

SECTION K: CASE MANAGEMENT

K.1 Approach to Case Management

K.1 Describe your approach to MCO case management. In particular, describe the following:

- *Characteristics of members that you will target for case management services;*
- *How you assess member needs;*
- *How you identify these members;*
- *How you encourage member participation;*
- *What tools you will be using for patient engagement including technology or mobile apps;*
- *How you develop and implement individualized plans of care, including coordination with providers and support services;*
- *How you will get data feeds from hospitals when your member is admitted, discharged or transferred;*
- *How you coordinate your disease management and case management programs;*
- *How you will coordinate your case management services with the PCP; and*
- *How you will incorporate provider input into strategies to influence behavior of members.*

Amerigroup Louisiana (Amerigroup), along with our affiliate health plans across the country, is a leader in providing integrated health care services to individuals who receive their health care through government-sponsored programs. Together with our affiliate health plans in 18 other states, our programs serve more than 4.3 million members through a “whole person” approach that supports their physical, behavioral, cognitive, functional, and social strengths and needs across a spectrum of health care services and settings.

Amerigroup uses local and national expertise, specialized programs, and innovative technology to give our Bayou Health members voice and choice in receiving the most appropriate care to support their health, wellness, and quality of life. Our case management model is person-centered and helps members optimize their use of benefits to get high quality health care in all settings. It emphasizes coordinating health care services, supports, and resources that address all members’ needs, incorporating health promotion and preventive care services, coordinating care among treating providers, and including social supports that reinforce positive health and quality of life outcomes.

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Figure K.1-1 Amerigroup’s Member-Centered Case Management Model illustrates how we *identify* members who will most benefit from case management, *stratify* the intensity of case management services based on their individual needs, and *establish* an individualized care plan that incorporates personalized case management services that *engage* them in their health care decisions, *improve* their health status and adherence to their plan of care, and *develop* self-management skills essential to their recovery.

Integrated Case Management Program

We deliver integrated, locally-based, telephonic and field-based case management services, including care coordination for pregnant members and those with physical and behavioral conditions. ***Our integrated team consists of Case Managers with physical and behavioral health expertise who work together in our three regional offices and the community to facilitate close collaboration.*** Their primary goal is developing a single, integrated care plan that is holistic, meets the biopsychosocial needs of the member, and guides the delivery of quality, well-coordinated care.

In order to fully integrate our members' health care, we have established processes, policies, and procedures for working with members, caregivers, families, providers, and external organizations providing services carved out of the Louisiana Bayou Health program, such as specialized behavioral health services, dental care, and home and community-based services and supports

(HCBS). This integrated system facilitates consistent teamwork, frequent training opportunities, and regular access to clinical consultation that supports information sharing and brainstorming among clinical staff to promote optimal health and independent living outcomes for our members.

Our integrated case management program drives the processes, policies, procedures, and tools that support the following activities:

- Identification of potential or actual case management needs through early screening and assessment
- Stratification of risk levels
- Development of an integrated care plan that addresses traditional and non-traditional, community-based, and carved-out supports and services
- Reciprocal referrals and information sharing
- Care coordination, including scheduling appointments, arranging transportation, conducting appointment reminder calls, following up to verify service initiation, member progress, and need for service adjustment and incorporation into the care plan
- Evaluation, including reviewing, tracking, monitoring, adjusting, and analyzing for outcomes, quality matrices, and performance improvement
- Emphasis on disease prevention and chronic condition management
- Greater access to specialty services

Figure K.1-1. Amerigroup's Integrated Case Management Program



Characteristics of Members Identified for Case Management

Amerigroup will prospectively review DHH-provided claims, internally generated reports, screening and assessment results, Nurse Medical Management team referrals, and provider information to identify members who may need case management services. ***Our predictive model, including the Chronic Illness Intensity Index (CI3) and Likelihood of Inpatient Admission (LIPA) scores, assigns a risk score based on the member's characteristics, and the level of care provided correlates to the severity of the score.*** It considers past utilization (claims, authorizations), general demographics, and information on aid categories to hone in on those members who will benefit most from case management.

The member characteristics we identify for case management include:

- Members with disabilities, home health, personal care, targeted case management, and HCBS needs
- Members with more than three non-emergent emergency department (ED) visits and ED Triage Score indicating a likelihood of continued ED use for low-level visits
- Members at high-risk for admission and readmission to an inpatient setting
- Women with high-risk pregnancies and newborns with complications at or following birth
- Clinically manageable conditions, such as HIV/AIDS, cardiovascular or pulmonary disease, diabetes or metabolic disorders
- Multiple medication prescriptions with high or low utilization
- Co-occurring or co-morbid physical and behavioral health diagnoses
- Members with a behavioral health predictive score indicating likelihood of a first-time inpatient admission for substance use disorders

Assessing Members' Needs

Our comprehensive assessments provide a holistic view of the member. 

Once members are enrolled in case management, we assign them a Louisiana-based Case Manager to work closely with the member and, with the member's permission, family, caregivers, and providers to complete the assessment. After establishing contact with the member, our Case Manager completes an initial assessment

using a standardized, best practice tool. The Case Manager assesses the member's total health care needs holistically, including physical, behavioral, functional, cognitive, and social factors, as well as access to care. We focus specific attention on developing tools and processes that facilitate member participation in the comprehensive assessment. Through that assessment, we gather a full understanding of the member's history, perceptions, and overall goals. The comprehensive assessment focuses on learning about the member's functional, physical, mental, and support status, then asks targeted questions regarding the member's and caregiver's perception of needs. The comprehensive nature of the assessment provides the care coordinator with a holistic view of the member.

By conducting such a thorough interview, the case manager builds trust and credibility with members, their providers, and natural supports. This trust is tantamount to person-centered care planning. In addition to assessing the member's needs and preferences, care coordinators conduct a risk assessment to determine whether the member's preferences and needs can be safely addressed in the setting they choose. The case manager carefully reviews any identified risks with the member and together they develop a risk agreement that details steps to mitigate those risks. The case manager also makes sure that the member is fully aware of any potential outcomes that may occur if the risk is not addressed. This open discussion fosters trust as the case manager and member work together to develop a person-centered plan that achieves the individual's goals.

While the assessment is a standardized tool, the process relies on the Case Manager's judgment and experience, with supervision as needed, to evaluate and apply its findings. This involves both objective (lab values) and subjective (emotional stability) factors. Our Case Manager completes updates to the member's assessment as needed based on significant changes in the condition, situation, and needs.

Identifying Members for Case Management

We proactively identify members who may benefit the most from case management. Our Continuous Case Finding (CCF) process uses predictive modeling tools that enable monthly data mining to identify and prioritize candidates for case management. The process begins each month with a review of the entire eligible member population. Members are identified through review of their available past 12 months of claims data. Additionally, the system considers member historical information, including diagnosis and demographics, to predict future outcomes.

Our predictive modeling tool enables us to proactively identify members who may need additional support. We also identify members for case management through welcome calls, our "no wrong door" approach, and network providers. Our multi-faceted, proactive approach allows us to intervene quickly and engage members in the level of support they need to achieve positive health outcomes and enhanced quality of life.

Predictive Modeling

Using the retrospective two years of claims data provided by DHH, Amerigroup identifies members who may have initial or on-going high-risk, complex, chronic or co-occurring needs, and may need additional support and/or referral during and after transition. We review provider types, procedure codes, dates of service, and other indicators, as well as data provided by external organizations providing carved-out services, such as specialized behavioral health services, dental care, and HCBS.

Our predictive modeling tool enables us to stratify all members appropriately based on their level of risk for adverse outcomes. We can then identify members with special health needs and conduct outreach to provide them with the services and supports they need to experience positive health outcomes.

The Chronic Illness Intensity Index (CI3) is a predictive model designed to support the Case Management Program. ***The CI3 score quantifies a member's relative predicted cost in the next year compared to the average Amerigroup Medicaid member, and enables targeting of members with chronic complex needs whose costs and clinical outcomes can be impacted through care management.*** It is based on Adjusted Clinical Groups (ACG), a model from Johns Hopkins University, which uses demographic, diagnostic, pharmacy, and claims data to predict future resource needs. For example, a member with a CI3 score of 1 is expected to have average medical costs over the next year, whereas one with a score of 3 is expected to be three times sicker/costlier than the average.

For those with the highest complex needs, we use the Likelihood of an Inpatient Admission (LIPA) score to determine which members are likely to have an admission in the next 60 days. It is a proprietary model that was built internally specifically for the Medicaid population. Along with our clinically manageable conditions list and LIPA score, the CI3 allows us to prioritize members into intervention groups and proactively connect those most in need with intensive case management services. Every month, each member is scored and that, along with extensive clinical and utilization data, are provided to the clinicians in a user-friendly format. Finally, clinical-level member outcomes are provided, enabling the case management team to efficiently monitor caseload.

Stratification by Risk Level

Case Managers use a prospective systematic approach to identify members with a risk of poor health outcomes and target them for case management services. This continuous case finding (CCF) system evaluates members of a given population according to disease factors and claims history to improve quality of life through proper use of necessary services and reduction of unnecessary services. This grouping triggers care management interventions commensurate with member risk levels needs, assuring that those who need immediate interventions receive the highest priority, as summarized in Table K.1-1 below.

Table K.1-1. Individualizing Interventions to Align with Individual Risk Levels

Group	Level	Description
Low Risk	Low to Moderate Service Needs	Identified for non-clinician outreach interventions by our Disease Management Centralized Care Unit (DMCCU). These members receive health promotion outreach, and those eligible for disease management may receive the following interventions: a program enrollment letter and an automated telephonic contact/educational outreach to assist them in better self-managing their specific conditions.
Moderate Risk	Moderate Case Management Service Needs	Targeted for interactive contact by the DMCCU. Members with the highest risk scores are queued for clinical outreach until caseload threshold is obtained. Members with more intensive needs will be referred to the local health plan case management team.
High Risk	High Complex Case Management Service Needs	Served by our Louisiana based staff through telephonic or face-to-face case management interventions based on each member’s individual assessed needs or request.
Predicted High Risk	Predicted High Complex Case Management Service Needs	Members predicted to have high complex case management service needs. These members’ needs are served by our Louisiana based staff through telephonic or face-to-face case management interventions based on each member’s assessed needs or request.

Most members of a given population do not exhibit characteristics that qualify for one of the three risk groups; however, CCF recognizes that members’ health status is highly fluid. Frequently, those who have not been stratified into one of the risk groups are identified as potentially needing case management services. They are referred to the appropriate Louisiana-based case management unit to be screened, assessed, manually stratified, and managed according to their risk stratification (Group 1, 2, 3 or 4).

New Member Engagement Strategies for Case Management

Amerigroup recognizes the importance of engaging members quickly upon enrollment into our plan. Within 14 days of sending the welcome packet, we conduct New Member Welcome Calls using our DHH-approved script to engage members, then identify immediate needs, including existing or potential specialized health care needs. New Member Welcome Calls give us the opportunity to establish a positive relationship with all new members and to learn more about their needs so we can support them in achieving positive health outcomes and improved quality of life.

Our New Member Welcome Call DHH-approved script is designed to encourage members to share health-related information, such as diagnoses, current health status, services and supports, history of ED use and inpatient admissions, living environment, and social and natural supports that may indicate complex, chronic, co-occurring, and co-morbid conditions. We train our Member Services employees in cultural competency and motivational interviewing to promote sensitivity and understanding during the welcome call to maximize member comfort and sharing. If we identify members with specialized needs during the call, our Members Services employees make a referral to our case management team for further outreach, screening, assessment, and referral as appropriate.

