



Care Integration
ANNUAL REPORT

Calendar Year
2016

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), disease management (DM), care coordination and population health management services to eligible members. The care integration program focuses on preventive health and enhancing and coordinating a member's care across an episode or continuum of care by:

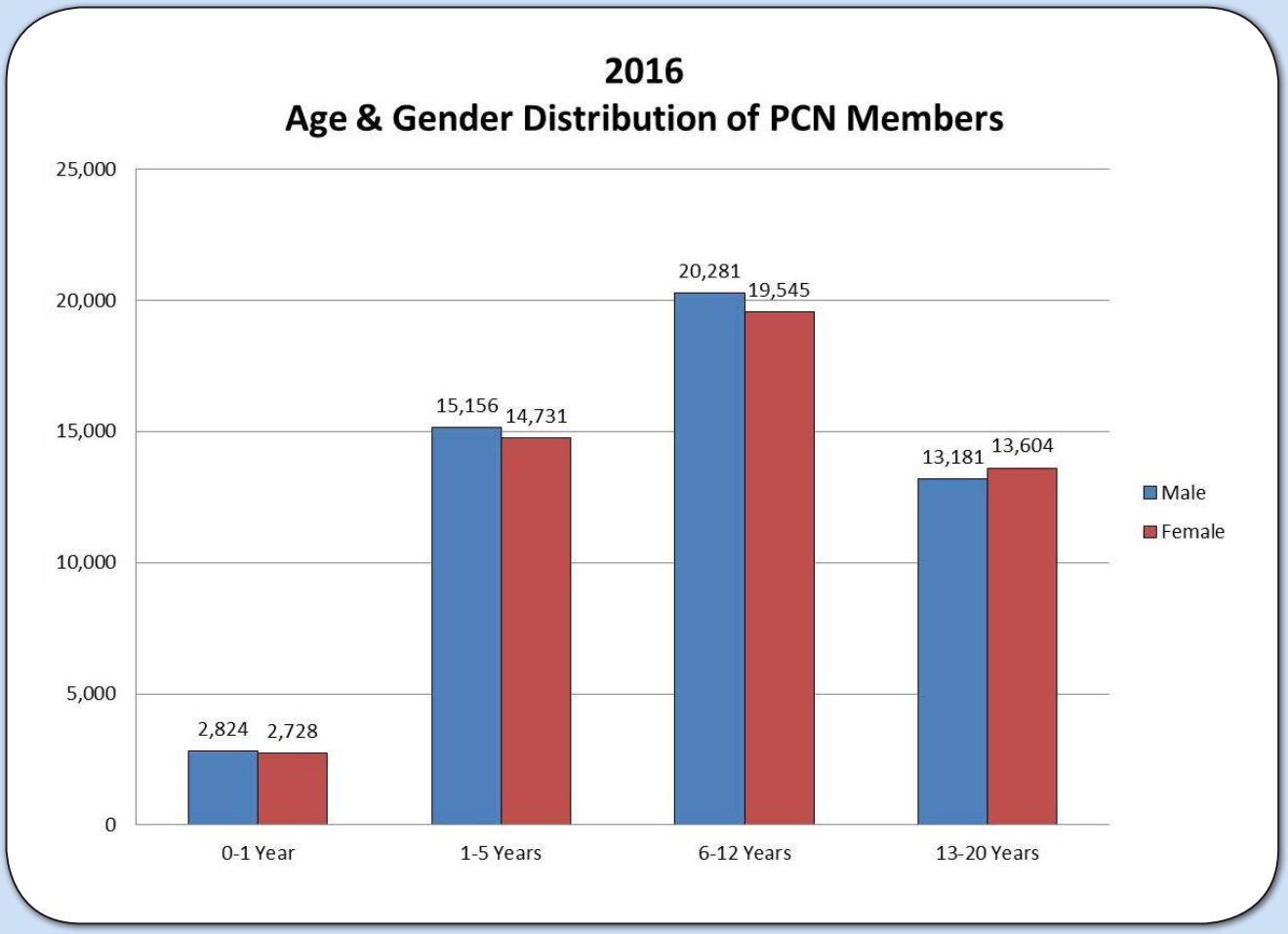
- Negotiating, procuring and coordinating services and resources needed by patients and families with complex needs
- Facilitating care transitions across care settings
- Ensuring and facilitating the achievement of quality, clinical and cost outcomes
- Intervening at key points for individual patients
- Addressing and resolving patterns of issues that have negative quality or cost impact
- Creating opportunities and systems to enhance 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 needs, disabilities, and other complex health issues. Disease management interventions focus on two chronic conditions that are most 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 two Medicaid managed care organizations in Missouri: Aetna Better Health of Missouri and Missouri Care/ WellCare. Since February 2012, the PCN has managed Aetna Better Health of Missouri members ages 20 and under in select counties of the Western Region. As of December 2016, the number of members being managed for Aetna was approximately 70,900. In February 2014, the PCN

entered into a similar agreement for delegated medical management with Missouri Care and as of December 2016, managed approximately 34,600 members ages 20 and under in the Western Region for Missouri Care. The PCN contracts directly with 43 primary care provider (PCP) practice locations, representing 175 PCPs in Kansas City.

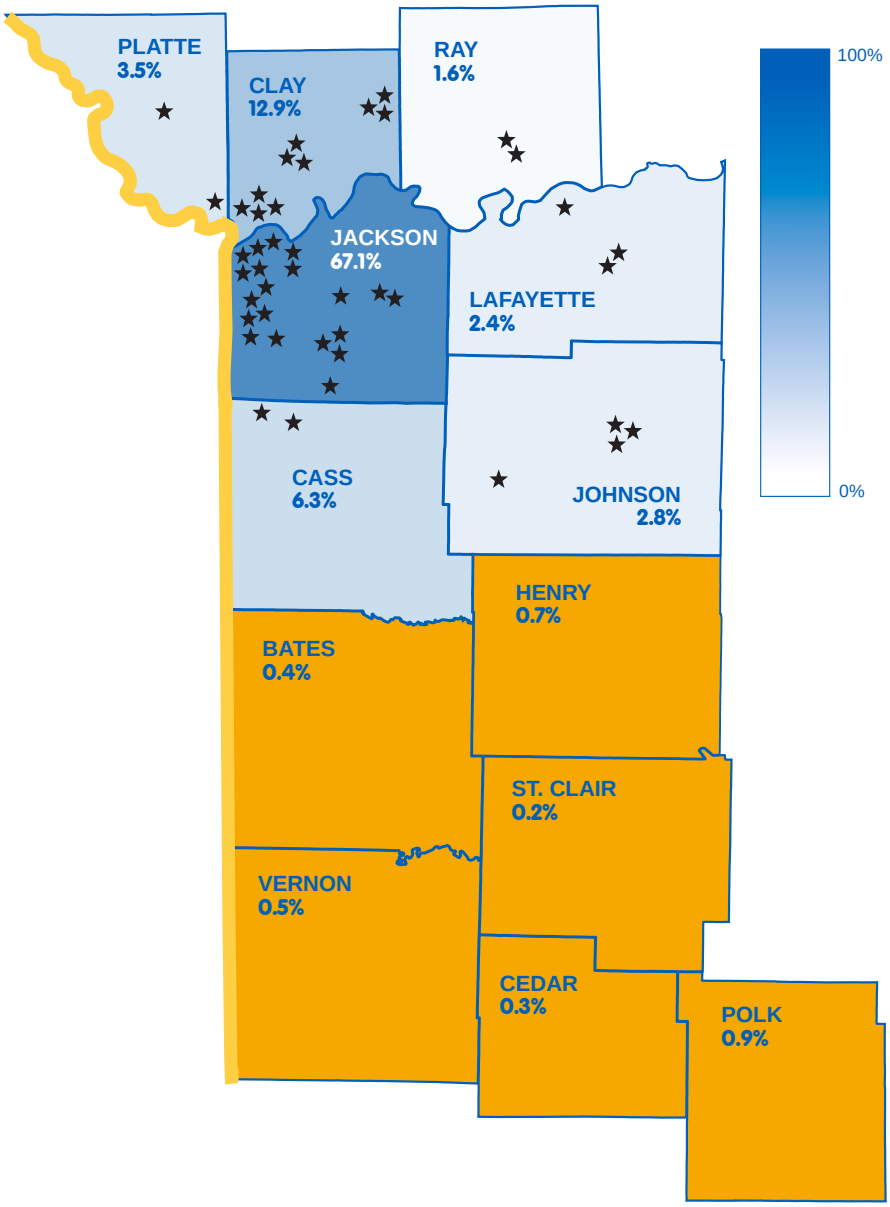
Through those value-based contracts, providers agree to engage with the PCN in transforming their practice using patient-centered medical home (PCMH) concepts and demonstrating sustainable outcomes through improved quality, improved patient satisfaction, and decreased cost.



Population Analysis/Characteristics

As of Dec. 31, 2016, the male to female ratio of the PCN population is roughly 50% and the most concentrated population (approximately 39%) is in the 6-12 year age category. See chart illustrating the age and gender distribution of PCN members in 2016.

PCN members live in thirteen metro counties, with a majority (67%) living in urban Jackson County. See county map distribution of PCN members and contracted PCP locations.



County	PCN
Jackson	67.1%
Clay	12.9%
Cass	6.3%
Platte	3.5%
Johnson	2.8%
Lafayette	2.4%
Ray	1.6%
Polk	0.9%
Henry	0.7%
Vernon	0.5%
Bates	0.4%
Cedar	0.3%
St. Clair	0.2%
Other	0.4%
	100.0%

★ Practice locations with contracted Pediatric Care Network PCPs

Counties in blue represent the enrollment area for Aetna Better Health of Missouri and Missouri Care. Counties in gold represent PCN enrollment for Missouri Care only.

PCN Network Providers -- Missouri

Baby and Child Associates
Blue Springs Pediatrics
Cass County Pediatrics and Adolescents
Children's Mercy Clinics on Broadway
Christine Moore, DO
Cockerell and McIntosh Blue Springs
Cockerell and McIntosh Higginsville
Cockerell and McIntosh Independence
Community Health Partners
Excelsior Springs Pediatric Clinic
Family Practice Associates of Higginsville
Family Practice of Warrensburg
Fernando Fernandez, MD
H. Andrew Pickett, M.D.
Holden Family Care
Hope Family Care
Independence Pediatrics
Kansas City Pediatric Group
Lee's Summit Pediatrics
Lee's Summit Physicians Group
Liberty Medical Center
Meritas Health Pediatrics
Meritas Health Richmond
Neighborhood Family Care
Platte County Pediatrics
Preferred Pediatrics LLC
Priority Care Pediatrics LLC (Kansas City)
Priority Care Pediatrics LLC (Liberty)
Raintree Pediatrics
Richmond Family Clinic
Robert Buzard, MD
Samuel U Rodgers
Samuel U Rodgers Clay County
Samuel U Rodgers Lafayette
Samuel U Rodgers Northland
Samuel U Rodgers Westside Clinic
Swope Health Center
Swope Health Center - Independence
Swope Health Center - Riverside
Swope Health Center - Troost
Tenney Pediatric & Adolescent Medicine
T.P. Children & Teens Care
Whistlestop Pediatrics

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 I.

PCP Aligned Care Teams

The PCN employs multiple disciplines for its population health management initiatives. The disciplines are organized into PCP-aligned Care Teams. Currently, six Care Team members have case management certification, as well as one certified asthma educator and one certified diabetes educator.

The Care Team objectives are as follows:

- Assists members in sustaining or achieving an optimal level of wellness and function by facilitating timely and appropriate health care services
- Promotes strong member/PCP relationships for coordination and continuity of care, using PCMH concepts
- Reduces inappropriate inpatient hospitalizations and utilization of emergency room services
- Promotes clinical care that is consistent with scientific evidence and member preferences
- Ensures the integration of medical and behavioral health services
- Educates members in self-advocacy and self-management
- Minimizes gaps in care and encourage use of preventive health services
- Achieves cost efficiency in the provision of health services while maximizing health care quality
- Mobilizes community resources to meet needs of members

The primary roles within the PCN working directly with patients, caregivers, and community providers are detailed as follows.

Care Navigators

Care Navigators are licensed Registered Nurses 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 patients. The Care Navigator provides care coordination services in order to make sure that patients receive well-coordinated care along the health care continuum and promotes quality care through appropriate, cost effective interventions.

The scope of practice for Care Navigators includes:

- Provides onsite care coordination, physically located in a Primary Care Provider office setting (Embedded Care Navigator)
- Engages 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
- Uses data analytic tools and registries to identify and address needs of at-risk populations
- Participates in quarterly Provider Practice Performance Profile reviews with each assigned PCP office and assists in identifying Care Team priorities based on data analysis and Care Team discussion
- Facilitates successful transitions of care for patients 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
- Follows a care planning process to identify patient-centric goals and establish priorities
- Utilizes a holistic approach, applying multiple theories and interventions, to motivate patient/family engagement
- Conducts psychosocial screening and interventions to address behavioral and social needs (SW Care Navigator)
- Addresses social determinants of health as part of the ongoing assessment and care planning process
- Facilitates access to behavioral health resources and services
- Provides targeted education and facilitation of available health plan benefits and incentive programs

- Participates in pre-visit planning with the healthcare team to identify patients appropriate for care coordination and/or tasks needed to meet patient needs (Embedded Care Navigator)
- Identifies and stratifies patient needs to facilitate referrals to other members of the Care Team (e.g., Community Health Worker, Social Worker, Nurse, Provider, Community Resource Agency, School, Family Member)
- Facilitates end of life support for patients, families and the healthcare team (SW Care Navigators)
- Promotes wellness through patient education on disease-specific conditions and preventative care
- Participates 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 patients/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 patients/families and the health or social service agencies.

The scope of practice for Community Health Workers includes:

- Continuously expands knowledge of community resource services and programs
- Helps patients and their families adopt healthy behaviors
- Establishes trusting relationships with patients and their families while providing general support and encouragement
- Refers and assists with accessing necessary social services (e.g., Legal Aid; housing, food, and transportation services)
- Facilitates successful appointments for patients and families, including: assisting with preparation for appointments, attending appointments, and helping patients and families understand information
- Assists patients 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
- Participates in shared accountability for the identified team-based population measures

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, patients and families, community agencies, and other health care professionals.

The scope of practice for Community Resource Specialists includes:

- Provides outreach and education to patients, families, and other healthcare team members in addressing gaps in care and resource needs
- Distributes tasks and referrals to appropriate Care Team members
- Participates in quarterly Provider Practice Performance Profile reviews with each assigned PCP office and assists in identifying Care Team priorities based on data analysis and Care Team discussion
- Assists members and families with problem solving, addressing concerns and ensuring education about available community resources
- Provides support with prior authorization processing for assigned Care Team
- Provides education and organization of community resources
- Establishes and maintains 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)
- Provides education and organization of community resources
- Participates in shared accountability for the identified team-based population measures

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.

Practice Facilitation Specialists

Practice Facilitation Specialists work with Primary Care Provider practices to facilitate practice transformation and support practice management processes aimed toward improving patient 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.

<u>The scope of practice for Practice Facilitation Specialists includes:</u>

- Provides training on data analytic tools, such as Valence, EMR, Provider Portal, etc. to support population health/PCMH initiatives.
- Assists Care Teams with data analytics for Provider Practice Performance Profile reviews to support Care Team discussions and initiatives
- Participates in quarterly Provider Practice Performance Profile reviews with each assigned PCP office and assists in identifying Care Team priorities based on data analysis and Care Team discussion
- Prepares PCP quarterly engagement progress reports and compensation education
- Teaches and supports PCMH concepts and monitors ongoing sustainability of processes
- Provides evidence-based, condition specific training for provider practices, including asthma, diabetes, and healthy lifestyles
- Participates 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.

<u>The scope of practice for Provider Relations Representatives includes:</u>

- Maintains accurate participating provider status, updating provider directories and assisting in maintenance of online provider directories
- Assists with resolution of provider issues regarding claims status and enrollment issues
- Assists with individual PCP assignment issues and PCP changes from the PCN providers to the MCO
- Facilitates a streamlined, non-redundant credentialing process for PCN providers
- Participates in quarterly Provider Practice Performance Profile reviews with each assigned PCP office and assists in identifying Care Team priorities based on data analysis
- Provides training on data analytic tools, such as Valence, Provider Portal, etc. to support population health/PCMH initiatives
- Assists Care Teams with data analytics for Provider Practice Performance Profile reviews to support Care Team discussions and initiatives
- Prepares PCP quarterly engagement progress reports and compensation education
- Participates in shared accountability for the identified team-based population measures analysis and team discussions

Staff Education and Development

The PCN provides training and staff education throughout the year for the Care Integration staff to support maintenance of core competencies and ongoing professional development. The following are some of the topics and educational trainings attended by the Care Integration staff in 2016.

- Adolescent Relationship Abuse
- Autism Spectrum Disorder
- Comprehensive Care for Survivors of IPV
- Cultural Competency
- Disorders of the Endocrine System
- Environmental Health
- HPV
- Ketogenic Diets
- Mental Health First Aid Training
- Mild Brain Injury and Concussions
- Motivational Interviewing
- Pulmonary Hypertension of the Sickle Cell Patient
- Safety Considerations and Solutions to Common Home Barriers
- Substance Abuse
- The Immune System
- Transgender Health
- Trauma Informed Schools
- Vicarious Trauma

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Population Health Management

- Patient-Centered Medical Home Transformation Program
- Provider Portal
- Behavioral Health & Community Integration
- Patient Experience
- Provider Experience
- Local Community Care Coordination Program (LCCCP) Measures
- Data Analytics Tools
- Provider Practice Performance Profile
- Quality Improvement Initiatives
- Next Steps

Population Health Management

Thomas Jefferson University College of Population Health defines population health management as follows: “Population Health Management (PHM) seeks to improve the health outcomes of a group by monitoring and identifying individual patients within that group.” They further define population health as “a systematic approach to health care that aims to prevent and cure disease by keeping people healthy. 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;
- 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; and
- 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, 2015

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, and (3) reduce the per capita cost of health care by advancing initiatives that emphasize quality improvement, data analytics, and the PCMH.

- Institute for Healthcare Improvement

Patient-Centered Medical Home Transformation Program

The patient-centered medical home (PCMH) 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, June 2012

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 NCQA consulting services
- Use of patient registries for population management
- Patient communication/outreach templates and material
- Gaps in Care reports for assigned members
- Quarterly 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, the office staff and patients/caregivers on appropriate diagnosis, treatment and management of chronic conditions and promote preventive care for the entire patient population.

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 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 the 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, June 2012

References:

Thomas Jefferson University. (2016). *Jefferson College of Population Health-About us.* Retreived from http://www.jefferson.edu/university/population-health.html

Institute for Healthcare Improvement. (2017). *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. *Defining the PCMH*. Retrieved from https://pcmh.ahrq.gov/page/defining-pcmh

PCMH Engagement

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Progress Report for Engagement Compensation **confidential and proprietary**

Clinic: **Date:**

	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun
1. The Practice has achieved recognition as a NCQA PCMH Level 1-3.				
• NCQA Recognition Level 1, 2, or 3 will be an automatic $1.50 engagement cap plus 1 point toward total				
2. The Practice will regularly use team-based care [e.g., huddles] to implement population health processes and address gaps in care & preventive care (HEDIS) measures by working 3 different registries. Examples include:				
• PCP Panel List				
• Preventive care (WCC, Immunizations, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents)				
• Chronic disease (Asthma, Diabetes, ADHD)				
3. The Practice solicits patient feedback for all providers annually using a Patient Satisfaction Survey.				
• Use CMPCN-provided or CMPCN-approved survey measurement tool				
• Implement and document one quality improvement (QI) Project based on PSS results				
4. The Practice, Providers, and Staff participate in the CMPCN Learning Collaborative.				
• Attend at least 6 web-based Learning Collaboratives (at least 1 per quarter)				
• Post response to Learning Collaborative topic on PCN portal discussion board				
5. The Practice demonstrates the use of QI tools and training.				
• Create or demonstrate CQI infrastructure for office including identification of CQI leader				
• Implement and document two QI initiatives during the year				
- One QI initiative must be an improvement in a HEDIS measure (AWC, CIS, WC34, WC15, ASM)				
- The PSS CQI project may count as one of the two.				
6. The Practice implements and documents a process/policy for closed loop referral tracking.				
7. The Practice implements and documents a process/policy to manage high risk patients.				
• Provide care coordination				
• Work ED high utilizer list (e.g., asthma)				
• Practice will disseminate information to patients about member incentive programs (e.g., update website, publications, awareness, etc.)				
8. The Practice implements and documents a process/policy to manage transitions.				
• Identify patients with a hospital admission and/or ER visits and ensure appropriate office follow up				
9. The Practice implements and documents a care coordination process/policy with PCN Care Managers.				
• Practice responds to case management summaries on a quarterly basis (May count PCN portal summaries)				
• Practice collaborates with PCN Care Managers as necessary for care coordination.				
10. The Practice implements and documents a process/policy for addressing behavioral health concerns.				
• Development of a written process and use of a Depression Screening Tool (ex: PHQ-2)				
• Utilize behavioral health resources				
• Care coordination with PCN Care Managers				

Engagement Compensation Grid:

1. The maximum engagement compensation that can be earned is $3.00 pmpm.
2. PCMH NCQA Recognition: Level 1-3=$1.50 engagement compensation
3. PCN Engagement Compensation Point Achievement:
    a. 0-4 points=$0.00 engagement compensation
    b. 5-6 points=$1.50 engagement compensation
    c. 7-10 points=$3.00 engagement compensation

Through continuted 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.

Learning Collaborative

The Learning Collaborative concept has been utilized extensively in the support of the dissemination of information required for PCMH transformation. The PCMH transformation team has developed a model to use in community settings to coach practices by providing education related to the medical home model and allowing for educational topics to be presented. Each month, a 30-minute topic is presented. All clinics are encouraged to participate, including staff as well as 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, care management, and care coordination.

This monthly format also includes common collaborative learning techniques such as structured problem solving and opportunities for brainstorming. Sessions are recorded, which offers the practices an opportunity to review the materials at a later date. After each webinar, a question is posted encouraging co-directional communication between the primary care practices via a message board in the provider portal.

Learning Collaborative Topics for 2016:

2016 Kickoff

Member Incentive Programs (Missouri Care & Aetna Better Health of MO)

Asthma Action Plans & My Patients

It Is a Crisis: Depression & Adolescents

Vicarious Trauma… Compassion Fatigue: How Do We Care For Each Other & Ourselves?

HEDIS 102

Promotion of Childhood Oral Health-Prevention is Key

Pediatric Environmental Health

Child Protector: A Smartphone App Decision Tool for Medical & Investigative Personnel

Care Coordination: A Team Effort

Pediatric Care Network Secure Portal Redesign

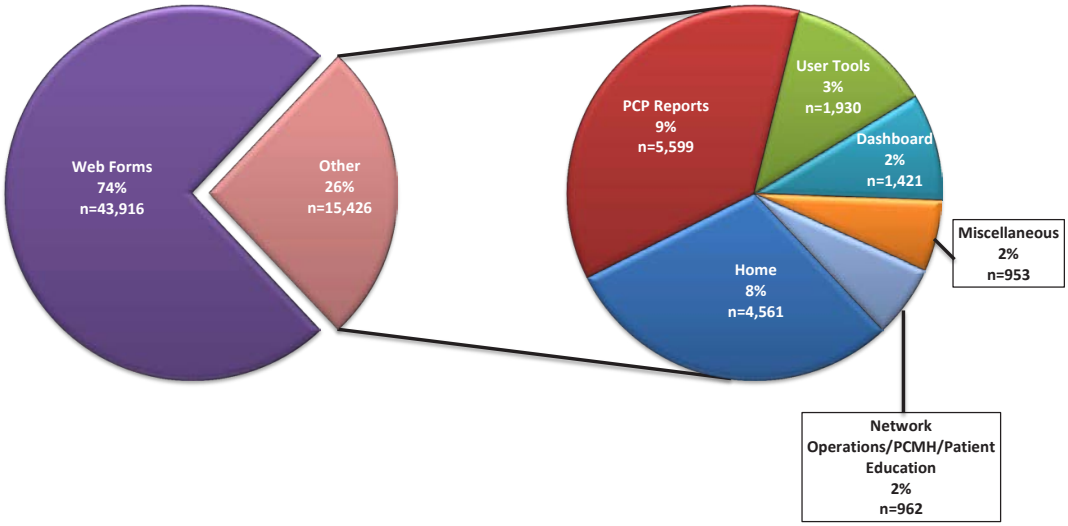
Quality Improvement: How to Get Started & Keep It Going!

Provider Portal

Usage of the secure portal by the providers is measured and monitored by the PCN. The following diagrams highlight the “hits” over the past three years and the areas utilized. The PCN Care Team staff continues to encourage use of the secure portal for population health efforts and increased communication and collaboration.

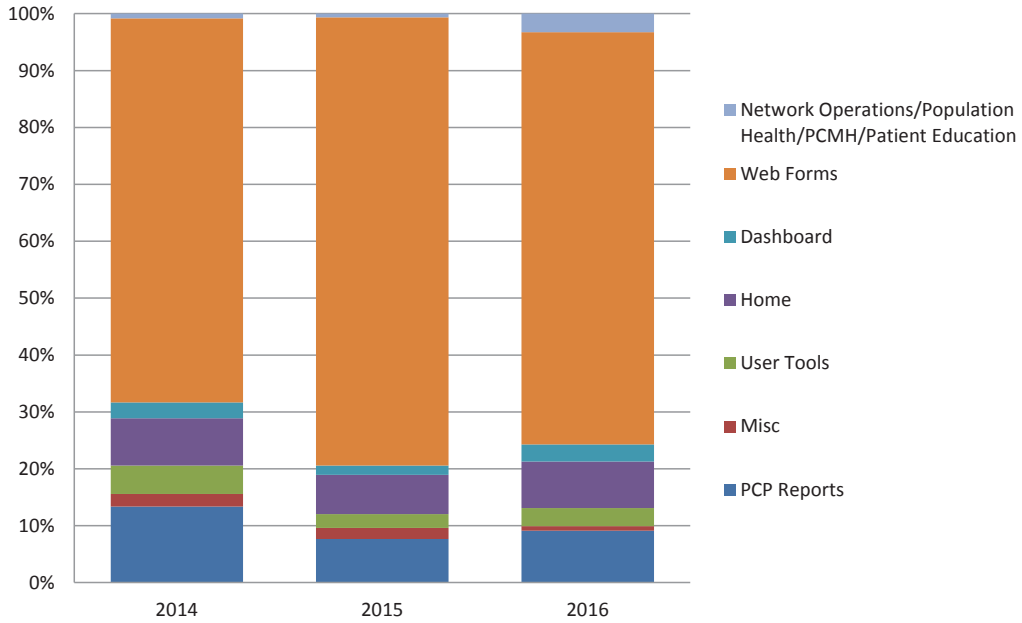
Provider Portal Hits

n=59,342
1/1/2014-12/31/2016



Provider Portal Hit Breakdown

n=59,342
1/1/2014-12/31/2016



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

Behavioral Health & Community Integration

There is ample data available to demonstrate improvements in patient outcomes, patient engagement, and decreased cost with a fully integrated medical and behavioral care delivery model. An important initiative for the PCN in 2016 involved a move in that direction through closer collaboration with the Health Plan partners to address medical/behavioral integration. While it will take several years to achieve full integration at the primary care level, resulting in co-location of primary medical and behavioral health services performed in a multi-disciplinary team environment, work toward this effort by the PCN started by cultivating improved communication and collaboration between the disciplines.

- Health Plan behavioral health case management staff were embedded with the PCN Care Teams for closer collaboration and co-management of medical and behavioral conditions for high-risk children.
- Provider surveys related to behavioral health were conducted in 2016 which identified gaps in behavioral health resources in the community and the lack of warm hand-off processes between PCPs and behavioral health providers. The Social Work Care Navigators will make onsite visits to the community mental health centers in 2017 to identify contacts within those organizations and bridge partnerships between the PCPs and community mental health centers.
- A process was developed for co-case management rounds to discuss difficult medical/behavioral cases with case management staff and leadership.
- One goal for 2016 was to co-lead a provider task force with the Health Plans to address integration of behavioral health and medical services – i.e., evaluate access and referral needs, educate about services available, facilitate communication between providers, etc. After further investigation, a local collaborative organization was discovered that includes both community behavioral health and community agency organizations. In 2016, two PCN Care Navigators became active participants in this group to enhance coordinated care across behavioral health, medical and community systems.
- In 2016, the PCN implemented a Community Connections Program aimed at identifying key community partners who interact with PCN members. The initiative involved developing relationships with individuals within the identified organizations, identifying educational needs from both PCN and the community agency, and facilitating information sharing and ongoing collaboration to meet the social and medical needs of the PCN population. As part of the Community Connections Program, a comprehensive online community and social service directory, the Community Engagement Resource Application (C.E.R.A.) was developed. This interactive tool is available to Care Teams, including provider practices, to assist in facilitating resources for patients and families. The database is designed around social determinants of health categories and allows for customized criteria to be searched, based on patient-specific needs. Another feature of C.E.R.A. is the ability for staff to search for educational opportunities and access agency specific event information. C.E.R.A. has proven to be a valuable resource for care coordination efforts. The Community Resource Specialist position was also created within the new Care Team model with many job duties related to the vetting of community resources and maintenance of the C.E.R.A. application.

Next Steps:

In 2017, the PCN SW Care Navigators will assist in coordinating educational opportunities for provider practices relating to behavioral health, in collaboration with Dr. Michelle Kilo and the Children's Mercy Developmental and Behavioral Clinic.

Topics include:

- Parenting and Behavioral Management for the PCP
- Basics of Pharmacology for the PCP
- Attention-Deficit/Hyperactivity Disorder (ADHD) for the PCP
- Trauma/Post-Traumatic Stress Disorder (PTSD) for the PCP
- Anxiety, Depression, & Suicidal Ideation for the PCP

Patient Experience

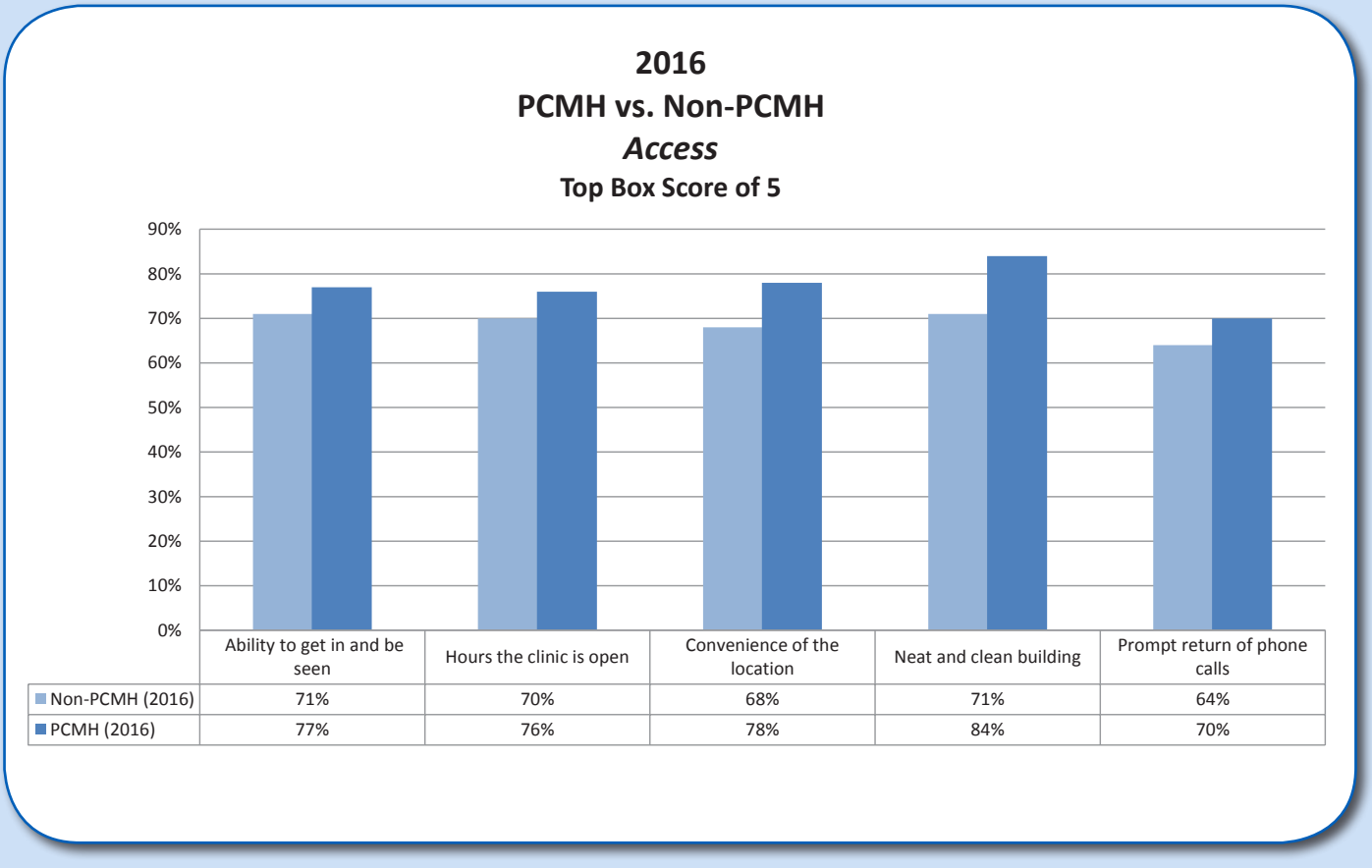
A component of PCMH encourages practices to obtain feedback from patients and families regarding their experience of care received. Four main categories are reviewed including: access, communication, whole-person care, and self-management.

For the Patient Satisfaction Survey, the PCN utilized a scale of 1 through 5 in which a score of 5 indicates "Great" and 1 indicates "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 accounts for the percentage of patients who selected a 5 as his/her response to a rating question on the survey. Responses that scored between the ranges of 1 and 4 were not accounted for as part of the top box scoring methodology.

Increased patient satisfaction among PCN members has been shown in almost all areas for the NCQA PCMH-recognized practices. In addition to comparing the year over year combined results for all PCN practices (2014-2016), the variable of NCQA PCMH-recognized vs. Non-PCMH recognized practices was included in the analysis beginning in 2016.

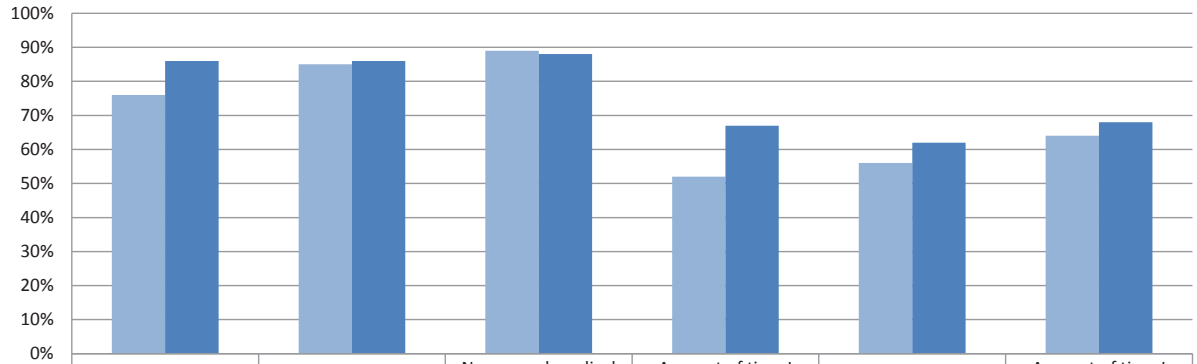
Analysis

The addition of the variable of NCQA PCMH-recognized vs. Non-PCMH recognized practices provided valuable insight on the value of becoming a PCMH-recognized practice to patients and their caregivers. As evidenced in the graphs, the scores are consistently higher for NCQA PCMH-recognized practices nearly across the board. This consistency outweighed a small decrease in combined scores for all PCN practices in 2016. The overall decrease in scores for all PCN practices can be attributed to a changing population and an ever-changing mix of provider practices who participate in the Patient Satisfaction Survey initiative.



