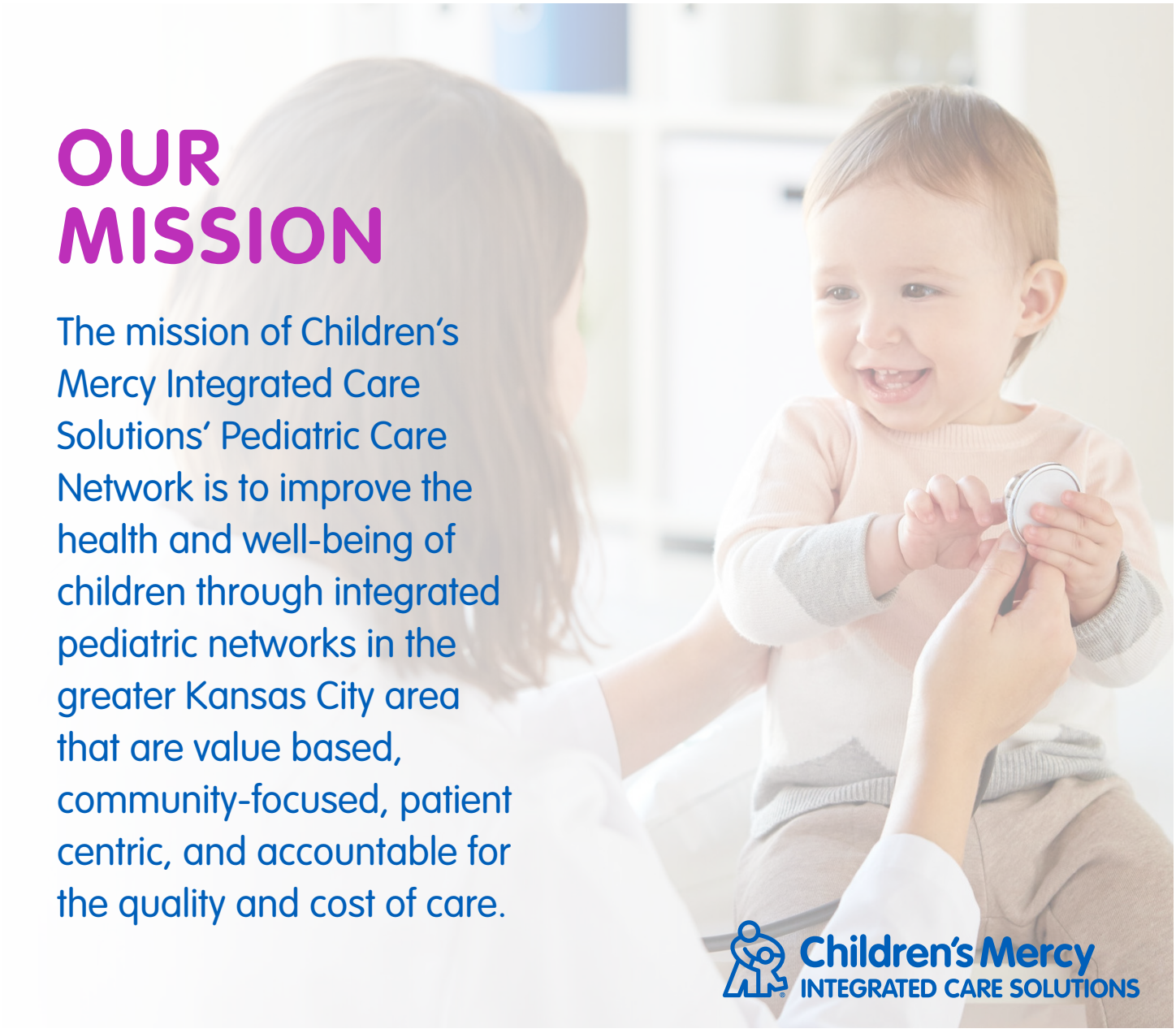
PEDIATRIC CARE NETWORK

ANNUAL REPORT

Children's Mercy
PEDIATRIC CARE NETWORK

2021



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 for select plans, 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:

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

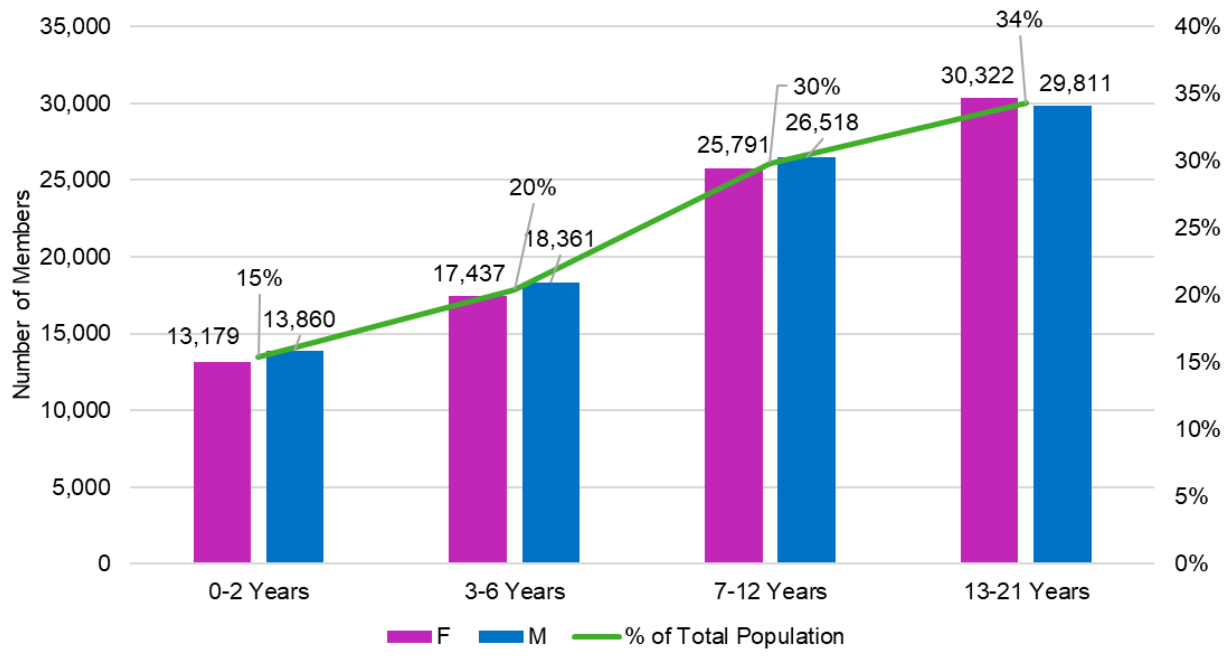
The PCN performs delegated medical management functions under capitated risk agreements with Medicaid managed care organizations in Missouri and Kansas. As of December 2021, PCN managed approximately 175,279 members.

