ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

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Quality Subcommittee of the
Medicaid Advisory Committee

James R. Thompson Center
100 W. Randolph
2nd Floor 2025
Chicago, IL

And

201 South Grand Avenue East
1st Floor Video Conference room
Springfield, Illinois

Conference Call
1-888-494-4032
7218869057#

August 8, 2017
10 a.m. – 12 p.m.

Agenda

I. Call to Order

II. Introductions

III. Approval of June 6, 2017 Meeting Minutes

IV. Old Business

V. Update on Diabetes Affinity Project

VI. New Business

a. Discuss Recommendations for Children's Special Healthcare Needs

VII. Other Business

VIII. Adjournment

Next Meeting Date: October 10, 2017

Illinois Department of Healthcare and Family Services
Quality Care Subcommittee June 6, 2017

Members Present

Ann Lundy, Chair, ACCESS Community Health
Kathy Chan, Cook County Health and Hospitals System
Jennifer Cartland, Lurie Children's Hospital
Barrett Hatches, Chicago Family Health Center
Dr. Krishna Das, Cook County Health and Hospitals System
Dr. Edward Pont, ICAAP
Dr. Alvia Siddiqi, Advocate Physician Partners (by phone)

Members Absent
Margaret Kirkegaard, Illinois Academy of Family Physicians

HFS Staff Present
Arvind K. Goyal
Kyle Daniels
Catina Latham
Sylvia Riperton-Lewis

Interested Parties
Greg Johnson, ISDS
Jill Hayden, Meridian Health Plan
Jordan Powell, IPHCA
Ken Ryan, ISMS
Ninos David, Next Level
Laurel Chadde, County Care
Nicole Kazee, Erie Family Health
Josh Keokuluy, HFS
Mike Holmes, Sunosion
Ollie Idowu, Harmony
Dan Coleman, Merck
Manjort Cam, FHN
Jennie Prohontz, ICAAP
Michael Lafond, Abbuie
Marie Daker, Harmoney
Ralph Schubert, UIC Division of Specialized Care for Children
Cyrus Winnett, IAMHP
Dionne Harvey, DQ
Cheri Hoots, IPHCA
Mona Vankaugen, IDPH
Caitlin Lueck, Meridian
Kim Burke, LCHD
Carol Leonard, Denta Quest
Anna Wojcik, UI Health
Sandy DeLeon, Ounce of Prevention
Karen Malamot, Merck
Kathleen Shanahan, CCAI
Brandi Calvert, AFL
Phil Mortes, Gilead
Lynn Seermon, Kaiser Health
Anna Carvallo, La Rabrida

Meeting Minutes

I. **Call to Order:** The regular bi-monthly meeting of the Medicaid Advisory Committee Quality Care Subcommittee was called to order June 6, 2017 10:00 a.m. by chair Ann Lundy. A quorum was established.

II. **Introductions:** Quality Care subcommittee members, HFS staff, and interested parties were introduced in Chicago, Springfield, and over the phone.

Illinois Department of Healthcare and Family Services
Quality Care Subcommittee June 6, 2017

III. **Approval of March 21, 2016 Meeting Minutes:** Ann Lundy led a discussion on the March meeting minutes. Ann Lundy made a motion to approve the March meeting minutes. This motion was seconded and approved.

New Business: Ann Lundy introduced the newest member to the Quality Subcommittee, Dr. Krishna Das. She also reiterated that the purpose of this committee is to provide recommendations around quality for the Medicaid program's vulnerable population, sharing lessons learned from best practices. She stated that sometimes these best practices may be outside of our borders so to speak, i.e. different states or different systems. The Subcommittee's role is to review and discuss approaches for improving quality and then provide recommendations to the Department. In addition, it is the Subcommittee's role to support the Department's transformation to value based care. Ms. Lundy closed by stating that the Subcommittee is a partner with the Department in its challenge to increase quality and the access to care for the Medicaid populations and at the same time lowering cost. This is the Subcommittee's core set of principles.

