



**Pediatric Care Network**  
**ANNUAL REPORT**

Calendar Year  
**2025**



# 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.



## TABLE OF CONTENTS

Overview .....	2
Utilization Management .....	5
Case Management and Disease Management.....	9
Population Health Management.....	18
2025 Work Plan Updates .....	24
2026 Work Plan .....	27



## OVERVIEW & POPULATION ANALYSIS

Case Management • Utilization Management • Disease Management

**The Pediatric Care Network (PCN)** provides a comprehensive care-integration program encompassing case management (CM), utilization management (UM), disease management (DM), and behavioral health services, all grounded in population health principles. The program prioritizes preventive care and coordinated support across the full continuum of a member's healthcare experience by:

- Assessing member needs and developing patient-centered care plans and interventions
- Coordinating and securing services and resources for patients and families with complex needs
- Supporting quality, clinical, and cost-effective outcomes
- Identifying and addressing recurring issues that impact quality or cost



PCN performs delegated medical-management functions under capitated risk agreements with Medicaid managed care organizations in Missouri and Kansas. The multidisciplinary team includes registered nurses, licensed social workers, mental health professionals, respiratory therapists, medical directors, and non-clinical staff.

Through these value-based contracts, primary care providers partner with PCN to advance practice transformation aligned with patient-centered medical home (PCMH) competencies, driving sustainable improvements in quality, patient experience, and cost efficiency.

## PCN Population Profile - Overview of the Patients We Serve!

**169,871**  
members  
enrolled

**74,909**  
members served  
by Care  
Integration

**42.9%**  
of population  
have a chronic  
condition

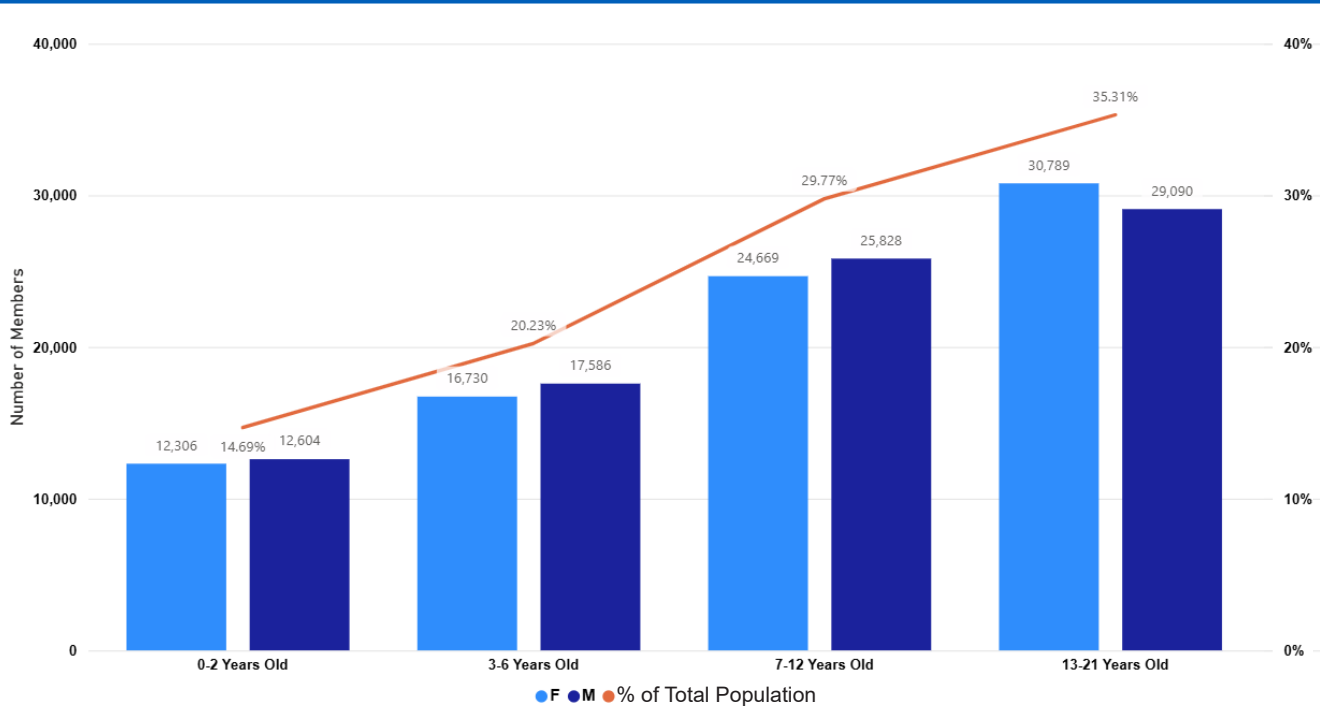
**8%** of the population  
has Asthma

**8%** have ADHD

**7%** have Anxiety

**3%** have Obesity

## 2025 PCN Member Age & Gender Distribution



## 2025 Pediatric Care Network Value Highlights

**4%**

average increase in HEDIS measure compliance for:

- Infant Well Child Visits 15-30 (2+ Visits)
- Age 3-21 Annual Well Child Visits

**2%**

increase in Age 13 Immunizations and Lead Screening

**92%**

Provider Satisfaction



## UTILIZATION MANAGEMENT



The PCN team has always been super helpful with getting our mutual patients taken care of!

-- Network Provider



**The Pediatric Care Network** conducts prior authorizations, inpatient reviews, discharge planning, and transitional care planning through a multidisciplinary team of licensed clinicians and non-clinical staff. Non-clinical staff manage eligibility verification, authorization entry, and communication of authorization outcomes to providers. Clinical staff, supported by medical directors, complete medical necessity reviews using internal protocols, state criteria, and Milliman Care Guidelines®. PCN performs quarterly staff and peer audits and monitors member and provider satisfaction related to care delivery.

PCN evaluates utilization across preventive, outpatient, and primary care services, as well as high-cost or high-frequency services such as inpatient admissions and emergency department use. These analyses help identify patterns of under and overutilization within the population.

## 2025 Accomplishments

- PCN successfully initiated utilization management services for Healthy Blue Kansas, establishing the operational, clinical, and administrative workflows needed to support high-quality care delivery from program launch.
- PCN expanded the use of the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS) tools to strengthen behavioral health decisions, ensure objective level of care determinations, and better align services with member needs.
- PCN delivered timely, consistent prior authorizations and medical necessity reviews by leveraging licensed clinical staff, medical director oversight, and standardized criteria, improving appropriateness of care decisions.
- Through multidisciplinary inpatient review, coordinated discharge planning, and transitional care planning, PCN supported safer transitions of care and reduced gaps following hospitalizations for pediatric members.
- Regular audits enabled PCN to identify under and overutilization trends, supporting quality improvement and informed provider engagement.

