The Inland Empire Health Plan's (IEHP) Coordinated Care Initiative (CCI) Three-Way contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) requires that IEHP staff, Delegates, Providers, and their staff, as part of the Member’s care team, receive an initial and annual training on the health plan’s care model for its dual-eligible Members.

In addition, California-specific measure CA3.2 requires care coordinators to be trained on how to support Member self-direction. These requirements also give us an opportunity to share more information about care management and care coordination services for our dual-eligible population.

**Our IEHP DualChoice Population**

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.

**Need more?**

Click on the link to view the Summary of Benefits to the IEHP DualChoice Cal MediConnect Plan

[CLICK HERE]
OUR IEHP DUALCHOICE POPULATION DESCRIPTION

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

- Likely to have multiple co-morbidities
- Likely to have behavioral health conditions
- May need help with at least 2 or more activities of daily living
- As a result are more likely to be sick, have higher utilization rates and need more intensive care

IEHP'S 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 as well as social determinants of health.

The HRA is performed initially and then annually, or sooner if the Member’s condition or health status changes.

HRA PROCESS

IEHP will conduct the HRA in-person if requested. Otherwise, IEHP will perform the HRA by mail or phone. HRA results are collected, analyzed, and used in development of an initial individualized care plan (ICP) for all Members, regardless of their risk satisfaction. The ICP must be developed within 90 calendar days of the Members enrollment.
IEHP DualChoice Members’ HRA completion status is displayed on the PCP’s Assigned Roster page on the secure IEHP Provider portal as shown below.
IEHP DUALCHOICE

IEHP DualChoice Members are separated into High Risk and Low Risk categories based on the 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.

MAINTENANCE OF INDIVIDUALIZED CARE PLAN (ICP)

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.
ICP REVIEW

Nurse Care Managers review ICPs with the Member upon development and on an ongoing basis. ICP will be mailed to the Member. The ICP is developed with input from Members, caregivers, and their families. The Member may determine the caregiver's level of involvement.

ICPs are re-evaluated and updated on a regular basis when:
- Member’s health status changes
- Member makes a Primary Care Provider (PCP) change

HRA & ICP ACCESSIBILITY

The HRA results and ICPs are available for Providers after they successfully log into the secure IEHP Provider portal. The Member's information is entered in the Eligibility section and the Provider Alerts section can be viewed.

---

**Eligibility**

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

Eligibility history available from 12/12/2015

---

**IEHP Provider Portal**

**Eligibility**

<table>
<thead>
<tr>
<th>Effective On</th>
<th>IEHP ID</th>
<th>Member</th>
<th>IPN Code</th>
<th>PCP(PCP ID)</th>
<th>Type</th>
<th>View/Download</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/06/2015</td>
<td>IEHP Direct</td>
<td>Complex</td>
<td>View</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CARE PLANNING

Providers are able to view specific details of the Member’s ICP.

CARE PLAN ATTESTATIONS

For Members receiving specialty mental health services, their PCP and Behavioral Health Provider review and attest to their ICP.
ELECTRONIC HEALTH INFORMATION

Electronic Medical Records are available for Providers through the secure IEHP Provider portal by entering the Member’s information in the Eligibility section, then clicking on Medical History Record.

INTERDISCIPLINARY CARE TEAM (ICT) PARTICIPANTS

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 reflect:
- A person-centered, outcomes-based approach
- A Member's right to self-direct the provision of Long-Term Services and Supports (LTSS)
- A Member's right to determine the appropriate level of involvement of their health care provider, LTSS providers, and caregivers.

