Inland Empire Health Plan's Approach to Health Homes

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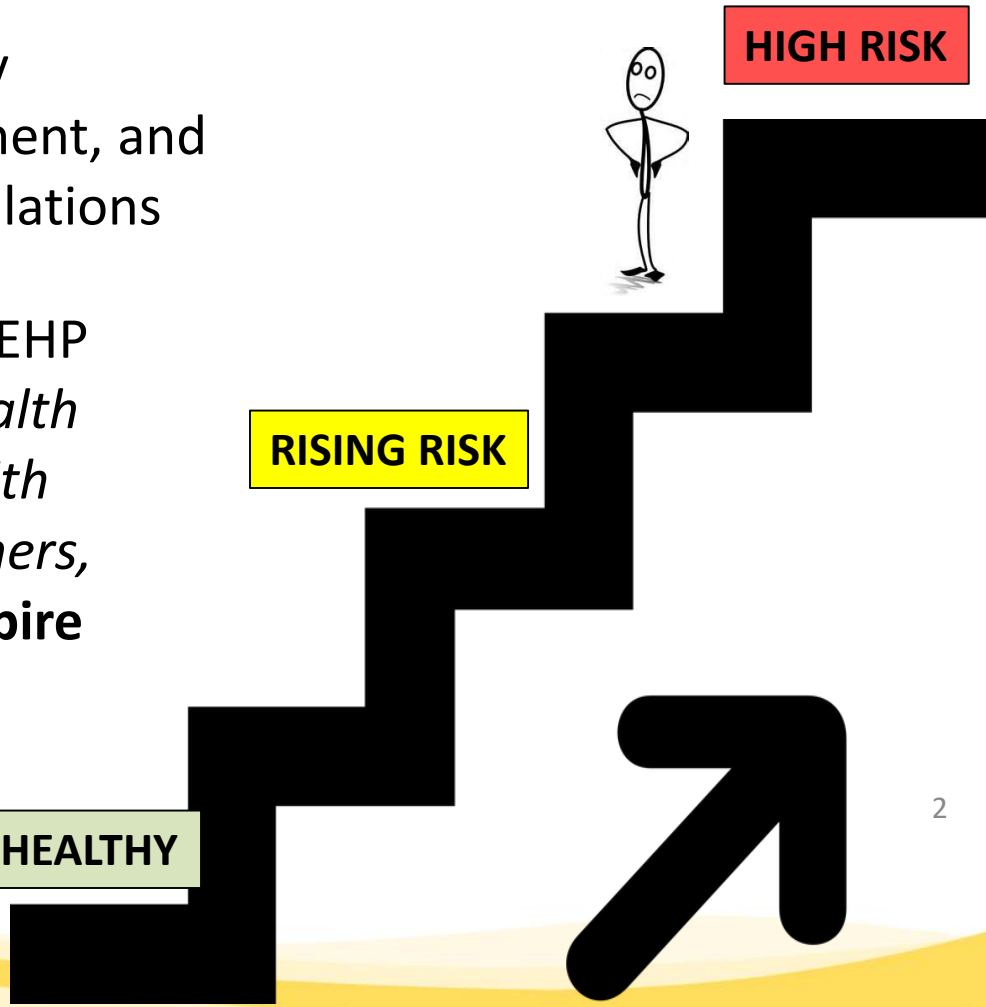
IEHP Vision for Population Health

- **Population Health Management Definition:** population health management refers to strategically managing the engagement, treatment, and clinical outcomes of selected populations

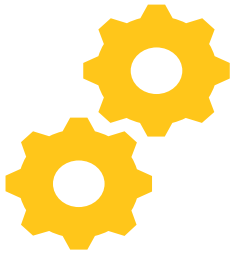
- **IEHP's Population Health Vision:** IEHP commits to *assure a Culture of Health and Equity, internally and along with our members, providers, and partners,* **where everyone in the Inland Empire has the opportunity to live their healthiest and most joyful life.**



