

IEHP Care Management/ Care Coordination

Presented By: Dr. Brad Gilbert, CEO
Inland Empire Health Plan

IEHP Care Management/Care Coordination

- **IEHP is a Joint Powers Agency, not-for-profit public entity that began serving Members September 1, 1996 (Labor Day!)**
- **Currently serve over 435,000 Members**
 - 364,000 Medi-Cal
 - 20,000 Medi-Cal Seniors and Persons with Disabilities
 - Many other individuals in Family Aid Codes with significant chronic illness (3N in particular)

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- **Identification**

- Integrated data including encounter data (office visits, ED visits, inpatient stays) and pharmacy data (very timely and complete) “queried” for diagnoses, medications and “events” that suggest chronic illness or other significant health issues
- Internal Member contact through Member Services, Care Management, Utilization Management, Pharmaceutical Services, etc
- Referral from treating physician

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- **Assessment**

- Phone based standardized and scored assessment of Member's health, psychosocial and activities of daily living status
- Treating physician contacted as needed
- Multiple contacts with Member as needed
- Contact with caregivers, family, etc as needed

- **Individualized Care Plan**

- Individual Care Plan developed after assessment
- Care Plan discussed with Members
- Care Plan sent to treating physician

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- **Multi-disciplinary Care Team (all categories exist – working on full integration)***
 - Nurses – RNs, LVNs
 - Social Workers
 - Coordinators – all bilingual
 - Health Management (Disease Management) nurses and specialists
 - Health Educators (not there yet)

*All of the above staff are IEHP employees, we believe an in house Team improves coordination across the company
- **Member has primary contact from list above based on multiple factors including illness/disability, psychosocial issues, relationships**
- **Care Team connected to inpatient review team, utilization management, pharmaceutical services, etc through common use of medical management software (contacts, assessments, care plans in system)**

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- **Continuum of Care**

- Health Education
- Health Management (issue/disease specific – asthma, diabetes, high risk OB – education and consultation)
- Care Coordination – referrals/ appointments/ transportation/ medication assistance/and coordination
- Complex Care Management – comprehensive approach to whole Member needs

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- **Lessons Learned**

- Hiring and placing a Social Worker at our Inland Regional Center (IRC) in 2004 – has greatly improved care for our Members that receive services from IRC
- Chronic Pain impacts a substantial number of our SPD Members and has required the development of innovative multi-disciplinary pain management programs which are still evolving
- Development of a CCS database that tracks CCS denials and authorizations has markedly improved coordination between IEHP and CCS
- Establishing excellent relationships with our two County Behavioral Health units has greatly facilitated behavioral health issues even when county resources are stretched

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- **“Carve outs” Remain a Challenge**
 - Behavioral Health – effective February 1, 2010 we brought Behavioral Health for Healthy Families and our Medicare SNP “in house” which will provide additional resources/expertise for our Medi-Cal Members both in terms of care management but also coordinating carve out services
 - Psychologist, LCSW and additional MSW’s added/being added to staff
 - CCS- dedicated staff and electronic database with CCS decisions to help coordinate care

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- **Other Thoughts**

- Need to further refine identification/intake process to ensure we are not “missing” anybody and have a meaningful/useful assessment
- Need to improve our connection in both directions (referral and care plan information) with treating physicians
- The Key is an organized, integrated multi-disciplinary approach as all Members have unique issues

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- **Outcomes**

- 2008 SPD CAHPS scores= 71.5% for Rating of Health Plan= 90th percentile Nationwide
- 20,000 SPD Members have voluntarily joined IEHP
- Over 5600 SPD Members who are served by IRC have chosen IEHP
- Our voluntary disenrollment rate of our SPD Members is .2%
- Our inpatient utilization rate for our SPD Members has decreased to 700 days/1,000 Members from 1000+ days/1,000 due to improved outpatient coordination of care