

Marketing Communications Plan for

Coventry Health Care of Kansas, Inc.

Formerly Family Health Partners

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Team Credentials



Sarah Kelly

Sarah Kelly is a sales analyst for Insituform Technologies, Inc. Sarah earned a bachelor's degree in accounting and marketing from Saint Louis University in 2005. After graduation, she joined Insituform Technologies and has been in sales and marketing for the company for the past seven years. Sarah expects to receive a master's degree in journalism with an emphasis in marketing communications from the University of Kansas in December 2012.



Danny Kim

Danny Kim is the owner of One Day Valet, a route-based Dry Cleaning business in Johnson County, Kansas. During the past seven years he has gained experience in developing and implementing a strategic route-based marketing plan. Danny holds a bachelor's degree in liberal arts from the University of Missouri-Kansas City and will receive his master's degree in journalism with an emphasis in marketing communications from the University of Kansas in May.



Alicia Mowder

Alicia Mowder is a senior retail-marketing analyst for Payless ShoeSource, Inc. in Topeka. She focuses on strategy development, promotions, and project management. Alicia earned a bachelor's degree in mass media from Washburn University, where she was a member of the nation's second ranked debate team. She will receive her master's degree in journalism with a concentration in marketing communications from the University of Kansas in May.



Carmen Smith

Carmen Smith is originally from Northern California and now resides in Shawnee, Kansas. Carmen received her bachelor's degree in broadcast journalism from California State University, Northridge. She is a staffing supervisor for the Zack Group, a small medical staffing agency. As supervisor, Carmen's everyday tasks consist of marketing the skills of nurses and certified nurse's aides to nursing homes and hospitals. Carmen will receive her master's degree in journalism with an emphasis in marketing communications from the University of Kansas in May.



Joshua Vaughn

Joshua Vaughn is a project analyst for FishNet Security, an information technology security consulting firm, headquartered in downtown Kansas City. Joshua has more than five years of experience as a technical writer for technology companies in the Kansas City area. He earned his bachelor's degree in technical and professional writing from Missouri State University in 2003, and will receive his master's degree in journalism with an emphasis in marketing communications from the University of Kansas in May.



James K. Gentry

This project was supervised by James K. Gentry, Ph.D., Clyde M. Reed Teaching Professor at the School of Journalism and Mass Communications at the University of Kansas. Prior to joining KU as journalism dean in 1997, Gentry was a dean at the University of Nevada, Reno for five years and was a member of the faculty at University of Missouri School of Journalism for 14 years, where he was a department chair for five years. He received his Ph.D. from the University of Missouri. He writes occasionally on the economics of sports for The New York Times.

Executive Summary

Graduate students at the University of Kansas worked closely with Coventry Health Care of Kansas, Inc. (CHC Kansas) to develop a strategic marketing communications plan for the organization. The primary goal of this marketing communications plan is to address CHC Kansas' ability to communicate with its audience more effectively, increase HEDIS and CAHPS scores and increase membership by addressing the following objectives:

1. Increase enrollment and member engagement
2. Improve HEDIS and CAHPS scores
3. Improve communication with its members
4. Effectively communicate industry change

During the development of this strategic marketing communications plan, the team conducted secondary research through which we acquired a fundamental knowledge of the managed health care industry, industry best practices, industry trends, the competitive landscape and target audiences.

The team also conducted extensive primary research through 10 in-depth interviews and a focus group. Interviewees included medical providers, the director of a managed care organization, current Medicaid recipients and community outreach professionals. The focus group was conducted with CHC Kansas' Community Relations Representatives and provided insights into the complex managed care industry.

The team developed four strategies to help CHC Kansas communicate more effectively with its members:

1. Build awareness and engagement among the target audience
2. Develop core messages
3. Deliver clear and personalized information to members
4. Strengthen CHC Kansas' understanding of its members

This marketing communications plan also contains supporting tactics, a suggested timeline for implementation, estimated budget guidance and detailed appendices.

All of the strategies suggested in this plan are supported by research. We believe that execution of the recommended strategies will allow CHC Kansas to improve the way it communicates with and serves the low-income population in the state of Kansas.

Situation Analysis

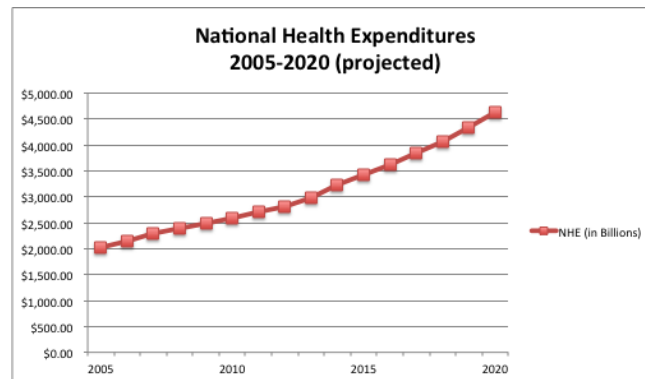
Health Insurance Market

The United States health insurance market is growing at a steady rate and is expected to sustain that growth through 2020. The United States leads the world in spending on health care, but ranks poorly across several categories related to quality of care in comparison to other countries.

In addition, monumental reforms in health care policies are on the horizon, with the Affordable Care Act (ACA) expected to take full effect in 2014.

Overview

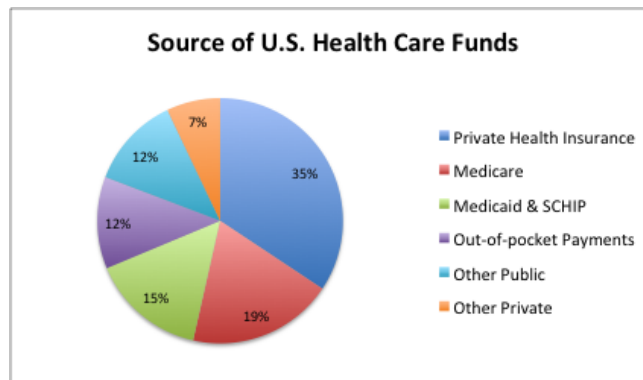
National health expenditures (NHE) were \$2.6 trillion in 2009, which reflected growth of 3.9 percent over the prior year (Historical, 2012). NHE are expected to reach a growth rate of 5.5 percent in 2013 as the economy continues to recover from the recent downturn (Health Care Spending Projections, 2010). Annual NHE from 2005 to 2020 are depicted below.



(Source: Health Care Spending Projections, 2010)

Spending growth is expected to continue through 2020 when NHE are expected to reach \$4.6 trillion (Health Care Spending Projections, 2010).

Current United States health care expenditures are allocated as shown in the table below:



(Source: Health Insurance – U.S., 2009)

In the United States, a majority of the population obtains health coverage through private sources. Fifteen percent of health care funding goes to Medicaid and State Children’s Health Insurance Programs (SCHIP or CHIP). Medicaid and SCHIP serve low-income populations by providing state-sponsored health coverage. In Kansas, Medicaid and SCHIP serve households that fall within 241 percent of the federal poverty level. Coventry Health Care of Kansas, Inc. (CHC Kansas) is a Medicaid and SCHIP provider for the state of Kansas.

Health care in the United States is considered subpar in serving underserved populations. According to the Commonwealth Fund, 80 percent of U.S. health care opinion leaders believe that the current health care system is unsuccessful in achieving equity in terms of access, quality and outcomes for vulnerable populations (Stremkis, Berenson & Riley, 2011).

The Obama administration has a ten-year, \$634 billion plan for health care reforms (Health Insurance – U.S., 2009). These reforms intend to make health care available to the 46 million uninsured Americans in the U.S. (Health Insurance – U.S., 2009). In recent years, coverage of uninsured children has been improving, while coverage of uninsured adults has been decreasing (The Kaiser Family Foundation, 2012).

Seven out of ten of the aforementioned opinion leaders believe that health care reform will improve access and financial protection for these vulnerable populations (Stremkis, K, et. al., 2011). As a result of these reforms, Medicaid eligibility and enrollment is expected to grow; spending in this sector is expected to grow 20.3 percent by 2014 (National Health Expenditures, 2011).

Medicaid

Medicaid is a joint venture between the states and the federal government, with the states receiving, for the most part, matching dollars from the federal government to meet the health needs of low-income and vulnerable populations (The Kaiser Family Foundation, 2011). In fiscal year 2010, state general funding for Medicaid was down 7.1 percent, which reflects recovery from a 10.9 percent drop in 2009 (Ellis, Gifford, Rudowitz, Smith & Snyder, 2010). The declines in 2009 and 2010 represent the only declines in state spending on Medicaid since its inception. (Ellis, et. al., 2010)

The federal government sets the parameters for who must be covered under Medicaid at the state level. This balance between federal oversight and states' prerogatives results in a kaleidoscopic variety in Medicaid programs state-to-state, as well as a somewhat fluid set of coverage parameters. According to the Kaiser Family Foundation, states have made it easier to enroll children, but have not made the same progress with adults (2011).

Many states will increase eligibility for parents and other adults with the expansion of Medicaid in 2014, while some states facing budgetary issues due to economic struggles are seeking to reduce Medicaid eligibility (The Kaiser Family Foundation, 2011).

In 2009, the American Recovery and Reinvestment Act (ARRA) provided states with federal fiscal relief. The purpose of the ARRA was to provide temporary financial relief to states by raising the Federal Medical Assistance Percentage (FMAP) (Ellis, et. al., 2010). Even as states continue to struggle with unprecedented budget shortfalls, the implementation of the Affordable Care Act (ACA) and the Patient Protection Act will place additional financial burden on states as Medicaid expands (Ellis, et. al 2010).

Medicaid enrollment is expected to grow at a slower rate due to the economic recovery (National Health Expenditures, 2011). After this period of deceleration, enrollment in Medicaid is expected to increase sharply reaching 75.6 million people in 2014, due to the enactment of the Affordable Care Act (ACA) (National Health Expenditures, 2011). Expenditures are expected to increase at a rate of 7.5 percent per year between 2015 and 2020, bringing total Medicaid expenditures to 20 percent of total health care expenditures in the U.S. (National Health Expenditures, 2011).

Expenditures will increase, and the allocation of those expenditures is expected to change. People gaining coverage through Medicaid in the coming years are expected to be younger and healthier, transferring more of the costs to physician and clinical services and prescription drugs, away from long term care (National Health Expenditures, 2011).

Managed Care Best Practices

As the economy continues to recover and budget shortfalls are beginning to be made up, health care spending throughout the country is beginning to increase. In 2009 and 2010, an estimated \$87 billion in fiscal relief from ARRA helped close budget shortfalls and support Medicaid programs (Ellis, et. al., 2010). Many managed care organizations and states are leveraging this fiscal power to improve Medicaid member engagement.

Critical elements that can produce a successful health care system include vision, collaboration, communication and engaged administrative personnel (Miller, Paradise, & Sommers, 2011). The complex health care landscape demands a good communication channel between states and other key stakeholders (Miller, et. al., 2011). Some of the best practices of organizations and states employing these tactics are outlined below.

Managed Care Organizations

CareOregon

This Portland, Ore.-based non-profit Medicaid health plan has developed innovative programs to enhance the delivery of care and case management. Much of its focus is on complex case management and the medical home model.

CareOregon has implemented a new program to carry out its vision called CareSupport, which provides centralized case management and care coordination services for its highest risk enrollees. The organization also has enhanced its administrative capacity by implementing electronic health records (EHR) to present access and clinical quality measurement for patients to care teams. The CareSupport program has yielded savings of \$400 per member per month, or \$5,000 per year (12 x \$400 = \$4,800), in the year following a member's enrollment (Klein, McCarthy, 2010).

CareOregon has also successfully incorporated incentive programs, which have improved member engagement and its Health Effectiveness Date and Information Set (HEDIS) scores. A case study titled "Transforming the Role of a Medicaid Health Plan from Payer to Partner," outlines CareOregon's three-tiered incentive program.

1. 1st Tier – rewarded providers for participating in the medical home collaborative, workgroups and learning sessions, and for reporting data.
2. 2nd Tier – paid providers for hitting targets on key metrics, including access to care and HEDIS clinical quality measures.
3. 3rd Tier – provided payment for decreasing ambulatory care-sensitive hospital admissions and emergency department visits, and for achieving HEDIS clinical quality benchmarks at/or above the 90th percentile.

San Francisco Health Plan (SFHP)

SFHP is a City and County of San Francisco-created licensed community health plan. Nationally, SFHP has the highest rate among Medicaid plans for Childhood Immunizations for 2008 and 2009 as well as Well-baby visits for 2010 (Gatewood, 2011). SFHP also was ranked second nationally for Childhood Immunizations while achieving the national Medicaid 90th percentile or better for 17 of 22 HEDIS measures (Gatewood, 2011).

According to Hunter Gatewood, the director of health improvement for SFHP, the three-part strategy to improve HEDIS scores is as follows (2011):

1. Supporting population management in practices through performance improvement interventions.
2. Directly engaging health plan members and providers through HEDIS incentives.
3. Aggressively capturing data during the HEDIS audit season, and on an ongoing basis.

SFHP also has launched a program called Strength in Numbers. The program has allowed clinics or providers in the area to assess the needs of its client population, as opposed to just traditional episode-based primary care.

SFHP also offered incentives to encourage member engagement. Incentives were generally gift cards, movie tickets, or raffles for products such as iPods or laptops. Gift cards ranged from \$25 to \$50 dollars. Gatewood found, "In February of 2011, SFHP's annual survey of our provider network found that 80% of our providers agree with a statement that SFHP member incentives are useful for their practice" (2011, p. 9).

SFHP engages in a variety of communications efforts to improve many of its HEDIS measures. These include:

1. Direct phone calls to members reminding them of the importance of screenings and recommended tests if they are overdue.
2. An afterhours HEDIS Push call event each fall to call members who have missed recommended tests or screenings.
3. Automated outreach reminder calls to patients.
4. Print media, educational supplies and outreach lists given to schools and providers to remind members of the importance of annual visits.
5. Educational material developed in numerous languages including Spanish, Cantonese and Russian.
6. Vendor relationships leveraged to conduct outreach efforts.

States

Massachusetts

Massachusetts has built relationships with its community partners that contribute to six in ten families enrolling in public coverage (The Kaiser Family Foundation, 2012). These community partners add value in a number of ways, from conducting outreach and tracking enrollment status, to helping families get and maintain their coverage using an online system known as the Virtual Gateway (The Kaiser Family Foundation, 2012). The state collaborates with its community partners by holding regular meetings and soliciting feedback (The Kaiser Family Foundation, 2012).

Massachusetts has been able to decrease its number of uninsured children by 11.2 percent between 2008 and 2010 (Kaiser Family Foundation, 2012). Massachusetts continues to face issues with long wait times for families needing assistance in the application process, but the state is seeking to remedy this through increased use of technology by transitioning to online applications and updating eligibility determination systems (Kaiser Family Foundation, 2012).

Oregon

With passage of the Healthy Kids Act in 2009, Oregon initiated its health care expansion effort called “Healthy Kids” (The Kaiser Family Foundation, 2012). This effort was created with a “dedicated funding source”, which the state has used to promote Healthy Kids through “an aggressive marketing and outreach campaign” (The Kaiser Family Foundation, 2012, p. 5). This campaign used tools such as magazines, billboards and radio, and focused on “schools, communities of color and businesses unable to offer health coverage to employees or their dependents” (The Kaiser Family Foundation, 2012, p. 19).

The application process also was simplified significantly; an online application option was added, and member information can now be stored online and used in pre-populated forms making renewal easier (The Kaiser Family Foundation, 2012). Thanks in part to these efforts, Oregon has successfully decreased the number of uninsured children by 27.9 percent (The Kaiser Family Foundation, 2012).

Iowa

Iowa has experienced strong support for its CHIP program known as “hawk-i” (The Kaiser Family Foundation, 2012). Because of its success with “hawk-i,” Iowa has been able to replicate improvements in its Medicaid program as well. (The Kaiser Family Foundation, 2012)

Through aggressive outreach and engaging community partners, Iowa has decreased its population of uninsured children by 19.4 percent (The Kaiser Family Foundation, 2012).

Alabama

Alabama has framed its CHIP program as a public health initiative and has worked closely with Medicaid agencies to see that simplifications and improvements made in the CHIP program are replicated in Medicaid when possible (The Kaiser Family Foundation, 2012). The efforts to promote the state's CHIP program have paid dividends for Medicaid enrollment as well, since "as families apply for CHIP, they are often found eligible for and enrolled in Medicaid" (The Kaiser Family Foundation, 2012, p.6). Alabama was one of the first states to offer an online application and also verifies income and citizenship online, streamlining the application process (The Kaiser Family Foundation, 2012).

Outreach is a common challenge throughout the country, but Alabama has managed to maintain outreach funding and the state proactively works with its partners to work to make program improvements (The Kaiser Family Foundation, 2012). Through strong legislative support, technological enhancements, community partnerships and effective outreach strategies, Alabama has decreased its number of uninsured children by 21.6 percent (The Kaiser Family Foundation, 2012).

All four states highlighted in the Kaiser Family Foundation Report continue to face challenges as they move forward with health care programs. Each continues to face decreasing administrative support and struggles to maintain solid enrollment and renewal processes (The Kaiser Family Foundation, 2012). All four are working to improve antiquated systems and are simultaneously trying to improve communication with families to improve the data put into these systems (The Kaiser Family Foundation, 2012). Each of these states has strong leadership and legislative support helping each experience the success enjoyed to date, and they all continue to look for ways to improve as the country embarks on Health Care Reform (The Kaiser Family Foundation, 2012).

See Appendix 1 for additional details on Managed Care Best Practices.

Marketing Trends

As the number of parents and children using digital media grows, online marketing is becoming more prevalent (Health Insurance – U.S., 2009). Despite the growth of the digital media, magazine advertising is currently the largest segment in health care advertising (Marketing Health to Parents and Children, 2009). Americans are going online to find information about their health coverage. Consumers are gathering information, shopping for the best price and even buying health insurance online (Health Insurance – U.S., 2009).

The managed care industry also is seeing a shift from print media to digital media (Lewis, 2011). An Austin-based health care marketing agency recently reported that

In January 2012, 72 percent of Kansas' Medicaid population participated in the program through CHC Kansas or a total of 156,770 members (HealthWave Population by County, 2012).

Kansas residents with income levels of up to 241 percent of the federal poverty level, which ranges from \$26,920 for an individual to \$55,550 for a family of four, are eligible for Medicaid coverage. The distribution of Kansas' Medicaid enrollment by percentage of the poverty level is depicted in the following chart.

Distribution of the Nonelderly with Medicaid by Federal Poverty Level		
	Kansas	U.S.
Under 100%	56%	55%
100-138%	13%	14%
139-250%	23%	19%
251-399%	NSD	7%
400%+	NSD	5%
Total	92%	100%

(Source: Kansas Medicaid & CHIP, 2009)

As mentioned above, more than 50 percent of Medicaid enrollees in Kansas are children. Medicaid enrollees by enrollment group in Kansas are depicted in the graph below.

Distribution of Medicaid Enrollees by Enrollment Group (FY2008)		
	Kansas	U.S.
Aged	10%	9%
Disabled	19%	16%
Adults	15%	26%
Children	56%	49%
Unknown	0%	0%
Total	100%	100%

(Source: Kansas Medicaid & CHIP, 2009)

Kansas Medicaid enrollees mirror the national distribution of enrollees by race as well as gender; however, Kansas is much less diverse in terms of race overall. More than half of Medicaid enrollees in Kansas are white, compared to the national average of 43 percent (Kansas Medicaid & CHIP, 2009). This majority is followed by 18 percent Hispanic and 17 percent black, both also below the national averages of 28 and 22 percent respectively (Kansas Medicaid & CHIP, 2009). Kansas Medicaid enrollees are split nearly 50-50 by gender: 51 percent female, 49 percent male (Kansas Medicaid & CHIP, 2009).

Please refer to Appendix 2 for a detailed summary of demographics of Medicaid enrollees in Kansas.

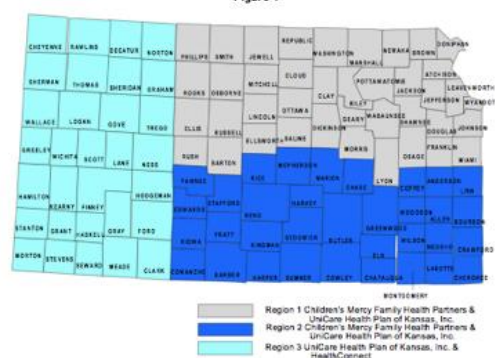
Competitive Context

Medicaid enrollees are given a choice of two health plans once they've enrolled in the program, giving CHC Kansas one direct competitor in Kansas. Kansas enrollees currently choose between CHC Kansas and UniCare in Regions 1 and 2 of the state.

CHC Kansas competes indirectly with safety net health clinics in Kansas as well. Often, Medicaid-eligible enrollees visit health clinics instead of enrolling in Medicaid because of the simplicity of the process.

UniCare

UniCare is CHC Kansas' only direct competitor in Kansas and the alternative plan for Medicaid enrollees in CHC Kansas' territory. UniCare is a national organization providing managed care services throughout the country (About Us, 2012). UniCare is a subsidiary of WellPoint, Inc., which has the broadest medical membership in the United States (About Us, 2012). WellPoint, Inc. reported revenue of \$58 million for the year ending December 31, 2010 (WellPoint, Inc. Common Stock, 2012). UniCare's parent company is larger than CHC Kansas' with 1.8 million members in 10 states (We Want to Work With You, 2011). The company describes its philosophy as a "unique, community-based and customer-centered approach to health care" (We Want to Work With You, 2011, p. 2).



(Source: HealthWave, 2009)

UniCare's contract with the State of Kansas extends across the entire state, so UniCare competes with CHC Kansas in Regions 1 and 2, and HealthConnect Kansas in Region 3. UniCare's growth rate of 2.83 percent in 2008 exceeded CHC Kansas' for HealthWave XIX at 2.52 percent, while it trailed CHC Kansas' HealthWave XXI growth rate of 5.87 percent (2009 Medicaid Program Transformation Review, 2009). UniCare serves about 32 percent of the HealthWave population with 51,000 members statewide (2009 Medicaid Program Transformation Review, 2009).

UniCare offers many of the same services that CHC Kansas provides, including community education and transportation. According to its Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, UniCare's strengths are in satisfaction with health plan and health care and getting non-urgent appointments as soon as possible (We Want to Work With You, 2011). U.S. News and World Report ranked UniCare tenth among health insurers in Kansas (Top Ten Health Insurance Companies in Kansas, 2011). Before the merger, Children's Mercy Family Health Partners ranked third, while new parent company Coventry Health Care of Kansas, Inc. ranked ninth (Top Ten Health Insurance Companies in Kansas, 2011).

Change in the Competitive Landscape

Although CHC Kansas currently competes against UniCare for Medicaid participants in Kansas, this will change in 2013. Five companies will be bidding to be selected as the choice health plans for Kansas Medicaid recipients in 2013. UniCare has chosen not to compete. CHC Kansas will be up against:

1. Amerigroup
2. Centene
3. UnitedHealthcare
4. WellCare

This bid will change the competitive landscape for Medicaid in Kansas. Each of these companies is profiled below.

Amerigroup

Amerigroup is a fortune 500 company with annual revenue for 2011 of \$6.3 billion (Amerigroup, Fast Facts, 2012). Amerigroup employs more than 5,000 associates and more than 1,200 nurses, doctors and social workers; its national scope is further highlighted by the fact that one out of every thirty-one Medicaid recipients in the country is covered by Amerigroup, as well as one in every twenty-nine CHIP recipients (Amerigroup, Fast Facts, 2012). Amerigroup's mission is nuanced and multifaceted and stated in its 4th Quarter 2011 Fact Sheet as: "To provide Real Solutions for members who need a little help by making the health care system work better while keeping it more affordable for taxpayers" (Amerigroup, 4th Quarter Fact Sheet, 2012).

