

**Event ID: 727152**  
**Building a Disability-Competent Provider Network**

Operator: Ladies and gentlemen, thank you for standing by, and welcome to the Disability-Competent Care conference call. At this time, all participants are in a listen-only mode. Later, we will conduct a question-and-answer session. Instructions will be given at that time. If you should require assistance during the call, please press star then zero.

I would now like to turn the conference over to your host, Chris Duff. Please go ahead.

Christopher Duff: Thank you, Terry. On behalf of the Lewin Group, Institute for Healthcare Improvement and Disability Practice Institute, I'd like to thank you for attending this eighth in our series on Disability-Competent Care.

My name is Chris Duff and I'm the Executive Director of Disability Practice Institute. First of all, a few quick things about this webinar platform, if your slides are not advancing, please push F5 on your computer keyboard and that should get them moving again.

Please note, initially the two icons circled at the bottom of the screen. The one on the right, that allows you to print a PDF of the slides for this presentation. The red one on the left is for questions. If your question is about the technology, someone behind the scenes will respond in real time. If it is a question for the presenters, we will be compiling them throughout the webinar and we'll return to them during the Q&A.

As I said, this is the eighth in a series of nine webinars. All webinars are recorded and will be available along with PDFs of the slides at the link on the bottom of this slide and all the other slides.

Today, we are focusing on building and supporting a disability-competent provider network. We will conclude this series next week with a presentation on provider and participant readiness with a focus on training.

As stated before, we will reserve 15 minutes for Q&A at the end of this webinar. You can submit questions in writing and we will additionally open the phone lines at the end of the presentation for live questions.

I would like to step back just a moment to give you the genesis of this series and share other tools for integrating healthcare services for dual-eligible populations. The Lewin Group along with the Institute for Healthcare Improvement in Cambridge has a contract with the Medicare and Medicaid coordination office of the Centers for Medicare and Medicaid Services to provide tools and technical assistance for providers that are seeking to integrate and better provide care for individuals who are eligible for both Medicare and Medicaid services commonly known as dual-eligibles.

We would like the remainder of this series and our future efforts to be as helpful as possible. So we are asking our participants to fill out a short survey at the end of this webinar. Please also send us your ideas for future webinar topics and other material of interest either at the end of the survey or to any of our email addresses listed at the end of the slide presentation.

In today's webinar, we will hear from Inland Empire Health Plan, a Medicaid health plan who are in their 10th-plus years experience providing -- building their disability-competency.

June Kailes, one of the coauthors of the disability-competency assessment tool has been a disability policy consultant for 35 years, working with a variety of health facilities, managed care organizations, and government-related projects as a trainer, writer, researcher and policy analyst.

She and a few colleagues have worked with IEHP to understand the needs of people with disability and their efforts to develop programs and strategies to meet those needs.

Before handing it over to June, I'd like to quickly go over the summary, the outline of this presentation. June will start with background for her work with IEHP and then William Henning will then start off with a first person story to reflect the needs and experiences of adults with disabilities as they attempt to obtain the care and support they need.

He will give us some background on IEHP and tell of their experience partnering with providers to improve access and readiness to serve this population. He will proceed to talk about their work with disability community and their disability program.

So at this point, I'll hand it over to June to start the presentation.

June Isaacson Kailes: Okay. Thank you, Chris. Well, as in your plan, about 15 years ago, IEHP, the Inland Empire Health Plan, reached out to the disability community and the Center for Disability and Health Policy at Western University of Health Sciences.

IEHP was not afraid to take risk, to acknowledge what they didn't know and what they didn't know to even ask. They were innovative, creative, pragmatic, thoughtful, passionate and sensitive.

We were representatives from the disability community, and IEHP, we're all new at this work. Together, we visited some model plans in other states. Working together has been a healthy mix of initial skepticism and doubt, mutual and new learning, fun, building up mutual respect over time and of course, dynamic tension.

An example, we told IEHP that they needed to incorporate physical communication and medical equipment access into their provider networks. They asked us to develop a survey tool.

Well, my first draft of that tool was about 30 pages long. And their response was to get that advocate out of here. But we kept at it. We kept working together. We negotiated, compromised, and through working and advocating together, we now have a tool that the State of California has actually adopted.

We, the community feel a sense of pride regarding our role in IEHP's successes and many of their outcomes. Some of which you will now hear about from Dr. William Henning who, since 2007, has served as the Inland Empire Health Plan's Chief Medical Officer. He oversees all medical services, which includes utilization, care management, wellness, quality management, behavioral health and pharmacy.

Prior to his work at IEHP, Dr. Henning served 15 years as director and practicing physician of a prominent San Diego primary care group. From 1994 through '95, he served as chief of staff and subsequently as a member of his local hospital governing board. So Dr. Henning, over to you.

William Henning: Thank you, June, and welcome everybody from sunny California. We're looking at a beautiful day here again this morning. I'm sorry if it's not so well where you are at.

Let me start a little bit about Inland Empire Health Plan because I think you need to understand the framework of the plan to understand the program that we've put together. In California, the Inland Empire is a term that refers to Riverside and San Bernardino counties.

So Inland Empire Health Plan serves just those two counties in Southern California. We're a public entity. We're not for profit, largely. We were begun in 1996. The State of California went to the major counties and said, you must have a managed Medicaid health plan in each county.

