Kansas Delivery System Reform Incentive Payment (DSRIP) Pool
Hospital DSRIP Plan

Project Title:
Expansion of Patient Centered Medical Homes and Neighborhood

Hospital Demographics Information

Date:	December 17, 2014	
Hospital Name:	Children's Mercy Hospital & Clinics	
Medicaid Number:	Main Facility	100080290A
	South Campus	100080290B
	Prof Group	100080290H
Contact Person:	Chad Moore	
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Background

Summary of Hospital's Community Context:

The mission of Children's Mercy – Kansas City ("Children's Mercy") is to improve the health and well-being of children by providing the highest level of comprehensive, family-centered healthcare, and by committing to excellence in research, academics, and service. Our vision is to become a national and international leader recognized for advancing pediatric health through innovation and high-value, integrated care.

Since 1897, Children's Mercy has provided high quality clinical and psychosocial care for children and families in our region, regardless of their ability to pay. In FY2013, the amount of uncompensated care totaled more than $135 million, which includes charity care, unreimbursed Medicaid[1], and other means-tested government programs, and subsidized health services. In total, Children's Mercy provided more than $176 million in community benefits and community building activities for our service area and served 645,885 people. Children's Mercy's commitment to its mission produces an array of benefits widely valued both by individual children and families and by the greater community.

For example, in FY 2013, Children's Mercy treated children from all 105 Kansas counties in Kansas. Within that same time year, approximately 35% of patient visits to Children's Mercy were from Kansas residents. Of those Kansas children treated at Children's Mercy, 40% were Kansas Medicaid recipients.

Describe the Hospital's Patient Population:

Children's Mercy provides comprehensive, family-centered health care to the children of Kansas and Missouri. Medicaid represents 51% of our annual patient revenue. Children from 44 states accessed services at Children's Mercy in FY13, with more than 14,000 inpatient admissions. During that year, Children's Mercy documented approximately 350,000 clinic and urgent care visits and more than 100,000 emergency room visits.

Describe the Hospital's Health System:

Children's Mercy provides the only pediatric trauma center between St. Louis and Denver. With more than 450 physicians and nearly 7,000 other employees, Children's Mercy operates hospitals on two campuses; the main campus (Adele Hall Campus) located on Hospital Hill near downtown Kansas City and its South Campus in Overland Park, Kansas. The health system also operates six ambulatory care centers in the Kansas City Metro Area; specifically, Children's Mercy Northland (Kansas City, Missouri); Children's Mercy East (Independence, Missouri); Children's Mercy West (Kansas City, Kansas); Children's Mercy Clinics on Broadway (Kansas

[1] "Unreimbursed" is the shortfall created when the amount paid by the government-sponsored program is less than the hospital's cost to care for that patient.

City, MO); Children's Mercy College Boulevard (Overland Park, Kansas); and Children's Mercy Blue Valley (Overland Park, Kansas).

The following is a list of Children's Mercy specialty and outreach clinic locations throughout its expansive service area:

- Great Bend, Kansas
- Junction City, Kansas
- Parsons, Kansas
- Pittsburg, Kansas
- Salina, Kansas
- Wichita, Kansas
- Joplin, Missouri
- St. Joseph, Missouri
- Springfield, Missouri

In 2012, Children's Mercy formed the Children's Mercy Pediatric Care Network (CMPCN) to provide an integrated pediatric network in the greater Kansas City area that is value-based, community-focused, patient-centric, and distinctly accountable for the quality and cost of care. CMPCN is comprised of Children's Mercy Hospital and its employed physicians, community pediatricians and other health care providers in the Kansas City area. To promote efficiency, value, and coordinated accountability, CMPCN contracts with Managed Care Organizations (MCOs) to provide all medical services for one global fee.

Over the past 3 years, CMPCN has developed a Missouri-based network of Primary Care Providers (PCPs) and facilitated transformation of individual practices to deliver care that meets the Triple Aim: better experience for patients, better health for populations and decreased costs per capita. The operation of CMPCN and the engagement/outcome-based compensation to network providers is funded by global fee contracts with Missouri Medicaid MCOs. The Missouri MCO contracts provide a mechanism for passing through funds for medical spending, plus an administrative fee, which covers the operation of the network's delegated medical management functions, the practice transformation services, and the engagement/outcome incentives for network providers.

To date, CMPCN has not developed similar agreements with Kansas MCOs and therefore has not provided this level of services to Kansas providers. CMPCN does have shared savings based contracts with two Kansas MCOs, however, these agreements do not provide for the development of a practice transformation network or assistance to any individual practice.

Challenges Facing the Hospital:

Children's Mercy's Kansas City facilities provide service to areas with some of the highest rates of childhood poverty in the region. Estimates for childhood poverty in these areas run as high as 32.8%, according to the US Census report. Children born into poverty have higher than average rates of low birth weight. The combination of impoverished, minority populations with a dearth of available health care leaves Kansas children at high risk for health disparities. The Patient Centered Medical Home (PCMH) model of health care delivery specifically addresses access and comprehensive care needs to directly impact health outcomes by focusing on a proactive system focused on preventative health care services.

Childhood asthma is a specific example of a major challenge facing the hospital. The disease is rapidly rising in the United States, particularly among minority inner-city children, with major negative impact on their health. Asthma is the main chronic illness causing children to miss school and is the second leading cause of children's emergency department visits. The rising rates of asthma are thought to be related to increases in allergies and damaging environmental exposures, such as mold, moisture, and other allergens. Lack of access to health care compounds the risks and effects of childhood asthma. The PCMH model offers care coordination in order to improve self-management support. Population management through targeted outreach efforts, with the use of disease management registries, also improves outcomes in high risk populations.

Since much of the housing in our communities is older, our patient population is faced with significant environmental hazards, including exposure to lead-based paint and increased asthma triggers. Because the literacy level of much of our population is lower, many of our patients and families face health difficulties exacerbated by lack of access to health information. Studies have shown that patients with poor literacy skills receive less preventive care, have less knowledge about chronic conditions, perform more poorly at asthma self-care, and have worse outcomes than those with better literacy. Access to care and correct diagnosis will have only marginal impact on a child's health if the parents cannot understand the treatment recommendations. Verbal or written, clean communication is essential, particularly when the need is high for cultural competency and sensitivity.

Project Title:

Expansion of Patient Centered Medical Homes and Neighborhood

Overall Goals of DSRIP Plan:

Access to comprehensive, quality health care services is essential for health equity and a good quality of life. Access is strongly connected to maintaining overall physical, social, and mental health; preventing disease and disability; detecting and treating illness and injury; raising the quality of life; forestalling death; and increasing life expectancy. With research support from professional research consultants, Children's Mercy identified access, including a "medical home," as a major community need.

Drawing on experience with the CMPCN and DSRIP funding, Children's Mercy will promote the PCMH model to transform the way pediatric primary care is organized and delivered in Kansas. Components of the PCMH DSRIP project will meet multiple DSRIP focus areas including increasing access to effective and efficient primary care services and increasing the use of population health management through health information technology. CMPCN will partner with four selected clinics that serve a high percentage or volume of Kansas Medicaid clients. As systems are developed that incorporate the efficiencies and effectiveness of the PCMH, our goal is to share these successes among the selected practices through expansion of knowledge in collaborative community partnerships and support of primary care services with educational outreach clinics through technology.

Through PCMH transformation and engagement/incentive based compensation, CMPCN and the

participating practices will deliver improved care that meets the Triple Aim. Specific outcomes based partly on the Healthy Kansas 2020 goals are described in the Project Milestones and Performance Indicators section. Additionally, the transformation process will position the selected practices to succeed in the Kansas Health Homes program and other value-based payment programs from private payors, should they choose to participate.

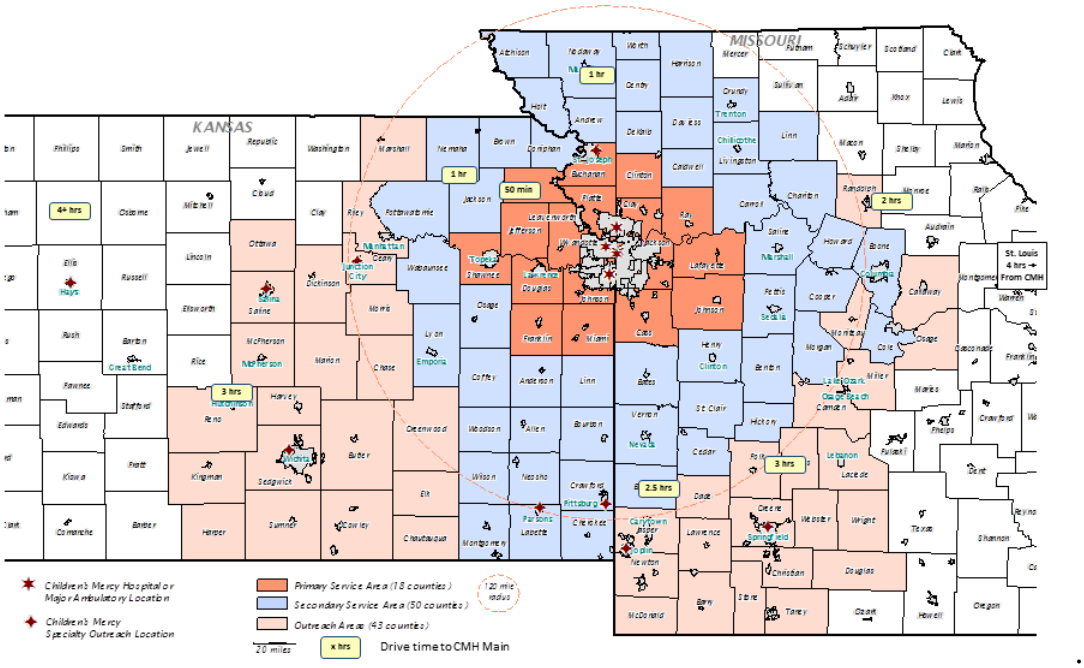
Other Hospital Initiatives funded by Health and Human Services:

There is no current Health and Human Services funding provided to Children's Mercy that overlaps with this DSRIP Project. See **Exhibit 1** attached hereto for complete listing of Health and Human Services related funding to Children's Mercy.

Hospital Service Area Definition:

Children's Mercy uses varying definitions of service areas that depend upon the clinical service or patient population being discussed. The Primary Service Area (PSA) (see Figure 1 below) is comprised of 18 counties surrounding the Kansas City Metropolitan Statistical Area. The pediatric population in our PSA includes approximately 630,000 children ages 0-17. Included within this PSA is the six-county Kansas City metro, which includes approximately 470,000 children ages 0-17. These six counties are located in both Missouri (four counties) and Kansas (two counties). A Secondary Service Area (SSA) is used when focusing on regional services. The SSA includes 20 counties in Kansas and 30 counties in Missouri that form a radius of approximately 120 miles around Children's Mercy Hospital-Adele Hall Campus. The pediatric population in our SSA is comprised of an additional 220,000 children ages 0-17 beyond the population of our PSA.

Figure 1



Community Partners Participating in Project:

Four primary care practices have been identified for focused improvement efforts in the Patient Centered Medical Home Project. Practices were selected from a group of nine Kansas practices within the Children's Mercy Pediatric Care Network (CMPCN) that are in Primary Care Health Professional Shortage Areas (HPSA) and/or Medically Underserved Areas (MUA) as defined by the US Department of Health and Human Services or are CMPCN contracted practices in Wyandotte County that accept a high volume of Kansas Medicaid patients. These are small practices which have insufficient resources but are in great demand in light of the high needs population they serve.

Using the parameters above, the four practices have been selected based on their willingness to partner with CMPCN on the PCMH project and their desire to pursue improvement that aligns with the Triple Aim. None of the four practices are currently pursuing PCMH recognition. None of the practices are owned or operated by Children's Mercy. Additional characteristics of the selected practices are described in Table 1. Narrative descriptions of the unique qualities of each practice are described below. These four practices have expressed strong interest in participating in this DSRIP project and contracting with CMPCN for transformation services and engagement/outcome-based compensation that mirrors that of the existing Missouri network practices.

