Care Integration
ANNUAL REPORT

CALENDAR YEAR
2017

Children's Mercy
PEDIATRIC CARE NETWORK

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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

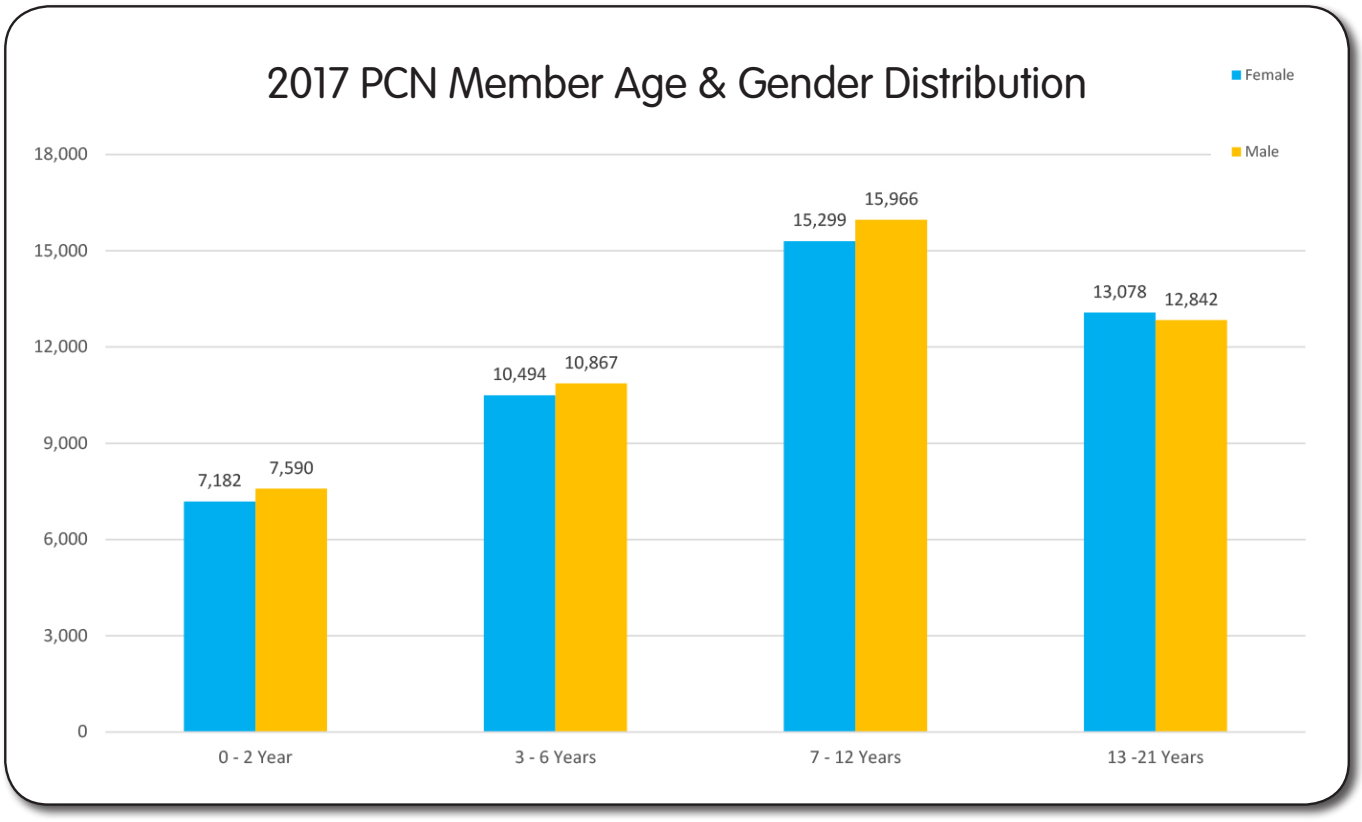
The Pediatric Care Network (PCN) offers a comprehensive care integration program, which provides case management (CM), care coordination (CC), utilization management (UM), and disease management (DM) using population health concepts and tools. The program focuses on preventive health and coordinating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

- Negotiating, procuring and coordinating services and resources needed by members 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 most prevalent in 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. From February 2012 to May 2017, PCN managed Aetna Better Health of Missouri members ages 20 and under in select counties of the Western Region. At the end of the contract in May 2017, the number of members managed for Aetna Better Health of Missouri was approximately 69,600. PCN entered into similar capitation agreements and delegated medical management with Missouri Care in February 2014 and with UnitedHealthcare Community Plan of Missouri in May 2017. As of December 2017, PCN managed approximately 63,689 Missouri Care members and 29,789 UnitedHealthcare Community Plan of Missouri members, ages 20 and under in the Western Region. Effective 11/1/2017, PCN entered into a similar contract with UnitedHealthcare Community Plan of Kansas for 26,677 members in select counties. Due to the timing of the Kansas membership implementation, population data for UnitedHealthcare Community Plan of Kansas is not reflected here.

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



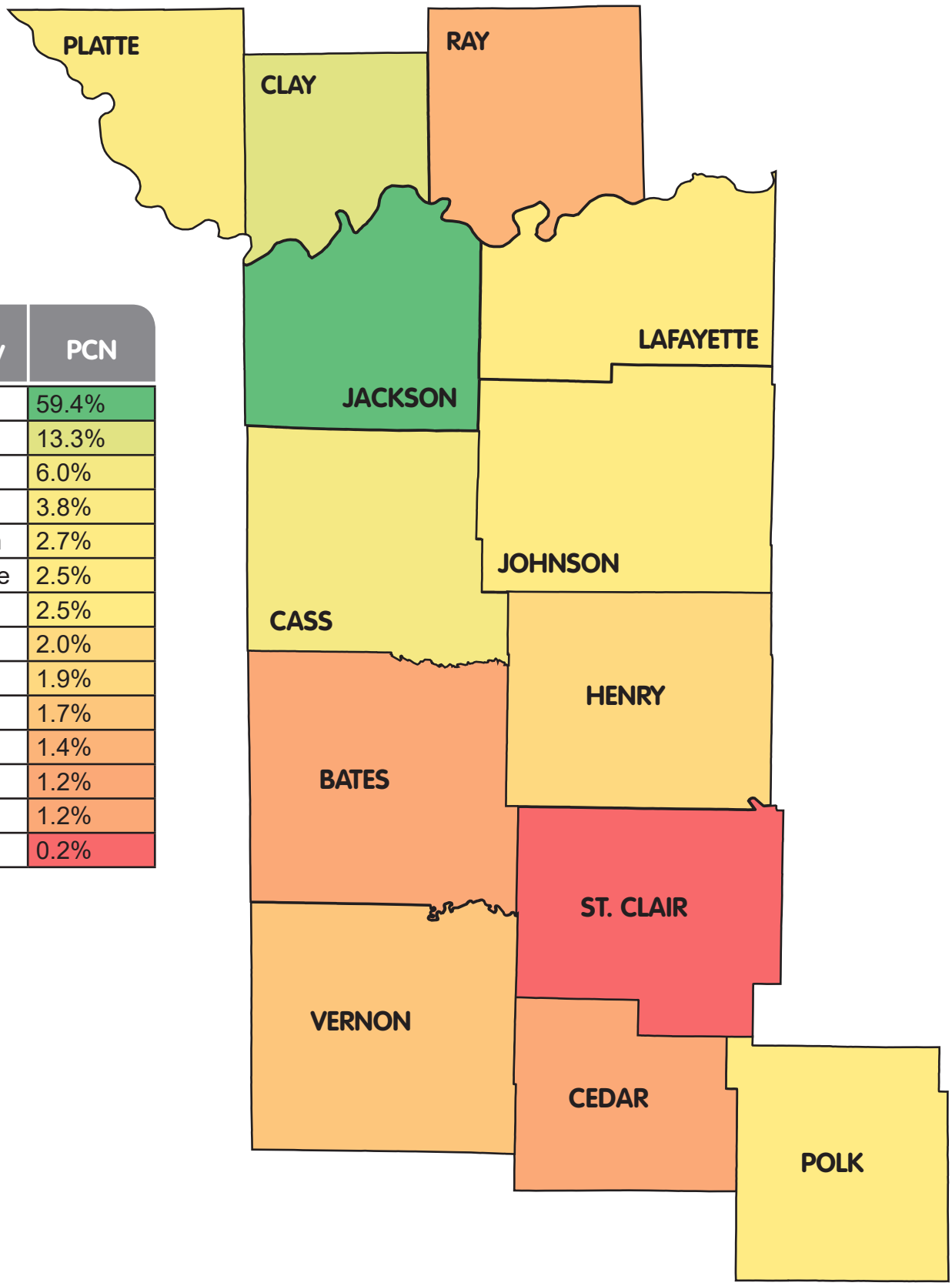
Population Analysis/Characteristics

As of Dec. 31, 2017, the male to female ratio of the PCN population is roughly 50% and the most concentrated population (approximately 23%) is in the 7-12 year age category. See chart illustrating the age and gender distribution of PCN members in 2017.

PCN Membership

PCN members live in 13 metro counties, with a majority (59%) living in urban Jackson County.

County	PCN
Jackson	59.4%
Clay	13.3%
Cass	6.0%
Platte	3.8%
Johnson	2.7%
Lafayette	2.5%
Polk	2.5%
Henry	2.0%
Other	1.9%
Vernon	1.7%
Ray	1.4%
Bates	1.2%
Cedar	1.2%
St. Clair	0.2%



PCN Network Providers -- Missouri

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

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

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

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

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

Cockerell and McIntosh Blue Springs
205 NW RD Mize Road, Ste 304
Blue Springs, MO 64014

Cockerell and McIntosh Higginsville
1717 Main, Higginsville, MO 64037

Cockerell and McIntosh Independence
11200 Winner Road
Independence, MO 64052

Family Practice Associates of Higginsville
1200 West 22nd St.
Higginsville, MO 64037

Family Practice of Warrensburg
513 Burkarth Road
Warrensburg, MO 64093

Fatima Mirza, MD
200 NE 54th St #120
Kansas City, MO 64118

Fernando Fernandez, MD
2750 Clay Edwards Drive, #320
Kansas City, MO 64116

H. Andrew Pickett, M.D.
1236 Jesse James Road
Excelsior Springs, MO 64024

Holden Family Care
612 E 10th St., Holden, MO 64040

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

Independence Pediatrics
4731 S Cochise Drive, #100
Independence, MO 64055

KC Care Clinic
4601 Independence Ave.
Kansas City, MO 64124

Lee's Summit Pediatrics
2 NE Sycamore,
Lee's Summit, MO 64086

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

Liberty Medical Center
1504 NE 96th St., Liberty, MO 64068

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

Meritas Health Richmond
902 Wollard Blvd.
Richmond, MO 64085

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

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

Priority Care Pediatrics LLC
9405 N Oak Trafficway
Kansas City, MO 64155

Priority Care Pediatrics LLC
1540 NE 96th St., Liberty, MO 64068

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

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

Richmond Family Clinic
420 Wollard Blvd., Richmond, MO 64085

Robert Buzard, MD
1010 N Jesse James Road
Excelsior Springs, MO 64024

Samuel U Rodgers
825 Euclid, Kansas City, MO 64124

Samuel U Rodgers Clay County
800 Haines Drive, Liberty, MO 64068

Samuel U Rodgers Lafayette
811 A South Highway 13
Lexington, MO 64067

Samuel U Rodgers Northland
5330 N Oak Trafficway., Suite 104,
Kansas City, MO 64118

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

Swope Health Center
3801 Blue Parkway
Kansas City, MO 64130

Swope Health Center - Independence
11320 E Truman Road
Independence, MO 64050

Swope Health Center - Riverside
4443 NW Gateway, Riverside, MO 64150

Swope Health Center - Troost
8825 Troost Ave.
Kansas City, MO 64131

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

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

Whistlestop Pediatrics
415 Burkarth Road
Warrensburg, MO 64093

NCQA Recognized Patient-Centered Medical Home Provider

Key Staff Roles and Credentials

The PCN currently utilizes Registered Nurses, 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 utilized 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, six Care Team members have case management certification, as well as one certified asthma educator and one certified diabetes educator.

<u>The Care Team objectives are as follows:</u>

- 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 of members

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

Care Navigators

Care Navigators are licensed Registered Nurses (RN) or Social Workers (SW) whose primary role is to provide care coordination 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 health care 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
- Participate in quarterly Provider Practice Performance Profile reviews with each assigned PCP office and assist in identifying Care Team priorities based on data analysis and Care Team discussion
- 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 care coordination 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 preventative 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 members 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 measures

Community Resource Specialists

Community Resource Specialists work as members of the Care Team to support population health initiatives and care coordination. 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:

- 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 quarterly Provider Practice Performance Profile reviews with each assigned PCP office and assists 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
- 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 education and organization of community resources
- Participate in shared accountability for the identified team-based population measures

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 care facilitation-related issues.
- Receive 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

Practice Facilitation Specialists

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

The scope of practice for Practice Facilitation Specialists includes:

- Provide training on data analytic tools, such as Evolent, Electronic Medical Record (EMR), Provider Portal, etc. to support population health/PCMH initiatives.
- Assist Care Teams with data analytics for Provider Practice Performance Profile reviews to support Care Team discussions and initiatives
- Participate in quarterly Provider Practice

Performance Profile reviews with each assigned PCP office and assist in identifying Care Team priorities based on data analysis and Care Team discussion
- Prepare PCP quarterly engagement progress reports and compensation education
- Teach and support PCMH concepts and monitors ongoing sustainability of processes
- Provide evidence-based, condition specific training for provider practices, including asthma, diabetes, and healthy lifestyles
- Participate in shared accountability for the identified team-based population measures

Provider Relations Representatives

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

The scope of practice for Provider Relations Representatives includes:

- Maintain accurate participating provider status, updating provider directories and assisting in maintenance of online provider directories
- Assist with resolution of provider issues regarding claims status and enrollment issues
- Assist with individual PCP assignment issues and PCP changes from the PCN providers to the MCO
- Facilitate a streamlined, non-redundant credentialing process for PCN providers
- Participate in quarterly Provider Practice Performance Profile reviews with each assigned PCP office and assist in identifying Care Team priorities based on data analysis
- Provide training on data analytic tools, such as Evolent, Provider Portal, etc. to support population health/PCMH initiatives
- Assist Care Teams with data analytics for Provider Practice Performance Profile reviews to support Care Team discussions and initiatives
- Prepare PCP quarterly engagement progress reports and compensation education
- Participate in shared accountability for the identified team-based population measures analysis and team discussions

Quality Improvement Team

PCN's Quality Improvement Team engages in work that supports population health management, patient-centered medical home transformation, and identification of opportunities to enhance PCN's care integration program.

Quality Improvement Program Manager

The ICS Quality Improvement Program Manager leads and supports population health work related to multiple quality improvement initiatives and programs. Responsibilities include identification of meaningful quality improvement opportunities, performing data collection and analysis, supporting project teams through the quality improvement process, designing and producing quality reports, and assessing and articulating the impact of specific quality improvement interventions to internal and external leadership.

The scope of practice for Quality Improvement Program Managers includes:

- Identify quality improvement opportunities and manage quality improvement initiatives related to population health interventions
- Develop reports and collect quality 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 performance and outcomes
- Prepare and present reports for internal and external stakeholders including annual reports, provider performance profiles, Local Community Care Coordination Program (LCCCP) reports, as well as other custom reports
- Analyze performance measure definitions to obtain deep understanding in order to educate Care Team and provider practices

- Mentor PCN staff in quality improvement processes and use of quality improvement tools

Clinical Project Manager

The Clinical Project Manager is a key position in supporting the PCN care integration management team with oversight and implementation of the programs for utilization management, case management and disease management. Responsibilities include assisting with key management reports, staff training, staff performance audits, policy and process development, serve as a Health Plan liaison for oversight, reporting and coordination of appeals and grievances, assist the Quality Improvement team with preparing reports for monitoring program metrics, lead quality improvement projects and teams, and assist the management team with monitoring processes and reporting to ensure all delegated medical management functions meet National Committee for Quality Assurance (NCQA), delegation agreement terms, and state and federal regulations.

The scope of practice for the Clinical Project Manager includes:

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

Quality Improvement Project Specialist

The Quality Improvement (QI) Project Specialist is responsible for the overall planning, management and completion of projects that support and advance the Care Integration department. The QI Project Specialist utilizes project management expertise to develop and implement project plans to ensure project goals and objectives are achieved on time and according to specification. The QI Project Specialist leads and supports population health work related to multiple quality improvement initiatives and programs. Responsibilities include identification of meaningful quality improvement opportunities, performing data collection and analysis, supporting project teams through the quality improvement process (i.e. lean and six sigma process flows) designing and producing quality reports, and assessing and articulating the impact of specific quality improvement interventions to internal and external stakeholders.

The scope of practice for the Quality Improvement Project Specialist includes:

- Interpret data, analyze results using statistical techniques, and design/deploy ongoing reports
- Identify, analyze and interpret trends or patterns in complex data sets
- Work with PCN management to prioritize analysis and reporting needs, identify quality/cost improvement opportunities and/or propose new reports/analysis to advance quality improvement strategies
- Develop reports and dashboards within databases and data collection systems, and use other strategies that optimize efficiency and quality of information
- Acquire data from primary and secondary data sources and maintain database reports and other weekly/monthly reports

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 **291 CEU's** were obtained in 2017. The following are some of the topics and educational offerings attended by the Care Integration staff.

- Antipsychotic Medications
- Anxiety Disorders
- Autism Spectrum Disorder
- Brain Death in the Pediatric Patient
- Building Trust, Love and Loyalty in Relationships
- Care Management and Population Health
- Celiac Disease
- Congenital Lesions in the Fetal Airway
- Co-Occurring Mental Health Disorders
- Cultural Competency
- Depression
- Diabetes Prevention & Management
- Diagnostic and Laboratory Tests
- Effects of Trauma
- Emotional Regulation
- Ethics and Boundary Issues
- Ethics and Respiratory Care in the NICU
- Health Literacy
- Inattentive Driving
- Intimate Partner Violence
- Legislative Advocacy
- Lung Cancer Screening
- Mental Health in the Emergency Department
- Neonatal Respiratory Emergencies
- Pain Rehabilitation
- Patient-Centered Care
- Pediatric Asthma
- Pediatric to Adult Transition
- Performance Improvement Processes
- Post-Traumatic Stress Disorder
- Religious Diversity
- Sleep Apnea in Infants
- Social Services for High-Need High-Cost Population
- Substance Use Disorders
- Suicide Prevention
- Transition of Care and the Prevention of Readmissions
- Using Humor in Depression
- Value Based Care

Conferences Attended by Care Integration Staff:

ACMA Missouri/Kansas 12th Annual Case Management Conference
18th Annual Respiratory Care Symposium Sponsored by Children's Mercy Hospital
CMSA Kansas City Chapter 24th Annual Case Management Conference
Practical Ways to Achieve Targets in Diabetes Care
Pediatric Case Management Conference Care Across the Continuum: Managing the Patient, Plan, and Payer
Care Coordination Summit
Children's Hospital Association's Accountable Health Learning Collaborative

2 Population Health Management

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

Population Health Management

Thomas Jefferson University College of Population Health defines population health management as follows: **"Population Health Management seeks to improve the health outcomes of a group by monitoring and identifying individual patients within that group."** They further define population health as "a systematic approach to health care that aims to prevent and cure disease by keeping people healthy. 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;
- 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; and
- 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, 2015

Quadruple Aim

In order to meet the demands of today's ever-changing health care environment, each PCN goal and initiative has been designed to reflect all four dimensions of the "Quadruple Aim," a framework designed by the Institute for Healthcare Improvement that describes an approach to optimizing health care delivery. Therefore, 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 PCMH, and
4. Improve the work life of healthcare clinicians and staff.

- Institute for Healthcare Improvement

Patient-Centered Medical Home Transformation Program

The Patient-Centered Medical Home (PCMH) 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, June 2012

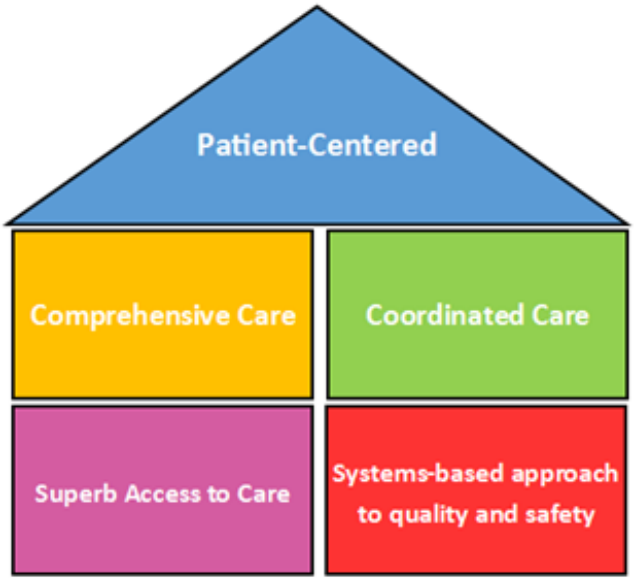
The PCN makes the following strategies and resources available to help practices transform and maintain Patient-Centered Medical Home (PCMH) components:

- PCMH readiness evaluation
- PCMH and NCQA consulting services
- Use of patient registries for population management
- Patient communication/outreach templates and material
- Gaps in Care reports for assigned members
- Quarterly 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 health care utilization. These programs are designed to educate providers, the office staff and patients/caregivers on appropriate diagnosis, treatment and management of chronic conditions and promote preventive care for the entire patient population.

The Patient-Centered Medical Home (PCMH) Program monitors the implementation of care processes and development of practice level PCMH infrastructure, meeting medical home qualification criteria, within the secure portal. This program began July 1, 2014 with customized quarterly progress reports provided to the participating provider offices.

Practice Facilitation Specialists work side-by-side with the practice staff to reinforce skills and foster behavior changes focused on the key elements of the PCMH. The medical home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. Building on the work of a large and growing community, the Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.



The medical home encompasses five functions and attributes:

Patient-centered: The primary care medical home provides primary health care 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 health care 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 health care system, including specialty care, hospitals, home health care, and community services 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, June 2012

References:

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PCMH Engagement

Children's Mercy
PEDIATRIC CARE NETWORK

Progress Report for Engagement Compensation **confidential and proprietary**

Clinic: **Date:**

	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun
1. The Practice has achieved recognition as a NCQA PCMH Level 1-3.				
• NCQA Recognition Level 1, 2, or 3 will be an automatic $1.50 engagement cap plus 1 point toward total				
2. The Practice will regularly use team-based care [e.g., huddles] to implement population health processes and address gaps in care & preventive care (HEDIS) measures by working 3 different registries .				
• PCP Panel List				
• Preventive care (WCC, Immunizations, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents)				
• Chronic disease (Asthma, Diabetes, ADHD)				
3. The Practice solicits patient feedback for all providers annually using a Patient Satisfaction Survey.				
• Use CMPCN-provided or CMPCN-approved survey measurement tool				
• Implement and document one quality improvement (QI) Project based on PSS results				
4. The Practice, Providers, and Staff participate in the CMPCN Learning Collaborative.				
• Attend at least 6 web-based Learning Collaboratives (at least 1 per quarter)				
• Post response to Learning Collaborative topic on PCN portal discussion board				
5. The Practice participates in the CMPCN Continuous Quality Improvement Program and Training.				
• Create or demonstrate CQI infrastructure for office including identification of CQI leader				
• Implement and document two QI initiatives during the year				
- One QI initiative must be an improvement in a HEDIS measure (AWC, CIS, WC34, WC15, ASM)				
- The PSS CQI project may count as one of the two.				
6. The Practice has implemented and documented a process for closed loop referral tracking.				
7. The Practice has established a process to manage high risk patients.				
• Provide care coordination				
• Work ED high utilizer list (e.g., asthma)				
• Practice will disseminate information to patients about member incentive programs (e.g., update website, publications, awareness, etc.)				
8. The Practice has established a process to manage transitions.				
• Identify patients with a hospital admission and/or ER visits and ensure appropriate office follow up				
9. The Practice implements care coordination protocols with PCN Care Managers.				
• Provider responds to case management summaries on a quarterly basis (PCN portal summaries may count)				
• Provider may refer to PCN care managers as necessary for care coordination.				
10. The Practice has their own process and policy for addressing behavioral health concerns.				
• Development of a written process and use of a Depression Screening Tool				
• Utilize behavioral health resources appropriately				
• Care coordination with PCN Care Managers (if needed)				

Engagement Compensation Grid:

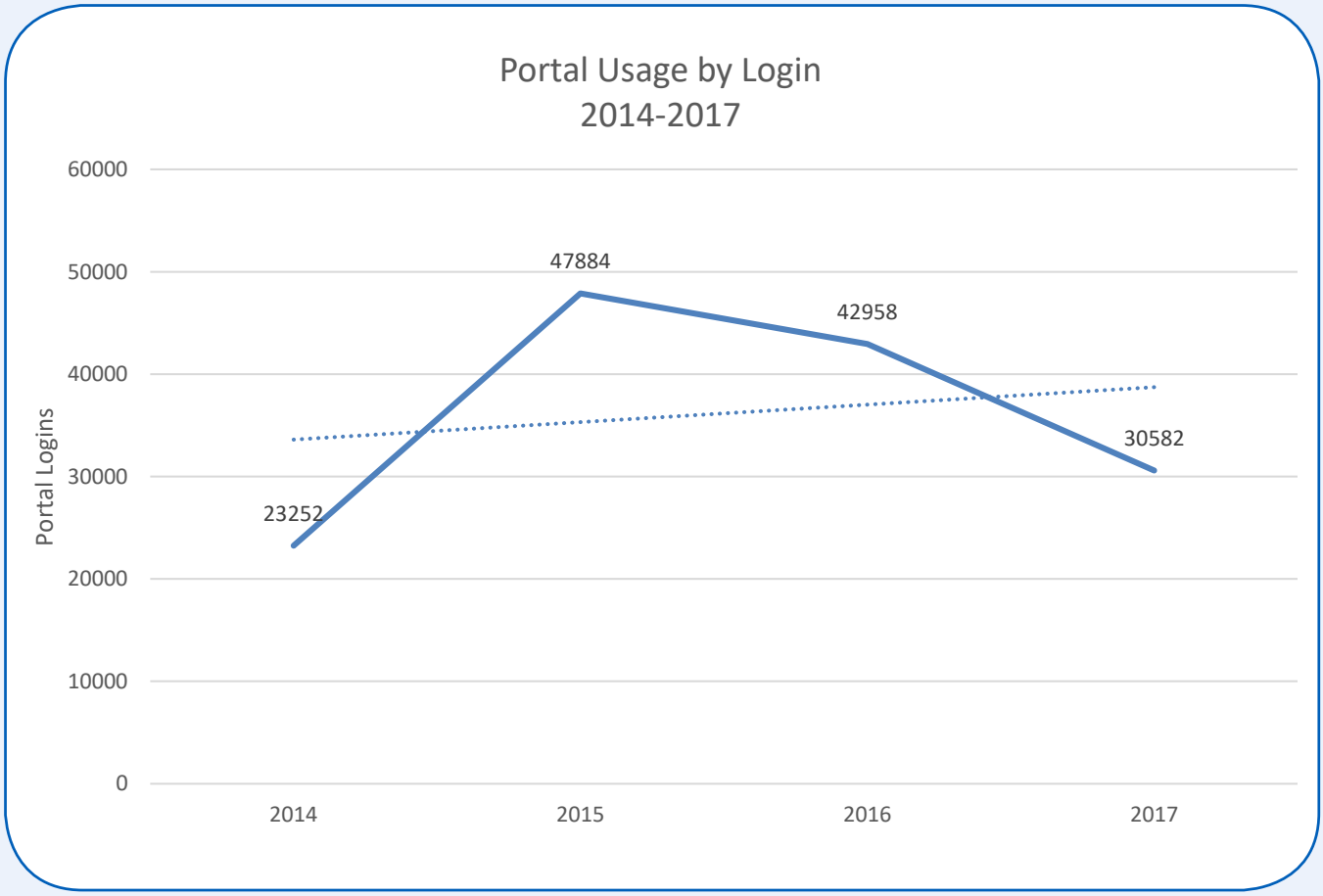
1. The maximum engagement compensation that can be earned is $3.00 pmpm.
2. PCMH NCQA Recognition: Level 1-3=$1.50 engagement compensation
3. PCN Engagement Compensation Point Achievement:
    a. 0-4 points=$0.00 engagement compensation
    b. 5-6 points=$1.50 engagement compensation
    c. 7-10 points=$3.00 engagement compensation

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

Provider Portal

PCN's secure Provider Portal was upgraded in 2016, provided a freshly redesigned tool to improve communication, collaboration, and access to resources and reports to practices within the network.

Features of the portal include personalized logins for each practice, access to a data analytic tool, clinical resources and tools that include access to clinical practice guidelines and various pediatric resources to help practices stay informed and continue to deliver evidence-based care. Other clinical tools include access to a custom community resource searchable database called the Community Engagement Resource Application or C.E.R.A (more information on pages 33-34). Also available in Clinical Tools and Resources are quick links to Pediatric Specialty Education webinars and quick links to previous and current Learning Collaborative's. Providers also get access to High-Risk Registries designed to identify patients in need of preventative care or patients who need chronic disease management.

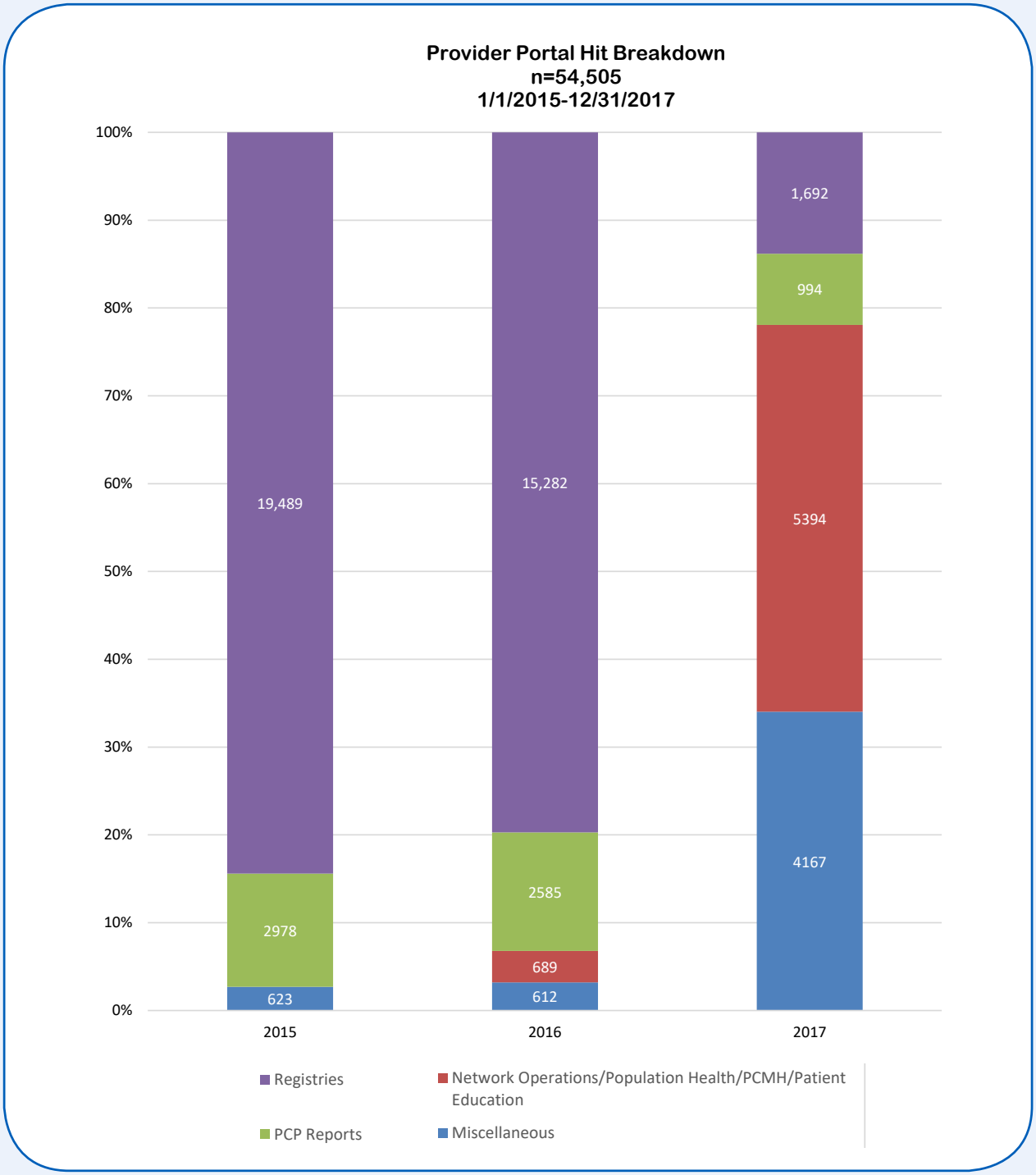


For more efficient use of time, quick access has been provided to reference tools, such as the PCN Tool Kit, quality improvement tools, measure descriptions, billing and coding guides, and much more. Other features of the Provider Portal include a page dedicated to current Patient Center Medical Homes and resources for those working to become certified.

A Network Operations page 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 provides a Report Center where practices have access to their panel lists, Gaps in Care reports, Engagement Compensation, and much more.

Due to the decline in 2017 portal log-ins, PCN Care Teams will continue to promote portal usage and evaluate why usage has declined.



Web Forms (Registries)	PCP Reports	Miscellaneous	Network Operations
• Asthma/Diabetes • ED Frequent Flyers • Members in Case Management • Age 2 Immunizations-Combo 2 • EPSDT • Well Child Visits • Radiology • Referrals & Consults	• ER Visits • Inpatient Admissions • Members Under Case Management • PCP Capitation • PCP Engagement Compensation • PCP Panel List	• Announcements • Calendar • Contact Us • Directory • Feedback • Provider Search • Research Links	• Clinical Practice Guidelines • Clinical Resources and Tools • Discussion Board • Learning Collaborative's • Links • Network Operations • Patient Centered Medical Home • Patient Education and Outreach • Population Health Platform

* New Population Health Reports were added between 2016 and 2017.

Learning Collaborative

The Learning Collaborative concept has been utilized extensively in the support of the dissemination of information required for PCMH transformation. The PCMH transformation team has developed a model to use in community settings to coach practices by providing education related to the medical home model and allowing for educational topics to be presented. Almost every month, a 30-minute topic is presented. All clinics are encouraged to participate, including staff as well as providers.

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, care management, and care coordination.

This monthly format also includes common collaborative learning techniques such as structured problem solving and opportunities for brainstorming. Sessions are recorded, which offers the practices an opportunity to review the materials at a later date. After each webinar, a question is posted encouraging co-directional communication between the primary care practices via a message board in the provider portal.

Learning Collaborative Topics for 2017:

Coding Tips for 2017

New CMH Outpatient Education Program for Newly Diagnosed Type 1 Diabetes (STAND)

Community Engagement Resource Application (C.E.R.A)

NCQA 2017 PCMH Standards

The Healthy Lifestyles Initiative-An Approach to Childhood Obesity Prevention in Primary Care

Promotion of Healthy Childhood Weight (PHIT Kids)

Office-Based Management of Children who are Overweight

Nocturnal Enuresis (sent from CHN recorded link, so not on Portal)

Transition to Adulthood: Prepare to Launch-Prepare to Land

Local Community Care Coordination Program (LCCCP) Measures

The PCN is a state-approved Local Community Care Coordination Program (LCCCP) model focusing on providing care management, care coordination and disease management through the local healthcare providers. Below are some of the key LCCCP metrics since implementing the LCCCP for calendar year 2017. PCN will utilize these baseline metrics to identify areas to target for improvement efforts. Metrics with ** were still in development.

		CY2017			
	Measure Description	**Q1**	**Q2**	**Q3**	**Q4**
Category	**General Population Data**				
Providers	**Total Number of Providers**: Number of providers in the LCCCP for the reporting period.	1,354	1,762	1,616	1,561
Members	**Total number of Members**: Number of members in the LCCCP for the reporting period.	100,950	84,093	90,082	90,013
Category	**Access**				
Access to Well Care Services	**Access to Well Care**: Percentage of ill/sick visits that are converted to a well care visit (opportunity taken to address preventive care during sick visit)	18.0 %	17.2 %	15.8 %	20.5 %
Category	**Care Coordination**				
Transitional Support	**Transitional Care Support**: Percentage of hospital-discharged members who had an ER visit within 30 days of discharge.	15.3 %	14.8 %	17.8 %	17.7 %
Member Engagement	**Member Engagement with Care Teams**: Percentage of at-risk members who had a plan of care initiated by the Care Team. ** Measure is in development	**	**	**	**
Provider Engagement	**Provider Engagement**: Percentage of providers that reviewed the care plan. ** Measure is in development	**	**	3.8 %	3.2 %
Community Engagement	**Community Engagement**: Percentage of at-risk members linked to community resources. ** Measure is in development	**	**	0.2 %	1.1 %
Care Team Engagement	**Interdisciplinary Team**: Percentage of care plans including more than one discipline (MD, RN, SW, CRS). ** Measure is in development	**	**	9.3 %	15.4 %
Member Activation	**Goal Completion**: Percentage of members that successfully completed a personal goal in the care plan.. ** Measure is in development	**	**	9.3 %	30.9 %
Category	**Condition Management**				
Pediatric Asthma	**Asthma Prevalence**: Members identified with a diagnosis of asthma as a percentage of total members through 20 years of age - lookback period of 12 months for asthma diagnosis	7.3 %	10.0 %	10.5 %	10.6 %
Pediatric Diabetes	**Diabetes Prevalence**: Members identified with a diagnosis of diabetes as a percentage of total members through 20 years of age - Type I and Type II combined - lookback period of 12 months for diabetes diagnosis	0.2 %	0.3 %	0.3 %	0.3 %
Ambulatory Sensitive Conditions - Pediatric Quality Acute Composite	**Pediatric Quality Acute Composite (AHRQ PDI 91)**: Composite of the following acute conditions per 100,000 population ages 6 to 17 years. PDI #16 - Gastroenteritis Admission Rate PDI #18 - Urinary Tract Infection Admission Rate	**	4.0	4.1	2.3
Ambulatory Sensitive Conditions - Pediatric Quality Chronic Composite	**Pediatric Quality Chronic Composite (AHRQ PDI 92)**: Composite of the following chronic conditions per 100,000 population ages 6 to 17 years. PDI #14 - Asthma Admission Rate PDI #15 - Diabetes Short-Term Complications Admission Rate	**	25.0	9.4	18.4
Category	**Utilization**				
Emergency Room	**Emergency Room Utilization**: ER Visits per 1,000 members	654	577	592	662
Inpatient	**Hospital Readmission**: Hospital readmissions within 30 days - all cause	11.8 %	9.0 %	11.8 %	9.3 %
Inpatient	**Inpatient Utilization - Admissions**: Inpatient Admissions per 1,000 members	54	44	54	57
Inpatient	**Inpatient Utilization - Days**: Inpatient Days per 1,000 members	218	165	190	191
Cost of Care	**Cost of Care: Hospital Inpatient - Acute Medical/Surgical**: Per Member Per Month (PMPM) cost total by service category.	$ 8	$ 27	$ 12	$ 8
Cost of Care	**Cost of Care: Hospital Inpatient - Maternity**: Per Member Per Month (PMPM) cost total by service category.	$ 3	$ 2	$ 1	$ 1
Cost of Care	**Cost of Care: Hospital Outpatient - ASU**: Per Member Per Month (PMPM) cost total by service category.	$ 22	$ 15	$ 15	$ 13
Cost of Care	**Cost of Care: Hospital Outpatient - ER**: Per Member Per Month (PMPM) cost total by service category.	$ 44	$ 45	$ 23	$ 21
Cost of Care	**Cost of Care: Hospital Outpatient - All Other**: Per Member Per Month (PMPM) cost total by service category.	$ 38	$ 26	$ 18	$ 18
Cost of Care	**Cost of Care: Physician/Professional - Office Visits**: Per Member Per Month (PMPM) cost total by service category.	$ 10	$ 12	$ 5	$ 5
Cost of Care	**Cost of Care: Physician/Professional - All Other**: Per Member Per Month (PMPM) cost total by service category.	$ 12	$ 17	$ 8	$ 6
Cost of Care	**Cost of Care: Pharmacy**: Per Member Per Month (PMPM) cost total by service category.	$ 72	$ 37	$ 28	$ 41
Cost of Care	**Cost of Care: Ancillary - DME**: Per Member Per Month (PMPM) cost total by service category.	$ 2	$ 2	$ 1	$ 1
Cost of Care	**Cost of Care: Ancillary - Home Health**: Per Member Per Month (PMPM) cost total by service category.	$ 1	$ 1	$ 1	$ 1
Cost of Care	**Cost of Care: Ancillary - All Other**: Per Member Per Month (PMPM) cost total by service category.	$ 1	$ 1	$ 0	$ 1
Out of Network Utilization	**Outside of LCCCP Primary Care Utilization**: Percentage of utilization for primary care services outside the LCCCP network.	11.3 %	8.8 %	8.0 %	10.4 %

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. Our financial analytic capabilities measure and track key health cost and utilization measures (i.e., risk levels, paid per member per month, admissions/1000, days/1000, average length of stay, ER visits/1000, etc.) at the network, practice, and provider level. PCN continues to use our financial analytical capabilities to support and evaluate existing programs and identify new initiatives to more effectively manage the population and deliver value.

PCN also continues to deliver actionable and meaningful cost and utilization data directly to PCN practices and providers (see Provider Practice Performance Profile package on pages 110-113). The Performance Profiles provide meaningful insights on cost/utilization variation as well as actionable information on a practice's highest cost and highest risk patients. PCN Care Teams review the Performance Profiles in detail with PCN practices four times per year, jointly identifying opportunities to outreach and/or collaborate on managing and caring for the high cost and highest risk patients. Based on practice feedback and an ongoing effort to enhance the value of these reports, PCN continues to refine and tailor the content. As an example, rates of inpatient admissions were updated to remove normal newborns, allowing for a more meaningful evaluation of admissions pertaining to chronic conditions.

Specialty Engagement & Episodes of Care

PCN recognizes that in order to effectively manage a Medicaid population, both primary care and specialty providers must be engaged. In 2017, PCN began to meet quarterly with select specialty divisions to further specialty collaboration.

Improving PCP to Specialist Coordination - Pediatric Specialty Education Spotlights

PCN has introduced "Pediatric Specialty Education Spotlights", 10-20 minutes recorded webinars where Children's Mercy specialists educate PCN primary care providers on what the PCP should do in managing a particular condition. The education is structured on a "visit documentation template" with the goal of better managing and coordinating care. Specialists cover key aspects of the history, physical examination, applicable tests/exams, medical management, and when it is or is not appropriate to refer.

Pediatric Specialty Education Spotlights

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

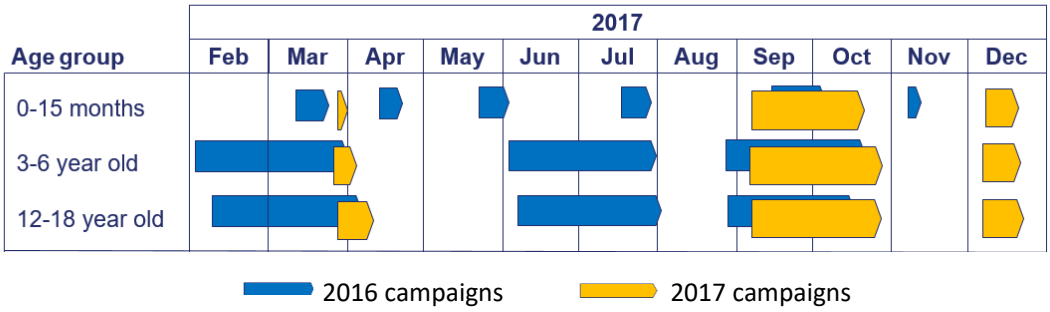
Most Recent Topics	Recorded Webinar	Slide Deck	Visit Documentation Template	Resource Packet
Limp in a Child or Adolescent	Watch Webinar	Download	Download	Download
Back Pain in a Child or Adolescent	Watch Webinar	Download	Download	N/A
Nocturnal Enuresis	Watch Webinar	Download	Download	Download

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

Patient Outreach Initiative (EMMI)

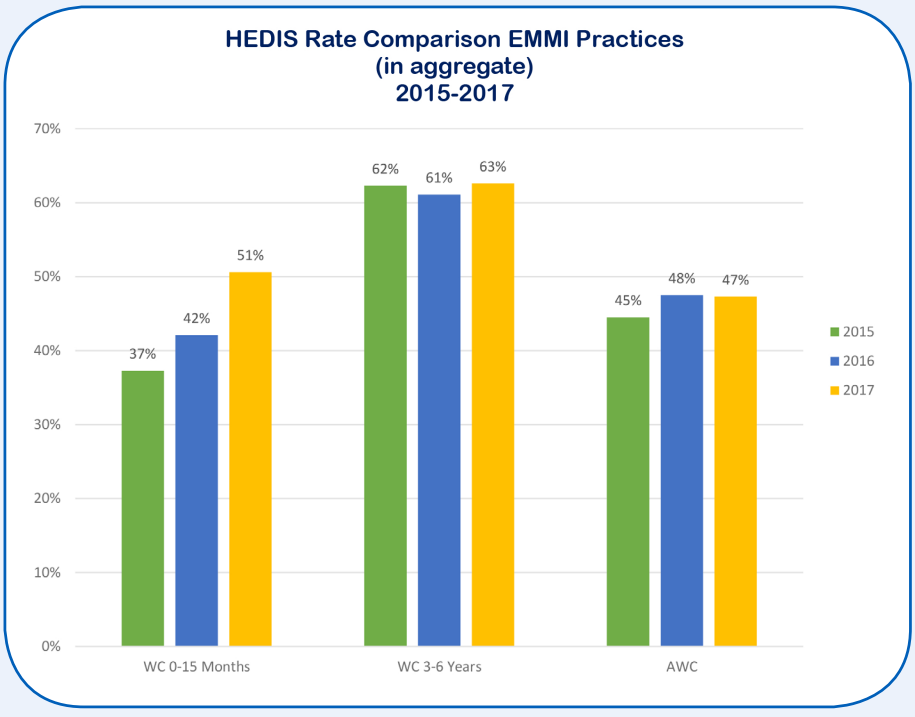
The PCN conducted the second phase of a pilot program with Evolent Health for Patient Outreach Services. In 2017, this pilot was extended to 18 PCN practices. The service uses interactive voice response technology (IVR) to place a series of automated calls to drive patient action. More than 25,000 outreaches have been made to over 21,000 patients since March 2017. There was a 2% increase in patient engagement rate (transferred to practice for scheduling, given scheduling information, or told they are due for a well-visit) from 19% in 2016 across all campaigns.

Summary of 2017 Campaign Timing



Summary of 2017 Patients Called

	0-15 month		3-6 year old		Adolescent		All campaigns		MO Medicaid assigned patients (Dec 2017)
	Distinct patients called	Total outreaches	Distinct patients called	Total outreaches	Distinct patients called	Total outreaches	Distinct patients called	Total outreaches	
Missouri Practice Total	1,203	1,215	8,911	10,288	11,667	13,677	21,781	25,180	55,674



Analysis:

The intervention of EMMI outreach has positively affected HEDIS rates in the pilot populations. In 2017, 10 additional practices were added to this pilot for a total of 18 practices involved in the 2017 phase. Data from 2015 (prior to implementation of the EMMI program) compared against the EMMI pilot years (2016 and 2017) show the largest trends in well child visits for 0-15 months measure while the well child 3-6 and adolescent well child measures have remained flat over the three year period. In 2016, a second wave of outreach calls was made in late spring. In 2017, due to the implementation of the new MO HealthNet contract on May 1, 2017, the second wave of EMMI outreach calls were delayed until September 2017.

