Care Integration

ANNUAL REPORT

CALENDAR YEAR

2019

Children's Mercy
PEDIATRIC CARE NETWORK


Behavioral Health
Physical Health
Social Determinants of Health
Population Health Analytics & Tools
Utilization Management
Transition of Care Support
Care Management
Disease Management
Quality, Compliance & Reporting
Person-Centered Care

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OUR MISSION

The Mission of Children's Mercy Integrated Care Solutions' Pediatric Care Network is to improve the health and well-being of children through integrated pediatric networks in the greater Kansas City area that are value based, community-focused, patient centric, and accountable for the quality and cost of care.

Children's Mercy
INTEGRATED CARE SOLUTIONS

Overview of the Pediatric Care Network

The Pediatric Care Network (PCN) offers a comprehensive Care Integration program, which provides case management (CM), utilization management (UM), and disease management (DM) using population health concepts and tools. The program focuses on preventive health and coordinating a member's care across an episode or continuum of care through:

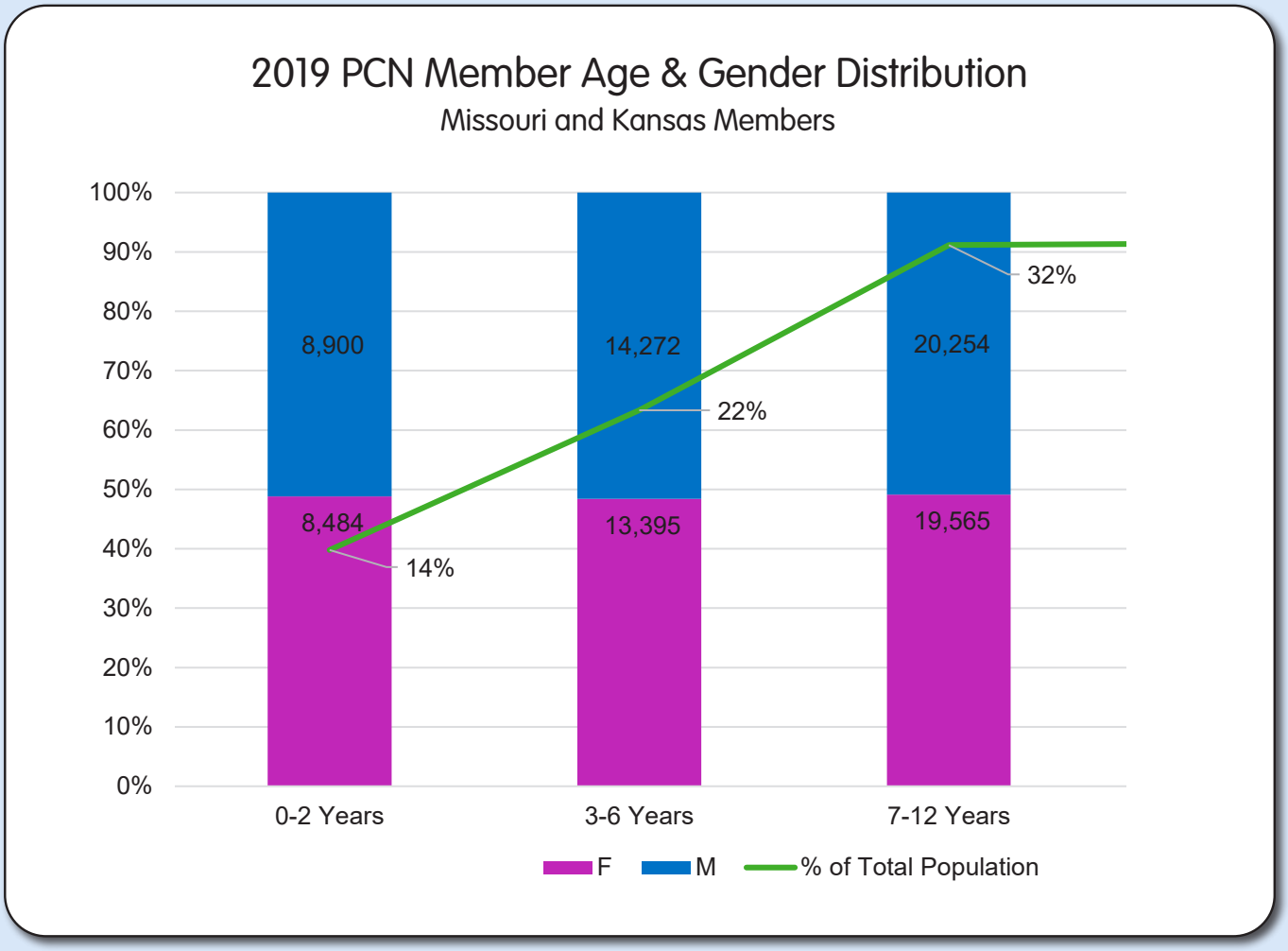
- Negotiating, procuring, and coordinating services and resources for patients and families with complex needs
- Facilitating care transitions across care settings
- Ensuring and facilitating the achievement of quality, clinical, and cost outcomes
- Assessing member needs and developing patient-centered care plans and interventions
- Addressing and resolving patterns of issues that have negative quality or cost impact
- Continually evaluating the effectiveness of program interventions to improve quality and health outcomes

Through data analysis and identification of high cost or high risk trends, the PCN continually assesses the characteristics and needs of the population and sub-populations being managed to identify opportunities to enhance and/or modify its care integration program, including children with special healthcare needs, disabilities, and other complex health issues. Disease management interventions focus on two chronic conditions that are relevant to the pediatric population: asthma and diabetes. The PCN continually assesses program interventions and resources to determine if changes are needed to better meet the needs of the population.

The PCN performs delegated medical management functions under capitated risk agreements with Medicaid managed care organizations in Missouri and Kansas. PCN entered into agreements with Missouri Care in February 2014 and with

UnitedHealthcare Community Plan of Missouri in May 2017. PCN entered into similar contracts with UnitedHealthcare Community Plan of Kansas (effective 11/1/2017) and Aetna Better Health of Kansas (effective 7/1/2019). As of December 2019, PCN managed approximately 47,616 Missouri Care members, 30,385 UnitedHealthcare Community Plan of Missouri members, ages 20 and under in the Western Region, 27,317 UnitedHealthcare Community Plan of Kansas members ages 21 and under in select counties, and 19,330 Aetna Better Health of Kansas members.

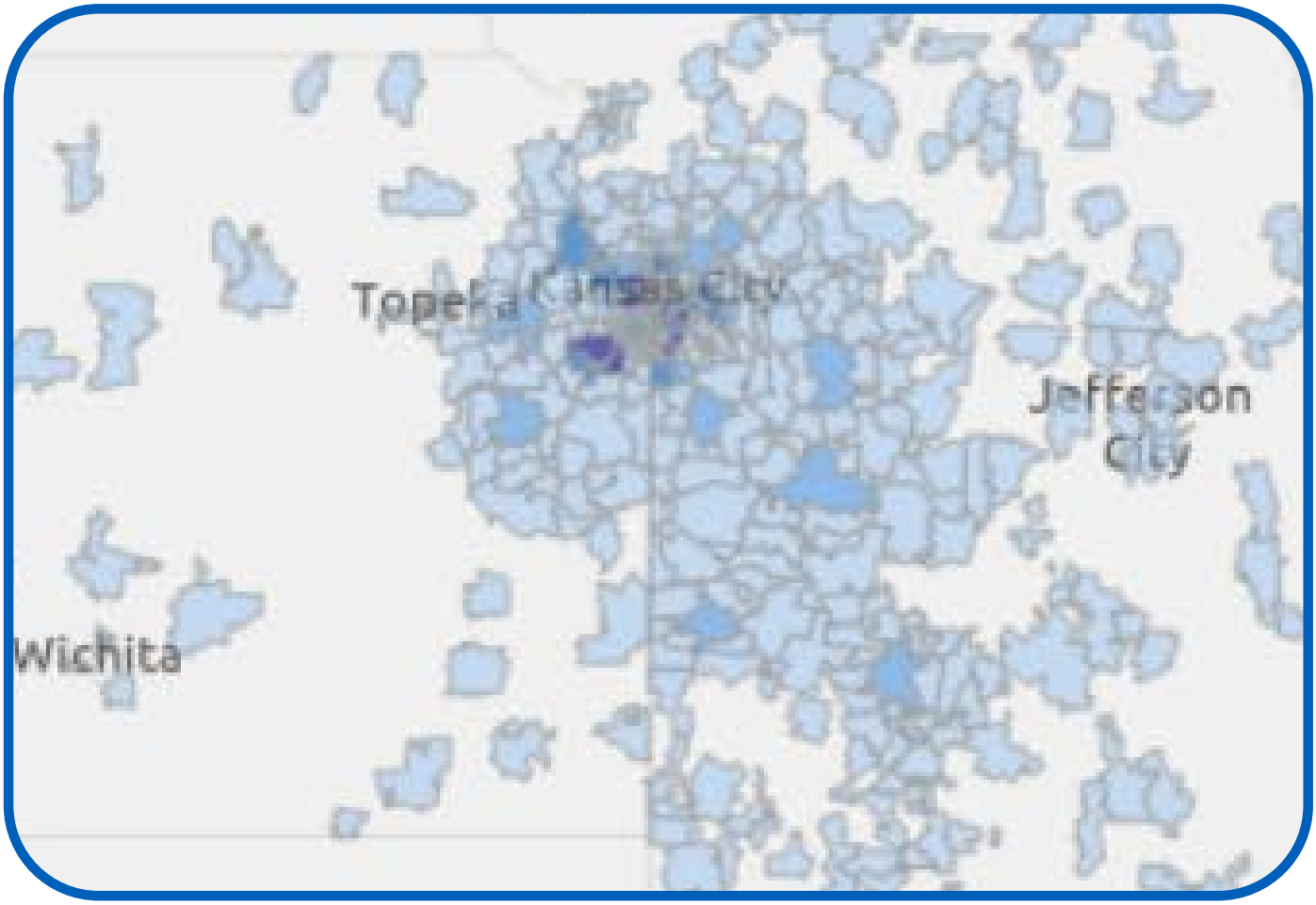
Through these value based contracts, providers agree to engage with the PCN in transforming their practice using patient-centered medical home (PCMH) concepts and demonstrating sustainable outcomes through improved quality, improved patient satisfaction, and decreased cost.



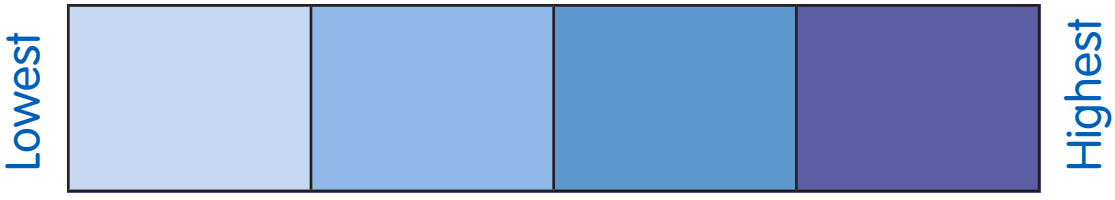
Population Analysis/Characteristics

As of Dec. 31, 2019, the male to female ratio of the PCN population is roughly 50% and the most concentrated population (approximately 65%) are in the 7-12 and 13-21 year age category. See chart above illustrating the age and gender distribution of the PCN members in 2019.

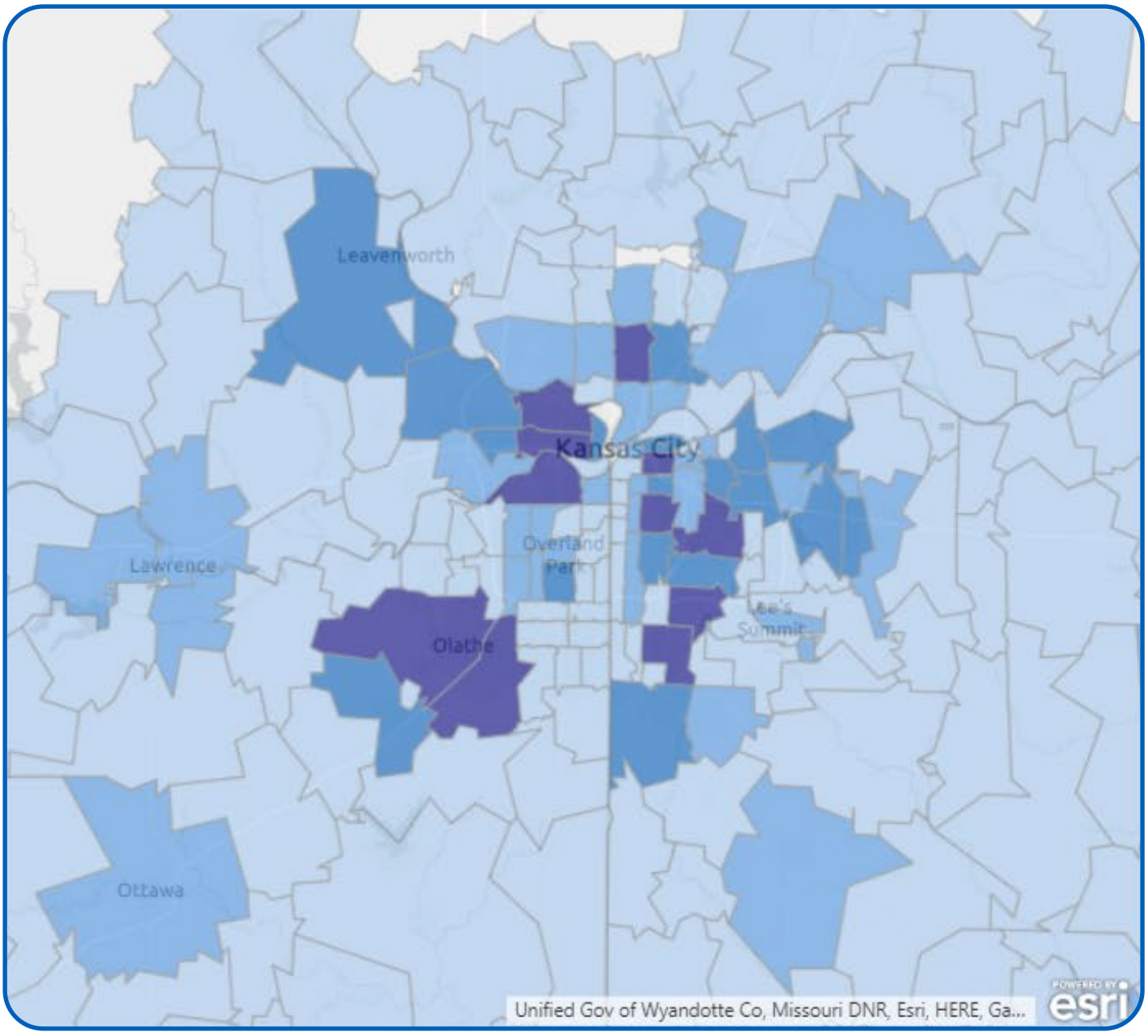
PCN Member Origin (Regional View)
124,828 Members



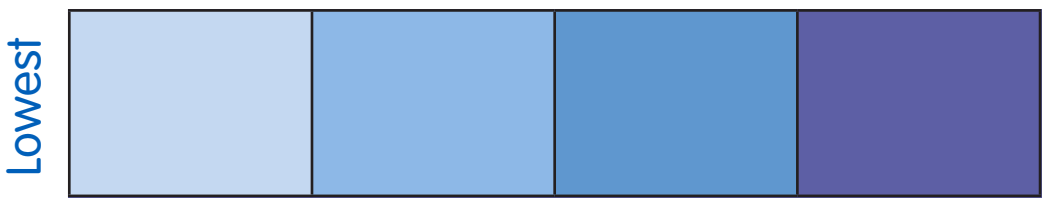
PCN Member Population Concentration



PCN Member Origin (Kansas City Metro View)
124,828 Members



PCN Member Population Concentration



PCN Network Providers -- Missouri

Baby and Child Associates
9140 Ward Parkway, Suite 201
Kansas City, MO 64114

Blue Springs Pediatrics
1600 NW South Outer Road
Blue Springs, MO 64015

Cass County Pediatrics and Adolescents -- an Affiliate of Children's Mercy
503 N Scott, Belton, MO 64102

Children's Mercy Broadway
3101 Broadway Blvd.
Kansas City, MO 64111

Children's Mercy Operation Breakthrough Clinic
3039 Troost Ave.
Kansas City, MO 64109

Christine Moore, DO
402 W Pine, Raymore, MO 64083

Cockerell and McIntosh
- **Blue Springs**
  205 NW RD Mize Road, Ste 304
  Blue Springs, MO 64014
- **Higginsville**
  1717 Main, Higginsville, MO 64037
- **Independence**
  11200 Winner Road
  Independence, MO 64052

Excelsior Springs Physicians Clinic
- **H. Andrew Pickett, MD**
  1236 Jesse James Road
  Excelsior Springs, MO 64024
- **Robert Buzard, MD**
  1010 N Jesse James Road
  Excelsior Springs, MO 64024

Family Practice of Central Missouri
- **Higginsville**
  1200 West 22nd St.
  Higginsville, MO 64037
- **Warrensburg**
  513 Burkarth Road
  Warrensburg, MO 64093

Hope Family Care
3027 Prospect Ave.
Kansas City, MO 64128

Independence & Lee's Summit Pediatrics
- **Independence**
  4731 S Cochise Drive, #100
  Independence, MO 64055
- **Lee's Summit**
  2 NE Sycamore
  Lee's Summit, MO 64086

KC Care Clinic
- 4601 Independence Ave.,
  Kansas City, MO 64124
- 3515 Broadway,
  Kansas City, MO 64111
- 2340 E. Meyer Boulevard,
  (Bld 1) Ste. 200, Kansas City,
  MO 64132
- 1106 E 30th St., Kansas City,
  MO 64109

Lee's Summit Physicians Group
1425 NW Blue Parkway
Lee's Summit, MO 64086

Meritas Health Pediatrics
2700 Clay Edwards Drive, #500
Kansas City, MO 64116

Meritas Health Richmond
902 Wollard Blvd.
Richmond, MO 64085

Platte County Pediatrics
1104 Platte Falls Road
Platte City, MO 64079

Preferred Pediatrics LLC -- an Affiliate of Children's Mercy
241 NW McNary Court
Lee's Summit, MO 64086

Priority Care Pediatrics LLC
- **North Oak Kansas City**
  9405 N Oak Trafficway
  Kansas City, MO 64155
- **Parkville**
  6320 N Lucerne Ave.
  Kansas City, MO 64151
- **Liberty**
  1540 NE 96th St.
  Liberty, MO 64068

Raintree Pediatrics
995 SW 34th St.
Lee's Summit, MO 64082

Redwood Pediatrics -- an Affiliate of Children's Mercy
9151 NE 81st St., Ste 240
Kansas City, MO 64158

Samuel U Rodgers
825 Euclid, Kansas City, MO 64124
- **Clay County**
  800 Haines Drive
  Liberty, MO 64068
- **Lafayette**
  811 A South Highway 13
  Lexington, MO 64067
- **Northland**
  5330 N Oak Trafficway.,
  Suite 104,
  Kansas City, MO 64118
- **Westside Clinic**
  2121 Summit
  Kansas City, MO 64108

Swope Health Center
3801 Blue Parkway
Kansas City, MO 64130
- **Belton**
  206 E. North Avenue
  Belton, MO 64012
- **Hickman Mills**
  Loma Vista Building
  8800 Blue Ridge Blvd., 2nd Floor
  Kansas City, MO 64138
- **Independence**
  11320 E Truman Road
  Independence, MO 64050
- **Northland**
  2906 NW Vivion Road
  Riverside, MO 64150

T.P. Children & Teens Care
2340 E Meyer Blvd.
Suite 208 Bldg. 1
Kansas City, MO 64132

Tenney Pediatric & Adolescent Medicine
6501 E. 87th St.
Kansas City, MO 64138

Whistlestop Pediatrics
415 Burkarth Road
Warrensburg, MO 64093

NCQA Recognized Patient-Centered Medical Home Provider

PCN Network Providers -- Kansas

Children's Mercy Clinics on Broadway*
3101 Broadway Blvd.
Kansas City, MO 64111

Children's Mercy West
4313 State Ave.
Kansas City, KS 66102

Claudia McAllaster, MD
3550 S 4th St., Ste 110
Leavenworth, KS 66048

Debra Heidgen, MD
3550 S 4th St., Ste 120
Leavenworth, KS 66048

Lori Ann Golon, MD
1001 6th Ave., Ste 210
Leavenworth, KS 66048

KU Medwest
7405 Renner Road
Shawnee, KS 66217

Panda Pediatrics
1803 W. 6th Street
Lawrence, KS 66044

Samuel U Rodgers
825 Euclid
Kansas City, MO 64124

Samuel U Rodgers Westside Clinic
2121 Summit
Kansas City, MO 64108

Swope Health Services
6013 Leavenworth Road
Kansas City, KS 66104

Swope Health Wyandotte
21 N 12th St., Ste 400
Kansas City, KS 66102

Vernon Mills, MD
3550 S 4th St., Ste 120
Leavenworth, KS 66048

Vibrant Health Wyandotte Neighborhood Clinics

- **Argentine**
  1428 S 32nd St. #100
  Kansas City, KS 66106
- **Central**
  21 N 12th St., Suite 300
  Kansas City, KS 66102
- **Children's Campus**
  444 Minnesota Ave.
  Kansas City, KS 66101

The University of Kansas Physicians (Prairie Village)
7301 Mission Road, Suite 350
Prairie Village, KS 66208

The University of Kansas Physicians (Kansas City, Kansas)
2010 West Olathe Blvd.
Kansas City, KS 66103

NCQA Recognized Patient-Centered Medical Home Provider

Key Staff Roles and Credentials

The PCN currently employs Registered Nurses, licensed Social Workers, Respiratory Therapists, Medical Directors, and administrative/non-clinical staff to support the medical management and practice transformation work. Please refer to the Care Team Diagram in Appendix A.

PCP Aligned Care Teams

The disciplines employed by PCN are organized into Primary Care Provider (PCP)-aligned Care Teams. Certification in case management and disease-specific coaching is strongly encouraged and/or required of the PCN clinical staff. Currently, ten Care Team members have case management certification, as well as one certified asthma educator and one certified diabetes educator.

The Care Team objectives are as follows:

- Assist members in sustaining or achieving an optimal level of wellness and function by facilitating timely and appropriate healthcare services
- Promote strong member/PCP relationships for coordination and continuity of care, using PCMH concepts
- Reduce inappropriate inpatient hospitalizations and utilization of emergency room services
- Promote clinical care that is consistent with scientific evidence and member preferences
- Ensure the integration of medical and behavioral health services
- Minimize gaps in care and encourage use of preventive health services
- Achieve cost efficiency in the provision of health services while maximizing healthcare quality
- Mobilize community resources to meet needs of members

The primary roles within the PCN working directly with members, caregivers, and community providers are detailed below.

Care Navigators

Care Navigators are Registered Nurses (RN) or Social Workers (SW) whose primary role is to provide case management for identified at-risk members, addressing barriers to care for an assigned population of members. The Care Navigator promotes coordination of care and services for members along the healthcare continuum, as well as promotes quality care through appropriate, cost effective interventions.

The scope of practice for Care Navigators includes:

- Engage with members and providers utilizing all available resources, including integrated platforms (e.g., telehealth, portal access, face-to-face visits) for effective communication and workflow process
- Use data analytic tools and registries to identify and address needs of at-risk populations
- Facilitate successful transitions of care for members and families across care settings, including assessing barriers, facilitating discharge planning, and promoting a seamless plan of care, which is communicated to all Care Team members
- Follow a care planning process to identify patient-centric goals and establish priorities
- Utilize a holistic approach, applying multiple theories and interventions, to motivate member/family engagement
- Conduct psychosocial screening and interventions to address behavioral and social needs
- Address social determinants of health as part of the ongoing assessment and care planning process
- Facilitate access to behavioral health resources and services
- Provide targeted education and facilitation of available health plan benefits and incentive programs
- Participate in pre-visit planning with the healthcare team to identify members appropriate for case management and/or tasks needed to meet member needs
- Identify and stratify member needs to facilitate referrals to other members of the Care Team (e.g., Community Health Worker, Social Worker, Nurse, Provider, Community Resource Agency, School, and Family Member)
- Facilitate end of life support for members, families, and the healthcare team
- Promote wellness through member education on disease-specific conditions and preventive care
- Participate in shared accountability for the identified team-based population measures

Community Health Workers

Community Health Workers are specially trained, non-licensed members of the Care Team who bridge the gap between health care providers and members/families in need of care. Community Health Workers are trusted member of and/or have a close understanding of the communities they serve. They serve as a link between the members/families and the health or social service agencies.

The scope of practice for Community Health Workers includes:

- Continuously expand knowledge of community resource services and programs
- Help members and their families adopt healthy behaviors
- Establish trusting relationships with members and their families while providing general support and encouragement
- Refer and assist with accessing necessary social services (e.g., Legal Aid, housing, food, and transportation services)
- Facilitate successful appointments for members and families including: assisting with preparation for appointments, attending appointments, and helping members and families understand information
- Assist members and their families in accessing health related services, including but not limited

to: connecting with a medical home, providing instruction on appropriate use of the medical home, and overcoming barriers to obtaining medical, social, and behavioral health services
- Participate in shared accountability for the identified team-based population measure

Community Resource Specialists

Community Resource Specialists work as members of the Care Team to support population health initiatives and case management. This position works closely with all areas of the PCN and its stakeholders, including providers, members and families, community agencies, and other health care professionals.

The scope of practice for Community Resource Specialists includes:

- Establish and maintain relationships with key community stakeholders through ongoing shared information and learning (e.g., lunch and learns, participation in volunteer opportunities, maintaining event calendar for team member access, ensuring key information is updated and shared)
- Provide outreach and education to members, families, and other healthcare team members in addressing gaps in care and resource needs
- Distribute tasks and referrals to appropriate Care Team members
- Participate in Triannual Performance Reviews with each assigned PCP office and assist in identifying Care Team priorities based on data analysis and Care Team discussion
- Assist members and families with problem solving, addressing concerns, and ensuring education about available community resources
- Provide support with prior authorization processing for assigned Care Team
- Provide education and organization of community resources

Care Facilitation Coordinators

Care Facilitation Coordinators are trained administrative staff who serve on the front lines answering provider calls and reviewing, processing, and distributing faxes to the Care Integration department. They assist with entering prior authorization information, screening pregnancy notification forms, facilitating referrals to home care agencies, and assisting the PCP-aligned Care Teams with other duties to support functions within the department.

The scope of practice for Care Facilitation Coordinators includes:

- Distribute work to Care Team members and perform general administrative duties to support the Care Teams and management staff
- Receive phone calls from PCN providers and answer questions regarding benefit plans, prior authorization process or status, or other related issues
- Process prior authorization requests from PCN providers and enter determinations into online documentation system based on pre-established criteria and per documentation standards
- Analyze data and identify opportunities for improvement in Care Integration department processes

Care Facilitation Nurses

Care Facilitation Nurses are Registered Nurses who are responsible for prior authorization functions for inpatient and outpatient services, using evidence-based clinical criteria. The Care Facilitation Nurse works in collaboration with the provider offices by providing education on the prior authorization process, facilitating referrals to network providers, providing member outreach to identify and screen members with complex needs for enrollment into Care Integration programs, and sharing of pertinent patient information with Care Teams to enhance coordination of care.

The scope of practice for Care Facilitation Nurses includes:

- Receive prior authorization requests requiring clinical review and enter determinations into online documentation system
- Conduct psychosocial pre-screening and interventions to identify members whom would benefit from enrollment into Care Integration programs
- Address social determinants of health as part of the screening process
- Provide targeted education and facilitation of available health plan benefits and incentive programs

Practice Facilitation Specialists

Practice Facilitation Specialists work with PCP practices to facilitate practice transformation and support practice management processes aimed toward improving member outcomes. Practice Facilitation Specialists use evidence-based guidelines and best practices as a basis for teaching chronic disease management, wellness promotion, and patient-centered medical home (PCMH) concepts. Their role includes promoting a culture of learning and quality improvement (QI) within practices and providing coaching to support transformation and sustained change.

The scope of practice for Practice Facilitation Specialists includes:

- Provide training on data analytic tools to support population health/PCMH initiatives
- Assist Care Teams with data analytics for Provider Practice Performance Profile reviews to support Care Team discussions and initiatives
- Participate in Triannual Performance Reviews with each assigned PCP office and assist in identifying Care Team priorities based on data analysis and Care Team discussion
- Prepare PCP triannual engagement progress reports and compensation education
- Teach and support PCMH concepts and monitor ongoing sustainability of processes
- Provide evidence-based, condition specific training for provider practices, including asthma, diabetes, and healthy lifestyles
- Participate in shared accountability for the identified team-based population measures

Provider Relations and Practice Representatives

The Provider Relations and Practice Representatives work as an integrated team to team to keep provider offices informed and functioning at the highest level possible with all population management tools and resources. They assist practices with understanding the Medicaid contracts and provide a streamlined communication with the Managed Care Organization (MCO) on behalf of the PCN providers.

The scope of practice for Provider Relations Representatives includes:

- Maintain accurate participating provider status, update provider directories, and assist in maintenance of online provider directories
- Assist with resolution of provider issues regarding claims status and enrollment issues
- Assist with individual PCP assignment issues and PCP changes from the PCN provider to the MCO
- Facilitate a streamlined, non-redundant credentialing process for PCN providers
- Participate in triannual Provider Practice Performance Profile reviews with each assigned PCP office and assist in identified team-based population measures analysis and team discussions
- Continued education for Patient Centered Medical Home objectives
- Focus on quality outcomes for pediatric populations
- Monitor value based performance of each practice

Operations & Population Health Management Team

PCN's Operations & Population Health Management Team engages in work that supports population health management, patient-centered medical home transformation, quality and cost improvement initiatives, and identification of opportunities to enhance PCN's Care Integration program.

Data Analytics Program Manager

The Data Analytics Program Manager is responsible for the overall planning, management, and completion of data and analytics projects that support and advance PCN strategic priorities. The Data Analytics Program Manager also leads and supports population health work related to multiple quality and cost improvement initiatives and programs.

The scope of practice for the Data Analytics Program Manager includes:

- Perform quality and cost improvement data analytics, design analytical tools/resources, and develop and generate new and existing reports
- Interpret data and analyze results using statistical techniques and design/deploy ongoing reports
- Identify, analyze, and interpret trends or patterns in complex data sets
- Develop reports and dashboards within databases and data collection systems
- Analyze, develop, and implement improvement activities to increase compliance rates as measured by nationally standardized benchmarks and definitions
- Collaborate with practices to integrate their claims and/or electronic medical record data into vendor population health management platform

Program Manager, Operations & Population Health Management

The Program Manager, Operations & Population Health Management leads and supports population health management and operations work related to multiple quality and cost improvement initiatives and programs.

The scope of practice for the Program Manager, Operations & Population Health Management includes:

- Assist and support PCN leadership and staff in program identification, development, and prioritization of quality, cost, population health management, and/or operations improvement initiatives
- Develop reports and collect quality and cost improvement data from various sources, including the clinical data integration platform, which drives initiatives within PCN, as well as contracted primary care provider offices
- Use established metrics to measure quality and cost performance and population health outcomes
- Prepare and present reports for internal and external stakeholders including annual reports, the Triannual Performance Review reports, state required reports, as well as other custom reports
- Analyze performance measures to obtain deep understanding in order to educate Care Team members and primary care provider offices
- Mentor PCN staff in quality and cost improvement processes and use of quality and cost improvement tools

Clinical Project Manager

The Clinical Project Manager is a key position in supporting the PCN management team with oversight and implementation of the programs for utilization management, case management, and disease management.

The scope of practice for the Clinical Project Manager includes:

- Support Care Integration processes and initiatives to ensure compliance with all delegation agreement terms, state, federal, and NCQA requirements
- Maintain internal clinical criteria ensuring annual review of literature, approval by appropriate committees, and distribution to staff and PCN provider network
- Maintain policies and desktop procedures ensuring annual review and distribution to staff
- Develop and distribute health plan oversight reports and prepare presentations for health plan oversight meetings
- Assist with the development of the Case Assessment Referral Evaluation (C.A.R.E. Web) documentation system to meet workflow processes and reporting requirements; assist in modifying C.A.R.E. Web prior authorization interfaces to meet health plan requirements
- Assist in developing and maintaining procedural manuals and facilitate training for staff on C.A.R.E. enhancements, documentation standards, NCQA requirements, and general processes
- Serve as primary liaison with the health plans for appeal and grievance coordination
- Identify and facilitate quality improvement opportunities related to daily work within the Care Integration department
- Lead work groups in developing annual competency assessment packets for each role within Care Integration

Staff Education and Development

Care Integration staff attended training and educational offerings throughout the year to support maintenance of core competencies and ongoing professional development.

A total of **337 CEUs** were obtained in 2019. The following are some of the topics and educational offerings attended by the Care Integration staff.

- Case Management Process
- Case Management Principles of Practice
- Hand in Hand: Mental Health Diagnosis and Psychotropics
- Youth Suicide Prevention and Intervention 2019: New Tools, New Strategies
- Health Literacy 102: Bridging the Gap
- Inside Look - Research of Proprietary High Acuity Readmission Risk Pediatric Screen Tool
- Adolescent Relationship Abuse
- Social Determinants of Health
- Six Year Review of the Development, Implementation and Maintenance of a Family Based Partial Hospitalization Program for Youth with Mood Disorders
- Mapping Moral Distress - Litmus Test for Moral Community
- Reducing Avoidable Utilization in the Most Medically Complex and Socially Vulnerable Youth - NICH Work(s)
- Inspiring the Next Generation of Respiratory Therapists
- How to Optimize Aerosol Drug Delivery During Noninvasive Ventilation and High Flow Nasal Cannula
- High Frequency Oscillation
- Preparing for Organ Transplant
- Quality Improvement 101
- Neurally Adjusted Ventilator Assist (NAVA)
- The Importance of 4-Month Mother-Infant Communication in the Origins of Secure and Insecure Attachment
- Testing and Validation of the ISC-Q in Pediatric Patient and their Caregivers
- Eating Disorders and Transgender Youth
- Womb(man(hood & Death - Infant Mortality and Maternal Health in the Black Community
- The Rights of a Child as Viewed Through a Global Lens - Stories from the Front Lines
- Car Seat Education
- A Patient's Perspective - The Unspoken Role You Play in Sustaining Life
- The Efficacy of Peppermint Oil Interventions at Children's Mercy
- Trauma and the Brain - Interventions that Work
- Evidence-Based Screening for Pediatric Abusive Head Trauma
- Basic Deaf-Friendly Training
- Health Equity and Ecosystems - Stretching Beyond the False Lines of Diversity
- Conversion Disorders
- How Children's Mercy Integrated Care Solutions is Supporting and Advancing Value Based Research at Children's Mercy
- Late Preterm Infants - So Close Yet So Far Away
- Cracking the Codes
- In Times of Technology: The Ethical Implications of Social Media Use by Social Workers and Nurses
- When to Consider Dementia Care
- Recognition and Response to Anxiety Disorders
- Patient Driven Change: Is Collaborative Care the Future of Medicine?
- Legal Issues and Professional Case Management
- Professional Development & Advancement: Value of Case Management
- Case Management Role and Function
- Child Protection Center: Interventions after Abuse Disclosure
- Respiratory Care Symposium
- Diagnosis & Management of Increased Respiratory Secretions
- When Less is More, High Value Care in Bronchiolitis
- Recognizing Human Trafficking for Health Care Workers
- Evolution of Respiratory Care Education over the Past 20 Years
- Vaping and Implications
- When Grief Visits the Bedside
- Leading by Example: How to Cultivate Courageous Conversations About Religious Diversity
- Substance Use Confidentiality Laws, Diagnoses and Treatment Placement Criteria
- Cultural Humility- Guiding Approach to Health Equity
- Council on Violence Prevention: Reducing Intentional and Unintentional Injuries in Children
- Malnutrition and Poverty in US Children Impact on Neurodevelopment
- Cultural Healing
- Heal Thyself: A Call to Action to Improve Patient Outcomes by Caring for the Caregiver
- Addressing Mental Health Among Ethnically Diverse Patients and Families
- The Burden of the Beside: PTSD in Nurses
- ACMA and Case Management: The Future of Case Management
- Maximizing the Social Work Expertise in Case Management
- The Physician Advisor: Optimizing the Relationship and Sharing Common Goals
- Case Management and Care Transitions Across the Continuum — Evolution, Discovery and Innovation
- The Impact of the Social Determinants of Health and Toxic Stress on Children's Neurodevelopment
- Treating Fear: How Healthcare Professionals Can Support Their Undocumented Patients
- Suicide Prevention: The Mindful Ecotherapy Center
- Ethics and Boundary Issues: Ce4Less.com
- Everyday Self Defense for Social Workers
- The Evidence for Advocacy: How Science and Policy are Necessary Partners for Child Health
- Mental Health First Aide
- Council on Violence Prevention: Support for the Survivor
- Vaping, Electronic Cigarettes, and Their Implications
- Nurse Attitudes Related to Trauma Informed Care
- Direct Care Nurses' Perception about Vaccines and Lessons Learned Conducting Qualitative Research
- Reducing Clinician Burnout: Going Beyond Yoga at Lunch
- Understanding the Dynamics of Protection Orders

Conferences Attended in 2019

ACMA Missouri/Kansas 14th Annual Case Management Conference – Overland Park, KS
ACMA Missouri/Kansas Summer Education Event – Overland Park, KS
2019 Heartland Conference on Health Equity and Patient Centered Care – Kansas City, KS
20th Annual Respiratory Care Symposium Sponsored by Children's Mercy Kansas City – Kansas City, MO

2 Population Health Management

- Patient-Centered Medical Home Transformation Program
- Provider Portal
- Data Analytic Tools
- Patient Outreach Initiative
- Triannual Performance Review
- C.A.R.E. Web
- Community Integration
- Patient Experience
- Program Measures
- Future Initiatives

Population Health Management

Thomas Jefferson University College of Population Health defines population health management as follows: **"Population health seeks to create conditions that promote health, prevent adverse events, and improve outcomes."** It addresses the large-scale social, economic, and environmental issues that impact health outcomes of groups of people. "Population health builds on public health foundations by:

- Connecting prevention, wellness, and behavioral health science with health care delivery, quality and safety, disease prevention/ management, and economic issues of value and risk – all in the service of a specific population, be it a city, provider's practice, employee group, hospital's primary service area, or age group;
- Identifying socio-economic and cultural factors that determine the health of populations and developing policies that address the impact of these determinants;
- Applying epidemiology and biostatistics in new ways to model disease states, map their incidence, and predict their impact;
- Using data analysis to design social and community interventions and new models of health care delivery that stress care coordination and ease of accessibility."

-Thomas Jefferson University, 2019

Quadruple Aim

In order to meet the demands of today's ever-changing healthcare environment, each PCN goal and initiative has been designed to reflect all four dimensions of the "Quadruple Aim," a framework based on the Institute for Healthcare Improvement's "Triple Aim" that describes an approach to optimizing healthcare delivery, and expands to encompass the wellbeing of providers and care teams. The PCN continues to engage community providers and practices by working to:

1. Improve the patient care experience;
2. Improve the health of the populations we serve;
3. Reduce the per capita cost of health care by advancing initiatives that emphasize quality improvement, data analytics, and the Patient-Centered Medical Home.
4. Improve the work life and wellbeing of providers and care teams.

- Institute for Healthcare Improvement, 2019; Bodenheimer and Sinsky, 2014

Patient-Centered Medical Home Transformation Program

The Patient-Centered Medical Home (PCMH) is a promising model for transforming the organization and delivery of primary care. A PCMH is defined not simply as a place but as a model that encompasses five functions and attributes of primary care: a patient-centered approach, comprehensive care, coordinated care, superb access to care, and a systems-based approach to quality and safety.

- Agency for Healthcare Research and Quality PCMH Resource Center, 2017

The PCN makes the following strategies and resources available to help practices transform and maintain PCMH components:

- PCMH readiness evaluation;
- PCMH and National Committee for Quality Assurance (NCQA) consulting services;
- Use of patient registries for population management;
- Patient communication/outreach templates and material;
- Gaps in Care reports for assigned members;
- Triannual progress reports provided and reviewed with the provider practice.

The PCN's programs target best practices and underscore the patient-provider relationship, patient self-management skills, and improved healthcare utilization. These programs are designed to educate providers, office staff, and patient/caregivers on appropriate diagnosis, treatment, and management of chronic conditions. Promotion of preventive care for the entire patient population continues to be a focus of the PCN's population health program.

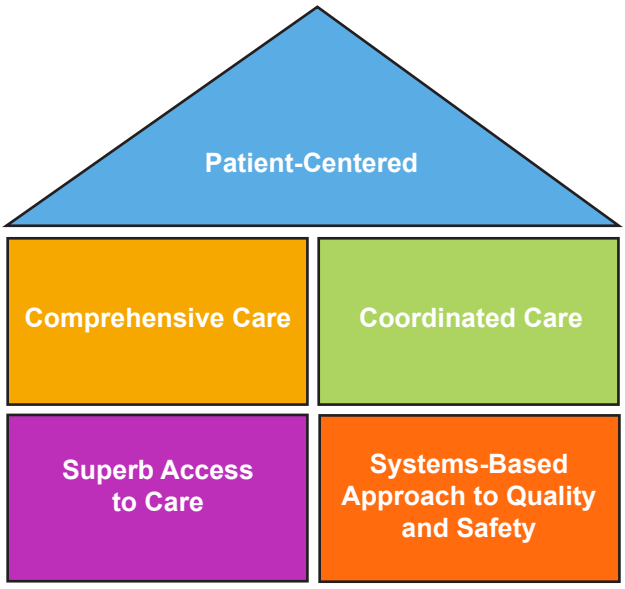
The PCMH Program monitors the implementation of care processes and development of practice level PCMH infrastructure, meeting medical home qualification criteria, within the secure PCN Provider Portal. This program began July 1, 2014 with customized quarterly progress reports provided to the participating provider offices. Practice Facilitation Specialists also work side-by-side with the practice staff to reinforce skills and foster behavior changes focused on the key elements of PCMH. This program transitioned to a triannual process in 2018.

The medical home encompasses five functions and attributes:

Patient-centered: The primary care medical home provides primary healthcare that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level of the patient's choosing. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.

Comprehensive care: The primary care medical home is accountable for meeting the large majority of each patient's physical and mental healthcare needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities.

Coordinated care: The primary care medical home coordinates care across all elements of the broader healthcare system, including specialty



care, hospitals, home health care, and community service and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.

Superb access to care: The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The medical home practice is responsive to patients' preferences regarding access.

