Care Integration
ANNUAL REPORT

CALENDAR YEAR
2018

Children's Mercy
PEDIATRIC CARE NETWORK

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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
INTEGRATED CARE SOLUTIONS

Overview of the Pediatric Care Network

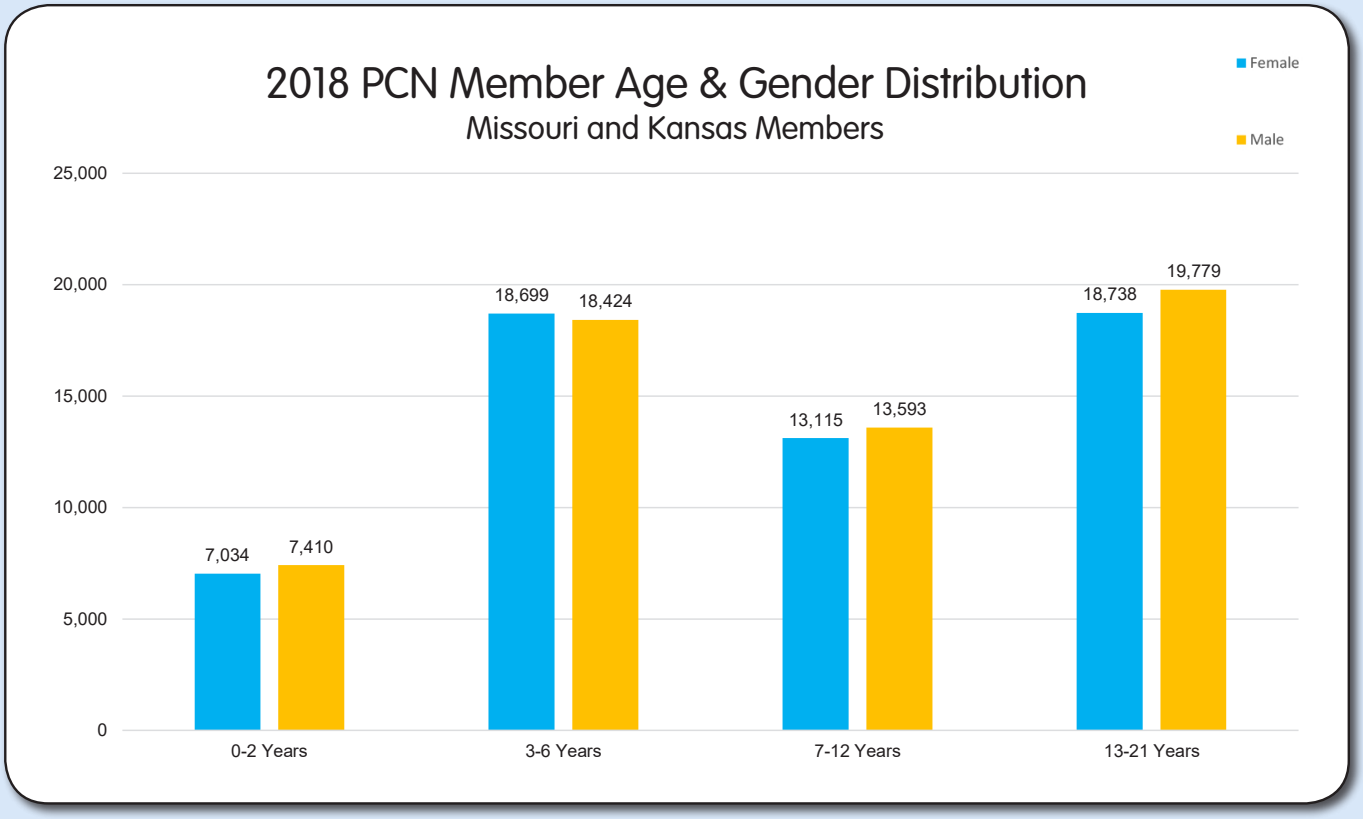
The Pediatric Care Network (PCN) offers a comprehensive Care Integration program, which provides case management (CM), care coordination (CC), utilization management (UM), and disease management (DM) using population health concepts and tools. The program focuses on preventive health and coordinating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

- Negotiating, procuring, and coordinating services and resources for patients and families with complex needs
- Facilitating care transitions across care settings
- Ensuring and facilitating the achievement of quality, clinical, and cost outcomes
- Assessing member needs and developing patient-centered care plans and interventions
- Addressing and resolving patterns of issues that have negative quality or cost impact
- Continually evaluating the effectiveness of program interventions to improve quality and health outcomes

Through data analysis and identification of high cost or high-risk trends, the PCN continually assesses the characteristics and needs of the population and sub-populations being managed to identify opportunities to enhance and/or modify its care integration program, including children with special healthcare needs, disabilities, and other complex health issues. Disease management interventions focus on two chronic conditions that are relevant to the pediatric population: asthma and diabetes. The PCN continually assesses program interventions and resources to determine if changes are needed to better meet the needs of the population.

The PCN performs delegated medical management functions under capitated risk agreements with Medicaid managed care organizations in Missouri and Kansas. PCN entered into agreements with Missouri Care in February 2014 and with UnitedHealthcare Community Plan of Missouri in May 2017. As of December 2018, PCN managed approximately 63,689 Missouri Care members and 29,789 UnitedHealthcare Community Plan of Missouri members, ages 20 and under in the Western Region. Effective 11/1/2017, PCN entered into a similar contract with UnitedHealthcare Community Plan of Kansas for 26,677 members, ages 21 and under in select counties.

Through those value-based contracts, providers agree to engage with the 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.

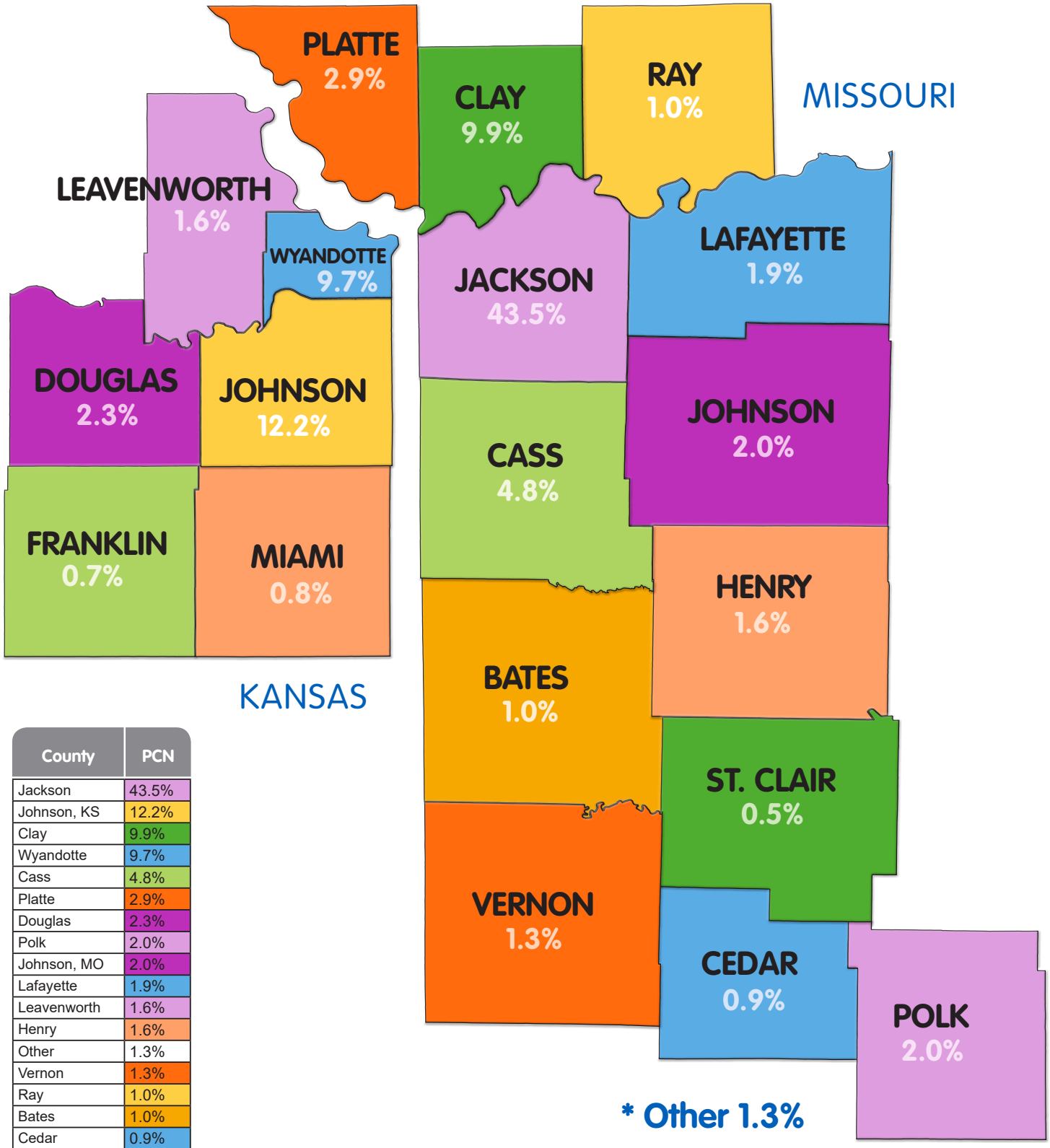


Population Analysis/Characteristics

As of Dec. 31, 2018, the male to female ratio of the PCN population is roughly 50% and the most concentrated population (approximately 65%) are in the 3-6 and 13-21 year age category. See chart illustrating the age and gender distribution of the PCN members in 2018.

PCN Membership

PCN members live in 19 metro counties, with a majority (43.5%) living in urban Jackson County.



County	PCN
Jackson	43.5%
Johnson, KS	12.2%
Clay	9.9%
Wyandotte	9.7%
Cass	4.8%
Platte	2.9%
Douglas	2.3%
Polk	2.0%
Johnson, MO	2.0%
Lafayette	1.9%
Leavenworth	1.6%
Henry	1.6%
Other	1.3%
Vernon	1.3%
Ray	1.0%
Bates	1.0%
Cedar	0.9%
Miami	0.8%
Franklin	0.7%
St. Clair	0.5%

PCN Network Providers -- Missouri

Baby and Child Associates
9140 Ward Parkway, Suite 201
Kansas City, MO 64114

Blue Springs Pediatrics
1600 NW South Outer Road
Blue Springs, MO 64015

Cass County Pediatrics and Adolescents -- an Affiliate of Children's Mercy
503 N Scott, Belton, MO 64102

Children's Mercy Broadway
3101 Broadway Blvd.
Kansas City, MO 64111

Children's Mercy Operation Breakthrough Clinic
3039 Troost Ave.
Kansas City, MO 64109

Christine Moore, DO
402 W Pine, Raymore, MO 64083

Cockerell and McIntosh
- **Blue Springs**
  205 NW RD Mize Road, Ste 304
  Blue Springs, MO 64014
- **Higginsville**
  1717 Main, Higginsville, MO 64037
- **Independence**
  11200 Winner Road
  Independence, MO 64052

Excelsior Springs Physicians Clinic
- **H. Andrew Pickett, MD**
  1236 Jesse James Road
  Excelsior Springs, MO 64024
- **Robert Buzard, MD**
  1010 N Jesse James Road
  Excelsior Springs, MO 64024

Family Practice Associates of West Central Missouri
- **Higginsville**
  1200 West 22nd St.
  Higginsville, MO 64037
- **Warrensburg**
  513 Burkarth Road
  Warrensburg, MO 64093

Hope Family Care
3027 Prospect Ave.
Kansas City, MO 64128

Independence & Lee's Summit Pediatrics
- **Independence**
  4731 S Cochise Drive, #100
  Independence, MO 64055
- **Lee's Summit**
  2 NE Sycamore
  Lee's Summit, MO 64086

KC Care Clinic
- 4601 Independence Ave.,
  Kansas City, MO 64124
- 3515 Broadway,
  Kansas City, MO 64111
- 2340 E. Meyer Boulevard,
  (Bld 1) Ste. 200, Kansas City,
  MO 64132

Lee's Summit Physicians Group
1425 NW Blue Parkway
Lee's Summit, MO 64086

Liberty Medical Center
1504 NE 96th St.
Liberty, MO 64068

Meritas Health Pediatrics
2700 Clay Edwards Drive, #500
Kansas City, MO 64116

Meritas Health Richmond
902 Wollard Blvd.
Richmond, MO 64085

Platte County Pediatrics
1104 Platte Falls Road
Platte City, MO 64079

Preferred Pediatrics LLC -- an Affiliate of Children's Mercy
241 NW McNary Court
Lee's Summit, MO 64086

Priority Care Pediatrics LLC
- **North Oak Kansas City**
  9405 N Oak Trafficway
  Kansas City, MO 64155
- **Parkville**
  6320 N Lucerne Ave.
  Kansas City, MO 64151
- **Liberty**
  1540 NE 96th St.
  Liberty, MO 64068

Raintree Pediatrics
995 SW 34th St.
Lee's Summit, MO 64082

Redwood Pediatrics -- an Affiliate of Children's Mercy
9151 NE 81st St., Ste 240
Kansas City, MO 64158

Samuel U Rodgers
825 Euclid, Kansas City, MO 64124
- **Clay County**
  800 Haines Drive
  Liberty, MO 64068
- **Lafayette**
  811 A South Highway 13
  Lexington, MO 64067
- **Northland**
  5330 N Oak Trafficway.,
  Suite 104,
  Kansas City, MO 64118
- **Westside Clinic**
  2121 Summit
  Kansas City, MO 64108

Swope Health Center
3801 Blue Parkway
Kansas City, MO 64130
- **Independence**
  11320 E Truman Road
  Independence, MO 64050
- **Riverside**
  4443 NW Gateway
  Riverside, MO 64150
- **Troost**
  8825 Troost Ave.
  Kansas City, MO 64131

T.P. Children & Teens Care
2340 E Meyer Blvd.
Suite 208 Bldg. 1
Kansas City, MO 64132

Tenney Pediatric & Adolescent Medicine
6501 E. 87th St.
Kansas City, MO 64138

Whistlestop Pediatrics
415 Burkarth Road
Warrensburg, MO 64093

NCQA Recognized Patient-Centered Medical Home Provider

PCN Network Providers -- Kansas

Children's Mercy Clinics on Broadway*
3101 Broadway Blvd.
Kansas City, MO 64111

Children's Mercy West
4313 State Ave.
Kansas City, KS 66102

Claudia McAllaster, MD
3550 S 4th St., Ste 110
Leavenworth, KS 66048

Debra Heidgen, MD
3550 S 4th St., Ste 120
Leavenworth, KS 66048

Lori Ann Golon, MD
1001 6th Ave., Ste 210
Leavenworth, KS 66048

Panda Pediatrics
346 Maine
Lawrence, KS 66044
- **Satellite Office**
  4824 Quail Crest Place
  Lawrence, KS 66049

Samuel U Rodgers
825 Euclid
Kansas City, MO 64124

Samuel U Rodgers Westside Clinic
2121 Summit
Kansas City, MO 64108

Swope Health Services
6013 Leavenworth Road
Kansas City, KS 66104

Swope Health Wyandotte
21 N 12th St., Ste 400
Kansas City, KS 66102

Vernon Mills, MD
3550 S 4th St., Ste 120
Leavenworth, KS 66048

Vibrant Health Wyandotte Neighborhood Clinics
- **Argentine**
  1428 S 32nd St. #100
  Kansas City, KS 66106
- **Central**
  21 N 12th St., Suite 300
  Kansas City, KS 66102
- **Children's Campus**
  444 Minnesota Ave.
  Kansas City, KS 66101

NCQA Recognized Patient-Centered Medical Home Provider

Key Staff Roles and Credentials

The PCN currently employs Registered Nurses, Social Workers, Respiratory Therapists, Medical Directors, and administrative/non-clinical staff to support the medical management and practice transformation work. Please refer to the Care Team Diagram in Appendix A.

PCP Aligned Care Teams

The disciplines employed by PCN are organized into Primary Care Provider (PCP)-aligned Care Teams. Certification in case management and disease-specific coaching is strongly encouraged and/or required of the PCN clinical staff. Currently, seven Care Team members have case management certification, as well as one certified asthma educator, one certified diabetes educator, and one certified Information and Referral Specialist.

<u>The Care Team objectives are as follows:</u>

- Assist members in sustaining or achieving an optimal level of wellness and function by facilitating timely and appropriate health care services
- Promote strong member/PCP relationships for coordination and continuity of care, using PCMH concepts
- Reduce inappropriate inpatient hospitalizations and utilization of emergency room services
- Promote clinical care that is consistent with scientific evidence and member preferences
- Ensure the integration of medical and behavioral health services
- Educate members in self-advocacy and self-management
- Minimize gaps in care and encourage use of preventive health services
- Achieve cost efficiency in the provision of

health services while maximizing health care quality
- Mobilize community resources to meet needs of members

The primary roles within the PCN working directly with members, caregivers, and community providers are detailed below.

Care Navigators

Care Navigators are licensed Registered Nurses (RN) or Social Workers (SW) whose primary role is to provide care coordination for identified at-risk members, addressing barriers to care for an assigned population of members. The Care Navigator promotes coordination of care and services for members along the health care continuum, as well as promotes quality care through appropriate, cost effective interventions.

The scope of practice for Care Navigators includes:
- Engage with members and providers utilizing all available resources, including integrated platforms (e.g., telehealth, portal access, face to face visits) for effective communication and workflow process
- Use data analytic tools and registries to identify and address needs of at-risk populations
- Participate in tri-annual Provider Practice Performance Profile reviews with each assigned PCP office and assist in identifying Care Team priorities based on data analysis and Care Team discussion
- Facilitate successful transitions of care for members and families across care settings, including assessing barriers, facilitating discharge planning, and promoting a seamless plan of care, which is communicated to all Care Team members
- Follow a care planning process to identify patient-centric goals and establish priorities
- Utilize a holistic approach, applying multiple theories and interventions, to motivate member/family engagement
- Conduct psychosocial screening and interventions to address behavioral and social needs
- Address social determinants of health as part of the ongoing assessment and care planning process
- Facilitate access to behavioral health resources and services
- Provide targeted education and facilitation of available health plan benefits and incentive programs
- Participate in pre-visit planning with the healthcare team to identify members appropriate for care coordination and/or tasks needed to meet member needs
- Identify and stratify member needs to facilitate referrals to other members of the Care Team (e.g., Community Health Worker, Social Worker, Nurse, Provider, Community Resource Agency, School, and Family Member)
- Facilitate end of life support for members, families, and the healthcare team
- Promote wellness through member education on disease-specific conditions and preventive care
- Participate in shared accountability for the identified team-based population measures

Community Health Workers

Community Health Workers are specially trained, non-licensed members of the Care Team who bridge the gap between health care providers and members/families in need of care. Community Health Workers are trusted members of and/or have a close understanding of the communities they serve. They serve as a link between the members/families and the health or social service agencies.

The scope of practice for Community Health Workers includes:
- Continuously expand knowledge of community resource services and programs
- Help members and their families adopt healthy behaviors
- Establish trusting relationships with members and their families while providing general support and encouragement
- Refer and assist with accessing necessary

social services (e.g., Legal Aid, housing, food, and transportation services)
- Facilitate successful appointments for members and families including: assisting with preparation for appointments, attending appointments, and helping members and families understand information
- Assist members and their families in accessing health related services, including but not limited to: connecting with a medical home, providing instruction on appropriate use of the medical home, and overcoming barriers to obtaining medical, social, and behavioral health services
- Participate in shared accountability for the identified team-based population measure

Community Resource Specialists

Community Resource Specialists work as members of the Care Team to support population health initiatives and care coordination. This position works closely with all areas of the PCN and its stakeholders, including providers, members and families, community agencies, and other health care professionals.

The scope of practice for Community Resource Specialists includes:
- Provide outreach and education to members, families, and other healthcare team members in addressing gaps in care and resource needs
- Distribute tasks and referrals to appropriate Care Team members
- Participate in tri-annual Provider Practice Performance Profile reviews with each assigned PCP office and assist in identifying Care Team priorities based on data analysis and Care Team discussion
- Assist members and families with problem solving, addressing concerns, and ensuring education about available community resources
- Provide support with prior authorization processing for assigned Care Team
- Provide education and organization of community resources
- Establish and maintain relationships with key community stakeholders through ongoing shared information and learning (e.g., lunch and learns, participation in volunteer opportunities, maintaining event calendar for team member access, ensuring key information is updated and shared)

Care Facilitation Coordinators

Care Facilitation Coordinators are trained administrative staff who serve on the front lines answering provider calls and reviewing, processing, and distributing faxes to the Care Integration department. They assist with entering prior authorization information, screening pregnancy notification forms, facilitating referrals to home care agencies, and assisting the PCP aligned Care Teams with other duties to support functions within the department.

The scope of practice for Care Facilitation Coordinators includes:
- Distribute work to Care Team members and perform general administrative duties to support the Care Teams and management staff
- Receive phone calls from PCN providers and answer questions regarding benefit plans, prior authorization process or status, or other related issues
- Process prior authorization requests from PCN providers and enter determinations into online documentation system based on pre-established criteria and per documentation standards
- Analyze data and identify opportunities for improvement in Care Integration department processes

Care Facilitation Nurses

Care Facilitation Nurses are Registered Nurses who are responsible for prior authorization functions for inpatient and outpatient services, using evidence-based clinical criteria. The Care Facilitation Nurse works in collaboration with the provider offices by providing education on the prior authorization process, facilitating referrals to

network providers, providing member outreach to identify and screen members with complex needs for enrollment into Care Integration programs, and sharing of pertinent patient information with Care Teams to enhance coordination of care.

The scope of practice for Care Facilitation Nurses includes:

- Receive prior authorization requests requiring clinical review and enter determinations into online documentation systems
- Conduct psychosocial pre-screening and interventions to identify members whom would benefit from enrollment into Care Integration programs
- Address social determinants of health as part of the screening process
- Provide targeted education and facilitation of available health plan benefits and incentive programs

Practice Facilitation Specialists

Practice Facilitation Specialists work with Primary Care Provider practices to facilitate practice transformation and support practice management processes aimed toward improving member outcomes. Practice Facilitation Specialists use evidence-based guidelines and best practices as a basis for teaching chronic disease management, wellness promotion, and patient-centered medical home (PCMH) concepts. Their role includes promoting a culture of learning and quality improvement (QI) within practices and providing coaching to support transformation and sustained change.

The scope of practice for Practice Facilitation Specialists includes:

- Provide training on data analytic tools to support population health/PCMH initiatives
- Assist Care Teams with data analytics for Provider Practice Performance Profile reviews to support Care Team discussions and initiatives
- Participate in tri-annual Provider Practice Performance Profile reviews with each assigned PCP office and assist in identifying Care Team priorities based on data analysis and Care Team discussion
- Prepare PCP tri-annual engagement progress reports and compensation education
- Teach and support PCMH concepts and monitor ongoing sustainability of processes
- Provide evidence-based, condition specific training for provider practices, including asthma, diabetes, and healthy lifestyles
- Participate in shared accountability for the identified team-based population measures

Provider Relations Representatives

The Provider Relations Representatives work as part of the Care Team to keep provider offices informed and functioning at the highest level possible with all population management tools and resources. They assist practices with understanding the Medicaid contracts and provide a streamlined communication with the Managed Care Organization (MCO) on behalf of the PCN providers.

The scope of practice for Provider Relations Representatives includes:

- Maintain accurate participating provider status, update provider directories, and assist in maintenance of online provider directories
- Assist with resolution of provider issues regarding claims status and enrollment issues
- Assist with individual PCP assignment issues and PCP changes from the PCN provider to the MCO
- Facilitate a streamlined, non-redundant credentialing process for PCN providers
- Participate in tri-annual Provider Practice Performance Profile reviews with each assigned PCP office and assist in identifying Care Team priorities based on data analysis
- Participate in shared accountability for identified team-based population measures analysis and team discussions

Quality Improvement Team

PCN's Quality Improvement Team engages in work that supports population health management, patient-centered medical home transformation, and identification of opportunities to enhance PCN's Care Integration program.

Quality Improvement Program Manager

The ICS Quality Improvement Program Manager leads and supports population health work related to multiple quality improvement initiatives and programs. Responsibilities include identification of meaningful quality improvement opportunities, performing data collection and analysis, supporting project teams through the quality improvement process, designing and producing quality reports, and assessing and articulating the impact of specific quality improvement interventions to internal and external leadership.

The scope of practice for the Quality Improvement Program Manager includes:

- Identify quality improvement opportunities and manage quality improvement initiatives related to population health interventions
- Develop reports and collect quality improvement data from various sources, including the clinical data integration platform, which drives initiatives within PCN, as well as contracted primary care provider offices
- Use established metrics to measure performance and outcomes
- Prepare and present reports for internal and external stakeholders including annual reports, Provider Practice Performance Profiles, state required reports, as well as other custom reports
- Analyze performance measure definitions to obtain deep understanding in order to educate Care Team and provider practices
- Mentor PCN staff in quality improvement processes and use of quality improvement tools

Clinical Project Manager

The Clinical Project Manager is a key position in supporting the PCN management team with oversight and implementation of the programs for utilization management, case management and disease management.

The scope of practice for the Clinical Project Manager includes:

- Support care integration processes and initiatives to ensure compliance with all delegation agreement terms, state, federal, and NCQA requirements
- Maintain internal clinical criteria, ensuring annual review of literature, approval by appropriate committees, and distribution to staff and PCN provider network
- Maintain policies and desktop procedures, ensuring annual review and distribution to staff
- Develop and distribute health plan oversight reports and prepare presentations for health plan oversight meetings
- Assist with the development of the Case Assessment Referral Evaluation (C.A.R.E. Web) documentation system to meet workflow processes and reporting requirements; assist in modifying C.A.R.E. Web prior authorization interfaces to meet health plan requirements
- Assist in developing and maintaining procedural manuals and facilitate training for staff on C.A.R.E. enhancements, documentation standards, NCQA requirements, and general processes
- Serve as primary liaison with the health plans for appeal and grievance coordination
- Identify and facilitate quality improvement opportunities related to daily work within the Care Integration department
- Lead work groups in developing annual competency assessment packets for each role within care integration

Staff Education and Development

Care Integration staff attended training and educational offerings throughout the year to support maintenance of core competencies and ongoing professional development.

A total of **365 CEUs** were obtained in 2018. The following are some of the topics and educational offerings attended by the Care Integration staff.

- Adolescent Substance Abuse
- Alternatives to Prescription Pain Medications
- Banishing Bullying Behaviors
- Behavioral Health Integration Strategies
- Case Management & Telemedicine
- Case Management Solutions
- Case Manager's Role in Behavioral Healthcare Integration
- Case Managers Tackle the Opioid Epidemic
- Childhood ADHD Health Outcomes
- Cultural Competency
- Cultural Humility
- Delayed Sequence Intubation
- Diabetes Care
- Disability in the Workplace
- Effective Communication
- Electronic Access to Health Care
- End Stage Heart Failure
- Ethical Decision Making
- Ethics in Nursing
- Fetal Spina Bifida Surgery
- Food Decision Making in Youth
- Fundamentals of Trauma
- Gang Violence Prevention
- Health Equity
- Health Literacy
- Healthcare for Children in Protective Custody
- Healthcare in the Community
- Healthy Homes
- Hospital Ethics Committees
- Human Trafficking
- Impact of Trauma on the Developing Brain
- Inpatient Bronchial Hygiene Treatments
- Interstitial Lung Disease
- Intimate Partner Violence
- Ketogenic Diet Support Group
- Language of Bioethics
- Legislation, Laws, and the Impact of Bullying
- Medical Director's Role in Case Management
- NAVA Mode of Ventilation in the NICU
- Neuroscience of Trauma
- Opioid Management
- Organ Donation
- Palliative Care Models
- Person-Centered Approach to DSM-V
- Post Intubation Sedation Strategies
- Pregnancy Complications
- Primary Ciliary Dyskinesia
- Resilience at Work
- Respiratory Management of Patients on ECMO
- Severe Asthma Therapies
- Social Determinants of Health in Primary Care
- Strategic Management of Bullying in Health Care
- Suicide Prevention
- Supporting Employees During Times of Need
- Supporting Transgender Youth in Healthcare
- Transgenerational Trauma and Resiliency
- Transportation Equity
- Traumatic Brain Injury
- Triple Aim in Hospital Case Management

Conferences Attended in 2018

ACMA Missouri/Kansas 13th Annual Case Management Conference- Overland Park, KS
2018 ACMA National Case Management Conference - Houston, TX
2018 Mental Health Kansas City Conference-Kansas City, MO
CMSA Kansas City Chapter 25th Annual Case Management Conference- Overland Park, KS
19th Annual Respiratory Care Symposium Sponsored by Children's Mercy Hospital-Kansas City, MO
2018 Heartland Conference on Health Equity and Patient Centered Care-Kansas City, KS
Achieve Targets in Diabetes Care Keystone Conference – Keystone, CO

2 Population Health Management

- Patient-Centered Medical Home Transformation Program
- Provider Portal
- Data Analytic Tools
- Patient Outreach Initiative
- Provider Performance Profile
- C.A.R.E. Web
- Community Integration
- Patient Experience
- Program Measures
- Future Initiatives

Population Health Management

Thomas Jefferson University College of Population Health defines population health management as follows: **"Population health seeks to create conditions that promote health, prevent adverse events, and improve outcomes."** It addresses the large-scale social, economic, and environmental issues that impact health outcomes of groups of people. "Population health builds on public health foundations by:

- Connecting prevention, wellness, and behavioral health science with health care delivery, quality and safety, disease prevention/ management, and economic issues of value and risk – all in the service of a specific population, be it a city, provider's practice, employee group, hospital's primary service area, or age group;
- Identifying socio-economic and cultural factors that determine the health of populations and developing policies that address the impact of these determinants;
- Applying epidemiology and biostatistics in new ways to model disease states, map their incidence, and predict their impact;
- Using data analysis to design social and community interventions and new models of health care delivery that stress care coordination and ease of accessibility."

-Thomas Jefferson University, 2016

Triple Aim

In order to meet the demands of today's ever-changing health care environment, each PCN goal and initiative has been designed to reflect all three dimensions of the "Triple Aim," a framework designed by the Institute for Healthcare Improvement that describes an approach to optimizing health care delivery. Therefore, the PCN continues to engage community providers and practices by working to:

1. Improve the patient care experience;
2. Improve the health of the populations we serve;
3. Reduce the per capita cost of health care by advancing initiatives that emphasize quality improvement, data analytics, and the Patient-Centered Medical Home.

- Institute for Healthcare Improvement, 2018

Patient-Centered Medical Home Transformation Program

The Patient-Centered Medical Home (PCMH) is a promising model for transforming the organization and delivery of primary care. A PCMH is defined not simply as a place but as a model that encompasses five functions and attributes of primary care: a patient-centered approach, comprehensive care, coordinated care, superb access to care, and a systems-based approach to quality and safety.

- Agency for Healthcare Research and Quality PCMH Resource Center, November 2017

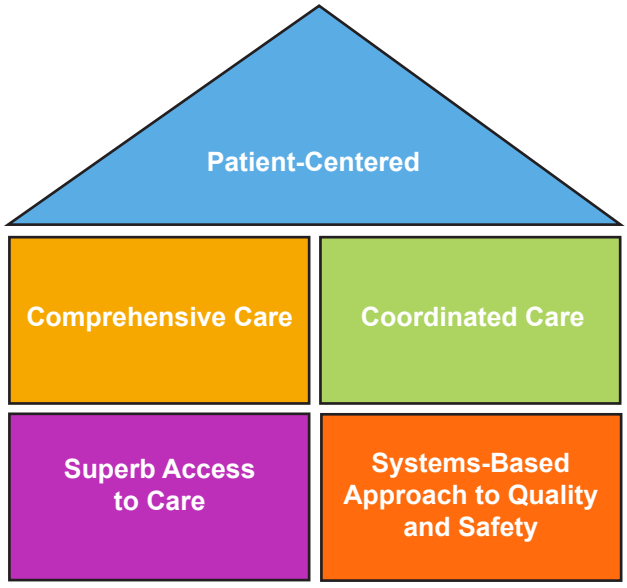
The PCN makes the following strategies and resources available to help practices transform and maintain Patient-Centered Medical Home (PCMH) components:

- PCMH readiness evaluation;
- PCMH and National Committee for Quality Assurance (NCQA) consulting services;
- Use of patient registries for population management;
- Patient communication/outreach templates and material;
- Gaps in Care reports for assigned members;
- Tri-annual progress reports provided and reviewed with the provider practice.

The PCN's programs target best practices and underscore the patient-provider relationship, patient self-management skills, and improved health care utilization. These programs are designed to educate providers, office staff, and patients/caregivers on appropriate diagnosis, treatment, and management of chronic conditions. Promotion of preventive care for the entire patient population continues to be a focus of the PCN's population health program.

The Patient-Centered Medical Home (PCMH) Program monitors the implementation of care processes and development of practice level PCMH infrastructure, meeting medical home qualification criteria, within the secure PCN Provider Portal. This program began July 1, 2014 with customized quarterly progress reports provided to the participating provider offices.

Practice Facilitation Specialists work side-by-side with the practice staff to reinforce skills and foster behavior changes focused on the key elements of PCMH. The medical home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. Building on the work of a large and



growing community, the Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.

The medical home encompasses five functions and attributes:

Patient-centered: The primary care medical home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level of the patient's choosing. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.

Comprehensive care: The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants,

nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities.

Coordinated care: The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.

Superb access to care: The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The medical home practice is responsive to patients' preferences regarding access.

A systems-based approach to quality and safety: The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

- Agency for Healthcare Research and Quality PCMH Resource Center, November 2017

References:

Thomas Jefferson University. (2017). Jefferson College of Population Health – About Us. Retrieved from https://www.jefferson.edu/university/population-health/about.html

Institute for Healthcare Improvement. (2018). The IHI Triple Aim. Retrieved from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Agency for Healthcare Research and Quality PCMH Resource Center. (2017). Defining the PCMH. Retrieved from https://pcmh.ahrq.gov/page/defining-pcmh

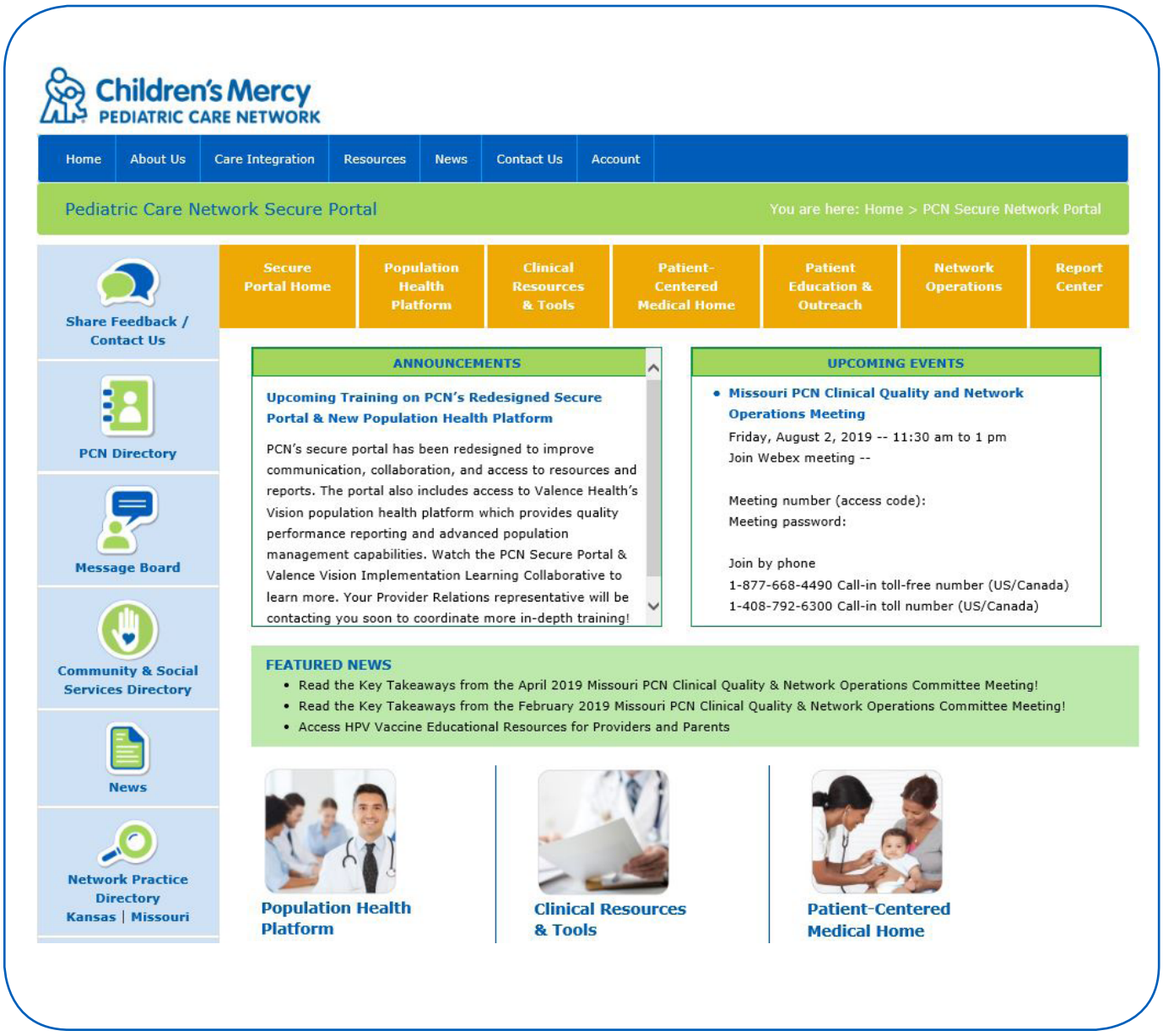
PCMH Engagement

	Score
NCQA PCMH Recognition (Level 1, 2, or 3) ** Pre 2017 standards **	0
Use of Team-Based Care to Work 3 Registries	0
Patient Satisfaction Survey & Improvement Initiative	0
Learning Collaborative Participation	0
CQI Infrastructure and/or 2 Quality Improvement Initiatives	0
Closed Loop Referral Tracking Process	0
Established Process to Manage High Risk Patients	0
Established Process to Manage Transitions	0
Established Care Coordination Process with PCN Care Navigators	0
Established Process to Address Behavioral Health Concerns	0
Total Points:	0

** A practice recognized as a 2017 NCQA Patient Centered Medical Home (PCMH) automatically receives credit for all "Practice Engagement Performance Measures" meeting goal.

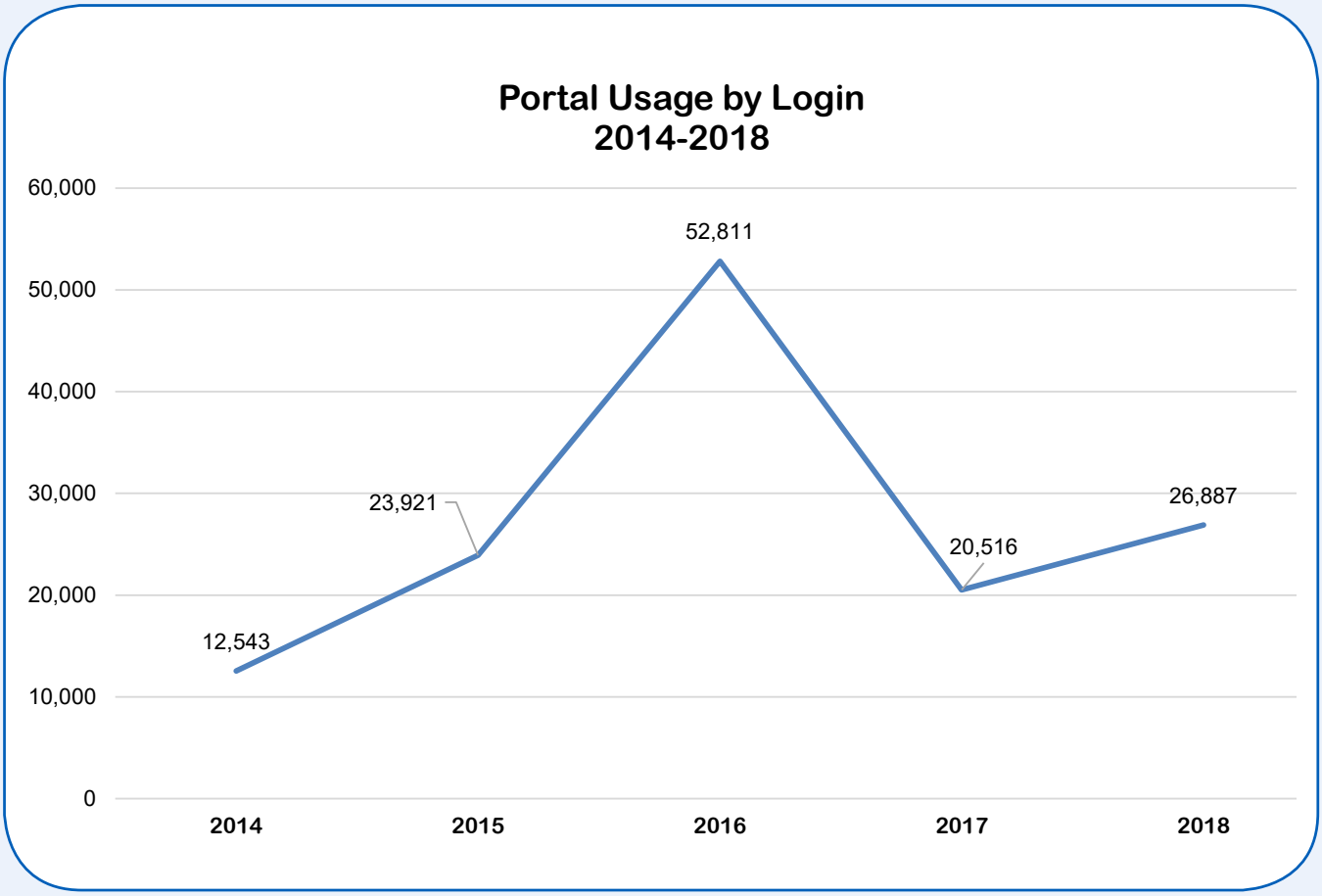
Through continued support of the medical home model and National Committee for Quality Assurance (NCQA) PCMH standards, further enhancements include closed-loop referral tracking, discussion board format for Learning Collaborative participation, and enhanced behavioral health integration. Alignment with the Missouri MO HealthNet contract is also included with the goals of improving Healthcare Effectiveness Data and Information Set (HEDIS) scores and completing timely Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams.

Provider Portal



PCN's secure Provider Portal provides a tool to facilitate communication, collaboration, and access to resources and reports to practices within the network. Since its creation, the PCN secure Provider Portal has undergone periodic updates and enhancements to ensure that it is a dynamic, up-to-date resource for PCN providers.

Features of the portal include personalized logins for each practice; access to data analytic tools and clinical practice guidelines; and various pediatric resources that help practices stay informed and continue to deliver evidence-based care. Also available in Clinical Tools and Resources are quick links to Pediatric Specialty Education webinars and previous and current Learning Collaborative recordings. Providers also get access to High-Risk Registries designed to identify patients in need of preventive care or patients who need chronic disease management.

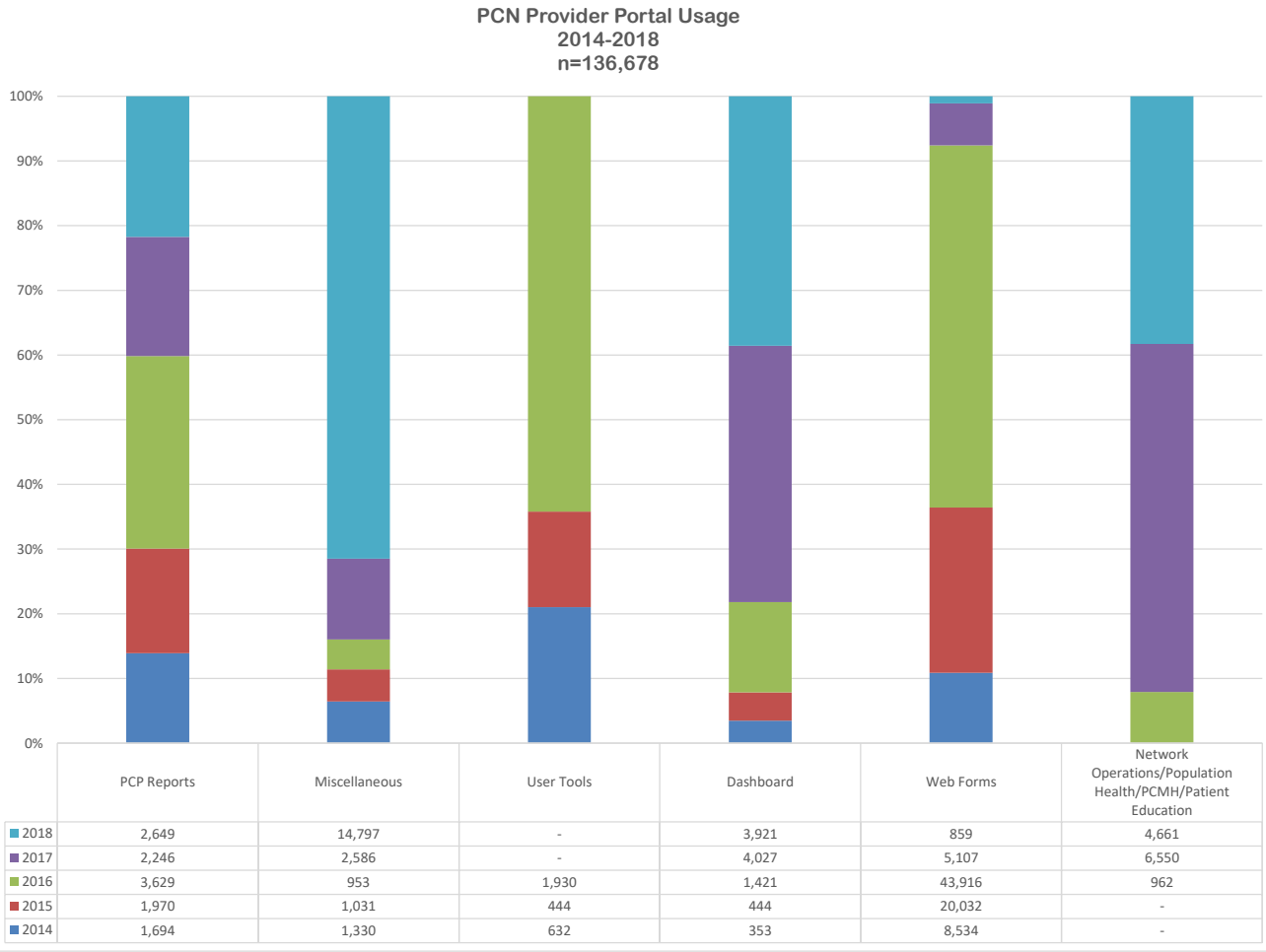


For more efficient use of time, quick access has been provided to reference tools, such as the PCN Quality Improvement Tool Kit, quality improvement tools, measure descriptions, billing and coding guides, and much more. Other features of the Provider Portal include a page dedicated to current Patient Center Medical Homes and resources for those working to become certified.

A Network Operations page provides access to Care Team documentation, information on network membership, payer contracts, and forms/resources to utilize clinical services (utilization management, case management, and disease management).

Lastly, the portal provides a Report Center where practices have access to their panel lists, Gaps in Care reports, and Engagement Compensation.

PCN Care Teams encouraged usage of the portal in 2018.
From 2017 to 2018, PCN saw a 31% increase in usage of the portal.



