Guidelines for Care Management
Learning Objectives

By the end of this training, Team Members will be able to do the following:

- Describe IEHP’s DualChoice Cal MediConnect Plan Line of Business
- Explain the Care Management Structure, including person-centered care planning and care coordination
- Recall the PCPs role in Behavioral Health Services
- Recognize Cultural and Cognitive Competency
- Summarize Accessibility and Accommodations
- Understand Independent living and recovery and wellness principles
- Outline Long-Term Services and Supports, including Home and Community-Based Services
- Discuss Dementia Care
Our Medicare Line of Business
Medicare Line of Business

• IEHP DualChoice Cal MediConnect Plan (CMC) was created by IEHP as part of the Coordinated Care Initiative (CCI) to enhance health outcomes and Member satisfaction.

Click on the link below for the Summary of Benefits for the IEHP DualChoice Cal MediConnect Plan
Description of the Dual-Eligible Population
Our IEHP DualChoice Population

• Our IEHP DualChoice population is composed of individuals who are dual-eligible (i.e., eligible for both Medicare and Medicaid by age 65 or by disability or medical condition).

• This population is characterized as follows:
  • Likely to have multiple co-morbidities;
  • Likely to have behavioral health conditions;
  • May need help with at least 2 activities of daily living; and
  • As a result are more likely to be sick, have higher utilization rates and need more intensive care.
Care Management Structure
Care Management Structure

Roles and Responsibilities

• IEHP, its delegates and providers will provide care coordination services to ALL Members, as needed, in accordance with the Member’s individual preferences and in a way that meets the needs of Members with disabilities.

• IEHP care coordination services will reflect:
  – A person-centered, outcomes-based approach;
  – A Member’s right to self-direct the provision of Long-Term Services and Supports (LTSS); and
  – A Member’s right to determine the appropriate involvement of his or her health care provider, LTSS providers and caregivers.
Assessment and Person-Centered Care Planning
A Health Risk Assessment (HRA) is a survey tool used to assess the Member’s medical, functional, cognitive, psychosocial, and mental health needs.

- IEHP will conduct the HRA in-person, if requested. Otherwise, IEHP will perform the HRA by mail or phone.
**Health Risk Assessment**

**IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) Members**

These Members are separated into High Risk and Low Risk categories based on initial health data.

- **HIGH RISK** - HRA will be conducted within forty-five (45) calendar days of the Member’s enrollment into the health plan.

- **LOW RISK** - HRA will be conducted within ninety (90) calendar days of the Member’s enrollment into the health plan.
Health Risk Assessment & Developing the ICP

• The HRA is performed initially and then annually, or sooner if the Member’s condition or health status changes.
• HRA results are collected, analyzed and used in development of an initial Individualized Care Plan (ICP) for all Members, regardless of their risk stratification.
• ICPs must be developed within 45 calendar days of the HRA completion date!
Health Risk Assessment

At IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan), we want to give you the best care we can. Please complete this Health Risk Assessment to help us know your health care needs. Your answers will not affect your benefits in any way. You may be told to skip over some questions. You can complete this survey in one of three ways:

1. **In Person:** An IEHP Team Member can meet with you to help you fill out the form.
2. **By Phone:** An IEHP Team Member can help you to fill out the form.
3. **By Mail:** You can fill out the form, then return it in the reply envelope provided.

If you would like to fill out this form over the phone, please call IEHP Member Services, and ask to fill out a “Health Risk Assessment.” The number to call is 1-877-761-6233, Monday – Friday, 8am – 5pm. TTY users should call 1-800-718-4347. Please keep your IEHP Member ID number handy when you call.

**YOUR HEALTH**

1. **What language do you prefer to speak and read?**

   - **SPEAKING**
     - a. English □
     - b. Spanish □
     - c. American Sign Language (ASL) □
     - d. Other □

   - **READING**
     - a. English □
     - b. Spanish □
     - c. American Sign Language (ASL) □
     - d. Other □
Person-Centered Care Planning

• Nurse Care Managers review Individualized Care Plans (ICPs) with the Members upon development and on an ongoing basis.
• The ICP will be mailed to the Member.
• The HRA results and the ICP are available for the PCP via the IEHP Provider Web Portal.
Provider Web Portal

Eligibility

Providers must verify eligibility on the Date of Service (DOS) prior to rendering service to an IEHP Member.