Next Steps:

Based on the positive results, PCN plans to implement EMMI as a standard tool for PCN practices. The 2018 waves of outreach calls will mirror the 2016 campaign in hopes to reach as many patients as possible earlier in the calendar year. The 2018 campaigns will target additional measures including Medication Management for People with Asthma (MMA). The program is on track to reach more patients with the additional campaign efforts.

Provider Performance Report Package

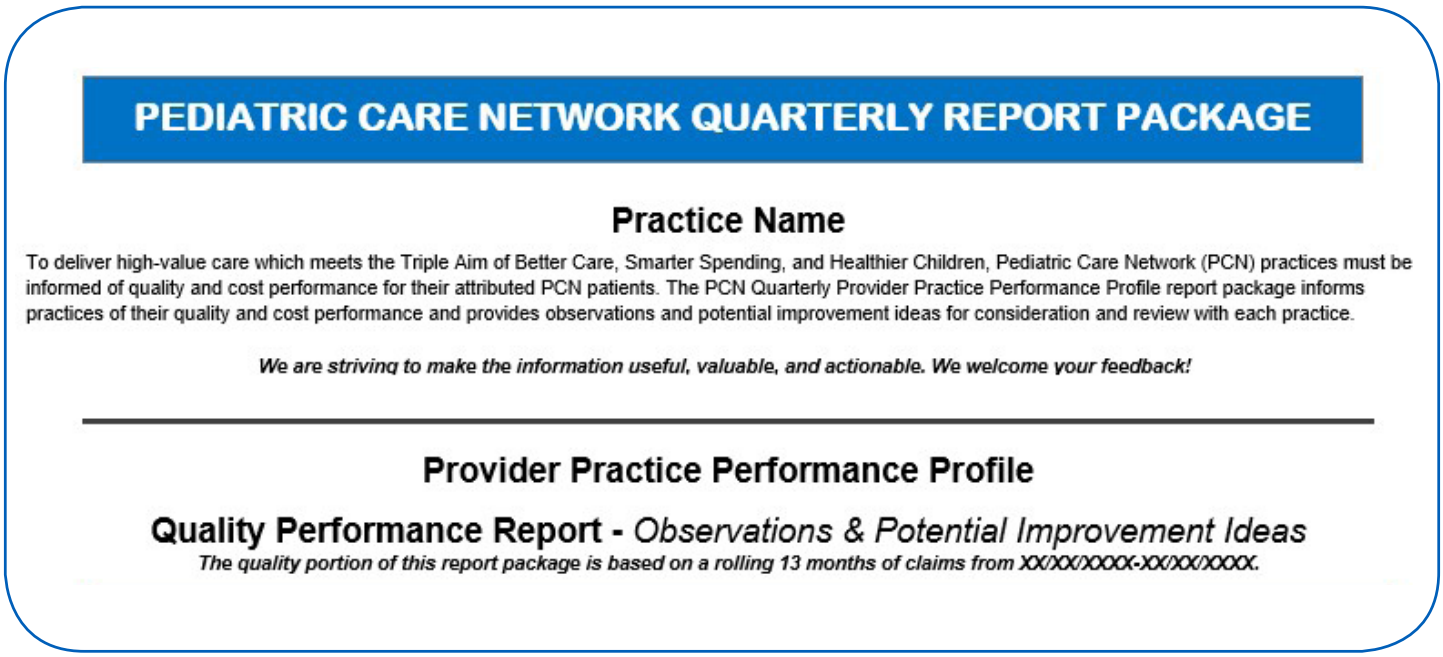
PCN continues to deliver actionable and meaningful cost and utilization data directly to PCN practices and providers (see Provider Practice Performance Profile package on pages 110-113). The Provider Performance Profiles provide meaningful insights on cost/utilization variation as well as actionable information on a practice's highest cost and highest risk patients. PCN Care Teams review the Provider Performance Profiles in detail with PCN practices four times per year, jointly identifying opportunities to outreach and/or collaborate on managing and caring for the high cost and highest risk patients. Based on practice feedback and an ongoing effort to enhance the value of these reports, the report content continues to be refined and tailored. As an example, rates of inpatient admissions have been updated to remove normal newborns, allowing for more a meaningful evaluation of admissions pertaining to chronic conditions.

The report package has three components. The Report Package Summary, Rolling Year and/or HEDIS Quality Measure Report, and the Cost and Utilization Report.

Report Package Summary

The Practice Summary provides a high level summary of both the quality and cost reports. It gives the practices a snapshot of what they did well and where they have room for improvement during that captured time period. The Care Teams work with the practices to develop goals for performance to help guide the practice on how to improve their selected incentives.

The Report Package Summary includes Potential Opportunities that the practices can work on throughout the year with instructions on how to accomplish those goals successfully.



PEDIATRIC CARE NETWORK QUARTERLY REPORT PACKAGE

Practice Name

To deliver high-value care which meets the Triple Aim of Better Care, Smarter Spending, and Healthier Children, Pediatric Care Network (PCN) practices must be informed of quality and cost performance for their attributed PCN patients. The PCN Quarterly Provider Practice Performance Profile report package informs practices of their quality and cost performance and provides observations and potential improvement ideas for consideration and review with each practice.

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

Provider Practice Performance Profile

Quality Performance Report - *Observations & Potential Improvement Ideas*

The quality portion of this report package is based on a rolling 13 months of claims from XX/XX/XXXX-XX/XX/XXXX.

HEDIS Reports and Rolling Year Quality Measure Reports

HEDIS Reports – HEDIS Quality Reports present the measurement year (MY) as shown below. HEDIS 2017 (MY 2016) indicates that the measurement year is calendar year 2016.

Rolling Year Reports – Rolling Year Reports are based on "estimated" rolling year by basing performance on the last 13 months of claims data. 13 months of claims data approximates a year because claims are not 100% complete in the most recent months.

The performance period for Early Periodic Screening Diagnosis and Treatment (EPSDT) and Provider Engagement are also presented at the top of the report if applicable.

There are two important differences between the HEDIS Quality Reports and the Rolling Year Quality Reports.
1. HEDIS Quality Reports are always based on a calendar year of performance.
2. HEDIS Quality Reports incorporate additional rules/exclusions regarding each patient's eligibility coverage throughout the year. See the PCN HEDIS Quality Measure Definitions for additional information.

Care Gap Report

The "Patient Outreach Care Gap Priority Report" is one of the resources and tools available in the PCN quality improvement tool kit. The report is based upon all data available to PCN to inform practices of what patients have particular gaps in care (based on age and diagnosis history).

The report provides detail on both "compensated" and "non-compensated" gaps in care and sorts the list in descending order of patients with the most compensated care gaps. This priority is recommended since bringing in a patient with the most care gaps allows a practice to increase performance across the most quality measures. This resource is similar in objective to the Patient Outreach functionality within the Evolent Vision Solution.

		Gaps In Care - Compensation											Gaps In Care - Non-Compensation						
		CIS	CIS	CIS	CIS	CIS	CIS	W15	W34	AWC	EPSDT	MMA	CIS	CIS	CIS	CIS	CHIPRA	CHIPRA	FLU
		Combo 2											Non - Combo 2						
# of Comp Care Gaps	# of Total Care Gaps	DTaP	HepB	HiB	IPV	MMR	VZV					75%	HepA	Infl	PCV	Roto	HbA1c	Neph	Infl
2	3	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a		n/a	n/a	n/a	n/a	n/a	n/a	n/a	
2	3	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a		n/a	n/a	n/a	n/a	n/a	n/a	n/a	
3	4	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a			n/a	n/a	n/a	n/a	n/a	n/a	

Cost and Utilization Report

To deliver high-value care, PCN practices must be informed of global quality and cost performance for their attributed patients. Pediatric Care Network has developed a Cost & Utilization Report within the PCN Practice Performance Profile to inform providers of cost and utilization information that is only accessible through payer claims. As the payment model shifts from a fee-for-service to fee-for-value model, it will be increasingly important to manage patient's cost and utilization. The report is based on payer data (medical claims, pharmacy claims) received from PCN-Contracted Missouri Medicaid Managed Care Organizations.

Definitions of reported numbers:

Admits/1,000

A normalized rate of admissions for attributed patients. The rate is normalized to represent the expected number of admissions in a year for a group of 1,000 attributed patients.

Days/1,000

A normalized rate of inpatient hospital days for attributed patients. The rate is normalized to represent the expected number of inpatient days in a year for a group of 1000 attributed patients.

ER visits/1,000

A normalized rate of emergency room visits for attributed patients. The rate is normalized to represent the expected number of emergency visits in a year for a group of 1,000 attributed patients.

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 his/her medical diagnoses and prescription medication history within a one-year period to determine a relative risk score. All risk scores are presented as relative risk ratios based on an average patient with a risk score of 1.0. In other words, a patient with a risk score of 2.0 is expected to be twice as costly as a patient with average expenditures and a patient with a risk score of 0.9

is expected to be 10% less costly. The CDPS risk scoring model is comparable to other nationally known risk scoring methodologies such as Episode Treatment Groupers (ETGs), Milliman Advanced Risk Adjusters (MARA), and Hierarchical Condition Categories (HCCs).

Risk Adjusted Paid PMPM

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

New PCN Quality Improvement Tools/Resources

PCN has developed a new Quality Improvement area within the PCN portal to centralize 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/or tips, and directly link to applicable training documentation, tools, and/or resources.

Quality Improvement

Quality Measure Definitions

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

Quality Improvement Resources

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

Cost Improvement Resources

PCN Quality Improvement TOOL KIT

Children's Mercy PEDIATRIC CARE NETWORK

Measure	Quality Improvement Strategies	CMICS Measure Specific Resources	Comments/Insights
Asthma - Medication Management for People With Asthma (>=75% Coverage)	To be Populated in Q1/Q2 2018	• Asthma Care Brochure and Asthma Care Quick Reference (Based on EPR-3 Clinical Guidelines) • Medication Management for Children with Asthma Definition Overview – Slide Deck	
EPSDT (Annual EPSDT Well Visit for Ages 1-6)	• Provider / Billing Staff Workflow Integration and Training • Sending non-billable claims when Medicaid is secondary insurance (ensures quality hit) • Target 3-6 Year Olds Without an Annual Well Visit (2 and under typically compliant due to newborn/infant well visits) • Well Visit Improvement Strategies: Patient Outreach, Appointment Reminders, Sick to Well-Visit Conversion	• EPSDT Billing and Code Guide • Use Vision Worklists to Target Overdue Patients 3-6 Years Old (see Vision Patient Outreach Training Guide) • Preventive Care Registry – EPSDT (PCN Portal → Clinical Resources & Tools)	• Ability to improve in short term since measure dependent on coding and patient receiving an annual preventive visit at any time during the measurement year.
Immunizations Age 2 (DTap, IPV, MMR, HiB, HepB, VZV)	• Standardization of Vaccination Adminstration within Pracitce (i.e. what products administered at each standard well visit up to 2 years old) • Patient/Family Education	• Use Vision Worklists to Target Patients 18-24 Months with Missing Age 2 Immunizations (see Vision Patient Outreach Training Guide) • Preventive Care Registry – Age 2 Immunizations (Combo2: DTaP, IPV, MMR, Hib, Hep B, VZV) (PCN Portal → Clinical Resources & Tools)	• Improvement takes significant amount of time (Why: performance evaluated based on all applicable immunizations up to age 2; patients only included after turning 2 years old)
Well-Child Visits in 3-6 Years of Life	• Patient Outreach • Appointment Reminders • Sick to Well-Visit Conversion	• Use Vision Worklists to Target Overdue Patients (see Vision Patient Outreach Training Guide) • Preventive Care Registry - Well Child Visits (PCN Portal → Clinical Resources & Tools)	• Ability to improve in short term since measure simply dependent on patient receiving an annual preventive visit at any time during the measurement year.
Well-Child Visits in First 15 Months of Life	• Advanced Scheduling of All Future 15 Month Well Visits • Patient Outreach • Appointment Reminders • Sick to Well-Visit Conversions	• Well Visit 15-Month Measure Definition & Best Practice Overview • Preventive Care Registry - Well Child Visits (PCN Portal → Clinical Resources & Tools) • New 15-Month Well Visit Status Report (To be Available Q1 2018)	• Improvement takes significant amount of time (Why: performance evaluated based on 6 visits over 15 months)
Well-Care Visits for Adolescents	• Patient Outreach • Appointment Reminders • Sick to Well-Visit Conversion	• Use Vision Worklists to Target Overdue Patients (see Vision Patient Outreach Training Guide) • Preventive Care Registry - Well Child Visits (PCN Portal → Clinical Resources & Tools)	• Ability to improve in short term since measure simply dependent on patient receiving an annual preventive visit at any time during the measurement year.

Overall Quality Improvement Resources (Applicable for All Measures)

1. HEDIS Quality Measure Definitions -- PCN Incentive Measures Only
2. Measure Compliance Quick Reference Billing & Coding Guide
3. **Evolent Vision Patient Worklists** - Use to Target & Prioritize Patients with Particular Gaps in Care (see Vision Patient Outreach Training Guide)
4. **Evolent Vision Pre-Visit Planning** - Use to Identify Gaps in Care At the Point of Care (i.e. preparing for & during a visit) (see Vision Pre-Visit Planning Guide)

General Clinical Practice Guidelines & Resources

Recommendations for Preventive Pediatric Health Care (Bright Futures / American Academy of Pediatrics, 2017)
2018 Recommended Immunization Schedules for Persons Aged 0 Through 18 Years (CDC / AAP)

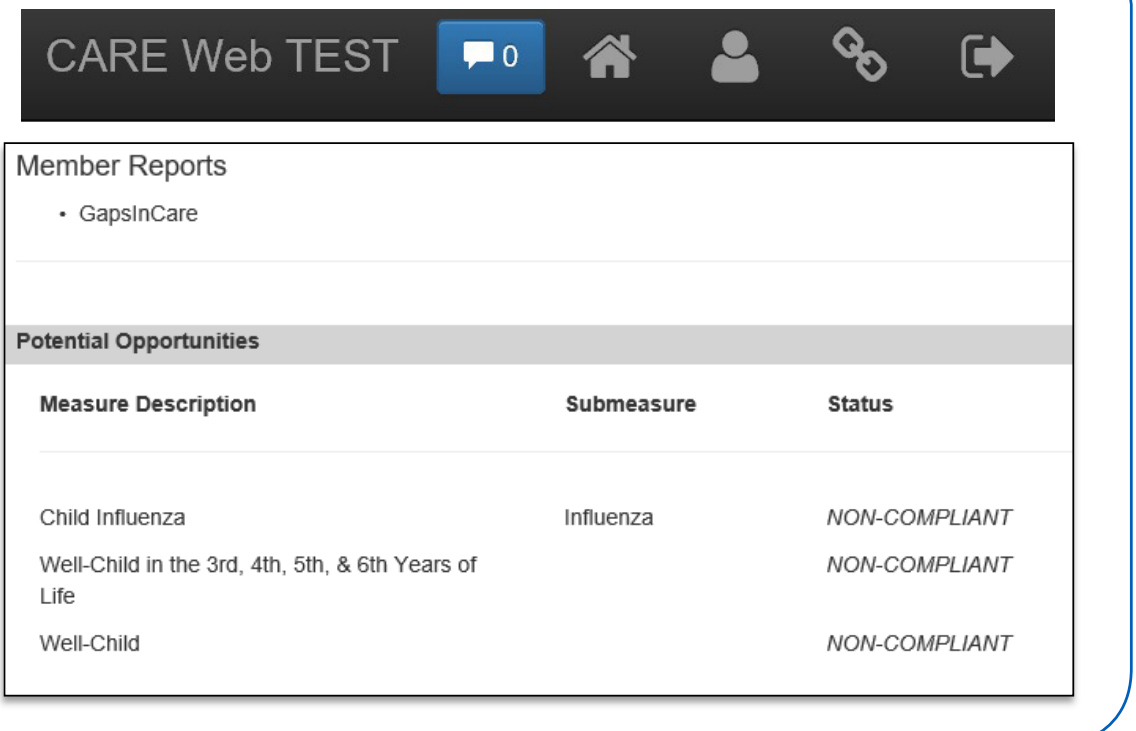
C.A.R.E. Web (Online Care Team Communication Tool)

In 2017 PCN developed and implemented a new web-based Care Team documentation and communication tool, Case Assessment Referral Evaluation (C.A.R.E. Web). Historically, C.A.R.E. served as a proprietary desktop application and documentation system used by PCN Care Teams to enter authorizations and care coordination activities, as well as view claims data. C.A.R.E. was converted into a web application (C.A.R.E. Web) for greater Care Team utilization in the community setting and to serve as a catalyst for provider and member engagement in the member-centered care plans. C.A.R.E. Web access will be given to provider practices in 2018 so they can view the care coordination activities of the PCN Care Teams and provide input or add goals to the care plan for their members. It will also be made available for members and caregivers to view the member's care plan. In 2018, a notification feature will be incorporated into C.A.R.E. Web that will allow all members of the Care Team (PCN Care Team, provider, member and caregivers) to communicate in real-time.

PCN continuously looks for ways to improve and enhance C.A.R.E. Web to better serve its users. Throughout 2017 PCN made the following enhancements:

- Applied a care management screening tool
- Created new health plan authorization screens
- Designed and implemented administrative reports
- Developed custom gaps in care reports
- Allowed Community Health Worker access

Notifications



Next Steps:

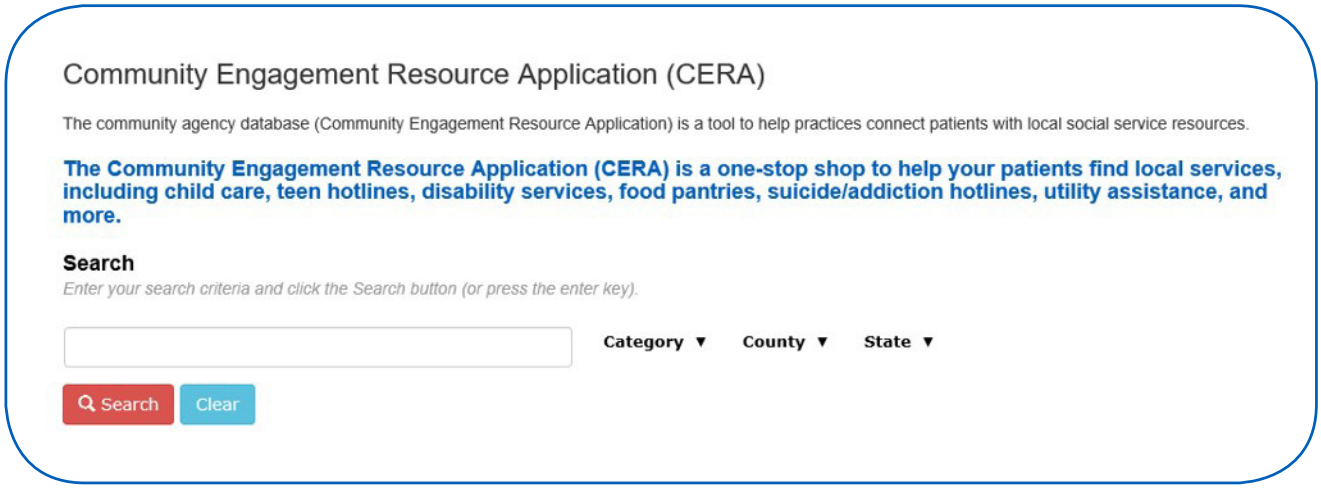
- Enhance provider access
- Notification to providers when members have been contacted
- Addition of button to alert provider that a care plan is ready for review/approval
- Community Care Team contact information
- Implement member and caregiver access to C.A.R.E Web

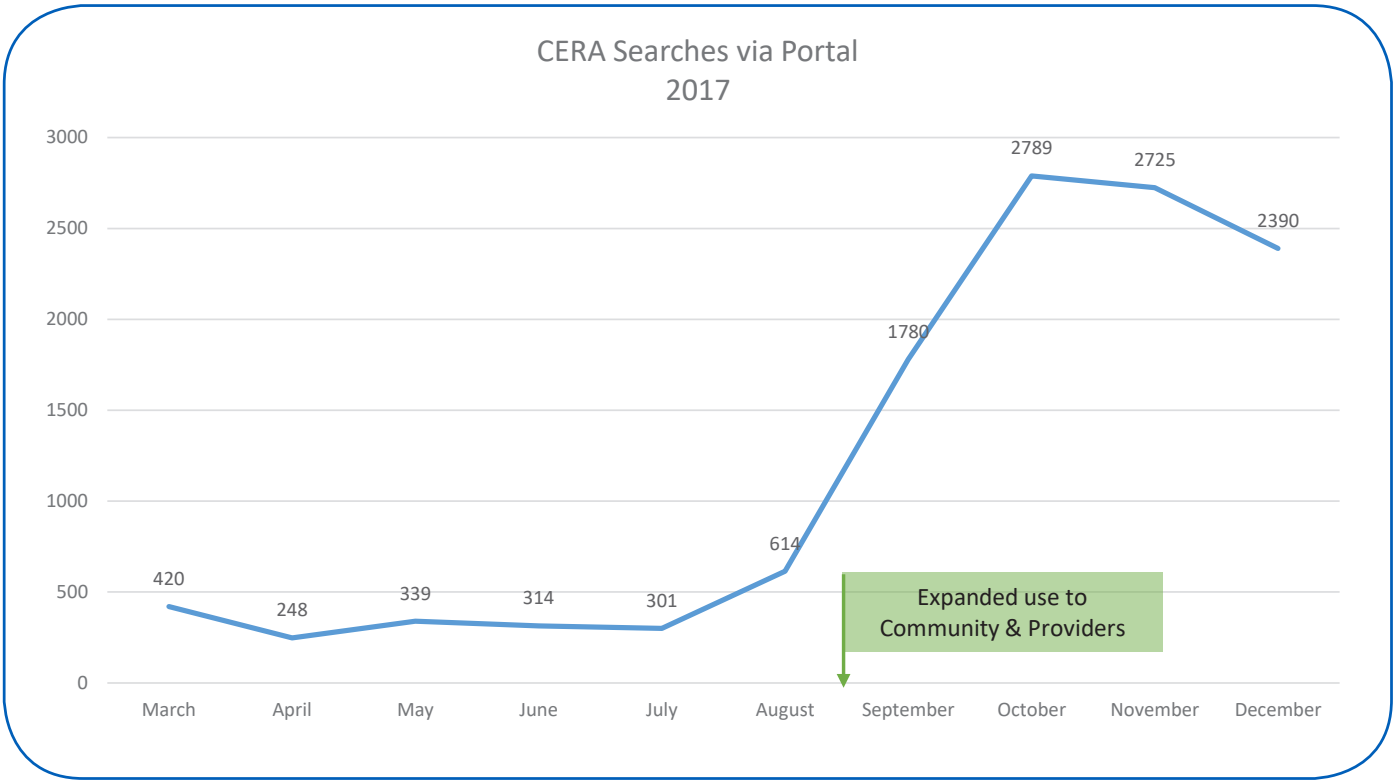
Community Integration

There is ample data available to demonstrate improvements in member outcomes, member engagement, and decreased cost with a fully integrated medical and behavioral care delivery model. An important initiative for the PCN in 2017 was having the Health Plan behavioral health case management staff embedded with the PCN Care Teams for closer collaboration and co-management of medical and behavioral conditions for high-risk children. The Social Work Care Navigators also made onsite visits to the community mental health centers to identify contacts within those organizations and bridge partnerships between the PCPs and community mental health centers. Co-case management rounds continued in 2017, to discuss difficult medical/ behavioral cases with case management staff and leadership. A Behavioral Health Master Class, in collaboration with Dr. Michelle Kilo and the Children's Mercy Developmental and Behavioral Clinic, was developed and offered to providers within the network to address integration of behavioral health and medical services – i.e., evaluate access and referral needs, educate about services available, facilitate communication between providers, etc. Topics included Parenting and Behavioral Management for the PCP, Basics of Pharmacology for the PCP, Attention-Deficit/Hyperactivity Disorder (ADHD) for the PCP, Trauma/Post-Traumatic Stress Disorder (PTSD) for the PCP, and Anxiety, Depression, & Suicidal Ideation for the PCP.

Community Engagement Resource Application (C.E.R.A)

In 2017, PCN continued the Community Connections Program aimed at identifying key community partners who interact with PCN members. The initiative involves developing relationships with individuals within identified organizations, identifying educational needs from both PCN and the community agency, and facilitating information sharing and ongoing collaboration to meet the social and medical needs of the PCN population. The Community Engagement Resource Application (C.E.R.A.) went live on the PCN Provider Portal and became available for use by the public via the PCN website. The database is designed around social determinants of health categories and allows for customized criteria to be searched, based on member- specific needs. Another feature of C.E.R.A. is the ability for staff to search for educational opportunities and access agency specific event information. C.E.R.A. has proven to be a valuable resource for care coordination efforts. The Community Resource Specialist position was also created within the new Care Team model with many job duties related to the vetting of community resources and maintenance of the C.E.R.A. application.





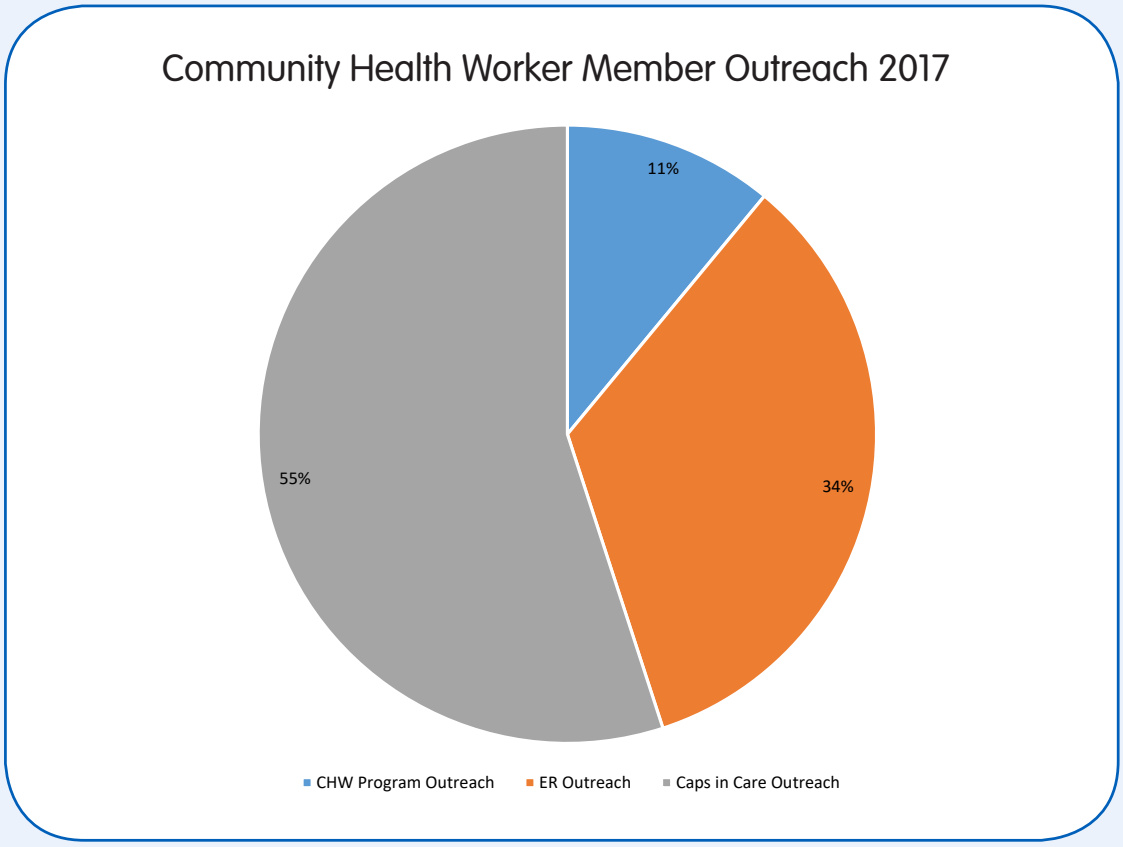
Next Steps:

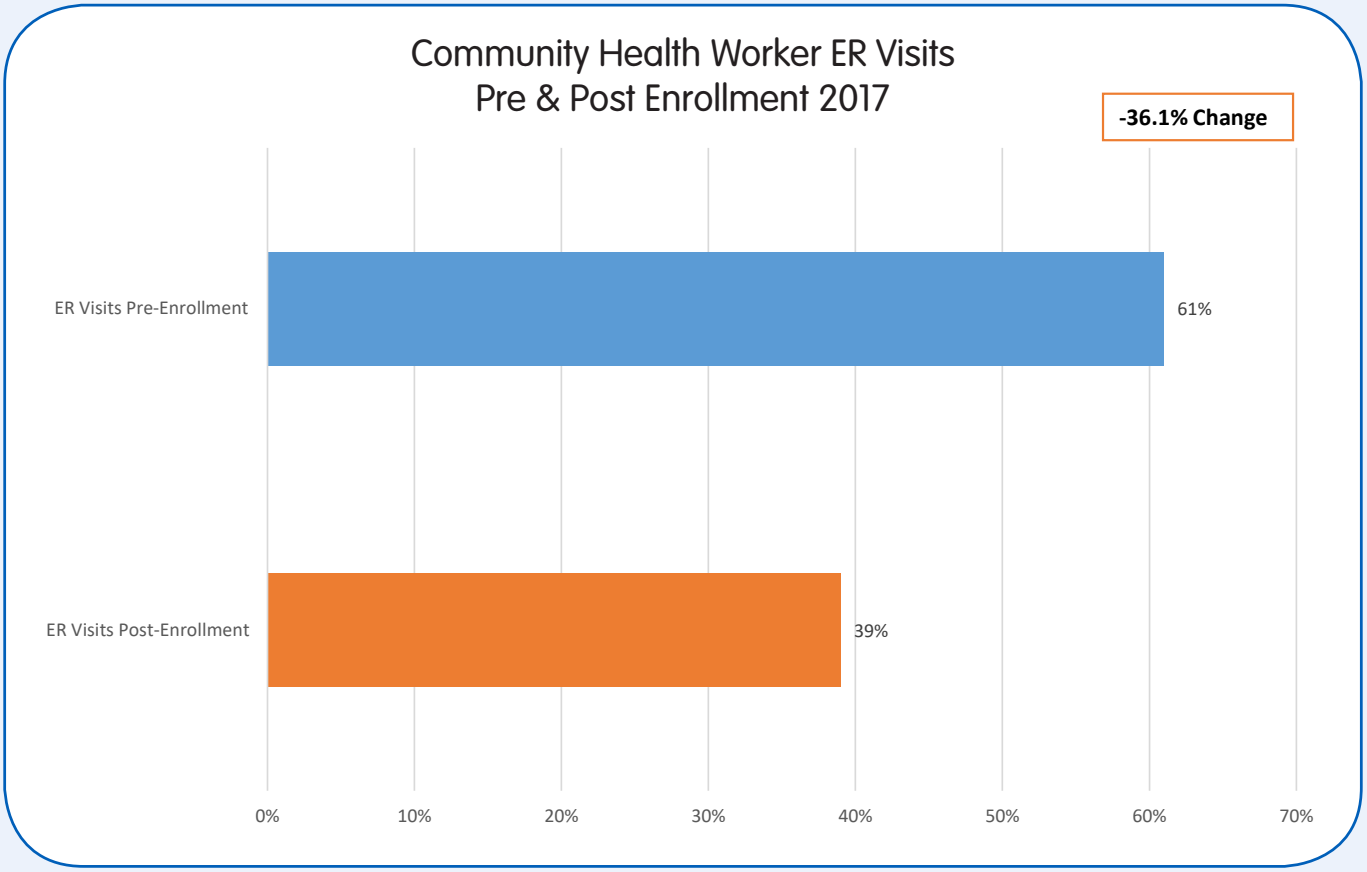
In 2018, PCN will continue to expand the C.E.R.A resource base, develop a tracking system for maintenance and accuracy of the application, and continue the partnerships with local community organizations with the ongoing goal of enhancing the health and well-being of members and their families. Innovative initiatives like the prescription food pantry will continue on as well. (see Care Team Successes with PCN Practices).

Community Health Worker

In June 2017, PCN partnered with a local safety net organization that specializing in community outreach and education for the most vulnerable populations. The partnership involved supporting the use of Community Health Workers (CHW) at two PCP practice locations. Members were screened initially by a Care Navigator and then referred to the CHW to address social determinates of health issues. Outreach lists, including members with gaps in care and non-emergent emergency room utilization, were provided to the CHW to connect with members that were not engaged in primary care services. The CHW provided education to the member and/or caregiver about appropriate emergency room utilization, benefits of well care and the CHW program. If the member agreed to enroll in the CHW program, an assessment was completed with the family to determine barriers and goals were identified for 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.

The Community Health Worker attempted outreach to over 900 members and created 90 tailored care plans to provide member education. Through the pilot program, 22 members enrolled in the CHW program in 2017. The preliminary data for the initial pilot phase demonstrated a 36% reduction in ER visits for CHW enrolled members.


Community Health Worker Member Outreach 2017
11%
34%
55%
CHW Program Outreach
ER Outreach
Caps in Care Outreach


Community Health Worker ER Visits
Pre & Post Enrollment 2017
-36.1% Change
ER Visits Pre-Enrollment
61%
ER Visits Post-Enrollment
39%
0%
10%
20%
30%
40%
50%
60%
70%

Next Steps:

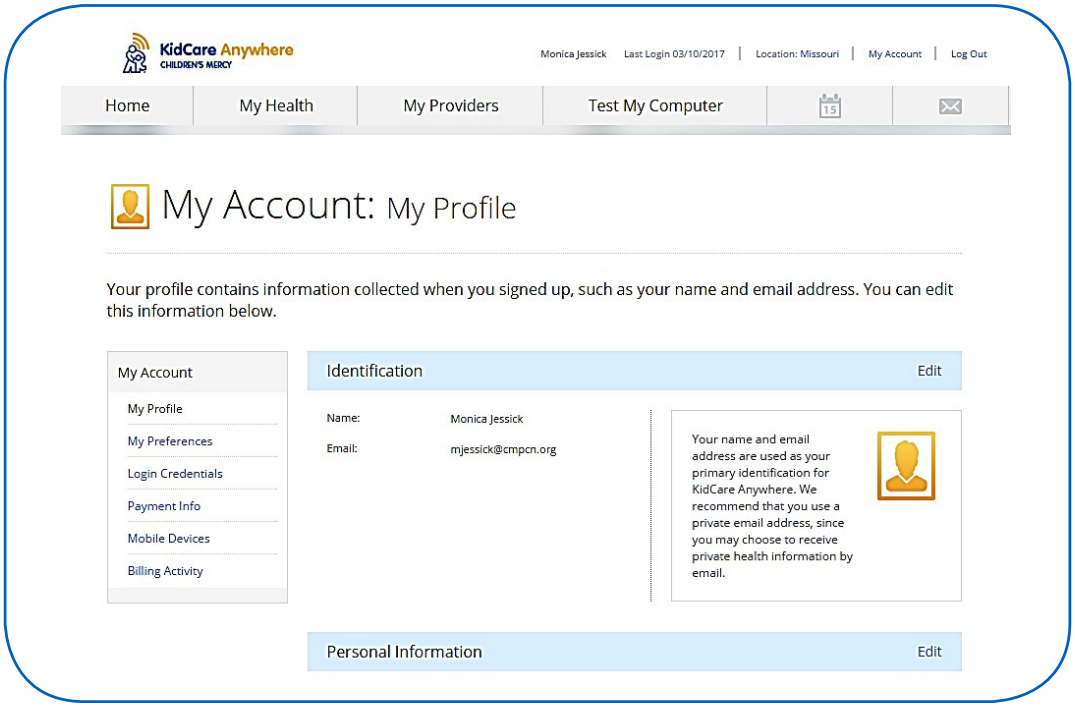
In 2018, the focus of the Community Health Worker will shift to test their interventions at alternative locations, including schools and community centers. Interventions will continue to be measured to determine sustainability of the program and impact to population health outcomes.

KidCare Anywhere

In 2017, Children's Mercy Hospital, in collaboration with PCN, launched a telehealth platform, KidCare Anywhere (KCA), in an effort to decrease emergency room utilization and redirect members to the primary care provider for non-emergent health concerns. This Children's Mercy Hospital initiative is staffed by Children's Mercy providers and intended to triage non-emergent conditions. Providers discuss the member's concern, provide guidance, and often provide treatment for minor ailments and illnesses. KCA is also used by PCN Care Teams as an alternative method for in-person consultations and coordinating care for at-risk members. At the end of December 2017, a total of 1,283 unique members were enrolled on the platform. Since the launch of the program on April 1, 2017 the platform has been used 95 times by PCN members. Low utilization of the service was expected in the early phase. PCN projects utilization to increase in calendar year 2018 with the platform being offered to more PCN members.

Next Steps:

For 2018, some new uses for the platform include assessing children with chronic ear infections, expanding access to more departments in the hospital for post-operative care, hospital post-discharge follow-up visits, developmental and behavioral health and social work services.



Patient Experience

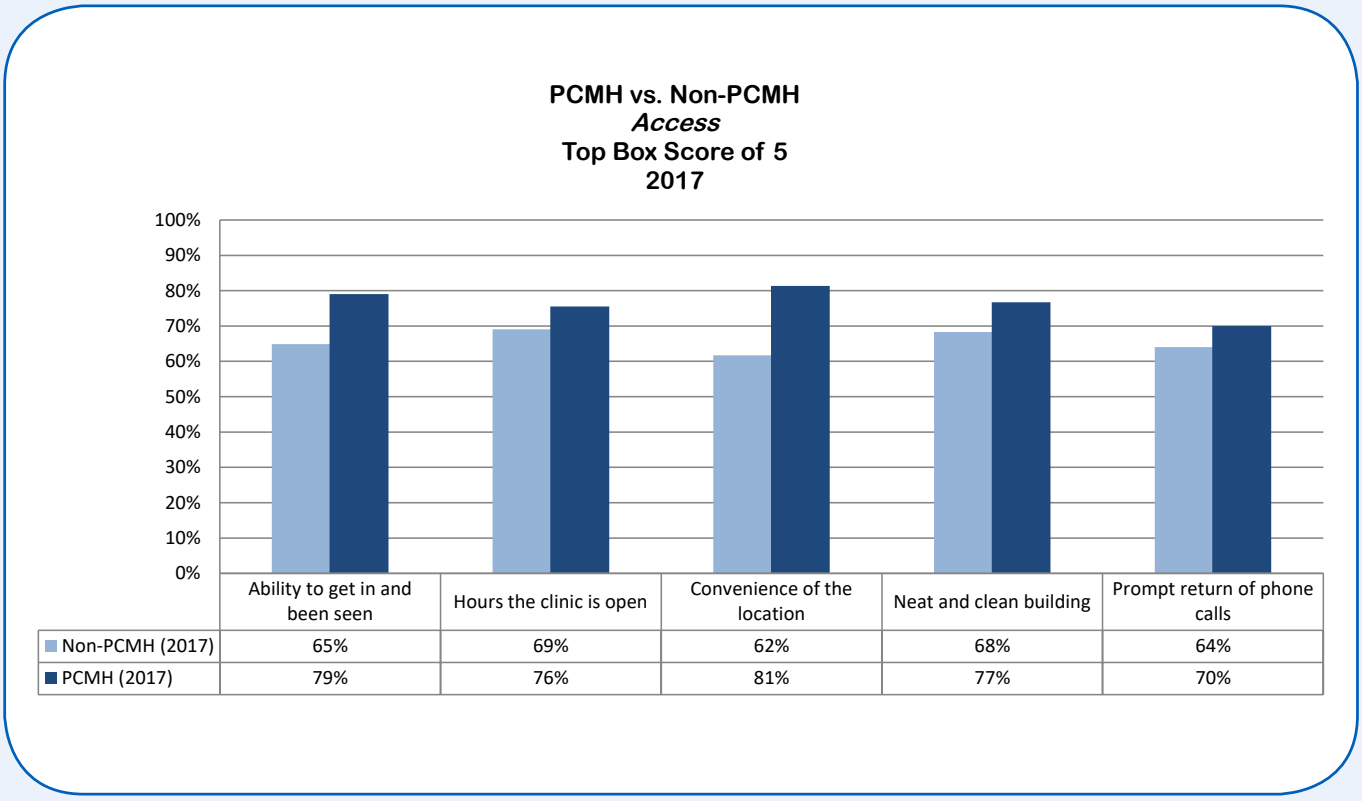
A component of PCMH encourages practices to obtain feedback from patients and families regarding their experience of care received. Four main categories are reviewed including: access, communication, whole-person care, and self-management.

For the Patient Satisfaction Survey, the PCN utilized a scale of 1 through 5 in which a score of 5 indicates "Great" and 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 accounts for the percentage of patients who selected a 5 as his/her response to a rating question on the survey. Responses that scored between the ranges of 1 and 4 were not accounted for as part of the top box scoring methodology.

Increased patient satisfaction among PCN members has been shown in almost all areas for the NCQA PCMH-recognized practices. In addition to comparing the year over year combined results for all PCN practices (2014-2017), the variable of NCQA PCMH-recognized vs. Non-PCMH recognized practices was included in the analysis beginning in 2016.

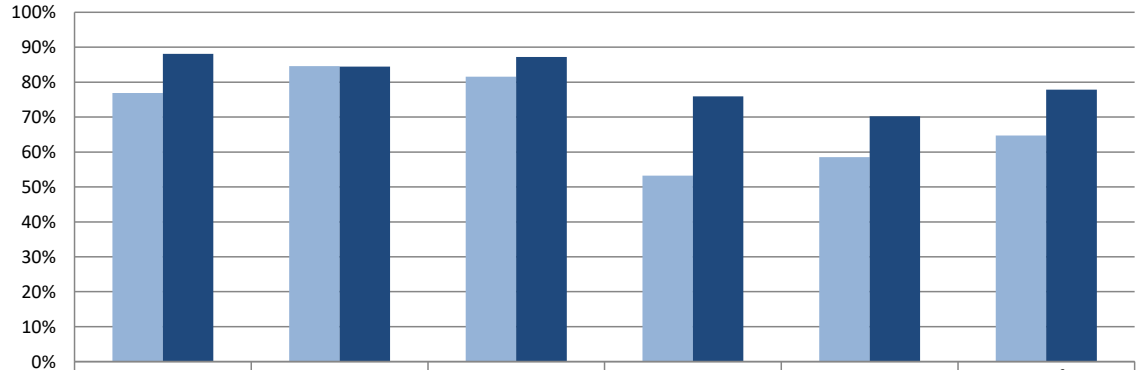
Analysis:

The addition of the variable of NCQA PCMH-recognized vs. Non-PCMH recognized practices provided valuable insight on the value of becoming a PCMH-recognized practice to patients and their caregivers. As evidenced in the graphs, the scores are consistently higher for NCQA PCMH-recognized practices nearly across the board. From 2016-2017 survey results were higher or within 1-2% points in all categories.