Amerigroup boasts more than 2 million members across 12 states (Our State Programs, 2012). Data taken from the end of 2011 shows how member enrollment is spread across the various products Amerigroup offers. Amerigroup's product categories are (Amerigroup, Fast Facts, 2012):

1. Temporary Assistance for Needy Families (TANF), a Medicaid product
2. CHIP
3. Seniors and People with Disabilities (SPD)
4. FamilyCare, a program that is "focused on uninsured adults and parents of CHIP or Medicaid eligible children"
5. Medicare Advantage

The majority of Amerigroup's members are served through TANF (Amerigroup, Fast Facts, 2012).

Amerigroup communicates some basic information about Medicaid, plan details etc., through its website, prominently displayed on its homepage. However, the truly relevant details on Medicaid eligibility are not located on this page. Instead, more detailed eligibility information is accessed through a less prominent link off of the homepage labeled "Members". Here, there are links to the 12 states where Amerigroup offers Medicaid coverage, and it's behind these links that more detailed, state-by-state eligibility requirements are contained.

Centene

Centene Corporation, Inc. is a Fortune 500 health care company headquartered in St. Louis (Q3-11_CNCfactsheet, 2011). The company's core philosophy is "quality healthcare is best delivered locally" (Centene, About US, 2011). Centene prides itself on this sentiment and expresses it repeatedly.

In its fourth quarter report for 2011, Centene reported annual revenues of \$5.18 billion (Centene Corporation, 2012). The company has more than 1.8 million managed care members from 12 states (Centene Corporation, 2012). Centene's offerings are broken out into six member categories:

1. Medicaid
2. CHIP & Foster Care
3. Aged, Blind, Disabled (ABD)
4. Medicare
5. Long-term Care
6. Hybrid programs

The vast majority of Centene's members fall into the Medicaid member category (Centene Corporation, 2012).

Centene makes no readily apparent attempt to communicate basic Medicaid information or eligibility requirements through its website. Centene does provide some information on health plans, on the "Health Plans" tab, which leads to a page containing links to Centene health plans, only offering rudimentary information with

an external link to each plan's site. With only a few exceptions, these standalone plan sites appear to be cloned off of one another, with two main sections: one for members and one for providers. So, while Centene offers information about its Medicaid plans, information regarding eligibility was not readily apparent.

UnitedHealthcare

UnitedHealthcare is a division of UnitedHealth Group, the largest health care provider in the U.S. (UnitedHealthcare, About Us, 2012). UnitedHealth Group provides coverage for approximately 70 million Americans (UnitedHealthcare, About Us, 2012). UnitedHealth Group, Inc. reported revenue of nearly \$102 billion in 2011 (UnitedHealth Group Incorporated, 2012).

UnitedHealthcare is the largest Medicaid MCO in the U.S.; it serves more than 3 million people through Medicaid, Medicare and SCHIP services (Medicaid, 2012). UnitedHealthcare reported \$87 billion in revenue in 2010 (A New Era in Health, 2010). UnitedHealthcare is committed to helping people live healthier lives and providing access to quality care (Medicaid, 2012). UnitedHealthcare is currently a Medicaid provider in 21 states (UnitedHealthcare Online, Medicaid, 2011).

UnitedHealthcare's website is extremely easy to navigate, and makes it easy for participants, or potential participants, to find information. First, it allows a prospect to enter a zip code or a state to find UnitedHealthcare plans in a specific area. If there are plans in that area, UnitedHealthcare offers a website dedicated to information specific to those in that state, also offering examples of who may qualify for coverage and where to direct questions about enrollment in state-sponsored health care.

WellCare

WellCare Health Plans Inc. is a Tampa, Fla.-based health care company that focuses on state-sponsored medical services specializing in Medicaid and Medicare (WellCare, 2012).

The company currently serves more than 2.4 million members and has approximately 3,500 associates nationwide (WellCare, 2012). WellCare's members include state-sponsored individuals, children, families, seniors, disabled, blind and prescription-eligible individuals.

WellCare is one of the largest managed care organizations in the country that focuses exclusively on government-sponsored health programs such as CHIP and Medicaid (WellCare, 2012). WellCare posted revenues of \$5.4 billion in 2010 and \$6.1 billion in 2011 (Yahoo Finance, 2012).

The organization's website is informative but not easily navigable. Prospective Medicaid members can call the toll free helpline for assistance, or check Medicaid programs in the eight states that WellCare currently covers. Once a prospective member selects a state, a list of available programs in that state is presented with additional information. The website serves as a bountiful informational resource; however, it could be more user-friendly. For example, WellCare's website is not mobile friendly.

CHC Kansas will be up against formidable competitors in 2013. Fortune ranked Insurance and Managed Care companies for 2012. Four out of the five companies bidding for a spot in Kansas made the top ten (CNN Money, 2012). UniCare's parent company ranks No. 4 (CNN Money, 2012).

1. **UnitedHealth Group**
2. Aetna
3. Humana
4. WellPoint
5. Cigna
6. **Amerigroup**
7. Health Net
8. **Coventry Health Care**
9. **WellCare Health Plans**
10. Universal American

CHC Kansas is up against competitors that perform better at an industry level; however, UnitedHealthcare seems to be the only stand out from a communication standpoint.

Indirect Competition

Health care safety net clinics are community-based providers offering health services to low-income and uninsured individuals. The majority of safety net patients are current Medicaid enrollees, the uninsured and other low-income individuals who pay a sliding scale discounted fee for primary care services based on their income. Primary care services provided by the safety net include, but are not limited to:

1. Urgent care
2. Acute and chronic disease treatment
3. Services based on local community need (mental health, dental, and vision)
4. Preventative care
5. Well Child care
6. Enabling services (translation/interpretation, case management, transportation and outreach, social services)

Some key characteristics of health care centers are that they are located in areas that are medically underserved, meet federal requirements for services offered, offer sliding

fee scales based on patient income and are governed by a board, with the majority being health center patients.

Federally Qualified Health Centers (FQHC) and similar look-alike clinics both receive grants and qualify under section 330 of the Public Health Service Act. In 1996, this act was revised by the Consolidated Health Centers Act which consolidated community health centers with migrant health centers, health care centers for the homeless and public housing programs (Catalog of Federal Domestic Assistance, 2012).

Clinics that wish to qualify for section 330 grants must meet certain criteria including serving a medically underserved area or population (Catalog of Federal Domestic Assistance, 2012). These clinics receive funding from a variety of sources including state, local and federal funds along with payments from private and public insurance as well as grants. For example, planning grants for the creation of additional clinics are part of an \$11 billion funding package tied to the federal Affordable Care Act (ACA).

Patients of health centers are racially diverse. In 2007, half of all health center patients were minorities and one third of all health center patients were Latino (Jones, Rosenbaum, & Shin, 2010). Many of these patients may have children that qualify for state programs, such as SCHIP, but may not qualify as parents for state programs, such as Medicaid, due to a variety of reasons including lack of proper documentation.

Health centers are an important component of both rural and urban communities that are in need of quality care without the complexity of the current medical landscape. Medicaid and uninsured patients are more likely to receive preventative services at health centers than in other settings (Jones et al., 2010).

The Greater Kansas City Cover the Uninsured Coalition leads the effort to generate exposure for safety net clinics in the Kansas City area. The latest publication in 2011 lists the contact information and addresses of safety net clinics in the area along with helpful phone numbers for assistance.

Please see Appendix 3 for a list of Safety Net Clinics in the Kansas City Metro Area.

CHC Kansas Overview

Company Overview

CHC Kansas, formerly known as Children's Mercy Family Health Partners (CMFHP), is the largest managed care organization in Kansas. CHC Kansas is a Medicaid health plan that recently was acquired by Coventry Healthcare, Inc.; the acquisition was completed January 3, 2012 (Coventry Health Care Completes Acquisition, 2012). CHC Kansas previously was owned by Children's Mercy Hospital in Kansas City. Coventry Health Care

provides services to nearly 900,000 Medicaid recipients in 10 states (Coventry Health Care Completes Acquisition, 2012).

CMFHP, now CHC Kansas, insured 155,000 members in Kansas in 2011, and annual revenue was more than \$450 million in 2011 (Children’s Mercy Wraps up Sale, 2012).

CHC Kansas covers adults and children under Kansas Title XIX and Title XXI. CHC Kansas target audiences include women ages 18 to 34, women ages 25 to 54 and grandparents ages 35 to 60. It also targets community advocates that work with low-income and assist them in obtaining Medicaid coverage. Medical providers that accept Medicaid are also a target audience for CHC Kansas.

Budget

Coventry Health Care of Kansas, Inc. Budget

<i>Approximate Budget</i>	<i>\$500,000</i>
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	Allocation	Total \$
Media/Outreach Advertising	30%	\$150,000
Sponsorships	25%	\$125,000
Printing	20%	\$100,000
Giveaways	9%	\$45,000
Travel/Expenses	8%	\$40,000
Misc. Administrative Costs	7%	\$32,500
Audio/Video Education	2%	\$7,500
		\$500,000

NOTES:

Media/Outreach Advertising	Sponsorships for media events in key areas where we would provide dollars to radio and TV to promote events that we were attending.
Sponsorships	Sponsorships toward programs that directly impacted the kids we were trying to reach, such as the Kansas Department of Education and its programs, the Kansas Learning Center for
Printing	Brochures, newsletters and other materials
Giveaways	Logo items
Travel/Expenses	Community Relations Reps

CHC Kansas Audience & Messaging

CHC Kansas focuses its messages around the application process, choosing a primary care provider, avoiding the emergency room, the importance of well child exams, the benefits provided through Medicaid and basic health education. CHC Kansas communicates with its target audiences using brochures, handbooks, newsletters,

customer service phone lines, letters and its website. The “high-touch” philosophy that CHC Kansas embodies helps to differentiate itself from other providers. Community Relations Representatives are out in the communities they serve every day, interacting with key partners in the community, members and the low-income population. This is a highly effective way to build relationships and recognition for the Medicaid program and CHC Kansas.

As the way America communicates continues to change, CHC Kansas has begun to explore using digital media outlets such as YouTube and Facebook. CHC Kansas is also researching additional social media outlets including Twitter and Google+, as well as alternative modes of communication such as text messaging.

Measures of Success

CHC Kansas measures its success based on HEDIS and CAHPS scores, which are national quality measurement benchmarks for health plans. CHC Kansas is currently working to improve its HEDIS and CAHPS scores in a number of areas. CHC Kansas engages in a variety of health education services targeted toward the needs of its members. A major challenge faced by CHC Kansas is member engagement. It can be difficult to get members to maintain appointments and follow-up visits. CHC Kansas offers free transportation and fuel reimbursements to help alleviate this problem.

HEDIS & CAHPS Scores

HEDIS scores are used as a benchmark for America’s health plans to measure performance on a variety of aspects of care and service (What is HEDIS?, 2011). Health plans, including CHC Kansas, use these metrics to identify areas for improvement.

CAHPS is an additional measure for health plans to gauge success. CAHPS surveys patients regarding their experiences with health care services (AHRQ, 2011). The standardized surveys are produced by the Agency for Healthcare Research and Quality’s (AHRQ) CAHPS program, and are designed to examine patients’ experiences with health care services, specifically with ambulatory and facility-level care (AHRQ, 2011).

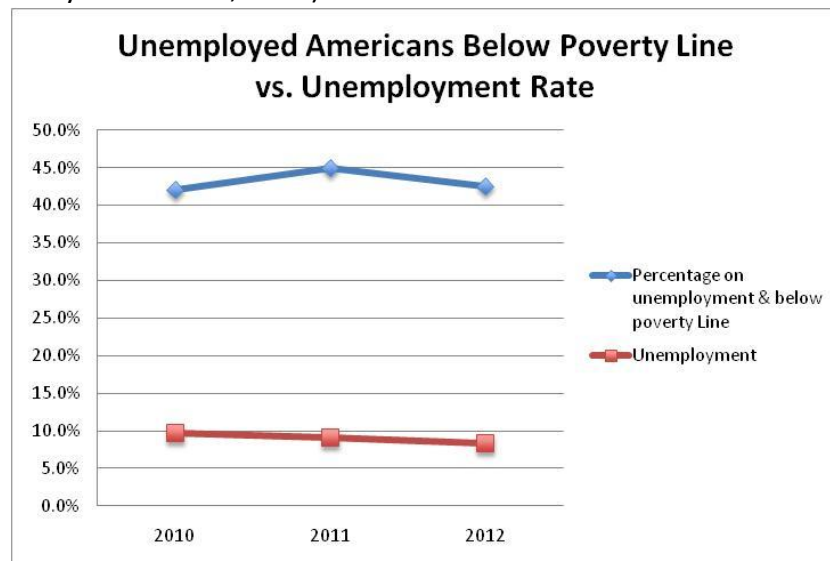
CHC Kansas performs at or above the national average in most categories for HEDIS and CAHPS scores. Areas for improvement in HEDIS scores are Well-child visits for the first 15 months of life and the third through sixth years of life as well as the use of proper medications for people with asthma. CHC Kansas is below the national average for health promotion and education and patient ratings of its specialists in its CAHPS scores.

Detailed HEDIS and CAHPS measurements for CHC Kansas measured against national averages can be found in Appendix 4 of this report.

Audiences

Low-Income Population of Kansas

The poverty rate in the U.S. at its highest in recent history, with an average of 13.8 percent of the population living below the poverty level, which is \$11,170 for an individual and \$23,050 for a family of four (Poverty on the Rise, 2012). To put that into perspective, a single mother with three kids would need to make a minimum of \$11 an hour working full time to be at or above the federal poverty level. This is slightly lower in Kansas, where 12.4 percent of the population living below the poverty level (Poverty on the Rise, 2012). The percentage of people living below the federal poverty level tends to follow the unemployment curve with a slightly longer peak to account for economic recovery (Poverty on the Rise, 2012).



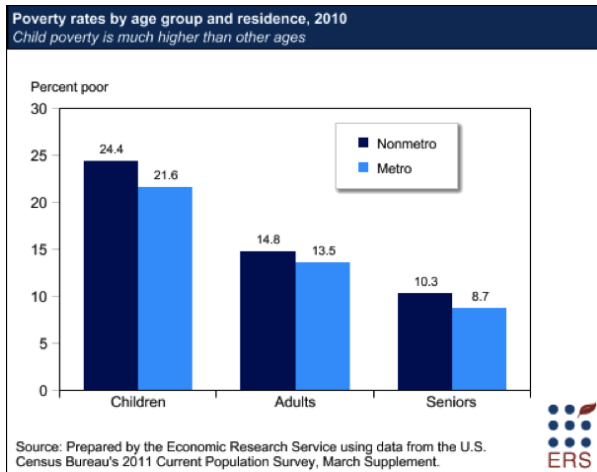
(Sources: Poverty on the Rise, 2012; Unemployment Situation, 2012; Goodman, 2010)

As the economy continues to recover, the percentage of Americans living below the poverty level is likely to decline; however, with health care reform pending, the percentage of Americans that will qualify for Medicaid is projected to grow. In fact, millions of workers could qualify for the first time this year because of a decrease in earnings or a change in marital or parental statuses in 2011 (Stottelmier, 2012). Many more may already qualify but don't know it, such as childless workers, people with English as a second language and grandparents raising their grandchildren (Stottelmier, 2012).

The low-income household is much more diverse than households above the poverty level. Twenty-six percent of U.S. children are raised in single parent households, with females running nearly 85 percent of single parent households (Marketing Health to Parents and Children, 2009). Of those single parent households, 27.7 percent of those

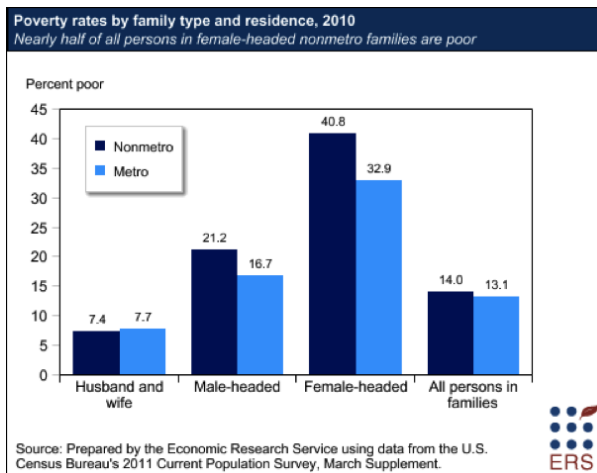
single mothers and their children live in poverty, and 11.1 percent of single fathers and their children live in poverty (Marketing Health to Parents and Children, 2009).

Children run a much higher risk of facing poverty than any other age group. Adults and seniors often have more opportunities to find work or alternative income to keep them above the poverty line. Children, however, do not have this ability. The percentage of children, adults and seniors in poverty during 2010 is broken out below by age group.



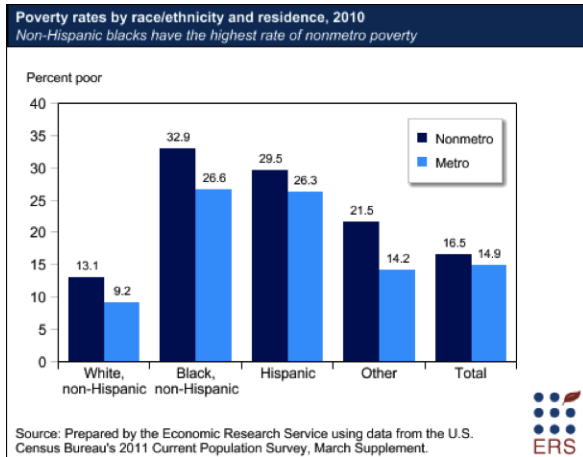
(Source: Economic Research Service, 2011)

Although children are the group with the highest rate of poverty, female-headed households are significantly more likely to be in poverty than male-headed households, by twice as much, as shown in the chart below.



(Source: Economic Research Service, 2011)

Considering these statistics, there is an opportunity to focus on single parent households, specifically female-headed households. These households have a higher likelihood of poverty and a higher percentage of children in the household.



(Source: Economic Research Service, 2011)

The low-income population of Kansas shares demographic and psychographic behaviors with CHC Kansas clients. A snapshot of the low-income population in Kansas is shown below.

1. Minority (black or Hispanic)
2. Female head of household
3. Have multiple children
4. Live in rural areas
5. Are unemployed, self-employed, or have income from a non-registered farm or business
6. More likely to not be proficient in English
7. Could be older (grandparents)
8. Have no tax filing requirement
9. Are recently divorced, have reduced income, are unemployed, or are experiencing other changes to their marital, financial, or parental status
10. Earnings declined or marital or parental status have recently changed
11. Have disabilities or are raising children with disabilities
12. Live in non-traditional homes, such as a grandparent raising a grandchild
13. On multiple forms of government assistance (Rent Assistance, WIC, Vision Card, reduced or free school lunches, HealthWave, Energy Bill Assistance Program)

Low Income and Health

In the United States, families that have lower incomes typically devote a lower percentage of income to healthy eating, and overall health and wellness (Marketing Health to Parents and Children, 2009). Single parent households are more likely to have low incomes and are more likely to face issues in maintaining health and wellness within their family units. Children in these households are at greater risk for health issues.

Hispanic, single parent households are particularly challenging when it comes to health (Marketing Health to Parents and Children, 2009). While they value health and wellness, lack of insurance often prevents it from becoming a focus (Marketing Health to Parents and Children, 2009). A lack of information is a major issue for this segment, which relies on a wide range of sources for health information.

Parents in low-income households are concerned with their children developing a variety of health conditions (Marketing Health to Parents and Children, 2009). This concern is justified as studies have shown that low-income areas have fewer supermarkets that carry health foods than white, middle-income neighborhoods (Friedman, 2008). While policy makers are responding and trying to bring supermarkets into low-income areas, costs associated with these healthier items may still limit a family's ability to purchase them (Friedman, 2008).

A low-income family's ability to afford healthy food may be all about perception. Although a higher percentage of income is allocated toward food, research has found that as families replaced high calorie snack foods with healthier foods, overall grocery costs actually went down (Golan, et. al., 2008). The food purchased at the grocery store is also often a status symbol for low-income households and households with income 130 percent of the poverty line are more likely to spend additional income on beef and frozen prepared foods rather than fruits and vegetables (Golan, et. al., 2008).

A focus group among low-income women living with more than one child found that decisions related to food purchases revolved around the following: cost, convenience, social influences, and health issues (Hampson, et. al., 2009). The same focus group also found that these women had varying knowledge when it came to what is actually healthy, and they had limited knowledge of federal nutrition guidelines (Hampson, et. al., 2009). This suggests that education will go a long way with this audience. In fact, another study showed that low-income Latino women are seeking this type of information most often when going to a free clinic (Abejuela, 2011).

Please see Appendix 5 for detailed findings from these studies.

Advocates have found that education helps low-income families make healthier choices. In many low-income areas the physical environment (proximity of fast food restaurants, lack of facilities, etc.) can be a major contributor to unhealthy habits (Yoshida, et. al.,

2010). Network for a Healthy California has shown that involvement can change activities. Students in one California school have actively sponsored activities such as health fairs and advocating removing fast food restaurants from the area and results have shown that this has positively influenced health and physical activity among these children (Yoshida, et. al., 2010).

Low Income and Mobile & Digital Media

People of all ages and income levels are using mobile and digital media. Broadband Internet access in the home is in line with socio-economic status (Dailey, et. al., 2010). Just 57 percent of the poorest households use the Internet, while 95 percent of high-income homes do (Wayne, 2010).

Broadband Home Adoption Rates	
All Americans	65%
Unemployed Americans	56%
Those not in the labor force	44%
Americans with income <\$25,000	35%
Americans over 65	30%

Libraries and other community organizations are often the sole providers of Internet in communities with low home adoption (Dailey, et. al., 2010). These facilities are often inadequate due to system availability or functionality.

Although home adoption rates vary in the low-income segment, many of them are still seeking health information online. Health information is the third most common topic searched for online, behind only e-mail and using a search engine (Fox, Feb. 2011). While only 38 percent of adults with less than a high school education go online, 62 percent of them are looking for health information when they go online (Fox, Feb. 2011).

Social Media is growing in popularity, but it may not be the best vehicle for those delivering health messages. Low-income parents reported low usage of these sites mainly due to lack of time and credibility, not lack of access (Stroeve, et. al., 2011). Americans still place the most trust in health information coming from doctors and other health experts (Health Insurance – U.S., 2009).

Approximately 35 percent of Americans own a smartphone of some kind; in fact, those aged 18-29 with income less than \$30,000 per year are just as likely to own a smartphone as the national average (Smith – Cell Phones, 2011). Americans with income of less than \$30,000, overall, are just as likely to own a smartphone as they are not to have a cell phone at all (Smith – Cell Phones, 2011).

Many smartphone owners go online with their phones rather than a computer (Smith – Cell Phones, 2011). One-third of this group does not have broadband Internet access at home (Smith – Cell Phones, 2011). Some 40 percent of Americans with household income less than \$30,000 go online mostly using their cell phones.

Urban and suburban residents are most likely to play games and access social networking sites using their mobile devices; however, African-Americans and Latinos have a higher rate of usage, in comparison with white cell phone owners, across a variety of mobile activities (Smith – Cell Phones, 2011).