Overview of HFS Metrics: Catina Latham and Sylvia Riperton-Lewis provided an overview of the quality metrics for HFS. They noted that at one point HFS had over 100 health measures from multiple sources. The Department worked to streamline the measures to less to 25 with the goal of making sure that all of the measures were standardized and comparable across the managed care organizations in the state and around the nation. As a result of that standardization, the Department was able to release its first Consumer Report card earlier this year.

IV. **Dental Needs:** Please see attachment regarding the topic entitled A Brief Overview on Illinois Oral Health Disease Burden & Utilization.

V. **Children with Special Health Care Needs:** Please see attachment regarding the topic entitled Children with Special Health Care Needs.

VI. **Other Business:** The next meeting will be held on August 8, 2017.

VII. **Adjournment:** The meeting was adjourned at 11:35 a.m.

HFS Subcommittee on Quality

A Brief Overview on Illinois Oral Health Disease Burden & Utilization

6.9.2017

Mona Van Kanegan, DDS, MS, MPH
Division of Oral Health, Chief
Office of Health Promotion

Foundational Concepts for better oral health for all ages

- Disease causative organisms are spread through kissing, sharing contaminated utensils such spoon or a glass
- To decrease transmission causative organism needs to be controlled/eliminated through prevention and treatment modalities
- Good habits and practices that limit causative bacterial load need to be sustained life-long
- Limiting inflammation in oral tissues decreases potential systemic impact

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Disease Burden

Dental caries and periodontal disease are common oral infections yet, are almost completely preventable

- 2011-2012 National Health and Nutrition Examination Survey report that 27% of adults 20 to 64 have untreated dental caries.
- 2012 Centers for Disease Control and Prevention report that 47.2% of adults aged 30 and over have active periodontal disease and
- 70% of people 65 and older have untreated periodontal disease

Role of Inflammation and Systemic Disease

Inflammatory cascade and the potential systemic spread of pro-inflammatory mediators such as fatty acids, interleukin 1, and TNFα are being studied to explain the observed link between oral disease and a wide range of systemic diseases.

There is strong evidence fro a causal link between periodontal disease and diabetes and emerging evidence for:

- Obesity
- Coronary artery disease
- Metabolic syndrome
- Oral health after menopause
- Helicobacter Pylori
- Adverse pregnancy outcomes

Mealey BL. Periodontal disease and diabetes: A two-way street. J Am Dent Assoc 2006;137:26-31

Oral Health Surveillance System

National Oral Health Surveillance System (NOHSS)

Joint effort between CDC, Association of State and Territorial Dental Directors (ASTDD) & Council of State and Territorial Epidemiologists (CSTE)

- monitor the burden of oral disease
- measure progress toward meeting HP 2010 objectives
- monitor status of community water fluoridation on both a state and national level.

Illinois Oral Health Surveillance System (IOHSS)

- Feed data into NOHSS
- Emergency Department Use, 2010-2015 - limited data presented here
- Oral Health Workforce
- Craniofacial Anomaly
- Safety Net Dental Clinics
- Other Secondary Data

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CMS 416

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.
- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified, and
- **Treatment:** Control, correct or reduce health problems found.

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Oral Health					
2014 Illinois BRFSS		Count	Col %	Confidence Interval %	Unweighted Count
LAST DENTAL VISIT	<= 1 year	6,293,617	63.9%	(62.1-65.7%)	3,493
	1-2 years	1,213,890	12.3%	(11.1-13.7%)	527
	> 2 years/never	2,340,208	23.8%	(22.2-25.4%)	1,027
Total		**9,847,716**	**100.0%**		**5,047**
NUMBER OF PERMANENT TEETH REMOVED	1 to 5	2,815,943	28.7%	(27.1-30.5%)	1,485
	6 or more, but not all	934,790	9.5%	(8.6-10.6%)	600
	all	452,184	4.6%	(4.0-5.4%)	291
	none	5,594,834	57.1%	(55.3-58.9%)	2,643
Total		**9,797,751**	**100.0%**		**5,019**

2014 Illinois BRFSS, Illinois Department of Public Health
*Unweighted counts of 5 or less and Confidence Intervals ± 12.5% or greater do not meet standards of reliability.

