Pediatric Care Network

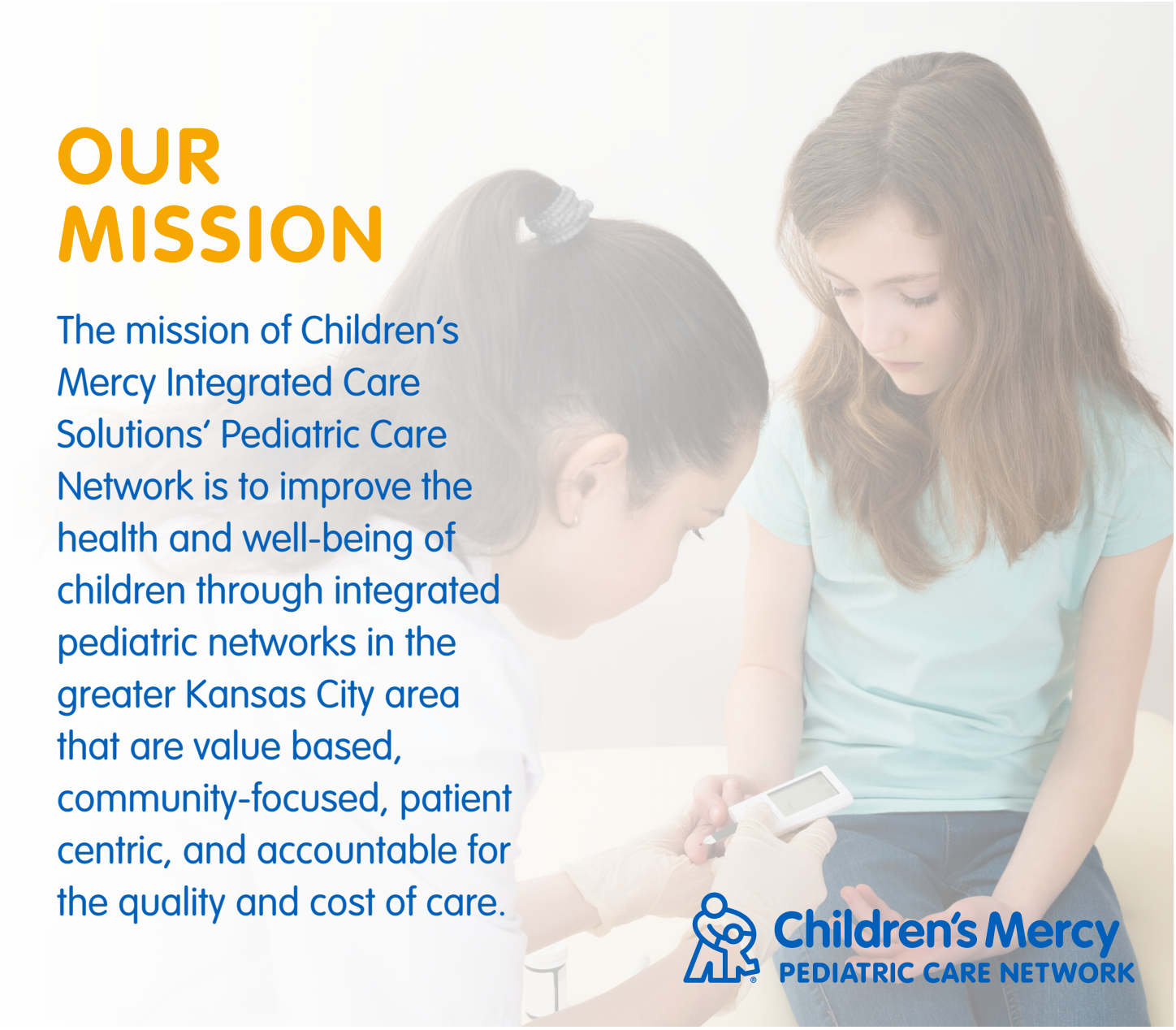
ANNUAL REPORT

CALENDAR YEAR 2024

Children's Mercy
PEDIATRIC CARE NETWORK

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
PEDIATRIC CARE NETWORK

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OVERVIEW & POPULATION ANALYSIS

Case Management • Utilization Management • Disease Management

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

- Assessing member needs and developing patient-centered care plans and interventions
- Negotiating, procuring, and coordinating services and resources for patients and families with complex needs
- Ensuring and facilitating the achievement of quality, clinical, and cost outcomes
- Resolving patterns of issues that have negative quality or cost impact

The PCN performs delegated medical management functions under capitated risk agreements with Medicaid managed care organizations in Missouri and Kansas. To support the work, PCN employs a diverse skillset of staff, including registered nurses, licensed social workers, mental health professionals, respiratory therapists, medical directors, and non-clinical staff to support medical management and practice transformation work. Through value-based contracts, providers agree to engage with 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.

PCN Population Profile - Overview of the Patients We Serve!

