Children's Mercy
PEDIATRIC CARE NETWORK

PEDIATRIC CARE NETWORK
ANNUAL REPORT


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:

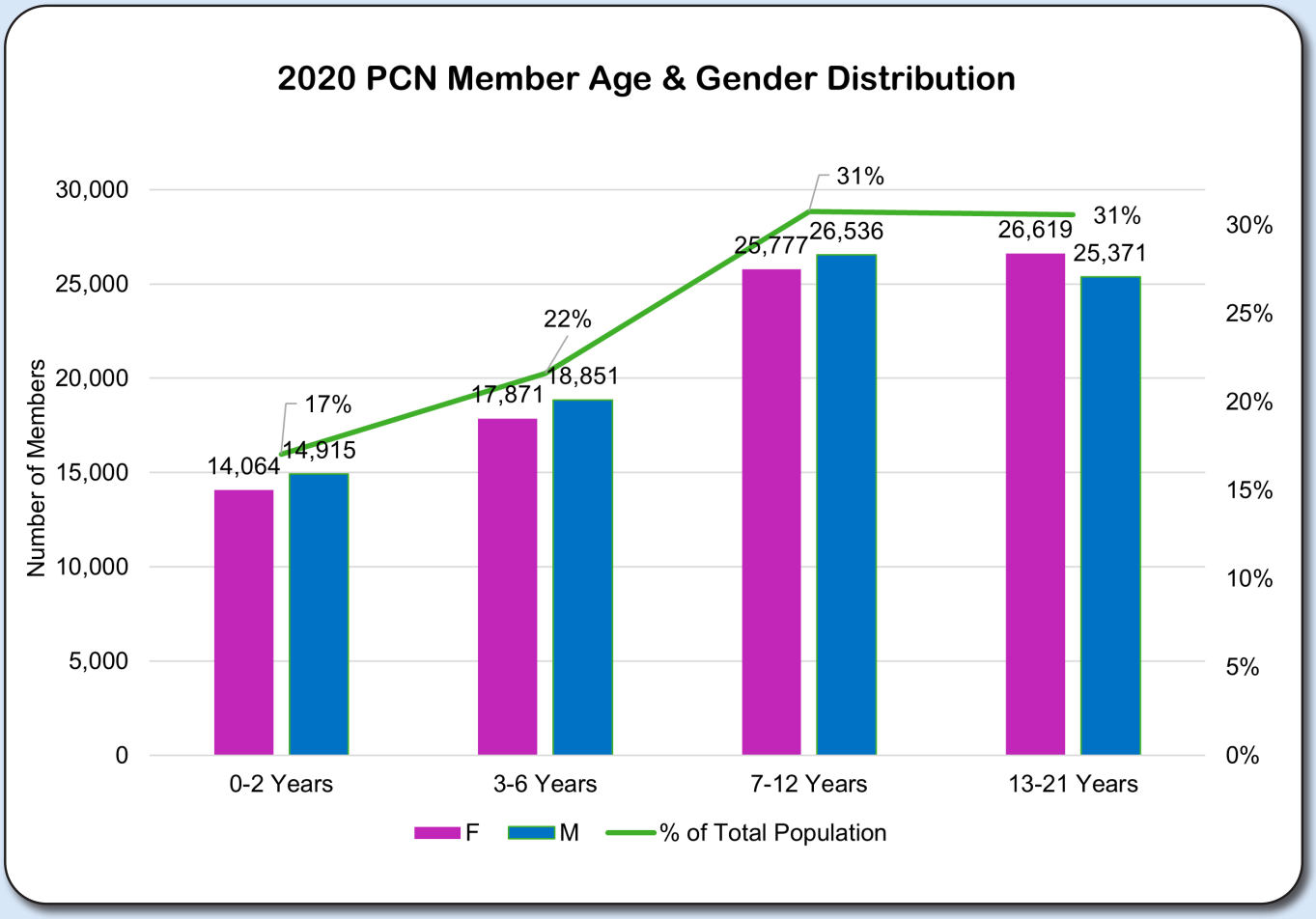
- Negotiating, procuring, and coordinating services and resources for patients and families with complex needs
- Facilitating care transitions across care settings
- Ensuring and facilitating the achievement of quality, clinical, and cost outcomes
- Assessing member needs and developing patient-centered 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 MissouriCare in February 2014, UnitedHealthcare Community Plan of Missouri in May 2017, and

UnitedHealthcare Community Plan of Kansas November 2017. PCN entered into a similar contract with Aetna Better Health of Kansas in July of 2019. As of December 2020, PCN managed approximately 170,000 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 December 31, 2020, the male to female ratio of the PCN population is roughly 50% and the most concentrated population (approximately 61%) 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 2020.

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, twelve Care Team members have case management certification, as well as one certified asthma 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

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

Population Health Network Team and Network Representatives

The Population Health Management Network Representatives (Network Reps) work with the Primary Care Practices to help facilitate practice transformation, which includes patient-centered medical home concepts as well as population health for the practice. Each representative is assigned to a Pediatric Care Network (PCN) Primary Care Provider (PCP) practice in the states of Missouri and Kansas. They assist each practice in understanding the Medicaid contracts and provide a streamlined communication process with the contracted Managed Care Organizations (MCO) for issues such as coverage, claim issues and eligibility issues. In addition, they support practice management processes of each PCN practice with the goal of improving member quality outcomes.

Each Network Rep conducts several meetings with his/her assigned practices to explore and train the practice staff on the use of our population health management software – Innovaccer. This population management software tool gathers data from contracted payers, providers, and other

sources, including information from the electronic medical records of each practice and Children's Mercy Hospital and Clinics. This data is then available to the practice, in real time, so that they have all the information on each of the members assigned to their PCPs. This data also provides the opportunity for real time data analytics on the quality metrics that are so important to each member and whether the patient is meeting the frequency of well child exams and other services that meet the quality value-based contracts. For example, during the pre-visit planning for a patient, the practice can ascertain immunization status, Emergency Room utilization and other data that they may not have in their own practice record.

This tool and understanding of its capabilities is a great tool for each practice that is looking to maximize quality outcomes to the pediatric population we serve.

The scope of work for the Population Health Network Team includes:

- Provide training on the population health management tools to support population health and PCMH initiatives
- Conduct tri-annual provider practice meetings to review quality metrics and opportunities to impact and improve quality metrics
- Maintain timely communication and information regarding the performance profile review for each assigned practice
- Instruct and support PCMH concepts and ongoing sustainability of processes as appropriate
- Maintain accurate PCN practice provider status and update provider directories
- Facilitate a streamlined, non-redundant credentialing process
- Assist the PCN provider office with claims issues and eligibility issues as the liaison between practice and contracted MCOs

Behavioral Health Specialists

When delegated for Behavioral Health, PCN additionally has the role of the Behavioral Health Specialist. The Behavioral Health Specialists are clinically licensed mental health professionals whose primary duties are to perform prior authorization and outreach functions for inpatient and outpatient behavioral health services, using evidence-based clinical criteria. The Behavioral Health Specialist works in collaboration with care providers through education on the prior authorization process, facilitation of referrals to network providers and services, and outreach to identify, screen, and engage members with complex behavioral health needs for enrollment into case management programs.

The scope of practice for Behavioral Health Specialists includes:

- Receive behavioral health related prior authorization requests requiring clinical review and enter determinations into online documentation system
- Facilitate successful transitions of care for members and families at times of discharge from acute and residential behavioral treatments including assessing barriers, facilitating discharge planning, and promoting a seamless plan of care, which is communicated to all Care Team members
- Support functions of the care facilitation team required to manage assigned tasks
- Conduct an in-depth biopsychosocial assessment of members requiring high level intensive behavioral health treatment.
- Follow a care planning process to identify patient-centric goals and establish priorities
- Facilitate access to behavioral health and substance abuse treatment resources
- Establish and maintain collaborative relationships with community behavioral health providers
- Partner with applicable entities on statewide behavioral health treatment process improvements behavioral health treatment process improvements

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 **156 CEUs** were obtained in 2020. The following are some of the topics and educational offerings attended by Care Integration staff.

- Advocacy Core Competency - Advance Directives: Social Work Role and Ethical Considerations
- Opioid Stewardship and Medication Safety
- "Not all Steroids Make You Big: Adrenal Suppression from Inhaled Corticosteroids"
- Behavioral Addictions
- Trauma Informed Care: Awareness
- Drug Dose Selection for Patients with Obesity in the Outpatient Setting
- Adolescent Relationship Abuse: Safety in Relationships
- Trauma Informed Care: Early Brain Development
- The Diagnosis and Treatment of Obsessive-Compulsive and Related Disorders
- The Diagnosis and Treatment of Trauma and Stressor Related Disorders
- Radical Solidarity: Moving from Ally to Accomplice
- Update on Controlled Substance Diversion Trends and Best Practices
- The Diagnosis and Treatment of Anxiety Disorders
- The Bisexual Client: Trauma Focused Care
- Integrating Mindfulness into Clinical Practice
- Trauma and Stressor Related Disorders
- Psychotic Disorders
- Psychosocial Intervention for Adolescent Spine Surgery: The SurgeryPal Study
- Pediatric Restraints and Seclusion
- Crisis Prevention through Verbal and Nonverbal De-escalation Strategies
- Eating Disorders
- Care of the Pediatric Patient with Suicidal Ideation
- Pediatric Restraints and Seclusions
- Human Factors: Empathy Science
- Addressing Diversity, Equity, & Inclusion in Research
- Implementing Trauma Informed Sensitive Practices 2020
- A Beautiful Day in the Neighborhood: Journey Toward a Trauma Informed & Developmental Care NICU
- Ethics in Nutrition Support
- Cultural Humility: A Journey Towards Health Equity and Trauma-Informed Healing
- Practical Tools to Incorporate Trauma Informed Care
- Sentinel Injuries of Infants: Minor Injuries, Major Concern
- Ethics for Certified Case Managers
- Social Determinants of Health
- Understanding Presentation, Diagnosis and Treatment of Mental Illness in African American Adolescents
- Trauma Sensitive Practices with Victims of Sexual Assaults and Patients in a Mental Health Crisis
- Call to Action: Climate Change and Equity in Kansas
- Disparities in Healthcare for Black Mothers and Infants
- Diversity & Inclusion Series (Culture, Disabilities, Gender, Generations, LGBTQ, Micro-Messages, Religion, and Veterans)
- Equity's Role in SDOH Interventions: Advocacy and Systems Change
- Suicide Prevention Protocols for Juvenile Justice Youth
- Cultural Humility: A Journey Towards Health Equity and Trauma-Informed Healing
- Leadership: Stuck Between a Rock and a Hard Place
- Supporting Transgender Youth to Navigate Healthcare
- Working with Suicidal Clients Using Motivational Interviewing
- Trauma Informed Care Specific Protocol Review
- Collaborative Relationships to Combat Human Trafficking
- It's the Family, Not the House: A Pediatric Liver Transplant Network
- Youth Suicide Case Studies: Risk and Resiliency
- COVID 19: Where Are We and What is Ahead?
- Radical Solidarity: Moving Forward as An Intervention Bystander
- Preventing Suicide: A Technical Package of Policy, Programs and Practices
- Healthy Use of Electronic Devices for Kids
- Western Schools-Humor in Health Care: The Laughter Prescription
- Trauma Informed Care
- Race & Ethnicity in Academic Medicine: Calling Out the Silent Curriculum
- DBT in the Acute Setting
- Equine Assisted Psychotherapy
- Transforming Trauma: How to do this Work and Sustain
- The Cumulative Toll & Exposure Response
- Practical Issues in Suicide Screening and Risk Assessment
- Asthma Education
- Diversity and Inclusion Series/ Understanding Dynamics of Differences
- Calm Through the Storm: Coping Well Through a Pandemic
- Supported Decision Making and Guardianship
- Immigrant and Refugee Families: Addressing Culturally Sensitive Strategies in a Healthcare System
- Laws and Ethics
- Advocating for Children During the COVID-19 School Closures
- Suicide Assessment for Clinicians: A Strength-Based Model
- Effective Techniques for Managing Highly Resistant Clients
- Common Psychiatric Diagnoses and Treatments: What Healthcare Social Workers Need to Know
- Youth Peer Violence Cyberbullying During the COVID-19 Pandemic: An Early Look
- The Pandemics of COVID-19 and Racism: Our Children are Watching
- Intimate Partner Violence Core Competency Part One: Safety Planning and Dynamics of IPV within a Pediatric Setting
- Health Equity: Using Health Literacy to Reduce Disparities
- Assessing Suicidal Thoughts and Behaviors
- Helping Vulnerable Families Navigate the Healthcare System
- Supporting Intimate Partner Violence Survivors and Their Children During the COVID-19 Pandemic
- Ethical Considerations When Working with Refugee and Immigrant Families
- Diversity and Inclusion Series Addressing Social Determinants of Health in a Pediatric Healthcare System
- How to Be an Ally in Addressing Racism and Discrimination
- Cultural Humility

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.

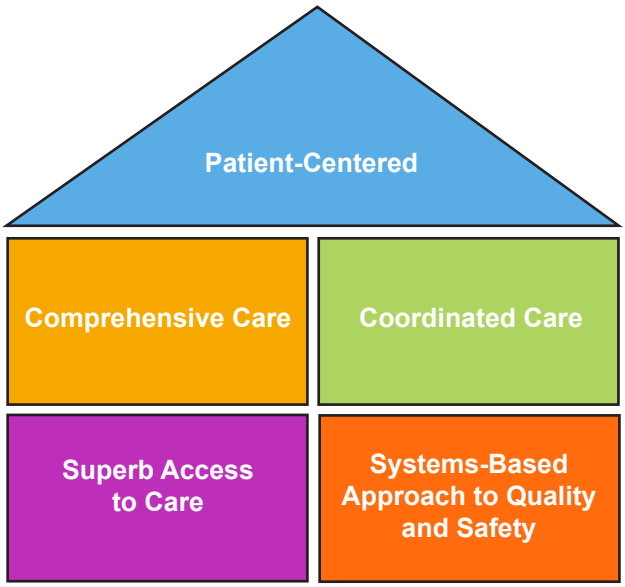
The PCMH Program monitors the implementation of care processes and development of practice level PCMH infrastructure, meeting medical home qualification criteria, within the secure PCN Provider Portal. This program began July 1, 2014 with customized quarterly progress reports provided to the participating 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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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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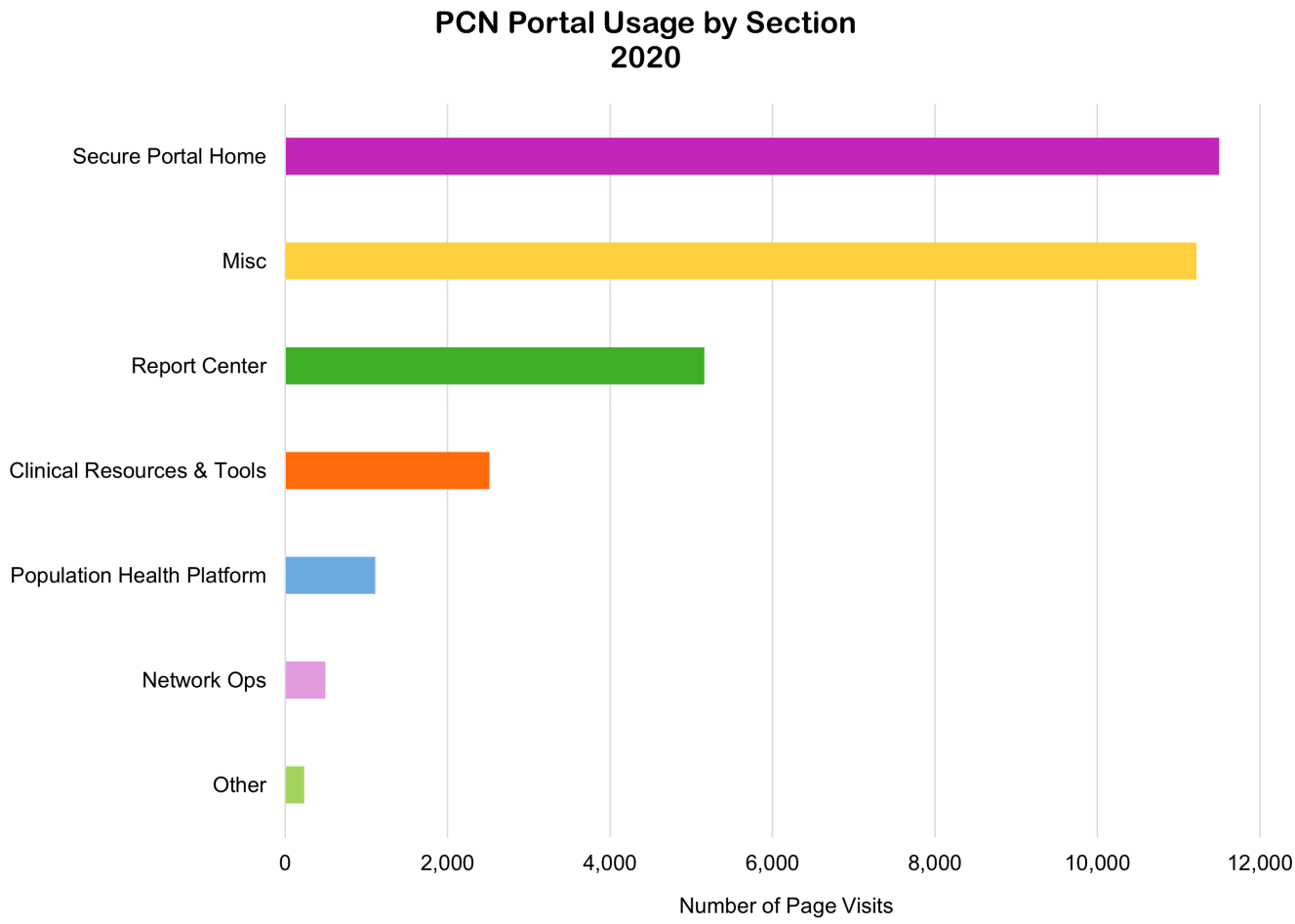
Provider Portal

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. 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.

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 measure 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 Per Month, Admissions/1,000, Day/1,000, Average Length of Stay, ER Visits/1,000, etc.) at the network, practice, and provider level. PCN continues to use financials 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 2020, 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 2020, 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.

Patient Outreach Initiative (InConnect)

The PCN transitioned past Patient Outreach Services work from Evolent Health to Innovaccer in 2020. The service uses interactive voice response (IVR) technology to place a series of automated calls to drive patient action. More than 52,000 outreaches were made to over 32,000 patients in 2020. The 2020 patient engagement rate (transferred to scheduling, given scheduling information, or told they were due for a well visit) increased 5 percentage points from 27% in 2019 to 32% in 2020 across all campaigns.

Triannual Performance Review

PCN continues to deliver actionable and meaningful cost and utilization data to PCN practices and providers. 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.

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, care is expected to be twice as costly for a patient with a risk score of 2.0 than a patient with a risk score of 0.9. 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.

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 several enhancements in 2020 to improve workflow for Care Teams.

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

- Online provider authorization requests were added. This new process allows providers to submit authorization requests electronically;
- Staffing notes and new health plan notes were added to member pages;
- The process of handling letters for both mailing and faxing was updated, including utilizing a printing vendor to print and mail letters and developing a new cloud-based faxing program to receive and send faxes. This allows staff to work remotely and socially distance.
- The ability to submit provider and member success stories directly into C.A.R.E. Web was added. This enhancement allows Care Teams to track their successes more easily and ensures that success story information is directly tied to the member.

Future Initiatives

In 2021, 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:

- Enhance staff task lists to allow for individualized organization and prioritization to further streamline intervention approaches.
- Adding in the moment reference text in screening/assessment pages to assist staff with sharing condition specific standard of care info
- Add to screening automation to help ensure all identified needs have individualized goals associated in Care Plan.
- Expand the function and utilization of the member alert to allow quick reference information to staff accessing the member's profile.
- Broaden provider access to allow more collaborative relationship between PCN Providers and other members of the care team

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 health care delivery model. In 2020, 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 virtual presentations for the PCN team.

MyResourceConnection

Beginning in 2019, PCN partnered with MyResourceConnection. In 2020, PCN continued this partnership. MyResourceConnection 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.

In 2020, PCN began a partnership with Aunt Bertha. Aunt Bertha is a nationally based social need directory platform that is free to the public. With just a zip code (no registration required), users can find hundreds of programs in their area in less than 5 seconds. This platform also allows individuals and their care teams to seek services with dignity and ease, to better communicate referrals to Community Based Organizations, and to track referral statuses. Aunt Bertha functionality includes notifications to the patient/family, Care Teams, and Community Based Organizations when/if resources have been provided. In 2021, PCN plans to tailor a customized Aunt Bertha website specific to pediatrics. This website will allow members and their families to seek services with ease and allow social need referrals to be tracked for the PCN member population.

Community Health Worker

In 2020, PCN continued its collaboration with KC Care Health Center 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.

In response to the coronavirus pandemic, the CHW discontinued home visits beginning in March 2020. Additionally, the Kansas City Missouri School District began teaching virtually in March 2020 and continued this virtual approach to teaching throughout the 2020 calendar year.

The CHW attempted to outreach to 161 members in 2020. Of those members, 65 enrolled in the CHW program (63 members enrolled in 2019). Of the 208 goals initiated with members in 2020, 29 were completed. The PCN team made 85 referrals to the CHW in 2020.

Members enrolled in the CHW program had lower emergency department use (44.1% decrease), inpatient visits (17.9% decrease), and total cost of care (3.3% decrease) after enrolling in the program. In addition to the success of the CHW program, the small denominator of members and member response to the coronavirus pandemic in 2020 contributed to those decreases. PCN and the CHW will continue to educate PCN members' caregivers on alternatives to utilizing the emergency department and encourage them to contact their primary care providers, utilize nurse advice lines, and visit trusted urgent care facilities.

Future Initiatives

The CHW program continues to partner with Central High School, but due to the coronavirus pandemic, referral rates in 2020 were very low. The CHW continued to engage with the PCN Care Teams during daily huddles, and Care Team members sent referrals to the CHW which she managed through phone communication. PCN will continue to evaluate the impact of the CHW program within the Kansas City Missouri School District and adjust the program approach as necessary based on coronavirus restrictions.

KidCare Anywhere

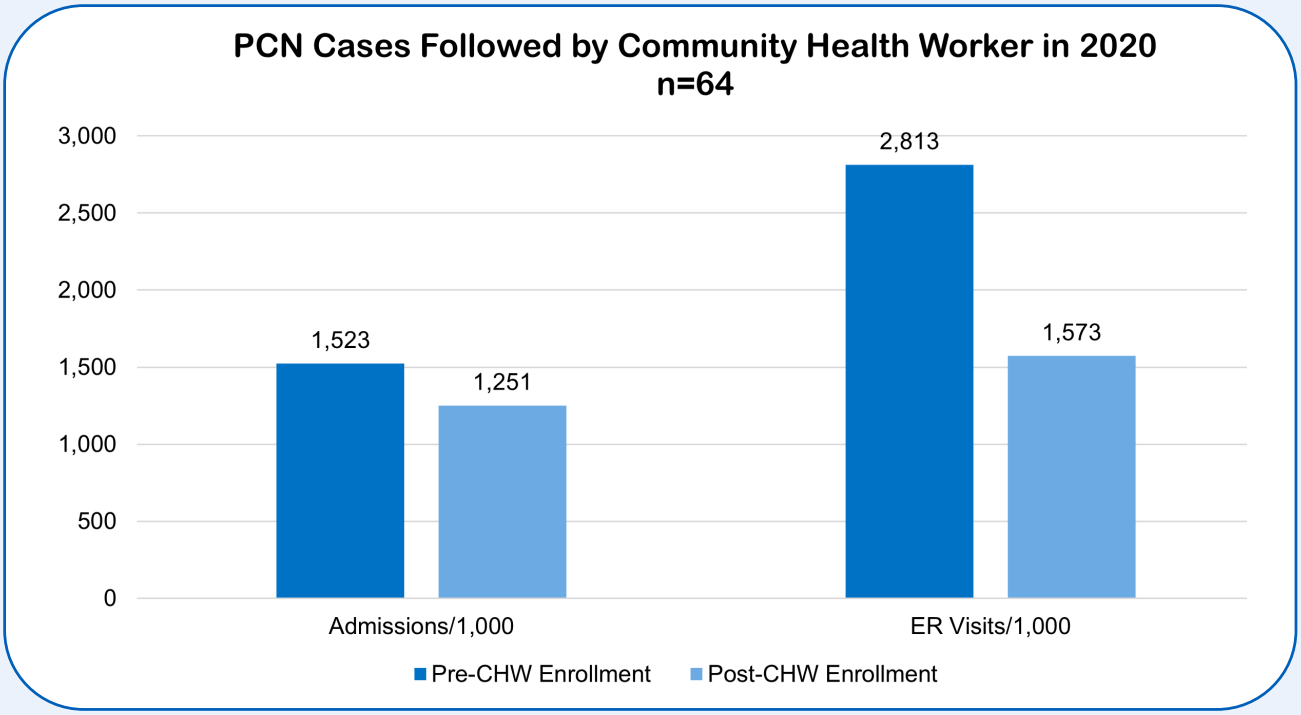
In 2017, PCN partnered with Children's Mercy Kansas City to develop a direct-to-consumer virtual health service, branded as KidCare Anywhere (KCA). The offering allows direct access to a Children's Mercy pediatric provider in minutes via smartphone, tablet, or computer.

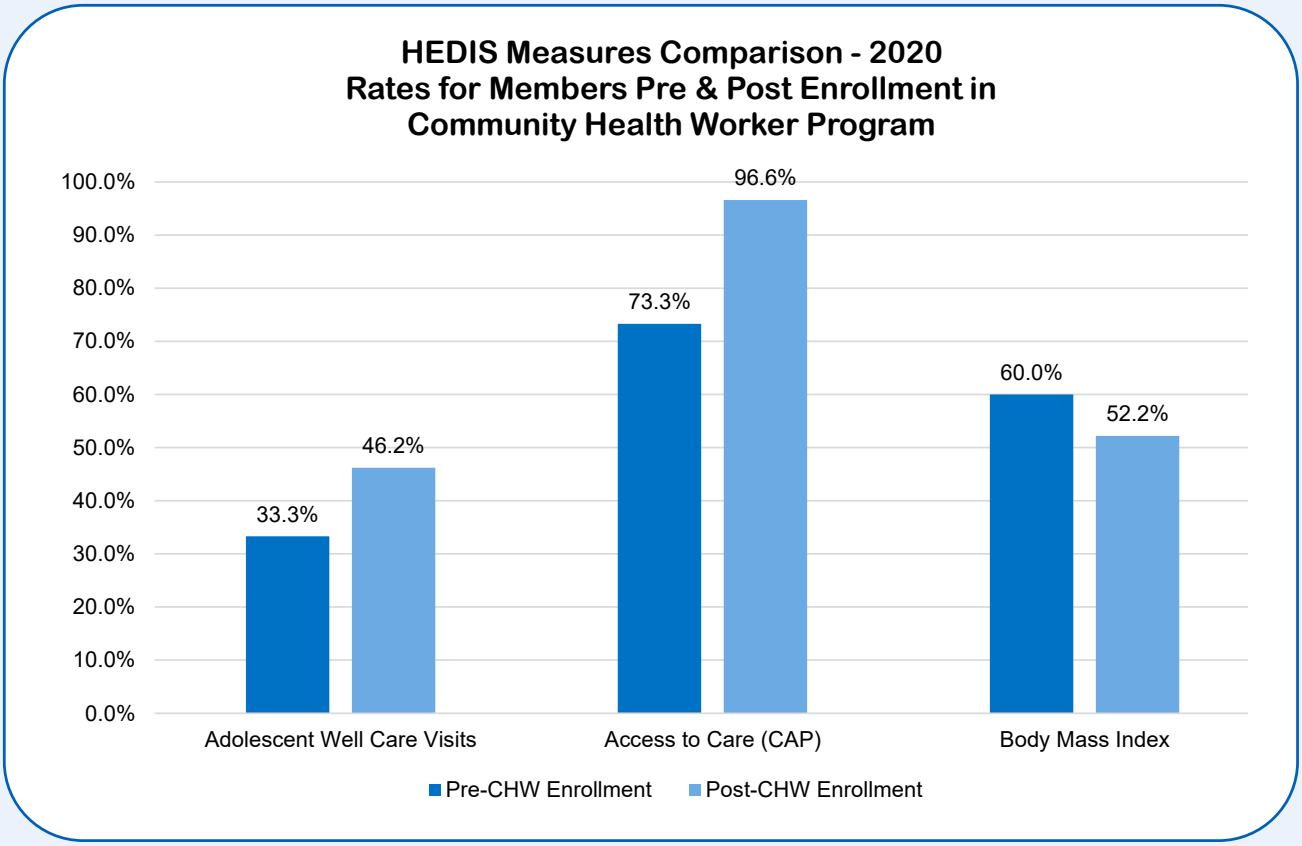
In response to the coronavirus pandemic, telehealth was brought to the forefront of the world's list of healthcare solutions. In 2020, KCA began expanding beyond the reach of the PCN population to include all Children's Mercy specialties and departments. In the future, providers from across Children's Mercy will begin using KCA as their connection point for virtual visits, both on-demand and scheduled. As an added incentive to the PCN member population, KidCare Anywhere will continue to be available to them at no cost.

Future Initiatives

PCN will continue to expand the KidCare Anywhere program to additional PCN patients, new divisions and providers within Children's Mercy Kansas City, and explore utilizing the platform for commercial insurance populations as well.

