

SECTION O: DISEASE MANAGEMENT PROGRAM

O.1 Amerigroup’s Chronic Care/Disease Management Program

O.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for Bayou Health. Include information on work you have conducted in other states, if applicable. Include how you measure success for each of the populations (i.e. 20% reduction in 30-day readmission rate for members with diabetes); any state models you plan to implement in Louisiana; and how you plan to partner with national, state, or community foundations to support this work. Your plan should include but is not limited to:

- *How recipients will be identified for inclusion into the Chronic Care/Disease Management program, including populations of special interest to Louisiana e.g. reproductive aged women with a history of a prior poor birth outcome and members with Diabetes, HIV, Hepatitis C and sickle cell disease.*
- *How you identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program.*
- *How you identify members who require in person case management services.*
- *Plans to integrate with existing resources/programs in Louisiana as well as your plans to have care managers “on the ground” in addition to telephonic case management*
- *How the Chronic Care/Disease Management program will coordinate information and services with the PCP.*
- *Methods for case management in ways other than simply telephone management. These may include the use of pre-existing community organizations, community hubs, community health workers etc.*
- *How you engage patients (in person, mobile apps, telephonic) and explain your model of case management including what types of personnel (lay health workers, nurses, social workers) are providing case management.*

Amerigroup Louisiana’s Chronic Care/Disease Management Program for diabetes resulted in a **22.9 percent** reduction in ED visits and a **16.3 percent** reduction in inpatient admissions in a 2012/2013 year-over year comparison. 

Since 2012, Amerigroup has been providing chronic care/disease management services to members in the Louisiana Bayou Health program to improve health outcomes for those with chronic illnesses. We have established processes, policies, and procedures based on our experience in Louisiana and our affiliates. We have 23 years of experience serving members with chronic illnesses who receive their health care from government-sponsored programs across the nation.

The key feature of Amerigroup’s Chronic Care/Disease Management program is our member-centered focus and approach. *We realize our members often must make significant changes to their lifestyles and daily living behaviors to achieve sustainable progress in health outcomes related to chronic conditions.*

Delivering health education has limited impact unless it is framed by members' readiness to make those changes and addresses their individual ambivalence about adopting new behaviors.

Amerigroup achieves positive outcomes by encouraging member education and self-care through motivational interviewing, collaboration and coordination of health care services and supports through our providers, and by providing interventions within a holistic care management model.

We support member behavioral, social, and physical health care needs by providing individualized services by screening, assessing, and developing tailored member interventions while working collaboratively with the member, family, caregivers, providers, and others involved in the member's care.

Amerigroup offers eleven Chronic Care/Disease Management programs for members in our Louisiana Bayou Health program, including ***eight programs with NCQA accreditation:***

- Asthma
- Diabetes
- Coronary artery disease
- Congestive heart failure
- Chronic obstructive pulmonary disease
- HIV/AIDS
- Major depressive disorder
- Schizophrenia

We also have three additional chronic care programs, based on prevalence in Louisiana, including bipolar disorder, hypertension, and substance use disorder (SUD). ***Amerigroup Louisiana (Amerigroup) has adopted standardized definitions to clearly define our Chronic Care/Disease Management programs that are based upon industry standards, nationally recognized and evidence-based clinical practice guidelines (CPGs), and regulatory requirements.***

Amerigroup recognizes and addresses other prevalent conditions that require more aggressive interventions in Louisiana through our Case Management program described in full in Section K. Case Management of this response. This includes tailored programs for reproductive aged women with prior poor birth outcomes, hepatitis-C, obesity, and sickle cell disease. We continually identify prevalent chronic care conditions that will benefit from a program that includes individualized outreach specifically tailored to our members' needs.

Table O.1-1 illustrates a sample set of reduction in ED visits as well as inpatient admissions across Amerigroup and our health plan affiliates offering Chronic Care/Disease Management programs. The below programs were chosen as they are representative of many of the most prevalent chronic conditions in the Bayou Health populations. The sample set below shows improved outcomes for members in our Chronic Care/Disease Management Program. ***Between 2012 and 2013, Amerigroup and our affiliate health plans experienced an overall reduction in all DM programs of 19.6 percent in emergency department (ED) visits and 25.3 percent for inpatient admissions based on claims analysis.***

Table O.1-1. Amerigroup and Our Affiliate Health Plans’ Chronic Care/Disease Management Programs Improved Member Outcomes for ED Visits and Inpatient Admissions from 2012 to 2013

Amerigroup and Our Affiliate Health Plans’ Chronic Care/Disease Management Results for Emergency Department Visits and Inpatient Admissions: 2012 – 2013 Year-Over-Year Comparison		
Disease Management Program	ED Visits Per 1,000 Members	Inpatient Admissions Per 1,000 Members
Asthma	- 27.2%	- 39.5%
Congestive Heart Failure	-12.5%	-10.6%
Diabetes	-14.7%	-8.2%
Major Depressive Disorder	16.5%	-9.9%
All Disease Management Programs	-19.6%	-25.3%

Through our comprehensive Chronic Care/Disease Management programs, we identify, educate, and coach members with chronic conditions to take greater responsibility for their health, wellness, and quality of life. We empower them to adopt improved self-management skills – thereby improving participation in primary and preventive care, enhancing health outcomes, and reducing preventable ED visits or inpatient admissions.

