

1. **Health Access Networks (HAN):** OHCA has three pilot health access networks, two in metropolitan areas and one serving rural Canadian County. The HAN enhances the capabilities of medical homes by facilitating Members' access to all levels of care within a community or a service region, augmenting the care coordination provided by other programs for persons with complex health care needs, assisting with the adoption of technology including electronic medical records, telemedicine; and promoting expanded quality improvement strategies.
2. **Health Homes:** OHCA and the Oklahoma Department of Mental Health and Substance Abuse Services are partnering to establish and operate health homes for individuals with multiple chronic health conditions, mental health conditions and/or substance abuse disorders. Health homes will integrate physical health and behavioral health services to enhance the coordination and quality of care for chronically ill patients.
3. **SoonerCare Population Care Management:** The SoonerCare Population Care Management staff strives to coordinate and collaborate with all SoonerCare-related service delivery systems to assure that members are served in the most appropriate manner and to avoid duplication of services. This unit houses three distinct units and programs to provide care management and coordination services for our SoonerCare members.
 - A. The Case Management unit provides episodic or event-based case management services provided by a team of nurses and social service coordinators. Members are identified through data mining, self-referral, provider referral, community agency/state partner agency referral, legislative referral and intra-agency (OHCA) referral. Supports provided by this unit are directed towards, but are not limited to, at-risk and high-risk obstetrical populations, at-risk and high-risk pediatric populations, members in the Oklahoma Cares breast and cervical cancer treatment program and members in need of out of state care coordination.
 - B. Oversight and operational guidance for the SoonerCare Health Management Program (HMP) is provided by the Population Care Management Department. The HMP is a vendor-operated chronic disease initiative. The program provides practice-based, chronic disease focused supports to SoonerCare members and primary care providers. The HMP provides specially trained process improvement support, known as practice facilitators, to practices with a significant burden of SoonerCare members with chronic illness. The practice facilitators work with practices to identify opportunities for team-based care, implement evidence-based guidelines, teach process and quality improvement principles and maximize use of electronic medical records and/or incorporation of a disease registry. The HMP also provides specially trained nurses, known as health coaches, to high-target primary care practices, to work directly with high-risk members with chronic conditions, or members at-risk for chronic conditions. These health coaches are embedded in the practice and focus on health literacy and improvement of self-management skills.
 - C. For members with chronic conditions who are not aligned with a primary care provider where a health coach is present, the Population Care Management Department has a 3rd unit known as the chronic care unit. The nurses in this

unit provides telephonic case management to our members in the high risk and at risk categories. Focus is on self-management skills, member education and resource support.

4. **Medical Home:** As identified by the patient centered Medical Home collaborative and adopted by OHCA, the principles of a Medical Home are as follows:
 - A. **Personal physician/Provider** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
 - B. **Physician/Provider directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
 - C. **Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
 - D. **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g. subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g. family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
 - E. **Quality and safety** are hallmarks of the medical home.
 - F. **Enhanced access to care** is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
 - G. **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Additional information on OHCA’s Medical Home may be found on the OHCA’s website by accessing the following link: <http://www.okhca.org/> and then browsing through both the Individual and Provider sections. Requirements for PCPs Participating in Medical Home may be accessed through OHCA’s Electronic Provider Enrollment (EPE) system at http://www.okhca.org/providers.aspx?id=109&menu=56&parts=7551_7553_7555

5. **CMS’ COMPREHENSIVE PRIMARY CARE INITIATIVE (CPCI):** Excerpted from a CMS’ New Release – In a strong show of support for effective, more affordable, higher quality health care, 45 commercial, federal, and State insurers – including two commercial insurers in the greater Tulsa and the Oklahoma Health Care Authority – today pledged to work with CMS to give more Americans access to quality health care at lower costs.

Under the CPCI, CMS will pay primary care practices a care management fee, initially set at an average of \$20.00 per beneficiary per month, to support enhanced, coordinated services. Simultaneously, participating commercial, State, and other federal insurance plans are also offering an enhanced payment to primary car

practices that provide high-quality primary care. Together, these investments in primary care practices will allow doctors to spend more time with their patients, stay open on weekends and evenings, provide additional services such as nutrition or smoking-cessation counseling, and coordinate care for their patients. CPCI began in Oklahoma in October 2012.

6. The Tulsa Health Innovation Zone (THIZ): Responding to Oklahoma's poor health status, health system performance, overall cost of care, access to care, health inequity and very low physician per capita ratio, a coalition of healthcare providers and payers in northeast Oklahoma has built the first three installments of a model health care delivery system to improve quality and access as well as improve the value and efficiency of care. In further advancing the quality and efficiency of the Tulsa region's health system, this coalition is committed to create a unique Health Innovation Zone (HIZ) with a central Accountable Care Organization (ACO) and the incorporation of health professions education. Our HIZ will comprise the northeast Oklahoma (the Tulsa Beacon Community) teaching hospitals, physicians, and other providers.