Children's Mercy Health Network

Top Takeaways from the May 2025 CMHN Committee Meetings

May CMHN Committee Content Now Available on Demand – Click Here to View Recording

New AI Podcast: Check Out Short AI Generated Podcast Summarizing May's Meeting! [Powered by Google Notebook[LM]]

Updated CMHN 2025 Incentive Performance Report: Use to Inform 2025 Improvement Efforts!

Click here to review your practice's rolling year performance to inform your quality improvement efforts!

Quality Performance Period:
- Aetna: Oct '23 to Sept '24
- Blue KC: April '24 to Mar '25
- Cigna: Jan '24 to Dec '24

- **Engagement:** Engagement Points Earned by End of 2025.
- **Clinical Quality:** 11 of 28 Practices Achieving 48+ Points Out of 60 Points
- **Cost & Utilization:** 24 of 28 Practices Achieving 25 Out of 25 Points.

TIP: Use the CMHN Quality Improvement Tool Kit to review and access quality improvement strategies and insights for all CMHN incentive measures!

Click here to review the 2025 CMHN Incentive Distribution Framework.

Age 2 Immunization Improvement

- Definition Overview – Age 2 Immunization: Completion of 10 immunization series (DTaP, IPV, MMR, Hib, Hepatitis B, PCV, VZV, Rotavirus, Hepatitis A, and Influenza) by the child's 2nd birthday.
- Continue to Use EMR and Age 2 Catch Up Previsit Planning Report to Support Improvement for 2025!

What is the Age 2 Catch Up Previsit Planning Report? Weekly Automated Report of Blue KC / Aetna Patients with Scheduled Visits in Next 7 Days Requiring an Age 2 Immunization Catch Up Vaccination.

Age 2 Immunization Care Gap Closure (Flu Excluded)

Age 2 Pre-Visit Planning Care Gap Closure Rate (ALL CARE GAPS W/O FLU) for 2/17-3/28 (6 weeks)			
Practice	Total Care Gaps	Total Closed Gaps	Closure Rate
Baby and Child Associates	2	0	0%
Cass County Pediatrics and Adolescents	5	2	40%
Children's Mercy	52	43	83%
Community Choice Pediatrics	19	13	68%
Cradle Thru College Care	3	1	33%
Johnson County Pediatrics	15	15	100%
Leawood Pediatrics	7	3	43%
Meritas Health Corporation	18	7	39%
Pediatric Associates	4	3	75%
Pediatric Care North	1	0	0%
Pediatric Partners	17	17	100%
Premier Pediatrics	2	2	100%
Priority Care Pediatrics	6	6	100%
Shawnee Mission Pediatrics	8	6	75%
Summit Pediatrics	1	0	0%
University of Kansas Pediatrics	18	14	78%
Grand Total	**178**	**132**	**74%**

Approximately 74% of Identified Past Due Care Gaps Were Closed

Over 6 Weeks, 46 Care Gaps Were Not Closed!

- Updated Age 2 Care Gap Closure Rates from 2/17 through 3/28 shown above. The objective of developing and sharing this report is to compare practice performance, identify best practices/barriers, and target opportunities for improvement.

Important Note: Practices not shown here either do not have patients with care gaps, the patient did not attend their most recent visit, OR we did do not have the practice's scheduling data.

New Provider-Level Performance Report Available – Share with Providers / Care Teams to Support Learning & Improvement

Purpose: Quickly Compare Provider Performance Rates

- Relative to Overall Practice Rates and Relative to 2025 Incentive Targets.
- Available for Chlamydia Screening, Age 2 Immunization, Age 13 Immunization, and All Other Incentive Measures.