186,131 members enrolled

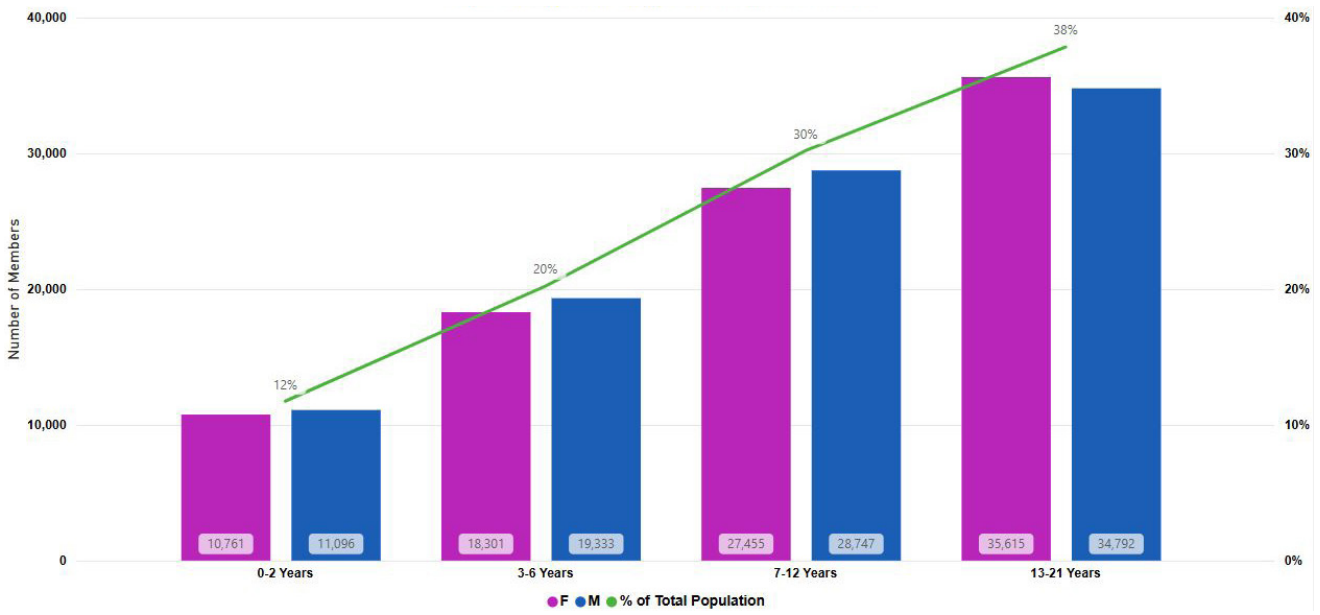
88,271 members served by Care Integration

40.4% of population have a chronic condition

9% of the population have Anxiety or Depression

8% Asthma, **7%** ADHD, **3.5%** Obesity

2024 PCN Member Age & Gender Distribution



Pediatric Care Network Value Highlights

95%

of providers indicated a positive experience

3%

average increase in HEDIS measure compliance for:

- Infant Well Child Visits
- Age 3-21 Well Child Visits
- Asthma Medication Ratio

2%

increase in Age 2 and Age 13 Immunizations

7%

increase in Lead Screening

UTILIZATION MANAGEMENT

> PCN team continues making a great & positive impact for the families they serve! I have been working with the PCN team for a number of years, and they are always a pleasure to work with.
>
> -- Network Provider

The Pediatric Care Network performs prior authorization, inpatient review, discharge planning, and transitional care planning with a multidisciplinary team comprised of clinically licensed and non-licensed staff. Eligibility verification, authorization entry, and authorization outcome communication with providers are functions of non-clinical staff. Clinical staff, with the support of the medical director(s), perform medical necessity reviews using internal protocols, state criteria, and Milliman Care Guidelines®. Staff and peer audits are conducted quarterly and PCN monitors satisfaction for both members and providers related to care delivery.

PCN monitors use of preventive services, outpatient services, PCP office-based services, as well as utilization of high-cost services such as inpatient and emergency department trends. This tracking of utilization trends for the

population contributes to identification of under- and over-utilization of services.

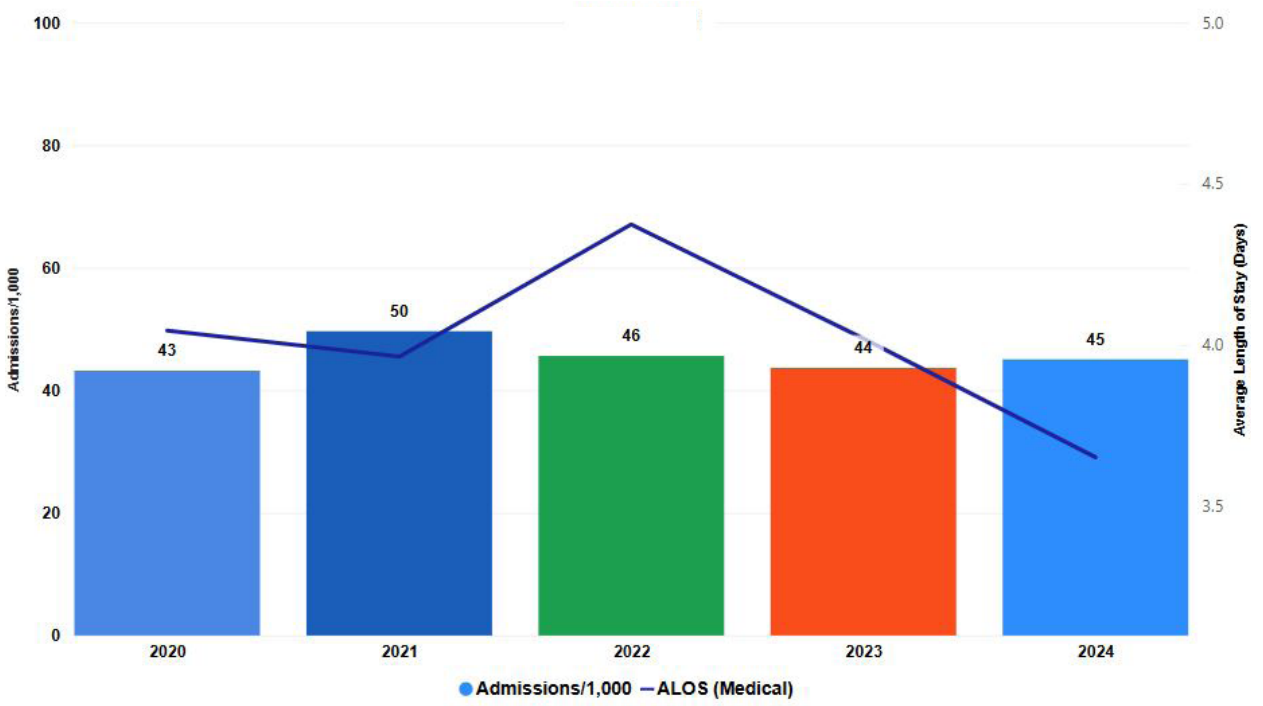
2024 Accomplishments

- Revised the authorization process for complex in-home services requests specific to private duty nursing and personal care services, effectively reducing barriers to accessing care and increasing parity with health plan processes.
- Evaluated effective processes for addressing retroactive changes in member eligibility and implemented changes to increase accuracy in prior authorizations.
- Updated the frequency of the daily hospital notification report from once daily to twice daily, supporting more streamlined notification to facilities regarding determination details.
- Implemented an automated notification to the appropriate health homes for admissions and discharges for identified health home members.
- Revised the inpatient discharge process to better identify and support transitional needs.