The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based program that gathers information on risk factors among Illinois adults 18 years of age and older through monthly telephone surveys. Established in 1984 as a collaboration between the U.S. Centers for Disease Control and Prevention (CDC) and state health departments, the BRFSS has grown to be the primary source of information on behaviors and conditions related to the leading causes of death for adults in the general population.

http://www.idph.state.il.us/brfss/statedata.asp?selTopic=oralhealth&area=il&yr=2014&form=strata&show=freq

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2014 Illinois PRAMS Data

Prenatal Dental Care

Percentage (%) of new mothers in Illinois who responded Yes to the following statements

Survey Question 29: This question is about the care of your teeth during your most recent pregnancy. For each item, check No if it is not true or does not apply to you or Yes if it is true.

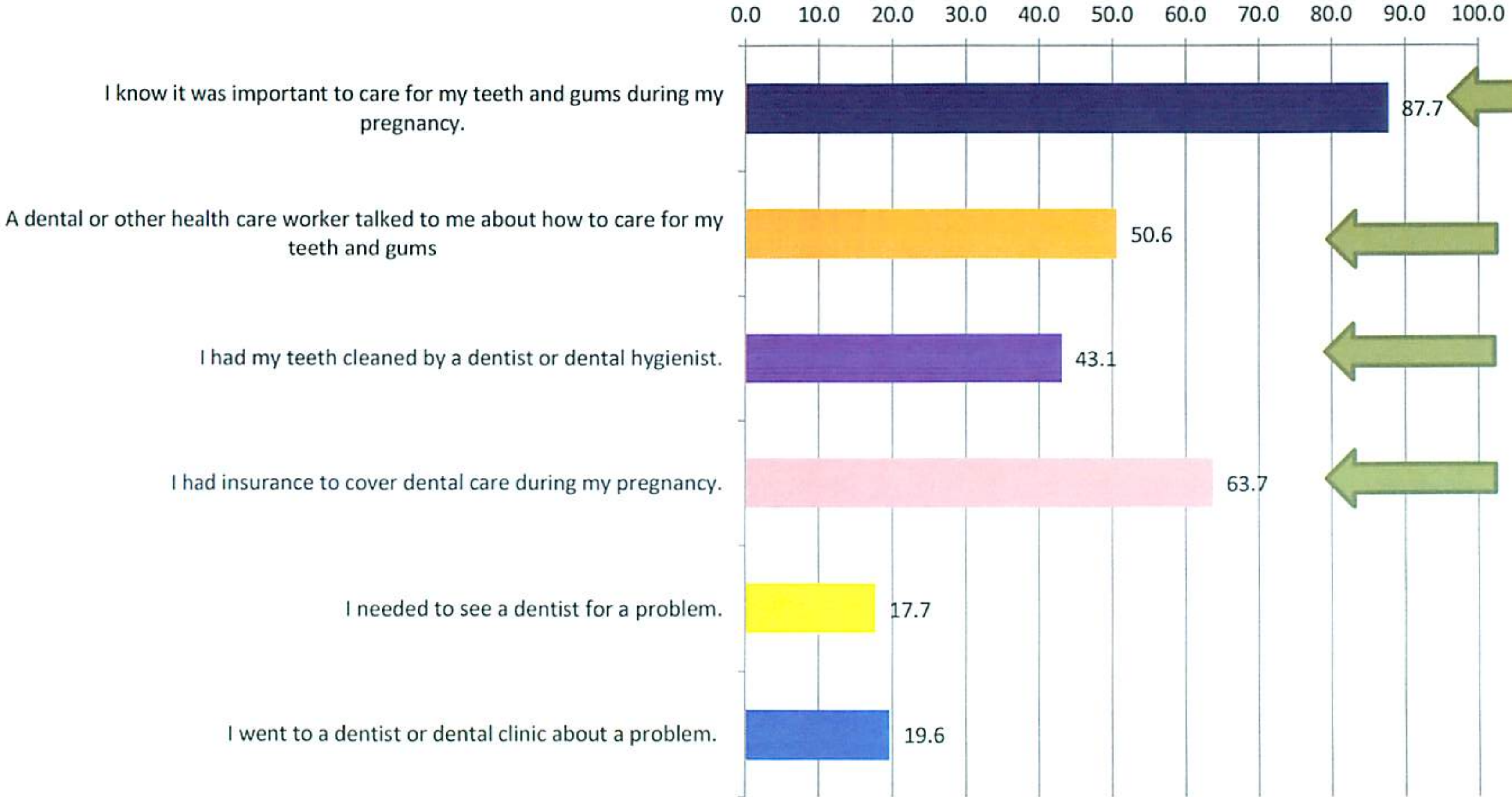

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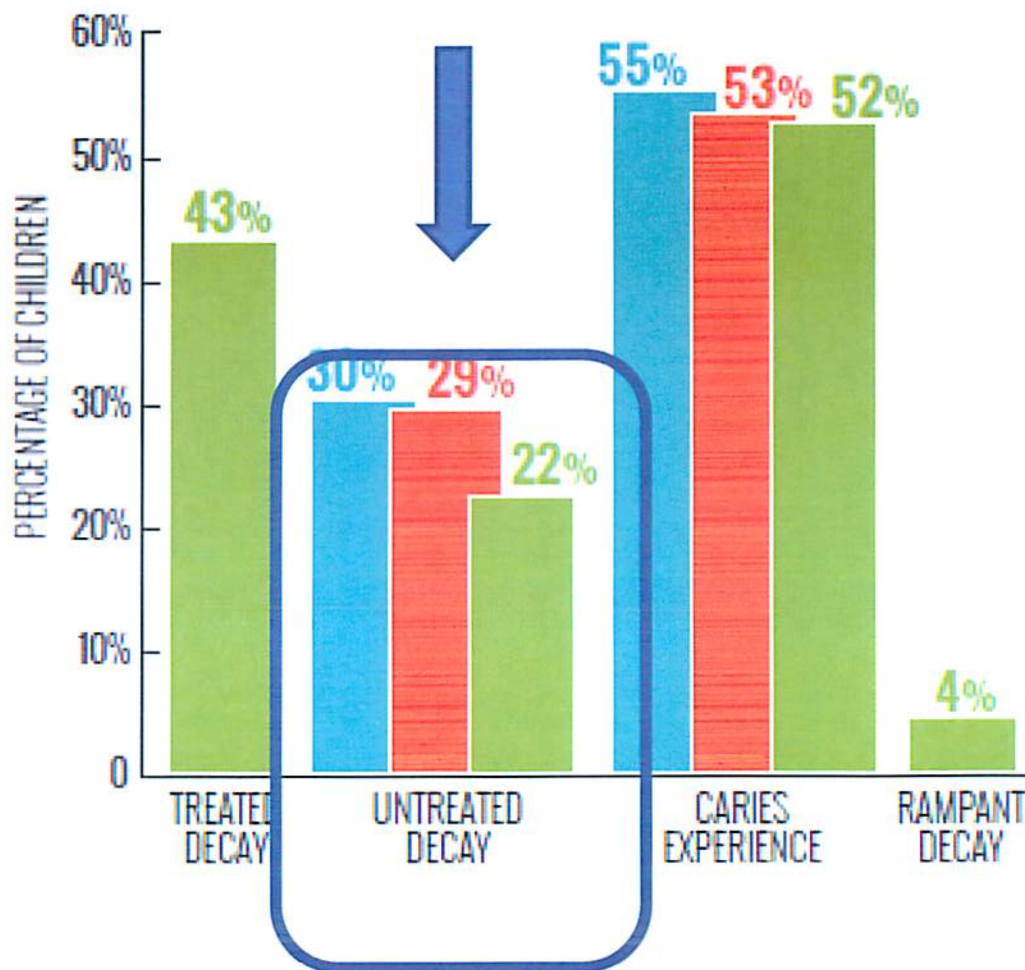
FIGURE 3. **PERCENTAGE OF ILLINOIS THIRD GRADE CHILDREN WITH TREATED DECAY, UNTREATED DECAY, CARIES EXPERIENCE, AND RAMPANT DECAY:** HSHG 2003-04, 2008-09, AND 2013-14.