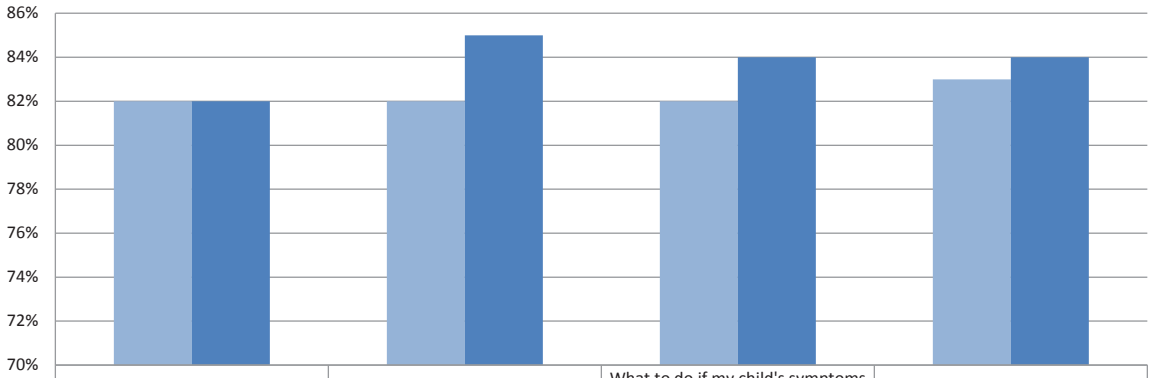
	Ability to get in and be seen	Hours the clinic is open	Convenience of the location	Neat and clean building	Prompt return of phone calls
Non-PCMH (2016)	71%	70%	68%	71%	64%
PCMH (2016)	77%	76%	78%	84%	70%

2016
PCMH vs. Non-PCMH
Communication
Top Box Score of 5



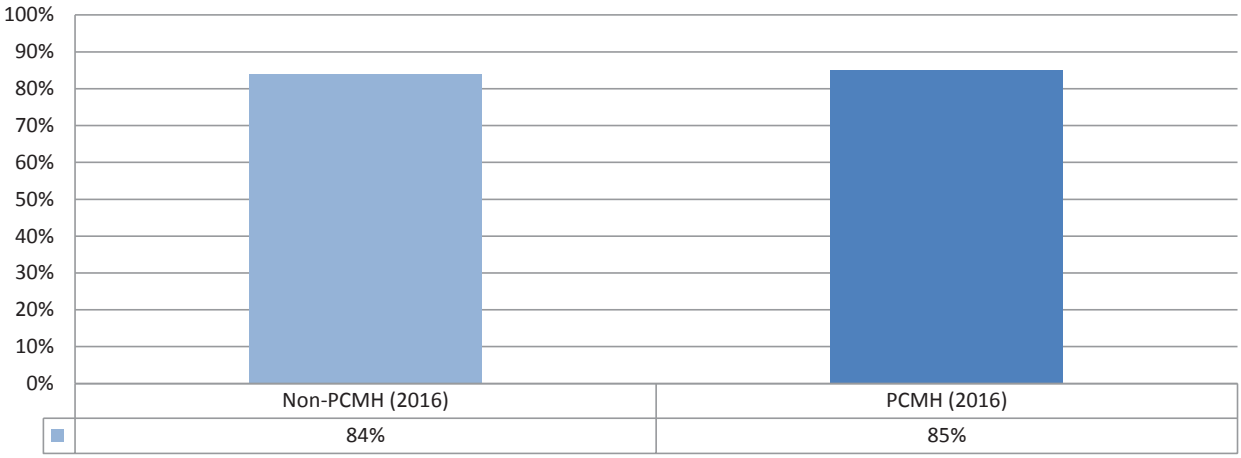
	Comfort and safety while waiting	Front desk is friendly and helpful	Nurses and medical assistants are friendly and helpful	Amount of time I spend in waiting room	Amount of time I spend in exam room	Amount of time I spend waiting for tests to be performed
Non-PCMH (2016)	76%	85%	89%	52%	56%	64%
PCMH (2016)	86%	86%	88%	67%	62%	68%

2016
PCMH vs. Non-PCMH
My provider helps me care for my family by explaining things like:
Top Box Score of 5

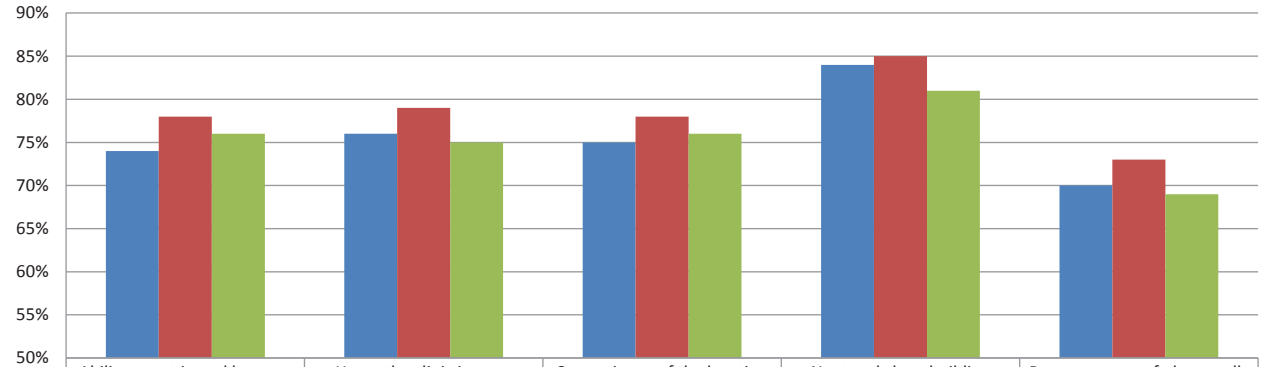


	Medications and side effects	How to care for my child at home	What to do if my child's symptoms change	Other help available to me
Non-PCMH (2016)	82%	82%	82%	83%
PCMH (2016)	82%	85%	84%	84%

2016
PCMH vs. Non-PCMH
What is the chance you would refer friends or family to us?
Top Box Score of 5

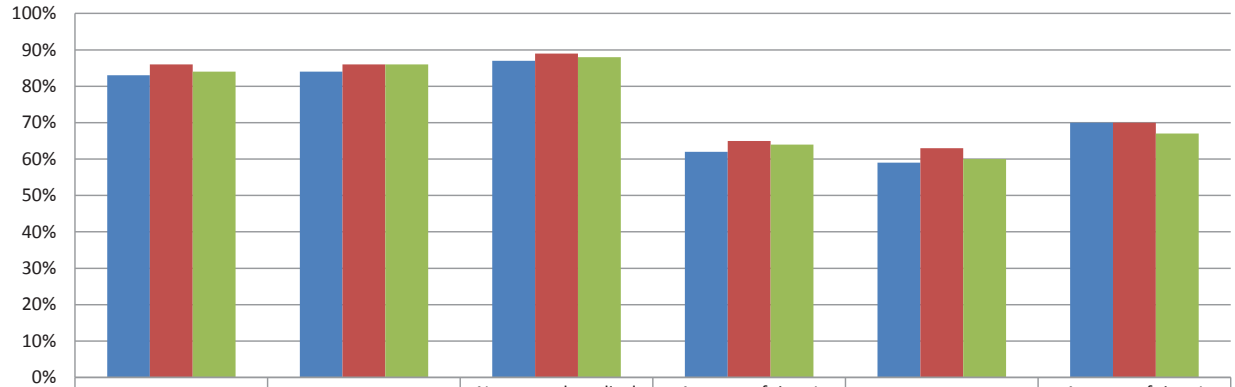


2014-2016
All PCN Practices
Access
Top Box Score of 5



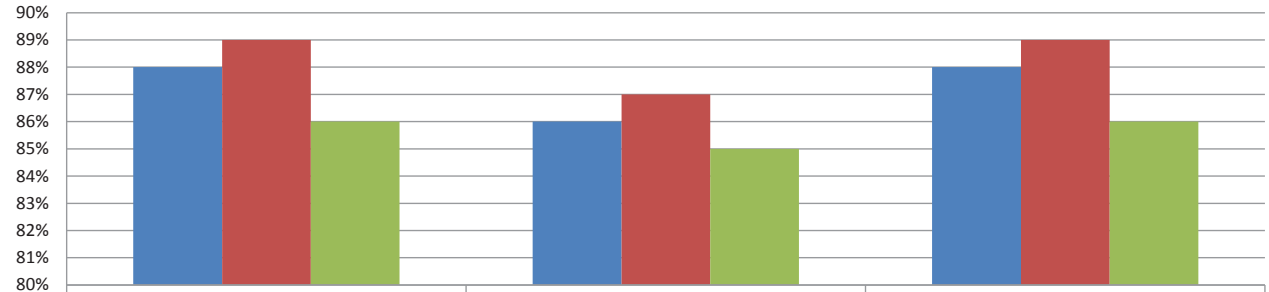
	Ability to get in and be seen	Hours the clinic is open	Convenience of the location	Neat and clean building	Prompt return of phone calls
2014	74%	76%	75%	84%	70%
2015	78%	79%	78%	85%	73%
2016	76%	75%	76%	81%	69%

2014-2016
All PCN Practices
Communication
Top Box Score of 5

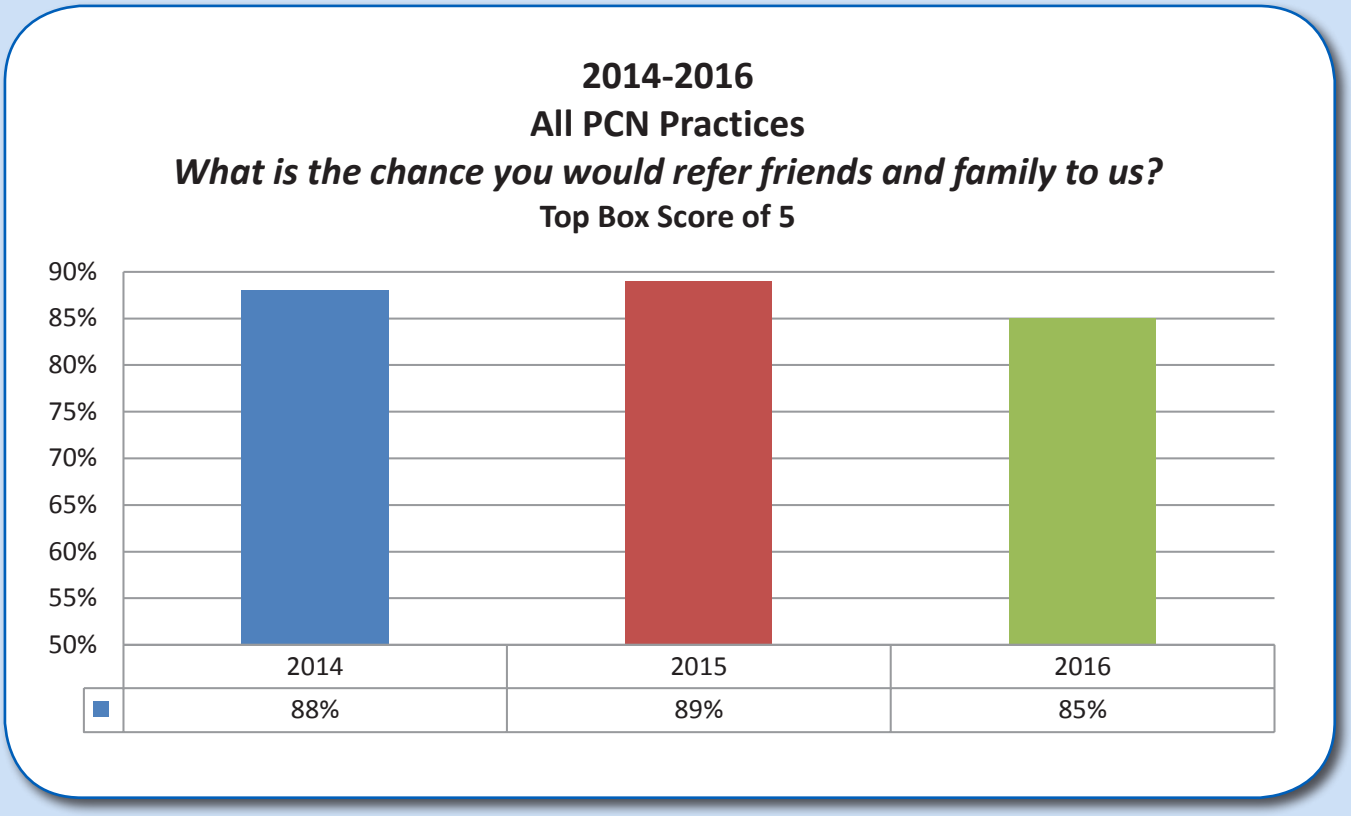


	Comfort and safety while waiting	Front desk is friendly and helpful	Nurses and medical assistants are friendly and helpful	Amount of time I spend in waiting room	Amount of time I spend in exam room	Amount of time I spend waiting for tests to be performed
2014	83%	84%	87%	62%	59%	70%
2015	86%	86%	89%	65%	63%	70%
2016	84%	86%	88%	64%	60%	67%

2014-2016
All PCN Practices
Communication/Whole Person Care
My provider.....
Top Box Score of 5



	Listens to me	Spends enough time with me	Explains what I want to know
2014	88%	86%	88%
2015	89%	87%	89%
2016	86%	85%	86%


2014-2016
All PCN Practices
What is the chance you would refer friends and family to us?
Top Box Score of 5
90%
85%
80%
75%
70%
65%
60%
55%
50%
2014
2015
2016
88%
89%
85%

Provider Experience

A short survey was distributed to all clinics in the PCN to assess their satisfaction with the medical home team, Care Navigators, and prior authorization staff members. The Provider Satisfaction Survey contained eight questions. Top scores produced from the PCN's Provider Satisfaction Survey show the PCN generating significant score increases from the prior year in the following areas:

- **Refer Patient To Case Management/ Disease Management**
  - I know how to refer a patient to the case management/disease management program.
    - 2015: 88.9%
    - 2016: 92.3%
- **Partnership with Medical Home Team**
  - Partnership with the CMPCN Medical Home Team has positively impacted patient care in the following way (care coordination).
    - 2015: 69.2%
    - 2016: 85.7%
- **Collaborative Service Agreements**
  - My practice would benefit from a collaborative agreement (consultation) with the specialist regarding the following to further enhance the medical neighborhood.
    - Clearly defined roles for each provider (PCP and specialist)
      - 2015: 7.7%
      - 2016: 38.5%
    - Concise summary of care collaboration needed
      - 2015: 46.2%
      - 2016: 53.9%
    - Decreasing chance of fragmented care
      - 2015: 38.5%
      - 2016: 46.2%

Using the top two box method (including 5 – "Agree" & 4 – "Somewhat Agree"), some questions maintained a score of 100% from 2015 to 2016, including the following:

- High Risk Disease Management
  - I'm able to easily identify my high risk disease management patients on the portal.
- Prior Auth Staff
  - When speaking with the PCN prior authorization staff, I find them to be respectful and courteous.
  - I am able to easily locate prior authorization forms and other resources on the PCN website.
  - Rate your overall experience with PCN prior authorization staff (rated "Excellent" or "Good").

In 2016, a question related to recent changes to the PCN Provider Portal was added to the survey.

- Have the recent changes to the PCN Provider Portal been beneficial?
  - Yes: 85%
  - No: 15%

Analysis:

With the increased emphasis from the providers on the importance of Collaborative Service Agreements (CSA) and the planned 2017 rollout of a Children's Mercy Hospital CSA, the PCN will provide guidance and support to the provider practices on this important tool for care coordination.

To address areas with score decreases from 2015-2016, the Care Teams will utilize the quarterly provider performance meetings to educate about key functions of the PCN such as prior auth, care coordination, etc. The Provider Satisfaction Survey will continue to serve as a metric to assess and improve the provider experience.

Local Community Care Coordination Program (LCCCP) Measures

The PCN is a state-approved Local Community Care Coordination Program (LCCCP) model focusing on providing care management, care coordination and disease management through the local healthcare providers. Below are some of the key LCCCP metrics since implementing the LCCCP on July 1, 2016. PCN will utilize these baseline metrics to identify areas to target for improvement efforts. Additional metrics are being added in 2017 to reflect care coordination and member and provider satisfaction.

Category	General Population Data	Frequency	Q1 July-Sept FY2017	Q2 Oct-Dec FY2017
Providers	**Total number of Providers:** Number of providers in the LCCCP for the reporting period.	Quarterly/Annual	1,216	1,220
Members	**Total number of Members:** Number of members in the LCCCP for the reporting period	Quarterly/Annual	68,055	70,935
Category	**Access**	**Frequency**	**Q1 July-Sept FY2017**	**Q2 Oct-Dec FY2017**
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)	Quarterly/Annual	16.0%	17.1%
Category	**Care Coordination**	**Frequency**	**Q1 July-Sept FY2017**	**Q2 Oct-Dec FY2017**
Transitional Support	**Transitional Care Support:** Percentage of hospital-discharged members who had an ER visit within 30 days of discharge.	Quarterly/Annual	2.7%	2.7%
Category	**Pediatric Behavioral Health**	**Frequency**	**Q1 July-Sept FY2017**	**Q2 Oct-Dec FY2017**
Pediatric Behavioral Health	**Depression Closed Loop Referral Process:** Percentage of PCP practices with a documented process that completed closed loop referral tracking process. This is measured based on a review of a minimum of 30 behavioral health chart audits from the previous 12 months, with a minimum of 7 chart audits from each quarter. Chart audit samples are based on members identified with behavioral health claims for depression.	Quarterly/Annual	17.4%	8.3%
Category	**Condition Management**	**Frequency**	**Q1 July-Sept FY2017**	**Q2 Oct-Dec FY2017**
Pediatric Asthma	**Asthma Prevalence:** Members identified with a diagnosis of asthma as a percentage of total members through 20 years of age - look back period of 12 months for asthma diagnosis	Quarterly/Annual	13.2%	13.5%
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 - look back period of 12 months for diabetes diagnosis	Quarterly/Annual	0.3%	0.3%

Category	Utilization	Frequency	Q1 July-Sept FY2017	Q2 Oct-Dec FY2017
Emergency Room	**Emergency Room Utilization:** ER Visits per 1,000 members	Quarterly/Annual	573	634
Inpatient	**Hospital Readmission:** Hospital readmissions within 30 days - all cause	Quarterly/Annual	2.3%	2.0%
	Inpatient Utilization - Admissions: Inpatient Admissions per 1,000 members	Quarterly/Annual	41	47
	Inpatient Utilization - Days: Inpatient Days per 1,000 members	Quarterly/Annual	148	176
Cost of Care	**Cost of Care: Hospital Inpatient – Acute Medical/Surgical:** Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$15	$17
	Cost of Care: Hospital Inpatient – Maternity: Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$2	$1
	Cost of Care: Hospital Outpatient – ASU: Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$26	$22
	Cost of Care: Hospital Outpatient – ER: Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$49	$49
	Cost of Care: Hospital Outpatient – All Other: Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$46	$39
	Cost of Care: Physician/Professional – Office Visits: Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$12	$11
	Cost of Care: Physician/Professional – All Other: Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$11	$10
	Cost of Care: Pharmacy: Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$58	$68
	Cost of Care: Ancillary – DME: Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$2	$2
	Cost of Care: Ancillary – Home Health: Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$1	$0
	Cost of Care: Ancillary – All Other: Per Member Per Month (PMPM) cost total and by service category.	Quarterly/Annual	$0	$1
Out of Network Utilization	**Outside of LCCCP Primary Care Utilization:** Percentage of utilization for primary care services outside the LCCCP network	Quarterly/Annual	13.4%	16.1%

Data Analytic Tools

Financial Data Analytics

The 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. Our financial analytic capabilities measure and track key health cost and utilization measures (i.e., risk levels, paid per member per month, admissions/1000, days/1000, average length of stay, ER visits/1000, etc.) at the network, practice, and provider level. We have developed capabilities to deliver actionable and meaningful cost and utilization data directly to PCN practices and providers. (See Provider Practice Performance Profile package on pages 30-38) More specifically, the data includes meaningful insights on cost/utilization variation as well as actionable information on a practice's highest cost and highest risk patients. Information was normalized and risk-adjusted to alleviate concerns of differences in patient acuity. Finally, our financial analytical capabilities continue to support our ability to evaluate existing programs and identify new initiatives to more effectively manage the population and deliver value.

Risk Stratification & Predictive Modeling

Risk stratification and predictive modeling are fundamental in terms of population management. Unfortunately, the patients who are the highest risk today are often not the highest risk patients from a year ago. In fact, only approximately 30% of patients who are highest risk today were also highest risk the previous year. Making the most effective use of resources to reduce overall spending requires increased focus on complex and costly patients. In a study of over 3 million patients, approximately 5% of the population accounted for 50% of health care costs each year, with more than one in three (~38%) of these "super-utilizers" remaining in the most costly 5 percent of people the following year (Figure 1).

Figure 1: Using Risk Stratification to Focus Resources on Medically Complex Super Utilizers

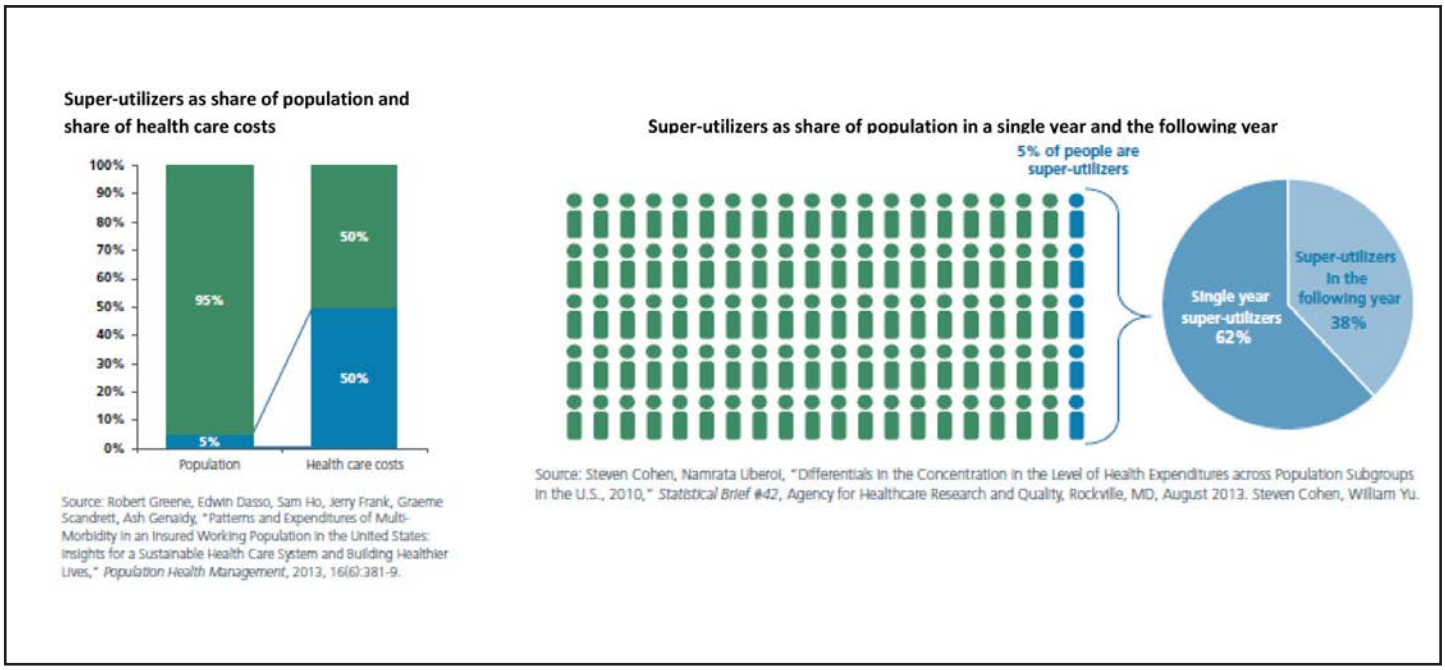
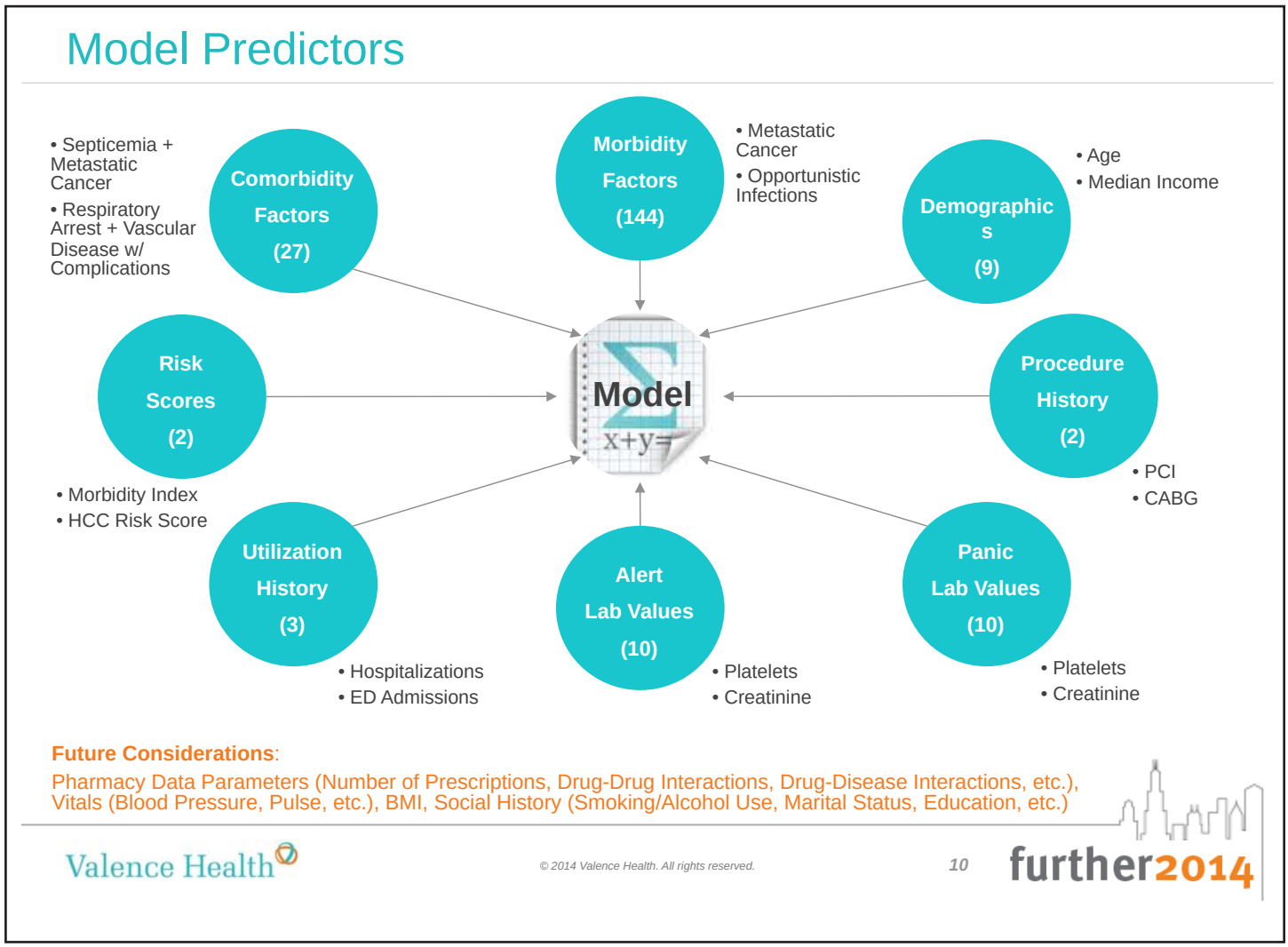


Figure 2: Example Financial Predictive Model

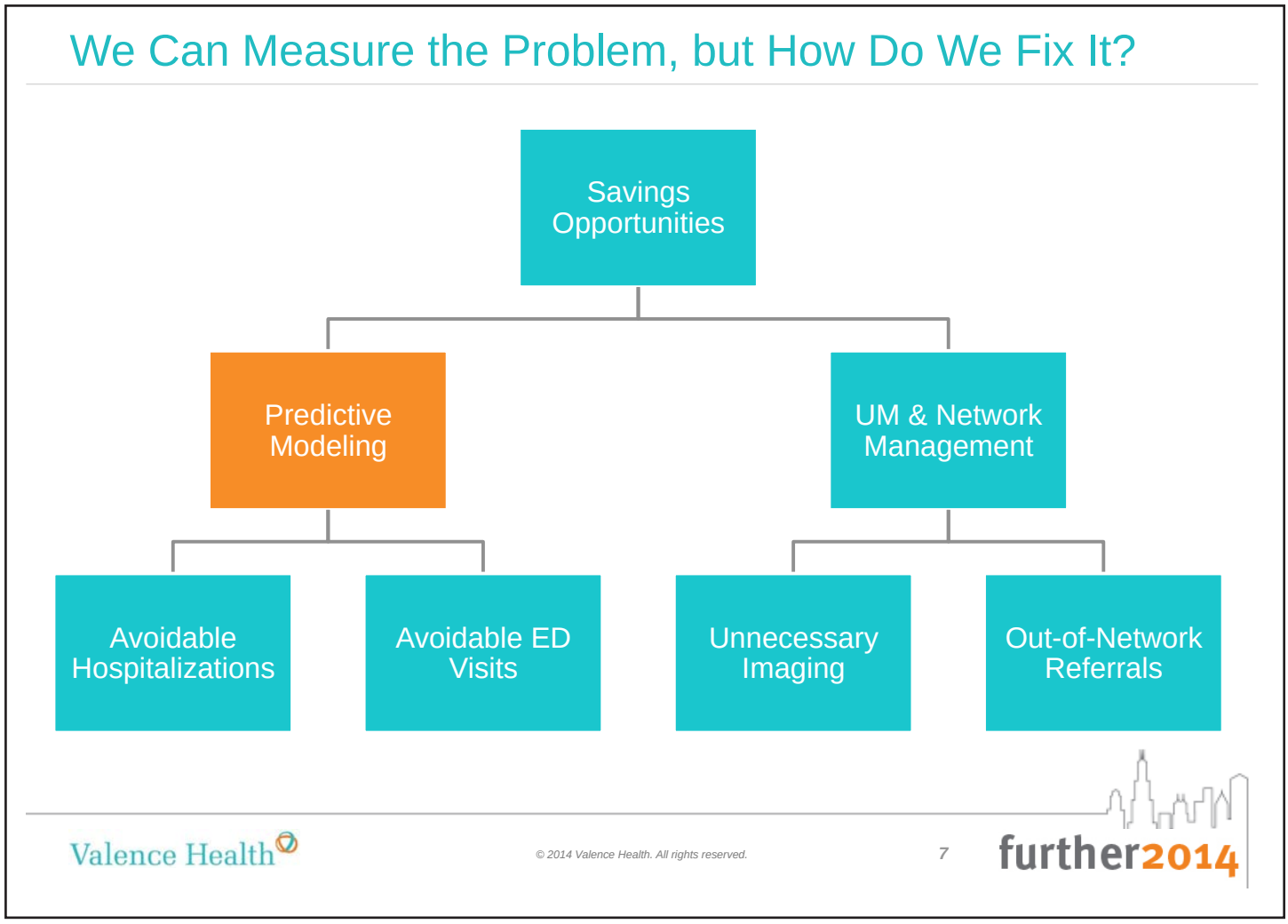


Valence Health Further 2014 Conference. Value-Based Insights & Opportunities. Sept 10-12, 2014.

The PCN uses risk stratification and predictive modeling capabilities to identify and actively manage these highest risk patients (Figure 2). Risk stratification is essential in the allocation of limited care management resources, allowing organizations to tailor care protocols and clinical guidelines to provide the most efficient and effective care (i.e., complex case management, case management, care coordination).

Advanced predictive models associate patients with the likelihood of a particular adverse event (i.e., ED visit, hospitalization, or readmission) and can allow the PCN to deploy targeted interventions. As the PCN's financial and clinical analytics vendor (Evolent, formerly Valence Health) develops more advanced predictive models, the PCN plans to use the information to prevent avoidable hospitalizations and ED visits (Figure 3). The PCN also plans to use our financial analytics solution to promote coordinated, non-redundant, high quality care within our network. Finally, the PCN plans to use our data to examine utilization patterns and identify potential areas to eliminate redundant and unnecessary services (imaging, labs, etc.).

Figure 3: Using Financial Analytics and Predictive Modeling to Identify Cost Saving Opportunities



Valence Health Further 2014 Conference. Value-Based Insights & Opportunities. Sept 10-12, 2014.

Enhanced Clinical Analytics

The PCN is advancing our clinical analytical capabilities (i.e., registries, HEDIS quality measures, care management, etc.) with the integration of claims data, risk stratification, and predictive modeling. For example, the PCN uses the cost data to measure the effectiveness and return on investment of specific care management protocols and programs (i.e., disease management, readmission prevention program, PCMH, complex case management, etc.). This is important for ongoing evaluation, allocating the right mix of resources for particular populations, and identifying areas for continuous improvement.

Provider Practice Performance Profile

The Provider Practice Performance Profile is a quarterly report provided to the PCN practices by the assigned PCN Care Teams. The report allows provider practices to review quarterly cost, utilization, and key quality metrics that compare performance at the network, practice, and provider levels.

In order to drive value and deliver insightful and actionable information, the PCN performs data analysis of trends and variation to identify potential opportunities to drive quality improvement initiatives, in collaboration with the provider practices. This profile includes the following reports: Network Profile Summary, Practice Detail Report, Provider Level Report, Patient Outreach Priority List, and Cost and Utilization Reports.

The planning and preparation for the Provider Practice Performance Profile was initiated in 2016 with an expected Q2 2017 rollout to the provider practices.

Provider Performance Practice Profile

The PCN Quarterly Provider Practice Performance Profile report package informs practices of their quality and cost performance and provides observations and potential improvement ideas for review and collaboration with each practice.

PEDIATRIC CARE NETWORK QUARTERLY REPORT PACKAGE

[redacted]

To deliver high-value care which meets the Triple Aim of Better Care, Smarter Spending, and Healthier Children, Pediatric Care Network (PCN) practices must be informed of quality and cost performance for their attributed PCN patients. The PCN Quarterly Provider Practice Performance Profile report package informs practices of their quality and cost performance and provides observations and potential improvement ideas for consideration and review with each practice.

This report package is being introduced in the second quarter of 2017.
We are striving to make the information useful, valuable, and actionable. We welcome your feedback!

Provider Practice Performance Profile

Quality Performance Report - *Observations & Potential Improvement Ideas*

Observations and Comments

Performed well in the following areas:

- Asthma Management (exceeded the network average **and** HEDIS 75th Percentile in 2016)
- Well-Child visits 0-15 months of age (exceeded the network average **and** HEDIS 75th Percentile in 2016)
- Adolescent Well-Child visits (exceeded the network average **and** HEDIS 50th Percentile 2016)
- PCN Provider & Practice Engagement Measure (received full compensation payout in 2016)

Potential opportunities:

- Immunizations: Combo-2 (needed 36 additional patients to meet the HEDIS 50th percentile in **and** 42 additional patients to meet the HEDIS 75th percentile in 2016)
- Well-Child visits 3-6 years of age (needed 61 additional patients to meet the HEDIS 50th percentile in **and** 97 additional patients to meet the HEDIS 75th percentile in 2016)
- PCP alignment rate of 77% (23% of assigned patients have not made a visit to the practice in the last 2 years)

Potential Improvement Ideas and Resources for Discussion

How to accomplish:

- Perform a clinical and billing/coding review with the practice to assess the cause of the variation in vaccinate rates within the combo-2 measure (DTaP - 62.6%, IPV – 75.6%, MMR – 81.7%, HiB- 80.5%, Hep B – 75.6%, VZV – 82.3%).
- Perform outreach to PCN patients needing a Well-Child visit in order to meet compliance on Well-Child visits 3-6 years of age.
- Develop a process for converting an ill/sick visit to a Well-Child visit using the Vision pre-visit planning tool. If unable to convert, develop process to schedule follow up well visit.
- Partner with Provider Relations representative to review PCP alignment process and work together to correctly assign patients' PCP.
- Follow up with education on current EMMI call procedure/policy.

Meeting Discussion Summary & Notes

Attendees: _____ Date of Onsite Review: _____

The following section is used for in-meeting notes and for PCN staff to document a summary of the meeting discussion.

Next Steps

The following next steps were identified during the quarterly review. Please identify the responsible resources and/or targeted timelines as applicable.

PCP Performance Reports

Network Overall Summary

Presents overall network performance, as well as individual performance, for each practice on key HEDIS measures

HEDIS Measurement Period: CMICS - HEDIS 2016 (MY 2016)
Data Source: Valence Vision
Run Date: 03/16/2017

Measure	Your Practice	50th Perc	75th Perc	Network Overall	PCN Practices 1	2	3	4	5	6	7	8	9	10	11	12	13	15	16	17
HEDIS Quality Performance Measures																				
Asthma Management																				
Medication management - 75% compliant	59.6%	24.2%	31.2%	49.0%	61%	39%	67%	36%	44%	100%	35%	60%	46%	41%	63%	72%	67%	62%	52%	63%
Immunizations - Childhood Age 2																				
Combo-2 (Dtap, IPV, MMR, HiB, HepB, VZV)	54.2%	75.5%	79.4%	40.8%	43%	35%	25%	46%	46%	33%	49%	31%	36%	22%	36%	28%	38%	39%	34%	55%
Well Child Visits - First 15 Months																				
6 well visits before 15 months of age	70.0%	59.8%	66.2%	43.1%	54%	32%	50%	36%	41%	33%	32%	67%	29%	31%	42%	31%	63%	45%	39%	51%
Well Child Visits - 3-6 Years																				
At least one annual well exam in measurement year	60.0%	72.0%	78.5%	49.4%	48%	62%	10%	46%	62%	25%	55%	41%	43%	35%	42%	22%	49%	43%	36%	49%
Well Child Visits - 12-21 Years																				
At least one annual well exam in measurement year	48.1%	49.2%	60.0%	37.0%	35%	49%	16%	34%	57%	9%	48%	21%	30%	22%	32%	15%	44%	34%	20%	32%
# of Measures Exceeding HEDIS 50th Percentile	2				1	1	1	1	2	1	1	2	1	1	1	1	2	1	1	1
Early & Periodic Screening, Diag., and Treatment - 0-6 Years																				
Expected screening in measurement year	67.7%	NA	80.0%	63.1%	64%	65%	33%	55%	77%	62%	70%	51%	59%	53%	66%	21%	70%	69%	55%	57%
PCN Provider & Practice Engagement Measure																				
NCQA PCMH Recognition (Level 1, 2, or 3)	1.0				1.0	1.0	NA	0.0	1.0	NA	1.0	NA	1.0	1.0	1.0	0.0	0.0	1.0	0.0	1.0
Use of Team-Based Care to Work 3 Registries	1.0				1.0	1.0	NA	1.0	1.0	NA	0.5	NA	1.0	1.0	1.0	1.0	1.0	1.0	0.0	1.0
Patient Satisfaction Survey & Improvement Initiative	0.5				0.5	0.5	NA	1.0	1.0	NA	0.5	NA	1.0	0.5	1.0	1.0	0.5	0.5	0.0	0.5
Learning Collaborative Participation	1.0				1.0	1.0	NA	1.0	1.0	NA	1.0	NA	1.0	1.0	0.0	0.0	1.0	0.5	0.0	1.0
CQI Infrastructure and/or 2 Quality Improvement Initiatives	0.5				1.0	0.5	NA	1.0	1.0	NA	0.5	NA	1.0	0.5	0.5	1.0	0.5	1.0	0.0	1.0
Closed Loop Referral Tracking Process	1.0				1.0	1.0	NA	1.0	1.0	NA	1.0	NA	1.0	1.0	1.0	1.0	1.0	1.0	0.0	1.0
Established Process to Manage High Risk Patients	1.0				1.0	1.0	NA	0.0	1.0	NA	0.5	NA	1.0	1.0	1.0	1.0	1.0	1.0	0.0	1.0
Established Process to Manage Transitions	1.0				1.0	1.0	NA	1.0	1.0	NA	1.0	NA	1.0	1.0	1.0	1.0	1.0	1.0	0.0	1.0
Established Care Coordination Process with PCN Care Navigators	1.0				1.0	1.0	NA	1.0	1.0	NA	1.0	NA	1.0	1.0	1.0	1.0	1.0	1.0	0.0	1.0
Established Process to Address Behavioral Health Concerns	1.0				1.0	0.5	NA	1.0	1.0	NA	1.0	NA	1.0	1.0	1.0	0.5	0.0	1.0	0.0	1.0
Total Engagement Points	9.0				9.5	8.5		8.0	10.0		8.0		10.0	9.0	8.5	7.5	7.0	9.0		9.5

Practice Detail Report

Presents a practice summary for the number of patients who have yet to be seen by the provider in order for the practice to meet the national benchmarks of either the 50th or 75th percentile of incentive-based quality measures.

HEDIS Measurement Period: CMICS - HEDIS 2016 (MY 2016)
Data Source: Valence Vision
Run Date: 03/16/2017

Measure	Num	Denom	Your Practice	50th Perc	Patients to 50th Perc	75th Perc	Patients to 75th Perc	Network Overall
HEDIS Quality Performance Measures								
Asthma Management								
Medication management - 75% compliant	31	52	59.6%	24.2%	0	31.2%	0	49%
Immunizations - Childhood Age 2								
Combo-2 (Dtap, IPV, MMR, HiB, HepB, VZV)	90	166	54.2%	75.5%	36	79.4%	42	41%
Well Child Visits - First 15 Months								
6 well visits before 15 months of age	126	180	70.0%	59.8%	0	66.2%	0	43%
Well Child Visits - 3-6 Years								
At least one annual well exam in measurement year	337	562	60.0%	72.0%	68	78.5%	105	49%
Well Child Visits - 12-21 Years								
At least one annual well exam in measurement year	242	503	48.1%	49.2%	6	60.0%	60	37%
# of Measures Exceeding HEDIS 50th Percentile			2					
Early & Periodic Screening, Diag., and Treatment - 0-6 Years								
Expected screening in measurement year	766	1131	67.7%	NA	NA	80.0%	139	63%
Number of Assigned Patients			2,345					

Benchmark percentiles are based upon 2015 National HEDIS performance for Medicaid

Performance exceeds HEDIS 75th Percentile

Performance is between HEDIS 50th & 75th Percentile

PCN HEDIS QualityCompensation

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

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

EPSDT Comp

EPSDT achie

above 80% for

age = $1.00

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

Provider Level Report

Presents a comparison of provider and practice level data to overall network performance.

HEDIS Measurement Period: CMICS - HEDIS 2016 (MY 2016)
Data Source: Valence Vision
Run Date: 03/16/2017

Measure	Num	Denom	Your Practice	50th Perc	Patients to 50th Perc	75th Perc	Patients to 75th Perc	Network Overall			
HEDIS Quality Performance Measures											
Asthma Management											
Medication management - 75% compliant	31	52	59.6%	24.2%	0	31.2%	0	49%	70%	36%	0%
Immunizations - Childhood Age 2											
Combo-2 (Dtap, IPV, MMR, HiB, HepB, VZV)	90	166	54.2%	75.5%	36	79.4%	42	41%	56%	51%	56%
Well Child Visits - First 15 Months											
6 well visits before 15 months of age	126	180	70.0%	59.8%	0	66.2%	0	43%	74%	67%	50%
Well Child Visits - 3-6 Years											
At least one annual well exam in measurement year	337	562	60.0%	72.0%	68	78.5%	105	49%	62%	56%	63%
Well Child Visits - 12-21 Years											
At least one annual well exam in measurement year	242	503	48.1%	49.2%	6	60.0%	60	37%	49%	49%	33%
# of Measures Exceeding HEDIS 50th Percentile			2						2	3	0
Early & Periodic Screening, Diag., and Treatment - 0-6 Years											
Expected screening in measurement year	766	1131	67.7%	NA	NA	80.0%	139	63%	68%	68%	60%
Number of Assigned Patients			2,345						1,393	844	108

Benchmark percentiles are based upon 2015 National HEDIS performance for Medicaid
Performance exceeds HEDIS 75th Percentile
Performance is between HEDIS 50th & 75th Percentile

PCN HEDIS QualityCompensation
1 Measure Achieving 50th Percentile AND 1 Measure Achieving 75th Percentile = $1.00 PMPM
At Least 3 of 5 Measures Achieving 50th Percentile = $1.50 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 Valence 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.

Patient Outreach Priority List (Most Care Gaps)

Presents provider and practice with a comprehensive list of their patients, allowing the practice to prioritize outreach contacts according to the patient's number of gaps in care.

