IEHP DualChoice (HMO D-SNP) Model of Care Training

START COURSE

IEHP DualChoice

INTRODUCTION

- Course Instructions
- Course Learning Objectives

OUR MEDICARE POPULATION

- IEHP DualChoice (HMO D-SNP) Population, including the Most Vulnerable Population

CARE COORDINATION PROCESS

- Roles and Responsibilities of the Interdisciplinary Care Team
- Health Risk Assessment
- Individualized Care Plan

CARE TRANSITIONS

- Introduction to Care Transitions

CLINICAL PRACTICE GUIDELINES

- A Closer Look at CPGs

CULTURAL AND COGNITIVE COMPETENCY

- Unconscious Bias
- Culturally Competent Care
- Race and Ethnicity
- Independent Living

LONG-TERM SERVICES AND SUPPORTS (LTSS)

- Long-Term Services and Supports Explored
- Home and Community Based Services

DEMENTIA CARE

- Background and Resources

INTEGRATION OF BENEFITS & COMMUNITY SUPPORTS SERVICES

- Community Supports Services
- Integration of Benefits

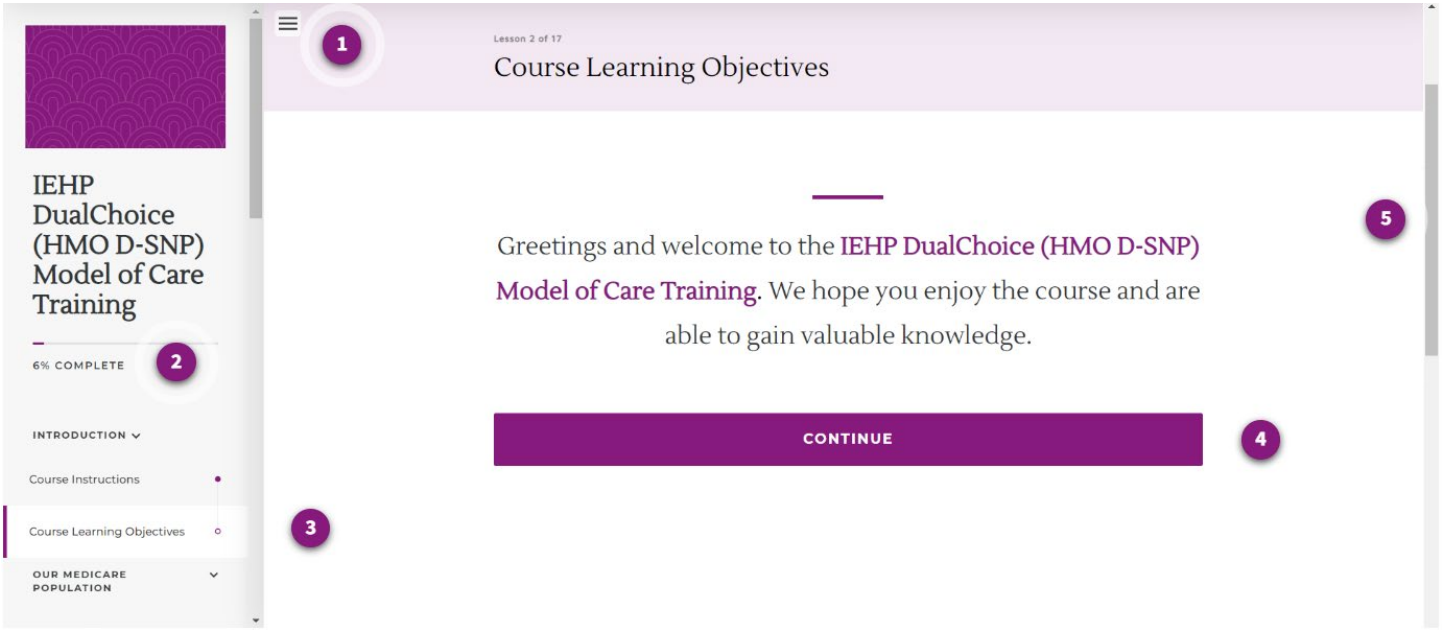
SUMMARY

- Wrap Up

Course Instructions

How to Navigate the Course

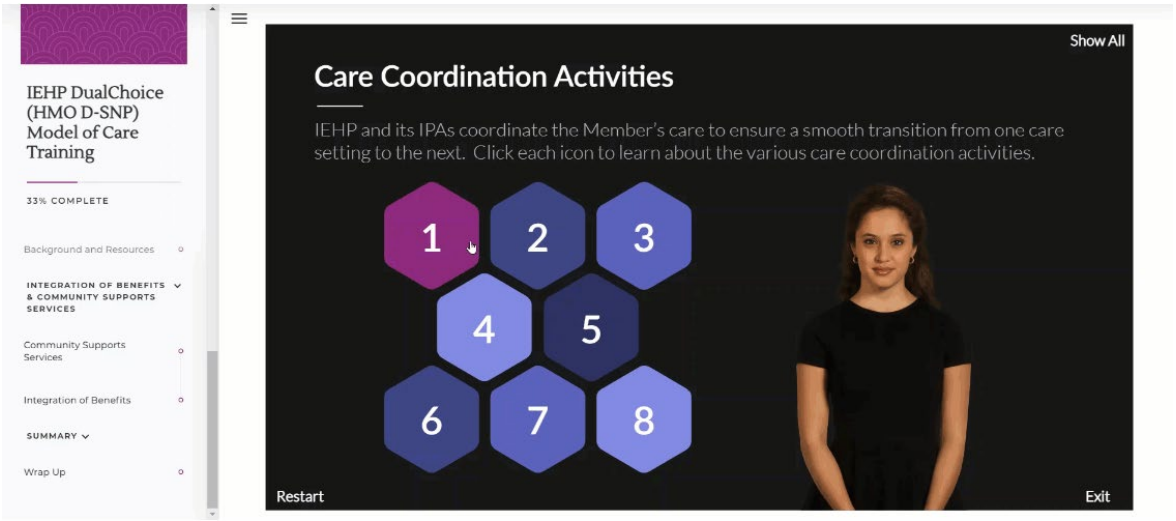
This course has been created in our new RISE format. This webpage-like design allows for easier navigation with a more modern feel.



1. Click here to collapse or expand the Table of Contents.
2. Overall percent of course completed.
3. Depending on the requirements of the course, navigation may be restricted. This means you must view all lessons in order. You can always click on an earlier title to revisit completed lessons.
4. Click the Continue button to move to new sections of the course. In some cases, the Continue button may be locked until all of the activities in the lesson have been completed.
5. Scroll to navigate through the course.

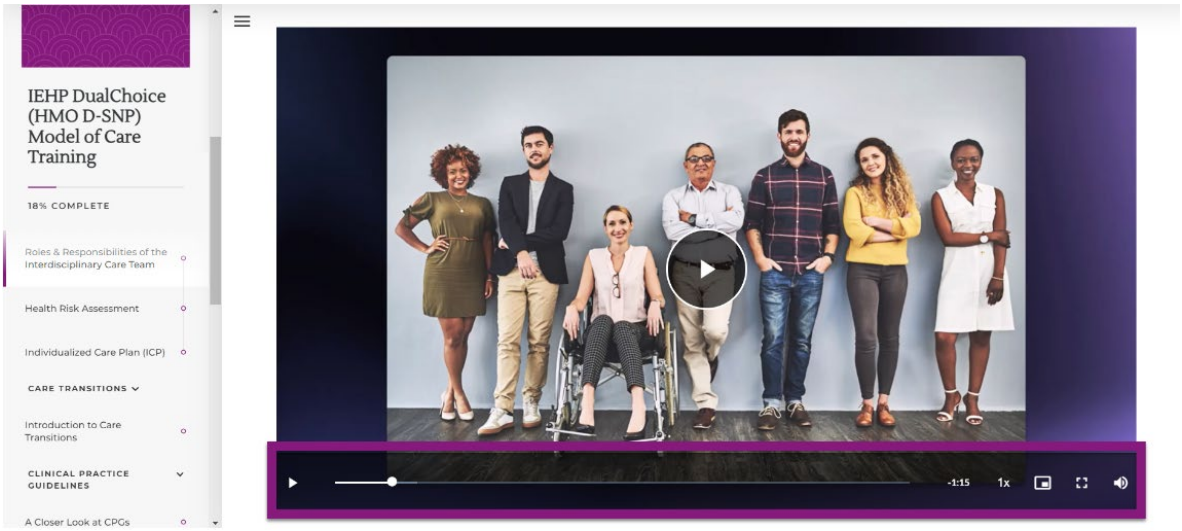
Interactive Sections

Throughout this course, you may see some lessons with interactive images and slides. Depending on the interaction, you may have to toggle to full-screen by clicking an image, dragging and dropping items, and/or clicking arrows to allow navigation of the interaction.



Video Sections

In this course you may see some lessons with videos. Use the player controls shown highlighted in the square below to toggle to full-screen, manage closed captions, control volume, and play/pause the video.



Knowledge Checks

The knowledge checks in this course will display a score based on your responses. You are encouraged to review the feedback provided to your responses to ensure you understand the content.

Retaking a knowledge check is optional and will not impact your completion of the course.

Continue

Course Learning Objectives

Upon completion of this course, you will be able to:

- Describe the IEHP DualChoice population, including the most vulnerable.

- Describe the specially tailored services available to IEHP DualChoice Members.

- Explain the care coordination process for IEHP DualChoice Members.

- Describe the aspects of care planning involved with IEHP DualChoice Members.

- Explain the different types of care transitions.

- Explain the process for modifying the use of IEHP's clinical practice guidelines.

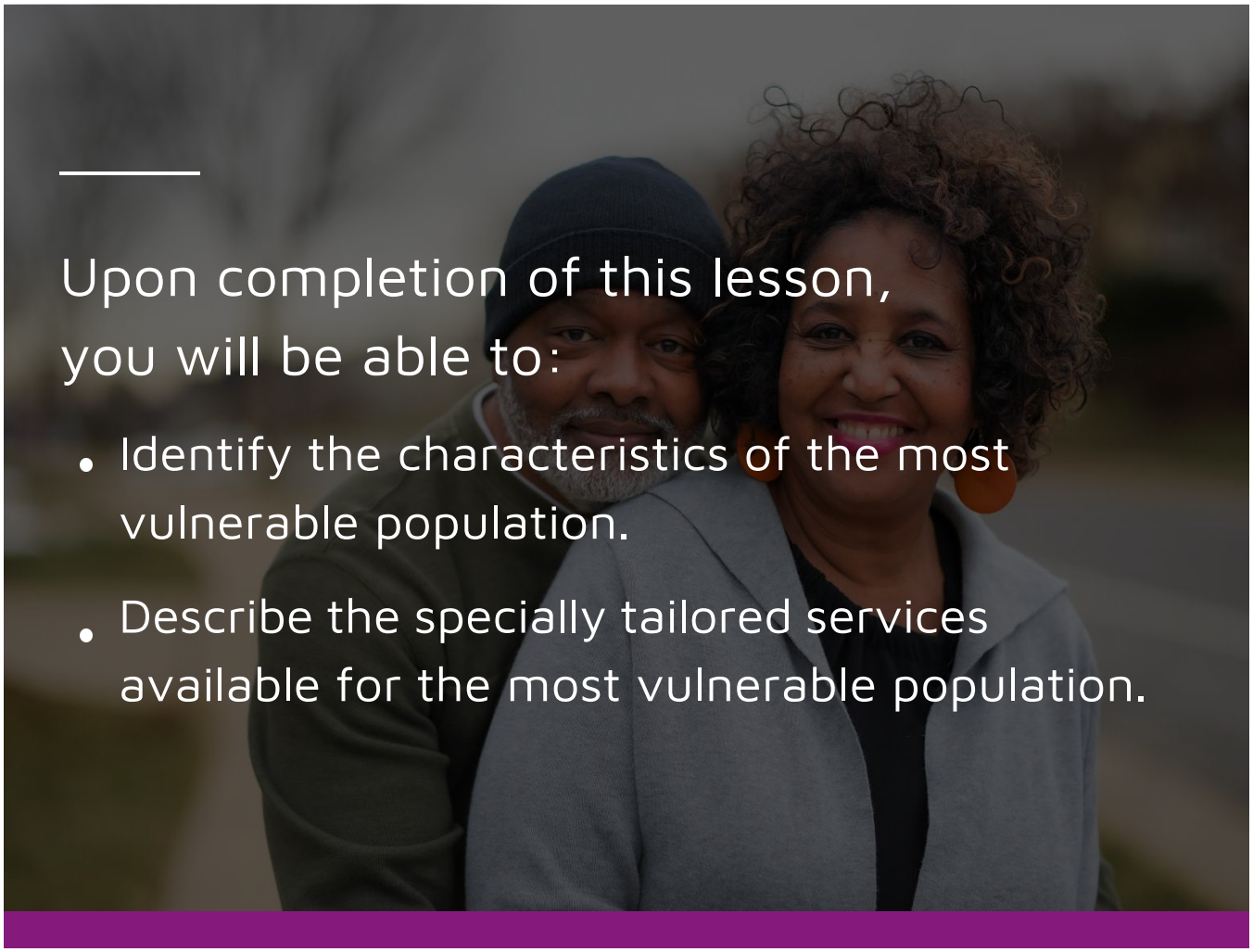
- Summarize how to interact with all IEHP Members, in a culturally and linguistically appropriate manner.

- Identify the various Long-Term Services and Supports, available to our IEHP DualChoice Members

I'm Ready To Learn!

Lesson 3 of 19

IEHP DualChoice (HMO D-SNP) Population, including the Most Vulnerable Population



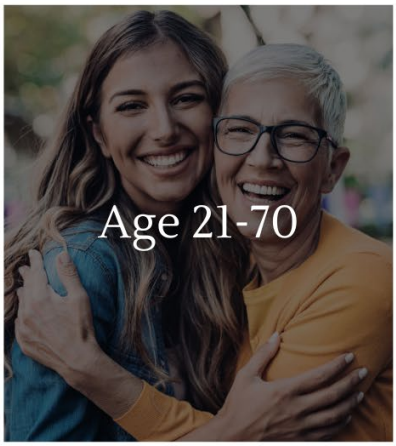
Upon completion of this lesson, you will be able to:

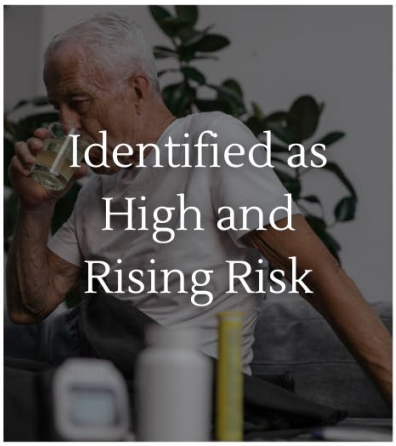
- Identify the characteristics of the most vulnerable population.
- Describe the specially tailored services available for the most vulnerable population.

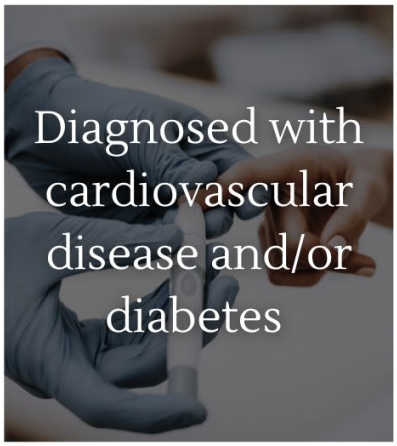
Start Lesson

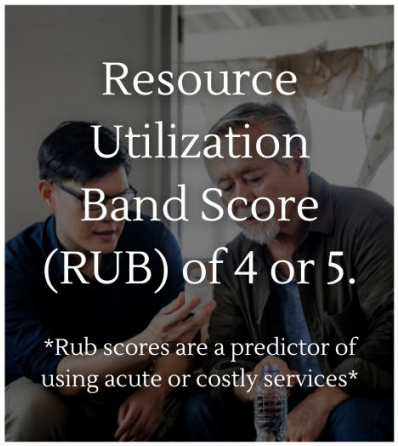
The **IEHP DualChoice (HMO D-SNP)** population is composed of individuals who are dual eligible for both Medicare and Medi-Cal in Riverside and San Bernardino counties, including the most vulnerable population.

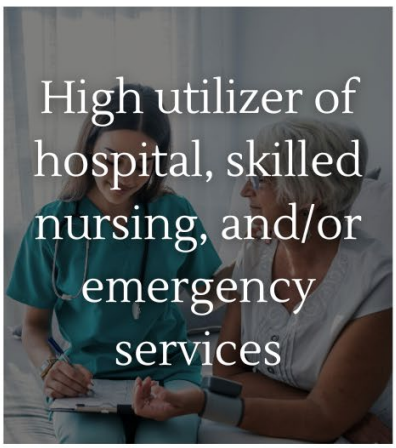
Review the characteristics of the most vulnerable population among IEHP DualChoice Members below.

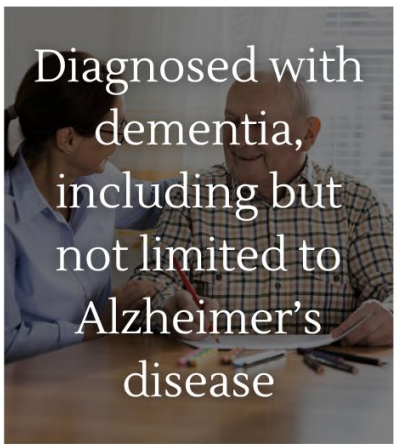


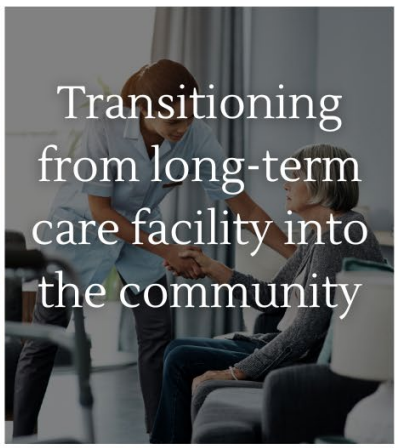


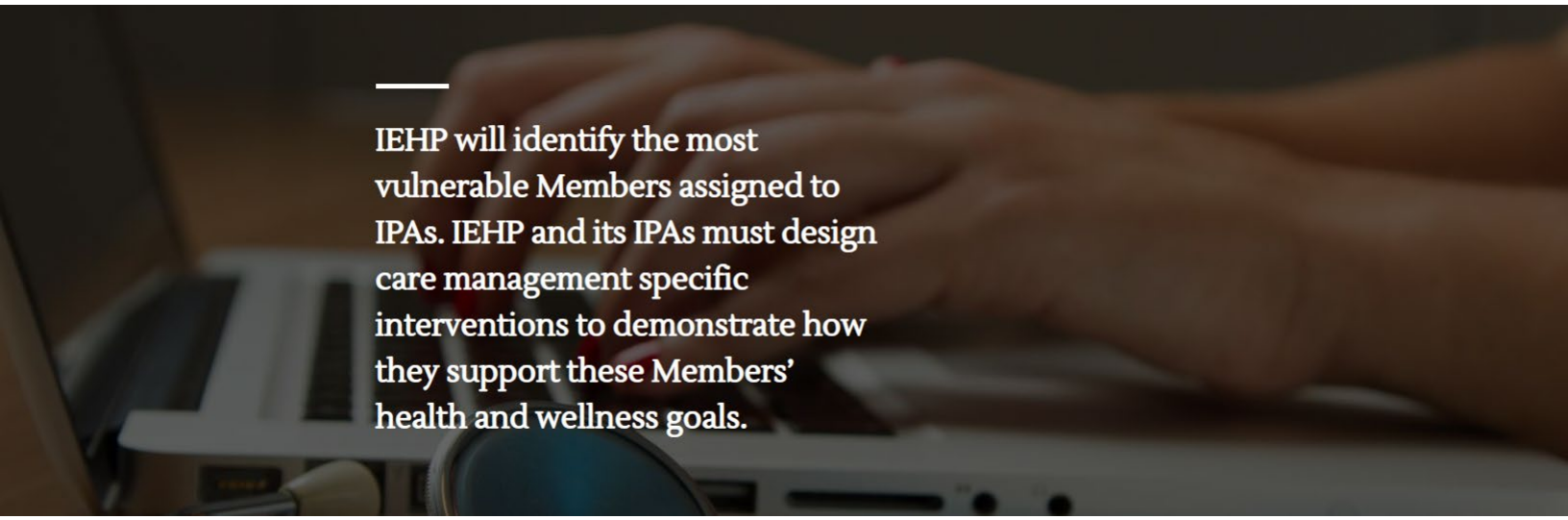












Review the graphic below to see some examples of Specially Tailored Services offered for the most vulnerable population.