Search Again

Search Results

Verification Number: 1225669 on 09/12/2016 at 12:07 PM

IEHPID: 1225669
DOS: 09/12/2016

Member: Doe, John
UIN: 1225669
Co-Pay: $0.00
Aid Code: 81
Gender: Male
County: San Bernardino (35)
DOB: 02/20/1970

PCP: Arthur Ejimelez
PCP ID: 000000000000000
PCP Phone: (760) 245-2300

Total Care Plans: 5

03/03/2016: Inland Empire Health Plan (HMO)
02/01/2016: Inland Empire Health Plan (HMO)
Person-Centered Care Planning

• An ICP serves as the initial and ongoing tool for documenting each Member’s medical, behavioral health, psychosocial, functional, cognitive and spiritual issues. The ICP contains an action plan with goals and interventions to address areas of concern.

• The ICP is developed with input from Members, caregivers and their families. The Member may determine the caregivers’ level of involvement.

• ICPs are re-evaluated and updated on a regular basis when:
  • Member’s Health status changes
  • Member makes a PCP change
Provider Access to the HRA & ICP

HRAs and ICPs are available for providers after they successfully log into the Provider Web Portal. The Member’s information is entered in the Eligibility section and the Provider Alerts section can be viewed.
Care Planning

Provider Portal

Total Care Plans: 2

- Effective On: 10/05/2018
  - IEHP Direct
  - Type: Dual Choice Care Plan

- Effective On: 04/06/2015
  - IEHP Direct
  - Type: Complex

Care Plan Details:
- Name:
- IEHP ID:
- PCP Name:
- PCP Phone:
- DOB:
- LOB:
- CM Nurse:
- Enrollment Date:
- Status:
- Status Reason:
- Term Date:
- Primary Condition:
- Primary Doc:
- Primary Specialty:

ICT - 01/04/2018

Problem

<table>
<thead>
<tr>
<th>Problem</th>
<th>Start Date</th>
<th>Target Date</th>
<th>Status/Term</th>
<th>Focus on Goal/Date Complete</th>
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<tbody>
<tr>
<td>Life Planning</td>
<td></td>
<td>Met</td>
<td>10/17/2017</td>
<td></td>
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</tbody>
</table>

Goal

- Description: Member will discuss life planning options with providers
- Status: Completed
- Term: Self Managed

Intervention

- Description: Educate member of life planning options
- Start Date: 10/16/2017
- Target Date: Complete: 10/17/2017

Notes:
- 10/16/17: Per HRA Mbr reports no advance directive or living will. After speaking with Mbr he states that he does have an advance directive that he is self managed. Mbr with obtaining one.
Provider Access to Electronic Health Information

Electronic Medical Records are available for providers through the **Provider Web Portal** by entering the Member’s information in the **Eligibility** section and clicking on **Medical History Record**.
Care Coordination
Interdisciplinary Care Team

• The Interdisciplinary Care Team (ICT) was developed to provide a multi-disciplinary approach to assessing and monitoring our IEHP DualChoice Members.

• The ICT strives to address the multiple issues that effect these Members (e.g. medical, behavioral health, psychosocial, cognitive, functional issues, and social determinates of health).

• IEHP or the Member’s assigned IPA ensures that all IEHP DualChoice Members are appropriately assigned to an ICT.
Interdisciplinary Care Team Meeting
Interdisciplinary Care Team

- At a minimum, the ICT shall consist of the IEHP or IPA Care Manager, Member, Member’s caregiver (or Member authorized representative), Member’s PCP, and In-Home Supportive Services (IHSS) social worker (if Member is receiving services). Additional ICT members may include:
  - Specialist, therapists, occupational therapists
  - Medical Director
  - Behavioral Health
  - Pharmacist
  - CBO Representatives
  - CBAS social worker; if participating
  - MSSP social worker; if participating
  - Other professionals, as appropriate
ICT Meeting/Conference

• What Members need to have an ICT Meeting?
  – All High-Risk Members
  – All Members with one or more identified problems or needs
  – Members who request and ICT meeting
Delegated Providers

- If a Member is receiving IHSS, the Delegate must invite the County IHSS Social Worker to the ICT. Contact information is available in the LTSS Roster.
How Does the ICT Communicate?

- IEHP or the IPA has regular case conferences and ad hoc meetings with members of the ICT to discuss the needs, challenges and successes of the Members.
- The Members discussed at these meetings are selected based on various criteria, including high risk status, issues with Members that are not meeting their goals, education and/or sharing of best practices.
- Outcomes are documented in the medical management system and communicated to ICT Members; via secure email, fax, web portals or written correspondence.
Member’s participation in ICT

• Member’s participation is voluntary
  – The ICT will continue its operations even without Member’s participation.
  – The Member remains enrolled with IEHP even if they choose not to participate in their ICT.

