Illinois Department of Healthcare and Family Services
PCCM / DM Maternal and Child Health Subcommittee
Minutes for Monday, April 9, 2007

Attendees:

Margaret Kirkegaard, MD, MPH, Chair, Medical Director for Automated Health Systems
Debby Saunders, Bureau Chief, Maternal and Child Health Promotion, Healthcare and Family Services
Vince Keenan, EVP Illinois Academy of Family Physicians (IAFP)
Kelly Carter, COO Illinois Primary Health Care Association
Scott Allen, EVP Illinois Chapter of American Academy of Pediatrics
Amy Harris, Healthcare and Family Services
Mary Miller, Healthcare and Family Services
Helen Baldoni, Quality Nurse, AHS
Jody Bierzychudek, Quality Manager for Illinois Health Connect, AHS
Kathleen Ludikowski, Nurse Practitioner
Stephanie Altman, Health and Disability Advocates
Steve Stabile, MD, Cook County
Steve Saunders, MD, MPH, Medical Advisor for Healthcare and Family Services
Fred Hanks, VP of Operations, AHS
Angela Plunkett, Training Specialist, AHS
Tiy Smith, Access Community Health Network
Marilyn Scott, NP, Prime Care
Darla Soleto, Quality Manager, AHS (Pittsburgh)

I. Overview of Illinois Health Connect operations to date

Dr. Kirkegaard chaired the meeting. She provided an overview of Illinois Health Connect (IHC) provider enrollment. The following statistics were shared:

Progress Enrolling Doctors & Clients by Region 4-5-07

Region	Clients/Recipient Count	PCP Count	PCP Panel Slots Capacity
Cook	831,8508	1,660	2,324,133
Collar	261,109	770	520,451
Northwest	181,358	388	302,090
Central	167,421	83	201,979
Southern	168,332	77	321,897
IA	0	12	23,830
IN	0	12	13,500
MO	0	3	13,275
Total	**1,610,070**	**3,005**	**3,721,155**

Dr. Kirkegaard noted that FQHCs are represented as individual PCPs on this chart and explained that physician recruitment was ongoing especially in the NW, Central and Southern Regions where client enrollment has not started yet. Dr. Kirkegaard also noted that whenever a client calls and requests a PCP who has not enrolled, our provider relations staff contacts that physician and attempts to enroll him or her. Dr. Kirkegaard asked for any help or suggestions for strategies to improve provider recruitment.

Dr. Kirkegaard reviewed client enrollment. The following statistics were shared:

Client Enrollment 4-5-07

Clients Enrolled (Voluntary)	67,056
Clients Enrolled (Mandatory)	127,847
Clients Enrolled-MCO(Mandatory)	129,027

Voluntary Client enrollment refers to clients enrolled in FQHCs throughout the state, Mandatory client enrollment refers to clients who are in Cook and the Collar Counties who are now part of the mandatory phase and Clients enrolled in MCOs refers to clients who are in Cook and the Collar counties who are part of the mandatory phase who have chosen an MCO as a medical home.

Dr. Stabile asked if the voluntary enrollment statistics included patients enrolled at the CCBHS. Dr. Kirkegaard and Amy Harris believed that it did but were uncertain. (Follow-up- yes, CCBHS enrollments are included). Dr. Stabile commented that the client enrollment website seemed easy to navigate but was unable to access a directory of PCPs without an actual patient's RIN. He questioned whether a PCP directory was available. Dr. Kirkegaard explained that no comprehensive directory was publicly available to protect physician privacy. Dr. Kirkegaard explained that a directory of available PCPs is sent to clients who are unable to make a definitive PCP choice on the phone or via the website request a directory. Kelly Carter asked what criteria were used to select the 10 PCPs. Dr. Kirkegaard explained that the PCPs were selected based on the ages of the clients, and the PCP specialties or other qualities requested by the clients. Fred Hanks clarified that the list was created by selecting the 10 PCPs matching the requested selection criteria who were closest to the client's address.

Stephanie Altman noted that there was confusion among clients about the HMOs and that clients thought that Illinois Health Connect was an HMO. Dr. Kirkegaard explained that in Cook County, all clients must be educated on all options. Dr. Stabile inquired which HMO programs were available. Dr. Kirkegaard responded that Harmony and Family Health Network were available in Cook County. Tiy Smith reported that Harmony appeared to be directly marketing to clients, which is prohibited. Amy Harris requested that any specific instances of suspected direct marketing be reported to her.

II. EPSDT Support Service Available through AHS

Fred Hanks gave an overview of all the EPSDT related support services provided to PCPs by AHS. He noted that AHS has been assisting with this type of service in five states since 1976. Services include: client outreach, appointment scheduling, tracking,

periodicity schedule, panel rosters, provider profiles, and providing information on Vaccines for Children Program (VFC) program. Marilyn Scott asked if HFS recommended objective developmental screening at every well-child visit. Debby Saunders explained the subjective developmental surveillance was recommended at every visit. Objective developmental screening with a validated tool was recommended by the American Acedmy of Pediatrics at 9, 18 and 36 months or at any time the clinician was concerned. Debby Saunders also noted that HFS reimburses providers for performing an objective developmental screening using a validated tool as acceptable to HFS, as long as it is properly coded and recorded in the patient's chart. (This activity is included in the FQHC or RHC encounter rate so no additional amount is available to the cost based reimbursed providers.) A list of the accepted validated tools can be found in the Healthy Kids Handbook Chapter 200 on the HFS website. Debby Saunders commented that FHQCs must detail this activity and all other procedures performed at the visit on their claim form submitted to HFS. Scott Allen noted that the ICAAP does office-based training on how to use these tools. Vince Keenan noted that www.iafp.com also has web-based CME modules that cover well child screening and coding.