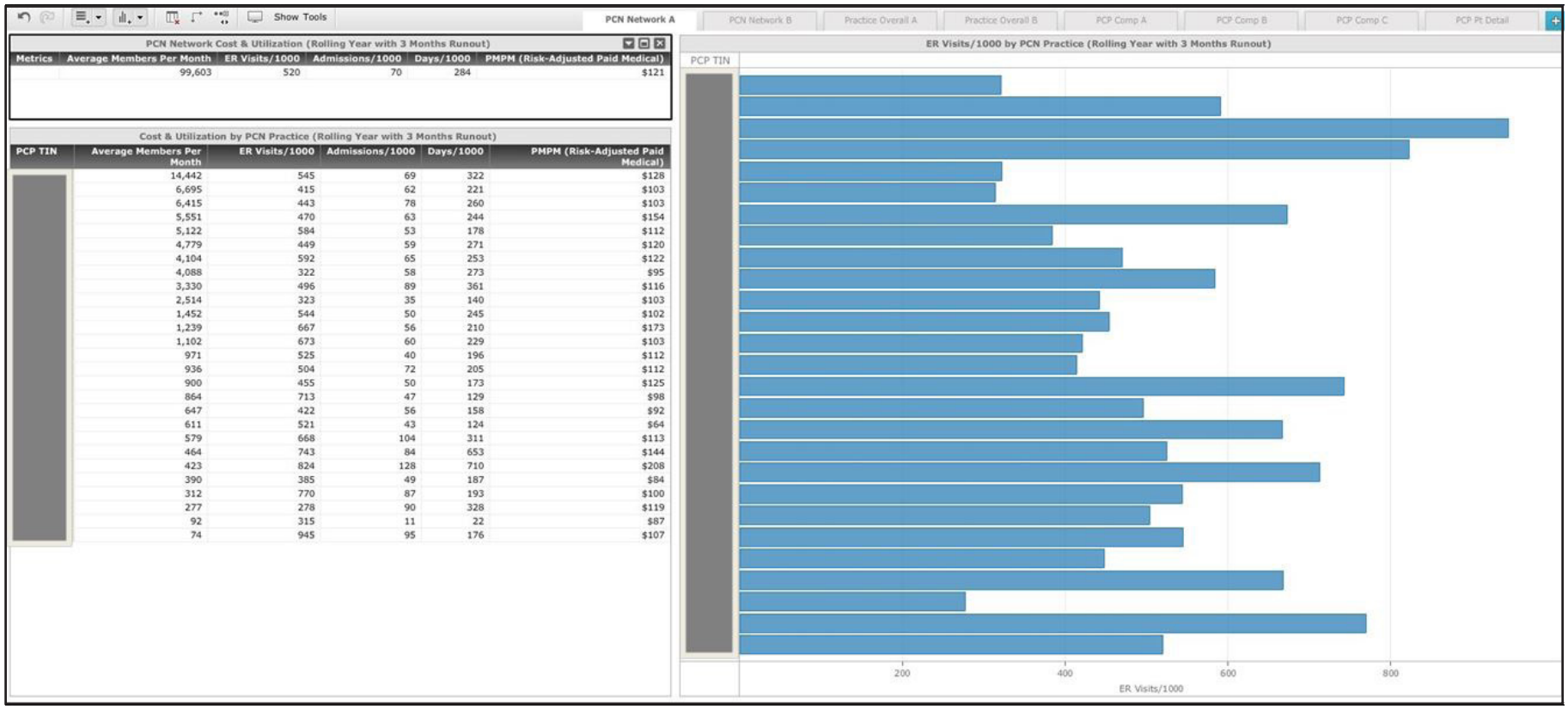
Data Last Updated: 3/15/2017
PCP OrgProviderID:
PCP OrgProvider TaxID:
PCP OrgProvider Name:
Compliant: X
Aged Out: A
Non-Compliant: blank
Not-Applicable: grayed out

										Gaps In Care - Compensation											Gaps In Care - Non-Compensation							
										CIS	CIS	CIS	CIS	CIS	CIS	W15	W34	AWC	EPSDT	MMA	CIS	CIS	CIS	CIS	CHIPRA	CHIPRA	FLU
										Combo 2											Non - Combo 2						
Mbr Name	Mbr DOB	Mbr Age	Gender	Mbr DCN	PCP Name	Mbr Phone #	Last PCP Visit With Our Practice	# of Comp Care Gaps	# of Total Care Gaps	DTaP	HepB	HiB	IPV	MMR	VZV					75%	HepA	Infl	PCV	Roto	HbA1c	Neph	Infl
		2	M					2	3	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	
		3	M					2	3	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	
		4	F					2	3	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	
		3	F					2	3	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	
		2	F					2	3	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	
		4	F					2	3	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	
		4	M					2	3	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	
		2	F					2	3	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	
		5	F					2	3	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	
		4	M					2	3	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	
		1	M					2	3							A	n/a	n/a		n/a					n/a	n/a	
		5	M					2	3	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	
		3	F					2	3	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	
		2	F					2	3	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	
		5	M					2	3	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	
		3	F					2	3	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	
		3	M					2	3	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	
		3	F					2	3	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	
		5	M					2	3	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	
		4	F					2	3	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	
		3	F					2	3	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	
		5	M					2	3	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	
		4	F					2	3	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	
		5	F					2	3	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	

Cost & Utilization Reports

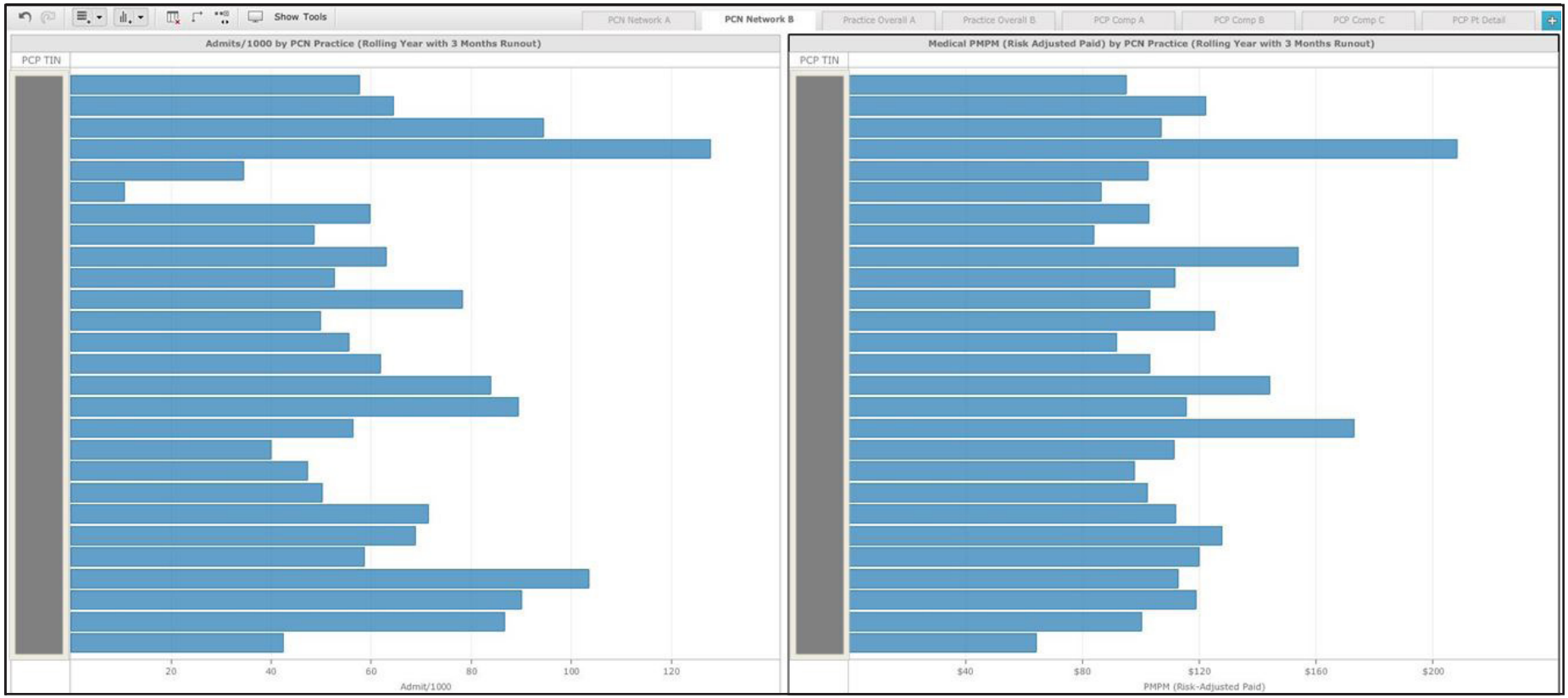
Network Overall Summary

Presents overall network performance, as well as individual performance, for each practice on key cost and utilization measures.



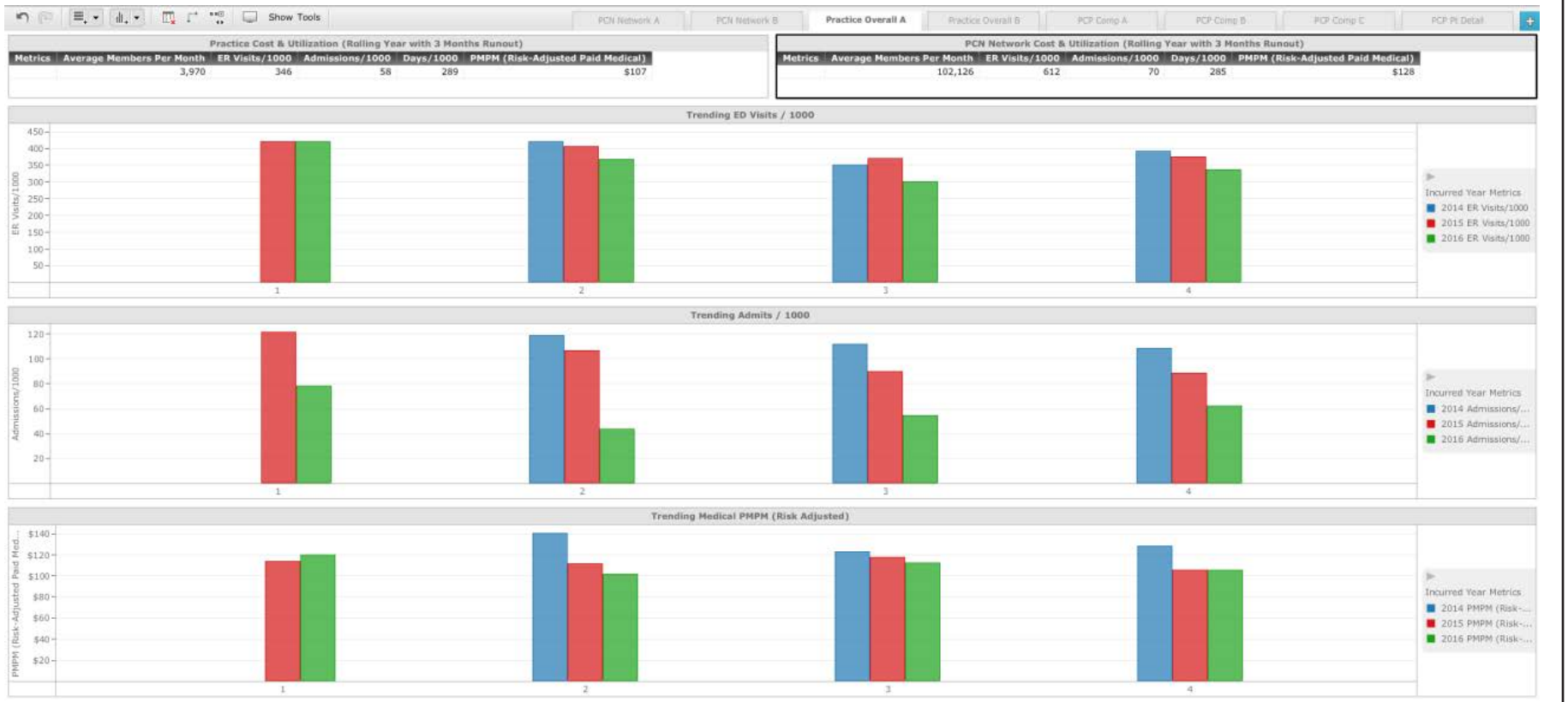
Network Overall Summary

Presents overall network performance, as well as individual performance, for each practice on key cost and utilization measures.



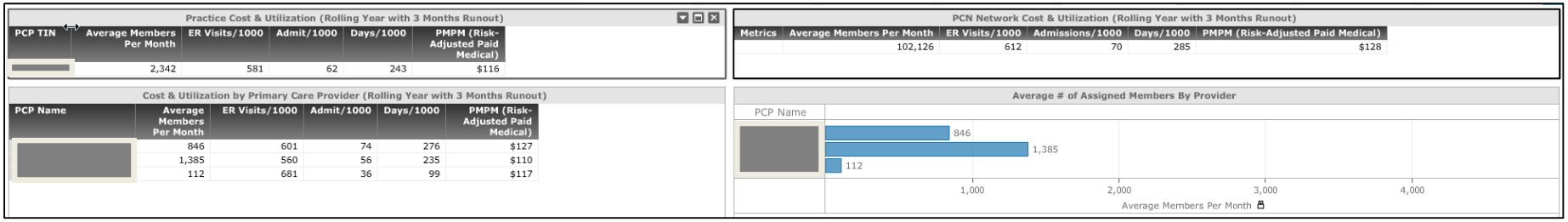
Practice Overall Summary

Presents trend performance for each practice on key cost and utilization measures.



Practice PCP Comparison Report

Presents a comparison of provider and practice level data to overall network performance.



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]	2,342	581	62	243	$116

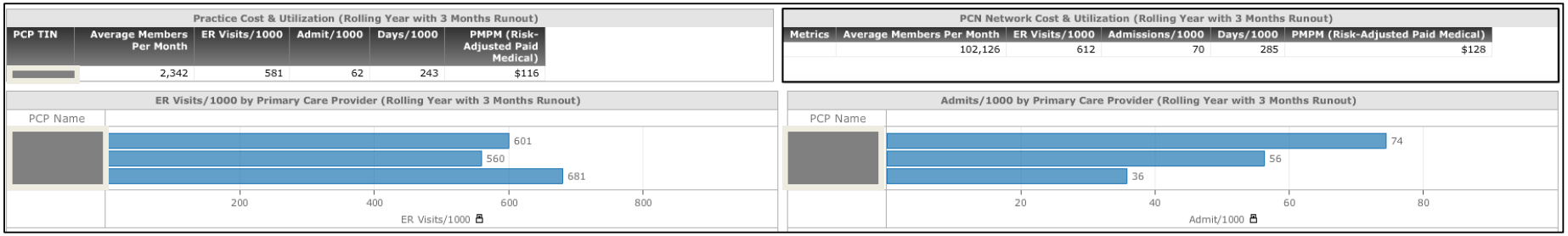
PCN Network Cost & Utilization (Rolling Year with 3 Months Runout)

Metrics	Average Members Per Month	ER Visits/1000	Admissions/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
	102,126	612	70	285	$128

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]	846	601	74	276	$127
	1,385	560	56	235	$110
	112	681	36	99	$117

Average # of Assigned Members By Provider



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

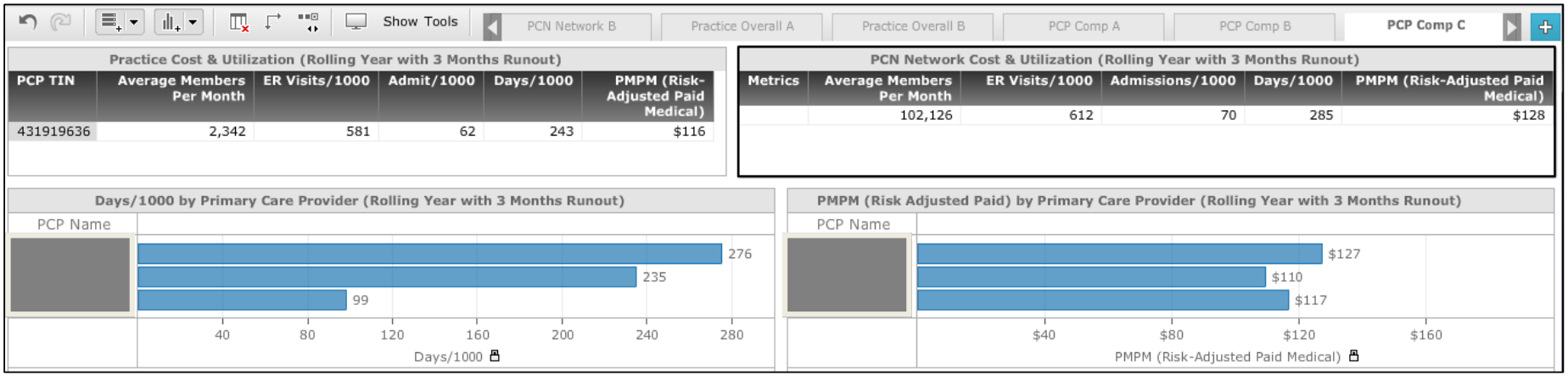
PCP TIN	Average Members Per Month	ER Visits/1000	Admit/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
[redacted]	2,342	581	62	243	$116

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

Metrics	Average Members Per Month	ER Visits/1000	Admissions/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
	102,126	612	70	285	$128

ER Visits/1000 by Primary Care Provider (Rolling Year with 3 Months Runout)

Admits/1000 by Primary Care Provider (Rolling Year with 3 Months Runout)



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)
431919636	2,342	581	62	243	$116

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

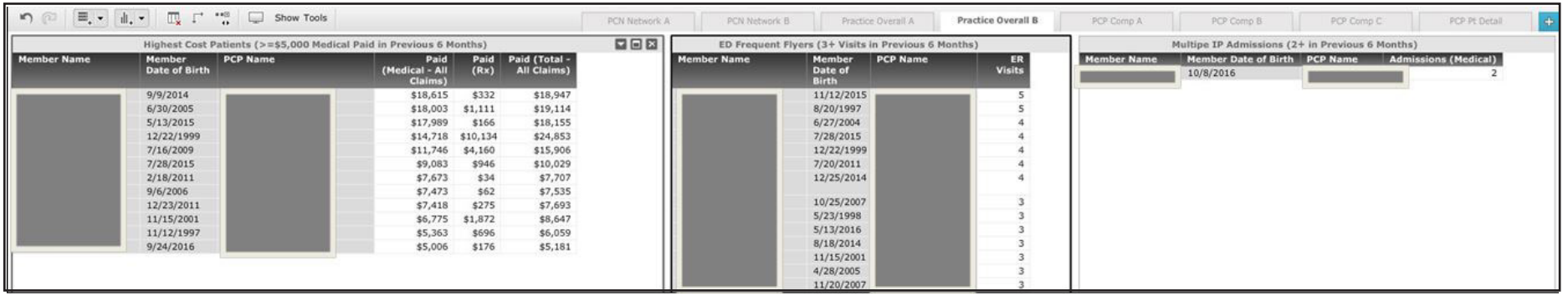
Metrics	Average Members Per Month	ER Visits/1000	Admissions/1000	Days/1000	PMPM (Risk-Adjusted Paid Medical)
	102,126	612	70	285	$128

Days/1000 by Primary Care Provider (Rolling Year with 3 Months Runout)

PMPM (Risk Adjusted Paid) by Primary Care Provider (Rolling Year with 3 Months Runout)

Practice PCP Action List Report

Presents actionable information for providers by sharing each provider's highest risk/cost patients and most frequent ED utilizers.

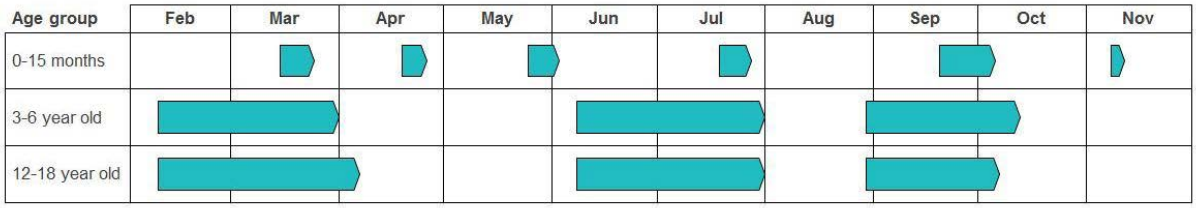


Quality Improvement Initiatives

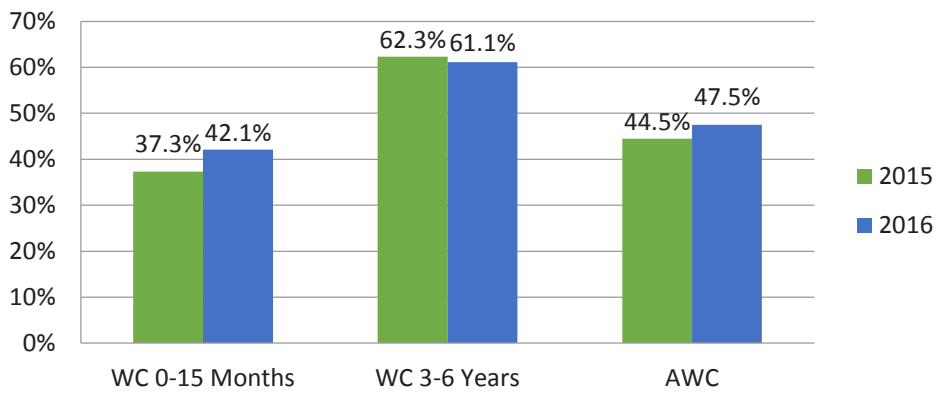
Patient Outreach Initiative (EMMI)

In early 2016, the PCN initiated a pilot of Valence Health's Patient Outreach Services with seven PCN practices. The service uses interactive voice response technology (IVR) to place a series of automated calls to drive patient action. Nearly 31,000 outreaches have been made to over 18,000 patients since February 2016. The service results have been promising with nearly 30 percent of patients engaged (transferred to practice for scheduling, given scheduling information, or told they are due for a well-visit).

Summary of 2016 Campaigns



	0-15 month		3-6 year old		Adolescent		All campaigns		Total assigned patients (Nov 2016)
	Distinct patients called	Total outreaches	Distinct patients called	Total outreaches	Distinct patients called	Total outreaches	Distinct patients called	Total outreaches	
[redacted]	633	1,615	1,843	2,793	3,332	5,609	5,808	10,017	19,929
	328	639	783	881	1,162	1,206	2,273	2,726	6,642
	99	279	414	629	693	1,186	1,206	2,094	2,551
	251	541	697	1,191	899	1,626	1,847	3,358	4,877
	326	682	835	1,341	1,431	2,542	2,592	4,565	5,827
	192	429	708	1,221	1,480	2,778	2,380	4,428	8,600
	285	699	754	1,272	974	1,780	2,013	3,751	4,277
Missouri Practice Total	2,114	4,884	6,034	9,328	9,971	16,727	18,119	30,939	52,703



Analysis: When comparing the HEDIS results in aggregate for the practices that participated in the EMMI campaign, increases were seen for both the Well-Child 0-15 Months and Adolescent Well-Care visits.

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 three different groups within the PCN. The comparison included the following:

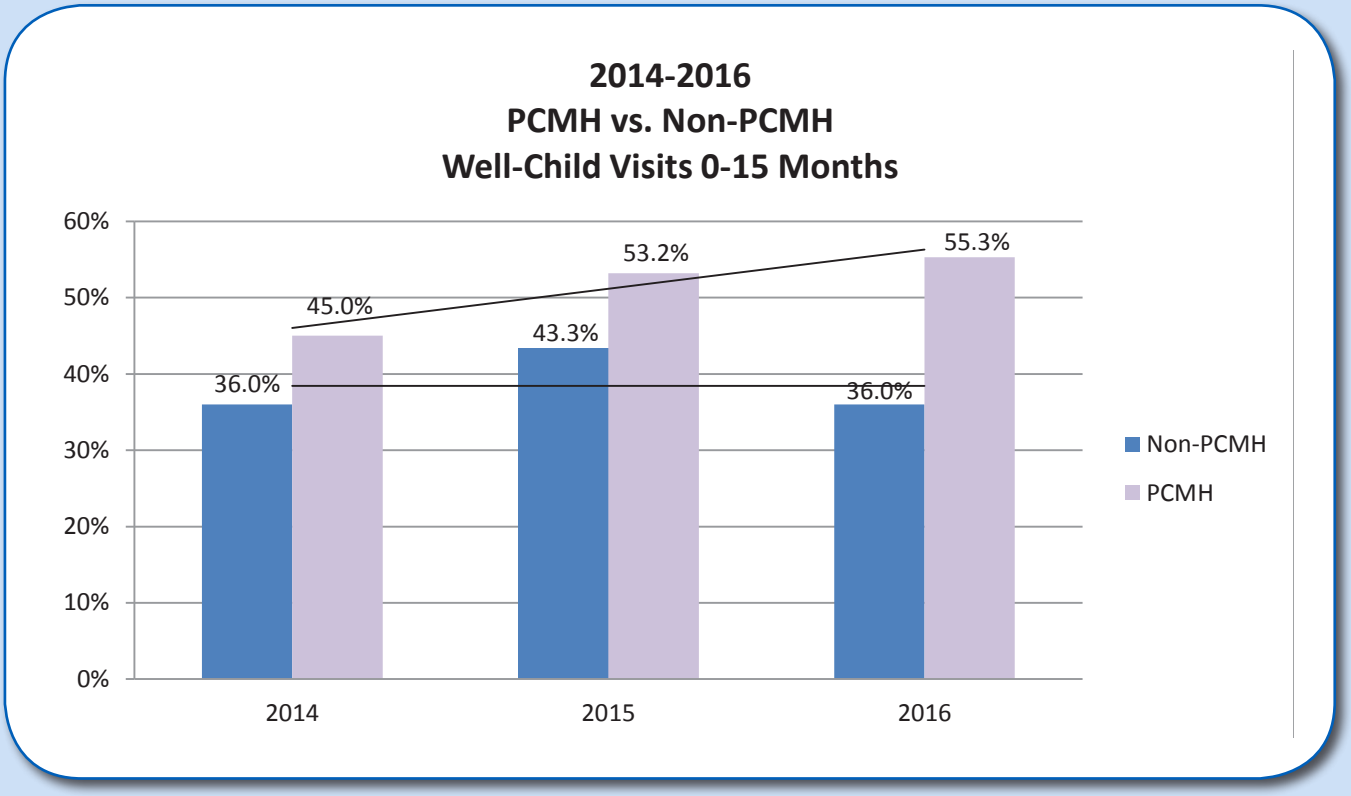
PCMH Practices
Includes all practices engaged with the PCN who have been designated as an NCQA-recognized PCMH for at least one year.

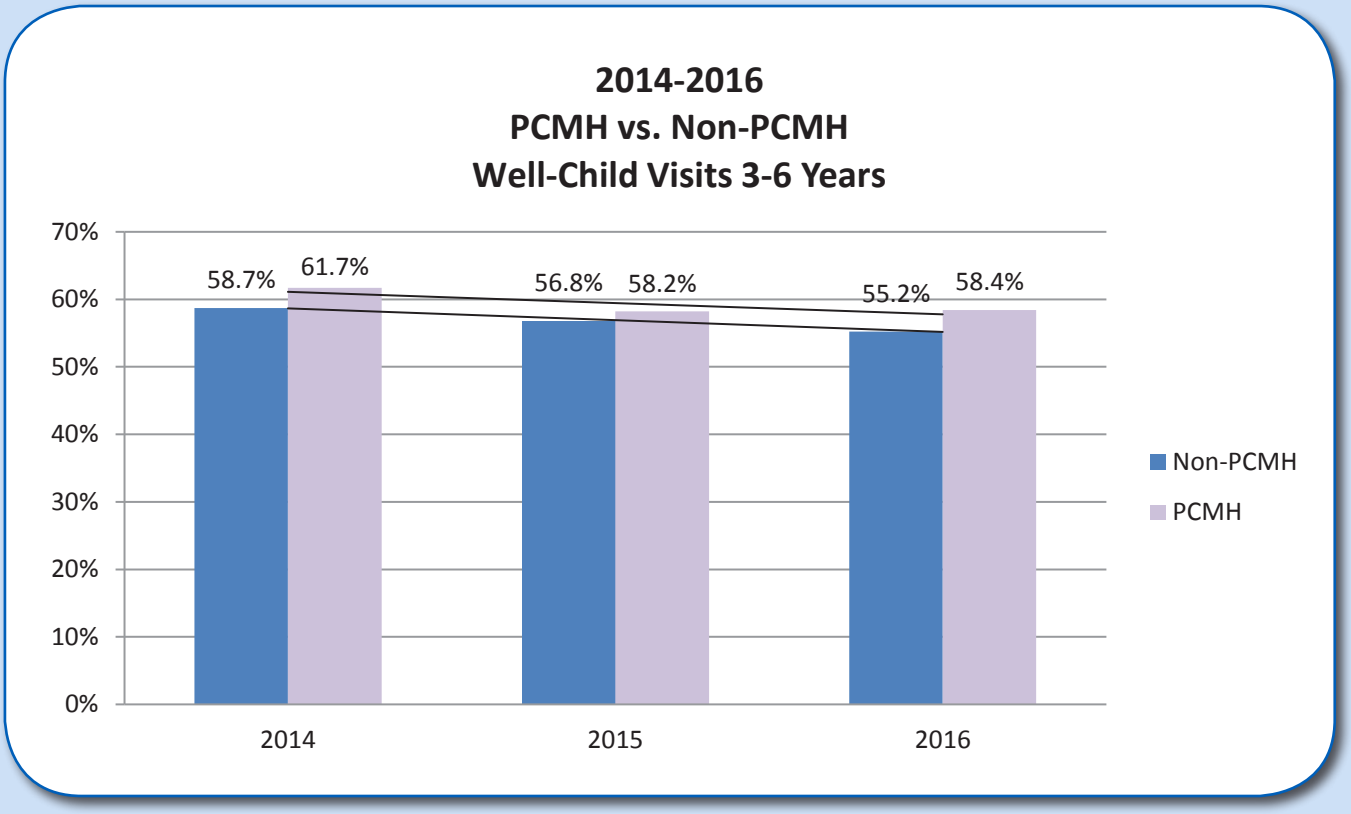
Non-PCMH Practices
Includes all practices engaged with the PCN who do not have NCQA designation as a PCMH, as well as practices not currently contracted with the PCN, typically family practice and rural provider offices. It is important to note that CMH primary care is included in this denominator. This subset includes the balance of an academic curriculum with the PCMH model. The Pediatric Care Clinic (PCC) within the CMH 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.

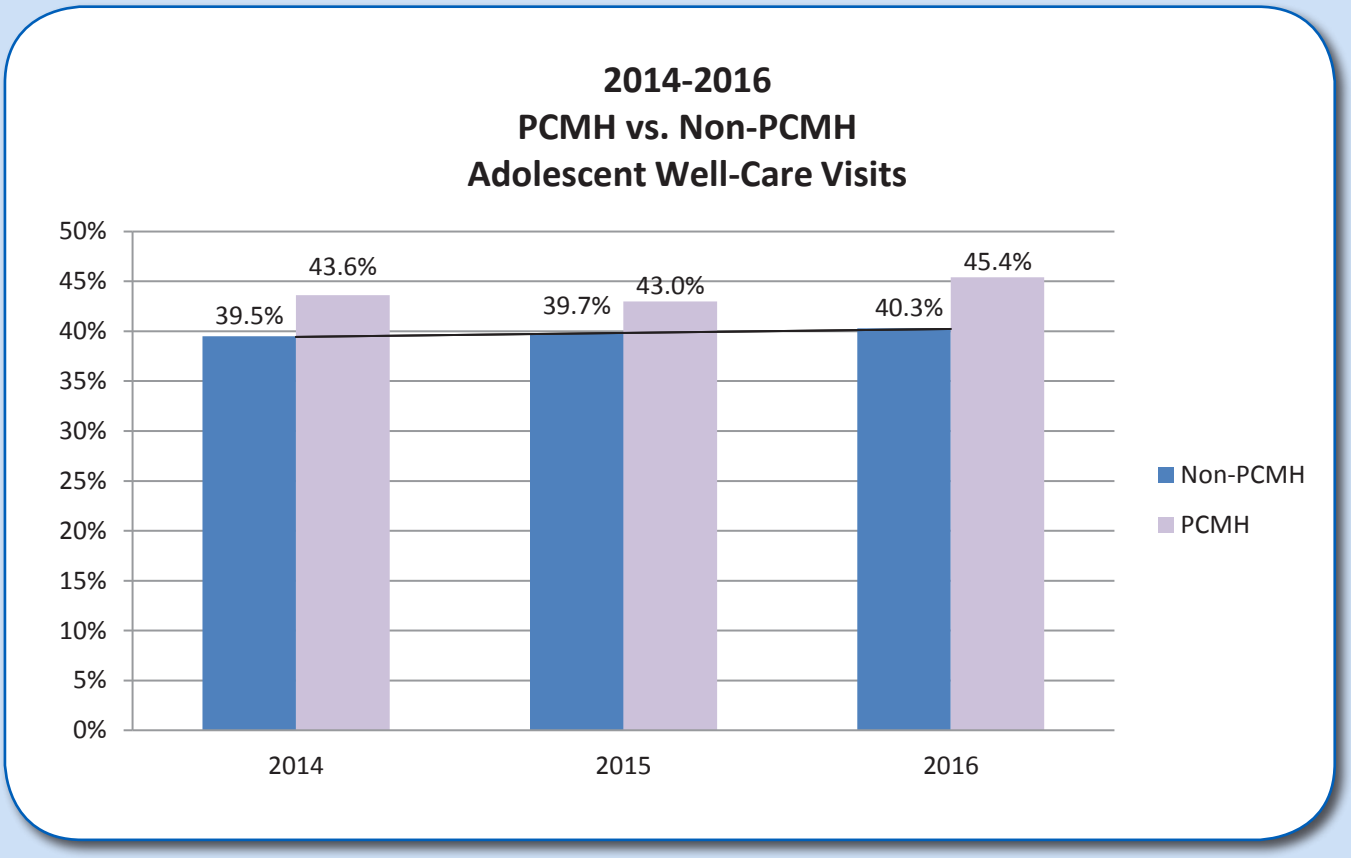
From a quality perspective, the following metrics were evaluated:
- Well-Child 0-15 Months
- Well-Child 3-6 Years
- Adolescent Well-Care Visits
- Chlamydia Screening
- Children & Adolescents' Access to Primary Care Practitioners (CAP)
- Lead Screening in Children
- Childhood Immunization Combo 2
- Asthma Medication Compliance-50%
- Asthma Medication Compliance-75%
- CHIPRA-HbA1c
- CHIPRA-Nephropathy

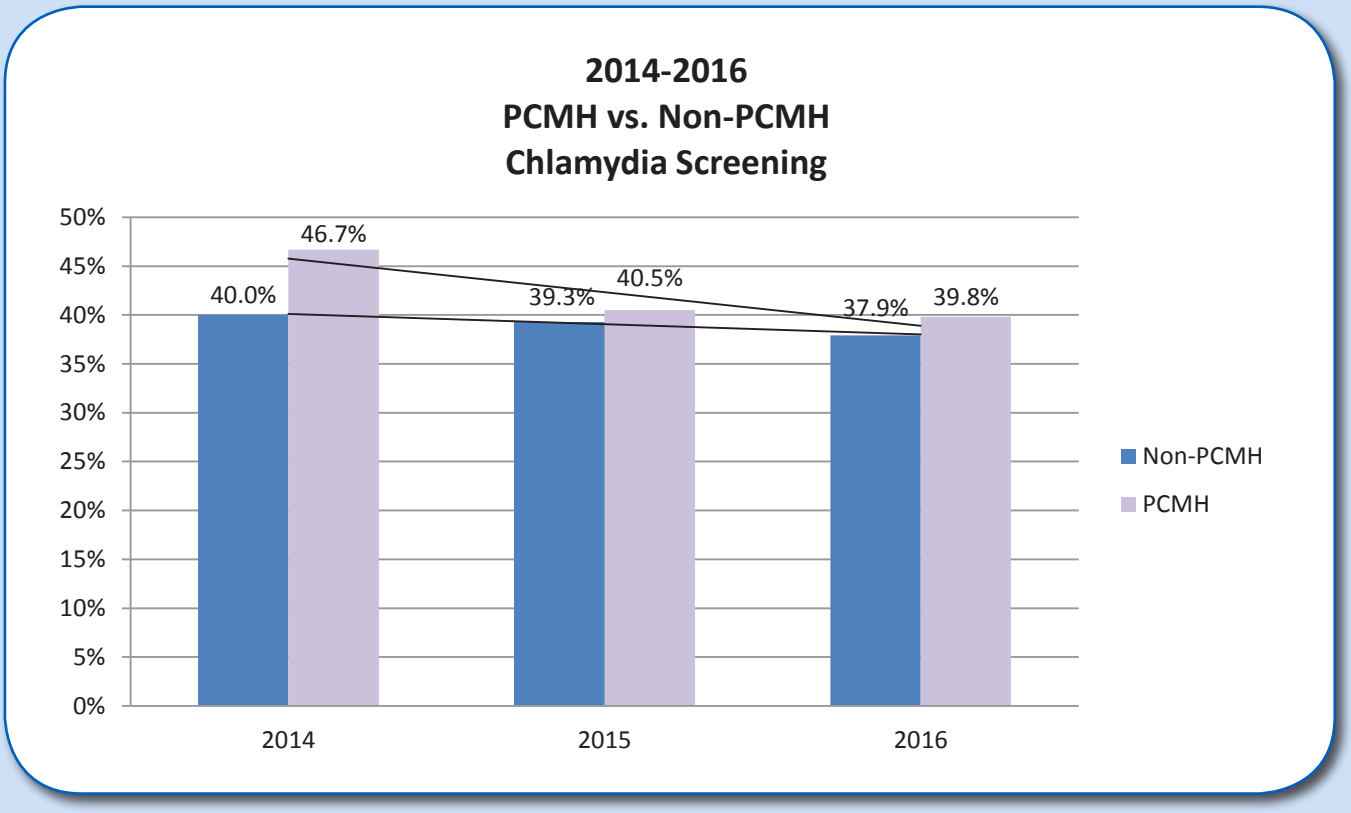
From a cost comparison perspective, the following metrics were evaluated:
- PMPM (Paid Medical)
- Risk-Adjusted PMPM (Paid Medical)

From a utilization comparison perspective, the following metrics were evaluated:
- ER Visits/1000
- Admissions/1000
- Inpatient Days/1000

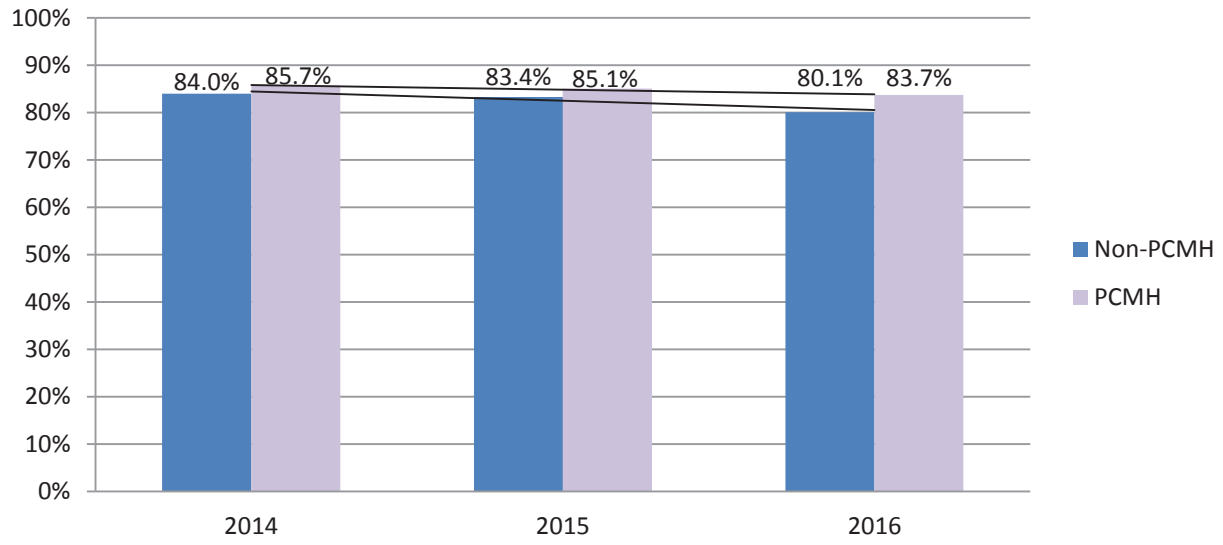

2014-2016
PCMH vs. Non-PCMH
Well-Child Visits 0-15 Months
60%
50%
40%
30%
20%
10%
0%
36.0%
45.0%
43.3%
53.2%
36.0%
55.3%
2014
2015
2016
Non-PCMH
PCMH


2014-2016
PCMH vs. Non-PCMH
Well-Child Visits 3-6 Years
70%
60%
50%
40%
30%
20%
10%
0%
58.7%
61.7%
56.8%
58.2%
55.2%
58.4%
2014
2015
2016
Non-PCMH
PCMH

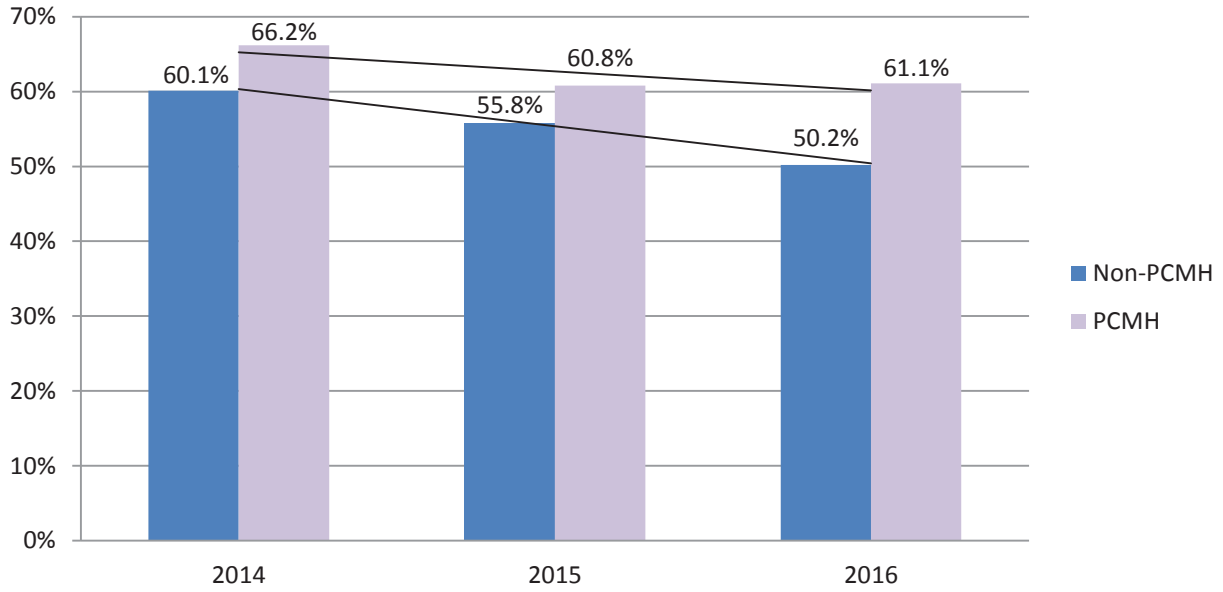

2014-2016
PCMH vs. Non-PCMH
Adolescent Well-Care Visits
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
39.5%
43.6%
39.7%
43.0%
40.3%
45.4%
2014
2015
2016
Non-PCMH
PCMH