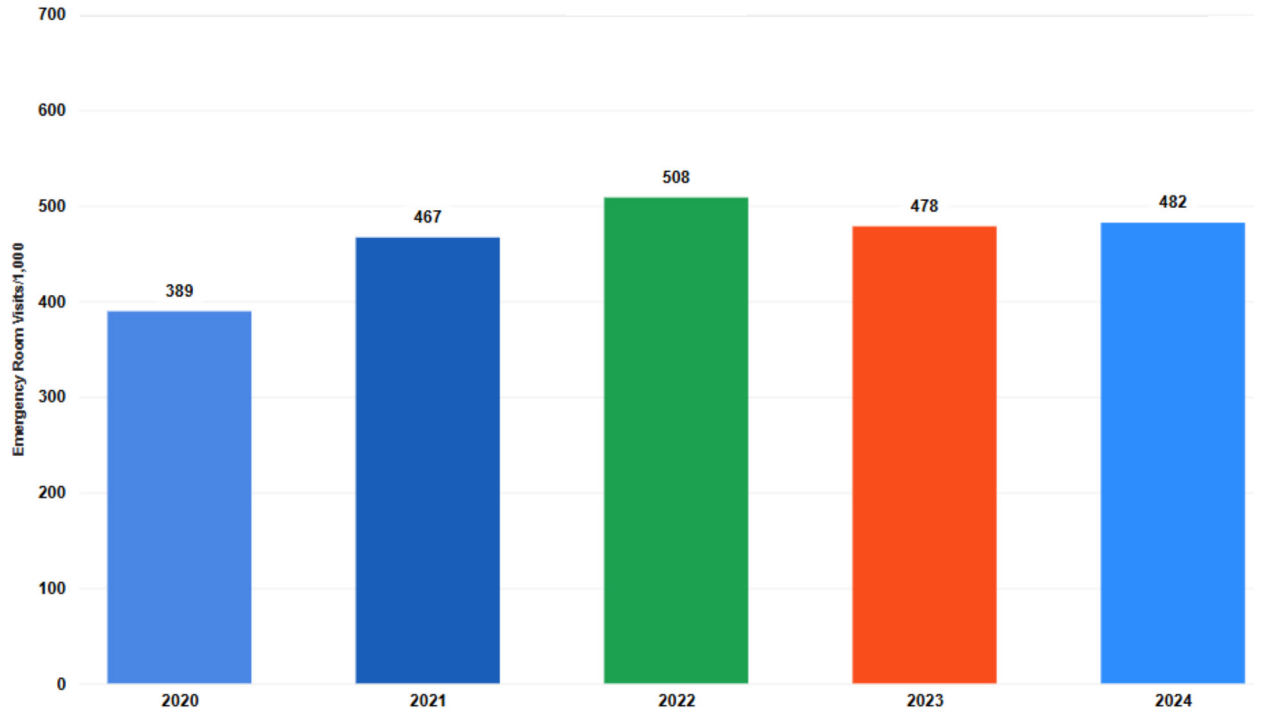
2025 Initiatives

- Enhancing data transparency regarding turnaround time frames to support timely processing.
- Full scale development and build of Healthy Blue Kansas authorizations to onboard a new health plan.
- Development of a Missouri specific process for PRTF prior authorization requests.
- Expanded implementation of Child and Adolescent Level of Care Utilization System (CALOCUS)/Level of Care Utilization System (LOCUS) and Early Childhood Service Intensity Instrument (ECSII) tools to guide determination of behavioral health authorizations.

PCN Utilization Admissions / 1,000
2020-2024



PCN Utilization Emergency Room Visits / 1,000
2020-2024



Success Story

PCN identified a member discharged with a new ostomy that was struggling to obtain necessary supplies. Without these supplies the member was at risk for unnecessary readmission. PCN identified an error in state systems that incorrectly indicated the billing code for the needed supplies as non-payable. Working with the ordering provider, medical supply company, healthplan, and state partners, PCN was able to ensure the member obtained the necessary supplies. With this error escalated, and rectified, PCN has also ensured future members do not face this barrier.

12,516
Prior authorizations completed in 2024

23%
of inpatient admissions related to behavioral health for plans where PCN provides holistic management

440 Average calls per month

11 Seconds
Average speed to answer

1.6%
Average call abandonment rate

CASE MANAGEMENT & DISEASE MANAGEMENT

Case Management and Disease Management

Case management (CM) and disease management (DM) are the central components of the care integration program. With a strong focus on continuity of care and alignment for improving health outcomes, the care integration teams work closely with the member's primary care provider, specialists, and other care providers. The CM and DM programs help members sustain or regain optimal health and reduce overall healthcare costs. Close coordination with the full care team creates a more robust assessment of the member's medical, social, and behavioral needs and facilitates support for available benefits and resources, and development while facilitating implementation of specific interventions to achieve optimal outcomes for members.

The CM/DM processes use data from a combination of claims data, hospital encounters, pharmacy utilization and/or lab test to identify members who are likely to benefit from care coordination support. Populations identified through these means can be organized and prioritized by chronic condition, high utilization, risk score, or gaps in care. Case management incorporates data from risk and post-hospital discharge screenings, assessments, care planning, and multi-disciplinary care coordination. These activities inform case types, level of complexity, and interventions required to achieve identified goals for whole person care. In 2024, 94% of cases required complex case management. Common conditions in complex case management include pregnancy, behavioral health, asthma, autism, lead, and diabetes. Quarterly audits are completed on all programs and multidisciplinary case reviews occur regularly. These forums enhance quality and promote consistency in the application of best practice for case management.