A systems-based approach to quality and safety: The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

- Agency for Healthcare Research and Quality PCMH Resource Center, November 2017

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Thomas Jefferson University. (2019). Jefferson College of Population Health – About Us. Retrieved from https://www.jefferson.edu/university/population-health/about.html

Institute for Healthcare Improvement. (2019). The IHI Triple Aim. Retrieved from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Bodenheimer, Thomas and Sinsky, Christine. (2014). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226781/

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PCMH Engagement

Provider Engagement Progress Report

	Score
Use of Team-Based Care to Work 3 Registries	3.25
Patient Satisfaction Survey & Improvement Initiative	3.25
Learning Collaborative Participation	3.25
Closed Loop Referral Tracking Process	3.25
Established Process to Manage High Risk Patients	3.25
Established Process to Manage Transitions	3.25
Established Care Coordination Process with PCN Care Navigators	3.25
Established Process to Address Behavioral Health Concerns	3.25
Total Points:	26

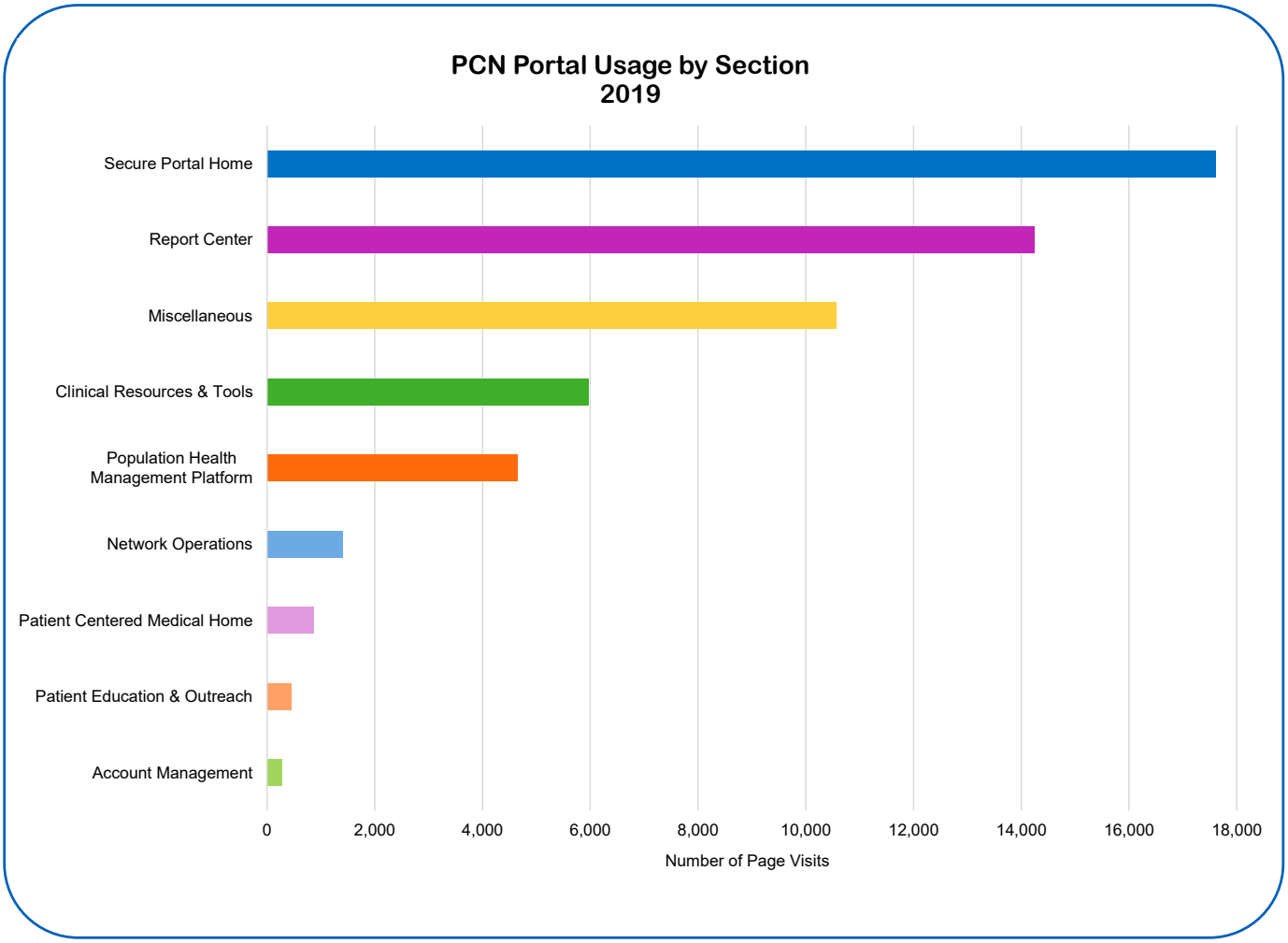
*Each Provider Engagement area score out of 3.25 possible points; Total Provider Engagement score out of 26 possible points

Through continued support of the medical home model and National Committee for Quality Assurance (NCQA) PCMH standards, further enhancements include closed-loop referral tracking, discussion board format for Learning Collaborative participation, and enhanced behavioral health integration. Alignment with the Missouri MO HealthNet contract is also included with the goals of improving Healthcare Effectiveness Data and Information Set (HEDIS) scores and completing timely Early and Perioding Screening, Diagnostic, and Treatment (EPSDT) exams.

Provider Portal

PCN's secure Provider Portal provides a tool to facilitate communication, collaboration, and access to resources and reports to practices within the network. Since its creation, the PCN secure Provider Portal has undergone periodic updates and enhancements to ensure that it is a dynamic, up-to-date resource for PCN providers. The Provider Portal is divided into seven sections: Secure Portal Home, Population Health Platform, Clinical Resources & Tools, Patient-Centered Medical Home, Patient Education & Outreach, Network Operations, and Report Center.

Features of the Portal include personalized logins for each practice, access to data analytic tools and clinical practice guidelines, and various pediatric resources that help practices stay informed and continue to deliver evidence-based care. Also available within the Clinical Resources & Tools section are quick links to Pediatric Specialty Education webinars and previous and current Learning Collaborative recordings. Providers can also access High-Risk Registries designed to identify patients in need of preventive care or patients who need chronic disease management.



The Clinical Resources & Tools page includes practice resources such as the PCN Quality Improvement Tool Kit, quality improvement tools, measure descriptions, billing and coding guides, and much more. Another feature of the Provider Portal is a section dedicated to current Patient-Centered Medical Homes and resources for those working to become certified.

A Network Operations section provides access to Care Team documentation, information on network membership, payer contracts, and forms/resources to utilize clinical services (utilization management, case management, and disease management).

Lastly, the Portal includes a Report Center where practices have access to their panel lists, Gaps in Care reports, and Engagement Compensation reports.

The chart above displays the number of visits to each PCN Portal page divided by section type. The section types include all primary PCN Portal sections mentioned above, plus Account Management (which includes Activate Account, Create Password, and Create Security Question) and Miscellaneous (which includes Feedback, Links, News, Provider Directory, and Provider Search).

Learning Collaborative

The Learning Collaborative concept has been utilized extensively in the support of dissemination of information required for PCMH transformation. The PCMH transformation team uses a model in community settings to coach practices by providing education related to the medical home model and allowing for educational topics to be presented. Two 30-minute topics are recorded each quarter. PCN distributes these recordings and their supporting documents to clinics to watch during a time that fits into the workflow of office staff and providers. Practices then utilize the secure Provider Portal message board to communicate key takeaways and best practices regarding these presentations.

The goals of the Learning Collaborative include providing education on the development of PCMH processes and policies while also sharing best practices in a supportive group environment. Didactic sessions offered include PCMH topics such as team-based care, quality improvement, case management, and care coordination.

Learning Collaborative Topics for 2019:

- Lead Poisoning
- Restricting Access to Methods in Suicide Prevention
- Overuse Injuries in Youth
- Caring for Children in State Custody: Tips for the General Pediatrician
- Weight Management: Recommendations on How to Manage & When to Refer

Local Community Care Coordination Program (LCCCP) Measures

The PCN is a state-approved Local Community Care Coordination Program (LCCCP) model for Missouri Medicaid focusing on providing case management, care coordination, and disease management in collaboration with local healthcare providers. Below are some of the key LCCCP metrics monitored in 2019.

		2019			
	Measure Description	**Q1**	**Q2**	**Q3**	**Q4**
Category	**General Population Data**				
Providers	**Total Number of Providers**: Number of providers in the LCCCP for the reporting period.	1,754	1,743	1,736	1,669
Members	**Total number of Members**: Number of members in the LCCCP for the reporting period.	87,659	82,853	78,846	76,523
Category	**Access**				
Access to Well Care Services	**Access to Well Care**: Percentage of ill/sick visits that are converted to a well care visit (opportunity taken to address preventive care during sick visit)	16.9 %	17.5 %	18.8 %	16.9 %
Category	**Care Coordination**				
Transitional Support	**Transitional Care Support**: Percentage of hospital-discharged members who had an ER visit within 30 days of discharge.	14.5 %	14.6 %	15.7 %	16.5 %
Member Engagement	**Member Engagement with Care Teams**: Percentage of at-risk members who had a plan of care initiated by the Care Team.	16.4 %	24.4 %	24.3 %	20.7 %
Provider Engagement	**Provider Engagement**: Percentage of providers that reviewed the care plan.	0.3 %	1.6 %	0.0 %	0.1 %
Community Engagement	**Community Engagement**: Percentage of members linked to community resources.	69.8 %	87.6 %	92.3 %	92.2 %
Care Team Engagement	**Interdisciplinary Team**: Percentage of care plans including more than one discipline (MD, RN, SW, CRS).	84.8 %	95.7 %	98.7 %	98.1 %
Member Activation	**Goal Completion**: Percentage of members that successfully completed a personal goal in the care plan.	80.1 %	85.2 %	85.0 %	83.4 %
Category	**Condition Management**				
Pediatric Asthma	**Asthma Prevalence**: Members identified with a diagnosis of asthma as a percentage of total members through 20 years of age - lookback period of 12 months for asthma diagnosis	10.9 %	10.9 %	10.5 %	11.9 %
Pediatric Diabetes	**Diabetes Prevalence**: Members identified with a diagnosis of diabetes as a percentage of total members through 20 years of age - Type I and Type II combined - lookback period of 12 months for diabetes diagnosis	0.3 %	0.3 %	0.3 %	0.4 %
Ambulatory Sensitive Conditions - Pediatric Quality Acute Composite	**Pediatric Quality Acute Composite (AHRQ PDI 91)**: Composite of the following acute conditions per 100,000 population ages 6 to 17 years. PDI #16 - Gastroenteritis Admission Rate PDI #18 - Urinary Tract Infection Admission Rate	3.9	4.1	5.1	3.1
Ambulatory Sensitive Conditions - Pediatric Quality Chronic Composite	**Pediatric Quality Chronic Composite (AHRQ PDI 92)**: Composite of the following chronic conditions per 100,000 population ages 6 to 17 years. PDI #14 - Asthma Admission Rate PDI #15 - Diabetes Short-Term Complications Admission Rate	10.5	10.7	14.1	10.7
Category	**Utilization**				
Emergency Room	**Emergency Room Utilization**: ER Visits per 1,000 members	511	582	564	591
Inpatient	**Hospital Readmission**: Hospital readmissions within 30 days - all cause	8.3 %	9.2 %	8.5 %	7.7 %
Inpatient	**Inpatient Utilization - Admissions**: Inpatient Admissions per 1,000 members	56	62	61	49
Inpatient	**Inpatient Utilization - Days**: Inpatient Days per 1,000 members	209	220	226	184
Cost of Care	**Cost of Care: Hospital Inpatient - Acute Medical/Surgical**: Per Member Per Month (PMPM) cost total by service category.	$ 22	$ 27	$ 28	$ 20
Cost of Care	**Cost of Care: Hospital Inpatient - Maternity**: Per Member Per Month (PMPM) cost total by service category.	$ 3	$ 4	$ 3	$ 2
Cost of Care	**Cost of Care: Hospital Outpatient - ASU**: Per Member Per Month (PMPM) cost total by service category.	$ 4	$ 7	$ 4	$ 27
Cost of Care	**Cost of Care: Hospital Outpatient - ER**: Per Member Per Month (PMPM) cost total by service category.	$ 27	$ 40	$ 37	$ 40
Cost of Care	**Cost of Care: Hospital Outpatient - All Other**: Per Member Per Month (PMPM) cost total by service category.	$ 26	$ 37	$ 39	$ 38
Cost of Care	**Cost of Care: Physician/Professional - Office Visits**: Per Member Per Month (PMPM) cost total by service category.	$ 8	$ 10	$ 10	$ 6
Cost of Care	**Cost of Care: Physician/Professional - All Other**: Per Member Per Month (PMPM) cost total by service category.	$ 12	$ 15	$ 14	$ 6
Cost of Care	**Cost of Care: Pharmacy**: Per Member Per Month (PMPM) cost total by service category.	$ 73	$ 80	$ 108	$ 112
Cost of Care	**Cost of Care: Ancillary - DME**: Per Member Per Month (PMPM) cost total by service category.	$ 1	$ 2	$ 2	$ 2
Cost of Care	**Cost of Care: Ancillary - Home Health**: Per Member Per Month (PMPM) cost total by service category.	$ 1	$ 0	$ 1	$ 1
Cost of Care	**Cost of Care: Ancillary - All Other**: Per Member Per Month (PMPM) cost total by service category.	$ 1	$ 1	$ 1	$ 1
Out of Network Utilization	**Outside of LCCCP Primary Care Utilization**: Percentage of utilization for primary care services outside the LCCCP network.	10.7 %	9.5 %	11.0 %	12.0 %

Data Analytic Tools

Financial Data Analytics

PCN recognizes that effectively managing a population requires the use of medical claims, pharmaceutical claims, and eligibility information to measures performance and gain insights into cost and utilization trends. PCN financial analytic capabilities measure and track key health cost and utilization measures (e.g. Risk Scores, Paid Per Member Month, Admissions/1,000, Days/1,000, Average Length of Stay, ER Visits/1,000, etc.) at the network, practice, and provider level. PCN continues to use financial analytic capabilities to support and evaluate existing programs and identify new initiatives to more effectively manage the population and deliver value.

Specialty Engagement & Episodes of Care

In order to effectively manage a Medicaid population, both primary care and specialty providers must be engaged. In 2019, PCN continued to meet quarterly with select specialty divisions to further collaboration and increase PCN engagement with specialty providers.

Improving PCP to Specialist Coordination - Pediatric Specialty Education Spotlights

In 2019, PCN continued the “Pediatric Specialty Education Spotlights” program, which are 10-20-minute recorded webinars presented by Children’s Mercy Kansas City specialists. These spotlights are structured to help support primary care providers in diagnosing, treating, managing, and referring patients. Each webinar utilizes a “visit documentation template” and focuses on what the PCP should do before the specialty consultation with the goal of better managing and coordinating care. Specialists cover key aspects of the history, physical examination, applicable tests/exams, medical management, and when it is or is not appropriate to refer.

Pediatric Specialty Education Spotlights

Access short 10-20 minute webinars by Children’s Mercy specialists that are structured on a "visit documentation template". Each webinar focuses on what the PCP should do before the specialty consultation (i.e. not what the specialist does in managing a condition) with the goal of better managing and coordinating care.

Most Recent Topics	Recorded Webinar	Slide Deck	Visit Documentation Template	Resource Packet
Short Stature with Normal Growth	Watch Webinar	Download	Download	Download
Limp in a Child or Adolescent	Watch Webinar	Download	Download	Download
Back Pain in a Child or Adolescent	Watch Webinar	Download	Download	N/A

Pediatric Specialty Education Archive — Access all previously recorded Pediatric Specialty Webinars.

Patient Outreach Initiative (EMMI)

The PCN continued to work with Evolent Health for Patient Outreach Services in 2019, making it a standard tool for PCN practices. The service uses interactive voice response technology (IVR) to place a series of automated calls to drive patient action. More than 125,000 outreaches were made to over 60,000 patients in 2019. The 2019 patient engagement rate (transferred to practice for scheduling, given scheduling information, or told they were due for a well visit) increased 1 percentage point from 26% in 2018 to 27% in 2019 across all campaigns.

Analysis

The intervention of Emmi outreach proves to be a valuable component for PCN patient outreach. In 2019, a total of 55 practices were included in the outreach initiative.

In 2019, PCN implemented an outreach campaign inviting patients to join the PCN Case Management program. This campaign aimed to elevate overall engagement for patients identified for case management and led to 8,117 outreach calls engaging 1,379 patients.

Future Initiatives

In order to better serve the member population, PCN will be transitioning from Emmi to Innovaccer's InConnect solution in the first quarter of 2020. The InConnect campaigns of 2020 will mirror those of Emmi in 2019, with the addition of outreach to members not currently seeing a primary care provider. These new InConnect campaigns are on track to reach more patients in more meaningful and valuable ways.

Triannual Performance Review

PCN continues to deliver actionable and meaningful cost and utilization data to PCN practices and providers (see Triannual Performance Review Report in Appendix B on pages 103-108). The Triannual Performance Review allows providers and care teams to review meaningful insights on cost and utilization variation as well as actionable information on a practice's highest cost and highest risk patients. PCN Care Teams review the Triannual Performance Review Reports in detail with PCN practices three times per year, jointly identifying opportunities to outreach and/or collaborate on managing and caring for the highest cost and highest risk patients.

The Triannual Performance Review has five components: the Executive Summary, the Provider Roster, the most recent Rolling Year Quality Measure Report, the Quality Improvement Recommendations Report, and the High Cost and High Utilization Report.

Executive Summary

The Executive Summary provides a high-level summary of all reports included in the Triannual Performance Review. It gives the practices a snapshot of what they did well and where they have room for improvement during the captured time period. It also provides their current performance compared to their most recent Triannual Performance Review. The Care Teams work with the practices to develop goals for performance to help guide each practice on how to improve their selected initiatives.

PEDIATRIC CARE NETWORK TRIANNUAL PERFORMANCE REVIEW REPORT PACKAGE

To deliver high-value care that meets the Triple Aim of Better Care, Smarter Spending, and Healthier Children, the PCN Triannual Report Package informs practices of their quality and cost performance and provides observations and potential improvement ideas for consideration and review with each practice.
We are striving to make the information useful, valuable, and actionable. We welcome your feedback!

Quality Performance Report - *Observations & Potential Improvement Ideas*

Observations and Comments

Quality Measure	Current Results	Prior Results	% Point Improvement	75th Percentile	90th Percentile
[Insert Quality Measure]	X	X	X	X	X
[Insert Quality Measure]	X	X	X	X	X
[Insert Quality Measure]	X	X	X	X	X
[Insert Quality Measure]	X	X	X	X	X
[Insert Quality Measure]	X	X	X	X	X
[Insert Quality Measure]	X	X	X	X	X

Potential Opportunities for Improvement:
- EPSDT X% from the HEDIS 75th Percentile

Potential Strategies/Tactics of How to Accomplish Goal(s):
- PCP alignment rate of X% (Y% of assigned patients have not made a visit to the practice in the last 2 years)

Follow Up & Review of Actions and Goals

Quality Goals	Status of Actions/Tasks
EPSDT (0-6 Years)	Has Improved X% over prior measurement period
[Insert Quality Goal]	[Insert Status]
[Insert Quality Goal]	[Insert Status]

Cost & Utilization Report - *Observations & Potential Improvement Ideas*

Observations and Comments

Cost Measure	Current Results	Prior Year Final Results	Target
[Insert Cost Measure]	X	X	X
[Insert Cost Measure]	X	X	X
[Insert Cost Measure]	X	X	X

Provider Roster

The Provider Roster is a list of all credentialed providers in a practice. This report allows PCN Care Teams to ensure all providers are accounted for within practice reports.

Rolling Year Quality Measure Reports

The Rolling Year HEDIS Quality Measure Report is based on the "estimated" rolling year by basing performance on the last 13 months of claims data. Thirteen months of claims data approximates a year because claims are not 100% complete in the most recent months. The report is broken down into whole practice performance and individual provider performance. The Rolling Year HEDIS Quality Measure Report also includes information on the practice Risk Score and Risk-Adjusted Paid PMPM.

Risk Score

The report uses the Chronic Disability Payment System (CDPS) risk scoring methodology. The methodology uses a patient's age and gender as well as their medical diagnoses and prescription medication history within a one-year period to determine a relative risk score. All risk scores are presented as relative risk ratios based on an average patient with a risk score of 1.0. In other words, a patient with a risk score of 2.0 is expected to be twice as costly as a patient with average expenditures, and a patient with a risk score of 0.9 is expected to be 10% less costly. The CDPS risk scoring model is comparable to other nationally known risk scoring methodologies such as Episode Treatment Groupers (ETGs), Milliman Advanced Risk Adjusters (MARA), and Hierarchical Condition Categories (HCCs).

Risk-Adjusted Paid PMPM

Risk-Adjusted Paid PMPM (Per Member Per Month) is the measure used to evaluate total cost of care. The measure is normalized for the number and risk of patients attributed to a provider or practice. Paid PMPM is calculated by taking the total cost of care for a particular month. Risk-Adjusted Paid PMPM is adjusted for risk by dividing Paid PMPM by the applicable risk score. Since the

measure is normalized for the medical complexity of attributed patients, it facilitates more meaningful comparisons across practices and providers.

Quality Improvement Priority Recommendations Report

The Quality Improvement Priority Recommendations Report highlights potential quality improvement recommendations tailored to each practice based solely on a practice's most current quality performance results. This report includes recommendations based on short term quality measures, medium term quality measures, and long term quality measures based on the amount of time it would take for a practice to see performance results on each measure.

High Cost and High Utilization Report

To deliver high-value care, PCN practices must be informed of global quality and cost performance for their attributed patients. PCN has developed a High Cost and High Utilization Report within the Triannual Performance Review to inform providers of cost and utilization information that is only accessible through payer claims. The report is based on payer data (medical and pharmacy claims) received from PCN-contracted Missouri and Kansas Medicaid Managed Care Organizations. It identifies individual patients who are the highest cost, visit the Emergency Department frequently, or have multiple inpatient admissions.

PCN Quality Improvement Tools/Resources

PCN uses a centralized Quality Improvement section with the PCN secure Provider Portal for quality improvement resources, documentation, and tools. PCN practices and Care Teams are able to efficiently access quality measure definitions, assess potential quality improvement strategies, review applicable insights and tips, and directly link to applicable training documentation, tools, and resources.

Quality Improvement

Quality Improvement TOOL KIT

Quality Measure Definitions

- HEDIS Quality Measure Definitions – PCN Payer Incentive Measures Only
- HEDIS Quality Measure Definitions – All HEDIS Measures in Vision - Missouri
- Clinical Integration Quality Measure Definitions

Quality Improvement Resources

- Appropriate Treatment for Upper Respiratory Infection – Provider Quick Reference
- Asthma Management Tool Kit
- BMI Percentile Measure Overview (Slide Deck)
- Chlamydia Screening Measure In Depth Practice Review – Slide Deck
- HPV Measure & Quality Improvement Overview – Slide Deck
- HPV Vaccine Provider & Parent Resource Packet
- Well Visit 15-Month Measure & Quality Improvement Overview – Slide Deck
- Vision Pre-Visit Planning Training Guide
- Vision Patient Outreach Training Guide

Cost Improvement Resources

- Managing Children with Complex Medical Conditions – Resources for Providers
- PCN Cost & Utilization Report FAQ
- Understanding Risk Adjustment (What, Why Important, How to Influence)

PCN Quality Improvement TOOL KIT

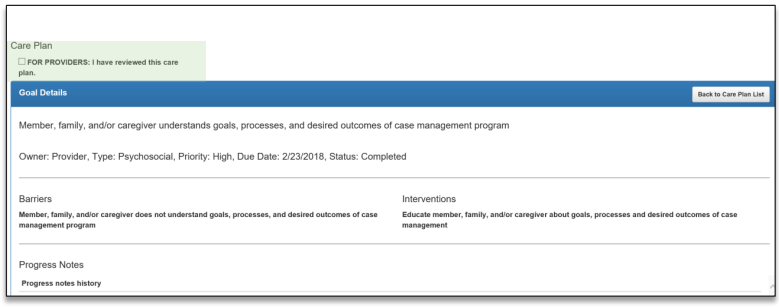
Children's Mercy PEDIATRIC CARE NETWORK

Measure	Quality Improvement Strategies	CMICS Measure Specific Resources	Comments/Insights
Asthma - Medication Management for People With Asthma (>=75% Coverage)	• Patient / Family Education on Asthma Medication • Targeted Patient Outreach for Eligible Asthma Patients	• Medication Management for Children with Asthma Definition & Key Learnings Overview – Slide Deck • Vision Worklists to Target Eligible Asthma Patients (see Vision Patient Outreach Training Guide) • Asthma Care Brochure and Asthma Care Quick Reference (Based on EPR-3 Clinical Guidelines)	• Limit available refills for asthma controller & relievers. Patients typically included for ≥ 4 asthma rx scripts in each of last 2 years. • Sample controller medications are not included. 75% days supply compliance is based exclusively on pharmacy claims • Measure denominator is small. Identify specific patients using Vision patient outreach.
Chlamydia Screening	• During Pre-Visit Planning, Add Chlamydia Screening Orders for Females on Contraceptives • Targeted Patient Outreach for Eligible Sexually Active Patients (Outreach Based on Need Well Visit) • Message Ob-Gyn to Help Complete Screening • Identify and Flag Patients Within EMR or Other Location • Integrate Pharmacy Data into EMR	• Chlamydia Screening Definition & Key Learnings – Slide Deck • Vision Worklists to Target Eligible Chlamydia Patients (see Vision Patient Outreach Training Guide)	• Denominator for measure is relatively small. Low denominator enables improvement in the short term • Patients are eligible for measure after 16th birthday but may qualify for sexual activity while 15 years old • Sexual activity trigger may be unknown to PCP (e.g. Ob-Gyn contraceptive diagnoses or scripts) • Consider ordering just the chlamydia test rather than the combined chlamydia/gonorrhea test
EPSDT (Annual EPSDT Well Visit for Ages 1-6)	• Provider / Billing Staff Workflow Integration and Training • Sending non-billable claims when Medicaid is secondary insurance (ensures quality hit) • Target 3-6 Year Olds Without an Annual Well Visit (2 and under typically compliant due to newborn/infant well visits) • Well Visit Improvement Strategies: Patient Outreach, Appointment Reminders, Sick to Well-Visit Conversion	• EPSDT Billing and Code Guide • Use Vision Worklists to Target Overdue Patients 3-6 Years Old (see Vision Patient Outreach Training Guide) • Preventive Care Registry – EPSDT (PCN Portal → Clinical Resources & Tools)	• Ability to improve in short term since measure dependent on coding and patient receiving an annual preventive visit at any time during the measurement year
Immunizations Age 2 (DTap, IPV, MMR, Hib, VZV, PCV, RV, Hep B, Hep A, Flu)	• Standardization of Vaccination Administration within Practice (i.e. what products administered at each standard well visit up to 2 years old) • Patient/Family Education	• Use Vision Worklists to Target Patients 18-24 Months with Missing Age 2 Immunizations (see Vision Patient Outreach Training Guide) • Use the Age 2 Childhood Immunizations Report to compare immunizations received versus expected as patients age. • Preventive Care Registry – Age 2 Immunizations (Combo10) (PCN Portal → Clinical Resources & Tools)	• Improvement takes significant amount of time (Why: performance evaluated based on all applicable immunizations up to age 2; patients only included after turning 2 years old)
Immunizations Age 13 (MCV, Tdap, HPV)	• Pre-Teen Bundle (i.e. Bundle HPV with Tdap/MCV) • Provider Education and Provider-to-Patient Communication • Patient/Family Education	• Immunizations Age 13 Measure Definition & Quality Improvement Overview (Slide Deck) • HPV Provider and Parent Education Resources • Vision Worklists to Target Overdue Patients 12-12.75 years Old (see Vision Patient Outreach Training Guide)	• Performance based primarily on HPV immunization rate • Improvement takes significant amount of time (Why: 2 HPV immunizations needed over 6 months; patients only included after turning 13 years old)

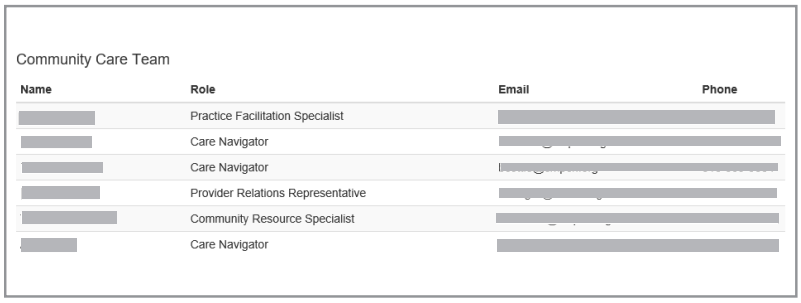
C.A.R.E. Web (Online Care Team Communication Tool)

The PCN's Care Team documentation and communication tool, C.A.R.E. Web (Case Assessment Referral Evaluation), received significant enhancements in 2019 focused on engagement with Social Work within Children's Mercy and more efficient workflow for Care Teams.

C.A.R.E. Web
Provider Checkbox Displaying Review of Care Plan



C.A.R.E. Web Community Care Team List
Name, Role, and Contact Information of Care Team Members



The following additional C.A.R.E. Web enhancements were made to allow for more efficient workflow for the Care Teams:

- Task feature enhanced to add Lead Case Management;
- Care Team now has the ability to search members by Children's Mercy Medical Record Number;
- Social Worker role was added to allow Social Workers at Children's Mercy to use C.A.R.E. Web for Children's Mercy patients;
- Attributed PCN was added to Member Profile screen;
- Date fields were changed from a text box to a calendar picker;
- Screening pages added for Behavioral Health, CRAFFT, and PSC-17 (specific to Aetna BetterHealth of Kansas health plan).

Future Initiatives

In 2020, the following C.A.R.E. Web enhancements are planned to be made to allow for greater provider engagement and more efficient workflow for Care Teams:

- Providers will have the ability to enter authorization requests online through the PCN Secure Portal;
- Care Team members will be able to enter Lead Levels and Lead Home Visits without having to open a Lead Case;
- Member Preferences will be added to allow Care Team members to edit a member's preferred name/ pronoun and gender identity. This information will display under the member's name on the header of every page;
- A new type of Transition of Care will be added for Behavioral Health (specific to the Aetna BetterHealth of Kansas health plan).

Community Integration

There is ample data available to demonstrate improvements in member outcomes, member engagement, and decreased cost with a fully integrated medical and behavioral care delivery model. The PCN continued the Health Plan behavioral case management initiative begun in 2017 by collaborating and co-managing high-risk children with embedded behavioral health case management staff. PCN has partnered and continued to foster relationships with numerous community agencies (SleepyHead Beds, Harvesters, Giving the Basics, local health departments, etc.) to facilitate resource acquisition and a more seamless referral process for PCN members. The PCN Community Resource Specialist team consistently attends community resource connection meetings through Jackson County, Wyandotte County, Clay County, Platte County, and Johnson County. The team also collaborates with community agencies to disseminate information and schedule on-site presentations for the PCN team.

MyResourceConnection

In 2019, PCN partnered with My Resource Connection. My Resource Connection is maintained and hosted by the government of Johnson County, Kansas. Significant contributions of data come from United Way 211 of Greater Kansas City, various departments within the local Johnson County government, and the Unified Government of Wyandotte County and Kansas City, Kansas. This resource database is public-facing and directs PCN members and Care Teams to organizations and resources within the greater Kansas City metro area.

Community Health Worker

In 2019, PCN continued its collaboration with KC Care Clinic to provide a Community Health Worker (CHW) for PCN member interventions. Members are screened by a Care Navigator and then referred to the CHW to address identified social determinants of health issues. Outreach lists, including members with gaps in care and non-emergent emergency room utilization, are provided to the CHW to connect with members that were not engaged in primary care services. The CHW provides education to the member and/or caregiver about appropriate emergency room utilization, benefits of care, and the CHW program. If the member agrees to enroll in the CHW program, an assessment is completed with the family to determine barriers and goals are identified in the following target areas: Child Care; Child Education; Adult Education; Parenting/ Coping Skills; Dental/Vision; Family/Partner/Social Relations; Health Insurance; Medical Needs; Mental Health and Substance Abuse; Income; Housing; Transportation; Food and Household Items; Language; Medication Cost; and Medication Adherence. In addition to providing community resources to families, the CHW model involves in-person contact with families in their community to help them navigate the health and social service systems.

Beginning in January 2019, inpatient Social Workers at Children's Mercy Kansas City were able to make referrals to the CHW for PCN members.

In late 2019, the Community Health Worker began working onsite at Central High School, which houses the school district's teenage parenting center, two days per week. Any student in the Kansas City Missouri School District can bring their baby to Central High School for free childcare. Placing the Community Health Worker in that location allows PCN to intervene with students with mental and physical health needs for themselves and their babies.

The Community Health Worker attempted to outreach to 144 members in 2019. Of those members, 63 enrolled in the CHW program (64 members enrolled in 2018). Of the 302 goals initiated with members in 2019, 51 were completed. The PCN team made 119 referrals to the Community Health Worker in 2019.

Members enrolled in the CHW program had higher emergency department use (22.8% increase), inpatient visits (52.4% increase), and slightly higher total cost of care (9.1% increase) after enrolling in the program. The small denominator of members in 2019 contributed to those increases. PCN and the Community Health Worker will continue to educate PCN members' caregivers on alternatives to utilizing the emergency room and encourage them to contact their primary care providers, utilize nurse advice lines, or visit trusted urgent care facilities.

Future Initiatives

The needs at Central High School are vast, and as the Community Health Worker's role develops at this location, PCN will better understand the full impact of the CHW program within this population and will adjust the program approach as necessary.

KidCare Anywhere

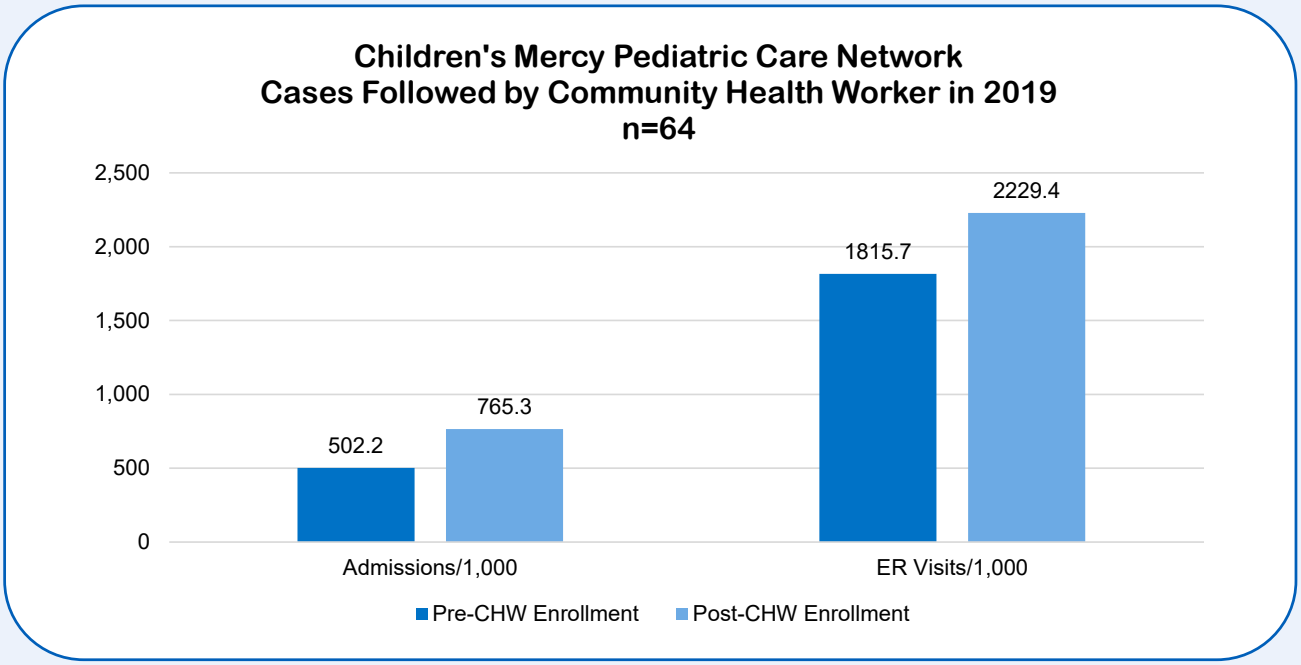
Pediatric Care Network has partnered with Children's Mercy Kansas City to develop a direct-to-consumer virtual health service that offers access to a Children's Mercy pediatric provider in minutes via smartphone, tablet, or computer to help treat a child's non-emergency conditions. This virtual health service is called KidCare Anywhere. Providers can discuss, provide guidance, and often treat children's minor ailments and illnesses while the patient is in the comfort of their own home – or anywhere.

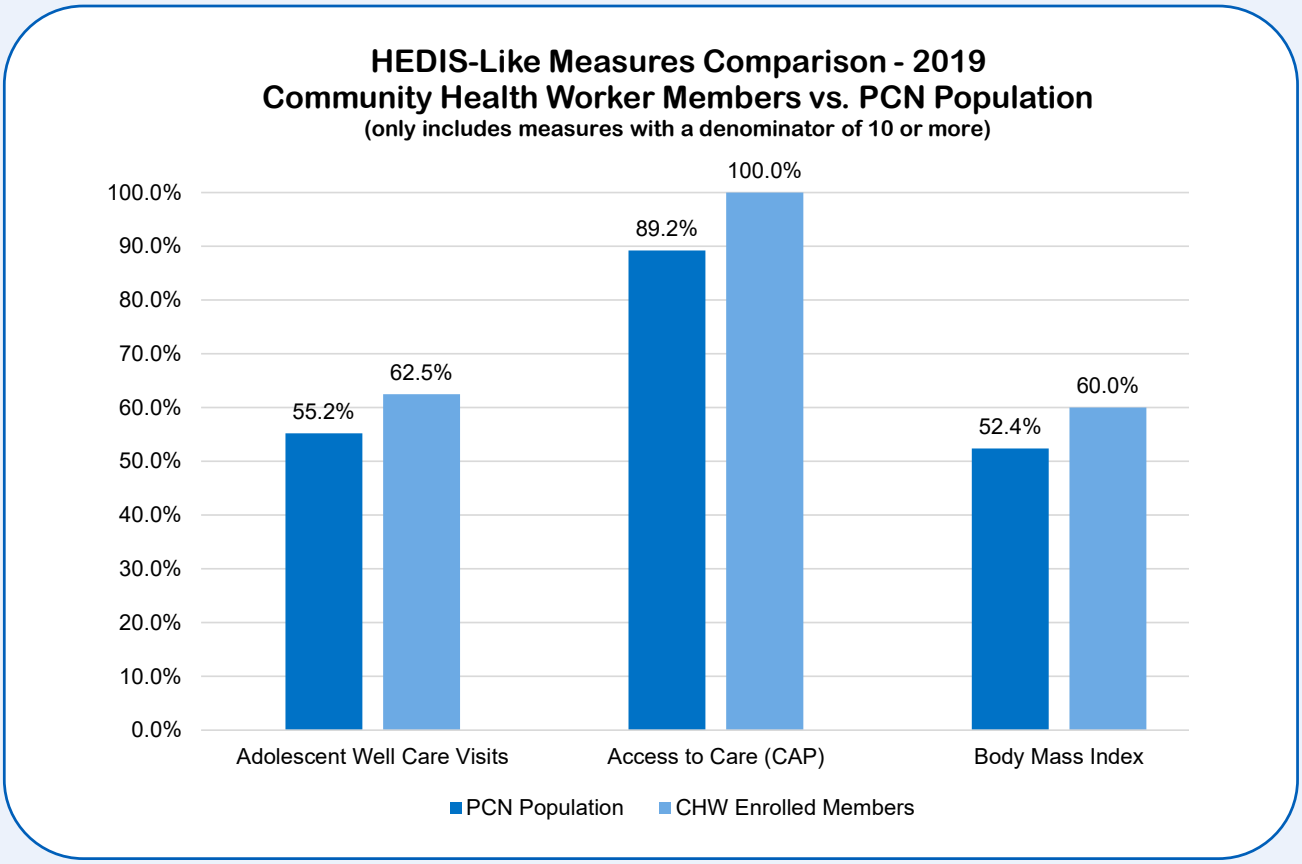
Since the inception of KidCare Anywhere, PCN has been working to promote the service and assist families in the registration process. All PCN members have been invited to register and use the service. KidCare Anywhere is available to PCN patients at no cost.

Future Initiatives

While registration and usage have been limited during the first few years of operation, PCN will continue to expand the program to additional PCN patients and leverage the technology under a new platform during Q1 2020.

Community Health Worker Cases 2019	
Members	64
% Change Pre vs. Post	
Admissions/1,000	52.4%
ER Visits/1,000	22.8%
Total Medical PMPM	9.1%





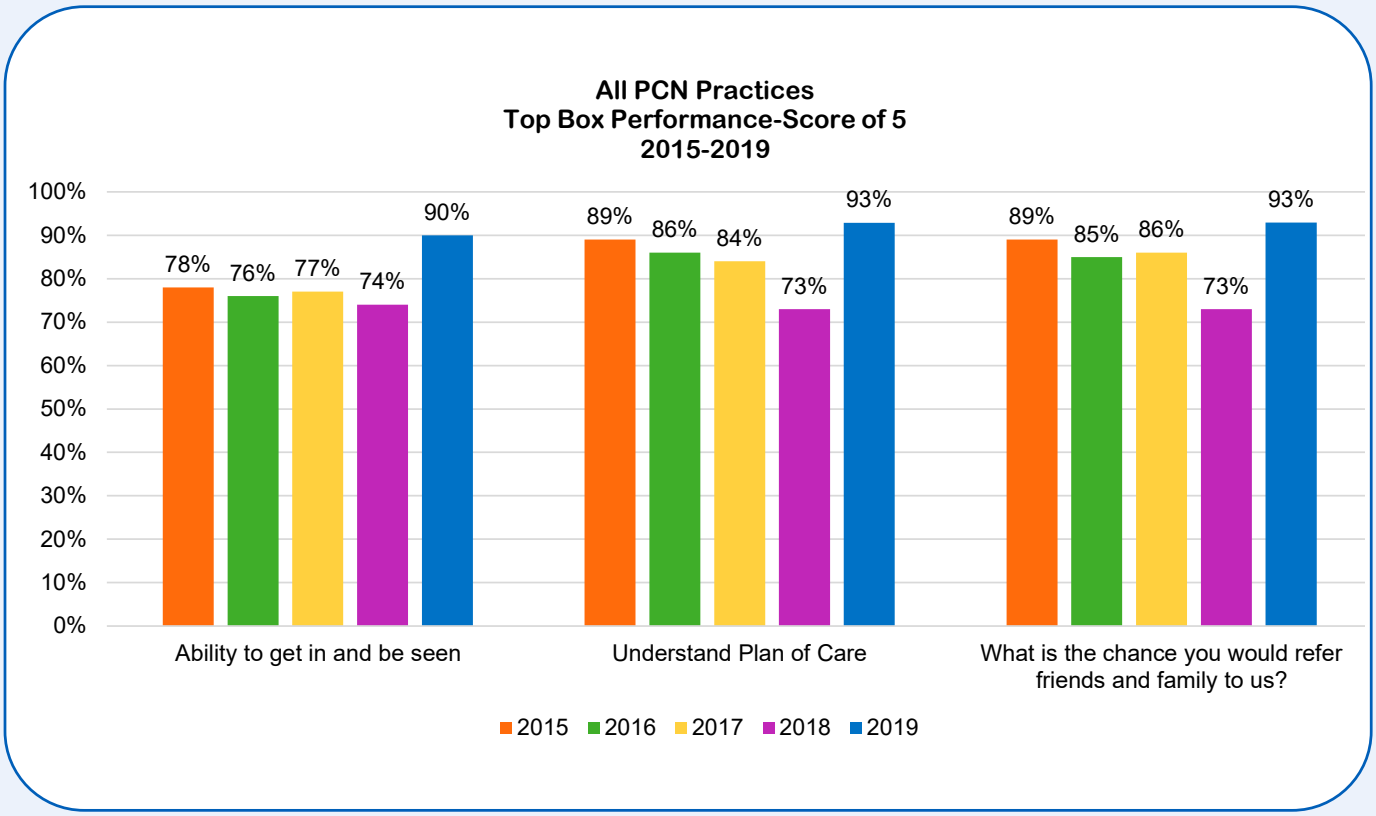
Patient Experience

A component of PCMH encourages practices to obtain feedback from patients and families regarding their experience of care received. Four main categories are reviewed including: access, communication, whole-person care, and self-management.