• Members that decline participation in their ICT
  – Care Coordinator/ Nurse Care Manager must provide his/her contact information
  – Care Coordinator/Nurse Care Manager must revisit ICT participation at reassessment or when Member request for PCP change.
Care Transitions
Care Transitions

• Care coordination is provided to Members to facilitate their safe transition across facility and community settings. For example:
  • Home to Hospital
  • Hospital to Skilled Nursing Facility (SNF)
  • Hospital to Home
  • SNF to Home

• UM/CM staff work together with physicians, facility staff, Members and their caregivers to ensure Members are supported during planned and unplanned care transitions.

• Care Coordination activities include:
  • Arranging follow-up appointments
  • Medication reconciliation
  • Updating the Individualized Care Plan (ICP)
Care Transitions

• The Member’s primary care physician (PCP) is notified within one business day of the health plan being notified of the Member’s transition.
Care Transitions

- For each care transition, the Member’s Care Team attempts to contact the Member to discuss their health status, plan of care, and options available for discharge (e.g., SNF, home with home health, etc.).
Behavioral Health Services
Behavioral Health (BH) Services

PCP Role in Identifying BH Needs

• Primary Care Physicians (PCP) are responsible for diagnosing and treating Members with BH conditions within their scope of service, including:
  • Depression
  • Anxiety
  • Adjustment reaction
  • ADHD

• PCPs are responsible for screening Members 18 years and older for alcohol misuse. This annual screening is referred to as Screening, Brief Intervention, and Referral to Treatment (SBIRT).

• For mild to moderate mental health conditions, PCPs can request a second opinion/consult from an IEHP network mental health provider, when necessary, to continue medication management.
Cultural Competence
Cultural Competence

• IEHP, its delegates and Providers will provide all medically necessary and covered services to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, gender identity, marital status, sexual orientation, health status, Limited English Proficiency, or disability.

• IEHP care coordination services will:
  – Deliver health care services that are respectful and responsive to the cultural and linguistic needs of IEHP Members.
Cultural Competence

LGBT Community

Heteronormative assumptions can dissuade Members who are Lesbian, Gay, Bisexual, Transgender (LGBT) from seeking future care.
  - Anticipate that all patients are not heterosexual
  - Use “partner” instead of boyfriend/girlfriend/spouse
  - Replace marital status with relationship status
  - Coming out to healthcare Provider/s can add a layer of anxiety and fear

Gender Identity

Member’s gender identity and/or expression may be different from that typically associated with their assigned sex at birth
  - Listen to how patients refer to themselves and loved ones (pronouns, names)
  - Use the same language they use
  - If you have a question or are not sure ask relevant and appropriate questions

* Cultural Competency Training for Healthcare Providers: Connecting with your patients. Industry Collaboration Effort (ICE) Cultural and Linguistic Services Main Team Cultural Competency Training Workgroup 2013
Cognitive Competence

IEHP, its Delegates and Providers will assist Members with cognitive impairments. For example:

• Allow additional time to meet with the Member.
• Assess level of understanding
• Use short, simple sentences, and plain language.
• Give the Member enough time to understand what you have said and to respond.
• Communicate without words if needed, use visual aids or demonstrate
Refugees and Immigrants
Refugees and Immigrants may:

- Not be familiar with the U.S. health care system.
- Experience illness related to life changes.
- Practice spiritual and botanic healing or treatments before seeking “western” medical advice.
- May not comply with a treatment because it conflicts with their beliefs or traditional practices.
- May already have their own ideas about what caused their illness.

Refugees and Immigrants

Understanding racial and ethnic differences may assist you in providing care for Members of diverse backgrounds.

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.
- Some treatments and “medicines” that are considered “folk” medicine or “herbal” medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are “hard to find” or that are purchased “at special stores” may get you a more accurate understanding of what people are using than asking about “alternative,” “traditional,” “folk,” or “herbal” medicine.
- Many patients may become dissuaded by the requirements set by visiting multiple doctors. Explain to Members why they have to be seen by another doctor and stress the need for follow-up care and medication adherence.
- Members may also be uncomfortable with a Provider or interpreter of a different sex. Team Members can accommodate with a doctor or interpreter of the same gender.
Limited English Proficiency
Limited English Proficiency

Who is a Member with LEP?

- Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered limited English proficient (LEP)*.

Perils of Having Limited English Proficiency

- Receiving lower quality health care.
- Poorer compliance with medical recommendations.
- Higher risk of medical errors.
- Difficulties understanding their diagnosis or why they receive particular types of care.
- Disproportionately high rates of infectious disease and infant mortality.
- Discordant communication resulting in both lower patient and clinician satisfaction.

