



A Public Entity

Inland Empire Health Plan

Health Homes Program



YEAR ONE IMPLEMENTATION REPORT
2019

Revised 06/12/20

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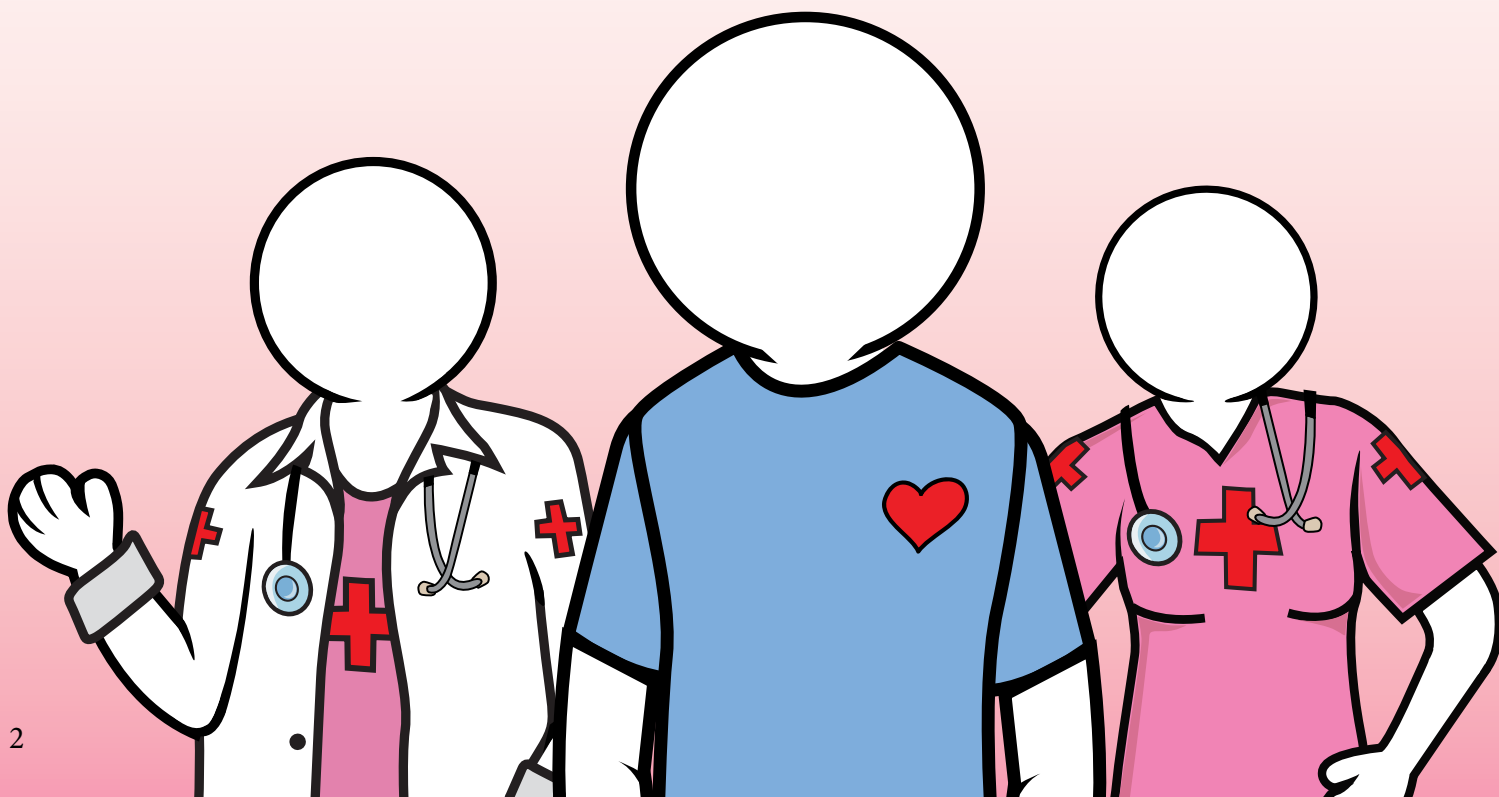
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I. INTRODUCTION

IEHP created a Health Homes Program (HHP) to provide an integrated care management program for patients with complex needs, building on IEHP's Behavioral Health Integration Complex Care Initiative (BHICCI) and as legislated by the Department of Health Care Services (DHCS). The HHP coordinates the physical, behavioral, and community-based Long-Term Services and Supports (LTSS) needs of Members with severe chronic physical and/or mental health conditions. The program began January 1st, 2019 for Members with chronic physical conditions and substance use disorders (SUD) and July 1st, 2019 for Members with severe mental illness. The primary goal of the HHP is to improve the overall health outcomes of enrolled Members through the delivery of care coordination and complex care management.

HHP is a complex care management model that focuses on providing individualized, whole-person care by a trained, integrated care team that works in close connection with the Member's Primary Care Provider (PCP). This integrated care team, known as the Community-Based Care Management Entity (CB-CME) is comprised of a registered nurse, behavioral health provider, care coordinator, and a community health worker. These team members work collaboratively to provide risk stratified services for a caseload of Health Home enrolled Members. The CB-CME delivers six core services: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services and Referral to Community and Social Supports.

These services, while in alignment with DHCS guidance, also embody and promote IEHP's commitment to person-centered, population health, and measurement-based care practices for the most complex and vulnerable populations within the Inland Empire.



II. NETWORK DEVELOPMENT & STAFFING

A. Models of CB-CMEs

The HHP is supported by a network of CB-CMEs. Through a volume analysis and geomapping of HHP eligible Members, network providers were identified and designated as either a Model 1 (M1) or Model 2 (M2) CB-CME.

1. Model 1 – For Providers with a high-volume of HHP Members, HHP care teams are embedded on-site, primarily in community provider offices.
2. Model 2 – For Providers with a low-volume of HHP Members (often rural), HHP services are regionalized and provided by IEHP HHP care teams.

B. Building the CB-CME Network

IEHP contracted with 18 health care organizations to serve as Model 1 CB-CMEs, resulting in 40 multidisciplinary HHP care teams embedded within the IEHP network. IEHP also hired 10, 4-person multidisciplinary Model 2 HHP care teams. These Model 2 HHP care teams are located regionally throughout the Inland Empire in volume dense areas to provide HHP services in coordination with PCPs with a low volume of HHP-eligible Members. In total, IEHP established 50 HHP care teams during year one of the program (see Exhibit 1).

CB-CME	HHP CARE TEAM SITES	MODEL
Arrowhead Regional Medical Center	Fontana McKee Quantum Westside	Model 1
Borrego Community Health Foundation	Arlanza Cathedral City Desert Hot Springs	Model 1
Central City Community Health Center Inc	Norco	Model 1
Clinicas de Salud Del Pueblo	Mecca	Model 1
Community Health Systems, Inc	Moreno Valley	Model 1
Desert Clinic Pain Institute	Palm Springs	Model 1
Dignity Health Medical Foundation	Fontana	Model 1
Inland Behavioral & Health Services	Inland Family	Model 1
LaSalle Medical Associates	Hesperia San Bernardino	Model 1
Pinnacle Medical Group	San Bernardino	Model 1
Neighborhood Healthcare	Temecula	Model 1
Riverside Family Physicians	University Parkway	Model 1

Exhibit 1. M1 & M2 CB-CMEs (Continued on page 4)

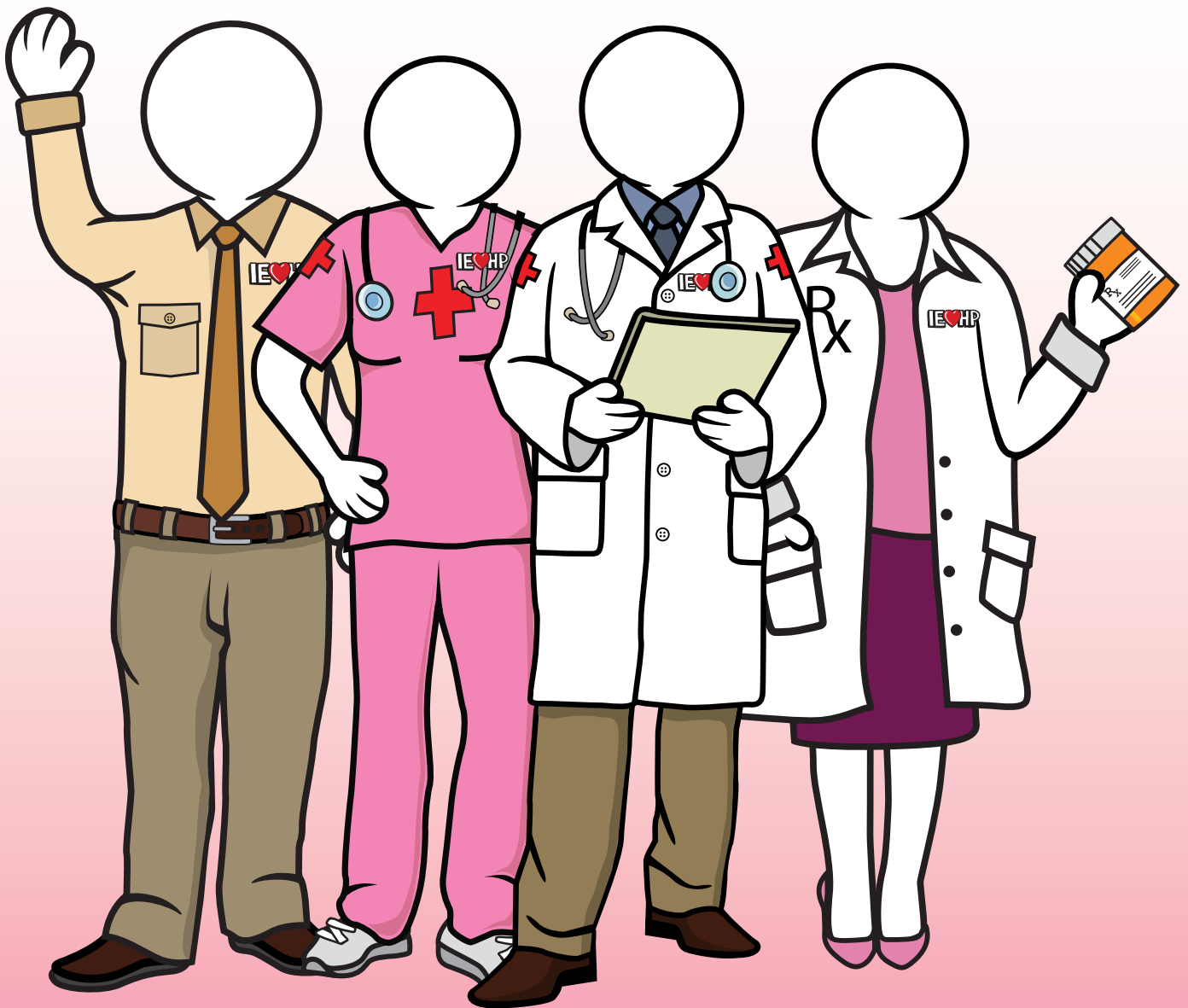
CB-CME	HHP CARE TEAM SITES	MODEL
Riverside University Health System	Banning Corona Hemet Indio Jurupa Lake Elsinore Med Ctr Family Care Center Med Ctr Internal Medicine Palm Springs Perris Riverside Neighborhood Rubidoux	Model 1
SAC Health System	<u>G Street Location</u> Family Medicine Internal Medicine Pediatrics <u>Norton</u> Norton Team 1 Norton Team 2	Model 1
St. Jude Hospital Yorba Linda Inc – St. Mary High Desert	Victorville	Model 1
Syed F. Azam Medical Associates Inc	Indus Medical	Model 1
San Bernardino County - Department of Behavioral Health	Mariposa Mesa Victorville	Model 1 (SMI)
Step Up on Second	San Bernardino	Model 1 (SMI)
Inland Empire Health Plan	Hemet Team 1 Murrieta Team 1 Palm Desert Team 1 Palm Desert Team 2 Rancho Cucamonga Team 1 Riverside Team 1 Riverside Team 2 San Bernardino Team 1 San Bernardino Team 2 Victorville Team 1	Model 2

