential problems before they become serious. The importance of this preventive health care service motivated our decision to include Child Health Checkups among our studies again this year. The goals of the study were to assess the EPSDT rates and compare results with previous years.

A random sample of members under the age of 21 years was chosen for the study, which used calendar year 2005 as its review period. We applied a hybrid approach to data collection. In addition to electronic data related to PCP encounters, copies of the members’ medical records were obtained from their PCPs. Clinically experienced staff members working for an external quality improvement organization examined the records. They found additional Child Health Checkups in the medical records that had not been identified electronically, increasing the rates by 2 percent to 5 percent,



## Members Receiving All Recommended ESPDT Visits



depending on the age group. Examination of medical records is time-consuming and cost-intensive, which is why we tend to rely on claims data, but these results point to a possible need to guide some providers toward more complete methods of reporting Child Health Checkups.

For those in the first 15 months of life, the OHCA periodicity schedule called for six Child Health Checkups. The study found that 91 percent of the children in this age group received at least one Child Health Checkup and more than half received five or more visits. The rates were lower for older members: 57 percent for 3- to 6-year-olds; 31 percent for 7 to 11-year-olds; and 29 percent for 12- to 20-year-olds.

A significant increase was found between 2004 and 2005 for two age groups: 7-11 years and 12-20 years. When examining the number of members in each age group who received all the recommended number of exams, the members with the highest rate were 3-6 years old. The next highest rate was associated with the members 0-15 months, the age group with the highest number of recommended visits.

In addition to identifying Child Health Checkups that had not been found in the electronic records, the medical record review also allowed an analysis of missed opportunities. A Child Health Checkup involves several components. The record review portion of the study looked for three components: health and developmental history, physical exam and anticipatory guidance. A given child could have had more than one missed opportunity if more than one component of a Child Health Checkup was missing or if multiple visits were documented without one or more components. Children in the 0- to 15-month age group have the highest expected number of Child Health Checkups, and they also were found to have the most missed opportunities. The missed opportunities were more likely to involve anticipatory guidance or health/developmental history.

We are using the results of this study to develop ideas for future interventions to improve our rates of Child Health Checkups.

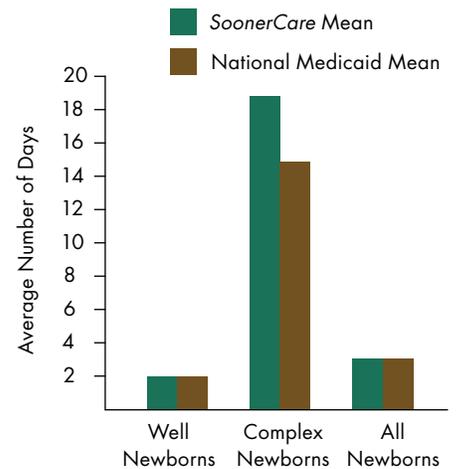
## Prenatal Care and Outcomes

A majority of **SoonerCare** members are babies and children, and we want them to be healthy from the start. That is why one of this year's studies centered on prenatal health care. A number of services are available to pregnant **SoonerCare** members: prenatal exams, vitamins, ultrasounds, pregnancy-related education, and so forth, which can contribute to healthier babies. The goal of this study was to increase our understanding of the health care services being used by expectant mothers and how these services related to birth outcomes.

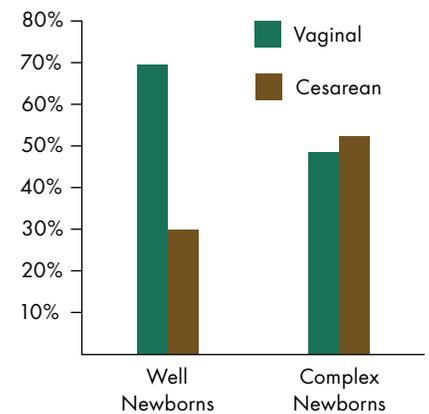
Some pregnant members establish their **SoonerCare** eligibility shortly before they give birth, so the OHCA does not have records of their prenatal care. Because each **SoonerCare** member is given an individual member identification number, it can be difficult to obtain data about individual members who are related, such as the case with the mothers and babies in this study. Using information from eligibility and claims data from SFY 2006 to determine familial relationships, we were able to match data from 22,950 babies (or 77 percent of the 29,654 babies in the study) with data about their mothers. Matching the information enabled us to look at our population in terms of the mothers' prenatal care and the babies' birth outcomes.

We found that a greater proportion of complex babies (those with longer hospital stays) were born to mothers with a higher number of prenatal visits. Although we would expect more positive outcomes for babies whose mothers received more prenatal care, these results may indicate that the providers had detected a possible complication with the pregnancies, which increased the number of visits. Another limitation on our ability to investigate the relationship between prenatal care and birth outcomes is the way that some providers can file a global claim for multiple services. Many services, from prenatal care through postpartum care, may be filed on a global claim, so the precise number of prenatal visits cannot be captured based on our claims data.

## Average Length of Stay, Newborns



## Birth Outcomes By Delivery Type





Nationally recognized measures of mothers' deliveries and babies' births were adapted for this study. The results showed that the average length of stay for all **SoonerCare** babies discharged from hospitals or birthing centers was 3.4 days, which was comparable to the national Medicaid mean of 3.3 days. About 92 percent of the babies were well newborns – that is, healthy babies with a hospital stay under five days. The rest were complex newborns, which included babies with hospital stays beyond five days and babies who died. The well newborns had an average stay of two days, which was comparable to the national mean, and the complex newborns had an average stay of almost 19 days, which was higher than the national mean of 15 days. Further study is needed to determine why the **SoonerCare** mean was higher than the national mean on this measure. About 75 percent of the mothers were between 20 and 34 years old; about 82 percent had at least one ultrasound. About 32 percent of the mothers had cesarean deliveries, and on average they stayed in the hospital for 3.2 days; the national Medicaid mean hospital stay for those with cesarean deliveries was 3.7 days.