The Department of Health and Human Services has recently launched several Text4Health Projects across the country. These projects will disseminate health information on a specific topic, ranging from babies and children to quitting smoking (HHS Text4Health, 2012). The Text4Baby Campaign has launched and reported positive results.

Please see Appendix 6 for detailed results from the Text4Baby Campaign.

The Department of Health and Human Services will launch more campaigns similar to this one in 2012. Initial results and mobile phone usage statistics suggest that there is opportunity here for CHC Kansas.

Communicating With Low-Income Populations

With changes on the horizon in the health care industry, effective communication will be even more critical. According to a study conducted among Florida Medicaid recipients, 30 percent of Medicaid enrollees in Florida were not aware they were enrolled in the program and 55 percent reported having trouble understanding plan information (Coughlin, et. al., 2008). Due to poor health literacy, sound decisions when it comes to medical coverage may be difficult – 20 to 37 percent of respondents to a survey reported having a general literacy problem (Coughlin, et. al., 2008).

Health literacy is a major issue with consumer-choice health plans. Florida implemented counselor services to assist enrollees in making informed decisions, but more than half of survey respondents were not aware that counseling was available (Coughlin, et. al., 2008).

Academic research has shown five key components of successful communication to the low health literate and low-income (Hoover-Dempsey & Walker, 2002 and Health Literacy Fact Sheet, 2011).

1. **Trust:** The receiver of the information needs to trust the source, including the sender and vehicle for the message. Part of this trust is a strong relationship between the sender/provider and the community leaders. This will establish a relationship in the mind of the receiver that will help to ensure the message is considered.
2. **Clear Message:** The message being sent needs to be clear, straightforward and simple. The receiver should not have to search for the message, meaning or purpose. The message should have no ambiguity and be written at a seventh grade reading level, taking into account the low health literacy rate of those on Medicaid.
3. **Purpose:** The message needs to have a purpose, not just repeat information. It should be ongoing, have a consistent format, seek input and feedback from the receiver, and ensure all information is up-to-date and compelling.
4. **Recognize Diversity:** The receivers of the message come from all different backgrounds, from different ethnicities, educational backgrounds, cultural norms, health experiences and illnesses and household lifestyles. These differences need to result in personalized messages that speak to the particular culture or health background of the receiver.
5. **Recognize Psychological Barriers:** The receivers of the message have had a variety of experiences relating to the health industry. They might feel a stigma from being on Medicaid and receiving help, which would be perceived as a “hand out.” Unpleasant history of treatment and results may limit the receiver’s willingness to be receptive to the message.

Research has identified a core of best practices that can enhance the likelihood of successful communication to the low health literate and low-income population (Silow-Carroll, et. al., 2006 and National Action Plan to Improve Health Literacy, 2010).

1. **Respect for patients' values and expressed needs:** Obtain information about patient's care preferences and priorities; inform and involve patient and family/caregivers in decision making; tailor care to the individual; promote a mutually respectful, consistent patient provider relationship.
2. **Patient empowerment or "activation":** Educate and encourage patients to expand their role in decision-making, health-related behaviors and self-management.
3. **Socio-cultural competence:** Understand and consider culture, economic and educational status, health literacy level, family patterns/situation and traditions (including alternative/folk remedies); communicate in a language and at a level that the patient understands.
4. **Coordination and integration of care:** Assess the need for formal and informal services that will have an impact on health or treatment, provide team-based care and care management, advocate for the patient and family, make appropriate referrals and ensure smooth transitions between different providers and phases of care.
5. **Access and navigation skills:** Provide what the patient can consider a "medical home," keep waiting times to a minimum, provide convenient service hours, promote access and patient flow, help patient attain skills to better navigate the health care system.
6. **Community outreach:** Make demonstrable, proactive efforts to understand and reach out to the local community.
7. **Simplifying and improving written materials:** Use video or other targeted approaches to patient education, and to improve patient-provider communication.
8. **Self-assessment for hospitals and health centers:** Assess an organization's strengths and weaknesses; assessment includes an action plan for reducing literacy-related barriers.

Medical Providers

With key reforms to health care anticipated, there is a growing concern that population growth and increasing numbers of elderly could strain the nation's primary care resources.

The expansion of Medicaid is expected to increase enrollment by as much as 25 percent. That market impact, along with the health needs of the newly enrolled could have a greater effect on how physicians view Medicaid than factors considered important today (Miller, et al., 2011).

Many barriers continue to exist regarding state-sponsored insurance programs and medical providers at the practice level. Some physicians may be handcuffed by their affiliated practices. Many practices have mandates that limit how many Medicaid patients are accepted.

According to a recent publication from Miller, et al., (2011) the key reasons for Primary Care Physicians' (PCPs) decisions to accept some or no new Medicaid patients are as follows:

Inadequate reimbursement	89.4%
Delayed reimbursement	75.7%
Billing requirements	76.2%
Practice already met Medicaid quota	56.0%
High clinical burden	60.1%
More than one of these reasons	90.5%

(Source: Miller, et al, 2011)

Primary care physicians (PCPs) cited inadequate reimbursement as the largest barrier (89.4 percent) to accepting new Medicaid patients during a study, which surveyed 4,720 physicians across the country. Miller, et al., (2011) found that three-fourths of respondents also cited "delayed reimbursement" and "billing requirements" as other major considerations (p. E7). Of the PCPs surveyed, many felt that raising the reimbursement for Medicaid patients could encourage their practices' leadership to allow delivery of health care to more Medicaid patients.

Another concern is the availability of specialists. These issues may be compounded in rural areas. In interviews, difficulty finding specialists to see Medicaid patients emerged as a major reason for limiting participation for some PCPs. Thus, low specialist participation in Medicaid may indirectly discourage PCP participation as well (Miller, et al., 2011).

How to Grow this Segment

Tactics that can be implemented to encourage PCPs to accept more Medicaid patients include:

1. A broader primary care workforce including registered nurses (RNs) that could alleviate health care delivery for PCPs.
2. Raising Medicaid reimbursement for PCPs.
3. Targeting PCPs who currently are accepting Medicaid patients.
4. More streamlined policies regarding billing requirements and enhanced communication.

Enabling nurse practitioners and RNs to spend more time with Medicaid patients and address medical conditions could relieve time constraints felt by many PCPs. In the study, it was noted that many PCPs would welcome the idea of hiring additional nurses or physician's assistants to aid Medicaid patients if it made financial sense.

Targeting PCPs who already accept Medicaid patients may be a more beneficial approach than to recruit new PCPs. Many existing PCPs may already have the practice resources and location to serve additional Medicaid patients.

A Medical Home model of health care delivery that has been implemented in Medicaid organizations such as CareOregon could enhance the delivery of health care and lower overall costs.

Communication Partners

Educating and collaborating with organizations such as health departments, schools and medical providers about the benefits of Medicaid enrollment provides numerous benefits.

Managed care organizations (MCOs) that are responsible for providing health-related services should be interested in prevention-oriented measures. As an MCO, there are financial incentives for supporting the early detection of health issues including chronic conditions.

Preventative care has the potential to control future risk factors and ultimately reduce the prevalence of costly chronic conditions in the future that may go untreated (Cohen,

Neumann, 2009). Collaborating with communication partners could provide MCOs with advocates who become willing participants to direct potential Medicaid enrollees to health plan providers. An added benefit to encouraging preventative care is an increase in member engagement and potentially increasing enrollment as well.

Medical Providers

MCOs represent a more structured system for delivering care that focuses on a defined population base. Conversely, individual providers and specialists are less organized and more fragmented. The scope of health care services a primary care physician provides may or may not be covered by Medicaid. To aid medical providers, MCOs must educate medical providers and seek their referrals when applicable.

Patients view physicians as a key trusted source for information. Empowering physicians and their staff with knowledge in Medicaid coverage and eligibility requirements could benefit both the patient and the MCO.

Schools

The school setting provides an excellent opportunity to enroll eligible children and their families in Medicaid and CHIP programs. MCOs should target this communication partner to drive new member enrollment and assist current enrollees with access to additional health-related benefits that may be available to them. The Department of Health and Human Services recommends targeting the following types of schools:

1. Schools in which large percentages of students get free or reduced-price school meals.
2. Title I schools, which serve elementary school children in low-income communities (Source: Department of Health and Human Services, 2010)

Educators and school counselors have tremendous influence on children and are conduits for reaching Medicaid and CHIP eligible children. In addition to partnering with schools, a Department of Health and Human Services publication, the “Get Covered. Get in the Game,” initiative provides helpful steps for utilizing schools and community youth sports programs as outreach pillars for Medicaid and CHIP awareness.

Health Departments and Community Organizations

Community organizations are not only advocating enrollment into programs such as CHIP and Medicaid, but they are receiving funding to do so. The 2009 CHIP Reauthorization Act provided separate funding for 100 percent federally funded CHIP outreach and enrollment grants to cover the various costs associated with outreach and enrollment (Annie E. Casey Foundation, 2010).

In 2009, over \$40 million was awarded to community-based organizations such as community health centers, faith-based organization and school districts (Annie E. Casey Foundation, 2010). Churches, shelters and other community organizations should be targeted as communication partners because of their influence on the low-income population.

Conclusion

CHC Kansas is up against a number of challenges in the complex health care industry. In addition to the implementation of the ACA in 2014, MCOs also face bureaucratic challenges when communicating with target audiences, the low-income and low health literate population.

The remainder of this report is designed to identify major challenges and opportunities for improvement to outline a plan to help CHC Kansas better reach its target audiences. Communicating more effectively with low-income and low health literate individuals should improve member engagement, increase the number of enrollees in Medicaid and CHIP programs and improve HEDIS and CAHPS scores for the organization.

SWOT Analysis

Strengths

- **“High-Touch” Philosophy** – One of CHC Kansas’ biggest strengths is its use of Community Relations Representatives, who are assigned to specific counties. They network with community leaders and speak with people in schools and WIC clinics, as well as with medical providers and other places where members are often found. The personal relationships forged by the Community Relations Representatives are among CHC Kansas’ biggest strengths.
- **Customer Service** – Interviews with members showed that the customer service offered by the CHC Kansas call center offers services that are superior to that of other managed care providers and even private insurance providers.
- **Cross-Cultural Communication** – CHC Kansas offers interpreter services and language lines to communicate with the diverse population that may be eligible for Medicaid.
- **Network of Providers** – CHC Kansas has an extensive list of providers for both primary care physicians and specialists across the counties it serves.
- **Incentives** – CHC Kansas provides incentives for key programs to help encourage members to keep appointments and live healthier lifestyles.
- **Social Media** – CHC Kansas is engaged in social media offering a Facebook page and a YouTube Channel that are integrated and offer members educational health information. UniCare does not offer information through Facebook or YouTube.

Weaknesses

- **Response Time** – In addition to being a business that works in the health care industry, which is already regulated and monitored closely, CHC Kansas also is regulated by the state and outside agencies. These hinder CHC Kansas’ ability to process requests and navigate the system in a timely manner.
- **Acquisition Distractions** – CHC Kansas recently was acquired by Coventry Health Care, and the organization is facing a number of changes, including a change in name, image, services offered and strategy. This causes uncertainty and potential confusion for employees and members, while also resulting in the loss of the Children’s Mercy connection.
- **Communication** – The members and eligible population have a low level of health literacy, making it difficult for the audience to understand and properly interpret the communication disseminated by CHC Kansas, despite the fact that it is written at a sixth grade reading level. This results in missed messages as well as an overall lack of awareness of the services provided by CHC Kansas.
- **Website** – CHC Kansas has a website that is difficult to navigate, partly because Kansas and Missouri members, advocates and providers are all accessing the same site. The website also is not smart phone enabled; research shows that the target population often uses its smart phones to access the Internet, so this is a communication and accessibility barrier.
- **Guidelines for Qualification** – Medicaid eligibility is based on income as a percentage of the federal poverty level. This is how CHC Kansas presents eligibility to its audience, which is in a format that the audience may not necessarily understand. The communication also neglects to explain qualification guidelines in terms that apply to specific situations, which often help this audience better relate to the information.

Opportunities

- **Health Care Education** – CHC Kansas recently eliminated a health education position. This position presents an opportunity to improve health among students and increase membership by getting CHC Kansas’ name in the hands of the target audience.
- **Relationships with Members** – Continuing to build relationships with members will not only better educate them about the services that their health plans offer, but also turn them into advocates on behalf of CHC Kansas.
- **Relationships with Community Partners** – CHC Kansas has an opportunity to use its relationships with key partners in schools, doctors’ offices, churches and clinics to its advantage. This will increase awareness of Medicaid and CHC Kansas in the state of Kansas.
- **Relationships with Medical Providers** – CHC Kansas should value its relationships with medical providers in its network. Working to improve reimbursement procedures and using tactics such as incentives for providers will strengthen these existing relationships, improve patient information obtained from providers and potentially help CHC Kansas expand its provider network offering more options for care to its members.
- **Uninsured Population** – Kansas has a large uninsured population. New programs and events geared toward the uninsured will get CHC Kansas’ name out to that target audience and aid its application process for Medicaid.
- **Member Engagement** – Members are generally not engaged with their health care provider. Efforts, such as incentives and transportation, are being made—and should be continued—to improve member engagement.
- **Advertising** – Because CHC Kansas faces problems with awareness, increased efforts in advertising and marketing could help get the word out. This is especially true if the message is repeated through multiple channels, such as radio, television, direct mail and the Internet.

Threats

- **Competition** – CHC Kansas has limited direct competition in Kansas (currently UniCare), which allows it to be slower to innovate and adapt to the changing population. With the entrance of four new companies vying for the two available managed care provider positions in the state of Kansas for 2013, the competitive landscape will change, and could threaten CHC Kansas’ position in the market.
- **Patient Information** – The Medicaid population is largely transient. This means that where they live and how best to get in contact with them can change frequently and without notice. Consequently, CHC Kansas often has outdated addresses, telephone numbers and email addresses. This causes communication gaps and makes it difficult for CHC Kansas to reach members for immunization reminders, wellness appointment reminders and policy renewal information. Additionally, CHC Kansas relies on the state to update member contact information.
- **Medicaid Stigma** – Medicaid is associated with the stigma that it is aid for the disadvantaged, or a handout for the poor; this could potentially discourage some eligible candidates. Safety net health clinics, which offer similar services to CHC Kansas, may be viewed as a better alternative to Medicaid because of attractive menu pricing and welcoming atmosphere.
- **Lack of Awareness** – Members are unaware of the variety of services offered by CHC Kansas; this could hurt CHC Kansas’ profitability and membership.
- **Cultural Norms and Differences** – With the diverse Medicaid population, cultural norms and differences in individuals’ preferences in their medical care (distrust) could create communication and relationship challenges.
- **Industry Change** – Health Care Reform and insurance plans, in general, present a large number of changes to the CHC Kansas audience. CHC Kansas must be able to effectively communicate these changes to its audience, or run the risk of losing membership as well as new enrollees and to prevent existing members from being faced with unaffordable medical bills.
- **Regulations** – CHC Kansas is subject to strict regulation by the state and Federal governments. Any change in policy can adversely affect CHC Kansas’ ability to continue operations, and presents additional communication challenges.
- **Provider Participation** – It is not uncommon for Medicaid recipients to miss appointments, making providers reluctant to accept a large number of Medicaid patients, which threatens CHC Kansas’ network of physicians.
- **Lack of Health Care Education** – Education programs are not widely available for the low-income population, which brings the overall health of this group down, increasing medical costs.

Primary Research Summary

Purpose

After conducting secondary research on the health insurance market, Medicaid and the low-income population, the team began to seek a deeper understanding of the CHC Kansas target audience as well as more information on the best practices of other MCOs in the U.S. We sought information from the low-income population in Kansas, Medicaid recipients in Kansas as well as outreach professionals who work with this audience on a daily basis. We also contacted industry professionals for additional insight into broader challenges faced by MCOs in this country. The information gleaned from these individuals gave us additional perspective on the CHC Kansas target audience as well as how to communicate with it more effectively and some practices that can be changed to improve member engagement.

Method

To gain insight into the thinking of the CHC Kansas customer, we conducted a number of in-depth interviews with health professionals and Medicaid recipients throughout the Kansas City area and beyond, and held a focus group with Community Relations Representatives for CHC Kansas. The interviews were conducted over the phone and in person. Our in-depth interviews provided perspective on the health care industry as well as Kansas' HealthWave program.

Our focus group brought us closer to the CHC Kansas audience as well as deeper into the company itself. The Community Relations Representatives spend the majority of their time in the field, interacting with the Medicaid-eligible population. This group provided great insight into the challenges faced by those with lower incomes when navigating the complex health care system.

In-Depth Interviews

In-depth Interview Participants

- *Community Outreach Coordinator, Health Partnership Clinic of Johnson County
- Lisa Erlinger-Teel, Johnson County Health Department
- *Director of Health Improvement, San Francisco Health Partners
- *Director of Marketing & Communications, San Francisco Health Partners
- Dr. Stephen Lauer, Vice Chair for Patient Care & Quality Improvement, KU Pediatrics
- *Marketing Specialist for Kansas City Marketing Firm Specializing in Health Care
- *Member, Children’s Mercy Family Health Partners
- *Member, HealthWave Kansas
- Dr. Mark Thompson, Radiation Oncologist, Kansas City Cancer Center
- Joy Wheeler- Healthcare Consultant, 35 years industry experience

*Interviewee requested that he or she remain anonymous.

Findings

Throughout the interviews, several common themes emerged. These are listed below, with summaries of the key findings and how they are applicable to achieving the goals of CHC Kansas.

Communication

Communication is one of the key areas for improvement at CHC Kansas. Health care professionals, marketers and members weighed in on how the target audience is most effectively communicated with and what improvements can be made.

Message

The overarching comment regarding message was that CHC Kansas must be focused on knowledge and education. Low health literacy is prevalent in the United States and Kansas, and this is concentrated in the low-income population. A Community Outreach Worker identified a major issue with members of this population as having a general lack of understanding of their health coverage. The key misunderstandings follow:

1. HealthWave vs. Medicaid
2. KS Title XIX vs. KS Title XXI
3. Choice of a health care plan
4. How to choose a Primary Care Physician (PCP)
5. Who to contact and where to go (HealthWave, CHC Kansas or PCP)

The education component needs to extend beyond definitions and “how to’s.” There needs to be a focus on preventative health care. Dr. Stephen Lauer emphasized that our health care system does not encourage continuity of care; it discourages the opposite (for example, regularly missing appointments, wellness exams, jumping around from doctor to doctor, etc.). He said, “We do not have a health care system in this country—we have an illness-care system. Health is relatively cheap; illness is expensive.” Education regarding the importance of preventative care would be helpful, not only for patient care and well being, but also for the general costs of health care to society. Preventative care is better for patients and less expensive than treating patients with advanced chronic diseases.

Communication Channels

With a refined message that focuses on knowledge and education, the next step is how best to get that message to the target audience. In our interviews, we asked for suggestions on how to better communicate with members and the low-income population. Below is a summary of the responses, listed descending in order of preference/effectiveness (most preferred/effective to least preferred/effective).

- 1. Face-to-Face Communication:** No other communication channel makes the connection or has the effectiveness of face-to-face communication. This helps reach individuals who do not think they qualify for Medicaid, members who do not understand written communication and even increases member engagement. This is often executed at community events, schools, health departments and health fairs.
- 2. Direct Mail:** Several of the MCOs highlighted in our best practices section have seen high success with direct mail. This is preferred to all other forms of media because it allows the receiver to read the communication when he or she has time and provides a source to return to for questions and contact information.
- 3. Telephone:** Similar to direct mail, this is also a favorite channel for communication for MCOs. This channel is best for targeting current members with reminders for renewals, wellness appointments that should be scheduled and for updating member contact information. For the elderly population, this form of communication is preferred over direct mail and face-to-face in most instances.
- 4. Mass Media:** Radio is a great way to reach the transient low-income population. It allows for a message to be repeated, enabling a broader

reach. Television is also an option, but this would need to be on local channels only.

- 5. Social Media:** San Francisco Health Partners and other marketers that work with the low-income population mentioned negative experiences using social media to communicate with members. In addition, legislation and privacy legislation limits what can be discussed through this communication channel.

Engagement

Member engagement is essential to any communication strategy, but especially when it is dealing with something as important as health care. Doctors and health care professionals interviewed agreed that when a member is engaged with the provider, she or he is more likely to attend appointments, regularly visit a primary care physician for wellness appointments and avoid lapses in coverage. The main forms of engagement that have been proven successful are detailed below:

Outreach

Even before speaking to the Community Relations Representative in the focus group, our in-depth interviews revealed the importance of outreach for member engagement. Doctors at practices that accept Medicaid said that social workers are very helpful in answering questions about Medicaid, and that it would benefit them to have a social worker in their offices. In addition to being in providers' offices, social workers also need to be in hospitals, schools, daycares and other places where the low-income population goes. Joy Wheeler, a health care consultant, said, "Having government case workers at the hospital works well. You've got to be where people are. We expect people to come to us; we need to take care to where people are." The personal connection to the members or target audience creates value and builds a relationship while showing compassion.

Outreach workers are also able to speed the application process for people applying for Medicaid. A community outreach worker also mentioned the important role that local HealthWave representatives can play in this process as well. HealthWave representatives are able to move paperwork through the central clearinghouse much more quickly, and can communicate challenges directly to the client, rather than waiting for information to come in the mail. A HealthWave member also said, "Health Departments and clinics are great places to get the word out about [Community Outreach Workers], who help with the application process."

Awareness

The biggest hurdle facing the low-income population is a lack of awareness about eligibility for Medicaid and how to start the process. Often, Medicaid information says that to qualify you must be within 241 percent of the Federal Poverty Level (FPL), but this population doesn't necessarily know what the FPL is or where to find that information. For members of Medicaid and CHC Kansas, the issues are awareness of services offered, how to select a primary care provider and who to contact with questions.

Lisa Erlinger-Teel, a social worker in Johnson County, Kan., described this lack of awareness among the population, saying, "Some families do not know their baby is covered for one year but after the year, they have to reapply for Medicaid. We send the renewal paperwork but it does not work." Several other awareness issues impact this population:

Non-members

1. Does the information provided also impact my welfare or other low-income benefits, etc.?
2. How long does the application process take?
3. Who do I call with a question?
4. What if I don't speak or understand English?
5. How many people are covered on the plan?

Members

1. What preventative care methods should be taken?
2. How do I change personal information when I move?
3. What services are offered by my provider such as transportation, translation, etc.?
4. Who do I call with a question?
5. What benefits are included in my plan?
6. Are dental, vision and prescription benefits included?

This lack of awareness can be addressed with properly structured messages and communication outreach, but it is important to identify these shortfalls in understanding and awareness so they can be targeted.

Incentives

Many of the best-practice providers said that incentives were one of the best ways to get members to attend appointments, go through vaccinations and wellness checks, and participate in health programs. When asked her thoughts on incentives, Joy Wheeler said, "Absolutely. It works." Many providers feel that

the incentives should be ones that actually help the member, such as diapers, formula, cribs for babies, gas cards, discounts off future appointments, etc. San Francisco Health Partners used gift card incentives as part of an overall strategy to significantly raise its CAHPS scores. The most effective incentive was a \$25 gift card, and although there are strict regulations around incentives, it is considered well worth the effort to provide them.

Target Audience

The target audience for CHC Kansas is the Medicaid population and low-income population that is Medicaid-eligible. While we were unable to conduct a survey of members due to state regulations, we were able to conduct in-depth interviews with two Medicaid recipients in Kansas. Several insights emerged regarding the Medicaid population and some of the challenges members face.