Table 1: Characteristics of Selected Practices

Name	City	Providers (MD, DO, APRN, PA)	Pediatric Patients with KS Medicaid			Total Pediatric Patients	EHR	Primary Care HPSA
			Sunflower	Amerigroup	United			
Project Eagle	KCK	1 MD/1 NP	-0-	-0-	-0-	TBD	Yes	Yes
Heigen & Mills	Leavenworth	2 MDs	287	909	175	3500	Yes	Yes
Associates in Family Medicine	KCK	1 MD/2NP	141	328	271	5930	Yes	Yes
Lori A. Golan MD	Leavenworth	1 MD / .5 MD	175	370	150	3000	Yes	Yes

EHR- Electronic Health Record

The first clinic, Project Eagle, is a new pilot clinic within the community that aims to improve access to care for a high risk, underserved population. The program uses innovative school-based and community-based clinic model in the urban core of Wyandotte County, Kansas. The clinic is located in the socially highest risk zip codes of the county and located near the Project EAGLE Center, Family Conservancy, and Juniper Gardens Children's Project in the Children's Campus of Kansas City. Project Eagle is scheduled to begin accepting patients in January 2015. Owned and operated by University of Kansas Hospital, the clinic is a collaborative effort with two pediatric academic programs that are in the process of becoming integrated; Children's Mercy Hospital and the University of Kansas Department of Pediatrics. The clinic is developing as an NCQA Patient Centered Medical Home model, integrated with behavioral health services. This design aligns the clinic model with Health Home service delivery model for an approach that provides patients with access to an interdisciplinary collaborative effort of medical care,

behavioral healthcare, and community-based social services to support chronic condition management. The goal of this clinic is to develop a sustainable and scalable model that can translate to all populations regardless of SES (Socioeconomic Status) level. This plan will allow the clinic to serve as an innovative model of service delivery that can be shared with other medical providers within the DSRIP project and ultimately, with providers across the state.

The second community practice is Heigen and Mills Pediatrics, located in Leavenworth, Kansas. More than 50% of its patients, approximately 1,250, are enrolled in Kansas Medicaid. A pediatric and adolescent primary care clinic, the practice has been in operation for 30 years, with staff that has been largely intact for nearly 10 years. The practice provides general pediatric care, vaccines, allergy injections, and radiology services, including primary care services. Their teen services include behavioral and ADD counseling, as well as reproductive health.

The third practice is Associates in Family Medicine located in Kansas City, Kansas. Dr. David Johnson has been in family practice for several years and will soon be joined in practice by his daughter. Associates in Family Medicine also includes two full time physician assistants. The practice currently treats more than 500 children in the Kansas Medicaid program across the three managed care plans. In addition they have several hundred more adult patients who receive Medicaid. Associates in Family Medicine strives to anticipate and respond to the lifelong needs of patients by providing excellent clinical care. They are committed to enhancing the health of the community; providing superior services to our patients, delivering outstanding value, embracing clinical innovations, providing medical and health education, and providing a knowledgeable, skilled and caring medical and employee staff. The opportunity to meet these goals through the establishment of the PCMH model is very exciting to them.

The fourth and final practice is that of Dr. Lori A. Golan, a pediatrician in Leavenworth, Kansas. The practice includes another pediatrician, Dr. Winter, who is available on a part time basis. Dr. Golan's practice is comprised of approximately 50% Medicaid patients with over 500 Medicaid members divided among the three managed care plans serving the state. She has been in practice for 17 years with an active and professional staff. The office uses an electronic medical record and is interested in exploring the PCMH recognition process.

Participation of these four practices is contingent upon confirmation of project funding followed by successful contract negotiation between each practice and CMPCN. If necessary, CMPCN will identify other practices that meet the criteria described above.

Project Description

Identification of Need for Project:

Kansas children need access to healthcare services that include an efficient, effective, and patient-centered medical home. Forty percent of children in Kansas do not receive care within a medical home, including many who are assigned to primary care providers who have not transformed their practices into patient-centered medical homes. The Maternal and Child Needs assessment (MCH 2015) identified the goal of "enhancing the health of all Kansas children and adolescents across the lifespan." Two of the three strategies identified to achieve this goal are

directly included in this project; a) ensuring that all children and youth receive health care through medical homes and b) that all children and youth achieve and maintain healthy weight. In addition, Children's Mercy has identified access, including access to an efficient, effective and patient-centered medical home, as one of the major pediatric health needs. The Children's Mercy hospital system, through external partnerships, has begun to participate in collaborative efforts focused on enhancing access and improving population health by facilitating the Patient Centered Medical Home transformation. To date, the majority of this work has taken place in Missouri. This project will extend the transformation to the children of Kansas.

A PCMH model can address multiple issues through delivering preventive medical services and health screening services, as well as counseling to reduce unhealthy behaviors. A medical home can also focus services efficiently on chronic medical issues such as obesity and asthma. The most recent data ranks Kansas as the 14th most obese state in the nation with rates of 29.9%, up from 22.6% in 2003 and 13.5% in 1995. Obesity leads to chronic medical problems such as diabetes, hypertension, heart disease, arthritis, and obesity-related cancers. According to Centers for Disease Control (CDC) reports, Wyandotte County, Kansas residents have been found to have low levels of physical activity and high levels of childhood obesity. Johnson County, Kansas faces similar levels of low physical activity. The PCMH model focuses efforts on ensuring adequate counseling regarding nutrition and physical activity with the potential for improvement in long term health outcomes.

Project Goals:

The project will focus on the expansion of Children's Mercy's existing system delivery reform efforts into Kansas via and practice transformation of four clinics using the PCMH model. These efforts are intended to improve access to and delivery of efficient, effective and patient-centered health care services and ultimately meet the goals of the Triple Aim. Specific goals are described below.

Patient Experience	Transform four selected practices to enhance high-value care that is patient centered, comprehensive, coordinated, accessible, and high quality
	Support the PCMH transformation effort community-wide by developing a medical neighborhood among the specialists at Children's Mercy
Health of Populations	Improve the health of the attributed population for this project as evidenced by improvements in vaccination rates, healthy weigh plan usage, screening rates for anemia and lead toxicity, well care/preventative visit rates and depression screening rates
Cost per Capita	Reduce the cost of care as evidenced by decreases in ED visits for asthma (attributed population), decreased overall ED utilization and decreased readmissions

Project Methods:

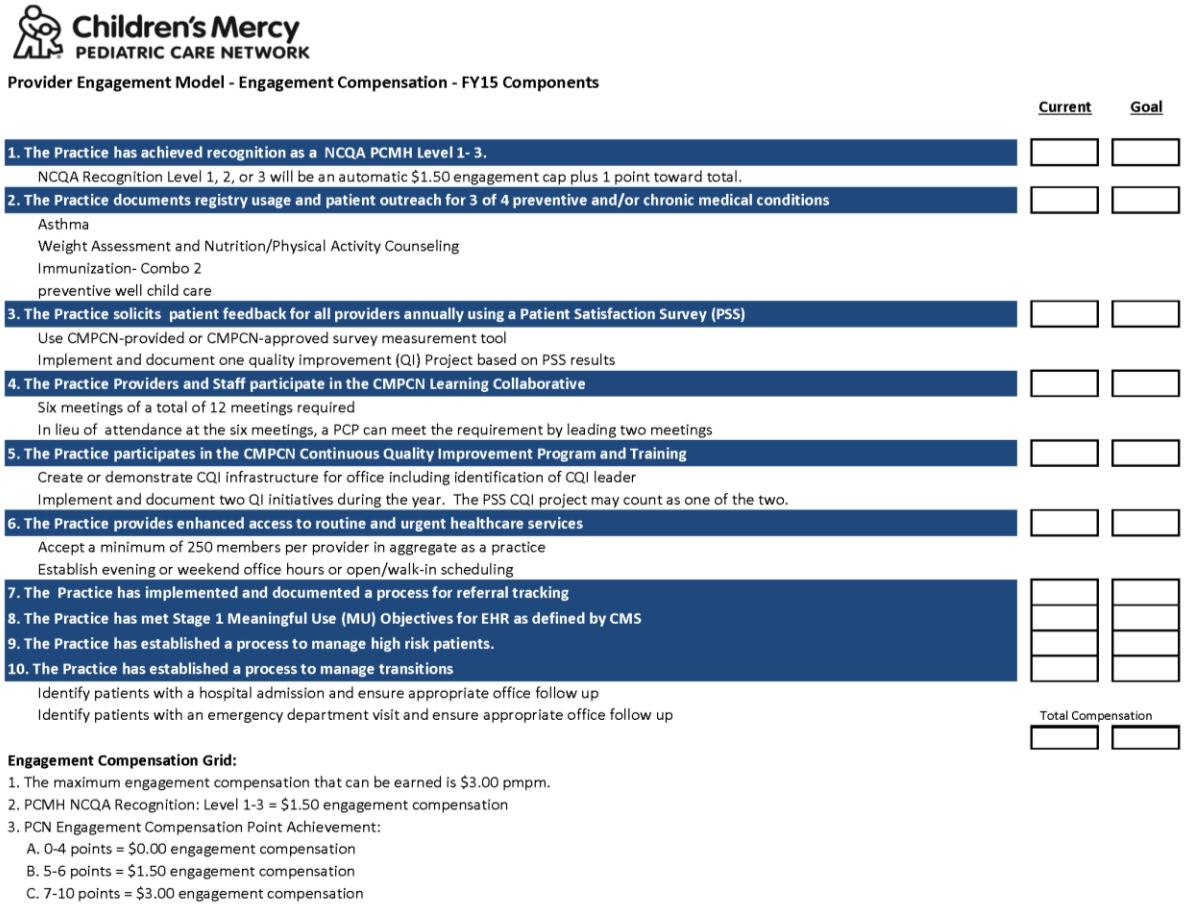
Children's Mercy Pediatric Care Network uses a model of practice transformation based on the Patient Centered Medical Home. It relies on changes in the payment model that allow the PCP to provide the right care at the right time in the right setting. CMPCN uses a team-based approach to reduce barriers, export resources and expertise from Children's Mercy Hospitals and Clinics, and support patient centered medical homes for the providers in our network. The DSRIP Patient Centered Medical Home Expansion Project will use these proven methods to facilitate the transformation of the four Kansas practices.

A two-tiered model of engagement incentives and outcome-based performance incentives are the foundation of the payment model change that allows PCPs to provide high-value care to meet the Triple Aim. The engagement incentive encourages practices to team up with CMPCN and complete the steps necessary to transform to a high-value care model. The outcome-based performance incentive rewards practices for delivering the desired outcomes via their transformed practices. Defined measures for each incentive ensure that the outcomes align with overall network objectives and strategies. Importantly, the existing engagement and outcome measures for the practice incentives differ from the proposed Category 1-4 Project Measures listed below. This is intentional as Children's Mercy believes that the current practice incentive format has been shown to be successful and will ultimately deliver the specific goals and measures specified for the DSRIP project.

The engagement incentive of $3.00 Per Member Per Month (PMPM) and performance incentives of $3.00 PMPM are available to providers. The engagement and performance incentives pertain only to attributed patients in the practice. Attributed patients are those patients who are assigned to the practice during the measurement period by the two Kansas Medicaid MCOs who have a contract with CMPCN; Amerigroup and Sunflower. Practices may earn a potential of $6.00 PMPM if all engagement and performance measures are met. Funding for this payment will be provided by Children's Mercy via the DSRIP program and is included in the project budget.

The Engagement incentive is designed around the tactics necessary to achieve transformation. Points are awarded for ten tactics with an emphasis towards National Committee for Quality Assurance (NCQA) PCMH recognition. Two point thresholds determine compensation for the following period at levels of $0, $1.50 or $3.00 PMPM. The Engagement incentive is awarded starting after a three month measurement period and adjusted quarterly thereafter. A complete description of the components and point values are illustrated below.

