ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES PCCM QUALITY MANAGEMENT SUBCOMMITTEE

MEETING MINUTES FOR WEDNESDAY, JULY 13, 2011

*** Save the Date: Next meeting scheduled for October 12, 2011 12 noon-1pm***

Attendees:

Cari VonderHaar, RN	Quality Manager, AHS
Margaret Kirkegaard, MD	Medical Director, AHS
Rannie Kloud, RN	QA Nurse, AHS
Amy Calvin, RN	QA Nurse, AHS
Mary Morrissey, RN	QA Nurse, AHS
Dr Nand, MD	Hospitalist, Chicago
Juanona Brewster	ICAAP
Rachel Sacks	ICAAP
Julie Garcia	VNA Health Center
Holly Nelson	Swedish American
Vicky Hosey	HFS
Kathy Moles	HFS
Michelle Maher	HFS
Gwen Smith	HFS/CHIPRA
Judy King	Independent
Jeannie Lewis	ILMCHC
Bob Urso	PCC Wellness
Barb Hay	Family Health Network
Heather Scalia	Meridian HP
Dr Dodda, MD	Family Practice
Dr Yabut, MD	Private Practice
Dr Wayne Franklin	Private Practice
Dr Silvany	Private Practice
Rajesh Parikh	IPHCA

Cari VonderHaar chaired the meeting and opened with a welcome and thank you to all for their participation in today's meeting.

2010BonusProgram:Updates:
Cari reported that the data process is complete for the 2010 Bonus Payment Program for High Performance. The information has been loaded under the Provider Portal for providers to view. The process for check printing is almost completed and mailing will begin within the next few days. 5,581 bonus checks will be mailed out, with the payment of $25 per measure.

Dr Nand asked if under the breast cancer screening measure, should there be a change to the beginning age from 40 to 50 years for mammograms? Dr Kirkegaard posed the question if national guidelines changed or rather recommendations that routine mammogram screening for ages 40-50 years may not be necessary. Discussion followed, with Dr Yabut reporting that the American Cancer Institute statement is that they are still looking at 2009 breast cancer task force guidelines, while the American Cancer Society goes by guidelines as originally recommended. Dr Kirkegaard recognized that this is an area under national scrutiny and review. She proposed a task force review and discuss further recommendations, and that the task force be a group of individuals from the QM Subcommittee. Drs Nand, Yabut, and Dodda agreed to be on the task force. Dr Kirkegaard thanked them and reported she would be in contact with them per email to organize further discussion on this subject.
Dr Nand did ask what impact patient refusal for a service, for example a mammogram, would have on a bonus measure rates for a provider. Dr Kirkegaard responded that IHC understands a patient may refuse no matter the degree of excellent education and outreach a provider may conduct. She went on to say that the bonus measure rates are formulated from claims data, and benchmarks are set to allow for a reasonable rate of patient refusal.

Dr Nand asked if there were plans to add any other quality indicators for review? Dr Kirkegaard replied that with the Fall 2011 Provider Profiles, plans are underway for adult preventive care and ED utilization measures to be added. Also, lead screening was added as a bonus measure for the current 2011 calendar year.

QualityAssuranceNurseWebinars: TopicsforJuly,August,September:
Cari reported that the Quality Assurance Nurse hosted webinars continue to be conducted two times per month, and topics being looked at the for the next quarter include EPSDT services, Bonus Payment Program, and Breast Cancer Screening.