Amerigroup recognizes that members with specialized needs may be difficult to reach at times. As a result, when we are unable to reach someone after three attempts, we mail a letter directly to the member offering assistance and providing a phone number to call for assistance. We will notify DHH on a monthly basis of our members who are difficult to reach.

Network Providers and Member Engagement

Amerigroup recognizes that our network providers are a primary resource for identifying members for case management. We require our providers to screen members for symptoms that may indicate potential specialized health care needs during every appointment and refer them to Amerigroup’s case management program, as appropriate. We train providers and give them the tools they need to appropriately screen, identify, and refer members who may benefit from additional support.

For example, more than half of patients seek treatment for behavioral health conditions from their PCPs; that results in non- psychiatrists writing more than three-fourths of antidepressant prescriptions. Amerigroup proposes to implement the PC-INSITE program for our Bayou Health population to improve the detection, diagnosis, treatment, and on-going management of persons experiencing depression and/or a substance use disorder (SUD). The PC-INSITE creates supports within the primary care setting to enhance PCP tools for diagnosing and treatment of behavioral health conditions, such as depression and substance use disorder. This whole-person approach gives patients the care they need in single locations while reducing morbidity and costs. The vision of PC-INSITE is to detect, identify, and intervene with individuals experiencing depression within primary health services. Depression impacts and complicates treatment of other health conditions; its effective treatment improves overall health, delivering *better outcomes*.

Through the implementation of PC-INSITE, Amerigroup seeks to achieve:

- Improved management of a member’s depression/SUD health, including other co-occurring conditions
- Enhanced health experience for the individual
- Improved health outcomes for the practice
- Lower health services costs



In addition to these overall program goals, the PC-INSITE program will provide benefits to participating primary care practices:

- Increased capacity to screen, assess, and treat patients with depression
- Enhanced treatment of physical disease and conditions as depression can affect recovery and treatment response
- Access to a Behavioral Health Coach to support patient treatment of depression

Encouraging Members to Participate in Case Management

Amerigroup believes that people want to engage in their health care but experience fear, anxiety, and stress navigating an often overwhelming, confusing system. ***Our member-directed approach engages individuals in achieving their health and independent living goals by meeting them where they are physically, emotionally, and socially,*** and offering opportunities to access services in a meaningful, convenient, and less stressful manner. We seek to connect with members where they are, by using multiple strategies to engage them in case management, including:

- Hiring and training the best staff
- Developing targeted case management programs
- Linking members to community-based resources

Building Member Trust By Hiring and Training the Best Staff

In our experience, members are more likely to engage in services if they have a positive relationship with their case manager. Therefore, we pay special attention to our staff hiring and training practices. Amerigroup directly recruits, trains, and develops a team of highly qualified care coordination professionals to provide our members with the highest quality services and supports. We actively seek individuals who bring a passion for our organizational mission and a commitment to helping members improve their health and well-being. ***We know that case managers who show compassion and enthusiasm enable us to engage, educate, and support members, their families, and caregivers to manage their own health.*** By hiring staff with the ability to establish warm and trusting relationships, we achieve sustainable improvements in members' quality of life and ability to live independently.

Our staff is the primary reason our members engage in our case management program. Amerigroup hires case managers who live and work in the communities they serve.

Amerigroup directly recruits, trains, and develops a team of highly qualified care coordination professionals who bring a passion for, and a commitment to helping members improve their health and well-being. 

Case managers work in the field and are expected to spend their time engaging members in face-to-face interactions that support them in achieving their individual health goals. Our case managers also work side-by-side with providers to assure members access to the services they need, when they need them. Our staffing model affords case managers first-hand knowledge of the challenges faced by the communities we serve, as well as available community resources to support our members.

Amerigroup is committed to providing case management staff with job-related training to give them the tools and skills they need to best serve our members. Our comprehensive training program promotes a consistent, member-centered, and informed approach to identifying those who can benefit from case management, developing two-way open communication that fosters trust, engaging members in their health care decisions, and achieving positive outcomes through care that is holistic and tailored to their conditions. Case management staff undergoes comprehensive

training that builds the skills and knowledge they need to address the diverse needs of our members. Our structured course curriculum includes training modules that educate care coordinators on:

- Care coordination skills, such as motivational interviewing strategies for engaging or coaching members to build self-care and medication-adherence strengths
- Technology tools and resources to support the care coordination processes
- Tools to support members during care transitions
- Care coordination programs, such as Money Follows the Person and Consumer Direction
- Identification of complementary community supports outside the scope of Bayou Health benefits

Beginning with new hire training, we educate our staff on our member-centric approach to care coordination, best practices, and strategies for engaging members as active participants in their service delivery. Throughout their employment, we provide on-going training, coaching, and supervision to support them in consistently applying these principles when serving our members. Table K.1-2 below describes our focused, member-centered, and comprehensive training for case management staff that comprises several phases.

Table K.1-2. Amerigroup Case Management Training Program

Level	Description
Case Management Skills and Processes	<p>This is designed to give new case managers focused training on their roles in the case management program. Major topics include:</p> <ul style="list-style-type: none"> • Introduction to the Amerigroup case management program • Member identification, screening, and grouping • Engagement and interviewing techniques • Assessment, including problem identification • Stratification and complexity leveling • Case planning, including setting goals • Interventions • Monitoring, evaluating, and reporting • Transfer, discharge evaluation, case closure • Skills Practice • Standards of care
Systems Training	<p>This training focuses on applicable IT systems and applications that support Amerigroup’s case management and utilization management. Topics include:</p> <ul style="list-style-type: none"> • Integrated care management systems • Application of relevant clinical criteria/guidelines and health care management services overview • HIPAA member rights • Access to Amerigroup tools through Heartbeat, including authorization rules, State Contracts, and policies.
Continuing Education	<p>To enable case management staff to maintain competence, we have an annual plan for providing them continuing education. It takes into account staff needs based on on-going monitoring efforts, such as case management audits to identify reciprocal referrals and sharing of information.</p>

Level	Description
Case Management Integrated Certification Program – Basic Level	<p>All case managers complete standard training on the following major topics:</p> <ul style="list-style-type: none"> • Motivational interviewing overview and health coaching • High-risk obstetrics • Asthma • Diabetes • Chronic obstructive pulmonary disease • Heart failure • Pain management • Behavioral health • HIV/AIDS • Renal disease
Case Management Integrated Certification Program – Advanced Level	<p>Case managers who have achieved basic level certification complete this training that includes the following major topics:</p> <ul style="list-style-type: none"> • Essentials of Case Management: A Certification in Case Management Preparatory Course • High-risk obstetrics • Obesity management • Wound care • Family planning in women with mental illness • The link between mental illness and metabolic syndrome • The relationship between mental illness and neurological injury • The recovery model • Motivational interviewing • Case managing members who are homeless or poverty-stricken

We also offer staff strategic training based on staff input, quality audits, and performance improvement activities. In addition to formal training, Amerigroup provides staff members with opportunities to enhance their professional knowledge through clinical supervision, case discussions with the Chief Medical Officer, and professional development exercises. These opportunities support our case managers in resolving specific member issues, in addition to teaching them skills they can apply when serving all members.



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Developing Individualized Care Plans

Amerigroup's approach to service planning emphasizes member choice, self-determination, and community integration. We work with members to determine how they want to live their lives and identify the supports they need to achieve their wellness goals. Our case managers consult with members and their natural supports to determine their unique needs, strengths, and preferences. We then integrate this information into a unified plan of care that includes the full spectrum of services (medical, behavioral, functional, and social supports). By doing so, we assist our members in enhancing their quality of life.

The culmination of our person-centered process is the plan of care, which is developed by the member, his/her support system, and the case manager. It incorporates the member's wellness goals, history, natural supports, services (paid and unpaid), disaster plan, and even a pet's name, as appropriate. The plan of care clearly outlines the member's goals and communicates the role each person plays helping the individual achieve those goals. Our case managers then follow up on the member's choices to connect the individual to the services needed to achieve their recovery goals.

Throughout the care planning process, we provide on-going clinical support for the member's multi-disciplinary care team through the clinical rounds process. Described below, clinical rounds bring together a multi-disciplinary team to develop targeted interventions for members with complex needs. Our goal is to develop creative solutions to address barriers to care, improving their health and wellness.

Engaging the Member in Creating an Integrated Care Plan

Case managers develop a single member-directed care plan that incorporates all the interventions necessary to improve the individual's health status across all conditions and reflecting all goals and preferences. Our case management system makes the care plan accessible to all case managers, helping teams work more effectively to assist members with co-morbid conditions. For example, a behavioral health case manager coordinating hospital discharge for a member with depression may need assistance from a medical case manager to verify that co-morbidities (such as diabetes mellitus) are well-controlled during the transition.

Through the care plan, case managers also link members with the array of social and community supports they need to stay on track. This is especially critical for those with behavioral health conditions who may be homeless; involved with multiple agencies, such as juvenile justice and child welfare; or have co-occurring substance use disorders or medical conditions that make it challenging for them to navigate the system.

Case managers will engage members and follow them across health care settings, collaborating with the multi-disciplinary care team to facilitate communication and provide access to resources. The team will work with members and their representatives to identify specific needs and interface with them and providers to facilitate access to high-quality, necessary, and cost-effective care. It will also work with other entities providing care coordination to align goals and make sure the system is responsive to members' changing needs, always striving to enhance our their engagement in their Medical Homes.

Our Transition of Care Team

Under our transition of care model, moderate- to high-risk members leaving inpatient care receive more intensive outreach and one-on-one coaching until they are stabilized at home. It is modeled on transitional care programs that have proven successful reducing readmission rates and improving overall health outcomes. Our goal is to reduce overall 30-day readmission rates for members, improve seven- and 30-day follow-up appointments adherence following discharge from a behavioral health facility, and facilitate a smooth transition between inpatient settings and the community or a lower level of care by providing intensive, short- term support. The program incorporates strategies for filling the gaps that most often drive readmissions, including inadequate access to follow-up care or poor coordination of follow-up services at and after discharge.

We recognize that our members' needs change frequently, and supporting them during critical transitions among care settings is one of the most crucial care coordination functions. These transitions comprise some of the most vulnerable times for our members; therefore, our case managers are dedicated to facilitating safe, successful movement between health care settings for our members.

SUPPORTING MEMBER CHOICE

During a recent hospital stay, Warren, a 60-year-old member with lung cancer, discovered that his cancer was terminal. During the discharge planning process, our transition case manager found that he was not aligned with an oncologist, and wanted to accept the hospice services that had been offered. The case manager identified a hospice provider and scheduled an appointment for Warren and his son to visit that same day. Upon discharge, the case manager confirmed with Warren and his son that they were very happy with the hospice program, and Warren was receiving the services and supports, including pain management, he wanted and needed. 

REAL STORIES

To facilitate safe, seamless member transitions, our case managers:

- Assess the member's health status during telephonic and face-to-face interactions to proactively determine changes in the individual's condition
- Complete a comprehensive needs assessment when members experience a change in condition to verify that the plan of care continues to meet their needs, and make adjustments to services and settings where required
- Coordinate with acute facilities to begin the discharge planning process at admission, assuring that those plans are appropriate to the member's level of care
- Share information and obtain input from the member's PCP and specialty providers
- Update the member's plan of care to reflect current health status and needs
- Make referrals for services and assist with scheduling caregivers and physician appointments
- Collaborate with the member, family/caregiver, facility staff, and providers to develop a transition plan

Our foremost concern during all transitions is our members' health and safety within the context of their goals. We have developed specific processes to support member transitions, including those to or from a nursing facility or community settings, out of the hospital, and between levels of care.

