Children's Mercy
PEDIATRIC CARE NETWORK

PEDIATRIC CARE NETWORK
ANNUAL REPORT

CALENDAR YEAR 2022

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

TABLE OF CONTENTS

OVERVIEW

Case Management • Utilization Management • Disease Management

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

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

The PCN performs delegated medical management functions under capitated risk agreements with Medicaid managed care organizations in Missouri and Kansas. To support the work, PCN employs a diverse skill set of staff, including registered nurses, licensed social workers, mental health professionals, respiratory therapists, medical directors, and non-clinical staff to support the medical management and practice transformation work. Through these value-based contracts, providers agree to engage with PCN in transforming their practice using patient-centered medical home (PCMH) concepts and demonstrating sustainable outcomes through improved quality, improved patient satisfaction and decreased cost.

176,055 members enrolled

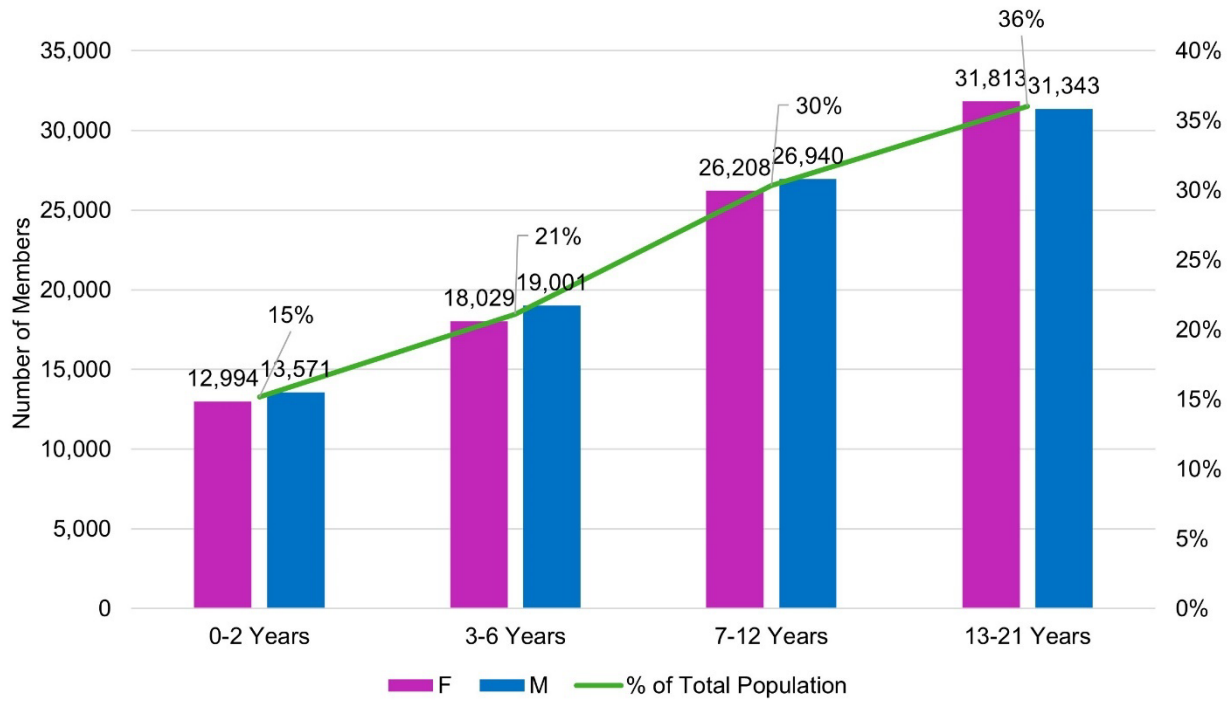
12,124 members served by Care Integration

29% of population have a chronic condition

12% of the member population have Attention Deficit and Hyperactivity Disorder

5% Depression, **5%** Asthma, **3%** Persistent Asthma

2022 PCN Member Age & Gender Distribution



100%

Provider Satisfaction with Prior Authorization Process

3%

Average increase in HEDIS measure compliance for:

- Social Determinants of Health Screening
- Immunization Rates
- Chlamydia Screenings

15%

Increase in Timeliness of Prenatal Care

UTILIZATION MANAGEMENT

> PCN is the most efficient and timely organization for reviewing authorizations. We love it!
>
> -- **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 and Milliman Care Guidelines®. Staff and peer audits are conducted quarterly and PCN monitors member satisfaction related to care delivery.