* U.S. Department of Health and Human Services OPHS, Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health Care

* Module 2: Cultural Competency: Race, Ethnicity, Language, and Unconscious Bias in Health Care, Cheri Wilson, MA, MHS, CPHQ
Limited English Proficiency

How to Identify a Member with LEP over the Phone

- Member is quiet or does not respond to questions.
- Member simply says yes, no, or gives inappropriate or inconsistent answers to your questions.
- Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate.
- Member identifies as having LEP by requesting language assistance.
Limited English Proficiency

IEHP monitors and meets the linguistic needs of its Members in the following ways:

- Provide face to face and telephonic interpretation services at medical appointments and when communicating with Members.
  - Call IEHP Member Services during regular business hours to schedule an interpreter.
  - Providers can call after hours, call Nurse Advice Line (1-888-244-4347).
  - IEHP Team Members can call Pacific Interpreters directly at 1-866-749-4906 for telephonic interpretation.
- Audit Provider offices for language capabilities.
- Assign Spanish speaking Team Members to the Member Services Spanish Queue.
Sample Case on Race, Ethnicity, and National Origin

An elderly woman from Bosnia being admitted with terminal cancer may present the following challenges for health care staff and organizations: she and her family do not read, speak or understand English; her Muslim faith requires modesty during physical examinations; and her family may have cultural reasons for not discussing end-of-life concerns or her impending death. A culturally and linguistically appropriate response would include interpreter staff; translated written materials; clinical and support staff who know to ask about and negotiate cultural issues; appropriate food choices; sensitive discussions about treatment consent and advance directive forms; and other measures. The provision of these kinds of services has the potential to improve patient outcomes and the efficiency and cost-effectiveness of health care delivery.*

Accessibility and Accommodations
Disability

What is a disability?
• The interaction of physical, sensory, or cognitive impairment with environmental factors.
  • Not all disabilities are visible or apparent, always ask Members how we can better assist them in achieving their health care goals.
  • Accommodations in communication (oral, written, visual), physical access and healthcare policy may be appropriate and necessary to achieve health goals.
  • Not all Members with disabilities identify as having a disability.
    • Listen to how patients refer to themselves and their situation.

* Cultural Competency Training for Healthcare Providers: Connecting with your patients. Industry Collaboration Effort (ICE) Cultural and Linguistic Services Main Team Cultural Competency Training Workgroup 2013
Accessibility and Accommodations

- IEHP continuously seeks to remove barriers that prevent access to care in transportation, Provider Sites, digital media and written and verbal communication.

- IEHP care coordination services will deliver health care services that are accessible and sensitive to the disability-related needs of IEHP Members.
Accessibility and Accommodations

• **Access to American Sign Language Interpretation:** IEHP offers Members with auditory disabilities American Sign Language Interpreters when accessing plan services and programs (PCP office visit, Specialist appointments, IEHP Community Resource Center, IEHP Atrium, etc.). Members must contact IEHP Member Services at least 5 days in advance to schedule their interpreter.

• **TTY Service:** TTY service is designed for individuals with hearing and speech difficulties that allows Members to communicate with IEHP through text communication over a telephone line. Members who utilize TTY can contact IEHP by using a dedicated phone number (1-800-718-4347).
Accessibility and Accommodations

• **Provider Office Accessibility Ratings:** IEHP conducts Facility Site Reviews of Provider offices to determine a clinic’s accessibility and specifically examines the interior/exterior of the building, restroom, exam room, provision of accessible medical equipment, and parking.

  —The information collected from the Facility Site Review is made available to Members and Team Members through the IEHP Provider Directory, iehp.org, and Member Services to select a Provider that meets the Member’s accessibility needs.
Accessibility and Accommodations

• IEHP provides Members with limited transportation resources with information on how to arrive to their medical appointments by using low-cost public transportation services.
  – Members and Team Members can access public transportation information by utilizing the IEHP Provider Directory, iehp.org, or calling Member Services.
Accessibility and Accommodations

• **Alternate Formats:** IEHP Members may choose to receive documents sent from IEHP in the alternate formats offered. Currently available are Braille, large print, e-text, text-to-ASL, and audio. IEHP Members can call Member Services to request alternative format for a specific document or all future correspondence.
Independent Living, Recovery and Wellness Principles

Independent Living
We believe each Member with a disability deserves an equal opportunity that allows him/her to live, work and take part in the community and access services that support independence.