Figure 2: Engagement Incentive Model



Children's Mercy
PEDIATRIC CARE NETWORK

Provider Engagement Model - Engagement Compensation - FY15 Components

	Current	Goal
1. The Practice has achieved recognition as a NCQA PCMH Level 1- 3.		
NCQA Recognition Level 1, 2, or 3 will be an automatic $1.50 engagement cap plus 1 point toward total.		
2. The Practice documents registry usage and patient outreach for 3 of 4 preventive and/or chronic medical conditions		
Asthma		
Weight Assessment and Nutrition/Physical Activity Counseling		
Immunization- Combo 2		
preventive well child care		
3. The Practice solicits patient feedback for all providers annually using a Patient Satisfaction Survey (PSS)		
Use CMPCN-provided or CMPCN-approved survey measurement tool		
Implement and document one quality improvement (QI) Project based on PSS results		
4. The Practice Providers and Staff participate in the CMPCN Learning Collaborative		
Six meetings of a total of 12 meetings required		
In lieu of attendance at the six meetings, a PCP can meet the requirement by leading two meetings		
5. The Practice participates in the CMPCN Continuous Quality Improvement Program and Training		
Create or demonstrate CQI infrastructure for office including identification of CQI leader		
Implement and document two QI initiatives during the year. The PSS CQI project may count as one of the two.		
6. The Practice provides enhanced access to routine and urgent healthcare services		
Accept a minimum of 250 members per provider in aggregate as a practice		
Establish evening or weekend office hours or open/walk-in scheduling		
7. The Practice has implemented and documented a process for referral tracking		
8. The Practice has met Stage 1 Meaningful Use (MU) Objectives for EHR as defined by CMS		
9. The Practice has established a process to manage high risk patients.		
10. The Practice has established a process to manage transitions		
Identify patients with a hospital admission and ensure appropriate office follow up		
Identify patients with an emergency department visit and ensure appropriate office follow up	Total Compensation	

Engagement Compensation Grid:

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

The performance award is based on two outcome categories; ED Utilization and HEDIS-like Measures. A target ED utilization expressed as less than a number of visits per thousand patients will be developed based on existing practice levels of utilization in all four practices. The second component of the performance incentive is scoring at or above the 50th percentile of the NCQA Medicaid National Benchmark in three of the five childhood HEDIS measures. Each of the two targets is valued at $1.50 PMPM with payment beginning after a six month measurement period and adjusted every six months thereafter. CMPCN may periodically change the measures and/or performance levels to address network priorities.

Children's Mercy Pediatric Care Network provides a PCMH transformation team for each practice which includes a Physician Expert, Quality Improvement Coach/Practice Facilitator, Provider Relations Representative, and a Population Health Specialist. This team will serve all four practices. The team also includes a DSRIP Project Manager that will oversee the work of the team. All team members will be full time staff of CMPCN with partial time devoted to this DSRIP project as outlined in the project budget below. Each practice will identify a practice manager and provider champion who will work closely with this team.

To assist the chosen practices in this PCMH transformation, the team utilizes tools and resources

developed to support NCQA PCMH standards. Some of the resources include: patient registries for outreach and disease management, patient satisfaction surveys, learning collaborative webinars, Quality Improvement training and program development, referral tracking, and care coordination processes.

Supporting this system-based approach to quality and safety, the Quality Improvement Coach/Practice Facilitator is a key team member who works with the practice on a regular basis. This role guides the practice in the creation of systems to target population health management as part of the PCMH foundation. This team member trains clinic staff to provide patient self-management support within the flow of practice and supports patient goal setting with systematic follow-up implementation. Quality improvement efforts are integrated in team-based care to improve health outcomes.

This team will work with the practice to educate providers and staff on the benefits of transitioning to a PCMH, assist with the planning and facilitate the steps required for transformation. Additionally, the Provider Relations Representative provides education and support for practice use of the CMPCN Web Portal and Children's Mercy's communication tools for the Medical Neighborhood.

The Medical Neighborhood concept includes setting up systems of communication between primary and specialty care which allow the delivery of coordinated care. A key step in this process is defined agreements which outline the duties of each party. These Collaborative Service Agreements (CSA) specify the reason for a referral to speciality care and the expected nature of the relationship. For example, a PCP could choose to send a patient for a consultation only, to request that the specialist provide ongoing management of the problem or transfer all care to the specialist for the duration of a serious illness such as cancer. The agreement may also specify whether the specialist may make secondary referrals to other specialists or whether all referrals should be coordinated by the PCP.

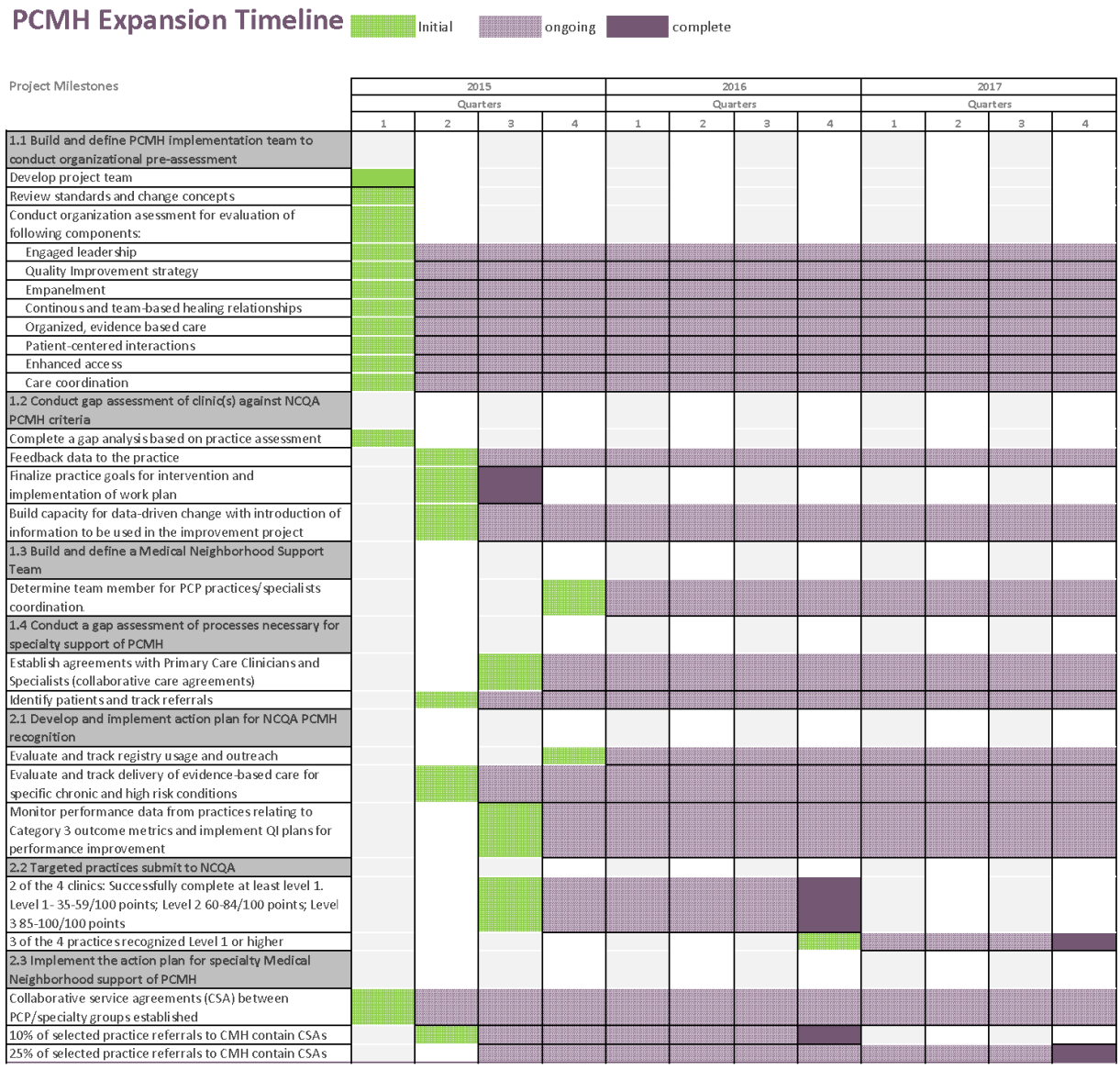
The DSRIP Project Manager oversees the administration of the DSRIP project for both Children's Mercy and Children's Mercy Pediatric Care Network. This position also leads the work of the practice transformation teams and facilitates the learning collaborative. Consultative services to assist with completing NCQA required documentation for PCMH recognition are also included in the project budget.

Practices will receive registry and population health data as well as provide attributed patient outcomes via the existing CMPCN Provider Portal and data structure, which will be expanded to include the four Kansas practices. The transformation team assists the practices in structuring their patient registries, outreach, and disease management to address the specific needs of their patient population from this claims data.

Claims data from the two Kansas MCOs, Amerigroup and Sunflower, is included. Currently, a limited claims data flow via the MCOs is available pursuant to the existing CMPCN shared-savings agreement. Plans are in place to improve the quality of the data with a complete data set from both MCOs available by the end of first quarter 2015. One year of historical data is expected to be included. Ongoing claims data is loaded weekly and typically has a 30-60 day lag

for claims processing. Additional clinical data from Children's Mercy is also included. Due to the need for complete claims data, only patients attributed to the selected practices and the two contracted MCOs are included in the registries, engagement and performance incentive measures outcome analysis and DSRIP project measures. However, the process changes and transformation in each practice will benefit all patients served by that practice.

Project Timeline:



Expected Results:

By the end of the project period, we intend to have four Kansas practices fully transitioned to enhance care that meets the Triple Aim. Additionally, the practices will be well prepared to sustain themselves with new models of value-based payment that may arise. Patients served by these practices will receive primary care that is (1) patient centered, (2) comprehensive, (3) coordinated, (4) accessible, and (5) high quality. This high-value care will be evidenced by the improved outcomes specified in the Category 3 and 4 Project Milestones and Performance Indicators, described later in this document. Additionally, CMPCN and Children's Mercy will gain documented experience with practice transformation in Kansas which could be reapplied to additional practices in the future.

The Health Home model, while different from the Patient Centered Medical Home model, has many areas of overlap. Table 2 outlines a cross-walk of the similarities and differences. Although this project is not designed around the Health Home model, the selected practices will be well positioned to participate should they choose.

Table 2- Comparison of Health Home and PCMH

	Health Homes Program	**PCMH**
Target Population	Enhanced Medicaid reimbursement for services to individuals with approved chronic conditions	Serves all populations across the lifespan
Typical Providers	May include primary care practices, community mental health organizations, addiction treatment providers, Federally Quality Health Centers, health home agencies, etc.	Typically defined as physician-led primary care practices, but may include some mid-level practitioners such as Nurse Practitioners
Payer(s)	Currently a Medicaid-only construct	Exist for multiple payers (e.g., Medicaid, commercial insurance)
How is Care Organized	Team-based, whole-person orientation with *explicit* focus on the integration of behavioral healthcare and primary care; includes individual and family support services	Team-based, whole person orientation achieved through care coordination
Provider Requirements	State Medicaid determined	State Medicaid and NCQA determined
Payment	Usually PMPM for 6 required services with more intensive care coordination and patient activation	Payment is in line with added value; usually small PMPM

Relationship to Other Projects:

Implementation of the Patient Centered Medical Home model of care is a Children's Mercy strategic initiative. Dedicated work teams are developing and implementing the changes necessary to become an NCQA-recognized PCMH within the Children's Mercy-owned primary care practices, which are different than those listed in the project. CMPCN has delevoped a transformation program for the Missouri independent community practices which make up it's network.

The DSRIP project will allow Children's Mercy to expand the transformation program to selected Kansas independent practices. The shared-savings agreements with two Kansas MCOs provide the necessary data and a basis for expanding the practice relationships. However, the agreements do not currently and are not expected to provide the financial support necessary for the engagement/performance compensation or the infrastructure for transformation of Kansas practices.

The second project in Children's Mercy's DSRIP proposal, Care for Children with Medical Complexity, is not included in the PCMH initiatives described above. The Beacon Program provides care for a limited population of children with specialized needs. Although the tenants of PCMH still apply, the infrastructure to provide these services on a local and regional basis is distinct.

Children's Mercy has also begun the process of developing a stronger foundation of subspecialty care with the development of a Medical Neighborhood to support the PCMH community wide, including both the Missouri and Kansas service areas. Although the majority of the Medical Neighborhood work is with Children's Mercy specialists and is outside the scope of this project, a measure of Medical Neighborhood support, the use of CSAs by the selected practices has been included in the Category 2 DSRIP measures.