Pregnancy complications are difficult for families, and we want our members to receive quality health care. As a steward of public funds, the OHCA also is responsible for reporting the costs associated with births. Seventy-eight percent of all newborns had costs under \$2,000. But the costs associated with those newborns accounted for only one-fourth of total newborn costs. Complex newborns (that is, those whose hospital day was 5 days or longer) accounted for only 8 percent of all **SoonerCare** births (or 2,385 babies), but accounted for 55 percent of all costs. Even more dramatically, 0.5 percent of all **SoonerCare** births (or 155 babies) had \$70,000 or more in costs, accounting for nearly 20 percent of all costs.

Efforts are being made to establish other ways of linking data on mothers and babies, which we hope will improve our ability to study the relationship between prenatal care and birth outcomes.

## Comprehensive Diabetes Care

A serious life-threatening illness, diabetes impacts thousands of Oklahomans and has motivated several interventions for our members suffering from this disease. During SFY 2007 we ran a followup study on Comprehensive Diabetes Care, a set of Healthcare Effectiveness Data and Information Set (HEDIS®) measures that allow us to compare our members' outcomes with national Medicaid means. The study used a combination of administrative data and medical record review, which involved identifying lab results, recording observations from PCP notes, and noting referrals related to the measures of interest.



The Comprehensive Diabetes Care Measures are:

- Hemoglobin A1c (HbA1c) testing, which provides an indication of the stability of a person's blood sugar;
- Poorly controlled HbA1c, meaning a reading greater than 9 percent;
- Low-density Lipoprotein Cholesterol (LDL-C) screening, or "bad cholesterol" testing;
- Well-controlled LDL-C, meaning a reading less than 100 mg/dL;
- Controlled LDL-C, meaning a reading less than 130 mg/dL;
- Retinal eye exam, an important screening because of the risk of diabetic retinopathy, which can cause blindness; and
- Diabetic nephropathy monitoring, meaning testing for kidney disease, a complication of diabetes that can lead to kidney failure.

Following the HEDIS® 2006 guidelines for systematic sampling, the OHCA and an external contractor, APS Healthcare, sampled 411 **SoonerCare** Choice members identified as having Type I or Type II diabetes. The only way to identify members as having controlled or well controlled LDL-C levels and those with poorly controlled HbA1c levels was the medical record review process. The remaining measures could be estimated from administrative claims, but the results from the medical record review process combined with the administrative data were as much as 17 percent higher than the rates based only on the administrative data.

We found that 69 percent of the members with diabetes had received a hemoglobin A1c test during the review period, and the medical record review showed that 64 percent of the sample had poorly controlled blood sugar levels. The hybrid analysis found 61 percent of those sampled had received the cholesterol screening; that 34 percent of the members had controlled LDL-C levels; and that 19 percent had well-controlled LDL-C levels. Half of the members had been monitored for diabetic nephropathy, and 32 percent had received a retinal eye exam.

When compared with previous years' results on these measures, the results were mixed. The 2005 rates on controlled and well-controlled LDL-C levels decreased significantly compared with the 2004 rates, with no significant change in the other measures. But several of the 2005 rates were significantly higher than they were two years earlier: HbA1c testing, retinal exams, LDL-C screening, controlled LDL-C levels and nephropathy monitoring all had statistically significantly higher rates in 2005 than in 2003. Yet the rate of poorly controlled HbA1c levels also was significantly higher in 2005 compared with 2003. When compared with national Medicaid means on these measures, all measures except nephropathy monitoring were significantly lower for the **SoonerCare** Choice sample.

These results are representative of the health status of many Oklahomans and provide evidence of the need for interventions such as the OHCA's Health Management Program. The results from the study of Comprehensive Diabetes Care will inform our work with contracted nurse care managers to improve the lives of members with this condition.



### **Medical Management of Depression**

Depression is a serious medical illness that can be treated effectively in a number of ways – counseling, medication, exercise and other approaches. Left untreated, depression can impact all facets of people's lives, including their other medical conditions, their relationships and their ability to work. These high stakes are the reason we chose the medical management of depression as the focus of a behavioral health study during SFY 2007.

It is important to note that in the following discussion of treated vs. untreated depression, we mainly are referring to treatment in the form of medication. Some measures included provider contacts, but the study primarily examined claims for antidepressants.

This study reviewed data for one year beginning May 1, 2004, a time period chosen because we were adapting HEDIS® measures, which defined the period of review so that results from various Medicaid plans would be comparable and could be combined into a national rate. We explored differences between **SoonerCare** Choice adult members who met or did not meet criteria for the following measures:

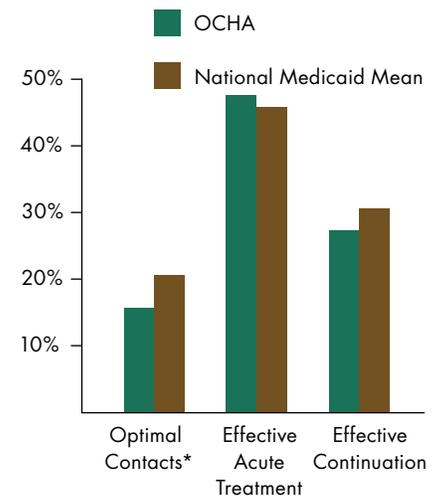
- Filling a prescription for an antidepressant and receiving at least three provider contacts during the first 12 weeks after the first depression diagnosis;
- Receiving a continuous course of antidepressant medication during those first 12 weeks; and
- Remaining on antidepressant medication continuously in the six months after the initial diagnosis.

These measures allowed for a limited number of gaps in treatment in the event that a change of medication was needed. The great strides in medical treatment of depression were reflected in our results. We found 6,705 adults who had been diagnosed with depression two or more times during the review period, but we had to look hard to identify members who were diagnosed with depression but not being treated: only 419 people (6.2 percent) either did not fill a prescription for an antidepressant or had no visits with a behavioral health provider.

A multivariate analysis found that the difference between being treated and not being treated with antidepressants was unrelated to gender, aid category or location in a rural vs. urban community. American Indian members were about twice as likely as Caucasian members to be untreated, whereas Caucasian and African American members were equally likely to be treated (Hispanic and Asian members were excluded from this analysis because their numbers were too low for valid statistical inference). The multivariate statistics also indicated that older members were less likely to be treated with antidepressants than younger members.