Everyday Challenges

While many Kansans plan what they are doing for the weekend or where to go on their next vacation, the low-income population is focused on the present. Lisa Erlinger-Teel, an employee at the Johnson County Health Department, said, “Most people are thinking about what is happening right now. They are trying to take care of basic needs and healthcare is not at the top of their list.” Joy Wheeler believes that society is largely unaware of the social and environmental issues that Medicaid members are dealing with, and that challenges of inadequate food, keeping the lights on, etc., are huge and can outweigh the ability to fully engage in their health care. A local health care marketing specialist referred to health care as an “avoidance topic.” Many do not think about it until it is needed.

Transportation

Another hurdle for the low-income and Medicaid population is that most patients have virtually no transportation. Public transportation is an option, but that may not work with their variable schedules and is also costly. Dr. Mark Thompson, an oncologist at the Kansas City Cancer Center, said that some patients are not aware of the free transportation available, and the fact that 72 hours’ notice must be given in order to receive transportation to appointments. If a member or one of her children becomes ill suddenly, there isn’t always time to give 72 hours notice for transportation. The member needs to see a doctor that day. Many health departments and clinics offer walk-in appointments to get around the transportation issue.

Cultural & Language Barriers

The low-income population is diverse, even in the state of Kansas. This has led to cultural and language barriers that make it difficult to reach and communicate

with the low-income population and members. Some significant barriers Medicaid members face are related to language barriers, as well as cultural norms and differences in individual preferences in their medical care (distrust). Many providers find it essential to have a Spanish-speaking receptionist available for the patients. In addition, most providers also contract with an interpreting service, and they use an interpreter via speakerphone to explain Medicaid and other information about preventative care. This helps to break down some of the barriers, but it does not dissolve them entirely.

A community outreach worker also cited the fact that there are few Spanish-speaking physicians in Johnson County. This offers few options for this large population aside from KU Med, which is quite distant for those living in Southern Johnson County.

Transient Population

It is extremely difficult to maintain up-to-date contact information for the low-income population. Population members tend to have unstable housing situations and can move at a moment's notice. They also often do not have landline telephones, so a prepaid cell phone is the only way to reach them after they move, although these too are discarded easily when they run out of minutes. Incorrect information also is provided, which causes other problems. A community outreach worker believes that some members deliberately give wrong information because they fear they may get calls and letters about unpaid bills.

Focus Group

Four Community Relations Representatives for CHC Kansas met with Sarah Kelly, Alicia Mowder and Carmen Smith for one hour at 2 p.m. on February 23. The Community Relations Representatives were not identified by name to preserve their privacy and ensure honest feedback could be given during the focus group. Chris Beurman, the Community Relations Manager, was not present during the discussion.

About the Respondents

The Community Relations Representatives have been with CHC Kansas for at least four years. The demographics varied across age and ethnicity. All were female, which is consistent with the industry norm. Female representatives are more common because they are perceived as approachable, understanding and non-threatening.

It was apparent from the beginning that the representatives are extremely passionate about the personal relationships they have with the communities and the members they serve. They enjoy talking to families, interacting with communities and being the face behind the policy. Their compassion is obvious as they talk about the stigma that tends to be associated with Medicaid and how they work to overcome that by talking to members at their own level, not down to them. The representatives understand there are several reasons for poverty, and the majority of the members did not grow up in poverty, but have simply fallen on hard times in recent years because of the economic downturn.

The job responsibilities are vast, but the main point is building relationships and recognition of the CHC Kansas name. To do this, they regularly visit Women, Infant and Children (WIC) clinics, schools, day cares, health departments, health fairs and other locations where the low-income population can often be found. They focus on education, which is executed in a variety of ways.

One representative was responsible for presenting to schools that had more than 40 percent of their students on a reduced lunch program. Formal educational outreach has been cut from the CHC Kansas program due to unrealized return on investment; the representatives speculate that this is mainly due to the transition from a non-profit organization to being a part of a publicly traded company, Coventry Health Care. At the schools, the representative discussed basic health guidelines with students, from how many servings of fruits and vegetables they need each day to how to make smart choices. The representatives felt this was a great program to get CHC Kansas' name in front of the right people, sending brochures and informational pamphlets home with the children to share with their parents.

In addition to educating youth through schools, the representatives focus on educating members about the services and benefits offered through managed care. The representatives realize that through education and exceptional service, the members become advocates for Medicaid programs and CHC Kansas out in the community.

Overarching Themes

The focus group discussion mirrored many of the themes found in earlier research. These themes include the competitive landscape for Kansas Medicaid, some of the challenges faced by members and some of the internal efforts that are working or not working for CHC Kansas.

Competition

The competition for Coventry Health Care of Kansas is UniCare, although that will change in 2013 when the managed care provider positions come up for rebid in Kansas. The representatives have a refreshing perspective on the competition. Community Rep Number 2 stated, “In the community we’re partners; in the market, we’re competitors.” This is not just a saying, but an active practice. The representatives encourage anyone to join Medicaid if he or she qualifies, and encourage the individual to call health plan customer service lines to learn more about the providers and plans, ensuring that each enrollee is choosing the right plan for her situation.

Member Challenges

1. **Lack of Awareness** – The low-income population faces many challenges with regard to health insurance. One of the biggest issues the community representatives see is a lack of awareness about the program. Despite all of the community involvement and communication efforts, many people qualify for Medicaid and are not aware of it. Even those who are members still have issues with awareness of services and accessibility to care.
2. **Difficulty Maintaining Contact** – The low-income population is a transient population. Not only is it difficult for the members to keep track of the required documentation due to frequent relocation, it is also difficult for CHC Kansas to keep track of the members and update their information as they move. Even when the members call CHC Kansas to update their information, they often don’t notify the state, causing them to miss essential renewal notices and information, which can lead to a lapse in coverage.
3. **Communication** – Communication is another challenge. The best communication vehicle is face-to-face communication through the community representatives, although it is also the most costly and time consuming. Mail is the second preferred option, yet many members do not look at the information closely and often throw away important information. This has been overcome by sending

information in different shapes, sizes and colors of envelopes and making the communication stand out.

- a. Radio is a good alternative communication outlet. Since not everyone has access to other sources such as the Internet, cable television, cell phones, etc., radio is everywhere and is a simpler way to get the message out.
 - b. The most common recommendation among the representatives was to have the same message sent through a variety of communication vehicles to give members the chance to put the message together after hearing it multiple times. This will help keep managed care and CHC Kansas at the top of the minds of its members and target audience.
4. **Cultural Barriers** – Cultural barriers have been a challenge that has been easier to overcome than others. CHC Kansas prioritizes this, ensuring all printed material is available in English and Spanish; the Community Relations Representatives that most often work with the Hispanic population speak Spanish, and CHC Kansas has a language telephone line for assistance in more than 100 languages.
- a. It is also notable that although the language line is available in more than 100 languages, this is not widely communicated to the Medicaid population. This can discourage the non-English or Spanish-speaking populations from trying to enroll in Medicaid.
 - b. In addition, there are guidelines and training courses on how to deal with people of different cultures in different areas (rural vs. farming communities, Native Americans, etc.); this ensures that the representatives have the proper tools to interact with the different cultures. The representatives feel that making sure they make an effort to know each culture helps to bridge the gap and establish trust.

What Works and What Doesn't

When asked overall, what works and what doesn't at CHC Kansas, the representatives identified a few key points.

What Works

1. Relationships and personal attention to the members. The representatives enjoy seeing that what they do on a daily basis has made an impact on the low-income population.
2. Incentive programs work well, especially the prenatal and newborn programs.
 - a. The representatives expect that with the transition to Coventry, the incentives will get even better, helping to ensure members comply with the required wellness and preventative treatments.

- b. The incentive programs work so well, the representatives feel there is an opportunity to carry them over into other areas, specifically where CHC Kansas needs to improve HEDIS scores.

What Doesn't Work

1. Time: Members do not seem to have the time to attend appointments, health fairs or read communications materials. Often, both parents work and there isn't time to take the children to the doctor.

This is out of the control of CHC Kansas, and although transportation is offered, it is still limiting since transportation is only offered to those that the appointment is for. This leaves the parents to find sitters for other children.

Summary

The focus group provided many key insights into CHC Kansas' relationship with its members and the low-income population, many of which were similar to the observations from the secondary research and in-depth interviews with the community outreach worker and social worker. Key strengths are the personal relationships the Community Relations Representatives have with CHC Kansas members and the community. Communication is seen as a major area for improvement, as is a repeated message through multiple communication vehicles so the members have exposure to the message multiple times. Despite a strong plan and access to Community Relations Representatives, program awareness is still the biggest hurdle for CHC Kansas. Improving communication and building program awareness will help CHC Kansas to achieve its goals.

Recommendations

Research Conclusion

Our research draws upon a variety of sources, including best practices from across the industry as well as insights from members and industry professionals. We believe that CHC Kansas has an opportunity to improve the way it communicates with its target audience. In addition to improving communication, CHC Kansas also has an opportunity to enhance its knowledge and understanding of its members. This can and should be done on an ongoing basis.

We have identified three areas of focus for CHC Kansas:

1. Building awareness and engagement among members and prospective members.
2. Providing more personalized information to members through communication.
3. Strengthening its understanding of its members.

We believe that by focusing efforts in these three areas, CHC Kansas will be able to achieve its objectives that we identified when we began our research.

Additionally, our research of best practices around the country shows that states with the most successful Medicaid and CHIP programs have strong leadership and legislative support behind these programs. Although this is out CHC Kansas' control, lobbying for greater support for Medicaid and CHIP programs in Kansas could result in favorable legislation fostering the organization's efforts and should be considered.

Objectives

1. Increase enrollment and member engagement
2. Improve HEDIS & CAHPS scores
3. Improve communication with its members
4. Effectively communicate change

Target Audiences

Primary Target Audience:

Low-income, low health literate population of Kansas

- CHC Kansas members
- Medicaid-eligible population in Kansas (prospective members)

Secondary Target Audiences:

- Community partners
- Medical providers

Strategies

Strategy 1: Build Awareness and Engagement among the Target Audience

The secondary and primary research presented several themes that CHC Kansas can utilize to build awareness and engagement among its target audience of members and prospective members. CHC Kansas should focus its efforts on building awareness and engagement in the following areas:

1. Community Outreach and Education
2. Community Partners
3. Incentives

Focusing on outreach and education will expand the coverage of CHC Kansas' existing outreach resource, its Community Relations Representatives. The six representatives are essential to each of the tactics and play a vital role in the engagement and awareness of members and potential members. It costs a business more to gain a new customer than it does to keep an old one, which is why the work the Community Relations Representatives do is essential. By redirecting the focus of the Community Relations Representatives to the most effective efforts, CHC Kansas would build awareness of Medicaid and the benefits and services that CHC Kansas has to offer, without adding significant expenditures.

Implementation of incentives will require additional budgetary allocations; however, best practices have yielded success through the use of incentives for both medical providers and members. Continuing current incentive efforts as well as adding new ones would help CHC Kansas reach its goal of increasing HEDIS & CAHPS scores.

Tactic: Continue and Expand Outreach Efforts by Community Relations Representatives

- The Community Relations Representatives should continue to regularly visit WIC clinics, schools, day cares, health departments, health fairs and other locations where the low-income population can be found. Events such as these present excellent opportunities to carry CHC Kansas' message into the hearts of the communities its managed healthcare solutions are designed to serve.
- The Community Relations Representatives should expand current efforts by conducting seminars and distributing printed material to teach educators, school nurses and counselors about the benefits offered through Medicaid and how to apply.
 - CHC Kansas' formal education program has been cut from the program; therefore, the Community Relations Representatives should fill this role

as described. If results from these efforts deliver and the budget allows, CHC Kansas should reinstate the Education Representative role.

Tactic: Build relationships with outreach workers throughout Kansas

- Community outreach workers can expand the footprint already established by Community Relations Representatives. Continue establishing and building relationships to expand the reach of CHC Kansas and increase awareness about Medicaid and CHC Kansas as a provider.
- Community Relations Representatives should attend community leadership meetings and network with outreach workers that have access to the low-income population in the community. During these meetings the representatives should:
 - Share information about the importance of health care
 - Discuss who qualifies and how to apply for Medicaid
 - Engage outreach workers about the benefits offered by CHC Kansas

Tactic: Network off of existing community partnerships

- Community Relations Representatives have established relationships at various WIC clinics, schools, day cares, etc., throughout the state. Understanding how new members are signing up for Medicaid and learning about CHC Kansas will point toward the most effective outreach methods.
- CHC Kansas should replicate existing partnerships throughout the network of community partners. It should focus on the most effective outreach methods.
 - For example, if CHC Kansas representatives are established in a school, then efforts should be made to expand that relationship into district-wide access (as appropriate).

Tactic: Educate members on the importance of check-ups and maintaining overall health and wellness

- CHC Kansas should illustrate the effect of wellness care on overall health insurance costs for members and provide information about regular check-ups. Examples of messages are:
 - Did you know your child should see a doctor six times during the first year of life?
 - Wellness check-ups not only maintain overall health, but can also detect serious medical conditions early on.
 - CHC Kansas can provide an example of a member detecting breast cancer, or another serious illness versus someone who catches it late, and how these affect medical treatment and costs.
- CHC Kansas should educate members regarding healthy eating by supplying families and children with examples of meals that meet the United States Department of Agriculture (USDA) guidelines. CHC Kansas should communicate

how grocery bills can change based on the foods purchased to encourage healthier purchases at the grocery store.

- For example, a family of four can eat at McDonalds for \$28 (two Big Macs, two Happy Meals, two medium fries, and two medium sodas), or a family of six can eat at home for \$14 (roasted chicken, two cans of no added salt vegetables, a bag of prepared salad with light dressing and milk).

Tactic: Pay for Performance (P4P) Incentives

- Pay for Performance, or P4P programs, motivate providers with financial incentives. When executed correctly, this type of incentive will standardize quality, improving HEDIS and CAHPS scores. An in-depth explanation of this incentive program is included in Appendix 9.
- A P4P program should be implemented by a Per Month per Member (PMPM) cost increase. These increases are modest, totaling less than a dollar PMPM.
 - For example, a 95 cent increase in cost, PMPM, by the medical plan would allow for provider incentives that can greatly impact the role of the provider.
- Based on best practices, high-volume providers—those serving more than 200 Medicaid patients—would receive a 30 cent PMPM incentive for their efforts; low-volume providers, serving less than 200 Medicaid patients, would receive 50 cents PMPM. Both would receive an additional 30 cents PMPM for the following:
 - Multilingual services (on call after hours)
 - Timely access including extended evening hours and weekends
 - Urgent care capability (reducing ER visits)
 - Preventative care

Tactic: Fee for Service

- Fee for service (FFS) incentives would increase the amount of information CHC Kansas would gather from provider patient health records while also providing incentives to the provider. An in-depth explanation of this incentive program is included in Appendix 9.
 - The provider would receive a \$25 incentive after completing an initial patient assessment online, and then would receive a \$10 incentive for each update to the patient’s profile online.
 - Updating the profiles online would complete required treatment or check-ups for the patient and CHC Kansas would receive confirmation of such completed treatments.
 - This tactic is most useful in the treatment of such conditions as diabetes and asthma that require a care plan.

Tactic: Gift Cards and Merchandise Incentives

- Incentives should be used to increase HEDIS and CAHPS scores in areas where there is the strongest opportunity for CHC Kansas to improve. CHC Kansas is near or below the national average in the following six areas:
 1. Prenatal Care
 2. Postpartum Care
 3. Childhood Immunizations
 4. Well-Child Visits
 5. Well-Adolescent Visits
 6. Diabetes Care

Please see Appendix 9 for specific tactics regarding incentives in the areas listed above.

- Gift cards and merchandise typically range from \$5 to \$50, with \$25 dollars being the average and most utilized amount.
 - \$50 gift cards are designated for the completion of an entire program such as childhood immunizations that require several visits and a longer commitment.
 - Merchandise includes items such as cribs for completing prenatal care appointments.
- Education is a vital component of financial incentives. CHC Kansas should require members to attend an educational session or meeting with a doctor before becoming eligible for incentives. The primary care doctor must approve the successful completion of a program for members to receive their incentives.

Strategy 2: Focus Messages on Key Deliverables

CHC Kansas does a good job of communicating to members and potential members, but the messages lack strategy and action. CHC Kansas has a tremendous opportunity to cut through the clutter and confusion that surrounds health care with key core messages. These messages should be consistently delivered across various media channels (e.g. billboard, radio, magazines) as appropriate.

Tactic: Identify the strategy for every message

- CHC Kansas should implement a communication strategy for all messages, regardless of the medium. Our research indicates CHC Kansas would benefit from using the following guidelines when developing communication for the low-income population (Hoover-Dempsey & Walker, 2002 and Health Literacy Fact Sheet, 2011):
 - Is the message straightforward and simple?
 - What is the purpose of the message?
 - What action does the member need to take?
 - What does the member gain from receiving the message?
 - Who does the member contact with questions and feedback?

To utilize the direct mail and messaging budget most effectively, communications need to follow the above guidelines to ensure the communication is essential and something will be gained by sending it.

Tactic: Identify the message

- CHC Kansas should only communicate messages focused on key deliverables, regardless of the medium. The messages should answer the question: “What do members get from CHC Kansas as their medical provider?” If the communication is not reinforcing one of the following messages, it should not be sent.
 - The importance of wellness and preventative care
 - The benefits provided and covered by the CHC Kansas medical plan (health, dental, vision, illness, wellness, preventative)
 - The providers in the CHC Kansas network (primary care doctors, safety net health clinics like CVS and Walgreens)
 - The services provided and covered by CHC Kansas (transportation, language line, incentives)
 - The relevant medical and health care industry changes
 - The action required (updates to personal information, membership renewal, change of address, designating primary doctor)

Strategy 3: Deliver Clear and Personalized Information to Members

CHC Kansas' target audience, the low-income, low health literate population, often finds messages provided from the organization as well as HealthWave, in general, confusing and unclear. CHC Kansas has an opportunity to communicate directly with its audience and provide clear messages that are easier for the audience to understand, avoiding confusion. This would improve engagement in the program and increase enrollment.

Tactic: Provide specific information about who qualifies for Medicaid and where to apply

- Medicaid eligibility is most often expressed as a percentage of the federal poverty level, and potential members may not understand what this means. CHC Kansas should provide specific scenarios that are relevant to the low-income population to generate interest among them and increase the number of applicants to build its membership base. It should also clearly direct members how to apply for Medicaid.
 - Kansas residents within 241 percent of the federal poverty level qualify for Medicaid. For example, children in a family of four with a monthly income of up to \$4,200 could be eligible for coverage. Contact HealthWave by calling 1-800-792-4884 to apply for state-sponsored health coverage.
 - The program also accepts applications from parents/guardians with income up to 150 percent of the federal poverty level. Thus, a family of four making up to \$2,625 per month may qualify. Contact HealthWave by calling 1-800-792-4884 to apply for state-sponsored coverage.
- It is common for children to qualify for CHIP programs, even though the family does not qualify for Medicaid. CHC Kansas should use its relationships with Kansas schools to reach children who may qualify for CHIP.
 - Simple messages to parents, such as, "You may not qualify, but your kids do," would inform parents that although they do not qualify for state-sponsored coverage, their children may qualify.
 - Parents should be screened for Medicaid eligibility during the CHIP screening process, potentially increasing enrollment in Medicaid and CHIP programs.

Tactic: Provide personalized and clear information online

- CHC Kansas should provide information to its members in a personalized and clear way, modeled after UnitedHealthcare's website.
 - The website is informative and easy to navigate. The information is specific to the member's health plan.

- Members are directed to a UnitedHealthcare Medicaid website based on their zip code, ensuring the member is receiving accurate information about the benefits of the health plans offered in the area.
- CHC Kansas should develop a mobile site to reach the 40 percent of the low-income population that goes online using a cell phone.

Tactic: Clearly communicate contact information for specific questions and problems

- Members are confused about where to direct phone calls when they have questions and are often discouraged by long wait times and redirected calls. CHC Kansas should offer specific guidelines on where to direct questions on specific subjects.
 - For example, “Have questions? Call the right number the first time.”
 - Questions about Medicaid applications or eligibility.
 - HealthWave*
 - Questions about the health plan, billing and benefits
 - CHC Kansas
 - Questions about appointments
 - Family doctor

*Note: CHC Kansas currently uses the link to www.kansashealthwave.org in its member communications. This redirects members to the home page for Kansas.gov. Use <http://www.kdheks.gov/hcf/healthwave/default.htm>, which will direct members to a page specifically devoted to HealthWave and Medicaid information.

- CHC Kansas should clearly communicate that members and potential members have access to interpreters who speak more than 100 languages, free of charge.
 - For example, “Don’t speak English or Spanish? CHC Kansas offers language lines with access to interpreters who speak more than 100 languages, free of charge.”
 - This message should be communicated in a variety of languages.

Tactic: Remove abbreviations and complex terms

- Medicaid members are unfamiliar with the term PCP, despite the frequency with which it is used within communications. CHC Kansas should avoid the term PCP and other abbreviations, explaining specifically what is being referred to and where information about that topic can be found.
 - Instead of “PCP,” use “your family doctor.”

Strategy 4: Strengthen CHC Kansas' Understanding of its Members

CHC Kansas apparently has a lack of statistical information about its members. Although member data is collected, it is often difficult to mine and does not produce useful information for tailoring communications to members. Because of this, CHC Kansas should strengthen its understanding of members, providing information to better communicate with and reach out to members in ways that are relevant and have impact to them. This would be an ongoing process that would help CHC Kansas adapt and modify core messages, strategies and tactics to fit the audience.

Tactic: Conduct surveys of new members

- New members to CHC Kansas often are new members to Medicaid and recently have had a life altering experience that has changed their families, incomes or living situations. CHC Kansas should provide a new member survey to get a better understanding of each new member and how best to position communication and services to her. Examples of important survey questions are below.
 - Where did you hear about Medicaid?
 - How did you hear about CHC Kansas?
 - What is your preferred method of communication?
 - What school district does your child attend (if applicable)?
 - Do you have a family doctor? If so, have you asked if that doctor is in-network for CHC Kansas?
 - Do you have a car or a reliable source of transportation?
 - Where do you most often shop for groceries and household necessities?

Tactic: Conduct surveys of existing members

- CHC Kansas should survey existing members to get a better understanding of their situations and areas for improvement. CHC Kansas should treat members as “existing” if they have been with CHC Kansas for nine months or more. This means they have had the opportunity to receive communications from CHC Kansas, establish a primary care provider and attend various wellness and preventative care appointments. Examples of important survey questions are below.
 - What is your preferred method of communication?
 - How many times has CHC Kansas communicated with you in the following ways over the past six months? (Email, Direct Mail, Text, Telephone, through brochures in locations you regularly visit, Community Representative)?
 - Have you visited a doctor in the past six months?
 - Have you missed an appointment in the past six months? If so, why?
 - Are you aware of the member services offered by CHC Kansas?

- Please identify any services offered by CHC Kansas that you have used in the past six months (translator, transportation, hotline number for questions, etc.).
- Where do you most often shop for groceries and household necessities?

Tactic: Embed feedback opportunities in communication

- CHC Kansas uses several vehicles to communicate with members, including direct mail, brochures, member handbooks, phone calls and customer service phone lines, website and email, to name a few. CHC Kansas should include a survey in all communications to measure the effectiveness of each communication, identifying what works and what doesn't, both in terms of message and vehicle. The following questions are examples of the types of questions that should be included in the survey.
 - Did you read this entire communication?
 - Did you learn something from this communication?
 - Is this information relevant to you? Why or Why Not?
 - Do you understand what action you need to take? Please list the action.
- CHC Kansas should execute the survey through the following vehicles, and then analyze which has the highest response rate to move forward with.
 - A prepaid Business Response Card is the most expensive form of survey, but also the most effective. Including this with all direct mail and brochures would increase the likelihood of a response.
 - Websites are also a good way to get responses, although the more steps that are required the lower the response rate.
 - Utilizing the hotline is another great vehicle for a survey. An automated survey after a member calls will allow members to provide feedback on the conversation they just had as well as feedback on other communication, in general.
- CHC Kansas should offer an incentive for responding to the survey, such as a drawing for a \$25 gift card.