Community Health Worker Cases 2020	
Members	64
% Change Pre vs. Post	
Admissions/1,000	-17.9%
ER Visits/1,000	-44.1%
Total Medical PMPM	-3.3%





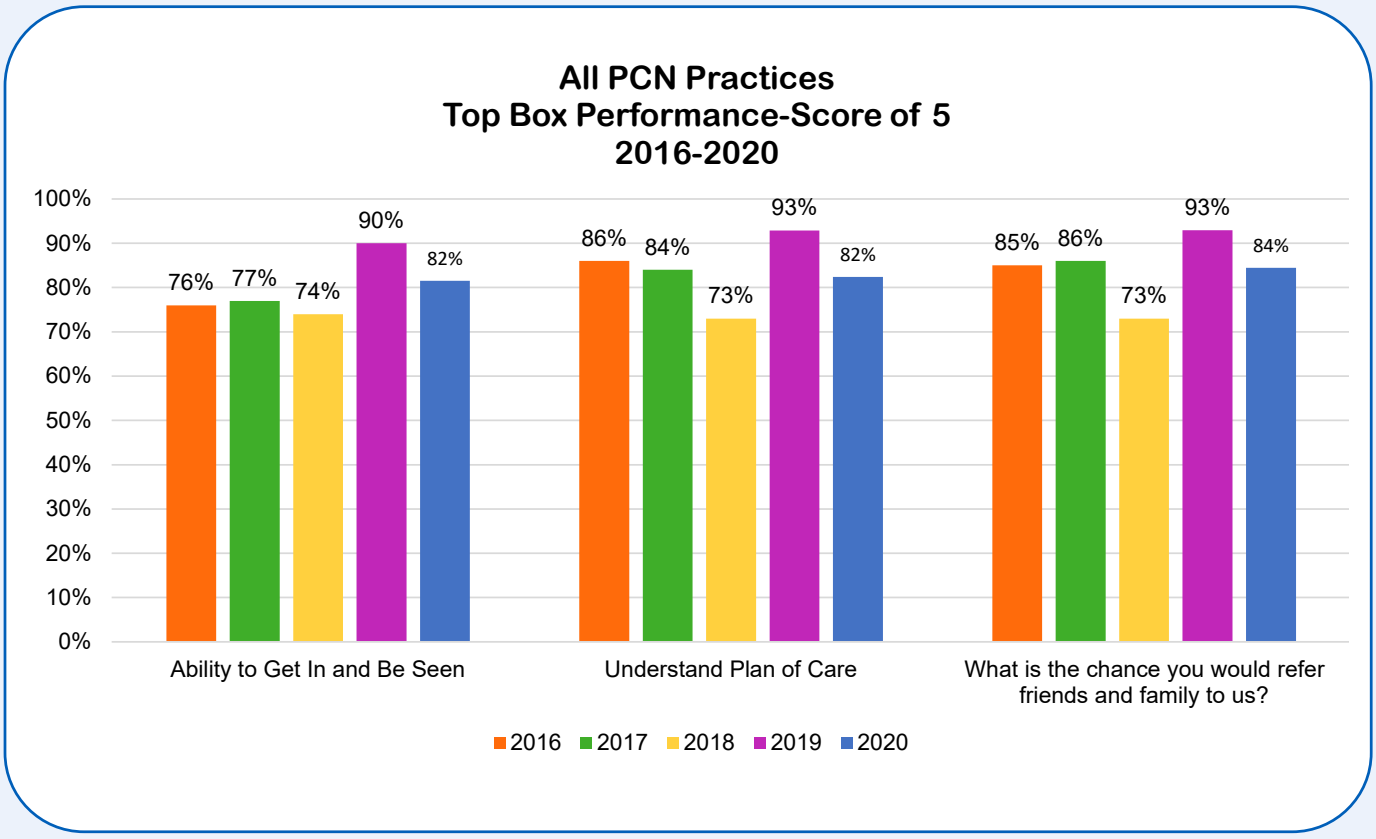
Patient Experience

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 (2016-2020). PCN has continued 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%

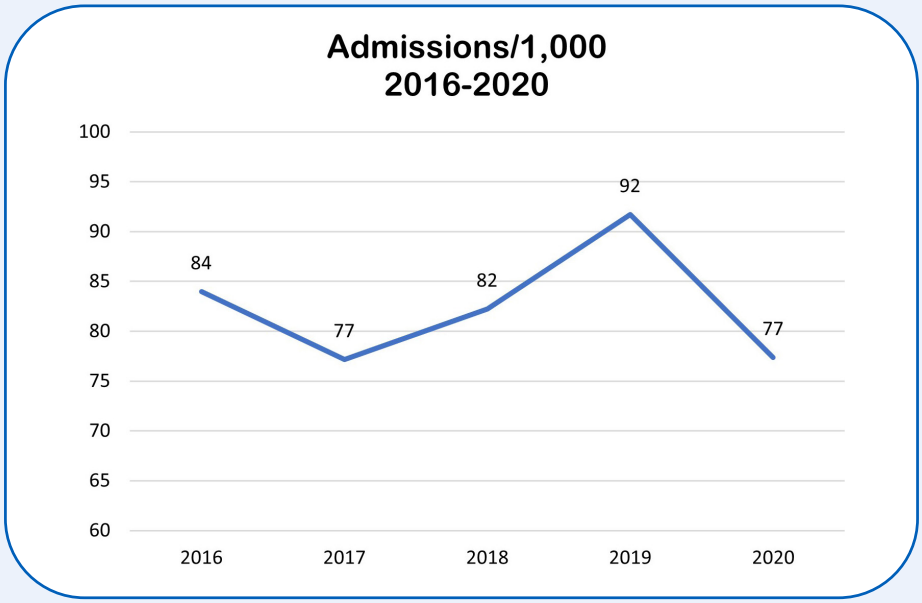
From a cost comparison perspective, the following metrics are evaluated:

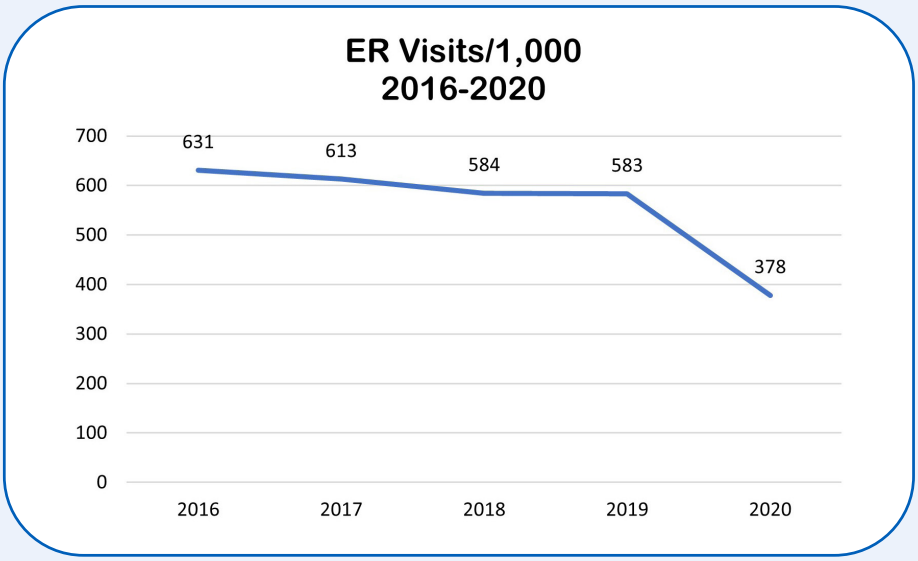
- PMPM (Paid Medical)
- Risk-Adjusted PMPM (Paid Medical)

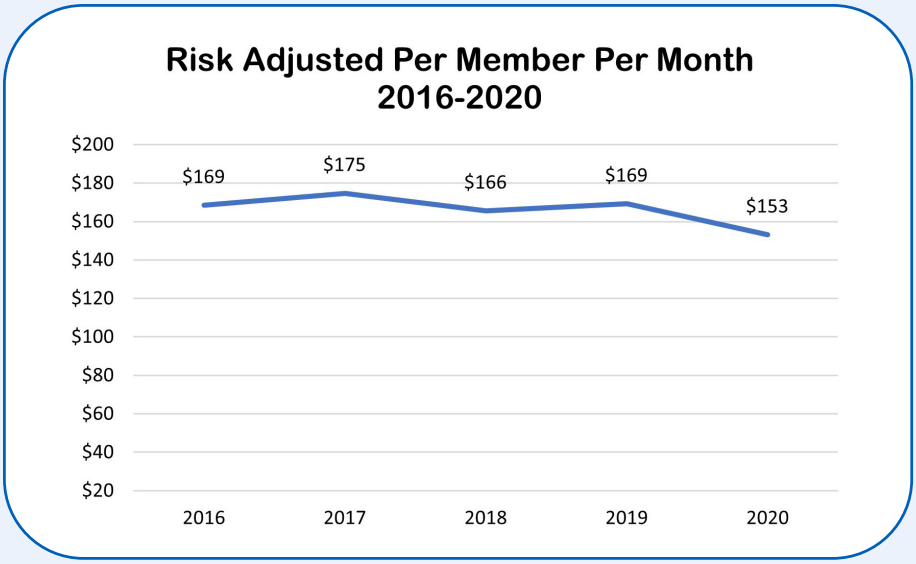
From a utilization comparison perspective, the following metrics are evaluated:

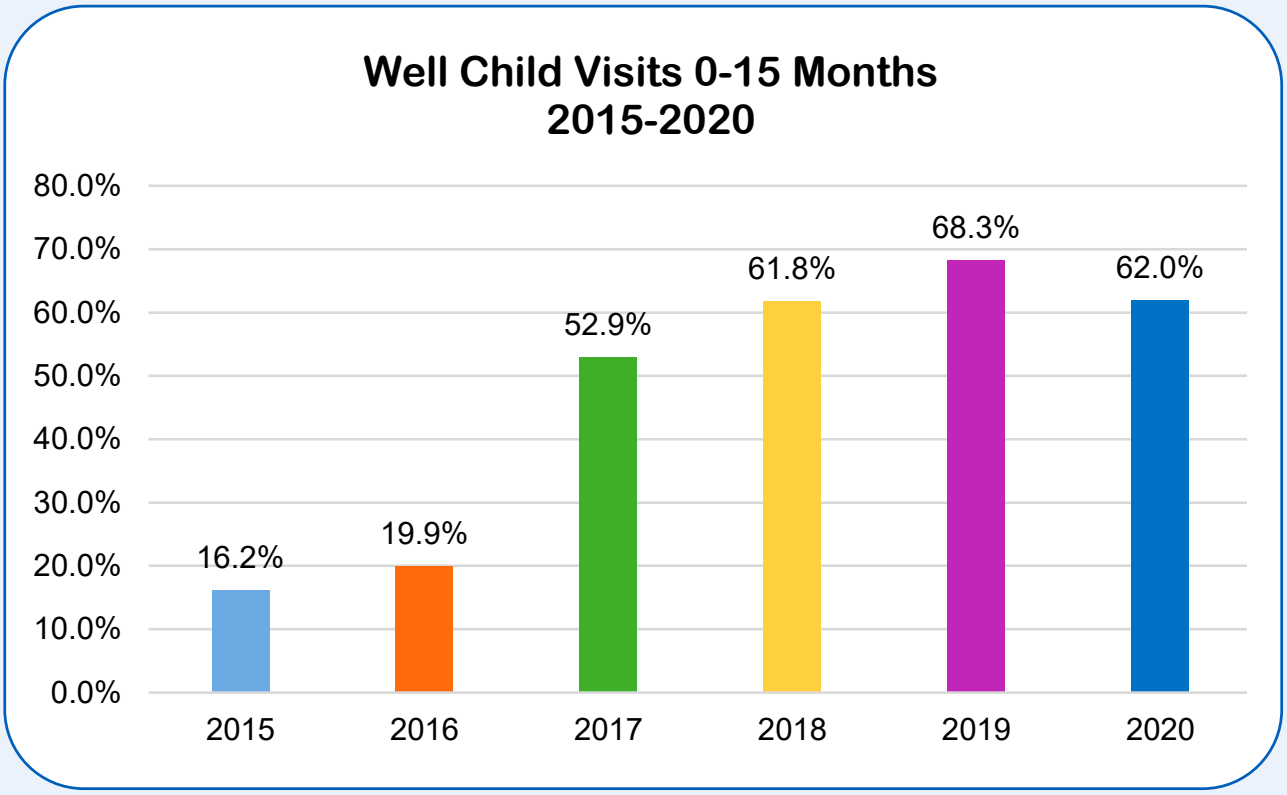
- Admissions/1,000
- Inpatient Days/1,000
- ER Visits/1,000
- Risk-Adjusted Avoidable ED Visits/1,000
- Risk-Adjusted Impactful Admission/1,000

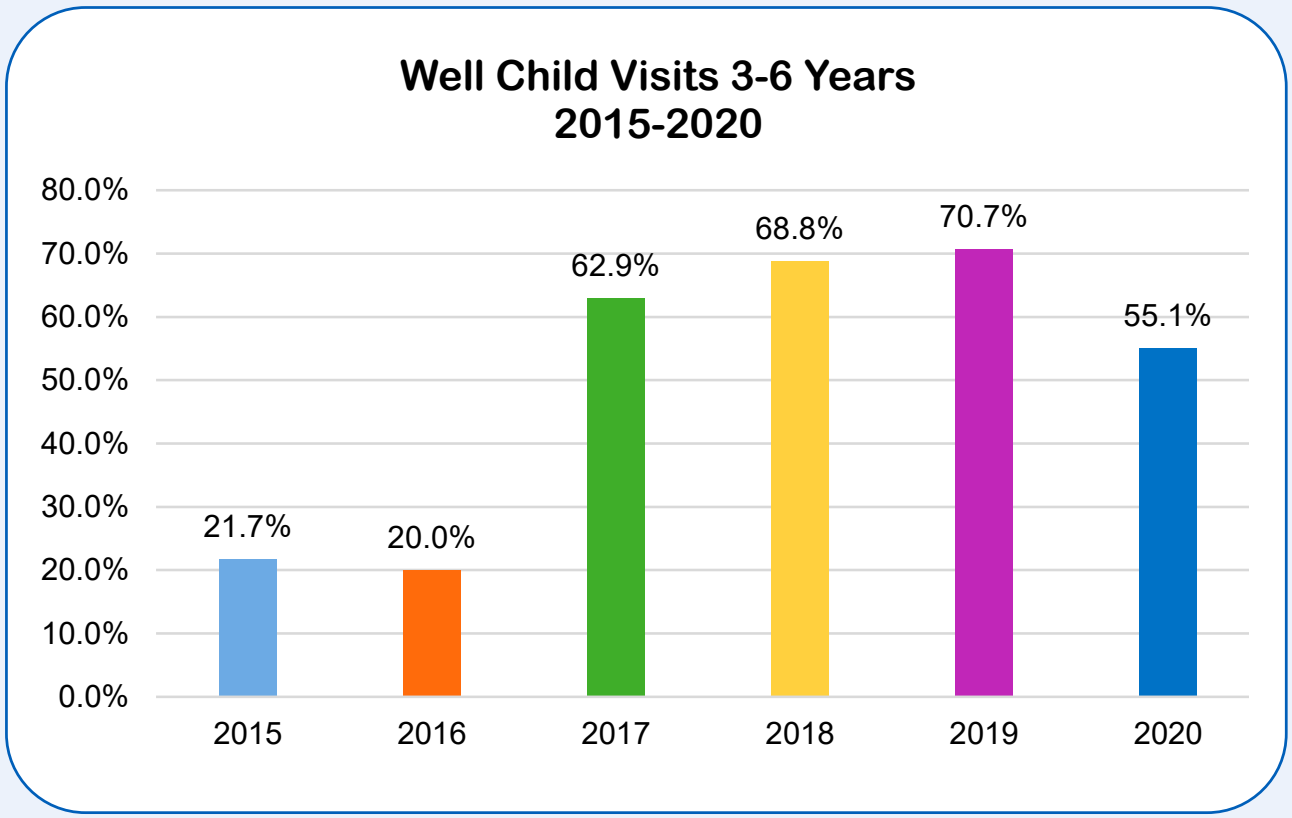
The following analysis includes the quality, cost, and utilization metrics above for all members in the PCN population. This includes data for Federally Qualified Health Centers (FQHCs) and hospital-based health systems.


Admissions/1,000
2016-2020
100
95
90
85
80
75
70
65
60
84
77
82
92
77
2016
2017
2018
2019
2020

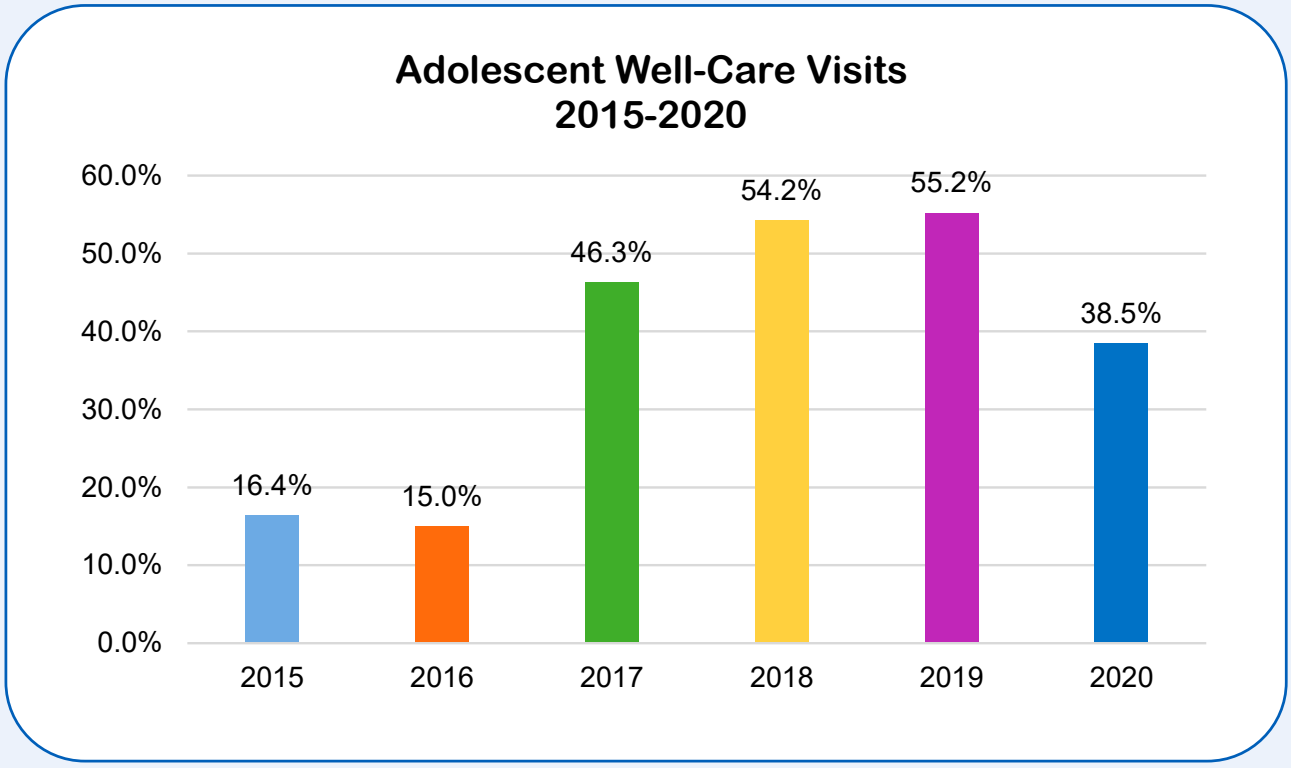

ER Visits/1,000
2016-2020
700
600
500
400
300
200
100
0
631
613
584
583
378
2016
2017
2018
2019
2020

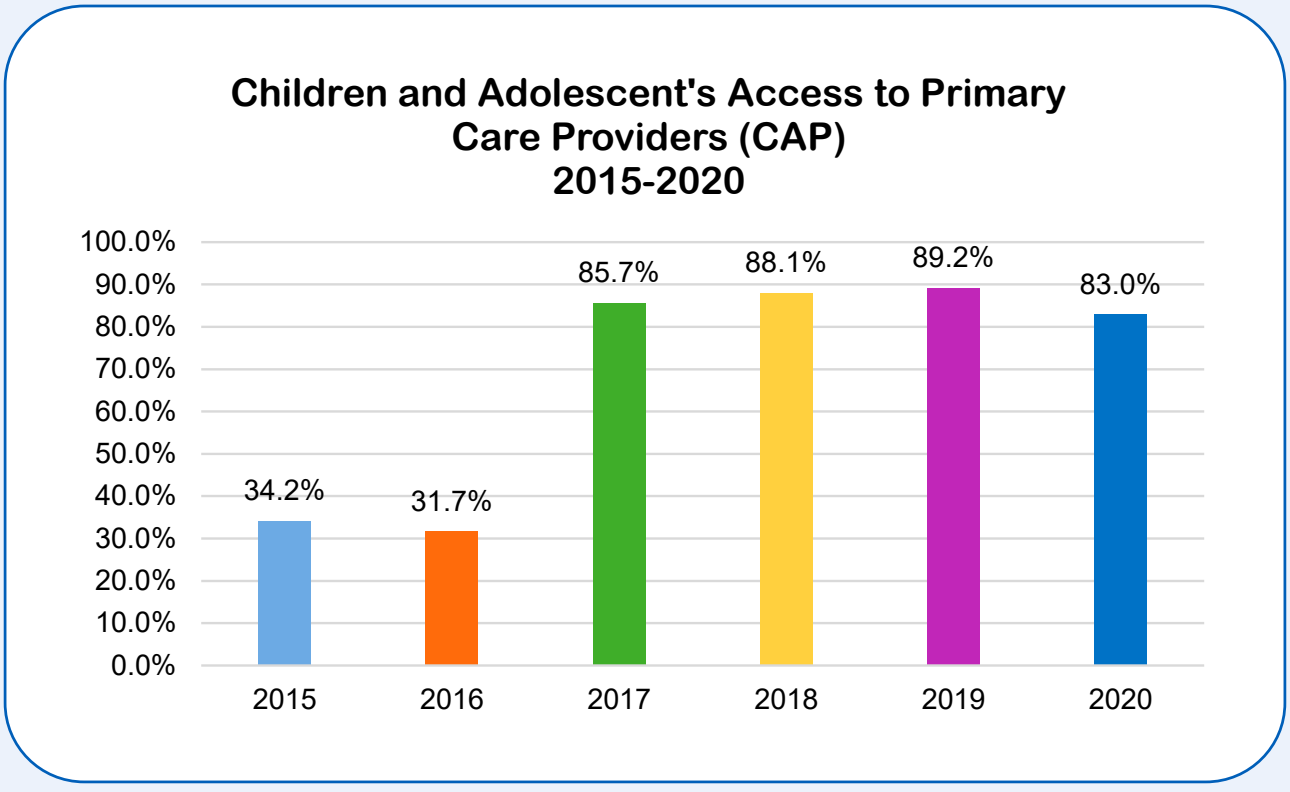

Risk Adjusted Per Member Per Month
2016-2020
$200
$180
$160
$140
$120
$100
$80
$60
$40
$20
$169
$175
$166
$169
$153
2016
2017
2018
2019
2020





***Please Note:** Due to the impact of the coronavirus pandemic, PCN has seen an overall reduction in all HEDIS measures in 2020. PCN will continue to monitor these trends and make appropriate adjustments to processes and quality improvement initiatives to improve these rates in 2021.





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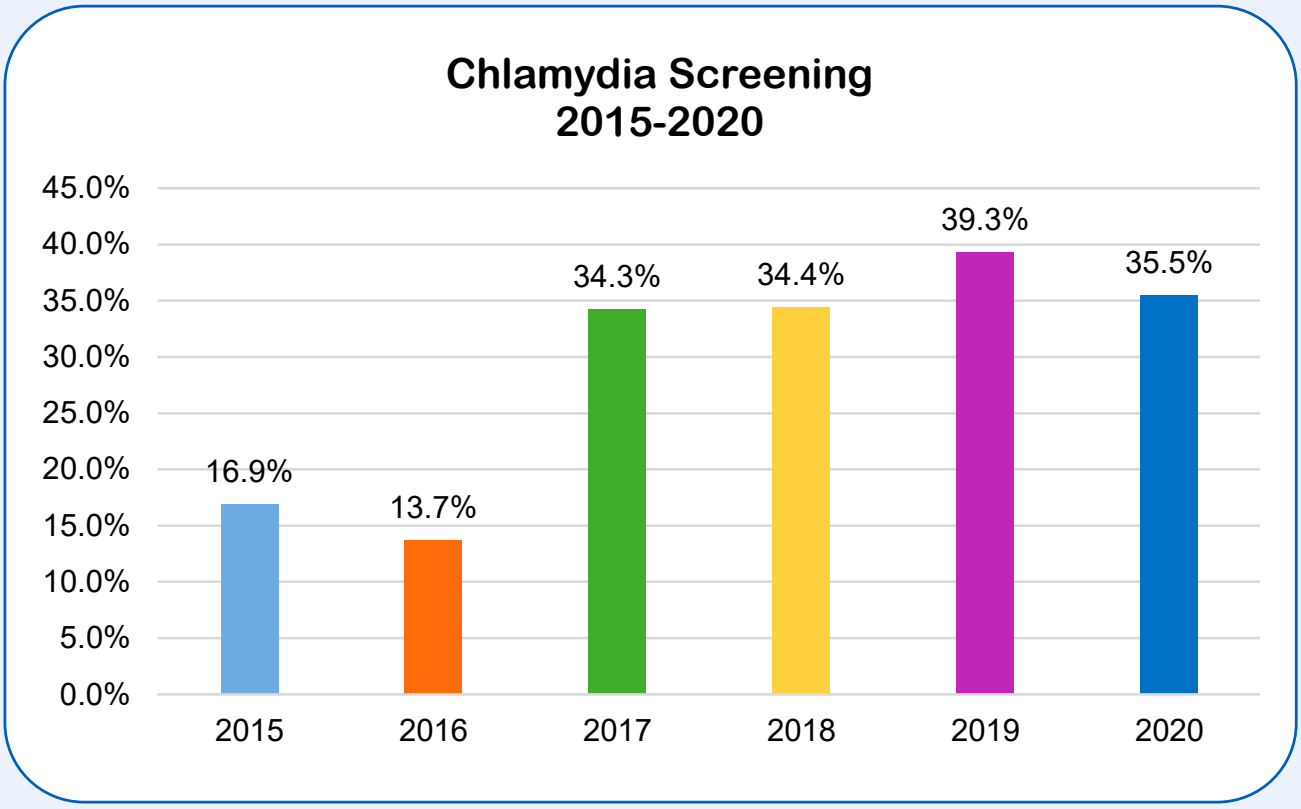
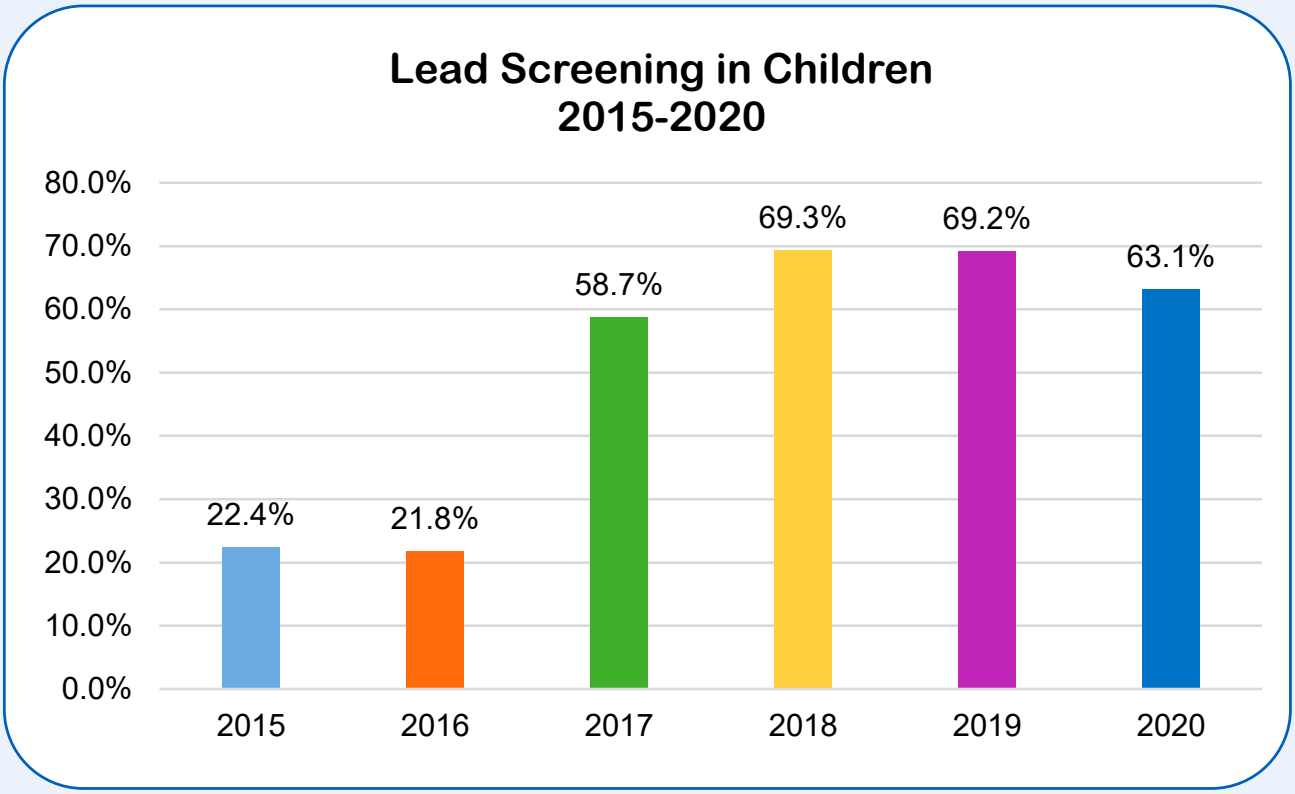
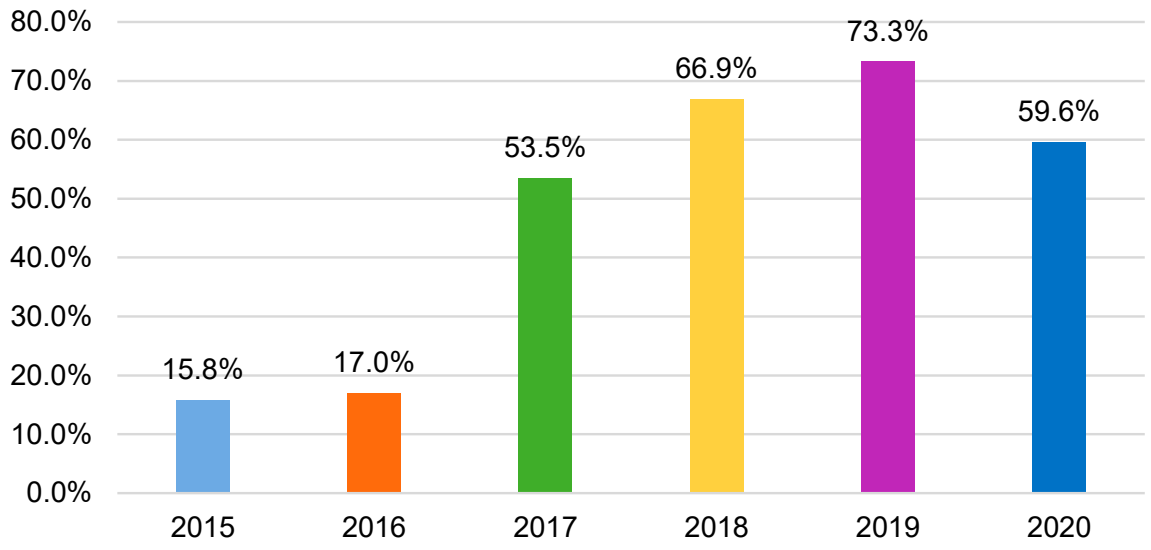


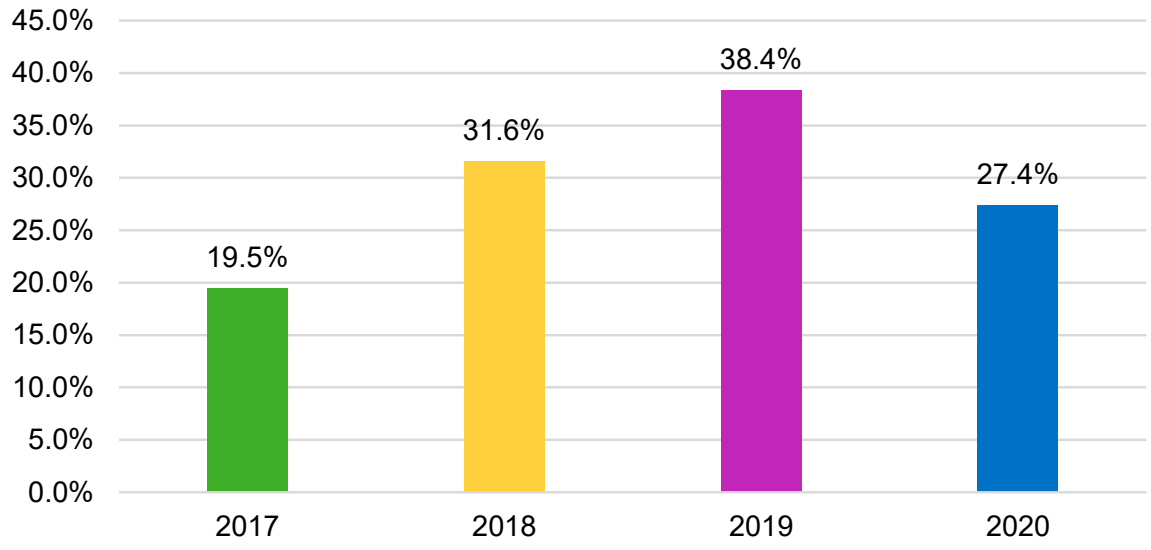


***Please Note:** Due to the impact of the coronavirus pandemic, PCN has seen an overall reduction in all HEDIS measures in 2020. PCN will continue to monitor these trends and make appropriate adjustments to processes and quality improvement initiatives to improve these rates in 2021.