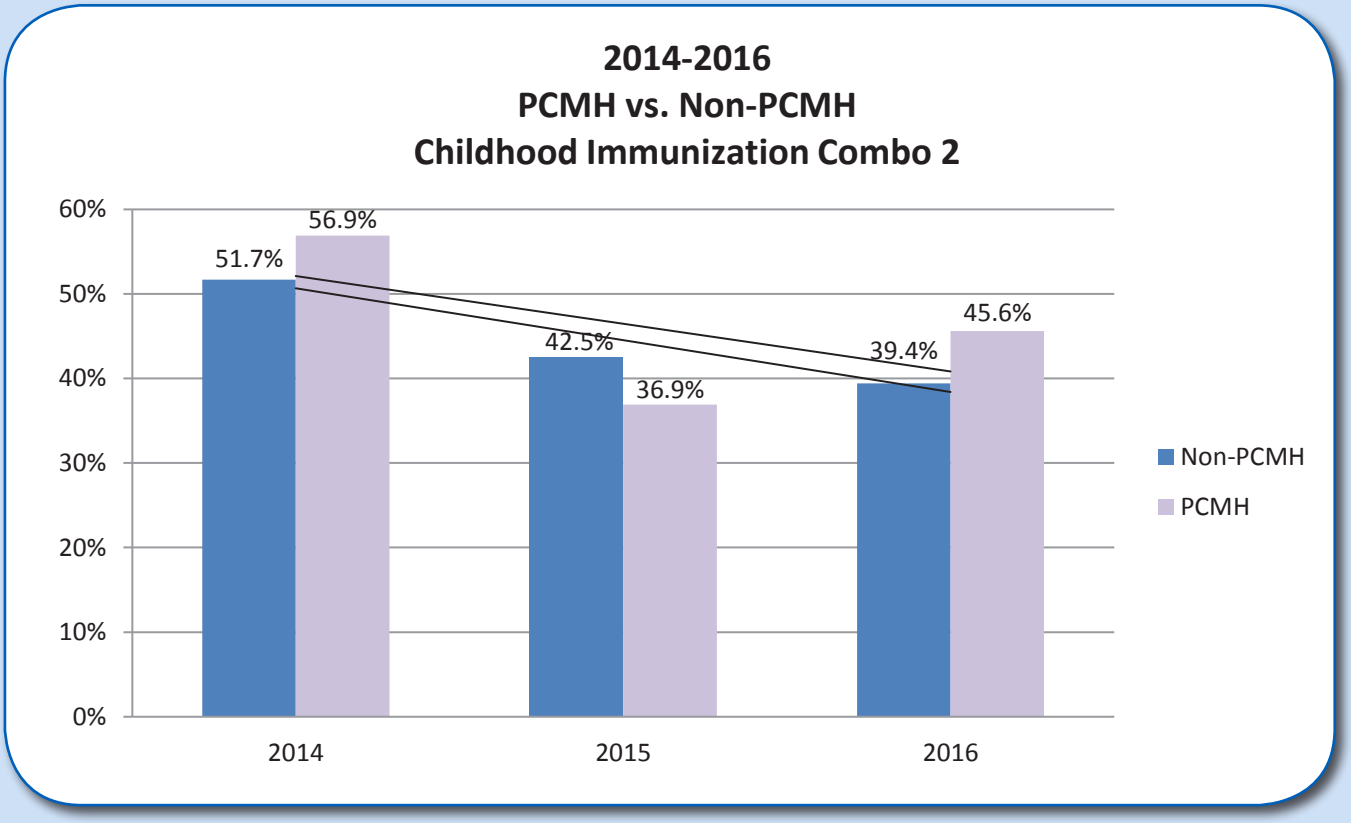

2014-2016
PCMH vs. Non-PCMH
Chlamydia Screening
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
40.0%
46.7%
39.3%
40.5%
37.9%
39.8%
2014
2015
2016
Non-PCMH
PCMH

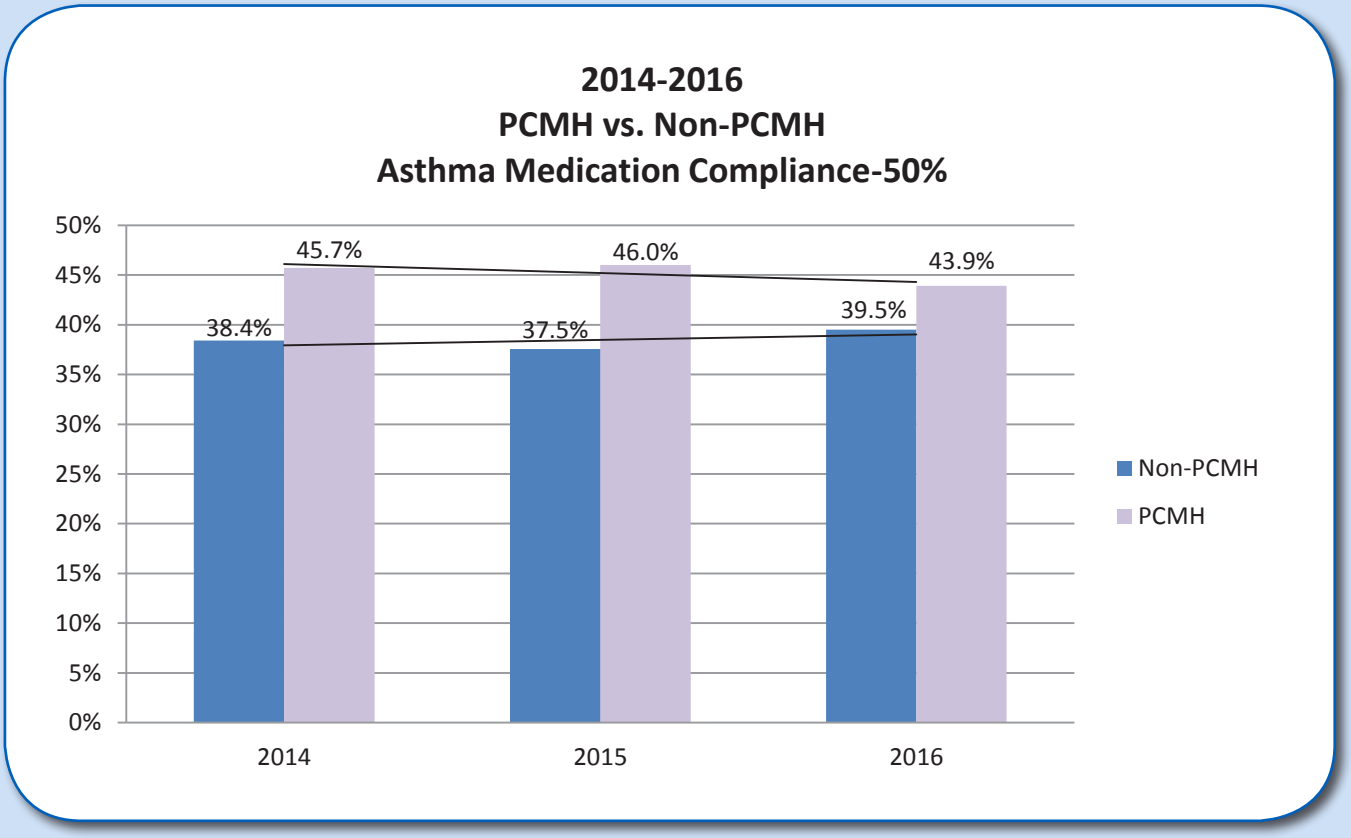
2014-2016
PCMH vs. Non-PCMH
Children & Adolescents' Access to Primary Care Practitioners (CAP)

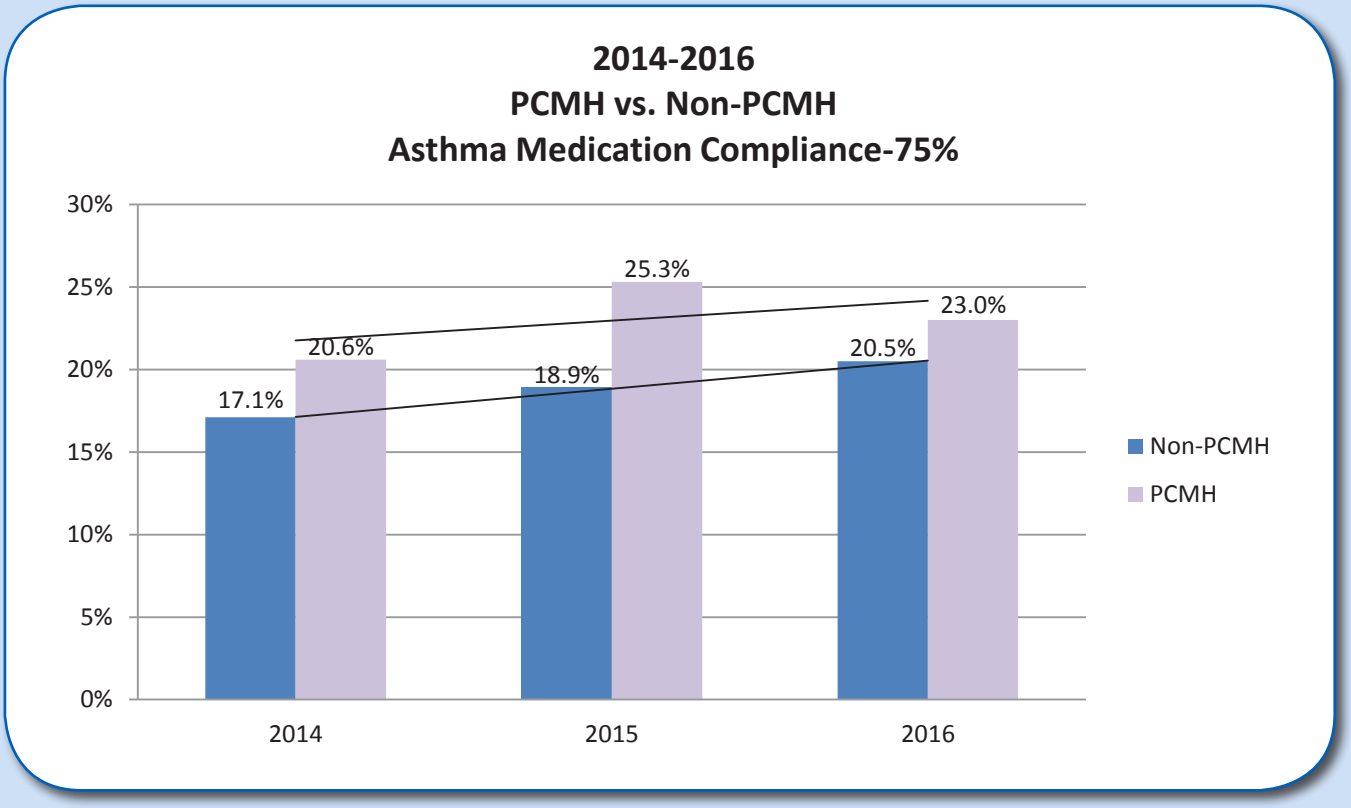


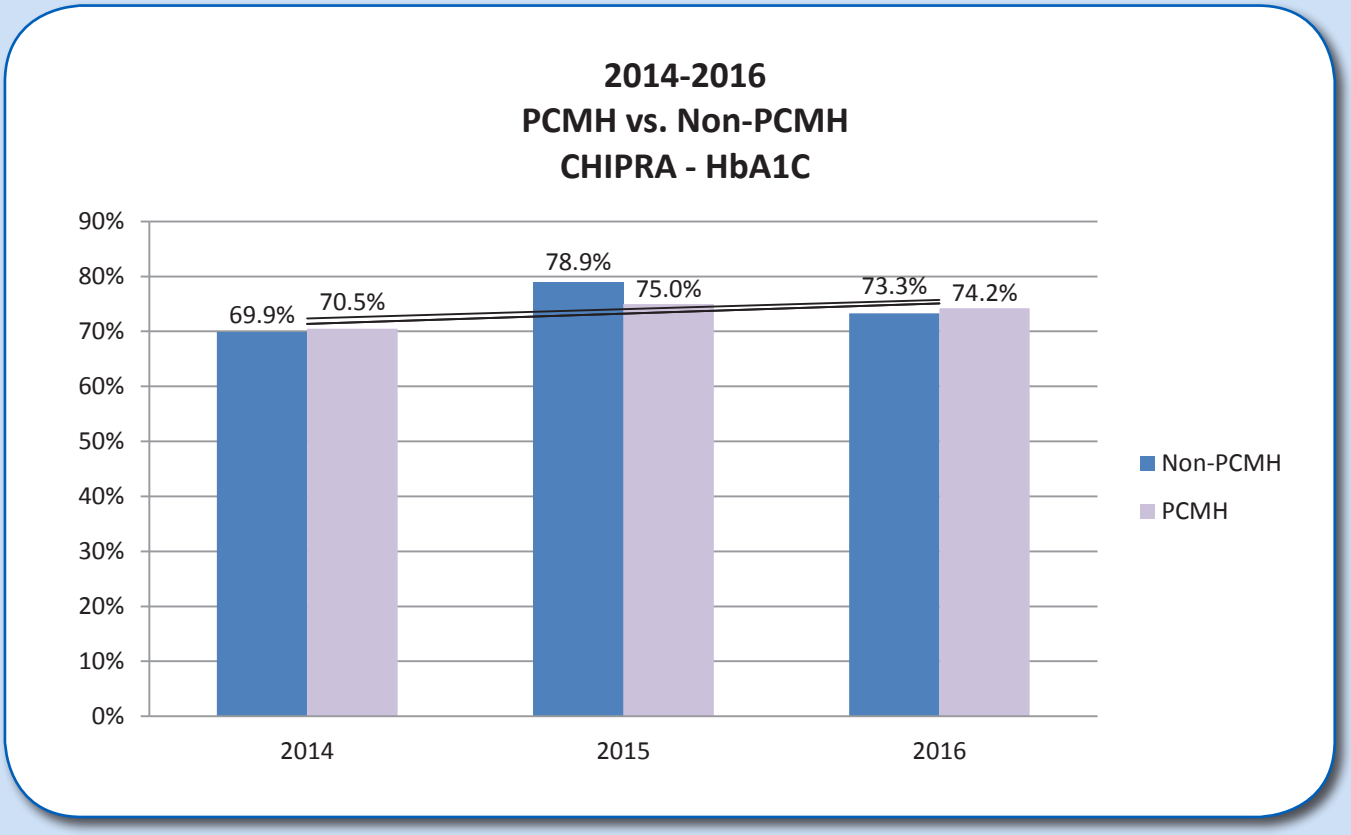
2014-2016
PCMH vs. Non-PCMH
Lead Screening in Children

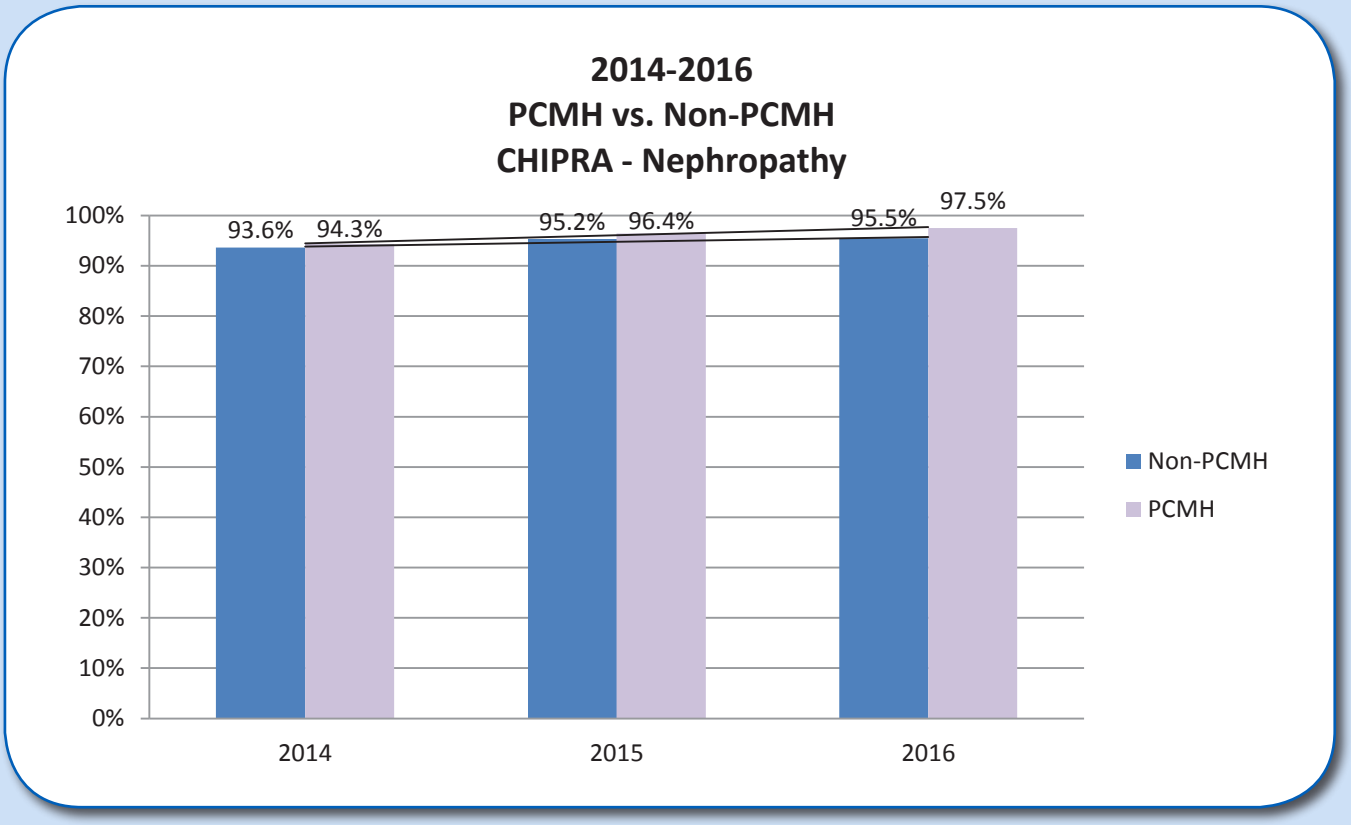



2014-2016
PCMH vs. Non-PCMH
Childhood Immunization Combo 2
60%
50%
40%
30%
20%
10%
0%
51.7%
56.9%
42.5%
36.9%
39.4%
45.6%
2014
2015
2016
Non-PCMH
PCMH

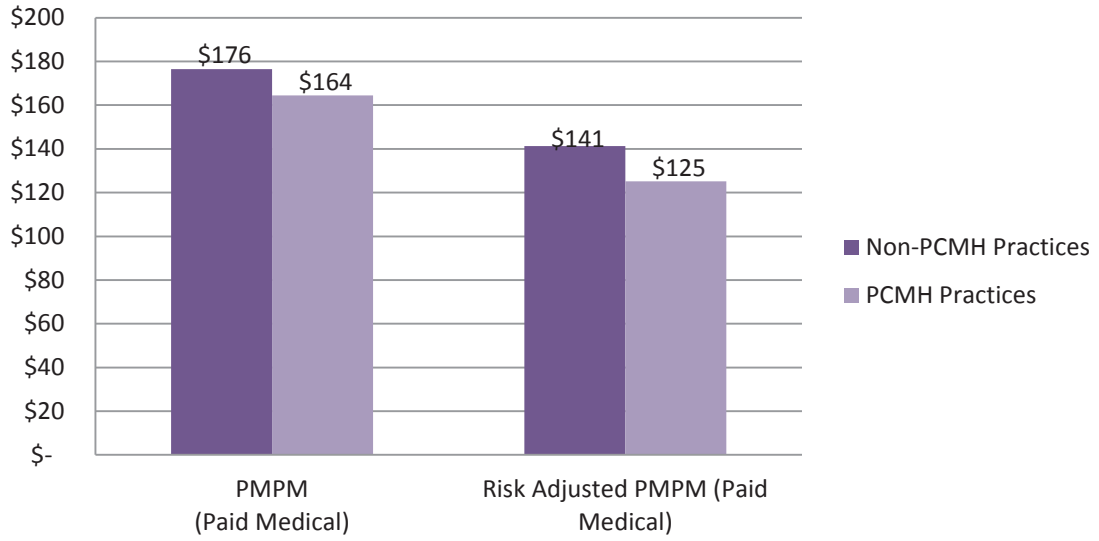

2014-2016
PCMH vs. Non-PCMH
Asthma Medication Compliance-50%
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
45.7%
46.0%
43.9%
38.4%
37.5%
39.5%
2014
2015
2016
Non-PCMH
PCMH


2014-2016
PCMH vs. Non-PCMH
Asthma Medication Compliance-75%
30%
25%
20%
15%
10%
5%
0%
25.3%
23.0%
20.6%
20.5%
18.9%
17.1%
2014
2015
2016
Non-PCMH
PCMH

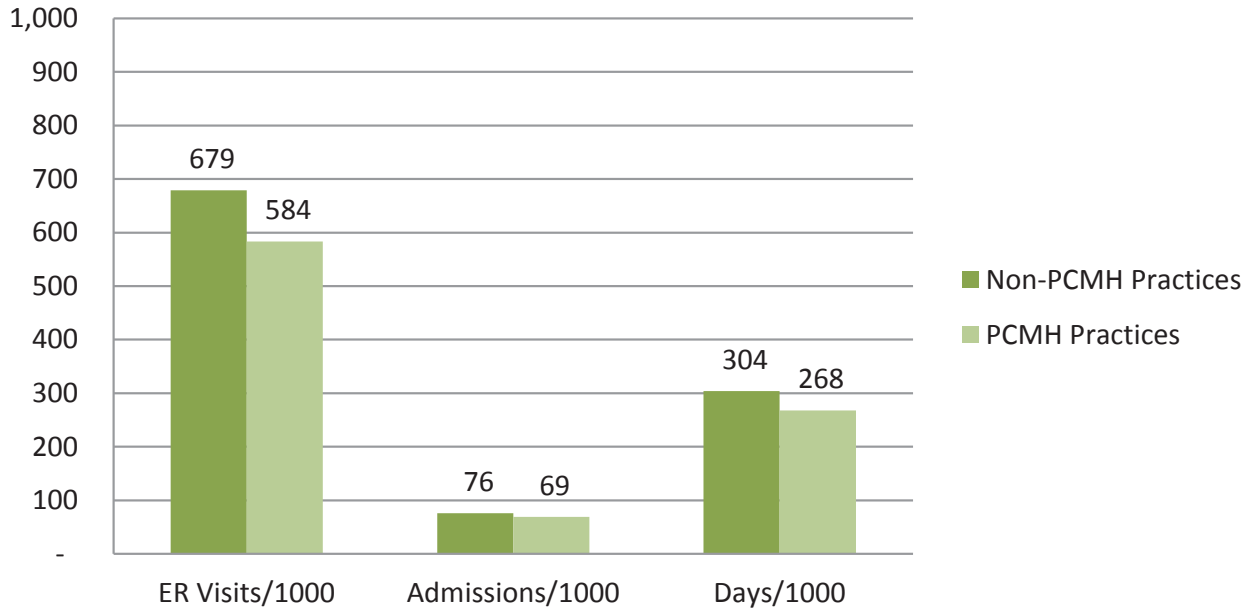

2014-2016
PCMH vs. Non-PCMH
CHIPRA - HbA1C
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
69.9%
70.5%
78.9%
75.0%
73.3%
74.2%
2014
2015
2016
Non-PCMH
PCMH


2014-2016
PCMH vs. Non-PCMH
CHIPRA - Nephropathy
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
93.6%
94.3%
95.2%
96.4%
95.5%
97.5%
2014
2015
2016
Non-PCMH
PCMH

2013-2016 (aggregate)
PCMH vs. Non-PCMH Practices
Per Member Per Month [Medical]



2013-2016 (aggregate)
PCMH vs. Non-PCMH Practices
ER & Inpatient Utilization



Analysis

In regards to HEDIS quality measures, the NCQA PCMH-recognized practices scored higher than Non-PCMH practices on all eleven (11) measures.

- Well-Child visits (0-15 months) had the highest differentiation with PCMH practices performing 19.3 percentage points higher than Non-PCMH practices; followed by Lead Screening with PCMH practices performing 10.9 percentage points higher than Non-PCMH practices.

Cost is better managed in NCQA PCMH-recognized practices when compared to Non-PCMH practices.

- Per member per month (paid medical): PCMH practices show to be 7% lower than Non-PCMH practices
- Risk-adjusted per member per month (paid medical): PCMH practices show to be approximately 11% lower than Non-PCMH practices

Utilization is better managed in practices with NCQA PCMH recognition when compared to Non-PCMH practices.

- ER Visits per 1000: PCMH practices show to be 14% lower than Non-PCMH practices
- Admissions per 1000: PCMH practices show to be 9% lower than Non-PCMH practices
- Days per 1000: PCMH practices show to be 12% lower than Non-PCMH practices

Next Steps

- In 2017, the Patient Outreach Initiative (EMMI) will expand to include eight (8) additional practices for a total of fifteen (15) participating practices and associated members.
- As the Practice Facilitation Specialists continue to support practice transformation in 2017, the promotion of patient-centered care and patient engagement through the Patient Satisfaction Survey and continuous quality improvement will remain a top priority.
- In 2017, the Provider Satisfaction Survey will be enhanced to include questions related to the Care Team model and the Local Community Care Coordination Program (LCCCP).
- In 2017, the PCN Care Teams will continue to support PCMH practice transformation as it has been evidenced that NCQA PCMH-recognized practices perform better than Non-PCMH practices in HEDIS quality measures, as well as cost and utilization.
- To address the HEDIS decreases in the population over the past year, the Care Teams implemented an interactive voice response (IVR) initiative to these targeted populations supporting timely well care with their assigned PCP. Additionally, the Care Teams will review the gaps in care and work with the primary care providers and Community Health Workers to schedule these patients for their exams.

3

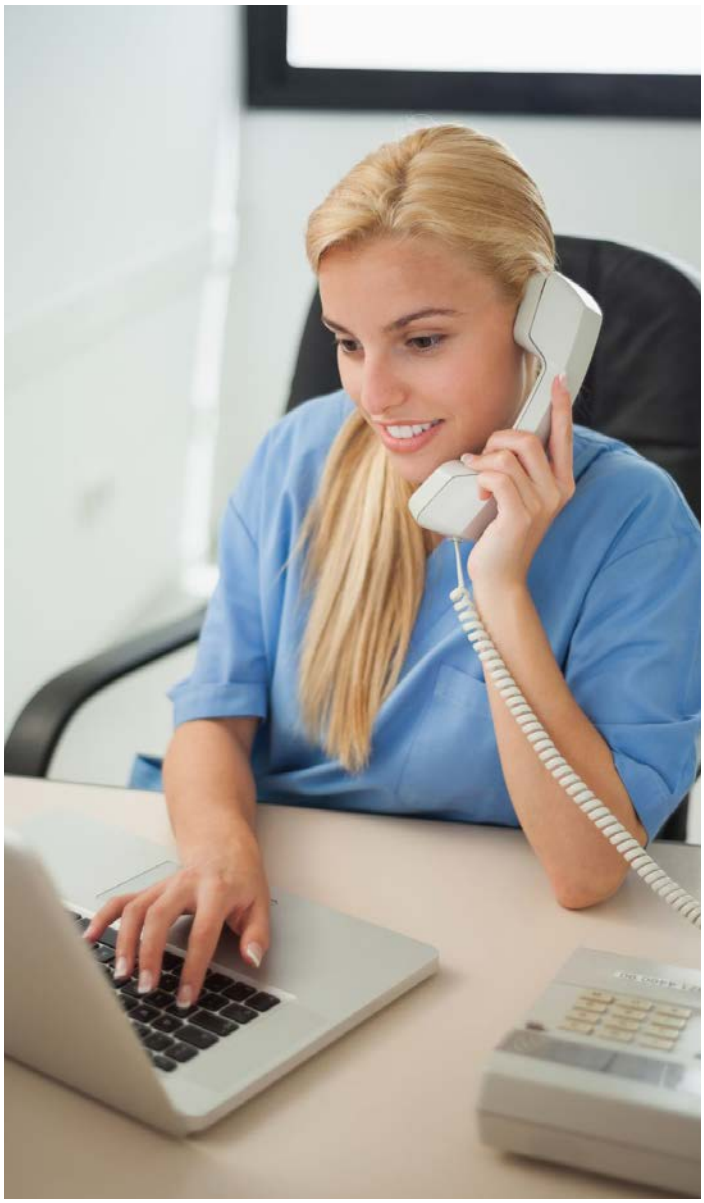
Utilization Management Evaluation

- Utilization Management Program Overview
- Program Measures
- Analysis
- Next Steps

Utilization Management (UM) Program Overview:

The PCN performs prior authorization, inpatient review, discharge planning, and transitional care planning. Prior authorization functions are performed by both clinical and non-clinical staff, who assist with verifying eligibility, entering authorization information in the online system, and faxing and/or calling authorization outcomes to providers, as well as clinical staff who perform medical necessity review. 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 management team conducts routine audits of prior authorization processes to ensure compliance with documentation, application of criteria, and processing timeframe standards. Current audit standards require that staff members who have been employed for greater than a year will meet or exceed an accuracy level of 95%. Timeframes for processing routine and urgent prior authorization requests are monitored on a monthly basis to ensure the program standards are consistently met. In addition, the phone queue system is monitored and call statistics are reviewed monthly to ensure calls are answered according to standards.

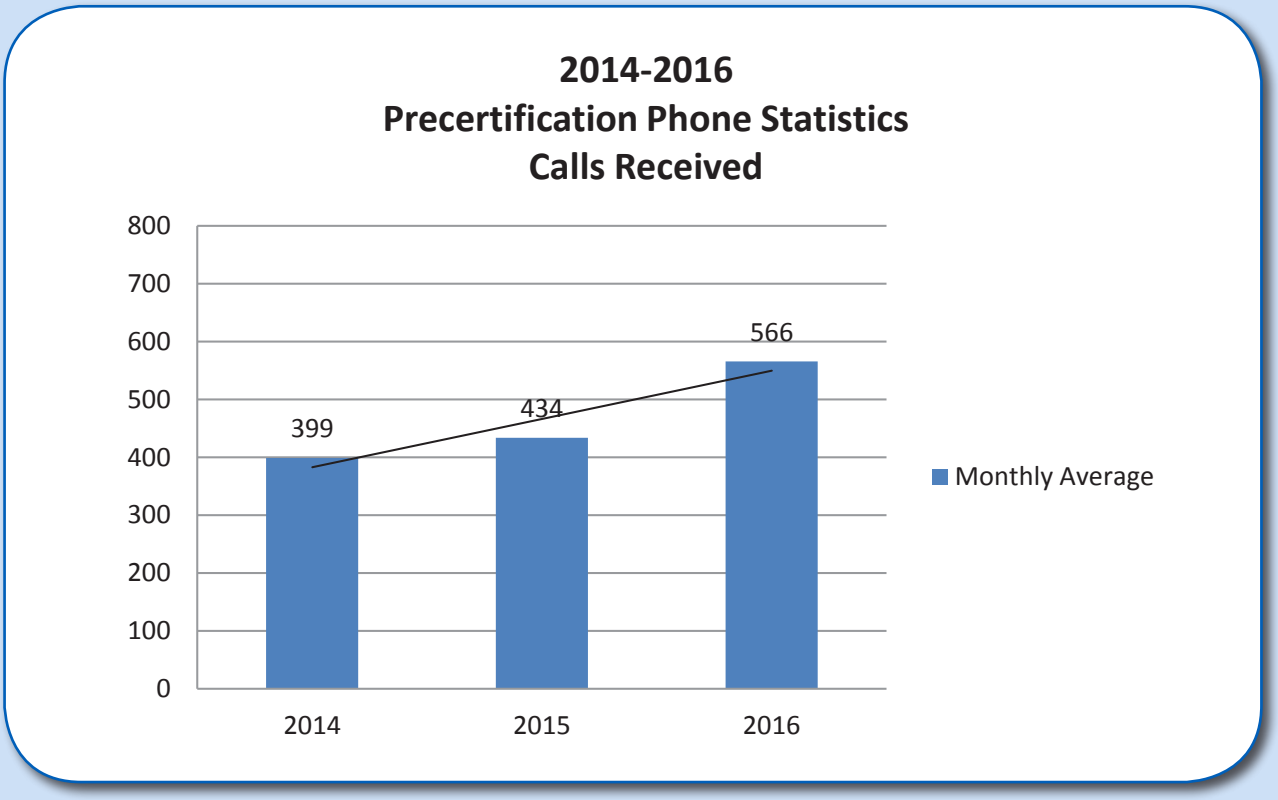
In addition to process measures, the PCN monitors utilization trends for the population to ensure there is not inappropriate over or under utilization of services provided to PCN members. To monitor for underutilization of services, the PCN relies on review of preventive services, outpatient services and PCP office-based services, as well as member complaints or grievances related to access to care or insufficient care delivery. The information specific to those measures are outlined in the Population Health Management and Case Management sections of this report. To monitor for overutilization 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 are presented here.

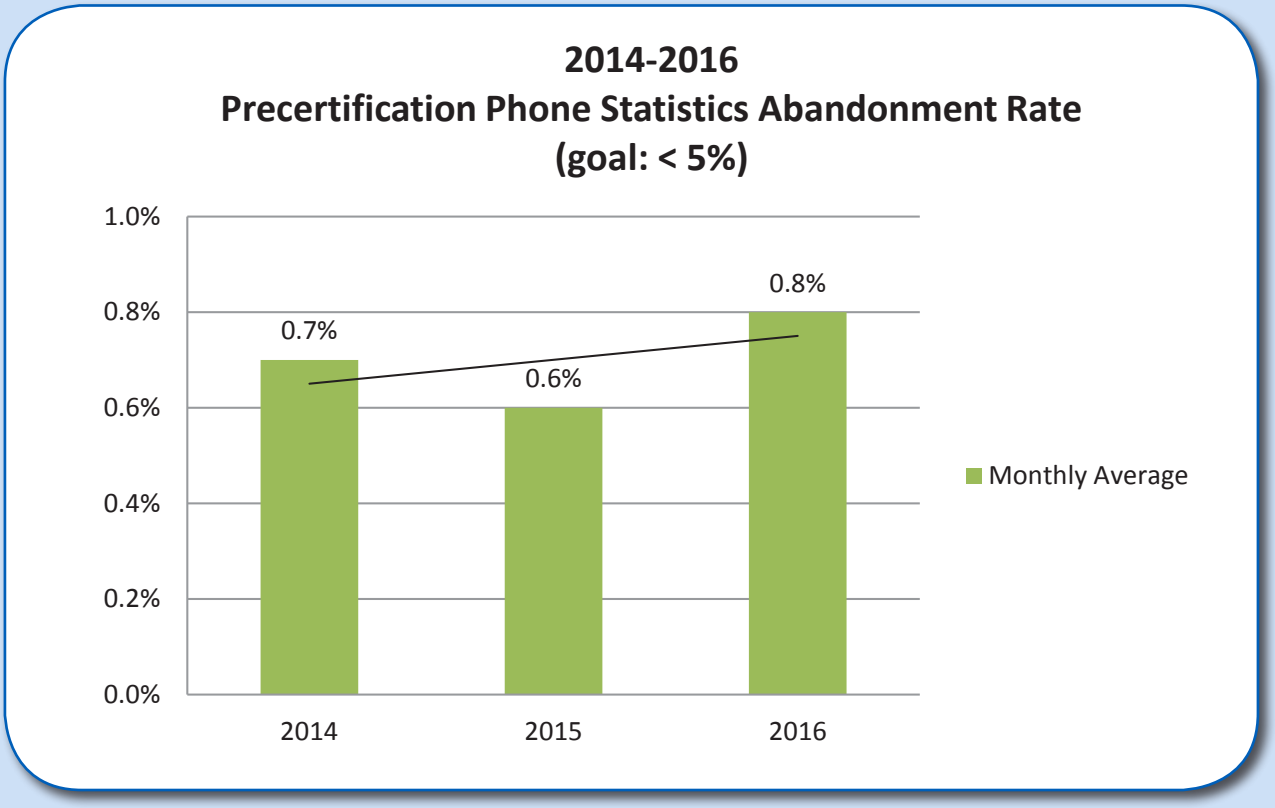


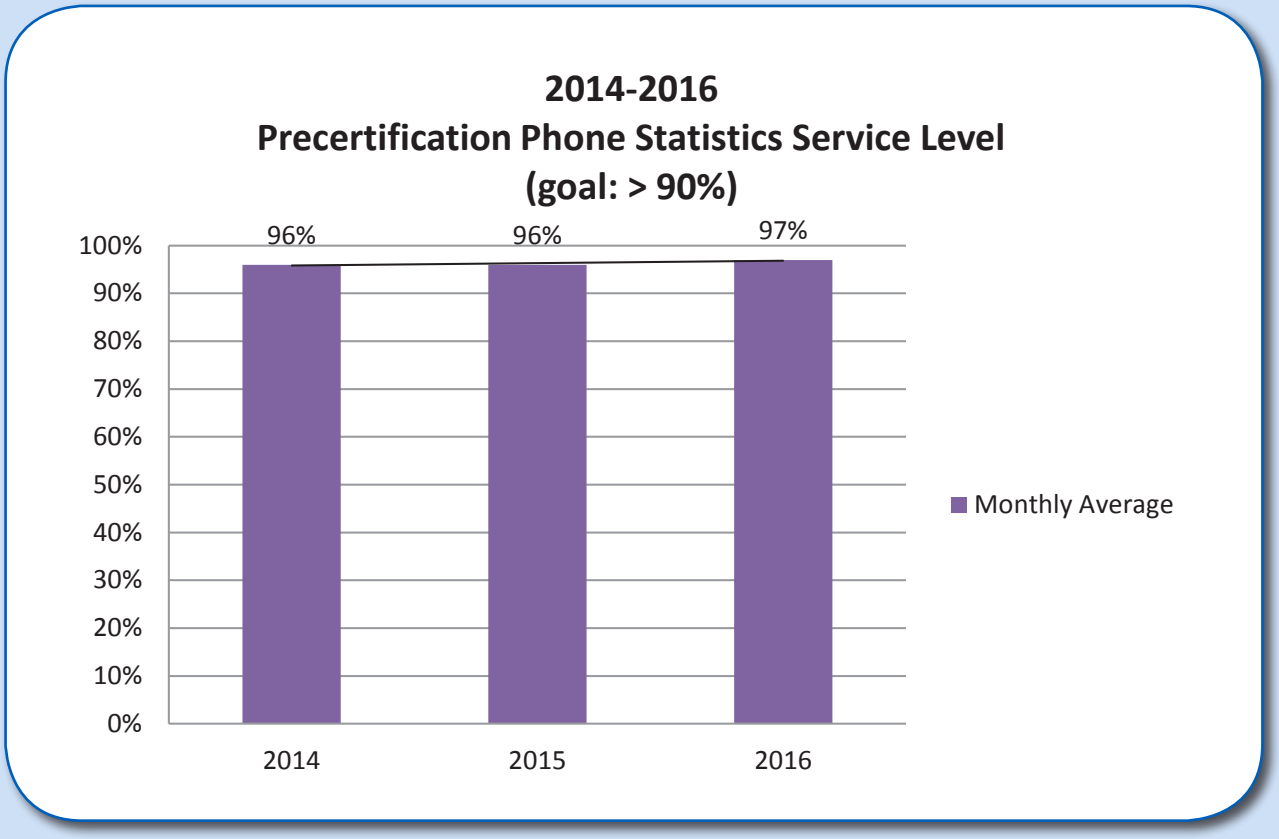
Program Measures:

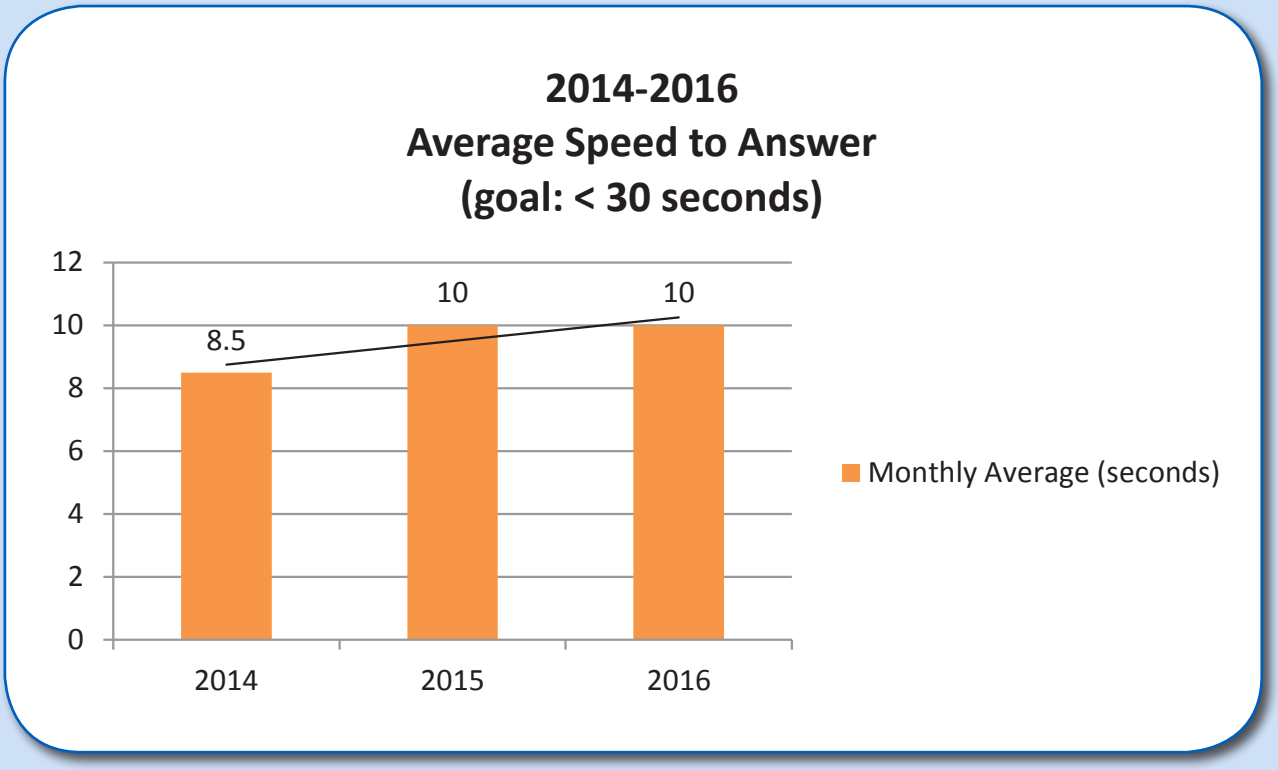
Authorization statistics related to the standards for phone call monitoring and processing medical necessity reviews are presented in the following charts and compare current year performance to prior year. In 2016, the phone statistics remained consistent and within the benchmarks. Denials for outpatient services in 2016, as well as types of denials, remain consistent with nearly 90% being issues related to lack of medical necessity.