For the members who were treated with antidepressants, about 16 percent met criteria as receiving Optimal Practitioner Contacts (at least three provider visits and filled prescriptions during the first 12 weeks after diagnosis with depression). This rate was significantly lower than the national Medicaid

## Medical Management of Depression



\*Significant Difference

mean. Another measure, Effective Acute Treatment, has the same criteria and time frame after diagnosis, except it has no specification for provider contacts. About 47 percent of **SoonerCare** Choice members were included in this measure, a rate that was statistically the same as the national Medicaid mean. Finally, the Effective Continuation measure counts those who were filling prescriptions on a regular basis during the six months after diagnosis. About 27 percent of **SoonerCare** Choice members met criteria to be counted on this measure, a rate that was statistically the same as the national Medicaid mean.

This study contained a number of more detailed findings that will guide our decision-making about how to provide quality health care to members with depression.



### **Emergency Room (ER) Utilization Study**

Emergency room (ER) visits can save lives, therefore they are an important part of health care coverage for **SoonerCare** members. We also want to encourage the development of good relationships between our members and PCPs so continuity of care is ensured. The OHCA has conducted multiple interventions with members and providers in attempts to minimize the number of unnecessary ER visits. This study examined the patterns of ER use by members under 21 years of age, who constitute a majority of our **SoonerCare** Choice population. Several interventions have been targeted toward people with high numbers of ER visits, so in this study we limited the analysis so that we could learn more about members visiting the ER more than once in a quarter, but not often enough to be flagged for intervention. One goal was to identify the factors most strongly associated with higher numbers of non-emergent ER visits so that we might have more information on how to reduce these numbers.

Analyzing claims from ER visits during SFY 2006, we found that a majority of visits were made by children under 11 years old, and 37.6 percent of ER visits were made within 90 days of enrollment in **SoonerCare** Choice. The top two diagnoses for members 10 years and younger were ear infections and upper respiratory infections, which may guide us in helping providers to teach parents/guardians about the best way of obtaining treatment for these

conditions. ER providers have told us about high numbers of children with asthma-related complications being treated in the ER; in this study, just over 2 percent of the claims listed asthma as the primary diagnosis. One factor that we explored as possibly being related to avoidable ER visits was time of day: Were parents/guardians taking their children to the ER because the PCP's office was closed? The study found that 71.4 percent of visits were outside of normal office hours, but some hospitals' claims lacked information on the time of day, limiting our inferences. If complete information can be obtained from claims in the future, we might be able to analyze whether the patterns of ER utilization (diagnoses, age groups, etc.) differ according to the time of day.



Part of the study used an algorithm created by New York University's Center for Health and Public Service Research to estimate the likelihood that the visits were non-emergent. Applying this algorithm, we ran statistical analyses to identify factors related to the probability that visits were non-emergent. Among the factors we examined were the distance of the child's home to the PCP, the size of the PCP's panel, the number of days that the child had been enrolled with the PCP, the number of PCP visits that the child had before the ER visit, the number of PCP visits the child had during the quarter, the number of PCP visits the child had in the first six months of eligibility, and demographic characteristics of the child, such as age, gender, and so forth. The only factors that emerged as predictors of non-emergent visits were age (younger children were more likely to have non-emergent ER visits) and the number of PCP visits during the quarter (children who had higher numbers of PCP visits also tended to have ER visits that were likely to be non-emergent).

The study also found that the older children tended to have more days of eligibility than the younger children did. Younger children had more ER visits that were likely to be non-emergent, and the study suggested that having no breaks in eligibility may serve as a protective factor that helps members avoid such ER visits. We also may need to look for more ways to educate members about the availability of the Patient Advice Line, which might be especially helpful outside of normal office hours and for parents/guardians of children with ear infections and upper respiratory infections.

# PERFORMANCE TRENDS



Some quality measures determine whether a standard has been met during a certain time frame, without regard to change across time. But to measure increases or decreases in rates, performance and quality must be measured more than once. This section will describe the results of an independent review of **SoonerCare** Choice, the outcome of two annual surveys of customer satisfaction and our performance on nationally recognized health care measures.

## External Quality Review

Every year the **SoonerCare** Choice program undergoes a quality review by an external organization, which provides an independent assessment of the degree to which we have met our obligations under state and federal laws and regulations. APS Healthcare conducted this independent review for SFY 2007 and concluded that **SoonerCare** Choice had achieved full compliance in all four domains of the review.

In previous years, the OHCA used the Quality Improvement System for Managed Care (QISMC), developed by the Centers for Medicare and Medicaid Services (CMS), as a means to assess the quality of the infrastructure, operations, and strengths and weaknesses of the **SoonerCare** Choice program. For SFY 2007 a new framework of assessment was developed that consisted of 122 measures. These measures replaced the QISMC, which CMS has discontinued for Medicaid managed care programs. The OHCA found the review to be a valuable accountability tool and chose to undergo the review with a quality assessment tool comparable to QISMC.

The 122 measures were organized in four domains:

- Domain 1 focused on the Quality Assurance (QA) program, the policymaking bodies in place to administer the program, its projects, and the data system maintained to ensure accurate, timely, and complete data collection.
- Domain 2 confirmed that the agency articulates members' rights, promotes the exercise of those rights, and ensures that OHCA staff and affiliated providers are familiar with member rights.
- Domain 3 covered several aspects of health care service delivery, including availability, accessibility, continuity of care, practice guidelines, provider qualifications and selection, member health records, and communication of clinical information.

- Domain 4 reviewed how the OHCA oversees and is accountable for any functions that are delegated to other entities.

The APS report complimented the OHCA on several achievements, including:

- our quality studies, representative of the needs of the program and our members;
- the exemplary services provided to children through the Newborn Outreach Initiative;
- the efforts of the Perinatal Advisory Task Force;
- the Member Services and Care Management staff members for their scope of services and responsiveness to the needs of **SoonerCare** members;
- the low rate of member complaints and low rate of provider and member formal appeals; and
- streamlined processes and secure website available to **SoonerCare** providers.