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

- At a minimum, the ICT shall consist of the IEHP or IPA Care Manager, Member, Member’s caregiver (or Member’s authorized representative), and the Member’s PCP.
- IEHP or the Member’s assigned IPA ensures that all IEHP DualChoice Members are appropriately assigned to an ICT
- ICT strives to address the multiple issues that affect these Members (e.g. medical, behavioral health, psychosocial, cognitive, functional issues, and Social Determinants of Health)

**ADDITIONAL ICT DETAILS:**

Which Members need to have an ICT Meeting?
- All High-Risk Members
- All Members with one or more identified problem or need
- Members who request or whose caregiver request an ICT meeting

**MEMBER’S PARTICIPATION IN ICT**
- 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 their contact information
- Care Coordinator/Nurse Care Manager must revisit ICT participation at reassessment or when Member requests PCP change

**ADDITIONAL ICT MEMBERS MAY INCLUDE:**
- Specialist, therapists, occupational therapists
- Medical Director, Behavioral Health Specialist & Pharmacist
- Community-Based Organizations (CBO)
- Community-Based Adult Services (CBAS) Provider, if receiving services
- In-Home Supportive Services (IHSS) Social Worker, if receiving services
- IHSS Provider, if authorized by the Member
- Multipurpose Senior Services Program (MSSP) Care Manager, if receiving services
- Other professionals, as appropriate

**DELEGATED PROVIDERS**

If a Member is receiving IHSS, the Delegate must invite the County IHSS Social Worker to the ICT. Contact information is available through the LTSS Roster on the secure Provider web portal.
ICT COMMUNICATION

- IEHP or the IPA has regular case conferences and adhoc 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, barriers causing Members to not meet 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.

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

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

The Member's Care Team works together with physicians, facility staff, Members and their caregivers to ensure Members are supported during planned and unplanned care transitions.

The Member’s Primary Care Provider (PCP) is notified within one business day of the health plan being notified of the Member’s transition.

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.).

PCPs' ROLE IN BEHAVIORAL HEALTH SERVICES

PCPs are responsible for diagnosing and treating Members with Behavioral Health conditions within their scope of service which includes depression, anxiety, Adjustment disorder & ADHD.

- PCPs are responsible for providing Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIR) to Members ages 11 years and older, including pregnant women.

- For mild to moderate mental health conditions, PCPs can directly refer the Member to a BH Provider for an initial assessment; although a referral is not required for Members to obtain an initial mental health assessment through a BH Provider.
IEHP, its Delegates, and Providers will provide all medically necessary and covered services to all Members regardless of: Race, color, ethnicity, ethnic group identification, national origin, ancestry, language, religion, sex, age, mental or physical disability or medical condition, gender, gender identity, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, marital status, or source of payment.

IEHP Care Coordination services will:
Deliver health care services that are respectful and responsive to the cultural and linguistic needs of IEHP Members.

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 Providers can add a layer of anxiety and fear
MEMBER’S 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

COGNITIVE COMPETENCE

IEHP, its Delegates, and Providers will assist Members with cognitive impairment. 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 U.S. health care system
- Experience illness related to life changes
- Practice spiritual and botanical healing or treatments before seeking "Western" medical advice
- Not comply with treatment because it conflicts with their beliefs or traditional practices
- Already have their own ideas about what caused their illness.

UNDERSTANDING RACIAL AND ETHICAL DIFFERENCES

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 (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.

PERILS OF HAVING LEP

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

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

HOW DOES IEHP MEET LINGUISTIC NEEDS OF ITS MEMBER

Providing face to face and telephonic interpretation services at medical appointments and when communicating with Members

- Members and Providers can call IEHP Member Services to access telephone interpretation service during business hours.
- After business hours, Members and Providers can call the 24-Hour Nurse Advice Line at (888) 244-IEHP (4347), or (866) 577-8355 for TTY users to access interpretation services.
- Call IEHP Member Services during regular business hours to schedule an interpreter.
- Verifying Provider offices’ language capabilities.
- Assigning Spanish speaking Team Members to the Member Service Spanish Queue.
SAMPLE CASE:

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.
ACCOMMODATIONS FOR IEHP MEMBERS

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

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

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

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.
ACCESS TO AMERICAN SIGN LANGUAGE INTERPRETATION:

IEHP offers Members with auditory disabilities American Sign Language Interpreters when accessing plan service and programs

- PCP office visit
- Specialist appointment
- IEHP Community Resource Center
- IEHP Atrium

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 speech difficulties that allows Members to communicate with IEHP through text communications over a telephone line.