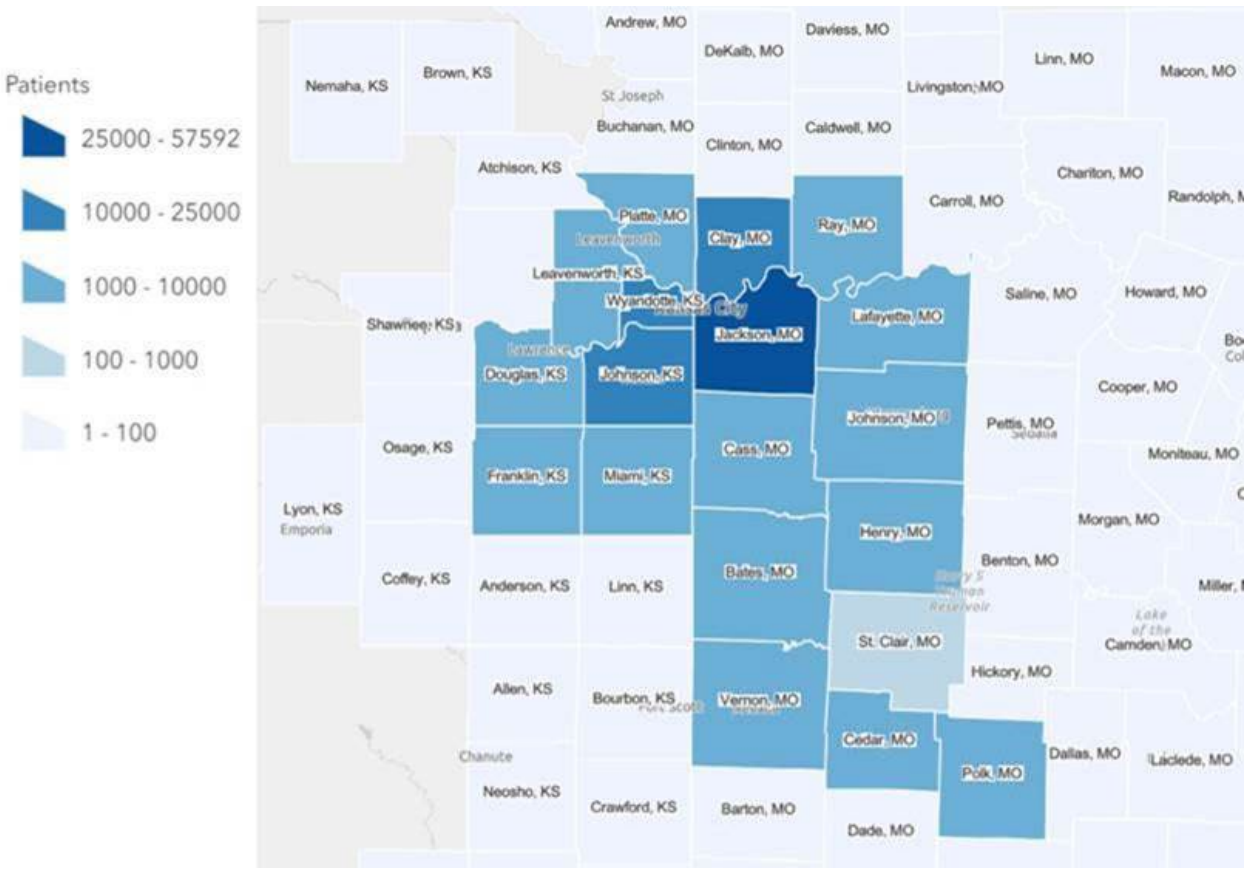
175,279 members enrolled

11,283 members served by Care Integration

27% of population have a chronic condition

2021 PCN Member Age & Gender Distribution





Through these 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.

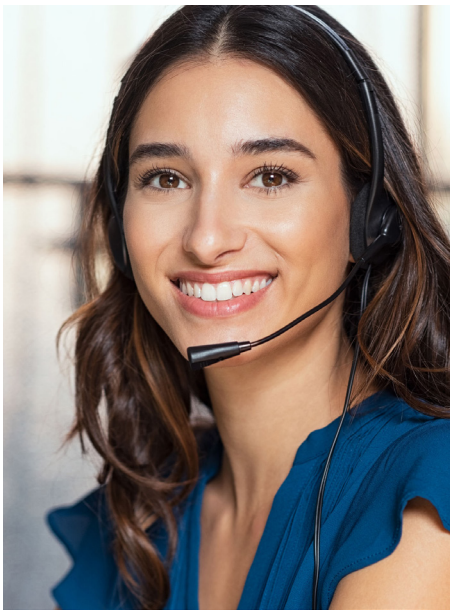
8%
reduction in PMPM cost*

*Over CY2019. Because 2020 was an anomaly, data points contained in this report use 2019 as a baseline.

94%
provider satisfaction

8%
average increase in HEDIS compliance for case management populations

STRUCTURE AND KEY STAFF ROLES



To support the work, the PCN employs a diverse skillset of supportive staff, including registered nurses, licensed social workers, mental health professionals, respiratory therapists, medical directors, and various administrative and non-clinical staff to support the medical management and practice transformation work.

The disciplines employed by PCN are organized into primary care provider (PCP)- aligned care teams. Certification in case management and disease-specific coaching is strongly encouraged and/or required of clinical staff. Care teams are made up of care navigators (Registered Nurses or social workers), community health workers, community resource specialists, care facilitation coordinators, care facilitation nurses, and behavioral health specialists. These multi-disciplinary teams seek to:

- Assist members in sustaining or achieving an optimal level of wellness and function by facilitating timely and appropriate healthcare 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
- Achieve cost efficiency in the provision of health services while maximizing healthcare quality
- Mobilize community resources to meet needs of members

UTILIZATION MANAGEMENT

> All the staff at PCN Prior Authorization are VERY helpful and even help me when I ask stupid questions. They are all wonderful!
>
> -- **Provider Experience Survey Comment**

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 to ensure compliance with documentation and call standards, application of criteria, and adherence to processing timeframe standards. In 2021, average audit scores were 98%, exceeding the internal benchmark requirement of 95%. Additionally, PCN monitors member satisfaction related to care delivery.