	PCP Reports	Miscellaneous	User Tools	Dashboard	Web Forms	Network Operations/Population Health/PCMH/Patient Education
2018	2,649	14,797	-	3,921	859	4,661
2017	2,246	2,586	-	4,027	5,107	6,550
2016	3,629	953	1,930	1,421	43,916	962
2015	1,970	1,031	444	444	20,032	-
2014	1,694	1,330	632	353	8,534	-

Web Forms (Registries)	PCP Reports	Miscellaneous	Network Operations
• Asthma/Diabetes	• ER Visits	• Announcements	÷ Clinical Practice Guidelines
• ED Frequent Flyers	• Inpatient Admissions	• Calendar	÷ Clinical Resources and Tools
• Members in Case Management	• Members Under Case Management	• Contact Us	÷ Discussion Board
• Age 2 Immunizations-Combo 2	• PCP Capitation	• Directory	÷ Learning Collaboratives
• EPSDT	• PCP Engagement Compensation	• Feedback	÷ Links
• Well Child Visits	• PCP Panel List	• Provider Search	÷ Network Operations
• Radiology		• Research Links	÷ Patient Centered Medical Home
• Referrals & Consults			÷ Patient Education and Outreach
			÷ Population Health Platform

Learning Collaborative

The Learning Collaborative concept has been utilized extensively in the support of dissemination of information required for PCMH transformation. The PCMH transformation team uses a model in community settings to coach practices by providing education related to the medical home model and allowing for educational topics to be presented. Two 30-minute topics are recorded each quarter. PCN distributes these recordings and their supporting documents to clinics to watch during a time that fits into the workflow of office staff and providers.

The goals of the Learning Collaborative include providing education on the development of PCMH processes and policies while also sharing best practices in a supportive group environment. Didactic sessions offered include PCMH topics such as team-based care, quality improvement, case management, and care coordination.

Learning Collaborative Topics for 2018:

Pediatric Stabilization Preparation
Brain Injury in Sports
Weight Management Flow Sheet
C.A.R.E. Web
Short Stature with Normal Growth
Highlighting Partnership with Harvesters
2017 Pediatric Blood Pressure Guideline Updates

Local Community Care Coordination Program (LCCCP) Measures

The PCN is a state-approved Local Community Care Coordination Program (LCCCP) model for Missouri Medicaid focusing on providing case management, care coordination, and disease management in collaboration with local healthcare providers. Below are some of the key LCCCP metrics monitored in 2018.

		2018			
	Measure Description	**Q1**	**Q2**	**Q3**	**Q4**
Category	**General Population Data**				
Providers	**Total Number of Providers**: Number of providers in the LCCCP for the reporting period.	1,616	1,563	1,632	1,659
Members	**Total number of Members**: Number of members in the LCCCP for the reporting period.	90,082	89,995	88,560	87,808
Category	**Access**				
Access to Well Care Services	**Access to Well Care**: Percentage of ill/sick visits that are converted to a well care visit (opportunity taken to address preventive care during sick visit)	15.8 %	20.6 %	18.9 %	15.5 %
Category	**Care Coordination**				
Transitional Support	**Transitional Care Support**: Percentage of hospital-discharged members who had an ER visit within 30 days of discharge.	17.7 %	17.9 %	16.8 %	13.2 %
Member Engagement	**Member Engagement with Care Teams**: Percentage of at-risk members who had a plan of care initiated by the Care Team.	1.7 %	2.3 %	5.4 %	7.1 %
Provider Engagement	**Provider Engagement**: Percentage of providers that reviewed the care plan.	3.8 %	3.2 %	5.5 %	1.0 %
Community Engagement	**Community Engagement**: Percentage of at-risk members linked to community resources.	0.2 %	1.1 %	4.2 %	8.7 %
Care Team Engagement	**Interdisciplinary Team**: Percentage of care plans including more than one discipline (MD, RN, SW, CRS).	9.3 %	15.4 %	35.3 %	50.5 %
Member Activation	**Goal Completion**: Percentage of members that successfully completed a personal goal in the care plan.	9.3 %	30.9 %	51.3 %	59.8 %
Category	**Condition Management**				
Pediatric Asthma	**Asthma Prevalence**: Members identified with a diagnosis of asthma as a percentage of total members through 20 years of age - lookback period of 12 months for asthma diagnosis	10.5 %	10.6 %	10.6 %	10.6 %
Pediatric Diabetes	**Diabetes Prevalence**: Members identified with a diagnosis of diabetes as a percentage of total members through 20 years of age - Type I and Type II combined - lookback period of 12 months for diabetes diagnosis	0.3 %	0.3 %	0.3 %	0.3 %
Ambulatory Sensitive Conditions - Pediatric Quality Acute Composite	**Pediatric Quality Acute Composite (AHRQ PDI 91)**: Composite of the following acute conditions per 100,000 population ages 6 to 17 years. PDI #16 - Gastroenteritis Admission Rate PDI #18 - Urinary Tract Infection Admission Rate	4.1	2.3	2.3	2.3
Ambulatory Sensitive Conditions - Pediatric Quality Chronic Composite	**Pediatric Quality Chronic Composite (AHRQ PDI 92)**: Composite of the following chronic conditions per 100,000 population ages 6 to 17 years. PDI #14 - Asthma Admission Rate PDI #15 - Diabetes Short-Term Complications Admission Rate	9.4	18.5	14.1	16.6
Category	**Utilization**				
Emergency Room	**Emergency Room Utilization**: ER Visits per 1,000 members	592	664	658	581
Inpatient	**Hospital Readmission**: Hospital readmissions within 30 days - all cause	11.8 %	9.6 %	8.8 %	7.0 %
Inpatient	**Inpatient Utilization - Admissions**: Inpatient Admissions per 1,000 members	54	57	41	50
Inpatient	**Inpatient Utilization - Days**: Inpatient Days per 1,000 members	190	195	136	170
Cost of Care	**Cost of Care: Hospital Inpatient - Acute Medical/Surgical**: Per Member Per Month (PMPM) cost total by service category.	$ 12	$ 22	$ 7	$ 24
Cost of Care	**Cost of Care: Hospital Inpatient - Maternity**: Per Member Per Month (PMPM) cost total by service category.	$ 1	$ 1	$ 0	$ 2
Cost of Care	**Cost of Care: Hospital Outpatient - ASU**: Per Member Per Month (PMPM) cost total by service category.	$ 15	$ 18	$ 22	$ 23
Cost of Care	**Cost of Care: Hospital Outpatient - ER**: Per Member Per Month (PMPM) cost total by service category.	$ 23	$ 29	$ 39	$ 35
Cost of Care	**Cost of Care: Hospital Outpatient - All Other**: Per Member Per Month (PMPM) cost total by service category.	$ 18	$ 29	$ 40	$ 37
Cost of Care	**Cost of Care: Physician/Professional - Office Visits**: Per Member Per Month (PMPM) cost total by service category.	$ 5	$ 7	$ 10	$ 9
Cost of Care	**Cost of Care: Physician/Professional - All Other**: Per Member Per Month (PMPM) cost total by service category.	$ 8	$ 11	$ 16	$ 14
Cost of Care	**Cost of Care: Pharmacy**: Per Member Per Month (PMPM) cost total by service category.	$ 28	$ 53	$ 73	$ 93
Cost of Care	**Cost of Care: Ancillary - DME**: Per Member Per Month (PMPM) cost total by service category.	$ 1	$ 2	$ 2	$ 2
Cost of Care	**Cost of Care: Ancillary - Home Health**: Per Member Per Month (PMPM) cost total by service category.	$ 1	$ 1	$ 2	$ 2
Cost of Care	**Cost of Care: Ancillary - All Other**: Per Member Per Month (PMPM) cost total by service category.	$ 0	$ 2	$ 2	$ 2
Out of Network Utilization	**Outside of LCCCP Primary Care Utilization**: Percentage of utilization for primary care services outside the LCCCP network.	8.0 %	10.4 %	10.3 %	11.2 %

Data Analytic Tools

Financial Data Analytics

PCN recognizes that effectively managing a population requires the use of medical claims, pharmaceutical claims, and eligibility information to measure performance and gain insights into cost and utilization trends. PCN financial analytic capabilities measure and track key health cost and utilization measures (e.g. Risk Scores, Paid Per Member Per Month, Admissions/1,000, Days/1,000, Average Length of Stay, ER Visits/1,000, etc.) at the network, practice, and provider level. PCN continues to use financial analytic capabilities to support and evaluate existing programs and identify new initiatives to more effectively manage the population and deliver value.

Specialty Engagement & Episodes of Care

In order to effectively manage a Medicaid population, both primary care and specialty providers must be engaged. In 2018, PCN continued to meet quarterly with select specialty divisions to further collaboration and increase PCN engagement with specialists.

Improving PCP to Specialist Coordination - Pediatric Specialty Education Spotlights

In 2017, PCN introduced “Pediatric Specialty Education Spotlights” which are 10-20-minute recorded webinars presented by Children’s Mercy specialists. These spotlights are structured to help support primary care providers in diagnosing, treating, managing, and referring patients. Each webinar utilizes a “visit documentation template” and focuses on what the PCP should do before the specialty consultation with the goal of better managing and coordinating care. Specialists cover key aspects of the history, physical examination, applicable tests/exams, medical management, and when it is or is not appropriate to refer.

Pediatric Specialty Education Spotlights

Access short 10-20 minute webinars by Children’s Mercy specialists that are structured on a "visit documentation template". Each webinar focuses on what the PCP should do before the specialty consultation (i.e. not what the specialist does in managing a condition) with the goal of better managing and coordinating care.

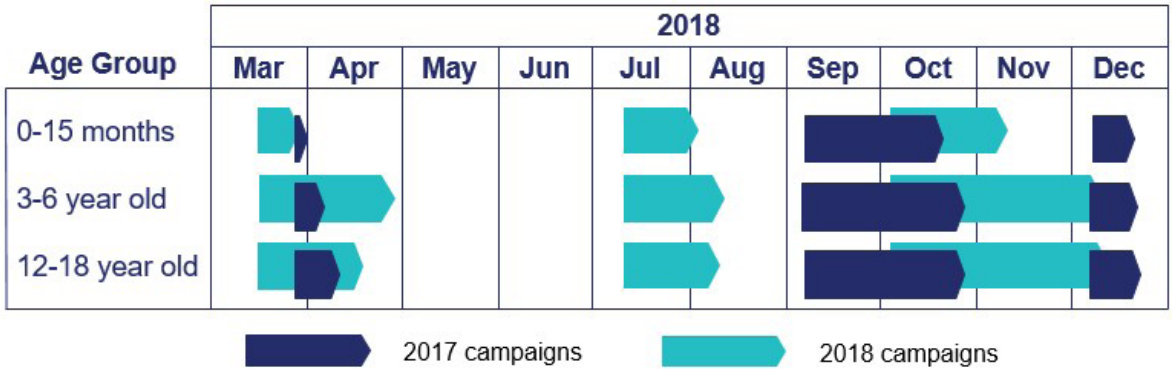
Most Recent Topics	Recorded Webinar	Slide Deck	Visit Documentation Template	Resource Packet
Short Stature with Normal Growth	Watch Webinar	Download	Download	Download
Limp in a Child or Adolescent	Watch Webinar	Download	Download	Download
Back Pain in a Child or Adolescent	Watch Webinar	Download	Download	N/A

Pediatric Specialty Education Archive — Access all previously recorded Pediatric Specialty Webinars.

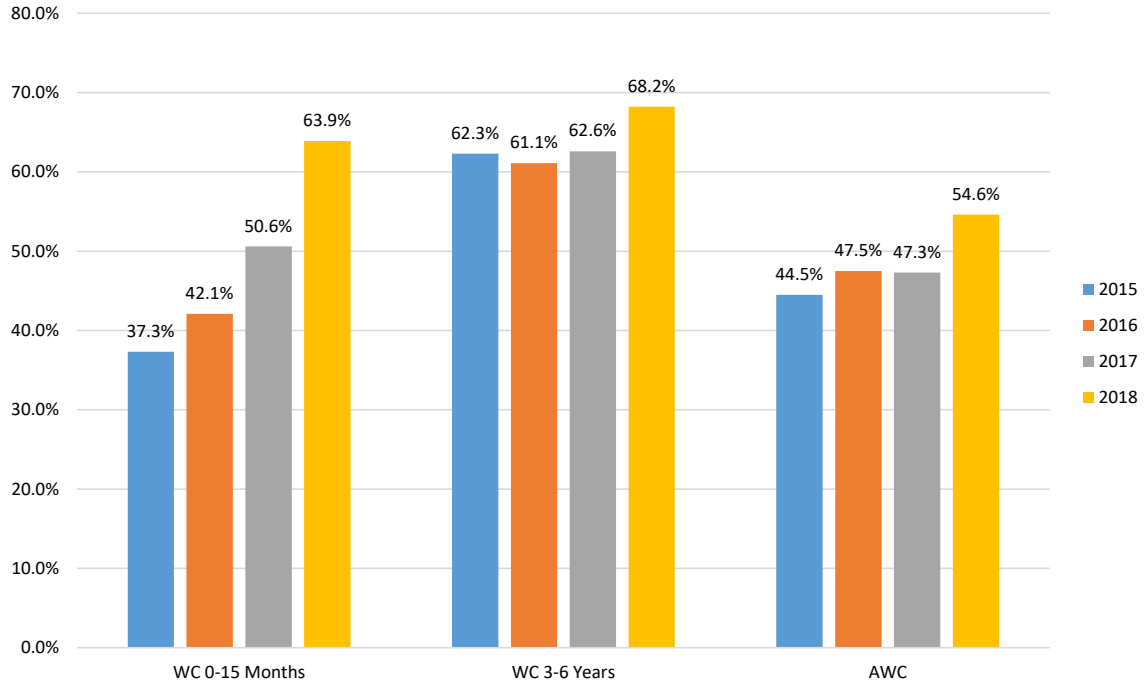
Patient Outreach Initiative (EMMI)

The PCN continued to work with Evolent Health for Patient Outreach Services in 2018, making it a standard tool for PCN practices. The service uses interactive voice response technology (IVR) to place a series of automated calls to drive patient action. More than 79,000 outreaches were made to over 41,000 patients in 2018. The 2018 patient engagement rate (transferred to practice for scheduling, given scheduling information, or told they are due for a well-visit) increased 5 percentage points from 21% in 2017 to 26% in 2018 across all campaigns.

Summary of 2018 Campaign Timing



HEDIS Rate Comparison EMMI Practices (in aggregate) 2015-2018



Analysis

The intervention of EMMI outreach proves to be a valuable component for PCN patient outreach. In 2018, a total of 16 practices were included in the outreach initiative. EMMI outreach focuses on increasing rates for key HEDIS measures within the program populations. These rates have increased 15 percentage points overall in 2018.

In 2018 PCN implemented an asthma outreach campaign during Phase 2. This campaign aimed to elevate overall engagement for patients with asthma and led to 2,100 outreach calls engaging 275 patients.

Future Initiatives

The PCN and EMMI partnership has shown positive results and EMMI will continue to be a standard tool for PCN practices. The 2019 phases will mirror those of 2018, with the hope to introduce a new campaign to target case management in the first quarter of 2019. The program is on track to reach more patients with these additional campaign efforts.

Provider Performance Profile

PCN continues to deliver actionable and meaningful cost and utilization data to PCN practices and providers (see Provider Practice Performance Profile on pages 106-109). The Provider Performance Profiles provide meaningful insights on cost and utilization variation as well as actionable information on a practice's highest cost and highest risk patients. PCN Care Teams review the Provider Performance Profiles in detail with PCN practices three times per year, jointly identifying opportunities to outreach and/or collaborate on managing and caring for the highest cost and highest risk patients. Based on practice feedback and an ongoing effort to enhance the value of these reports, the report content continues to be refined and tailored. As an example, rates of inpatient admission have been updated to remove normal newborns, allowing for a more meaningful evaluation of admissions pertaining to chronic conditions.

The Provider Performance Profile has four components: the Report Package Summary, the Rolling Year Measure Report, the Cost and Utilization Report, and the High Cost and High Utilization Report.

Report Package Summary

The Report Package Summary provides a high-level summary of both the quality and cost reports. It gives the practices a snapshot of what they did well and where they have room for improvement during that captured time period. The Care Teams work with the practices to develop goals for performance to help guide each practice on how to improve their selected initiatives.

PEDIATRIC CARE NETWORK TRI-ANNUAL REPORT PACKAGE

To deliver high-value care that meets the Triple Aim of Better Care, Smarter Spending, and Healthier Children, the PCN Tri-Annual Report Package informs practices of their quality and cost performance and provides observations and potential improvement ideas for consideration and review with each practice.

We are striving to make the information useful, valuable, and actionable. We welcome your feedback!

Quality Performance Report - *Observations & Potential Improvement Ideas*

Observations and Comments

Rolling Year Quality Measure Reports

Rolling Year Reports are based on the “estimated” rolling year by basing performance on the last 13 months of claims data. Thirteen months of claims data approximates a year because claims are not 100% complete in the most recent months.

The performance period for Early Periodic Screening, Diagnosis and Treatment (EPSDT) and Provider Engagement are also presented at the top of the report if applicable.

Care Gap Report

The Patient Outreach Care Gap Priority Report is one of the resources and tools available in the PCN Quality Improvement Tool Kit. The report is based upon all data available to PCN to inform practices of which patients have particular gaps in care (based on age and diagnosis history).

The report provides detail on both “compensated” and “non-compensated” gaps in care and sorts the list in descending order of patients with the most compensated care gaps. This priority is recommended since bringing in a patient with the most care gaps allows a practice to increase performance across the most quality measures. This resource is similar in objective to the Patient Outreach functionality within the Evolent Vision Solution.

Gaps In Care - Compensation																					Gaps In Care - Non-Compensation		
CIS	CIS	CIS	CIS	CIS	CIS	CIS	CIS	CIS	CIS	IMA	IMA	IMA	W15	W34	AWC	EPSDT	MMA	BMI	LSC	CHL	CHIPRA	CHIPRA	FLU
				Combo 10						Age 13 Imms													
DTaP	HepB	HiB	IPV	MMR	VZV	HepA	Infl	PCV	RV	MCV	Tdap	HPV					75%				HbA1c	Neph	Infl
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	1	n/a	n/a		n/a	n/a	n/a	n/a	n/a	n/a	n/a	
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	n/a	n/a		n/a	n/a	n/a	n/a	n/a	n/a	n/a	
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	n/a	n/a	X	n/a	n/a		n/a	n/a	n/a	n/a	
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	n/a	n/a		n/a	n/a	n/a	n/a	n/a	n/a	n/a	
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	n/a	n/a	X	n/a	n/a	X	n/a	n/a	n/a	n/a	
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	1	n/a	n/a	X	n/a	n/a	X	n/a	n/a	n/a	n/a	X
n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0	1	n/a	n/a	X	n/a	n/a	X	n/a	n/a	n/a	n/a	X

Cost and Utilization Report

To deliver high-value care, PCN practices must be informed of global quality and cost performance for their attributed patients. PCN has developed a Cost and Utilization Report within the Practice Performance Profile to inform providers of cost and utilization information that is only accessible through payer claims. The report is based on payer data (medical and pharmacy claims) received from PCN-contracted Missouri and Kansas Medicaid Managed Care Organizations.

Definitions of reported numbers:

Admits/1,000

A normalized rate of admissions for attributed patients. The rate is normalized to represent the expected number of admissions in a year for a group of 1,000 attributed patients.

Inpatient Days/1,000

A normalized rate of inpatient hospital days for attributed patients. The rate is normalized to represent the expected number of inpatients days in a year for a group of 1,000 attributed patients.

ER Visits/1,000

A normalized rate of emergency room visits for attributed patients. The rate is normalized to represent the expected number of emergency room visits in a year for a group of 1,000 attributed patients.

Risk Score

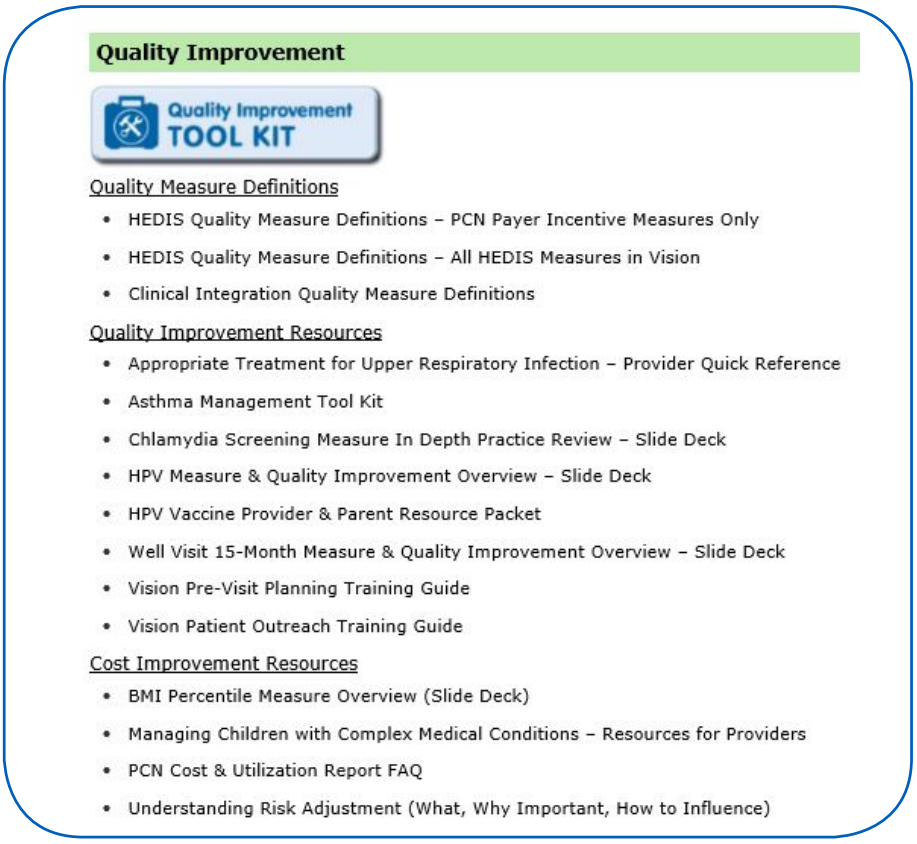
The report uses the Chronic Disability Payment System (CDPS) risk scoring methodology. The methodology uses a patient's age and gender as well as their medical diagnoses and prescription medication history within a one-year period to determine a relative risk score. All risk scores are presented as relative risk ratios based on an average patient with a risk score of 1.0. In other words, a patient with a risk score of 2.0 is expected to be twice as costly as a patient with average expenditures and a patient with a risk score of 0.9 is expected to be 10% less costly. The CDPS risk scoring model is comparable to other nationally known risk scoring methodologies such as Episode Treatment Groupers (ETGs), Milliman Advanced Risk Adjusters (MARA), and Hierarchical Condition Categories (HCCs).

Risk Adjusted Paid PMPM

Risk Adjusted Paid PMPM (Per Member Per Month) is the measure used to evaluate total cost of care. The measure is normalized for the number and risk of patients attributed to a provider or practice. Paid PMPM is calculated by taking the total cost of care for a particular month divided by the number of attributed patients in the month. Risk Adjusted Paid PMPM is adjusted for risk by dividing Paid PMPM by the applicable risk score. Since the measure is normalized for the medical complexity of attributed patients, it facilitates more meaningful comparisons across practices and providers.

PCN Quality Improvement Tools/Resources

PCN uses a centralized Quality Improvement section within the PCN Provider Portal for quality improvement resources, documentation, and tools. PCN practices and Care Teams are able to efficiently access quality measure definitions, assess potential quality improvement strategies, review applicable insights and tips, and directly link to applicable training documentation, tools, and resources.



PCN Quality Improvement TOOL KIT

Children's Mercy PEDIATRIC CARE NETWORK

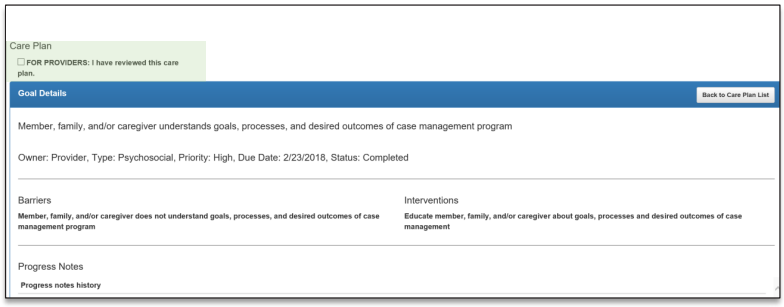
Measure	Quality Improvement Strategies	CMICS Measure Specific Resources	Comments/Insights
Asthma - Medication Management for People With Asthma (>=75% Coverage)	• Patient / Family Education on Asthma Medication • Targeted Patient Outreach for Eligible Asthma Patients	• Medication Management for Children with Asthma Definition & Key Learnings Overview – Slide Deck • Vision Worklists to Target Eligible Asthma Patients (see Vision Patient Outreach Training Guide) • Asthma Care Brochure and Asthma Care Quick Reference (Based on EPR-3 Clinical Guidelines)	• Limit available refills for asthma controller & relievers. Patients typically included for ≥ 4 asthma rx scripts in each of last 2 years. • Sample controller medications are not included. 75% days supply compliance is based exclusively on pharmacy claims. • Measure denominator is small. Identify specific patients using Vision patient outreach.
EPSDT (Annual EPSDT Well Visit for Ages 1-6)	• Provider / Billing Staff Workflow Integration and Training • Sending non-billable claims when Medicaid is secondary insurance (ensures quality hit) • Target 3-6 Year Olds Without an Annual Well Visit (2 and under typically compliant due to newborn/infant well visits) • Well Visit Improvement Strategies: Patient Outreach, Appointment Reminders, Sick to Well-Visit Conversion	• EPSDT Billing and Code Guide • Use Vision Worklists to Target Overdue Patients 3-6 Years Old (see Vision Patient Outreach Training Guide) • Preventive Care Registry – EPSDT (PCN Portal → Clinical Resources & Tools)	• Ability to improve in short term since measure dependent on coding and patient receiving an annual preventive visit at any time during the measurement year.
Immunizations Age 2 (DTap, IPV, MMR, Hib, VZV, PCV, RV, Hep B, Hep A, Flu)	• Standardization of Vaccination Administration within Practice (i.e. what products administered at each standard well visit up to 2 years old) • Patient/Family Education	• Use Vision Worklists to Target Patients 18-24 Months with Missing Age 2 Immunizations (see Vision Patient Outreach Training Guide) • Use the Age 2 Childhood Immunizations Report to compare immunizations received versus expected as patients age. • Preventive Care Registry – Age 2 Immunizations (Combo10) (PCN Portal → Clinical Resources & Tools)	• Improvement takes significant amount of time (Why: performance evaluated based on all applicable immunizations up to age 2; patients only included after turning 2 years old)
Immunizations Age 13 (MCV, Tdap, HPV)	• Pre-Teen Bundle (i.e. Bundle HPV with Tdap/MCV) • Provider Education and Provider-to-Patient Communication • Patient/Family Education	• Immunizations Age 13 Measure Definition & Quality Improvement Overview (Slide Deck) • HPV Provider and Parent Education Resources • Vision Worklists to Target Overdue Patients 12-12.75 years Old (see Vision Patient Outreach Training Guide)	• Performance based primarily on HPV immunization rate. • Improvement takes significant amount of time (Why: 2 HPV immunizations needed over 6 months; patients only included after turning 13 years old)
Well-Child Visits in 3-6 Years of Life	• Patient Outreach • Appointment Reminders • Sick to Well-Visit Conversion	• Use Vision Worklists to Target Overdue Patients (see Vision Patient Outreach Training Guide) • Preventive Care Registry - Well Child Visits (PCN Portal → Clinical Resources & Tools)	• Ability to improve in short term since measure simply dependent on patient receiving an annual preventive visit at any time during the measurement year.

C.A.R.E. Web (Online Care Team Communication Tool)

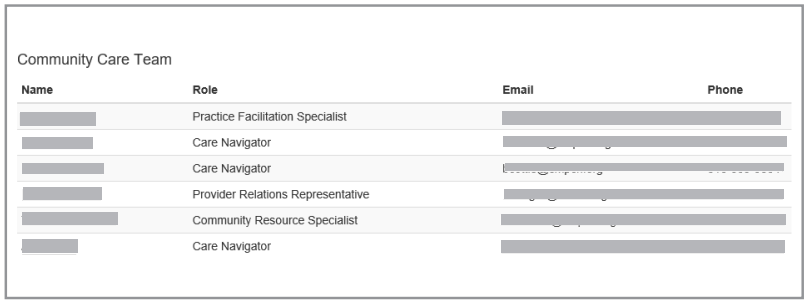
The PCN's Care Team documentation and communication tool, C.A.R.E. Web (Case Assessment Referral Evaluation), received significant enhancements in 2018 focused on allowing provider engagement with the patient-centered care plans and a more efficient work flow for Care Teams.

A Community Care Team list was created to display the name, role and contact information for each person assigned to a specific member's Care Team. Any PCP with a C.A.R.E. Web user account could be added to the team list. The PCP and Care Team members were given the ability to securely send messages back and forth within the C.A.R.E. Web system. The date the message was created, who created it, and who it was directed to are all documented in the system. This bidirectional communication platform allows Care Navigators to send patient-centered care plans to the member's assigned PCP for review and input into the plan of care.

C.A.R.E. Web
Provider Checkbox Displaying Review of Care Plan



C.A.R.E. Web Community Care Team List
Name, Role, and Contact Information of Care Team Members



The following additional C.A.R.E. Web enhancements were made to allow for a more efficient work flow for the Care Teams:

- Task feature enhanced to prioritize urgent tasks;
- Assessments expanded to include home environment, lead, and autism assessments;
- Care Navigators now have the ability to track member's appointments and medications after an assessment is completed;
- Assessment driven care plans;
- Seamless referral for case management services from the prior authorization screen;
- Ability to capture provider email addresses in order to survey providers about their experience with the UM process.

Future Initiatives

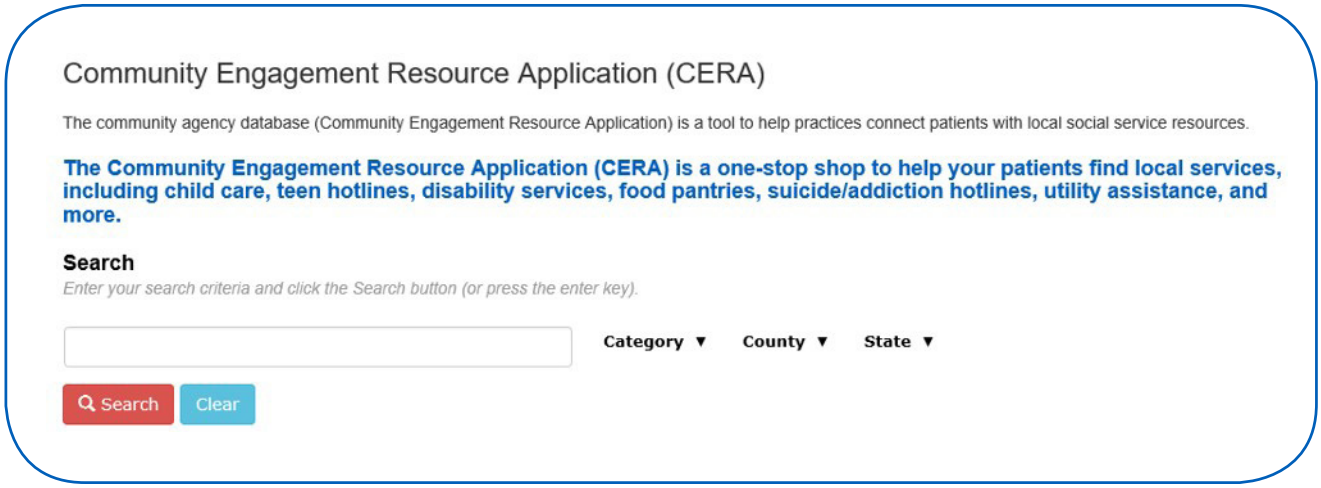
- In 2019, the team will work on implementing member and caregiver access to the C.A.R.E. Web system for viewing and bidirectional communication into the patient-centered care plan.

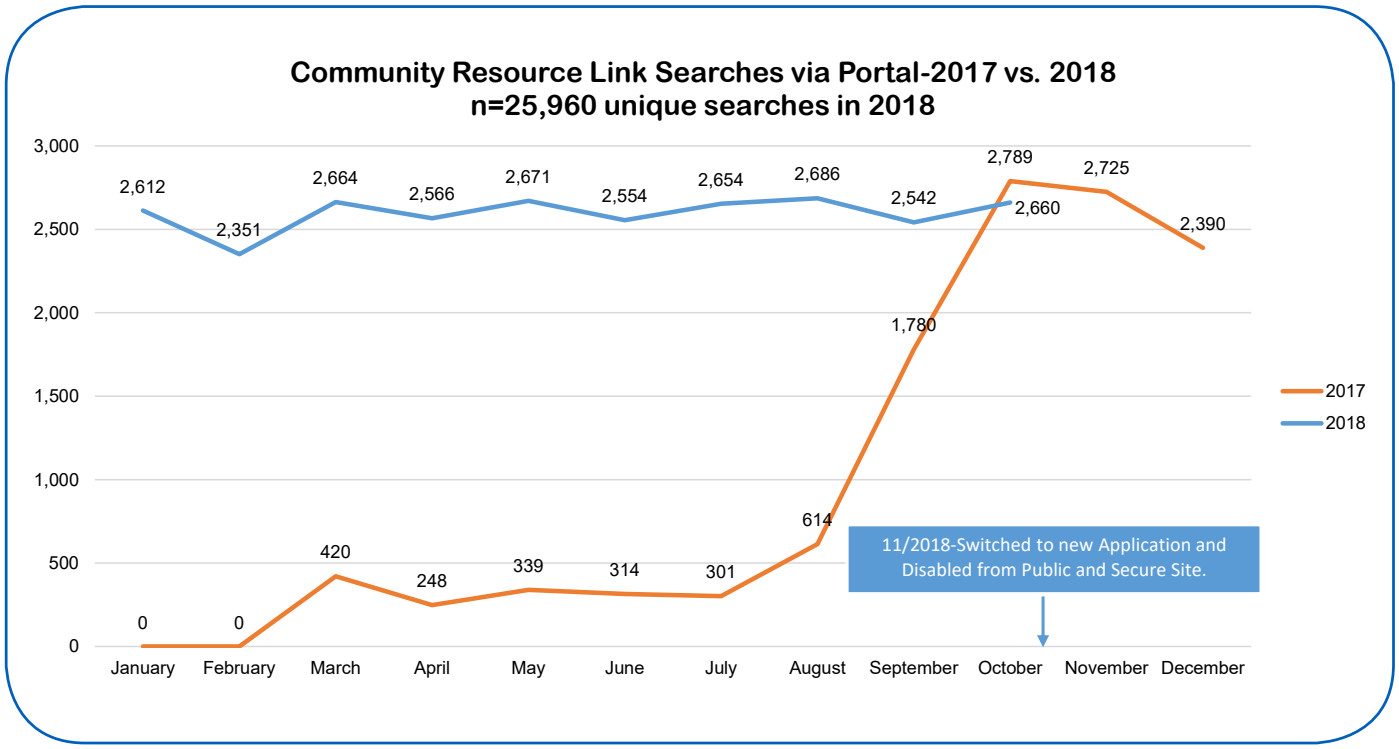
Community Integration

There is ample data available to demonstrate improvements in member outcomes, member engagement and decreased cost with a fully integrated medical and behavioral care delivery model. The PCN continued the Health Plan behavioral case management initiative begun in 2017 by collaborating and co-managing high-risk children with embedded behavioral health case management staff. PCN has partnered and continued to foster relationships with numerous community agencies (SleepyHead Beds, Harvesters, Giving the Basics, local health departments, etc.) to facilitate resource acquisition and a more seamless referral process for PCN members. The PCN Community Resource Specialist team consistently attends community resource connection meetings through Jackson County, Wyandotte County, Clay County, Platte County, and Johnson County. The team also collaborates with community agencies to disseminate information and schedule on-site presentations for the PCN team.

Community Engagement Resource Application (C.E.R.A.)

The Community Engagement Resource Application (C.E.R.A.) is a database designed around social determinants of health categories and allows for customized criteria to be searched based on patient-specific needs. In 2018, PCN continued to maintain C.E.R.A. and engage with key community partners who interact with PCN members. C.E.R.A. was originally developed because there were no other user-friendly resources available to aggregate local community resources. As research on social determinants of health evolved, so has the technology to link families to the resources in the community. Over the last year, PCN evaluated the internal resources required to maintain C.E.R.A. and assessed multiple local organizations leading this industry. In the coming year, PCN will discontinue the use of C.E.R.A. and transition to a local organization for support in connecting members to community resources. Providers will also be given access to this same site.





Community Health Worker

In 2018, PCN continued its collaboration with KC Care Clinic to provide a Community Health Worker (CHW) for PCN member interventions. Members were screened by a Care Navigator and then referred to the CHW to address identified social determinants of health issues. Outreach lists, including members with gaps in care and non-emergent emergency room utilization, were provided to the CHW to connect with members that were not engaged in primary care services. The CHW provided education to the member and/or caregiver about appropriate emergency room utilization, benefits of well care, and the CHW program. If the member agreed to enroll in the CHW program, an assessment was completed with the family to determine barriers and goals were identified in the following target areas: Child Care; Child Education; Adult Education; Parenting/Coping Skills; Dental/Vision; Family/Partner/Social Relations; Health Insurance; Medical Needs; Mental Health and Substance Abuse; Income; Housing; Transportation; Food and Household Items; Language; Medication Cost; and Medication Adherence. In addition to providing community resources to families, the CHW model involves in-person contact with families in their community to help them navigate the health and social service systems.

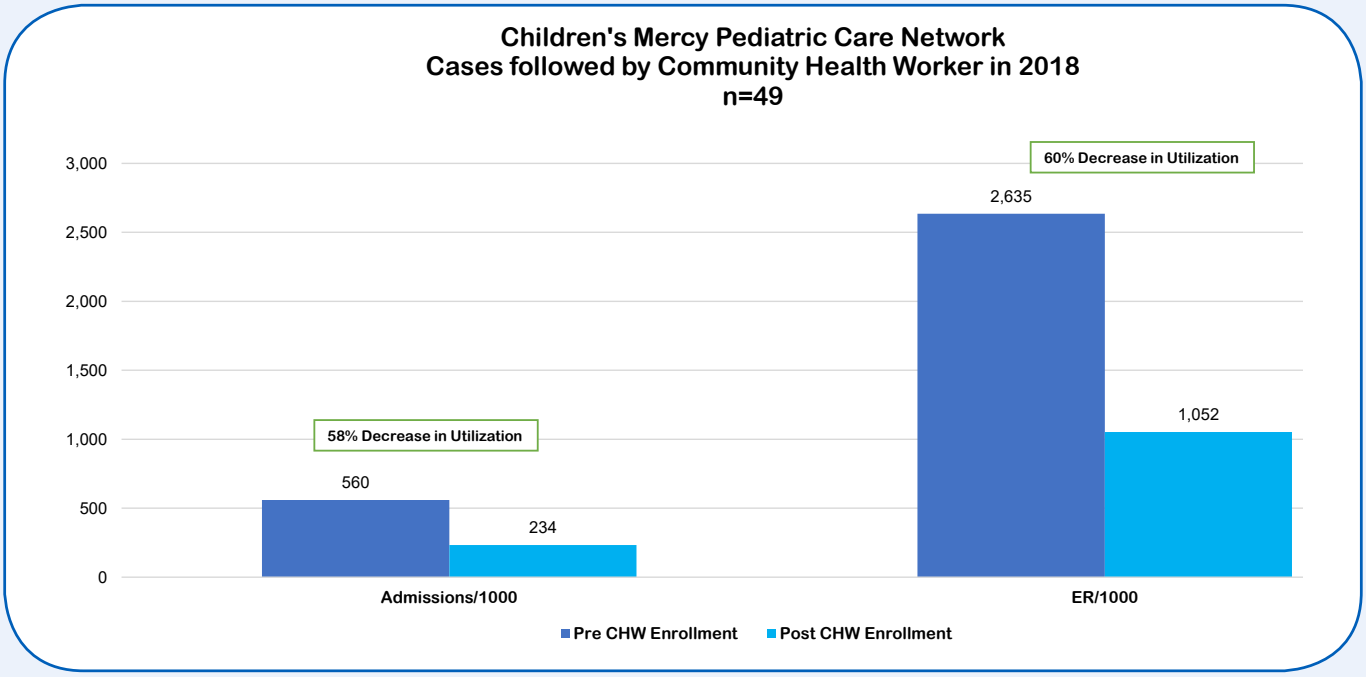
In May 2018, to assist in more seamless care team collaboration, the CHW moved on-site at the PCN office and began attending daily PCN Care Team huddles and accepting on-the-spot referrals.

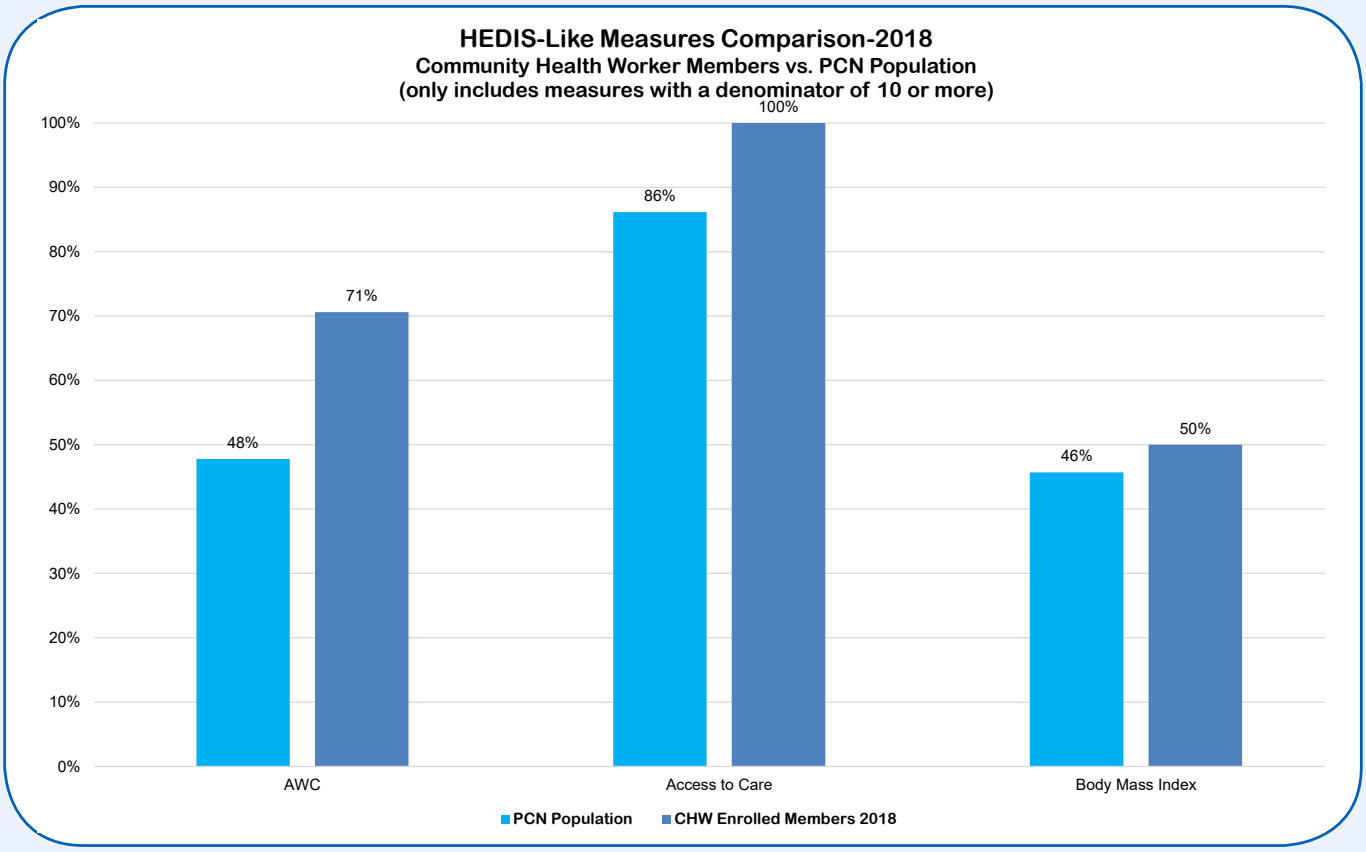
The Community Health Worker attempted outreach to 184 members in 2018. Of those members, 64 enrolled in the CHW program, which is an increase of over 290% (22 members enrolled in 2017). Of the 163 goals initiated with members in 2018, 116 were completed (71.2%).

Future Initiatives

PCN is currently working with the Kansas City Missouri School District to begin accepting referrals from Central High School's Teen Parenting Center. Beginning in January 2019, inpatient Social Workers at Children's Mercy Kansas City will also be able to make referrals to the CHW for PCN members.

Community Health Worker Cases 2018	Pre Enrollment Date	Post Enrollment Date
Members	49	
% Change Pre vs. Post		
Admissions/1000	-58.2%	
ER Visits/1000	-60.1%	
Total Medical PMPM	-70.0%	



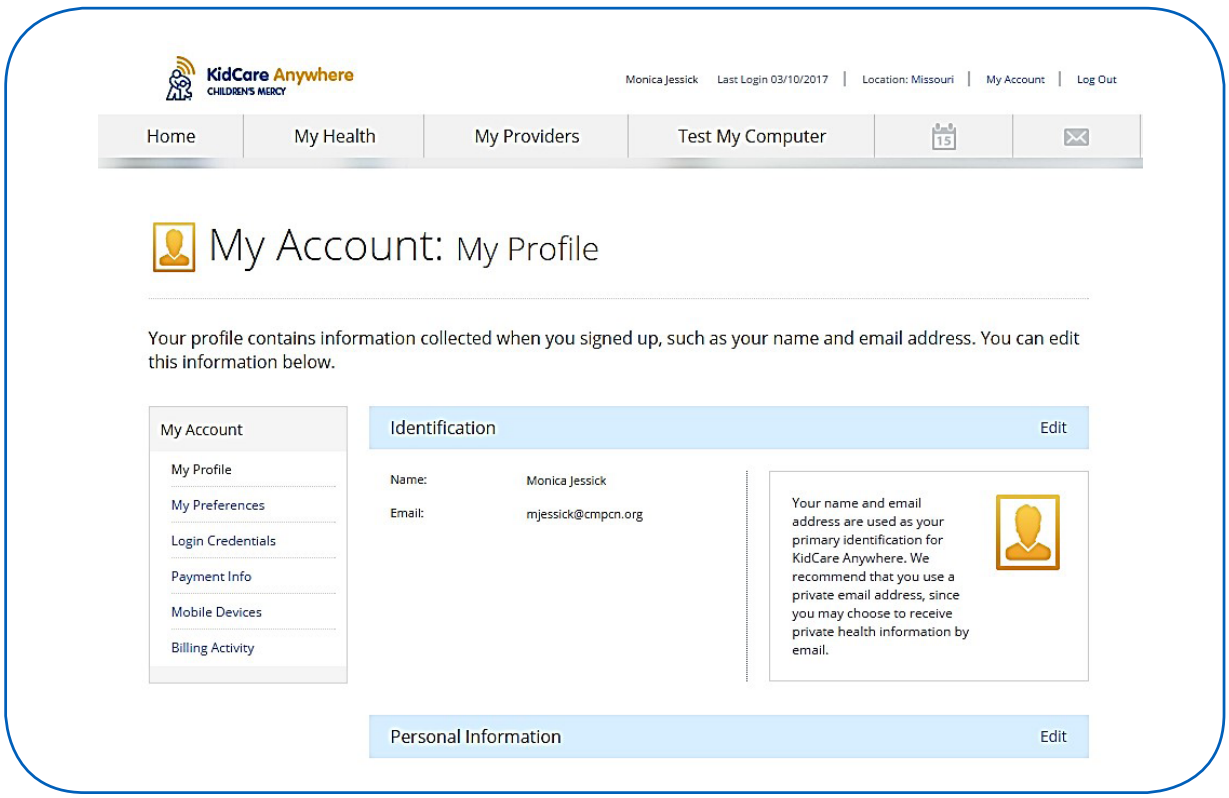


KidCare Anywhere

In 2017, Children's Mercy Kansas City launched a telehealth platform, KidCare Anywhere (KCA), in an effort to decrease emergency room utilization and redirect members to the PCP for non-emergent health concerns. This Children's Mercy Kansas City initiative is staffed by Children's Mercy providers and is intended to triage non-emergent conditions. This service is available to PCN members at no cost. Providers discuss the member's concern, provide guidance, and often provide treatment for minor ailments and illnesses. This year (2018) has been a year of learning and growth for KidCare Anywhere with the launch of an application program interface (API) feed that automatically determines eligibility to the platform at the time the member is ready to use the program. Children's Mercy continues to notify eligible members of this alternative to the urgent care or the emergency room. PCN has also continued to inform the PCN population of the service through mailers and their PCP. The goal is to increase the use of this application for members as an alternative to avoidable emergency room or urgent care visits.