Linking Members to Resources and Services in Their Own Communities

Amerigroup believes members are more comfortable receiving care from providers and resources located in their communities, because they are more likely to understand the strengths, culture, beliefs, and values there, as well as the barriers residents face in accessing services. For example, assistance with utilities can minimize the threat of having electricity turned off in the heat of summer, which could exacerbate a chronic condition like asthma or diabetes – since members need their insulin refrigerated. ***To connect our members with community resources, we will give them, case managers, and providers access to LINK,*** a web-based, reliable source of information about available community resources and how to access them. In this way, we will help members get their basic needs met, reduce barriers to care, and develop a positive relationship with them.

Amerigroup Community Resource LINK

As a value-added benefit, Amerigroup will give members a searchable online resource for programs, benefits, and services available in the community – all displayed in easy-to-use format and searchable with GPS technology. In collaboration with Louisiana's 2-1-1 network, the Amerigroup Link will be a reliable source for information about the wide range of programs and services available throughout the state. Available via the member portal, the Amerigroup Link capitalizes on available technology to create a comprehensive resource for members. Using multiple channels to identify programs from nonprofit, government, and private sources, it will create a reliable, all inclusive source for use by members, providers, and our Case Managers to find and access services. The tool uses a combination of custom scripting and web technologies to speed up data acquisition by automatically extracting data elements needed for program listings. Quality Assurance specialists conduct a review of the data to promote confidence in the information that the tool reports. Information is kept up to date with a technology that acquires the most recent data from program websites. Additionally, the Amerigroup Link platform also provides an online interface so programs and case managers in a given community can suggest updates and changes.

By giving members, providers, and case managers easy access to programs and services available in the community, we will **improve coordination of care** and support **better health outcomes**. As members are accessing this information for their own needs, we are helping them to increase their **personal responsibility and self-management**.

Intensive Case Management Programs

Amerigroup has specialized, more intensive case management programs for our members who are pregnant or with newborns, or have complex, chronic, or specialized health care needs requiring a higher level of care coordination for multiple issues or more challenging benefits and services. They frequently receive services through in- and out-of-network providers and other external organizations that offer carved-out services, such as specialized behavioral health services provided by the Louisiana Behavioral Health Partnership (LBHP), Statewide Management Organization (SMO), and Magellan Health Services of Louisiana (Magellan). Our case managers verify that all needed supports and services, as well as gaps in care and barriers to access, are identified and resolved through frequent communication and information sharing to foster services that are synchronized, unduplicated, and consistently delivered for every member. Below are examples of specialized case management programs:

Amerigroup's Prenatal Case Management – Taking Care of Baby and Me

Amerigroup's "Taking Care of Baby and Me[®]" program provides an individualized, one-on-one, comprehensive case management and care coordination program supporting pregnant women at the highest risk. Educational material, information on community resources, and incentives to keep scheduled prenatal and postpartum visits, as well as well-child visits after the baby is born provide extra encouragement and motivation for our members.

Case Management for Members with Hepatitis C

Amerigroup recognizes the high prevalence of hepatitis C in Louisiana and the high cost of medications available to treat this condition. As part of our fully integrated case and disease management programs, we will work to provide solutions that empower members and providers with information, education, and resources to help members adhere to treatment plans and take their medications as prescribed. With many available treatment options depending on the individual's unique situation, it is crucial that members understand and adhere to their individual treatment plans.

Through specially-trained pharmacists and pharmacy staff, we will provide personalized outreach consultation to members and their providers, with the primary goal of assuring completion of therapy. Additionally, we will help educate and manage members' care, including assessing and addressing any drug interactions, potential side effects of medication, contraindications, and possible co-morbid concerns through targeted reviews where appropriate.

Obtaining Data on Members who are Hospitalized

Amerigroup recognizes that members are best served in the community. Inpatient admissions often indicate that the member is not fully engaged in care with their PCP. Therefore, we have mechanisms in place for timely notification of the member's admission, allowing us to immediately begin engaging the individual. We will obtain information on members who are hospitalized through:

- Inpatient data from the daily census to calculate a readmission risk score, which is used to refer members to our Stabilization Program to support transition and prevent readmission
- Data review of real-time admission and current medical necessity services while a member is hospitalized

- Identification by co-located Transition of Care Nurse Medical Management clinicians of members admitted to the hospital within 24 hours or one business day. These nurses also assist hospital Utilization Management Departments in developing discharge plans, with authorizations for post-acute care services, and attend family conferences to improve member transitions and prevent barriers to continued treatment.

Through these mechanisms, we are notified of the admission within 24 hours, enabling us to immediately begin discharge planning to facilitate the member’s successful transition to the community.

Coordinating Case Management and Chronic Care/Disease Management

INTEGRATION AND COORDINATION

- Regional Teams
- Hospital On-site Clinical Collaboration
- Collaborative Care Planning
- Multi-Specialty Physician Expertise
- Field Case Management
- Provider Quality Strategies
- EPSDT Provider Tool Kits
- Periodic Screening Member Opportunity Lists
- Home and Community Based Waiver Coordination
- Case Management and Coordination of Care Services
- Preventative/ Well Care Visits

Amerigroup’s care management model fully integrates disease and case management while fostering continuity for our members. Rather than enroll members in separate care management programs based on their specific conditions (for example, separate plans for managing diabetes and depression for a member diagnosed with both), Amerigroup’s integrated program reflects accountability for coordinating care for each member.

Once the member is enrolled in a program (disease or case management), an assigned disease or case manager assumes sole responsibility for coordinating all necessary care across the spectrum of services. However, when a member’s needs change (for example, complications increase their condition’s acuity level), the individual may be transferred from the disease management (DM) program to case management, where the Nurse Case Manager can provide more intensive hands-on assistance as needed. Conversely, if during the course of case management, a member’s condition improves and that level of support is no longer necessary, the Nurse Case Manager may transfer the individual to DM.

Coordinating Case Management Services with Primary Care Providers

Successful relations with our network providers, community-based providers, out-of-network providers, and other organizations who render care to our members require two-way communication, clear expectations, continuity, and consistency. We believe it is crucial for providers to have a thorough understanding of the importance – and benefits – of case management, as well as how to fully invest and participate without fearing additional work and burden on their practices. In fact, providers who recognize the increased value case management services bring to their members, while reducing stress on their office staffs, will find themselves rendering more proactive, effective care than those who do not.

Amerigroup’s case management program reinforces the importance of the PCP as the member’s Medical Home, actively engaged in case management planning and on-going monitoring through telephone calls and periodic written updates to the plan.

During the case management planning process, Amerigroup’s Nurse Case Manager engages the PCP and other treating providers by calling them to gather information on the member’s history and health care needs, and solicit input into the plan. PCPs also receive, by mail or fax, a copy of the case management

plan and relevant clinical practice guidelines, and the Nurse Case Manager alerts the PCP of any changes to it. On an continuing basis, the Nurse Case Manager contacts the PCP, typically by telephone, mail or fax, to monitor the member's progress with respect to his or her care plan, obtains updates from the provider on any changes in the individual's needs, and solicit feedback on any changes required.

Our case management program respects the role of the PCP and, for members who may not be progressing, Amerigroup's Chief Medical Officer may initiate more in-depth discussions with the PCP to strategize potential solutions.

Incorporating Provider Input into Strategies to Influence Member Behavior

We engage all treating providers in the case management planning process, soliciting feedback and sharing information. In addition to telephone calls soliciting their input and feedback, we communicate with them throughout the process – assisting with appointments, addressing questions about the member's care, monitoring the individual's progress, and sharing evidence-based clinical practice guidelines as appropriate.

Upon the member's enrollment in case or disease management, we contact the provider to discuss the individual's participation, provider responsibility in the care planning process, the clinical practice guideline associated with the member's condition, and a copy of the care plan. When we update or modify the member's care plan, we contact all involved providers and incorporate their input into the plan. We provide regular updates through written communications and through the *provider facing* Member 360^o tools.

Providers who have members attributed to them can see the member record via the Amerigroup provider portal giving them simple, easy-to-access data and information to assist them in ***engaging the member in their health and well-being***. The integrated data will be displayed to make it easy for the provider to act on it and making sure their patients are getting the services they need. This view will enable any provider who is treating our members to see the full picture including care plans and assessment information, enhancing their ability to reduce duplication and improve their quality of care. The physician view will enable them to understand from a population health perspective, how their members are doing and more importantly, give them information that helps them achieve better results. Our platform will support the providers in achieving the quality incentives defined in the Amerigroup quality programs. For example, the provider will be able to search on the patients with diabetes to see their most recent HBA1c results. The tool will take the providers to the next level by delivering much more than data, instead it gives them information that is synthesized and displayed in a succinct view to create obvious, actionable items right in front of them.

At the systems level, we work closely with providers through our Medical Advisory Committee (MAC) to identify and address barriers to member engagement in care. The MAC consists of an array of network providers – PCPs and specialty providers, MDs, and NPs. It is included in the development and monitoring of the case management program and offers an excellent opportunity for local providers to influence how Amerigroup delivers case management services. The MAC receives updates on the program, and also reviews and adopts the annual program description and program evaluation. At every opportunity, we invite provider feedback about how we can best collaborate to improve the health and well-being of the members we serve.

On the following pages we illustrate how our Maternal-Child Program incorporates our case management program strategies and tools described throughout this section.

Amerigroup’s Maternal-Child Program

Amerigroup understands that Louisiana’s Birth Outcomes Initiative (BOI) was created to improve the health of the State’s mothers and babies by making positive impacts on women’s health, infant health, and the care of women and infants in the hospital. The 39 Week Initiative was developed by the BOI to end non-medically indicated deliveries prior to 39 weeks of pregnancy that commonly result in NICU admissions, serious disabilities, increased costs, and infant death. Amerigroup shares the BOI goal of assuring our youngest population of the best possible start to life by increasing compliance with clinical care guidelines, best practices, and quality metrics. Amerigroup’s Maternal-Child program illustrates how case managements fits into our overall care strategy.



We believe that healthy babies begin with healthy moms. As a result, we have built our Maternal-Child program on a foundation of health and wellness that is key to preventing premature births and improving perinatal outcomes. As illustrated in Table K.1-3, we focus on the holistic care of women across the following spectrum of management, including services and supports, beginning with preconception health through prenatal, postnatal, and newborn care. This includes a comprehensive continuum of pregnancy outreach, case management, and chronic care management resources.

Table K.1-3. Maternal-Child Program Management Continuum

Maternal-Child Services Program					
Identification	Risk Screening	Assignment to CM Group	Outreach & Engagement	Assessment & Leveling	Care Planning
Members are identified through various avenues to assure maximum reach.	The potential need for case management is assessed using predictive modeling.	Based on the risk screening criteria, the member is assigned to one of four risk groups.	The member is contacted to explain the CM program, offer health promotion tools, and describe CM for high risk.	A comprehensive clinical assessment is administered and the member is assigned a complexity level.	A Care Plan is developed that includes goals, interventions designed to assist in meeting goals, and strategies to address barriers.