3,786
members identified for case management

217 days
average time to resolution

Decrease of 22 days compared to 2023

59%
of member-driven goals achieved in year

43.5%
of enrollees achieved all goals

587
new enrollments in case management

10%
of enrollees identified for a Behavioral Health need

Disease Management

Well established DM programs for Asthma and Diabetes were expanded to include Weight Management and Depression in 2023. Depression programs are specific to plans where PCN manages behavioral health needs for the population. Using a unique approach to manage chronic conditions, PCN's disease management (DM) program incorporates close collaboration between the primary care provider and the care team. Rather than relying exclusively on phone consultations or patient education materials, care integration staff form personal relationships with primary care providers (PCP's) to help them implement comprehensive disease management in their offices. Care navigators proactively engage high-risk members to provide education, support medication management, develop disease-specific care plans, and assist members and caregivers in successful condition management. By identifying members with a chronic disease early and partnering with their treating provider(s), they can be proactive in promoting activities that help maintain good control of their illness and lower acute care utilization.

25,000+ members followed by Disease Management

8% Asthma prevalence in population

3.5% Obesity prevalence in population

3% Depression prevalence in population

0.5% Diabetes prevalence in population

335 members agreed to participate in complex case management with a condition-specific asthma, diabetes, or obesity need.

102 members agreed to participate in complex case management with a condition-specific behavioral health need.

Transitional Care Program

The PCN's Transitional Care Program facilitates a seamless transition from inpatient to home and community settings. This program includes post-discharge phone calls to members and caregivers focused on assessing and screening for barriers to care following inpatient admission. If needs are identified, the care team works in partnership with the member's PCP to address immediate barriers to care such as access to medications, home services, transportation, and appointment scheduling. Members with long term, ongoing needs for case management are referred to a care navigator for additional support.

2,613 admissions identified for follow-up

62% of members successfully contacted

5.6% subsequently enrolled in care management for additional support

Patient Success Stories

Ricky is a 14 year old child in foster care supported by Crystal, PCN Behavioral Health Care Navigator. He was discharged from a psychiatric residential treatment facility (PRTF) to live at a youth ranch. Aggressive and unsafe behaviors resulted in multiple changes in living arrangements and created challenges in staying connected to community behavioral health resources. Crystal helped his guardian to resubmit for PRTF support and was successfully admitted following a 2 month wait. Ricky completed 9 months of treatment, graduating high school and starting college all while at the PRTF! He successfully transitioned to a foster home with continued follow up supports and is learning how to drive.

Connie was recently diagnosed with Ulcerative Colitis and had surgery for an ostomy following a long hospital stay. Erik, PCN Care Navigator, called to check on discharge needs and identified ostomy supply issues. Working with Connie's doctors and the medical supply company, all the needed supplies were shipped except for one item. Erik continued to partner with the health plan and discovered a state system error in the billing process. Once this was corrected, Connie was able to receive the missing supply item and successfully care for her new ostomy.

A playset in your backyard is every 8 year old's dream. Annie has autism and struggles with eloping which made playing outside challenging. Renae, PCN Community Resource Specialist, worked with community partners and identified funding to build a backyard playset! Annie is now able to exercise and safely play with her family.

2024 Accomplishments

- Enhanced co-management of complex medical and social needs members through expansion of the community resource specialist role in case goal management.
- Aligned assessment process and tools for Social Determinant of Health screenings with PCN network practices.
- Reorganized maternity case management processes to align with state and MCO practices inclusive of incorporating new Missouri Notification of Pregnancy processes.
- Expanded relationships with Children's Mercy Endocrinology Clinics to increase collaboration around members with complex needs.
- Successful sunsetting of previous MCO partner relationship which included a smooth transition of all impacted Case Managed members to new health plan.

2025 Initiatives

- Expand current Cerner hand-off processes to formalize referrals and information sharing from PCN to other CMH teams inclusive of Rheumatology and Neurology
- Expand behavioral health case management and depression disease management to United Healthcare Community Plan of Kansas.
- Increase face to face member contact in alignment with contract requirements.
- Re-align case leveling to ensure identification of most at need populations.

POPULATION HEALTH MANAGEMENT

Population Health Management (PHM) refers to the process of improving health outcomes for groups of people with shared needs through improved clinical processes, care coordination, and patient engagement. The process is supported by data analytics and technology across an integrated system of care in which best practices can be identified and disseminated across collaborative networks. The PHM network team works with community practices to educate and support them with Medicaid coverage, eligibility issues, claims resolution, and regulatory changes, as well as quality/cost improvement initiatives and HEDIS measure improvement.

Practice Transformation

The PCN network of providers participate in a value-based incentive program that provides the practice with a per member per month capitation incentive for reaching identified quality goals for metrics such as well child exams and immunizations. The PCN value-based model goes beyond traditional pay-for-performance programs, as it incorporates not only HEDIS/NCQA quality performance metrics, but also engages participating practices in population health strategies, regular clinical quality meetings, learning collaborative sessions, and triannual practice performance reviews. The program also evaluates cost & utilization performance via a risk adjusted avoidable ED visit measure and a shared savings opportunity based on total cost of care. Recognizing the importance of delivering whole person care, the value-based model includes goals to screen for social determinants of health for over 50% of patients and also supports more accurate collection of patient/family demographics

to support efforts to identify and address health disparities. PCN representatives also provide training and support in patient centered medical home principles, a key component in population health management.

In partnership with ICS Operations, the Population Health Management Network Team has worked with the practices over the years to focus on several HEDIS quality improvement efforts, including chlamydia screening, lead screening, and age 2 immunizations. These measures have shown a steady rise compared to other Medicaid populations. Key performance improvement activity has included transparent practice-level reporting, targeted weekly pre-visit planning reports, and in-depth care team meetings to understand and improve clinical workflows. Chlamydia screening has averaged 8% higher, lead screening 5-6% higher, and improvement in age 2 immunizations continues. In addition, all pediatric well visit HEDIS measures have continued to stay above average.