VisionScreeningKits:DiscussionofInitiative:
Juanona Brewster and Rachel Sacks from ICAAP then led the discussion regarding a new initiative. They reported that they, along with IHC and HFS, are currently involved with a pilot program to address vision screening in the three to six year old population. The screening is meant to be conducted along with the well child visit. ICAAP is now in the process of seeking “trainers” for the vision kits to assist provider sites that agree to be part of the pilot program, and stated there has been a high level of interest so far. The kits would be offered at no charge to the provider sites that participate. There will be a total of 250 kits available, and IHC plans to be involved with distribution to provider sites once the site “trainers” complete the required training, most likely through webinar format. Dr Kirkegaard added that for the pilot program, they would like to involve provider sites with a high volume of pediatric patients in the age group noted. Dr Yabut asked if providers with low vision rates should also be considered with the pilot. Dr Yabut also asked if there were any changes with this compared to the American Academy of Pediatrics or HFS guidelines for screening? Juanona replied there were not different guidelines involved, but that the kits are an actual tool to utilize and assist the provider with conducting the recommended screening per Bright Futures. Rachel added that the tool addresses any possible issues the child may have with articulation as it utilizes symbols, as a type of modified Snellen.

Dr Yabut asked if CME offering could be considered for those providers completing the vision kit training. Dr Kirkegaard stated she would follow up on this with ICAAP.

Judy King posed the discussion item if eye exams for adults with diabetes have been looked at as this population group has a low rate of receiving vision exams. Dr Kirkegaard commented that this aspect of care for adult diabetics was not being monitored by IHC, however, there is a marker on the IHC provider panel roster that identifies patients which meet the diabetes indicator criteria.
Dr Nand commented that perhaps chronic disease populations could be monitored in the future, including CHF and COPD for examples.

CervicalCancerScreening:
Dr Kirkegaard reported back from the Pap Task Force that formed from the QM Subcommittee, which followed the April, 2010 QM Subcommittee Advisory meeting.

She reported that clinically, yearly pap tests are not recommended, but as always, is per provider discretion regarding national recommendations and guidelines. The Task Force proposes the recommendation to update panel roster and provider profile criteria to go along with the ACOG recommendation of routine pap testing every three years. Judy King then asked when the Task Force met, and who served on the Task Force. She was referred to the past QM Subcommittee Meeting minutes for these details on Task Force formation. Ms King also stated that it should be considered as to the population that needs the screening is being reached. Dr Kirkegaard stated that recommendations are to help with clinical guidelines are never meant to trump clinical judgement. IHC assists providers with utilizing outreach tools to increase patient access to services. Details involving race, geography, and age subpopulations would need to be requested directly to HFS. Dr Kirkegaard commented that the discussion points were all good points for consideration.

PediatricSpecialtyClinicReferrals:CookCounty:
Dr Kirkegaard informed the Subcommittee members of a web based system called IRIS, which is the Internet Referral Information System, that assists with scheduling pediatric specialty care in Cook County. Thirty-four providers are utilizing to date. Information is relayed back to the medical home and primary care provider on the specialty care scheduled, with the medical home being responsible to monitor the follow up as needed. The patient can be connected directly through an operator to schedule their specialty appointment or the medical home can assist. IHC staff is also able to utilize the IRIS system to assist. Judy King asked what type of referral information is obtained and what types of specialty clinics are being requested. Dr Kirkegaard replied that IHC does track requests for types of specialty to assist with access to specialty care. As with statewide request data shows, providers for mental health and surgical care requests are high, but an array of specialty clinic types are requested. Dr Silvany said his practice has the IRIS system installed and works well, but as some of his patients do not wish to go to Cook County for care. He wondered if other hospital and specialty care clinics could be offered as well, such as academic health centers. Dr Kirkegaard voiced her agreement, and different approaches are being looked at statewide, including the IRIS model.

PanelRosters: LastPCPvisitandDMcriteria:
Dr Kirkegaard reported that the provider panel rosters are intended to be a valuable tool for PCP offices to utilize, including sorting for patient outreach. Flags or “markers” are included, for example, to

designate frequent ED users. In addition, the last PCP visit information and diabetes criteria have recently been added. It is realized that the data provided has limitations since based on claims data, but as with the PCP visit, there is value with the patients seeing one clinician. This provides a base for continuity of practice and identification of a relationship with one main provider. Outreach can be done if no PCP visit is listed for the patient to access care as well.

With no further business, the meeting adjourned.

The next QM Subcommittee Advisory meeting is scheduled for October 12, 2011 at 12 noon.