Exhibit 1. M1 & M2 CB-CMEs (Continued from page 3)

C. Staffing the HHP Care Teams

IEHP has prescribed a staffing model for the HHP care team which includes a nurse care manager (RNCM), behavioral health care manager (BHCM), care coordinator/housing navigator (CC), and a community health worker (CHW). Model 1 CB-CMEs employ and maintain this multidisciplinary care team under their organization's management. A PCP champion is also identified to support the care team and lead change efforts within the practice. Model 2 CB-CME HHP care teams are supported by centralized management at IEHP which includes a Clinical Director and three Managers.

CB-CMEs have been challenged to recruit, hire, and retain care team members who are well equipped to care for the complex HHP population. Care team turnover is approximately 20%, and CB-CMEs in good faith promptly attempt to fill open care team vacancies through reassignment of other staff, recruitment of new staff, or both. Recognizing that outpatient complex care management is new within the Inland Empire health care delivery system, IEHP has established relationships with local health care schools, including nursing schools. For example, California Baptist University College of Nursing has entered into an agreement with IEHP to send nursing students to an outpatient care management rotation with an IEHP Model 2 HHP care team.



III. HHP TRAINING PROGRAM

A. Program Components

The IEHP HHP Training Program is a comprehensive multi-modal training program designed to form a two-county learning community and aimed at improving the awareness, knowledge, and skills of the HHP provider network. The HHP training program components are listed in Exhibit 2.

ACTIVITY	PURPOSE
DHCS Required Trainings	DHCS Compliance, Introduction to HHP
Learning Sessions	Community Building, Support, Standardization, Celebration
Webinars	Knowledge, Familiarity, Model of Care Literacy
Care Director [®] Training	Electronic Care Management Platform Training
Motivational Interviewing (MI) Training	MI Practice, Skill Building
Practice Coaching	Team Building, Role Clarity, Skill Building, Synthesis and Reinforcement of all Trainings
Community Health Worker (CHW) Training	Intensive training and skill building in preparation for joining an integrated care team

Exhibit 2. HHP Training Program Components

B. DHCS Required Trainings

The DHCS Required Trainings were created in partnership with the IEHP Learning Technology team and have the primary purpose of assuring compliance with the DHCS HHP training requirements. As of August of 2019, each of the six required trainings had a completion rate between 88 and 95 percent.

C. Learning Sessions

The IEHP HHP Learning Sessions serve a broad purpose of formal training, community and goodwill building, sharing and standardizing practices, and celebration. Three HHP learning sessions, at 6-month intervals, have been completed so far, with attendance of approximately 200 participants at each session. The themes for the Learning Sessions have been:

1. Learning Session I: Kickoff celebration, team-building, and basic skills
2. Learning Session 2: Solidifying basic skills, introduction to Severe Mental Illness and Substance Use Disorder (SMI and SUD) topics in preparation for the SMI HHP cohort go-live
3. Learning Session 3: Celebrating 1 year – Review of first year learning and discipline-specific skills

Participant evaluation scores have generally been very high and, when trended, show improvement as HHP Learning Sessions are tailored to meet the needs of the HHP care teams.

D. Webinars

The IEHP HHP Webinars serve as the primary vehicle to assure that all HHP care teams have the necessary subject matter familiarity and knowledge required to perform their HHP duties. To date IEHP has provided over 40 live weekly webinars on a variety of subjects in the following categories:

1. HHP Core Skills and Workflows
2. Population Health
3. Measurement Based Care
4. Medication Monitoring and Reconciliation
5. Evidence-Based Interventions
6. Care Management Software - Care Director©
7. Housing
8. Chronic Medical Conditions
9. Serious Mental Illness and Substance Use Disorders
10. Quality Improvement
11. Special Populations and Special Topics

Average weekly attendance at the online webinars is approximately 100 unique callers, though actual viewers may be greater as there may be more than one person on each line. All webinars are recorded.

E. Care Director©

Care Director© (CD) is a web-based care management platform customized by IEHP to meet the documentation and data sharing needs of the HHP. All HHP care teams utilize CD to document HHP services, including HHP enrollment, comprehensive assessment, care planning, and care management-related activities. It is a complex enterprise platform that requires extensive training and support for successful utilization. The training program for CD is itself a multi-modal training series focused on providing HHP care teams with the skills needed to successfully navigate this software. It includes an initial intensive 4-hour in-person training along with bi-weekly “office hours,” a monthly webinar, on demand technical assistance, and supplemental written reference materials. As of July 2019, over 250 HHP care team members have attended the in-person training, generally held twice per month for up to 16 learners.

F. Motivational Interviewing

Motivational Interviewing (MI) is an evidence-based, patient-centered interviewing technique that HHP care team members use to promote behavior change. IEHP provided MI training, and the first cohort of 83 learners attended in Spring 2019. This training was very highly evaluated. Due to care team turnover IEHP offers quarterly MI training on an ongoing basis.

G. Practice Coaching

The IEHP HHP model for Practice Coaching is based on the Agency for Healthcare Research and Quality (AHRQ) model for clinical system transformation and is similar to other programs such as the Camden “Putting Care First” model of complex care. As they begin the HHP program, every CB-CME care team is assigned a practice coach dyad: a primary coach with behavioral health expertise and a physician partner coach who provides support in training the team members and engaging team leaders.

Practice coaching in year one focused heavily on establishing HHP care team roles. The introduction of a HHP care team into the outpatient setting created a new paradigm of health care delivery that required clear role setting to foster collaboration amongst the multi-disciplinary care team members and the organization at large. In addition, with ongoing challenges related to staffing, Practice Coaches provided support on how to implement HHP workflows in the absence of various team members, and how to shift those roles as additional team members were hired. Coaching included team-building activities to identify individual and team strengths and how to solidify communication strategies. Additionally, coaches worked with the team leadership to ensure that teams were supported in their daily work and that quality improvement efforts were consistently utilized to address areas of opportunity.

Care management was another area of heavy coaching focus. This involved training and reinforcing several skills, including MI, effective outreach and engagement, comprehensive assessment, shared care plan development, transitions of care management, population health and measurement-based care approaches, and the effective use of Systematic Caseload Review (SCR). The above training activities are all supported by a growing library of written materials that includes a detailed HHP Manual, job aids, workflows, FAQs, newsletters, and electronic communications.

H. Community Health Workers

IEHP considered CHWs a critical component of the integrated HHP care team given the evidence base around their ability to build both individual and community capacity for health literacy and self-sufficiency. IEHP also recognized that the CHW is a new member of the workforce for the Inland Empire and therefore committed to CHW workforce development. San Manuel Gateway College (SMGC) at Loma Linda University was contracted to provide training for CHWs preparing to join HHP care teams. The customized training curriculum was delivered over an intensive nine-week period and included didactic, skills lab, practicum, and professional development. The curriculum focused on integrating behavioral, physical, and social determinants of health to address health disparities in the Health Homes population. To date SMGC has trained approximately 100 CHWs (across four cohorts) and continues to provide on-going monthly education for all course graduates. These CHWs are essential additions to the HHP care teams and critical resources for patients and communities in the Inland Empire.

IV. CORE SERVICES OF THE HHP

IEHP's clinical model for the HHP is built on the key principles of multidisciplinary team-based care, population health, and measurement-based care and applies these tenets to the delivery of core services including outreach and engagement, assessment, shared care planning, and transitions of care management.