Recovery and Wellness Principles
IEHP helps the Member through “a process of change” – from living with a behavioral health disorder (or a substance use disorder) – to leading a healthier life. In this process, IEHP can empower the Member to improve his/her health and wellness.
Independent Living Philosophy

• Independent Living Philosophy emphasizes consumer control, the idea that people with disabilities are the best experts on their own needs, having crucial and valuable perspective to contribute and deserving of equal opportunity to decide how to live, work, and take part in their communities, particularly in reference to services that powerfully affect their day-to-day lives and access to independence. In this model, the problem lies in the environment, not the individual. Though many people have physical, intellectual, or mental attributes that deviate from the ‘norm,’ disability is manifested in society through created and maintained physical, programmatic, and attitudinal barriers. (Adapted from The National Council on Independent Living http://www.ncil.org/about/aboutil/).
Independent Living Philosophy

• IEHP proactively seeks to improve access, communication, and healthcare services for seniors and persons with disabilities. Accessibility initiatives within the health plan include the Independent Living and Diversity Services department, Long-Term Services and Supports unit, Care Management Interdisciplinary Care Team meetings and disability cultural competency trainings.

• The Independent Living and Diversity Services department provides training to all Team Members and to IEHP Providers as requested to address the Independent Living Philosophy and Disability Awareness.
Independent Living Philosophy

• The Independent Living and Diversity Services Program offers the **Resource and Referral Service** to connect seniors and persons with disabilities to local resources. Like LTSS, **these resources are provided to assist Members to remain safely in their home and prevent or delay placement in a skilled nursing facility.** The Resource and Referral Service provides access to organizations in Riverside and San Bernardino counties that provide peer support, transportation, support groups, education, housing, employment, and other basic needs.
Long-Term Services and Supports (LTSS) including Home and Community-Based Services
Long-Term Services and Supports

- Long-Term Services and Supports (LTSS) make up a Member-centered, long-term support system in which older adults and people with disabilities have access to a full array of quality medical and social services that assist Members to remain safely in their home and prevent or delay placement in a skilled nursing facility.
Long-Term Services and Supports

Least Restrictive Setting

Members will receive services in the Least Restrictive Environment when:

• Placement is appropriate
• Member does not oppose to these services; and
• Services can be reasonably accommodated

Long-Term Services and Supports

Programs:

• In-Home Supportive Services (IHSS) – County – run program provides caregivers for people who need help with activities of daily living;
• Community-Based Adult Services (CBAS) – Adult Day healthcare at a nonresidential center with daily nursing care and supervision;
• Multipurpose Senior Services Program (MSSP) – County-run case management program for people 65 or older;
• Long-Term Care facility – long-term care provided in a facility.
Long-Term Services and Supports

Who is eligible for IHSS?
Members who:

• Are disabled, blind, or age 65+; and
• Have a condition that will last more than 12 months; and
• Are unable to perform Activities of Daily Living; and
• Are at risk of hospitalization or placement in a long-term care facility; and
• Have a medical certification form signed by a licensed health care professional
Long-Term Services and Supports

IHSS services may include, but are not limited to:

• Housecleaning;
• Preparation of meals;
• Routine laundry;
• Grocery shopping;
• Personal care services;
• Accompaniments to medical appointments;
• Protective supervision for Members with mental impairment;
• Paramedical services such as wound care, injections, glucose monitoring, tube feeding, catheter insertions, and colostomy irrigation.
Who is eligible for CBAS?

Members who:

• Are 18 years of age or older;

• Have one or more chronic medical, cognitive, or Behavioral Health (BH) conditions that limit activities of daily living, but do not require twenty-four-hour institutional care;

• Require on-going or intermittent protective supervision or skilled observation/intervention to minimize deterioration;

• Have high potential for further impairment and probable need for institutional care if additional services are not received.
Long-Term Services and Supports

CBAS services may include, but are not limited to:
• Adult day healthcare at a nonresidential center with daily nursing care and supervision;
• Therapeutic activities designed to improve movement, flexibility, memory, and mood;
• Social services;
• Healthy meals/snacks; and
• Personal care services.
• The following are additional services that will be provided if specified in the Member’s Individualized Care Plan (ICP):
  —Therapies, as needed (Physical, Occupational, and Speech);
  —Psychiatric and psychosocial services;
  —Registered dietician services; and/or
  —Transportation to/from CBAS center and Member’s place of residence
Goals for CBAS Centers:
– Allow Member to remain in their own home or residence with supported “day healthcare”;
– Prevent costly and preventable hospitalizations, ER use, and avoid placement in a nursing facility; and
– Maintain optimal capacity for self-care and personal independence.
Long-Term Services and Supports

Who is eligible for MSSP?

