

## SECTION K – CASE MANAGEMENT

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

### Approach to Case Management

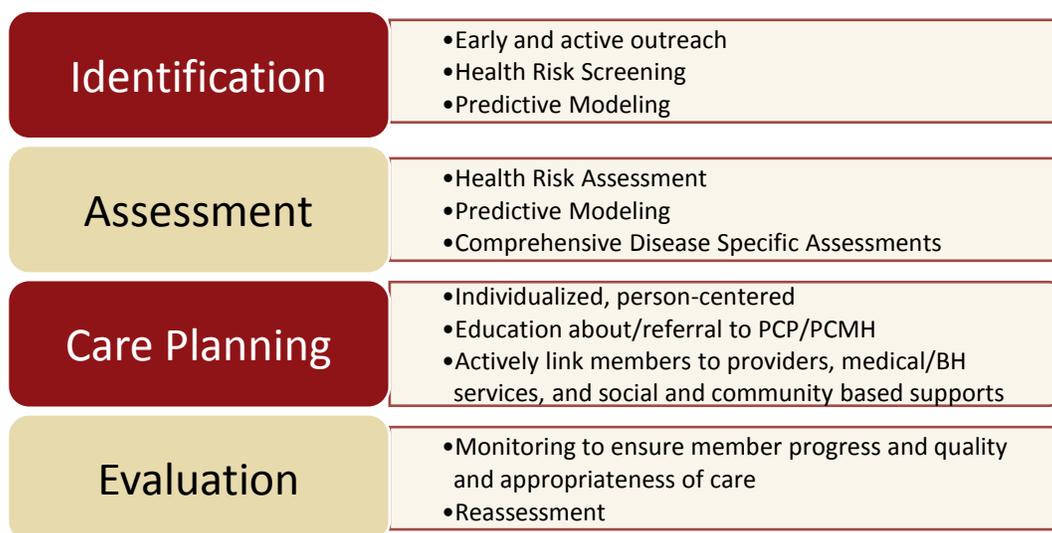
Louisiana Health Care Connections (LHCC) currently manages care for approximately 150,000 Bayou Health members. Our experience in managing care for members of all ages, across the continuum of care, covers a wide range of needs, conditions and situations such as high-risk pregnancy, neonatal intensive care unit (NICU) babies, trauma, acute conditions, transplants, physical disabilities, other chronic and complex conditions, and preventive care for adults and children.

Through our Case Management (CM) Program, we coordinate all covered and non-covered services the Member receives to create a system of care

around each Member. This includes social and other non-clinical services that have an impact on clinical outcomes. Our CM Model places the Member at the center of an integrated care team comprised of Case Management staff (nurses, social workers, BH clinicians, and non-clinical personnel); the PCP/medical home, treating providers, caregivers and informal supports, and community providers; as well as the Statewide Management Organization (SMO) for individuals with specialty BH needs.

**Program Components.** Our CM Program ensures and promotes timely access to and delivery of appropriate and medically-related services, social services, and basic behavioral health services; and coordination and integration of all care the Member requires. We accomplish this through a process that consists of member-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. These high-level steps include the following:

**The total number of ER visits within 90 days of members engaged in our Case Management Program decreased by 62% from 2012 to 2013.**



Case Management staff identify, plan, obtain and monitor all services for identified members who are high risk or have unique, chronic, or complex needs. Case Management staff use a process that integrates the member's and Case Manager's review of member strengths and needs, resulting in a mutually agreed upon, appropriate plan that meets the member's medical, functional, social and BH needs.

**Multidisciplinary Approach For Holistic Care.** Case Management staff carry out responsibilities and activities within a multidisciplinary team model, recognizing that the Bayou Health population includes individuals with multiple chronic conditions as well as medical, BH, and social needs. Our Integrated Care Teams (IC Teams) include the following Case Management staff:

- Registered Nurse and BH clinician *Case Managers*
- Licensed and non-licensed social worker *Program Specialists*
- Unlicensed, non-clinical support staff *Program Coordinators*
- Clinical *Health Coaches* (licensed respiratory therapist, certified diabetes educator, registered dietician, exercise physiologist).

We staff our IC Teams to reflect the needs of each member, and base the team lead assignment on the member's primary need for Case Management. Each team member provides input and recommendations based on their expertise and background, with the team lead acting as the single point of accountability and contact for the Member and caregivers. Our integrated approach allows non-medical personnel to perform non-clinical coordination and clerical functions, and permits the licensed professional staff to focus on complex and clinical needs. For example, our community outreach workers (MemberConnections™ Representatives - MCRs) connect members to services in the community and assist with outreach and education. Hired from within the communities they serve, MCRs provide culturally competent assistance, including in person outreach to high risk members we cannot reach by phone or who require more intensive assistance.

**High Touch Approach.** We attribute much of our Case Management Program's success to our local approach and focus on in-person Member contact. We have located Case Management staff onsite with providers, such as Affinity Health Group (a large group practice in Monroe) and at the David Raines Community Health Center in Shreveport, which has allowed us to provide in-person case management to our members who receive services from these providers.

We have applied lessons learned from the earlier location of Case Management staff onsite at two FQHCs in New Orleans to develop education for our provider partners regarding roles and appropriate responsibilities for our onsite Case Management staff. We are working with Affinity to enhance the clinical integration of our Chronic Care Management Program (CCMP) services with their primary care services. We are also discussing placement of onsite staff with our **two largest provider practices in Lake Charles**. Locating staff throughout the state facilitates in-person and more culturally-competent member and provider interaction, as well as providing local jobs. We are increasing our field-based Case Management staff, including locating staff onsite at additional **high-volume pediatric practices**; and hiring Case Managers who will work from home and conduct outreach, education, assessment, and other activities in person with members who live in their area. This field-based approach will improve our ability to serve members in rural areas, particularly the voluntary opt-in population and others with significant service needs.

*2012 to 2013, our Start Smart For Your Baby pregnancy and perinatal management program achieved the following improvements:*

- 83.1 % increase in NOPs received (29.31% to 53.67%) 2012 to 2013
- 7.9% decrease in preterm birth rate (<37 weeks) (15.35% to 14.13%) 2012 to 2013
- 32.9% decrease in NICU admission rate (6.24% to 4.19%) From 2012 to 2013
- 35.2% decrease in NICU days per 1000 births (879 to 565) 2012 to 2013.
- 8.1% decrease in low birth weight births (< 2500 g) (13.31% of births CY2012 to 12.23% CY2013)

Our concurrent review nurses (CRNs), located onsite at 17 network hospitals, improves our ability to identify and participate in discharge planning for inpatient members. We are working to expand onsite CRNs at five additional hospitals. To support the efforts of our other in-field staff, our MCRs provide intensive, one-on-one education and assistance to members in their homes and community locations such as provider offices.

**Targeting Top Care Opportunities.** Another successful aspect of our Case Management Program is the targeted approach we use to direct CM Program resources to address top care opportunities. For example, we developed our Emergency Department (ED) Diversion Program to target our top ED utilizers and practices with the highest ED utilization for outreach, education, and assistance identifying and addressing root causes. Average ED visits per member in the 90 days before (Q3 2013) and after (Q4 2013) members received interventions through the program fell from 5.21 to 2.54 visits per member. We are in the process of adding clinical BH staff to enhance our ability to manage care for members with BH needs, including members that require co-management with the SMO.

In addition, we dedicate Case Management resources to identify subsets of members with special needs. For example, we hired a Case Manager with over ten years of experience with state long term services and supports programs to manage members who receive those services. This Case Manager is also assisting with training other Case Management staff on these services. We have developed additional programs and dedicated CM Program resources to address specific subsets of our enrolled population, which represent key opportunities for improving care and outcomes. These programs are described below in Table B.

**• Characteristics of members that you will target for case management services;**

LHCC has established identification criteria, processes, and triggers for referral and admission into our CM Program to ensure we identify all members who may benefit from Case Management services, particularly those with special health care needs. Once we identify members who could be potential candidates for case management, we contact them and offer to enroll them in our CM Program. Characteristics of members we target for Case Management include, but are not limited to members who:

- Have special healthcare needs and/or disabilities
- Have catastrophic, high-cost, or high-risk conditions
- Have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure appropriate services and care
- Have been non-compliant in less intensive programs
- Are frail, elderly, or at the end of life
- Have a high-risk pregnancy and/or are a reproductive-age women with a history of prior poor birth outcomes.

A sample of criteria we use to identify members for the CM Program is shown in the table below.

TABLE A: Selected Criteria for Case Management	
<ul style="list-style-type: none"> <li>• Impact Pro risk score of &gt;7</li> <li>• 3+ inpatient admissions within the last 6 months for same/similar diagnosis</li> <li>• 3+ ED visits in the last 3 months</li> <li>• Chronic or non-healing wounds/Stage 3</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple co-morbidities that require 3 or more specialists</li> <li>• Diabetes with Lower Extremity episode/complication or HgbA1c &gt;7</li> <li>• High risk pregnancy (including those who need</li> </ul>

<b>TABLE A: Selected Criteria for Case Management</b>	
burns requiring extensive wound care or skin grafts	17-P)
<ul style="list-style-type: none"> <li>• Requires life sustaining device such as ventilator, tracheostomy, oxygen, CPAP/BIPAP, tracheostomy care or suctioning</li> <li>• TPN or continuous tube feedings</li> <li>• Recent functional decline within 90 days</li> <li>• Private Duty Nursing</li> <li>• Skilled Nursing Visits &gt;3 visits/week</li> </ul>	<ul style="list-style-type: none"> <li>• Post-transplant within 6 months</li> <li>• NICU with LOS &gt;7 days</li> <li>• Catastrophic illness or injury, e.g. transplants, HIV/AIDS, cancer, serious motor vehicle accidents</li> <li>• End Stage Renal Disease</li> <li>• Dual diagnosis (members with serious, chronic behavioral health and physical health diagnoses)</li> </ul>

As described above, we dedicate Case Management resources to target top care opportunities. When we identify a member with any of the characteristics above, we look further to identify those with characteristics that align with one of our targeted Case Management programs, which are described in the table below.

<b>TABLE B: Case Management Programs Targeting Select Member Sub-Populations</b>
<p><b>ED Diversion Program</b></p> <p>The goal of our ED Diversion Program is to redirect members to appropriate levels of care to decrease inappropriate ED utilization. A specialized Integrated Care Team consisting of experienced RN Case Managers and Social Workers focuses on access to care issues and resource education. Interventions include linking the member to a PCP, educating them about and helping them to access transportation, and providing education on the importance of getting the right care, at the right time, in the right setting. Member Connections Representatives provide in-person visits and education for members who need intensive assistance. In 2014, we expanded on the success of this program by allocating additional staff resources to increase assessment of members who are high ED utilizers. We will continue to target our top 75 practices each quarter whose assigned members have the highest ED utilization. We also provide education and incentives to providers, such as incentives for serving as a Patient Centered Medical Home.</p>
<p><b>Perinatal/NICU Management Program</b></p> <p>Our Start Smart for Baby® pregnancy management program emphasizes early identification and stratification of pregnant members, and education and Case Management interventions to improve birth outcomes for all pregnant members. The program includes:</p> <ul style="list-style-type: none"> <li>• Early identification of pregnancy</li> <li>• Risk screening and stratification to determine appropriate interventions</li> <li>• Member outreach and education</li> <li>• Member incentives for accessing prenatal and post-partum care</li> <li>• A 17P program that may include home visits</li> <li>• Specialized management of pregnant members with depression or substance use disorder</li> <li>• NICU management and follow up</li> <li>• Provider education and incentives for improving birth outcomes and access to appropriate prenatal and post-partum care</li> </ul> <p>It also includes high risk OB management for reproductive age women with a history of poor birth outcomes and those with high risk pregnancies. Start Smart staff assist members, in person when necessary, to gain access to prenatal care, provide education on their healthcare needs, assist with social needs and concerns, and coordinate referrals to appropriate specialists and non-covered services, such as specialty BH services and dental services, and community resources. The program extends through the postpartum</p>

**TABLE B: Case Management Programs Targeting Select Member Sub-Populations**

period to improve maternal outcomes and prevent risk in subsequent pregnancies, and extends through the first year of life for LHCC-enrolled babies.

Our Start Smart Program is modeled on our parent company Centene’s award-winning program, was named a best practice by NCQA in 2009. The program received the 2010 URAC/ Global Knowledge Exchange Network International Health Promotion Award, and a Platinum Award for Consumer Empowerment at the URAC Quality Summit. In 2014, Start Smart received a Case In Point Platinum Award honorable mention.

**Sickle Cell Management Program**

We are enhancing our Sickle Cell Management Program to incorporate population health components and transition to a formalized, evidence-based Chronic Care Management Program that addresses quality of life issues, such as pain, which are a primary cause of clinical decline. The program provides educational materials, offers Case Management and Care Coordination services, and promotes use of, and adherence to, hydroxyurea (a medication used to reduce sickle cell crisis caused by painful events, acute chest syndrome, and anemia).

We will offer the program to all members with sickle cell disease, and prioritize outreach for program enrollment to those with ED visits for a chief complaint of pain and multiple readmissions related to hydration issues. The Case Manager works with the member and treating providers to develop a care plan that addresses physical, psychological, social, and environmental needs, goals, and interventions. Case Managers provide education on key areas such as hydration and safety. The care plan also incorporates a pain management plan that outlines how the member can appropriately manage their pain at home and includes pre-defined thresholds for the use of opioids and guidelines for when they should contact their provider.

**Hemophilia Management Program**

LHCC is testing and developing a program for members with hemophilia and Von Willebrand disease. While hemophilia is low in prevalence, the timely and appropriate use of clotting factors and other medications is critical to these members’ health and quality of life. Case Management can be provided two ways: in partnership with our specialty pharmacy affiliate AcariaHealth, or by using in-house Case Management and Pharmacy staff. For members who choose AcariaHealth as their medication supplier, Case Managers will inform them of AcariaHealth’s care management program, which uses Registered Nurses and Pharmacists who evaluate severity levels, health literacy, risk factors, dosing, and other criteria using the National Hemophilia Foundation’s Medical and Scientific Advisory Committee guidelines. LHCC’s case management program will be similarly structured. *Use of LHCC’s Case Management Program and/or AcariaHealth’s program is not required, and left to the choice of the member and provider.* LHCC will identify potential Program candidates via analysis of claims data (for claims with diagnosis code related to hemophilia), and initial and ongoing assessment of members in Case Management.

Our Case Management staff assist members in navigating the complexities of their treatment plan, including condition specific education, assistance with reimbursement issues, home care needs and care coordination. For applicable members, AcariaHealth provides hemophilia specialty medications along with 24/7 pharmacist support. AcariaHealth also provides information regarding support networks, and any additional tools necessary for the member to best cope with and managing their health. LHCC and AcariaHealth both link members to information and support provided through community and national organizations, such as local Hemophilia Chapters, the National Hemophilia Foundation, and Hemophilia Family Association.