A. Outreach and Engagement

Over a period of ninety (90) days, Members determined to be eligible for the HHP are contacted by HHP care teams based on a prioritized tiered approach and using a range of evidence-based and/or best practice outreach and engagement strategies. Most notably, HHP care teams demonstrated great success in engaging Members through CHW hospital visitation. Eligible Members are given the opportunity to voluntarily consent to enroll or decline to participate in HHP. IEHP also supports a process whereby Members, CB-CMEs, and providers can refer Members to the HHP who may not have initially been identified by DHCS or IEHP as being HHP-eligible.

B. Comprehensive Assessment

Once a Member is enrolled, the HHP care team conducts a comprehensive health assessment (CHA) with the intent to establish a rapport with the Member and begin to identify the Member's health and wellness goals and needs. IEHP developed a custom CHA based on DHCS' requirements, stakeholder input, and care management best practices to thoroughly assess daily function and quality of life, general health and history, social determinants of health, and behavioral health. This assessment is available in three versions that are tailored for ages birth-10, 11-18, and 18+ in Spanish and English languages.

After completing the CHA, validated behavioral health surveys and physical health vitals are completed for enrolled Members.

- The Patient Health Questionnaire-9 (PHQ-9 or PSC-17 for Members ages 11-17) to assess for depression
- The Generalized Anxiety Disorder-7 (GAD-7) to assess for anxiety
- Blood pressure
- Body Mass Index (BMI) to assess for weight concerns

Additional assessments are completed based on the Member's needs.

- If the substance use screener in the CHA is positive, the Brief Addiction Monitor (BAM) is administered.
- If the CHA identifies housing insecurity, a standardized housing assessment is completed.
- If the Member has a diagnosis of type 1 or type 2 diabetes, a provider-ordered HbA1c is obtained.

Condition-specific and scored assessments like the PHQ-9, GAD-7, blood pressure, BMI, and HbA1c are administered over time as clinically indicated to systematically track progress and identify Members whose health outcomes are not improving as expected so the HHP care team can intervene and discuss changes in treatment.

C. Shared Care Planning

This rich assessment process prepares the HHP care team to collaborate with a Member on the development of a shared care plan (SCP), IEHP's terminology for DHCS' Health Action Plan (HAP). The SCP is an individualized, Member-centric care plan driven by the Member's preferences and priorities that is initiated within ninety (90) days of HHP enrollment in coordination with the Member, his or her family or supports, and the CB-CME care team using data from the CHA and other sources.

The SCP incorporates the Member's needs in the areas of physical health, mental health, substance use, community-based LTSS, palliative care, trauma-informed care, social supports, and, for individuals experiencing homelessness, housing. The elements of the SCP are standardized in IEHP's care management tool Care Director, and CB-CME care teams are trained to define patient-stated problems/needs, goals, and interventions using patient-friendly language and the SMART (specific, measurable, achievable, realistic, time-bound) goal setting framework. Once initiated, the SCP becomes the dynamic roadmap that guides the HHP care team's and Member's work together.

D. Transitions of Care (TOC) Management

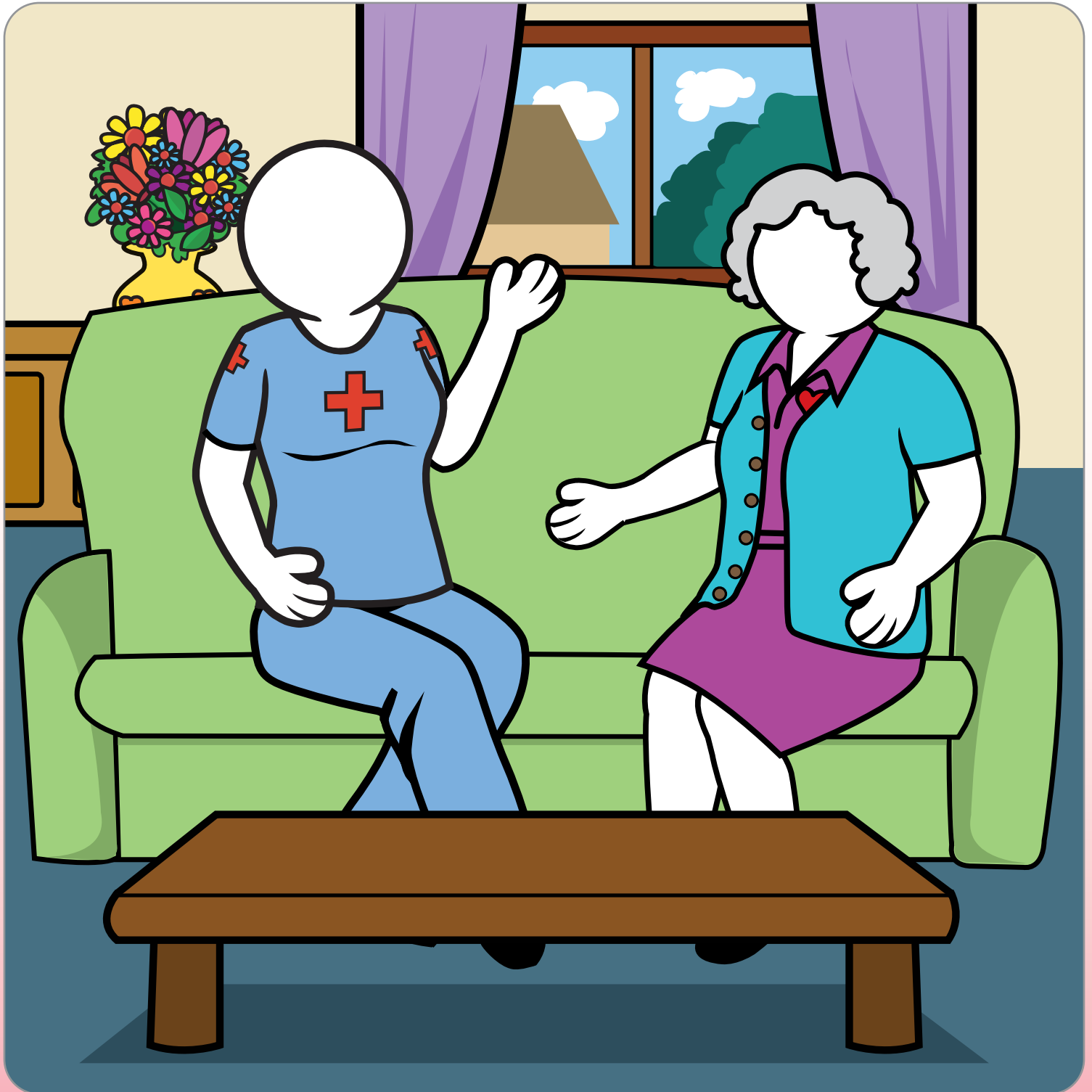
Emergency Department (ED) and inpatient (IP) events are prevalent in the HHP population. HHP care teams provide support to HHP-enrolled and eligible Members at admission and upon discharge. IEHP notifies HHP care teams of ED and IP events via Admission, Discharge, and Transfer (ADT) alerts in CD®, and HHP care teams follow a detailed workflow to respond to these alerts. Early successes of the transitions of care support include engagement of hard-to-reach Members who are not yet enrolled in the HHP. Initial findings suggest that Members who are engaged while in the hospital have a higher rate of enrollment into the HHP and greater sustained engagement over time.

E. Systematic Caseload Review

While outreach and engagement, assessment, shared care planning, and transitions of care services are provided at the individual Member level, the systematic caseload review (SCR) is an activity conducted by the HHP care team to ensure the needs of the HHP population are met and that Members who are not engaging or improving as expected do not fall through the cracks. An SCR is a regularly occurring meeting (at least twice per month) that occurs during a carved-out time when the HHP care team and a PCP champion systematically review prioritized patients within the HHP population. Members may be prioritized for discussion based on enrollment status (i.e. Members who are newly enrolled), recent or frequent ED or IP utilization, or lack of improvement in health outcomes. The objective of the SCR is to develop a "to-do" list of action items for each Member discussed that correspond with changes in health and disease management. Overall, an SCR is an efficient way for CB-CMEs to discuss the most vulnerable Members on a frequent basis and make changes in treatment to improve health and wellbeing.

V. NARRATIVE SUMMARY

The first year of the HHP saw the establishment of 50 CB-CME care teams and the implementation of new workflows to support the delivery of core HHP services including outreach and engagement, assessment, shared care planning, transitions of care support, and systematic caseload review. These services, while in alignment with DHCS guidance, also embody and promote IEHP's commitment to person-centered, population health, and measurement-based care practices.



VI. QUANTITATIVE DATA

These data represent findings for HHP-enrolled Members from January-October 2019.

Exhibit 3 displays the enrollments for Health Homes Membership for both Model 1 and 2 by month. Counts in the figure represent monthly enrollment counts and not a count of aggregate enrollees over the measurement period from January to October. Starting in July, SMI Members became eligible for the program and enrollment grew during July, August, September, and October. However, because there are only four SMI care teams, the enrollment of these Members has been slower. Building capacity for SMI Care Teams is still underway.

