

MAC Binder Section 9 – Good News Stories

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Located online at <http://chfs.ky.gov/dms/mac.htm>

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The MCOs submit good news stories to DMS on a monthly basis. These stories reflect the positive impact of managed care and demonstrate the diligence of the MCOs efforts at the improved and continued health care for KY Medicaid members.

2 – Good News_Apr2015:

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March 2015 MCO Good News Reports

MCOs Going Above and Beyond

All MCO staff and members' names have been changed to protect member privacy.



WellCare

A 45-year-old WellCare of Kentucky Medicaid member suffers from narcolepsy with cataplexy – a neurological sleep disorder characterized by chronic, excessive attacks of drowsiness during the day with sudden extreme muscle weakness.

Prior to her doctor prescribing Xyrem, a medication to treat the disorder, the member was unable to function normally, couldn't work, and was in danger of losing her psychology practice. Without her work and practice, she would be unable to provide for herself and her child. The member said the medication was a lifesaver. It allowed her to begin to work and enjoy life again.

The member recently received news that the doctor who prescribed her Xyrem was moving away from the area. Because of the potential for abuse, very few doctors can write a prescription for this medication. The member reached out to the distributor, who provided her with a list of doctors who could prescribe it. Unfortunately, the nearest one was not a participating WellCare provider. Others were located at least 120 miles away.

Because the member had previously worked with a WellCare of Kentucky field service coordinator, she called her to ask for help. The service coordinator immediately contacted the nearest doctor's office and asked if they would be willing to accept WellCare for this one member. They agreed and the coordinator received a prior authorization from their office the following day. She then contacted WellCare of Kentucky's medical director for behavioral health and he approved the member to see this doctor.

Because of the service coordinator's quick action, this member did not have to miss one dose of her medication. This allowed her to continue to take care of her overall health and to work to rebuild her psychology practice to better provide for herself and her child. Over time, the member may no longer need to be a Medicaid beneficiary.



A WellCare of Kentucky field service coordinator contacted a 48-year-old WellCare of Kentucky Medicaid member to find out how she was doing following a severe winter storm. The member, who suffers from hypertension and mental health issues, was also recovering from a sprained knee.

The member told the field coordinator that during the storm the pipes in her home had frozen, leaving her without running water for drinking, bathing or flushing toilets. Although she had contacted her landlord, he was unable to get to the member's home to provide help. She also told the coordinator that she cares for two small children in her home.

The coordinator immediately sprang into action, gathering bottled water, groceries, as well some small toys for the children, which she personally delivered to the member. She then worked with a transportation vendor to provide the member with rides to and from her doctor's appointments.

Due to the coordinator's actions, the member had enough food and water to hold her until her water pipes could be fixed. This relieved some of her stress and enabled her to focus on fixing the problem.



A 21-year-old WellCare of Kentucky Medicaid member with depression, anxiety and asthma frequently visited the emergency room for breathing issues.

A WellCare of Kentucky field service coordinator conducted a phone assessment and scheduled a future in-home visit with the member. During the phone assessment the service coordinator stressed the importance of reserving emergency room visits for true emergencies and educated her on using a primary care physician, 24-hour nurse advice line or visiting an urgent care center instead. The member said she was going to the E.R. because she was not happy with her primary care physician and she didn't know where else to go. She also said she had not had her eyes examined in years.

The coordinator immediately scheduled an appointment for the member with a new primary care doctor and also scheduled an eye exam for her. She also offered the member a behavioral health referral for her depression and anxiety, but she turned it down. The coordinator used WellCare's HealthConnections Referral Tracker (HCRT), which is a database with more than 9,000 Kentucky-based community organizations that WellCare can refer its members to for social services support. She then connected the member with the Kentucky Vision Project for free eyeglasses.

Due to the service coordinator's assistance, the member is able to establish a relationship with a primary care doctor who will provide continuity of care and potentially reduce her need for emergency room visits. Finally, the eyeglasses will help improve her quality of life.



A 60-year-old WellCare of Kentucky Medicaid member who has high blood pressure, diabetes, Chronic Obstructive Pulmonary Disease (COPD), and who had two heart attacks, was frequently visiting the emergency room for abdominal pain and bronchitis.

A WellCare of Kentucky field service coordinator was asked to contact this member, who had been difficult to locate. The service coordinator immediately began to monitor her claims and discovered that she was hard to find because she frequently moved from place to place. Because of the coordinator's persistence, he was able to locate the member through her friend, who gave him the telephone number for the motel where she was staying.

The service coordinator was able to reach the member and conducted an in-person visit. The member told her that she couldn't afford a cell phone. She also said that she did not check her blood pressure because she didn't have a monitor. The coordinator ordered the member a blood pressure cuff and showed her how to fill out an application for a free cell phone. When he noticed that the member couldn't see the application very well, he asked if she needed glasses. She said that she did, but couldn't afford them.

The service coordinator used WellCare's HealthConnections Referral Tracker (HCRT), which is a database with more than 9,000 Kentucky-based community organizations that WellCare can refer its members to for social services support. He then connected the member with the Kentucky Vision Project for free eyeglasses. He also used the system to educate the member about available assistance through local food banks.

Due to the coordinator's assistance, the member is now able to have WellCare's disease management team contact her via her new cell phone. The team can help to manage escalating health issues by encouraging appropriate actions, including visiting her primary care doctor when needed. His assistance in getting the blood pressure monitor and teaching her how to report the results to her doctor will also help to improve her overall health. Finally, the eyeglasses will help her to better care for herself and improve her quality of life.



