**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**7500 Security Boulevard, Mail Stop S2-25-26**
**Baltimore, Maryland 21244-1850**


**State Demonstrations Group**

December 16, 2020

Sarah Fertig
Medicaid Director
Kansas Department of Health and Environment
900 SW Jackson, Suite 900 N
Topeka, KS 66612

Dear Ms. Fertig:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the DSRIP Evaluation Design, which is required by the Special Terms and Conditions (STC) of the Kansas section 1115 demonstration, "KanCare" (Project No: 11-W-00283/7). CMS has determined that the evaluation design, which was submitted on January 17, 2020, and revised on September 25, 2020, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's DSRIP evaluation design as a complement to the broader KanCare evaluation design approved on February 19, 2020.

CMS has added the approved DSRIP evaluation design to the demonstration's Special Terms and Conditions (STC) as a part of Attachment O. A copy of the STCs, which includes the updated attachment, in enclosed with this letter. In accordance with 42 CFR 431.424, the approved evaluation design may now be posted to the state's Medicaid website within thirty days. CMS will also post the approved evaluation design as a standalone document, separate from the STCs, on Medicaid.gov.

It is our expectation that the DSRIP evaluation report, consistent with the approved evaluation design, will be submitted by April 30, 2021. We hope that the forthcoming report will serve as a helpful guide on lessons learned and achievements from the DSRIP program as the state continues to work on development of its alternate payment model (APM). In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the quarterly and annual monitoring reports.

We look forward to our continued partnership on the Kansas KanCare section 1115 demonstration. If you have any questions, please contact your CMS project officer, Michael Trieger. Mr. Trieger may be reached by email at Michael.Trieger1@cms.hhs.gov.

Sincerely,

Danielle Daly -S
Digitally signed by Danielle Daly -S
Date: 2020.12.16 06:48:40 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Angela D. Garner -S
Digitally signed by Angela D. Garner -S
Date: 2020.12.16 15:06:39 -05'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

cc: Michala Walker, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

# Delivery System Reform Incentive Payment (DSRIP) Pool Evaluation Plan

**Contract Number:** 46100

**Initial Submission Date:** May 15, 2015
**Revised Submission Date:** September 25, 2020

**Review Team:** Lynne Valdivia, MSW,BSN, RN, CCEP, Vice President, Director of Quality Review, and Compliance Officer
Ghazala Perveen, MBBS, PhD, MPH, Epidemiologist Consultant
John McNamee, Ph.D., MA, Senior Health Data Analyst
Jason Orr, MPH, Health Quality Data Analyst

**Prepared for:**

KanCare

# Kansas Delivery System Reform Incentive Payment pool (DSRIP) Evaluation Plan

The Delivery System Reform Incentive Payment (DSRIP) pool program is a component of the Kansas Section 1115 demonstration waiver, KanCare, which was approved for renewal from January 1, 2019 through December 31, 2023. The Kansas DSRIP projects were implemented in 2015 and now extend through 2020. An Alternate Payment Model (APM) program will replace DSRIP. This updated evaluation plan reflects an additional two years of DSRIP assessment and a final overall evaluation summary. The State will use the insights gained from DSRIP when determining metrics to test during the 2021 Bridge year. Experiences from DSRIP and the Bridge year will help inform the development of the APM program, effective 2022.

The DSRIP program supports hospital efforts to enhance access to health care, quality of care, and the health of patients and families they serve. The program aims to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. Participating hospitals work with community partners statewide to implement projects that have measurable milestones for improvements in infrastructure, processes, and healthcare quality.

The DSRIP program in Kansas includes two hospitals, Children's Mercy Hospital (CMH) and the University of Kansas Health System (UKHS) that are major medical service providers to Kansas residents. The CMH projects are, "Expansion of Patient Centered Medical Homes and Neighborhood," and "Implementation of Beacon Program to Improve Care for Children with Medical Complexity (CMC)." The UKHS projects are "Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)," and "STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis." As the DSRIP funding is based on provision of services to Medicaid and uninsured Kansas residents, the approved metrics and the overall DSRIP evaluation focus on Kansas populations. The Kansas Foundation for Medical Care, Inc., (KFMC) is the External Quality Review Organization (EQRO) for the State's Medicaid program (KanCare) and the independent evaluator of the DSRIP program.

UKHS and CMH have specific semi annual reporting requirements and timelines that are monitored by the Kansas Department of Health and Environment, Division of Health Care Finance, (KDHE-DHCF) and evaluated by KFMC. Reports are submitted to CMS accordingly. The 2020 DSRIP year has been impacted by the COVID-19 pandemic, with UKHS, CMH, and their identified project participants focused on the pandemic response and ongoing non-COVID patient care. Patterns of availability and utilization of health care services have been altered, and quality measure data collection and reporting are affected.

Furthermore, methods for collecting additional DSRIP evaluation data are impacted by the need to help reduce administrative burden for the DSRIP hospitals and identified project participants, as they focus on the pandemic response.