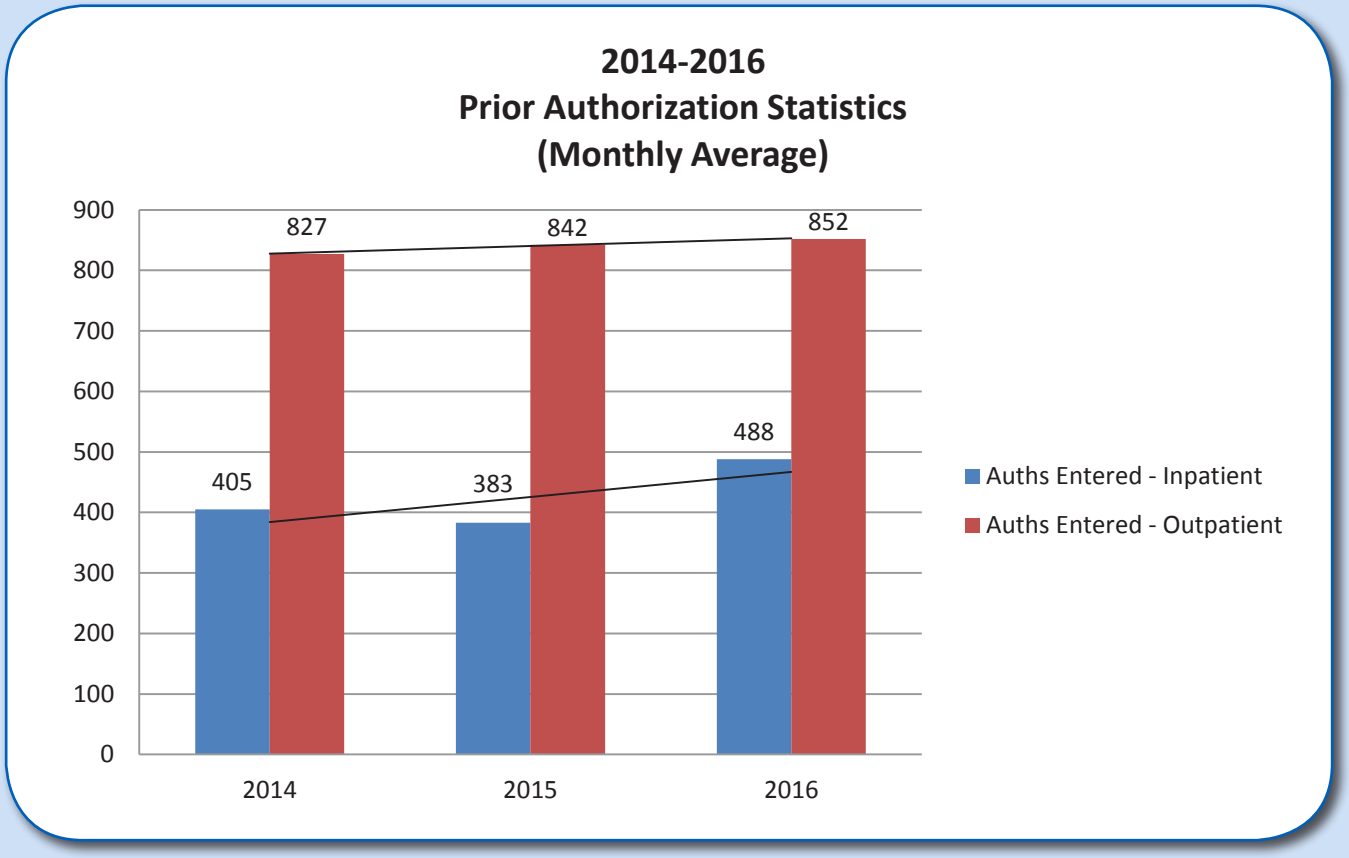
Average Monthly Phone Statistics and Prior Authorization Statistics (2014-2016)

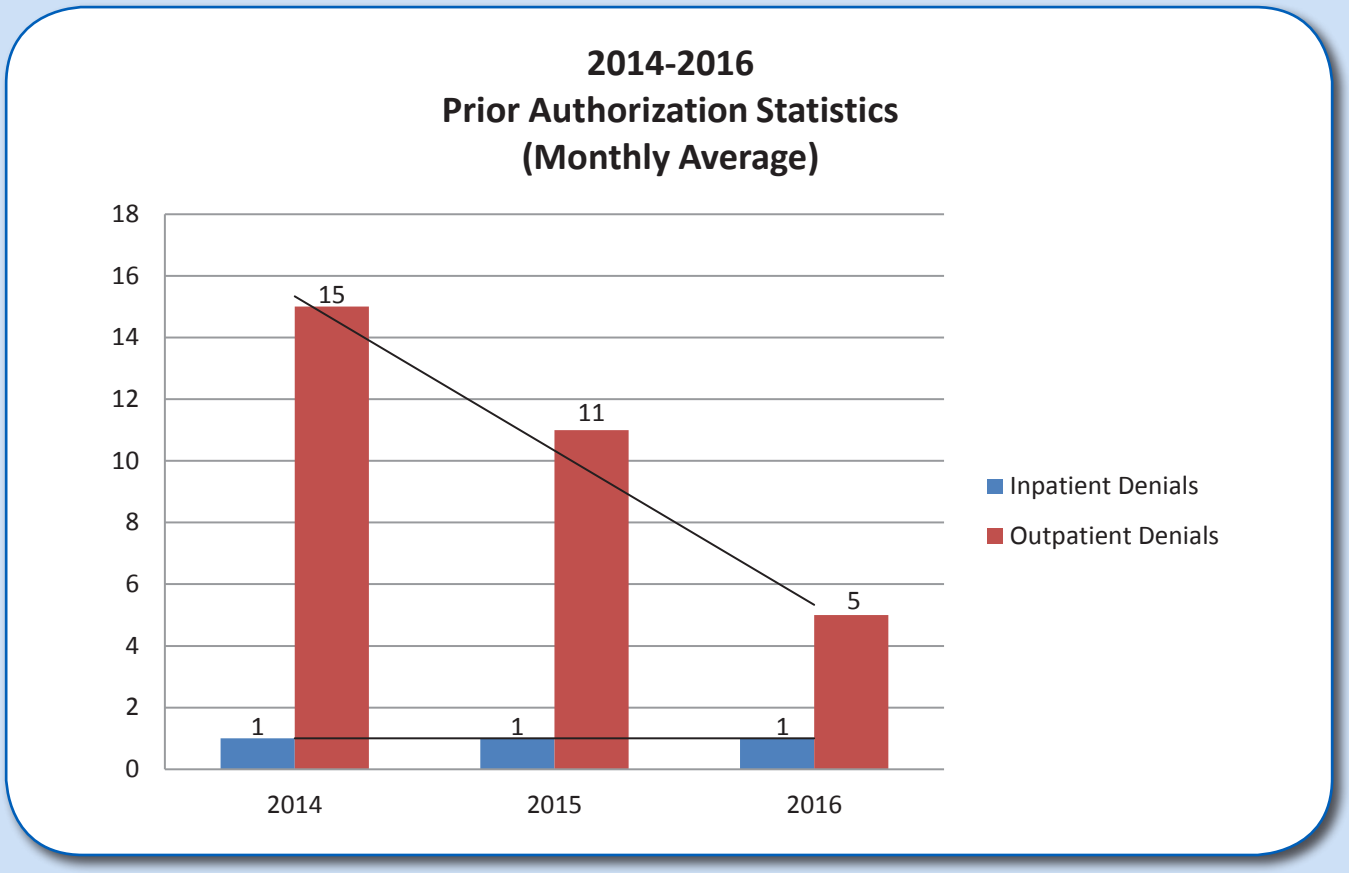


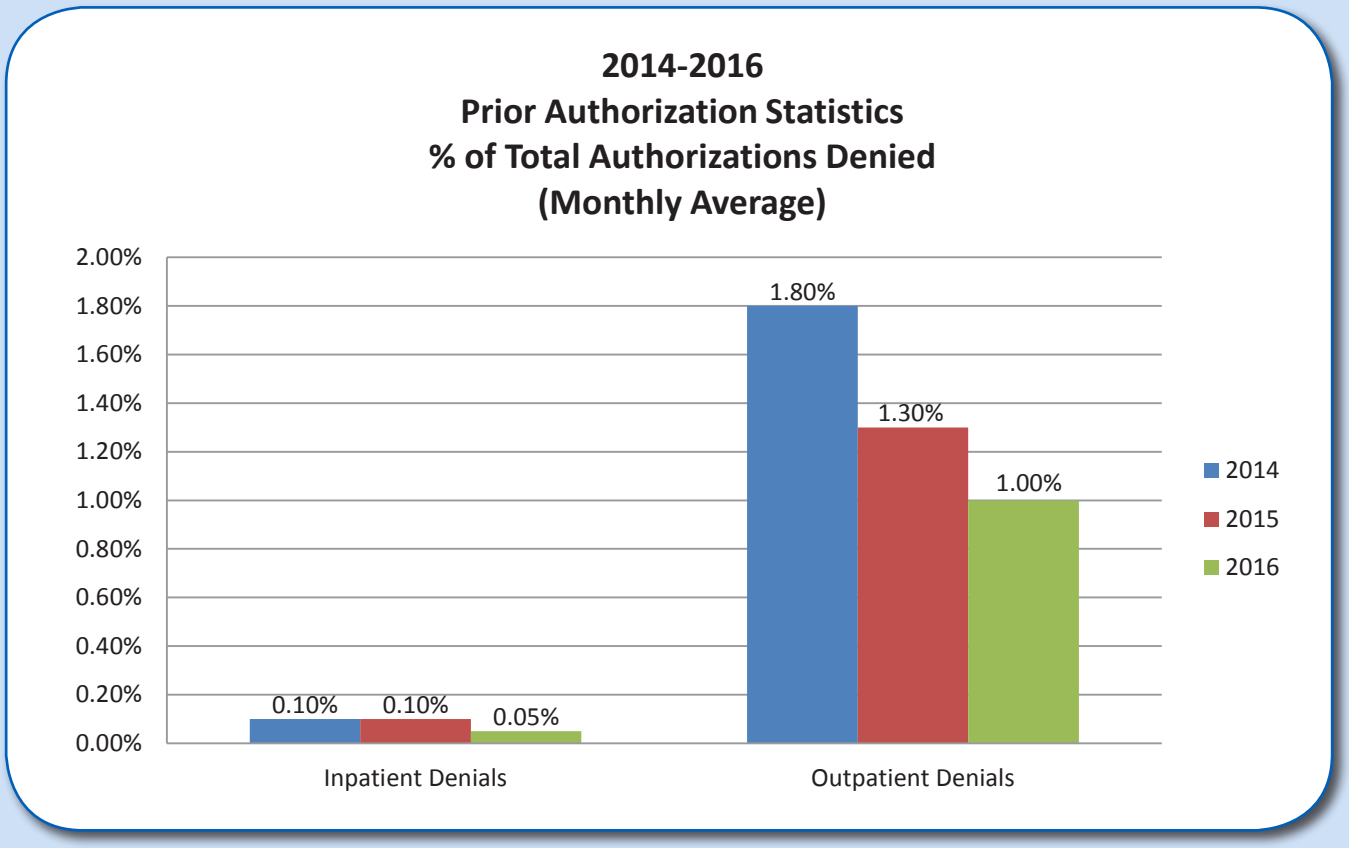


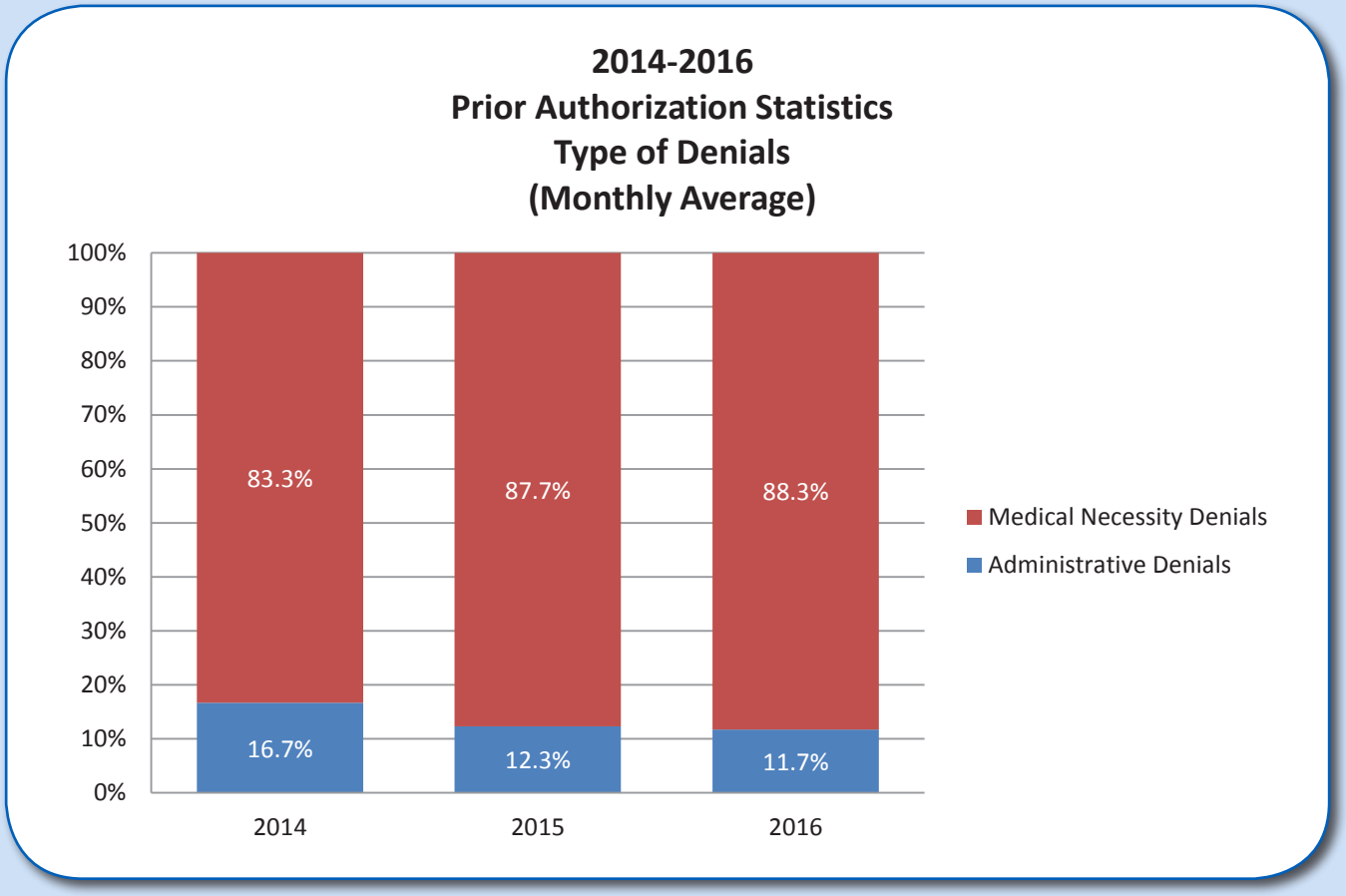

2014-2016
Precertification Phone Statistics Service Level
(goal: > 90%)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
96%
96%
97%
2014
2015
2016
Monthly Average


2014-2016
Average Speed to Answer
(goal: < 30 seconds)
12
10
8
6
4
2
0
8.5
10
10
2014
2015
2016
Monthly Average (seconds)


2014-2016
Prior Authorization Statistics
(Monthly Average)
900
800
700
600
500
400
300
200
100
0
827
842
852
405
383
488
2014
2015
2016
Auths Entered - Inpatient
Auths Entered - Outpatient

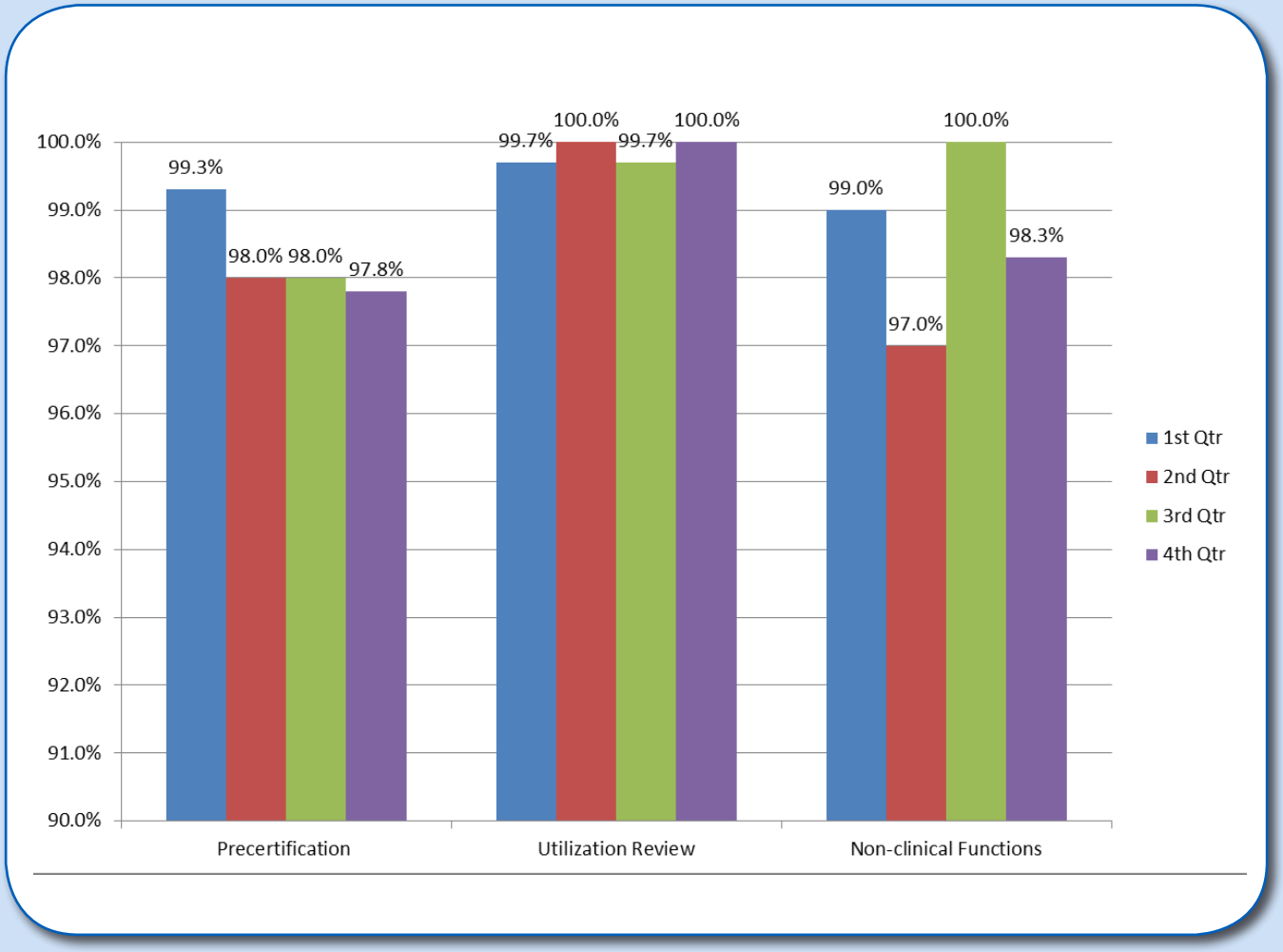

2014-2016
Prior Authorization Statistics
(Monthly Average)
18
16
14
12
10
8
6
4
2
0
15
11
5
1
1
1
2014
2015
2016
Inpatient Denials
Outpatient Denials


2014-2016
Prior Authorization Statistics
% of Total Authorizations Denied
(Monthly Average)
2.00%
1.80%
1.60%
1.40%
1.20%
1.00%
0.80%
0.60%
0.40%
0.20%
0.00%
0.10%
0.10%
0.05%
1.80%
1.30%
1.00%
Inpatient Denials
Outpatient Denials
2014
2015
2016


2014-2016
Prior Authorization Statistics
Type of Denials
(Monthly Average)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
83.3%
87.7%
88.3%
16.7%
12.3%
11.7%
2014
2015
2016
Medical Necessity Denials
Administrative Denials

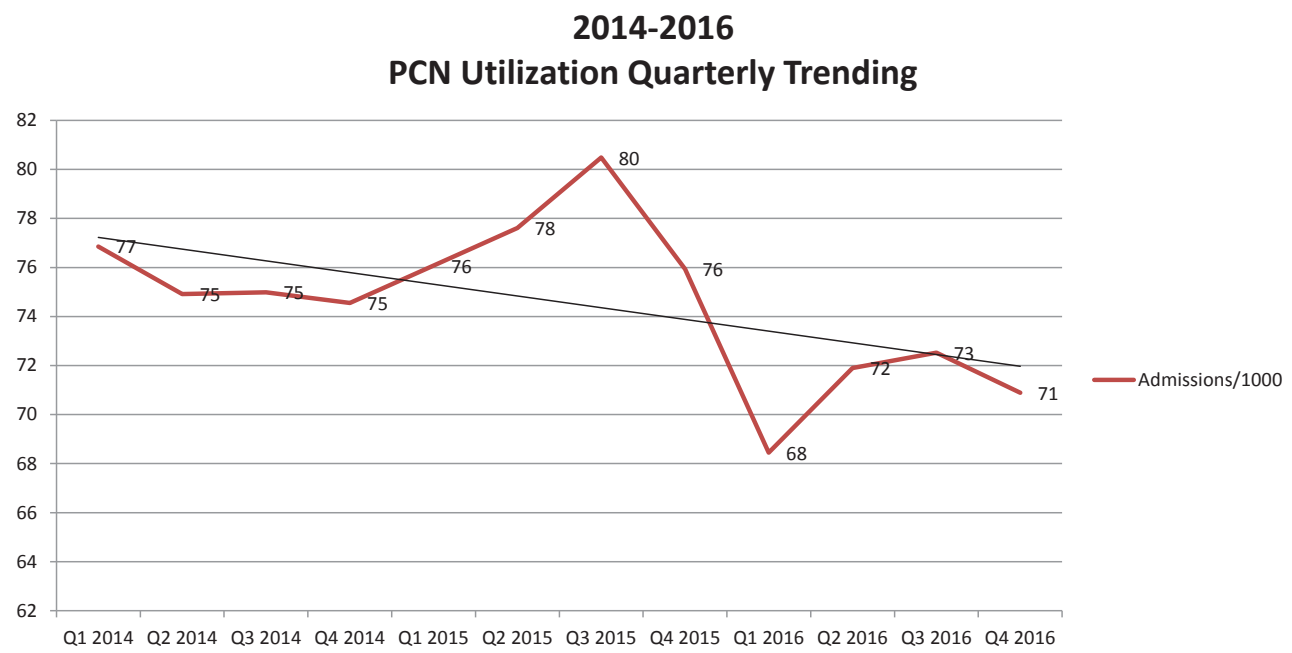
2016 Utilization Management Audit Results

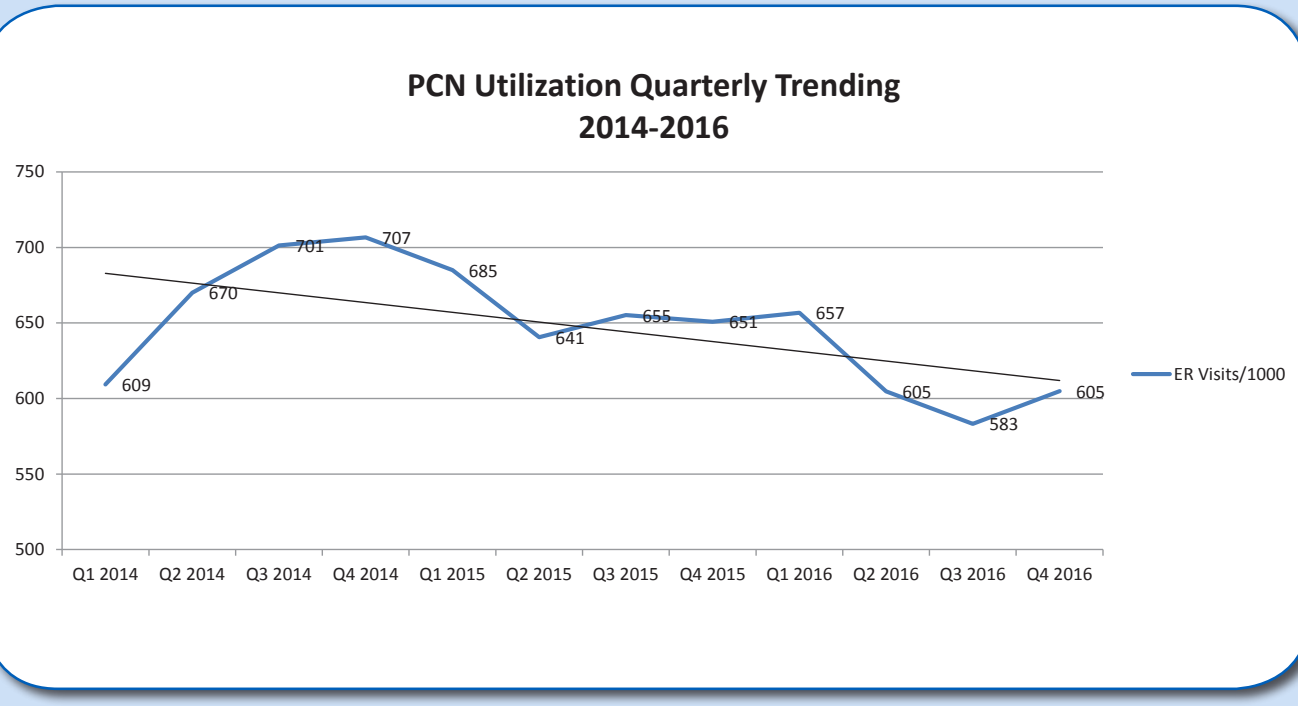
Below are the 2016 aggregate audit results for each function within Utilization Management. Audit scores for all three categories consistently exceed the established threshold of 95%.



Inpatient and ER Utilization Statistics: 2014-2016

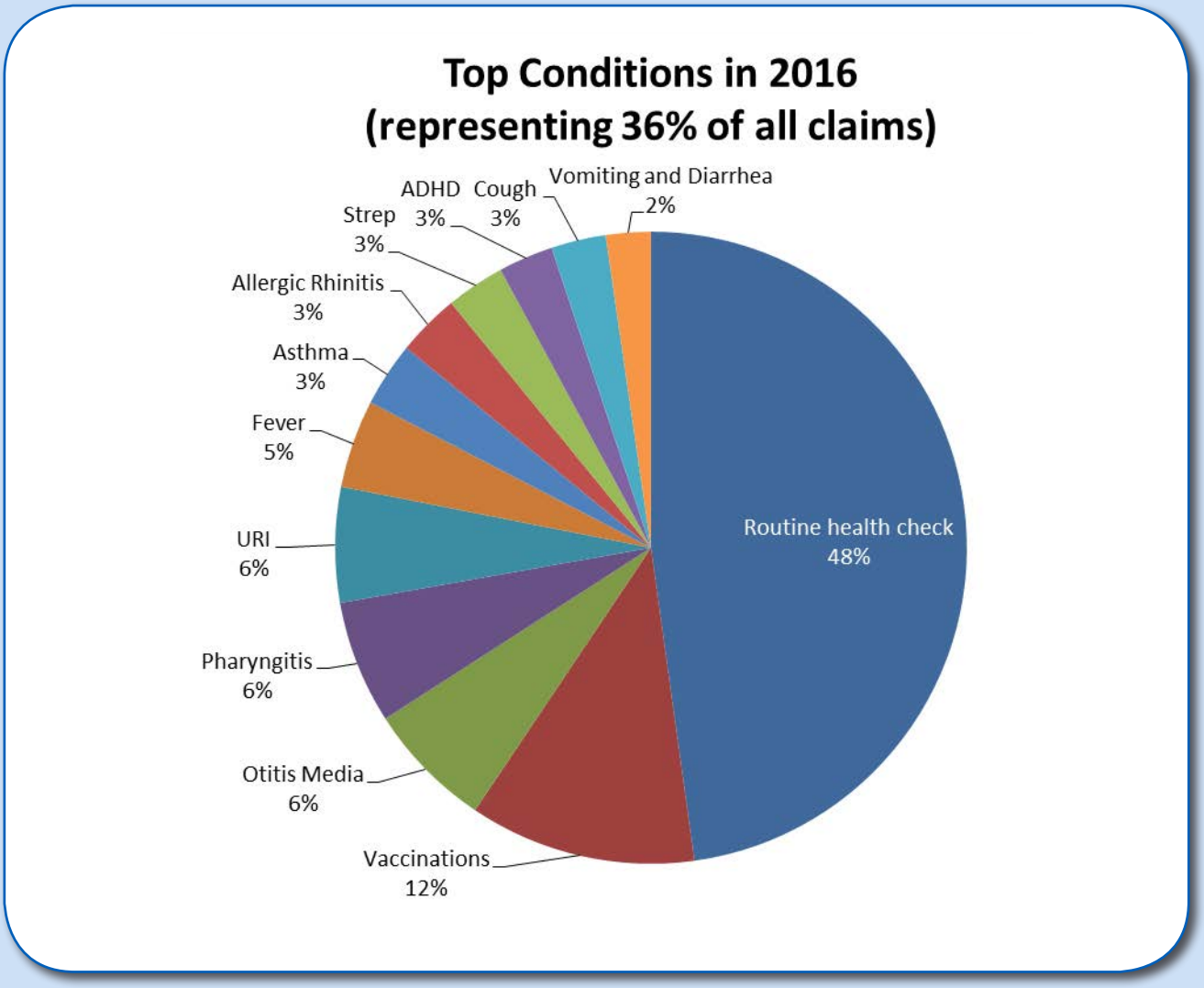
Below are the inpatient and ER utilization trends for the PCN population based on claims data.



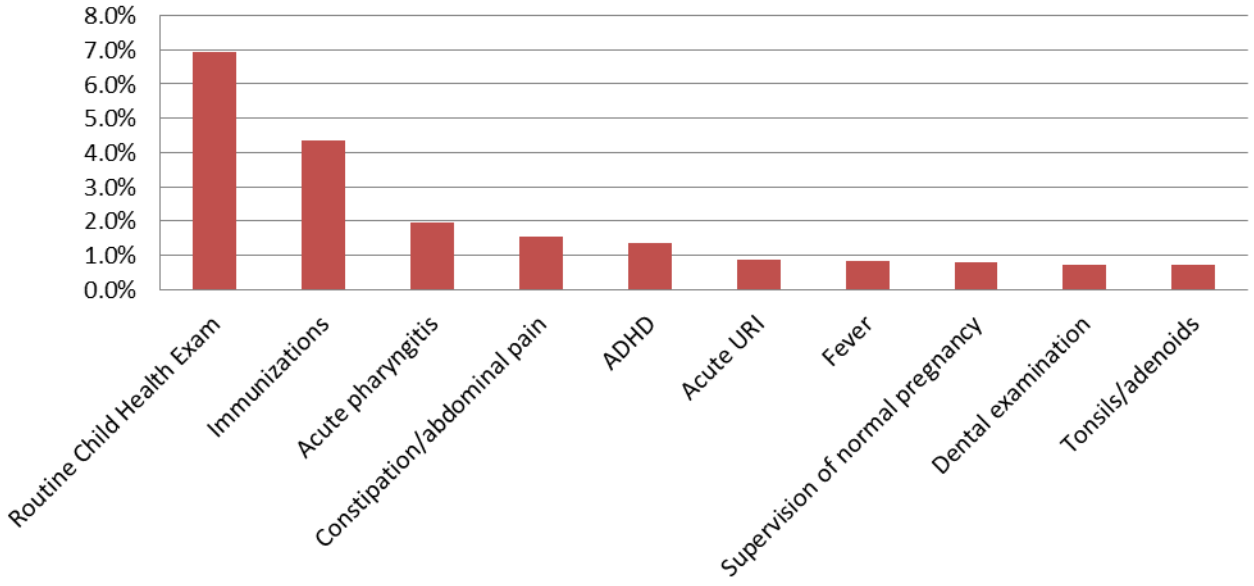


Year over Year Comparisons of Utilization: 2014–2016

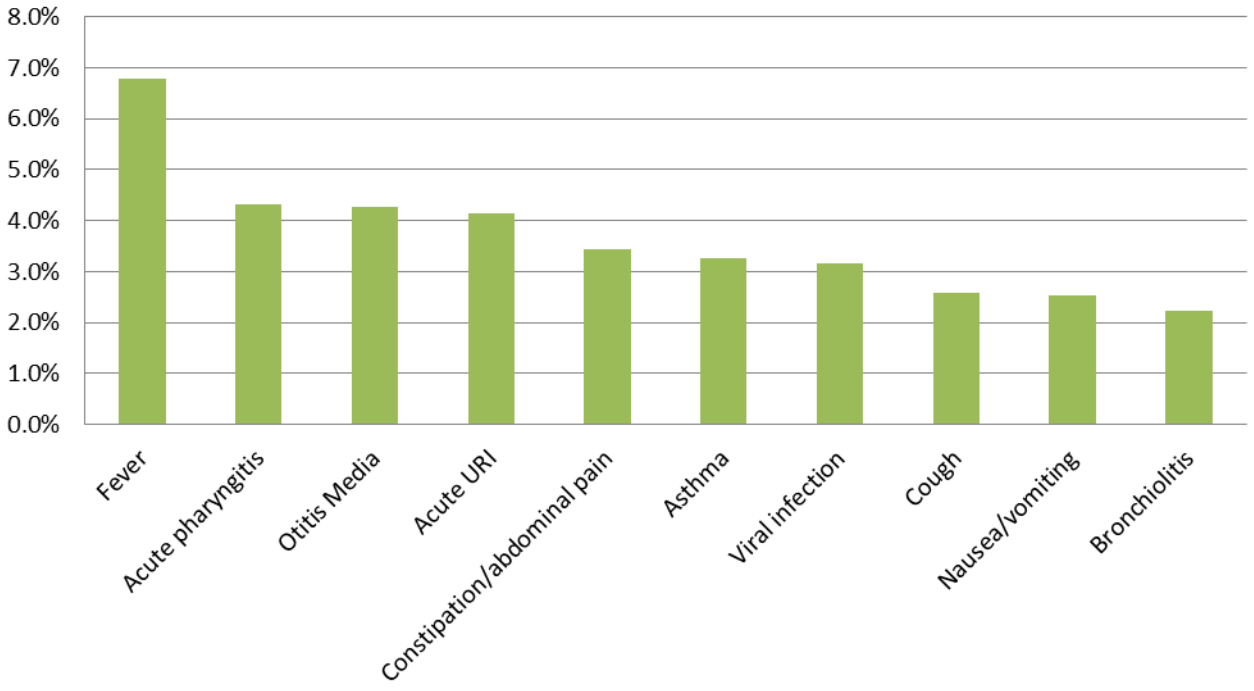
	CY14	CY15	CY16
Admits/1000	75.4	77.3	70.3
Days/1000	278.3	318.4	291.1
ER Visits/1000	671.7	659.1	644.5
ALOS	3.7	4.1	4.1
		% Change from PY	% Change from PY
Admits/1000		2.6%	-9.1%
Days/1000		14.4%	-8.6%
ER Visits/1000		-1.9%	-2.2%
ALOS		11.7%	0.0%

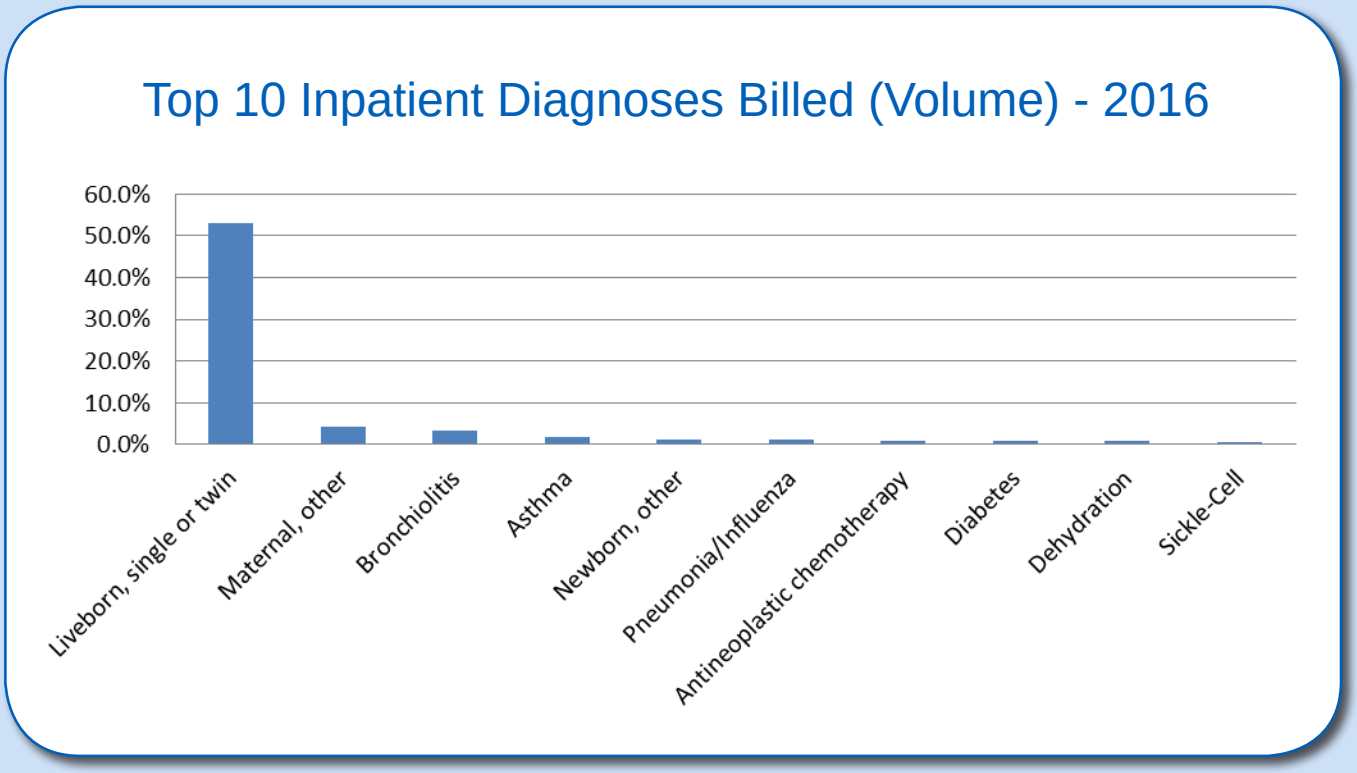


Top 10 Outpatient Diagnoses Billed (Volume) - 2016



Top 10 ER Diagnoses Billed (Volume) - 2016




Top 10 Inpatient Diagnoses Billed (Volume) - 2016
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Liveborn, single or twin
Maternal, other
Bronchiolitis
Asthma
Newborn, other
Pneumonia/Influenza
Antineoplastic chemotherapy
Diabetes
Dehydration
Sickle-Cell

Analysis:

Emergency room utilization continues to trend downward through collaboration with the primary care provider practices and appropriate identification and outreach to high emergency room utilizers.

Two trends are driving the higher ALOS from FY14. First, due to member mix changes, there are proportionally fewer regular newborns, which have very short lengths of stay, as a percentage of overall admissions. This increases the overall average length of stay. Second, and more importantly, as care integration processes deepen across the PCN population, lower acuity inpatient admissions are removed through timely identification and active management of at-risk members. By similar logic, as lower acuity/lower lengths of stay are removed from inpatient admission data for the population, there is a natural increase in the overall length of stay.

The formation of Care Teams to meet the LCCCP requirements allowed the PCN to restructure the utilization management area. Previously, a small team of Care Facilitation Nurses were responsible for all utilization management functions. With Care Teams developed, the UM functions were realigned.

Care Facilitation Nurses were placed on each Care Team and transitioned to a Care Navigator role. This not only allowed these responsibilities to be shared by a larger group but also allowed for professional development for the clinicians on the Care Teams. Each Care Team is responsible for utilization management functions for their assigned population. Prior authorization requests are received by Care Facilitation Coordinators and electronically distributed to the appropriate Care Team. The Community Resource Specialist (CRS) is the hub of the Care Team and receives all incoming tasks for the Care Team, including prior authorization requests. The CRS reviews and processes the request according to PCN policy. If the request is beyond the scope of a non-clinical staff member, the CRS enters a portion of the authorization into the system and then sends the request electronically to a clinician for review and completion. This process has minimized the volume of authorizations that are processed by a clinician allowing professionals to work to the top of their license. Care Teams also huddle each morning to review all inpatient admissions, discussing anticipated discharge needs and planning for transitional care and necessary follow up.

The 2016 utilization management audit results continue to exceed the established threshold of 95%.

The 2015 Annual Report noted that the PCN would be incorporating the Low Acuity Non-Emergent (LANE) ER logic into the software system. LANE ER logic has not been made available in the data analytics platform. Care Teams continue to reach out to high emergency room utilizers to assist with barriers to care, redirect to the primary care provider and provide education about appropriate use of the emergency room.

Next Steps:

The PCN continues to evaluate services that currently require prior authorization but are routinely approved. Through this evaluation, additional CPT and HCPCS codes have been identified to be removed from the PCN prior authorization requirements in 2017.

In 2017, the PCN will also be piloting a telehealth platform, KidCare Anywhere, in an effort to decrease emergency room utilization and redirect members to the primary care provider for non-emergent health concerns. This Children's Mercy Hospital initiative will be staffed by Children's Mercy providers initially to help triage non-emergent conditions. Providers will discuss the member's concern, provide guidance, and often provide treatment for minor ailments and illnesses. KidCare Anywhere will also be used by PCN Care Teams as an alternative method for in-person consultation, coordinating care for at-risk members over the platform.