## 2026 Initiatives

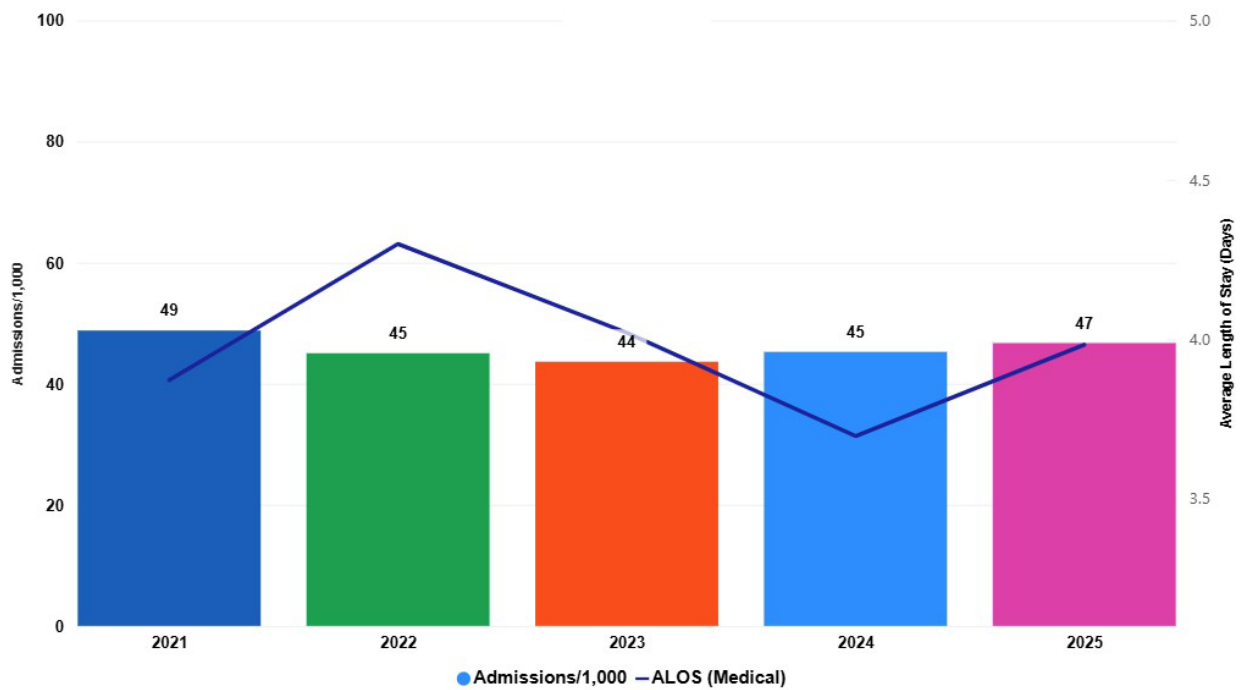
- PCN will design and implement Kansas-specific patient care service processes to streamline Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service requests. This work will align internal workflows with state and health plan requirements, improve provider clarity, and strengthen the consistency and timeliness of



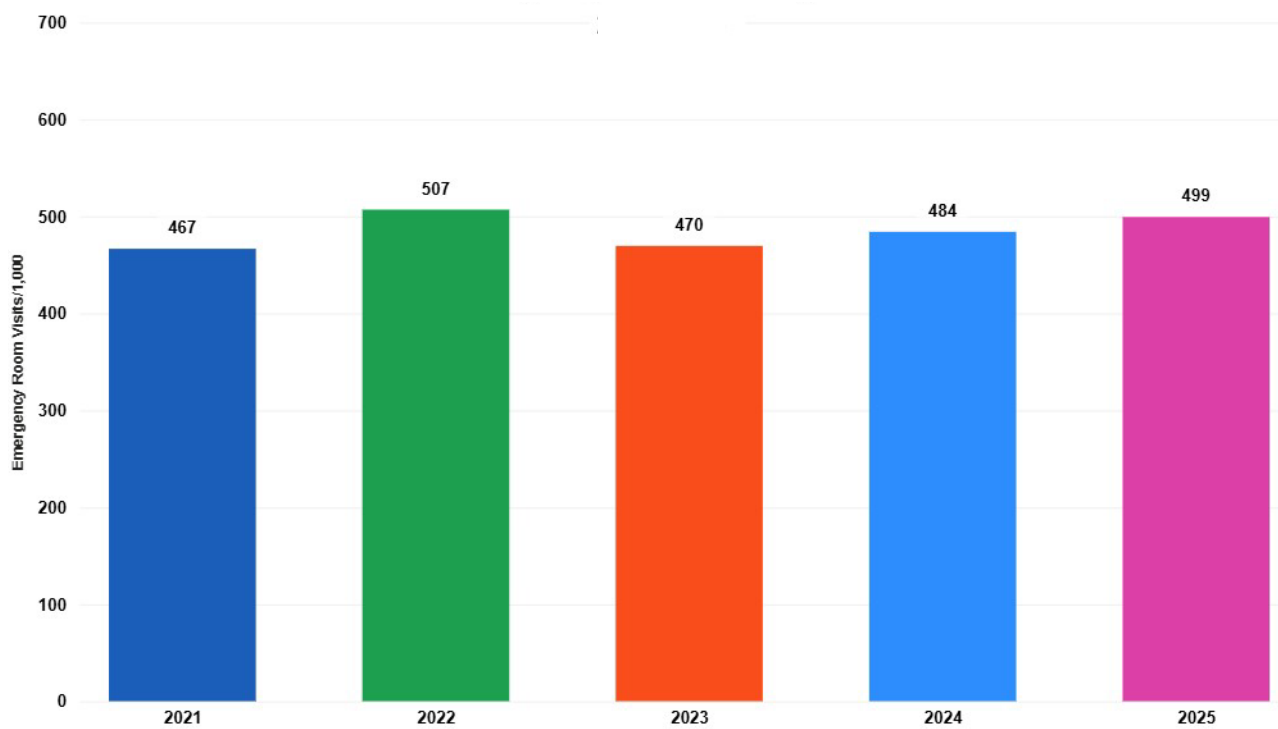
EPSDT reviews. By standardizing procedures and enhancing coordination between clinical and administrative teams, PCN will improve access to medically necessary pediatric services while supporting compliance and efficient utilization management.

- PCN will leverage existing infrastructure and clinical expertise to expand market reach and deliver high-quality care management, disease management and utilization management services to more members and health plan partners.
- PCN will implement targeted improvements to the medical director's review process to increase efficiency, consistency, and clinical alignment. Enhancements anticipated to include refined escalation criteria, streamlined documentation, and stronger integration between clinical reviewers and medical directors. These updates will support timely decision making, more consistent application of medical necessity criteria, reduced rework, and improved provider communication, ultimately improving member access to appropriate care.

## PCN Utilization Admissions / 1,000 2021-2025



## PCN Utilization Emergency Room Visits / 1,000 2021-2025





# 12,697

prior authorizations  
completed in 2025

# 482

 average calls  
per month

# 7 seconds

average speed to answer

# 0.7%

 average call  
abandonment  
rate

## Success Story

*Dr. Melton, an emergency physician at a rural hospital, contacted CMH to request support for Heather, a 2-year-old with cerebral palsy and seizures who required specialized medical equipment. She needed a suction machine and an adjustable hospital bed to reduce aspiration risk during gastrostomy feeds. Karen, PCN Care Navigator, quickly coordinated with local medical supply providers to arrange same-day delivery of the suction machine and next-day delivery of the hospital bed to Heather's home. This timely coordination prevented the need for hospital admission and transfer.*



## CASE MANAGEMENT & DISEASE MANAGEMENT

Case management (CM) and disease management (DM) are core components of the care integration program. To promote continuity of care and improve health outcomes, care integration teams collaborate closely with members' primary care providers, specialists, and care partners. CM and DM services support members in achieving or maintaining optimal health while helping reduce overall healthcare costs. This coordinated approach enables comprehensive assessment of medical, social, and behavioral needs and guides the development and implementation of targeted interventions, benefits navigation, and resource support.

CM & DM processes draw on claims data, hospital encounters, pharmacy utilization, and laboratory results to identify members most likely to benefit from care coordination. Identified populations are prioritized based on chronic conditions, high acute utilization, risk scores, social needs, and gaps in care. Case management activities include risk-based and post-discharge screenings, assessments, care planning,

and multidisciplinary coordination. These inputs determine case type, complexity, and the level of intervention required to support whole-person care. In 2025, 80% of cases required complex case management, with common conditions including pregnancy, behavioral health needs, asthma, autism, lead exposure, and diabetes.