Future Initiatives

For 2019, novel uses for KidCare Anywhere include expanding the platform's reach outside of the PCN population, access to more Children's Mercy departments for post-operative care, hospital post-discharge follow-up visits, Developmental and Behavioral Health, Social Work services, Endocrine research, and continued support of reducing emergency room visits through Children's Mercy's Nurse Advice Line and continuous community education.



Patient Experience

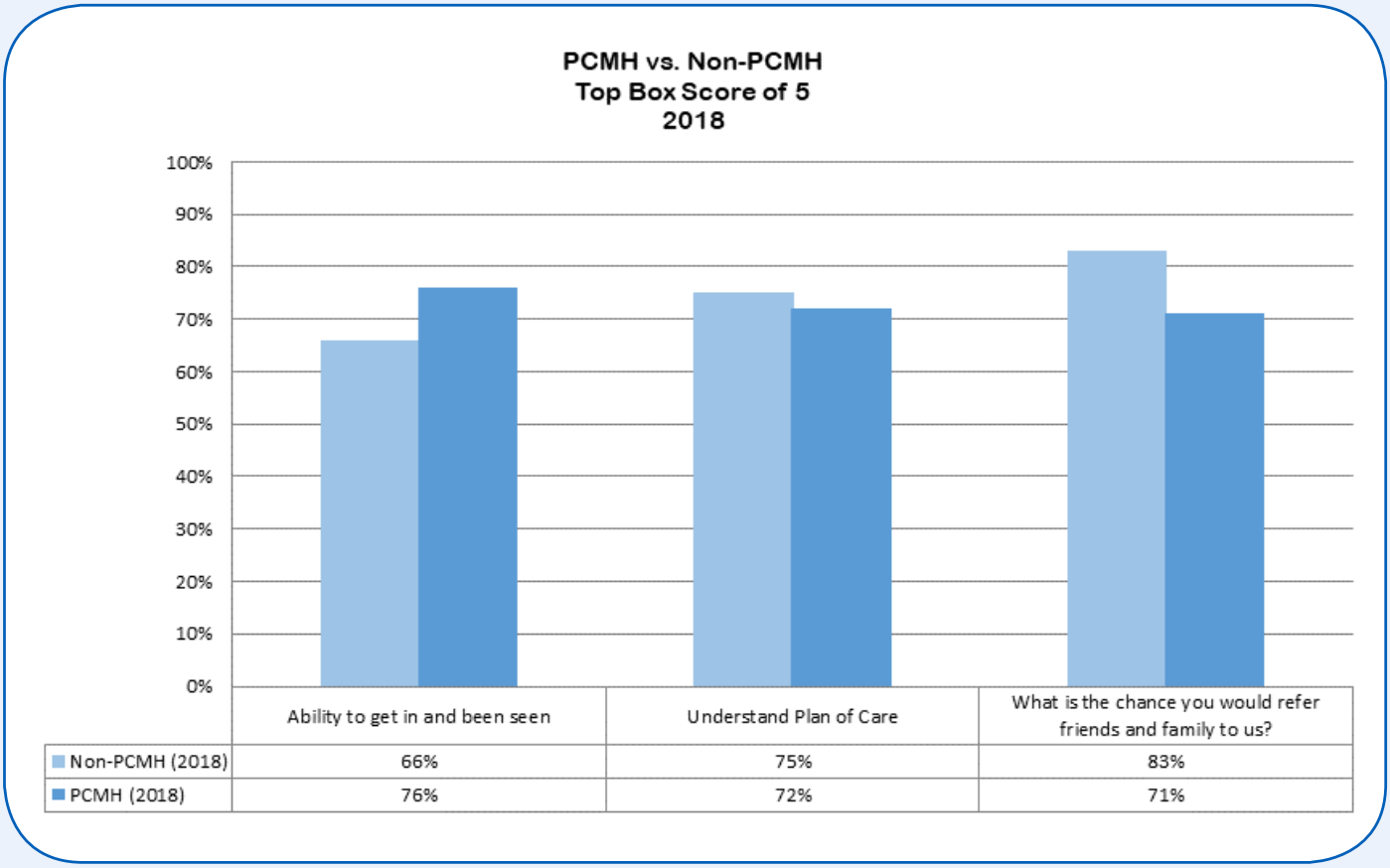
A component of PCMH encourages practices to obtain feedback from patients and families regarding their experience of care received. Four main categories are reviewed including: access, communication, whole-person care, and self-management.

For the Patient Satisfaction Survey, the PCN utilized a scale of 1 through 5 in which a score of 5 indicates “Great” and a score of 1 indicated “Poor.” For this evaluation, the PCN applied the top box scoring method in order to more effectively measure the concentration of high performance scores. For example, the top box method only accounted for the percentage of patients who selected a 5 as his/her response to a rating question in the survey. Responses that scored between the ranges of 1 and 4 were not accounted for as part of the top box scoring methodology.

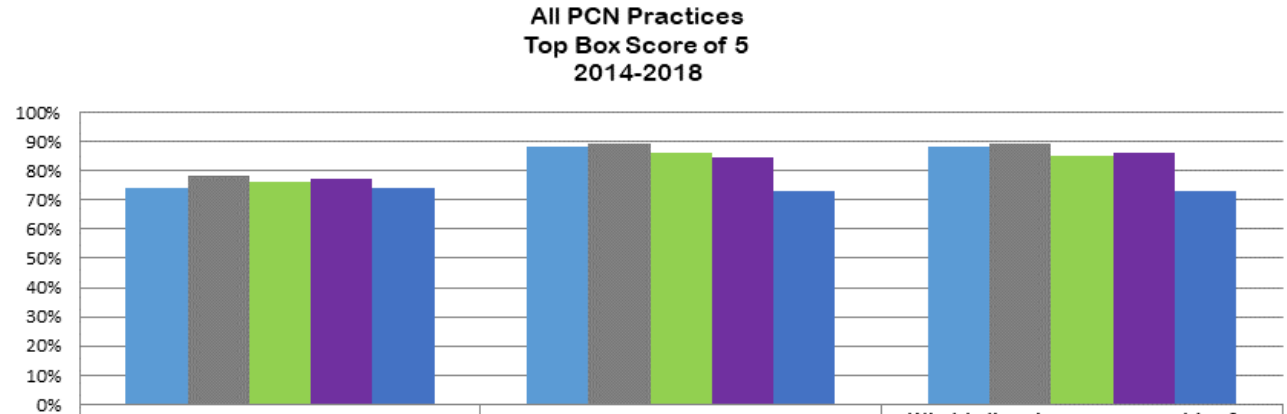
In addition to comparing the year over year combined results for all PCN practices (2014-2018), the variable of NCQA-recognized PCMH vs. non-PCMH practices was included in the analysis beginning in 2016.

Analysis

The addition of the variable of NCQA-recognized PCMH vs. non-PCMH practices provided valuable insight on the value of becoming an NCQA-recognized PCMH to patients and their caregivers. Although the NCQA-recognized PCMH vs. non-PCMH practice scores are similar, NCQA-recognized PCMH practices offer a more robust model for transforming the organization and delivery of primary care. PCN will be implementing several initiatives in 2018 in an effort to increase patient experience and satisfaction (see Future Initiatives on page 49 for details).



	Ability to get in and been seen	Understand Plan of Care	What is the chance you would refer friends and family to us?
Non-PCMH (2018)	66%	75%	83%
PCMH (2018)	76%	72%	71%



	Ability to get in and be seen	Understand Plan of Care	What is the chance you would refer friends and family to us?
2014	74%	88%	88%
2015	78%	89%	89%
2016	76%	86%	85%
2017	77%	84%	86%
2018	74%	73%	73%

PCMH vs. Non-PCMH Analysis of Cost, Utilization & Quality Measures

Measuring the Value of PCMH

By adopting the PCMH model, the PCN demonstrates its strong advocacy for high quality care, empowering patients and building collaborative relationships between patients and providers. The PCMH model has been shown to lower costs and increase value for both patients and providers. In order to take a closer look at the value-added impact of the PCMH model, the PCN conducted cost and utilization comparisons between two different groups within the PCN. The comparison included the following:

PCMH Practices
Includes all practices engaged with the PCN who have been designated as an NCQA-recognized PCMH for at least one year.

Non-PCMH Practices
Includes all practices engaged with the PCN who do not have NCQA designation as a PCMH, as well as practices not currently contracted with the PCN, typically family practice and rural provider offices. It is important to note that Children's Mercy Kansas City primary care is included in this denominator. This subset includes the balance of an academic curriculum with the PCMH model. The Pediatric Care Clinic (PCC) within Children's Mercy Kansas City is unique (accounts for approximately 10% of the PCN membership) in comparison to the other PCN practices in terms of size and scope of operations. In addition, the PCC is currently pursuing national recognition as a designated PCMH practice, which will impact the PCMH versus non-PCMH data comparison in the future.

From a quality perspective, the following metrics were evaluated:

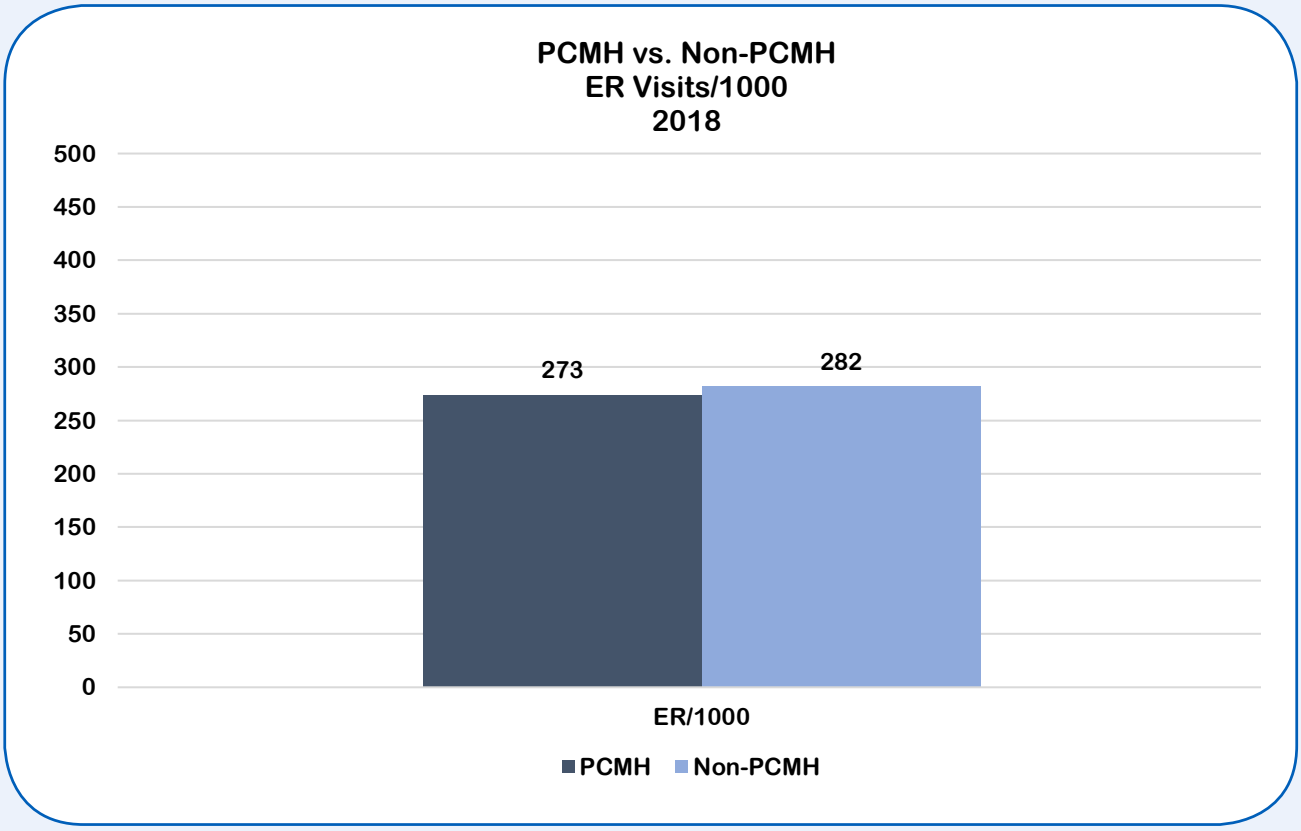
- Well-Child 0-15 Months
- Well-Child 3-6 Years
- Adolescent Well-Care Visits
- Chlamydia Screening
- Children & Adolescents' Access to Primary Care Practitioners (CAP)
- Lead Screening in Children
- Childhood Immunizations Combo 10
- Age 13 Immunizations
- Asthma Medication Compliance – 50%
- Asthma Medication Compliance – 75%
- CHIPRA-HbA1c
- CHIPRA-Neuropathy

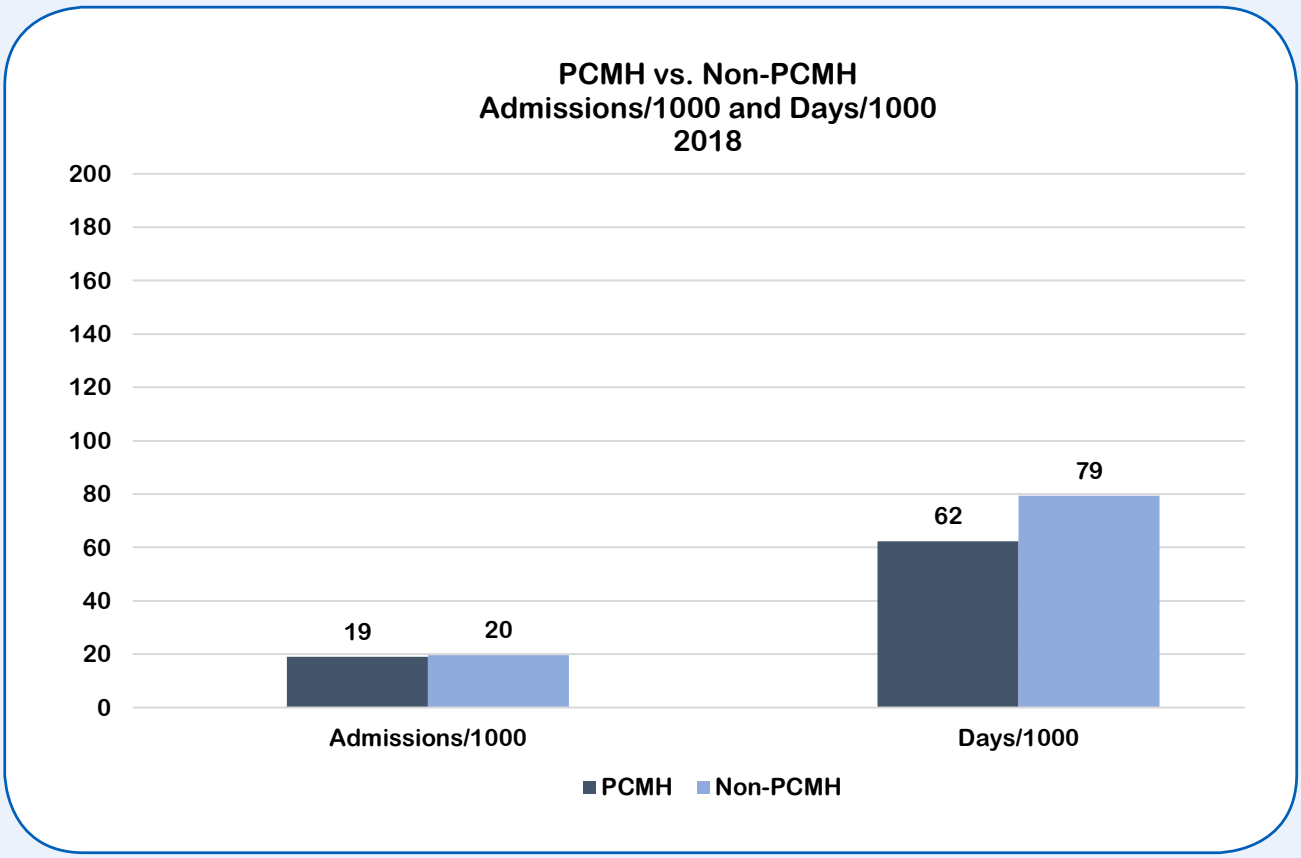
From a cost comparison perspective, the following metrics were evaluated:

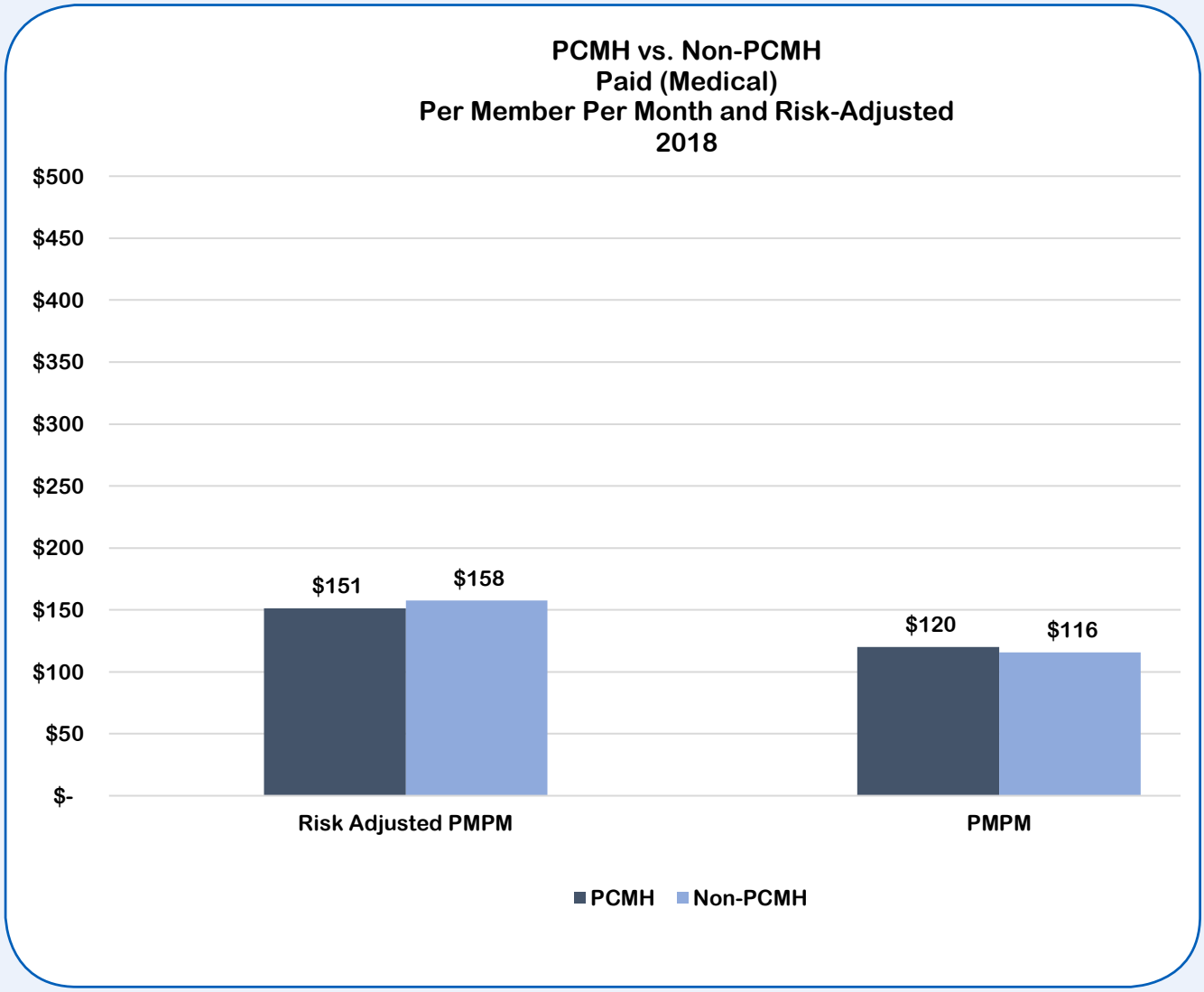
- PMPM (Paid Medical)
- Risk-Adjusted PMPM (Paid Medical)

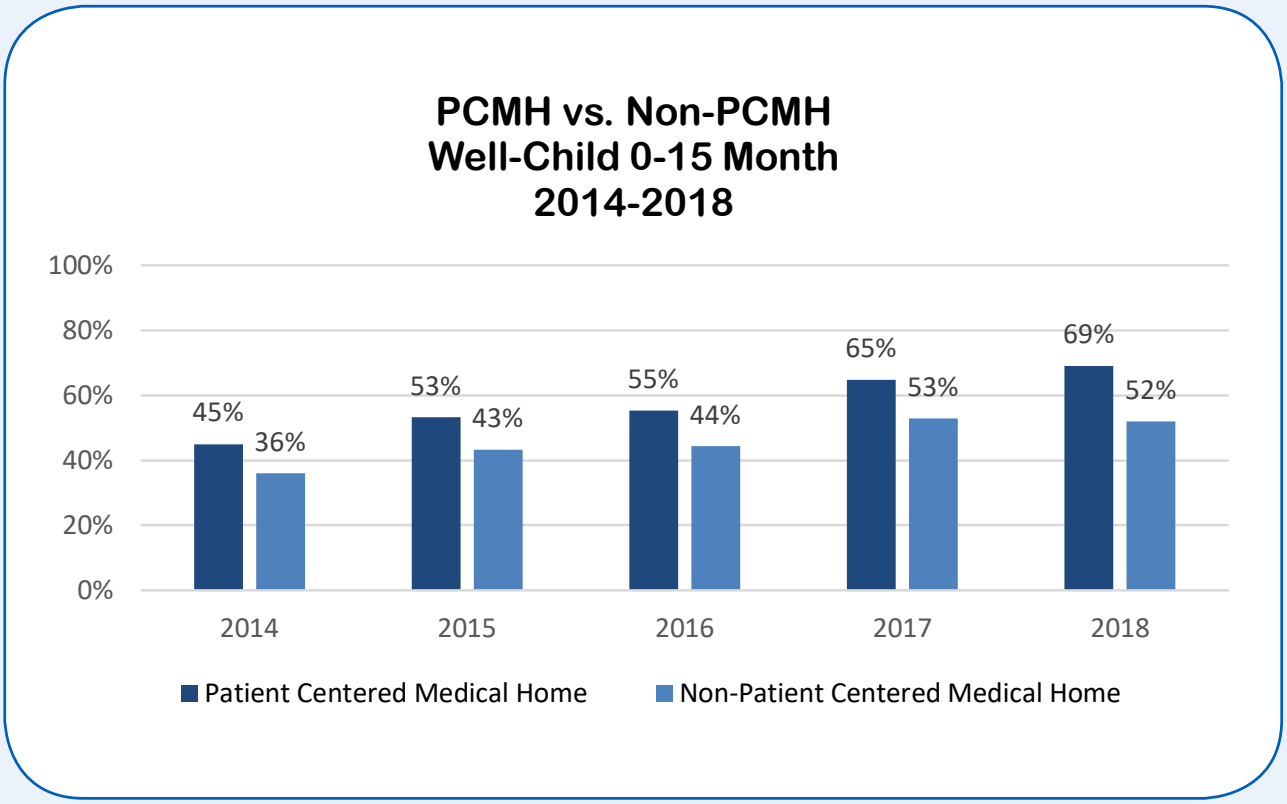
From a utilization comparison perspective, the following metrics were evaluated:

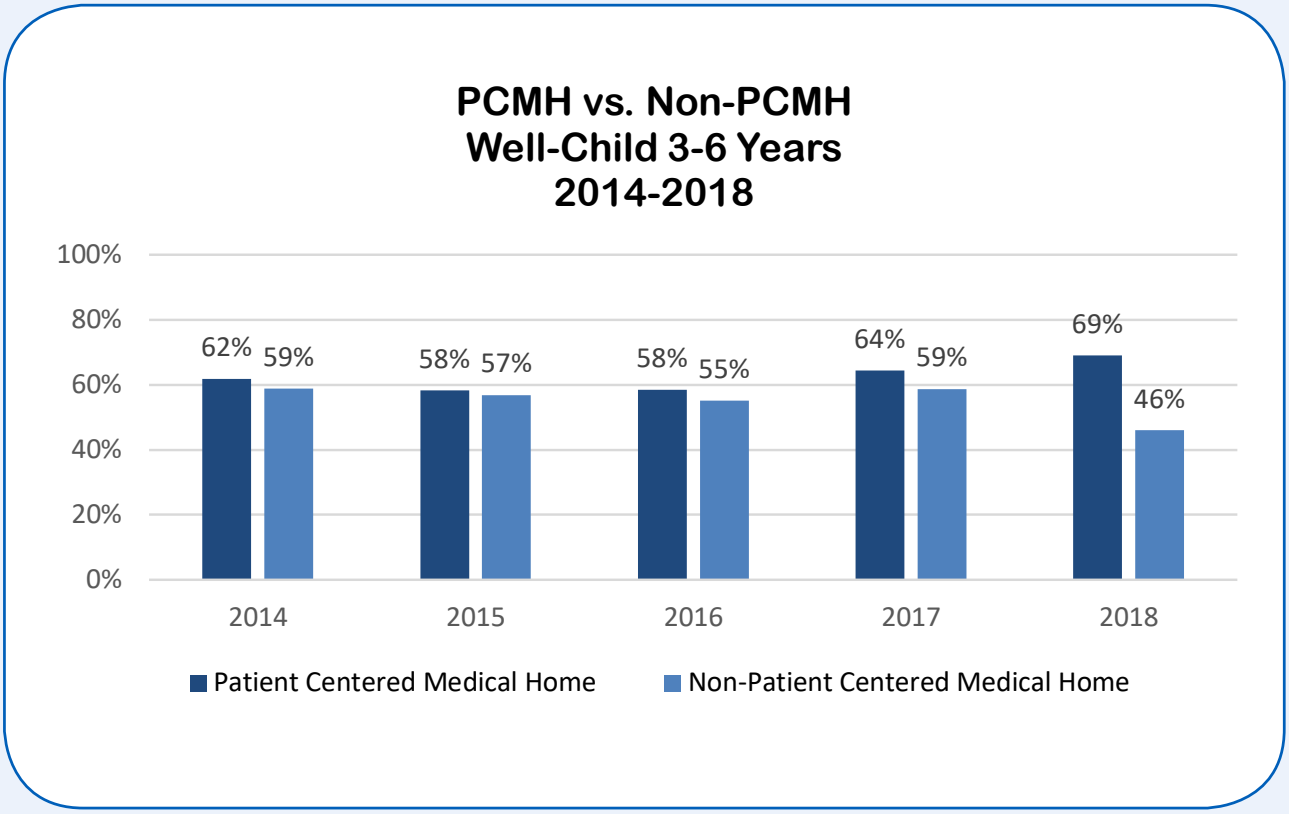
- Admits/1,000
- Inpatient Days/1,000
- ER Visits/1,000

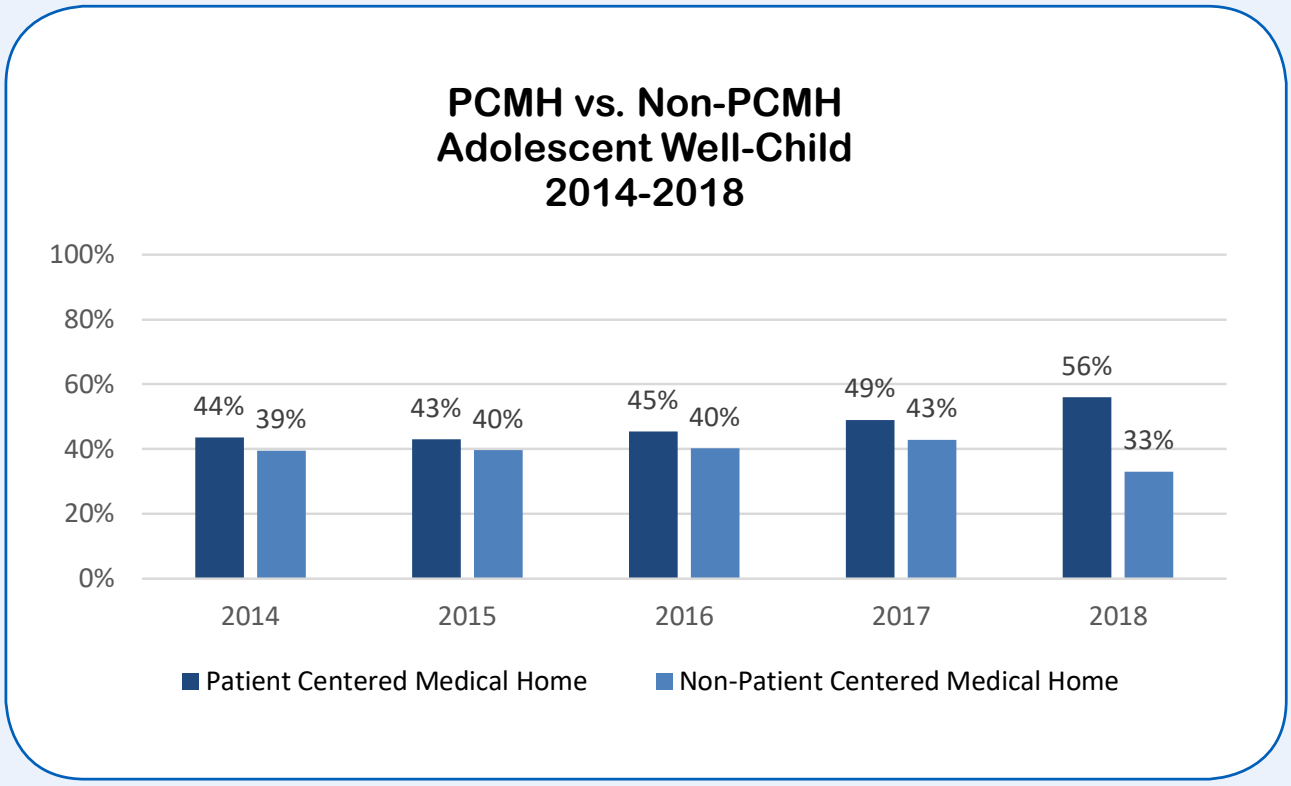

PCMH vs. Non-PCMH
ER Visits/1000
2018
500
450
400
350
300
250
200
150
100
50
0
273
282
ER/1000
PCMH
Non-PCMH

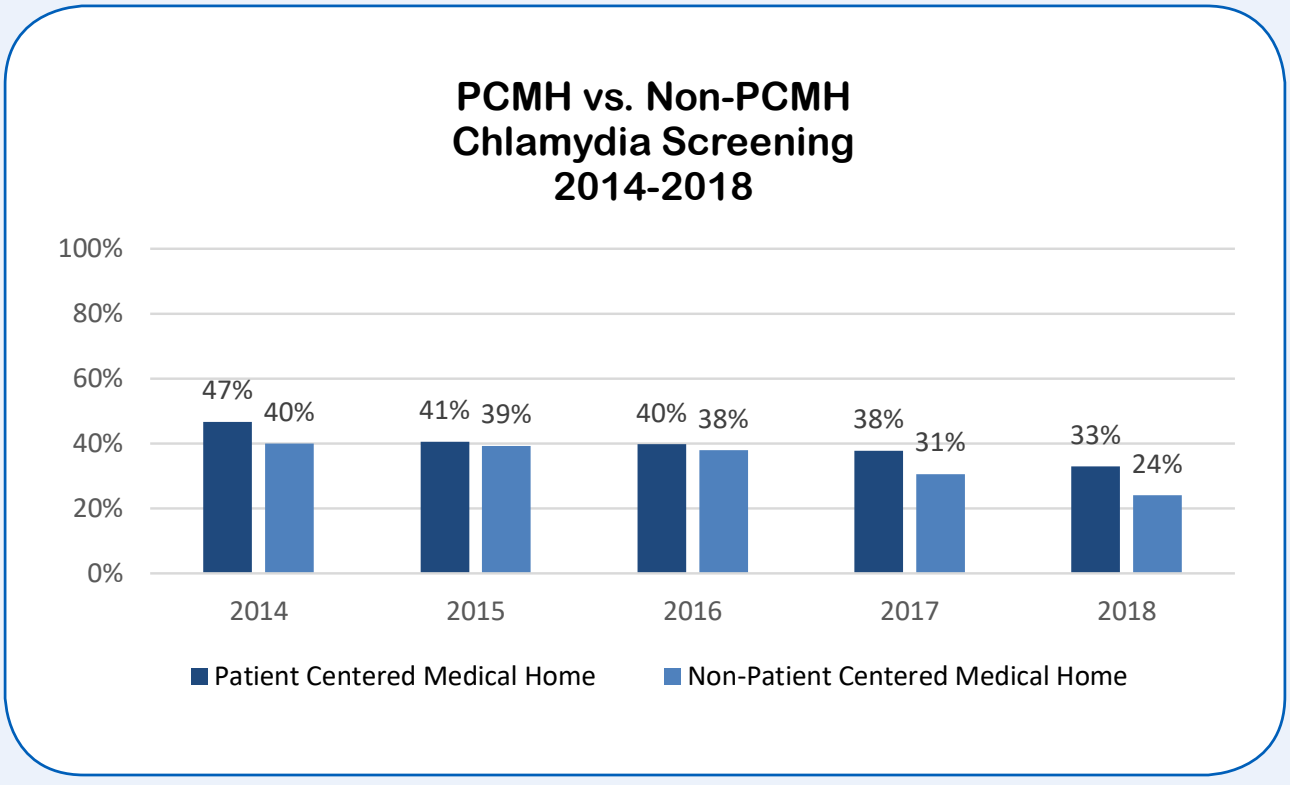

PCMH vs. Non-PCMH
Admissions/1000 and Days/1000
2018
200
180
160
140
120
100
80
60
40
20
0
19
20
62
79
Admissions/1000
Days/1000
PCMH
Non-PCMH

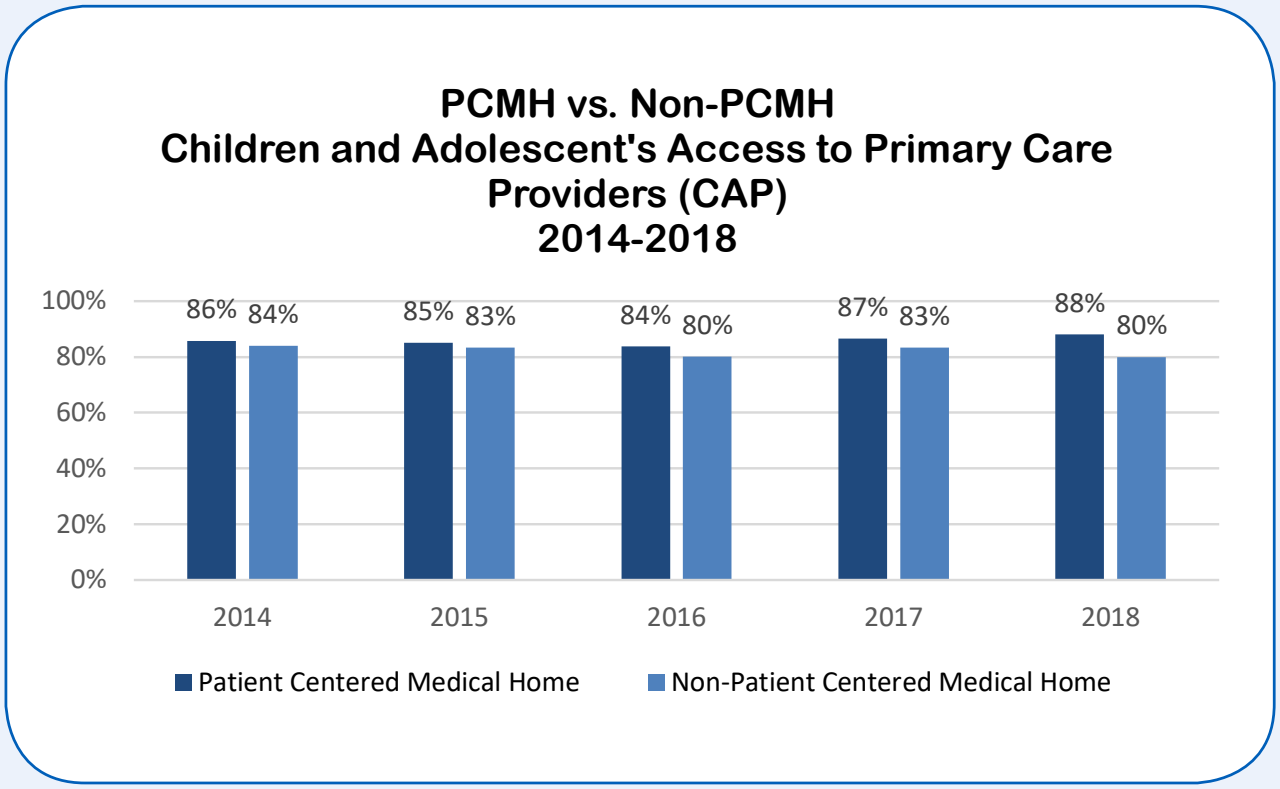

PCMH vs. Non-PCMH
Paid (Medical)
Per Member Per Month and Risk-Adjusted
2018
$500
$450
$400
$350
$300
$250
$200
$150
$100
$50
$-
$151
$158
$120
$116
Risk Adjusted PMPM
PMPM
PCMH
Non-PCMH

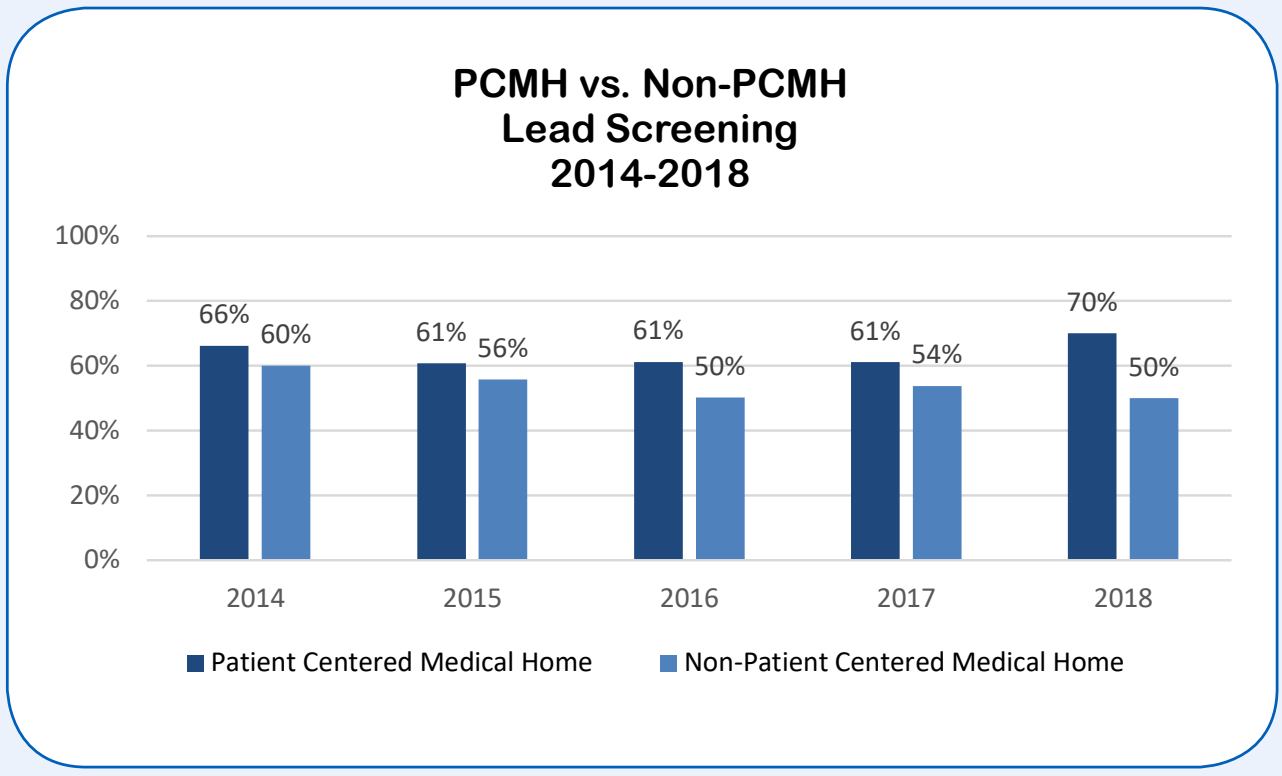

PCMH vs. Non-PCMH
Well-Child 0-15 Month
2014-2018
100%
80%
60%
40%
20%
0%
45%
36%
53%
43%
55%
44%
65%
53%
69%
52%
2014
2015
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home

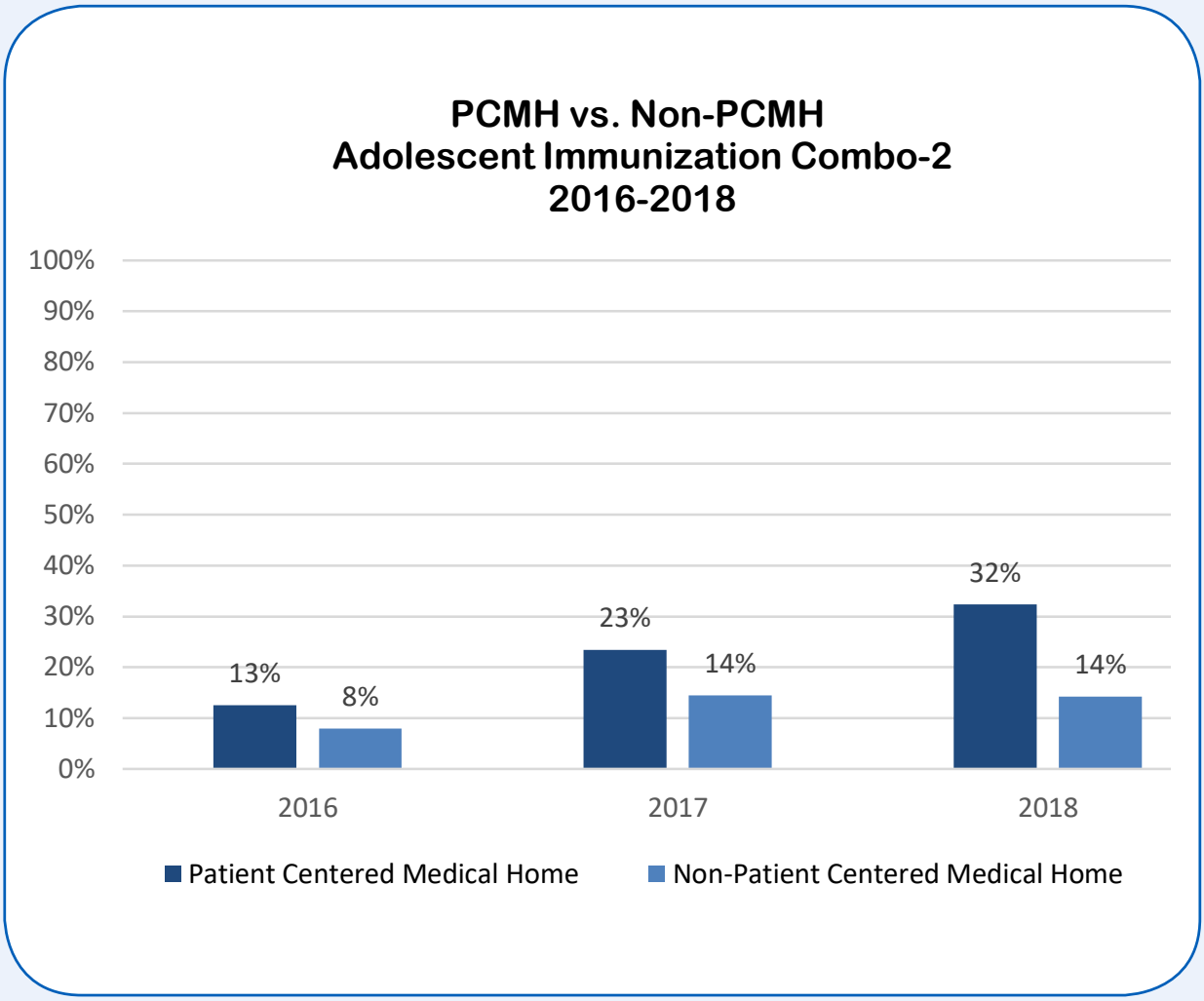

PCMH vs. Non-PCMH
Well-Child 3-6 Years
2014-2018
100%
80%
60%
40%
20%
0%
62%
59%
58%
57%
58%
55%
64%
59%
69%
46%
2014
2015
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home

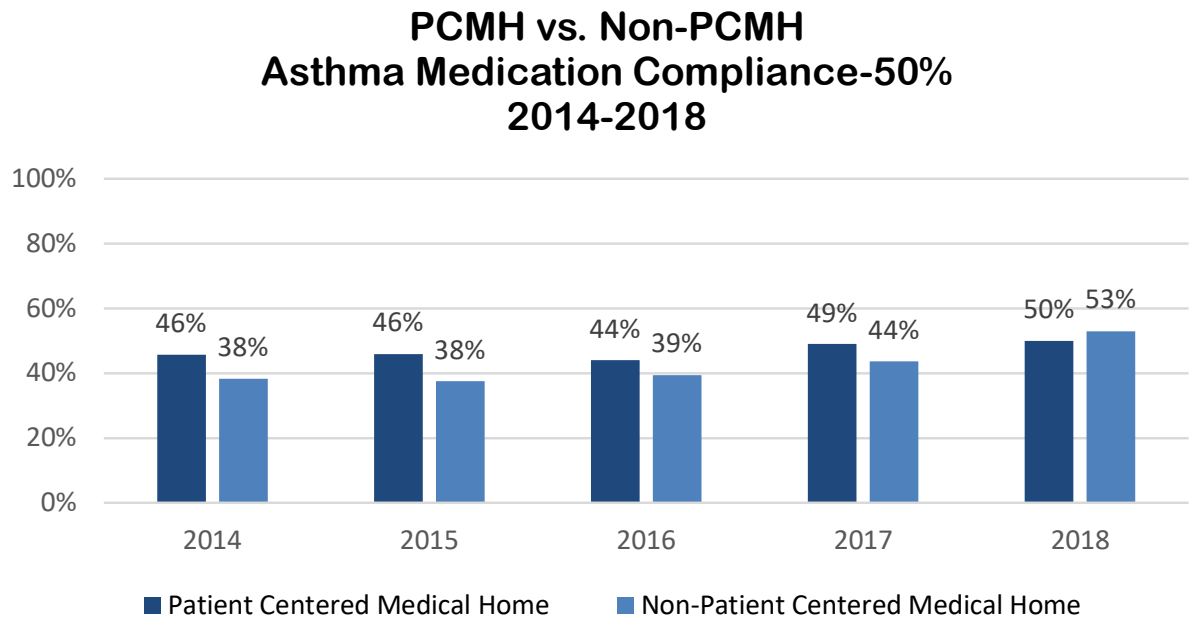

PCMH vs. Non-PCMH
Adolescent Well-Child
2014-2018
100%
80%
60%
40%
20%
0%
44%
39%
43%
40%
45%
40%
49%
43%
56%
33%
2014
2015
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home