Anthem

Although Region 3 is not in our service area, Anthem supports, as part of our mission, several organizations in the Louisville area, including the Boys and Girls Clubs, Goodwill, and the Neighborhood House. For example, we provide foundation and other event funding, and for over 9 years Anthem has had an executive serving on the Board of Directors of Neighborhood House, a local nonprofit community center in the Portland neighborhood in Louisville, KY, helping people break the cycle of poverty. Anthem Medicaid President, Celia Manlove, was recently appointed to the Neighborhood House Board of Directors and had the honor, along with many others, of personally showing support of the Neighborhood House during a visit on March 20, 2015 by British royalty, the Duchess of Cornwall, Camilla Parker Bowles, and Kentucky's First Lady, Jane Beshear. The Duchess personally selected the Neighborhood House out of all the places she could have visited, because, like Anthem, she also believes in their mission and understands the importance of the work that they do.



Across the state and to warm communities, Anthem donated 1000 pair of gloves, 1000 hats, and 575 blankets. Anthem is proud to be able to help and serve the community, especially in times of need.

A few weeks ago, Kentucky was hit hard by snow storms and frigid cold temperatures. A Community Liaison with Anthem, visited the Gateway Homeless Coalition office in Morehead, KY. In addition to her visit, she was also delivering some much needed items. Gateway's Executive Director was overjoyed by Anthem's generosity and remarked that she was impressed with Anthem's dedication to helping those in need. So many people come to Gateway for assistance and help. The director stated that the blankets are great because it is

something people can take with them to use even after they get back on their feet. She could not wait to hand these items out and invited Anthem staff back to volunteer in the future.



CoventryCares

A 32-year old member was referred to a high-risk OB nurse from a phone call about a medication issue.

She has had multiple pregnancies and has delivered four children early due to health issues. She was diagnosed with high blood pressure, history of heart disease and history of heroin use. She received injections during two prior pregnancies to assist with carrying babies until delivery.

The member has been receiving prenatal care early in this pregnancy. Her doctor felt she needed the injections with this pregnancy but did not submit the correct information for the approval. She worked with the Coventry case manager, RN and assisted her with getting the information needed in order to obtain the authorization. An authorization was obtained and member was able to get the injections she needed.

The member worked with the case manager as well as a social worker for assistance with multiple issues. While participating in case management, the member delivered a term infant. Baby was full term, but admitted to NICU due to heroin withdrawal. The social worker assisted the mother in obtaining transportation back and forth to the hospital to visit her baby in the NICU. The nurse, social worker, and a Child Protection Services (CPS) employee worked closely together to get the member into a suboxone program and counseling. CPS was involved with the case due to the history of heroin abuse. During the pregnancy, the member was on medication for withdrawal from heroin and needed to be transitioned to another program within six weeks of delivery. Through frequent contacts with member, the nurse and social worker were able to get the mother through her 20-day withdrawal from one medication to the start of the new medication.

The baby was discharged home in good condition to the care of the mother. The member remains active in her therapy and continues to receive supportive education and calls from both the nurse and the social worker.

Positive outcomes:

- Collaboration between Case Manager, member and OB office
- Positive communication between member and case manager
- Case manager intervention helped prevent fetal demise



A 62-year old member with multiple chronic diseases: high blood pressure, pulmonary disease, chronic pain, and another chronic disease.

The member was enrolled in case management with a Coventry RN. During assessment, the RN found out that he had several issues that included: no electricity or water due to damage to his trailer from a tornado and issues getting medications through the mail due to being in the lock-in program.

The member was identified for the lock-in program due to overuse of pharmacy and providers for controlled substance. He was placed in the program on March 1, 2014.

The RN was able to enlist assistance from a Coventry social worker to aid with guiding the member to FEMA for assistance from the disaster. The social worker assisted him with contacting the American Red Cross, as well as multiple other agencies to assist with rebuilding his home and obtaining food. Between the RN and the social worker, the member was provided with resources that included: food pantries, community action services to assist with utilities, transportation broker to assist with transportation to physician appointments as well as information about subsidized housing. When these topics were initially discussed with the member, he refused the assistance stating he is a very private person and does not want people to know his business. The RN and social worker were able to provide encouragement to him as well as education about these services. The member finally was able to accept the assistance from the food pantries as well as assistance for rebuilding his home.

The member's most recent issue was with obtaining specialized medicine to treat a chronic disease. His provider has a clinic with a pharmacy that will ship the medication to his home. With the assistance of the RN as well as the lock-in coordinator, the specific pharmacy was able to be added for him to use. This allows the pharmacy to ship the specialized medication directly to his home rather than having to find transportation to get to the pharmacy.

Positive Outcomes:

- Collaboration between member and case manager
- Positive reinforcement and encouragement for use of local resources
- Collaboration between multiple departments in assisting member with medication compliance.



Humana

A Humana member recently suffered a stroke with residual left-side weakness. She has a history of diabetes and thyroid problems. She had a follow-up appointment scheduled with a neurologist and sees an endocrinologist but did not have a primary care physician. A Case Manager at Humana – CareSource, reached out to the member and helped her find and make an appointment with a primary care physician who could coordinate all of her care. Her primary care physician could also help her manage her diabetes including monitoring regular Hgb A1c testing and annual eye exams.

