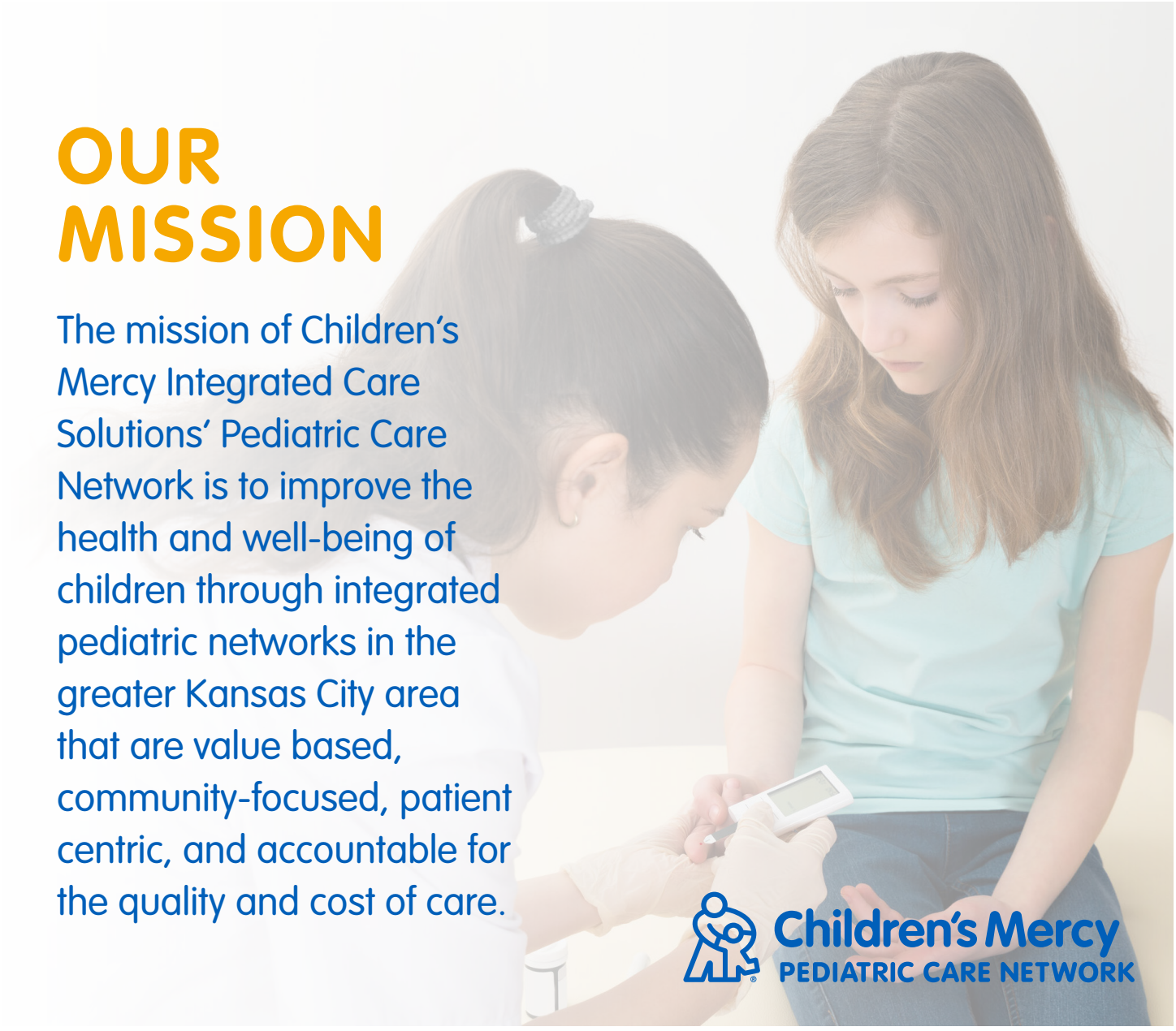
Pediatric Care Network

ANNUAL REPORT

CALENDAR YEAR 2023

Children's Mercy
PEDIATRIC CARE NETWORK



OUR MISSION

The mission of Children's Mercy Integrated Care Solutions' Pediatric Care Network is to improve the health and well-being of children through integrated pediatric networks in the greater Kansas City area that are value based, community-focused, patient centric, and accountable for the quality and cost of care.

Children's Mercy
PEDIATRIC CARE NETWORK

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OVERVIEW

Case Management • Utilization Management • Disease Management

The Pediatric Care Network (PCN) performs delegated medical management functions under capitated risk agreements with Medicaid managed care organizations in Missouri and Kansas. To support medical management and practice transformation, the PCN employs a diverse skill set of staff, including registered nurses, licensed social workers, mental health professionals, respiratory therapists, medical directors, and non-clinical staff. Through value-based agreements, 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.

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

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

PCN Population Profile - Overview of the Patients We Serve!