Members with hemophilia are presented at LHCC Case Management rounds, during which Case Management staff, with participation, as appropriate, by AcariaHealth staff, discuss medical and claims history, and evaluate total pharmacy expenditures, hemophilia only pharmacy expenditures, inpatient and

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ED utilization, and level of engagement with treating providers. LHCC and AcariaHealth staff provide recommendations aimed at improving patient outcomes, and decreasing inpatient and ED utilization.
<b>Transplant Management</b>
Designated Case Management staff manage and coordinate care and access to transplant centers of excellence for members who need transplants through our specialized Transplant Case Management Program. Program staff work closely with appropriate providers to obtain necessary clinical information and required lab work to facilitate timely evaluation of transplant candidates, assist in processing prior authorization (PA) requests for transplant services, assist Members in coordinating needed care and transportation and lodging for out-of-town evaluations or procedures, and follow Members for up to 12 months post-transplant.
<b>Community Paramedicine Program</b>
LHCC is working with Acadian Ambulance to implement a Community Paramedicine Program for members with asthma who are 21 years old and under and live in the New Orleans area. The program will provide real time support from a paramedic, including triage, home assessment, and appropriate redirection for this targeted group of members, with a goal of decreasing unnecessary emergency department visits and inpatient stays. If the program is successful in decreasing unnecessary ED visits and inpatient admissions/readmissions for the target population, we will evaluate the feasibility of expanding the program as part of our strategy to monitor post-discharge care in remote areas.
<b>Pain Management Program</b>
We are expanding our current Low Back Pain Program to address other types of chronic pain, including but not limited to members with sickle cell disease and those with five or more ED visits in a 12-month period for a chief complaint of pain. In addition to Exercise Physiologists that currently focus on low back pain, the expanded Pain Management Program will use Health Coaches as well as Case Managers and Program Specialists who will be trained and certified in pain management. These staff will work with the member, PCP, treating providers, and, as applicable, ED staff to develop, implement, and monitor a pain management plan.
<b>Palliative Care and Hospice Program</b>
<p>We are developing a Palliative Care and Hospice Program to serve members with cancer and other advanced chronic and debilitating illnesses with indicators of persistent challenges with pain and symptom management, as identified by such factors as pharmacy and ED use. Our IC Team for this program will include an RN Case Manager, who is certified through the National Board for Certification of Hospice and Palliative Nurses; as well as a Program Specialist and Program Coordinator to assist with non-medical and non-clinical needs.</p> <p>IC Team staff will work with the member and treating providers (and family/guardian as appropriate) to develop and monitor a Care Plan that meets the member’s health and psychosocial needs, recognizing the critical role of family/caregivers in supporting the member’s psychosocial wellness. IC Team staff will leverage the expertise of our BH Medical Director and BH Case Managers in addressing behavioral health issues, such as when the receipt of stressful and difficult information or the need for end-of-life decision making triggers challenging family dynamics. Case Managers will make referrals for and incorporate hospice services into the care plan as appropriate.</p> <p>Through our Centene affiliate and national leader in physician house call medicine, US Medical Management, we will provide home-based physician services when appropriate, such as evaluation and</p>

**TABLE B: Case Management Programs Targeting Select Member Sub-Populations**

management of the medical condition and pain, and the discussion of treatment goals, including advance care planning or hospice. We also will provide and educate providers about guidelines from the National Hospice and Palliative Care Organization in the Provider Manual and on our Provider Portal. Program staff will inform providers of the guidelines when coordinating with the provider in developing and monitoring the member’s Care Plan. LHCC will become a member of the Louisiana-Mississippi Hospice and Palliative Care Organization to leverage resources for staff training and member education, as well as to stay current on recommended practices and local support resources for members.

**Pharmacy Lock-In Program**

Our Pharmacy Lock-In Program will use DHH approved policies and procedures to ensure appropriate use of Medicaid benefits and serve as an educational and monitoring parameter. Pharmacy staff will monitor claims data to identify signs of a consistent pattern of misuse or overuse, using the following criteria:

- Prescriptions written on a stolen, forged or altered prescription blank issued by a licensed prescriber
- Prescribed medications that do not correlate with the member’s medical condition
- Member receives more than five therapeutic agents or three controlled substances per month
- Member receives duplicative therapy from different practitioners
- Member has filled prescriptions at more than two pharmacies per month or more than five pharmacies per year
- Member receives prescriptions from more than two prescribers per month
- Member has been seen in hospital Emergency Room more than two times per year
- Member has diagnosis of narcotic poisoning or drug abuse on file
- Number of prescriptions for controlled substance exceeds 10% of total number of prescriptions

Our Pharmacy Director and/or Medical Director will validate inappropriate use and determine whether to enroll the member in the Program. If the determination is positive, pharmacy staff will contact the member via certified letter to explain the decision and details about the program, including:

- The restriction to a designated pharmacy and/or prescriber(s).
- Sharing a list of at least three pharmacies from which the member may choose one for the Lock In program.
- The availability to obtain necessary drugs in an emergency, and to obtain a 72-hour emergency supply from a different pharmacy.
- The member’s right to appeal the decision and the process for doing so.

The Pharmacy Department will send a copy of the letter to the designated pharmacy, prescriber(s), and PCP. A Case Manager will attempt to contact the member to provide education about appropriate pharmacy utilization. If the member is pregnant, we will attempt to enroll her in our Perinatal SUD Management program, through which we will provide a BH Case Manager to coordinate care and support her recovery.

Pharmacy staff will review the member’s pharmacy claims at least annually from the original lock-in effective date to determine compliance and appropriate pharmacy utilization. Once the member is compliant for a period of four consecutive quarters, the Pharmacy Department will notify the member, PCP, and pharmacy via letter that the lock-in is being removed and the member is free to access any network pharmacy.

**Transition of Care (TOC) Program**

Through our TOC Program, our Concurrent Review Nurses (CRNs) and our dedicated Transition of Care Team (TOC Team) of RNs and a social worker, collaborate to handle care transitions, including inpatient care coordination and follow-up, for high-risk members, including those who require home care and other post-discharge services. CRNs work with facility staff, providers, and the member to coordinate care, ensure a safe discharge, and reduce readmission risk. TOC Team staff coordinate post-discharge authorizations and service initiation, follow up with the member after discharge, and monitor services

**TABLE B: Case Management Programs Targeting Select Member Sub-Populations**

during the transition period to ensure the member receives needed care, adheres to medication and treatment regimens, and avoids readmission or ED visits.

To expand our TOC Program capabilities further, we are adding BH clinicians to our Case Management staff, which will enable our TOC Program staff to access behavioral health expertise and support. A BH Case Manager will provide clinical input to CRNs and TOC Team staff, and coordinate with the Statewide Management Organization (SMO) for members with a BH admission.

We also are adding field-based Case Managers to increase our ability to provide in-person assessment and support to members, including but not limited to accompanying high risk members to post-discharge follow-up PCP visits when appropriate. Through our **Medication Therapy Management (MTM) Program**, we offer individualized medication review and counseling by a pharmacist.

**• How you assess member needs;**

Case Management (CM) and Utilization Management (UM) staff proactively identify members who may meet the above characteristics and criteria through ongoing review of sources such as the following:

**TABLE C: Selected Sources Used to Identify Members for Case Management**

<b>Enrollment, historical claims</b> , or other information from the state or another MCO reflecting existing and pending authorizations or any of the above criteria/characteristics
<b>Pharmacy data</b> from the state, another MCO, or LHCC to identify Members with prescriptions that indicate a chronic or complex condition
Our <b>Health Risk Screening</b> conducted with all new Members within 30 days of enrollment
Provider <b>requests for authorizations and referrals</b> , and <b>notification</b> of Members with special needs, such as those with existing or potential BH needs
<b>Predictive modeling and utilization data</b> indicating any of the above criteria/characteristics
Information from our <b>concurrent review nurses</b> onsite at network hospitals
<b>Phone or in-person contact from Members</b> or family/caregivers

Staff from NurseWise (our 24/7 nurse advice line) use our Health Risk Screening (HRS) tool to screen new members during a Welcome Call within 14 days of enrollment. LHCC provides tools and training to enable NurseWise to identify critical needs and urgent situations that require immediate referral to a Case Manager, such as signs and symptoms of preterm labor with admission to hospital, or a high risk pregnancy for which we do not have an NOP on file. NurseWise staff transmit information to LHCC via a daily report that Case and Utilization Management staff use to identify members for outreach and assessment and, as applicable, generate authorizations and outreach to providers of ongoing care.

**Prioritizing Outreach to Identified Members.** Case Management staff or an MCR phones identified Members to educate them about the CM Program and request participation, schedule an initial comprehensive assessment, and determine if the member wishes to have anyone else present during the assessment, such as informal or formal caregivers or other supports. To assist in prioritizing our outreach, they also validate the information used to identify the member, and attempt to complete a screening that

helps to further identify clinical history and needs that may not be available through claims data and predictive modeling. This includes, but is not limited to:

- Special needs such as developmental delay, severe orthopedic or persistent muscle tone abnormalities, seizure disorder, major chromosomal abnormalities
- Assistance needed with activities of daily living (e.g. bathing, toileting, dressing, ambulating); or instrumental activities of daily living (e.g. preparing meals, shopping, basic housekeeping), particularly when there is no support system
- Social or economic constraint such as lack of financial support; lack of social, family or significant other support; illiteracy or significant communication barriers; access to care issues; transportation; or abuse or suspected abuse.

• *How you identify these members;*

**Initial Assessment.** A Case Manager reviews information available on the member prior to contacting them to complete the assessment. We may conduct the assessment in person for members entering Case Management due to frequent inpatient admission, or if the member is considered high risk and telephonic outreach is unsuccessful. In-person assessment may be conducted at the member’s home, family/friend’s home, public place, or a doctor’s office.

In addition to information solicited through the assessment tools below and questions about member goals and preferences, our Case Manager attempts to identify the PCP and any treating providers, and obtains consent from the member to share information with all treating providers. The Case Manager contacts these providers to confirm the type, frequency and provider(s) of current care and services. In addition, the Case Manager attempts outreach to the member and/or authorized representative or guardian telephonically within one week for members identified as high priority to perform an in-depth assessment to more closely identify and prioritize the member’s individual needs.

Case Managers work with providers, and the member/representative, caregiver/family and other informal supports as desired by the member to complete a comprehensive assessment of functional, medical, BH, social and other needs. This includes, but is not limited to screening for domestic violence and assessing disease management education needs. We use the assessment process to identify the member’s goals and preferences; the types and level of support the member needs; and non-covered services needs such as BH, dental, or long term services and supports.

**Reassessment.** As described below under Development and Implementation of Individualized Care Plans, Case Managers regularly monitor members to determine whether services continue to meet needs, and to identify potential new or changed needs that trigger a reassessment. Triggers for reassessment include, but are not limited to, transitions in care settings, hospitalizations or ED visits, requests for

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**Mobile Flexibility/Support**

LHCC Case Management staff will use TruCare on the Go, our mobile-enabled, secure software which is totally integrated with our enterprise TruCare health management collaborative care platform. Using tablet technology, our Case Managers will use TruCare on the Go to facilitate interaction with the member, family, and caregivers, by showing them real-time information such as assessments, Care Plans, and other important data. TruCare on the Go is HIPAA-compliant, remote technology that will also allow our Case Managers to provide on-screen video education and conduct real-time assessments. This mobile technology will enable Case Managers to spend more time in the field, face-to-face with members, caregivers, and providers. Additionally, our TruScan system will allow our Case Manager to take photos of documents (such as documents in a provider’s medical chart for the member), tag them for the appropriate member record and then later, securely upload those documents to the member’s master record in TruCare.

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additional home care services, changes in medical condition, and requests from the member, caregiver, and/or provider. When we identify a trigger, and at least annually, the Case Manager completes a reassessment and revises the Care Plan following the same process as for initial Care Plan development.

**• How you encourage member participation;**

We use multiple methods to actively engage members in Case Management. Our Case Management staff make multiple attempts to engage the member, using a variety of methods. Should the member choose not to engage, our staff document the refusal and reasons in TruCare. We also require Case Management staff to track utilization for these members to identify additional opportunities to outreach and engage them in care.

Ultimately, we cannot force a member to engage, but we make every effort to understand and address the reasons for the refusal, and ensure the member knows they can change their minds at any time and how to contact us if this occurs.

**Best Practice Engagement Techniques.** LHCC trains our Case Management and outreach staff to use best practice techniques to effectively engage members. Engagement training topics include, but are not limited to the following:

<b>TABLE D: Selected Engagement Training Topics</b>	
<b>Member Engagement Skills</b>	How to effectively establish trust, credibility and rapport with each member. This helps open resistant or hesitant members to condition-management objectives and enables staff to recognize members interested in progressing.
<b>Motivational Interviewing</b>	How to take a partnership approach with members, using open-ended questions, affirmations, various types of reflections and summarizing to assess member attitudes about change and appropriate next steps.
<b>Positive Psychology</b>	Helps staff effectively provide feedback and help members provide feedback to themselves. Staff use this approach to help members focus on what they can control when dealing with a chronic disease or making lifestyle changes, and identify member strengths that may help them be more successful in managing their lives.

Our Case Managers use such techniques to educate, encourage and empower members to actively manage their own care and take responsibility for adherence. In addition, they educate members on strategies that support self-management and adherence, such as suggesting special pill containers so that members can easily distinguish multiple medications, and creating visual reminders. Case Managers also help members make the connection between effective self-management/adherence and reaching their goals, such as feeling better, getting a job, or maintaining important relationships.

Despite these techniques and interventions, member behaviors may change due to onset of depression, changes in their condition, or disease progression. Consequently, we educate members to be on the lookout for changes and to contact their Case Manager promptly should they occur. To address behavior changes as a result of a condition, Case Managers coordinate with treating providers to determine needed interventions or medication changes, and provide referral to the SMO for specialty BH services when

indicated. We also invite members to participate in our Depression Management Program when depression is a factor.

**Outreach Strategies.** Successfully engaging Members often requires repeated contact attempts using multiple strategies (written, telephonic, and in-person) and a strong method for tracking and documenting attempts and member contact information. Our Case Management staff go into the community to directly interface with members, a high-touch approach that helps us gain their trust and identify opportunities to engage them.

**“Meet Me Where I Am” Approach.** We meet members where they are both literally (their physical location in the community) and figuratively (their health literacy and willingness to take steps to manage their own health). MCRs are familiar with local organizations members trust, such as social services providers and churches, and can leverage their help in engaging members. MCRs also spend time in the community developing relationships with members to gain trust and identify points at which the member may be persuadable. This helps Case Managers tailor interventions to the member’s willingness to engage and determine the right time to offer interventions.

We take this approach even further through our field-based Case Management staff to facilitate in-person member contact. For example, home visits demonstrate our commitment to their health, and facilitate stronger relationships than are possible by telephonic contact alone. Face-to-face health education and outreach is especially useful for members with serious mental illness, cognitive impairments or very low health literacy, which may limit their understanding of educational information delivered by telephone and written contacts.

**Trigger Events.** We use biweekly predictive modeling reports and referrals to identify significant health events, such as a heart attack, which can motivate a person to make lifestyle changes. Case Management staff outreach to these Members to check on their condition, ask about any unmet needs and determine if the care plan needs updating. Since trigger events may also result in the need for BH services, Case Management staff assess for and track changing BH needs, and provide referrals to the SMO when indicated.

**Addressing Cultural Factors.** Our staff cultural competence training is extensive, in order to prevent any cultural barriers to engagement. We understand that culture goes beyond race and ethnicity to encompass such issues as poverty and disability, so we involve community-based organizations such as Louisiana Assistive Technology Access Network in training to ensure staff are familiar with characteristics (particularly those related to health care access) and needs of predominant groups. We educate staff about barriers members experience in making and keeping appointments, as well as about health disparities. We continually look for opportunities to address cultural issues. For example, we found that members were refusing calls from LHCC because they thought the toll-free area code meant the calls were from a bill collector. We addressed this by arranging for outbound calls to show a local area code.

### **LHCC in Action...**

Our Case Management staff found that members were refusing calls from LHCC because they thought the toll-free area code meant the calls were from a bill collector. We addressed this by arranging for outbound calls to show a local area code.

**CentAccount™ Member Rewards Program.** LHCC will continue rewarding Bayou Health members’ healthy choices through our CentAccount™ Member Rewards Program. Through CentAccount™, members earn dollar rewards for staying up to date on preventive care such as getting Annual Adult Check Ups, Well-Child Visits, Immunizations, and Health Risk Screenings. Other ways to earn rewards include completing recommended chronic care services such as appropriate diabetes testing.

We load rewards onto a personalized pre-paid reward card that members can use to buy health-related items, such as scales for monitoring weight, fresh foods and groceries, frozen foods, baby items and

clothing (diapers, formula, baby foods) as well as over the counter drugs (allergy, cold meds) and other personal items (deodorant, soap, shampoo). Members will be able to use their CentAccount card at select retailers including Meijer, RiteAid, Dollar General, Family Dollar, and Wal Mart (slated for inclusion soon) plus other locations as we continue expanding our list of retail partners.

Members can visit our Member Portal for the most up-to-date listing of approved items and retailers. We inform members of this incentive in the new member Welcome Packet; the Member Handbook; on the Member Portal; through new Member Welcome Calls; email blasts and anytime a member who has not completed applicable healthy behaviors contacts the Member Call Center. As further described below, members can check their CentAccount balance on our Member Portal and through our mobile app technology.

**Facilitating Communication.** Our award-winning ConnectionsPlus™ Program, described in more detail below, offers restricted-use cell phones to certain high-risk members who lack reliable phone access. We program the phones with numbers such as for the PCP, treating Providers, Case Manager, and NurseWise. Having the means to contact their health care team empowers our members to take more accountability for their health care needs.

**• What tools you will be using for patient engagement including technology or mobile apps;**

LHCC offers a number of patient engagement tools, including technology and a mobile app, to educate and engage our members in a wide range of healthy behaviors and taking responsibility for their own care.