Arrow Indicates Individual Provider Rate Relative to Overall Practice Rate

Above Practice Rate

Below Practice Rate

Rate is **below** Lower Target (0% of Incentive)

Rate is **exceeding Lower Target (50% of Incentive)**

Rate is **exceeding Middle Target (75% of Incentive)**

Rate is **exceeding the Top Target (100% of Incentive)**

CMHN Practice	Attributed Physician Name	Measure Name	Numer	Deno	Rate	Practice Rate		Targets Low	Mid	Top
[redacted]		Age 2 Immunization Combo 10 (DTaP, HepA, HepB, Hib, I	7	14	50.0%	73.8%	↓	50.6%	59%	66%
		Age 2 Immunization Combo 10 (DTaP, HepA, HepB, Hib, I	8	11	72.7%	73.8%	↓	50.6%	59%	66%
		Age 2 Immunization Combo 10 (DTaP, HepA, HepB, Hib, I	1	1	100.0%	73.8%	↑	50.6%	59%	66%
		Age 2 Immunization Combo 10 (DTaP, HepA, HepB, Hib, I	19	21	90.5%	73.8%	↑	50.6%	59%	66%
		Age 2 Immunization Combo 10 (DTaP, HepA, HepB, Hib, I	5	7	71.4%	73.8%	↓	50.6%	59%	66%
		Age 2 Immunization Combo 10 (DTaP, HepA, HepB, Hib, I	13	14	92.9%	73.8%	↑	50.6%	59%	66%
		Age 2 Immunization Combo 10 (DTaP, HepA, HepB, Hib, I	5	12	41.7%	73.8%	↓	50.6%	59%	66%
		Age 2 Immunization Combo 10 (DTaP, HepA, HepB, Hib, I	10	14	71.4%	73.8%	↓	50.6%	59%	66%

Recommendation: Share Report with Your Providers and Care Teams to Support Learning & Improvement.

Longitudinal Care Management (LCM) – Referral Process and Risk Stratification Overview

What is Longitudinal Care Management (LCM)? Care coordination services that supports patients and families across clinicians, settings, and conditions to keep kids healthy and reduce overall costs.

750% Increase (4 to 34) in LCM Referrals Over Last 2 Months!

Reminder: The 2025 Practice Engagement incentive includes a new Longitudinal Care Management measure.

- Centralized Practices: Refer at Least 0.2% of Blue KC attributed patients over 12 months.
- Decentralized Practices: 100% timely completion of audits.

How do I make a LCM Referral? Use the e-referral form here: https://www.cmics.org/cmreferral. You may also complete the referral form manually and email to LCM@cmics.org or fax to 1-888-670-7260.

- *Important: Log-in to CMICS Portal required. Instructions to create login/reset password included in link above.*

Thank you for your feedback! Improvements to referral form are underway. Member ID is no longer required and working to make referrals available outside of the CMICS Portal.

What is the Purpose of the Monthly LCM Risk Stratification Report?

Provide awareness of high risk Blue KC patients and support referral to LCM services.

What are Ways to Support Referrals to LCM Services?

Tactic #1: Recommend and refer high risk patients with upcoming scheduled appointments. Patients with upcoming appointments are highlighted yellow in the report.	**Tip:** Consider adding a note directly in the patient's chart or connecting with the scheduled provider to make them aware of the eligible patient, discuss/ recommend LCM services during the visit, and potentially refer the patient to LCM services.
Tactic #2: Outreach to patients and recommend LCM services.	**Tip:** Review report and reach out to patients/families who are likely to benefit and likely to engage in LCM services. Use LCM Overview to help recommend services during outreach.
Tactic #3: Schedule annual well visit and then recommend/refer to LCM services.	**Tip:** Outreach to high risk patients in need of their annual well visit to schedule visit. During their well visit, discuss/recommend LCM services and potentially refer the patient for LCM services.
Tactic #4: Any active Blue KC patient is eligible for LCM services.	**Tip:** Referrals can be made for Blue KC patients who are not on the high risk report.

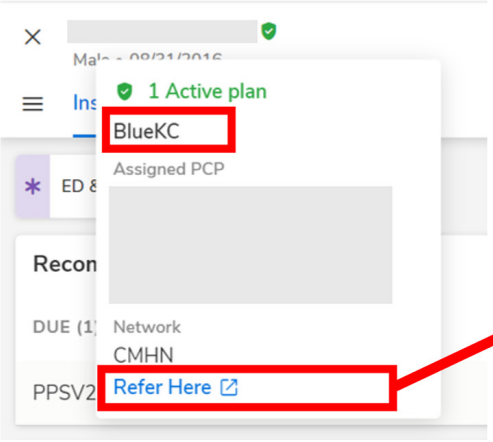
Access the LCM Risk Stratification Reference Guide for an educational resourrce for you and your care teams!