Members who utilize TTY can contact IEHP by using a dedicated phone (1-800-718-4347)

DIFFERENT SERVICES OFFERED TO IEHP MEMBERS

IEHP offers different services to Members who have disability-related needs.

Public transportation information is available in the IEHP Provider Directory and online at www.iehp.org, or by calling IEHP Member Services.

IEHP provides both non-medical transportation (NMT) and non-emergency medical transportation (NEMT) services for prior authorized services and Medicare and/or Medi-Cal covered services within San Bernardino and Riverside counties.

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 for all future correspondence.
LONG-TERM SERVICES AND SUPPORTS (LTSS) INCLUDING HOME AND COMMUNITY-BASED SERVICES (HCBS)

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

We believe each Member with a disability deserves an equal opportunity that allows them 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” - living with a behavioral health disorder (or substance use disorder) - to leading a healthier life. In this process, IEHP can empower the Member to improve their health and wellness.

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 Philosophy and Diversity Services Department, Long-Term Services and Supports Unit, Care Management Interdisciplinary Care Team meetings, and disability cultural competency training.

The Independent Living Philosophy 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.

The Independent Living Philosophy 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)

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 in remaining safely in their home and preventing or delaying placement in a skilled nursing facility.

Least Restrictive Environment

Members will receive services in the least restrictive environment when:

- Placement is appropriate
- Member does not oppose these services
- Services can be reasonably accommodated

LTSS provides different types of services and supports depending on the Member's need.
In-Home Supportive Services (IHSS)

In-Home Supportive Services (IHSS) - County - run program provides caregivers for people who need help with activities of daily living.

**IHSS ELIGIBILITY REQUIREMENTS**

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

**IHSS SERVICES**

- 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
Community Based Adult Services (CBAS)

Community-Based Adult Services (CBAS) - Adult day healthcare at a nonresidential center with daily monitoring and supervision by a nurse.

The goal for the CBAS Centers are to allow Members to remain in their own home or residence with supported "day healthcare", leading to maintaining optimal capacity for self-care and personal independence. Lastly, it aims to prevent costly and preventable hospitalizations, ER use, and avoid placement in a nursing facility.

<table>
<thead>
<tr>
<th>CBAS ELIGIBILITY REQUIREMENTS</th>
<th>CBAS SERVICES</th>
<th>ADDITIONAL SERVICES IF SPECIFIED IN THE ICP</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 18 years of age or older</td>
<td>• Adult day healthcare at nonresidential center with daily nursing care and supervision</td>
<td>• Therapies as needed (Physical, Occupational, and Speech)</td>
</tr>
<tr>
<td>• Have one or more chronic medical, cognitive, or Behavioral Health conditions that limit Activities of Daily Living, but do not require twenty-four-hour institutional care</td>
<td>• Therapeutic activities designed to improve movement flexibility, memory and mood</td>
<td>• Psychiatric and psychosocial services</td>
</tr>
<tr>
<td>• Require on-going or intermittent protective supervision or skilled observation/intervention to minimize deterioration</td>
<td>• Social Services</td>
<td>• Registered dietician services</td>
</tr>
<tr>
<td>• Have a high potential for further impairment and probably need for institutional care if additional services are not received</td>
<td>• Healthy meals/snacks</td>
<td>• Transportation to/from CBAS center and Member’s residence</td>
</tr>
<tr>
<td></td>
<td>• Personal care services</td>
<td></td>
</tr>
</tbody>
</table>
**MSSP**

Multipurpose Senior Services Program (MSSP) is a county-run case management program for people 65 years of age or older.