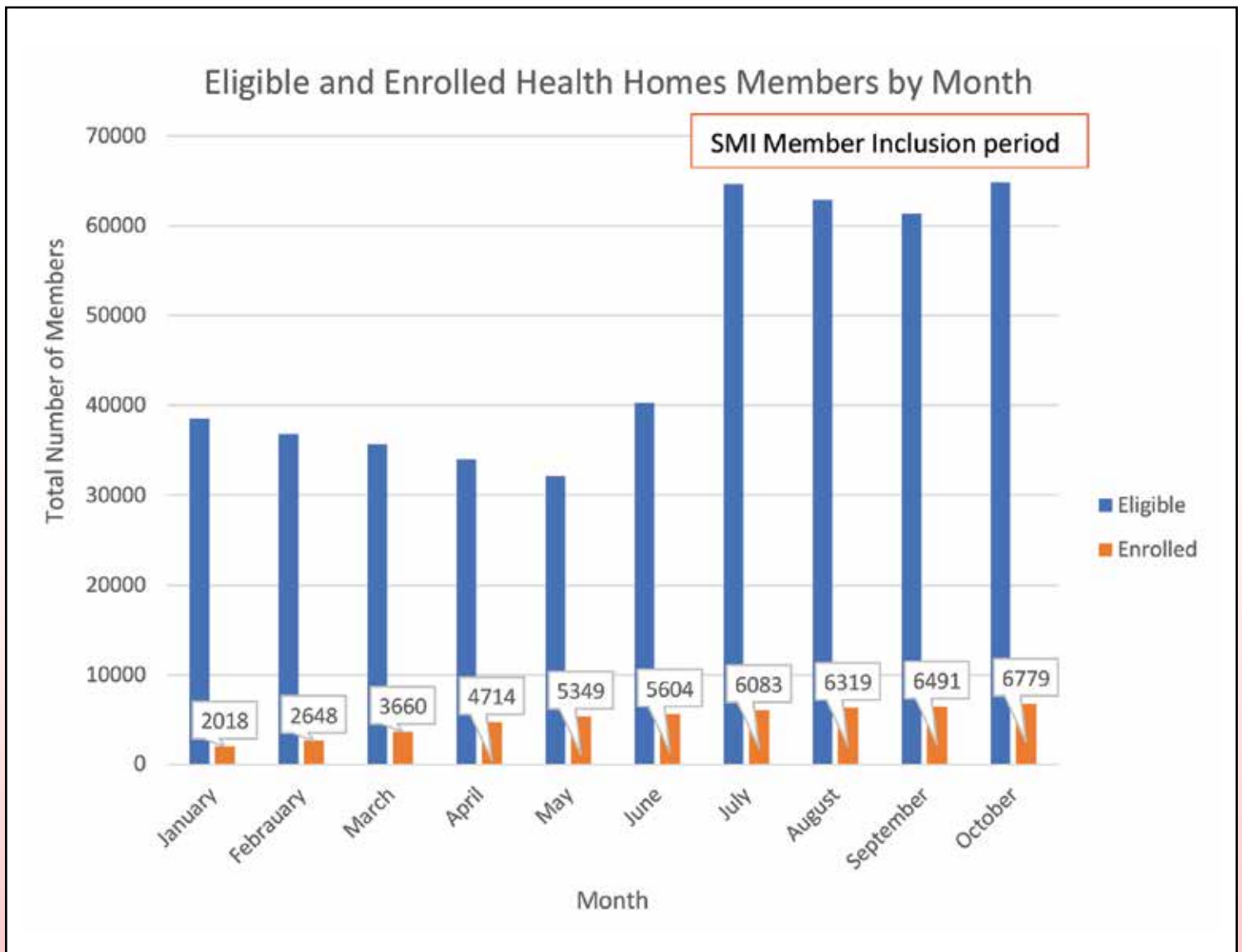


Exhibit 3. Eligible and Enrolled Health Homes Members by Month

All IEHP Membership is assigned a risk tier (low, rising, or high) using the Johns Hopkins ACG system and an IEHP internal population health stratification algorithm. Exhibit 4 provides the distribution of risk for Members enrolled in the HHP during the measurement period. The final distribution of risk across Health Homes enrolled Membership is determined by many factors including the TEL, the IEHP acuity assignment, the processes and priorities for outreach to Members to get them enrolled as well as unmeasured factors like the social determinants of health and limited behavioral health data.

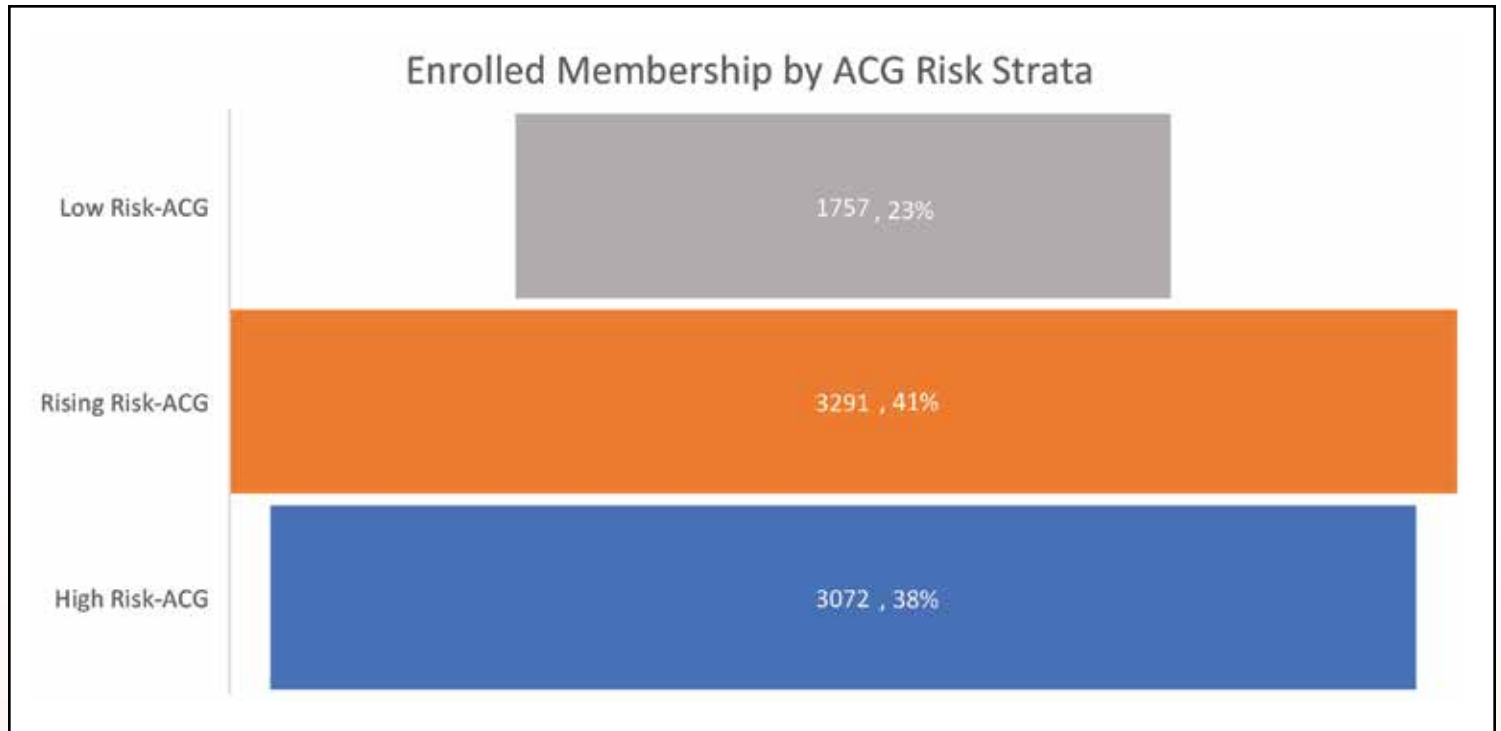


Exhibit 4. Health Homes Enrolled Membership by ACG Risk Strata

On average, Members across all acuity and risk strata levels were enrolled for 164 days (Exhibit 5).

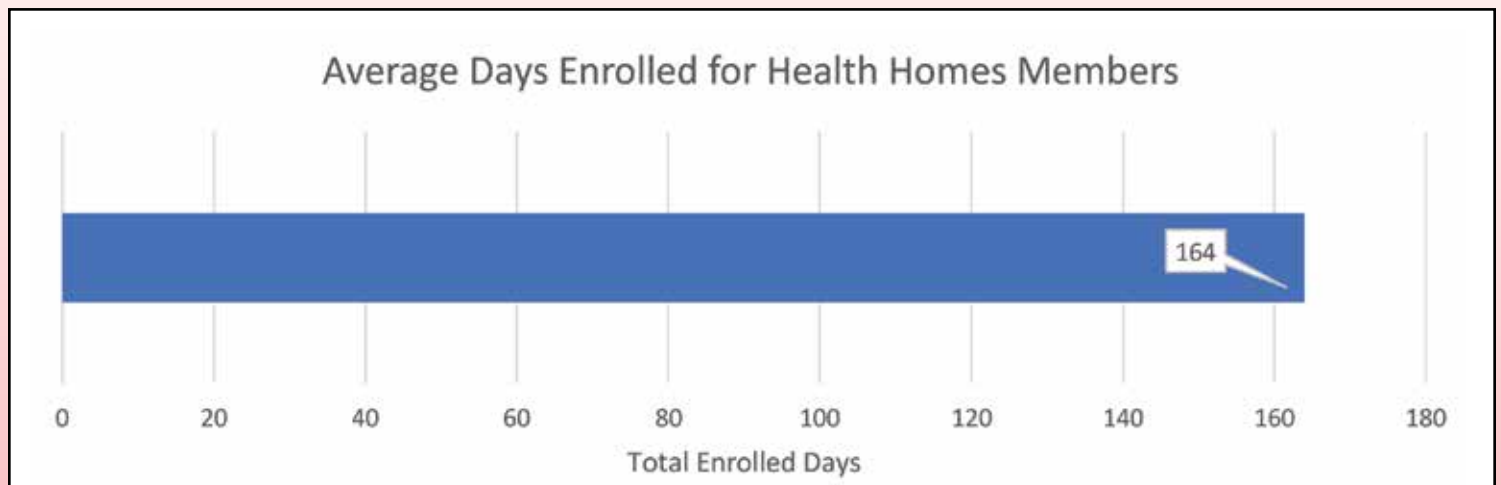


Exhibit 5. Average Length of Enrollment

During the first 10 months of the Health Homes program, the majority of enrollees consisted of those aged 51-60. Those aged 61-70 made up the second largest category of enrollees followed by those aged 31-40 (Exhibit 6).