2024 Accomplishments

In 2024, the PHM team helped target several quality and practice improvement initiatives with PCN contracted provider offices, including:

- For the past several years, PCN has invested in the technology, people, and processes to move beyond social need screening to perform closed-loop social need referrals. PCN has integrated our social need referral platform Lift Up KC (www.liftupkc.org | Powered by findhelp.org) into the clinical workflows of both Children's Mercy Hospital system (via Cerner) and community pediatric practices (via Innovaccer). Most importantly, PCN has established formal partnerships with full-service community-based organizations (CBOs) distributed across the Kansas City metropolitan area. In exchange for funding, these organizations help to complete closed-loop social need referrals, working with families to address food insecurity, lack of transportation, inadequate housing, unemployment, etc. Highlights of 2024 activity

include a sustained rate of monthly referrals of approximately 300 per month, use of Lift Up KC by over 900 care team users, over 20,000 Lift Up KC hits by internal/external users, and a successful pilot and recruitment of Catholic Charities of Northeast Kansas as an official partner of PCN's trusted CBO network. PCN also implemented technology workflow improvements that streamlined data entry and supported better integration of referrals across Children's Mercy Hospital and community pediatric practices. To top it all off, PCN's closed-loop social need referral strategy was recognized as a KLAS Social Determinants of Health Points of Light Case Study in October 2024.

Patient Success Stories

A single mom with four kids needed help with rent assistance. Her toddler was diagnosed with level 3 autism last year, forcing her to quit her job. The program was able to help the mom with past due rent payments and also enrolled her in an employment assistance program to help find a work-from-home job.

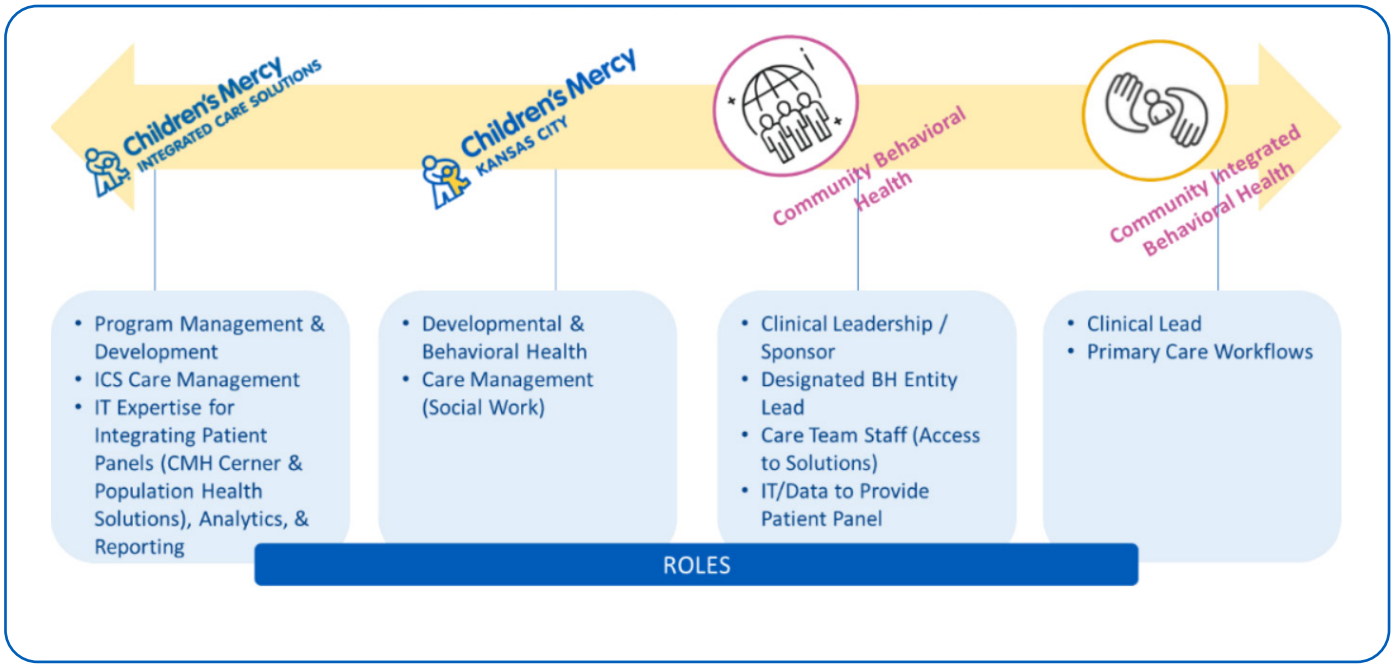
A single mother of two children had to leave her job due to her son being diagnosed with nonverbal level three autism. Mom was unable to work full-time due to her son's intensive therapy schedule. The program helped the family cover their past due rent.

A single mother of two lost her job after her father was diagnosed with lung cancer and needed a full-time caregiver. She took care of him until he sadly passed away in November 2024. The program assisted with past due utility bills, giving her and her children space to grieve and time to search for new employment.

- In February 2024, PCN formally launched a Behavioral Health Advisory Committee, the operating structure of PCN's strategy to extend the network to include behavioral health entities. The strategy's objectives include improving the health & well-being of children, supporting behavioral health entity participation and performance in value-based payment models, sharing population health management infrastructure and technology, and creating a 'learning collaborative' to iterate and innovate together. As outlined in the image below, the strategy brings together a broad spectrum of stakeholders, including PCN, Children's Mercy Hospital, community behavioral health entities, and behavioral health providers integrated within community primary care practices. 2024 activity was structured around the following 3 guiding pillars.
    - **Technology Platforms Access & Deployment:** Participating community mental health centers established active patient panel rosters and received access and training on MyPatientConnections (Access to Cerner; Children's Mercy Hospital's EMR), and PCN's population health management platform (Innovaccer).
    - **Acute Visit Notification Report:** Network deployed a daily acute visit notification report to provide timely awareness of all ED visits at Children's Mercy Hospital and inpatient admissions/discharges at Children's Mercy and other inpatient facilities. For the first time, behavioral entities had necessary information to be able to provide timely follow up to acute events!

- **Learning Collaborative:** Stakeholders used unique cross continuum forum to share and learn from each other on various topics including substance use disorder services, crisis response services, autism resources, etc.

In the last quarter of 2024, PCN launched a second phase of behavioral health entity recruitment that targeted 10-15 psychology, counseling, behavioral health therapy clinics, and psychiatric clinics.