Identification of Members for Chronic Care/Disease Management

Amerigroup’s goal is to intervene early – before members even have symptoms or are diagnosed with a chronic condition. We accomplish this by outreaching our members to develop relationships, conducting assessments as needed, and developing a member-centered care plan that includes our members’ strengths, conditions, symptoms, needs, goals, and preferences. We also continually monitor and analyze member health status, risk factors, and family history to assess their risk for existing, potential, impactable, and preventable chronic conditions.

Referrals to Chronic Care/Disease Management

While Amerigroup has very robust systems to identify and stratify members’ risk and capture the information that supports their engagement and progress, we know that one of the most important elements in engaging them in healthy behaviors and self-care is the human factor. Under the direction of our Chief Medical Officer, our program connects people to collaborate and coordinate care that is holistic and individualized to our members’ conditions. We begin by identifying members through the following types of referral sources:

- New Member Welcome Call screening
- Member self-referral, family members, and caregivers
- Member Services and *Nurse HelpLine*® representatives
- Network providers
- External organizations that provide carved out services, such as behavioral health, dental care, and home and community-based services and supports (HCBS)
- Utilization management personnel
- Integrated clinical rounds

Case Management Referrals

A member may also be transferred from our case management programs to the Chronic Care/Disease Management program. Upon identification of a member’s chronic illness, our Nurse Case Manager (Case Manager) ascertains the individual’s interest in a condition-related program. If clinically indicated and with the member’s permission, the case management staff coordinates with the appropriate chronic care/disease management point of contact by sending a referral that describes the member’s condition, progress, and readiness for transition. Subsequently, if clinical intensity is indicated, the Case Manager transitions the member to our Chronic Care/Disease Management program.

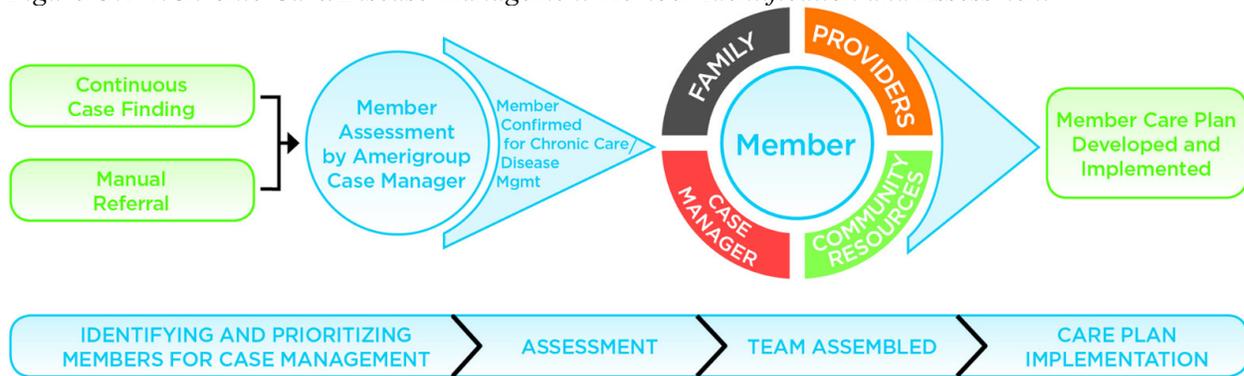
Behavioral Health Referrals

If, during initial screening or through other contact, a member is identified as needing further behavioral health assessment, he or she is referred to our Behavioral Health (BH) Case Manager for further assessment. Our BH Case Manager determines whether the behavioral health needs are specialized or routine in nature. If basic in nature, the Case Manager completes a referral to the member’s PCP or other appropriate provider based on the individual’s conditions. If more specialized behavioral health interventions, such as further behavioral health assessment, therapeutic services, psychotherapy, substance use, or detoxification are needed, the BH Case Manager refers the member to the Louisiana Behavioral Health Partnership (LBHP) Statewide Management Organization (SMO).

Use of Data

Amerigroup also uses the two-year data provided by DHH, as well as systematic case finding and assessment methodologies, to identify members eligible for chronic care/disease management services and interventions. Member information is integrated from multiple sources, including claims and encounter data, assessments, and referral information. Figure O.1-1 illustrates our process for identifying and prioritizing members for our Chronic Care/Disease Management program, completing the intake assessment, identifying care team participants, and developing the member care plan.