- Remote Patient Monitoring
- Medically Tailored Meals and other Community Supports
- Nutrition Education
- Pharmacy Services, including medication reconciliation and other programs
- Palliative Care and Services
- Long-Term Services and Supports (LTSS)
- Telehealth Behavioral Health Services
- Transportation
- More frequent Care Management contact
- Nurse Advice Line services

Let's take a moment to review your understanding.

True or False?

The IEHP DualChoice population is composed of individuals who are dual eligible for both Medicare and Medi-Cal, including the most vulnerable population.

- [x] True
- [ ] False

Correct

The IEHP DualChoice population ***is*** composed of individuals who are dual eligible for both Medicare and Medi-Cal, including the most vulnerable population.

Which of the following are characteristics of the most vulnerable population among IEHP DualChoice Members? Select all that apply.

- [x] Identified as High and/or Rising Risk
- [x] Diagnosed with Cardiovascular Disease and/or Diabetes
- [x] Resource Utilization Band Score (RUB) of 4 or 5
- [x] Ages 21 - 70

Correct

Some of the characteristics of the most vulnerable population among IEHP DualChoice Members are:
- Identified as High and/or Rising Risk
- Diagnosed with Cardiovascular Disease and/or Diabetes
- Resource Utilization Band Score (RUB) of 4 or 5
- Ages 21 - 70

Now that you have learned about the IEHP DualChoice population and some of the specially tailored services that are available for them, you can move on to the next lesson where you will learn about the role that the Interdisciplinary Care Team plays in the care for our IEHP DualChoice Members, along with some of their responsibilities.

Roles and Responsibilities of the Interdisciplinary Care Team

Upon completion of this lesson, you will be able to:

- Explain the role of the Interdisciplinary Care Team (ICT).

Begin Lesson

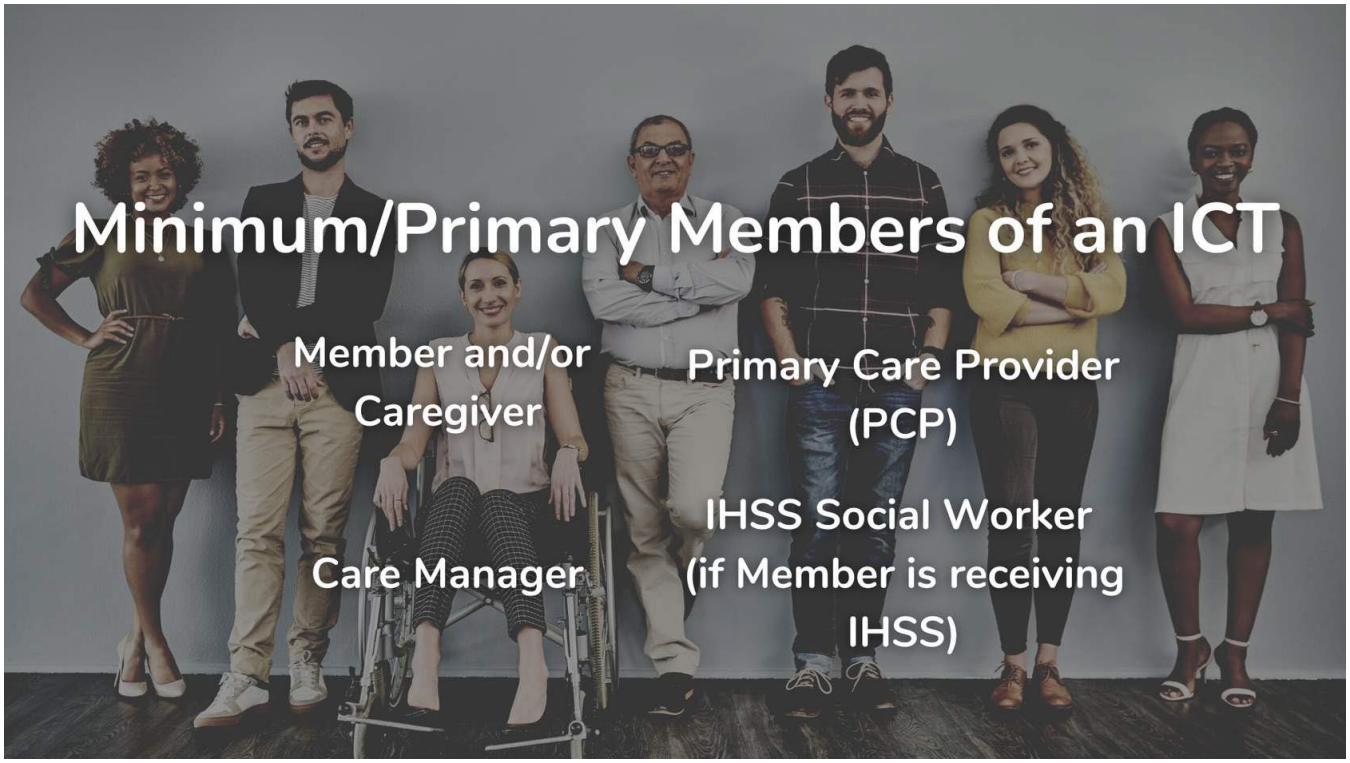
Interdisciplinary Care Team

Every D-SNP Member has the support of an **Interdisciplinary Care Team (ICT)** and the development of each team is based on the Member's individualized needs.

At a minimum, the ICT is comprised of the Member and/or caregiver, Care Manager, IHSS Social Worker (if Member is receiving IHSS), and Primary Care Provider.

Other ICT participants may be:

- Specialty Care Provider
- Home Health Providers
- Community Resource Partners (ex. IRC, Alzheimer's Greater Los Angeles, etc.)
- LTSS Providers (e.g, CBAS, MSSP, LTC etc.)
- Registered Dieticians/Nutritionists
- Health Educators
- Behavioral Health Professionals
- Pharmacist
- Utilization Management Representative
- Provider Service Representative
- Medical Director
- Spiritual Care
- Other Health Plan Staff



Review each of the tabs in the section below to learn more about the ICT.

PRIMARY CARE PROVIDERS | CARE MANAGERS | COMMUNITY HEALTH WORKERS | PHARMACISTS | COC

Primary Care Providers (PCPs) are responsible for:

- Supervising, coordinating, and providing initial and primary care to the Member; initiating referrals and maintaining the continuity of patient care.
- Referring to IEHP or the IPA, Members that may benefit from case management.
- Reviewing the Member's health risk assessment and individualized care plan and incorporating this information into the Member's medical record.

CARE MANAGERS | COMMUNITY HEALTH WORKERS | PHARMACISTS | COORDINATORS

Care Managers must have the appropriate experience and knowledge to support the care coordination needs of the Member. Care Managers may be:

- Registered Nurses (RN)
- Licensed Vocational Nurses (LVN)
- Social Workers

RN & Social Worker Care Managers are recommended primary Care Managers for high risk or complex Members, including the most vulnerable population.

CARE MANAGERS | COMMUNITY HEALTH WORKERS | PHARMACISTS | COORDINATORS

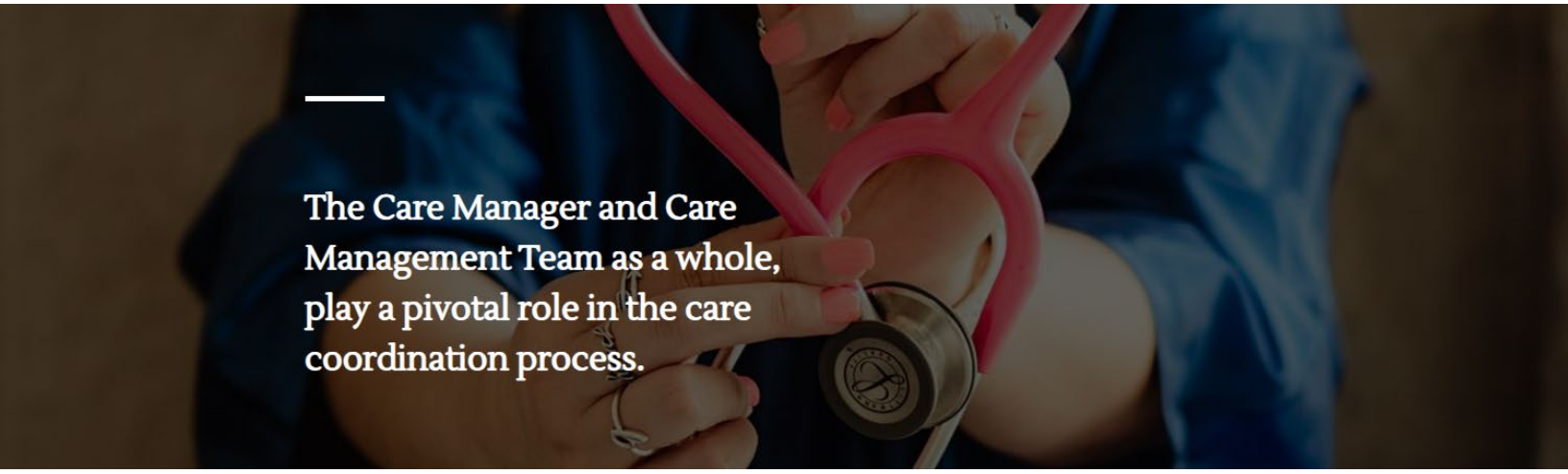
LVNs and Community Health Workers may be equipped to provide support for Members who are low or rising risk as part of the ICT.

CARE MANAGERS	COMMUNITY HEALTH WORKERS	PHARMACISTS	COORDINATORS

In their role as part of the ICT, Pharmacists focus on Medication Reconciliation and Medication Adherence programs.

CARE MANAGERS	COMMUNITY HEALTH WORKERS	PHARMACISTS	COORDINATORS

Non-licensed Coordinator roles provide administrative and care coordination assistance as a member of the ICT.

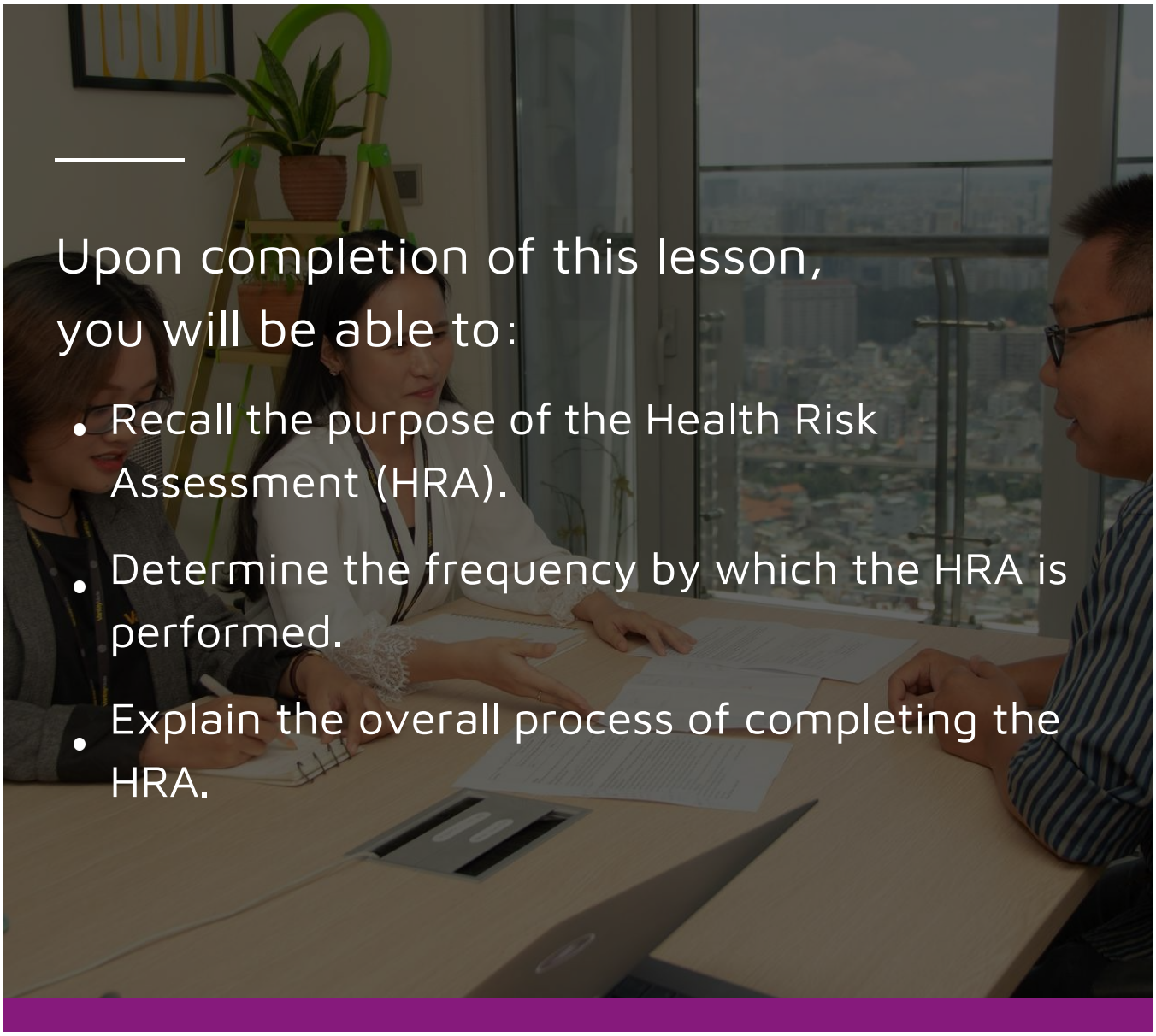


Responsibilities in the ICT

- Conduct outreach and engagement
- Review Health Risk Assessment (HRA) responses
- Help prioritize problems, goals, and interventions
- Assist with Care Transitions and ensure appropriate follow-up care is received
- Facilitate communication between Interdisciplinary Care Team (ICT) participants
- Assist Members/Caregivers to obtain all Medicare, Medi-Cal, and Community-Based benefits & services
- Communicate with the appropriate ICT participants when the expected outcomes are not achieved, allowing the ICT participants to recommend changes or adjustments
- Review Member health outcomes to determine if adjustments to the individualized care plan should be made to support health care needs

Now that you have learned about the role of the ICT, and some of the responsibilities of the Care Management Team, you can move to the next lesson to learn about the Health Risk Assessment.

Health Risk Assessment



Upon completion of this lesson, you will be able to:

- Recall the purpose of the Health Risk Assessment (HRA).
- Determine the frequency by which the HRA is performed.
- Explain the overall process of completing the HRA.

Start Lesson

A Health Risk Assessment (HRA) is a survey tool used to assess the Member's medical, functional, cognitive, psychosocial, behavioral health needs, and Medi-Cal services currently being accessed by the Member.

IEHP also conducts an assessment for Members with cognitive impairment to determine if the Member is eligible for LTSS services.

The HRA is considered the starting point in the care coordination process.

IEHP is responsible for completing the initial and annual HRA, which are available in threshold languages. The initial HRA must be conducted within **90 days** of enrollment into IEHP, while annual HRAs (reassessments) must be conducted within **one year** of the initial HRA or from the date of the last HRA.

The HRA Process

Review the next section to discover more about the overall process of completing the HRA.

There are four different methods in which HRAs can be completed:

- Telephonically
- Face-to-Face
- Mail
- Via the Member Portal

The HRA consists of 28 questions in total, including a question to address Advanced Care Planning (ACP).

'Do you have a living will or Advanced Care Directive?'

An Advanced Care Plan (ACP) is a way for a person to make their health care wishes known if they are unable to speak for themselves or prefer someone else to speak for them. Primary Care Providers should discuss ACP with Members at least annually.

Examples of Advanced Care Plans include:

- Living will
- Durable power of attorney for health care
- Physician Order for Life Sustaining Treatment (POLST)
- Medical Orders for Life Sustaining Treatment (MOLST)

One of the questions in the HRA asks the Member for their top 3 concerns. The response to this question is a great place for the Care Manager to start developing the Individualized Care Plan (ICP) as well as building trust and confidence in the care management relationship.

Note that you will learn more about the ICP later in the course

On a daily basis, IEHP posts completed HRAs to its secure Provider Portal for IPA Care Management Teams and Primary Care Providers to access and review. HRA data is also posted to IEHP's Secure File Transfer Protocol daily for IPAs.

Incomplete HRA

In some cases, IEHP is unable to contact the Member or they refuse to complete the HRA.

If a Member does not complete an HRA, the Primary Care Provider (PCP) is encouraged to reach out to the Member to schedule a visit and/or connect the Member with IEHP DualChoice Member Services at 877-273-4347 / 800-718-4347 (TTY) to complete their HRA.

If a Member does not complete an HRA, the Care Manager must:

- Document the reason for the missing HRA
- Continue outreach efforts to engage the Member and complete the HRA
    - Outreach is recommended quarterly at a minimum
- Develop an Individualized Care Plan (ICP) with any existing data
- If no historical data is available, open an ICP with the following basic problems:
    - Annual Flu Shot
    - Annual Wellness Visit with PCP
    - Community Resources & Wellness Connection

Click the file below to download a copy of the IEHP DualChoice (HMO D-SNP) HRA Tool

PDF IEHP_DualChoice_HRA_Tool.pdf
414.6 KB

Let's take a moment to review your understanding.

True or False?

The HRA is considered the starting point in the care coordination process.

- [x] True
- [ ] False

Correct

Select the methods which HRAs can be completed.

- [x] Telephonically
- [x] Face-to-Face
- [x] Mail
- [x] Member Portal

Correct

True or False?

The Member's Individualized Care Plan may not be developed without a complete HRA.

- ⊗ True
- ✓ False

Correct

The Member's Individualized Care Plan ***may*** be developed without a complete HRA.

How does IEHP share completed HRA response information with IPAs and Providers? Select all that apply.