The PCN monitors utilization trends for the population to ensure appropriate utilization of services occurs. To monitor for under-utilization of services, PCN relies on reviews of preventive services, outpatient services, and PCP office-based services. For over-utilization of services, PCN relies on review of frequent and/or high-cost services such as inpatient and emergency department trends. In calendar year 2021, utilization trends decreased over 2019 levels for all monitored metrics.

Prior Authorizations

14,280

492

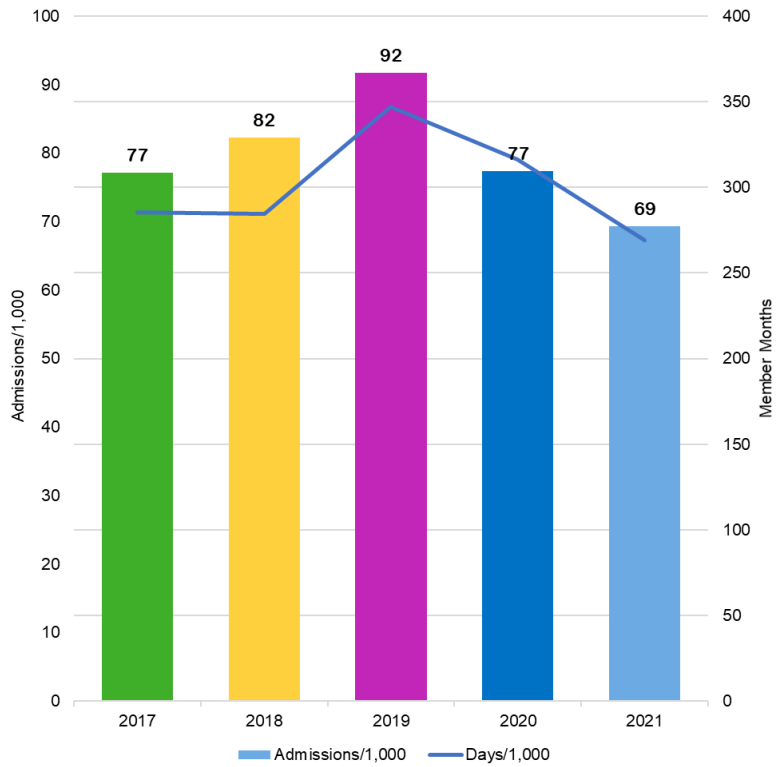
Average Call Volume per Month

17 Seconds - Average Speed to Answer

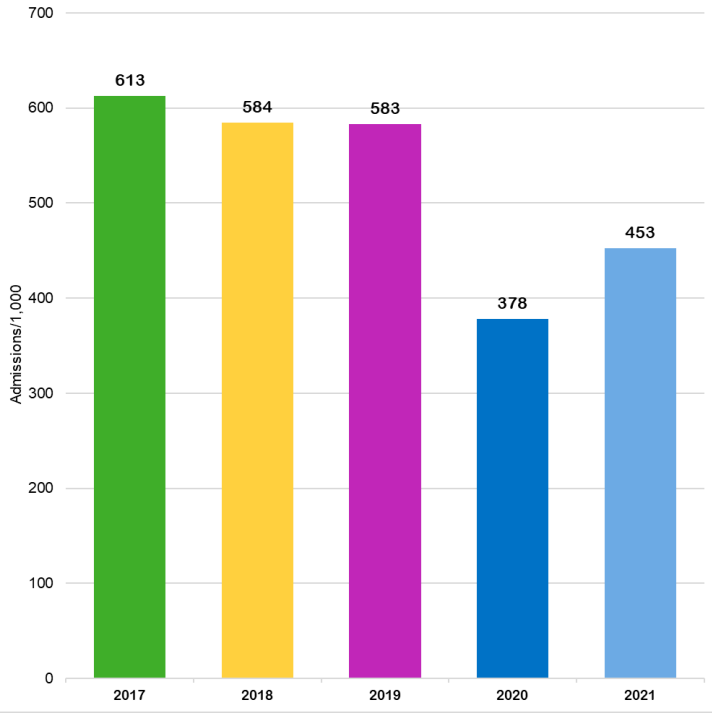
2.2%

Average Call Abandonment Rate

PCN Utilization Admissions / 1,000 2017-2021



PCN Utilization ED Visits / 1,000 2017-2021



Despite the challenges of the COVID-19 pandemic, all utilization metrics improved in 2021 over 2019 levels. Admissions per 1000 members and inpatient days per 1000 members decreased by 25% and 22%, respectively. ED visits per 1000 members also decreased by 22%.

Chronic Conditions	% of Member Population
Attention Deficit and Hyperactivity Disorder	10.7%
Asthma or Persistent Asthma	6.2%
Depression	5.9%
Chronic Kidney Disease	1.3%
Other Chronic Conditions	1.1%
Epilepsy	1.0%
Diabetes	0.6%

Behavioral health, asthma, and ADHD continue to be the top chronic conditions among members across all health plans.

Future Initiatives

- The PCN will continue to evaluate the list of services that require prior authorization. Through this annual evaluation, additional services may be identified as appropriate to either be added or removed from the requirements. PCN continues to monitor trends with services removed from prior authorization to identify potential over-utilization.
- The PCN will continue to educate providers on the availability of the electronic prior authorization platform to ensure efficiency in prior authorization and processing.
- The PCN will further explore opportunities for remote access and automated census reports to streamline processing of inpatient certifications.
- As the PCN further expands populations served for behavioral health, PCN will review prior authorization policies to ensure mental health parity.

CASE MANAGEMENT & DISEASE MANAGEMENT

Case management and disease management

are important components of the care integration program. Case management and disease management help members sustain or regain optimal health and reduce overall healthcare costs. The PCN achieves these goals through well-coordinated efforts between the 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.