Age 13 Immunization Combo 1 (MCV, Tdap) 2015-2020

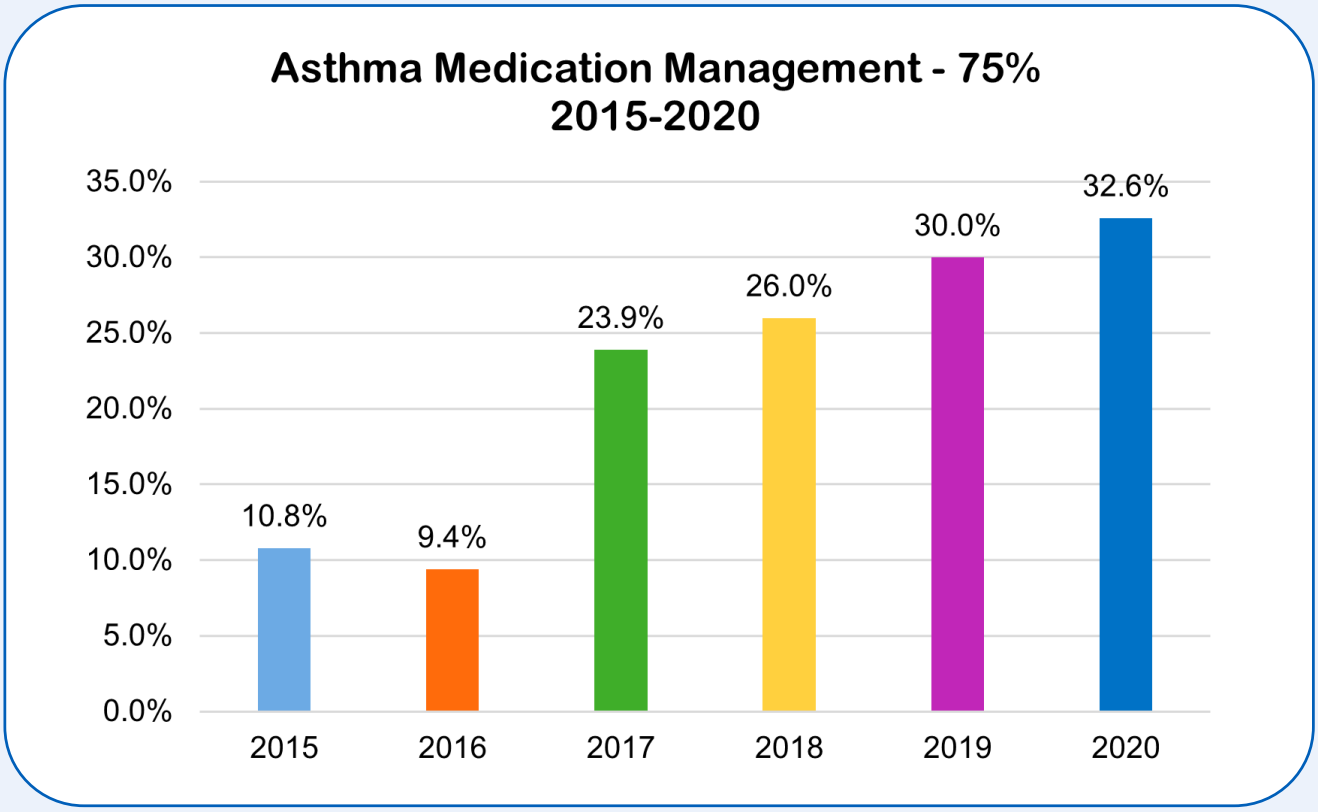


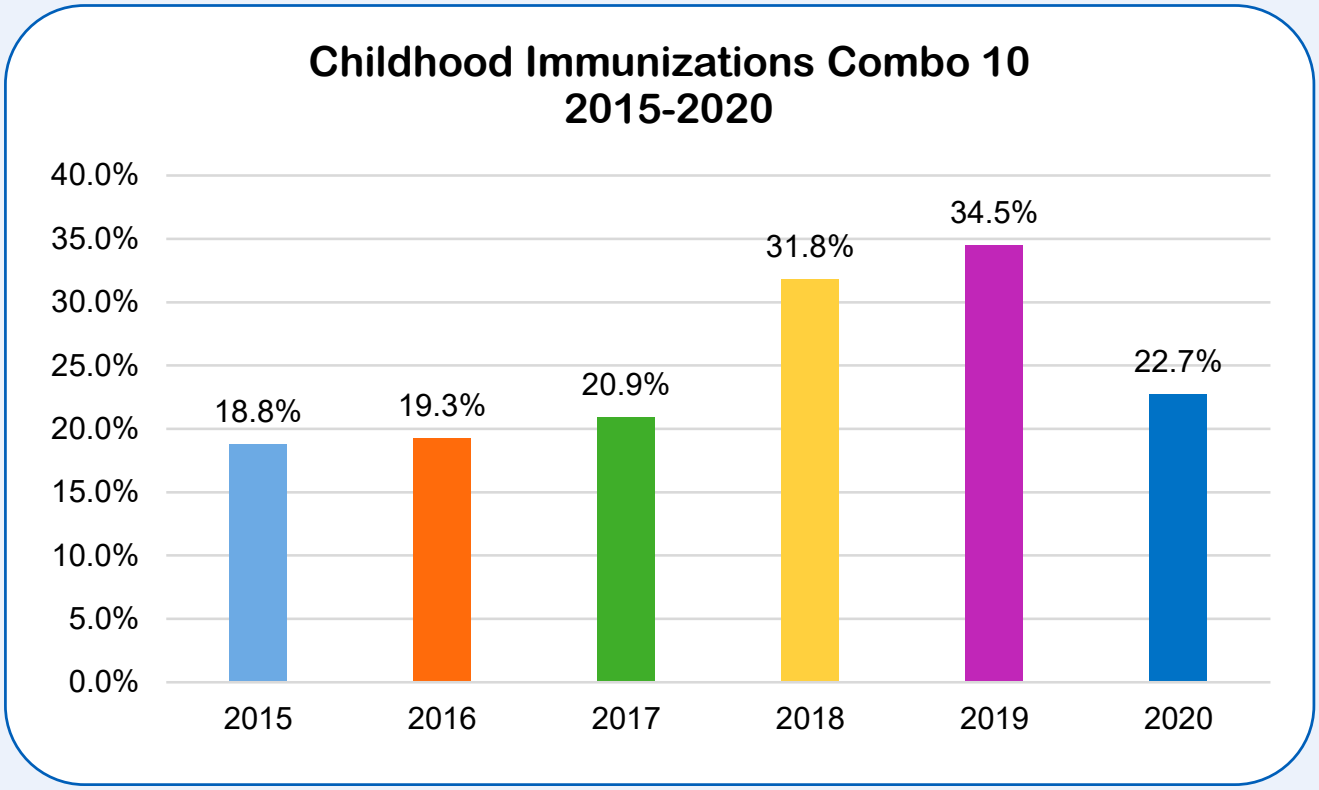
Age 13 Immunization Combo 2 (MCV, Tdap, HPV) 2017-2020



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

***Please Note:** Due to the impact of the coronavirus pandemic, PCN has seen an overall reduction in all HEDIS measures in 2020. PCN will continue to monitor these trends and make appropriate adjustments to processes and quality improvement initiatives to improve these rates in 2021.





***Please Note:** Due to the impact of the coronavirus pandemic, PCN has seen an overall reduction in all HEDIS measures in 2020. PCN will continue to monitor these trends and make appropriate adjustments to processes and quality improvement initiatives to improve these rates in 2021.

Future Initiatives

Due to the impact of the coronavirus pandemic, PCN has seen an overall reduction in member's accessing preventative care services. This has resulted in an overall reduction in all HEDIS measures in 2020. Based on the analysis of the program metrics, the following interventions will be included in PCN's 2021 initiatives:

- Continued delivery of actionable and meaningful cost and utilization data via triannual performance review to assist in identification of population preventative service gaps.
- Ongoing utilization of interactive voice response (IVR) technology to drive patient action towards preventative services.
- Enhance partnership with providers in enabling telehealth services and encouraging member utilization of such platforms.

3 Utilization Management

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

Utilization Management (UM) Program Overview

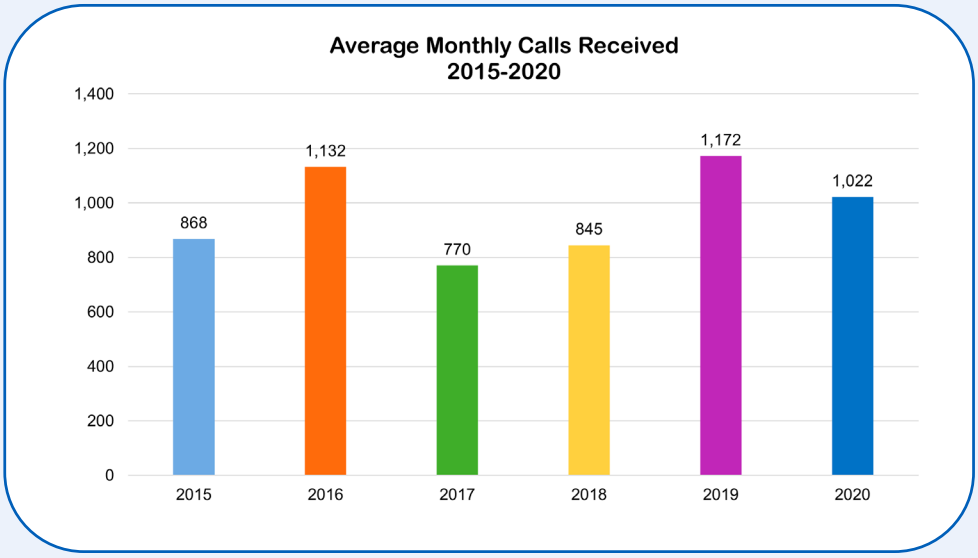
PCN performs prior authorization, inpatient review, discharge planning, and transitional care planning. Both clinical and non-clinical staff perform prior authorization functions. Non-clinical staff assist with verifying eligibility, entering authorization information in the online system, and faxing 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 related guidelines or policies are sent to the Medical Director for review and final decision. The Care Integration Manager conducts staff audits and oversees 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 one year meet or exceed an accuracy level of 95% or higher. In 2020, 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 in monitored by the Care Integration Manager, and call statistics are reviewed monthly to ensure calls are answered according to standards.

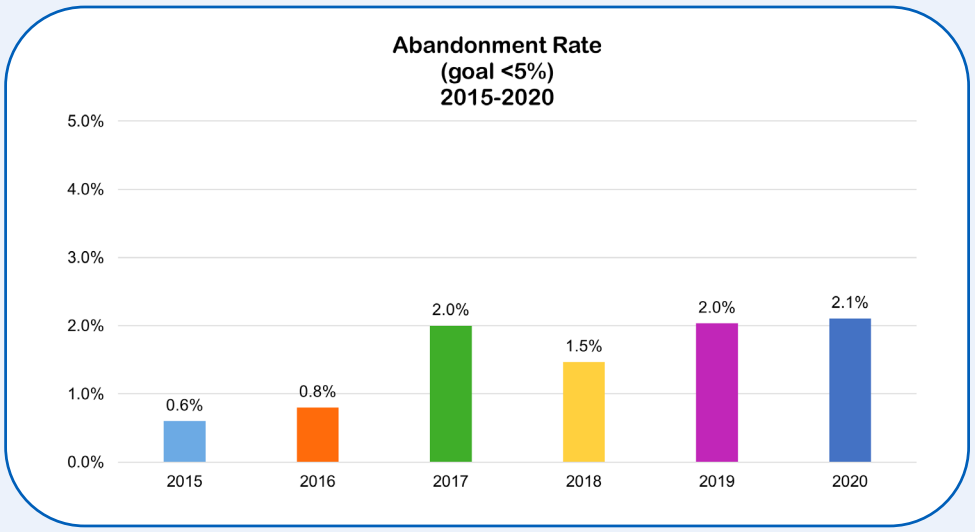
In addition to process measures, PCN monitors utilization trends for the population to ensure appropriate utilization of services occurs. To monitor for under-utilization of services, PCN relies on review of preventive services, outpatient services, and PCP office-based services. Additionally, PCN monitors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

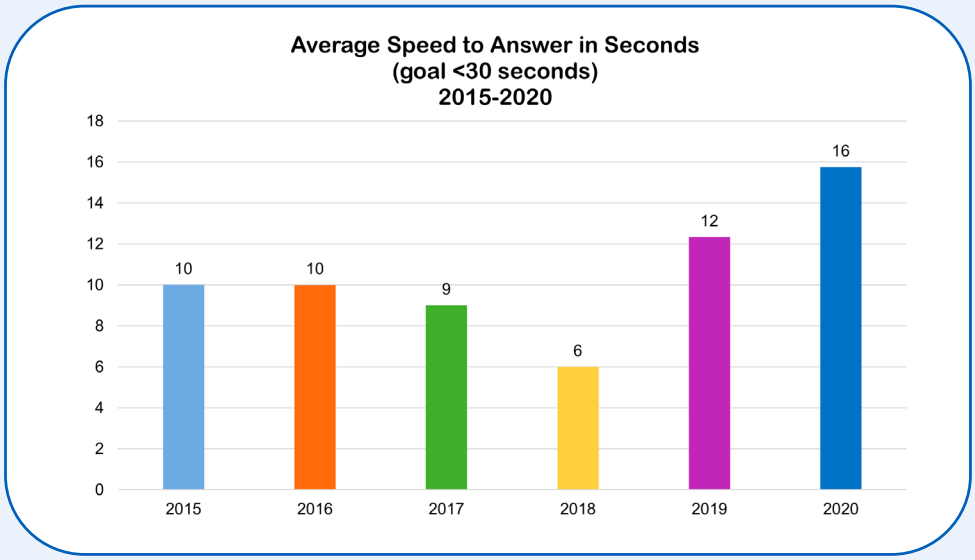
Program Measures

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 2020, the phone statistics remained consistent and well within the benchmarks. The average number of calls received monthly in 2020 decreased by 48.2% from 2019. Additionally, denials for outpatient services remained consistent from 2019 to 2020.

Precertification Phone Statistics

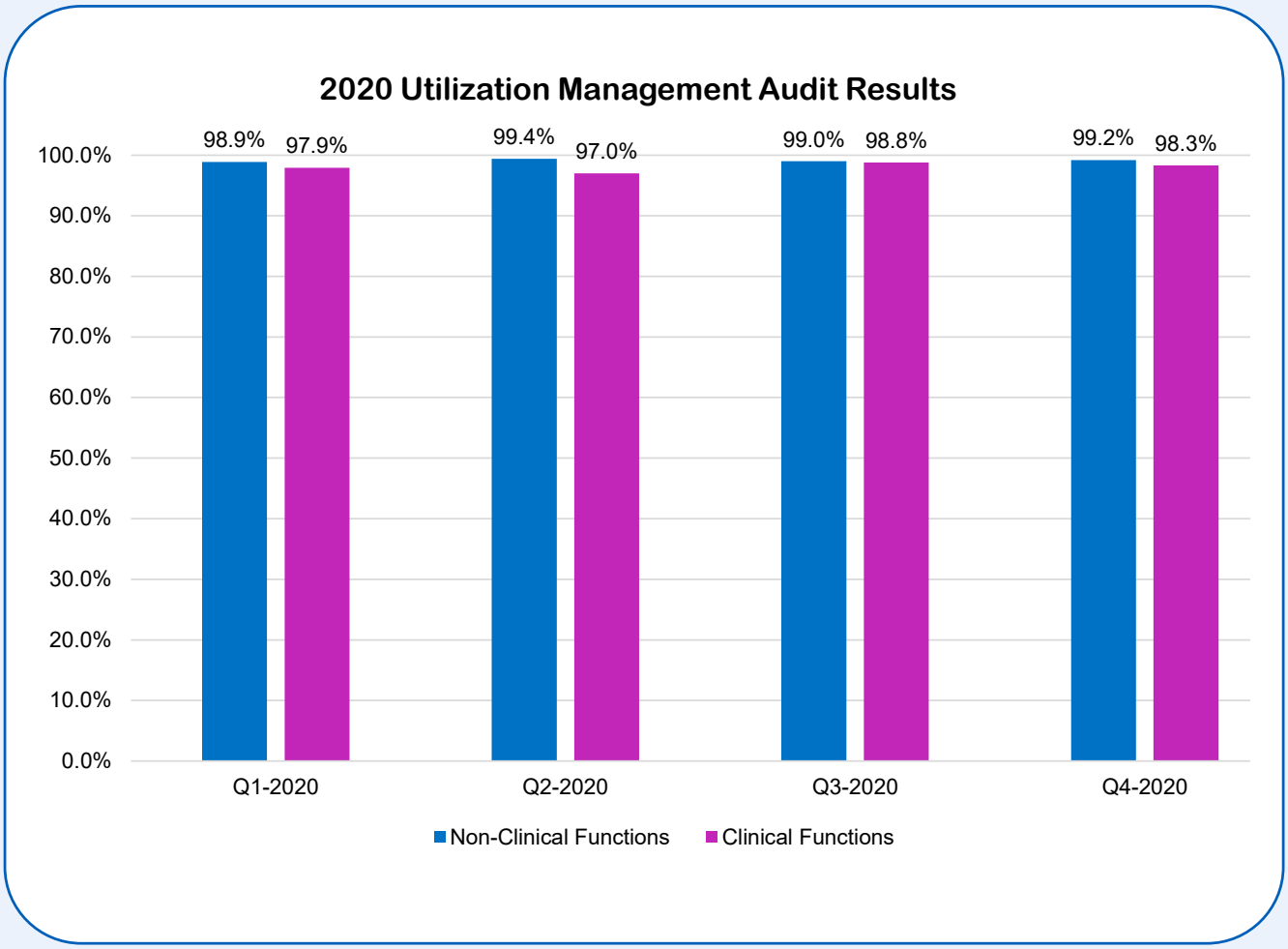




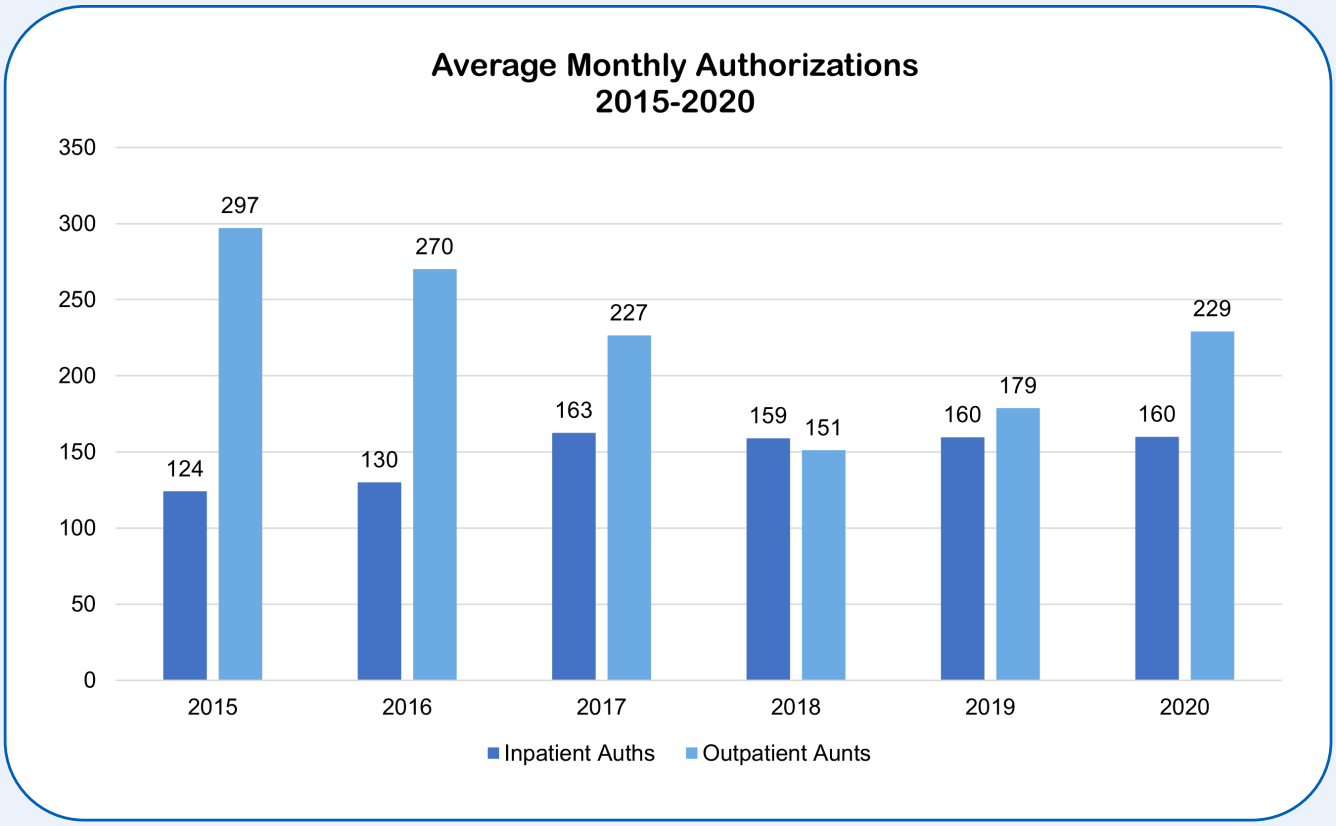


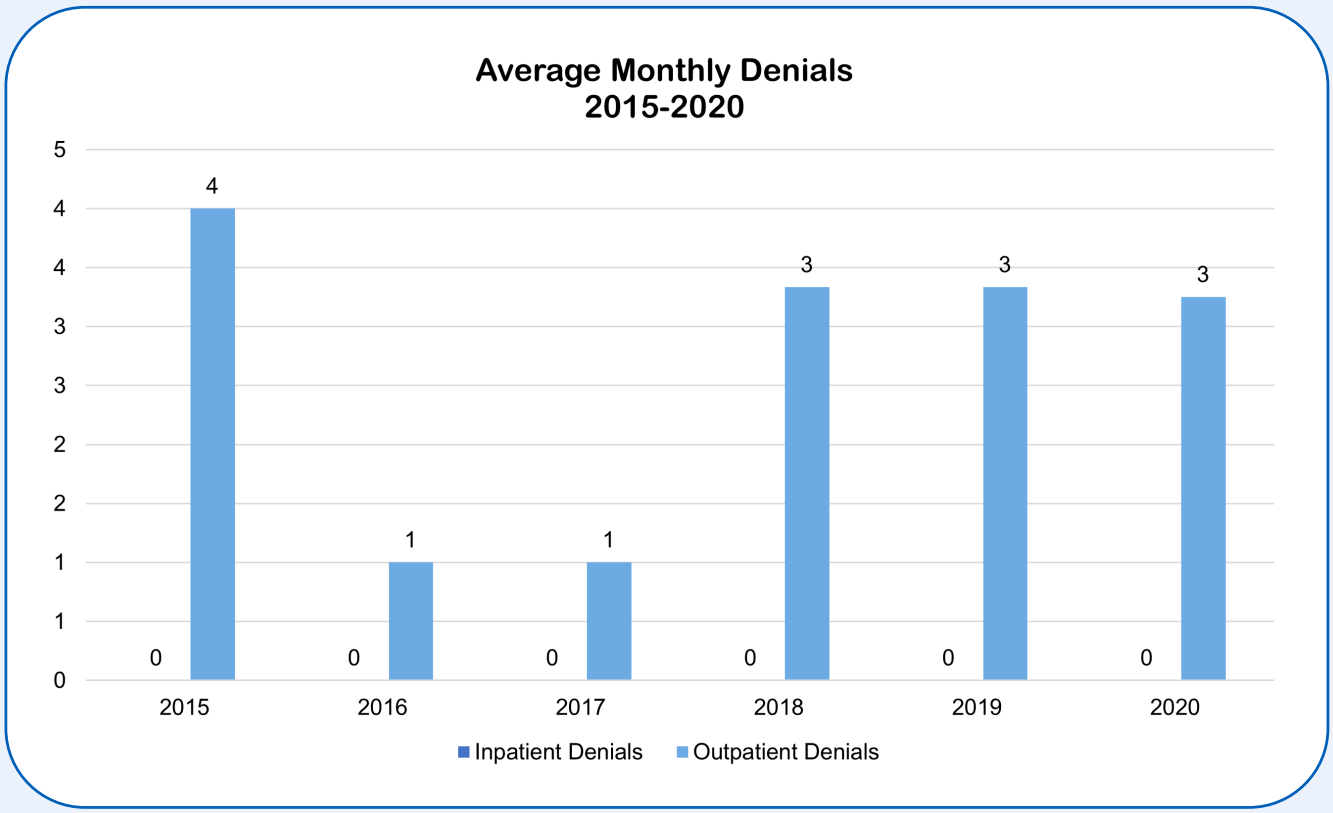
2020 Utilization Management Audit Results

Below are the 2020 aggregate audit results for clinical and non-clinical staff performing utilization functions. Audit scores for both groups consistently exceeded the established benchmark of 95% throughout 2020.

