IE HP
A Public Entity
Inland Empire Health Plan

# Long-Term Services and Supports Summit



# Making CCI Work:

## One Health Plan's Approach to Care Coordination.

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**Inland Empire Health Plan**

# Agenda



- About IEHP
- Why Integration was needed
- Development and Integration of CCI
  - Workgroups
  - New Responsibilities and New Departments
  - Care coordination
    - Care Management, LTSS, Behavioral Health
- Lessons Learned

# Inland Empire Health Plan

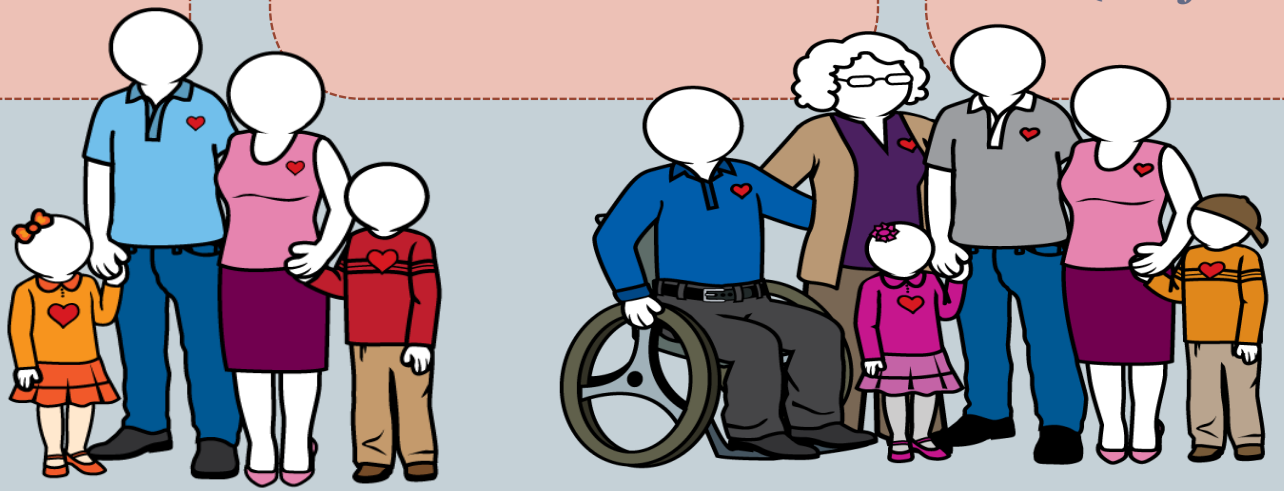


- Public, Not-for-profit Health Plan serving low income individuals and families in San Bernardino and Riverside County
- 1,121,183 Members compared to 400,000 in 2009
  - 22,000+ CMC Members
- Projected growth to well over 1,300,000 by 2016
- 37,642 Members utilizing LTSS