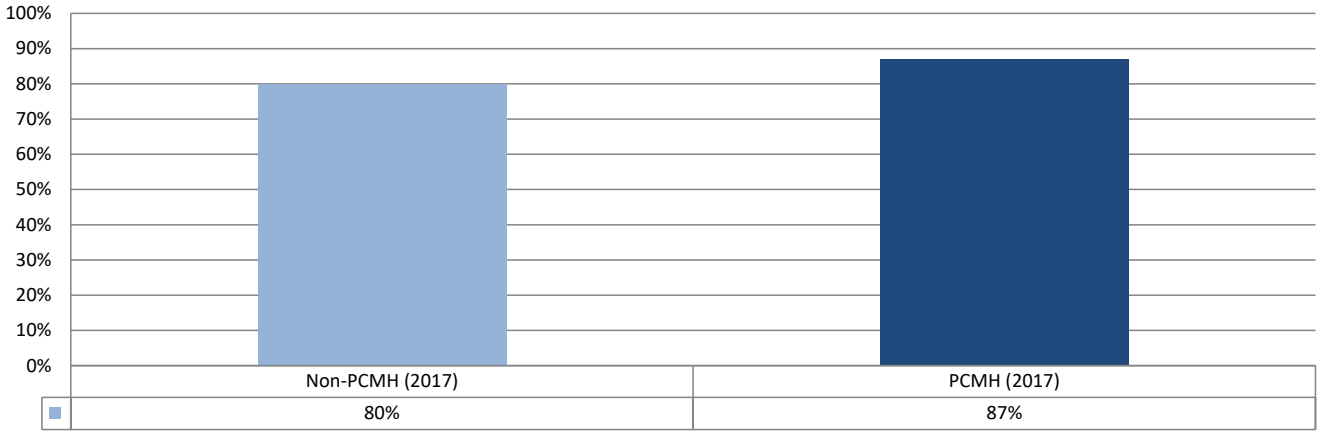
	Ability to get in and been seen	Hours the clinic is open	Convenience of the location	Neat and clean building	Prompt return of phone calls
Non-PCMH (2017)	65%	69%	62%	68%	64%
PCMH (2017)	79%	76%	81%	77%	70%

PCMH vs. Non-PCMH
Communication
Top Box Score of 5
2017

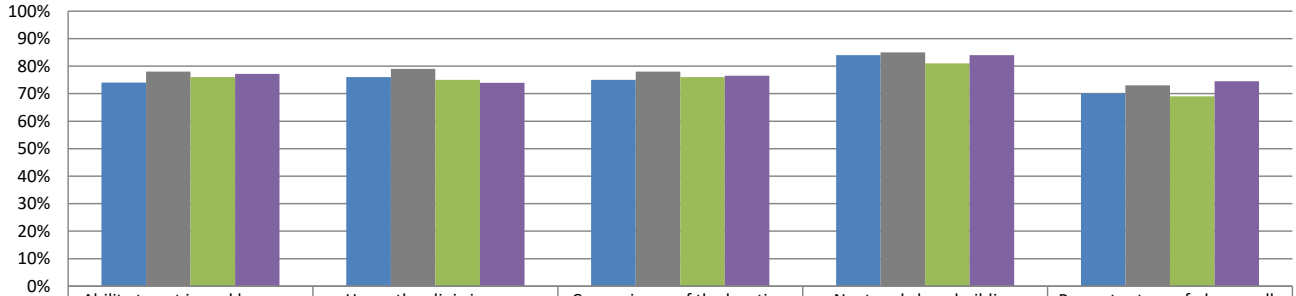


	Comfort and safety while waiting	Front desk is friendly and helpful	Nurses and medical assistants are friendly and helpful	Amount of time I spend in waiting room	Amount of time I spend in exam room	Amount of time I spend waiting for tests to be performed
Non-PCMH (2017)	77%	85%	82%	53%	59%	65%
PCMH (2017)	88%	84%	87%	76%	70%	78%

PCMH vs. Non-PCMH
What is the chance you would refer friends or family to us?
Top Box Score of 5
2017

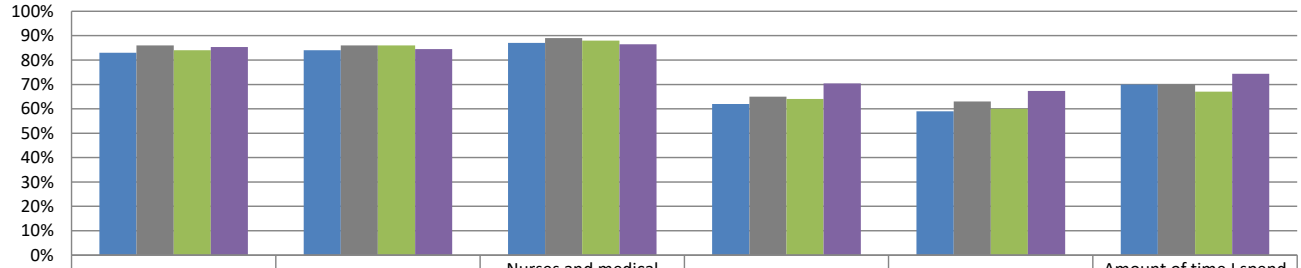


All PCN Practices
Access
Top Box Score of 5
2014-2017



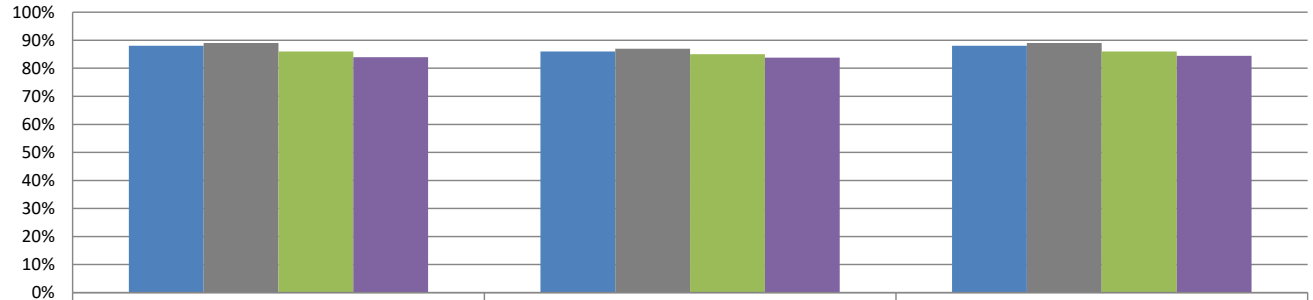
	Ability to get in and be seen	Hours the clinic is open	Convenience of the location	Neat and clean building	Prompt return of phone calls
2014	74%	76%	75%	84%	70%
2015	78%	79%	78%	85%	73%
2016	76%	75%	76%	81%	69%
2017	77%	74%	77%	84%	75%

All PCN Practices
Communication
Top Box Score of 5
2014-2017



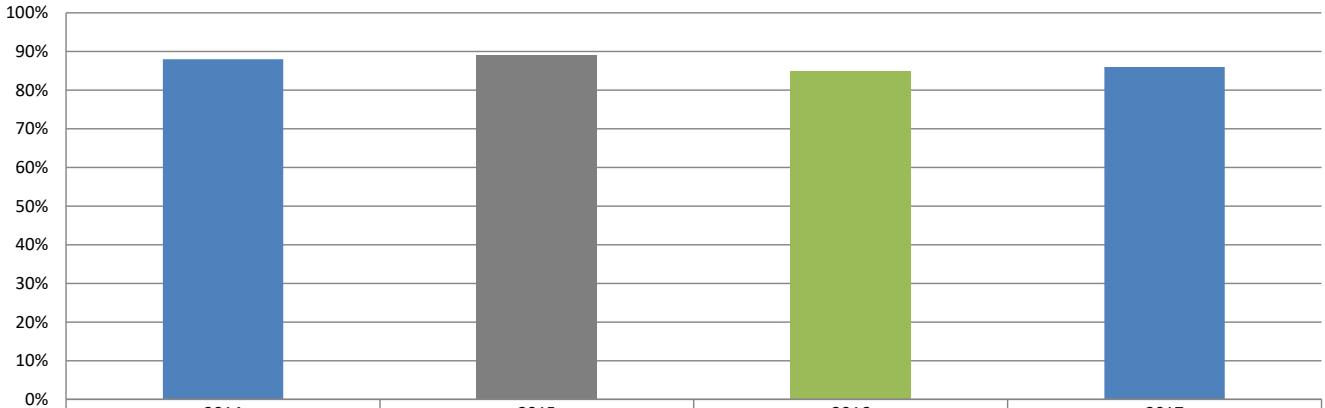
	Comfort and safety while waiting	Front desk is friendly and helpful	Nurses and medical assistants are friendly and helpful	Amount of time I spend in waiting room	Amount of time I spend in exam room	Amount of time I spend waiting for tests to be performed
2014	83%	84%	87%	62%	59%	70%
2015	86%	86%	89%	65%	63%	70%
2016	84%	86%	88%	64%	60%	67%
2017	85%	84%	86%	70%	67%	74%

All PCN Practices
Communication/Whole Person Care
My provider...
Top Box Score of 5
2014-2017



	Listens to me	Spends enough time with me	Explains what I want to know
2014	88%	86%	88%
2015	89%	87%	89%
2016	86%	85%	86%
2017	84%	84%	84%

All PCN Practices
What is the chance you would refer friends and family to us?
Top Box Score of 5
2014-2017

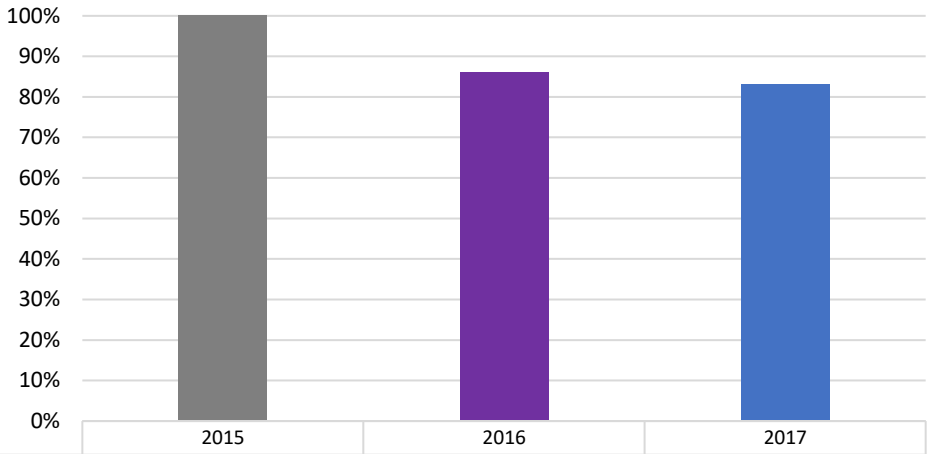


	2014	2015	2016	2017
	88%	89%	85%	86%

Provider Experience

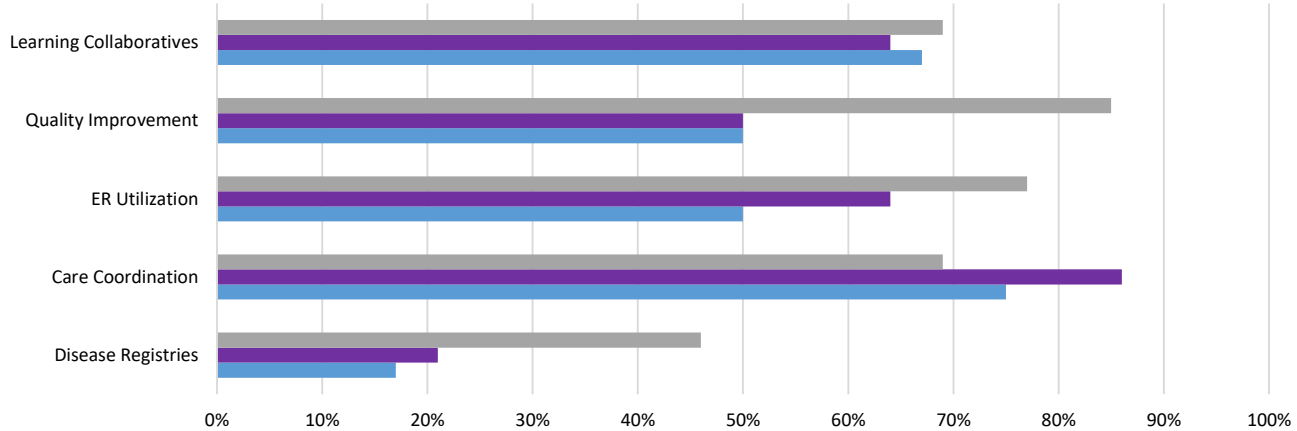
A short survey was distributed to all clinics/PCMH offices in the PCN to assess their satisfaction with the medical home team, Care Navigators, and prior authorization staff members. The Provider Satisfaction Survey contained eight questions. PCN's Provider Satisfaction Survey results from 2015-2017 are shown below:

Partnership with the CMPCN Medical Home Team has been helpful in my practice's implementation of medical home concepts.



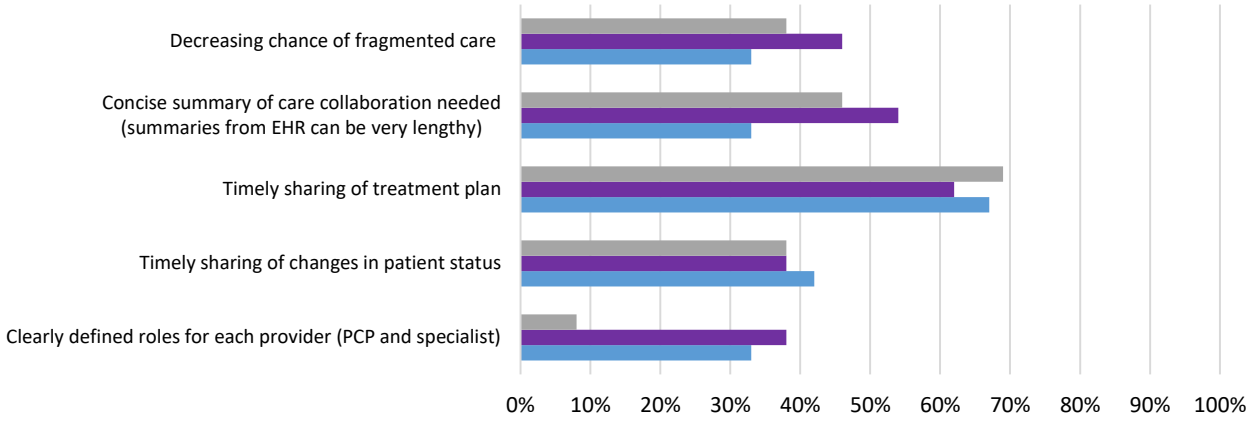
	2015	2016	2017
Partnership with the CMPCN Medical Home Team has been helpful in my practice's implementation of medical home concepts.	100%	86%	83%

Partnership with the CMPCN Medical Home/Care Team has positively impacted patient care in the following ways (check all that apply):



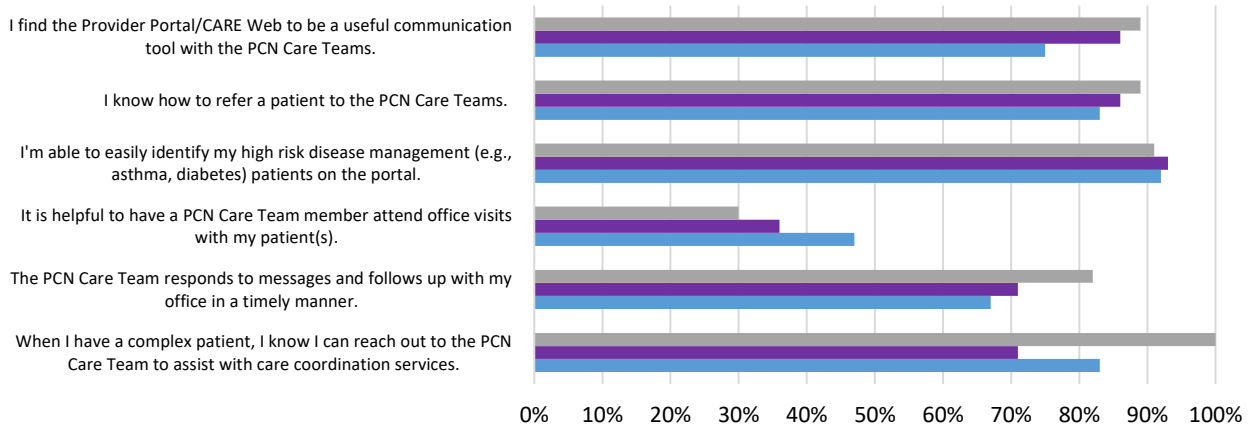
	Disease Registries	Care Coordination	ER Utilization	Quality Improvement	Learning Collaboratives
2015 (13 responses)	46%	69%	77%	85%	69%
2016 (14 responses)	21%	86%	64%	50%	64%
2017 (12 responses)	17%	75%	50%	50%	67%

My practice would benefit from a collaborative agreement (consultation) with the specialist regarding the following to further enhance the medical neighborhood. Check all that apply.



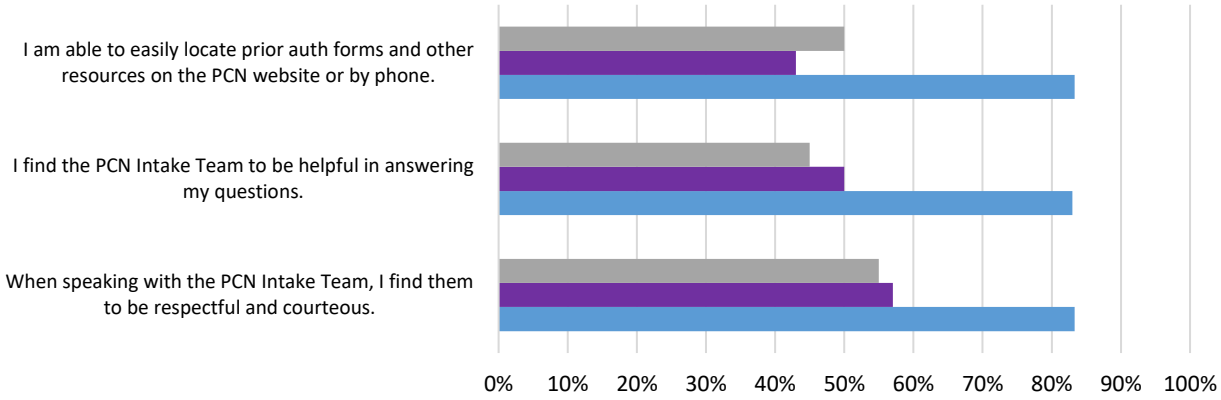
	Clearly defined roles for each provider (PCP and specialist)	Timely sharing of changes in patient status	Timely sharing of treatment plan	Concise summary of care collaboration needed (summaries from EHR can be very lengthy)	Decreasing chance of fragmented care
2015 (13 responses)	8%	38%	69%	46%	38%
2016 (13 responses)	38%	38%	62%	54%	46%
2017 (12 responses)	33%	42%	67%	33%	33%

Case Management



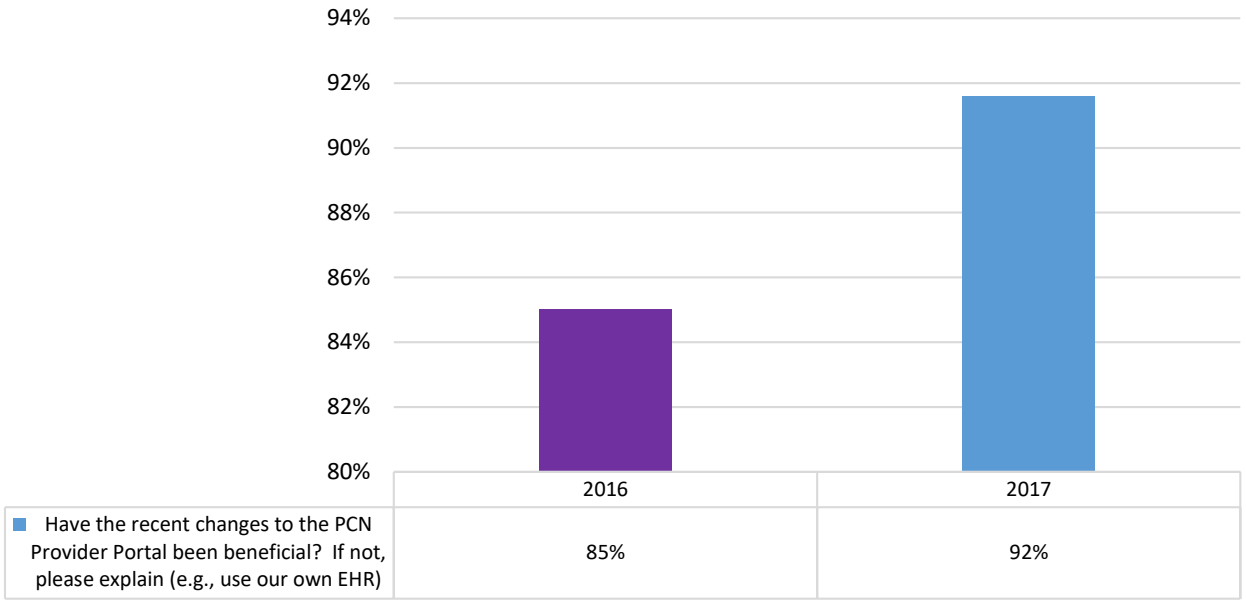
	When I have a complex patient, I know I can reach out to the PCN Care Team to assist with care coordination services.	The PCN Care Team responds to messages and follows up with my office in a timely manner.	It is helpful to have a PCN Care Team member attend office visits with my patient(s).	I'm able to easily identify my high risk disease management (e.g., asthma, diabetes) patients on the portal.	I know how to refer a patient to the PCN Care Teams.	I find the Provider Portal/CARE Web to be a useful communication tool with the PCN Care Teams.
2015 (12 responses)	100%	82%	30%	91%	89%	89%
2016 (14 responses)	71%	71%	36%	93%	86%	86%
2017 (12 responses)	83%	67%	47%	92%	83%	75%

Prior Authorization



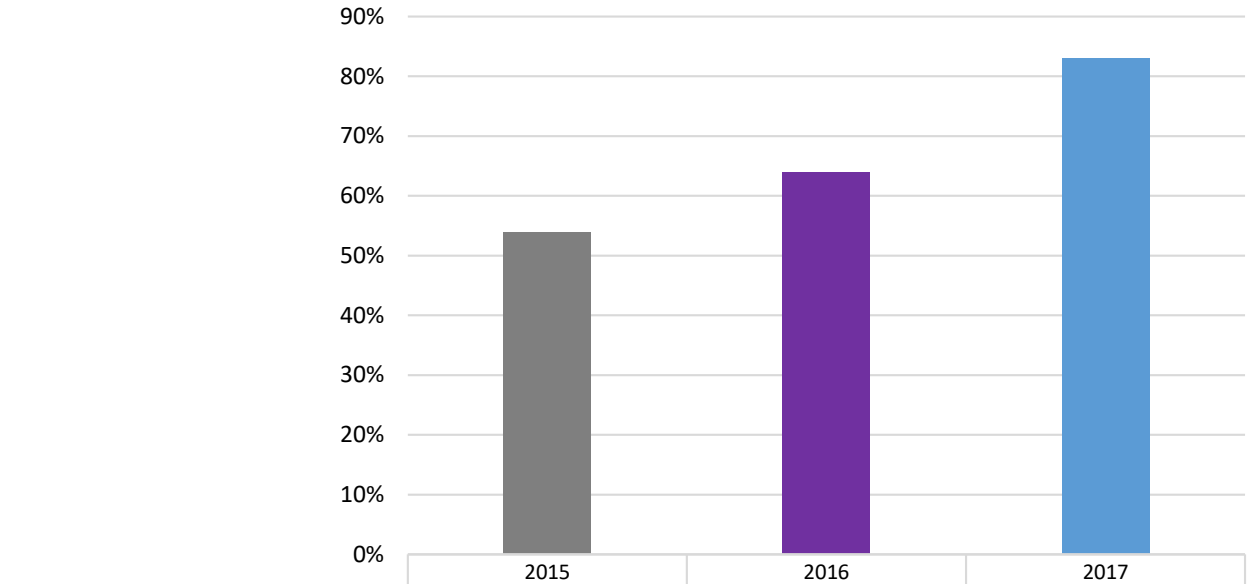
	When speaking with the PCN Intake Team, I find them to be respectful and courteous.	I find the PCN Intake Team to be helpful in answering my questions.	I am able to easily locate prior auth forms and other resources on the PCN website or by phone.
2015 (12 responses)	55%	45%	50%
2016 (14 responses)	57%	50%	43%
2017 (12 responses)	83%	83%	83%

Have the recent changes to the PCN Provider Portal been beneficial? If not, please explain (e.g., use our own EHR)



	2016	2017
Have the recent changes to the PCN Provider Portal been beneficial? If not, please explain (e.g., use our own EHR)	85%	92%

Please rate your overall experience with PCN Intake Team:



	2015	2016	2017
Please rate your overall experience with PCN Intake Team:	54%	64%	83%

PCMH vs. Non-PCMH Analysis of Cost, Utilization & Quality Measures

Measuring the Value of PCMH

By adopting the 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 conducted cost and utilization comparisons between three different groups within the PCN. The comparison included the following:

PCMH Practices
Includes all practices engaged with the PCN who have been designated as an NCQA-recognized PCMH for at least one year.

Non-PCMH Practices
Includes all practices engaged with the PCN who do not have NCQA designation as a PCMH, as well as practices not currently contracted with the PCN, typically family practice and rural provider offices. It is important to note that CMH primary care is included in this denominator. This subset includes the balance of an academic curriculum with the PCMH model. The Pediatric Care Clinic (PCC) within the CMH is unique (accounts for approximately 10% of the PCN membership) in comparison to the other PCN practices in terms of size and scope of operations. In addition, the PCC is currently pursuing national recognition as a designated PCMH practice, which will impact the PCMH versus Non-PCMH data comparison in the future.

From a quality perspective, the following metrics were evaluated:

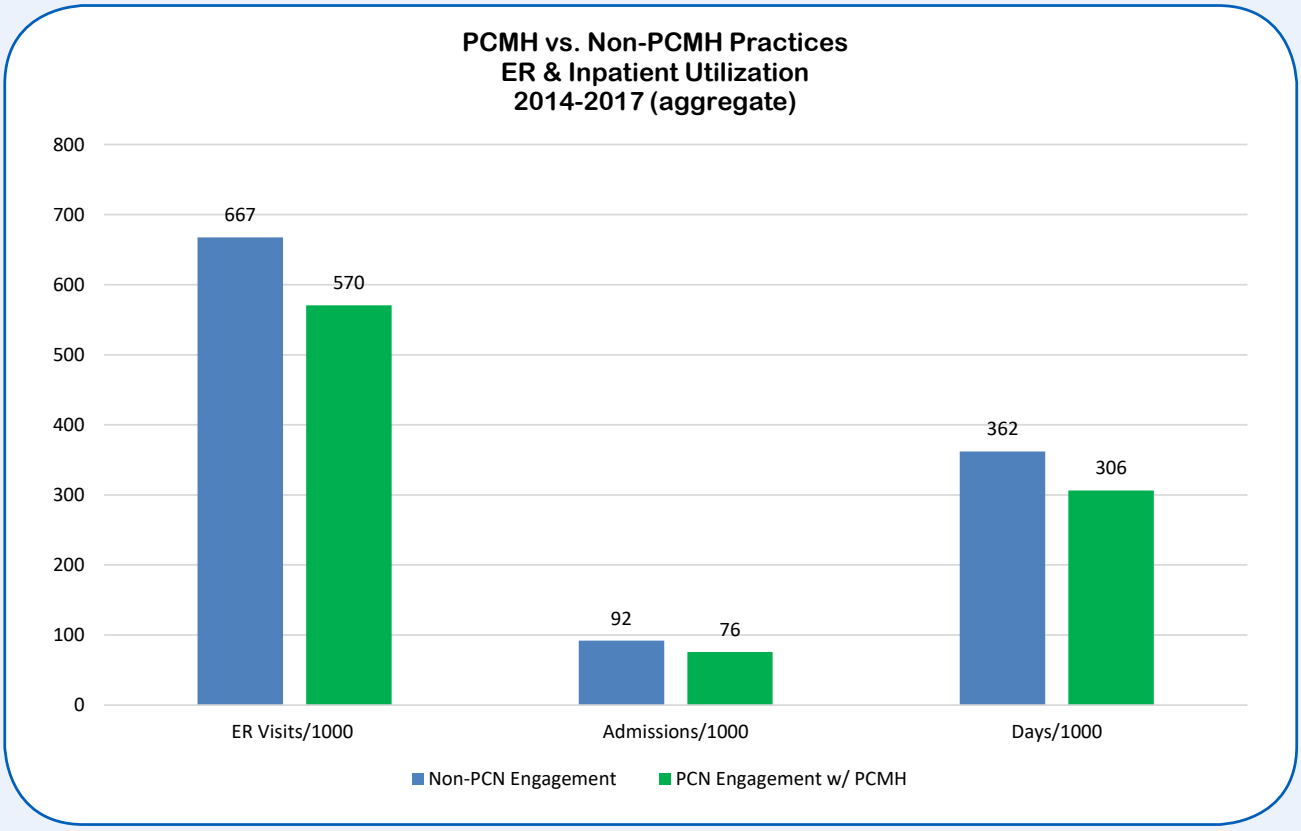
- Well-Child 0-15 Months
- Well-Child 3-6 Years
- Adolescent Well-Care Visits
- Chlamydia Screening
- Children & Adolescents' Access to Primary Care Practitioners (CAP)
- Lead Screening in Children
- Childhood Immunization Combo 2
- Asthma Medication Compliance-50%
- Asthma Medication Compliance-75%
- CHIPRA-HbA1c
- CHIPRA-Nephropathy

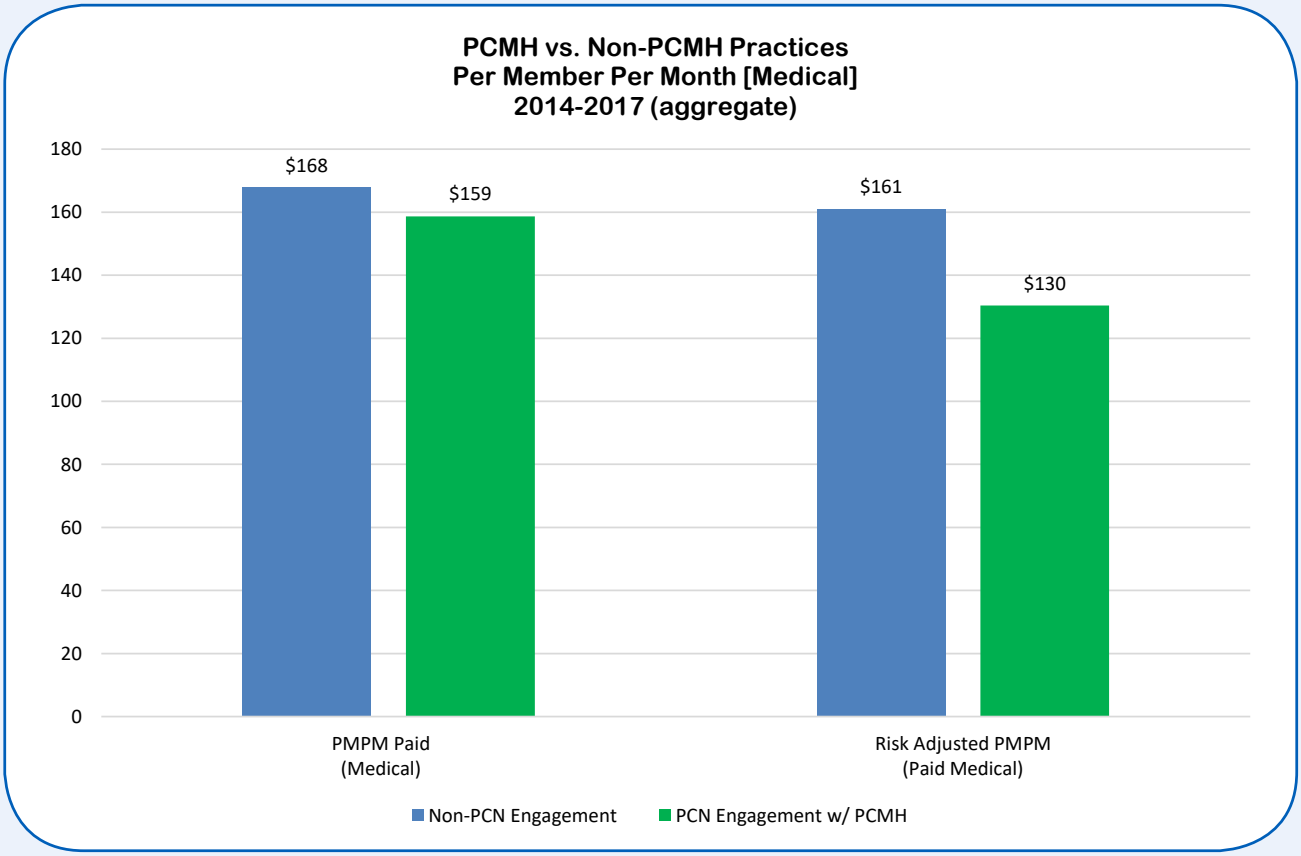
From a cost comparison perspective, the following metrics were evaluated:

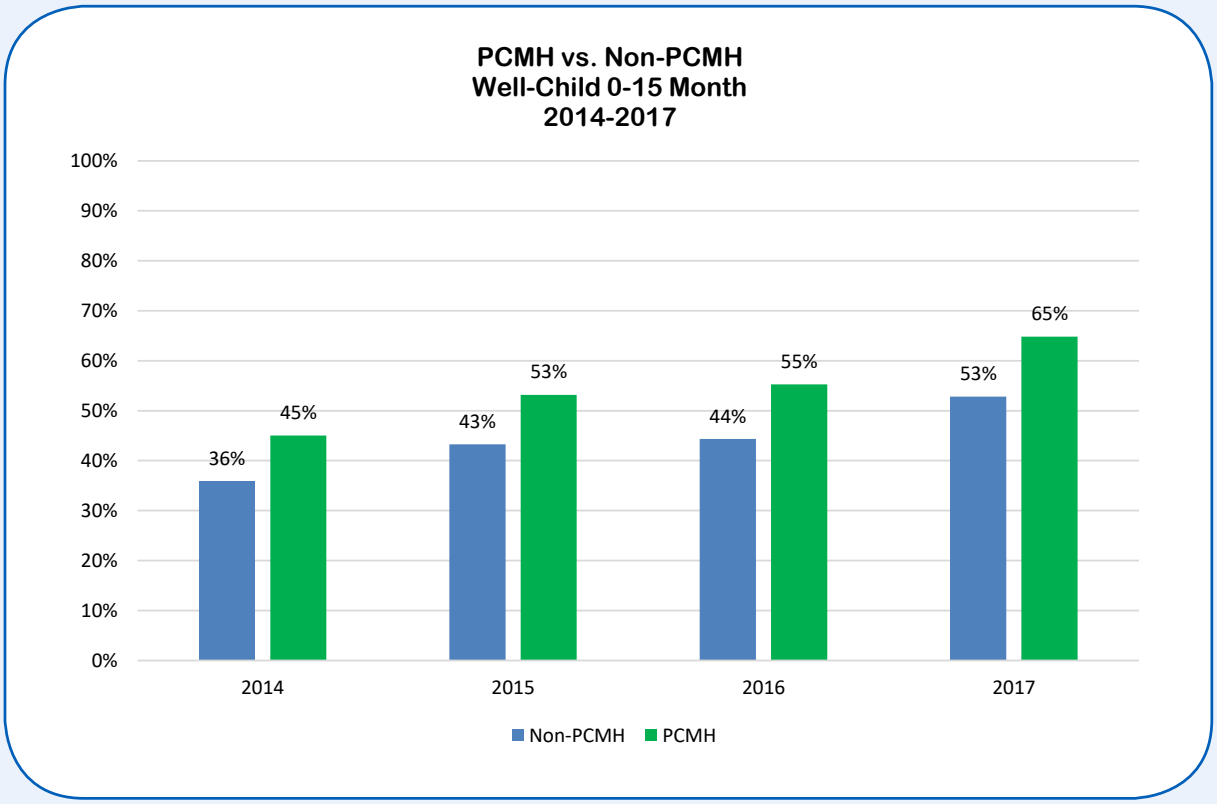
- PMPM (Paid Medical)
- Risk-Adjusted PMPM (Paid Medical)

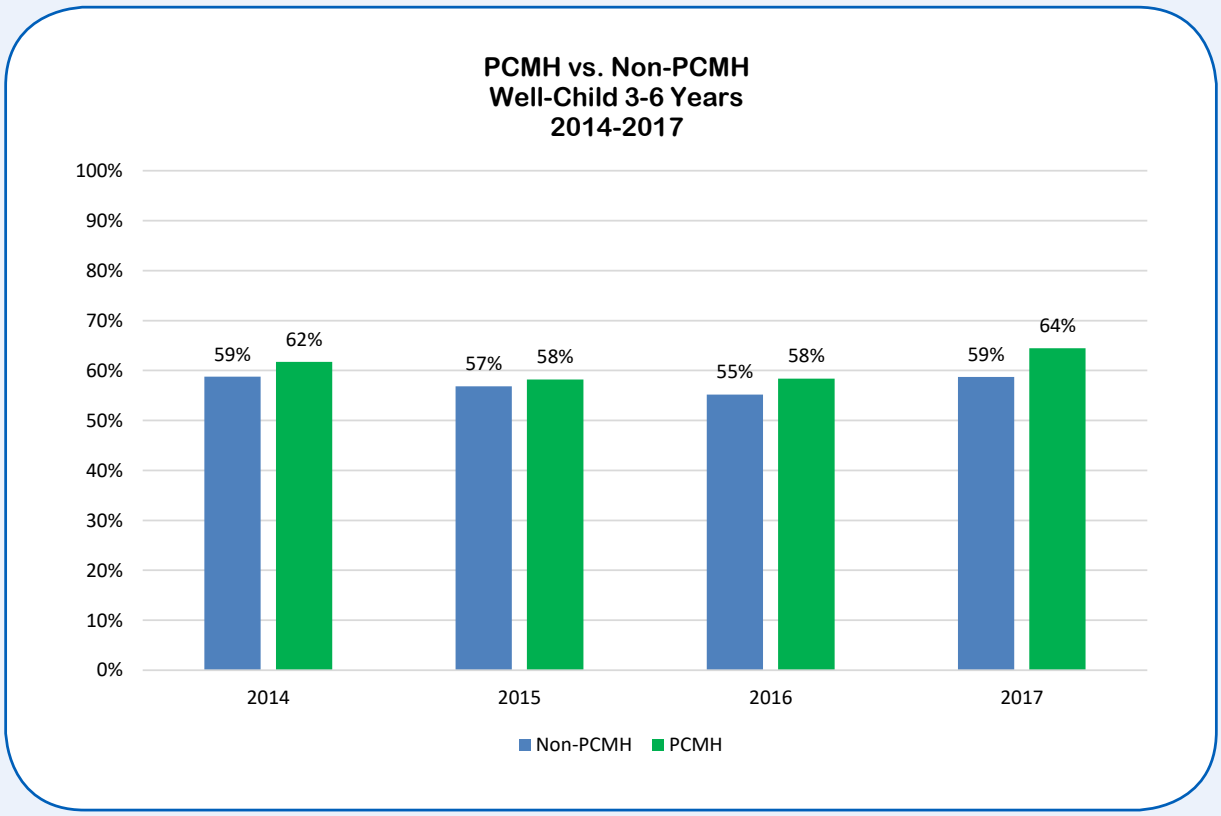
From a utilization comparison perspective, the following metrics were evaluated:

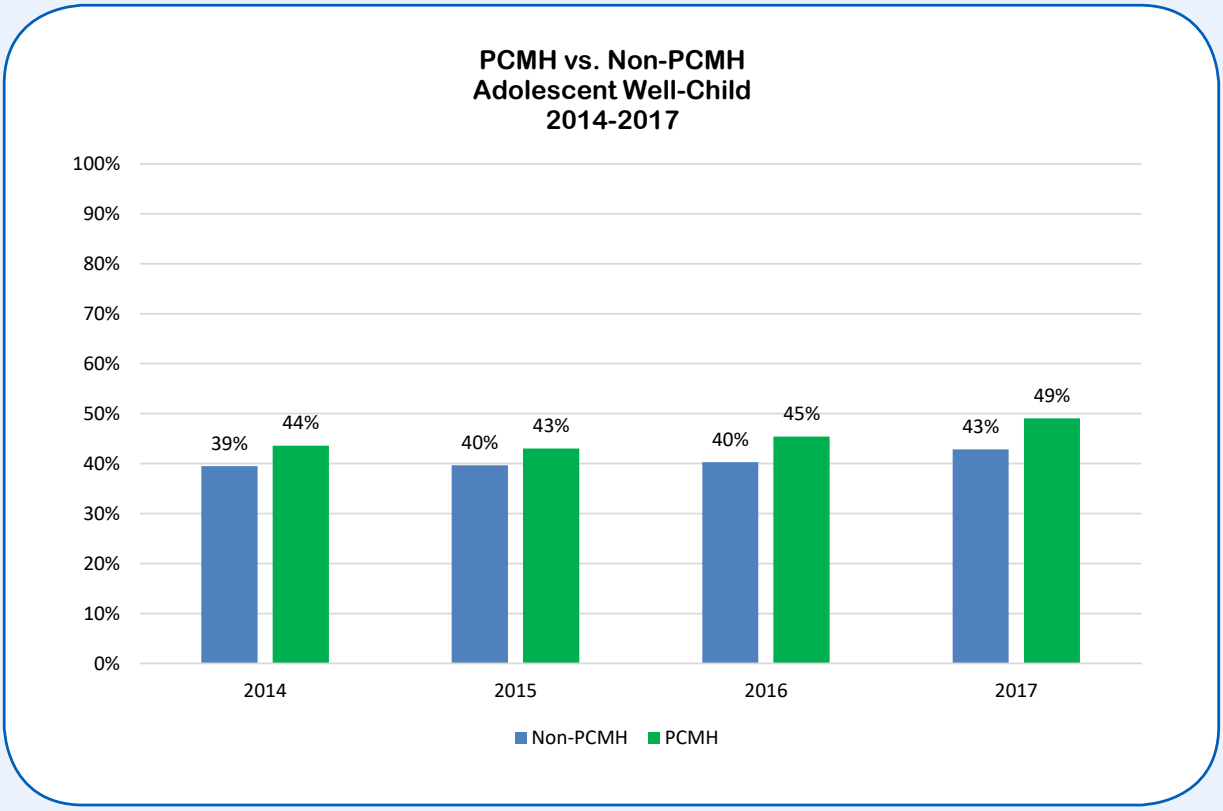
- ER Visits/1000
- Admissions/1000
- Inpatient Days/1000

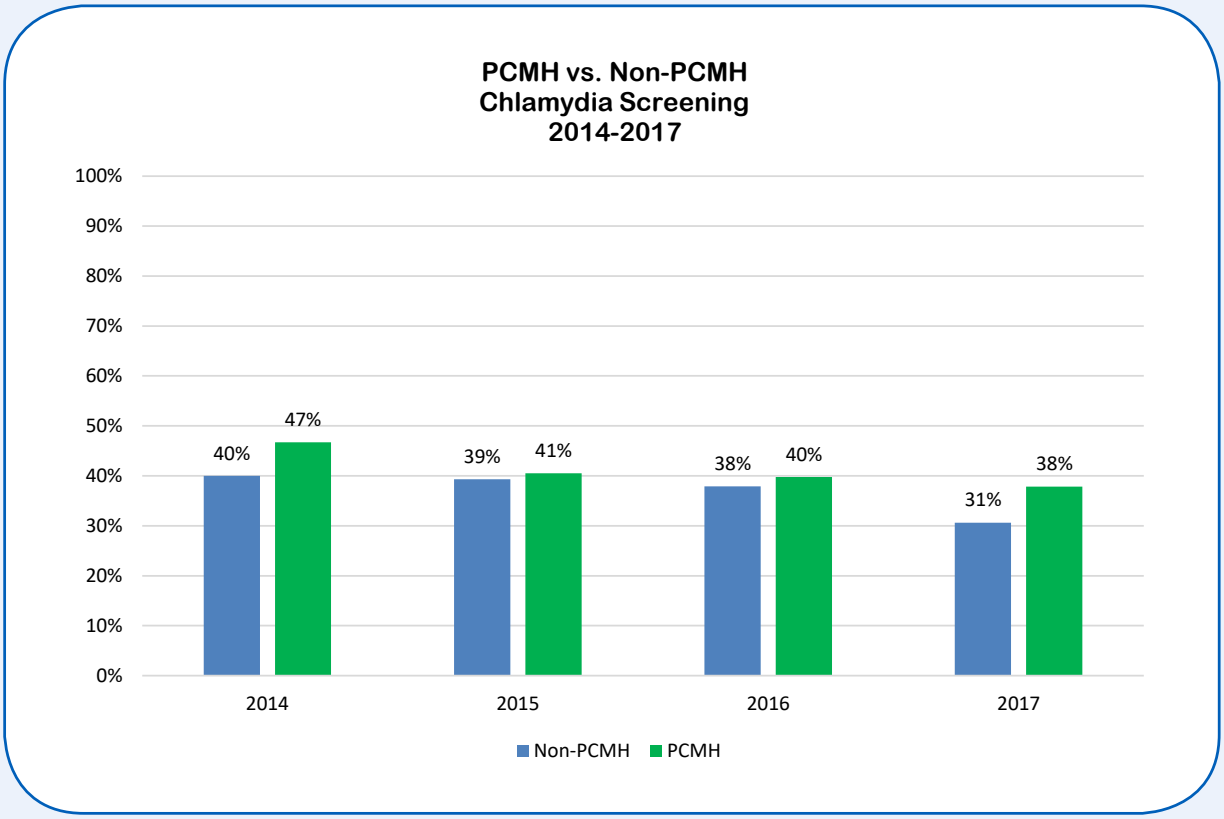

PCMH vs. Non-PCMH Practices
ER & Inpatient Utilization
2014-2017 (aggregate)
800
700
600
500
400
300
200
100
0
667
570
92
76
362
306
ER Visits/1000
Admissions/1000
Days/1000
Non-PCN Engagement
PCN Engagement w/ PCMH

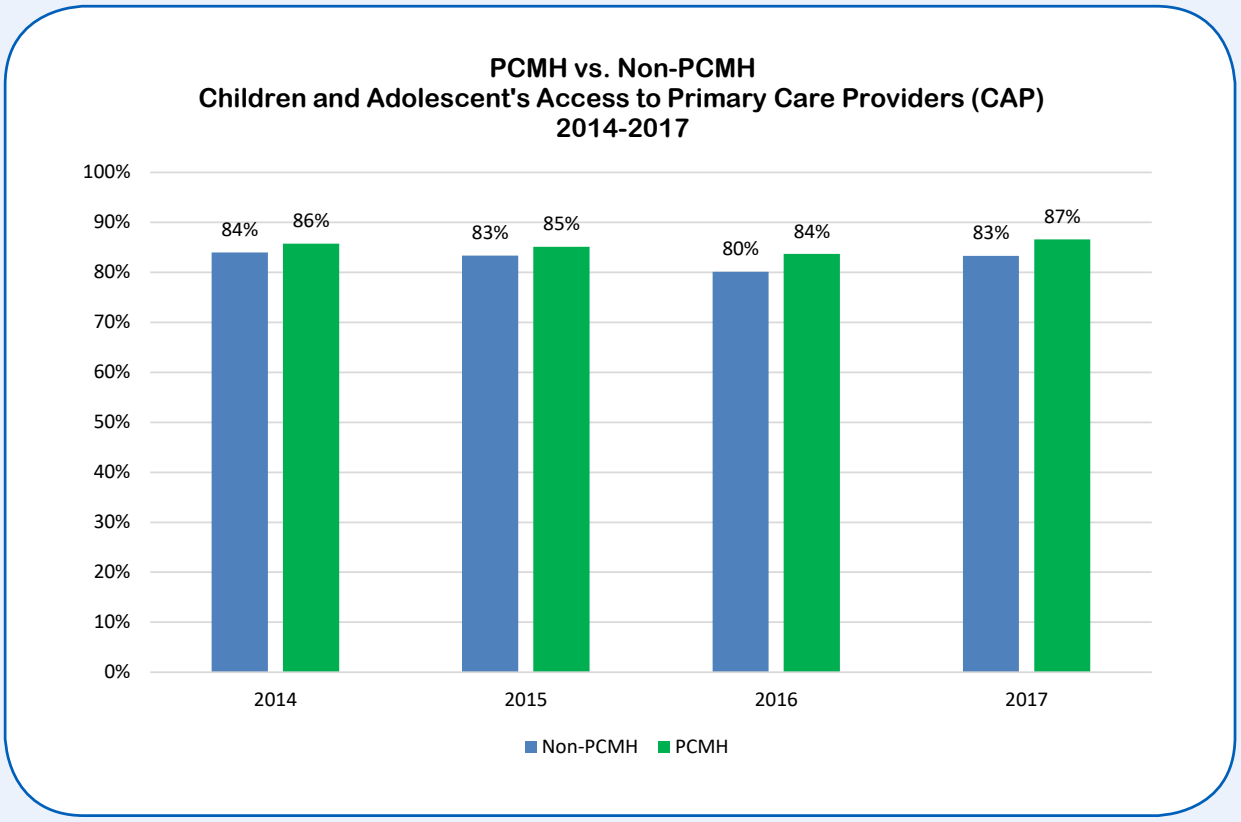

PCMH vs. Non-PCMH Practices
Per Member Per Month [Medical]
2014-2017 (aggregate)
180
160
140
120
100
80
60
40
20
0
$168
$159
$161
$130
PMPM Paid
(Medical)
Risk Adjusted PMPM
(Paid Medical)
Non-PCN Engagement
PCN Engagement w/ PCMH