The member declined being enrolled in the Case Management program. She did, however, express concern over several things: she wasn't receiving any kind of therapy after being discharged from the hospital; she was living with her daughter and said they needed assistance with transportation and paying their utility bills; and the doctor said she could resume all her normal activities and even return to work but she was having trouble getting through her days without help.

The case manager interceded. She offered to coordinate with the neurologist and the member stated she would discuss her concerns at her next doctor's appointment, which was only a few days away. The case manager talked about transportation assistance. She also found resources that could help with utilities and gave the member contact information for these. Not wanting to leave the member with unresolved worries, the case manager asked if she could call again even though she was not interested in the Case Management program and the member agreed. The case manager also advised the member to talk with her employer about FMLA and short and long-term disability to see if any of these options are available to her. The member said she hadn't even thought about this and she would call that day.

The case manager instructed the member about having regular Hgb A1c testing and annual eye exams as part of her diabetes care (HEDIS measures); the member expressed understanding.



A member over 50 years old has a lot of serious medical conditions including diabetes, asthma, heart dysrhythmias, and Parkinson's disease. Although she sees her doctor regularly and tries very hard to stay active, she kept running into the same roadblock – consistently taking medications. She could not always afford to pay for the medications that the doctor prescribed. This prevented her from managing her chronic conditions appropriately.

This came to the attention of her Humana – CareSource Case Manager not long after she agreed to be enrolled in the program. When the Humana – CareSource Case Manager called her, the member confessed she had been out of her heart medication for four months. This put her at serious risk.

The case manager began investigating right away. Humana – CareSource found that the pharmacy was charging the member \$75 for her medicine and she simply did not have the money to obtain her medication. The case manager collaborated with the doctor and the pharmacy for authorization and completion of the transaction at no charge. The misunderstanding about the member's eligibility for both Medicaid and Medicare was causing her to be billed incorrectly. She expressed that she was "thrilled" with the help she received.

Without the care of the Humana – CareSource Case Manager, the member would have continued to not taking the medications prescribed for her heart condition. The Case Manager saw the issue of payment as a barrier to medication management and addressed the situation directly. Because of her efforts, the member is adhering to her doctor's recommendations and managing her conditions.



Passport

Last year, a Passport member made the brave decision to prioritize the health of her four children after they developed respiratory issues from mold in their Section 8 rental unit. Despite the help of legal aid and her

honest efforts to follow the process honorably, her landlord evicted her family from the property. In the process, most of their possessions were stolen or destroyed.

When an Embedded Case Manager met her in her primary care provider's (PCP) office in early November, the member was trying to stay positive but admitted concern for her family's future. Because of the landlord's actions, she had lost her Section 8 benefits and possessed only a few items beyond what her children had taken to school the day they were evicted. She worked quickly to obtain a new home for her family, but knew they would soon be homeless because she had no way to pay rent.

Knowing that the health of the member and her young children were at risk without a safe and stable living environment, the case manager launched to action. He advocated with the property group to extend the due date for her rent, and then worked with numerous local community agencies to obtain donations to help the member pay rent for November and December. He empowered her to contact as many community resources as she could think of. He also worked with her and her Section 8 case worker to have her benefits reinstated by January 2015.

Going even further above and beyond the call of duty to help this struggling family in need, the case manager also organized various community efforts that provided the family with almost everything they needed to start over again - a queen-sized bed and two bunk beds, a desk, and numerous other basic kitchen and household goods. They even found an agency to provide Christmas presents for all of the children.

During this time, the case manager spoke with the member on an almost daily basis. He said that "I have never met someone more determined and proactive. She never once asked for or felt entitled to help, and has been so moved by the experience that she is now volunteering at the Salvation Army. The only help she ever asked of me was to see if I could contact the health department to keep the family that had moved into her previous property from getting sick from the mold. She was only thinking of other people."

Because of these amazing efforts through Passport's embedded case management program, the member and her family were kept from being homeless and had a very merry Christmas. She is one of 4,345 members served by our Embedded Case Management program in 2014.

☺☺☺

When a Disease Manager first spoke with a Passport member, he was severely confused about the severity of his recent triple heart bypass and the importance of making all follow-up appointments and taking medications as prescribed.

The disease manager patiently educated him on his heart disease and how to start a healthy lifestyle. When the member admitted to not taking his medication for several months prior to his heart attack, the disease manager reinforced the importance of keeping up with refills. Before their call was disconnected, the manager learned that the member did not have a follow-up appointment with his PCP, so he contacted the cardiologist and PCP to make sure they would reschedule him and also work on medication reconciliation post-discharge.

Passport's Healthy Heart program served 4,001 members like this one in 2014.

☺☺☺

For over one year, a Passport member was miserable every time she tried to eat. She was unable to keep food down and lost 40 pounds. Finally, after trying everything they could think of, her providers placed a feeding tube as a new treatment option for her. Within 4 weeks of getting the new tube, she gained back nine pounds.

Then suddenly the feeding tube malfunctioned. In pain, the member rushed to the emergency room and her feeding tube was removed. She was discharged shortly thereafter but was unable to reach her provider to determine when the feeding tube could be replaced. When she finally called a Passport case manager, she hadn't had anything to eat in 4 days.

The case manager immediately contacted the provider's office and explained the urgency of the member's situation. She requested that she be seen as soon as possible. The provider's office was surprised and the case manager quickly realized that there had been some miscommunication. The member's son had called the office and left a message for them to call back, but had not made it clear how urgent his mother's condition became.