Figure O.1-1. Chronic Care/Disease Management Member Identification and Assessment



Timely and Accurate Information

Amerigroup recognizes the importance of receiving accurate information in a timely manner to expedite interventions that can prevent escalation of the symptoms our members’ experience. All referrals to the program are documented in our care management system. Member 360° combines member data and information from various sources into a single record to provide a holistic picture of the member’s utilization, care management services and gaps in care. Member 360° includes such information as member health risk assessments, care plans, longitudinal member health records, and clinical data.

Amerigroup is advancing providers access to member health care information and further *supporting the development of Patient Centered Medical homes* via our integrated care management platform, Member 360SM. Through the *provider facing* Member 360SM tools, providers who have members attributed to them can see the member record via the Amerigroup provider portal giving them simple, easy-to-access data and information to assist them in *engaging the member in their health and well-being*. The integrated data will be displayed to make it easy for the provider to act on it and making sure their patients are getting the services they need. This view will enable any provider who is treating our members to see the full picture including care plans and assessment information, enhancing their ability to reduce duplication and improve their quality of care. The physician view will enable them to understand from a population health perspective, how their members are doing and more importantly, give them information that helps them achieve better results.

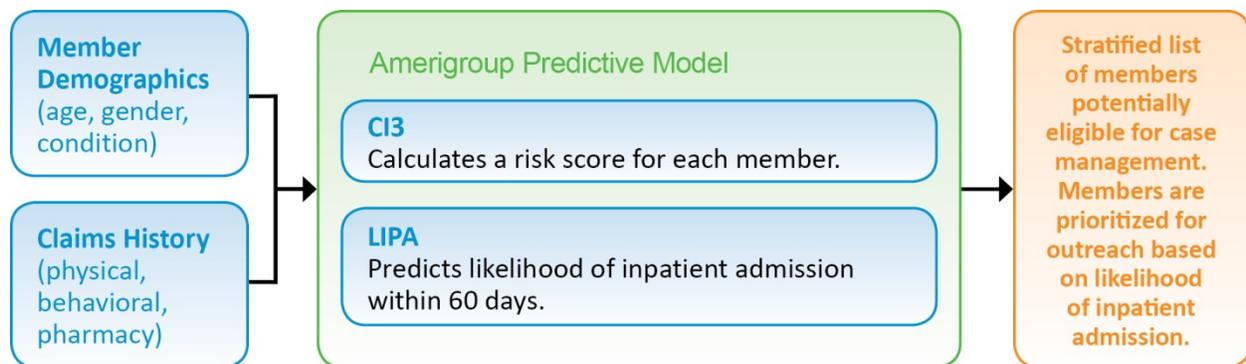
Our platform will support the providers in achieving the quality incentives defined in the Amerigroup quality programs. For example, the provider will be able to search on the patients with diabetes to see their most recent HBA1c results. The tool will take the providers to the next level by delivering much more than data, instead it gives them information that is synthesized and displayed in a succinct view to create obvious, actionable items right in front of them.

It enables our Disease Managers to focus directly on the member during the assessment, care planning, and referral processes. Prior to the transfer, documentation in our care management system is updated and the transfer noted. Upon referral, our Case Managers contact the member to discuss the program, complete the intake assessment, and identify any immediate needs to be addressed.

Predictive Modeling

Amerigroup believes that the primary way of identifying our members with chronic conditions is through meaningful conversations about their experiences, goals, strengths, and preferences. In addition to developing relationships and trust with our members, Amerigroup uses other tools to help us identify chronic conditions early and efficiently. One such tool is our predictive modeling processes. Our Chronic Care/Disease Management program uses systematic case finding and assessment methodologies to identify members eligible for services and interventions based on individual need and risk level. Member information is integrated from multiple sources, including the DHH two-year data, claims and encounter data, assessments, and referral information. Figure O.1-2 illustrates our process for stratifying members potentially eligible for case management, level of anticipated outreach intensity, and likelihood of inpatient admission.

Figure O.1-2. Amerigroup's Predictive Modeling Stratifies Members into Risk Groups



Our predictive modeling tools use demographics, clinical data, and historical physical and behavioral health claims data to predict future outcomes and identify and refer members with elevated risks or ongoing medical or behavioral health conditions for intensive care coordination. Amerigroup's proprietary predictive modeling system contains two main components:

- **Chronic Illness Intensity Index (CI3)** identifies members who are very ill and those with the most complex health conditions needing intensive care coordination. The model incorporates specific diagnoses that our team of medical and behavioral health specialists consider clinically impactful and, therefore, particularly amenable to care coordination. It identifies members who have the greatest disease burden and are most likely to benefit from intervention.
- **Likelihood of Inpatient Admission (LIPA)** index prioritizes members for outreach by predicting the probability of inpatient services. By evaluating data on the use of hospital services, diagnoses, and demographics, the LIPA model determines a member's probability of a medical/surgical or behavioral health admission within the next 60 days.