2003-2004
2008-2009
2013-2014



https://www.heartlandalliance.org/wp-content/uploads/sites/3/2016/02/healthy-smiles-healthy-growth_final.pdf

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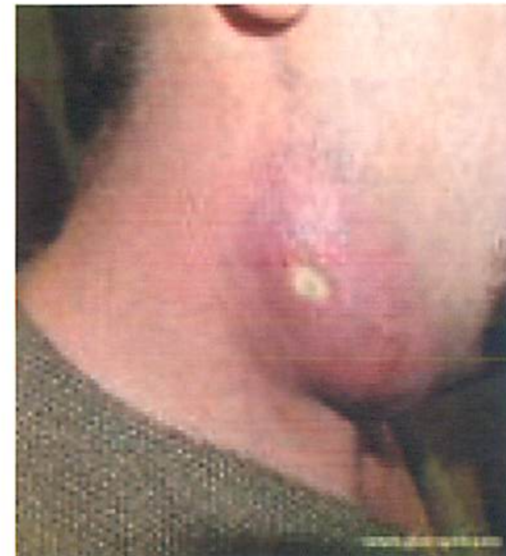
Use of Emergency Departments Associated with Delayed/Untreated Disease

- Illinois Department of Public Health Division of Patient Safety and Quality provided Emergency Department (ED) discharge summary data for ICD9 and ICD10 for non-traumatic oral health concern
- Data analyses were conducted on visits where the dental issue was one or more of the first three diagnoses



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Age-Adjusted Rate of Oral Health ED Visits in Illinois, 2010-2015

Overall rates of ED visits for oral health reasons are increasing over the six year period. They have increased by 17% between 2010 and 2015.

Source: Illinois Department of Public Health, Hospital Discharge Dataset, 2010-2015; Analysis by IDPH Office of Health Promotion

Age-Adjusted Rate of Oral Health ED Visits, 2010-2015

Age-Adjusted Rate per 100,000

250
200
150
100
50
0

2010 2011 2012 2013 2014 2015

127.4 134.7 135.0 123.1 216.0 250.4 198.1 239.7 52.2 84.2 23.3 46.9

<18 18-24 25-34 35-49 50-64 65+

Age Groups

1. Larger increases in ED rates for adults and older adults compared to youth (5% increase). Young adults (18-24)declined by 8.8%.

a. 25-34 age group: 15.9%
b. 35-49 age group: 21%
c. 50-64 age group: 61%
d. 65+ age group: 101.2%

2. Adult age groups: 25-34 and 35-49 have the highest rates of ED visits.

3. Rates doubled for adults over 65, even though they have lower rates overall

Source: Illinois Department of Public Health, Hospital Discharge Dataset, 2010-2015; Analysis by IDPH Office of Health Promotion

Percent of Oral Health ED Visits by Payer, 2010-2015

Age-Adjusted Rate per 100,000

50
45
40
35
30
25
20
15
10
5
0

2010 2011 2012 2013 2014 2015

Medicaid
Self-Pay
Commercial
Medicare
Other
HMO

2013 saw an increase in ED visits among Medicaid and decline among self-pay. Medicare visits also increased. Recall 7/2012-6/2014 SMART Act limitations for dental care were in effect; ACA expansion was initiated in January of 2014.

Source: Illinois Department of Public Health, Hospital Discharge Dataset, 2010-2015; Analysis by IDPH Office of Health Promotion

What data are missing?