So we were begun as a public plan. At that time, we since added a Medicare Special Needs Plan which we call DualChoice. And we're in the process of becoming two of the eight demonstration counties for the duals demonstration project, the CCI. And so we'll have about one-third of all the duals demonstration membership in the State of California if that rolls out.

We currently serve about just under 650,000 people of which a little over 11,000 are in our D-SNP, our duals program. And out of those 650,000 combined between our seniors and persons with disability Medicaid and our duals, there's about 76,000 people that qualify with disabilities.

Now one of our great challenges in the Inland Empire, these two counties, is the two counties together are roughly geographically the size of Kentucky. And if you look at them on the map, the whole eastern half of these counties are desert. There's very little infrastructure and certainly very little medical infrastructure out in those areas.

Access is difficult across the two counties, especially in the eastern parts. If you look at the physician ratio in the Inland Empire, these two counties compared to California, we have about half of the recommended physician ratios in both primary care and specialty care.

So you combine that with vast distances, it's not unusual for persons with disabilities to maybe travel 100 miles from an outlying town to a major medical center to try to access specialty care. So very difficult access issues because of geography.

And then those of you who are in California know, outside of California, maybe not so much, but are what we call Medi-Cal or Medicaid funding in California, is some of the lowest in the nation.

And so our ability to pay safety net providers is limited in the funds that we receive, and so it's quite challenging sometimes keeping networks and especially specialty networks together, with limited funding. So you roll all that together and I'm talking about both a quality and otherwise challenged environment for providing a program in disability care.

We're going to start with a story because I think sometimes when you start with a real person, it brings home the challenges. We're not talking about abstract ideas, we're talking about real patients and most of us, I think on the call, live in that world where we're dealing day to day with real patients.

Marcus is a challenging member, but not unique. We have many, many challenging members in our disability community. And they're challenging because of their life and the challenges they see in their life. So Marcus in particular is a 56-year-old with multiple chronic illnesses.

His illnesses include both mental health and physical health conditions. He has bipolar disorder and he has chronic pain. He's obese. He has diabetes. He's unemployed. He's divorced. He's estranged. He lives independently in a small apartment.

So as I paint this picture, I will say that his biggest risk is the fact that he has no support system. And you know that working with people with no support system means challenges to access healthcare correctly.

I'm going to try to avoid reading slides and bullets because you have those in front of you and if you're like me, you simply read them as we go along anyway. I'm going to try and focus maybe a little bit on some of the lessons learned.

And one of the lessons learned here that I'll hit on right away, someone who has no support system in the disability community is going to be a challenge for readmissions. All of you are working on readmissions right now as we are and trying to come up with innovative ideas on dropping our readmission rates.

One of the things we learned with Marcus is that he doesn't look at a readmission to the hospital the way you and I would. He welcomes readmission to the hospital. He lives alone. He's lonely. He doesn't have the ability to put food in the fridge. He's living on a very limited income, on his disability income.

And so as we're walking into this with our glasses on that say, hey, patients are going to partner with us on our readmission efforts, we found out actually that in this community, that may not be true, that they may at least subconsciously sabotage our efforts to keep them out of the hospital because they like going back into the hospital. That's their social atmosphere. They know the nurses, they know the hospital, they know the routine, they like three meals a day and TV and cable. And so you have to recognize the differences in this community. We're going to touch on that quite a bit during the presentation.

So Marcus is followed by a number of specialists. You see he's got physiatrist and psychiatrist, neurologist, pulmonologist, endocrinologist. He's hit most of the 'gists here. But what you don't see is a medical home. You don't see a primary care physician here acting as quarterback for his care.

He's on 20-plus medications. That's not unusual when you've got multiple specialists on the case. And these different specialists and medications are not in an electronically connected system.

So the Inland Empire is very challenged in our quality metric, certainly challenged in our adoption of electronic medical records and no good way yet to connect electronic medical records between disparate practitioners.

The Inland Empire has built a health information exchange. We are perhaps, due to member files, the largest health information exchange in the state, soon to be perhaps the largest in the nation. We have over 9 million files in our health information exchange and crowing about 9 million records does not help doctors actually exchange information across that exchange.

So important concept here. And we'll also touch about innovative ideas in connecting specialists going forward.

He's been in the hospital eight times with multiple medical and psychological issues. So what kind of care coordination challenges are we seeing here? One, we mentioned, he doesn't actually have a primary care physician, even though he's assigned one. By definition because he is a member in our organization, he's assigned to PCP. But he doesn't see that PCP as an important member of the team. He actually sees his physiatrist more commonly than any of the rest of his specialty care.

He has comorbid medical and mental health, very significant as you know. Any time you see comorbidity in these two environments, you're going to see significantly increased hospitalization and poor integration of health.

We've actually start -- well, when we looked at our persons with disability population, we found that 50% of them actually have a behavioral health diagnosis. Half of them have some behavioral health diagnosis. Now the majority of those are fairly lower grade. They're anxiety, they're depression, they're chronic pain, chronic back pain, chronic migraine pain. And only 17% have serious mental health issues.

One of the problems we have there is that for serious mental health issues, they are carved out into a separate system of care. So they're receiving their mental health in a distinct system of care separate from the health plan.

So one of our innovative solutions was to develop our own network of mental health providers and they are tied together through a web-based program. The mental health providers are required to send us their evaluations, they don't get paid unless an evaluation comes after every visit. We are then able to post those to a website for the primary care provider to pick up.

We've gone to almost 80%, 85% coordination of medical records between mental health and medical health by doing this system now, where before it was almost 20% when we outsourced to an outside provider.