Thanks to the case manager's fast work, the member was taken in for surgery the next day and the feeding tube was replaced. This allowed her not only to replenish the nutrition she had been missing for several

days, but also to improve her emotional well-being. The member had made so much progress with the feeding tube and losing it was a very traumatic experience.

This member is one of 695 members served by our Complex Case Management program in 2014.



A Passport member with dual-eligibility with Medicaid and Medicare benefits, didn't realize she was overpaying for her medication until an Embedded Case Manager noticed a \$15 copay on her claim. After they spoke, the case manager contacted her Part D plan. He discovered that the plan required a prior authorization for her prescription, and her provider had never submitted one. The case manager relayed the message to the member's PCP, who submitted the authorization immediately. Once approved, the copayment for this very important medication was reduced to \$1.20! This made it easier for her to afford and reduced the incidence of her unable to afford her needed medication.

The member is one of 4,345 members served by our Embedded Case Management program in 2014.



After months of working together, our Disease Manager received an inspirational phone call from a Passport member and lifelong smoker who has Chronic Obstructive Pulmonary Disease (COPD). Thanks to the Disease Manager's caring and assistance, the member has obtained important medical equipment and has been smoke-free for 3 weeks!

It all started several months ago when the member first received some educational materials from Passport in the mail and called the Disease Manager to learn more. During their discussion, she discovered the member was a smoker. She stressed the importance of ceasing smoking due to his condition, and explained Passport's smoking cessation benefits. She also investigated his claims and noticed that he was waiting to obtain a CPAP machine (continuous positive airway pressure), which is an important type of ventilation (breathing) therapy for patients with COPD. Upon further research she learned the DME (durable medical equipment) provider had sent information to the wrong managed care organization (MCO). She contacted the DME and helped get the claim resolved so that the member soon received the CPAP machine.

Once he received it, the Disease Manager also offered him ongoing support in setting up and adjusting to using the CPAP machine. She explained that she had personal experience setting up CPAP machines with patients at her previous home health job. The member was so appreciative and told her that he had never dealt with people who cared so much.

A few weeks later, the member called to share that he has felt so much better since starting his CPAP therapy. Now he has more energy, feels rested, no headaches every morning and (per his family) the house is much quieter. (No more snoring!) At the end of the conversation, the member stated "Oh yeah I almost forgot to tell you-I have been smoke-free for 3 weeks!" He told the Disease Manager his doctor couldn't believe he was asking for a prescription to quit smoking. "Passport isn't like other insurance companies," he said. She told him "Thank you, I work with a lot of great people and it's so much more than just about the insurance."

The Disease Manager plans to keep in touch with the member throughout his upcoming smoke-free milestones. "His call to let me know how our help has made a difference," she says. "So many members are frustrated with how bad their health is, but he was willing to take the extra step and ask for help, ask for a prescription to quit smoking and stick with wearing the CPAP even though it was a big adjustment initially." These types of efforts have helped Passport to obtain the following rankings for national HEDIS® in 2014:

Advising to quit: 90th percentile

Discussion of cessation strategies: 50th percentile

Discussion of cessation medications 50th percentile



Recently, a Passport Foster Care Liaison became aware of a foster child member with autism and low IQ who needed an eye examination but becomes reactive and aggressive in settings where he is medically examined. The child's state worker was hoping to find a doctor in their rural location who could do an eye exam while the member was under sedation.

Instead of telling the guardian/state worker to do the research themselves, the liaison searched on his own for participating ophthalmologists in Passport's provider network. He managed to find a practice where the doctors perform exams under sedation (when necessary) at the surgical center, which is about a mile away from the closest hospital to the child. He relayed the provider's contact information back to the state worker and his supervisor so that they could make arrangements to have the member seen.

The foster child's situation is one of 186 issues/needs resolved by Passport's Foster Care program during January through February 2015.



The psychiatrist at a local community mental health center (CMHC) recently asked our Behavioral Health Liaison to assist a Passport member with scheduling a neurology appointment, stating that the family felt they were not successful in scheduling through the PCP. Easing the burden on both provider offices, Monica contacted (Passport's Embedded Case Manager at the PCP's office and asked for assistance. Together, within the span of a few days, the embedded case manager contacted the appropriate staff within the PCP's office AND had the member's appointment scheduled with the neurologist.

"The embedded case manager was *extremely* helpful," says the behavioral Health Liaison. "She knew who to ask for assistance there in order to get something done and followed up to make sure that the member had an appointment scheduled. The fact that Passport has staff embedded in various offices made this possible... and illustrates that sometimes a plan really can come together!"

Thanks to these efforts, the psychiatrist and member's family are pleased, the member will get the care he needs and both of the embedded staff feel like we got something accomplished. The member is one of 4,345 members served in 2014 by our Embedded Case Management program.



A Passport Embedded Case Manager was thrilled when he recently learned one of our pediatric providers was making concerted efforts to improve their practice's asthma management by offering patients asthma action plans during every planned asthma visit.

After several weeks of working together on the logistics, the case manager found a way to support these efforts when he is onsite two days a week. Now, when any provider in this practice notices a member in need of asthma care management, he/she can simply send the case manager a notification through the member's chart as opposed to making a phone call or email.

"This is a great way to 'wrap-around' our members with asthma," says the case manager. "We will be able to give this provider pertinent information they otherwise wouldn't have access to or wouldn't have the time to access. This will give insight into how our members are responding to treatment, and help us identify members who need more education."