**Member Rewards Program.** LHCC's CentAccount™ Program, described above, actively promotes personal health care responsibility and engagement in care by offering our members financial incentives for certain healthy behaviors and adherence to their Care Plan.

**Promoting Access to Cell Phones.** LHCC has partnered with Safelink to provide free cell phones to our members. This federal program provides free cell phones to individuals that are in a certain low-income bracket. Through our partnership, LHCC members will receive the standard 250 minutes per month; however, calls and texts to and from LHCC are free. Additionally, our Case Management staff can add minutes based on clinical need.

When SafeLink is not an option for members, such as when another person at the same address already has a SafeLink phone or if the member is homeless, LHCC may offer our ConnectionsPlus® Program which provides restricted-use cell phones to certain high-risk members. ConnectionsPlus phones are pre-programmed with numbers for the Complex Case Management, NurseWise, 911, PCP and other treating providers. LHCC Team staff will use the phones to contact members for education, appointment reminders and ongoing coaching and support for wellness and compliance.

With the members consent, we will also send text messages with health information targeted to the member's condition. Our cell phone program enables members to make or receive calls from their providers or plan staff, for example, when they require motivational Case Manager contact or have questions about their chronic conditions or a new symptom. Case Managers can contact members for outreach and assessments, to provide assistance such as reminders to take medicine on time and pick up refills, or provide useful health information via verbal or text messages.

Especially in rural areas, increased telephonic communication helps members overcome the barrier to care that travel distances sometimes pose. This program contributes to reductions in preventable or inappropriate ED use or hospital admissions through improved access to Case Managers, health care information, and treating providers.

**Technology and Mobile Apps.** We are building on our current technology capabilities to provide additional tools for engaging members in their care. These tools include but are not limited to those described in the table below.

<b>Table E: Engagement Tools</b>
<b>Tools on LHCC’s Website</b>
LHCC’s secure Member Portal, with self-service features, offers members the tools they need to help them take personal accountability for their health care. The Portal provides important basic information (such as eligibility and benefit information); helps members understand what they have to do (care opportunities, care gap alerts, health and wellness reminders, and health information specific to the member) to take responsibility for their health; and provides self-service support tools, such as the ability to choose or change their PCP online, print a temporary ID card, exchange secure bi-directional messages with our staff, and manage their Member Portal web account information and communication preferences. Members also can check the status of their CentAccount™ Rewards balance.
<b><i>Enhanced Interactive Capabilities</i></b>
In 2015, we are enhancing our website through the incorporation of LiveLook technology, allowing members to click, enter their phone number, and get an immediate call from our Customer Service Representatives. LiveLook also enhances our screen sharing capabilities to mobile devices, allows site visitors to give permission to our CSRs to take control of their web or mobile screen to assist them in learning to navigate through the various functions Member Portal.
<b><i>Member Access To Their Care Plan</i></b>
Members can access their care plans on our secure Member Portal so they can track their own care and services. For members with special health care needs, we will provide a Member Health Profile summarizing key information such as diagnoses and medications, to help the member or family, guardian or caregiver (as applicable) understand and track the member’s conditions and services rendered. Easy access to care plan and Profile information will enhance member ability to participate meaningfully in directing their own care, such as by alerting a new specialty provider of treatment they are receiving from other providers.
<b><i>Member Notification of Care Gaps</i></b>
Starting in Q1 2015, we will expand our Care Gap notifications to allow members who register to use our secure Member Portal the option of receiving email notifications on their mobile device or personal computer as soon as our Centelligence platform identifies care gaps. These e-mails will supply a link for the member to click, prompting them to login to the Member Portal from their mobile device or PC. Once logged in, the member will immediately go to their care gap information.
<b><i>Community Connections Guide</i></b>
We are placing our internal community resource guide for Customer Service and Case Management staff on our website to empower members to take charge of their social and other non-covered services needs. This Guide will provide resources such as food pantries, clothes closets, support groups, and other social services, by community, to assist members in identifying potential sources of assistance and support.
<b>Mobile Application and Other Technology</b>
In addition to continuing support of our mobile optimized website, we are deploying access to key online functions via our comprehensive LHCC Mobile App with an ever-expanding set of convenient interactive

**Table E: Engagement Tools**

tools for mobile devices. Our Mobile App platform is designed to provide a comprehensive and integrated mobile “one stop shop” for our members. As we develop and add new tools, members will be able to access them directly through LHCC’s consolidated Mobile App rather than searching for new apps.

Our mobile tools are all designed and distributed with a consistent and secure user experience across all platforms, and all fully branded as LHCC mobile tools. Our members will know instantly where to turn to for any assistance. The LHCC Mobile App will be available, free of charge for our members, via the Mobile App Resources section of our public website, as well as the Apple iTunes Store (for iPhone), and Google Play Store (for Android devices). Selected components of our Mobile App include the following features.

***CentAccount™ Mobile***

During the 2<sup>nd</sup> Quarter of 2015, we will add to our suite of uniformly branded apps with LHCC’s Mobile CentAccount™, which gives the member access to their CentAccount rewards information, including status against their health goals and reward points earned to date.

***Mobile Find-a-Provider***

This app uses the native Global Positioning System (GPS) technology included in mobile devices to help members not only find network providers; but automatically get directions to those providers; and allows instant calling to a selected provider.

***The StartSmart for your Baby® for Bayou Health (Start Smart Mobile)***

Building on the success of our ConnectionsPlus® mobile phone program, StartSmart Mobile will provide a broad range of integrated interactive tracking tools, self-service functions, alerts, communication capabilities, and accessible resources for pregnant and postpartum members. Powered by our partner Wildflower Health, a leading mobile health technology company focused on women’s health throughout their pregnancy with apps serving over 50,000 women, Start Smart Mobile will allow our pregnant members to:

Engage with Self Service Tools

- Enter information from OB/GYN visits such as weight, blood pressure, blood sugar, fetal heart rate
- Use tools and trackers such as setting custom reminders for appointments
- View information on the time and place of next medical visit
- Track pregnancy milestones
- View and earn CentAccount™ Rewards
- Access the Baby Name Picker feature and see the current list of top baby names
- Access the Baby Gift Registry

Communicate Quickly and Efficiently with a Nurse

- Provides a pop-up phone number that enables an immediate telephone call to NurseWise, our 24/7 nurse advice line
- Provides a short, pre-populated, “contact me” form for NurseWise call-backs
- Includes Common Questions and Answers from NurseWise for expectant moms in mobile format
- Links to local public health resources

Access Information on Demand

- Personalized health advice
- Information on more than 50 risk factors for pregnancy complications
- Gestational risks and considerations
- Informative photos and ultrasounds by weekly pregnancy stage
- Daily advice to help get ready for baby
- Related topics and podcasts in our Health Library

<b>Table E: Engagement Tools</b>	
<b><i>SS4Baby Texting Program</i></b>	<p>In addition to encouraging and assisting all pregnant members to enroll in the national Text4Baby texting program, we offer a texting program through Start Smart. Our SS4B Texting Program sends texts with prenatal education and an email that promotes breastfeeding initiation. After delivery, breastfeeding moms are encouraged to enter the survey arm of the texting program, which contains additional breastfeeding information and support and a survey component that tracks breastfeeding duration and exclusivity.</p> <p>This data (not available elsewhere) will help us understand the current state of breastfeeding among our members which will help us develop effective breastfeeding support strategies. The program also tracks maternal weight and encourages timely postpartum and well child visits. Members can earn \$5 on their CentAccount card for taking the SS4B survey.</p>
<b><i>MyStrength.</i></b>	<p>Provides tools and resources for managing mental health issues such as depression and anxiety, including wellness assessment, mood tracker, interactive eLearning programs, action plans with suggested steps, structured exercises and daily guidance on topics such as weight and stress management, and personalized expert resources.</p>
<b><i>Health and Wellness</i></b>	<p>A coordinated set of interactive mobile tools to keep our members engaged in their health, with health challenges, personal health trackers, and other online resources, developed in conjunction with our mobile health technology partner, LiveHealthier, Inc. (a global provider of innovative health management apps to engage and keep health plan members healthy).</p> <p>Of particular note, LHCC's <i>Health and Wellness</i> section of our app will include our Mobile Health Risk Assessment (Mobile HRA), allowing a user to complete our HRA via a desktop or mobile device. The HRA question set will be consistent across all devices, but will display appropriately based on the device on which the HRA is being viewed.</p> <p>Data will be securely transmitted and loaded into our TruCare collaborative case management platform, for display within the member's clinical record. The HRA data will also be systematically incorporated into our Centelligence™ analytics platform for integration with other member clinical data in support of reporting and predictive modeling to identify potential member health alerts and care gaps.</p>

***• How you develop and implement individualized plans of care, including coordination with providers and support services;***

**Care Plan Development.** Once a member is enrolled in our Case Management Program, our Case Managers work with the member, authorized family members or guardians, and all treating providers (including providers of non-covered services when possible) to develop a person-centered, strengths-based, integrated care plan. The Case Manager reviews available records and assessments as well as predictive modeling risk scores and other data indicating care opportunities (care and services that are recommended for a specific condition using evidence-based clinical practice guidelines) and care gaps (overdue care and services). The Case Manager then helps the member articulate goals, including health and quality of life goals. For example, a member with asthma may have a goal to join the school soccer team. The Case Manager also discusses results of the assessment, educates the member and involved

family/guardian about service options, and asks the member about preferences for providers and their characteristics (such as preferred gender or language), and other aspects of their services.

The PCP and treating providers play a crucial role in identifying needed services, avoiding harmful drug interactions or contraindications, and ensuring treatment or medications for one condition do not undermine treatment for another condition. The Case Manager facilitates collaboration among all providers in care plan development. This occurs through soliciting care plan recommendations from providers and sharing them with other treating providers along with assessment and other member information. For Members with co-morbid BH conditions, the Case Manager obtains input from our BH Case Manager (or, going forward, our new BH Medical Director), PCP, and SMO staff and specialty BH providers on appropriate services and integrating the full range of needed care.

The Care Plan identifies the right provider and right service, in the right amount, duration, and least restrictive setting. For members with critical needs such as dialysis, ventilator dependence, and limited mobility, the Care Plan includes an emergency preparedness plan. In case the member needs to evacuate, such as due to a hurricane, the emergency preparedness plan indicates where the member will relocate to and how, as well as a plan for coordinating continued services in the relocation area. See our response to Section MM for more details.

**Care Plan Implementation.** Once the Care Plan is finalized, Case Management staff coordinate with Utilization Management (UM) staff to obtain and distribute authorizations to providers. We arrange initiation of in-home services, such as home health or Personal Care Services, and Case Management staff contact the member to verify initiation. Case Management staff also provide referrals, such as for LHCC specialist and subspecialist services; specialty BH services through the SMO; dental services through the DBM; and for community resources. We track referrals and all required follow-up in TruCare.

**Assistance and Education.** Staff assist the member, as needed, with scheduling and transportation to covered and non-covered services appointments. Health Coaches and other Case Management staff (depending on risk level) outreach to the member to provide condition-specific education, such as education about managing risk factors. Staff may provide in-person education to high-risk members and those requiring more intensive assistance, such as those with very low health literacy or who require education on use of equipment such as a glucometer. Case Management staff also outreach to provide appointment reminders, such as prenatal care reminders.

**Monitoring Services and Member Progress and Needs.** **Effective** Care Plans are not static records but living documents that quickly adapt to changes in member health and support status. Case Managers review the Care Plan during each Member interaction to assess progress on goals, reassess preferences and needs, and make any necessary modifications based on changes in the member's health, psychosocial or support status.

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#### **Care Plan Components**

- Member-driven goals that support quality of life
  - Short and long term treatment objectives
  - A responsive set of interventions customized to reflect the member's goals, needs, preferences and potential for improvement or stabilization
  - Easy-to-understand information provided in formats and methods tailored to each member's cultural and linguistic needs, functional abilities, learning style and health literacy
  - The member's recommended preventive health screenings
  - The member's regular evaluation of their progress toward completing action steps
  - Discussions of barriers to and alternative steps for achieving goals
  - Minimal duplication, especially for members with multiple co-morbid conditions and integration of all services
  - Referrals to LHCC as well as other providers for needed services, including but not limited to BH and dental services.
-

Case Managers monitor delivery of services and member condition and progress not only through direct contact with the member and caregiver/designated supports, but also through review of data such as:

- Utilization, claims, pharmacy, and predictive modeling data
- Telemonitoring (for certain high-risk members)
- Member complaints
- Provider referrals and input
- SMO, DBM or other entity referrals and input
- Critical incident reports.

Electronic Visit Verification. LHCC also proposes to use electronic visit verification (EVV) as part of our monitoring of home health, hospice, and Personal Care Services. This will allow us to ensure that services are delivered according to the timeframe and frequency specified in the Care Plan, through Case Management staff comparing actual visits to the established schedule. In addition, Case Management staff and our home health providers will work off the same electronic scheduling page, which will alert LHCC staff to any missed home care appointments in real time. Please see our response to W.1 Information Systems for more details on our EVV system and incentives for providers who choose to use it.

Collaboration with Providers/Members. Case Management staff continuously monitor and collaborate with providers including the PCP to coordinate care, determine effectiveness of services, and identify new or changed needs that require a modification to the Care Plan. They also enlist members and their families/representatives as partners in monitoring by educating them on specific expectations for caregivers and other service providers, and how to report a critical gap in services. If a member/family member notifies us with a quality of care (QOC) concern, the Case Manager collects available information from the member and may schedule MemberConnections™ staff to make a home visit to obtain additional information. We follow up through our Quality Improvement (QI) staff for QOC issues.

Integrated Rounds. Case Management staff conduct monthly rounds on high risk, complex members to discuss monitoring results and member progress. These rounds allow our Case Management staff to share experiences and ideas on managing complex cases. Rounds include Case Management staff, Medical Director, and other clinical staff such as our Pharmacist and BH Medical Director. We also conduct integrated rounds bi-weekly via phone, and monthly in person, with SMO staff to discuss shared members.

***Member Contact Frequency.*** Our Case Managers contact members to monitor progress and services at a frequency determined by risk level and member needs (shown below). We risk stratify each member using an algorithm that considers severity/complexity of illness(s), intensity of service, diagnoses, available services and supports and urgency of interventions.

TABLE F: Member Contact Frequency by Acuity Level			
Acuity	Needs	Setting	Contact Frequency
High - Unstable	Episode of illness or injury needs, discharge planning and outpatient coordination of services.	Inpatient, Outpatient or Home	Weekly post-discharge until stable then either twice a month or monthly
	Complex or chronic condition, symptomatic and at risk for admission or readmission.	Outpatient or Home	Daily until stable, then weekly or twice a month as determined, then monthly
Moderate - Complex but Stable	Complex condition with many health care needs/services.	Outpatient or Home	Weekly to monthly
Low - Stable	No current unmet need for health care services but history of condition that places the Member at risk for potential problems or complications.	Outpatient or Home	One or two contacts and evaluation for care coordination discharge as appropriate

**Care Plan Revisions.** The Case Manager works with the member, family/caregiver, provider(s) and others (such as SMO staff for those receiving specialty BH care) to evaluate member progress and monitoring results and determine if care plan revisions are necessary. For example, action steps may need to change to reflect challenges with adherence; or additional services may be necessary to address new or changed needs. The Case Manager develops revisions using the same collaborative process described for initial care plan development, and coordinates with UM staff to create, modify, or terminate authorizations to reflect the changes in the care plan and promptly notify providers.

**• How you will get data feeds from hospitals when your member is admitted, discharged or transferred;**

LHCC currently obtains information about our inpatient members via a report from network hospitals, which we use to generate a Daily Inpatient Census report. We also receive information through our onsite CRNs, as well as through CRN access to electronic medical records at some network hospitals.

**Health Information Exchange.** LHCC shares DHH’s interest in furthering the meaningful use of clinical data, such as by ensuring hospitals provide data feeds to MCOs to facilitate early involvement in discharge planning. Further, we agree with DHH’s and LaHIE’s approach to creating widespread health information exchange by focusing on an initial project, such as LaHIE’s *ED Visit Registry*. Such a project can have a powerful and beneficial impact on patient care quality and overall health costs. We also know that building a critical mass of ADT-submitting hospitals is a logistical challenge.

LHCC proposes to replicate the early and rapid success of our affiliate health plan in Florida in implementing secure, yet quickly established direct transfers of admission, discharge, and transfer (ADT) data from network hospitals. Over a period of one year, our affiliate has implemented direct ADT submission capabilities with over 20 hospitals, while the state continues to build health information exchange (HIE) capabilities.