Non-complex cases saw an increase from 2024 to 2025 related to low-risk foster care youth enrollment. Quarterly audits and regular multidisciplinary case reviews reinforce quality and ensure consistent application of best practices.

**5,661** members identified for case management

**29%** of enrollees achieved all goals

**231 days** average time to completion

**1,155** new enrollments in case management  
*568 more patients compared to 2024*

**76%** of member-driven goals achieved in year  
*17% point increase compared to 2024*

**7%** of enrollees identified for a Behavioral Health need



## Disease Management

PCN's DM model emphasizes close collaboration between primary care providers and care teams, moving beyond traditional phone-based outreach or educational materials. Our team builds relationships with primary care practices to support implementation of comprehensive, office-based disease management. Disease conditions of focus include asthma, diabetes, and healthy weight management. PCN also includes a depression program for plans where PCN manages behavioral health needs.

Care Navigators proactively engage members at risk of adverse health outcomes to provide education, support medication management, develop disease specific care plans, and assist members and caregivers in effective condition management. Early identification of members with chronic conditions, combined with strong partnerships with treating providers, enables proactive interventions that promote disease control and reduce acute care utilization.

**23,000+** members followed by Disease Management

**13%** of members followed by Disease Management have a diagnosis of **obesity**.

**8%** of members followed by Disease Management have a diagnosis of **asthma**.

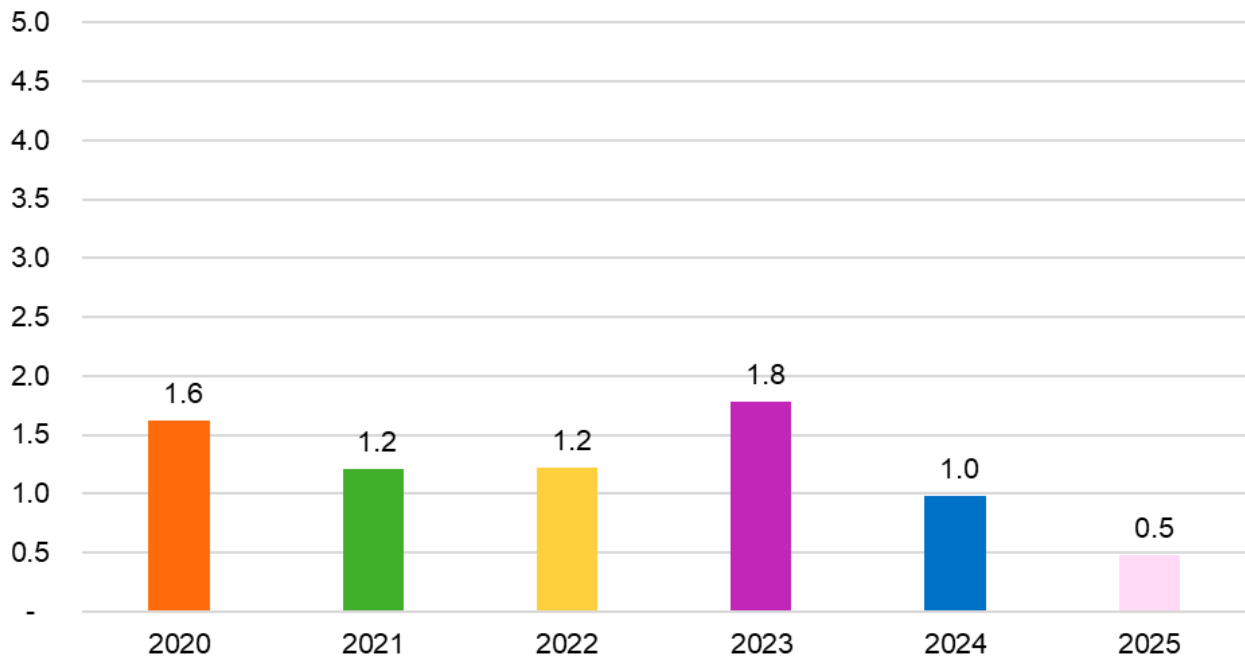
**7%** of members followed by Disease Management have a diagnosis of **depression**.

**1%** of members followed by Disease Management have a diagnosis of **diabetes**.

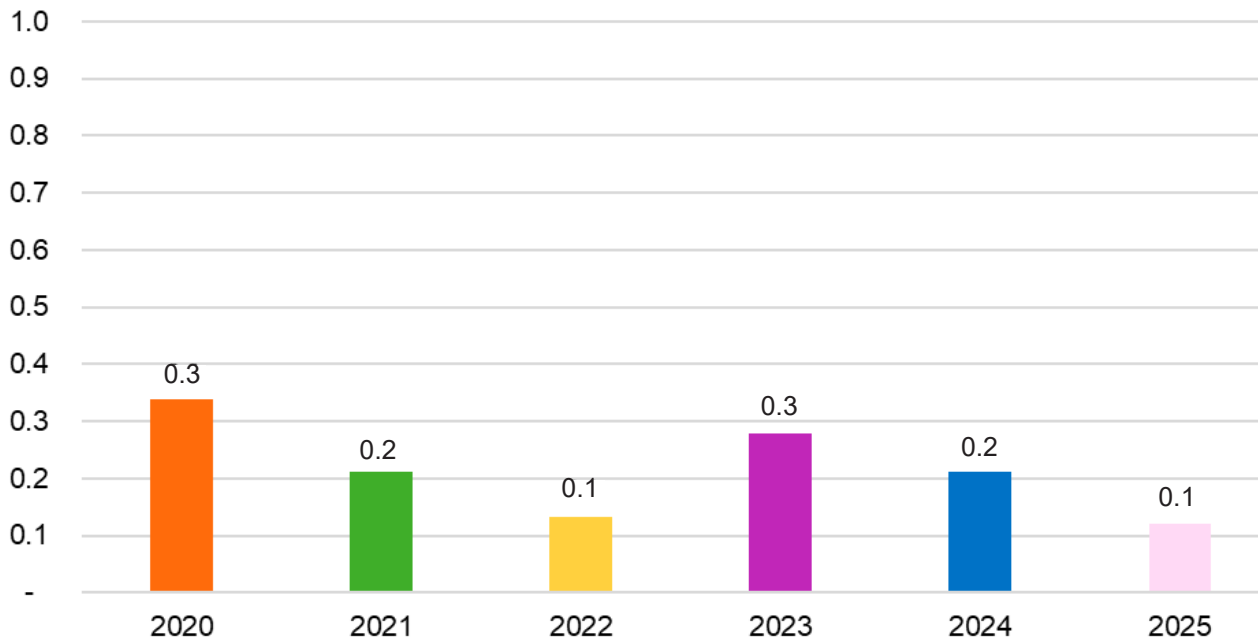
**272** members enrolled in complex case management with condition-specific needs related to asthma, diabetes, or obesity