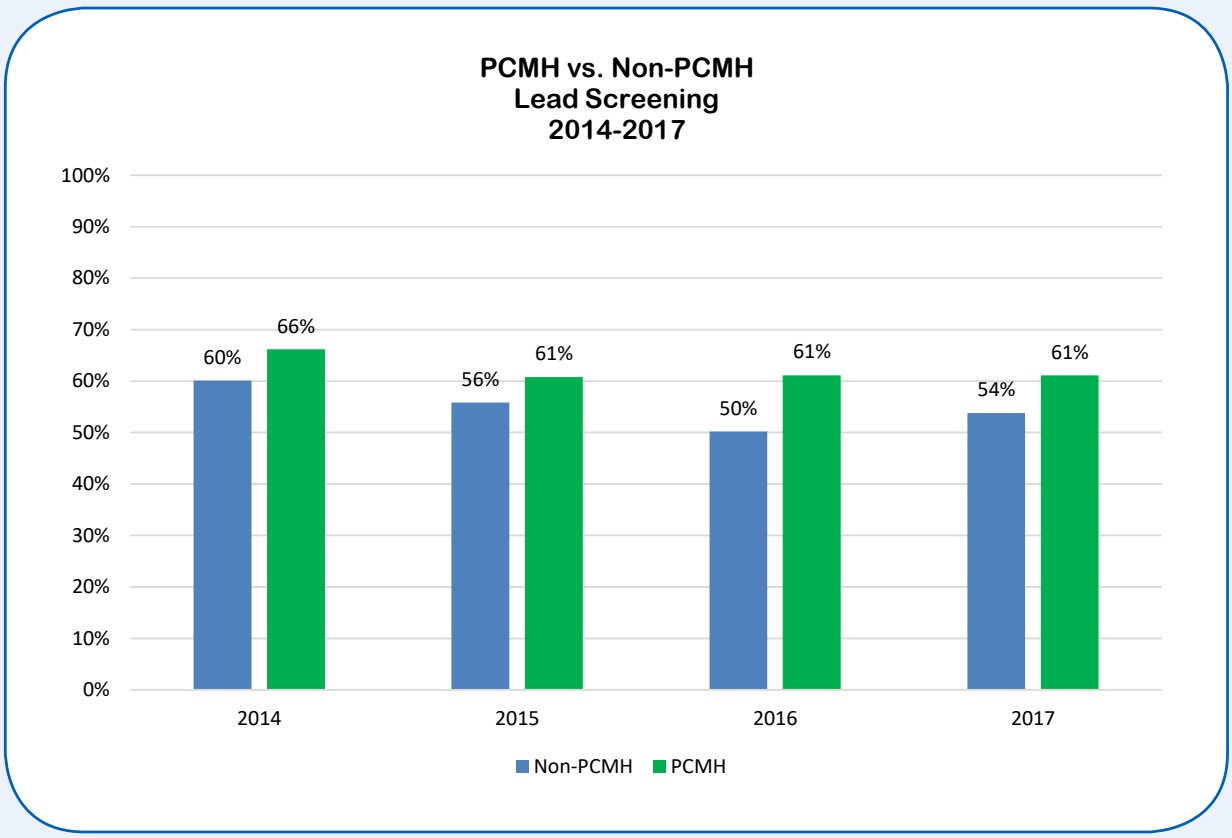

PCMH vs. Non-PCMH
Well-Child 0-15 Month
2014-2017
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
36%
45%
43%
53%
44%
55%
53%
65%
2014
2015
2016
2017
Non-PCMH
PCMH

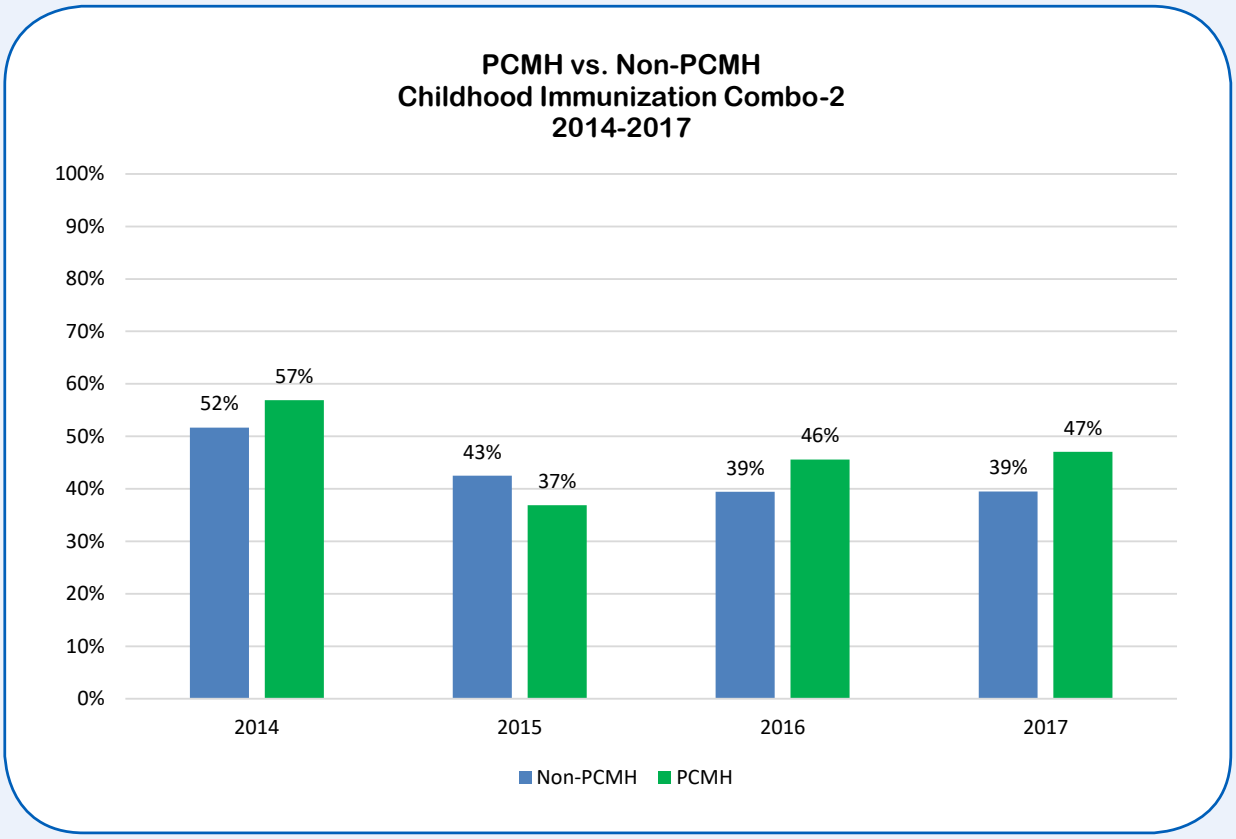

PCMH vs. Non-PCMH
Well-Child 3-6 Years
2014-2017
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
59%
62%
57%
58%
55%
58%
59%
64%
2014
2015
2016
2017
Non-PCMH
PCMH

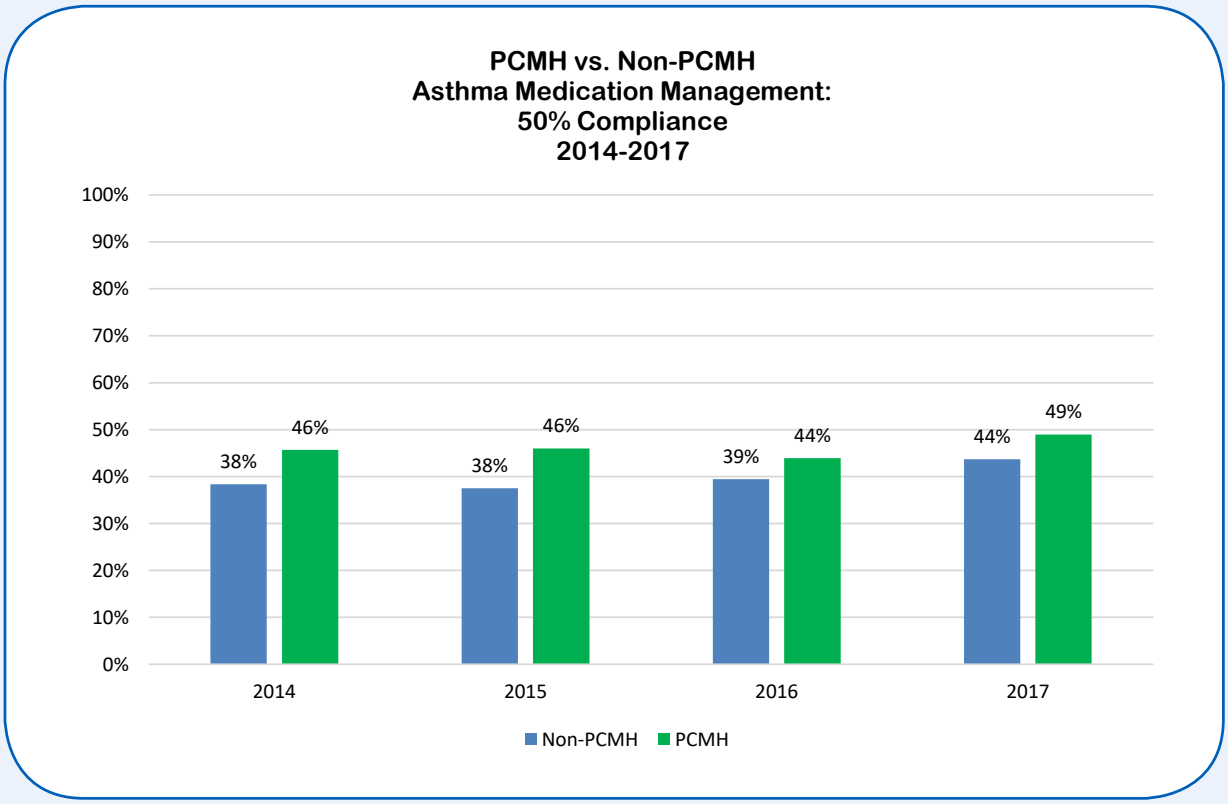

PCMH vs. Non-PCMH
Adolescent Well-Child
2014-2017
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
39%
44%
40%
43%
40%
45%
43%
49%
2014
2015
2016
2017
Non-PCMH
PCMH

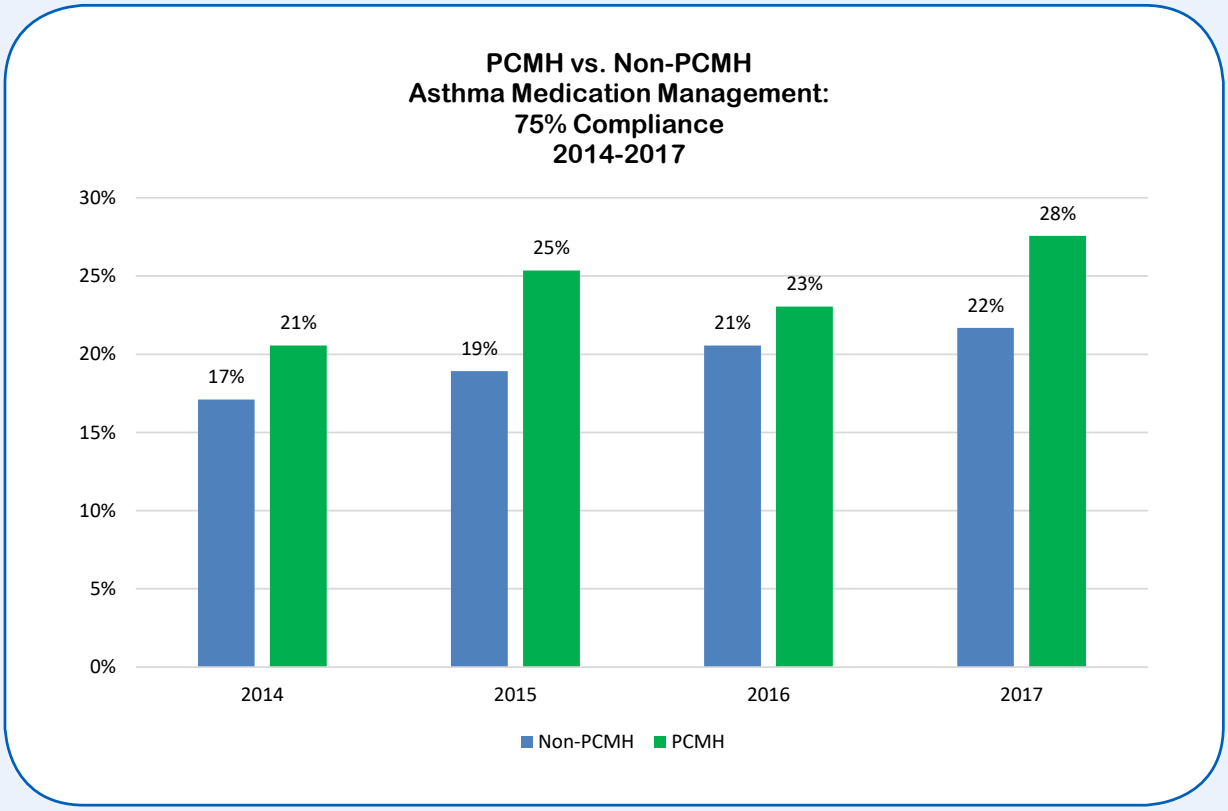

PCMH vs. Non-PCMH
Chlamydia Screening
2014-2017
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
40%
47%
39%
41%
38%
40%
31%
38%
2014
2015
2016
2017
Non-PCMH
PCMH

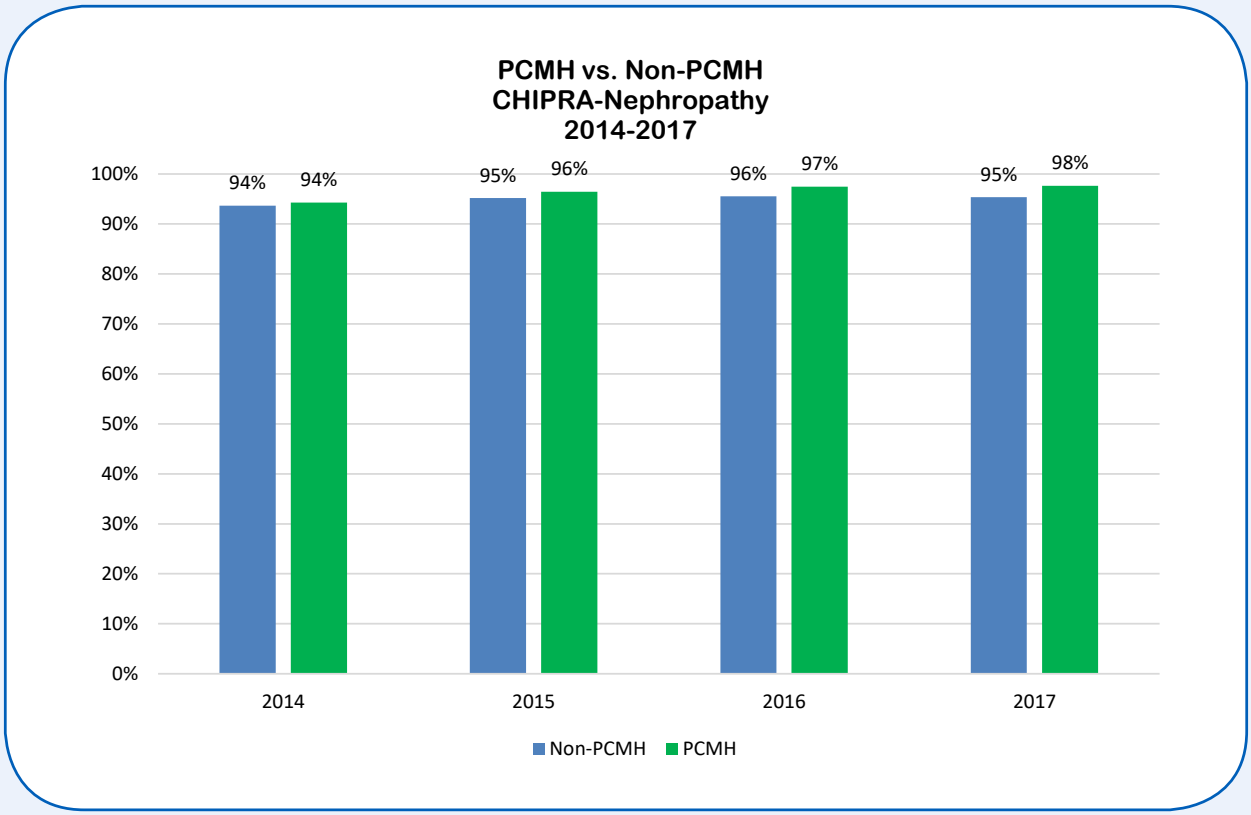

PCMH vs. Non-PCMH
Children and Adolescent's Access to Primary Care Providers (CAP)
2014-2017
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
84%
86%
83%
85%
80%
84%
83%
87%
2014
2015
2016
2017
Non-PCMH
PCMH

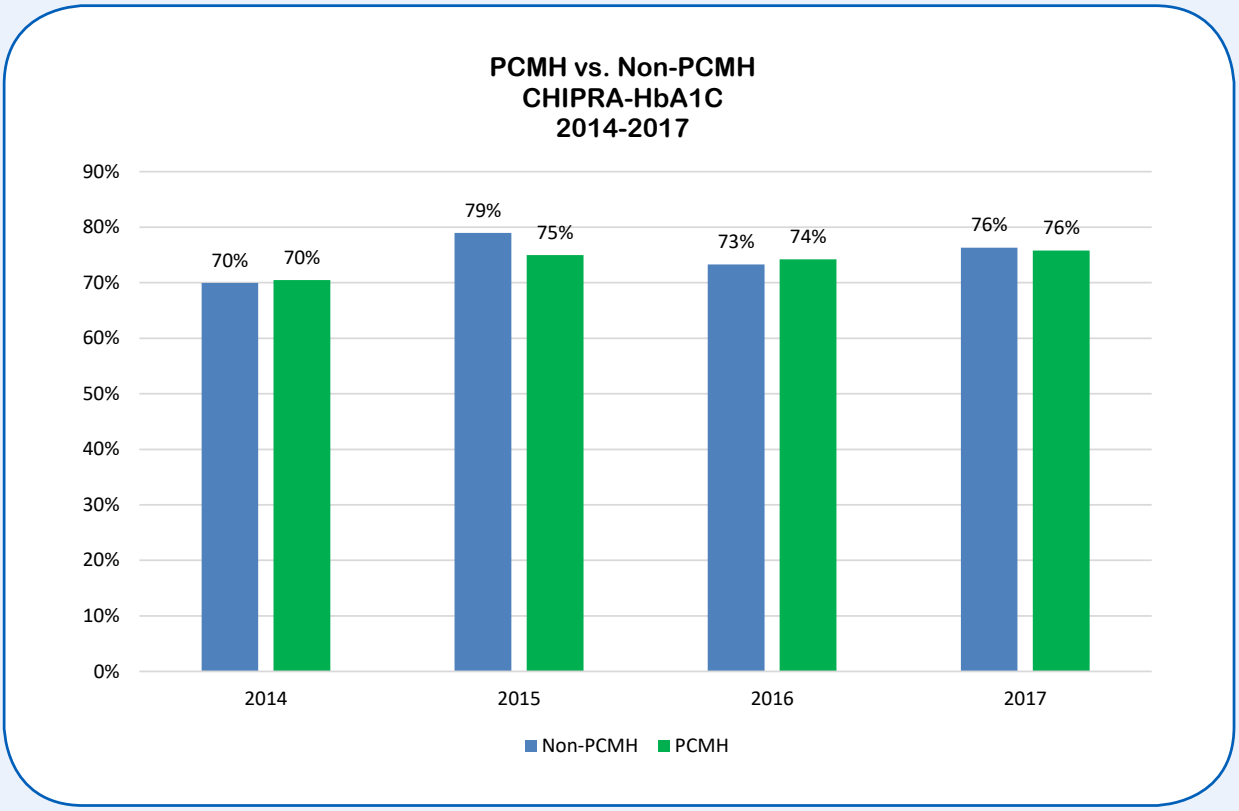

PCMH vs. Non-PCMH
Lead Screening
2014-2017
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
60%
66%
56%
61%
50%
61%
54%
61%
2014
2015
2016
2017
Non-PCMH
PCMH


PCMH vs. Non-PCMH
Childhood Immunization Combo-2
2014-2017
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
52%
57%
43%
37%
39%
46%
39%
47%
2014
2015
2016
2017
Non-PCMH
PCMH


PCMH vs. Non-PCMH
Asthma Medication Management:
50% Compliance
2014-2017
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
38%
46%
38%
46%
39%
44%
44%
49%
2014
2015
2016
2017
Non-PCMH
PCMH


PCMH vs. Non-PCMH
Asthma Medication Management:
75% Compliance
2014-2017
30%
25%
20%
15%
10%
5%
0%
17%
21%
19%
25%
21%
23%
22%
28%
2014
2015
2016
2017
Non-PCMH
PCMH


PCMH vs. Non-PCMH
CHIPRA-Nephropathy
2014-2017
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
94%
94%
95%
96%
96%
97%
95%
98%
2014
2015
2016
2017
Non-PCMH
PCMH


PCMH vs. Non-PCMH
CHIPRA-HbA1C
2014-2017
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
70%
70%
79%
75%
73%
74%
76%
76%
2014
2015
2016
2017
Non-PCMH
PCMH

Next Steps Summary

- The Patient Outreach Initiative (EMMI) will continue with a total of 18 practices and expand outreach efforts to asthma patients.
- Patient Satisfaction Survey will continue to grow adding three practices to provide invaluable practice insight and maintain quality improvement.
- PCN will implement three additional quality incentive measures: weight assessment, Combo 10 immunization and HPV vaccination.
- PCN Care Teams will continue to support PCMH practice transformation as it has been evidenced that NCQA PCMH-recognized practices perform better than Non-PCMH practices in HEDIS quality measures, as well as cost and utilization.
- Practice Provider Profile reports will shift from quarterly to a tri-annual term.
- Tri-Annual meetings with all contracted PCN Practices will continue in 2018 to further medical transparency and cooperation.

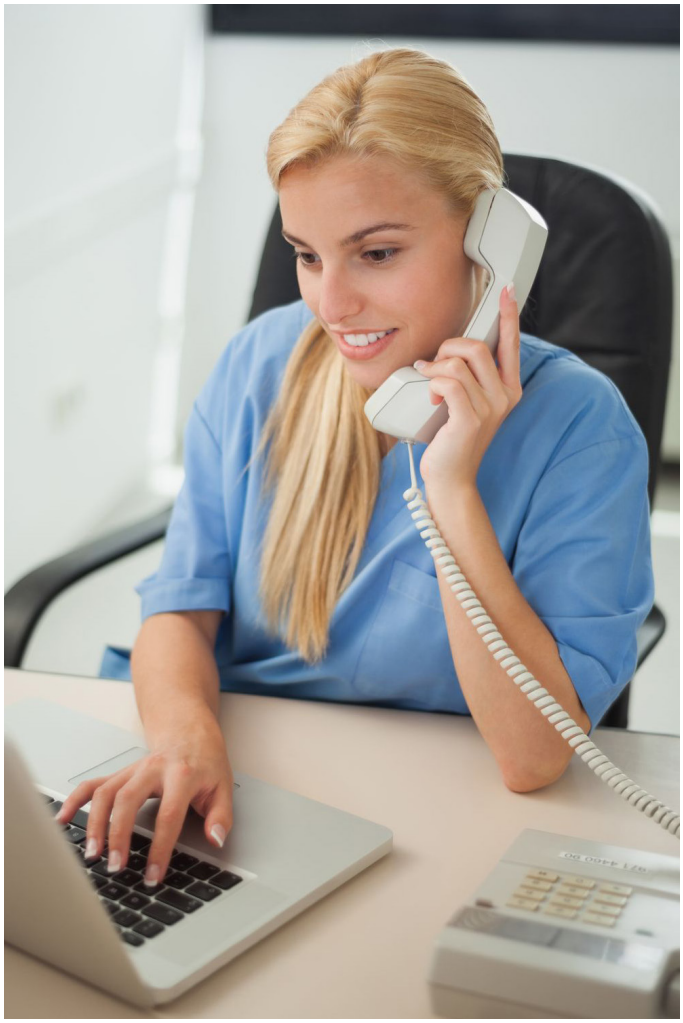
3 Utilization Management

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

Utilization Management (UM) Program Overview

The PCN performs prior authorization, inpatient review, discharge planning, and transitional care planning. Both clinical and non-clinical staff perform prior authorization functions. Non-clinical staff assist with verifying eligibility, entering authorization information in the online system, and faxing and/or calling authorization outcomes to providers. Clinical staff perform medical necessity review and discharge planning. The review process utilizes national guidelines, Milliman Care Guidelines®, as well as internally developed guidelines, to determine medical necessity of service requests. All requests that do not meet the related guideline or policy are sent to a Medical Director for review and final decision. The Care Integration management team and Clinical Project Manager conduct staff audits and oversee the peer audit process. This involves members of the Care Teams conducting audits on their peers' performance of the prior authorization processes to ensure compliance with documentation, application of criteria, and adherence to processing timeframe standards. Current audit standards require that staff members who have been employed for greater than a year will meet or exceed an accuracy level of 95%. In 2017, the average audit scores for both clinical and non-clinical staff exceeded 98%. Timeframes for processing routine and urgent prior authorization requests are monitored on a monthly basis to ensure the program standards are consistently met. The phone queue system is monitored and call statistics are reviewed monthly to ensure calls are answered according to standards.

In addition to process measures, the PCN monitors utilization trends for the population to ensure there is no inappropriate over or under utilization of services provided to PCN members. To monitor for underutilization of services, the PCN relies on review of preventive services, outpatient services and PCP office-based services, as well as member complaints or grievances related to access to care or insufficient care delivery. The information specific to those measures is outlined

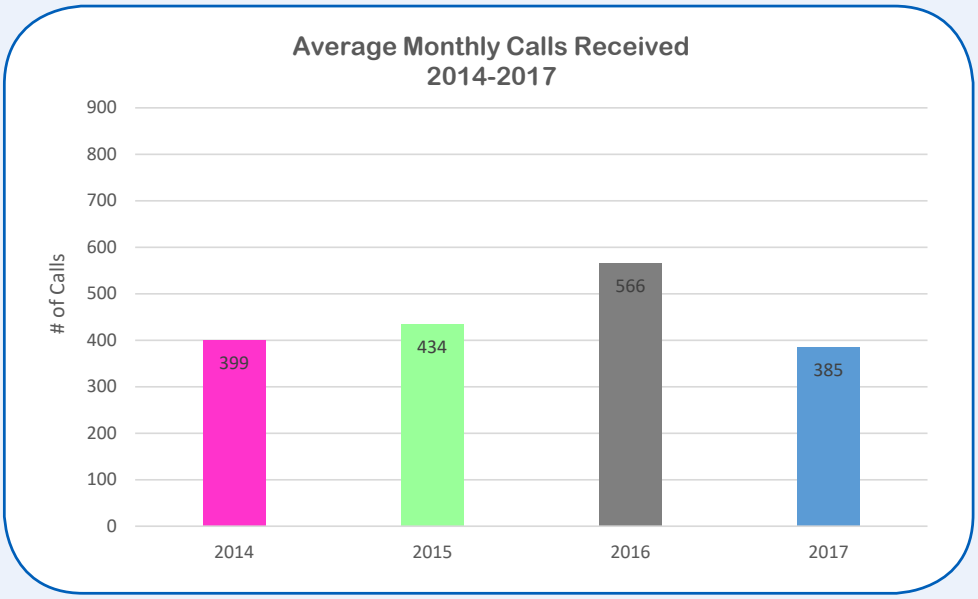


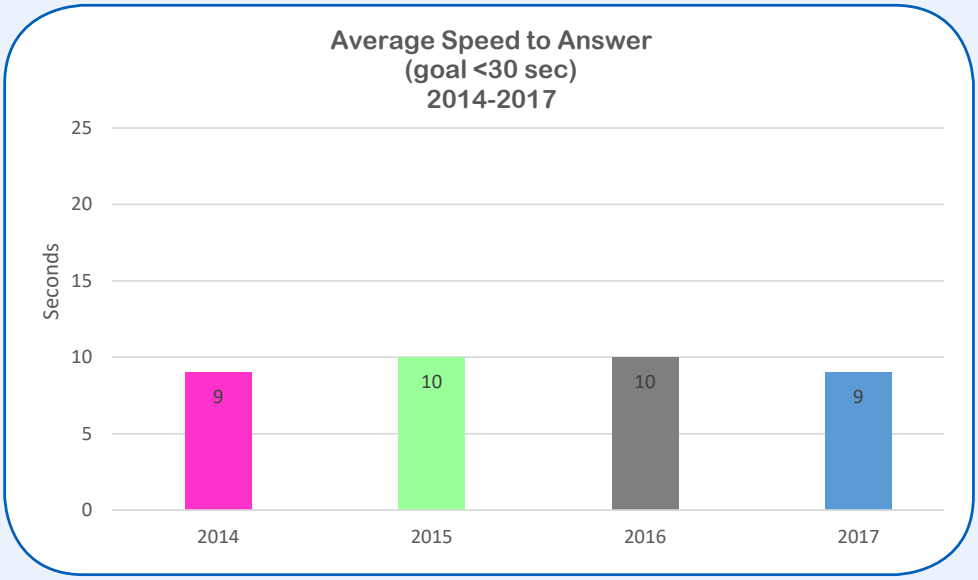
in the Population Health Management and Case Management/Disease Management sections of this report. To monitor for overutilization of services, the PCN relies on review of frequent and/or high-cost services such as inpatient and emergency room (ER) trends. The data specific to those measures is presented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

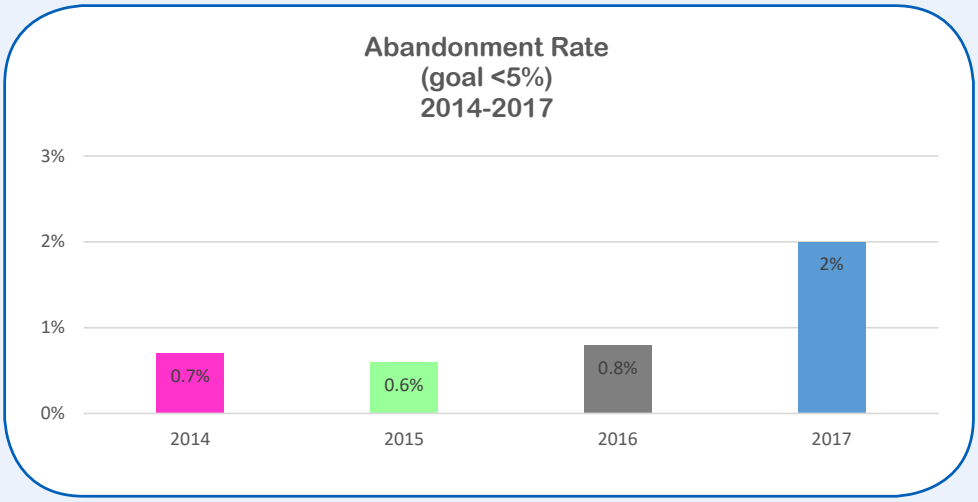
Program Measures:

Authorization statistics related to the 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 2017, the phone statistics remained consistent and within the benchmarks. Denials for outpatient services in 2017, as well as types of denials, remain consistent with nearly 70% being issues related to lack of medical necessity.

Precertification Phone Statistics

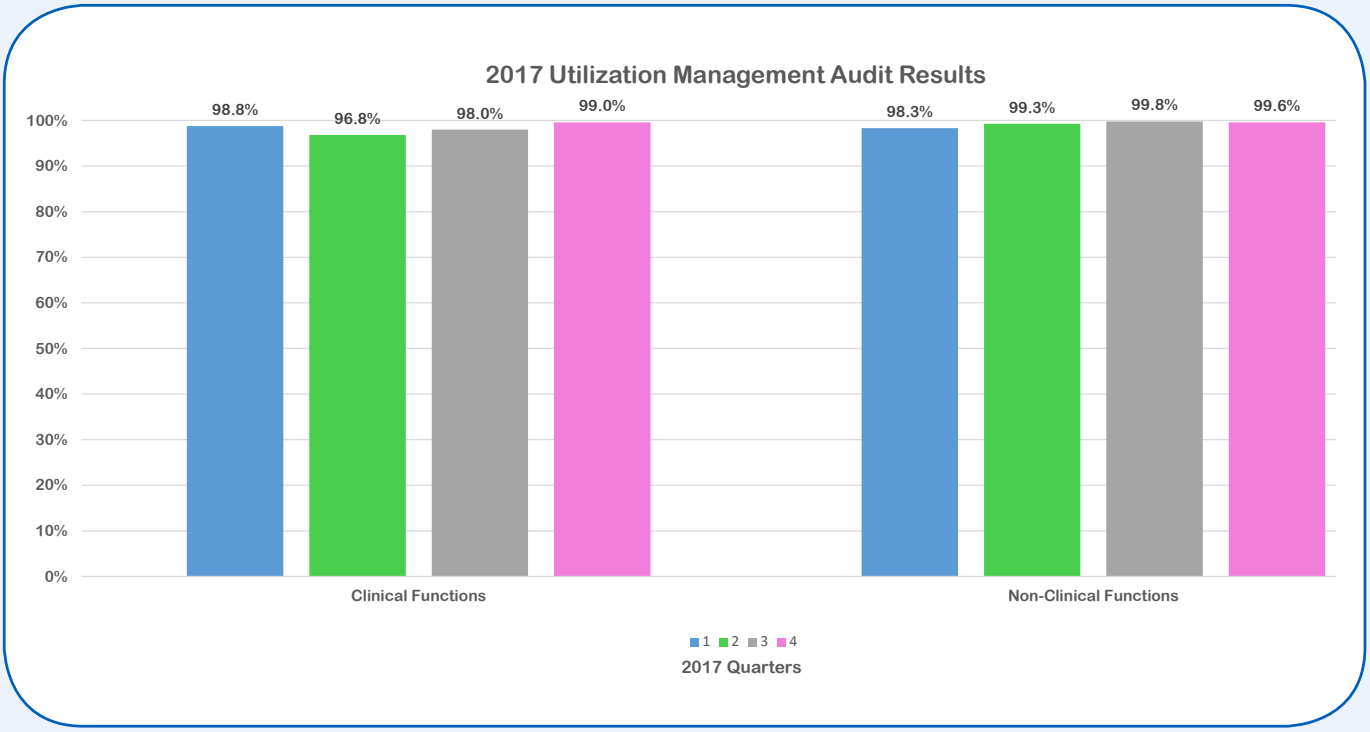




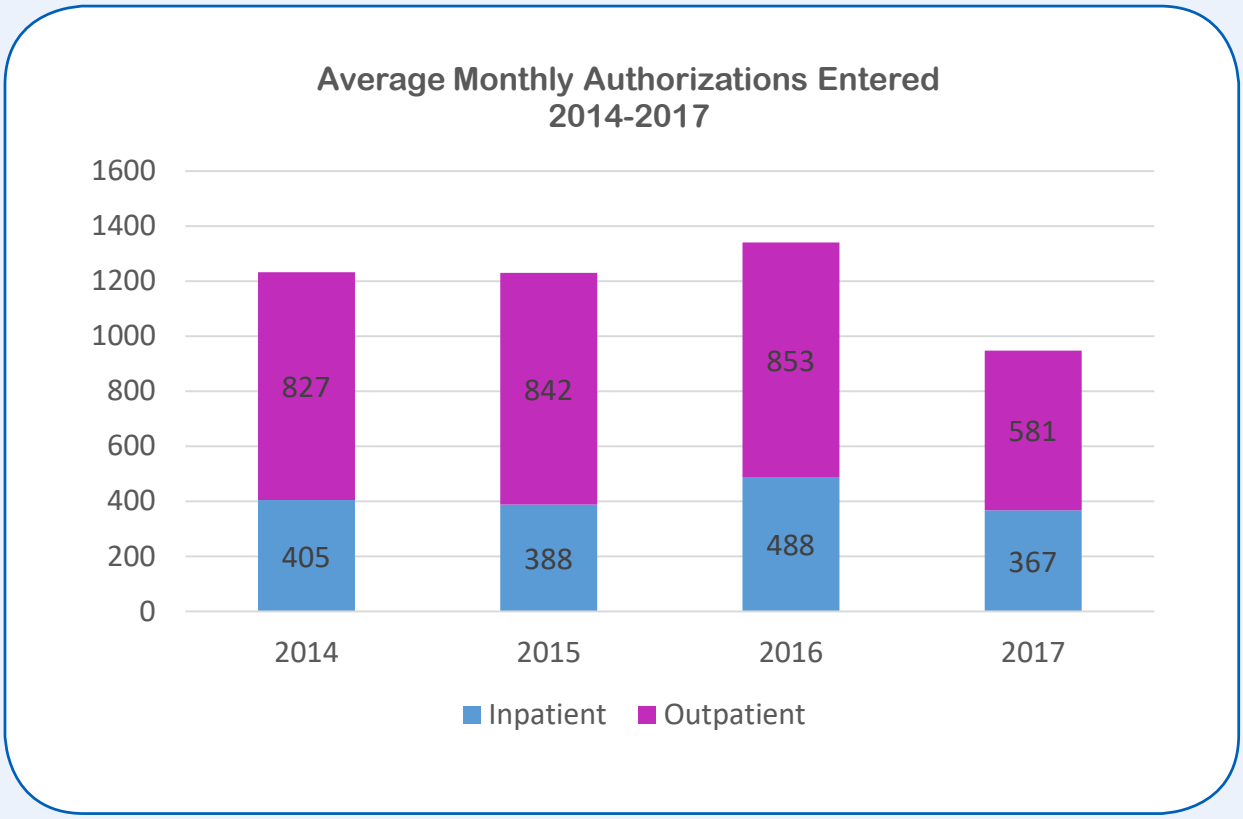


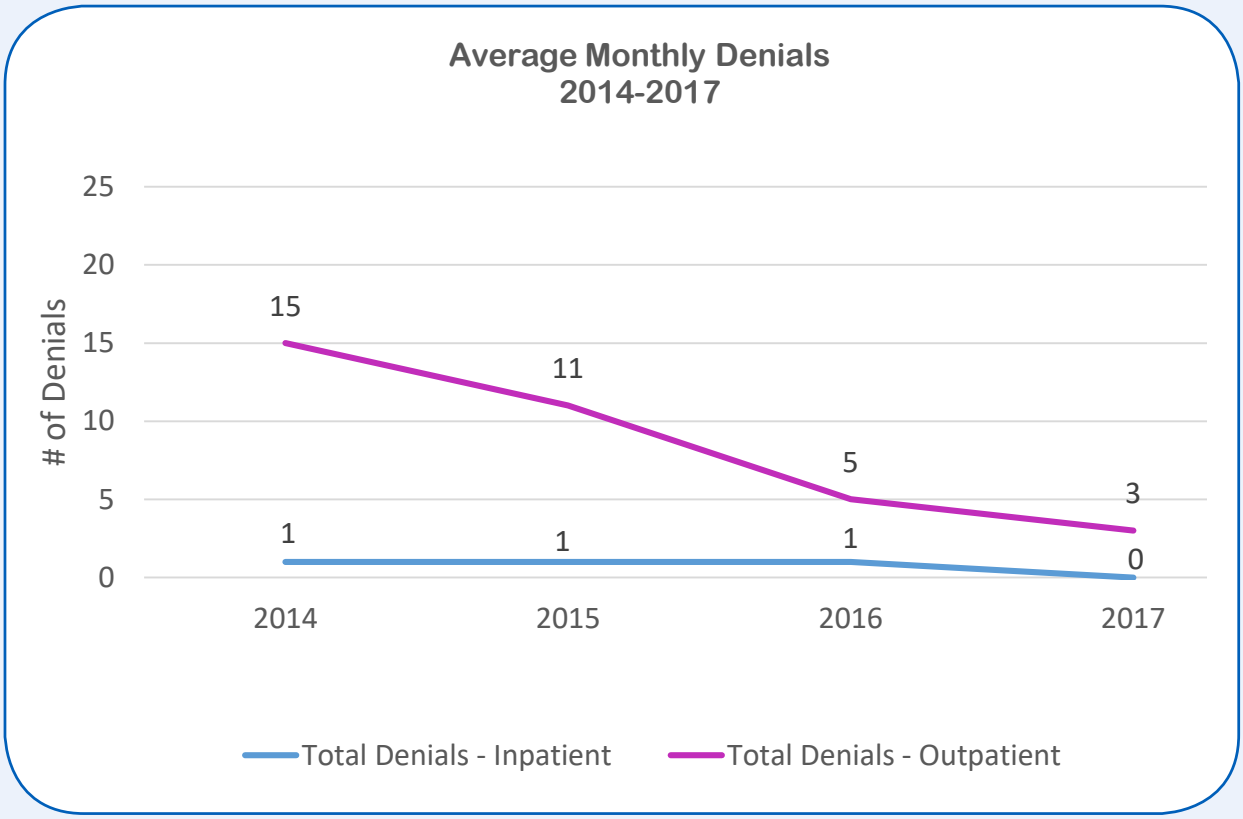
2017 Utilization Management Audit Results

Below are the 2017 aggregate audit results for each function within Utilization Management. Audit scores for all three categories consistently exceed the established threshold of 95%.