- In 2024, PCN continued to advance efforts to identify and address health disparities by improving the collection and use of race, ethnicity, and language (REL) data. Building on previous efforts to standardize REL questions/data and scripting, the network added a bonus incentive measure that targeted an industry best practice of having an "unknown race rate" (declined responses, unknown/not present/not provided) under 5%. The model supported improvement by extending 2, 4, or 6 bonus points based on unknown rates less than 25%, 15%, or 5%, respectively. Through standardization and improvement in patient intake processes, the Unknown Race Rate decreased in nearly all PCN practices with the average rate falling from 12% to just over 5%.
- PCN launched and piloted an innovative Chronic Condition Value Based Care Program in partnership with Children's Mercy's Endocrinology department. The program, which is one of the nation's first value based program's designed exclusively for pediatric specialists, is designed to empower Children's Mercy specialty divisions to take ownership and accountability for a defined patient population, independently drive clinical improvements, reduce utilization, decrease the total cost of care, and ultimately improve health outcomes. The program includes two value-based payments, one payment that is guaranteed and supports care model infrastructure improvements (e.g. care coordination, QI resources, etc.) and a second payment that is performance-based. The performance-based

payment, which is 50% based on quality performance and 50% based on utilization performance, provides additional funding for improving health outcomes when agreed upon targets are exceeded. The 2024 pilot included selection of program measures, setting targets, development of a reporting environment, and establishing a sustainable funding mechanism. Two foundational requirements were identified for program success: 1. Strong alignment and engagement from the division's triad leadership team (physicians, nursing, administration) and 2. Availability of meaningful clinical quality measures. Overall, the program was used to elevate existing division initiatives (clinical pathways, research, performance improvement) and support improved coordination and collaboration with PCN care management. As of the end of 2024, Endocrinology was positioned to earn 75% or more of the available funds, and PCN was in advanced discussion to extend the program to two additional chronic conditions (Epilepsy, Juvenile Idiopathic Arthritis) for 2025.

2025 Initiatives

- Sustain, expand, and evaluate the impact of referrals to community-based organizations (CBOs) to address patient/family social needs. 2025 will focus on extending SDOH screening workflows across Children's Mercy ambulatory clinics and continue efforts to cultivate and improve relationships and processes with CBOs. Network will also more closely evaluate the "got help" rate to identify improvement opportunities and further analyze the impact of social need referrals on health outcomes.

- In collaboration with our behavioral health community partners, develop "Follow-up After ED/Hospitalization for Mental Illness" measures, share data transparently to inform performance improvement, develop a behavioral health access dashboard, and launch recruitment of inpatient psych facilities.
- Using improved race, ethnicity, and language (REL) data, analyze health disparities and identify/launch a quality improvement initiative targeted at reducing a health disparity within a particular preventive care or chronic care quality measure.
- Expand the "Chronic Condition Value Based Care Program" to 2 additional specialty clinics. Using learnings from the 2024 pilot program, demonstrate scalability and configurability while further improving the program structure and operations.
- Launch targeted quality improvement initiatives on the Childhood Immunization Status (CIS) HEDIS measure and RSV antibody protection. Childhood immunization status efforts anticipated to include pre-visit planning improvements, tactics to address vaccination hesitancy, and targeted flu vaccination improvement tactics. RSV antibody protection will be a new custom measure to promote protection and prevent infant hospitalizations.

2024 Work Plan Updates

Initiative	Process & Scope	Update
Sustain and Enhance Community Connections to Address Social Needs	Sustain and maintain a strong network of partner community-based organizations (CBOs) to address patient/family social needs. 2024 strategic areas of focus include replacement of an existing CBO partner, the ongoing evaluation of the impact of addressing social needs on process measures and health outcomes (clinical quality, total cost of care, acute utilization), and advance operational and technological changes to the social need referral workflow that adds value, efficiency, and benefits to CBOs.	PCN maintained a strong trusted network of CBOs, highlighted by the successful pilot and recruitment of Catholic Charities of Northeast Kansas as an official partner. Monthly referral activity was sustained at an average rate of 300 per month and technology enhancements supported more streamlined data entry and improved data integration.
Integrated Behavioral Health Services	Launch a third location for Integrated Behavioral Health to increase access to mental health services in the community and evaluate the impact of this service on provider satisfaction, utilization, and total cost of care.	The third location for Integrated Behavioral Health in Primary Care was launched in the fall of 2024 and early data shows high levels of provider satisfaction and increased access to behavioral health services.
Extend PCN Network to Include Behavioral Health Entities	Continue to advance strategy to extend network to include behavioral health organizations. Activity to include the formal launch of the Behavioral Health Advisory Committee, implement and deploy the use and access of available technology (1. Children's Mercy Cerner access via My Patient Connections 2. Population Health Management solution (Innovaccer)), and improve communication / collaboration across sites of care (specialty behavioral health care, ambulatory behavioral health care, and primary care practices). In the latter portion of 2024, launch phase 2 of behavioral health entity recruitment to psychology, counseling and behavioral health therapy clinics, and psychiatry clinics.	PCN formally launched the Behavioral Health Advisory Committee in February 2024 with all 8 community mental health centers in the Kansas City region. In 2024, behavioral health entities established active patient panel roster data feeds and received access to Children's Mercy's EMR & Population Health Management solution. Network also activated timely notification of ED/inpatient admissions to support follow up care & used network as a learning collaborative. In Q4 2024, network launched phase 2 recruitment.
Advance Health Equity	PCN will continue to improve race, ethnicity, and language (REL) data collection across Children's Mercy & community primary care practices. After establishing data collection standards in 2023, 2024 will focus on ongoing improvement, measured by the "unknown race rate" (declined responses, unknown/not present/not provided). Target will be to achieve an unknown rate under 5%. Improvement tactics to potentially include an "unknown rate" threshold to achieve bonus points within network's 2024 incentive model.	PCN advanced previous efforts to improve REL data collection by including an "unknown race rate" as a bonus incentive measure. With continued improvement of patient intake processes & the added value of an incentive, overall network's unknown rate fell 7% points to just over 5%.