For the Patient Satisfaction Survey, the PCN utilized a scale of 1 through 5 in which a score of 5 indicates “Great” and a score of 1 indicates “Poor.” For this evaluation, the PCN applied the top box scoring method in order to more effectively measure the concentration of high-performance scores. For example, the top box method only accounted for the percentage of patients who selected a 5 as his/her response to a rating question in the survey. Responses that score between the ranges of 1 and 4 are not accounted for as part of the top box scoring methodology.

Analysis

The analysis below compares the year-over-year combined results for all PCN practices (2015-2019). In 2018, PCN implemented several initiatives in an effort to increase patient experience and satisfaction such as continuing to support practices in quality and cost improvement initiatives through the Triannual Performance Review meetings. These initiatives have allowed practices to increase their overall patient satisfaction scores related to the patient’s/family’s ability to get in and be seen, the patient/family understanding the plan of care, and the likelihood that patients/families would refer friends and family to PCN practices.



PCMH Analysis of Cost, Utilization & Quality Measures

Measuring the Value of PCMH

By adopting a PCMH model, the PCN demonstrates its strong advocacy for high quality care, empowering patients, and building collaborative relationships between patients and providers. The PCMH model has been shown to lower costs and increase value for both patients and providers. In order to take a closer look at the value-added impact of the PCMH model, the PCN conducts trending cost and utilization analysis. This analysis includes the following:

From a quality perspective, the following metrics were evaluated:

- Well-Child 0-15 Months
- Well-Child 3-6 Years
- Adolescent Well-Care Visits
- Chlamydia Screening
- Children & Adolescents' Access to Primary Care Practitioners (CAP)
- Lead Screening in Children
- Childhood Immunizations Combo 10
- Age 13 Immunizations
- Asthma Medication Compliance – 75%

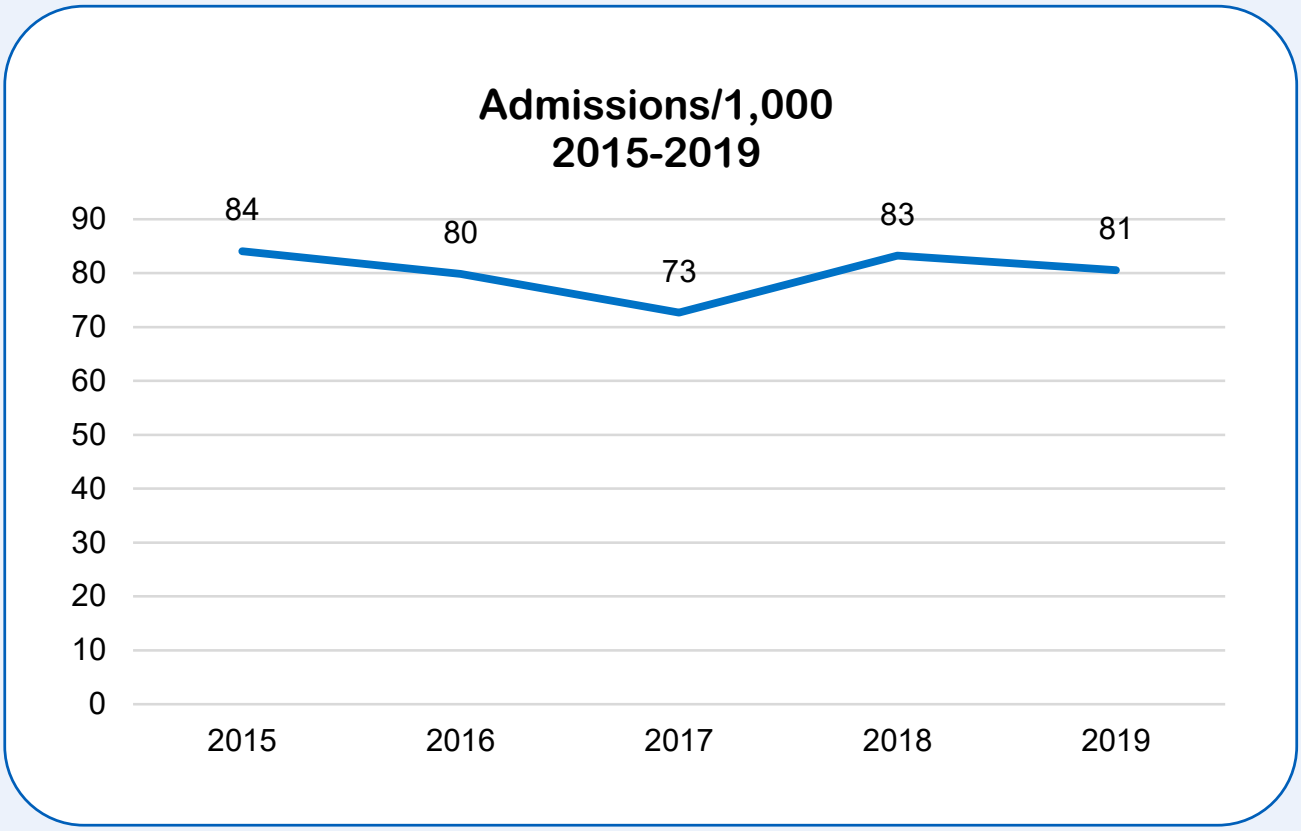
From a cost comparison perspective, the following metrics are evaluated:

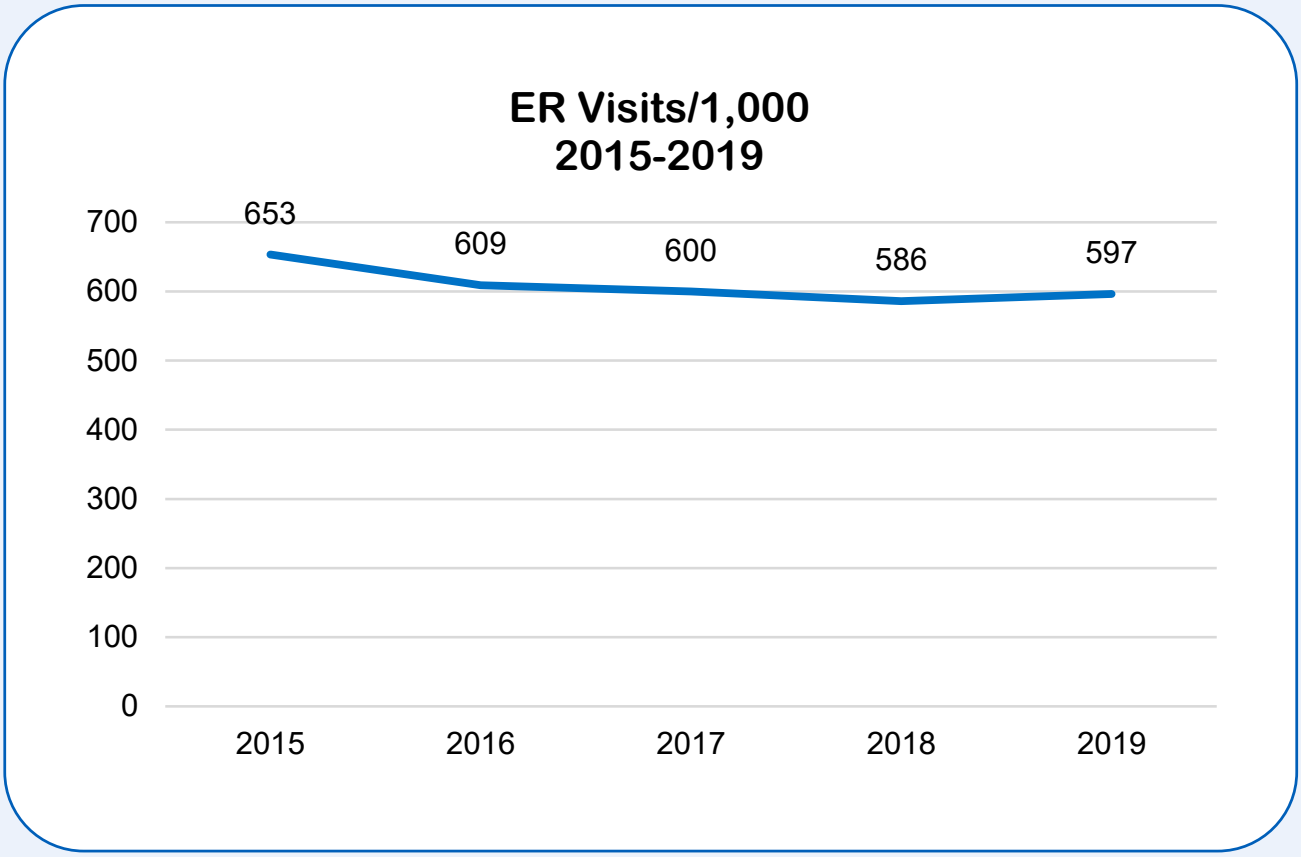
- PMPM (Paid Medical)
- Risk-Adjusted PMPM (Paid Medical)

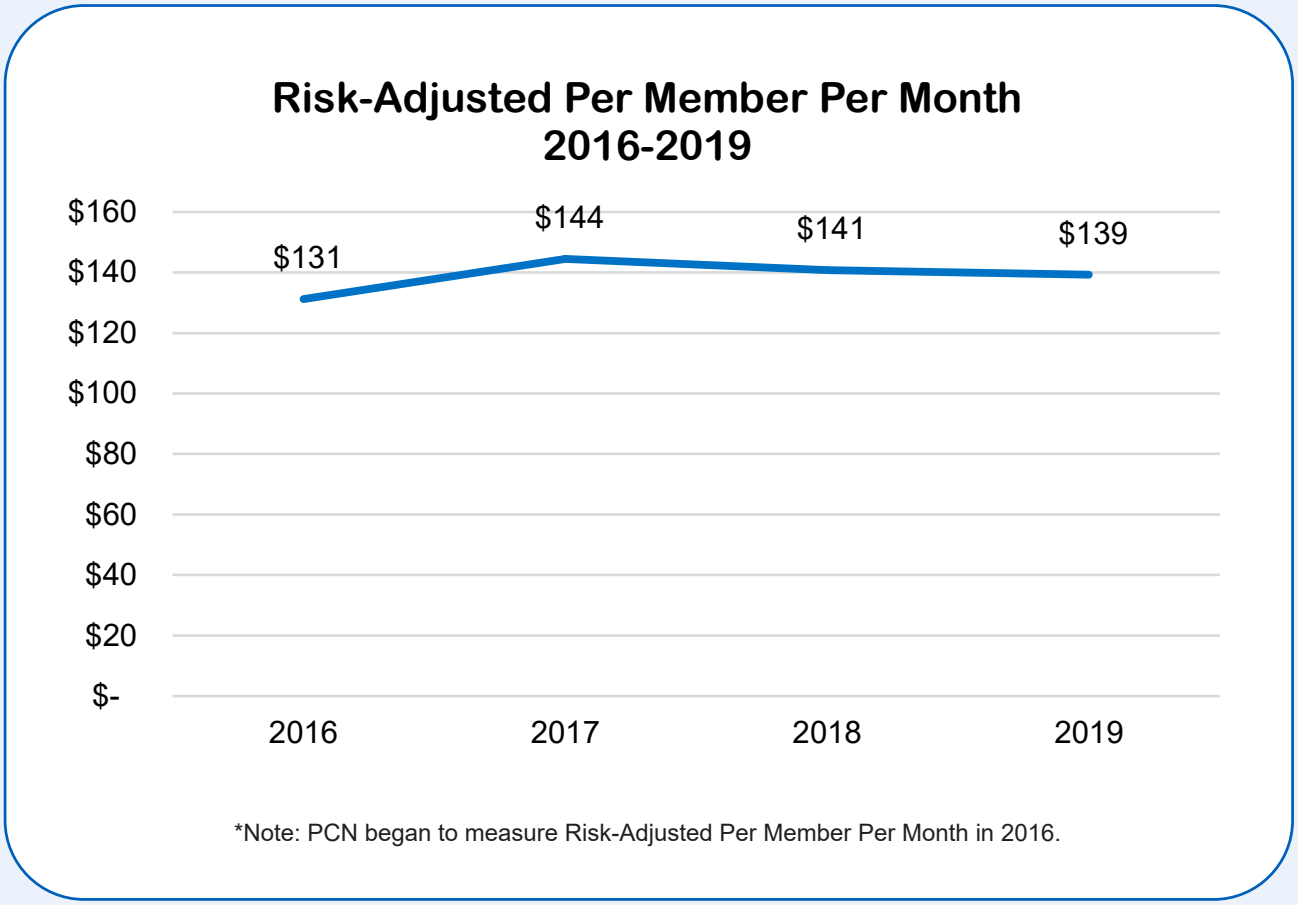
From a utilization comparison perspective, the following metrics are evaluated:

- Admissions/1,000
- Inpatient Days/1,000
- ER Visits/1,000
- Risk-Adjusted Avoidable ED Visits/1,000
- Risk-Adjusted Impactful Admission/1,000

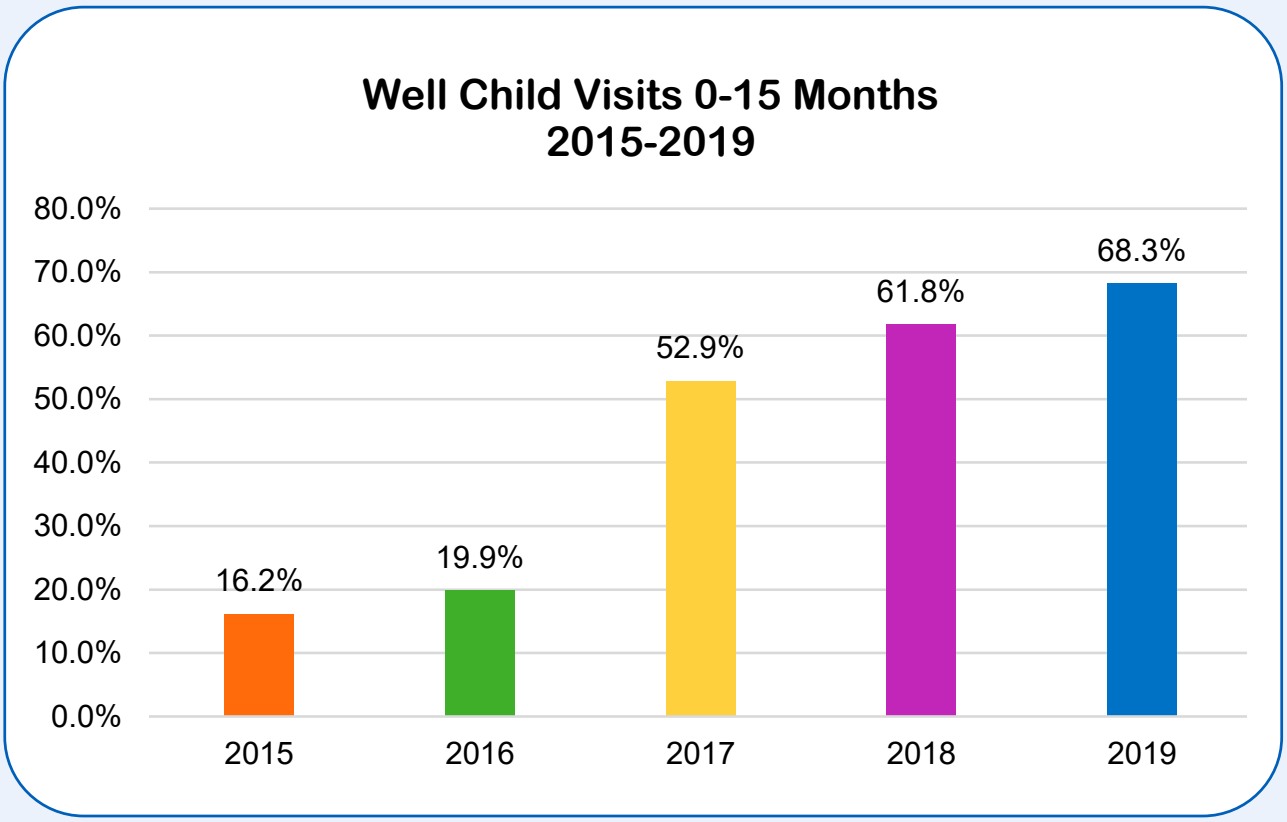
The following analysis includes the quality, cost, and utilization metrics above for all members in the PCN population. This includes data for Federally Qualified Health Centers (FQHCs) and hospital-based health systems.

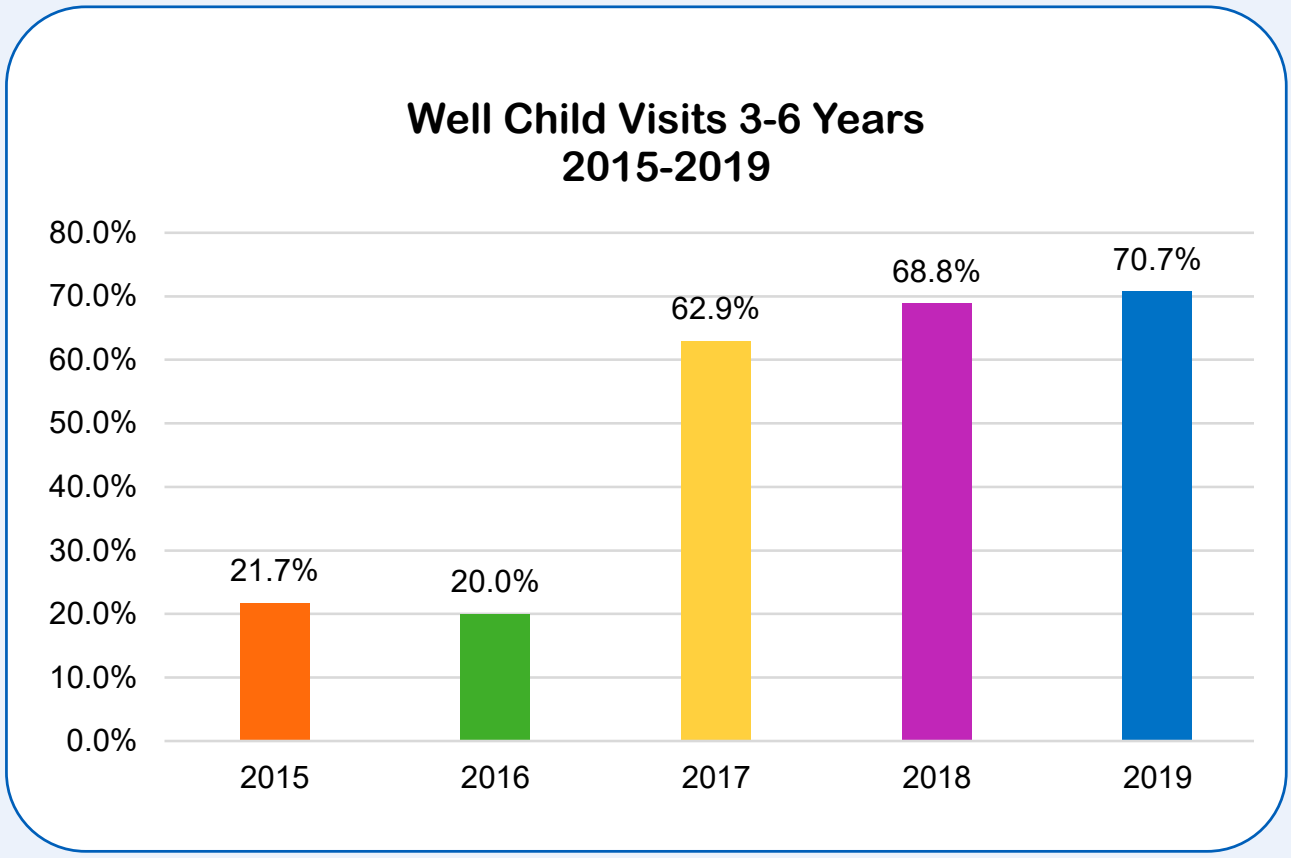

Admissions/1,000
2015-2019
90
80
70
60
50
40
30
20
10
0
84
80
73
83
81
2015
2016
2017
2018
2019

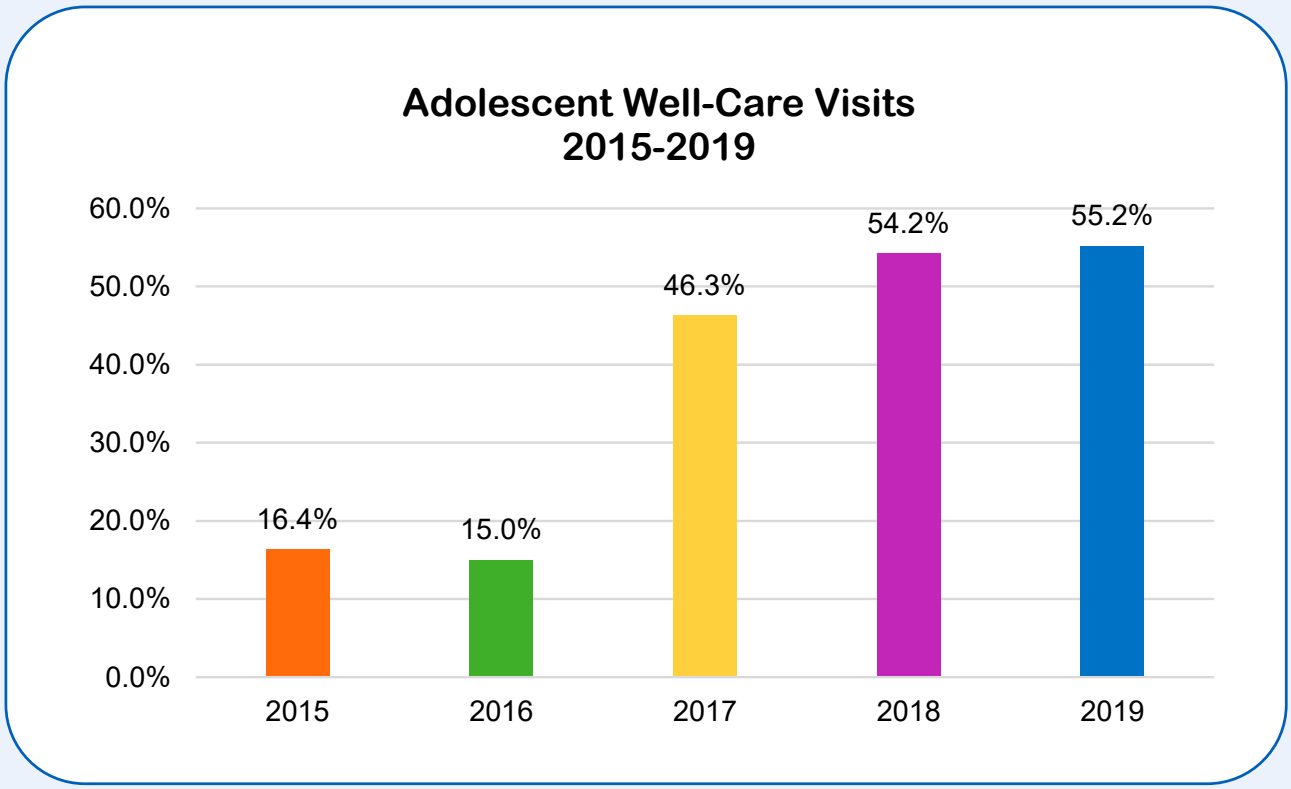

ER Visits/1,000
2015-2019
700
600
500
400
300
200
100
0
653
609
600
586
597
2015
2016
2017
2018
2019

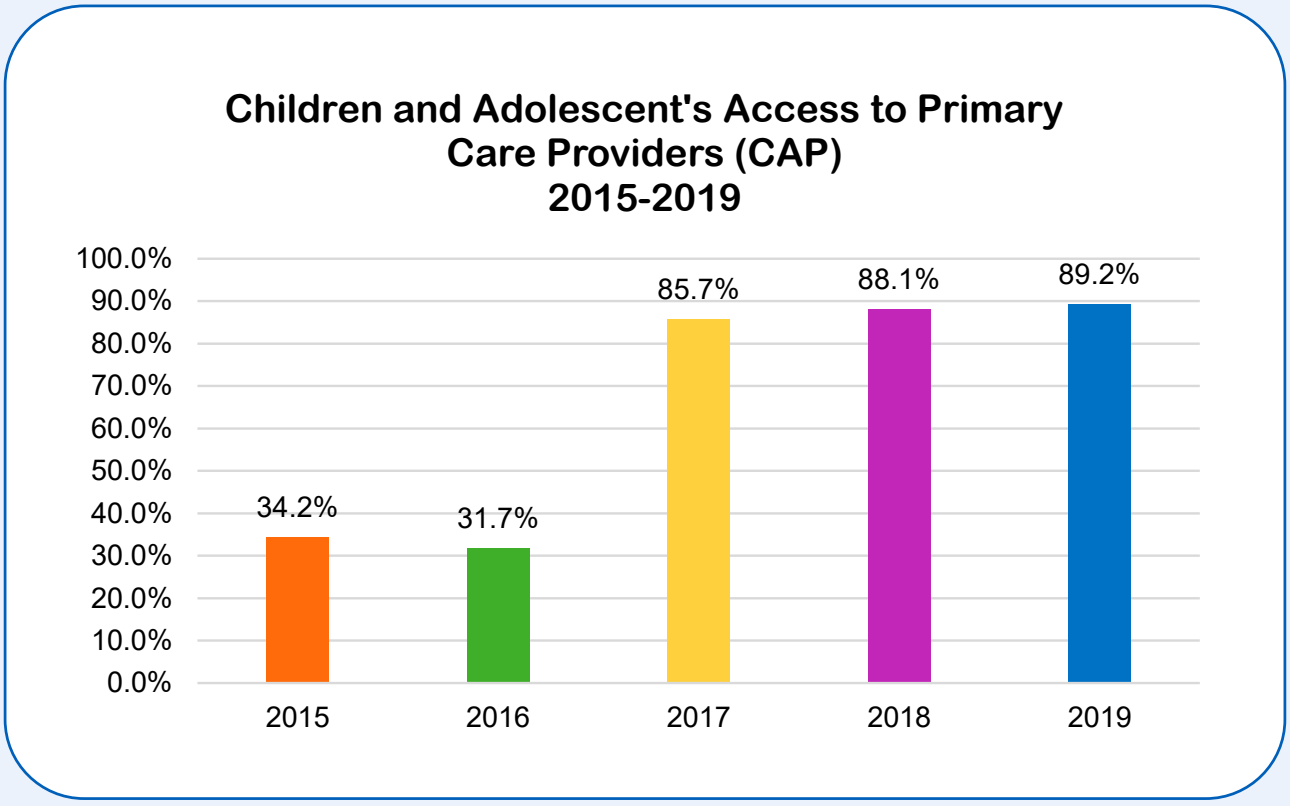


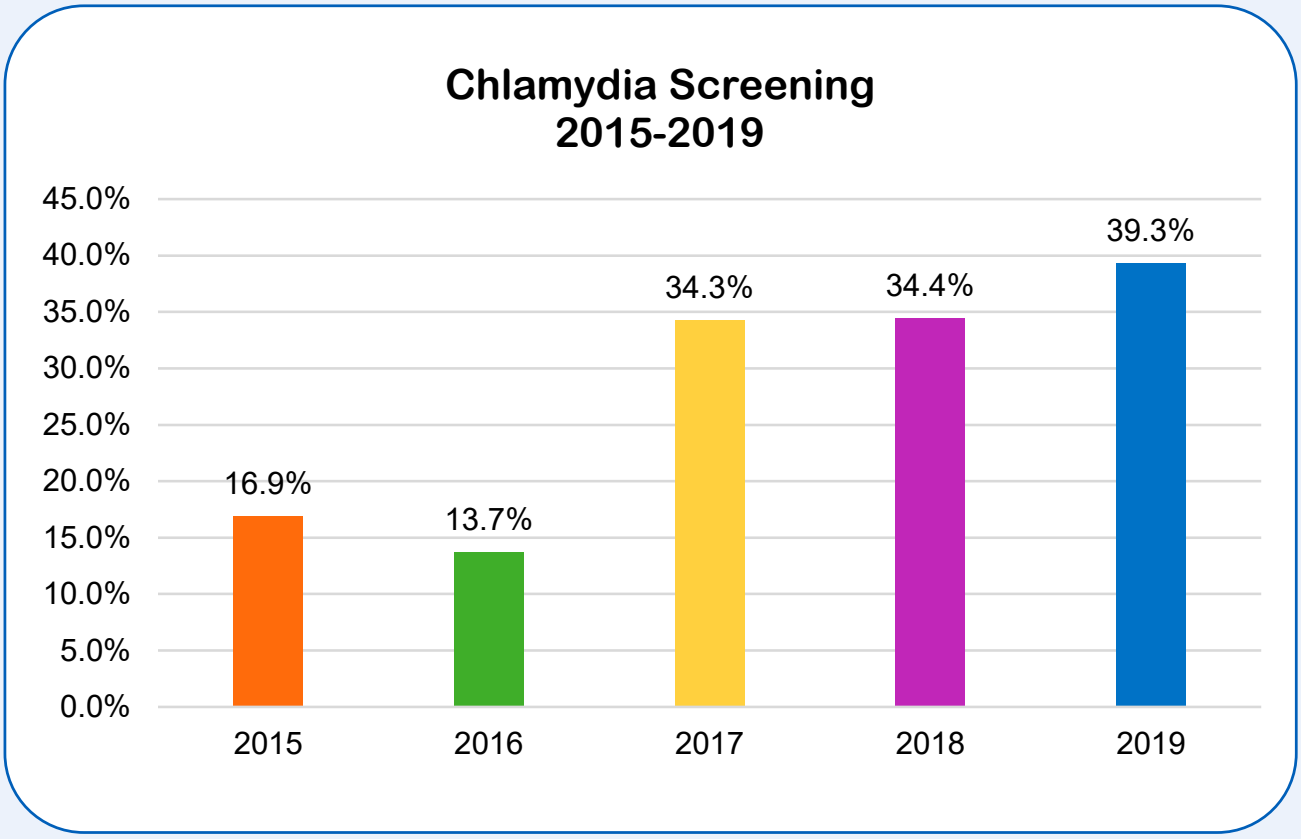
*Note: PCN began to measure Risk-Adjusted Per Member Per Month in 2016.

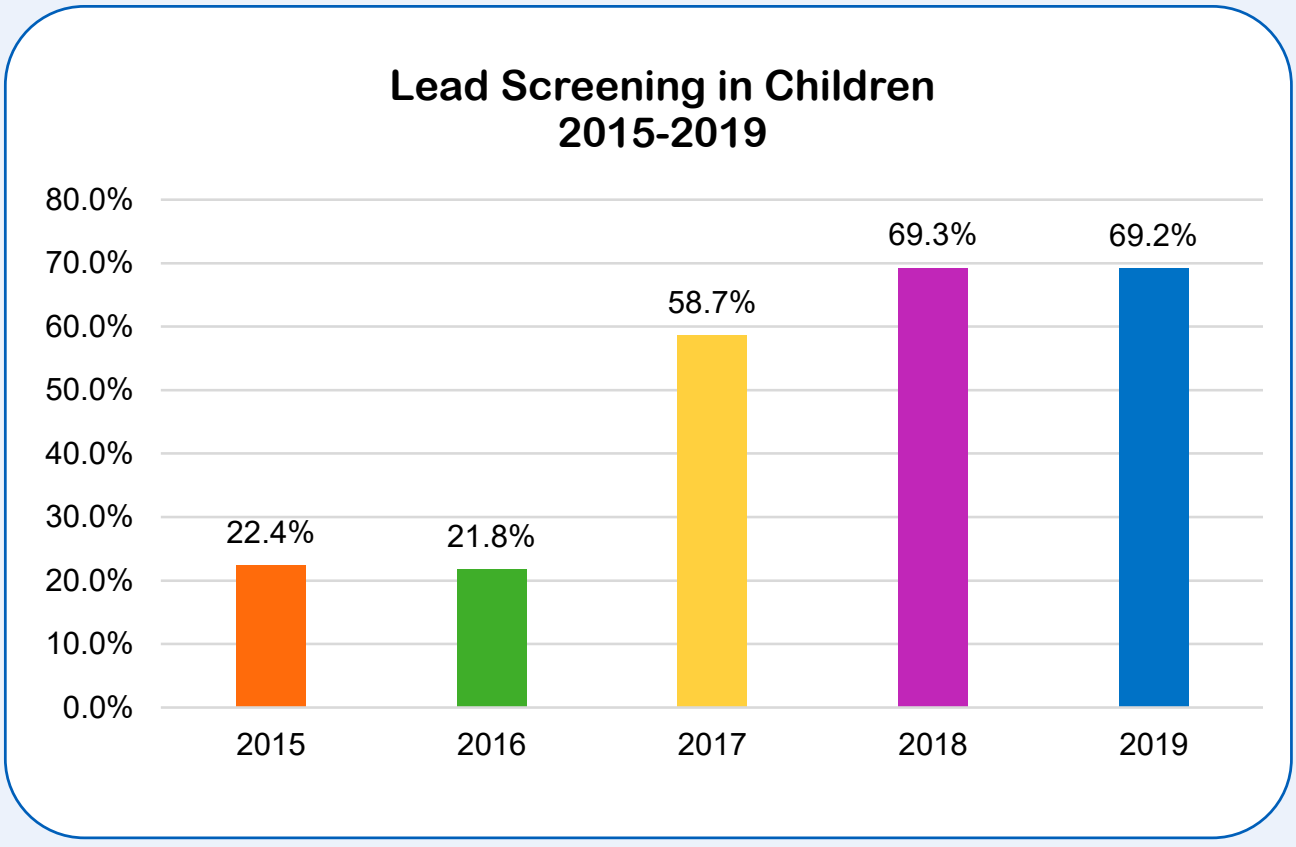

Well Child Visits 0-15 Months
2015-2019
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
16.2%
19.9%
52.9%
61.8%
68.3%
2015
2016
2017
2018
2019


Well Child Visits 3-6 Years
2015-2019
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
21.7%
20.0%
62.9%
68.8%
70.7%
2015
2016
2017
2018
2019

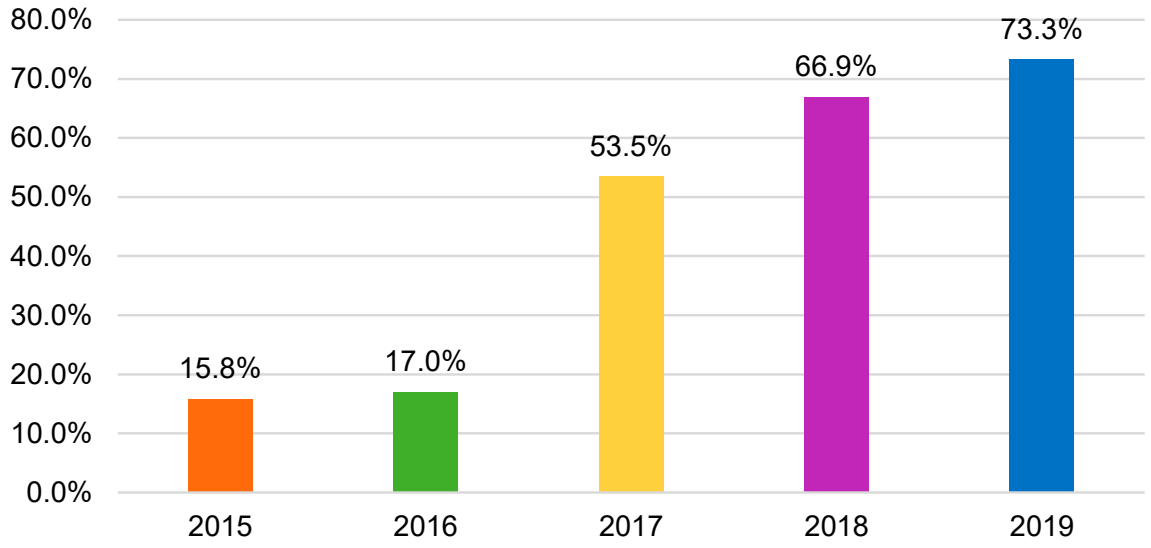

Adolescent Well-Care Visits
2015-2019
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
16.4%
15.0%
46.3%
54.2%
55.2%
2015
2016
2017
2018
2019


Children and Adolescent's Access to Primary Care Providers (CAP)
2015-2019
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
34.2%
31.7%
85.7%
88.1%
89.2%
2015
2016
2017
2018
2019

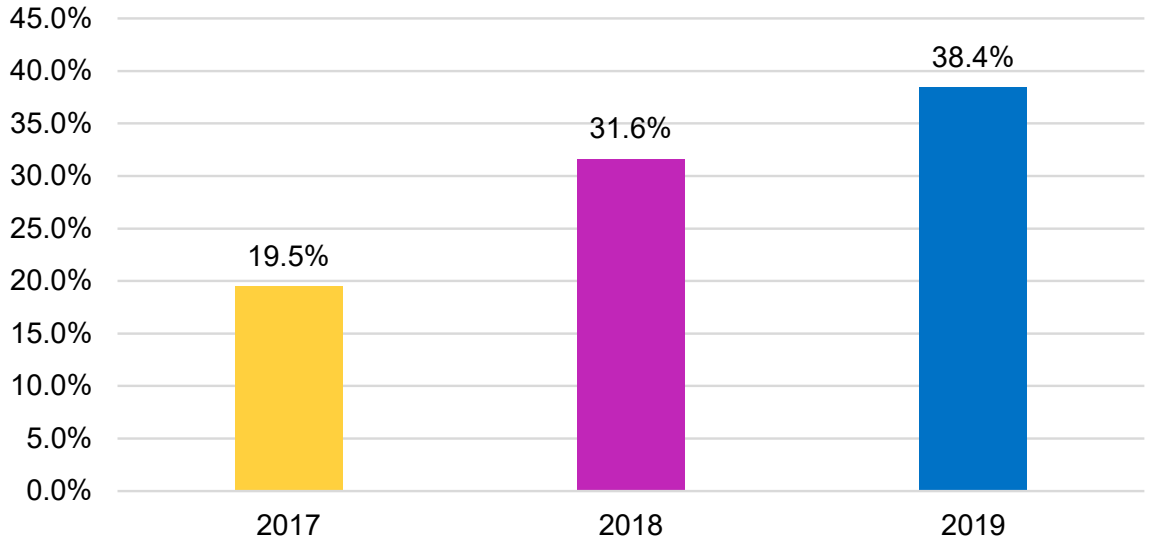

Chlamydia Screening
2015-2019
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
16.9%
13.7%
34.3%
34.4%
39.3%
2015
2016
2017
2018
2019


Lead Screening in Children
2015-2019
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
22.4%
21.8%
58.7%
69.3%
69.2%
2015
2016
2017
2018
2019

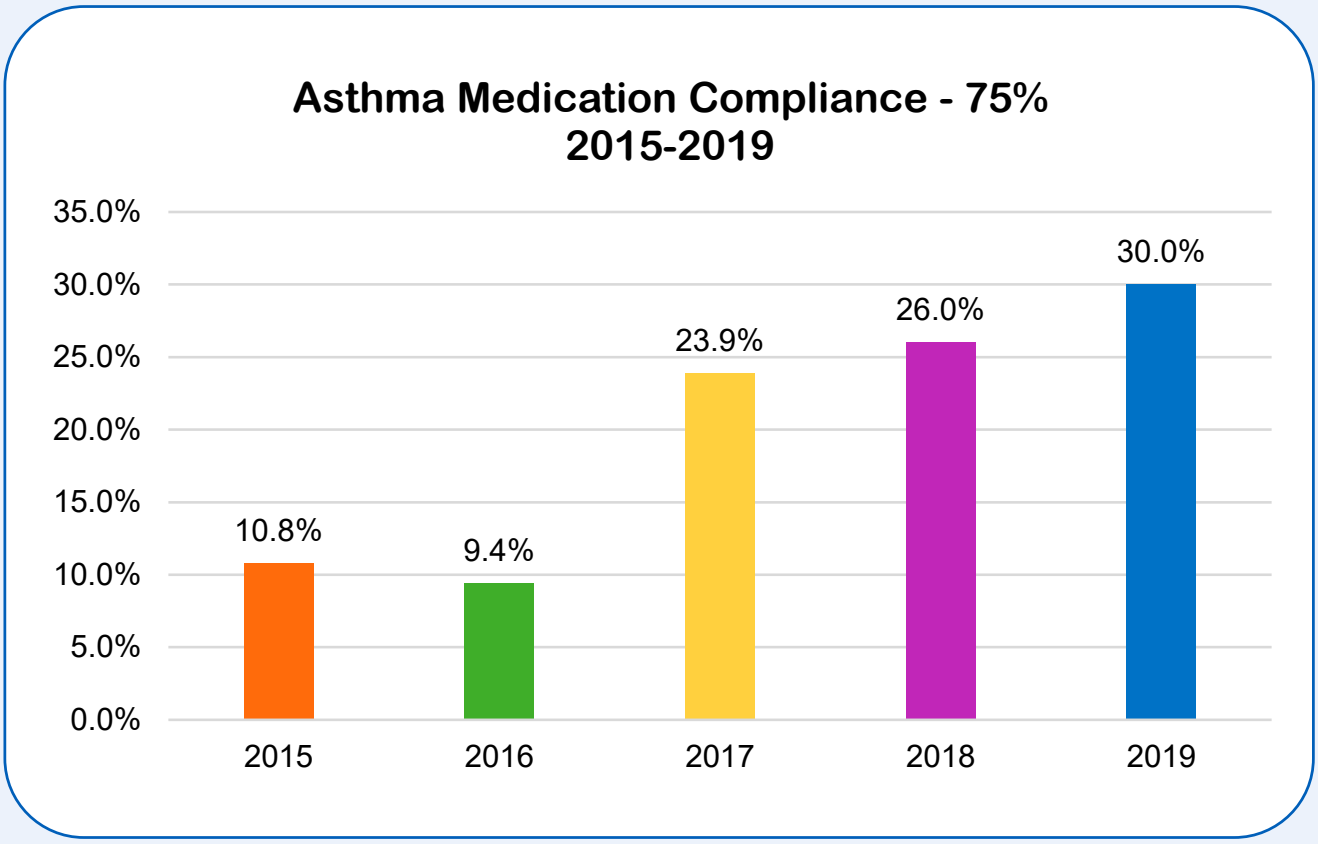
Age 13 Immunization Combo 1 (MCV, Tdap) 2015-2019

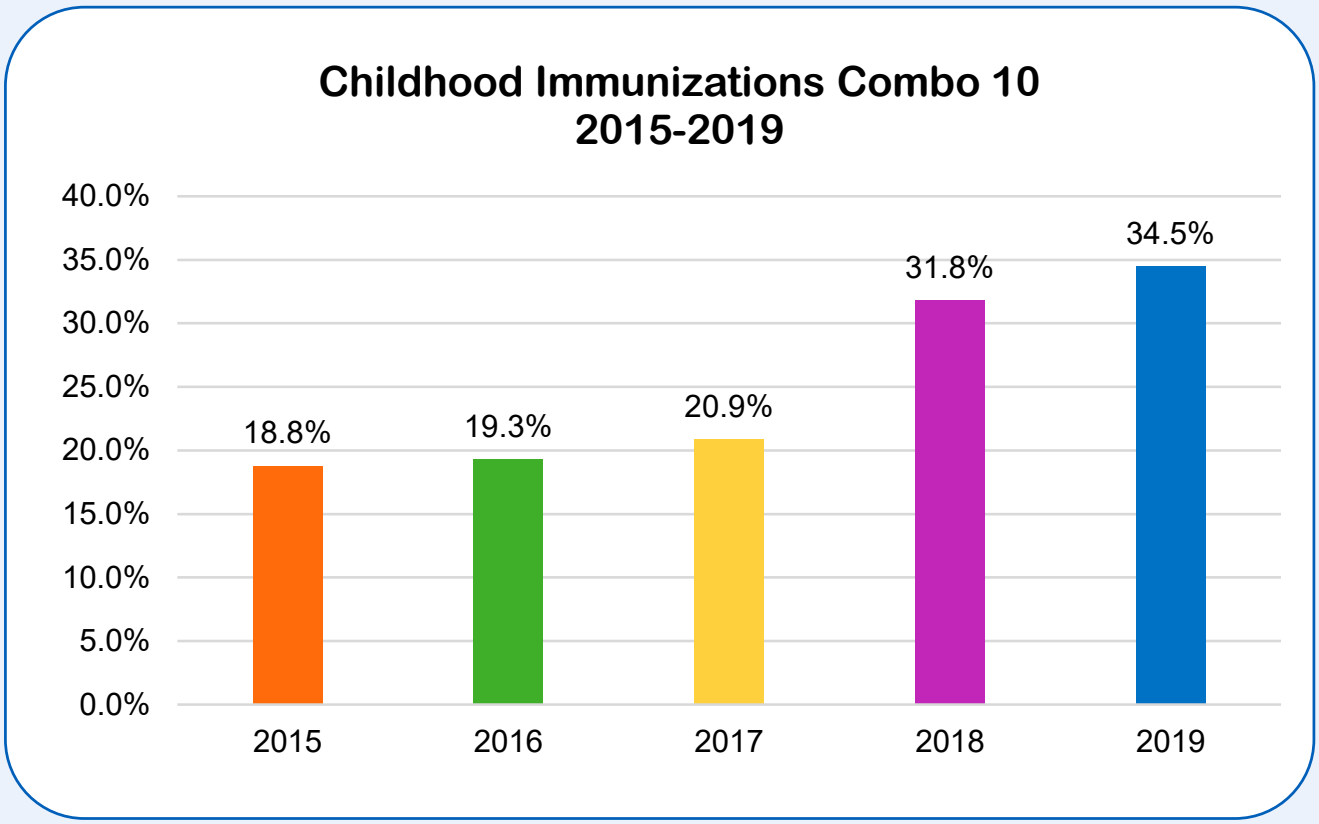


Age 13 Immunization Combo 2 (MCV, Tdap, HPV) 2017-2019



*Note: PCN began to measure Age 13 Immunization Combo 2 (MCV, Tdap, HPV) in 2017.


