We heal and inspire the human spirit.

To: IEHP Direct DualChoice PCPs (High Desert)

From: IEHP – Provider Operations

Date: April 17, 2026

Subject: **IEHP Update: Chronic Disease Management Program Launch at the Victorville Community Wellness Center**

Dear High Desert Community Physicians,

We are pleased to share an important update that reflects our ongoing commitment to improving access and health outcomes for the members we serve together. Building on the November 2025 pilot, we are expanding services at the health services center within the Victorville Community Wellness Center through the launch of a structured Chronic Disease Management (CDM) Program. The program will focus initially on DSNP members with uncontrolled hypertension and/or diabetes who may benefit from more frequent touchpoints and targeted chronic disease support.

Chronic Disease Management services at the health services center will be available five days per week, Monday through Friday. This program is an IEHP initiative and represents the continued development of the IEHP Care Division. We have engaged Greater Good Health (GGH), a clinical services organization and their care team includes nurse practitioners and outreach coordinators, who will be private labeled as IEHP providers. As the primary care physician, you remain at the center of the member's care team, and GGH will coordinate directly with your practice as well as our care management team. This partnership is intended to strengthen support for you and your patients by improving access, promoting consistent follow-up, and helping drive better outcomes across key quality measures.

Importantly, member attribution remains fully with your practice. Any quality improvements completed through the CDM Program, including chronic disease stabilization, care gap closure, medication adherence support, and diversion of avoidable hospital use, count toward your quality performance and incentive payments. Your incentive payments and attribution are unaffected by member participation in the CDM Program.

Members who elect to participate may do so through outreach conducted by GGH. Members who elect to participate will receive:

- Comprehensive initial assessment, which may include completion of the Annual Wellness Visit, as well as a health risk assessment, medication review, PHQ2/9, cognitive screening, ADL and fall risk evaluation, and review of historical and suspect conditions.

- Longitudinal chronic disease monitoring with structured clinical protocols for hypertension and diabetes, including HbA1c and point-of-care testing, blood pressure management, and lipid and statin review
- Proactive outreach and engagement from dedicated outreach coordinators focused on adherence, appointment follow-through, and identifying barriers to care
- Care gap closure is aligned with HEDIS measures such as blood pressure control, managing A1c and monitoring kidney function for diabetics with GGH NPs coordinating necessary orders, referrals, and medication updates and sharing results with the member's PCP
- Disease specific patient action plans in English and Spanish to guide member self-management between visits
- Hospital and emergency department post-discharge engagement through early clinical intervention and escalation protocols for members showing signs of decompensation
- Visit notes and care coordination updates routed to your office via e-fax within 72 hours of each encounter

What This Means For Your Practice

When your member chooses to enroll, the CDM team becomes responsible for coordinating their chronic disease management and closing quality gaps in care between office visits. Your role as the physician of record does not change. All clinical decisions of consequence, including treatment recommendations and referrals, remain under your direction.
The program is designed to support your practice, not add burden. The GGH team will keep you informed, communicate care plans, prepare referrals on your behalf for your approval, and ensure no care is delayed. This model centralizes between visit work and outreach, so your staff does not have to carry it alone, while preserving your oversight of each member's care.

If you determine the model is not appropriate for a specific patient, IEHP will work with you to adjust the arrangement. Participation is voluntary, and we honor both the member's choice and your clinical judgment.

We appreciate your partnership and your commitment to our shared members. If you have questions please refer to the FAQ, or would like to discuss further, please contact your Provider Relations Manager or reach out to Dara Francisco, VP of Care Division, at Dara.Francisco@iehp.org

FAQ: Chronic Disease Management (CDM) Program

April 17, 2026

1. **What is the purpose of the Chronic Disease Management (CDM) Program and who will it serve?**
   The CDM Program is designed to provide structured, evidence based chronic disease support for DSNP members with uncontrolled hypertension and/or diabetes. The goal is to improve access, stabilize chronic conditions, close care gaps, and reduce avoidable hospital utilization.