# Membership

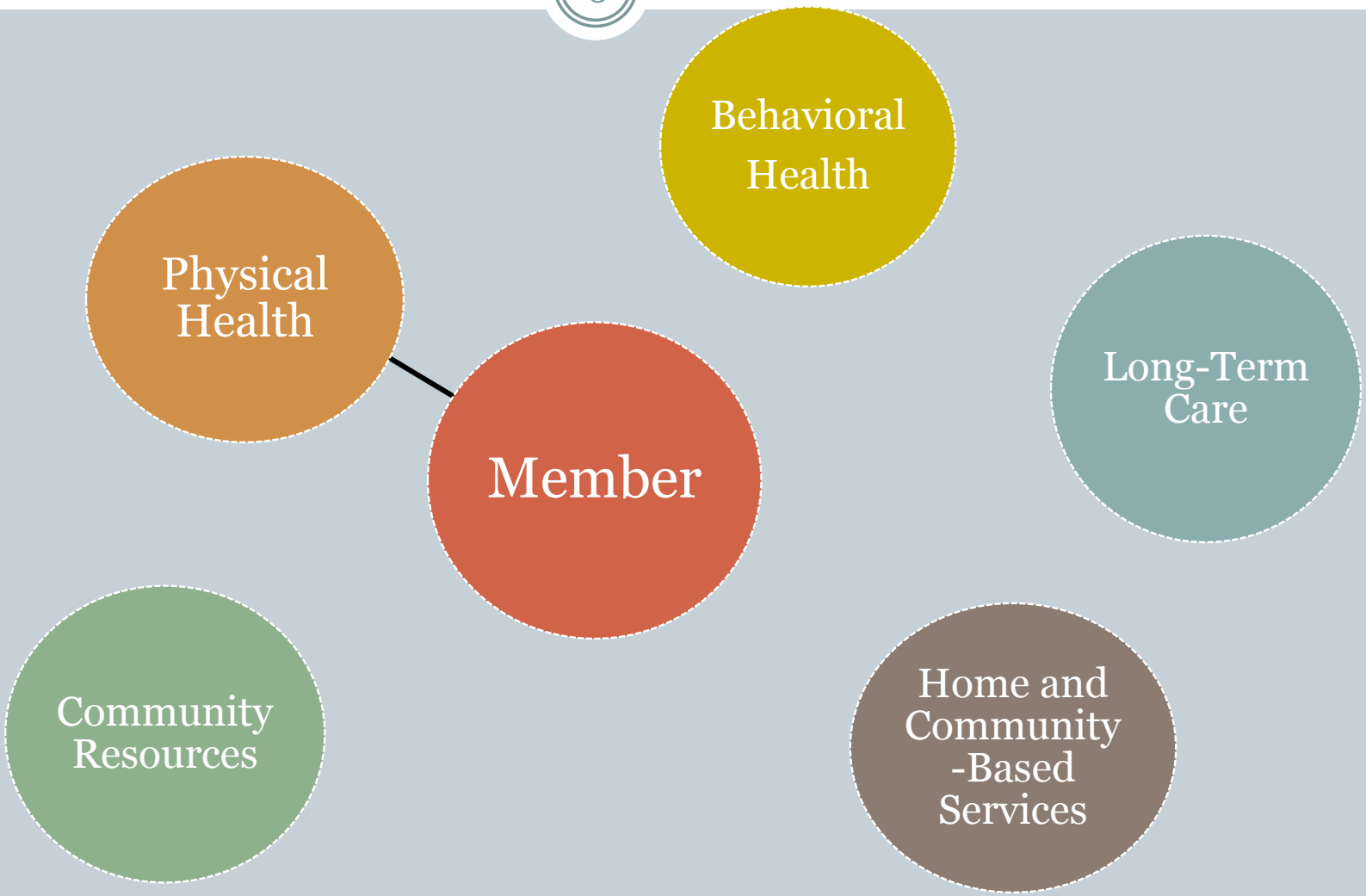


| 2009 | 2015 | 2016 |
| --- | --- | --- |
| 400,000 | 1,100,000 | 1,300,000 (Projected) |



# Why Integration was needed:





# Why Integration was needed:



- Physical health, Behavioral health, and LTSS were separate and disconnected.
- Coordination of Care was limited
- Data sharing was limited
- Multiple assessments being used by various agencies
- Silos!

# New Requirements



- Behavioral health services for mild to moderate
- Health Risk Assessments/Individualized Care Plan
- Long-Term Care – Nursing facilities
- Home and Community-Based Services
  - In-Home Supportive Services
  - Multipurpose Senior Services Program
  - Community-Based Adult Services

# New Positions / Staffing



- Behavioral Health Specialists
- Transition of Care Coaches
- LCSWs
- LTSS Nurse Care Managers
- LTSS Social Worker Care Manager
- CBAS Nurses
- Disability Program Coordinator
- Long Term Care/Skilled Nursing Facility Unit
- IEHP Care Management Team has doubled in size

# Internal Workgroups



- MSSP Workgroup
- IHSS Workgroup
- Duals/CCI Data Sharing
- Gaps/Optional Services
- External Relationships
- LTC Program Design
- Coordinating and Integrating Member Care
- In-House LTSS Program Design

# Stakeholder Workgroups



- Persons with Disabilities Workgroup
  - Members who are Seniors and Persons with Disabilities
- Public Policy Participation Committee
  - Members who have Medi-Cal
- CCI Stakeholder Advisory Committee
  - Members, Advocates, Physicians, IHSS, Public Authority, Community-Based Organizations, Unions, Program for All Inclusive Care for the Elderly, Office on Aging, and Hospital Association.