- [x] Secure Provider Portal
- [ ] Mail
- [x] Secure File Transfer Protocol
- [ ] Email

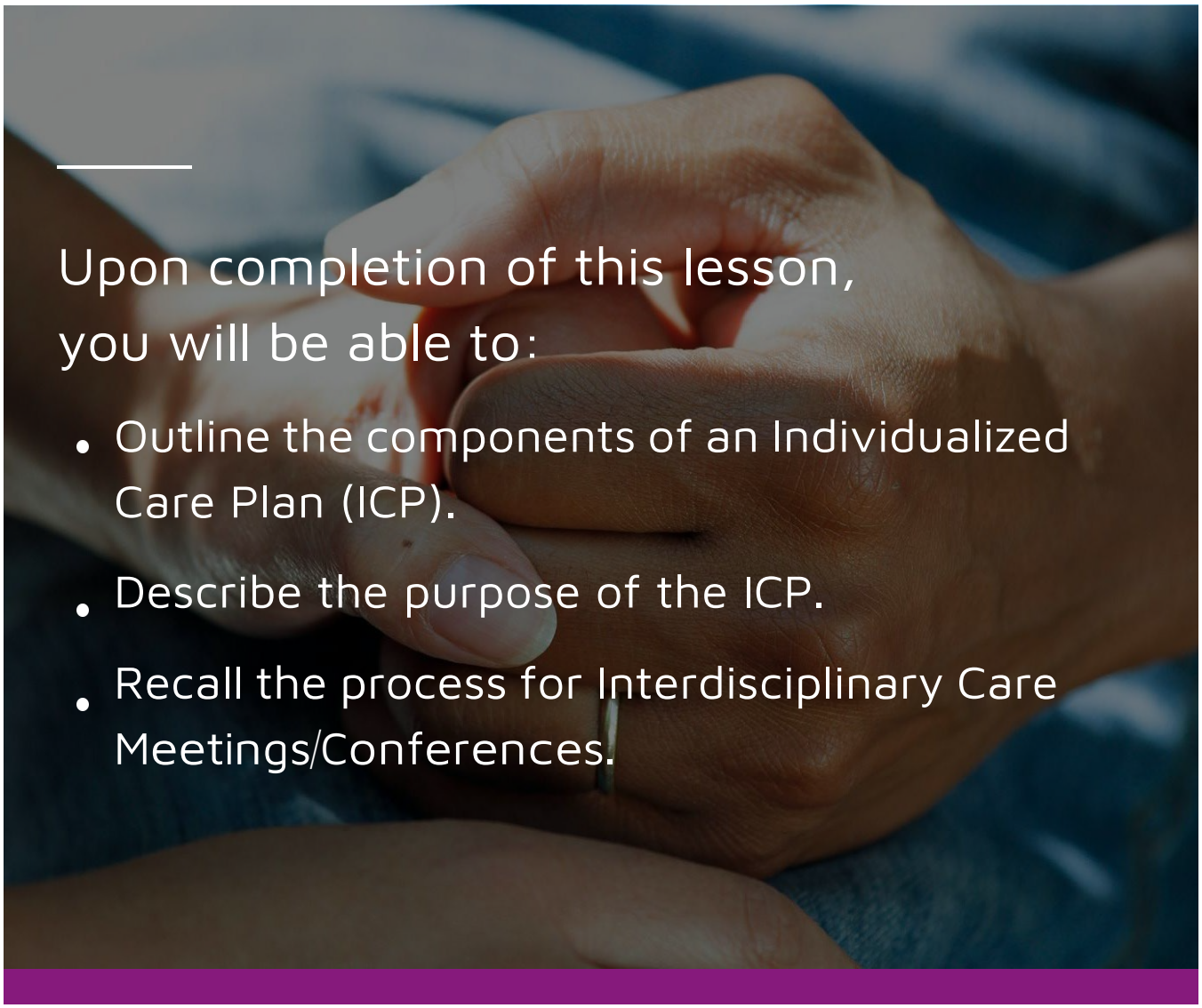
Correct

IEHP shares completed HRA response information with its IPAs and Providers through the secure Provider Portal. IPAs also receive this information through IEHP's Secure File Transfer Protocol.

TAKE AGAIN

Now that you have learned about the HRA process, you can move on to the next section where you will learn about Individualized Care Plans and the role that the Interdisciplinary Care Team plays in that process.

Individualized Care Plan



Upon completion of this lesson, you will be able to:

- Outline the components of an Individualized Care Plan (ICP).
- Describe the purpose of the ICP.
- Recall the process for Interdisciplinary Care Meetings/Conferences.

Begin Lesson

An **Individualized Care Plan (ICP)** is a comprehensive, person-centered, and outcome-based plan of care for Member wellness and built upon feedback from the Member and other data sources.

An ICP is developed for every IEHP DualChoice Member. Ideally, the initial and annual HRA serves as the starting point to develop the ICP. The ICP must be developed within 90 days of initial plan enrollment, updated at least annually, and when the Member's health status changes.

The ICP is a dynamic document/place where input from the Member, their caregiver, family member, and/or authorized support persons, their preferences and abilities are documented. The ICP is also a place where recommendations from the **Interdisciplinary Care Team (ICT)** and the Interdisciplinary Care Conference (ICC) participants are included.

The components of the ICP are Problems, Goals and Interventions, which include:

The Member's self-management goals and objectives, including whether goals were met or not met.

The Member's personal health care needs and preferences, including Medi-Cal carved-out and dental services.

Role of the Member's caregiver.

Interventions specifically tailored to the Member's needs.

The Interdisciplinary Care Team reviews Member health care outcomes to determine if adjustments to the Individualized Care Plan should be made to support health care needs.

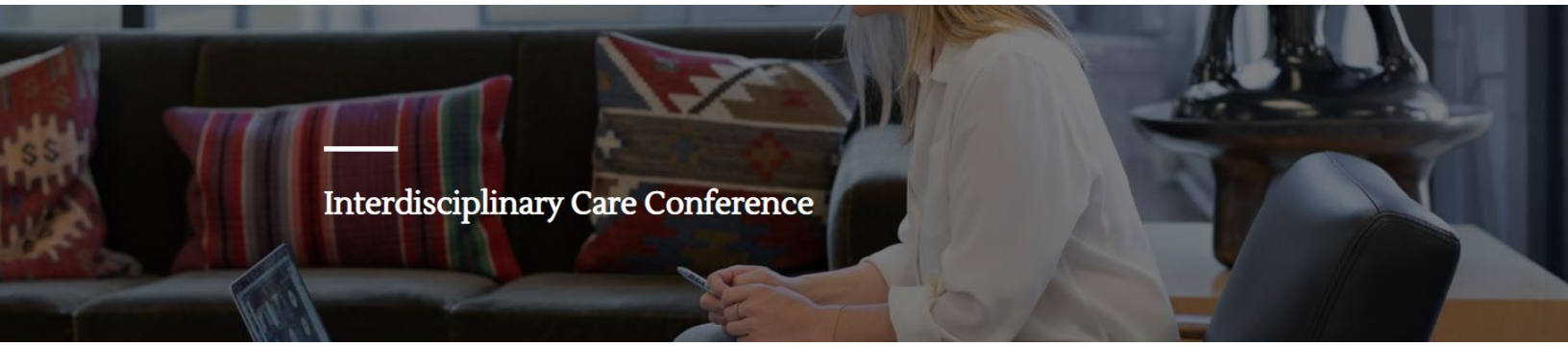
Role of the Interdisciplinary Care Team (ICT)

The ICP is shared with the Interdisciplinary Care Team (ICT) as necessary and every time the Member transitions from one care setting to another. ICT participants should contribute to the ICP per their expertise, as documented in the ICP.

The Care Manager is responsible for developing, maintaining, and updating the ICP. The ICP should be updated to reflect changes in condition, changes to goals, progress to the goals, and changes in the interventions.

As a member of the ICT, the Primary Care Provider is responsible for reviewing the Member's ICP, as shared by IEHP through the secure Provider portal or by the Member's IPA.

The timeframe for follow up with the Member/Caregiver should be appropriate for the established goals and interventions. Time/date to follow up should be clearly documented in the ICP.



Interdisciplinary Care Conference

IEHP's Model Of Care (MOC) does not prescribe the frequency of Interdisciplinary Care Conferences (ICCs) or meetings.

Should a need for a formal ICC be identified, the Member, their caregiver, family member, guardian and/or authorized support person(s) are invited and encouraged to participate.

All formal ICCs and informal interdisciplinary care team discussions must be clearly documented in the medical management system or ICP.

The Member, their caregiver, family member, guardian, and/or authorized support person(s) are informed of ICC participant recommendations during follow-up calls and/or in writing, if requested.

Let's take a moment to review your understanding.

The acronym ICP means:

- ✗ Individualized Choice Plan
- ✓ Individualized Care Plan
- ✗ Independent Care Plan
- ✗ Internal Case Plan

Correct

ICP is short for Individualized Care Plan.

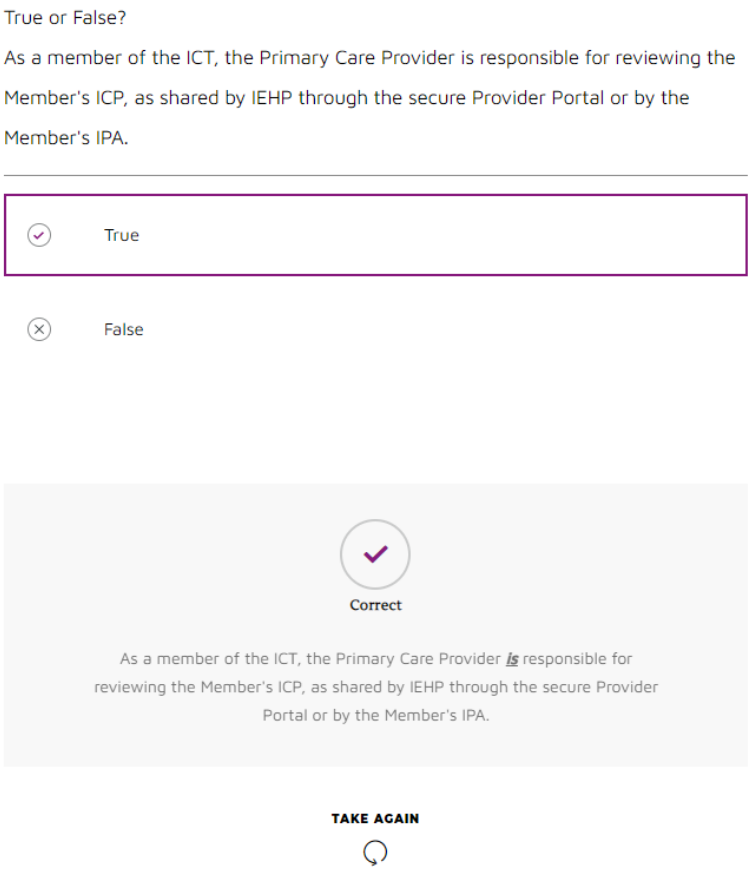
True or False?

The ICP must be shared with the Member's ICT as necessary and every time the Member transitions from one care setting to another.

- ✓ True
- ✗ False

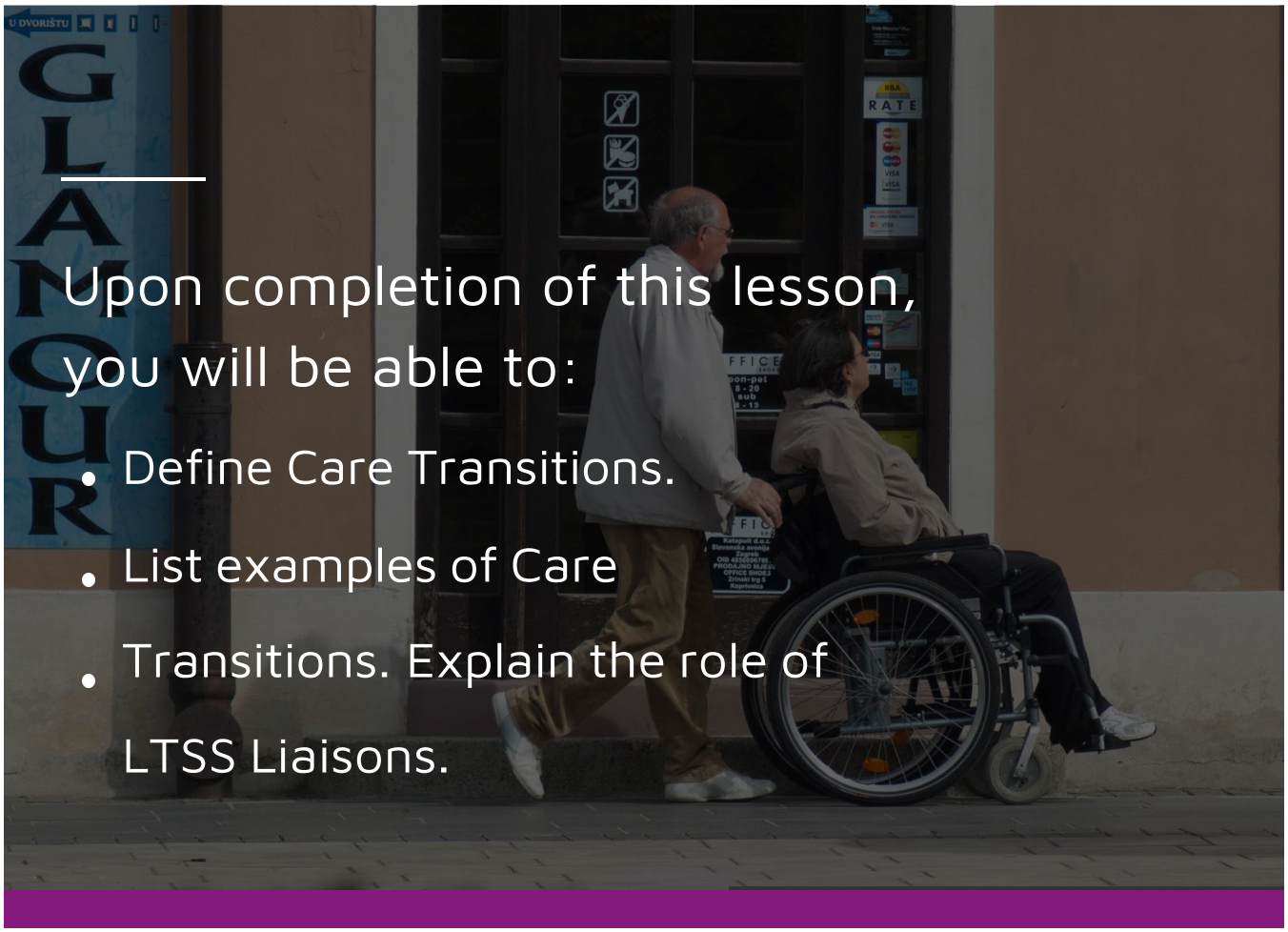
Correct

The ICP ***must*** be shared with the Member's ICT and ***every time*** the Member transitions from one care setting to another.



In the next lesson, you will learn about the coordination involved with Care Transitions.

Introduction to Care Transitions

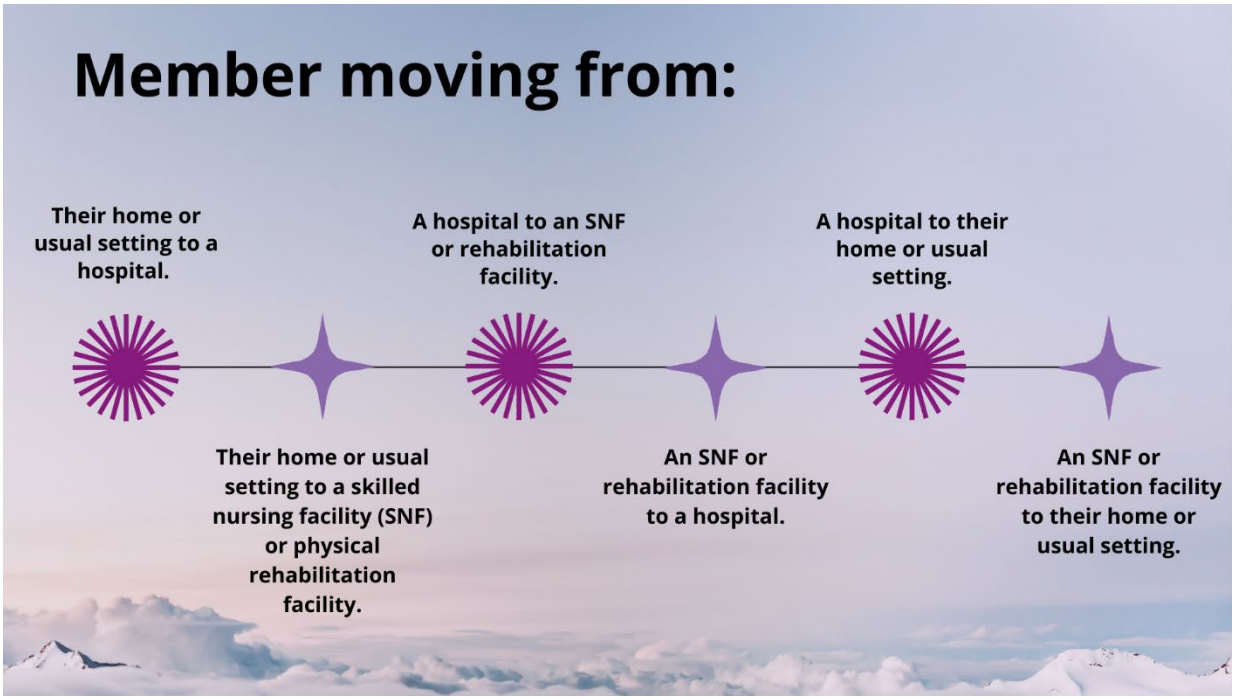


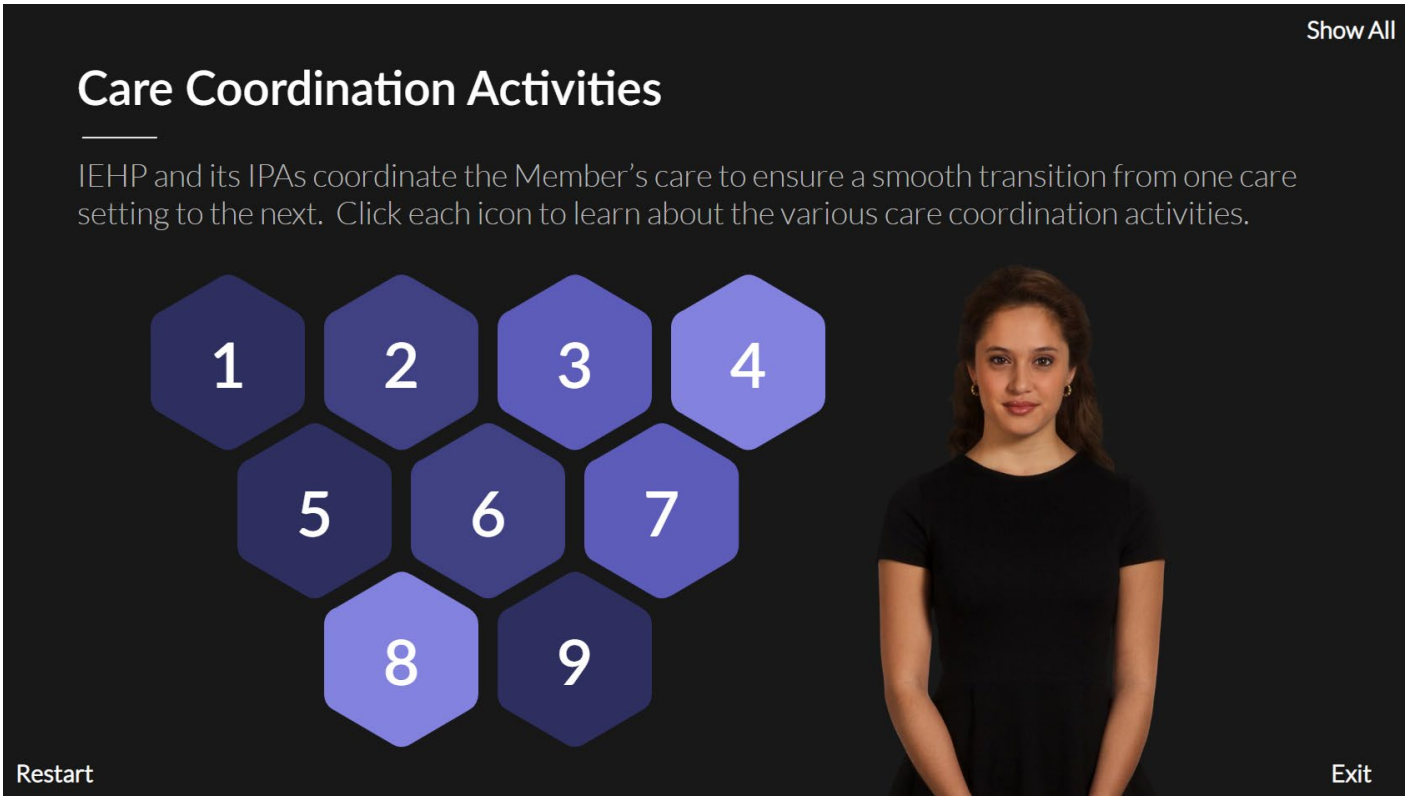
Upon completion of this lesson, you will be able to:

- Define Care Transitions.
- List examples of Care
- Transitions. Explain the role of LTSS Liaisons.

Begin Lesson

A Care Transition is when a Member transitions from one care setting to another. There are several different examples of Care Transitions.





Notification of Transition

The IPA notifies the Member and/or their Caregiver, PCP, and receiving facility of the admission or discharge.

Close

Communication Between Health Care Settings

The receiving health care setting receives a plan of care from the sending setting.

Close

Central Point of Contact

The Member's IPA provides a central point of contact for the Member and/or Caregiver.

Close

Post-Transition Needs Assessment

The IPA reaches out to the Member and/or their Caregiver after each transition to assess for change in Member's needs, including other Medi-Cal home and community-based services.