201,516 members enrolled

71,929 Kansas Members

131,404 Missouri Members

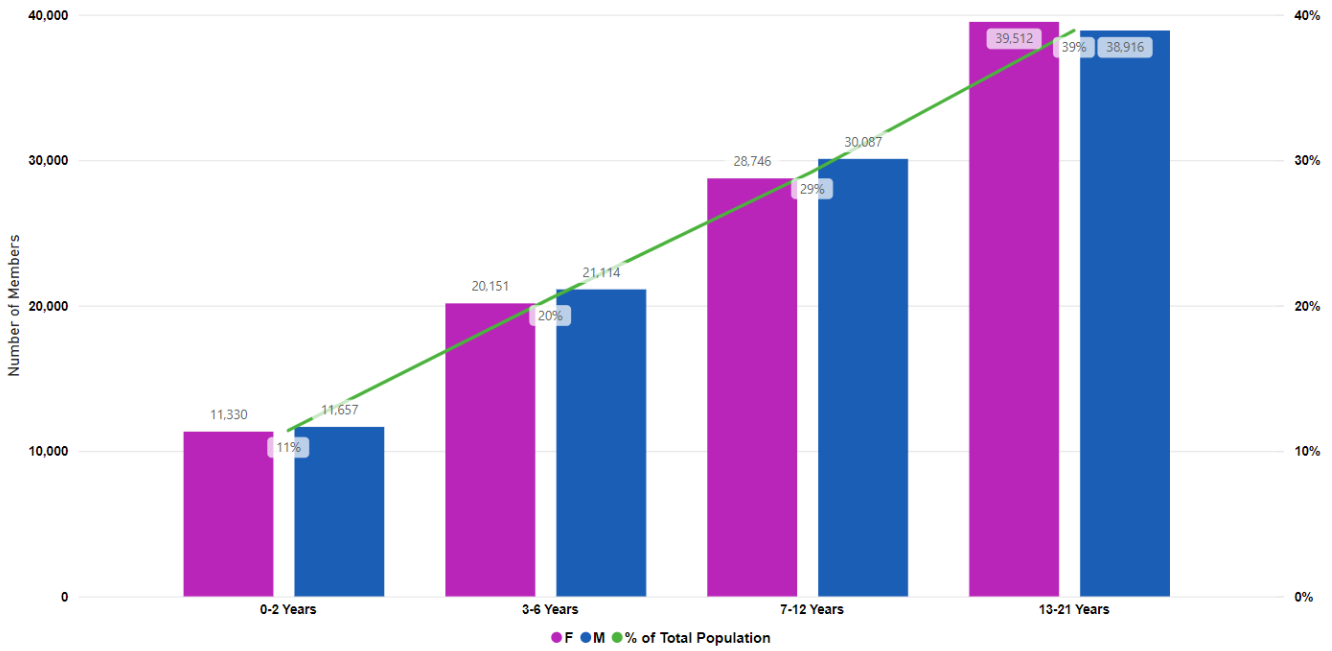
50.5% Males | 49.5% Females

39.7% of population have a chronic condition

10% of the member population have Anxiety or Depression

7.5% Asthma, **6.5%** ADHD, **3%** Obesity

2023 PCN Member Age & Gender Distribution



Pediatric Care Network Value Highlights

13,174

members served by Care Integration

95%

of providers indicated a positive experience

3%

average increase in HEDIS measure compliance for:

- Infant Well Child Visits
- Age 3-21 Well Child Visits
- ADHD Follow Up

7%

increase in Lead Screening

UTILIZATION MANAGEMENT

> Fantastic partnership and the value they add in this industry is incredible! Love working with the PCN team!
>
> -- **Network Provider**

The Pediatric Care Network performs prior authorization, inpatient review, discharge planning, and transitional care planning. Non-clinical staff verify eligibility, enter authorization information, and communicate authorization outcomes with providers. Clinical staff, with the support of the medical director(s), perform medical necessity reviews using internal protocols, Payer policies, and Milliman Care Guidelines®. Staff and peer audits are conducted quarterly and PCN monitors member and provider satisfaction related to care delivery.

The PCN monitors utilization trends for the population for under- and over-utilization of services. PCN reviews preventive services, outpatient services, PCP office-based services, and utilization trends of high-cost services such as inpatient and emergency department visits.

2023 Accomplishments

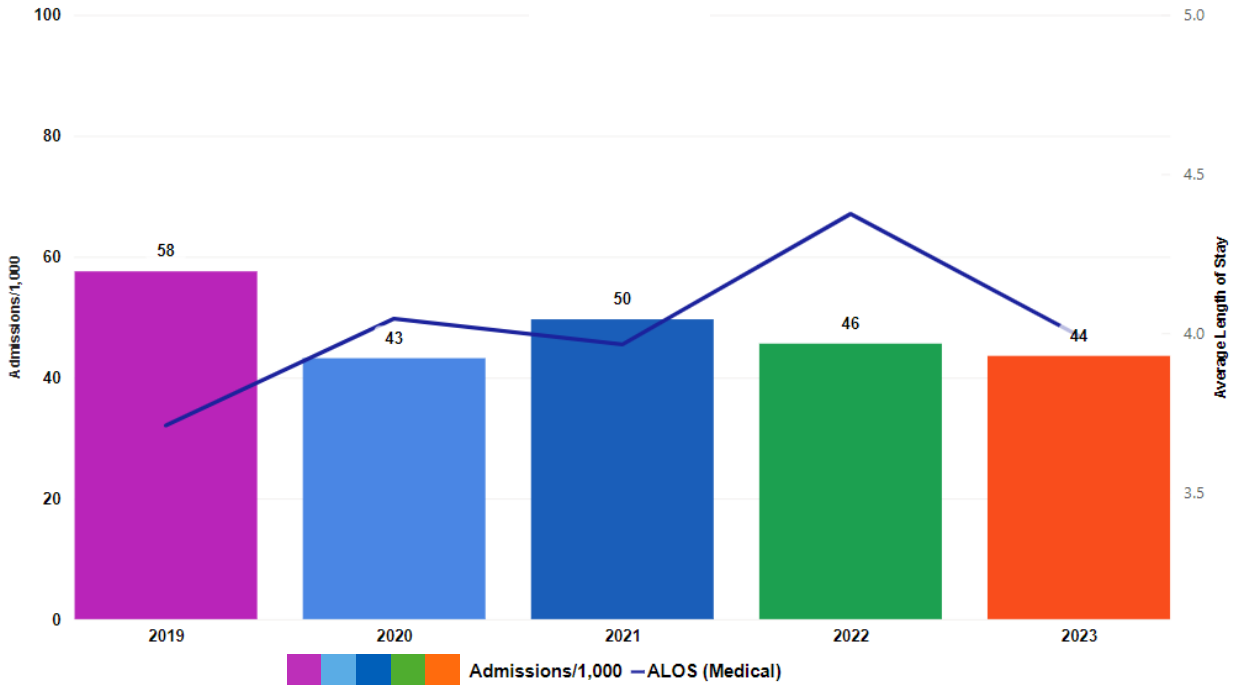
- Partnered with area facilities to refine daily census reports, effectively streamlining authorization processes for timely entry and processing.
- Improved accuracy in automated notification of approvals for medical inpatient stays and acute inpatient psychiatric stays with a daily notification report, reducing instances of delayed notification and opportunities for Protected Health Information (PHI) breach.
- Collaborated with a local behavioral health inpatient facility to create a manual daily census for Healthy Blue and Aetna Better Health acute psychiatric admissions.
- Developed internal tools to support frontline staff specific to guidance on state, health plan, and clinical criteria ensuring timely and accurate authorization processing.
- Expanded electronic prior authorization portal submission to include additional facilities, allowing for electronic inpatient admission notification.
- Refinement of partnership with health plans and the state of Kansas to effectively monitor the Psychiatric Residential Treatment Facility waitlist to enable efforts to minimize wait times for members warranting this high level of care.