These types of efforts have helped Passport to obtain the following rankings for national HEDIS® in 2014: Medications Mngt. for People with Asthma 75% Compliance Total 5-64 Years: 44.65 (90th percentile)



While hospitalized recently, a young Passport member was prescribed an important medication for his Cystic Fibrosis which was not on Passport's formulary. When a Passport Case Manager learned that his provider hadn't submitted a prior authorization to have it covered after his discharge, she contacted the provider to remind them so that a prior authorization could be initiated.

Not wanting to waste any time, the case manager went a step beyond and contacted our Medical Director and provided the necessary medical information to ensure medical necessity, and Passport's Pharmacy Program and Analytics Manager. That manager quickly placed an override so that the member's mother could get his medication for the month.

She was thrilled. She has two young children with severe health conditions and lacks a good support system, so having one medication quickly approved truly made a difference in alleviating one of the struggles she faced. This success story was made possible by Passport's Complex Case Management program, which assisted 695 members in 2014.



A couple of months ago, an Embedded Case Manager met a Passport member who had six children and was in need of clothing and toiletries. The children did not even have socks. The case manager collaborated with another case manager to try to provide resources for clothing and toiletries. However, when the member came back to the PCP office, she still had not been able to access to the resources that were provided for her. She explained that because she could not speak English, and could not read or write, she was unable to get to any of the places that could provide assistance.

Coming to her aid, the case manager found a local group to give donations of socks, underwear, clothing, toys, soap, shampoo, toothpaste, and much more.

“The member was very grateful,” recalls the case manager. “She smiled more than I've ever seen her smile before. Her children were also excited to receive the toys. With a little bit of effort and teamwork, we were able to help this member and her whole family!”

This success story was made possible by Passport’s Embedded Case Management program, which assisted 4,345 members in 2014.



April 2015 MCO Good News Reports

MCOs Going Above and Beyond

All MCO staff and members' names have been changed to protect member privacy.



Anthem

Anthem received a letter from the CFO of River Valley Behavioral Health, who wanted to share some positive feedback. River Valley is a CMHC in Owensboro, Kentucky. The CFO noted that Anthem's staff had been very helpful as they have moved forward with the new processes in the Medicaid market. They had several Anthem members in case management and they were unaware that Anthem requires pre-authorization. Upon realizing the error, they worked with an Anthem associate who was able to internally coordinate correction of the problem and have their claims processed. Anthem's solution was to waive prior authorization for those services and retro actively approve them. The CFO stated that although this was not necessary on Anthem's part, it showed him the collaborative nature of the relationship Anthem has with River Valley.



Anthem received a communication from a staff member at Lexington OBGYN stating how appreciative she was of the work being done by an Anthem provider relations associate. She stated that they work with several MCOs and that the associate and Anthem Medicaid have been the most responsive to her problems. The associate has effectively solved issues such as helping with claims in a timely manner and addresses concerns with any member issues. Her proactive approach is not one that the staff member had seen with other MCOs. She is confident that Anthem will respond with any issues quickly. They previously had issues with taxonomy numbers on claims and the associate was able to have them resolved and the denied claims paid within a month. The Lexington OBGYN staff member felt that the knowledge that she can easily speak to someone who will have problems addressed made Anthem a plus to work with.



An Anthem Case Manager recently spoke to a member who was very grateful for the work Anthem does as part of our case management. The member had been in the hospital eight times within the past year due to many chronic health issues and thought she should go to the emergency room whenever she was sick. She had a primary care provider (PCP) but stated that she did not get along with him and therefore did not make appointments.

In order to help manage the member's medical conditions, the case manager began talking to her and shared things that she could do in order to avoid going to the hospital, such as weighing herself daily and knowing when to contact her doctor versus going to the emergency room. The case manager also helped the member change her PCP and was able to make an appointment for her that same week. She further provided the member with educational information regarding healthy eating tips and smoking cessation, including Anthem benefits for generic nicotine replacement patches.

The case manager further discussed the importance of scheduling follow up appointments with specialists following hospital discharge, as the member had not been doing. Following up with these specialists early on can prevent future hospital admissions by getting necessary medications and treatment to stay healthy. The member agreed to schedule an appointment with a pulmonary specialist after her discussions with the case manager. She now appears motivated to make the changes needed in order to take better care of her health and she has a goal of staying out of hospitals for at least the next six months.



An Anthem Community Outreach associate recently met an Anthem Medicaid member during the Hillbilly Days Festival in Pikeville. The member had moved from another state a few months ago as she had been in an abusive relationship and was fearful for her safety. However, she now has fears concerning how unstable her life had become with no job or other source of income, no home of her own and no health insurance. She was especially concerned for her health since she takes several medications.

Sara had learned that she would be eligible for some form of medical coverage for which she could apply through Kentucky's new online health exchange, kynect. The member began the application process and found that she was eligible for Medicaid. She selected Anthem as she had been familiar with our coverage in the past. She reported that she now has all of her medications covered without any copays. The member became very emotional telling her story and personally thanked the outreach associate, even unexpectedly giving him a heartfelt hug. She left with his contact information so that she would have a direct contact for any future needs or concerns.