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

2022 Accomplishments

- Removed prior authorization requirements for enteral nutrition and circumcision to align with health plan partners and minimize provider administrative burden
- Integrated behavioral health management for Healthy Blue effective 10/01/2022 allowing for holistic management of population needs
- Standardized automatic notification of authorization approvals for behavioral health facilities ensuring timely concurrent request responses
- Enhanced electronic prior authorization portal to allow inpatient notification and streamline the provider authorization process
- Partnered with health plans and the state of Kansas to gather data on the Psychiatric Residential Treatment Facility wait list to enable efforts to minimize wait times for members warranting this high level of care

2023 Initiatives

- Implement automated surveys to improve monitoring of member/family satisfaction with PCN care integration services
- Evaluate the prior authorization process using provider input for opportunities to decrease submission work for providers and enhance efficiency

> Fastest turnaround time for an authorization request BY FAR. Extremely beneficial for patient's plan of care within medical rehabilitation.
>
> - Network Provider

13,876

Prior Authorizations completed in 2022

392.92

Average calls per month

12

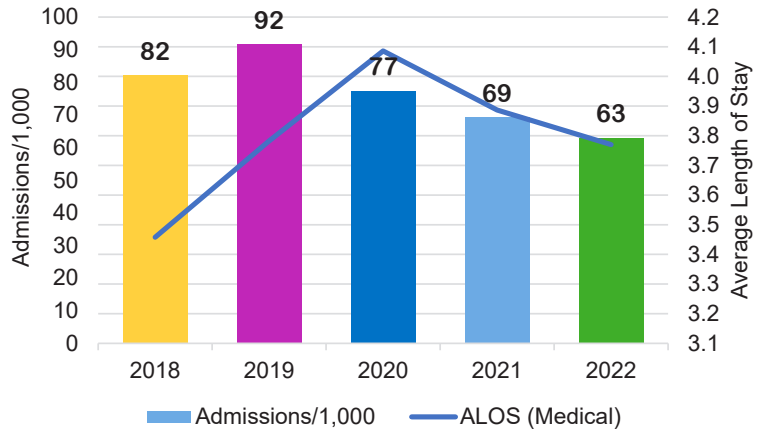
Seconds

Average speed to answer

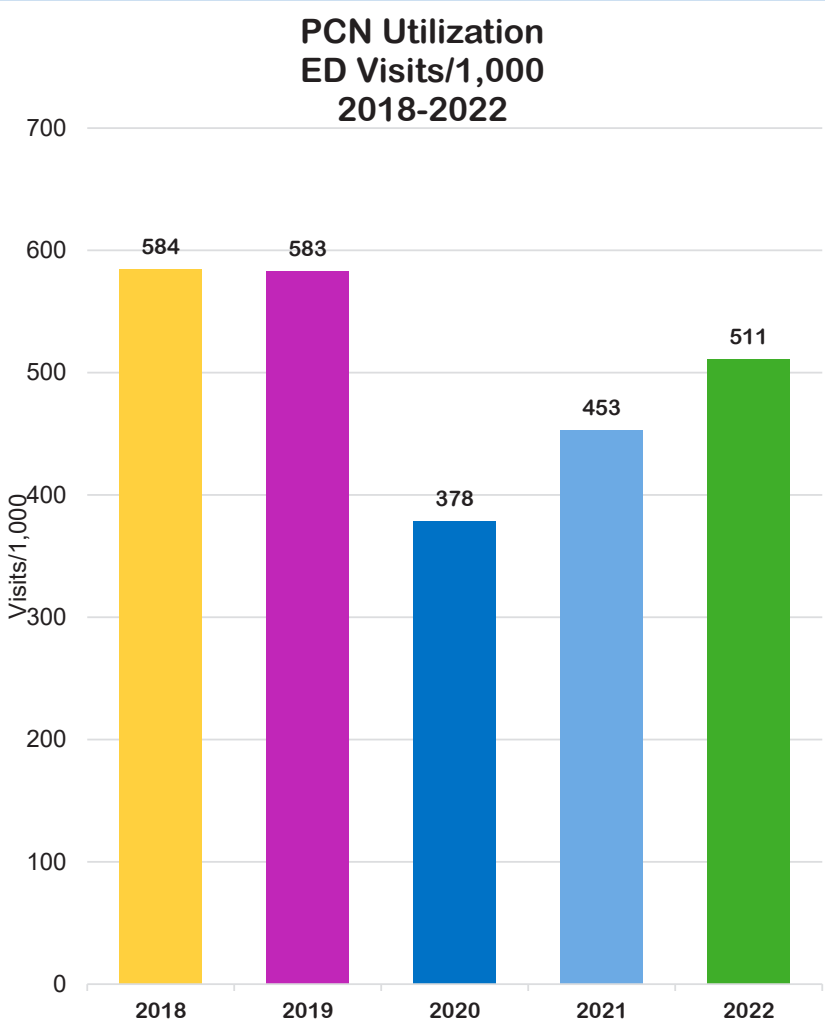
2.76%

Average call abandonment rate

PCN Utilization Admissions / 1,000 2018-2022



PCN Utilization ED Visits / 1,000 2018-2022



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 risk and 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 2022, 95% of cases required complex case management. Common conditions in complex case management include pregnancy, behavioral health, asthma, autism, lead, and diabetes.

3,464
members identified for case management

282 days
average time to completion

62.6%
of member driven goals achieved in year

47.2%
of enrollees achieved all goals

87%
care plan completion rate

482
new enrollments in case management

Reasons for referral:

- Pregnancy
- Asthma or Diabetes 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 of Caregiver Contact
- Lead
- Social/Community Resources Concerns

Disease Management

PCN's disease management (DM) programs use a unique approach to manage chronic asthma and diabetes through collaboration between the primary care providers and the care teams. 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.

15,000+ members followed by Disease Management

8% Asthma prevalence in population