2024 Initiatives

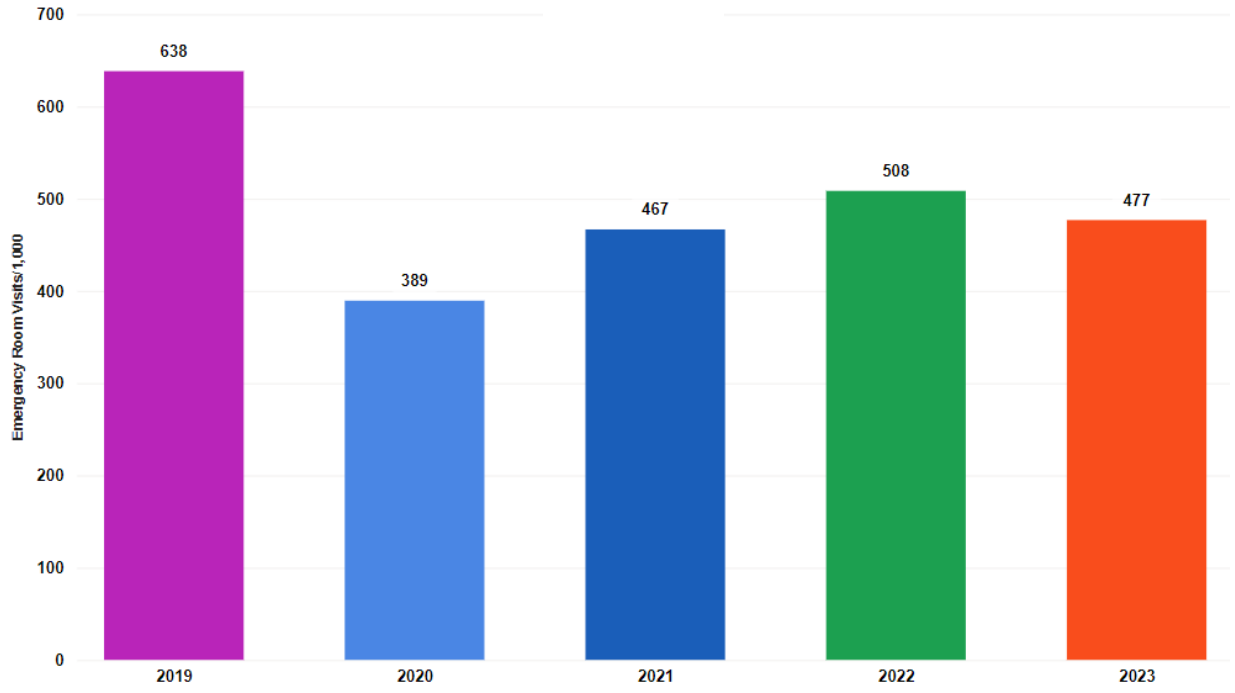
- Implement revised authorization process for complex in-home service requests specific to private duty nursing and personal care services to reduce barriers to accessing care and increase parity with health plan processes.
- Evaluate effective processes for addressing retroactive changes in member eligibility.

> I have enjoyed working with all of the reviewers. They are always nice, and very easy to work with.
>
> - Network Provider

PCN Utilization Admissions / 1,000
2019-2023



PCN Utilization Emergency Room Visits / 1,000
2019-2023



Success Story

PCN received an urgent request at the end of a business day from an out of network provider for surgery to fix a fracture and take a biopsy. Approval was shared back with the provider early the next morning. The requesting provider called Bridget, PCN Care Facilitation Nurse, to express, "sincere gratefulness for the fast turn-around time and all-around great service." She shared the absence of complications along with partnering to ensure the needed services were delivered was "refreshing".