Our predictive model compares the complexity of the conditions of all members in our diverse population. This allows us to stratify member risk appropriately, thus identifying those with the most complex needs/conditions requiring intensive case management. It integrates and systematically reviews up to twelve months of member eligibility, claims, number of potential chronic disease care gaps by disease band (CDCG indicator), and encounter information to predict future risk.

This monthly process considers information, including diagnosis, prescriptions, prior costs, gaps in care, and prior utilization – all sourced from claims, as well as individual demographics sourced from member eligibility information to determine individual risk. Through a proprietary clinical algorithm, CI3 identifies members eligible for chronic care/disease management services and then prioritizes them based on their clinical risk ranking. This process assigns members a clinical profile that indicates their individual levels of risk and risk ranking, physical and behavioral conditions, gaps in care, co-morbidities, and both past and prospective utilization patterns.

Our predictive model allows us to stratify members appropriately by comparing the complexity of the conditions of all members in our diverse population. 

Assessment of Member Needs

Once identified for chronic care/disease management, members are further assessed through our comprehensive clinical intake process that identifies their needs across a continuum of services and supports. The intake process includes the use of our assessment to identify and confirm both physical and behavioral health conditions, additional health concerns (such as cognitive impairments and physical limitations), screens members for substance use, evaluates health risk behaviors, and assesses both psychosocial and environmental needs, including family, caregiver, and natural supports.

Data collected through the clinical intake process is documented in the Chronic Care/Disease Management data registry. It is then automatically channeled through a standardized stratification algorithm to calculate an additional risk ranking used to determine both the intensity and frequency of interventions and care planning tailored to individual member needs. Table O.1-2 illustrates the levels of risk stratification with their associated recommended interventions.

Table O.1-2. Recommended Intervention Intensity and Frequency based on Risk Level of Chronic Condition

Stratification Level	Criteria	Contact Frequency	Member/Provider Written Communication	Referral to Case Mgt
High risk	5+ gaps/needs identified	biweekly	Upon enrollment and every 4 th member follow-up assessment	Yes
Moderate risk	1-4 gaps/needs identified	monthly	Upon enrollment and every 2 nd member follow-up assessment	Yes
Low risk	Gaps resolved and member stable with care plan in place	quarterly	Upon enrollment and quarterly to correspond to the quarterly outreach	Monitor for Increase in Symptoms

This information is summarized and communicated to the member’s care team including primary care, behavioral health, and specialty providers. ***An abbreviated version of the intake assessment is administered at each follow-up discussion with the member to assure unmet, new, or undiagnosed conditions are identified and incorporated into the stratification, risk ranking, and integrated care plan.***

Disease States and Recipient Types Identified for Chronic Care/ Disease Management Program

Amerigroup understands the most important element of our Chronic Care/Disease Management program is a thorough understanding of the populations we serve, including those with the chronic conditions most prevalent in Louisiana; have the greatest impact on our members’ health, well-being, and quality of life; and are preventable or impactable through intervention, education, and healthy behaviors.

Under the direction of our Chief Medical Officer, we conduct frequent and on-going prospecting activities to identify conditions that are chronic in nature, usually lasting three months or more, that are impacted by health-damaging behaviors, such as tobacco use, lack of physical activity, poor hygiene, and poor eating habits. We review and analyze available data, including the two-year data provided by DHH; daily census reports; open authorizations; member demographics, including diagnoses; behavioral health, pharmacy, and dental utilization reports; notification of pregnancy for members with prior poor birth outcomes; and case management enrollment.

Identification of Members for In-Person Case Management

As described above, Amerigroup has a variety of means to identify and continually assess members who may require in-person case management including:

- Clinical expertise of Case Managers who develop relationships with our members and their families or caregivers
- DHH two-year data
- Claims and encounter data analyses that identify risk indicators, such as under- or over-utilization of medications, frequent ED visits, and recent inpatient admissions
- Predictive modeling and risk stratification results
- New member welcome call
- Assessment results

We recognize that our members' needs may frequently fluctuate across the spectrum of services and supports needed to prevent deterioration of their functioning, manage difficult or painful symptoms, and preserve their emotional and physical well-being. Our Case Managers continually monitor members through telephonic or in-person contacts, and are trained to adjust the level of intervention as required by the member's physical and behavioral health status.