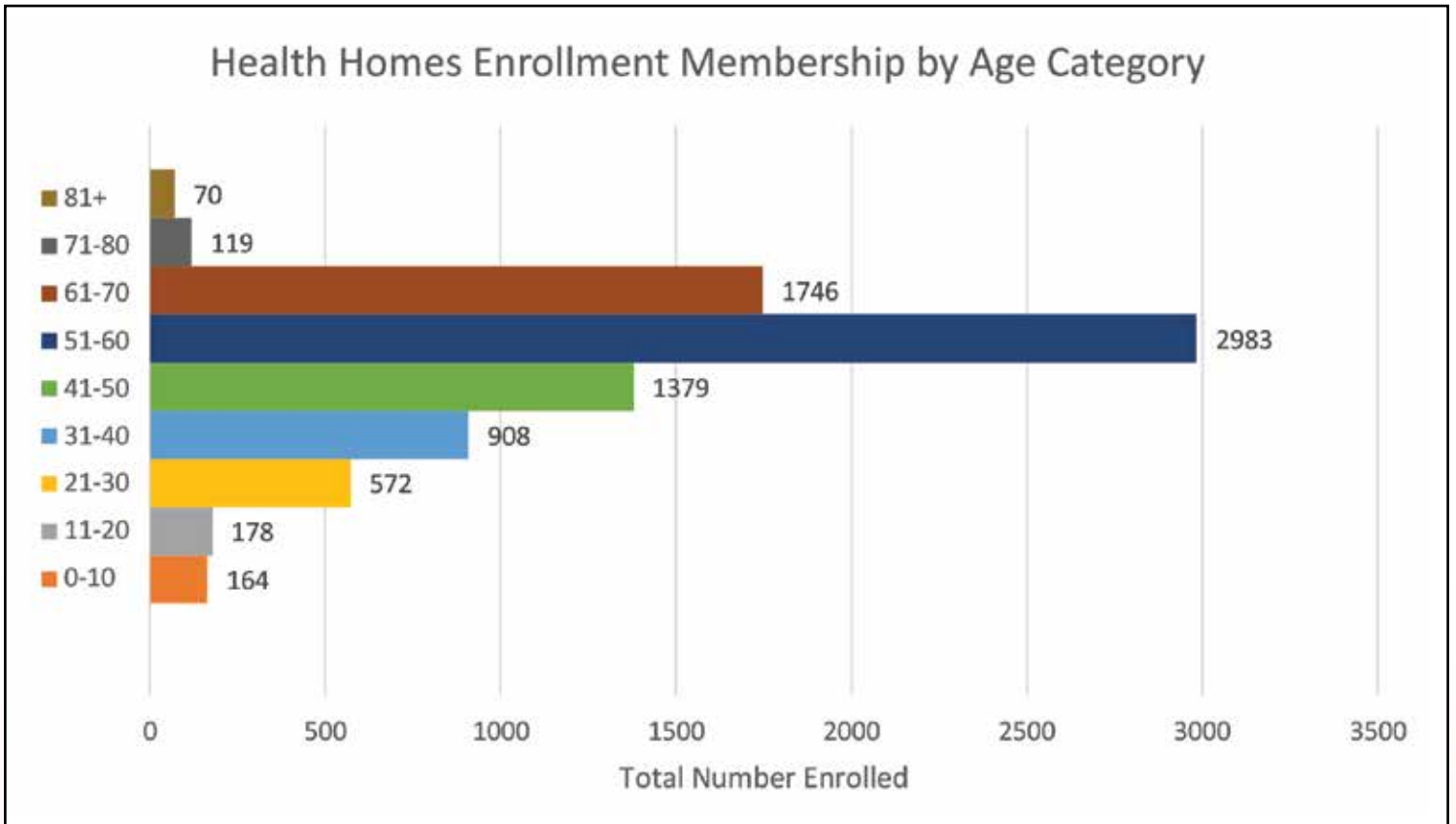


Exhibit 6. Health Homes Enrolled Membership by Age Category

Females made up the majority of enrollees at 61% with males making up 39% of enrollees (Exhibit 7).

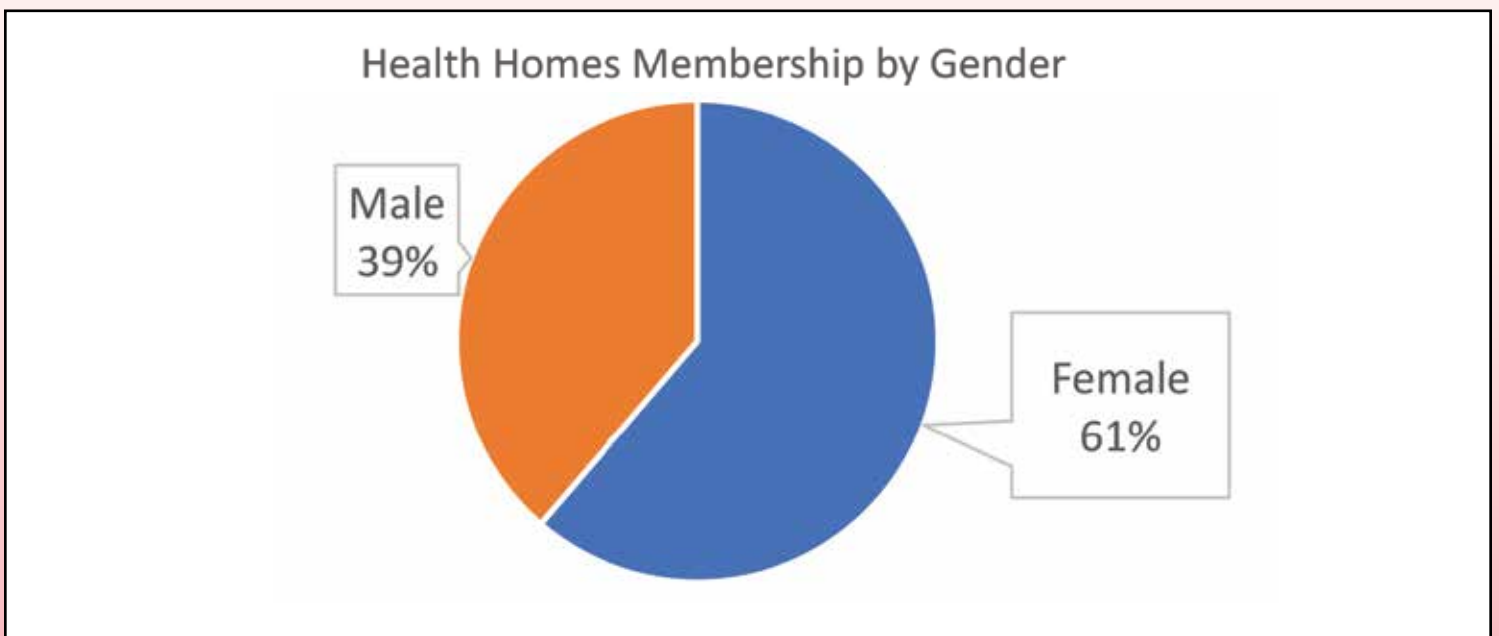


Exhibit 7. Health Homes Enrolled Membership by Gender

Exhibit 8 describes Health Homes enrollment by Member acuity level. The categories of acuity are not exclusive, and Members may fall into more than one category. The distribution of enrollees across acuity levels is nearly even for those Members with three or more ED visits and those with one or more inpatient visits within 12 months. Members with three or more HHP qualifying conditions compose the most prevalent acuity criteria and Members who are homeless compose the least prevalent acuity criteria.