Close

Collaboration

The Member's PCP, Specialty Care Providers, and other members of the ICT collaborate to ensure safety and continuity of care between transitions.

Close

Member Education

The IPA educates the Member on their current plan of care and health risks.

Close

Arranging Appointments and Services

The IPA coordinates discharge planning and authorization of services.

Close

Medication Reconciliation

The Member's IPA reaches out to them to review and reconcile their medication.

Close

Member Follow-up

The IPA arranges follow-up with the Member to take place within 30 days of their transition to home.

Close

The Member's IPA reaches out to them to review and reconcile their medication.

The receiving health care setting receives a plan of care from the sending setting.

The Member's IPA provides a central point of contact for the Member and/or Caregiver.

IPA reaches out to the Member and/or Caregiver after each transition to assess for change in needs, including other Medi-Cal home and community-based services.

The Member's PCP, Specialty Care Providers, and other members of the ICT collaborate to ensure safety and continuity of care between transitions.

The IPA educates the Member on their current plan of care and health risks.

The IPA coordinates discharge planning and authorization of services.

The Member's IPA reaches out to them to review and reconcile their medication.

The IPA arranges follow-up with the Member to take place within 30 days of their transition to home.

Providers, as members of the ICT, must collaborate with the Member's IPA to ensure safety and continuity of care between transitions.

Additionally, Facilities (Hospitals, Skilled Nursing Facilities, and Physical Rehabilitation Facilities) must be timely in notifying the IPA of admissions and discharges.

LTSS Liaison

D-SNP Plans are required to identify an individual dedicated to serving as the liaison for the Long-Term Services & Supports (LTSS) provider community to help facilitate Member care transitions.

Role of LTSS Liaison

The LTSS Liaison assists with coordinating LTSS services such as caregiver support, Community-Based Adult Services (CBAS) services, evaluation for increasing In-Home Supportive Services (IHSS) hours due to change in condition and functional/cognitive status. The LTSS Liaison is engaged in the ICT, as appropriate, for Members accessing LTSS services.

IEHP's dedicated LTSS Liaison can be reached by:

- Contacting the Provider Call Center at (866) 223-4347 or (909) 890-2054
- Contacting the LTSS Liaison by phone at (909) 486-9808 or by email at jauregui-b@iehp.org.

To refer Members to LTSS services, complete and submit the CM Referral Form to CMReferralTeam@iehp.org (download the form below).

PDF

IEHP Care Management Referral Form.pdf

305.5 KB

Let's take a moment to review your understanding.

True or False?

The Member's PCP, Specialty Care Providers, and other members of the ICT collaborate to ensure safety and continuity of care between transitions.

- [x] True
- [ ] False

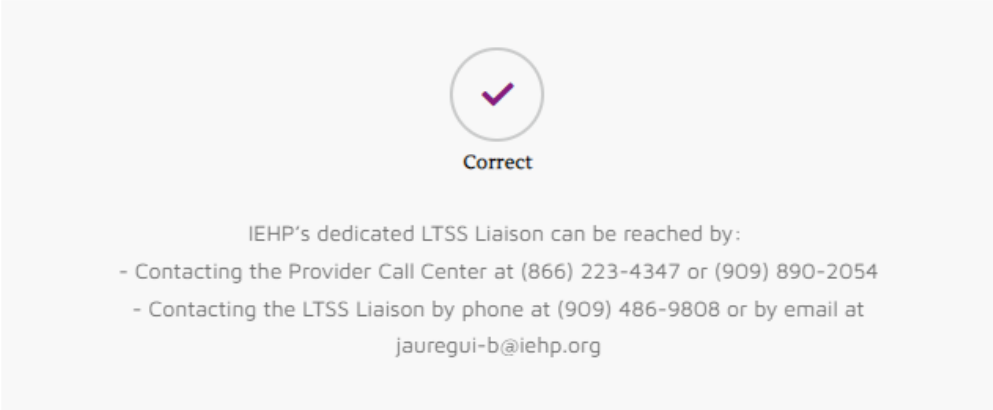
Correct

The Member's PCP, Specialty Care Providers, and other members of the ICT ***does*** ensure safety and continuity of care between transitions.

IEHP's dedicated LTSS Liaison can be reached by:

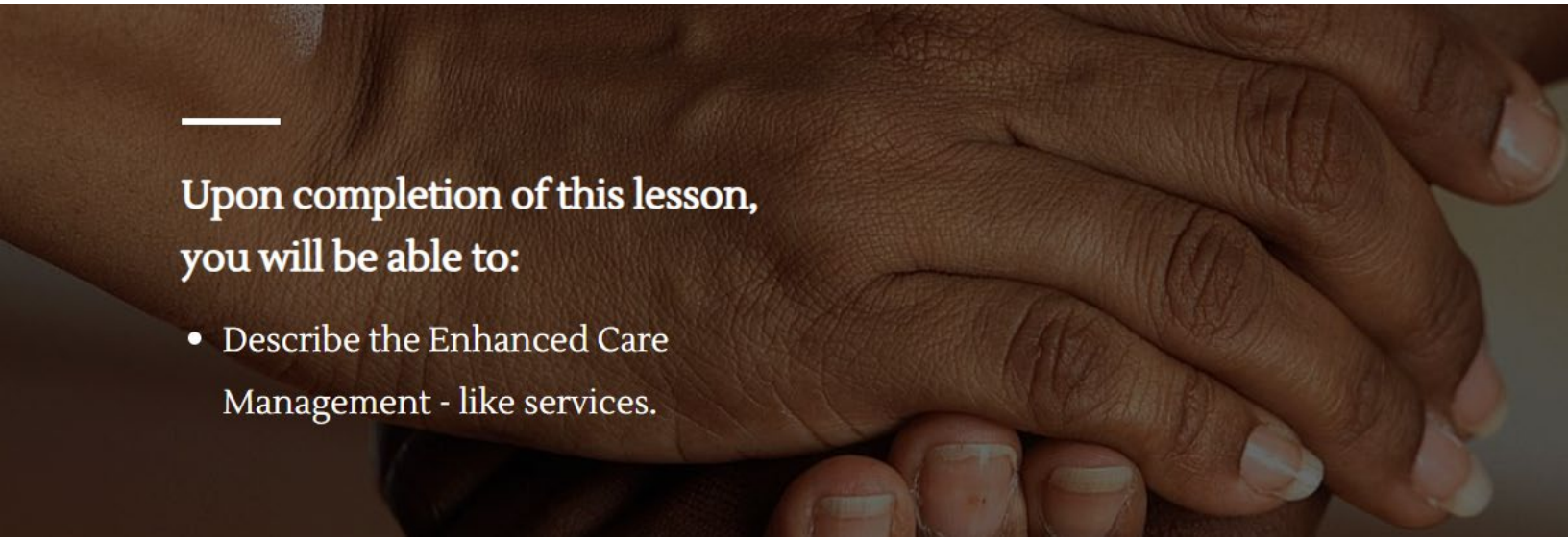
Select all that apply.

- [x] Contacting the Provider Call Center
- [x] Contacting the LTSS Liaison directly
- [ ] Contacting IEHP Member Services
- [ ] Submitting the CM Referral Form



Now that you have learned about Care Transitions and the role of the LTSS Liaison, you can continue with the next lesson to learn about Clinical Practice Guidelines.

Enhanced Care Management - Like Services



Start Lesson

IEHP and its IPAs provide IEHP DualChoice Members comprehensive, individualized, in-person whole-person care in collaboration with the Member's Primary Care Provider (PCP).

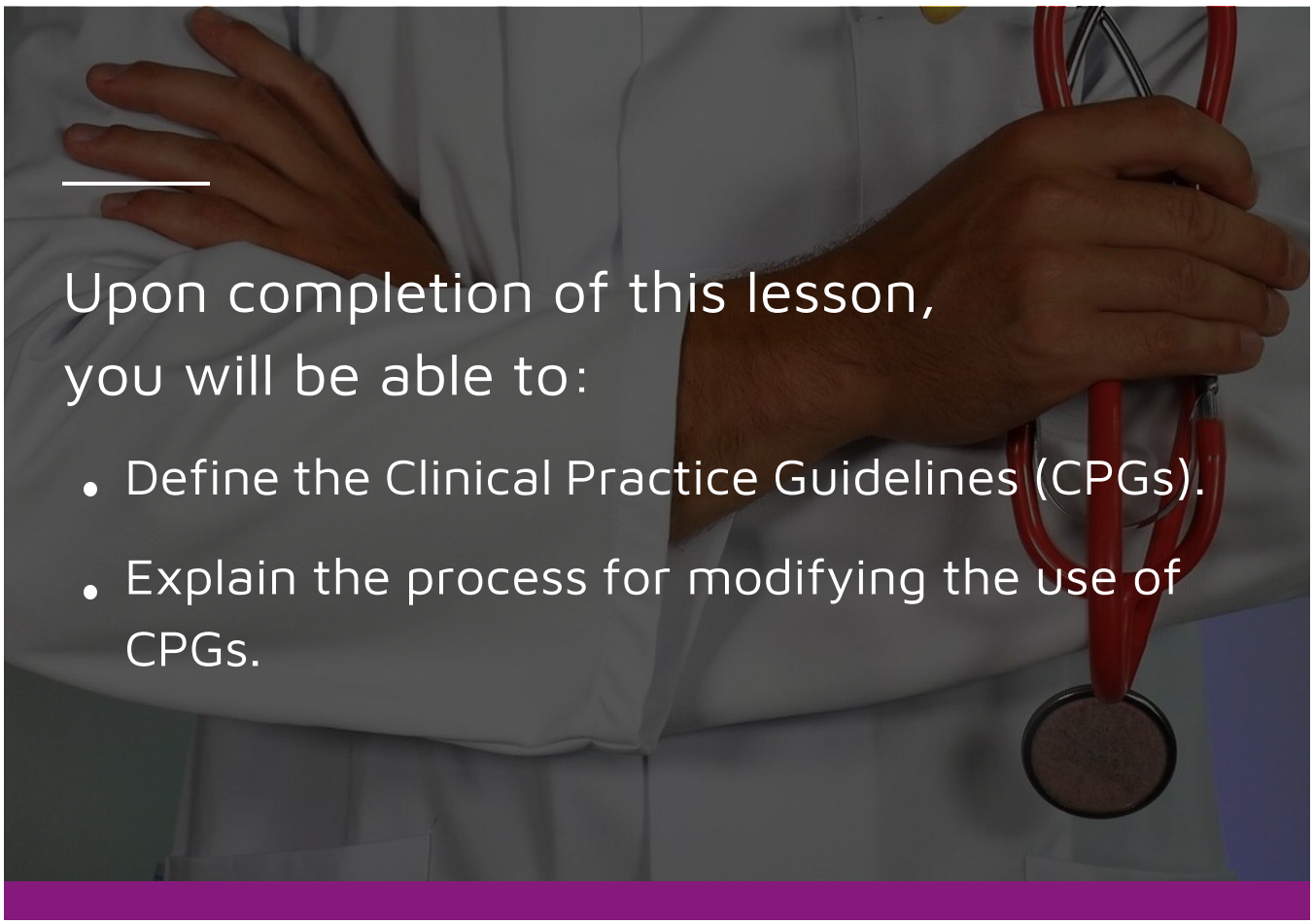
The Member's IPA serves as the central point for coordinating care and ensuring communication amongst all relevant parties engaged in the delivery of the following core ECM services:

- Outreach and Engagement
- Comprehensive Assessment and Care Management Plan
- Enhanced Care Coordination
- Health Population
- Comprehensive Transitional Care
- Member and Family Support
- Coordination of and Referral to Community and Social Support Services

In the next lesson we will take a closer look at Clinical Practice Guidelines. Click the button below to continue.

Continue

A Closer Look at CPGs



Upon completion of this lesson, you will be able to:

- Define the Clinical Practice Guidelines (CPGs).
- Explain the process for modifying the use of CPGs.

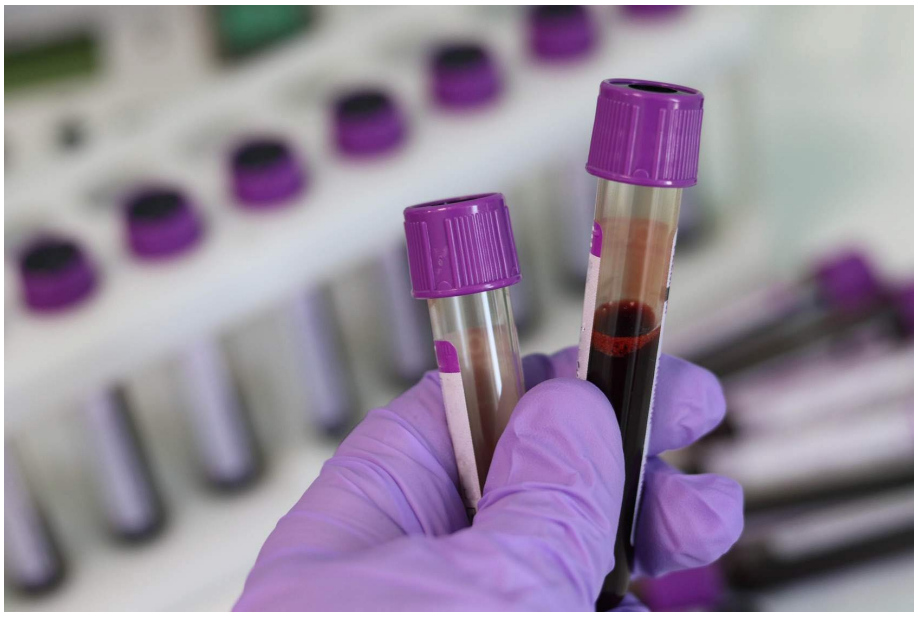
Start Lesson

Definition

Clinical Practice Guidelines, or CPGs as they're sometimes referred to, are evidence-based treatment recommendations which serve as a framework for clinical decisions and supporting best practices. CPGs are statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence, and an assessment of the benefits and harms of alternative care options.

An example of a CPG:

Patients with persistent high cholesterol blood values should be started on a lipid-lowering medication.



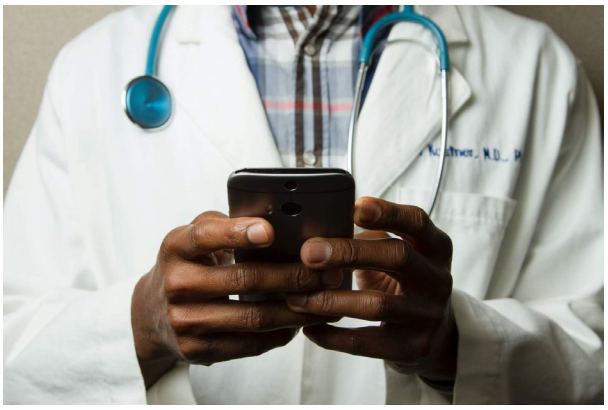
Communication

IEHP and IPA Providers must refer to IEHP-approved Clinical Practice Guidelines when developing treatment plans. Additionally, IEHP communicates about approved, new and updated CPGs to the Provider Network through the IEHP Provider website, and with notification sent via Blast Fax.

IEHP's Clinical Practice Guidelines

Click the button to view the IEHP CPGs, located on our website.

IEHP CPGS



When a modification must be made to the treatment plan due Member-specific preference, tolerance or contraindication, the Provider must update the documentation in the medical record.

- For any change to the use of CPG discussed during the Interdisciplinary Care Conference (ICC), the Care Manager will document the reason for the modification in the ICP.
- The Care Manager notifies the appropriate ICT participants to contribute additional recommendations or adjust their actions if indicated.
- Documentation is required when there are any modifications from the use of CPGs and if recommended by ICT participants.
- The notice to all ICT participants of the modified use of CPGs must also be documented.

Example Modifying the Use of a Clinical Practice Guideline

Member is given a prescription for a statin to lower cholesterol. After two weeks on the statin, Member develops severe muscle pain seriously impairing the Member's quality of life and adherence to the medication. Provider prescribes an alternative treatment/medication.

- Documentation must be completed as described above.

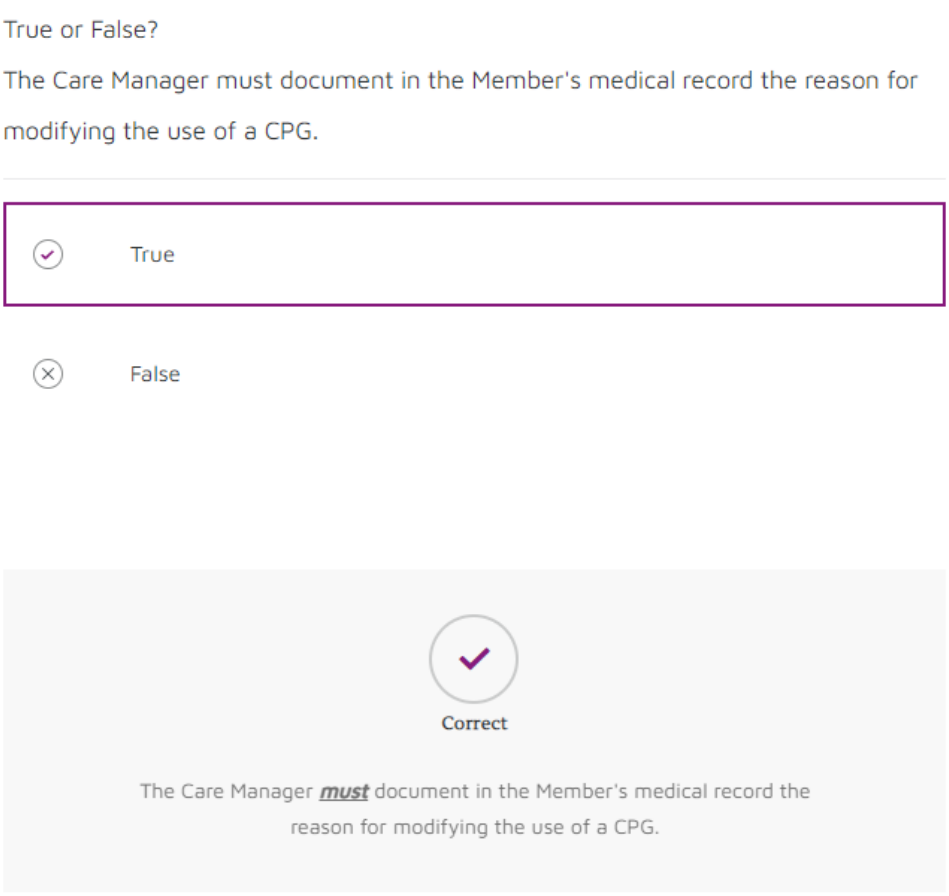
Let's take a moment to review your understanding.

IEHP communicates approved, new and updated CPGs to our Provider Network via which of the following? Select all that apply.