1,930 Member-Driven Goals Created for Care Plans in 2021

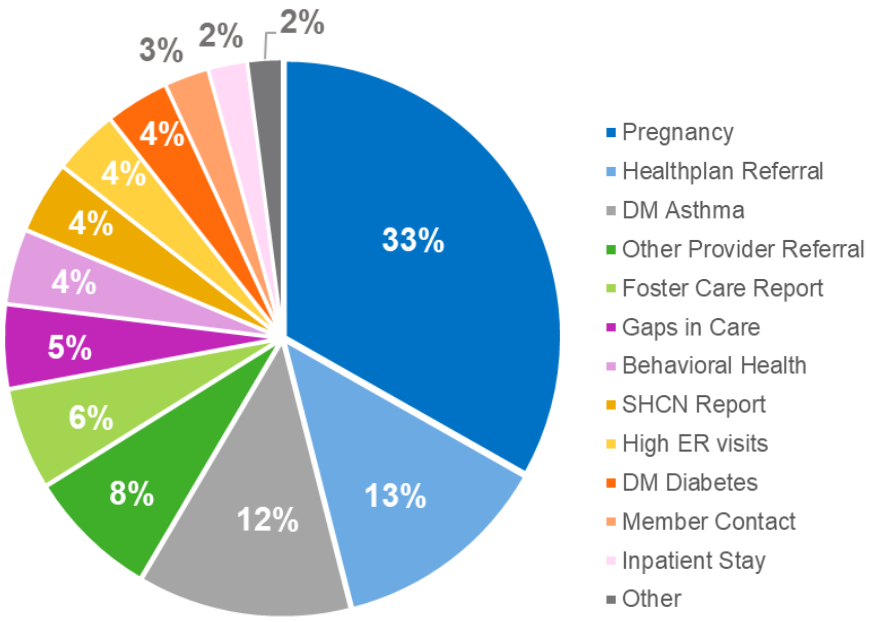
→

54% Goals Achieved During the Year

The PCN regularly reviews processes for identifying members, determining and documenting interventions, and the measurement of outcomes. The process incorporates case management screenings, assessments, care plans, routing of cases, and the coordination of tasks across team members. Assigned populations can be organized and prioritized by chronic condition, high utilization, risk score, or gaps in care.

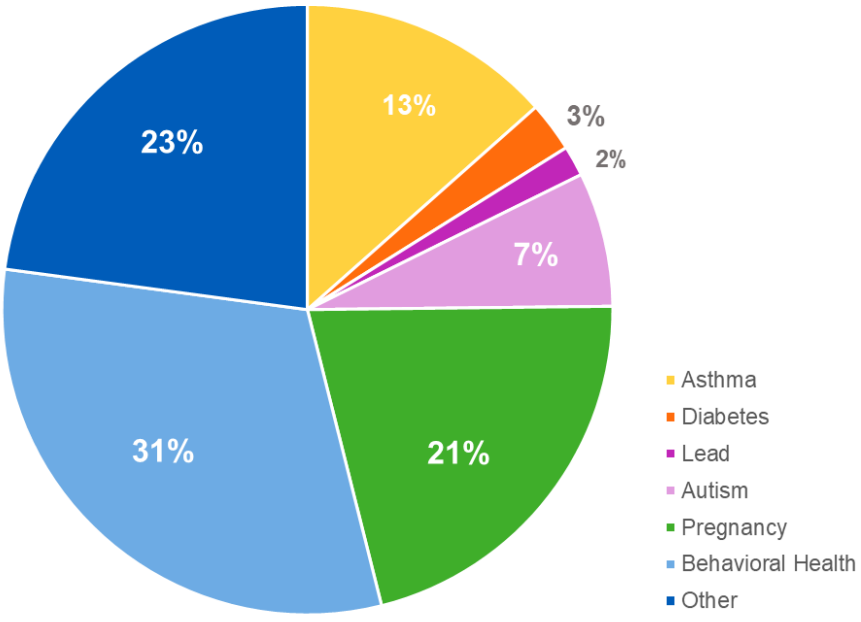
Audits are performed quarterly on all case, transitional, and disease management programs to ensure compliance with documentation and assessment standards, as well as health plan and state requirements. Staff are required to meet or exceed an accuracy level of 95%; in 2021, audit scores averaged 99%. Additionally, regular case reviews with management and peers enhance quality and promote consistency in application of case management principles through the discussion of barriers to care, analysis of intervention opportunities, and identification of goals for complex cases.

Reasons for Referral to Case Management



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 2021, 94% of the open cases required complex case management. Common conditions in complex case management included: pregnancy, behavioral health, asthma, autism, lead, and diabetes.

Complex Case Management Case Types



3,094
Members Proactively Identified for Case Management Services

532
New CM Participants in 2021

288
Average Days Duration of CM Participation

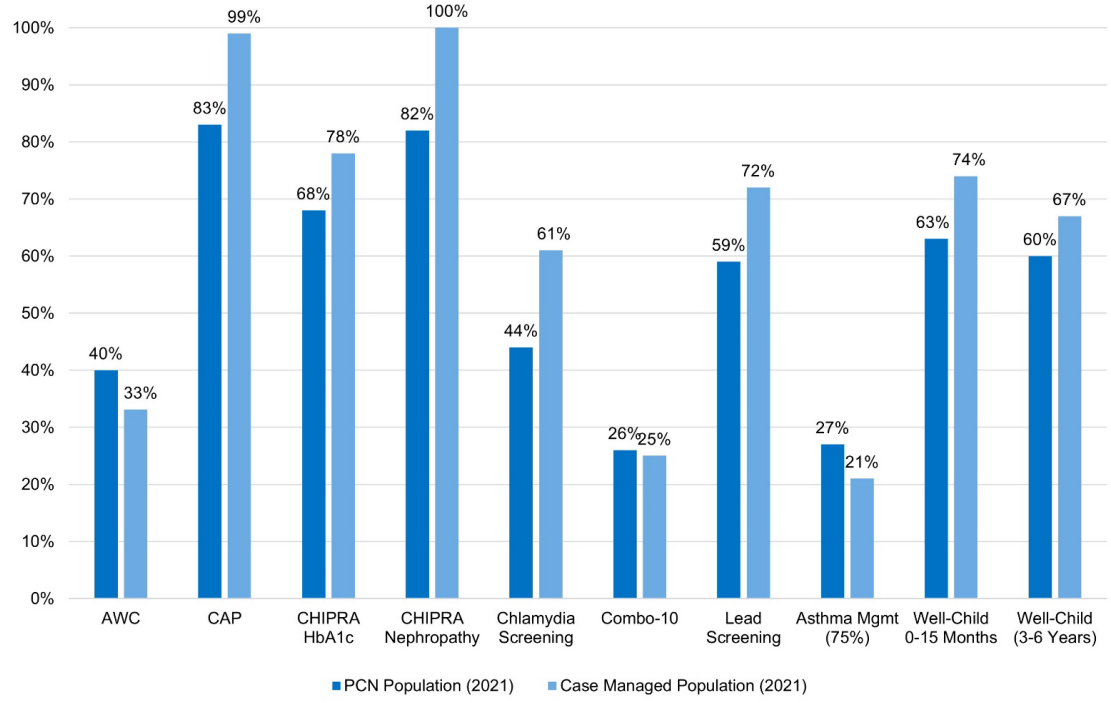
226
CM Participants Achieved All Their Goals

"Ally" is a 12-year-old with Type 1 Diabetes who has trouble keeping her Continuous Glucose Monitor (CGM) sensors on due to oily skin. She needed more than the allotted three per month. The family was also in need of housing support due to an eviction. The Diabetes Disease Management report helped identify that Ally and her family could use additional support.