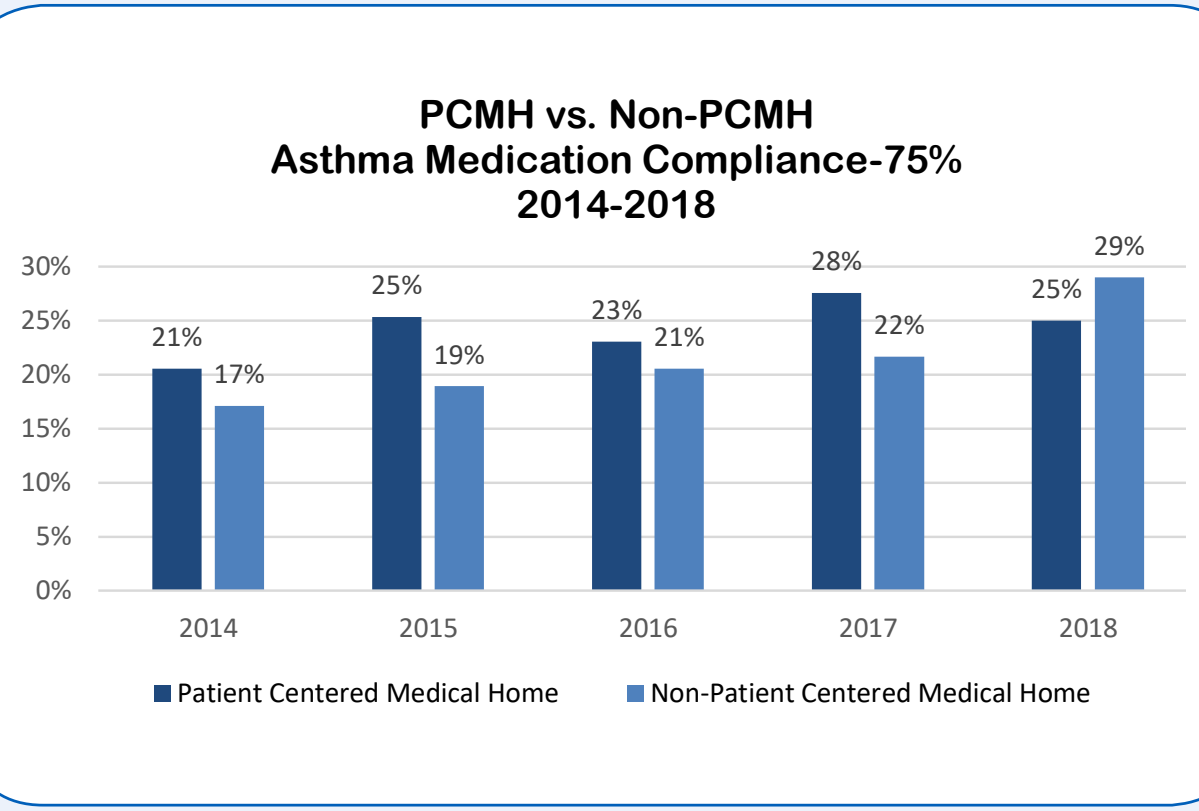

PCMH vs. Non-PCMH
Chlamydia Screening
2014-2018
100%
80%
60%
40%
20%
0%
47%
40%
41%
39%
40%
38%
38%
31%
33%
24%
2014
2015
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home

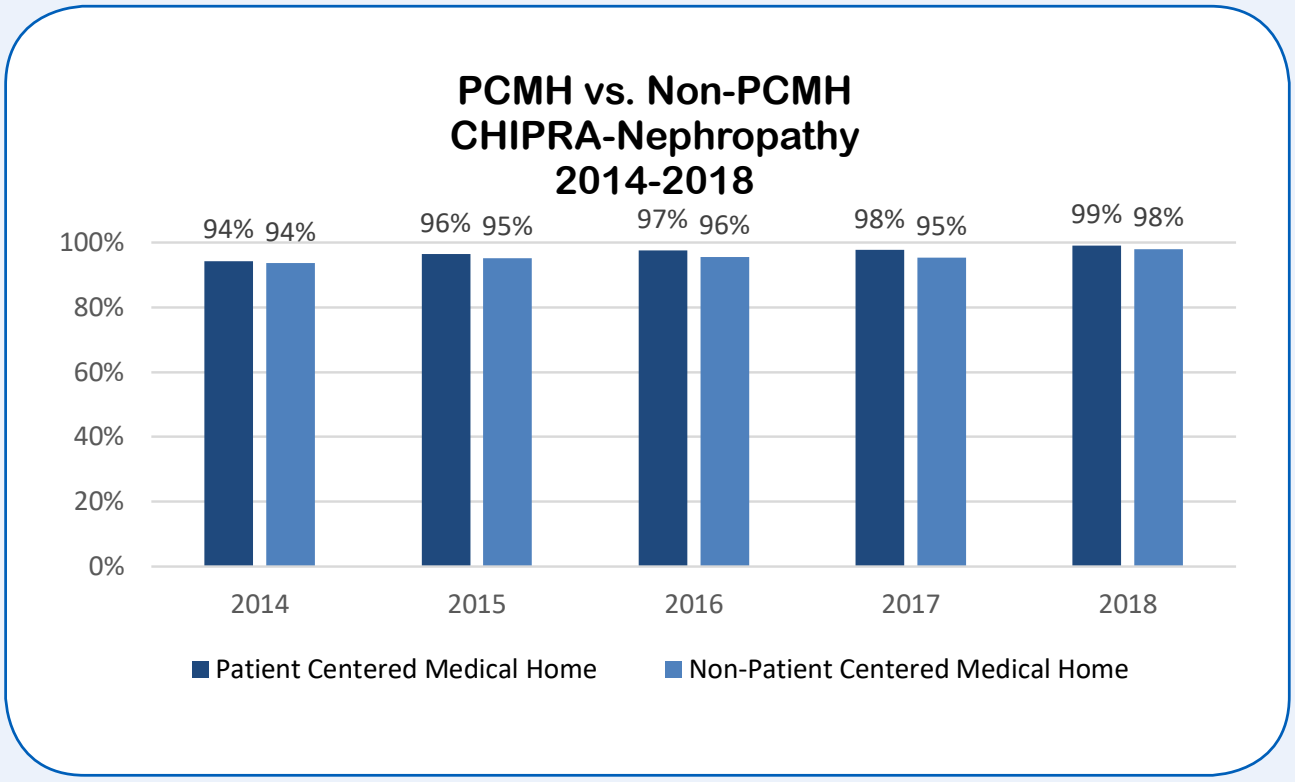

PCMH vs. Non-PCMH
Children and Adolescent's Access to Primary Care Providers (CAP)
2014-2018
100%
80%
60%
40%
20%
0%
86% 84%
85% 83%
84% 80%
87% 83%
88% 80%
2014
2015
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home

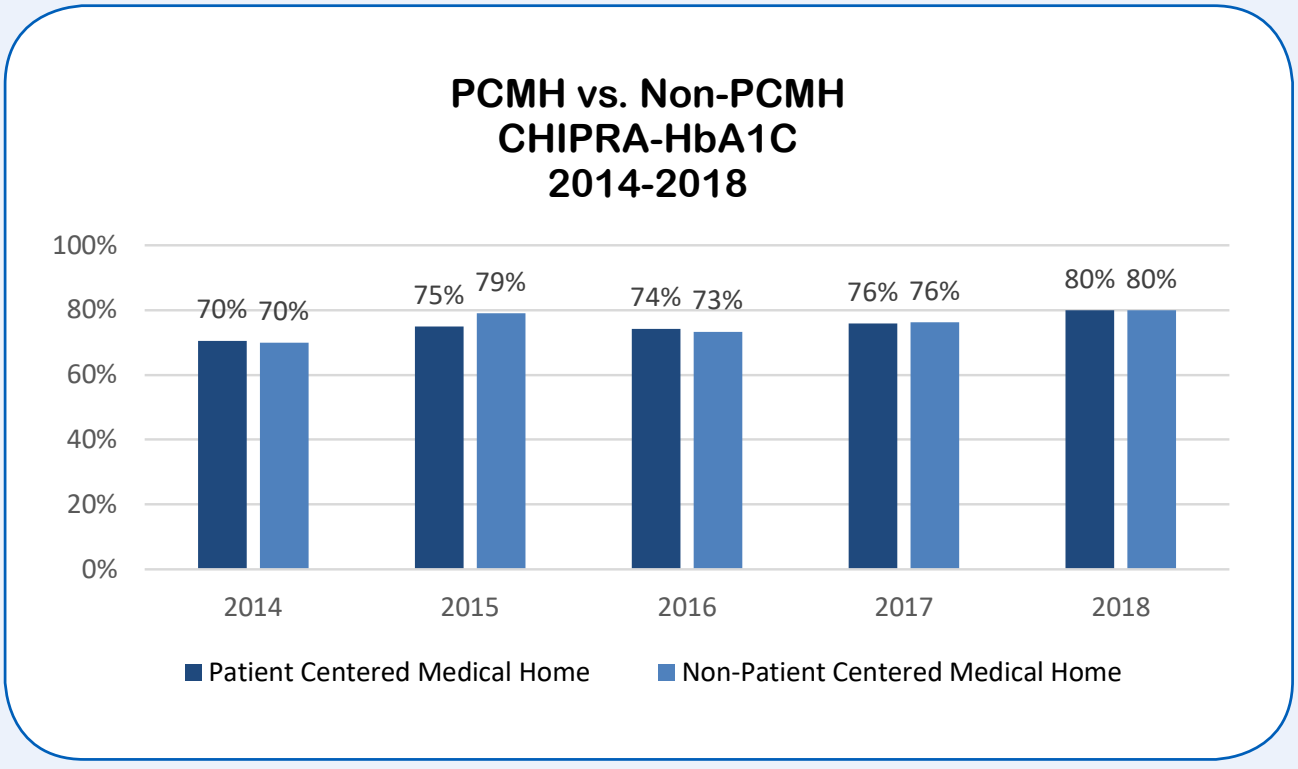

PCMH vs. Non-PCMH
Lead Screening
2014-2018
100%
80%
60%
40%
20%
0%
66% 60%
61% 56%
61% 50%
61% 54%
70% 50%
2014
2015
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home


PCMH vs. Non-PCMH
Adolescent Immunization Combo-2
2016-2018
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
13%
8%
23%
14%
32%
14%
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home


PCMH vs. Non-PCMH
Asthma Medication Compliance-50%
2014-2018
100%
80%
60%
40%
20%
0%
46%
38%
46%
38%
44%
39%
49%
44%
50%
53%
2014
2015
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home


PCMH vs. Non-PCMH
Asthma Medication Compliance-75%
2014-2018
30%
25%
20%
15%
10%
5%
0%
21%
17%
25%
19%
23%
21%
28%
22%
25%
29%
2014
2015
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home


PCMH vs. Non-PCMH
CHIPRA-Nephropathy
2014-2018
100%
80%
60%
40%
20%
0%
94% 94%
96% 95%
97% 96%
98% 95%
99% 98%
2014
2015
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home


PCMH vs. Non-PCMH
CHIPRA-HbA1C
2014-2018
100%
80%
60%
40%
20%
0%
70% 70%
75% 79%
74% 73%
76% 76%
80% 80%
2014
2015
2016
2017
2018
Patient Centered Medical Home
Non-Patient Centered Medical Home

Future Initiatives

- The Patient Outreach Initiative (EMMI) will continue to be a standard tool for PCN practices. The 2019 phases will mirror those of 2018, with the hope to introduce a new campaign to target case management in the first quarter of 2019;
- C.A.R.E. Web will implement member and caregiver access for viewing and participating in the patient-centered care plan within the web-based tool;
- In early 2019, the Community Resource Specialist team will complete Safe Sleep Training through the Mother and Child Health Coalition in order to offer education and connect eligible PCN members with resources;
- PCN is currently working with the Kansas City Missouri School District to begin accepting referrals from Central High School's Teen Parenting Center;
- Inpatient Social Workers at Children's Mercy Kansas City will be granted the ability to make referrals to the Community Health Worker for PCN members;
- PCN Care Teams will continue to support PCMH practice transformation;
- Tri-annual meetings with all contracted PCN practices will continue in 2019 to further medical transparency and cooperation.

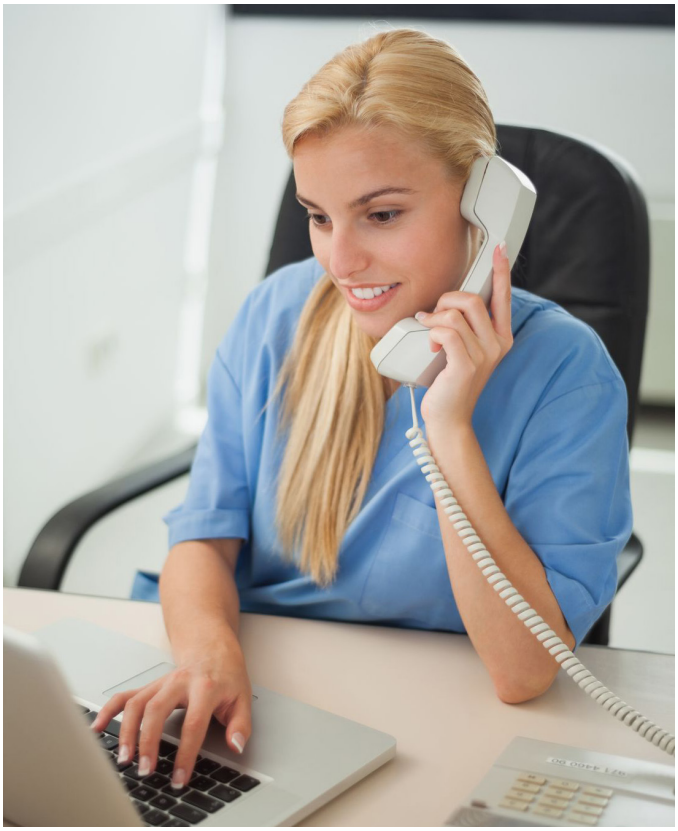
3 Utilization Management

- Utilization Management Program Overview
- Program Measures
- Provider Experience
- Analysis
- Future Initiatives

Utilization Management (UM) Program Overview

The PCN performs prior authorization, inpatient review, discharge planning, and transitional care planning. Both clinical and non-clinical staff perform prior authorization functions. Non-clinical staff assist with verifying eligibility, entering authorization information in the online system, and faxing and/or calling authorization outcomes to providers. Clinical staff perform medical necessity review and discharge planning. The review process utilizes national guidelines, Milliman Care Guidelines®, as well as internally developed guidelines, to determine medical necessity of service requests. All requests that do not meet the related guideline or policy are sent to a Medical Director for review and final decision. The Care Integration Manager and Clinical Project Manager conduct staff audits and oversee the peer audit process. This involves members of the Care Teams conducting audits on their peers' performance of the prior authorization processes to ensure compliance with documentation standards, application of criteria, and adherence to processing timeframe standards. Current audit standards require that staff members who have been employed for greater than a year meet or exceed an accuracy level of 95%. In 2018, the average audit scores for both clinical and non-clinical staff exceeded the established 95% benchmark. The PCN monitors timeframes for processing routine and urgent prior authorization requests on a monthly basis to ensure the program standards are consistently met. The phone queue system is monitored by the Clinical Project Manager, and call statistics are reviewed monthly to ensure calls are answered according to standards.

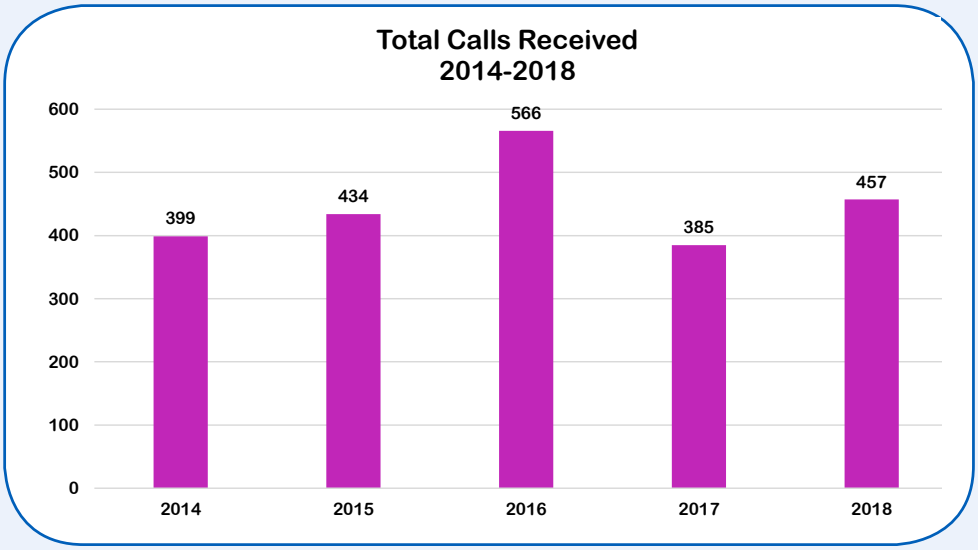
In addition to process measures, the PCN monitors utilization trends for the population to ensure appropriate utilization of services occurs. To monitor for under-utilization of services, the PCN relies on review of preventive services, outpatient services, and PCP office-based services. Additionally, the PCN monitors member complaints or grievances related to access to care or insufficient care delivery. The information specific to those measures is outlined in the Population Health Management and Case Management/Disease Management sections of this report. To monitor for over-utilization of services, the PCN relies on review of frequent and/or high-cost services such as inpatient and emergency room (ER) trends. The data specific to those measures is presented here.

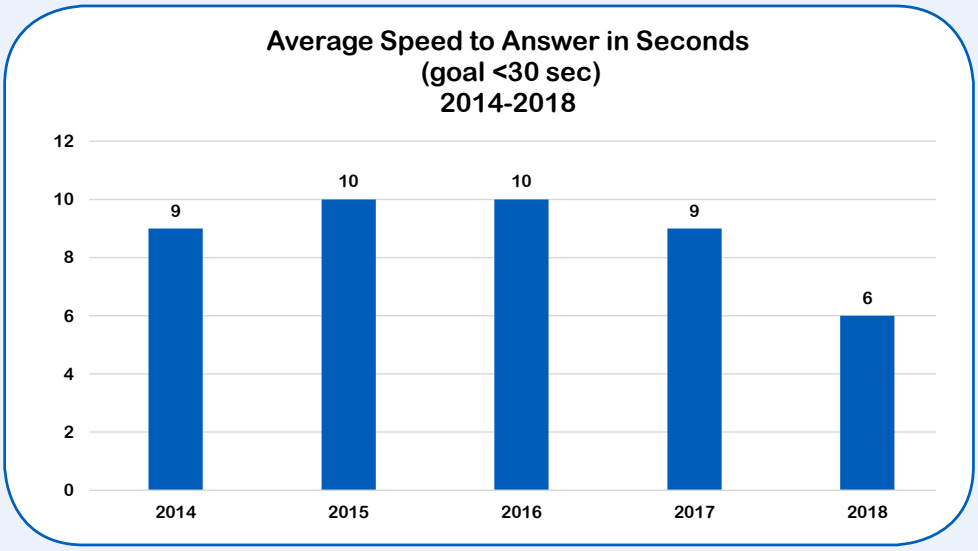


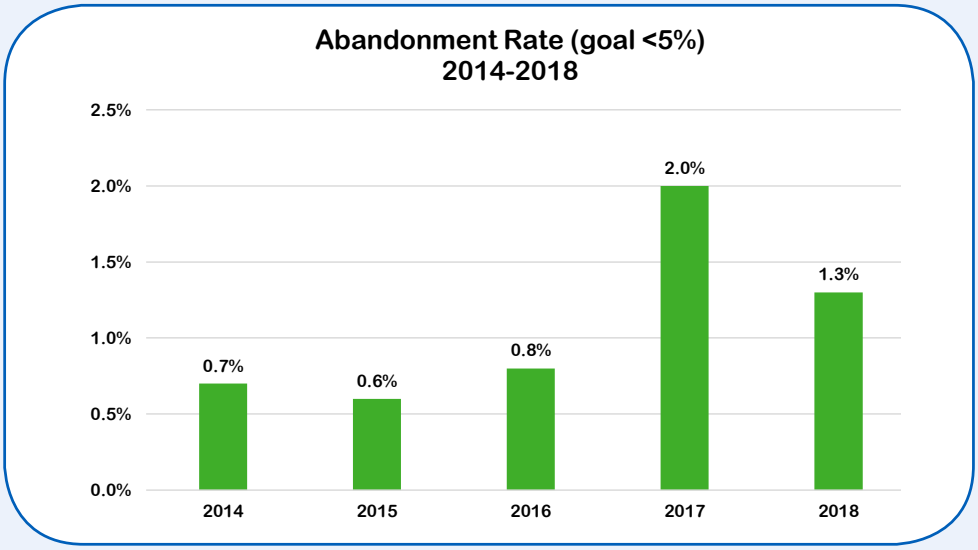
Program Measures

Authorization statistics related to the standards for phone call monitoring and processing medical necessity reviews are presented in the following charts and compare current year performance to prior years. In 2018, the phone statistics remained consistent and well within the benchmarks. Denials for outpatient services increased in 2018 due to a change in the medical necessity review and administrative denial processes. Similarly, there was an upward trend in the percentage of authorizations denied and percentage of administrative denials due to the same process changes.

Precertification Phone Statistics

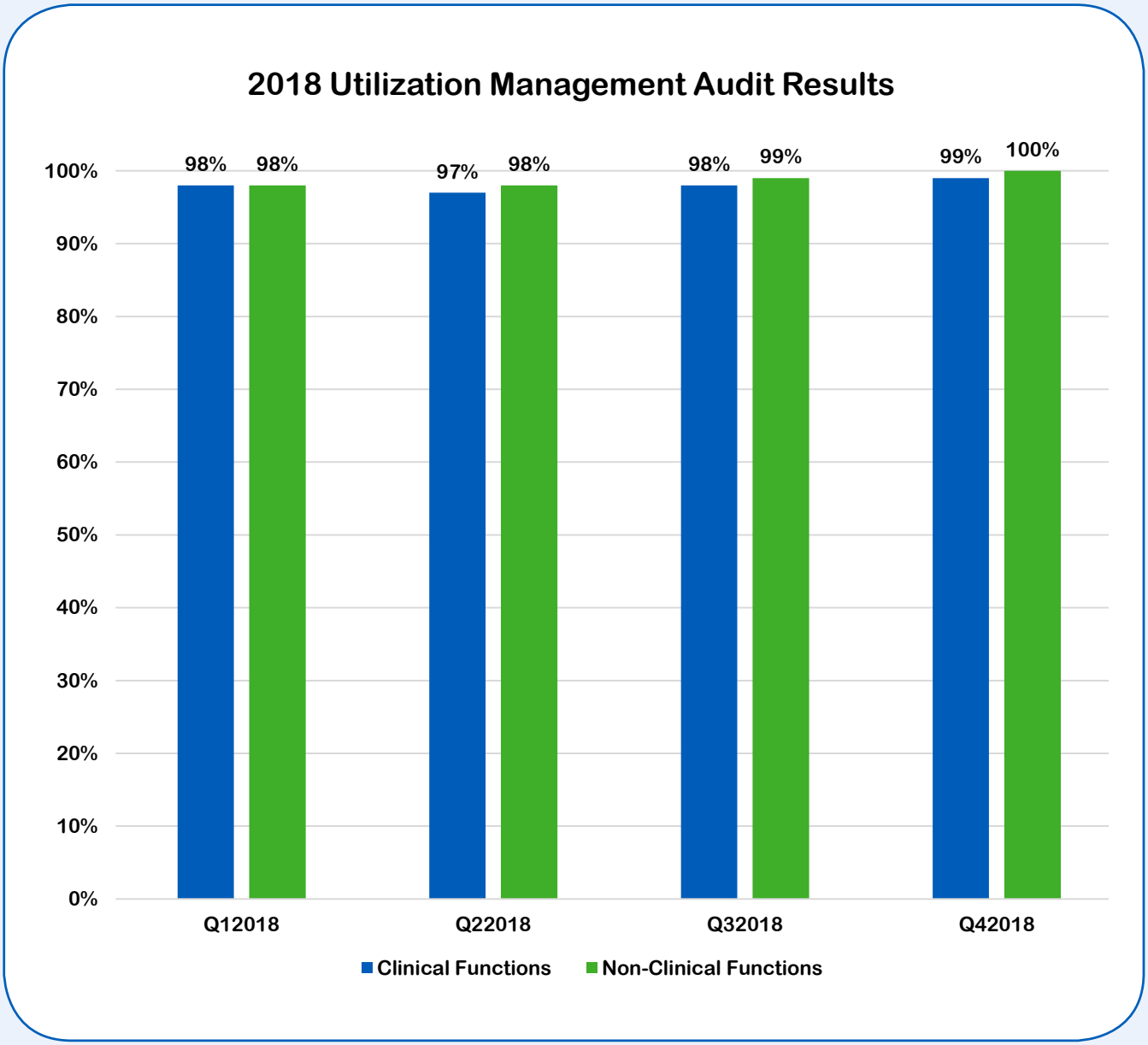




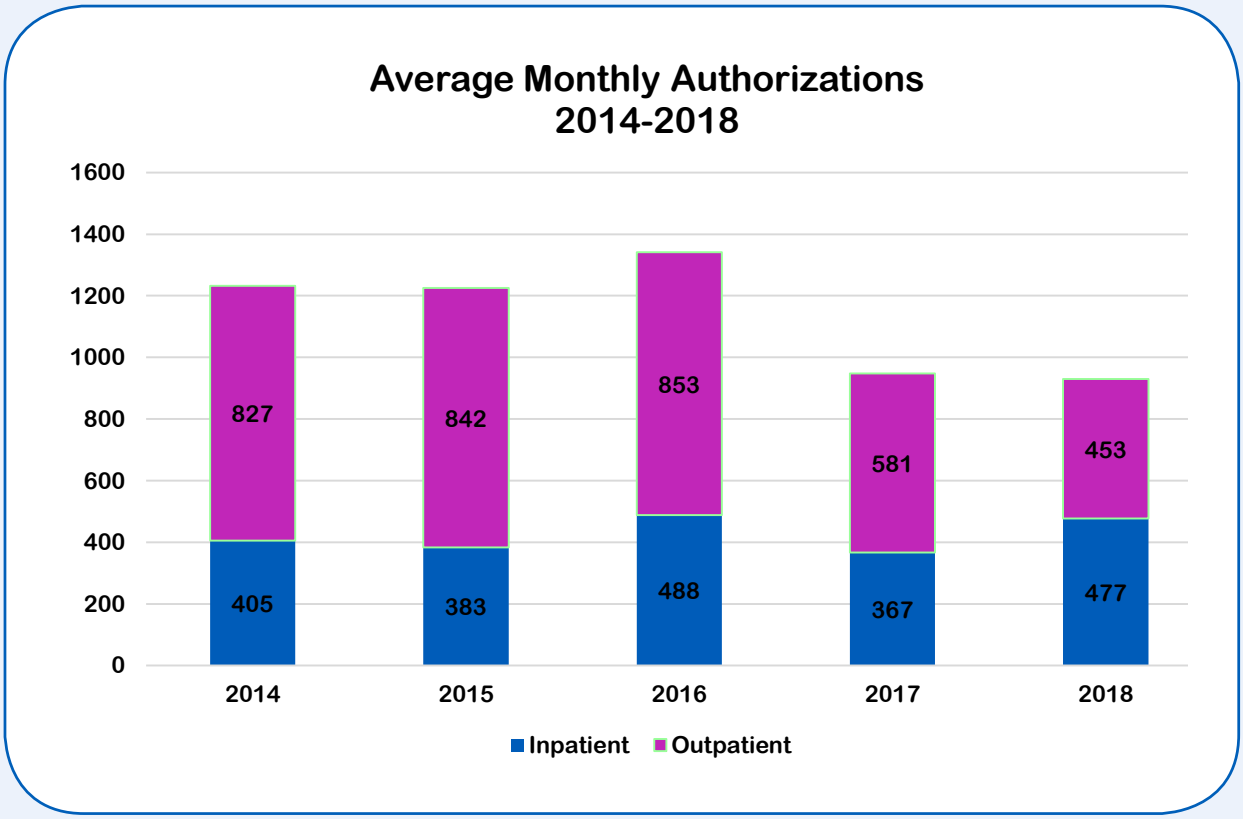


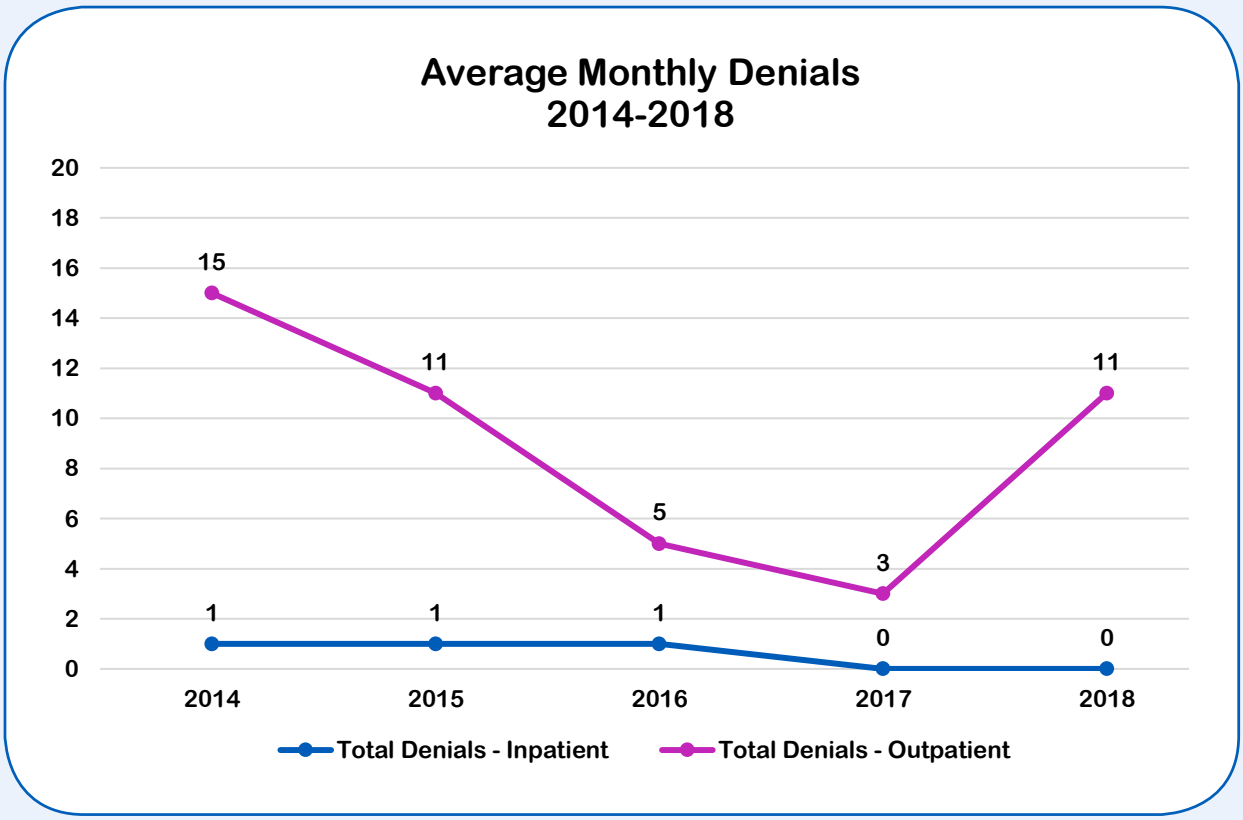
2018 Utilization Management Audit Results

Below are the 2018 aggregate audit results for clinical and non-clinical staff performing utilization management functions. PCN experienced an increase in staff turnover in 2018. Audit results for nine (9) new staff members are included in the audit results below reflecting a strong onboarding process for new staff. Audit scores for both groups consistently exceeded the established benchmark of 95% throughout 2018.



Prior Authorization Statistics





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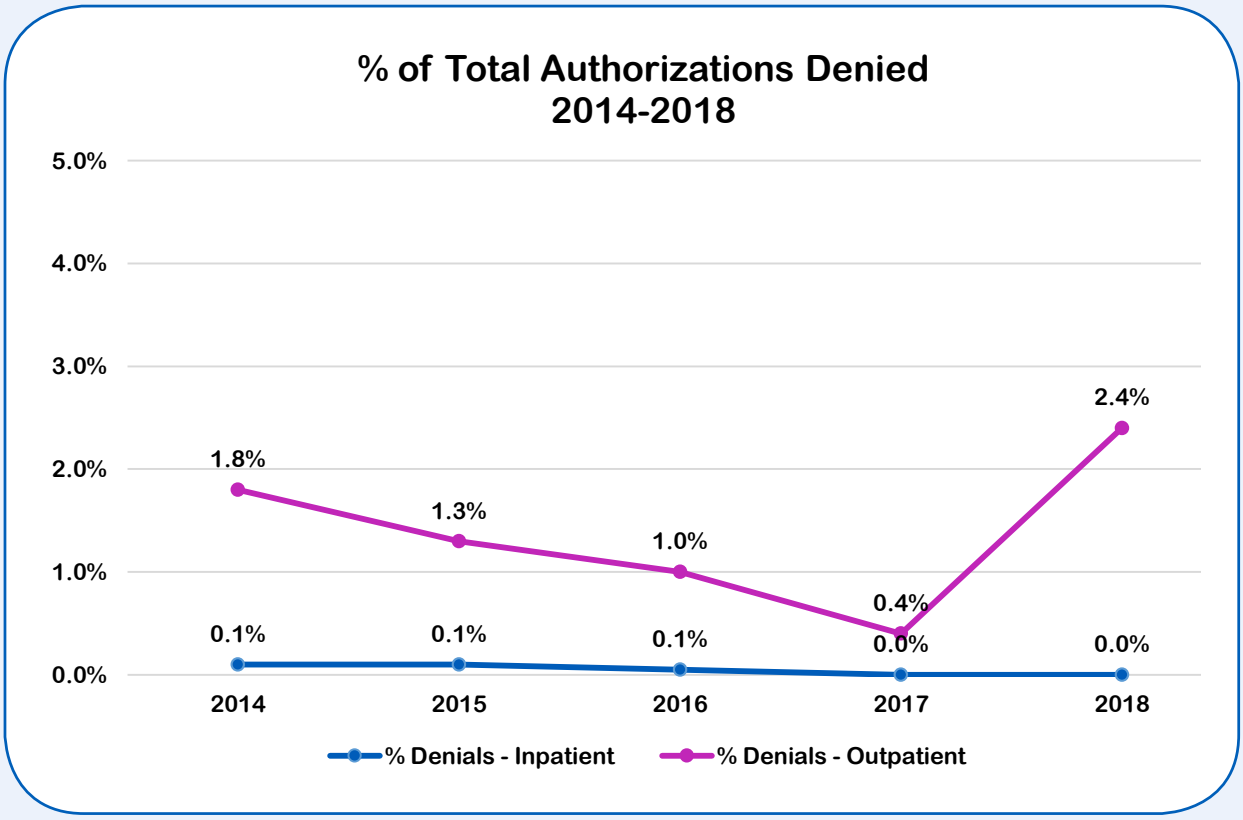
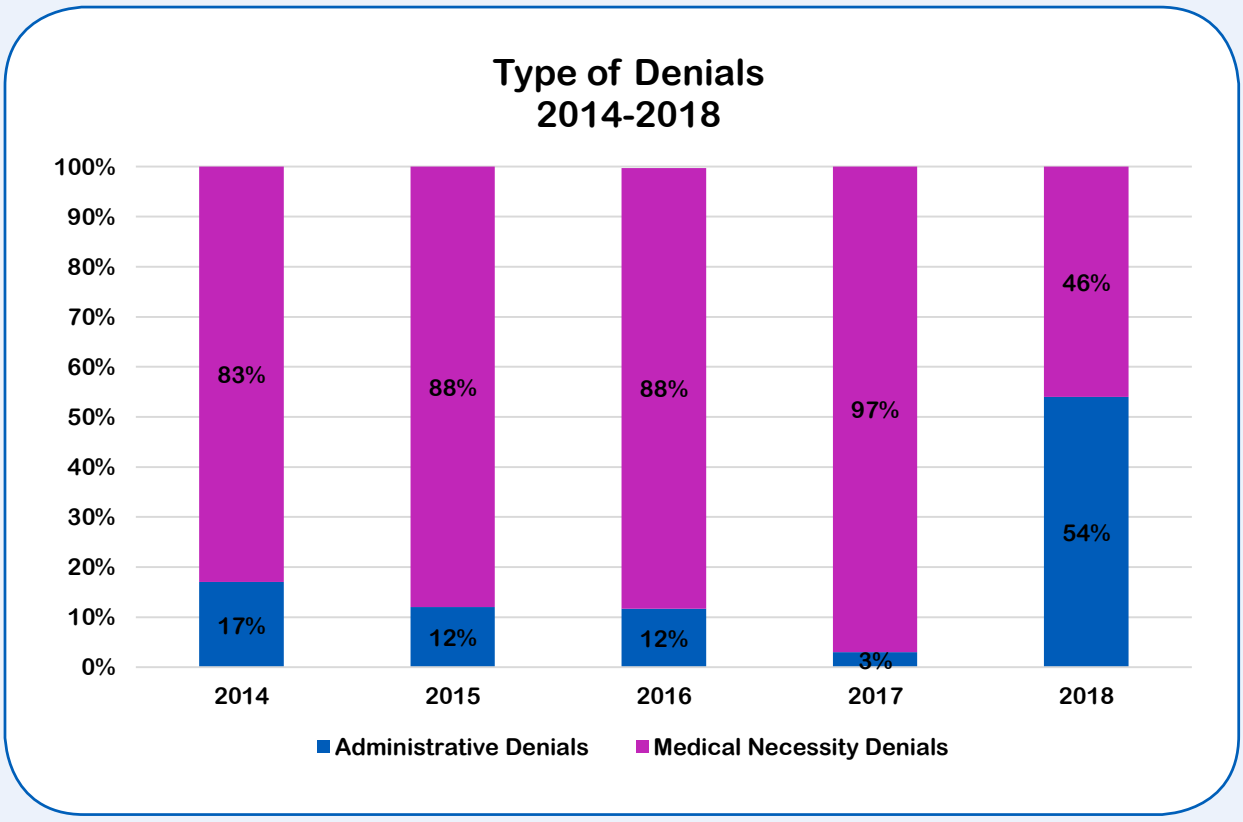
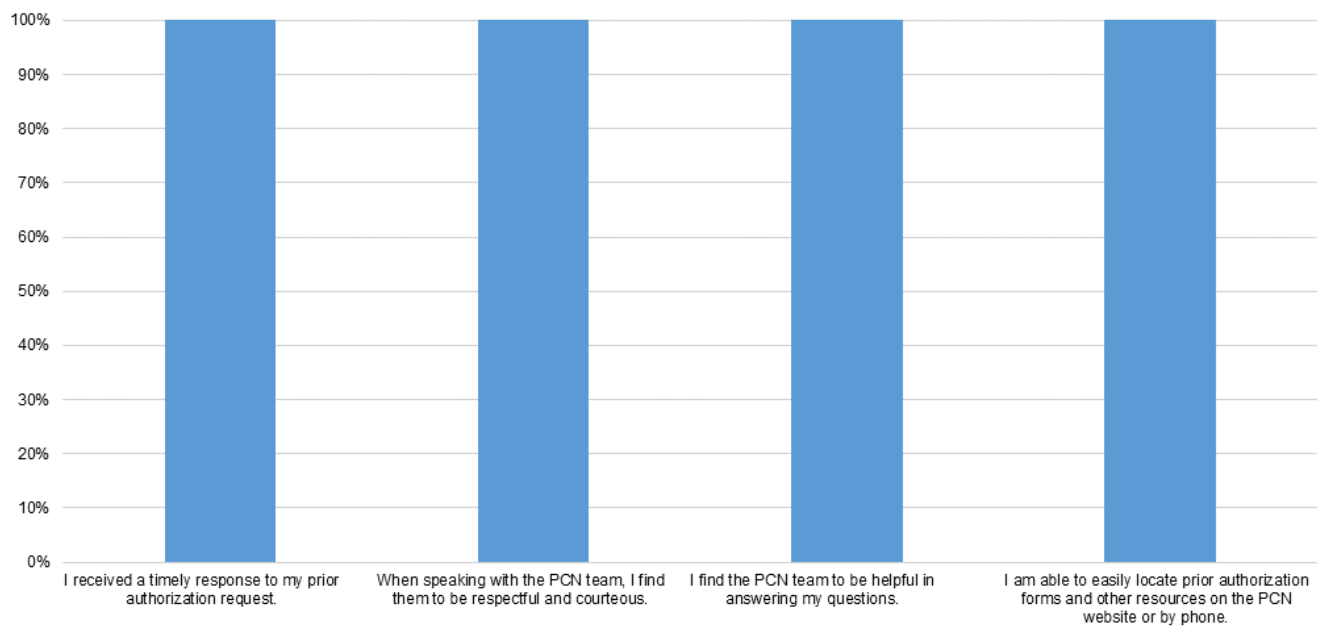
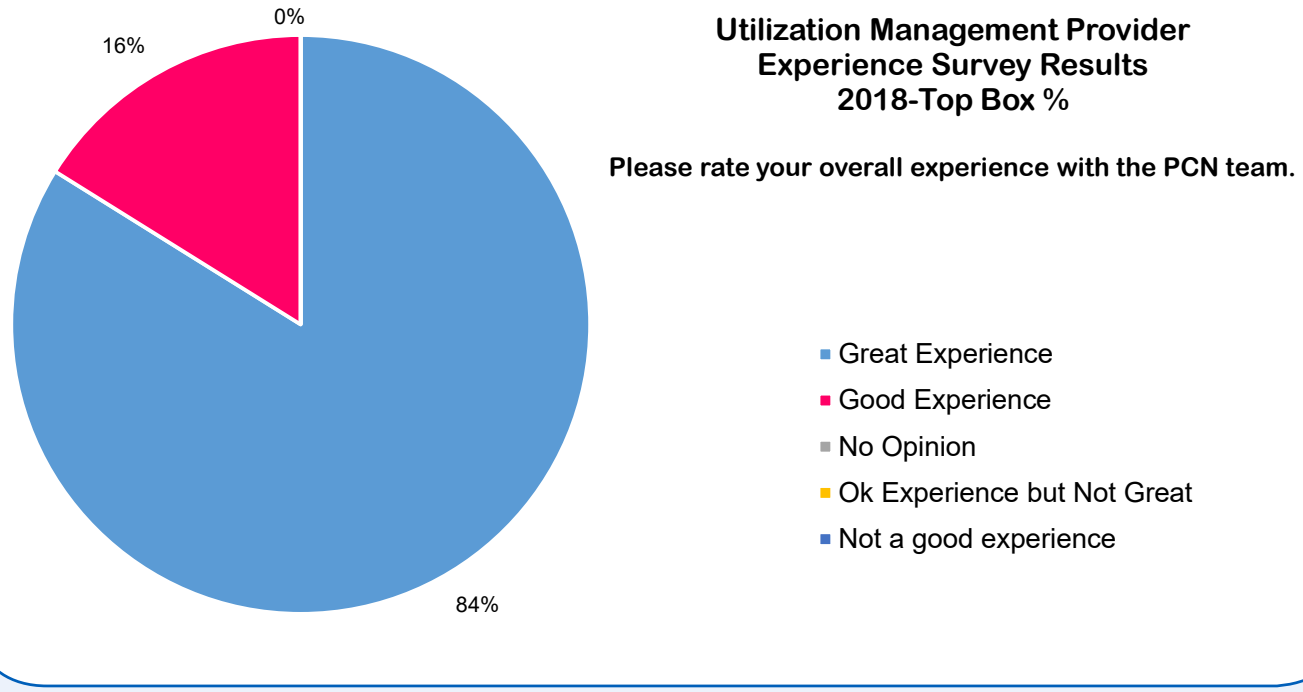




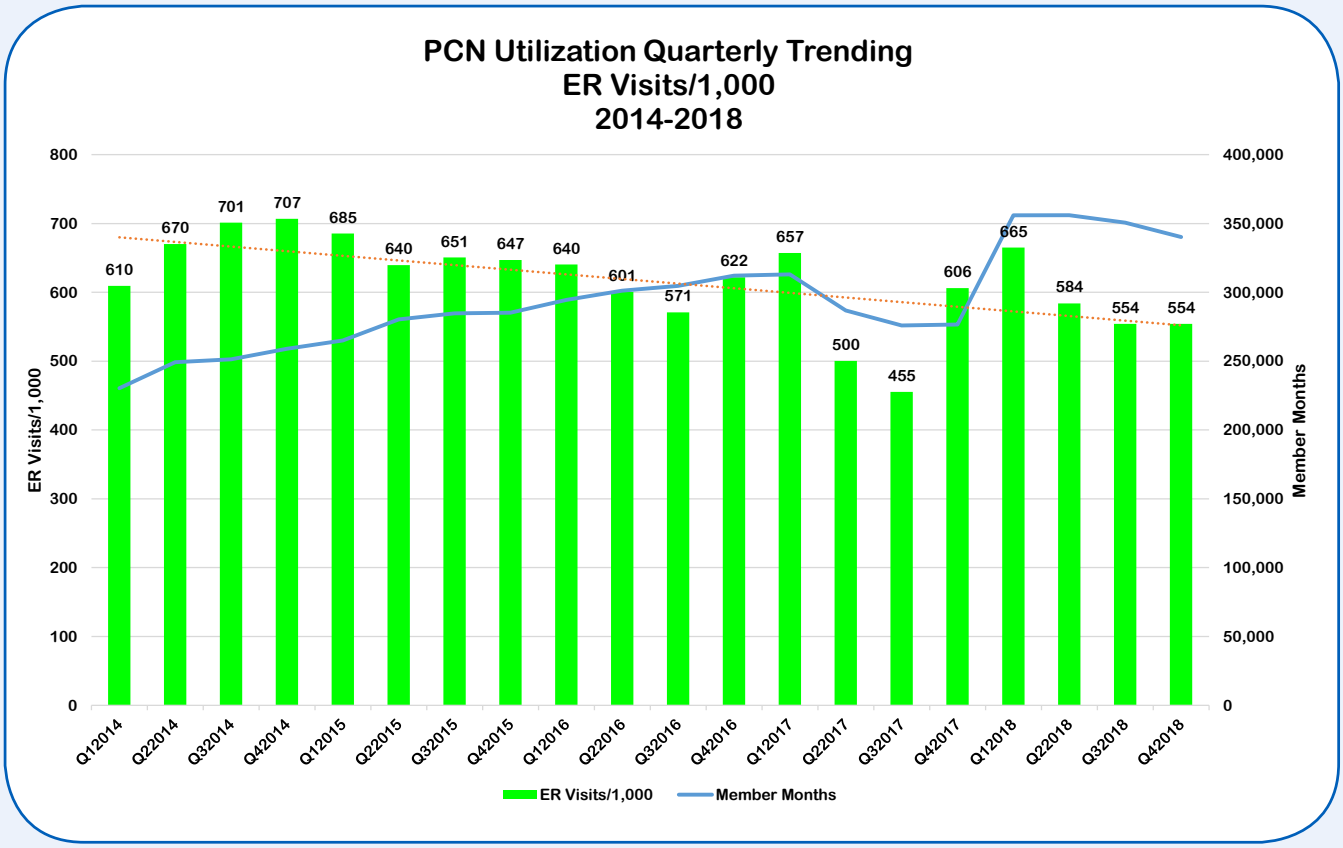
Provider Experience

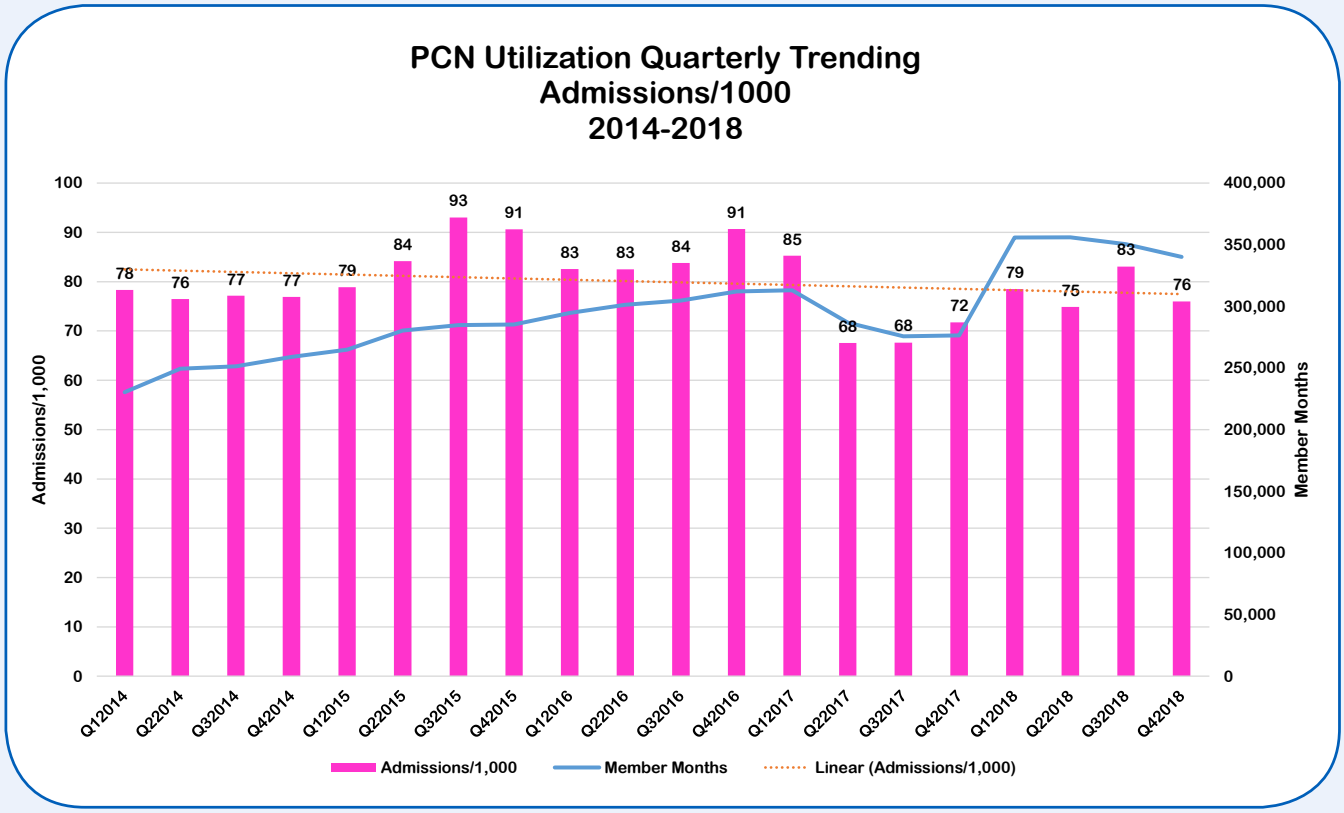
A short survey was distributed to all clinics/PCMH offices in the PCN to assess their satisfaction with the prior authorization process. The Provider Satisfaction Survey contained five questions. PCN's Provider Satisfaction Survey results from 2018 are shown below:





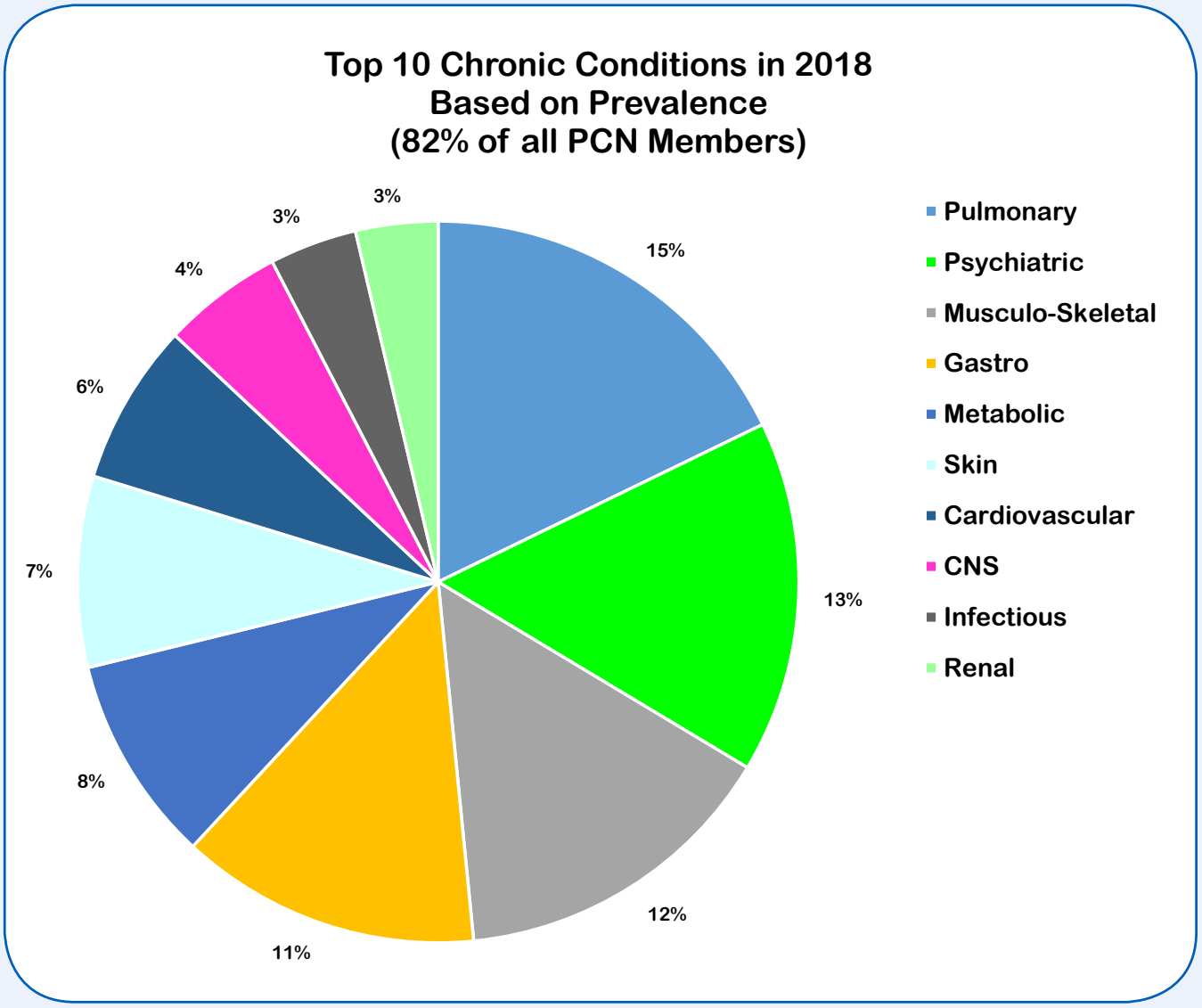
Inpatient and ER Utilization Statistics: 2014-2018





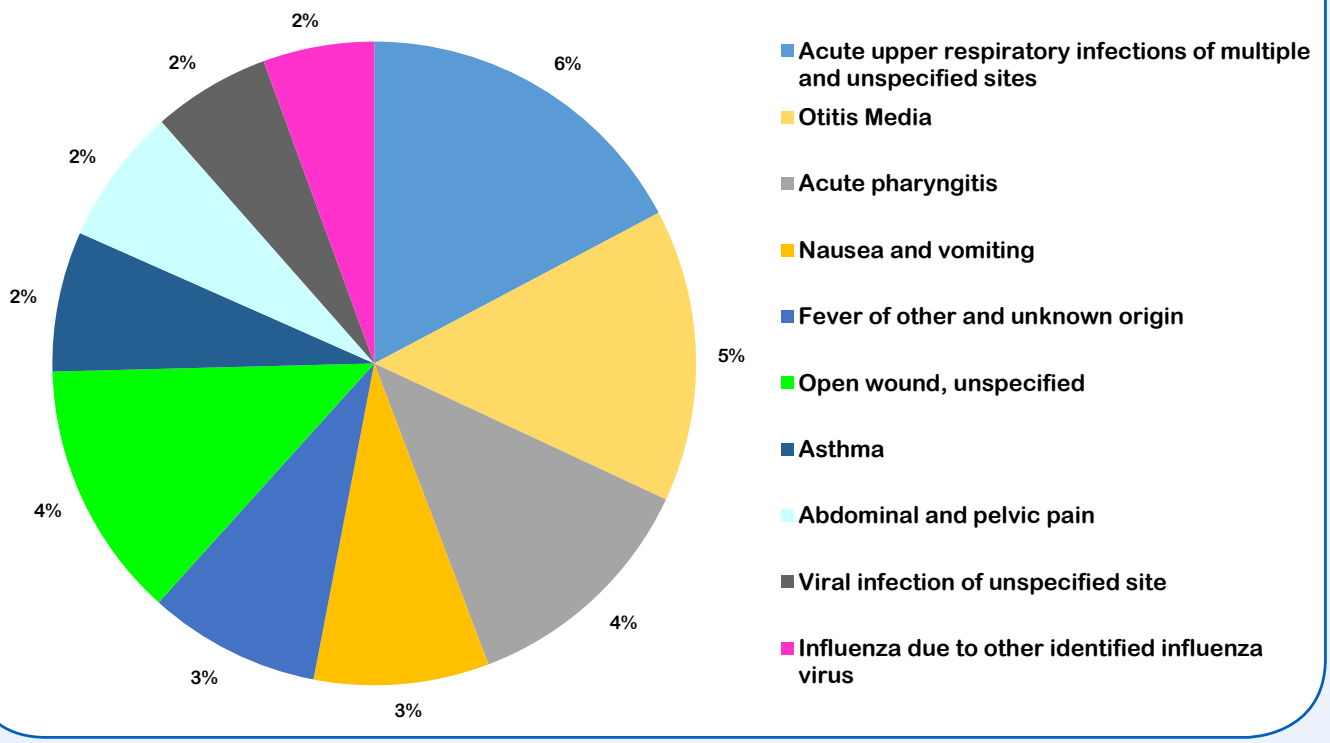
Year over Year Comparisons of Utilization: 2014-2018

Incurred Year	2014	2015	2016	2017	2018
Admissions/1000	77	87	85	73	66
Days/1000	287	374	379	289	246
ER Visits/1000	673	655	608	557	590
ALOS (Medical)	3.7	4.3	4.5	3.9	3.7
% Change from PY	**2014**	**2015**	**2016**	**2017**	**2018**
Admissions/1000	NA	12.9%	-2.3%	-14.1%	-9.6%
Days/1000	NA	30.3%	1.3%	-23.8%	-14.9%
ER Visits/1000	NA	-2.7%	-7.2%	-8.4%	-5.9%
ALOS (Medical)	NA	16.2%	4.7%	-13.3%	-5.1%

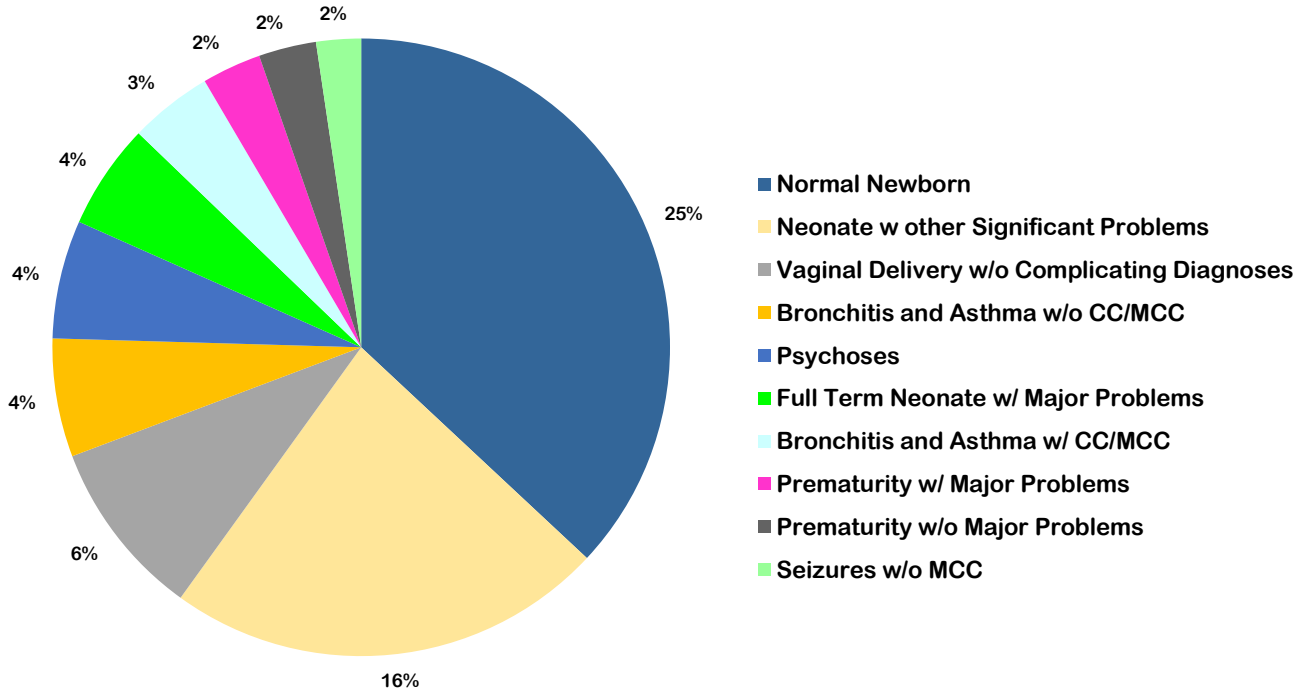


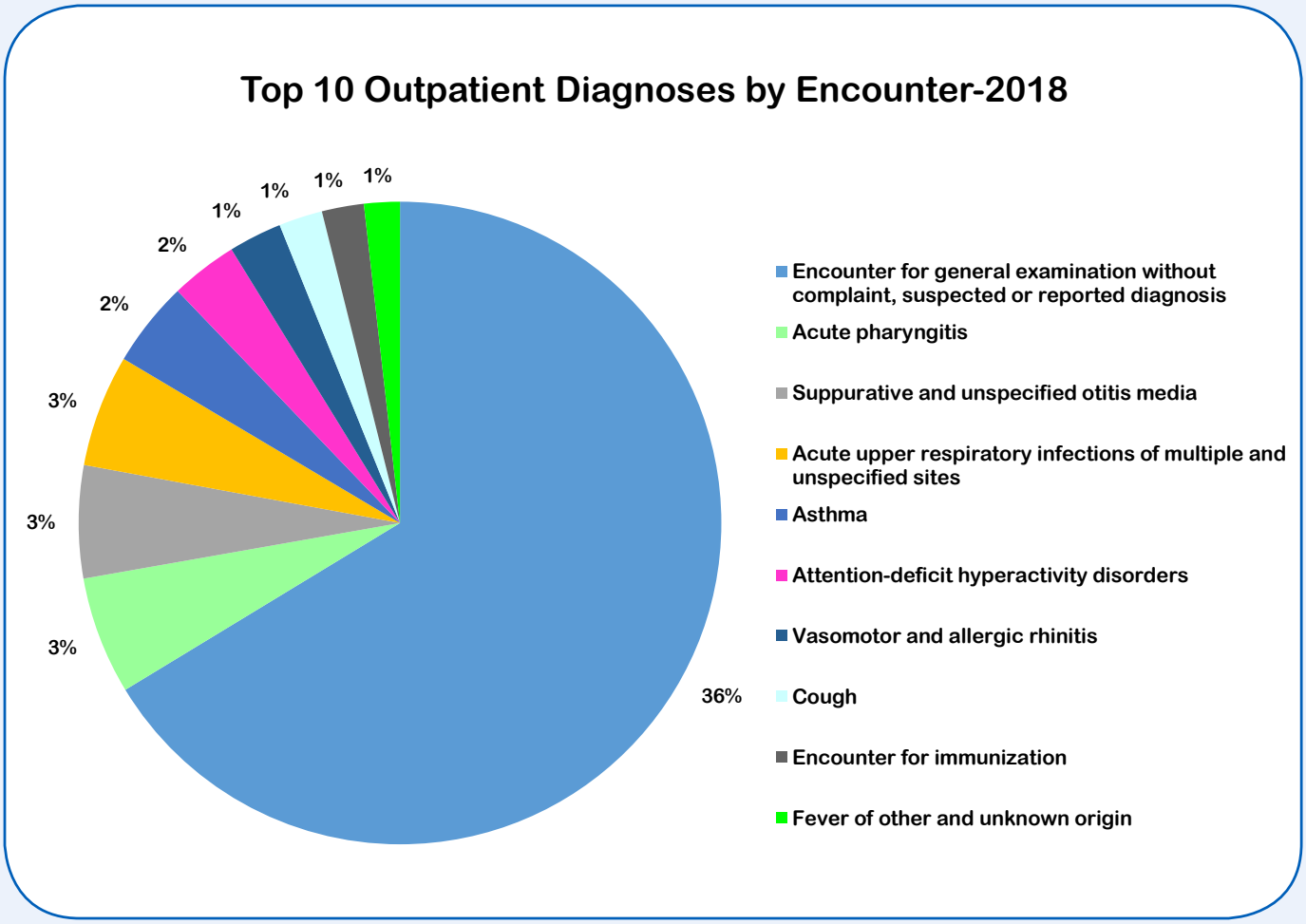
Top 10 Diagnoses by Encounter

Top 10 ER Diagnoses by Encounter-2018



Top 10 Inpatient Diagnoses by Encounter-2018





Utilization Analysis

The PCN Care Teams are responsible for utilization management functions for their assigned population. Prior authorization requests are received by a Care Facilitation Coordinator for electronic distribution to the appropriate staff member. Care Facilitation Nurses review and process routine requests that require clinical review. Complicated requests that will require coordination between providers and members are sent to the Care Team for review and processing. The Community Resource Specialist (CRS) is the hub of the Care Team and receives all incoming tasks, including prior authorization requests. The CRS reviews and processes the request according to policy. If the request is beyond the scope of a non-clinical staff member, the CRS initiates the authorization into the system and then sends the request electronically to a Care Navigator for review and completion.

PCN has incorporated a peer-audit component into the quarterly staff audit process which provides a learning opportunity for each staff member. By reviewing the work of their peers and verifying accuracy through desktop procedures and policies, staff members are able to increase their own knowledge base. This is demonstrated in the 2018 UM audit results which exceeded the established threshold of 95%. Peer audits are reviewed by leadership to confirm the audit findings. Staff and leadership meet quarterly to review aggregate audit results, discuss themes identified during the audit, and provide re-education to staff.

The PCN routinely evaluates services that require

prior authorization. Through this evaluation, additional CPT and HCPCS codes were removed from the PCN prior authorization list in 2017. This reduction accounts for the decreasing trend in average monthly outpatient authorizations entered in 2017 and 2018.

Emergency room utilization for PCN members continues to trend downward through collaboration with primary care provider practices and appropriate identification and outreach to high emergency room utilizers. This is evidenced by an 8% decrease in ER visits per 1,000 from 2017 to 2018. The top ER diagnoses based on claims encounter data were viral infection, head injuries, and abdominal/pelvic pain.

Similar to the downward trend in ER utilization, there has been a downward trend in inpatient utilization. From 2017 to 2018, there was a 14% decrease in admissions per 1,000 and a 13% decrease in average length of stay (ALOS). As Care Integration processes deepen across the PCN population, lower acuity inpatient admissions decrease through timely identification and active care coordination of at-risk members. The top inpatient diagnoses in 2018 were pregnancy, major depressive disorder, and pregnancy complications.

The broader Care Continuum program within Children's Mercy Kansas City's system allows the Care Teams to more efficiently work in tandem with providers, as well as inpatient and ambulatory Social Workers and Care Managers, to provide the best possible care to members. With this open collaboration, Care Teams are able to provide practices with follow up information from inpatient and emergency room visits to help ensure members have timely follow up appointments with their assigned primary care providers.

In an effort to decrease emergency room utilization and redirect members to the primary care provider for non-emergent health concerns, the PCN continued the telehealth initiative, KidCare Anywhere, in 2018. This is a Children's Mercy Kansas City initiative and is addressed in more detail in the Population Health Management section of this document.

Future Initiatives

- PCN continues to evaluate the list of services that require prior authorization. Through this evaluation, on an annual basis, additional services may be identified as appropriate to either be added or removed from the requirements. PCN continues to monitor trends with services removed from prior authorization to identify potential over-utilization;
- Timely identification of at-risk members and evaluation of emergency room services for non-urgent/non-emergent needs will continue to be priorities for the PCN Care Teams;
- An online prior authorization request tool will be piloted in 2019 to increase efficiencies in the process for providers and staff.

4 Transitional Care Program Evaluation

- Transitional Care Program Overview
- Program Measures
- Analysis

Transitional Care Program Overview

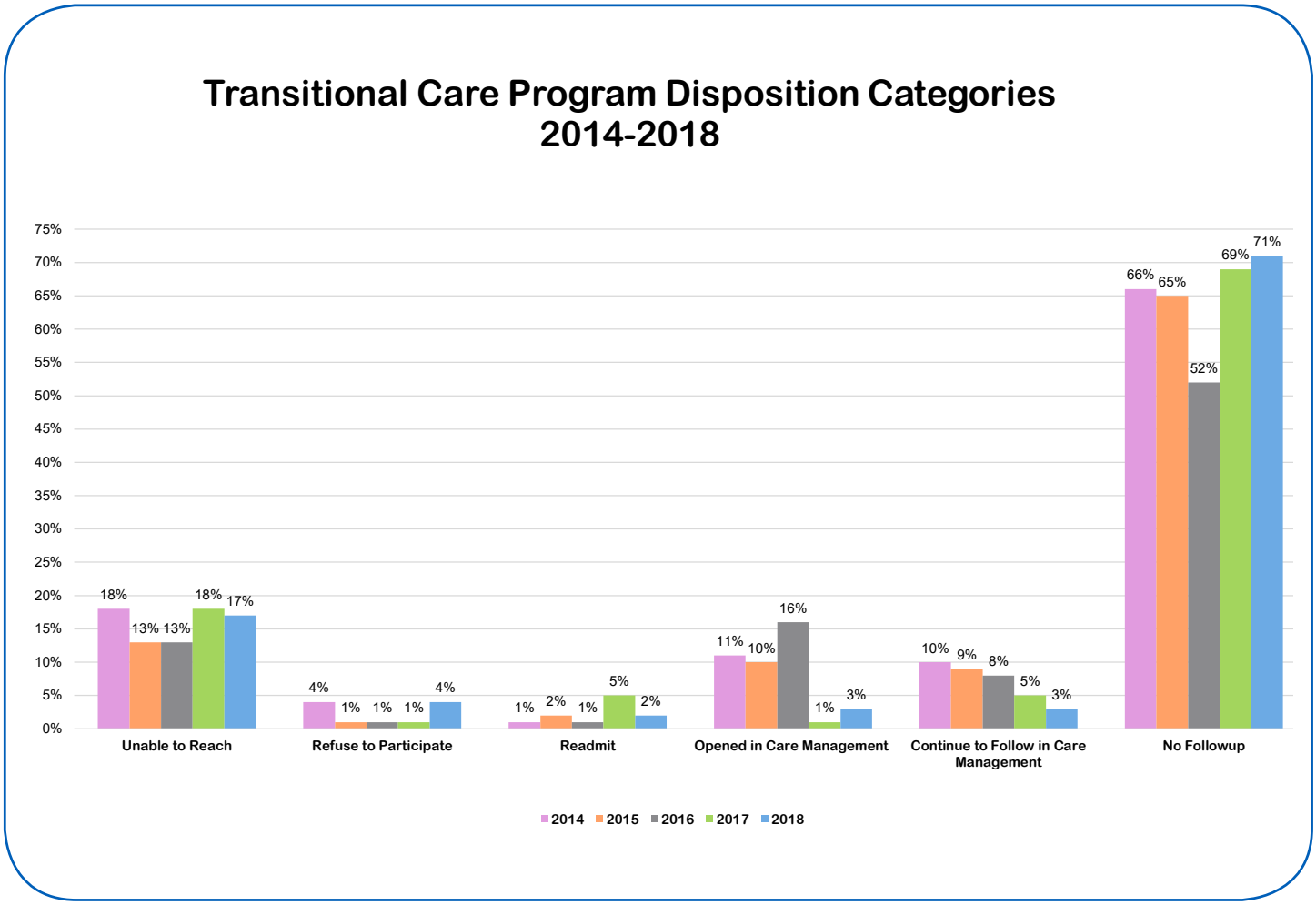
In an effort to facilitate a seamless transition from inpatient to home and community settings, the Care Teams deploy a transitional care program. This program involves making post-discharge phone calls to members and caregivers focused on assessing and screening for barriers to care following inpatient admission. Level 1 transitional care calls are made on inpatient discharges that meet the following criteria: members with complex medical needs, inpatient stays greater than 14 days, readmission within 30 days with same or similar diagnosis, members enrolled in care management, or the facility has requested assistance with discharge planning. Exclusions to this list include observation stays, planned admissions (e.g. chemotherapy, EEG), obstetrics deliveries, and those with transitional care support provided by another primary insurance. A subsequent Level 2 transitional call is completed on members who meet the following criteria: did not successfully complete a Level 1 call because the discharge plan was still in process, the member had new or worsening symptoms related to the inpatient stay, the member was discharged from the NICU, or the member answered “no” to two or more specific screening questions in the Level 1 call indicating further intervention needs.

Level 1 calls are conducted within 1-2 days of discharge notification. A minimum of three outreach attempts are completed. If a Level 2 call is needed, the second call is completed within 10-14 days from

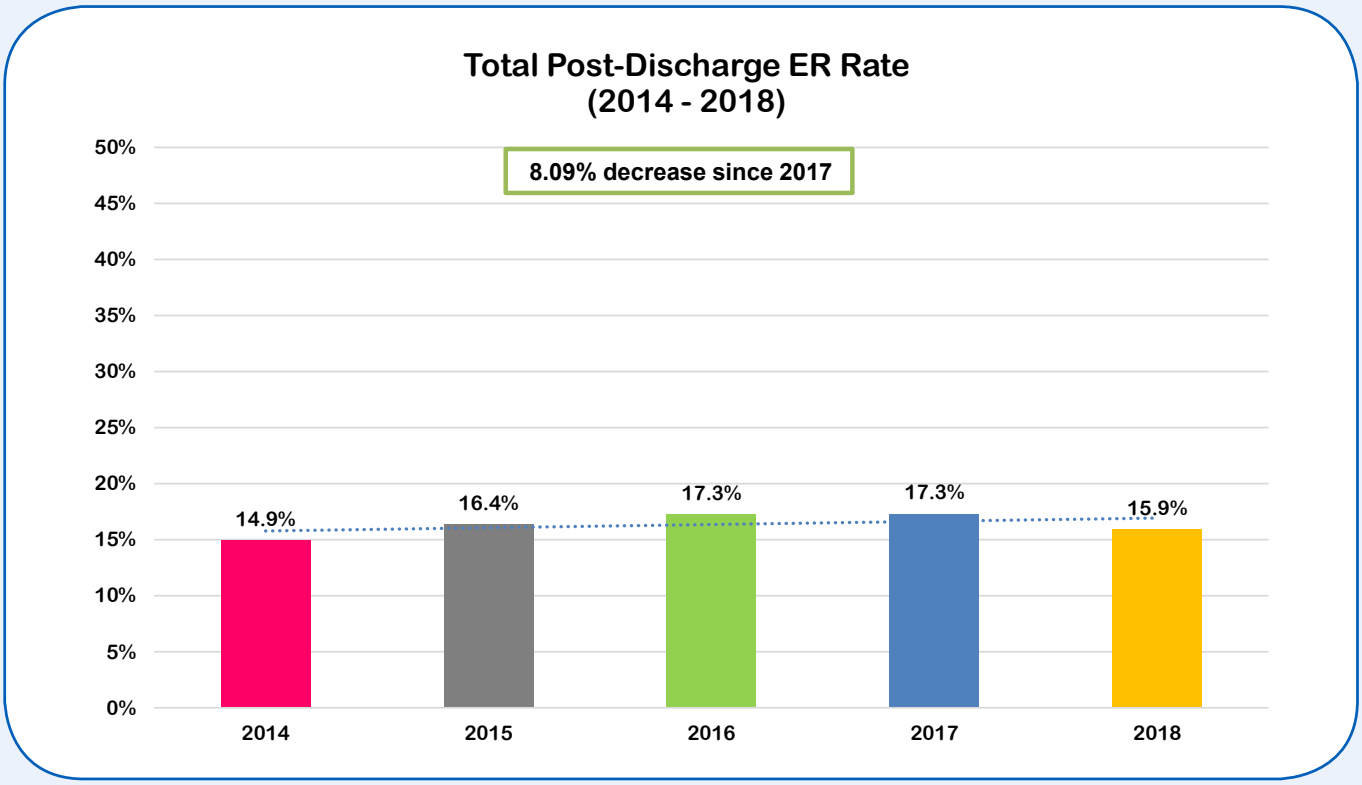
the date of the successful Level 1 call. If needs are identified during one or both calls, the Care Team works in partnership with the member's PCP to address the member's immediate barriers to care including access to medications, home services, transportation, and appointment scheduling. A summary of the transitional call outcome is sent to the member's PCP to communicate the interventions provided to the member. Members with long term, ongoing needs for care coordination are referred to a Care Navigator for additional support.

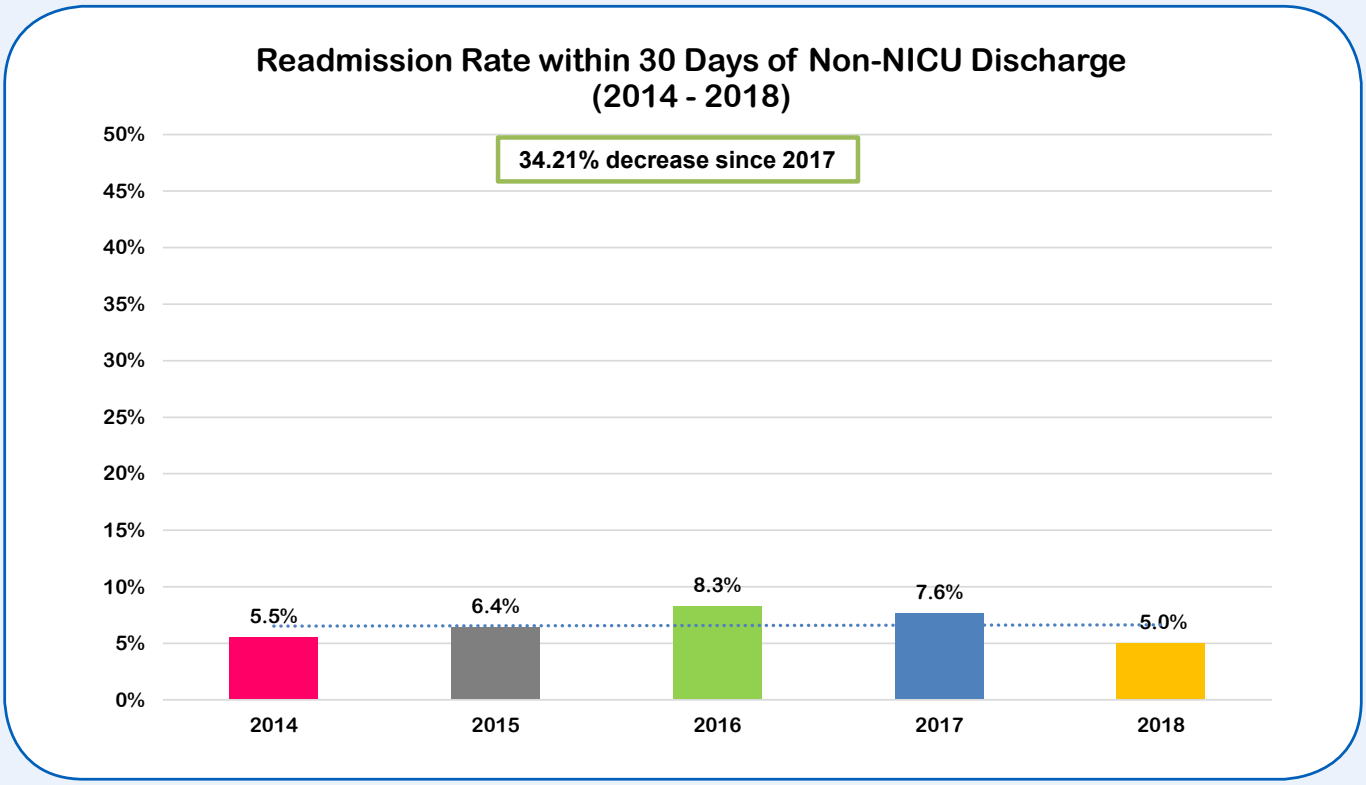
Program Measures

Care Navigators document transitional care program screenings in C.A.R.E. Web (PCN proprietary online documentation and communication tool), and statistics are reviewed monthly. Care Team staff monitor and track the number of calls attempted, the disposition of calls (e.g. opened in care management, no follow up needed, etc.), and the number of members who refused to participate in the program. In 2018, a total of 472 calls were completed through the transitional care program. When comparing the past five years of results, there was an increase in the disposition of no follow-up needed and a decrease in cases opened in case management. This can be attributed to a change in the program structure where members were historically followed longer in the transitional care program until all issues were resolved, rather than being opened in case management. See chart below for disposition category results.

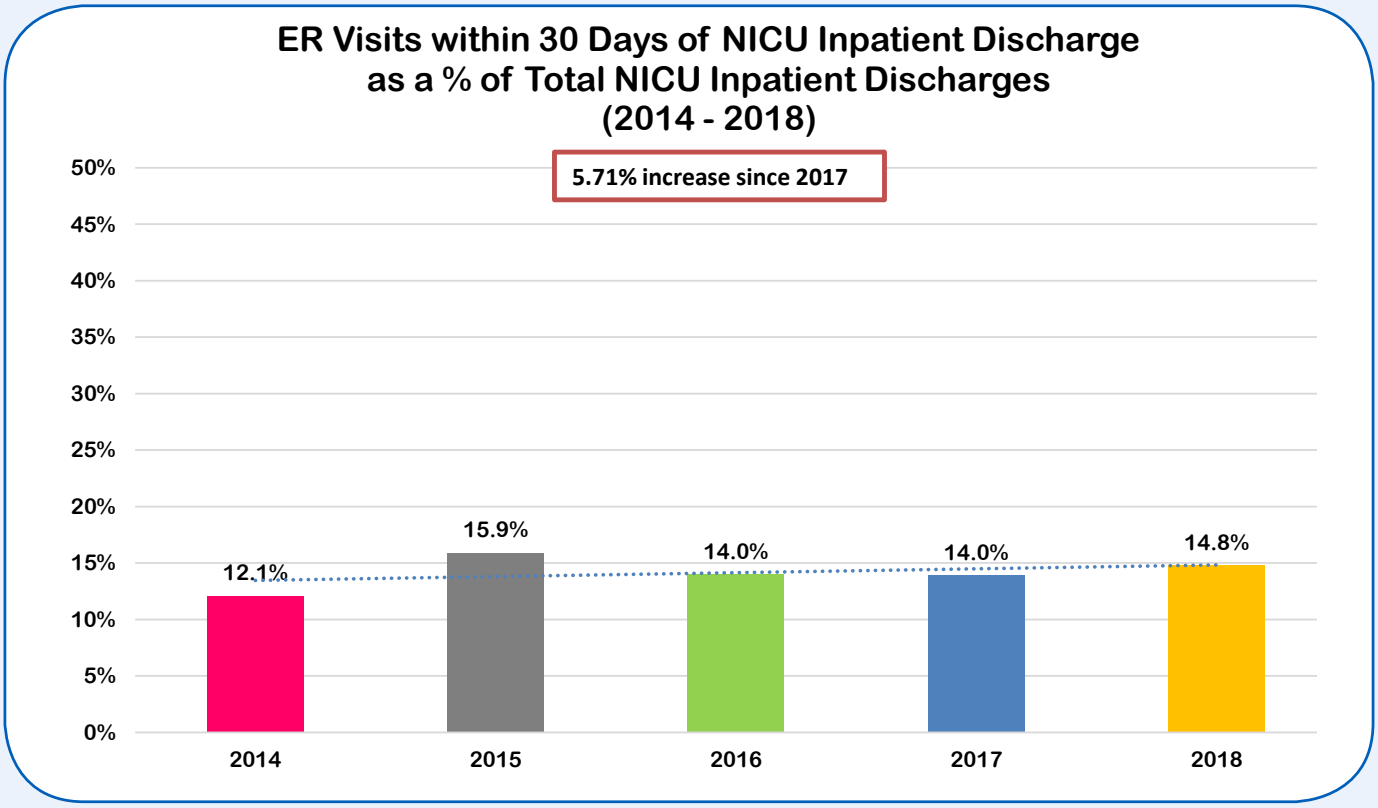


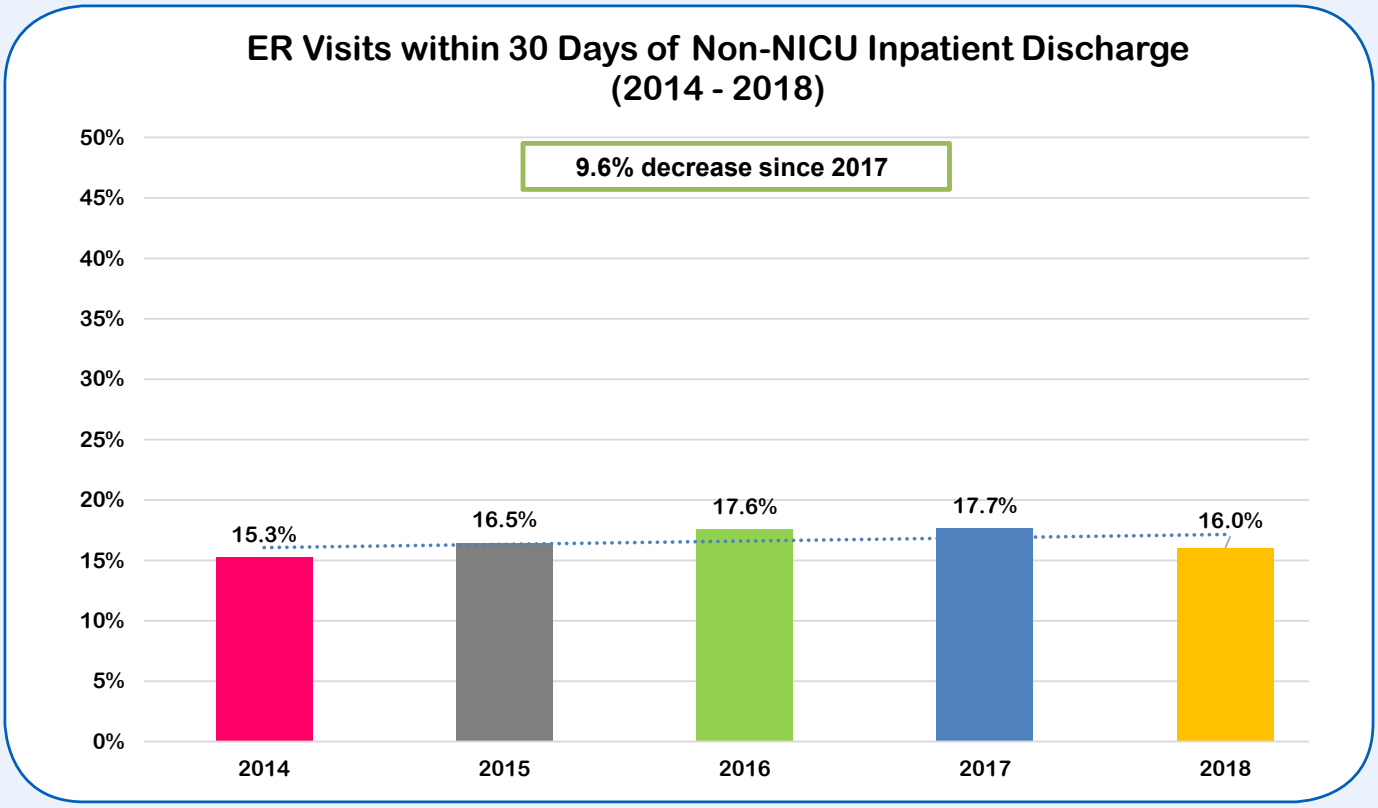
The overarching goal of the transitional care program is to decrease emergency room visits and unplanned hospital readmissions. Below is a five year trend (2014-2018), based on claims data, of 30 day post-discharge ER visit rates and all-cause readmission rates for the PCN population.





The below charts further detail data for post-discharge ER visits by non-NICU and NICU discharges.





Analysis

As an enhancement to the existing transitional care program and to further support successful transitions home following inpatient admission, the PCN implemented a quality improvement initiative with interventions focused on reducing post-discharge ER visits for babies being discharged from the NICU. This initiative included a partnership with the Children's Mercy Home Care department in order to provide in-home nurse and social work assessments and interventions for members discharged from high volume NICU facilities. The initiative, which was implemented in August 2016 and continued throughout 2018, was designed to provide up to 6 weeks post-discharge support and education to caregivers in the home. Members with complex medical needs requiring skilled nursing services in the home were excluded from this program.

The program has successfully demonstrated an impact on the medical cost and utilization of care of the members who accepted the services. The program has served 183 NICU babies since implementation. The program was compared to a control group of 186 NICU babies in the same hospitals who refused the Home Care services. The analysis was favorable for the Home Care group with over 55% reduction in paid medical cost, 74% reduction in admissions, 93% reduction in hospital days, and 84% reduction in readmissions. The Home Care group was 22% higher in ER visits. After further analysis, ER visits were mainly due to respiratory issues and chronic recurring ear infections. More than one fourth of the ER visits were from 10 unique members. PCN and Children's Mercy Home Care will evaluate ways to educate PCN members' caregivers on alternatives to utilizing the emergency room and encourage them to contact their primary care providers, utilize nurse advice lines, or visit trusted urgent care facilities.

NICU Cost & Utilization Statistics

	Cost and Utilization					
	Babies	Risk Score	ER Visits/ 1000	Admissions/ 1000	Days/ 1000	Readmissions/ 1000
Control Group	186	4.9	1,388	183	1,747	77
Home Care Group	183	3.4	1,695	48	115	12
% Difference			22%	-74%	-93%	-84%

5 Case Management/ Disease Management Evaluation

- Case Management/Disease Management Program Overview
- Program Measures
- Analysis
- Future Initiatives

Case Management & Disease Management Program Overview

Case management and disease management are important components of the Care Integration program. The goals of both case management and disease management include helping members sustain or regain optimal health and reduce overall healthcare costs. The PCN achieves this through well-coordinated efforts between the Care Teams, members, caregivers, providers, and community agencies. Including the primary care providers in case management activities assures continuity of care and alignment for improving health outcomes.

The Care Integration Care Teams work closely with the member's PCP, specialists, and other healthcare providers involved in their care to assess the member's medical, social, and behavioral needs; determine available benefits and resources; and develop and implement specific interventions to achieve optimal outcomes for members. Care Teams are responsible for executing all Care Integration programs for the assigned population including but not limited to case management, disease management, and utilization management.

The program objectives are as follows:

- Assist members in sustaining or achieving an optimal level of wellness and function by facilitating timely and appropriate health care services
- Promote strong member/PCP relationships for coordination and continuity of care, using PCMH concepts
- Reduce inappropriate inpatient hospitalizations and utilization of emergency room services
- Promote clinical care that is consistent with scientific evidence and member preferences
- Ensure the integration of medical and

behavioral health services
- Educate members in self-advocacy and self-management
- Minimize gaps in care and encourage use of preventive health services
- Achieve cost efficiency in the provision of health services while maximizing health care quality
- Mobilize community resources to meet needs of members

The PCN regularly reviews the processes for identifying members, determining interventions, documenting interventions, and the measurement of outcomes. The PCN case management documentation system, or C.A.R.E. Web, incorporates case management screenings, assessments, care plans, routing of cases, and sending tasks to other Care Team members. Within C.A.R.E. Web, Care Teams have the ability to filter the assigned population and prioritize member outreach. Assigned populations can be organized by chronic condition, high utilizer, risk score, or gaps in care. From there, the Care Team can determine a strategy for member outreach and screening.

The Care Integration Manager oversees the quarterly audit process of Care Team staff to ensure compliance with documentation and assessment standards. Current audit standards require that staff meet or exceed an accuracy level of 95% after the first year of employment. In 2018, PCN implemented a peer-audit process into the quarterly review process to provide additional learning opportunities for staff. PCN staff submit completed peer audits to the Care Integration Manager for leadership level accuracy review. Leadership conducts a quarterly meeting with staff to review aggregate audit results, provide education to staff on themes identified during the audit process, and discuss opportunities for enhancements to the documentation system or processes. PCN implemented action plans for those who did not meet the standard and all who had action plans were able to resolve the issues in a subsequent audit. In addition, the PCN Medical Director(s) and Care Integration Manager conduct routine case rounds with the case management staff to review current status of cases, discuss barriers to care, explore intervention opportunities, and identify goals for complex cases. This forum provides an ongoing process for Care Navigators to learn from others and promotes consistency in applying case management principles.

The following case management program enhancements were implemented or adjusted in 2018:

The Provider Practice Performance Profile reports and tri-annual meetings with PCN practices to review cost, utilization and quality data, piloted in 2017, have shown to be incredibly valuable (see page 29 for details). Care Teams received training on the reports, including how to analyze the data to develop collaborative projects with the practices aimed at improving outcomes. In order to have the greatest impact on quality measures, Care Teams transitioned to tri-annual meetings in 2018. This has allowed for the last collaborative visit of the calendar year to be in the fall, helping emphasize best practices and strategies to engage patients with gaps in care before the end of the year.

With minimal guidance from the State on the expectations and monitoring for case management services under the LCCCP, the PCN transitioned from short-term care coordination services to more traditional case management approaches during the third quarter of 2018. This transition included documentation system and process enhancements to address levels of case management, enhance screenings, assessments, care plans, and develop case open and closure criteria.

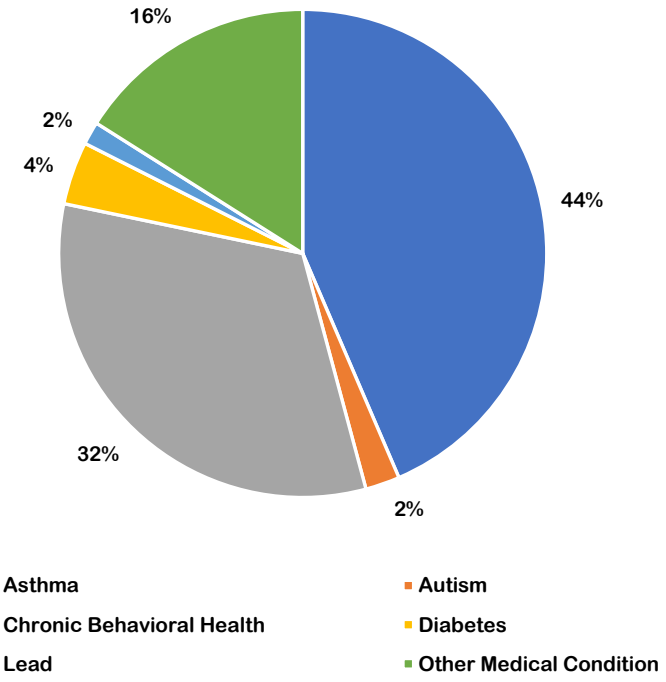
In an effort to connect members diagnosed with asthma to their PCP for proactive condition management, PCN implemented an automated campaign to outreach to members in the medium and high stratification levels of the disease management program. This process provides members the option to transfer seamlessly to their PCP office to schedule an appointment or back to the PCN for case management services.