**143** members participated in complex case management with a condition-specific behavioral health need.

### Obesity Admissions / 1,000 2020-2025

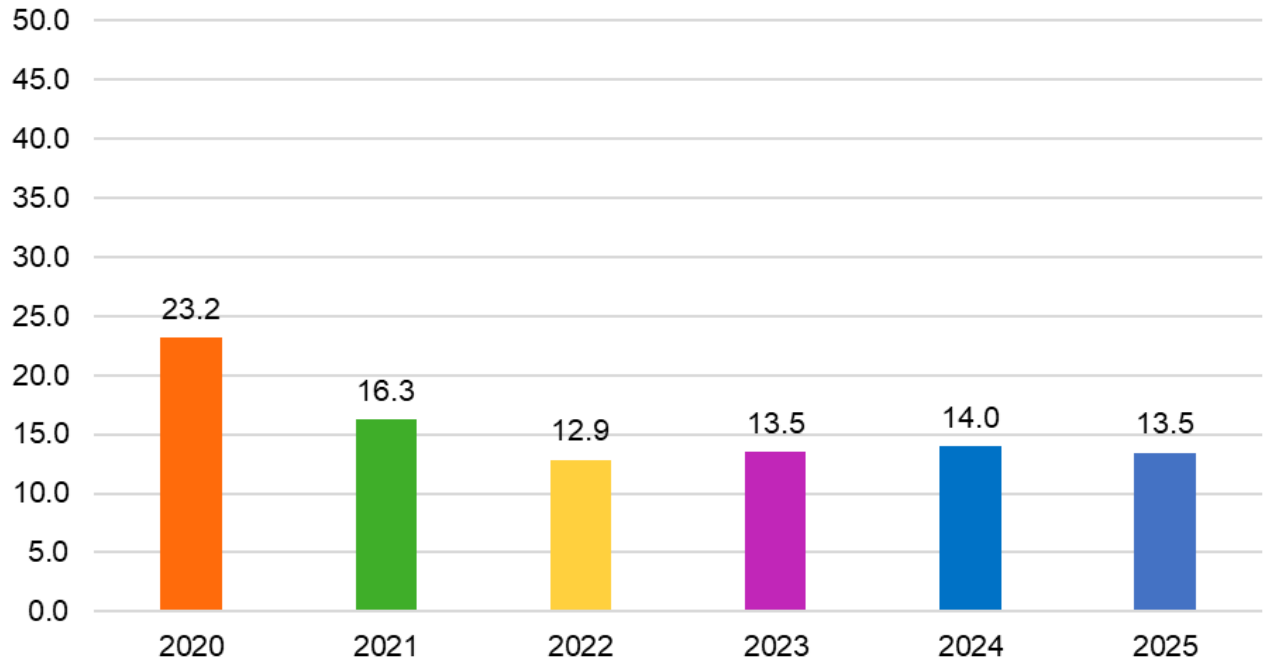


### Obesity ED Visits / 1,000 2020-2025

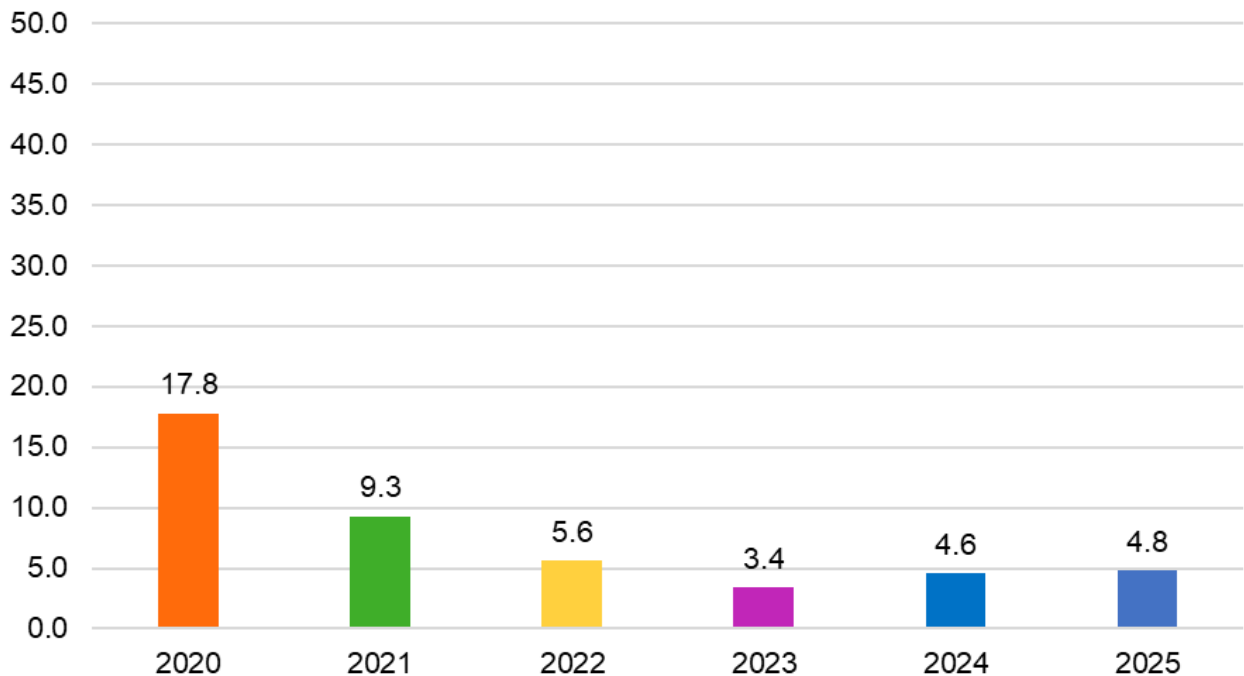


Includes all inpatient or ED visits with **obesity** documented in any diagnosis position on the claim