Tactic: Facilitate focus groups annually

- CHC Kansas should hold a focus group with members to understand how they feel about specific areas of interest and emphasis, based on HEDIS and CAHPS results, and new marketing and communication initiatives.
 - This focus group should be held in a neutral environment for the members and provide incentives such as a meal or a small token of appreciation (gift card, necessary item, etc.). Ideally, there would be a variety of focus groups throughout the largest communities in Kansas to get a random mix of individuals and responses. Topics should focus on the following areas.
 - Communication

- Engagement
- CHC Kansas as a provider
- Services offered by CHC Kansas
- Health care plan coverage
- Areas where scores were low

Measurement

Measurement is a key component of any Marketing Communications Plan. Tactical execution of marketing strategy must be tied to demonstrable results. Not only will these results help more effectively allocate funding in optimal areas in the future, it will also justify the dollars spent for upper management.

Our marketing plan includes measurable tactics, which will allow CHC Kansas to track the success of each tactic implemented. As CHC Kansas tracks its progress, it will be able to identify the most effective tactics and reallocate the budget accordingly. Suggestions for how to measure the success of the tactics included in the marketing communication plan are outlined below. The suggested measures are followed by a sample dashboard-style report designed to illustrate the success of marketing efforts to upper management.

Community Partners

- In addition to developing community partner relationships, we have also suggested that CHC Kansas survey new members; each new member should be asked how she first heard of CHC Kansas. This will help CHC Kansas track ROI with community partners, as well as determine which partnerships return the most new members.
- Metrics:
 - Establish a baseline for community partnerships, and track growth over time
 - Events with community partners should be analyzed on the following metrics:
 - Event type
 - Type of partner (school, day care, etc.)
 - Estimated attendance
 - Estimated cost
 - Number of applicants and members tied to the event
 - Number of new members gained through each partner type
 - How members are hearing about CHC Kansas
 - Whether or not they've met with a Community Relations Representative

Outreach Workers

- Track where people are hearing about Medicaid and receiving applications
- Determine which areas result in the most successful outreach efforts

Provider Incentives

- Based on our recommendations, medical providers will receive incentives for providing information about patients for CHC Kansas. This will help CHC Kansas

better target its future communication efforts. This is also part of an effort to expand the provider network.

- Metrics
 - Provider participation
 - Services being used the most
 - Average number of patients seen by each provider
 - Trend over time
 - Number of patient assessments being filled out
 - Because doctors will be filling out patient assessments, CHC Kansas will have access to more data about the health of its members, helping it better target communication efforts as well as track the success of current efforts
 - Number of patient profiles being filled out
 - May eventually switch to tracking number of profiles updated
 - HEDIS & CAHPS scores for preventative care appointments
 - HEDIS & CAHPS scores for treatment of chronic conditions such as diabetes and asthma

Member Incentives

- Metrics
 - HEDIS & CAHPS Scores for the areas where incentives are being used
 - Incidences of illness visits to the doctor or emergency room

Messaging

- Messaging Strategy
 - Number of messages being sent
- Who Qualifies
 - Trend in application rate
 - Number of children being enrolled without parents
- Information Online
 - Number of unique visitors to website
 - Click-throughs for website
 - Traffic on mobile site
- Illness/Wellness
 - Audience's knowledge of healthy foods (to be determined through surveys)
 - Number of members attending wellness appointments
 - Overall health and wellness of members
 - Incidences of conditions such as Type 2 Diabetes or obesity
 - Early detection rates (tracked through provider network)
- Where to direct questions
 - Number of people calling the customer service line

- Number of people being referred to another number
- Usage of language lines
- Number of languages being translated
- Eliminating abbreviations and jargon
 - Moving from the term PCP to family doctor
 - Include a question in member surveys administered asking members to name the family doctor
 - Track the results
 - Number of people answering the question correctly

New Member Surveys

- Number of new members registered on a regular basis
 - Monthly
 - Quarterly
 - Etc.
- New member engagement

Existing Member Surveys

- Number of existing members
- Existing member engagement
- Number of missed appointments
- Member awareness of services provided by CHC Kansas

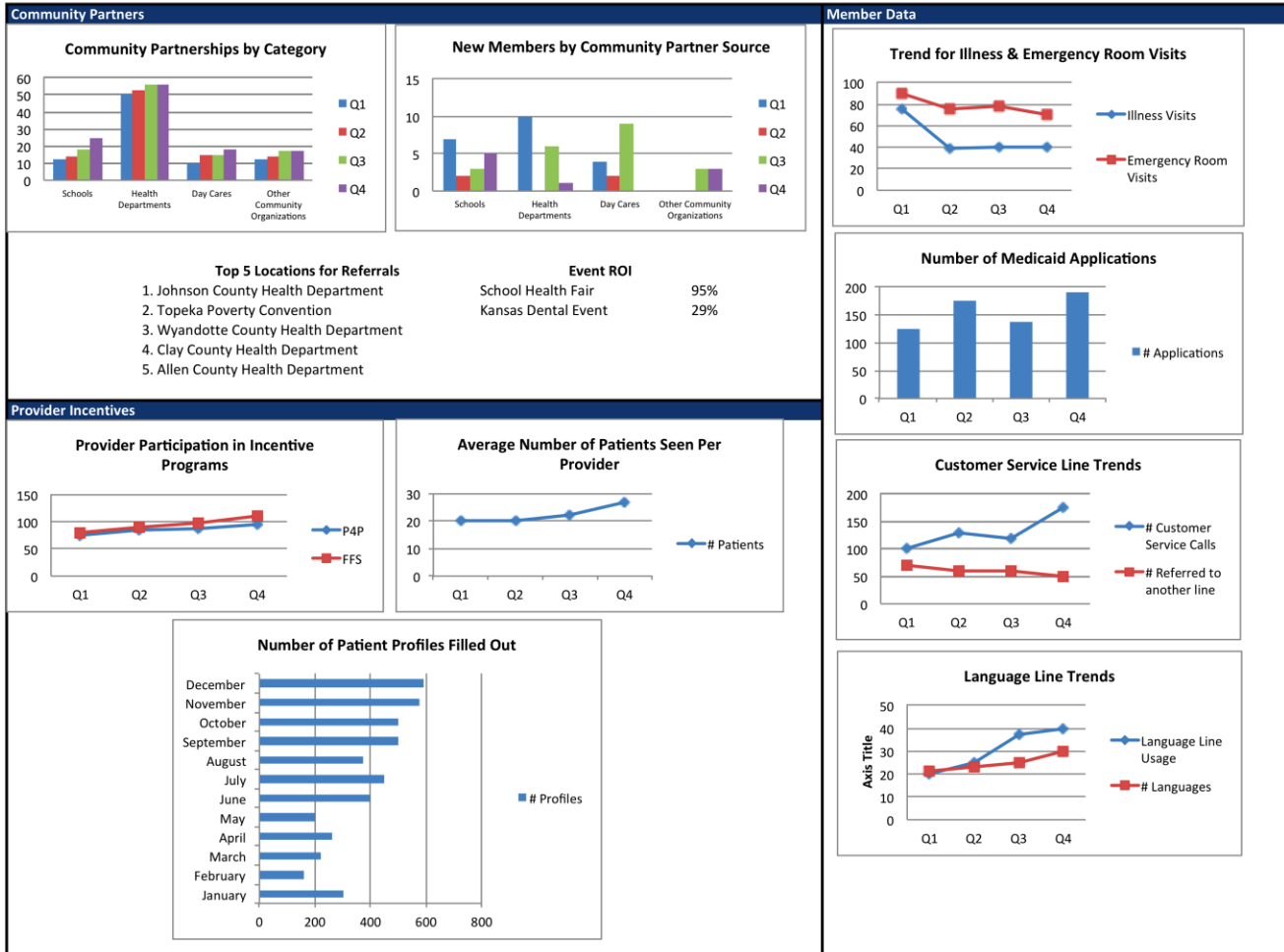
Survey Vehicles

- Survey respondents

Focus Group

- Member Engagement
- HEDIS & CAHPS measures for topics identified in most recent focus group

CHC Kansas Marketing Communication Dashboard*



*All data included in this report is fictitious. This report is strictly intended to serve as a sample format.

Timeline

To assist CHC Kansas in the implementation of this communication plan, we have established a timeline suggesting how CHC Kansas can take action. We have organized this timeline into two categories: Critical Priority (0-6 months) and High Priority (6-18 months). We considered two attributes for each tactic: relative impact and ease of implementation. Relative impact is based on the tactic's potential effect on the target audience and expected effect on HEDIS & CAHPS scores; ease of implementation relates to the amount of additional research and planning required prior to implementation. We used these two attributes to guide our decision between critical and high priority.

Immediate Implementation (0-6 Months)

- **Tactic: Continue and Expand Outreach Efforts by Community Relations Representatives**
 - CHC Kansas Community Relations Representatives should continue visiting WIC clinics, schools, day cares, health departments, health fairs and other locations.
- **Tactic: Build relationships with outreach workers throughout Kansas**
 - Partnering with the community outreach staff members working with the target population will allow CHC Kansas to piggyback on community leadership initiatives and meetings that are already taking place.
- **Tactic: Network off existing community partnerships**
 - Similar to the previous tactics, this one should receive immediate attention simply because the relatively limited additional effort involved in deliberately exploring existing relationships for new opportunities could yield as yet untapped outreach opportunities.
- **Tactic: Identify the strategy for every message**
 - We have recommended that CHC Kansas work on communicating more effectively with its target audience. It should begin to use these guidelines as it develops new messages.
- **Tactic: Identify the message**
 - We have recommended that CHC Kansas develop messages to communicate clearly its mission to its members. Repeating simpler messages will give CHC Kansas a more distinct image in the minds of its customers and the contents of these messages should be carefully planned.
- **Tactic: Provide specific information about who qualifies for Medicaid and where to apply**
 - CHC Kansas should immediately begin to simplify eligibility information and phrase it in a way that is easy for potential applicants to understand.

- **Tactic: Provide personalized and clear information online**
 - Overhauling the manner in which CHC Kansas information is presented online certainly will not be easy, but it must begin immediately. One look at the simple, streamlined website of an organization (UnitedHealthcare) that will be competing with CHC Kansas in the RFP for 2013 makes it clear that this should be an immediate priority.
 - Developing a mobile site also falls under this tactic of “clear information online” and, we believe that this portion of the tactic can be a long-term priority since developing the main website is more important at this time.
- **Tactic: Educate members on the importance of check-ups and maintaining overall health and wellness**
 - The health literacy of the target audience cannot improve overnight; so the sooner this tactic can be deployed the better.
- **Tactic: Clearly communicate contact information for specific questions and problems**
 - Communicating contact information for CHC Kansas is one of the first steps in making the organization more available and accessible to the public, which is why we recommend that it be implemented immediately.
- **Tactic: Remove abbreviations and complex terms**
 - CHC Kansas should eliminate the use of complex terms and abbreviations, which will aid in the effort to communicate more effectively with the target audience and the process should begin immediately.
- **Tactic: Embed feedback opportunities in communication**
 - This tactic should be implemented immediately so that CHC Kansas has more of an opportunity to engage in a conversation with its members by hearing more feedback from them; this feedback should, in turn, further inform CHC Kansas’ communication, marketing and business efforts.

Long Term Implementation (6-18 Months)

- **Tactic: Pay for Performance (P4P) Incentives**
 - The inherent complexity of this initiative warrants that it be sufficiently studied prior to roll out and that other more “low hanging fruit” tactics be executed first.
- **Tactic: Fee for Service Incentives**
 - The potential hurdles and parameters set at the state level warrant careful study and consideration prior to roll out; there may also be approval procedures required before this tactic can be fully carried out.
- **Tactic: Gift Cards and Merchandise Incentives**
 - CHC Kansas is currently employing tactics using gift cards and other incentives. We have recommended that the organization focus its incentive efforts on HEDIS and CAHPS measures that need improvement. We recognize that there are potential state and legislative restrictions that govern these types of programs, and any changes that are made will need to go through a review process before being implemented.
- **Tactic: Conduct surveys of new members**
 - Once CHC Kansas has had time to implement some of the other tactics mentioned in this report, creating a survey of new members could reveal some telling insights into why a person became a member, which could in turn inform efforts to reach other non-members who are in similar circumstances. We also recognize the state limitations on surveys of Medicaid members may further delay the implementation of this tactic and should be considered when planning it.
- **Tactic: Conduct surveys of existing members**
 - Creating a survey of existing members could reveal some telling insights about what CHC Kansas does well and what it could improve upon, which could in turn inform efforts to better serve the member base.
- **Tactic: Facilitate focus groups annually**
 - Similar to the survey efforts mentioned above, but more concentrated and potentially more informative, an annual focus group could certainly be used to continue to improve and mature CHC Kansas’ communication plan and product offerings.

Budget Considerations

CHC Kansas' annual marketing budget is about \$500,000 and includes outreach, education and media activities. Our recommended strategies and tactics for CHC Kansas are designed to use existing resources to get the most out of budget dollars. By expanding the reach of the Community Relations Representatives through further education and building relationships with community partners, CHC Kansas will need to allocate additional funding toward printing, giveaways and outreach.

We have budgeted \$12,500 for the execution of our tactics. Recognizing that a budget increase may not be realistic under new ownership, we recommend that CHC Kansas decrease its current budget for sponsorships by 10 percent to offset the cost of additional printing, giveaways and outreach. As the Community Relations representatives expand their reach, sponsorships will not be as necessary to help CHC Kansas get its name in front of members and prospective members.

Our budgetary considerations for our recommended strategies and tactics are outlined below.

CHC Kansas Budget Considerations

Tactic	Estimated Cost	Allocation
Continue and expand outreach by Community Relations Representatives	\$4,000	giveaways, media/outreach, printing, travel/expenses
Build relationships with outreach workers	\$625	giveaways, media/outreach, printing, travel/expenses
Build relationships with community partners	\$625	giveaways, media/outreach, printing, travel/expenses
P4P incentives for providers	staff resources	media/outreach, printing, travel/expenses
Fee for Service incentives	staff resources	media/outreach, printing, travel/expenses
Gift cards and merchandise incentives	staff resources	giveaways, media/outreach, printing, travel/expenses
Identify a strategy for every message	staff resources	media/outreach, printing, sponsorships
Identify the message	staff resources	media/outreach, printing, sponsorships
Communicate specific Medicaid eligibility requirements and where to apply	\$1,250	printing
Provide personalized and clear messages online	\$5,000	printing, media/outreach
Educate members on wellness and regular preventative checkups	\$1,000	giveaways, media/outreach, printing, sponsorships, travel/expenses
Clearly communicate contact information for specific questions/problems	staff resources	printing
Remove complex terminology and abbreviations	staff resources	printing
Conduct surveys of new members	staff resources	administrative expenses, travel/expenses
Conduct surveys of existing members	staff resources	administrative expenses, travel/expenses
Embed feedback opportunities in communication	staff resources	printing
Conduct focus groups annually	staff resources	administrative expenses, travel/expenses

Total **\$12,500**

Legend

Strategy 1: Build Awareness and Engagement among the Target Audience

Strategy 2: Develop Core Messages

Strategy 3: Deliver Clear and Personalized Core Messages

Strategy 4: Strengthen CHC Kansas' Understanding of its Members

Note: Additional funds may be available by raising capitation rates for members in the health plan.

Appendices

Appendix 1

Managed Care Best Practices

SFHP HEDIS Measure Incentives

SFHP HEDIS Measure Incentives			
HEDIS Measure	Eligible Members, Required Services	SFHP Incentive Program	2009 Member Response Rate
Prenatal Care	Expectant mothers. Must attend a prenatal medical visit during first trimester, or within 42 days of SFHP enrollment.	Women's health mailer includes description of incentive. Interested members call SFHP for incentive card. If provider signs, member gets incentive. \$25 gift card.	35% of members who request incentive info submit a card that qualified for incentive gift.
Postpartum Care (New for 2011)	New mothers. Must attend a postpartum medical visit within 3 to 8 weeks of delivery.	Women's health mailer includes description of incentive. Members may call for incentive card. SFHP also does live outreach calls to postpartum women. \$25 gift card.	NEW! This incentive will launch in 2011.
Childhood Immunizations	Children up to their second birthday. Must receive all doses for 10 immunizations: DTaP, Flu, HepA, HepB, HiB, MMR, Polio, Pneumococcal, Rotavirus, Varicella.	Incentive-specific mailer to all eligible member-parents includes card for provider to sign for completed immunizations. Live and automated reminder calls to member-parents reminding them to make/keep appointments and reminder of incentive. \$50 gift card.	23% of all eligible members returned fully completed cards that qualified for incentive gift.
Well-child Visits	Children between ages of 3 and 6. Must attend a well-child medical visit within the calendar year.	Mailer to all eligible member-parents each year at child's birthday. Automated phone call reminders go out just prior to mailing. \$25 gift card.	41% of eligible members returned fully completed cards that qualified for incentive gift.
Well-adolescent Visits - SFHP Members - SFHP Providers	Adolescents between ages of 12 to 21. Must attend a well-adolescent medical visit within the calendar year.	Mailer and automated reminder calls to all eligible members at birthday. \$15 gift card or 2 movie tickets; entered in annual raffle of iPod Nano and laptop. Providers can receive \$20 for each patient with a complete annual visit.	26% of eligible members returned an incentive card that qualified for the incentive gift.
Comprehensive Diabetes Care	Members with diabetes, ages 18 to 75. Must receive six screening tests in the year: hemoglobin A1c, blood pressure, cholesterol (LDL-C), neuropathy, eye exam, diabetic foot exam.	Mailer to all eligible members includes card for provider to sign attesting to the completion of the six required screening tests. \$25 gift card.	8% of all eligible members returned an incentive card. Of these, 46% qualified for the incentive gift.

(Source: SFHP)

SFHP Incentives (Gatewood, 2011)

- 80 percent of provider networks agreed that incentives were helpful in their practices
- Along with incentives, live and automated phone calls are important components to a successful incentive plan
- Best practices for incentives include distributing incentives at the conclusion of a care program to avoid incomplete treatment of care (motivate members to fulfill care obligations)

- Educating providers about incentives is an important component of a successful incentive program
- Approval for incentives may need to come from the State in which it will be administered
- Gift cards have been shown to be successful while products or merchandise have had mixed results

CareOregon- Care Support Team Model

Exhibit 3. Role of CareSupport Case Management Team Members	
Team Member	Role
Registered nurse case manager (RN)	<ul style="list-style-type: none"> • Monitor assigned populations of patients to identify risk situations before crises occur • Assist patients by encouraging, teaching, and coordinating services • Assist providers by supporting their treatment plans when working with patients and sharing critical patient information
Behavioral health case managers (Social Worker)	<ul style="list-style-type: none"> • Assist patients with mental health, substance abuse, inadequate social supports, and behavioral challenges
Health care guides (Health Guide)	<ul style="list-style-type: none"> • Engage and develop strong, ongoing relationships with patients while performing tasks important to improving patients' health, such as scheduling appointments, arranging transportation, or connecting patients with community resources, shelter, food, and clothing. The role is filled by a paraprofessional who is supervised by a clinician.

(Source: CareOregon)

Care Support (Klein & McCarthy, 2010)

- Provides a centralized case management and care coordination model
- CareSupport seeks to find members with the highest risk for poor health outcomes
- Multidisciplinary care teams help members beyond just medical care (assist with behavioral issues and substance abuse as examples)

CareSupport has helped reduce costs by taking preventive measures. In some cases, \$400 dollars per month was saved by implementing this program.

Appendix 2

Demographics of Medicaid Enrollees

Distribution of the Nonelderly with Medicaid by Race/Ethnicity, states (2009-2010), U.S. (2010)					
	KS #	KS %	KS % of U.S. Total	U.S. #	U.S. %
White	178,700	57%	<1%	19,501,500	43%
Black	51,600	17%	<1%	9,689,100	22%
Hispanic	56,400	18%	<1%	12,523,200	28%
Other	24,700	8%	<1%	3,332,800	7%
Total	311,400	100%	<1%	45,046,700	100%

(Source: Kansas Medicaid & CHIP, 2009)

Distribution of the Nonelderly with Medicaid by Gender, states (2009-2010), U.S. 2010				
	KS #	KS %	U.S. #	U.S. %
Female	159,300	51%	23,787,100	53%
Male	152,200	49%	21,259,600	47%
Total	311,400	100%	45,046,700	100%

(Source: Kansas Medicaid & CHIP, 2009)

Distribution of Medicaid Enrollees by Enrollment Group, FY2008				
	KS #	KS %	U.S. #	U.S. %
Aged	35,700	10%	5,363,300	9%
Disabled	67,800	19%	9,729,700	16%
Adults	52,600	15%	15,462,300	26%
Children	198,600	56%	28,966,800	49%
Unknown	0	0%	1,400	0%
Total	354,700	100%	59,523,600	100%

(Source: Kansas Medicaid & CHIP, 2009)

Appendix 3

Safety Net Clinics in Kansas City

MISSOURI	Safety Net Clinics – Missouri Directory of Services	Accepts Medicaid	Adult Medicine	Adult Immunizations	Mental Health	Dental Care – Adults
	Cabot Westside Health Center, Kansas City, Mo.	●	●	●		●
	Cass County Dental Clinic, Belton, Mo.	●				
	Children’s Mercy Northland, Kansas City, Mo.	●				
	Children’s Mercy Pediatric and Specialty Care, Kansas City, Mo.	●			●	
	Children’s Mercy Teen Clinic, Kansas City, Mo.	●				
	Hope Family Care Center, Kansas City, Mo.	●	●	●		
	Kansas City Free Health Clinic, Kansas City, Mo.		●	●	●	
	Kansas City Free Health Clinic – Prospect, Kansas City, Mo.		●	●		●
	KCMO Public Health, Kansas City, Mo.	●		●		
	Lafayette Health Department, Lexington, Mo.			●		
	Mercy & Truth Medical Missions, Raytown, Mo.	●	●	●		●
	Platte County Health Department Clinics – Platte City, Mo.	●	●	●		
	Platte County Health Department Clinics – Riverside, Mo.	●	●	●		
	Samuel U. Rodgers Dental Clinic, Independence, Mo.	●				●
	Samuel U. Rodgers – J.A. Rodgers Family Dental, Kansas City, Mo.	●				
	Samuel U. Rodgers Clinic – Lafayette, Lexington, Mo.	●	●	●		●
	Samuel U. Rodgers South Therapeutic Intervention Center – Substance Abuse, Kansas City, Mo.	●			●	
	Samuel U. Rodgers Health Center, Kansas City, Mo.	●	●	●	●	●
	Samuel U. Rodgers Clay County Health Center, Liberty, Mo.	●	●	●		
	Samuel U. Rodgers North Health Center, Kansas City, Mo.	●	●	●		
	Seton Center, Kansas City, Mo.	●				●
	Shared Care Free Clinic of Jackson County, Independence, Mo.		●	●		
	Sojourner Health Clinic, Kansas City, Mo.		●			
	Swope Health Northland, Riverside, Mo.	●	●	●	●	●
	Swope Health Independence, Independence, Mo.	●	●	●		●
	Swope Health Central, Kansas City, Mo.	●	●	●	●	●
	Swope Health South, Kansas City, Mo.	●	●	●		
	Truman Medical Centers Behavioral Health, Kansas City, Mo.	●			●	
	University of Missouri – Kansas City School of Dentistry Clinic, Kansas City, Mo.	●				●