13,556

Prior Authorizations completed in 2023

28%

Admissions related to behavioral health for Health Plans for which PCN provides delegated integrated behavioral health management

490 Average calls per month

25% increase from 2022

12 Seconds

Average speed to answer

1.2%

Average call abandonment rate

CASE MANAGEMENT & DISEASE MANAGEMENT

Case Management and Disease Management

Case management (CM) and disease management (DM) are the central components of the care integration program. CM and DM help members sustain or regain optimal health and reduce overall healthcare costs through coordinated efforts between care teams, members, caregivers, providers, and community agencies. To ensure continuity of care and alignment for improving health outcomes, the care integration teams work closely with the member's primary care provider, specialists, and other care providers 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 CM process incorporates post-hospital discharge screenings, assessments, care planning, and multi-disciplinary care coordination. Populations can be organized and prioritized by chronic condition, high utilization, risk score, or gaps in care. Audits are performed quarterly on all programs and regular case reviews enhance quality and promote consistency in the application of case management principles.

Case types are determined based on the member's screening, assessment, and care plan development. This establishes the level of complexity and interventions required. In 2023, 94% of cases required complex case management. Common conditions in complex case management include pregnancy, behavioral health, asthma, autism, lead, and diabetes.

3,821
members identified for case management

An over 10% increase compared to 2022

239 days
average time to resolution

Decrease of 43 days (15%) compared to 2022

64%
of member driven goals achieved

623
new enrollments in case management

A 30% increase compared to 2022

45.8%
of enrollees achieved all goals

16%
of enrollees identified for a Behavioral Health need

Reasons for referral:

- Pregnancy
- High Risk Disease Management
- Health Plan Referral
- Gaps in Care
- Referred by Provider/PCP
- Frequent ER visits
- Behavioral Health
- Identified on Internal Risk Reports
- Inpatient or NICU Stay
- Member or Caregiver Contact
- Lead
- Social/Community Resources Needs

Disease Management

PCN's disease management (DM) programs use a unique approach to manage the most common pediatric chronic conditions through collaboration among primary care providers and care teams across the care continuum. In 2023, Healthy Weight Management was added to the existing disease management programs for Asthma and Diabetes. For plans where PCN manages behavioral health, the program was expanded to include Depression. The care teams work with PCPs to implement comprehensive disease management concepts within their practices. Moderate and high-risk members are assigned a dedicated care navigator to provide education, medication management, develop disease-specific care plans, and assist members and caregivers in successful condition management.

27,000+ members followed by Disease Management

8% Asthma prevalence in population

3% Obesity prevalence in population

0.5% Diabetes prevalence in population

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

3% Depression prevalence in behaviorally managed population

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

Transitional Care Program

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

2,582 admissions identified for follow-up

73% increase in admissions identified for follow-up in 2023 related to Behavioral Health and Pregnancy transitional support

58% of members successfully contacted

9% accepted enrollment in care management for additional support

2023 Accomplishments

- Refined new Disease Management programs for Healthy Weight Management and Depression, including criteria adjustments to ensure best support for high risk members.
- Incorporated transition of care processes to include all members post-delivery, ensuring timely education and support for new moms and newborns.
- Enhanced CMH EMR Handoff Process to allow streamlined communication of needs, information seeking, and direct referrals from CMH to PCN teams.
- Partnered with health plans and the state of Missouri to gather data on staffing trends and community support for Private Duty Nursing. This facilitates process improvement to accessing needed in-home care for medically fragile children.
- Restructured processes to address Social Determinant of Health needs to manage referrals within the PCN team, enhancing collaboration between clinical and non-clinical staff within care teams.

2024 Initiatives

- Collaborate with health plan and community partners in Missouri to develop relationships with Psychiatric Residential Treatment Facility (PRTF), Intensive Outpatient Program (IOP), and Partial Hospitalization Program (PHP) to support high risk behavioral health needs for members.
- Continue to expand and improve the CMH EMR handoff process to streamline referrals and information sharing between PCN and CMH Teams.

Patient Success Stories

Wally is a 7-year-old whose family was homeless and living for short periods of time with friends and family. Wally has asthma and was also experiencing some behavioral health issues. His mom, Patty, reached out for case management support. **Cori**, PCN Care Navigator, helped connect Wally to needed therapies – art, equine, medication management, and individual therapy – to help him improve coping skills. Partnering with a local community resource, Habitat for Humanity's Greenline project, Wally's family moved into a new home! Additional community support provided new beds and assisted with utilities.

Sasha, foster mom to newborn triplets, asked for help in getting a 3-in-1 stroller. **Shanae**, PCN Community Resource Specialist, contacted a local community partner and applied for stroller funding. The request was approved and Sasha received a new stroller for the triplets. Sasha can attend appointments and shop for baby supplies with the triplets safely buckled in one stroller.

Annie, a 14-year-old, was referred for case management due to a lack of social support during her pregnancy. While her mother was experiencing a mental health crisis, Annie moved frequently, living with different family members and sought medical care on her own. **Jean**, PCN Care Navigator, partnered with Annie to help her attend her own appointments for OB care, navigate dental and vision benefits, and access a breast pump. After months of overcoming barriers to these needs for Annie, **Jean** was also able to work with Annie and the state to finalize a Medicaid application for her infant.