Of all the challenges on this list, transportation as we sort of touched on, one of the greatest. Trying to get somebody 100 miles. Loma Linda is our tertiary care center here. And it may be 100 miles for him to see a specialty neurologist at Loma Linda. There isn't a bus that goes 100 miles from Barstow to Loma Linda. And so we're challenged to come up with transportation.

I'll bring up another pearl that comes out of focus groups. And we're going to talk a little bit about focus groups and why do people go to the emergency room. And we all or the industry has certain beliefs about why people go to the emergency room, and I will challenge you to actually talk to your members, your patients about why they go to the emergency room because what I learned when we did that was not what we believed it was going to be the case.

What we learned was people go to the emergency room because it's a smart thing to do. I was talking to a mother of five who's 18-years-old and have a methamphetamine problem and has three children with significant cognitive issues including autism and one of her five children with severe asthmatic problems.

So if she has to have her child seen for an asthma problem, to get to a primary care physician means taking two buses, and she was in Section 8 Housing. And after getting two buses, she can get to her doctor's office. But if she has to go to lab work or to the pharmacy or to x-ray, she has to go somewhere else and the bus doesn't go there.

Instead, she can jump one bus and go to the emergency room, and the emergency rooms in California are now actively advertising for patient visits for acute care visits. They see themselves as acute care provider for specialty services -- for services.

And so in one bus, she can be in the ER, she can be seen in five minutes. She can be out of the ER in 45 minutes with her lab, her x-rays, her pharmacy, everything bundled together. And all five of her kids jump back on the bus and go home.

So I'll ask you, who's doing the smart thing here? The patient or the health plan? It's not the health plan. She's doing what you and I would all do and doing what's right for her and her family, and we have to address those dynamics if we're going to address our ER problem.

Slide or -- page 13, some of the high points here, as you know, there's no real specialty for disability-based care. We have specialists for almost everything else. We're doing a pilot program with a physician who's based at one of our county hospitals who is doing a disability primary care program.

And there are some important lessons there too that we'll touch on. But basically, what we're finding out, though, even though he's an expert, he has the time, he has the tools to provide specialized and unique care, it's very difficult to get patients to switch away from their primary care doctor. They like their doc and they don't necessarily want to go to another doc even if they can get advanced care through that doctor.

So you're looking for physicians, primary care physicians specifically, that have specific knowledge and comfort levels, accessible facilities, and the sufficient time, time being a very important variable here.

The problem is how are you going to pay them for that, right? And so if they're capitated, that doesn't work because access is significantly higher in this patient population. And I don't know about your states, but Medicaid fee-for-service isn't even going to come close to reimbursing somebody an adequate fee for the amount of time they have to take for this unique environment.

What are the provider network requirements? This really looks at who the team is, who's the core team, and what are the tools we use. Now if you look at this list, these are largely not health plan employees. They are community partners. And we'll be touching on that time and time again.

Conceptualize the team that you use is not the staff in your office. It is the partners in the community. And what you are is the connector between those partners. And so we bring the partners together, we set up the referral system to connect and leverage community-based organizations, a very important concept. A key pearl to take away today.

So our philosophy is very much about improving outcomes. We are very much outcome based. And the philosophy is to partner with stakeholders in the community. I really look at it as building relationships around the medical home.

And sometimes that's a virtual medical home. So saw with Marcus, he doesn't actually have a medical home. And his choice is to access his psychiatrist as his main caregiver. And so that means the health plan in that case has to wrap services and communication around what he chooses as his home even though they're not set up with those tools.

And you'll see how we wrap some of those services around and use that philosophy to gear his care coordination in a wrap-type system.

Page 16, Slide 16, very important concept here. There's two ways to do this. One is to identify specialized centers that would be your access point for your persons with disability. The other is the choice that we make, recognizing in our very large geography that just wasn't going to work. There was no way for us to get people geographically to centers.

And even if we built those centers, the lesson we've learned is people don't want to go to them. We did this with diabetes. We've built specialized diabetes centers thinking that we would take people out of the medical home for their diabetes care and coordinate that with a primary care physician. And we found time and time again, people wouldn't go to the center. They wanted to stay with their primary care physician.

So what we do instead is have a philosophy, a training program to train PCPs. We want them to stay with the PCP they've chosen and what we intend to do is train that PCP to become a specialist in providing care for persons with disabilities.

And then we wrap care management support around that PCP where it's necessary. And of course, there's all different levels of competency depending on where they are with medical home. And that involves us and our ability to wrap services around each.

We're going to talk a little bit about how do we improve access, how do we measure access for a second here. California has adopted a state-wide accessibility audit tool. So in California, we the health plan or the health plans in each region are responsible for auditing primary care offices every three years, or more often if necessary.

And part of what we do and developed over the last 10 years is develop an audit tool added to the regular Medicaid audit tool that looks at accessibility in their office and then I'll show you how we publish that accessibility.

We actually co-wrote the tool and provided it to the state. So we perfected this tool over 10 years, and when the state decided, this is a really good idea and started pushing it out to the other health plans, they really adopted our tool.

We want to get that information into the members and so they can use that when they choose their primary care provider. And so that accessibility information that we discovered in our audits is published in our provider directory in different ways. And it's also incorporated in a Find a Doctor Tool that is a web-based tool they can use when they come to our website.



So the next page, you see the three different levels of accessibility that grades each office in the directory and you can read what those are, but they are limited, basic, and then specialty equipment access if available. It's listed in the directory.