- [x] IEHP Provider Website
- [ ] Phone Call
- [ ] Certified Courier
- [x] Blast Fax

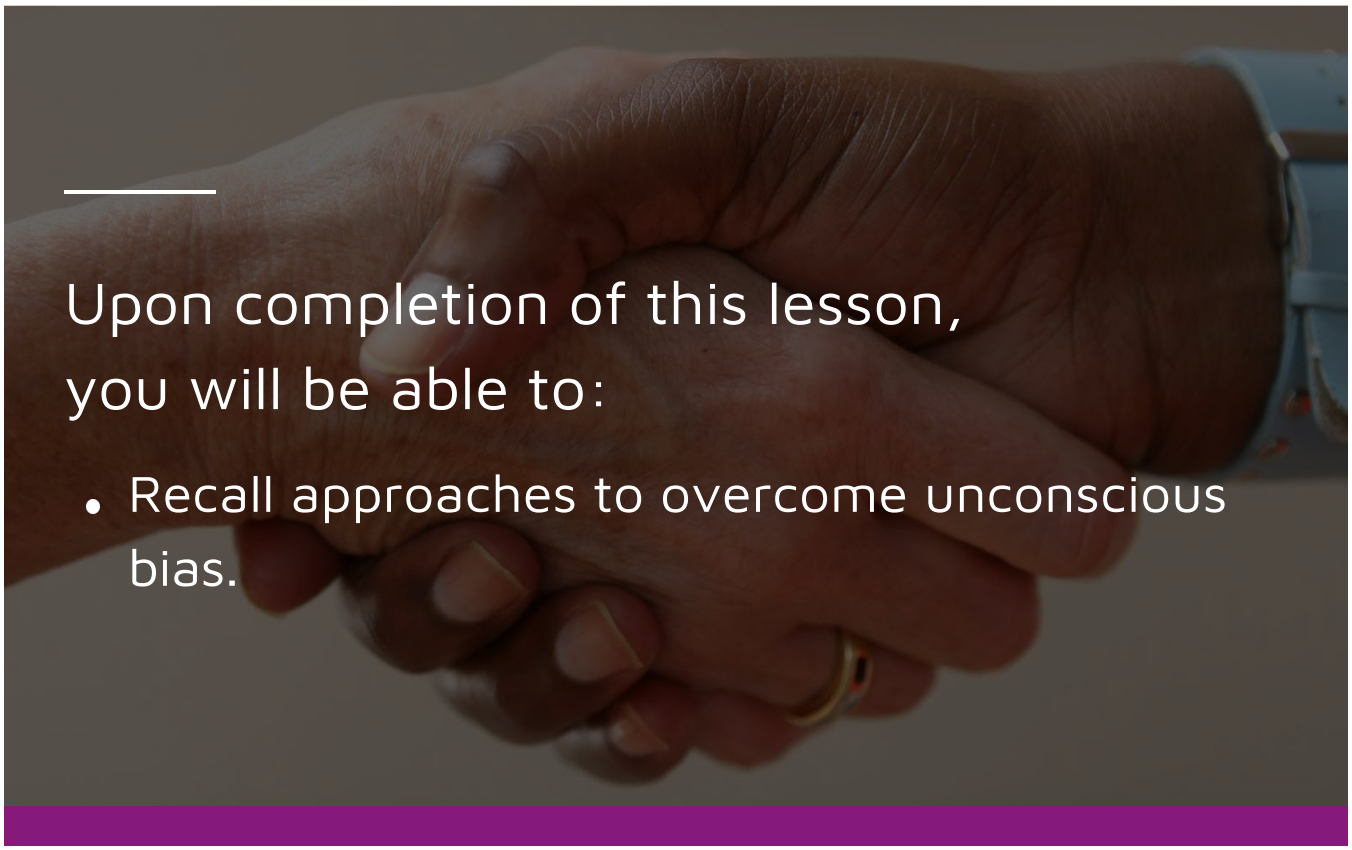
Correct

IEHP communicates approved, new and updated CPGs to the Provider Network via the **IEHP Provider website**, and with notification sent via **Blast Fax**.



The next lesson in this course covers the important topic of Cultural and Cognitive Competency.

Unconscious Bias



Upon completion of this lesson, you will be able to:

- Recall approaches to overcome unconscious bias.

Start Lesson

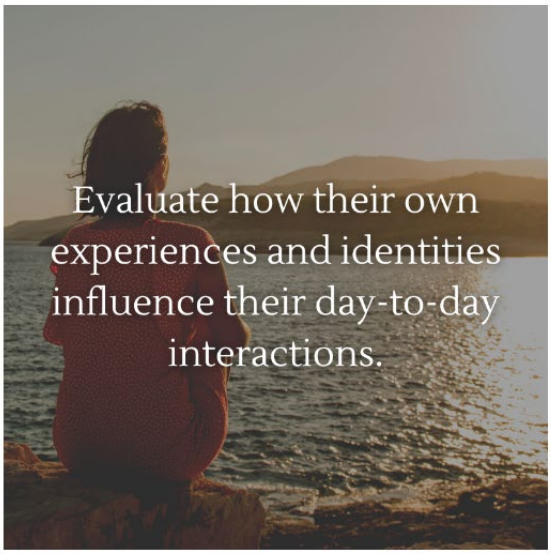
Unconscious biases are social stereotypes about certain groups of people that individuals form outside their own conscious awareness. Everyone holds unconscious beliefs about various social and identity groups, and while bias is a normal part of human brain function, it can often reinforce stereotypes.

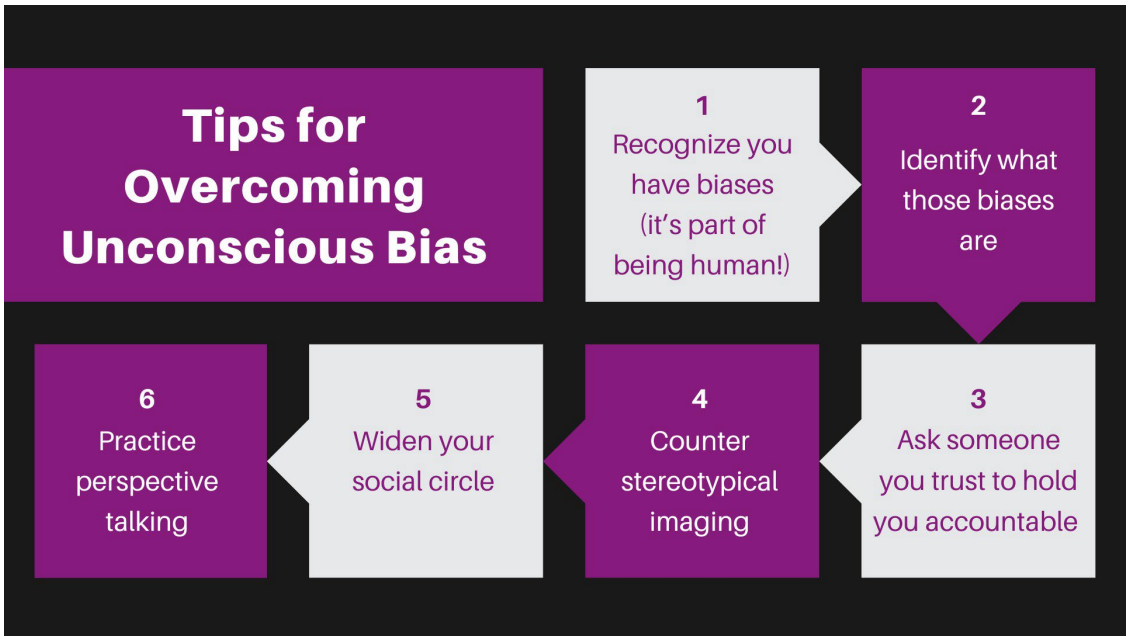
A Culture of Inclusion

IEHP believes in a culture of inclusion. All people, regardless of their abilities, disabilities, or health care needs, have the right to be respected and appreciated as valuable. Because of IEHP's diverse populations, IEHP is committed to delivering health care services that are respectful and responsive to the access and cultural needs of its Members.

It is important for all Team Members to be self-aware of their own unconscious biases before these affect encounters with Members, community or other Team Members at IEHP.

Every person should:





Lesson 11 of 19

Culturally Competent Care

Upon completion of this lesson, you will be able to:

- Recognize the importance of culturally competent care, including LGBTQ+ communities.

Begin Lesson

Cultural competence is the capability to effectively deal with people from different cultures. A culturally competent health care system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities.

Cultural Competence Attributes

Effectively dealing with people from different cultures.

Having a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals to enable them to work effectively in cross-cultural situations.

Becoming more culturally competent and promoting cultural engagement.

Effectively using a combination of knowledge, attitude, and skills.

Culture refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people. We become assimilated into our culture and the way we reflect our culture is often without conscious thought.

Cultural factors include, but are not limited to, geography, age, socioeconomic status, religion, gender, education, politics, sexual orientation, gender identity, race, and ethnicity.

How Does Culture Impact the Community?

Culture informs on:

- Concepts of health, healing.
- How illness, disease, and their causes are perceived.
- The behaviors of patients who are seeking health care.
- Attitudes toward health care providers.

Cultural Influences:

- Acculturation.
- Botanical Treatments and Healers.
- Decision Making.
- Privacy.
- Language Skills and Preferences.

Review the sections below to learn about the importance of these terminologies and how orientation differs from gender identity.

Orientation Terminology

Sexual Orientation – A person's emotional, sexual, and/or relational attraction to others. Usually as heterosexual, bisexual, and homosexual (i.e. lesbian and gay).
Bisexual – One whose sexual or romantic attractions and behaviors are directed towards both sexes to a significant degree. Bisexuality is a distinct sexual orientation.
MSM – Men who have sex with men. May identify as gay.
WSW – Women who have sex with women. May identify as lesbian.

Gender Identity Terminology

Transgender – Describes people whose gender identity and/or expression is different from that typically associated with their assigned sex at birth.

Genderqueer – Describes people who see themselves as outside the usually binary man/woman definitions. Having elements of many genders, being androgynous or having no gender. Also Gender Non-Conforming (GNC).

Bigender – Describes people whose gender identity encompasses both male and female genders. Some may feel that one identity is stronger, but both are present.

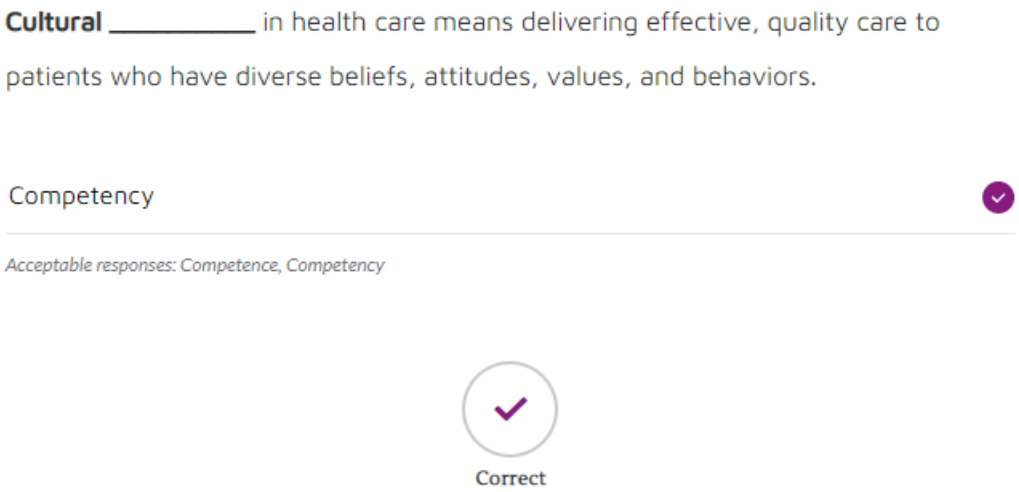
Cisgender – Describes people whose gender identity matches their sex assigned at birth. "Cis" means same.

MtF - Male-to-Female; a person who was assigned the male sex at birth but identifies and lives as a female. Also trans woman. MtF persons will still need to have prostate exams according to standard guidelines.

FtM - Female-to-Male; a person who was assigned the female sex at birth but identifies and lives as a male. Also trans man or trans male. FtM persons will need to have breast exams and Pap tests according to standard guidelines.

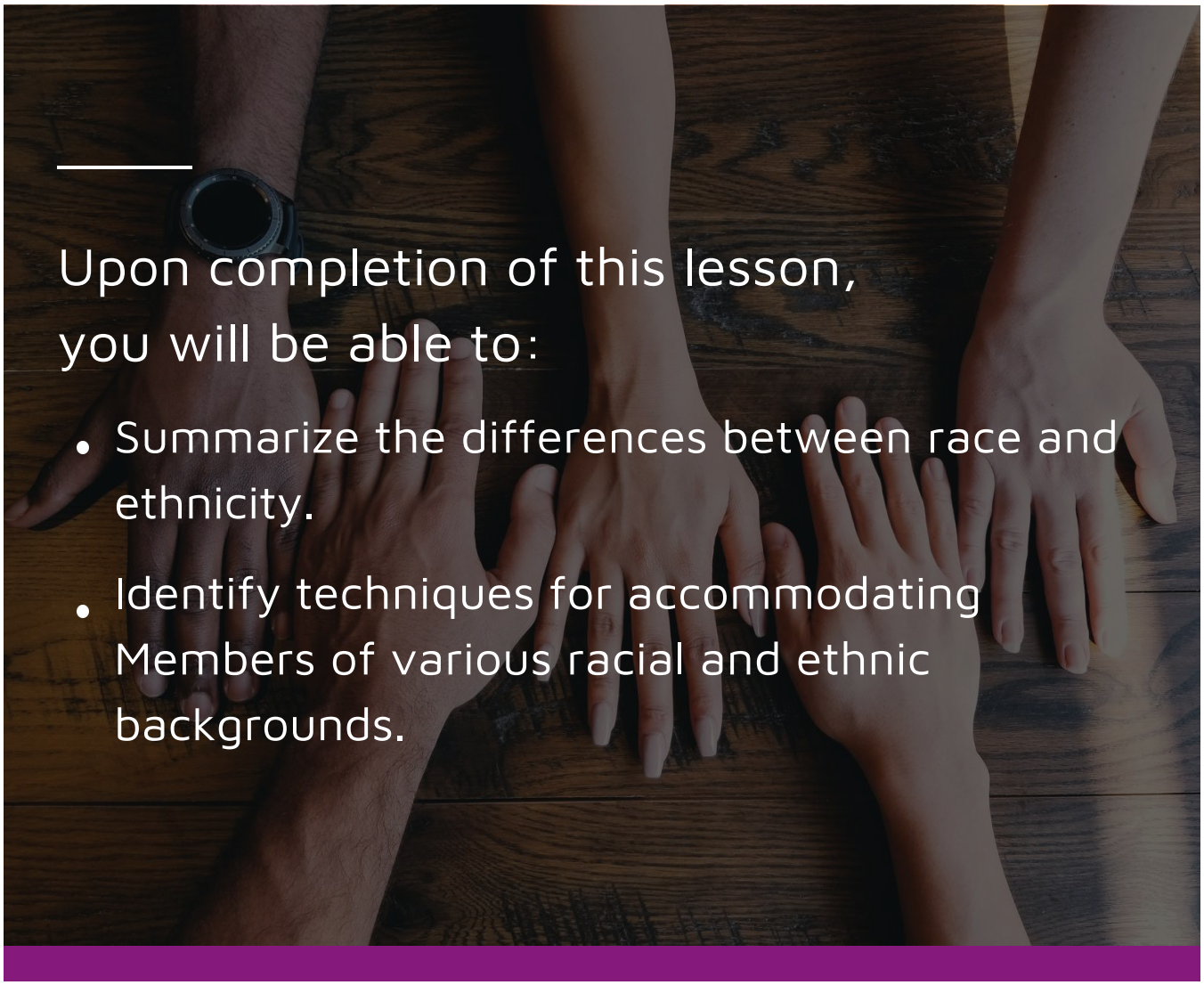
Transsexual – Medical term for people who have used surgery or hormones to modify their bodies. Some trans people find this term offensive.

Let's take a moment to review your understanding.



In the last two lessons, you have learned about Unconscious Bias and Cultural Competency. Now you can continue with the next lesson where you will learn about the role of race and ethnicity in health care.

Race and Ethnicity



Begin Lesson

Definition of Race

A human population that is believed to be distinct in some way from other humans based on real or imagined physical differences.

Rooted in the idea of biological classification of humans according to morphological features such as skin color or facial characteristics.

Delineating Race in the United States

Review each of the cards below by clicking to discover more about different races.

American Indian / Alaska Native

Having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian

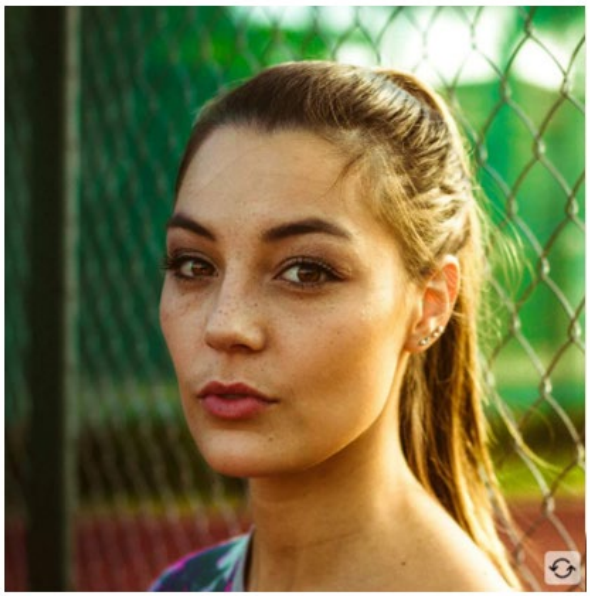
Having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black/African American

Having origins in any of the black racial groups of Africa. Terms such as Haitian, Dominican, or Somali can be used in addition to Black or African American.

Native Hawaiian / Pacific Islander

Having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.



White

Having origins in any of the original peoples of Europe, the Middle East, or North Africa.

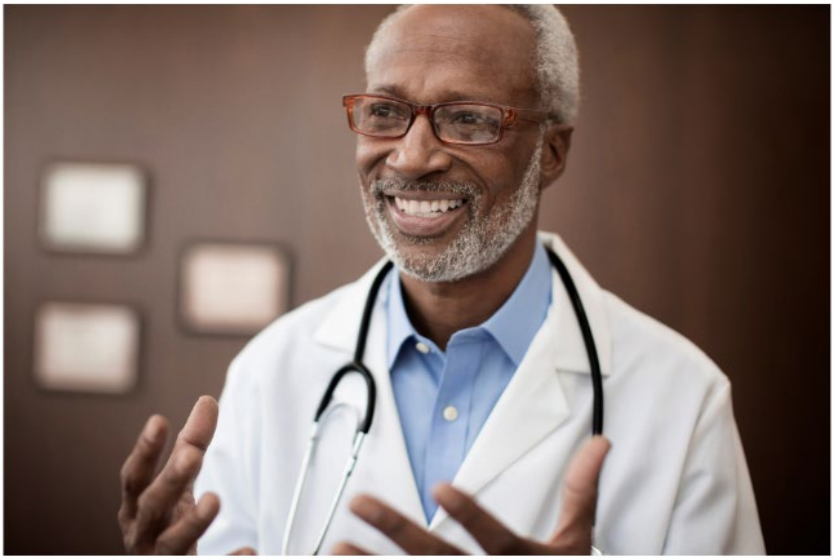
Ethnicity refers not to physical characteristics but social traits that are shared by a human population.

Some of the social traits often used for ethnic classification include nationality, tribe, religious faith, shared language, shared culture, and shared traditions.

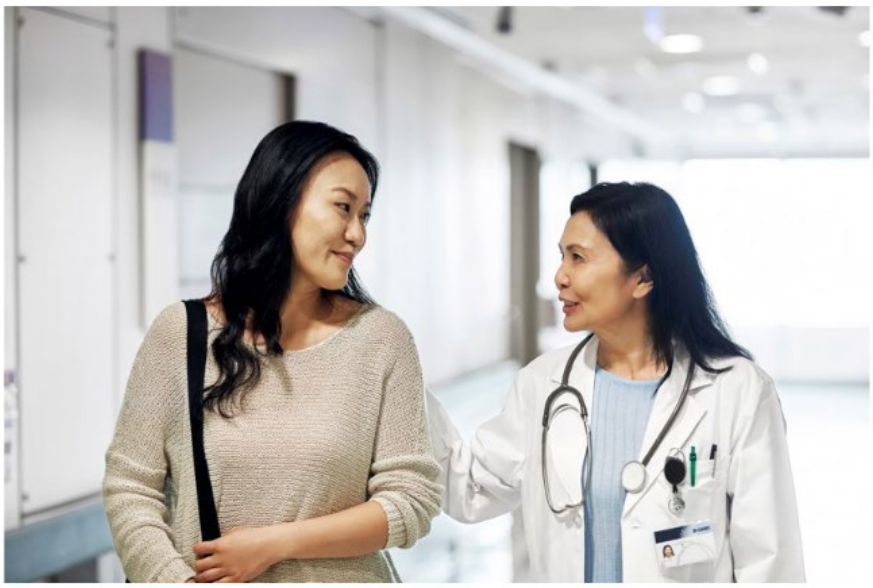
- Hispanic or Latino describes a person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, Spanish origin can be used in addition to Hispanic or Latino.
- Not Hispanic or Latino.

Understanding racial and ethnic differences may assist you in providing services for people of diverse backgrounds.

Read through some techniques to aid you in your work with Members of various racial and ethnic backgrounds.



