Case Study: Care Coordination Pilot

INLAND EMPIRE HEALTH PLAN (IEHP)

The Challenge:

Inland Empire Health Plan (IEHP) is a public health plan serving low-income families and individuals in two of the largest counties in the country: Riverside and San Bernardino, California. With healthcare reform and Medicaid expansion, IEHP's membership will expand significantly by 2015. IEHP wanted to take proactive steps to improve services for their members with the most significant physical and behavioral health issues, including people who are eligible for both Medicaid and Medicare.

Three of IEHP's most significant service goals were to:

- Reduce medical ER use
- Reduce psych re-admissions
- Reduce psych bed days

IEHP wanted an approach that was cost-effective, clinically effective, and aligned with their mission of organizing and improving the delivery of quality, accessible, and wellness-based healthcare services for their community.

> "You have reached the patients and changed their ED usage. It is attributable to your team's interventions. We did a control study and did not see change like this in the control group."
>
> *— Dr. Peter Currie, Ph.D., Clinical Director of Behavioral Health, Inland Empire Health Plan (IEHP)*

IEHP CLIENT, CHARLES, WITH CARE COORDINATOR, JERICA GAILEY

The Approach: Care Coordination Services

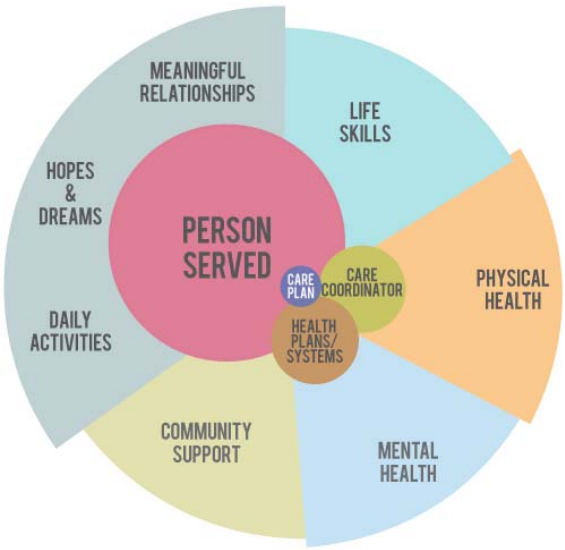
To achieve this, IEHP partnered with Telecare Corporation to implement a Care Coordination Pilot Program. Care coordination is the deliberate organization of patient care between different systems, providers and services. It facilitates the appropriate delivery of care across systems, keeping services coordinated and aligned for both clients and providers.

IEHP PILOT PROGRAM AT A GLANCE

- Program name: IEHP/MAPS
- Opened June 2011. Program had five members at inception. It expanded to 15 in 2013. It will expand again in 2014 to serve a maximum of 50 members.
- The program was designed as an add-on to an existing ACT-based program which already had clinical, psychiatric, and administrative team infrastructure. A care coordinator position that works exclusively with IEHP was added as part of the pilot..
- Services include a full array of community-based behavioral health supports, with the addition of health-focused care coordination services.

One Client's Experience: Charles

The IEHP/MAPS program specializes in serving people with complex health and behavioral health needs. Clients in the program range in age from 30s to 50s and are identified by IEHP for referral into the care coordination program.



Like Charles, most of the clients in the program are coping with a wide range of factors that affect their health and well-being. Care coordination is a powerful approach— it flexes and adapts to an individual's needs while creating a virtual health network around that person. Services are patient-centered and partnership-driven. By working together, the program, the clients, and IEHP are able to reach their goals and achieve healthful, positive change.

CHARLES'S STARTING POINT

Charles entered the IEHP program with a variety of needs:

- Medical: Diabetes mellitus, hypertension, gastroesophageal reflux disease (GERD), obesity.
- Psych: Major Depressive Disorder, severe auditory hallucinations, withdrawal.
- Other: History of previous heroin use. Physical, mental and sexual abuse from a parent. Dropped out of high school. Lived in group home for two years prior to entering IEHP/MAPS.

Prior to admission, Charles was calling 911 two to three times a month and had been placed on a psychiatric hold for at least seven days at a time. When a doctor evaluated him at the MAPS offices in March 2013, Charles had had multiple suicide attempts, and was recently discharged from a two-week stay at a behavioral health facility following a threat to walk into traffic.