To better inform oral health program goals: is health status improved, timely & quality care delivered in an appropriate setting that is cost effective? A better understanding of the below is needed:

Children

- Annual Dental Visit
- Children who received at least on fluoride treatment
- Children (6-9 and 10-14) who receive at least one dental sealant

Adults

- General adult access/utilization of any dental service in a dental setting (not EDs) including that of special populations such as diabetics
- Preventive and periodontal access/utilization during pregnancy
- Number of ED visits that had a follow up visit with a dentist within 30 days.

Satisfaction

If you or your child sought dental care, did you receive services when you needed them?

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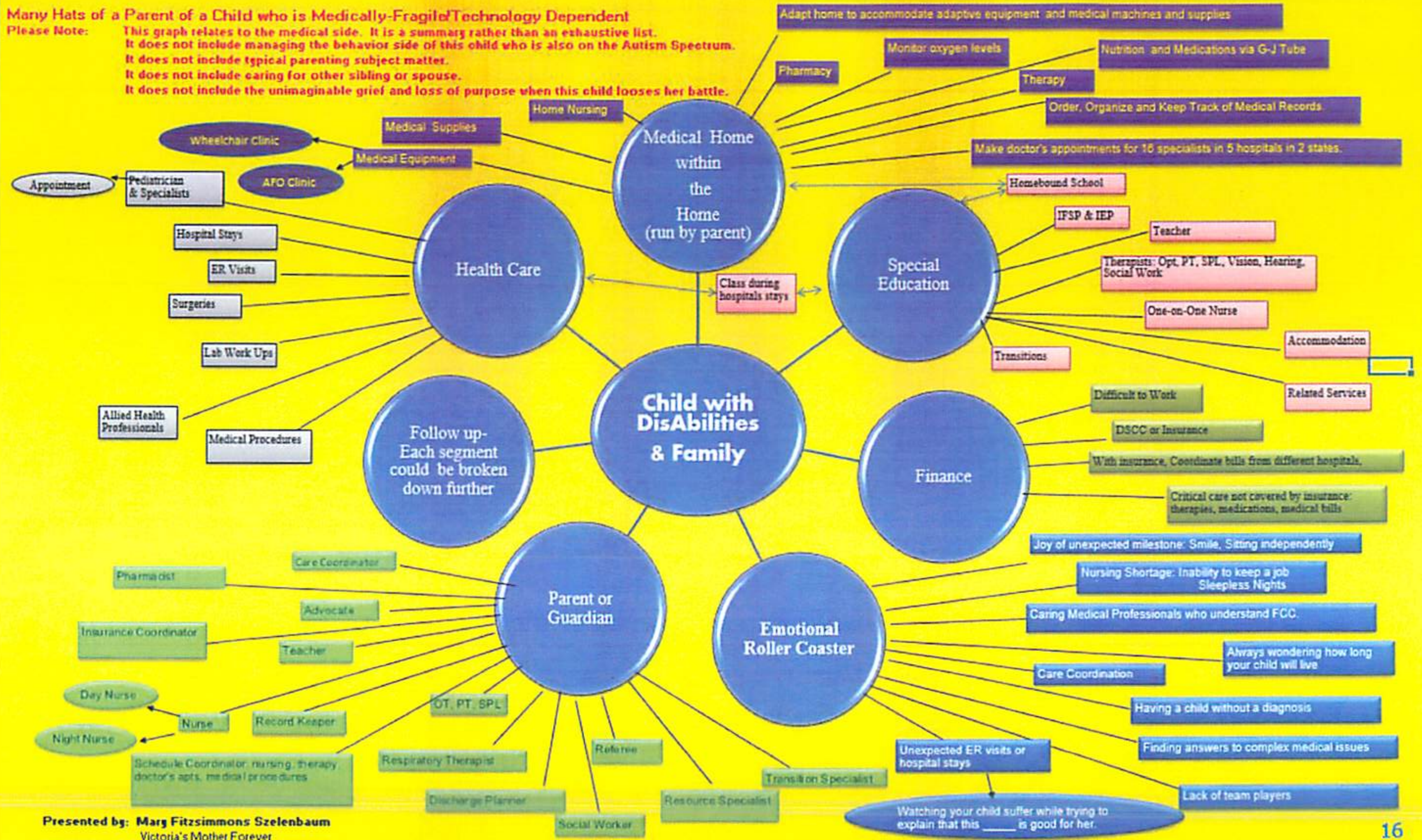
Children's Hospital of Chicago™

