Illinois Department of Healthcare and Family Services
PCCM/DM Provider Network Subcommittee
Meeting Minutes for May 5, 2010

Attendees:

Margaret Kirkegaard, MD	AHS
Cari VonderHaar, RN	AHS
Michelle Maher	HFS
Vicky Hosey	HFS
Kathy Moles	HFS
Mary Miller	HFS
Amy Harris	HFS
Sharon Pittman	HFS
Sue Wickey	Loyola University
Kate McGovern	Loyola University
Kathleen Warnick	McKesson/YHP
Carrie Nelson, MD	McKesson/YHP
Allison Thomas	Take Care Health
Mike Cotton, MD	Meridian Health Plan
Marie Lindsey	ISAPN
LaDonna Brown-Miller	TCA
Vince Keenan	IAFP
Karen Fyalka	Litchfield FP
Pam Northrup	La Rabida
Daniel Perez, MD	private practitioner
Brad Kupferberg	Children's Memorial Hospital
Darin Jordan, MD	Central DuPage Hospital
Steve Stabile, MD	CCBHS
Kirit Bhatt, MD	private practitioner
Gerri Clark	DSCC
Mike Temporal, MD	SIHF
Katherine Matthews, MD	SIHF
Dr. Ross	SIHF
Tim McCurry, MD	Resurrection FM Residency
Erma Contreras	PrimeCare FQHC
Lisa Washington	Access Community Health Care

Dr. Kirkegaard chaired the meeting. Introductions and roll call were performed.

IHC Referral System

Dr. Kirkegaard noted that IHC Referral System had been implemented in the Central and Southern Regions on April 1, 2010. She noted that there had been a steady increase in call volume to the call center, mostly to change or confirm PCPs. AHS was working hard to manage the call center queue to assure that the wait times were as short as possible and all calls were

handled efficiently. She noted that the average queue times during March and April for all call lines (including English and Spanish) were less than one minute. She asked for any feedback. Dr. Stabile at CCBHS stated that he had noticed an uptick in the number of specialists requiring some sort of referral from the PCP. Dr. Kirkegaard responded that no referrals were required for patients to see a specialist but that good communication and coordination of care were essential features of the medical home and IHC was supportive of the idea of specialists asking for some sort of referral. She wondered if IHC could assist this process by creating a universal referral form that could be used optionally at this time until Phase II was implemented. No other providers responded about whether this would be useful. Pam Northrup from La Rabida noted that their site was having unique difficulties because they provided both primary care and specialty care and they were having difficulty securing referrals for the specialty care. Dr. Kirkegaard noted that there were approximately 100-200 IHC PCPs who actually had this type of dual status who were potentially impacted by the phased implementation of the referral system. She stated that HFS had not completely defined their policy about this dual status but in the meantime, all providers who are serving as IHC PCPs need to get a referral for any patient who is not currently listed on their panels regardless if the patient is seeking primary or specialty care. Dr. Kirkegaard offered to follow up with La Rabida for further discussion off-line. Dr. Bhatt also queried if referrals were required for specialty care and Dr. Kirkegaard confirmed that Phase I only required referrals if the patient was seen by another IHC PCP.

YHP Chart Reminder Project

Dr. Nelson, the medical director for Your Healthcare Plus, gave an overview of the current chart reminder project for chronic diseases. She noted that for several months, providers have been receiving notices to file in patients' chart that serve as a reminder for missing labs or treatments according to standard guidelines. These reminders are focused on CAD, CHF and diabetes. She noted that the overall project had been successful in increasing several metrics such as lipid testing, statin use and ACE/ARB prescribing. She also noted that these reminders may be helpful in identifying patients who had not filled their prescriptions since they were drawn from claims data. She added that YHP was expanding the chart reminder project to other chronic diseases such as COPD. She added that YHP and IHC had recently created a summary sheet for asthma guidelines that included information about billing and coding. This is currently posted on the IHC website at http://www.illinoishealthconnect.com/files/ProviderImportantNotices/HFS_Asthma_Billing_Guidelines_and_Education.pdf.