LHCC will require our hospitals and their Emergency Departments (EDs) to submit ADT data to LaHIE, but we also will offer these providers the option of a free, direct, and secure connection to LHCC for receipt of ADT transactions. LHCC will serve as a collection point of ADT data for LaHIE and, subject to the execution of a HIPAA Business Associate Agreement with LaHIE, we will batch and forward collected ADT data to LaHIE for populating the ED Visit Registry.

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**Louisiana Healthcare Connections will incent any provider sending us ADT data by waiving the need for inpatient admission notices.**

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In our view, it is critical that hospitals and EDs see a near term benefit of ADT transaction submissions. For this reason, we also will incent any provider sending us ADT data by waiving the need for inpatient admission notices. This represents a significant opportunity for LHCC to remove a substantive administrative burden from our network hospitals and EDs.

Our Management Information System (MIS), provided by our parent company, Centene Corporation (Centene), is ready for HIE projects. In 2013, at the request of another affiliate plan, Grant Thornton, LLP conducted a **HIE Readiness Assessment** of Centene's MIS, and concluded that our readiness to participate in that state's standard health exchange met standards and requirements for HIE participation. Grant Thornton awarded Centene the highest score on their assessment.

**• How you coordinate your disease management and case management programs;**

We comprehensively coordinate Case Management services with our Chronic Care Management Program (CCMP) services through our IC Team model. All Case Management staff including Health Coaches and BH Case Managers (for our Depression CCMP) work together to efficiently and effectively address the needs of members receiving both Case Management and CCMP services. Our Health Coaches, also trained in engagement techniques described above for Case Management staff, provide education and support for self-management and treatment adherence related to specific health conditions and issues. We also use TruCare to document and share relevant clinical information among all plan clinical staff serving the member.

The assigned Case Manager oversees provision of both Case Management and CCMP services, with Health Coach involvement in chronic care management assessments, care planning, coaching and in-home and other interventions as needed for the targeted chronic condition. For example, when the Case Manager identifies that the member has a diagnosis of asthma, our certified Respiratory Therapist Health Coach may visit the member in their home to educate the member and caregiver about how to appropriately use and clean an inhaler and spacer, and conduct an environmental assessment to identify possible asthma symptom triggers in the home, such as pet hair or mold. The Health Coach documents their clinical notes from this intervention, and confers as needed with the lead Case Manager about the member's health. The Health Coach also assists in ongoing data analysis to identify effectiveness of treatment and self-management and adherence issues, and provides input on strategies to address lack of progress and adherence.

The Health Coach completes an assessment of the member's chronic health conditions such as diabetes and lifestyle factors such as smoking, and works with the member to develop a plan that emphasizes self-management and personal accountability. The plan also reflects member preferences and long and short-term goals in increasing their self-care and modifying unhealthy behaviors. Health Coaches identify and discuss barriers to compliance; facilitate a readiness for change; obtain true buy-in for behavioral modification; and encourage solution-oriented problem solving. Between contacts, all members can access the Health Coach via a toll-free number.

As with Case Managers, Health Coaches educate members to be on the lookout for changes that might indicate depression, a change in condition, or disease progression, and to contact them or the Case Manager promptly. Please see our response to Question O for more details on our Chronic Care Management Program and how we coordinate Case and Chronic Care Management services.

**• How you will coordinate your case management services with the PCP; and**

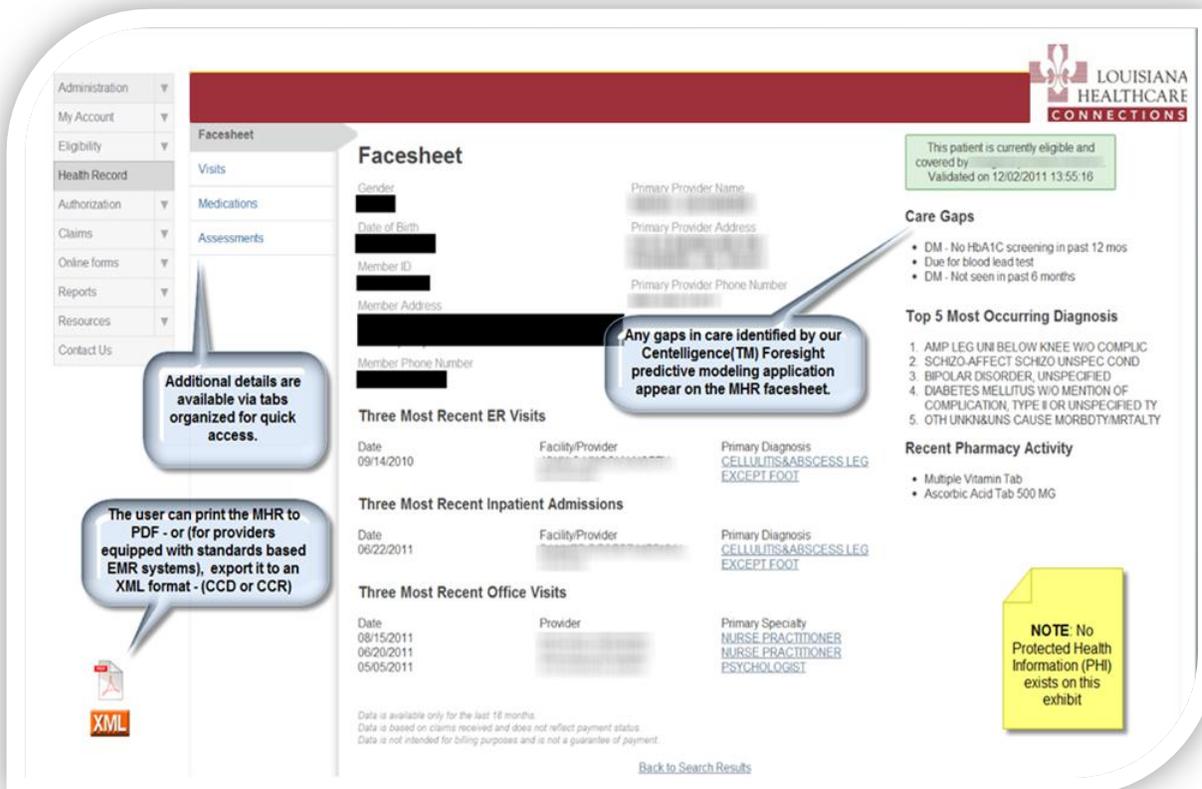
We coordinate Case Management services with the PCP to support the medical home and ensure PCPs have the information they need to provide oversight of the member’s full range of care. We provide assessment results, Care Plans, monitoring results, recommendations from other treating providers, and other member information to PCPs in a variety of ways. These methods vary based on such factors as the needs of the member, the urgency of the situation, and the number of treating providers and/or external case managers involved. Methods include confidential fax, phone, conference call, certified mail, joint case conferences and joint assessments.

**Case Management Staff Coordination.** Case Management staff regularly share member information and interface with providers, as well as upon provider request, and at established coordination points within the Case Management process. The key coordination points and activities during which the Case Management staff coordinate with the PCP include, but may not be limited to the following:

<b>TABLE G: Coordination with PCPs</b>	
<b>Coordination Point</b>	<b>Key Coordination Activities</b>
<b>Enrollment of member with existing authorizations and need for ongoing care</b>	<ul style="list-style-type: none"> <li>• Obtain authorization information, assessment results, treatment plan</li> <li>• Inform about continuity of care policies and procedures</li> <li>• Provide automatic authorization of ongoing covered services</li> </ul>
<b>Care Plan development and revision</b>	<ul style="list-style-type: none"> <li>• Share assessment results, member goals and preferences, Case Manager recommendations, other provider recommendations</li> <li>• Obtain input on care plan/revisions</li> <li>• Ensure PCP and all treating providers are involved</li> </ul>
<b>Care Plan implementation</b>	<ul style="list-style-type: none"> <li>• Provide authorizations</li> <li>• Ensure timely initiation of care plan services</li> </ul>
<b>Care Plan monitoring</b>	<ul style="list-style-type: none"> <li>• Ensure PCP and treating providers are aware of member progress, self-management, adherence</li> <li>• Alert providers to gaps in care</li> <li>• Coordinate care and facilitate provider communication</li> </ul>
<b>Change in member condition, status, needs, preferences</b>	<ul style="list-style-type: none"> <li>• Ensure PCP and treating providers are aware of member progress, self-management, adherence</li> <li>• Alert providers to screening and reassessment needs, potential need for treatment plan changes</li> </ul>
<b>Care transition (such as inpatient, ED admissions and discharges)</b>	<ul style="list-style-type: none"> <li>• Alert PCP and providers to transition</li> <li>• Ensure new care setting has care plan, provider treatment plans and other member information</li> <li>• Coordinate care and facilitate provider communication</li> <li>• Ensure PCP and all treating providers are involved in planning for anticipated transitions (such as discharges)</li> </ul>
<b>Transition out of plan</b>	<ul style="list-style-type: none"> <li>• Inform about continuity of care policies and procedures</li> <li>• Ensure transfer of information as required to receiving MCO or entity</li> </ul>

**Technology Support for Coordination with the PCP.** Our secure Provider Portal supplements Case Manager interaction by allowing all authorized network and OON providers who have executed a Single Case Agreement (subject to HIPAA Minimum Necessary Rules) to view a wide variety of data and information about the members they are treating such as:

- Member Care Plans presented in an engaging, well organized online format.
- Our comprehensive ***Online Member Health Record (MHR)***, which provides PCPs with a well-organized view of a member's care gaps, as well as a cursory clinical "face sheet" (see graphic, below) and detailed clinical tabs for each member for whom we have supporting data. The MHR is based on current and historic medical and pharmacy claims information, lab test results, health risk assessments, and other information systematically received and processed in Centene's Enterprise Data Warehouse.
- ***Our ED Flag*** on the Portal enables us to notify PCPs of ED utilization when the provider checks member eligibility. This improves PCP awareness of members who may not be appropriately accessing primary and preventive services, thereby supporting the PCP's own outreach and education efforts.
- Our ***Online Care Gap Alerts*** feature pushes alerts to the provider when a member's record is presented as a result of an eligibility inquiry and will show if a member is due for or missing a service recommended by evidence-based guidelines. As shown below, PCPs can view clinical quality and cost utilization drill down reports generated by our Centelligence™ system that encompasses data for all services delivered to the member by that provider, when we have sufficient claims data from that provider to display meaningful information.



**• How you will incorporate provider input into strategies to influence behavior of members.**

We recognize that the relationships providers develop with members gives them valuable insight into member behavior and strategies that may be effective in improving healthy behaviors or encouraging engagement in care. We solicit provider input, both at the individual member level and at the plan level, on strategies that may affect our entire membership.

At the individual member level, the member’s IC Team involves providers in assessment, Care Plan development, and monitoring to obtain input into services as well as education and outreach strategies. For example, the PCP may be aware that the member needs support and reminders to keep preventive and primary care appointments. IC Team staff can enter alerts into TruCare that trigger staff to contact the member in advance of needed appointments, provide reminders, and offer assistance with scheduling appointments and transportation.

For members receiving specialty BH care through the SMO, IC Team staff coordinate with SMO staff to contact BH providers for input on strategies, such as to improve medication adherence, or to manage behaviors when the member attends PCP or LHCC specialist appointments. When appropriate, the Medical Director outreaches to a provider for peer-to-peer discussion of root causes of undesirable behavior (such as continued noncompliance with treatment or challenging behaviors in provider offices) related to medical or BH conditions, and potential solutions. Our new BH Medical Director will also conduct peer-to-peer discussions as appropriate to identify solutions with the provider.

We also solicit provider input at the plan level, though our **Provider Advisory Committee** and incorporation of providers on our Quality Assessment and Performance Improvement Committee (QAPI

Committee). For example, Dr. Bryan Sibley, a provider in Region 4, provided input during a Provider Advisory Committee meeting on a more efficient mechanism for providers to notify LHCC of members who are non-compliant, or who may require CCMP services. Based upon his recommendations, LHCC created an online submission form for these referrals. Providers may now electronically submit information directly to our outreach staff about members such as those requiring outreach to support compliance.

Providers may also electronically submit our Chronic Care Management referral form, which immediately notifies the Case Management Department of members who may need health coaching or other CCMP services. Since implementing an electronic referral method in 2014, the number of referrals from providers for outreach and CCMP services has increased from an average of three referrals per month in the three months prior to implementing the method, to an average of eight referrals per month in the three months following implementation.

*K.2 Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adopt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid MCO members.*

### **Culturally Competent, Proven Strategies to Promote Wellness Behavior**

Louisiana HealthCare Connection's (LHCC's) approach to education and outreach is grounded in proven strategies for member engagement, and our commitment to the success of Bayou Health and wellbeing of our members. Our staff engage members, providers, and community organizations as partners in motivating members and their communities in adopting healthy behaviors and accessing care at the right time and in the right place to support optimal health outcomes. Using culturally relevant, targeted outreach that focuses on direct member interaction, we help ensure that members access comprehensive prevention and intervention services that adhere to evidence-based clinical practice guidelines. This section describes our strategies and tools for influencing members, and provides examples of two key programs that focus on influencing member behavior as a primary strategy for ensuring appropriate access to care: our ED Diversion and Start Smart for Your Baby® (Start Smart) Programs.

About 90% of our staff overall, and all member-facing staff, are from Louisiana. We share the accent, we know the correct pronunciation of our towns, and when we talk with members, they hear a familiar voice.

### **Engaging Members as Partners**

Changing a member's behavior requires an understanding of that member's readiness for change and motivating them accordingly. It is also very important to support the effort required for change, monitor sustained change, and provide support to help the member maintain healthy behaviors. Using Motivational Interviewing techniques, LHCC Case Management (CM) staff determine a member's readiness for behavior change based on Prochaska's Model of Behavioral Change, and focus their interaction with that member to provide education and support at the member's assessed level of readiness. We help members progress from lack of awareness and resistance to change all the way to full adoption and maintenance of new behaviors. We employ similar techniques on a broader scale to promote wellness among members, their families and friends, and their communities.

**Motivational Interviewing.** All of our member-facing staff receive thorough training in cultural competency and customer service, in addition to training tailored to their job functions. For example, all of our Case Managers complete initial and annual refresher training on Motivational Interviewing, a best

practice engagement technique. We are developing similar training, tailored by staff function, for our Customer Service Representatives (CSRs) who answer our Member call center, and for our MemberConnections™ Representatives (MCRs), lay health workers we hire from within the communities they serve. In the following table we highlight each of the different motivational stages, as well as LHCC’s role in motivating members and the support/resources we can provide to support the member at every stage.

Motivational Stage	LHCC Role	Support and Resources
<ul style="list-style-type: none"> <li>Unaware of Unhealthy Behavior/Health Issue</li> <li>Unengaged</li> </ul>	<ul style="list-style-type: none"> <li>Engage members</li> <li>Provide information</li> <li>Help members analyze/understand risks</li> </ul>	<ul style="list-style-type: none"> <li>Centelligence™ analysis of member demographics, utilization and access patterns, etc., to tailor initial and ongoing outreach</li> <li>MCR “on the ground” support for individual and community awareness outreach</li> <li>LHCC Chronic Care Management (CCMP) programs and Specialized IC Teams</li> <li>Network of local providers as partners in influencing behavior</li> <li>Network of local and community resources</li> <li>Culturally relevant, engaging outreach and educational tools and materials</li> </ul>
<ul style="list-style-type: none"> <li>Deciding to Change or Not to Change</li> <li>Preparing</li> </ul>	<ul style="list-style-type: none"> <li>Discuss pros and cons of change</li> <li>Develop with member a plan of action with established, achievable goals</li> <li>Identify and address barriers to following plan</li> </ul>	
Taking Action	<ul style="list-style-type: none"> <li>Provide support and encouragement</li> <li>Continue to analyze and address barriers</li> </ul>	
Maintaining Change	<ul style="list-style-type: none"> <li>Monitor adherence to plan</li> <li>Provide ongoing support</li> </ul>	
Relapse	<ul style="list-style-type: none"> <li>Evaluate cause with member</li> <li>Review benefits of behavior</li> <li>Motivate based on previous success and demonstrated ability to achieve goals</li> <li>Provide support</li> </ul>	

**General Outreach.** The first step in influencing change is informing members about the services available to them and how they can be accessed, and how LHCC can support them. In addition, we provide ongoing reminders to all members about upcoming medical appointments and information about a variety of programs and health topics so that they can take charge of their own care.