Preconception Health and Family Planning



Amerigroup educates our female members about contraception, family planning benefits, and supplies to engage them in active decision-making prior to increasing their family size. That includes helping them achieve birth intervals of at least 18 months, which has been proven to lessen risks associated with a subsequent pregnancy too soon after delivery.

Amerigroup believes that our network providers are key to educating our members about preconception health and family planning opportunities. Consequently, we require our providers to include anticipatory guidance and education related to member reproductive health and needs during appointments. We also provide family planning information our member handbook, on our web-based member portal, and in contraceptive counseling that is offered to the member and provided upon request. Our members will have access to all methods of contraception approved by the Federal Food and

Drug Administration, including long acting reversible contraceptives.

Amerigroup will eliminate barriers for women seeking contraception by offering long-acting contraceptives as a pharmacy benefit, giving members easy access to these types of contraceptives, and reimbursing providers for placement of a long acting contraceptive during a woman's postpartum stay in addition to the rate paid for the delivery.

We encourage our members in the inter-conception period to obtain a comprehensive medical history and physical examination annually – or more often when indicated based to her health care needs. We support our members' access to contraceptive and family planning services and related supplies from appropriate Medicaid providers outside of our network by eliminating any restrictions.

When women who are participating in our reproductive health education program become pregnant, our established relationship with them enables us to quickly refer and engage her in early, first trimester prenatal care and our *Taking Care of Baby and Me*[®] program. Our Nurse Case Managers will provide information to her Obstetricians/Gynecologist (OB/GYN) physician regarding the member's previous birth outcome, which will be particularly important if she does not use the same obstetrician who cared for her in the earlier pregnancy.

Our pregnancy risk assessment includes a screen for tobacco, alcohol, and substance use. We refer members to maternal fetal medicine specialists for high-risk obstetrical members requiring further evaluation, consultation, or care and delivery, as recommended by the appropriate guidelines of the American College of Obstetricians and Gynecologists.

Our policies and procedures surrounding family planning are in compliance with the emergency rule published in the June 20, 2014, *Louisiana Register*. We do not exclude coverage of any service on moral or religious objections. We cover all methods of contraception approved by the Federal Food and Drug Administration.

Identification and Screening



Amerigroup believes that early identification of members who are pregnant is an essential element of being able to impact positive pregnancy and birth outcomes. As a result, we have established processes and systems that support early identification of members who are pregnant.

- Network providers who develop relationships and engage in preconception discussions with their members will often be one of the first to know when a woman becomes pregnant. Our providers are required to furnish notification of pregnancy (NOP) to Amerigroup upon the member’s first prenatal visit

through our Provider Relations hotline.

- New member outreach, including the member handbook, welcome calls, and the self-administered health risk assessment, will include targeted information and questions to help identify women who may be pregnant. They will be educated on the importance of notifying the health plan as soon as possible to engage them in the health care that will support their own health and that of their baby.
- Members will have 24/7 access to our member services and *Nurse HelpLine* call centers to notify us if they suspect or have confirmed a pregnancy.
- Frequent and on-going analysis of enrollment files, claims data, laboratory reports, hospital census reports, provider referrals, and self-referrals. Currently, 57 percent of our members who are pregnant are identified upon enrollment.

Amerigroup screens all pregnant members for possible referral into our High Risk OB Program, which is a component of *Taking Care of Baby and Me*. We will initiate a program to provide case management services, particularly reproductive health education, to reproductive-aged women with a history of prior poor birth outcomes, including those with pre-term deliveries at less than 37 weeks.

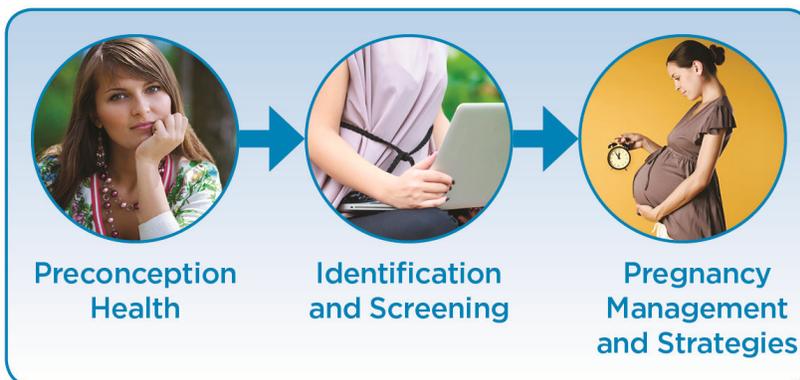
Our Statistical OB Risk (STORK) score was built for the Maternal–Child OB Case Management program to determine pregnant members most at risk for having a NICU infant. The score is calculated from a member's answers to the OB Screener and is also displayed monthly on the CI3 list. Our case managers use the following screening questionnaire to predict a pregnant woman’s chance of having a child who may be admitted to the NICU. *Figure K.1-2. Statistical OB Risk (Stork) Screening Questionnaire* illustrates the questions our members answer, resulting in a Stork Score used to stratify women who are pregnant into different risk groupings.

Figure K.1-2. Statistical OB Risk (Stork) Screening Questionnaire

Question	
Multiple Gestation	Are you carrying more than 1 baby now?
History of Preterm Labor	Have you had preterm labor during any previous pregnancies?
History of Preterm Birth	Have you ever given birth to a baby more than 3 weeks before your due date?
History of LBW	Have you ever given birth to a baby that weighed less than 5 pounds?
Diabetes	Have you ever been told that you had any type of diabetes
Hypertension	Do you have high blood pressure now?
STD	Have you had a sexually transmitted disease in the past year?
Health Plan	If in GA MD, NV, OH, TXDAL, TXFTW then reduced risk of NICU
Current PTL	Have you had preterm labor during this pregnancy?
Prior C-section	Have you ever had a C-section?
Asthma	Do you have asthma now?
Depression	Over the past 2 weeks, have you felt down, depressed, or hopeless?
Tobacco Use	During th past year, have you used cigarettes or other tobacco products?
Drug Use	During th past year, have you used illegal drugs?
Hospital Admission	Have you been admitted to the hospital during this pregnancy for a pregnancy-related condition?
ER Visit	Have you been to the emergency room during this pregnancy for a pregnancy-related condition?

If a member’s Stork Score indicates existing or potential high-risk for having a premature baby or one admitted to the NICU, she receives intensive outreach and educational materials about having a healthy baby or having a baby admitted to the NICU. We also promote postpartum maternal health, and monitor any on-going risk indicators, such as high blood pressure, tobacco use, or depression.

Pregnancy Management and Strategies



Each year, pre-term birth affects nearly 500,000 babies—one of every eight infants born in the United States. The Centers for Disease Control and Prevention (CDC) has stated that the leading cause of neurological disabilities in children is pre-term birth, defined as those which occur prior to 37 weeks of pregnancy. According to data released by the CDC, the nation's pre-term birth

rate in 2012 was 11.5 percent, which is a 15-year low, while Louisiana’s pre-term birth rate in 2013 was 15.3 percent. Recognizing the disparities in pre-term birth rates among different ethnicities, Amerigroup is committed to early identification and intervention for all members who are pregnant.

As soon as a member is identified as pregnant, she is referred to our comprehensive *Taking Care of Baby and Me* program. It provides quality, culturally-competent case management services to pregnant women during the prenatal and postpartum periods, and to their infants.

***Taking Care of Baby and Me* engages members as advocates for their own health care by helping them understand the essential elements of assuring a healthy pregnancy, successful childbirth, and full-term baby.**

Under the direction of our Case Management Administrator, Nurse Case Managers with expertise and clinical experience in maternal and child health care work closely with members to complete a comprehensive assessment to determine individual strengths, needs, and health risks, then access the interventions, services, and supports that are commensurate with each woman's needs and risk level. Our Nurse Case Managers also encourage pregnant women to take action to optimize the outcome of their pregnancy, select a pediatrician for their child's care, prepare for the delivery and homecoming of their infant, and participate in their baby's care should a NICU stay be required.

For example, a Nurse Case Manager may arrange transportation for a woman needing help getting to her prenatal appointments, or may establish a referral for behavioral health or dental services. We provide additional support to members in the *Taking Care of Baby and Me* program based on their health risk as follows:

- **Low:** Women at the lowest risk level are provided educational materials, contact information for questions, and incentive cards for seeking prenatal care. We also enroll them in our Warm Health program that provides outbound calls for health promotion information and well checks throughout their pregnancy in case their health condition changes.
- **Moderate:** Members at moderate risk are monitored more closely and paired with a Nurse Case Manager who works closely with them to help her understand the opportunities and barriers for accessing quality, appropriate care, and provide on-going case management and support, even after the baby is born.
- **High:** For high-risk members, Amerigroup monitors their health more often, and also coordinates all necessary services, such as home visiting services for management of hyperemesis or hypertension and diabetes education. Women who are determined to be high-risk are also engaged in our High-Risk Obstetrics Case Management program where they receive individualized interventions in addition to all services included in *Taking Care of Baby and Me*.

Our Maternal-Child Health/EPSDT Coordinator also has lead responsibility for promoting the receipt of early prenatal care and completion of the postpartum visit. This coordinator works closely with the Quality Management and Nurse Case Management departments to design and implement interventions that encourage maternal health and perinatal care, and develop and maintains connections with community partners to promote reproductive health.

REDUCING PREGNANCY-RELATED RISKS

When her provider notified us that Elizabeth was pregnant, case management began urgent outreach. She had lost her first child pre-term at 25 weeks. First, our OB case manager contacted her to discuss our *Taking Care of Baby and Me* program and the services and supports available to her, including our 17-Hydroxyprogesterone caproate program that promotes full-term pregnancies.

To avoid a third hospitalization for pre-term labor, Elizabeth enrolled in the *Taking Care of Baby and Me* program and began her medication protocol. She also received intensive education on prenatal and postpartum care, including nutrition, bed rest, medication adherence, selecting a pediatrician for her baby, and what to expect with a newborn. Elizabeth carried to full-term and now she and her healthy baby continue to receive support from our postpartum case manager. 🌸

REAL STORIES

Confidential, proprietary, and/or trade secret language has been redacted from this page. Please refer to our proposal binders marked "Original" to access a non-redacted version of our response.

Warm Health - Mobile Health Technology Outreach

Amerigroup is expanding use of technology to enhance our member engagement and outreach platform to improve maternal and new baby health outcomes. Through the Amerigroup Warm Health program, pregnant members will receive proactive, culturally-appropriate outreach and education through a multi-faceted technology, as a supplementary tool to extend the reach of our high-risk pregnancy program. The goal of the expanded outreach is to identify pregnant women who have become high risk, to facilitate connections between members and our case managers, and improve member and baby outcomes. Warm Health will conduct a simple health risk assessment that was developed in collaboration with Amerigroup clinicians. The assessments will be conducted through an automated, interactive voice recognition system. Based on responses to questions from Warm Health, an alert will come to Amerigroup through technology that allows our case managers to reach out in near real time and help members more quickly, easily, and effectively.

The Warm Health tool further supports our maternal outreach and education program to promote healthy behaviors. We will leverage the tool to send educational messages and reminders to both pregnant women and new moms. It facilitates education of pregnant women and new moms via interactive voice response, text message, or smart phone applications. Enrollees will receive twice weekly messages during the prenatal phase, and weekly postpartum and well-child messaging. By two-way texting or live chat, members can get their questions answered and receive timely, relevant information about their pregnancy or infant care.