Many participants may become dissuaded by the requirements set by visiting multiple doctors. Explain to Members why they have to be seen by another doctor and stress the need for follow-up care and medication adherence.



Members may also be uncomfortable with a Provider or interpreter of a different sex. Team Members can accommodate with a doctor or interpreter of the same gender.

People who have lived in poverty or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.

Some treatments and medicines that are considered *folk* medicine or *herbal* medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are hard to find or that are purchased at special stores may get you a more accurate understanding of what people are using than asking about *alternative*, *traditional*, *folk*, or *herbal* medicine.

Continue with the next lesson where you will learn about Independent Living.

Independent Living

Upon completion of this lesson, you will be able to:

- Explain the Independent Living philosophy for IEHP DualChoice Members.

Start Lesson

"Independent Living is not doing things yourself; it is being in control of how things are done."

Judy Heumann

IEHP seeks to remove barriers in transportation, provider sites, digital media, and written and verbal communication.

Take a moment to watch the video below.

YOUTUBE

Ed Roberts: Free Wheeling

"If we have learned one thing from the civil rights movement in the U.S., it's that when others speak for you, you lose."- Ed Roberts

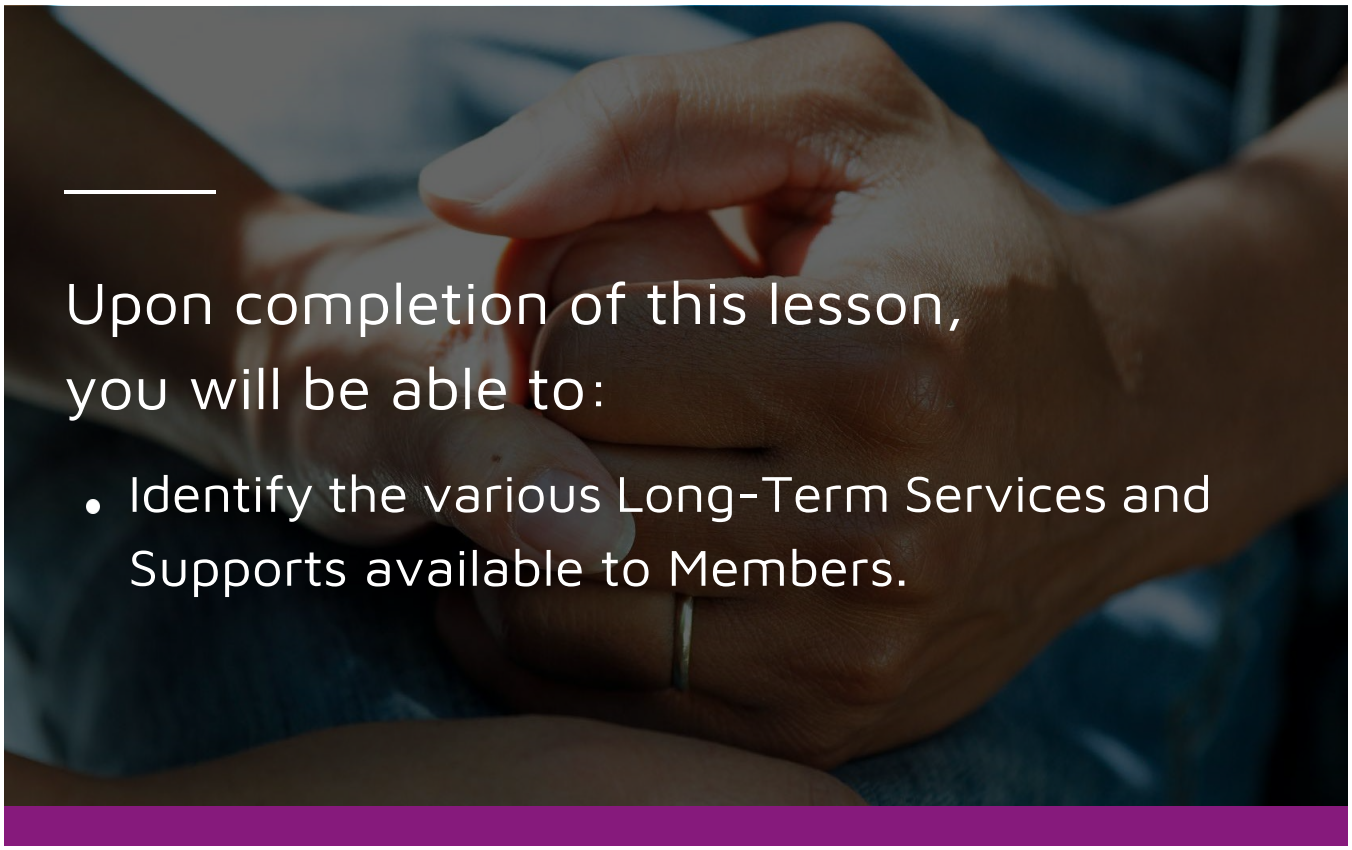
Independent Living Philosophy

Here are some tips to use with Members to support the independent living philosophy:

- Use People First Language. For example, instead of using the term *Disabled Person,* consider using the *Person with a Disability.*
- Talk to the person, not the interpreter.
- Avoid saying *wheelchair-bound* or *confined to a wheelchair.*
- Not all disabilities are visible.
- Ask first if a person needs help.
- Drop the "H-Word" and the "R-Word".
- Avoid pity.
- Relax.

In the next lesson, you will learn more about Long-Term Services and Supports.

Long-Term Services and Supports Explored



Upon completion of this lesson, you will be able to:

- Identify the various Long-Term Services and Supports available to Members.

Start Lesson

Long-Term Services and Supports (LTSS) make up a Member-centered, long-term support system in which older adults and people with disabilities have access to a full array of quality medical and social services that assist Members in remaining safely in their home and preventing or delaying placement in a skilled nursing facility.

Least Restrictive Environment

Members will receive services in the least restrictive environment when:

1. Placement is appropriate
2. Member does not oppose these services
3. Services can be reasonably accommodated

LTSS provides different types of services and supports depending on the Member's need. Review each section below to learn about the different LTSS programs available to Members.

IHSS	CBAS	MSSP	LTC

In-Home Supportive Services (IHSS) is a county-run program that provides caregivers for people who need help with activities for daily living.

IHSS Eligibility Requirements

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

IHSS Services

· Housecleaning

· Preparation of meals

· Protective supervision for Members with mental impairment

· Routine laundry

· Grocery shopping

· Accompaniments to medical appointments

· Personal care services

· Paramedical services such as wound care, injections, glucose monitoring, tube feeding, catheter insertions and colostomy irrigation

IHSS	CBAS	MSSP	LTC

Community-Based Adult Services (CBAS) is an adult day health care at a nonresidential center with daily monitoring and supervision by a nurse. The goal for the CBAS Centers is to allow Members to remain in their own home or residence with supported "day health care", leading to maintaining optimal capacity for self-care and personal independence. Lastly, it aims to prevent costly and preventable hospitalizations, ER use, and avoid placement in a nursing facility.

CBAS Eligibility Requirements

- 18 years of age or older
- Have one or more chronic medical, cognitive, or behavioral health conditions that limit activities of daily living, but do not require 24-hour institutional care
- Require ongoing or intermittent protective supervision or skilled observation/intervention to minimize deterioration
- Have a high potential for further impairment and probable need for institutional care if additional services are not received

CBAS Services

· Adult day health care at non-residential center with daily nursing care and supervision
· Therapeutic activities designed to improve movement flexibility, memory and mood
· Social services
· Healthy meals/snacks
· Personal care services

Additional services if specified in the ICP
· Therapies as needed (physical, occupational, and speech)
· Psychiatric and psychosocial services
· Registered dietician services
· Transportation to/from CBAS center and Member's residence

IHSS	CBAS	MSSP	LTC

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

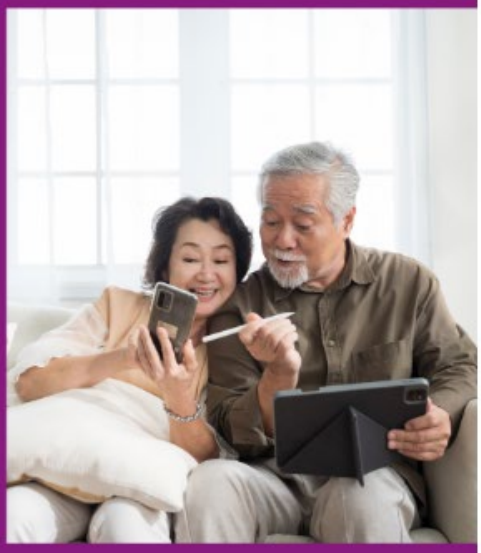
CBAS Eligibility Requirements

- Are 65 or older
- Are certified for placement in nursing facility
- Able to be served within MSSP's cost limitations
- Are appropriate for care management services

(See next section for information on how to refer Members to MSSP services)

MSSP Services

- Case management
- Personal care services
- Respite care (in-home or out-of-home)
- Environmental accessibility adaptions
- Housing assistance/minor home repair etc.
- Transportation
- Chore services
- Personal Emergency Response System (PERS) / Communication device
- Adult day care
- Protective supervision
- Meal services-congregate/home-delivered



IHSS	CBAS	MSSP	LTC

Long Term Care (LTC) refers to rehabilitative, restorative and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living.

LTC Eligibility Requirements

- A Member may qualify for LTC services if they have physical or cognitive limitation and need high level of care
- LTC services must be prescribed by a doctor and given by a licensed skilled nursing facility.
- Doctors can submit a referral to IEHP's UM Department for review

LTC Services

· Skilled nursing care

· Care management

· Bed and board (daily meals)

· X-Ray and laboratory

· Physical, speech and occupational therapy

Referrals to County MSSP

- Providers can refer directly to the County MSSP Program
- The LTSS Team will accept referrals from Providers then assess, refer, coordinate care, and facilitate communication among all Providers
- Eligibility will be determined by the County MSSP staff once they complete their assessment
- MSSP has a waiting list that may take 3-6 months
- IEHP will assist the practitioners with coordinating available services for Members awaiting the County MSSP intake process

County MSSP Assessment Process

- Members are assessed by a County MSSP nurse and social workers at intake
- A care plan is developed to address the needs and to coordinate care. The care plan is updated when there is a change in condition
- Informal no-cost resources, community resources, or purchased services identified in the care plan are provided
- Members are reassessed at least annually

The Member's IPA coordinates with the PCP to ensure that the Member receives medically necessary health care services and/or MSSP-like services, regardless of approval to the MSSP program.

The Member's IPA maintains continuous and unimpeded flow of medical information between practitioners, including assisting the PCP to obtain MSSP assessments and care plans, if needed.

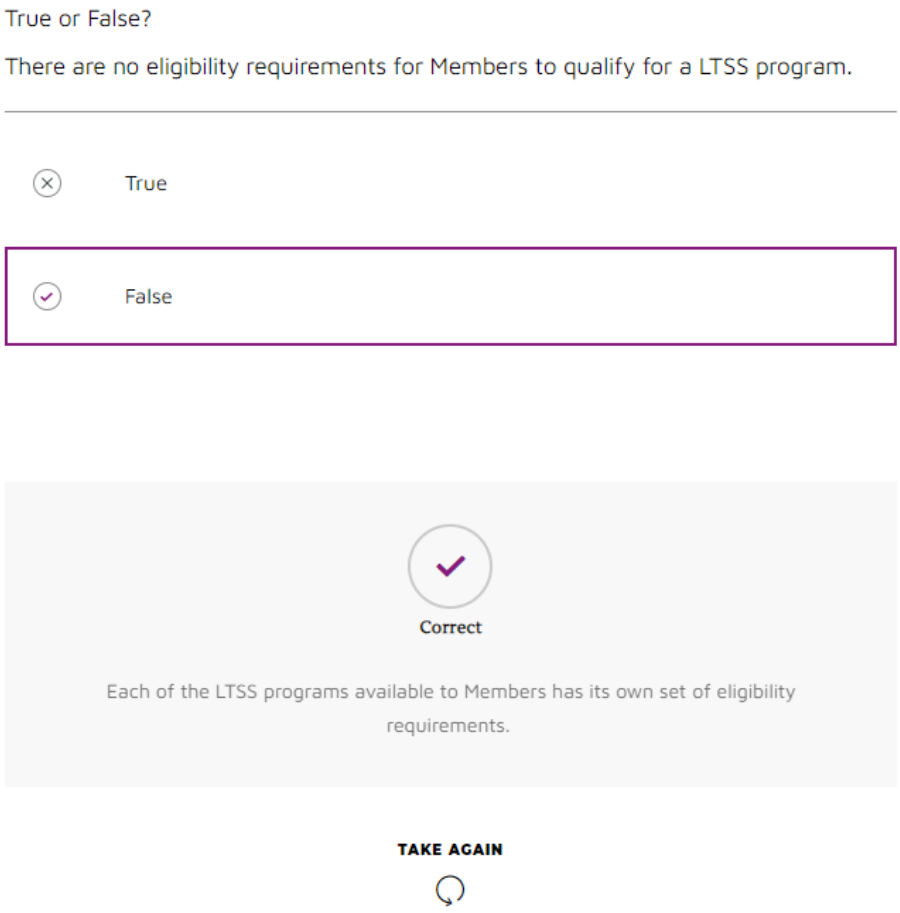
Let's take a moment to review your understanding.

Which of the following are Long-Term Services and Supports (LTSS) programs? Select all that apply.

- [x] In-Home Supportive Services (IHSS)
- [x] Community-Based Adult Services (CBAS)
- [x] Multipurpose Senior Services Program (MSSP)
- [x] Long Term Care (LTC)

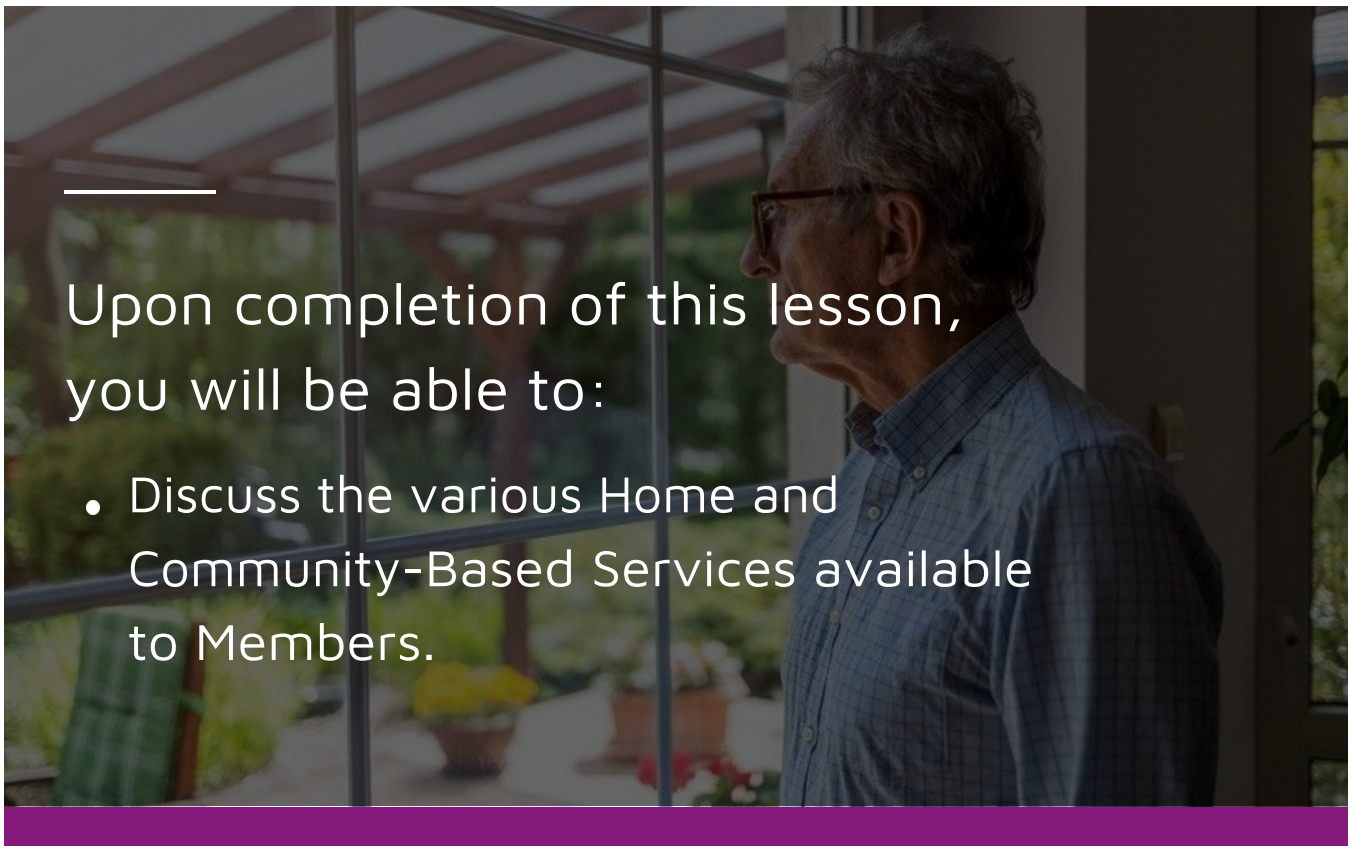
Correct

IHSS, CBAS, MSSP, and LTC are ***all*** Long-Term Services and Supports (LTSS) programs.



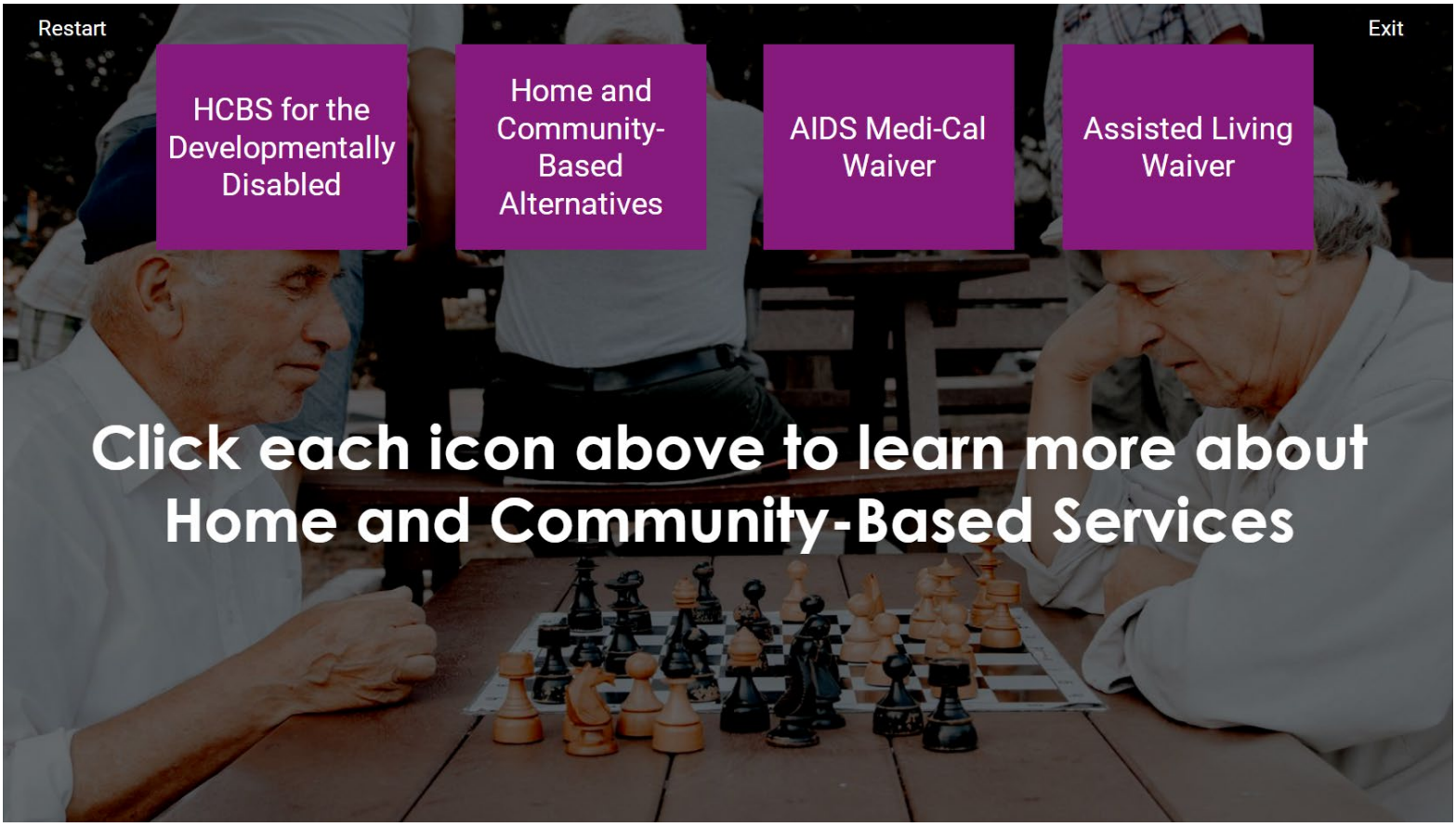
In the next lesson, you will learn more about the Home and Community-Based Services that are available to our Members.