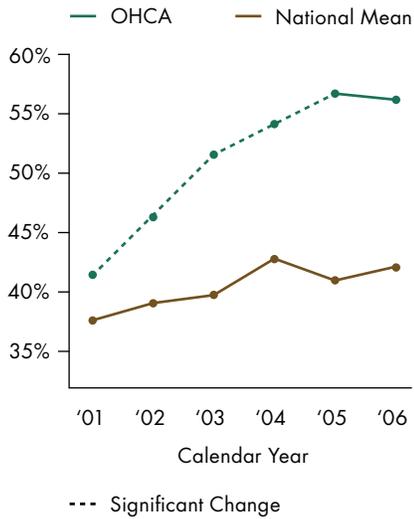
### Healthcare Effectiveness Data and Information Set (HEDIS®) Trend Report

Most American health plans use a standardized set of measures to track their performance on several important dimensions of care and service. This set of measures is called the Healthcare Effectiveness Data and Information Set (HEDIS®). Using administrative (paid claim/encounter) data, we annually complete a review of HEDIS® measures to identify areas for improvement and monitor effectiveness of performance improvement initiatives. These results have allowed us to track performance across time, a practice we plan to continue.



We have tracked several HEDIS® measures for a number of years (some only since 2003), and these results are shown in the table in this section. The latest review period for which we have **SoonerCare** results is calendar year 2006. For this year's quality report we analyzed the trend data to check whether apparent changes are statistically significant. The dotted lines on the following line graphs indicate a statistically significant change (increase or decrease) from the previous year. Occasionally the definition of a HEDIS® measure will change, just as our understanding of best medical

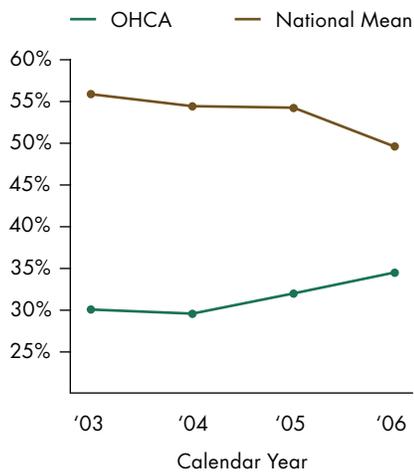
### Annual Dental Visit, Members Under 21 Years



practices evolves. When a measure has changed and the results could not be compared to the previous year’s results, the graphs will have no lines connecting those two years. A table of results follows the graphs.

**Dental care:** This measure tabulates the number of members who were eligible for dental benefits (i.e., those under 21 years in this review period) and had at least one dental visit. The rate for **SoonerCare** members increased significantly every year through 2005, which had statistically the same rate as 2006. The **SoonerCare** rate consistently has been higher than the national Medicaid mean.

### Breast Cancer Screening

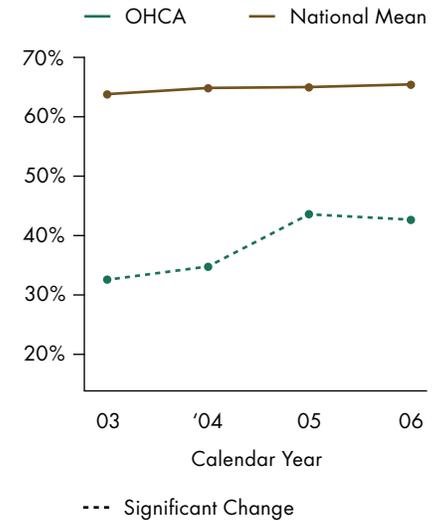


**Breast Cancer Screening:** The OHCA’s rate of breast cancer screenings for women 40 and older appears to be slowly increasing, although when we compared each year’s rate with the previous rate, no statistically significant annual changes were noted. What these rates do not show is that the number of women getting screened has increased dramatically. In 2005, 662 members received a mammogram. In 2006 this figure was up to 2,427. The specifications for this HEDIS measure limit the count to women with 11 or 12 months of eligibility in both 2005 and 2006 and mammograms conducted during these years. So this figure does not reflect the total number of mammograms provided to **SoonerCare** members in this age group, whose benefits do not depend upon how long they have been members. The “Looking Ahead” section of this report talks about an upcoming initiative that we hope will have a positive impact on this rate.

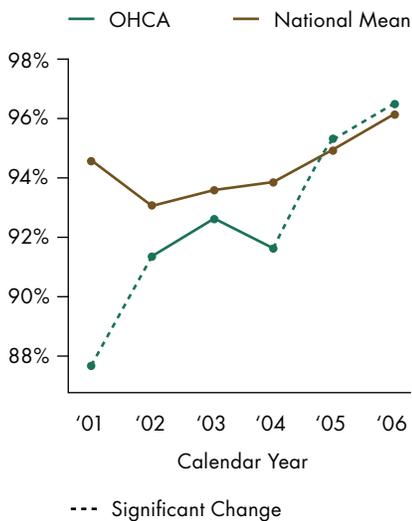
**Cervical cancer screening:** After two years of significant increases in the rate of cervical cancer screening, the OHCA had a small decline from 2005 to 2006. The “Looking Ahead” section of this report details a new intervention that we hope will increase awareness of the need for Pap tests.

**Child Health Checkups:** The OHCA has been targeting several efforts toward increasing the number of children receiving Child Health Checkups (also known as EPSDT visits). These graphs illustrate significant improvements in the rates of those who had at least one Child Health Checkup during the year. The rates are higher for younger children, which may reflect the fact that our periodicity schedule calls for more exams when children are younger. Another factor impacting our rates is that our periodicity schedule calls for Child Health Checkups on alternating years after the age of 6, whereas the HEDIS® measure assumes annual visits. For the youngest age group (birth to 15 months), our rate significantly increased for the last two years and now is statistically the same as the national average.