4 Transitional Care

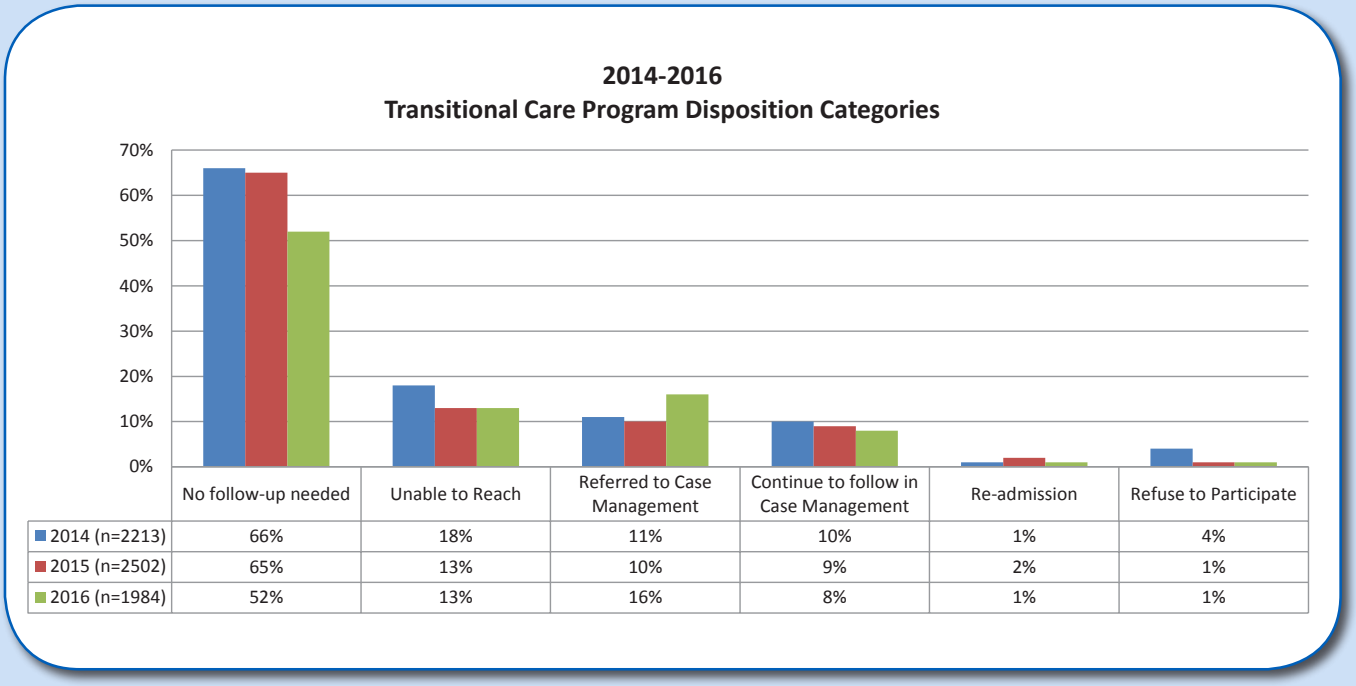
- Transitional Care Program Overview
- Program Measures
- Analysis
- Next Steps

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 patients and caregivers focusing on assessing and screening for barriers to care following inpatient admission. All inpatient discharges receive an initial call within 2-3 days post-discharge to assess the patient's needs related to PCP and specialist appointments, transportation, medication reconciliation, nutrition, durable medical equipment and skilled nursing services in the home. If needs are identified during the initial call, the Care Navigator coordinates services with the appropriate providers or vendors to ensure that the patient's needs are addressed. For patients with ongoing needs, a second call is made 10-14 days after discharge to address any other barriers to care. All patients discharged from the NICU receive both the initial and follow-up post-discharge phone calls. Upon completion of the phone calls, a transitional care summary is sent to the patient's PCP to communicate any barriers to care and interventions implemented by the Care Navigator.

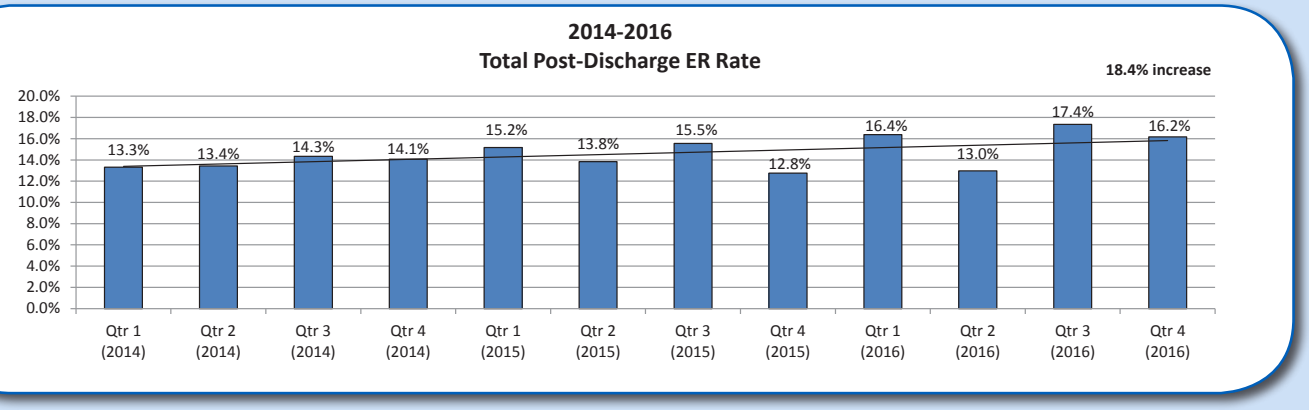
Program Measures:

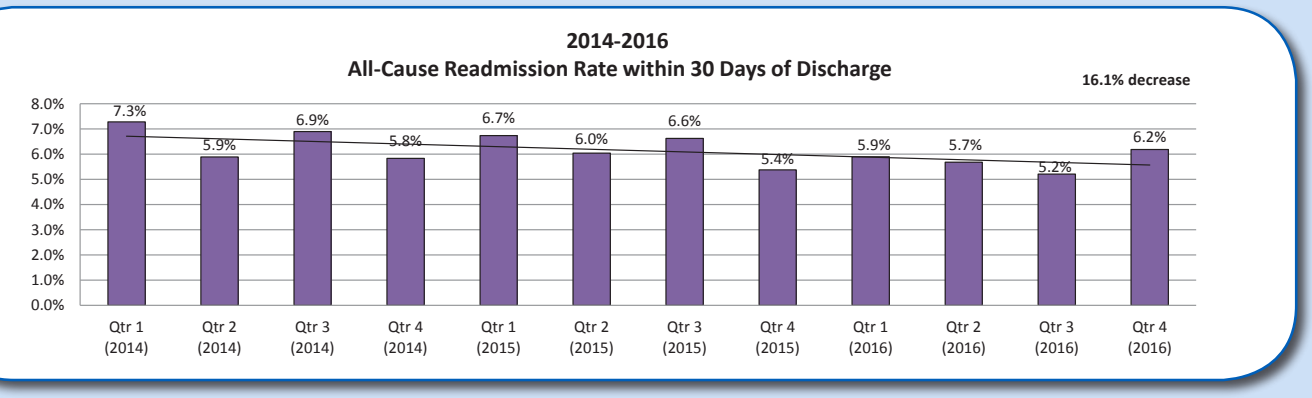
Care Navigators document transitional care program screenings in CARE (online documentation and communication tool), and statistics are reviewed monthly, including number of calls made, referrals to care management, and number who refuse to participate. In 2016, a total of 1,984 calls were completed through the transitional care program. When comparing 2014 to 2016 results, there is a decrease in the disposition of no follow up needed but an increase in referrals to care management. See chart below for disposition category results.



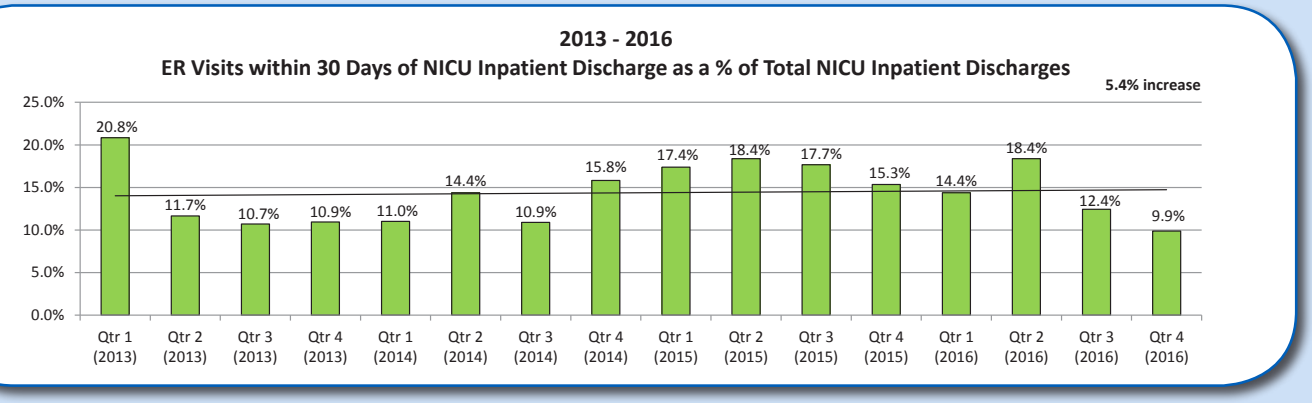
	No follow-up needed	Unable to Reach	Referred to Case Management	Continue to follow in Case Management	Re-admission	Refuse to Participate
2014 (n=2213)	66%	18%	11%	10%	1%	4%
2015 (n=2502)	65%	13%	10%	9%	2%	1%
2016 (n=1984)	52%	13%	16%	8%	1%	1%

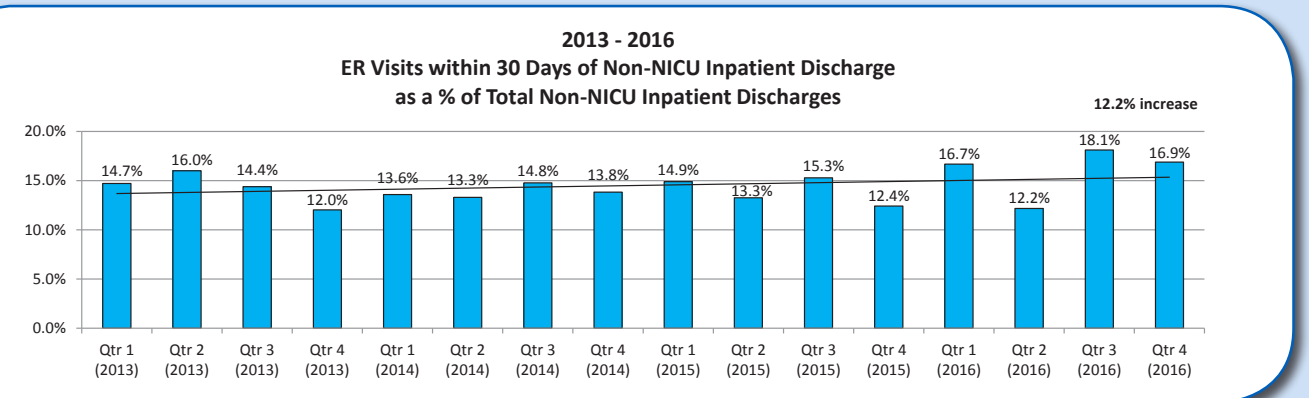
The overarching goal of the Transitional Care Program is to decrease emergency room visits and unplanned hospital readmissions. Below is a three year trend (2014-2016), based on claims data, of 30 day post-discharge ER rates and all-cause readmission rates for the PCN population.





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





Analysis:

Over a three-year reporting period, the data reveals an overall decrease in all-cause readmission rates within 30 days of hospital discharge by 16.1%. The PCN has demonstrated progress in decreasing the readmission rates but continues to face challenges in impacting post-discharge ER rates. The rate for 30 day post-discharge ER visits increased during the same reporting timeframe by 18.4%. In 2016, the data shows that there was a 5.4% increase in ER visits within 30 days after discharge from the NICU and a 12.2% increase in ER visits within 30 days for non-NICU patients.

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 Hospital Home Care department in order to provide in-home nurse and social work assessments and interventions for patients discharged from high volume NICU facilities. The initiative was implemented in August 2016 and designed to provide up to 6 weeks post-discharge support and education to caregivers in the home. Patients with complex medical needs requiring skilled nursing services in the home were excluded from this program.

Next Steps:

The quality improvement team met in early 2017 to review preliminary data on the post-discharge ER home care initiative. Early data indicates no change in the post-discharge ER rate for NICU babies being discharged from the high volume facilities with home care support (the intervention group) versus those who did not receive the home care intervention (the control group), however it is too early to provide a comprehensive analysis of the effectiveness of the intervention. Anecdotally, the home care nursing staff believe the program has been successful in preventing ER visits in the patients they were able

to actively engage in the program, citing examples of where they have identified feeding issues and lack of weight gain early and provided interventions resulting in a change in the patient's plan of care. The quality improvement team determined ways to further analyze the initiative, including adding interpreter information, as well as standardizing the referral process and disposition categories for patients being closed from the home care program. In addition, the team identified an opportunity to add education about well child and immunization schedules to the home visit teaching program. Additional measures of compliance with recommended well child and immunization schedules will be added to the study. Final analysis of the intervention will occur in early Fall 2017 after a full year of post-intervention data is available.

5

Care Management/Disease Management Evaluation

- Care Management/Disease Management Program Overview
- Program Measures
- Analysis
- Next Steps

Care Management & Disease Management Program Overview:

Care management and disease management are important components of the Care Integration program. The goals of both care management and disease management include helping members sustain or regain optimal health, improve quality of life, and reduce overall healthcare costs. This is achieved through the well-coordinated efforts between the program staff, members, caregivers, providers, and community agencies. Including the PCPs in this integration assures continuity of care and alignment for improving health outcomes.

The Care Integration Care Teams work closely with the member's PCP and other specialists and 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.

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 way we identify members, the processes for interventions, the documentation of those interventions, and the measurement of outcomes. The PCN care management application, or CARE, incorporates comprehensive assessment forms, case documentation, and referral tracking for all care management activities.

The Care Integration management team conducts quarterly audits of care management 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. Action plans were implemented 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 management team conduct routine case rounds with the care management staff to review current status of cases, discuss barriers to care, and identify interventions and goals for complex cases. This forum provides an ongoing process for care management staff to learn from others and promotes consistency in applying care management principles.

The following care management program enhancements were implemented in 2016:

- Redefined risk levels for care management incorporating social and behavioral determinants of health into the evaluation and screening process
- Added Social Work Care Navigators to the care management team
- Development of psychosocial assessment for the Social Work Care Navigators to use for members with primarily high risk social barriers to care
- Care Navigators implemented a Quality of Life survey for caregivers when a case was initiated, every six months and at case closure
- Development and implementation of Community Engagement Resource Application (C.E.R.A.) to aid Care Navigators and community providers with community resources linkage for members
- Developed clinically-focused education for Care Integration staff
- Conducted chart audits in PCP offices for behavioral health integration
- Implemented NICU Post-Discharge Home Care program
- To identify patients at risk for depression, PHQ-2 and PHQ-9 screenings were implemented with all members age 12 and above. We will begin measuring this intervention in 2017.

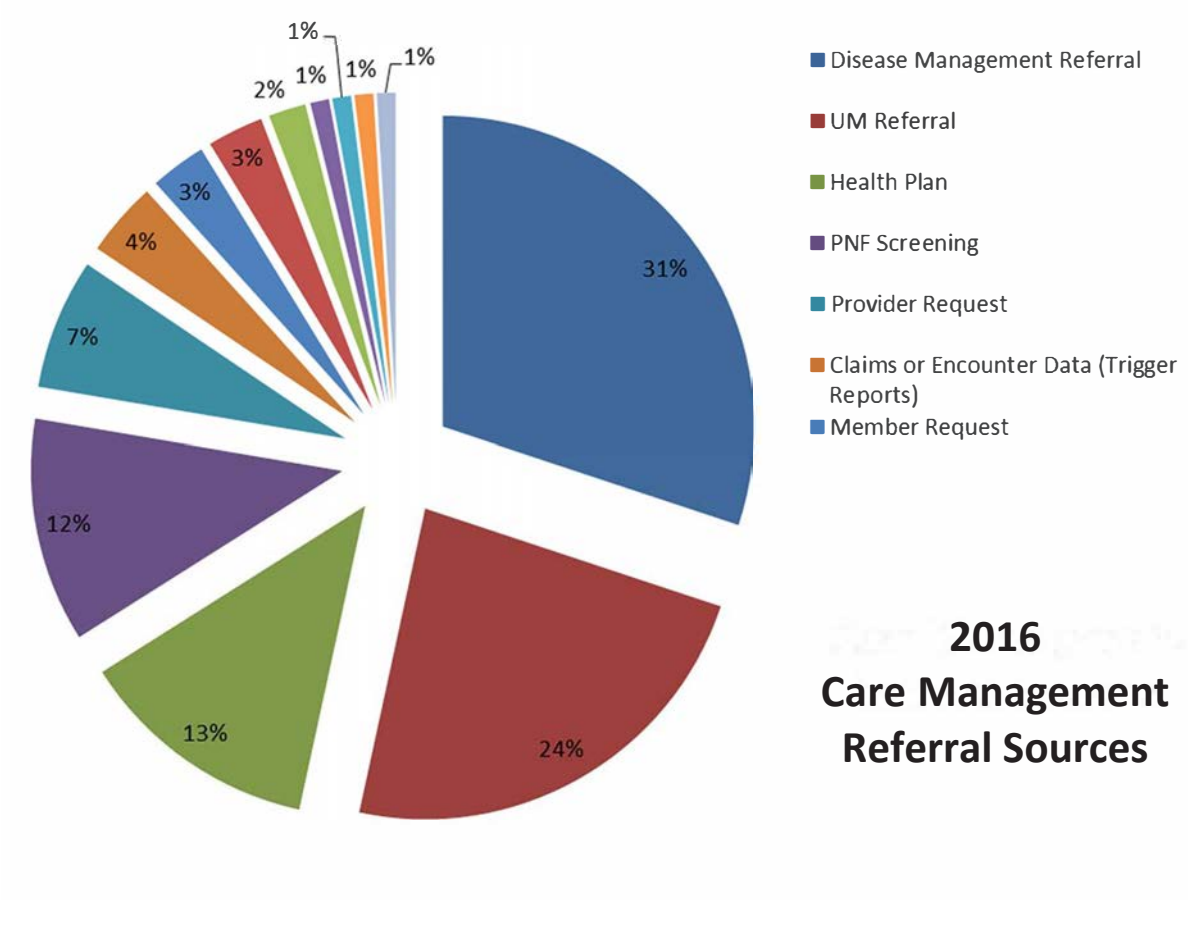
PROGRAM MEASURES:

Program Referral Statistics

Care Management Referral Sources

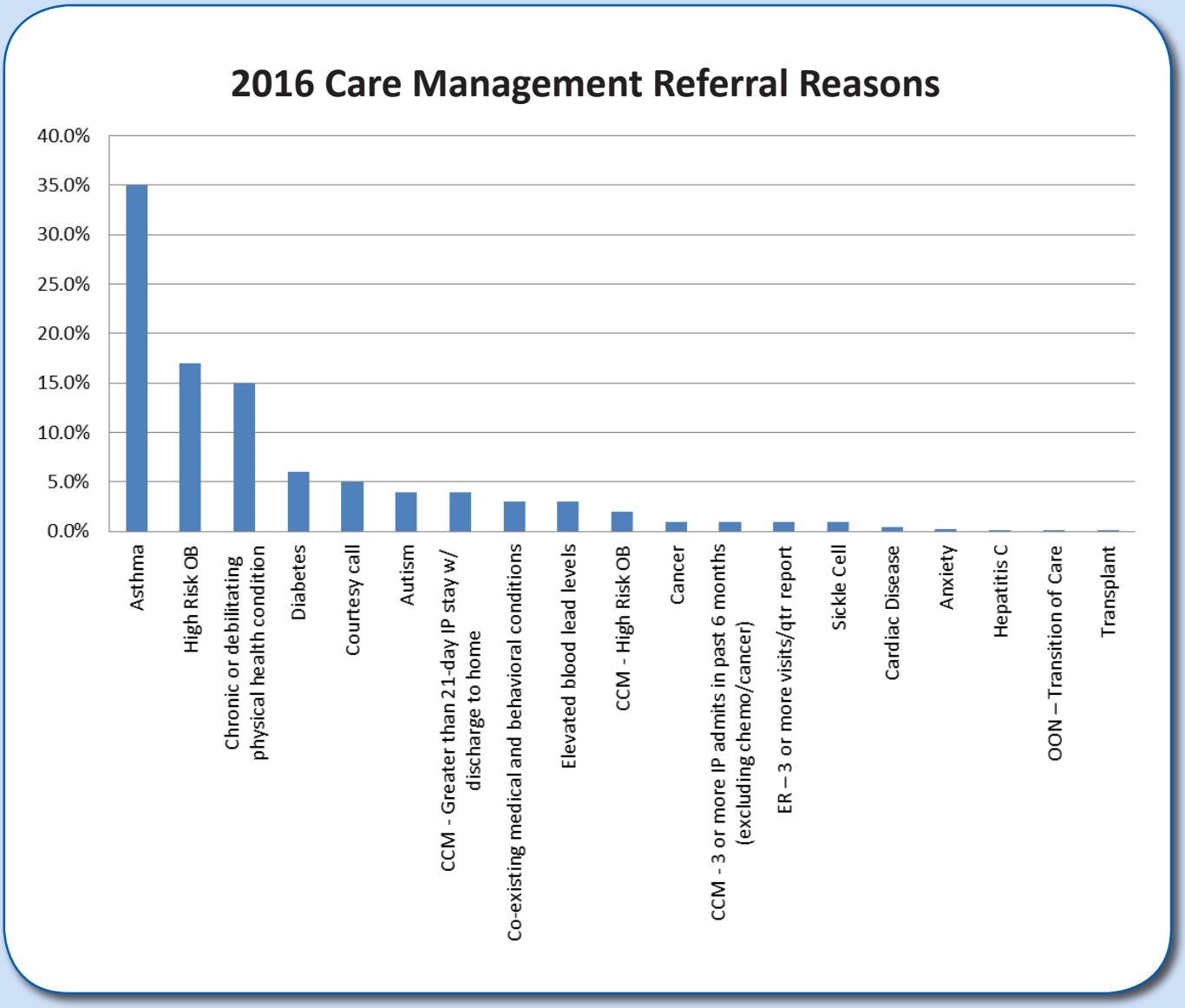
In 2016, the care management team received a total of 1,668 referrals and opened 1,111 unique cases, or 73% of referrals. There were 1,463 total members in care management at some point in 2016, which includes cases that were opened prior to 2016. This compares to 1,134 referrals in the prior year (2015), with 1,005 unique cases opened, or approximately 84% of referrals.

The largest referral source for cases opened in care management originated from the disease management registry auto-referral process (31%). Each month the disease management registry stratifies members into low, medium and high categories. Members stratified at medium or high are automatically referred for care management assessments and interventions. The second highest referral source is Utilization Management (UM). UM process referrals come from the daily inpatient census review, the discharge planning process, and/or the post discharge transitional care process.



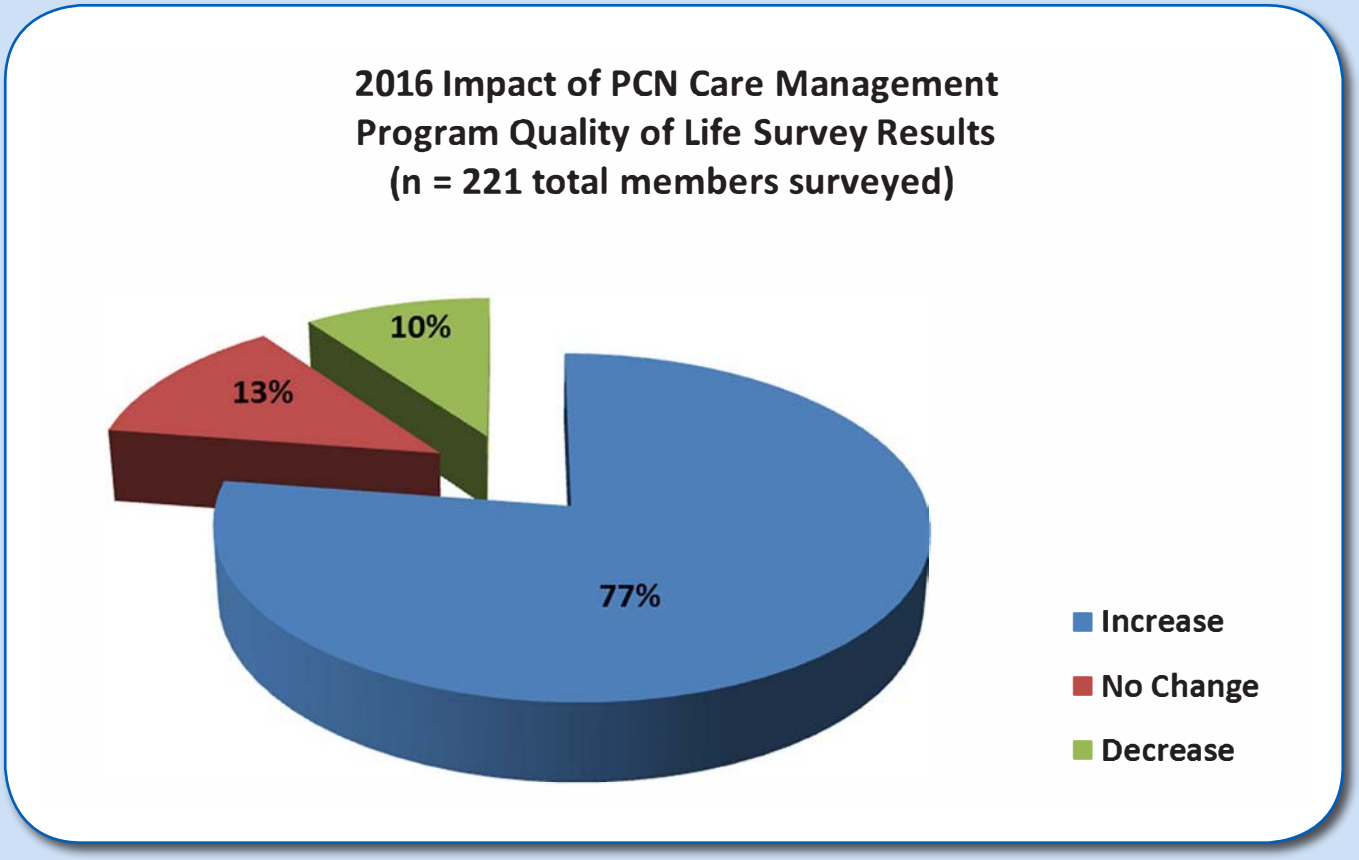
Care Management Referral Reasons

In addition to referral sources, the care management system reports on the referral reasons for each referral sent. For 2016, the highest referral reason was asthma (35%) with high risk OB second highest (17%) and chronic or debilitating physical health condition third highest (15%).



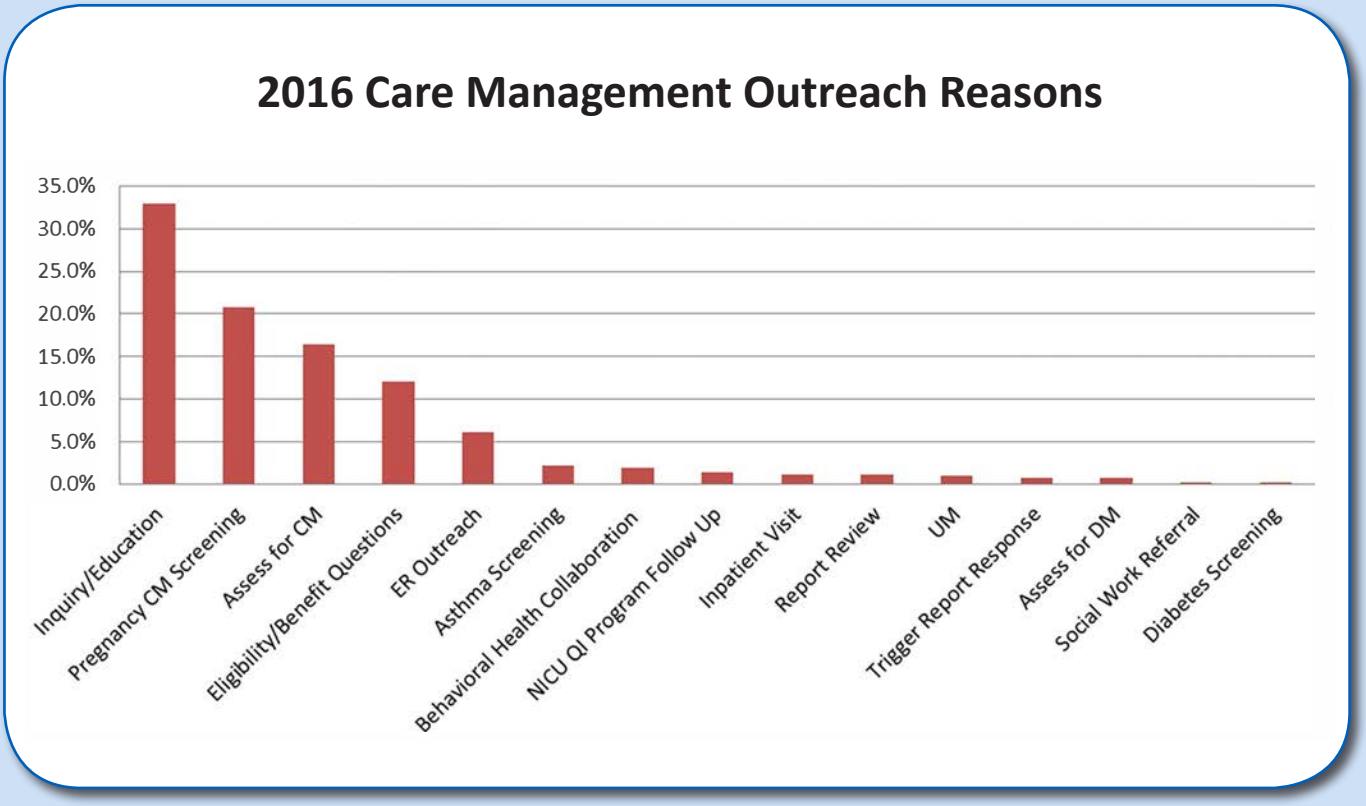
Quality of Life

Caregiver Quality of Life surveys were initiated when a case was opened, every six month and at case closure. The graph below shows the change of the caregiver's quality of life over the course of enrollment in the care management program. There was a 77% increase in caregiver quality of life from the enrollment to closure in the care management program.



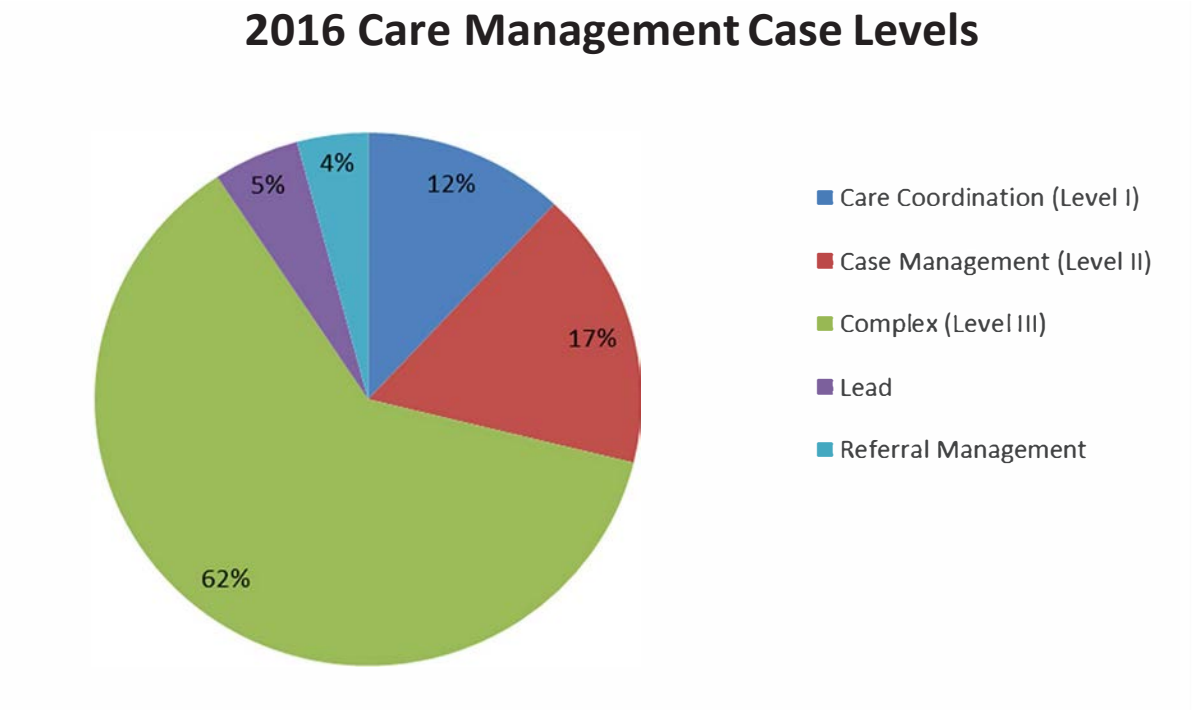
Care Management Outreach Reasons

The care management team performs outreach to non-care managed members throughout the year for short-term education related to benefits, assistance with PCP connections, frequent flier ER education, pregnancy risk screening, and other general screening for care management services. In 2016, the team performed outreach to 4,779 members, compared to outreach performed with 3,480 members in the previous year. Below are the categories of outreach performed by the care management team in 2016.



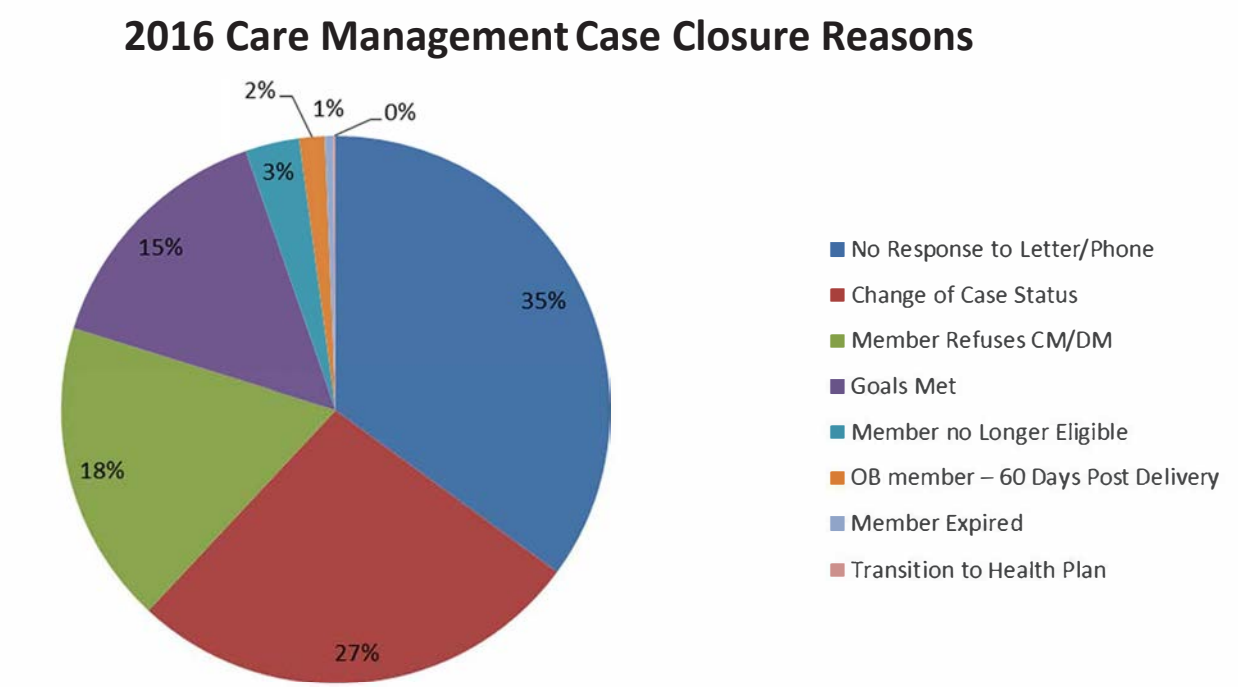
Care Management Case Levels

Case types are determined based on program criteria and help to establish levels of complexity and interventions, as well as assist with caseload evaluation and equity of workload among the case management team. In 2016, the following case types were used and reflected in the below chart: Referral Management, Care Coordination – Level I, Case Management – Level II, Complex – Level III, and Lead.



Care Management Case Closure Reasons

For each case that is closed, 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 percentage closed due to lack of member engagement. The primary reason for case closure in 2016 was No Response to Letter/Phone (35%), followed by Change of Case Status (27%), Member Refused CM/DM (18%) and Goals Met (15%). Below are the case closure reasons for 2016.



Program Utilization: Cost for Care Managed Population
(pre and post care management intervention)

The PCN evaluates the rate of hospitalizations and ER visits, as well as per member per month costs for members enrolled in care management. The data analytics team evaluates members opened at least sixty (60) days in care 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 to be the date the member was opened in the care management program.

Note: Due to the nature of the pre/post care management cost analysis, the cases included in this figure were opened in 2015.

Children's Mercy Pediatric Care Network			
Complex Care Management Cases - Opened Calendar Year 2015			
Aetna and Missouri Care Missouri Medicaid Members			
January 1, 2014 thru December 31, 2016 Dates of Service			
Metric	**Pre Case Date**	**Post Case Date**	**% Change**
Members	288	288	
Member Months	2,601	3,249	
IP Admits per 1000	93	63	-32%
Average LOS	11.5	6.4	
IP Costs per Day	$2,521	$2,023	
ER Visits per 1000	281	220	-22%
ER Cost per Visit	$845	$949	
IP PMPM	$2,692	$826	
OP PMPM	$678	$655	
ER PMPM	$238	$209	
PHYS PMPM	$409	$630	
Total Medical PMPM	$4,017	$2,320	-42%

Program Quality Outcomes (HEDIS-like measures)

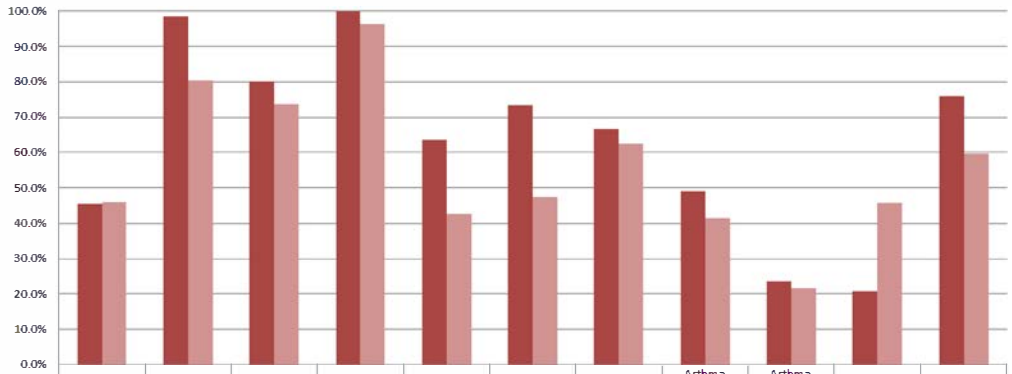
The PCN evaluates pediatric-focused HEDIS measures using claims/administrative data to compare its care managed population outcomes to the PCN population as a whole. Only HEDIS measures with 10 patients or more in the denominator within the measurement year were selected for the comparison. For this year's analysis, eleven (11) HEDIS measures were reviewed and are displayed in the chart below. These measures focus on Adolescent Well-Care visits (AWC); access to care (CAP); CHIPRA measures; chlamydia screenings; immunizations; lead screenings; asthma medication management; as well as Well-Child visits for children ages 0-15 months and 3-6 years of age.

Using the chi square statistical method, five (5) of the eleven (11) HEDIS measures selected showed statistically significant ($p \leq .05$) differences between the care managed population and the non-care managed population. These measures included the following:

- Access to care (CAP)
- Chlamydia screenings
- Immunizations (Combo 2)
- Well-Child visits (0-15 months of age)
- Well-Child visits (3-6 years of age)

Note: Well-Child visits (0-15 months of age) for complex care management cases showed to be statistically lower (20.7%) than the overall PCN population. This complex newborn population faces barriers to attaining six (6) Well-Child visits by the age of fifteen (15) months. If the number of patients with five (5) Well-Child visits were added to the number of patients with six (6) Well-Child visits, the rate would then be 51.7%.

