Children's Mercy Health Network

Top Takeaways from the January 2025 CMHN Committee Meetings

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

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: Apr '23 to Mar '24
- Blue KC: July '23 to June '24
- Cigna: July '23 to June '24

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 View Slide Deck Summary of Proposed Changes. Model to be Finalized in March by CMHN Board.

Key Changes to 2025 Incentive Model:

- Incentive Point Distribution:
  - Adding 5 points to Practice Engagement and removing 5 points from Cost & Utilization Performance to allow for "New" Practice Engagement measure
- Engagement:
  - Practice Engagement now includes a new Longitudinal Care Management (LCM) measure
    - Centralized Practices: Refer at least 0.3% of Blue KC attributed patients over 12 months
    - Decentralized Practices: 100% timely completion of quarterly audits
- Clinical Quality and Cost & Utilization Measures:
  - Same 11 clinical quality measures and 2 cost/utilization measures as 2024
- Targets:
  - Two-tiered quality targets for all measures except new Age 2 Immunization measure
    - Lower target set to 75th percentile | 50% of incentive earned
    - Top target set to 90th percentile | 100% of incentive earned
  - Three-tiered quality targets for new Age 2 Immunization measure
    - Lower target set to 50th percentile | 50% of incentive earned
    - Middle target set to 75th percentile | 75% of incentive earned
    - Top target set to 90th percentile | 100% of incentive earned
  - Clinical quality measures have updated targets to align with HEDIS benchmark updates
    - All 11 clinical quality measures (including SDOH Screening & SDOH Positivity) equally weighted: each measure worth 5.5 incentives points
    - SDOH Screening target remains the same: 70%
  - Both cost/utilization measure targets remain the same, but each measure is now worth 12.5 points (previously 15 points)
- Health Equity Bonus Incentive Opportunity: *Builds upon previous Health Equity work to achieve demonstrated improvement in collection of REL data by striving for an industry best practice rate under 5%*
  - End of Year Race Unknown Rate:
    - >7.5% and ≤ 10%: 1 Bonus Point
    - > 5.0% and ≤ 7.5%: 2 Bonus Points
    - ≤ 5.0%: 3 Bonus Points
  - What's New/Different?: Recalibrated to Maximum of 3 Points (versus 6 Points)
- Age 2 Improvement Bonus Incentive Opportunity: *Allows all practices the opportunity to achieve additional points for improvement in measure performance*
  - 2.5 incentive bonus points for every 5% point improvement (compares final CY2025 rate to final CY2024 rate)
    - Max of 10 additional bonus points
    - Applied to overall incentive model so can be used to offset lower engagement, quality, and/or cost/utilization performance

Age 2 Immunizations – Use EMR Tools / Age 2 Catch Up Pre-Visit Planning Report to Support Improvement for 2025!

Definition Overview – Age 2 Immunizations:
Completion of 10 immunization series (DTaP, IPV, MMR, Hib, Hepatitis B, PCV, VZV, Rotavirus, Hepatitis A, and Influenza by the child's 2nd birthday.

Age 2 Catch Up Pre-Visit Planning Report (Started Sending in August 2024):
Weekly Automated Report of Blue KC / Aetna Patients with Schedule Visits in Next 7 Days Requiring an Age 2 Immunization Catch Up Vaccination

- To assess % of care gaps closed after inclusion in pre-visit planning report, a new care gap closure report was developed. Results for 5 weeks of confirmed visits shared below. The objective of developing and sharing this new care gap closure report is to compare practice performance, identify best practices/barriers, and target opportunities for improvement.
  - Key Findings:
    - Approximately 50% of identified past due care gaps were closed, leaving substantial opportunity for improvement!
    - 83% of the past due care gaps not closed/ missed during the scheduled visit were Influenza Vaccine.

Age 2 Immunization Care Gap Closure

Age 2 Pre-visit Planning Care Gap Closure Rate (ALL CARE GAPS) for 11/25-12/27 [5 Weeks]

Practice Name	Total Care Gaps	Care Gaps Closed	Closure Rate
Cass County Pediatrics and Adolescents	1	0	0%
Children's Mercy	33	15	45%
Cockerell & McIntosh Pediatrics	6	1	17%
Community Choice Pediatrics	57	17	30%
Cradle Thru College Care	3	1	33%
Health Care for Children	2	0	0%
Johnson County Pediatrics	14	12	86%
Leawood Pediatrics	7	0	0%
Meritas Health Corporation	68	27	40%
Pediatric Associates	31	21	68%
Pediatric Care North	1	0	0%
Pediatric Partners	37	21	57%
Priority Care Pediatrics	45	16	36%
Summit Pediatrics	10	3	30%
University of Kansas Pediatrics	126	69	55%
Grand Total	441	203	46%

Approximately 50% of Identified Past Due Care Gaps Were Closed

Over 5 Weeks, ~240 Care Gaps Were Not Closed!

***Reminder**: Only 140 Additional Patients to Meeting Age 2 Immunizations 90th Percentile Target*

What Can Practices and/or Network Do to Increase Closure Rate?

What's a Reasonable Improvement Target for Closure?

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.

Longitudinal Care Management (LCM) – Common Referral Triggers & Referral Process

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.

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

- Centralized Practices: Refer at least 0.3% of Blue KC attributed patients over 12 months
- Decentralized Practices: 100% timely completion of quarterly audits

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CMHN Longitudinal Care Manager

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What conditions/factors would warrant a referrals for LCM? See above for common referral triggers and contact information for the CMHN Longitudinal Care Manager.

How do I make a LCM Referral? Use this web form – https://www.cmics.org/cmreferral
Important: Log-in to CMICS Portal required. Instructions to create login/reset password included in link above.

For more information, please see the Longitudinal Care Management Manual.

"Talk with Me Baby" Research Opportunity
Language Nutrition in Primary Care

For young children, early learning experiences are important for development and academic success. Providing education for parents about how to promote early learning opportunities is one way to support early child development. The *Talk With Me Baby* study will look at how information can be shared during well-child visits to help support early child development. We also hope to see whether the information health care provider's share helps parents learn more about supporting their child's development.

TALK WITH ME BABY

How *Talk With Me Baby* Fits Well-Child Care

- Efficient, evidence-based tools for language promotion
- Integrates into existing practices with no extra time required
- Improves quality of parent-child interactions
- Strongest predictor of academic success is quality of interactions

Your Role as a Clinic Partner in *Talk With Me Baby* Study

- Receive *Talk With Me Baby* training | 2 hours CME/CNE
- MOC Part 4 Credit opportunities
- Use *Talk With Me Baby* in well-child visits for 2 years
- Share feedback | 2-min survey 3x/year & 10-min survey at end
- Receive incentive for training and survey completion

Contact: Brenda Salley, bsalley@kumc.edu, talkwithmebaby.kumc.edu

Looking for 8 partner clinics to pioneer this study! Interested?

SCAN ME!

See *Talk With Me Baby* Flyer HERE for more information.

Blue Cross Value-Based Programs Spring Forum – Advancing Equity in Health: An Interactive Theater Event

Blue Cross and Blue Shield of Kansas City is sponsoring an interactive and innovative implicit bias training. Special guest Sharla Smith, PhD, MPH, will explore the impact of chronic stress due to inequities. In addition, the Racial Equity Collaborative will lead scripted health scenarios that will enable participants to practice complex conversations and interrupt identified bias recognized by audience members.

See invitation linked HERE.

Space is Limited.

Register Today!

Scan the QR code or visit
https://bit.ly/4eKX3NQ

For more information, contact
Tia Kennedy at Tia.Kennedy@BlueKC.com
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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.