### Depression Admissions / 1,000 2020-2025

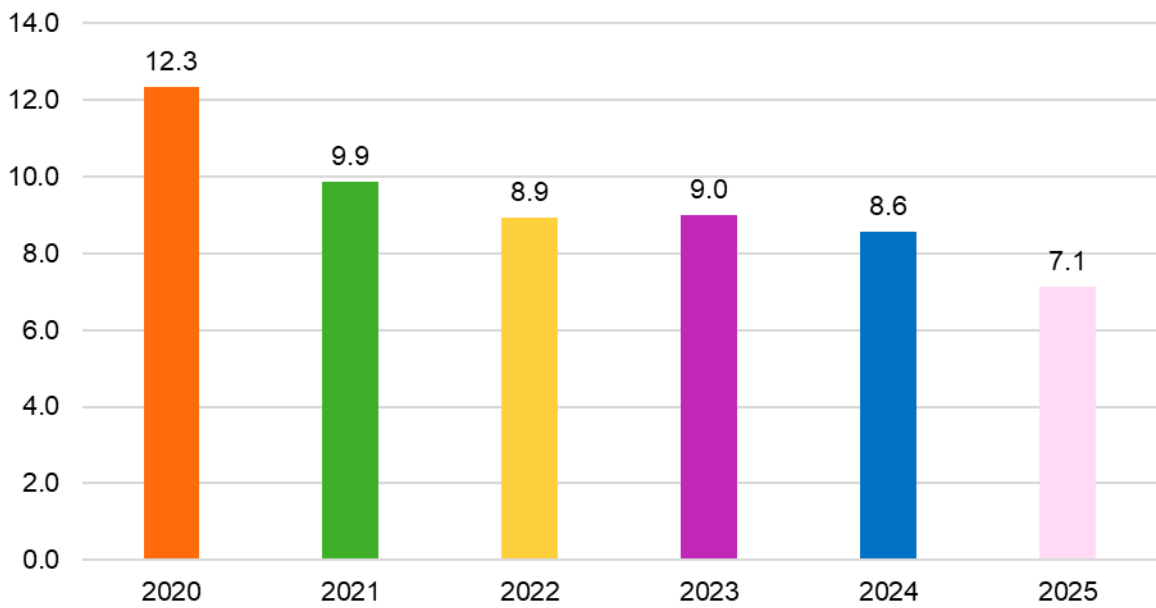


### Depression ER Visits / 1,000 2020-2025

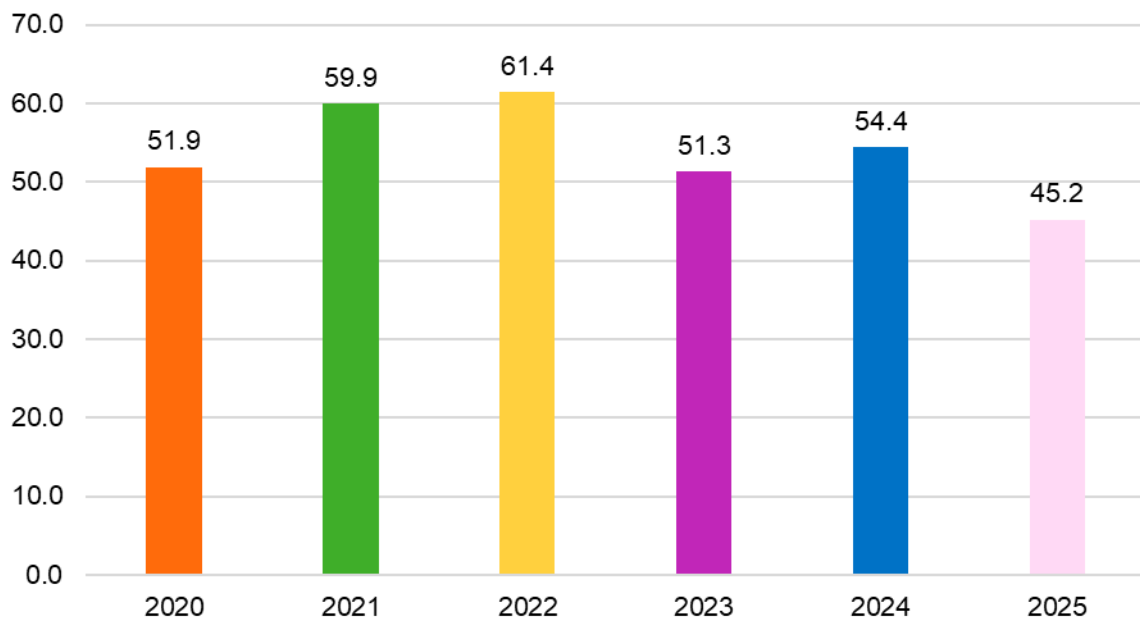


Includes all inpatient or ED visits with **depression** documented in any diagnosis position on the claim

### Asthma Admissions / 1,000 2020-2025

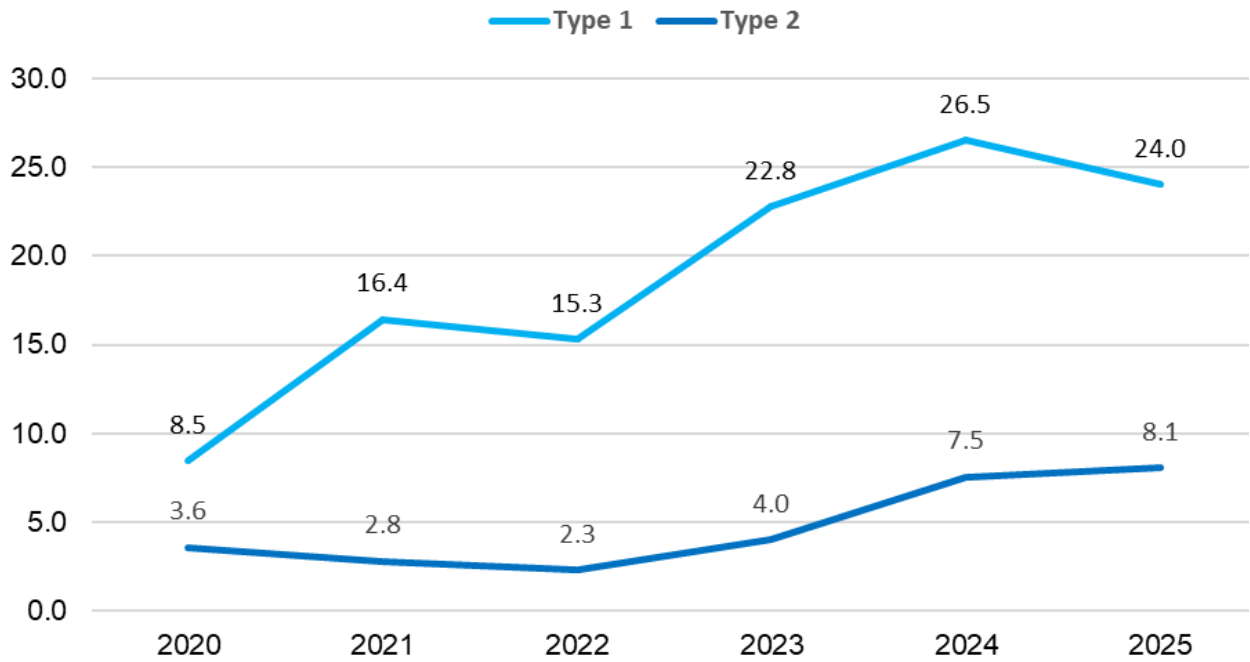


### Asthma ER Visits / 1,000 2020-2025

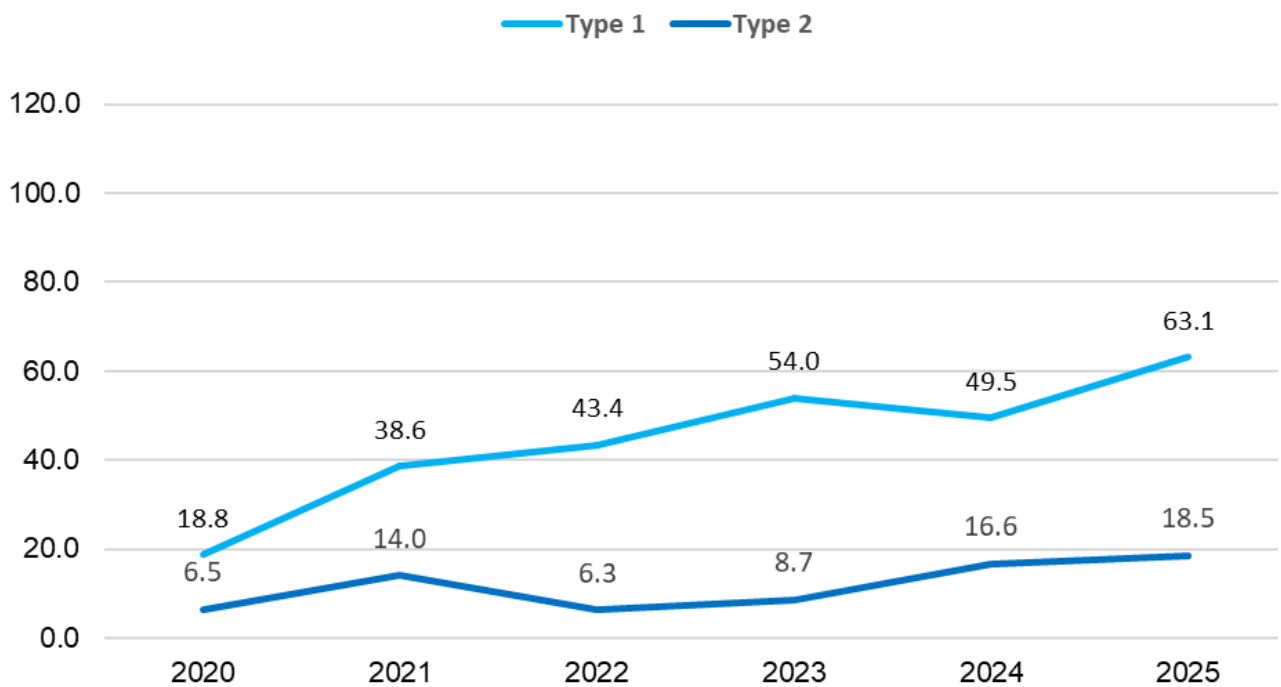


Includes all inpatient or ED visits with **asthma** documented in any diagnosis position on the claim

## Diabetes Admissions / 1,000 - Type 1 vs Type 2 2020-2025



## Diabetes ER Visits / 1,000 - Type 1 vs Type 2 2020-2025



Includes all inpatient or ED visits with **diabetes** documented in any diagnosis position on the claim



## Transitional Care Program

PCN's Transitional Care Program supports a smooth transition from inpatient settings to home and community-based care. The program includes post-discharge outreach to members and caregivers to assess and identify barriers to care. When needs are identified, the care team collaborates with the member's primary care provider to resolve immediate issues such as medication access, home services, transportation, and appointment scheduling. Members requiring ongoing support are referred to a Care Navigator for continued case management.