*New member orientation* includes our Welcome Call and a Welcome Packet of printed literature. During the call, and within all of our literature, we repeatedly emphasize the importance of health screenings and preventive services. We also verify that each member has a PCP that meets their needs and preferences, and help them to find and select one as needed. In addition, we help members complete an initial Health Risk Screening that helps us to determine how to ensure that they receive necessary services and supports. In addition, our Welcome Packet and online materials include information about how and when to access care appropriately. For example, we provide an EPSDT reminder and calendar, brochures about our 24/7 nurse advice line and when to use the ED, and personal health account guide to accessing the secure Member Portal. With DHH approval, we will include in our Welcome Packets an “About Your Medical Home” brochure to help us explain the Patient Centered Medical Home model and the benefits to members of coordinating their care through their PCPs.

*Ongoing outreach and education* supports wellness behaviors. LHCC provides a variety of materials to reinforce wellness and disease prevention messages, often partnering with community organizations to provide materials in conjunction with wellness events for members and non-members. For example, through our Healthy Lifestyles Program, we provide home visits to help member identify issues in their

homes that may impact their health, such as mold or lead; nutritional consults to help them make Healthy Choices when selecting foods, and healthy cooking demonstrations that teach members how to prepare food on a limited budget.

Through our Healthy Congregations Program, we reach members via their faith-based organizations, an especially effective way to reach African-American members, as well as other Bayou Health members. Research shows that “church attendance is an important correlate of positive health care practices, especially for the most vulnerable subgroups, the uninsured and chronically ill. Community- and faith-based organizations present additional opportunities to improve the health of low-income and minority populations.”<sup>1</sup>

We maintain all our materials on our website and encourage members to take charge of their wellness by accessing our extensive *Online Health Library* that features a searchable Krames Health Sheet database with more than 4000 topics. We offer Krames health sheets, available in English, Spanish and other languages as needed (including Vietnamese), on *prevention* topics such as “Exercise: Why Fitness Matters,” which describes the benefits of exercise for staying healthy, maintaining a healthy weight, reducing risks for disease, improving sleep and energy levels, and managing stress.

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**Our Spring 2014 issue of our member newsletter featured articles on heart health, our award-winning Start Smart Program; as well as topics related to asthma, mental health, ADHD, our Case Management, Disease Management, and Pharmacy Programs; and Member Rights and Responsibilities**

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We also provide a number of member postcards and letters on topics such as the need for a colon cancer screening, diabetes or eye exam, well woman visit, and a yearly physical. Our quarterly *HealthConnect member newsletter* provides information about screening, wellness initiatives, and LHCC programs. Please see Section T.1 for descriptions of our health and wellness support materials. LHCC also provides regular telephonic outreach in person and via our automatic messaging system to remind members about wellness appointments and provide wellness messages as part of a comprehensive outreach campaign.

**Targeting and Tailoring Outreach.** Using our Centelligence™ suite of data informatics and reporting solutions, LHCC tracks and monitors service utilization and access patterns. From the moment members enroll in LHCC, we identify and monitor those in need of prevention and intervention services and outreach to them using multiple methods and points of contact (described below) to *proactively* support wellness care. By cross-referencing and integrating multiple sources of data and information, we also can identify members’ PCPs or specialty providers (eg, OB/GYN), barriers to compliance, behavioral health (BH) needs, and much more. This empowers LHCC staff to work as a team to target outreach to individual members who need more support to modify behaviors and comply with wellness care requirements; and to assist them with arranging transportation, making appointments, arranging interpreter services, etc. In addition, we can use predictive modeling to target broader initiatives, such as educational and screening events, to those members *and communities* most at risk for missing important screenings, and/or for a particular health issue.

We know that members are more likely to access services that are developed based on an understanding of unique member characteristics; as well as community assessments that take into account our members’ cultural values. For example, an assessment may show that members in a particular region or within a local community have lower access rates for a particular intervention, such as STI screening. By cross-referencing such information with, for example, racial/ethnic data, we can tailor our approach and messaging consistent with local cultural beliefs about accessing health care services. In addition, we can

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<sup>1</sup>[Kaytura Felix Aaron, MD](#), <sup>1</sup>[David Levine, MD, ScD](#), and [Helen R Burstin, MD, MPH](#). “African-American Church Participation and Healthcare Practices,” *J Gen Intern Med*. Nov 2003; 18(11): 908–913. Accessed via [10.1046/j.1525-1497.2003.20936.x](https://doi.org/10.1046/j.1525-1497.2003.20936.x) on 9/18/14.

more effectively engage local community organizations and providers to help us approach members and build our credibility within communities we serve.

**Chronic Care Management.** We provide specialized outreach to approximately 3,735 LHCC members participating in our Chronic Care Management (CCM) Program, described fully in Section O.1. Our CCM Program includes coordinated support to help members manage a wide range of chronic conditions.

We will continue to train all Integrated Care Team staff and Customer Service Representatives (CSRs) to educate and refer members who express an interest in quitting, or who are identified as smokers, to the Louisiana Tobacco Quitline and the Smoking

Cessation Trust resources. Our Case Managers/Health Coaches will continue to incorporate into a member’s individualized care plan the program’s Quit Plan and supports.

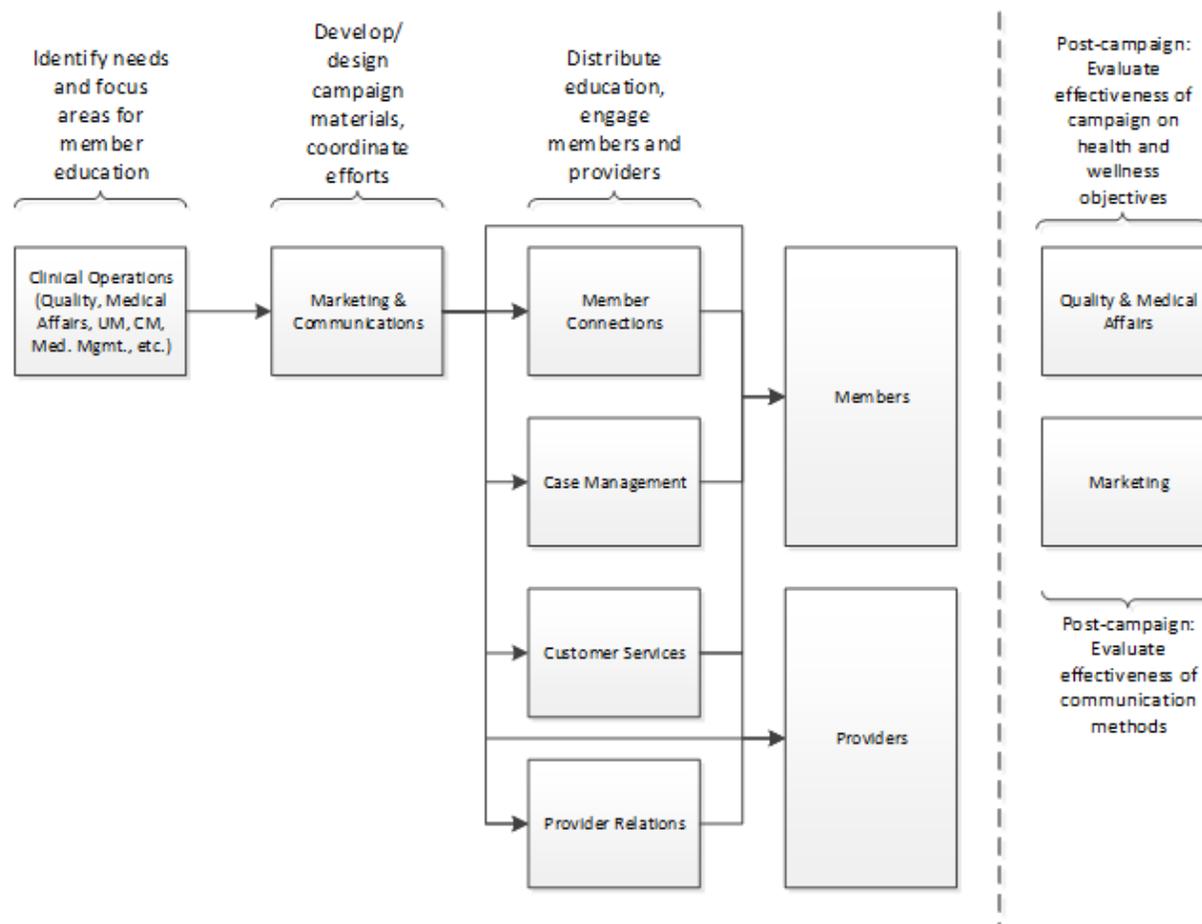
**MemberConnections™ Program (Connections).** MCRs are LHCC’s community health outreach workers hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of each region. MCRs receive comprehensive training and become an integral part of our Customer Service and Case Management teams, which benefits our members and increases our effectiveness. MCRs make home visits to high-risk members we cannot reach by phone, and assist with member outreach, coordinate social services, and attend community functions to provide health education and outreach. Please see the Community Outreach section below for descriptions of events and community outreach.

**Additional Motivational Strategies and Tools.** Case Management targets those members at greatest risk for escalating health problems or who face more barriers to accessing care appropriately. However, we provide comprehensive, coordinated outreach and assistance to *all members* to empower them to make healthy decisions. We also provide a number of supportive tools and incentives to help members take responsibility for their own health and wellness.

**Coordinated Comprehensive Outreach and Support.** LHCC staff work as a team to provide information in a variety of ways and settings to reinforce messages about the importance of wellness and screenings. For example, at community events we provide, or work with local organizations to provide, information to promote preventive health strategies in areas such as perinatal care and breastfeeding support, pregnancy prevention/family planning, and child and adult wellness. Our Case Management staff work with members enrolled in our Case Management or CCM Programs to develop care plans that incorporate all needed services. Our Customer Service Representatives (CSRs) and MCRs remind and assist members to access care. Our Case Management Director works with our Quality Improvement (QI) and Marketing Teams to target and develop outreach to engage members effectively. The following chart illustrates how we develop and coordinate a member education campaign.

**LHCC Chronic Care Management Programs**

ADHD	Hepatitis C
Anxiety	HIV/AIDS
Asthma	Hypertension
CHF	Obesity
Diabetes	Pain Management
Depression	Perinatal SUD
Sickle Cell Disease	



***CentAccount™ Member Rewards Program.*** LHCC will continue rewarding Bayou Health members’ healthy choices through our CentAccount program. We are improving the benefits to members by offering a new closed-loop card, which can be used for even more items and products to drive healthy behaviors and healthy outcomes. Members can earn dollar rewards by staying up to date on preventive care such as getting annual Adult Check Ups, Well-Child Visits, immunizations, flu shots, prenatal visits and more. Members will be able to buy things like fresh foods and groceries, frozen foods, baby items and clothing (diapers, formula, baby foods) as well as over the counter drugs and other personal items (deodorant, soap, shampoo). By expanding our program, members will be able to use their CentAccount card at a select number of retailers including RiteAid, Dollar General and Family Dollar, plus other locations as we continue expanding our list of retail partners. Members can visit our Member Portal for the most up-to-date listing of approved items and retailers. We inform members of this incentive in the new member Welcome Packet; the Member Handbook; on the Member Portal; through new Member Welcome Calls; email blasts and anytime a member who has not completed applicable healthy behaviors contacts the call center.

***SafeLink and Connections Plus®.*** LHCC has partnered with Safelink to provide free cell phones to our members. This federal program provides free cell phones to individuals that are in a certain low-income bracket. Through our partnership, LHCC members will receive the standard 250 minutes per month; however, calls and texts to and from LHCC are free. Additionally, our Case Management staff can upgrade minutes based on clinical need. When SafeLink is not an option for members, LHCC may offer

our Connections Plus program which provides restricted-use cell phones to certain high-risk members. Connections Plus phones are pre-programmed with numbers such as for the Case Manager, NurseWise, 911, PCP and other treating providers. LHCC staff use the phones to contact members for education, appointment reminders and ongoing coaching and support for wellness and compliance. With member consent, we also send text messages with health information targeted to the member’s condition. At the end of this year, LHCC will offer a texting program for members with Safelink phones. Messages will remind them to complete well-checks and provide a range of health messages on priority topics, such as diabetes and heart health. We also will be able to conduct quick satisfaction survey to get member feedback about LHCC and our messaging.

**Start Smart Texting Program.** In addition to participating in the national Text4 Baby program, we provide our own texting program that provides prenatal education and an email that promotes breastfeeding initiation. After delivery, breastfeeding moms are encouraged to enter the survey arm of the texting program, which contains additional breastfeeding information and support and a survey component that tracks breastfeeding duration and exclusivity. This data will help us understand the current state of breastfeeding among our members and develop effective breastfeeding support strategies. The program also tracks maternal weight and encourages timely postpartum and well child visits.

**LHCC Website Member Engagement Tools.** We offer several engagement tools on our website, including some new or enhanced tools, as illustrated in the following chart.

Member Engagement Tools on LHCC’s Website
<p><b>Call Back from LHCC Staff.</b> Starting in 2015, our Member Portal will have an icon on each page that the member may click to receive a call back from a Customer Services Representative. The member inputs the call back number, and our system instantly puts the request in the CSR queue for response, allowing them to easily reach us with questions and concerns.</p>
<p><b>Member Access To Their Care Plan.</b> Members can access their care plans on our secure Member Portal to track their care and services. For those with special health care needs, we provide health utilization information, such as diagnoses and medications, in a user-friendly format to help the member or caregiver understand and track the member’s conditions and services. Access to care plan and Profile information will enhance member ability to direct their own care, such as by alerting a new provider of treatment they are receiving from other providers.</p>
<p><b>Enhanced Community Connections Resource Guide.</b> We are upgrading our previously static Resource Guide to a searchable Community Connections Resource Guide that empowers members to find services based on their needs, and in their own regions of the state. Our MCRs, Case Management and Customer Service staff use the database regularly and will continue to work with members to access community resources such as housing assistance and food banks. Our user-friendly, online format will encourage members to seek services on their own, thus promoting personal responsibility and member engagement in their own wellbeing.</p>
<p><b>Member Notification of Care Gaps.</b> Starting in 2015, members may choose to receive care gap notifications via their Member Portal account. An email notification will indicate that they have an important message about their health care waiting, and provide a link to sign into the Portal. Once signed in, they will see information about the care gap and how to receive assistance, such as help with scheduling a preventive care visit</p>

Technology Tools for Member Engagement. LHCC offers and is developing a range of engagement tools focused on prevention and intervention and overall wellness. LHCC’s websites, including our public website and secured Provider and Member Portals, have been mobile-enabled since 2010, with web experiences that translate into easily accessible content when viewed on PCs or mobile devices. For 2015, we are enriching user ability to engage on our websites and enhancing the "mobile friendliness" of our websites to increase adaptability and optimization of our online content for mobile devices.

**Per RFP Section 22.13. Proprietary and/or Confidential Information, this information is confidential and has been redacted from this copy.**

Other products that will be rolled out through our Health and Wellness app capability include:

- **on.track.** Through the **on.track** program, members are inspired to set and achieve specific health goals by taking advantage of one of more than 100 leading health and fitness apps available on the market, including dozens of free and low-cost alternatives. Using **on.track**, a member will be able to select activities to track based on their personal health goals, such as nutrition, fitness, weight management, stress and sleep management, tobacco cessation, diabetes and/or hypertension

management. Simple to use, the member chooses an app, links it to his or her **on.track** account and begins activity tracking with just three taps. Seamlessly, data from the tracker is pulled into the on.track Lifestyle Manager, where the member can monitor progress toward health goals.

- **on.board Action Plans.** **on.board** action plans are individualized health behavior change programs designed to target an individual member’s most severe health risks, unique risk level and readiness to change. With a focus on physical activity, nutrition, stress management and tobacco cessation, **on.board** action plans leverage the fundamentals of game theory to engage an individual and motivate them to learn about and improve their health behavior.
  - Comprised of three to five levels, each action plan includes interactive activities, such as quizzes, videos, activity tracking (leveraging **on.track** available apps and devices) and challenging-yet-achievable to-do’s. Members will be able to achieve badges as they progress through levels of these the evidence-based programs, which are specifically designed to be self-rewarding and ultimately drive sustained healthy behaviors. Beyond addressing specific health risks, these dynamic action plans are also tailored to a member’s specific learning style—to further foster program efficacy.