Relationship to other participating providers' projects and plan for Learning Collaborative:

Learning Collaboratives have been used extensively in the support of the dissemination of information required for PCMH transformation. The CMPCN PCMH transformation team has developed a model to use in community settings to coach practices by providing education, advise, and to supply opportunities for group learning. Content from the Missouri Learning Collaborative has been developed over the last 12-18 months and is archived for later use. However, the four selected practices for this project will be at an earlier point in their transformation than the existing collaborative. Therefore, the team will revise the Learning Collaborative content based on the needs of the DSRIP project and the progress of the selected practices in their transformation.

Learning Collaborative participants will receive education on the development of PCMH processes and policies and will share best practices in a supportive group environment. The Collaborative will meet monthly via webinar with topics that will be based on the initial assessment results targeting the common areas that need improvement. Didactic sessions will be

offered on common PCMH topics such as team based care, quality improvement, care management, and care coordination. When possible, a peer level practice that has recently participated in a PCMH transformation effort will be included in the webinar.

The format may also include common collaborative learning techniques such as structured problem solving and brainstorming opportunities. Sessions will be recorded offering the practices an opportunity to review the materials at a later date. After each webinar, a survey will be administered to document participation and seek practice feedback which will be used to make the Learning Collaborative as effective as possible.

Recordings of Learning Collaborative sessions will be made available to the Kansas Department of Health and Environment (KDHE) for use at their discretion.

This project meets the following Health Kansans 2020 goals and ties into the tri-part aim (Triple Aim) in the following ways:

Priority Strategy Five of the Healthy Kansans 2020 plan concerns Access to Services and states its intent: *"Promote integrated health care delivery by encouraging providers to move toward integrative models of care,[and], increase health care access …and the use of telemedicine, and expand the number of providers who adopt electronic health records (EHR) systems and connect to and use a health information exchange."* Practice Transformation using the Patient Centered Medical Home model aligns this strategy with the strategies suggested by the Institute for Healthcare Improvement as components of a system that will accomplish the Triple Aim. These strategies include:

1. A focus on individuals and families
2. Redesign of primary care services and structures
3. Population health management
4. A cost-control platform
5. System integration and execution

The Patient Centered Medical Home model of team-based health care delivery has been associated with improved health outcomes by improving the experience of care, improving the health of populations, and reducing per capita cost of care aligning with the Triple Aim. Through the Patient Centered Medical Home transformation approach, this project will address portions of all 12 health focus areas in the Healthy Kansans 2020 plan.

The weight management model incorporated into the PCMH disease registry and management program is an example of how the program corresponds with several of the HP 2020 objectives. The weight management program helps clinic staff members properly diagnose obesity in children and treat obesity-related co-morbidities with a team-based care system. The goal of the program is to help our providers and the staff with the tools, knowledge, and resources needed to diagnose and treat overweight children and to diagnose and treat obesity-related conditions, such as hypertension, high cholesterol, and diabetes. The program incorporates interventions known to be effective, specifically the promotion of healthy lifestyles that include, increased activity, improved nutrition and modified health behaviors, all of which are consistent with the Healthy

Kansans 2020 recommendations and HP 2020 goals.

In addition to supporting primary healthcare, the PCMH model provides families with much needed social services support. These services include assistance with transportation, food, clothing, and finances. The services also include counseling support, crisis intervention, parenting education, and patient education. Although the practice may not provide all of the services directly, including discussions of needs and referral to services is a component of patient-centered care. Providing this type of support aligns with the HP 2020 objectives of creating social and physical environments that promote good health for all and achieving health equity. The supports offered by the PCMH model have been shown in numerous studies to reduce and potentially eliminate health disparities by addressing the social determinants of health.

Challenges:

Our experience with practice tranformation has shown that many of the current attitudinal, educational, and organizational barriers necessitate a team approach. Because practices with large percentages of patients with Mediciad are frequently underfunded, they often have difficulty with broad scale change. Such supports as practice transformation assistance and adequate funding for practices are key to overcoming these barriers.

5-Year Expected Outcomes for Provider and Patients:

Social and health disparities in early childhood may lead to poor health outcomes in later years. By improving access to efficient, effective and patient-centered healthcare, specific improvements may be realized within five years, including more routine immunizations and well-child visits; an increased number of patients and families who, through better understanding of the underlying causes of both asthma and obesity, and can manage these conditions; and a gradual gain in the number of patient visits by families who need them most within five years, we expect to document outcomes for children in the form of greater access to care in a patient-centered medical home, improved care coordination, higher immunization rates, more effective and appropriate screening measures, decreased inpatient hospital stays and emergency department visits, and a reduced number of school absences.

Further, providers will become more knowledgeable in delivering healthcare services by using a team-based approach. They will gain an understanding of and appreciation for the various components of PCMH-based care. These components including reliance on registries for population health management, on the use of basic quality improvement tools, on care coordination, and on the education of patients and parents in self-management techniques.

Starting Point/Baseline:

The experience of CMPCN with other network clinic intiatives in Missouri indicates that most practices are not well prepared for becoming a PCMH and lack sufficient resources to complete the transformation. Some do not have EHRs and most do not have any access to comprehensive registry or population health data for the patients in their practice. Therefore, obtaining baseline

data is difficult.

Creation of population health management tools is essential for effective Patient Centered Medical Home transformation efforts. This key portion of the transformation to PCMHs is developing and using data systems that provide the information needed to identify specific populations within the practice (e.g patients with asthma), evaluate baselines, establish processes for care of these populations, and measure outcomes. CMPCN has an existing data systems in place that will be applied in each selected practice once funding is authorized, MCO data streams are optimized, and contracts are in place.

Administering the engagement and performance-based compensation programs requires measurement at both the practice and provider level and beyond those listed for the project as a whole. These measures will be collected and targets established as described in the Project Methods section. DSRIP Project measures will be aggregated among all patients attributed to each practice by the two contracted MCOs. The MCO data currently being received is incomplete so specific baselines for the selected practices can't be determined at this time. Alternatively, baseline measures were obtained from the Kansas Combined MCO HEDIS rates from 2013. Goals were established based on the higher top decile for national data. Yearly improvement targets were identified using the methodology of reducing the gap to goal by 10%, recalculating annually.

Rationale for the Project:

The Patient Centered Medical Home model is widely recognized as a key component of healthcare which delivers the Triple Aim. Children's Mercy has already experienced success with the Patient Centered Medical Home model. Children's Mercy Pediatric Care Network (CMPCN), essentially Children's Mercy's Accountable Care Organization (ACO), currently operates in the Medicaid sector and has negotiated full risk contracts with two Missouri Medicaid managed care organizations. CMPCN developed its network of primary care providers more than two years ago. At the same time, it developed a community-based, medical home transformation approach with its PCPs (mostly pediatricians), which compensates providers based on meeting certain core utilization measures (i.e. ED utilization, HEDIS (well-child visits, immunizations, etc.), and inpatient utilization). CMPCN also assists providers with the medical home journey by paying providers in its Missouri network a Per Member Per Month fee for meaningful engagement in the medical home transformation effort.

To date, CMPCN has had some very positive results relating to key patient/provider utilization metrics for its community based practices. Specifically, between 2010 and 2013, CMPCN's network of community providers documented a 21% reduction in ER visits per thousand members. Further, these practices have experienced a significant decline (27%) in inpatient days for their assigned patients. CMPCN credits these reductions in unnecessary ED use and unplanned hospitalizations to the tenets of the Patient Centered Medical Home.

CMPCN has a network of primary care providers in Kansas. This network is composed of providers who care for children with Kansas Medicaid. Although CMPCN has shared savings agreements with two of the three Medicaid MCOs in Kansas, it has not been able to extend the

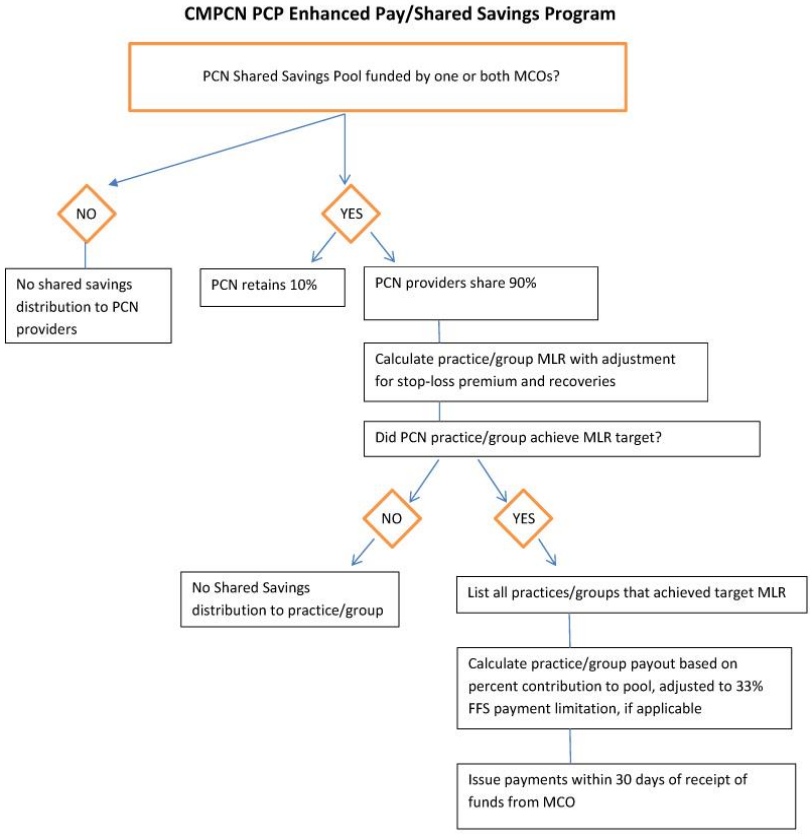
PCMH transformation effort to the Kansas practices because funding for such activities is not included in the agreements. This project will provide the opportunity for Children's Mercy, through CMPCN, to assist the four Kansas network practices in transformation to PCMH.

This project represents a new initiative or significantly enhances an existing delivery system reform initiative in the following ways:

This project represents expansion of an existing delivery sytem reform project to four Kansas practices that would otherwise not be included in the effort. Over the past 3 years, CMPCN has developed a Missouri based network of PCPs and facilitated transformation of individual practices to deliver care that meets the Triple Aim. The operation of CMPCN and the engagement/outcome based compensation to network providers is funded by global fee contracts with Missouri Medicaid MCOs. To date, CMPCN has not developed similar agreements with Kansas MCOs and therefore has not provided this level of services to Kansas providers.

CMPCN does have shared-savings based contracts with two Kansas MCOs, however, these agreements do not provide for the development of a practice transformation network or assistance to any individual practice. To the extent that any savings are generated, 90% are distributed to providers and only 10% is retained for operation of network data systems. See Fig. 3 below for an illustration of the shared savings funds distribution.

Figure 3: CMPCN Kansas Shared Savings Funds Distribution



Rapid Cycle Evaluation

Rapid cycle evaluations are the foundation of the continuous quality improvement methodologies that have been developed to support medical home model implementation. We collect data through claims stored in the CMCPN Data Warehouse. Claims data is provided from the MCOs which CMPCN contracts with in the state of Kansas; Amerigroup and Sunflower. Further data is collected through onsite review by the PCMH transformation team. This review may include related category 2-3 outcome measures including the presence of completed Asthma Action Plans and depression screenings.

This team will use the data to form an engagement compensation model with specific components to further develop medical home processes. For example, this team may assist a practice in creating and using related registries that document gaps in care. The progress report is reviewed and discussed with the assigned Practice Facilitator. Based on that review, this document will become the methodology for disseminating outcomes. For example, the team may share with appropriate staff the results of chart reviews and assist in development of PDSA rapid cycles (Plan-Do-Study-Act Cycles) related to implementation of a new process to improve outcomes. CMPCN's PCMH Team has used rapid cycle improvement extensively with its network practices in Missouri.