2. **How are members identified?**
   Members are identified through IEHP's risk stratification process. Eligibility focuses on DSNP members with uncontrolled chronic conditions who may benefit from more frequent touchpoints and added clinical support.

3. **Does my patient have a choice about enrolling?**
   Yes. Enrollment is voluntary and member driven. No member is enrolled without their verbal consent. Eligible members are contacted directly through Greater Good Health outreach

4. **Will I know when one of my patients is enrolled?**
   Yes. Your office will be notified when an eligible member from your panel elects to participate. After each encounter, comprehensive visit notes are sent to your practice via e-fax within 72 hours.

5. **Who is Greater Good Health?**
   Greater Good Health (GGH) is a clinical services organization specializing in comprehensive preventive health and chronic disease management for complex populations. Engaged by IEHP, the team includes nurse practitioners and outreach coordinators who follow evidence-based protocols aligned with IEHP standards and DSNP population needs.

6. **How will the CDM team collaborate with my practice and with IEHP Care Management?**
   IEHP has engaged Greater Good Health (GGH), a clinical services organization and their care team includes nurse practitioners and outreach coordinators. GGH nurse practitioners will share visit notes, coordinate care recommendations, and partner with IEHP care management's team on wraparound services, social needs, and complex case management. As the physician of record, you retain oversight of the care plan. Any new referrals or recommended treatment changes are routed to your office for your approval and initiation, ensuring continuity and alignment across all care settings. PCPs will review GGH medication recommendations and incorporate changes as clinically appropriate to maintain continuity of care.

7. **Where and how will members be seen?**
   Members may be seen in person at the health services center, via telehealth, or through home visits. CDM services at the health services center will be available five days per week, Monday through Friday. This multimodal approach is designed to reach members who face transportation challenges, inconsistent access, or difficulty engaging in traditional primary care settings.

8. **Does my practice lose attribution or quality credit for enrolled members?**
No. Member attribution does not change. All quality work completed through the CDM Program, including care gap closure, chronic disease stabilization, medication adherence support, and hospital diversion, counts toward your practice's performance metrics and incentives.

9. **What services will the GGH nurse practitioners provide?**
Services include:
• Comprehensive initial assessment
• Medication review and adherence support
• Chronic disease management (i.e., hypertension and diabetes)
• Point-of-care testing (HbA1c)
• Care gap identification and orders, referrals and medication management for HEDIS gap closure (CBP, GSD, KED, COL, BCS, TRC)
• PHQ2/9, cognitive, ADL and fall risk screening
• Disease-specific action plans (English and Spanish)
• Hospital and ED diversion support through early clinical intervention

10. **How does clinical oversight work?**
If a member's condition worsens or falls outside the CDM scope, the GGH nurse practitioner will document findings and notify your office promptly. You determine the appropriate clinical course, including referrals or treatment changes. The CDM team then carries out coordination in alignment with your direction and collaborates with IEHP Care Management to ensure continuity.

11. **Will the CDM Program be advertised to members?**
No. Outreach will be conducted directly and only to eligible DSNP members. The program is not being publicly promoted at this time.

12. **Can I refer members to the CDM Program?**
Yes. If you have a patient who may benefit, you may request that the member be considered by contacting your Provider Relations Manager or Dara Francisco, VP of Care Division at **Dara.Francisco@iehp.org**.

13. **How can my practice support coordinated care with the CDM team?**
• Review comprehensive visit notes upon receipt
• Review GGH medication recommendations and incorporate changes as clinically appropriate
• Approve and submit referral requests and treatment recommendations promptly
• Ensure member contact information is current
• Notify the CDM team of hospitalizations, clinical changes, or care concerns
• Reinforce ongoing follow-up and encourage continued engagement with both the CDM team and your practice

14. **How can I share feedback or learn more?**
    Please contact your Provider Relations Manager or contact Dara Francisco, VP of Care Division at **Dara.Francisco@iehp.org**

If you have any questions, please contact the IEHP Provider Call Center at (909) 890-2054, (866) 223-4347 or email ProviderServices@iehp.org

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