(Source: Health Resource Guide of Kansas City)

		Safety Net Clinics – Kansas Directory of Services				
		Accepts Medicaid	Adult Medicine	Adult Immunizations	Mental Health	Dental Care – Adults
KANSAS	Children’s Mercy West/The Cordell Meeks Jr. Clinic, Kansas City, Kan.	●				
	Duchesne Clinic, Kansas City, Kan.		●	●	●	
	Health Partnership, Olathe, Kan.		●	●		●
	Health Partnership, Overland Park, Kan.		●	●		
	JayDoc Free Health Clinic, Kansas City, Kan.		●			
	Johnson County Community College Dental Hygiene Clinic, Overland Park, Kan.					●
	Johnson County Mental Health Center, Overland Park, Kan.	●			●	
	Johnson County Public Health – Mission, Kan.	●		●		
	Johnson County Public Health – Olathe, Kan.	●		●		
	Mercy & Truth Medical Missions, Kansas City, Kan.	●	●	●		
	Mercy & Truth Medical Missions, Shawnee, Kan.		●			
	Quindaro Boulevard Family Health Care Clinic (The “Q” Clinic), Kansas City, Kan.	●	●	●	●	●
	Saint Vincent Clinic, Leavenworth, Kan.		●	●	●	
	Silver City Health Center, Kansas City, Kan.	●	●	●	●	
	Southwest Boulevard Family Health Care Clinic, Kansas City, Kan.	●	●	●	●	●
	Swope Health Midtown, Kansas City, Kan.	●	●	●		
	Swope Health and Dental Clinic – Wyandotte, Kansas City, Kan.	●	●	●		●
	Swope Health – West, Kansas City, Kan.	●	●	●		
	Turner House Children’s Clinic, Kansas City, Kan.	●				
	Unified Government WYCO/KCK Clinical Services, Kansas City, Kan.	●		●		

(Source: Health Resource Guide of Kansas City)

Appendix 4

HEDIS & CAHPS Scores

CHC Kansas HEDIS Scores

HEDIS Measures ¹	K19			K21			2009 National Average ³	2011 National Average (Quality Compass) ⁴	2012 National Benchmarks 90th Percentile ⁵	Recent HEDIS Score Variance from 2011 National Average ⁷	Recent HEDIS Score Variance from 2011 National Average ⁷
	CMFHP* 2009 ²	CMFHP* 2010 ²	CMFHP* 2011 ²	CMFHP* 2009 ²	CMFHP* 2010 ²	CMFHP* 2011 ²					
Effectiveness of Care											
Childhood Immunization Status - Combo 2	86.4	83.5	N/A	86.4	83.5	N/A	77.4	79.14	86	4.36	4.36
Childhood Immunization Status - Combo 3	81.8	79.9	N/A	81.8	79.9	N/A	72.7	75.52		4.38	4.38
Lead Screening in Children	56.5	61.6	58.9	58.9	64.3	56.2	70			58.9	56.2
Breast Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	53.8	70.26	65	N/A	N/A
Cervical Cancer Screening	63.3	72.5	67.4	N/A	N/A	N/A	68.9	76.93	79	-9.53	N/A
Chlamydia Screening in Women - Total	49.7	55.6	55.7	37.1	43.2	37.8	57.9		69	-2.2	-20.1
Access/Availability of Care											
Adults' Access to Preventative Health Services	89.5	89.7	88.3	N/A	N/A	N/A		95.44		-7.14	N/A
Children's and Adolescent's Access to Primary Care Practitioners ⁸	92.8	93.9	92.8	92.2	94.8	94.6		92.52		0.28	2.08
Timeliness of Prenatal Care	81.2	84.7	83.2	76.5	72.2	73.3	85.8	75.73	92	7.47	-2.43
Postpartum Care	62.2	65.5	66.7	64.7	70.4	51.1	65.8	65.93	71	0.77	-14.83
Utilization and Relative Resource Use											
Well-Child Visits in the First 15 Months of Life	51.6	53.5	54.4	58.5	60.1	40		76.54		-22.14	-36.54
Well-Child Visits in the Third - Sixth years of Life	74	69.2	68.1	68.9	67.8	70.5		72.74		-4.64	-2.24
Adolescent Well-Care Visits	49.3	50.3	49.9	42.9	50.1	46.4		44.14		5.76	2.26
Disease Management											
CDC - Eye Examination	41.9	40.9	47.2	N/A	N/A	N/A		57.1	74	-9.9	N/A
CDC - HbA1c Testing	73.1	67.4	74.7	N/A	N/A	N/A		89.89	90	-15.19	N/A
CDC - HbA1c Poorly Controlled (>9.0%) Note: Lower is better.	54.2	75.2	63.4	N/A	N/A	N/A		26.69	28	36.71	N/A
Use of Appropriate Medications for People with Asthma	89	90.4	90.5	93.1	89.9	91.8	88.4	92.93	93	-2.43	-1.13
CDC - LDL-C Cholesterol Screening Performed	56.2	50.4	54.7	N/A	N/A	N/A	77.1	85.59	89	-30.89	N/A
CDC - Medical Attention for Nephropathy	55.8	61.7	68.7	N/A	N/A	N/A	79.6	83.32	94	-14.62	N/A

*CMFHP was recently purchased by Coventry Health Care and has changed its name to Coventry Health Care of Kansas. Scores from 2009-2011 are attributable to CMFHP.

¹ These HEDIS measures represent only those reported to us by CMFHP. They are named here as they are in the CMFHP spreadsheet "HEDIS_Scores.xlsx", except where otherwise noted. Source: CMFHP. (n.d.). HEDIS_Scores

²Source: CMFHP. (n.d.). HEDIS_Scores

³Source: NCQA. (2010). The State of Healthcare Quality 2010. Retrieved from <http://www.ncqa.org/tabid/59/default.aspx> The values are from the "Accredited" column of the table on page 118.

⁴ Source: Health Alliance. (n.d.). HEDIS_Results_2011. Retrieved from https://healthalliance.org/media/HEDIS_Results_2011.pdf

⁵ Source: Dahill, Patrick. (2012). 2012 Accreditation Benchmarks and Thresholds. Retrieved from <http://www.ncqa.org/tabid/123/Default.aspx>

⁶ The only numbers that do not represent averages are those that pull from a year that is NA. In those instances, the number represented is the only year for which there is data.

⁷ If 2011 average not available 2009 data was used

⁸ The wording used here for this measure is from NCQA's Summary Table of Measures document. Source: NCQA. (2011). Summary Table of Measures, Product Lines and Changes. Retrieved from <http://www.ncqa.org/tabid/1415/Default.aspx>

CHC Kansas CAHPS Scores

Measure	Adults					Children (K19)					Children (K21)				
	CMFHP* 2010 CAHPS 4.0 Summary Rate ²	CMFHP* 2011 CAHPS 4.0 Summary Rate ²	2011 TMG BoB ^{2,3}	Variance from TMG	YOY Variance	CMFHP* 2010 CAHPS 4.0 Summary Rate ⁴	CMFHP* 2011 CAHPS 4.0 Summary Rate ⁴	2011 TMG BoB ^{4,3}	Variance from TMG	YOY Variance	CMFHP* 2010 CAHPS 4.0 Summary Rate ⁵	CMFHP* 2011 CAHPS 4.0 Summary Rate ⁵	2011 TMG BoB ^{5,3}	Variance from TMG	YOY Variance
Getting Needed Care	77.1	77.5	77.4	0.1	0.4	83.8	89	81.1	7.9	5.2	87.8	89.8	81.1	8.7	2
Ease of getting appointment with a specialist	75.8	74.1	75.2	-1.1	-1.7	79.9	85	76.2	8.8	5.1	85	87	76.2	10.8	2
Getting care, tests or treatments necessary	78.3	80.9	79.6	1.3	2.6	87.8	93.1	85.9	7.2	5.3	90.7	92.5	85.9	6.6	1.8
Getting Care Quickly	84.8	86.2	81.5	4.7	1.4	89.9	91.4	88.9	2.5	1.5	91.7	92.2	88.9	3.3	0.5
Obtaining needed care right away	86.1	87.3	82.8	4.5	1.2	90.7	95	91.4	3.6	4.3	94.3	94.8	91.4	3.4	0.5
Obtaining care when needed, not when needed right away	83.5														
		85.1	80.1	5	1.6	89	87.7	86.4	1.3	-1.3	89.2	89.6	86.4	3.2	0.4
How well doctors communicate	88	89.2	88.1	1.1	1.2	93.7	96	92.9	3.1	2.3	94.7	95.5	92.9	2.6	0.8
Doctors explaining things in an understandable way	90.5	91.2	88.2	3	0.7	94.9	97.9	93.9	4	3	96.8	96.7	93.9	2.8	-0.1
Doctors listening carefully to you	87.8	89.4	88.7	0.7	1.6	95.1	96	94.1	1.9	0.9	95.5	97.1	94.1	3	1.6
Doctors showing respect for what you had to say	90.1	90.9	90.2	0.7	0.8	94.2	98.4	95.2	3.2	4.2	96.1	97.1	95.2	1.9	1
Doctors spending enough time with you ¹	83.5	85.3	85.2	0.1	1.8	90.4	91.5	88.4	3.1	1.1	90.5	91.4	88.4	3	0.9
Customer Service	74.8	84.4	79.2	5.2	9.6	68.6	88.5	84.4	4.1	19.9	78.7	84.8	84.4	0.4	6.1
Getting information help from customer service	63.1	77.6	70.4	7.2	14.5	60	83.1	77.9	5.2	23.1	71.3	78.4	77.9	0.5	7.1
Treated with courtesy and respect by customer service	86.6	91.3	88	3.3	4.7	77.1	93.8	91	2.8	16.7	86	91.2	91	0.2	5.2
Shared Decision Making	61.1	70.6	60.8	9.8	9.5	65.6	69.1	66.9	2.2	3.5	65.4	73.4	66.9	6.5	8
Health provider talked about pros and cons of treatment	64.3	72.6	63.4	9.2	8.3	64	71	69.6	1.4	7	65.9	76.4	69.6	6.8	10.5
Doctor/provider asked which choice you thought was best	57.8	68.7	58.2	10.5	10.9	67.3	67.2	64.2	3	-0.1	64.9	70.4	64.2	6.2	5.5
Health Promotion and Education	56.7	56	59.4	-3.4	-0.7	63.5	62.5	63.8	-1.3	-1	60.8	61.4	63.8	-2.4	0.6
Coordination of Care	71.6	81	76.7	4.3	9.4	76	78.8	78.8	0	2.8	77.6	83	78.8	4.2	5.4
Rating of Health Care	69.6	72.4	69.9	2.5	2.8	80	86.3	82.9	3.4	6.3	89.5	86.3	82.9	3.4	-3.2
Rating of Personal Doctor	76.6	77.7	76.8	0.9	1.1	86.1	88.1	86.2	1.9	2	87	88.5	86.2	2.3	1.5
Rating of Specialist	73	73.7	77.1	-3.4	0.7	81.7	76	80.4	-4.4	-5.7	89.7	86.2	80.4	5.8	-3.5
Rating of Health Plan	73.4	79.4	73.7	5.7	6	84.4	89.8	83.5	6.3	5.4	87.9	86.8	83.5	3.3	-1.1

*CMFHP was recently purchased by Coventry Health Care and has changed its name to Coventry Health Care of Kansas. Scores from 2009-2011 are attributable to CMFHP.

¹ For K19 and K21, this question ends with "your child".

² Source: The Myers Group. (n.d.). CAHPS® 2011 Medicaid Adult Survey Project Number: 49392 At-A-Glance Report

³ TMG BoB is defined on page 8 of all three sources as: "The 2011 Myers Group Book of Business consists of 43 Medicaid adult samples that conducted surveys with TMG in 2011 and submitted to

⁴ Source: The Myers Group. (n.d.). CAHPS® 2011 Medicaid Child with CCC Survey Project Number: 69395 At-A-Glance Report.

⁵ Source: The Myers Group. (n.d.). CAHPS® 2011 Medicaid Child with CCC Survey Project Number: 69396 At-A-Glance Report.

Appendix 5

Low-Income Population on Health & Nutrition

Low-Income Women & Nutrition

- Those of lower socio-economic status are less likely to follow a healthy diet (Hampson, et. al., 2009).
- Findings (74 women – 74% white, 12% Native American, 8% Hispanic, 4% Black, 2% Asian; 67% 18-29, living with more than one child): (Hampson, et. al., 2009).

Table 2 Coding scheme: examples of themes and sub-themes organized into the four broad themes

Broad theme	Examples of themes	Examples of sub-themes
Cost	Cost of groceries Shopping strategy Cost of eating out Cost of healthy eating	Value for money Shop to a list, shop when pay cheque arrives, avoid impulse buying A treat Healthy food is more expensive
Convenience	Convenient shopping Convenient foods Convenient eating out	Kid-friendly, customer service Healthy foods not convenient When tired or it is too hot to cook
Social influences	On food purchases On restaurant choices On food preparation at home	Advertising to kids, kids' and partners' preferences Family-friendly Fixing different dishes to accommodate family members' food preferences
Health issues	Definition of healthy food Strategies to increase healthy eating Advantages	Meat is important, low fat and low sugar Set a good example, shop without the kids More energy, avoid obesity

(Source: Hampson, et. al., 2009)

- Cost Conscious (Hampson, et. al., 2009)
 - Cost was mentioned as an important decision-making factor when grocery shopping, eating out and eating healthy foods
 - Shop for highest quality they can afford
 - Produce viewed as healthy, but low value because it perishes quickly
 - Use coupons to reduce grocery bills
 - Portion size and value are considerations
- Convenience (Hampson, et. al., 2009)
 - One-stop shopping, and not having to drive a long distance
 - Will forgo convenience for value
 - Convenience foods are favored
- Social Influences (Hampson, et. al., 2009)
 - Family members and children influence purchases
 - Concern of children being “picky eaters”
 - Children tended to eat better if the family sat down for a meal together
 - Involving children in meal preparation made it more likely they would eat the meal
- Health Issues (Hampson, et. al., 2009)
 - The link between good nutrition and health was clearer for women dealing health problems within their family (i.e. diabetes, ADHD)

- Pregnancy is viewed as a time to indulge in unhealthy cravings
- Understanding of a healthy diet varied greatly
 - Most health information from WIC
 - Little knowledge of current food pyramid
- Some used nutrition labels, others found them hard to understand
- There was an emphasis on meat being the most important component of the meal (Hampson, et. al., 2009)

Information Sought at Free Clinics by Low-Income Latino Women

- Top Types of information sought (Abejuela, 2011)
 - Choose healthy foods
 - Keep a healthy weight
 - Healthy cooking
 - Chronic disease management
 - Deal with stress
- Top Services Used (Abejuela, 2011)
 - General medical services
 - Reproductive care
 - Prenatal classes
- Types of Counseling Services Received (Abejuela, 2011)
 - Fruits & Vegetables
 - Exercise
 - Quit smoking

Appendix 6

U.S. Department of Health & Human Services Text4Baby Campaign Results

- Women reported high satisfaction with text4baby, with Spanish speaking women reporting even higher satisfaction scores than English-speaking women (Vaughan, 2011)
- 63.1 percent of women reported that text4baby helped them remember an appointment or immunization that they or their child needed (Vaughan, 2011)
- 75.4 percent reported that text4baby messages informed them of medical warning signs they did not know (Vaughan, 2011)
- 71.3 percent reported talking to their doctor about a topic that they read on a text4baby message (Vaughan, 2011)
- 38.5 percent reported that they called a service or phone number that they received from text4baby (Vaughan, 2011)

Appendix 7

Focus Group

Focus Group Concepts

Position: Children’s Mercy Family Health Partners needs to improve communication and engagement with current members. Before making recommendations, we want to understand from the community relations representatives their experiences and opportunities for improvement.

Objective: Engage Senior Community Relations Representatives for CMFHP in regard to:

- Key partners (social service agencies, community health councils, businesses, churches, etc) that are used to reach the Medicaid/low income population
- Opportunities to improve communication.
- Ideal channels to communicate with Medicaid and uninsured individual
- Trends in the Medicaid recipient population of Kansas
- Learning from participating in health and safety related events in communities

Moderator Introduction

Thank you and purpose (1 minute)

Hello. My name is _____. I’d like to start off by thanking each of you for taking time today to speak with us. We’ll be here for about an hour.

The reason we’re here today is to get your opinions and attitudes about your experience and issues regarding Medicaid and HealthWave recipients.

I’m going to lead our discussion today. I am not here to convince you of anything or try to sway your opinion. My job is just to ask you questions and then encourage and moderate our discussion.

I also would like to introduce _____. They will be recording our discussion today and assisting with the discussion as necessary.

Ground rules (2 minutes)

To allow our conversation to flow more freely, I’d like to go over some ground rules.

1. Only one person speaks at a time.
2. Please avoid side conversations.
3. Everyone doesn’t have to answer every single question, but I’d like to hear from each of you as the discussion progresses.
4. This is a confidential discussion in that I will not report your names or who said what to Chris with CMFHP. Names of participants will not be included in the final

- report about this meeting; instead you will be identified as “community representative 1-6.” It also means that, except for the report that will be written, what is said in this room stays in this room. When you walk out of here, what you remember the most is what you should not be talking about.
5. We stress confidentiality because we want an open discussion. We want all of you to feel free to comment on each other’s remarks without fear that your comments will be repeated later and possibly taken out of context.
 6. There are no “wrong answers,” just different opinions. Say what is true for you, even if you’re the only one who feels that way. Don’t let the group sway you. But if you do change your mind, just let me know.

Introduction of participants (10 minutes)

Before we start, I’d like to know a little about each of you. Please tell me:

- Your name
- Number of years in current position
- Favorite thing about your job

General questions (15 minutes)

1. To start off, let’s open up the discussion to things that CMFHP does well compared to other managed care providers in the industry.
 - Prompt: Having field reps, communication, member engagement, incentives, doctors in network
2. Now that we’ve talked about what CMFHP does well, I’d like to discuss the areas for improvement.
 - Prompt: Having field reps, communication, member engagement, incentives, doctors in network
3. What are some of the best practices from other providers (managed care and private) that you’ve seen in the communities where you’re engaged?
 - Prompt: A well designed booth, sitting at the health department three days a week, a particular incentive, specific marketing/communication materials

Specific questions (30 minutes)

Barriers

1. What are the challenges and barriers that you see members facing most often?
 - Prompt: Language, no transportation, unable to find child care when they need to go to an appointment, too much uncertainty to have a regular appointment, not being communicated to, not understand communications.
2. How do you resolve these challenges? **(Potential cut)**

- Prompt: Refer to language services, point out incentives and services offered, offer to walk through the issue, do nothing
3. Is there anything that you feel that Children’s Mercy Family Health Partners or HealthWave can do to minimize the challenges and barriers that you’ve mentioned?
 - Prompt: Offer one-on-one language support, more incentives, better communication, free child care, “how to” guides for enrollment and policy changes.

Communication

1. What are some areas for improvement in terms of communication to Medicaid members?
 - Prompt: Communication with HealthWave clearinghouse, Income guidelines, Address changes, Medicaid vs. HealthWave, Communication outlets, Available services.
2. From your experience, do you think Medicaid recipients are aware and receive the necessary information with regard to their plans and services offered?
(Potential Cut)
3. What do you think Children’s Mercy Family Health Partners can do to improve members’ receipt of pertinent information and awareness of services?
 - Prompt: Add a service list, when patients get the bill send a list of services also offered, seasonal reminders, etc.

Closing question (5 minutes)

1. What advice would you give the communication manager of CMFHP?
2. Is there anything that we have not covered that you would like to share?

Closing (2 minutes)

Thanks for coming today and talking about these issues. Your comments have given me lots of different ways to see this issue. I thank you for your time. You can contact us if anything else comes to mind (hand out business cards with our three names and contact information)

Focus Group Consent

Written Consent Text for focus groups, Journalism 850

Focus group for the Children's Mercy Family Health Partners campaign


As journalism students in Journalism 850, Capstone in Marketing Communication, at the University of Kansas' Edwards Campus, we are conducting research regarding insurance use among underserved populations, particularly as it relates to Children's Mercy Family Health Partners, to create a campaign that help create more awareness about insurance for the underserved. We would like to learn about your experiences with insurance and awareness of various insurance options.


You have no obligation to participate and you may discontinue your involvement at any time. Participation in this interview indicates your willingness to take part in this study and that you are at least 18 years old. Should you have any questions about this project or your participation in it, you may ask me or my faculty supervisor, Professor James K. Gentry, in the KU School of Journalism (jgentry@ku.edu, 785-864-4757).

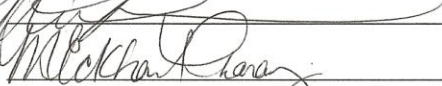
If you have any questions about your rights as a research participant, you may call the Human Subjects Protection Office at (785) 864-7385 or email irb@ku.edu.

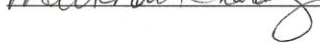
This focus group interview should take approximately one hour. We would like your permission to record this interview to assist us in note taking. Our notes will be pooled so that individual participants cannot be identified. After this project, the recordings will be destroyed.

Please sign below:

- ① 

- ② 

- ③ 

- ④ 

- _____
- _____

Appendix 8

In-depth Interviews

In-depth Interview Transcripts

In-depth Interview: Dr. Stephen Lauer, Vice-Chair for Patient Care and Quality Improvement and Medical Director at KU Pediatrics

1. Background: Name, Professional Title, Years of Experience

Dr. Stephen Lauer, Vice-Chair for Patient Care and Quality Improvement and Medical Director at KU Pediatrics. Dr. Lauer has been a pediatrician for almost 12 years.

2. Approximately what percentage of your patients would you say are Medicaid recipients?

The average for his practice is approximately 50%. Practice has no cap and it will take whoever comes to it. Dr. Lauer estimates that there may be two private practices in JOCO that take Medicaid patients.

3. What is your background in working with Medicaid recipients in Kansas and Missouri?

“Medicaid patients are the basis of our practice. They have their own special challenges but we enjoy seeing these patients.”

“We do not have a health care system in this country – we have an illness-care system.”

“Health is relatively cheap; illness is expensive.” – these quotes were given in the context of how a more preventative (wellness checks, regular doctor’s visits, etc.) approach to health care is, in his opinion, much more affordable in the long run than not doing so.

“Our biggest push is to try and get the kids to come and see us rather than their going to the emergency room because their kids ‘look sick.’” He thinks it is important to consider how (society and the health care industry) can avoid all that extraneous care – e.g., unnecessary ER visits.

In his opinion, one of the real drawbacks to Medicaid is that it places very few limits on who the user can go see. While the provider is not obligated to see Medicaid patients, technically, they can go see whomever they want. With Commercial insurance, there is a strong disincentive for members to go outside of their network. That mechanism is not in place with Medicaid. For example, on the individual’s Medicaid card a PCP is listed; however, that PCP has nothing to do with who they actually see or who they’ve been seeing for years. In other

words, the system is not set up to engender continuity of care or to dissuade lack of continuity of care.

4. How can Children’s Mercy Family Health Partners do a better job of communicating the importance of health care to the low-income, low health literate population of Kansas?

Dr. Lauer believes some of this has to do with the structure of the whole system, there is no real mechanism for saying, “Here’s your doctor and who you should be seeing.”