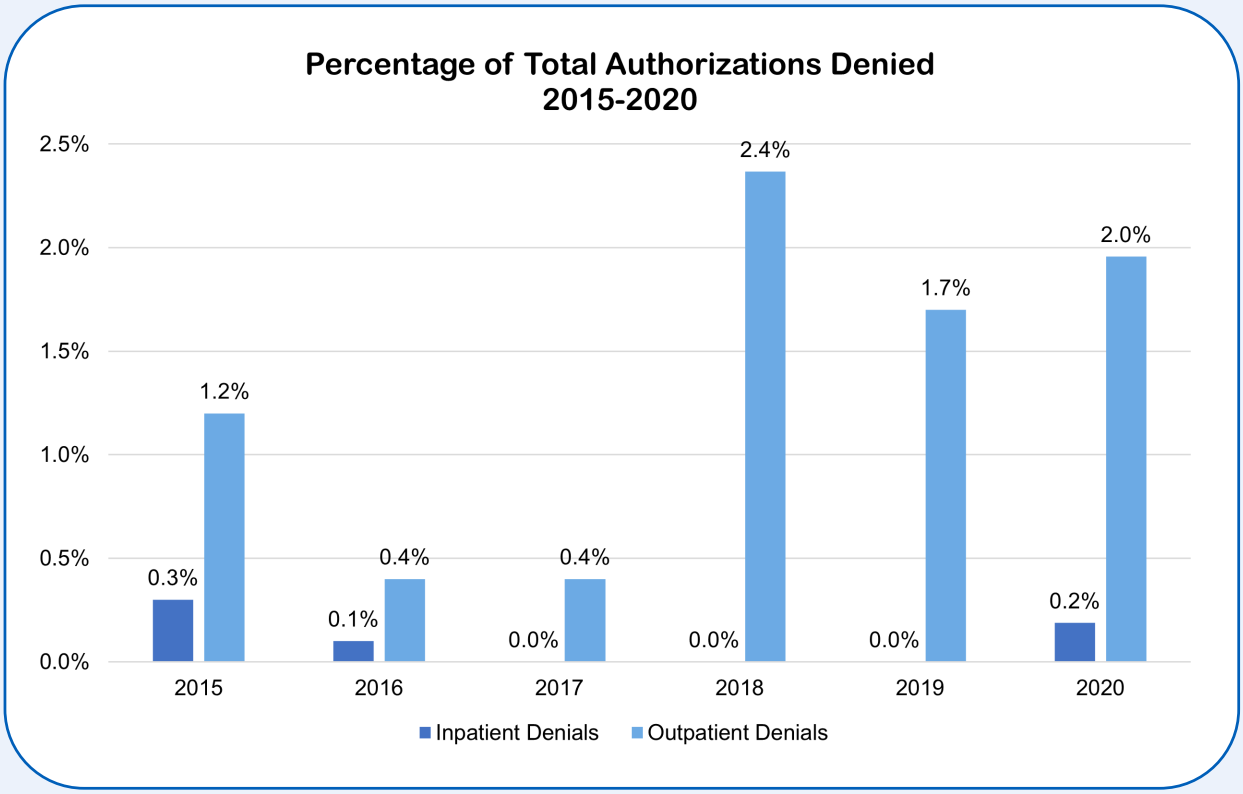


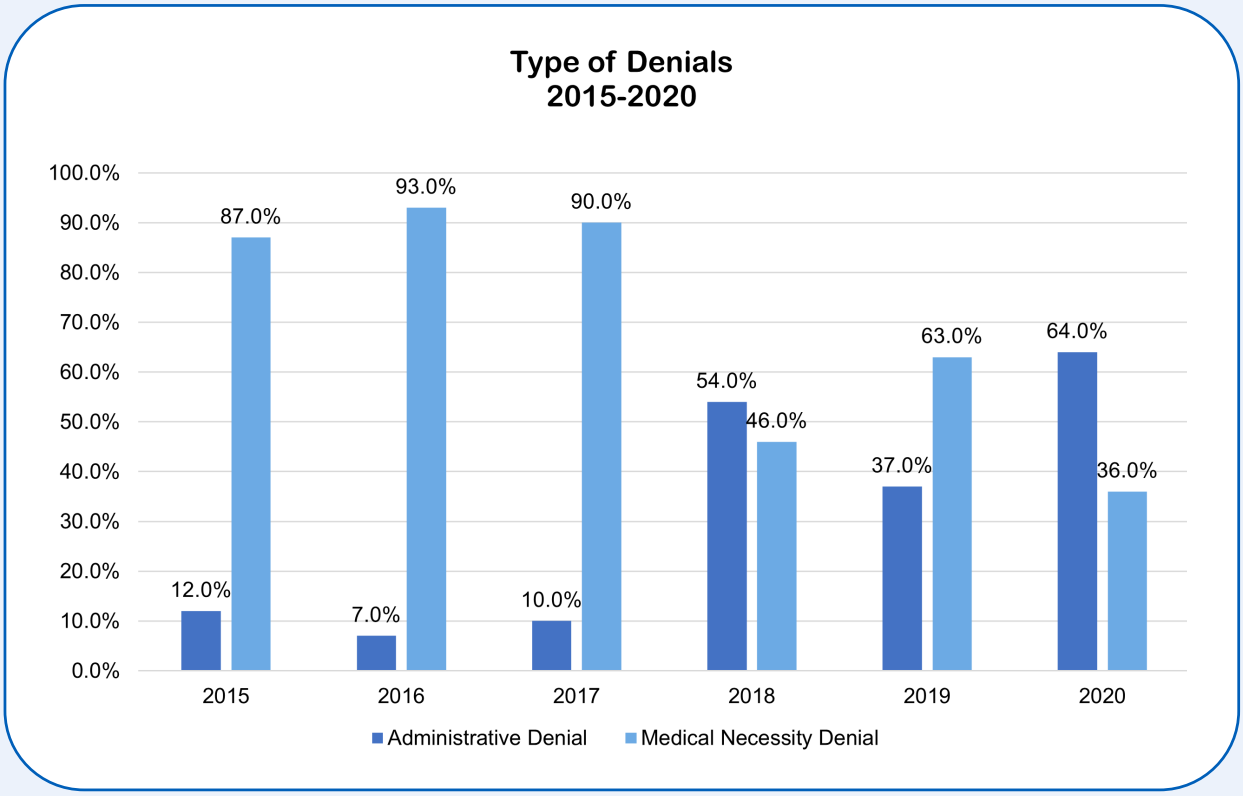
Prior Authorization Statistics





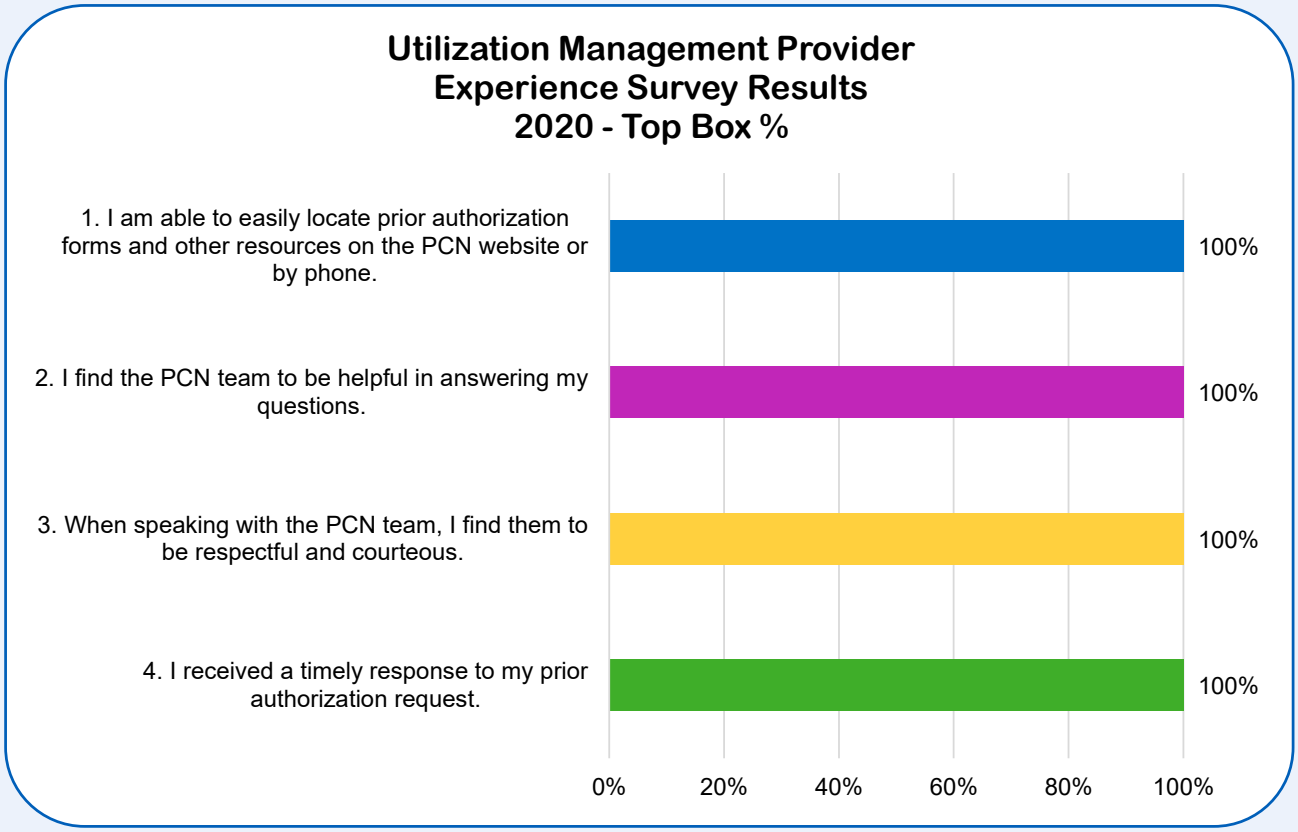
Prior Authorization Statistics

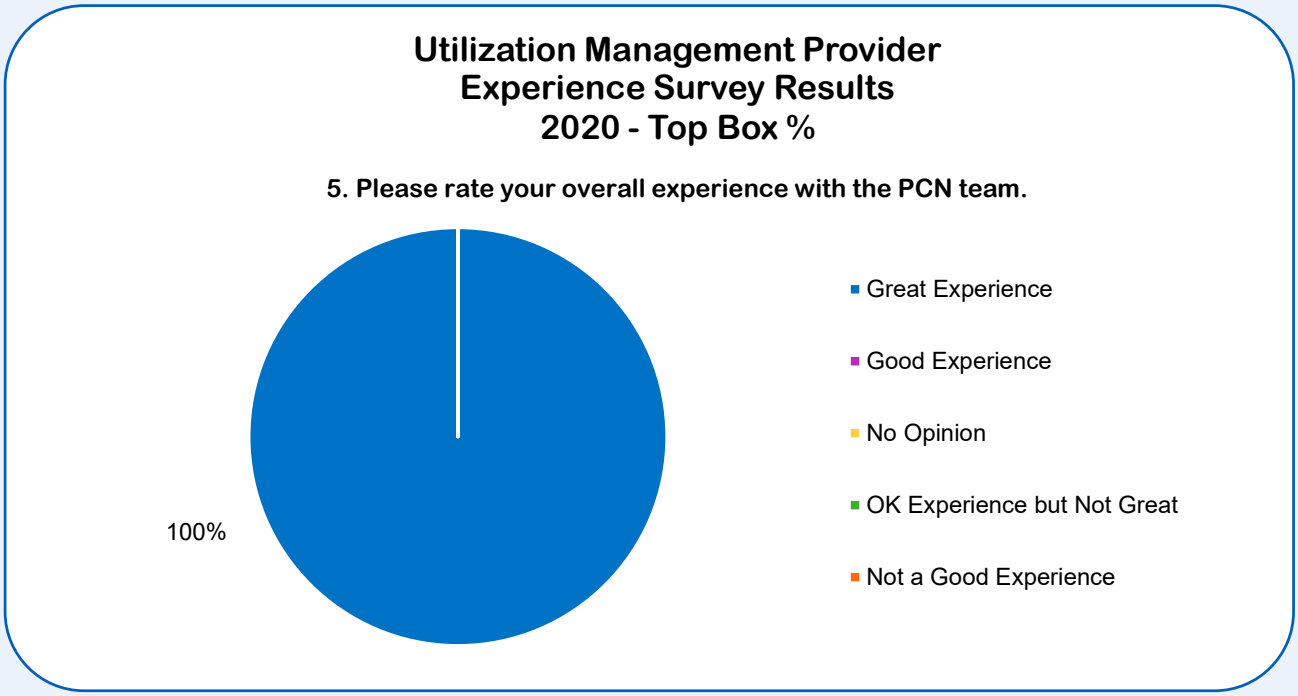




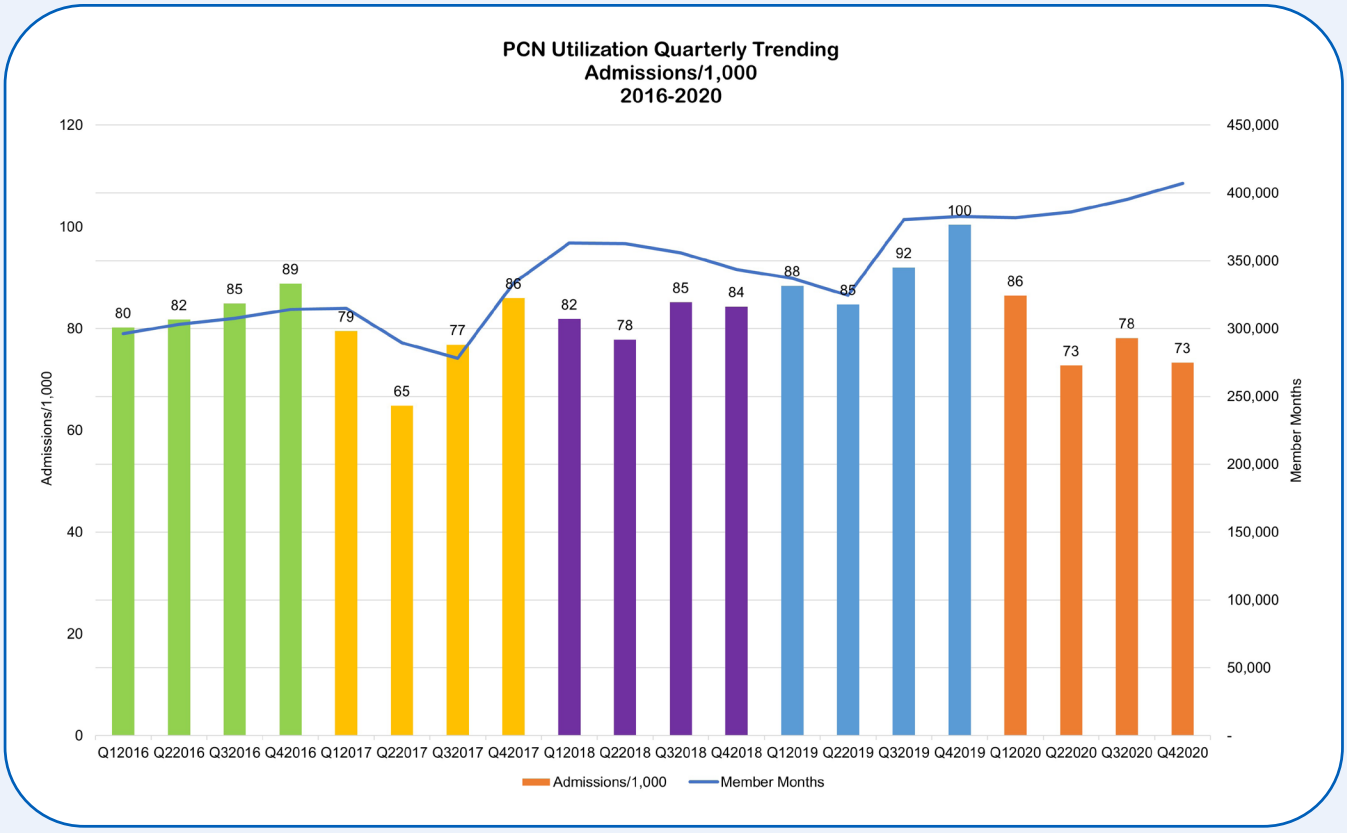
Provider Experience

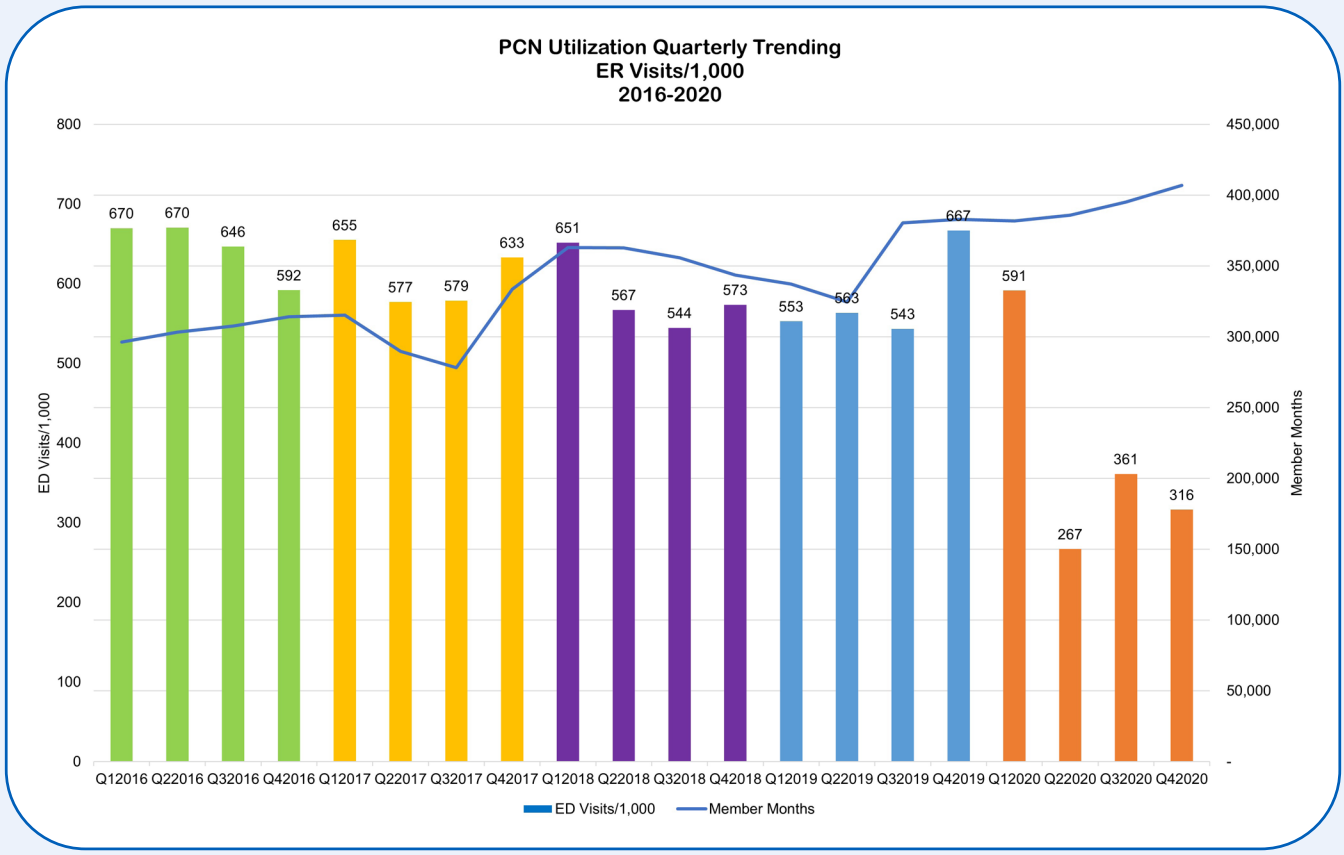
A short survey is distributed to all clinics/PCMH offices in PCN to assess their satisfaction with the prior authorization process. The Provider Satisfaction Survey contains five questions. PCN's Provider Satisfaction Survey results from 2020 are shown below.





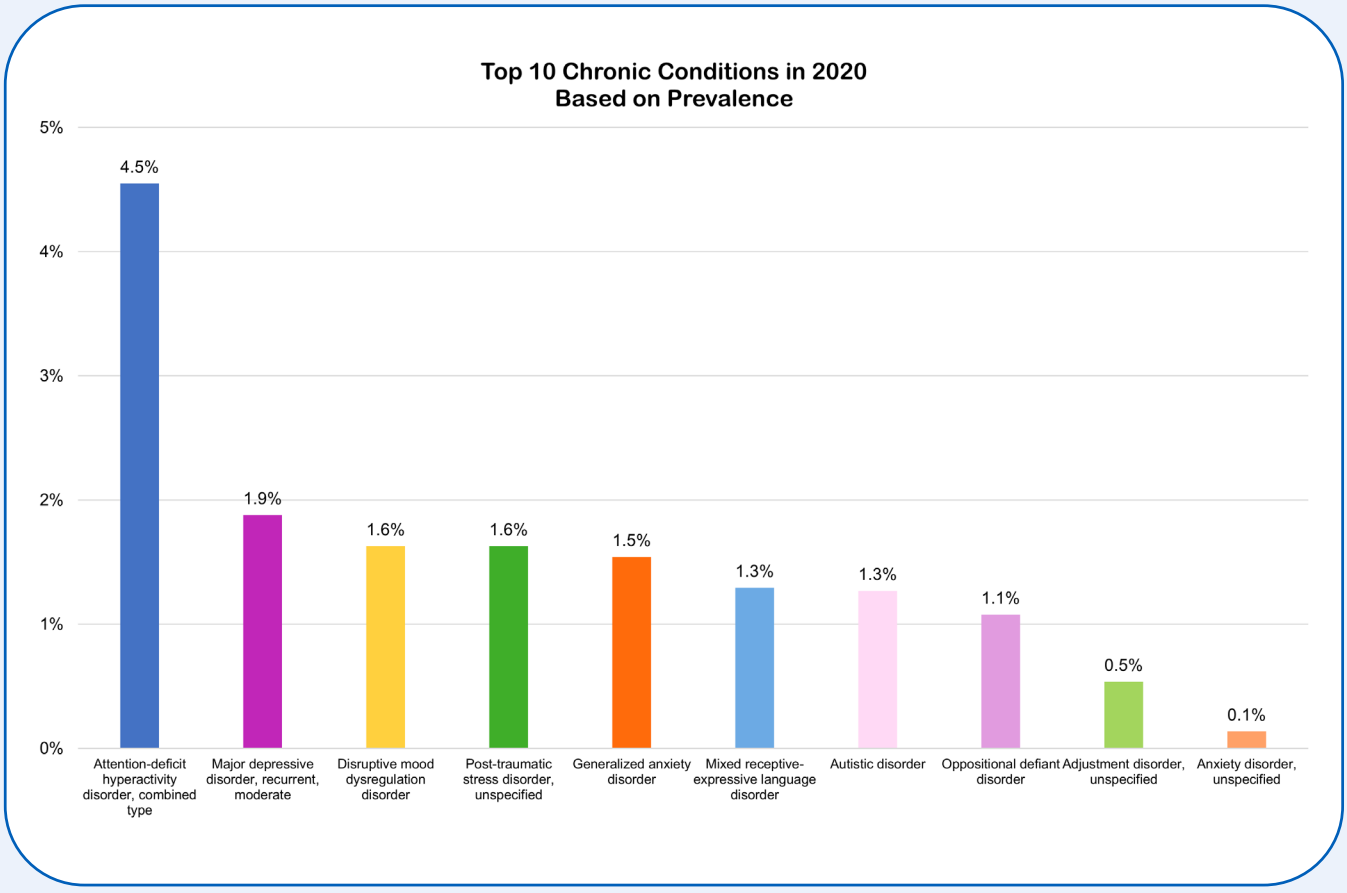
Inpatient and ER Utilization Statistics: 2016-2020



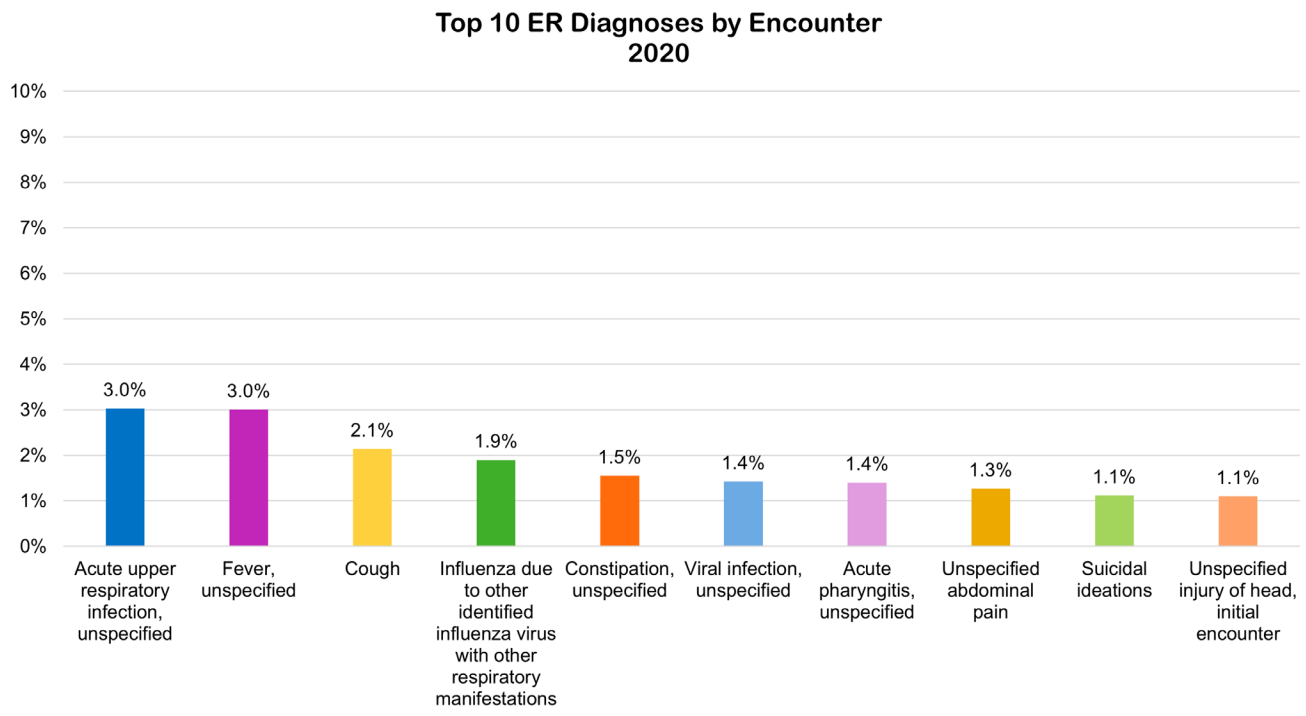


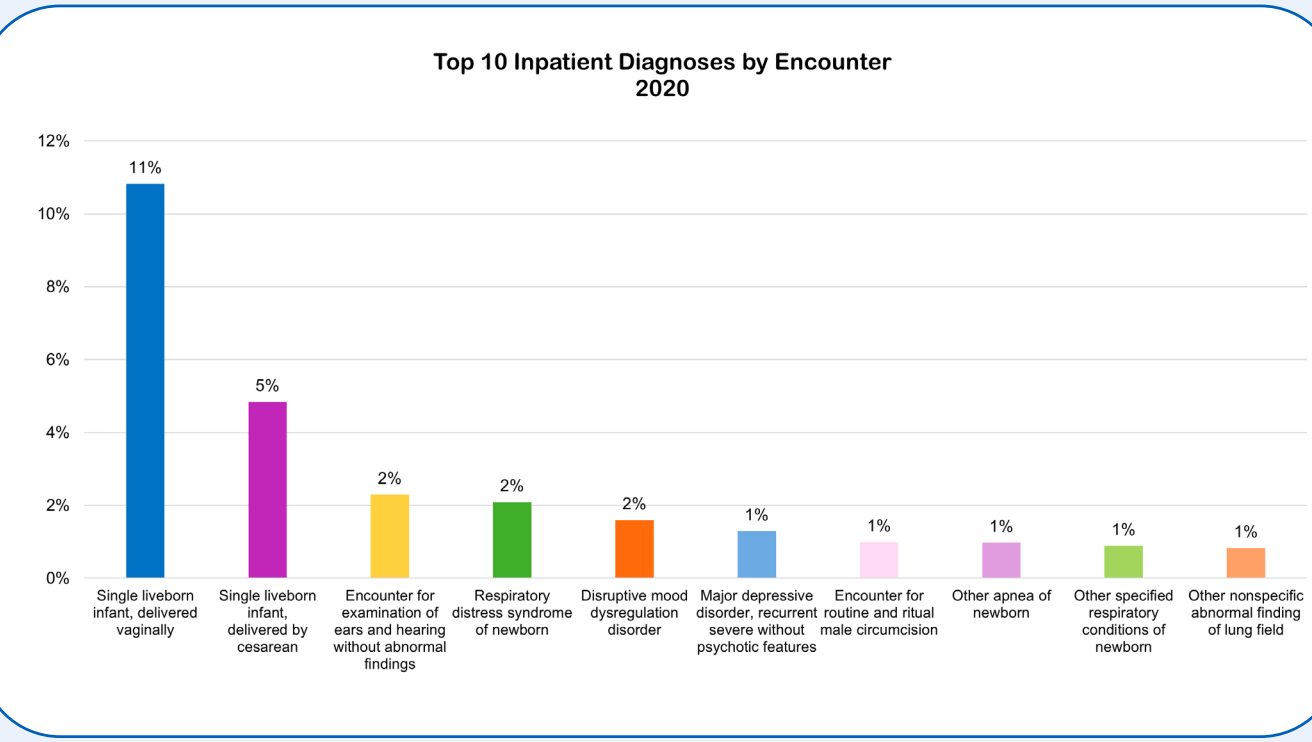
Year over Year Comparisons of Utilization: 2015-2020

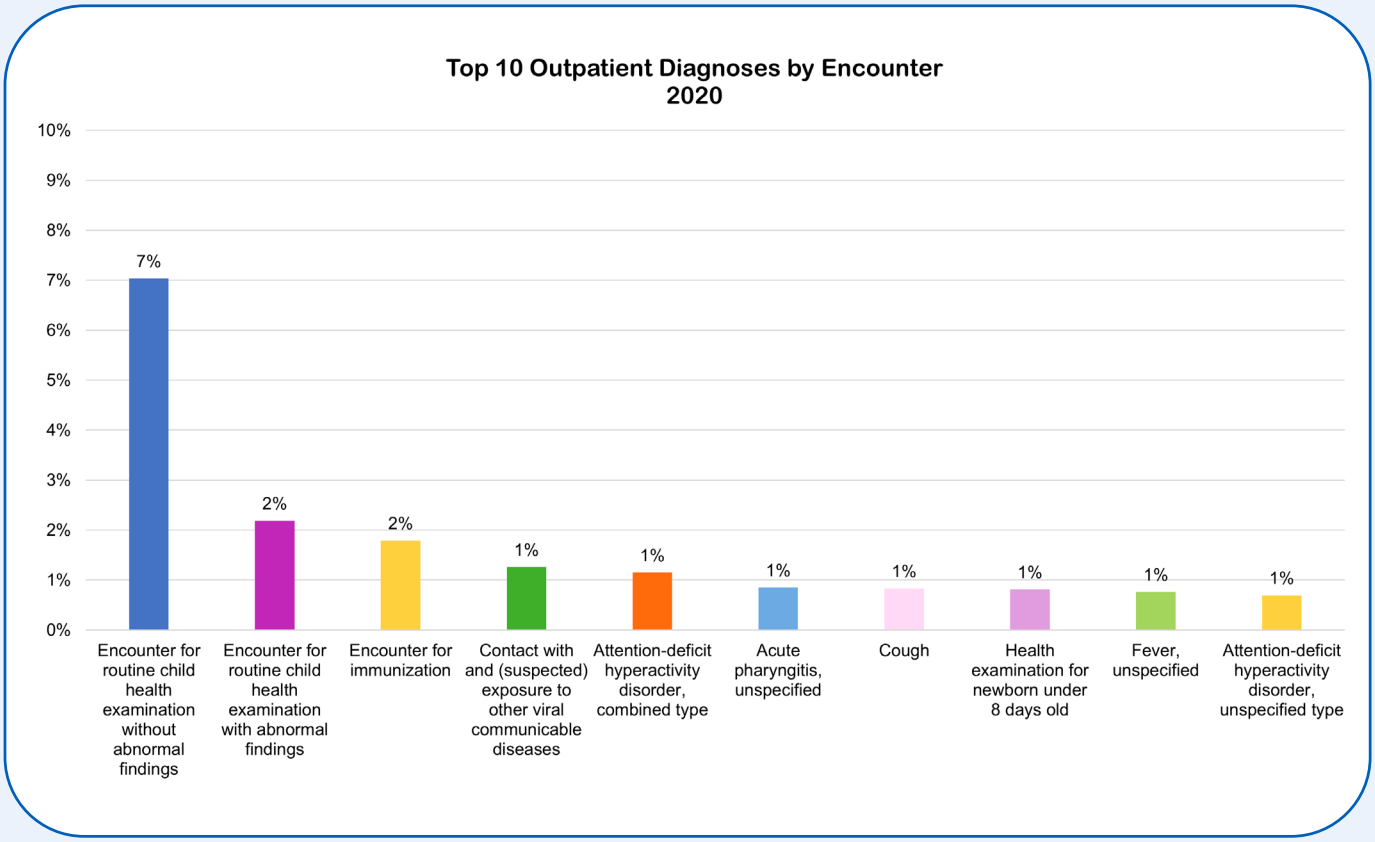
Incurred Year	2015	2016	2017	2018	2019	2020
Admissions/1,000	84	84	77	82	92	77
Days/1,000	343	350	285	284	347	316
ER Visits/1,000	672	631	613	584	583	378
ALOS (Medical)	4.1	4.2	3.7	3.5	3.8	4.1
% Change from PY	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Admissions/1,000	NA	0.3%	-8.1%	6.6%	11.5%	-15.6%
Days/1,000	NA	2.1%	-18.5%	-0.3%	22.0%	-8.9%
ER Visits/1,000	NA	-6.2%	-2.8%	-4.6%	-0.2%	-35.2%
ALOS (Medical)	NA	1.8%	-11.3%	-6.4%	9.4%	8.0%



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 medical requests that require clinical review. Complicated medical requests that will require coordination between providers and members are sent to the Care Team for review and processing. The Care Facilitation Coordinator (CFC) is the hub of the Care Team and receives all incoming tasks, including prior authorization requests. The CFC reviews and processes the request according to policy. If the request is beyond the scope of a non-clinical staff member, the CFC initiates authorization into the system and then send 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 component 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 2020 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 a 33.5% decrease in ER visits per 1,000 from 2019 to 2020. The top ER diagnoses based on claims encounter data were related to Acute upper respiratory infection, unspecified; Fever, unspecified; Cough; Influenza due to other identified virus with other respiratory manifestations; Constipation, unspecified; Viral infection, unspecified; Acute pharyngitis, unspecified; Unspecified abdominal pain; Suicidal ideations and Unspecified injury of head, initial encounter.

From 2019 to 2020, there was a 2.5% increase in admissions per 1,000. Additionally, there was a 61% increase in inpatient days per 1,000 and a 7.5% increase in Average Length of Stay (ALOS – Medical). As inpatient admissions shift to higher acuity admissions, PCN expects the inpatient days per 1,000 and ALOS rates to increase slightly. Additionally, it is unclear the impact the coronavirus pandemic has on these rates, but PCN plans to evaluate trends and update processes as needed. The top inpatient diagnoses in 2020 were related to Single liveborn infant, delivered vaginally; Single liveborn infant, delivered by cesarean; Encounter for examination for ears and hearing without abnormal findings; Respiratory distress syndrome of newborn; Disruptive mood dysregulation disorder; Major depressive disorder, recurrent severe without psychotic features; Encounter for routine and ritual male circumcision; Other apnea of newborn; Other specified respiratory condition of newborn; and Other nonspecific abnormal finding of lung field.

Future Initiatives

- As applicable, 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;
- Continued identification of at-risk members and evaluation of emergency room services for non-urgent/non-emergent needs to prioritize outreach for enrollment into Case Management and Disease Management programs.
- Partner with providers to gain input to further develop and enhance the electronic prior auth portal to increase efficiencies in the process for providers and staff

4 Transitional Care Program Evaluation

- Transitional Care Program Overview
- Program Measures
- Future Initiatives

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;
- The facility has requested assistance with discharge planning; or
- All members discharging from an inpatient psychiatric stay (when delegated for Behavioral Health).

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.