And on Page 19, the indicators that are also used in the directory. They show physical accessibility.

The other thing we show in the directory that's not shown here, quite innovative of Ben and who you're going to hear from -- well, we might hear from Ben in just a second. But Ben and his team are able to reach out to specialty providers who are able to put bus routes and bus stops into our directory.

So think of yourself as a challenged person with a physical limitation and you're going to our directory, what you want to know is, can I get there on a bus? How close is the bus stop to my doctor's office? If it's two blocks away, some people may not be able to walk that two blocks and so they may need different transportation.

But most of our members are using buses to access care. And so very important information for them to have. And we talked about why patients actually go to the emergency room sometimes is because that's where the bus goes. All of our major medical centers have a bus stop out in front of their facility.

So we work on educating the providers and giving them the tools also on their side to provide physical accessibility in their office. We're going to look at little more about what that training guide looks like.

But one of the key points on Slide 20, Page 20, is that the statistics show that persons with disability are less likely than other members to receive basic routine healthcare and preventive healthcare.

Now why is that? Well of course, what happens is in our prejudice in our offices and myself as a primary care provider, often times we see the disability, we don't see the person. And so we we're reaching out to try and treat the disability and forgetting that person with the disability who also have the same basic healthcare needs the rest of us have and everybody has.

And so one of the things we train our offices on is recognizing how to provide those preventive and chronic disease management tools as well.

Page 21 starts looking a little bit, and this is just a sample of what our training guide looks like for our providers. There's a whole manual for them and that manual is available. I believe that we can talk to Chris at the end about how -- if we've provided a link to what that manual looks like then you can link to it.

But this talks about physical accessibility and what the physical accessibility ought to look like in your office and then the picture on 22 is representative of what the training manual looks like and just visual guides on how to set your office up for physical accessibility.

Now I will put one of my own personal soapbox issues here, that if you actually look at your persons with disability and their diagnoses, you'll find that about 10% of them are wheelchair-bound or has severe physical limitations and yet we always sort of default to physical limitations when we talk about office accessibility. Probably not the right thing to do.

We have to have the cognition that persons with disability are represented by a very wide variety of diagnoses and limitations, more often it's sight, hearing, cognition or chronic pain. And of course, when we start talking about how to rearrange your office for wheelchairs, we're sort of ignoring sometimes those other people with disabilities.

So Page 23, we start getting into the training that we do. And this gets fairly involve a lot of different training. The focus is around something we call IEHP University for our physicians, other providers and their staff and don't forget about office staff. One of the key important training opportunities is with your provider office staff.

We also do a lot of in-house staff and office staff monthly activities around awareness activities, and so we have this whole month of disability awareness and we do sign language classes, and guest speakers and resources and videos. Every year is a different set, really focused at our staff and office staff.

Page 24 is an example of one of the guides we give to physicians around pre-visit information to gain from the member and their needs and their special needs when they show up for their appointment. So hopefully our physicians and providers are aware of special needs before the people even get to the office.

Page 25. When we asked our staff what are some of the specific training issues that we run into time and time again in our provider communities, what kind of things do we need to know?

General tips. Things like speak directly to the person. Don't speak to their caregiver. Don't speak to their translator if they're in the room. The patient is the person that's sitting in front of you and they deserve the respect of direct communication.

Anticipate language issues. If you're going to need a translator, if you're going to need an American Sign Language person, you'd have that person there ahead of time and arrange for that.

We covered that in California. The health plan is responsible for covering the cost of those. So we provide access to those services for our provider offices. They simply need

to call in and say, hey, we need American Sign Language at this for this visit and we'll help coordinate that visit.

Page 26. A reminder that each person is unique. Marcus is unique. His needs are unique. A cookie-cutter approach is not going to work for Marcus and it's not going to work for a vast majority of the people in these programs.

And so both our physicians, our providers have to be aware that we're going to have to set up different care coordination, different needs for everybody who walks through the door. And along with that, the third bullet, important here. We see ourselves as the networker for community resources for both the physician offices and the members and connecting them all together.

So as you're going to see next, we were very involved in the community-based organization resources and community-based organization network within our two counties.

I am challenging our department, our internal disabilities department to sort of change their metric. They have been very much this focused, building this community-based organization network, but as we move into our duals demonstration and this ever enlarging population of person with disability, what we recognize is we need this directly connect numbers to community-based organizations. And so we need that resource for the members, not just the doctors and for us, the health plans and the other vendors in the community.

Really, if you understand, a different dynamic and a slightly different direction. I don't want to lose what we've got here because what you're going to see in a minute is very large and very valuable. But we're going to be also challenging to make those connections, especially with people who need long-term support services and people who are in long-term care.

Those of you who are getting the duals demonstration-type projects in California, the state took the opportunity to not just bring mandatory Medicare in but at the same time, they're passing the risk for long-term care and long-term support services over to the health plans on the regional level, so a whole new workload for us to try and understand long-term support services.

We really think that this is the right fit, that long-term support services are really about leveraging community-based services and what's available in the community and what's available at the counties. And you'll see how we're going to liaison into those services.

A real quick word about our Members with Disabilities Workgroup. We recognized early on that these were not just members and receivers of services but they were a valuable resource themselves with helping us to design our programs. And so we formed this workgroup and this is really a focus group.