Dr. Perez stated that having reminders for non-compliant patients was useful but also questioned about whether these patients could ultimately be removed from the provider's panel roster. Dr. Nelson responded that engaging patients was indeed a difficult task but that YHP could support and assist the practice with finding patients and help encourage compliance. Dr. Perez thanked YHP for their help and indicated that the YHP assessment forms that were sent on each patient were too lengthy. Dr. Nelson agreed that the communication process was under review. Dr. Kirkegaard injected that the issue of patients who remain "non-engaged" (i.e. do not come into the medical home) had been discussed at several other subcommittee meetings in the past and that the consensus was to not create any policy for removing patients

until the referral system had been in place for several months and IHC and HFS could assess whether this helped to get patients to use their medical home.

Dr. Perez asked if some incentives could be created to stimulate patients to get recommended tests. Dr. Kirkegaard responded that any incentives that targeted the entire IHC patient population would be prohibitively expensive since the overall number of patients was 1.8 million. She also pointed out that the public perception was that patients were already getting "free" healthcare and should not be rewarded for using their "free" healthcare. Dr. Perez added that disincentives could be used such as limiting their benefits if patients continued to use the ED and not their medical home. Marie Lindsey also added that retaining non-compliant patients on the panel roster may create liability issues. Dr. Kirkegaard agreed that a full discussion of this topic was needed at future meetings.

YHP Outreach

Dr. Nelson indicated that YHP was working with a number of professional societies and sites and thanked all the participants for their collaborative spirit. She indicated that she was willing to travel to any part of the state to assist providers with understanding and using the YHP program to its full advantage for improving patient care. Kathleen Warnick added that YHP made every effort to outreach to patients and asked that providers who noted that patients were eligible for services could refer patients to YHP for additional assistance. She noted that YHP had nurses, social workers, lay community educators, and complex case managers and a number of other resources so that they could provide a "personal touch" to assisting with the coordination of patient care.

Vince Keenan from IAFP added that IAFP was contracted to provide CME to support the disease management components of YHP and that the educational curriculum was undergoing significant updates and would be re-launched later this month under a new learning management system. IAFP had already updated 4 of 8 CME modules and the others were scheduled for updating later this year. Mr. Keenan also drew attention to a recent article from Crain's Chicago Business that noted in FY 2009, the programs saved the state $320 million dollars. Dr. Nelson noted that such successes were not possible without the cooperation of the provider community and the collaborative efforts such as the Provider Network Subcommittee.

ED Care Coordination Discussion

Dr. Kirkegaard had prepared the following list of questions to be discussed by the subcommittee. Dr. Nelson led the discussion. The discussion answers are summarized below each question. Individual answers by each participant are not recorded here.

1) Are you contacted by the ED while the pt is present for consultation?
   A: usually not contacted unless a significant clinical issue or urgent issue is identified. Varies by hospital. Children's Memorial has a good system for prompt notification even for non-staff physicians.
2) What type of follow-up documentation would you receive from the treating ED in this scenario?

A: Communication varies. Would like to get diagnosis, testing results and medications prescribed at minimum. Very difficult to get records from certain hospitals.

3) For either of these questions, does being on the medical staff of the treating ED impact communization from the ED?
   A: Yes, more likely to get info from hospital where on staff. Useful if patient contacts PCP for instructions as to which hospital to go to first.
4) Assuming that you receive a treatment report from the ED within 3-4 days, what are you likely to do with the information?
   A: Depends on clinical severity. If an urgent issue (like abnormal CXR), then patient is contacted for follow-up but otherwise report is filed in the chart. One doctor reported trying to educate patients about appropriate ED use but none of the discussants indicated that they had a standard "script" or guidelines about the educational process.
5) What is your standard practice for reviewing the necessity of ED visits with patients?
   A: Only one site indicated that they had written information to give to patients about after-hours care. One physician noted that he indicates a recent ED visit in his problem list so that follow-up could be performed when the patient returned. Others agreed that any education is "very informal". Kathleen Warnick asked if querying patients about recent ED use was standard. Practitioners agreed that it was not standard.
6) How often are you able to identify that patient has used multiple EDs or had multiple ED visits?
   A: Very difficult to identify ED use in patients. Little communication from EDs.
7) What tools would be useful to enhance your knowledge of patients' ED use and your ability to educate them about appropriate ED use?
   A: Amount of ED use probably depends on patient's age and medical conditions. Providers did not seem to be aware that the IHC Panel Roster does indicate patients who meet the criteria for 6 or more ED visits in the past 12 months. Outreach by sites would depend on resources.
8) If YHP notified you about a pt's frequent ED use, what information would need to be included on the notification?
   A: specific information on a notification was not discussed.

The meeting was adjourned. The date for the next meeting was not set.