Asthma Medication Compliance - 75%
2015-2019
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
10.8%
9.4%
23.9%
26.0%
30.0%
2015
2016
2017
2018
2019


Childhood Immunizations Combo 10
2015-2019
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
18.8%
19.3%
20.9%
31.8%
34.5%
2015
2016
2017
2018
2019

Future Initiatives

- PCN will be transitioning from the current patient outreach initiative platform, Emmi, to Innovaccer's InConnect solution in the first quarter of 2020. These new InConnect campaigns are on track to reach more patients in more meaningful and valuable ways;
- C.A.R.E. Web will implement new enhancements to allow for greater provider engagement and more efficient workflow for Care Teams;
- As the Community Health Worker role develops at Central High School, PCN will continue to evaluate the impact of the CHW program within this population and will adjust the program approach as necessary;
- PCN will continue to expand the KidCare Anywhere program to additional PCN patients and leverage new platform technology.

3 Utilization Management

- Utilization Management Program Overview
- Program Measures
- Provider Experience
- Analysis
- Future Initiatives

Utilization Management (UM) Program Overview

PCN performs prior authorization, inpatient review, discharge planning, and transitional care planning. Both clinical and non-clinical staff perform prior authorization functions. Non-clinical staff assist with verifying eligibility, entering authorization information in the online system, and faxing and/or calling authorization outcomes to providers. Clinical staff perform medical necessity review and discharge planning. The review process utilizes national guidelines, Milliman Care Guidelines®, as well as internally developed guidelines, to determine medical necessity of service requests. All requests that do not meet the related guideline or policy are sent to a Medical Director for review and final decision. The Care Integration Manager and Clinical Project Manager conduct staff audits and oversee the peer audit process. This involves members of the Care Teams conducting audits on their peers' performance of the prior authorization processes to ensure compliance with documentation standards, application of criteria, and adherence to processing timeframe standards. Current audit standards require that staff members who have been employed for greater than a year meet or exceed an accuracy level of 95%. In 2019, the average audit scores for both clinical and non-clinical staff exceeded the established 95% benchmark. PCN monitors timeframes for processing routine and urgent prior authorization requests on a monthly basis to ensure the program standards are consistently met. The phone queue system is monitored by the Clinical Project Manager, and call statistics are reviewed monthly to ensure calls are answered according to standards.

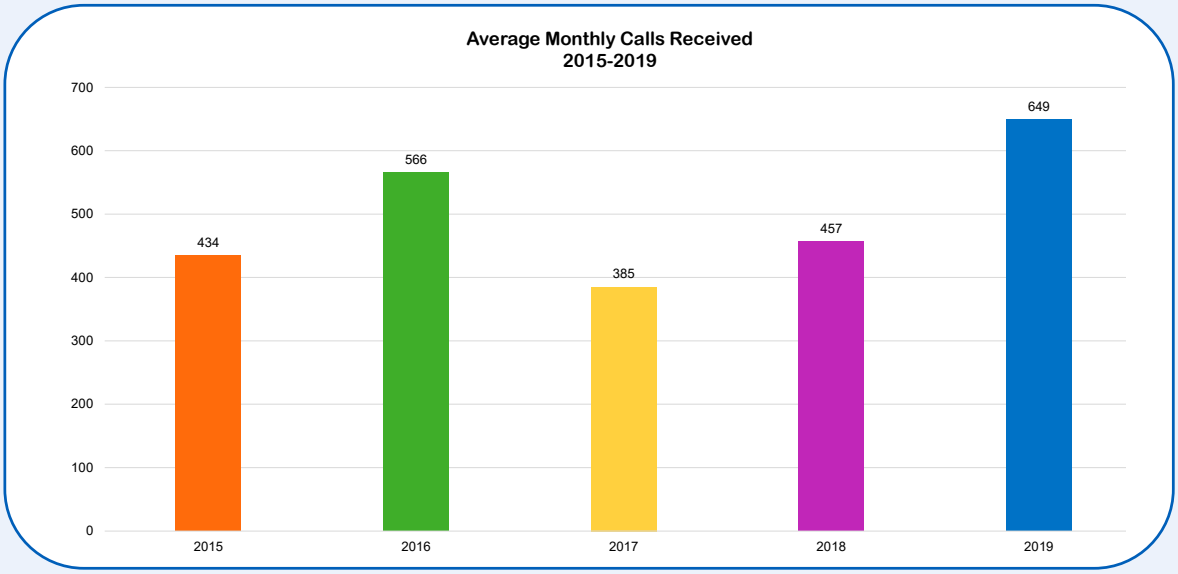
In addition to process measures, PCN monitors utilization trends for the population to ensure appropriate utilization of services occurs. To monitor for under-utilization of services, PCN relies on review of preventive services, outpatient services, and PCP office-based services. Additionally, PCN monitors member complaints or grievances related to access to care or insufficient care delivery. The information specific to those

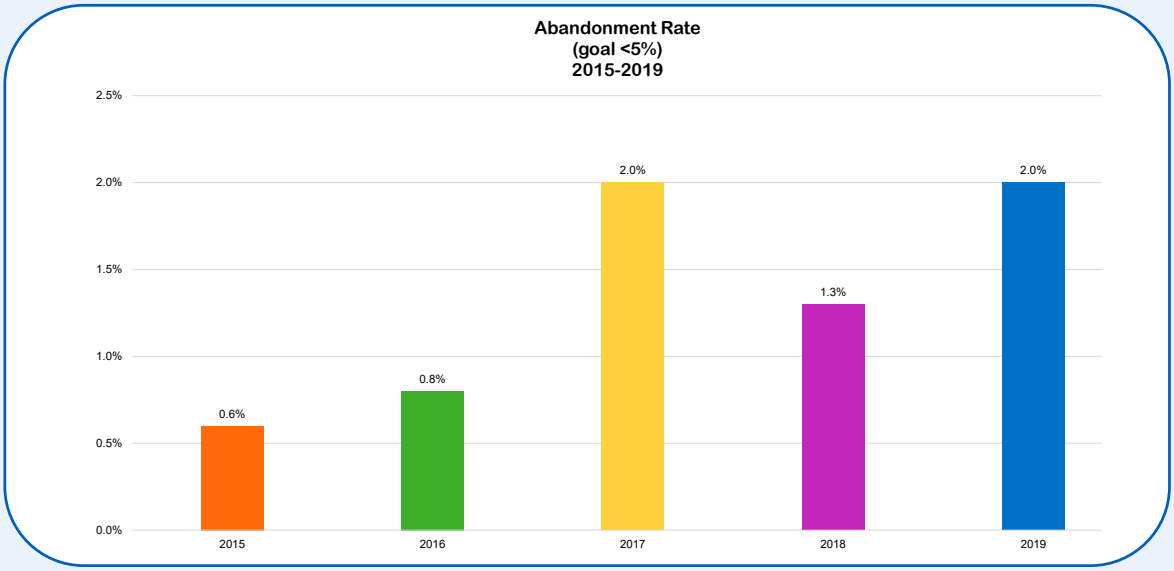
measures is outlined in the Population Health Management and Case Management/Disease Management sections of this report. To monitor for over-utilization of services, PCN relies on review of frequent and/or high-cost services such as inpatient and emergency room (ER) trends. The data specific to those measures is presented here.

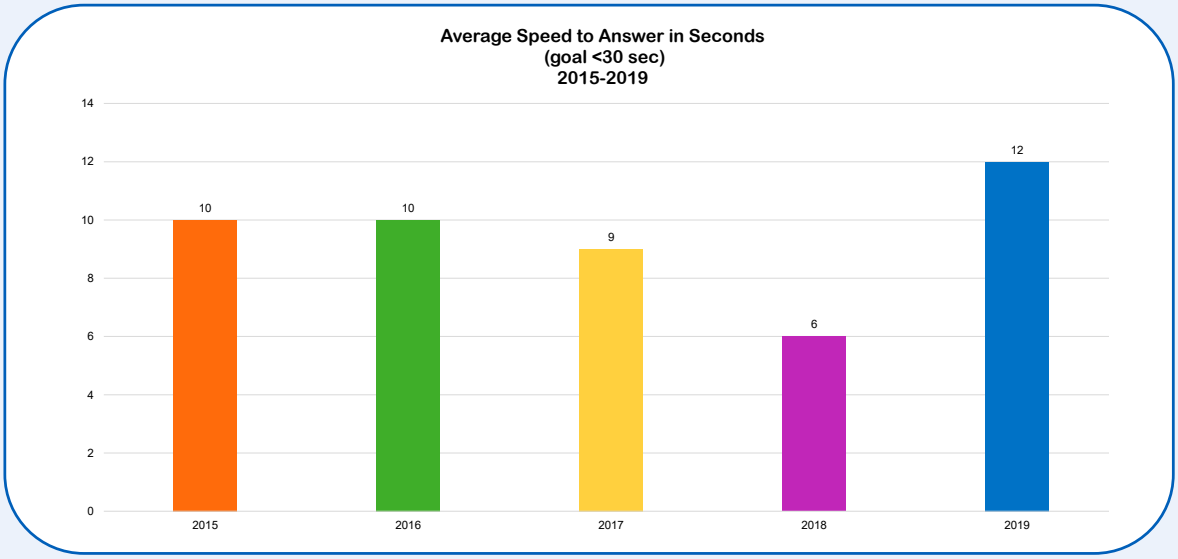
Program Measures

Authorization statistics related to those standards for phone call monitoring and processing medical necessity reviews are presented in the following charts and compare current year performance to prior years. In 2019, the phone statistics remained consistent and well within the benchmarks. The average number of calls received monthly in 2019 increased by 30% from 2018 due to the addition of the Aetna BetterHealth of Kansas health plan. There was a slight increase in the abandonment rate and average speed to answer in seconds, however these statistics still fell well within the benchmark goal. Additionally, denials for outpatient services remained consistent from 2018 to 2019.

Precertification Phone Statistics

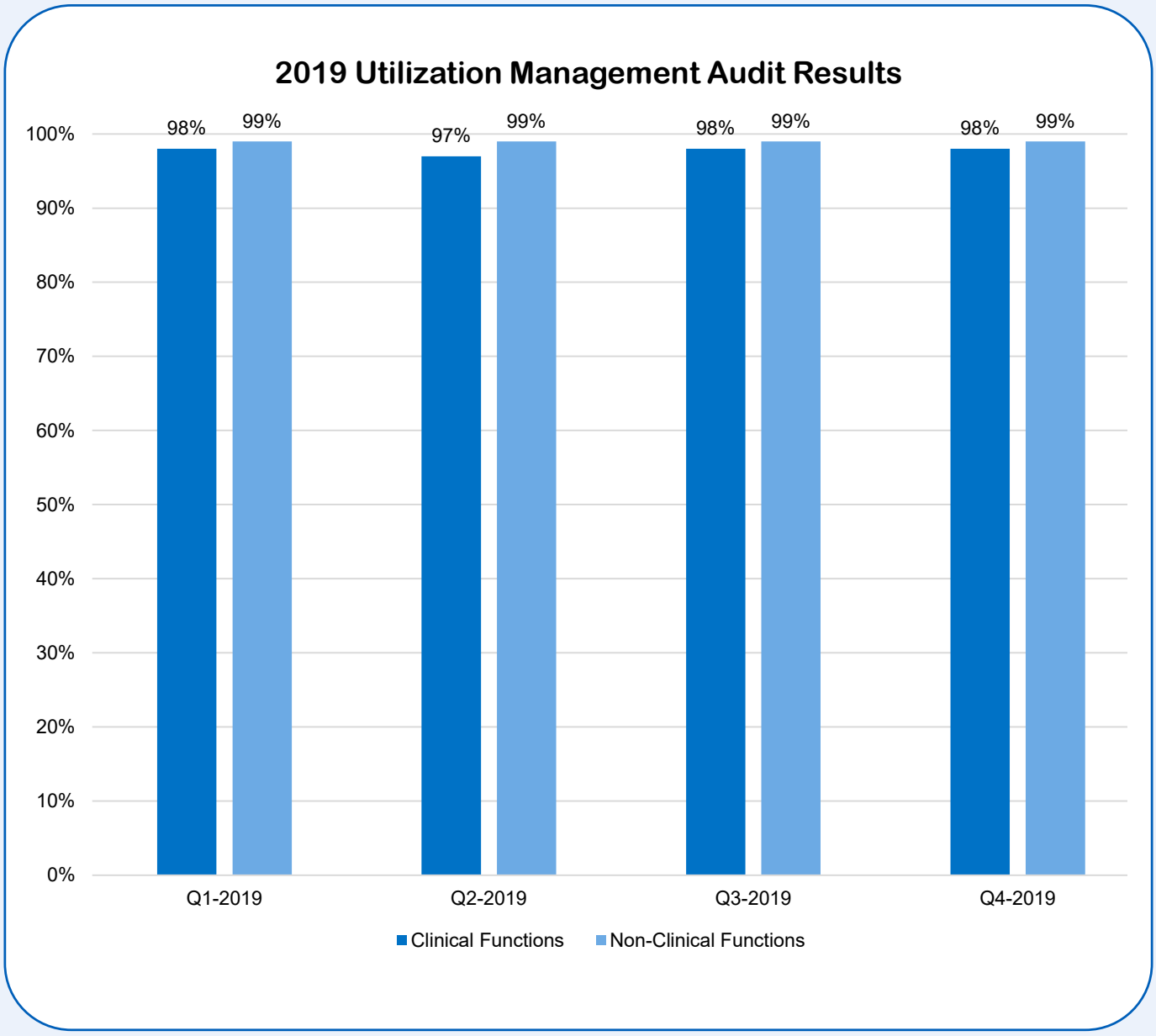




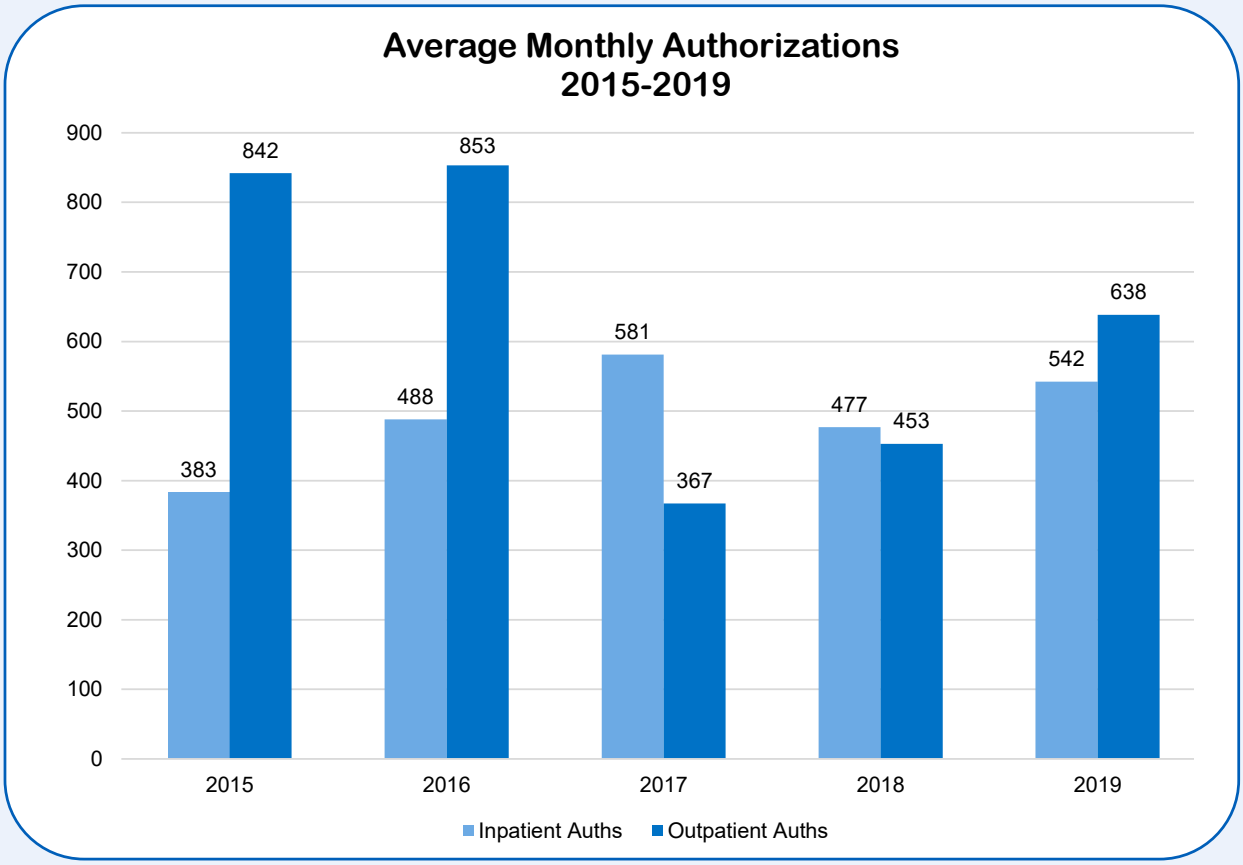


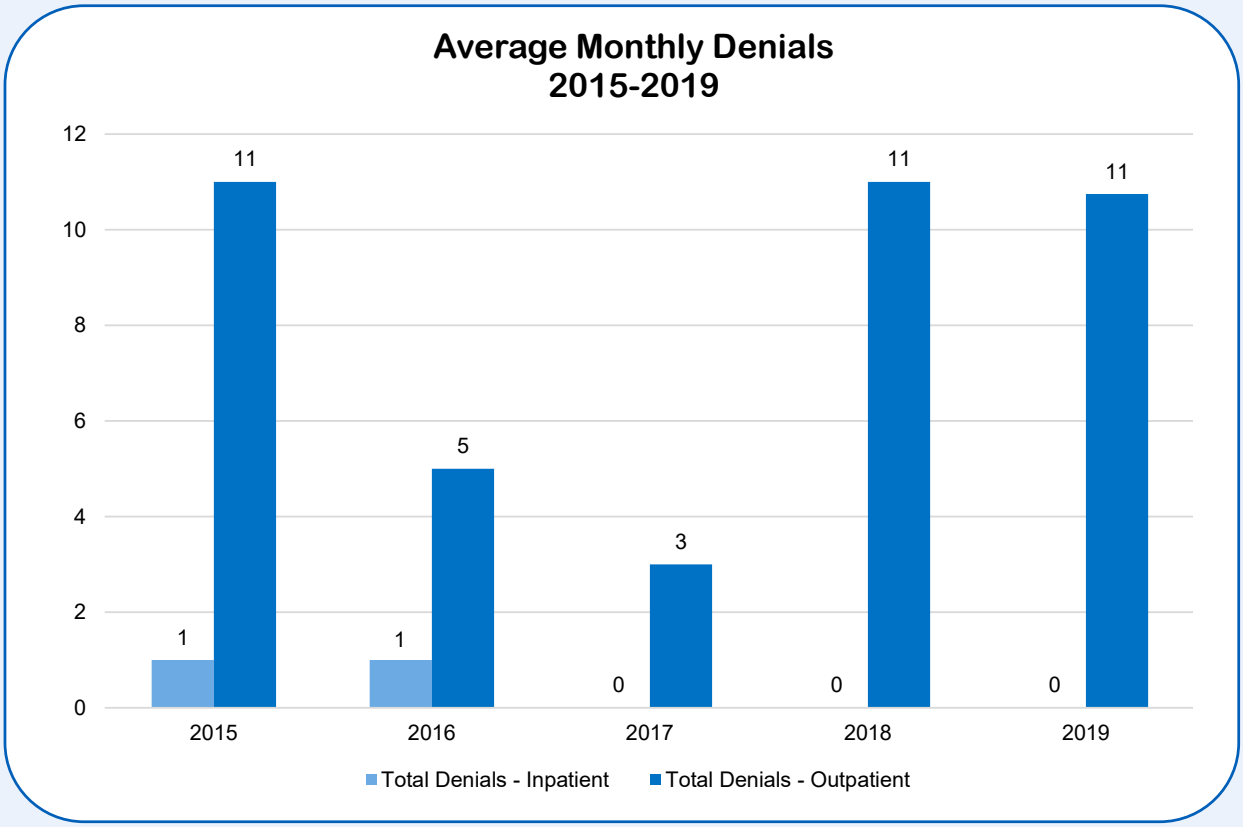
2019 Utilization Management Audit Results

Below are the 2019 aggregate audit results for clinical and non-clinical staff performing utilization management functions. Audit scores for both groups consistently exceeded the established benchmark of 95% throughout 2019.

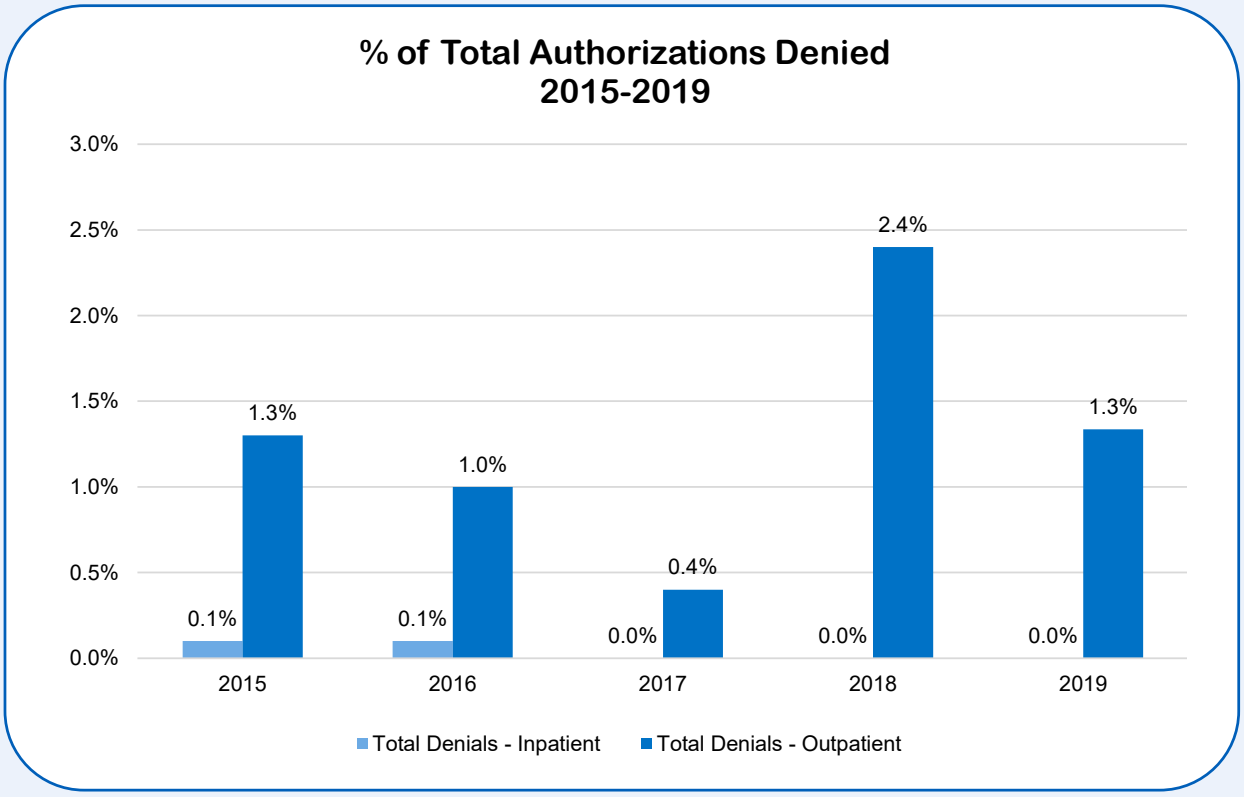


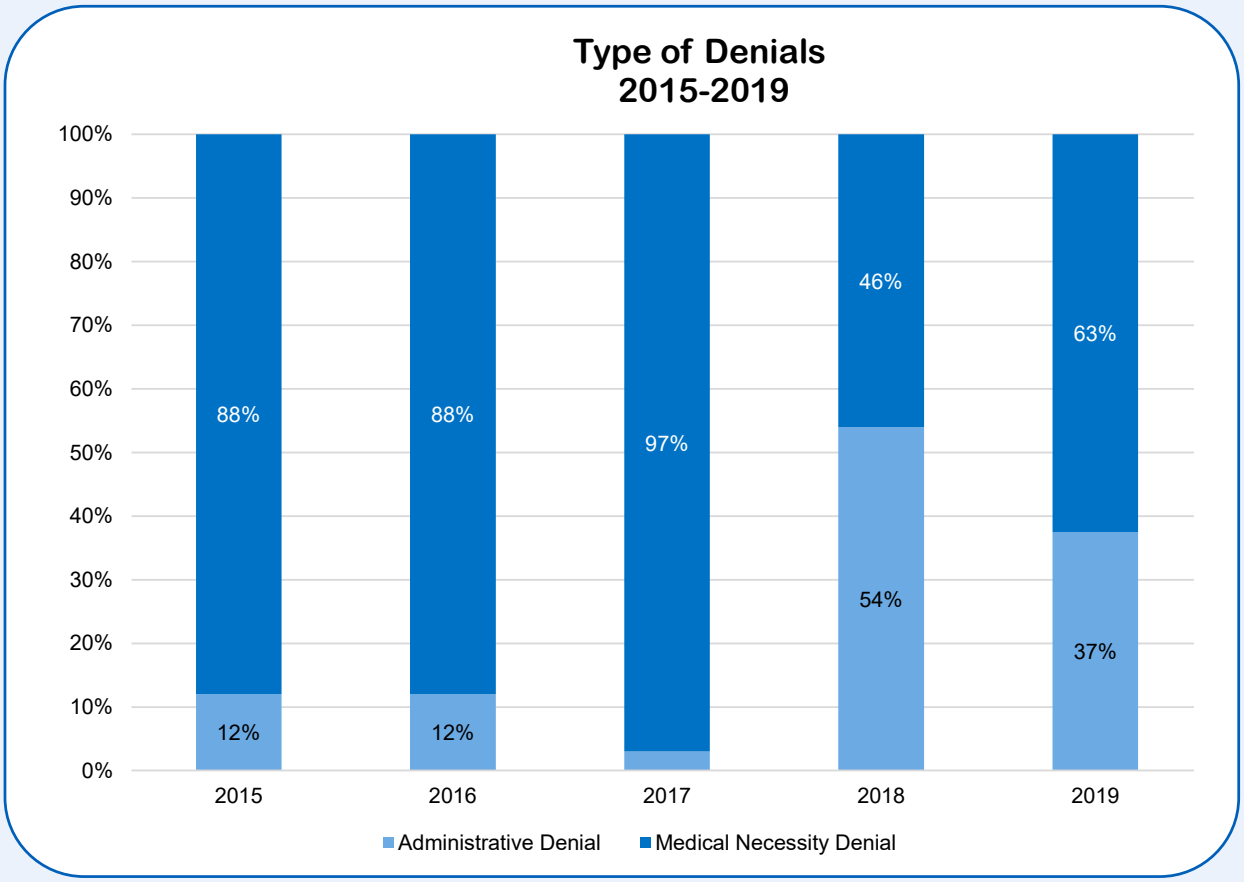
Prior Authorization Statistics





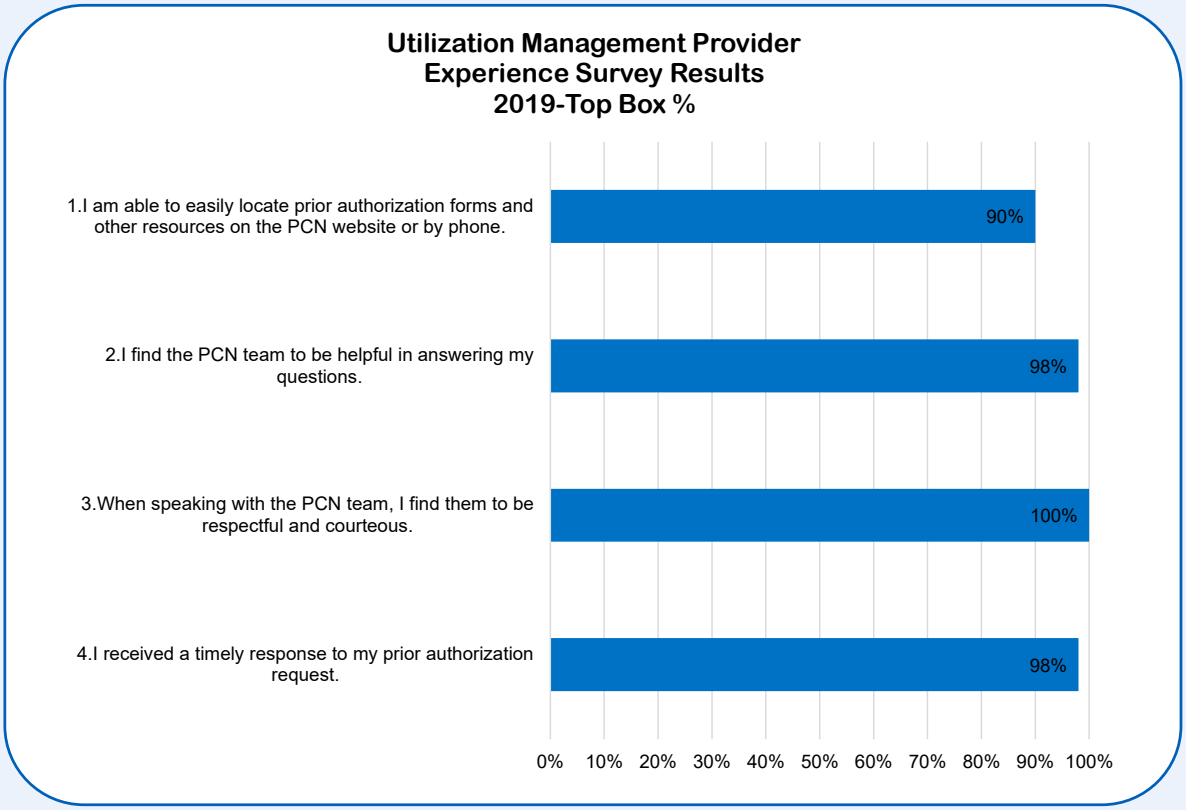
Prior Authorization Statistics

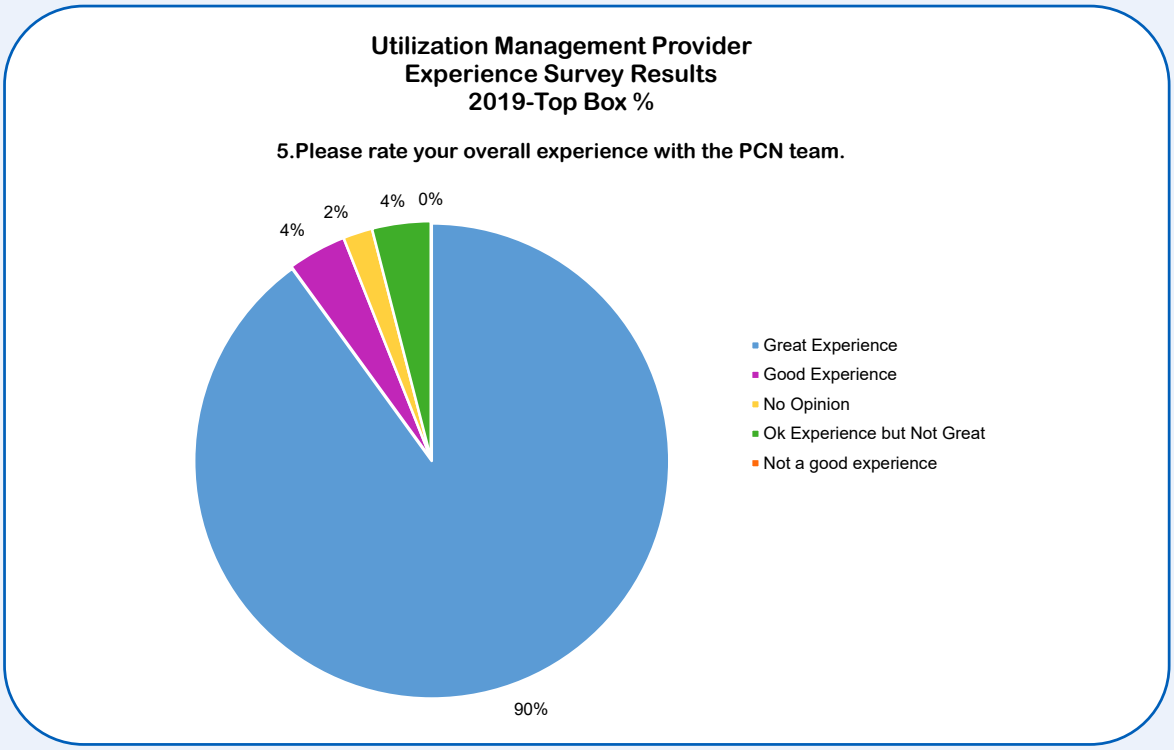




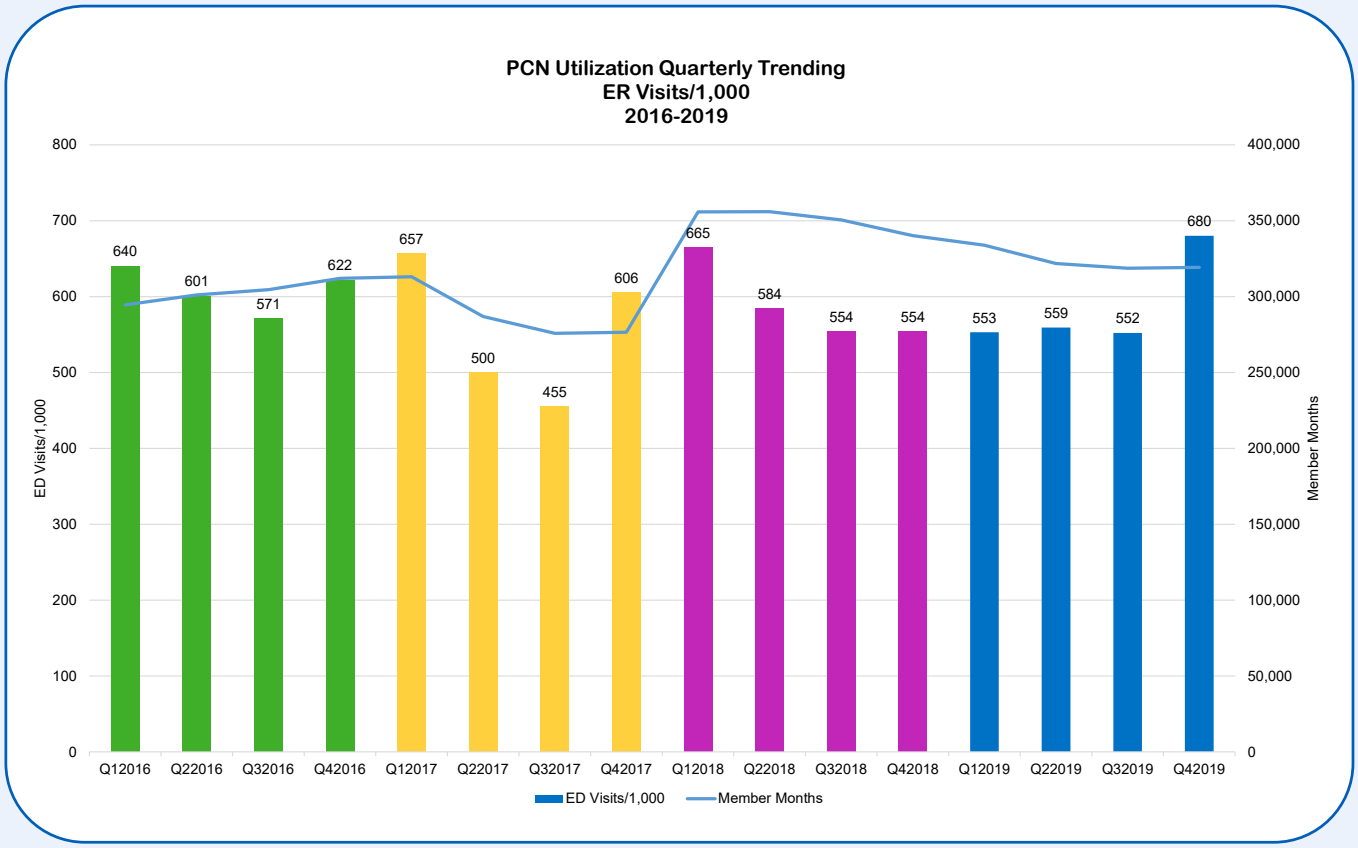
Provider Experience

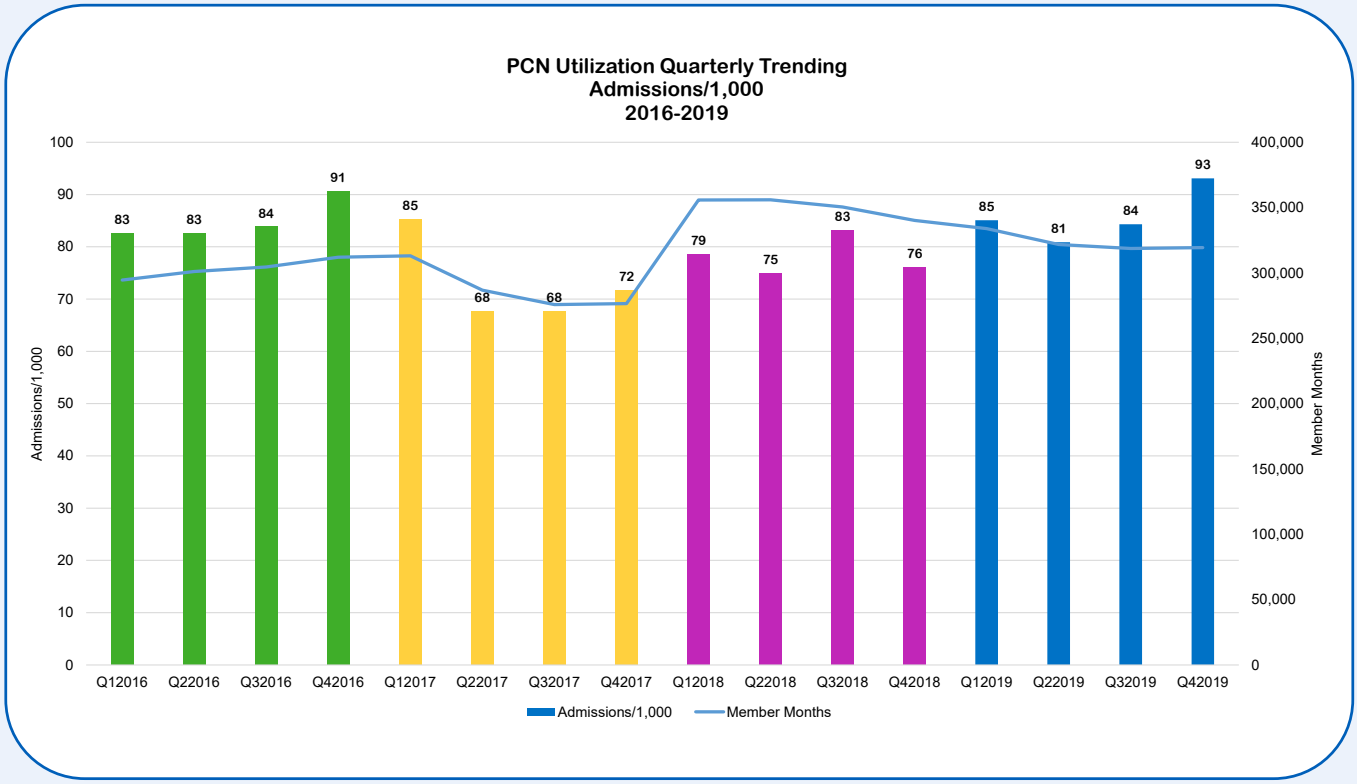
A short survey was distributed to all clinics/PCMH offices in PCN to assess their satisfaction with the prior authorization process. The Provider Satisfaction Survey contains five questions. PCN's Provider Satisfaction Survey results from 2019 are shown below.