The subliminal message from the system is that it doesn’t matter who you see. Targeted information about the importance of seeing a regular provider would be hugely helpful. For example in an ideal situation, by the time he sees a child at their 18-month visit, if all wellness visits and recommended checkups/appointments have been kept, he has seen the child nine times (the 18-month checkup being the ninth time). If he is seeing a child for the first time at 18 months they have to start from scratch and go all the way back to pregnancy and try to rebuild a medical history for the child. Again, the system does not encourage continuity of care or discourage the opposite – any disincentive that made it the least bit difficult to do the opposite would be helpful, not only for patient care and for well-being, but for the general costs of health care to society. Currently Medicaid users are largely separated from the economic impact of their medical decisions.

5. A large portion of Medicaid recipients do not take advantage of their health care resources (doctor’s appointments and well-baby visits, etc), in what areas do you think the industry could make changes to potentially improve member engagement?

Dr. Lauer believes that it is critical to convince Medicaid recipients that preventative care is better and less expensive in the long run.

6. What is your opinion about physicians participating in Medicaid through The State Loan Repayment Program, SLRP. SLRP is funded by the state of Kansas and the National Health Service Corps. Do you participate?

Dr. Lauer is familiar with programs that reimburse for medical school and thinks they make sense. He does not participate. “It’s a great way to get some service back. The problem is that it sets up a revolving door in communities for doctors – on the other hand, it’s better than nothing.”

7. In your experience, what do you see as the greatest business challenges in accepting and treating Medicaid patients?

“The perception is that you lose money seeing them, although that’s not necessarily the case right now. Right now, at least at KU, if you see enough Medicaid patients, we get quarterly payments that help adjust for the disparity between what commercial insurance pays and what Medicaid pays.”

8. What challenges do you face in treating and communicating with Medicaid patients?

Dr. Lauer believes that people who aren’t as involved in their health care don’t do as well, and that it’s not a function of income or wealth - it’s a function of how interested and involved the individual is.

9. In your experience, as Vice-Chair, what efforts have you seen put forth that have been effective in solving some of the issues that you face with Medicaid patients in your clinic?

Dr. Lauer believes that FHP does a good job with their programs that are targeted to a diagnosis. The asthma program, and the coaches they provide, is a great example of this. He thinks it’s a great program. He believes that the programs that stay in contact with patients about their own health care work the best.

10. Are there any areas in which Medicaid providers could make changes that would incline you or other physicians in general, to accept more Medicaid patients? (Reimbursements on the same level as Medicare or other insurance programs.)

“The reality today, is that there has to be an equitable payment system.” Dr. Lauer believes that if Medicaid can make the switch from “sick care” to actual “health care” then it will make more economic sense for more doctors to see more Medicaid patients.

In-depth Interview: Dr. Mark Thompson, Radiation Oncologist

1. Name: Mark Thompson

Professional Title: Radiation Oncologist

Years of Experience: 11 years and worked at Kansas City Cancer for 10 years

2. Approximately what percentage of your patients would you say are Medicaid recipients?

About 10 percent

3. What is your background in working with Medicaid recipients in Kansas and Missouri?

We still get patients from the Kansas side and we get patients from Truman Medical from the Missouri side. Patients are referred to me because I am a specialist.

4. A large portion of Medicaid recipients do not take advantage of their health care resources (doctor's appointments and well-baby visits, etc), in what areas do you think the industry could make changes to potentially improve member engagement?

Member engagement is important. I find this is true if it is harder to cure because of advanced illness. Some patients have virtually no transportation, no groceries or gas. In addition, the patients have to buy medicines, etc. I recently treated an assistant minister who is 30 years old and his wife had just lost her job. The minister's family was only receiving income from the church. Money is a big obstacle for patients on Medicaid. Other patients don't have any transportation because they have to be close to bus lines. Patients who live in the city have an advantage because they live near bus routes and in the rural, it is more difficult. Some patients are not aware of the free transportation. Transportation is one of the biggest issues. Unfortunately, there has to be 72 hours' notice needed before transportation by patients.

5. What is your opinion about physicians participating in Medicaid through The State Loan Repayment Program, SLRP. (Offers eligible health professionals an opportunity to receive assistance with the repayment of their qualified educational loans in exchange for a minimum 2-year commitment to provide health care services.) SLRP is funded by the state of Kansas and the National Health Service Corps. Do you participate?

No, I do not. I don't know much about that. You have to be in a rural area for that.

6. In your opinion, what do you see as the greatest business challenges in accepting and treating Medicaid patients?

Payments are a challenge...what is a viable percentage? Payment is lower; therefore, we are reimbursed lower. KU has to approve but no mandated cap on number of Medicaid patients. Payment and whether or not they are actually reimbursed for their services.

7. What challenges do you face in treating and communicating with Medicaid patients?

Spanish speaking and Asian patients can be difficult to communicate with; however, we have a translation service that provides interpreters to come into the office. Most patients are further along with disease due to lack of preventative care; interpreters will arrange to come in with the patients.

8. Are there any areas in which Medicaid providers could make changes that would incline you or other physicians in general, to accept more Medicaid patients? (Reimbursements on the same level as Medicare or other insurance programs.)

Increase reimbursements. We are able to get PET scans approved but follow-up scans are harder to approve. It's also difficult to get follow-up appointments approved through Medicaid. Doctors are being squeezed from every angle. Reimbursements are going down; malpractice insurance is going up, so they need to make money. Many physicians don't take Medicaid because it costs more money to perform a procedure than they are paid from Medicaid for doing it. My office takes Medicaid almost as a loss leader. An ENT (Ear, Nose and Throat) will refer Medicaid patients and many others to us and they make money off the others.

9. What are some things you think the health care industry is doing right with regard to Medicaid coverage and patient communication?

The industry is trying by offering transportation to try to improve engagement. We need a social worker in the office. We don't have a social worker in office to help answer questions about Medicaid. (Pamphlets for doctor's offices with a little "cheat sheet" of care.)

10. Do you see any opportunities for Medicaid providers, specifically, to improve member engagement?

Higher reimbursements for doctors and improving communication. Patients need to know why it is important to get wellness visits and then they go to places where they know they will get the best care.

11. Do you, or any other providers that you know of, provide incentives to patients to encourage them to keep appointments and maintain healthy lives? If so, in what areas? Have you seen any that were particularly effective?

Doctors cannot provide incentives. If health care changes, people with more money will get less; people with less will get more.

In-depth Interview: Lisa Erlinger-Teel, Social Worker, Johnson County Health Department

1. Background:

Name: Lisa Erlinger-Teel, LMSW (Licensed Masters Social Worker)

Professional Title: Social Worker for the Johnson Country Health Department

Years of Experience: I have 17 years' experience in social work. My first position was in public health and worked in foster care for 10 months. I have held my current position for 10 years at the Johnson County Health Department.

2. Can you please give an overview of what you do as a social worker for the Johnson County Health Department?

I assist in various programs. My main position is in women and men's health and the prenatal program. I educate women and men about no-cost contraceptives, prenatal services and prevention. In addition, nurses refer people to me if women and/or men are involved in a domestic violence situation. I also give support in regards to Medicaid and refer the proper resources if I feel they can apply for Medicaid. I also follow up with teen in the prenatal program, education about IUDs and screen patients for Medicaid.

3. What is your background working with Medicaid recipients?

I work with prenatal recipients on Medicaid. We used to have a well-child program, where children would come in have physicals but the program was stopped in June 2011. I assist Medicaid patient with finding a doctor whom can take Medicaid.

4. What struggles have you faced when educating the low-health literate KS residents about the benefits of health care?

Language Barrier: We have a contract with an interpreting service. We use an interpreter via speakerphone to explain Medicaid and other information about prevention. We also have an interpreter come in twice a week.

Education: The majority of the people I encounter have an average of a 6th to 9th grade education.

Lack of Understanding of Health Benefits: Some of the women do not receive early prenatal care because they think they are going to be charged an expensive fee; therefore, they wait until almost the end of the pregnancy to receive care. I find families abuse the emergency room services for minor problems. Most people do not understand what a Primary Care Physician (PCP) is. When I ask a person who is their PCP, they say, "Shawnee Mission Medical." I try to explain to them if they get a PCP, they would not have to go to the ER and wait to see a doctor. A PCP is the gatekeeper of your health

and would have all your and your child's records on file. If people keep going to ER and abusing the services, our health care costs will continue to rise.

5. In your experience, do you find it difficult educating Medicaid recipients about how important it is to keep their doctor's visits?

Yes, as I mentioned before, the PCP is the gatekeeper to their health. The PCP will have a medical history on them and their child's health. I tell them Medicaid provides transportation for the appointments. However, I believe you need to let the transportation services know 72 hours in advance, which I know does not help with last minute appointments.

6. In your opinion, what are the barriers Medicaid members face when seeking services (i.e., lack of transportation, etc.)?

- Transportation is limited and knowing where the doctor's office is.
- Finding a provider who takes Medicaid
- Taking time off of work, poverty issues
- Lack of finding more information about their PCPs. Some recipients are appointed doctors and they do not know who the doctor is or even if they have one. Some people do not know they can change doctors.

7. Do you find it difficult for residents to maintain consistent contact info, have you found any tactics that help to track this information more effectively?

It's amazing because it's an ongoing problem for us, too. We cannot keep a consistent number on most people. It maybe human error with people entering number wrong in our database but is seldom the case. Most people deliberately give is wrong numbers because they feel they may get calls about bills. Most of the populations are transients. We do send out letter to keep up on contact information.

8. What are the general issues you perceive that Medicaid recipients face when navigating the complex health care system?

I find myself having to explain what a PCP is. I have to find a provider who is culturally competent, meaning, I have to make sure the office has a Spanish-speaking people for the patients.

9. What effective strategies have you seen used to assist low-literate health care consumers? (Social media, text messaging, regular mail, face to face contact, etc.)

I find younger people use social media. The teenagers or young adults (U.S. natives) come in and mention that they found our information on our website. People with lower income do not use the computer as much because they have to go to the library to use a computer but this topic is still developing for us. In this job, it is all about face-to-face contact.

10. What are some tactics you have used to minimize cancellation rates of patients?

Well, patients no show to many of their appointments. We would have a PCP come in for our women and men health services and no one would show. We now have a 'walk-in model' where people can walk in for health services; STD treatment, immunizations, birth control and pregnancy tests. We provide evening appointments so people can come after work; we have teen focus once a week. We have two places where we provide 'walk-in models'. We have one office in Olathe and the other is in Mission.

11. What are the primary reasons you think some eligible for Medicaid coverage choose to be uninsured?

Some reasons are child support, not wanting to tell who the father of their child is and hassle of application process. Some women do not want to divulge their income or they will not receive more child support. Some families do not know their baby is covered for one year but after the year, they have to reapply for Medicaid. We send the renewal paperwork but it does not work.

12. How can we do a better job of communicating the importance of health to the low-income, low health literate population of Kansas?

Word of mouth, community events and advertising on the radio or television.

13. How can we better communicate the changes in the health insurance industry to low-income/low health literate Kansas residents?

It's difficult to communicate something that maybe long term. Most people are thinking about what is happening right now. They are trying to take care of basic needs and health care is not at the top of their list. I would love if someone came to my office and trained all of us on the changes in health insurance in Kansas.

14. Are there any policies in place to help eligible Medicaid recipients apply for health care? (Assist in applying for Medicaid/health care).

Healthwave helps recipients and medical outreach supports like Francesca Beard. We need to make sure we are still getting people to come in for the face-to-face appointments who may not understand their eligibility. Most people do not think they qualify until I do a screening on them. If a woman is pregnant, we push them through the process quickly. I have seen Francesca get women on Medicaid within a week, if they have the proper documents.

In-depth Interview: Joy Wheeler

1. Background: Name, Professional Title, Years of Experience

Joy D. Wheeler, Healthcare Consultant, 35 years industry experience

2. What is your background in working with Medicaid recipients in Kansas and Missouri?

Joy started a Medicaid HMO, First Guard Healthplan, that served the entire state of KS and 9 counties in Missouri.

3. What is your opinion of the current state of managed care in the region and nationally?

Joy believes it's a broken fragmented system of "sick care" where historically financial incentives have rewarded providers for doing tests, procedures and surgery rather than improving health status. We need to turn that system around to be outcomes based—improving the health of individuals and communities. The other thing is, the system is not patient centered; it's been provider centered and/or investor centered. We spend more per capita on health care in this country than any other country and we have some of the worst outcomes in critical areas.

4. Specifically, how do you view the state of Kansas' Health Care system?

While Joy believes her firsthand knowledge of Kansas' health care system may be a bit dated, she does note that Kansas privatized its Medicaid delivery system for mothers and children years ago. The positive of this action has been a more coordinated care system for the individuals and now the state is extending a managed delivery care system to include the remaining Medicaid population (aged, blind, disabled).

5. In your opinion, what are the barriers Medicaid members face when seeking services (i.e., lack of transportation, etc.)?

Joy believes some significant barriers Medicaid members face are related to lack of transportation, language barriers, as well as cultural norms and differences in individuals preferences in their medical care (distrust). She also believes there is a barrier when there is an absence of a personal advocate acting on an individual's behalf. The healthcare system is very difficult to navigate for all of us even with the absence of the challenges Medicaid members face.

6. In your opinion, what are the barriers inhibiting those who are eligible for Medicaid from actually enrolling? (e.g., trouble with application process, lack of awareness, etc.)

In Joy's opinion, not knowing exactly where they are supposed to go is a barrier preventing people from enrolling in Medicaid. Illegal immigrants are very fearful of the system. Kansas did a major marketing campaign years ago that was very effective at getting people knowledgeable. When Kansas pushed out SCHIP, that campaign was also very effective. Having government case workers at the hospital works well. You've got to be where people are. We expect people to come to us, we need to take care to where people are.

7. A large portion of Medicaid members do not take advantage of their healthcare resources (doctor's appointments and well-baby visits, etc), in what ways do you think the industry could change to potentially improve member engagement?

Joy believes that society is largely unaware of the social and environmental issues that Medicaid members are dealing with. Challenges in adequate food, keeping the lights on, etc., are huge and can outweigh the ability to fully engage in their healthcare. "That's what we're not dealing with in this country are the social issues that are negatively impacting health."

8. In what ways do you think the industry could better communicate with Medicaid members to potentially improve member engagement?

Joy believes that the language grade level requirements are already in place. Sending people tons of stuff to read doesn't work. Keep it simple, direct. Cell phone use in this population is high. Using schools and churches is real important.

9. What are some things you think the health care industry is doing right with regard to Medicaid coverage and patient communication?

In her opinion, the health care industry is starting to deal with the level of "sickness" in this country and promoting/investing in wellness and healthy lifestyles. They need to continue focusing on health outcomes and aligning incentives. We also must address the absence of individual responsibility that the system has created. (Joy responded to this question with regard to Americans in general, and did not target this response to Medicaid.)

10. What are your thoughts and opinions of incentivizing Medicaid members to participate in the healthcare system?

“Absolutely. It works.” But Joy believes the incentives should be given that actually help the member (diapers, formula, etc.).

11. What must managed care providers be doing now to better serve their consumers given the changes coming to the health care industry?

“Getting people engaged in being responsible for their own health.”

12. What do you see as the biggest challenges for Medicaid providers as the industry faces change?

Dramatically increasing the load of patients, while not equipping or compensating the providers to handle that increased load.

13. If you could change one thing about the healthcare industry as it relates to serving those in poverty, what would it be and why?

Make it patient focused. Mayo is example of a patient centered delivery system. (Joy responded to this question with regard to Americans in general, and did not target this response to Medicaid.)

In –depth Interview: Kansas City Health Care Marketing Specialist

1. Background: Name, Professional Title, Years of Experience

Senior Account Manager for Health Care Marketing Company- 3 years
Director of Marketing for health system – 8 years

2. Can you please give a general overview of what you do?

I work for a health care division of a marketing company. As an account manager, I work with clients across the country on a variety of marketing and advertising needs. We work with clients on research, marketing plan strategy and develop, and consumer advertising. We work with hospitals of all sizes – from critical access to large tertiary facilities - in markets of all sizes.

3. What is your background in working with health care providers, specifically those that care for Medicaid recipients in Kansas?

During my time with the health system, I worked with hospitals in Kansas: Saint Luke’s South in Overland Park, Cushing Memorial Hospital in Leavenworth, and Anderson County Hospital in Garnett.

At the marketing firm, we work with several hospitals in Kansas, including Stormont-Vail HealthCare in Topeka, Menorah Medical Center and Overland Park Regional Medical Center in Overland Park, and Ransom Memorial Hospital in Ottawa.

4. What are the most common challenges you see health care providers facing with communicating to the target audience, especially Medicaid recipients?

One of the greatest challenges in health care advertising is that health care is an avoidance topic. People don’t think about health care until they have a need for the services. This applies to Medicaid recipients as well. Because of limited health care budgets, advertising tends to be more general – directed toward everyone regardless of his or her insurance; therefore, there are limited communications just for Medicaid patients.

5. In what ways can provider organizations improve its communication strategy?

Many health care organizations limit the amount of direct mail they use because it can be very expensive. Using a customer relationship management (CRM) tool allows health care organizations to be more targeted with their communications. CRM allows hospitals to mine the data so they can identify patients who have, for example, not been to see a doctor for the past year or more, who have missed their annual mammogram or colonoscopy. CRM also allows hospitals to review propensity data to identify patients who are at higher risk for certain health issues. For example, if an individual has risk factors for developing a heart condition, we can begin reaching out to these individuals with information about healthy lifestyle changes to begin eliminating the risk.

6. Are there any specific methods of communication you see underutilized, or that have particular value with the target audience for health care providers, specifically providers for Medicaid recipients? (New method such as social or mobile media, traditional methods such as print)

As mentioned above, I think direct mail is underutilized. The other medium I think is underutilized is online. Most hospitals have websites, but I think there is still potential for them to be more consumers friendly. Hospitals tend to make websites online brochures, packed full of tons of information. We need to make the websites geared more to the information patients and potential patients need.

When looking just at Medicaid recipients, you have to look at their media use to make the best decision on how to reach them. Historically, Medicaid recipients come from lower income households who might not have newspaper subscriptions or cable. These are important factors that need to be considered when developing a communication plan.

7. Are there aspects of the Medicaid application process or the Medicaid program in general, your clients see as positive? If so, what are they, and why are they pleased with them?

I am not familiar with the application process – this is not something I have been engaged in during my time in health care.

8. What are the positive things that you see in the Health Care industry, and what can Medicaid providers do to help leverage these to improve member engagement.

I think Medicaid providers need to embrace the movement of focusing on wellness. Since Medicaid patients include children I think we need to start encouraging a healthy lifestyle while they are still young – before they develop unhealthy habits.

Another thing is that with the rise in health care cost, and the increased utilization of high-deductible insurance plans hospitals are becoming more transparent in posting prices. I think this is a positive trend because it encourages people to be more proactive when planning their health care usage.

9. Do your clients target communications to Medicaid recipient patients compared to privately insured patients?

I am not aware of any communications my clients have specifically for Medicaid or Managed Care patients. I do have clients that have mailings specific for Medicare patients, but that is a different audience.

10. How can organizations do a better job communicating the importance of health to the target audience, especially those receiving Medicaid?

I think the biggest way to accomplish this is to put more emphasis on wellness and to encourage and reward people for living a healthier lifestyle. By encouraging people to live better, we will reduce the number of people who are affected by chronic illnesses down the line. Another benefit is that by engaging people to be proactive about wellness we will help reduce health care spending.

In-depth Interview: San Francisco Health Partners, Director of Health Improvement and Director of Marketing and Communications.

1. Can you please state your background, title, and years of experience?

Director, Marketing and Communications, since 2003. Director for two years.

2. Could you elaborate on your “Strength in Numbers” program and population management work?

Strengths in numbers are a formal Quality Improvement model used to drive the improvement of HEDIS scores. It centers a lot around sharing data across the entire network and focuses on 11 required measures. We use I2I track software and the largest challenges are to get providers to shift the way they look at providing medical care in their clinics.

3. Could you also elaborate on the Optimizing the Primary care experience? How were you able to reduce wait times and appointment availability?

More information will be emailed to me. They did say that this was a difficult.

4. Where are some areas that you feel can be improved upon in terms of marketing and communications in your organization? In the managed care industry, in general?

Regulations currently do not allow San Francisco Health Partners to directly text or email their members. Legal issues are current hurdles, there must be a consent form filled out to do this, and right now they were advised by their lawyers to not participate in these activities. They said that any communication to remind patients of a renewal visit etc. would be a PHI compliance issue and HIPPA issue.

5. What do you see as the largest challenges that other organizations may face when trying to emulate your blueprint for success in raising HEDIS scores?

Again, the biggest challenge is educating and giving incentives to your medical providers to get on board with your mission. It all starts with communication and education. Sharing of information is vital.

6. Were clinics allowed to adjust your marketing message depending on their population base?

They participate in a population-based model. They said that it was extremely difficult to raise their HEDIS scores by trying to provide great care to their existing patients. They had to reach out and help patients understand other preventative screenings etc. that were available for them and the area. This also includes communication in areas near clinics so prospective patients knew what services were available to them.

7. What has been the most successful communications strategy? (print, in person, telephone, automated messages, texting, social media, etc.) How do you see that changing in the future?

Social media was a bad experience. SFHP provides medical care to the uninsured population including undocumented workers. The problem with Facebook, LinkedIn was that many people who opposed illegal immigration etc. voiced their opinions on Facebook; there is no longer the ability to comment on their pages. It's a tricky two way street in terms of communicating via Social Media. Also in California, there is Can Spam etc. that limits the amount of information that can be sent electronically. Every fine for improper distribution of unwanted solicitation is a \$16,000 fine per occurrence. Also, current software does not enable SFHP to filter through their database and find out which texts etc. get sent to whom.

8. Which incentive models did your organization find most effective, and what do you as the reasons why? Which were the least effective, and what do you see as the reasons why?

By far the most effective incentive model is the \$25 gift card. The marketing department many years ago found that the \$25 incentive was enough to motivate people. Also, instead of giving incentives using a tiered approach, incentives should be to entice initial engagement and reward the completion of a program. Simply giving out incentives during the process (immunizations) does not work; there should be an incentive to finish the process. Also, books and supplies don't work; gift cards do. One thing not to do is communicate prenatal incentives to women/girls; there was a lot of backlash from mothers who felt their daughters were too young to be receiving that sort of material. Also, if the organization does not have the budget to offer incentives, they can institute a raffle or lottery system. That way, someone will win the gift card, but not everyone will receive one.

9. Are there any innovative incentives models that you would like to see implemented in the future?

Still feel that offering gift cards as incentives is the best model.

10. What were the most effective communication tactics for spreading the word about the incentives that SFHP offered? Were there any that simply did not work?

Calling clients directly, and targeting the audience with mailings.

11. Are there any significant state hurdles in determining incentives? Is there an annual cap limit? Where do funds for incentives originate?

Certainly, there lot of hurdles with state and government agencies regarding offering incentives. In the end, "it is well worth it." The process can take several months at times, but they do help.

12. How is SFHP preparing to accommodate newly eligible Medicaid patients in 2014? Has that process already started?

Yes, already has started. Some communications hurdles were that the elderly really engaged with us through primarily telephone. Additional telephone customer service representatives were needed to help answer questions. For blind individuals, we partnered with a local blind organization in SF to create materials in braille. For the elderly they used much larger font sizes. It's was very important that with the elderly population that SFHP differentiated themselves with Blue Cross/Blue Shield because those patients have a choice between the state ran SFHP and Anthem BCBS.

13. In terms of health care, do you believe that a broader workforce including nurse practitioners and physician assistants could play a larger role in health care in the future to alleviate the burden on Primary Care Physicians?

Did not have enough time to ask this question.