The evaluation will identify lessons learned and achievements from 2015 through 2020 for each project and the DSRIP program overall. Data sources include quantitative and qualitative data from the following:

- UKHS and CMH DSRIP reports
- KFMC DSRIP evaluation reports
- KDHE key informant interviews/surveys

The evaluation will be structured by the phases of the DSRIP project, including:

- Pre-DSRIP implementation – program planning (including development of metric specifications, application templates, and reporting templates) and project proposal approval processes.
- Project implementation – learning collaborative and overlapping stages of defined activities and metrics (Appendix A):
  - **Infrastructure milestones (Category 1)** – laying the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
  - **Process milestones (Category 2)** – process changes and improvements.
  - **Quality and outcomes milestones (Category 3)** – Metrics associated with these milestones address the impact of the project on quality metrics and beneficiary outcomes.
  - **Population focused improvement milestones (Category 4)** – Metrics associated with the broader impact of the selected projects.
- Reporting and evaluation – DSRIP hospital reporting (semiannual and annual), State feedback, KFMC evaluation and recommendations, DSRIP hospital follow-up to recommendations, and overall DSRIP evaluation.

The following key evaluation themes will be addressed for the DSRIP phases noted above:

- Process and outcome successes
- Strengths
- Characteristics that facilitated success
- Process and outcome deficiencies
- Barriers to success
- Ability to spread/transfer successful processes
- Ability to sustain successes
- Other lessons learned
- Suggestions for future projects

Table 1 includes examples of specific topics to be considered when addressing the key evaluation themes.

This area intentionally left blank

| Table 1. Potential Topics for Evaluation |
|---|
| |
| Changes to the health care system overall |
| Growth of Partnerships/collaboration – hospital to community providers/ and with clinical and community partners |
| Successes and challenges regarding DSRIP planning, implementation, and operation |
| Facilitation of DSRIP hospitals to address innovative population health efforts that Medicaid would not typically reimburse |
| Data sharing to improve quality of care and population health |
| Challenges associated with ongoing program maintenance and expansion and required policy changes |
| Strengthening perceived value and effectiveness of patient care models structured for population health management |
| Strategies used to address policy, legal, and business operation issues |
| Strategies for recruiting partners by type of partner (physician practices, other hospitals, NFs, EMS, non-clinical community organizations) |
| Connection with other programs and services received by participants |
| Hospital data collection and analytic capacity for meeting data reporting requirement and data exchanges with community partners |
| Organizational characteristics that had the most influence, positive or negative, on the ability to implement HIT strategies for data sharing |
| Use of rapid-cycle evaluation tools/PDSA |
| Progress by providers in building infrastructure to support redesigned processes of care delivery |
| Improvement in quality of care and health |
| Changes in data capabilities of reporting partners |

# Appendix A

# Delivery System Reform Incentive Payment (DSRIP) Pool Evaluation Plan

## CMS-Approved Project Metrics

## For Categories 1 to 4

Kansas Foundation for Medical Care, Inc.

**Table A1: Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 1** | | | | | | |
| 1.1 | Identify community partners | Number of participating community partners (hospitals, nursing facilities, clinics, etc. | UKHS | Number of community partners interested/Total potential partners<br>Number of community partners fully engaged/Total potential partners | 10% of potential community partners | ongoing |
| 1.2 | Conduct assessment of readmission for HF patients with the participating | Identify patients eligible for SPARCC training | UKHS | Number of HF patients identified/Number of potential HF patients in the 43 identified counties | ≥30% | ongoing |
| **Category 2** | | | | | | |
| 2.1 | Develop train-the-trainer modules | Number of trainers prepared | UKHS | Number of trainers trained/Number of trainers required | 75% of required trained for first 6 months | ongoing |
| 2.2 | Identify mechanisms by which to contact and disseminate information about the SPARCC | # patients who respond or indicate interest | UKHS | Number of patients identified/Total target number of patients | ≥30% | ongoing |
| 2.3 | Patients participating | Number of patients participating in SPARCC/resilience training program and | UKHS | Number of patients that participate/Number of patients that are eligible | ≥25% | ongoing |
| 2.4 | Develop virtual method to deliver and monitor program | Ability to deliver and monitor training remotely | UKHS | Beta test completed 6 months | Beta version validated | ongoing |
| **Category 3** | | | | | | |
| 3.1 | Monitor HF/DM patients' blood glucose (BG) | Number of patients in HF training with comorbid DM/HF | UKHS | Number of patients with HF/DM reporting well-controlled or adequately controlled BG/Number of patients with poorly controlled BG | 50% reporting well or adequately controlled BG | ongoing |
| 3.2 | Quality of life and functional health status | Measured by Patient Reported Outcomes Measurement Information System (PROMIS-29) Survey responses | UKHS | Baseline score/Post-intervention score | ≥10% improvement | ongoing |

**Table A1: Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC) (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 3 (Continued)** | | | | | | |
| 3.3 | Depression Assessment/Screening | Measured by the PROMIS Anxiety and Depression Form | CMS | Baseline score/post intervention score | ≥10% improvement | ongoing |
| 3.4 | Daily Weight Monitoring | Measured by weekly weight and blood pressure readings as well as self-report (daily tracking) to the health professional. PROMIS-29 captures compliance via the functional health | UKHS | Enrolled patients weighing/# total patients enrolled | ≥10% improvement | ongoing |
| 3.5 | Heart Failure Admission Rate | Measured by the average time between admissions for patients who have gone through SPARCC training | DAI | Rate of readmission for patients in the program/national readmission rate | ≥10% improvement | ongoing |
| **Category 4** | | | | | | |
| 4.1a | Reduce overall ED utilization | # ED visits | Medicaid claims data statewide | Numerator: Number of ED visits<br>Denominator: Population of the state (same reporting period) | 10% improvement in the the metric each time reported for purposes of payment | "n/a (ongoing; likely beyond initial DSRIP period)" |
| 4.1b | | # of frequent users of ED | Medicaid claims data statewide | Numerator: Number of patients visiting the ED four times a year or more<br>Denominator: Number of total ED visits | 10% improvement in the the metric each time reported for purposes of payment | "n/a (ongoing; likely beyond initial DSRIP period)" |