Develop and Pilot a New Chronic Condition Value-Based Care Program	Develop and pilot a new "Chronic Condition Value Based Care Program" with the aim of transforming the way specialty services are delivered by supporting care model transformation (i.e. shifting accountability & responsibility from only those patients seen within a clinic to a population of chronic patients in the community) and promoting high quality, cost-effective specialty care that encourages care coordination and reduces ineffective, preventable, and inappropriate treatments. The program, which includes both infrastructure and performance-dependent funding, will create a mechanism to engage specialists in value based care where they can take ownership and accountability for a population of patients. The program will be piloted for diabetes patients in 2024 with the hope to expand to 2 to 3 additional chronic conditions in 2025.	The 2024 Chronic Condition Value Based Care Program pilot for diabetes patients included selection of program measures, setting targets, development of a reporting environment, and establishing a sustainable funding mechanism. Program used to elevate existing division initiatives and supported improved coordination and collaboration with PCN care management. As of the end of 2024, Endocrinology positioned to earn 75% or more of the available funds, and PCN was in advanced discussion to extend the program to two additional chronic conditions (Epilepsy, Juvenile Idiopathic Arthritis) for 2025.
Enhanced Care Management Referral & Communication with Community Primary Care Practices	Develop more enhanced and effective mechanisms for community practices to place care management referrals (i.e. e-form submission in addition to fax/ telephonic options). Increase communication to community practices on PCN care management activity (case open, monthly update, case closure) to maximize collaborative care. Also, network will evaluate mechanism to bring greater awareness to patients who may benefit from PCN care management services, so community practices can provide warm hand-off referrals to PCN staff.	A new referral form was created to streamline the referral process for community providers to request support for patients in need of care coordination.
Exploration of Methods to Expand Case Management Availability	Research and pilot alternative work schedules to allow for expanded case management availability and promote work/life balance.	Alternative work schedules were piloted and are now an option for all staff. High levels of satisfaction are reported for those who participate.
Revision of Authorization Process for Complex In-home Service Requests	Implement revised authorization process for complex in-home service requests specific to private duty nursing and personal care services with an overarching goal to reduce barriers to accessing care and increased parity with health plan processes.	Revised process was implemented. Results reflected a more efficient process that better supported timely decisions ensuring optimal member care.

2025 SUMMARY, GOALS, WORK PLAN

Sustain & Enhance Community Connections to Address Social Needs

PCN will continue to invest in the capabilities, technology, processes, and relationships to address social drivers of health that account for up to 75% of health outcomes.[1] In 2025, PCN will further partner with Children's Mercy Hospital (CMH), both directly with particular specialty divisions and through participation in a CMH Care Integration Ecosystem initiative that will more broadly deploy and integrate SDOH screening & referrals within existing specialty clinic workflows. PCN will also partner closely with findhelp and CMH IT to integrate Lift Up KC into Children's Mercy's new EMR (Epic) targeted to go live in Spring 2026. The network will also continue to maintain and update its strong, trusted network of community based organizations (CBOs). With a few years of SDOH referral data now available, PCN will also more closely evaluate "got help" rates to evaluate the overall program, assess alignment of appropriate CBO partners, and identify/apply potential updates. Finally, PCN will continue efforts to increase capacity funding to CBOs through funding source diversification and will also continue to partner with researchers to evaluate the impact of addressing social needs on process measures and health outcomes.

Integrated Behavioral Health Services

Integrated Care Solutions continued to build on early successes from embedding behavioral health clinicians in primary care settings. In 2024, a third primary care office added an embedded behavioral health clinician who served more than 250 patients in the first four months of implementation. Between all three practices there have been more than 2,000 visits. The program has proven to be a cost-effective way to provide early intervention for children with behavioral health concerns and yields high levels of provider satisfaction. In 2025, the goal is to expand the program to include an additional primary care practice to serve more children and families.

Advance Care Collaboration with Behavioral Health Entities

Network will continue to advance strategy to further partner and collaborate with behavioral health organizations to improve the health and wellbeing of children. The first half of 2025 will focus on completing the recruitment and onboarding of phase 2 behavioral health entities, which is expected to target 10 to 15 psychology, counseling and behavioral health therapy clinics. Onboarding may require additional resources as strategy will be onboarding smaller clinics with fewer back office resources. Operations will continue to use data and technology to bring timely and actionable data (e.g. ED and inpatient activity notifications) to network participants with iterative sharing and

[1] https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html

exchange of value stories. 2025 initiatives will also focus on introducing transparent performance reporting on ED/hospitalization follow up care and potentially other HEDIS behavioral health quality measures. The network plans to introduce a Behavioral Health Services Access Board to better inform care teams of what behavioral services are available, at what locations, and in what capacity (i.e. expected time to appointment). Finally, in second half of 2025, the network will launch a third phase of behavioral health entity recruitment to include inpatient psychiatric facilities.

Advancing Quality by Identifying & Reducing Health Disparities

Improving the health of a population requires efforts that not only improve outcomes of the overall population but also decrease health disparities among different groups of people, such as racial or ethnic minorities or individuals with lower socioeconomic status. Fortunately, due to efforts over the last couple of years to improve the collection of race, ethnicity, and language data, PCN is well positioned to accurately evaluate disparities. The network will closely examine disparities across various demographic factors for important preventive care and chronic care measures, including well visit measure, immunizations, asthma management, chlamydia screening, and lead screening. Network will systematically evaluate disparities and present the finding to community pediatricians to identify and launch a quality improvement initiative in second half of 2025.

Expand Chronic Condition Value Based Care Program from 1 to 3 Chronic Conditions

PCN will continue to advance a new Chronic Condition Value Based Care (VBC) Program with the aim of transforming the way specialty services are delivered by supporting care model transformation (i.e. shifting accountability & responsibility from only those patients seen within a clinic to a population of chronic patients in the community) and promoting high quality, cost-effective specialty care that encourages care coordination and reduces ineffective, preventable, and inappropriate treatments. 2025 will take learnings from the 2024 pilot and extend to include two additional specialty clinics (Neurology: Refractory Epilepsy | Rheumatology: Juvenile Idiopathic Arthritis). Effort will focus on developing operational frameworks and standardized process to ensure effective engagement and program stability/sustainability. 2025 will continue to emphasize alignment by elevating existing clinical processes and division initiatives (i.e. research, performance improvement) that provide better care at a lower cost for PCN patients. PCN will also continue to partner will specialty divisions to improve referral workflows, communication, and collaboration with PCN Care Management.