14. Care Oregon, Partnership HealthPlan of California and L.A. Care Plan were mentioned in your report, were there any other managed care organizations that you benchmark your organization against?

UPMC is a great organization that studied the use of incentives for patients (Pittsburgh Medical Center). CareOregon is a beacon in the industry. They are (CareOregon) great at complex case management w/ physicians.

15. Would you be willing to share the CAHPS detailed analysis that was mentioned in your report with us?

Yes. I will email them over.

Thank you so much for your time today, we really appreciate it. I feel that this information will help us tremendously during our research. If there were any additional questions in the future, would it be okay to send a few questions by email later?

In-Depth Interview: Community Outreach Coordinator, Health Partnership Clinic Johnson County

1. Background

Name: Francesca Beard

Professional Title: Medical Outreach Coordinator

Years of Experience: Current position since September 2011, with two years prior experience in Outreach; 10 years of experience with Medicaid

2. Can you please give a general overview of what you do for the Health Partnership Clinic?

My position is to help Johnson County families navigate through the Medicaid application process. I help them with any challenges, the renewal process, applications, etc. I work exclusively with families with children.

3. What is your background in working with Medicaid recipients in Kansas?

- I assist clients in filling out the application and give them an overview of the services available to them.
 - I explain the differences between KS 19 and KS 21 as well as the difference between HealthWave and Medicaid.
- I assist in trying to find primary care providers and in choosing a health care plan.

4. In your opinion, what are some of the barriers Medicaid members face when seeking services (i.e., lack of transportation, etc.)?

- Transportation
 - Transportation is provided but most recipients are not aware of that service.
 - They do not know what much of the current communication means.
- The Spanish-speaking population, especially, does not sit down and read the documentation; members need to be told in person.
- Language
 - There are few Spanish speaking pediatricians in Johnson County.
 - KU is one of the only places to go to find Spanish-speaking physicians, which is far for southern Johnson County residents.
- There is an overall lack of education of what services are offered, including transportation.

- Many do not know what their health care plan means; they have incurred bills at Olathe Medical because they didn't know it wasn't covered in their plan.
- Members receive two health care cards, one for Medicaid and one for their health plan; they do not know what each of these cards means to them.

5. What are the most common challenges you see Medicaid recipients facing with the application process?

The application itself is very simple, just two pages long.

- The problem is, they do not know what to send with it. They don't know what's required for citizenship, identity, etc. and it's not clearly communicated to them on the application.
 - They end up going back and forth with HealthWave for an extended period of time.
 - It takes time to find out that something is missing, not to mention what's missing, which delays the process all together.
 - **Example**
 - An Asian woman submitted her application by mail and received a letter noting that she needed citizenship documents, but she did not know what to send.
 - Later, she received a notice that she had 45 days to respond, and she came in to Francesca for help.
 - The notice that was sent to her did not explain what she needed to send for citizenship documents or other requirements.
- In general, the communication coming from the HealthWave clearinghouse is unclear to patients. There is not a lot of communication from the clearinghouse.
 - Most of the time, the clients don't know what to do.
- The HealthWave application requires monthly income rather than annual. Many clients throw away their pay stubs and have trouble getting income documents from their employer to send in with application.
 - Many employers are reluctant to give the information for a variety of reasons including the fact that some employ illegal immigrants.
- Once they are approved and receive the health plan information, it's not clear to them what's covered.
 - HealthWave docs don't explain much. If you don't know what a managed care plan is, how can you choose a plan?
- Many clients are not getting the booklets in the mail and do not have Internet access to get the information.

- It makes it difficult to choose between plans and then choose a provider, when they are not getting the booklets.

Communication with the HealthWave clearinghouse is difficult. Many clients mail or fax their application, but it is not received by HealthWave. They do not realize they should call and confirm that it was received. Frequently, months go by without notice. Most often, clients don't call to check their application status until they haven't heard anything.

- They should be notified that they should call and verify they app has been received.
- Many give up calling to see where they are in the process. One woman reported waiting more than 45 minutes, left a message and still hadn't heard back for two days.
 - This woman came into see Francesca to get help.
 - Members can call with Francesca to get in faster (conference call or in person)
 - ONLY for those who have already submitted their paperwork.
 - She can contact an outreach worker in Kansas City, which is better than dealing with the clearinghouse.
 - This eliminates a lot of barriers, because the Kansas City contact calls when there is missing info, instead of sending a letter.
 - She is a Kansas Health Policy Authority (KHPA) Outreach Eligibility Specialist
 - She is housed in Wyandotte County and serves Johnson County
 - There are several throughout KS
 - Francesca works through the local KHPA outreach worker
 - Has eliminated a lot of problems (personal touch)
 - The best case scenario is to send application with everything the first time, and most will need assistance to make sure that happens.

6. Are there any policies in place to help eligible Medicaid recipients apply for health care? (Assist in applying for Medicaid/health care)

- People find about Francesca and her services through active outreach.
 - Her position is funded through United Way
 - She works with local agencies to reach out to Medicaid recipients

- She goes to the Johnson County Health Department 3 days a week, to reach out to those that are eligible or need help
 - She can then help them fill out app or process already submitted application
 - She can usually get an application processed in a week through local Kansas City contact
 - The HealthWave clearinghouse has 45 days to provide with decision (not including time if they are missing documents)
- Francesca believes there needs to be a mass media campaign to familiarize this audience with the HeathWave process
 - This would also notify the audience that there are people to help them as well as what coverage is offered.
 - Many do not know what is offered – dental, vision, help with behavioral problems
 - Receive too much generic information, nothing that is helpful
- Personal Anecdote:
 - Francesca needed to have her niece covered, so she applied for Medicaid. She never received anything saying what is covered.
 - Francesca did not get the package with choice of health care plans – inconsistent delivery – she knew she had to choose, so she called to get the information.
- The packet includes income guidelines on the packet, but many times the packet is out of date
 - It is not clear what age group it's referring to.
 - Some people think they qualify and don't, others aren't sure.
 - The details for each specific situation are not included in the guidelines.
 - For example, income is calculated for a pregnant woman using her income, the husband's (if he lives with her) and the child being carried. Other children are not included for care.
 - People are turned away because they are confused by the guidelines – many think they don't qualify but they do.
 - It would be helpful if the guidelines were illustrated for their specific situation
- HealthWave vs. Medicaid is confusing
 - Don't understand difference between HealthWave 19(Medicaid) and 21(CHIP)
 - Explanation is unclear

7. In what ways do you think these challenges impact members' engagement within the community?

- Many members are not utilizing services that are offered because they don't know what's offered.
 - Especially services beyond medical
 - Dental, behavioral, vision
 - Transportation
 - Spanish-speaking services and other languages that resources can offer
 - Interpreters
 - Providers have them as well as outreach
 - HealthWave offers English and Spanish on the phone, and then connects with an interpreter.

8. In what ways can provider organizations improve the way the application requirements and processes are communicated to members?

Having the local HealthWave worker in Kansas City has helped a lot, but the information needs to get out.

9. A large portion of Medicaid recipients do not leverage the health care resources (doctor's appointments, health fairs, etc), do you think improvement in communication would help improve member engagement?

- It is necessary to verbally communicate some of this to them.
- Providers need to make sure its members know what it means to choose a health care plan.
- Outreach workers are key; they can go through the process with them.
 - Explain the differences between 19 and 21
 - Explain their benefits
 - Explain the process after the application is submitted
 - Actually show them what they may receive after they've applied and what that material means
 - Explain that they need to choose a plan
 - Explain they will be automatically assigned if they do not choose (if they have more than one child, these children could be assigned to different plans with different physicians)
 - Explain all benefits and services available for them.

- Many don't realize that they need to renew each year; they may move and not inform the clearinghouse and, therefore, do not receive renewal application and do not realize that they have not renewed.
- Biggest Problem; They move and lose contact with the clearinghouse
 - The process and the need to notify just needs to be explained
- There is an 800 number for HealthWave once you get the paperwork
 - Wait times can be long and people give up
- Many times providers can help
- Health Department social workers can help
- Johnson County offers multi-service centers and schools that also provide resources
- The school system itself needs help – nurses have some knowledge, but in order to best help students, the school districts need more education on the process itself and the health care system to really be able to help the students
 - Some kind of screening process to make sure children are insured
 - Implement education to help get them on if they qualify
 - Similar to the school lunch program.

10. Are there aspects of the Medicaid application process or the Medicaid program in general, your clients see as positive? If so, what are they, and why are they pleased with them?

- The clients that I have dealt with like the process of working with the local HealthWave worker.
 - This is positive for my clients. It speeds up the process and makes it easier for them.
 - She is really able to help and turn a negative experience around when she comes in in the middle.
 - It makes their lives much easier
 - The decision is made more quickly
- Personal Anecdote:
 - At the Health Department: A man has told her how much she has helped his family, since she walked him through the process to apply and helped them get it through.
 - The last time they did this, the process took 14 months. She was able to get the application in and processed within one day of submitting the application.

- He came in on a Friday and needed to get additional paperwork.
 - He got the paperwork to her on Monday, and had a decision by lunch time on Monday
- He continues to call and thank her, and refers others to her.
- The speed of this process is due in large part to the local HealthWave worker.

11. What are the general issues you perceive that Medicaid recipients face when navigating the complex health care system?

- Speed of application process
- Knowing who to call when there is a question
- Finding out what their benefits are
- It is complex, even for someone who understands it
- There are many layers
 - HealthWave: application, status checks, documents
 - Enrollment Center: to choose a plan
 - Health Plan: to choose a provider
- When there is a change, they do not know who to call
 - This is often a contributing factor to fact that people don't let the state know when they move or when they have a question.
 - They are referred to another place, but don't even know how to find the number
 - Language barrier adds more complication

12. What are the positive things that you see in the Health Care industry, and what can Medicaid providers do to help leverage these to improve member engagement?

- Services that are offered through HealthWave are great.
- There just needs to be more awareness in general.
- More people should apply and become aware.
- Providers should be encouraged to offer more information to clients.
 - Remind them of the services available.
 - If they have Medicaid, let them know what other services are available.
- Educate providers – Health Department has outreach workers there, and can encourage people to apply.
 - Help them understand the process, and where there are resources to help patients.

- Providers could be more involved.
- Kansas needs more providers who speak Spanish; the Spanish-speaking population currently has limited places to go.
 - They can communicate with the provider and if they have questions they can ask.

13. How can organizations do a better job communicating the importance of health to those receiving Medicaid?

- Getting the word out to community organizations and schools.
- Get established with primary care physicians.

14. How can we better communicate the changes in the health insurance industry to low-income/low health literate Kansas residents?

- Mass media – communicate as much as possible through ad campaigns
- Letting members know what’s available
- Education to community organizations that deal with these clients.
- School districts hold a key to this because they deal with families and children.
- Daycares, Head start, other places where these families and children go in the community.

Additional Comments:

Getting out in the community is a big deal – using the Community Relations Reps to get out there and reach out directly to this group.

--- She has some clients and other outreach workers that we can contact

--- Local KHPA worker – also does outreach

In-depth Interview: Children's Mercy Family Health Partners Member

1. Please tell me your HealthWave story.

- I have 3 children
- I took one child in to be seen at the Johnson County Health Dept.
- I have medication that costs more than \$2000/month; another child on expensive medication with ongoing medical issues
- Tammy recently moved to Kansas from Missouri
- The people at the Health Department recommended that she go through Francesca to get on HealthWave insurance
- Francesca was able to have Medicaid approved within a few days
 - It would have taken me 4-6 weeks to get through the process
- Had a great experience using Francesca
- Received her packet in the mail and is currently making her choice of plans

2. Who is your health insurance provider?

- I will choose Children's Mercy Family Health Partners
- We used that in Missouri too

3. Is it difficult for you to get to the doctor?

No.

4. How well does your health insurance provider communicate with you?

I have not had any problems in the past.

5. If you had trouble understanding communication from your provider, did you receive help trying to understand it? N/A

6. What is the best way for you to receive information about your medical coverage?

Regular mail.

7. Are you interested/open to in receiving health information in the following ways:

Telephone	yes
Text Messaging	yes
E-mail	yes
Social Media	yes
Mail	yes
Doctor or Insurance Provider	yes

In-Depth Interview: Healthwave Member

1. Please tell me your HealthWave story.

This member signed up when she had her daughter. At the beginning, it was a really good experience. There was a quick response from the application process, and the customer service representatives were very helpful. Once she had a good job, she discontinued the service. She was married and they were stable. When the economy went south and her husband was laid off, they reapplied. This was not a good experience. It took nine months to get a response back, and after several calls they finally were able to get insurance, but were uncovered for nine months.

Application process was difficult in terms of working with customer service. Customer service representative was unknowledgeable, asked to call back to repetitive numbers, lots of red tape in terms of not having files updated once she was married. Filing out the applications was straight forward, but getting approved and sorting through problems was not.

Experience overall is more good than bad, but frustrating with reapplying.

2. Who is your health insurance provider?

Blue Cross Blue Shield (BCBS)

Between them BCBS and HealthWave, there was a better experience with HealthWave. BCBS had a lot out of pocket requirements and minimums, and she always had to get referrals. HealthWave would always trouble shoot and helped determine purpose for bill and sort out any issues. Blue Cross Blue Shield would just “take it into consideration,” then decline to pay.

3. Is it difficult for you to get to the doctor?

No. Primary doctor was the same on BCBS and on HealthWave.

No problem getting to doctor. Have multiple vehicles for transportation between her and her husband.

4. How well does your health insurance provider communicate with you?

There were flyers about wellness, which were very helpful. The communication was very self-explanatory.

Right on target with communicating changes and notices. For renewal, all they had to do was mark one box and send it back. HealthWave even pre-communicated that next year that would change.

Blue Cross Blue Shield didn't communicate as frequently and did not provide wellness and preventative care.

5. If you had trouble understanding communication from your provider, did you receive help trying to understand it?

All communication was easy to understand

6. What is the best way for you to receive information about your medical coverage?

Prefer to receive by mail. Always open and read mail, often email can get caught in junk mail or may not be viewed for several days. Skeptical to open any emails due to potential of a virus. Not open to text message or social media interaction.

7. How interested are you in receiving health information in the following ways:

Telephone

Text Messaging

E-mail

Social Media

Mail (Most preferred)

Doctor or Insurance Provider

8. Additional comments

Information she likes to receive:

Wellness

Community Events

Having personalized information is the best.

It is essential to keep communication clear and consistent. She believes members should not have to start all over again when reapplying. Ensure notes are kept in the computer system.

In-depth Interview Consent Forms

Capstone in Marketing Communication Information Statement

The School of Journalism and Mass Communications at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

We are conducting this study to better understand peoples' perceptions of the health care industry. This will involve your being asked and responding to a few questions. The process should take no more than forty five minutes to complete.

Your participation is strictly voluntary. We might want to use your name with your comments. If you agree to allow us to use your comments, please sign below and put the date next to your signature.

Answering these questions indicates your willingness to participate in this project and that you are over the age of 18. If you have any additional questions about your rights as a research participant, contact our supervising professor, whose information is below, or contact the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email mdenning@ku.edu, or 785) 864-7429 or (785) 864-7385.

Sincerely,

James K. Gentry, Ph.D.
Clyde M. Reed Teaching Professor
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School of Journalism and Mass Communications
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785-218-4755
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Mark Thompson
2/29/12

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APPROVED; JOY WHEELER 2/19/2010

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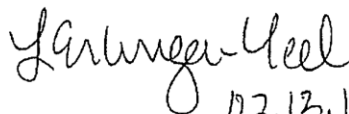
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02.13.12

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Appendix 9

Additional Information Regarding Recommendations

In-Depth explanation of Incentives

Pay for Performance

Pay for Performance Programs, or P4P, are designed to motivate providers with financial incentives. If executed correctly, a standardized quality improvement model can effectively improve HEDIS and CAHPS scores, and cultivate a stronger relationship between providers and CHC Kansas. The idea behind a P4P program is to provide additional incentive funding for all practices that qualify; not all practices are guaranteed additional funding. Additional funding for practices can only be obtained by demonstrating progress over a period of time.

P4P represents an innovative approach to provider payments. Traditionally, payments to medical providers were based on the actual care process as opposed to the effects of treatments administered on a patient's overall health. P4Ps seek to provide medical services that are timely, effective and based on the needs of the patient.

A P4P gauges a variety of measures to give incentives to providers. These include extended business hours and performance. Extended business hours, including weekends, can reduce ER visits and offer multilingual staff members for easier communication. Performance is measured in various approaches by states with the ultimate goal to improve quality of care. A performance-based P4P must focus on a consensus-based standard of quality that is measurable for all Medicaid providers.

P4P programs are funded in a variety of ways. The state of Rhode Island was successful by imposing a 95 cent per member per month (PMPM) increase to the state's health plan capitation rate. This allowed for funds to be raised for provider incentives. The health plan agreed to the provider incentives and provided outreach and education. The plan also selected the performance measures, collected and analyzed data and then passed the funds raised onto the provider as an incentive.

Additional funding options include federal and state assistance, savings from existing services as a result of improved efficiency or withholding or reducing existing payment levels for providers out of the general fund. A key takeaway is that in a risk-based managed care scenario, states are not allowed to directly give incentives to providers. Therefore, excellent communication and collaboration is required by both the state and the health plan provider.

Fee for Service

Traditional Fee for Service (FFS) is a widely implemented payment model that provides payments for physicians who complete treatments for Medicaid patients. Traditional FFS gives incentives to providers based on the total number of visits, which lately has created controversy within the medical industry. For example, some providers have manipulated the current model by providing unnecessary treatments to receive additional payments.

While traditional FFS has been linked to higher costs, decreased efficiency and influenced fraudulent billings, FFS incentives aim to bundle FFS visits and create care plans that are able to be monitored by health plans.

The state of Missouri is currently revising its health plan contract to include a FFS incentive program. Under it, physicians and physicians of FQHQs in targeted areas receive \$25 for every care plan initiated, and \$10 for every update made to the care plan. These plans are being monitored by care coordinators and are most effective in the treatment of chronic diseases such as diabetes, asthma, reflux disease and cardiovascular disease.

This new bundled FFS aligns traditional FFS with an incentive program to better monitor care plans and coordinate a higher quality of care to the patient. A FFS incentive program aims to reduce costs associated with patients that leave chronic conditions untreated and raise HEDIS and CAHPS scores by delivering higher quality overall care.

Sample Tactics for Incentives Using Gift Cards and Merchandise

Prenatal Care

- The goal of an effective prenatal care program is to detect any issues associated with pregnancy at an early stage. If needed, recommendations such as diet, exercise and nutrition are made. Prenatal care can reduce issues such as miscarriages, birth defects and other preventable issues.
- We recommend that CHC Kansas attempt to require expectant mothers to attend a prenatal medical visit during their first trimester. During this visit, they will be educated on the prenatal care program and incentive program.
 - Mailers will be sent to women who attend their prenatal medical visits.
 - When the program is complete, a doctor will confirm and sign the mailer.
- Women who successfully complete the program and submit their completed mailers will receive a \$25 gift card. Research has shown that if this program is executed properly, a 35% or higher participation rate can be expected.

Postpartum Care

- The primary focus of postpartum or postnatal care is to ensure that the mother is healthy and able care of her newborn. During this program, the mother will be educated on issues such as breastfeeding, reproductive health and daily life adjustments.

- CHC Kansas should attempt to require all new mothers to attend a postpartum medical visit within 8 weeks of delivery.
 - A mailer will be sent to new mothers outlining the incentive program. The mother will be required to receive a doctor's signature and confirmation after completing the postpartum care program.
 - This mailer will then be submitted to CHC Kansas.
- Upon successful completion of the program, members will receive a \$25 gift card.

Childhood Immunizations

- An immunization schedule is important for children to remain healthy and to fight disease. Children are expected to have the required vaccinations before they are enrolled in school. Additionally, children who never received the proper immunizations are required to receive the vaccinations regardless of age.
- We recommend that CHC Kansas mandate that all children from age 2 receive all required doses for all required immunizations.
- Incentive information will be mailed to members and doctors will sign for each immunization that was required.
- Upon completion of the immunization program, members will receive a \$50 gift card.
- Research has shown that if this program is executed properly, a 23 percent or higher participation rate can be expected.

Well-Child Visits

- Children between the ages of 3 to 6 are encouraged to complete annual visits to their doctor to monitor their health. These visits can be helpful in identifying health risks at an early age to promote better overall health and prevent costly medical expenses in the future.
- CHC Kansas should provide incentives for members with mailers outlining the incentive program guidelines.
- For each year a child receives an annual checkup (ages 3 through 6) and receives signature confirmation from her or his doctor, the member will receive a \$25 gift card.
- Research has shown that if this program is executed properly, a 41 percent or higher participation rate can be expected.

Well-Adolescent Visits

- Adolescents between the ages of 12 to 21 are encouraged to complete annual visits to doctors to monitor their health. These visits can be helpful in identifying health risks at an early age to promote better overall health and prevent costly medical expenses in the future.
- CHC Kansas should send mailers outlining the incentive program guidelines.
- For each year a child receives an annual checkup (ages 12 to 21) and receives signature confirmation from their doctor, the member will receive a \$25 gift card.

- In addition to offering a \$25 gift card, iPod nanos and movie tickets have been utilized to motivate adolescents.
- Research has shown that if this program is executed properly, a 26 percent or higher participation rate can be expected.

Comprehensive Diabetes Care

- Members with Type 1 and Type 2 diabetes need to be educated on diet, exercise and blood glucose levels. Also, there is a greater risk of cardiovascular disease for individuals with diabetes so a healthy active lifestyle is recommended. If diabetes is left untreated, it can pose significant threats not limited to vision, cardiovascular disease and heart disease.
- We recommend that CHC Kansas provide incentives to members aged 18 to 75 with diabetes care.
- This program will encompass six different measures annually that will closely monitor diabetes and improve the health of its members. Along with healthier members, preventative measures against diabetes can reduce costs associated with a chronic disease.
- Mailers will be mailed to members that require a doctor signature.
 - Once the annual program is completed, a \$25 gift card will be provided to the member.
- Research has shown that if this program is executed properly, an 8% or higher participation rate can be expected.
- Metrics:
 - Percentage of pregnant members who completed a prenatal checkup within the first trimester of their pregnancy.
 - Percentage of members who receive postpartum care within 8 weeks of delivery.
 - Percentage of children who received all required shots by 18 years of age.
 - Percentage of enrolled members 3 to 6 years of age who completed well-child visits during the measurement year.
 - Percentage of enrolled members 12 to 21 years of age who completed annual health visits during the measurement year.
 - Percentage of members between the ages of 18 to 75 with diabetes (type 1 or type 2) who were administered required care.

Elements of a clear message

- Use bullet points
- Limit the number of messages in printed material (Wigington, 2008)
- Make it clear what information can be found
- Make the information relevant to the audience (Wigington, 2008)
- “Eliminate unnecessary words, jargon and technical terms wherever possible” (Wigington, 2008, p. 1)
- Tell the audience what they need to know (Wigington, 2008)
- Avoid acronyms, or spell them out the first time they are used
- Avoid this:
 - **Need medical care? See the PCP on your ID card.**
 - Know who your PCP is—check your CHC Kansas ID card.
 - Call your PCP when you need health care. Your PCP’s phone number is on your CHC Kansas card. Your PCP will help you get the care you need or refer you to a specialist.
 - Take your ID card and your state-issued card to all appointments and the pharmacy.
 - See your ID card for dates of coverage.
- Try this:
 - **Do you need to see a doctor?**
 - Contact the family doctor you selected at the time of enrollment.
 - The doctor’s (or, primary care provider (PCP)) name can be found on your CHC Kansas card.
 - Lost your card?
 - Call 1-800-347-9363 (toll-free)

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