<table>
<thead>
<tr>
<th>MSSP ELIGIBILITY REQUIREMENTS</th>
<th>MSSP SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Are 65 or older</td>
<td>• Case management</td>
</tr>
<tr>
<td>• Are certified for placement in nursing facility</td>
<td>• Personal care services</td>
</tr>
<tr>
<td>• Able to be served within MSSP’s cost limitations</td>
<td>• Respite care (in-home or out of home)</td>
</tr>
<tr>
<td>• Are appropriate for care management services</td>
<td>• Environmental accessibility adaptations</td>
</tr>
</tbody>
</table>

**LONG-TERM CARE**

<table>
<thead>
<tr>
<th>SKILLED NURSING FACILITY (SNF) ELIGIBILITY REQUIREMENTS</th>
<th>SKILLED NURSING FACILITY (SNF) SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A Member may qualify for SNF services if they have physical disability and need high level of care</td>
<td>• Skilled nursing care</td>
</tr>
<tr>
<td>• SNF services must be prescribed by a doctor and given in a licensed SNF</td>
<td>• Care management</td>
</tr>
<tr>
<td>• Doctors can submit a referral to IEHP’s UM Department for review</td>
<td>• Bed and board (daily meals)</td>
</tr>
<tr>
<td></td>
<td>• X-ray and laboratory</td>
</tr>
<tr>
<td></td>
<td>• Physical, speech, and occupational therapy</td>
</tr>
<tr>
<td></td>
<td>• Prescribed medicine, medical supplies, and equipment normally given by the SNF</td>
</tr>
</tbody>
</table>
MSSP Services

Referrals to County MSSP

- The LTSS Team will accept referrals from Providers then assess, refer, coordinate care, and facilitate communication among all providers
- Eligibility will be determined by the Count 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

County MSSP Assessment and Reassessment Process

- Members are assessed by a County MSSP Nurse and 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

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
- Maintaining continuous and unimpeded flow of medical information between practitioners, including assisting the PCP to obtain MSSP assessments and care plans, if needed
CARE PLAN OPTIONS

Optional services known as Care Plan Options (CPO) are not benefits but may be provided at IEHP's discretion and cost, and in accordance with the Member's Individualized Care Plan.

IEHP will review and approve CPO services based on IEHP-developed and approved criteria. Examples of CPO services may include:

- Nutritional Assessment
- Supplements and home-delivered meals
- Habilitation
- Personal care and chore type services
- Respite Care, etc.

HOME AND COMMUNITY BASED SERVICES (HCBS)

There are other Home and Community-Based Services (HCBS) not covered by IEHP, but available through Medi-Cal such as:

- 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 (DHCS) department or HCBS Provider, i.e., Inland Regional Center, Desert AIDS Project, etc. Providers can also contact IEHP Behavioral Health & Care Management Department for assistance if needed.

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 and Day habilitation
- Environmental modifications
- Vehicle adaptations
- Personal emergency response systems
- Psychological services
- Communication aids
- Crisis Intervention

Referrals for HCBS can be sent via mail or fax to:
Inland Regional Center 1365 S. Waterman Ave, San Bernardino, CA 92408
Fax:1-909-890-3000

HOME AND COMMUNITY-BASED ALTERNATIVES (HCBA) WAIVER PROGRAM

HCBA Waiver Program is for Members with physical disabilities who are at risk or require care for 90 consecutive days or greater in a SNF.

Services include:
- Psychological services and counseling to family members
- Home Health Aid Services
- Case Management, including transitional CM
- Private Duty Nursing
- Environmental accessibility adaptations
- Personal Emergency response system
- Medical equipment operating expenses
- Waiver personal care services
- Respite care (home and facility)
- Developmentally Disabled/Continuous Nursing Care (Non-ventilator and ventilator dependent services)

Referrals can be sent via mail or fax to: Institute on Aging
3575 Geary Boulevard, San Francisco, CA 94118
Fax 1-415-750-4111

AIDS MEDI-CAL WAIVER PROGRAM

Provides in-home and community-based services to Members with or related diseases as an alternative to institutionalized care. The 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
COMPLETE THE REFERRAL FORM

Please provide documentation to support the referral to Case Management.