At the KPTAA forum held on April 17th at Bellarmine College, PT Pros in Harlan, Kentucky presented a case by PowerPoint presentation of one of Anthem's members in need of physical therapy. The purpose of the presentation was to illustrate that Anthem was "doing it right" and that we were easy to work with. This member was a 25-year old female presented to PT Pros with a complaint of low back and knee pain from a right knee meniscus tear (non-surgical) from an old motor vehicle accident. She had an abnormal gait due to fear avoidance of extending her leg due to knee pain. She had loss of range of motion, strength, balance, and coordination. She also was the primary caregiver of her father who had suffered a stroke. She had unreliable and inconsistent transportation to and from therapy visits. This young woman reported she had been disabled for several years and had previously been treated for depression. She was authorized for an initial eight visits and for the first few visits required one-on-one neuromuscular retraining to allow her heel to touch down in order to walk normally. She had an additional eight visits approved to work on joint mobility, soft tissue release, strengthening and her exercise program was advanced. Physical therapy has improved her current health so that she has less pain and can now walk in a normal gait.



CoventryCares

Member is a 50 year old with a history of cancer of the jaw. Member has undergone treatment that included both chemotherapy and radiation therapy. As a result of the treatment, he has had a removal of part of his jaw. He was provided with dentures that did not fit due to the removal of part of his jaw. He was not able to undergo reconstruction of the jaw due to his treatments and his jaw needing to heal.

Member enrolled in case management with an RN. He expressed to the RN that he was depressed due to the cancer and his treatments. He was not able to eat normal food due to missing part of his jaw. He told her that everyone was having issues understanding him, everyone looked at him funny due to the fact he was missing part of his jaw, and he couldn't eat. He voiced that he wanted to get back to normal with being able to eat and wanted to be able to go back to work.

The RN worked with him on his depression. She gave him suggestions as to make his food more appealing, assisted him in getting appointments with an in network dentist, assisted with getting him in to an oral surgery clinic and assisted with behavioral health benefits to start therapy for his depression.

Member was able to get dental implants with the assistance of the RN, CM working closely with the prior authorization department and medical director. As this process for restoration is a 2-part process, he is now ready for the 2nd phase of his reconstruction with the insertion of a prosthesis for his jaw. He has worked closed with the RN in keeping his follow-up appointments as well as preparation for this final phase. A prior authorization request was received this week for the prosthesis and with the assistance of the RN, CM, this was approved.

Member is thankful for all of the assistance. His depression and diabetes are controlled. He is looking forward to being able to eat a steak after the 2nd phase of his surgery.

Positive Outcomes:

- Collaboration between member and case manager
- Collaboration between different departments within health plan that includes: prior authorization, medical director, management
- Holistic care for the member to assist with behavioral health issues as well as physical health issue.



Member is a 63 year old female with a history of congestive heart failure and diabetes who was enrolled in case management. Coventry's RN was working with member, who was always unwilling to actively participate in case management. Recently, the RN underwent training in motivational interviewing which assists the case management team in building a more positive relationship with the member by using open ended questions and allowing the member to decide what goals need to be worked on and actively participate and make decisions in the management of their care.

The RN called the member and asked permission to speak with her about her health and if this was a good time to talk, she stated "No, but let's just get this over". The RN started asking more open questions (rather than just yes/no questions), and the member started opening up and talking more about her issues and what she would like to see happen. She was able to set some short-term goals that were achievable that included starting an exercise program to build up her stamina. At the end of the conversation, the member asked the RN, "So when are you going to be calling again and thank you so much for listening".

Various communication techniques have been tried and failed which included talking to the member rather than talking with the member; telling the member what needs to be done rather than working with the member on what is important to the member.

Positive Outcomes:

- Collaboration between member and case manager
- Member able to actively participate in management of disease



Humana

A member joined Humana – CareSource (HCS) after losing her job and the employer sponsored insurance plan that came with it. Under her old insurance plan, she had been taking Lyrica with good results, but encountered some problems getting her prescriptions filled after she switched to HCS. Because the member had not tried the generic version prior to starting Lyrica, per HCS policy, she received a denial. A HCS Case Manager, created a care plan for the member that included obtaining her medical records and contacting her physician to submit the proper documentation.

About a month after the care plan was developed, the case member received an email from HCS's Behavioral Health partner Beacon informing her that the member seemed to be having some medical problems. She immediately reached out to the member who informed the case manager that she was still unable to receive her medications and was suffering from shortness of breath because she could not refill her inhaler prescription. The case manager investigated and discovered that the provider who had written the prescriptions was not on the KY Master Provider List, which caused the prescriptions to be denied. She then contacted the member's new provider who called in prescriptions for the necessary medication.

Thanks to the collective efforts of Humana's case manager and Beacon, HCS was able to identify that the member was in need of assistance and was able to help her get the medications she needed even though the member was reluctant to reach out to HCS for help.



A Humana – CareSource (HCS) Case Manager learned about a member from a provider's list of members who had not taken an A1C (HEDIS measure) test for their diabetes. The case manager contacted him and learned that the member has cancer and was not properly treating or monitoring his diabetes. She engaged him in case management to help him better manage his condition. After speaking with the case manager, the member agreed to allow her to make an appointment with his PCP as long as she met him at the appointment, to which she gladly agreed. At the member's request, the case manager agreed to stay in the room with him during the exam. After it was completed the case manager thoroughly explained his medications to him and the importance of keeping a record of his blood pressure and blood sugars. At his next appointment, it was clear that he had taken her advice to heart because she confirmed with his physician that the member had brought both records with him to the appointment.

The member is in regular contact with his case manager and continues to monitor his blood pressure and blood sugars daily. He will soon have surgery to remove his cancer, after which they are scheduled to meet again in person to discuss his recovery and develop a care plan for the future.