Using the Engagement Incentive Model progress report (see Figure 2), and the relationships the team develops with practice leadership and staff, we are able to continue moving each practice toward implementing the PCMH model. Each practice in this project will have a Quality Improvement Coach to support, evaluate, and oversee this progress towards implementation. Plan-Do-Study-Act Cycles will be used to plan and document the Tests of Change that are associated with each individual PCMH transformation. Each practice will be encouraged to maintain a record of their PDSA rapid cycles and related quality improvement efforts. In addition, progress and results will be collected by the CMPCN PCMH team and shared with KDHE and CMS as directed. Results can also be shared in the learning collaborative as a regular topic.

The progress report designed for engagement compensation has proved to be a valuable evaluation tool with practices in Missouri. The success of this evaluation design appears to be replicable and appropriate for this project.

Multiple features will indicate progress toward PCMH values. We will evaluate progress based on the following outcomes: 1) practices are using PDSA rapid cycles to improve their processes, 2) practices are learning to use their own data to develop processes that strengthen patient and family centered care, and 3) practices are improving access to efficient, effective and patient-centered primary care while decreasing unnecessary ED visits and inpatient admissions.

Project Budget

Provide a detailed budget for all three years of DSRIP the project:

Expansion of PCMH Neighborhood
DSRIP Project Plan Budget

		Project Year 3		Project Year 4		Project Year 5	
Staffing*		FTE	Labor w/fringe	FTE	Labor w/fringe	FTE	Labor w/fringe
Physician PCMH Expert (0.1/clinic)		0.4	$ 98,432.00	0.4	$ 98,492.00	0.4	$ 98,492.00
Quality Coach/PCMH Facilitator (0.25/Clinic)		1	$ 79,700.00	1	$ 79,700.00	1	$ 79,700.00
Provider Relations Representative (0.1/clinic)		0.4	$ 27,775.00	0.4	$ 27,775.00	0.4	$ 27,775.00
Population Health Specialist (0.25/clinic)		1	$ 89,107.00	1	$ 89,107.00	1	$ 89,107.00
DSRIP Project Manager		0.5	$ 59,525.00	0.5	$ 59,525.00	0.5	$ 59,525.00
Decision Support / Analytics		0.5	$ 42,000.00	0.5	$ 42,000.00	0.5	$ 42,000.00
	Subtotal	**3.8**	**$ 396,539.00**	**3.8**	**$ 396,599.00**	**3.8**	**$ 396,599.00**
PCMH Consulting							
External Consulting Cost			**9,000.00**		**$ 9,000.00**		**$ 9,000.00**
PCP Compensation Potential**							
Engagement Incentive (2500pts x $3 x 12 months)		9 months	67,500.00		$ 90,000.00		$ 90,000.00
Peformance Incentive (2500 pts x $3 x12 months)		6 months	45,000.00		$ 90,000.00		$ 90,000.00
	Subtotal		**112,500.00**		**$ 180,000.00**		**$ 180,000.00**
Facilities - PCN Cost Allocation			**41,048.00**		**$ 41,048.00**		**$ 41,048.00**
	Total		**559,087.00**		**$ 626,647.00**		**$ 626,647.00**
						Total Project Cost	**$ 1,812,381.00**

Note:

* This budget does not consider the cost of the PCP Office staff, provider champion, and practie manager in each of the selected clinics

** We estimate that as many as 2500 Kansas Medicaid patients could be attributed to this compensation model.

Project Governance

Children's Mercy Pediatric Care Network has contracts with approximately 54 primacy care providers in Kansas at 17 practice locations. CMPCN negotiated two shared savings agreements with two KanCare managed care organizations which it administers for its Kansas practices. Kansas CMPCN members are defined as KanCare members (age 21 and under) who are enrolled with one of the managed care organizations that contracted with CMPCN; Amerigroup or Sunflower. These members have selected or been assigned to a primary care provider with whom CMPCN has contract within the CMPCN Service Area. There are more than 15,000 patients aggregated in these agreements. The focus of this project will be the subgroup of patients located within this aggregate patient population and the four selected practices.

Children's Mercy proposes to use four CMPCN contracted clinics (see Community Partners section above) for focused improvement efforts for the Patient Centered Medical Home Project. These practices in Wyandotte County, Kansas are practices that accept a high volume of Kansas Medicaid patients. They are small practices with insufficient resources and yet are in great demand due to the high needs of the population they serve. Children's Mercy has identified four practices based on their willingness to partner with Children's Mercy on the path to transformation to PCMHs and on their desire to work toward improvements that align with the Triple Aim.

Data Sharing and Confidentiality

With all of the candidate practices, CMPCN has network agreements in place that allow for a HIPAA-compliant exchange of data. These agreements include clinical and claims information for patients attributed to those practices by the two participating MCOs; Amerigroup and Sunflower. With its agreements with the MCOs, CMPCN also receives claims data directly from the two contracted MCOs.

Expectation of Sustainability

This transformation effort will lead to a cultural and organizational change that provides practices with greater satisfaction for patients, providers, and staff. The tools and process changes lead to improved efficiencies and effectiveness that provide long-term benefits of better outcomes. The ability to deliver improved outcomes via PCMH will allow the practices to thrive in the value-based payment environment that is rapidly evolving in health care systems nationwide.

The PCMH model is an important part of the strategic direction of Children's Mercy. The model is also at the center of how CMPCN practices are successfully transforming the way to deliver patient and family-centered care. Children's Mercy is committed to this model. Exploring ways that PCMH practices can continue to develop into Health Homes for our patients offers more opportunities for long range sustainability and success.

Project Milestones and Performance Indicators

Submit project milestones from categories 1 through 4 for each demonstration year.

Category 1 measures are meant to focus on *infrastructure milestones.* These milestones lay the foundation for delivery system transformation through investments in technology, tools, and human resources. As such, Children's Mercy has revised its Category 1 milestones and metrics to better address this purpose. Attached is Exhibit 2, which includes all related Category Measures.

Related Category 1 Outcome Measures:

Metrics

- 1.1 Build and define PCMH implementation team
    - Metric: Identification of a mulitdisciplinary team from each practice site to conduct an initial assessment of the practice readiness
    - Complete an organizational assessment that includes evaluation of the following components:
        - Engaged leadership
        - Quality Improvement strategy
        - Empanelment
        - Continous and team-based healing relationships
        - Organized, evidence based care
        - Patient Centered interactions
        - Enhanced access
        - Care coordination

- 1.2 NCQA PCMH Gap assessment of clinic(s)
    - Metric: Develop and implement a work plan to complete gap analysis against NCQA PCMH recognition criteria
        - Complete a gap analysis based on practice assessment
        - Feedback data to the practice
        - Finalize practice goals for intervention and implementation of work plan
        - Build capacity for data driven change with introduction of information to that may be used in the improvement project

- 1.3 Build and define a Medical Neighborhood Support Team
    - Metric: Identification of Team Members representing network primary care practices and Children's Mercy specialists
- 1.4 Gap assessment of processes necessary for specialty support of PCMH
    - Metric: Develop and implement a work plan to address gaps that will focus on the

following elements:

- Establishing Collaborative Service Agreements (CSA) with primary care clinicians to exchange key information
- Systematic approach to identify and track patients to coordinate care
- Improve processes related to transitions to primary care from outpatient, ED and inpatient services

Related Category 2 Outcome Measures:

Metrics

- 2.1 Develop and implement action plan for NCQA PCMH recognition and track processes associated with PCMH implementation
    - Evaluate and track registry usage and outreach
    - Evaluate and track delivery of evidence based care for specific chronic and high risk conditions
    - Monitor performance data from practices related to Category 3 Outcome metrics and implement QI plans for performance improvement
    - Metric: Documentation submission of the PCMH implementation work plan with periodic updates of progress in the areas decribed above.
    - Target:
        - Year 3- 4 Practices with complete work plan

- 2.2 Percentage of Targeted Practices recognized as PCMH
    - Metric: Percent of selected clinics recognized PCMH
    - Target:
        - Year 3- Application Period
        - Year 4- 2 Practices with NCQA PCMH Level I Recognition or higher
        - Year 5- 3 Practices with NCQA PCMH Level I Recognition or higher
    - Rationale: Although PCMH recognition provides a path for transformation, the actual recognition is not a major measure of success. Practices may not have an EHR or may lack other systems which prevent certification at a level greater than NCQA Level I PCMH Recogntion but can still transform to operations which hit the Triple Aim.

- 2.3 Implement the action plan for Medical Neighborhood support of PCMH
    - Implementation of Collaborative Service Agreement and related processes (CSA) with mechanisms to ensure timely and appropriate consultation with bi-directional communication.
    - Metric: Collaborative Service Agreements use by selected practices with initial referral to CMH Specialists

- Target:
    - Year 3- Plan for Implementation of Collaborative Service Agreements in place
    - Year 4- 10% of selected practice referrals to CMH contain CCA
    - Year 5- 25% of selected practice referrals to CMH contain CCA

Related Category 3 Quality and Outcome Measures:

Metrics

Note: All Category 3 Measures include only the aggregated attributed population of patients assigned to the selected practices by the two participating MCOs.

- 3.1 Height\Weight\BMI screening and Nutrition and Physical Activity for children aged 3-17 years..
    - Metric: Healthy Weight Plan/Counseling for Nutrition and Physical Activity for children 3-17 yoa
    - Denominator: number of patients 3-17 yoa
    - #1 Numerator: number of pts 3-17 yoa who had height, weight, BMI documented during the measurement year. #2 Numerator: number of pts 3-17 yoa who had nutritional counseling during the measurement year. #3 Numerator: number of patients 3-17 yoa who had counseling for physical activity.
    - Target:
        - Year 3- Year 3- BMI- 39.2%; Counseling for Nutrition50%; Counseling for Physical Activity 47%
        - Year 4- 10% reduction in the gap to goal) in the number of patients in targeted population will have documented Weight Assessment & Counseling for Nutrition and Physical Activity
        - Year 5- 10% reduction in the gap to goal) in the number of patients in targeted population will have a documented Weight Assessment & Counseling for Nutrition and Physical Activity
    - Rationale: Weight Assessment along with Nutrition and Physical Activity counseling with age specific dietary modification is considered to be a cornerstone of treatment. There is significant evidence that there is opportunity for improvement in this area based on the increasing rates of childhood obesity.
- 3.2 Childhood Immunization Rate
    - Metric: Percent of patients who have completed recommended HEDIS combination 2 immunizations by age 2 years
    - Denominator: The number of patients who turn 2 years old during the measurement period. Numerator: The number of patients who received each of the following vaccines on or before their 2nd birthday: 4 DTaP; 3 IPV; 1 MMR; 3

HIB; 3 HepB; 1 VZV; 2 Influenza; and 2 Rotavirus (on or before 8 months of age

- Target:
  - Year 3- 70.7 % of patients age 2yoa have completed recommended HEDIS Combo 2 immunizations.
  - Year 4- Year 4- 10% reduction in the gap to goal of immunization rate in targeted population
  - Year 5- Year 4- 10% reduction in the gap to goal of immunization rate in targeted population
- Rationale: Childhood immunizations directly result in reduction in disease. Receipt of all recommended vaccines by age 2 years results in reduction in the potential for outbreaks of disease. In Kansas, the Healthy People 2020 goal for immunizations was only being met for three vaccines demonstrating an opportunity for improvement.

- 3.3 Lead Screening in Children
  - Metric: Percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by thirty months of age.
  - Denominator: Children who turn two years of age during the measurement year.
  - Numerator: Children who turn two years of age during the measurement year with at least one capillary or venous blood test for lead on or before the child's second birthday
  - Target:
    - Year 3- 45.7 % of children age two years of age will have one or more blood lead tests
    - Year 4- Year 4- 10% reduction in the gap to goal of lead screening rate in targeted population
    - Year 5- Year 4- 10% reduction in the gap to goal of lead screening rate in targeted population
  - Rationale: Lead poisoning is a preventable condition and a public health priority for Kansas. Despite mandatory requirement as part of the Kan Be Health EPSDT screening in Kansas Medicaid the screening levels throughout Kansas have opportunities for improvement.
- 3.4 Anemia Screening in Children
  - Metric: Percentage of children two years of age who had hemoglobin/hematocrit testing by their second birthday.
  - Denominator: Children who turn two years of age during the measurement year.
  - Numerator: Children who turn two years of age during the measurement year with a hemoglobin/hematocrit test on or before the child's second birthday.