Integration of Chronic Care/Disease Management into the Louisiana Bayou Health Program

Amerigroup integrates chronic condition awareness throughout all levels of our organization and system of care (SOC). We have established comprehensive processes, policies, and procedures for the Louisiana Bayou Health Program including:

- Educating our members on types of chronic conditions, including symptomatology, best practice interventions that control or reduce the impact of symptoms on their lives, and self-management strategies that empower them to participate in their health care decisions
- Training network providers and health plan staff on common types of chronic conditions our members experience, how to identify existing or potential chronic conditions, referral processes, role of the Disease Manager, care coordination activities, collaboration among case management professionals, sharing of information processes, and follow up and referral to other programs, as appropriate, based on changes in members' conditions
- Employing a "no wrong door" approach for identifying members with existing or potential chronic conditions, comprising Member Services representatives, network providers, Disease Managers, Case Managers, Nurse Medical Management clinicians co-

TRANSITION PLANNING FOR SPECIALIZED BEHAVIORAL HEALTH CONDITIONS

Susan, a 15-year-old who had been hospitalized for suicidal ideation, was introduced to our Behavioral Health Nurse Case Manager (case manager) during her stay. Through many different conversations, the case manager discovered Susan was being bullied, fighting at school, and recently suspended. Susan's mother and the case manager also discussed concerns that Susan may be abusing substances.

The case manager initiated an assessment to help identify existing or potential substance use—Susan admitted she was using alcohol and prescription drugs. Our case manager completed a referral to the SMO and notified our BH Liaison for further support in contacting the most appropriate substance use services.

Led by Susan and her mother, the team developed a care plan. It included a referral to the SMO for further assessment and interventions plus a crisis plan that included resources and natural supports. The team also worked to make sure Susan was discharged with her prescribed medications. The BH Liaison contacted the SMO to schedule an assessment and made sure her records were provided as well. The case manager also educated Susan and her mother on bullying. She discussed how they can approach the school about any issues related to bullying and engaged Susan in our Teen Program. The case manager continues to monitor Susan's progress, as well as her engagement in behavioral health services and supports. 🌸

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located at key hospitals, utilization management staff, and external organizations that render carved out services, such as behavioral health and dental care services

- Providing user-friendly, as well as culturally- and linguistically-appropriate educational materials that attract our members’ attention, provide them with relevant and meaningful information for their conditions, and encourage them to engage in their own health care decisions
- Using nationally-recognized CPGs to guide our care coordination, case management, and utilization management processes that support the identification of, and access to, the most appropriate interventions for each member’s condition
- Maintaining robust, innovative systems, such as our Member 360^o care management system, that are flexible and scalable to support transition processes, as well as timely and accurate access to member information

Our established policies and procedures (P&Ps); clinical tools, such as assessment, predictive modeling, and risk stratification; workflow; and technology promote full integration of disease management in the Louisiana Bayou Health program. We review our program annually to identify areas where we can improve and enhance performance. We submit Amerigroup’s Chronic Care/Disease Management program description and P&Ps to DHH annually.

Sharing Information with the Primary Care Provider

Amerigroup maintains a close working relationship with our Louisiana Bayou Health providers. We leverage this relationship to inform providers about the benefits of our program, available education, services, and materials, reciprocal sharing of information requirements, and how they can access chronic condition information to improve member care.

Our Disease Managers as well as our Case Managers facilitate the information sharing process by on-going collaboration with the member’s health care team to assure services are synchronized, unduplicated, and consistently delivered for every individual. The member’s health care team may consist of various types of providers, including PCPs, medical and behavioral health specialists, and social workers. Examples of reciprocal sharing of information can include diabetic information that goes to both the cardiac specialist who will educate the member on diabetes and heart health and the behavioral health provider for behavioral modification

Sharing of Information. Upon the member’s enrollment in case or chronic care/disease management, we capture our members’ information in a secure, centralized care management system to support timely access to the most appropriate services for the member’s conditions and prevent duplication. Through the *provider facing* Member 360^o tools, providers who have

EDUCATING OUR MEMBERS

Diagnosed with high blood pressure and type 2 diabetes with a history of cellulitis infections, John was contacted by our Nurse Case Manager (case manager) for further assessment. John’s case manager discovered he was taking Lantus insulin at night and at random times during the day. John and his case manager discussed his diagnosis and his understanding of and adherence to his prescription regime. With John’s permission, the case manager contacted his PCP about the situation. She obtained a glucometer for him to check his blood sugar level. She also scheduled an educational visit with a home health agency so John could better understand diabetes and the proper use of his glucometer. His case manager continues to support John as he manages his conditions with help from his PCP. 🌸

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members attributed to them can see the member record via the Amerigroup provider portal giving them simple, easy-to-access data and information to assist them in *engaging the member in their health and well-being*. The integrated data will be displayed to make it easy for the provider to act on it and making sure their patients are getting the services they need. This view will enable any provider who is treating our members to see the full picture including care plans and assessment information, enhancing their ability to reduce duplication and improve their quality of care. We also send the provider a letter of introduction explaining the individual's participation, provider responsibility in the care planning process, the CPG associated with the member's condition, and a copy of the care plan.