CARE COORDINATION PLAN

Engagement & Stabilization: To engage Charles in the beginning, a team made up of a care coordinator, nurse, and psychiatrist alternated meeting with him three times a week at his home. Alternatively, IEHP provided transportation for Charles to go to the MAPS office.

"What makes a big difference is the level which we're able to engage with them," said Cheryl Stebbings, team leader at MAPS. "We're fortunate to be able to take a person out for coffee, and when we're able to meet people on that level we're not just an official care coordinator or nurse—we're just another person across the table drinking coffee with them. It builds trust at a level you don't necessarily get if you're going to a doctor's appointment at an office. It really helps people turn that corner and start building strong relationships with us."

"Charles had a hard time staying out of the hospital for even a week," said Jerica Gailey, Charles's care coordinator at the program. "We provided a 24-hour crisis line, so whenever he was feeling depression or was experiencing auditory hallucinations he could use that service instead of immediately going to a psych unit or calling 911."

Care Transitions: When an individual is hospitalized, the IEHP/MAPS program responds quickly. IEHP requires that the program meet with hospitalized individuals within seven days of hospitalization. But whenever possible, the care coordinator strives to meet with people at the hospital either before they are discharged or within 72 hours of discharge.

Periodically, IEHP will identify a person who is currently in the hospital, but not yet enrolled or engaged in the IEHP/MAPS program. IEHP will sometimes refer these clients to the program and the care coordinator will reach out immediately in these cases as well.

“When we have someone who has been hospitalized, a licensed team member will follow up within seven days, and within 30 days the patient will have seen a psychiatrist,” said Cheryl Stebbings.

Coordination: To maintain a coordinated service plan with IEHP, the main care coordinator at the program faxes or emails progress reports monthly, and is in contact with IEHP on an almost daily basis. The program team and IEHP have monthly face-to-face meetings to provide regular updates and keep everyone involved. “It’s been a dual learning experience,” said Cheryl. “IEHP is learning how our program works, and we’re learning their requirements.”

Health Building: Consistent engagement with the care coordination team has provided Charles the opportunity to focus on other factors contributing to his health—managing medication, enrolling in individual therapy and becoming active in the community.

“A person is a whole unit: medical, physical, psychiatric. Even though our main focus is on the psychiatric part, there are still a lot of medical-type services we provide,” said Cheryl Stebbings. “We’re helping them get to appointments, helping them schedule appointments, and sometimes redirecting them to urgent care or a primary care physician. By stabilizing their psychiatric needs we can make an impact on the medical side as well.”

Achieving Goals: After working with Charles for several months on his depression and self-esteem issues, the team started working on his short-term personal goals to help him stay focused on the present and stay out of the hospital.

“It initially took several months before Charles was willing to work with us in the beginning. He would rarely come outside,” said Jerica Gailey. They began with a goal of one week without hospitalizations, then increased to two. “And then he just made a commitment with IEHP and he went a full month without hospitalization,” said Jerica. “He said, ‘I don’t want to go to a hospital again’— it’s been eight months since he’s been hospitalized.”

CHARLES NOW

As of May 2014, Charles is still focusing on maintaining a healthy lifestyle with consistent medication management. He has completed his GED and his new goal is to become a certified peer support specialist and a mentor. Charles joined a gym to improve his physical health and cultivated a relationship with his roommate, whom he is currently mentoring.

“He is taking his medication the way he should be taking it and he is attending therapy,” said Cheryl Stebbings. “He really attributes all of his success to being able to work toward his goals and to staying in the IEHP program.”

Pilot Program Outcomes

Dr. Peter Currie, Ph.D., is Clinical Director of Behavioral Health at IEHP. Dr. Currie was the driving force behind the IEHP/MAPS program, and behind IEHP's adoption of care coordination as a strategy for addressing the needs of their members with complex physical and mental health needs.

> "Not treating behavioral health issues drives up medical and social costs. In a well-integrated model of care, open access to behavioral health care services pays for itself in medical cost offsets."
>
> — Dr. Peter Currie, Ph.D., IEHP

"In 2009, IEHP took an in-depth look at the behavioral health services our members were receiving and found that outpatient mental health services were under-utilized, and substance abuse treatment was nil," said Dr. Currie. "When our primary care providers referred people for behavioral health services, they did not know if their patients actually received those services. It has to do with the segregated nature of mental health services in our system."