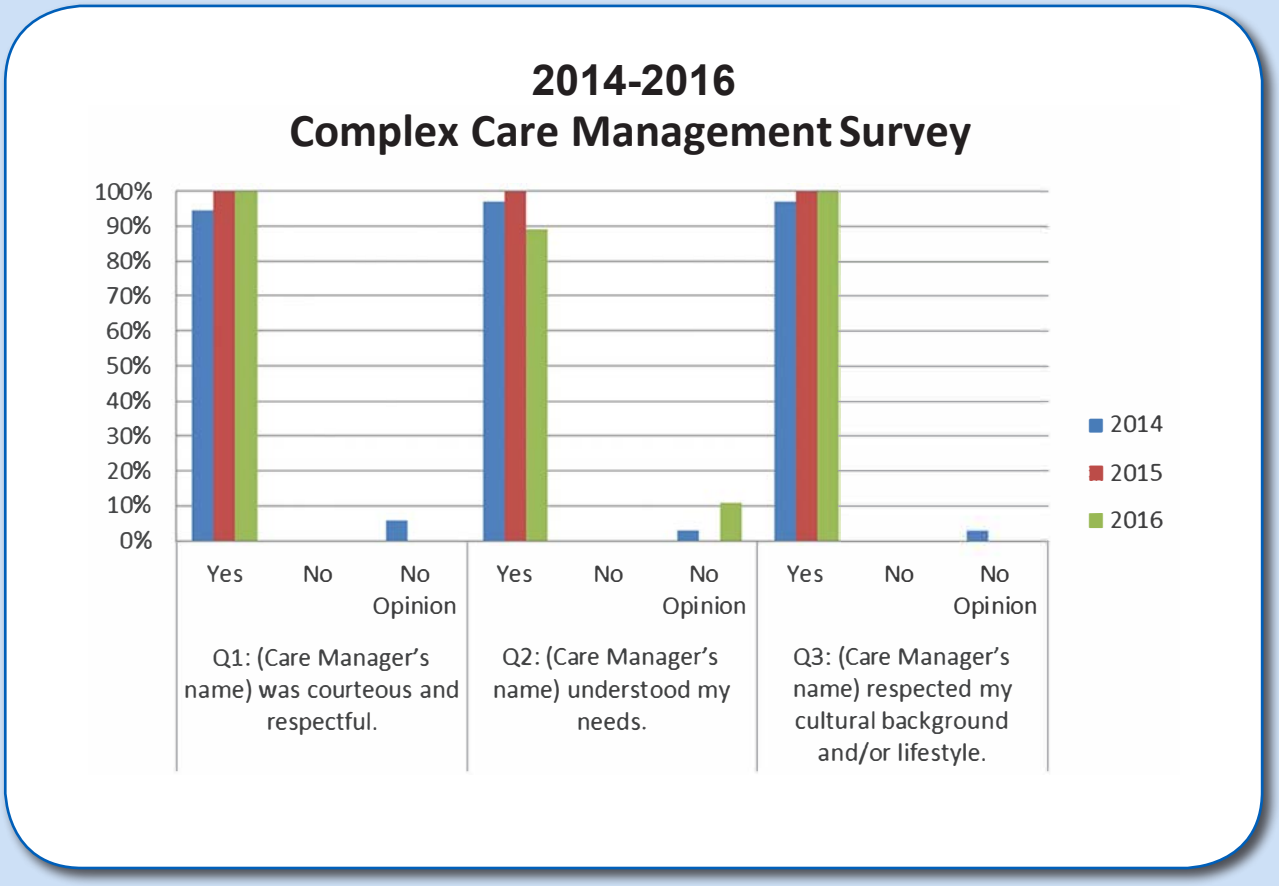
2016 HEDIS-like Measures Comparison
Care Managed Population vs. PCN Population
(only includes measures with 10 or more in the denominator)



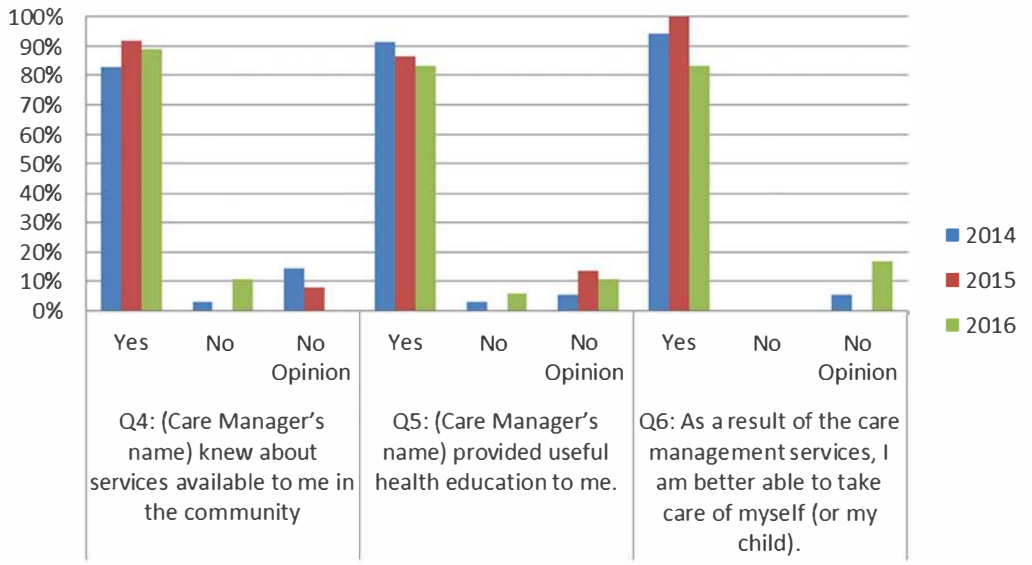
	AWC	CAP	CHIPRA HbA1c	CHIPRA Nephropathy	Chlamydia Screening	Combo-2	Lead Screening	Asthma Medication Mgmt (50%)	Asthma Medication Mgmt (75%)	Well-Child (0-15 months)	Well-Child (3-6 years)
Care Managed Population (2016)	45.3%	98.6%	80.0%	100.0%	63.6%	73.3%	66.7%	49.0%	23.5%	20.7%	75.8%
PCN Population (2016)	46.0%	80.3%	73.6%	96.3%	42.6%	47.3%	62.4%	41.6%	21.7%	45.7%	59.7%

Member/Caregiver Experience with Care Management

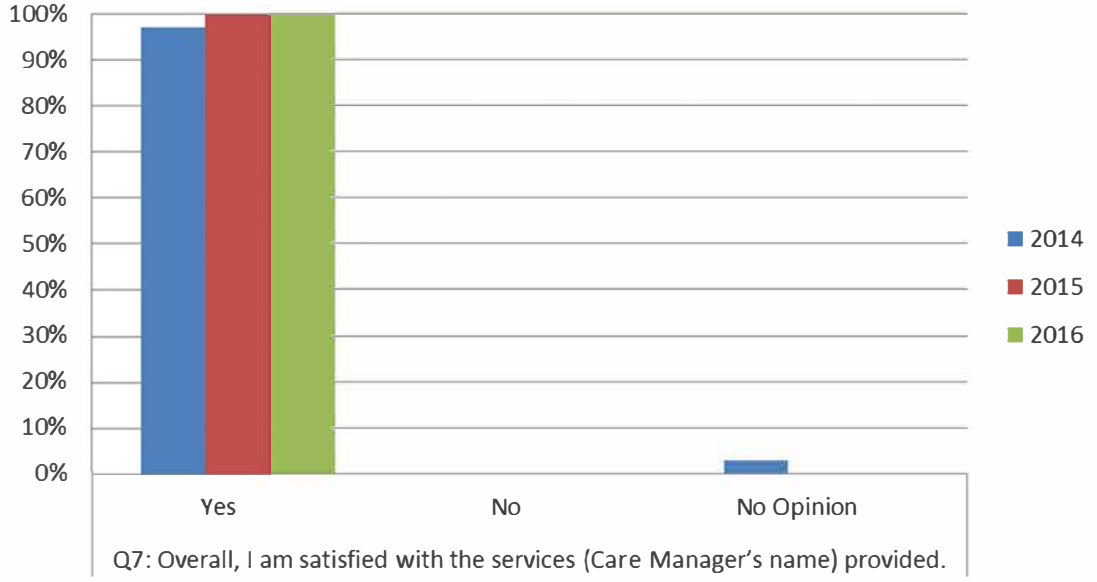
The PCN conducts quarterly member satisfaction surveys with members and their caregivers who have been enrolled in the complex care management program for a minimum of sixty (60) days. The survey involves asking seven (7) questions with an open ended opportunity for member comments at the end of the survey. The 2016 survey results were compared to 2014 and 2015 survey results and are displayed here. In 2014, 34 member satisfaction surveys were completed; with 41 completed in 2015 and 22 completed in 2016.



2014-2016
Complex Care Management Survey

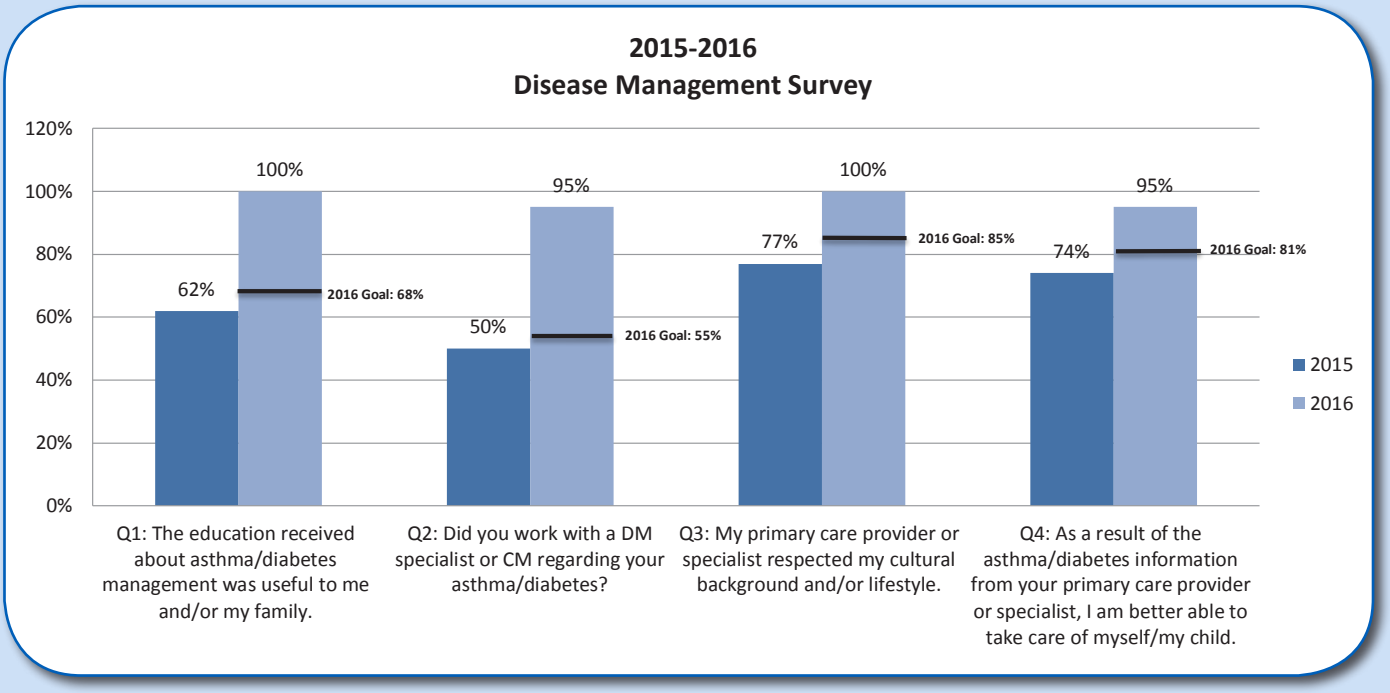


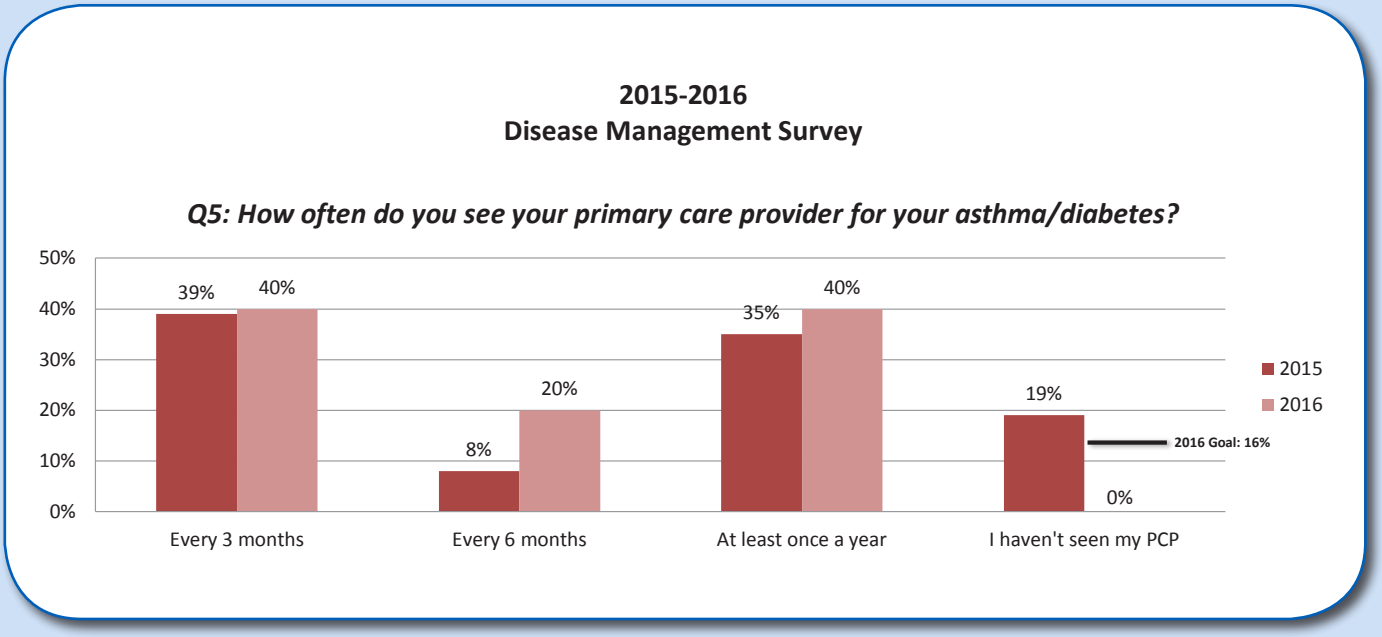
2014-2016
Complex Care Management Survey



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. 2016 was the second year the survey was conducted by the PCN; the 2016 survey results were compared to 2015 survey results and are displayed here. In 2015, 37 disease management surveys were completed and in 2016, 20 surveys were completed.





Member Complaints and Grievances

PCN is not delegated to perform complaint, grievance, and appeal processes but is notified by the Health Plan if a member issues a complaint or grievance related to the PCN's programs. In 2016, no member complaints or grievances were received related to the PCN's care management or disease management programs.

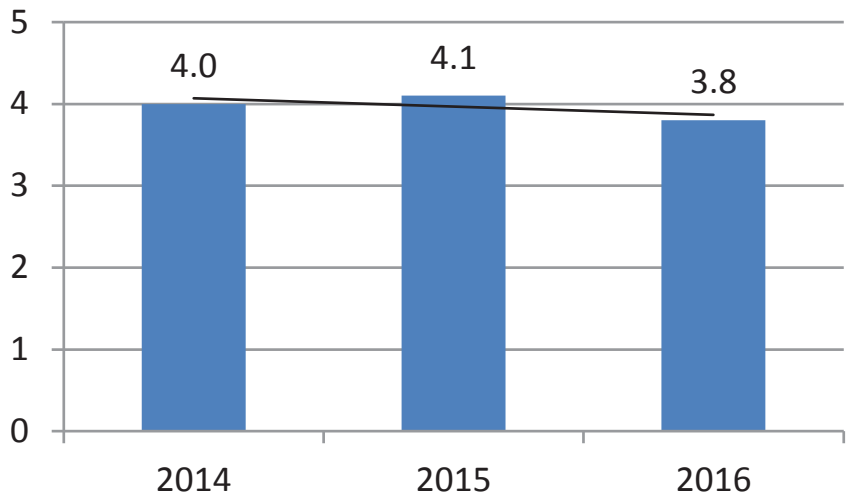
Disease Management Outcomes for Asthma & Diabetes

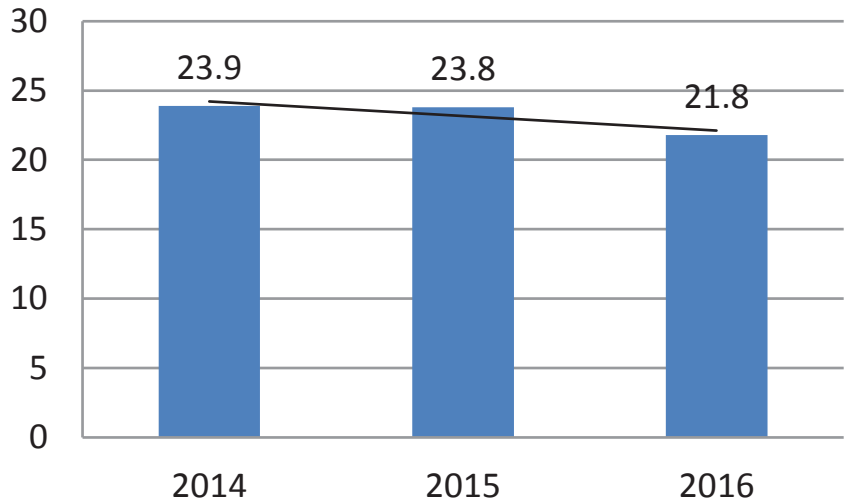
PCN's Disease Management programs use a unique approach to manage chronic asthma and diabetes. It is a collaborative effort between the primary care providers, Patient Centered Medical Home team (PCMH) and care management team. The PCMH team provides Practice Facilitation Specialists who work with the primary care provider offices to implement comprehensive disease management concepts into their practices and the Care Navigators work with the medium/moderate and high risk members identified on the disease management registries. Success of the program requires ongoing collaboration between the Care Team, PCP, patient, and caregivers.

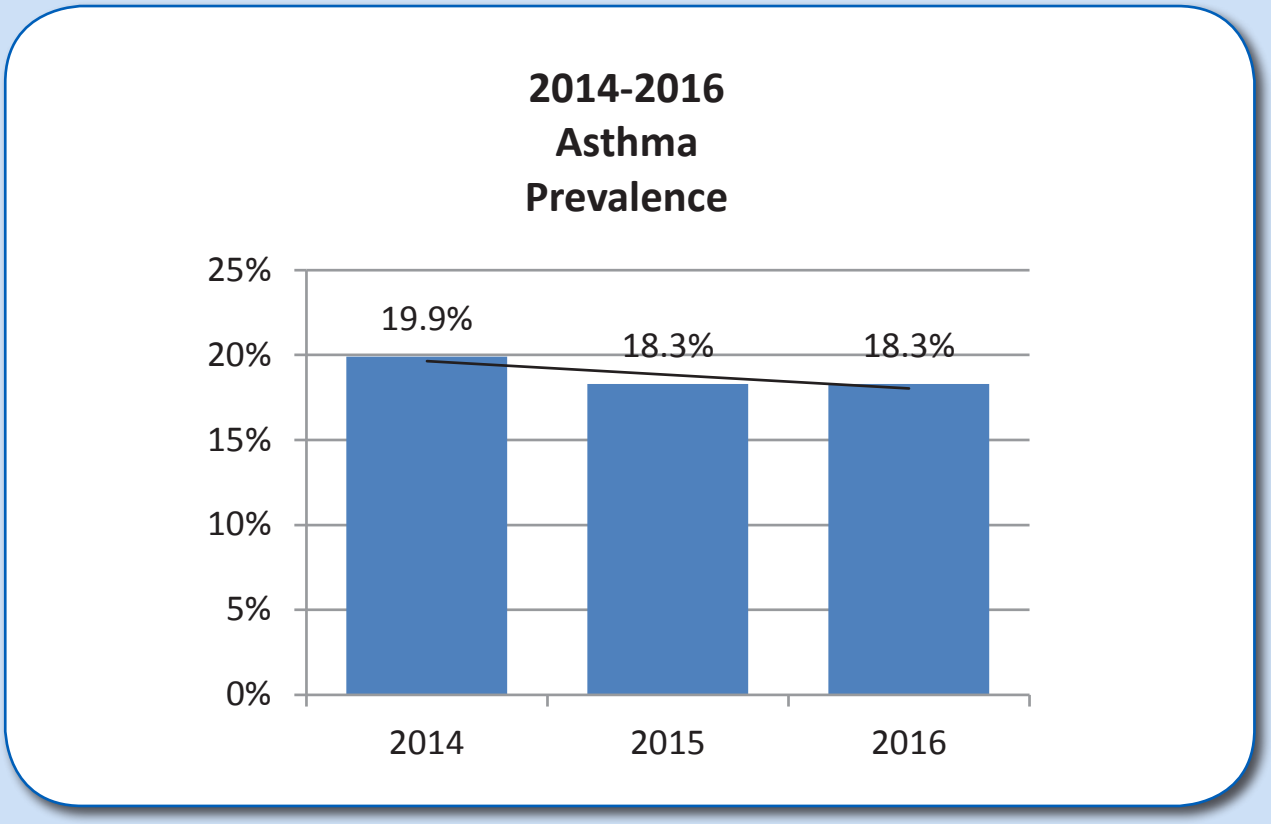
The program consists of physician office education, Patient Centered Medical Home support, quality improvement techniques, data analytics and reporting, and focused care management interventions, with the goals of improving the health of the population and reducing cost.

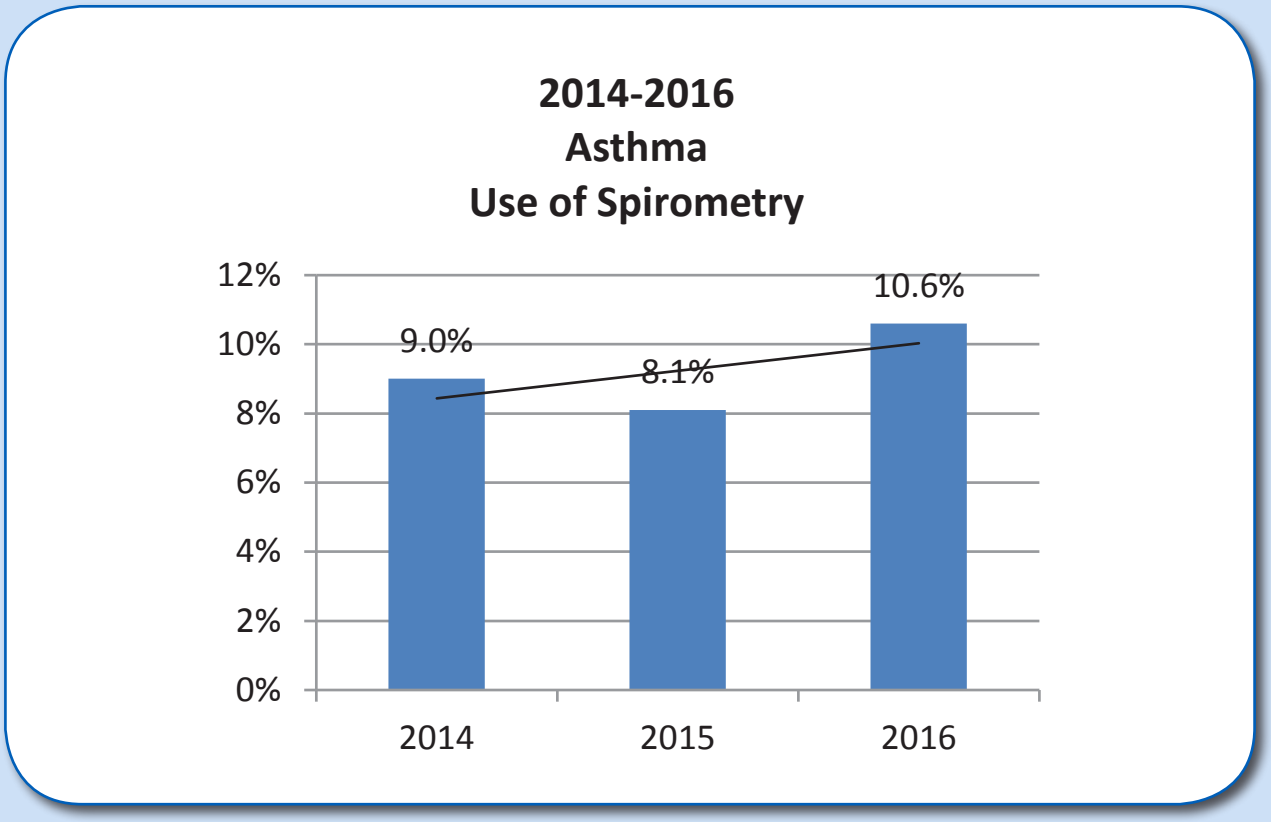
The care management staff received education on asthma and diabetes management and tools were built into the care management system to allow for effective management of this population. The care management audit tool includes disease management components to hold staff accountable to disease management requirements.

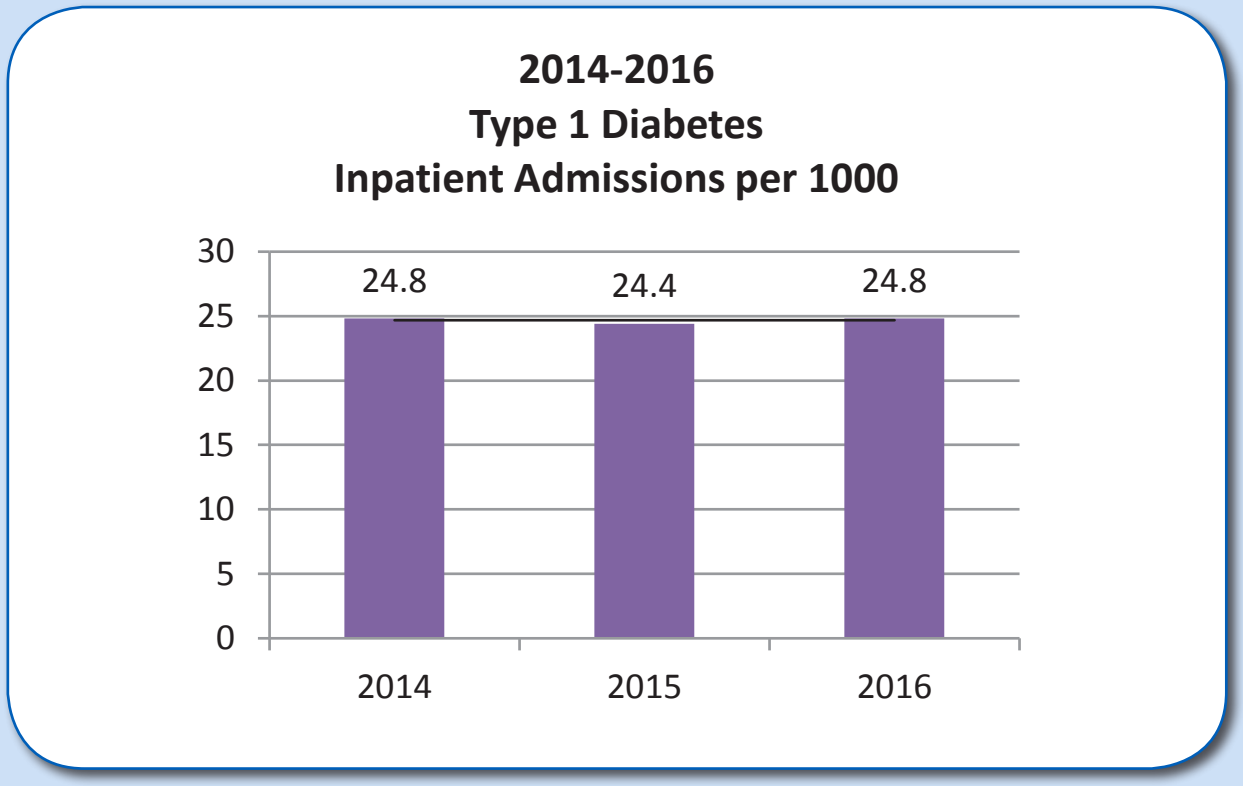
Disease Management Outcomes

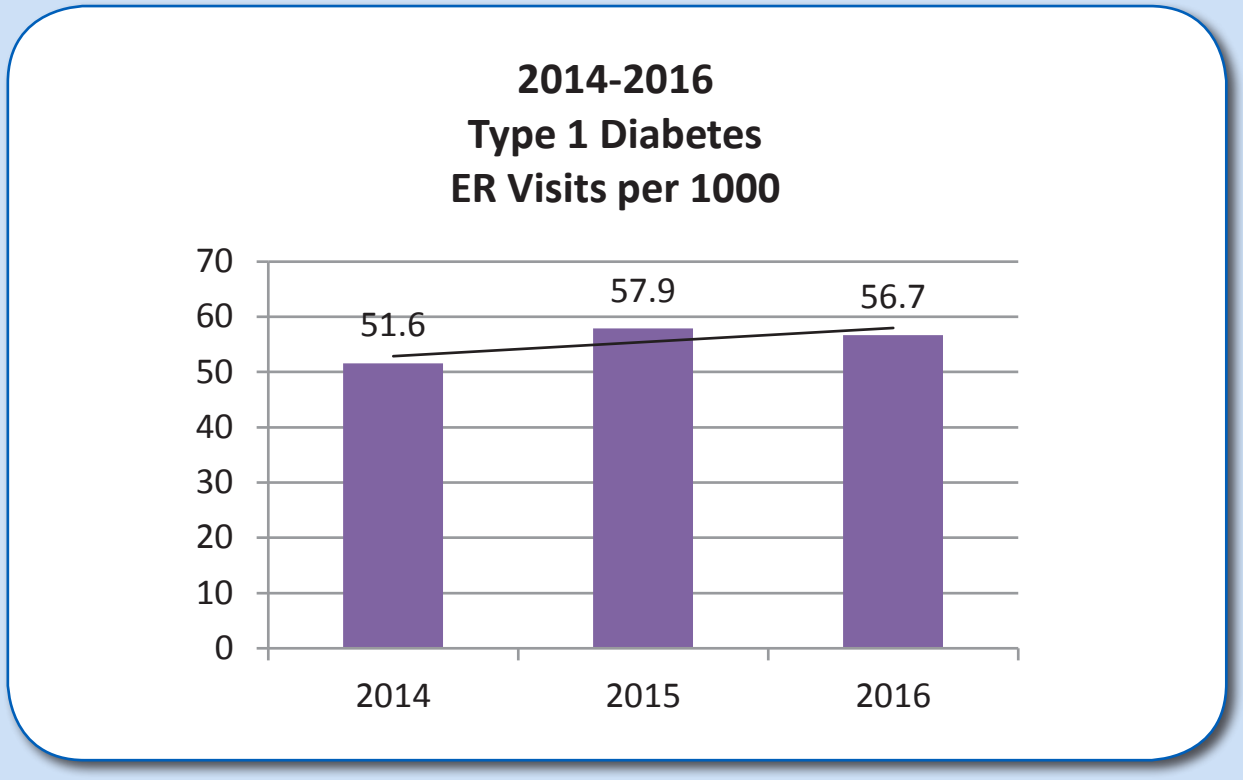


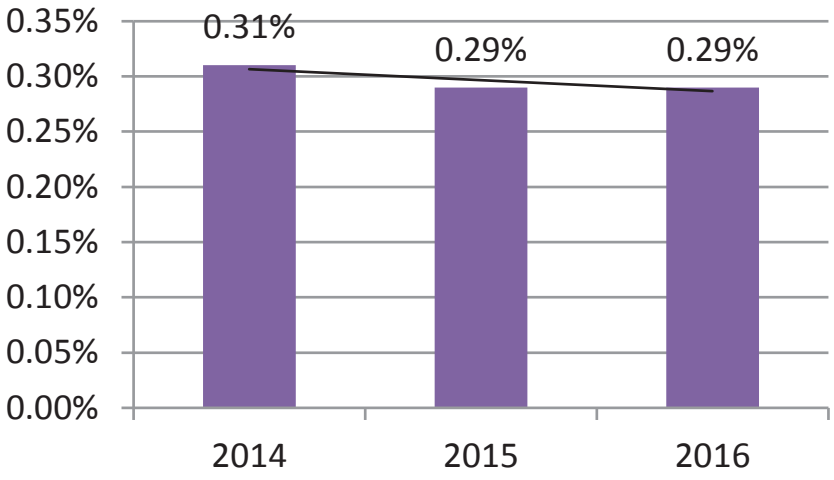


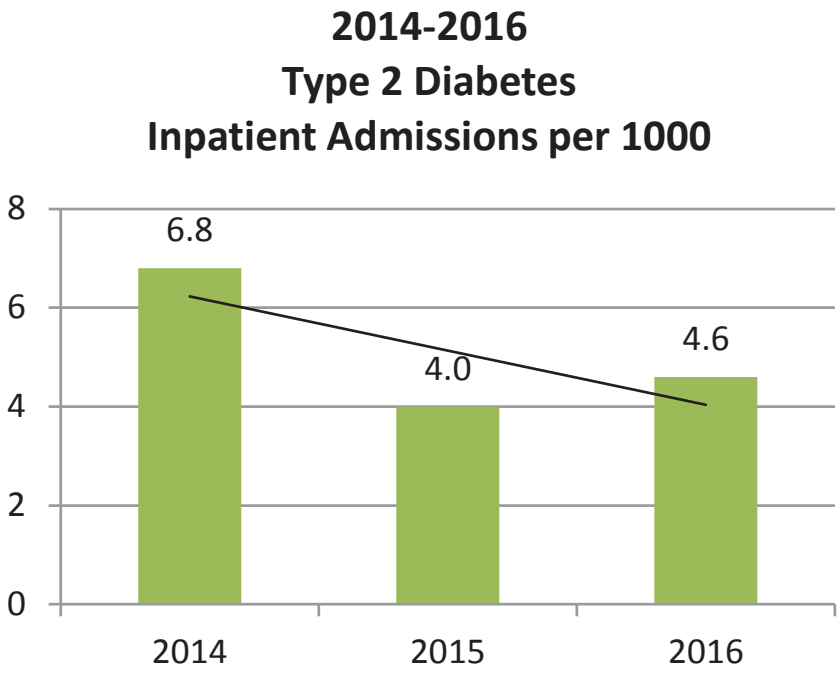

2014-2016
Asthma
Prevalence
25%
20%
15%
10%
5%
0%
19.9%
18.3%
18.3%
2014
2015
2016

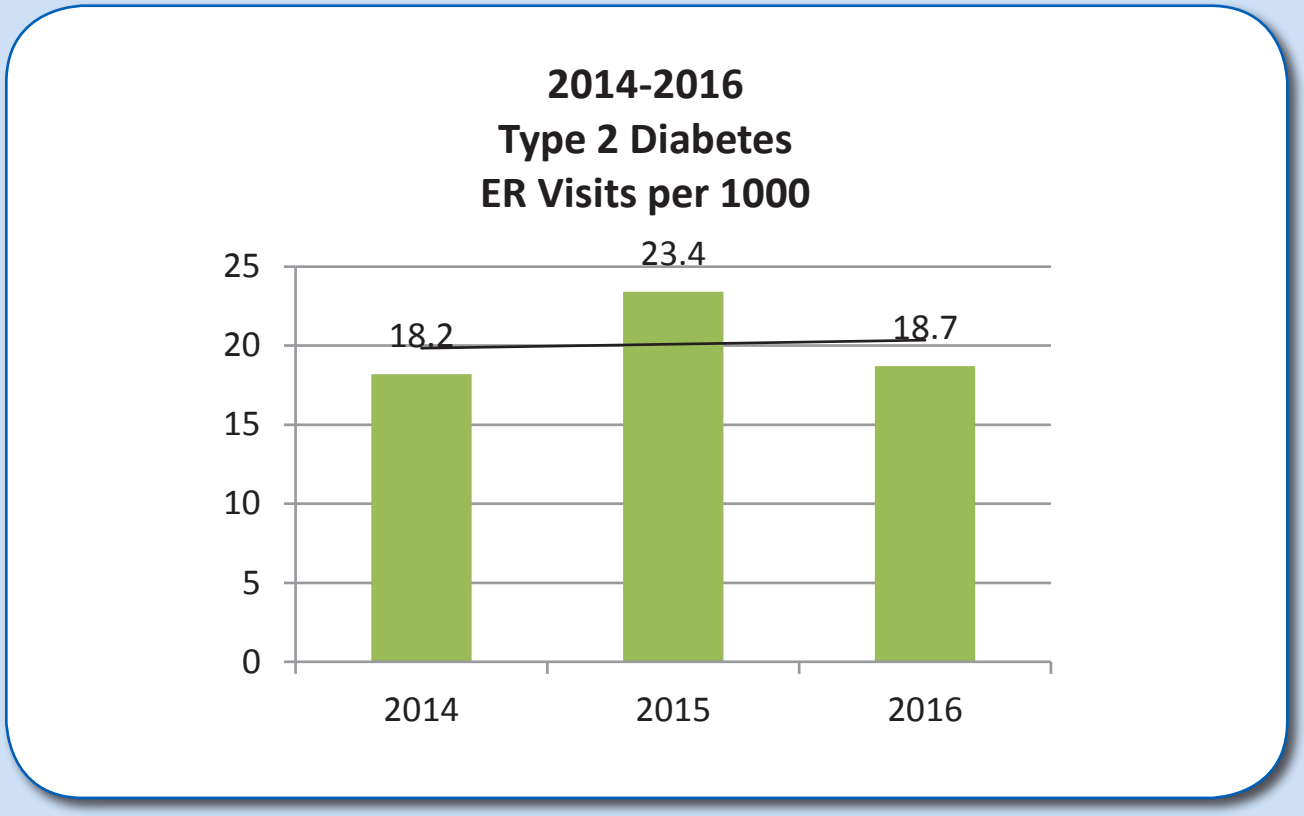

2014-2016
Asthma
Use of Spirometry
12%
10%
8%
6%
4%
2%
0%
9.0%
8.1%
10.6%
2014
2015
2016

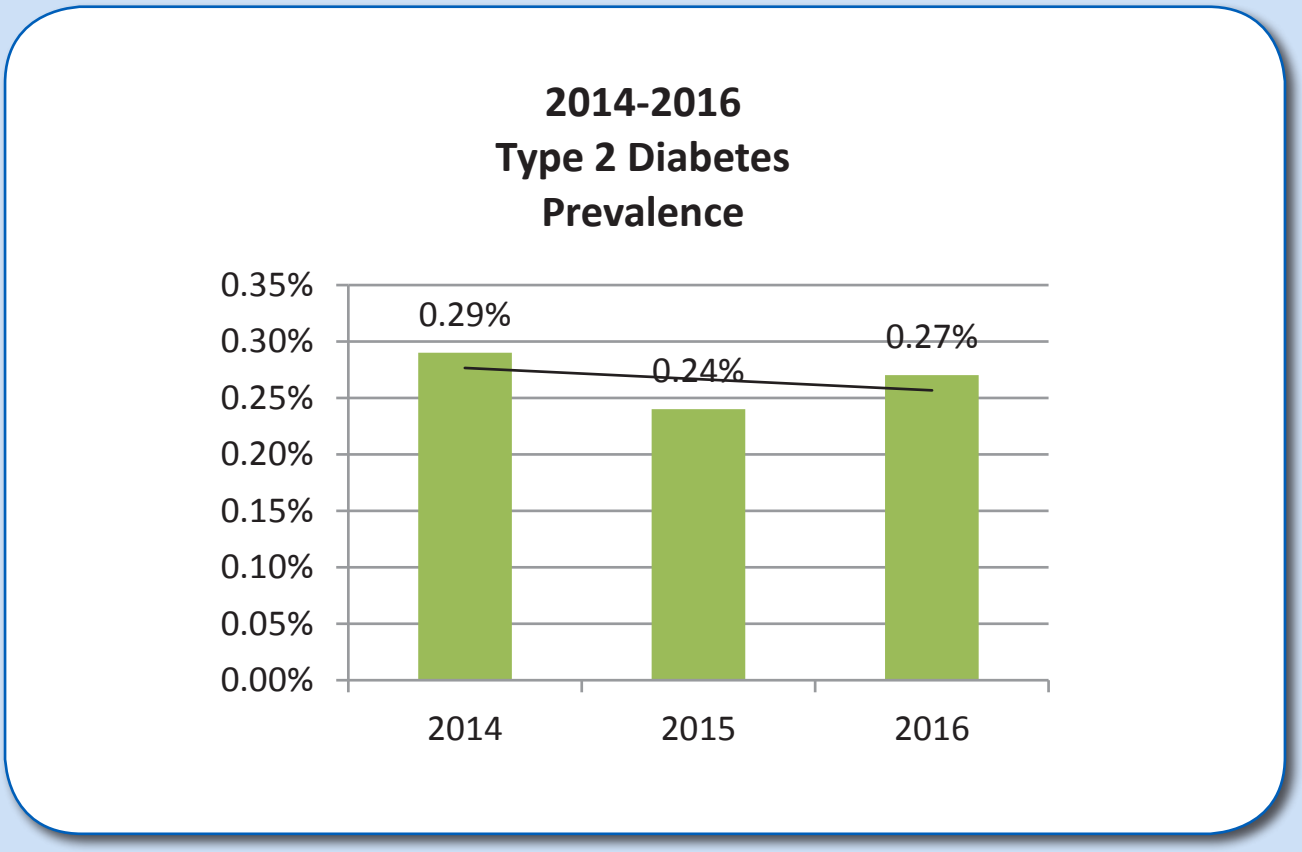

2014-2016
Type 1 Diabetes
Inpatient Admissions per 1000
30
25
20
15
10
5
0
24.8
24.4
24.8
2014
2015
2016