Tiy Smith inquired when the provider profiles would be sent to PCPs. Dr. Kirkegaard clarified that Panel Rosters with EPSDT indicators would be sent monthly and were available on-line 24/7. Provider profiles that measured performance on basic care indicators such as immunizations and vision screening would be sent semi-annually and start at a later date.

Darla Soleto continued to explain what AHS has done in Pennsylvania to support PCPs and their efforts to provide EPSDT services. She stated that training materials about topics such as age-appropriate behavior and milestones, tools concerning lead exposure and TB exposure risks, and vaccination schedules were distributed. Dr. Kirkegaard indicated that no chart audits are planned however, data regarding topics needing additional education will be derived from the quality assessments explained in the Quality Plan and the provider profiles.

Debby Saunders added that precise coding, even in encounter rate clinics, was crucial to accurate assessment of quality and obtaining any financial pay-for-performance bonuses. Dr. Kirkegaard inquired if IPHCA would be willing to help educate the FQHCs about this and Kelly Carter agreed to discuss this with Dr. Kirkegaard and Debby Saunders (relative to MCH preventive services) at a later date.

III. Review of Panel Rosters

A sample panel roster with mock data was sent to MCH Subcommittee members to review. Steve Saunders asked if the panel rosters should contain immunization data. Fred Hanks responded that 7 years of immunization data would be available online through the paid claims data as soon as the security systems for protecting patient privacy had been implemented. He noted that including immunization data on the panel rosters would likely double or triple the size of the rosters.

The panel rosters will be sent of PCPs each month. The first set of rosters was sent at the end of March and the next set will be sent in mid-April. They are also available on the web 24/7 in a pdf format. AHS is working on the programming necessary to make the rosters available in an Excel format so that groups would be able to download several panel rosters and combine them into one master panel roster.

Debby Saunders inquired if there would be training about how to access the panel rosters and recommended web based training. Dr. Kirkegaard responded that the Provider Service Representatives were available to assist all PCPs with web access. Monthly "Webinars" are now scheduled to also help PCPs and office staff learn more about the operations of Illinois Health Connect.

IV. HEDIS Lead Screening Indicator

The members of the MCH Subcommittee were given a copy of the newly proposed HEDIS Lead Screening Indicator which outlines the requirement for one blood lead level before age 12 months and a second blood lead level screening test between age 12 months and 24 months. Debby Saunders noted that leads screening was not included on the panel rosters currently. Fred Hanks responded that it would be included in the paid claims data. Debby Saunders also noted that there were other databases that might be used for lead screening tracking through the IDPH. She also added that since the blood lead samples are analyzed through the IDPH, providers are allowed to draw the blood and charge for the blood draw whereas providers are not generally allowed to charge for blood samples that are drawn at one facility and analyzed at a separate facility. Tiy Smith inquired if the current lead tracking was accurate since they had noted several discrepancies in their patient population. Debby Saunders agreed to investigate if specific information were obtained from the providers

Scott Allen noted that some of the children who are currently insured through the All Kids program are not technically part of the at-risk population identified by HEDIS (lower SES children on Medicaid) and that screening with a blood lead level might not be appropriate. Dr. Saunders responded that this was likely a very small percentage of the overall population of children. Dr. Stabile noted the HEDIS measure assessed whether the blood lead level had been drawn by age 12 months. He noted that it was standard clinical practice to order the blood lead level at the 12 month visit and wondered if a "grace period" should be allowed. Dr. Kirkegaard responded that initially the indicator for lead screening developed by the Quality Management Subcommittee for Illinois Health Connect had contained a 2 month "grace period' and measured the percentage of kids who received a blood lead level by age 14 months. However, since HEDIS had released this standardized measure, the Quality Management Subcommittee was committed to using HEDIS measures whenever possible to standardize data collection for comparison purposes between various care plans and even between states. Dr. Stabile noted that meeting this measure would then involve a clinical shift to ordering the lead level at the 9 month visit especially since some immunizations cannot be given before 12 months of age and a blood lead level after12 months of age would not meet the standard.

V. Review of Vaccines for Children (VFC) Policy

Dr, Kirkegaard reviewed that initially participation in the VFC program was a requirement for becoming a PCP in Illinois Health Connect. However, many providers noted that this was an onerous requirement and redundant to services provided by others in the community such as the health departments. The requirement for participation was dropped but PCPs do need to indicate that they have a relationship with a VFC site and that they obtain records of the immunizations. Dr Kirkegaard reported that only approximately 45% of the PCPs participate in the VFC program. AHS gives each provider a summary sheet about VFC (which was provided to the Subcommittee prior to the meeting) and plans to increase educational efforts about enrolling in VFC. Dr. Saunders requested that contact information about VFC be included on any additional VFC materials. Debby Saunders noted that IDPH had a notice about the VFC and administrative fees for each vaccine and would try to provide this to the MCH Subcommittee in the minutes. (add here) Dr. Saunders suggested that IAFP and ICAAP would also be excellent partners in promoting the VFC program. Scott Allen commented that ICAAP has done this in the past and would be willing to help on any VFC educational program

The time for the next MCH Subcommittee has not been scheduled. Members will be notified via email prior to the meeting.