We engage all treating providers in the case management planning process - soliciting feedback and sharing of information throughout the member's care planning and case management. In addition,, we communicate with all treating providers as appropriate throughout the process to:

- Provide regular status updates to the provider regarding the member's stratification level, changes in health status, and contact frequency
- Assist with scheduling appointments or arranging transportation
- Address provider questions about the member's care
- Monitor the member's engagement in services and supports
- Share provider collaboration and communication details
- Reinforce evidence-based CPGs

Contacts are primarily telephonic, but we also regularly deliver updated case management plans by mail or fax to the provider.

Provider Education. We educate our providers on reciprocal sharing of information, as well as other important components of our program during our initial, on-going, ad hoc, and annual training. Information includes:

- Provider rights
- Services provided by Chronic Care/Disease Management programs, including how Amerigroup works with members in those programs
- How to enroll a member in the program and use its services
- Provider access to provider facing Member 360^o™ tools
- Reciprocal referral and sharing of information policies and procedures
- Disease Manager contact information, including phone number, address, and email
- Case Manager contact information, including phone number, address, and email

FINDING THE RIGHT PROVIDER

Terese, a diabetic, was referred to our case management program for coordination of care due to a non-healing wound. During the health assessment, she mentioned that she didn't receive much assistance from her current provider. Terese and the case manager worked to find a convenient provider who would best meet her needs and scheduled an appointment. The case manager also contacted our Provider Relations department for outreach to the provider for further training and support. Terese now sees her new provider and reports that her wound is healing and her blood glucose levels are improving. She said that the case manager's efforts helped her "see the light at the end of the tunnel." 

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- How to provide feedback or communicate complaints
- How Case Managers furnish feedback to providers about their members

Methods for Case Management

Amerigroup is acutely aware that chronic illnesses and conditions are among the most common, preventable, and costly of all health care issues. These chronic illnesses include diabetes, coronary artery disease, congestive heart failure, and chronic obstructive pulmonary disease. We also understand there are primary risk behaviors that can cause or exacerbate chronic illnesses, such as poor nutrition, lack of physical activity, and substance use, as well as the social and environmental barriers that can compromise member adherence to the care plan or medication regimen. Adding to the complexity, the rate of co-morbid physical and behavioral conditions among populations, such as children with special health care needs and adults, seniors and members with physical and behavioral disabilities, requires an approach that considers the whole individual, not just a diagnosis.

We have adopted a holistic chronic care/disease management approach that promotes member engagement in the interventions most appropriate for their conditions. Rather than simply educating members about a single condition, such as diabetes, our Disease Managers educate them on, and coordinate the care for, many of their needs – physical, behavioral health, and social support. As described below, our Disease Managers, guided by our evidence-based CPGs, are skilled at understanding and coordinating care across diagnoses.

In our experience, members achieve positive outcomes when we take a hands-on approach to assessing their awareness and understanding of their condition(s), helping them obtain their personal goals, and identifying any gaps in care, knowledge, or access. Then, in collaboration with each member, family, and treating providers, we develop an integrated care plan that is a road map to improving the member's health, well-being, and quality of life. Amerigroup is committed to understanding and addressing the challenges our members face that compromise their ability to take charge of their health status to improve outcomes. For many of them, this requires more than one approach. We work to make sure our members select the providers that are most appropriate for their conditions and have the tools they need to monitor their health – peak flow meters for asthma, blood glucose meters for diabetes, weight scales for congestive heart failure, or blood pressure cuffs for hypertension. We also assess whether their environment is conducive to care plan adherence.

Engagement of Members Including Model of Case Management and Types of Personnel

Amerigroup's program promotes optimal outcomes by assessing the member's readiness to change at the onset. We apply motivational interviewing techniques to engage each person by exploring and resolving any barriers to making those lifestyle changes. This highly personalized approach enables us to engage members at the highest level and keep them motivated to continue participation in the program and achieve their health care goals. Figure O.1-3 represents Amerigroup's member-centered model of case management the supports early engagement of members in their health care.

Figure O.1-3 Amerigroup’s Member-Centered Case Management Model



Supporting this goal, *we use a combination of motivational interviewing, coaching and behavioral modification to assess the member’s level of readiness and tailor our interventions to it.* We use small, manageable steps to build member confidence and awareness, and encourage behavior change opportunities that are not only realistic and achievable, but also support success throughout his or her participation.

Every interaction with members enrolled in our Chronic Care/Disease Management program is grounded by evidence-based CPGs.