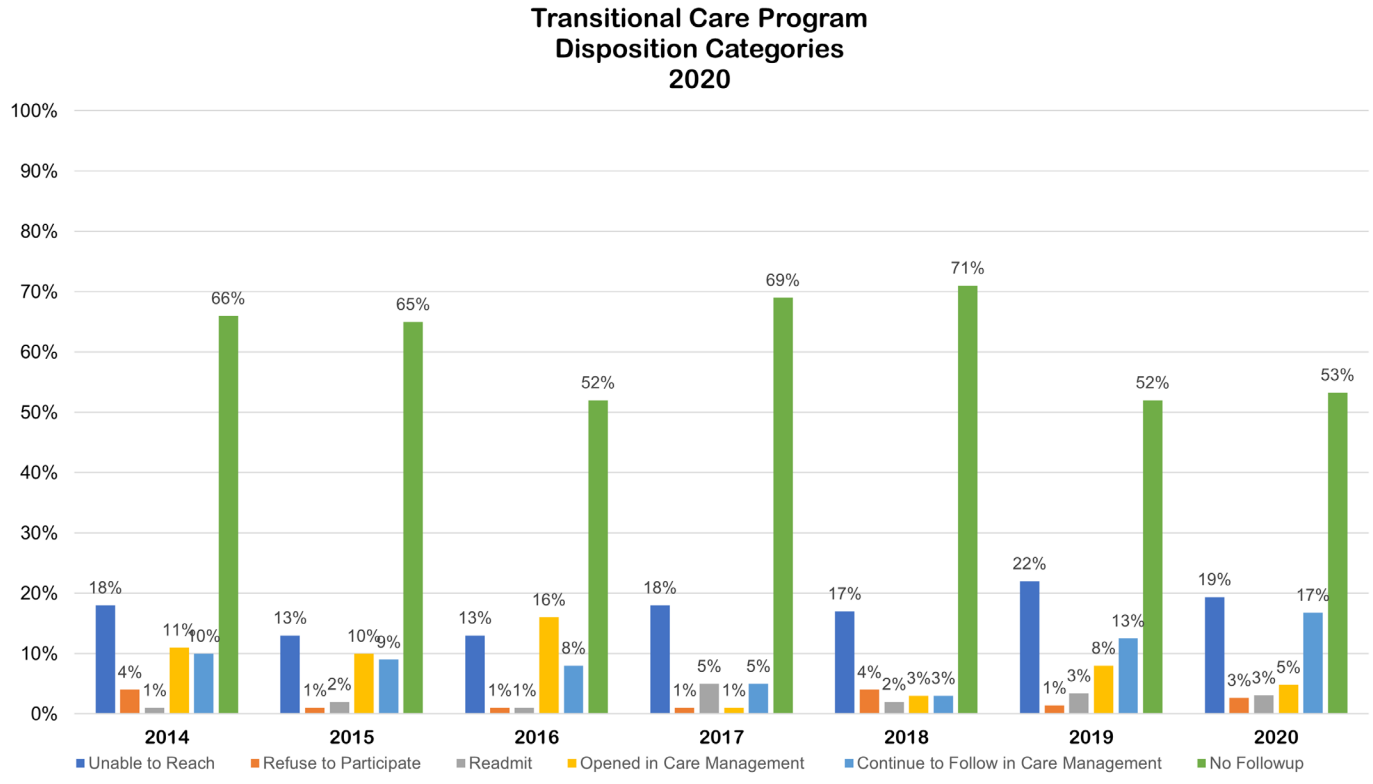
Program Measures

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 2020, a total of 363 members were identified for the transitional care program. Of those members, 315 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.

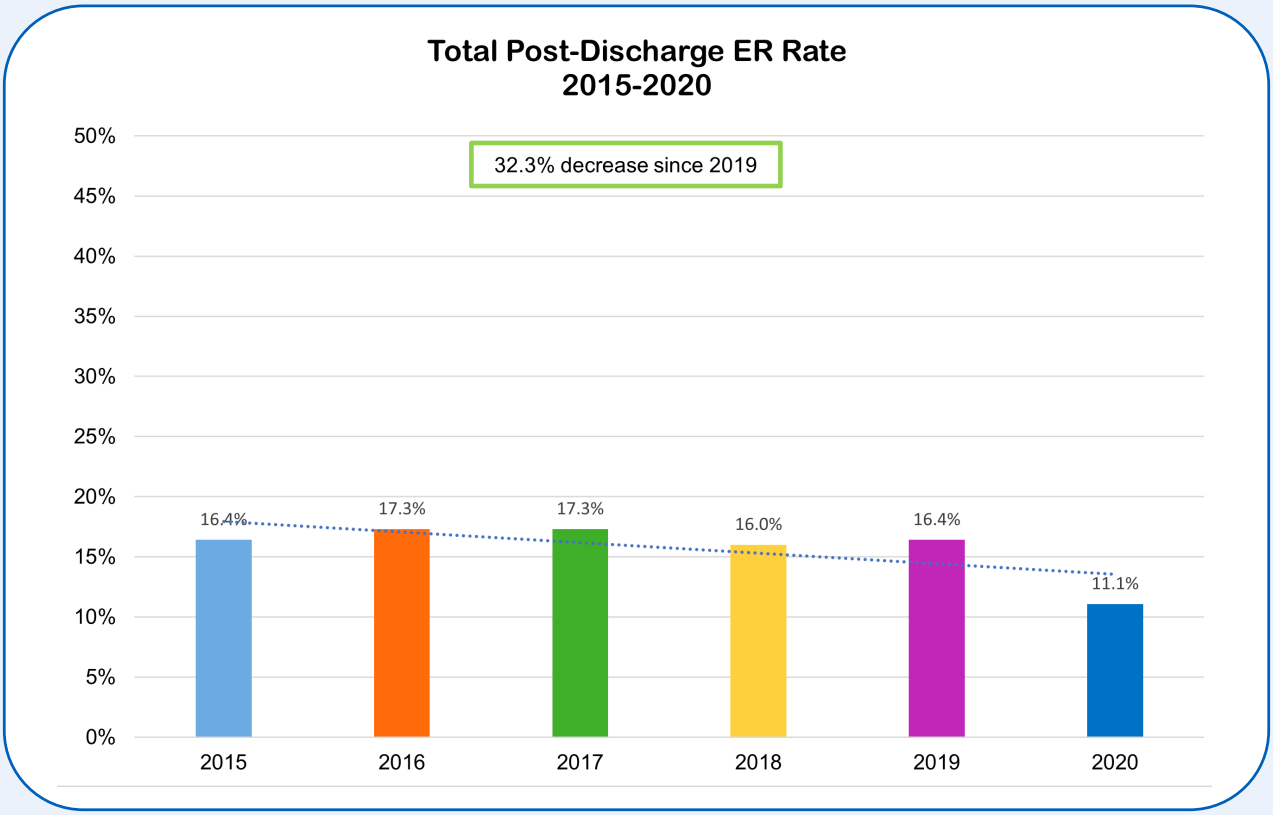
Future Initiatives

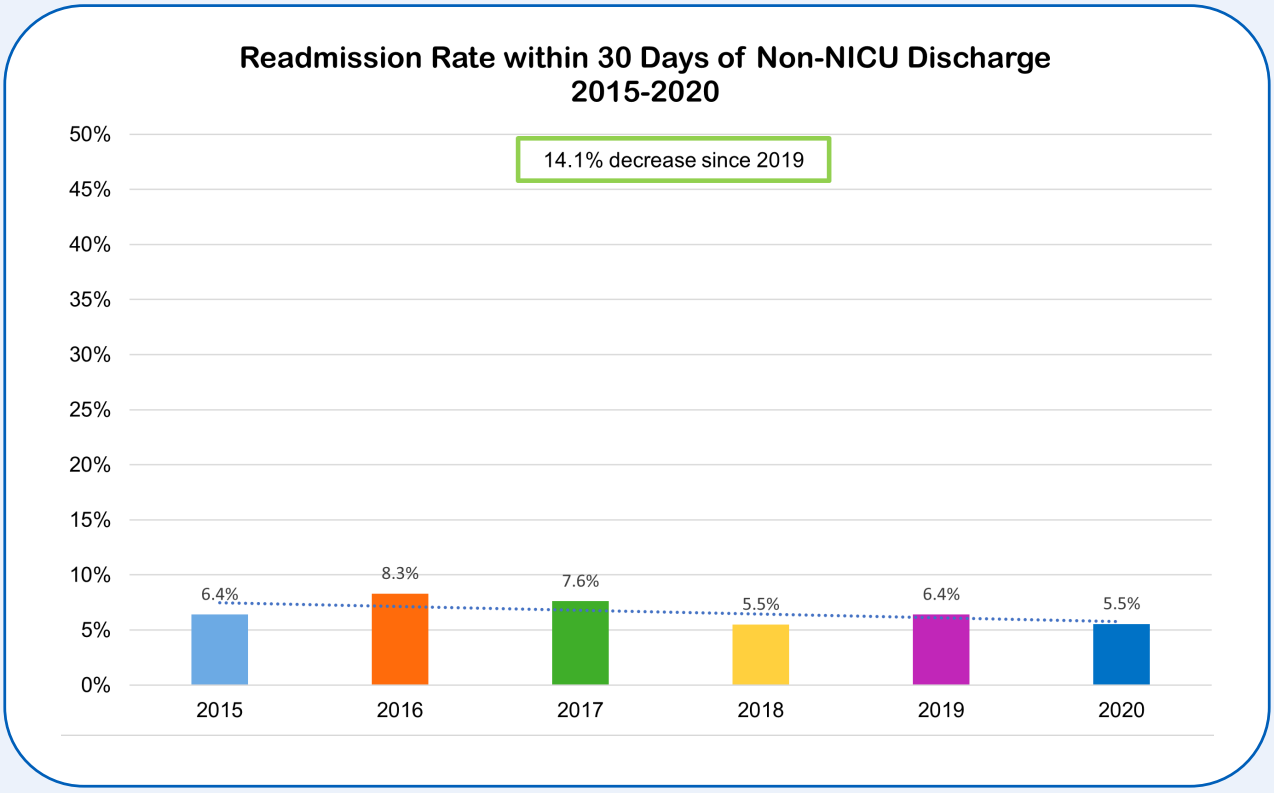
Due to the impact of the coronavirus pandemic, PCN has seen an overall reduction in hospital admissions. However, the pandemic's similar impact on primary care utilization created scenarios where medically complex members discharging from the hospital were more likely to readmit prior to connecting with their primary care physicians (PCP). Based on the analysis of the program metrics, the following interventions will be included in PCN's 2021 initiatives:

- Continued identification of at-risk medically complex members for transitional support, engagement and facilitation of timely post discharge follow-up.
- Focused education on maintaining communication with providers around any post discharge concerns or decompensations.
- Ongoing partnership with healthplans in correct PCP identification and alignment to enable care team communication and collaboration with providers to support transitions.

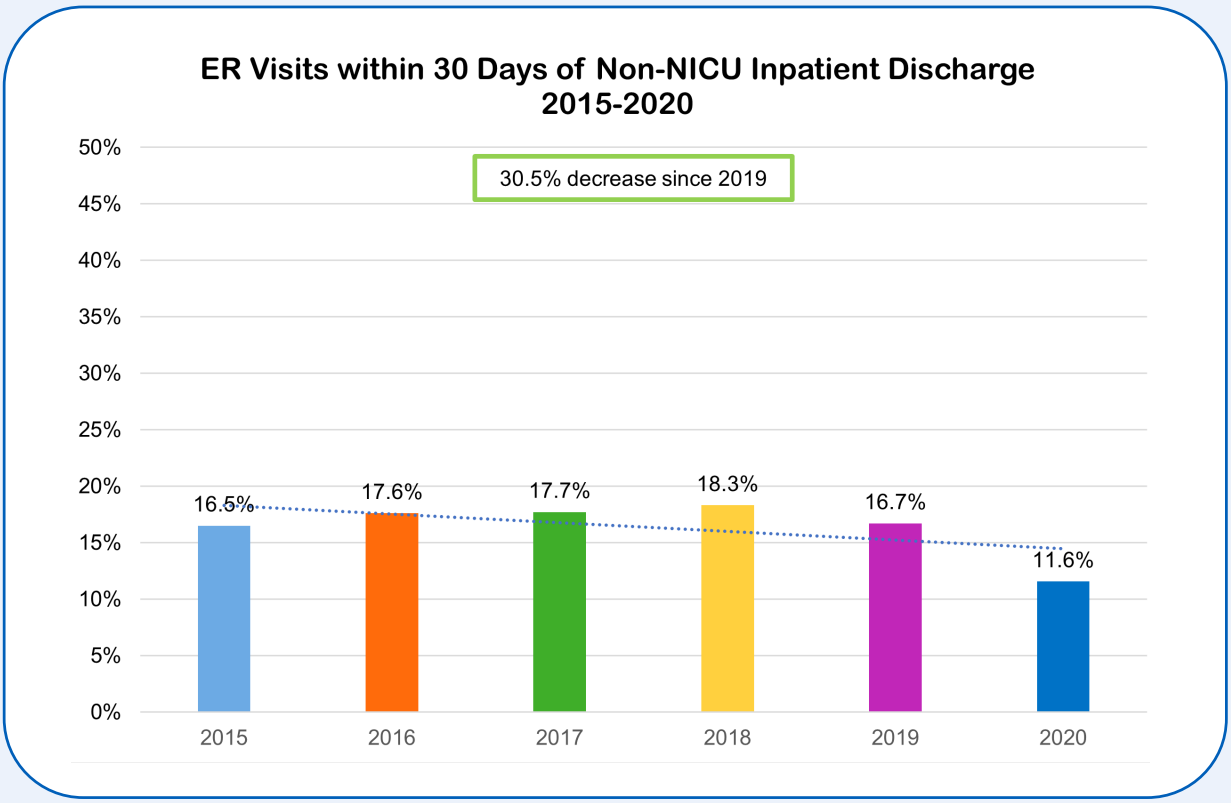


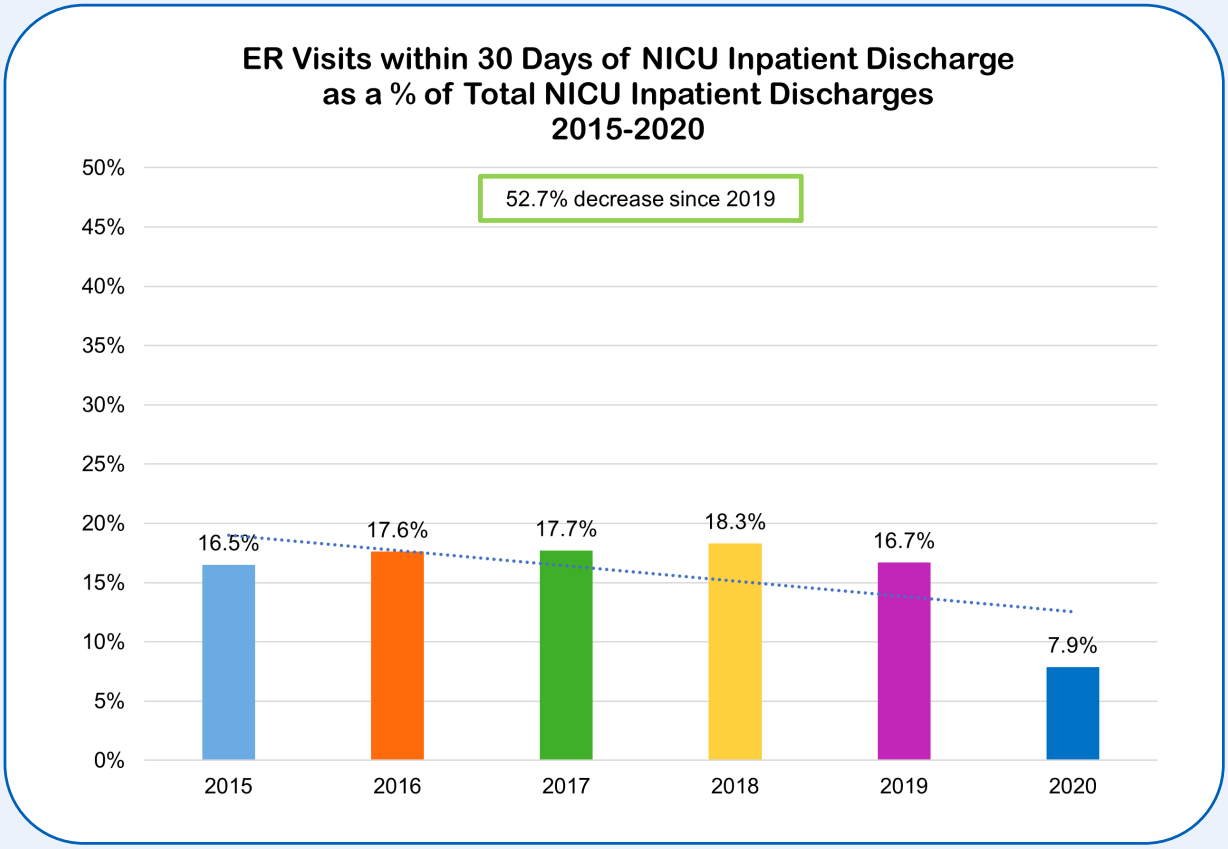
The overarching goal of the transitional care program is to decrease emergency room visits and unplanned hospital readmissions. Below is a six-year trend (2015-2020), based on claims data, of 30-day post-discharge ER visit rates and all-cause readmission rates for the PCN population.





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





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:

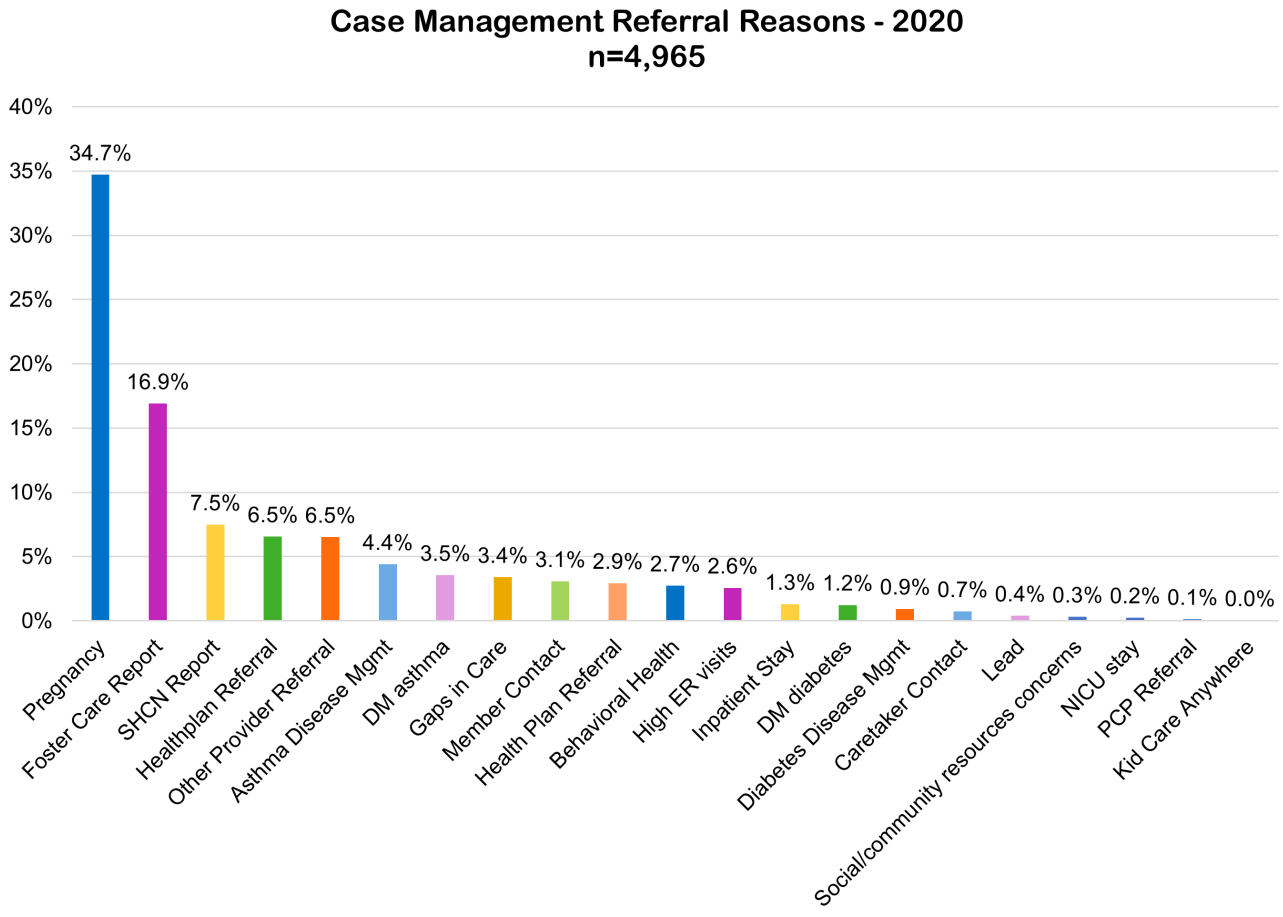
- Assist members in sustaining or achieving an optimal level of wellness and function by facilitating timely and appropriate health care services;
- Promote strong member/PCP relationships for coordination and continuity of care, using PCMH concepts;
- Reduce inappropriate inpatient hospitalizations 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 2020, PCN completed leader led audits as part of the quarterly review process to provide additional learning opportunities. PCN staff presented their case files in a 1:1 setting with either the Care Integration Manager or the Director of Integrated Care for live audit scoring and feedback. 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 Care Integration Manager, and as needed, the PCN medical director, 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

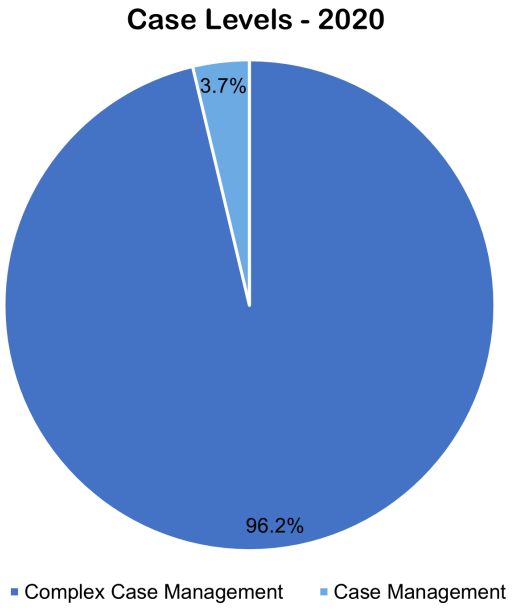
In 2020, 3,900 unique members were identified for case management services. Case Management Case Levels Case types are determined based on the member's screening, assessment, and care plan development. This establishes the level of complexity and interventions. The chart below reflects the most common case management referral reasons in 2020.

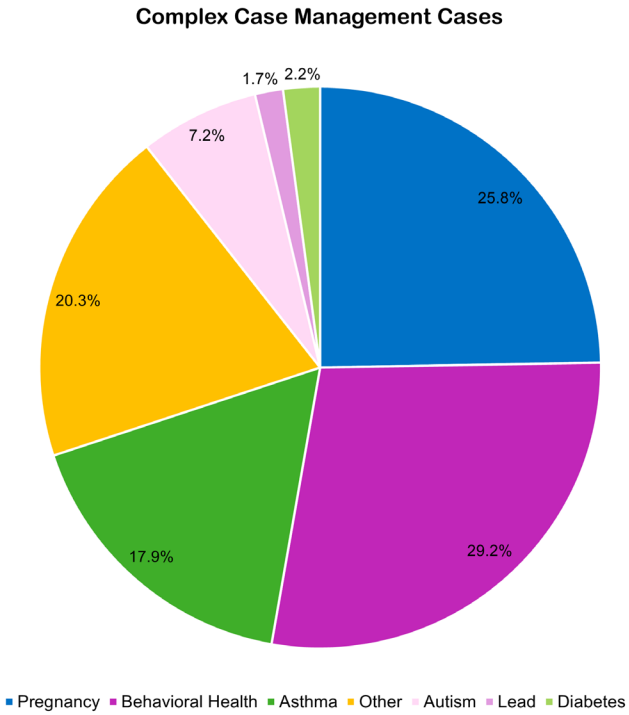


Note: To best capture, the Care Team members can choose more than one referral reason for each unique member screened.

Case Management Case Levels

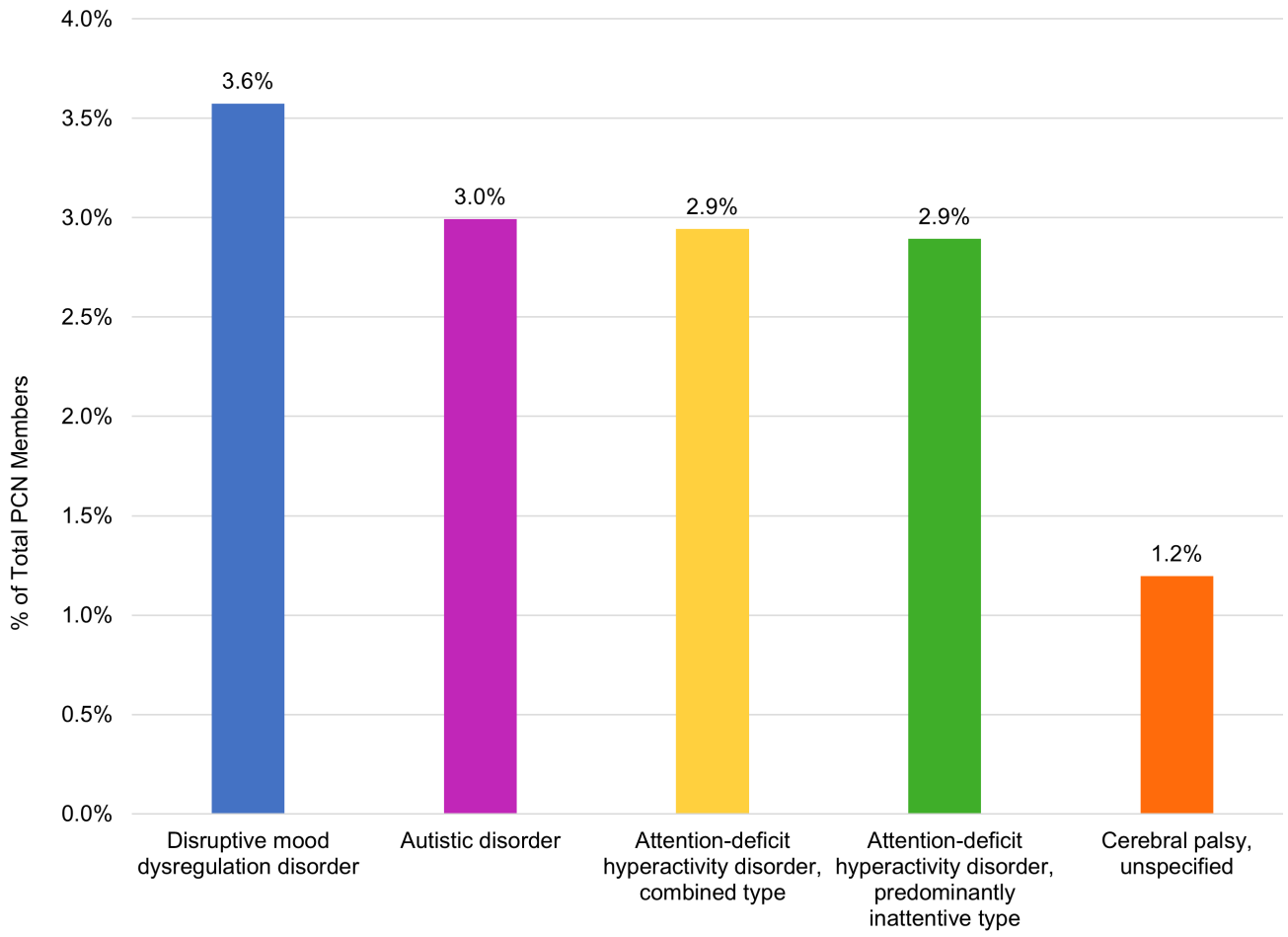
Case types are determined based on the member's screening, assessment, and care plan development. This establishes the level of complexity and interventions. In 2020, 3% of the program referrals required case management and 97% of the referrals were deemed complex case management. The chart below reflects the common conditions in complex case management (cases opened for ≥ 60 days): Pregnancy (31%), Behavioral Health (26%), Asthma (21%), Other Medical Conditions (20%), Autism (7%), Lead (3%), and Diabetes (2%).





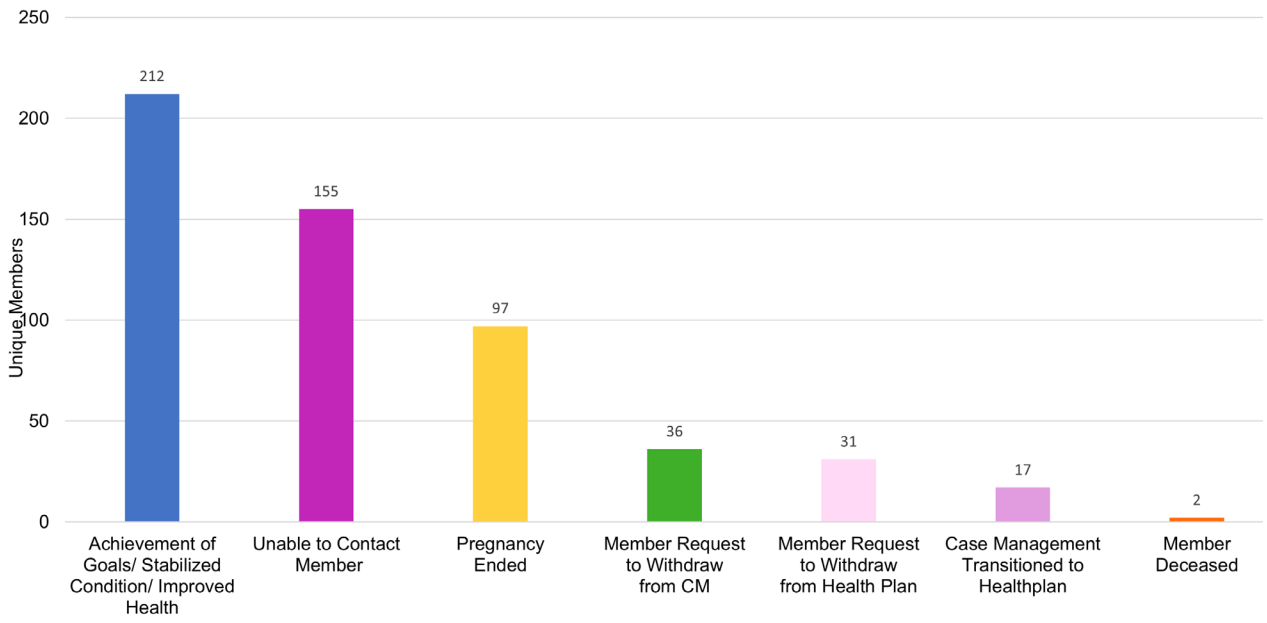
Case Management Top 5 Conditions

In addition to referral sources, the case management assessment helps to identify the chronic conditions for each screened member. In 2020, claims indicate that the top five chronic condition categories for members receiving case management services are: Disruptive mood dysregulation, Autistic disorder, Attention-deficit hyperactivity disorder, combined type, Attention-deficit disorder, predominantly inattentive type, and Cerebral palsy, unspecified. Members could be categorized in more than one chronic condition category.