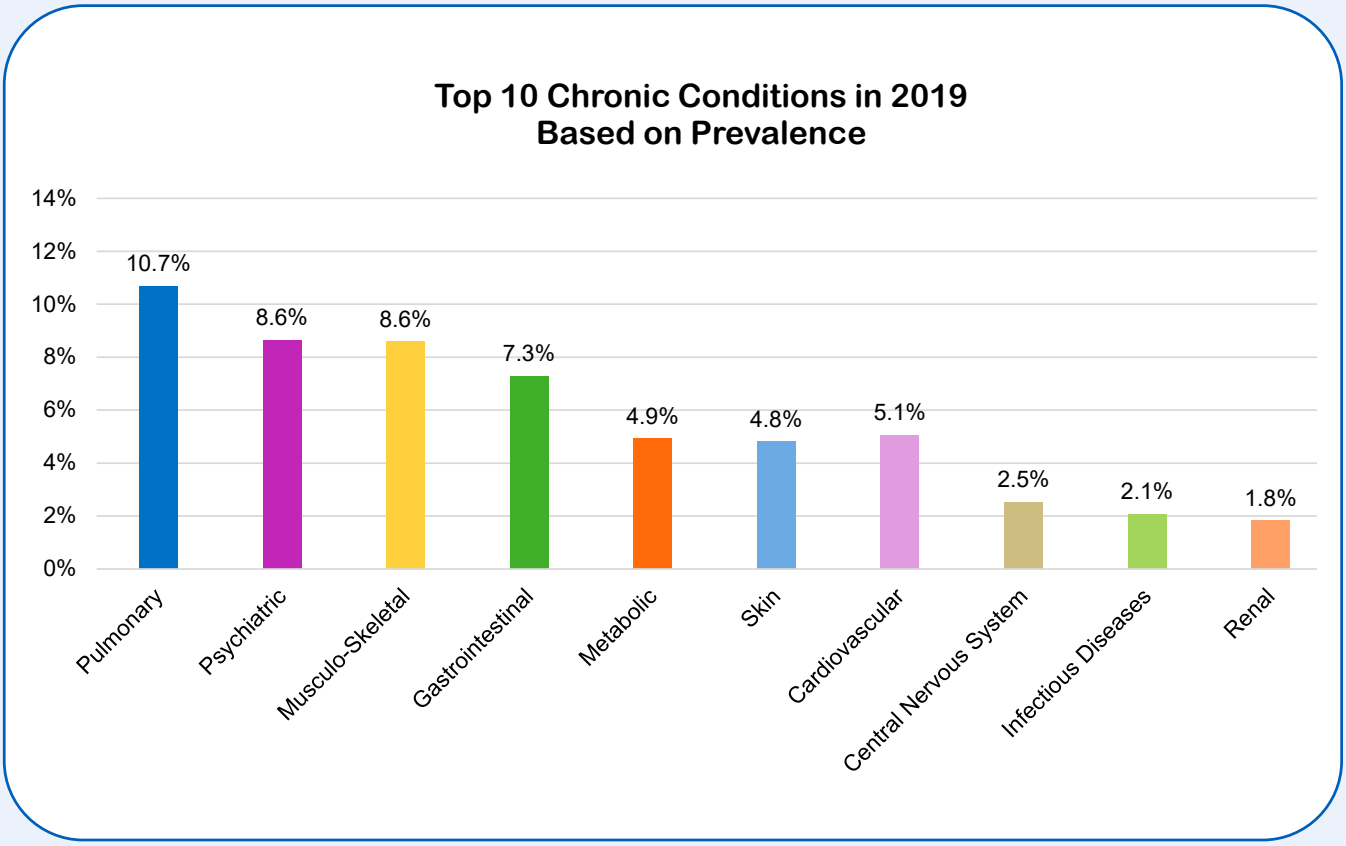
Inpatient and ER Utilization Statistics: 2016-2019



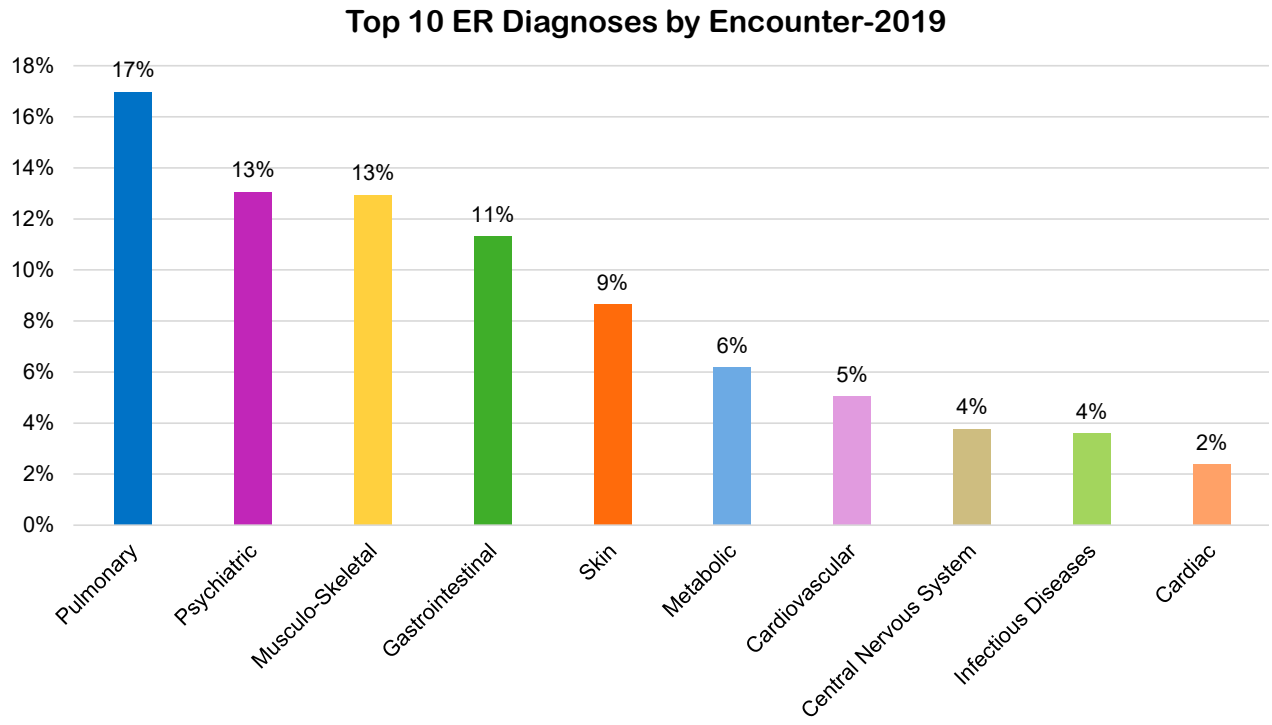


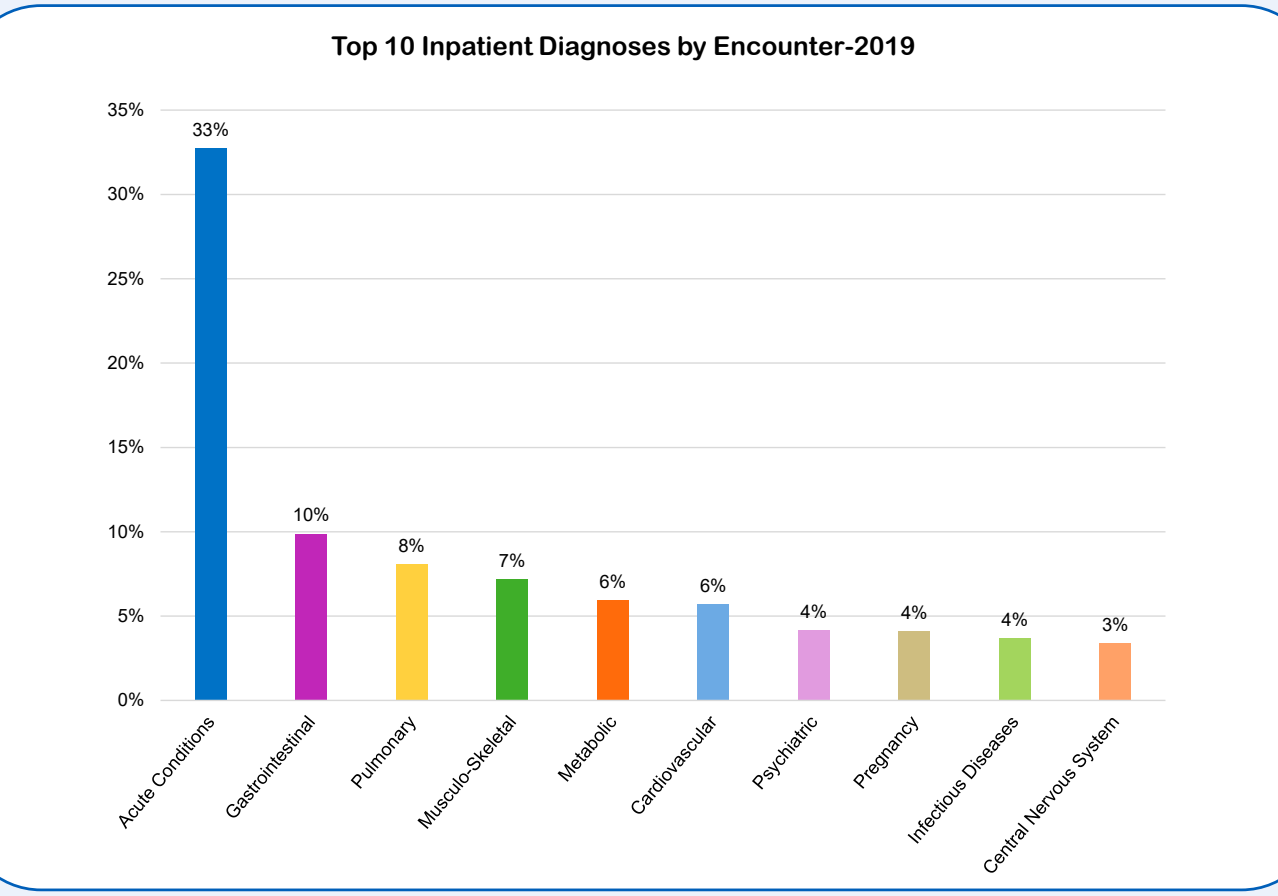
Year over Year Comparisons of Utilization: 2015-2019

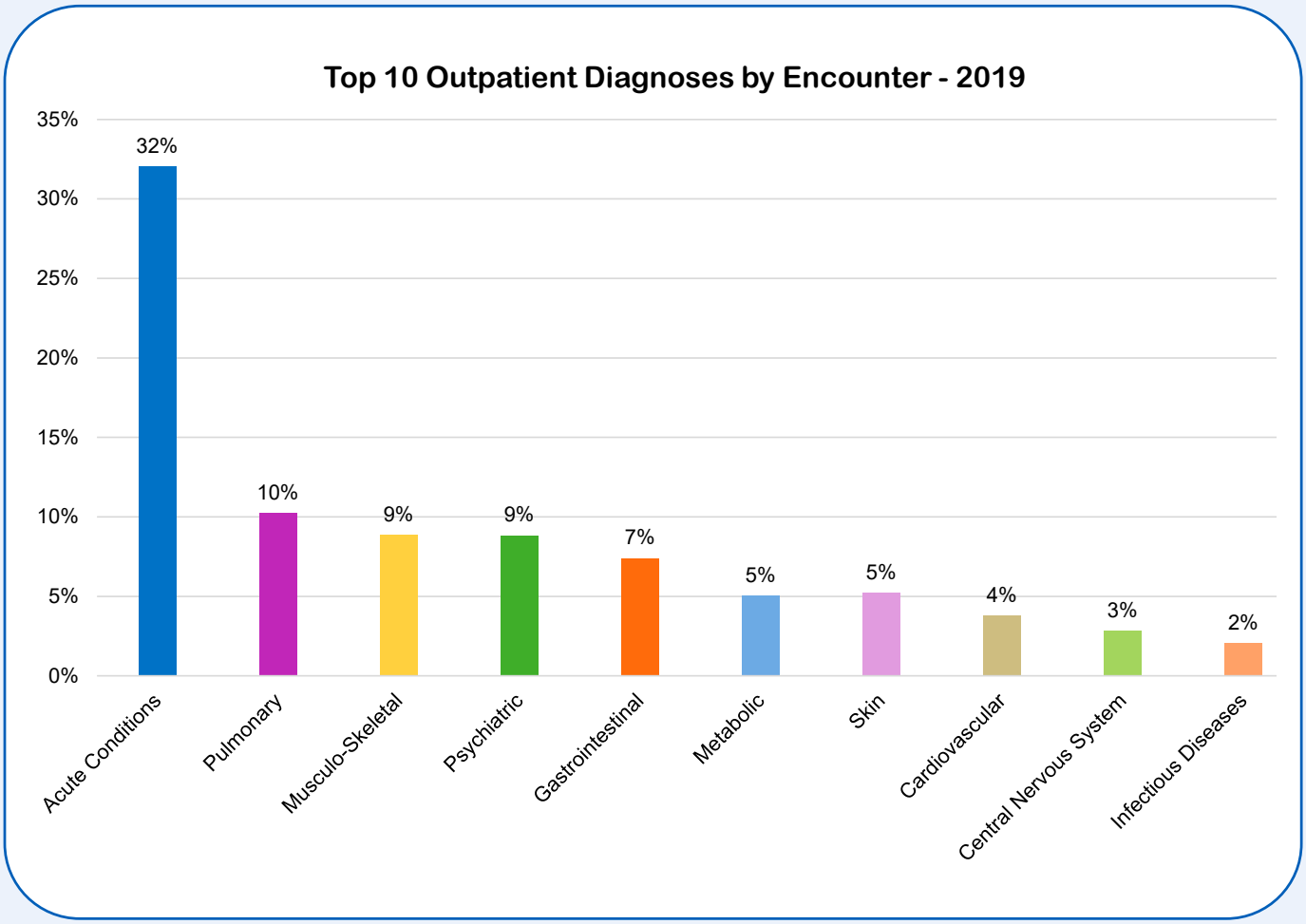
Incurred Year	2015	2016	2017	2018	2019
Admissions/1000	96	86	80	70	62
Days/1000	404	405	348	238	248
ER Visits/1000	718	633	590	583	555
ALOS (Medical)	4.2	4.7	4.4	3.4	4.0
% Change from PY	**2015**	**2016**	**2017**	**2018**	**2019**
Admissions/1000	NA	-10.4%	-7.0%	-12.6%	-11.3%
Days/1000	NA	0.2%	-14.1%	-31.6%	4.4%
ER Visits/1000	NA	-11.8%	-6.8%	-1.2%	-4.8%
ALOS (Medical)	NA	11.9%	-6.4%	-22.7%	17.6%



Top 10 Diagnoses by Encounter







Utilization Analysis

The PCN Care Teams are responsible for utilization management functions for their assigned population. Prior authorization requests are received by a Care Facilitation Coordinator for electronic distribution to the appropriate staff member. Care Facilitation Nurses review and process routine requests that require clinical review. Complicated requests that will require coordination between providers and members are sent to the Care Team for review and processing. The Community Resource Specialist (CRS) is the hub of the Care Team and receives all incoming tasks, including prior authorization requests. The CRS reviews and processes the request according to policy. If the request is beyond the scope of a non-clinical staff member, the CRS initiates the authorization into the system and then sends the request electronically to a Care Navigator for review and completion.

PCN has incorporated a peer audit component into the quarterly staff audit process which provides a learning opportunity for each staff member. By reviewing the work of their peers and verifying accuracy through desktop procedures and policies, staff members are able to increase their own knowledge base. This is demonstrated in the 2019 UM audit results which exceeded the established threshold of 95%. Peer audits are reviewed by leadership to confirm the audit findings. Staff and leadership meet quarterly to review aggregate audit results, discuss themes identified during the audit, and provide re-education to staff.

Emergency room utilization for PCN members continues to trend downward through collaboration with primary care provider practices and appropriate identification and outreach to high ER utilizers. This is evidenced by an 4.8% decrease in ER visits per 1,000 from 2018 to 2019. The top ER diagnoses based on claims encounter data were related to Pulmonary, Psychiatric, Musculo-Skeletal, and Gastrointestinal concerns.

Similar to the downward trend in ER utilization, there has been a downward trend in inpatient utilization. From 2018 to 2019, there was an 11.3% decrease in admissions per 1,000. However, there was a 4.4% increase in inpatient days per 1,000 and a 17.6% increase in Average Length of Stay (ALOS – Medical). As Care Integration processes deepen across the PCN population, lower acuity inpatient admissions decrease through timely identification and active case management of at-risk members. As inpatient admissions shift to higher acuity admissions, PCN expects the inpatient days per 1,000 and ALOS rates to increase slightly. The top inpatient diagnoses in 2019 were related to Acute Conditions, Gastrointestinal, Pulmonary, Musculo-Skeletal, Metabolic, and Cardiovascular concerns.

The broader Care Continuum program within Children's Mercy Kansas City's system allows the Care Teams to more efficiently work in tandem with providers, as well as inpatient and ambulatory Social Workers and Care Managers, to provide the best possible care to members. With this open collaboration, Care Teams are able to provide practices with follow up information from inpatient and emergency room visits to help ensure members have timely follow up appointments with their assigned primary care providers.

In an effort to decrease emergency room utilization and redirect members to the primary care provider for non-emergent health concerns, PCN continued the telehealth initiative, KidCare Anywhere, in 2019. This is a Children's Mercy Kansas City initiative and is addressed in more detail in the Population Health Management section of this document.

Future Initiatives

- PCN continues to evaluate the list of services that require prior authorization. Through this evaluation, on an annual basis, additional services may be identified as appropriate to either be added or removed from the requirements. PCN continues to monitor trends with services removed from prior authorization to identify potential over-utilization;
- Timely identification of at-risk members and evaluation of emergency room services for non-urgent/non-emergent needs will continue to be priorities for the PCN Care Teams;
- An online prior authorization tool will be piloted in 2020 to increase efficiencies in the process for providers and staff.

4 Transitional Care Program Evaluation

- Transitional Care Program Overview
- Program Measures
- Analysis

Transitional Care Program Evaluation

In an effort to facilitate a seamless transition from inpatient to home and community settings, the Care Teams deploy a transitional care program. This program involves making post-discharge phone calls to members and caregivers focused on assessing and screening for barriers to care following inpatient admission. Level 1 transitional care calls are made on inpatient discharges that meet the following criteria:

- Members with complex medical needs;
- Inpatient stays greater than 14 days;
- Readmission within 30 days with same or similar diagnosis;
- Members enrolled in case management; or
- The facility has requested assistance with discharge planning.

Exclusions to this list include observation stays, planned admissions (e.g. chemotherapy, EEG), obstetrics deliveries, and those with transitional care support provided by another primary insurance. A subsequent Level 2 transitional call is completed on members who meet the following criteria:

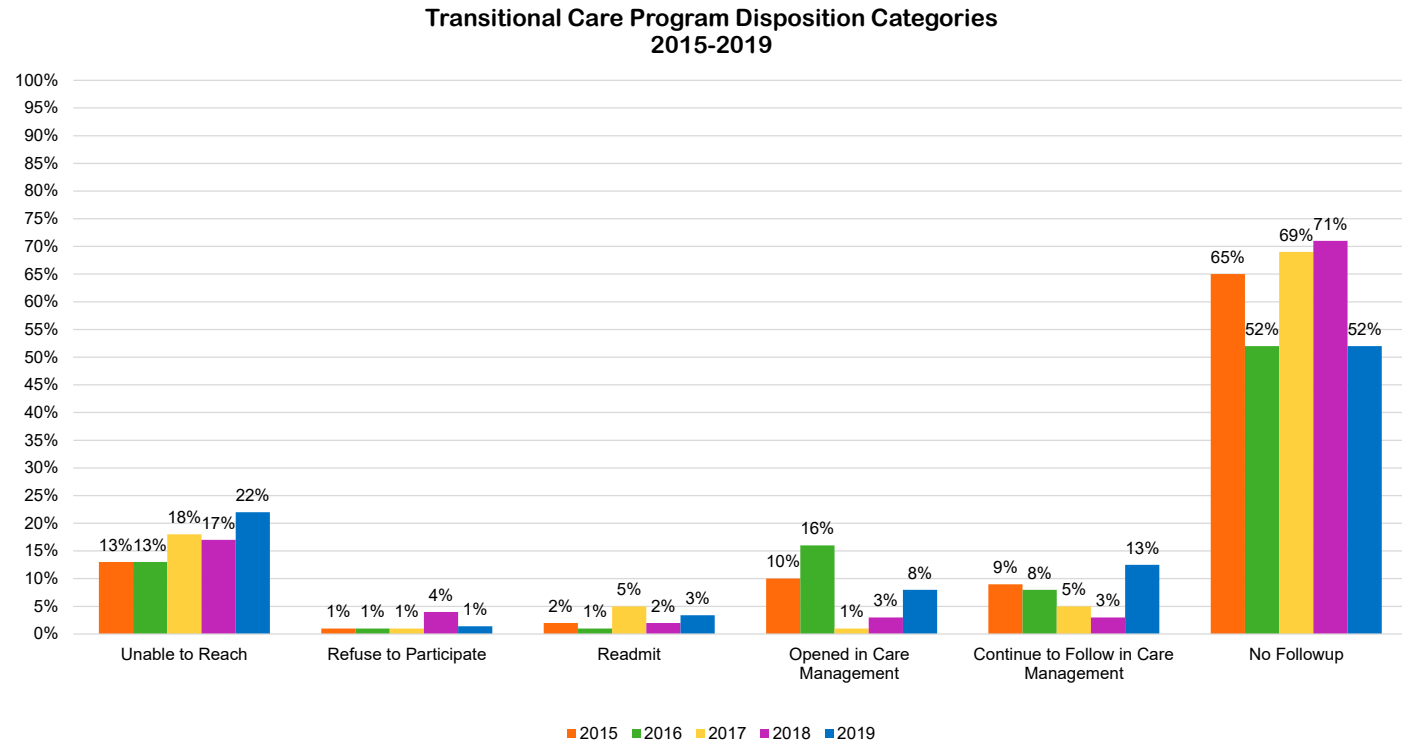
- Did not successfully complete a Level 1 call because the discharge plan was still in process;
- The member had new or worsening symptoms related to the inpatient stay;
- The member was discharged from the NICU; or
- The member answered “no” to two or more specific screening questions in the Level 1 call indicating further intervention needs.

Level 1 calls are conducted within 1-2 days of discharge notification. A minimum of three outreach attempts are completed. If a Level 2 call is needed, the second call is completed within 10-14 days from the date of the successful Level 1 call. If needs are

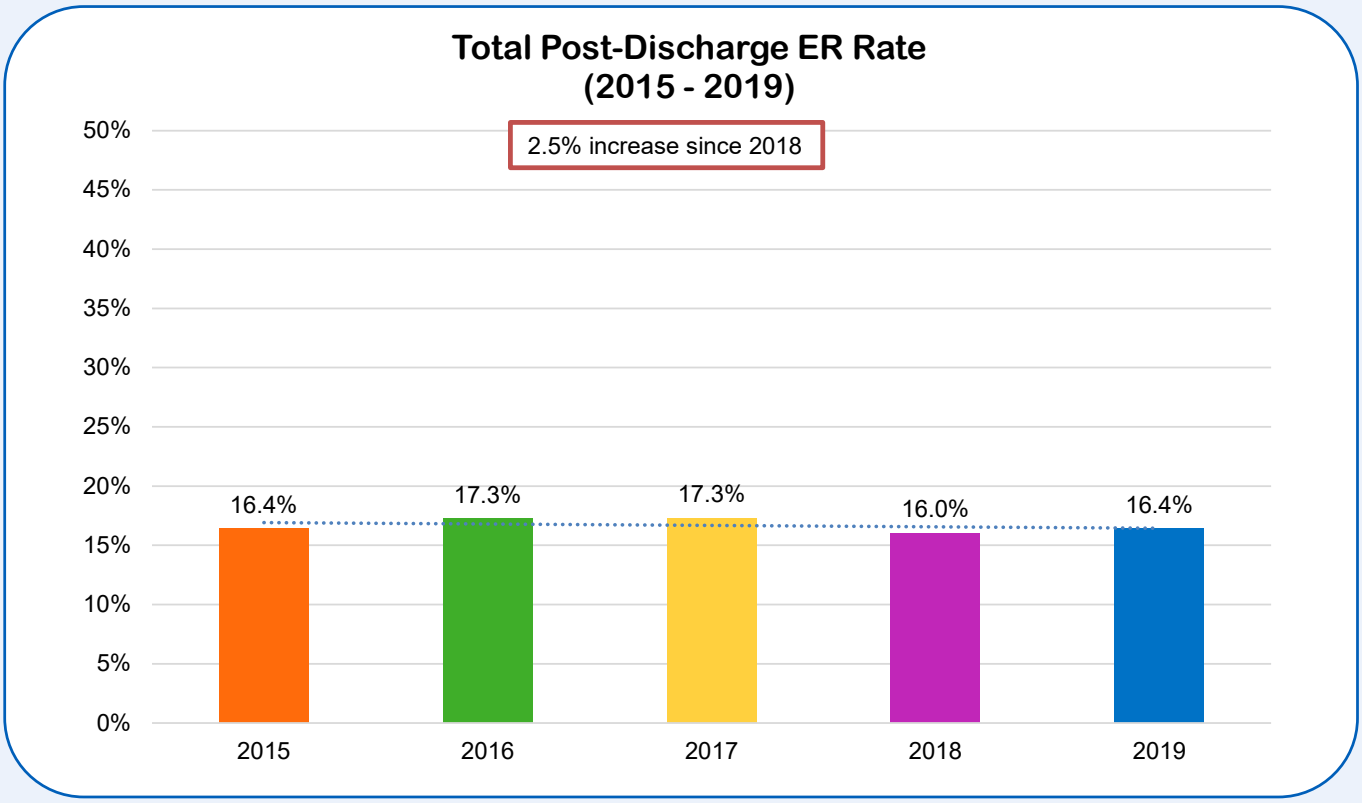
identified during one or both calls, the Care Team works in partnership with the member's PCP to address the member's immediate barriers to care including access to medications, home services, transportation, and appointment scheduling. A summary of the transitional call outcome is sent to the member's PCP to communicate the interventions provided to the member. Members with long term, ongoing needs for case management are referred to a Care Navigator for additional support.

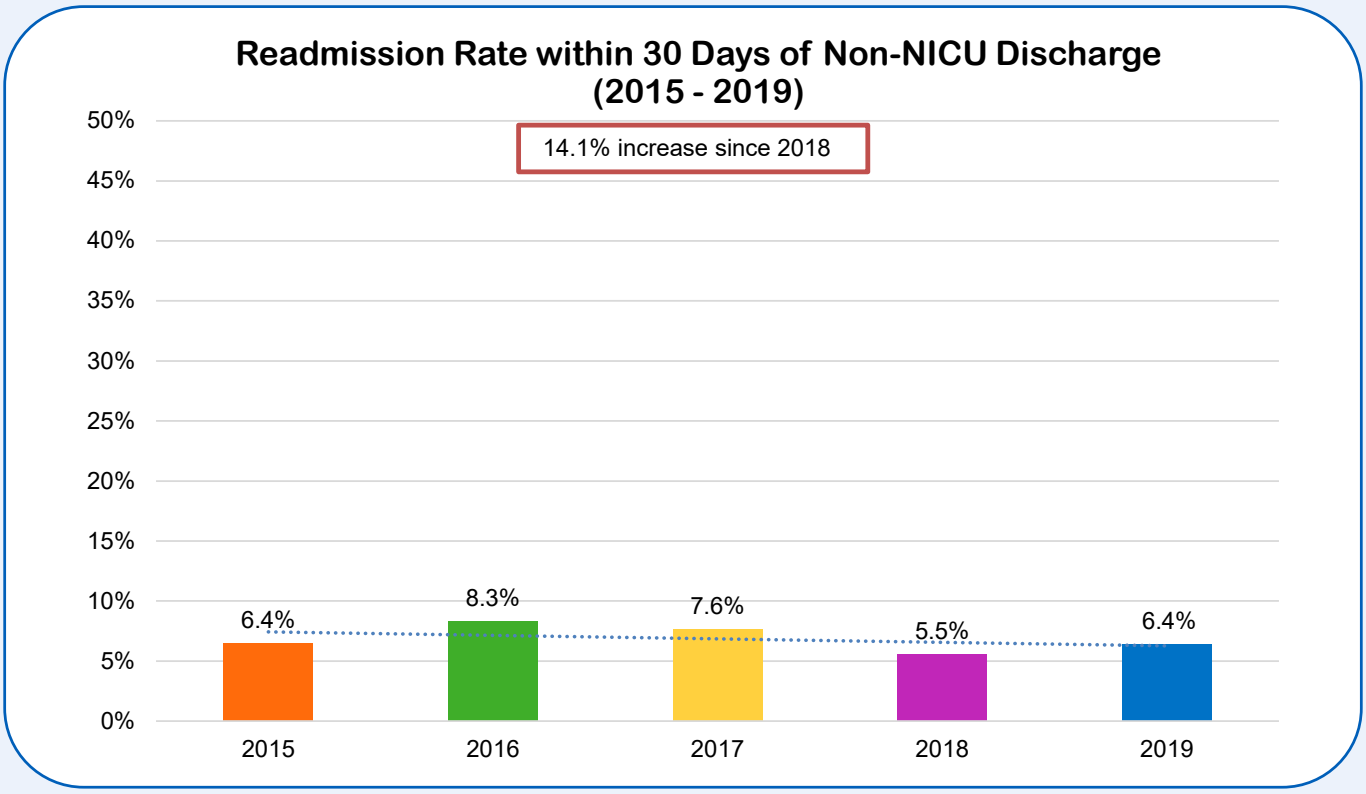
Program Measures

Care Navigators document transitional care program screenings in C.A.R.E. Web (PCN proprietary online documentation and communication tool), and statistics are reviewed monthly. Care Team staff monitor and track the number of calls attempted, the disposition of calls (e.g. opened in case management, no follow up needed, etc.), and the number of members who refused to participate in the program. In 2019, a total of 1,016 members were identified for the transitional care program. Of those members, 785 were successfully contacted. When comparing the past five years of results, there was a decrease in the disposition of no follow-up needed and a decrease in cases opened in case management. See chart below for disposition category results.

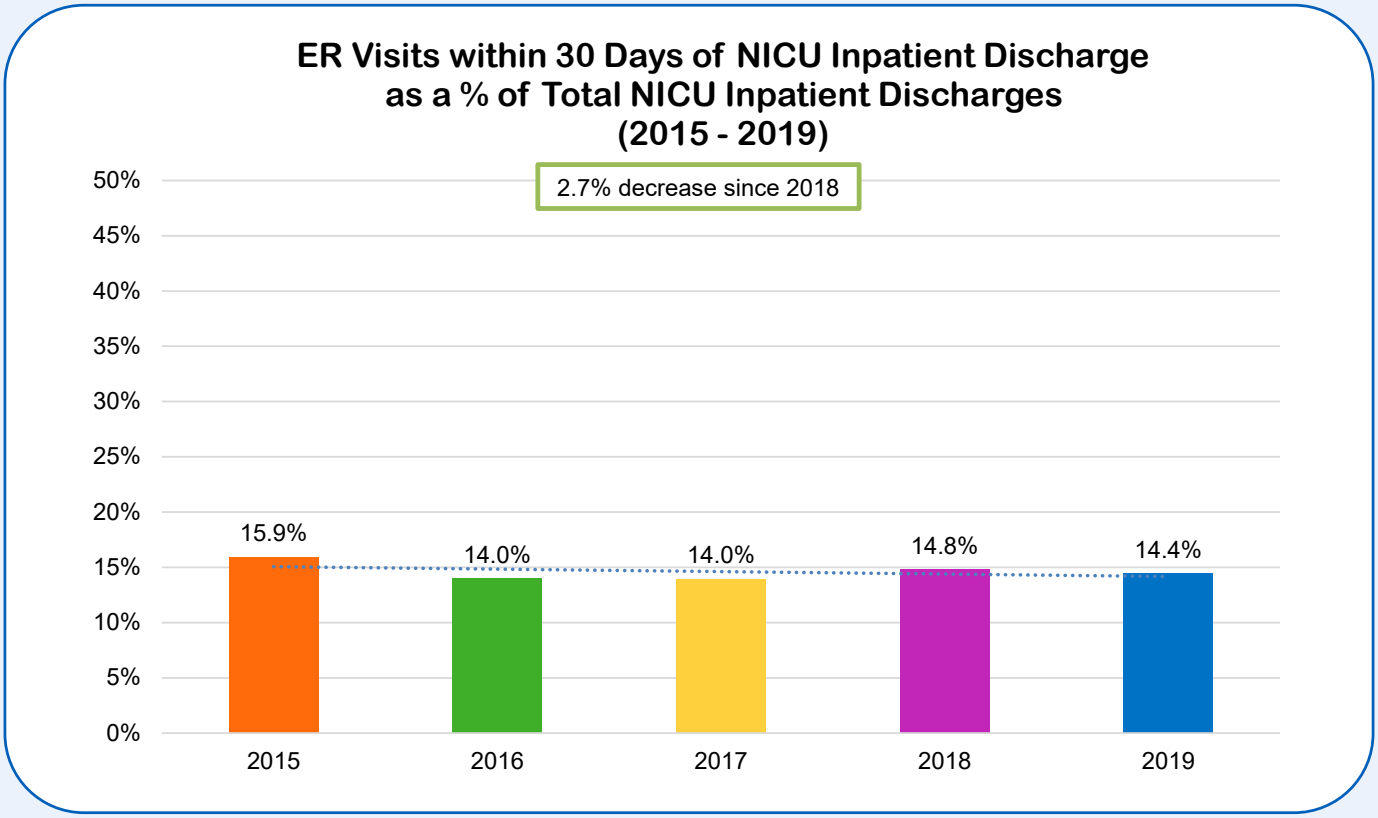


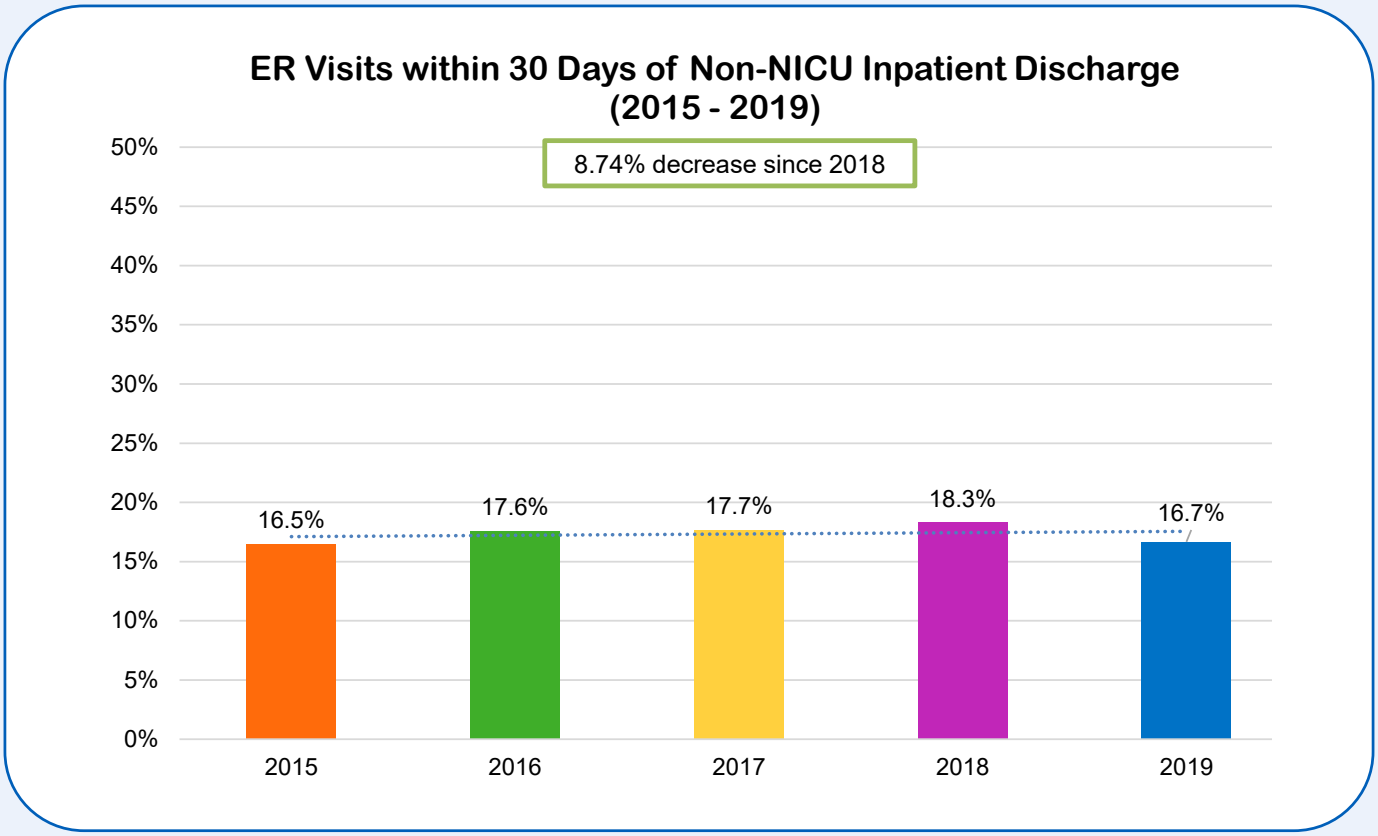
The overarching goal of the transitional care program is to decrease emergency room visits and unplanned hospital readmissions. Below is a five-year trend (2015-2019), based on claims data, of 30-day post-discharge ER visit rates and all-cause readmission rates for the PCN population.





The below charts further detail data for post-discharge ER visits by non-NICU and NICU discharges.





Post-NICU Home Care Support Program

In 2019, PCN continued a quality improvement initiative with interventions focused on reducing post-discharge ER visits for babies being discharged from the NICU. This initiative included a partnership with the Children's Mercy Home Care department in order to provide in-home nurse and social work assessments and interventions for members discharged from high volume NICU facilities. The initiative, which was implemented in August 2016, was designed to provide up to 6 weeks post-discharge support and education to caregivers in the home. Members with complex medical needs requiring skilled nursing services in the home were excluded from this program.

The program has successfully demonstrated an impact on the medical cost and utilization of care of the members who accepted the services. The program has served 183 NICU babies in 2019. The analysis of the program below compares the 183 members pre-enrollment into the NICU Home Care Support Program and post-enrollment. The analysis was favorable for the group with a 0.35% reduction in ER visits, 33% reduction in admissions, 38% reduction in hospital days, and 70% reduction in readmissions. To ensure this trend continues, PCN and Children's Mercy Home Care will continue to educate PCN members' caregivers on alternatives to utilizing the emergency room and encourage them to contact their primary care providers, utilize nurse advice lines, or visit trusted urgent care facilities.

NICU Cost & Utilization Statistics

Post-NICU Home Care Support Program Cost and Utilization Statistics n=183				
Babies Pre vs Post NICU Program	**ER Visits/ 1,000**	**Admissions/ 1,000**	**Days/ 1,000**	**Readmissions/ 1,000**
Pre-Enrollment Utilization (NICU Enrollment-12/31/2018)	1,995	477	1,995	217
Post-Enrollment Utilization (1/1/2019-12/31/2019)	1,988	318	1,246	66
% Difference	-0.35%	-33%	-38%	-70%

5 Case Management/ Disease Management Evaluation

- Case Management/Disease Management Program Overview
- Program Measures
- Analysis
- Future Initiatives

Case Management & Disease Management Program Overview

Case management and disease management are important components of the Care Integration program. The goals of both case management and disease management include helping members sustain or regain optimal health and reduce overall healthcare costs. The PCN achieves this through well-coordinated efforts between the Care Teams, members, caregivers, providers, and community agencies. Including the primary care providers in case management activities assures continuity of care and alignment for improving health outcomes.

The Care Integration Care Teams work closely with the member's PCP, specialists, and other healthcare providers involved in their care to assess the member's medical, social, and behavioral needs; determine available benefits and resources; and develop and implement specific interventions to achieve optimal outcomes for members. Care Teams are responsible for executing all Care Integration programs for the assigned population including but not limited to case management, disease management, and utilization management.

The program objectives are as follows:

- Assist members in sustaining or achieving an optimal level of wellness and function by facilitating timely and appropriate health care services;
- Promote strong member/PCP relationships for coordination and continuity of care, using PCMH concepts;
- Reduce inappropriate inpatient hospitalizations and utilization of emergency room services;
- Promote clinical care that is consistent with scientific evidence and member preferences;
- Ensure the integration of medical and behavioral health services;
- Educate members in self-advocacy and self-management;
- Minimize gaps in care and encourage use of preventive health services;
- Achieve cost efficiency in the provision of health services while maximizing health care quality;
- Mobilize community resources to meet needs for members.

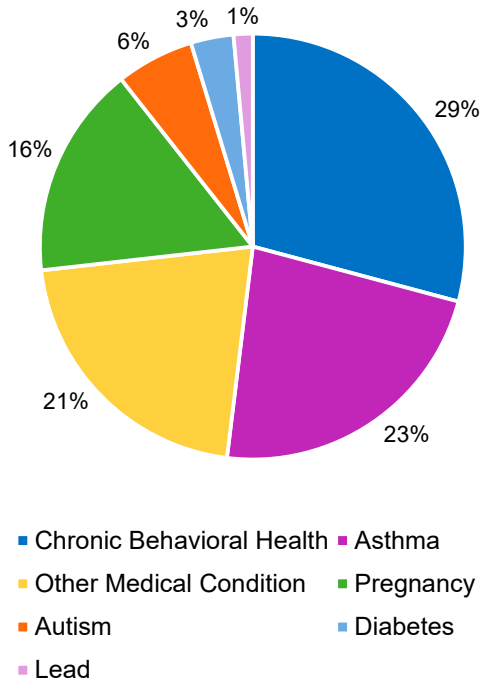
The PCN regularly reviews the processes for identifying members, determining interventions, documenting interventions, and the measurement of outcomes. The PCN case management documentation system, or C.A.R.E. Web, incorporates case management screenings, assessments, care plans, routing of cases, and the ability to have tasks assigned to multiple Care Team members. Within C.A.R.E. Web, Care Teams have the ability to filter the assigned population and prioritize member outreach. Assigned populations can be organized by chronic condition, high utilization, risk score, or gaps in care. From there, the Care Team can determine a strategy for member outreach and screening.

The Care Integration Manager oversees the quarterly audit process of Care Team staff to ensure compliance with documentation and assessment standards. Current audit standards require that staff meet or exceed an accuracy level of 95% after the first year of employment. In 2019, PCN continued a peer audit process as part of the quarterly review process to provide additional learning opportunities for staff. PCN staff submit completed peer audits to the Care Integration Manager for leadership level accuracy review. Leadership conducts a quarterly meeting with staff to review aggregate audit results, provide education to staff on themes identified during the audit process, and discuss opportunities for enhancements to the documentation system or processes. PCN implemented action plans for those who did not meet the standards and all who had action plans were able to resolve the issues in a subsequent audit. In addition, the PCN Medical Director and Care Integration Manager conduct routine case rounds with the case management staff to review current status of cases, discuss barriers to care, explore intervention opportunities, and identify goals for complex cases. This forum provides an ongoing process for Care Navigators to learn from others and promotes consistency in applying case management principles.