**2,478** admissions identified for follow-up

**68%** of members successfully contacted

**3%** subsequently enrolled in care management for additional support

## 2025 Accomplishments

- Updated and streamlined the referral process for hospital and community partners to request support from a PCN team member
- Added behavioral health delegation for the United Healthcare Community Plan of Kansas
- Successfully onboarded delegation for Healthy Blue Kansas
- Expanded face-to-face engagement with members in alignment with contract requirements
- Implemented enhanced safety protocols for team members conducting home visits

## 2026 Initiatives

- Explore how artificial intelligence can redesign workflows and strengthen care models and processes to better support members, families, and care teams
- Evaluate programs that provide in-home medical devices to enable remote physical exams, improving convenience and timely access to care for children
- Partner with the Healthy Homes Program to expand support for members affected by lead poisoning
- Modernize processes to provide timely notification to primary care providers and care teams on the status of members enrolled in care management





## Patient Success Stories

Navigating behavioral health services can be challenging. Ann, PCN Behavioral Health Care Navigator, supported Julie, a 12-year-old with depression, anxiety, and a history of suicide attempts, and her family following three acute psychiatric hospitalizations. Julie's mother, Brenda, was able to schedule individual therapy but needed additional services, including an SED waiver assessment, family therapy, and psychiatric support for medication management. Ann assisted Brenda in advocating for these services with the Community Mental Health Center (CMHC) and collaborated with CMHC staff to ensure comprehensive wraparound support aimed at reducing future hospitalizations. Julie was successfully enrolled in the SED waiver, with expanded services now in place.

---

Transportation is essential for maintaining consistent access to healthcare. Trevor, an 18-year-old in foster care with PTSD and a history of substance use, attends EMDR and therapy sessions three times per week. His foster mother needed support arranging transportation. Erik, PCN Care Navigator, collaborated with ModivCare and Trevor's behavioral health providers to secure an exception allowing him to use his transportation benefit for unaccompanied rides to and from appointments. Trevor now independently schedules his rides and reliably attends his sessions, helping ensure uninterrupted care and continued progress.

---

Connection with Children's Mercy Kansas City's Weight Management Clinic is helping Anthony, a 15-year-old with autism spectrum disorder and obesity, work toward his health and weight loss goals. His family needed a home scale to monitor progress but lacked the financial resources. Amber and Erik, PCN Care Navigators, collaborated with Healthy Blue Kansas partners to request an exception, which was approved. Anthony has since made significant progress, including walking after school to support weight loss. He also completed vision and dental exams, connected with a therapist for behavioral health support, obtained Social Security benefits, and was added to the IDD waiver waitlist.



## POPULATION HEALTH MANAGEMENT

Population Health Management (PHM) focuses on improving outcomes for populations with shared needs through stronger clinical processes, coordinated care, and active patient engagement. This work is enabled by data analytics and technology across an integrated care system that supports the identification and distribution of best practices across a collaborative network of primary care practices. The Operations and Population Health Management Team partners with community practices to provide education and operational support around Medicaid coverage and eligibility, claims resolution, regulatory changes, technology and data analytics, and targeted initiatives that improve quality, cost efficiency, and HEDIS performance.

### **Practice Transformation**

The PCN provider network participates in a value-based incentive program that offers per-member-per-month incentive for achieving defined quality and cost efficiency goals, including well child visits,

immunizations, clinical and social risk screenings, and avoidable ED visits. PCN's value-based model extends beyond traditional pay-for-performance models by incorporating NCQA HEDIS quality metrics, population health strategies, regular clinical quality meetings, learning collaboratives, and triannual performance reviews. The program also evaluates cost and utilization through a risk-adjusted avoidable ED visit measure and a shared savings opportunity tied to total cost of care.

To support whole person care, the model includes targets for screening more than 50% to 70% of patients for social drivers of health. Recognizing that screening is simply the first step, PCN has invested in the technology, people, and processes to support closed-loop social need referrals to address food insecurity, lack of transportation, inadequate housing, and other identified needs. PCN's incentive model also incorporates a measure to improve the accuracy of demographic data collection to better measure, identify, and address health disparities.

The Operations and Population Health Management (PHM) Team continues to partner with our practices to drive essential quality improvement (QI) initiatives, focusing on lead screening and age 2 immunizations. Through weekly targeted population lists and on-site data reviews, our collaborative efforts with PCN-contracted practices resulted in a 2% increase in lead screening and a 4% increase in age 2 immunizations, consistently outperforming other Medicaid populations. Notably, we achieved an average 10% increase in Age 13 immunizations across all PCN-contracted practices between 2024 and 2025. In addition to these established metrics, the PHM team successfully launched a new RSV Antibody Protection Initiative, assisting

community practices in implementing robust processes to capture and track this critical preventive work.

## 2025 Accomplishments

In 2025, the PHM team supported several quality and practice improvement initiatives with PCN contracted provider offices, including:

- PCN continued to advance Childhood Immunization Status (i.e. age 2 immunizations) performance through a combination of targeted outreach, data transparency, and disparity-informed improvement strategies. Efforts included a multi-channel flu vaccine campaign in partnership with Children's Mercy Hospital that reached more than 60,000 individuals through social media, parent outreach, provider messaging, and newsletter distribution. Additional tools to address immunization hesitancy were developed, including practice-ready posters and educational materials, alongside weekly influenza activity updates. PCN also provided enhanced practice-level reporting with detailed insights by provider, vaccine series, and individual dose—equipping practices with actionable data to support targeted outreach and care improvement.
- Based on previous efforts to improve the collection of race, ethnicity, and language (REL) data, PCN developed equity dashboards and completed a comprehensive disparity analysis across nearly all value based quality measures. This work identified a significant gap in Childhood Immunization Status for Black/African American children, directly informing targeted, network wide quality improvement strategies planned for 2026 to specifically address vaccine hesitancy, strengthen well visit adherence, and reduce



inequities in care delivery.

- PCN launched an RSV antibody protection improvement initiative aimed at improving infant health outcomes across the network. Despite RSV being one of the leading causes of infant hospitalization, only 56% of U.S. infants were protected against severe RSV disease as of late 2024. The initiative focused on improving identification and measurement of RSV protection by developing a new RSV measure that captured both direct infant protection and maternal vaccination. Key efforts included establishing a standardized coding process to systematically capture maternal RSV protection and implementing targeted outreach and quality improvement strategies to increase protection rates.
- 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](http://www.liftupkc.org) |

Powered by [findhelp.org](http://findhelp.org)), into the clinical workflows of both Children’s Mercy and community pediatric practices. 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. In 2025, PCN significantly advanced its social determinants of health strategy through expanded use of Lift Up KC. Nearly 6,000 social need referrals were made during the year—an average of 500 referrals per month—representing a 68% increase over the prior year. Lift Up KC continued to see broad adoption across both internal and external audiences, with more than 1,500 care team users across Children’s Mercy Hospital, PCN, and community practices, and over

65,000 annual visits to the public site. Building on a successful partnership with Catholic Charities of Northeast Kansas, PCN expanded its community-based organization (CBO) network to include Catholic Charities of Kansas City and St. Joseph, extending service coverage across Jackson County and strengthening access to community-based supports. Throughout the year, the network sustained a “got help” rate of approximately 30% for referrals sent to CBO partners, reflecting meaningful follow-through on identified social needs.