And one of the pearls for you; if you were looking to expand your services or if you are looking to start services, this is a good place to start. There are two keys -- hire the right person for the manager of your program, and we'll talk a little bit about who that person is. But the other is form the focus group early on because these people will tell you what your program needs to look like and they will help you review your program.

So we have 30 people. They meet quarterly for two hours. We bring them to the health plan and they help advise us. The examples of the things that we address as we're looking at the hospital readmission issue, we ask them. Why do people go back into the hospital? What are the challenges in their life that cause readmission?

And they were able to identify the transportation issue and the desire to go back and the difficulty getting to their primary care office and getting their lab works and their x-rays. Number two, here in California, everyone receives -- every new patient in the disability community receives a health risk assessment on entering to the program and then a refresher every year.

And so we use the focus group to look at the health risk assessment and say, do these questions make sense to you? Are we asking the right questions? If we ask this question, what does that mean to you? And you'll be amazed at what you learn. People who believe they have cancer because they were given a diagnosis that sounded like cancer to them but which in fact wasn't.

And so wording is very important here. Another example, long-term support services. As we are trying to learn more about long-term support services, we very much want to know what that means to the community; what does long-term support service mean to you; what services are you accessing; did you know that these were a benefit; did you not know; and if you had access to them, how would you go about that; who would you call, what would you do. So very much helps us design our programs.

Slide 28, Partnering with the Community. So we're going to talk a little bit about our disability collaborative because our community hub really revolves around that collaborative. And I will say, this is going to look a little overwhelming to you and many of you will look at this and go, no, we could never do that.

But it started small. We started this a little over 10 years ago. And it grew itself. You'll see very quickly the value drives this collaborative. And so very quickly, everybody who heard about it in the disability community wanted to be a member of the collaborative, whether they were a vendor, an agency, a representative of people in the disability community. They wanted in on this collaborative early on. It grew itself. We didn't have to do much outreach. We didn't have to do a lot of marketing. People wanted to be at the table.

What the health plan does is serve as a hub. And so we are the -- we pull the group together, we provide the space, we give them lunch. We do the things that pull them

together. And those administrative services can be done with minimal staff as you'll see in a minute.

But this collaborative has 700-plus members in it now and you see who's represented here in that collaborative. They meet monthly. We have major speakers come in. And so, not to steal thunder from Ben, but major speakers call and want to speak to this collaborative because it's a venue where they can reach an awful lot of people in the community in a centralized meeting. There's also biannual conferences for the professionals, and we'll touch a little bit more on that.

So what do the monthly meetings look like and who comes? The examples of who's coming is on this page again. The picture at the bottom, there's a picture of Herb Schultz. Herb Schultz is the representative for CMS. He reports directly to Kathleen Sebelius and he is our Regional California Representative to DHCS. Just an example of people who want to come and speak to the members at the collaborative.

The next slide, Annual Disability and Resource Expo. Annually, Ben and his team put on an expo and that's basically a consumer expo. We've had to expand into the local convention center because it's become so large it's the only venue large enough to hold it. There's 1,800-plus attendees, there's over 180 vendors.

And so members, consumers are able to come and see all the varied services that are available to them. They are, in one spot, able to connect many of those services. And again, this is something that just keeps growing on the strength of its value to the community.

Slide 31, just some examples, some pictures of what that expo looks like. The sports team, the basketball team, we support a lot of different physically challenged athletes. We believe it's a very important piece of the community we can be involved with.

Okay, what does the conference look like? This is sort of for professionals. We have over 270 attendees. These are professionals that work in the disability community. We provide 24 different workshops within this conference over a number of days. And so they get to hear speakers, they get to learn different aspects of disability care.

And it's very well attended, very highly looked at. Some pictures on Page 33 of what this looks like. And you can see very large halls full of people learning more about disability rights care.

So where do you start? So establishing our program, where did we start, how did we do it, what does it look like? And again, it looks like a lot of resources. I'm going to show you it's not a lot of resources. We've been at this a little more than 10 years.

And so it started just before I came to the program. A little bit before. I wasn't here at the very start so I can't say I was involved in the discussions on how to start the program. And in fact, I'm not even sure it was a conscious decision to say, hey, here's our mission.

Our mission is such that -- and we are very much a mission-driven organization that clearly sees our mission as providing access to quality healthcare for the safety net community including those persons with disability.

It's always been that way. Even though they were not mandatorily enrolled with us, they voluntarily enrolled with us oftentimes. And so it really started with one person and that one person was brought in to help us understand the community better. And around that one person who came out of the disability community grew the staffing and grew the vision of what this could be.

And like I said, because of the value we brought to the table, it grew to this very large program that you see today. Our current program is led by a disability program manager, that's Ben Jauregui. Ben has three disability community representatives and one AA. So we're talking about a staff of five people that does everything that you see in front of you right now.

It is important, and this is another key pearl to take away. Ben's position, I would not do otherwise. You need to hire that person out of the disability community. They understand the community. They are connected already in the community. In Ben's case, he came out of the independent living center community and so he's very connected and he advises us on our relationships and our connections to the community. But it doesn't take a lot of staff to do what you've seen today.

So the program on Slide 35, some of the bullet points on what we see as our mission here. The different things, a lot of what we touched on already. This is an evolving program that will always evolve. It started small. It's continued to get bigger. Our next step, as we talked about, is asking our in-house staff to become specialists in connecting us especially around long-term care and long-term support services and connecting our members better into those community-based organizations and leveraging their use.

