Illinois Department of Healthcare and Family Services PCCM Behavioral Health Subcommittee

Meeting Minutes for Nov 10, 2011

Attendees:

Margaret Kirkegaard, MD	AHS
Cari VonderHaar, RN	AHS
Vicky Hosey	HFS
Kathy Moles	HFS
Sharon Pittman	HFS
Michelle Maher	HFS
Wendie Medina	HFS
Vince Keenan	IAFP
Jayne Antonacci	DASA
Robert Baechle	DuPage Co HD
Toya Clay, MD	IL Doc Assist
Maria Devens, MD	UIC, Family Medicine
Jordan Litvak	DMH
Lori Good	Meridian Health Plan
Mike Naylor, MD	UIC, Closing the Gap
Rhonda Keck	DMH
Susan Routburg	Children's Memorial Hospital
Margaret Wiedmann, MD	IL Masonic
Marvin Lindsey	CBHCA

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

Illinois DocAssist

Dr. Toya Clay, the medical director for Illinois Doc Assist, was invited to attend the meeting to give an update on the program. She noted that IL DocAssist is in its fourth year and is funded by HFS. In the past, funding was also obtained from DMH and Children's Mental Health Partnership. She described the program as providing phone consultation to pediatric providers for assistance in management of child psychiatric issues. She added that the program now had 2 to 3 times the number of calls than 2 years ago and was now at approximately 100 calls per month. The program now employs the equivalent of 2 FTE psychiatric providers. Dr. Clay indicated that future plans were to try to regionalize the program so that assistance could be tailored to available resources. The NW region of the state was now covered by a pediatric psychiatrist in Rockford. They were also discussing hiring a psychiatric APN to assist in the southern region of the state through the El Dorado HD. Dr. Clay noted that their staff was very willing to travel and deliver educational workshops across the state and that she wanted to improve collaboration with IHC. Dr. Clay stated that the satisfaction was very high among the primary care providers who utilized the service. They strive to adhere to a biopsychosocial model of healthcare and are cautious prescribers of psychotropic medications. The program was working to develop flexible scripts that could be applied to behavioral health scenarios to empower primary care clinicians and help them develop communication and motivational interviewing skills. Dr. Devens emphasized that the program was extremely helpful to primary care physicians such as herself. There were no additional questions.

HFS Care Coordination Innovations Program

Michelle Maher, Bureau Chief for Managed Care at HFS, reported on this agenda item. She started by noting that the health care reform law passed in January of 2011 required 50% of all patients to be enrolled in systems of care coordination by 2015. While Managed Care Organizations (MCOs) are regarded as examples of care coordination systems, she noted that HFS was seeking more innovative solutions and asking providers to create entities for care coordination that did not involve an MCO as an intermediary. She added that would ensure more choice for clients, and allow clients to keep their current provider networks and encourage more collaborative care among existing providers.

HFS will create a solicitation describing in more detail the requirements for these Care Coordination Entities (CCE) by Jan 2012. Ms. Maher added that, at a minimum, the CCEs will include hospital care, primary care and behavioral health. She continued that the CCEs will have 3 years and then be expected to transition to a more risk-based entity similar to the Managed Care Community Network (MCCN). She explained that the MCCN is a health care delivery system unique to Illinois, which is a provider sponsored full-risk model for Medicaid only. In the beginning of the program, the CCEs will receive a care management fee based on the proposed scope of care coordination activities and that every CCE would be different depending on the proposal. Ms. Maher noted that any of the three components could be a lead agency and this will drive collaboration between the existing mental health system and primary care and hospital care. Dr. Kirkegaard asked if HFS expected the behavioral health components to be delivered through the public mental health system and Ms. Maher responded that HFS expected that existing providers would likely provide the majority of care in the CCEs. Jordan Litvak asked if there was a minimum number of patients enrolled in the CCEs. Ms. Maher responded that the minimum number was 500 patients in a priority population including seniors and adult with disabilities and dual eligibles. Mr. Litvak also asked if HFS expected there to be one provider or more than one provider in each CCE. Ms. Maher stated that 500 patients was the minimum but, in fact, they expected most CCEs to be much larger and have multiple providers. There would also be an opportunity to include the healthier family members in the CCEs along with the patients in the target population. Mr. Litvak clarified if the CCEs would propose the care management fees and Ms. Maher agreed and also added that the patients in the CCEs would remain in IHC and that the PCPs would continue to receive the IHC care management fees in addition to any care coordination fees paid through the CCEs. Ms. Maher said that this was an enhanced medical home initiative. Ms. Maher noted that HFS had collected questions based on the presentation Oct 13 and were preparing written responses. Additional materials are available on the HFS website at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx

Marvin Lindsey asked Ms. Maher to clarify the requirement for CCEs to have an EMR. He asked if this was an “EMR” or an “EHR” noting that an EHR generally communicated across different provider types whereas EMRs were usually limited to medical providers. Ms. Maher noted that the details of the solicitation were under development and thought that initially CCEs may not have to have a shared EHR but that some sort of communication vehicle was necessary to ensure care coordination. Mr. Lindsey added that he was happy that HFS had included mental health and substance abuse as key components of the CCEs.

Mike Naylor, MD, asked if HFS was collaborating with DCFS since this patient population had high behavioral health morbidity. Ms. Maher agreed that care coordination would be beneficial for DCFS children but also noted that federal regulations prevented those children from being mandatorily enrolled in any managed care program. She added that more talks were underway with DCFS and that children could voluntarily enroll in the CCEs.

Closing the Gap

Dr. Mike Naylor from UIC was invited to provide an overview of this initiative. He stated that the program began with the Illinois Council of Child and Adolescent Psychiatry and hosting a conference last June to examine existing relationship between primary care and child behavioral health and determine how better integration could be facilitated. He noted that many current providers and agencies were represented at the meeting including HFS, DMH, DCFS, Illinois Psychiatric Society, IL Academy of Family Physicians, Illinois Chapter of AAP, and the Illinois Children's Healthcare Foundation. He explained that they invited Reed Sulig, MD, from MN to speak on the successful integration of behavioral health and primary care in MN Medicaid. The group divided into four workgroups to consider additional questions and created a report. (Dr. Naylor subsequently submitted the report to be included with the distribution of the minutes.) He noted that a follow up meeting was held a few weeks ago and two workgroups were formed to further the work from the initial conference focusing on educational interventions and links to existing programs. Dr. Kirkegaard asked what the structure was for sustainability of the initiative. Dr. Naylor agreed that the grant was limited to hosting a conference and
a few follow up meetings and that sustainability would be a challenge. Dr. Kirkegaard noted that the CCE program offered a potential opportunity for better integration of behavioral health and primary care and that children with serious mental health issues might be an important component of some of the CCEs. Dr. Naylor agreed that this would be a great opportunity and also emphasized again that collaboration with DCFS was important.

IHC Updates

Dr. Kirkegaard informed the group that IHC had created a 6 min educational video for clients. While the content was specific to IHC, the video provides a great overview of the medical home concept and encourages continuity of care and appropriate ED use. Dr. Devens asked if FQHCs knew about the video. Dr. Kirkegaard stated that IHC has worked hard to promote the video to all participating PCPs and also
to agencies that work with IHC clients. She encouraged all participants on the call to review the video and share with colleagues.

Dr. Kirkegaard also reviewed the Claims History that is available through the IHC Provider Portal and contains 2 years of claims data for every current HFS client including clients who are currently excluded from IHC. She noted that due to recent changes in the IL confidentiality statutes, the IHC Claims History now contained psychiatric information and she provided an example to the group for review.

Dr. Kirkegaard noted that DMH had given a webinar for IHC PCPs last May on the public mental health system and that DASA was scheduled to do a webinar in Feb 2012. Dr. Kirkegaard noted that IHC was eager to create more collaboration between DMH/DASA and IHC PCPs. Marvin Lindsey asked what educational efforts had been undertaken to assist PCPs in understanding the DMH services. Dr. Kirkegaard said that IHC had worked to inform PCP s about available services. IHC has also created a new resources handout that will be distributed to all PCPs starting in January. The IHC Handbook also contains information and IHC was developing a one-pager that was awaiting HFS approval about DMH/DASA to distribute to PCPs and blast fax and email. Dr. Kirkegaard noted that many PCPs still had misconceptions about the DMH services that the education was an ongoing challenge. There were no additional questions.

Dr. Kirkegaard thanked the group for attending and giving input.
The next Behavioral Health Subcommittee Advisory meeting is scheduled for May 2, 2012 at 12 noon.