> I'm so very pleased with all the help you have given. Thank you.
>
> -- Ally's Mom

Successful care management engagement led to big wins for this family. Ally's mom was overwhelmed and shared, "I'm so very pleased with all the help you have given. Thank you." Karen, the PCN care navigator partnered with the Children's Mercy Endocrine Clinic to identify a new medical equipment provider for Ally's insulin pump and CGM supplies, and she now can better care for herself. Additionally, connecting with Kansas Legal Aid through Children's Mercy Center for Community Connections ensured a safe, new home following education on housing rights and lawyer assignment.

HEDIS Measures Comparison
PCN Population vs. Case Managed Population 2021



The PCN evaluates pediatric-focused HEDIS measures using claims and administrative data to compare its case managed population outcomes to the entire PCN population. In 2021, measures monitored included Well-Child Visits, Lead Screenings, and Asthma Management.

Disease Management

PCN's disease management programs use a unique approach to manage chronic asthma and diabetes through collaborative efforts between the primary care providers and the care teams. The care teams work with PCP offices 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.

6.2%
Asthma Prevalence in Population
→
394
Members Enrolled in DM
→
2%
Reduction in Visits per 1,000

0.6%
Diabetes Prevalence in Population
→
107
Members Enrolled in DM
→
15%
Reduction in Inpatient Utilization for Members with Type 2 Diabetes

"Bobby" is an 8-year-old with epilepsy and autism. He is non-verbal, frequently aggressive, and wanders easily. Bobby's family is from Iraq with Arabic as their native language. PCN began supporting Bobby following a referral from their health plan for assistance with diapers.

> "Thank you, my angel!"
> **- Bobby's Mom**

PCN Care Navigator, Erik recognized several potential barriers for Bobby and his family and enrolled them in the Case Management program. Erik continued to support the family for several months to ensure connection to a new primary care doctor was established, resolve a long-standing issue obtaining diapers, and starting much needed therapy. Bobby is also now connected with the local Community Developmental Disability Organization and is on the Kansas waiver waitlist for additional supports. Bobby's mother expresses her gratitude by ending each call with Erik by saying "Thank you, my Angel!".

"Peter" is a 6-year-old cancer survivor with Down Syndrome. Due to his health needs, including chemotherapy, during the COVID pandemic he has been isolated for the past several years. This isolation, including the inability to socialize with peers in daycare, school, or community, has led to a lack of awareness for his surroundings. In public settings, Peter demonstrates no fear. He will run away or grab on to a stranger's hand and walk away with them if not monitored closely. A GPS tracking device was not covered by his insurance, and the family was struggling to find the necessary resources to maintain Peter's safety. Peter is currently on the Kansas Waiver waitlist and has an assigned case manager who referred him to PCN for assistance with a GPS safety device called AngelSense.

The PCN team referred the family to the Love Fund who covered the full price of the AngelSense device, and for a one-year subscription. Love Fund will also cover subscriptions for subsequent years if the family re-applies for assistance. The PCN team was happy to deliver this device to the family's home.

Peter's mother was extremely grateful and impressed that PCN was able to help so quickly. She had been trying to obtain financial assistance for a GPS tracking device for a very long time. The family even submitted an article to be published in Love Fund's newsletter to express their gratitude. Peter's mother was quoted as saying, "We really appreciate the Love Fund for doing this for our family and helping to keep Peter safe as he starts Kindergarten this year. Peter participates in the Take Me Home program with local law enforcement and we can share this GPS information with those who need it (police, teachers, etc.). Thank you so much for your generosity!"

Transitional Care Program

To facilitate a seamless transition from inpatient to home and community settings, the care teams deploy a transitional care program. This program involves making post-discharge phone calls to members and caregivers focused on assessing and screening for barriers to care following inpatient admission. There are two levels of transitional care. Level 1 transitional care calls are conducted within two days of discharge from an inpatient setting for members who meet criteria. A subsequent Level 2 transitional care call is completed 10-14 days following the Level 1 call for members who meet additional follow-up criteria.

If needs are identified during a call, the care team works in partnerships 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.

1,353 Members
Identified for a TOC Call

72% of Identified
Members Successfully Contacted

5% of Contacted Members
Subsequently Referred to
Care Management

Future Initiatives

- The PCN will ensure continued identification of at-risk complex members for transitional support, engagement, and facilitation of timely post discharge follow-up.
- In support of community provider initiatives to integrate behavioral health in primary care, PCN Care Integration teams will maintain communication with providers around any post discharge concerns or decompensations related to holistic care.
- In 2022, the PCN will actively seek opportunities to more closely partner with area health systems to assist members and families in navigating their healthcare journey across the spectrum of levels of care.
- The PCN will strengthen ongoing partnerships with health plans to correct PCP identification and alignment to enable communication and collaboration with providers.
- Care Integration will incorporate additional educational opportunities for staff and providers related to behavioral health interventions and addressing social determinants of health needs.
- Documentation system enhancements will be implemented to support staff efficiency with expansion of behavioral health management into additional populations.
- The PCN will explore alternative delivery methods for the case management and disease management patient experience surveys to obtain a broader patient voice in program development and growth.

POPULATION HEALTH MANAGEMENT

> Population health seeks to create conditions that promote health, prevent adverse events, and improve outcomes.
>
> -- Thomas Jefferson University, 2019

Population health management (PHM) refers to the process of improving health outcomes 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. In 2021, CMICS completed the implementation of Innovaccer, a PHM technology vendor, in nearly all affiliated practices. Innovaccer is a primary care point-of-care solution which integrates directly into the care team's clinical workflow. It uses a robust data infrastructure and advanced PHM capabilities to provide quality reporting & analytics, payer financial analytics, automated patient/family outreach, point-of-care clinical recommendations, and improved

Focused outreach campaigns for: care management, wellness visits, and asthma care visits.