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## Care Management

Jeanna Kendrick, RN, BSN,
Senior Director of Care Management

# Care Management Then



- Care Management (CM) prior to CCI at IEHP was a very reactive approach to care coordination.
- No real “requirements” for a formalized CM program until NCQA CCM and now CCI.
- Care Plans were developed based on disease specific criteria
- The term “ICT” was foreign to most of us
- CM approach was usually what “we” wanted the Member to do, instead of what the Member wanted.

# Care Management Now



- CCI requires ALL members receive CM
- All members are to have a Health Risk Assessment and Individualized Care Plan (ICP)
- ICP is to be developed in collaboration with the Member and Members of the care team (instead of us telling the member what we want them to do)
- We are encouraged to collaborate as a team to meet the needs of the member
- We've learned that it's much easier to do this together than alone.
- And… if it's easier for us, it's much easier for the Member

# Interdisciplinary Care Team



- ICT Members
  - Member
  - Caregiver
  - Family Member(s)
  - Primary Care Physician
  - Specialist
  - IHSS Social Worker
  - Public Authority Social Worker
- Health Plan ICT Staff
  - Nurse Care Manager
  - LTSS Care Manager
  - Behavioral Health Care Manager
  - Transition of Care Coach
  - LCSW
  - Pharmacy Program Specialist
  - Disability Program Coordinator
  - Medical Director
  - Nutritionist

# Case Study



- BH Provider noticed that the Member had bilateral edema and weeping wounds of his lower extremities, and advised the Member to seek care in the ER immediately.
- ICT assembled with BH provider, Member & Caregiver. Other members of ICT included BH staff, NCM, Medical Director, Nutritionist and Pharmacy.
- Interventions – ICP developed, change in wound care provider, referral for home visit for assessment, IHSS referral, transportation.

# Care Management Lessons Learned



- Need the resources to do this correctly
- ICP can only be developed with the Members input/approval otherwise who's Care Plan is it?
- HRA improvement strategies, easier said than done
- Member info is usually not correct/current
- You need the right disciplines on your ICT
- Continue to adapt your program as the membership changes
- You can't do this alone
- We can make a difference

# Challenges



- Duals who Opt Out remain a challenge
- Contacting Members who have moved or changed telephone numbers
- Establishing data sharing protocols