144 members agreeing to participate in complex case management with a condition-specific asthma or diabetes need

1% Diabetes prevalence in population

Behavioral Health Management

Recognizing the importance of addressing the full spectrum of member's needs, PCN's Care Integration Team placed a renewed focus on whole person care. This work was bolstered by expansion of the partnership with Healthy Blue of Missouri to include behavioral health. Whole person care is shown to improve engagement and help address the unique needs of each member. With this expansion, PCN now manages both physical and behavioral health for 50% of their contracted health plans.

45% increase in behavioral health care navigator caseloads

1,055 behavioral health authorizations processed in 2022

53% of behavioral health authorizations were for psychiatric acute inpatient stays

Transitional Care Program

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

1,493 admissions identified for follow-up

58.7% of members successfully contacted

6.5% subsequently enrolled in care management for additional support

Following a multi-trauma event, Gabe was a teenager with new paraplegia. He worked hard through inpatient rehabilitation. **Joe**, PCN Care Navigator, worked alongside him to ensure connection to needed supports and services. Ten months after his injury, Gabe had at a part-time job, and had graduated from outpatient rehab. Currently, he is working full time and saving to buy a car, with plans to attend a driving program!

Rusty's mom was having a hard time finding Applied Behavioral Analysis therapy options. Their PCN care navigator, **Brook**, was able to identify options. Rusty is now successfully attending and enjoying therapy!

Safety beds are not covered by Medicaid. Louis' parents wanted a bed that would support his behavioral health needs through the night. Their PCN care navigator, **Bekah**, helped connect Louis' family with community funding to successfully secure a safety bed. Louis loves his bed, and his parents are able to sleep better, too!

Lisa is always there for us and always helps problem solve and does an outstanding job. When **Lisa** does not answer right away she always promptly responds back right away.

Cori really helped with every question I had and was amazing.

Really good, nice and caring. Enjoyed talking to **Sarah**.

Karen was awesome! She was able to provide her with info to an eyeglasses place. Mom says that they are ordered and on the way!

Very helpful, provided helpful information. Would have never known services existed if it were not for **Joe**'s call.

Erik was absolutely wonderful. He was able to help set up child [for their] next two appointments.

It's been great working with **Ann**!

Bekah is amazing! Never let her go.