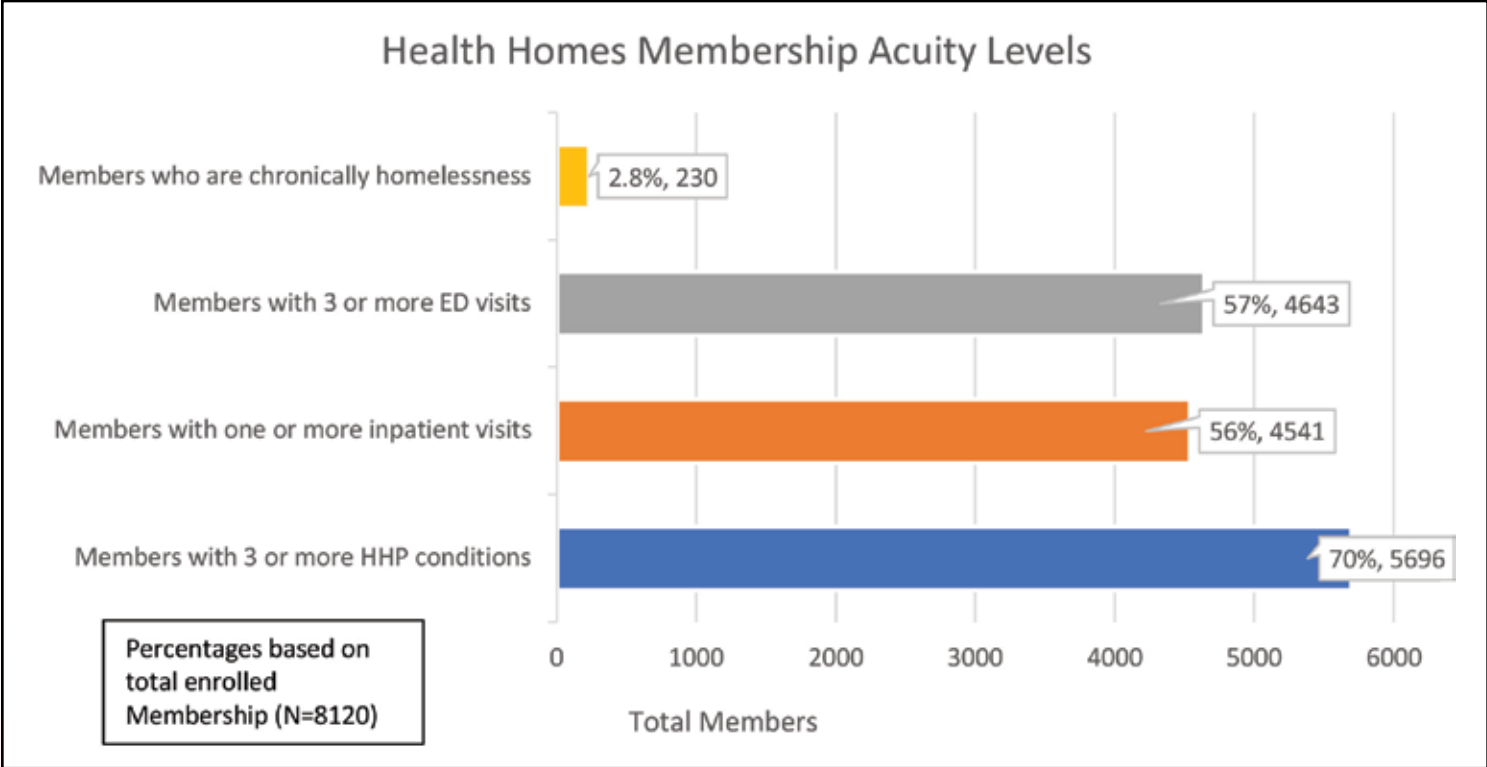


Exhibit 8. Health Homes Enrolled Membership by Acuity Level

Exhibit 9 describes the number of conditions present in the enrolled Health Homes Membership. The categories of disease are not exclusive, and Members may have multiple conditions. The top three conditions present in the Health Homes enrolled Membership are High Blood Pressure (76.3%), Diabetes (56.9%), and Major Depressive Disorder (45.6%). Asthma (28.8%), Congestive Heart Failure (22.8%), and Liver Disease (20.0%) make up the next three largest categories of prevalent conditions within the enrolled Members of the Health Homes Program.

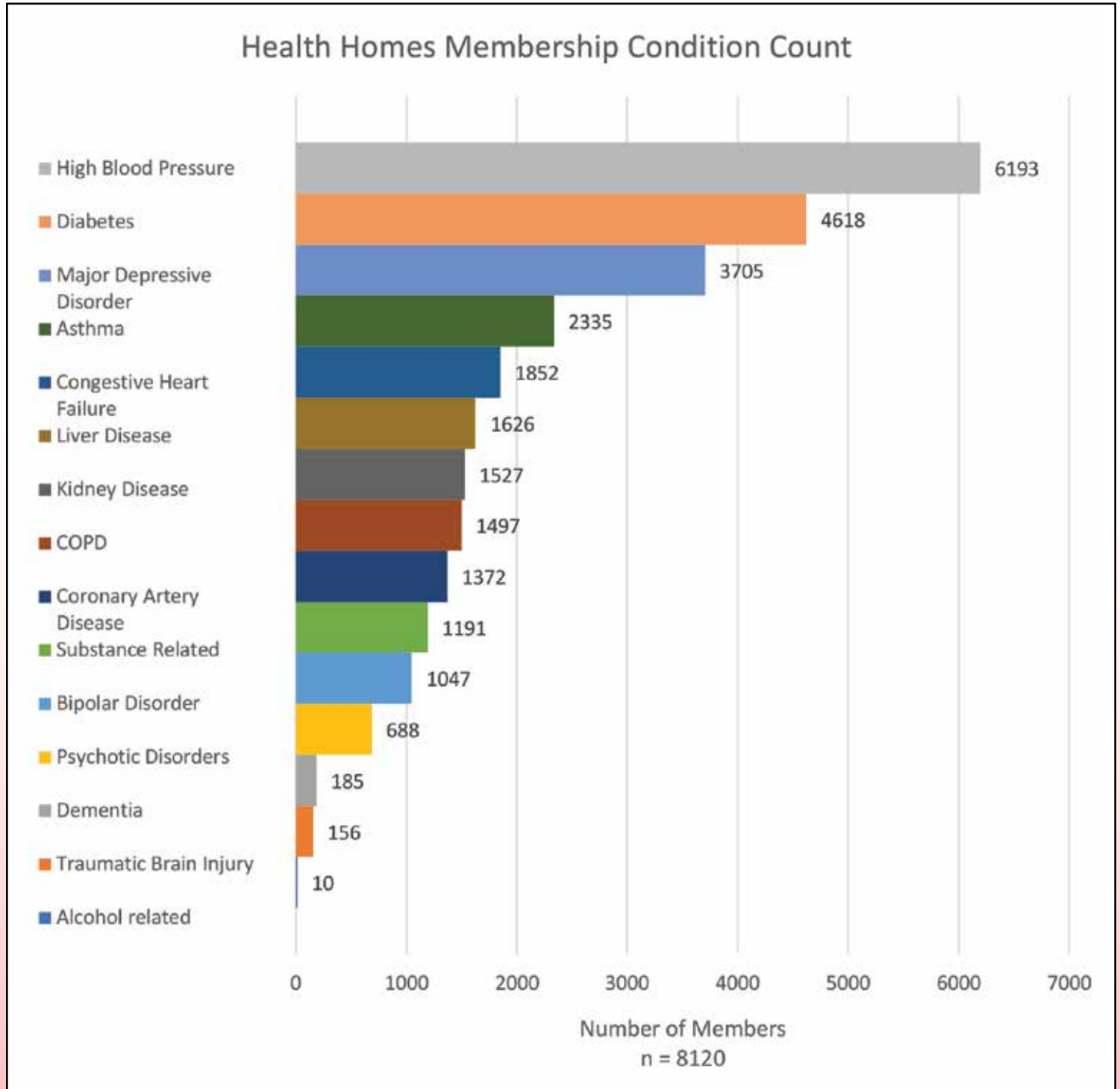


Exhibit 9. Count of Conditions for Health Homes Enrolled Membership

Exhibit 10 displays exclusion reasons for the HHP. One thousand nine hundred and eighty-two patients have been excluded from IEHP's HHP in accordance with DHCS guidelines. The Members that have been excluded were Members that were identified to be enrolled into HHP by either outreach or referral but were not enrolled into HHP. The most common reason for exclusion from HHP was a Member declined to participate.

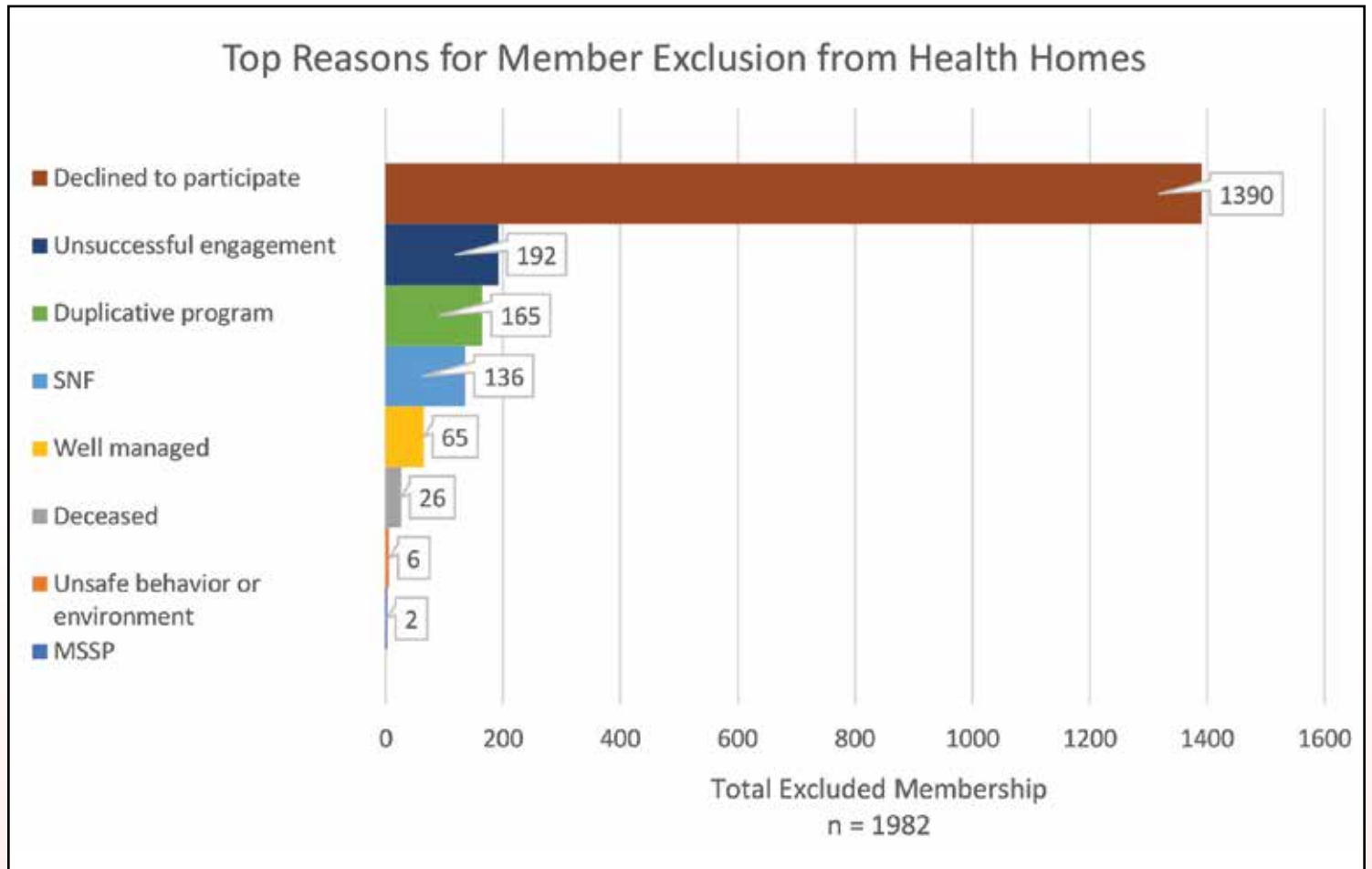


Exhibit 10. Top Reasons for Member Exclusion from the Health Homes Program

Exhibit 11 displays the disenrollment reasons for the HHP. Eight hundred and eight patients have been disenrolled from IEHP’s HHP in accordance with DHCS guidelines. The Members that have been disenrolled were Members that were enrolled in the program but then later were disenrolled for the reasons given below. The most common reason for disenrollment from HHP was a Member’s lack of active participation for 90 days or more.