Children with special health care needs:

Who they are and how we know whether we are serving them well

Jenifer Cartland, PhD

Vice President, Data Analytics and Reporting



Many Hats of a Parent of a Child who is Medically-Fragile/Technology Dependent
Please Note: This graph relates to the medical side. It is a summary rather than an exhaustive list.
It does not include managing the behavior side of this child who is also on the Autism Spectrum.
It does not include typical parenting subject matter.
It does not include caring for other sibling or spouse.
It does not include the unimaginable grief and loss of purpose when this child looses her battle.
Child with DisAbilities & Family
Medical Home within the Home (run by parent)
Adapt home to accommodate adaptive equipment and medical machines and supplies
Pharmacy
Monitor oxygen levels
Nutrition and Medications via G-J Tube
Therapy
Order, Organize and Keep Track of Medical Records
Make doctor's appointments for 16 specialists in 5 hospitals in 2 states.
Home Nursing
Medical Supplies
Medical Equipment
Wheelchair Clinic
AFO Clinic
Health Care
Appointment
Pediatrician & Specialists
Hospital Stays
ER Visits
Surgeries
Lab Work Ups
Allied Health Professionals
Medical Procedures
Class during hospitals stays
Special Education
Homebound School
IFSP & IEP
Teacher
Therapists: Opt, PT, SPL, Vision, Hearing, Social Work
One-on-One Nurse
Accommodation
Transitions
Related Services
Finance
Difficult to Work
DSCC or Insurance
With insurance, Coordinate bills from different hospitals.
Critical care not covered by insurance: therapies, medications, medical bills
Follow up- Each segment could be broken down further
Emotional Roller Coaster
Joy of unexpected milestone: Smile, Sitting independently
Nursing Shortage: Inability to keep a job Sleepless Nights
Caring Medical Professionals who understand FCC.
Always wondering how long your child will live
Care Coordination
Having a child without a diagnosis
Finding answers to complex medical issues
Unexpected ER visits or hospital stays
Lack of team players
Watching your child suffer while trying to explain that this _____ is good for her.
Parent or Guardian
Care Coordinator
Pharmacist
Advocate
Insurance Coordinator
Teacher
Day Nurse
Night Nurse
Nurse
Record Keeper
OT, PT, SPL
Schedule Coordinator: nursing, therapy doctor's apts, medical procedures
Respiratory Therapist
Discharge Planner
Social Worker
Referee
Resource Specialist
Transition Specialist
Presented by: Mary Fitzsimmons Szelenbaum
Victoria's Mother Forever

Background

- The current healthcare system rarely addresses the medical needs of medically complex children and adolescents
- These children often do not get needed or timely outpatient services because of the disjointed nature of the healthcare system
- The lack of highly coordinated care puts the well-being of medically complex children at risk and uses very expensive disconnected services in a sub-optimal manner
- Costs associated with this population can be 7 times the average costs for the pediatric population

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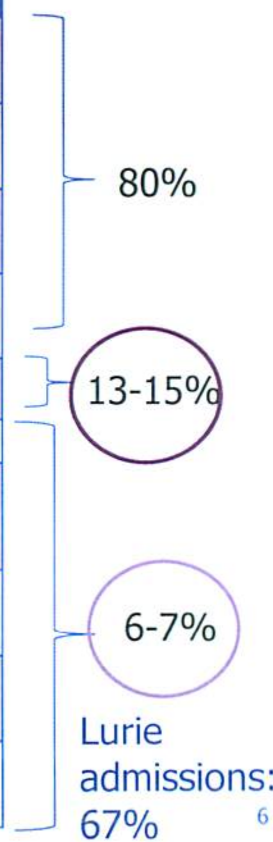
Who are children with special health care needs?