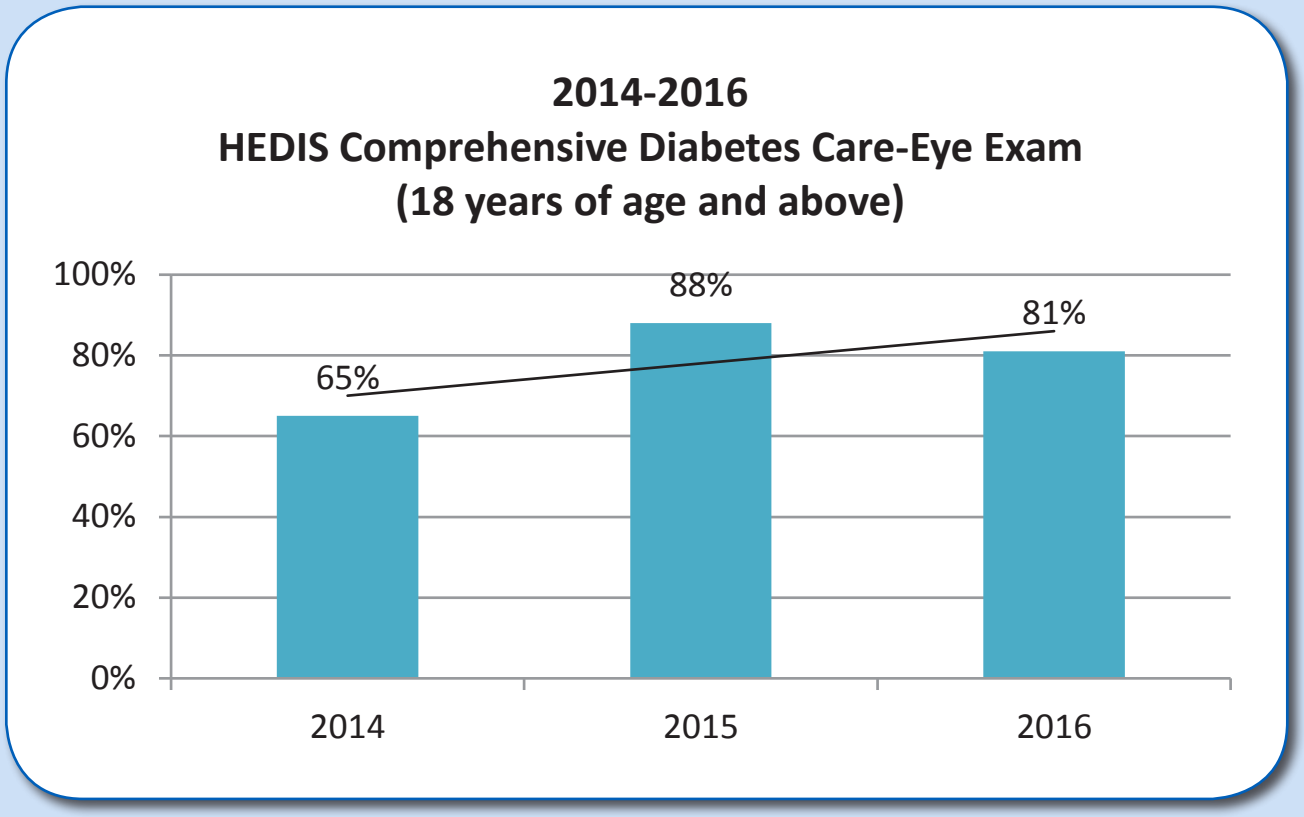

2014-2016
Type 1 Diabetes
ER Visits per 1000
70
60
50
40
30
20
10
0
51.6
57.9
56.7
2014
2015
2016

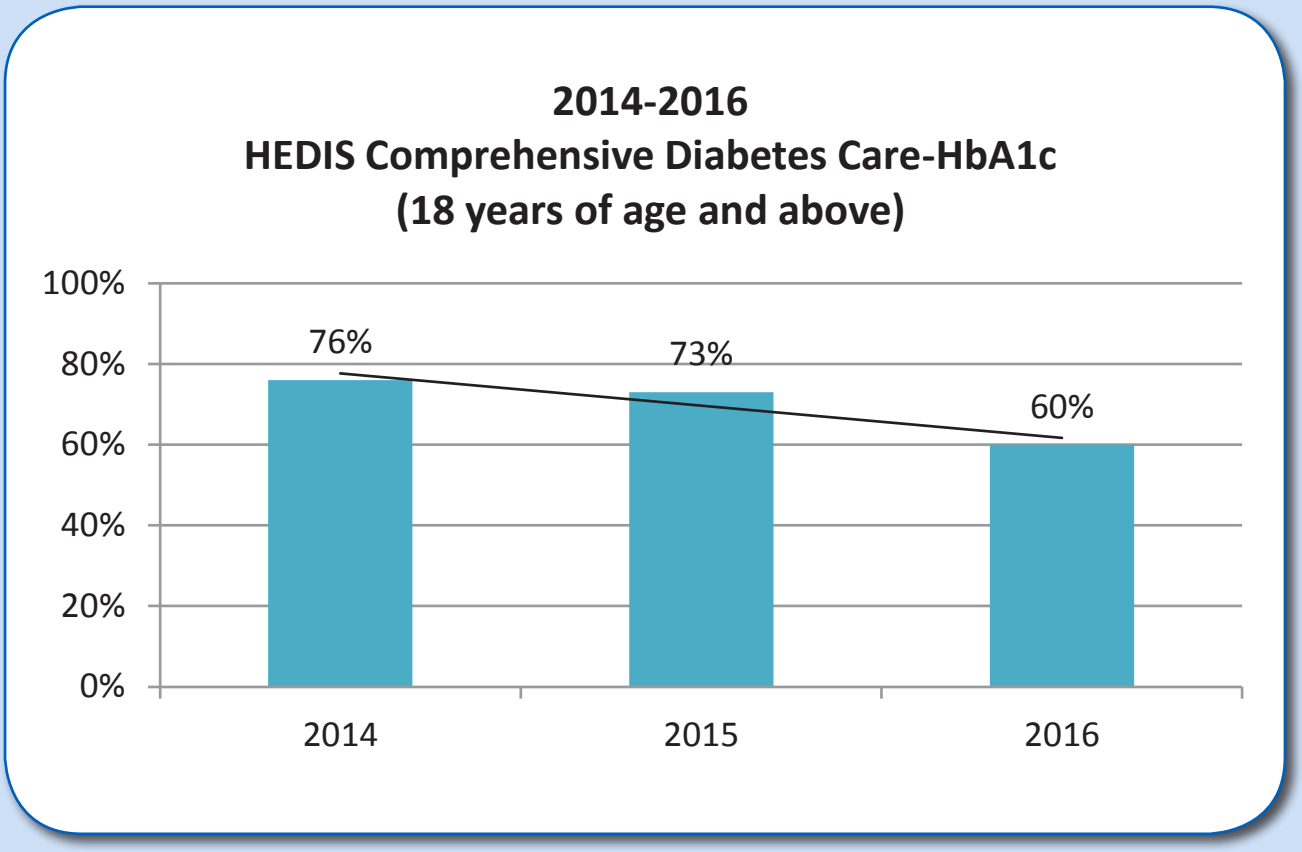

2014-2016
Type 1 Diabetes
Prevalence
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
0.31%
0.29%
0.29%
2014
2015
2016

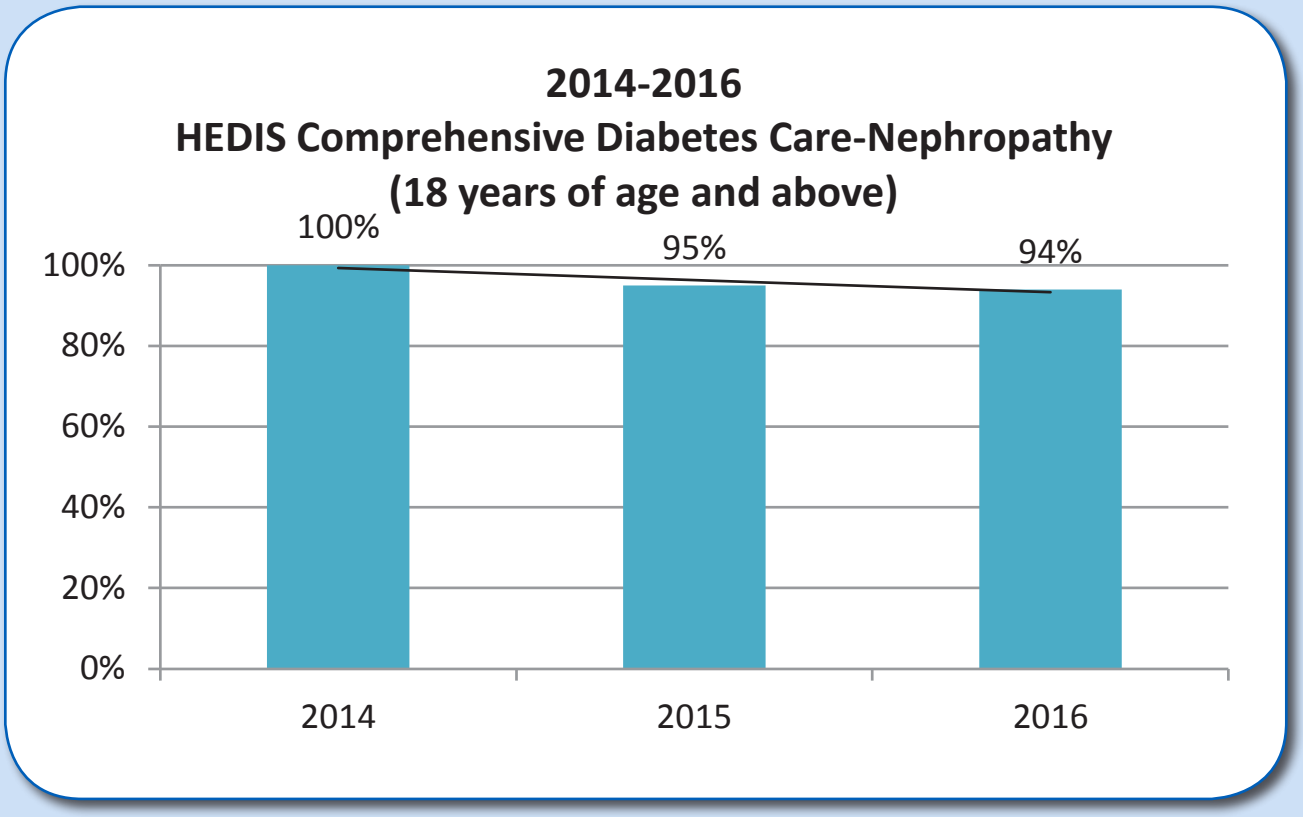

2014-2016
Type 2 Diabetes
Inpatient Admissions per 1000
8
6
4
2
0
6.8
4.0
4.6
2014
2015
2016

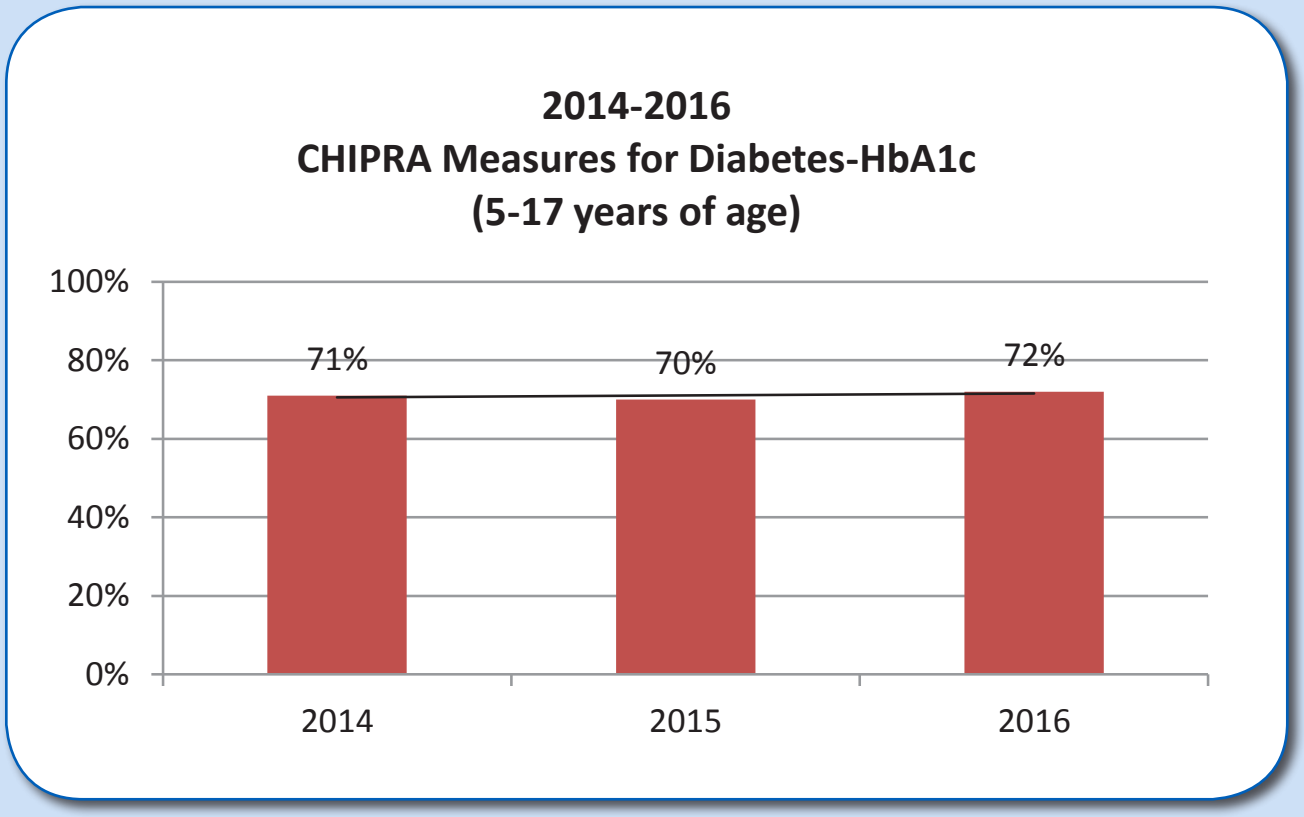

2014-2016
Type 2 Diabetes
ER Visits per 1000
25
20
15
10
5
0
18.2
23.4
18.7
2014
2015
2016

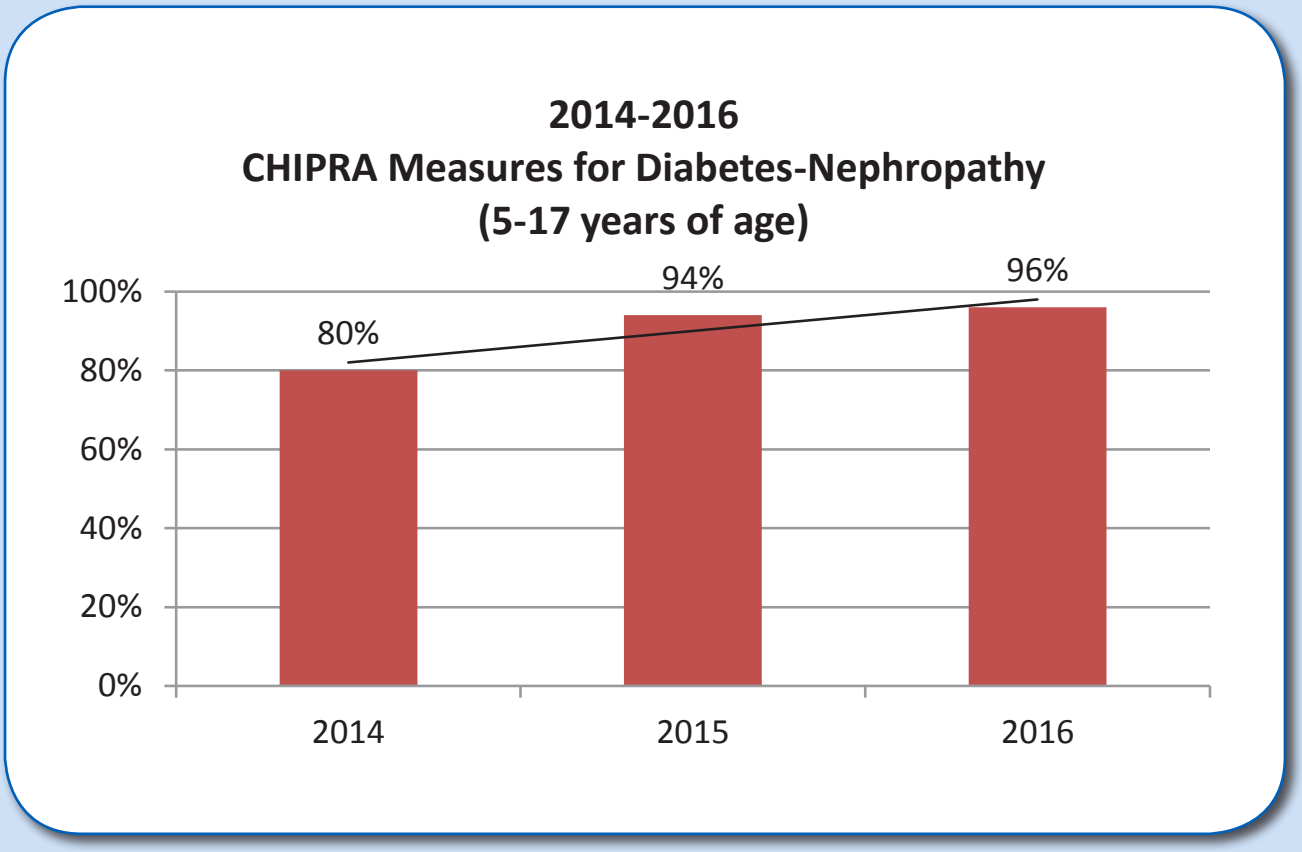

2014-2016
Type 2 Diabetes
Prevalence
0.35%
0.30%
0.25%
0.20%
0.15%
0.10%
0.05%
0.00%
0.29%
0.24%
0.27%
2014
2015
2016


2014-2016
HEDIS Comprehensive Diabetes Care-Eye Exam
(18 years of age and above)
100%
80%
60%
40%
20%
0%
65%
88%
81%
2014
2015
2016


2014-2016
HEDIS Comprehensive Diabetes Care-HbA1c
(18 years of age and above)
100%
80%
60%
40%
20%
0%
76%
73%
60%
2014
2015
2016


2014-2016
HEDIS Comprehensive Diabetes Care-Nephropathy
(18 years of age and above)
100%
95%
94%
100%
80%
60%
40%
20%
0%
2014
2015
2016


2014-2016
CHIPRA Measures for Diabetes-HbA1c
(5-17 years of age)
100%
80%
60%
40%
20%
0%
71%
70%
72%
2014
2015
2016


2014-2016
CHIPRA Measures for Diabetes-Nephropathy
(5-17 years of age)
100%
80%
60%
40%
20%
0%
80%
94%
96%
2014
2015
2016

Analysis:

Referral, Outreach and Case Activity:

Several enhancements to the care management program in 2016 impacted the referral process and distribution of cases. In 2016, the care management program levels were revised to expand the complex care management criteria and incorporate Social Work Care Navigators in the Care Teams. All cases that had a primary medical concern were referred to a Registered Nurse Care Navigator and opened in complex care management.

An evidence-based psychosocial assessment was created and cases were redirected to Social Work Care Navigators when the primary concern was related to social or behavioral determinants of health. This increased the rate of cases opened in complex care management from 5% in 2015 to 62% in 2016. As members progressed through the care plan, members were transitioned to a lower level of acuity. Cases opened in care coordination also decreased from 30% in 2015 to 12% in 2016. This reflects members with limited medical needs who were opened by a Social Work Care Navigator for addressing psychosocial needs. The change in care management risk levels allowed cases to be allocated to the appropriate professional to more effectively address member needs.

A process was developed in 2016 to automatically refer medium and high risk disease management members to care management for interventions. Disease management as the referral source increased from 8% in 2015 to 31% in 2016. There was a decrease in utilization management referrals from 35% in 2015 to 24% in 2016. This data demonstrates the PCN journey towards proactive population health methods of identifying at-risk members and intervening before hospitalization.

There was a significant increase in outreach efforts by the care management team in 2016 to provide health education, address gaps in care and screen for care management needs. Outreach efforts increased from 3,480 members in 2015 to 4,779 members in 2016. The top three reasons for outreach were to provide education to a member, complete a pregnancy screening or perform an initial screening for care management needs.

It is a goal of the care management program to have the primary case closure reason be “Goals Met.” This goal was not achieved in 2016. The primary case closure reason in 2016 was No Response to Letter/Phone; 35% of cases were closed for this reason. Goals Met as a case closure reason decreased from 22% in 2015 to 15% in 2016. In 2016, processes were developed to have medium and high risk disease management members automatically referred to care management for additional interventions. This process increased the number of referrals to care management but also decreased the success rate of reaching members. As the care management program shifts to the LCCCP model, continued emphasis will be placed on patient engagement techniques.

Cost and Utilization Pre and Post Case Management:

Due to the transient nature of cases in care management, the population available for analysis pre and post intervention is not the same year over year, therefore PCN reviews trends each year in the population available for studying and expects improvements in inpatient and ER utilization, as well as overall medical spend, based on care management interventions. For the population analyzed this year, there was a 31% reduction in inpatient admissions per 1000 members; a 21% reduction in ER visits per 1000 members; and a 44% reduction in overall per member per month cost post intervention. As expected when care management interventions begin, overall inpatient and ER costs should decrease, while outpatient and physician-related costs increase, as members become more compliant with preventive services and are connected to a medical home for management of their care.

HEDIS-like Performance for Care Management:

In the seven (7) measures analyzed, the care managed population rates outperformed the PCN

population rates in six (6) of the measures. The only measure not improved with the care managed population was Well-Child visits before 15 months of age. Chlamydia screening in the 16-20 year olds, the childhood immunization rates, and Well-Child Visits in the 3-6 year olds were all statistically significantly higher in the care managed population when compared to the general PCN population rate. Continued education of the care management team on the use of Gaps in Care reports with every member encounter will occur in 2017.

Member/Caregiver Experience with Care Management:

All members surveyed reported that they were overall satisfied with the services provided through the PCN care management program. Members unanimously identified that PCN staff are courteous, respectful and respected the member's cultural needs.

Member health education materials were approved by both health plans and the State of Missouri in 2016. The care management team was encouraged to utilize this literature when educating members. When asked if the Care Manager provided useful health education, 86.5% of members reported a positive response, with 6% responding negatively (Q5). Members also reported that the Care Manager did not know about services available in the community 11% of the time (Q4). Two questions scored lower than previous years due to member responses of "no opinion" (Q2 & Q6).

As a result of this year's analysis and considering the evolution of the care management program, staff will receive additional education on health literacy resources that can be used with members. The development and implementation of C.E.R.A. will be an additional resource for staff to use to be aware and disseminate information to members about resources in the community.

Member/Caregiver Experience with Disease Management (DM):

The 2016 disease management survey indicates significant improvements in chronic disease education, management and engagement with medical providers.

All 2016 established goals were exceeded. The survey demonstrates an increase in member engagement with the Care Teams and providers. Members reported a better understanding of the chronic disease through member literature, working with a Care Team member, and increased utilization of primary care providers/specialists.

In 2016, the PCN also enhanced outreach efforts to high risk members by sending a home visiting agency to the home of high risk members who were unable to be reached by telephone. The home visiting agency provides education, identifies environmental barriers to health and assists with coordinating care for the member.

Asthma Outcomes: Prevalence and Utilization

The current rate of diagnosis for asthma is approximately 18% within the PCN managed population. This rate is consistent with a large population living in an urban setting. 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

The PCN's rate for the newly established HEDIS measure, medication management for people with asthma, is trending higher than the national average at 49% [HEDIS 75th percentile: 31%].

Inpatient and ER asthma-related utilization decreased in 2016 compared to previous years' data. As the data continues to mature and populations stabilize, PCN will continue to monitor these trends. Spirometry is the most common of the pulmonary function tests, measuring lung function and specifically the measurement of the amount and/or speed of air that can be inhaled and exhaled.

Spirometry is an important tool used for assessing conditions such as asthma. As demonstrated in the data, spirometry use is slowly trending up in the primary care provider offices for members with asthma. Spirometry continues to be a best practice for asthma care and PCN staff will continue to educate provider offices on the importance of implementation of national guidelines.

Using data analytic tools, the PCN can now report on timely office visits for members with persistent asthma. This data shows a consistent trend. This will continue to be reported and monitored over time.

Diabetes Outcomes: Prevalence and Utilization

As a pediatric focused organization, the population of members with diabetes continues to be a smaller percentage with approximately 283 identified with Type I diabetes and 283 with Type II diabetes. Over the three years, inpatient and overall costs decreased, while ER visit rates increased. Due to the small population, those fluctuations are not significant enough to warrant changes to the program.

Provider and Member Adherence

The HEDIS comprehensive diabetes measures for members 18 years of age and above trended downward in all three measures over the three-year period to 81% for eye exam screening, 60% for HbA1c testing, and a slight decrease to 94% for nephropathy screening in 2016. Compliance with recommended HbA1c monitoring will continue to be a focus of the PCN's provider and member education for diabetes related care.

Using data analytic tools, the PCN can now report on timely office visits for members with Type 1 and Type 2 Diabetes. It is the first year the PCN has evaluated this metric. The PCN will continue to work with community providers and specialists related to the importance of timely visits with this population.

New Initiatives Implemented in 2016:

In 2016, the disease management program was enhanced by revising current documentation software to allow for automated referrals to the Care Team for identified medium and high risk disease management members. This allowed for outreach and earlier interventions with this population.

Next Steps:

Based on analysis of the program metrics, the following interventions will be included in PCN's 2017 initiatives:

- Alerts will be created in CARE Web (online care documentation and communication tool) to identify medium and high risk members (12 years old and older) that have not completed a depression screen with a Care Team member, we will begin measuring this intervention in 2017
- Utilize the infrastructure of the Care Team and newly developed Provider Practice Performance Profile through onsite visits and ongoing coordination with provider practices to improve health outcomes
- Evaluate the disease management stratification data to identify Care Team interventions that can be deployed at the low risk level to mitigate future potential risks for the population
- In an effort to engage with patients using technology, KidCare Anywhere will be available to Care Navigators to use as an alternative method for in-person consultation and coordinating care. This will allow the Care Navigator to engage with the patient face to face while the patient remains in the comfort of their home.
- Enhanced data analytic tools will be made available to the Children's Mercy Endocrinology team in 2017 to assist in easy identification of patients with gaps in care. These tools will assist providers in addressing the important chronic condition management measures related to diabetes.

6 Success Stories

Success Story #1

Synopsis: *A 2 year-old former 26-week preemie with a past medical history of failure-to-thrive, developmental delays, spastic quadriplegia, gastric tube feedings, and seizures was referred to the PCN for care coordination. The member had 9 emergency room visits in one year, and was frequently kept home from school due to seizures. The social worker at Children's Mercy Neurology Clinic contacted the PCN Care Navigator to inquire about private duty nursing. The Care Navigator reached out to the member's mother and identified several concerns; in addition to caring for this high-risk child, the member's mother was in the midst of a high-risk pregnancy and was responsible for the care of her ill mother-in-law. The Care Navigator met with the member and his mother at a PCP appointment. The member's mother was obviously overwhelmed with all of the demands placed upon her. A private duty nursing evaluation was requested by the PCP, but due to the member's father not wanting a stranger in the home, the request was declined by the family.*

Outcome: The Care Navigator collaborated with the social worker and PCP, which resulted in transitioning the member's care to the complex care clinic at CMH, where he could receive specialized care and his family could receive adequate support. Since transitioning to the complex care clinic, the member has had only 2 ER visits and no inpatient stays in the past 6 months. Although the member's mother continues to require a great deal of support in managing appointments, the member is getting needed services, including outpatient occupational therapy, and is receiving follow-up calls from the complex care clinic for any missed appointments.

Success Story #2

Synopsis: *A 15 year-old member was referred by her PCP to the PCN for care coordination due to increasing emergency room visits and missed clinic appointments. Her medical history included chronic diffuse pain, migraine headaches, anxiety, and depression. She also had poor coping mechanisms, poor medication compliance, and a high school attendance rate of only 40%. The member was referred to Children's Mercy Rehabilitation for Amplified Pain Syndrome program (RAPS) which is a multidisciplinary service that treats children with severe pain and disability. The RAPS program is an option for patients who have tried outpatient treatment methods but are still unable to function normally. The member's mother was not able to transport her to RAPS appointments or accompany the member. The hospital social worker contacted the PCN Care Navigator for assistance in arranging transportation to the RAPS program. The Care Navigator collaborated with two other agencies that were also providing services to this member to arrange transportation. In addition, she contacted the health plan transportation vendor to arrange transportation to visits not covered by the other two agencies and to obtain consent allowing the member to travel to appointments without adult supervision.*

Outcome: Through collaboration between the PCN Care Navigator and the member's other providers, transportation was arranged allowing the member to attend RAPS appointments and benefit from the program. The member learned skills needed to cope with increased sensory issues, gained the tools to cope in her daily life, and is able to apply self-management concepts. The member has become more compliant with her medications, has had decreased ER visits, and reports her overall quality of life has improved.

Success Story #3

Synopsis: *A 1 year-old male's lead testing revealed a capillary lead level of 16 ug/dl. Due to the elevated lead level, the PCN Care Navigator contacted the member's parents and provided instruction that the member needed to follow up with his PCP for venous lead testing. The venous lead level came back even higher, 19ug/dl, resulting in a home visit by the state lead inspector and the PCN Care Navigator. The lead home visit and evaluation did not reveal any lead hazards in the family's mobile home. However, it was noted that the member had been mouthing sidewalk chalk, which tested positive for high amounts of lead via the lead analyzer machine. In addition, the member's father worked in construction and was bringing dust into the home on his work clothing. The Care Navigator provided education to the family about how to prevent lead exposure. The member had a follow-up venous lead test one month later, which revealed a decreasing lead level of 9 ug/dl.*

Outcome: The family followed the Care Navigator's instruction on ways to prevent lead exposure. The member's lead level was reduced to a safe level in a very short period of time. In addition, the family received a $30.00 gift card from the health plan as an incentive for obtaining lead testing and participating in care coordination.

Success Story #4

Synopsis: *A referral was made to one of the PCN Care Teams to assist in securing resources for a family in need of housing assistance, clothing, food, and translation services. The PCN Community Resource Specialist accessed the Community Engagement and Resources Application (C.E.R.A.), which was developed internally by PCN staff to locate resources for PCN members and their families.*

Outcome: *The list of resources was sent to the Care Team's social worker, who then made contact with the family, providing the resources and coordinating care. By utilizing C.E.R.A., all needed resources were located quickly in one place, allowing the resources to be provided to the family in a timely manner.*

Success Story #5

Synopsis: *A 17 year-old member was referred to one of the PCN Care Teams for care coordination after being identified as medium risk on the asthma disease management registry. In addition, she had not been seen for an annual adolescent well visit, had 5 ER visits in the past year, and had previously screened positive for depression. The Care Navigator was able to make contact with the member's mother, who agreed to be contacted by the health plan's behavioral health Care Manager. During the conversation, it was also identified that the member's PCP was incorrect. A three-way call was placed to the health plan. During the call, the member, along with her four siblings, were re-aligned with the correct PCP.*

Outcome: With the PCN Care Navigator's assistance, the member was referred to behavioral health case management and was immediately able to speak with an onsite behavior health care manager. As a result of the collaboration between the PCN Care Navigator and the health plan behavioral health Care Manager, the member was connected with needed resources, potentially avoiding unnecessary ER visits. In addition, the member and her siblings were connected with a PCP and have received annual well-visits to eliminate any gaps in care.

Success Story #6

Synopsis: *An 18 year-old pregnant member was seen 13 times in the emergency room and was admitted 7 times for hyperemesis gravidarum during her first trimester of pregnancy. In addition, she had a 13% weight loss, a low potassium level, and EKG changes. She left the hospital several times against medical advice, which resulted in multiple emergency room and inpatient readmissions. The PCN Care Navigator attempted unsuccessfully to reach her telephonically. A referral was made to Eden Health for prenatal home visits. Eden was able to make contact with the member and provide education about the importance of prenatal care and treatment for hyperemesis. After speaking with the Care Navigator and the Eden Health nurse, the member and her mother realized how critical the situation had become, not only for the member, but also for her baby. The member scheduled a follow-up appointment with her OB physician and agreed to IV infusions in the home. The Care Navigator will continue to follow this member's care through delivery.*

Outcome: During a follow-up call between the member and the Care Navigator, the member stated she was doing much better and for the first time, was actually excited about the pregnancy. As a result of the Eden Health nurse and Care Navigator's collaborative interventions, the member's chance of delivering a full-term, healthy baby are improved.

7

Summary of Calendar Year 2017 Goals & Objectives

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

- **Community Health Worker Pilot**
- **Relationships with Community Mental Health Centers**
- **Community Connections Program & Community Engagement Resources Application (C.E.R.A)**
- **Provider Practice Performance Profile**
- **KidCare Anywhere**
- **CARE Web (Online Care Team Communication Tool)**

Community Health Worker Pilot

Evaluate a pilot Community Health Worker program aimed at addressing social and behavioral determinants of health and community resource connection for PCN members through a partnership with locally trained community health workers. While this goal was originally slated for 2016, implementation is now scheduled for Q2 2017.

Relationships with Community Mental Health Centers

In 2016, Practice Facilitation Specialists conducted PCP surveys to identify care coordination barriers and educational needs related to behavioral health. The survey identified gaps in behavioral health resources in the community; namely that there are currently no warm hand off processes between PCPs and behavioral health providers. In order to address this issue, PCN Social Work Care Navigators will be making onsite visits in 2017 to the community mental health centers to identify contacts within those organizations and bridge partnerships between the PCPs and community mental health centers.

Community Connections Program & Community Engagement Resources Application (C.E.R.A)

The Community Connections Program and Community Engagement Resources Application (C.E.R.A.) has plans to expand in 2017. These plans include collaboration and information sharing with an increased number of community organizations that assist our members with addressing the various social determinants of health. In 2017, along with the continuous addition to and review of agencies in C.E.R.A., any user will have the option to create personalized, printable lists of organizations that can assist with their specific need(s). C.E.R.A. usage will be measured in 2017 through the number of website “hits” it obtains.

Provider Practice Performance Profile

As outlined in pages 30-36, the Provider Practice Performance Profile, as well as the accompanying performance and cost and utilization reports, serves as a tool for the PCN Care Teams to review quarterly cost, utilization, and key quality metrics with the provider practices. The Provider Practice Performance Profile will allow for greater interaction and collaboration with the provider practices and the opportunity to establish actionable goals that the PCN Care Teams can assist with, as needed, to improve the health outcomes of the PCN population.

KidCare Anywhere

KidCare Anywhere offers members access to a pediatric provider in minutes via smartphone, tablet or computer to help treat non-emergency conditions. Providers can discuss, provide guidance and often treat the member’s minor ailments and illnesses from the comfort of the family’s home - or anywhere. A summary of this visit is provided to the member’s primary care provider. The initial pilot in 2017 will offer this service to high emergency room utilizer with minimal primary care engagement in an effort to redirect members back to the medical home for non-emergent and well-care services. The vision is to expand this no-cost service to all PCN members in phase two of this pilot. PCN Care Teams will receive weekly and monthly reports of members in this pilot that continue to utilize the emergency room for non-emergent health issues. The PCN Care Teams will perform outreach to these members to provide education on this mobile application, assist with registration and educate families on the appropriate use of the primary care practice for well-care and non-emergent health care concerns.

CARE Web
(Online Care Team Communication Tool)

In an effort to coordinate care in a more meaningful way at the provider practice level, it is necessary to have an interactive online communication tool for all Care Team members; including not only PCN Care Teams, but also the primary care provider, members and caregivers. Historically, CARE served as the proprietary desktop application and documentation system used by PCN Care Teams to enter authorizations and care coordination activities, as well as view claims. In 2017, CARE will be converted into a web application (CARE Web) for greater Care Team utilization in the community setting and to serve as a catalyst for provider and member engagement in the patient-centered care plans. CARE Web access will be given to provider practices in 2017 so they can view the care coordination activities of the PCN Care Teams, provide input or add goals to the care plan for their patients. It will also be made available for patients and caregivers to view the care plan.
A task feature will be incorporated into CARE Web that will allow all members of the Care Team (PCN Care Team, provider, member and caregivers) to communicate in real-time.

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: Ma'ata J. Lipford, RN, MBA, CCM — June 27, 2017

Ma'ata Lipford, RN, MBA, CCM
Senior Administrative Director, Care Continuum

Date

Approval: _____ June 27, 2017

Just for Kids (JFK) Committee

Date

_____ _____

Clinical Quality Committee

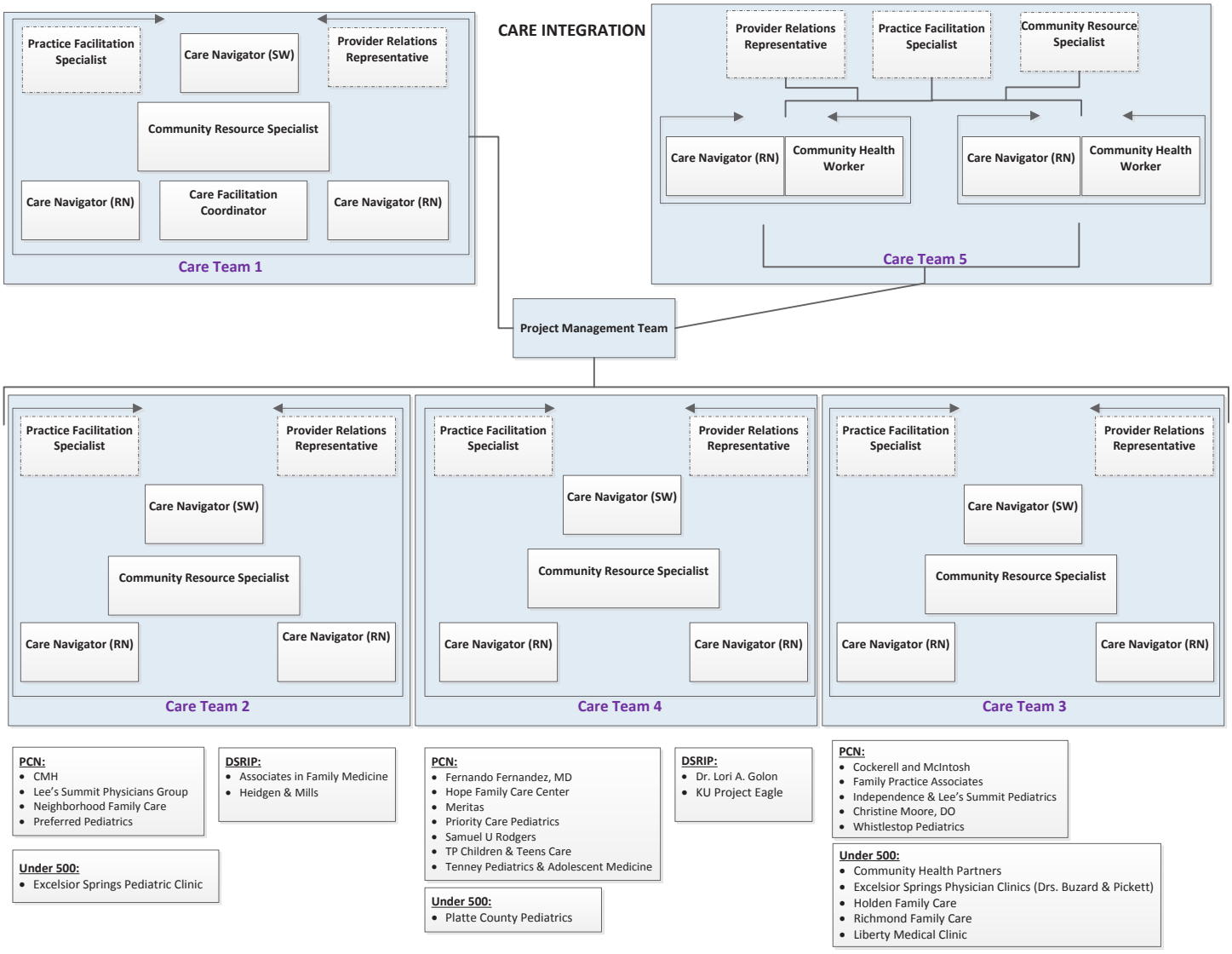
Date

2017 Care Integration Annual Evaluation Work Plan Summary

Children's Mercy PEDIATRIC CARE NETWORK

	Project Title	Operational Lead	1st Q 17	2nd Q 17	3rd Q 17	4th Q 17	Scope & Process	Resources for Spread
1	Implement Community Health Worker Pilot Program in Community PCP offices	Ma'ata/ Candace		X	X	X	Pilot a community health worker with an embedded Care Navigator comparing outcomes to traditional care processes in order to improve quality and utilization metrics.	ICS Care Teams; QI Team; Data analytics
2	Establish relationships with community mental health centers	Candace/ Shanna		X	X	X	Social Work Care Navigators will visit local community mental health centers to establish a relationship and connect primary care providers to these local resources.	ICS Care Teams; Health Plan liaisons
3	Community Connections Program and Community Engagement Resources Application (C.E.R.A)	Candace/ Shanna	X	X	X	X	Expand collaboration with community organizations and add customization options to C.E.R.A.	ICS Care Teams, ICS IT Team
4	Provider Practice Performance Profile	Candace/ Shanna		X	X	X	Develop a process for evaluating quality and cost metrics for contracted PCN primary care practices and schedule quarterly meetings with the practices to review data and discuss coordinated interventions to address opportunities for improvement.	ICS Care Teams, Data analytics, Provider Relations
5	KidCare Anywhere	Candace/ Shanna		X	X	X	Care Navigators will utilize the KidCare Anywhere platform to provide face to face care coordination to members.	ICS Care Teams
6	CARE Web (Online care communication tool)	Candace/ Shanna	X	X	X	X	CARE documentation system will be transitioned to an online tool for care teams to utilize in the community and to broaden the use to providers and members.	ICS Care Teams, ICS IT Team, Data analytics, Provider Relations

Appendix I: Care Team Diagram



PCN:
- CMH
- Lee's Summit Physicians Group
- Neighborhood Family Care
- Preferred Pediatrics

DSRIP:
- Associates in Family Medicine
- Heidgen & Mills

Under 500:
- Excelsior Springs Pediatric Clinic

PCN:
- Fernando Fernandez, MD
- Hope Family Care Center
- Meritas
- Priority Care Pediatrics
- Samuel U Rodgers
- TP Children & Teens Care
- Tenney Pediatrics & Adolescent Medicine

Under 500:
- Platte County Pediatrics

DSRIP:
- Dr. Lori A. Golon
- KU Project Eagle

PCN:
- Cockerell and McIntosh
- Family Practice Associates
- Independence & Lee's Summit Pediatrics
- Christine Moore, DO
- Whistlestop Pediatrics

Under 500:
- Community Health Partners
- Excelsior Springs Physician Clinics (Drs. Buzard & Pickett)
- Holden Family Care
- Richmond Family Care
- Liberty Medical Clinic