Program Measures: Care Coordination Statistics

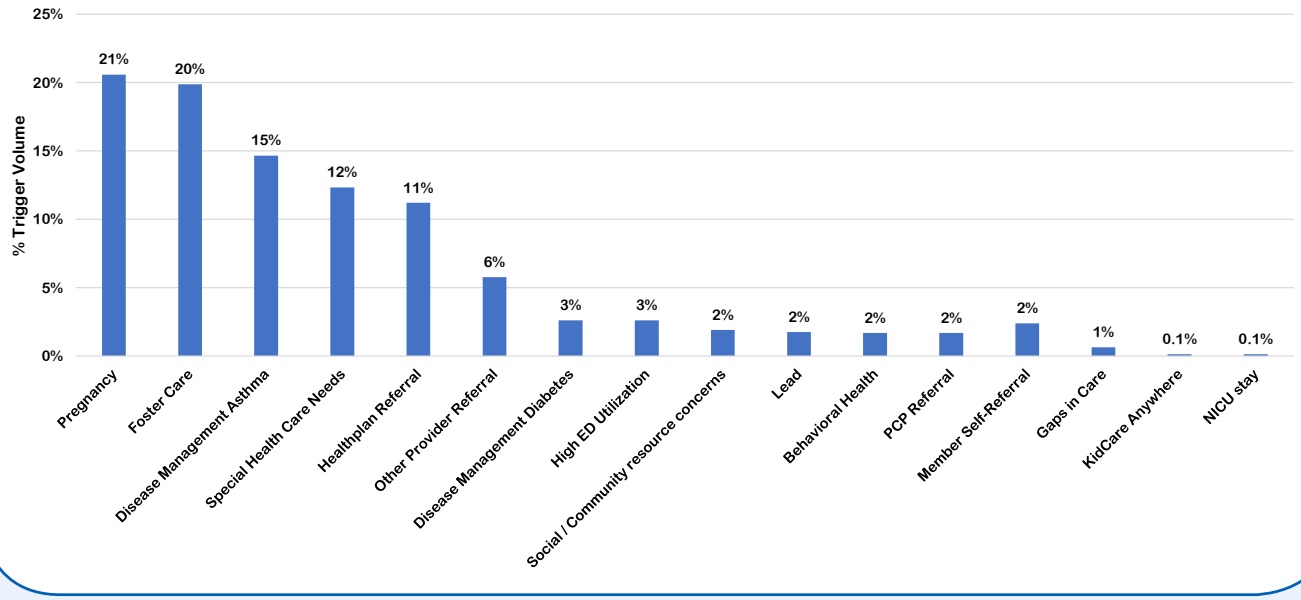
Program Measures: Case Management Statistics

In 2018, 3,572 unique members were identified for case management services, compared to 3,269 in 2017. Forty percent of those members identified for case management services had referral reasons presented in the graph below. Of those patients, 44% were identified as having asthma, 32% had chronic behavioral health concerns, 16% had other medical conditions, 4% had diabetes, 2% had autism, and 2% were due to elevated lead levels.

Care Coordination Outreach Types

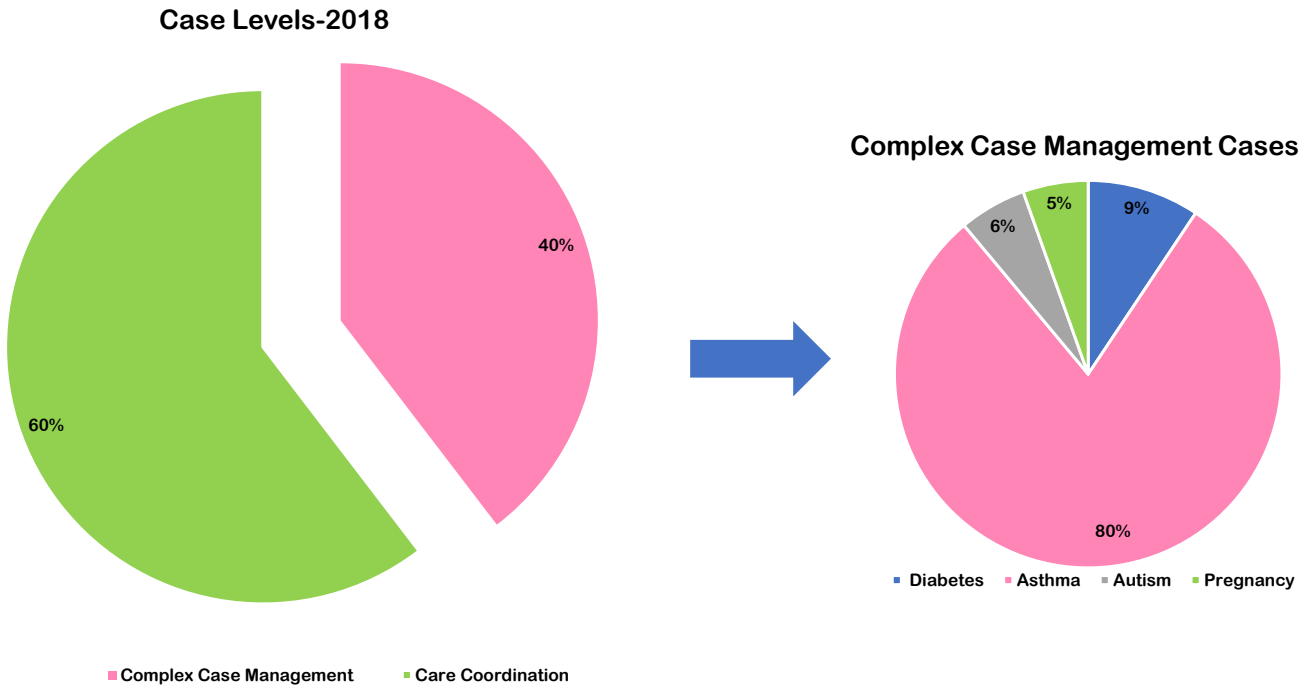


Care Coordination Referral Reasons-2018 n=1,419



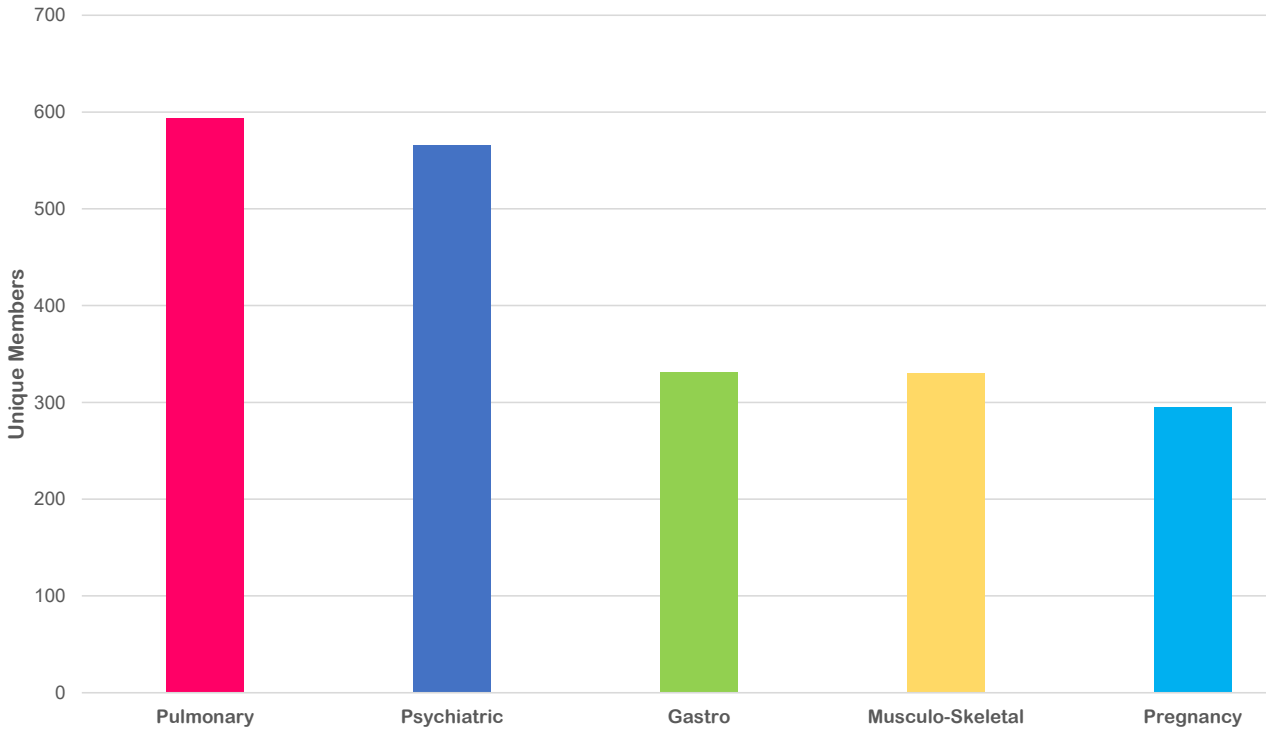
Case Management Case Levels - 2018

Case types are determined based on the member's screening, assessment, and care plan development. This establishes the level of complexity and interventions. In 2018, 60% of the program referrals required care coordination and 40% of were deemed complex case management. The chart below reflects the common conditions in complex case management (case opened for ≥ 60 days): Asthma (80%), Diabetes (9%), Autism (6%), and Pregnancy (5%).



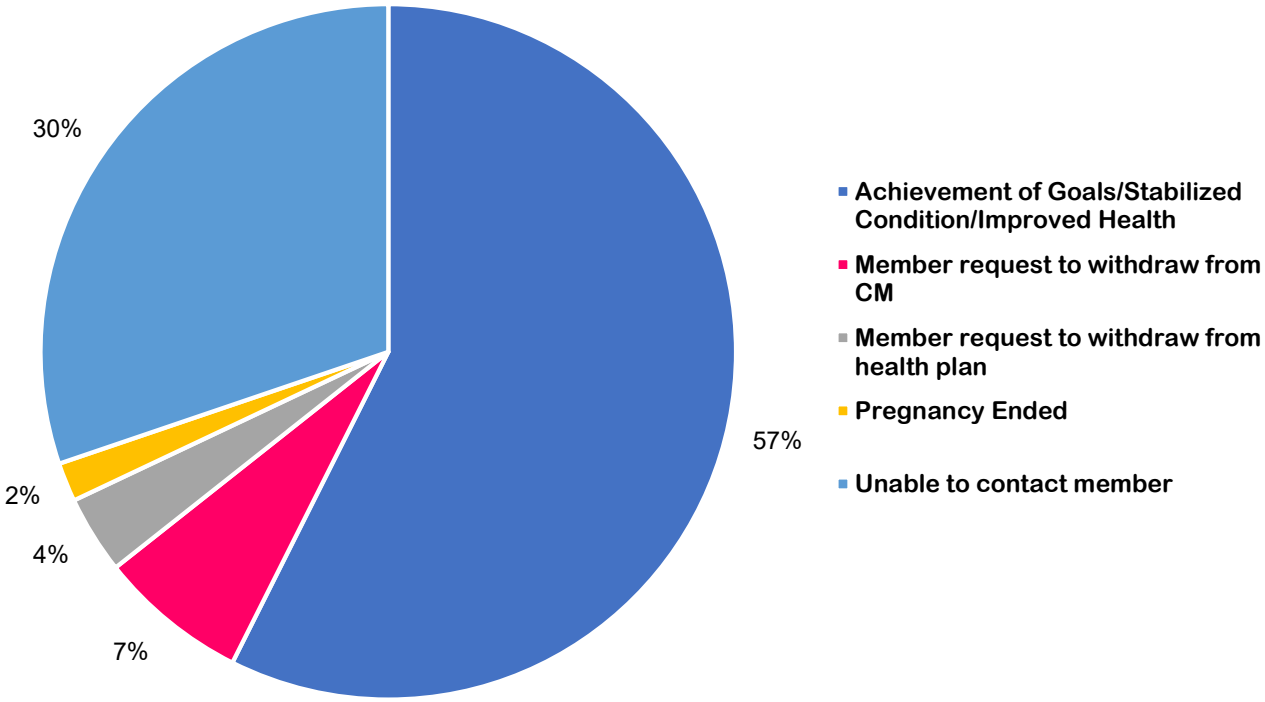
Case Management Top 5 Conditions - 2018

In addition to referral sources, the case management assessment helps to identify the chronic conditions for each screened member. For 2018, claims indicate that the top five chronic condition categories for members receiving case management services are: Pulmonary, Psychiatric, Gastrointestinal, Skeletal, and Pregnancy. Members could be categorized in more than one chronic condition category.



Case Management Case Closure Reasons - 2018

At the completion of case management services, the Care Navigator assigns a primary reason for the case closure. The PCN team strives to continuously improve the rate of cases closed due to goals met and decrease the rate of cases closed due to lack of member engagement. The primary reasons for case closure in 2018 were Achievement of Goals/Stabilized Condition/Improved Health (57%), Unable to Contact Member (30%), Member Request to Withdraw from Case Management (7%), Member Request to Withdraw from Health Plan (4%), and Pregnancy Ended (2%).

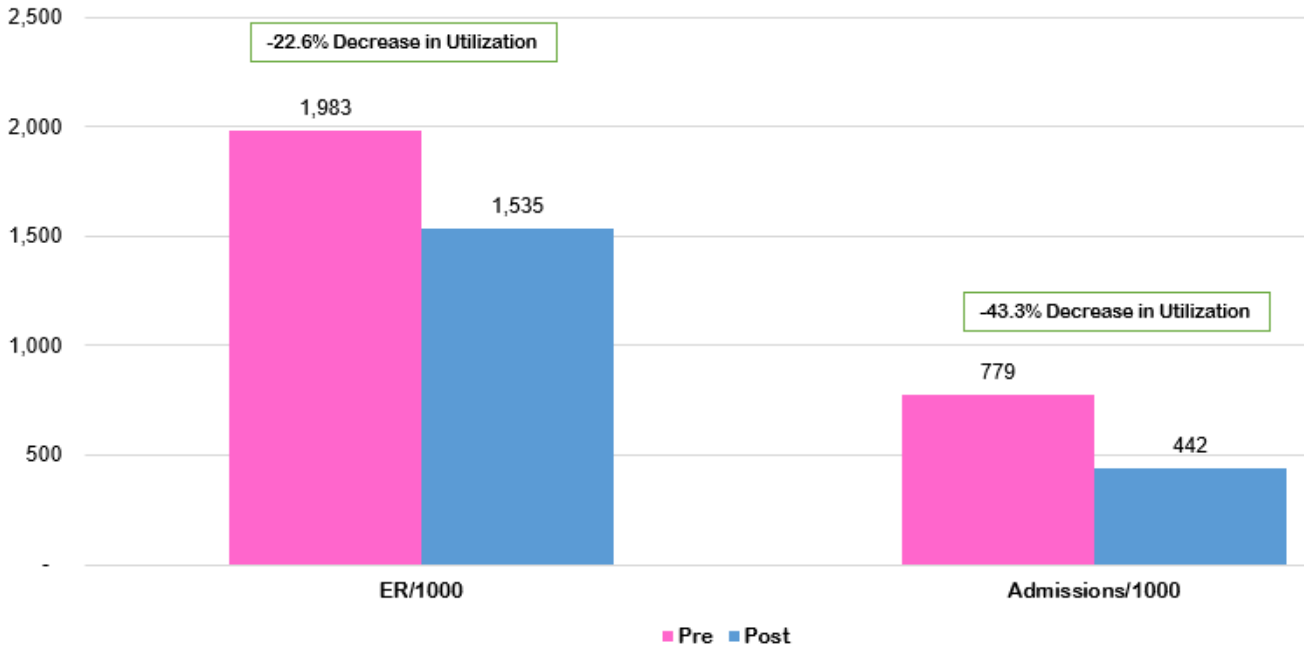


Program Utilization: Cost for Case Managed Population

The PCN evaluates the rate of hospitalizations and ER visits as well as per member per month costs for members enrolled in case management. The Quality Improvement Team evaluates members opened at least sixty (60) days in case management and includes all available pre-intervention and post-intervention data for each member, normalizing it to a per member per month rate. The intervention date is considered the date the member was opened in the case management program. Note: Due to the need for sufficient post intervention data for this analysis, the cases included in this report were those opened in 2017.

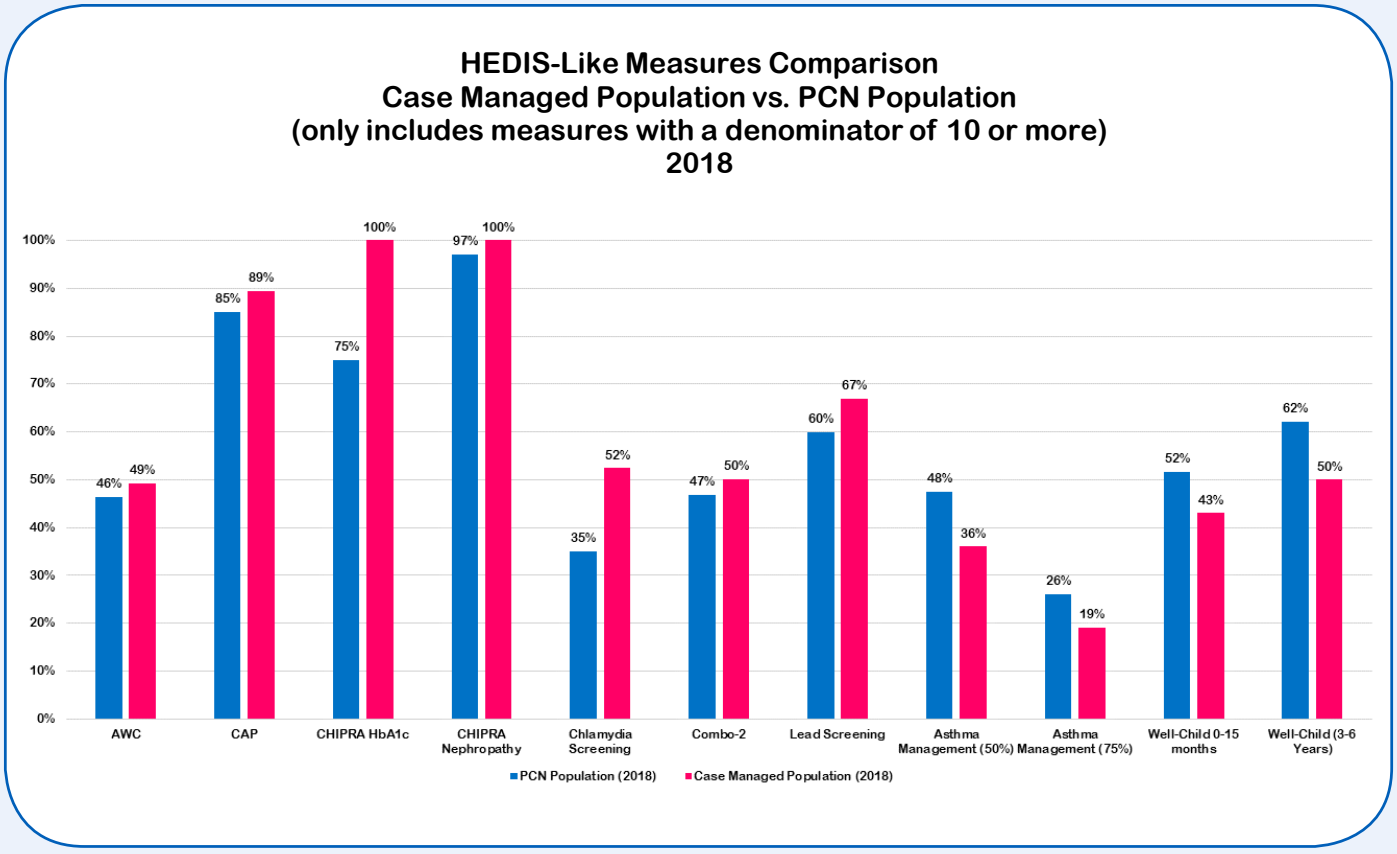
Complex Cases Opened in 2017	Pre Case Date	Post Case Date
Members	214	
% Change Pre vs. Post		
Admissions/1000	-61.6%	
ER Visits/1000	-54.1%	
Total Medical PMPM	-42.6%	

Children's Mercy Pediatric Care Network
Complex Case Management Cases-Opened in Calendar Year 2017
January 1, 2016 thru December 31, 2018



Program Quality Outcomes (HEDIS-Like Measures)

The PCN evaluates pediatric-focused HEDIS measures using claims/administrative data to compare its case managed population outcomes to the entire PCN population. For this year's analysis, fourteen (14) HEDIS measures were reviewed and are displayed in the chart below. These measures focus on Access to Care (CAP), CHIPRA Measures for Diabetes, Asthma Medication Management, Chlamydia Screenings, Lead Screenings, Age 2 Immunizations (Combo 2 - not including flu vaccine and Combo 10 - including flu vaccine), Body Mass Index (BMI), Well-Child Visits for Children Ages 0-15 Months (at least 6 total visits), Well-Child Visits for Children 3-6 Years of Age, and Adolescent Well-Care Visits (AWC).



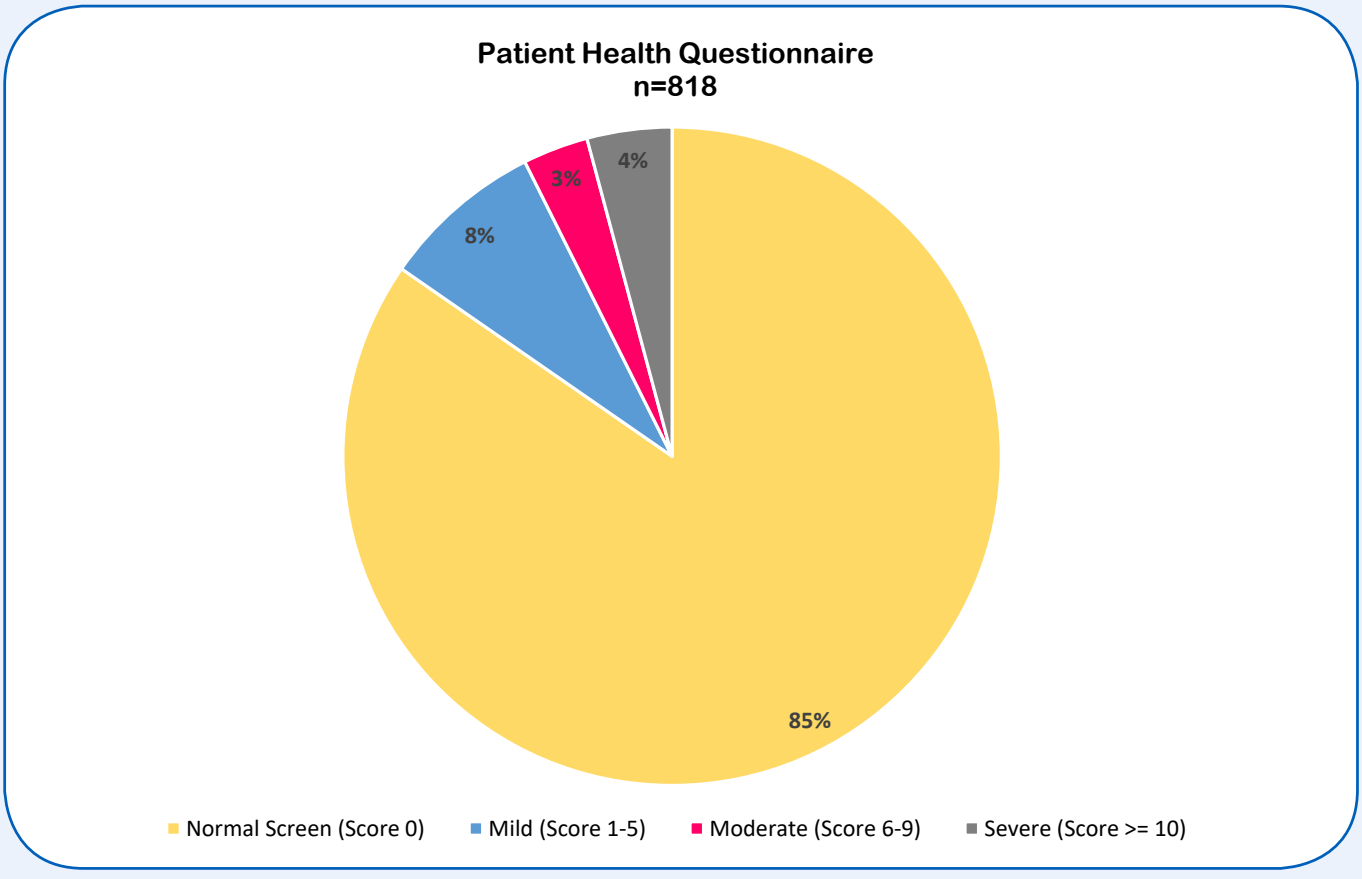
Patient Health Questionnaire 9 Screening

The Patient Health Questionnaire (PHQ-9) is a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression. PCN utilizes this tool for the screening of depression on every outreached member ≥ 12 years old. If the member responds "yes" to either of the first two questions (PHQ-2) on the questionnaire, the Care Navigator is prompted to proceed with the remaining seven questions on the PHQ-9 screening.

The Care Navigator's interventions are dependent upon the severity of the depression score. Questions 1 through 8 of the survey evaluate a patient's state of mind with regard to depressive symptoms. Question 9 demonstrates the presence and potential duration of suicidal ideation of the patient. Question 10 then provides a non-scored result which rates the severity index of the problems.

Interventions may include education with the member/caregiver on the available behavioral health benefit, referral for behavioral health services, and/or reporting the screening outcome to the member's PCP for ongoing monitoring. The Care Navigator develops goals and self-management plan activities to monitor the member's progress in this area. The Care Navigator can also re-assess the member using the PHQ-9. The member is evaluated at next contact if they shows signs of severe depression, in three months for moderate depression, and in six months for mild depression.

The PHQ-9 is a useful tool that the Care Navigators use to screen members quickly while they discuss their care plans via-phone calls. Additionally, C.A.R.E. Web auto-scores the PHQ-9 while advising the Care Navigator of appropriate next steps.



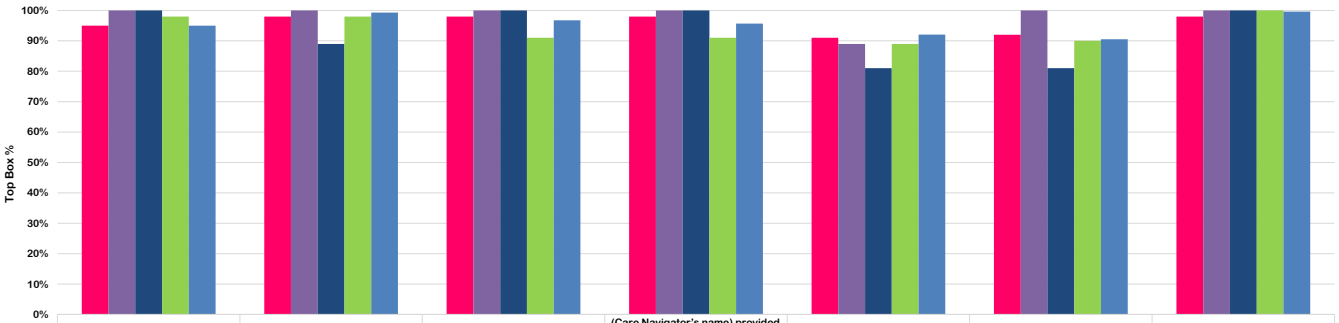
Member/Caregiver Experience with Case Management

The PCN conducts member satisfaction surveys with members and their caregivers who receive case management services from a Care Navigator. This telephonic survey includes seven (7) questions with an open-ended opportunity for member comments at the end of the survey. There was a dramatic increase (181%) in the number of completed surveys from the previous year due to process improvement initiatives implemented by the Care Teams in 2018 to increase the number of surveys offered in real-time. The 2018 survey results compared to 2014-2017 survey results are displayed below.

Survey Volume

2014	2015	2016	2017	2018
34	41	22	62	276

Care Coordination Patient Experience Survey Results 2014-2018

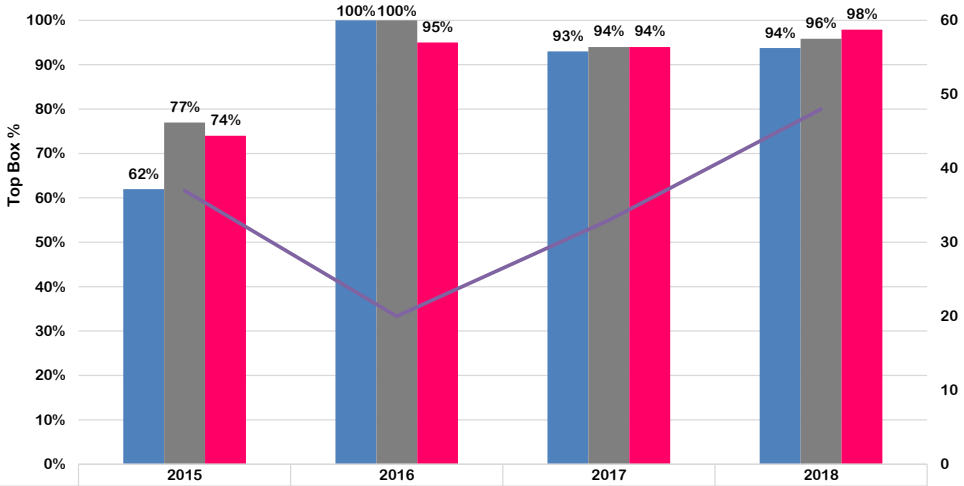


	(Care Navigator's name) was courteous and respectful.	(Care Navigator's name) understood my needs.	(Care Navigator's name) respected my cultural background and/or lifestyle.	(Care Navigator's name) provided education to me about services or resources available to me in the community.	(Care Navigator's name) provided useful health education to me.	After speaking with (Care Navigator's name), I'm better able to take care of myself or my child.	Overall, I am satisfied with the services (Care Navigator's name) provided.
2014	95%	98%	98%	98%	91%	92%	98%
2015	100%	100%	100%	100%	89%	100%	100%
2016	100%	89%	100%	100%	81%	81%	100%
2017	98%	98%	91%	91%	89%	90%	100%
2018	95%	99%	97%	96%	92%	91%	100%

Member/Caregiver Experience with Disease Management

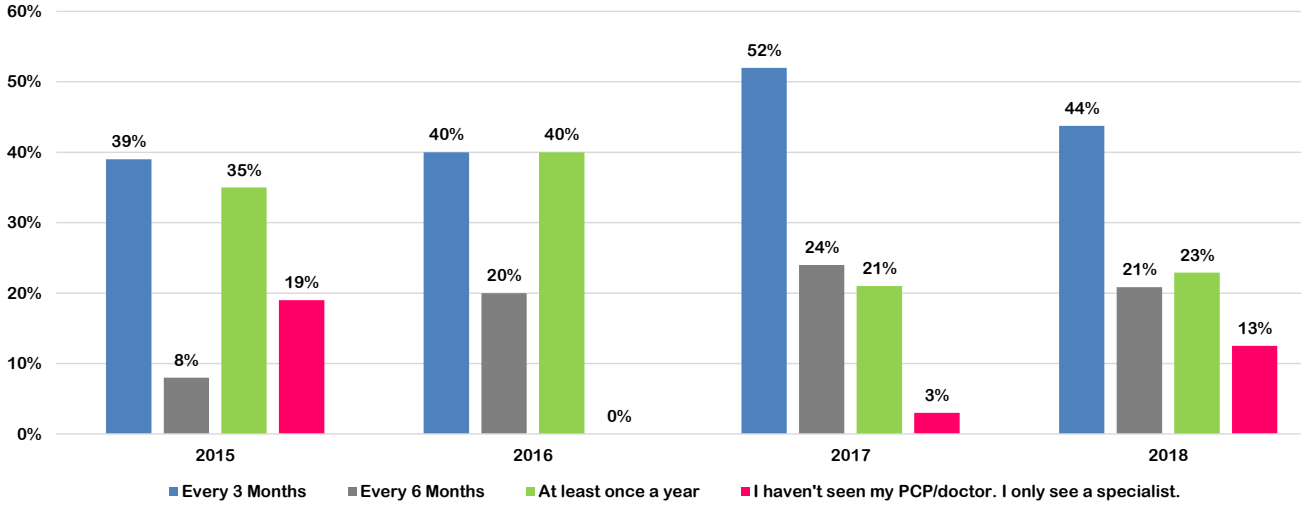
The disease management survey measures the member's satisfaction with PCN staff, primary care providers/specialists, and health literature provided through the program. The survey was conducted for the third time in 2018; the 2015-2018 survey results were compared and are displayed below.

Disease Management Survey Results 2015-2018



	2015	2016	2017	2018
The education received about asthma/diabetes management were useful to me and /or my family. (This may include website, mailings, newsletters, member handbook.	62%	100%	93%	94%
(Care Navigator's name) respected my cultural background and/or lifestyle.	77%	100%	94%	96%
As a result of the asthma/diabetes information from my primary care provider or specialist, I am better able to take care of myself/my child.	74%	95%	94%	98%
Survey Volume	37	20	33	48

How Often do you see your primary care provider for your asthma/diabetes?



Member Complaints and Grievances

PCN is not delegated to perform complaint, grievance or appeal processes but is notified by the Health Plans if a member issues a complaint or grievance related to PCN programs. In 2018, four grievances were received related to PCN's case management or disease management programs. All four grievances were reviewed by Care Integration leadership and resolved.

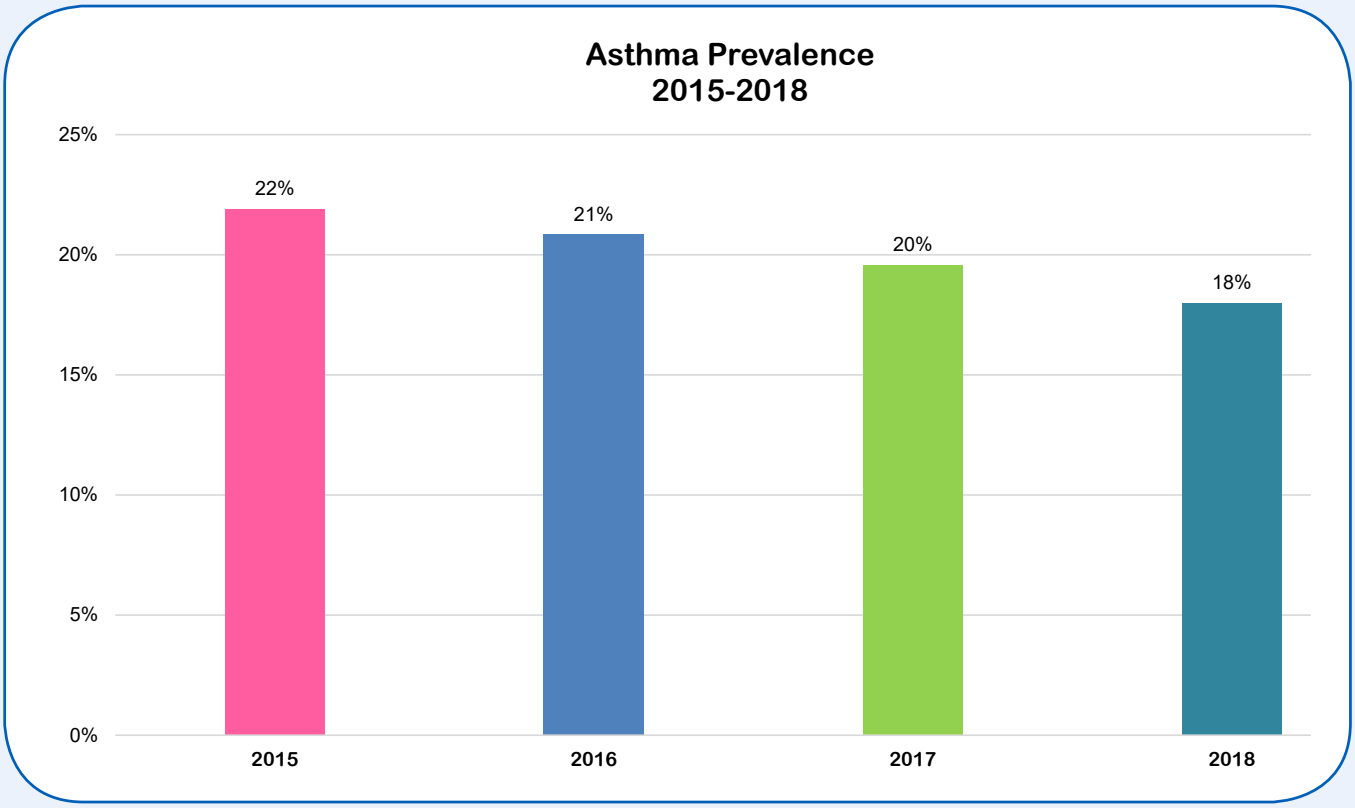
Disease Management Outcomes for Asthma & Diabetes

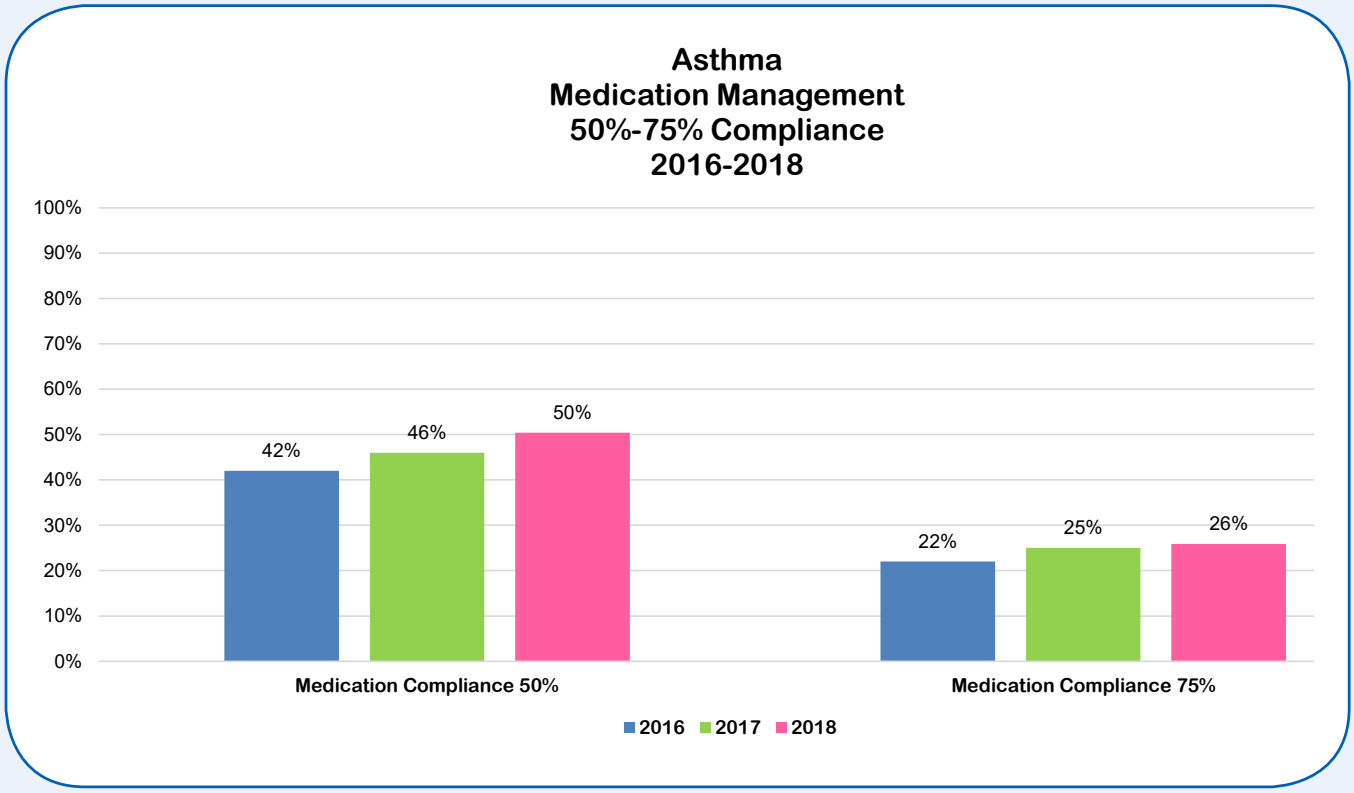
PCN's disease management programs use a unique approach to manage chronic asthma and diabetes through collaborative efforts between the primary care providers and the Care Teams. The Care Teams are comprised of Practice Facilitation Specialists who work with primary care provider offices to implement comprehensive disease management concepts into their practices. Care Navigators on the Care Teams work with the moderate and high-risk members identified on the disease management registries. Success of the program requires ongoing collaboration between the Care Team, PCP, member, and caregivers.

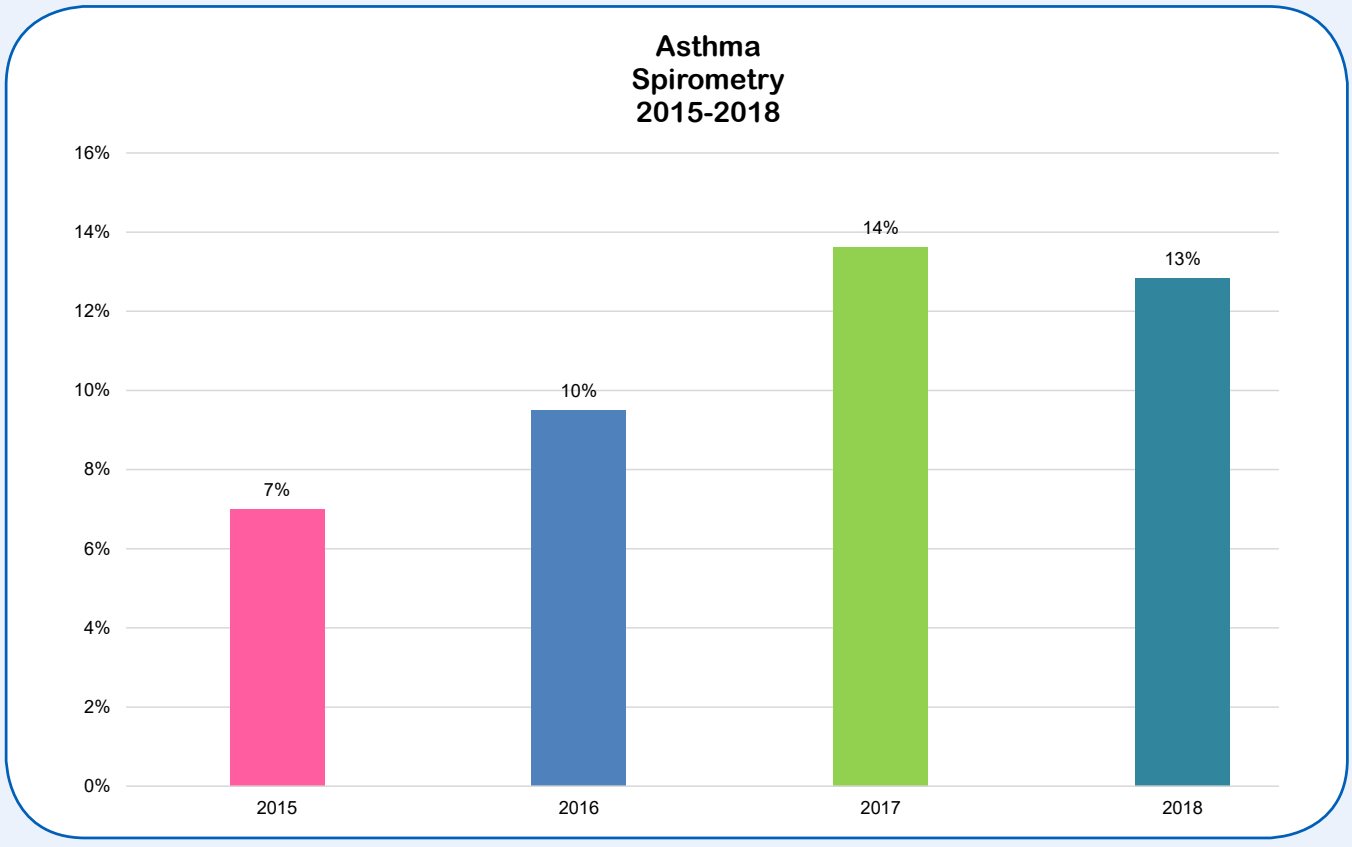
The program consists of physician office education, Patient-Centered Medical Home support, quality improvement techniques, data analytics and reporting, and focused case management interventions, with the goal of improving the health of the population and reducing cost.

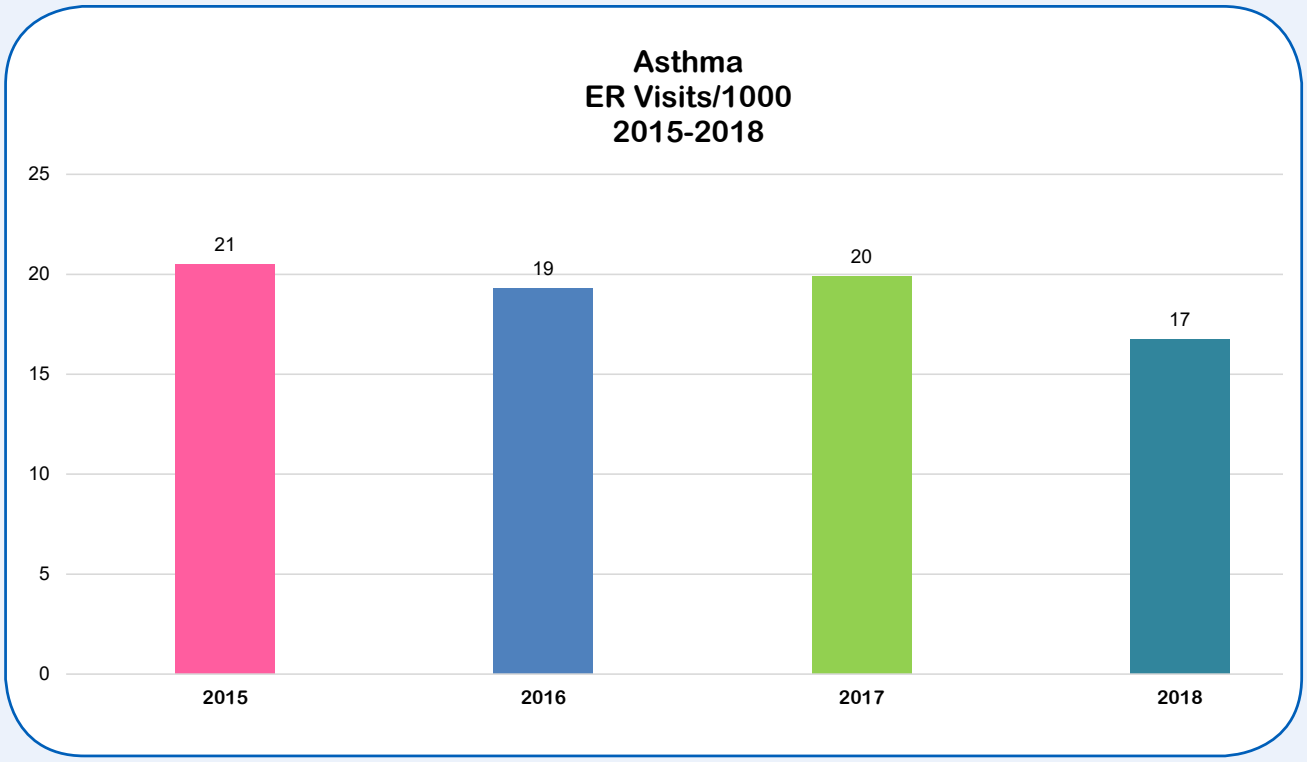
Care Navigators received education on asthma and diabetes management and tools were built into the C.A.R.E. Web documentation system to allow for effective management of this population. The Care Navigator audit tool includes disease management components, holding staff accountable to disease management program requirements.