Home and Community-Based Services

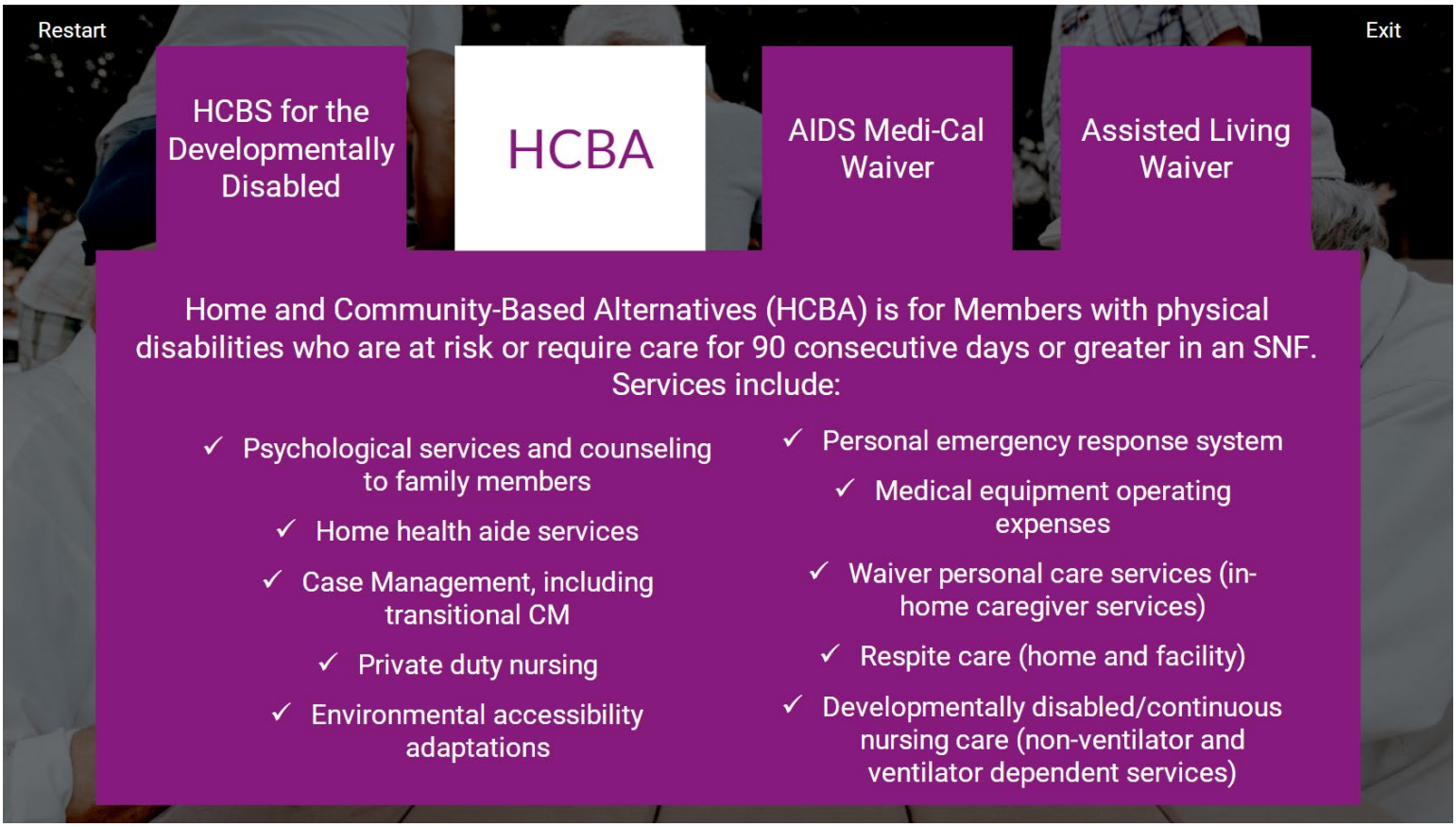


Begin Lesson

Home and Community Based Services (HCBS) are types of person-centered care delivered in the home and community. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care.


Restart
Exit
HCBS for the Developmentally Disabled
Home and Community-Based Alternatives
AIDS Medi-Cal Waiver
Assisted Living Waiver
Click each icon above to learn more about Home and Community-Based Services


Restart
Exit
HCBS-DD
Home and Community-Based Alternatives
AIDS Medi-Cal Waiver
Assisted Living Waiver
HCBS for the Developmentally Disabled (HCBS-DD) provides in-home care to Members with developmental disabilities that need an intermediate level of care as an alternative to institutionalization. Services include:
✓ Skilled nursing services
✓ Home health aide services
✓ Residential and day rehabilitation
✓ Environmental modifications
✓ Vehicle adaptations
✓ Personal emergency response systems
✓ Psychological services
✓ Communication aids
✓ Crisis Intervention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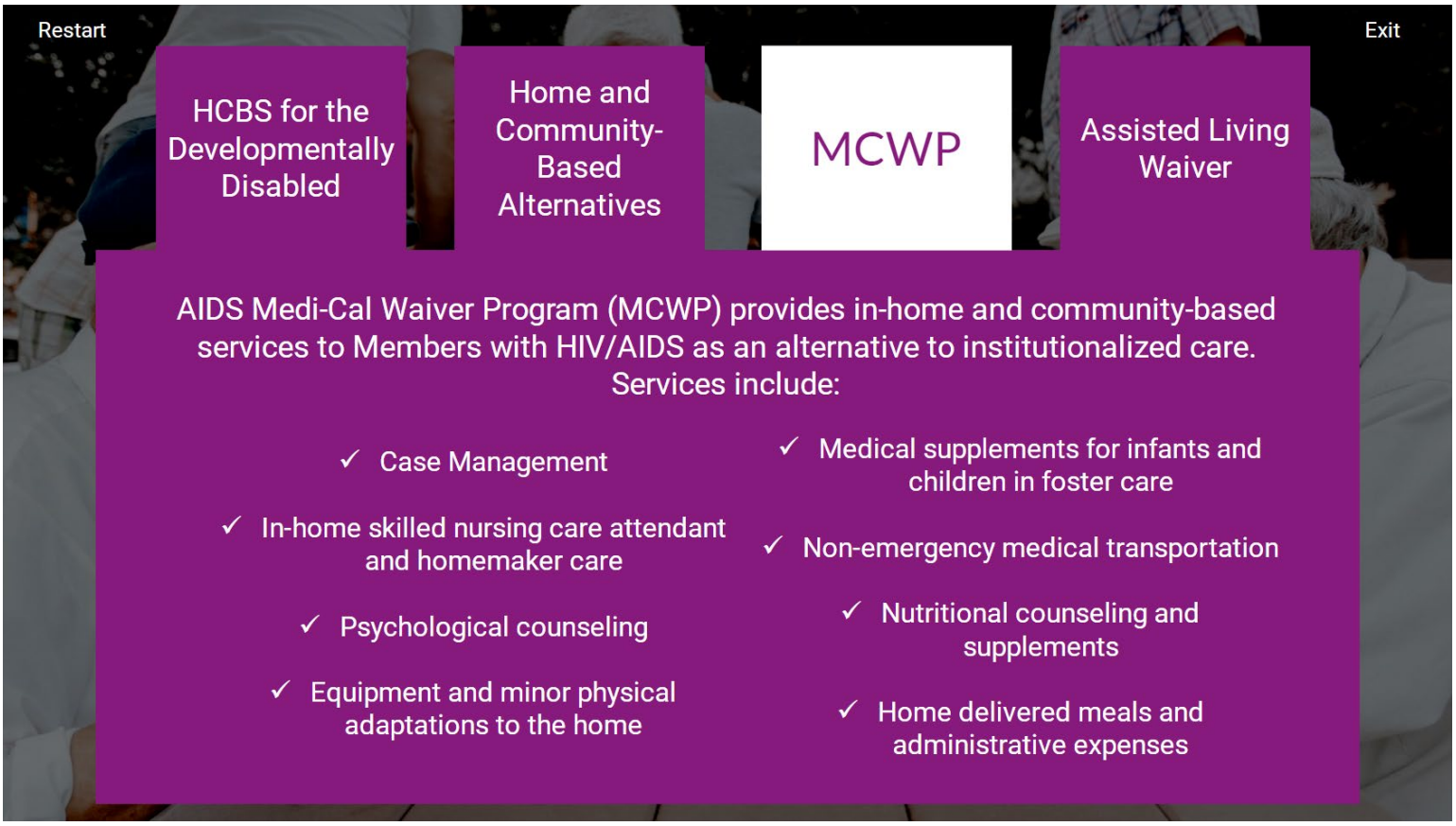
HCBS for the Developmentally Disabled
HCBA
AIDS Medi-Cal Waiver
Assisted Living Waiver
Home and Community-Based Alternatives (HCBA) is for Members with physical disabilities who are at risk or require care for 90 consecutive days or greater in an SNF. Services include:
✓ Psychological services and counseling to family members
✓ Home health aide services
✓ Case Management, including transitional CM
✓ Private duty nursing
✓ Environmental accessibility adaptations
✓ Personal emergency response system
✓ Medical equipment operating expenses
✓ Waiver personal care services (in-home caregiver services)
✓ Respite care (home and facility)
✓ Developmentally disabled/continuous nursing care (non-ventilator and ventilator dependent services)


Restart
Exit
HCBS for the Developmentally Disabled
Home and Community-Based Alternatives
MCWP
Assisted Living Waiver
AIDS Medi-Cal Waiver Program (MCWP) provides in-home and community-based services to Members with HIV/AIDS as an alternative to institutionalized care. Services include:
✓ Case Management
✓ In-home skilled nursing care attendant and homemaker care
✓ Psychological counseling
✓ Equipment and minor physical adaptations to the home
✓ Medical supplements for infants and children in foster care
✓ Non-emergency medical transportation
✓ Nutritional counseling and supplements
✓ Home delivered meals and administrative expenses

Referrals for HCBS can be sent via mail or fax to:

Inland Regional Center
1365 S Waterman Ave.
San Bernardino, CA 92408

Fax 909-890-3000

Referrals for HCBA can be sent via mail or fax to:

Institute on Aging
3575 Geary Blvd., San Francisco, CA 94118

Fax 415-750-4111

Completing the IEHP Care Management Referral Form

The following documentation needs to be provided to support the referral to Case Management.

- Clinical Notes
- Any Active Authorizations
- IPA Care Manager contact info

Once the documentation for the referral is complete, email the form securely to cmreferralteam@iehp.org

It may take up to 5 business days for referral to be processed and for a response, and if the Member does not meet criteria, the Member will be referred back to the IPA.

IPAs and Providers are encouraged to work directly with the Inland Regional Center and/or Institute on Aging for HCBS referrals. If additional assistance is needed, they can reach out to IEHP through the IEHP Care Management Referral Form.

IEHP Care Management Referral Form
Click the Download button to access the form.

DOWNLOAD

Let's take a moment to review your understanding.

Which of the following programs are Home and Community-Based Services? Select all that apply.

- [x] HCBS for the Developmentally Disabled
- [x] Home and Community-Based Alternatives Waiver Program
- [x] AIDS Medi-Cal Waiver Program
- [x] Assisted Living Waiver Program

Correct

All of the programs listed are Home and Community-Based Services.

Which of the following programs are Home and Community Based Services? Select all that apply.

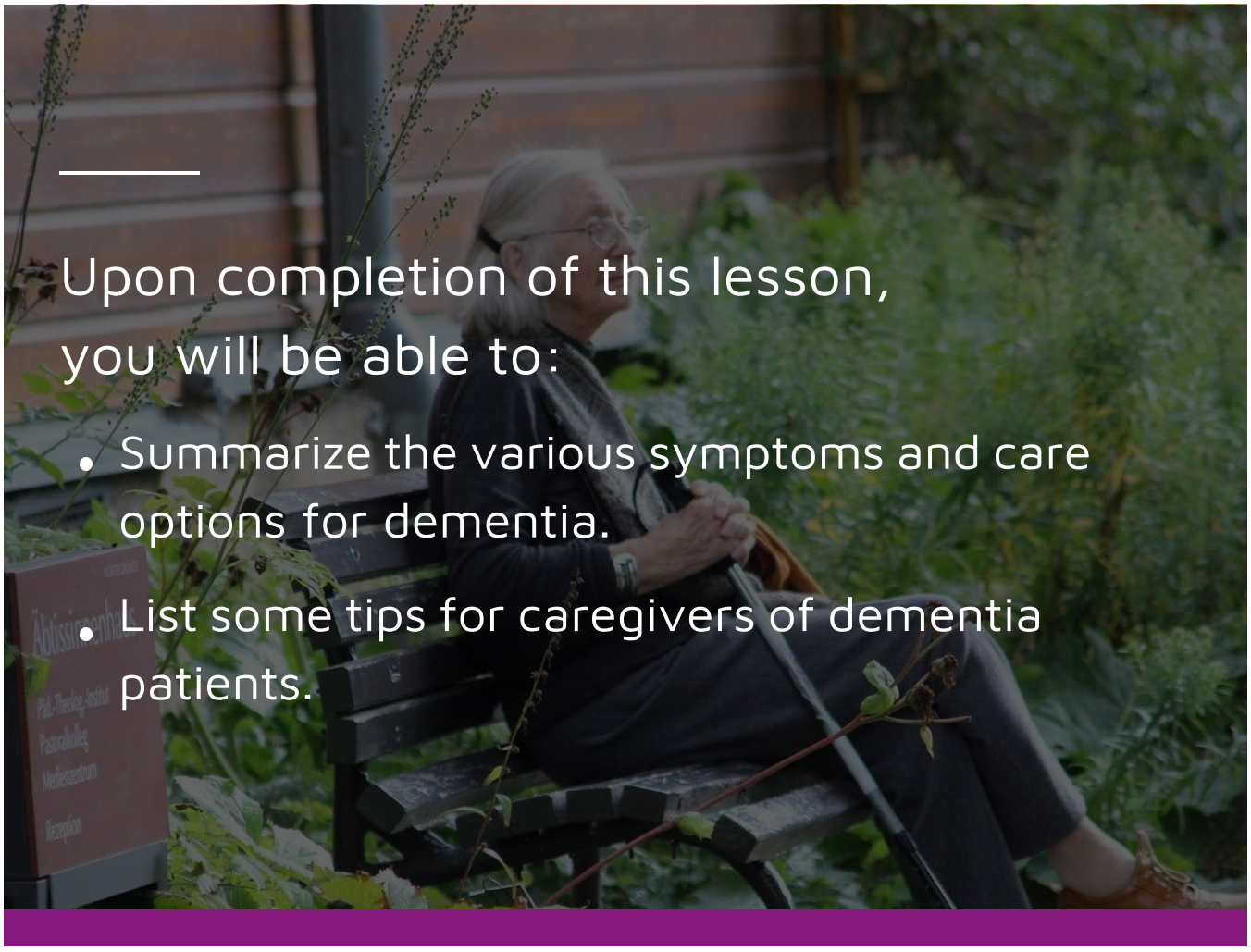
- [x] HCBS for the Developmentally Disabled
- [x] Home and Community-Based Alternatives Waiver Program
- [x] AIDS Medi-Cal Waiver Program
- [x] Assisted Living Waiver Program

Correct

All of the programs listed are Home and Community Based Services.

Now that you have learned about the various HCBS programs, continue to the next lesson where you will learn about dementia and some tips for caregivers of dementia patients.

Background and Resources



Upon completion of this lesson, you will be able to:

- Summarize the various symptoms and care options for dementia.
- List some tips for caregivers of dementia patients.

Start Lesson

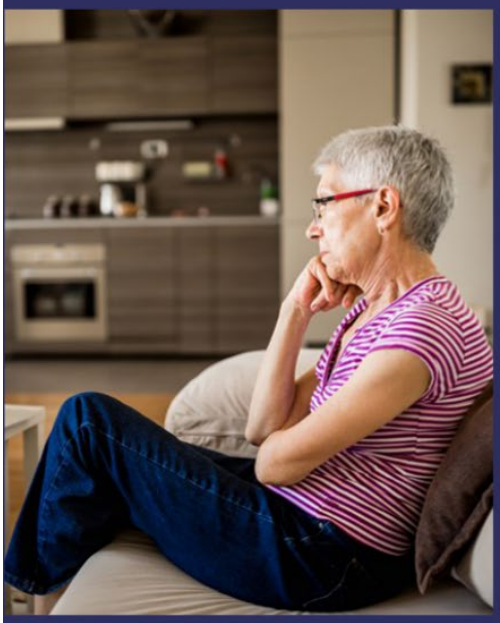
What is Dementia?

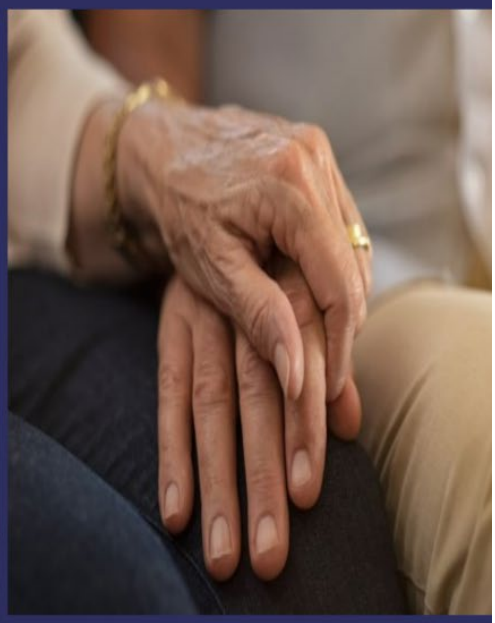
According to the Alzheimer's Association, dementia is a general term for a decline in mental ability severe enough to interfere with daily life.

Who is Affected?

- Prevalence: 690,000 Californians
- Gender: Almost two-thirds of Americans with Alzheimer's are women
- Underdiagnosis: a substantial portion of those who would meet the diagnostic criteria for Alzheimer's and other dementias are not diagnosed with dementia by a physician
- 5th leading cause of death in California
- Top 10 conditions without a known cause or cure
- Race and ethnicity: Older non-Hispanic Blacks and Hispanic Americans are disproportionately more likely than older whites to have Alzheimer's or other dementias

Click each image to learn more about symptoms, care, and barriers to care of dementia.





Restart Exit

Barriers to Dementia Care

Racial disparities exist in the African American, Hispanic, and Asian American communities. Members from these communities lack a diagnosis or are being diagnosed late in the stages of the disease.

There are diverse views of dementia and its negative stigma that might prevent Members from seeking care. Views also vary on the use of formal health care services.

Other barriers include:

- Late diagnosis; symptoms are often masked
- Family is unaware of resources or support for their loved one
- Family/caregiver burnout
- Overmedicated

Common Symptoms of Dementia

- Memory Loss
- Impaired judgement to maintain daily activities, such as paying bills or becoming lost while driving

Care Options for Dementia

Pharmacological Treatments / Medications	• Donepezil, Memantine, Galantamine, and Rivastigmine
Non-Pharmacological Options	• Refer to CBAS Day Program • Alert bracelet for those who wander
Safety Plans	• Fall risk, wandering, and home safety • Environmental modification
Support for Caregivers	• Respite • Support Groups

Care Manager's Role

Our Care Managers play a pivotal role for out Members with Dementia with the following:

- Access the needs:
  - Health Risk Assessment
  - Lont-Term Services and Supports Assessment
  - AD8 Dementia Screening Tool
  - Access for Caregiver burnout
- Confirm Provider involvement
- Provide support to Member and Caregiver(s)

Tips for Caregivers

Additionally, every IEHP DualChoice Member's Care Team must include a Dementia Care Specialist, who may serve as the primary care manager for Members with dementia, or a supportive resource within the Care Team. This individual does not have to be clinically licensed but must have received training based on content provided by experts within the field, such as local or national Alzheimer's Associations.