Obviously, if you think from just the financial side, we don't have the dollars to pay for all the services that are needed in this community -- for ramps, for home modification, rehabilitation oftentimes. And the way it's set up for our financing, we are not reimbursed for many of those services. We're not reimbursed for board and care.

If I want to move somebody out of a long-term care facility right now, I don't get reimbursed to put them in long-term care. And so what I have to do is figure out innovative ways to get somebody into long-term care and cover those needs. And that's what this organization, this group is going to be doing is leveraging those community-based organizations and the expertise that they bring to the table.

In Slide 36, one of the things that we've done also that's a little innovative is recognize that we have very significant partners in the community that share the same membership with us. And so Inland Regional Center, I'm not sure, you probably call it different things, but the Regional Centers in California have specific -- a mission to take care of persons with developmental disability.

And so they are shared membership. They are our members but they are also in the Regional Center and the Regional Center provides a lot of the care management wraparound services for that membership.

We recognize that those were very high-risk people and they were often falling in the cracks between our two programs. And so what we did is we hired a social worker who now is embedded in the Regional Center, has access to their system and our system. And so when there's a problem patient, they are able to connect the two systems together and coordinate care across the two systems.

It's been very valuable in providing patients needed services but also very valuable, and as you can see, in relationship building with our Regional Center. So we have a very strong relationship.

We expanded that liaison program into our two County Mental Health Departments, recognizing the very large opportunity for missed communication, missed integration of services. And so we've embedded a social worker again in both County Mental Health Departments.

They're our employee but they really live most of their life there connecting the two systems. We're in the process of hiring for long-term support services, so in California that's called IHSS and MSSSP. But basically, these are in-home support services for people who qualify at a custodial hospital level of care to keep them out of the custodial hospital, obviously a very high-risk population for us. We want a lot of coordination with services in those programs.

I think I'm getting to the end of my slides. My summary. So in summary, some of the bullets, some of the pearls I really wanted you to pull out of this, we developed a really service-centric, another way of saying member-centric, program. An example of this, I was allowed to just redesign our whole case management program.

When I started here nine-plus years ago, I want to say we had about three or four case management nurses. It was before we really got big time into this type of business. I'm guessing I'm looking at somewhere north of 130 nurses today.

And what was happening is we, like everybody else, evolved systems that became fragmented. And so we recognized we cannot be fragmented. We needed to focus our care management around the member. I want one member assigned to one nurse. So every time that member calls in, they're working with the same person.

We redesigned the whole care management system to do that, so a very member-centric department. We want people to stay in their medical home. We want them in a medical home and when we need to, we are going to wrap services around that medical home. So we provide a lot of the care coordination. As you saw, we provide a lot of the translation

services, transportation services, the things we need to do to keep them in that medical home.

The third bullet, you need adaptable programs; stay malleable. A cookie cutter approach, this isn't going to work oftentimes and we've learned that over and over again. And then the last bullet, really, you are a partner in the community. You can't do this alone. You need to leverage the services of all those other agencies and programs out there, learn who they are and learn how to work together with them.

So that's the end. I'm going to hand it back to Chris who I believe is going to open it up for any questions at this time.

Christopher Duff: Thank you, Dr. Henning. That was absolutely great. I really also specially appreciated the pearls you dropped in throughout. There's no easy and there's no -- recipe to follow to serve this population well because it's so contextual. And I think one of the key messages you brought forward is engaging and listening to people with disabilities, your members and the people who are closest to them. And I really appreciate your willingness to share your experiences.

Terry, would you now open the lines for questions?

Operator: Thank you. And ladies and gentlemen, if you wish to ask a question, please press star then zero on your touchtone phone. If you're using a speaker phone, please pick up the handset before pressing those numbers. Once again, it's star zero if you would like to ask a question.

Christopher Duff: We have one question that was submitted online and that is from Jeminak Kodowa -- I don't know if I'm pronouncing her name right; if I'm not, excuse me -- to Dr. Henning. Is there any way the hospitals will create or could be encouraged to create a triage area for either ER or urgent care to limit the ER visits with bad ER situations?

William Henning: That's a great question. And we struggle this as all Medicaid plans have; limiting access. There are perverse financial incentives and actually some legal problems that prevent us from doing that. But the hospital ER actually has a perverse incentive to bring our patients and roll them through quickly due to payment methodologies.

But also, there are hospitals that do that. And so they have a triage and they fast track people either to an urgent care side or to an ER side. But unfortunately, the billing codes are the same for both. And so the levels of ER professional access are the same on both sides of the fence.

And from our financial side, it really doesn't make a lot of difference. So, no, we haven't been successful in trying that idea. It hasn't really helped us. The hospitals will hide



behind EMTALA and say, look, EMTALA, once they show up, we can't triage them somewhere else. That's not really true.

EMTALA says that if they show up with a true emergency, they have to be stabilized. If they show up with a cold, they don't have to be seen. They could be triaged to an urgent care. But the hospitals, for legal reasons and liability reasons, really aren't willing to see that.

And financially, honestly, that single mom with five kids shows up, gets in and out in 45 minutes. She never makes it to a bed. They sit in the plastic chair in the hallway, gets all their care, and the hospital and the provider really gets the same level of fees from us as they would if they came in with a heart attack almost.

So, again, perverse incentives, CMS of course is looking at co-pays. It's been very unsuccessful trying to get that instituted. So anybody who's got great ideas in the year, that's a whole another webinar, but we have not been successful.