POPULATION HEALTH MANAGEMENT

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

Practice Transformation

The PCN network of providers participate in a value-based incentive program that provides the practice with a per member per month payment for reaching identified quality goals, such as well child exams and immunizations, cost/utilization goals, and engagement goals. The PCN value-based model goes beyond traditional pay-for-performance programs, as it incorporates not only HEDIS/NCQA quality performance metrics but also engages participating practices in population health strategies, regular clinical quality meetings, learning collaborative sessions, and triannual practice performance reviews. The PHM network team also provide training and support in patient centered medical home principles, a key component in population health management. Two key areas that continue to be an important component of Practice Transformations are Social Determinants of Health (SDOH) and Health Equity. The PCN value-based model includes specific goals for SDOH screening

and collection of race, ethnicity, and language information. This was stressed in 2023 and will continue to be an important area of performance improvement in 2024.

As the Population Health Management Network Team has worked with the practices and focused on several quality improvement efforts over the years, we have seen a steady rise in the PCN population HEDIS measures compared to the rest of the Medicaid population, especially in chlamydia screening (average 8% higher) and age 13 immunizations (average 14% higher.) Even though there were challenges during the last three years with the COVID-19 public health emergency, PCN continued to stay above the average in HEDIS measures related to well child visits (Adolescent Well: average 7.5% higher; Age 3-6: average 7.5% higher; First 15 months: average 6% higher) and Age 2 immunizations (average 5.5% higher).

2023 Accomplishments

In 2023, the PHM network team helped target several quality and practice improvement initiatives with PCN contracted provider offices, including:

- Advance health equity by partnering with practices to collect more accurate and complete sociodemographic data such as race, ethnicity, and language (REL) data. Accurate and comprehensive data collection is critical since PCN cannot address health inequities if the inequities are not measurable. Building upon foundational work completed in 2022, PCN incorporated health equity requirements within the PCN 2023 value

based incentive model. To meet the new requirements and earn incentive points, practices had to require REL questions (i.e. with an option to decline/opt out), standardize REL data fields to capture a minimum level of specificity, and utilize standard scripting to address common questions/concerns. To support our efforts, PCN developed a Health Equity Improvement Guide, including REL data collection standards, scripting and training for care staff, and an FAQ to help address patient/family concerns. In addition, CMICS developed a health equity dashboard to support efforts to review and stratify measures by race, ethnicity, and primary language to help assess and identify health disparities.

- Since 2020, PCN has invested in the technology, people, and processes to move beyond social need screening to perform closed-loop social need referrals. CMICS has integrated our social need referral platform Lift Up KC (www.liftupkc.org | Powered by findhelp.org) into the clinical workflows of both Children's Mercy (via CMH EMR) and community pediatric practices (via Innovaccer). In 2023, CMICS transitioned the pilot program that established formal partnerships with full-service community-based organizations (CBOs) distributed across the Kansas City metropolitan area into an established and sustainable program. In fact, PCN doubled the funding in order to strengthen our partner CBO relationships and support CBO efforts to extend closed-loop social need referrals to additional locations. Rather than extend funding to additional CBOs, CMICS increased funding for existing CBO partners to strengthen the relationships and support our partner CBO efforts to extend closed-loop referrals to additional locations. Since early 2022, social need referrals through Lift Up KC have increased from an average of 23 referrals per month to nearly 300 referrals per month, totaling more than 6,000 referrals.
- From September through December 2023, PCN developed and distributed targeted "end of year" improvement packets that included prioritized patients with recommended actions to address one or more care gaps. The purpose of the packets was to assist practices in identifying non-compliant patients, provide measure definition education, and encourage patient outreach to ultimately increase measure compliance and performance. Targeted measures included Chlamydia Screening, Lead Screening, HPV Vaccination, Asthma Medication Ratio, and Well Visit measures.

2024 Initiatives

- Sustain and maintain a strong network of partner community-based organizations (CBOs) to address patient/family social needs. 2024 will focus on the evaluation of the impact of addressing social needs on process measures and health outcomes (clinical quality, total cost of care, acute utilization). Network will also prioritize efforts to advance operational and technological changes to the social need referral workflow that adds value, efficiency, and benefits to CBOs.
- PCN will continue to improve race, ethnicity, and language (REL) data collection across Children's Mercy and community primary care practices. After establishing data collection standards in 2023, 2024 will focus on ongoing improvement, measured by the "unknown race rate" (declined responses, unknown/not present/not provided) with a goal of achieving an unknown rate under 5%.
- Develop more enhanced and effective mechanisms for community practices to place care management referrals and improve how and when PCN care management activity (case open, monthly, case closure) is communicated to community practices, so information can be integrated into practice clinical workflow.
- Develop and pilot a new "Chronic Condition Value Based Care Program" with the aim of transforming the way specialty services are delivered by supporting care model transformation and promoting high quality, cost-effective specialty care that encourages care coordination and reduces ineffective, preventable, and inappropriate treatments.