IN 2021

7 patient outreach campaigns →

called **61,000+** unique patients → **131,000** calls

texted **11,000+** patients → sent **20,000+** texts

care coordination across the spectrum of care. The data infrastructure includes data feeds from payers, providers, and external laboratories, including near real-time data feeds from over 15 different EMR vendors across nearly 40 CMICS practices.

The PHM operations and network teams work collaboratively to bring population health solutions to each PCN Practice. CMICS provides training and guidance for the implementation of Innovaccer and its multiple uses. Innovaccer allows affiliated practices to proactively identify trending health needs of their patient populations as well individual health needs. Patient social determinants of health needs can be assessed, and families provided resources that may be of help, and gaps in care can be addressed during the visit.

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 metric goals, such as well child exams and immunizations. Practice engagement and participation are also key components of our value-based incentive programs.

> Every team member I have worked with is professional and very quick to respond to my requests. In a single word, spectacular!
>
> -- **Provider Experience Survey Comment**

The PCN Value Based program goes beyond traditional pay for performance programs, as we incorporate not only HEDIS/NCQA quality performance metrics but also practice engagement in population health strategies, regular and required attendance of Value-Based PCN clinical quality meetings, and review of practice performance in all areas. PCN representatives continue to provide training and support in patient centered medical home principles, which are a key component in population health management. PCN also conducts learning collaborative sessions with each practice and provides regular and timely feedback regarding quality metrics performance to staff and primary care physicians.

In summary, the PCN Incentive Program provides a per member per month capitation based on the following:

- Population health management
- Patient-Centered Medical Home concepts
- Practice engagement and participation in program initiatives
- Social Determinants of Health
- ER utilization and overall cost/utilization performance
- Quality HEDIS metrics based on NCQA Medicaid metrics.

Community Integration

To facilitate resource access and a more seamless referral process for members and affiliated practices, PCN partners with numerous community agencies (SleepyHead Beds, Harvesters, Giving the Basics, local health departments, etc.). In 2021, PCN launched Lift Up KC (www.liftupkc.org) in partnership with findhelp.org, to connect families with trusted community resources. Lift Up KC allows users to search a vast network of relevant services and resources using their zip code. Referrals are tracked within the platform to support follow-though and collaboration across the continuum of care.

236
Referrals on Lift Up KC

Additionally, PCN continues its collaboration with KC Care Health Center to provide a community health worker (CHW) for PCN

member interventions. CHWs are members of the community they serve and provide community resources and support to assist families with navigating their health and social services systems.

33%

PMPM Cost Decrease for Members Supported by Community Health Worker

Finally, PCN continues to provide a direct-to-consumer virtual health service, KidCareAnywhere (KCA). KCA allows direct access to a Children's Mercy pediatric provider via a smartphone, tablet, or computer at no cost to the member. Throughout 2021, KCA provided **36,971** virtual visits to members.

Practice Tools and Support

PCN affiliated practices have many additional tools to support their quality improvement, practice transformation, and patient education and outreach efforts. Practice supports include dedicated network representatives to assist with data analysis and reporting and practice transformation efforts; a provider portal for care team communication and tailored reporting; patient outreach initiatives; and a triannual performance review to provide actionable insights and collaboration to jointly identify strategies for caring for the highest cost and highest risk patients. (See Appendix B for sample packet.)

Future Initiatives

- Continued effort to develop a point-of-care solution (InNote) specifically designed for specialists, including additional functionality related to laboratory tests and imaging. Solution to be introduced to specialists in 2022.
- Continued effort to develop an Episodes of Care analytical framework to meaningfully engage specialty divisions. Iterative development improved process to identify patients and attribute specialty providers. The analytical framework will be used to deliver useful and actionable cost and utilization information to support specialty care model improvement.
- Prepared to launch a new social determinants of health pilot in 2022 to fund community-based organizations (CBOs) to further develop relationships, evaluate/improve the 'closed loop' social need referral workflow, and provide social need services to patients.

SUMMARY, GOALS, WORK PLAN

Evolve Triannual Performance Review Process

The PCN Community Resource Team worked on numerous projects throughout 2021. Although in person community resources connection meetings were placed on hold due to the COVID pandemic, the PCN Community Resource team continued to partner and foster relationships with numerous community agencies (SleepyHead Beds, Harvesters, Giving the Basics, local health departments, etc.) to facilitate resource acquisition and a more seamless referral process for PCN members. The team also collaborated with community agencies to disseminate information and schedule virtual presentations for the PCN team and broader Children's Mercy System. In 2022, in tandem with the roll out of Lift Up KC the PCN Community Resource team will continue to investigate opportunities for resource acquisition to best support the needs of members.

Enhance Population Health Management Point-of-Care Solution

PCN will continue to deploy and enhance a population health management point-of-care solution called Innovaccer InNote to all PCN practices. The InNote solution functions agnostic of a practice's EMR and is an 'overlay solution' that automatically recognizes the patient being viewed in the native EMR to bring relevant information concisely and efficiently at the point-of-care. Information includes care gaps, acute visit history, future/past specialty visits, direct access to Children's Mercy specialty notes, and access to the patient's full longitudinal record. In 2022, the point of care solution will add the ability to perform closed loop social need referrals and provide direct access to applicable provider/practice dashboards. With the core capabilities in place, 2022 will focus on educating provider and extended care team members on how best to use the solution to inform care and improve health outcomes. PCN will also engage closely with end users of various roles (providers, clinical support staff, and administrative staff) to collect feedback, prioritize enhancements, and continue to extend the use and value of the solution.

Improve Social Determinants of Health Platform & Enhance Community Connections

PCN will continue to partner with findhelp (formerly Aunt Bertha) to improve Children's Mercy branded social determinants of health directory and closed loop social needs referral platform Lift Up KC (https://www.liftupkc.org). With the infrastructure in place, in 2022, the PCN will focus on integrating the use of the platform into standard clinical workflows. This includes the integration of the platform into Children's Mercy's electronic medical record (Cerner) and PCN's population health management solution (Innovaccer), as well as iterative and ongoing education and communication (e.g. monthly newsletter, feedback surveys, user group feedback sessions) with care management staff, care teams, and providers. In partnership with findhelp and based on end-user feedback, the platform will be iteratively improved to optimize search results, prioritize 'partnership' programs, improve program management, and more seamlessly share referral information across all applicable stakeholders. Also, the community resource team will continue to partner and foster meaningful relationships with numerous community agencies to create awareness of PCN care teams, facilitate a more seamless referral process, and best support the needs of PCN members. The community resource team provides feedback to continuously improve the Lift Up KC platform for all users. Overall, efforts will support better coordination of social services, greater awareness of a person's needs for all stakeholders, and more efficient referrals to community organizations.