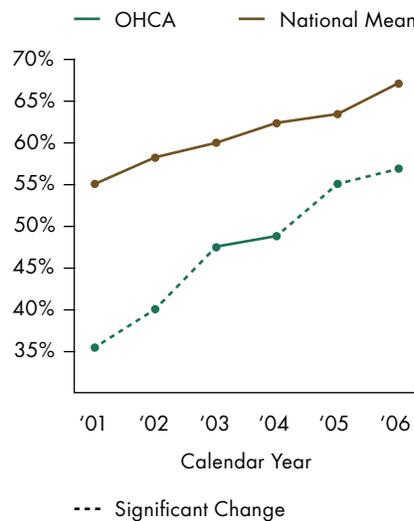
### Cervical Cancer Screening



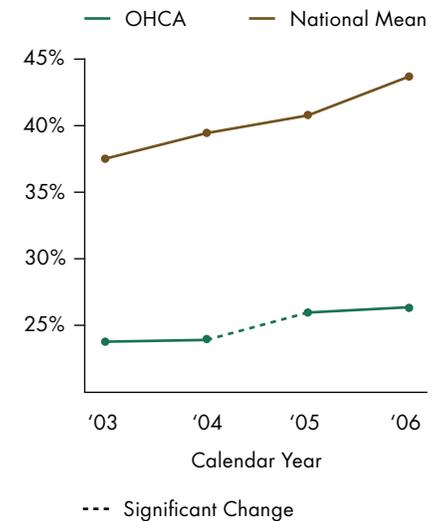
### Annual Child Health Checkup, Ages 0–15 Months



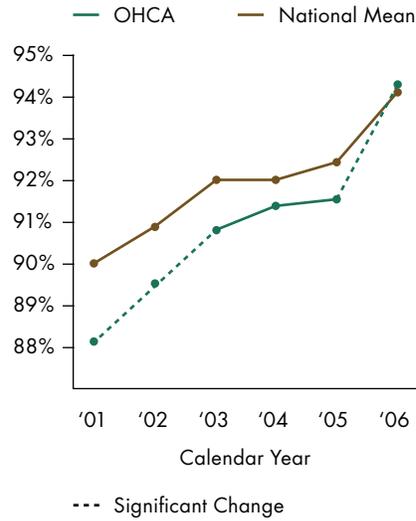
### Annual Child Health Checkup, Ages 3–6 Years



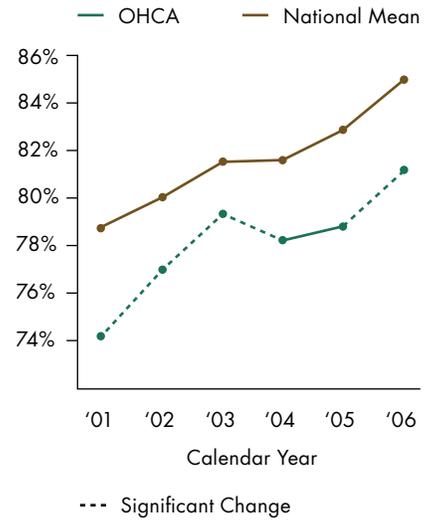
### Annual Child Health Checkup, Adolescents



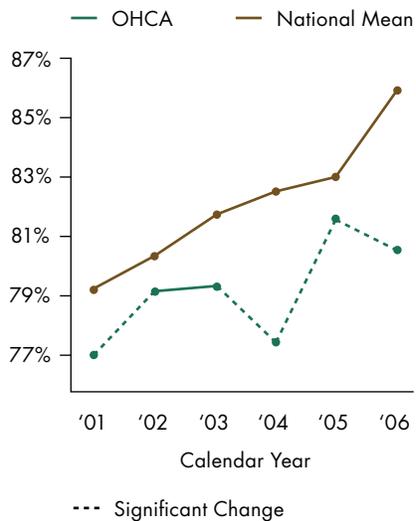
At Least One PCP Visit,  
Ages 12–24 Months



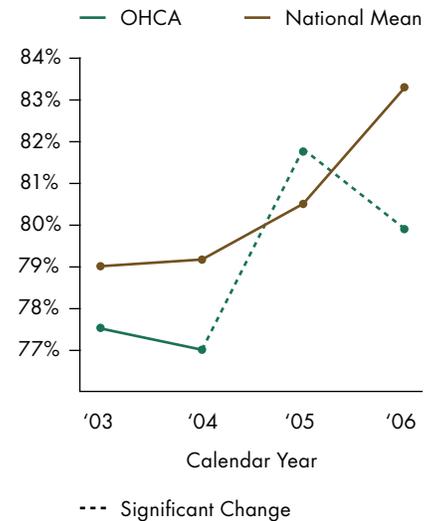
At Least One PCP Visit,  
Ages 25 Months–6 Years



At Least One PCP Visit,  
Ages 7–11 Years

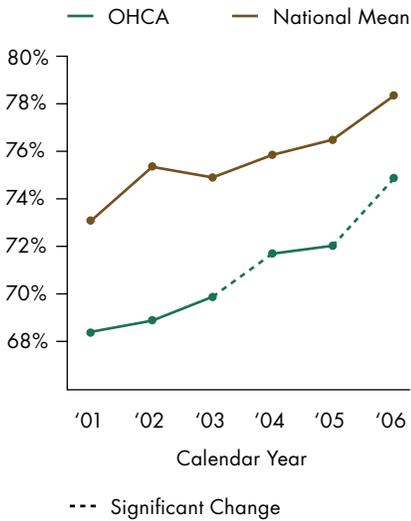


At Least One PCP Visit,  
Ages 12–19 Years

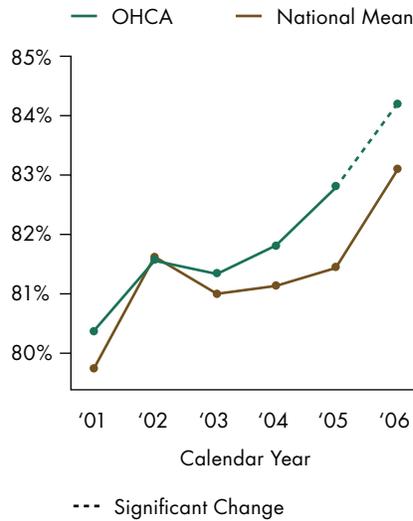


**Accessing care:** This measure calculates the percentage of members who accessed care (i.e., had at least one PCP visit) during the calendar year. These measures include four age groups for children and two age groups for adults. Comparing 2005 with 2006, the children in the two younger groups had significant increases in their rates, with the rate for members 12-24 months being statistically the same as the national mean. Children in the two older groups had significant decreases in their rates, while the rates for both adult age groups significantly increased. The rate for adults ages 45-64 was significantly higher than the national mean.