2022 Accomplishments

- Developed the framework for new disease management programs (DM) for depression and healthy weight management to improve care options for members with those conditions
- Designed and implemented enhancements to the in-house documentation systems to support PCN's UM, CM and DM functions
- Expanded the behavioral health program to include Healthy Blue members, including the addition of four behavioral health care navigators
- Grew the capacity of the CM program with the addition of a care navigator
- Added text response functionality to longitudinal CM surveys to increase response rates and ease of access for members
- Welcomed education from community partners to support member's social determinants of health needs
- Hosted a biannual behavioral health learning collaborative for partner practices. Participants learned from one another and shared strategies on how to engage community mental health providers to meet the growing demand for services

2023 Initiatives

- PCN has long recognized the importance of identifying and supporting members with high-risk conditions that may lead to poor health outcomes. In 2023, PCN will implement the new depression and weight management programs across their managed populations. These new programs will provide members and their families support from a PCN team member to develop care plans to achieve their goals toward better health.
- PCN values the important relationships with our hospital partners. In 2023, PCN will explore opportunities to enhance collaboration with internal and external stakeholders to maximize patient outcomes.
- Behavioral health is just as important as physical health needs. That's why in 2023 we will engage behavioral health providers to collaborate on shared patients to improve processes and health outcomes for our members.

POPULATION HEALTH MANAGEMENT

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

Practice Transformation

The PCN network of providers participate in a value-based incentive program that provides the practice with a per member per month capitation for reaching identified quality goals, such as well child exams and immunizations. The PCN value-based model goes beyond traditional pay-for-performance programs, as it incorporates not only HEDIS/NCQA quality performance metrics but also engages participating practices in population health strategies, regular clinical quality meetings and learning collaborative sessions, and triannual practice performance reviews. PCN representatives also provide training and support in patient centered medical home principles, a key component in population health management.

As the PCN 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, the 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) as well.

2022 Accomplishments

In 2022, the PHM network team helped target several quality and practice improvement initiatives with PCN contracted provider offices, including:

- Social determinants of health (SDOH) screening and intervention training and tools. Partner practices were provided support and training to utilize a point of care tool, Lift Up KC, for SDOH need referrals. With this tool, providers and care team members in the practice can refer patients to community-based organizations (CBOs) electronically and then track the referrals to make sure the patients receive the help they need.

388 referrals were submitted through the Lift Up KC platform in 2022.

100% of PCN practices operationalized a formal social needs assessment in 2022.

The SDOH screening rate for PCN was **51%** with an 11% positivity rate, indicating an SDOH need was present.

66% of referrals were sent to one of CMICS's five formal CBO Referral Partners.

80% of referred patients got help after they were able to connect with the CBO.

- Health equity practice initiatives. The PHM network team worked with partner practices on addressing health disparities based on race, ethnicity, and language. The team met with practices to understand their data collection processes and identify areas of opportunity. This will be an ongoing focus for PCN in the future.
- Closing gaps in lead & chlamydia screening. Representatives helped practices spotlight and share best practices in their lead and chlamydia screenings. Utilizing a pre-visit planning report, the need for screenings were more effectively identified and addressed at patient appointments. Additionally, billing and coding improvements increased capture rate and reimbursement. PCN practices have begun to see improvement in their screening measures based on these quality improvement efforts.

2023 Initiatives

- Continue to advance the maturity and sustainability of our network of community-based organizations (CBO) closing social need referrals. PCN will continue to cultivate CBO relationships, working closely with CBOs to increase the value proposition of using Lift Up KC and making the referral process as efficient and effective as possible.
- Continue to advance the collection of race, ethnicity, and language data by adding more formal requirements, standards, and education to practices and care teams.
- Increase the adoption and use of PCN's population health management platform using value stories, re-education, and comparative performance reports. Also, continue to extend the value with new features such as high utilization indicators, care management referrals, and immediate access to lab results, dispensed medications, and imaging.