While working with the member, his or her PCP, and treating providers, our focus remains on coordinating treatment and education around these guidelines. Whether a member has one chronic condition or three, the Case Manager develops a care plan that details interventions for each as recommended in the CPGs. The Case Manager then works with the member, the family, and the treating provider to verify that the individual is making and keeping appropriate appointments; obtaining screenings or lab tests; and engaging in self-care activities (such as blood glucose testing, use of a peak flow meter, diet modification).

For example, Amerigroup has adopted the American Diabetes Association’s (ADA) clinical practice recommendations for treatment of diabetes. Our Case Managers work closely with members with diabetes to focus on healthy behaviors that impact their condition, such as smoking cessation, weight management, nutrition, and glucose monitoring. We provide educational materials and on-going telephonic outreach, as well as member incentives, to encourage engagement in their health care. We refer members with more

complex needs to our complex case management program that may include face-to-face outreach. Our Case Managers monitor that members with diabetes are receiving examinations, testing, and immunizations in accordance with the ADA schedule.

Member Education

Members have 24/7 access to chronic care/disease management educational materials through our web-based member portal as well as written materials sent directly to the member for easy reference. Our educational materials include easy-to-understand information written at no higher than a 6.9-grade-level that are aligned with the member’s diagnoses and the symptoms the member is likely to experience. We have materials that address chronic condition-specific information such as symptoms, types of treatment, and self-management tools. For example, our written materials include booklets on “Facts about Alcohol,” including information on Alcoholics Anonymous or Alanon community meetings and common reactions to being diagnosed with a chronic condition.

We also make information available for members and families dealing with end-of-life issues. This information covers advance directives, hospice, and respite care. Other educational materials that address behavioral change, and that we make available to all members in our program, include: “Making a Change – How to Start,” “Making a Change – Making it Last,” and “Making a Change – My Action Plan.”

Our educational efforts flow from nationally recognized best practices and CPGs focused on those elements outlined as examples in Table O.1-3.

Table O.1-3. Examples of Targeted Member Education for Identified Chronic Conditions

Condition	Educational Materials	Intervention Topics	Risk Level
Asthma	<ul style="list-style-type: none"> • Asthma • Asthma Triggers • Asthma action plan • Tobacco Use – Reasons to Quit • Tobacco Use – Breaking the Habit • Tobacco Use • Teenagers and Tobacco 	<ul style="list-style-type: none"> • Asthma education • Self-management of asthma • Role of controller medications • Predictors of exacerbation • Allergy avoidance 	<ul style="list-style-type: none"> • Low • Moderate • High
Congestive Heart Failure	<ul style="list-style-type: none"> • Congestive Heart Failure • Reading food labels • Tobacco Use – Reasons to Quit • Tobacco Use – Breaking the Habit • Tobacco Use 	<ul style="list-style-type: none"> • Smoking cessation • Treatment of hypertension • Dietary sodium reduction • Daily weight monitoring • Medication adherence 	<ul style="list-style-type: none"> • Low • Moderate • High
Diabetes	<ul style="list-style-type: none"> • Diabetes • Diabetes Type 1 • Diabetes Type 2 • Hypoglycemia • Hyperglycemia • Reading food labels • Tobacco Use 	<ul style="list-style-type: none"> • Blood glucose self-monitoring • Diabetic diet plan • Symptoms of high blood sugar • Necessary annual exams (retinal and foot) • Exercise 	<ul style="list-style-type: none"> • Low • Moderate • High

We also send out invitations to community events, promoting events where we can share with our members different types of health information such as immunizations, prenatal/postpartum care, health lifestyles, childhood lead, and how to talk to your PCP.

Disease Managers

All members in the program are assigned Case Managers who are experienced, knowledgeable, and trained to support those with chronic conditions. We recruit, hire, train, monitor, and retain experienced professionals, and support those who have demonstrated experience in health care, chronic condition management, discharge planning, or behavioral health care, as well as knowledge of Louisiana and the challenges our members face.

Amerigroup's Disease Managers are licensed health care professionals, such as registered nurses with behavioral health and social work expertise, licensed clinical social workers, or licensed professional counselors with the experience necessary to assess our members' needs and willingness to make lifestyle changes to incorporate self-directed improvements in their health, well-being, and quality of life.

The Disease Manager uses assessment information, as well as clinical judgment, to determine whether a member would benefit from face-to-face support. Disease Managers also interface with health plan staff, such as our Chief Medical Officer, Behavioral Health Medical Director, or pharmacist for consultation on complex cases. Using assessment results, our Disease Managers work with members to develop an individualized, strengths-based care plan that identifies their needs related to the identified chronic illness and other

present health care conditions, as well as barriers to access and gaps in care. This helps our members set realistic, achievable short-term goals, thereby optimizing progress towards long-term goal attainment.