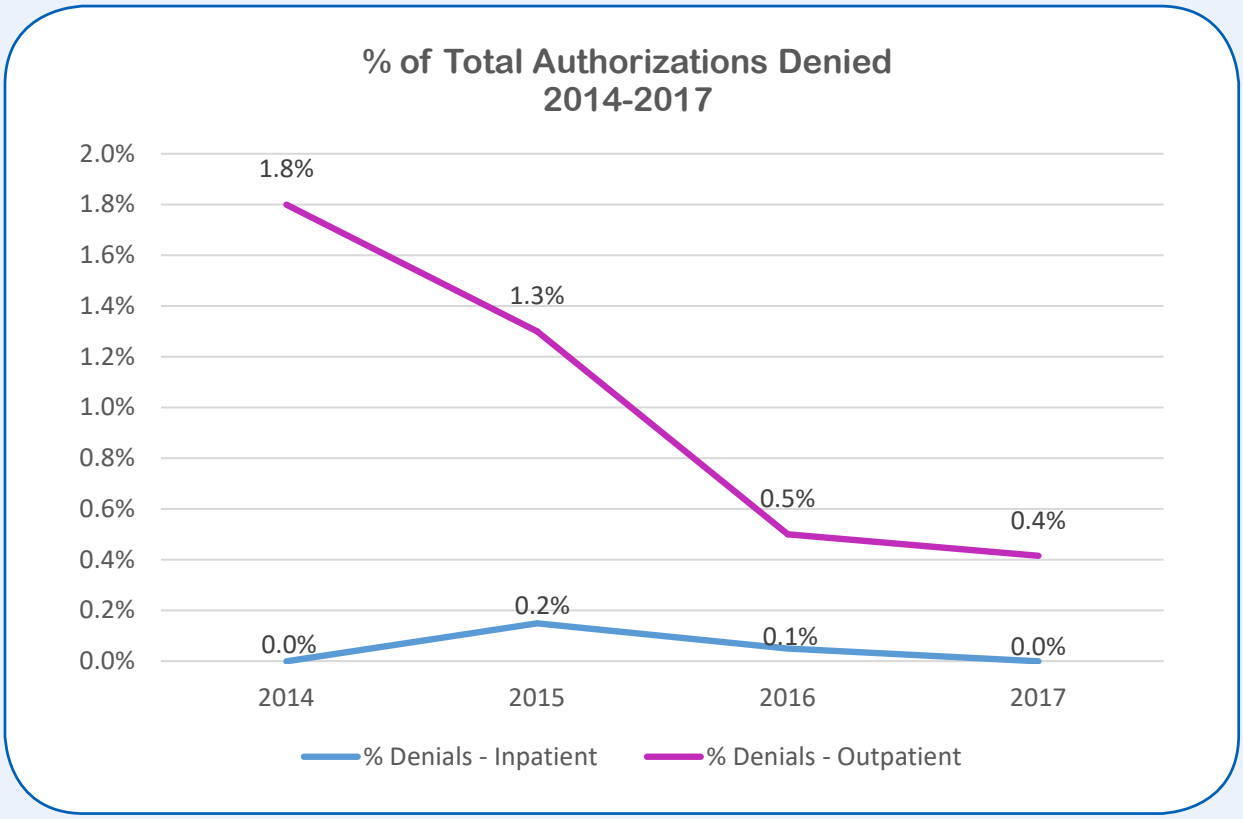


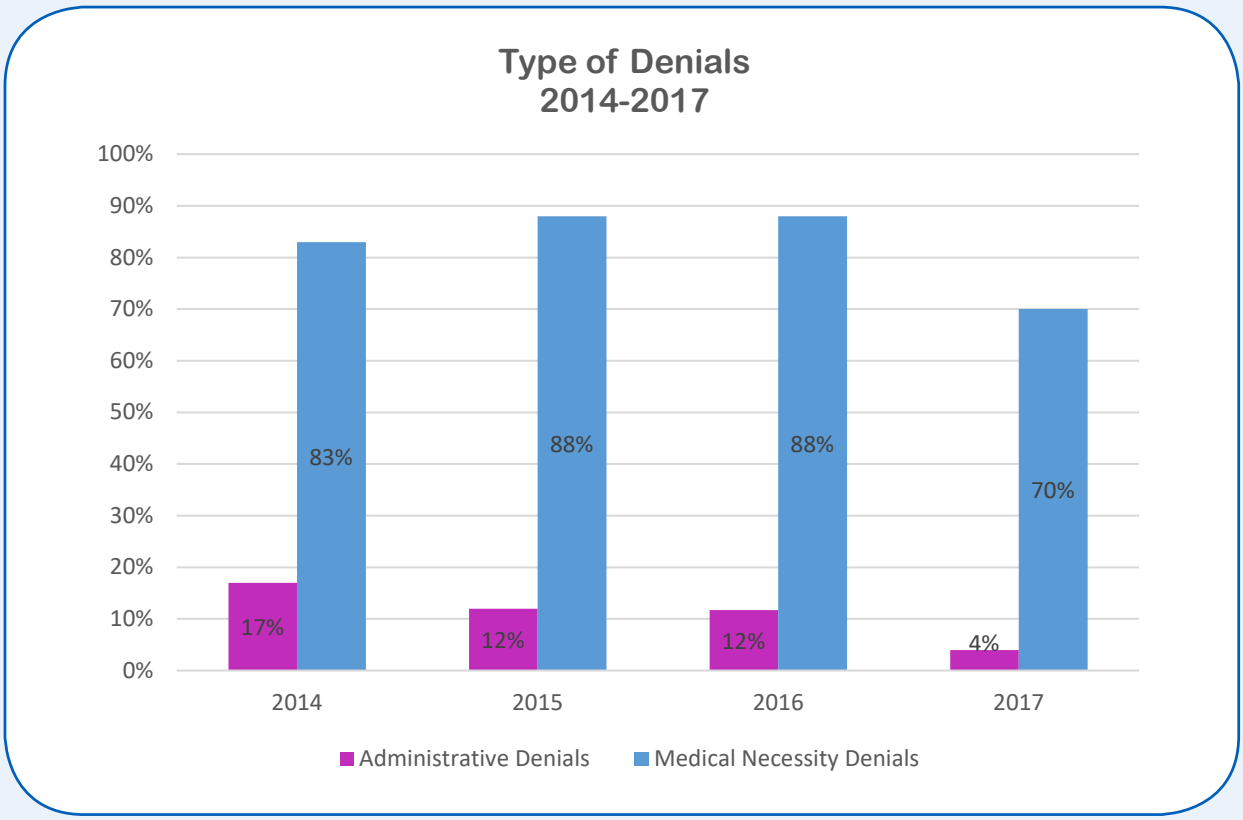
Prior Authorization Statistics



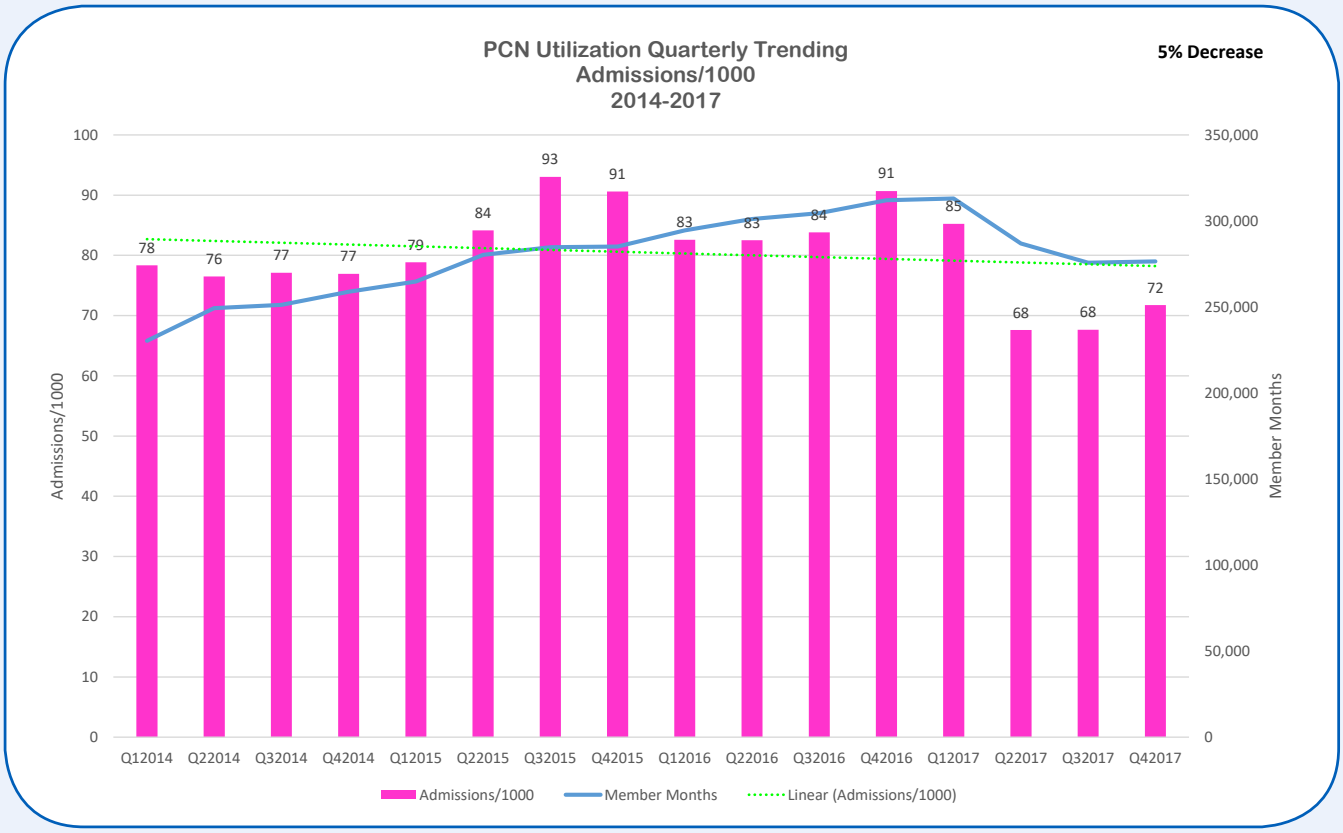


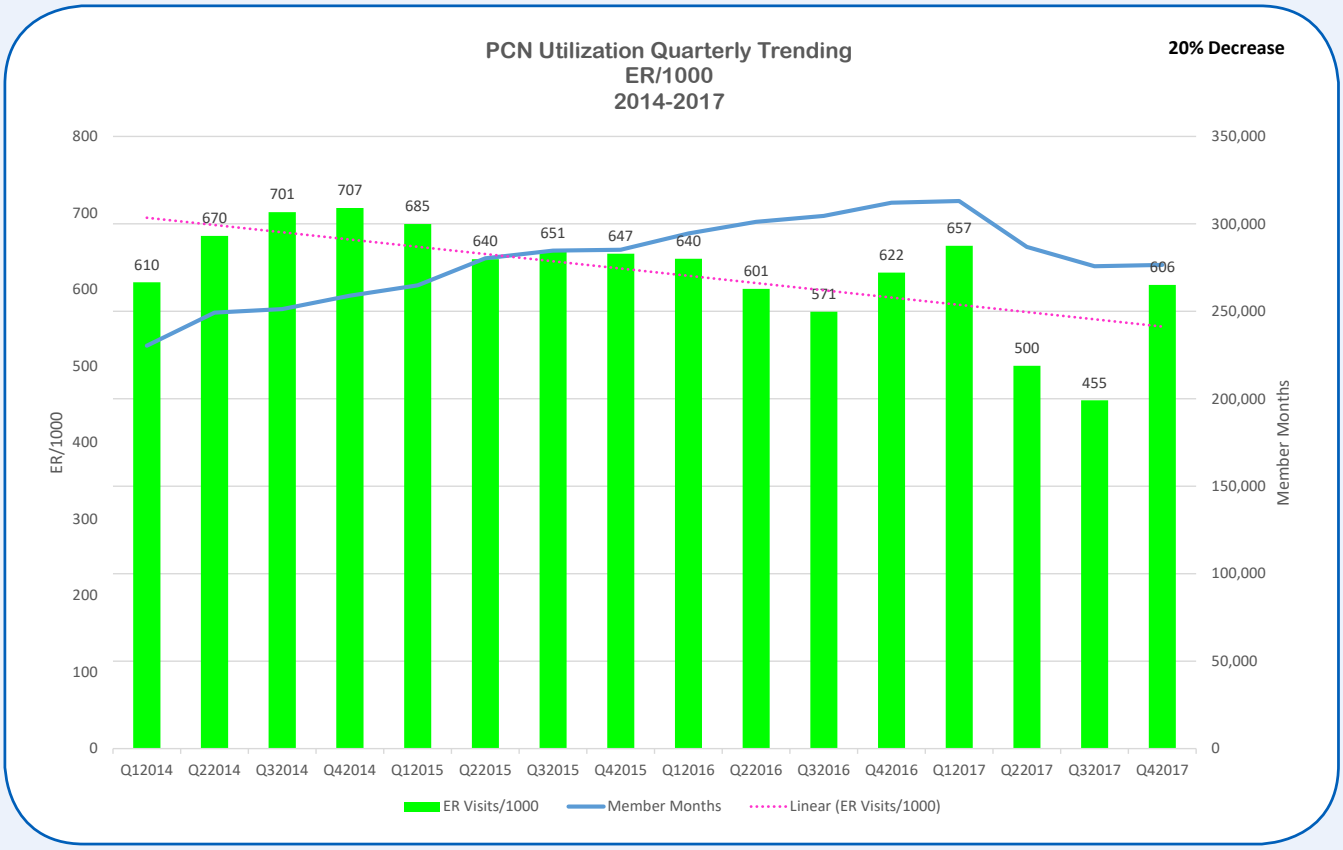
Prior Authorization Statistics





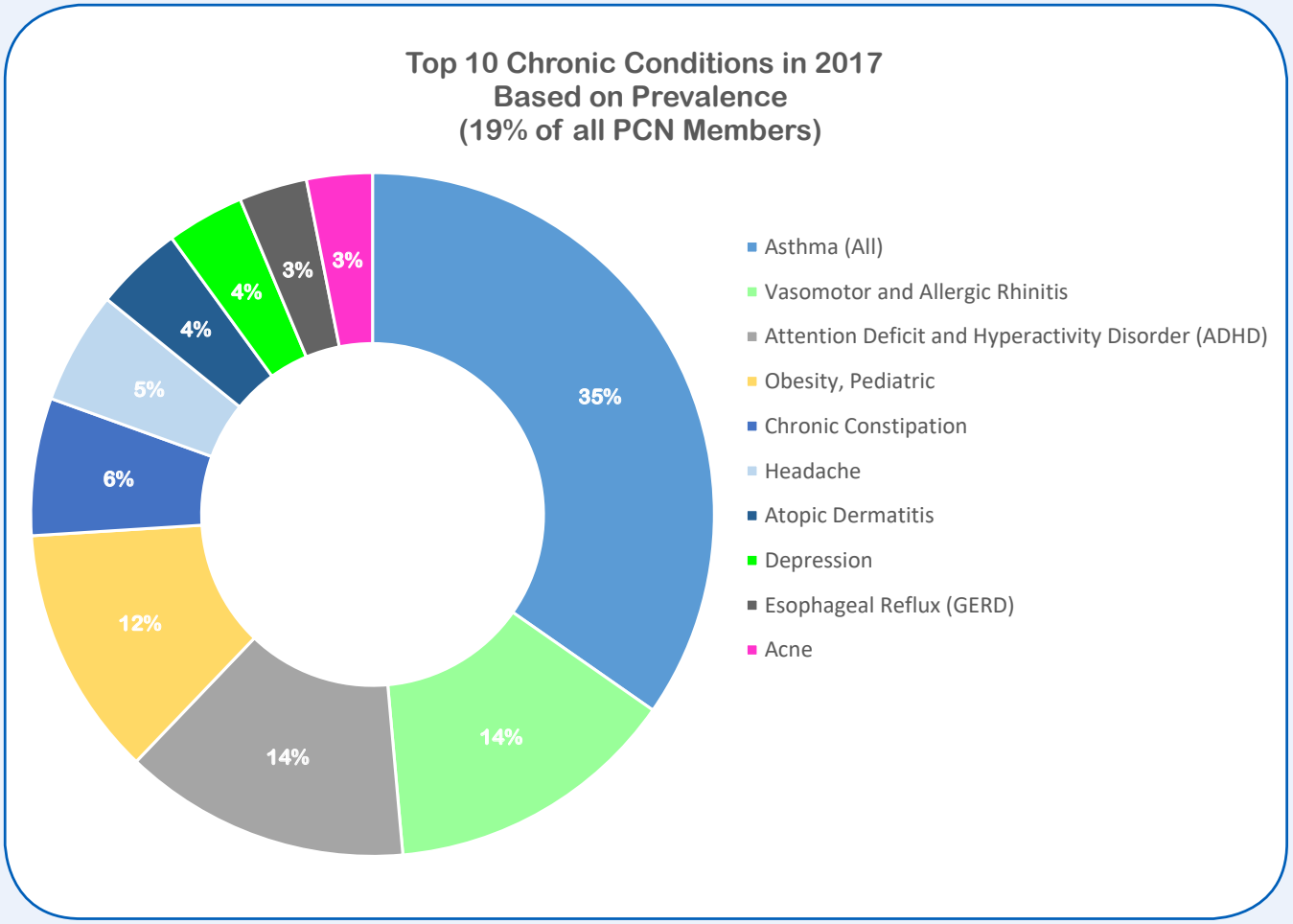
Inpatient and ER Utilization Statistics: 2014-2017





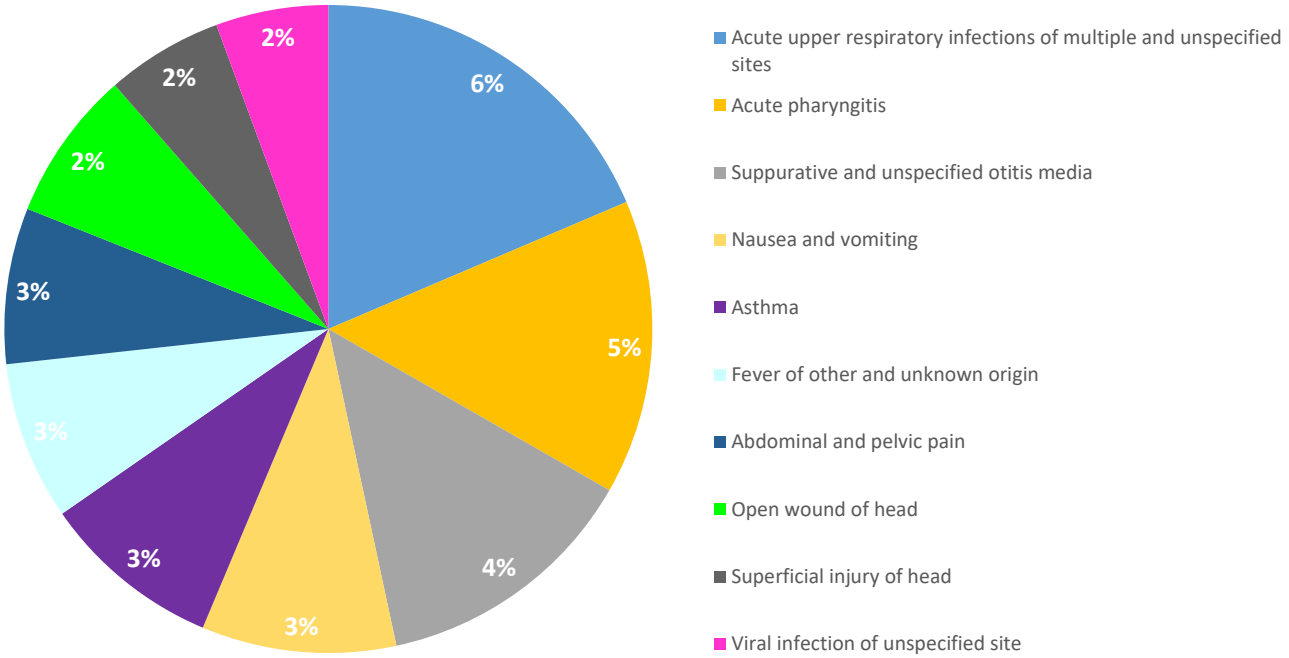
Year over Year Comparisons of Utilization: 2014-2017

Incurred Year	2014	2015	2016	2017
Admissions/1000	77	87	85	73
Days/1000	287	374	379	289
ER Visits/1000	673	655	608	557
ALOS (Medical)	3.7	4.3	4.5	3.9
% Change from PY	**2014**	**2015**	**2016**	**2017**
Admissions/1000	NA	12.9%	-2.3%	-14.1%
Days/1000	NA	30.3%	1.3%	-23.8%
ER Visits/1000	NA	-2.7%	-7.2%	-8.4%
ALOS (Medical)	NA	16.2%	4.7%	-13.3%

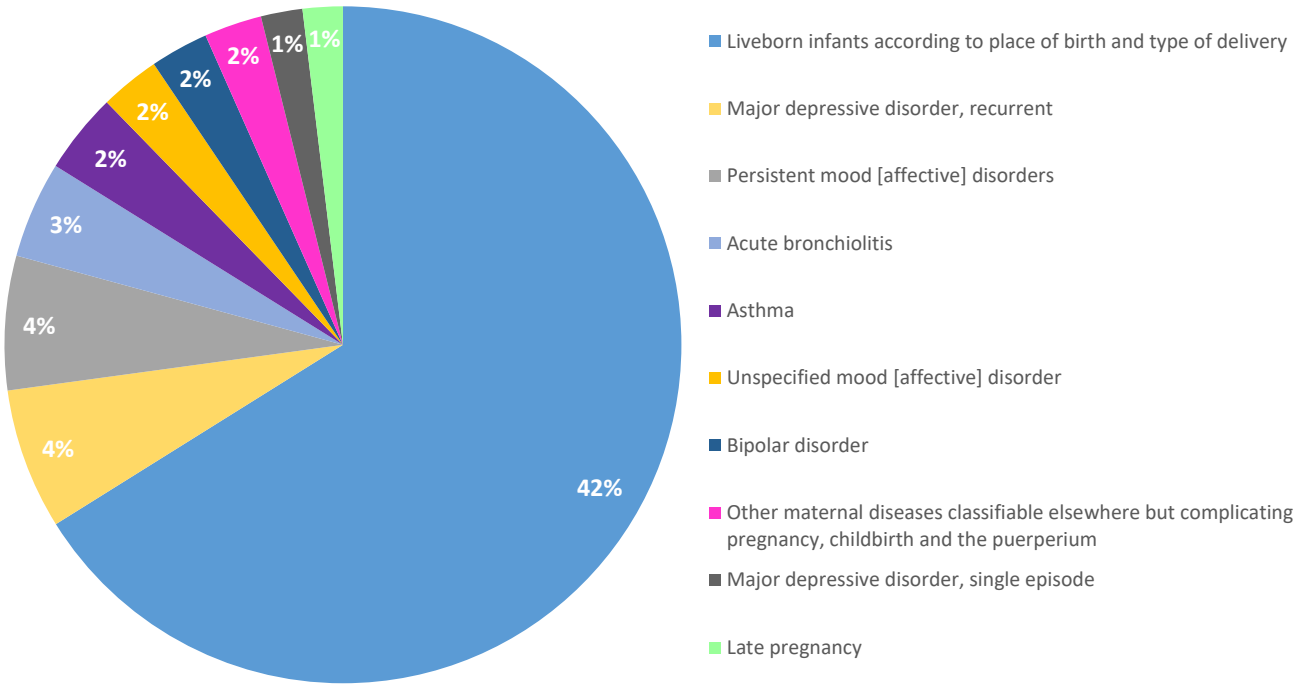


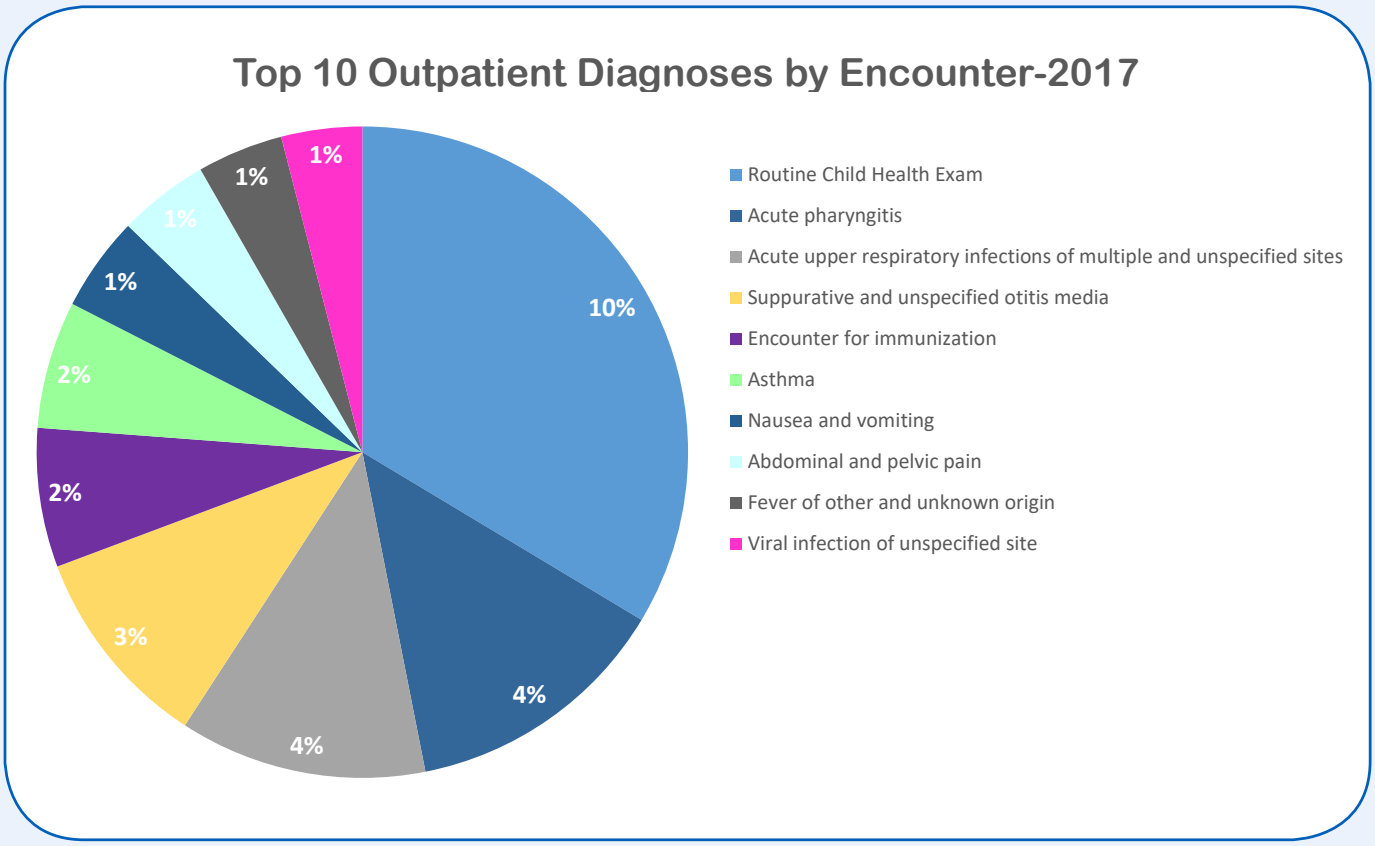
Top 10 Diagnoses by Encounter

Top 10 ER Diagnoses by Encounter-2017



Top 10 Inpatient Diagnoses by Encounter-2017





Utilization Analysis:

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

PCN has incorporated a peer-audit component into the quarterly staff audit process which provides a learning opportunity for each staff member. By reviewing the work of their peers and verifying accuracy through desktop procedures and policies, staff members are able to increase their own knowledge base. This is demonstrated in the 2017 UM audit results which exceeded the established threshold of 95%.

The PCN routinely evaluates services that require prior authorization. Through this evaluation, additional CPT and HCPCS codes were removed from the PCN prior authorization list in 2017. This reduction accounts for the decrease in average monthly outpatient authorizations entered in 2017.

Emergency room utilization for PCN members continues to trend downward through collaboration with the primary care provider practices and appropriate identification and outreach to high emergency room utilizers. This is evidenced by an 8% decrease in ER visits per 1000 from 2016 and 2017. The top ER diagnoses based on claims encounter data were viral infection, head injuries and abdominal/pelvic pain.

Similar to the downward trend in ER utilization, there has been a downward trend in inpatient utilization as well. From 2016 to 2017, there was a 14% decrease in admissions per 1000 and a 13% decrease in average length of stay (ALOS). As care integration processes deepen across the PCN population, lower acuity inpatient admissions decrease through timely identification and active care coordination of at-risk members. The top inpatient diagnoses in 2017 were pregnancy, major depressive disorder and pregnancy complications.

The broader Care Continuum program within Children's Mercy Hospital's system allows the Care Teams to more efficiently work in tandem with providers, as well as inpatient and ambulatory social workers and care managers, to provide the best possible care to members. With this open collaboration, Care Teams are now better able to provide practices with follow up information from inpatient and emergency room visits to help members get in for follow up appointments with their assigned Primary Care Providers.

In 2017, the PCN began a telehealth pilot with KidCare Anywhere in an effort to decrease emergency room utilization and redirect members to the primary care provider for non-emergent health concerns. This is a Children's Mercy Hospital initiative and is addressed in more detail in the Population Health Management section of this document under Community Integration.

Next Steps:

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

4 Transitional Care Program Evaluation

- Transitional Care Program Overview
- Program Measures
- Analysis
- Future Initiatives

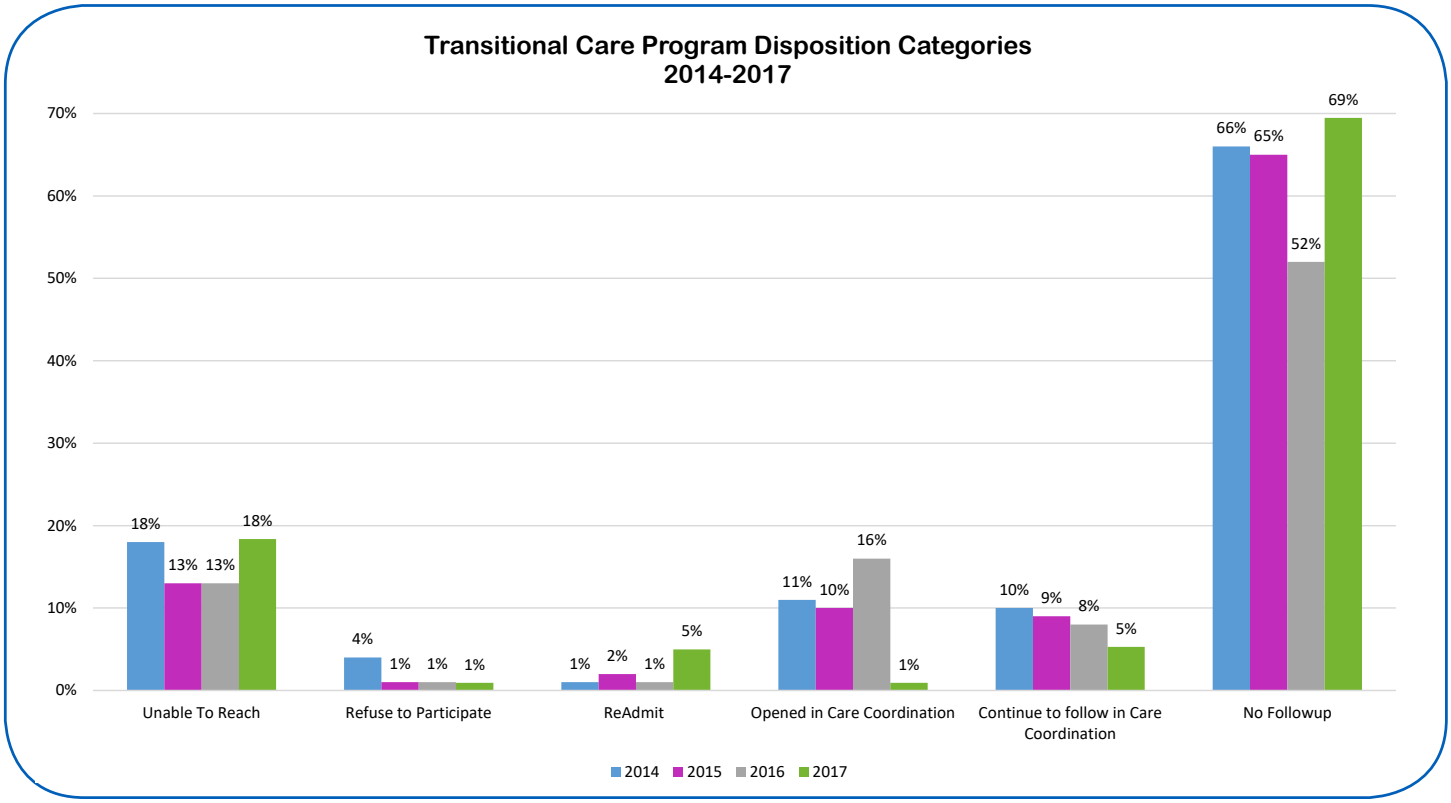
Transitional Care Program Overview

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 who meet the following criteria: members with complex medical needs, inpatient stays greater than 14 days, or readmission within 30 days with same or similar diagnosis. Exclusions to this list include observation stays, planned admissions (i.e. chemotherapy, EEG), obstetrics deliveries, and those with another primary insurance. Level 2 transitional calls are completed on patients that did not successfully compete a level 1 call because the discharge plan was still in process or was a NICU discharge.

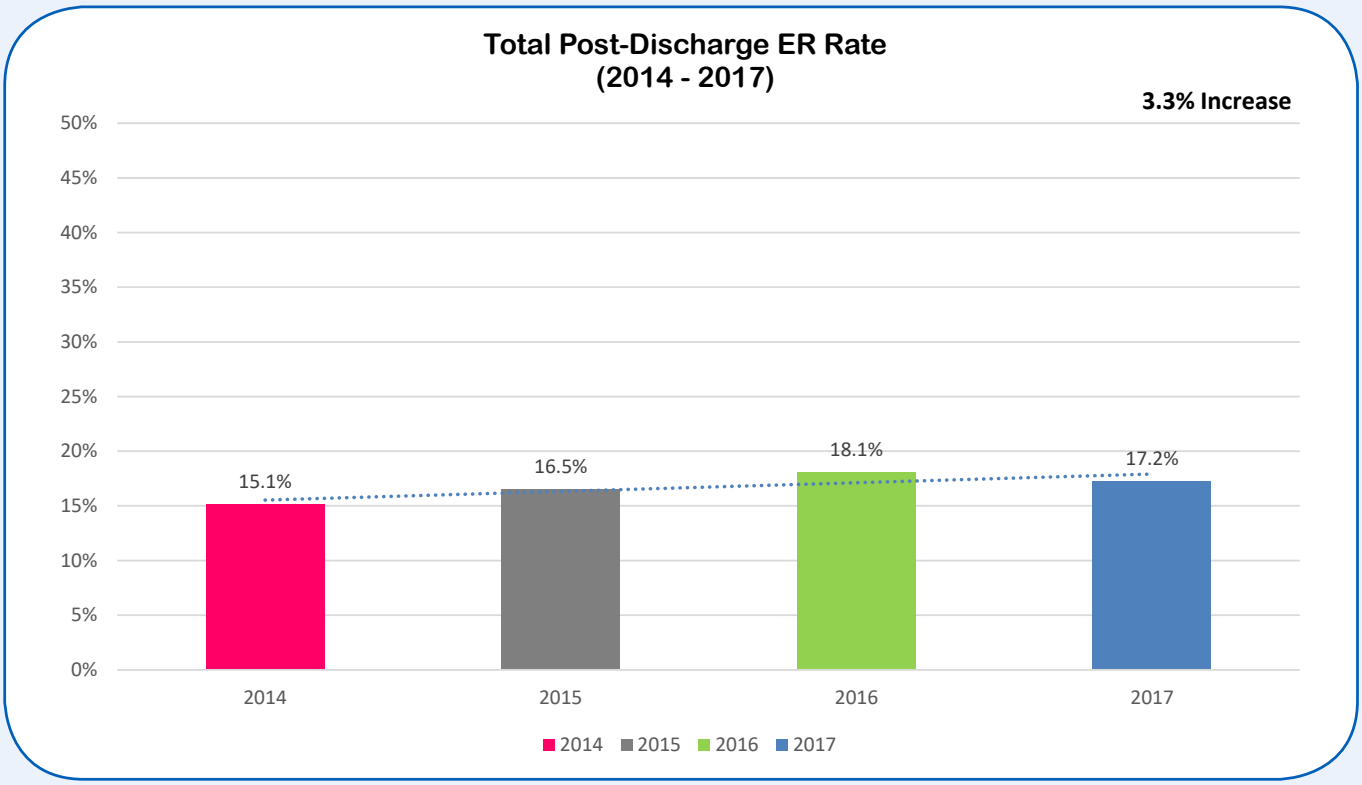
Level 1 calls are conducted within 1-3 days of discharge notification. A minimum of three outreach attempts are completed. A series of questions are asked to the member or member's caregiver during the call and if the member or caregiver answers "no" to two or more out of the four standard questions, a level 2 call is warranted 10-14 days from the date of the successful level 1 call. If needs are identified during one or both of the calls, the Care Team works in partnership with the member's PCP to update and share necessary information with member or caregiver's consent.

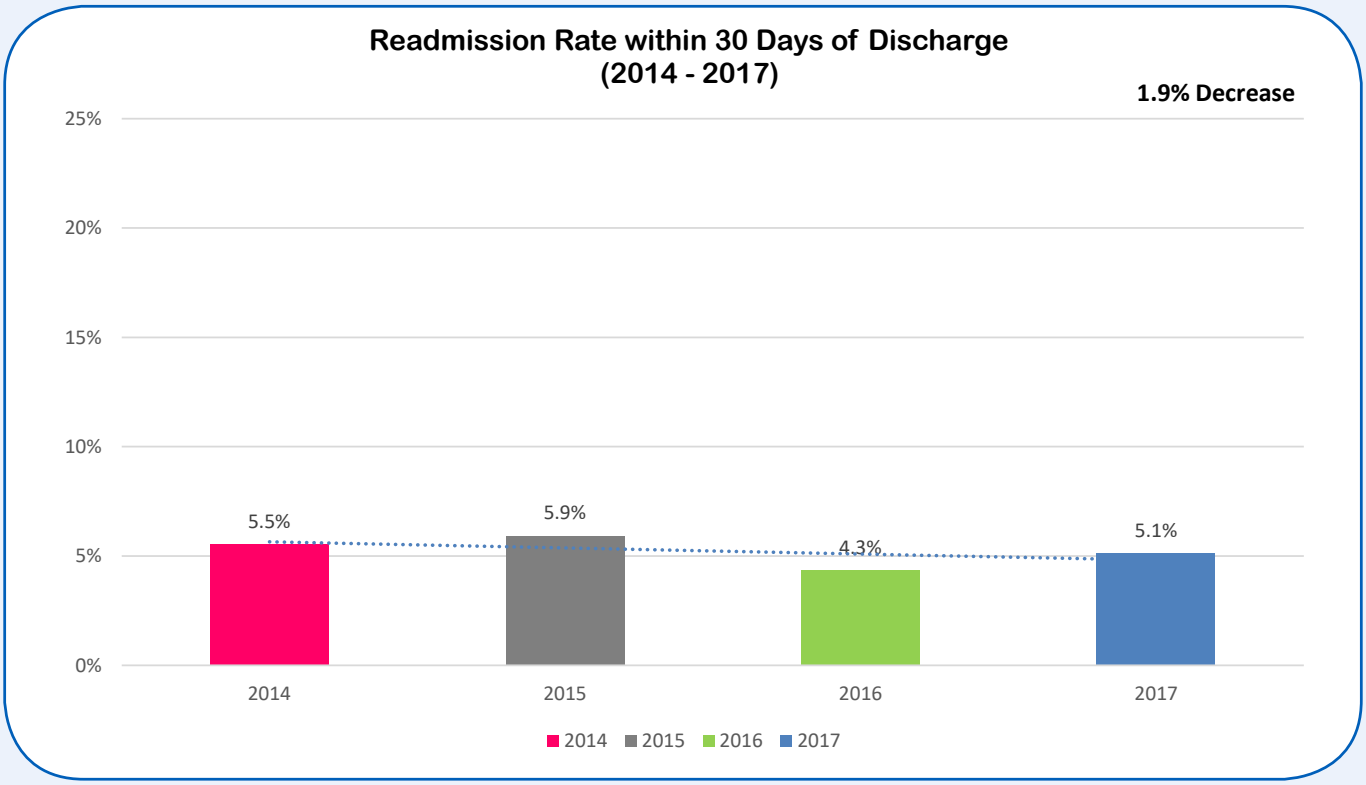
Program Measures:

Care Navigators document transitional care program screenings in C.A.R.E. Web (online documentation and communication tool), and statistics are reviewed monthly, including number of calls made, disposition of calls (i.e. opened in care coordination, no follow up needed, etc.), and number who refuse to participate. In 2017, a total of 592 calls were completed through the transitional care program. When comparing the past four years of results, there was an increase in the disposition of no follow up needed but decrease in cases opened in care coordination. This can be attributed to a change in the program structure where members were followed longer in the transitional care program until all issues were resolved, rather than being opened in care coordination. See chart below for disposition category results.

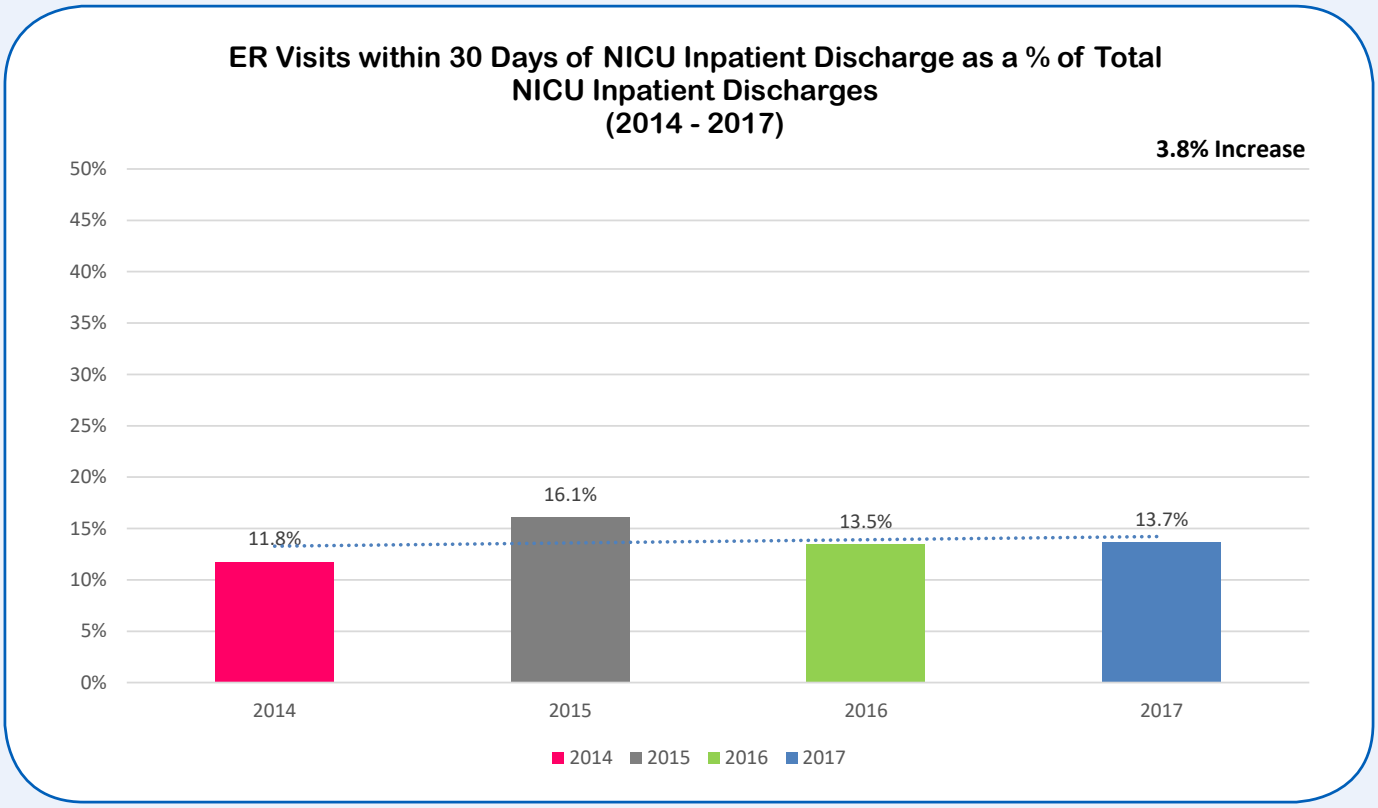


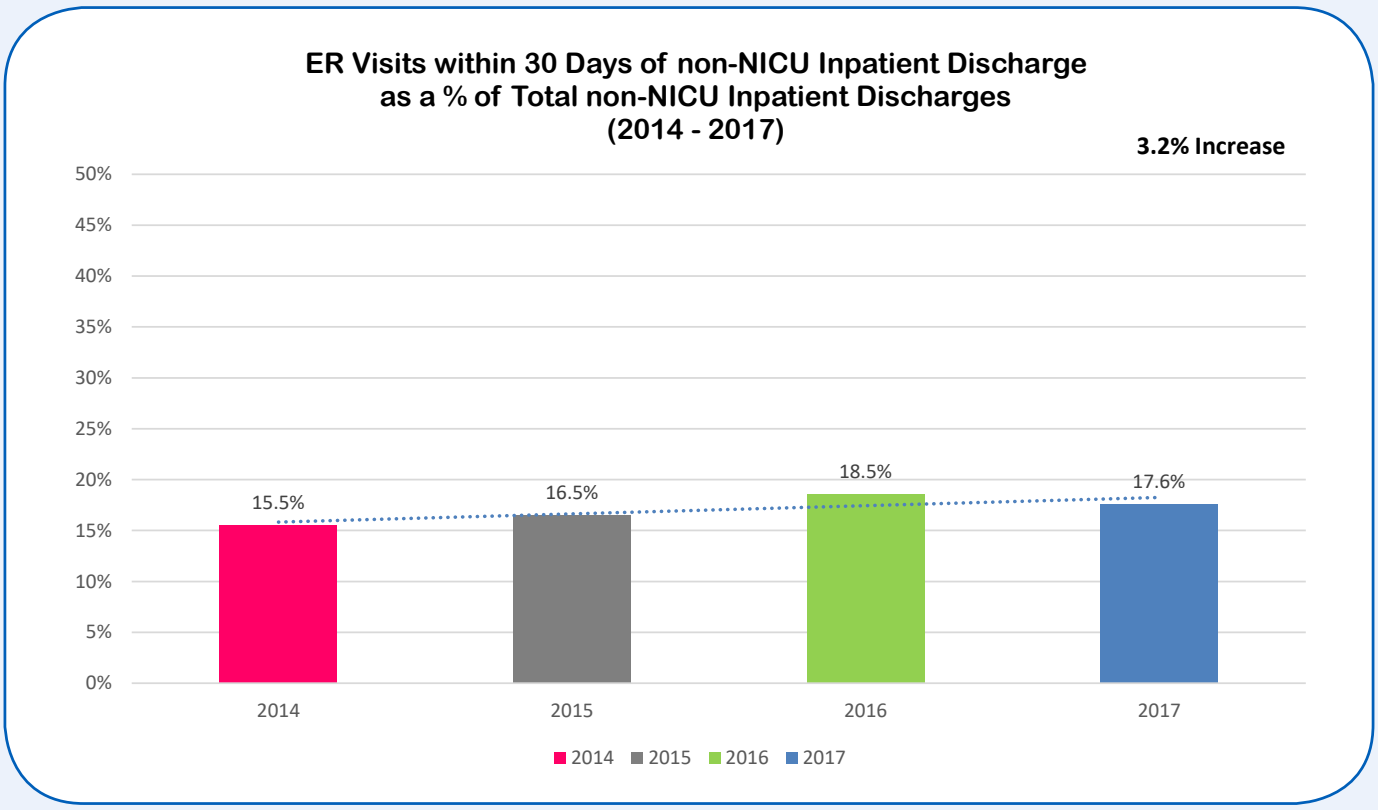
The overarching goal of the Transitional Care Program is to decrease emergency room visits and unplanned hospital readmissions. Below is a four year trend (2014-2017), based on claims data, of 30 day post-discharge ER rates and all-cause readmission rates for the PCN population.





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





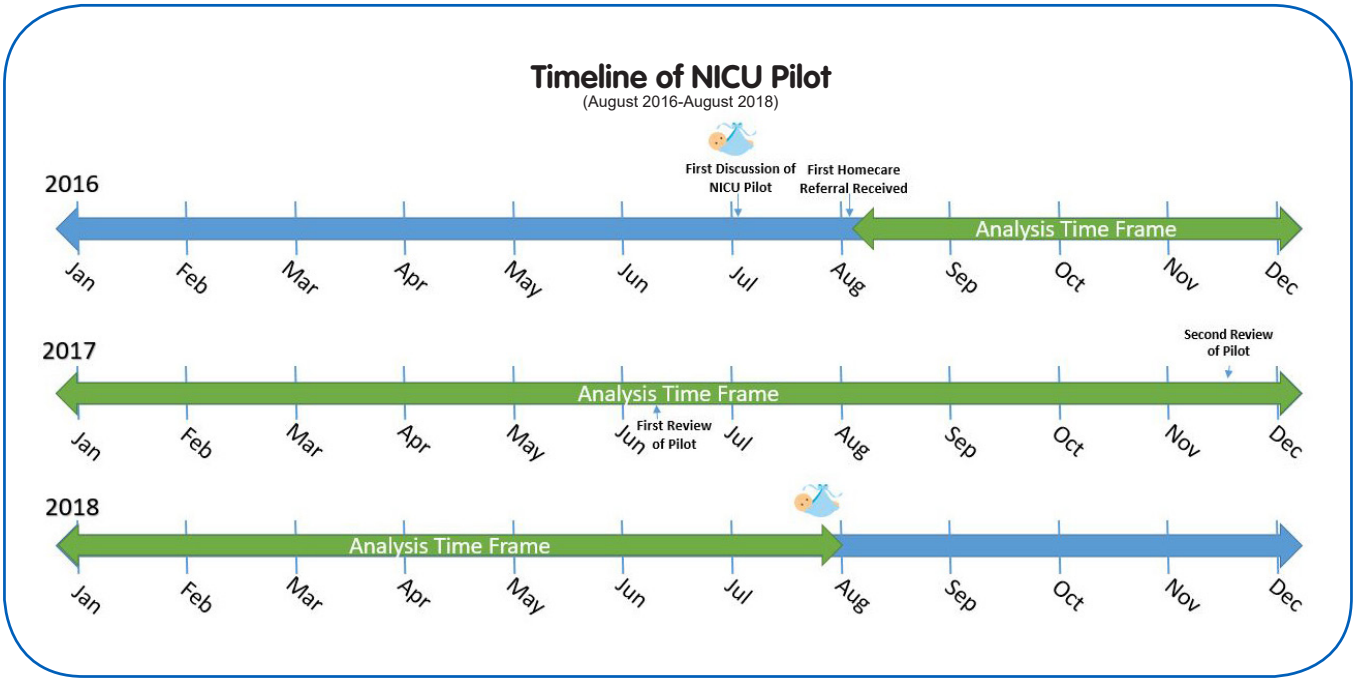
Analysis:

As an enhancement to the existing transitional care program and to further support successful transitions home following inpatient admission, the PCN implemented a quality improvement initiative with interventions focused on reducing post-discharge ER visits for babies being discharged from the NICU. This initiative included a partnership with the Children's Mercy Hospital Home Care department in order to provide in-home nurse and social work assessments and interventions for members discharged from high volume NICU facilities. The initiative which was implemented in August 2016 and continued throughout 2017, was designed to provide up to 6 weeks post-discharge support and education to caregivers in the home. Members with complex medical needs requiring skilled nursing services in the home were excluded from this program.

The Quality Improvement (QI) Team met in early 2017 to review preliminary data on the post-discharge ER home care initiative. Early data indicated no change in the post-discharge ER rate for NICU babies being discharged from the high volume facilities with home care support (the intervention group) versus those who did not receive the home care intervention (the control group); however, it is too early to provide a comprehensive analysis of the effectiveness of the intervention. Anecdotally, the Home Care nursing staff believe the program has been successful in preventing ER visits in the members they were able to actively engage in the program, citing examples of where they have identified feeding issues and lack of weight gain early and provided interventions resulting in a change in the patient's plan of care. Per a short survey provided to parents of members who participated in the pilot, positive feedback was received from them as well. Parents reported they were very appreciative of the reassurance, support, education and regular visits provided by the home care staff.

The Quality Improvement Team determined ways to further enhance the initiative, including adding interpreter information, as well as standardizing the referral process and disposition categories for patients being closed from the home care program. In addition, the QI Team identified an opportunity to add education about well child and immunization schedules to the home visit teaching program.

Over a four-year reporting period, the PCN has



demonstrated progress in decreasing readmission rates. The data reveals an overall decrease in all-cause readmission rates within 30 days of hospital discharge by 1.9%. Historically, PCN has faced challenges in impacting ER utilization. There was an increase in total 30 day post-discharge ER visits of 3.3%. The NICU 30 day post-discharge ER rate increased by 3.8%.

Next Steps:

The NICU pilot has been extended an additional year to conduct a final analysis of ER utilization between the members who participated in the pilot against those who declined the pilot. By August 2018, after a full 2 years of post-intervention data is available, a final decision will be made to determine whether to sustain the program as a standard offering for all NICU babies, continue in only a select number of hospitals, or discontinue the program altogether.

5 Case Management/ Disease Management Evaluation

- Case Management/Disease Management Program Overview
- Clinical Practice Guidelines
- 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. This is achieved through the well-coordinated efforts between the Care Teams, members, caregivers, providers, and community agencies. Including the Primary Care Provider's 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 and other specialists and 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 care 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 of members

The PCN regularly reviews the way we identify members, the processes for interventions, the documentation of those interventions, and the measurement of outcomes. The PCN case management documentation system, or C.A.R.E. Web, incorporates case management screenings, assessments and care plans, routing of cases, and sending tasks to other 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 utilizer, risk score or gaps in care and then the Care Team can determine a strategy for member outreach and screening.