# Thank you Letters

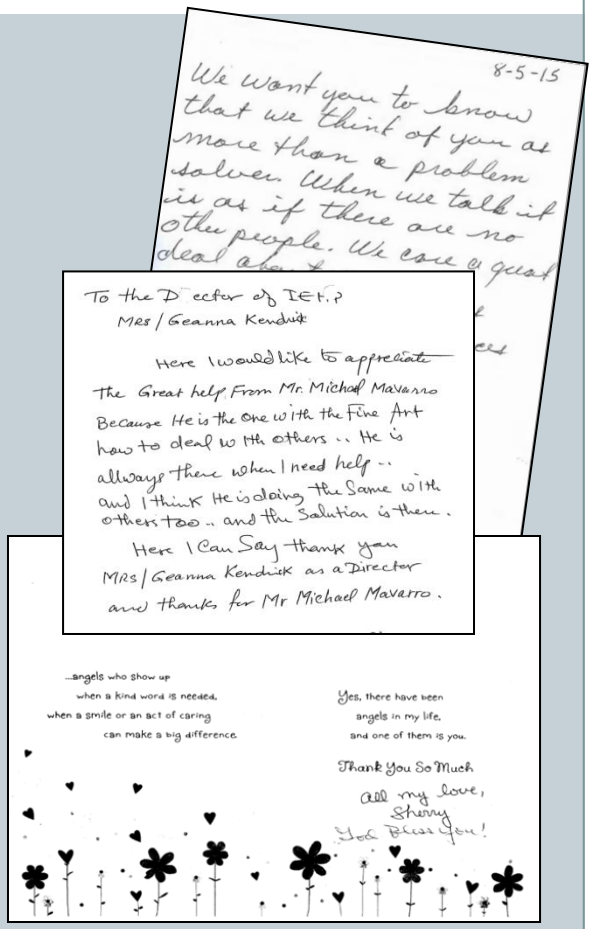


Dear Sir/Madam,

I would like to take this great opportunity to express my appreciation for the high level of service exhibited by one of your employee named JOY. During a call, she was able to answer all my questions and doubts about iEHP. Her courteous and polite nature eased my own anxiety when all the services my mother used to get from her previous insurance are being denied all at the same time due to the transition process.

Not every call is as complicated as mine, not every call requires urgency. But the service I got from her can be substantial and have a long lasting effect. The kindness that your employee JOY exhibited went above and beyond everyday routine to make sure we were okay and had the information I needed to proceed in the days ahead. Thank you to her and to your department for such a fine demonstration of good training and excellent handling of a confused and worried time for me and my mother. Her kindness and good customer service demeanor did not go unnoticed and was so very much appreciated.

Very sincerely yours,




*"When we talk its is as if there are no other people."*

# Long-Term Services and Supports

Ben Jauregui, MPA,
Long-Term Services and Supports Manager

# LTSS Unit Established



- Identify potential Members for LTSS through referrals from Care Managers, encounter data, inpatient admissions, outpatient referrals, and provider referrals.
- Advocate for and Coordinate LTSS Benefits
- Assist Members in accessing LTSS benefits
- Coordinate Care between IEHP/LTSS Provider/ County/Community Based Organizations
- Identify Members needing a higher level of care or formal Interdisciplinary Care Team Meeting.

# LTSS Integration Results



- Improved coordination between health plan and LTSS providers.
- Increased data sharing between health plan and County programs.
- Comprehensive assessments from CBAS and MSSP used to plan members care.

# LTSS Success Stories



- 64 year old male living alone. Physical and Cognitive disabilities. Denied IHSS twice. Care Manager referred Member to IHSS Unit and Care Manager assisted with application. Member approved for IHSS.

- 56 year old female receiving 60 hours a month. After surgical procedure needed temporary raise in IHSS hours. LTSS unit coordinated with the County to temporarily increase hours to 209.