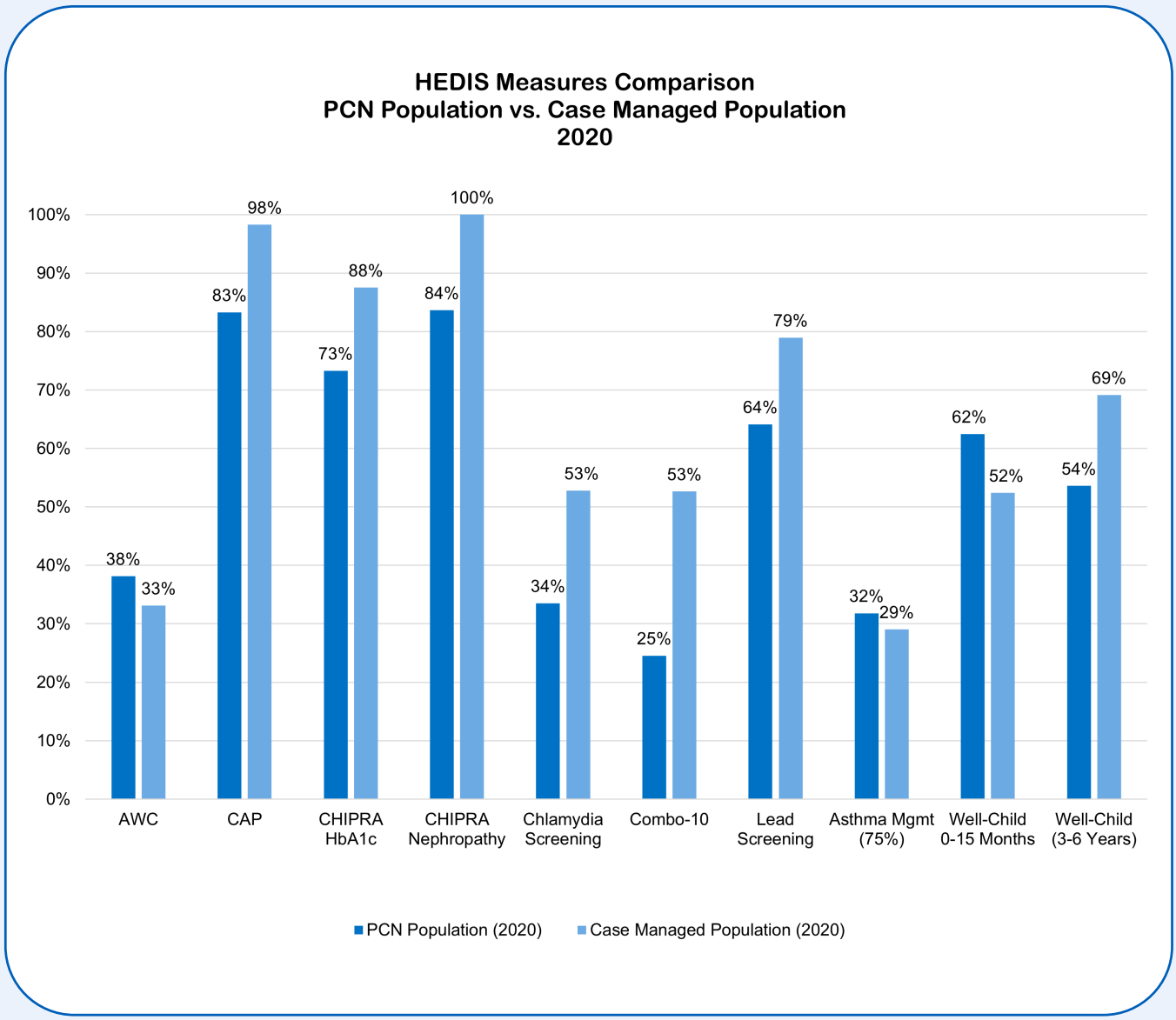
Case Management Case Closure Reasons

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 2020 were Achievement of Goals/Stabilized Condition/Improved Health (212 members), Unable to Contact Member (155 members), Pregnancy Ended (97 members), Member Request to Withdraw from Case Management (36 members), and Member Request to Withdraw from Health Plan (31 members), Case Management Transitioned to Healthplan (17 members), and Member Deceased (2).



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.



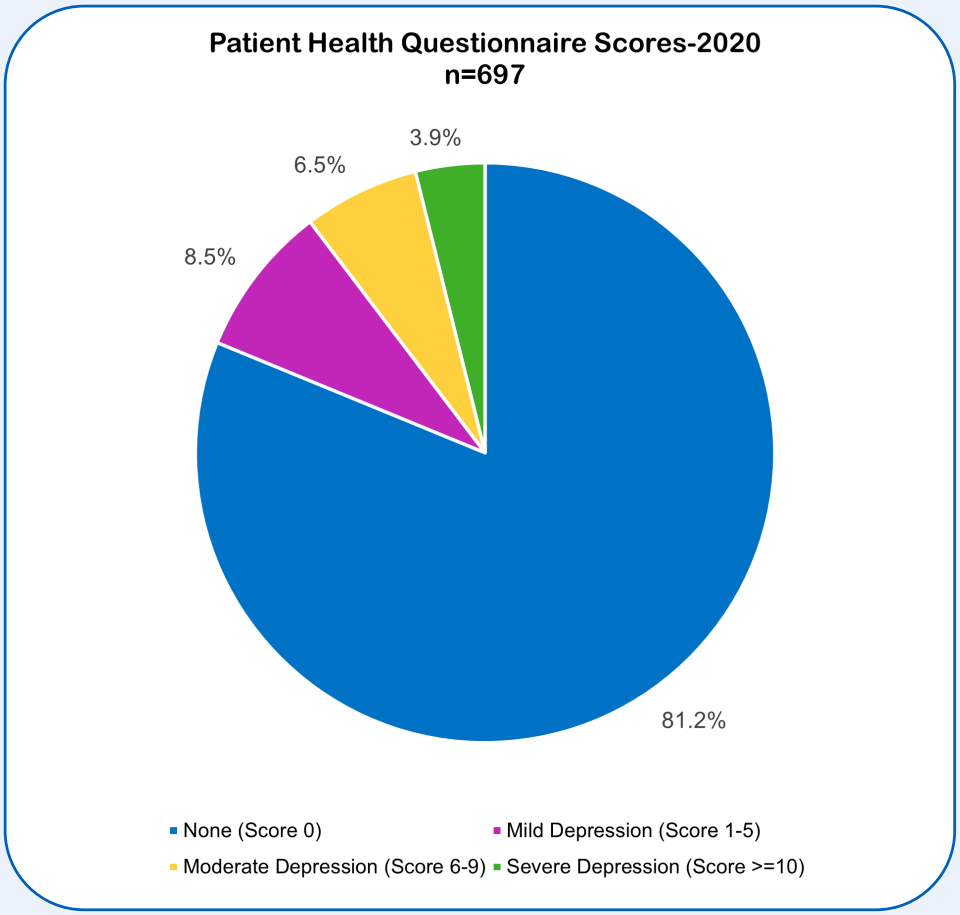
Patient Health Questionnaire 9 Screening

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.

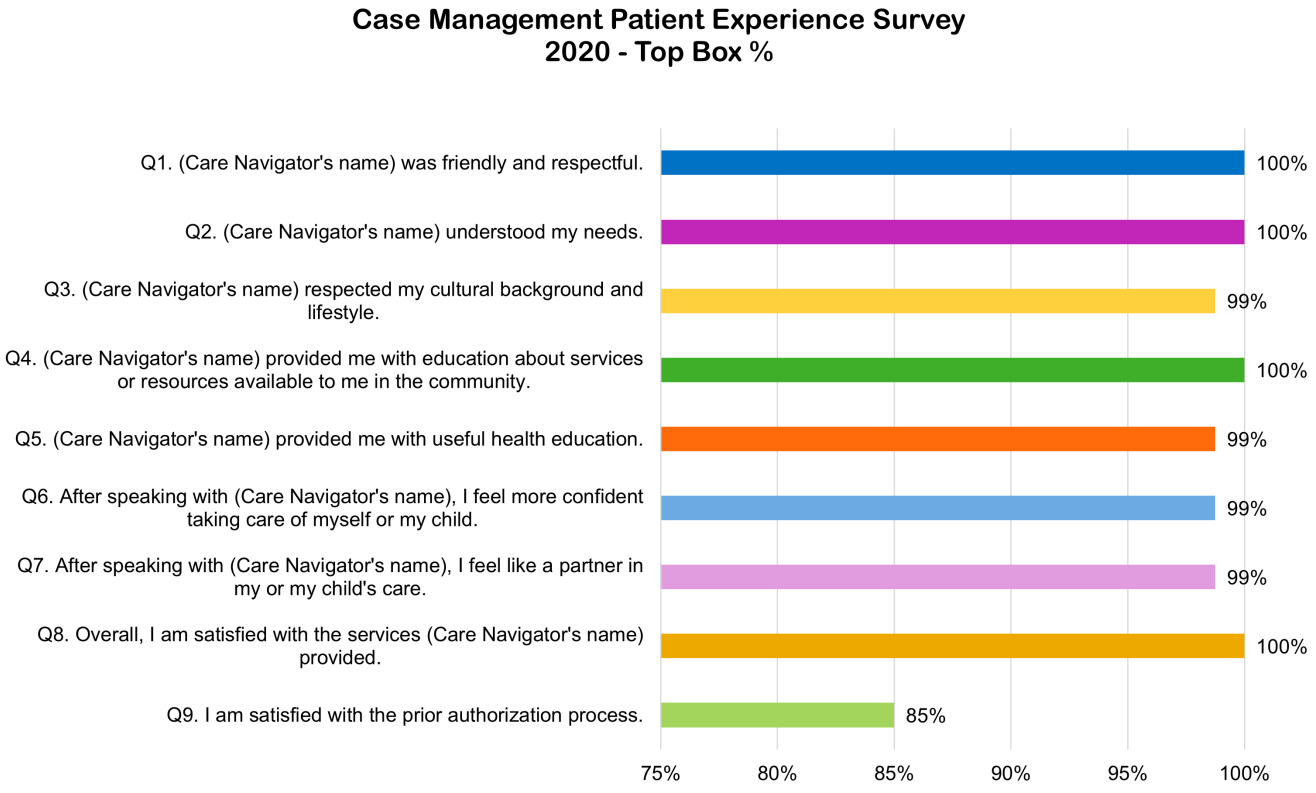
Interventions may include education with the member/caregiver on the available behavioral health benefit, referral for behavioral health services, and/or reporting the screening outcome to the member’s PCP for ongoing monitoring. The Care Navigator develops goals and self-management plan activities to 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.



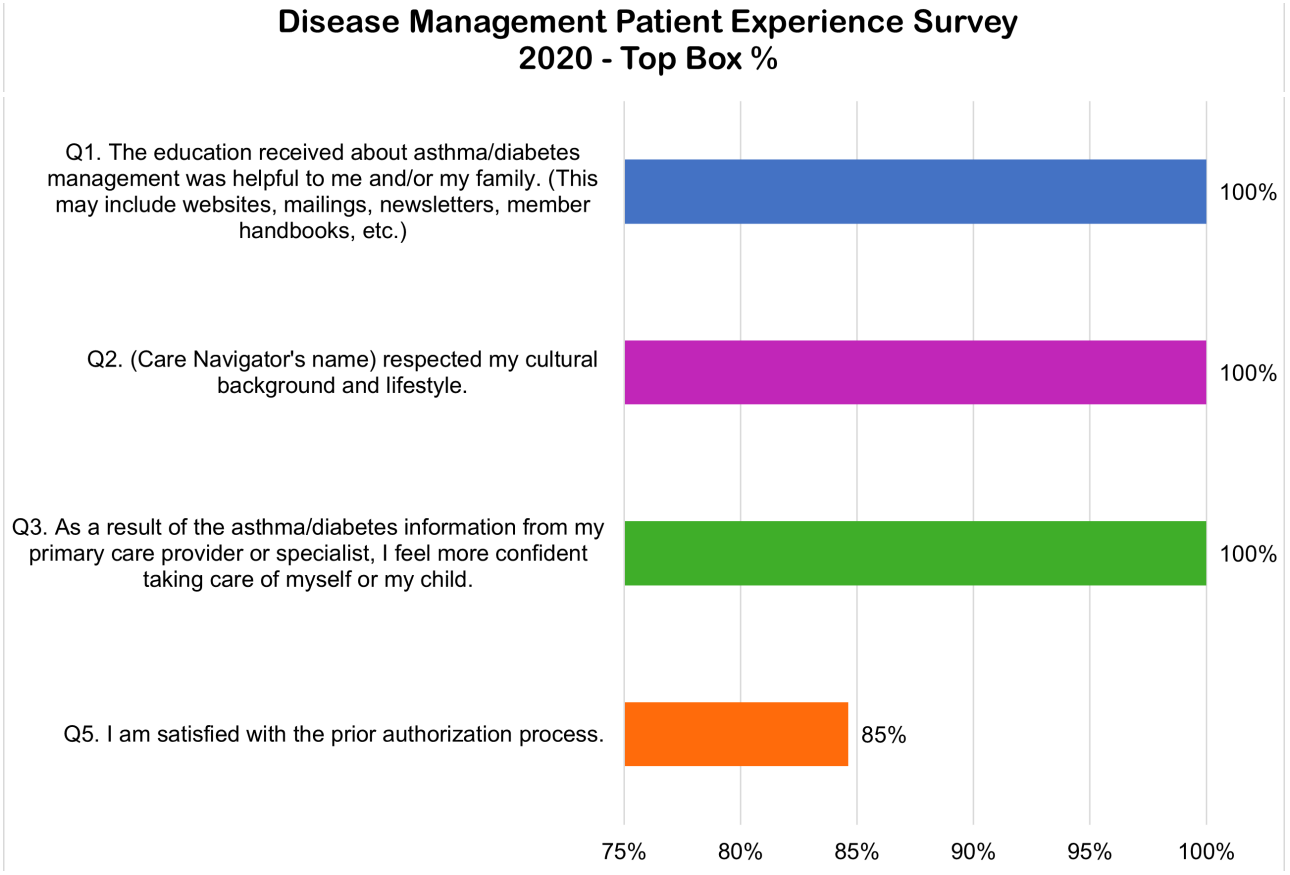
Member/Caregiver Experience with Case Management

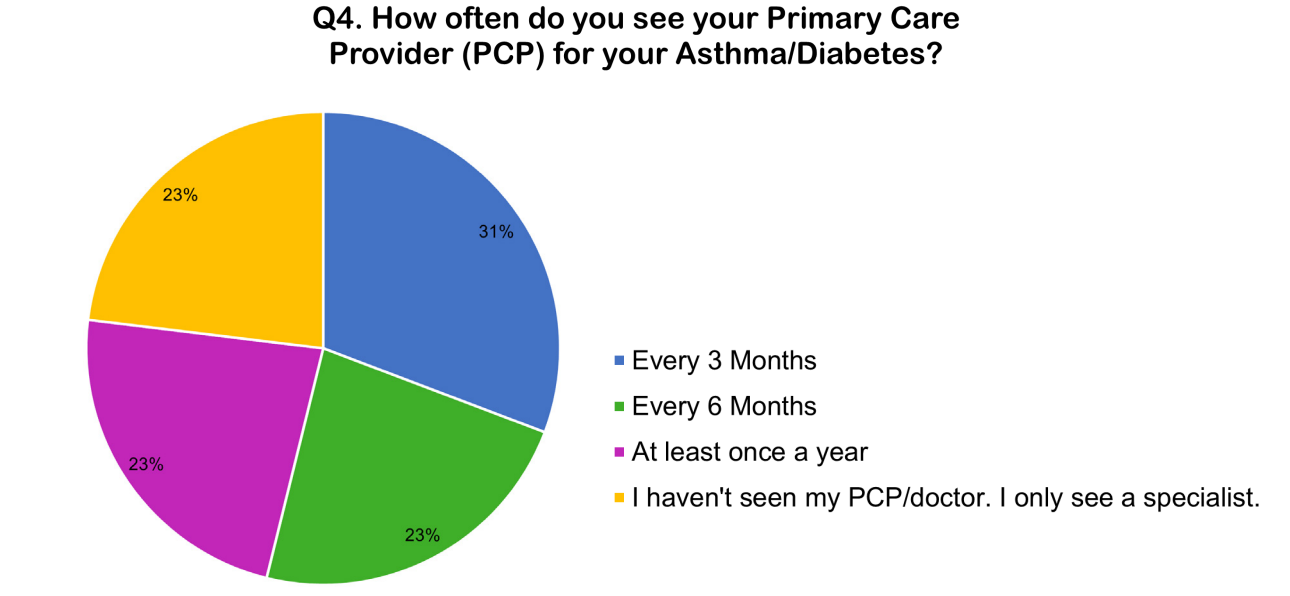
The PCN conducts member satisfaction surveys with members and their caregivers who receive case managed services from a Care Navigator. This telephonic survey includes nine (9) questions with an open-ended opportunity for member comments at the end of the survey. The 2020 survey results are displayed below.



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 2020 survey results are displayed below.





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 2020, there were no grievances received related to PCN's case management and disease management programs.

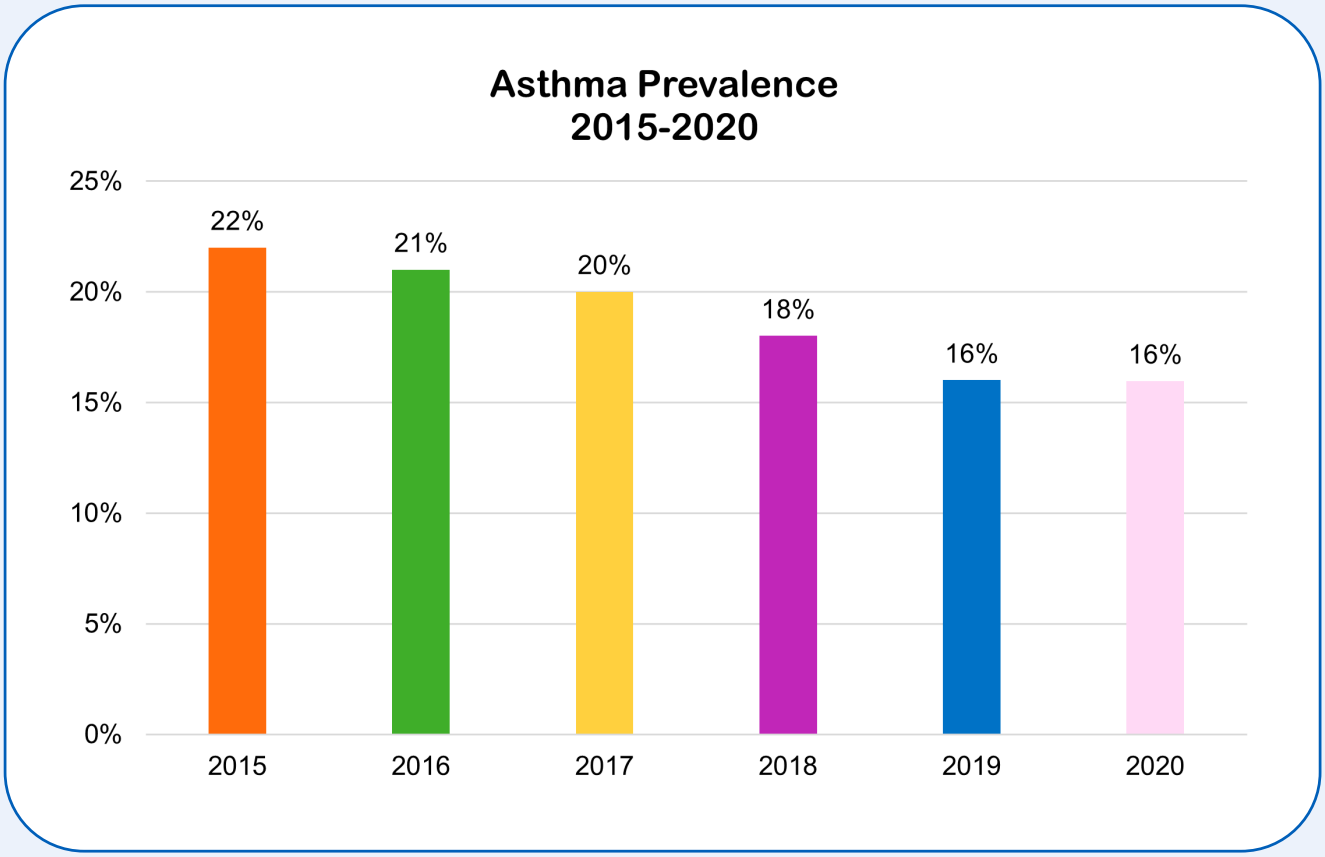
Disease Management Outcomes for Asthma & Diabetes

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 Population Health Management Representatives 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.

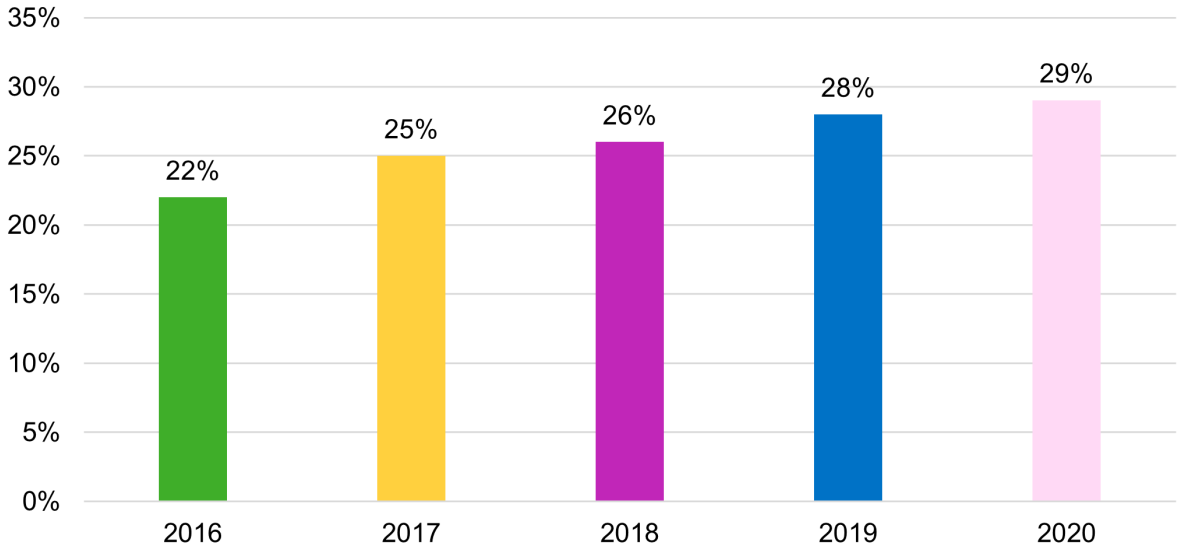
The program consists of physician office education, Patient-Centered Medical Home support, quality improvement techniques, data analytics and reporting, and focused case management interventions, with the goal of improving the health of the population and reducing cost.

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

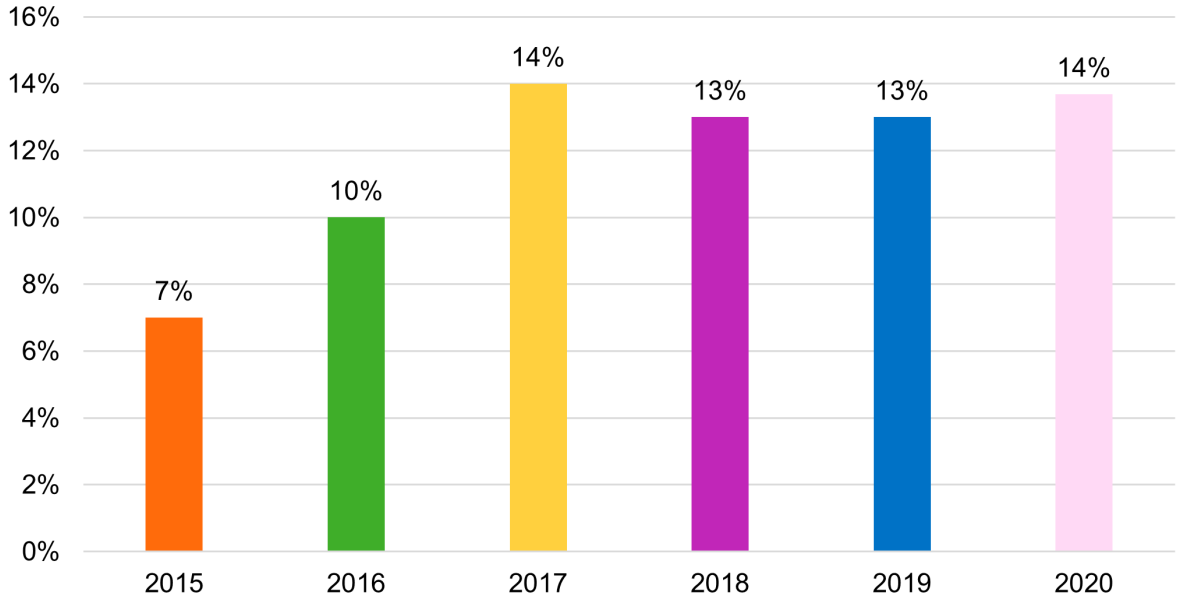


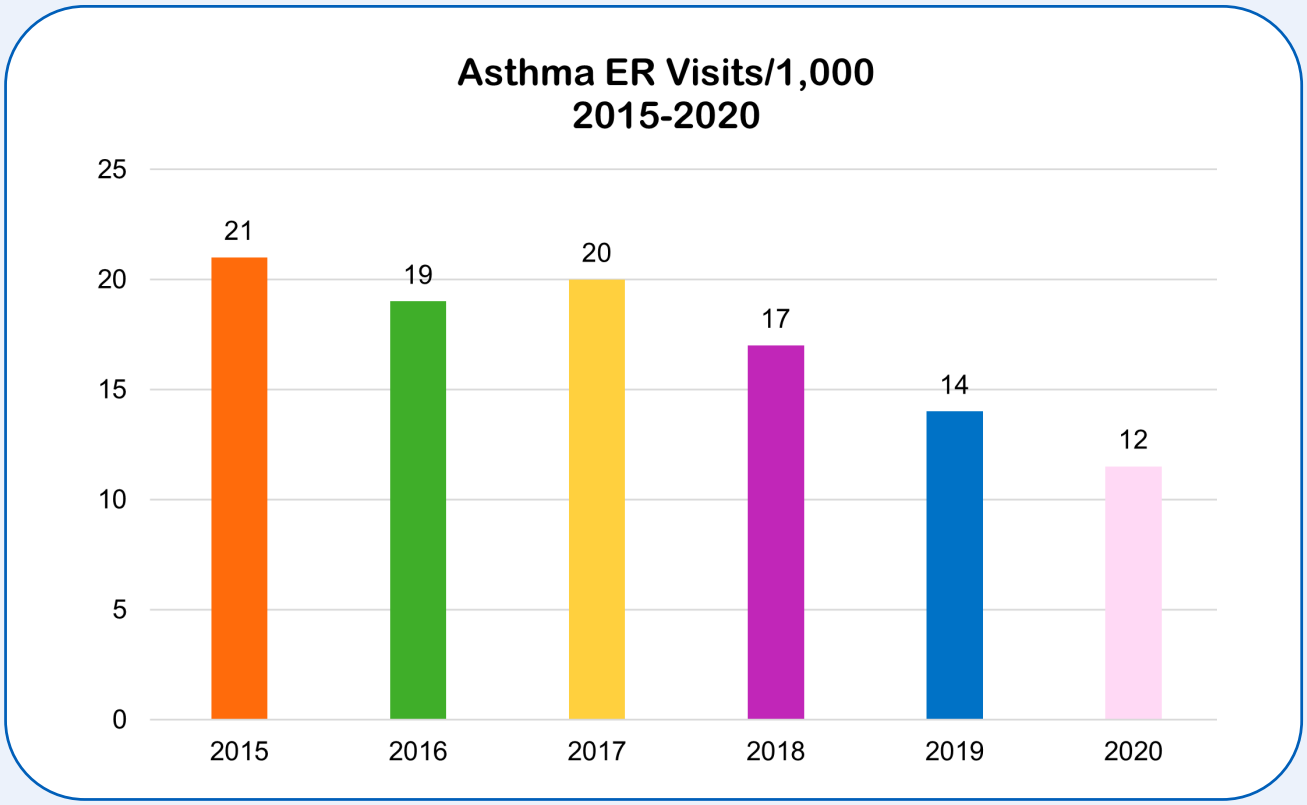
Asthma Medication Management 75% Compliance 2016-2020

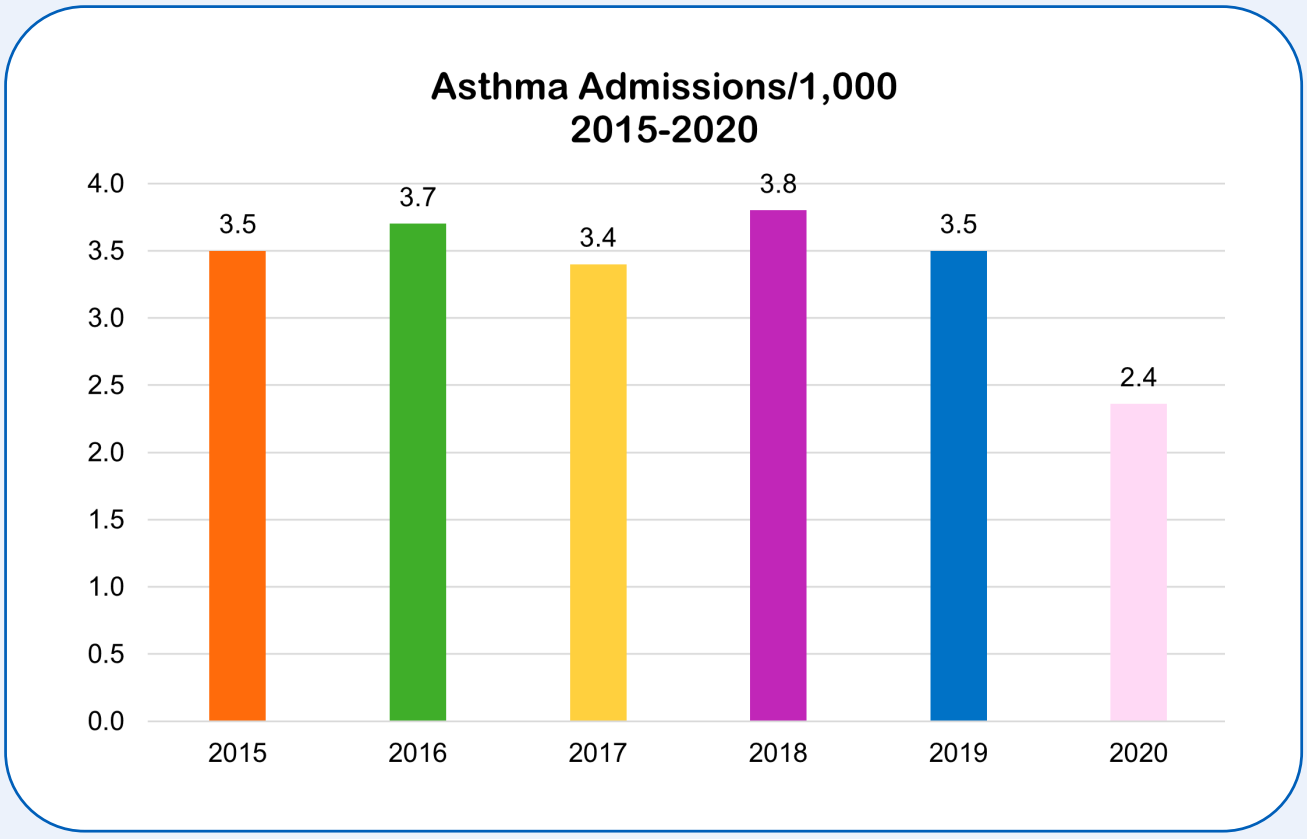


*Note: PCN began to measure Asthma Medication Management 75% Compliance in 2016.