In 2017, PCN Care Teams shifted from traditional case management practices to broader population health management strategies. Instead of Care Teams awaiting referrals, Care Teams are expected to utilize data to proactively identify potential members for the case management program. Care Navigators then complete a screening and assessment with the member to determine needs for case management services. Some members will receive short-term care coordination interventions to address barriers to care and others require more intensive care management services.

The Care Integration management team conducts quarterly audits 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. Action plans were implemented for those who did not meet the standard and all who had action plans were able to resolve the issues in a subsequent audit. In addition, the PCN Medical Director(s) and Care Integration management team conduct routine case rounds with the case management staff to review current status of cases, discuss barriers to care, and identify interventions and goals for complex cases. This forum provides an ongoing process for Care Navigators to learn from others and promotes consistency in applying care management principles.

The following case management program enhancements were implemented in 2017:

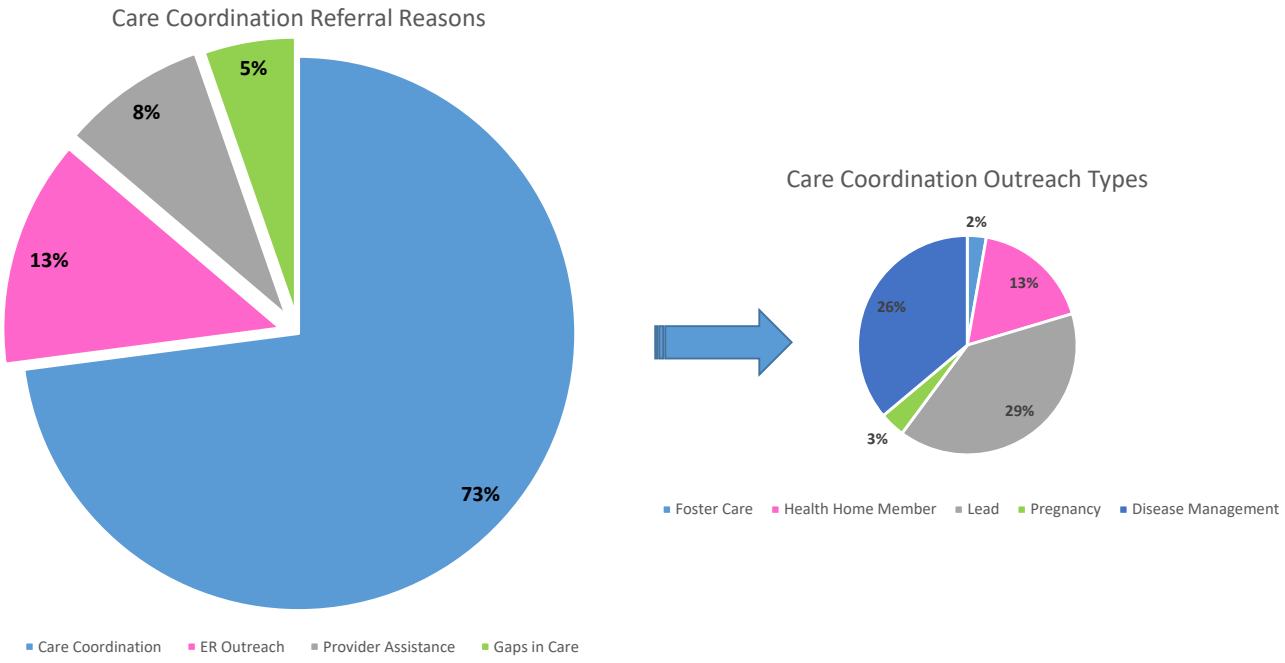
Development of Provider Practice Performance Profiles reports and implementation of quarterly meetings with PCN practices to review cost, utilization, and quality data. Care Teams received training on the reports and how to analyze the data to develop collaborative projects with the practices aimed at improving outcomes. This has been a valuable process for all members of the Care Team. In order to have the greatest impact on quality measures, Care Teams will transition to tri-annual meetings with practices to review data. This allows for the last collaboration visit of the calendar year to be in the fall with an emphasis for the remainder of the year on engaging patients with gaps in care.

The KidCare Anywhere platform was extended to the Care Teams as another communication medium for the Care Teams to pilot with members. Care Navigators were provided access and training to facilitate face-to-face encounters with members and caregivers. The premise of this project was that face-to-face encounters would eliminate the barriers of telephonic case management allowing for a more thorough assessment, increased education opportunities and promote rapport building with families. There has been a slow adoption by the member population of this communication platform. For this technology to work in the realm of care coordination, it is important for the relationship with the member to be well established before introducing this communication medium. PCN Care Teams will continue to support KidCare Anywhere as a menu of options to communicate with families.

Program Measures: Care Coordination Statistics

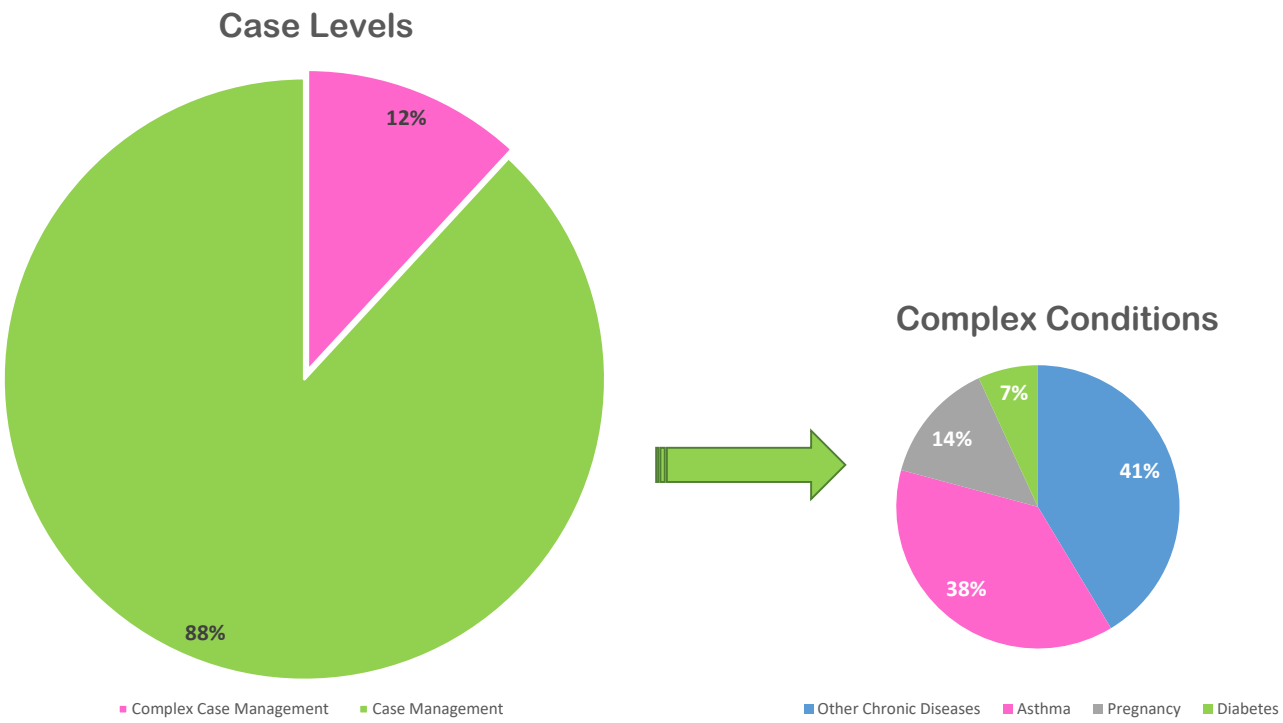
Program Referral Statistics - 2017

In 2017, 3,269 unique members were identified for case management services, compared to 1,668 in 2016. Seventy-five percent of the referrals resulted in care coordination interventions depicted below with referral reasons related to foster care (2%), lead (29%), health home (13%), pregnancy (3%), and disease management (26%).



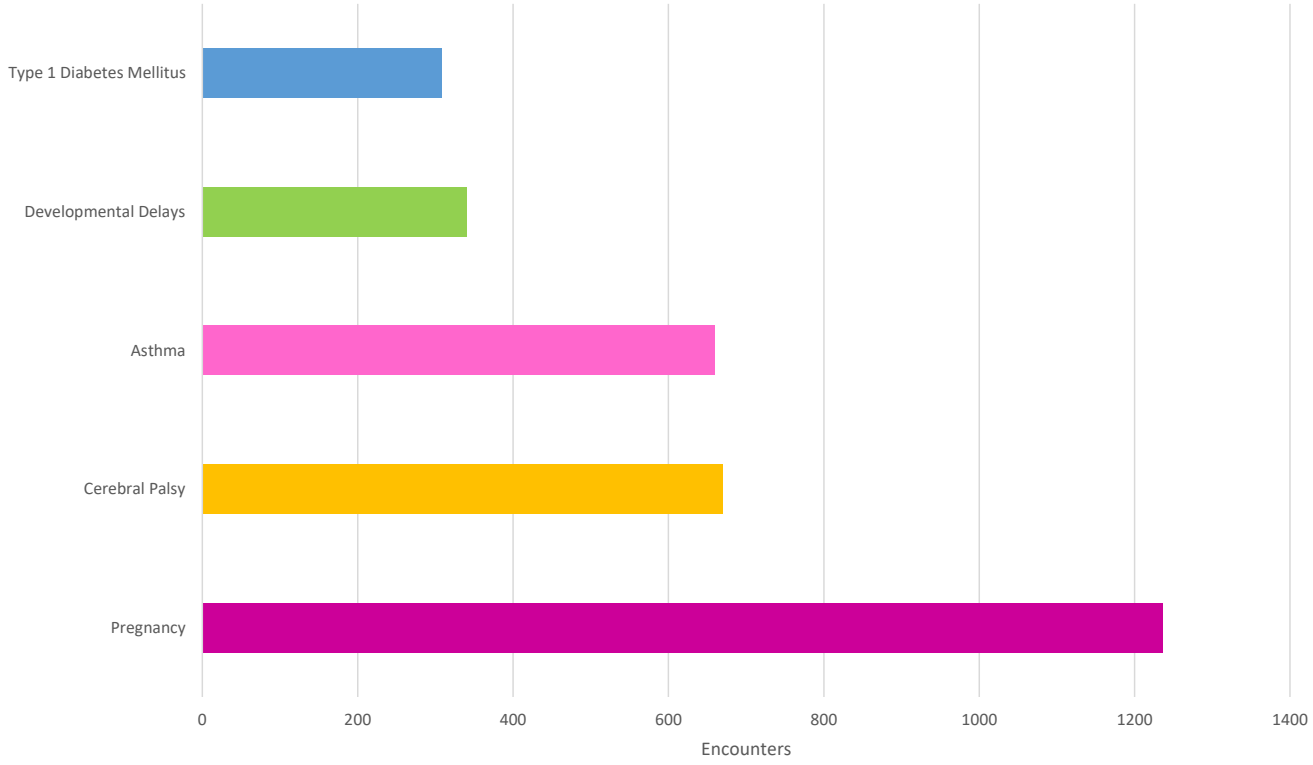
Case Management Case Levels - 2017

Case types are determined based on the member's screening, assessment and care plan development. This establishes the level of complexity and interventions. In 2017, 25% of the program referrals required more intensive case management interventions. As depicted below, 88% were opened in general case management and 12% were deemed complex case management. The chart below reflects the common conditions in complex case management (case opened for >60 days): chronic disease (41%), asthma (38%), pregnancy (14%) and diabetes (3%).



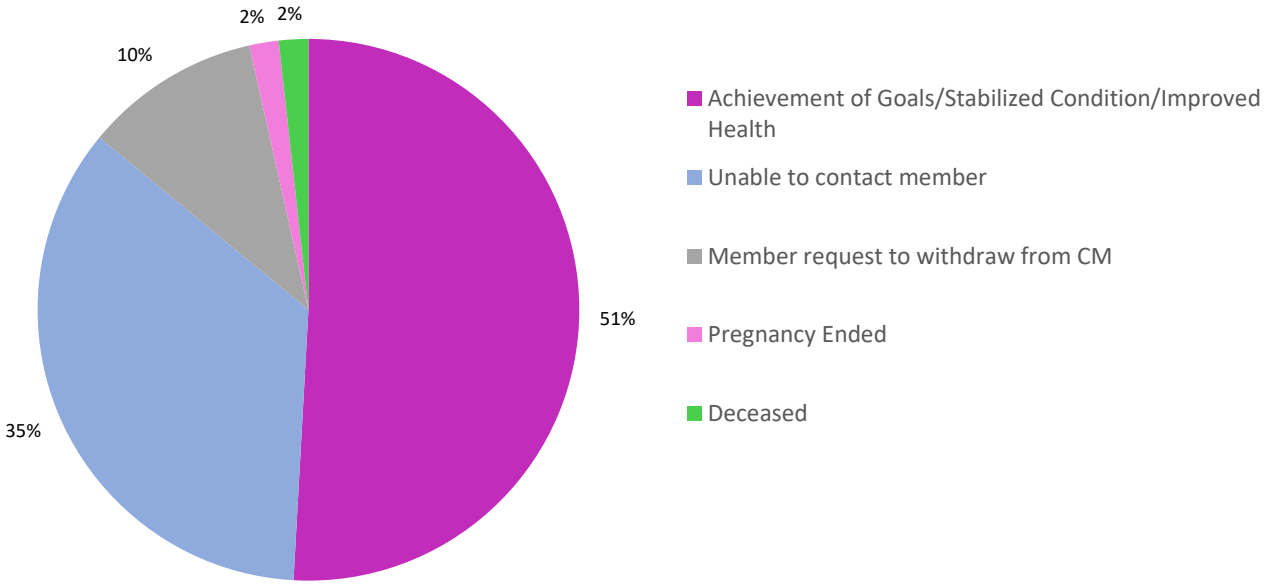
Case Management Top 5 Conditions - 2017

In addition to referral sources, the case management assessment identifies the referral reasons for each member. For 2017, the highest referral reasons were High Risk OB (38%), Cerebral Palsy (21%), Asthma (21%), Developmental Delays (11%) and Type 1 Diabetes (10%).



Case Management Case Closure Reasons - 2017

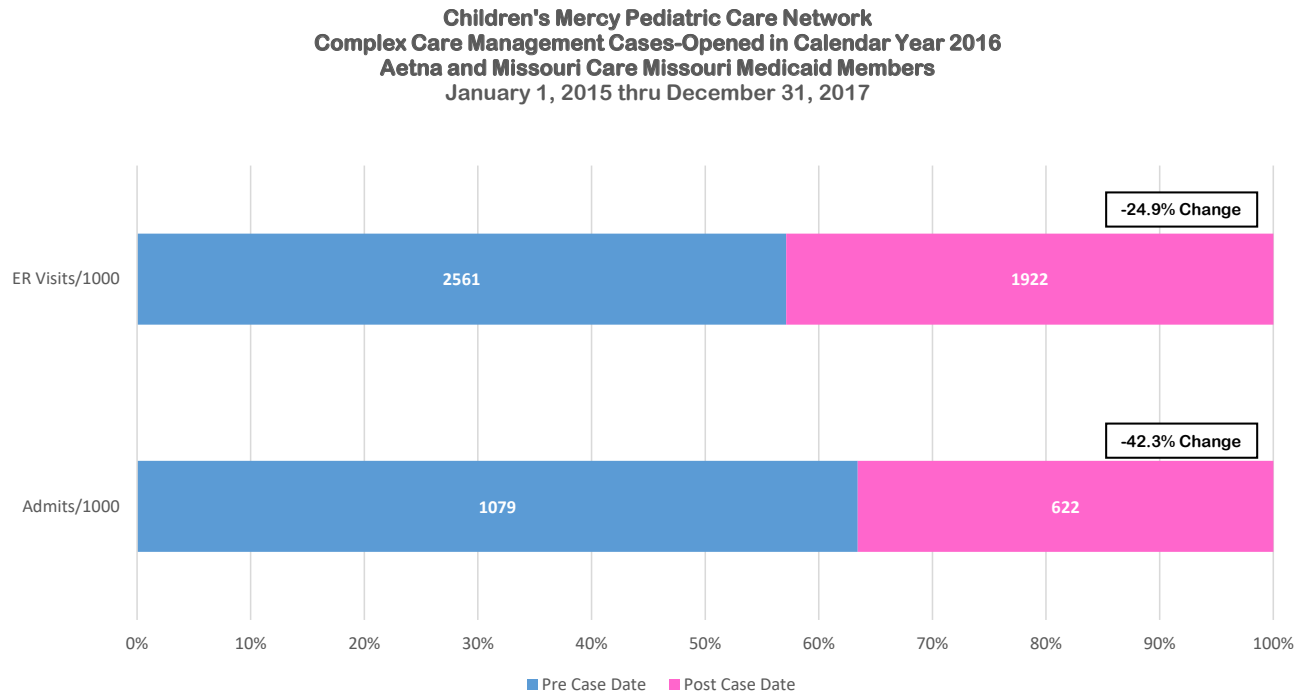
For each case that is closed, the Care Navigator assigns a primary reason for the case closure. The PCN team strives to continuously improve the rate of cases closed due to goals met and decrease the percentage closed due to lack of member engagement. The primary reason for case closure in 2017 was Achievement of Goals/Stabilized Condition/Improved Health (51%), Unable to contact member (35%), Member request to withdraw from Case Management (11%), Pregnancy Ended (2%), and member Deceased (2%).



Program Utilization: Cost for Case Managed Population (Pre and Post Case Management Intervention)

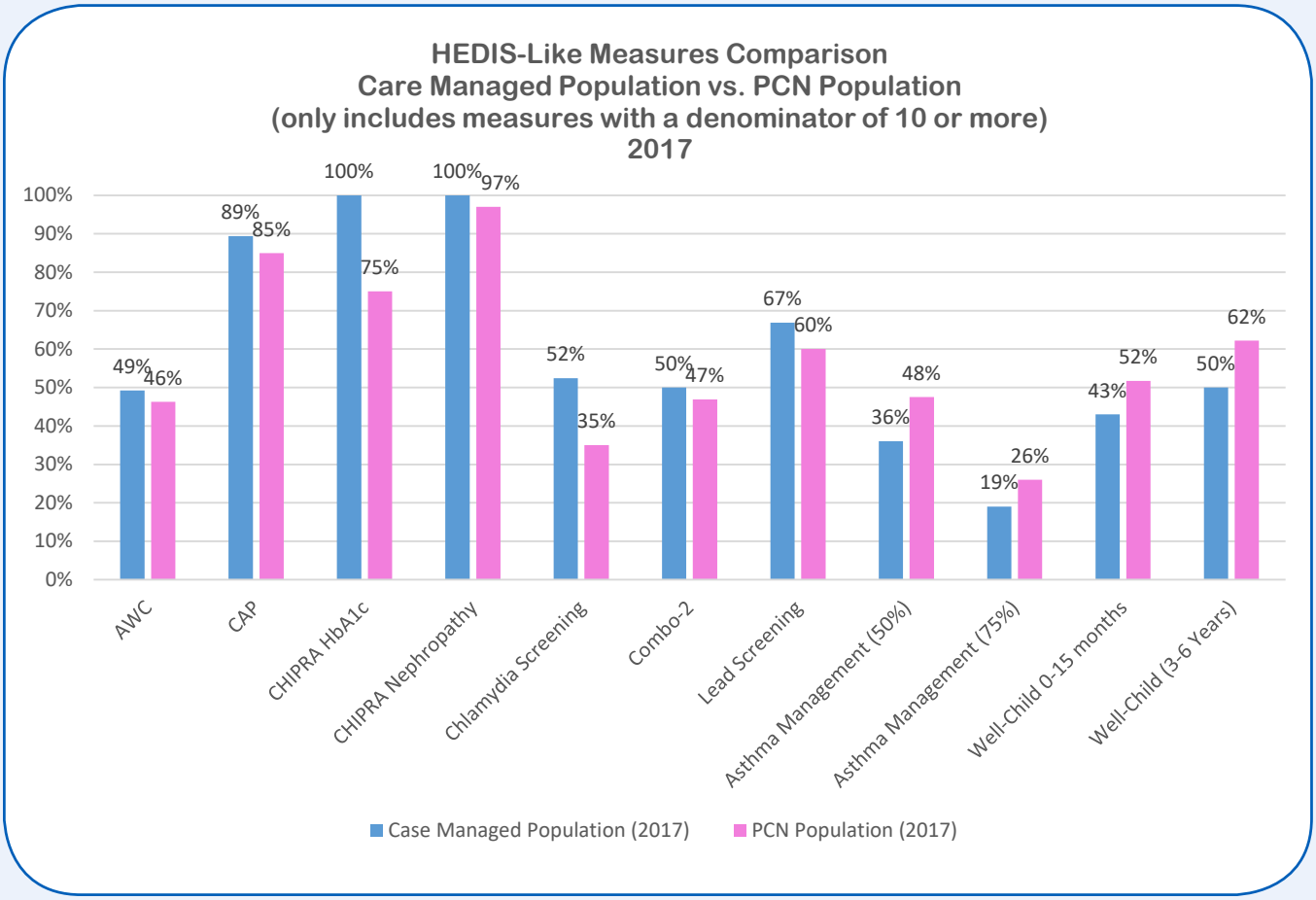
The PCN evaluates the rate of hospitalizations and ER visits as well as per member per month costs for members enrolled in case management. The Quality Improvement Team evaluates members opened at least sixty (60) days in case management and includes all available pre-intervention and post-intervention data for each member, normalizing it to a per member per month rate. The intervention date is considered the date the member was opened in the case management program. Note: Due to the need for sufficient post-intervention data for this analysis, the cases included in this report were those opened in 2016.

Metric	Pre Case Date	Post Case Date
Members	397	397
Member Months	2,980	6,362
% Change Pre vs. Post		
Admits/1000	-42.3%	
ER Visits/1000	-24.9%	
Total Medical PMPM	-17.95%	



Program Quality Outcomes (HEDIS-like measures)

The PCN evaluates pediatric-focused HEDIS measures using claims/administrative data to compare its case managed population outcomes to the PCN population as a whole. Only HEDIS measures with 10 patients or more in the denominator within the measurement year were selected for the comparison. For this year's analysis, eleven (11) 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; immunizations; lead screenings; asthma medication management; as well as Well-Child visits for children ages 0-15 months and 3-6 years of age.



Patient Health Questionnaire 9 Screening

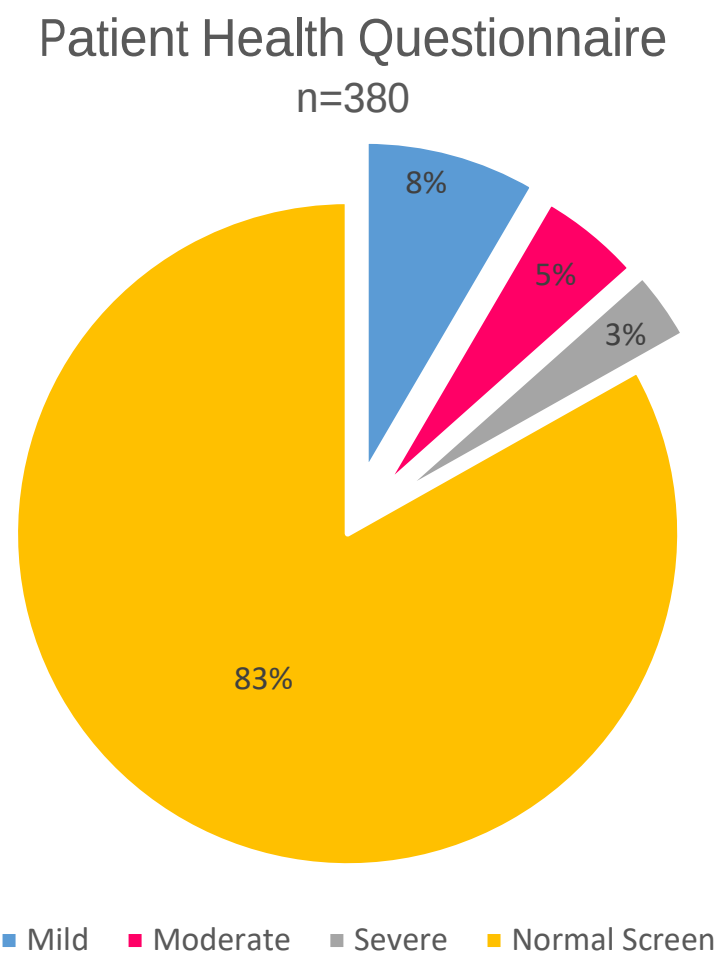
The Patient Health Questionnaire (PHQ-9) is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. PCN utilizes this tool for the screening of depression on every outreached member ≥ 12 years and older. If the member responds "yes" to either of the first 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. Interventions may include education with the member/ caregiver on the available behavioral health benefit, referral for behavioral health services, and 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 during the next contact for a member with severe depression, in three months for moderate depression and in six months for mild depression.

Question 9 provides the screener with the presence and potential duration of suicidal ideation of the patient. A follow-up question then provides a non-scored result which then provides the result of the severity index to show the patients current state of mind in regards to depressive symptoms.

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



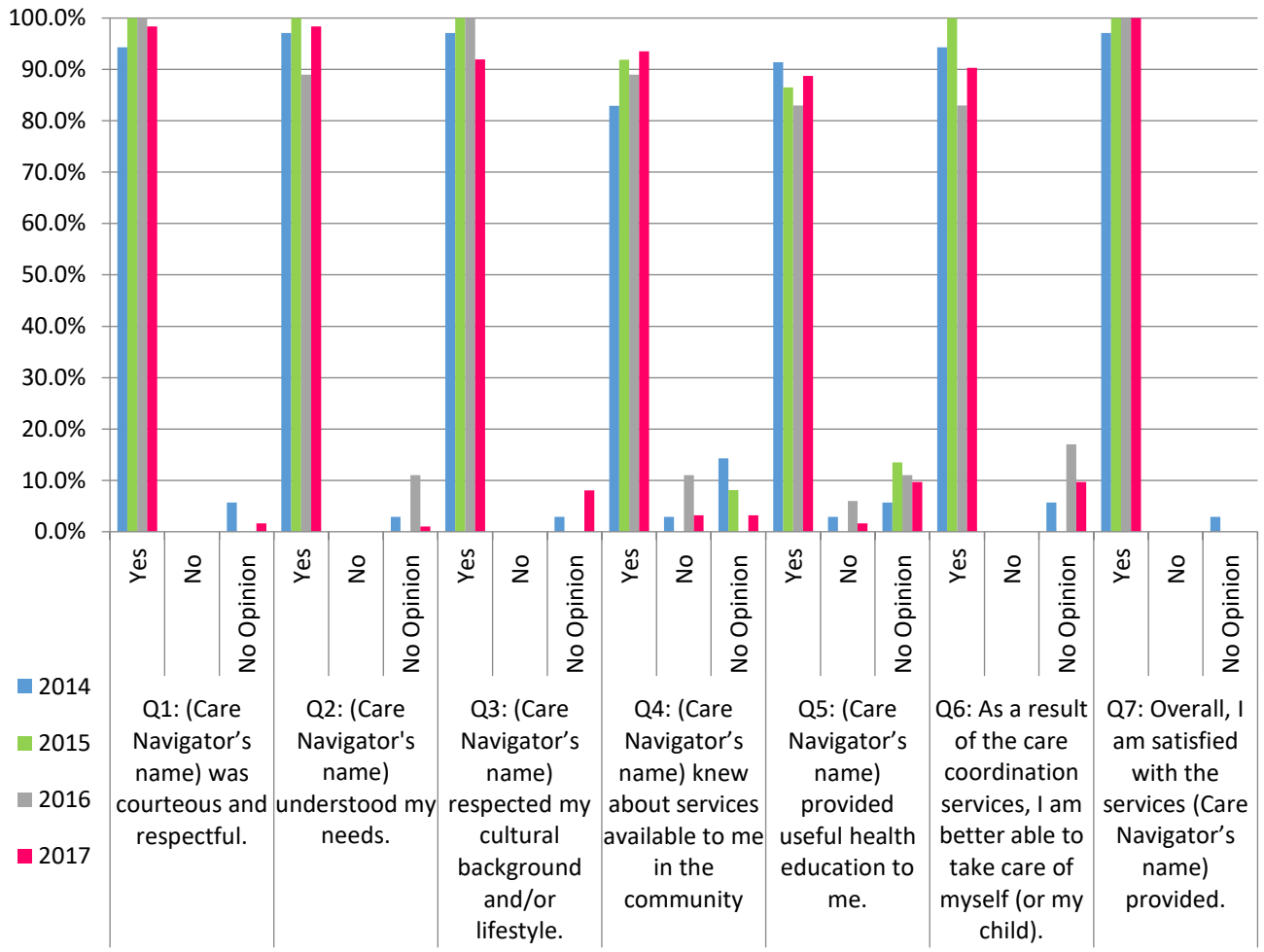
Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

Member/Caregiver Experience with Care Coordination

The PCN conducts quarterly member satisfaction surveys with members and their caregivers who received care coordination services from a Care Navigator. This telephonic survey involves asking seven (7) questions with an open-ended opportunity for member comments at the end of the survey. There was a dramatic increase (181%) in the number of completed surveys from the previous year due to process improvement initiatives implemented by the Care Teams to increase the number of surveys offered in real-time. The 2017 survey results compared to 2014-2016 survey results are displayed below.

Survey Volume

2014	2015	2016	2017
34	41	22	62

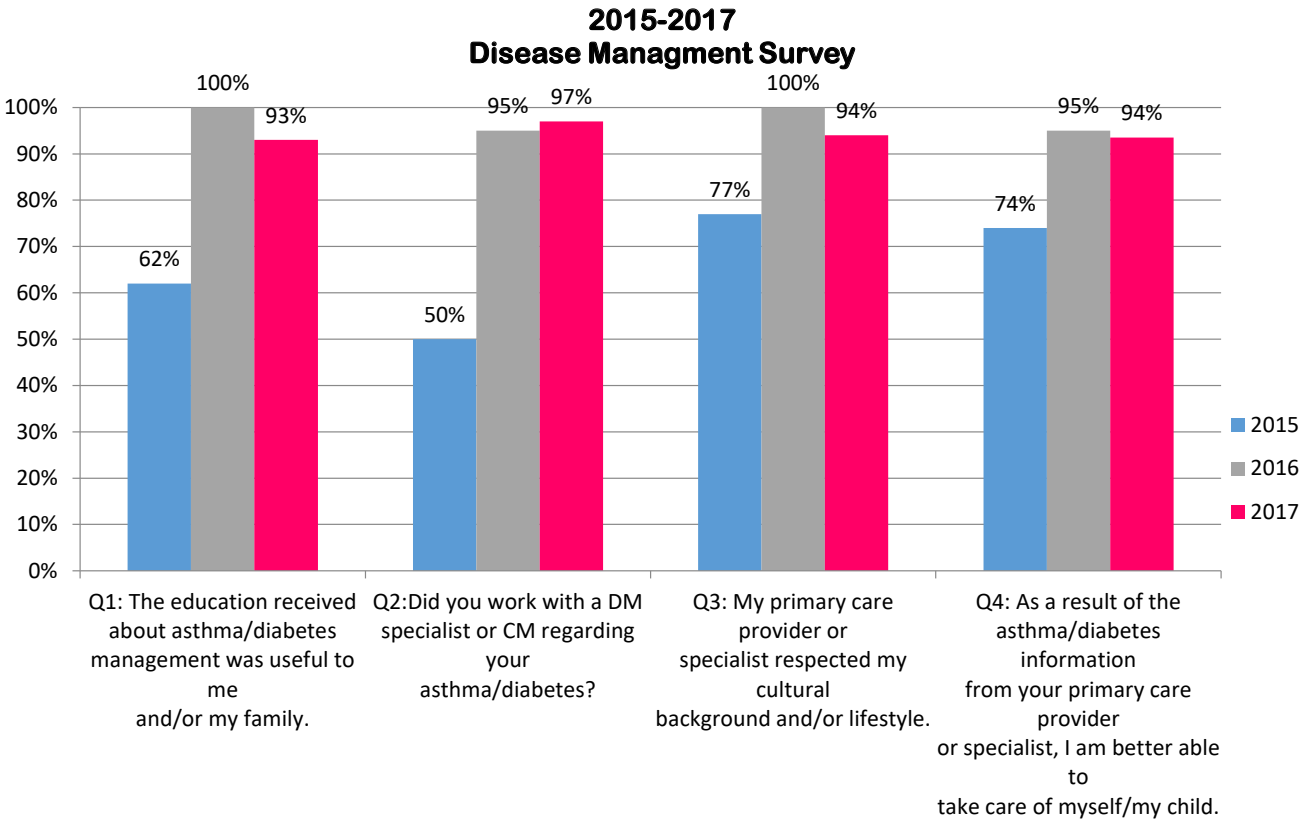


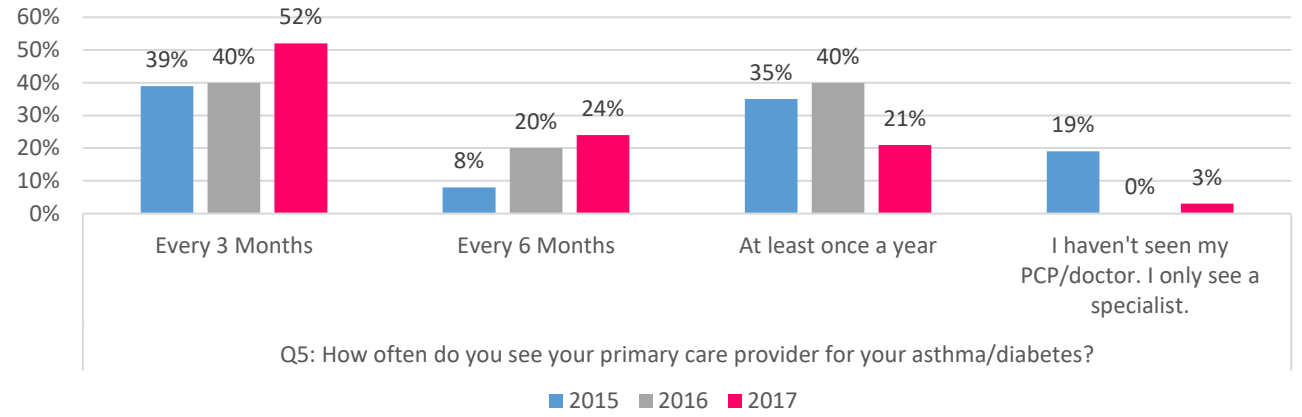
Member/Caregiver Experience with Disease Management

The disease management survey measures the member's satisfaction with PCN staff, primary care providers/specialists and health literature provided through the program. 2017 was the third year the survey was conducted by the PCN; the 2015-2017 survey results were compared and are displayed here.

Survey Totals

2015	2016	2017
37	20	33





Member Complaints and Grievances

PCN is not delegated to perform complaint, grievance, and appeal processes but is notified by the Health Plans if a member issues a complaint or grievance related to the PCN's programs. In 2017, no member complaints or grievances were received related to the PCN's case management or disease management programs.

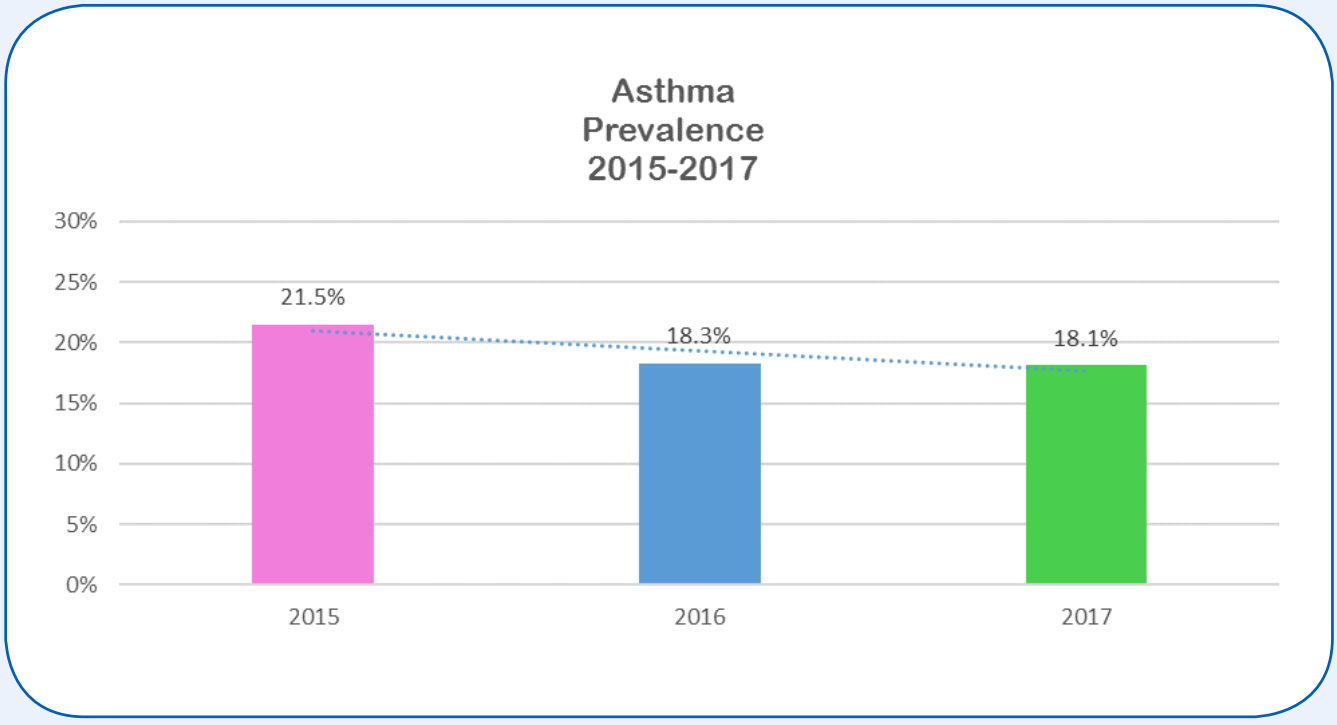
Disease Management Outcomes for Asthma & Diabetes

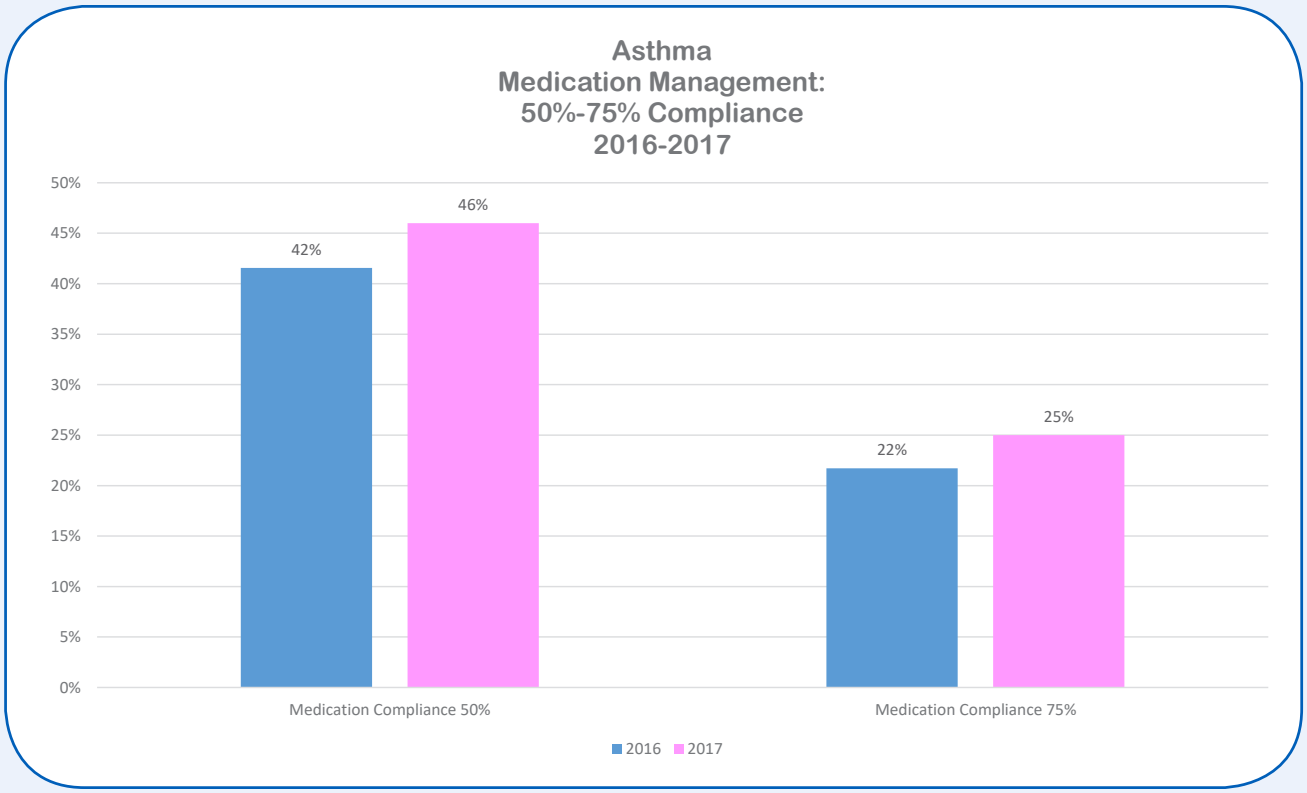
PCN's Disease Management programs use a unique approach to manage chronic asthma and diabetes. It is a collaborative effort between the primary care providers and the Care Teams. The Care Teams are comprised of Practice Facilitation Specialists who work with primary care provider offices to implement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

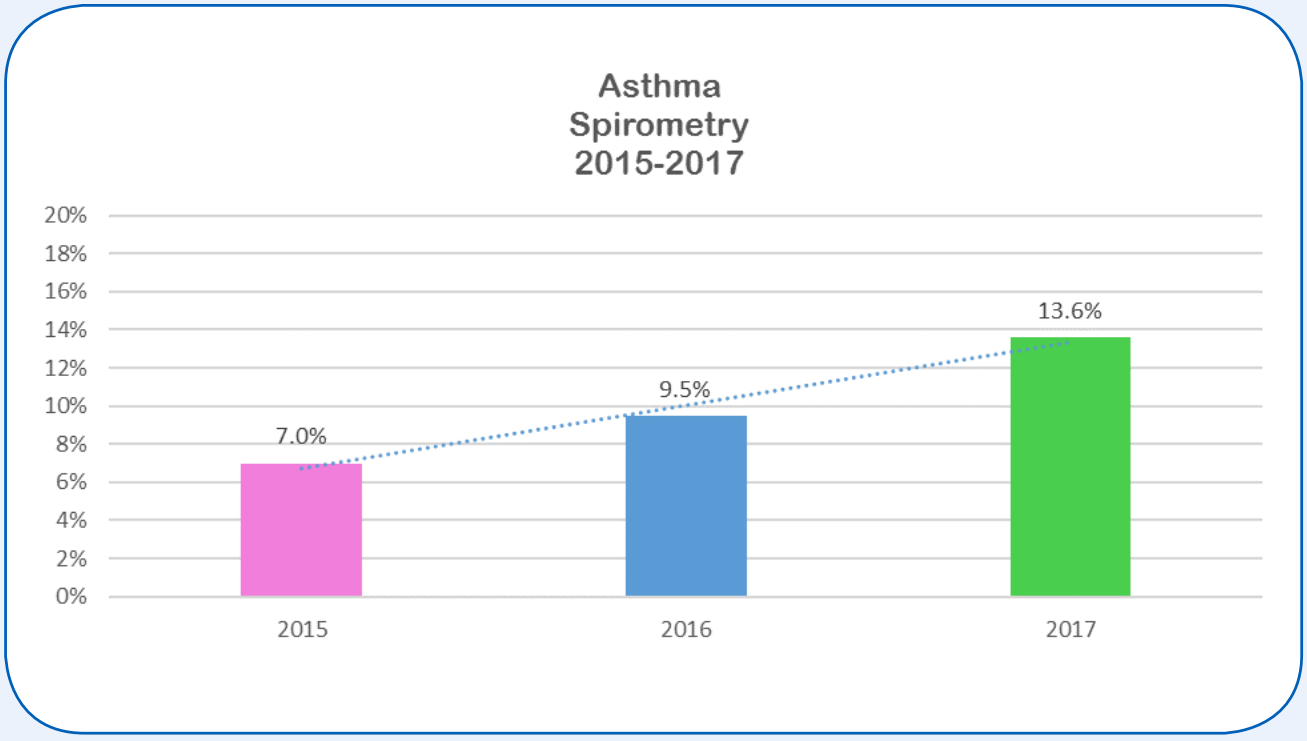
The program consists of physician office education, Patient Centered Medical Home support, quality improvement techniques, data analytics and reporting, and focused case management interventions, with the goal of improving the health of the population and reducing cost.