2022 Work Plan Updates

Initiative	Update
Evolve Triannual Performance Review Process Continue to evaluate quality and cost metrics for contracted PCN primary care practices, schedule tri-annual meetings with the practices to review data, discuss coordinated interventions to address improvement opportunities and evaluate progress with metrics. Identify unique opportunities by practice.	These meetings continue to be well attended by physicians and other clinical staff from each of the PCN Practices. It is also during this time that any changes to the IT Solution: Innovaccer are introduced. This has led to more practice involvement with the tool in examining its effectiveness. The team also works with practice billing and coding teams to ensure correct coding for all quality metrics. *"The PCN has been a tremendous support for the care of our pediatric patients across Swope Health. Our Pediatric Clinic has especially benefited from a longstanding relationship with the PCN. The personal attention given to us via our Triannual meetings has been invaluable. Not only do we receive a deep dive into our data, but we receive guidance and resources that not only help improve network performance, but that actually enhance direct patient care. The PCN continues to directly influence our pediatric Quality Improvement initiatives, process and workflows. Our Network Representative, Katie Edney, is knowledgeable and always available when needed. She is a great facilitator and communicator between Swope and the PCN."* **Kenneth Thomas, MD --** Swope Health
Enhance Population Health Management Point-of-Care Solution Continue deployment and optimization of PCN's population health management point-of- care solution.	Completed full integration of Lift Up KC to enable community practices to place closed-loop social need referrals at point-of-care. Continued to support & educate practices, nearly doubling active users on the platform.
Improve Social Determinants of Health Platform & Enhance Community Connections Integrate use of Lift Up KC into standard clinical workflows and iteratively improve search, program content, and referral communication.	Children's Mercy & PCN community primary care practices formalized SDOH screening and referral processes and integrated them into standard workflows. Completed comprehensive education to enable practice staff and/or designated super users to place electronic social need referrals via Lift Up KC.
Build a Trusted Network of Community Based Organizations Establish formal partnerships with community-based organizations. Partnerships will include capacity-building funding and focus on developing sustainable closed-loop social need referral processes.	Launched formal, funded partnerships with five full-service community-based organizations distributed across KC metro to complete closed-loop social need referrals. Developed trust and collaborative relationships via monthly operational engagements.

Advance Health Equity Improve the collection of race, ethnicity, and language (REL) data and stratify standard clinical outcomes by these factors. Identify a targeted health disparity quality improvement initiative and develop and implement an associated care improvement plan.	Used REL data collected from practice EMRs to evaluate and identify health inequities. Identified and implemented a quality improvement plan to address 7% lower rate of chlamydia screening in Hispanic population. Intervention led to 29% reduction in disparity in Hispanics relative to overall population.
Increase Behavioral Health Integration in Primary Care Support and encourage community primary care providers to integrate behavioral health through resource sharing, engagement meetings and collaborative case discussions.	With the generous support of philanthropic funds, PCN will partner with three community primary care practices to integrate behavioral health services by adding a master's level mental health provider who will consult with physicians to identify and intervene in behavioral health needs
Broaden the Scope of Behavioral Health Delegation Implement additional programming, staff education, and C.A.R.E. Web enhancements to support expansion of behavioral health management into an additional population.	Throughout 2022 PCN Care Integration staff worked with both internal and external partners to build their first Behavioral Health program for the state of Missouri. This work included broadening case management assessments, additional data/report builds, and a revamp of prior authorization systems. This work culminated in the successful inclusion of Behavioral Health delegation for Healthy Blue of Missouri.
Operations/ Clinical Quality Meeting with FQHC's only- PCN FQHCs in Kansas and Missouri This process will allow mutual discussion about the uniqueness of the Federally Qualified Health Center (FQHC) operations process, share best practices and overcoming hurdles and identify assigned vs attributed membership for quality metrics. The tri-annual meetings and FQHC meetings will focus on their organizations.	The Clinical Quality Committee exclusively for FQHC's began in early 2023 with good representation. We are able to talk about the unique issues facing FQHC's that community practices do not encounter.
Increase Efficiency of Prior Authorization Process Evaluate and streamline the prior authorization process for ease of access and to reduce provider burden in requesting services.	Through review of prior authorization requirements (Missouri) and processes (Kansas and Missouri), PCN's care integration team implemented multiple changes to streamline prior authorization processes. These changes included the removal of certain prior authorization requirements and further enhancements to electronic requests systems to allow for inpatient notification. Furthermore, PCN worked closely with local health systems where PCN has remote access to implement daily census reports eliminating the burden of individual notifications for each admit and discharge.

SUMMARY, GOALS, WORK PLAN

Sustain and 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 80% of health outcomes (Institute for Clinical Systems Improvement, 2014). In 2023, PCN will build upon the partnerships established with five full-service CBOs distributed across the Kansas City metropolitan area by transitioning from a pilot to a sustainable program. Budgeted funding will be nearly double as PCN looks to expand existing partnerships or add additional CBOs to better serve our patients and families. Recognizing that CBOs are critical to our success, PCN will continue to work closely with CBOs to receive and respond to feedback, improve communication and coordination, and enhance the value received. Additionally, further steps and ongoing education will be completed to further integrate social need referrals into Children's Mercy and community practice workflows. Finally, research and analyses will be initiated to evaluate the effect of social need referrals on health outcomes to guide other institutions and inform further investments in our community.