Christopher Duff: Thanks for the response -- while the concept that she put forward was kind of a no-brainer concept, in practice it hasn't proved viable in your context. So therefore, what you did is you've then turned it around and said, okay, we need to work with our members to see if we can meet their needs in a context or in a manner that would eliminate their need to go to the ER.

William Henning: Great point, Chris. So let's bring that a little more. So remember, that mom is doing a smart thing. She would do the same thing that you and I would do in this context, right?

And so if we want to change this dynamic, we need to change her world. We need to change her options. We need to give her an option that's easier than the emergency room, that works better for her. And if we don't do that, we're not going to change her behavior.

Christopher Duff: Thank you. Another question's from Lisa Price Stevens from Fallon Total Care, I believe, in Massachusetts. It is, how are you able to engage your physicians in training? Physicians are often busy and find it difficult to attend training sessions or even participate in webinars.

William Henning: Good question. So we don't do webinars. We didn't have a lot of success with that. We tried that but they just couldn't book their time to be available for a webinar. And even with incentives, it didn't work very well.

So trying to bring them to the universities, there are some small incentives there. But I'm really thinking -- the model that I like best is the pharmaceutical model, that detail model that trains people to go into the physician office and bring value to them. As a physician, if you came into my office and you brought me some value, I will talk to you. If you came and just wanted to sell me your product, you probably didn't get face time.

And so we have two different levels of value there. Esther and her group are responsible for our Provider Services people. They're really taking up the technical skills and showing them how to train correctly on policies and web-based tools.

And then recently, we started hiring nurses. We call them nurse educators. And they're very much like pharmaceutical detail people. They go to the offices and they bring clinical training tools. How do you do better on HEDIS? How do you do better on office-based setup and training for disability community? If you want to market better to this community, what do you need to do to your office?

And so they're bringing real value to the office and we're simply replicating the tool that's been successful for the pharmaceutical industry.

Christopher Duff: Thank you. Terry, are there any questions? Anyone online?

Operator: I have no questions from the phone lines.

Christopher Duff: Okay, let me go back to the online submissions here. Can you speak specifically about the role of the social worker that you have embedded in the mental health office at the counties?

William Henning: Okay. They're very much a care management person, right? So they're trained as a medical social worker. It's that license, that master's in social work that we're looking at. And they really have a desk in both places, so they spend probably three-fifths of their time over inside the -- the actual county.

And more than anything, they simply coordinate care. And so what's happened is that the care management folks, the social workers, the licensed workers, the psychiatrist at the county have learned they're there and use them as a resource and say, look, I've got a problem. I just picked this person up. They're on the wrong antidepressant medication from their primary care provider but I can't get a hold of their primary care provider. Can you help me arrange that conversation or can you get a message out to them? Or I need to get some medical records from such and such a place, can you help us figure out where are those medical records?

So they're doing the same thing a care management person may do in many different places. But they're specially trained to fit inside of that environment and connect our two. And if nothing else, just being able to connect their electronic system with our electronic system since it's almost impossible to build good interfaces between systems.

They can drop -- they have rights into their electronic system. They can look at their electronic records and then they can look at our records as well at the same time and make sure they can find out if the psychiatrist needs to know -- patient says they saw a psychiatrist in LA County last month, can you figure out who that is; we can go into our claims base system and see who they saw. So it's just connecting systems.

Christopher Duff: Thank you. Somewhat similar to this and I know you weren't at IEHP when the disabilities department was established, but why did IEHP decide to establish a separate independent disabilities department versus embedding those three, four, five staff in different departments throughout your health plan?

William Henning: Yes, and that's another good question. And you could do it that way. But if you think about how it works, you're working with a very limited staff in our case, very efficient. And honestly, I'd like to say again, that was a conscious decision but it probably wasn't so much conscious as it's the way it evolved and it was the way it naturally wanted to evolve.

And it really evolved that way because we were externally focused, originally, in our disability program. Our focus was very much how do we connect with the community partners out there.

Ben, are you on the phone? Do you want to answer that? Do you have history there as to why did we consciously select that or thoughts on which is a better way to do it?

Ben Jauregui: I wasn't here in the beginning. I believe I came on three years after the program had started. But you're right. In the past, we had an external focus of finding those community partners and also doing outreach to the community, to potential members, doing presentations in the community, attending health fairs, resource fairs and things like that.

So very focused on marketing, developing those community connections and it's just evolved over time to where there's a lot of internal support that we now provide to various departments. And I can't take all the credit for all the great work that IEHP does. I simply support all of our team, all of our departments in their efforts in improving the healthcare services.

For example, Provider Services, we have a great team there led by Esther. And she trains the providers, gives them tools and information and I simply support them in their efforts and provide them with whatever it is that they need to provide that information.

But we don't have, per se, experts in different departments but I would say all of our departments are very -- I believe they're all experts in their own field. But they also recognize the needs of our members and the disabilities. And so they always contact me for information resources.

I'm involved in many, many committees, too many to name right now. But I'm there to support all of our internal teams in their efforts.

Christopher Duff: So it's in your plan, your area has been set up then to be kind of the content expert related to disability and research to serve people with disabilities?

Ben Jauregui: Correct.

Christopher Duff: Okay, great, thank you. Someone from United Healthcare has asked whether the tool can be shared with them. And I'm assuming the tool they talk about there is the site assessment tool. And yes, IEHP has been more than generous in sharing with us a variety of tools they have developed. And we will be putting them up on their website -- or not on their website, on the website that's identified at the bottom of the slides and if they're not there now, they will be there within a few days.