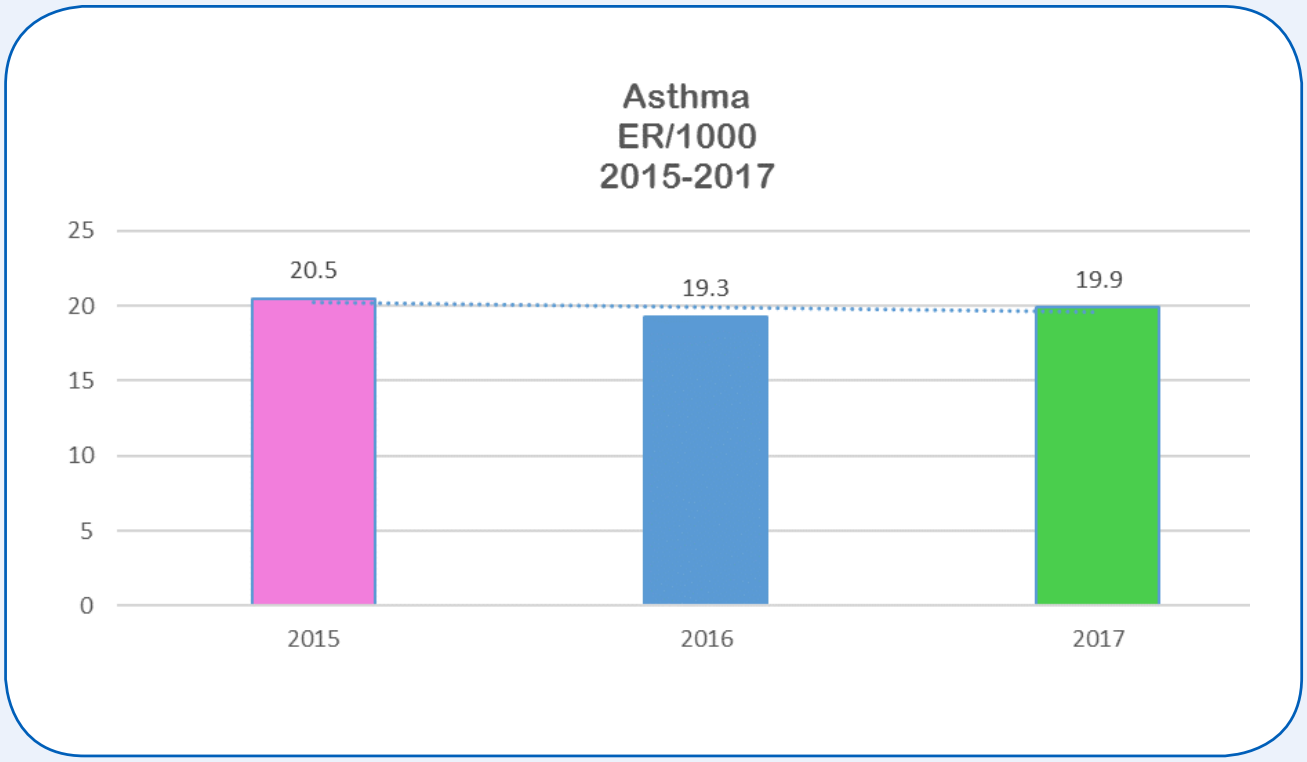
Care Navigators received education on asthma and diabetes management and tools were built into the C.A.R.E Web documentation system to allow for effective management of this population. The Care Navigator audit tool includes disease management components, holding staff accountable to disease management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

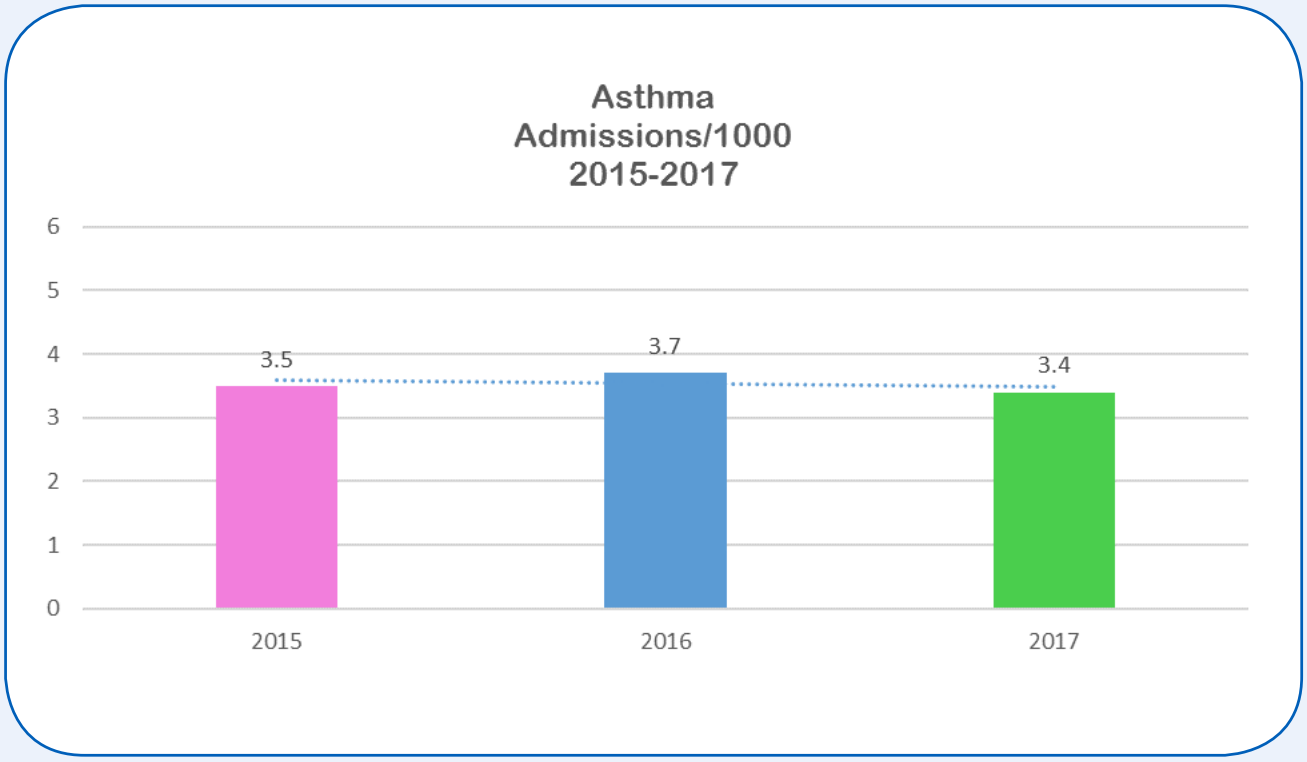
Asthma



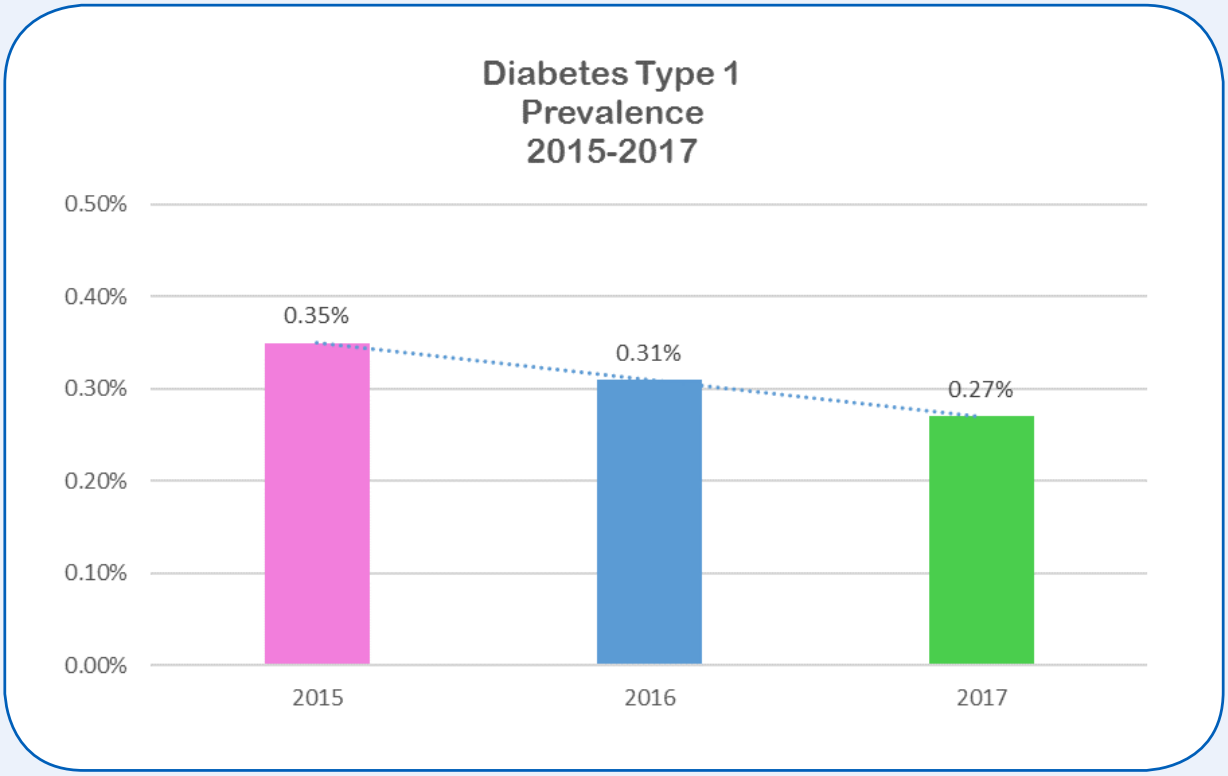

Asthma
Medication Management:
50%-75% Compliance
2016-2017
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
42%
46%
22%
25%
Medication Compliance 50%
Medication Compliance 75%
2016
2017

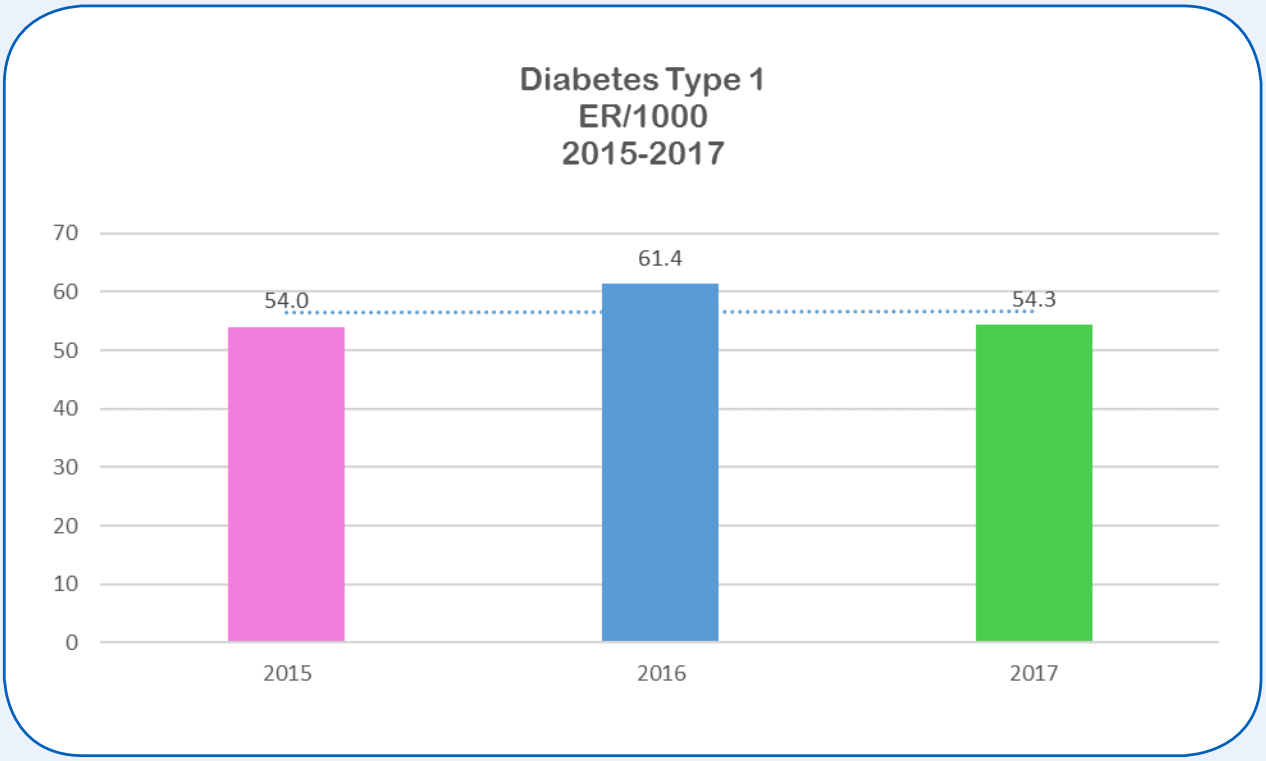

Asthma
Spirometry
2015-2017
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
7.0%
9.5%
13.6%
2015
2016
2017

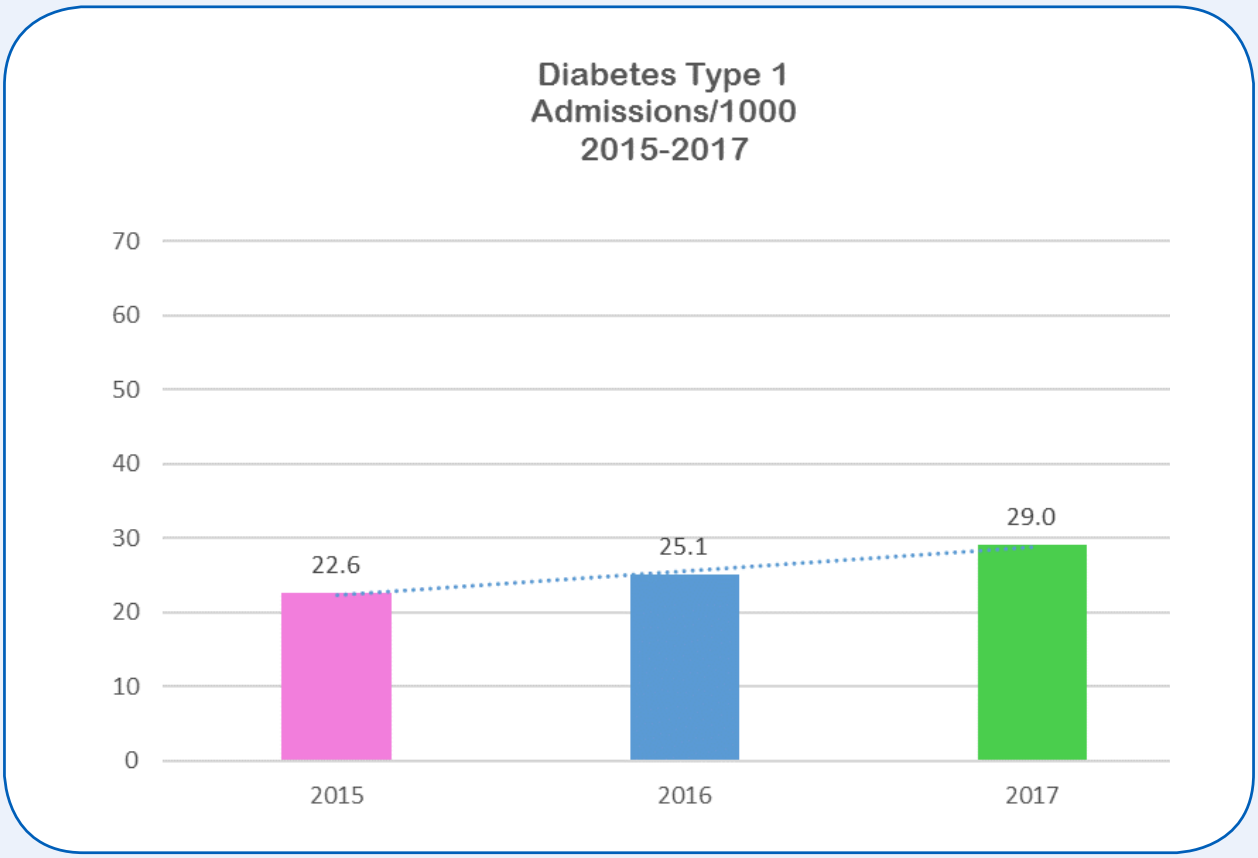

Asthma
ER/1000
2015-2017
25
20
15
10
5
0
20.5
19.3
19.9
2015
2016
2017

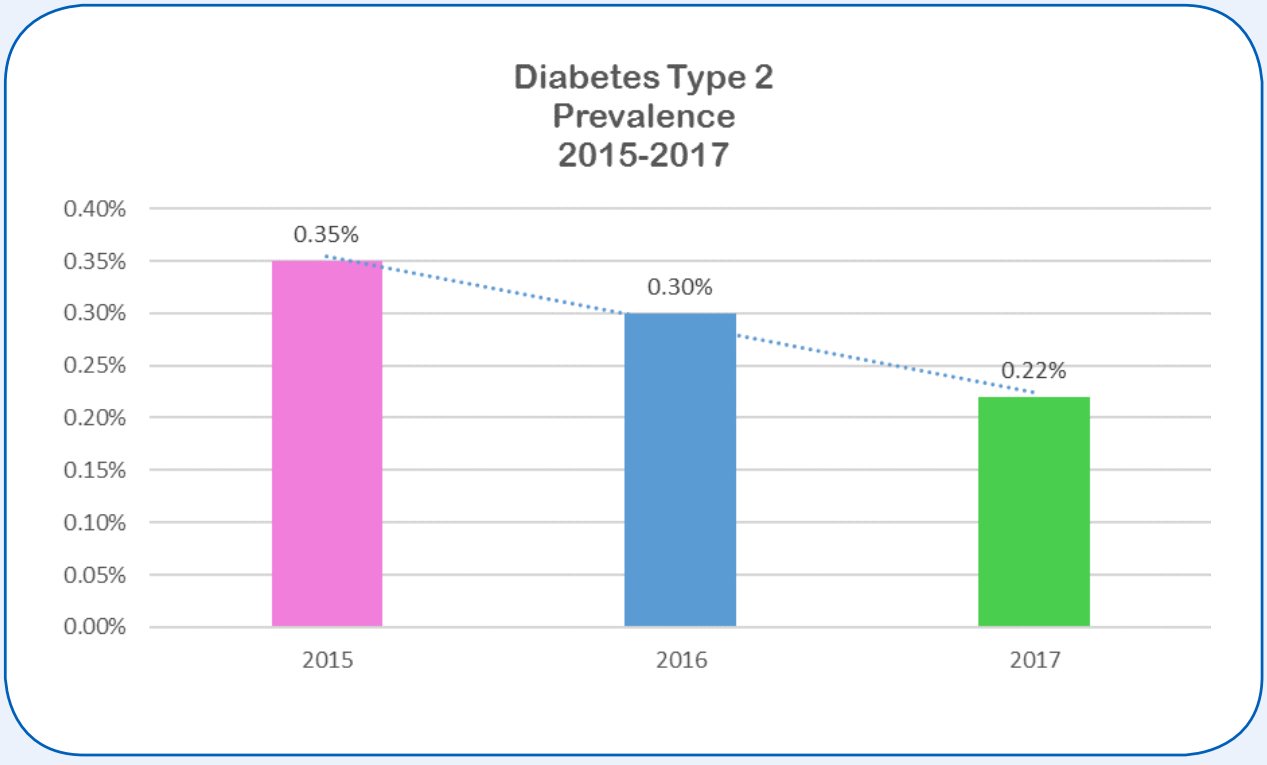

Asthma
Admissions/1000
2015-2017
6
5
4
3
2
1
0
3.5
3.7
3.4
2015
2016
2017

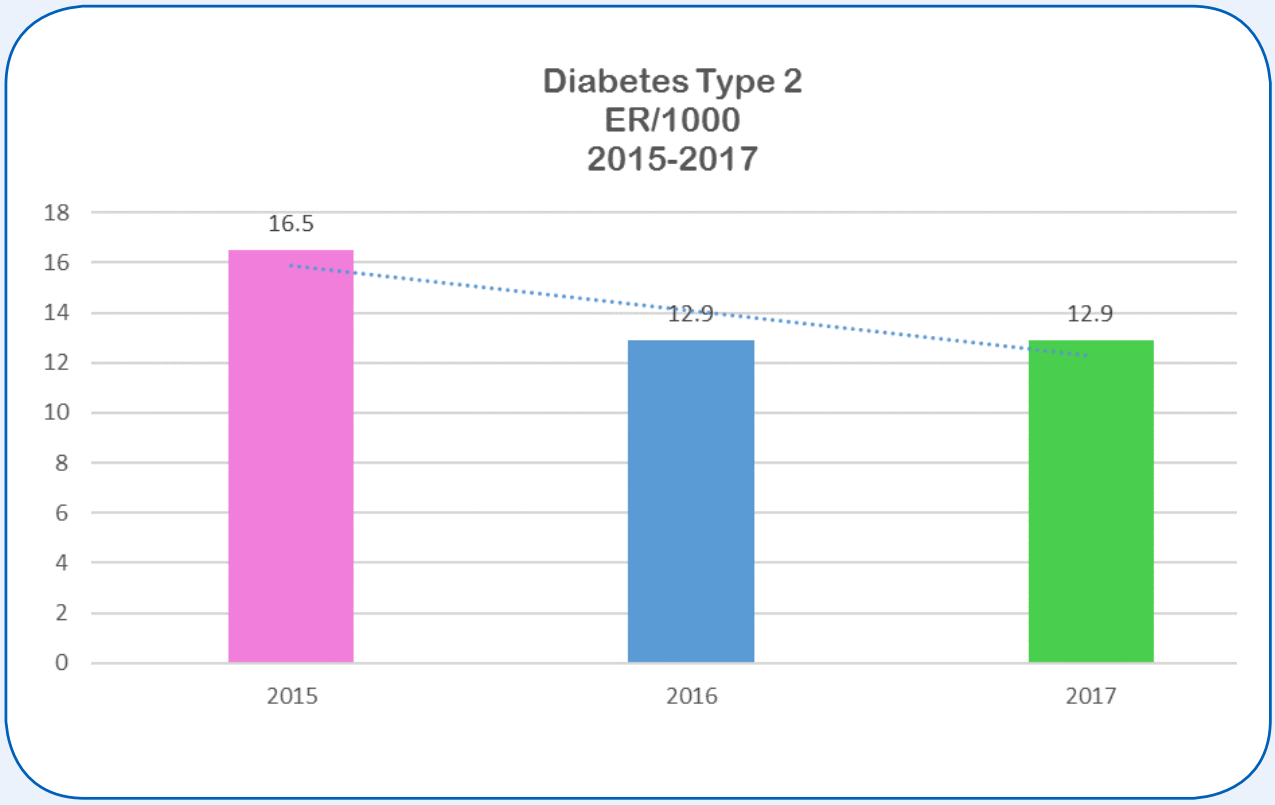
Diabetes

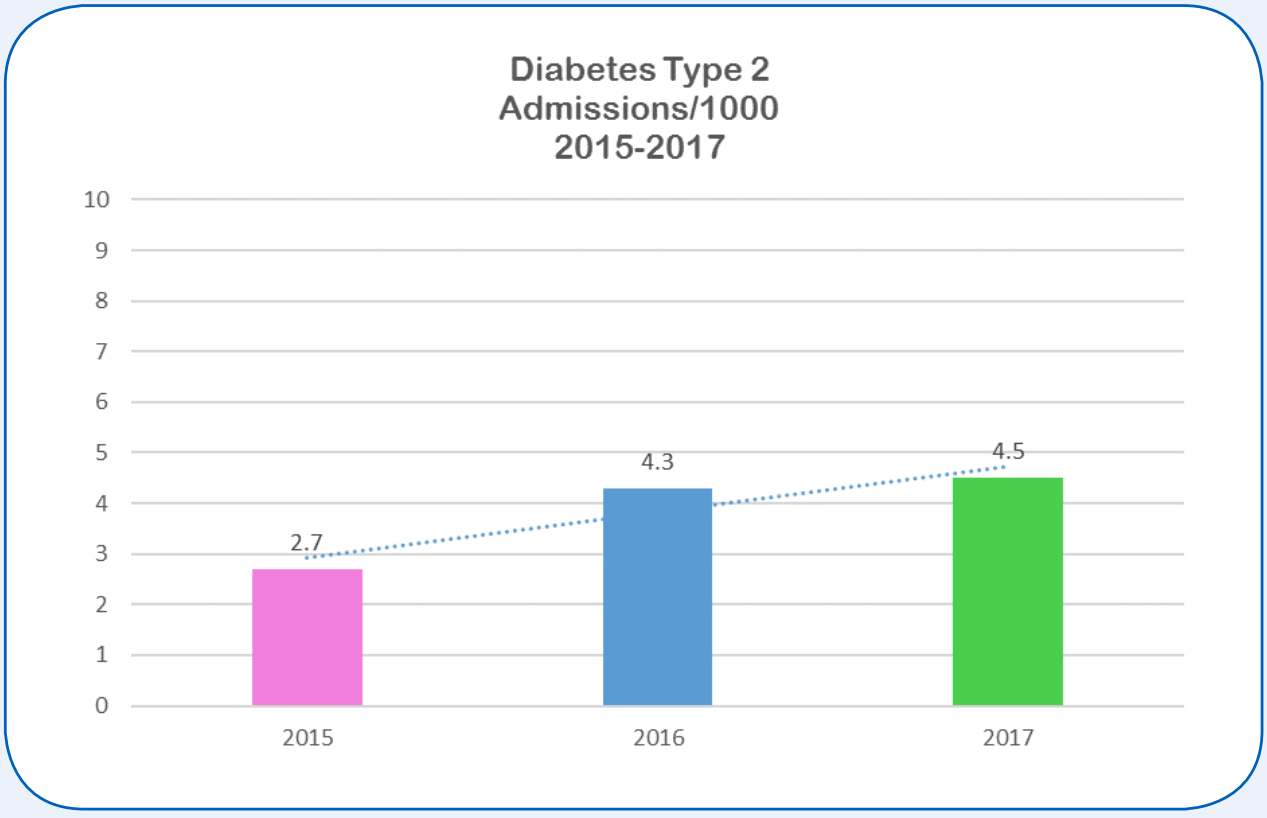

Diabetes Type 1
Prevalence
2015-2017
0.50%
0.40%
0.30%
0.20%
0.10%
0.00%
0.35%
0.31%
0.27%
2015
2016
2017


Diabetes Type 1
ER/1000
2015-2017
70
60
50
40
30
20
10
0
54.0
61.4
54.3
2015
2016
2017

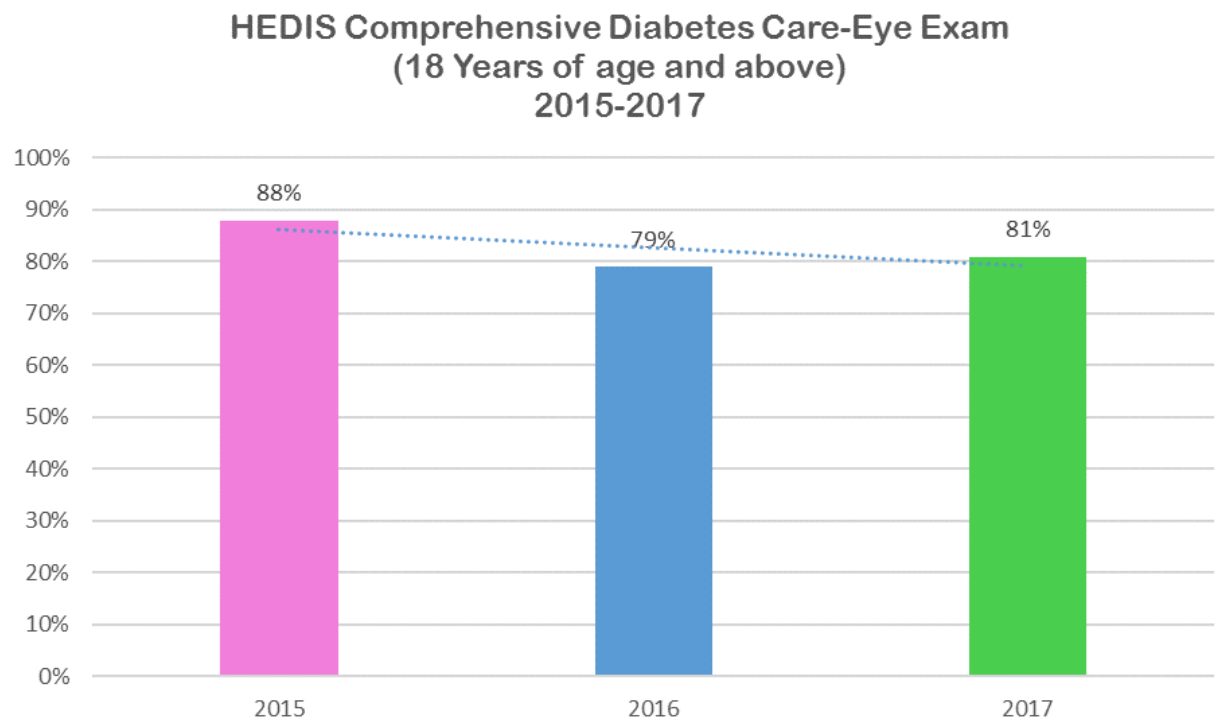

Diabetes Type 1
Admissions/1000
2015-2017
70
60
50
40
30
20
10
0
22.6
25.1
29.0
2015
2016
2017

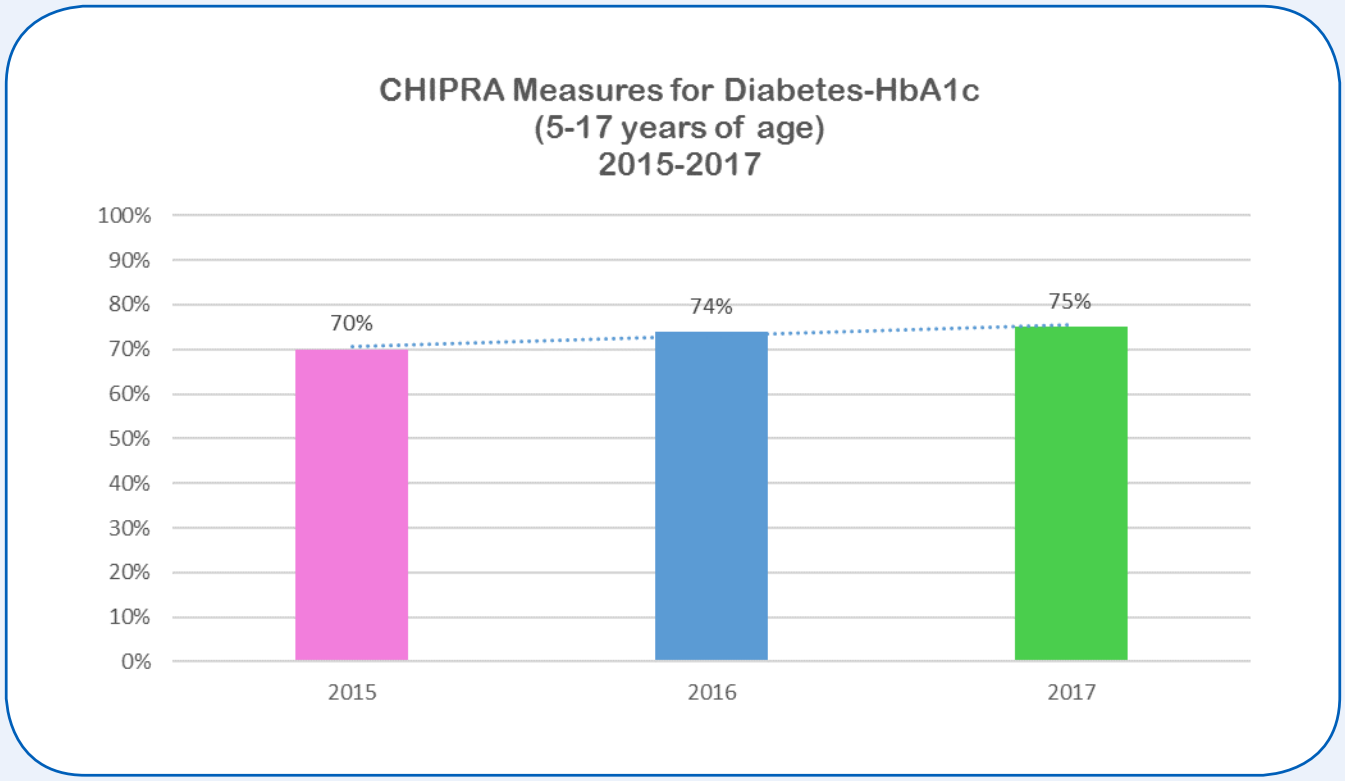

Diabetes Type 2
Prevalence
2015-2017
0.40%
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
0.35%
0.30%
0.22%
2015
2016
2017

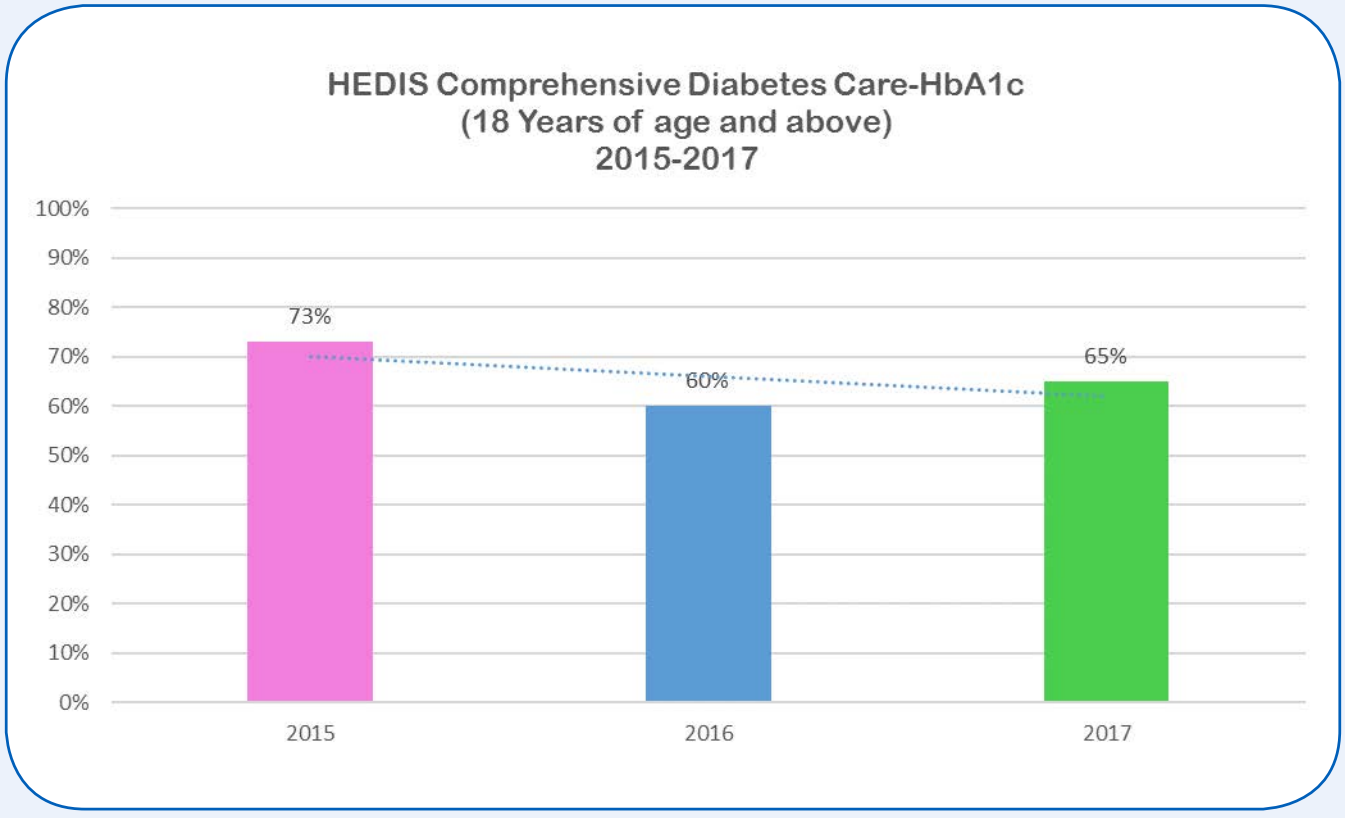

Diabetes Type 2
ER/1000
2015-2017
18
16
14
12
10
8
6
4
2
0
16.5
12.9
12.9
2015
2016
2017

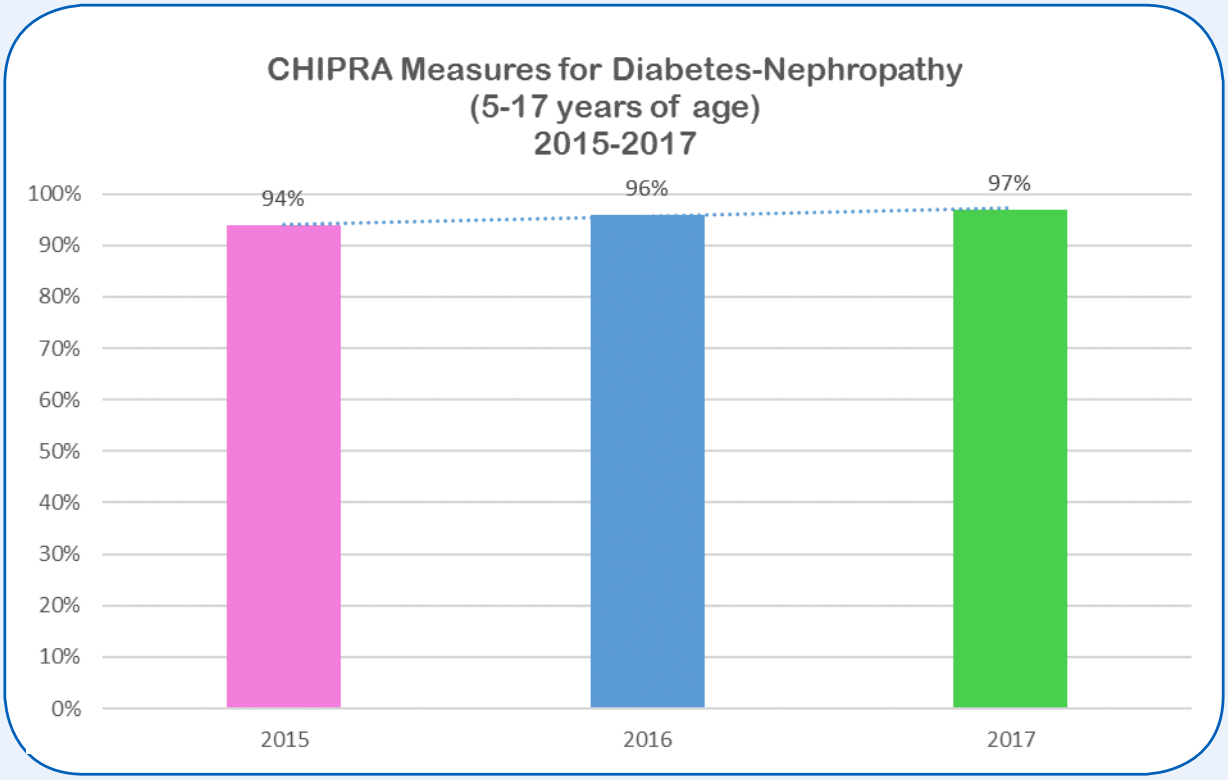

Diabetes Type 2
Admissions/1000
2015-2017
10
9
8
7
6
5
4
3
2
1
0
2.7
4.3
4.5
2015
2016
2017

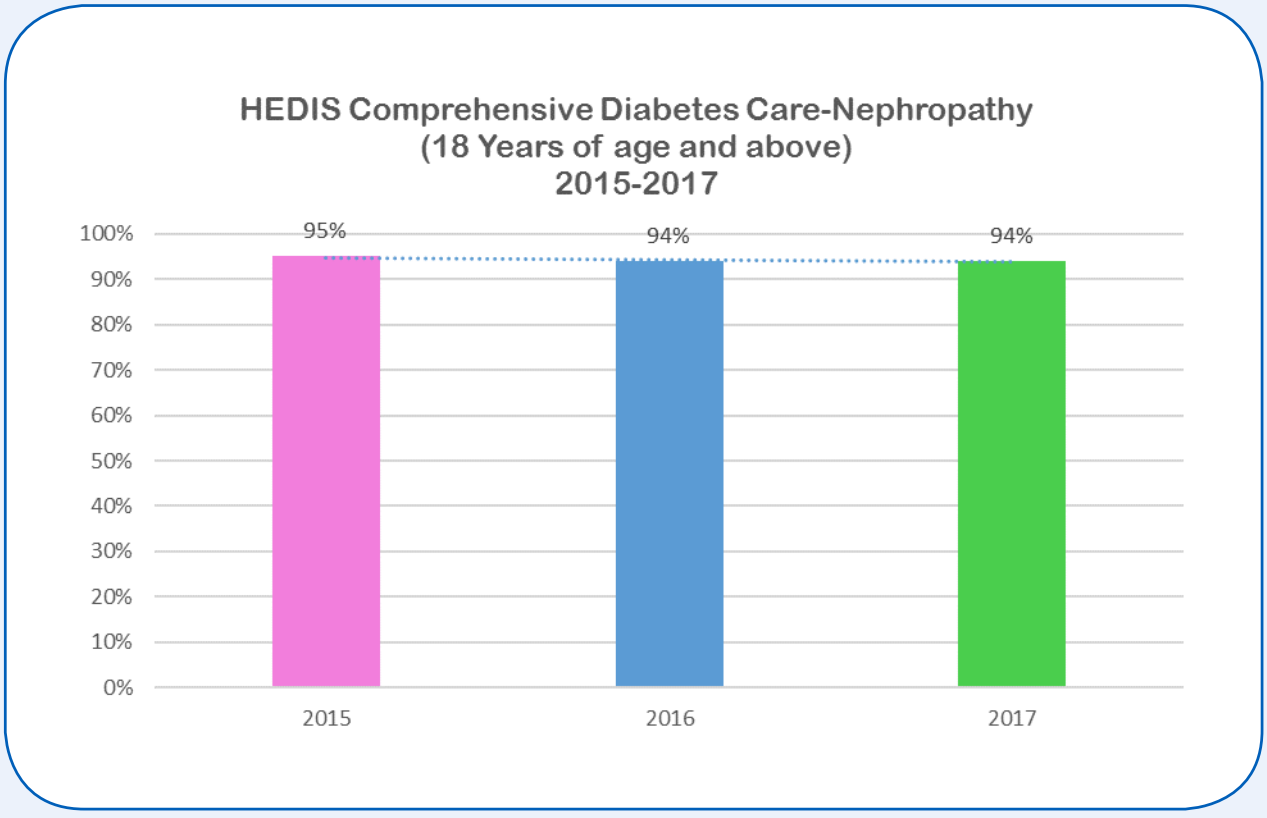
HEDIS Comprehensive




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


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


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


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

Analysis:

Referral, Outreach and Case Activity:

PCN Care Teams transitioned in 2017 to population health management strategies for identified at-risk and emerging risk members for outreach and screening. This proactive approach increased referrals from 1,668 in 2016 to 3,269 in 2017. The top referral conditions has remained consistent from 2016 to 2017 with high risk pregnancy, cerebral palsy, asthma, developmental delays and diabetes being the most prevalent referral reasons. The PCN also utilized all members of the Care Team to reach out to members, thus, increasing the capacity for screening members. 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 care coordination.

In 2017, the Care Integration program shifted away from levels of case management. The C.A.R.E. Web screening and assessment tool meets the NCQA complex case management assessment requirements for all members. Complex cases are defined as members with a case opened for >60 days and have a completed condition specific assessment. This evolution lead to a decrease in complex case management cases from 62% in 2016 to 12% in 2017 but a greater capacity for Care Teams to impact more members. Members with minimal needs are provided with care coordination services through short-term interventions. Seventy-five percent of the referrals are managed in this manner. The PCN processes remain true to case management philosophies of

assessing, planning, implementing and evaluating with an emphasis on sharing care plan goals and empowering members and providers to be engaged in the process.

PCN continues to strive to develop patient -centered care plans that are specific, measureable and attainable while eliminating barriers to care. In 2017, achievement of goals/stabilized condition/ improved health was the primary case closure reason for 51% of the cases closed. This is an increase from 15% in 2016.

True to the IHI Quadruple Aim, the PCN strives to improve the work life of staff. The PCN routinely elicits feedback from staff members to improve programs and processes. In 2017, Care Teams disclosed dissatisfaction with the current Care Team structure noting the inability to continue to process prior authorization requests, conduct member screening and outreach, and deploy meaningful case management interventions. Staff assisted in designing an Intake/Outreach Team. This team will be implemented in 2018. The Intake/ Outreach Team will be responsible for receiving and processing routine prior authorization requests, conducting screening and referral to Care Teams, and providing short-term outreach to members.

Cost and Utilization Pre and Post Case Management:

Due to the transient nature of cases in case management, the population available for analysis pre and post intervention is not the same year over year, therefore PCN reviews trends each year in the population available for studying and expects improvements in inpatient and ER utilization, as well as overall medical spend, based on case management interventions. For the population analyzed this year, there was a 42% reduction in inpatient admissions per 1000 ; a 25% reduction in ER visits per 1000 ; and a 42% reduction in overall per member per month cost post intervention. As expected when case management interventions begin, overall inpatient and ER costs should decrease, while outpatient and physician-related costs increase as members become more compliant with preventive services and are connected to a medical home for management of their care.

HEDIS-like Performance for Case Management:

In the eleven (11) measures analyzed, the case managed population rates outperformed the PCN population rates in seven (7) of the measures. Adolescent Well-Care, access to care, CHIPRA measures, chlamydia screening, immunizations and lead screening were higher when compared with the general PCN population. The measures that were not higher in the case managed population were Asthma Management (50% and 75%) and Well-Child visits (0-15 months and 3-6 years). The increased asthma and well-care measures in the general PCN population is reflective of the ongoing work with community providers. It is difficult to determine the reason for lower rates in the case managed population in those areas, however due to higher medical complexity; members are more likely seen for ill visits without conversion to a well visit. Education to providers will continue to include the importance of addressing gaps in care for members seen for ill visits and chronic conditions.

Member/Caregiver Experience with Case Management:

The number of members surveyed in 2017 increased by 181% due to increased efficiencies in the member survey process. All members surveyed reported that they were overall satisfied with the services provided through the PCN case management program. Favorable member responses increased in 2017 from the prior year in the following topics: Care Navigator understands the member's needs (Q2), knowledge about services available in the community (Q4), providing useful health education (Q5) and the caregiver being better equipped to manage the member's condition (Q6). The increased utilization of C.E.R.A and the addition of Community Resource Specialists on the Care Teams have had a positive impact on the case management program, as evident by this member survey.

There was a minimal decrease (100% in 2016 to 98.4% in 2017) in the question related to the courteous and respectful nature of the Care Navigator (Q1). There was a more notable decline from 2016 (100%) to 2017 (91.9%) in the Care Navigator showing respect to the member's background and/or lifestyle (Q3). Members responded "no opinion" 8.1% (2017) which is an increase from a 0% in 2016 on this same question.

As a result of this year's analysis, additional staff education will be provided related to cultural diversity and how to assess and incorporate the member's culture and lifestyle into the care plan development process. This will be accomplished through the implementation of a standardized training platform with built in case management modules.

Member/Caregiver Experience with Disease Management:

The 2017 disease management survey results indicate significant improvement in chronic disease management, education, and engagement with medical providers. Member outreach and care coordination were provided by the entire Care Team, comprised of Nurse Care Navigators, licensed Social Work Care Navigators, Community Resource Specialists, and Provider Relations representatives, who all work closely with the member's PCP to support population health strategies. All 2017 goals exceeded the previous year's results. The survey demonstrated an increase in member engagement with the Care Teams and providers. In addition, members reported a better understanding of their chronic disease through member literature, working with Care Team staff, and increased utilization of primary care providers and specialists.

During 2017, Care Teams focused on chronic disease management and ongoing outreach to medium and high risk members with asthma and diabetes. Members who fell within this criteria who were 12 years of age or older had an annual depression screening completed using the Patient Health Questionnaire 'PHQ-9' (pg. 80). High-risk

members who were unable to be reached by telephone received a visit by a home health nurse to provide additional education and support. As a result of this year's analysis, the program changes made in 2017 will continue with plans for ongoing collaboration with providers for chronic disease management. PCN will track and continue to trend the member satisfaction survey results for identifying areas of opportunity for improvement.

Asthma Outcomes:

Prevalence and Utilization

The current prevalence rate of asthma in the PCN population based on claims data is approximately 18%. 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 the members. The Care Teams have also implemented an outreach program for high utilizers of the emergency room related to asthma and other chronic conditions.

Provider and Member Adherence

Medication management for people with asthma was a newly established HEDIS measure in 2016. This measure looks at the percentage of members who remained on an asthma controller medication for at least 50% or 75% of their treatment period. In 2016, the HEDIS 75th percentile was 31%. PCN exceeded this with a result of 49%. From 2016 to 2017, the data shows an increase in members who remained on controller medication for both 50% and 75% of their treatment period.

Spirometry is an important tool used in assessing conditions such as asthma. As demonstrated in the data, there was a 4% increase in spirometry use for members with asthma from 2016 to 2017. This trend is consistent with the upward trend in spirometry usage over the last three years. Spirometry continues to be considered a best practice for asthma care and PCN staff will continue to educate provider offices on the importance of implementation according to national guidelines for asthma management.

Inpatient and ER utilization related to asthma remained consistent from 2016 to 2017.