Approach to Population Health

Value-based Payment

Delivery System Supports for Whole Person Care

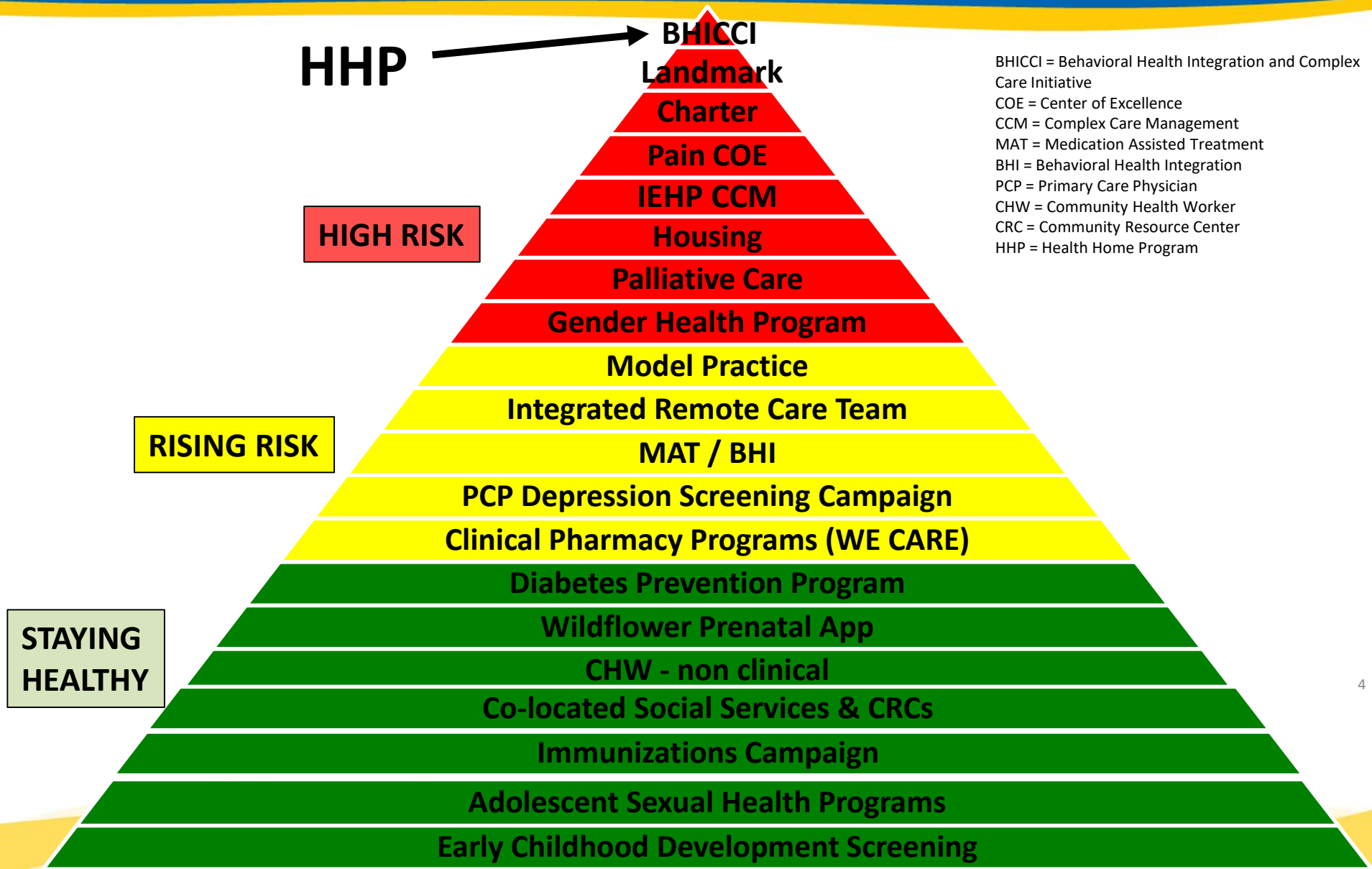


Enhanced Data and Analytics

Value-Driven Care

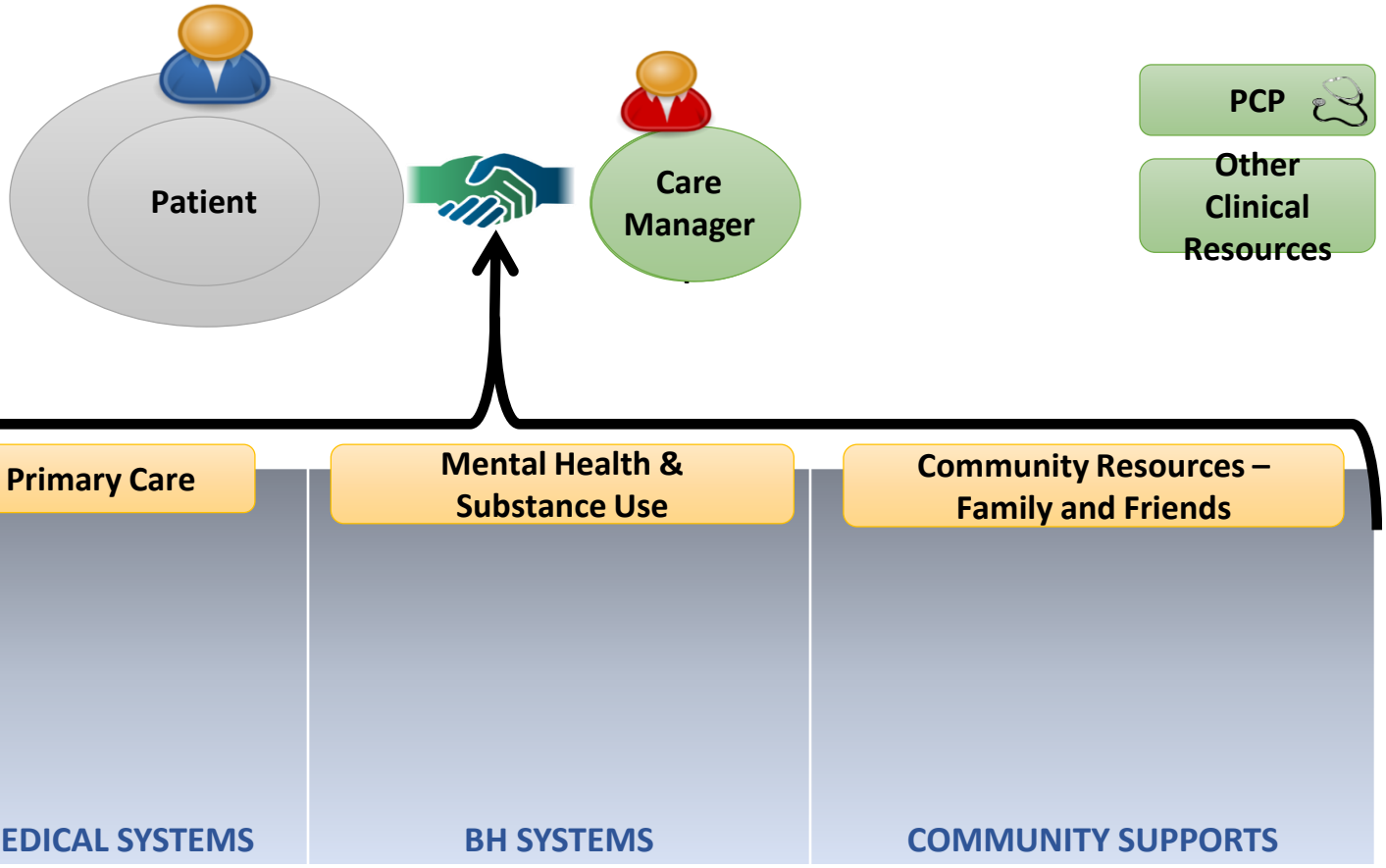
IEHP's strategic priorities and initiatives support investments in value-driven care to improve member experience and foster a high-performing provider network.

Current Programs Supporting Whole Person Care



BHICCI = Behavioral Health Integration and Complex Care Initiative
COE = Center of Excellence
CCM = Complex Care Management
MAT = Medication Assisted Treatment
BHI = Behavioral Health Integration
PCP = Primary Care Physician
CHW = Community Health Worker
CRC = Community Resource Center
HHP = Health Home Program