2023 Work Plan Updates

Initiative	Process & Scope	Update
Sustain and Enhance Community Connections to Address Social Needs	Transition existing network of partnering community-based organizations (CBOs) into a sustainable engagement program. Continue to partner with CBOs to meet them where they are at and identify and support operational changes and/or Lift Up KC enhancements that add value, efficiency, and benefits to CBOs. Also, research and analyses will be initiated to evaluate the effect of social need referrals on health outcomes.	PCN successfully transitioned the pilot program launched in 2022 into an established and sustainable program. In fact, PCN doubled funding distributed through the program. Rather than extend funding to additional CBOs, PCN increased funding for existing CBO partners to strengthen the relationships and support existing partner CBO efforts to extend closed-loop referrals to additional locations. By end of 2023, PCN averaged nearly 300 closed-loop referrals per month. PCN is also partnering with a Children's Mercy academic researcher to evaluate process and health outcome metrics related to social need referrals.
Integrated Behavioral Health Services	Develop strategy to embed behavioral health services into community practices. Size and scope of the services are to be determined but would be staffed by a licensed mental health professional (LPC, LCSW, or LMFT) that performs screenings, assessments, and short-term (up to 4 months) therapy. Long-term objective is to create a self-sustaining, scalable model for integrated behavioral health in primary care.	Behavioral Health Clinicians (BHC's) were placed in two community practices in 2023. BHC's support primary care providers in identifying and managing mental health needs, reduce barriers for families seeking mental health services, and increase equitable access to evidence based interventions. Over 200 patients were served in 2023.
Extend PCN Network to Include Behavioral Health Entities	Develop strategy to partner with behavioral health organizations (community mental health centers, psychology/BH therapy services, psychiatrists) to improve care and health outcomes through increased collaboration (care management), care coordination (transitions, referrals), cross-system visibility, and data/ analytics.	Completed first phase of behavioral health entity recruitment, resulting in all 8 community mental health centers in the Kansas City area joining our network. In 2023, foundational work was completed to formalize the operational structure, finalize applicable agreements (Network Agreement, BAA, Data Use Agreement), define & initiate the data onboarding process, prepare for technology deployment (i.e. Cerner MyPatientConnections, Innovaccer Population Health Management Platform), and perform listening sessions to better understand barriers and opportunities.

Advance Health Equity	Continue to improve the collection of race, ethnicity, and language (REL) data foundational to identifying and addressing health inequities. Formal education and support to be developed and provided to practices to further standardize REL data collection & capture rate. Staff to be provided scripting and best practice resources. To support adoption and implementation, health equity requirements to be incorporated into PCN's value-based incentive model. Development of a health equity dashboard will help to understand where disparities exist, prioritize future health equity projects, and support efforts to initiate work to address gaps.	PCN incorporated health equity requirements within the 2023 value based incentive model. To meet the incentive requirements, practices had to require REL questions (i.e. with an option to decline/opt out), standardize REL data fields to capture a minimum level of specificity, and utilize standard scripting to address common questions/concerns. To support this effort, PCN developed a Health Equity Improvement Guide, which included REL data collection standards, scripting and training for care staff, an on-demand Diversity, Equity, & Inclusion Learning Module, and an FAQ to help address patient/family concerns. PCN also developed a health equity dashboard to support efforts to review and stratify measures by race, ethnicity, and primary language to assess and identify health disparities.
Enhance Population Health Management Point-of-Care Solution	Continue to deploy and optimize the use of PCN's population health management point-of-care solution and platform. 2023 enhancements will focus on optimizing the solution to improve communication, coordination, and user experience. This will include the ability to refer to PCN care management via the point-of-care solution, expanding clinical note access at point of care to include all Children's Mercy acute visits (inpatient, ED, urgent care), and improved visibility to high cost and/or high utilization patients.	New population health management point-of-care features deployed in 2023 included high utilizer and high cost patient indicators, new lab and imaging cards, and more efficient access to Children's Mercy clinical notes for urgent care visits, ED visits, and inpatient discharges. Also, the PCN Care Management referral phone number was added within the point-of-care solution to streamline the PCN care management referral process.
Expand Disease Management Programming	PCN's Care Integration team will implement the new depression and weight management programs developed in 2022 across their managed populations. These new programs will provide members and their families with support from a PCN team member to develop care plans to achieve their goals toward better health related to these conditions.	Weight management and depression disease management programs were successfully implemented in early 2023. Since implementation these programs have identified more than 14,500 members to receive educational outreach and service offerings.
Restructure Care Team Structure for Efficient Provision of Services	PCN's Care Integration team will review the current team structure for opportunities to re-align population assignment and role duties. Through this work, service provision from both Case Management and Utilization Management perspectives will be streamlined for greater optimization of care.	Care Teams were successfully restructured, and roles redefined in 2023 resulting in more streamlined service provision. This streamlining resulted in increased parity and efficiency in workflow between behavioral and physical health requests, and incoming case management referrals.

2024 SUMMARY, GOALS, WORK PLAN

Sustain & Enhance Community Connections to Address Social Needs

PCN will continue to invest in the capabilities, technology, processes, and relationships to address social drivers of health that account for up to 75% of health outcomes.[1] In 2024, PCN will continue ongoing efforts to educate care teams and improve social need referral workflows from the clinical team to community based organizations (CBOs) to ensure referrals are appropriate, efficient, and effective. PCN will also replace an existing CBO partner who left the program due to a shift in service offering to address long-term social needs. PCN will continue a close collaboration with Children's Mercy academic researchers to support a long-term evaluation of the impact of addressing social needs on process measures and health outcomes (clinical quality, total cost of care, acute utilization). PCN recognizes the program's success depends on strong engagement from CBOs. As a result, PCN will focus on advancing operational and technological changes to the social need workflow that adds value, efficiency, and benefits to CBOs.

Integrated Behavioral Health Services

Physical and behavioral health are inextricably linked and taking time away from work and school to see a mental health provider is a barrier for many families. Like any other chronic condition, early intervention is vital to long term success. Integrated behavioral health (IBH) in primary care is a team-based, cost effective, proactive approach to providing patient-centered care to address mental health needs in the primary care setting. IBH supports primary care providers in managing mental health needs, reduces barriers for families seeking mental health services, and increases equitable access to evidence-based interventions.

In 2023, Integrated Care Solutions added Behavioral Health Clinicians to two community primary care practices to provide behavioral health services. More than 200 children and families have already benefitted from this program and received timely treatment for mental health concerns. ICS aims to create a sustainable model that can be expanded to additional primary care practices supporting more children and families in 2024 and beyond.