Diabetes Outcomes:

Prevalence and Utilization

As a pediatric focused organization, the population of members with diabetes is much smaller than the asthma population. In 2017, the prevalence of both type 1 and type 2 diabetes in the PCN managed population was less than 1%. From 2015 to 2017, inpatient utilization increased slightly for both type 1 & type 2 diabetes. ER utilization for members with type 2 diabetes remained consistent, but decreased for members with type 1 from 61 visits per 1000 in 2016 to 54 visits per 1000 in 2017. Due to the small population, those fluctuations were not significant enough to warrant changes in the diabetes program.

Provider and Member Adherence

Two of the HEDIS comprehensive diabetes measures for members 18 years of age and above increased slightly from 2016 to 2017. Diabetes eye exam screening increased from 79% to 81% and HbA1c testing increased from 60% to 65%, while nephropathy screening remained consistent at 94% for both years. Similarly, there was a slight increase in all three measures during the same timeframe in the 5-17 year old population. Compliance with recommended HbA1c monitoring will continue to be a focus of the PCN's provider and member education for diabetes management.

New Initiatives Implement in 2017:

PCN Care Teams increased collaboration with the hospital's Endocrine department in 2017 by providing enhanced analytical tools to providers to aid in management of members with chronic conditions.

Next Steps:

Based on the analysis of the program metrics, the following interventions will be included in PCN's 2018 initiatives:

- Enhance C.A.R.E. Web to allow providers access to Care Team documentation, review and input into member care plans and bidirectional communication with Care Team members.
- Enhance C.A.R.E. Web to allow members access to view care plans and communicate with Care Team members.
- Tri-annual visits with PCP practices to review Provider Performance Profiles and discuss collaborative projects for outreach to at-risk populations.
- Implementation of an Intake/Outreach Care Team to process prior authorization requests and conduct screening and outreach to members.
- Implement automated call campaigns (Interactive Voice Response system) to medium and high-risk members with asthma to encourage follow up with a provider every 6 months.
- Provide additional and routine staff education on cultural diversity and applications in case management.
- Provide education to the Endocrine Team on the functions of PCN Care Teams and how to utilize them for care coordination.

6 2017 Success Stories

- Care Team Successes with PCN Practices
- Care Team Successes with Members
- NICU Pilot Post Discharge Successes
- Community Health Worker Pilot Successes

Care Team Successes with PCN Practices

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

Success Story #1

Synopsis: *A large, multi-location PCN practice requested their quality metric data be broken down by provider and location so they could compare the performance of each location and their relative impact on the overall HEDIS quality measure percentage. The PCN Care Team took the raw data, separated it out by provider and location, and then presented it in report form to the practice administrators and staff. These reports showed the numerator, denominator, and percentage for each quality measure at the provider level, as well as the overall numerator, denominator, and percentage for each location. Additionally, the report showed the relative impact on each measure, both at the provider and location levels.*

Outcome: The practice greatly appreciated these reports as they allowed them greater insight into how each provider and location contribute to the success of each quality measure. This enhancement to the quality reports was initiated in 3rd quarter 2017 and will continue to be included in all future reports, as well as regular meeting discussions with this practice.

Success Story #2

Synopsis: *This success was a team effort between one of the PCN Care Teams and a large network provider practice, working together to align members with correct PCPs and enhancing the practice's billing process to ensure credit was received for all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits. To increase PCP alignment, the practice notified PCN of members who had moved and needed assignment to a different PCP. Next, the PCN Care Team ran reports identifying members who were either assigned to the practice but seeing other providers, or who were seen at the practice but had another provider listed as their PCP. This assisted in getting members reassigned correctly. To ensure the practice received credit for all EPSDT visits, the Care Team instructed the practice to submit claims to the health plans, even when the member had other primary insurance. Historically, the practice had not done this, not realizing they were missing EPSDT hits.*

Outcome: The practice implemented a change in their billing process, resulting not only in correct billing, but also in receiving credit for EPSDT visits, regardless of the member's primary insurance. For the first time ever, the practice qualified for the EPSDT incentive compensation payment after hitting 80% or above on the measure from July to December 2017.

Success Story #3

Synopsis: *In an effort to improve HEDIS outcomes and improve quality of care, a network pediatric practice hired a care coordinator who collaborated with one of the PCN Care Teams on multiple projects. The Care Team provided reports to the care coordinator, allowing her to work the lists and schedule members for needed appointments. One of the reports was a list of PCN members assigned to the practice, but who had not received preventive care from any provider. The care coordinator reached out to these members and gave them the opportunity to establish care at the practice. Another report listed members 0-15 months of age needing 1 additional visit to meet the 0-15 month HEDIS measure. The Care Team collaborated with the care coordinator by reaching out to the identified members, obtained correct phone numbers if needed, then connected the members to the practice's front desk to schedule an appointment. Additionally, the Care Team provided lists of members recently discharged from Children's Mercy Hospital that were also identified as having gaps in care. The practice care coordinator scheduled these members for post discharge follow up visits, converting them to a well care visit as well. This sick-to-well visit process allowed members who may not have otherwise come in for their well-child checks to become compliant with those gaps in care.*

In addition to making improvements in their HEDIS measures, the practice also improved their community engagement efforts. The assigned PCN Care Team was able to assist in scheduling a meeting between the office staff members (office manager, care coordinator, and medical assistant) and the director of the Food Equality Initiative in Kansas City. As a product of this meeting, the practice was able to implement a food insecurity screening and referral process for patients that have food allergies or intolerances and are considered food insecure.

Outcome: In 2017, the practice took great strides to improve their HEDIS performance. Beginning with hiring a care coordinator, they were able to find ways to not only improve their overall quality of care, but also their HEDIS quality measures. They came within less than 1% of meeting the EPSDT HEDIS measure in 2017, which is a 5% improvement from the previous year. The number of members who came in for 0-15 month well-child checks increased, and the practice exceeded the 50% benchmark on adolescent well-child checks. In addition, they have made many efforts to improve their community engagement and total quality of care.

Success Story #4

Synopsis: *PCN staff develop partnerships with local community organizations with a goal of enhancing the health and well-being of members and their families. The PCN Care Team assigned to a local Federally Qualified Health Center (FQHC) shared with the practice a collaborative effort between another pediatric office, the PCN and their community partner Harvesters, in which healthy eating classes and bags of groceries were available to teens and their families at office visits. They also shared Harvester's desire to have more of a presence in the medical community. The practice expressed interest in this initiative, so the Care Team connected them to the Director of Education Services at Harvesters.*

Harvesters shared with the FQHC a list of services they could provide in a medical office including a prescription food pantry. The rationale behind prescription food pantries is to provide healthy food options to families while at their PCP office. At this time, PCN members were not able to use the Medicaid transportation benefits to obtain food, but could use it for office visits. Having healthy food available at their provider's office is an incentive for members to keep their well visits.

The FQHC leadership decided to pursue the prescription food pantry, and were awarded a grant from the Kansas City Heath Foundation to help defray the costs of the program. It was decided that the best option for the health center was to have pre-packaged boxes of healthy food available with a prescription from the member's provider. Additionally, a truck would come twice a month to their parking lot, allowing families to pick out fresh fruit and vegetables.

Outcome: The prescription food pantry is now in operation at the FQHC and is doing well. It is the first prescription food pantry in the Kansas City area which targets families in which one family member has diabetes. Their hope is to expand the program in the future, and replicate the work of other successful prescription food pantries.

Success Story #5

Synopsis: *The PCN provider portal includes member data by assigned practice. One of PCN's largest providers has many members on their panel that the practice has never seen. With the help of PCN Information Technology and Provider Relations staff, a standard portal report was created to report the last provider seen by PCN members identified as having the practice as their PCP. From that report, the practice was able to identify coding errors, incomplete charting and claims not being submitted to the health plans for payment. This resulted in the practice not receiving credit for HEDIS measures. The practice implemented a new process to educate and audit each provider ensuring charting was complete and claims submitted.*

This collaborative report shared by the Care Team and practice assisted in outreach to members for disease management and Well Child Care follow up calls. PCN staff worked to align PCPs and contact members with gaps in care who were going to other practices.

Outcome: The issues above were identified and process improvement initiated in June 2017. The practice saw a 5.8% increase in EPSDT rates and an 8% increase in asthma medication management from 3rd to 4th quarters in 2017. In addition, the process improved access and follow up care, facilitated PCP alignment, and brought in additional revenue for the practice.

Care Team Successes with Members

Collaborative work of the Care Team members resulted in the following success stories.

Success Story #1

Synopsis: *A 4-year old former 26 week preemie with a past medical history of an atrial septal defect and hydrocephalus with ventriculo-peritoneal shunt placement was referred to a PCN Care Navigator for assistance with transportation to and from neurosurgery, radiology and physical therapy appointments at Children's Mercy Hospital. The member's family was Spanish speaking, and to complicate things further, the family had only one vehicle which was used by the mother's boyfriend to get to work. When he was able to take off work, he transported the member, member's mother and other siblings to the member's appointments. Unfortunately, he was not able to leave work for every appointment, so visits were frequently cancelled, re-scheduled or missed altogether because of the lack of transportation. The member's mother had been told she could not bring siblings along if Medicaid transportation was used. The Care Navigator made a call to non-emergency medical transportation (NEMT) vendor and confirmed that if car seats or booster seats were available for the member's siblings, they could use the transportation benefit and all siblings could ride along with no issues. She relayed this information to the member's mother using an interpreter, provided instruction on scheduling rides through Logisticare, and mailed out trip logs and a transportation flier.*

Outcome: Through collaboration between the PCN Care Navigator, interpreter, and (NEMT) vendor, instruction was provided to the member's mother on setting up transportation and completing trip logs using the Medicaid transportation benefit. As a result, the member has had no missed neurosurgery, radiology or physical therapy appointments. In addition, the mother's boyfriend does not have to leave work to transport the family to appointments, which has alleviated the financial hardship caused by missed work time.

Success Story #2

Synopsis: *A PCN Community Resource Specialist received a referral from a Care Navigator about a PCN family in need of resources to get their HVAC system cleaned prior to moving into a new rental home. Due to the member's numerous health conditions, including chronic lung issues, the family was concerned about the unclean condition of the home causing the member further health complications. The Community Resource Specialist conducted a search of companies that could assist with this type of service. She contacted Oddjobbers to verify if cleaning HVAC systems was something they could help with and clarified the areas they serve. Oddjobbers responded that they did not have anyone with that skillset, but did have a fund designated to help pay for services and materials for those that couldn't afford the expenses. The Community Resource Specialist contacted the member's mother and informed her that Oddjobbers would present the family with a check once a service provider was located in their area.*

Outcome: The member's family was able to move into their new home after having the HVAC system cleaned out, potentially avoiding additional health issues for the member. Having the service paid for eliminated any financial hardship for the family that might have been caused by them paying for the service on their own.

NICU Pilot Post Discharge Successes

As part of the quality initiative between PCN and Children's Mercy Home Care to reduce NICU post-discharge ER visits, in-home nursing and social work services were provided to PCN members. The following successes are a result of this initiative.

Success Story #1

Synopsis: *Twins born to a young couple were discharged home on oxygen and an oxygen saturation monitor. Multiple follow-up appointments were scheduled for the two babies. The family had limited resources, lived in an urban setting, and coupled with the overwhelming appointment schedule, resulted in missed appointments. During the two-month period the home care nurse saw the babies, she reinforced the importance of keeping appointments and provided clarification on why the babies were seeing each provider, i.e. which one the babies were seeing for well visits and immunizations, which one monitored their respiratory status and oxygen requirements, etc. In addition, the home care nurse coordinated care with the DME provider to ensure the necessary supplies were delivered.*

Outcome: Both babies remained free from re-admission throughout the two-month time frame home nursing was in place, and all appointments were kept. On one occasion the mother had planned to take the babies to the ER, but knew the home care nurse was coming, so instead, decided to wait until the nurse arrived. The family followed the advice of the home health nurse, and avoided an unnecessary trip to the ER for a non-urgent issue.

Success Story #2

Synopsis: *A breast fed baby weighing less than 2kg was discharged home. The member's mother was having trouble breastfeeding, and during the first home visit, the nurse determined the baby was not getting enough calories and subsequently, was not gaining weight. A call was placed by the nurse to the member's PCP. The nurse practitioner in the PCP's office gave instructions for breast feeding to be supplemented with formula. The baby's mother decided to discontinue breastfeeding and feed the baby formula only.*

Outcome: Weight gain goals were reached throughout the following home visits. The baby was discharged from home health nurse without further problems or re-admissions.

Success Story #3

Synopsis: *A low birth weight baby with Down syndrome was referred for post-NICU discharge home visits. Week to week, the baby's weight gain fluctuated from adequate to inadequate. Several feeding and formula changes were made. The baby had episodes of spitting up in response to the feeding changes, and also had respiratory issues. The home health nurse placed a call to the PCP's office, and facilitated a same-day appointment. In addition, the home health nurse assisted mom with getting on Medicaid.*

Outcome: The baby was evaluated by his PCP, the respiratory issues were determined to be viral, and an unnecessary visit to the ER was avoided. Being a young teen mother, she appreciated the guidance and weekly visits the home nurse provided. In addition, the home health nurse assisted the family with their Medicaid application, alleviating the financial burden of paying for medical expenses out of pocket.

Community Health Worker Pilot Successes

In June 2017, a partnership was formed between the Pediatric Care Network and a local community health agency in which community health workers were embedded within two PCN practices. The following successes are related to this pilot.

Success Story #1

Synopsis: *While working with a community health worker (CHW), a parent of a PCN member established these 3 goals: 1) Meeting with a health insurance navigator to apply for medical coverage for herself; 2) Utilizing a community resource to get a bed for her child; 3) Following up with the Housing Authority to confirm her status on the Section 8 waitlist. The client expressed her appreciation and enthusiasm for the community health worker program, and was impressed by the CHW's knowledge of community resources.*

Outcome: The member's parent was successful in accomplishing all 3 of these goals in a short time with the assistance of the community health worker who guided her through the system and even accompanied her to appointments, which had never occurred in the past.

Success Story #2

Synopsis: *A PCN member with a diagnosis of cancer was referred to the community health worker, who saw her for the first time while admitted to Children's Mercy Hospital. The member's mother was very ill and also hospitalized in another facility. Due to the member's mother not being there, the CHW was unable to complete the full interview, so instead just chatted with the member who explained that she would not be able attend school when it was back in session because of her condition. When the CHW inquired if the member had any hobbies, the member replied that she enjoyed basketball. The CHW contacted the athletic director of the Boy's and Girl's Club to see if they would be willing to donate a basketball to this young lady. The Boy's and Girl's Club contacted the University of Missouri – Kansas City (UMKC) basketball team, the Roos, who were able to have the UMKC girls' basketball team sign a basketball and tee shirt for this member.*

Outcome: The UMKC athletic director, several members of the UMKC Roos team, and the CHW went to the member's home and presented the gifts to her.

7 Summary

- 2018 Goals and Objectives
- 2018 Work Plan

Summary of Calendar Year 2018 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 Connections Program and Community Engagement Resource Application (C.E.R.A.)
- Provider Performance Profile Process
- C.A.R.E Web (Online Care Team Communication Tool)
- Community Health Worker Pilot
- NICU Post-Discharge Pilot
- Intake/Outreach Care Team
- Asthma Follow-up Call Campaign
- Standardized Training Software Platform

Community Connections Program and Community Engagement Resource Application (C.E.R.A.)

The Community Connections Program will expand collaboration and information sharing with additional community organizations in the Kansas City Metro and surrounding counties with a focus on meeting the social and medical needs of the PCN population. C.E.R.A has proven to be a valuable resource for connecting members and their families with local social service resources. A tracking system will be developed to monitor the usage of C.E.R.A both internally and externally, and as a means for maintaining accuracy of the application.

Provider Performance Profile Process

Care Teams will continue to evaluate quality and cost metrics for contracted PCN primary care practices through the use of Provider Performance Profile reports. The reports will shift from quarterly to tri-annually to better align sharing of actionable data with provider availability. This process will continue to evolve as Care Teams and providers deploy new and improved population health initiatives and quality improvement strategies, driving forward population health for the entire network.

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 care coordination activities, and send tasks to other members of the Care Team. The scope of C.A.R.E. Web will broaden to include members and providers as part of the Care Team. Provider access will be expanded to allow input or goals to be added to a member's care plan and to receive notification when a care plan is ready for review or when a member has been contacted. Members and caregivers will have the ability to view member care plans. In addition, Care Team members will be able to communicate in real-time and their contact information will be available in Care Web to aid in communication.

Community Health Worker Pilot

The Community Health Worker (CHW) pilot began in 2017 with a focus on addressing social determinants of health for PCN members. The CHW's were embedded in primary care offices and worked alongside the PCN Care Navigator to provide outreach and education. The pilot will continue with a shift in focus to include other locations (i.e. schools and community centers) while continuing to monitor interventions to determine the sustainability of the program and the impact to population health outcomes.

NICU Post-Discharge Pilot

A quality improvement initiative designed to provide support for newly discharged NICU babies, while decreasing post-discharge ER visits, was initiated in 2016 and continued throughout 2017. The pilot received positive feedback from home health staff, as well as parents and caregivers. The QI team met in early 2017 and determined it was too early to provide a comprehensive analysis of the program. The decision was made to continue the

NICU pilot through August of 2018. At that time, a 2-year post intervention analysis will be conducted to determine whether to expand the program as a standard offering for all NICU babies, continue the program on a limited scope, or discontinue the program.

Intake/Outreach Care Team

An Intake/Outreach Team will be implemented within the Care Integration department to assist with processing prior authorization requests, conducting member screenings, and providing outreach to members. This team will be comprised of non-clinical Care Facilitation Coordinators and Care Facilitation Nurses. The Care Facilitation Coordinators will answer precertification phone calls and initiate prior authorization requests and inpatient approvals. The focus of the Care Facilitation Nurses will be on performing medical necessity reviews and member screenings. Implementing this team will allow the PCP aligned Care Teams to focus on working collaboratively with contracted PCN practices to coordinate care for members and improve quality, cost and utilization outcomes.

Asthma Follow-up Call Campaign

Automated call campaigns via the interactive voice response system, EMMI, will target medium and high-risk asthma members and encourage follow-up visits with providers every six months. EMMI has seen great success with other pediatric population health efforts. Focusing on members with asthma will allow channeled resources and attention to collectively improve asthma outcomes.

Standardized Training Software Platform

In an effort to automate and stream-line training processes for on-boarding of new staff, as well as conduct annual and ongoing education of existing staff, a standardized software training platform will be implemented through the Children's Mercy Hospital's Cornerstones program. This will allow for more efficient and thorough training modules to be accessed in a group or individual setting. Modules will contain a variety of educational topics, such as accessing Care Integration policies and procedures, utilizing resources and tools, and applications in case management and cultural diversity.

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. Our team will continue to forge strong relationships with the patient population we serve and 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 high risk, vulnerable populations.

Submitted: Ma'ata J Lipford, RN, MBA, CCM — April 20, 2018

Ma'ata Lipford, RN, MBA, CCM
Senior Administrative Director, Care Continuum

Date

Approval: _____ April 24, 2018

Just for Kids (JFK) Committee

Date

_____ July 27, 2018

Clinical Quality Committee

Date

2018 Annual Work Plan

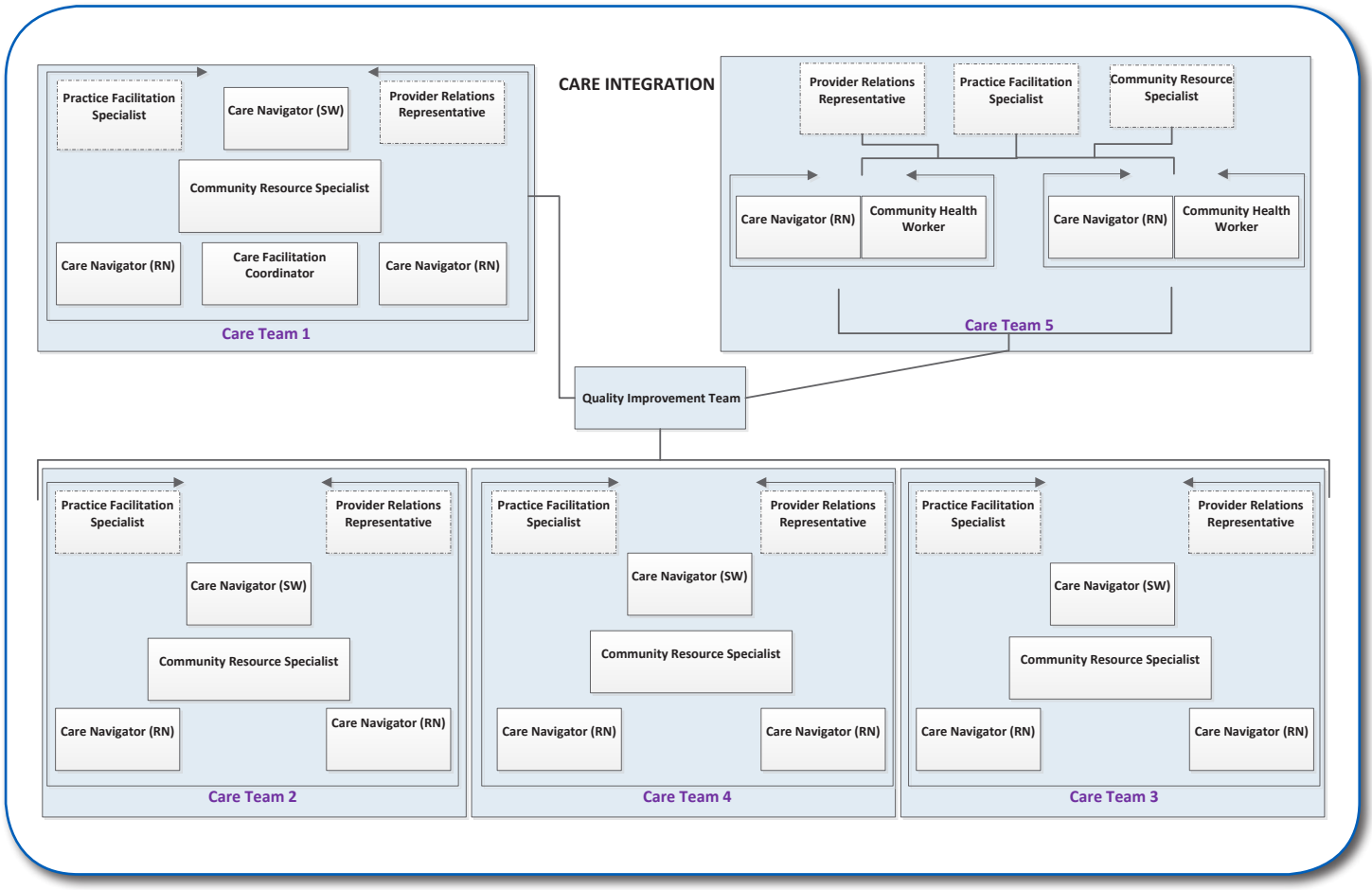
	Initiative	Operational Lead	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Scope & Process	ICS Resources for Spread (Operational Leader, Project Manager)
1	Enhance Community Connections Program and use of Community Engagement Resource Application (C.E.R.A.)	Care Team 4 Community Resource Specialist		X	X	X	Expand collaboration with community organizations, develop a tracking system within C.E.R.A. for maintenance and accuracy of the application, and continue to monitor usage of C.E.R.A both internally and externally.	Care Teams; IT Team; QI Team
2	Evolve Provider Performance Profile process	Quality Improvement Program Manager	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/QI Team; Provider Relations Team
3	Broaden the scope of C.A.R.E Web	Director of Complex Care	X	X	X	X	Broaden the scope of C.A.R.E. Web to include members and providers as part of the care team, provide real-time communication between all Care Team members.	Care Teams; IT Team; Management Team; Provider Relations Team
4	Evaluate Community Health Worker pilot effectiveness	Director of Social Work Care Continuum			X	X	Ongoing pilot with community health workers with shift in focus to include other locations (i.e. schools and community centers) while continuing to monitor interventions to determine the sustainability of the program.	Data Analytics/ QI Team; Management Teams

5	Peform two-year post intervention analysis of NICU post-discharge pilot	Quality Improvement Program Manager			X		Continue NICU pilot and conduct a 2-year post intervention analysis to determine whether to expand the program as a standard offering for all NICU babies, continue the program on a limited scope, or discontinue the program.	Data Analytics/QI Team
6	Implementation of an Intake/ Outreach Care Team	Manager of Care Integration	X	X			Implementation of an Intake/Outreach Team to process prior authorization requests, conduct screening, and outreach to members.	Intake/Outreach Team; Management Team; QI Team
7	Implement call campaign to improve compliance with asthma follow-up	Quality Improvement Program Manager			X	X	Implement automated call campaigns (interactive voice response system) to medium and high-risk members with asthma to encourage follow up with a provider every 6 months.	Data Analytics/QI Team; Provider Relations Team
8	Implement a standardized training software platform for on-going staff education and on-boarding of new staff	Clinical Project Manager			X	X	Develop new staff on-boarding and annual education through Cornerstones program to automate and stream-line processes for more efficient and thorough training modules. Provide routine and additional staff education on cultural diversity and applications in care management.	Care Teams; Management Team; QI Team

8 Appendix

- Care Team Diagram
- Provider Performance Profile
- Kid Care Anywhere

Appendix A: Care Team Diagram



Appendix B: Provider Performance Profile

Pediatric Care Network Report Package Summary

PEDIATRIC CARE NETWORK QUARTERLY REPORT PACKAGE

[Insert Practice Name]

To deliver high-value care which meets the Triple Aim of Better Care, Smarter Spending, and Healthier Children, Pediatric Care Network (PCN) practices must be informed of quality and cost performance for their attributed PCN patients. The PCN Quarterly Provider Practice Performance Profile report package informs practices of their quality and cost performance and provides observations and potential improvement ideas for consideration and review with each practice.

This report package is based on a rolling 13 months of claims from (measurement period).
We are striving to make the information useful, valuable, and actionable. We welcome your feedback!

Provider Practice Performance Profile
Quality Performance Report - *Observations & Potential Improvement Ideas*

Observations and Comments

Performed well in the following areas:

Potential opportunities:

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

Potential Improvement Ideas and Resources for Discussion

How to accomplish:

- Partner with Provider Relations representative to review PCP alignment process and work together to correctly assign patients' PCPs.
- Provide education to practices on coordination of benefits, the importance of billing both primary and secondary insurance and how this could improve HEDIS rates.

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

Observations and Comments

Performed well in the following areas:

Potential Opportunities:

Potential Improvement Ideas and Resources for Discussion

How to accomplish:

- Identify and refer patients with high utilization or high cost to care teams for assessment, identification of barriers to care, and interventions to optimize outcomes.
- Partner with care teams to develop plans to engage with patient and family to identify barriers of care and develop interventions to optimize outcomes (e.g., C.E.R.A.).

Published: [Insert Date]

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Pediatric Care Network Cost and Utilization Report Package

PEDIATRIC CARE NETWORK COST & UTILIZATION REPORT PACKAGE – PRACTICE NAME

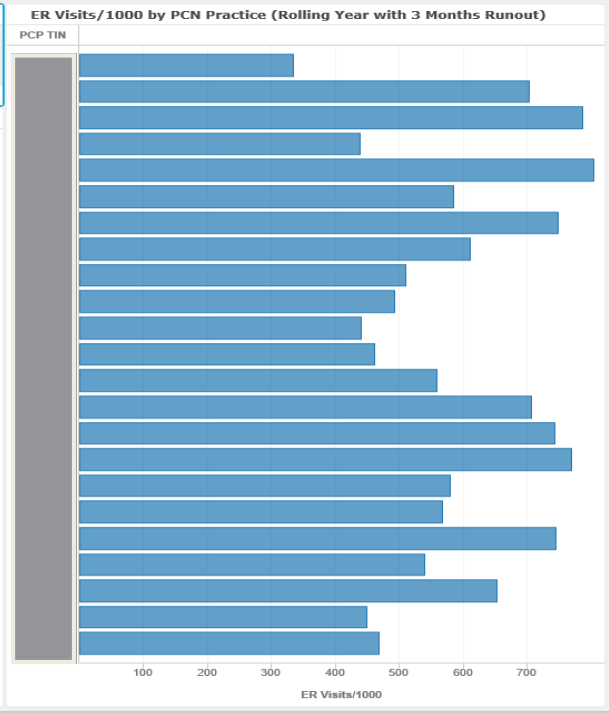
Cost & Utilization Performance – Network and Practice Comparison Report *[Measurement Period: XX/XX/XXXX to XX/XX/XXXX]* *Page 1 of 2*

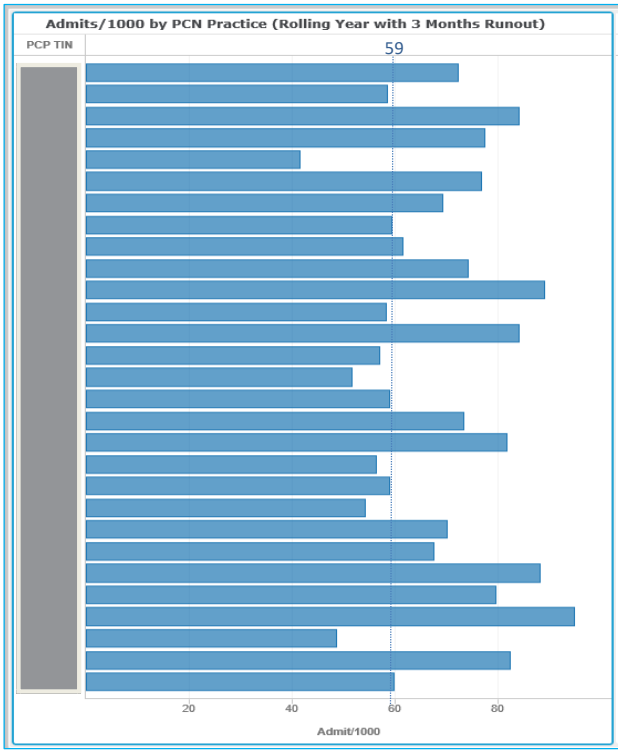
PCN Network Cost & Utilization (Rolling Year with 3 Months Runout)

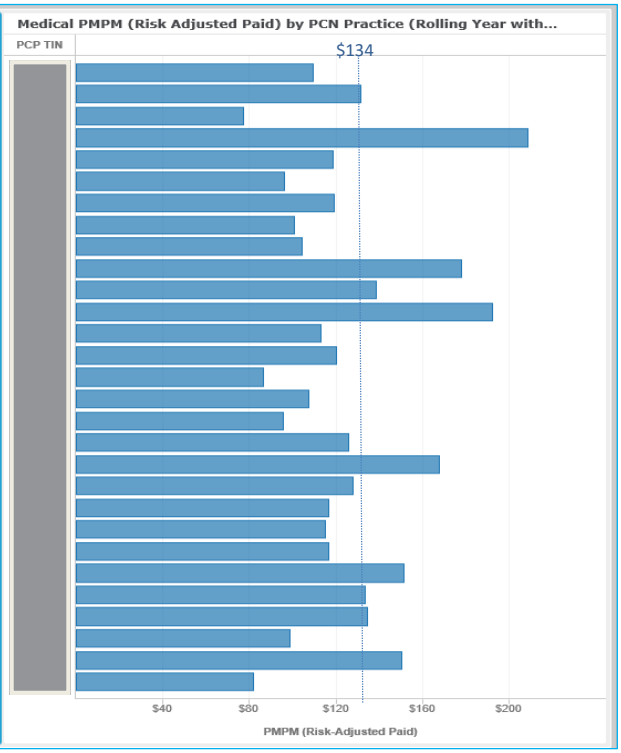
Average Members Per Month	ER Visits/1000	Admissions/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
101,783	604	81	332	$134

Cost & Utilization by PCN Practice (Rolling Year with 3 Months Runout)

PCP TIN	Average Members Per Month	ER Visits/	Admissions	Days/1000	PMPM (Risk-Adjusted Paid Medical)
	47	450	129	1,693	$420
	1,317	788	77	345	$209
	841	611	58	194	$192
	5,927	585	74	332	$178
	320	707	56	250	$168
	10,453	745	88	395	$152
	4,745	749	89	340	$139
	5,166	540	80	310	$134
	4,099	704	59	224	$132
	3,192	743	59	210	$128
	3,276	559	82	326	$126
	562	493	57	201	$120
	1,330	805	69	301	$119
	2,556	439	41	122	$119
	289	654	111	287	$119
	832	771	54	165	$117
	2,253	569	67	259	$116
	1,142	579	70	380	$115
	7,436	510	84	307	$113
	3,991	334	72	316	$109
	7,067	462	59	265	$107
	621	441	52	235	$86
	619	468	60	216	$82







Pediatric Care Network Cost and Utilization Report Package

PEDIATRIC CARE NETWORK COST & UTILIZATION REPORT PACKAGE – PRACTICE NAME

Cost & Utilization Performance – Provider Comparison Report *[Measurement Period: XX/XX/XXXX to XX/XX/XXXX]* *Page 1 of 1*

Practice Cost & Utilization (Rolling Year with 3 Months Runout)

PCP TIN	Average Members Per Month	ER Visits/1000	Admit/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
[redacted]	3,192	743	59	210	$128

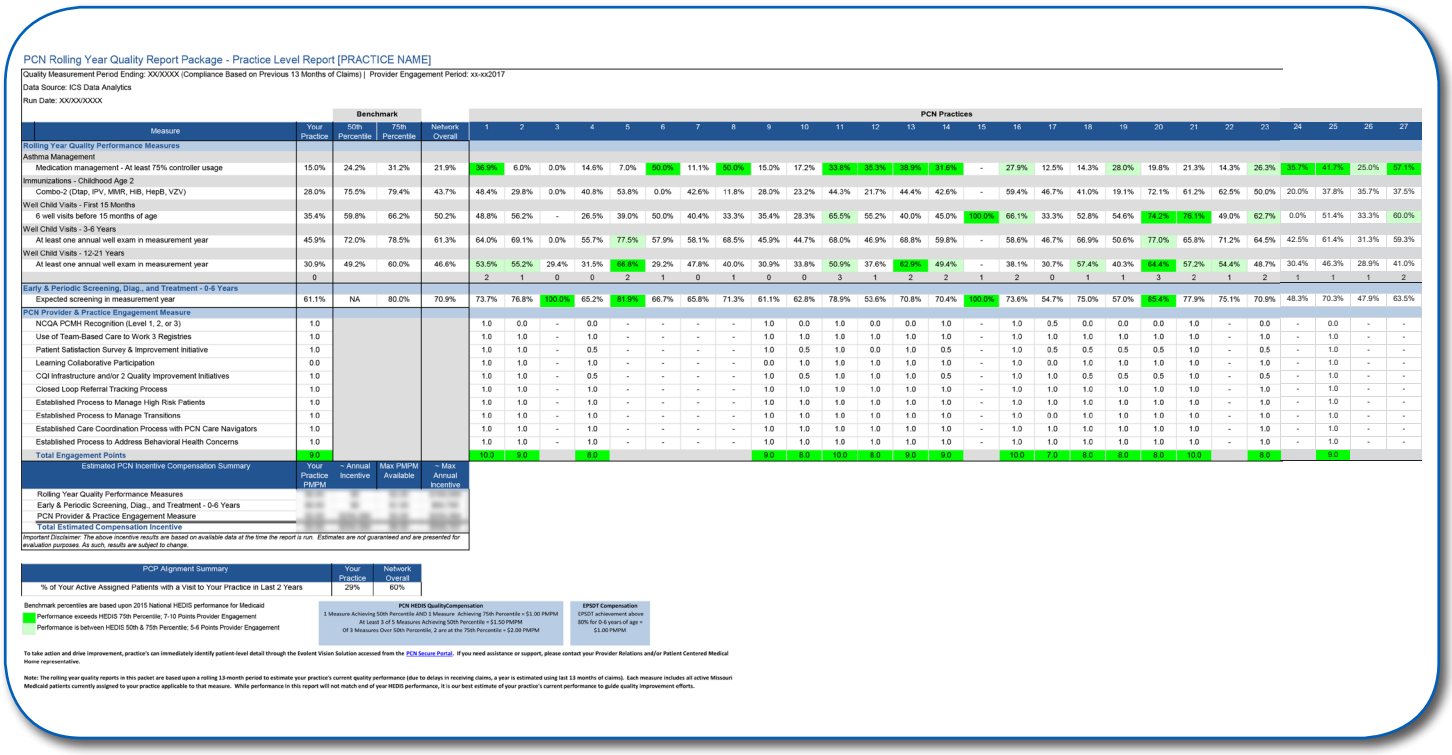
PCN Network Cost & Utilization (Rolling Year with 3 Months Runout)

Average Members Per Month	ER Visits/1000	Admissions/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
101,783	604	81	332	$134

Cost & Utilization by Primary Care Provider (Rolling Year with 3 Months Runout)

PCP Name	Average Members Per Month	ER Visits/1000	Admit/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
[redacted]	1,324	757	72	260	$141
	920	694	46	172	$126
	905	767	55	180	$114
	30	797	33	133	$103
	12	938	0	0	$65
	0	0	0	0	$312

PCN Rolling Year and HEDIS Calendar Year Quality Report Package



PCN Rolling Year Quality Report Package - Practice Level Report [PRACTICE NAME]

Quality Measurement Period Ending: XX/XXXX (Compliance Based on Previous 13 Months of Claims) | Provider Engagement Period: xx-xx2017

Data Source: ICS Data Analytics

Run Date: XX/XX/XXXX

Measure	Your Practice	Benchmark 50th Percentile	Benchmark 75th Percentile	Network Overall	PCN Practices 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
Rolling Year Quality Performance Measures																															
Asthma Management																															
Medication management - At least 75% controller usage	15.0%	24.2%	31.2%	21.9%	36.9%	6.0%	0.0%	14.6%	7.0%	50.0%	11.1%	50.0%	15.0%	17.2%	33.8%	35.3%	38.9%	31.6%	-	27.9%	12.5%	14.3%	28.0%	19.8%	21.3%	14.3%	26.3%	35.7%	41.7%	25.0%	57.1%
Immunizations - Childhood Age 2																															
Combo-2 (Dtap, IPV, MMR, HiB, HepB, VZV)	28.0%	75.5%	79.4%	43.7%	48.4%	29.8%	0.0%	40.8%	53.8%	0.0%	42.6%	11.8%	28.0%	23.2%	44.3%	21.7%	44.4%	42.6%	-	59.4%	46.7%	41.0%	19.1%	72.1%	61.2%	62.5%	50.0%	20.0%	37.8%	35.7%	37.5%
Well Child Visits - First 15 Months																															
6 well visits before 15 months of age	35.4%	59.8%	66.2%	50.2%	48.8%	56.2%	-	26.5%	39.0%	50.0%	40.4%	33.3%	35.4%	28.3%	65.5%	55.2%	40.0%	45.0%	100.0%	66.1%	33.3%	52.8%	54.6%	74.2%	76.1%	49.0%	62.7%	0.0%	51.4%	33.3%	60.0%
Well Child Visits - 3-6 Years																															
At least one annual well exam in measurement year	45.9%	72.0%	78.5%	61.3%	64.0%	69.1%	0.0%	55.7%	77.5%	57.9%	58.1%	68.5%	45.9%	44.7%	68.0%	46.9%	68.8%	59.8%	-	58.6%	46.7%	66.9%	50.6%	77.0%	65.8%	71.2%	64.5%	42.5%	61.4%	31.3%	59.3%
Well Child Visits - 12-21 Years																															
At least one annual well exam in measurement year	30.9%	49.2%	60.0%	46.6%	53.5%	55.2%	29.4%	31.5%	66.8%	29.2%	47.8%	40.0%	30.9%	33.8%	50.9%	37.6%	62.9%	49.4%	-	38.1%	30.7%	57.4%	40.3%	64.4%	57.2%	54.4%	48.7%	30.4%	46.3%	28.9%	41.0%
	0				2	1	0	0	2	1	0	1	0	0	3	1	2	2	1	2	0	1	1	3	2	1	2	1	1	1	2
Early & Periodic Screening, Diag., and Treatment - 0-6 Years																															
Expected screening in measurement year	61.1%	NA	80.0%	70.9%	73.7%	76.8%	100.0%	65.2%	81.9%	66.7%	65.8%	71.3%	61.1%	62.8%	78.9%	53.6%	70.8%	70.4%	100.0%	73.6%	54.7%	75.0%	57.0%	85.4%	77.9%	75.1%	70.9%	48.3%	70.3%	47.9%	63.5%
PCN Provider & Practice Engagement Measure																															
NCQA PCMH Recognition (Level 1, 2, or 3)	1.0				1.0	0.0	-	0.0	-	-	-	-	1.0	0.0	1.0	0.0	0.0	1.0	-	1.0	0.5	0.0	0.0	0.0	1.0	-	0.0	-	0.0	-	-
Use of Team-Based Care to Work 3 Registries	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Patient Satisfaction Survey & Improvement Initiative	1.0				1.0	1.0	-	0.5	-	-	-	-	1.0	0.5	1.0	0.0	1.0	0.5	-	1.0	0.5	0.5	0.5	0.5	1.0	-	0.5	-	1.0	-	-
Learning Collaborative Participation	0.0				1.0	1.0	-	1.0	-	-	-	-	0.0	1.0	1.0	1.0	1.0	1.0	-	1.0	0.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
CQI Infrastructure and/or 2 Quality Improvement Initiatives	1.0				1.0	1.0	-	0.5	-	-	-	-	1.0	0.5	1.0	1.0	1.0	0.5	-	1.0	1.0	0.5	0.5	0.5	1.0	-	0.5	-	1.0	-	-
Closed Loop Referral Tracking Process	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Established Process to Manage High Risk Patients	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Established Process to Manage Transitions	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	0.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Established Care Coordination Process with PCN Care Navigators	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Established Process to Address Behavioral Health Concerns	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Total Engagement Points	9.0				10.0	9.0		8.0					9.0	8.0	10.0	8.0	9.0	9.0		10.0	7.0	8.0	8.0	8.0	10.0		8.0		9.0		

Estimated PCN Incentive Compensation Summary	Your Practice PMPM	~ Annual Incentive	Max PMPM Available	~ Max Annual Incentive
Rolling Year Quality Performance Measures				
Early & Periodic Screening, Diag., and Treatment - 0-6 Years				
PCN Provider & Practice Engagement Measure				
Total Estimated Compensation Incentive				

Important Disclaimer: The above incentive results are based on available data at the time the report is run. Estimates are not guaranteed and are presented for evaluation purposes. As such, results are subject to change.

PCP Alignment Summary	Your Practice	Network Overall
% of Your Active Assigned Patients with a Visit to Your Practice in Last 2 Years	29%	60%

Benchmark percentiles are based upon 2015 National HEDIS performance for Medicaid

Performance exceeds HEDIS 75th Percentile, 7-10 Points Provider Engagement

Performance is between HEDIS 50th & 75th Percentile, 5-6 Points Provider Engagement

PCN HEDIS QualityCompensation

1 Measure Achieving 50th Percentile AND 3 Measure Achieving 75th Percentile = $1.00 PMPM

At Least 3 of 5 Measures Achieving 50th Percentile = $1.50 PMPM

Of 3 Measures Over 50th Percentile, 2 are at the 75th Percentile = $2.00 PMPM

EPSDT Compensation

EPSDT achievement above 80% for 0-6 years of age = $1.00 PMPM

To take action and drive improvement, practice's can immediately identify patient-level detail through the Evolent Vision Solution accessed from the PCN Secure Portal. If you need assistance or support, please contact your Provider Relations and/or Patient Centered Medical Home representative.

Note: The rolling year quality reports in this packet are based upon a rolling 13-month period to estimate your practice's current quality performance (due to delays in receiving claims, a year is estimated using last 13 months of claims). Each measure includes all active Missouri Medicaid patients currently assigned to your practice applicable to that measure. While performance in this report will not match end of year HEDIS performance, it is our best estimate of your practice's current performance to guide quality improvement efforts.

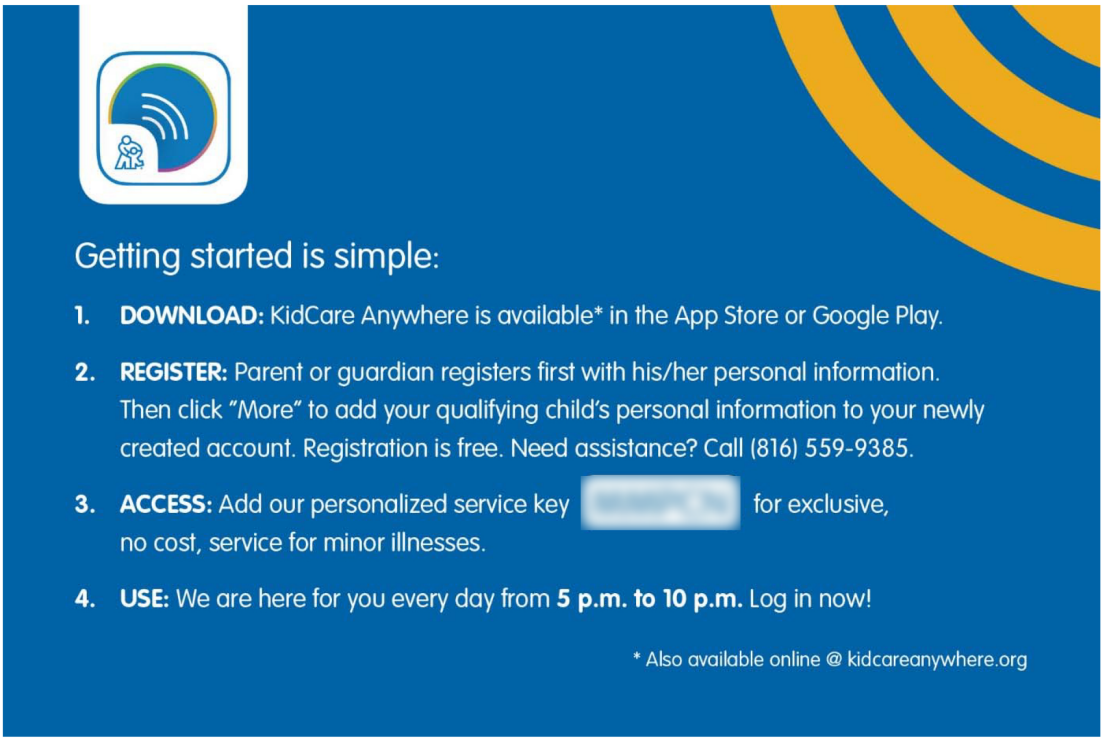
Appendix C: KidCare Anywhere

Children's Mercy KANSAS CITY

KidCare Anywhere CHILDREN'S MERCY

We are excited to share that your child qualifies for a new, no-cost service called **KidCare Anywhere**, which can help you treat your child's minor illnesses without having to leave the comfort of home.

KidCare Anywhere is an app and online service that offers you quick access to a Children's Mercy doctor or advanced practice nurse to help treat your child's non-emergency conditions. They can discuss, provide guidance, and often treat your child's minor ailments and illnesses. They can also send your pharmacy a prescription when needed; AND you can do all of this quickly, easily and conveniently through your smartphone, tablet, or computer!



We hope you take advantage of this easy and convenient option, when your Primary Care Pediatrician is not available.

If you have any questions, please contact us at (816) 559-9385.

KidCare Anywhere