Appendix A

Kansas Delivery System Reform Incentive Payment (DSRIP) Pool Evaluation

CMS-Approved Measures and Metrics

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.	TUKH	Number of community partners interested/Total potential partners 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	TUKH	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	TUKH	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	TUKH	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	TUKH	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	TUKH	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	TUKH	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	TUKH	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	TUKH	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 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 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 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 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 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 Long-Term Care Facilities Community Hospitals EMS	TUKH	Numerator: Number of facilities participating in sepsis initiative 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	TUKH	Numerator: Number of registered facilities entering data 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	TUKH	Numerator: Number of healthcare staff surveyed 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	TUKH	Numerator: Number of registered facilities entering data 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	TUKH	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	TUKH	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 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 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 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 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 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 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 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 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 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 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 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 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 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 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: * 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	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 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: *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: *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: *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 Q4 2016 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 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: *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: *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: *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 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