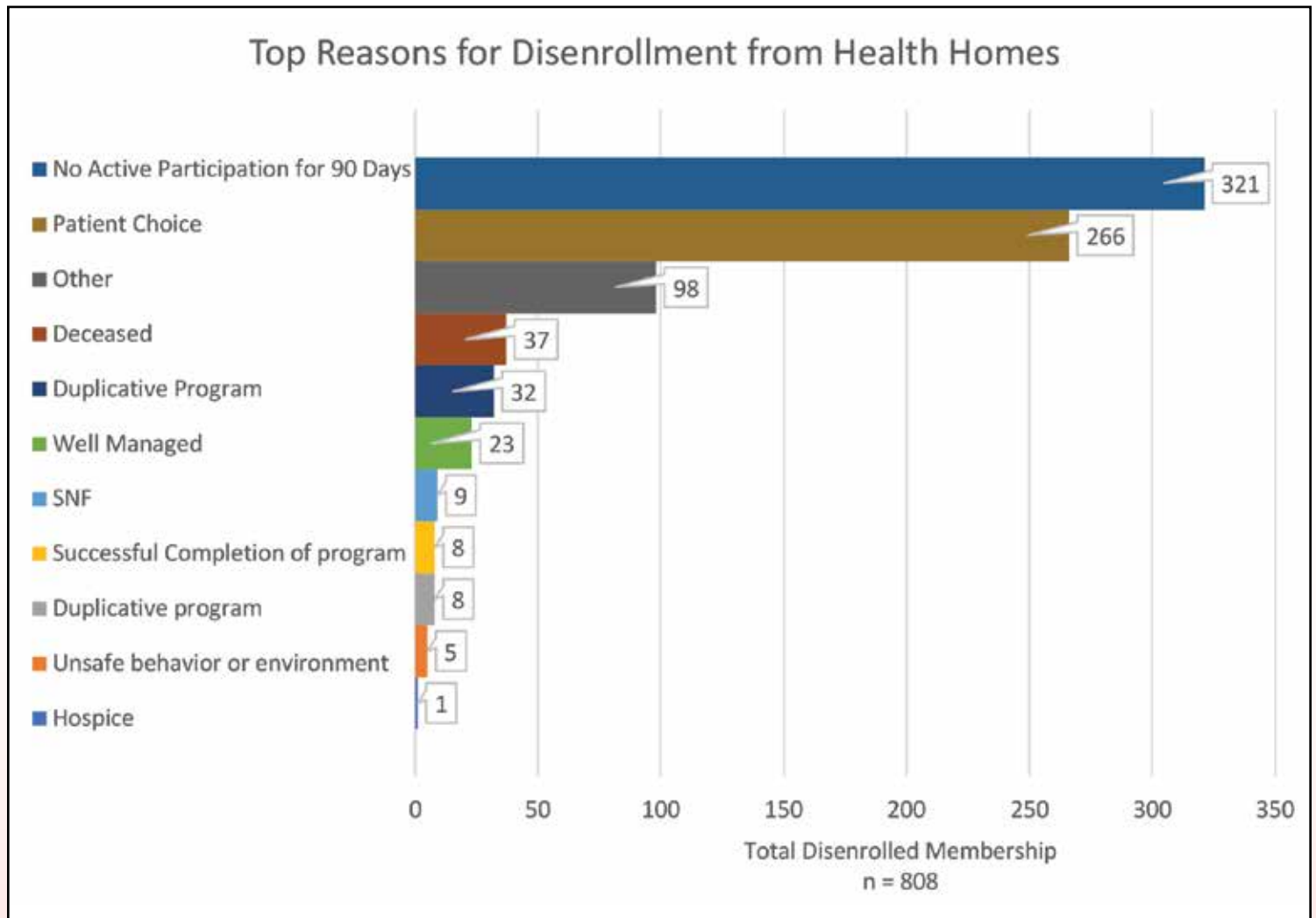


Exhibit 11. Top Reasons for Member Disenrollment from the Health Homes Program

Exhibit 12 displays changes in utilization for HHP-enrolled Members. Utilization was evaluated through comparison with a propensity matched control group identified within the HHP eligible, but not enrolled, population. A t-test of means was conducted to determine if there was a significant difference in the utilization outcomes for the HHP-enrolled Members and the propensity matched control group. A statistically significant difference was found for Primary Care Provider visits, Emergency Department visits, and total cost.

	TOTAL MEMBERS	PER MEMBER PER MONTH MEAN	PTMPY ¹
Primary Care Provider Visits			
Enrolled Membership	3503	0.69	8,253.25*
Matched Eligible but not Enrolled Membership	2633	0.32	3,841.67
<i>HHP enrolled Members had a statistically significant higher rate of PCP visits compared to the control group.</i>			
Inpatient Admissions			
Enrolled Membership	281	0.33	3,907.14
Matched Eligible but not Enrolled Membership	278	0.34	4,100.90
<i>Although not statistically significant, HHP enrolled Members had fewer admissions on average compared to the control group.</i>			
Bed Days			
Enrolled Membership	790	0.49	5,903.86
Matched Eligible but not Enrolled Membership	800	0.54	6,478.61
<i>Although not statistically significant, HHP enrolled Members had fewer bed days on average compared to the control group.</i>			
Emergency Department Visits			
Enrolled Membership	1810	0.21	2,523.15*
Matched Eligible but not Enrolled Membership	1758	0.23	2,816.53
<i>HHP enrolled Members had a statistically significant lower rate of Emergency Department visits compared to the control group.</i>			
Urgent Care Visits			
Enrolled Membership	1101	0.20	2,437.09
Matched Eligible but not Enrolled Membership	953	0.21	2,498.29
<i>Although not statistically significant, HHP enrolled Members had fewer urgent care visits on average compared to the control group.</i>			
Total Cost (\$)			
Enrolled Membership	3802	616.46	7,397,568.54*
Matched Eligible but not Enrolled Membership	3649	371.70	4,460,457.64
<i>HHP enrolled Members had a statistically significant higher mean cost compared to the control group. The costs accounted for in this calculation include medical and pharmacy costs and do not include capitation or other HHP-related payments.</i>			

Exhibit 12. Means and Rates of Primary Care Provider Visits, Inpatient Admissions, Bed Days, Emergency Department Visits, Urgent Care Visits, and Total Cost

¹ PTMPY (per thousand Members per year)

* p <0.05 (indicates statistical significance)

Exhibit 13 displays the changes in clinical outcomes measured for HHP enrolled Members with abnormal measurements at baseline. The Members who had an abnormal baseline measurement and at least one follow-up measurement were included in the significance test presented below. Overall, for Members with an abnormal baseline measurement and a follow-up measurement, clinical outcomes significantly improved for Systolic Blood Pressure, HbA1C, and the Patient Health Questionnaire-9.

	SCREENED AT BASELINE	EXCEEDED CLINICAL THRESHOLD AT BASELINE	MEMBERS WITH BASELINE AND AT LEAST ONE FOLLOW-UP	AVERAGE BASELINE MEASUREMENT FOR THOSE EXCEEDING CLINICAL THRESHOLD	AVERAGE FOLLOW-UP MEASUREMENT FOR THOSE EXCEEDING CLINICAL THRESHOLD AT BASELINE ¹
Systolic Blood Pressure					
Number	3733	939	553	--	--
Percent or mean	100.00%	25.15%	58.89%	153	140*
HbA1C					
Number	2264	769	344	--	--
Percent or mean	100.00%	33.97%	44.73%	10.24	9.5*
Patient Health Questionnaire-9					
Number	4636	2051	831	--	--
Percent or mean	100.00%	44.24%	40.52%	16	13*

Exhibit 13. Changes in Clinical Outcomes Among Health Homes Enrolled Membership Qualifying for Each Measure

¹ *t*-test for significance between baseline and follow-up measurement

* $p < 0.001$

Member Experience feedback was collected monthly and then aggregated to provide a yearly average. Overall, Members reported high levels of agreement with the experience survey items with all average responses scoring between an “Agree” or “Strongly Agree.”

