



## **Illinois Health Connect: Ensuring a Medical Home**

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Margaret Kirkegaard, MD, MPH, IHC Medical Director, [mkirkegaard@automated-health.com](mailto:mkirkegaard@automated-health.com)

### **Illinois Health Connect Overview**

- Numerous studies have shown that patients who have access to a medical home have better health outcomes and lower healthcare costs.
- In 2006, the Illinois Department of Healthcare and Family Services (HFS) moved to a primary care case management model called Illinois Health Connect (IHC) to ensure that HFS clients have a medical home. IHC is administered by Automated Health Systems.
- Illinois Health Connect has created a primary care provider (PCP) network of over 5,600 primary care physicians, clinics and other providers who have agreed to create a medical home for their clients. Currently the IHC PCP network has a capacity for 5.3 million clients and approximately 1.8 million clients are enrolled.
- IHC also provides services such as assisting clients with making well-child appointments with their medical home and helping clients locate specialty providers and ancillary medical services, such as podiatry.
- IHC provides numerous quality tools to participating providers including a monthly "panel roster" that lists the name and demographic information of each client who is linked to that medical home along with a summary of the patient's most recent clinical information such as dates of last preventive care services, for instance mammography or well-child visits. IHC also provides electronic access to a database of 2 years of claims data that allows clinicians to determine what care has been provided to patients in the past two years, including prescription and immunization data.
- IHC has created a Bonus Payment Program for High Performance targeting 5 common clinical measures for quality improvement. In 2009, over \$2.8 million was distributed to nearly 4,500 providers for care provided in 2008 that exceeded the quality standards.
- Your Healthcare Plus (YHP) is a disease management program that targets 250,000 IHC patients with chronic diseases and high utilization and provides additional care coordination ranging from face-to-face visits to phone support. IHC and YHP work collaboratively.

### **Successes to Date:**

- Through securing a "best fit" medical home, IHC improves continuity of care, access to preventive services and coordination of chronic disease care for the client. IHC has reduced both inpatient hospitalizations and emergency room visits and estimates suggest a significant savings in FY 2008.
- In the 2009 Provider Satisfaction Survey, 91% of respondents (N=875) indicated that IHC was beneficial to their patients and 84% of respondents found the administration of the program to be satisfactory.
- In the 2009 Client Survey, both rural and urban clients who had been enrolled in IHC for longer than 6 months were interviewed via phone. In both groups, more than 95% of respondents were satisfied or highly satisfied with both the IHC program and their medical home.
- IHC is beginning to track population-based clinical metrics such as rates of immunizations and mammography. Some rates, such as the rate of developmental screenings, are beginning to show improvement.