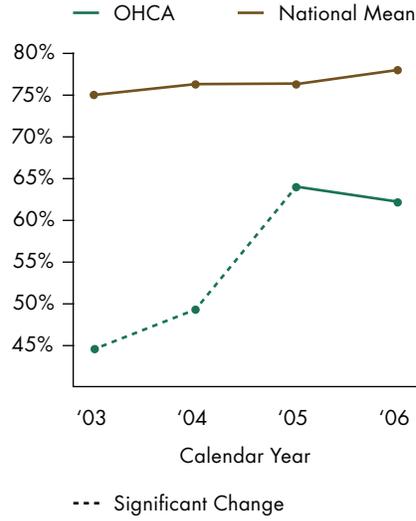
Adults Ages 20–44 Accessing Preventive/Ambulatory Services



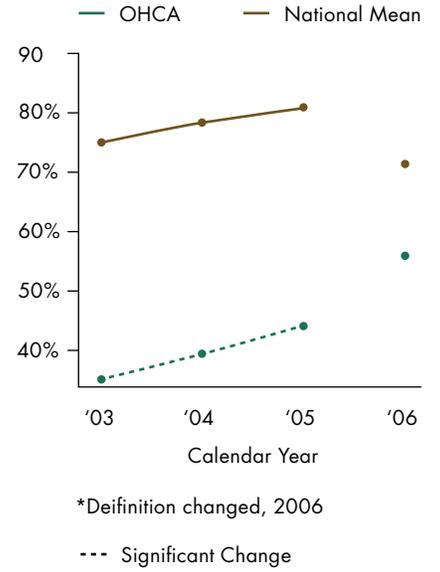
Adults Ages 45–64 Accessing Preventive/Ambulatory Services



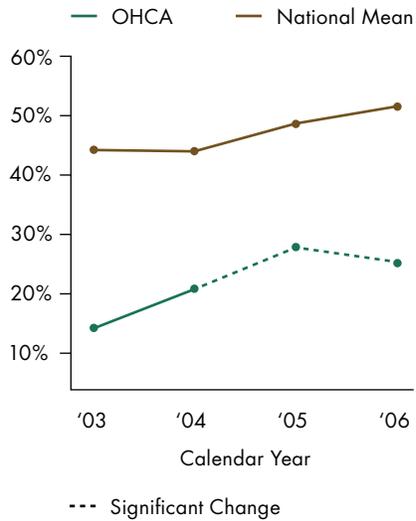
### Comprehensive Diabetes Care: HbA1C



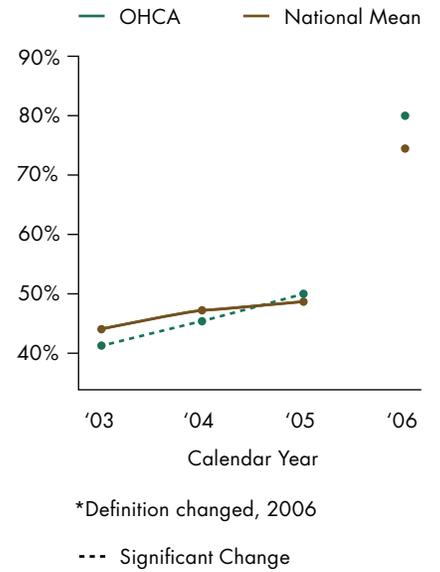
### Comprehensive Diabetes Care: LDL-C\*



### Comprehensive Diabetes Care: Eye Exam



### Comprehensive Diabetes Care: Nephropathy Screening\*



**Comprehensive Diabetes Care:** Diabetes is a complicated disease that impacts a person's health in a number of ways. People with diabetes can suffer from vision problems, kidney damage, nerve damage, and problems of the heart and circulatory system. The Comprehensive Diabetes Care measure has four parts. We calculated the rates of people with diabetes who received the following tests during 2006:

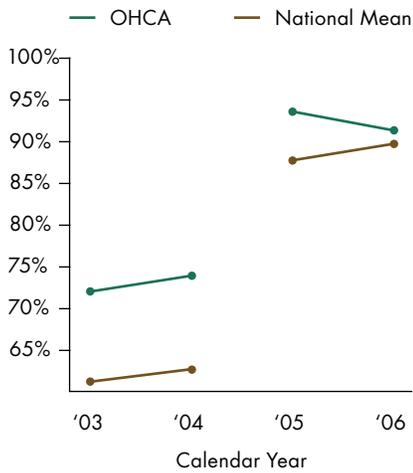
- Hemoglobin A1C (HbA1C) test, which measures average blood sugar in the previous three months;
- LDL-C test, which is a measure of "bad" cholesterol;
- Dilated eye exam, which checks for vision problems related to diabetes; and
- Nephropathy screening, which checks for kidney disease.

HEDIS® changed the specifications on the LDL-C and nephropathy measures, so the rates for 2006 cannot be compared statistically with the rates from previous years.

After two successive years of higher rates, the 2006 rate for HbA1C tests for people with diabetes was statistically unchanged from 2005. For the rate of people with diabetes being screened for "bad" cholesterol, rates increased for two years, but a change in the technical specifications for the measure makes a statistical comparison between 2005 and 2006 impossible. The rates of eye exams for people with diabetes have been variable. The nephropathy screening rate increased, and although a comparison between 2005 and 2006 cannot be made because of a change in this measure, our rate for 2006 exceeded the national average.