Expand behavioral health delegation to UHC Kansas

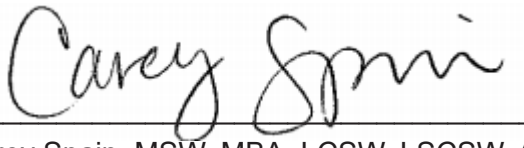
PCN has long recognized the importance of coordinated behavioral health services for our members. To enhance service delivery and improve member outcomes PCN will expand support to UHC Kansas members to include behavioral health delegation.

Create a home visiting team of Care Navigators and Community Resource Specialists

PCN will create a new home visiting team dedicated to supporting pregnant members and those in foster care to ensure these members receive the extra support they need during critical times in their lives. This team will connect members to essential services to support and enhance their overall wellbeing.

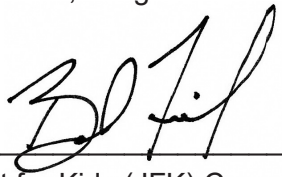
Targeted 2025 Quality Improvement Initiatives (Childhood Immunization Status, RSV Antibody Protection)

PCN plans to develop additional tactics and resources to further support Childhood Immunization Status (CIS) improvement (i.e. 10 vaccine series completed by 2nd birthday) due to overall increased vaccine hesitancy and the network's performance gap to national percentiles. PCN also plans to launch a new quality improvement initiative to increase infant RSV antibody protection since RSV is the most common cause of hospitalization in infants. Initiative to include measure development, assessment of clinical/data barriers, deployment of process/technology interventions, & evaluation of outcomes.

Submitted:  June 2, 2025

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

Date

Approval:  June 2, 2025

Just for Kids (JFK) Committee

Date

 June 2, 2025

Clinical Quality & Operations Committee

Date

2025 Work Plan

	Initiative	Process and Scope
1	**Sustain, Expand, & Evaluate Community Connections to Address Patient & Family Social Needs**	Sustain a strong network of partner community-based organizations (CBOs) to address patient/family social needs. 2025 strategic areas of focus to include expansion of the SDOH screening workflows across additional Children's Mercy Hospital ambulatory clinics, integration of findhelp into Children's Mercy Hospitals' new EMR (Epic), an effort to increase capacity funding to CBOs through funding source diversification, and the ongoing evaluation of the impact of addressing social needs on process measures and health outcomes. The network will also evaluate the "got help" rate and the "funding per successful referral" of each CBO to identify and implement improvement opportunities for the overall program & SDOH screening and referral workflows.
2	**Integrated Behavioral Health Services**	Increase referrals in existing primary care practices with an embedded behavioral health clinician and expand to one additional practice in 2025.
3	**Advance Care Collaboration with Behavioral Health Entities**	Continue to advance strategy to extend network to include behavioral health organizations with the goal of improving collaboration and communication across the care continuum. The first half of 2025 will focus on completing the recruitment and onboarding of phase 2 behavioral health entities (psychology, counseling and behavioral health therapy clinics). Strategy will continue to use data and technology to bring timely and actionable data (e.g. ED and inpatient activity notifications) to network participants, with 2025 activity expanding to include transparent performance on ED/hospitalization follow up care within 7 and 30 days. In the latter portion of 2025, network will launch the third and final phase of behavioral health entity recruitment to include inpatient psychiatric facilities.
4	**Measuring & Reducing Health Disparities**	PCN will continue to improve race, ethnicity, and language (REL) data collection across Children's Mercy & community primary care practices. 2025 will build upon previous efforts to standardize and improve REL data collection (REL data elements collected, care team scripting, health equity bonus incentive). Network will retain the "Race Unknown Rate" (declined responses, unknown/not present/ not provided) bonus incentive within the PCN incentive model with goal of achieving industry best practice of less than 5% of patients with an unknown race. With improved data, network will analyze updated & more accurate REL data to assess health disparities and identify and launch a quality improvement initiative in second half of 2025.

5	**Expand Chronic Condition Value Based Care Program from 1 to 3 Chronic Conditions**	Expand the "Chronic Condition Value Based Care Program", a “nested” value-based program funded by shared savings, from 1 chronic condition (Diabetes) to 3 chronic conditions (Diabetes, Epilepsy, Juvenile Idiopathic Arthritis) in 2025. The global aim of the program is to transform the way specialty services are delivered by supporting care model transformation (i.e. shifting accountability & responsibility from only those patients seen within a clinic to a population of chronic patients in the community) and promoting high quality, cost-effective specialty care that encourages care coordination and reduces ineffective, preventable, and inappropriate treatments. The program, which includes both infrastructure and performance-dependent funding, creates a mechanism to engage specialists in value based care where the specialty division takes ownership and accountability for a population of patients.
6	**Expand behavioral health delegation to UHC Kansas**	PCN has long recognized the importance of coordinated behavioral health services for our members. To enhance service delivery and improve member outcomes PCN will expand support to UHC Kansas members to include behavioral health delegation.
7	**Create a home visiting team of Care Navigators and Community Resource Specialists**	PCN will create a new home visiting team dedicated to supporting pregnant members and those in foster care to ensure these members receive the extra support they need during critical times in their lives. This team will connect members to essential services to support and enhance their overall wellbeing.
8	**Targeted 2025 Quality Improvement Initiatives (Childhood Immunization Status, RSV Antibody Protection)**	PCN plans to develop additional tactics and resources to further support Childhood Immunization Status (CIS) improvement (i.e. 10 vaccine series completed by 2nd birthday) due to overall increased vaccine hesitancy and the network’s performance gap to national percentiles. PCN also plans to launch a new quality improvement initiative to increase infant RSV antibody protection since RSV is the most common cause of hospitalization in infants. Initiative to include measure development, assessment of clinical/data barriers, deployment of process/technology interventions, & evaluation of outcomes.

P.O. Box 411596 • Kansas City, MO 64141
Phone: (888) 670-7261 • www.cmics.org/pcn