**Table A1: Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC) (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 4 (Continued)** | | | | | | |
| 4.2 | Decrease 30-day, readmission rate following hospitalization | # of patients readmitted to the index hospital following a hospitalization | Medicaid claims data statewide | Numerator: Number of readmissions<br>Denominator: Total hospital admissions | 10% improvement in the the metric each time reported for purposes of payment | "n/a (ongoing; likely beyond initial DSRIP period)" |
| 4.3 | Controlling high blood pressure (HBP) | Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement period | CMS | Numerator: Number of patients diagnosed with HBP whose BP was adequately controlled<br>Denominator: Number of patients with a diagnosis of HBP | 10% improvement in the the metric each time reported for purposes of payment | "n/a (ongoing; likely beyond initial DSRIP period)" |
| 4.4 | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user | CMS | Numerator: Number of patients age 18+ screened and counseled if identified as a tobacco user<br>Denominator: Total tobacco users identified | 10% improvement in the the metric each time reported for purposes of payment | "n/a (ongoing; likely beyond initial DSRIP period)" |

**Table A2: STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 1** | | | | | | |
| 1.1 | Identify community partners | Nursing homes<br>Long-Term Care Facilities<br>Community Hospitals<br>EMS | UKHS | Numerator: Number of facilities participating in sepsis initiative<br>Denominator: Total number of potential facilities & EMS in designated areas | 10% reduction in Gap or 10% increase in participation?) | 2017 |
| 1.2 | Database development | Number of community partners utilizing data to track sepsis and protocol activities | UKHS | Numerator: Number of registered facilities entering data<br>Denominator: Number of facilities that register with database | 10% increase in completion of data base | ongoing |
| 1.3 | Baseline Awareness Survey | Number of staff in participating facilities that are surveyed for their knowledge of the early signs and symptoms of sepsis and proper application escalation of care processes for the specific facility | UKHS | Numerator: Number of healthcare staff surveyed<br>Denominator: Number of applicable healthcare staff in facility | 10% reduction in Gap or 10% increase in participation?) | ongoing |
| **Category 2** | | | | | | |
| 2.1 | LCA Engagement | Submission of monthly of data into the database | UKHS | Numerator: Number of registered facilities entering data<br>Denominator: Number of facilities that register with database | 10% increase in completion of data base | ongoing |
| 2.2a | Educational curriculum development | Complete professional web-based modules | UKHS | Draft of Curriculum at start of project | BETA Curriculum 1.0 June 30, 2015 | 6/30/2015 |
| 2.2b | | Complete Curriculum specific for nursing facilities | UKHS | Draft of Curriculum at start of project | BETA Curriculum 1.0 June 30, 2015 | 6/30/2015 |
| **Category 3** | | | | | | |
| 3.1 | Improved in-hospital implementation of sepsis management bundles as defined by the Surviving Sepsis Campaign | Number of in-hospital documented, appropriate interventions using sepsis management bundles as defined by the Surviving Sepsis Campaign | Kansas Sepsis Project Database | Numerator: Number of hospitals following sepsis protocol<br>Denominator: Number of hospitals with a protocol | 10% reduction in Gap | ongoing |
| 3.2 | Increased ED identification of septic patients at any state of the continuum | Number of ED patients identified as septic pre- and post-implementation at each facility | Kansas Sepsis Database with DAI substantiation | Numerator: Number of patients identified with severe sepsis/septic shock at onset<br>Denominator: Number of actual sepsis patients (identified at onset + identified retrospectively) | 10% reduction in Gap | ongoing |

**Table A2: STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 3 (Continued)** | | | | | | |
| 3.3 | Increased ED identification of septic patients in early stages of sepsis | Number of ED patients identified as septic at early stages at each facility | Kansas Sepsis Project Database | Numerator: Number of patients identified with early onset of sepsis<br>Denominator: Number of actual early stage sepsis patients (identified at onset + identified retrospectively) | 10% reduction in Gap | ongoing |
| 3.4 | Increased ED identification of septic patients with severe sepsis | Number of ED patients diagnosed initially with severe sepsis at each facility | Kansas Sepsis Database with DAI substantiation | Numerator: Number of patients identified with severe sepsis/septic shock at onset-early<br>Denominator: Number of actual early stage sepsis patients (identified at onset + identified retrospectively) | 10% reduction in Gap | ongoing |
| 3.5 | Increased ED identification of septic patients | Number of ED patients diagnosed initially with septic shock at each facility | Kansas Sepsis Project Database | Numerator: Number of patients identified with septic shock<br>Denominator: Number of actual ED patients with septic shock (baseline) | 10% reduction in Gap | ongoing |
| 3.6 | Improved ED implementation of sepsis management bundles as defined by the Surviving Sepsis Campaign | Number of ED documented, appropriate interventions using sepsis management bundles as defined by the Surviving Sepsis Campaign | Kansas Sepsis Project Database | Numerator: Number of EDs following sepsis protocol<br>Denominator: Number of EDs with a protocol | 10% reduction in Gap | ongoing |
| 3.7 | Decrease in transfer of septic patients to a higher level facility | Number of septic patients transferred to a higher level facility | Kansas Sepsis Database with DAI substantiation | Numerator: Number of septic patients transferred from a hospital<br>Denominator: Total number of transferring hospital septic patients in timeframe | 10% reduction | ongoing |
| 3.8 | Increased identification of septic patients transferred to the hospital from a long-term care facility | Number of septic patients transferred to the hospital from a long-term care facility who are identified as septic pre- and post-implementation at each participating facility | Kansas Sepsis Database with DAI substantiation | Numerator: Septic patients transferred in time to hospitals<br>Denominator: Patients identified with severe sepsis or septic shock at the facility | Increase in appropriate transfers | ongoing |
| 3.9 | Decrease in proportion of septic patients progressing to septic shock after 12 months of facility participation | Ratio of septic shock patients to number of total of identified septic patients | Kansas Sepsis Database with DAI substantiation | Numerator: Total number of septic shock patients<br>Denominator: Total # of severe sepsis + septic shock patients | 10% reduction | ongoing |