IEHP Intro to Health Homes: BHICCI Framework



Practice Change

- Quality Improvement Framework
- Multidisciplinary Team-Based Care
- Measurement Based Care
- Population Health Analytics
- Complex Care Management/ Care Coordination

Measurable Success - Clinical

From first to latest assessment, improvement in 3 indicators overall:

- HbA1c Measurement

  9.4 to 8.8 ▼

- Systolic Blood Pressure Reading

  153.1 to 136.5 ▼

- PHQ-9 Depression Questionnaire

  16.8 to 11.8 ▼

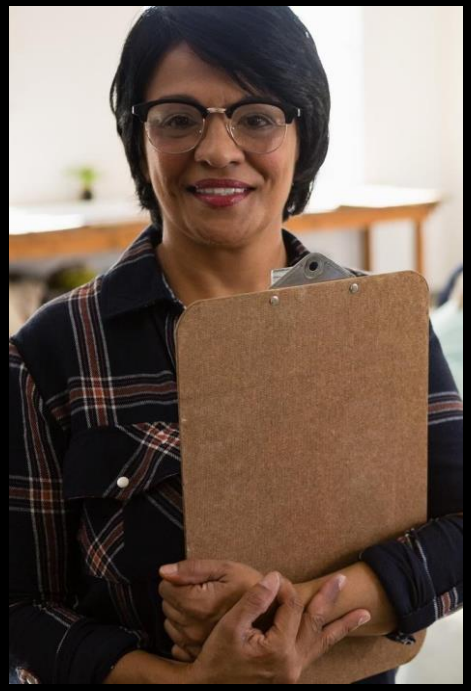
*For Patients with pre-defined baseline score

**Data as of 5/4/2018

Measurable Success - Cost

- Inpatient and emergency room costs decreased by $490 per patient per month.
- Outpatient and pharmacy costs per patient increased on average.

