Illinois Department of Healthcare and Family Services
PCCM Respiratory Health Advisory Subcommittee
Meeting Minutes for January 18, 2007

Participants

Jay Shannon
Ted Naureckas
Maureen Damitz
Amy Miller
Dawn McCullough
Jennifer Fabian
De Shauna (Sinai person)
Karen Malamut

HFS

Mary Miller

McKesson

Maureen Mangotich
Caryn Jacobi
Art Sprenkle

House Keeping

The meeting was a Web-Ex and the participants were asked to evaluate it through the process and make recommendations regarding their perceptions at the end of the meeting.

The members were reminded that certain information shared in these meetings was proprietary and that it should remain confidential among the meeting participants. .***ACTION REQUIRED: send NDA (nondisclosure document) to all meeting participants***

The meeting time was also discussed. It was explained that through polling of the members this was the best time to get the greatest participation, especially among the clinicians. It also was explained that this time did not work well for a number of members. ***ACTION REQUIRED: it was agreed that holding the meeting at 4:00 would work for most of the clinicians and that is what will be suggested for the next meeting.***

Introductions

The participants introduced themselves

IDPH Asthma Pilot Update

Blank gave a summary update of the 7 IDPH pilots that were underway. The pilots ranged from having a maximum of 41 enrolled (Sinai) to one not yet having started enrollment (Rockford) and everything in between. A process has been established that links the pilots and their staff with the YHP program staff and referrals between the programs are taking place. Unfortunately very few referrals from the YHP program to the IDHP pilots have taken place to date. One reason for this is that the YHP patients need to be evaluated before they are referred. ***ACTION REQIURED: Dr. Sprenkle will explore a more accelerated approach that might result in a higher rate of referrals*** It was disclosed that IDPH hopes to extend the pilots 18 months beyond the scheduled June of 2007 end date so that new members could be enrolled through June of 2008 with the program ending in December of that year.

Meeting Content

The remainder of the meeting was spent reviewing information related to the performance of the program to date specifically with respect to the asthmatic enrollment and eligibility and the characteristics of the asthmatic population assessed to date.

Enrollment and Assessment

In summary related to enrollment and assessment: The entire program population including all conditions is risk stratified. The asthma component is included with the other conditions like diabetes and heart disease. SLIDE 1 shows the breakdown of the current total enrolled population. Of the total, one third (68,900) are the persistent asthmatics. SLIDE 2 shows that of the 99,198 non-institutionalized adults, 12,847 have asthma which represents 13% of the total population. Of these, 299 are listed as High, 8,237 as Moderate and 4,311 as Low Risk. High are managed by case managers. Moderate by the DM nurses and Low receive mailings of program materials and an IVR assessment. If they are identified as being at higher risk through the IVR they will receive an assessment by a nurse. All 299 High risks have been evaluated and are in the program. As of December 31, 2006, most of the Moderate risk were still being pursued for assessment. SLIDE 3 shows the breakdown of the Persistent Asthma component of the program. 80% or 55,139 of the total PA population have been stratified. Of those, 241 are High risk and they are all actively involved in the program. 2,352 are moderate risk and most of those are currently being sought for assessment. As of mid-December 2006, 872 Disabled asthmatics had been assessed and 521 Persistent Asthmatics. SLIDE 4 shows the Intervention Profile of the entire program as of December 31. A total of 4,468 patients have been assessed and are under active management.

Related to the enrollment numbers there were two questions from the advisory board members. One was whether the Frequent ER User classification supersedes the asthma management aspect or not. The other was what mechanism there is within the program to deal with patients who will not or cannot be evaluated through the IVR process. It was stated that there is a procedure to deal with this and that we would get back with the details. ***ACTION REQUIRED***: ***Caryn Jacobi will get back to the group on the default process for failing the IVR process and on the ER prioritization impact on the asthma program.***

Program Participant Characteristics

Every patient who has an assessment has the details of the assessment recorded. This information is available in a database and Dr. Sprenkle presented a summary of a number of these data elements. The details of this information are contained in the attached PowerPoint presentation. Some of the findings included: 1) Gender distribution: The normal male prevalence was seen in the <5 age category, but over age 20 almost all the patients were female. Although the over age 20 population represents predominantly the Disabled population there are also family members of the Persistent Asthma in that group as well. It was suggested by one of the board members that this might represent an inherent gender bias in how individuals actually become eligible for the Disabled Adult benefit. 2) Co-morbidities: the assessed population has a high incidence of reported GERD symptoms (over 50% for those over the age of 19). Dr. Naureckas is currently involved with an acid stimulation study that is attempting to define the prevalence of GERD in the asthma population. ***ACTION REQUIRED: Attempt to link up current study results when available with patient-reported GERD symptoms in program population.*** Approximately one third of those over 19 admit to still smoking and approximately 50% of that same group have passive smoke exposure. Approximately 50% of the Disabled and 30% of the PA population have the current diagnosis of depression. Approximately 25% of the PA population said they had written asthma action plans whereas less than 10% of the Disabled population did. 3) Distribution by catchment area: The persistent asthma population who have been assessed was broken down by catchment area and although the largest number (65) of enrollees was in one Cook County area, most of them were not from in and around Chicago. This breakdown was not presented for the disabled asthmatic population. ***ACTION REQUIRED: perform breakdown by catchment of Disabled population and redistribute ZIP list by catchment area.*** The advisory group members expressed a great deal of interest in the characteristics of the population as reported through the assessments. ***ACTION REQUIRED: Provide members of the advisory board fields available in patient data set. Explore possibly making more information available to academic institutions for research purposes.***

Other important observations and requests were made by the advisory board members. One was to see if we could correlate the patients' self-reported through nurse interview severity score with their medications. Another was to correlate this specifically with their use of beta-agonists. It was pointed out that the claims-based reports at this time are not part of the data-set so we could not do a number of the suggested analyses without more data. ***ACTION REQUIRED: attempt to correlate self reported severity with medication fill history.*** Another interesting question was raised related to the number of

different physicians a patient sees, not just the number of scheduled visits themselves. ***ACTION REQIRED: attempt to get a report that shows number of different physicians a member sees for primary care routine care.***

MEETING CONCLUSION

The meeting ended on schedule. There seemed to be consensus that Web-Ex was a good format for the meeting and probably allowed for greater participation than would be possible otherwise. It was agreed that we would try to hold the next meeting at 4:00 to hopefully also allow the greatest number to participate.