**Table A2: STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 4** | | | | | | |
| 4.1a | Reduce overall ED utilization | # ED visits | Medicaid claims data statewide | Numerator: Number of ED visits<br>Denominator: Population of the state (same reporting period) | 10% improvement in the the metric each time reported for purposes of payment | "n/a (ongoing; likely beyond initial DSRIP period)" |
| 4.1b | | # of frequent users of ED | Medicaid claims data statewide | Numerator: Number of patients visiting the ED four times a year or more<br>Denominator: Number of total ED visits | 10% improvement in the the metric each time reported for purposes of payment | "n/a (ongoing; likely beyond initial DSRIP period)" |
| 4.2 | Decrease 30-day, readmission rate following hospitalization | # of patients readmitted to the index hospital following a hospitalization | Medicaid claims data statewide | Numerator: Number of readmissions<br>Denominator: Total hospital admissions | 10% improvement in the the metric each time reported for purposes of payment | "n/a (ongoing; likely beyond initial DSRIP period)" |
| 4.3 | Controlling high blood pressure (HBP) | Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement period | CMS | Numerator: Number of patients diagnosed with HBP whose BP was adequately controlled<br>Denominator: Number of patients with a diagnosis of HBP | 10% improvement in the the metric each time reported for purposes of payment | "n/a (ongoing; likely beyond initial DSRIP period)" |
| 4.4 | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user | CMS | Numerator: Number of patients age 18+ screened and counseled if identified as a tobacco user<br>Denominator: Total tobacco users identified | 10% improvement in the the metric each time reported for purposes of payment | "n/a (ongoing; likely beyond initial DSRIP period)" |

**Table A3: Expansion of Patient Centered Medical Homes and Neighborhood**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion date |
|---|---|---|---|---|---|---|
| **Category 1** | | | | | | |
| 1.1 | Build and define PCMH implementation team | Identification of a multidisciplinary team from each practice site to conduct an initial assessment of the practice readiness | Report | N/A | Documentation of PCMH implementation team | Q1 2015 |
| 1.2 | NCQA PCMH Gap assessment of clinic(s) | Develop and implement a work plan to complete gap analysis against NCQA PCMH recognition criteria | Report | N/A | Report of gap assessment | Q3 2015 |
| 1.3 | Build and define a Medical Neighborhood Support Team | Identification of Team Members representing network primary care practices and Children's Mercy Specialists | Report | N/A | Documentation of Medical Neighborhood Support Team | N/A |
| 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:<br>* Establish Collaborative Service Agreements (CSA) with primary care clinicians to exchange key information<br>* Systematic approach to identify and track patients to coordinate care<br>* Improve processes related to transitions to primary care from outpatient, ED, and inpatient services | Report | N/A | Report of gap assessment | Q4 2015 |
| **Category 2** | | | | | | |
| 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 described above | Report | N/A | Four practices with complete work plans | Q4 2017 |

**Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion date |
|---|---|---|---|---|---|---|
| **Category 2 (Continued)** | | | | | | |
| 2.2 | Percentage of Targeted Practices recognized as PCMH | Percent of selected clinics recognized PCMH | Report | N/A | Year 3 - Application period | Q4 2015 |
| | | | | | Year 4 - 2 practices NCQA PCMH Level 1 or Higher | Q4 2016 |
| | | | | | Year 5 - 3 Practices NCQA Level 1 or Higher | Q4 2017 |
| 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 | Report | N/A | Year 3 - Plan for implementation in place | Q4 2015 |
| | | | | | Year 4 - 10% of selected practice referrals to CMH contain CSA | Q4 2016 |
| | | | | | Year 5 - 25% of selected practice referrals to CMH contain CSA | Q4 2017 |
| **Category 3** | | | | | | |
| 3.1.a | Height/Weight/BMI screening with Counseling for Nutrition and Physical Activity | Height/Weight/BMI screeningchildren 3-17 yoa | EHR/Claims | **BMI** | Year 3 - 39.2% | Q4 2015 |
| | | | | Baseline 34.7% | Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment | Q4 2016 |
| | | | | National benchmark - 90th | | |
| | | | | Numerator: Number of patients 3-17 yoa who had height, weight, BMI documented during the measurement year. | Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment | Q4 2017 |
| | | | | Denominator: Number of patients 3-17 yoa | | |

**Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion date |
|---|---|---|---|---|---|---|
| **Category 3 (Continued)** | | | | | | |
| 3.1.b | Height/Weight/BMI screening with Counseling for Nutrition and Physical Activity | Counseling for Nutrition for children 3-17 yoa | EHR/Claims | **Counseling for Nutrition** | Year 3 - 50% | Q4 2015 |
| | | | | Baseline 46.9% | Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition | Q4 2016 |
| | | | | National benchmark - 90th | | |
| | | | | Numerator: Number of patients 3-17 yoa who had nutritional counseling during the measurement year. | Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition | Q4 2017 |
| | | | | Denominator: Number of patients 3-17 yoa | | |
| 3.1.c | Height/Weight/BMI screening with Counseling for Nutrition and Physical Activity | Counseling for Physical Activity for children 3-17 yoa | EHR/Claims | **Counseling for Physical Activity** | Year 3 - 47% | Q4 2015 |
| | | | | Baseline 44% | Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Physical Activity | Q4 2016 |
| | | | | National benchmark - 90th | | |
| | | | | Numerator: Number of patients 3-17 yoa who had counseling for physical activity during the measurement year. | Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Physical Activity | Q4 2017 |
| | | | | Denominator: Number of patients 3-17 yoa | | |

**Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion date |
|---|---|---|---|---|---|---|
| **Category 3 (Continued)** | | | | | | |
| 3.2 | Increase Immunization Rate in Children | Percent of patients who have completed recommended HEDIS combination 2 immunizations - children age 2 yoa | EHR/Claims | Baseline: 69% of patients aged 2 yoa have completed recommended HEDIS Combo 2 immunizations | Year 3 - 70.7% of patients age 2 yoa have completed recommended HEDIS Combo 2 immunizations | Q4 2015 |
| | | | | National benchmark - 90th | | |
| | | | | 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) | Year 4 - 10% reduction in the gap to goal of HEDIS Combo 2 immunization rate in targeted population | Q4 2016 |
| | | | | Denominator: The number of patients who turn 2 years old during the measurement period | Year 5 - 10% reduction in the gap to goal of HEDIS Combo 2 immunization rate in targeted population | Q4 2017 |
| 3.3 | Lead Screening | Percentage of children who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday | Hybrid Measure - Claims Data and Chart Review | Baseline: 42.7% of children age 2 yrs have at least one capillary of venous blood test | Year 3 - 45.7% of patients age 2 yoa have one or more blood lead tests | Q4 2015 |
| | | | | National benchmark - 90th | | |
| | | | | Numerator: Children who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday. | Year 4 - 10% reduction in the gap to goal of lead screening rate in targeted population | Q4 2016 |
| | | | | Denominator: Children who turn 2 years old during the measurement period | Year 5 - 10% reduction in the gap to goal of lead screening rate in targeted population | Q4 2017 |

**Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion date |
|---|---|---|---|---|---|---|
| **Category 3 (Continued)** | | | | | | |
| 3.4 | Anemia in Children | Percentage of children who turn two years of age who had hemoglobin and/or hematocrit testing for anemia screening by their second birthday | Hybrid Measure - Claims Data and Chart Review | Baseline: | Year 3 - 40% of children age two years of age will have one or more blood tests for anemia | Q4 2015 |
| | | | | Numerator: Children who turn two years of age during the measurement year with a hemoglobin and/or hematocrit test on or before the child's second birthday | Year 4 - 10% reduction in the gap to goal of screening rate in targeted population | Q4 2016 |
| | | | | Denominator: Children who turn 2 years old during the measurement period | Year 5 - 10% reduction in the gap to goal of screening rate in targeted population | Q4 2017 |
| 3.5 | Adolescent Well-Care Visits | Percentage of patients 12-21 years of age who had at least one comprehenxive well-care visit. | Claims Data | Baseline: 42.3% of adolescents have at least one comprehensive well-care visit<br>National benchmark - 90th: 65% | Year 3 - 44.6% of adolescents will have well-care visit | Q4 2015 |
| | | | | Numerator: Number of adolescent patients with two or more chronic conditions or one chronic condition that had a well-care visit. | Year 4 - 10% reduction in the gap to goal in well care visit rate in targeted population | Q4 2016 |
| | | | | Denominator: Number of adolescent patients with two or more chronic conditions or one chronic condition at risk for a second in the measurement period. | Year 5 - 10% reduction in the gap to goal in well care visit rate in targeted population | Q4 2017 |

**Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion date |
|---|---|---|---|---|---|---|
| **Category 3 (Continued)** | | | | | | |
| 3.6 | Reduce ED Visits for patients with asthma | Percentage of patients 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). | DAI | Baseline: need to be determined | Year 3 - Baseline data collection | Q4 2015 |
| | | | | Numerator: Number of patients 2-17 yrs with a diagnosis of asthma who have one or more ED visits in the last 6 months | Year 4 - 5% reduction from baseline ED visit rate in targeted population | Q4 2016 |
| | | | | Denominator: Number of patients 2-17 yrs with a diagnosis of asthma | Year 5 - 10% reduction from baseline ED visit rate in targeted population | Q4 2017 |
| **Category 4** | | | | | | |
| 4.1 | ED utilization for asthma | X CMH ED visits with primary diagnosis of asthma/1,000 CMH patients with Kansas Medicaid and diagnosis of asthma | Report/EHR | Baseline rate 305/1,000 | Year 3 - 300/1,000 | Q4 2015 |
| | | | | Numerator: Number of CMH patients 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 | Year 4 - 2.5% decrease from baseline | Q4 2016 |
| | | | | Denominator | Year 5 - 5% decrease from baseline | Q4 2017 |
| 4.2 | Decrease readmissions | 30 day all-cause readmission rate following hospitalization for patients with Kansas Medicaid | | Numerator: Number of CMH inpatient hospitalizations among Kansas Medicaid patients that occur within 30 days of admission to the hospital after an inpatient stay | Year 3 - Baseline data collection | Q4 2015 |
| | | | | | Year 4 - 1% decrease from baseline | Q4 2016 |
| | | | | Denominator: The number of Kansas Medicaid patients admitted to CMH that had an inpatient hospital stay during the evaluation period | Year 5 - 2% decrease from baseline | Q4 2017 |

**Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion date |
|---|---|---|---|---|---|---|
| **Category 4 (Continued)** | | | | | | |
| 4.3.a | 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:<br>*Height, weight, and body mass index (BMI) percentile documentation | EHR/Claims | **BMI** | Year 3 - 39.2% | Q4 2015 |
| | | | | Baseline 34.7% | Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment | Q4 2016 |
| | | | | National benchmark - 90th | | |
| | | | | Numerator: Number of patients 3-17 yoa who had height, weight, BMI documented during the measurement year. | Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment | Q4 2017 |
| | | | | Denominator: Number of patients 3-17 yoa | | |
| 4.3.b | 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:<br>*Counseling for nutrition | EHR/Claims | **Counseling for Nutrition** | Year 3 - 50% | Q4 2015 |
| | | | | Baseline 46.9% | Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition | Q4 2016 |
| | | | | National benchmark - 90th | | |
| | | | | Numerator: Number of patients 3-17 yoa who had nutritional counseling during the measurement year. | Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition | Q4 2017 |
| | | | | Denominator: Number of patients 3-17 yoa | | |
| 4.3.c | 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:<br>*Counseling for physical activity | EHR/Claims | **Counseling for Physical Activity** | Year 3 - 47% | Q4 2015 |
| | | | | Baseline 44% | Year 4 & Year 5 - 10% reduction each year in gap to goal in number of patients in targeted population will have documented Counseling for Physical Activity | Q4 2016 |
| | | | | National benchmark - 90th | | Q4 2017 |
| | | | | Numerator: Number of patients 3-17 yoa who had counseling for physical activity during the measurement year. | | |
| | | | | Denominator: Number of patients 3-17 yoa | | |

**Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion date |
|---|---|---|---|---|---|---|
| **Category 4 (Continued)** | | | | | | |
| 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 | EHR/Claims | Baseline: 51.6% | Year 3 = 55.9% | Q4 2015 |
| | | | | National benchmark- 90th | 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 | Q4 2016 |
| | | | | 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 | 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 | Q4 2017 |
| | | | | Denominator: The number of children 2-18 years of age who were diagnosed with pharyngitis and dispensed an antibiotic | | |
| 4.5 | Lead Testing | Percentage of children with Kansas Medicaid who had an outpatient well-child visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday | EHR/Claims | Baseline: 42.7% of children age 2 yrs have at least one capillary of venous blood test | Year 3 - 45.7% of patients age 2 yoa have one or more blood lead tests | Q4 2015 |
| | | | | National benchmark - 90th | | |
| | | | | Numerator: Children who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday that have a well-child visit with a CMH Primary Care Physician. | Year 4 - 10% reduction in the gap to goal of lead screening rate in targeted population | Q4 2016 |
| | | | | Denominator: Children who turn 2 years old during the measurement period that have a well-child visit with a CMH Primary Care PHysician | Year 5 - 10% reduction in the gap to goal of lead screening rate in targeted population | Q4 2017 |

**Table A4: Implementation of Beacon Program to Improve Care for CMC**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 1** | | | | | | |
| 1.1 | Build and define Beacon's PCMH implementation team | Identification of a multidisciplinary team from Beacon to conduct an initial assessment of the clinic's readiness assessement of the practice readiness | Report | N/A | Documentation of Beacon implementation team | Q1 2015 |
| 1.2 | Conduct gap assessment of Beacon Program against NCQA PCMH criteria | Develop and implement a work plan to complete gap analysis against NCQA PCMH recognition criteria | Report | N/A | Report of gap assessment | Q3 2015 |
| 1.3 | Expand Beacon Program staff in order to provide a comprehensive care coordination program for Kansas Medicaid CMC | Develop a multi-disciplinary team to implement and expand teh Beacon Program for Kansas Medicaid CMC | Report | N/A | Submission of annual FTE report | Q4 2015<br>Q4 2016<br>Q4 2017 |
| 1.4 | Create reporting mechanisms/Electronic Care Plan Template | Submission of Care Plan delivered to internal and community based PCPs | Report | N/A | Care Plan Report Submission | Q4 2015 |
| 1.5 | Develop electronic documentation templates and order sets to support the evidence-based care of and the reporing on the patients served by this clinic | Completion of electronic documentation templates and order sets | Report | N/A | Order sets report submission | Q4 2015<br>Q4 2016 |
| **Category 2** | | | | | | |
| 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 described above | Report | N/A | Work plan submission | Q4 2015 |
| 2.2 | Beacon Program recognized as NCQA PCMH | Beacon Program is recognized as a Level III PCMH | Report | N/A | Year 3 - Application period | Q4 2015 |
| | | | | | Year 4 - Beacon receives Level 3 | Q4 2016 |

**Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 2 (Continued)** | | | | | | |
| 2.3 | Develop and implement the action plan for Medical Neighborhood support of Beacon | Collaborative Service Agreements (CSA) use by Beacon with initial referral to CMH Specialists | Report | N/A | Year 3 - Plan for implementation of Care Service Agreements | Q4 2015 |
| | | | | | Year 4 - Implement the Plan for executing CSAs including significant changes to the EMR as well as staff training on use of CSAs to effectuate medical neighborhoods | Q4 2016 |
| | | | | | Year 5 - 10% of Beacon referrals to Children's Mercy specialists and subspecialists contain CSAs | Q4 2017 |
| **Category 3** | | | | | | |
| 3.1.a | Increase Immunization Rate in Children | Increase Immunization Rates for Children 2 years of age | DAI | Baseline: 38% for Beacon patients | Year 3 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile) (90th percentile for HHS Region 7 - 86%) | Q4 2015 |
| | | | | Numerator: The number of patients assigned to Beacon primary care provider 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) | Year 4 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile) | Q4 2016 |
| | | | | Denominator: The number of patients assigned to Beacon primary care provider who turn 2 years old during the measurement period | Year 5 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile) | Q4 2017 |

**Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 3 (Continued)** | | | | | | |
| 3.1.b | Increase Immunization Rate in Children | Increase Immunization Rates for Children 6 years of age | DAI | Baseline: 75% for Beacon patients | Year 3 - Increase percentage by at least 10% annually or a total goal of at least 90%. | |
| | | | | Numerator: The number of patients who are up-to-date on the following immunizations, including boosters: MMR, VZV, DTaP, IPV, Hep A, Hep B | Year 4 - Increase percentage by at least 10% annually or a total goal of at least 90%. | Q4 2016 |
| | | | | Denominator: The number of patients assigned to Beacon primary care provider who turn 6 years old during the measurement period | Year 5 - Increase percentage by at least 10% annually or a total goal of at least 90%. | Q4 2017 |
| 3.2.a | Increase Immunization Rate in Adolescents and Adults | Increase the percent of patients assigned to Beacon primary care provider who have completed recommended immunizations - adolescents | DAI | Baseline: 75% for Beacon patients | Year 3 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile) | Q4 2015 |
| | | | | Numerator: The number of patients that have each of the following on or before their 13th birthday: 1 MCV, 1 Tdap or 1 Td | Year 4 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile) | Q4 2016 |
| | | | | Denominator: The number of patients assigned to Beacon primary care provider who turn 13 years old during the measurement period | Year 5 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile) | Q4 2017 |
| | | | | Baseline: 18% for Beacon patients | Year 3 - Increase percentage by at least 10% annually or a total goal of at least 50%. | |

**Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 3 (Continued)** | | | | | | |
| 3.2.b Cont'd. | Increase Immunization Rate in Adolescents and Adults | Increase the percent of patients assigned to Beacon primary care provider who have completed recommended immunizations - adolescents | DAI | Numerator: The number of patients assigned to Beacon primary care provider who receive the meningococcal vaccine (MCV) booster between their 16th and 18th birthdays | Year 4 - Increase percentage by at least 10% annually or a total goal of at least 50%. | Q4 2016 |
| | | | | Denominator: The number of patients assigned to Beacon primary care provider who turn 17 or 18 years old during the measurement period | Year 5 - Increase percentage by at least 10% annually or a total goal of at least 50%. | Q4 2017 |
| 3.3 | Asthma Influenza Vaccine | Increase the percent of patients assigned to Beacon primary care provider with a diagnosis of asthma who receive an annual influenza vaccination | Claims, Vaccine Registry | Baseline: 68% for Beacon patients | Year 3 - Increase percentage by at least 10% annually or a total goal of at least 90% | Q4 2015 |
| | | | | Numerator: Number of patients assigned to Beacon primary care provider with diagnosis of asthma who have a record of influenza immunization in the previous 12 months. | Year 4 - Increase percentage by at least 10% annually or a total goal of at least 90% | Q4 2016 |
| | | | | Denominator: Number of patients assigned to Beacon primary care provider with a diagnosis of asthma | Year 5 - Increase percentage by at least 10% annually or a total goal of at least 90% | Q4 2017 |
| 3.4 | Anemia in Children | Increase the percentage of children two years of age who had hemoglobin/hematocrit testing by their second birthday | Hybrid Measure - Claims Data and Chart Review | Baseline: 88% for Beacon patients | Year 3 - Increase percentage by at least 10% annually or a total goal of at least 98% | Q4 2015 |
| | | | | Numerator: Children assigned to Beacon primary care provider who turn two years of age during the measurement year with a hemoglobin and/or hematocrit test on or before the child's second birthday | Year 4 - Increase percentage by at least 10% annually or a total goal of at least 98% | Q4 2016 |
| | | | | Denominator: Children assigned to Beacon primary care provider who turn 2 years old during the measurement period | Year 5 - Increase percentage by at least 10% annually or a total goal of at least 98% | Q4 2017 |

**Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 3 (Continued)** | | | | | | |
| 3.5 | Patient/Family Experience Coordination of Care | Improve the patient/family experience Coordination of Care; "If your provider ordered labs/x-rays, or other studies, did someone call to follow up the results in a timely manner?" (Yes 90% of time) | Survey | Baseline: 68.2% for Beacon patients | Year 3 - Increase percentage by at least 10% annually, or a total goal of at least 80% | Q4 2015 |
| | | | | Numerator: Number of adolescent patients with two or more chronic conditions or one chronic condition at risk for a second that receive depression screening with a standardized tool. | Year 4 - Increase percentage by at least 10% annually, or a total goal of at least 80% | Q4 2016 |
| | | | | Denominator: Number of adolescent patients with two or more chronic conditions or one chronic condition at risk for a second in the measurement period. | Year 5 - Increase percentage by at least 10% annually, or a total goal of at least 80% | Q4 2017 |
| 3.6 | Establish Emergency Information Form (EIF) | Increase the percent of Beacon patients who have an Emergency Information Form for use by EMS and receiving health organizations | Medical Record Review | Baseline: 3% for Beacon patients | Year 3 - Increase percentage by at least 25% annually or a total goal of at least 90% | Q4 2015 |
| | | | | Numerator: Number of Beacon patients who have a Pediatric Information Form for EMS completed in a 12 month period | Year 4 - Increase percentage by at least 25% annually or a total goal of at least 90% | Q4 2016 |
| | | | | Denominator: Number of Beacon patients | Year 5 - Increase percentage by at least 25% annually or a total goal of at least 90% | Q4 2017 |
| 3.7 | Care Plan Development | Improve the number of Beacon patients who receive effective care coordination of healthcare services when needed | Medical Record Review | Baseline: 0% since "Health and Services computerized template is not completed" | Year 3 - Increase percentage by at least 30% annually or a total goal of at least 90% | Q4 2015 |
| | | | | Numerator: Number of eligible Beacon patients with a documented Health and Services care plan in the previous 13 months | Year 4 - Increase percentage by at least 30% annually or a total goal of at least 90% | Q4 2016 |
| | | | | Denominator: Number of eligible Beacon patients | Year 5 - Increase percentage by at least 30% annually or a total goal of at least 90% | Q4 2017 |

**Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 4** | | | | | | |
| 4.1 | ED utilization for asthma | X CMH ED visits with primary diagnosis of asthma/1,000 CMH patients with Kansas Medicaid and diagnosis of asthma | Report/EHR | Baseline rate 305/1,000 | Year 3 - 300/1,000 | Q4 2015 |
| | | | | Numerator: Number of CMH patients 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 | Year 4 - 2.5% decrease from baseline | Q4 2016 |
| | | | | Denominator - Number of CMH patients ages 2-17 who have had a diagnosis of asthma in the previous six months | Year 5 - 5% decrease from baseline | Q4 2017 |
| 4.2 | Decrease readmissions | 30 day all-cause readmission rate following hospitalization for patients with Kansas Medicaid | | Numerator: Number of CMH inpatient hospitalizations among Kansas Medicaid patients that occur within 30 days of admission to the hospital after an inpatient stay | Year 3 - Baseline data collection | Q4 2015 |
| | | | | | Year 4 - 1% decrease from baseline | Q4 2016 |
| | | | | Denominator: The number of Kansas Medicaid patients admitted to CMH that had an inpatient hospital stay during the evaluation period | Year 5 - 2% decrease from baseline | Q4 2017 |
| 4.3.a | 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:<br>*Height, weight, and body mass index (BMI) percentile documentation | EHR/Claims | **BMI** | Year 3 - 39.2% | Q4 2015 |
| | | | | Baseline 34.7% | Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment | Q4 2016 |
| | | | | National benchmark - 90th | | |
| | | | | Numerator: Number of patients 3-17 yoa who had height, weight, BMI documented during the measurement year. | Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment | Q4 2017 |
| | | | | Denominator: Number of patients 3-17 yoa | | |

**Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 4 (Continued)** | | | | | | |
| 4.3.b | 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:<br>*Counseling for nutrition | EHR/Claims | **Counseling for Nutrition** | Year 3 - 50% | Q4 2015 |
| | | | | Baseline 46.9% | Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition | Q4 2016 |
| | | | | National benchmark - 90th | | |
| | | | | Numerator: Number of patients 3-17 yoa who had nutritional counseling during the measurement year. | Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition | Q4 2017 |
| | | | | Denominator: Number of patients 3-17 yoa | | |
| 4.3.c | 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:<br>*Counseling for physical activity | EHR/Claims | **Counseling for Physical Activity** | Year 3 - 47% | Q4 2015 |
| | | | | Baseline 44% | Year 4 & Year 5 - 10% reduction each year in gap to goal in number of patients in targeted population will have documented Counseling for Physical Activity | Q4 2016 |
| | | | | National benchmark - 90th | | Q4 2017 |
| | | | | Numerator: Number of patients 3-17 yoa who had counseling for physical activity during the measurement year. | | |
| | | | | Denominator: Number of patients 3-17 yoa | | |
| 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 | EHR/Claims | Baseline: 51.6% | Year 3 - 55.9% | Q4 2015 |
| | | | | National benchmark- 90th | 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 | Q4 2016 |
| | | | | 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 | 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 | Q4 2017 |
| | | | | Denominator: The number of children 2-18 years of age who were diagnosed with pharyngitis and dispensed an antibiotic | | |

**Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)**

| Category | Measure | Metric | Data source | Baseline Performance Level (include numerator/denominator) | Target | Completion Date |
|---|---|---|---|---|---|---|
| **Category 4 (Continued)** | | | | | | |
| 4.5 | Lead Testing | Percentage of children with Kansas Medicaid who had an outpatient well-child visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday | EHR/Claims | Baseline: 42.7% of children age 2 yrs have at least one capillary of venous blood test<br>National benchmark - 90th | Year 3 - 45.7% of patients age 2 yoa have one or more blood lead tests | Q4 2015 |
| | | | | Numerator: Children who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday that have a well-child visit with a CMH Primary Care Physician. | Year 4 - 10% reduction in the gap to goal of lead screening rate in targeted population | Q4 2016 |
| | | | | Denominator: Children who turn 2 years old during the measurement period that have a well-child visit with a CMH Primary Care Physician | Year 5 - 10% reduction in the gap to goal of lead screening rate in targeted population | Q4 2017 |