Children's Mercy KANSAS CITY | LIFT UP KC

Build a Trusted Network of Community Based Organizations

Recognizing that a social need referral platform is simply an enabling technology, PCN is partnering with community-based organizations (CBOs) to develop relationships, understand and improve social sector workflows, and ensure patients and families get connected to resources. In 2022, PCN will partner with and provide capacity-building funding to three to five 'full service' CBOs (i.e. addressing multiple social needs and/or referring to other CBOs as applicable) serving different regions of the Kansas City metro. Through these partnerships, PCN will work with each CBO to utilize Lift Up KC to perform closed social need referrals to ensure families get the help they need. Importantly, PCN will meet regularly with the partner CBOs with a goal of developing sustainable processes that will demonstrate the value of these relationships and inform further investment in community resources to address social needs of the families we serve.

Advance Health Equity

Racial and ethnic disparities in health care are well documented and have only been further highlighted by the COVID-19 pandemic and national racial injustices. PCN is committed to initiating and supporting efforts to measure and reduce disparities in healthcare delivery. PCN will use its broad data infrastructure and advanced measurement capabilities to stratify standard clinical outcomes by factors such as race, ethnicity, and/or language. We will also partner with the Children's Mercy Diversity, Equity, and Inclusion team to improve the precision and accuracy of how race, ethnicity, and language data is collected. PCN will identify a targeted health disparity quality improvement initiative that will develop and implement a care improvement plan. This new initiative will include a review of relevant literature, a detailed understanding the provider/care team perspective, consultations with internal DEI (diversity, equity, and inclusion) experts, engagement with applicable family advisory boards, and development of culturally sensitive content for patients, families, and care teams.

Increase Behavioral Health Integration in Primary Care

The mental health crisis continues to be spotlighted by the pandemic with rates of depression and anxiety soaring. Early identification of these mental health needs is a critical prevention strategy. PCN remains committed to supporting community providers to integrate behavioral health in primary care as one way to proactively identify and intervene with mental health concerns. In 2022, PCN will continue to support practices through resource sharing, engagement meetings and collaborative case discussions.

Broaden the Scope of Behavioral Health Delegation

Behavioral health needs are seldom independent from medical needs. PCN recognizes the importance of providing holistic support to our members to ensure optimal healthcare outcomes. Depending on services delegated as part of their contracts, PCN staff either manage behavioral health needs internally via the behavioral health specialist role or work collaboratively with health plan behavioral health staff to coordinate and manage the medical and behavioral health needs of members. In 2022, PCN will further expand its behavioral health delegation to additional populations. As part of this expansion, PCN will implement additional programing enhancements, staff educational opportunities, and documentation system enhancements.

Population Health Management Network Team (PHM Network Representatives)

In 2022, the PHM Network Reps will continue to work with the PCN Practices to provide tools and training that will assist each practice on the Population Health Management journey. Each network representative is assigned a group of practices and meets with them at least quarterly, but usually monthly. They provide ongoing education with regard to patient-centered medical homes, value-based contracts, performance metrics and practice and patient engagement. PCN reviews results annually for each practice and then makes program enhancements for the network providers. In 2022, we will develop a program specifically for the FQHCs, as their barriers for improvement are different from a standard community practice.

PCN has developed a value-based program that each PCN practice participates in and offers a per member per moth capitation to performing practices. This will continue in 2022 with a focus on social determinants of health. This value- based program goes beyond traditional pay for performance as we incorporate not only HEDIS/NCQA quality performance metrics but also practice performance and engagement in population health strategies, PCN network meetings, social determinants of health, cost and utilization metrics and patient-centered medical home components. Incentives are based on the practice performance in each category (up to $6.00 per member per month) based on a point system assigned each calendar year. This strategy, and in concert with several departments within PCN, integrates the PCN provider network that includes 20 primary care community practices and the 750+ pediatricians and specialists from Children's Mercy Kansas City, with the Medicaid Managed Care health plan pediatric assigned members. The overriding goal is to improve quality and the patient experience, reduce waste, recognize the social determinants of health, and deliver more coordinated and effective care.

Increase the Efficiency of the Prior Authorization Process

PCN is dedicated to ensuring members receive the right care, at the right place, and at the right time. The prior authorization process can be cumbersome if not appropriately managed. In 2022, PCN will evaluate and streamline the prior authorization process for ease of access and to reduce provider burden in requesting services. This will be accomplished through feedback obtained via provider surveys, ongoing evaluation of the electronic prior authorization system for potential enhancements, and an assessment of services that require prior authorization.

Submitted: _____ June 9, 2022

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

Date

Approval: _____ June 20, 2022

Just for Kids (JFK) Committee

Date

_____ June 20, 2022

Clinical Quality & Operations Committee

Date

2022 Annual Work Plan

	Initiative	Operational Lead	Q1	Q2	Q3	Q4	Scope & Process	ICS Resources for Spread (Operational Leader, Project Manager)
1	Evolve Triannual Performance Review Process	Program Manager, Operations & Population Health Management Population Health Network Management	X	X	X	X	Continue to evaluate quality and cost metrics for contracted PCN primary care practices, schedule tri-annual meetings with the practices to review data, discuss coordinated interventions to address improvement opportunities and evaluate progress with metrics. Identify unique opportunities by practice.	Care Teams; Data Analytics/Operations & Population Health Management Team; Population Health Network Reps.
2	Enhance Population Health Management Point-of-Care Solution	Program Manager, Operations & Population Health Management	X	X	X	X	Continue to deploy and optimize the use of PCN's population health management point-of-care solution.	Operations & Population Health Management Team; Management Team; Population Health Management Network Team
3	Improve Social Determinants of Health Platform & Enhance Community Connections	Program Manager, Operations & Population Health Management | Community Resource Specialist Team	X	X	X	X	Integrate use of Lift Up KC into standard clinical workflows and iteratively improve search, program content, and referral communication.	Operations & Population Health Management Team; Management Team; Population Health Management Reps; Care Teams; IT Team; Community Resource Specialist Team
4	Build a Trusted Network of Community Based Organizations	Program Manager, Operations & Population Health Management	X	X	X	X	Establish formal partnerships with community-based organizations. Partnerships will include capacity-building funding and focus on developing sustainable closed-loop social need referral processes.	Operations & Population Health Management Team; Management Team; Population Health Management Reps; Care Teams; IT Team; Community Resource Specialist Team