Data validates that women who participated in the outreach program attended 30 percent more prenatal care visits and six percent more postpartum visits. The program increased obstetric screenings by 3.5 percent.

SafeLink phones

In cooperation with SafeLink Wireless (SafeLink), a U.S. government program that ensures telephone service to eligible Medicaid recipients who lack another communication source, qualified Amerigroup members receive a free cell phone. They also receive up to 250 free minutes a month, depending on the plan they choose. Additionally, members who are not existing SafeLink subscribers can also receive a one-time 200-minute bonus. Amerigroup facilitates the SafeLink Wireless process by helping pregnant members get the phone. These additional minutes give Amerigroup Nurse Case Managers real-time access to members to encourage them to keep appointments and fill prescriptions.

We assist our members who have higher risk pregnancies in obtaining SafeLink phones, allowing us to send automated messages that include prenatal care information and reminders for prenatal visits, address missed appointments, and encourage postpartum follow-up.

Text4baby

In addition to our WarmHealth program described above, Amerigroup has joined with the text4baby program to promote this free text message information service. Once pregnant members enroll, they receive educational messages and helpful reminders tailored to their particular weeks of pregnancy and through their baby's first year.

Smoking Cessation

The CDC and the March of Dimes maintain active, on-going campaigns to educate women on the dangers of smoking during pregnancy. Amerigroup carries their messages to our members and offers support and assistance. During the risk screening survey, every woman is asked about her recent smoking history. Women who smoke are offered the telephone number for the Louisiana Quitline. Through the one-on-one relationship established by the case manager with every high-risk pregnant woman, we urge our members to take advantage of the smoking cessation benefits available to them. Emphasizing that pregnancy is an

ideal time to stop smoking, all our Nurse Case Managers are trained in coaching techniques on how to approach the topic of quitting.

Additionally, *we provide members with a Stop Smoking Quitline and a variety of resources and tools to help them to stop smoking.* We use QuitLogix, a web-based program with the latest information and research-based tools, to help tobacco users through all stages of change, including access to tailored motivational messages, step-by-step guides to cutting down and quitting tobacco, and online support from other quitters and quitting specialists.

We adopted a clinical practice guideline on smoking cessation during pregnancy. Providers are required to ask all pregnant members about tobacco use and smoke exposure at initial and all subsequent prenatal visits. For those who admit to tobacco use, the provider should deliver pregnancy-tailored counseling. Appropriate interventions include the following:

- The Five As of smoking cessation: Ask, Advise, Assess, Assist, and Arrange
- Referral to the smoking Quitline, 1-800-QUIT NOW
- Physician counseling regarding smoking-related health risks
- A videotape with information on risks, barriers, and tips for quitting in conjunction with provider counseling (10-minute session), self-help manual, and follow-up letters
- Pregnancy-specific self-help guide and a 10-minute counseling session with a health educator
- Counseling in one 90-minute session, plus twice-monthly telephone follow-up calls during pregnancy, and monthly telephone calls after delivery
- Education about the risk of exposure to second-hand smoke
- Screening and intervention for alcohol and other drug use
- Determination of the member's intention to return to smoking after pregnancy
- Assistance identifying social support systems to remain smoke-free

We identify, track, and trend tobacco use in pregnancy data, as well as referrals to Quitlines and/or services.

Substance Use Disorders in Pregnancy

Amerigroup understands that identifying risky substance use in pregnancy, intervening to provide a woman with the assistance she needs to stop, and providing case management and care coordination to help her access specialty services improves the chance of improving outcomes and reducing the following issues for the current pregnancy and for subsequent care of the newborn child.

- Poor self-care
- Low birth weight
- Placental abruptions
- Pre-term birth
- Birth defects
- Neonatal abstinence syndrome
- Parenting difficulties

We screen all women identified as pregnant for use of alcohol, illegal substances, and tobacco products. Our OB Nurse Case Managers use a *screening, brief intervention, and referral to treatment* (SBIRT) approach to substance use that includes the identification, reduction, and prevention of problematic use

of, abuse of, and dependence on alcohol and/or drugs. SBIRT has been shown to be effective at reducing risky alcohol and other substance use, and is endorsed by CMS, ACOG, and SAMHSA.

Should the SBIRT indicate potential substance use, our Nurse Case Managers will use our OB Health Risk Assessment for further screening. It incorporates best practice tools, such as the 4Ps shown to be effective in maternal-child settings. They are parent, partner, past use, present use. This assessment includes specific questions about tobacco, alcohol, and drug use.

If any answers indicate current use, our Nurse Case Manager does a brief intervention, providing education and using motivational interviewing (MI) techniques to raise awareness of the specific risks identified in screening, and increase motivation to change behavior and make choices that support health. Providing brief interventions using MI, in the context of general health assessment, has been validated as effective in reducing risky use. Because substance use questions are integrated with all questions, including screening for depression and intimate partner violence, as well as general health concerns, our Nurse Case Manager is able to get a holistic picture of current problems and address other physical, social, or emotional impediments that may be affecting substance use.

Members whose screening indicates a further need for assistance beyond a brief intervention, such as for pervasive and continued alcohol, drug, or tobacco use, are immediately referred for comprehensive assessment and care provision through the SMO.

CenteringPregnancy®

Amerigroup was instrumental in applying for and receiving the CenteringPregnancy grant in the State of Louisiana. Through CenteringPregnancy, we support a small group intervention model of care that supports information sharing and promotes understanding through shared experience. Amerigroup identifies existing CenteringPregnancy sites in our network and informs members of their availability.

CenteringPregnancy is a multi-faceted model of group care that integrates the three major components of care: health assessment, education, and support. It uses a group setting to maximize the opportunity to educate women and help them learn from each other and their shared experience. Small groups of eight to twelve women with similar gestational ages meet with the provider, learn care skills, and participate in facilitated discussions. The group learning facilitates not only broader learning opportunities, but also creates a support network among the other members. Each group meets for 10 sessions throughout pregnancy and early postpartum periods.

Nurse-Family Partnership®

Amerigroup recognizes that DHH fully supports the Nurse-Family Partnership Program, and our affiliate health plans throughout the nation actively collaborate with the Partnership to offer our members additional support through pregnancy and the infant years. Through the Nurse-Family Partnership, public health nurses visit low-income, first-time pregnant women at risk during their pregnancy and until the baby is two years old.

The program offers additional support and resources for the new mom and helps her transition to the community after having a baby. The nurses teach parenting and life skills, and help new moms gain access to job training and education programs. The nurse becomes an essential resource for the woman, offering her knowledgeable guidance and resources to assist her in the community.

What really made the difference for me was that my nurse didn't tell me to do something — she showed me how to do it the right way.

— Rebecca, 17 year-old mom participating in the Nurse-Family Partnership

TESTIMONIAL

We include Nurse Family Partnership program information, including how to access the program, in our Prenatal Incentive Packet sent to all members who are pregnant. The Nurse Family Partnership is designed to accomplish the following:

- Increase chances for a healthy pregnancy and a healthy baby
- Develop parenting skills
- Build a strong network of support for the member and her baby
- Promote child safety
- Facilitate referrals for health care, childcare, job training, and other support services available in the community
- Promote continued education and development of job skills
- Assist the member with setting future goals and defining the steps needed to achieve them
- Encourage the father, family, and friends to attend visits to learn how they can better support the member during this time

Throughout her pregnancy and after the birth of her child, each Amerigroup member receives support from dedicated groups of employees and providers. We collaborate with community agencies and programs to extend the reach of our case management program and connect members with programs and services to assist them with other social and economic needs. Some of these programs include WIC, Social Services, public housing agencies, childcare agencies, local court systems, advocacy programs, workforce education and training programs, and home visiting programs.

Prior Pre-term Pregnancy Program

Our 17-Hydroxyprogesterone caproate Program resulted in a decrease in the overall preterm birthrate percent to 12.6 — down from 13.5 percent in 2012 and decreased infants born with a birth weight of <2500 grams to 11 percent — down from 12.1 percent in 2012.

17-Hydroxyprogesterone caproate is an injectable, synthetic form of progesterone, typically initiated between weeks 16 and 20 of pregnancy, that has been shown to lower the risk of premature births in women with a singleton pregnancy and a history of prior pre-term delivery.

Through our partnership with a national leader in pharmacy innovations, our providers are able to promote member access to 17-Hydroxyprogesterone caproate. Our Nurse Case Managers work closely with the mother and provider to expedite access to this medication and the services to administer it. This is just one example of our tailored interventions to keep women and their providers informed about current best practices, and support providers in delivering services effectively. The program offers provider

education and notification of members who may be candidates for 17-Hydroxyprogesterone caproate therapy and eliminates barriers to accessing the medically necessary medication.

Through our screening survey, women at risk for having a repeat pre-term birth are identified. Twice-weekly alerts are faxed to providers to inform them of members who may be candidates for 17-Hydroxyprogesterone caproate. Women who have had a prior pre-term birth are enrolled in case management and monitored for adherence to the weekly therapy. Amerigroup's OB/GYN providers may order 17-Hydroxyprogesterone caproate for office or home administration.

NICU and Postpartum Management



The *Taking Care of Baby and Me* program includes NICU Case Management where Louisiana NICU Nurse Medical Management clinicians and Louisiana Nurse Case Managers coordinate the care of pre-term infants beginning at delivery. This program assures high-risk infants

of quality and cost effective NICU care, identifies barriers to discharge, and leads to a successful transition to the home environment through a well-defined plan of care.

Postpartum Support

After the delivery, a postpartum packet is sent to moms whose babies are enrolled in Amerigroup. It provides educational information on self-care for the mother and care of her newborn. Additionally, it contains a \$25 incentive gift card to encourage moms to get the care they need by returning for a postpartum visit and to help their babies have a healthy start as well.

Postpartum Appointment Reminders

Amerigroup mails a reminder postcard to the member after the postpartum appointment is scheduled.



Reminder calls are made to the member five days prior to the appointment date. We call the provider the day after the scheduled visit date to verify that the appointment was kept.

If the member is not able to be reached by phone, we also mail a “trying to reach you” postcard that lets her know we have been unable to make contact and would like her to call in, as well as provide updated telephone information.. By engaging women during the inter-pregnancy period, we encourage health care that will potentially improve outcomes of a future pregnancy.

Our inter-conception health service will identify women of child-bearing years who have delivered an at-risk child for continued management beyond the postpartum phase of traditional OB care. The criteria for engagement will be women with a history of poor birth outcomes and known risk factors, such as chronic medical and behavioral health conditions and social stressors. Interventions will include the following:

- Encouraging women to space pregnancies at least two years apart
- Folic acid supplementation
- Managing high-risk conditions, such as obesity, hypertension, and diabetes
- Abstinence from nicotine, alcohol, and drug use
- Living free of interpersonal violence with healthy relationships
- Reduction of risk factors for transmission of sexually transmitted infections

We will make appropriate referrals for long-acting, reversible contraception and community resources that will best support our member and her child, including appropriate safe housing. We will also work closely with and support community partners who are doing similar work to avoid duplication and promote a single message regarding reproductive health.