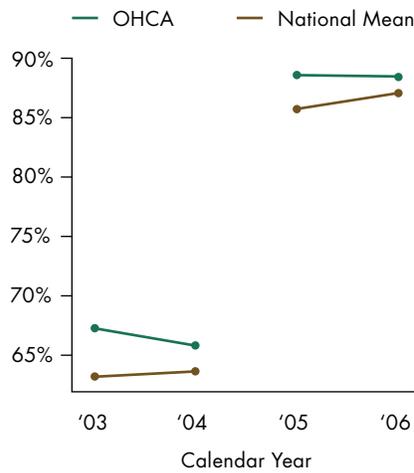
**Appropriate Medications for Asthma:** We track three age groups on this measure, which has stringent guidelines, making the number of people eligible to be counted quite small. In statistics, the probability of finding a significance difference is lower with smaller sample sizes. This is the likely reason that none of the evident changes in the rates on the asthma measure were statistically significant. In addition, the difference between our 2004 and 2005 rates for appropriate asthma medications cannot be tested statistically because of a change in the HEDIS® definition for this measure. Nonetheless, it is noteworthy that two of **SoonerCare**'s three age groups had rates that were statistically equal to the national average in 2006.

Appropriate Asthma Medication:  
Ages 5–9 Yrs\*



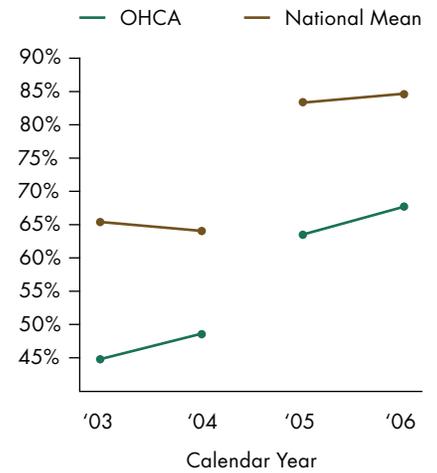
\*Definition changed, 2005

Appropriate Asthma Medication:  
Ages 10–17 Yrs\*



\*Definition changed, 2005

Appropriate Asthma Medication:  
Ages 18–56 Yrs\*



\*Definition changed, 2005

## Performance Tracking Across Time: HEDIS® Results

	OHCA Administrative Data		SoonerCare Choice			
	2001	2002	2003	2004	2005	2006
Annual Dental Visit (Combined rate <21 years)	41.6%	46.6%	51.2%	53.6%	56.6%	<b>56.3%</b>
Breast Cancer Screening	N/A	N/A	29.8%	29.8%	31.9%	<b>34.1%</b>
Cervical Cancer Screening	N/A	N/A	32.6%	34.5%	43.5%	<b>42.3%</b>
<b>Child Health Checkups (EPSDT)</b>						
Child Health Checkups in first 15 months (1 or more visits)	87.6%	91.4%	92.6%	91.6%	95.2%	<b>96.5%</b>
Child Health Checkups 3-6 yrs (1 or more visits)	35.3%	40.1%	47.3%	48.6%	54.7%	<b>56.7%</b>
Child Health Checkups adolescent (1 or more visits)	N/A	N/A	23.7%	23.8%	25.9%	<b>25.9%</b>
<b>Children's Access to PCP</b>						
12-24 months	88.1%	89.5%	90.8%	91.4%	91.2%	<b>94.3%</b>
25 months-6 yrs	74.1%	77.0%	79.3%	78.2%	78.0%	<b>81.2%</b>
7-11 yrs	76.7%	79.0%	79.2%	77.3%	81.2%	<b>80.4%</b>
12-19 yrs	N/A	N/A	77.4%	77.0%	81.1%	<b>79.8%</b>
<b>Adult Access to Preventive/Ambulatory Health Services</b>						
20-44 yrs	68.4%	68.8%	69.8%	71.6%	72.0%	<b>74.9%</b>
45-64 yrs	80.3%	81.5%	81.3%	81.8%	82.8%	<b>84.2%</b>
<b>Comprehensive Diabetes Care</b>						
HbA1C Screening	N/A	N/A	44.4%	49.2%	64.1%	<b>62.0%</b>
LDL-C Screening	N/A	N/A	34.7%	39.4%	43.9%	<b>55.8%*</b>
Eye Exam Screening for diabetic retinopathy	N/A	N/A	14.1%	20.7%	27.7%	<b>25.4%</b>
Nephropathy Screening (for evidence of nephropathy)	N/A	N/A	40.9%	45.3%	49.9%	<b>79.6%*</b>
<b>Appropriate Medications for the Treatment of Asthma</b>						
Age Group 5-9 yrs	N/A	N/A	72.1%	73.9%	93.7%*	<b>91.3%</b>
Age Group 10-17 yrs	N/A	N/A	65.7%	64.2%	88.3%*	<b>88.4%</b>
Age Group 18-56 yrs	N/A	N/A	44.7%	48.6%	64.2%*	<b>67.6%</b>

Significant increase from previous year
  Significant decrease from previous year

\* No valid statistical comparison to previous year because of changes in the measure's technical specifications.



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

We conduct two surveys annually to assess member satisfaction with **SoonerCare** and the health care they receive from our providers. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) focuses on medical care, and the Experience of Care and Health Outcomes (ECHO®) concerns behavioral health services. We alternate the age groups for the surveys from year to year. For SFY 2007 we gave the CAHPS survey to parents/guardians to answer regarding their children's medical treatment, and we gave the ECHO survey to adults to rate their satisfaction with behavioral health services.