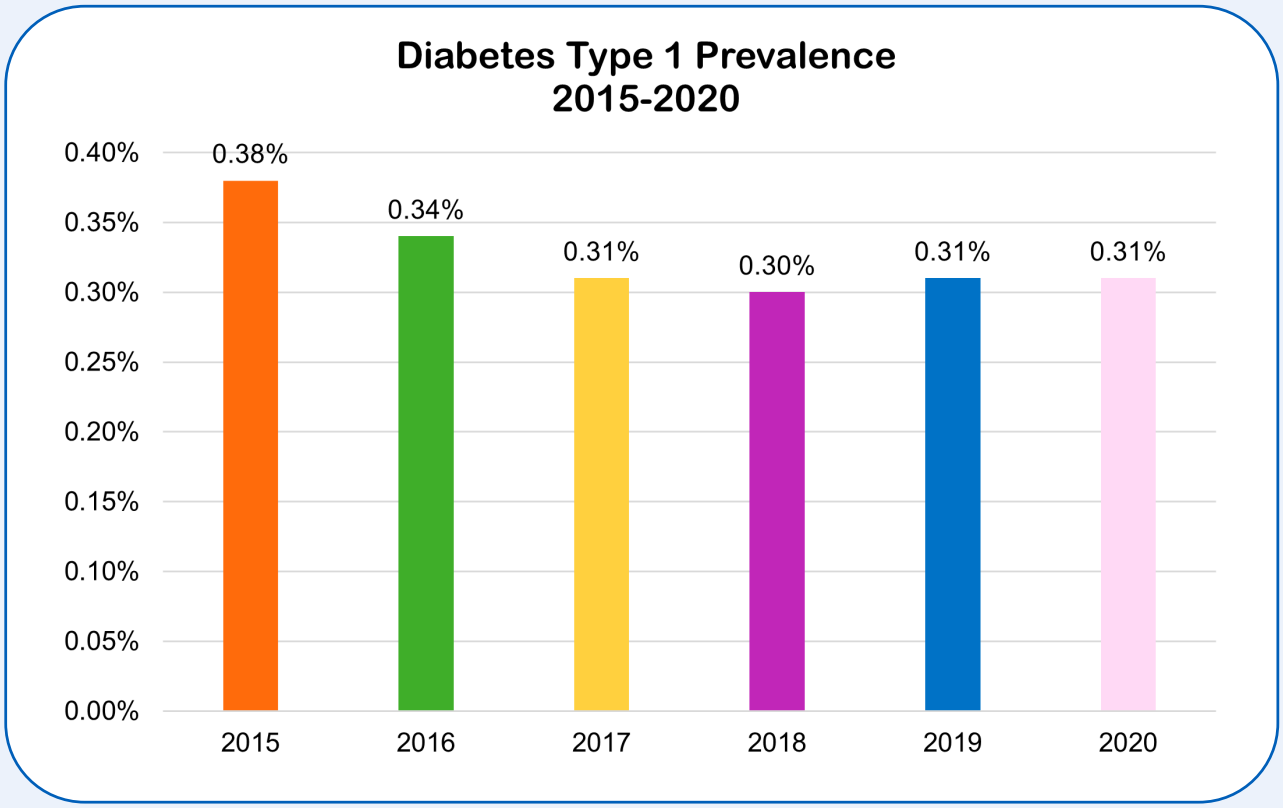
Asthma Spirometry 2015-2020

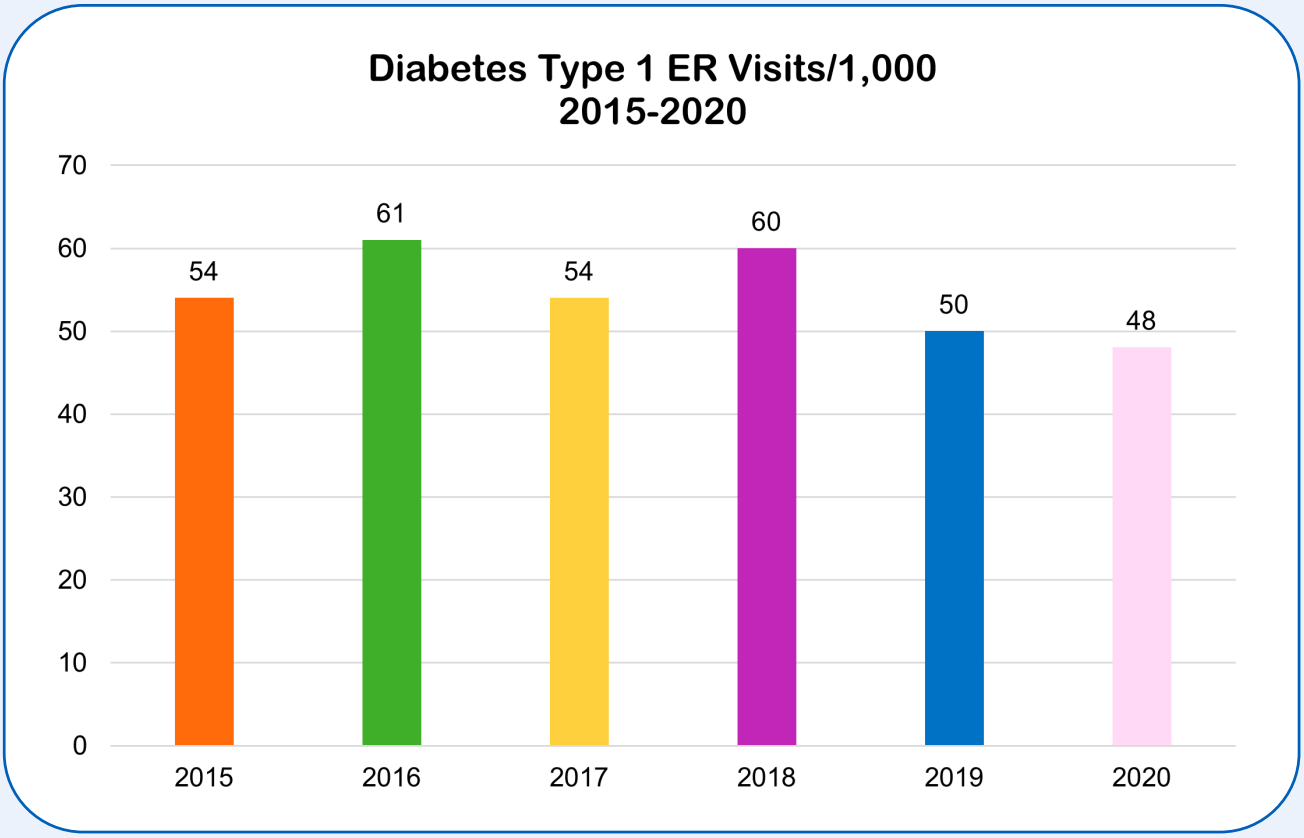


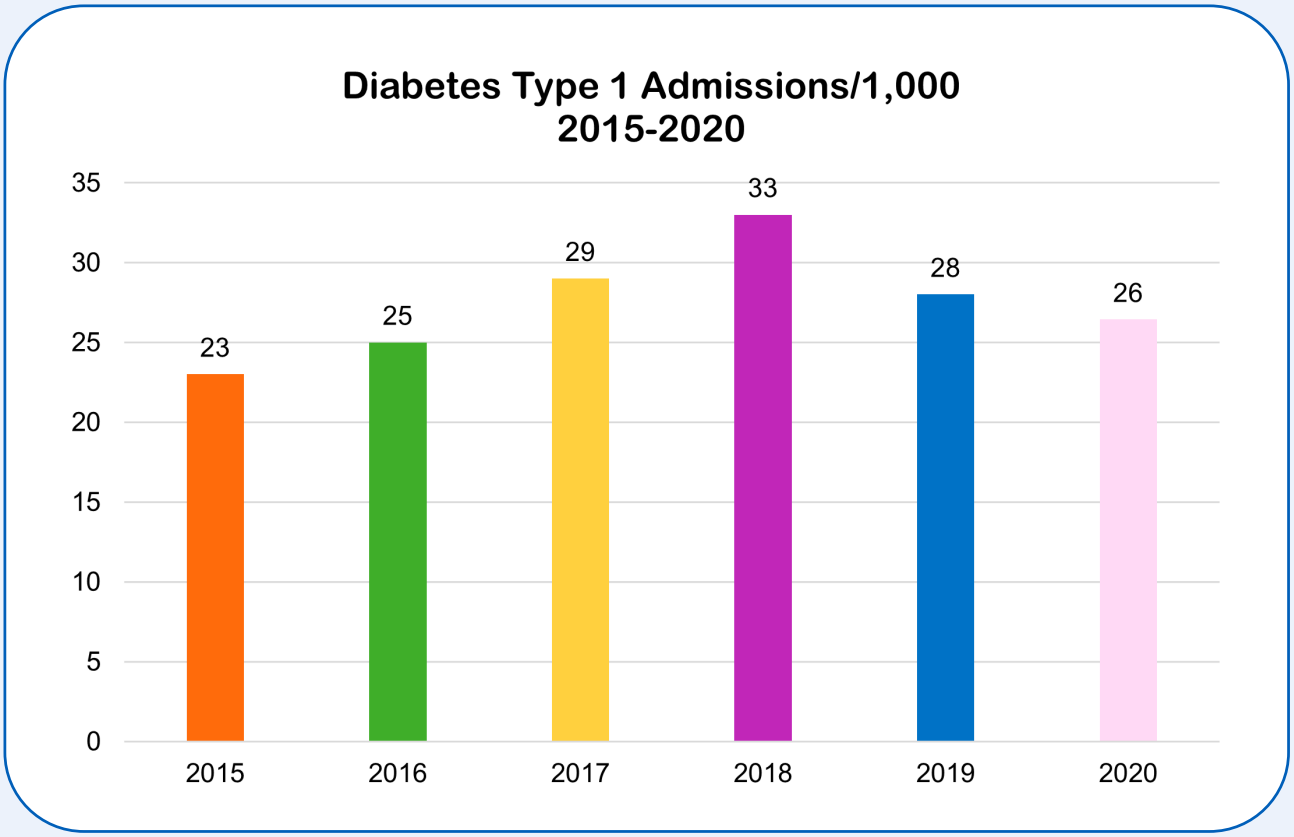

Asthma ER Visits/1,000
2015-2020
25
20
15
10
5
0
21
19
20
17
14
12
2015
2016
2017
2018
2019
2020

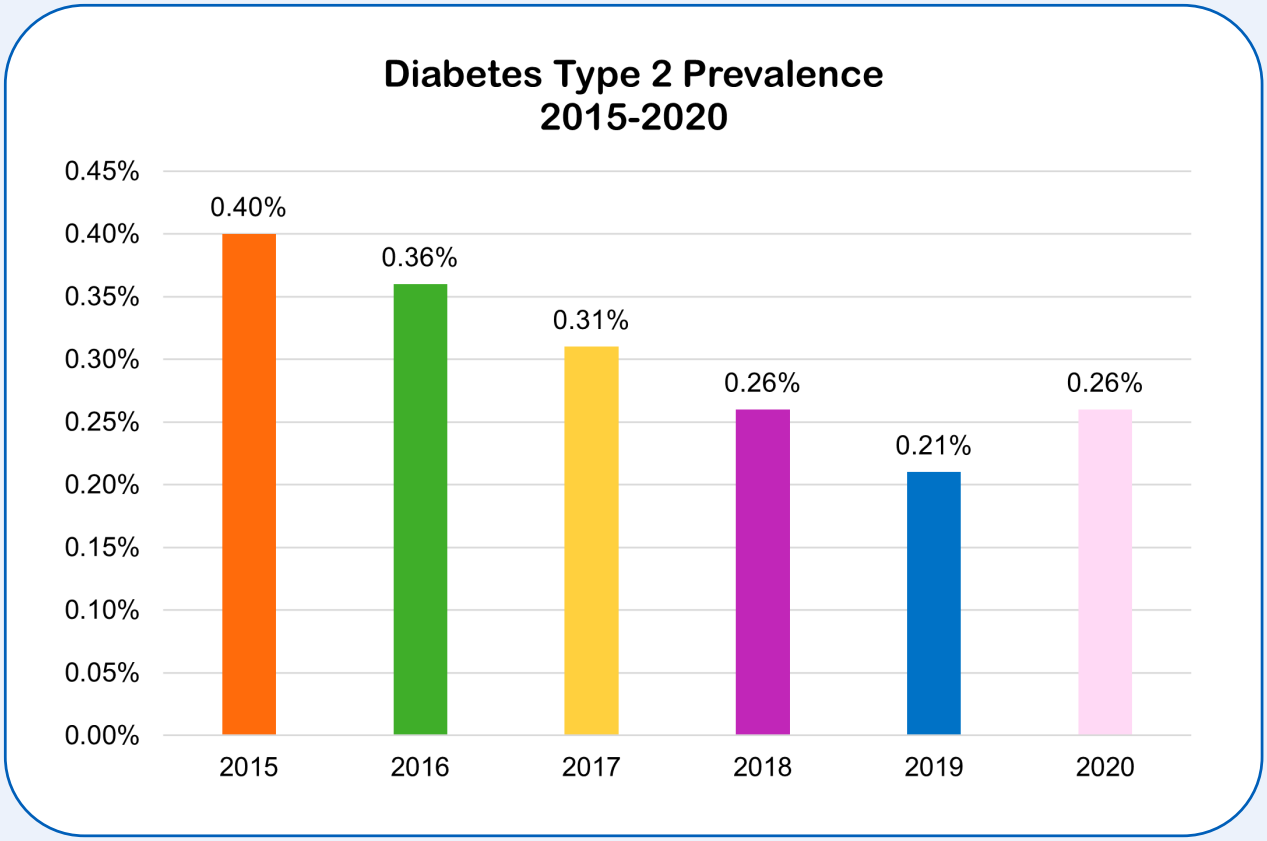

Asthma Admissions/1,000
2015-2020
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
3.5
3.7
3.4
3.8
3.5
2.4
2015
2016
2017
2018
2019
2020

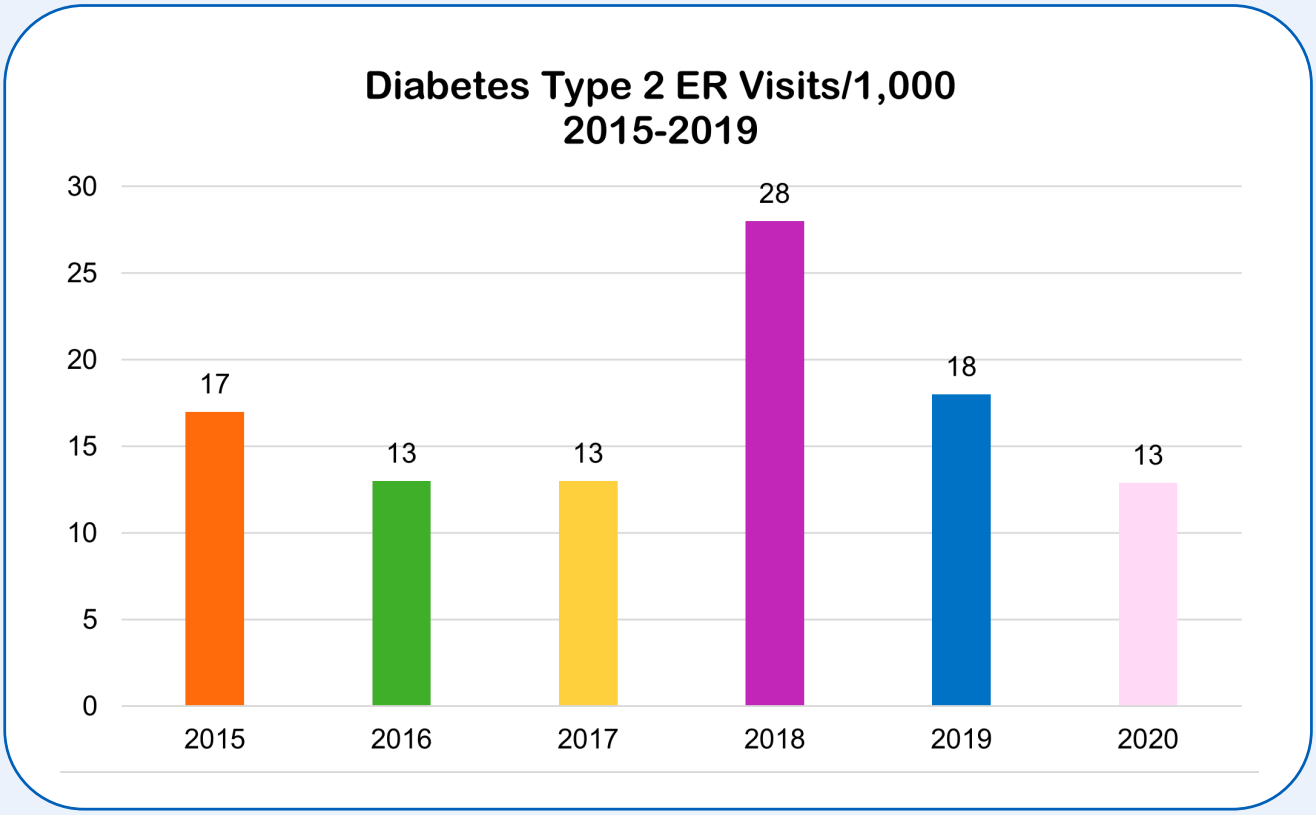
Diabetes

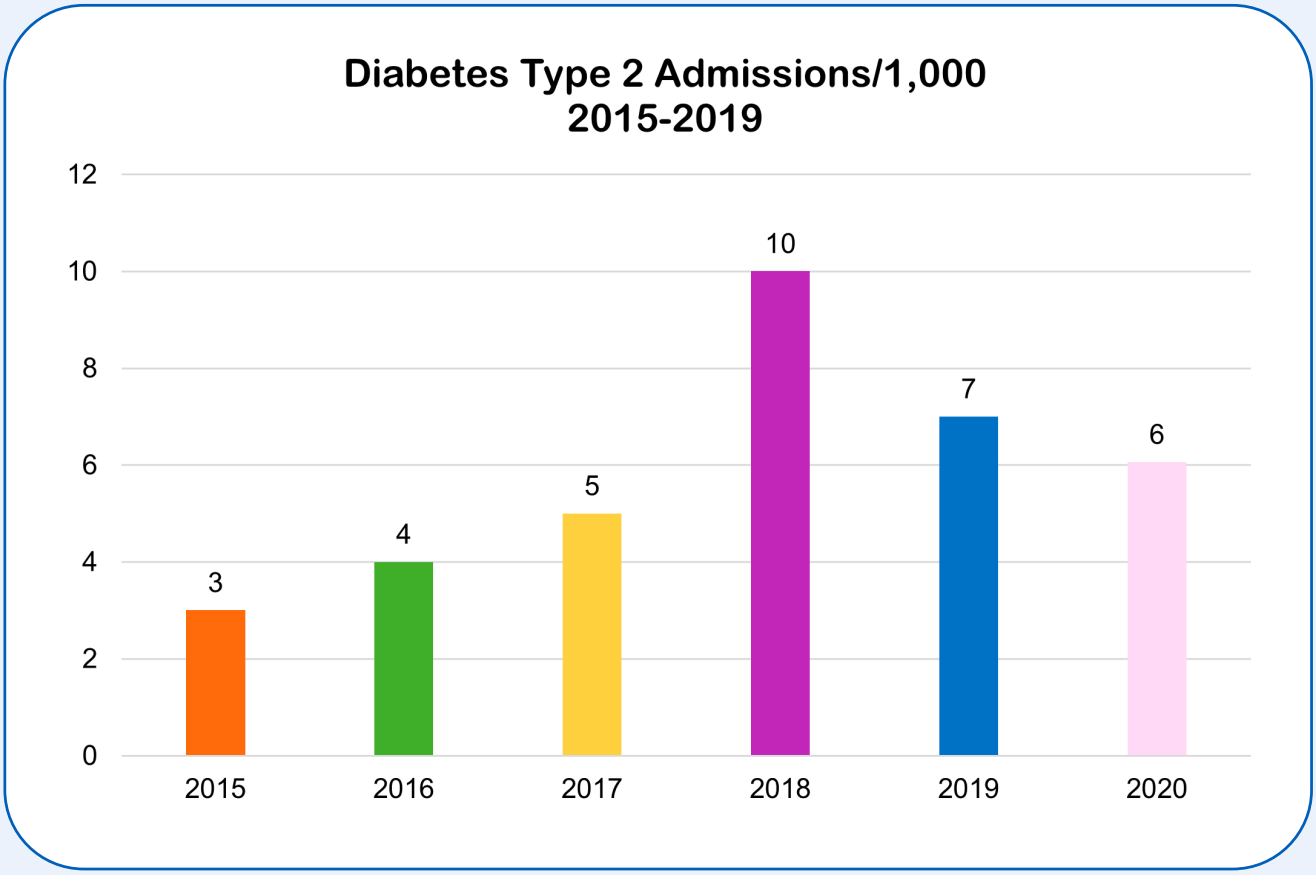

Diabetes Type 1 Prevalence
2015-2020
0.40%
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
0.38%
0.34%
0.31%
0.30%
0.31%
0.31%
2015
2016
2017
2018
2019
2020

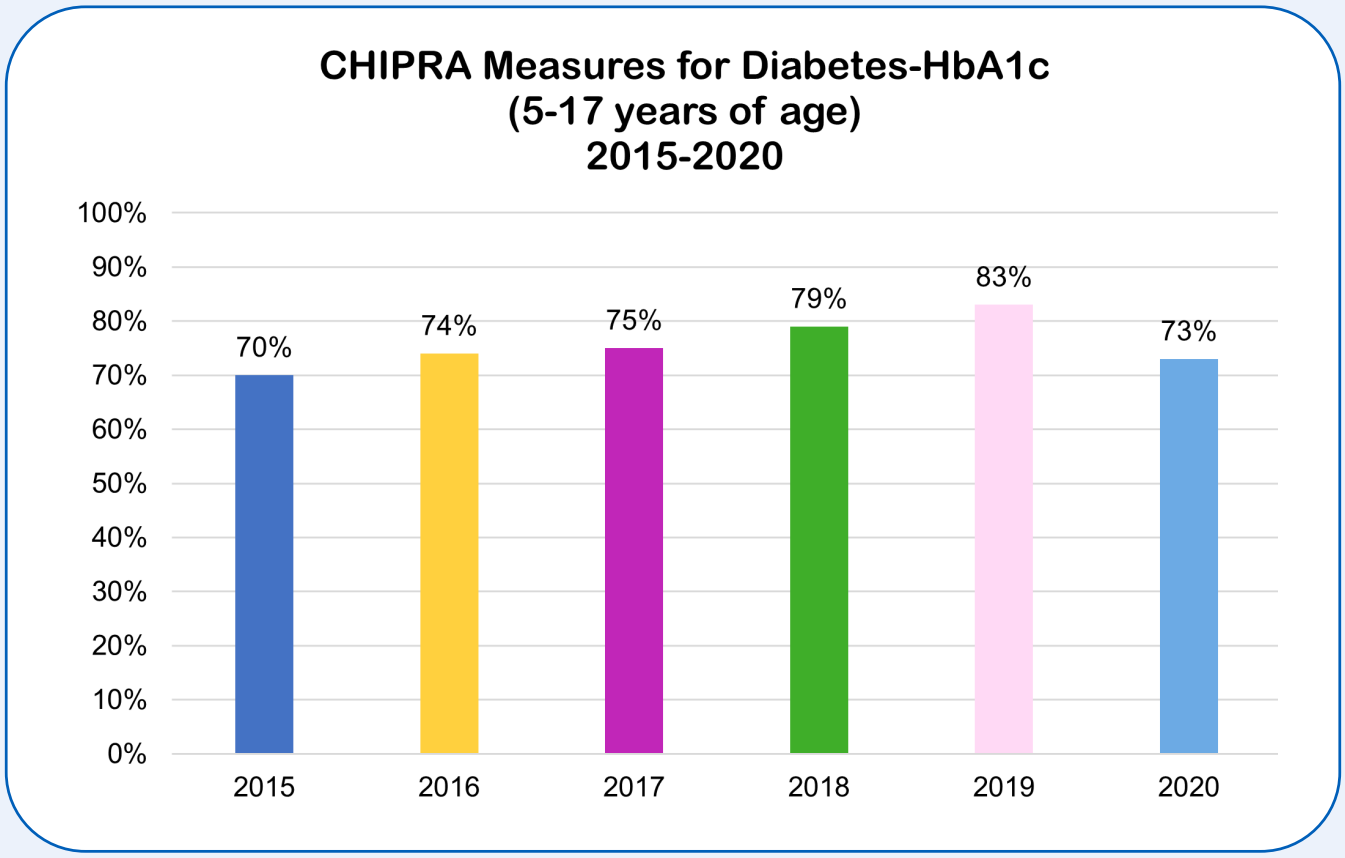

Diabetes Type 1 ER Visits/1,000
2015-2020
70
60
50
40
30
20
10
0
54
61
54
60
50
48
2015
2016
2017
2018
2019
2020

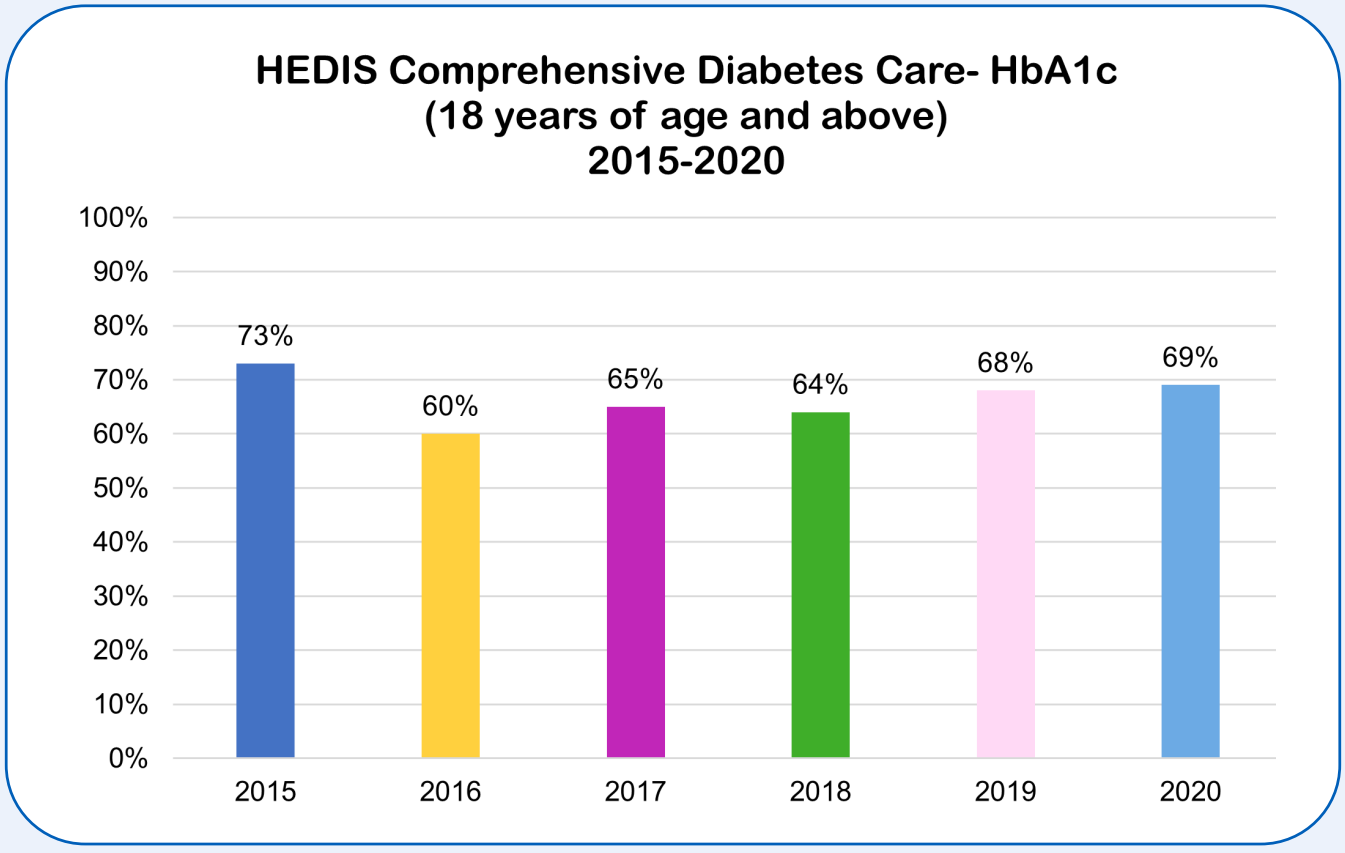

Diabetes Type 1 Admissions/1,000
2015-2020
35
30
25
20
15
10
5
0
23
25
29
33
28
26
2015
2016
2017
2018
2019
2020

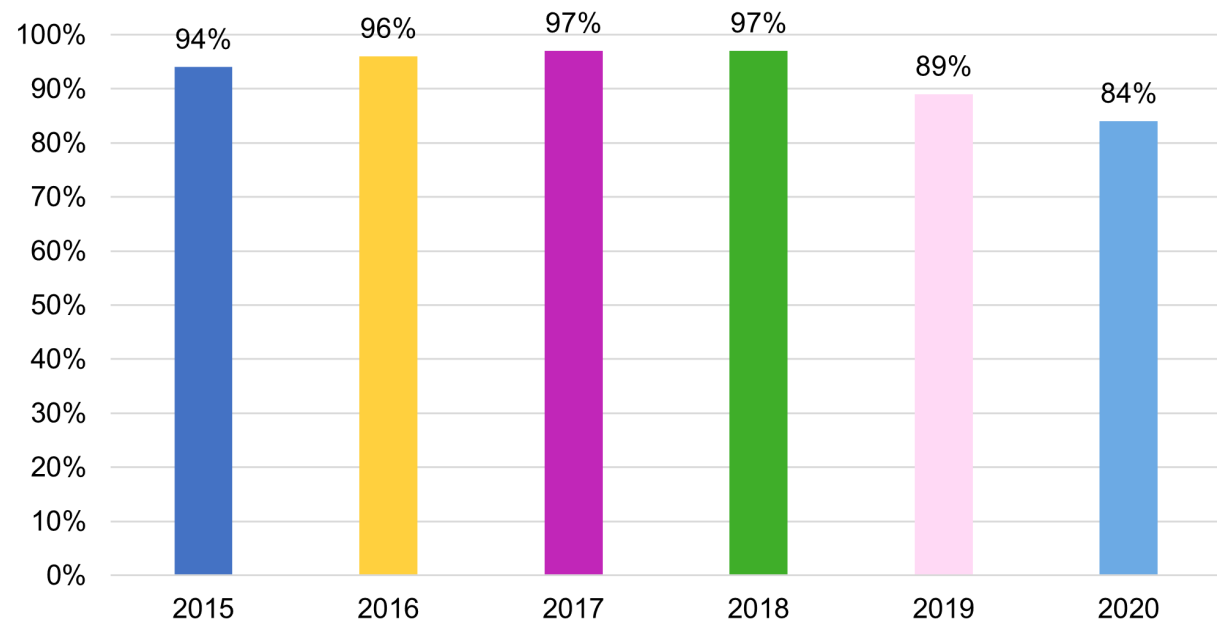

Diabetes Type 2 Prevalence
2015-2020
0.45%
0.40%
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
0.40%
0.36%
0.31%
0.26%
0.21%
0.26%
2015
2016
2017
2018
2019
2020

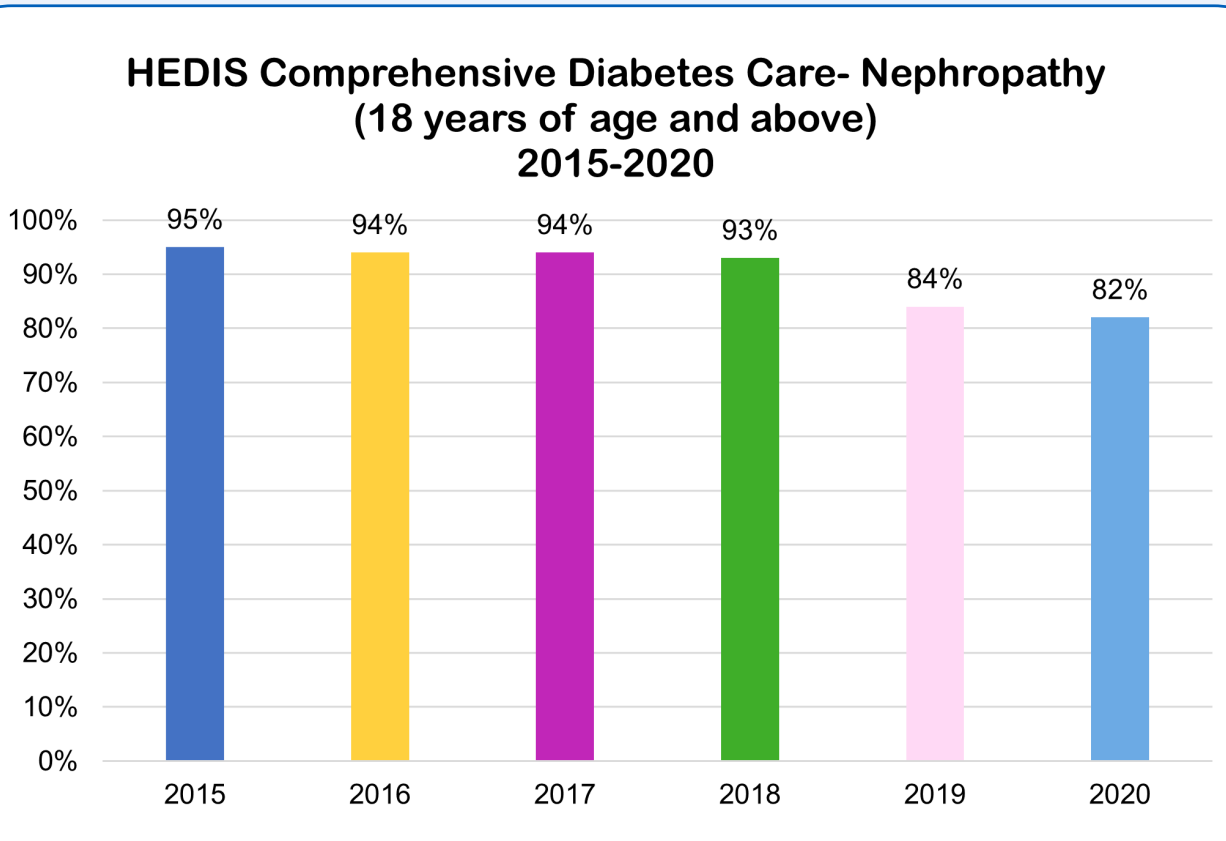

Diabetes Type 2 ER Visits/1,000
2015-2019
30
25
20
15
10
5
0
17
13
13
28
18
13
2015
2016
2017
2018
2019
2020