Amerigroup offers an array of member incentives during pregnancy and in the postpartum period to support the health and safety of the baby, including the following:

Behavioral Health Support for Parent(s) with a Baby in the NICU

Amerigroup recognizes that the costs of pre-term birth consist of more than the financial charges for hospitalization and follow-up care. There are also potential non-financial costs experienced by parents and families, such as adverse psychological and emotional reactions, family disruption, strained relationships, and deterioration in both physical and mental health. We know that children cared for by mothers with post-traumatic stress disorder (PTSD) and depression are at significantly higher risk for psychological aggression, child abuse, and neglect. In response, Amerigroup has developed a program focused on the identification and intervention of existing or potential PTSD in our members with a baby in the NICU.

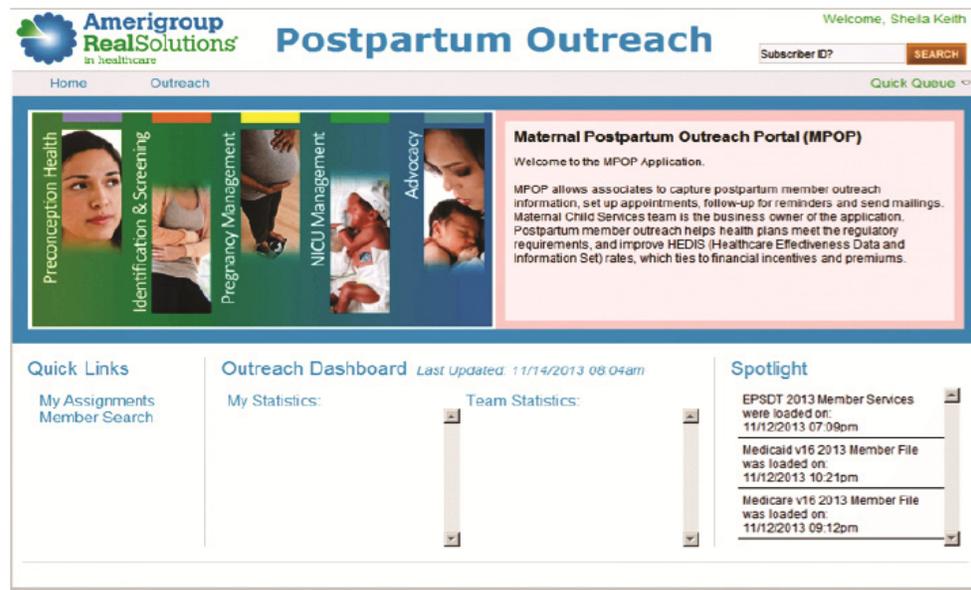
Our medical management employees who are co-located at key hospitals will interact with mothers who have a baby in the NICU to monitor behavioral health symptomatology, offer stress management techniques and information, and provide additional emotional support. Should a risk be identified, further screening will be conducted through a Primary Care PTSD screen that will identify existing or potential conditions and prompt referral of the member for additional services and supports. Incorporating that screening into our care for mothers' and infants' families and referring parents to support programs may mitigate the impact of PTSD on our members, decrease neonatal length of stay, and improve the health of our member families and their children.

Maternal Postpartum Outreach Program

The Maternal Postpartum Outreach Program (MPOP) is a web-based outreach tracking tool that Amerigroup plans to implement in the fourth quarter of 2014 or early 2015. It displays all members who need a

postpartum call and captures all relevant data related to the appointment process. It prompts the Nurse Case Manager to call the member for a reminder and to call the provider to verify the visit. It also captures member mailings and other postpartum strategies that

Figure K.1-3. Identification of Member Needs at a Glance



may be indicated for a given member, such as home visits and transportation scheduling. Figure K.1-3 is an actual screen that our Nurse Case Managers access to monitor outreach needs for our member’s with high-risk postpartum conditions.

- **Louisiana Crib & Car Seat.** The Amerigroup Crib and Car Seat program is designed to motivate expectant mothers to attend their prenatal appointments. If the provider confirms at least 7 prenatal checkups were attended, the expectant mother may choose a portable crib or car seat for each baby delivered.
- **Booster Seat.** To incentivize parents to make sure their children complete their EPSDT visits, Amerigroup is providing this additional incentive for those whose children complete all their well-child visits and EPSDT screenings by their sixth birthday.
- **Physician Home Visits for Postpartum Care.** As part of Amerigroup’s comprehensive maternal and child health program, Amerigroup will provide in-home physician visits to make sure delivered women have their postpartum care. Amerigroup is making home visits available for women who experience barriers in getting to the obstetrician for their postpartum visit. In partnership with Allegis/Home Physicians, we will send a physician to conduct the postpartum home visit.
- **OB Provider Profile.** Amerigroup offers our obstetricians a provider profile that allows them to view and compare their performance to their network peers on an array of key performance metrics related to the care of Amerigroup members. It includes both numerical and graphical comparisons of performance for the following measures:
 - Pre-term birth rate
 - C-section rate
 - Early term elective C-section rate
 - 17 Hydroxyprogesterone caproate use
 - Timeliness of prenatal care
 - Postpartum care

Figure K.1-4 is an example of the data we compile and use to monitor provider performance.

Figure K.1-4 Maternal-Child Services OB Provider Profile

Measure	Provider	Health Plan	Specialty Group	Panel Group	Benchmark	
					National	State
Preterm Birth Rate	10.0%	9.2%	9.0%	9.6%	11.6%	13.7%
C-section Rate	36.4%	31.5%	31.4%	33.2%	32.8%	38.1%
Early Term Elective C-section Rate	10.0%	2.4%	2.4%	2.1%	5.0%	
17-Hydroxyprogesterone caproate	0.0%	2.2%	2.3%	1.7%	3.0%	
Timeliness of Prenatal Care	100.0%	74.1%	74.0%	72.9%	92.8%	
Postpartum Care	77.8%	56.0%	55.8%	72.9%	73.8%	

Also under development is an easy-to-use HEDIS® encounter reporting system that is tied to the claims system, enabling OB providers to view outstanding gaps in care and report visit dates. It will supplement the OB Provider Profile report.

Newborn Management and Support



Our final phase of holistic Maternal-Child care lies in our newborn management and support information and strategies. We communicate with

new moms using various channels—web, text and phone—to deliver educational content and identify members in need of additional support. Our messages are designed to motivate positive behavior and generate higher rates of member adherence to recommendations. ***This helps members learn to identify health problems and triggers before they become serious, helping them avoid unnecessary emergency department visits, disruptions in their lives and primary care, and to take a more active role in working with a physician.***

Educational topics that are communicated to our postpartum members include:

- Holding and gentle care of new baby
- Care and cleaning of baby’s umbilical cord
- Caring for baby’s skin and scalp
- First month baby check-up and mother’s postpartum check-up
- Breast milk benefits
- Baby’s safe sleeping tips
- Formula feeding and safety tips
- Lead poisoning awareness
- Diaper rash prevention and care
- Making the home safe for baby, including water safety
- Monitoring baby’s colds and other symptoms of mild illness
- Possible dangers for baby: awareness and tips

If the medium for communication is IVR or text, the member is asked to respond to questions about her condition and needs. Based on the response, an alert comes to Amerigroup’s Case Manager to quickly and personally reach out and help members in need easily and effectively. Our communications are available to members in the primary languages of the areas we serve, including English, Spanish, and Vietnamese.

Confidential, proprietary, and/or trade secret language has been redacted from this page. Please refer to our proposal binders marked "Original" to access a non-redacted version of our response.

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Increasing Member Contact with SafeLink

Amerigroup partners with SafeLink, to provide Bayou Health members with cell phones. This service provides our case management team and our providers with more consistent and reliable access to members. Members are able to receive text message reminders about doctor visits and calls from case managers and providers, for example. This improves appointment compliance, adherence to treatment plans, and appropriate follow-up.

SafeLink phones allow our Nurse Case Managers and DM Nurses to have real time, consistent contact with members including but not limited to:

- Reminding members of scheduled appointments

- Scheduling of wellness and checkup appointments for members with special health care needs such as chronic illness or members who are pregnant or have a newborn
- Scheduling of preventive services such as EPSDT, flu shots, and PCP well checks
- Arranging transportation as needed
- Adhering to prescribed medications
- Providing nutritional or weight-management tips
- Accessing the Nurse Case Manager contact information

The objectives of the SafeLink program are to improve members' ability to access and engage in the care that is available for their conditions by reducing barriers, resulting in improved outcomes for the member.

DRAMATIC CHANGES IN QUALITY OF LIFE

Chronic heart failure, chronic obstructive pulmonary disease, asthma, sleep apnea, and uncontrolled high blood pressure were a volatile combination for Emilie, and she was frequently admitted to the hospital. She met with her case manager and discussed how diet and smoking impacted her conditions, as well as the importance of taking medications as directed. When offered, Emilie enthusiastically joined our smoking cessation program and attended her pulmonologist visits. Her case manager also educated her on the appropriate use of the ED, and when and how to contact her providers and case manager. Emilie says that since working with her case manager, she feels better, is tobacco free, and taking fewer medications. 🌿

REAL STORIES

Improving Wellness through Smoking Cessation

The CDC and the March of Dimes maintain active and on-going campaigns to educate women on the dangers of smoking during pregnancy. Amerigroup carries their messages to our members and offers support and assistance. During the risk screening survey every woman is asked about her recent smoking history. Women who do smoke are offered the telephone number for the Louisiana Quitline. Through the one-on-one relationship established by the Nurse

Case Manager with every high-risk pregnant woman, we urge our members to take advantage of the smoking cessation benefits available to them. Emphasizing that pregnancy is an ideal time to stop smoking, all our Nurse Case Managers are trained in coaching techniques on how to approach the topic of quitting.

Additionally, we provide members with a variety of resources and tools to help them stop smoking. Through National Jewish Health, we offer a telephonic coaching program that connects members with personalized support to stop smoking. In addition to being able to speak with their coach, members receive educational materials to assist them in meeting their quit-smoking goals. Based on their needs, and medical clearance, if appropriate, members can also access Nicotine Replacement Therapy (NRT) such as gum, lozenges, and patches to stop smoking.

Helping Members Achieve Healthier Lifestyles through AmeriTips

Amerigroup provides easy-to-read and appealing tip sheets that provide information on preventive health care and management of chronic disease conditions to our members at providers' offices, community organizations, and community events. These materials are examples of methods we use to educate members and promote healthy behaviors. *AmeriTips topics include immunizations, asthma triggers, a healthy lifestyle for your child, lead poisoning, and flu shots, just to name a few.* Members may request tip sheets on topics of interest from their assigned Nurse Case Managers or Member Services, as well as access them on our web-based member portal.

Health A to Z — Amerigroup’s Health Encyclopedia and Tools

The Amerigroup member website offers members access to *Health A to Z* (powered by the Healthwise® KnowledgeBase). *Health A to Z* includes a variety of tools such as an award-winning Symptom Checker. An industry-leading tool used by health plans, hundreds of hospitals and other organizations, Healthwise can help consumers make better health decisions by providing them with accessible and easy-to-use online content. Resources like the Healthwise KnowledgeBase empower members to take preventive and proactive steps to managing their own health. The Healthwise Knowledgebase (English and Spanish) meets the needs of our members, from those managing chronic conditions to those seeking better ways to maintain good health. The KnowledgeBase includes the breadth and depth of health content people need as they work independently or with their physicians to make wise health decisions. Members can easily find information by selecting from 6,000 topics, including:

- Understanding their symptoms
- Health conditions and diseases
- Health and wellness
- Medical tests
- Surgical and other treatment procedures
- Prescriptions, over-the-counter medications, and nutritional supplements
- Complementary and alternative medicine
- Self-help and support group information

Through the use of technology, members can connect with resources that will assist them in learning to self-manage, empowering the member to take charge of their health and wellness. 