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. Recognizing this crisis cannot be addressed solely by primary care practices, PCN will implement a strategy to extend network and value-based relationships to behavioral health entities. These relationships will improve access to the appropriate level of mental health services, improve care transitions and referral coordination, and increase cross-system visibility. The strategy will help break down long-standing silos between medical and behavioral health systems to facilitate innovation, collaboration, and coordination to improve care and health outcomes.

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 to improve the completeness and accuracy of race, ethnicity, and language (REL) data. To support these efforts, PCN will incorporate health equity requirements within the 2023 value-based incentive model for all community practices. These requirements will require REL questions (i.e. with an option to decline/opt out), further standardize REL data elements, and provide training and education so practice staff are well-informed and equipped to collect REL data. In parallel to improving foundational REL data, PCN will develop a health equity dashboard to stratify all preventive and chronic care pediatric quality and cost/utilization metrics to understand where disparities exist, prioritize health equity projects, and initiate work to address gaps.

Enhance Population Health Management Point-of-Care Solution

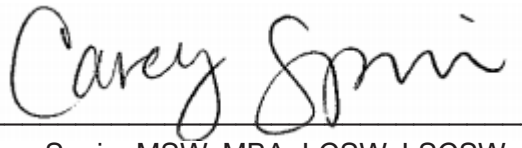
PCN will continue to improve our population health management point-of-care solution called Innovaccer InNote. This point-of-care solution is critical to our quality and cost improvement strategy since the solution integrates directly within the care team's clinical workflow regardless of the practice's EMR. Most importantly, InNote brings key insights and capabilities (care gaps, coding gaps, acute visit history, specialty visit history, closed-loop social need referrals) efficiently to care team members, so they can take action to improve care. For 2023, the solution will continue to be optimized with key features supporting improved communication, coordination, and user experience. Additional enhancements planned for 2023 include more efficient access to Children's Mercy acute visit notes (inpatient, ED, urgent care) and improved visibility to high cost and high utilization patients.

Expand Disease Management Programming

Since its creation PCN has had intensive disease management programs focused on specific conditions from both the micro member focused level and the macro population level. Historically, these programs focused on asthma and diabetes. In 2022 PCN collaborated with local specialists to design additional programs focused on depression and obesity. Beginning in 2023 PCN will implement these programs. Continued evaluation and growth of the programs will occur in partnership with local specialists and the PCN network providers.

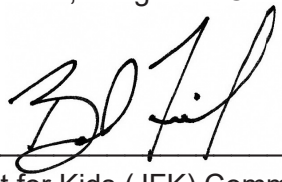
Restructure Care Team Structure for Efficient Provision of Services

PCN's Care Integration team operates in a holistic care team model. These teams include both clinical and non-clinical staff who work closely together to support the members they are assigned. In 2023 this model, and the responsibilities of the roles within it, will be restructured to support more efficient process flows and optimize provision of care. Ongoing review of this structure will continue and opportunities for further enhancement will be explored.

Submitted:  August 7, 2023

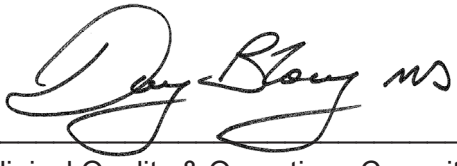
Carey Spain, MSW, MBA, LCSW, LSCSW, ACM
Senior Director, Integrated Community Care

Date

Approval:  August 7, 2023

Just for Kids (JFK) Committee

Date

 August 7, 2023

Clinical Quality & Operations Committee

Date

2023 Annual Work Plan

	Initiative	Process and Scope
1	**Sustain and Enhance Community Connections to Address Social Needs**	Transition existing network of partnering community-based organizations 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.
2	**Integrated Behavioral Health Services**	Develop strategy to embed behavioral health services into practices. Size and scope of the services are to be determined but would be staffed by a licensed mental health therapist (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.
3	**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.
4	**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.
5	**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.
6	**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.
7	**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.

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