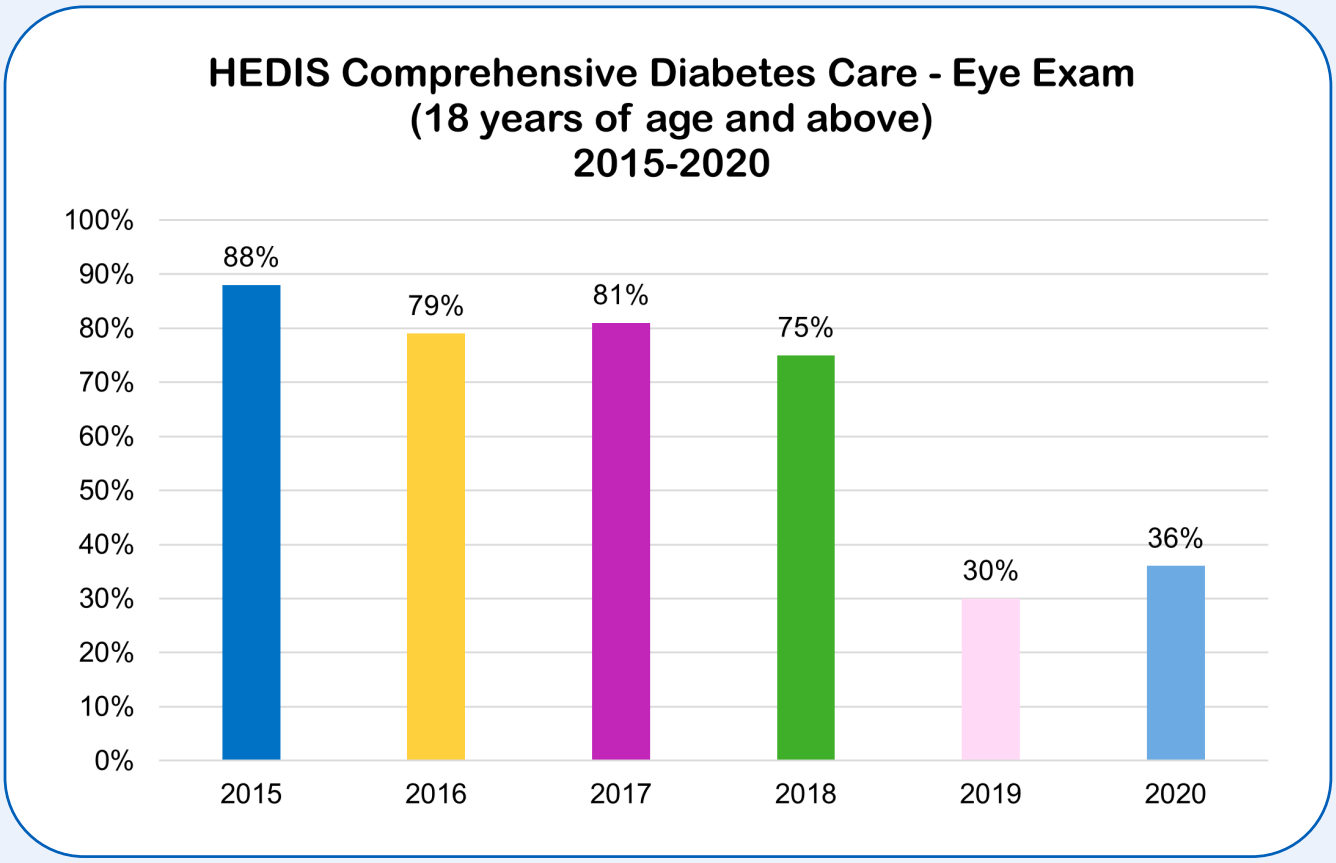

Diabetes Type 2 Admissions/1,000
2015-2019
12
10
8
6
4
2
0
3
4
5
10
7
6
2015
2016
2017
2018
2019
2020


CHIPRA Measures for Diabetes-HbA1c
(5-17 years of age)
2015-2020
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
70%
74%
75%
79%
83%
73%
2015
2016
2017
2018
2019
2020


HEDIS Comprehensive Diabetes Care- HbA1c
(18 years of age and above)
2015-2020
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
73%
60%
65%
64%
68%
69%
2015
2016
2017
2018
2019
2020


CHIPRA Measures for Diabetes-Nephropathy
(5-17 years of age)
2015-2020
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
94%
96%
97%
97%
89%
84%
2015
2016
2017
2018
2019
2020


HEDIS Comprehensive Diabetes Care- Nephropathy
(18 years of age and above)
2015-2020
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
95%
94%
94%
93%
84%
82%
2015
2016
2017
2018
2019
2020



Analysis

Referral, Outreach, and Case Activity

Referrals increased 17% from 3,334 in 2019 to 3,900 in 2020. The top referral conditions have remained consistent from 2019 to 2020 with high-risk pregnancy and foster care 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 2020, the Care Integration program screened 3,900 members for case management services. Of those, 942 members (24%) were subsequently enrolled into services. Complex cases, those opened for ≥ 60 days with a completed condition-specific assessment, accounted for 96.2% of cases opened. Members with minimal needs are opened as case management cases and receive brief solution-focused interventions, 3% of cases were 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 2020, Achievement of Goals/Stabilized Condition/Improved Health was the primary case closure reason for 39% of the cases closed. This case closure reason was attributed to 35% of cases closed in 2019.
In addition to daily huddles, Care Teams also

participate in Lean Work Groups and develop Lean quality improvement initiatives for their work duties. In 2019, PCN also developed mini work groups focused on Private Duty Nursing and Transplant member needs, which have continued through 2020.

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: Access to Care, CHIPRA HbA1c Monitoring, CHIPRA Nephropathy Screening, Chlamydia Screening, Age 2 Immunizations (Combo 10 – including flu vaccine), Lead Screening, and Well-Child Visits 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 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 following measures: Adolescent Well Care Visits, Asthma Medication Management (75% Compliance), and Well-Child Visits 0-15 Months (6 or more visits). PCN attributes many of these decreases to the overall impact of the 2020 coronavirus public health emergency. To ensure improvement in these areas moving forward, PCN will encourage quality improvement strategies within PCN practices, and incorporate discussion of those topics into the Triannual Performance Review meetings (see the Population Health Management section for more details).

Member/Caregiver Experience with Case Management

In 2020, 100% of members surveyed reported that they were overall satisfied with the services provided through the PCN case management program. PCN scores consistently well across the survey responses. Changes were made in 2020 to increase health literacy and ease of access of the survey.

Member/Caregiver Experience with Disease Management

The 2020 disease management survey results demonstrate member engagement with the Care Teams and providers. In addition, members report 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. 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 Population Health Management Network Representatives, who all work closely with the member's PCP to support population health strategies.

During 2020, Care Teams focused on chronic disease management and ongoing outreach to medium and high-risk member 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'.

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 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 are remained on an asthma controller medication for at least 75% of their treatment period. In 2020, PCN saw a % point increase in this measure (26% in 2019 to 29% in 2020).

Spirometry is an important tool used in assessing conditions such as asthma. As demonstrated in the data, spirometry uses for members with asthma increased 1% point from 2019 to 2020.

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 2020, the prevalence of both type 1 and type 2 diabetes in the PCN population was less than 1%. From 2019 to 2020, inpatient utilization decreased for members with type 1 and type 2 diabetes. ER utilization for members with type 1 and type 2 diabetes also decreased.

Provider and Member Adherence

CHIPRA, which accounts for the bulk of PCN's diabetic population, saw an increase in HbA1c testing (from 83% to 84%) and no change in nephropathy screening (84%). 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:

- Incorporate additional educational opportunities related to trauma informed care and resiliency to further support provision of quality services.
- Re-evaluate levels of case management to further incorporate best practices related to interventions and follow-up schedules.
- Partner with contracted health plans for ongoing staff education on available benefits and resources to assist in further member engagement and positive outcomes.
- Explore alternative delivery methods of the Case Management and Disease Management Patient Experience surveys to assist in obtaining a broader patient voice in program development and growth.

6 2020 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: *The Care Navigator (CN) received an outreach request from the Children's Mercy Developmental and Behavioral Clinic to assist mother in getting pull ups for a 5 year old member. The member had Autism and experienced significant issues with speech, toileting and wandering. The member participated in speech therapy at CMH and used an iPad at school to facilitate his communication. His mother was unaware that he may be able to have a communication device at home as well. During contact, the member's mother also spoke tearfully about an incident during one of the coldest days of the winter in which the member wandered away from the family home and had to be located by the police.*

Outcome: The CN made contact with the member's Primary Care Provider who agreed to send an order to a DME company for pull ups to assist with member's toileting issues. The CN also made a request to PCP for an evaluation at Ability KC for an Augmented Communication Device. In response to the mother interest in a GPS monitor for member due to the safety issues associated with his wandering behaviors the CN researched options. GPS monitors are not covered by Kansas Medicaid but the CN connected mother with the Kansas Bureau of Special Healthcare Needs and the member is now on a wait list to have this item granted as a special bequest.

Success Story #2

Synopsis: *A 14 year old member who recently had gained 20 pounds was referred to a PCN Care Navigator (CN). The member's mother outreached PCN for resources regarding weight management issues. Through assessment it was noted the member also had begun showing depressive symptoms. Through their work together, the CN assisted in connecting the member with the Weight Management Clinic at Children's' Mercy. The CN also helped the mother identify/connect with behavioral health resources through the member's healthplan.*

Outcome: The member is regularly seeing a therapist and his mother states the member presents as "happier". The member has also lost between 25-30 lbs and continues to work with a case manager through the Weight Management Clinic. Through connection with a CN, the member was able to engage in services that address both his medical and his behavioral needs, thus ensuring his holistic health.

Success Story #3

Synopsis: *The Care Navigator (CN) received a referral from Children's Mercy Home Care for an 8-month-old infant. The mother, who spoke English and Burmese, was needing community resources and the infant was needing to be seen for a well child check (WCC). After identification of multifaceted needs, the CN involved the Community Health Worker (CHW) to assist in supporting mother, who was legally blind, in exploring resources for her own health needs. The CN also involved the Community Resource Specialist (CRS) who assisted mother in obtaining beds for the children, obtaining utility assistance, and looking at potential options to address housing insecurity. Finally, the CN also worked with the member's PCP to get a WCC scheduled to ensuring ongoing health of the member.*

Outcome: Through the collaboration of the PCN Care Team, CHW, and provider this family's social determinants of health needs were addressed in such a way that it allowed the member's medical needs, namely a WCC, to occur.

Success Story #4

Synopsis: *The PCN Behavioral Health Specialist (BHS) worked closely with a 16-year-old member who was on multiple waitlist for Psychiatric Residential Treatment Facility (PRTF) treatment while being held at JDC. The member was struggling with depressive symptoms, self-harm, suicidal thoughts, and mood dysregulation. The BHS worked closely with JDC to ensure the member was obtaining the appropriate services while on the waitlist for multiple months. Despite these services, the member was actively in crisis often, and frequently required acute hospitalization despite having round the clock supervision at JDC. When a bed became available at a local PRTF the member was declined as the facility believed the member to be too acute for their program. However, the BHS advocated for the member to have access to this bed based on his motivation levels for treatment, his desire to seek help, and his mental health not being managed effectively in JDC (due to this not being the most effective setting for mental health treatment).*

Outcome: Due to the advocacy of the BHS, the facility re-reviewed the member and accepted the member into their program that week. Post PRTF treatment, the member was successfully discharged to home with his mother and was able to maintain successfully in his home with community-based services.

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 #5

Synopsis: *The Community Resource Specialist (CRS) was alerted to a 17-year-old member expecting a baby with reported lack of access to resources for baby supplies including crib, car seat, etc. The member's primary language was Arabic, which created barriers to self-acquisition of resource assistance. CRS attempted to connect member with known resources, however they were unable to assist due to the language barrier. The CRS continued outreach on behalf of this member and as part of the outreach contacted the members medical provider to arrange member's enrollment in their office's Healthy Start program as well as discussing need for ongoing care/outreach from provider.*

Outcome: As a result of the CRS's collaboration with the member's PCP, the member was successfully enrolled into the provider's Healthy Start program and received assistance in connecting to many resources including crib, car seat, diapers, breastfeeding information, pregnancy classes, etc. This connection also helped build the relationship between the member and her medical provider.

Success Story #6

Synopsis: *The PCN Care Navigator (CN) was case managing a 1-year-old boy with a congenital malformation of his heart. The member was on oxygen, GJ Tube feeds, and receiving Private Duty Nursing. The home also had another complex needs child. Due to the father's loss of employment, the family had to suddenly move to Springfield, Missouri. The CN partnered with mother in identifying primary care provider (PCP) options in the Springfield area. The CN partnered with Children's Mercy Hospital's Case Management team to find a DME Provider in the Springfield area for transition of the member's enteral and oxygen services. However, once these services were arranged, the mother alerted the CN of frustration that the new provider's standard enteral kit varied from those provided by her previous provider. Specifically, the new provider did not provide Flexitak and Primafix tape to keep this active member's GJ Tube/Tubing in place. The CN partnered with the previous provider to obtain a full listing of brands of enteral supplies the member had been using and provided this to the new provider. In turn, the new provider was able to identify corresponding products they carried and formed a specialized enteral supply kit to meet the member's needs. Through all of this, the CN also worked with private duty nursing agency to transition the member's Private Duty Nursing to the agencies branch in Springfield. Once supplies and services were arranged, the CN transitioned case management for both children to United HealthCare Community Plan of Missouri as their new address removed them from PCN alignment.*

Outcome: The PCN CN's coordination, and advocacy, with providers served to ensure the member was able to receive the appropriate enteral supplies and oxygen supplies that met his specific needs. This coordination also ensured the member had a seamless transition of his Private Duty Nursing from Kansas City to Springfield. Finally, by partnering with the previous PCP and the mother, the Care Navigator was able to support the identification and connection with a new PCP close to where the member now resides.

Success Story #7

Synopsis: *A 22 year old African American female was referred for pregnancy outreach. This member had recently relocated to the Lawrence, KS area- she had some psychosocial needs and a history of behavioral health needs which was being monitored by the Care Navigator (CN). The member had established care with a local OB provider but felt that this provider was not sensitive to her cultural needs.*

Outcome: The member called her Care Navigator and requested assistance finding African American OB providers as well as African American Pediatricians for her child. The CN did sought out and located African American OB provider in Johnson County, KS. Once ensuring the provider was accepting new patients, the CN assisted the member in quickly transitioning care. The CN also provided the member with options for African American Pediatricians and after delivering her child, the member was able to engage in care with one of the pediatricians found by the CN. The member had very positive, affirming experiences with both of these providers and was extremely grateful for the assistance from PCN. Through this work, the CN also educated the member about how to use mileage reimbursement benefit for her trips to and from Johnson Co to see her OB provider.

Success Story #8

Synopsis: *The PCN Care Navigator (CN) was working with a 21-year-old with a diagnosis of muscular dystrophy and autism. The family was Spanish speaking and required interpretation/intensive assistance with Care Coordination due to cultural/language barriers. Part of the identified care plan for this member was a goal related to need for preventive services/having an exercise plan in place. The member's mother noted that the member was needing ongoing outpatient physical therapy (PT) to address needs related to Muscular Dystrophy. These services had not been arranged despite orders from the member's primary care provider(PCP). The CN was able to work with the member's PCP and other providers to discover the provider referred to for services had declined to initiate as they do not provide outpatient services. It was also discovered that the member requires a hoyer lift for PT to ensure safety, and many outpatient PT locations do not have a hoyer on site. The CN partnered with the family and PCP to identify a local rehabilitation hospital who was able to accommodate this need in their outpatient setting.*

Outcome: With mother's approval, the CN assisted the PCP office in submitting applicable referral/intake information to the rehabilitation program. Subsequently, the member was able to connect with these needed services through a provider that was able to accommodate all his needs to ensure safety during provision of cares.

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 #9

Synopsis: *A family with two young children was referred to the CHW for assistance with furniture, including beds for the children. The father recently separated from the children's mother due to substance abuse concerns. As the mother worked on her recovery, she continued to have visits with the children and, in time returned to living in the home. The mother also had untreated medical issues and needed help getting ongoing medications.*

Outcome: The CHW was able to work with the family to connect with community agencies and obtain living room furniture and beds for the children. Additionally, the CHW was able to connect the mother with a community agency for assistance with her medications and partnered with mother to identify resources for substance use treatment. Despite previous issues with treatment adherence, with the additional support of the CHW the mother was encouraged to continue to attend treatment. By helping address the family's social needs as a whole, and helping the parent's address their own needs, the CHW was able to support them in better caring for their children.

Success Story #10

Synopsis: *Due to the COVID pandemic, and subsequent stay at home orders, the Community Health Worker (CHW) made the transition to working from home. This transition posed a challenge, as the CHW was not able to meet with patients face-to-face or go into the community during a time of increased vulnerability. The CHW contacted all the patients she had established work with to notify them and to check on resources the families may need during the stay-at-home order.*

Outcome: The CHW was able to provide updated information for food and utility assistance to all families who had a need. The CHW also was able educate the families on how to get the latest updates on COVID-19 to make sure they had the information they needed to keep their families safe during this unprecedented time.

Success Story #11

Synopsis: *The CHW began working with a Burmese speaking family. One of the children was ill, and had been on hospice. Due to care needs of the child, the parents had been unable to work and the family had limited financial resources. Despite the good news of the child's health improving to the point of no longer being on hospice, the time the family had spent caring for her meant they needed assistance with rent and utilities. With the family's consent, the CHW contacted local community based organizations to identify resources.*

Outcome: The CHW was able to connect the family with a local community agency who not only was able to assist with the immediate needs of rental/utility assistance, but also had interpretation staff available that were familiar with working with and supporting refugees. Through connection with the CHW the family was able to have their immediate needs addressed, while also building a connection with an agency that could support them more longitudinally should future needs arise.

Success Story #12

Synopsis: *Through her work at Central High School the CHW received a referral for an 18 year old with housing issues. Through her work with the member, the CHW discovered this student had lived at 8 different address, with multiple relatives, and at one point was in state custody. At the time of referral, he stated he was currently living with his grandmother and slept in a chair. In addition to going to school, the member was working 8 hours a night at a warehouse to help support finances. The CHW identified Synergy as a potential resource and assisted the member in completing the online application. Once submitted, the member agreed to check in with Synergy regularly to ensure his application was received, check on progress, and maintain contact with the CHW during this time.*

Outcome: The CHW checked in with the member ever 2-3 weeks, and approximately 1-2 months later the CHW was able to confirm with the member that he was now scheduled to move into his new apartment. The CHW was able to further support the member with grocery resources for his new home. By working with the CHW, the member was able to obtain stable housing for the first time he could recall and had begun saving his earnings.

7 Summary

- 2021 Goals and Objectives
- 2021 Work Plan

Summary of Calendar Year 2021 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
- Patient Outreach Solution (InConnect)
- Population Health Management Point-of-Care Solution (InNote)
- Social Determinants of Health Directory (Lift Up KC)
- Behavioral Health Collaboration

Community Resource Team

The PCN Community Resource Team worked on numerous projects throughout 2020. Although in person community resources connection meetings were placed on hold due to the COVID pandemic, the PCN Community Resource team continued to partnered and 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 team also collaborated with community agencies to disseminate information and schedule virtual presentations for the PCN team and broader Children's Mercy System. In 2021, in tandem with the roll out of Lift Up KC the PCN Community Resource team will continue to investigate opportunities for resource acquisition to best support the needs of members.

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 2020focused on allowing providers to have the ability to enter authorization requests online through the PCN secure portal, and allowing PCN team members to add member preferences to C.A.R.E. Web to display a member's preferred name/pronoun and gender identity. In 2021, PCN will focus on C.A.R.E web enhancements that incorporate more streamlined layout to allow seamless team collaboration including the functionality of member alerts, allowing for individualized task list organization, and incorporate more automated features that ensure all identified needs have individualized goals associated in Care Plan.

Community Health Worker Program

The Community Health Worker (CHW) moved off-site at the start of the pandemic but continued to attend daily PCN Care Team huddles virtually and accept referrals from the PCN and hospital social work teams. Although students were not attending school in person, the CHW remained connected to the staff at Central High School and worked to support students in need. In 2020 the CHW program received 85 referrals of PCN members and enrolled more than 65% into a case management program. Despite the pandemic, 68% of the goals set by families in partnership with their case manager were achieved. When schools reopen and students return to the classroom, the CHW will again be on-site at Central High School to engage students in achieving physical and mental wellbeing.

Patient Outreach Solution (InConnect)

In 2020, PCN successfully transitioned patient outreach campaigns to Innovaccer's InConnect solution. PCN will continue campaigns three times a year for patients in need of well visits, which includes those patients who have not seen their primary care provider in over a year. PCN will also continue to target medium and high-risk asthma members in two seasonal asthma campaigns to encourage visits with providers every six months. PCN will also continue the use of weekly outreach campaigns inviting patients to join the PCN Case Management program. This campaign is aimed at engaging eligible patients, based on high utilization or new chronic diagnoses, in a timely manner. The InConnect solution provides near real-time feedback on the effectiveness of the campaigns and offers much greater flexibility to configure campaign settings to help PCN more effectively reach patients in more meaningful and valuable ways.

Population Health Management Point-of-Care Solution (InNote)

PCN is in the process of deploying a new population health management point-of-care solution called Innovaccer InNote to all PCN practices. The InNote solution functions agnostic of EMR. The application is an 'overlay solution' that automatically recognizes the patient being viewed in the native EMR to bring relevant information concisely and efficiently at the point care. This includes care gaps, acute visit history, and future/past specialty visits. New functionality in 2021 will include direct access to Children's Mercy specialty notes and the ability to perform closed loop social need referrals. The deployment of InNote is proceeded by the implementation of a near real-time comprehensive EMR data feed with each PCN practice, making the information at the point of care accurate and up-to-date. The EMR data feed is typically sent daily and includes most EMR data elements (i.e.. procedure codes, diagnostic codes, immunizations, problem lists, ordered medications, scheduling data, vitals, etc.).

Children's Mercy Social Determinants of Health Directory & Platform

PCN began working with Aunt Bertha in September 2020 to develop a Children's Mercy branded Aunt Bertha website. The website will serve as a regional directory of social need services and serve as a platform to perform closed loop social need referrals. The site's purpose is to seamlessly connect patients and families to community resources and services to improve health outcomes. Recognizing that the site is simply a technology, PCN is partnering with community based organizations (CBOs) and other regional stakeholders to develop relationships to improve the coordination of services. Our goal is to partner with our community to create the infrastructure necessary to evaluate the effectiveness and further investment in community resources to address social needs of the families we serve. The site will be branded as Lift Up KC (https://www.liftupkc.org) and is targeted to launch in the second quarter of 2021.

Behavioral Health Collaboration

Behavioral Health Specialists are Registered Nurses or Clinically Licensed mental health professionals responsible for prior authorization and outreach for inpatient and outpatient behavioral health services. The Behavioral Health Specialist works in collaboration with care providers through education on the prior authorization process, facilitation of referrals to network providers and services, outreach to identify, screen and engage members with complex behavioral health needs for enrollment into Care Integration programs. Depending on services delegated as part of their contracts, PCN staff either manage behavioral health needs internally via the Behavioral Health Specialist role or work collaboratively with the Health Plan behavioral health staff to coordinate and manage the medical and behavioral health needs of members. In 2021 PCN will utilize this role to further expand partnership with healthplan and community behavioral health resources through engagement meetings and incorporate collaborative case discussions to ensure care planning addresses the holistic member.

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 — June 8, 2021

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

Date

Approval: _____ June 8, 2021

Just for Kids (JFK) Committee

Date

_____ June 17, 2021

Clinical Quality & Operations Committee

Date

2021 Annual Work Plan

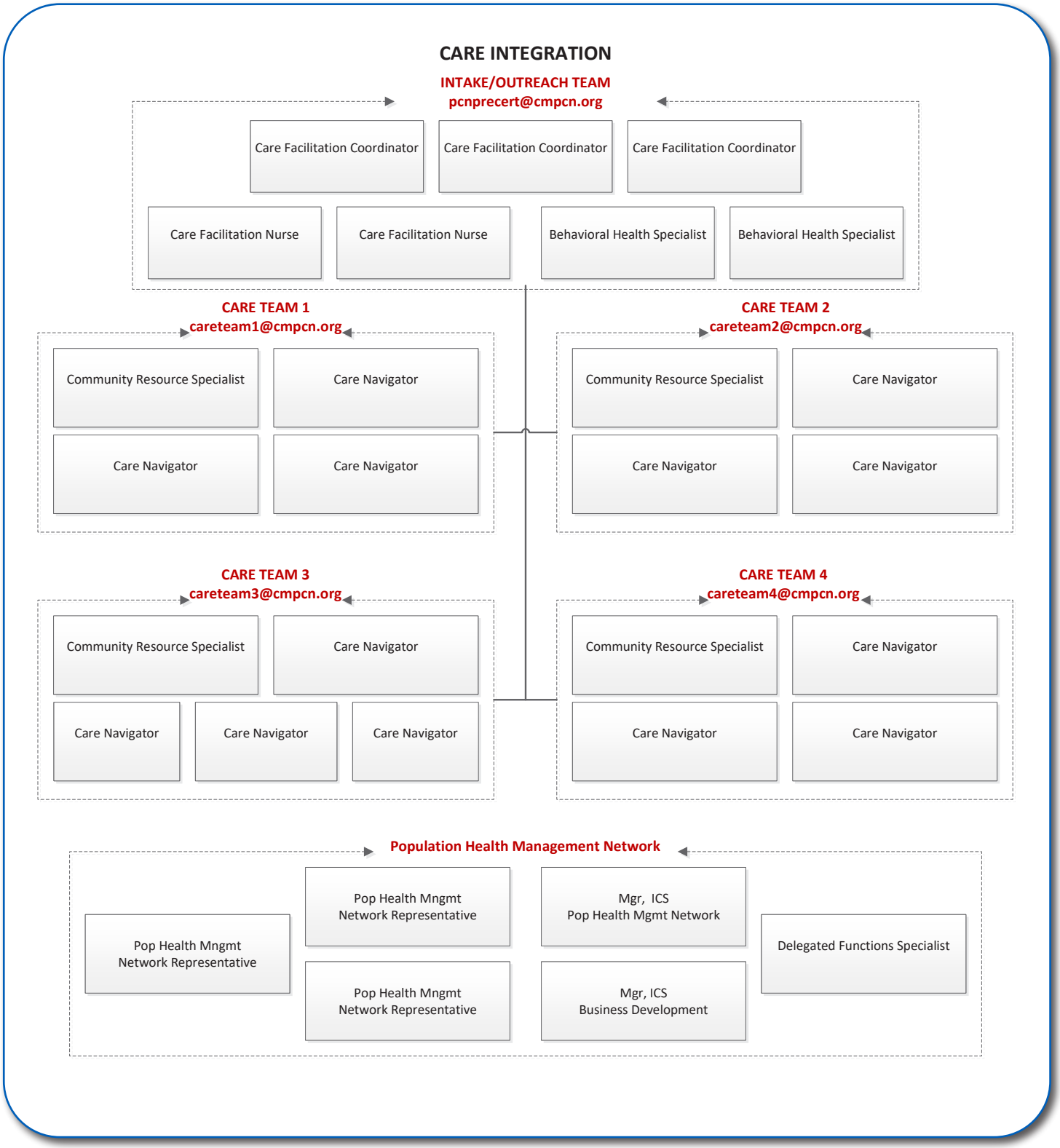
	Initiative	Operational Lead	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Scope & Process	ICS Resources for Spread (Operational Leader, Project Manager)
1	Enhance community connections and resource allocation	Community Resource Specialist Team	X	X	X	X	Expand collaboration with community organizations through engagement meetings and continue to investigate opportunities for resource acquisition through the Children's Mercy branded Aunt Bertha website (Lift Up KC).	Care Teams; IT Team; Operations & Population Health Management Team; Community Resource Specialist Team Population Health Network Team
2	Evolve Triannual Performance Review Process	Program Manager, Operations & Population Health Management Population Health Network 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; Population Health Network Reps.
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 work flow efficiency and ease of access for provider engagement.	Care Teams; IT Team; Management Team
4	Expand the Community Health Worker program	Senior Director of Integrated Community Care	X	X	X	X	Community Health Worker will be deployed to Central High School to support PCN members in maintaining healthy behaviors. PCN will monitor referral volumes and outcomes to determine sustainability of the program.	Data Analytics/ Operations & Population Health Management Team; Management Team
5	Continue & improve use of patient outreach platform (Innovaccer InConnect)	Program Manager, Operations & Population Health Management	X	X	X	X	Continue automated outreach campaigns for patients in need of well visits, medium and high-risk asthma patients, and patients identified as potentially needing care management services (based on frequent ED utilization or new chronic diagnoses).	Intake/ Outreach Team; Management Team; Operations & Population Health Management Team; Population Health Network Management Team

6	Deploy Population Health Management Point-of-Care Solution to All PCN Practices	Program Manager, Operations & Population Health Management	X	X	X	X	Complete deployment of population health management point-of-care solution to all PCN Practices. Solution functions agnostic of EMR and brings actionable insights to the point of care, including care gaps, acute visit history, and future/ past specialty visits. New functionality in 2021 to include access to Children's Mercy specialty notes and the ability to perform closed loop SDOH referrals.	Operations & Population Health Management Team; Management Team; Population Health Management Network Team
7	Launch Children's Mercy Social Determinants of Health Directory & Platform	Program Manager, Operations & Population Health Management	X	X	X	X	Launch a Children's Mercy branded Aunt Bertha website to serve as a regional directory of social need services and a platform to perform closed loop SDOH referrals. Site will be branded as Lift Up KC and targeted to launch in Q2 2021 (https://www.liftupkc.org/)	Operations & Population Health Management Team; Management Team; Population Health Management Reps; Care Teams; IT Team; Community Resource Specialist Team
8	Enhance Behavioral Health Collaboration and enhance integration	Director of Integrated Care	X	X	X	X	Expand partnership with behavioral health resources through engagement meetings and incorporate collaborative case discussions to ensure care planning addresses the holistic member	Care Teams; Operations & Population Health Management Team; Community Resource Specialist Team; Behavioral Specialist Team Population Health Management Network Reps

8 Appendix

- Care Team Diagram

Appendix A: Care Team Diagram



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