Useful but confusing terms (unofficial definitions)

Term:	Used to describe children who require:	Examples:
Children with special needs	Educational, health care or other supports that are not typical	Autism, dyslexia, all health care needs
Children with special health care needs	Health services that are not typical (often also need educational supports)	Cerebral palsy, sickle cell, mental health conditions, epilepsy
Children who are medically fragile	Supportive technology	Some cerebral palsy, some epilepsies
Children with chronic conditions	Ongoing care (of any level)	Asthma, diabetes, cerebral palsy
Children with medical complexity	Care across many systems and medical specialties	Cancer, cerebral palsy, muscular dystrophy, some epilepsies, severe mental/emotional problems

More precision (3M Clinical Risk Groupings):

CRG Status	Definition	Example
1	Healthy (no recent procedures or significant acute conditions)	Well child
2	Recent history of a significant acute disease	Recent significant injury
3	Single minor chronic disease	One condition - ADHD, excema, allergic rhinitis
4	Minor chronic disease(s) affecting multiple organ systems	More than one condition -ADHD, excema, allergic rhinitis
5a	Single dominant chronic disease	Asthma, obesity
5b	Single dominant chronic disease	Diabetes Type I, sickle cell
6	Significant chronic disease affecting multiple organ systems	Diabetes Type I with mental health problem, sickle cell with respiratory problem
7	Dominant chronic disease affecting three or more organ systems	Endocrine conditions
8	Dominant , metastatic and complicated malignancies	Cancer
9	Catastrophic and progressive conditions	Muscular dystrophy; transplants



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How do we know if we are serving them well?

Well-coordinated care saves costs and increases access to services

Service pattern to achieve savings is different than other populations.

Service	Cost Savings
Inpatient	-40%
Outpatient	+10%
Emergency Room	-20%
Primary Care Services	+30%
Prescription Drugs	+10%
Medical Cost Savings	-13% to -10%

Care coordination studies generally focus on the CRG 5b-9 group.

Studies of Lurie Children's efforts generally replicate findings from other, published studies.

Summary of Available Evidence and Methodology for Determining Potential Medicaid Savings from Improving Care Coordination for Medically Complex Children; Dobson & DaVanzo, 2013

Well coordinated care assures access to needed services

Medical/health home indicators:	Private insurance	Medicaid/ public insurance
CSHCN has no usual source of sick and well care	7.6%	17.5%
CSHCN has no personal doctor or nurse	3.6%	10.1%
CSHCN receives family-driven care	74.8%	59.5%
CSHCN has problems getting a needed referral	18.4%	29.4%
CSHCN has care that meets all care coordination requirements	47.4%	41.0%

Source: 2009/10 National Survey of Children with Special Health Care Needs (Illinois)

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Well coordinated care provides integration across sectors

Indicators of cross-sector coordination	Private insurance	Medicaid/ public insurance
Difficulty/delayed in getting community-based services in last year	27.0%	33.8%
Never frustrated getting services in last year	73.2%	55.5%
Communication was needed between the physician and the school in the last 12 months	26.8%	38.7%
Very satisfied with the physician-school communication in the last year	56.5%	55.8%
CSHCN has an IEP	27.1%	33.9%

Source: 2009/10 National Survey of Children with Special Health Care Needs (Illinois)

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Metrics relevant to children with special health care needs

Proposed metrics

Patient satisfaction surveys (CAHPS survey for children with chronic conditions)	**HEDIS (claims-based)**	**HFS (claims-based)**
Access to and use of specialized services	Influenza immunization rate	Vision screening
Access to and use of prescription medication	Developmental screening in the first three years of life	Ambulatory follow-up after IP visit and ED visits
Family-centered care	Preventive dental services	
	Well child visits (through adolescence)	
	Lead screening	

Questions?