- Target:
    - Year 3- 40 % of children age 30 months of age will have one or more blood lead tests
    - Year 4- 10% improvement (from baseline) of anemia screening rate in targeted population
    - Year 5- 25% improvement (from baseline) of anemia screening rate in targeted population
- Rationale: Iron deficiency anemia is associated psychomotor and cognitive abnormalities in children. Iron supplementation in children with iron deficiency may improve neurodevelopmental outcomes.

- 3.5 Adolescent Well-Care Visits with two or more chronic conditions or one chronic condition at risk for a second
    - Metric: Percentage of enrolled members 12-21 years of age with two or more chronic conditions or one chronic condition at risk for a second who had at least one comprehensive well-care visit.
    - Numerator: Number of adolescent patients with two or more chronic conditions or one chronic condition that had a well-care visit.
    - Denominator: Number of adolescent patients with two or more chronic conditions or one chronic condition at risk for a second in the measurement period
    - Target:
        - Year 3- 44.6% of adolescents will have well-care visit
        - Year 4- 10% reduction in the gap to goal in well care visit rate in targeted population
    - Year 5- 10% reduction in the gap to goal in well care visit rate in targeted population
    - Rationale: Many adolescents frequently do not access preventative health care services. Those with chronic conditions are at significant risk for poor outcomes.

- 3.7 Reduce ED Utilization for Asthma
    - Metric: Percentage of pts 2-17 yrs with diagnosis of asthma who have had an ED visit for asthma in the last 6 months. (Exclude pregnancy, childbirth, transfer from other institution, additional diagnosis of cystic fibrosis or anomalies of the respiratory system).
    - Numerator: Number of pts 2-17 yrs with a diagnosis of asthma who have 1 or more ED visits in the last 6 months.
    - Denominator: Number of pts 2-17 yrs with a diagnosis of asthma.
    - Target:
        - Year 3- Baseline Data Collection

        - Year 4- 5% reduction from baseline ED visit rate in targeted population
        - Year 5- 10% reduction from baseline ED visit rate in targeted population
    - Rationale: Asthma has high prevalence in children with potentially lethal consequence. Asthma is costly to society and disruptive to the lives of Kansans. Asthma is a leading cause of ED visits and hospitalizations. Early identification of children with asthma and appropriate asthma management with self-management education should result in the reduction of the frequency of Emergency Department visits for asthma.

Related Category 4 Outcome Measures:

Metrics

- 4.1 ED Utilization for Asthma
    - Metric: X CMH ED visits with primary diagnosis of asthma/1000 CMH patients with Kansas Medicaid and diagnosis of asthma
    - Numerator: Number of CMH pts 2-17 yrs with a diagnosis of asthma who have 1 or more ED visits with primary diagnosis of asthma in the last 6 months.
    - Denominator: Number of CMH pts 2-17 yrs with a diagnosis of asthma
    - Target:
        - Year 3- 305/1000 CMH patients
        - Year 4- 2.5% decrease from baseline
        - Year 5- 5% decrease from baseline
    - Rationale: ED Utilization is a measure of access to effective primary and urgent care.
- 4.2 Decrease readmissions
    - Metric: 30 day all-cause readmission rate following hospitalization
    - Denominator: number of CMH inpatient hospitalizations among Kansas Medicaid patients that occur within 30-days of admission to the hospital after an inpatient hospital stay.
    - Numerator: the number of Kansas Medicaid patients admitted to CMH that had an inpatient hospital stay during the evaluation period..
    - Target:
        - Year 3- Baseline Data Collection
        - Year 4- 1% decrease from baseline
        - Year 5- 2% decrease from baseline
    - Rationale: all-cause readmission is not an important measure for pediatrics as the

readmission rate is very low with the exclusion of planned readmissions for chemotherapy, staged surgeries, etc.

- 4.3 Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

    - Metric: Percentage of patients 3-17 years of age with Kansas Medicaid who had an outpatient visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care Clinic with:
        - Height, weight, and body mass index (BMI) percentile documentation.
        - Counseling for nutrition.
        - Counseling for physical activity
    - Denominator: number of patients 3-17 yoa with Kansas Medicaid who had a well-child visit.
    - Numerator: number of pts 3-17 yoa with Kansas Medicaid who had height, weight, BMI documented during the measurement year. #2 Numerator: number of pts 3-17 yoa who had nutritional counseling during the measurement year. #3 Numerator: number of patients 3-17 yoa who had counseling for physical activity

    - Target:
        - Year 3- BMI- 39.2%; Counseling for Nutrition50%; Counseling for Physical Activity 47%
        - Year 4- 10% reduction in the gap to goal) in the number of patients in targeted population will have documented Weight Assessment & Counseling for Nutrition and Physical Activity
        - Year 5- 10% reduction in the gap to goal) in the number of patients in targeted population will have a documented Weight Assessment & Counseling for Nutrition and Physical Activity

- 4.4 Appropriate Testing for Children with Pharyngitis
    - Metric: Percentage of children 2-18 Years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

    - Denominator: The number of children 2-18 years of age who were diagnosed with pharyngitis and dispensed an antibiotic

    - Numerator: A group A streptococcus test in the seven day period from three days prior to the Index Episode Start Date (IESD) through three days after the IESD

Project Valuation

Children's Mercy will participate in the Border City Children's Hospital (BCCH) portion of the DSRIP Pool. The total funding available in the BCCH Pool after DY 5 is $15 million.

Of each year's funding, 75% is considered the base valuation. As stated in the DSRIP protocols, Children's Mercy will be eligible for secondary valuation payments based on the number of Medicaid/CHIP beneficiaries served through the project, and the percent of patients primarily served by external community partners. If at least 20% of the patients served through the project are served through affiliated external community partners, Children's Mercy will be eligible for an additional 20% of the available BCCH Pool, called the "Partner valuation payment." The final 10% of the BCCH Pool, or the 'Trailblazer valuation payments,' will be available to Children's Mercy if the organization includes outreach and capacity-building components that expand access to best practices by disseminating the project's methods and outcomes to rural and underserved areas of Kansas.

In total, Children's Mercy may be eligible for $2.5 million in DY 3, $5 million in DY 4, and $7.5 million in DY 5. Children's Mercy proposes that this project (Expansion of Patient Centered Medical Homes and Neighborhood) and its related Metric Milestone Categories represent 50% of the overall valuation formula used to determine the applicable BCCH Pool payment.

Exhibit 1

FEDERAL AWARD NUMBER	PRINCIPAL INVESTIGATOR	FULL TITLE	Current period funding	Start date	End date	DIRECT SPONSOR NAME	PRIME SPONSOR NAME
HHSN275201000003I	Abdel-Rahman, Susan	PTN Baby Tape study	$ 32,584	09/01/14	03/14/16	Duke University	National Institutes of Health
R01GM099773	Allen, Geoffrey	Stratification of Pediatric Septic Shock	PP	09/01/13	08/31/15	Children's Hospital Medical Center	National Institutes of Health
K23HD071967	Anderst, James	Occult Injury Screening and the Detection of Physical Abuse in Young Children	$ 3,000	04/01/14	03/31/15	Children's Hospital of Philadelphia	National Institutes of Health
U01AR057956	Bass, Julie	Pediatric PROMIS: Advancing the Measurement and Conceptualization of Child Health	$ 7,000	11/01/14	06/30/15	Children's Hospital of Philadelphia	National Institutes of Health
5P01AR048929-08	Becker, Mara	Gene Expression in Pediatric Arthritis	PP	09/01/14	08/31/15	Children's Hospital Medical Center	National Institutes of Health
5U01NS076788-03	Bickel-Young, Jennifer	Amitriptyline and Topiramate in the Prevention of Childhood Migraine (CHAMP)	PP	09/01/14	08/31/15	Cincinnati Children's Hospital	National Institutes of Health
1U01HL114623-01A1	Black, Philip	OPTIMIZing Treatment for Early Pseudomonas Aeruginosa Infection in Cystic Fibrosis: The OPTIMIZE Multicenter Randomized Trial - Clinical Coordinating Center	$ 87,450	09/15/13	06/30/18	Seattle Children's Hospital	National Institutes of Health
5H30MC24051 / 0008966L	Carpenter, Shannon	Hemophilia Treatment Centers (SPRANS)	$ 31,426	06/01/14	05/31/15	The University of Texas Health Science Center at Houston	Health Resources and Services Administration - HRSA
ATHN: ATHN2011-VI; CDC: 1U27DD000862-03	Carpenter, Shannon	Public Health Surveillance for the Prevention of Complications of Bleeding and Clotting Disorders	$ 31,426	06/01/14	05/31/15	University of Texas Health Science Center at Houston	American Thrombosis and Hemostasis Network / CDC
1R01HD072267-01A1	Carter, Brian	Neonatal Neurobehavior and Outcomes and Very Preterm Infants [NOVI]	$ 43,209	09/01/14	08/31/15	Women and Infants Hospital of Rhode Island	National Institutes of Health
1R01DK100779	Clements, Mark	Longitudinal test of adherence & control in kids new to T1 diabetes & 5-9 yrs old [TACKLE]	$ 77,292	08/01/14	07/31/15	University of Kansas Medical Center	National Institutes of Health
5R01AR061513-04	Connelly, Mark	WebSMART: Efficacy of web-based self-management for adolescents with JIA	$ 281,475	07/01/14	06/30/15		National Institutes of Health
2R44HD066920-03A1	Connelly, Mark	An intervention to improve adolescent headache self-management	$ 9,269	10/01/14	09/30/15	Inflexxion, Inc.	National Institutes of Health
5R01HL085707-05	Dalal, Jignesh	RD Safe: A Multicenter Study of Hematopoietic Stem Cell Donor Safety and Quality of Life	PP	10/01/09	06/30/50	National Marrow Donor Program	National Institutes of Health

FEDERAL AWARD NUMBER	PRINCIPAL INVESTIGATOR	FULL TITLE	Current period funding	Start date	End date	DIRECT SPONSOR NAME	PRIME SPONSOR NAME
U10HL069294	Dalal, Jignesh	NMDP BMT-CTN Clinical Protocol #0501	PP	06/24/13	06/23/50	Children's Hospital of Philadelphia	National Institutes of Health
1R41AI108016-01	Domen, Adrianus	Novel indication for myeloid progenitor use: Induction of tolerance	$ 107,567	02/27/13	07/31/15	Cellerant Therapeutics, Inc.	National Institutes of Health
1R21HD076116-01A1	Dreyer-Gillette, Meredith	Modifiable Behavior & Dietary Predictors of Overweight in Children with ASD	$ 65,051	01/01/14	12/31/14	University of Kansas Medical Center	National Institutes of Health
R01DA035736	Gaedigk, Andrea	CYP2D6 Genotype and Cognitive Deficits in Methamphetamine Users with/without HIV	$ 51,866	03/01/14	02/28/15	University of California - San Diego	National Institutes of Health
1R01CA165277-01A1	Gamis, Alan	Toxicity Monitoring on Phase III Trials with Administrative Data	$ 1,400	08/03/12	05/31/15	Children's Hospital of Philadelphia	National Institutes of Health
5R01HD076673-02	Goggin, Kathy	Evalution of the HITSystem to Improve Early Infant Diagnosis Outcomes in Kenya	$ 43,355	05/01/14	04/30/15	University of Kansas Medical Center	National Institutes of Health
1R24MD007951-01	Goggin, Kathy	Multilevel Health Promotion in African American Churches	$ 32,247	01/01/14	12/31/14	University of Missouri Kansas City (UMKC)	National Institutes of Health
1R01HD072633	Goggin, Kathy	Determinants of Use of Safer Conception Strategies Among HIC Clients in Uganda	$ 50,187	04/01/14	03/31/15	RAND Corporation	National Institutes of Health
1R01DK093592-01A1	Goggin, Kathy	System CHANGE: An RCT for Medication Adherence in Kidney Transplant Recipients	$ 9,832	06/01/14	05/31/15	University of Missouri Kansas City (UMKC)	National Institutes of Health
1R01MH099981-01A1	Goggin, Kathy	Assessing HIV Screening in African American Churches	$ 12,203	05/01/14	02/28/15	University of Missouri Kansas City (UMKC)	National Institutes of Health
HHSN275201000003I	Goldman, Jennifer	Safety and Pharmacokinetics of Multiple-Dose Intravenous and Oral Clindamycin in Pediatric Subjects with BMI ≥ 85th Percentile	PP	04/18/13	03/27/15	Duke University	National Institutes of Health
HHSN272200800008C; PO #1000920057	Harrison, Christopher	MRSA decolonization practices in the Neonatal Intensive Care Unit	$ 100,000	06/08/11	12/06/14	University of Iowa	National Institutes of Health
HHSN272200800008C	Harrison, Christopher	A Phase II Open-Label Study in Healthy Pediatric Populations to Assess the Safety, Reactogenicity, and Immunogenicity of an Intramuscular Unadjuvanted Subvirion Monovalent Inactivated Influenza H3N2 Variant (H3N2v) Vaccine	$ 290,178	08/01/14	07/31/15	University of Iowa	National Institutes of Health
UM1CA097452	Hetherington, Maxine	Phase I Per Case Reimbursement	PP	01/13/14	06/30/50	Children's Hospital of Philadelphia	National Institutes of Health