**Per RFP Section 22.13. Proprietary and/or Confidential Information, this information is confidential and has been redacted from this copy.**

### **Providers as Partners**

Providers play an important role in ensuring our members complete screenings and in motivating them to adopt healthy lifestyle choices. We educate them about their responsibilities as a medical home, and provide tools that identify members who need services and that support PCP outreach efforts. We inform all our PCPs of appointment scheduling requirements during provider orientation, and educate them about best practices for meeting their responsibilities via our orientation process and ongoing education such as through written materials and quarterly site visits.

***Enhanced Provider Incentives.*** LHCC restructured our performance incentive program for PCP practices to further expand our network of designated PCMH providers and to provide greater rewards to providers for meeting state HEDIS benchmarks for their LHCC member panel, including wellness screenings. In addition, we incent providers to offer after-hours care to enable those members who cannot miss school or work to make and keep their wellness appointments.

***Enhanced Member and Provider Care Gap Alerts.*** We will help Providers encourage Members with our enhanced online Care Gap Alerts. Our Care Gap Alert feature is an important tool for providers in keeping up with preventive and follow-up care requirements. To make our Care Gap Alerts more useful and user-friendly, we enhanced our “flags” to provide information about what follow-up is due without having to open the member record. Our new alert flags would indicate on the patient roster any needs for wellness visits, immunizations, screenings and follow-up care.

## LHCC Programs Targeting Specific Behaviors

Using Centelligence™ reporting to inform our decisions, LHCC implements Performance Improvement Projects (PIPs) and/or intervention initiatives tested and proven among our affiliate health plans to target specific priority issues for our state. For example, we have used the Start Smart Program since Bayou Health inception as our key vehicle to promote education and communication among pregnant members, case managers, and physicians to ensure a healthy pregnancy and first year of life for babies. Start Smart received the 2010 URAC/ Global Knowledge Exchange Network **International Health Promotion Award**, and a Platinum Award for Consumer Empowerment at the URAC Quality Summit. In 2009, Start Smart was named an NCQA Best Practice.

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### Start Smart For Your Baby®

#### **Program Components**

- Early identification of pregnancy
  - Risk screening and stratification to determine appropriate interventions
  - Member outreach and education
  - Member incentives for accessing prenatal and post-partum care
  - One-on-one Case Management for reproductive age women with a history of poor birth outcomes and those with high risk pregnancies
  - A 17P program that may include home visits
  - HIV/STI testing per new CDC guidelines
  - Specialized management of pregnant members with depression or substance use disorder
  - Management and follow up of NICU stays
  - Provider education and incentives for improving birth outcomes and access to appropriate prenatal and post-partum care.
- 

## Start Smart For Your Baby® Program

Louisiana ranks 46th among the states in teen birth rates, and more of our infants are born prematurely and/or at low birth weight (LBW), according to the Kaiser Family Foundation. The LBW rate for Blacks/African Americans is 15.4 percent, nearly double the rate for Whites, and our preterm birth rate for African-Americans is 19.8 percent compared to the national average of 17.1. More than half of Bayou Health enrollees are African American. Based on this information, we know that we need to provide strategic, comprehensive intervention to improve birth outcomes. Start Smart incorporates Case Management, care coordination, and disease/population health management strategies to improve birth outcomes and infant health. Start Smart's key program objectives include extending the gestational period and reducing low birth weight; reducing the risks of pregnancy complications, premature delivery, and infant disease; and ensuring a healthy first year of life for the newborn. We automatically enroll all identified pregnant members into the Start Smart Program. A Start Smart Case Manager attempts to contact each high or moderate risk pregnant member to provide education and assistance to access prenatal care, and to complete a full OB assessment of pregnancy-related risk factors. The Case Manager also assesses overall health and needs for carved out/non-covered services including behavioral health, dental, and social services. The assessment incorporates information from the member and family/caregiver as applicable; OB and other treating providers; as well as any claims, utilization, and other information we have about the member, to develop a holistic picture of the member's conditions and needs. We use results to stratify members by risk level for appropriate intervention. All pregnant members receive education and assistance (described below) to empower them to access prenatal care appropriately and take actions to promote a healthy pregnancy. Members stratified as medium or high risk receive additional interventions such as those described below to address identified risks.

**Start Smart Outreach and Education.** We mail a Start Smart educational packet to our pregnant members that explains Start Smart and our CentAccount Member Incentive Program, which provides incentives attending prenatal and postpartum appointments, and accessing other services (see below for

information on incentives). The packet includes our toll-free phone number and Start Smart website address; member rights and responsibilities; our recommendation and process for changing their PCP to an OB; information about our 24/7 nurse advice line; and pregnancy-specific information. Start Smart materials encourage members to schedule (or contact us for assistance scheduling) a prenatal care visit

**Start Smart Welcome Packet**

- Overview of Start Smart
- Incentives available through our CentAccount Program for submitting a NOP form and accessing recommended care
- LHCC’s toll-free phone number and Start Smart website address
- Member rights and responsibilities
- How to change their PCP to an OB
- Information about our 24/7 nurse advice line
- Behaviors for a healthy pregnancy
- The importance of scheduling a prenatal care visit within the first trimester, or as soon as possible if the member is past the first trimester.

within the first trimester, or as soon as possible if the member is past the first trimester.

In addition, we send regular periodic educational mailings throughout pregnancy that encourage a healthy lifestyle and provide information about fetal development. For example, we educate members on the benefits of exercise during pregnancy, and provide information on how to set up a safe walking program before and after delivery, a log for tracking steps, and a pedometer. The mailings also encourage appropriate prenatal visits during the pregnancy and provide suggestions related to pediatrician selection.

We invite pregnant members to Start Smart events focused on prenatal visits, breastfeeding, stages of birth, oral hygiene and care, mental health, family planning, and newborn care. Start Smart Case Managers and our MCRs partner with providers and

community-based organizations such as schools and community centers to present educational workshops and other events to provide a venue for expectant moms to ask questions and share concerns. These workshops and events also enable LHCC to identify and outreach to potential high or moderate risk pregnant members and provide education about WIC and other community resources. For example, our Baby Showers educate pregnant members about prenatal and postpartum care for themselves and their newborn. We also host Diaper Days, targeted to families of newborns to focus on postpartum care, infant care, EPSDT services and issues related to being new parents. (Please see a description of Baby Showers and Diaper Days in the community organizations section).

<b>Incentives for Accessing Recommended Perinatal Care</b>	
Prenatal visits	\$10 every 3 prenatal visits w/max of \$30
Postpartum visit within 30 days of delivery	\$10
Annual Chlamydia & STI (including HIV) Screening	\$15
Infant well-child visits	\$5 per visit
Bonus for completing 9+ prenatal visits, 1 post-partum visit, and Start Smart for Baby text survey	\$100

As noted, we offer our Start Smart texting program that provides texts with prenatal education and an email that promote breastfeeding initiation, as well as our Start Smart Mobile.

***Incentives.*** We provide incentives of nominal value, such as a Start Smart digital thermometer or onesie, to encourage completion of Notification of Pregnancy forms and participation in events. As noted, members can earn financial rewards via the CentAccount program for accessing specific services.

## LHCC's Emergency Department (ED) Diversion Program

Misuse of ED services is neither cost-effective nor supportive of the medical home model. We prevent and reduce non-emergent ED use through multiple strategies, such as promoting primary care through the medical home, ensuring availability of appropriate urgent care settings, and interventions targeted to super-utilizers, described in the relevant sections below. In addition, we educate members and providers regarding appropriate utilization of ED services, including utilization for behavioral health emergencies, and monitor utilization by provider and member. We address inappropriate ED utilization through our **ED Diversion Program**, which builds upon and expands our 2013 Ambulatory-ED Visits Performance Improvement Project (PIP).

**51.3% reduction in the ED utilization rate of members in**

**Ambulatory-ED Visits PIP.** In Q4 2012, we identified 1254 high ED utilizers (members with three or more ED visits in the previous 90 days), and our Case Managers attempted to contact each of them to provide education and offer Case Management services. Our Case Managers stressed the importance of a medical home and how to access it, appropriate options for non-emergent health care needs, and alternatives to utilizing the ED, such as accessing after-hours appointments and using urgent care clinics near them. MCRs also reminded members to call our 24/7 nurse advice line to ask questions and determine the level of care needed, and to ask for assistance scheduling appointments and arranging transportation. Members who agreed to participate in our Case Management Program were assigned a Case Manager to complete a comprehensive assessment and care plan that addressed the member's full range of needs, including but not limited to behavioral health needs requiring referral to the Statewide Management Organization (SMO) for specialty services. Case Managers provided additional education and scheduling and transportation assistance as needed.

In addition, our Provider Relations Specialists (PR Specialists) contacted the 75 practices with the highest ED utilization each quarter, along with our network FQHCs, Medical Home eligible providers, and other providers. PR staff provided each with information on their ED rates; and encouraged them to contact their patients on the ED list to provide education, offer preventive and primary care appointments, and ensure their office schedules could accommodate our members. PR Specialists also discussed the member's barriers that contributed to their high utilization rates to help the provider tailor their own outreach to the member.

**ED Diversion Program** We have capitalized on the success of our Ambulatory-ED Visits PIP by allocating additional staff resources to focus on identifying and addressing high and non-emergent ED utilization. Currently, our ED Diversion Program targets our top 2400 ED utilizers in addition to the 75 practices each quarter whose assigned members have the highest ED utilization. We will continue member and provider outreach strategies described, and increase in-person outreach for members we cannot reach by phone, or who need more intensive support. We also will track shared LHCC/SMO members who visit the ED. QI staff will distribute monthly reports to the SMO that include names of these members and service dates. Case Managers will discuss ED utilization during bi-weekly rounds for co-managed members; to coordinate education and other collaborative strategies to address utilization.

*Describe how you will leverage existing state and local resources to support health and wellness of your members including but not limited to:*

- *Strategies you will use to work with the Louisiana Office of Public Health to utilize existing capacity in the state for services, outreach or education. Include models you have used in other states that are in partnership or utilize a state's public health infrastructure.*

## **Leveraging State and Local Resources to Support Health and Wellness**

LHCC will work with local organizations, including state entities, to share HIPAA-compliant information and data as needed to target and coordinate outreach to members and communities, and to increase our capacity and theirs to help Louisianans live well and healthier. We understand that the health of our members is closely tied to the wellbeing of their communities. All of our fellow Louisianans benefit from Bayou Health stakeholder collaboration. Working with formal and informal health infrastructure organizations in Louisiana, we can help our members and their families and friends make lifestyle changes, all the while strengthening the infrastructure and enhancing its capacity for the greater good of communities and our state.

Following is an overview of how we work with organizations to leverage resources. The final section below that focuses on community partnerships provides expanded descriptions of some of the initiatives described here.

### **Educating Members About and Linking Them To Existing State and Local Resources.**

Our MCRs and Case Management staff educate our members about and help them to access vital services and supports not covered through Bayou Health, as well as to help us educate communities to create a culture of wellness. For example, when Case Managers and/or MCRs are providing information about proper nutrition to a member who is pregnant, they will refer that member to the WIC program and/or food bank locally, as needed, to ensure that the member can get the healthy food they need during and after pregnancy. We have invited WIC representatives to our Baby Shower events (described in the community partnerships section below), many of which we have conducted in collaboration with local organizations.

### **LHCC IN ACTION...**

At a Baby Shower in June in Livingston Parish, we invited a representative of Southeast Advocates for Family Empowerment, a local domestic violence advocacy group, to talk about domestic violence, which is a prevalent issue in our state. We also invited the Sheriff's Department to teach members how to safely install and use car seats.

Our searchable Community Connections Resource Guide enables our MCRs, Case Management and Customer Services staff to work with members to access community resources such as housing assistance and food banks in the member's region. In addition, MCRs and CM staff regularly rely on their strong local connections to leverage resources to address barriers to member wellness, such as hunger and problems in the home environment. For example, we have linked members with the St. Vincent DePaul Society to help them get food and clothing, or with Catholic Charities for assistance with rent and utilities payments. Our continual outreach builds credibility and relationships locally and creates additional opportunities to leverage the strengths and services of our partner organizations to promote wellbeing among our members and their communities.

**Linking Community Organizations to Promote Synergy.** We capitalize on opportunities to create synergy and expand the resources available in the community by linking organizations with one another to provide more robust services. For example, we participated in a community health fair organized by La Raza's Louisiana Affiliate, Puentes New Orleans. Another participant, A Community Voice, an organization of community members representing families, the elderly, women, children and workers in low-income communities, identified a need for health screenings in their community. Our MCRs

participated in the fair, but also helped them organize and coordinate with one of our providers, EXCELth, to bring a mobile clinic to provide much-needed dental screenings.

**Leveraging and Expanding Provider Capacity for Community.** LHCC's network FQHCs and RHCs have worked with us to provide opportunities for Louisianans to complete vital health screenings and assessments. Building on our relationships with our providers, we are working toward better leveraging their strengths to expand service capacity for their patients/our members. Specifically, we are working with practices that include mobile units to reach people in rural or underserved areas to ensure that communities can access preventive health screenings. For example, we will collaborate with Our Lady of the Lake Hospital to use their mobile clinics to a greater extent in 2015. In addition to the cholesterol, blood pressure and weight assessments that we often collaborate with providers to offer at health fairs; Our Lady of the Lake and other partners will provide *full* EPSDT exams, vision screening, mammograms, HIV and Chlamydia screening, and HbA1c testing.

We are partnering with Louisiana State University's KidMed Clinics in Monroe, Shreveport, Alexandria and Baton Rouge, to implement focused EPSDT screening efforts for our members through the month of September—allowing us to schedule up to 10 members to complete screenings per each half-hour increment. LHCC is training providers to use a specific billing code to receive incentive payments for participating in this pilot effort and committing their staff and resources. We will evaluate this joint initiative with LSU to determine whether to move toward more intensive EPSDT scheduling in their KidMed clinics year-round.

In May, we coordinated with Primary Care Providers for a Healthy Feliciana (PCPHF), a non-profit organization that operates RKM Primary Care FQHCs in Clinton and Port Allen, and four FQHCs adjacent to schools in the East Feliciana Parish Public School System; to target members for a wellness screening event. As a result, PCPHF approached us about helping them with their Be Fit Program that targets children (6-18) at risk for poor health habits. LHCC sponsored the fitness activities for the seven-week day camp this summer. In addition, every Wednesday our MCRs engaged in four hours of fun fitness activities (relay racing, jump roping, etc.) with the 60 campers, then provided healthy snacks.

### **Working with the Office of Public Health to Serve our Members**

LHCC leverages the capacity of the Office of Public Health (OPH) currently by including every OPH Parish Health Unit and School-Based Health Center in our provider network. They have been valued providers since Bayou Health began, and we continually seek feedback from them and our other providers about how to improve our processes and services.

LHCC will coordinate our public health-related activities with the OPH via one or more Memoranda of Understanding (MOUs) as per RFP Appendix RR, particularly in regard to sexually transmitted diseases, including HIV/AIDS prevention and treatment, TB screening and reporting, immunizations, WIC programs, family planning, maternal and child health, population-based services and Children's Special Health Services. We have in place, as noted throughout this RFP response, several programs addressing these Louisiana public health priorities; and we are ready and willing to coordinate and collaborate with all Bayou Health stakeholder organizations, including other MCOs, to better reach our identified common goals, priority populations and conditions and measureable objectives as agreed to via the MOUs.

**Data Sharing and Reporting.** We share and report data in coordination with our OPH network Parish Health Units and School-Based Health Clinics. We will work with DHH and other MCOs, per DHH needs and preferences and any HIPAA-compliant MOU, to implement data-sharing processes across our organizations that enable Bayou Health stakeholders to utilize data to jointly address health outcomes. For example, Centelligence™, our integrated data management system, can accept data from State Immunization Registries, and we welcome any opportunity to work with DHH and OPH on protocols that

would enable MCOs to receive regular data extracts from the Louisiana Immunization Network for Kids Statewide (LINKS). Currently we can access LINKS data online in the manner that providers do. However, an immunization data extract would allow us to import and integrate immunization data for our members to expand the “overall health picture” we have for our child members. This expanded view would further enhance our ability to identify needed EPSDT and other child health service needs.