- 50 year old Male, referred by County MH to CBAS Center. Before CBAS, was homeless, several psych inpatient stays, several Board and Care and Room and Board. Several ER visits. Attends CBAS 4 days a week regularly and living at same Board and Care.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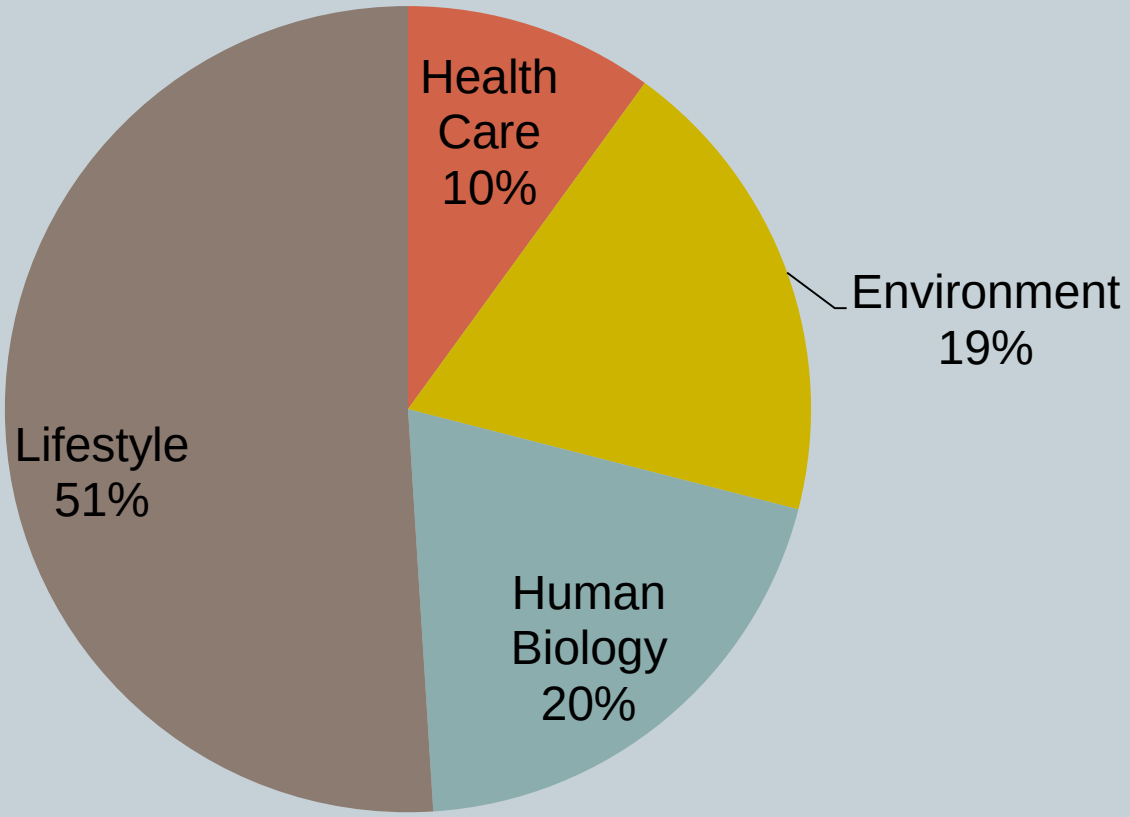
## Behavioral Health

Peter Currie, Ph.D.,
Senior Director of Clinical Transformation & Integration

# Traditional Health Care is NOT the Primary Determinate of Health Status






Schroeder, NEJM 357; 12

# Social Determinants:
# Drivers of Population Health and Patient Experience



# The BH Integration Plan



- Fully Integrated BH Program – “In House”
- Streamline the coordination of physical and mental health benefits
- Redirect MBHO Admin/Profit (50%)to fund Expanded BH Services
- Directly Contracted BH Network – Identify and Support Best Practices
- Eliminate reliance on vendors for all BH expertise including NCQA compliance

# The Launch



- One phone # access at IEHP for physical & mental health
- BH Call Center:  Triage & referral by BH Care Managers
- Higher than average rate of pay for the initial evaluation:
  - Incentivize prompt Access
  - Payment triggered by Coordination of Care Treatment Report Web Form – eliminating the “Black Hole”
- Added Intensive Outpatient Programs (IOP)
- Direct Partnership with County Mental Health

# BH Integration Results



- Increased access to BH services – **Cost Neutral to Plan**
- Improved coordination of physical & behavioral healthcare
- Medical Cost-Offsets for high-risk/high-cost populations
- Infusing BH expertise within IEHP for crisis calls
- IEHP's BH network - Private Sector, FQHCs, County Mental Health & CBOs

# Lessons Learned: Integration of BH Key to achieving the Triple Aim



- Integration of Behavioral & Physical Health Care at the Health Plan enables Population Health Care
- Health Plans Need to develop direct relationships with BH Providers in private practice, County BH programs and Community Based Organizations
- In a well integrated Model of Care, Open Access to BH Services pays for itself in Medical Cost Offsets