- Clinical notes
- Active authorizations
- IPA Care Manager contact info
- Email form securely to cmreferralteam@iehp.org
- If Member does not meet criteria, the Member will be referred back to the IPA

REFERRAL SUBMISSION COMPLETE

- Allow up to 5 business days for referral to be processed and for a response
- Refer to Attachment A for IEHP Care Management Referral Form

DEMENTIA CARE & RESOURCES

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
- 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
COMMON SYMPTOMS OF DEMENTIA
- Memory loss
- Impaired judgement to maintain daily activities such as paying bills or becoming lost while driving

IMPORTANT FACTS
- 5th leading cause of death in California
- Top 10 conditions without a known cause or cure

COMMON PHARMACOLOGICAL TREATMENTS
- Medication: Donepezil, Memantine, Galantamine, and Rivastigmine

NON-PHARMACOLOGICAL OPTIONS
- Referral to CBAS day program
- Alert bracelet for those who wander

SAFETY PLAN
- Fall risk, wandering & home safety
- Environmental modification

SUPPORT FOR CAREGIVERS
- Respite, support groups, etc.

BARRIERS TO DEMENTIA CARE
- Late diagnosis: symptoms are often masked
- Family is unaware of resources or support for their loved one
- Family/care giver burnout
- Over medicated
- Racial Disparities exist in the African American, Hispanic, and Asian American communities. Members from these communities lack a diagnosis or are being diagnosed late in the stages of the disease. There are diverse views of dementia and its negative stigma that might prevent Members from seeking care. Views also vary on the use of formal healthcare services.

CARE MANAGER’S ROLE
- Care Manager’s role for our Members with Dementia
  - Assess the needs
    - Health Risk Assessment
    - Long-Term Services and Supports assessment AD8
    - Dementia Screening Tool
  - Assess for Caregiver burnout
- Confirm Provider Involvement
- Provide resources for support

TIPS FOR CAREGIVERS

CARE MANAGERS WILL REMIND CAREGIVERS TO:
- Be patient and sensitive when responding
- Communicate with family of any changes
- Inform PCP of changes; especially with medications
- Use proper body mechanics when providing care

BATHING CHALLENGES:
- Stay calm
- Give step by step instructions
- Don’t argue
- Consider sponge bath instead of bathing in tub

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
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 as possible

RESOURCES

- For DualChoice Members, explore Care Plan Options for respite services.
- Connect IE Website (www.connectie.org) can provide local community resources on:
  - Assertive technology
  - Support groups
  - Caregivers

- Inland Caregiver Resources Center
  - 1-800-675-6694
  - www.inlandcaregives.org

- IHSS Public Authority (Caregiver Registry)
  - Riverside County 1-888-470-4477
  - San Bernardino County 1-866-985-6322

- Office on Aging
  - Riverside County 1-951-867-3800
  - San Bernardino County 1-909-948-6235

- Alzheimer's Greater Los Angeles
  - https://www.alzheimersla.org/
  - 24/7 Alzheimer helpline 1-844-435-7259
  -

- IEHP LTSS resources webpage
MEMBERS’ RIGHTS & RESPONSIBILITIES

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

To access the IEHP DualChoice Cal MediConnect Plan (Medicare and Medicaid Plan) Member Handbook, go online to:

Questions or More Information:
• IEHP Team Member, contact your supervisor or manager
• IEHP Providers can contact:
  ◦ The Provider Relations Team at 1-909-890-2054, 8am-5pm, Monday-Friday or email providerservices@iehp.org.

IEHP CARE MANAGEMENT REFERRAL FORM

CLICK HERE