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FEDERAL AWARD NUMBER	PRINCIPAL INVESTIGATOR	FULL TITLE	Current period funding	Start date	End date	DIRECT SPONSOR NAME	PRIME SPONSOR NAME
1R18 HS021163-03	Humiston, Sharon	School Located Influenza Vaccinations for Children: Community-Wide Dissemination	$ 66,019	08/01/14	07/31/15	University of Rochester	Agency for Healthcare Research & Quality
5U01IP000502-03	Humiston, Sharon	Optimizing the Practical Application of Immunization Information System Use in Primary Care Settings	$ 40,831	09/01/14	08/31/15	University of Rochester	Centers for Disease Control and Prevention
5U66IP000671-03	Humiston, Sharon	Increasing Adolescent Immunization through Pediatric Partnerships	$ 20,000	09/01/14	08/31/15	American Academy of Pediatrics	Centers for Disease Control and Prevention
1U66IP000673-03	Humiston, Sharon	National Partnerships for Adolescent Immunization	$ 31,353	09/01/14	08/31/15	American Pediatric Association	Centers for Disease Control and Prevention
1U38OT00167-01	Humiston, Sharon	PPHF 2013: OSTLTS Partnerships - CBA of the Public Health System	$ 28,169	07/01/14	06/30/15	American Academy of Pediatrics	Centers for Disease Control and Prevention
3U38OT000167-01S1	Humiston, Sharon	PPHF 2013: OSTLTS Partnerships - CBA of the Public Health System [HPV-specific]	$ 85,827	09/30/14	09/29/15	American Academy of Pediatrics	Centers for Disease Control and Prevention
1H23IP000952-01	Humiston, Sharon	Improving Immunization Rates and Enhancing Disease Prevention through Partnerships with Providers	$ 85,827	09/30/14	09/29/15	American Academy of Pediatrics	Centers for Disease Control and Prevention
R01FD003341	Iqbal, Corey	Phase III Multicenter Trial of Magnetic Alteration of Pectus Excavatum	$ 16,750	05/01/14	04/30/15	University of California - San Francisco	Food and Drug Administration
5K23HL105783-04	Jones, Bridgette	Characterization of the Role of Histamine in Children with Asthma	$ 128,625	05/01/14	04/30/15		National Institutes of Health
R01HD060543	Kearns, Gregory	Metabolism and Toxicity of Acetominophen in Preterm Infants	$ 19,681	06/01/14	05/31/15	Children's Research Insitute	National Institutes of Health
HHSN275201000003I	Kearns, Gregory	PTN Clinical Trials Manager Salary	$ 499,626	05/08/12	02/14/15	Duke University	National Institutes of Health
HHSN275201000003I	Kearns, Gregory	Pediatric Trials Network: Core Chair Agreement	$ 177,040	09/30/11	09/29/15	Duke University	National Institutes of Health
HHSN275201000003I	Kearns, Gregory	The Effect of Obesity on the Pharmacokinetics of Pantoprazole in Children and Adolescents (Task Order 23) [Protocol development]	$ 73,032	12/01/13	07/28/15	Duke University	National Institutes of Health
5T32HD069038-04	Kearns, Gregory	Children's Mercy Hospital Collaborative Fellowship Program in Pediatric Pharmacology	$ 196,857	05/01/14	04/30/15		National Institutes of Health
1R01DK091823-02	Kingsmore, Stephen	Identification of Common and Uncommon Gene Variants in PBC	$ 186,432	09/01/14	08/31/15	Regents of the University of California	National Institutes of Health
1U19HD077693-01	Kingsmore, Stephen	Clinical and Social Implications of 2-day Genome Results in Acutely Ill Newborns	$ 1,141,278	09/01/14	08/31/15		National Institutes of Health

FEDERAL AWARD NUMBER	PRINCIPAL INVESTIGATOR	FULL TITLE	Current period funding	Start date	End date	DIRECT SPONSOR NAME	PRIME SPONSOR NAME
8UL1TR000001-02	Lantos, John	Heartland Institute for Clinical and Translational Research	$ 44,280	03/01/14	02/28/15	University of Kansas Medical Center Research Institute, Inc.	National Institutes of Health
U10NS077356	Le Pichon, Jean-Baptiste	Heartland Unit for Neuroscience Trials	$ 6,000	07/01/14	06/30/15	University of Kansas Medical Center	National Institutes of Health
5R01HD058556-05	Leeder, J. Steven	Exogenous and Endogenous Biomarkers of CYP2D6 Variability in Pediatrics	$ 561,688	03/01/14	02/28/15		National Institutes of Health
HHSN275201000003I	Lowry, Jennifer	Pharmacokinetics of Multiple Dose Methadone in Children	PP	12/12/13	07/21/15	Duke University	National Institutes of Health
1UM1AI109565-01	Moore, Wayne	TIDAL - Inducing Remission in New Onset T1DM with Alefacept (Amevive®)	$ 19,046	05/01/14	12/31/15	Benaroya Research Institute	National Institutes of Health
HHSN26700800019C	Moore, Wayne	Natural History Study of the Development of Type I Diabetes	PP	12/02/11	06/30/15	University of South Florida	National Institutes of Health
HHSN26700800019C	Moore, Wayne	Oral Insulin for Prevention of Diabetes in Relatives at Risk for Type 1 Diabetes Mellitus	PP	11/17/11	06/30/15	University of South Florida	National Institutes of Health
HHSN26700800019C	Moore, Wayne	TN10	PP	07/01/13	06/30/15	University of South Florida	National Institutes of Health
6119-1144-00-F	Moore, Wayne	TN07	PP	07/01/13	06/30/15	University of South Florida	National Institutes of Health
6119-1144-00-F	Moore, Wayne	DPT TrialNet	PP	07/01/14	06/30/15	University of South Florida	National Institutes of Health
HHSN26700800019C	Moore, Wayne	CTLA-4 Ig (Abatacept) for prevention of abnormal glucose tolerance (AGT) and diabetes in relatives at-risk for Type 1 diabetes mellitus (T1DM)	PP	11/08/11	06/30/15	University of South Florida	National Institutes of Health
HHSN275201000003I	Neville, Kathleen	Pharmacokinetics of Understudied Drugs Administered to Children per Standard of Care [POPS extension]	PP	09/26/12	06/25/15	Duke University	National Institutes of Health
U10CA098543	Neville, Kathleen	Temozolomide, Irinotecan Plus Bevacizumab (NSC #704865, BB-IND #7921) for Recurrent/Refractory Medulloblastoma/CNS PNET of	PP	01/13/14	06/30/50	Children's Hospital of Philadelphia	National Institutes of Health
UM1CA097452	Neville, Kathleen	Phase I Per Case Reimbursement	PP	01/13/14	06/30/50	Children's Hospital of Philadelphia	National Institutes of Health
5U54HD071598-03	Pearce, Robin	Indiana University Center for Pediatric Pharmacology	$ 10,000	07/01/14	06/01/15	Indiana University	National Institutes of Health
2R01AR052113-07	Price, Nigel	Bracing in Adolescent Idiopathic Arthritis [BrAIST]	$ 10,574	09/01/12	08/31/15	University of Iowa	National Institutes of Health

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FEDERAL AWARD NUMBER	PRINCIPAL INVESTIGATOR	FULL TITLE	Current period funding	Start date	End date	DIRECT SPONSOR NAME	PRIME SPONSOR NAME
1U01AI087881-01A1	Puls, Henry	Prospective Cohort Study of Severe Bronchitis and Risk of Recurrent Wheezing	$ 3,257	09/01/14	08/31/15	Massachusetts General Hospital	National Institutes of Health
5U01IP000460-04S1	Selvarangan, Rangaraj	Enhanced Surveillance for New Vaccine Preventable Diseases	$ 391,529	08/01/14	07/31/15		Centers for Disease Control and Prevention
3U01IP000460-03W1	Selvarangan, Rangaraj	Enhanced Surveillance for New Vaccine Preventable Diseases [ACA supplement]	$ 191,291	08/01/14	07/31/15		Centers for Disease Control and Prevention
HHSN275201000003I	Shakhnovich, Valentina	The Effect of Obesity on the Pharmacokinetics of Pantoprazole in Children and Adolescents (Task Order 23)	PP	03/27/14	08/28/15	Duke University	National Institutes of Health
5UM1DK100866-02	Srivastava, Tarak	Integrative Proteomics & Metabolomics for Pediatric Glomerula Disease Biomarkers	$ 9,705	06/01/14	05/31/15	Nationwide Children's Hospital	National Institutes of Health
R01CA16281-06	Stegenga, Kristin	Music Video and parent Intervention for Family Resilience during Cancer Treatment	$ 29,377	06/01/14	05/31/15	Indiana University	National Cancer Institute
90CB0194-02-00	Templeton, Oneta	Team for Infants Endangered by Substance Abuse (TIES)	$ 475,000	09/30/14	09/29/15		Department of Health and Human Services / Adminstration for Children and Families
U01HL094338	Truog, William	TOLSURF capitation	PP	04/15/10	06/30/50	The Regents of The University of California (University of California San Francisco)	National Institutes of Health
U01HL112748	Truog, William	NRN capitation	PP	04/01/11	03/31/15	RTI International	National Institutes of Health
U01HL094338	Truog, William	Trial of Late Surfactant to Prevent BPD - Clinical Coordinating Center	$ 2,250	08/01/14	07/31/15	The Regents of The Univesity of California (University of California San Francisco)	National Institutes of Health
5U10HD068284-04	Truog, William	The Children's Mercy-Truman-UMKC Center: A New Addition for the Next 5 Years [Neonatal Research Network]	$ 280,150	04/01/14	03/31/15		National Institutes of Health
5U01DK061230-11	Ugrasbul-Eksinar, Figen	TODAY Study Group Genetics Protocol	PP	03/01/13	02/28/15	The George Washington University	National Institutes of Health
2U01DK066143-11	Warady, Bradley	Chronic Kidney Disease in Children (CKiD III)	$ 1,016,466	08/01/14	07/31/15		National Institutes of Health
U10 EY11751	Waters, Amy	Amblyopia Treatment Study ATS15: Increasing Patching for Amblyopia	PP	07/01/09	12/31/18	JAEB Center for Health Research, Inc.	National Institutes of Health

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FEDERAL AWARD NUMBER	PRINCIPAL INVESTIGATOR	FULL TITLE	Current period funding	Start date	End date	DIRECT SPONSOR NAME	PRIME SPONSOR NAME
U10 EY11751	Waters, Amy	Intermittent Exotropia Study 1 (IXT1). A Randomized Trial of Bilateral Lateral Rectus Recession versus Unilateral Lateral Rectus Recession with Medical Rectus Resection of Intermittent Exotropia	PP	12/07/09	12/31/18	Jaeb Center for Health Research, Inc.	National Institutes of Health
U10 EY11751	Waters, Amy	ATS16 Augmenting Atropine Treatment for Amblyopia	PP	05/22/12	12/31/18	Jaeb Center for Health Research, Inc.	National Institutes of Health
U10 EY11751	Waters, Amy	HTS1-Glasses Vs. Observation for Moderate Hyperopia in Young Children (LEVEL A)	PP	05/22/12	12/31/18	Jaeb Center for Health Research, Inc.	National Institutes of Health
U10EY11751	Waters, Amy	Pediatric Cataract Surgery Outcomes Registry (CO2)	$ 1,200	05/22/12	12/31/18	Jaeb Center for Health Research, Inc.	National Institutes of Health
R01Ai03315	Yin, Dwight	Multi-Center Studies to Improve Diagnosis and Treatment of Pediatric Candidiasis	PP	01/01/14	12/31/17	Duke University	National Institutes of Health