Members who:

• Are age 65 or older; and
• Are certified for placement in a nursing facility; and
• Are able to be served within MSSP’s cost limitations; and
• Are appropriate for care management services.
Long-Term Services and Supports

MSSP services may include, but are not limited to:

• Case management;
• Personal care services;
• Respite care (in-home and out-of-home);
• Environmental accessibility adaptations;
• Housing assistance/minor home repair, etc.;
• Transportation;
• Chore services;
• Personal Emergency Response System /Communication device;
• Adult day care;
• Protective supervision;
• Meal services – Congregate/Home delivered;
Long-Term Services and Supports

Referrals to County MSSP

• The LTSS Team will assess, refer, coordinate care, and facilitate communication among all providers.
• Eligibility will be determined by the County MSSP staff once they complete their assessment.
• MSSP has a waiting list that may take 3-6 months.
• IEHP will assist the practitioners with coordinating available services for Members awaiting the County MSSP intake process.
Long-Term Services and Supports

County MSSP Assessment and Reassessment Process

• Members are assessed by a County MSSP Nurse and a Social Worker at intake.
• A care plan is developed to address the needs and to coordinate care.
• The care plan is updated when there is a change in condition.
• Informal no-cost resources, community resources, or Purchased Services identified in the care plan are provided.
• Members are reassessed at least annually.
Long Term Care

Skilled Nursing Facility (SNF)
A Member may qualify for Skilled Nursing Facility (SNF) services if they have a physical disability and need a high level of care. SNF services must be prescribed by a Doctor and given in a licensed SNF.

Covered benefits:
• Skilled nursing care
• Care management
• Bed and board (daily meals)
• X-ray and laboratory
• Physical, speech and occupational therapy
• Prescribed medicine, medical supplies, and equipment normally given by the Skilled Nursing Facility

Doctors can submit a referral to IEHP UM department for review.
Home and Community-Based Services

Other Home and Community-Based Services (HCBS) not covered by IEHP but available through Medi-Cal.

- HCBS for the Developmentally Disabled provided by Inland Regional Center
- Home and Community-Based Alternatives Waiver Program
- AIDS Medi-Cal Waiver Program

Providers can refer Member identified as needing these services to the appropriate Department of Health Care Services department or HCBS Provider, i.e., Inland Regional Center, Desert AIDS Project, etc.
Home and Community-Based Services

HCBS for the Developmentally Disabled

• Provides in-home care to Members with developmental disabilities that need an intermediate level of care as an alternative to institutionalization.
• Services include:
  • Skilled nursing services, home health aide services, residential habilitation, day habilitation, environmental modifications, vehicle adaptations, personal emergency response systems, psychological services, communication aids and crisis intervention.

Referrals: Inland Regional Center
1365 S. Waterman Ave San Bernardino, CA 92408
(909) 890-3000
Home and Community-Based Services

Home and Community-Based Alternatives (HCBA) Waiver Program

• For Members with physical disabilities who are at risk or require care for 90 consecutive days or greater in a SNF.

• Services include:
  • Case Management, Transitional CM, Private Duty Nursing, Home Health Aid Services, Psychological services and counseling to family members, environmental accessibility adaptations, personal emergency response system, medical equipment operating expenses, Waiver Personal Care Services, Habilitation Services, Respite Care (home and facility), Developmentally Disabled/Continuous Nursing Care Non-ventilator and ventilator dependent services.

Referrals: Institute on Aging
3575 Geary Boulevard  San Francisco, CA 94118
(415) 750-4111
Home and Community-Based Services

AIDS Medi-Cal Waiver Program

• Provides in-home and community-based services to Members with AIDS or related diseases as an alternative to institutionalized care.
• Services include:
  • Case Management, in-home skilled nursing care, attendant and homemaker care, psychological counseling, equipment and minor physical adaptations to the home, medical supplements for infants and children in foster care, non-emergency medical transportation, nutritional counseling and supplements, home-delivered meals and administrative expenses.