- In 2025, PCN continued to strengthen its population health management technology foundation, building on a multi-year partnership with Innovaccer to support data-driven care across an integrated system. Since 2019, this partnership has enabled the development of a robust data infrastructure and advanced PHM capabilities, including quality and financial analytics, automated patient and family outreach, and point-of-care clinical workflow tools—supported by near real-time data feeds from payers, external laboratories, and more than 12 EMR vendors across nearly 30 network

practices. Leveraging this foundation, PCN and Innovaccer piloted an AI-powered pre-visit summary tool in 2025, introducing a new approach to pre-visit planning by synthesizing key clinical information into actionable, provider-ready insights. The pilot demonstrated meaningful time savings for clinicians, increased coordination with pediatric specialty care, and positive care team feedback, positioning AI-enabled pre-visit planning as a scalable enhancement to care delivery in 2026.

- In 2025, PCN’s behavioral health network strategy continued to mature and scale, advancing a coordinated and collaborative approach to pediatric behavioral health across the continuum of care. Building on foundational work launched in 2023 and expanded in 2024, the network deepened integration among hospital partners, community behavioral health organizations, and primary care. During the year, the network expanded to include a total of 16 community behavioral health organizations (see image below) and initiated a third phase of recruitment focused on inpatient psychiatric facilities. This marked an important step in

## Participating Behavioral Health Organizations

### • 8 Community Mental Health Centers



All 8 Community Mental Health Centers in KC Metro

### • 8 Psychology, Counseling, & BH Therapy Clinics | Psychiatric Clinics



150+ Therapists/Psychologists Across 8 Entities



extending collaboration further upstream and downstream across the continuum of care, strengthening coordination around acute events, transitions of care, and follow-up planning.

In parallel, the behavioral health network advanced key capabilities across technology, performance improvement, and collaboration. All 16 participating organizations established active patient panel rosters, with expanded access to clinical documentation, broader use of Children's Mercy's EMR, and deployment or trial of PCN's population health management platform. Focused performance improvement efforts progressed through transparent sharing of follow-up performance after behavioral health ED and inpatient discharges, deployment of daily acute visit notification reports, and development of a discharge intake process inventory to support more streamlined and

coordinated transitions.

- PCN continued to advance a Chronic Condition Value-Based Care Program, considered one of the nation's first value-based models designed specifically for pediatric specialty care. Embedded within PCN's existing value-based agreements and funded through internally generated value-based revenues, the program supports the transition from fee-for-service to population-based, value-driven care for children with chronic conditions. The model empowers Children's Mercy specialty divisions to assume accountability for defined patient populations by investing in care coordination or care model innovations to improve outcomes, reduce preventable acute utilization, and lower the total cost of care. Funding includes a combination of upfront infrastructure support and performance-based funds tied equally to quality and utilization outcomes.

In 2025, PCN expanded the program from one to three chronic conditions, partnering with Children’s Mercy Endocrinology (diabetes), Neurology (epilepsy), and Rheumatology (juvenile idiopathic arthritis). Each specialty division completed program onboarding, including measure selection, target setting, data and reporting enablement, education on PCN care management services, and quarterly performance reviews. Collaboration between specialty divisions and PCN care management was further strengthened through enhanced high-risk patient identification, improved pre-visit planning, and expanded care coordination workflows.

## 2026 Initiatives

- Sustain and strengthen community-based partnerships to address patient and family social needs. 2026 will focus on maintaining or improving an approximate 30% help rate, advancing Lift Up KC as the single source of truth for Children’s Mercy community programs, and successfully integrating Lift Up KC with Epic at the March 2026 go-live.
- As part of the PCN behavioral health network extension strategy, PCN will complete recruitment and onboarding of all Kansas City–area inpatient psychiatric facilities. The team will deploy tactics to strengthen discharge coordination across inpatient psychiatry, community behavioral health providers, and primary care. PCN will also explore partnership opportunities with Children’s Mercy Behavioral Health to implement Lift Up KC as a comprehensive, up-to-date behavioral health resource for patients and families.
- Implement automated risk identification and referral workflows to proactively connect



high-risk patients to PCN care management, and standardize EMR-based care plan communication with community practices to support timely outreach, collaboration, and continuity of care.

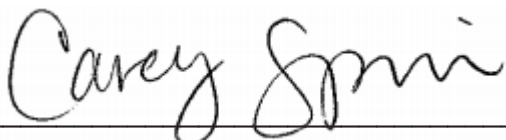
- Maximize value from the population health platform by driving adoption of existing and new capabilities, including AI-powered pre-visit summaries, enhanced clinical note access post-Epic transition, and care management/SDOH tools—supported by targeted re-education, comparative insights, and a broad Innovaccer redeployment campaign.
- Advance key quality outcomes by deploying network-wide strategies to reduce avoidable ED utilization, improve age 2 immunization rates, and increase annual well visits—leveraging enhanced reporting, provider and family education, urgent care support, and AI-enabled outreach to drive access, engagement, and preventive care.

# 2025 Work Plan Updates

Initiative	Process & Scope	Update
<p><b>Sustain, Expand, &amp; Evaluate Community Connections to Address Patient &amp; Family Social Needs</b></p>	<p>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 (clinical quality, total cost of care, acute utilization). 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 and SDOH screening and referral workflows.</p>	<p>PCN maintained a strong trusted network of five CBOs. PCN expanded its formal CBO partnerships to include Catholic Charities of Kansas City and St. Joseph addressing a critical coverage gap in Jackson County. In 2025, PCN placed nearly 6,000 social need referrals though Lift Up KC with a sustained and healthy “got help” rate of approximately 30%.</p>
<p><b>Integrated Behavioral Health Services</b></p>	<p>Increase referrals in existing primary care practices with an embedded behavioral health clinician and expand to one additional practice in 2025.</p>	<p>Our integrated behavioral health program strengthened access to timely support by increasing referrals and reducing barriers to care. By partnering behavioral health clinicians with pediatric providers, the program offered coordinated, family-centered support that benefited patients, caregivers, and care teams alike. Providers reported greater confidence in addressing behavioral health needs, while families experienced more seamless, supportive care.</p>
<p><b>Advance Care Collaboration with Behavioral Health Entities</b></p>	<p>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.</p>	<p>PCN completed phase 2 recruitment, adding 8 additional community organizations offering behavioral health services. In late 2025, PCN initiated a third phase of recruitment by initiating discussions with inpatient psychiatric facilities. Network also continued to educate and share technology (Children’s Mercy EMR   PCN Population Health Management solution) and transparently shared performance rates for follow up care after behavioral health ED visits and inpatient discharges.</p>