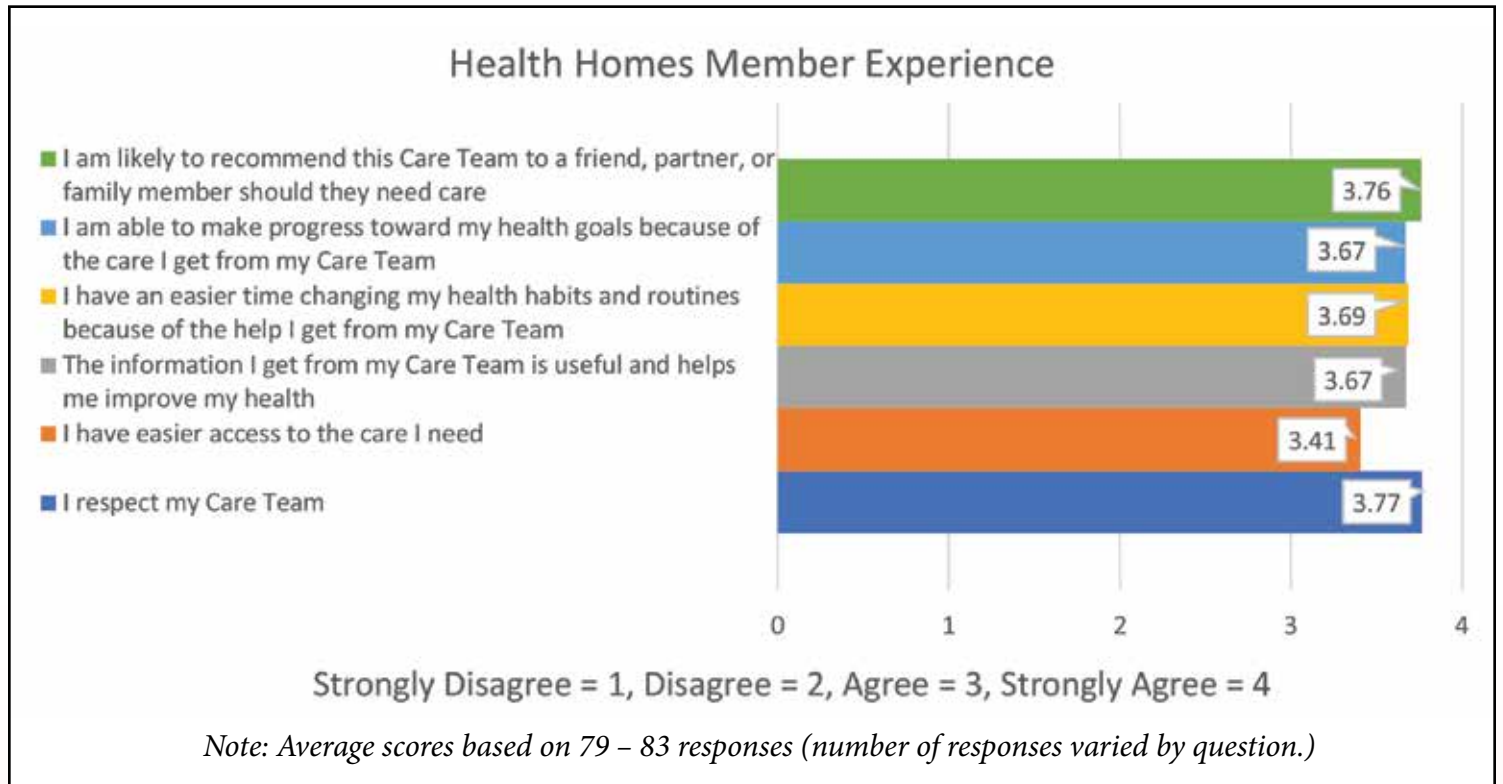


Exhibit 14. Annual Average Member Experience

Care Team Member Experience feedback was collected quarterly and then aggregated to provide a yearly average. Overall, Care Team members reported high levels of agreement with the experience survey items with all average responses scoring between an “Agree” or “Strongly Agree.”

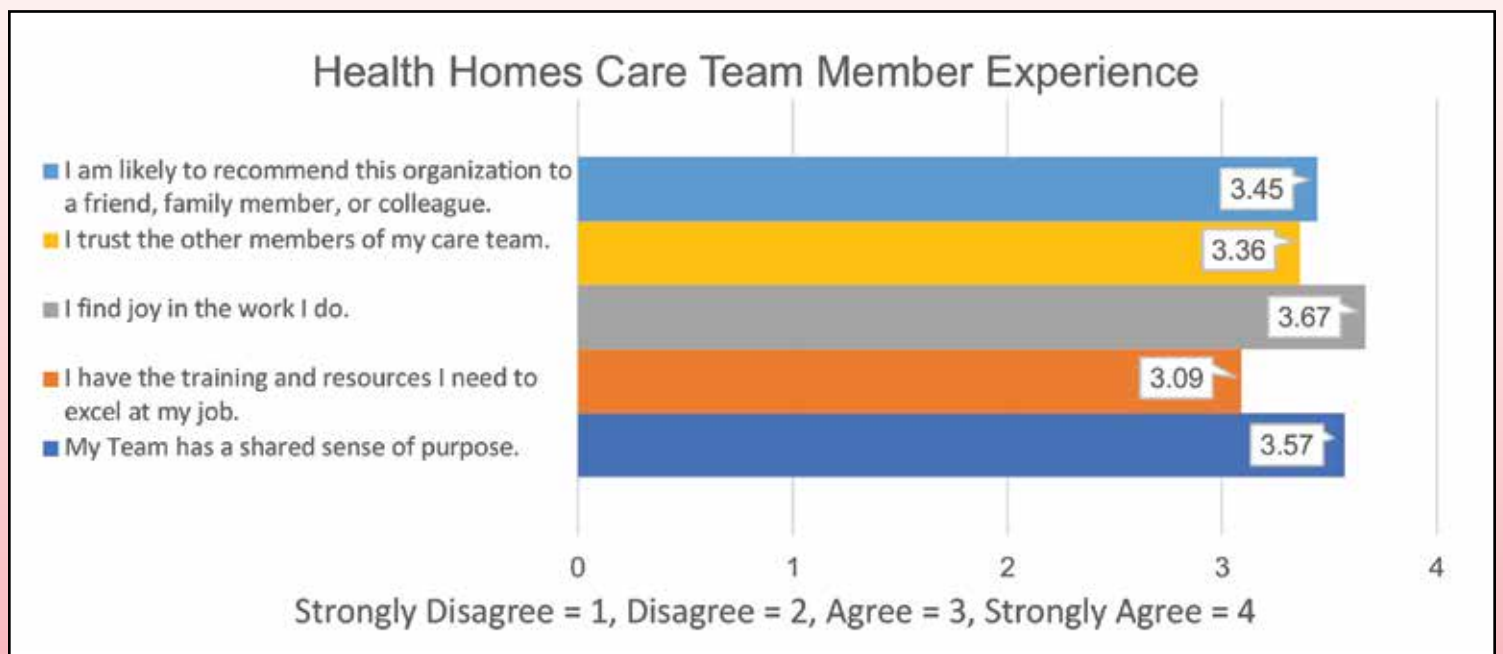
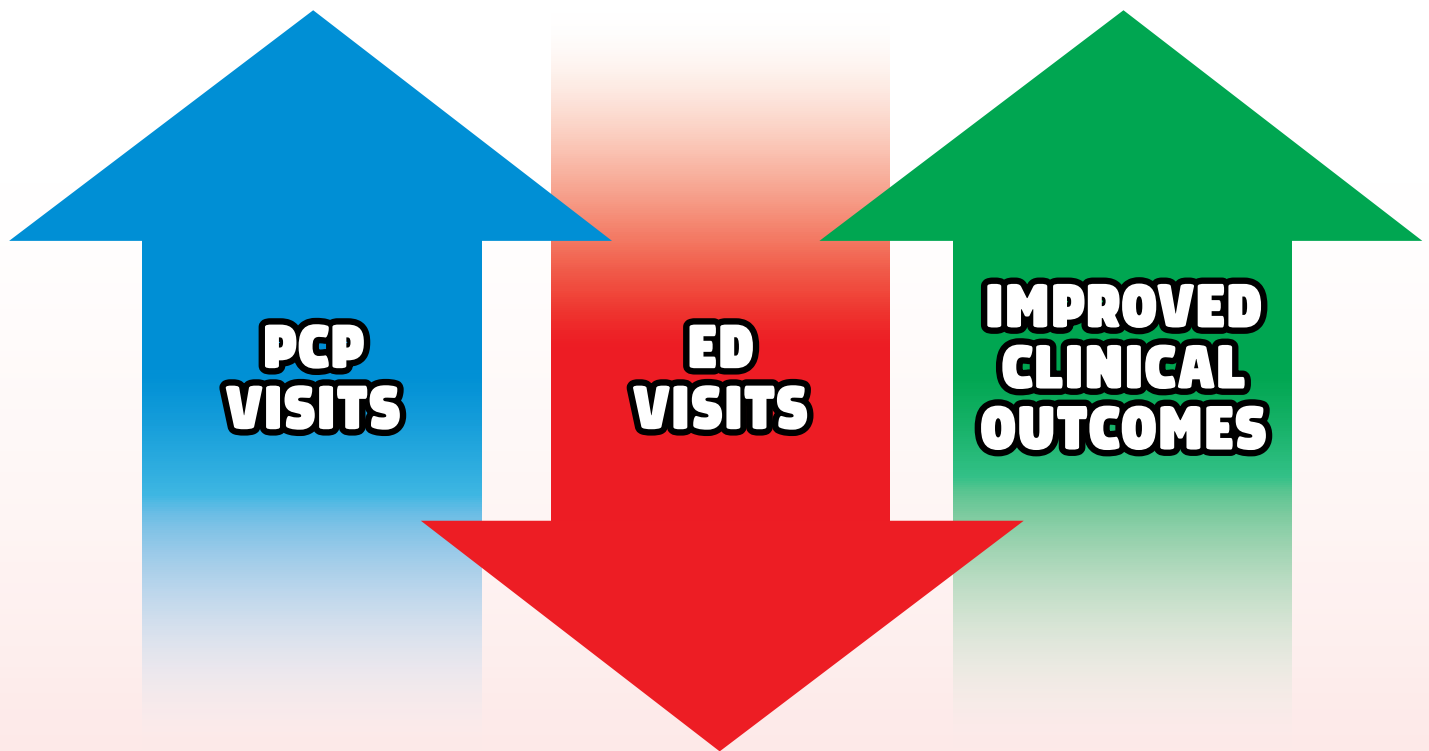


Exhibit 15. Annual Average Team Member Experience

VII. CONCLUSION

The above report summarizes the results of IEHP's first year experience with the HHP. Year one successes include achieving statistically significant improvements in clinical outcomes for Systolic Blood Pressure, HbA1C, and the Patient Health Questionnaire-9. Although initial total cost of care analysis revealed a statistically significant increase in overall cost for HHP-enrolled Members, it is too early in the life of the program to draw any conclusions about the HHP's overall impact on total cost of care. Other utilization markers indicate statistically significant improvements including an increase in PCP visits and a decrease in Emergency Department visits.





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