Referrals: Desert AIDS Project
1695 N. Sunrise Way Palm Springs, CA 92262
(760) 323-4197
IEHP & Delegate Responsibilities

—Coordinating with the PCP to ensure that the Member receives medically necessary health care services and/or MSSP like services, regardless of approval to the MSSP Program; and

—Maintaining continuous and unimpeded flow of medical information between practitioners, including assisting the PCP to obtain MSSP assessments and care plans if needed.
Referrals

CM Referral Form is available on IEHP website

IEHP Care Management Referral Form

Member Name: [Field]
Member ID: [Field]
DOB: [Field]
Date: [Field]
Member ID#: [Field]
IPA: [Field]
Member Phone: [Field]
Alt Phone: [Field]
Caregiver/Family Member Name: [Field]
Caregiver/Family Phone: [Field]
Referral Source: [Field]
Referral by: [Field]
Contact phone: [Field]
Contact email: [Field]

Reason for Referral:
- Diagnosis
- High Utilization
- Social Needs
- Behavioral Health
- Rx
- Maternal/Child Health Needs
- Long-Term Services and Supports (In-Home Support Services, Community-Based Adult Services, Multiservice Senior Services Program)

Diagnosis Triggers
- Advanced liver disease
- Severe psychoses
- New cerebral vascular accident
- Trauma (current)
- Metastatic cancer/pediatric cancer
- Decompensating neurological conditions
- Complex pain management control issues
- Multiple chronic illnesses-uncontrolled

Utilization Triggers
- Projected cost of care within a 12-month period anticipated to be >$100,000 (including high-cost medications and/or DME)

Psychosocial/Frailty Triggers
- Malnutrition and/or catabolic illness, loss of weight
- Severe and persistent mental illness
- Major problems of urine/bowel retention or control
- Social support needs (e.g., housing/food)
- Difficulty in walking/fall risk
- Decubitus ulcer (Stage 3, Stage 4)
- Suspected or reported abuse of Member

Triggers for referral to Long-Term Services and Supports
- Alzheimer’s or Dementia
- Needs a caregiver
- Needs ongoing nursing monitoring and supervision at Adult Day Healthcare Center
- Needs long-term care facility
- Needs pneumonia monitoring and supervision at Adult Day Healthcare Center

Please return completed Form via Secure Email to CMReferralForm@iehp.org and attach all applicable documentation.
(Please allow up to 5 business days for referral to be processed and response)

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# IEHP Care Management Referral Form

**Demographics**

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Member ID#</th>
<th>Date</th>
</tr>
</thead>
</table>

**Line of Business:**
- [ ] Medi-Cal
- [ ] CalMedConnect (LTSS referrals only)

**Member DOB:** IPA

**Member Phone:** Alt Phone:

**Caregiver/Family Member Name:**

**Caregiver/Family Phone:**

**Referred by**

**Reason for Referral:**
- [ ] Diagnosis
- [ ] High Utilization
- [ ] Social Needs
- [ ] Behavioral Health
- [ ] Maternity/Child Health Needs

**Diagnosis Triggers**
- [ ] Advanced liver disease
- [ ] Severe psychosis
- [ ] New cerebral vascular accident
- [ ] Trauma (current)
- [ ] Metastatic cancer/pediatric cancer
- [ ] Dementia/neurological conditions
- [ ] Complex pain management control issues
- [ ] Multiple chronic illnesses/uncontrolled

**Utilization Triggers**
- [ ] 6 or more ER visits in the past 12 months
- [ ] 2 or more readmissions to acute setting within 30 days
- [ ] 4 or more inpatient stays in the past 12 months
- [ ] On multiple medications for multiple chronic conditions
- [ ] Projected cost of care within a 12-month period anticipated to be >$100,000 (including high-cost medications and/or DME)

**Psychosocial/Frailty Triggers**
- [ ] Malnutrition and/or metabolic illness, loss of weight
- [ ] Major problems of urine/urinary retention or control
- [ ] Difficulty in walking/fall risk
- [ ] Decubitus ulcer (Stage 3, Stage 4)
- [ ] Social support needs (e.g., housing/food)
- [ ] Suspected or reported abuse of Member

**Triggers for referral to Long-Term Services and Supports**
- [ ] 65+ and at risk of placement in a Long-Term Care facility
- [ ] Severe and persistent mental illness
- [ ] Disabled, blind, or senior unable to perform activities of daily living
- [ ] Needs a caregiver
- [ ] Alzheimer's or Dementia
- [ ] Needs ongoing nursing monitoring and supervision at Adult Day Healthcare Center

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Please email all completed forms to CMReferralTeam@iehp.org and attach all applicable documentation.

*(Please allow up to 5 business days for referral to be processed and response)*

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Send form to...

• Please provide supporting documentation to support the referral to Complex Case Management.
  – Clinical notes
  – Active authorization
  – IPA Care Manager contact info

• Email form securely to cmreferralteam@iehp.org

• Allow up to 5 business days for referral to be processed and a response.