Passport

While working in a local primary care provider (PCP) office, a Passport Embedded Case Manager learned something troubling about one of our young members. He had recently survived surgery for a very serious condition, but now the PCP was unable to contact his non-English speaking family. While making a routine lab call, the PCP's office discovered the family had moved to another part of Kentucky to be near extended family. When the PCP office called back later to discuss continued care, the number had been disconnected. They were worried that the member did not have follow-up care established and that his parents might not understand the severity of his condition.

Thanking the PCP for this very appropriate and timely referral, the case manager immediately contacted the refugee agency in their newly-relocated area. This advocate connected her with the family, and she in turn was able to find a new PCP in their area who was willing to accept the member. The case manager helped his family schedule the first appointment, transfer medical records, and also contacted his cardiologist to reschedule his services in their local satellite office. Thanks to the case manager's help, this medically fragile child now has access to primary care and cardiology services he needs. The family is also more knowledgeable of the healthcare system and their benefits.

Kentucky is the 15th largest resettlement state in the U.S., and Passport serves many refugees who come to Kentucky.



A Passport member was recently hospitalized and diagnosed with Atrial Fibrillation, an irregular, often rapid heart rate that commonly causes poor blood flow and increases risk for stroke. When she got home, everything seemed fine except that she had continued questions and concerns about her condition. A Passport disease Manager addressed her concerns over the phone and helped her better understand her disease and how to prevent it. Thanks to the disease manager's help as part of Passport's Healthy Heart Program, the member is now more confident in her medication regimen, symptoms to report to her physician and overall management of her heart disease. In 2014, our Healthy Heart Program served 4,001 members in Kentucky.



After a very long year of gastrointestinal (stomach) misery with doctors searching for answers, a Passport member was finally admitted to the hospital for abdominal surgery. When she was discharged after being hospitalized for a full month, her doctor reassured her that Passport would help coordinate the care he was ordering, which included tube feedings (and a nurse to help her learn how to use it), personal care, new medications, PT, OT, nutritional supplements, supplies and equipment.

A Passport Case Manager became immediately engaged when the initial services were denied. Upon review, she quickly realized that the services were not being approved because the member's discharge had not been reported by a previous home health agency. The case manager contacted the agency and explained the process for them to report the discharge so that we could approve services through new agencies. Ultimately, with the help of three Passport Precertification Nurses, the case manager resolved the issue and the member began receiving services to continue her recovery at home.

"I was so touched by this member's situation," says the case manager. She has lost approximately 40 pounds this year because she couldn't take in any nutrition. I had a virus for about 3 days and experienced some of the nausea and diarrhea she had been experiencing for a whole year...that made me want to do whatever I could do to lessen her distress. Her current treatment seems to be working well which makes me very proud of our team and how we worked together to assist this member."

This member is one of just 231 members served by Passport's complex case management program in first quarter 2015.



When a Passport Community Engagement Coordinator attended the first Hardin County Interagency Council in January 2015, she had no idea meeting a case manager for the local mental health clinic would soon lead to helping a member in need.

A few weeks after the first meeting, the clinic's case manager contacted Passport's engagement coordinator about a client she was working with who had been auto-assigned to an MCO whose network could not meet his healthcare needs. The man wanted to switch to Passport because his physician and therapist were out of network, but due to mental health and language barriers (he only spoke Spanish), he was unable to navigate the system. Later that day, the clinic's case manager was able to provide the man with the instructions

so that he could contact the Department for Medicaid Services to consider his request to move to a health plan where his therapist and primary care physician were in-network.

This member is just one of many served through our Community Engagement team's important connections with 107 boards, committees, and advisory groups across all parts of Kentucky.

☪☪☪

A Passport member arrived for her children's appointments with their primary care provider (PCP). When he came into the room to meet with them, a Passport Embedded Case Manager noticed that the member clearly was not feeling well and had several symptoms including sore throat, nasal congestion, and coughing. After he completed his work with the children, the case manager asked the member if she would like him to assist her in making an appointment with her PCP.

She stated she did not have a PCP because she did not have insurance. With the member's permission, the case manager took the time to verify that she indeed had coverage. The case manager was able to obtain a PCP appointment for her that same day.

Thanks to the case manager's efforts, the member received treatment for her symptoms which could have progressed to a much worse state due to her other chronic medical conditions. She was also relieved to know that she did not have to suffer to the point where she felt she would need to visit the emergency room.

These types of efforts have helped Passport to obtain the following rankings for national HEDIS®** in 2014: Adults' Access to Preventive/Ambulatory Health Services 20-44 Years: 90.45 (95th percentile).

☪☪☪

A Passport member in her 50's is a cancer survivor. She also has chronic back pain and chronic behavioral health issues. "The member is a fighter," says a Passport Case Manager. "I have been acquainted with her since her initial bout with cancer a couple of years ago in which she almost died. I was so relieved that she survived that and knowing that she has to go through cancer again is very sad."

When the member approached the case manager several weeks ago and told her about some difficulties obtaining a CT scan from her radiologist, the case manager sprang into action. She contacted several individuals in our Rapid Response, Appeals, and Radiology areas, including another Case Manager, a Research Appeals Coordinator, Director of Utilization Management and a Clinical Programs staff member.

As a result of the case manager's assistance, the CT scan was approved and the member's scan was immediately scheduled by her doctor's office. It was one less issue for her to worry about in her upcoming battle against cancer. She is one of 1,225 members served in 1st quarter 2015 by our Embedded Case Management program.