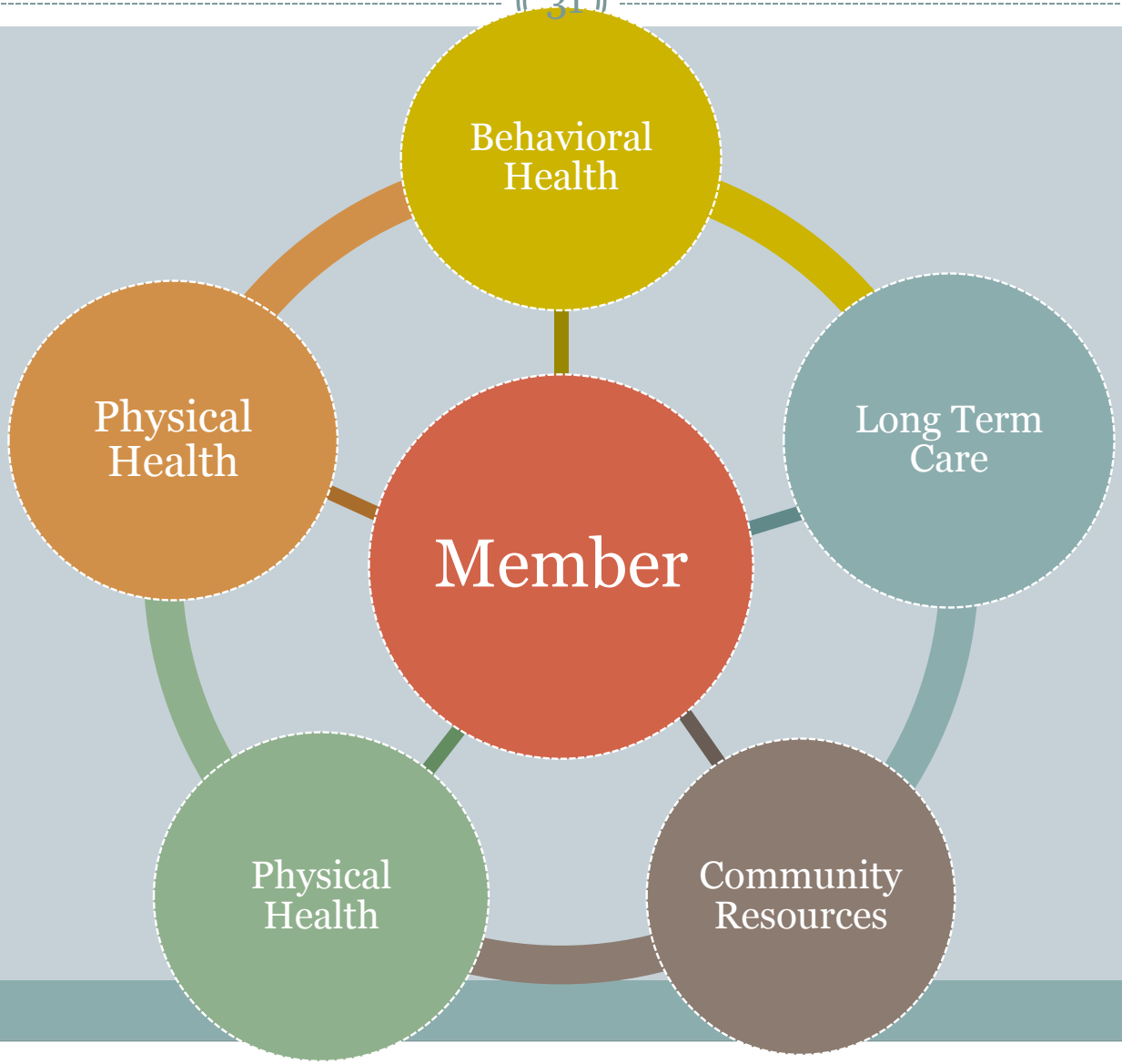
# Lessons from Riverside County Co-Location Pilot



- Patients arrive to health care providers “fully integrated” with physical and BH needs intertwined
- Health care providers in the Inland Empire operate mostly in silos which limits their impact on overall health status
  - ✓ People seek care where they are welcomed and comfortable
  - ✓ Rather than refer out to the “black hole” bring the missing/needed care to where the population is getting care

# Coordination Now





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*Questions or Comments?*