Top Takeaways from the March 2017 CHN Committee Meetings

Blue KC Value Based Agreement Updates

Monthly Blue KC Payments Shift to Performance Based Incentive

Starting in July 2017, the incentive payment shifts from a Care Coordination Fee (CCF) to a Performance Based Incentive (PBI) based on 2016 performance.

$625k annualized CHN incentive → July 2017 → Estimated $1.2M Annualized PBI Incentive

- Each practice's 2016 calendar year performance is expected to be available to CHN in May 2017.
- What is my practice's estimated performance based on historical results?
  Click to view Blue KC Quality & Cost Performance Report.

Blue KC Data Integration into CHN's Population Health Technology Platform on Track for May 2017

Blue KC data will allow CHN practices to evaluate current Blue KC performance and target attributed Blue KC patients with gaps in care (e.g. 12-12.5 year olds in need of HPV immunization to exceed the 14% incentive target) to drive improvement in each Blue KC incentive measure.

On track to be available May, 2017

More information and training to be provided in May/June 2017.

CHN Network Operations Dashboard – Thank You!

The following dashboard highlights CHN accomplishments in the past 3-6 months and sets the stage for upcoming activity. Collectively, the network continues to advance our capabilities and resources to deliver on our objective of higher quality and more cost effective care for our patients!

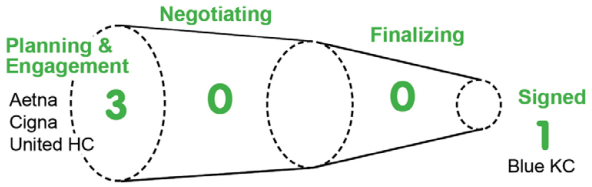
CHN NETWORK OPERATIONS DASHBOARD

935 Providers

17 Organizations

185 Primary Care Providers 750 Pediatric Specialists

Contract Pipeline



Covered Lives

Highlights

- Finalized First CHN Value-Based Agreement, Effective Jan 1st 2017 (Blue KC; ~30,000 patients)
- Enhanced CHN Communication with All CHN Primary Care Providers (Nov 2016)
- Initiated Patient-Centered Medical Home Care Model Implementation (Jan / Feb 2017)
- Successfully Piloted Valence Pre-Visit Planning Functionality with 2 CHN Practices (Feb 2017)
- Implemented CHN Patient Experience Operating Model (Jan - March 2017)
- Initiated Plan to Increase CMH Specialty Engagement via Relevant Pediatric Primary Care Topics (Feb / March 2017)

Upcoming Activity

- Advance Value-Based Agreements with Other Commercial Payers (Cigna, Aetna, United Healthcare)
- Complete Integration of Blue KC Data into CHN's Population Management Data Infrastructure
- Pilot and Deploy use of CHN's Patient Outreach Functionality
- Continue to Advance PCMH Care Model Transformation
- Develop CHN Membership Accountability Framework

Patient-Centered Medical Home (PCMH) Expectations

What are the Expectations and Requirements?

CHN practices are in the process of initiating and/or continuing the PCMH journey for 2 key reasons:

1. Research & evidence have demonstrated the PCMH care model improves quality and helps controls costs.
2. Commercial payers such as Blue KC are requiring PCMH care models for participation in value-based agreements.

PCMH/Patient Experience Account for ~$1.1 Million (over 40%) of Blue KC's Maximum Annual Performance Incentive

CHN is focused on measuring the "true" implementation of PCMH concepts and competencies integrated into the daily workflow of your clinic. As a result, CHN has developed the updated PCMH progress summary report shown below to reflect what actually occurs within your practice on an ongoing basis.

- CHN does not require NCQA PCMH certification (practices may decide to pursue on their own).
- Click to View the complete CHN PCMH Summary and Detail Report

So what are the PCMH Performance Expectations of Each CHN Practice?

Practices must progress through the PCMH journey through 2017 and demonstrate engagement, improvement, and sustainability. Practices do not have to fully integrate 100% of all PCMH principles by end of 2017!

CHN's PCMH team will be working with your practices to support you on this journey.

	PCMH Concepts						
	TC	KM	AC	CM	CC	QI	
Children's Health Network Practice	Team-Based Care	Know & Manage Patients	Access & Continuity	Care Management & Support	Care Coordination & Care Transitions	Measure & Improve	Overall % of Competencies Fully Integrated
	100%	60%	100%	0%	33%	0%	55%
	100%	40%	0%	0%	33%	0%	40%
	100%	40%	0%	0%	33%	0%	40%
	100%	100%	50%	100%	33%	33%	75%
	0%	0%	0%	0%	0%	0%	0%
	100%	60%	100%	0%	33%	0%	55%
	100%	40%	0%	0%	33%	0%	40%
	100%	100%	50%	100%	33%	33%	75%
	100%	60%	100%	0%	33%	0%	55%
	100%	40%	0%	0%	33%	0%	40%
	100%	100%	50%	100%	33%	33%	75%
	100%	60%	100%	0%	33%	0%	55%
	100%	40%	0%	0%	67%	0%	45%
	100%	100%	50%	100%	33%	67%	80%
	100%	100%	100%	100%	33%	67%	85%
	0%	0%	100%	0%	0%	33%	15%
	100%	40%	0%	0%	33%	0%	40%
	100%	100%	50%	100%	33%	33%	75%
	100%	60%	100%	0%	33%	0%	55%

Last Updated 03/10/2017

Patient-Centered Medical Home Concepts Summary

Team-Based Care [TC]	Continuity, medical home responsibilities, team-based care…
Knowing & Managing Your Patients [KM]	Same day appointments, 24/7 access to clinical advice, electronic access, medication management, use of community resources…
Access & Continuity [AC]	Same day appointments, 24/7 access to clinical advice, electronic access, empanelment management…
Care Management & Support [CM]	Care management identification, care planning & self-care support, joint care plans, …..
Care Coordination & Care Transitions [CC]	Coordinate care transitions (IP discharges, ED visits), test tracking & follow up, referral tracking & follow up…
Measure & Improve [QI]	Measure clinical quality performance, measure patient/family experience, measure resource use & care coordination, prioritize continuous quality improvement using benchmarks, ….

- 100% of core competencies are implemented and fully integrated into clinic workflow and operations.
- >=50% of core competencies are implemented and fully integrated into clinic workflow and operations.
- 1-49% of the core competencies are implemented and fully integrated into clinic workflow and operations.
- 0% of the core competencies are implemented and fully integrated into clinic workflow and operations.

Click to Access Prior Monthly CHN Committee Takeaways

Questions or Comments? Please ask your Children's Health Network committee member representative or contact Children's Health Network staff at ProviderRelations@cmpcn.org.