TITLE OF PROJECT: PCMH Expansion										
Measure Count	**Measure Name**	**Metric**	**NQF#**	**Measure Steward**	**Data Source**	**Baseline Performance Level (include numerator/ denominator)**	**Anticipated Completion Date if applicable**	**Report Deliverables to State**	**Data Periodicity**	**Anticipated target level for triggering payment**
CATEGORY										
1.1	Build and define PCMH implementation team	Identification of a mulitdisciplinary team from each practice site to conduct an initial assessment of the practice readiness	N\A	N\A	Report	N\A	Q1 2015	Q4 2015	Annual	Documentation of PCMH implementation team
1.2	NCQA PCMH Gap assessment of clinic(s)	Develop and implement a work plan to complete gap analysis against NCQA PCMH recognition criteria	N\A	N\A	Report	N\A	Q3 2015	Q4 2015	Annual	Report of gap assessment
1.3	Build and define a Medical Neighborhood Support Team	Identification of Team Members representing network primary care practices and Children's Mercy specialists	N\A	N\A	Report	N\A	N\A	Q4 2015	Annual	Documentation of Medical Neighborhood Support Team
1.4	Gap assessment of processes necessary for specialty support of PCMH	Develop and implement a work plan to address gaps that will focus on the following elements: • Establish Collaborative Service Agreements (CSA) with primary care clinicians to exchange key information • Systematic approach to identify and track patients to coordinate care • Improve processes related to transitions to primary care from outpatient, ED and inpatient services	N\A	N\A	Report	N\A	Q4 2015	Q4 2015	Annual	Report of Gap Assessment

CATEGORY 2 MEASURES	Measure Name	Metric	NQF#	Measure Steward	Data Source	Baseline Performance Level (include numerator/denominator)	Anticipated Completion Date	Report Deliverables to State	Data Periodicity	Anticipated target level for triggering payment
2.1	Develop and implement action plan for NCQA PCMH recognition and track processes associated with PCMH implementation	Documentation submission of the PCMH implementation work plan with periodic updates of progress in the areas decribed above	N\A	N\A	Report	N\A	Q4 2017	Q4 2015	Annual	Four practices with complete work plans
2.2	Percentage of Targeted Practices recognized as PCMH	Percent of selected clinics recognized PCMH	N\A	N\A	Report	N\A	Q4 2017	Q4 2015	Annual	Year 3- Application Period Year 4- 2 Practices NCQA PCMH Level 1 or Higher Year 5- 3 Practices NCQA Level 1 or Higher
2.3	Implement the action plan for Medical Neighborhood support of PCMH	Collaborative Service Agreements (CSA)use by selected practices with initial referral to CMH Specialists	N\A	N\A	Report	N\A	Q4 2017	Q4 2015	Annual	Year 3- Plan for Implementation of in place Year 4- 10% of selected practice referrals to CMH contain CSA Year 5- 25% of selected practice referrals to CMH contain CSA

CATEGORY 3 MEASURES	Measure Name	Metric	NQF#	Measure Steward	Data Source	Baseline Performance Level (include numerator/denominator)	Anticipated Completion Date if applicable	Report Deliverables to State	Data Periodicity	Anticipated target level for triggering payment
3.1	Height\Weight\BMI screening	Height\Weight\BMI screening and Counseling for Nutrition and Physical Activity for children 3-17 yoa	NQF 0024	NCQA	EHR\Claims	**Baseline:** BMI- 34.7% ; Counseling for Nutrition 46.9%; Counseling for Physical Activity 44% **National benchmark- 90th=**BMI- 80% ; Counseling for Nutrition 78%; Counseling for Physical Activity 65% **Numerator:** number of pts 3-17 yoa who had height, weight, BMI documented during the measurement year. #2 Numerator: number of pts 3-17 yoa who had nutritional counseling during the measurement year. #3 Numerator: number of patients 3-17 yoa who had counseling for physical activity **Denominator:** number of patients 3-17 yoa	Q4 2017	Q4 2015	Annual	Year 3- BMI- 39.2%; Counseling for Nutrition50%; Counseling for Physical Activity 47% Year 4- 10% reduction in the gap to goal) in the number of patients in targeted population will have documented Weight Assessment & Counseling for Nutrition and Physical Activity Year 5- 10% reduction in the gap to goal) in the number of patients in targeted population will have a documented Weight Assessment & Counseling for Nutrition and Physical Activity

3.2	Increase Immunization Rate in Children	Percent of patients who have completed recommended HEDIS combination 2 immunizations – children age 2yoa	NQF 0038	NCQA	EHR\Claims	**Baseline:** 69 % of patients aged 2yoa have completed recommended HEDIS Combo 2 immunizations. **National benchmark-90th**= 86% **Numerator**: The number of patients who received each of the following vaccines on or before their 2nd birthday: 4 DTaP; 3 IPV; 1 MMR; 3 HIB; 3 HepB; 1 VZV; 2 Influenza; and 2 Rotavirus (on or before 8 months of age) **Denominator:** The number of patients who turn 2 years old during the measurement period.	Q4 2017	Q4 2015	Annual	Year 3- 70.7 % of patients age 2yoa have completed recommended HEDIS Combo 2 immunizations. Year 4- Year 4- 10% reduction in the gap to goal of immunization rate in targeted population Year 5- Year 4- 10% reduction in the gap to goal of immunization rate in targeted population
3.3	Lead Screening	Percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by thirty months of age	N\A	NCQA/ HEDIS 2014	Hybrid Measure – Claims Data and Chart Review	**Baseline:** 42.7% of children age 2yrs have at least on capillary of venous blood test **National benchmark-90th=** 65.5% **Numerator:** Children who turn two years of age during the measurement year with at least one capillary or venous blood test on or before the child's second birthday **Denominator:** Children who turn two years of age during the measurement year.	Q4 2017	Q4 2015	Annual	Year 3- 45.7 % of children age two years of age will have one or more blood lead tests Year 4- Year 4- 10% reduction in the gap to goal of lead screening rate in targeted population Year 5- Year 4- 10% reduction in the gap to goal of lead screening rate in targeted population

3.4	Anemia in Children	Percentage of children two years of age who had hemoglobin/hematocrit testing by their second birthday	N\A	N\A	Hybrid Measure – Claims Data and Chart Review	**Numerator:** Children who turn two years of age during the measurement year with a hemoglobin/hematocrit test on or before the child's second birthday **Denominator:** Children who turn two years of age during the measurement year.	Q4 2017	Q4 2015	Annual	Year 3- 40 % of children age two years of age will have one or more blood lead tests Year 4- Year 4- 10% reduction in the gap to goal of lead screening rate in targeted population Year 5- Year 4- 10% reduction in the gap to goal of lead screening rate in targeted population
3.5	Adolescent Well-Care Visits	Percentage of patients 12-21 years of age with who had at least one comprehensive well-care visit	N\A	NCQA/ HEDIS	Claims Data	**Baseline:** 42.3 percent of adolescents have at least one comprehensive well-care visit **National benchmark-90th**= 65% **Numerator:** Number of adolescent patients with with two or more chronic conditions or one chronic condition that had a well-care vist. **Denominator:** Number of adolescent patients with with two or more chronic conditions or one chronic condition at risk for a secondin the measurement period	Q4 2017	Q4 2015		Year 3- 44.6% of adolescents will have well-care visit Year 4- 10% reduction in the gap to goal in well care visit rate in targeted population Year 5- 10% reduction in the gap to goal in well care visit rate in targeted population

3.6	Reduce ED Visits for patients with asthma	Percentages of pts 2-17 yoa with diagnosis of asthma that have had an ED visit for asthma in the last 6 months. (Exclude pregnancy, childbirth, transfer from other institution, additional diagnosis of cystic fibrosis or anomalies of the respiratory system).	0728 (modified)	AHRQ/ HRSA Asthma Collaborative	DAI	**Numerator:** Number of pts 2-17 yrs with a diagnosis of asthma who have 1 or more ED visits in the last 6 months. **Denominator:** Number of pts 2-17 yrs with a diagnosis of asthma	Q4 2017	Q4 2015		Year 3- Baseline Data Collection Year 4- 5% reduction from baseline ED visit rate in targeted population Year 5- 10% reduction from baseline ED visit rate in targeted population

CATEGORY 4 MEASURES	Measure Name	Metric	NQF#	Measure Steward	Data Source	Baseline Performance Level (include numerator/denominator)	Anticipated Completion Date if applicable	Report Deliverables to State	Data Periodicity	Anticipated target level for triggering payment
4.1	ED utilization for asthma –	X CMH ED visits with primary diagnosis of asthma/1000 CMH patients with Kansas Medicaid and diagnosis of asthma	N\A		Report\ EHR	Baseline rate 305/1000 patients **Numerator**: Number of CMH pts 2-17 yoa with a diagnosis of asthma who have 1 or more ED visits with primary diagnosis of asthma in the last 6 months. **Denominator**: Number of CMH pts 2-17 yoa with a diagnosis of asthma	Q4 2017	Q4 2015	Annual	Year 3- 300/1000 Year 4- 2.5% decrease from baseline Year 5- 5% decrease from baseline
4.2	Decrease readmissions	30 day all-cause readmission rate following hospitalization for patients with Kansas Medicaid	N\A			**Numerator**: number of CMH inpatient hospitalizations among Kansas Medicaid patients that occur within 30-days of admission to the hospital after an inpatient hospital stay. **Denominator**: the number of Kansas Medicaid patients admitted to CMH that had an inpatient hospital stay during the evaluation period.	Q4 2017	Q4 2015	Annual	Year 3- Baseline Data Collection Year 4- 1% decrease from baseline Year 5- 2% decrease from baseline

4.3	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age with Kansas Medicaid who had an outpatient visit with a CMH Primary Care Physician (PCP)in a Children's Mercy Primary Care clinic with: ▪ height, weight, and body mass index (BMI) percentile documentation. ▪ counseling for nutrition. ▪ counseling for physical activity	NQF 0024	NCQA	EHR\Claims	**Baseline**: BMI- 34.7%- goal; Counseling for Nutrition 46.9%; Counseling for Physical Activity 44% **National benchmark-90th=** BMI- 80% ; Counseling for Nutrition 78%; Counseling for Physical Activity 65% **Numerator:** number of pts 3-17 yoa who had height, weight, BMI documented during the measurement year. **#2 Numerator**: number of pts 3-17 yoa who had nutritional counseling during the measurement year. **#3 Numerator:** number of patients 3-17 yoa who had counseling for physical activity **Denominator:** number of patients 3-17 yoa	Q4 2017	Q4 2015	Annual	Year 3- BMI- 39.2%; Counseling for Nutrition50%; Counseling for Physical Activity 47% Year 4- 10% reduction in the gap to goal) in the number of patients in targeted population will have documented Weight Assessment & Counseling for Nutrition and Physical Activity Year 5- 10% reduction in the gap to goal) in the number of patients in targeted population will have a documented Weight Assessment & Counseling for Nutrition and Physical Activity

4.4	Appropriate Testing for Children with Pharyngitis	The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode	NQF 0002	NCQA	EHR\Claims	**Baseline:** 51.6% **National benchmark-90th=**95 **Numerator:** A group A streptococcus test in the seven-day period from three days prior to the Index Episode Start Date (IESD) through three days after the IESD **Denominator** The number of children 2-18 years of age who were diagnosed with pharyngitis and dispensed an antibiotic	Q4 2017	Q4 2015	Annual	Year 3= 55.9% Year 4- 10% reduction in the gap to goal) in the number of patients in targeted population will have Appropriate Testing for Children with Pharyngitis Year 5- 10% reduction in the gap to goal) in the number of patients in targeted population will have Appropriate Testing for Children with Pharyngitis