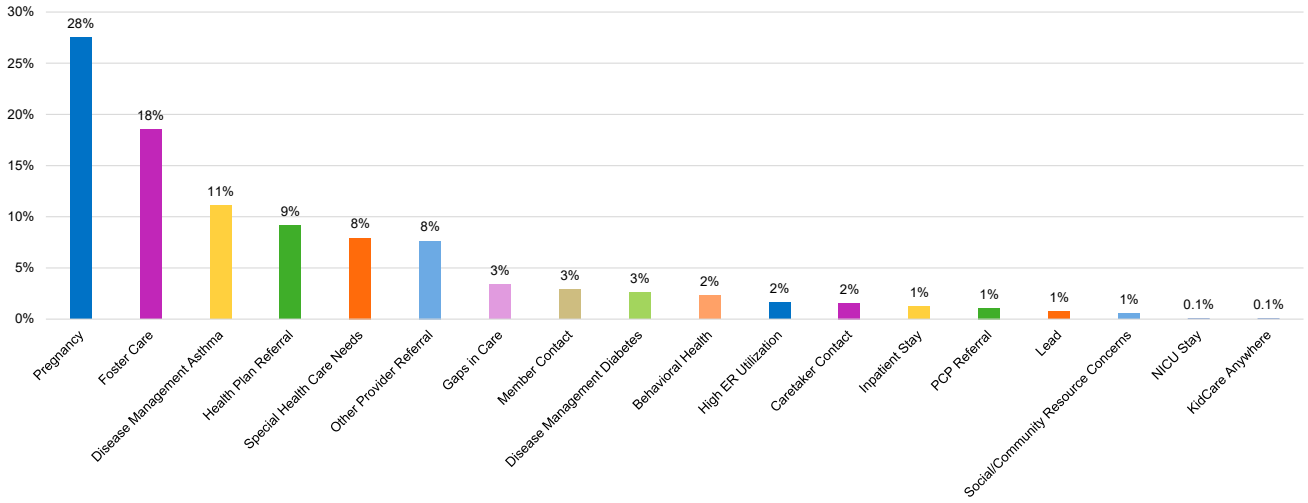
Program Measures: Case Management Statistics

In 2019, 3,334 unique members were identified for case management services, compared to 3,572 in 2018. Of the patients identified for case management services, 29% had chronic behavioral health concerns, 23% were identified as having asthma, 21% had other medical conditions, 16% were identified as pregnant, 6% had autism, 3% had diabetes, and 1% were due to elevated lead levels.

Case Management Outreach Types



Case Management Referral Reasons-2019 n=4,271

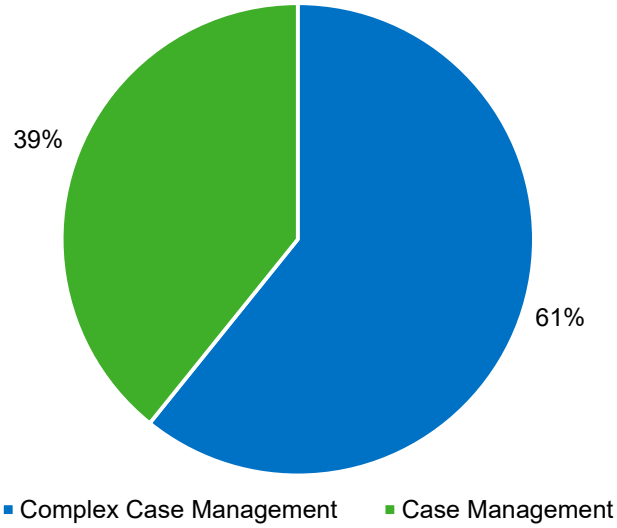


* Note: To best capture, the Care Team members can choose more than one referral reason for each unique member screened. Because of this, the number of referral reasons increased by 300% from 2018 to 2019 (1,419 in 2018; 4,271 in 2019).

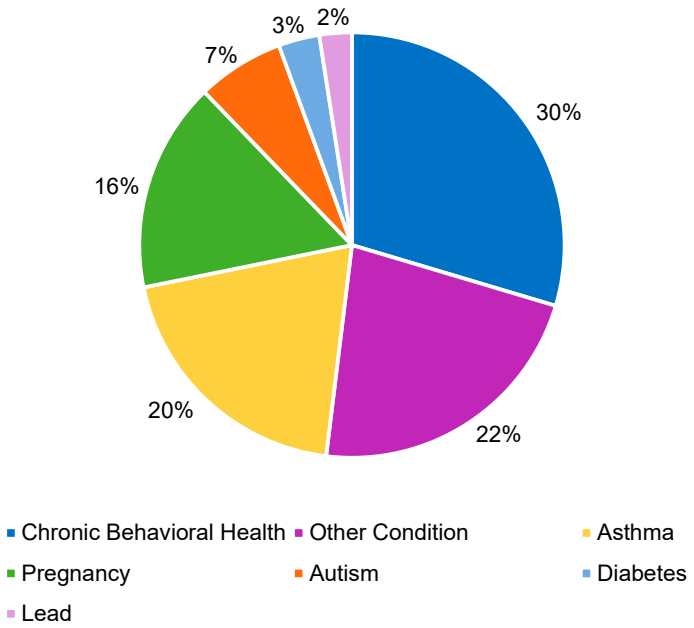
Case Management Case Levels

Case types are determined based on the member's screening, assessment, and care plan development. This establishes the level of complexity and interventions. In 2019, 39% of the program referrals required case management and 61% of the referrals were deemed complex case management. The chart below reflects the common conditions in complex case management (cases open for ≥ 60 days): Chronic Behavioral Health (30%), Other Medical Conditions (22%), Asthma (20%), Pregnancy (16%), Autism (7%), Diabetes (3%), and elevated lead levels (2%).

Case Levels-2019

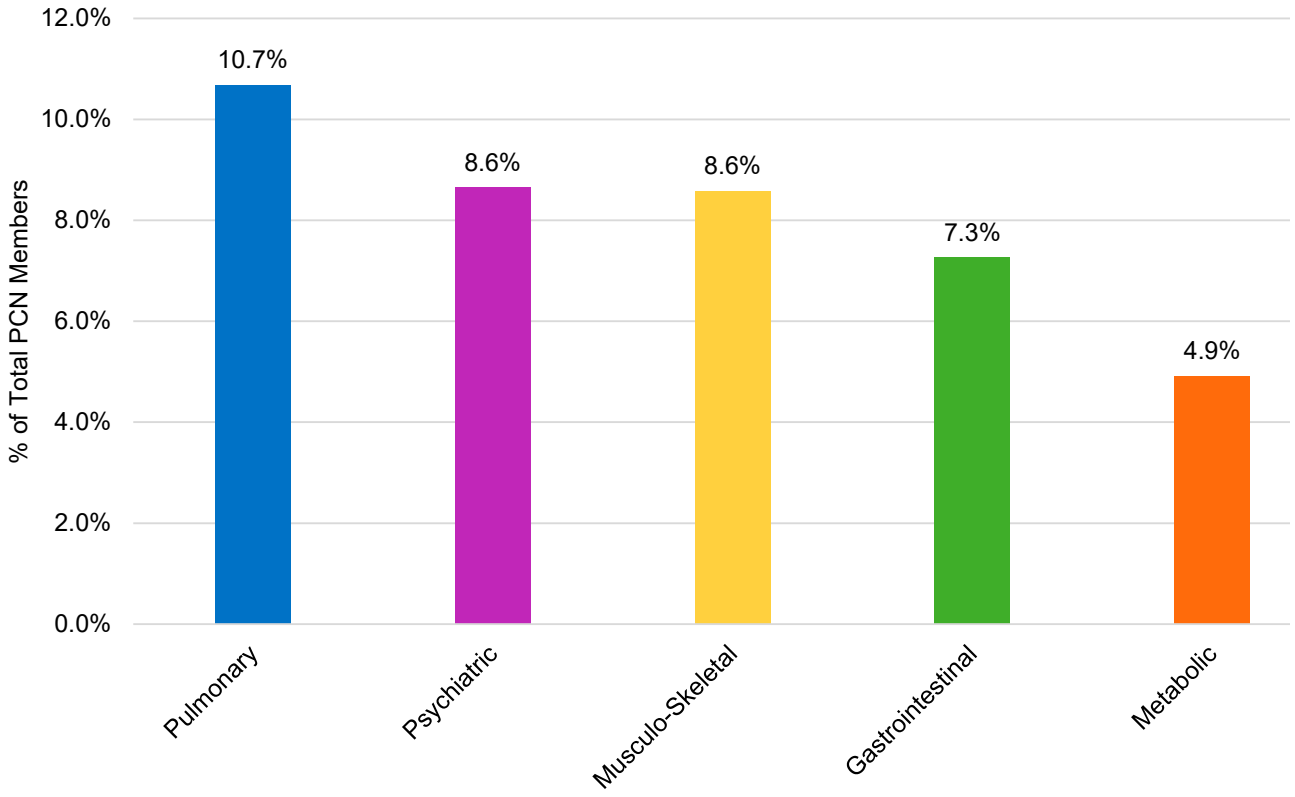


Complex Case Management Cases



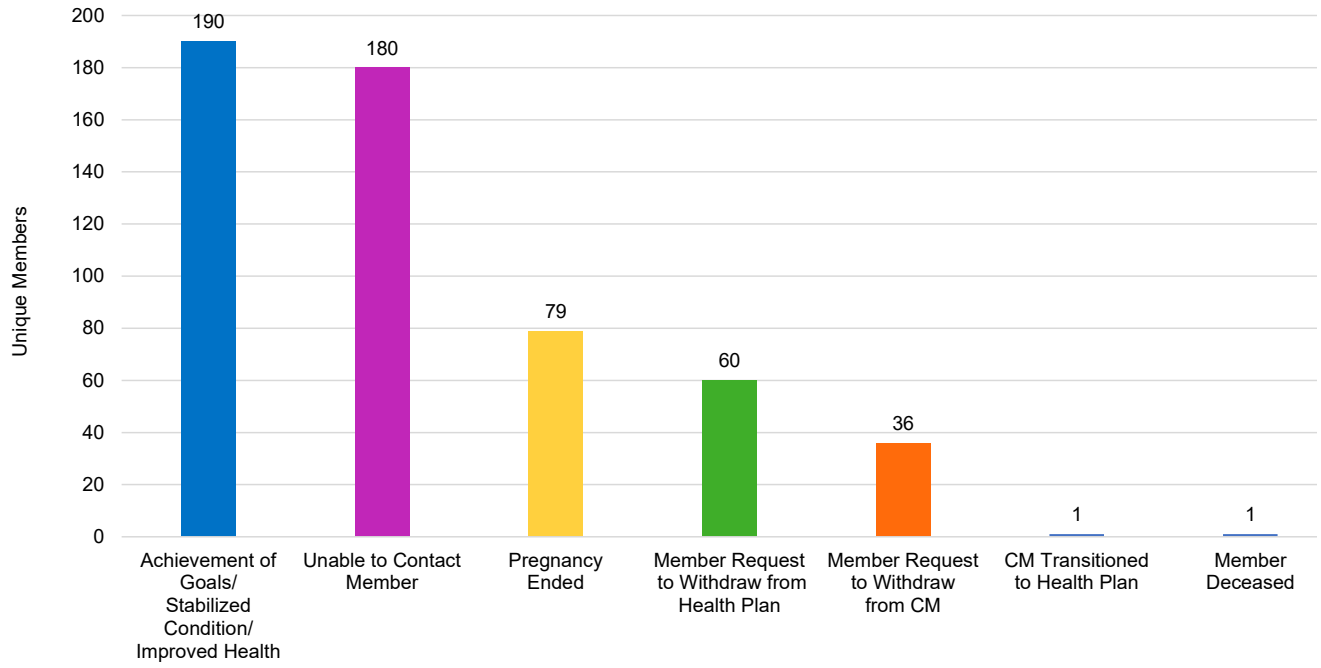
Case Management Top 5 Conditions

In addition to referral sources, the case management assessment helps to identify the chronic conditions for each screened member. For 2019, claims indicate that the top five chronic condition categories for members receiving case management services are: Pulmonary, Psychiatric, Musculo-Skeletal, Gastrointestinal, and Metabolic. Members could be categorized in more than one chronic condition category.



Case Management Case Closure Reasons

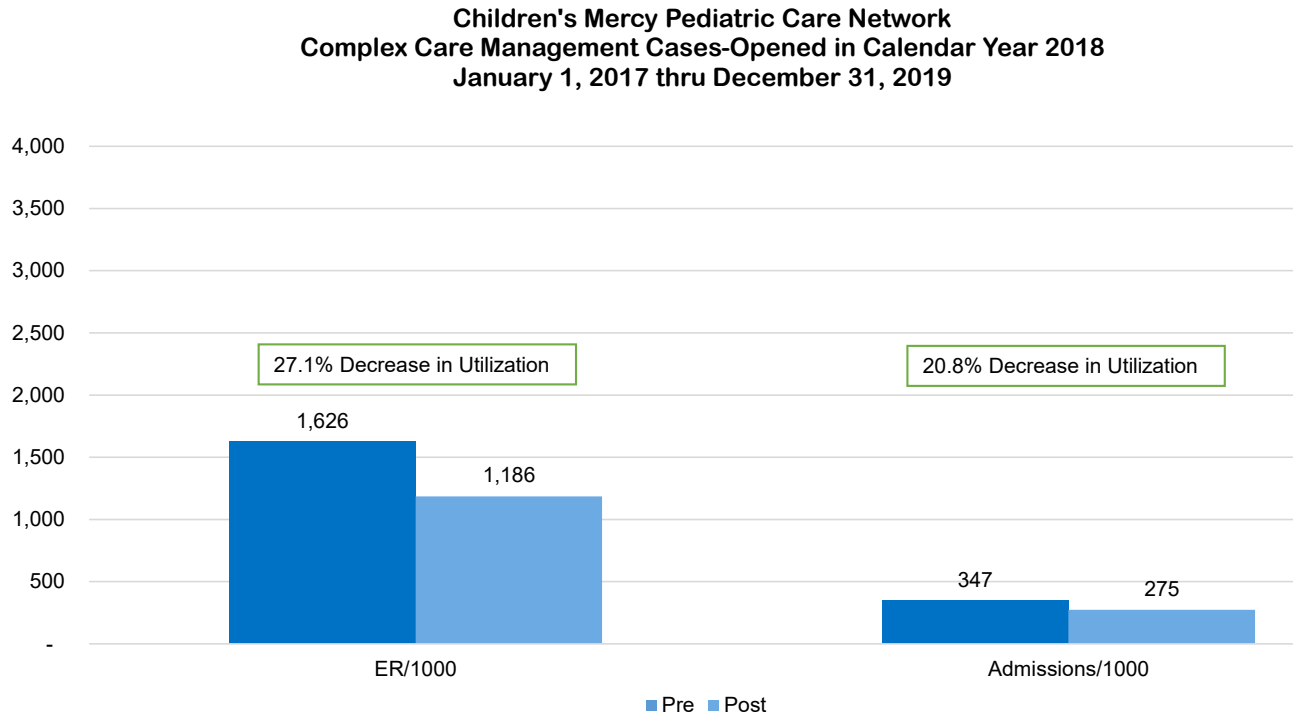
At the completion of case management services, the Care Navigator assigns a primary reason for the case closure. The PCN team strives to continuously improve the rate of cases closed due to goals met and decrease the rate of cases closed due to lack of member engagement. The primary reasons for case closure in 2019 were Achievement of Goals/ Stabilized Condition/Improved Health (190 members), Unable to Contact Member (180 members), Pregnancy Ended (79 members), Member Request to Withdraw from Health Plan (60 members), Member Request to Withdraw from Case Management (36 members), Case Management Transitioned to Health Plan (1 member), and Member Deceased (1 member).



Program Utilization: Cost for Case Managed Population

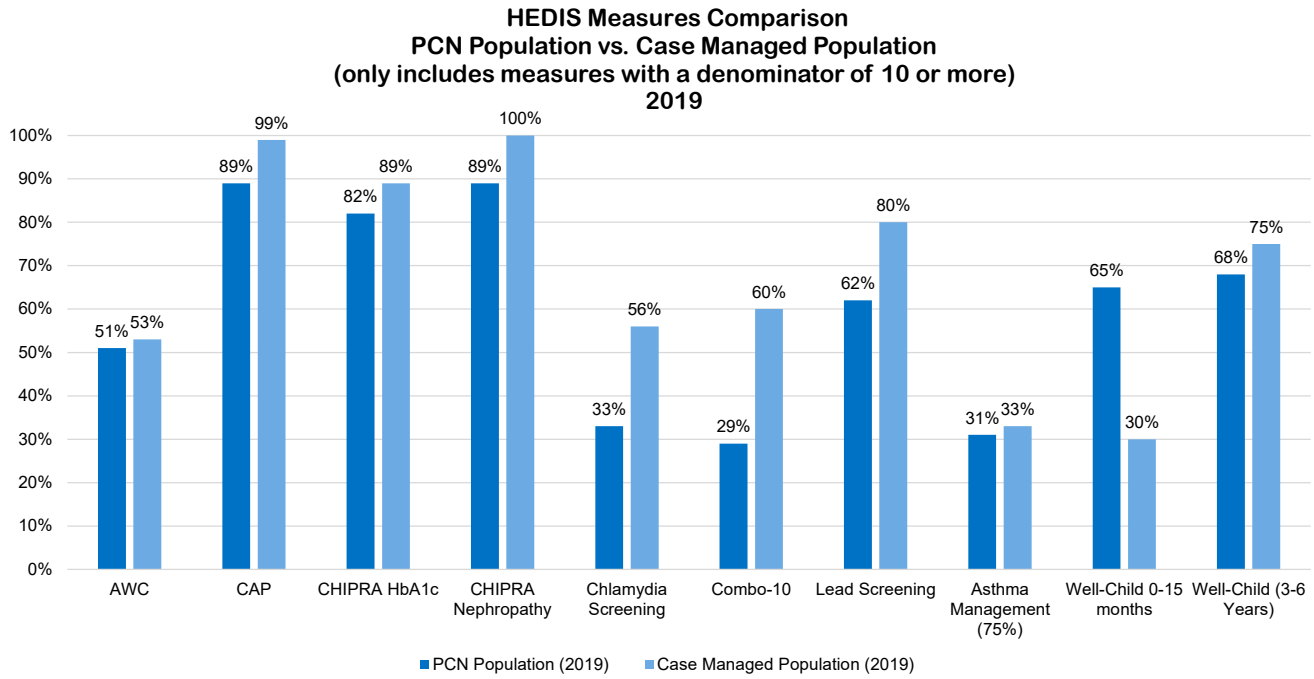
The PCN evaluates the rate of hospitalizations and ER visits as well as per member per month costs for members enrolled in case management. The evaluation below includes members opened at least sixty (60) days in case management and includes all available pre-intervention and post-intervention data for each member, normalizing it to a per member per month rate. The intervention date is considered the date a member was opened in the case management program. Note: Due to the need for sufficient post-intervention data for this analysis, the cases included in this report were opened in 2018. Because this analysis evaluates cost and utilization pre and post-enrollment for members, the measurement period is January 2017 to December 2019.

Complex Cases Opened in 2018	Pre Case Date	Post Case Date
Members	1,375	
% Change Pre vs. Post		
Admissions/1000	-20.8%	
ER Visits/1000	-27.1%	
Total Medical PMPM	-1.7%	



Program Quality Outcomes (HEDIS Measures)

The PCN evaluates pediatric-focused HEDIS measures using claims/administrative data to compare its case managed population outcomes to the entire PCN population. For this year's analysis, ten HEDIS measures were reviewed and are displayed in the chart below. These measures focus on Adolescent Well Care Visits (AWC), Access to Care (CAP), CHIPRA Measures for Diabetes, Chlamydia Screenings, Age 2 Immunizations (Combo 10 – including flu vaccine), Lead Screenings, Asthma Medication Management (75% Compliance), Well Child Visits for Children Ages 0-15 Months (at least 6 total visits), and Well Child Visits for Children 3-6 Years of Age.



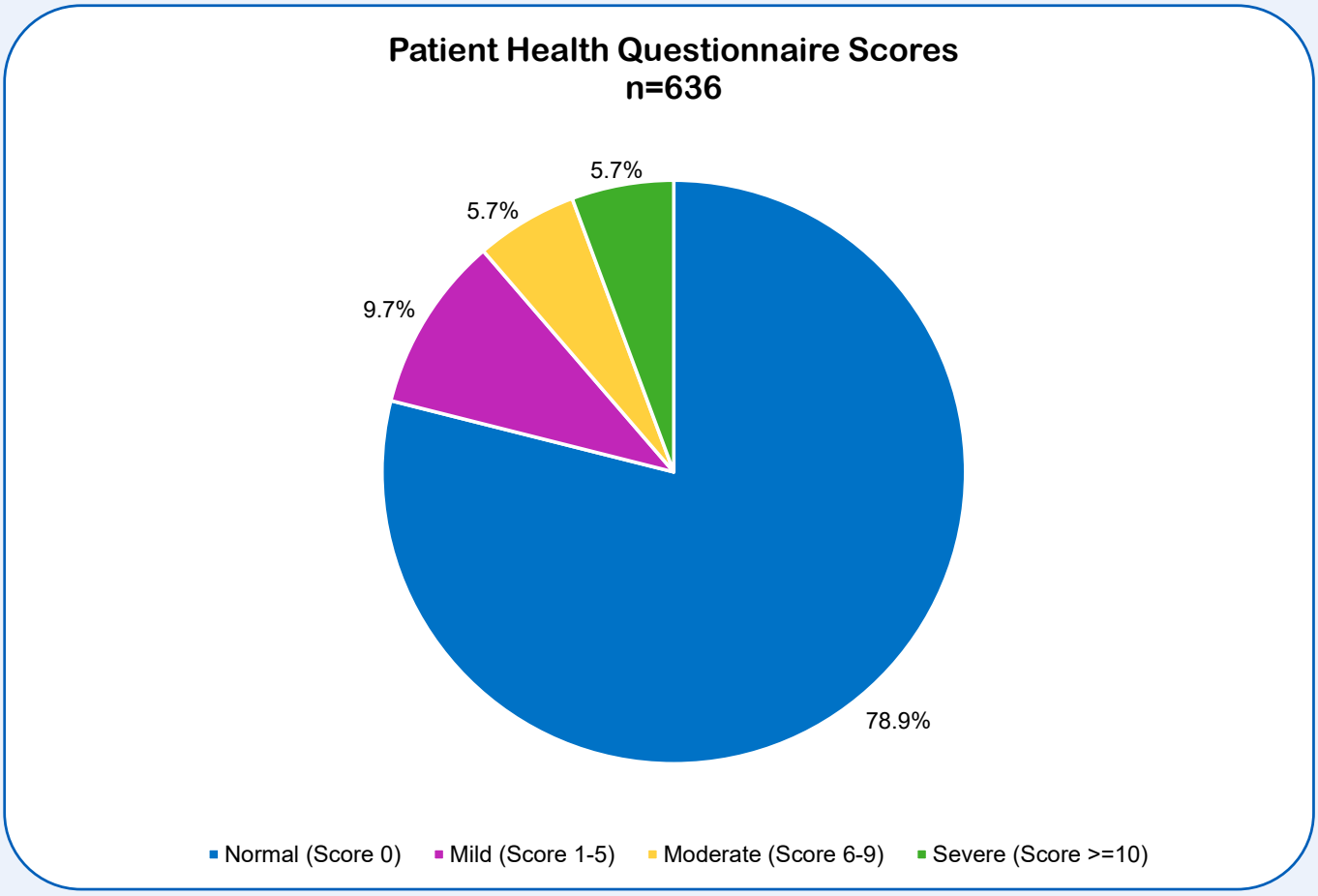
Patient Health Questionnaire 9 Screening

The Patient Health Questionnaire (PHQ-9) is a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression. PCN utilizes this tool for the screening of depression on every outreached member ≥ 12 years old. If the member responds "yes" to either of the first two questions (PHQ-2) on the questionnaire, the Care Navigator is prompted to proceed with the remaining seven questions on the PHQ-9 screening.

The Care Navigator's interventions are dependent upon the severity of the depression score. Questions 1 through 8 of the survey evaluate a patient's state of mind with regard to depressive symptoms. Question 9 demonstrates the presence and potential duration of suicidal ideation of the patient. Question 10 then provides a non-scored result which rates the severity index of the problems.

Interventions may include education with the member/caregiver on the available behavioral health benefit, referral for behavioral health services, and/or reporting the screening outcome to the member's PCP for ongoing monitoring. The Care Navigator develops goals and self-management plan activities to monitor the member's progress in this area. The Care Navigator can also re-assess the member using the PHQ-9. The member is evaluated at next contact if they show signs of severe depression, in three months for moderate depression, and in six months for mild depression.

The PHQ-9 is a useful tool that the Care Navigators use to screen members quickly while they discuss their care plans via phone calls. Additionally, C.A.R.E. Web auto-scores the PHQ-9 while advising the Care Navigator of appropriate next steps.



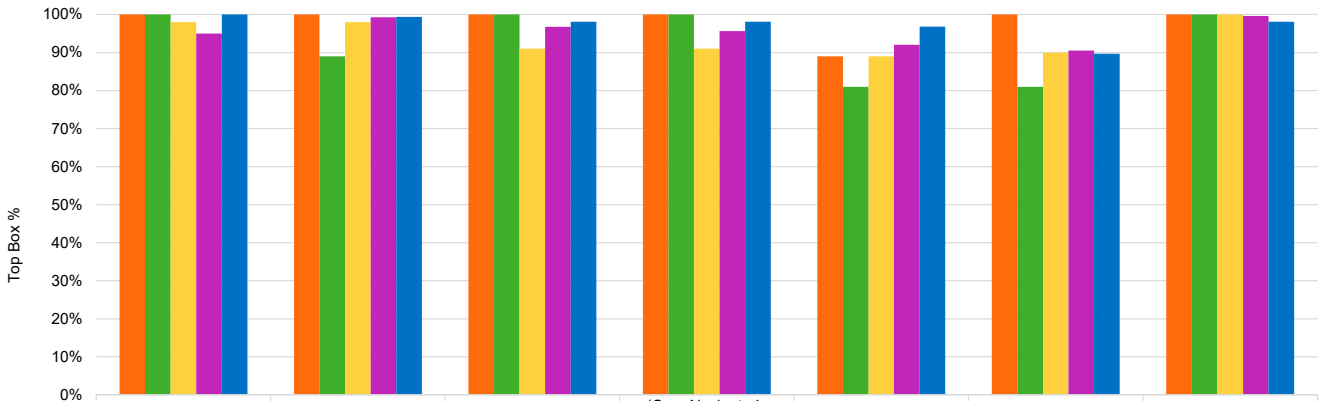
Member/Caregiver Experience with Case Management

The PCN conducts member satisfaction surveys with members and their caregivers who receive case management services from a Care Navigator. This telephonic survey includes seven (7) questions with an open-ended opportunity for member comments at the end of the survey. The 2019 survey results compared to the 2015-2018 survey results are displayed below.

Case Management Patient Experience Survey Results 2015-2019

Survey Volume

2015	2016	2017	2018	2019
41	22	62	276	155



	(Care Navigator's name) was courteous and respectful.	(Care Navigator's name) understood my needs.	(Care Navigator's name) respected my cultural background and/or lifestyle.	(Care Navigator's name) provided education to me about services or resources available to me in the community.	(Care Navigator's name) provided useful health education to me.	After speaking with (Care Navigator's name), I'm better able to take care of myself or my child.	Overall, I am satisfied with the services (Care Navigator's name) provided.
2015	100%	100%	100%	100%	89%	100%	100%
2016	100%	89%	100%	100%	81%	81%	100%
2017	98%	98%	91%	91%	89%	90%	100%
2018	95%	99%	97%	96%	92%	91%	100%
2019	100%	99%	98%	98%	97%	90%	98%

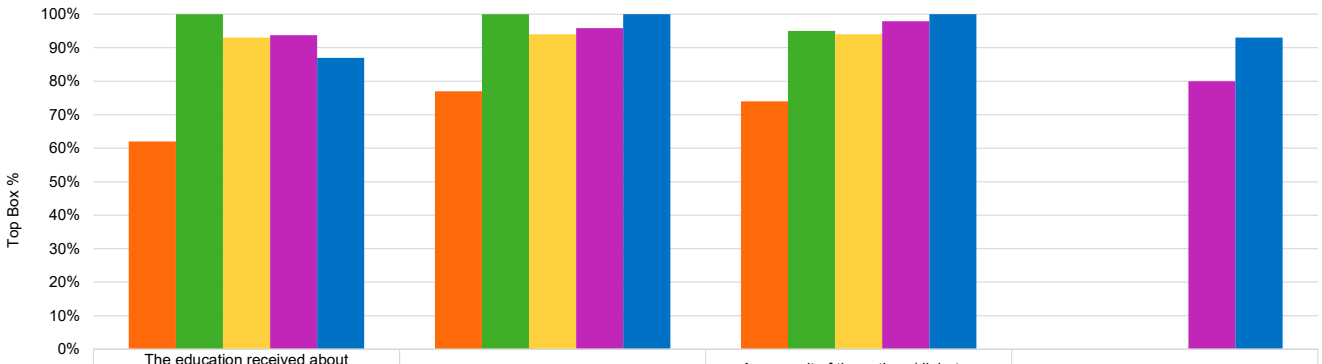
Member/Caregiver Experience with Disease Management

The disease management survey measures the member's satisfaction with PCN staff, primary care providers/specialists, and health literature provided through the program. The survey was conducted for the fifth time in 2019; the 2015-2019 survey results are compared and displayed below.

Disease Management Survey Results 2015-2019

Survey Volume

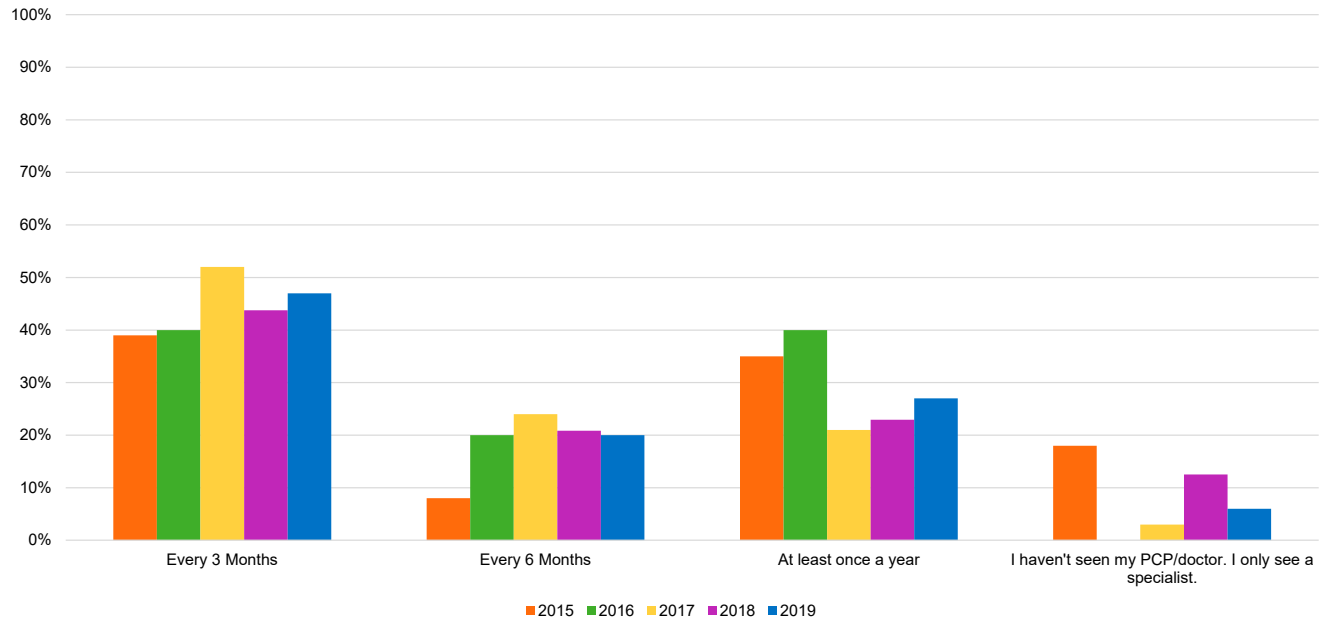
2015	2016	2017	2018	2019
37	20	33	48	15



	The education received about asthma/diabetes management was useful to me and/or my family. (This may include website, mailings, newsletters, member handbook.)	(Care Navigator's name) respected my cultural background and/or lifestyle.	As a result of the asthma/diabetes information from my primary care provider or specialist, I am better able to take care of myself/my child.	I am satisfied with the prior authorization process.*
2015	62%	77%	74%	0%
2016	100%	100%	95%	0%
2017	93%	94%	94%	0%
2018	94%	96%	98%	80%
2019	87%	100%	100%	93%

*Note: Question added to survey in 2018.

How Often Do You See Your Primary Care Provider for Your Asthma/Diabetes?



Member Complaints and Grievances

PCN is not delegated to perform complaint, grievance, or appeal processes but is notified by the health plans if a member issues a complaint or grievance related to PCN programs. In 2019, there were no grievances received related to PCN's case management and disease management programs.

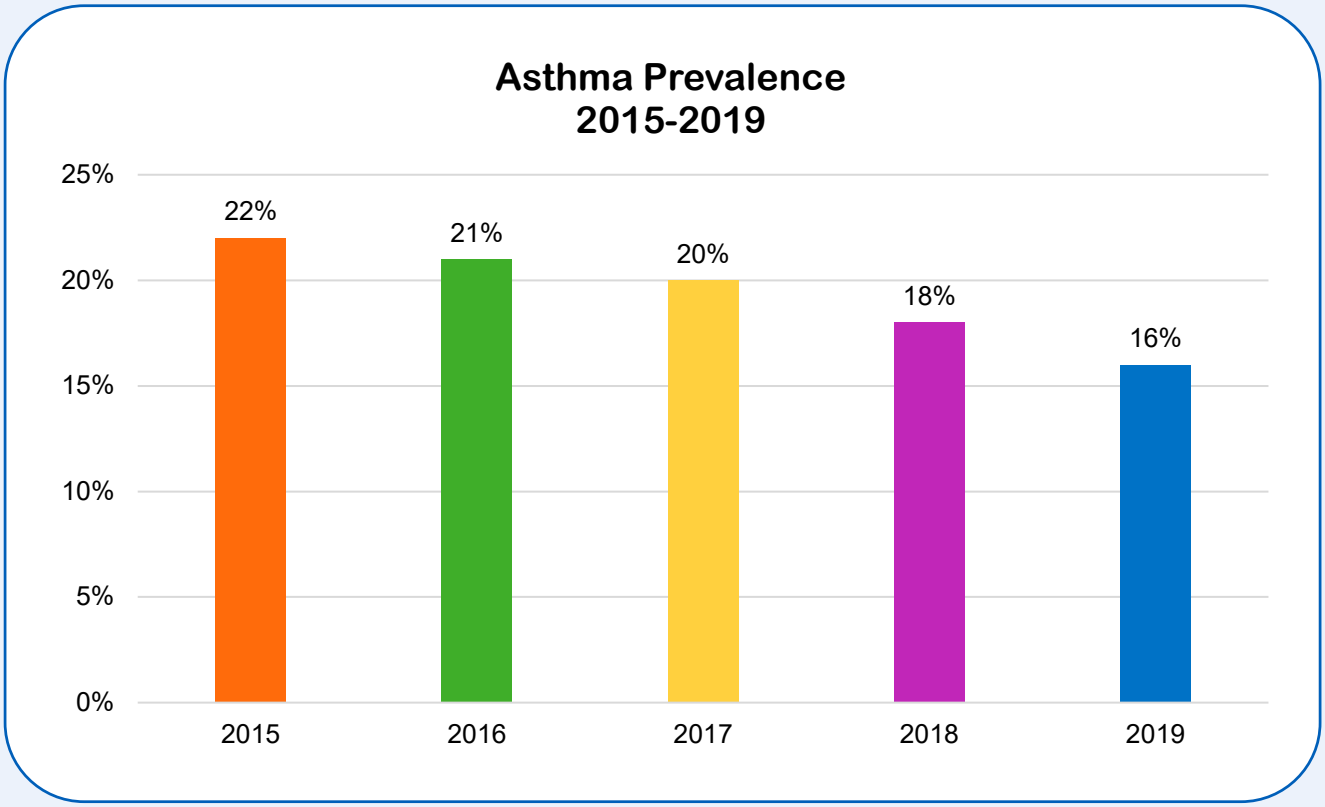
Disease Management Outcomes for Asthma & Diabetes

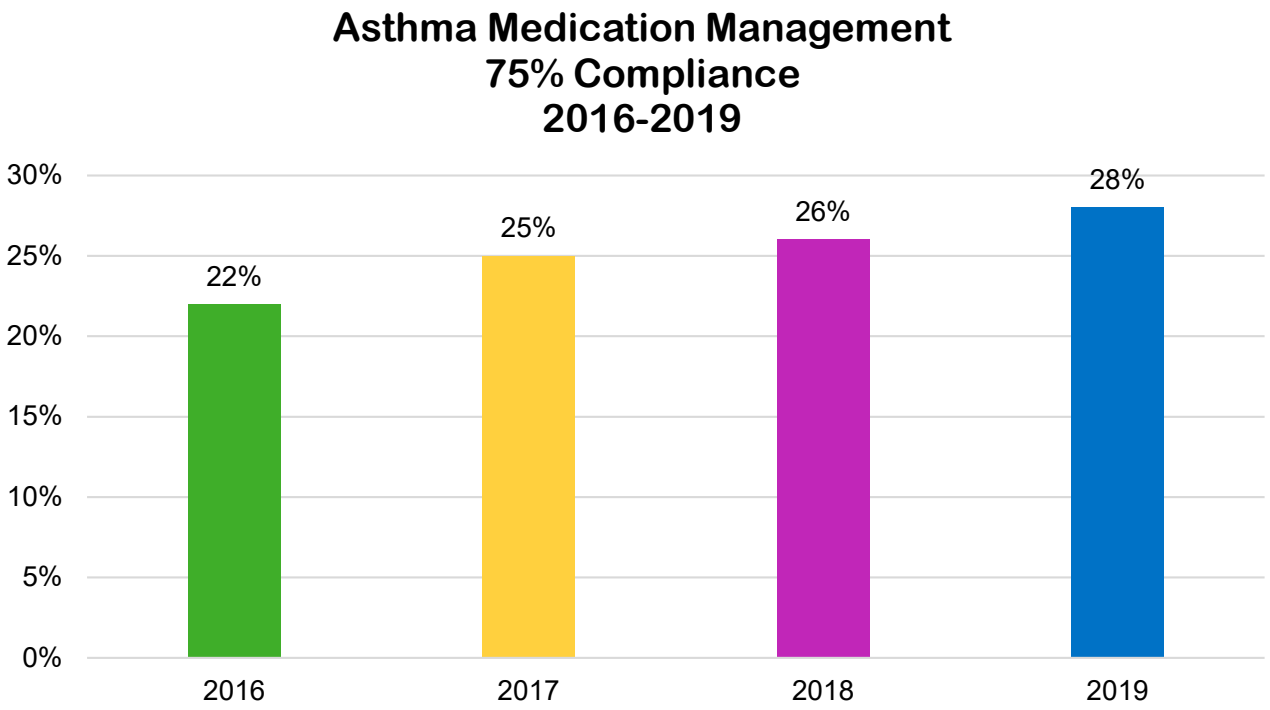
PCN's disease management programs use a unique approach to manage chronic asthma and diabetes through collaborative efforts between the primary care providers and the Care Teams. The Care Teams are comprised of Practice Facilitation Specialists who work with primary care provider offices to implement comprehensive disease management concepts into their practices. Care Navigators on the Care Teams work with the moderate and high-risk members identified on the disease management registries. Success of the program requires ongoing collaboration between the Care Team, PCP, member, and caregivers.

The program consists of physician office education, Patient-Centered Medical Home support, quality improvement techniques, data analytics and reporting, and focused case management interventions, with the goal of improving the health of the population and reducing cost.

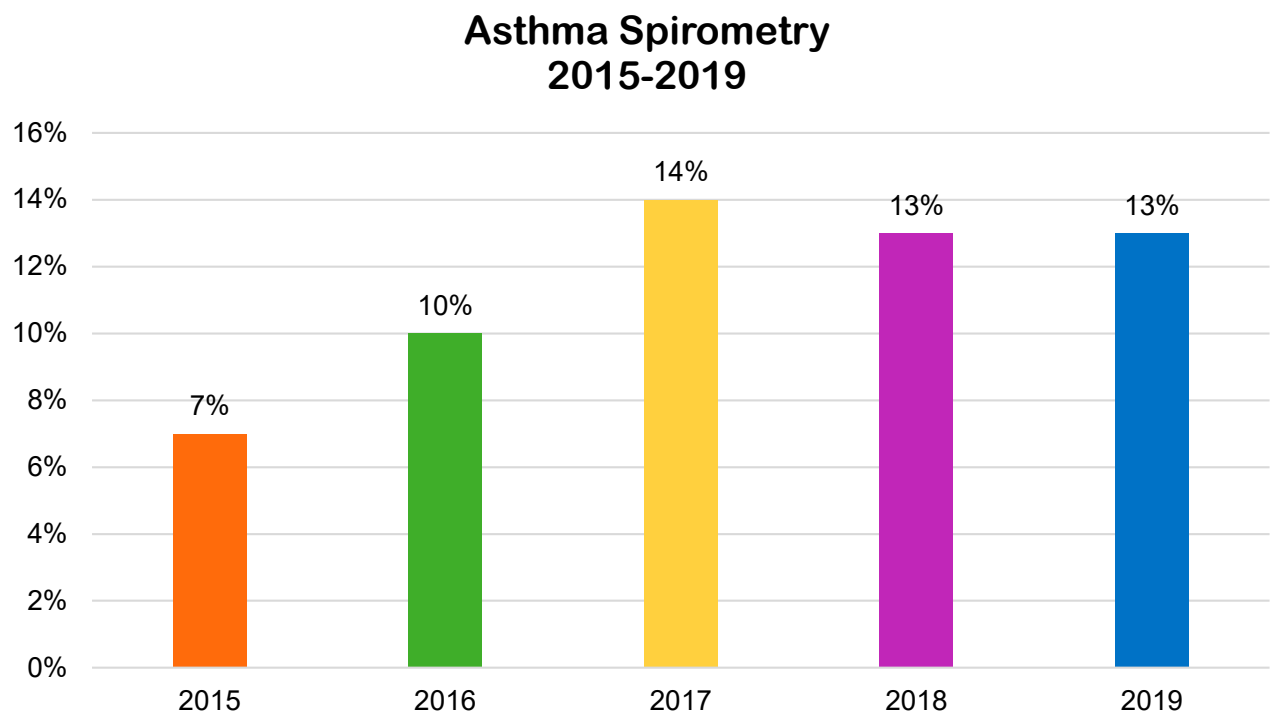
Care Navigators received education on asthma and diabetes management and tools were built into the C.A.R.E. Web documentation system to allow for effective management of this population. The Care Navigator audit tool includes disease management components, holding staff accountable to disease management program requirements.