Increasing Self-Management with Online Peer Support

Amerigroup will enable members increased personal responsibility and self-management by providing an online peer support tool to help members manage their chronic conditions. 

Amerigroup will provide an online peer support tool to help members manage their chronic conditions. We will partner with an external vendor specializing in the development of social networking tools to provide members with virtual peer support. This innovative program uses a social networking platform that connects members to peer support and behavior change professionals for help in managing chronic and behavioral health conditions. Members may participate in group chat, online meetings, and expert discussions.

The program leverages gaming and online social networking techniques to build online peer support communities and behavioral modification programs. Programs treat a range of substance use disorders and behavioral conditions, including depression, anxiety, eating disorders, gambling, smoking cessation and obesity. Delivered through a secure, HIPAA-compliant online and mobile platform, the program will provide members access to integrated, condition-specific social health communities that offer emotional check-ins, evidence-based tools, and game mechanics to help them manage their own care and sustain positive behavior change.

Improving Outcomes for Women and Babies with Taking Care of Baby and Me® Program

Our *Taking Care of Baby and Me* program builds an array of services around the pregnant woman and her newborn to provide the best opportunity to have a healthy baby and to be a successful mom. From the time we know she is pregnant through the birth of the child and the postpartum period, Amerigroup supports the woman in each major stage, helping her achieve a healthy outcome. For Amerigroup, this objective is not about the business of health care or managed care, but about our passion for helping people—it is personal.

Amerigroup’s *Taking Care of Baby and Me* program provides a number of supports, services, resources, and incentives to engage our members who are pregnant or have newborns in their health care and motivate long-lasting health behaviors. These include but are not limited to the following:

- Prenatal incentive packet
- SafeLink phones
- Text4baby
- Smoking Cessation
- Prior Preterm Pregnancy
- CenteringPregnancy®
- Nurse-Family Partnership®
- Postpartum Support, including appointment reminders, outreach, and the use of two-way communication technology
- Substance Use Disorders during Pregnancy
- Post-traumatic Stress Disorder program for women who have newborns in the neonatal intensive care unit (NICU)
- OB Provider Profile

Connecting with Members through Social Media

Amerigroup strives to meet members where they are, and as they become more mobile, so do we. We offer our Bayou Health members applications for cell phones and Internet communities such as Twitter community access, Facebook community access, and YouTube community meeting space to interact with us, other members, and those who share similar needs and stories. We are excited to welcome members to our social communities where they will access a daily dose of health and wellness information, as well as share their thoughts about good health.

Health. Join In. on Twitter. We have a Twitter handle ([@HealthJoinIn](#)) with more than 50,000 followers getting motivated and motivating each other with daily health and wellness content, including “fitspiration,” articles, videos, photos, and real-time advice, as well as diet, exercise, emotional health, and wellness tips. Our Twitter page is more than just a place to get answers; it is a two-way conversation where we are providing members with the following:

REDUCING PREGNANCY-RELATED RISKS

When her provider notified us that Elizabeth was pregnant, case management began urgent outreach. She had lost her first child pre-term at 25 weeks. First, our OB case manager contacted her to discuss our *Taking Care of Baby and Me* program and the services and supports available to her, including our 17-Hydroxyprogesterone caproate program that promotes full-term pregnancies.

To avoid a third hospitalization for pre-term labor, Elizabeth enrolled in the *Taking Care of Baby and Me* program and began her medication protocol. She also received intensive education on prenatal and postpartum care, including nutrition, bed rest, medication adherence, selecting a pediatrician for her baby, and what to expect with a newborn. Elizabeth carried to full-term and now she and her healthy baby continue to receive support from our postpartum case manager. 🌸

REAL STORIES

- Tips and information to get the most out of their health benefits
- Simple self-service solutions
- Valuable offers and more

Health. Join In. on Facebook. We have expanded our presence on Facebook (facebook.com/HealthJoinIn) with a community of more than 500,000 who meet to motivate and inspire each other to get healthy and stay healthy. Our Facebook community features dynamic content, including fitness challenges, videos, and real-time inspiration, diet, exercise, and wellness tips.

Health. Join In. on YouTube. We developed a brand channel on YouTube (youtube.com/HealthJoinIn) to create a viral community around health and wellness. The YouTube channel houses content, including our Real Health videos, HIX content, health and wellness stories and tips, and past campaigns such as the five-day Boost series. The channel also incorporates videos showcasing our internal employees in a “Meet Anthem” campaign, as well as NBC health education videos. Users can subscribe to the channel and receive updates as new videos are posted. To date, we have had more than seven million video views.

Health. Join In. on Pinterest. Our Health. Join In. Pinterest channel engages our community through healthy pins, motivational content, DIY ideas, and inspiration to eat well, exercise more, and stress less.

Examples of Strategies that Influence Member Behavior from Other Amerigroup Medicaid/CHIP Managed Care Contracts

The following strategies are successfully functioning in Amerigroup affiliate health plans across the country and will be implemented in our Louisiana Bayou Health program.

Alegis Care

Alegis Care is a premier health services management organization dedicated to serving the diverse needs of patients, health plans, and health care systems in individuals' residences, assisted living facilities, and independent living facilities where they are most comfortable. As part of our efforts to ensure women with newborns participate in postpartum care, our health plan affiliate in Maryland contracted with Alegis Home Physicians (Home Physicians) to provide in-home postpartum visits for women who find it difficult to attend their visits.

Through this program, Amerigroup supplies providers with a list of enrolled members from their panel to contact by phone or mail to initiate the process of the comprehensive assessment and on-going well checks. The member list is provided on a monthly basis and includes the member's name, address, and contact information. During the first appointment, providers conduct a face-to-face comprehensive assessment in the member's environment such as the home, group setting, or nursing home. The assessment will identify the member's biopsychosocial needs, including physiological, behavioral, functional, and environmental strengths, needs, and conditions in compliance with HEDIS and other quality measures. The Home Physician will also collect information on the

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Alegis Care is a premier health services management organization dedicated to serving the diverse needs of patients, health plans and healthcare systems in individuals' residences, assisted living facilities, and independent living facilities where they are most comfortable. As part of our efforts to ensure women with newborns participate in post partum care — our health plan affiliate in Maryland contracted with Alegis Home Physicians to provide in-home post partum visits for women who find it difficult to attend their visits. ♣

member's medical history, medications, diet, and caregiver dynamics, as well as conduct a full physical. The provider documents assessment results in the member's electronic health record (EHR), transmits the information to Amerigroup, and submits encounters with applicable diagnostic codes. Clinical information from the assessment is shared with the member's integrated care team to inform and support the member's care plan.

Women who participated in Warm Health attended **30 percent more** prenatal care visits than other pregnant women. 

Amerigroup Maryland has realized improved HEDIS rates for postpartum follow-up visits, which support the implementation of this program for the Louisiana Bayou Health program.

Warm Health™

Warm Health is a health education and screening service provided by Altegra, our vendor partner that supports the provision of health education to members who are pregnant. Warm Health outreach and communications are tailored to the needs of the member and stage of pregnancy and delivered through telephone calls, text messaging, smartphone applications, and secure and confidential warm websites where the member can chat live with a Nurse Case Manager or send an alert to their assigned Nurse Case Manager for follow-up the following day. Members select the modality of preference and receive outreach twice weekly during the prenatal phase, weekly during the postpartum period, and weekly for well-child messaging for up to three months after delivery.

Clinic Days

Our affiliate health plans partner with physicians, health departments, and other primary care delivery sites to hold clinic days where members obtain timely preventive services, screenings, and diagnostic tests to close identified gaps in care. In partnership with network providers, the plan hosts a series of Clinic Days for Care Connect members who have not received immunizations, other preventive services, or postpartum care or who are due for diabetes or other chronic condition care. Members are directed to the office of the provider identified as their PCP. The plan coordinates transportation for members, as needed, and members may be eligible for related Healthy Rewards incentives. For our affiliate health plan, clinic days are an effective way to help make sure members receive necessary preventive services and screenings to maintain health or avoid exacerbation of chronic conditions.

Amerigroup is committed to collaborating with the public health department to identify, prevent, and address community health care issues. 

Strategies for Working with the Louisiana Office of Public Health

Under the direction of our Chief Executive Officer (CEO), Amerigroup has established a strong relationship with the Louisiana Office of Public Health (OPH). We are committed to collaborating with OPH to identify, prevent, and address health care issues such as lack of health literacy, homelessness, poor birth outcomes, and obesity. We work hand-in-hand with OPH and system partners to

provide leadership and resources to meet the needs of the community.

We recognize that our members are frequently impacted by one or more of the services and programs operated by DHH departments on a daily basis. We will continue our relationships with key staff from these departments to develop, integrate, and coordinate efforts to promote member health and well-being, improve outcomes, and reduce duplication and costs associated with us operating independently.

Departments we collaborate with include:

- Office of Community and Preventive Health
- Office of Emergency Preparedness
- Office of Environmental Health
- Office of Food Inspections
- Office of Vital Records
- Office of Primary Care and Rural Health

We work to identify common needs, duplication of programs, and how we can educate our members, providers, and health plan staff on the availability and referral processes for these programs. Amerigroup sits at the same table with OPH to address issues that impact all of us. This includes improving our processes for:

- Leveraging existing State programs rather than duplicating efforts
- Connecting our members to the State-based programs and agencies that support and/or provide interventions for members with specialized health care needs
- Sharing of information in a timely and accurate manner
- Identifying opportunities for program improvement based on access barriers and gaps in care
- Complying with State, federal, and Contractual laws requirements

Amerigroup has effectively partnered with OPH to support programs that improve the health of our members and the communities we serve. Our collaborative efforts include:

Best Babies Zone

Best Babies Zone has been a valued partner since 2012 and we have diligently supported its efforts to give each family a chance for improved health and quality of life.

Best Babies Zone Hollygrove is one of three pilot cities where a lead agency convenes partners from the health, education, community, and health care sectors to improve birth outcomes, remove environmental stressors, and undo the social determinants of health through collective impact. These partnerships result in the development of programs driven by the community's needs such as the Mom2Mom group, designed to improve peer support among mothers; the HiSet Test Prep and Coaching program, focusing on literacy, providing individuals with a high school equivalency degree, and supporting workforce entry/re-entry; and environmental testing to determine if any major environmental media (air, soil) is compromising the health of residents.

We envision healthy families who are empowered, independent, and supported by a strong network of partnering agencies. As such, we sincerely appreciate Amerigroup's commitment to the reduction in disease burden among New Orleans most vulnerable. 🌿

— Robin Gruenfeld
Best Babies Zone Program Lead

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Centering Louisiana Strong Start: Improving Maternal Health Outcomes and Reducing Preterm Births in Louisiana

Amerigroup was instrumental in applying for and receiving the CenteringPregnancy grant in the State of Louisiana. Through CenteringPregnancy, we support a small group intervention model of care that supports information sharing and promotes understanding through shared experience. Amerigroup identifies existing CenteringPregnancy sites in our network and provides education to members of their availability.

CenteringPregnancy is a multifaceted model of group care that integrates the three major components of care: health assessment, education, and support. The model uses a group setting to maximize the opportunity to educate women and to help them learn from each other and their shared experience. Small groups of eight to 12 women with similar gestational ages meet with the provider, learn care skills, and participate in facilitated discussions. The group-learning facilitates not only broader learning opportunities, but also creates a support network for the woman with other group members. Each group meets for 10 sessions throughout pregnancy and early postpartum periods.