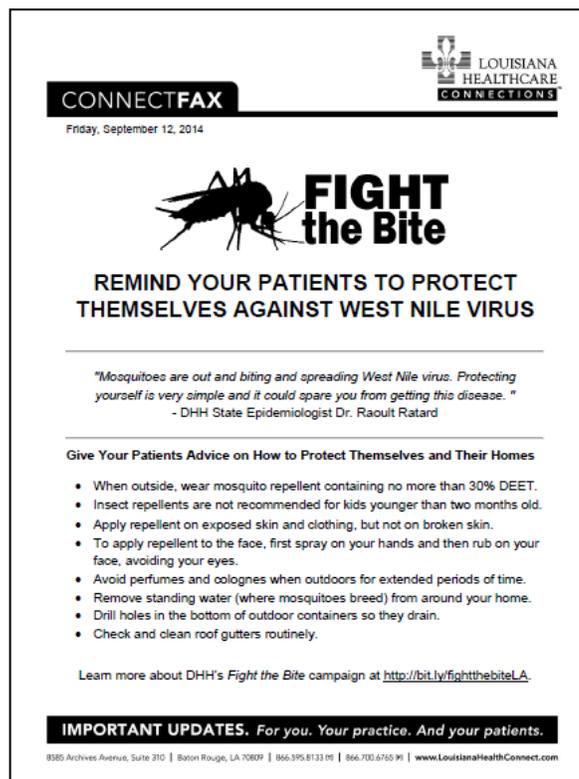
LHCC’s members and providers benefit from the state’s immunization program, and we train providers during orientation, and through the Provider Manual and Portal, about their responsibilities to use vaccines available via the Vaccine for Children (VFC) Program and how to report immunization data into the Louisiana Immunization Network for Kids (LINKS) administered by OPH. We also train them to coordinate with the WIC program to report required medical information and refer our potentially eligible members who would benefit from WIC services.

We use information from OPH to stay abreast of emerging public health issues so that we can take appropriate action. Based on OPH updates about the incidence of West Nile Virus and related deaths, for example, we sent a blast-fax to our providers (shown in the picture to the right) using OPH “Fight the Bite” campaign materials to alert them of the need to remind their patients to use simple protection against mosquito-borne transmission. We also directed providers to the OPH Fight the Bite webpage for information.

**Coordinated Outreach and Education.** We collaborate with our OPH providers to participate in health fairs, as allowable under state and federal marketing restrictions, which target members and non-members for health screenings and awareness information about Bayou Health and services available. We also reach members and work with the Public Health infrastructure through our practice of involving providers as partners in educating members.

Because we already share many health and wellness outcomes goals with DHH, we believe that greater coordination of outreach and education would greatly benefit not only our members, but all Bayou Health members. However, federal and state marketing restrictions prohibit health plans from outreaching to members through the OPH clinics to ensure that no MCO can influence enrollment of potential members who access care at the Parish Health Units.

Our affiliate health plans in other states coordinate outreach and education with other contracted health plans and the state contracting entity to provide compliant outreach and education to benefit all Medicaid members. For example, health plans in Mississippi, including our affiliate, Magnolia Health Plan (Magnolia), regularly provide education about important health and Medicaid issues in conjunction with Medicaid MCOs and the state’s Health Division. In addition, the plans suggest content based on feedback from their members. For example, Magnolia’s Community Advisory Committee uncovered a need for member training in a particular region to explain transportation benefits. Magnolia provided this outreach in coordination with the Division and another MCO that served that region.



**WIC and other OPH-Related Maternal and Child Health Services.** Since breastfeeding is so beneficial to babies and their mothers, as well as a natural means of birth control under certain conditions, LHCC and all Centene affiliate plans promote and support breastfeeding through collaborating with local WIC programs, and via our Start Smart texting program that provides breastfeeding information and support to members. We invite WIC representatives to our Baby Showers and Diaper Days to help educate our members about WIC services, the importance of nutrition in Maternal and Child Health and the benefits of breastfeeding. Our Start Smart for Your Baby (Start Smart) perinatal program includes WIC information in its educational materials.

### **Lifecourse Initiative for Healthy Families**

LHCC's Wisconsin affiliate plan is a member of the statewide Wisconsin Partnership Program at the University of Wisconsin School of Medicine and Public Health. The partnership includes local providers, MCOs, public health departments, business owners, community members, WIC representatives and regional faith-based organizations and advocacy groups. Through four regional coalitions, these entities work together to address high infant mortality in African American communities in Beloit, Kenosha, Milwaukee and Racine. They create an action plan for each target community which builds on that community's strengths. Focus areas are prenatal care, strengthening social support networks for families, and strengthening father involvement.

We also are a partner in the statewide Nurse-Family Partnership (NFP) that provides support for new first-time mothers for up to two years post-delivery. Partners meet to discuss local needs and issues and collaborate to address them. Our Case Managers attended the NFP Conference last year, and we regularly invite NFP representatives to our Baby Showers. We also invited an NFP representative to provide training to

our Case Management staff about referral criteria and processes, and refer members based on NFP criteria and our Start Smart screenings and assessments.

LHCC also will collaborate with state and other partners to support the **Ochsner Health System (Ochsner) Breastfeeding Peer Counselor (BPC) Program**, currently a proposed pilot project that builds on the WIC "Loving Support Peer Training Counseling" program and local breastfeeding awareness and education efforts. Peer breastfeeding support and education that continues as new mothers return home post-delivery is anticipated to improve breastfeeding exclusivity at discharge and 3 months of life by 20-40%, duration of breastfeeding up to 6 months, mothers' breastfeeding self-efficacy, and community awareness of breastfeeding benefits, and reduce the number of urgent care visits and related expenditures.

We provided a letter of commitment for Ochsner's grant application to the Kellogg Foundation, pledging to assist Ochsner in developing a sustainable reimbursement model; including defining covered services, eligibility criteria, and Peer Counselor qualifications. We also will establish a system for referring to the program eligible members from our Start Smart program and to coordinate education and outreach to support breastfeeding.

LHCC will explore additional ways to leverage state public health resources to support Maternal and Child Health. For example, we may outreach to our OPH clinics that provide WIC and other nutritional counseling services to collaborate with us via our Healthy Lifestyles Program to host healthy cooking events that feature cooking demonstrations with recipes developed based on Louisiana WIC food list.

**STI Screenings.** Members are often uncomfortable going to their PCPs for services and screenings related to sexually transmitted diseases. Because of the importance of these screenings, we pay claims from any Medicaid-eligible providers and urge members to complete testing at any location, though we prefer, encourage and support access to care through the member's medical home.

We provide information about the services available (such as family planning and HIV screening) at each Parish Health Unit and School Based Health Clinic. In addition, two of our **MCRs are certified OPH HIV Prevention Counselors**, and all of our MCRs will complete the **HIV Prevention Counseling and**

**Rapid Testing by Q2 2015. This will enhance our ability to engage and refer members for screening.**

We also participated in an event targeting teens organized in part by **Office of Public Health**, and the **Baton Rouge AIDS Society**—an OPH-contracted HIV/STD Program community organization. We will continue to find opportunities to work with providers and community organizations involved with the OPH HIV/STD program to leverage their experience when reaching out to our members in their communities about this sensitive issue.

*Strategies to utilize faith based, social and civic groups, resident associations, and other community based organizations that now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services*

### **Approach to Partnering with Community Based Organizations**

LHCC’s strategies to utilize community-based organizations includes engaging traditional Medicaid providers, locating in communities where members live and work, and partnering with those local providers and health and human services organizations to reinvest in community-based services that contribute to the overall well-being and quality of life of our members and their families, friends and neighbors. We seek to partner with those whose knowledge, strengths, and expertise, when joined with ours, can impact generations of families. Thus, we focus primarily on partnerships that:

**Over the last two years, we have donated more than \$750,000 back into the community.**

- Strengthen the health and human service infrastructure
- Target initiatives to prevent or address emerging or existing issues
- Address disparities and barriers to accessing services.

The following section is organized according to these main priorities. The final sections describe how we engage with and foster accountability to the communities we serve and provide some examples of organizations that we support financially because they share our priorities and commitment to our communities

### **Building the Health and Human Services Infrastructure**

LHCC reinvests locally with organizations and providers to help ensure a range of comprehensive community-based comprehensive services that are available to all community members. Such partnership enables us to help build the infrastructure to support healthy communities.

**Urban League of Greater New Orleans.** Urban League is the oldest community-based initiative in the country to empower disadvantaged, ethnically disenfranchised communities, and their community affiliates have improved employment opportunities, health, education and housing for disadvantaged citizens in every area they serve. ULGNO is no exception, and their mission aligns with ours. We **pledged \$600,000 over a three-year period to help ULGNO build a permanent headquarters and increase their capacity** to serve communities throughout the Greater New Orleans Area. We have provided the first of three payments toward funding their new home in New Orleans’ Mid City neighborhood on North Carrollton Avenue.

The ULGNO provides services to more than 10,000 Louisianans per year through its Centers of Excellence focused on education and youth development, workforce and economic development, and public policy and advocacy. The new headquarters will provide needed additional space to support UNGLO’s community programs that help overcome educational, economic and health disparities. These include their Project Ready (college preparation program), Parent Information Center, and early Head Start Program that provides whole family services, such as perinatal education, pregnancy support and health screenings.

In helping ULGNO expand their capacity, we are creating opportunities to expand our own capacity. We are exploring with ULGMO ways that we may leverage our existing collaboration to enhance services and/or outreach, For example, we will work with ULGNO, as well as other partners, to possibly develop and/or expand on the following initiatives and ideas.

Ongoing and Potential LHCC-ULGNO Expanded Partnership Initiatives	
<b>Early Childhood Literacy</b>	ULGNO operates an Early Head Start program for preschool children. Our MCRs will work with them to incorporate our Adopt-a-School literacy events into their curriculum in ways that complement what they are teaching. For example, we might focus on fitness and a “Healthy Snack Attack,” to engage children in physical activities and choosing healthy foods during their scheduled recess or snack periods.
<b>Teen Pregnancy Prevention</b>	National Urban League (UL) and Centene collaborated to create our <i>Off the Chain: Teens and Pregnancy</i> book, and we will explore how to use this book to support a teen pregnancy prevention initiative. For example, we might jointly host our “Teen Talk Chit-Chat Sessions” to engage adolescents about making good choices, or we could offer them as part of ULGNO’s outreach to high school kids.  Centene is working with UL to pilot a pregnancy prevention program based on Off the Chain materials that incorporates online modules that will qualify for high school credit. The three-year pilot will begin in 2015 in Georgia, Florida and South Carolina. If the pilot shows measurable success, LHCC may work with ULGNO to adopt it in the future.
<b>Obesity Prevention and Intervention</b>	LHCC is partnering with ULGNO and the Children’s Hospital to implement a multi-faceted obesity prevention program, <i>Let’s Move GNO!</i> based on the <i>Let’s Move!</i> Meet-up model championed by Michelle Obama. We will seek additional community partners, including schools, community organizations and universities. We will incorporate elements of our Healthy Lifestyles program related to healthy food and cooking, and our other initiatives described more fully in the section on prevention and intervention partnerships that follows.
<b>Hudson Initiative Small Enterprise Certification Training</b>	We are working with UGLNO, and in collaboration with the Lake Charles, Shreveport and Baton Rouge Chapters of 100 Black Men; and the Baton Rouge, New Orleans and Houma Regional NAACP affiliates, on an initiative to educate local small business owners about the state’s Hudson Initiative and assist them in becoming certified Small Entrepreneurs as a way to build community resilience and employment opportunities. LHCC will help develop components of the training and publicize it via our network of community partners.

When the new ULGNO headquarters are complete, LHCC will rent office space, further ensuring sustainability for their programs with a regular source of income while also allowing us to locate a team of member-facing staff in the ULGNO building. This will facilitate our joint efforts to serve communities. We provide regular sponsorship support for ULGNO’s and National Urban League events. When the ULGNO hosted the National Urban League conference in New Orleans in 2012, LHCC and Centene teamed up to provide one of three major sponsorships for the event, providing \$25,000 in support, and we have continued this support for ULGNO, providing another \$25,000 for ULGNO’s 2013 annual gala, and

\$75,000 for this year's gala. ULGNO appointed Jamie Schlottman, LHCC CEO, to their board of directors, and chose him as their 2014 Gala Chair. We also donated \$1,000 toward a ULGNO Scholarship to a graduating senior this year.

We are linked with Urban League nationwide through our affiliated plans in other states that also collaborate with local Urban League chapters, and Michael Niedorff, Centene's CEO, is on the UL National Board of Trustees. In fact, Centene is the only MCO representative on the UL Health Advisory Council that proactively addresses local issues at the federal level by providing unbiased, clear information to congressional staff, including staff for the Congressional Tri-Caucus, representing citizens of African-American, Asian/Pacific Islander and Hispanic descent.

**Metromorphosis.** LHCC supports MetroMorphosis, a nonprofit organization in Baton Rouge working to transform inner-city neighborhoods in the areas of health, education, and community development. We do so both financially and in a leadership capacity through our CEO's service on the board of directors. Founded by Pastor Raymond Jetson, a Harvard Advanced Leaders Institute graduate and respected community leader in Baton Rouge and New Orleans, MetroMorphosis convenes a wide array of community partners, using an innovative approach to church congregations as change agents, to tackle the root causes of some of the Capital Area's most challenging problems.

- **Medical-Legal Partnership:** This healthcare delivery model integrates legal assistance into patient care. For example, Medical-Legal Partnership works on behalf of children with asthma exacerbations due to triggers in poor housing conditions (mold, rats, cockroaches) by negotiating with landlords to remove the triggers. Addressing these legal concerns is an important part of effective health care.
- **Better Baton Rouge:** Better Baton Rouge community partners engage in a collaborative process to address complex issues affecting the growth and progress of urban communities.
- **Urban Congregations:** Unleashing the Untapped Potential of Urban Congregations is designed to effectively engage, organize, and deploy a human resource pool to create positive change.
- **Urban Leadership Development Initiative:** The Urban Leadership Initiative is offered to selected individuals to teach them how to identify opportunities, develop innovative solutions, and build coalitions to implement those solutions.

**Capitol Area Homeless Alliance.** LHCC is partnering with the Capitol Area Homeless Alliance to expand health care services to those without adequate or stable housing. As an Alliance board member, our Director of External Relations helped coordinate an Alliance initiative to help the homeless access critical health care services, including preventive care that could address unnecessary ED utilization and prolonged or exacerbated health problems, by assisting them in enrolling in Medicaid. LHCC's MCRs also support people without permanent housing by volunteering weekly at Abraham's Tent in Lake Charles. They help prepare the dining hall, serve lunches, distribute non-perishable food items and clothing, and clean up the dining hall after the meal.

### **Partnering for Prevention and Intervention**

LHCC partners with providers and organizations that target initiatives to address the most prevalent health issues in their communities, as well as those dedicated to prevention and early intervention.

**YMCA/YWCA.** LHCC partners with regional YMCA affiliates to offer several programs that promote community wellness. Partnering with the ExxonMobil YMCA in Baton Rouge, for example, we sponsored enrollment for 150 kids from low-income families to participate in swimming and water safety lessons in the **Swim, Succeed and Survive** program.

We also partnered with YMCAs in Regions 2 and 3 and with YMCAs/YWCAs in Regions 6 and 7 to engage kids in **Be Fit**, a program that engages elementary school children in monthly strength-building, fun competition to encourage fitness and build teamwork skills. We also partnered with these organizations on Kiddie Olympics, which provides activities for elementary school children and toddlers annually during Spring Break. Other partner organizations for these programs include RKM clinics, Boys and Girls Club and Ryan Elementary School, Northwestern State University, Caddo Community Action Agency, and Einstein Academy.

### LHCC IN ACTION...

*"84% of the children in our camps and swim lessons are only able to participate as a result of the contributions and support of organizations such as Louisiana Healthcare Connections."*

Ronald Smith, Executive Director, ExxonMobil YMCA

In addition, we participate in Lunch and Learn meetings at the YMCAs in Regions 2, 6, and 4 to engage senior citizens in fitness activities and teach them about good nutrition and avoiding dehydration. We provide educational materials such as our *My Route to Health* book and cookbook. LHCC is working with our YMCA partners and all affiliates statewide to expand these Lunch and Learn and fitness programs throughout Louisiana beginning in 2015.

**Eat for Life Fresh Foods Health Fair.** LHCC has partnered with **Kingsley House** (the oldest Settlement House in the South that serves families, children, and people who are elderly, frail or medically fragile) and Market Umbrella, an organization that supports local markets to preserve traditions and support small producers, such as farmers. We worked with these organizations to host two *Eat for Life* Fresh Foods Health Fairs to raise awareness of the link between diet and health. Targeted to Kingsley House children and families, the fair

showcased the benefits of growing, cooking and eating fresh fruits and vegetables.