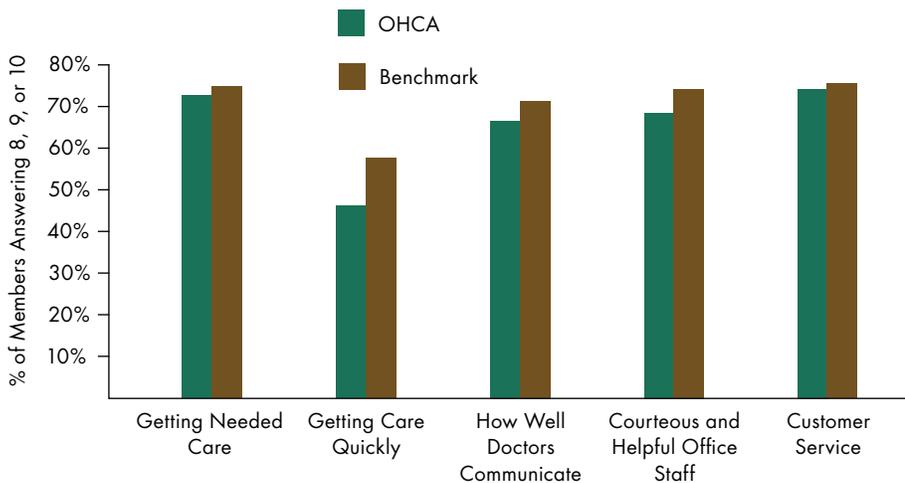
The CAHPS survey asks questions related to consumers' experiences with providers and the **SoonerCare** system. The main composite measures are Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Courteous and Helpful Office Staff and Customer Service. To help Medicaid plans determine how they are doing on these measures, the National Committee for Quality Assurance (NCQA) provides benchmarks based on the results from many states. The benchmarks for this year's survey were calculated on data from 33 Medicaid plans. Our CAHPS results on these composite measures were statistically the same as the benchmarks.

Some differences were noted on individual questions, however. For example, respondents were asked to rate their children's personal doctor on a scale from 0 = "worst possible" to 10 = "best possible." Results showed that 75 percent of **SoonerCare** members answered 8, 9 or 10 on this question, which was significantly lower than the benchmark of 83 percent. Another question asked for a similar rating of the members' health care in general. About 74 percent of respondents answered 8, 9 or 10, statistically lower than the benchmark of 83 percent. Comparing the latest results with the

last administration of the child CAHPS survey, this year's survey showed a significantly higher percentage of respondents saying there was no problem getting help when they called our customer service (74 percent vs. 61 percent in 2004-05).

The ECHO survey contained similar questions about adults' experiences with behavioral health care providers. NCQA provides no national benchmarks for the ECHO survey, so we compared the results from 2007 with the results from the last adult ECHO survey, in 2004-05. The results showed that a significantly higher percentage of people in 2007 reported problems with delays in waiting for approval from **SoonerCare** before services were obtained. We take these satisfaction surveys seriously, and we will look for ways to improve our processes so that **SoonerCare** members can obtain the services they need in the most efficient and timely manner possible.

### Adult CAHPS Composite Measures of Satisfaction\*



\*No Significant Differences

# ONGOING QUALITY REVIEWS



Overseeing the process of health-care delivery is a major responsibility for the OHCA. We employ medical professionals and an outside contractor to conduct routine reviews of medical records and reports of potential quality issues. The following section describes our methods of monitoring the quality of services and investigating reports of possible problems.

## On-Site Provider Reviews

QA/I compliance analysts and review nurses conduct on-site reviews of contracted **SoonerCare** Choice providers using standardized audit tools and scoring. During SFY 2007, staff members completed 213 on-site reviews, which impacted hundreds of providers and thousands of members. These reviews are an opportunity for us to help providers with accurate claims resolution and for us to learn from providers about ways to improve our system. We also provide education about the **SoonerCare** program and OHCA rules, making referrals to other OHCA departments as needed. Our goal is to assure that quality health care services are provided through these partnerships with contracted providers.

The **SoonerCare** contract requires 24-hour access to medical providers so that members have access to timely and appropriate services. One way of ensuring that members have 24-hour access involves an ongoing survey after ordinary business hours. Every quarter Provider Services staff members telephone all **SoonerCare** PCP service locations after 5 p.m. to determine whether a member needing help would have access to care. We made 2,205 provider contacts during SFY 2007 and determined that for 85 percent of these calls, 24-hour access was available. The other providers were given information to help them bring their practices into compliance, and followup phone calls were made to these providers.

Ongoing communication with providers increases the quality of the **SoonerCare** program, and we look forward to continuing to foster these mutually beneficial relationships.

## Dental Provider Audits

The Dental Unit of the OHCA has instituted a system of reviewing services from dental providers. By the end of SFY 2007, about 75 practices had been reviewed. Each month, we randomly sampled about 20 dental providers. For each provider we analyzed data from members served. These analyses

identify any possible concerns according to the number of claims in various categories of service. Then a dentist employed by the OHCA visited the randomly chosen practices to look at members' records and provide outreach to the practices. The goal of these audits is to ensure quality services are being provided to our members; to improve communication with providers; and to help solve any problems they might be having with filing claims. We have been refining the dental audit process and plan to continue this quality assurance effort in the future.

### **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 SFY 2007, APS Healthcare Inc. was the external quality review organization contracted to complete this work. APS randomly selected 12,334 inpatient hospital admission cases and 1,207 outpatient observation service cases for retrospective review. Each monthly inpatient 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 may monitor and profile the cases for emergence of patterns. Cases also may be referred to the Medical Education and Intervention Committee (MEIC) for review and evaluation. Actively practicing physicians from both urban and rural areas and various specialties serve on the MEIC. 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**

Whenever the OHCA receives a report – from members, providers or stakeholders – of a potential issue related to quality of care, the QA/I department investigates. 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.



# 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 at programs that we expect to feature in future issues of this report.

Our emphasis on preventive services motivated the creation of three new provider profiles, which we worked on during SFY 2007 and mailed for the first time at the beginning of SFY 2008. These profiles focused on the following preventive services:

- Child Health Checkups (Early Periodic Screening, Diagnosis and Treatment, or EPSDT exams), taking into account the different numbers of exams expected for children of various ages;
- Cervical cancer screenings, or Pap tests, taking into account the recommended ages for members to receive these tests; and
- Breast cancer screenings, or mammograms, also taking into account the ages of members and frequency of exams that medical professional organizations recommend.

Providers who had enough data for a valid statistical analysis received a letter and a profile showing how their rate of actual exams compared with the expected number of screenings. The profile also showed how providers ranked among their peers statewide. We plan to create these profiles twice a year, and we expect the SFY 2008 quality report to include a complete description of these new ways of communicating with providers.

As we have shown in this report, our quality improvement work for our members and providers involves many collaborations, and ideas often come from those outside of the agency. Do you have ideas for helping us provide better health care services? We'd like to hear from you at (405) 522-7300.

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

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