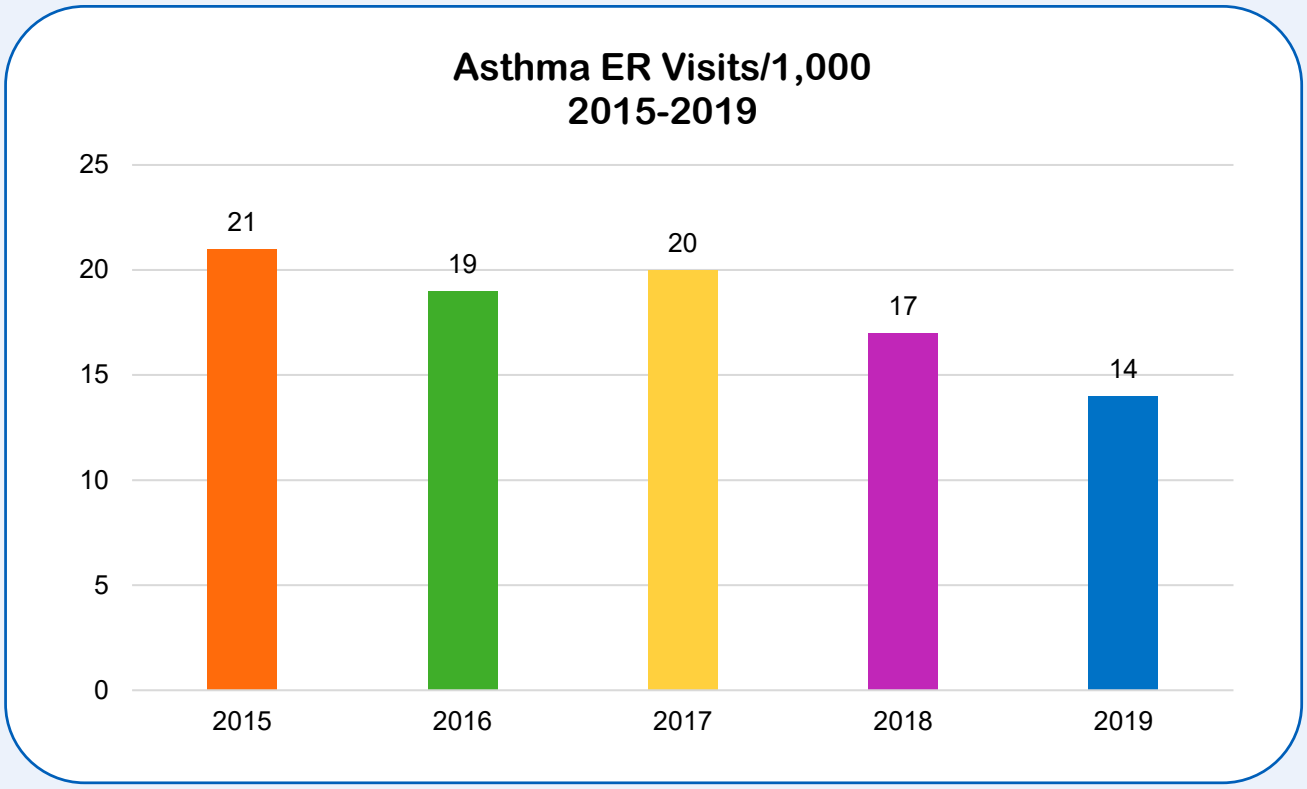
Asthma

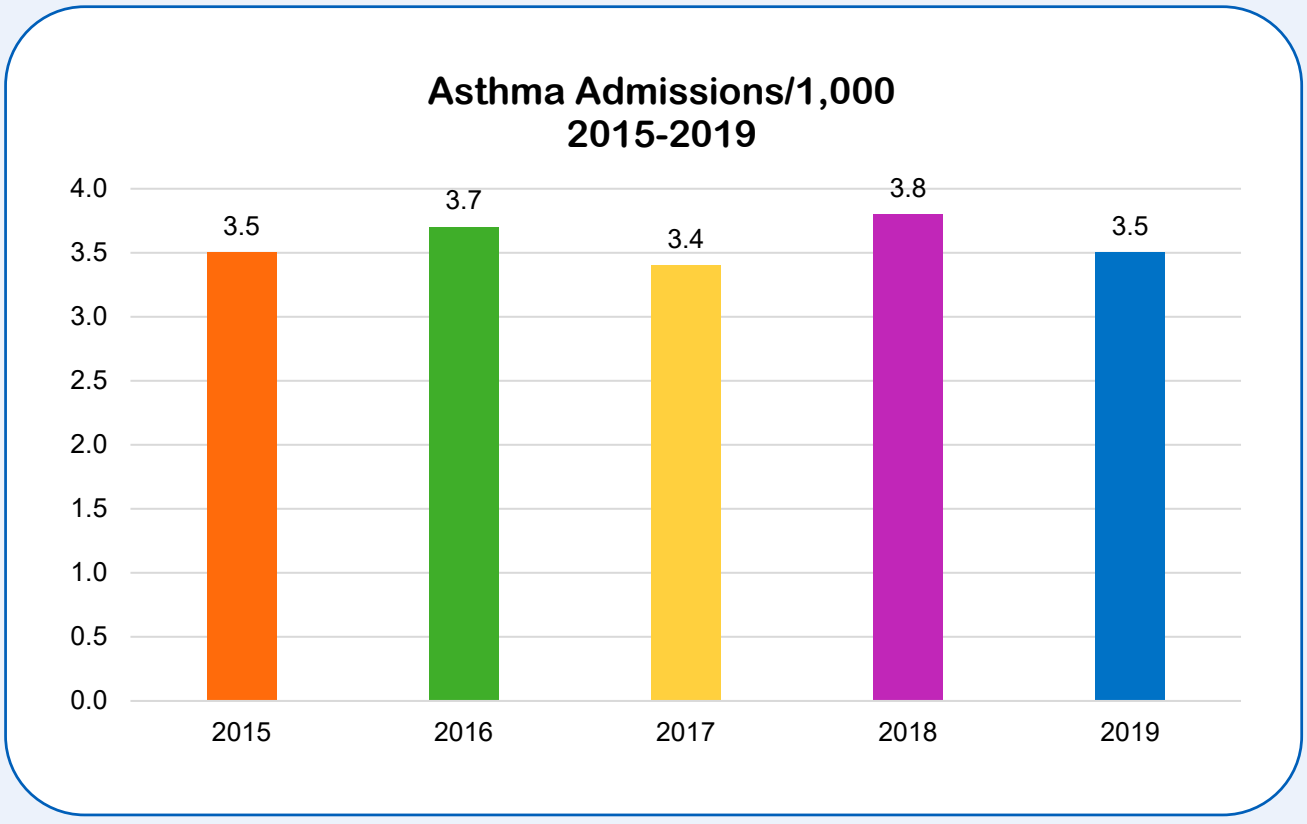




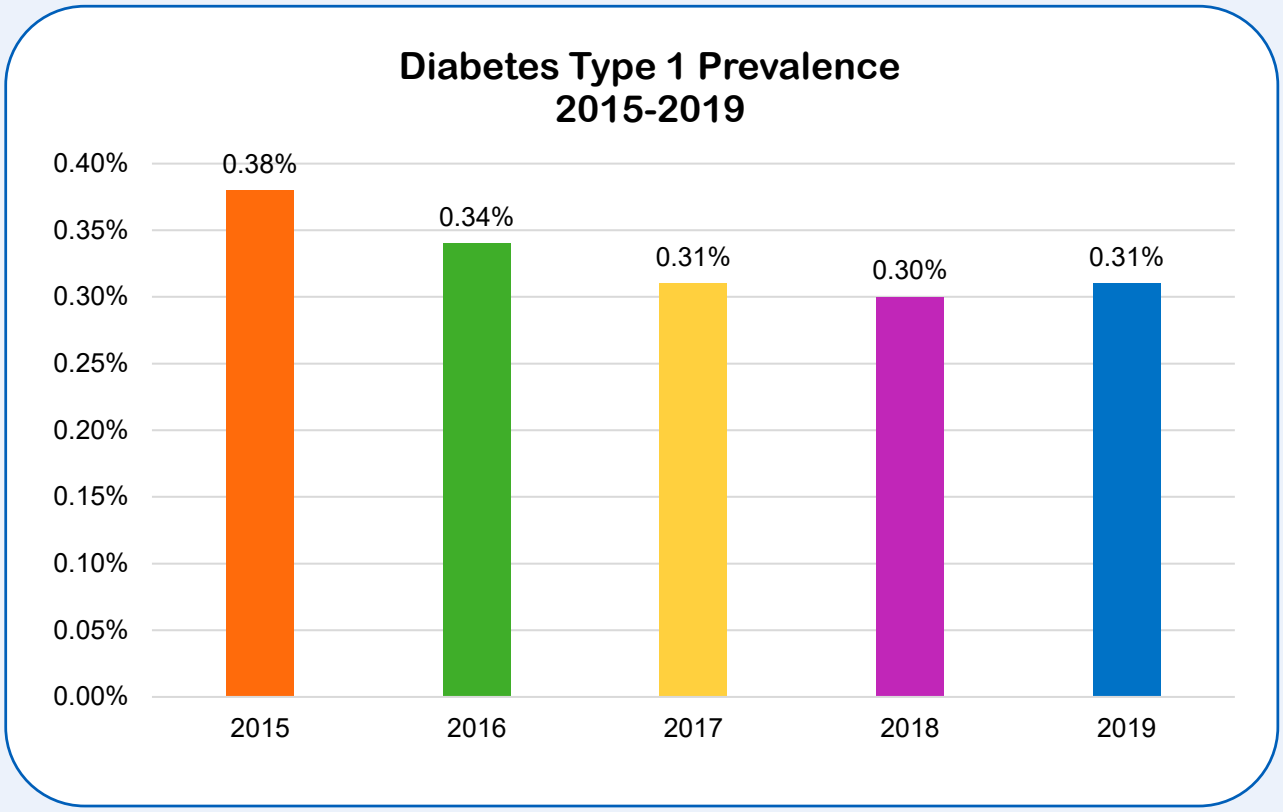
*Note: PCN began to measure Asthma Medication Management 75% Compliance in 2016.

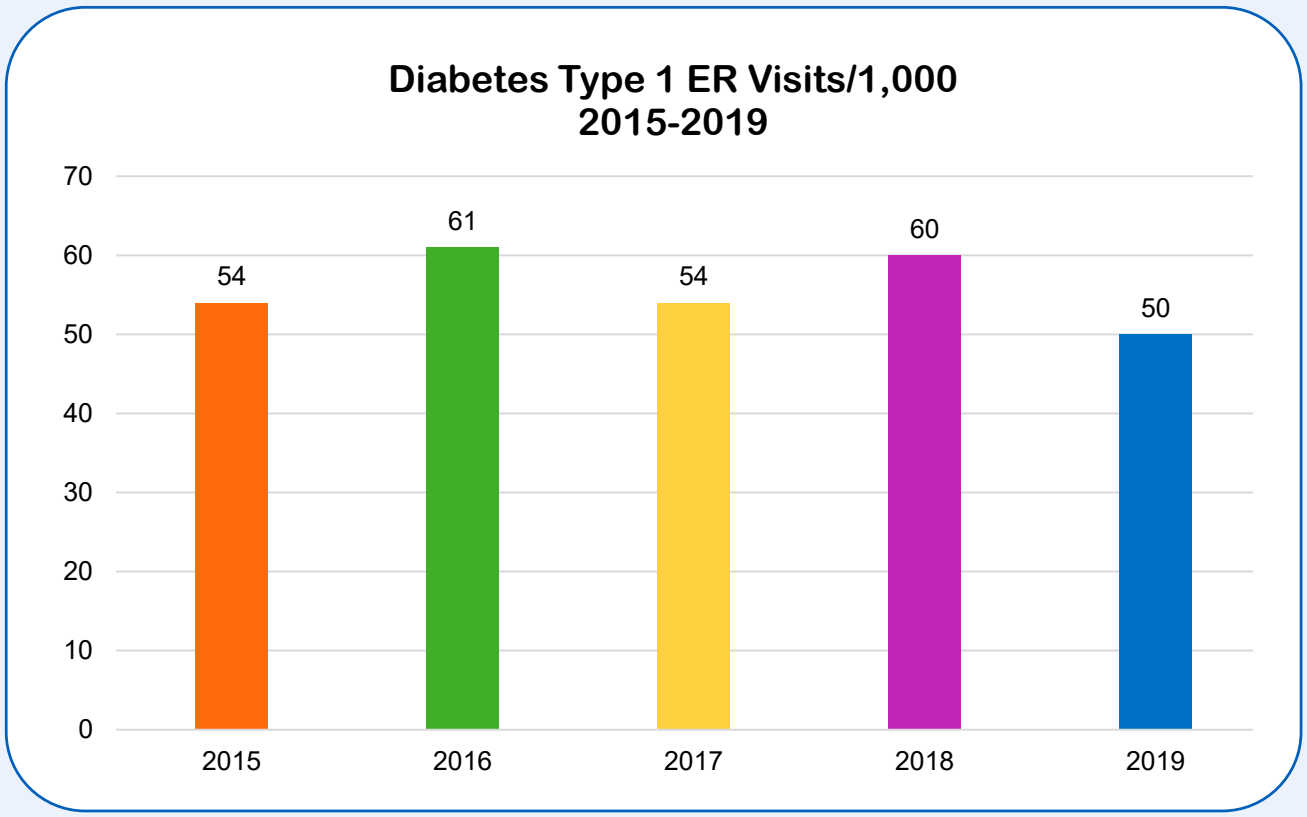


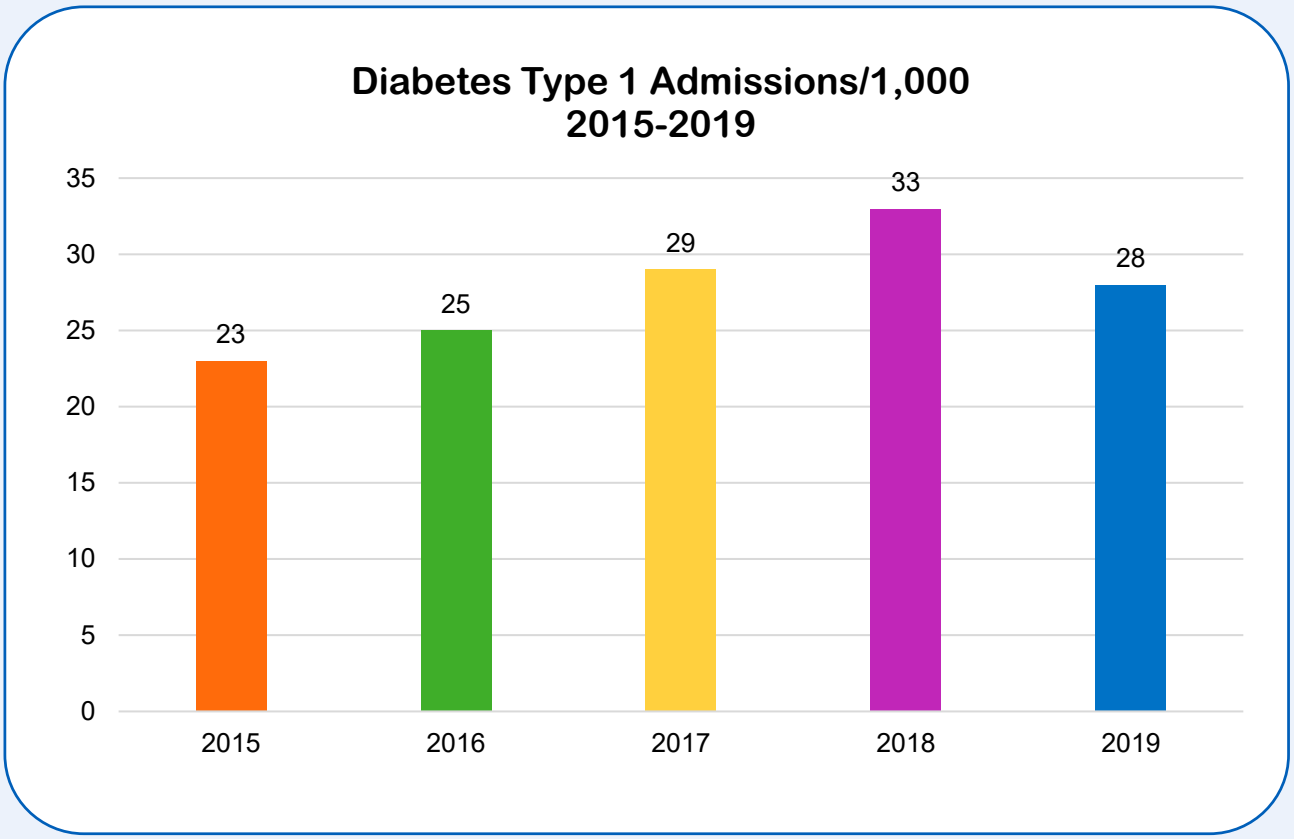

Asthma ER Visits/1,000
2015-2019
25
20
15
10
5
0
21
19
20
17
14
2015
2016
2017
2018
2019

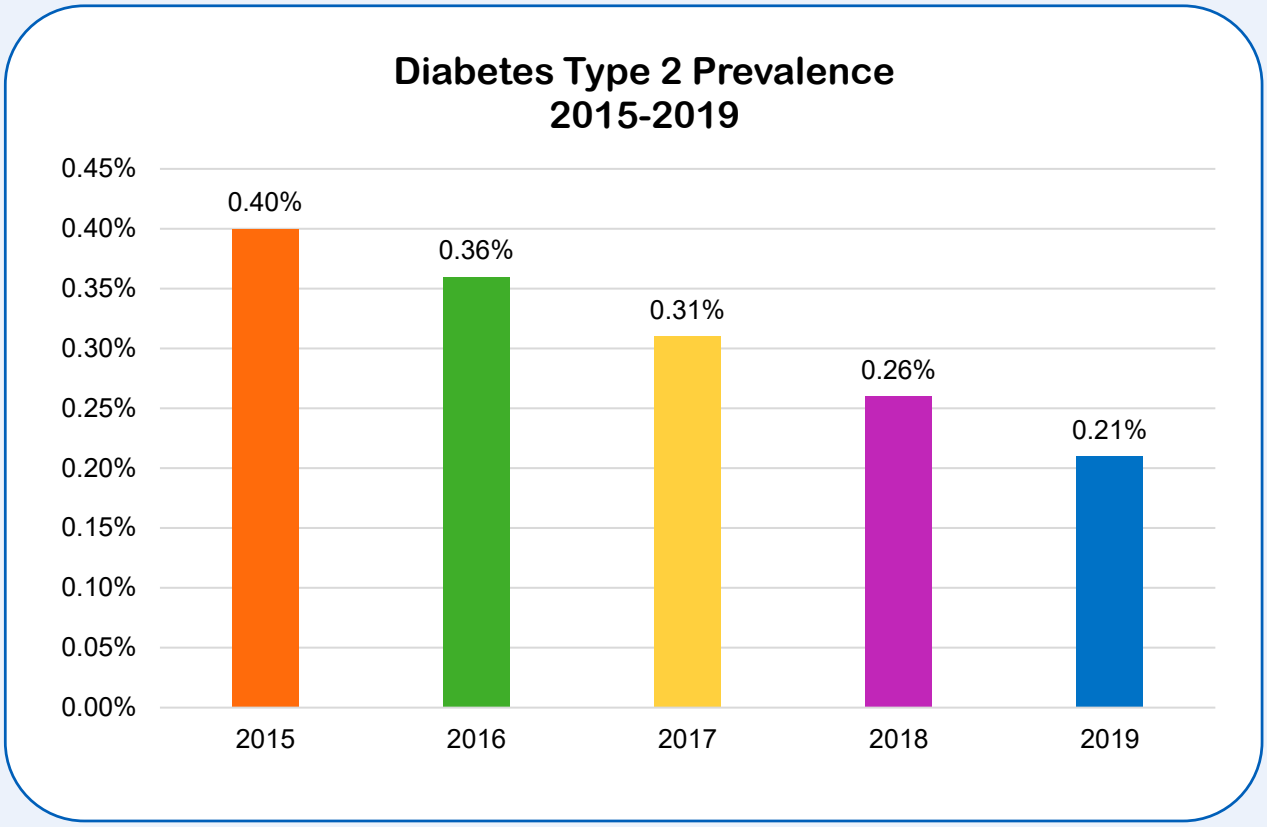

Asthma Admissions/1,000
2015-2019
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
3.5
3.7
3.4
3.8
3.5
2015
2016
2017
2018
2019

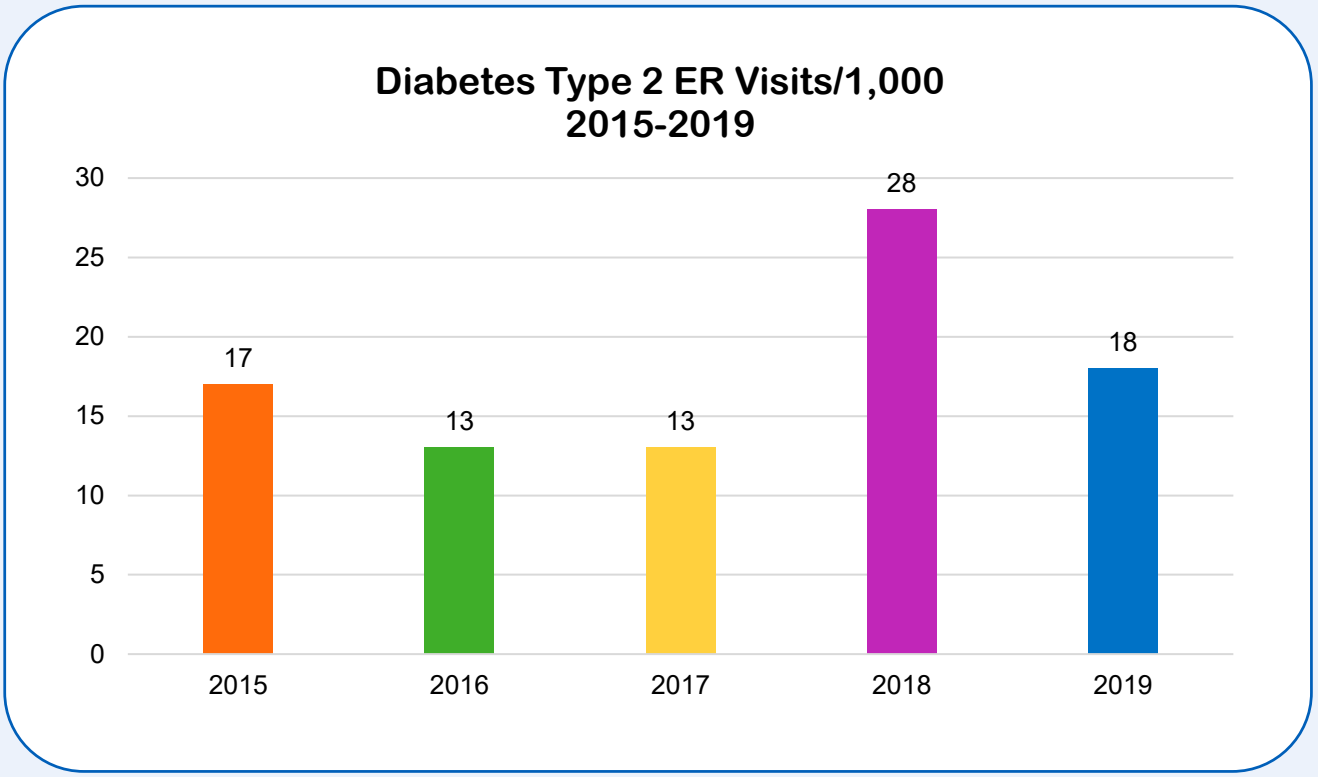
Diabetes

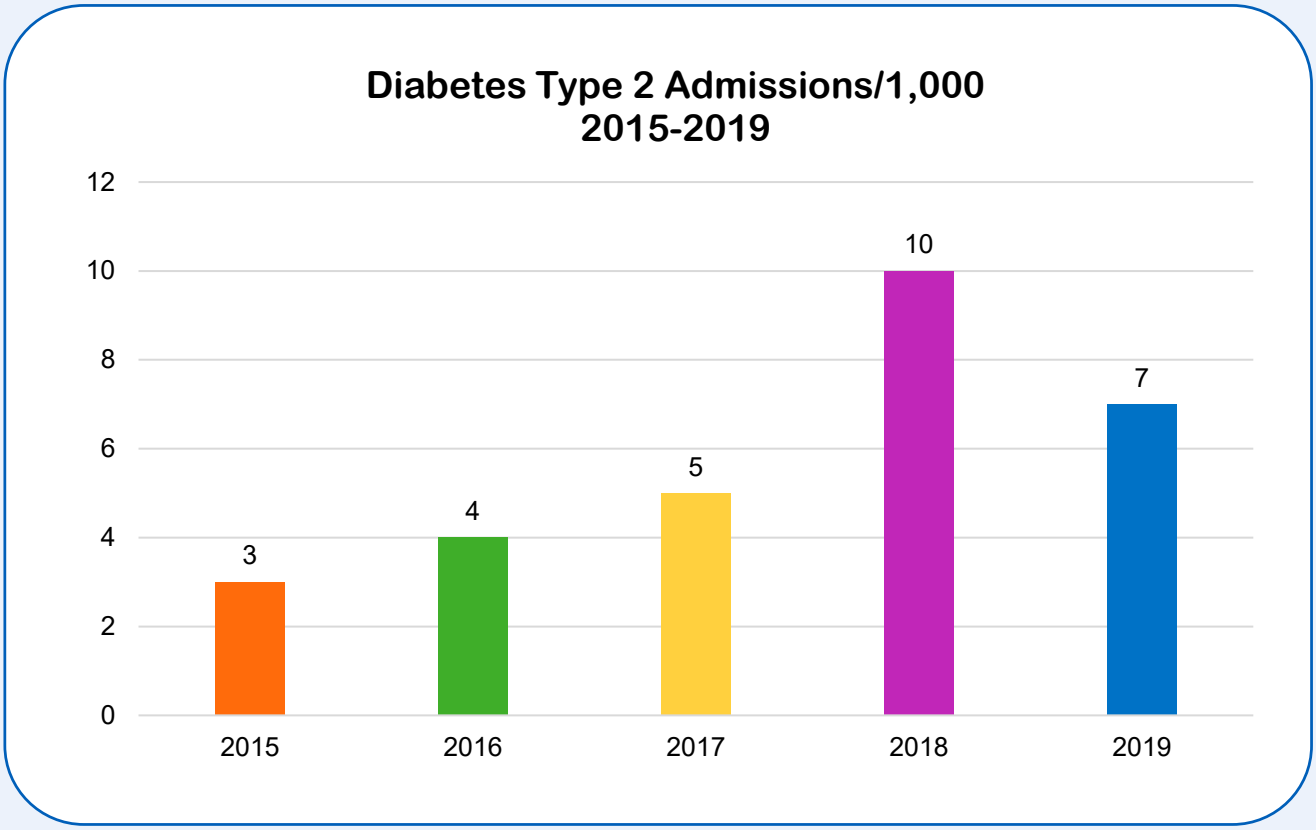

Diabetes Type 1 Prevalence
2015-2019
0.40%
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
0.38%
0.34%
0.31%
0.30%
0.31%
2015
2016
2017
2018
2019

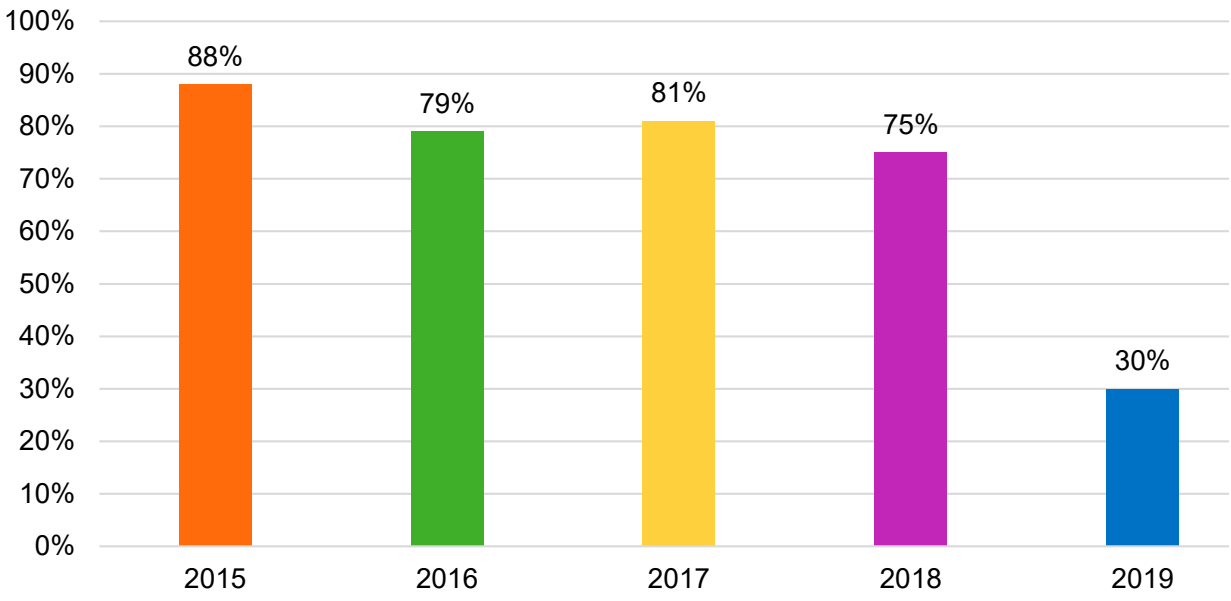

Diabetes Type 1 ER Visits/1,000
2015-2019
70
60
50
40
30
20
10
0
54
61
54
60
50
2015
2016
2017
2018
2019


Diabetes Type 1 Admissions/1,000
2015-2019
35
30
25
20
15
10
5
0
23
25
29
33
28
2015
2016
2017
2018
2019

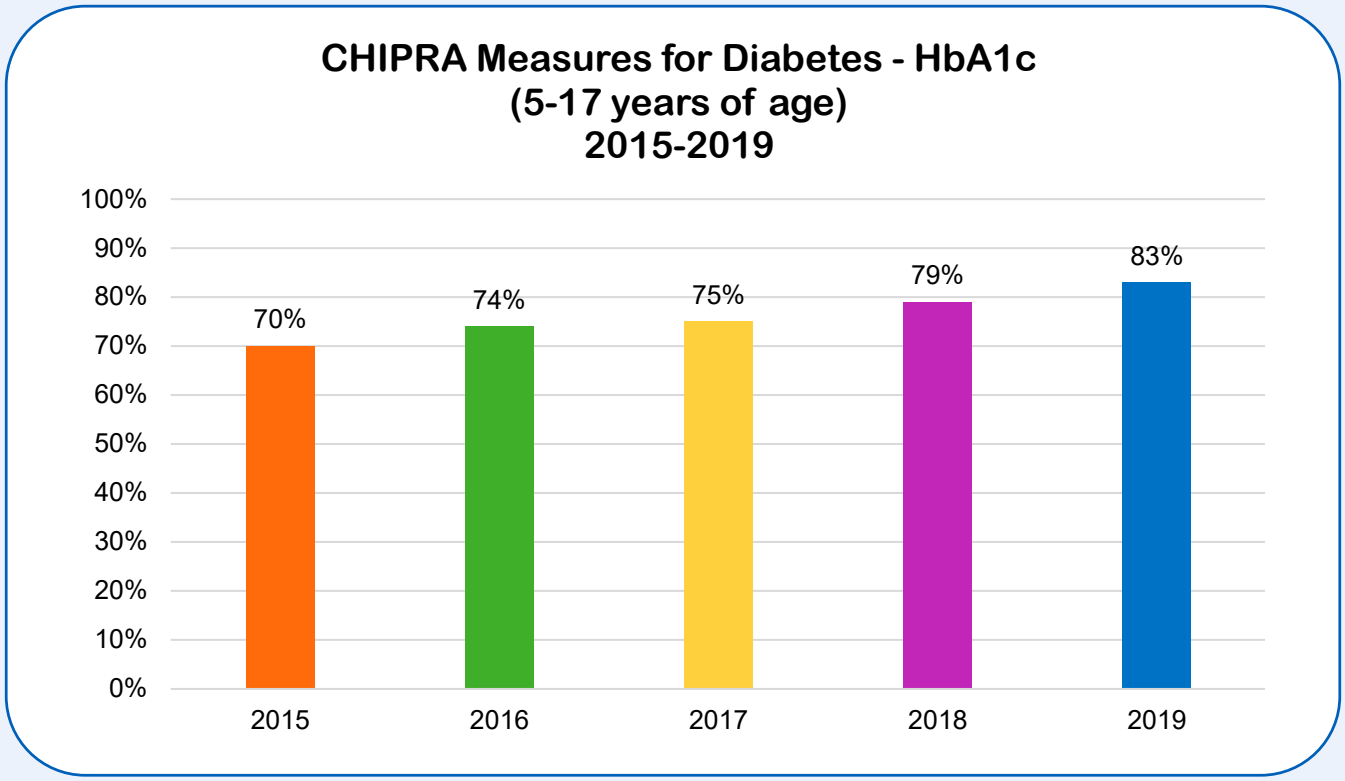

Diabetes Type 2 Prevalence
2015-2019
0.45%
0.40%
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
0.40%
0.36%
0.31%
0.26%
0.21%
2015
2016
2017
2018
2019

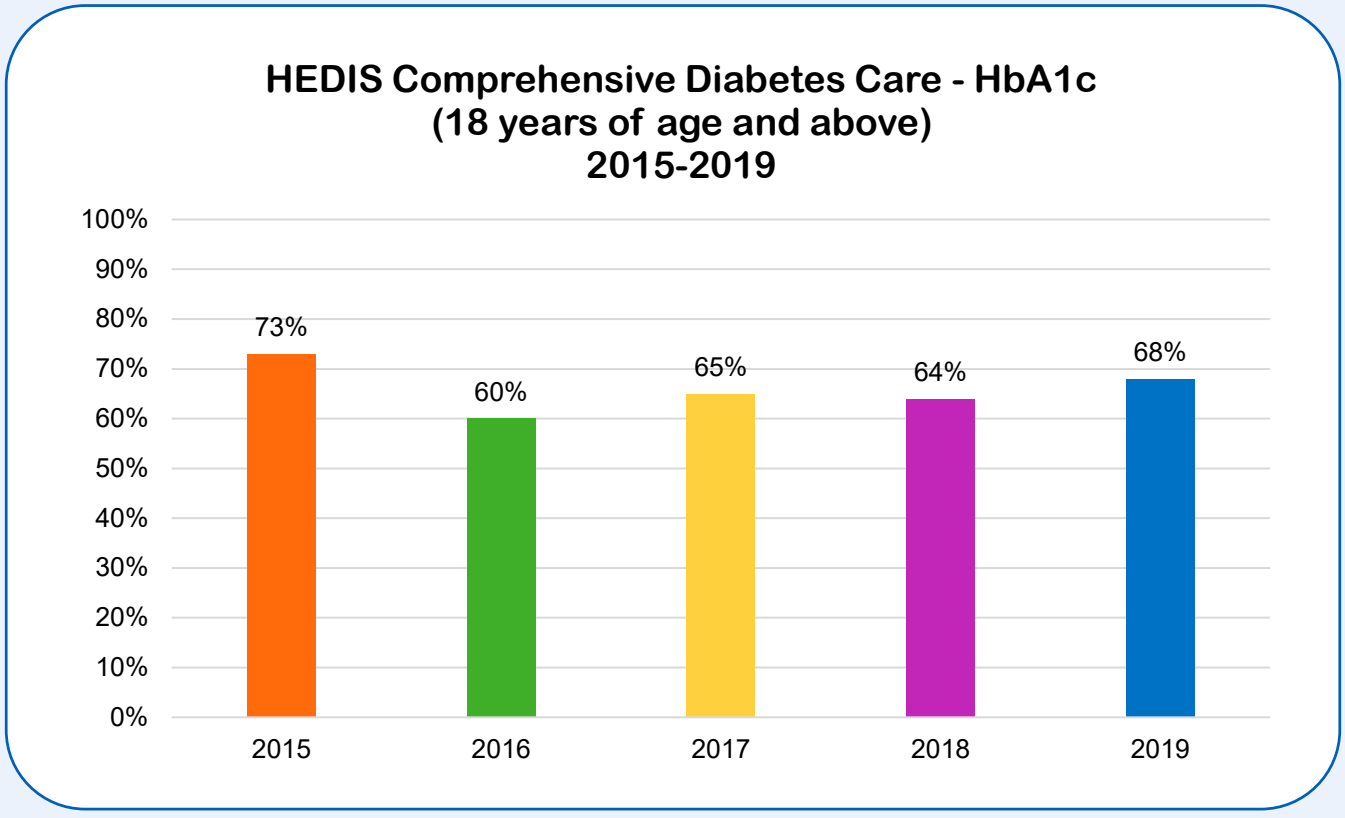

Diabetes Type 2 ER Visits/1,000
2015-2019
30
25
20
15
10
5
0
17
13
13
28
18
2015
2016
2017
2018
2019

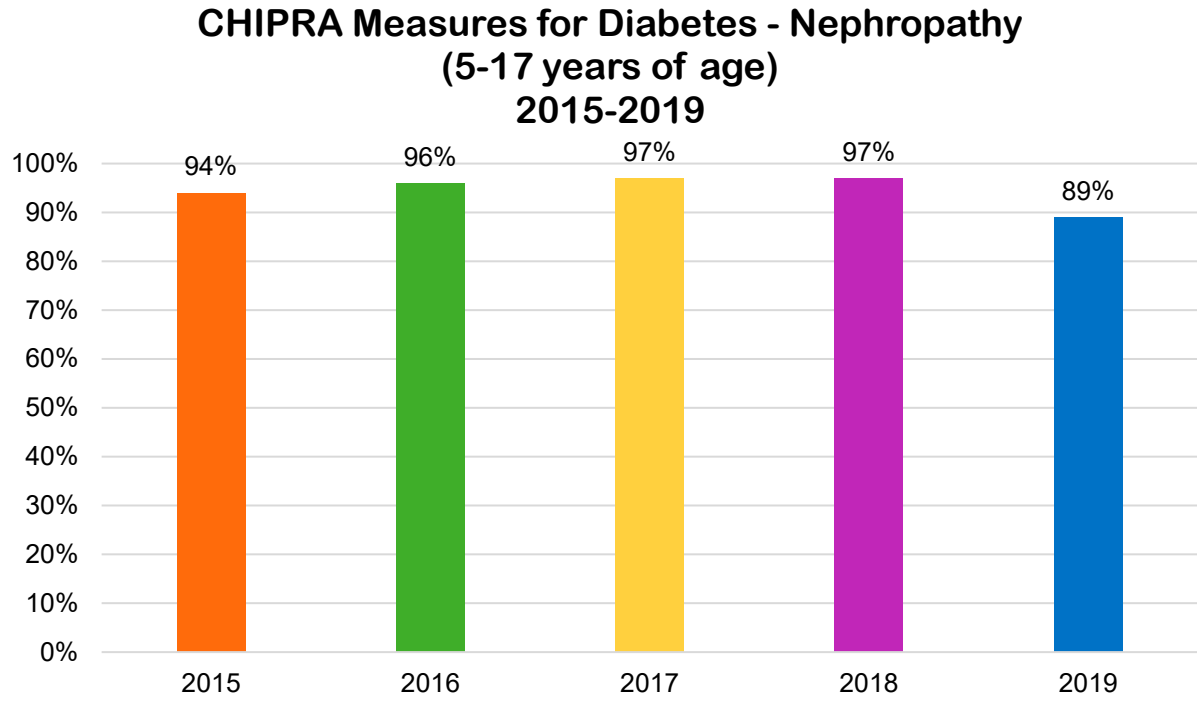

Diabetes Type 2 Admissions/1,000
2015-2019
12
10
8
6
4
2
0
3
4
5
10
7
2015
2016
2017
2018
2019

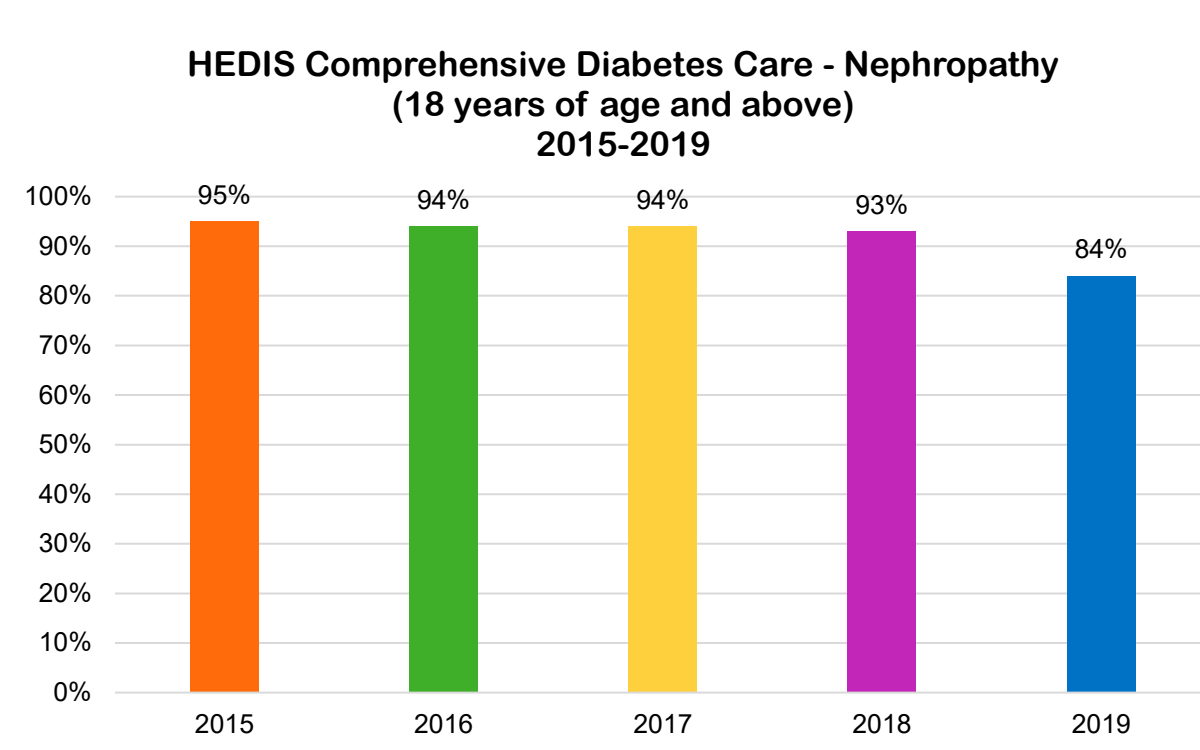


*Note: Decrease in performance due to very small patient population. See page 89 for details.


CHIPRA Measures for Diabetes - HbA1c
(5-17 years of age)
2015-2019
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
70%
74%
75%
79%
83%
2015
2016
2017
2018
2019


HEDIS Comprehensive Diabetes Care - HbA1c
(18 years of age and above)
2015-2019
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
73%
60%
65%
64%
68%
2015
2016
2017
2018
2019


CHIPRA Measures for Diabetes - Nephropathy
(5-17 years of age)
2015-2019
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
94%
96%
97%
97%
89%
2015
2016
2017
2018
2019


HEDIS Comprehensive Diabetes Care - Nephropathy
(18 years of age and above)
2015-2019
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
95%
94%
94%
93%
84%
2015
2016
2017
2018
2019

Analysis

Referral, Outreach, and Case Activity

Referrals decreased 7%, from 3,572 in 2018 to 3,334 in 2019. The top referral conditions have remained consistent from 2018 to 2019 with high-risk pregnancy, foster care, and high-risk asthma being the most prevalent. Referrals to Care Teams are generated through the utilization management process, member and provider referrals, and mining of encounter and EMR data. Care Teams conduct daily huddles to discuss assigned member populations, including those currently inpatient and those with emerging risk, to develop a strategic plan for member outreach and case management.