"Privacy standards have been used as an excuse not to coordinate care. To serve clients well, we need to build in feedback loops between mental health and primary care. In our model, we are making care coordination an expectation. In other words, the behavioral health provider does not get paid unless there is coordination of care. It's incredibly important for the people we serve and their families to know that their doctors and therapists are willing to communicate with each other to improve the care they provide," said Dr. Currie.

"The IEHP/MAPS program has demonstrated that separate is not equal. Parity is not enough. Parity is a mandate and integration is the work that has to be done. Care coordination is not the answer by itself, but it's a tool that helps us really move toward the integration of behavioral health and physical health care in a meaningful way."

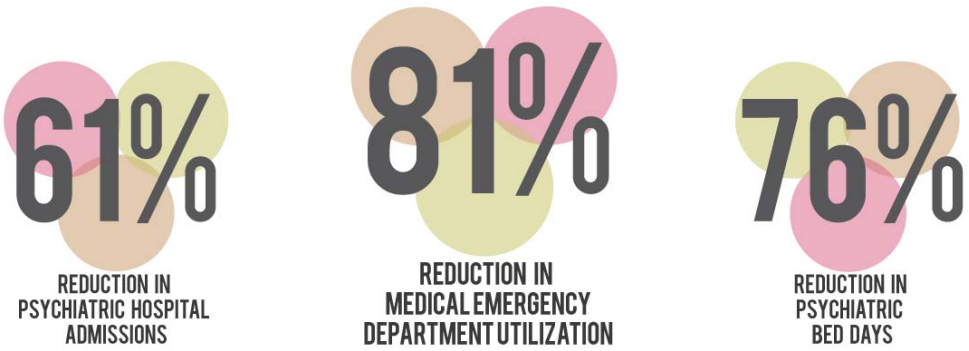
Dr. Currie advises other health plans to develop direct relationships with behavioral health providers. "Direct relationships are the best. Minimize the use of middlemen who can limit access." He adds, "Your behavioral health providers should contract at the highest possible level of the funding stream, directly with health plans when possible. They also need to demonstrate value by measuring results and proving return on investment."

IMPROVING ACCESS & SPEED OF CARE

One of IEHP's goals was to ensure speedy access to care. The IEHP/MAPS program meets this goal by seeing all clients within seven days of discharge from hospitalization and immediately providing related documentation to IEHP.

IMPACT ON MEDICAL ER, PSYCH RE-ADMISSIONS & PSYCH BED DAYS

For each member in the IEHP pilot, information was collected six months prior to enrollment in the program. Following is a summary of reductions in utilization from pre-Telecare and post-Telecare.



In Summary

In the short time the IEHP/MAPS program has been in operation at Telecare, it has enlightened us on several points. We learned that relationships and engagement matter—two of the most essential ingredients that impact care and help members more effectively manage their own health.

> "That 81% reduction in ED utilization is really the tip of the iceberg. You have taken a very high-risk, high-utilization population and dramatically reduced ED usage simply by being close enough to the member to get them linked with proper healthcare resources. It was not magic. It is just what wraparound services can do because you are actually out there, with the member, taking them step-by-step through getting their needs met."
>
> — Dr. Peter Currie, Ph.D., IEHP

It's been exciting to see that care coordination services can improve the way that people access healthcare. The specific skills of mental health professionals—particularly those who work with very complex needs—can make a highly effective contribution in the larger healthcare arena. This pilot has shown us that we can help clients stop the cycle of ED usage by building health and mental health stability, managing crises, identifying their personal goals and motivations, and fully utilizing the resources available through primary care. The real-life, positive impacts of care coordination are gratifying and quantifiable.

IEHP/MAPS: GOING FORWARD

In our commitment to continuous improvement, we are actively working on the following:

- Increasing substance abuse expertise: The needs of people with substance abuse issues are a significant complicating factor affecting care of all kinds. As the program expands it will add two new positions: an additional RN and a CAADAC-certified (California Association of Alcoholism and Drug Abuse Counselors) substance abuse specialist.
- Increasing access to medical data and registry: IEHP has given the program access to its existing claims and utilization data via its web portal system. The program will begin working with this portal to gain a broader view of the healthcare issues clients are facing and the services they are using. Going forward, Telecare will also be working on the development of a client registry — a database of clients which will help clinicians understand how clients are doing daily on a core set of measures, so clinicians can focus their attention on members with the highest and most immediate needs.

Contact Information

For more information on Telecare's IEHP program, please contact:

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