Louisiana Health Assessment Referral and Treatment (LaHART)

Amerigroup fully supports the LaHART initiative, which is a web-based tool for prenatal behavioral health screens. Providers can use the screen at any time during prenatal care to assess tobacco, alcohol, and substance use, as well as domestic violence. The referral component of the screen encompasses tobacco cessation services provided through the tobacco quit line, alcohol and drug treatment services provided through Magellan, and domestic violence assistance provided through local organizations. Amerigroup supports the use of this tool and the vision of all babies being free of prenatal exposure to alcohol, tobacco, and other drugs and of all mothers in need being referred to appropriate health care resources and treatment facilities.

Greater New Orleans Immunization Network

Amerigroup actively participates in this program, working with the Immunization Bus to provide members and the community with information on Early Periodic Screening, Diagnostic, and Treatment (EPSDT); healthy eating; and exercise. This partnership gives us the opportunity to promote health and wellness in the communities we serve.

Amerigroup Collaboration with Public Health Departments across the Country

Amerigroup and our affiliate plans partner with 189 public health departments across the country. We recognize that public health departments, along with other system partners, fill a critical gap in access to care, and we are proud of our record of successful partnerships throughout the states in which Amerigroup and our affiliate health plans serve members. As we do in Louisiana, we collaborate with public health departments across the country in a variety of ways, including the examples outlined below.

Amerigroup and our
affiliate plans partner with
**189 public health
departments**
across the country. 

Member Outreach and Education

In many states, including Louisiana, we partner with WIC programs and are featured speakers in their new member education classes on how to access health care. In addition to our own member outreach programs, we provide financial support to many public health departments for community-wide events that increase the overall health and well-being of individuals living in that community.

Nurse-Family Partnership®

Amerigroup collaborates with the Nurse-Family Partnership (NFP) in our health plans across the country. As a result of these collaborations, we offer our members additional support through pregnancy and the infant years. Through the NFP, Public Health Nurses visit low-income pregnant women in communities at risk during their pregnancy and until the baby is 2 years old. The program offers additional support and resources for the new mom and helps her transition to the community after having a baby. Nurses teach parenting and life skills and help new moms gain access to job training and educational programs. The nurse becomes an essential resource for the woman by offering her knowledgeable guidance and resources to assist her in the community.

In 2006, a special report by the Robert Wood Johnson Foundation reported on a 15-year follow-up evaluation of the long-term effects of the NFP. The report showed that *nurse visits benefitted mothers and children in the following ways*:

- 56 percent fewer doctor and hospital visits due to childhood injuries through age 2
- 25 percent reduction in smoking by mothers during their pregnancy
- 48 percent less child abuse and neglect through age 15
- 69 percent less criminal convictions among the children at age 15
- 83 percent increase in workforce participation by low-income unmarried mothers by the time the child was 4 years old

Preventive and Screening Services

Public health departments provide a variety of preventive and screening services, including well-child exams, evaluation and management visits, immunizations, school-based services, and preventive screenings. Amerigroup and our affiliate plans meet regularly with representatives from local health departments to share information and develop creative solutions for working together to promote health and wellness in each community we serve. The plans also develop agreements with public health departments to provide reimbursement for Medicaid covered services.

Program Development and Implementation

Amerigroup and our affiliate plans work collaboratively with public health departments when implementing Medicaid programs. We form steering committees, bringing these key partners to the table to identify health issues and develop creative solutions and programs to meet the unique needs of each community.

Data Sharing

We recognize that public health departments may have data and information valuable to our ability to deliver medical coordination services to our members. In many states, we collaborate with public health to share information related to member health through registries and public health reporting initiatives.

Vaccines for Children Program

We encourage PCPs to enroll in the public health department Vaccines for Children Program. We assist providers in enrolling in the program, report back to Public Health if providers experience difficulties accessing vaccines, and confirm that providers are reporting immunizations through public health immunization registries.

Strategies to Work with Faith-based and Community-based Organizations to Engage and Empower Members

The relationships and collaborations we have established with our community partners in Louisiana, both public and private, have opened many doors and presented multiple opportunities for member outreach and education. 

We collaborate with a range of faith-based and community-based organizations to provide health education materials and wellness, preventive, and specialized supports to engage members. Amerigroup encourages all individuals to seek and engage in care within their communities and through the services and encourages recipients and members to seek care within the same communities where they use traditional and essential Medicaid providers such as County Health Departments (CHDs), Federally Qualified Health Centers (FQHCs), Community-based Mental Health Centers (CMHCs), Rural Health Centers, and local school districts.

Amerigroup has achieved success in member education through our community partners, which is reflected in the summaries of events found throughout this section and the number of Louisiana citizens who attend these functions and benefit from the sponsorships to local community partners.

We have established a presence in the community through our feet-on-the-street efforts. We have been successful in using that presence as the foundation for our member education. The relationships and collaborations we have established with our community partners in Louisiana, both public and private, have opened many doors and presented multiple opportunities for member outreach and education.

Cortana Mall Partnership — Baton Rouge

In Baton Rouge, we worked with the Cortana Mall to access an empty storefront. This provided us with a neutral location to host outreach and education events, as well as an opportunity to build stronger ties with the community. At the Cortana Mall location, we hosted or partnered with other leading community organizations to host the following events:

- The Ultimate Baby Shower, in partnership with the March of Dimes, Woman’s Hospital and Family Services of Greater Baton Rouge, and Cortana Mall
- Breakfast with Santa, in partnership with Cortana Mall
- Town hall and member meetings
- Early Bird Back-to-School, in partnership with Lexlee’s Kid’s and Cortana Mall
- Weekly meetings of the Big Buddies Program of Baton Rouge

Catholic Charities Head Start Program

We provided sponsorship and worked closely with the Catholic Charities Head Start Program, in which Amerigroup supported 387 students last year at five Head Start locations. This partnership allowed Amerigroup to strengthen the academic service for Louisiana children; provide items that enhance the

fitness program such as footballs, basketballs, and jump ropes; and provide a needed resource for the parents to enhance the students' health. We have provided resources to attend the Head Start monthly parent meetings; these monthly parent meetings encourage parent participation in school life and stress the vital role that parents play in their children's lives. By partnering with Head Start, we can engage members and families in health and wellness activities.

Healthy Start New Orleans

Amerigroup has partnered with Healthy Start New Orleans, a community-based agency committed to structuring the community through health care, education, and socioeconomic assistance and opportunities that avert negative birth outcomes and promote healthy families and communities. Healthy Start New Orleans is open to residents of the Greater New Orleans parishes who are pregnant or have an infant/toddler under the age of 2 years. We have supported Healthy Start New Orleans community health events and sponsored nutritional food supplements and appropriate incentive items. Our support has allowed Healthy Starts New Orleans to successfully host many health events that outreach and engage members in the local communities we serve.

Big Buddy Program of Baton Rouge

Through this partnership, we have been able to promote healthy habits for youth and support the efforts of impacting youth through mentoring, extended learning opportunities, and workforce development. The Big Buddy Program has been able to use the storefront at Cortana Mall, which provides a stable place to conduct mentor training, staff training, special parent activities, and group meetings.

Lexlee's Kids

Lexlee's Kids is well known and respected in the community and has many opportunities *to keep kids safe and healthy*. We worked with this organization in 2013 to:

- Inspect 471 car seats
- Distribute 211 car seats to families in need
- Deliver 85 teen driver safety and alcohol prevention programs (reaching 2,810 teens)
- Deliver 49 school-based gun safety programs
- Participate in 86 community events and reach approximately 26,131 individuals
- Organize 10 bike and pedestrian safety activities (distributing 15 bikes and 786 bicycle helmets)

Amerigroup's partnership with this organization has allowed us opportunities to improve the lives and health of the children and families they serve.

Liga de Veteranos Renato Varela (Veterans Renato Varela Soccer League)

This partnership allowed us the opportunity to support a Healthy Choices campaign by building a youth soccer field for young players. While our donation helped fund the field, we didn't stop there—this field allows our representatives to actively participate in the activities held at this field. The objective

Lexlee's Kids is well known and respected in the community and has many opportunities to keep kids safe and healthy while placing a spotlight on Amerigroup and all the wonderful community services provided by our agencies as a team. The partnership experienced thus far has been amazing, and we look forward to a bright future.

— Crystal Pichon
Executive Director, Lexlee's Kids

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of the field was to provide an outlet to underserved youth who enjoy soccer and want to make healthy choices by keeping fit and exercising while playing their favorite sport.

Cervantes Fundación Hispanoamericana de Arte, in the Greater New Orleans area

For the past two years we have assisted in sponsoring events such as the Que Pasa Fest, which celebrates Hispanic Heritage every October, and Christmas of Hope. These events help raise funds that benefit children. By supporting Cervantes, we have become an important component in their mission, which is to educate the non-Spanish-speaking community about the rich art and culture of the Latino people. These efforts have created positive relationships and educated us on the beliefs, values, and culture of our members who are Hispanic, thus reducing barriers and improving the delivery of culturally and linguistically competent services.

United Way of Northwest Louisiana Considers Amerigroup a Valuable Partner

Amerigroup is a loyal contributor, particularly to the 2012 and 2013 United Way community campaigns. We award Foundation grant dollars to support School-based Health Centers (SBCH) in the Cedar Grove neighborhood in Shreveport, Louisiana. With this help, they were able to serve three centers, comprised of 1,700 students, with over 7,000 visits. SBHCs provide a seamless delivery system for health education and services, promoting systemic change. The United Way of Northwest Louisiana works in the forefront with numerous partners, including Amerigroup, in the region to sustain critical programs while expanding services to the underserved populations: communities of color, people with disabilities, people living in poverty, and people with addictive or mental health disorders.

Homeless Outreach

We work with community organizations to help us locate our members who are homeless, since they will most likely know where they are “sheltering” themselves and their families. Gathering points can be a shelter, soup kitchen, Walmart, clinic, church, or school event. We will use these venues to reach members who are using these areas as temporary shelter during the day to meet with them and connect them to appropriate housing and health care resources. Amerigroup will continue to expand our relationships with organizations that serve homeless individuals such as shelters, soup kitchens, and faith-based organizations. For example, we have sponsored the annual Homeless Awareness Summit organized by the Central Louisiana Homeless Coalition in Alexandria, worked with the Bishop Ott Homeless Shelter (Baton Rouge), and actively participated in coalition meetings with HOPE for the Homeless in Shreveport. We are actively pursuing relationships with the Capital Area Alliance for the Homeless and the Acadiana Regional Coalition on Homelessness to further increase our reach.

NO/AIDS Task Force

Amerigroup Louisiana has been a valued partner of this organization during the last several years, assisting members with health care needs. When NO/AIDS reached out to the five Bayou Health Plans after the State discontinued the HIV case management waiver program, Amerigroup was the only health plan to respond. We hosted several meetings to establish a seamless transition for the HIV case management component of their health insurance plan for our members. In addition, Amerigroup has been a sponsor in the NO/AIDS Task Force’s annual Empowerment Conference for the past two years an annual all-day educational conference for individuals living with HIV, with over 400 individuals attending the conference each year. Through our collaborations with faith-based and community organizations, Amerigroup reaches into the communities we serve to support our members and the community at large to adopt healthier lifestyles and appropriately access health care services.

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