Scroll through each card to learn tips for caregivers.

START >

1

Care Managers should remind caregivers to:

- Be patient and sensitive when responding
- Communicate with family about any changes
- Inform PCP of changes, especially with medications
- Use proper body mechanics when providing care
- Support for Caregivers include respite, support groups, etc.

2

Bathing Challenges

- Stay calm
- Give step-by-step instructions
- Don't argue
- Consider sponge bath instead of bathing in tub

3

Stress Management Tips

- Physical activity, such as walking, is one of the best stress relievers for all involved
- Involve the Member in simple activities such as: folding laundry, looking at magazines or newspaper or photo albums
- Calming music or play Member's favorite music
- Pets can be helpful

4

Tips for Lessening Symptoms

- Reduce noise
- Distract with an activity, e.g., puzzles
- Keep routine as much as possible
- Close drapes/curtain at dusk to minimize confusion when possible

Sundowning

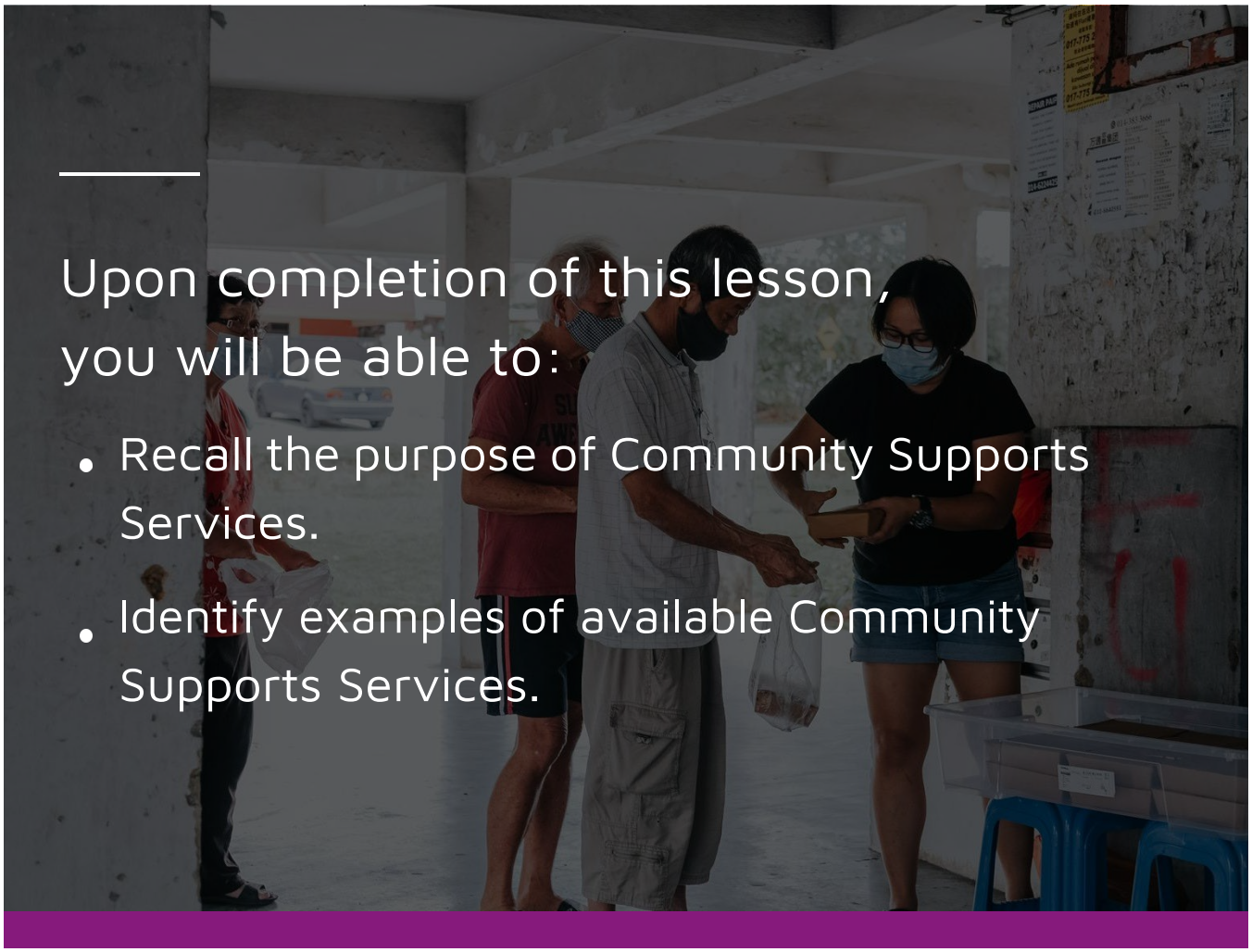
The term "sundowning" refers to a state of confusion occurring in the late afternoon and lasting into the night. Sundowning can cause different behaviors, such as confusion, anxiety, aggression or ignoring directions. Sundowning can also lead to pacing or wandering.

Common Behaviors	Actions for Lessening Symptoms
• Confusion	• Reduce noise
• Anxiety	• Distract with an activity (e.g. puzzles)
• Aggression	• Keep routine as much as possible
• Ignoring directions	• Close drapes/curtain at dusk to minimize confusion as possible

Additional Resources

Understanding some of the various symptoms and care options of dementia is key in being able to offer guidance to our impacted Members. In the next lesson, you will learn more about the Community Supports Services available to Members.

Community Supports Services



Upon completion of this lesson, you will be able to:

- Recall the purpose of Community Supports Services.
- Identify examples of available Community Supports Services.

Begin Lesson

Community Supports Services are optional services or settings that Managed Care Plans (MCPs) such as IEHP may offer in place of services or settings covered under the Medicaid State Plan. These services should be medically appropriate and cost-effective alternatives.

IEHP offers Community Supports Services, pre-approved by DHCS, to comprehensively address the needs of Members – including those with the most complex challenges affecting health such as:

- Homelessness
- Unstable and unsafe housing
- Other social needs

A key goal of Community Supports Services is to allow Members to obtain care in the least restrictive setting possible, although they are not required to use Community Supports.

Click the button to learn more about the available Community Supports Services.

CLICK HERE

Frequently Asked Questions

1. How would a PCP or Specialist know if one of their Members is likely to be eligible for Community Supports Services?

Should a PCP or Specialist determine Member would benefit from a Community Supports service, they may submit a referral to Utilization Management (UM) via the IEHP Provider Portal or fax at 909-890- 5751. It would be the responsibility of UM to determine eligibility based on criteria.

2. If a Provider is in their exam room with a Member and identifies a possible need for Community Supports services, what do they do?

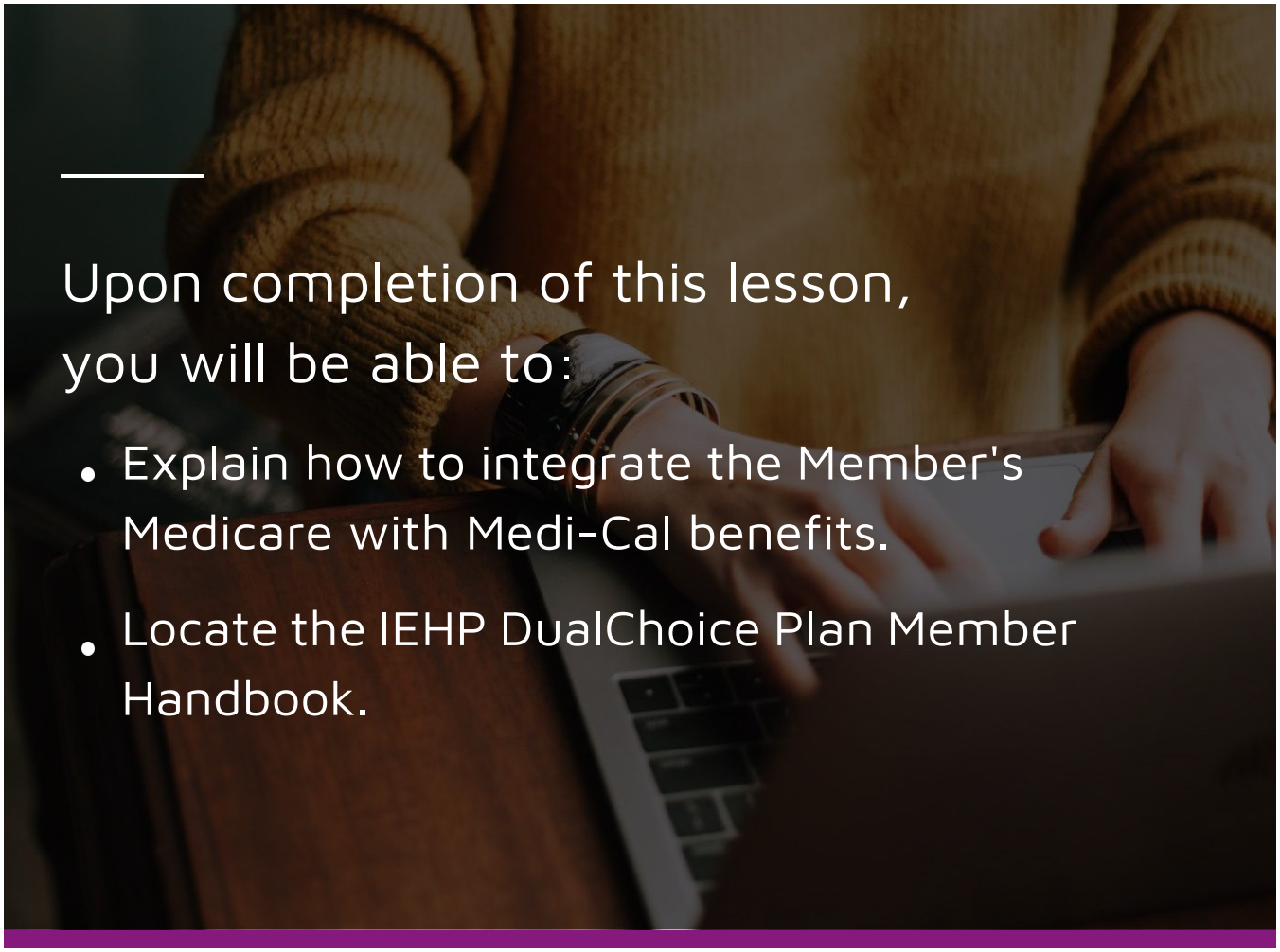
Providers may submit a referral to UM via the IEHP Provider Portal or fax -909-890-5751. If a Member has additional questions, the Member may contact IEHP Member Services at 800-440-4347 Monday - Friday, 8am - 5pm. TTY users should call 800-718-4347.

3. What number can IEHP Providers call should they have questions about Community Supports services?

Providers may contact IEHP Provider Call Center at 866-223-4347 or 909-890-2054. They will be connected with their Provider Service Representative.

Continue to the next lesson to discover more about the integration of Medi-Cal and Medicare benefits, along with details about the Members' rights and responsibilities.

Integration of Benefits



Upon completion of this lesson, you will be able to:

- Explain how to integrate the Member's Medicare with Medi-Cal benefits.
- Locate the IEHP DualChoice Plan Member Handbook.

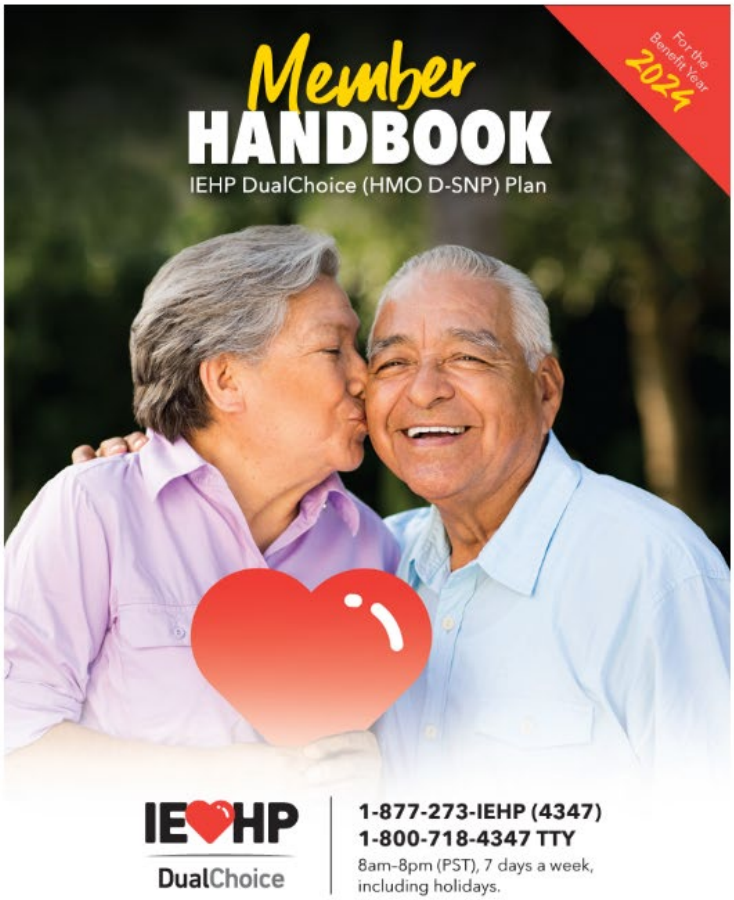
Start Lesson

The Care Management Team must be knowledgeable about all Medicare and Medi-Cal benefits available to our IEHP DualChoice (HMO D-SNP) Members. If a benefit is not covered by Medicare, Medi-Cal benefits are examined next.

There are Medi-Cal covered benefits and services that can help our Members stay independent and safe such as:

- Community-Based Adult Services (CBAS)
- Community Supports Services
- Some Durable Medical Equipment & Supplies

If Medicare and Medi-Cal does not cover a recommended item/service, there are many Community Based Organizations (CBOs) that may be able to help. It is the responsibility of the Care Management Team to coordinate the referrals to CBOs.

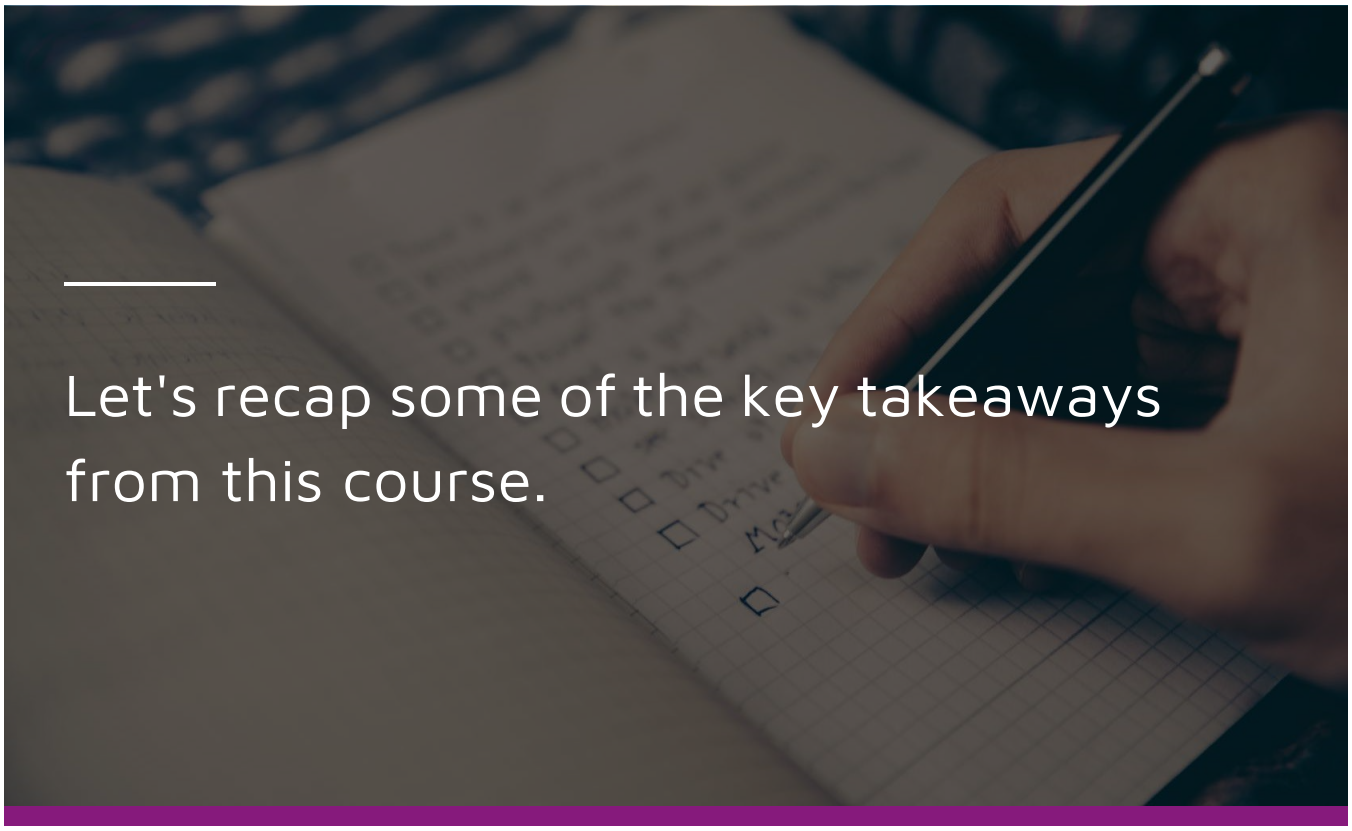


Members' Rights and Responsibilities

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

You can access the IEHP DualChoice Member Handbook via our website.

Wrap Up



- [ ] Some examples of Specially Tailored Services for IEHP DualChoice Members include:

  - Community Supports Services
  - Nutrition Education
  - Long-Term Services and Supports (LTSS)
  - Transportation

- [ ] Every IEHP DualChoice Member has the support of an Interdisciplinary Care Team (ICT) and the development of each team is based on the Member's individualized needs. At a minimum, the ICT is comprised of the Member and/or caregiver, Care Manager, In-Home Supportive Services (IHSS) Social Worker if Member is receiving IHSS, and Primary Care Provider.

- [ ] The Health Risk Assessment (HRA) is considered the starting point in the care coordination process.

- [ ] An Individualized Care Plan (ICP) is a comprehensive, person-centered, and outcome-based plan of care for Member wellness and built upon feedback from the Member and other data sources.

  - The Member's self-management goals and objectives including whether goals were met or not.
  - The Member's personal health care preferences.
  - Interventions specifically tailored to the Member's needs.
  - Role of the Member's Caregiver.

- [ ] IEHP and its IPAs coordinate the Member's care to ensure a smooth care transition from one care setting to the next.

- [ ] IEHP and IPA Providers must refer to IEHP approved Clinical Practice Guidelines when developing treatment plans. Additionally, IEHP communicates about approved, new and updated CPGs to the Provider Network through the IEHP Provider website, and with notification sent via Blast Fax.

- [ ] IEHP believes in a culture of inclusion. All people, regardless of their abilities, disabilities, or health care needs, have the right to be respected and appreciated as valuable.

☐ Long-Term Services and Supports (LTSS) make up a Member-centered, long-term support system in which older adults and people with disabilities have access to a full array of quality medical and social services that assist Members in remaining safely in their home and preventing or delaying placement in a skilled nursing facility.

Questions or More Information:

- IEHP Team Members may contact their supervisor or manager to understand their specific role in IEHP's' Model of Care, and for any questions.
- IPAs and Providers may contact the Provider Call Center at 866-223-4347 or 909-890-2054 8am-5pm, Monday-Friday or email providerservices@iehp.org

You have now completed the **IEHP DualChoice (HMO D-SNP) Model of Care Training**. We hope you enjoyed the course!