<p><b>Advance Health Equity</b></p>	<p>PCN will continue to improve race, ethnicity, and language (REL) data collection across Children's Mercy and 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 and more accurate REL data to assess health disparities and identify and launch a health equity improvement initiative in second half of 2025.</p>	<p>PCN achieved and sustained a race unknown rate of less than 5%, supported by inclusion of REL data collection requirements into the PCN value-based incentive model. PCN completed a comprehensive disparity analysis across nearly all clinical quality measures and identified most significant disparity within the Childhood Immunization Status measure (24% rate for African Americans vs. 50% rate for White patients). Through practice deep dives, key contributing factors included higher levels of vaccine hesitancy and lower attendance of well-child visits after one year of age.</p>
<p><b>Expand Chronic Condition Value-Based Care Program from 1 to 3 Chronic Conditions</b></p>	<p>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 and 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.</p>	<p>PCN completed extension of program to three CMH specialty divisions and chronic conditions (diabetes, epilepsy, juvenile idiopathic arthritis). Program supported care model innovations and increased coordination and collaboration between specialty division and PCN care management services. 2025 efforts improved definition of high-risk patients included in a pre-visit planning report, continued education on PCN care management services with case examples, and development of family-facing resources in Spanish.</p>
<p><b>Expand Behavioral Health Delegation to UHC Kansas</b></p>	<p>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.</p>	<p>PCN successfully advanced implementation of behavioral health delegation for UHC Kansas members. This expansion strengthened care coordination, streamlined service delivery, and improved access to integrated behavioral health services through enhanced collaboration with providers and more timely interventions for members.</p>

<p><b>Create a Home Visiting Team of Care Navigators and Community Resource Specialists</b></p>	<p>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.</p>	<p>PCN established a dedicated home visiting team focused on proactive outreach, care coordination, and connection to essential medical, behavioral health, and community services. This targeted approach enhanced member engagement, addressed social and health needs, and strengthened overall wellbeing for some of PCN's most vulnerable populations.</p>
<p><b>Targeted 2025 Quality Improvement Initiatives (Childhood Immunization Status, RSV Antibody Protection)</b></p>	<p>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, and evaluation of outcomes.</p>	<p>PCN implemented CIS performance improvements by partnering with CMH Marketing on a multi-channel flu vaccine campaign, addressing immunization hesitancy, and providing weekly flu updates and enhanced performance reporting.</p> <p>PCN launched an RSV protection initiative which included creating a new measure capturing infant and maternal protection, standardizing maternal RSV protection coding, and deploying targeted outreach and reporting to improve rates.</p>

Submitted:  May 28, 2026  
 Carey Spain, MSW, MBA, LCSW, LSCSW, ACM  
 Senior Director, Integrated Community Care  
 Date

Approval:  May 28, 2026  
 Just for Kids (JFK) Committee  
 Date

 May 28, 2026  
 Clinical Quality & Operations Committee  
 Date

# 2026 Work Plan

Initiative	Process & Scope
<b>Sustain, Expand, &amp; Evaluate Community Connections to Address Patient &amp; Family Social Needs</b>	<p>In 2026, PCN will sustain a strong network of community-based partners to address patient and family social needs while striving to sustain or increase the current 30% “got help rate.” Key focus areas will include integrating Children’s Mercy internal resources (e.g. Healthy Homes, Community Baby Showers, Summer Kids Eat Free Program, etc.) into Lift Up KC and positioning Lift Up KC as the single source of truth for sharing Children’s Mercy program information with the community. Work plan will also include integration of Lift Up KC into Children’s Mercy’s new EMR with the Epic go-live in March 2026.</p>
<b>Advance Care Collaboration with Behavioral Health Entities</b>	<p>In 2026, PCN will complete recruitment and onboarding of all Kansas City–area inpatient psychiatric facilities; strengthen discharge planning coordination across inpatient psych facilities, community behavioral health providers, and primary care practices; develop a behavioral health access board, and partner with Children’s Mercy Behavioral Health to implement Lift Up KC as a comprehensive, up-to-date behavioral health resource for patients and families.</p>
<b>Integrated Behavioral Health Services</b>	<p>Demonstrate financial sustainability of the model within predominantly Medicaid practices by optimizing clinical and operational workflows, improving patient scheduling and engagement, and identifying opportunities to align care delivery with available reimbursement. Sustainability may be supported by supplemental value-based funding, particularly where the model demonstrates measurable cost avoidance and improved outcomes.</p>
<b>Improved Case Management Collaboration with Community Practices</b>	<p>PCN will implement automated processes to identify and proactively distribute high risk patients most likely to benefit from PCN care management to support increased referrals and collaboration with community primary care practices. PCN will also modernize processes to provide timely notification to primary care providers and their care team on the status of members enrolled in care management. Practices will use this information to integrate care plans into the local medical record to support timely outreach, referrals, and continuity of care.</p>
<b>Advancing Use of Agentic AI to Support Patient Engagement &amp; Extend Care Management Services</b>	<p>In 2026, PCN will evaluate the use of agentic AI to enable clinical staff to focus on higher acuity and complex care while AI agents support lower risk, nondiagnostic patient communication, engagement, screening, and follow up care coordination. Priority use cases include welcoming and enrolling high risk patients into PCN care management, supporting ED and low risk inpatient discharge follow up, and conducting outreach to reengage patients overdue for preventive care to establish a primary care medical home.</p>
<b>Remote Medical Monitoring</b>	<p>Evaluate and identify programs that provide in home medical devices to support remote physical exams, with the goal of increasing access to care, reducing barriers for families, and streamlining processes so children receive timely, appropriate care.</p>

<p><b>Healthy Homes Partnership for Lead Poisoning</b></p>	<p>Our Care Management team will initiate a partnership with the Healthy Homes program to better support children identified with lead poisoning. By coordinating care management services with timely home-based environmental assessments, families will receive faster identification of lead hazards, targeted education, and connection to remediation and medical follow up. This integrated approach will improve care coordination, reduce care gaps between clinical treatment and environmental intervention, and help families address the root causes of lead exposure. Together, the partnership will advance our shared goal of improving health outcomes and long term well being for children affected by lead poisoning.</p>
<p><b>Redeployment of Advanced Population Health Management Point-of-Care Solution with AI Previsit Planning</b></p>	<p>In 2026, PCN will focus on improving adoption and maximizing value from existing population health management platform capabilities while incrementally enhancing functionality. PCN will partner closely with Innovaccer to introduce and feature a new AI-powered pre-visit summary tool. The new feature improves pre-visit planning by synthesizing key clinical data into actionable summaries. Strategies will include targeted reeducation and comparative performance insights to drive adoption and highlight newer features such as enhanced clinical note access, AI previsit summaries, and care management / SDOH referral tools. Incremental development will prioritize improving the completeness and timeliness of Children’s Mercy clinical notes following the Epic transition, expanding and deploying innovative AI previsit planning functionality, and executing a broad Innovaccer reeducation and redeployment campaign to reinforce user value and increase consistent use.</p>
<p><b>Targeted 2026 Quality Improvement Initiatives (Avoidable ED Visit Reduction, Childhood Immunization Status, Annual Well Visits-3 to 21 Years)</b></p>	<p>Avoidable ED improvement tactics will be developed to address the most significant barriers (1. Access to Care 2. Lack of Access Awareness 3. Family Education on Level of Care Needed). PCN will identify best practices and support distribution and implementation of these tactics across the network. PCN will also improve reporting by incorporating ED visit times to inform practice access improvement strategies.</p> <p>Age 2 Immunizations: PCN will continue to advance immunization improvement efforts by developing tools to support provider conversations around vaccine hesitancy, potentially administer vaccines in Children’s Mercy urgent care settings for patients who are behind, and continue to deliver targeted, actionable immunization reports to support transparency, outreach, and performance improvement.</p> <p>Annual Well Visits: PCN will utilize technology and reporting capabilities to drive improvement. Agentic AI will strive to influence highly unengaged patients to seek preventive care for the first time in over 2 years, support sick-to-well conversions using data driven strategies, and continue timely and actionable outreach.</p>





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