• If Member does not meet criteria, Member will be referred back to IPA.
Dementia Care
Dementia Care

• What is Dementia?
  – According to the Alzheimer's Association, dementia is a general term for a decline in mental ability severe enough to interfere with daily life.

• Who is affected?
  – 5.4 million Americans have been diagnosed with Alzheimer's/Dementia

• Those diagnosed with Dementia include:
  – 610,000 Californians
    • Only 5% are diagnosed at age 65
    • More women have Alzheimer's than men
    • African Americans & Hispanics are affected more often than Caucasians
Dementia Care

- Common symptoms of Dementia
  - Memory loss
  - Impaired judgment to maintain daily activities such as paying bills or becoming lost while driving
- Important Facts
  - 5th leading cause of death in California
  - Top 10 condition without a known cause or cure
Dementia Care

• Common Pharmacological Treatments
  – Medication: Donepezil, Memantine, Gaiantamine and Rivastigmine
• Non-Pharmacological Options
  – Referral to CBAS day program
  – Alert bracelet for those who wander
• Support for Caregivers
  - Respite, support groups, etc.
• Safety plan
  – fall risk, wandering & home safety
  – Environmental modification
Dementia Care

• Barriers to Dementia care
  – Late diagnosis; symptoms are often masked
  – Family is unaware of resources or support for their loved one
  – Caregiver/family burnout
  – Over medicated
Dementia Care

- Care Managers role for our Members with Dementia
  - Assess the needs
    - Health Risk Assessment
    - Long-Term Services and Supports assessment
    - AD8 Dementia Screening tool
      - Confirm Provider involvement
      - Assess for Caregiver burnout
        - Caregiver Strain Assessment
        - Provide resources for support
# Dementia Care

## AD8 Dementia Screening

<table>
<thead>
<tr>
<th>AD8 Dementia Screening Interview</th>
<th>YES, A change</th>
<th>NO, No change</th>
<th>N/A, Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remember, “Yes, a change” indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Less interest in hobbies/activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Repeats the same things over and over (questions, stories, or statements)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, microwave, computer)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient ID#:__________**

**CS ID#:__________**

**Date:__________**

CCI 3-Way
Dementia Care

Tips for Caregivers

- Care Managers will remind Caregivers to...
  - Be patient and sensitive when responding to the Member’s needs
  - Communicate with family any changes
  - Inform PCP of changes; especially with medications
  - Use proper body mechanics when providing care
Dementia Care

Tips for Caregivers

• Bathing Challenges
  – Stay calm
  – Give step by step instructions
  – Don’t argue
  – Consider sponge bath instead of bathing in a tub
Dementia Care

Tips for Caregivers

- Sundowning
  - Common behaviors
    - Confusion, anxiety, aggression, or ignoring directions
  - Lessening symptoms
    - Reduce noise
    - Distract with an activity e.g. puzzles
    - Keep routine as much as possible
    - Close drapes/curtain at dusk to minimize confusion
Dementia Care
Managing Behaviors

- Stress management tips
  – Physical activity: such as walking, is one of the best stress relievers for all involved
  – Involve the Member in simple activities such as; folding laundry, looking at magazines or newspaper or photo albums
  – Calming music or play Member’s favorite music
  – Pets can be helpful
Resources

• Dual-eligible explore Care Plan Options for respite
• Connect IE website (www.connectie.org) can provide local community resources on:
  – Assistive technology
  – Support groups
  – Caregiver resources
Resources

• Inland Caregiver Resource Center
  – (800) 675-6694
  – www.Inlandcaregivers.org

• IHSS Public Authority (Caregiver Registry)
  SB County (866) 985-6322
  Riverside County (888) 470-4477

• Office on Aging
  – Riverside County (951) 867-3800
  – San Bernardino County (909) 948-6235

• Alzheimer's Greater Los Angeles
  – http://www.alzgla.org/
  – 24/7 Alzheimer helpline
    (844) 435-7259
Resources

Alzheimer’s Greater Los Angeles

Resource Videos

• Alzheimer's Association 2017 Alzheimer's Disease Facts & Figures

• Experience 12-Minutes In Alzheimer's Dementia
MEMBER RIGHTS & RESPONSIBILITIES

Upon enrollment, IEHP Members receive an Enrollment Packet, which includes the Member Handbook. The Member Handbook includes the Member Rights and Responsibilities:

Click here to access the IEHP Medi-Cal Member Handbook

Click here to access the IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) Member Handbook
Please contact the following for more information:

IEHP Providers are instructed to, call the Provider Relations Team at (909) 890-2054, 8am-5pm, Monday-Friday or email providerservices@iehp.org