In 2019, the Care Integration program screened 686 members for complex case management. Of those 686 members, 417 (61%) were subsequently enrolled in complex case management. Complex cases are defined as members with a case opened for ≥60 days with a completed condition-specific assessment. This evolution led to an increase in complex case management cases from 40% in 2018 to 61% in 2019. Members with minimal needs are opened as case management cases and receive brief solution-focused interventions. Thirty-nine percent of referrals are managed in this manner. PCN processes remain true to case management philosophies of assessing, planning, implementing, and evaluating member cases with an emphasis on sharing care plan goals and the empowerment of members and providers to be engaged in the process.

PCN strives to develop patient-centered care plans that are specific, measurable, and attainable while eliminating barriers to care. In 2019, Achievement of Goals/Stabilized Condition/Improved Health was the primary case closure reason for 35% of the cases closed. This case closure reason was attributed to 57% of cases closed in 2018.

In addition to daily huddles, Care Teams also participate in Lean Work Groups and develop Lean quality improvement initiatives for their work duties. The Lean Work Group was developed in 2019 and has been crucial in creating a consistent, department-wide huddle structure which includes metric measurement, situational awareness, and escalation of issues as necessary. In 2019, PCN also developed mini work groups focused on Private Duty Nursing and Transplant member needs.

Cost and Utilization Pre and Post-Case Management

Due to the transient nature of cases in case management, the population available for pre and post-intervention analysis was not the same year over year. PCN reviews trends each year in the population available for study and expects improvements in inpatient and ER utilization and overall medical spend based on case management interventions. For the population analyzed this year, there was a 38.2% increase in inpatient admissions per 1,000, a 45.4% reduction in ER visits per 1,000, and a 256% increase in overall per member per month costs post-intervention. When case management interventions began, overall ER costs decreased significantly while inpatient, outpatient, and physician-related costs increased. This can be attributed to members becoming more compliant with preventive services and better connected to a medical home for management of their care. Additionally, beginning in July 2019, PCN began delegated services for the Aetna BetterHealth of Kansas plan. PCN anticipates that overall cost of care and inpatient and ER utilization will decrease as members become established with case management services and programs.

HEDIS Performance for Case Management

In the ten measures analyzed, the case managed population rates outperformed the PCN overall population rates in nine of the measures. The case managed population performed better than the PCN overall population in the following measures: Adolescent Well Care Visits (AWC), Access to Care (CAP), CHIPRA Measures for Diabetes, Chlamydia Screenings, Age 2 Immunizations (Combo 10 – including flu vaccine), Lead Screenings, Asthma Medication Management (75% Compliance), and Well Child Visits for Children 3-6 Years of Age. PCN attributes much of this improvement to increased communication with community providers and preventive health education provided to members and caregivers. Providers and PCN staff now have the ability to exchange secure messages through the C.A.R.E. Web online communication tool ensuring timely collaboration around member's need and care planning interventions. The case managed population had a lower rate than the PCN population in the Well Child Visits for Children Ages 0-15 Months (at least 6 total visits) measure. Performance increases in this measure take a significant amount of time to improve because it requires members to attend 6 total visits. Additionally, members are not eligible for the measure until they turn 2 years of age. To ensure improvement in this area, PCN will encourage quality improvement strategies within PCN practices, and incorporate discussion of those topics into the Triannual Performance Review meetings (see page 103 for details on the Triannual Performance Review).

Member/Caregiver Experience with Case Management

In 2018, PCN began a strategic quality improvement project to increase the number of members surveyed. The project included both the automation of disseminated survey links and weekly survey tracking. This project was continued in 2019, and the number of surveys remained higher compared to previous years. Ninety-eight percent of members surveyed reported that they

were overall satisfied with the services provided through the PCN case management program. Favorable member responses increased or stayed constant in 2019 from the prior year in five out of seven topics. The increased utilization of the PCN's community resource links and the addition of Community Resource Specialists on the Care Teams have had a positive impact on the case management program, as evidenced by the member survey results. PCN performance decreased slightly in two topics: "I'm better able to take care of myself or my child," and "Overall, I am satisfied with the services provided." In 2019, PCN conducted a review of the health literacy of the patient experience survey. Changes will be made to the survey in Q1 of 2020 to increase health literacy and ease of access of the survey.

Member/Caregiver Experience with Disease Management

The 2019 disease management survey results indicate significant improvement in chronic disease management, disease education, and engagement with medical providers. Member outreach and case management were provided by the entire Care Team, comprised of Nurse Care Navigators, Social Work Care Navigators, Community Resource Specialists, and Provider Relations Representatives, who all work closely with the member's PCP to support population health strategies. All 2019 survey results exceeded the 2018 results. The survey demonstrated an increase in member engagement with the Care Teams and providers. In addition, members reported a better understanding of their chronic disease through use of member educational literature, working with Care Team staff, and increased utilization of primary care providers and specialists.

During 2019, Care Teams focused on chronic disease management and ongoing outreach to medium and high-risk members with asthma and diabetes. Members who fell within these criteria and were 12 years of age or older had an annual depression screening completed using the Patient Health Questionnaire 'PHQ-9' (see page 74 for more details).

Asthma Outcomes

Prevalence and Utilization

The current prevalence rate of asthma in the PCN population based on claims data is approximately 16%. This rate is consistent with national averages for large urban populations. PCN continues to reinforce provider education for asthma management, supporting registry use and outreach from the PCP to members. The Care Teams have also implemented an outreach program for high utilizers of the emergency room related to asthma and other chronic conditions.

Provider and Member Adherence

Medication Management for People with Asthma observes the percentage of members who remained on an asthma controller medication for at least 75% of their treatment period. In 2019, PCN saw a 2% point increase in this measure (26% in 2018 to 28% in 2019).

Spirometry is an important tool used in assessing conditions such as asthma. As demonstrated in the data, spirometry use for members with asthma remained consistent from 2018 to 2019. In 2018 and 2019, there was increased education and focus placed on asthma overall, and PCN has noted the challenges of performing spirometry in the PCN setting. PCN has increased the availability of educational resources and has developed a Learning Collaborative presentation, in collaboration with Children's Mercy Kansas City specialists, to further support education of the PCN community providers. PCN hopes to see a more consistent upward trend in the use of spirometry by increasing clinical best practice focus and the availability of educational resources to providers within the network.

Inpatient and ER utilization related to asthma decreased slightly from 2018 to 2019.

Diabetes Outcomes

Prevalence and Utilization

As with many pediatric-focused organizations, the population of PCN members with diabetes is much smaller than the population of members with asthma. In 2019, the prevalence of both type 1 and type 2 diabetes in the PCN population was less than 1%. From 2018 to 2019, inpatient utilization decreased for both type 1 and type 2 diabetes. ER utilization for members with type 1 and type 2 diabetes also decreased.

Provider and Member Adherence

Diabetes eye exam screenings for members 18 years of age and above decreased from 75% to 30%, HbA1c testing increased from 64% to 68%, and nephropathy screening decreased from 93% to 84%. Due to the small population, those fluctuations were not significant enough to warrant changes in the diabetes disease management program. CHIPRA, which accounts for the bulk of PCN's diabetic population, saw an increase in HbA1c testing (from 79% to 83%) and a decrease in nephropathy screening (from 97% to 89%). Compliance with recommended HbA1c monitoring and nephropathy screening will continue to be a focus of the PCN's provider and member education for diabetes.

Future Initiatives

Based on the analysis of the program metrics, the following interventions will be included in PCN's 2020 initiatives:

- Enhance the Case Management and Disease Management Patient Experience surveys to include language focused on health literacy and diversity;
- Enhance levels of case management to encompass new expectations of state contracts;
- Provide ongoing staff education on specific chronic disease conditions related to the pediatric population (including training regarding Behavioral Health).

6 2019 Success Stories

- Care Team Successes with PCN Members
- Care Team Successes with PCN Providers
- Community Health Worker Successes with PCN Members

Care Team Successes with PCN Members

PCN Care Teams work collaboratively with other disciplines within the Children's Mercy Care Continuum department and with care managers from other health plan partners to ensure a seamless health care journey for PCN members. The following success stories are examples of these collaborative efforts.

Success Story #1

Synopsis: *A 20-year old was referred to a PCN Care Team. This member was 30 weeks pregnant, and had a history of a psychotic event, depression, and ADHD. The member's caregiver had been very supportive in trying to obtain necessary treatment for both psychological and obstetric (OB) needs. The caregiver had been directed to a facility for Behavioral Health. After being screened and working with the PCN Care Team member, the member was seen for a prenatal visit. The member's caregiver detailed what situations could be a psychological trigger, mentioning the pregnancy and mentions of a "baby" could cause mother distress. The caregiver also explained that she was taking the member to a Behavioral Health appointment to get the member medication to help with her psychotic episodes. The OB provider spoke with the Behavioral Health provider and communicated that it was safe to prescribe necessary medication.*

Outcome: Through collaboration between the PCN Care Team, the OB provider, and the Behavioral Health provider, this member was able to receive needed Behavioral Health care during her pregnancy. The PCN Care Team member took the lead to communicate with all disciplines involved in this member's care. This ensured that the member stayed healthy, physically and mentally, and was able to have a healthy, well-monitored pregnancy.

Success Story #2

Synopsis: *While reviewing a referred member's information, a PCN Care Team member determined that the female sibling of the referred family had a well-child check scheduled for a couple weeks following the capillary lead level. The male sibling did not have a well-child check scheduled until a couple months following the elevated capillary lead level. The PCN Care Team member messaged the female sibling's PCP via secure messaging to arrange that the female sibling receive a venous confirmation test at her well-child check appointment. The PCN Care Team member also messaged the male sibling's PCP to obtain orders for venous testing in order for the male sibling to get his lead levels tested at the time of his sister's well-child check. The PCN Care Team member received a message from the female sibling's PCP on the day of the female sibling's well-child check to notify PCN that the set of siblings had critically high lead levels that would require them to be admitted inpatient.*

Outcome: By coordinating care with these members' PCPs, the siblings got venous confirmation within an appropriate time frame. Due to the critically high level of lead in the members' blood, it was incredibly important that these siblings received venous confirmation and timely medical attention. Had the PCN Care Team member not reached out to the members' PCPs, the children may not have received venous testing and could have suffered negative health outcomes from the unknown critically high level of lead in their blood. Additionally, the PCN Care Team member was able to complete immediate outreach to the family to provide confirmation and support during the inpatient admission.

Care Team Successes with PCN Practices

PCN Care Teams work collaboratively with contracted PCN practices to coordinate care for members resulting in improved quality, cost, and utilization outcomes. The following are examples of these collaborative efforts.

Success Story #1

Synopsis: *A PCN Care Team member was attending a local event where Children's Mercy Kansas City doctors provide free sports physicals to students old enough to play sports for their school. A family came to the sports physical location wanting well-child checks for their two small children. The children were needing well-child checks before the end of the next week, and they did not have an established Primary Care Provider (PCP). The PCN Care Team member asked to see the children's insurance cards and identified the health plan and assigned PCP. The PCN Care Team member inquired if the parents had any preference for PCPs for the children; the family did not have preferences and had not established care anywhere yet. The family was agreeable to take their children to their assigned PCP. That PCN had a mobile health unit at the event as well. The Care Team member escorted the family to the mobile health unit and the children were able to get well-child checks that day.*

Outcome: Through the collaboration of the PCN Care Team member and the PCN contracted practice, the members were able to establish and receive needed care with their assigned Primary Care Provider.

Success Story #2

Synopsis: *While reviewing a referred member's history to prepare for outreach, a PCN Care Team member noted that in C.A.R.E. Web the patient had a well child visit and an ER visit on the same day. However, when reviewing with the contracted PCN practice, there was no record on an ER visit at their facility – only evidence of the well child visit. The Care Team member escalated the issue to PCN leadership, and the information was reviewed with the billing department of the PCN contracted practice. The billing department confirmed that there was no record of an ER visit at their facility. After further research into the claims codes with the PCN IT team, it was identified that the incorrect practice location was included on the claim. The PCN contracted practice's billing department resubmitted a corrected claim.*

Outcome: The PCN Care Team member was able to identify this issue and find the root cause within two days. Identification of this issue allowed the PCN contracted practice to review their billing processes to ensure that a larger scale problem did not exist. Additionally, proper location coding allows performance outcomes for PCN contracted practices to be as precise as possible.

Success Story #3

Synopsis: *The PCN Care Team received a referral for a member with a diagnosis of Autism Spectrum Disorder (ASD). While speaking with the family, the PCN Care Team member identified that the family is low income and in need of community support. The member was initially linked with a behavioral health facility in the year prior, however the facility case worker assigned to the member did not communicate with the member's mother, and she was unsure of any goals or plans of care to assist the member with accessing needed supports, resources, and services for his ASD. The member has significant running behaviors that are a safety concern. A safety bed was approved as medical equipment for the member to prevent elopement during the night. Additionally, the member's mother expressed a desire for assistance with a GPS tracking system for the member to increase his safety during waking hours. The mother had initially requested assistance from behavioral health facility case worker to address this need, but the mother never received follow up. The PCN Care Team member assisted the parents in completing an application for Fox 4 Love Fund for Kids to cover the cost of the GPS device.*

Outcome: The family's application for the Fox 4 Love Fund for Kids was approved, and they were able to obtain a GPS device for the member. The member's safety has now increased as he has a GPS monitoring system to track him when he engages in running behaviors. Additionally, the parents have more confidence in patient's safety when he is at school or in any other public setting. The PCN Care Team member was also able to connect the family with a new case worker at the behavioral health facility who can assist and address resource and service needs for the member's ASD.

Success Story #4

Synopsis: *Synopsis: An 8-year-old male member was referred to PCN from his school nurse. The member has an extensive past medical history and needs a lot of direct care. The member's mother is on disability and the maternal grandmother assists with care when she is able. On a call with the member's mother, she communicated to the PCN Care Team member that the member was struggling to get in/out of vehicle due to his medical conditions. The PCN Care Team member facilitated referral of the family to a community agency. The case manager from the community agency completed a home visit, located a company to install running boards on the family vehicle, and paid for the installation.*

Outcome: As a result of the PCN Care Team's collaboration with the community agency, the member was able to exit and enter the family vehicle by himself. This change helped the member develop a sense of independence, and his mother communicated to the PCN Care Team how happy the member was that he could now do this on his own.

Community Health Worker Successes with PCN Members

PCN partners with Community Health Workers from a local agency to assists members in navigating the health care system, linking members with needed health and social services and empowering members to take an active role in managing their health care needs.

Success Story #1

Synopsis: *A patient was referred to the Community Health Worker (CHW) by an Inpatient Social Worker at Children's Mercy Kansas City. The patient was admitted to Children's Mercy with a self-inflicted gunshot wound to the head. The CHW and the CHW's supervisor participated in a phone conference call with the hospital care team to get the details of the patient's progress. The CHW and supervisor met with the mother of the child and mother's significant other to complete a needs assessment. Through the needs assessment it was determined the mother would need assistance with accessible housing, employment, and education. The mother's priority was finding a job and finding a place to live. The young mother indicated she had never worked before and did not have a high school diploma or GED. The CHW educated the mother on the resources available for low-income housing and the process for applying. The CHW explained there are waiting lists for affordable housing, but she could assist her with applying. A couple of weeks later, the mother informed the CHW that her child was taken into state's custody and she no longer was able to visit the child. The CHW offered to continue helping her with employment and housing and offered to assist her with understanding what is going on with her case with the state if needed. The mother wanted to continue the CHW services and work on the goals of finding a job and housing. The CHW met with the mother at the public library. With the support of the CHW, the mother contacted resources for employment and job training. The mother was able to sign up for a job club, obtained a library card, and met an entrepreneur that shared their story of success with her.*

Outcome: The mother was approved for housing and received a voucher for a 2-bedroom apartment. The CHW followed up with the mother to see how the search for housing was going. The mother expressed she was having difficulty finding someone to rent to her. The CHW scheduled a visit with the mother at the library, as the mother was having difficulty reading and understanding the voucher. The CHW showed the mother how to access a website with a list of available housing. The CHW supported the mother in calling some of the apartments and guided her on what questions to ask. The mother was more comfortable with the process after her visit with the CHW and was able to obtain housing. Without intervention from the CHW, the family would likely have been left homeless.

Success Story #2

Synopsis: *The CHW began working with a mother in December 2018 who wanted to access the Fox 4 Love Fund for Kids. The family was in need of clothing for the children and other household items. Additionally, the referred child had profound developmental disabilities, which caused the single mother to have to take time off from work. This caused her to lose several jobs. The mother wanted to find work again that would fit her family's schedule so the CHW assisted the mother with completing applications for employment. Additionally, the CHW determined that the family had to be referred to the Love Fund through an agency. The CHW completed the application to refer the family and continued to check in with the family periodically.*

Outcome: In July 2019, the CHW received an approval letter for the family to receive funds from the Love Fund. The family received a $300 voucher to Walmart. The CHW contacted the family to let them know they were approved and made arrangements to get the voucher to the family. As the CHW was speaking with the mother, the mother stated she had started a new job as well. With support from the CHW, the mother was able to obtain employment and the family was able to receive much needed funds from the Fox 4 Love Fund for Kids.

7 Summary

- 2020 Goals and Objectives
- 2020 Work Plan

Summary of Calendar Year 2020 Goals and Objectives

Based on this year's analyses of data and trends, PCN has identified several areas for implementing new initiatives and enhancing existing programs in the coming year. These areas are identified below:

- Community Resource Team
- Triannual Performance Review Process
- C.A.R.E. Web (Online Care Team Communication Tool)
- Community Health Worker Program
- Post-NICU Home Care Support Program
- Patient Outreach Initiative (InConnect)

Community Resource Team

The PCN Community Resource Team worked on numerous projects throughout 2019. The PCN Community Resource team has partnered and continued to foster relationships with numerous community agencies (SleepyHead Beds, Harvesters, Giving the Basics, local health departments, etc.) to facilitate resource acquisition and a more seamless referral process for PCN members. The PCN Community Resource team consistently attends community resource connection meetings through Jackson County, Wyandotte County, Clay County, Platte County, and Johnson County. The team also collaborates with community agencies to disseminate information and schedule on-site presentations for the PCN team.

Triannual Performance Review Process

Care Teams will continue to evaluate quality and cost metrics for contracted PCN primary care practices through the use of the Triannual Performance Review reports. This process will continue to evolve, driving forward population health for the entire network, as Care Teams and providers deploy new and improved population health initiatives and quality and cost/utilization improvement strategies.

C.A.R.E. Web (Online Care Team Communication Tool)

C.A.R.E. Web is the online application utilized by Care Teams to enter authorizations, document case management activities, and send tasks to other members of the Care Team. Significant enhancements were made to C.A.R.E. Web in 2019 focused on engagement with Social Work within Children's Mercy Kansas City and more efficient workflow for Care Teams. In addition, C.A.R.E. Web was updated to allow Care Team members to search for members by Children's Mercy Medical Record Number, and a Social Worker role was added to allow Children's Mercy Social Workers to use C.A.R.E. Web for PCN members receiving care at Children's Mercy. In 2020, PCN plans to add enhancements for providers to have the ability to enter authorization requests online through the PCN secure portal, and PCN plans to add member preferences to C.A.R.E. Web to display a member's preferred name/pronoun and gender identity.

Community Health Worker Program

In 2019, the Community Health Worker (CHW) continued to attend daily PCN Care Team huddles and take on-the-spot referrals. Additionally, in late 2019, the CHW began working onsite at Central High School (which has a childcare site for students with children) two days per week. Placing the CHW in that location allows PCN to intervene with students with mental and physical health needs for themselves and their babies. Members enrolled in the CHW program had higher emergency department use (22.8% increase), inpatient visits (52.4% increase), and slightly higher total cost of care (9.1% increase) after enrolling in the program. The small denominator of members in 2019 contributed to those increases. PCN and the Community Health Worker will continue to educate PCN members' caregivers on alternatives to utilizing the emergency room and encourage them to contact their primary care providers, utilize nurse advice lines, or visit trusted urgent care facilities. Members enrolled in the CHW program also had better HEDIS measure results when compared to

the PCN population overall. Given its sustained success, the program will continue in 2020.

Post-NICU Home Care Support Program

A quality improvement initiative designed to provide support for newly discharged NICU babies, while decreasing post-discharge ER visits, was initiated in 2016 and continued through 2018. The pilot received positive feedback from home health staff, as well as parents and caregivers, and was subsequently integrated into the standard workflow for all NICU discharges. The program has successfully demonstrated an impact on the medical cost and utilization of care of the members who accepted the services. Since its initiation, the program has served 186 NICU babies. When compared to the control group of 183 NICU babies in the same hospitals who declined the Home Care services, the analysis was favorable for the Home Care group with over 55% reduction in paid medical cost, 74% reduction in admissions, 93% reduction in hospital stays, and 84% reduction in readmissions. However, the intervention group had 22% higher rates for ER visits. After further analysis, ER visits were mainly due to respiratory issues and chronic recurring ear infections. More than one fourth of the ER visits were from 10 unique members. In 2019, PCN and Children's Mercy Home Care will evaluate ways to educate PCN members' caregivers on alternatives to utilizing the emergency room and encourage them to contact their primary care providers, utilize nurse advice line, or visit trusted urgent care facilities.

Patient Outreach Initiative (InConnect)

In 2019, automated call campaigns via the interactive voice response system, Emmi, targeted medium and high-risk asthma members to encourage follow-up visits with providers every six months. Additionally, PCN implemented an outreach campaign inviting patients to join the PCN Case Management program, aimed to elevate overall engagement for patients identified for case management. Emmi has seen great success with other pediatric population health efforts. In order to better serve the member population, PCN will be transitioning from Emmi to Innovaccer's InConnect solution in the first quarter of 2020. The InConnect campaigns of 2020 will mirror those of Emmi in 2019, with the addition of outreach to members not currently seeing a primary care provider. These new InConnect campaigns are on track to reach more patients in more meaningful and valuable ways.

The PCN maintains a strong commitment to improving the health of the population, decreasing the overall cost of care, and improving patient and provider experience with care delivery. The PCN team will continue to forge strong relationships with the patient population it serves in addition to their healthcare providers and communities to continually improve access to care, promote preventive services, and develop strong multi-disciplinary care delivery models for effectively managing vulnerable high-risk populations.

Submitted: Carey Spain — July 22, 2020

Carey Spain, MSW, MBA, LCSW, LSCSW, ACM
Senior Director, Integrated Community Care

Approval: _____ — July 28, 2020

Just for Kids (JFK) Committee

_____ — July 29, 2020

Clinical Quality & Operations Committee

2020 Annual Work Plan

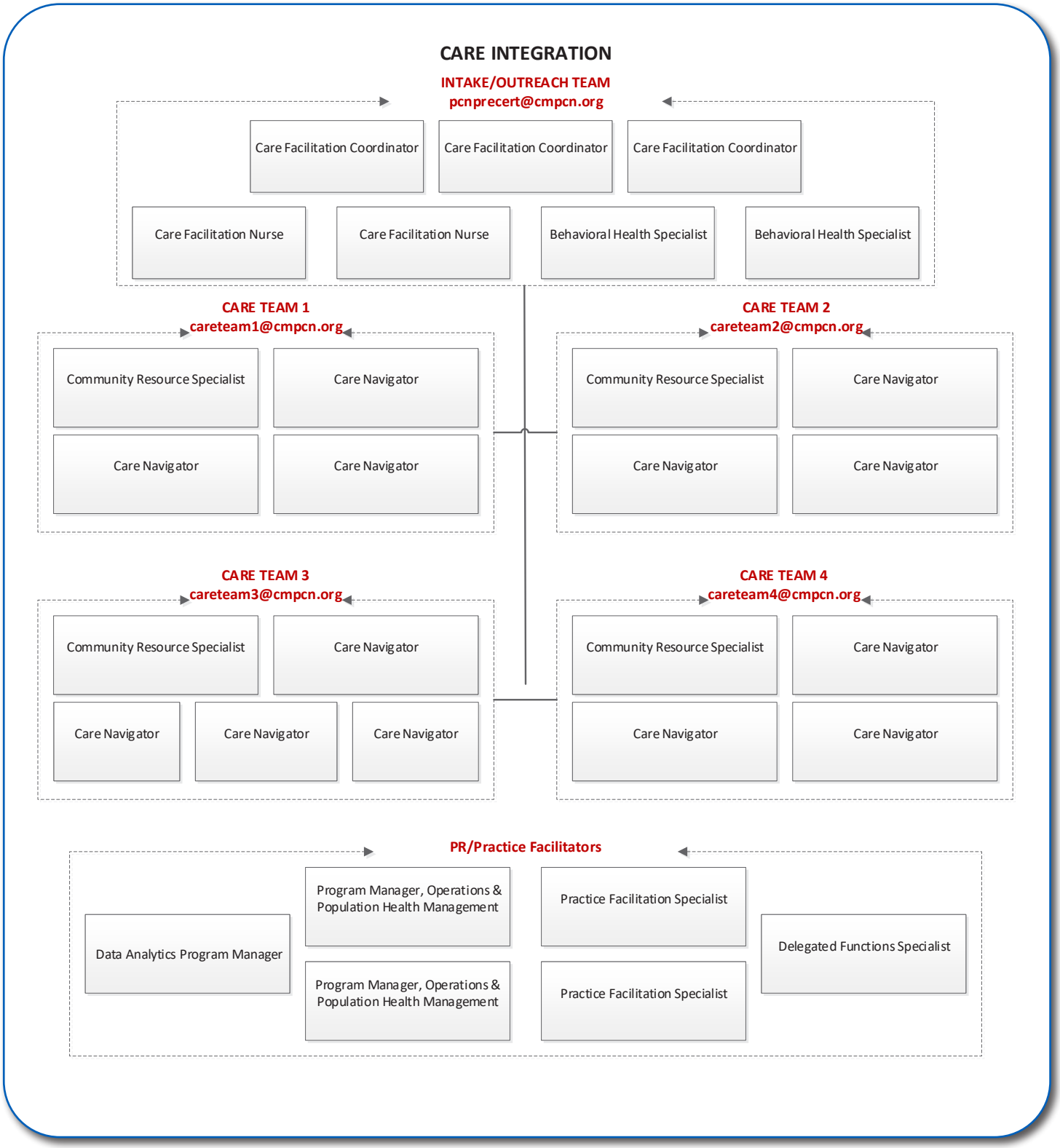
	Initiative	Operational Lead	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Scope & Process	ICS Resources for Spread (Operational Leader, Project Manager)
1	Enhance community connections and resource allocation	Community Resource Specialist Team	X	X	X	X	Expand collaboration with community organizations and continue to investigate opportunities for resource acquisition through the new resource hosting service.	Care Teams; IT Team; Operations & Population Health Management Team; Community Resource Specialist Team
2	Evolve Triannual Performance Review Process	Program Manager, Operations & Population Health Management	X	X	X	X	Continue to evaluate quality and cost metrics for contracted PCN primary care practices, schedule tri-annual meetings with the practices to review data, discuss coordinated interventions to address improvement opportunities, and evaluate progress with metrics.	Care Teams; Data Analytics/ Operations & Population Health Management Team; Practice Facilitation Specialist Team; Provider Relations Team
3	Broaden the scope of C.A.R.E Web	Director of Integrated Care	X	X	X	X	Implement new C.A.R.E. Web enhancements to allow for greater provider engagement and more efficient workflow for Care Teams.	Care Teams; IT Team; Management Team
4	Continue and expand Community Health Worker program	Director of Integrated Community Care	X	X	X	X	Ongoing Community Health Worker program will continue to develop at Central High School; PCN will continue to monitor interventions to determine sustainability of the program.	Data Analytics/ Operations & Population Health Management Team; Management Team

5	Expand NICU post-discharge program	Director of Integrated Care	X	X	X	X	Expand NICU post-discharge program to additional hospitals. Continue to monitor program outcomes and enhance education provided to families regarding appropriate setting for healthcare services (PCP, urgent care, emergency room, etc.).	Data Analytics/ Operations & Population Health Management Team; Management Teams
6	New patient outreach initiative platform InConnect	Program Manager, Operations & Population Health Management	X	X	X	X	Implement automated call campaigns for medium and high-risk asthma patients to encourage follow up with PCP providers. Implement new automated call campaigns to outreach to members not currently seeing a primary care provider.	Intake/ Outreach Team; Management Team; Operations & Population Health Management Team; Provider Relations Team

8 Appendix

- Care Team Diagram
- Triannual Performance Review

Appendix A: Care Team Diagram



Appendix B: Triannual Performance Review

PEDIATRIC CARE NETWORK TRIANNUAL PERFORMANCE REVIEW REPORT PACKAGE

To deliver high-value care that meets the Triple Aim of Better Care, Smarter Spending, and Healthier Children, the PCN Triannual Report Package informs practices of their quality and cost performance and provides observations and potential improvement ideas for consideration and review with each practice.

We are striving to make the information useful, valuable, and actionable. We welcome your feedback!

Quality Performance Report - *Observations & Potential Improvement Ideas*

Observations and Comments

Quality Measure	Current Results	Prior Results	% Point Improvement	75th Percentile	90th Percentile
[Insert Quality Measure]	X	X	X	X	X
[Insert Quality Measure]	X	X	X	X	X
[Insert Quality Measure]	X	X	X	X	X
[Insert Quality Measure]	X	X	X	X	X
[Insert Quality Measure]	X	X	X	X	X
[Insert Quality Measure]	X	X	X	X	X

Potential Opportunities for Improvement:

- EPSDT X% from the HEDIS 75th Percentile

Potential Strategies/Tactics of How to Accomplish Goal(s):

- PCP alignment rate of X% (Y% of assigned patients have not made a visit to the practice in the last 2 years)

Follow Up & Review of Actions and Goals

Quality Goals	Status of Actions/Tasks
EPSDT (0-6 Years)	Has Improved X% over prior measurement period
[Insert Quality Goal]	[Insert Status]
[Insert Quality Goal]	[Insert Status]

Cost & Utilization Report - *Observations & Potential Improvement Ideas*

Observations and Comments

Cost Measure	Current Results	Prior Year Final Results	Target
[Insert Cost Measure]	X	X	X
[Insert Cost Measure]	X	X	X
[Insert Cost Measure]	X	X	X

Potential Improvement Ideas and Resources for Discussion

How to Accomplish:

- [Insert Cost Improvement Ideas and Resources]
-

[Insert Practice Name] Provider Roster

Children's Mercy PEDIATRIC CARE NETWORK

Published: [Insert Date]

Provider Last Name	Provider First Name	Provider NPI	Provider Type	Practice Name
[Insert Last Name]	[Insert First Name]	[Insert NPI]	[Insert Provider Type]	[Insert Practice Name]
[Insert Last Name]	[Insert First Name]	[Insert NPI]	[Insert Provider Type]	[Insert Practice Name]
[Insert Last Name]	[Insert First Name]	[Insert NPI]	[Insert Provider Type]	[Insert Practice Name]

PCN 2019 Incentive Rolling HEDIS Quality Report Package - Practice Level Report [Insert Practice Name]

Measurement Period: XX/XX/XXXX-XX/XX/XXXX | Prior Measurement Period: XX/XX/XXXX-XX/XX/XXXX

Run Date: [Insert Date]

			Benchmarks			
Quality Measure	Current Results	Prior Year Final Results	% Point Improvement	75th Percentile	90th Percentile	[Insert Practice Name]
Clinical Quality Performance						
Asthma Management						
Medication management - At least 75% controller usage	36.4%	29.7%	6.7%	35.0%	43.2%	36.4%
Immunizations - Childhood Age 2						
Combo-10 (Dtap, IPV, MMR, HiB, VZV, PCV, RV, HepB, HepA, Flu)	58.7%	60.5%	-1.8%	40.9%	48.4%	58.7%
Immunizations - Age 13						
Combo (MCV, Tdap)	86.4%	69.7%	16.7%	85.6%	88.1%	86.4%
Well Child Visits - First 15 Months						
6 well visits before 15 months of age	92.1%	88.1%	4.0%	71.3%	75.4%	92.1%
Well Child Visits - 3-6 Years						
At least one annual well exam in measurement year	83.3%	80.2%	3.1%	79.3%	83.7%	83.3%
Well Child Visits - 12-21 Years						
At least one annual well exam in measurement year	76.4%	76.9%	-0.5%	62.0%	66.8%	76.4%
Lead Screening by Age 2						
At least one lead blood test by age 2	84.8%	90.6%	-5.9%	80.1%	85.6%	84.8%
Chlamydia Screening in Women - 16-24 Years						
At least one test for chlamydia in the measurement year	41.9%	35.1%	6.7%	62.9%	69.8%	41.9%
Weight Assessment & Counseling - 3-17 Years						
BMI Percentile	86.4%	85.4%	1.0%	82.6%	88.0%	86.4%
Early & Periodic Screening, Diag., and Treatment - 0-6 Years						
Expected screening in measurement year	84.6%	95.7%	-11.1%	65.0%	80.0%	84.6%
Immunizations - Age 13						
Combo (MCV, Tdap, HPV)	47.5%	47.8%	-0.3%	37.7%	46.7%	47.5%

Cost Measure	Current Results	Prior Year Final Results		Improvement	Benchmark	[Insert Practice Name]
Cost & Utilization Performance						
Risk Score	1.4	1.6				1.4
Risk-Adjusted Admits/1000 (Non-Newborn & Non-Deliveries)	23.7	21.9		1.8	30.0	23.7
Risk-Adjusted Avoidable ER Visits/1000 (Non-Emergent)	94.3	91.9		2.3	110.0	94.3

PCP Alignment Summary	Your Practice	Network Overall
% of Assigned Patients Going to Another PCP	X%	X%
% of Patients Not Seeing a PCP	X%	X%
% of Your Active Assigned Patients with a Visit to Your Practice in Last 2 Years	X%	X%

PCN 2019 Incentive Rolling HEDIS Quality Report Package - Practice Engagement Performance [Insert Practice Name]

Measurement Period: XX/XX/XXXX-XX/XX/XXXX

Run Date: [Insert Date]

Practice Engagement Performance	Current Results	[Insert Practice Name]
Patient Centered Medical Home		
Use of Team-Based Care to Work 3 Registries	Yes	3.25
Patient Satisfaction Survey & Improvement Initiative	Yes	3.25
Learning Collaborative Participation	Yes	3.25
Closed Loop Referral Tracking Process	Yes	3.25
Established Process to Manage High Risk Patients	Yes	3.25
Established Process to Manage Transitions	Yes	3.25
Established Care Coordination Process with PCN Care Navigators	Yes	3.25
Established Process to Address Behavioral Health Concerns	Yes	3.25
Practice Engagement Performance		
PCMH [>= 20 PCMH Points / 2017+ NCQA PCMH] (See Above)	Yes	5.00
Practice Attendance to 3 PCN Committee Meetings [100% Attendance]	No	0.00
Triannual Quality Improvement Meetings with QI Plan	Yes	5.00
1 Annual All-Provider PCN In-Practice Meeting [>=75% Attendance]	No	0.00

PCN Rolling-HEDIS Quality Report Package - Provider Level Report [Insert Practice Name]

Quality Measurement Period: XX/XX/XXXX-XX/XX/XXXX

Run Date: [Insert Date]

				Benchmark					
Measure	Num	Denom	Your Practice	75th Percentile	Patients to 75th Percentile	90th Percentile	Patients to 90th Percentile	[Provider A]	[Provider B]
Clinical Quality Performance									
Asthma Management									
Medication management - At least 75% controller usage	20	55	36.4%	35.0%	0	43.2%	4	29.2%	41.9%
Immunizations - Childhood Age 2									
Combo-10 (Dtap, IPV, MMR, HiB, VZV, PCV, RV, HepB, HepA, Flu)	27	46	58.7%	40.9%	0	48.4%	0	64.7%	55.2%
Immunizations - Age 13									
Combo (MCV, Tdap)	51	59	86.4%	85.6%	0	88.1%	1	85.7%	87.5%
Well Child Visits - First 15 Months									
6 well visits before 15 months of age	35	38	92.1%	71.3%	0	75.4%	0	94.1%	90.5%
Well Child Visits - 3-6 Years									
At least one annual well exam in measurement year	184	221	83.3%	79.3%	0	83.7%	1	83.2%	83.3%
Well Child Visits - 12-21 Years									
At least one annual well exam in measurement year	243	318	76.4%	62.0%	0	66.8%	0	72.3%	79.6%
Lead Screening by Age 2									
At least one lead blood test by age 2	39	46	84.8%	80.1%	0	85.6%	1	88.2%	82.8%
Chlamydia Screening in Women - 16-24 Years									
At least one test for chlamydia in the measurement year	18	43	41.9%	62.9%	10	69.8%	12	52.9%	34.6%
Weight Assessment & Counseling - 3-17 Years (Non-Incentive Measure)									
BMI Percentile	655	758	86.4%	82.6%	0	88.0%	12	85.6%	87.2%
Early & Periodic Screening, Diag., and Treatment - 0-6 Years (Non-Incentive Measure)									
Expected screening in measurement year	523	618	84.6%	65.0%	0	80.0%	0	84.6%	84.6%
Immunizations - Age 13 (Non-Incentive Measure)									
Combo (MCV, Tdap, HPV)	28	59	47.5%	37.7%	0	46.7%	0	45.7%	50.0%
Number of Active Assigned Patients			1,139					551	588

Benchmark percentiles are based upon National HEDIS performance for Medicaid

Performance exceeds HEDIS 90th Percentile

Performance is between HEDIS 75th & 90th Percentile

PCN Quality Improvement Priority Recommendations - [Insert Practice Name]

Measurement Period: XX/XX/XXXX-XX/XX/XXXX | Prior Year Measurement Period: XX/XX/XXXX-XX/XX/XXXX

Published Date: [Insert Date]

Overview: The below quality improvement recommendations are based solely on the practice's current quality performance results.

			Improvement Benchmarks		75th Percentile Benchmark			90th Percentile Benchmark			Quality Improvement Recommendations		Measure Detail	
Measure	Your Practice Current Results	Prior Year Final Results	% Point Improvement	# of Pts to Improvement Goal	75th Percentile	Percentage Pts to 75th Percentile	Annual Patients to Meet 75th Percentile	90th Percentile	Percentage Pts to 90th Percentile	Annual Patients to Meet 90th Percentile	Priority Ranking	Comments	Num	Denom
Short Term Quality Measures														
Well Child Visits 3-6 Years	83.3%	80.2%	3.1%	11	79.3%	Met	Met	83.7%	0.4%	1	**1**	Use Vision Worklists to target overdue patients.	184	221
EPSDT (1 Annual EPSDT	84.6%	95.7%	-11.1%	31	65.0%	Met	Met	80.0%	Met	Met	**2**	Use Vision Worklists to target overdue patients.	523	618
Adolescent Well Care Visits	76.4%	76.9%	-0.5%	16	62.0%	Met	Met	66.8%	Met	Met	**3**	Use Vision Worklists to target overdue patients.	243	318
Mid Term Quality Measures														
Chlamydia Screening	41.9%	34.2%	7.7%	2	62.9%	21.0%	10	69.8%	27.9%	13	**1**	Update pre-visit planning process to add chlamydia screening orders for any females on contraceptives. Utilize the Vision Worklists target overdue patients when patients are in need of a well visit; complete screening at next visit.	18	43
Immunizations - Age 13 (MCV, Tdap)	86.4%	79.1%	7.3%	3	85.6%	Met	Met	88.1%	1.7%	1	**2**	Utilize the Vision Worklists identify patients in need of vaccinations.	51	59
Immunizations - Age 13 (MCV, Tdap, HPV)	47.5%	47.8%	-0.3%	3	37.7%	Met	Met	46.7%	Met	Met	**3**	Utilize the Vision Worklists or the HPV Immunization Patient Outreach Report (PCN Secure Portal) to help identify patients 12-12.75 years old that need to receive the HPV vaccine. Try bundling the adolescent vaccines together and not emphasizing the HPV vaccine.	28	59
Long Term Quality Measures														
Lead Screening by Age 2	84.8%	88.4%	-3.6%	2	80.1%	Met	Met	85.6%	0.8%	1	**1**	Update standard pre-visit planning process to order lead screening for patients under 2 years old in need of lead screening. Patients require one (1) capillary or venous screen before their 2nd birthday.	39	46
Asthma Medication Management (>=75% Controller) (Ages 5+)	36.4%	29.7%	6.7%	3	35.0%	Met	Met	43.2%	6.8%	4	**2**	Utilize the Vision Worklists to get patients in for their asthma office visits every 6 months (or more frequently as clinically appropriate).	20	55
BMI Percentile (3-17 Years)	86.4%	83.1%	3.3%	38	82.6%	Met	Met	88.0%	1.6%	13	**3**	Review the current process for coding BMI percentile.	655	758
Immunizations - Age 2 Combo 10	58.7%	60.5%	-1.8%	2	40.9%	Met	Met	48.4%	Met	Met	**4**	Utilize the Age 2 Childhood Immunizations Detail Report (located in secure portal) to target patients eligible for the Combo 10 vaccine series before their 2nd birthday. (Combo 10: DTap (4), IPV (3), MMR (1), HiB (4), Hepatitis B (3), PCV (4), VZV (1), Rotavirus (2 or 3*), Hepatitis A (1), Influenza (2)).	27	46
Well Child Visits First 15 Months (6+ Visits)	92.1%	88.1%	4.0%	2	71.3%	Met	Met	75.4%	Met	Met	**5**	Use Well-Child 15 Month Graduated Compliance Report and target those members with 5 visits. Schedule the next recommended visit before the family leaves the office. Consider scheduling multiple visits (or all 15 month well visits) at a time. Utilize appointment reminders to remind family of upcoming appointments. Ensure that the "By 1-Month" PCP visit is more than 14 days after the "3-5 Day" visit.	35	38

Practice Performance exceeds HEDIS 75th Percentile

Practice Performance exceeds HEDIS 90th Percentile

PCN Cost & Utilization Report - Risk Adjusted Impactful Admissions Visits Summary

Measurement Period: XX/XX/XXXX-XX/XX/XXXX

Publication Date: [Insert Date]

PCP TIN Name	Estimated # of Attributed Patients	Risk Score	Risk-Adjusted Non-Emergent Avoidable ED Visits/1000
[Insert Practice Name]	**2,195**	**1.2**	**17.7**
[Provider A]	1,215	1.2	12.9
[Provider B]	980	1.3	23.0
Proposed Target			**30.0**

Current practice rate is **above** Benchmark Goal

Current practice rate is **below** Benchmark Goal

PCN Cost & Utilization Report - Risk Adjusted Avoidable ED Visits Summary

Measurement Period: XX/XX/XXXX-XX/XX/XXXX
Publication Date: [Insert Date]

PCP TIN Name	Estimated # of Attributed Patients	Risk Score	Risk-Adjusted Non-Emergent Avoidable ED Visits/1000
[Insert Practice Name]	**2,195**	**1.2**	**72.6**
[Provider A]	1,215	1.2	67.9
[Provider B]	980	1.3	77.0
Proposed Target			**110.0**

Current practice rate is **above** Benchmark Goal
Current practice rate is **below** Benchmark Goal