Key Elements of Success



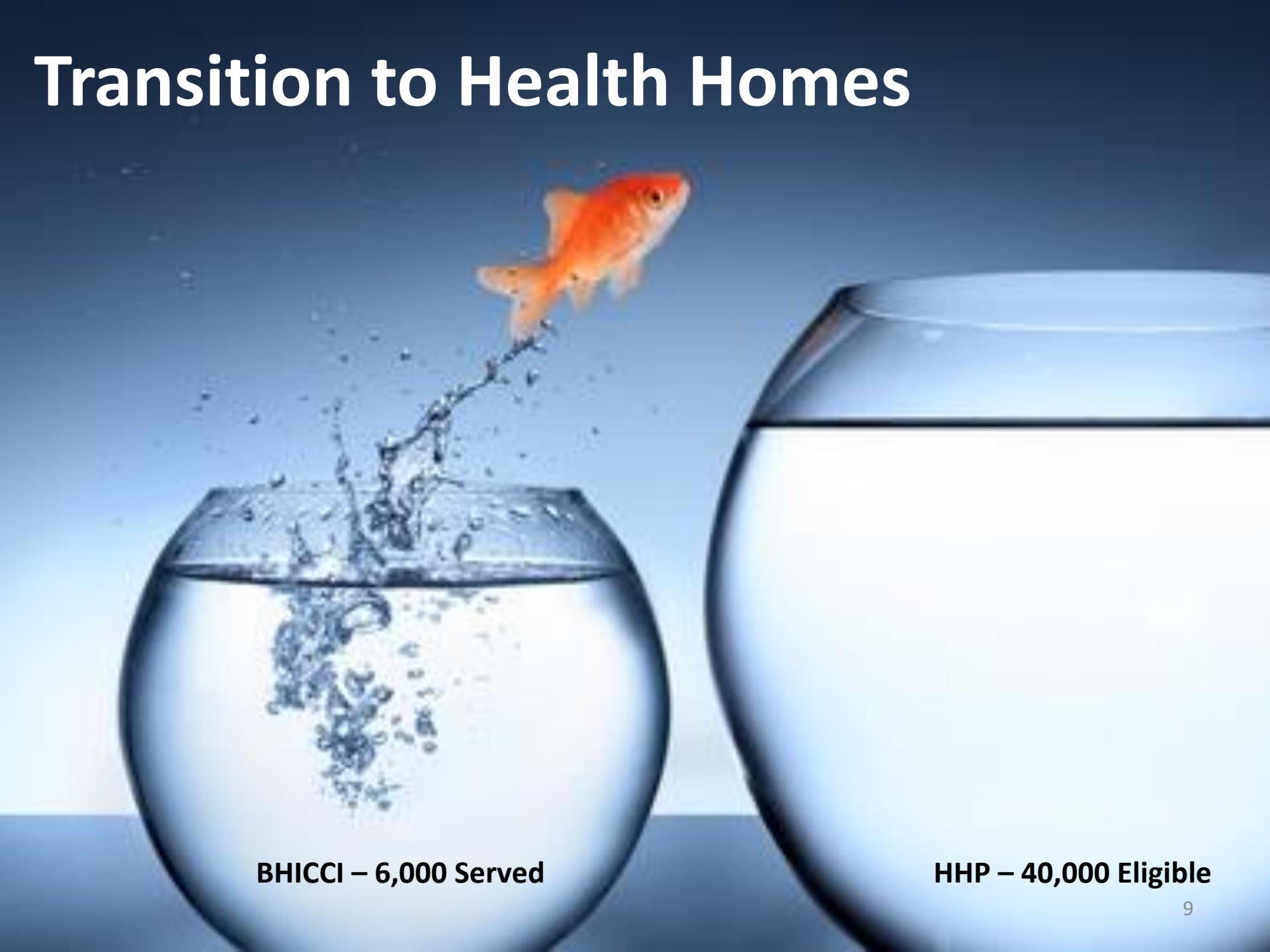
Community Health Worker

Health Information Technology

Training

Practice Coaching

Transition to Health Homes



IEHP Health Homes Program

- Health Homes Program (HHP): 90% federal / 10% state matched 24 mo program to address costs and outcomes of most complex Managed Care Medi-Cal members
- Whole person care model that addresses physical, behavioral, and social health of Medi-Cal patients
- HHP team that is integrated into the medical home, and leverages resources across health system, plan, and community
- Demonstrate improved outcomes and savings over 24 month period

Discussion