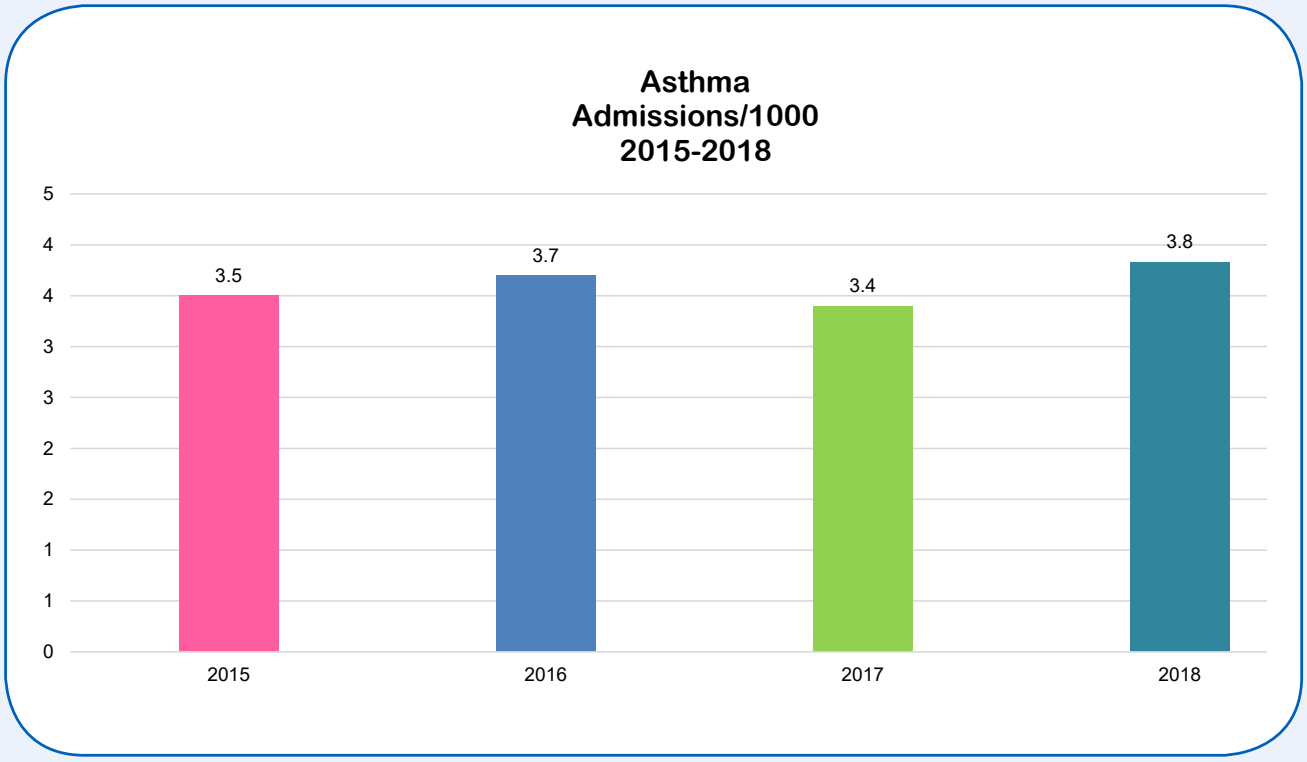
Asthma



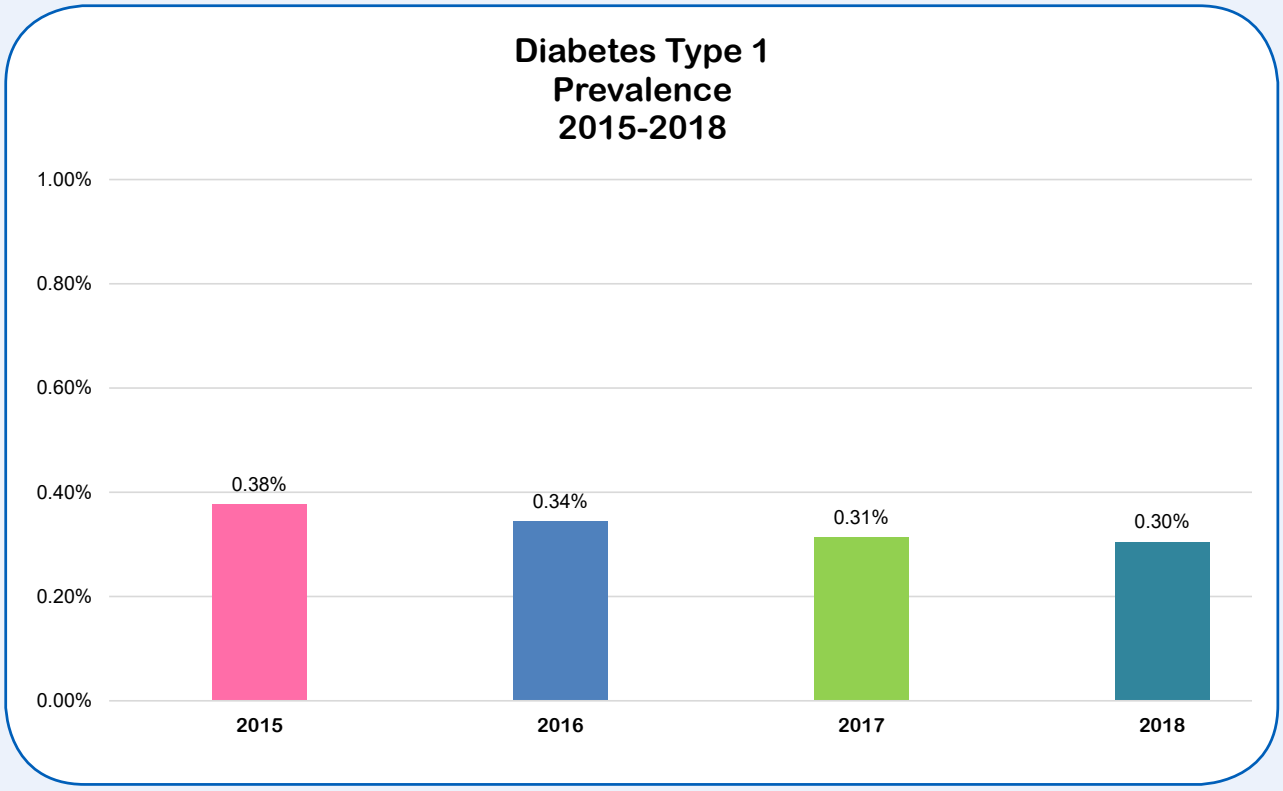

Asthma
Medication Management
50%-75% Compliance
2016-2018
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
42%
46%
50%
22%
25%
26%
Medication Compliance 50%
Medication Compliance 75%
2016
2017
2018

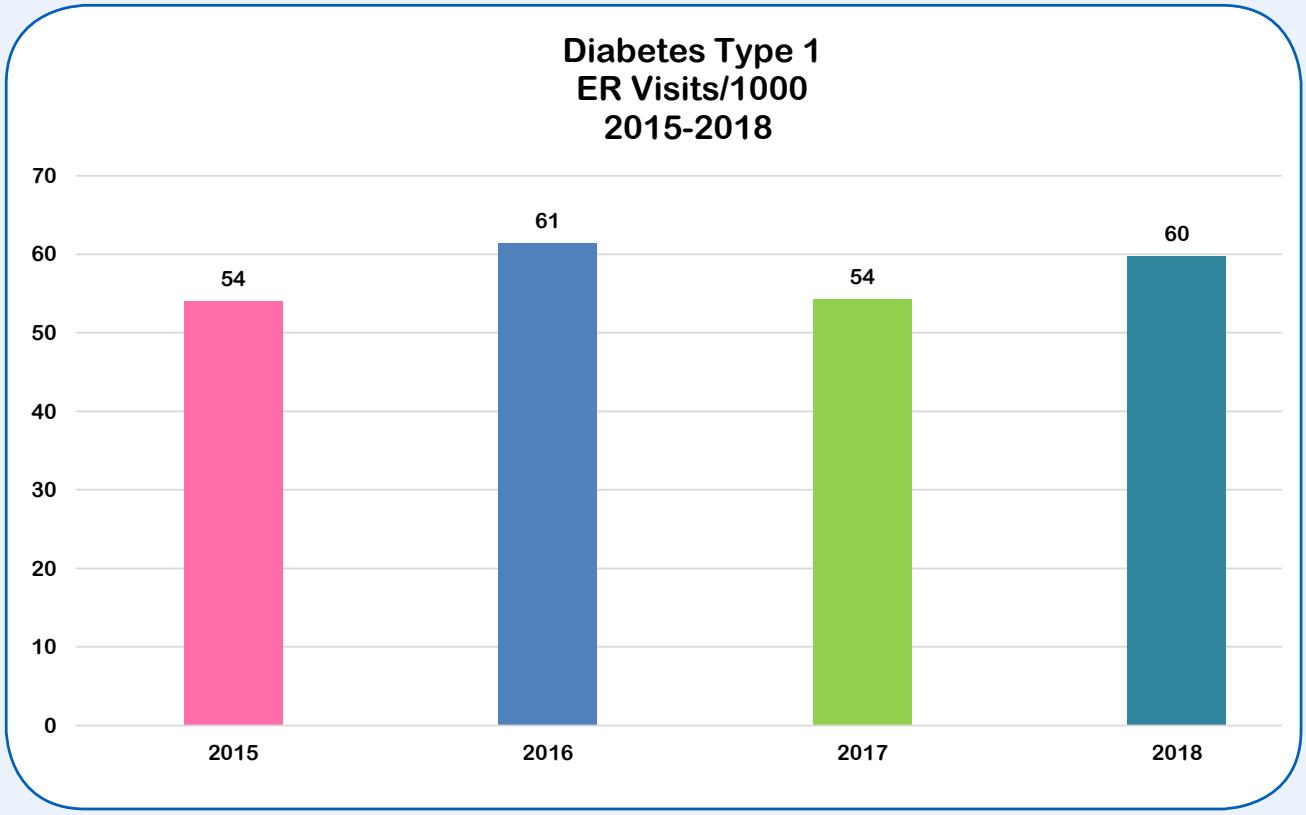

Asthma
Spirometry
2015-2018
16%
14%
12%
10%
8%
6%
4%
2%
0%
7%
10%
14%
13%
2015
2016
2017
2018

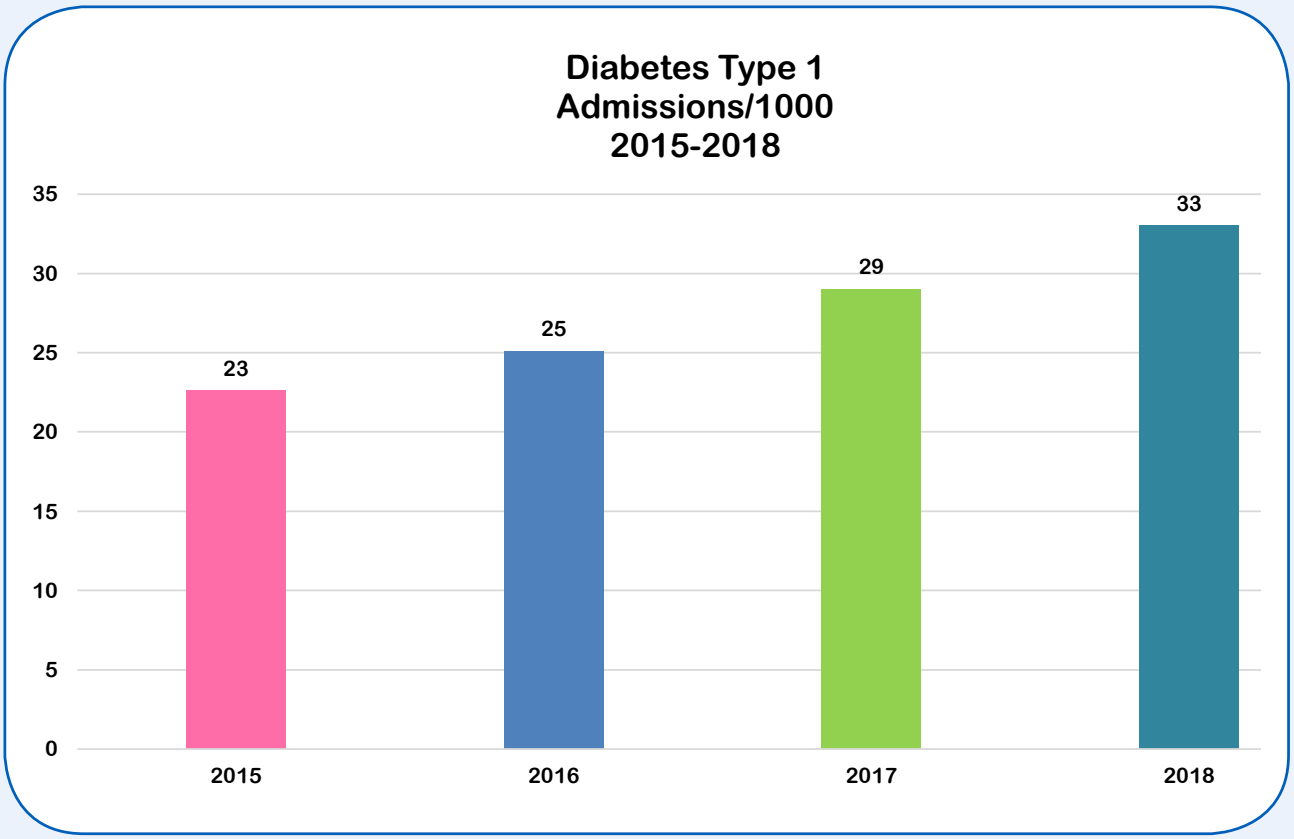

Asthma
ER Visits/1000
2015-2018
25
20
15
10
5
0
21
19
20
17
2015
2016
2017
2018

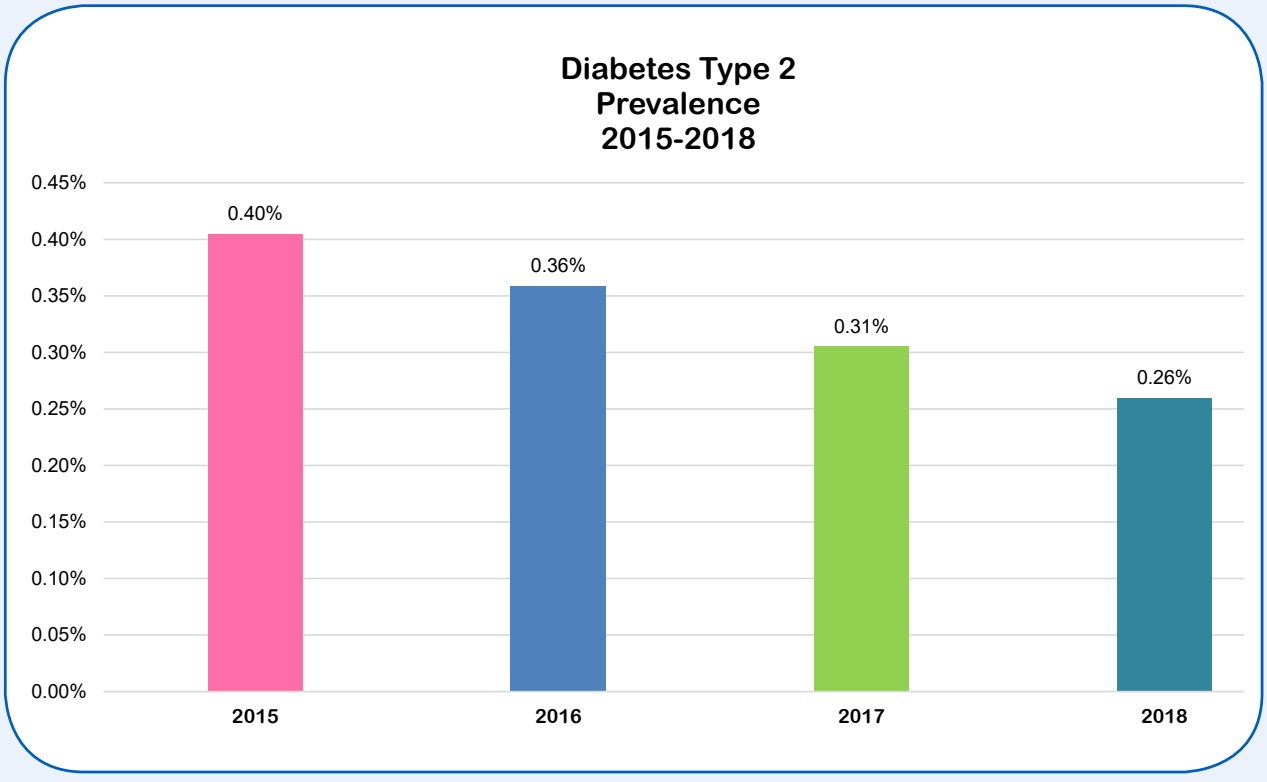

Asthma
Admissions/1000
2015-2018
5
4
4
3
3
2
2
1
1
0
3.5
3.7
3.4
3.8
2015
2016
2017
2018

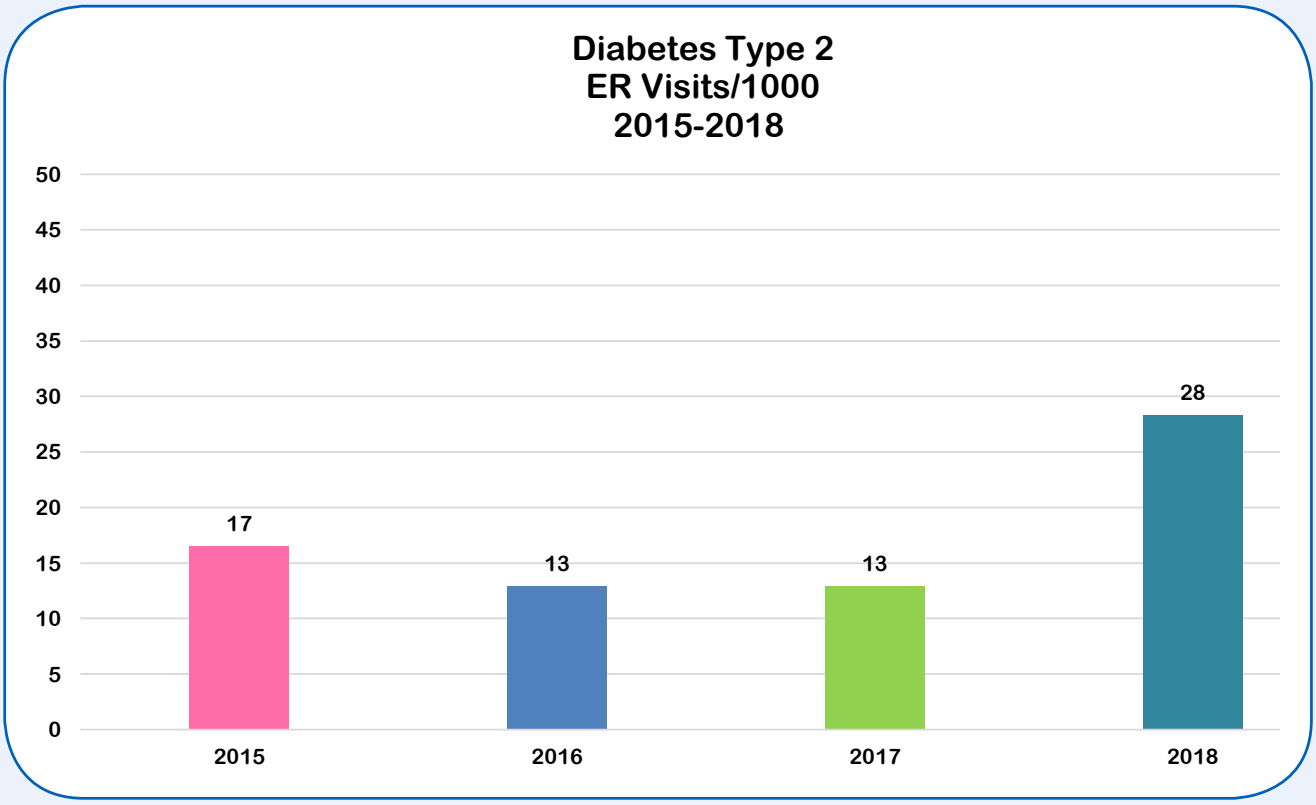
Diabetes

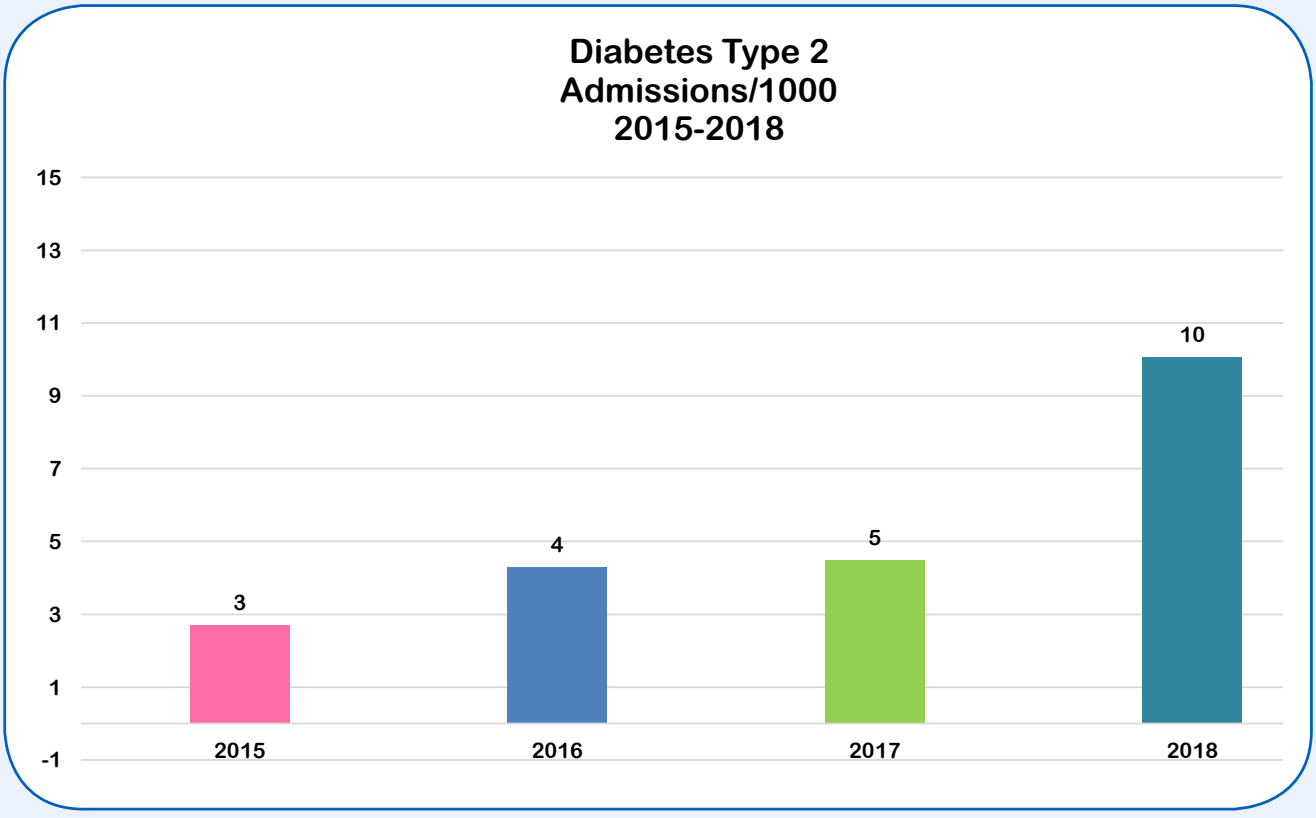

Diabetes Type 1
Prevalence
2015-2018
1.00%
0.80%
0.60%
0.40%
0.20%
0.00%
0.38%
0.34%
0.31%
0.30%
2015
2016
2017
2018

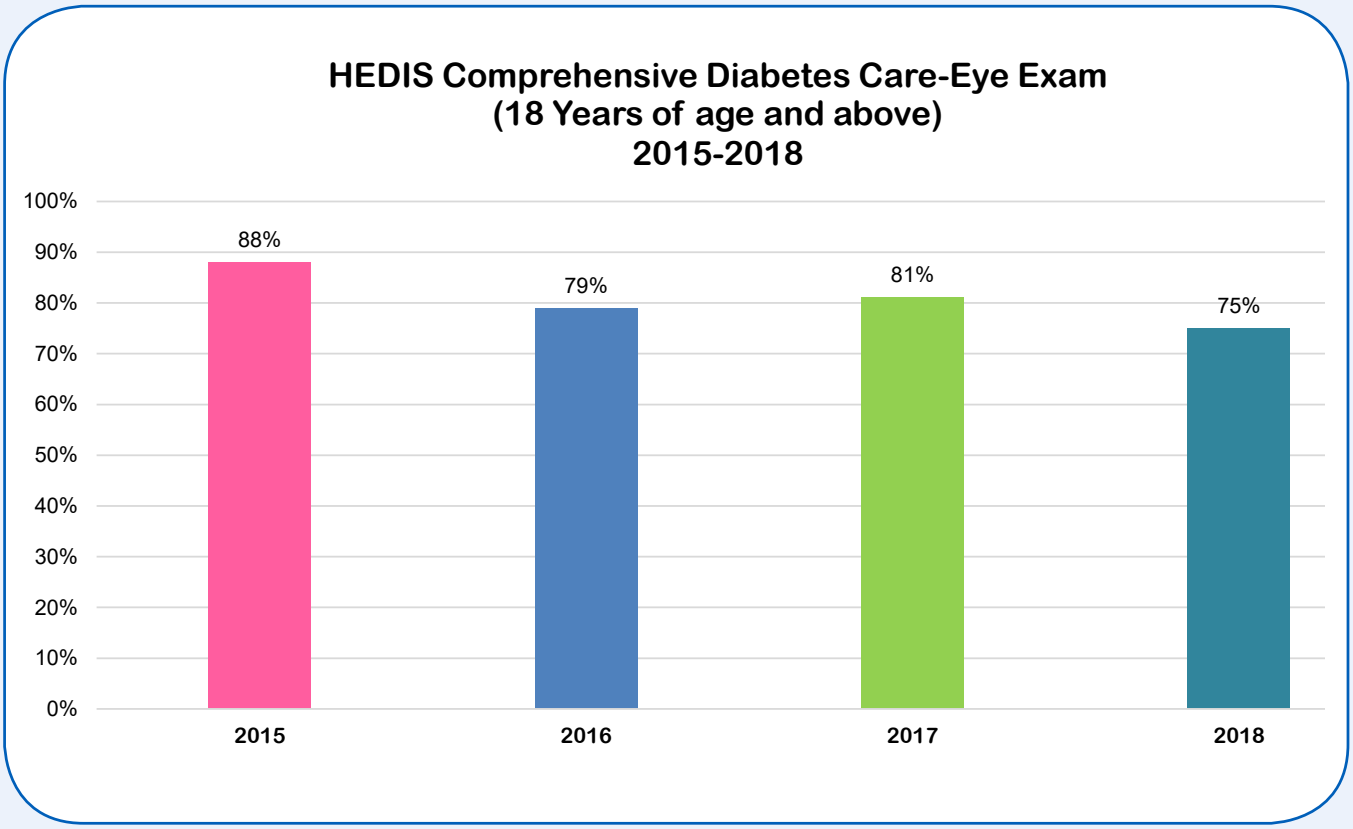

Diabetes Type 1
ER Visits/1000
2015-2018
70
60
50
40
30
20
10
0
54
61
54
60
2015
2016
2017
2018

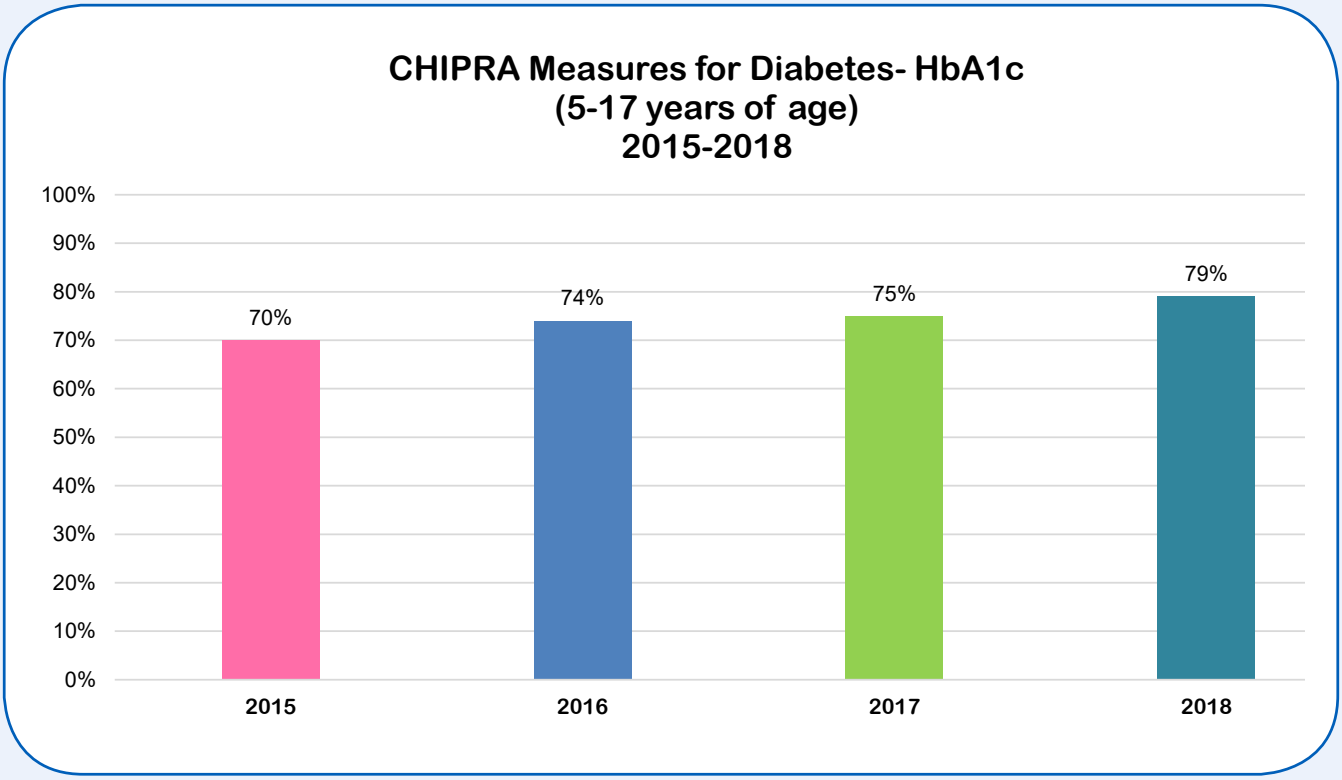

Diabetes Type 1
Admissions/1000
2015-2018
35
30
25
20
15
10
5
0
23
25
29
33
2015
2016
2017
2018

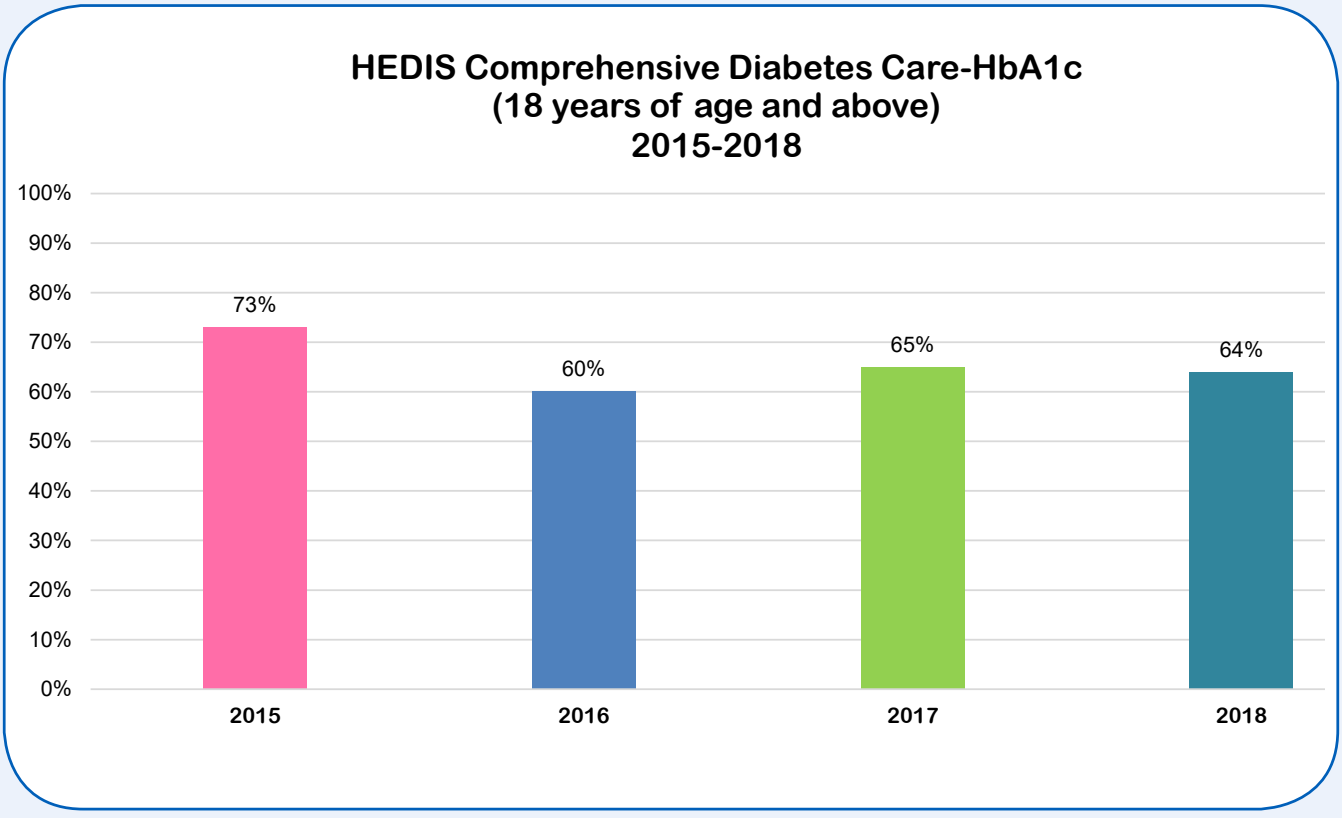

Diabetes Type 2
Prevalence
2015-2018
0.45%
0.40%
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
0.40%
0.36%
0.31%
0.26%
2015
2016
2017
2018

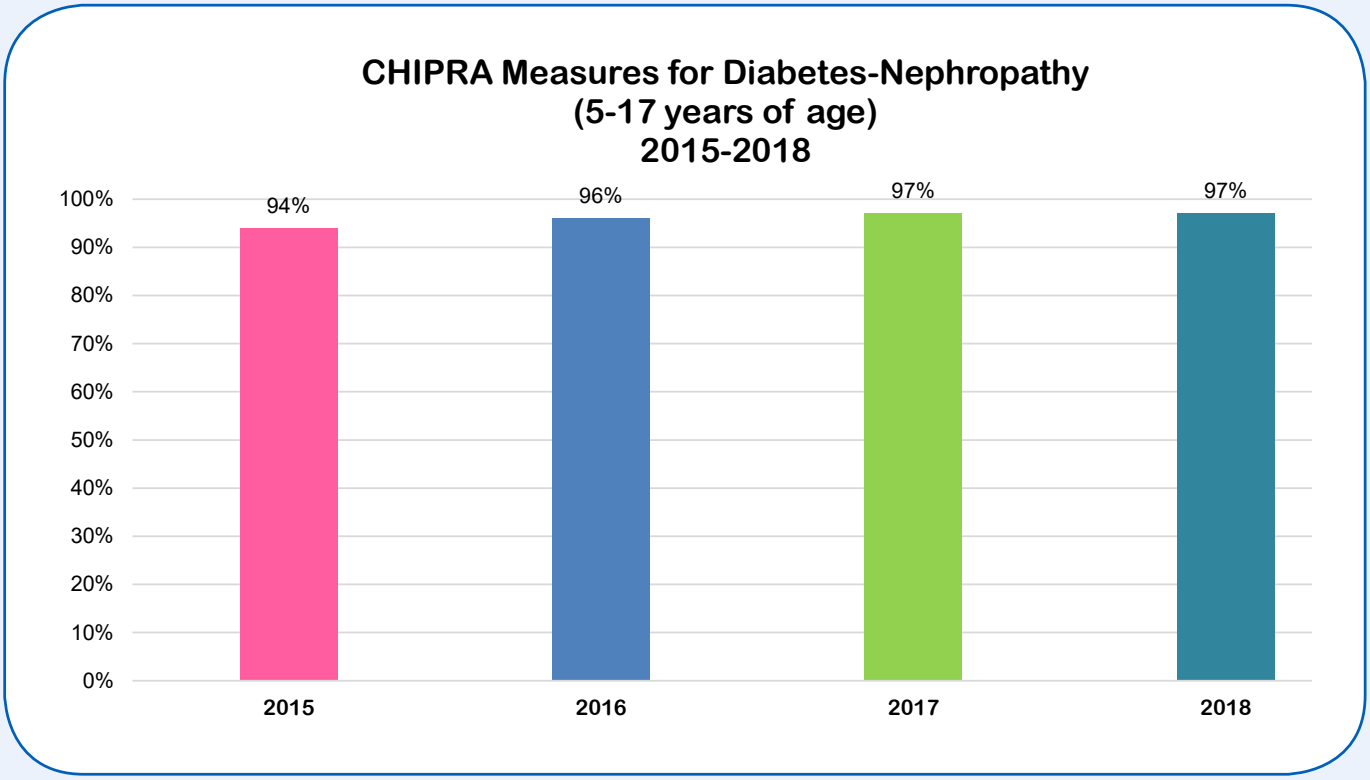

Diabetes Type 2
ER Visits/1000
2015-2018
50
45
40
35
30
25
20
15
10
5
0
17
13
13
28
2015
2016
2017
2018

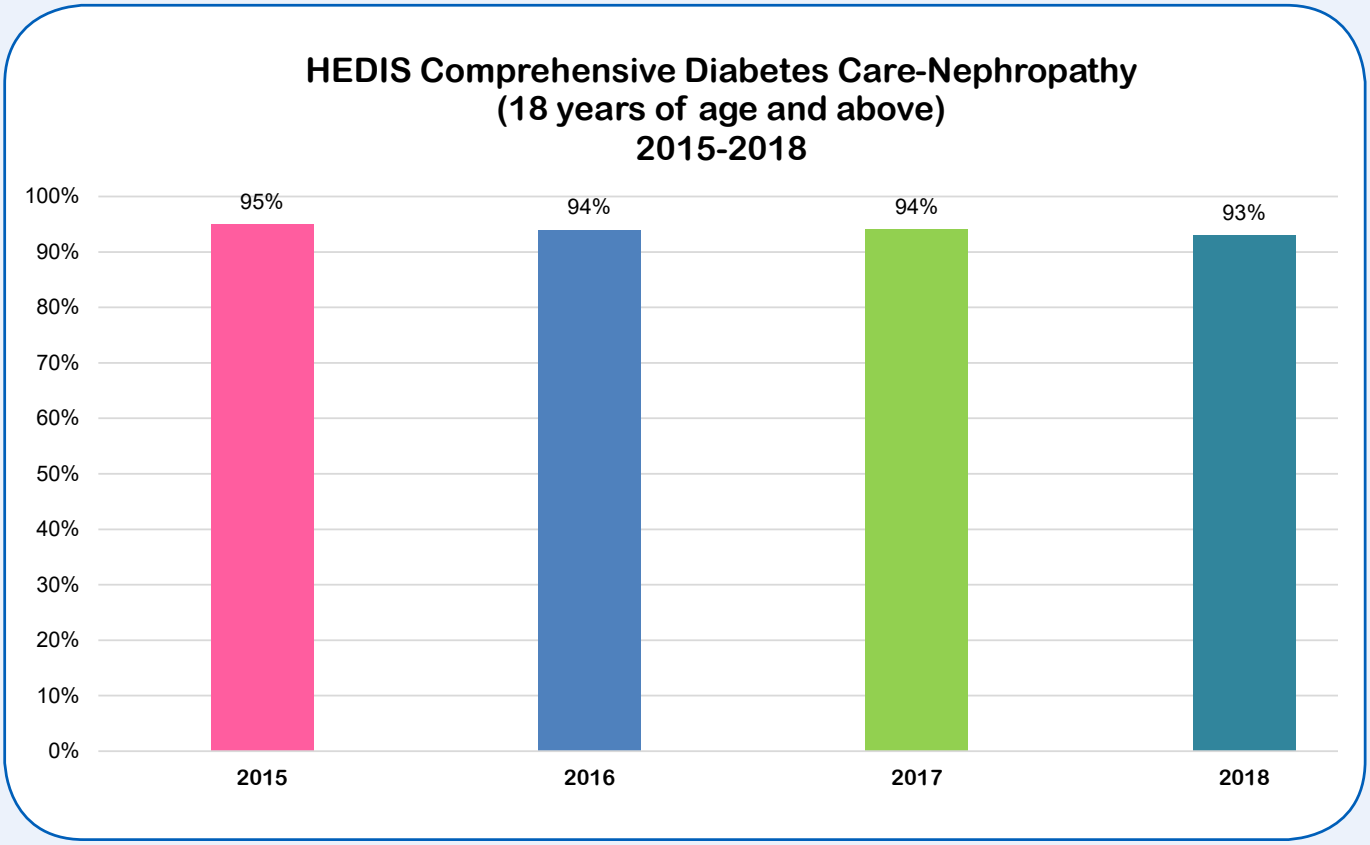

Diabetes Type 2
Admissions/1000
2015-2018
15
13
11
9
7
5
3
1
-1
3
4
5
10
2015
2016
2017
2018


HEDIS Comprehensive Diabetes Care-Eye Exam
(18 Years of age and above)
2015-2018
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
88%
79%
81%
75%
2015
2016
2017
2018


CHIPRA Measures for Diabetes- HbA1c
(5-17 years of age)
2015-2018
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
70%
74%
75%
79%
2015
2016
2017
2018


HEDIS Comprehensive Diabetes Care-HbA1c
(18 years of age and above)
2015-2018
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
73%
60%
65%
64%
2015
2016
2017
2018


CHIPRA Measures for Diabetes-Nephropathy
(5-17 years of age)
2015-2018
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
94%
96%
97%
97%
2015
2016
2017
2018


HEDIS Comprehensive Diabetes Care-Nephropathy
(18 years of age and above)
2015-2018
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
95%
94%
94%
93%
2015
2016
2017
2018

Analysis

Referral, Outreach, and Case Activity

In 2017, PCN Care Teams transitioned to population health management strategies for identified at-risk and emerging risk members for outreach and screening. This proactive approach was continued and fine-tuned in 2018. It has led to a 9.2% increase in referrals, from 3,269 in 2017 to 3,572 in 2018. The top referral conditions have remained consistent from 2017 to 2018 with high-risk pregnancy, foster care, and high-risk asthma being the most prevalent. PCN also utilized all members of the Care Team to reach out to members, thus increasing the capacity for member screenings. Referrals to Care Teams are generated through the utilization management process, member and provider referrals, and mining of encounter and EMR data. Care Teams conduct daily huddles to discuss assigned member populations, including those currently inpatient and those with emerging risk, to develop a strategic plan for member outreach and case management.

In 2018, the Care Integration program screened 1,482 members for complex case management. Of those 1,482 members, 587 were subsequently enrolled in complex case management. The C.A.R.E. Web screening and assessment tool meets the NCQA complex case management assessment requirements for all members. Complex cases are defined as members with a case opened for ≥60 days with a completed condition-specific assessment. This evolution led to an increase in complex case management cases from 12% in 2017 to 40% in 2018. Members with minimal needs are opened as care coordination cases and receive brief solution focused interventions. Sixty percent of referrals

are managed in this manner. PCN processes remain true to case management philosophies of assessing, planning, implementing, and evaluating member cases with an emphasis on sharing care plan goals and the empowerment of members and providers to be engaged in the process.

PCN strives to develop patient-centered care plans that are specific, measurable, and attainable while eliminating barriers to care. In 2018, Achievement of Goals/Stabilized Condition/Improved Health was the primary case closure reason for 57% of the cases closed. This case closure reason was attributed to 6% of cases closed in 2017.

PCN routinely elicits feedback from staff members to improve programs and processes. In 2017, Care Teams disclosed dissatisfaction with the current Care Team structure, noting the inability to effectively manage processing prior authorization requests, conducting member screening and outreach, and deploying meaningful care management interventions. In response, staff assisted in designing an Intake/Outreach Team, which was implemented in 2018. The Intake/Outreach Team is responsible for receiving and processing routine prior authorization requests, conducting screening and referral to Care Teams, and providing brief issue resolution for members and providers. During 2018, the Intake/Outreach Team completed 6,196 prior authorization requests.

Cost and Utilization Pre and Post-Case Management

Due to the transient nature of cases in case management, the population available for pre and post-intervention analysis is not the same year over year. PCN reviews trends each year in the population available for study and expects improvements in inpatient and ER utilization and overall medical spend based on case management interventions. For the population analyzed this year, there was a 44% reduction in inpatient admissions per 1,000, a 23% reduction in ER visits per 1,000, and a 52% reduction in overall per member per month costs post-intervention. When case management interventions began, overall inpatient and ER costs decreased while outpatient and physician-related costs increased. This can be attributed to members becoming more compliant with preventive services and better connected to a medical home for management of their care.

HEDIS-Like Performance for Case Management

In the fourteen (14) measures analyzed, the case managed population rates outperformed the PCN overall population rates in nine (9) of the measures. New measures that were included in 2018 were Age 2 Immunizations - Combo 10, Age 13 Immunizations - Combo 2, and Body Mass Index. The case managed population performed better than the PCN overall population in the following nine measures: all Well-Child Visit measures, Age 2 Immunizations – Combo 10 with flu, Chlamydia Screening, Asthma Management (75%), and Access to Care. The case managed population had the same rate or within less than 3% of the non-case managed population in the following measures: Asthma Management (50%), Lead Screening, Age 13 Immunizations - Combo 2, and Age 2 Immunizations - Combo 10. The only measure that was not higher in the case managed population was Body Mass Index. This measure was only 4.7% below the PCN overall population. Body Mass Index is a new measure that PCN has placed strategic focus on for calendar year 2019. The PCN overall population has seen increases in all HEDIS-like measures except for Asthma Management (75%) and Lead Screening. Lead Screening will have an increased focus in calendar year 2019 as well. Compared to the case managed population in calendar year 2017, the 2018 case managed population has seen increases in measure performance as high as 27% in Well-Child Visits for Children Ages 0-15 Months, 21% in Well-Child Visits for Children Ages 3 to 6 Years, and 11% in Asthma Management (50%). PCN attributes much of this improvement to increased communication with community providers and preventive health education provided to members and caregivers. Providers and PCN staff now have the ability to exchange secure messages through the C.A.R.E. Web online communication

tool ensuring timely collaboration around member's need and care planning interventions.

Member/Caregiver Experience with Case Management

The number of members surveyed in 2018 increased by a substantial 345% due to a strategic quality improvement project. The project included both the automation of disseminated survey links and weekly survey tracking. All members surveyed reported that they were overall satisfied with the services provided through the PCN case management program. Favorable member responses increased in 2018 from the prior year in the following topics: "Care Navigator understands my needs;" "Care Navigator respected my cultural background and/or lifestyle;" "Care Navigator provided education to me about services or resources available to me in the community;" "Care Navigator provided useful health education to me;" and "After speaking with Care Navigator I am better able to take care of myself or my child." The increased utilization of the PCN's community resource links and the addition of Community Resource Specialists on the Care Teams have had a positive impact on the case management program, as evidenced by the member survey results.

There was no change in the overall satisfaction with the services provided by the Care Navigator. There was a slight decrease in the rate of the Care Navigator being courteous and respectful, however the rate is still high at 95%.

As a result of this year's analysis, additional staff education will be provided related to service excellence during all member encounters.