☪☪☪

A Passport member has a history of heart failure and uncontrolled diabetes, as well as ongoing mental health issues. Over the past few years, he has been not been keeping his medical and behavioral health appointments. Throughout it all, a Behavioral Health Liaison has been by his side. She continually touched base with the member and attempted numerous times to convince him of the need to follow up with his PCP and mental health providers.

Thanks to the liaison's unfailing support, the member finally made it to the appointments with his PCP and mental health provider. He also promised her that he will keep his appointments in the future. "It was a real breakthrough," says the liaison. "He appeared to not be interested in following up with his physical and mental health issues for so long."

The liaison and member met face-to-face last week, and he stated he was very glad that he has been keeping his appointments. He also stated that he feels better and is now interested in trying to work with the young people in his neighborhood to try and steer them away from violence. The liaison suggested several programs for which he might be able to volunteer.

These types of efforts have helped Passport to obtain the following rankings for national HEDIS® in 2014: Adults' Access to Preventive/Ambulatory Health Services 45-64 Years: 94.78 (90th Percentile).

☪☪☪

A Passport Embedded Case Manager was scheduled to meet a member at her PCP's office for a check-up related to her asthma. Before she arrived, the case manager took the time to review her medical history and noticed an unusual dosing instruction for the member's inhaler.

By the time the case manager went in to meet the member face-to-face, he was able to speak with her PCP, give her accurate dosing instructions, educate her about asthma, and complete an Asthma Action Plan so

that future questions on dosing would be proactively identified. Robert also discussed why Rosie was non-compliant with medications and helped her understand the importance of taking medications every day, even when she felt fine. She is one of 1,225 members served in 1st quarter 2015 by our Embedded Case Management program.



WellCare

A WellCare of Kentucky Medicaid member contacted a community liaison at WellCare's toll-free Community Assistance Line (CAL). The member explained that although she thought the food pantry WellCare had previously referred her to would work, it was farther from her home than she realized, and she could not afford to travel to it.

The community liaison checked WellCare's HealthConnections Referral Tracker (HCRT), a database with approximately 9,000 Kentucky-based community organizations that WellCare refers its members to for social services support. When the liaison verified that there weren't any food banks in the data base that were closer to the member's home, she immediately submitted an urgent GAP services request. These requests alert the WellCare team to a member's need that is not currently served by the HCRT.

As soon as a WellCare community advocate received the GAP request, she began searching for a food bank closer to the member's home. When she found one, she contacted the organization and confirmed that they were open and available to assist the member. The advocate worked with WellCare's Case Management team to contact the member and provide her with the food pantry's address.

Because of the community liaison's and the community advocate's efforts, the member was able to make it to the pantry before it closed that day and received the food she needed to ensure proper nutrition for herself and her family. In addition, the advocate added this new food bank to the HCRT, so that WellCare could easily connect those in need with its services in the future.



A WellCare field outreach coordinator called a 35-year-old WellCare of Kentucky Medicaid member to check on her after a number of emergency room visits related to her kidney stones. The member, who also has ovarian cancer and hearing loss, lives with her mother and two sons, and works two jobs to make ends meet. She told the outreach coordinator that she had not been back to the emergency room because she had a new specialist treating her kidney stones. However, she did share that she needed, but couldn't afford, eyeglasses, hearing aids and a cell phone. The outreach coordinator assigned the case to a field service coordinator, to help the member with her request. The coordinator immediately scheduled to meet with the member in her home and checked WellCare's HCRT to find resources to help meet the member's needs.

During the in-home visit, the field coordinator helped the member fill out applications for eyeglasses through the Kentucky Vision Project, hearing aids through the Starkey Foundation, and a free cell phone from Safelink Wireless. As they talked, the member told the coordinator that she was worried about her 16-year-old son, who was also a WellCare member. He had recently begun cutting – making cuts on his body with a sharp object to break the skin and make it bleed. The field coordinator understood cutting because he had a behavioral health background. He explained how serious the problem is and told the member that teenagers typically cut as a way to cope with emotional pain, intense anger and frustration. He urged the member to get her son mental health counseling and provided her with contact information for a local mental health clinic. The member quickly scheduled an appointment for her son.

Because of the telephone assessment and the coordinator's ability to connect with the member in person, two members received the help they needed. The 16-year-old was able to get mental health treatment to provide him with better coping tools to stabilize his condition and improve his mental health and quality of life. His mother was relieved that he was getting help. She was also happy to have new eyeglasses, hearing aids and a free cell phone, which should help to improve her quality of life.



A 43-year-old WellCare of Kentucky Medicaid member with asthma, bronchitis and psychosis is hard of hearing and unable to speak on the phone. Her husband contacted a WellCare of Kentucky clinical social worker, when their power was shut off because they couldn't pay their electric bill. It had already been off for several days when the member's husband became concerned as weather forecasts called for the temperature to drop to eight degrees overnight.

The social worker immediately checked WellCare's HCRT for social services support. She located the Daniel Boone Community Action Agency which offers home heating help to eligible low-income households. Alena called them to find out what could be done and found out that the member would have to pay a percentage of the bill to receive the agency's help.

The member's husband told the social worker they did not have that much money and he asked her if she would call a customer service person at the electric company. She made the call and explained the situation to customer service and the member's power was back on within 30 minutes.

Because of the social worker's efforts, the member and her husband were able to receive emergency help so they could stay safely and comfortably in their home during a brutal winter storm. With the immediate crisis avoided, the member and her husband were able to find help from a family member who paid the percentage of the electric bill required for the Daniel Boone Community Action Agency to work out a solution with the electric company.