Extend PCN Network to Include Behavioral Health Entities

The mental health crisis, declared as a national emergency by the American Academy of Pediatrics in October 2021, has been further exasperated by the pandemic with rising rates of depression, anxiety, feelings of hopelessness, and suicidal thoughts & behaviors.[2] Recognizing this crisis cannot be addressed solely by primary care practices, PCN began to advance a strategy in 2023 to extend

[1] https://www.cdc.gov/nchstp/socialdeterminants/faq.html#b

[2] https://www.npr.org/2021/10/20/1047624943/pediatricians-call-mental-health-crisis-among-kids-a-national-emergency

PCN network participation to include behavioral health entities with the goal of improving care coordination, collaboration, and communication across the continuum of care. 2024 activity will include the formal launch of the Behavioral Health Advisory Committee which includes two leaders (1 clinical, 1 administrative) from each behavioral health entity, leadership within Children's Mercy's Development and Behavioral Health Division, behavioral health staff integrated within network primary care practices, and PCN leadership. Another strategic area of focus will be the implementation, deployment, and use of available technology (1. Children's Mercy EMR access via My Patient Connections 2. Population Health Management solution (Innovaccer)) to provide behavioral health entities a more timely and comprehensive view of patient's care. Additional efforts are also planned to push daily notifications regarding ED visits and inpatient admissions/discharges to support care transitions and appropriate follow up care. Finally, in the latter portion of 2024, PCN will launch phase 2 of behavioral health entity recruitment to include psychology, counseling and behavioral health therapy clinics, and psychiatry clinics.

Advance Health Equity

Health equity ensures everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, preferred language, sexual orientation, and any other factors that affect health outcomes. Recognizing that we can't improve what we can't measure, PCN will build on work initiated in 2022 and 2023 to improve the completeness and accuracy of race, ethnicity, and language (REL) data. To support these efforts, PCN will focus on ongoing REL data improvement, measured by the "unknown race rate" (declined responses, unknown/not present/not provided). Target will be to achieve an unknown rate under 5%. PCN is planning to add an "unknown rate" target threshold to achieve bonus points within the network's 2024 incentive model. Also, best practices, such as adjusting the intake process to "require a REL data response" (via systems such as Phreesia) will be identified and distributed across all PCN practices. In parallel to improving foundational REL data, PCN will perform an in-depth analysis of pediatric quality and cost/utilization metrics to understand where disparities exist. Network will also assess ability to improve disparities based on practice feedback and literature review with the goal of identifying a targeted health equity improvement initiative for 2025.

Develop & Pilot a New Chronic Condition Value Based Care Program

PCN is developing a new Chronic Condition Value Based Care (VBC) Program with the aim of transforming the way specialty services are delivered by supporting care model transformation (i.e. shifting accountability & responsibility from only those patients seen within a clinic to a population of chronic patients in the community) and promoting high quality, cost-effective specialty care that encourages care coordination and reduces ineffective, preventable, duplicative, and inappropriate treatments.

Foundational components & objectives of the VBC program include:

- **Operational Framework:** A systematic, structured, sustainable, and scalable framework structured around a pediatric chronic condition (e.g. diabetes) evaluated over the calendar year.
- **Infrastructure & Investment Opportunity:** Supports funding via an infrastructure investment and a performance-based payment to support transition from fee-for-service (volume) to value-driven, population-based care and payment.
- **Advance Innovation:** Creates a mechanism for specialty clinics to take ownership & accountability to implement, evaluate, and iterate on innovations and interventions that lead to reduced utilization, decreased total cost of care, and better health outcomes.

By formalizing a Chronic Condition VBC Program, PCN is striving to maintain Children's Mercy as a national leader in pediatric value based care and align operational and strategic investment in care models necessary to deliver better health outcomes, better experience, and increased value to our patients and communities. Strategic aspects of the program will also support better coordination and communication with PCN care management services. The program will be piloted for diabetes patients in 2024 with the hope to expand to 2 to 3 additional chronic conditions in 2025.

PCN Exploring Opportunity to Bring Prescribed Pediatric Extended Care Services to Kansas City

Children with complex medical conditions represent only 6% of the Medicaid population but comprise 40% of the spend.[3] Unfortunately, these children are frequently admitted to the hospital or forced to have prolonged hospital stays due to the lack of appropriate and accessible community-based care (i.e. home health care, private duty nursing). As a result, PCN is exploring an opportunity to partner with an organization to bring Prescribed Pediatric Extended Care (PPEC) services to the Kansas City region. PPEC services provide medical daycare services for children with medically complex conditions in a community-based setting. The services are provided for up to 12 hours per day and include reliable, team-based nursing services, educational/social services, developmental therapies (e.g., physical therapy, speech therapy, occupational therapy), and potentially other services (mental health, dental, specialist support).

Exploration of the opportunity will include close collaboration with Children's Mercy services that directly care for children with medical complexity (i.e. Children's Mercy's Beacon Clinic, NICU, PICU, Infant Tracheostomy & Home Ventilation Clinic), and placement of a center would be influenced by an in-depth analysis of where PCN's members with complex medical conditions live. PCN is excited and supportive of legislative developments in Missouri that are advancing PPEC licensing requirements (Senate Bill (SB) 1111) and hopeful Kansas will advance legislation similar to other states (Texas, Florida) that have recognized the value of PPEC services. With over 1,000 children with medical complexity within PCN's member population, PPEC services would bring reliable, advanced medical care and therapies in a centralized setting that is safe, supports social interaction & development, and helps children with medical complexity reach their full potential.