Member/Caregiver Experience with Disease Management

The 2018 disease management survey results indicate significant improvement in chronic disease management, disease education, and engagement with medical providers. Member outreach and case management were provided by the entire Care Team, comprised of Nurse Care Navigators,

licensed Social Work Care Navigators, Community Resource Specialists, and Provider Relations Representatives, who all work closely with the member's PCP to support population health strategies. All 2018 survey results exceeded the 2017 results. The survey demonstrated an increase in member engagement with the Care Teams and providers. In addition, members reported a better understanding of their chronic disease through use of member educational literature, working with Care Team staff, and increased utilization of primary care providers and specialists.

During 2018, Care Teams focused on chronic disease management and ongoing outreach to medium and high-risk members with asthma and diabetes. Members who fell within these criteria and were 12 years of age or older had an annual depression screening completed using the Patient Health Questionnaire 'PHQ-9' (see p.77 for more details).

Asthma Outcomes

Prevalence and Utilization

The current prevalence rate of asthma in the PCN population based on claims data is approximately 18%. This rate is consistent with national averages for large urban populations. PCN continues to reinforce provider education for asthma management, supporting registry use and outreach from the PCP to the members. The Care Teams have also implemented an outreach program for high utilizers of the emergency room related to asthma and other chronic conditions.

Provider and Member Adherence

Medication Management for People with Asthma was a newly established HEDIS measure in 2016 and observes the percentage of members who remained on an asthma controller medication for at least 50% or 75% of their treatment period. In 2018, PCN saw an increase in both the 50% (+4%) and 75% (+1%) measures.

Spirometry is an important tool used in assessing conditions such as asthma. As demonstrated in the data, there was a minimal change in spirometry use for members with asthma from 2017 to 2018. There has been increased education and focus placed on asthma overall, and PCN has noted the challenges of performing spirometry in the PCP setting. PCN has increased the availability of educational resources and is developing a Learning Collaborative, in collaboration with Children's Mercy Kansas City specialists, to further support education of the PCN community providers. PCN hopes to see a more consistent upward trend in the use of spirometry by increasing clinical best practice focus and the availability of educational resources to providers within the network.

Inpatient and ER utilization related to asthma remained consistent from 2017 to 2018.

Diabetes Outcomes

Prevalence and Utilization

As with many pediatric-focused organizations, the population of PCN members with diabetes is much smaller than the population of members with asthma. In 2018, the prevalence of both type 1 and type 2 diabetes in the PCN population was less than 1%. From 2017 to 2018, inpatient utilization increased slightly for both type 1 & type 2 diabetes. ER utilization for members with type 1 & type 2 diabetes also slightly increased. Due to the small population, those fluctuations were not significant enough to warrant changes in the diabetes disease management program.

Provider and Member Adherence

All of the HEDIS comprehensive diabetes measures for members 18 years of age stayed consistent with some slight decreases from 2017 to 2018. Diabetes eye exam screenings decreased from 81% to 75%, HbA1c testing decreased from 65% to 64%, and nephropathy screening decreased from 94% to 93%. CHIPRA, which accounts for the bulk of PCN's diabetic population, saw an increase or no change in both measures. Compliance with recommended HbA1c monitoring will continue to be a focus of the PCN's provider and member education for diabetes management.

Ongoing Initiatives in 2018

PCN Care Teams and Quality Improvement Team continue to collaborate with Children's Mercy Kansas City's Endocrine department by providing enhanced analytical tools to providers to aid in management of members with chronic conditions. This project focuses on the sharing and collaboration of measure improvement, including data sharing for a research project aimed at improving quality of life for patients.

Future Initiatives

Based on the analysis of the program metrics, the following interventions will be included in PCN's 2019 initiatives:

- Provide Service Excellence training to all staff to ensure that Care Integration staff are consistently respectful and courteous during all member and provider encounters;
- Enhance levels of case management to encompass new expectations of state contracts;
- Enhance C.A.R.E. Web to allow members to access and view care plans and communicate with Care Team members;
- Provide ongoing staff education on specific chronic disease conditions related to the pediatric population;
- Enhance program requirements to include more face to face encounters with members to establish meaningful relationships with families.

6 2018 Success Stories

- Care Team Successes with PCN Members
- Care Team Successes with PCN Providers
- Community Health Worker Successes with PCN Members

Care Team Successes with PCN Members

PCN Care Teams work collaboratively with other disciplines within the Children's Mercy Care Continuum department and with care managers from our health plan partners to ensure a seamless healthcare journey for PCN members. The following success stories are examples of these collaborative efforts.

Success Story #1

Synopsis: *A 22-month-old member with a complex medical history of stage 4 kidney disease (resulting from reflux neuropathy), obstructive uropathy, recurrent urinary tract infections (UTIs), congenital heart disease, and failure to thrive was referred to a PCN Care Navigator by a Children's Mercy inpatient social worker after being admitted for significant weight loss. In a one-year period, the member had 8 hospitalizations resulting in 88 days in the hospital for this member. Many of the admissions were related to poor weight gain and recurrent UTI. Complicating the situation further, this member was seen by multiple specialists, along with a PCP outside the hospital system. Additionally, he had multiple social workers following him, private duty nursing in the home, and an additional primary insurance company. The member's mother was involved in his care but frequently changed his feeding regimen and implemented alternative therapies, which unfortunately increased his weight loss even further. The PCN Care Navigator attended a care conference for this member and was able to collaborate with the specialists, social workers, and nutritionists on this member's case.*

Outcome: Positive outcomes resulted from the care conference. The member's nephrologist is now working closely with the PCP to ensure the member receives regular weight checks and immunizations. Moreover, when he becomes ill and has a positive urine culture, the member is sent to the nephrologist for further evaluation. The member's mother has been given direction that no changes in diet can occur without first discussing them with the outpatient dietician who is also closely following. In addition, the outpatient dietician will communicate any changes in diet to the PCP and private duty nursing agency. Although the member's renal function is worsening, processes have been put in place to carefully monitor his weight and overall health so that he can be placed on the kidney transplant list.

Success Story #2

Synopsis: *A 16-year old member scored high on a post-partum depression screening. The involved PCN Care Navigator identified that the member needed assistance securing mental health resources for treatment of postpartum depression. In addition, she needed assistance getting set up with WIC: the Special Supplemental Nutrition program for women, infants and children. The member's mother disclosed to the Care Navigator that an immediate family member had committed suicide recently. The family had received counseling services, but at the time of intervention the services had been discontinued. Due to the level of behavioral health needs identified, the member was referred to the health plan behavioral health care manager. The member's mother was encouraged to get a postpartum visit scheduled with the obstetrician so the member could get started on medication if needed. In addition, home nursing and social work visits were arranged for this member to address her Coumadin level and ensure that any needed community resources were arranged.*

Outcome: As a result of the collaboration between the PCN Care Navigator, the health plan behavior health care manager, and the home care agency, the member's mother reported she had started on a new medication, received the needed services, and was doing much better.

Success Story #3

Synopsis: *A 2-year old Sudanese member with an elevated lead level who was in need of care coordination services was referred to a PCN Care Team. The Care Navigator and Community Resource Specialist (CRS) planned two home visits to provide education to this large family who had resided in their current residence for two years. Education provided to the family included the importance of using soap and water when cleaning, hand hygiene, diet, and following up for a lead re-test with the member's PCP. Following the visits, the CRS obtained and delivered a cleaning supply kit to the family on behalf of the Kansas City, MO Health Department. In addition, the CRS provided the family with Harvesters food pantry locations to address identified food insecurity.*

Outcome: The family now has adequate cleaning supplies, knowledge of potential lead hazards, and food security. Within one month of the Care Team's interventions, the member's lab work showed a decrease in venous blood lead level.

Success Story #4

Synopsis: *A 7-year-old chronically underweight member, whose nutrition plan of care had not been updated in three years, was identified by a Care Navigator through receipt of a prior authorization request to approve additional nutritional supplementation. In reviewing his medical records, the Care Navigator also identified that he had not been seen by his PCP for a well-child visit in over a year. After further inquiry, the Care Navigator learned that the member had a well-child visit scheduled within the next week. The Care Navigator felt this was the perfect opportunity to notify the member's PCP that he was in need of a nutritional evaluation and an updated nutrition plan of care. She passed this information on to the care coordinator at the PCP's office.*

Outcome: Through collaboration between the PCN Care Navigator and PCP care coordinator, the member received a nutritional evaluation at his well-child visit the following week. The member's nutrition plan of care was updated to include close monitoring of his nutritional supplement intake, as well as adding a meal/snack plan to assist in weight gain.

Care Team Successes with PCN Practices

PCN Care Teams work collaboratively with contracted PCN practices to coordinate care for members resulting in improved quality, cost, and utilization outcomes. The following are examples of these collaborative efforts.

Success Story #1

Synopsis: *A PCN contracted practice expressed to their PCP-aligned Care Team an interest in addressing the social determinants of health in the primary care setting. Understanding the importance of health equity and utilization of community-based resources can help address the avoidable inequalities that significantly impact health. The practice chose to use extra space in their office to house resources, allowing them to fulfill some of the immediate needs of their patients. Two of the areas that this practice chose to focus on were the correlation between hygiene and health and the intersection of hunger and health.*

The Care Team was able to connect this provider office with two separate community-based resource organizations to address the two social determinants of health this practice chose to focus on. The first organization, Giving the Basics, is a "hygiene hub" which provides hygiene and personal care items to different local agencies in Kansas City to distribute to their clients. The second organization, Harvesters, is a "food network" which provides food to local agencies in Kansas City to address food inequality in their clients.

Outcome: Through the partnership with Giving the Basics, this provider office is now housing a "hygiene closet" in their office allowing them to provide items such as feminine hygiene products, soap, toothpaste, etc. to their patients in need. Furthermore, the partnership with Harvesters has allowed the practice to supply shelf-stable meals which can be provided to any person (children, parents, or siblings) visiting this practice who screens positive for food insecurity or indicates they are hungry. The PCN Care Team helped facilitate both connections by developing relationships with these resource organizations and coordinating efforts to order and supply the needed products to these offices each month.

Success Story #2

Synopsis: *A PCN contracted practice was interested in increasing the number of children age three and above who were receiving well-child visits. The PCN Care Team, the practice, and Harvesters collaborated in the development of a program that would allow children coming in for well child visits on designated days to receive a sack of produce that they could take home to share with their family. The Care Team provided the practice with a list of members due for well visits and appointments were scheduled on the designated days produce would be given out. The office designed flyers to display on their office door letting families know about the special produce days. The goal of the program was to increase the number of well-child visits for the practice, while also distributing healthy food.*

Outcome: The Care Team presented the office with a report demonstrating the success of the program. Well child visits for PCN members during the 3-month period the program was in place increased 300% from 42 in 2017 to 148 in 2018. From this partnership, Harvesters agreed to provide the practice with shelf stable food meal kits to distribute to patients identified as having food insecurity. A medical assistant at the office who was very motivated to make the program successful has become the program champion. The practice and Harvesters plan to continue the program.

Community Health Worker Successes with PCN Members

PCN partners with community health workers from a local agency to assist members in navigating the health care system, linking members with needed health and social services and empowering members to take an active role in managing their health care needs.

Success Story #1

Synopsis: *A referral was made to the community health worker (CHW) for a 21-year-old pregnant member. The member had one child, lived in public housing, and participated in "Youth Build," an organization designed to help young people get their GED and learn a valuable trade in home building and repair. The member stated she was unhappy with the program and wanted to quit so she could get a job. After interviewing the member, the CHW determined that the member was not feeling well, had a past medical history of gallstones, and was in constant pain. The member's physician recommended she have surgery to remove the gallstones. The CHW suggested that the member speak with her obstetrician about collaborating with a surgeon on treatment for the gallstones. The member agreed to this plan. Identifying the member was also in need of a dental check-up, he CHW provided her with several dental resources. The member agreed to make the appointment on her own. The CHW followed up with the member regularly to discuss progress made toward these two goals.*

Outcome: After several months of contact with the CHW, the member shared that her next sonogram would include imaging of the gallbladder to assist her physicians in determining a treatment plan for her. She also shared she had made a dental appointment and was planning to keep it. The member expressed appreciation for the CHW's assistance. With the support of her family and the CHW, she felt empowered to take control and manage her medical needs.

Success Story #2

Synopsis: *A family in need of assistance with a $2,000 water bill was referred to the CHW. The CHW reached out and completed an assessment with the member's mother. In completing the assessment, she discovered that they had 6 children and that the family lived in Section 8 housing. The mother stated the excessive water bill may have resulted from an issue with the washing machine. The CHW began searching for resources for the family. The family was under threat of eviction from Section 8 housing if the water was turned off. Loss of housing would only lead to more problems for the family. The CHW was unsuccessful at locating an agency that would cover the entire water bill, however advised the mother she could apply for assistance with multiple agencies. The mother applied for assistance with every identified utility assistance program in the city. She was able to get $600 from the various agencies and SAVE Inc. agreed to pay the remaining balance. Unfortunately, the employee at Save Inc. who approved the funding left the agency and paperwork documenting the approval was not available. The mother tried advocating for herself with SAVE Inc., but the agency would not return her calls. The CHW provided education on how she could better advocate for herself by assisting the mother in drafting a letter to the agency. She also provided employment resources and job leads to the mother to assist her in finding a job.*

Outcome: In response to the letter submitted to SAVE, Inc., the mother received an immediate response that the remainder of the water bill would be paid. Subsequently, the water was turned back on at the family's residence. In addition, with the CHW's assistance, the mother was able to obtain employment and begin providing for her family. Without intervention from the CHW, the family would likely have been evicted from their home and been left homeless. This would have resulted in insurmountable issues for this mother and her six children.

7 Summary

- 2019 Goals and Objectives
- 2019 Work Plan

Summary of Calendar Year 2019 Goals and Objectives

Based on this year's analyses of data and trends, PCN has identified several areas for implementing new initiatives and enhancing existing programs in the coming year. These areas are identified below:

- Community Resource Team and Online CERA Application
- Provider Performance Profile Process
- C.A.R.E. Web (Online Care Team Communication Tool)
- Community Health Worker Pilot
- NICU Post-Discharge Program
- Asthma Follow-Up Call Campaign
- Standardized Training Software Platform
- Online Prior Authorization Tool

Community Resource Team and Online CERA Application

The PCN Community Resource Team worked on numerous projects throughout 2018. In 2018, the Community Resource Team began focusing on promoting literacy in the Kansas City community by connecting pregnant PCN members in case management to Imagination Library, an organization which will send a book to the child every month from birth to age 5. The Community Resource Team has collaborated, and continued to foster relationships, with numerous community agencies including (but not limited to) SleepyHead Beds, Harvesters, Giving the Basics, and local public health agencies to facilitate resource acquisition and a more seamless referral process for PCN members. The PCN Community Resource Team consistently attends community resource connection meetings through Jackson, Wyandotte, Clay, Platte, and Johnson counties. The team also collaborates with community agencies to disseminate information and schedule on-site presentations for the PCN team.

The online C.E.R.A. application has proven to be a valuable resource for connecting members and their families with local social service resources. In November of 2018, PCN decided to change to a new hosting service. The new service is now up and available for calendar year 2019. PCN expects to continue to see consistent use of the resource service in 2019.

Provider Performance Profile Process

Care Teams will continue to evaluate quality and cost metrics for contracted PCN primary care practices through the use of the Provider Performance Profile reports. Meetings with the PCP practices to review the reports will continue to occur tri-annually. This process will continue to evolve, driving forward population health for the entire network, as Care Teams and providers deploy new and improved population health initiatives and quality improvement strategies.

C.A.R.E. Web (Online Care Team Communication Tool)

C.A.R.E. Web is the online application utilized by Care Teams to enter authorizations, document case management activities, and send tasks to other members of the Care Team. Significant enhancements were made to C.A.R.E. Web in 2018 allowing provider engagement in the patient-centered care plans and allowing a more efficient work flow for Care Teams. In addition, Care Team members' contact information was made available, allowing real-time communication between PCPs and the Care Teams. In 2019, the scope of C.A.R.E. Web will broaden to allow member and caregiver access to the patient-centered care plan.

Community Health Worker Pilot

In May 2018, the Community Health Worker moved on-site at the PCN office and began attending daily PCN Care Team huddles and taking on-the-spot referrals. The CHW program proved to be very beneficial in the reduction of cost and utilization with significant decreases in emergency department use (50% decrease), inpatient visits (67% decrease), and total cost of care (69% decrease). Also, members enrolled in the CHW program also had

better HEDIS measure results when compared to the PCN population over-all. Given its sustained success, the program will continue in 2019.

NICU Post-Discharge Pilot

A quality improvement initiative designed to provide support for newly discharged NICU babies, while decreasing post-discharge ER visits, was initiated in 2016 and continued through 2018. The pilot received positive feedback from home health staff, as well as parents and caregivers, and was subsequently integrated into the standard workflow for all NICU discharges. The program has successfully demonstrated an impact on the medical cost and utilization of care of the members who accepted the services. Since its initiation, the program has served 186 NICU babies. When compared to a control group of 183 NICU babies in the same hospitals who declined the Home Care services, the analysis was favorable for the Home Care group with over 55% reduction in paid medical cost, 74% reduction in admissions, 93% reduction in hospital days, and 84% reduction in readmissions. However, the intervention group had 22% higher rates for ER visits. After further analysis, ER visits were mainly due to respiratory issues and chronic recurring ear infections. More than one fourth of the ER visits were from 10 unique members. In 2019, PCN and Children's Mercy Home Care will evaluate ways to educate PCN members' caregivers on alternatives to utilizing the emergency room and encourage them to contact their primary care providers, utilize nurse advice line, or visit trusted urgent care facilities.

Asthma Follow-Up Call Campaign

Automated call campaigns via the interactive voice response system, EMMI, will target medium and high-risk asthma members and encourage follow-up visits with providers every six months. EMMI has seen great success with other pediatric population health efforts. Focusing on members with asthma

will allow channeled resources and attention to collectively improving asthma outcomes for the higher risk patients.

Standardized Training Software Platform

In an effort to automate and streamline training processes for onboarding of new staff, as well as conduct annual and ongoing education of existing staff, a standardized software training platform was implemented through the Children's Mercy Cornerstone program, allowing for more efficient and thorough training modules to be accessed in a group or individual setting. In 2019, further development of the training platform is planned on a variety of educational topics, such as accessing Care Integration policies and procedures, utilizing resources and tools, applications in case management, and cultural diversity.

Online Prior Authorization Tool

An online tool allowing providers to request a prior authorization will be piloted in 2019. Instead of filling out a form and faxing it to PCN for manual entry, the provider will be able to enter the authorization information directly into the online tool. That information will then be routed to the PCN Intake/Outreach Team to review and process. The online authorization tool is being designed to increase efficiencies for both providers and PCN staff.

The PCN maintains a strong commitment to improving the health of the population, decreasing the overall cost of care, and improving patient and provider experience with care delivery. The PCN team will continue to forge strong relationships with the patient population it serves in addition to their healthcare providers and communities to continually improve access to care, promote preventive services, and develop strong multi-disciplinary care delivery models for effectively managing vulnerable high-risk populations.

The PCN maintains a strong commitment to improving the health of the population, decreasing the overall cost of care, and improving patient and provider experience with care delivery. Our team will continue to forge strong relationships with the patient population we serve and their healthcare providers and communities to continually improve access to care, promote preventive services, and develop strong, multi-disciplinary care delivery models for effectively managing high risk, vulnerable populations.

Submitted: _____ May 29, 2019
Ma'ata Hardman, BSN, MBA, CCM — Date
Senior Administrative Director, Care Continuum

Approval: _____ May 31, 2019
Just for Kids (JFK) Committee — Date

_____ August 2, 2019
Clinical Quality & Operations Committee — Date

2019 Annual Work Plan

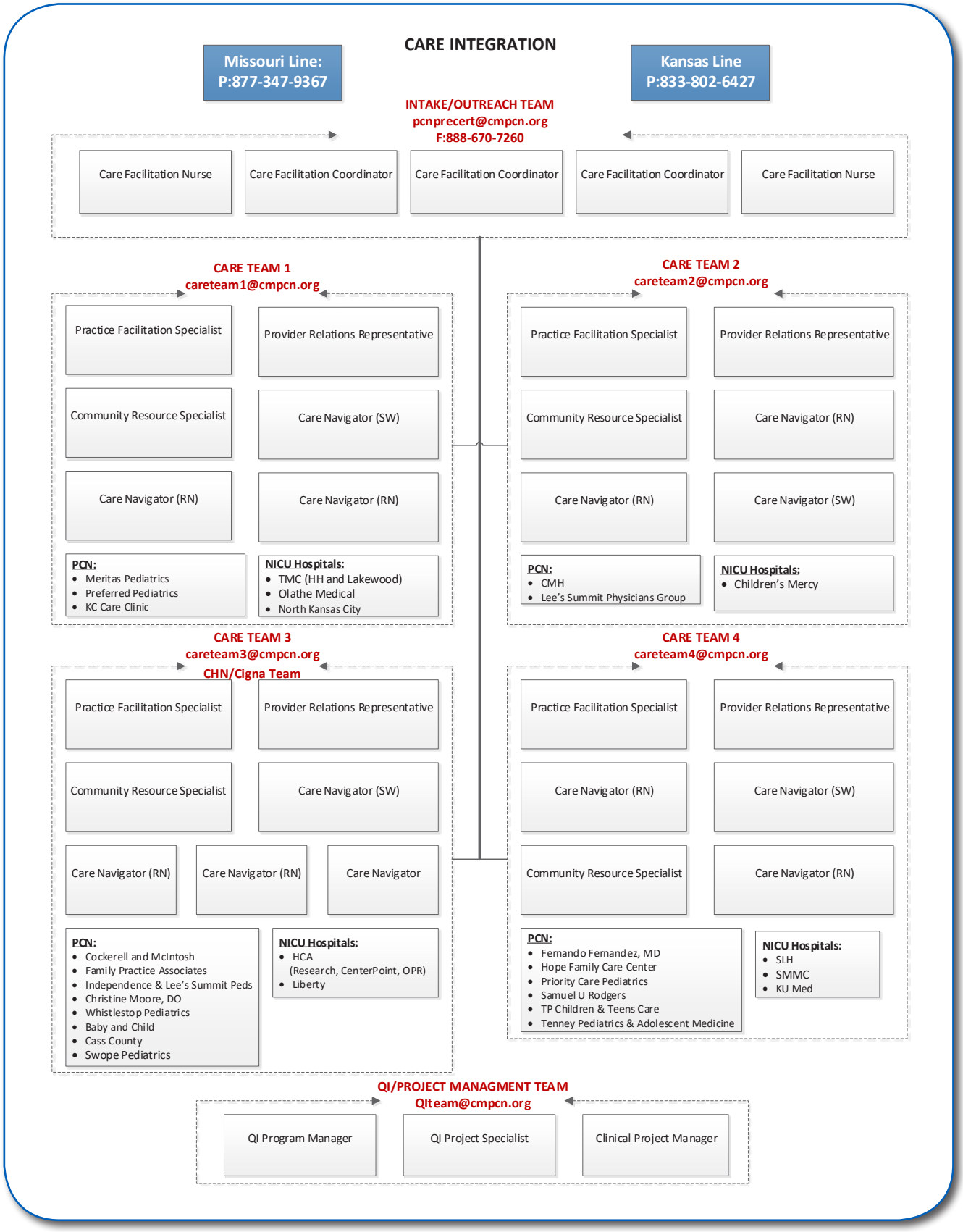
	Initiative	Operational Lead	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Scope & Process	ICS Resources for Spread (Operational Leader, Project Manager)
1	Enhance community connections and resource allocation	Community Resource Specialist Team	X	X	X	X	Expand collaboration with community organizations and continue to investigate opportunities for resource acquisition through the new resource hosting service.	Care Teams; IT Team; QI Team; Community Resource Specialist Team
2	Evolve Provider Performance Profile process	Quality Improvement Program Manager	X	X	X	X	Continue to evaluate quality and cost metrics for contracted PCN primary care practices, schedule tri-annual meetings with the practices to review data, discuss coordinated interventions to address improvement opportunities, and evaluate progress with metrics.	Care Teams; Data Analytics/QI Team; Practice Facilitation Specialist Team; Provider Relations Team
3	Broaden the scope of C.A.R.E Web	Director of Integrated Care			X	X	Broaden the scope of C.A.R.E. Web to include members as part of the care team and provide real-time communication between all Care Team members.	Care Teams; IT Team; Management Team
4	Evaluate Community Health Worker pilot effectiveness	Director of Social Work Care Continuum	X	X	X	X	Ongoing pilot with Community Health Workers with shift in focus to include other locations (i.e. schools and community centers) while continuing to monitor interventions to determine sustainability of the program.	Data Analytics/ QI Team; Management Teams

5	Expand NICU post-discharge program	Director of Integrated Care	X	X	X	X	Expand NICU post-discharge program to additional hospitals. Continue to monitor program outcomes and enhance education provided to families regarding the appropriate setting for healthcare services (PCP, urgent care, emergency room, etc.).	Data Analytics/ QI Team; Management Team
6	Asthma Follow-Up Campaign	Director of Integrated Care	X	X	X	X	Implement an automated call campaign for medium and high-risk asthma patients to encourage follow up with PCP providers.	Intake/ Outreach Team; Management Team; QI Team; Provider Relations Team
7	Enhance the standardized training software platform for ongoing staff education and onboarding of new staff	Manager of Care Integration		X	X	X	Develop new staff onboarding and annual education through the Cornerstone program to automate and streamline processes for more efficient and thorough training modules. Provide routine and additional staff education on cultural diversity and applications in case management.	Care Teams; Management Team; QI Team
8	Implement online prior authorization tool	Director of Integrated Care		X	X	X	Create and pilot a secure online tool for providers to submit prior authorization requests.	Intake/Outreach Team; IT Team; Management Team

8 Appendix

- Care Team Diagram
- Provider Performance Profile
- Kid Care Anywhere

Appendix A: Care Team Diagram



Appendix B: Provider Performance Profile

Pediatric Care Network Report Package Summary

PEDIATRIC CARE NETWORK TRI-ANNUAL REPORT PACKAGE

To deliver high-value care that meets the Triple Aim of Better Care, Smarter Spending, and Healthier Children, the PCN Tri-Annual Report Package informs practices of their quality and cost performance and provides observations and potential improvement ideas for consideration and review with each practice.

We are striving to make the information useful, valuable, and actionable. We welcome your feedback!

Quality Performance Report - *Observations & Potential Improvement Ideas*

Observations and Comments

Potential Opportunities for Improvement:

- EPSDT X% from the HEDIS 75th Percentile

Potential Strategies/Tactics of How to Accomplish Goal(s):

- PCP alignment rate of X% (Y% of assigned patients have not made a visit to the practice in the last 2 years).

Follow Up & Review of Actions and Goals

Quality Goals	Status of Actions/Tasks
EPSDT (0-6 Years)	Has improved X% over prior measurement period
[Insert Quality Goal]	[Insert Status]
[Insert Quality Goal]	[Insert Status]

Cost & Utilization Report - *Observations & Potential Improvement Ideas*

Observations and Comments

Potential Opportunities for Improvement:

- Access

Potential Strategies/Tactics of How to Accomplish Goal(s):

- Consider increasing access hours during weekdays again – currently only Saturday hours 9a-12p

Potential Improvement Ideas and Resources for Discussion

How to Accomplish:

- Identify and refer patients with high utilization or high cost to care teams for assessment, identification of barriers to care, and interventions to optimize outcomes.
- Partner with care teams to develop plans to engage with patient and family to identify barriers of care and develop interventions to optimize outcomes.

Published: [Insert Date]

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Pediatric Care Network Cost and Utilization Report Package

PEDIATRIC CARE NETWORK COST & UTILIZATION REPORT PACKAGE – PRACTICE NAME

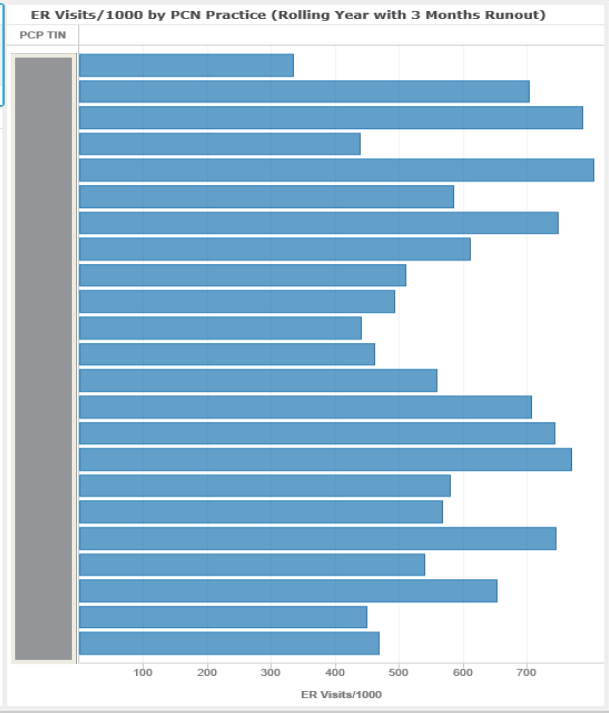
Cost & Utilization Performance – Network and Practice Comparison Report *[Measurement Period: XX/XX/XXXX to XX/XX/XXXX]* *Page 1 of 2*

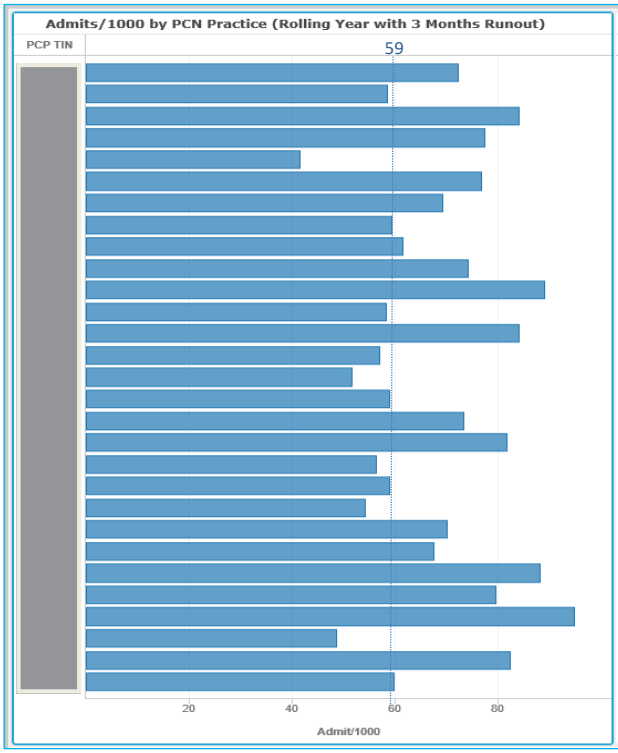
PCN Network Cost & Utilization (Rolling Year with 3 Months Runout)

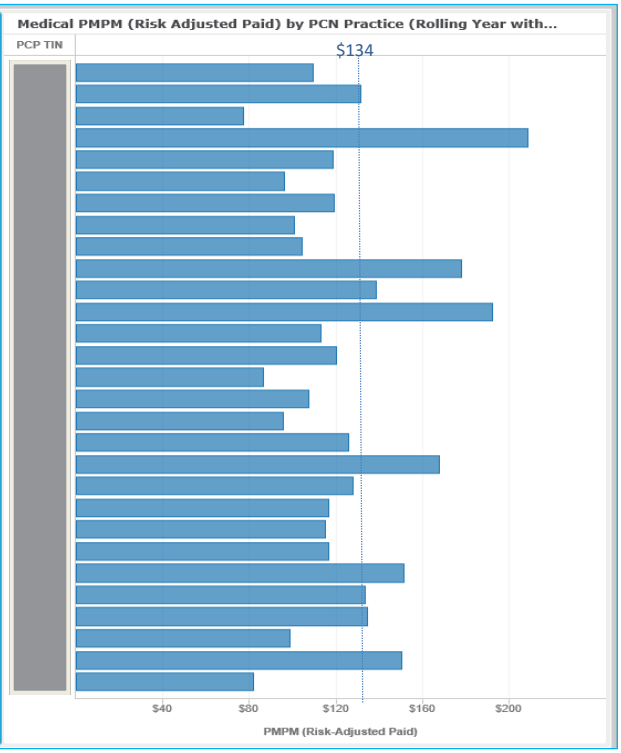
Average Members Per Month	ER Visits/1000	Admissions/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
101,783	604	81	332	$134

Cost & Utilization by PCN Practice (Rolling Year with 3 Months Runout)

PCP TIN	Average Members Per Month	ER Visits/	Admissions	Days/1000	PMPM (Risk-Adjusted Paid Medical)
	47	450	129	1,693	$420
	1,317	788	77	345	$209
	841	611	58	194	$192
	5,927	585	74	332	$178
	320	707	56	250	$168
	10,453	745	88	395	$152
	4,745	749	89	340	$139
	5,166	540	80	310	$134
	4,099	704	59	224	$132
	3,192	743	59	210	$128
	3,276	559	82	326	$126
	562	493	57	201	$120
	1,330	805	69	301	$119
	2,556	439	41	122	$119
	289	654	111	287	$119
	832	771	54	165	$117
	2,253	569	67	259	$116
	1,142	579	70	380	$115
	7,436	510	84	307	$113
	3,991	334	72	316	$109
	7,067	462	59	265	$107
	621	441	52	235	$86
	619	468	60	216	$82







Pediatric Care Network Cost and Utilization Report Package

PEDIATRIC CARE NETWORK COST & UTILIZATION REPORT PACKAGE – PRACTICE NAME

Cost & Utilization Performance – Provider Comparison Report *[Measurement Period: XX/XX/XXXX to XX/XX/XXXX]* *Page 1 of 1*

Practice Cost & Utilization (Rolling Year with 3 Months Runout)

PCP TIN	Average Members Per Month	ER Visits/1000	Admit/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
[redacted]	3,192	743	59	210	$128

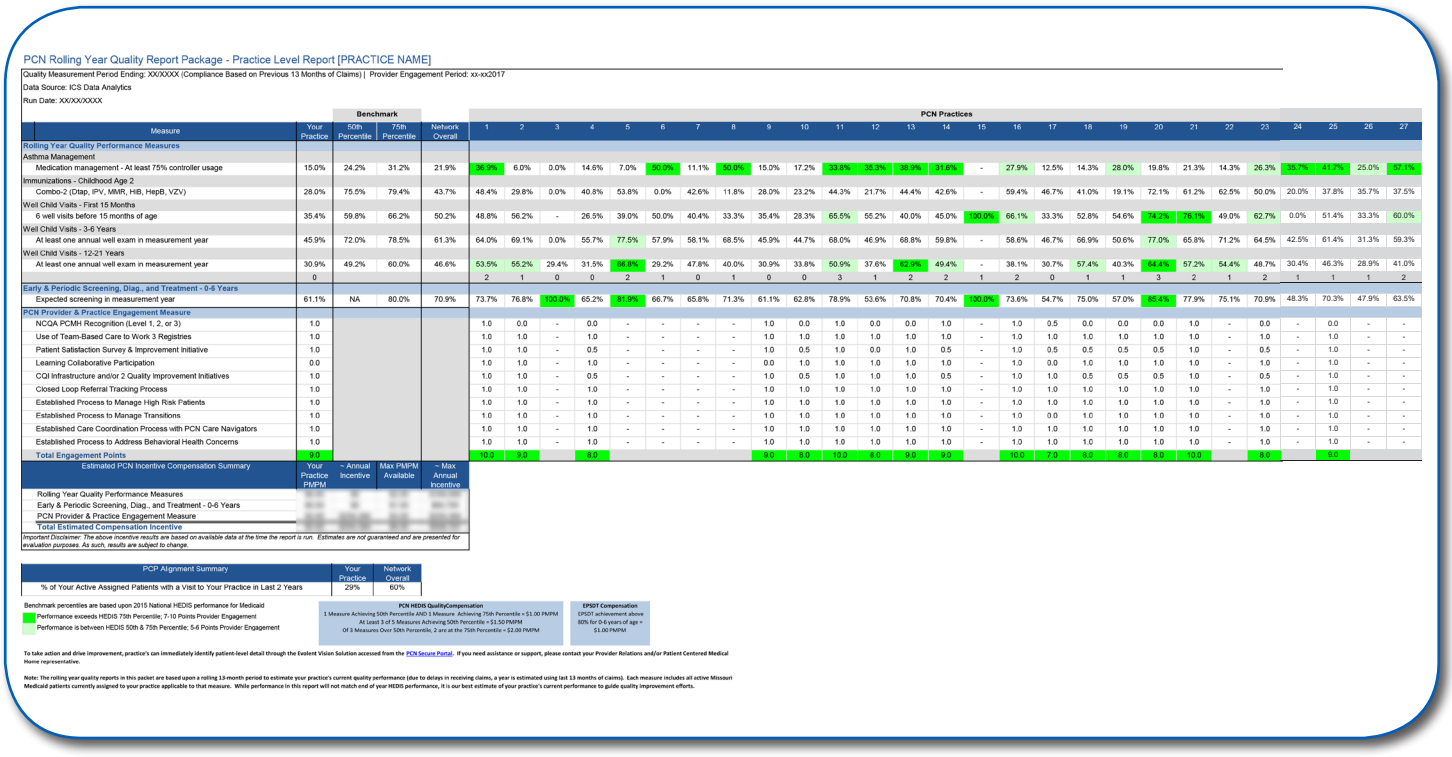
PCN Network Cost & Utilization (Rolling Year with 3 Months Runout)

Average Members Per Month	ER Visits/1000	Admissions/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
101,783	604	81	332	$134

Cost & Utilization by Primary Care Provider (Rolling Year with 3 Months Runout)

PCP Name	Average Members Per Month	ER Visits/1000	Admit/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
[redacted]	1,324	757	72	260	$141
	920	694	46	172	$126
	905	767	55	180	$114
	30	797	33	133	$103
	12	938	0	0	$65
	0	0	0	0	$312

PCN Rolling Year and HEDIS Calendar Year Quality Report Package



PCN Rolling Year Quality Report Package - Practice Level Report [PRACTICE NAME]

Quality Measurement Period Ending: XX/XXXX (Compliance Based on Previous 13 Months of Claims) | Provider Engagement Period: xx-xx2017

Data Source: ICS Data Analytics

Run Date: XX/XX/XXXX

Measure	Your Practice	Benchmark 50th Percentile	Benchmark 75th Percentile	Network Overall	PCN Practices 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
Rolling Year Quality Performance Measures																															
Asthma Management																															
Medication management - At least 75% controller usage	15.0%	24.2%	31.2%	21.9%	36.9%	6.0%	0.0%	14.6%	7.0%	50.0%	11.1%	50.0%	15.0%	17.2%	33.8%	35.3%	38.9%	31.6%	-	27.9%	12.5%	14.3%	28.0%	19.8%	21.3%	14.3%	26.3%	35.7%	41.7%	25.0%	57.1%
Immunizations - Childhood Age 2																															
Combo-2 (Dtap, IPV, MMR, HiB, HepB, VZV)	28.0%	75.5%	79.4%	43.7%	48.4%	29.8%	0.0%	40.8%	53.8%	0.0%	42.6%	11.8%	28.0%	23.2%	44.3%	21.7%	44.4%	42.6%	-	59.4%	46.7%	41.0%	19.1%	72.1%	61.2%	62.5%	50.0%	20.0%	37.8%	35.7%	37.5%
Well Child Visits - First 15 Months																															
6 well visits before 15 months of age	35.4%	59.8%	66.2%	50.2%	48.8%	56.2%	-	26.5%	39.0%	50.0%	40.4%	33.3%	35.4%	28.3%	65.5%	55.2%	40.0%	45.0%	100.0%	66.1%	33.3%	52.8%	54.6%	74.2%	76.1%	49.0%	62.7%	0.0%	51.4%	33.3%	60.0%
Well Child Visits - 3-6 Years																															
At least one annual well exam in measurement year	45.9%	72.0%	78.5%	61.3%	64.0%	69.1%	0.0%	55.7%	77.5%	57.9%	58.1%	68.5%	45.9%	44.7%	68.0%	46.9%	68.8%	59.8%	-	58.6%	46.7%	66.9%	50.6%	77.0%	65.8%	71.2%	64.5%	42.5%	61.4%	31.3%	59.3%
Well Child Visits - 12-21 Years																															
At least one annual well exam in measurement year	30.9%	49.2%	60.0%	46.6%	53.5%	55.2%	29.4%	31.5%	66.8%	29.2%	47.8%	40.0%	30.9%	33.8%	50.9%	37.6%	62.9%	49.4%	-	38.1%	30.7%	57.4%	40.3%	64.4%	57.2%	54.4%	48.7%	30.4%	46.3%	28.9%	41.0%
	0				2	1	0	0	2	1	0	1	0	0	3	1	2	2	1	2	0	1	1	3	2	1	2	1	1	1	2
Early & Periodic Screening, Diag., and Treatment - 0-6 Years																															
Expected screening in measurement year	61.1%	NA	80.0%	70.9%	73.7%	76.8%	100.0%	65.2%	81.9%	66.7%	65.8%	71.3%	61.1%	62.8%	78.9%	53.6%	70.8%	70.4%	100.0%	73.6%	54.7%	75.0%	57.0%	85.4%	77.9%	75.1%	70.9%	48.3%	70.3%	47.9%	63.5%
PCN Provider & Practice Engagement Measure																															
NCQA PCMH Recognition (Level 1, 2, or 3)	1.0				1.0	0.0	-	0.0	-	-	-	-	1.0	0.0	1.0	0.0	0.0	1.0	-	1.0	0.5	0.0	0.0	0.0	1.0	-	0.0	-	0.0	-	-
Use of Team-Based Care to Work 3 Registries	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Patient Satisfaction Survey & Improvement Initiative	1.0				1.0	1.0	-	0.5	-	-	-	-	1.0	0.5	1.0	0.0	1.0	0.5	-	1.0	0.5	0.5	0.5	0.5	1.0	-	0.5	-	1.0	-	-
Learning Collaborative Participation	0.0				1.0	1.0	-	1.0	-	-	-	-	0.0	1.0	1.0	1.0	1.0	1.0	-	1.0	0.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
CQI Infrastructure and/or 2 Quality Improvement Initiatives	1.0				1.0	1.0	-	0.5	-	-	-	-	1.0	0.5	1.0	1.0	1.0	0.5	-	1.0	1.0	0.5	0.5	0.5	1.0	-	0.5	-	1.0	-	-
Closed Loop Referral Tracking Process	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Established Process to Manage High Risk Patients	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Established Process to Manage Transitions	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	0.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Established Care Coordination Process with PCN Care Navigators	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Established Process to Address Behavioral Health Concerns	1.0				1.0	1.0	-	1.0	-	-	-	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	1.0	1.0	1.0	1.0	1.0	-	1.0	-	1.0	-	-
Total Engagement Points	9.0				10.0	9.0		8.0					9.0	8.0	10.0	8.0	9.0	9.0		10.0	7.0	8.0	8.0	8.0	10.0		8.0		9.0		

Estimated PCN Incentive Compensation Summary	Your Practice PMPM	~ Annual Incentive	Max PMPM Available	~ Max Annual Incentive
Rolling Year Quality Performance Measures				
Early & Periodic Screening, Diag., and Treatment - 0-6 Years				
PCN Provider & Practice Engagement Measure				
Total Estimated Compensation Incentive				

Important Disclaimer: The above incentive results are based on available data at the time the report is run. Estimates are not guaranteed and are presented for evaluation purposes. As such, results are subject to change.

PCP Alignment Summary	Your Practice	Network Overall
% of Your Active Assigned Patients with a Visit to Your Practice in Last 2 Years	29%	60%

Benchmark percentiles are based upon 2015 National HEDIS performance for Medicaid

Performance exceeds HEDIS 75th Percentile, 7-10 Points Provider Engagement

Performance is between HEDIS 50th & 75th Percentile, 5-6 Points Provider Engagement

PCN HEDIS QualityCompensation

1 Measure Achieving 50th Percentile AND 3 Measure Achieving 75th Percentile = $1.00 PMPM

At Least 3 of 5 Measures Achieving 50th Percentile = $1.50 PMPM

Of 3 Measures Over 50th Percentile, 2 are at the 75th Percentile = $2.00 PMPM

EPSDT Compensation

EPSDT achievement above 80% for 0-6 years of age = $1.00 PMPM

To take action and drive improvement, practice's can immediately identify patient-level detail through the Evolent Vision Solution accessed from the PCN Secure Portal. If you need assistance or support, please contact your Provider Relations and/or Patient Centered Medical Home representative.

Note: The rolling year quality reports in this packet are based upon a rolling 13-month period to estimate your practice's current quality performance (due to delays in receiving claims, a year is estimated using last 13 months of claims). Each measure includes all active Missouri Medicaid patients currently assigned to your practice applicable to that measure. While performance in this report will not match end of year HEDIS performance, it is our best estimate of your practice's current performance to guide quality improvement efforts.

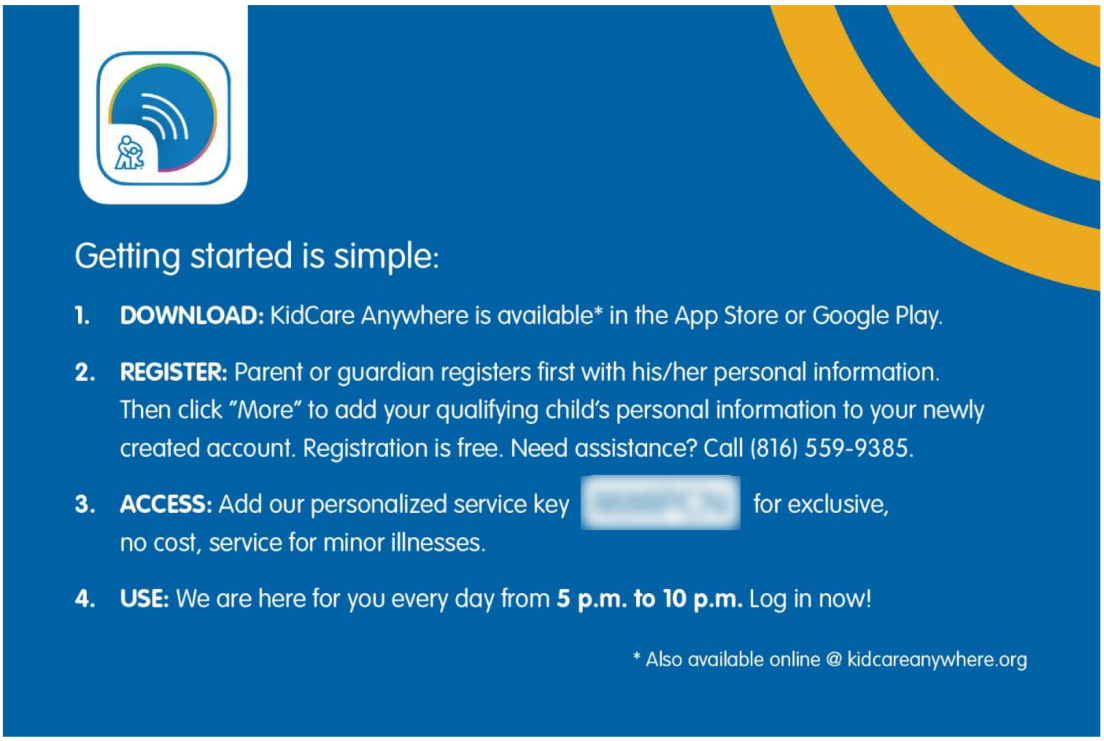
Appendix C: KidCare Anywhere

Children's Mercy KANSAS CITY

KidCare Anywhere CHILDREN'S MERCY

We are excited to share that your child qualifies for a new, no-cost service called **KidCare Anywhere**, which can help you treat your child's minor illnesses without having to leave the comfort of home.

KidCare Anywhere is an app and online service that offers you quick access to a Children's Mercy doctor or advanced practice nurse to help treat your child's non-emergency conditions. They can discuss, provide guidance, and often treat your child's minor ailments and illnesses. They can also send your pharmacy a prescription when needed; AND you can do all of this quickly, easily and conveniently through your smartphone, tablet, or computer!



We hope you take advantage of this easy and convenient option, when your Primary Care Pediatrician is not available.

If you have any questions, please contact us at (816) 559-9385.

KidCare Anywhere