In addition to assessment completion and care plan development, coordination, and monitoring, responsibilities include:

- Educating members about their conditions and best practice interventions that align with them
- Coordinating the care the member receives from the PCP, specialist, and external organizations that provide carved out services, such as behavioral health services, dental care, and HCBS
- Monitoring changes in the member's behavior or symptomatology
- Facilitating referrals to providers
- Scheduling appointments and arranging for transportation as needed
- Directing members to community-based resources and supports
- Monitoring and evaluating the effectiveness of interventions and adjusting as needed

EMPOWERING OUR MEMBERS

Peter, a 22-year-old with high blood pressure, was not seeing his PCP but was frequenting the ED. He was referred to a case manager and found he had reading, writing, and comprehension challenges, which resulted in his dependence on others for his shopping and getting to his PCP visits. Peter had also recently been robbed of his money and prescription medication. Peter and his case manager worked together so he could better understand his condition, found and scheduled an appointment with a local PCP, and arranged transportation to his appointments. They also identified a family member who could help him with his personal needs, including paying bills and managing his medicine. Peter now attends his PCP appointments without disruption and has not visited the ED since he enrolled in case management. 🌸

REAL STORIES

Medical Management Specialist

Our Louisiana-based Medical Management Specialists respond to inbound calls to properly route members to the appropriate Disease Manager. Medical Management Specialists are not licensed health care professionals, but are trained to connect callers to the most appropriate Disease Manager and warm transfer urgent or crisis calls to the most appropriate responder.

Transition between Programs

Our Disease Managers work closely with other case management program employees to provide seamless care to our members. When a member enrolled in case management no longer needs that intensive level of intervention, the case management case is closed (upon member approval), and the individual is enrolled in the Chronic Care/Disease Management program for monitoring and intervention to maintain the level of health he or she has attained. Conversely, if a member's condition deteriorates, the Disease Manager transitions the member to the most appropriate case management program. All member information and progress notes are captured in CareCompass, our care management system that feeds into Member 360SM to promote the access to timely, consistent, and comprehensive information that the receiving program employees need to begin engagement.

Disease Managers also refer pregnant members to the *Taking Care of Baby and Me*[®] program for the duration of their pregnancies. Members with chronic conditions are referred back to the Chronic Care/Disease Management program six weeks postpartum for re-assessment and on-going management of their conditions. Members enrolled in the cancer program remain with the assigned Disease Manager as long as they are eligible for Amerigroup. All those members are candidates for transition of care when entering or leaving the health plan to assure continuity of care.

Integrated Clinical Oversight

Amerigroup's behavioral and medical clinical leadership provides oversight of care plans and actively collaborates as necessary to engage providers, members, and their families. Our program incorporates clinical case rounds with a multi-disciplinary team of professionals. Weekly chronic condition rounds include our medical and behavioral health medical directors; Utilization Managers; subject matter experts on issues with children, individuals who are aged, or with disabilities; a pharmacist; and Disease Managers. Disease Managers prepare and present cases at rounds for validation of the care plan, and to obtain suggestions on how to better manage the member. The team discusses available community resources and receives input from the medical directors regarding medical management, medications, and suggested modifications to the treatment plan.

Employee Training

One of the strengths of our program is the breadth and depth of training that build the skills necessary to coach members toward achievement of their goals. Because co-morbid behavioral and physical health challenges are common within Medicaid populations, Amerigroup has developed an innovative integrated case management certification program. It assures that all care management staff is equipped with the core competencies required to address the diverse physical, behavioral, and social support needs of each individual. Our training program is accredited and provides continuing education units for our licensed participants.

Over a period of several months, Amerigroup conducts formal training to confirm that all Disease Managers meet measurable competency standards. The structured course curriculum includes a series of training modules that educate Disease Managers across an array of topics, including:

- Evidence-based best practices for coordinating care for specific disease conditions, both medical (for example, asthma or chronic obstructive pulmonary disease) and behavioral (such as major depressive

disorders, anxiety disorders, and substance use), including identifying and addressing any potential risks for harm)

- Disease management skills, such as motivational interviewing strategies for engaging members with co-morbid conditions or coaching them to build self-care and medication adherence strengths
- Technology tools and resources that are available to support the disease management process, such as education materials or structured assessments appropriate for each member

The incorporation of motivational interviewing into our program training and interactions with members has transformed our traditional, single-condition chronic care model into a holistic model that manages the multiple needs of moderate-risk members in a single source environment. Motivational interviewing techniques provide Disease Managers with a framework to help members explore barriers, set achievable goals, and gain increased confidence to sustain positive outcomes.

When compared to traditional disease management models, results indicate members managed with motivational interviewing are meeting their goals more often, increasing compliance with medications, and experiencing a better quality of life. Empathy and reflective listening are keys to motivational interviewing which helps members accept the need for change, set goals, develop small doable steps, and move toward self-management, as well as reduce episodes of acute care or the need for emergent intervention.