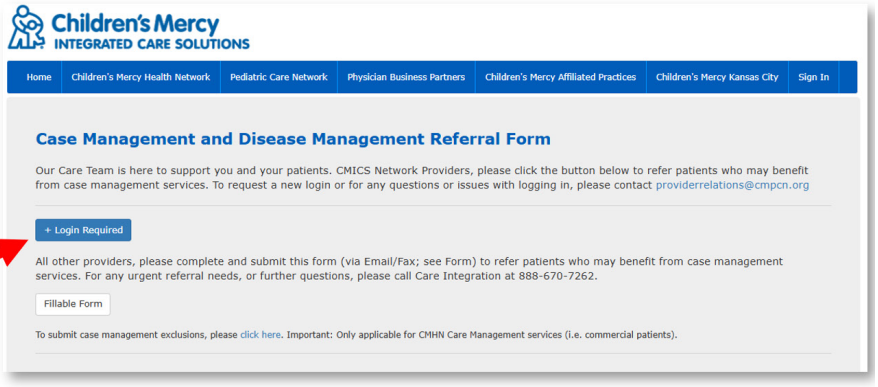
For more information on LCM, please see the LCM Overview or Longitudinal Care Management Manual.

New Innovaccer Enhancements Now Available in Platform!

CMICS Care Management Referral Link

- Refer to Case Management through embedded referral form link within InNote – hover on icon next to the patient's name to show clickable 'Refer Here' link for **Blue KC**, PCN MO, and PCN KS patients.
    - Note: This is the same e-referral form to submit LCM referrals for **Blue KC** patients!

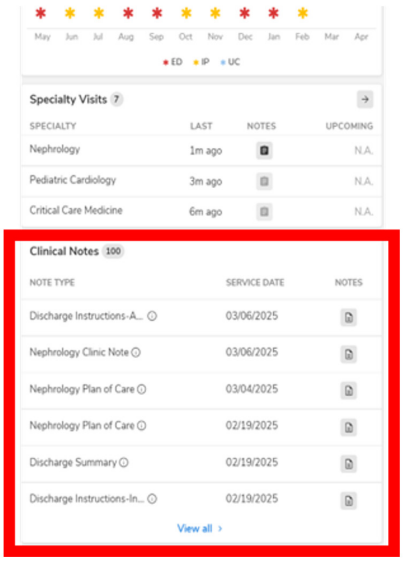




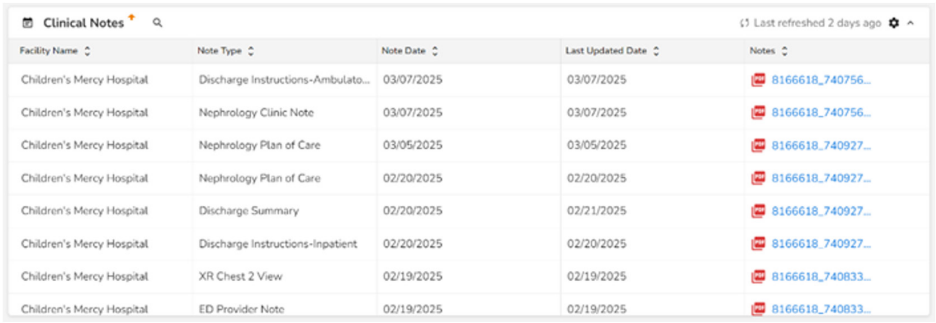
Children's Mercy Clinical Notes Card in InNote and Patient 360 (P360)

- "One-stop" location for all available CMH clinical notes for a particular patient. A key feature of the new card is bringing access to clinical notes not tied to any encounter.
    - Note examples include: ED Crisis Screening Report, Action Plans, Care Coordination Related Notes, Assessments, and many other non-encounter based notes.

InNote View



P360 View



Click to Access Prior Monthly CMHN Committee Takeaways

Questions or Comments? Please ask your Children's Mercy Health Network PHM Network Representative or contact Children's Mercy Health Network staff at ProviderRelations@cmpcn.org.