More than 500 Kingsley House Head Start, Summer Camp Adult Services and Senior Center participants attended our most recent fair in 2012. Participants sampled healthy chef-prepared foods, vegetables, and yogurt. The New Orleans Food and Farm network taught participants how to plant seeds and children sampled tomatoes grown in the Kingsley House garden. In addition, all participants received a voucher redeemable

for \$10 in tokens at the Crescent City Farmers Market to be distributed for use during upcoming field trips to the farmers markets over the next week. The photo below shows kids dancing along with Radio Disney.



**Let's Move! GNO.** LHCC is partnering with ULGNO and Children's Hospital to develop a multi-faceted obesity prevention program for 2015, *Let's Move GNO!* based on the *Let's Move!* Meet-up model championed by Michelle Obama. We will seek additional community partners, including schools, community organizations and universities. For our part, we will incorporate elements of our Healthy Lifestyles program includes components related to healthy food and cooking, and choosing nutritious, health foods on a limited budget. Our overall goals are to help Louisianans to *Eat*

*Healthy, Get Active and Live Well* through events and activities, such as community gardening (especially in "Food Deserts"), health education and screenings, and physical activities.

Beyond a Let's Move! event, we will support ongoing initiatives around our three goals, such as creating a "Train the Trainer" program kit for schools and other community organizations to remind Louisianans to maintain healthy behaviors, and we will sponsor and/or support recreational sports leagues (registration fees, equipment, etc.), with the hope of engaging more than 500 Louisianans.

**Baby Showers and Diaper Days.** Through our MCRs, LHCC hosts quarterly baby showers, rotating the locations throughout LHCC's service areas, for our pregnant and recently-delivered members. Partnering with community health centers and local health and human services organizations, we provide educational materials, including our March of Dimes endorsed Start Smart Pregnancy Book, information about infant care, lead poisoning, child safety and the importance of scheduling well visits. We invite all new and expectant mothers by region and provide refreshments and DHH-approved baby gift items, such as sippy cups, bibs and baby books, as an incentive to participate. When our baby showers are part of an event hosted by a local service organization, MCRs will set up a booth to provide educational materials and baby gifts. Our Start Smart Case Managers often attend the baby showers to provide in-person education.

Similar to Baby Showers, Diaper Days are more targeted to the families of newborns. We focus on postpartum care, infant care, EPSDT services and issues related to being new parents. We host Diaper Days monthly, and we engage new mothers and fathers and support them in being active in their baby's development and health and wellness care. We provide baby gifts and child wellness literature, as well as our *Dad: Little Word, Big Deal* book for new fathers. Along with **Family Services of Greater New Orleans' NOLA Dads program**, which provides support, mentoring and education, we hosted a "Diaper Days for Dads," exclusively for young new fathers in the area on June 26, 2014. We plan to continue partnering with NOLA Dads to host targeted events for fathers.

As of the end of August (prior to submitting this RFP response), we have hosted 54 Baby Shower and Diapers Days statewide for 2014. We have collaborated with a wide range of organizations for these events, such as **Volunteers of America** in Alexandria; **Battered Women's Program** in Baton Rouge to provide education to women with young children staying in the shelter; and **The Providence House**, a shelter in Shreveport, in support of homeless families. We also participated in the Healthy Baby Expo and Diaper Derby in Lake Charles organized by the **Zeta Phi Beta Sorority** (a national sorority for African American women), Lake Charles Chapter, and other events focused on maternal and child health and supporting new parents.

### LHCC IN ACTION...

#### LHCC and Let's Move!

LHCC invited all Bayou Health MCOs in 2013 to join us in an initiative to raise a healthier generation of kids. Our initial Let's Move! Project featured quarterly health fairs for families with activities such as jump rope and hula hoop contests, dancing and Zumba, to get participants to move!

Building on the success of this effort, LHCC and our partners will create a permanent Let's Move! GNO obesity prevention program in 2015 to engage more than 500 Louisianans in Orleans and Jefferson Parishes.

## Partnering to Address Disparities

All of our partnerships and sponsorships address health disparities by focusing on prevention and/or the determinants of health. By having our MCRs and partners in the community proactively addressing health literacy and strengthening school and community educational efforts, we are helping to address one of the main determinants of health— educational attainment.

**School-based Events.** Our MCRs partner with public elementary schools across the state monthly to read books about health and wellness to students in preschool and up to Grade 5, also completing an activity related to the book topic. For example, we read Scholastic’s *Froggy Goes to the Doctor* book that addresses the anxiety some children have about doctor visits, and focuses on the importance of regular visits. MCRs ask questions about the stories, and give a copy of the book to the student who correctly answers the most questions. We often read from the *Boingg and Sprockette* series, particularly *Adventures in Fitropolis*, or we talk about good nutrition and provide healthy snacks and the *Super Centeam 5 Cookbook*. Students complete activities related to the focus topic, and they receive related items such as coloring books and colors, cookbooks and water bottles. We regularly visit 20 elementary schools and Head Start or preschool programs. Our MCRs also target outreach and activities specifically to teens through schools and faith-based organizations, as noted below.

“Louisiana Healthcare Connections has been an active and engaged good corporate citizen and has generously provided resources that are greatly needed in our community and we are witnesses to the powerful impact that LHC’s commitment to better health has produced.”

**Tonya Robertson,**  
Executive Director,  
Young Leaders Academy of Baton Rouge

**Young Leaders Academy of Baton Rouge.** LHCC supports the **Young Leaders Academy (YLA)**, a non-profit organization that operates a mentoring program for African-American teenage boys in a low-income area of Baton Rouge. In addition to providing leadership support through our Director of External Relations’ board membership, we regularly provide financial support. We funded YLA’s September Town Hall meeting organized in response to the situation in Ferguson, Missouri following the death of a young African-American man during a police visit. Community leaders from the District Attorney’s office, Police Department, churches and other organizations came together with local residents to discuss how to avoid a situation like the one in Ferguson, open up channels of communication, and proactively

develop a plan to “act, rather than re-act” to strengthen their community and make it safer. Hundreds of community members attended the meeting, for which we provided a venue and food.

### LHCC IN ACTION...

#### Supporting Innovative Education

*The MAX Charter School was the first school in Louisiana dedicated to educating students with dyslexia and related learning differences. We are proud to support innovative technology here and in other schools to enrich teaching.*

**Health Initiatives for Teens.** Our MCRs use our “Off the Chain” series for adolescents that addresses a variety of health issues as a way to facilitate communication with teens. Teen Talk Tuesdays and Teen Chit-Chat Sessions provide a forum to discuss with tweens, pre-teens and young adults the issues they face, such as peer

pressure, keeping a positive attitude, healthy behaviors and choices, resume building, conflict resolution (anti-bullying), conduct for using social media, and personal hygiene. Building on her strong ties to her church and rapport with its young congregation, one of our MCRs initiated a **Teen Chit-Chat Session series** with youth at **Ivory Chapel Baptist Church** in Bastrop as a segment within their monthly youth day events. Based on her success, another MCR initiated **Teen Talk Tuesdays** at **The Louisiana College**

**in Pineville and University of Louisiana at Lafayette.** All of our MCRs work with middle and high schools and other organizations to talk to teens and offer “Off the Chain” materials

**Supriya Jindal Foundation for Louisiana’s Children.** LHCC partners with the Supriya Jindal Foundation for Louisiana’s Children to provide interactive whiteboard technology to classrooms at **Max Charter School** in Thibodaux and **Ridgewood Preparatory School** in Metairie. Studies show that such technology gives students the opportunity to learn by combining visual representations, sounds, and the ability to interact with the whiteboard and their fellow students. These interactive whiteboards allow teachers to engage and support students with varied learning styles.

### Accountability to Local Communities

**MCRs Making a Difference in the Community.** Our MCRs are our “SWAT Team” in reaching out to impact communities in which our members live and work to help strengthen communities and build relationships. As noted, they are community health workers from those areas they serve. We encourage and support them to build on the relationships they have developed with organizations in their communities because they live in those communities.

Our MCRs have developed partnerships with numerous community services groups, schools and faith-based organizations in each region. They participate in and facilitating events such as health literacy readings; math and science fairs; nutrition education; physical fitness activities; anti-bullying programs; hygiene presentations for junior high school students and pep rallies to motivate students to prepare for success in state achievement testing (LEAP) and as they become adults. In addition, they work in their communities to feed the homeless, collect gifts and food for low-income families for holidays and other times, and so much more. The network of collaboration they create fosters community support and trust, enabling LHCC to more effectively provide health education to our members and their communities.

Each MCR conducts home visits to high-risk members to support our Case Management staff when members are difficult to reach, as well as visit providers to let them know how MCRs can help them engage members, and to engage them as partners in educating members assigned to them, such as through our Healthy Celebrations. Through their role outreaching more broadly to local health and human service organization, our MCRs connect us to members and their families and friends to an extent that is unique among Bayou Health MCOs. Our MCR Manager works closely with our 12 regional MCRs to ensure statewide member and community engagement on a regular schedule.

#### LHCC IN ACTION...

*“Since Bayou Health launched, Louisiana Healthcare Connections has provided resources central to the vitality of our community, and we have seen the impact of your commitment to better health.”*

**Lorri Burgess, COO, Baton Rouge  
Sickle Cell Anemia Foundation**

#### LHCC IN ACTION...

*“The weekly Snack Attacks allow kids to taste and create fun snacks to share with family and friends. Students are super creative and have great ideas for healthy snacks.”*

**LHCC MCR Manager**

For example, in addition to hosting the monthly and quarterly outreach activities noted previously MCRs participate in community events, such as health fairs, each month; join and participate in monthly meetings with community collaboration organizations in their regions; and complete additional events *weekly*. For example, MCRs visit schools for “Snack Attacks,” where they help kids choose foods to make healthy snack after school, or many other volunteer activities that promotes community wellbeing. Not only do our MCRs thoroughly engage themselves in their communities, they help organize, motivate and coordinate all LHCC staff to do so in support of our culture of giving back to our communities.

**Community Events and Health Fairs.** MCRs participate in numerous health fairs throughout the state each year. As noted, we organize community events and encourage and support all staff to participate in events such as community health awareness walks and fundraising events for organizations that support health literacy and overall wellness.

MCRs helped organize and promote LHCC staff participation in a Sickle Cell Awareness 5K Walk/Run in August hosted by the **Sickle Cell Anemia Foundation of Baton Rouge**. LHCC sponsored the event, in which 42 LHCC staff participated. We have sponsored and participated in their 5K annually since 2012, as well as provided financial support for **Southwest Louisiana Sickle Cell Anemia, Inc.**, which provides genetic testing, counseling, case management and behavioral health support for individuals and families.

So far this year MCRs have participated in wellness and education events such as:

- The NOLA Life Festival hosted by Greater St. Stephen Ministries
- The Dads, Dunks and Dominoes fair targeting young men in New Orleans
- Teche Action Clinic Health Fair in Pierre Part
- West Monroe Community Health Fair
- Carroll High School (Monroe) Spring Extravaganza for students, parents and community members
- Donaldsonville Teen Summit, hosted by the Office of Public Health, Baton Rouge AIDS Society, Catholic Charities, and Councilmembers Oliver Joseph and Ronnie Edwards.

We participated in **Job Corps' 50<sup>th</sup> Anniversary Health Fair Celebration** in New Orleans, and our MCR in Regions 1-2 also attends the **Job Corps Community Committee** meetings (please see the community coalition section below) in Shreveport, where representatives from about 30 local organizations work together to coordinate and keep informed of services available in this rural area to maximize their impact on community health outcomes.

**Community Coalitions.** MCRs meet regionally with local coalitions organized to bring together a variety of community partners, such as health advocacy groups, Bayou Health MCOs, and community health clinics (FQHCs) to share information about upcoming events, potential collaborations, and to identify and address local and regional health disparities and unmet needs. Many times, these meetings directly result in our participation in a community event, or a more long-term initiative.

As a member of the Louisiana Community Health Outreach Network (LaCHON), one of our MCRs learned about the **Louisiana Community Health Worker Training Institute (LCHWTI) at Tulane University School of Medicine**. When our MemberConnections Manager expressed interest in Community Health Worker Certification for our Connections team, that MCR connected her with LCHWTI Director, Dr. Ashley Wennerstrom. As a result, we are exploring the possibility of certification for our senior MCR staff, as well as ongoing staff training through LCHWTI.

**MCRs work with coalitions such as:**  
Gulf Coast Coalition  
Healthy Community Coalition  
Central City Renaissance Alliance  
Lafourche Parish Library  
LSU Agricultural Center  
United Way

LHCC participates with Families Helping Families in their annual Resource Information Workshop to provide a “resource hub” for the local communities where they are held; and an Educational and Empowerment Resource fair to help community members access preventive health care and community services (food, clothing, etc.) with a health information exhibit. Our MCRs have participated in events with or are members of numerous coalition organizations (see box, left, for examples) that help provide health education to our members and their communities.

**National Health Awareness and Education Campaigns.** MCRs and other LHCC staff have participated in or initiated activities related to national health awareness months. For example, MCRs have participated in a community awareness fair at Louisiana State University’s Earl K. Long Hospital for **World HIV/AIDS Awareness Day** for the last two years, and we collaborate with several of our network hospitals (such as Children’s Hospital of New Orleans, St. Jude Children’s Research Hospital and Our Lady of the Lake Children’s Hospital) to visit children as part of **National Leukemia and Lymphoma Awareness Day** and provide them with teddy bears.

As part of LHCC’s partnership with the **American Heart Association (AHA)**, MCRs engaged Oak Park Elementary School as a partner to participate in **National Wear Red Day** in 2013 and 2014 as part of our regular literacy outreach. We encouraged students and teachers to wear red for a fundraising event that we helped the children organize. The students’ Wear Red Day fundraising efforts brought in \$250.00 in 2013 and in 2014 raised \$385.00 to donate to the **American Heart Association**.

LHCC’s **CEO** is on the **AHA Board of Directors** and we sponsored a “Circle of Red” table at AHA’s annual fundraiser luncheon in support of their “Go Red for Women” campaign to increase awareness of the symptoms of heart disease in women, which often go undetected until a woman has a life-threatening event, such as a heart attack or stroke. We provided \$25,000 in funding in 2013. LHCC employees have participated in the AHA Capitol Region 5K Walk/Run every year since 2012.

**LHCC Employees Strengthening Their Own Communities.** Because our employees live and work here, they also provide valuable feedback as community members. We encourage and support them to volunteer in their communities by providing time off and company-wide recognition. As valued members of their communities – parents and coaches and neighbors and friends -- LHCC employees have a stake in working to make them stronger. Our employees volunteer time and effort organizations such as Boys and Girls Club of Baton Rouge, Baton Rouge Youth Coalition, local schools and churches, and many others.

Staff members have organized teams to participate in the March of Dimes 5K, and to collect toys, food and clothing for low-income families. They are beginning preparation for LHCC’s annual food drive that culminates in a volunteer day at Greater Baton Rouge Food Bank where they stock shelves and serve and distribute food for the holidays. They partnered earlier this year with the St. Vincent DePaul Society, Kean’s Cleaners, and WAFB television to provide gently used uniforms to youth in the East Baton Rouge Parish School System.

Each year, LHCC’s employees also participate in corporate-wide giving campaign to raise money for the United Way. Centene Chair/CEO Michael Neidorff encourages executive staff of all our affiliated health plans to participate and pledged to match funds at 50 percent of all funds raised in each state to donate to local United Way organizations. LHCC employees developed and held fundraiser activities that included an email bingo game, garage sale, bake sale, and pay to ride the elevator fundraiser. Our staff donated more than \$20,000 to Louisiana United Way chapters. With its focus on addressing health, income and educational disparities, United Way is a valued partner organization that shares our commitment to improving the wellbeing of Louisianans.

### LHCC IN ACTION...

Our employees identify opportunities for LHCC to make a difference. As “Reading Partners” at University Baptist Church, our VP of Finance and his wife mentor and work with students to improve literacy at Highland Elementary School, which primarily serves families in poverty. When they learned that the school would have to discontinue its Accelerated Reader Program due to budgetary constraints, LHCC intervened to fund the program for the year. Our VP perfectly summed up the value of our shared investment in Highland: “We just love being a part of helping children improve their reading skills. I think I’m the one getting the reward.”