5	Advance Health Equity	Program Manager, Operations & Population Health Management	X	X	X	X	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.	Operations & Population Health Management Team; Management Team; Population Health Management Reps; Care Teams; IT Team
6	Increase Behavioral Health Integration in Primary Care	Sr. Director Integrated Community Care	X	X	X	X	Support and encourage community primary care providers to integrate behavioral health through resource sharing, engagement meetings and collaborative case discussions.	Care Teams; Operations & Population Health Management Team; Community Resource Specialist Team; Behavioral Specialist Team Population Health Management Network Reps
7	Broaden the Scope of Behavioral Health Delegation	Dir. Integrated Care		X	X	X	Implement additional programming, staff education, and C.A.R.E. Web enhancements to support expansion of behavioral health management into an additional population.	Care Teams; IT Team; Management Team
8	Operations/ Clinical Quality Meeting with FQHC's only-PCN FQHCs in KS and MO.	Dir. ICS Medicaid OPS & Population Health Network Mgmt.	X	X	X	X	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 all FQHC meetings will focus on their organizations.	Care Teams; Data Analytics/Operations & Population Health Management Team; Population Health Network Reps.
9	Increase Efficiency of Prior Authorization Process	Dir. Integrated Care	X	X	X	X	Evaluate and streamline the prior authorization process for ease of access and to reduce provider burden in requesting services.	Care Teams; IT Team; Management Team

APPENDIX A: SAMPLE PRACTICE PACKET

PCN MO Quality Improvement Priority Recommendations

Quality Performance Period: March 2020-February 2021

Published Date: 06/03/2021

Overview: The below quality improvement recommendations are based solely on the practice's current quality performance results and the PCN MO 2021 incentive model.

Payer Agreements Included: Unitedhealthcare Community Plan of Missouri and Healthy Blue

PCN MO Practice

PREFERRED PEDIATRICS

		75th Percentile Benchmark			90th Percentile Benchmark			Quality Improvement Recommendations	Measure Detail	
Short Term Measure Name	Your Rate	75th Percentile	Percentage Pts to 75th Percentile	Annual Patients to 75th Percentile	90th Percentile	Percentage Pts to 90th Percentile	Annual Patients to Meet 90th Percentile	Comments	Numer.	Denom.
Well Child Visits - 3-6 Years of Life	71.7%	80.3%	8.6%	40	84.2%	12.5%	58	Use Innovaccer Worklists to Target Overdue Patients.	329	459
Well Child Visits - 12-21 Years of Life	67.2%	64.7%	0.0%	0	70.7%	3.4%	19	Use Innovaccer Worklists to Target Overdue Patients.	357	531

Mid Term Measure Name	Your Rate	75th Percentile	Percentage Pts to 75th Percentile	Annual Patients to 75th Percentile	90th Percentile	Percentage Pts to 90th Percentile	Annual Patients to Meet 90th Percentile	Comments	Numer.	Denom.
Chlamydia Screening in Women (16-20 Years)	64.2%	63.4%	0.0%	0	70.5%	6.3%	4	Use InNote to Identify Chlamydia Screening Gaps at Point of Care or Use Innovaccer Worklists to Target Eligible Chlamydia Patients.	34	53
Lead Screening in Children	91.4%	81.0%	0.0%	0	86.6%	0.0%	0	Use Innovaccer Worklists to Target Overdue Patients 1-2 Years Old or Use InNote to Identify Lead Screening Gaps at the Point of Care.	53	58
Age 13 Immunization Combo 2 (MCV, Tdap)	84.6%	87.3%	2.7%	3	90.0%	5.4%	5	Use Innovaccer Worklists to Target Overdue Patients 12-13 years old.	66	78
Social Determinants of Health Screening	13.5%	30.0%	16.5%	152	50.0%	36.5%	335	Use InNote to Identify SDOH Screening Gaps at the Point of Care.	124	917

Long Term Measure Name	Your Rate	75th Percentile	Percentage Pts to 75th Percentile	Annual Patients to 75th Percentile	90th Percentile	Percentage Pts to 90th Percentile	Annual Patients to Meet 90th Percentile	Comments	Numer.	Denom.
Well Child Visits - First 15 Months	78.3%	73.0%	0.0%	0	77.1%	0.0%	0	Use the Well Visit 15 Month Graduated Compliance Report to compare actual visits to expected number of visits as a patient ages.	72	92
Age 2 Immunization-Combo 10	32.8%	44.8%	12.0%	7	52.1%	19.3%	12	Use Innovaccer Worklists to Target Patients 18-24 Months with Missing Age 2 Immunizations	19	58

Important: *Measures exceeding target are sorted on the top of each section of the report (i.e. green shading /green check marks). Please prioritize QI efforts based on order of measures immediately after measures hitting targets.*

Practice Performance exceeds HEDIS 75th Percentile (2021 PCN MO Incentive Target Benchmark)

xx% *Practice Performance exceeds HEDIS 90th Percentile*

Practice Performance exceeds the HEDIS 75th and/or 90th Percentile

SAMPLE

PEDIATRIC CARE NETWORK REPORT PACKAGE – [PRACTICE NAME] TRIANNUAL VISIT 2 – JULY 2021

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

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

Observations & Potential Improvement Ideas

Quality & Cost Performance Observations and Comments

Potential Opportunities for Improvement:

- Immunizations – Age 2 & Age 13
- Well Child Visits – Age 3-6
- SDOH Screenings

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

- Utilize Innovaccer worklists to target patients 18-24 mos with missing Age 2 immunizations
- Utilize Innovaccer worklists to target patients overdue for well visits
- Screen for SDOH (Social Determinants of Health) to identify social issues that can effect health (both mental and physical) and patient outcomes. Provide community resources for those with positive screen and bill GCodes.
-

Ongoing Review of Actions and Goals

Quality Goals	Date Goal Began (if applicable)	Status of Actions/Tasks
Asthma		Have been attempting asthma visits during Well Child. Also have them come in for meds; try to limit med refills given over the phone.
Well Child 3-6		

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