We also plan to take some of these tools and see if we can expand. As an example, California I think is quite mature thanks to IEHP in their site assessments of primary care. And so there are just some learnings from that that we can use to try to bring to some other states. So we'll be putting these resources online in the near future.

And someone -- Amy Mung from AgeWell has a question and it's a very interesting question. How do you work with a client with a cultural taboo, the taboo being not seeking medical treatment?

William Henning: That is the key question, right? And instead of maybe just answering towards taboos, let's talk about challenging patients who don't want to work with the health plan.

And so, as I said, remember, the majority of our persons with disability are disabled with chronic pain. They are on narcotics. I have somewhere in the neighborhood of 30,000 people taking hydrocodone or Vicodin more than 90 days. That's probably inappropriate use of Vicodin. And yet at the health plan calls, they don't want to talk to us because they want their medication, right? If my health plan calls me, I don't talk to them. Why do I want to talk to my health plan? And so there's a bias right up front that the health plan's out to get you and not your partner in this.

The way you change this is what I touched on with care management. You change people's behavior when you develop a relationship with the person. And so you need that person with the cultural taboo or whatever to trust a person, a nurse, a coordinator at IEHP. And they know that when that person calls, they're working with them to help them, to provide value in their life.

If you don't get to that point, you're never going to change that person's behavior. And there's good studies out there that show that that's really -- whether it's physicians or clients or patients, that's how you change behavior. You develop a personal relationship and you develop trust. And then once trust is established, you might sometimes change behavior.

Christopher Duff: Another example that we learned in Minnesota is we had a large Mali population. And if they saw that the call was coming from our organizations, they would not answer it. Now that could have been distrust, could also have been a simple communication issue.

But what we then moved to is we hired a community health worker who was from this Mali community. And she actually served as the main communication with most of those numbers. And she was very successful not only in connecting with them but hearing what their fears and resistance were and then communicating that back to the care team to figure out how do we work with this.

So community health workers who are often trained at kind of an associate level are not highly trained in a -- somewhat financially cost-effective, have been reused in a lot of programs across the country to reach culturally diverse programs.

I think we have time for one more question. That's from Jim Doa at WMRO. Do you have a separate policy in place for providers, physicians that are seeing the persons with developmental disabilities?

William Henning: No, no. So the provider network is ours. The Regional Centers don't have a provider network, per se. And so the challenge -- in fact, the physician or provider may not even know they're a Regional Center client when they're seeing them. They may, depending on how intense the case management has been.

That's not to say the Regional Center doesn't have some specialists who do clinics at the Regional Center. But for primary care, it's somewhat invisible at the provider level. That care coordination is more a function of our teams and the Regional Center teams working together and again working around that patient to provide those services.

Christopher Duff: Great. At this point, I'm going to call your attention to the last slide where there is a link to the survey. We are just now in the process of developing plans for this coming year.

So besides feedback on this webinar, we hope that you'll give us some ideas on what -- what are some of your questions going forward. I know in many states you're looking towards implementing dual initiatives in 2014 and I'm sure you're just overwhelmed with all that you don't know. And so if there are some specific questions or areas that you would like some -- for the training, whether it's webinars or other material, please let us know either at the end of that survey or separately through email to any of the names provided in one of the last slides.

So at this point, I'm going to take one last question. Is there any question online?

Operator: I have no questions in queue.

Christopher Duff: Okay. So then the last question I'll take is -- and it's a question about your nurse educators. How much time do your nurse educators spend with individuals face to face in visits with doctors?

William Henning: Yes, a good question. So the way they're set up -- and so they're kind of set up to spend roughly an hour in an office working both with staff and doctors. And

they're working office-specific projects and those projects sort of cycle depending on HEDIS calendar and other needs.

And so one of the recent projects was helping physicians change their systems to enhance their HEDIS scores for diabetes. And so, you know, what do you need to do? If you don't have a registry, what are you going to do to do outreach to make sure people get their A1cs and LDLs.

And so they have -- that whole calendar is coordinated. If you can imagine, what we don't really want is different people showing up in doctors' offices that aren't coordinated at all. So we need Esther's Provider Services people to be coordinated with our nursing people and anybody else who may be showing up at the doctor's office.

So we have an annual calendar that really looks at during this month, we're going to really be focusing on this issue, and this training so everybody knows what's going on in that month. And so the geography is so large and they're regionally based. They don't have -- we don't want them spending a lot of their time driving between offices so you have to schedule and bundle and get those things together.

And honestly, we found it more effective to focus on select offices in a period of time. And so you'll say, okay, we really want to affect diabetes. Who are the offices that have 80% of our diabetics? And so we're going to really focus just on those offices for this period of time and then we'll flip to another project and do an analysis to help us know better how to get the best bang for our buck.

Christopher Duff: Good, basic common sense.

William Henning: Yes.

Christopher Duff: Well, I'm going to need to wrap this up at this point. I would like to thank the speakers for sharing your wisdom and experience. This is a journey, not a destination. And you've certainly had many more years under your belt than many of us and we appreciate you taking the time to share that with us.

We have received a few questions that we were unable to answer and we will make sure that we get back to those individuals offline. As I indicated at the beginning, we have one more webinar, a week from today at this time. Everyone who signed up for previous webinars as well as this one will receive notice about our future webinars and our future activities.

I would like to thank you again for your participation and I'm looking forward to your joining us this coming week. Thank you.