[3] https://www.childrenshospitals.org/content/quality/report/reducing-the-health-care-spend-for-children-with-complex-medical-conditions

Enhanced Care Management Referral & Communication with Community Primary Care Practices

PCN will improve the referral and communication processes of care management services with primary care practices. PCN will expand options for community practices to place care management referrals including an e-form submission process to complement existing fax/telephonic options. PCN will also implement monthly communication of high-risk patients, targeted for potential care management services, to increase awareness of patients who may benefit from increased support. Within this communication, PCN will highlight high risk patients who have upcoming scheduled appointments. This will allow practices to assess whether the patient/family would benefit from increased support and, as applicable, support a warm handoff to PCN Care Management as an extension of services from the practice. Efforts are also planned to improve how and when PCN care management activity (case open, monthly, case closure) is communicated to community practices, so information can be more effectively integrated into the clinical workflow of the practice.

Revision of Authorization Process for Complex In-home Service Requests

In 2024 PCN will partner with health-plan partners, state entities, and community agencies to support process improvement around the management of complex in home services (i.e.- private duty nursing and personal care services). This work will include streamlining processes for the management of associated authorizations by educating ordering providers on required documentation, removing redundant processing steps, and minimizing paperwork. Through this work, youth and families that would most benefit from these services will be able to access them more quickly and consistently and ensure the most appropriate level of care is provided.

Submitted: _____ June 10, 2024

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

Date

Approval: _____ June 14, 2024

Just for Kids (JFK) Committee

Date

_____ June 14, 2024

Clinical Quality & Operations Committee

Date

2024 Annual Work Plan

	Initiative	Process and Scope
1	**Sustain and Enhance Community Connections to Address Social Needs**	Sustain and maintain a strong network of partner community-based organizations (CBOs) to address patient/family social needs. 2024 strategic areas of focus include replacement of an existing CBO partner, the ongoing evaluation of the impact of addressing social needs on process measures and health outcomes (clinical quality, total cost of care, acute utilization), and advance operational and technological changes to the social need referral workflow that adds value, efficiency, and benefits to CBOs.
2	**Integrated Behavioral Health Services**	Launch a third location for Integrated Behavioral Health to increase access to mental health services in the community and evaluate the impact of this service on provider satisfaction, utilization, and total cost of care.
3	**Extend PCN Network to Include Behavioral Health Entities**	Continue to advance strategy to extend network to include behavioral health organizations. Activity to include the formal launch of the Behavioral Health Advisory Committee, implement and deploy the use and access of available technology (1. Children's Mercy Cerner access via My Patient Connections 2. Population Health Management solution (Innovaccer)), and improve communication/collaboration across sites of care (specialty behavioral health care, ambulatory behavioral health care, and primary care practices). In the latter portion of 2024, launch phase 2 of behavioral health entity recruitment to psychology, counseling and behavioral health therapy clinics, and psychiatry clinics.
4	**Advance Health Equity**	PCN will continue to improve race, ethnicity, and language (REL) data collection across Children's Mercy & community primary care practices. After establishing data collection standards in 2023, 2024 will focus on ongoing improvement, measured by the "unknown race rate" (declined responses, unknown/not present/ not provided). Target will be to achieve an unknown rate under 5%. Improvement tactics to potentially include an "unknown rate" threshold to achieve bonus points within network's 2024 incentive model.
5	**Develop and Pilot a New Chronic Condition Value Based Care Program**	Develop and pilot a new "Chronic Condition Value Based Care Program" with the aim of transforming the way specialty services are delivered by supporting care model transformation (i.e. shifting accountability & responsibility from only those patients seen within a clinic to a population of chronic patients in the community) and promoting high quality, cost-effective specialty care that encourages care coordination and reduces ineffective, preventable, and inappropriate treatments. The program, which includes both infrastructure and performance-dependent funding, will create a mechanism to engage specialists in value based care where they can take ownership and accountability for a population of patients. The program will be piloted for diabetes patients in 2024 with the hope to expand to 2 to 3 additional chronic conditions in 2025.

6	**Prescribed Pediatric Extended Care Services Opportunity**	PCN is exploring an opportunity to partner with an organization to bring Prescribed Pediatric Extended Care (PPEC) services to the Kansas City region. PPEC services provide medical daycare services for children with medically complex conditions in a community-based setting. The services are provided for up to 12 hours per day and include reliable, team-based nursing services, educational/ social services, developmental therapies, and potentially other services. PPEC services provide reliable, advanced medical care and therapies in a centralized setting that is safe, supports social interaction, and helps children with medical complexity reach their full potential. With over 1,000 children with medical complexity within PCN's member population, PPEC services would support efforts to reduce total medical spend by lowering inpatient admissions, shortening inpatient stays, and replacing/complementing private duty nursing services.
7	**Enhanced Care Management Referral & Communication with Community Primary Care Practices**	Develop more enhanced and effective mechanisms for community practices to place care management referrals (i.e. e-form submission in addition to fax/ telephonic options). Increase communication to community practices on PCN care management activity (case open, monthly update, case closure) to maximize collaborative care. Also, network will evaluate mechanism to bring greater awareness to patients who may benefit from PCN care management services, so community practices can provide warm handoff referrals to PCN staff.
8	**Revision of Authorization Process for Complex In-home Service Requests**	Implement revised authorization process for complex in-home service requests specific to private duty nursing and personal care services with an overarching goal to reduce barriers to accessing care and increased parity with health plan processes.

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